PUBLIC HEARING

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

S-2005

(An Act establishing a youth suicide prevention demonstration program and making an appropriation therefor)

Held:
September 6, 1984
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Richard J. Codey, Chairman
Senator Francis J. McManimon, Vice Chairman
Senator Garrett W. Hagedorn
Senator C. Louis Bassano

ALSO PRESENT:

Eleanor H. Seel, Research Associate
Office of Legislative Services
Aide, Senate Institutions, Health & Welfare Committee

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SENATE, No. 2005

STATE OF NEW JERSEY

INTRODUCED JUNE 28, 1984

By Senator CODEY

Referred to Committee on Institutions, Health and Welfare

AN ACT establishing a youth suicide prevention demonstration program and making an appropriation therefor.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that the incidence of suicide among adolescents has increased alarmingly and suicide presently ranks as the second leading cause of death for adolescents between the ages of 15 and 24 years; that the increase in the rate of adolescent suicide is often associated with the significant changes in lifestyles, values and family relationships that are occurring in our society; that the occurrence of adolescent suicide is found among youth of all racial, social and economic backgrounds and even though suicide is underreported as a cause of death for adolescents, in 1982 114 youth suicides were reported in New Jersey; that mental health professionals believe that many suicides can be prevented through suicide awareness education programs in the schools and crisis intervention programs for adolescents and their families in the community; and that in order to ensure that the most effective prevention and crisis intervention programs are available and ultimately developed Statewide, it is necessary to establish a youth suicide prevention demonstration program in the State Department of Education which will be administered by local boards of education in cooperation with community mental health services providers.

2. The Commissioner of the Department of Education shall establish a program of youth suicide prevention demonstration

projects which shall be administered by local boards of education. The objectives of the program shall include but are not limited to the following:

a. Classroom instruction designed to achieve the following objectives: to teach students facts about adolescent suicide and how to recognize signs of suicidal tendencies; to inform students of available community services aimed at prevention of suicide; and to increase students' awareness of the relationship between adolescent suicide and drug and alcohol use.

b. Nonclassroom school or community based programs such as a 24-hour "hotline" telephone service staffed by trained professional counselors, crisis intervention and postintervention services and parent education programs.

c. Training programs for classroom teachers and guidance counselors in suicide prevention.

3. a. The Commissioner of Education shall prepare guidelines for the youth suicide prevention demonstration program. In addition to emphasizing the objectives provided in section 2 of this act, the guidelines shall foster cooperation between local boards of education and community mental health services providers.

b. The commissioner shall solicit proposals for demonstration projects from local boards of education interested in participating in the program.

c. The commissioner shall review the project proposals and approve and fund within the limits of monies appropriated for this purpose, at least two proposals which best meet the objectives of the demonstration program.

4. The Commissioner of Education shall report to the Governor and Legislature no later than three months before the expiration date of this act concerning:

a. The effects of the demonstration program on adolescents in the schools;

b. An assessment of the most efficient and effective methods for establishing youth suicide prevention programs in the schools and in conjunction with community services agencies;

c. The projected costs for establishing prevention programs throughout the State; and

d. Recommendations for establishing a Statewide youth suicide prevention program.

5. There is appropriated $75,000.00 from the General Fund to the Department of Education to carry out the purposes of this act.

6. This act shall take effect immediately and shall expire on September 30 following the third anniversary of the effective date.

STATEMENT

The incidence of adolescent suicide has grown alarmingly over the last 20 years, from a rate of 5.2 per 100,000 youths in 1960 to a rate of 12.5 per 100,000 in 1980. Suicide is now the second leading cause of death among adolescents aged 15 through 24. Professionals agree that no single theory can account for all suicides and no single measure can prevent them; however, the increase in suicides among adolescents is often attributed to the pressures that the changing values, lifestyles and family relationships in our society have placed on the adolescents. While suicides cannot be prevented in all cases, many experts agree that suicides among adolescents can be reduced through organized programs in the schools and in the community which teach adolescents, their parents and teachers about suicide and how suicide may be prevented.

In response to the need for organized programs dealing with adolescent suicide, this bill establishes a demonstration youth suicide prevention program in the Department of Education. The Commissioner of Education is directed to establish guidelines for prevention projects which will be administered by local boards of education in cooperation with community mental health services providers. The commissioner will solicit proposals for model projects from local boards of education and select and fund at least two projects for the demonstration program. The bill appropriates $75,000.00 to carry out the program.

The demonstration program will operate for three years and at the end of the program the Commissioner of Education is required to report to the Legislature and Governor on the effects of the program and provide recommendations for establishing suicide prevention programs Statewide.

SENATOR RICHARD J. CODEY (Chairman): I would like to start this morning's public hearing, please. My name is Senator Richard Codey; I am the Chairman of this Committee. We have with us this morning Senator Garrett Hagedorn of Bergen County, who is also a member of this Committee.

We are all aware, of course, of the subject matter for discussion. I would like to start with our first witness, Lieutenant Governor Alfred DelBello from the State of New York. Mr. DelBello, please.

LT. GOVERNOR ALFRED DelBELLO: Thank you very much, Senator. Senator Codey and members of the Committee: Thank you very much for having us today, but more importantly, thank you for taking the time out to have a hearing on this particular piece of legislation, and most importantly, on this subject.

I have not prepared formal testimony for the record today only because of the very short notice I had. However, we will be distributing to you a white paper that we are using nationally, which is a captive way of stating the subject in six pages. We think we hit the highlights of the importance of the subject before us, and we would like you to have that for your own purposes, and for your record.

My contact with the problem of youth suicide goes back to the days when I was County Executive of Westchester County in New York. It was brought to my attention through the Mental Health Department of our County that the incidence of teen-age suicide in high schools was starting to concern our people. It was going up, and it was going up in some of the best schools. We reacted to it as so many other public officials did by building into our normal program efforts. At that time, we had a Student Intervention Program, and we merely built in a component to deal with what appeared to be, although a very serious problem, one that had not overtaken us as a crisis.

I then went on to become Lieutenant Governor of the State of New York, not giving too much attention to the youth suicide problem until survivors -- parents of those young people who took their lives -- started to describe to me in detail the extent of the problem on a national basis. I have to admit that I was, quite frankly, shocked. I had never for a moment witnessed or experienced the fact that over

6,000 killed themselves last year, a number that is so gross that when we compare it to other serious kinds of problems that induce death, it stands out. Just to give you one example we use to point up the drama of this, during the entire Vietnam Wa,r 6,000 lives a year on an annualized basis were not lost, and yet our teen-agers, our youths, are destroying themselves at that rate.

So, it really is a national crisis by all of its dimensions, by the very nature of the fact that we are killing off our young people, or allowing them to kill off themselves. And yet, when you look across the nation, you don't see a strong reaction. People are concerned, but there is very little going on, less going on in government circles than really in the private voluntary sector. And, that is a concern to me. As the parents -- whom we call survivors -- came forward, one of them addressed my staff not too long ago and said, "If there is another teen-age suicide, you people will be accomplices to murder." That might be an overstatement, but I understand that and I think you do also, Senator. What it really means is that we have been ignoring the problem for too long. We have not taken an initiative that I think has been commensurate with the extent of the problem. We are trying to do that now.

I have been across this country speaking about this issue with a degree of effect, but not the kind of effect I think we should have. We have a national committee established now which I am cochairing with a person named Charlotte Ross from California, who is a professional who heads a suicide intervention program. We have representatives in all 50 states. The purpose of this committee is to cause to be established a national commission on youth suicide to investigate the problem and to come up with some answers, if possible, to develop model programming, disseminate it to the states throughout the United States, and come up with a valid statistical base. We know that the statistics we are using are fallible and inaccurate, but yet they are the only ones we can use. I can go into that further with you about how some areas of statistics are totally misleading.

So, there is a national effort under way, but it is not receiving the kind of attention that it should to mobilize the political system, and to mobilize the mental health and health systems

in this country to cause a response equal to the epidemic that is under way. That is why I was most anxious to come testify this morning. You are taking a step that I think is extremely important. You are officially recognizing the problem and initiating something legislatively to start dealing with it. I think the State of New Jersey should be extremely interested in your initiative in this case. Let me say, however, that New Jersey is certainly not behind in the subject. The greatest assistance we have received as a committee, the greatest assistance I have received individually, and my staff has received, was from New Jersey -- Bergen County, New Jersey. You are going to have the Director of that Program, Diane Ryerson, testifying before you very shortly. Diane has helped us tremendously with a program that we feel is one of the most successful ones in the United States of America. You have it here in New Jersey. It is so good, as a matter of fact, that we are stealing part of it from you. We are starting a pilot program in Putnam County, New York, and Diane Ryerson and her staff -- the Bergen County people -- are designing that program and are training our educators and our mental health officials in Putnam County. On September 24, we expect to kick off a pilot type program on a countywide basis that is really the result of New Jersey and Bergen County's contribution to New York State.

With New Jersey taking the lead, with you, Senator, propelling it in the Legislature, and with Bergen County being very experienced and very expert in this, I would love to see New York and New Jersey lead the way. I would love to see us begin sharing information and sharing experiences, as we are already doing between Bergen County and Putnam County, but more on an official statewide basis. Our experiences in New York have been very severe, and yet we do not have the programming in place that we need. I think New Jersey has taken the lead in program efforts. We are going to learn from you, and we would hope that you can learn from us.

So, I wholeheartedly support your legislative initiative. Seventy-five thousand dollars may not appear to be a great deal of money, but because we do not have too many answers, it is enough money to start pilots so that we can get some answers and so that we can get some experience. We are proposing to do Putnam County with $52,000 --

$26,000 state money and $26,000 matched from the local community. If people try to criticize the amount in this bill, I think they are wrong and do not understand the problem. I wish I had $75,000 available to me right now to go out and start a few more pilots. I think we will be getting it in New York.

So again, I wholeheartedly support the thrust. I point out the fact that your Bergen County is extremely experienced, and I would highly recommend that you use it for source material, experiential data, and program design. We are using Bergen County as such, and we thank you for that. Again, good luck, and if there is anything we can do together, I would most certainly be happy to cooperate.

SENATOR CODEY: Mr. DelBello, this morning I read some transcripts of a show that you participated in -- the Phil Donahue Show. In it you spoke of that national commission. Could you explain that just briefly?

LT. GOVERNOR DelBELLO: Well, in getting close to the problem, getting to understand it more, looking at the statistics, talking to survivors, and talking to professionals, mental health people -- and I might say I have talked extensively to teen-agers-- I happen to be a strong believer that if we are going to deal with a youth problem, we ought to be talking to the youth, not the adults. I have rapped with youths for many hours to find out whether or not they agree with what our views are. One thing becomes apparent: It is a national problem. It is not a local problem; it is not a state problem. There are 17 to 18 young people killing themselves everyday in every socioeconomic bracket, in urban America, in rural America, and in suburban America. The publicity and attention is brought to what we call the "clusters." When there is a cluster of suicides in one area, all the T.V. cameras, photographers, and reporters play it up big, ignoring the fact that in another community, in another area of the country, ten minutes later, a half hour later, or an hour later, another teen-ager has killed himself -- 17 to 18 a day.

So, it is a national problem of national epidemic proportions, and it is happening in every walk of life. No matter who you talk to, no matter how professional -- psychiatric, mental health officials, health officials, or teen-agers themselves -- they will tell

you that no one actually has a handle on it. There is no common strain that you could put a label on and say, "That is the cause or relationship." Because of that, I think we need a national commitment. We need a focus by Congress and by the President that says, "This is of epidemic proportions. It is dealing with our most precious commodity. We have to get to the bottom of it. We have to find out, no matter how difficult and traumatic that experience may be." I say this because I happen to believe that what we will be doing will be going right into the depths of our own society, of our own institutions, of our own family make-up, and of our own religious beliefs. We are going to find a lot of problems in the way we do business today as adults, which I think is part of the problem that is impacting our young people. But, we need a national commitment. This problem cannot be solved by passing a law. If we don't like the rate at which teen-agers are killing themselves as a result of drinking, we raise the age for DWI from 18 to 19, to 20, to 21, and as politicians we feel that we have done something, and we probably have. If we do not like the rate of deaths in auto accidents, we pass laws concerning air bags and safety belts, and we have done something. But, we cannot pass a law that is going to affect the rate of youth suicides. Therefore, we have to do something that commences a process by which an understanding can be derived, and I think that process has to be a national commitment through a commission of very heavyweight, prominent individuals, citizen types, survivors and professionals.

We are recommending a commission of 21 people, and that commission has to have as its goal a three-pronged attack. One is research and investigation, commiting national researchers to investigate what is happening in society today that is causing an increase in the rate of youth suicide.

Secondly, the development of a reliable data base. We know there are coroners, medical examiners, and law enforcement officials who, recognizing a suicide, do not even report it as such out of pure sympathy for the family. You can recognize that that is a human response, but it tends to distort the figures. For example, we are investigating in our state the single-occupant automobile accident, because it is believed that a lot of those are intentional deaths or

suicides, even though they are recorded as automobile accidents. I could go on and on about situations that are inaccurately recorded.

The third purpose of this is to help us as states. We should have national models of intervention and awareness programs. We should have national testing of programs to find out which ones are reacting in which ways, so that as you initiate legislation, such as you are doing, as Bergen County works in New Jersey so successfully, we would have results of that work and we could measure it and say, "That is the kind of program that would be best suited to my Putnam County, Westchester County, or New York City. We do not have that kind of Federal assistance, so the National Commission on Youth Suicide is designed to provide us with that result.

I guess as a fourth purpose, it automatically elevates the awareness of the problem in the minds of parents and guardians to start getting concerned. I did a radio program on this subject not too long ago, on WOR, and I received a phone call from a man I know who told me he was driving-- I think he was coming from New Jersey to New York; he was going to his office. He just happened to be on the road while this program was on the air and he listened to it. By the end of the program as he got closer to his office, he said, "Damn it, what am I going to my office for? Let me go see my kids. I don't spend enough time with my kids." He went home and spent two hours with his kids, and then he went to the office. That is just awareness; that is just exposing people to the fact that they cannot consider their children beyond the realm of this problem. So, I think awareness is a very important aspect of everything we are doing.

SENATOR CODEY: Senator Hagedorn?

SENATOR HAGEDORN: No questions.

SENATOR CODEY: Mr. DelBello, would you agree that the problem does not seem to go to any economic class of people, any race of people, or whatever, that it seems to cover the whole spectrum of society?

LT. GOVERNOR DelBELLO: It certainly seems to. You are going to have people testifying before you who are far more expert than I, and I do not pretend to be an expert or intend to become an expert in this field. I think your job as State legislators and my job is to

create a dynamic from which experts can get the resources and assistance to do the job. But, from the contact I have had with the subject over a period of time, I agree with that statement totally. It seems that youth suicide is occurring in urban areas, in suburban areas, and in rural areas, in every socioeconomic bracket. The press likes to focus on the upward mobile communities that have suicides because that seems to be a contradiction that makes good reading. They do not focus on a poverty kid in an urban area who intentionally overdoses, intentionally jumps off a building, or something. That is not great news. We have to get a broader exposure to the whole subject, and I think the media has a very direct responsibility in this area to inform people of what is going on on a fair basis. I might say that the media is reacting. There are dramatizations being prepared. There is a CBS dramatization that will be shown on October 30, a full-length movie on the case history of a teen-age suicide. I think it is going to be very dramatic, very informative, and very provocative, and will start the public becoming more aware of the problem. But, yes, it is right across the board, right across our country.

SENATOR CODEY: Senator McManimon?

SENATOR McMANIMON: No questions.

SENATOR CODEY: By the way, Mr. DelBello, you mentioned before about stealing something from Bergen County. It seems we have stolen so much from New York and put it in Bergen County that you are welcome to something.

I just want to thank you ever so much for coming here and focusing attention on the problem that we both face, not only here in New Jersey, but, of course, where you reside in New York. As I have said to you before, my awareness of the problem came from living in northern New Jersey and reading so much about the problem that received a lot of press attention in Westchester County. So certainly, in a way, your own neighborhood has brought the problem to us. Again, on behalf of myself and my Committee, we thank you for coming. I would just ask you one favor, sir. When you finish, could you please go outside the room and let the press talk to you so we can continue our hearing? Thank you very much.

LT. GOVERNOR DelBELLO: Thank you, and good luck with your legislation.

SENATOR CODEY: Our next witnesses will be Marsha Heiman and Rick Lamb from the Rutgers Medical School in Piscataway. Good morning.

MARSHA HEIMAN, Ph.D.: Good morning. My name is Marsha Heiman and I am a licensed Child Clinical Psychologist at the University of Medicine and Dentistry of New Jersey, Rutgers Community Mental Health Center. I want to thank the Committee for its interest in the topic of youth suicide. I welcome this opportunity to address what I consider to be an alarming social problem, namely, the death of a young person by suicide.

Most adolescents have depressive moments and think about suicide. What is unfortunate is that too many of those adolescents are now turning those thoughts into action. As you may already know, suicide is the second leading cause of death among adolescents aged 15 to 24, surpassed only by accidents. Throughout the country, approximately 18 adolescents kill themselves daily. For every recorded suicide, two or three deaths may be certified as accidental that were actually completed suicides. For every completed suicide, anywhere from 50 to 100 suicide attempts are made. Before you are statistics compiled by the New Jersey Department of Education on both the overall suicide rate for each county in New Jersey, as well as suicide rates for adolescents. This year alone in New Jersey, a 15-year old male shot himself; a 16-year old male threw himself in front of a train; a 14-year old male and a 12-year old male died by hanging; and, a 14-year old female and a 15-year old female ended their lives with guns. There were 13 other young adults in their early 20's from New Jersey who died this year by suicide. I know of these particular young people -- and I am sure there are a lot more I do not know of -- because their families attend a survivor suicide group at our mental health center. I can't tell you what devastating effects a teen-age suicide has on a family, a school, and a community.

It is a myth that childhood is a happy, carefree time. The changing values, lifestyles, and family relations have placed an enormous strain on our young people. I feel we live in a society that does not teach frustration tolerance, delaying of gratification, or

problem-solving skills. Our culture abounds -- and this is what concerns me the most -- with constant messages that suicide is an acceptable answer or solution to a problem. I want to just take a minute to cite you an example of a song that was written and recorded by a popular artist. It was the song that was found on a New Jersey adolescent's stereo the night he killed himself. The song was written by Elton John and Bernie Taupin and is entitled, "Think I'm Gonna Kill Myself." It says, "People rushing everywhere, swarming around like flies; think I'll buy a forty-four, give'em all a surprise. Think I'm gonna kill myself, cause a little suicide; stick around for a couple of days, what a scandal if I died. Yeah. I'm gonna kill myself, get a little headline news; I'd like to see what the papers say, on the state of teen-age blues." What I want to draw your attention to is the fact that this is a song that is often played and heard by adolescents. There are four things that are really important. Number one, it talks about suicide and outlines the actual method of suicide. It talks about immortality and about the grief reaction of survivors, which is a real glorification of suicide, and, lastly, it is certainly a cry for help. This song is a very clear illustration that our youth are not innocent in their knowledge about suicide. The problem, however, is that adolescents have distorted, inaccurate, and oftentimes misleading information about the topic. My concern is that our silence about suicide as adults only makes the issue more mysterious, adding to the long list of forbidden but tempting fruits.

Historically, we have shied away from introducing information on suicide and depression. Often given as a reason for not educating youth is the fear that talking about the subject will cause it to happen. Another frequently cited objection is the fear of manipulation, that is, the notion that adolescents will use suicidal messages as threats or emotional blackmail to gain desired results. I don't think we can allow these fears to immobilize us any longer from taking preventive action. To paraphrase Charlotte Ross -- who was already mentioned today-- She has been very instrumental in getting legislation passed in California. When she was trying to address what these concerns and fears are, she said -- and I think it is very well stated -- "We cannot any longer allow our fear of manipulative

adolescents, who are really oftentimes the exception, to deter us from educating, because that is really like failing to install fire alarms for fear that children will ring them falsely." So, we can't let this fear immobilize us any longer.

We have a suicide prevention project at our center and for that, we have become convinced that education is actually the only way and is the key to prevention. Schools provide the unique opportunity for reaching our young people. Students, teachers, and guidance personnel need to understand the problem and need to know what they can do to prevent suicide. I want to emphasize that it is fear, not lack of concern that immobilizes a school system, and it is a lack of skills, not indifference toward doing something, that renders school professionals unable to act effectively. In our project, we have four key components we have been instituting in various counties in New Jersey. One is teacher awareness training. Here we have designed a one-day intensive workshop to increase teacher awareness and sensitize them to the warning signs of suicide and depression. The goal is merely to help teachers become better observers of student behavior, to create an awareness of the potentially high-risk student, and to acquaint teachers with procedures for how and when to refer students for help. What we stress to teachers is -- and I think our emphasis has made teachers very receptive to coming on board as far as wanting this kind of education -- that we are not there to teach them to be counselors. They are not in the role of treating adolescents. All we want them to do is identify those students and then refer them to the people in the school who are more in that role. That has really alleviated their fears that they are going to be stuck with doing things like counseling.

A second component is crisis intervention training. Here we have done intensive workshops, either in the format of a two-day intensive workshop or an eight-week, two-hour course that is directed at child study team personnel, guidance people, nurses, and even administrators, to really teach them specific skills and increase their comfort level in direct intervention. Our training model combines a cognitive and effective approach, utilizes small groups, role-plays, video tapes, and demonstration interviews. What I want to emphasize is

the fact that we have found, our experience says that cognitive information is not sufficient to address the problem. You really have to deal with school personnel on how they feel about the subject. You have to walk them through exercises like talking with adolescents. For example, you have to do things like getting them to say to adolescents, "I hear you are feeling depressed. I hear you are feeling bad. I'm wondering, have you ever had any thoughts about hurting yourself?" Just those statements create an enormous amount of tension, so we do a lot of work to just get them to say those kinds of statements.

A third component of our program is school consultation. What we do there is more of a system level consultation, helping schools devise procedures and policies for what you do when there is a threat. That is a very important part that needs to be instituted. I can give you an example of one school in which they had no policy for an adolescent who threatened suicide, or who had made an attempt. An adolescent took a handful of pills. It wasn't a lethal dose, but it was certainly something to be concerned about. The school had no policy and they decided to treat it as drug abuse and, therefore, suspended the student for five days. I certainly don't have to tell you that that could be very detrimental and could have devastating consequences.

Another part of our work which has certainly been a very sad, touching part is to consult with schools once there has been a completed suicide. We have gone into schools and worked with them about their survival guilt, how they feel about it, as well as going in and helping them to minimize the contagious effect, which is a real problem once there has been a suicide.

The fourth component is student curriculum development. Here we are still in the planning stages. What we have been doing is networking with existing programs. Colorado and California are implementing curriculum right now to try to compare notes and find out what other people are doing. From our experience in networking, as well as working directly with schools, there are several components that we have become convinced must be put in place in a curriculum, and I would just like to very quickly outline those.

The first is that information on the signs of suicidal tendencies must be included, along with information on depression. Both of those are very important. A second thing is that students need to be taught decision-making and problem-solving skills. Information about the relationship between drug and alcohol abuse and suicide needs to be given. And, what I consider as probably one of the most critical components in student curriculum is that you need to address issues of peer loyalty and methods for helping students respond effectively when their peers give them suicidal communication. Lastly, you need to inform students of available resources.

I want to emphasize the importance of developing student curriculum. All of our studies document that adolescents turn first to their peers for help, not to adults. In every school which we have consulted following a successful suicide, we were informed that students, not adults, knew of the friend's intent. The friend had actually called someone and said, "I think I am going to kill myself." Students did not tell adults because, number one, they thought, "No, my friend is not serious," and, number two, they felt they would be betraying a confidence or breaking a loyalty. This is a cardinal sin for adolescents. That is why they really need help in processing that issue. Therefore, I really believe that since adolescents are likely to fall heir to the rescuer role, they need to be equipped to deal with this burden. I want to stress that curriculum certainly needs to be carefully developed and delivered by trained professionals in a sensitive and thoughtful manner. Student curriculum can only, and I want to underscore "only," be introduced after school professionals have been trained and policies have been made in the schools.

I want to end by strongly endorsing this bill. I can't tell you what a delight it is to see such a bill. It is really a step in the right direction. I would like to suggest, however, that the legislation take a very strong stand on delineating the joint role between educators and mental health professionals. Schools absolutely cannot be left alone with the burden of suicide prevention. They are not equipped for the task; it is simply not their primary role. Instead, what really needs to happen is educators need to join forces with mental health professionals, and together, with each of their

particular areas of expertise, they must share the responsibility of helping our young people struggle through their problems and teaching them alternatives to suicide. I don't think we can wait any longer to take action. Instead, we need to move forward in a very planful, reflective way to establish programs that can address this national epidemic. Thank you.

SENATOR CODEY: Do you have any questions, Senator McManimon?

SENATOR McMANIMON: I think she pretty much covered all bases.

SENATOR CODEY: Senator Hagedorn?

SENATOR HAGEDORN: I have one question. You mentioned awareness and, of course, the bill we are addressing today is concerned with our educational institutions. Should we also have an ongoing program to alert and educate parents that they should become more aware so that they might also help in that direction?

DR. HEIMAN: Absolutely. I think that one of the things that parents often say to us after a child has completed suicide is, "I saw things, but I just didn't think he would really do it. I had those thoughts as a youngster; I survived it." That is one of the myths that they carry with them sometimes, the fact that their child will survive it. So, I think that is an excellent avenue that also needs to be explored.

SENATOR CODEY: The statistics that you gave us, where and how were they compiled?

DR. HEIMAN: These are from the New Jersey State Department of Education. The Department made them available to me. They are also old; they are from 1981.

SENATOR CODEY: I understand that the Department of Health does not even keep these statistics. Is that correct? (no response) For some reason, we were unable to get up-to-date statistics from the Department of Education, so we do appreciate them even though they are somewhat old.

DR. HEIMAN: I want to also draw your attention to the fact that New Jersey, at least in 1981, was somewhat below the annual average. However, if you look at it by county, what you see is that, in fact, there are some counties that are higher in the adolescent

suicide rate than in the overall suicide rate. Cumberland County, for example, has a very high rate.

SENATOR McMANIMON: Thank you very much. We appreciate it.

FREDERICK LAMB: I, too, want to thank this Committee for giving me the opportunity to testify and, more importantly, thank this Committee for being here. My name is Frederick Lamb. I am a social worker and a mental health administrator. For the last five years, I have been the Administrative Director for Youth Services of the Community Mental Health Center of Rutgers Medical School, University of Medicine and Dentistry of New Jersey.

In that capacity, I have the administrative responsibility for a variety of programs for children and adolescents, including two-day hospital programs, an in-patient psychiatric unit, and an emergency screening and evaluation unit. I have also been personally involved in the development of the adolescent suicide prevention project at our Center, and in providing training and consultation to other professionals, including school personnel.

I welcome the opportunity to testify before this Committee and I very much support the proposed legislation establishing a Suicide Youth Demonstration Program involving a partnership between public schools and community mental health agencies. I believe it represents a practical and constructive step toward strengthening the State's resources in dealing with the problem of teen-age suicide.

I would like to focus my remarks on the present system of services for suicidal adolescents and how the enactment of this bill will complement that system. As you are probably aware, the State has been divided into various regions for the delivery of emergency psychiatric services to children and adolescents. Our Mental Health Center, located in Piscataway, has been designated as a Regional Center by the Department of Mental Health and Hospitals, providing services to Middlesex, Monmouth, Ocean, Somerset, Hunterdon, and part of Union County. There are about two million people in that area, and about 300,000 adolescents. Within each of these counties, one or more mental health facilities has agreed to act as a primary resource for troubled adolescents. They refer adolescents to us when they cannot provide services, or if they feel hospitalization is indicated.

Concern about suicidal potential is the number one reason for referrals of adolescents to Regional Center services and the number one reason for the admission of adolescents to our psychiatric hospital unit. In Fiscal Year 1984, we received over 1,400 phone calls about troubled adolescents. We saw 408 adolescents, often with their families, for the purpose of crisis intervention and evaluation. We admitted 165 adolescents to our psychiatric unit. The threat of suicide constituted the reason for admission in over 55% of these cases. No other single problem came even close. My contacts with professionals in other regions suggest similar phenomena.

It is my general impression that this system of emergency services is working reasonably well and that we can help teen-agers who are referred to us. However, no emergency service can help the child they do not see. Unfortunately, adolescents rarely seek professional help on their own. They need an adult to guide them in the right direction. Often, of course, it is the family who can provide this guidance, but sometimes, for all kinds of complex reasons, families do not recognize the warning signs or cannot cope effectively with the problem. This is where I believe the public schools can help. No other institution has access to so many adolescents for such a prolonged period of time. This provides the schools with a unique opportunity to observe teen-agers as they deal with the social, academic, and developmental stresses of this critical period of their lives. Thus, schools could become a critical early warning system that would identify and refer for help potentially suicidal adolescents. The schools also have the opportunity to engage in primary prevention by educating students about depression and self-destructive behavior.

I believe this legislation represents an efficient and effective approach, providing the tools that the schools need to do this job. However, I do have some suggestions about the implementation of this legislation which I believe will maximize its potential benefits.

My first suggestion is that emphasis needs to be given to staff training over curriculum development or the establishment of specific intervention programs with students. I say this because in my 15 years of experience working with troubled adolescents and the adults

who work with them also, it has been my experience that no issue causes more stress for professionals or the systems they work for than the threat of suicide by a teen-ager. We all have strong personal reactions to issues such as death, suicide, and depression. Add to this the anxiety anyone must feel attempting to prevent the death of a child, and you get some idea of the kinds of feelings that professionals must master when they try to make interventions in suicidal crises.

Individuals who are not in control of such feelings, no matter how well-intented they are or how knowledgeable they are on the topic theoretically, can do more harm than good. It is for this reason that the training program developed by our Center-- We spend as much time on feelings about suicide as we do on the facts of suicide. We also work with school systems in the development of comprehensive suicide policies and procedures, something that almost no school has. This lack of policies and procedures is probably, in itself, a kind of systems anxiety, especially concerned about legal liability.

My second suggestion is that this legislation not be implemented in such a way as to seem to place yet another burden on the public schools to do someone else's job. Schools should not be expected to become mental health facilities. What this bill calls for, as I understand it, is cooperation and collaboration between schools and mental health agencies; however, it must be a collaboration that respects the appropriate boundaries between the different functions of these two systems.

This leads to my final suggestion. In the real world, two highly complex bureaucracies, like the education system and the mental health system, often have great difficulty working together. Bureaucracies, like adolescents, sometimes need a gentle push to do the right thing. I am concerned that in this case without that push, there might be a tendency for either system to try to develop a program without sufficient input from the other. To counter this, I would like to see added to the legislation more specific language spelling out the requirements for mutual cooperation. One possibility might be to require a purchase of service agreement between the local school and the local community mental health agency.

Thank you, again, for giving me this opportunity. I would welcome any questions or comments you may have.

SENATOR CODEY: Thank you, Mr. Lamb. Are there any questions? (negative response) All right. Some of your suggestions are already under consideration and the others will be considered when we do the bill in Committee, which will be shortly. Thank you very much, Mr. Lamb.

Our next witness will be Mrs. Margie Maloney.

MARGIE MALONEY: Senator Codey, first I would like to congratulate you for doing what you have done so far. I really hope we can get something worthwhile going, not only in New Jersey, but in the whole United States. I am the parent of a suicide so, of course, I feel very emotional about this.

SENATOR CODEY: Take your time.

MRS. MALONEY: On February 26, 1980, our son, just one month short of his nineteenth birthday, drove a car into our garage, closed the doors, stuffed rags under the doors, started the engine, and laid down for the last time with his head at the exhaust pipe. It was a senseless death, as all teen suicides are, perpetrated by a confused boy who had some solvable problems and mistakenly thought that life was not worth living. He was probably typical of youngsters who attempt or succeed in killing themselves and have very mixed feelings to the end as to whether dying was the answer.

Suicide is preventable. The perpetrators really only want to solve their problems and make the pain and anguish they are experiencing go away. They do not really want to die. This is subtantiated by studies of people who seriously tried, but failed to complete the act. If suicide is preventable, then we must do what we can to prevent it.

After the death of our son, we read everything we could find on the subject of suicide in an effort to understand what had happened and why. We soon realized how vital it would have been to us to have known before our son took his life what we now know. It became very apparent to us that we must share this new awareness and knowledge with other parents, teachers, and teen-agers, so other families would have a chance to avert the tragedy that had befallen us. We began to receive

requests from churches and PTA's to speak; we appeared on panels and numerous T.V. shows; we helped students with their theses and research papers; and, what is most important to you, we were asked to speak to the health classes at our local high school. This request, by the way, was after pressure was exerted by the students and the faculty. The parents and faculty thought that we should not speak to the students. We had spoken to the parents, and they did not want the students to hear about it.

The students wanted to discuss and understand what was on their minds. Never do yourself or others an injustice by thinking this is a subject that should not be discussed for fear it will get someone thinking about suicide who might not have thought about it otherwise. One high school did not address the subject after a suicide, but after additional suicides in rapid succession, they realized that the most intelligent approach is to get the subject out in the open and to properly address it.

After our classes with the students, we received many letters from them. I would like to read you a few comments taken from those letters, and I have brought some excerpts that you may peruse if you wish to. (The following are excerpts:)

Craig: I thought your presentation was very sincere and effective. It really hit home with everyone, and one person I know of in particular took it straight to heart and realized the stupidity of the way he was thinking.

Kelly: It -- suicide -- is rarely talked about or even thought about which is why it is such a problem. It is vitally important for people to be able to pick up the suicide signs of someone else.

Jim: The talk helped me see the problems of a friend who is always giving warning signals and had attempted to take her life. Now that I see the problem, and with the help of your talk, I can help her.

Kevin: Your presentation helped me realize that everybody has problems and that sticking it out is the always the best solution.

Robin: I only wish there were more people like yourself to visit kids and to give them an insight on suicide.

These few statements give you an idea of the impact on students when you do talk about it. You tell them the warning signs if they have friends or perhaps they take it to heart themselves. They want to hear about it. They want to discuss it. They are scared, especially when they hear about a suicide.

In our little town of Berkeley Heights we average one reported suicide a year. I know every year of several that are not reported suicides. That is a small town.

How can we stem the tidal wave of teen suicides? There are several positive steps that can be taken. They take planning, dedication, and money. Education of parents, teachers, and teen friends, as to the danger signals and trigger mechanisms that are so common in most cases, is one important cornerstone of prevention. Certain behavior, changes in behavior, and statements made are played over and over again in the scenario of youths in despair, contemplating the final way out of their troubles.

Suicides do not exclusively occur in broken homes or homes where there is poverty, crime, incest, and all those things. In fact statistically, the biggest rise in adolescent suicide is in the middle to high-income suburbs, where there is generally stability and love in the family and other children in the family who are fine.

Many loving, caring parents are oblivious to the meaning of their child's actions. Their heads are in the sand like an ostrich, not seeing, not wanting to contemplate that their child might be thinking of taking his life. I understand this. I was one of them. We need to confront them with the possibility and educate them as to what signs are significant and what to do about them. Teachers, counselors, and coaches, too, need to have this kind of information as they see our children, especially our teenagers, as many or more hours a day as we parents do and have the opportunity to aid in detection of a possibily troubled youth.

Equally as important are the adolescent's friends. It is typical after a completed suicide for friends to say they knew how troubled the youth was or even that they knew he or she was contemplating suicide. They may have been sworn to secrecy or afraid to interfere or just didn't know what to do with the knowledge. They

too must be educated as to what to do and the importance of breaking a confidence in this case.

Then there is the adolescent who is considering suicide. We must try to get several things across to him:

1. He or she is not alone in having times of despair and difficult problems to confront.

2. All problems are solvable.

3. Suicide is a permanent solution to those temporary problems.

4. There are a lot of people out there who care and want to help and who have the wherewithal to do so.

Please put the money where it is so needed. Ass yourselves how much it is worth to save a youngster. Think of a youth close to you. How much would you pay to save his or her life? Thank you.

SENATOR CODEY: Thank you ever so much for the courage to come here this morning and talk out. We deeply appreciate that. Thanks again.

Our next witness will be Michael Salvatore. Thank you for coming.

MICHAEL SALVATORE: Thank you for affording us this opportunity and taking the courageous step that is needed. As you have already heard this morning, the topic of suicide and the epidemic of suicide with our youth is one that no one wishes to address. I think your actions are very commendable. What can be done in the form of this legislation is much needed to get pilot projects started and to address the problem.

Our daughter, Colette, committed suicide two years ago in November. She took a shotgun to her head and we found her at home. We were not aware that she was going to commit suicide, obviously. We would have done whatever we would have had to do to prevent it. I feel it was quite circumstantial. There was no note; there was no evidence of any particular problem other than what all adolescents, all teenagers, go through. What we see as adults as non-problems are major consequences for some of our children.

I am a participant of the group at Rutgers Mental Health Clinic. We gather monthly to try to support each other. Those of us who have experienced an anniversary -- that is an anniversary of the

death of the suicide of our children -- can share with the new members of the group who have not had their first anniversary or have not been through their first Christmas or the first birthday without their child. Each of those times that are joyous for all of us are also very, very painful. With what you are attempting to provide, you will hopefully not have persons like myself and Mrs. Maloney here to share with you the by-products of solving the problem, problems, or what seem to be problems of our youth in a permanent manner.

I am available for any questions.

SENATOR CODEY: Mr. Salvatore, like Mrs. Maloney, I really appreciate your coming out here under the circumstances. Do you have any other children?

MR. SALVATORE: Yes, we have one son.

SENATOR CODEY: What was the effect on your other child of the suicide?

MR. SALVATORE: Unfortunately he is bottled up. He is not addressing the problem, the issue. This is not atypical. What we have found by sharing with other persons who have siblings, is that this is one of the big problems which has not been mentioned -- the sibling survival. I think sibling survival is now coming on the national forefront focus. What happens is that parents-- Usually when you suffer a death in the family, you are in a grieving process. It is either the wife's or the husband's parent and one is available to support; here, both have a difficult time attempting to support the other. While they are in their grieving process, the siblings, their other children, are kind of possibly neglected. It is almost a chicken and egg situation. What comes first? Do you neglect them or not identify them because you are in your own shock, in your own world, or do they try to insulate themselves from it? Say for instance, they are not being a problem; then you can deal with your own grieving process. But what we have found out by experience is that most siblings almost try to shut down. For a couple of years they are strong and carry this load and don't share. Later, two, three, four, or five years down the road, they start their grieving process and their impact is tremendous. I think one of the aspects that should be addressed in the pilot -- and I am glad you asked the question -- is to deal with the survivors, the sibling survivors.

SENATOR CODEY: Mr. Salvatore, what was the reaction of your daughter's friends to the suicide? What kind of conversations did they have with you and your wife afterwards?

MR. SALVATORE: The conversations were of disbelief. As a matter of fact, for almost a week, up until the time of the funeral for Colette, her friends called in disbelief. They wanted to speak to Colette. We constantly received telephone calls from her friends. This was not accepting. They talked about her in terms of her having a difficult day that particular day. That particular day seemed to be an up day. Both my wife and I had taken our son to visit a college, and Colette was going to have a friend over and go to a basketball game that evening. She was going to cook dinner and have it prepared for us. As she left she was kind of cheery and said, "Okay, have a good day; I'll see you when you get here and I'll have dinner ready." Great, and so-and-so, whom she had discussed the evening before, was going to be there with her. As we understand from her friends, this other girlfriend of hers who has going to accompany her that evening was ill and couldn't make it, and some other typical everyday teenage-kind of situation arose with friends, and we found her at home.

SENATOR CODEY: Any questions? (negative response) Once again, thank you very, Mr. Salvatore.

MR. SALVATORE: Thank you.

MRS. MALONEY: Could I make a comment?

SENATOR CODEY: Mrs. Maloney, sure.

MRS. MALONEY: I just wanted to comment on helping the siblings afterwards. I think in your program it is important to let the schools know how important they are. My then-10 year old was with me when I found my son. She was involved in calling the rescue squad and that type of thing, so it wasn't just something that was told to her. Intuitively, it was wonderfully handled by the principal of her school. It made a great difference in her recovery to be treated pretty normally and not to have a lot of questions and this type of thing. He really did her a great service. So, this is an important part of the whole program. If you haven't been able to prevent a suicide, you may help a great deal in the recovery of the siblings. School situations are very important.

SENATOR CODEY: Thank you very much.

Our next witness will be Mr. Cas Jukubik from Summit High School.

DR. CAS JAKUBIK: We also would like to thank Senator Codey and the other Committee members for inviting the Summit district to participate in this hearing and thereby give us an opportunity to describe a program of suicide education that was implemented at Summit High School. It was started in the school year, 1981-1982.

Actually what prompted us to investigate this area were the suicides in Ridgewood, Chapagua in New York, and also our own experience in Summit, which started back in 1972, when a youngster killed himself with a shotgun. Back in 1980 we had two suicides in proximity to each other. Unfortunately one of the suicides was the son of Mrs. Maloney, who is a witness today.

We started to look at Ridgewood and spoke with the school psychologist there, Dave Mattis, who, I suppose, became an expert by experience. He spoke with our Board of Education, PTA, leaders, clergy, and other interested people in the community. The community gave it a great deal of support. Dave also gave talks at our district in-service programs which are well attended by teachers. It seemed to us at the time that the teachers were very aware of what was going on, and by their attendance showed a great deal of interest.

However, those of us who were involved in the program became convinced that to just work with teachers and administrators was not enough. We felt that there should be some direct communication, direct contact with students. Therefore, we began to look for a curriculum which we could use with our students directly in the high school. We were able to contact the Director of Community Education at St. Clare's Hospital in Denville. There may have been more resources at the time, but we were not aware of them. The Director of Community Education came over and spoke with us; she was the person who introduced this program into the Summit district.

Let me characterize the program initially. It is educational in nature. It is not group therapy. It does not have a clinical intent nor does it make the school the treatment center. It focuses directly on students, as I said, and their needs and struggles, not

just on faculty sensitivity or helping the faculty to identify symptoms in youngsters, although there is a component in the program for faculty. One of the things that we had to deal with internally was, again, here is one more thing for the school to do; there is family life education, driver education, and a whole list of other things. We felt, and we felt very strongly, that this program was a necessity because basically the school is a life-supporting institution, and we felt that because of this, we must pay attention to this problem. We can't become another school that has turned its back on this serious problem. We can't be another school that gives into denial.

What I would like to do is just very quickly run through a description of the program, just to give the Committee an idea of the components of the program.

At the present time there are three sections: what we call a beginning curriculum; an intermediate curriculum; and an advanced curriculum. Each one was developed annually based on our experience in the prior year.

The first one is basically on a cognitive level, where we tell the kids the incidence of suicide among adolescents. We present facts, misconceptions, and myths about suicide in general. The other things we do is to teach them the possible warning signs of suicide.

The next thing we do is-- Okay, when you notice the possible warning signs of suicide, what should you do? Specifically what we teach the kids to do in the classroom is to ask "Are you considering killing yourself?" Other question to ask that may follow that are, "How have you thought about doing it? Have you thought about when you would do it?" Each time there is a response to this, it denotes a certain level of seriousness. At one point we would say to a youngster, "If a student were to answer these questions in certain ways, you really should not leave your friend. What you should do is seek help without leaving the person physically." If it is something less threatening or something that is just a passing remark by a youngster, we ask the students to go to see someone in the school, preferably a counselor, possibly a teacher, possibly an administrator, or someone whom they trust in the schools, and these people are identified to the kids in the classroom. They are told, "These are the people whom you would come to for help for your friend."

In terms of community resources, we distribute wallet cards to each youngster in the school as part of the class. On this wallet card are the possible signs of suicide, some of the questions to ask as a reminder, also community resources, and hot line numbers to call if something were to happen on a weekend or at night or at some other inopportune time.

The second part, the intermediate curriculum, is experienced by that student who has experienced the beginning one and is more affective in nature. Part of this is a movie about a youngster who has committed suicide and the feelings that are involved. Feelings are evoked from students and a discussion is held. Again, we review warning signs of suicide and try to improve their skills or remind them of their skills of what to do.

The final one is the advanced curriculum given to our seniors. Basically what we do is try to equip them with the skills that they will need because, from now on -- after graduation -- they will be off somewhere else. We won't have access to the kids. We try to tell them that most likely, outside of their parents, they will probably never get the individual attention they received in high school, and that they should be pretty self-sufficient in terms of skills to help either themselves or someone who they know who may be in danger. Part of this third curriculum is an audio tape of a social worker interviewing a person who just tried to commit suicide about two weeks prior to the making of the tape. Then there is some exercises, discussions, and those kinds of things about the problem-solving techniques that this person should be using at this point. Problem-solving techniques are a very important part of the advanced or final curriculum.

Just some miscellaneous points: A number of prior witnesses have emphasized the importance of training for those people who would implement any program, no matter what the program is. This is critical because of the sensitivity of this particular issue and the institutional characteristics of our schools. In terms of in-service, this particular program, because the people who implemented it were all counselors, it took a morning to bring it to fruition. Part of the in-service was a demonstration class by the person who was presenting

or leading the in-service. She would actually go into one of the classes and provide a demonstration class, so that the people who would be implementing the program, in this case, the counselors, would be sitting there observing what was going on. There would be less anxiety on their part.

The people who we look to train -- although it doesn't always have to be a counselor; there could be other staff members such as teachers, administrators, or child study team members -- should be characterized by their approachability by kids and other staff, and the fact that they could be somewhat comfortable with the material. We look for a person who is nonjudgmental in nature or who is able to be nonjudgmental, a person who is basically life-affirming, a person who is basically willing, but hesitant and a little careful and aware of the complexity of this type of approach. We look for a person who is also willing to participate in training and not just bring a lesson plan into a room, a person who is willing to read and be aware of what is happening in the world around him, and a person willing to read articles in newspapers, magazines, and so forth even after training.

A question which arose was, will the program plant the idea of suicide in students' heads? The experts who live, eat, and sleep suicide say, "No." There is no proof of this; however, we had to go with the people who are doing this for a living, who know pretty much what is going on, although it is intuitive.

We feel what it does, on the contrary, rather than plant the idea, is it gives the kids permission to talk about suicide, and that is very, very important. Society denies it, as previous witnesses have said. Peers have a loyalty to each other, the same way they wouldn't turn in a youngster who threw an eraser at a teacher in the classroom when his back was turned. They feel the same sort of loyalty, and yet what has to happen is that the staff member has to get beyond this loyalty, to say the right things, and to provide a place for a student to come if he wants "to tell about a peer."

The other thing we had to deal with was the directness of the program. Some people wanted to call it an "Adolescent Depression Program." We felt this type of approach would be another denial of the reality. Kids are aware of suicide. Kids are aware that other kids

commit suicide. It is just that if you were to call a program "Adolescent Depression," it would just be trying to brush the problem under the rug. We would be teaching kids that is not something to really talk about.

Implementation is relatively simple. All we did was -- we are a three-year high school -- we took all the biology classes for sophomores, and English III and English IV classes for juniors and seniors. It is in a sense a one-shot deal; the beginning curriculum is a one 45-minute to an hour presentation. However, what we do is require the teachers to be present, which increases their sensitivity, and as a result the entire school is somehow being trained and sensitized. What happens is, we have faculty coming to us all through the year saying, "You really should take a look at so-and-so. This is what he said the other day. This is what he wrote in my English composition assignment the other day. This is what he drew at the top of the essay that I assigned," and you see a tombstone with the youngster's name on it with RIP under that. This kid would get immediate attention.

Finally, the program that has been in existence in Summit for the last three years is certainly not a panacea. We feel that the program may help prevent unnecessary deaths and unnecessary pain on the part of the educators in the district. After a suicide there is typically a lot of guilt feelings because people might say, "Why didn't I say something." There is a lot of scapegoating, such as, "You didn't say anything either," and that sort of thing. We feel fairly confident that in our school the students, the administrators, the teachers, the counselors, and the child study team members are very, very knowledgeable about the signs and symptoms of suicide, and what to do about it.

In terms of evaluation of the program, we have gotten only narrative answers to, "What do you think of the program?" from kids, and I do have a list of those things. I have a copy of the program if the Committee wants to examine it; the caution is, again, that in-service training is critical. We are very happy in Summit to endorse this particular bill. I think it is very important. I think it is also going to force school districts in the State to face their denial.

I know a situation where a counselor in a school district called the Child Study Team school psychologist and said that she was concerned that one of her counselees was in an emergency situation with regard to suicide. This particular school pyschologist -- and certainly most would not respond in this way -- said that he didn't want to get involved because of a possible lawsuit. This counselor was also bounced at the end of the year because she took it to the principal and then to the superintendent, but nothing was done by that school district with that particular kid. She was given a notice at the end of the year.

So, the bill, if anything -- and it will do many things -- will force schools to pay attention.

SENATOR CODEY: Thank you very much. We appreciate it. Eleanor Seel will be in touch with you with regard to your program. Thanks again.

Diane Ryerson of the Bergen Regional Counselling Center.

DIANE M. RYERSON: Good morning, Mr. Chairman and members of the Committee. I am Diane Ryerson, and I am very, very pleased to be here and to have been invited today to appear before this distinguished Committee to testify on Bill 2005, "An Act establishing a youth suicide prevention demonstration program and marking an appropriation therefor."

First, I would like to tell the Committee something about my professional background and my reasons for being so concerned about the present major social problem of adolescent suicide.

I am Director of Consultation and Education Services for the South Bergen Mental Health Center, Inc., and its affliate, the Bergen Regional Counselling Center. Together we service approximately 22 communities for a total population of 360,000 people in central and southern Bergen County.

I am a certified social worker, and I am a graduate of Columbia University. My duties include the training of school officials, teachers, and students in a wide variety of mental health-related areas. However, for the past four years one of my most important duties has been the development and the implementation of adolescent suicide prevention programs in Bergen County.

I am also the mother of a soon-to-be-adolescent daughter, and I recognize the need to have her and her friends educated about the reality of teen suicide and what they can do to monitor their friends and also to keep an eye on their own mental health.

The background of our program: Several years ago the Executive Board of our Center and also the staff and the management team began to focus on the dramatic increase in teen suicides in the County and also in the State and in the nation. I'm certain -- well, I know now after having to listened to all the other witnesses -- that you are all familiar with the statistics of the State of New Jersey. They have been presented to you in very dramatic and effective terms, so I will bleep whatever I was going to say in that area.

Our organization, as a mental health center, deals with the consequences of mental health and emotional illness and trauma. We see, consult with, and treat people who have been impacted by an adolescent suicide. We recognized, when we first started thinking about prevention programs, that the development of the school-based community program, which would educate school officials, parents, teachers, and students themselves to the growing danger of adolescent suicide, had the potential for reducing the suicides in this age group.

Our agency then decided to start a program in 1981. By the end of this year, December 1984, our program, which is titled "Recognizing and Preventing the Self-Destructive Behavior of Adolescents," will have been presented to the staff of all the public senior high schools in our service area, all of the junior high schools, and 15 additional schools. We will have trained over 3,000 educators in adolescent suicide prevention techniques by that time. To date, it is about 2,500. We have several workshops scheduled for the fall.

We also have included a number of other schools at their request. We have done programs in parochial schools, in vocational schools, and in special needs schools. We have found them all equally receptive to the program.

We have also given the program to 600 tenth-graders during the past three years. Most of the schools in which we have given an

educator or a student program have also sponsored parent education workshops, and more than 700 parents have participated in our workshops to date. Again, we have a great number of workshops planned for this coming academic year.

While there is no statistically-verifiable data to prove that our program was responsible for the reduction, I am pleased to report to you that there has been a significant decline in adolescent suicide in Bergen County over the past two years, countering a statewide and national trend. In 1980, there were 16 documented suicides in the adolescent age group; in 1982, there were 11.

I would like to give you a quick overview of our comprehensive adolescent suicide prevention program, which is called "Recognizing and Preventing the Self-Destructive Behavior of Adolescents." When we first started the program, we elected to focus on self-destruction rather than on just suicide, so we wouldn't limit the program just to a suicide prevention program. Also, when we started the program it was before any suicide had taken place in any one of our particular towns, so we wanted to alert people to possible self-destructive behaviors rather than react to problems that already occurred.

The management of our organization became increasingly concerned about the number of depressed and potentially suicidal teen-agers on our caseload. Concurrently, we were receiving lots of requests from local school counselors and adminstrators for the development of some kind of effective method of dealing with depressed students. It was at that time when we were pondering the development of a pilot program in 1981 that we were approached by Mr. Frank Acocella, the physical education supervisor for River Dell Regional High School. Mr. Acocella was looking for assistance in developing an adolescent suicide awareness curriculum. River Dell is also, by the way, the school that was recently visited by President Reagan and Governor Kean in recognition of their alcohol awareness program, which was also initiated by Mr. Acocella. Mr. Acocella is here today, and perhaps it might be helpful for us to give you an idea of how a school system and a mental health system work together. We can do that later if you feel that would be valuable for you.

It was with River Dell's farsightedness and cooperation that we developed our initial program. It took a lot of courage on the part of their administration and board to get into a suicide prevention program before there was a suicide. We really applaud their initiatives in this area. They made it possible for us to develop the student-portion of our program.

After we had done pilots in River Dell, we selected several additional schools as pilots and spent the next 18 months revising and improving our program. We have received invaluable input over the years from school administrators, teachers, students, and parents. Everyone in the community from the mayor to the local police chief has had something to say about our program and how it impacts on their community.

Our approach was developed since its inception as an awareness and a prevention program, rather than as a response to a tragedy that had already occurred. Since it was developed in a deliberate and considered manner, we had the time to work out major kinks and to rearrange implementation strategies without the understandable pressure that might have arisen had we done so with the aftermath of a tragedy. We are convinced that our approach has been correct. I think that many of the other people who have testified today have added fuel to my fire in saying that we believe that there must be a connection between the mental health providers and the local educators in order to have a good program.

A comprehensive description of our program is available, and I would be more than delighted to share it with you or members of the Committee. Since other witnesses have spent some time detailing the kind of content that goes into these programs, I won't go into that in detail, but I would be more than happy to discuss it with you at another time.

What I can tell you is that our program does have all of the elements that are enumerated in the pending legislation. We have classroom instruction for high school students. We offer seminars for school administrators and teachers. We offer seminars for parents of students, both in high-risk groups and just the average student. We have a 24-hour emergency crisis service. We also offer follow-up

treatment and hospitalization for potential suicidal teenagers if that is indicated.

In addition, we recently developed an implementation strategy for assisting school systems that have suffered a tragedy -- a suicide or perhaps the death of several of their students in a car accident or a similar tragedy. We also developed and have had in place for about three years, a self-help group for survivors of suicides. It is run by one of our board members who is also a social worker, and she is also a survivor herself. Mrs. Josephine Pazaressi is here with us today. She is also on the statewide committee for impaired physicians and does a lot of consulting with them regarding suicide in physicians.

At this time we are also working on developing an adolescent self-help group; that is on the drawing board. Another thing that has come to our attention is that we have had a number of colleges in our service area and in Bergen County, and we know that the highest rate of suicide is at age 18, so to put programs just in the high school may not be enough. We are beginning to develop a strategy for introducing similar programs into local colleges as well.

Our program has attracted a fair amount of attention and we are very gratified by that. I should tell you that we had guiding goals to our program; it is really our overriding philosophy on how we approach teen suicide. These have been in place since the beginning of our program.

The first is to disseminate essential information to communities about the causes and warning signs of adolescent suicide and how individuals, be they parents, educators, or kids themselves, can help in a suicidal crisis, information on where they can go in the community for help, and how they can utilize existing community services. Other witnesses have also said that this is a critical issue in their communities.

Our second major philosophy and probably as important as the first is to forge lasting relationships between school systems and community-based mental health services, thereby ensuring that adolescents at risk are identified early, and we get the help for them in a timely and appropriate fashion.

Our teen-age suicide prevention program has attracted widespread attention. We constantly receive telephone calls and letters from mental health organizations, schools, parents, and concerned citizens in other states and counties. The electronic and print media have done a number of programs and stories which have contained interviews from our executives. A number have featured our program in action. They have actually come into our schools when we are working with the kids and the teachers. A television station is now preparing a story on adolescent suicide prevention. Our program will be highlighted in that story. We have presented outlines of our program to numerous professional and citizens groups around New Jersey. We have given the program to a number of schools that are outside our service area. In addition, we made presentations to the New Jersey Education Association at their annual convention, and we will be back there again doing our number this year in Atlantic City. We have also talked with Bergen County superintendents, Bergen County guidance counselors, who have been tremendously supportive to our program, and the New Jersey Supervisors and Principals Association. We have a number of things lined up this year that we will be moving on to.

We recognize that one of the greatest strengths of the program is its ability to link together the schools and the mental health providers. As a result, we no longer will do a program outside our service area. What we have designed is a training procedure in which we train mental health agency staff to deliver our program to the schools in their service area, independently of us. They utilize our program and our consultation, but they do the actual delivery. What happens as a result of that is, the school systems and the people begin to build the linkages with their community health provider, rather than the outside expert who does a program and leaves.

The Bergen County Mental Health Board, together with our local advisory committee on alcoholism, has been very enthusiastic about our program, and the Bergen County Mental Health administrator is here today to testify. Those two groups have appropriated funds to enable us to train the staffs of the other community mental health centers in Bergen County, so we will be replicating our program through

local mental health providers and local school systems over the next year.

Our program has also attracted some national attention, and I was very gratified by the kind comments of Lieutenant Governor DelBello earlier today. We are going to be serving on his committee on youth suicide prevention that he is chairing with Charlotte Ross of California and we are very pleased by that. Both California and New York have made major commitments toward developing suicide prevention programs. We at South Bergen Mental Health Center, Inc. are very pleased that ours has been selected as a pilot program for New York State. We will beginning the Putnam program in the near future.

I would like at this point to just make some specific comments on the proposed legislation. First of all, we are delighted by this legislation and wholeheartedly support the objections of the act under discussion. We are most grateful that this farsighted legislation is now on the drawing boards of our New Jersey Legislature. Thank you.

We would like, however, to make some recommendations which we believe might further strengthen its effectiveness.

In Section 3.a. the text reads as follows:

"The Commissioner of Education shall prepare guidelines for the youth suicide prevention demonstration program. In addition to emphasizing the objectives outlined in Section 2 of this act, the guidelines shall foster cooperation between local boards of education and community mental health services providers."

We would like to offer the expertise of our agency's staff to the Commissioner in preparing the above-mentioned guidelines. For example, we have found in our rather extensive experience that it is very inadvisable to begin working directly with students in the school system before preparing the school environment properly. The reason for this is the material that is covered in any adolescent suicide prevention program is of an extremely sensitive and volatile nature. Perhaps the most important consideration is that adolescent suicide prevention programs should impact on the entire school community. The order in which the training and consultation is provided, we have found, to be critical to the success and the acceptance of our

program. Prior to working with adolescents themselves, it is essential that the educators be trained. When we say educators we mean everybody in the school from the secretary and school nurse to the superintendent and all administrative staff; it is just not the teachers themselves. As one other witness mentioned, it is also essential that a procedure be developed for managing potentially suicidal adolescents. This is critical. This procedure should include, at minimum, a well-developed referral network with local community mental health providers and private practitioners. To be realistic, many of our students don't necessarily go to the local mental health center for treatment; they go to a private practitioner. They should know what is going on in the schools and be able to network with us as well. We also think that there ought to be a very strong connection with all drug and alcohol facilities in a service area, and that is very important in our program."

Next, in Section 3.b., the following language appears:

"The Commissioner shall solicit proposals for demonstration projects from local boards of education interested in participating in the program."

We would like to suggest that this language be modified to include proposals from local boards of education and/or community mental health providers. By funding projects through organizations that cover larger geographical areas than one local school system, two significant benefits can be realized. First, the project can be made available to a large audience more quickly and more economically. Second, by funding community mental health centers, the project can effect a significant change in the relationships between the local education and mental health systems that will promote cooperation in identifying and managing our youth at risk.

In Section 3.c., the proposed legislation reads:

"The Commissioner shall review the project proposals and approve and fund within the limits of moneys appropriated for this purpose, at least two proposals which best meet the objectives of the demonstration program."

May we respectfully call to the attention of the Committee that a great deal of work has already been done in this field in New Jersey, and I think we have certainly seen that here today.

We would suggest that the Commissioner of Education be given the latitude to review the track records of existing operational adolescent suicide prevention programs within the State to determine if one or more of these meets the legislative mandate. Should the Commissioner find this to be the case, the Commissioner should further be permitted the option to select one or two believed best to meet the needs of New Jersey. This approach may reduce significantly the time and the funding required to develop a suitable statewide suicide prevention program.

In conclusion, the South Bergen Mental Health Center, Inc., supports the legislative objectives of Senate Bill 2005, and we offer our assistance in any form that would be helpful.

We strongly believe that a statewide effective adolescent suicide prevention program given in all schools in New Jersey, both public and private, be implemented within 18 months from existing programs, such as ours and others that already exist in the State. These programs may, of course, need to be modified, but a great deal of developmental work has already taken place. An effective adolescent suicide prevention program should be implemented as rapidly as feasible to prevent unnecessary future deaths.

The time has come for state governments to mobilize the many and varied resources within their state boundaries to conquer this second-leading killer of our young people. We sincerely applaud your initiative, and we offer any expertise and knowledge that we may have to this social imperative.

We would like to request that the record be held open so we might be able to comment or respond to other witnesses' testimony, if that seems like that is indicated.

May we also offer the Committee, as exhibits, several printed brochures and newspaper articles which go into more depth about the "how to" part of it, which I think we can forego today.

I shall now be pleased to answer any questions you may have. I want to thank you very much for permitting me to appear and to testify today. We are very enthusiastic about your legislation. If you have any comments or questions, I would be happy to take them.

SENATOR CODEY: Senator Hagedorn.

SENATOR HAGEDORN: I just have a comment. I am very proud that I have you in Bergen County and for the record that you certainly have established. I am familiar with the South Bergen Mental Health from way back. We are proud to have you here.

MS. RYERSON: Thank you very much. That is very nice to hear.

SENATOR HAGEDORN: We look forward to your help as we develop the program.

MS. RYERSON: Good. We would be very happy to provide any kind of assistance that we can.

SENATOR CODEY: If you could, after the hearing is over, provide our staff person with the brochure, I would appreciate that.

MS. RYERSON: Fine.

SENATOR CODEY: Thank you very much, Ms. Ryerson.

MS. RYERSON: Thank you.

SENATOR CODEY: You are welcome. The next witness will be Frank Acocella from River Dell Regional High School.

FRANK ACOCELLA: I, too, would like to thank the Committee for allowing me to come here today and speak to you. In fact, I wouldn't have missed it; I found out about it and I was very happy to have the opportunity.

I have a varied background. I am a certified guidance counselor. I have a B.S. degree and an M.A. degree in Administration Supervision. I am certified as an administrator and as supervisor and, as I said, a guidance counselor. In addition to just being involved with physical education, health, and driver education, I think I am able to put everything into perspective. The result is that I think my purpose here today is many-fold.

I would like to make a statement. I would like to express this: A program in the prevention of teen-age depression and suicide should be offered in every school. Then I think about what I said, and I think it should be mandatory much the same as drug education, family living, alcohol education, and tobacco education. We see and we know. All kinds of statistics were put forth here today. I have a folder full of newspaper articles that we have been gathering. Personally, as

I gather them, I tend to get sick to my stomach when I see what is happening throughout the states, especially in the State of New Jersey.

I feel that we have an obligation to educate our youngsters as well as others -- this means parents and educators -- on how to deal with this problem.

We also have a secondary problem which I think has to be addressed. Few schools, administrators, districts, or communities want to admit that they have a problem. Let me say that no school or community is immune. I think that is proven over and over again.

My purpose, then, is to inform you that River Dell Regional High School, in conjunction with the Bergen Regional Counselling Center, has developed a program that is working in all respects. As I go along I will try to explain various facets of it, if I can. I would like to move along with you.

I provided you with a copy of a text, which Ms. Ryerson and myself co-authored, that will appear in the fall issue of the Principals and Supervisors Association of New Jersey. In it, I think it gives a good explanation of our program. The key to the program is that it exemplifies school and community cooperation to solve a common problem. No one can do it alone. We don't have the facilities. I don't think we have the expertise. We don't have the resources. I have listened to the other people make statements, and I think I hear the same thing being said. We attempt to try to make use of all available resources.

As you heard Diane Ryerson say, we have made presentations of this program to various organizations, such as the NJEA. We have been videotaped by Channel Two and Channel Nine, and it has been presented on television. Miss Ryerson appeared on the Phil Donahue Show, and you heard that.

We have to ask ourselves, how successful is this program? As another person also said, hard statistics are sometimes very difficult to come by. But I can say this, and I offer myself and my system as an example, that the parents want it. When we presented the program to the senior high school, the junior high school parents wanted to know why they were left out. As we presented it to various schools in our

general area and the surrounding area, we got the same type of reaction; that is, why don't we have it and why don't we get it? We find out then that not only do we have to develop a program on this level, but on the junior high school level, the elementary school level, the college level, and so forth. It almost becomes an impossible task. But, I think we have to make an effort.

We have nothing but positive results from parents who have been involved with the program. As Ms. Ryerson said, we also make presentations to parents' groups, P.T.O., and the like.

We have conducted student surveys for each of the programs that we have presented. They are positive in all respects, always on the upper level. In fact, we can't get over how similar they are. This tells us that the students want this type of program. They are looking for it, they need it, and they appreciate it.

We also get positive results from the administration. We see the other districts in our general area -- and Ms. Ryerson also mentioned this -- just about every school in Bergen County is going to be or has been exposed at all levels to this program.

The program has been offered in four schools as teacher training, student training, parent training, and so forth. You also heard Lieutenant Governor DelBello say that it will be used as a pilot project in Putnam County and also possibly it will be adopted by the State of New York.

I personally would like to see this program or something similar adopted by the State of New Jersey.

Administrators, school districts, and communities have an obligation; if they are not offering such a program, then they are not aware of statistics and they are not facing facts. This is very difficult for them to do because it is very difficult for them to admit that they have a problem. When I go out to speak to some groups, I like to hold up a picture -- it's a picture of a group of empty seats -- and I say to the administrators, "You can't teach to empty seats. You can't teach if that kid is not there and he has committed suicide."

As educators, we should be able to say that we have done all that we can to prevent a tragedy. Then, and only then, have we met our obligations and responsibilities to educate our youth in this

particular area. River Dell, in conjunction with the Bergen Regional Counselling Center, has a working, proven program. Use their experience in disseminating the information; use their expertise and ours because now we have trained people to deliver the instrument. We are available to offer our services. I think it is an excellent example of school/community cooperation and the sharing of responsibilities. It is a hands-on program.

The program is not a one-shot deal. The program consists of four hours -- either four one-hour sessions or two two-hour sessions. Basically it is presented by the mental health agency staff, assisted by our staff members -- guidance counselors, child study teams, psychologists, physical education department staff, and social workers. They work in a large-group situation for the first hour, then break up into smaller groups and begin to go over a lot of information material, such as signs, symptoms, self-analysis, and what have you. They make themselves visible. Every youngster who goes through that program knows that such-and-such is available in an area. They know the name and where this guidance counselor or child study team member is located. They know also what agencies are available in a community. They come back in the next few weeks and they go through other areas of self-analysis. They go over, maybe, an example of a person who has committed suicide and try to pick out signs and symptoms. They go through a list of things that they might do to help themselves or to help their friends.

We have approximately 25 people directly involved in this program. Three years ago we began a pilot program consisting of 50 to 60 tenth graders. Two years we again ran a pilot program because, frankly, we were amazed at the results and the reactions, which were positive. Then last year, we offered it to every tenth grader for a four-hour program. Last year, the first three sessions were predominantly taught by the mental health agency and assisted by our people. The last session was taught by our people -- our staff -- and assisted by the mental health agency. This year when we present the program it will be solely presented by our staff.

What I am trying to say is that money then is not a problem. The moneys that we have and that we use is kept within a district, and

it does not require an expense by our school system or any other school system that uses this program. It is then a self-sustaining program. The people are visible. Our agency is available on call to us, and from there on in, it is our baby.

I would like to say that I am happy and pleased that we were able to get together with the Bergen Regional Counselling Center, and in particular Diane Ryerson; I think we formed a perfect combination and I hope we can be of service to you.

If you would like to ask me any questions, I would be happy to answer them.

SENATOR CODEY: Thank you for testifying, sir. As we said, we want a brochure of the program, not only for us here, but I would like to take it back to my own community and show them.

Are you originally from East Orange?

MR. ACOCELLA: That's right. I am very familiar it. If I may also just add one thing -- as Ms. Ryerson mentioned, President Reagan came to commend our school on our alcohol awareness program. What we are doing now is combining both programs because we have an on-site counselor to deal specifically with these areas. The concern of alcoholism, of drinking and driving, and teen-age suicide are all being put into one pot, so to speak, and treated as a common problem, which it is .

SENATOR CODEY: Thank you again, Sir.

Mr. Ernest Salerno and Ms. Lorraine Licata. Are you going to both testify at the same time? (affirmative response)

ERNEST SALERNO: My name is Ernie Salerno. I am a school social worker in Monroe Township in Middlesex County. We thank the Committee for having us here today to testify on behalf of this bill. I realize that we are running into the lunch hour and we really do not have a formal presentation -- we were notified quite late -- so I thought what we would do is give you kind of an overview of what our district went through last year after its first suicide. I think this overscores the need for a systematic and joint venture between mental health people and school districts to provide an ongoing service to the local boards of education.

Monroe Township is a combined rural/suburban type of district. We have 2,500 children. Like many other districts, we did very little thinking about the suicide issue. We were aware of it. Certainly the papers played it up. We had not experienced it, so nothing was solidified within the district.

In May of last year, unfortunately, we had our first completed suicide. I can share with you some of my personal frustrations and upsets. I have been a social worker for 20 years and had experienced, I thought up to that point, just about anything, in terms of human problems and difficulties. I felt confident in dealing with them and responding to them. When the issue of suicide came up and the event happened, I was very scared, frightened, and upset. Certainly a degree of guilt came over me. As a team -- which Ms. Licata will discuss in a moment -- we were kind of looking around for help. We didn't know what to do exactly and where to go. Fortunately, we did hook up with the people who testified earlier from the Rutgers Mental Health facility -- Mr. Lamb and Dr. Heimen. They were able, literally, to calm us down and say, "We realize what you are going through. These are the steps you can take to get back on the right track."

Through their help, we were able to set up parent groups -- a general open-house forum for parents -- to vent their feelings. After that, we had meetings with the teachers, both the complete staff of the school district and then, more importantly, the local school district where the suicide child happened to attend. There were intensive meetings held with that staff, and more particularly, with the actual teachers that he had. It was surprising how much guilt was felt by the staff, and this certainly had to be dealt with. Rick and his people helped us a great deal with it.

I think to underscore the need for continual service, I'll let Lori get into the further health growth of the suicide.

LORRAINE LICATA: We were braced from research while going through journals, that after a completed suicide, there would be a contagion effect, and indeed there was. That following school year, we had nine attempts that required hospitalization. We have five suicidal gestures that were caught in time. By that, I mean superficial cutting of the

arm or a mild overdose of pills, etc. We were overwhelmed as a school, and we were overwhelmed as a child study team.

I think that in taking a look at the child who committed suicide, he was not your classic stereotype. There were no indicators that he was suicidal. I had him in a group of boys who just had mild school problems. During my weekly meetings with him, none of the depressed indicators came out. He was a sensitive boy from a good, loving, intact family, but he was torn between peer expectation. He was not a loner; he was a very popular kid. I just want to make that point because we are not dealing with the classic loner who doesn't have a lot of friends.

One of the things that we ran up against during this subsequent year was a lot of parental resistance to acknowledge the fact that, indeed, their children may be at a risk. I think this is one of the things that has to be a focal point in your program.

The second thing is, the peers have to have confidence that they are not breaking a loyalty by coming for help when one of their friends speaks to them about a suicide intent. One thing I have to go back to is, this boy who did commit suicide telephoned five of his peers, warned them of the suicide, and thanked them for being his best friends. To me and to everyone involved, that was his call for help. There was another child upstairs in his house. The boy who committed suicide went downstairs, fired the gun, and then came upstairs and talked to the other child. Then he went downstairs and put the gun to his head. He didn't want to kill himself. He wanted help, and he didn't know where to turn. He was turning to his peers.

One of the other issues is the need for a 24-hour hotline. This happened before school. Things like this usually happen after school hours.

Then you get the gray area that the schools have between parental rights and child rights. If a child comes to us seeking help, telling us that he wants to kill himself, we refer him to the parent. If the parent will not acknowledge the fact -- because they feel it is a reflection on their parenting skills -- there is nowhere for the school to proceed after that. We can't put the parent into jail; we can't force the parent to get help for his child. There is a liability

factor involved. Parents have to be educated that it is not a reflection on their own parenting skills. The more publicity that is put out about this -- it is an epidemic that people have this problem -- I think the more results will come from that.

SENATOR CODEY: Are there any questions? (no response) Thank you both very much; I appreciate it.

Our next witness will be Mr. Dennis Crowley from the State Department of Education. I would appreciate it if our next witnesses would limit their remarks to about four or five minutes.

DENNIS CROWLEY: I am Dennis Crowley. I am the Legislative Liaison for the Department of Education. I would like to join the rest of the speakers in commending and encouraging this Committee to look into an issue of such importance. We share your concern.

It seems as though the activity of today's hearing has been a gathering of what is already going on in New Jersey. I think that theme was begun by the Lieutenant Governor from New York who said that New Jersey was, in fact, one of the leaders in this area. It seems as though the testimony has borne that out. We don't seem to be facing the question of, "Should we be doing something?" but, rather, "How can we best coordinate all of the many things that are going on in New Jersey in this area?"

Let me add a couple of pieces to the mosaics so that for your benefit, you will be able to know, as you deliberate on this bill in later sessions, what the Department of Education has been doing in this area.

In 1980, the Department's Division of Personnel Services became aware, much in the same way everyone else has become aware, of the issue of teen-age suicide -- adolescent suicide -- among the school children of New Jersey. They began to look around for projects that might reflect the kind of thing that could be duplicated across the State. It was a very primitive attempt to find out what the state of the art was.

There was a joint conference sponsored by the Department among guidance counsellors and social workers across the State to further explore the issue of what was taking place.

In 1982, the Department was able to obtain a small amount of money from what was known as the "Regional Resource Center" of the Federal government to fund the development of some technical assistance materials to provide to the local teachers in local districts, so they would have some understanding as to what they could or could not do about it. This has been finalized, and in the spring of this last year, we field tested in a small pilot sampling of about 150 practitioners -- classroom practitioners -- from what we call "Regional Curriculum Service Units" across the State. We provided them with a draft of a training manual, and I'll describe the contents of that training manual in just a moment. We provided them with a training manual which employed a turn-key approach in the hope that we could spread some of the information that has been highlighted in this meeting today to the teachers in the local school districts in order that they may be encouraged and informed about what they should be doing in this area. That pilot has completed its work, and we are in the process of finalizing a technical assistance training manual to be distributed through the Regional Curriculum Service Units of the State. One is located in East Orange, one in East Brunswick, and one in Sewell, New Jersey.

You asked me to condense what I have to say, so I think the best way I can help you understand what we have done is to just simply read the introduction of the training manual. It might give you an idea of what we're trying to do.

"It can be said to be a sign of the times that this training manual has been developed under the aegis of the New Jersey State Department of Education." This Division has been, in many ways, closest to this alarming social problem, and I think that idea has been echoed by several speakers in that teachers and school personnel are the very contact point that we need to be able to use in this effort.

High school and junior high school teachers, school guidance personnel, nurses, administrative staff, and child study teams are increasingly facing the student who is entering puberty, who are in an adolescent stage, and who have shown suicidally-prone behavior. Suicidal behavior and the active suicide itself frightens and disorients professionals and lay persons alike. Life, almost

universally, is seen as a precious and sanctified gift by these people, and they find it incredible and impossible for young people, especially on the threshold of this life, to want to end it.

This training manual aims at sensitizing -- an interest point I would like to call your close attention to -- and desensitizing school personnel. The use of the term "desensitizing" in this context means that we must bring to these people factual knowledge, statistics, and information currently understood about adolescent suicidal behavior to help them reduce some of their own insecurity, helplessness, anxiety, and fear, as many have mentioned, felt by these professionals as they deal with young people exhibiting this kind of behavior. At the same time, there is a need to sensitize those people -- those relevant school personnel and teaching staff -- to this problem so that they can provide appropriate kinds of support and services to these children.

To further emphasize, this training manual is primarily concerned with heightening the awareness and raising the consciousness. From the outset, it has been recognized that school system personnel cannot be expected to treat the suicidal adolescent. Rather, they need to recognize that they are in a position; therefore, they must aid in the identification of those young people who may be suicidally prone, and to intervene in order to link those young people, their parents, and their families to the treatment programs available.

In addition, school personnel need to be better prepared to sensitively relate to suicidal young people following a suicidal attempt and to deal with the intense emotional reactions of the school community following an actual suicide.

These are the basic objectives of the adolescence suicidal awareness training program in this training manual. This manual contains an overview of -- and, these are the topics again; we've heard so many of these things raised today as essential ingredients of any training program -- adolescent suicide, adolescence and the crisis of puberty, identification of potentially high-risk pupils, the involvement of parents and families, community resources and outreach programs, intervention strategies, follow-up activities, and the school system's response following a suicide. These and other materials are going to be available to local districts.

Admittedly, this is going to be a very small program. We have three Regional Curriculum Service Units, and each of those units, beginning in October, will be communicating with every school district to let them know that training sessions will be available and conducted by the RCSU personnel for a local school district's staff. We intend that the local district will send people to the RCSU to be trained in the basic contents of the manual, take that information back to their local school districts, and then attempt to disseminate that material through the staff of the district itself. Again, this is a small effort, and only one effort, in many of the other efforts that are taking place. I'm sure that as you begin your study of the bill itself, you will see that there are many, many more things taking place in New Jersey that we haven't discussed today.

In the effort you are going to be commencing, we stand ready to help you in any way we can to assist you in developing whatever it takes to develop an adequate support system, both for the personnel in school districts and for the families of these children themselves.

I guess that it is. Thank you.

SENATOR CODEY: Thank you very much, Mr. Crowley.

MR. CROWLEY: Oh, by the way, I want to add that I'll make copies of this manual available to you.

SENATOR CODEY: Senator Hagedorn has a question.

SENATOR HAGEDORN: While I think we heard quite a bit of testimony this morning from the community health centers about the plans and programs they have made, which apparently seem quite effective, my question is, is the Department of Education ready to sit down and develop a cooperative plan with these community mental health centers so that we can get the maximum benefit?

MR. CROWLEY: Certainly. That is one of the key elements of what we are trying to do. The first step, we feel, is to make sure that local personnel know there is that network out there. I said I wasn't going to comment on the bill, but let me just make a comment about the bill. It may be that we are so much further ahead of what the bill intends to pilot that we ought not to be piloting what the bill pilots. We should be developing mechanisms to, in fact, perform that linkage.

One of the things you might like to look at as you study this is Assembly Bill 2286, which, I think, takes the larger perspective of setting up these networks at county levels through the Division of Mental Health. That is another option you might want to look at.

SENATOR CODEY: Thank you very much. Mr. Richard Konet, Assistant Principal of Westfield High School?

RICHARD KONET: Senator Codey, may I give you some brochures at this time because I want to limit myself to five minutes? (Senator Codey acknowledges affirmatively)

Thank you for inviting me here to testify. Part of your bill recommends that the schools implement programs, and I think at Westfield, we have already done just that. These brochures go home to each and everyone of the youngsters at our senior high school, and are read by the parents. Thus, we hopefully contact all of the youngsters and the parents, and as a matter of fact, many of the other people in the community.

As you can see on Page 1, our function is really to make an initial assessment of students who are extremely withdrawn, depressed, or in a crisis, and for those students whom we can identify as being in need of a particular referral agency or the like, we follow up accordingly. The problem has been well-documented by others who have spoken before this Committee, so I won't go into that any further.

We in the school are not trying any in-depth counselling, but we are at least offering support and options to these youngsters that many of them, I can assure you, would not have. As has been said earlier, a great many of the parents are totally unaware of the fact that their sons or daughters exemplify far different behavior in the school setting than they might exemplify at home. Of course, as has been said earlier, we tend to see the youngsters many times for more hours by far than mom or dad at home does.

The signs of the problem are a way of both educating our staff and other youngsters because many of our referrals come right from the kids. The peer group effect has also been stated frequently at this hearing, and I can tell you from my own experience, the kids often have a great many secrets to hold on each other, and sometimes trying to draw them out and get the information we need to go forth and help others--

The next page -- "How to Contact the Crisis Management Team" -- I am very happy with, because as you will notice, we don't rely simply on our school social worker or psychologist. We have trained a number of our teachers. Many of them have gone to Rutgers Mental Health Center to receive their in-service training. The teachers are strategically placed throughout the building, so hopefully any youngster, no matter what class he is taking, be it a foreign language, shop, or art class, will be in the vicinity of someone on the crisis management team. At the bottom of the page, you can see our little card, and many of the youngsters have taken these and put them in their wallets or purses.

The next page reveals the help available in Union County. Westfield, of course, is located in that county. That is a partial listing, but there are other services available.

At the high school, we have the people listed whom the kids can contact.

Finally, we have some guidelines for the team members, the students, and the staff in general, about what they can do, such as to show concern, listen to the boy or girl, explain that with help and support he or she can enjoy better times again, and stay close. That is very important because we have had a few near suicides in Westfield -- at least from what we can tell. Certainly, we had a very close one last spring. We spent the entire afternoon with the youngster until we could get the parents out of New York. I think we adverted a possible tragedy.

Finally, remember that a concerted effort by school and community can avoid the problem some students might encounter.

At this time, this is what we are doing in Westfield. I think we have an emerging and developing program. I don't know if we have answers to each and every one of the questions, but I can tell you that there are a lot of boys and girls out there in need of help. The societal problems that were cited earlier in testimony are very much present in Westfield, and I think we have been at work quite hard in helping the youngsters in our town.

SENATOR CODEY: Mr. Konet, how many teen-agers -- roughly say in a period of a year -- respond or seek help through this program?

MR. KONET: Without breaching confidentiality -- I keep records on that -- we're getting at least several referrals per month. We have a school of 1,500 youngsters, and as one of the gentlemen stated earlier, the junior high schools are clamoring to have our program sent down to their level. I think that will be coming; that will definitely be forthcoming because those kids, too, can use our services.

Last year, we had at least several per month. But, they did run the range. Some were things that luckily were not that serious; it was more of a case of depression -- apparently a case of severe depression because of examinations and the like. Others were definitely heading towards a possible suicidal state.

SENATOR CODEY: Okay. Are there any other questions? (no response) Thank you very much, and congratulations on your program, sir.

MR. KONET: Thank you for having me.

SENATOR CODEY: The next witness will be Ms. Charlotte Henshaw, the Bergen County Administrator of Mental Health.

CHARLOTTE HENSHAW: Good morning. My name is Charlotte Henshaw. I am the Bergen County Mental Health Administrator.

In New Jersey, each county has a mental health administrator and a Mental Health Board that is statutorily mandated, and whose members are appointed by the Boards of Chosen Freeholders. The Mental Health Boards make recommendations to the Division of Mental Health and Hospitals regarding the distribution of mental health funds after studying needs' assessments and spending plans, and reviewing applications for funding.

The State is divided into 60 service areas based on population size. In Bergen, we have six service areas, and they are identified on the pink sheet you have, each with a community mental health center whose services are available to all residents of the area. There are over 73,000 adolescents of high school age in Bergen County.

We are directed by the Mental Health Boards and State policy to use the majority of our State funding for community care of the chronically mentally ill, those in greatest danger of being

institutionalized. Everyone in the mental health field welcomes an opportunity to focus on youth, and especially on prevention.

The South Bergen Mental Health Center has developed a program, "Recognizing and Preventing Self Destructive Behavior of Adolescents," based on the public health model of service delivery. Identification of risk factors is a means of allowing broad access that is cost-effective and helps build partnerships within the community. Early intervention is facilitated by the increasing awareness of depression, alcoholism in the home, or severe family disruption.

County officials have been very impressed with the program, and have planned to make it available throughout our county. The Mental Health Board voted in June to provide half of the necessary funding, and the Local Advisory Committee on Alcoholism intends to provide the other half. Under this plan, South Bergen's expert will teach professionals from the other mental health centers how to present the program to local educators. We hope that by providing this training, we will begin to meet the need for the development of an ongoing partnership between mental health clinicians and teachers within each individual community.

The training will be available to teachers throughout the county within a few months, and we believe that we will have laid the groundwork for effective referral and collaboration between professionals.

Thank you very much.

SENATOR CODEY: By the way, one thing you touched on in your statement was that the State funding usually goes to the chronically mentally ill, not the kind of people we are talking about here today. The focus has never been on them before. I think that is a very valid point, and I thank you for bringing it up. Thank you.

Our last witness today will be the Reverend Krehel, the national consultant to Kids are Winners.

REVEREND DOCTOR THEOPHIL KREHEL: Good afternoon, Chairman Codey, and members of the Committee. I thank you for your invitation.

I don't want to expand upon many of the issues that previous speakers have related to. However, I want to give you a little of my background.

I am a former member of the Arts Council of this State; I served two terms. Earlier in my career, I was a national consultant to Urban America, which dealt with the creation of nonprofit housing throughout the United States. I was a board member of the Urban Christian Training Center in Chicago, which helped develop young men in the black sector, and of which Reverend Jessie Jackson was a fellow member. My position today is as a national consultant to a national program called "Kids are Winners."

This program, and the twist of this approach to the problem that has been alluded to, is the utilization of the United State's Olympic champions. The founder of this nonprofit corporation is Don Nielson, who has been a three-time participant in the Olympics. He was a biathlon champion and captain of the team. The utilization of the Olympics and sports people in the field is the twist and necessary ingredient to capture the attention of youth.

The epidemic problem of team suicide, depression, substance abuse, and low self esteem is the core of what brings about the issue of suicide and all such related problems. But, there must be a catalyst.

We appreciate everything that the schools have been doing -- the Departments of Mental Health and the like -- but, this is not a State problem. It is a national problem. In treating the problem, we must act on a national basis in order to really help solve the problem of our youth today. Accepting everything that the previous speakers have spoken about, I simply say that we must relate and coordinate the problem on a national level, so that the efforts and good capabilities of the people involved will derive the richest rewards to help solve the problem.

The Miller Lite Report speaks about the role of sports in American life, and states that a majority of all Americans feel that athletes are good role models for young people. Kids themselves unanimously show more attention and enthusiasm for well-spoken, empathetic athletes than for teachers, and that is really the crux of the approach to the whole problem of our youth. It is the plan and objective of this problem in dealing with the kids by introducing concepts that have been outlined and set forth in this nonprofit project created by Don Nielson.

The entity is based in Colorado -- Boulder, Colorado -- but its implications are quite apparent when see the activity in the various states -- in New York, obviously here in New Jersey, and in other states. So, I feel that if this effort is coordinated at the outset-- The legislation proposed by the Legislature of this State is very important, but in order to make it really work, we have to do it in such a manner as to utilize the capabilities of everyone concerned -- most so on the part of leaders in the nation.

This program is, and has been, reviewed by our own Senator, U. S. Senator Bill Bradley; Mayor Gibson of Newark has reviewed, and they support the program. It is currently in formulation to the members of the Board. Obviously, the most important aspect is funding and utilization of that funding in order to bring the results we desire.

I simply will leave the project, the business plan, and the whole concept of how this will be done-- It will be done through schools, through both public and private schools -- the high school, the junior high school, the grade school -- through video programs developed through seminars where the athletes are brought to the school for a day and one-half seminar, followed up by appearances, discussions, and training of local teachers and health personnel, so that the impact of sports people in the field will have its greatest benefit. They certainly will have the listening ears of the students.

I will conclude by simply stating that I will leave the papers -- the position papers -- and the information on this entity. At this time, I would be happy to answer any questions.

SENATOR CODEY: Are there any questions? (no response) Thank you very much, Reverend.

That concludes our testimony today. Thank you.

(HEARING CONCLUDED)

APPENDIX

RECOGNIZING AND PREVENTING THE SELF-DESTRUCTIVE BEHAVIOR OF ADOLESCENTS

What one school system is doing about it! River Dell Regional H.S.

By

Frank Acocella
Supervisor of Physical Education
Health & Driver Education
River Dell Regional Schools

Diane Ryerson
Coordinator/Education Director
Bergen Regional Counselling Ctr.
South Bergen Mental Health Ctr.

Due to the alarming nationwide and local statistics on teen-age suicide, the River Dell Regional school district working cooperatively with the Bergen Regional Counselling Center and South Bergen Mental Health Center, local mental health agencies, developed a program in an attempt to fight this threat to our youth. **Not to belabor a point by quoting statistics, suffice it to say, suicide is** becoming a hidden epidemic in the United States. Suicide is now the number two killer of adolescents between 15 and 24 and there are 6,000 documented teen suicides a year; that is just the tip of the iceberg! Many deaths which are self inflicted are reported as accidents by officials who wish to spare family and friends the agonizing guilt and stigma of suicide. For every completed suicide, statiticians predict that there are 50-100 attempts. That means that between 300,000 and 600,000 teenagers a year make a self-inflicted attempt on their own life.

Due to the magnitude of this problem, every attempt should be made to reduce the growing numbers. The tragedy of a teenage suicide reaches far beyond the untimely death of a junior high or high school student. It is the parents, siblings, friends, teachers, and communities who are often devastated by this ultimate and final rejection. These survivors of adolescent suicide are often plagued by severe guilt and depression, prolonged grieving, acute family problems, work performance, and increase self-destructive behavior. For every suicide, there are usually between ten and thirty people whose lives are seriously disrupted by the emotional fallout of the death.

The best approach to the problem, or cure, if you will, is through prevention: educating as many people as possible about the social and psychological causes of teen suicide, teaching as many people as possible about the warning signs of severe depression and lethal behavior, and instructing as many people as possible on how to help when someone is considering self-destruction. Recognizing and Preventing the Self-Destructive Behavior of Adolescents was developed to meet this critical need.

PROGRAM GOALS

1. To educate all concerned groups about the realities of teen suicide, its warning signs and appropriate crisis intervention strategies;

2. To develop a close working relationship between school personnel and the Community Mental Health Center staff to facilitate open communication for service, speedy referrals, and appropriate requests;

3. To establish with teachers, parents, and students that mental health professionals are approachable, caring people who have the professional expertise to help in a crisis;

4. To develop, in conjunction with school personnel, inschool primary prevention programs aimed at identifying and assisting high rish students.

Fortunately, the River Dell Regional Board of Education and Administration recognized this need, and further, recognized the role that the school could play in the development of a preventive program. They have supported the program without reservation as have parents, teachers, and the student body. Many school districts, on the other hand, fail to recognize or accept the fact that teen suicide is or could be a problem in their district. Therefore, most school programs are developed only after one or several suicides occur. We believe it is better to face reality and be prepared to do everything possible to prevent a tragedy before the fact rather than after.

The first prerequisite in establishing a prevention program is to secure positive encouragement from the administration and Board of Education, hence, it is paramount that justification and need be established by presenting all background information to them. Secondly, work closely and in conjunction with a local mental health agency that has the same basic philosophy and concerns. The program consists of four self-contained, but interelated, areas:

1. The Educator's Seminar: a two-hour intensive workshop for teachers, administration, and support staff (Child Study Team, Guidance Personnel, school nurse, etc.). Representatives from the local Board of Education and the mayor and council, and juvenile officers, are often invited.

2. The Parent's Program: a two-hour presentation for parents of junior high and senior high school student who are concerned about self-destructive behavior and/or wish to learn more about depression in adolescents, and what they can do individually or as a group to reduce the risk of teen suicide. This program is often sponsored by the Home/School Association.

3. Student's Workshop: an intensive four-hour workshop designed to raise the level of understanding of high school students about the realities of adolescent self-destructive behavior, and to prepare them to deal with depression in friends and family members, as well as in themselves. Focus is placed on when and how to obtain appropriate assistance as well as on identifying potentially lethal behavior in a friend.

4. Primary Prevention Program: a specially tailored program for each school system which employs a number of prevention strategies which are developed together with in-house personnel. The mental health agency then remains involved in program consultation and supervision in addition to evaluating and counselling students with suicide potential or other emotional distress.

At River Dell Regional High School, we have completed two pilot programs in which 80-90 tenth grade students participated. In addition, an introductory presentation was made to the 12th grade student body who missed the initial program and a reinforcement program was presented to our 11th graders who were the subject of our first pilot program two years ago.

We have thus touched every student in our school! This year we plan to present the program to the entire 10th grade class. In conjunction with the presentations made to our student body, programs have also been presented to our teaching staff, Parent Teacher Organization, and the borough council.

In conclusion, teachers, parents, and students must address three critical areas. They are:

1. An awareness of developmental pressures of adolescence and the causes of adolescent suicide;

2. An identification of the warning signs of suicidal behavior, and;

3. A program for preventing self-destructive behavior in troubled teens.

If we meet our goals, we will have met our responsibility as educators and will have provided a practical service to all students and the community; if we sit idly by and do not act, we risk the loss of a very precious commodity - human life!

For further information, please contact Frank Acocella at (201) 261-4500 or Diane Ryerson at (201) 646-0333.

BERGEN COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF MENTAL HEALTH
327 East Ridgewood Ave., Paramus, N.J. 07650 201/646-2633

Michael A. Guarino, MPH
Director

Charlotte V. Henshaw, ACSW, MPA
Assistant Director for Mental Health

COMMUNITY MENTAL HEALTH SERVICES

Community mental health centers are private, non-profit agencies which receive government funds to provide the following services to residents of a specific geographic area. All fees are on a sliding scale, based on ability to pay.

- Individual, family and group outpatient therapy for children and adults
- 24-hour emergency contact; alcohol and drug emergency treatment
- Partial hospital treatment; inpatient referral; after-care services
- Residential facilities or placement
- Client advocacy; consultation and education for the community

Service Area 45

Allendale
Franklin Lakes
Glen Rock
Ho-Ho-Kus
Mahwah
Midland Park
Oakland
Ramsey
Ridgewood
Saddle River
Upper Saddle River
Waldwick
Wyckoff

WEST BERGEN
MENTAL HEALTH CENTER

74 Oak Street
Ridgewood 07450
444-3550

60 E. Main St.
Ramsey 07446
934-1160

Service Area 48

Cliffside Park
Edgewater
Englewood
Englewood Cliffs
Fairview
Fort Lee
Leonia
Palisades Park
Ridgefield
Ridgefield Park
Teaneck

CLIFFWOOD
MENTAL HEALTH CENTER

93 W. Palisade Avenue
Englewood 07631
567-0500

Service Area 46

MID-BERGEN COMMUNITY
MENTAL HEALTH CENTER

11 Park Place
Paramus 07652
265-8200

Elmwood Park
Fair Lawn
Hillsdale
Montvale
Paramus
ParkRidge
Saddle Brook
Washington Township
Westwood
Woodcliff Lake

For Fair Lawn residents only:
FAIR LAWN MENTAL HEALTH CENTER
17-07 Romaine Street
Fair Lawn 07410
797-2660

Service Area 49

BERGEN REGIONAL
COUNSELLING CENTER

395 Main Street
Hackensack 07601
646-0333

After 5 and weekends:
646-9228

Bogota
Emerson
Hackensack
Hasbrouck Heights
Little Ferry
Lodi
Maywood
New Milford
Oradell
River Edge
Rochelle Park
South Hackensack
Teterboro

Service Area 47

Alpine
Bergenfield
Closter
Cresskill
Demarest
Dumont
Harrington Park
Haworth
Northvale
Norwood
Old Tappan
Rockleigh
Tenafly

COMMUNITY CENTER FOR
MENTAL HEALTH
2 Park Ave.
[illegible]
Dumont 07628
385-4400

Service Area 50

Carlstadt
East Rutherford
Garfield
Lyndhurst
Moonachie
North Arlington
Rutherford
Wallington
Woodridge

SOUTH BERGEN
MENTAL HEALTH CENTER

516 Valley Brook Ave.
Lyndhurst 07071
935-3322

186 Paterson Avenue
E. Rutherford 07073
460-0160

After 5 and weekends: 646-9228

The following agencies provide county-wide programs and services:

FRIENDSHIP HOUSE
125 Atlantic St.
Hackensack 07601
488-2121
Vocational rehabilitation; transitional employment services; job placement

PROJECT ENGAGE
Cliffwood Mental H.C.
Englewood 07631
567-0500
Education and support services for parents of chronically disturbed young adults

MENTAL HEALTH LAW PROJECT:
327 Ridgewood Ave.
Paramus 07652
646-3432
Provides legal services for indigent psychiatric patients in civil cases

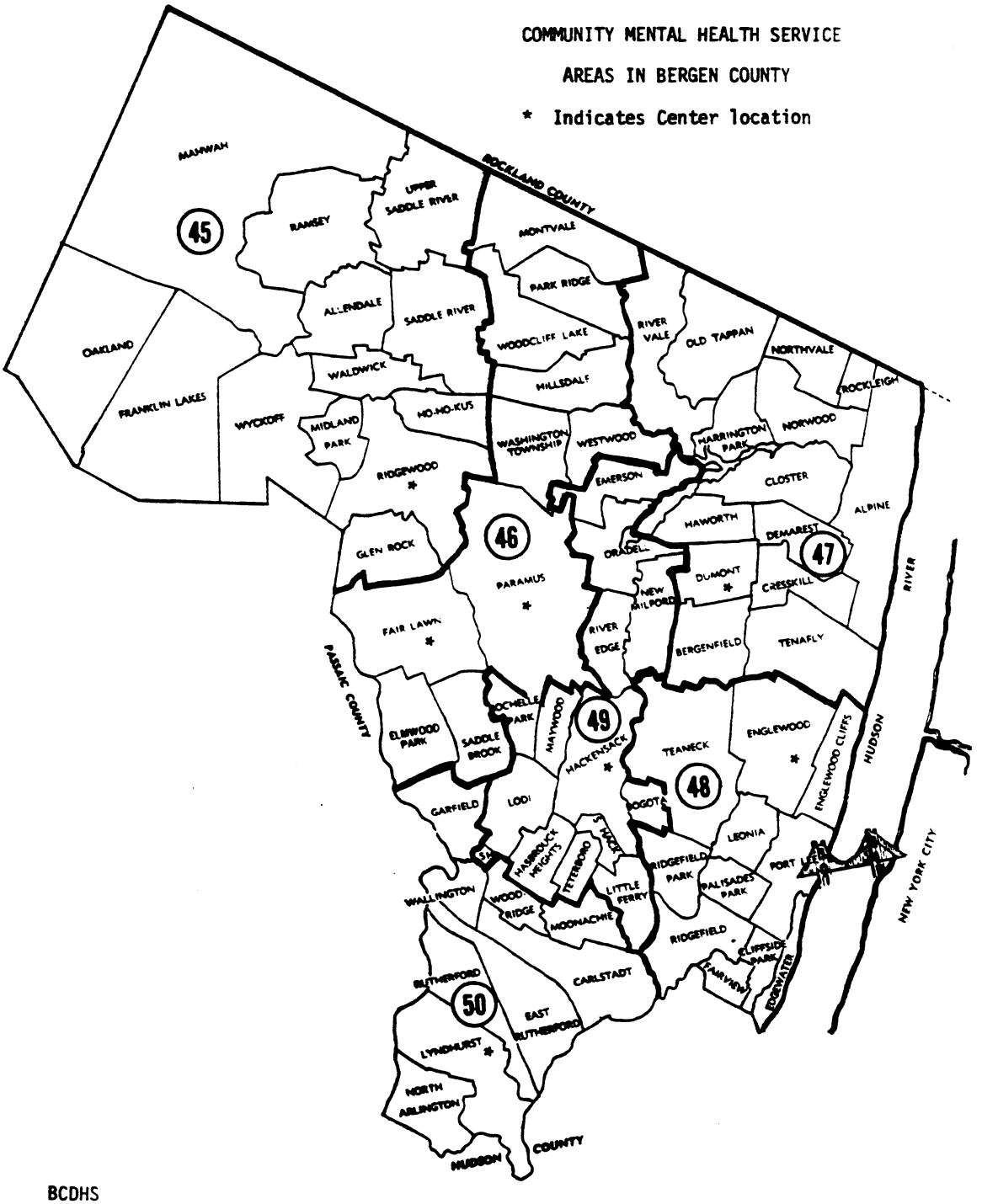
MENTAL HEALTH ADVOCACY GROUP:
319 Main Street
Fort Lee 07024
592-8651
Provides family support and information; lobbying activities on mental health issues

5x

COMMUNITY MENTAL HEALTH SERVICE

AREAS IN BERGEN COUNTY

* Indicates Center location



BCDHS
484 166-12

NEW JERSEY PTA

900 Berkeley Avenue
Trenton, New Jersey 08618
(609) 393-6709, 393-5004

September 6, 1984

To the Chairman of the Senate Institutions, Health and Welfare Committee

Dear Chairman Codey:

On behalf of the 215,000 members of the New Jersey PTA, I would like to express our support for Senate Bill 2005. We are deeply concerned about the rising epidemic of suicides in young people.

As the statistics demonstrate, suicide is the second leading cause of death of young people, the leading cause of death being automobile accidents. It should also be noted that certain one-car, automobile injuries and fatalities may actually be suicide or suicide attempts. Further, the true extent of the incidence of suicide among youth is probably under-reported, in part because of social stigma and insurance concerns.

We feel that it is critical that there be funding to implement programs and services to identify and prevent this tragedy. Prevention programs developed by the schools and community which would provide education, "hot lines" and appropriate intervention and procedures are very much in need.

The New Jersey PTA supports efforts to address the needs of young people at risk of suicide. As parents and teachers we recognize the importance of Lester and Lester's observation "parents and school officials have a great deal of control over adolescents... and can also watch closely for the warning signs of depression and suicidal preoccupation", however appropriate support and services are needed in order to help these troubled youth.

Respectfully,

Mia Andersen

Mia Andersen
Chairman, Juvenile Protection

MA:sm

7x