REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

YOUTH SUICIDE PREVENTION

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Report of the
Joint Subcommittee Studying Youth Suicide Prevention
Pursuant to SJR 173 and HJR 312
The Governor and the General Assembly of Virginia
Richmond, Virginia
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To: Honorable Gerald L. Baliles, Governor of Virginia
and
The General Assembly of Virginia

LEGISLATIVE HISTORY

In response to the growing problem of youth suicide, the 1987 General Assembly, pursuant to Senate Joint Resolution No. 173 and House Joint Resolution No. 312, established a joint subcommittee to study the causes of suicide among children and youth, develop strategies to implement effective youth suicide prevention programs and to request the cooperation of local and state officials, the public, educators, youth, parents and other interested parties to participate in the study as the joint subcommittee deemed appropriate.

The members of the joint subcommittee were: Senators Daniel W. Bird, Jr. of Wytheville, Richard L. Saslaw of Springfield, Elliot S. Schewel of Lynchburg, Delegates Jean W. Cunningham of Richmond, Alan E. Mayer of Lincolnia, Yvonne B. Miller of Norfolk and Warren G. Stambaugh of Arlington. Senator Richard L. Saslaw served as Chairman of the joint subcommittee.

WORK OF THE JOINT SUBCOMMITTEE

The joint subcommittee endeavored to determine the magnitude of the problem of youth suicide by reviewing the recent health statistics on reported suicides and related indicators, and by holding three public hearings wherein it received testimony from state agency heads, community services boards, youth, parents, law enforcement agencies, prevention specialists, the clergy, professional counselors, local school divisions and other interested persons. Also, to gain a better understanding of the dynamics of the problem, the joint subcommittee reviewed the staff briefing paper and other research data which were provided by the staff. The joint subcommittee determined that it is impossible to isolate a single cause of suicide as the problem is too complex. However, it reasoned that a multidisciplinary, multifaceted program to provide prevention, intervention and postvention services would be the most appropriate response.

SUICIDE

Magnitude of the Problem

> "Eleven-year-old Becky swallowed an entire bottle of aspirin. She said she did it because she didn't have anything to live for since she had just lost her best friend. After several months of erratic eating and sleeping, Becky tried again- this time she died." (Youth Suicide National Center, undated)

Over the last thirty years in the United States, the suicide rate for youth 15-24 years of age has increased dramatically, moving suicide from the fifth leading cause of death for this age group in 1960 to the third leading cause in 1980. Between 1970 and 1980, 49,496 youth between the ages of 15 and 24 committed suicide, increasing the rate in this age group from 8.8 deaths per 100,000 in 1970 to 12.3 per 100,000 in 1980, an increase of forty percent (Youth Suicide, 1986). It is important to note that for "every suicide there is a larger number of people who attempt suicide and fail (parasuicide). Empirical studies of parasuicide rates for children and adolescents are rare and the available data extremely variable. The published data indicate a low estimate of less than a hundred parasuicides per 100,000 persons to a high estimate of over 700 per 100,000 persons. Failure to complete suicide may be intentional or accidental, with some being cries for help, or an ambivalence with regard to their intentions" (Kenley, Ehrmantraut and Erickson, 1986).

In Virginia, "suicides among all ages have shown a remarkable increase since 1950. It was the seventh leading cause of death in 1985, and it has been among the ten leading causes of death since 1966. The number of suicides is highest for white males in all age groups, followed by black males, white females and black females. There were 751 suicide deaths recorded for Virginia residents in 1985, resulting in an increase of 5.8 percent over the 710 occurring in 1984. Virginia's rate, 13.1 deaths per 100,000 population, was higher than the United States rate of 12.0 for 1985. The largest number (159) of those taking their own lives occurred for the group aged 25-34 years, with the greatest age specific rate occurring in the group of persons aged 55-64. There were no suicides reported for persons under ten years old. Suicide was the second leading cause of death for the age group 15-24 (after accidents) and it was the fourth leading cause for the age group 25-44 (after accidents, cancer and heart disease) in 1985. While nonwhites comprised 21.4 percent of the population in 1985, only 11.2 percent of the suicidal deaths occurred in that group. Of all suicides, 68.7 percent involved white males; 20.1 percent, white females; 10.0 percent, nonwhite males; and 1.2 percent, nonwhite females. The methods of suicide most often chosen were firearms and explosives. These implements were used in 67.4 percent of the suicides. Of the 506 deaths by this means, 53.2 percent were under age 45. This method was used by 376, or 72.9 percent, of the 516 white males committing suicide and by 51, or 68.0 percent, of the nonwhite males. Hanging, strangulation and suffocation, the second most used method in 1985, was responsible for 88, or 11.7 percent, of the total suicides; 73.9 percent of these were white males. As of August 31, 1987, there have been thirty-eight reported teen suicides in Virginia.

This figure represents seven and one-half percent of the 510 suicides committed in the Commonwealth during the first eight months of the year. Of the thirty-eight youth suicides committed, two were in the 10-15 year old age group and thirty-six were in the 15-19 year old age group. The methods of suicide for such youth were 26 gunshots, 7 carbon dioxide poisonings, 4 hangings and 1 drug overdose" (Virginia Vital Statistics, 1986).

History of Suicide

A review of the history of suicide in Western civilization reveals a shifting of attitudes toward from the earliest periods of recorded time to the present. The earliest recorded text concerning suicide is believed to be an Egyptian papyrus between 2160 - 1788 B.C. entitled 'The dispute with his soul of one who is tired of life.' This document concerns the merits of life and death and whether life is worth living or not. For the Greeks and the Romans, suicide was an acceptable and honorable alternative to a life of shame and misery, though the Greeks did not condone it. Plato's belief that those who commit suicide "from want of sloath or manliness" should be buried in unmarked graves is a concept that was codified by the Catholic Church and by most nations of Western Europe for over a thousand years. Aristotle advanced that suicide was a crime against the state and worthy of punishment. However, the Romans attached no stigma to suicide, with the exception of the suicide of slaves and soldiers. In this instance, Roman law specifically made suicide for these persons a crime. The rationale for this exception was that soldiers and slaves were property of the state and were not independent agents; therefore, they did not have a right to commit suicide. Criminals were also forbidden to commit suicide under Roman law. The commission of suicide by criminals was considered an admission of guilt and resulted in the confiscation of their property.

The introduction of Christianity into the Roman world at a time when suicide was an acceptable alternative to a life of pain resulted in a dramatic rise in the suicides of Christians as a means to escape persecution and torture and to achieve eternal glory or sainthood. Eventually, the church's position on suicide changed. The Council of Orleans of 533 A.D., confirming in part what had been in Roman law, denied burial to anyone who committed suicide while being accused of a crime. By 563 A.D., funeral rites were denied to all suicides and this prohibition was written into Canon Law (Hatton and Valente, 1984). It should be noted that other civilizations have also forbade suicide, e.g. Islam, the Omaha Indians, the Thompson Indians of British Columbia, the Paharias of India, the Dahomey in Africa, the Bannavs of Cambodia and the Lochbroom of Scotland (Hatton and Valente, 1984).

With the rise of humanism during the Renaissance, life was considered of value for the present and not as a transition period for the eternal. The concept of suicide as an alternative to a miserable life was spoken about openly. It was considered by some to be a form of euthanasia acceptable to those afflicted with an incurable disease; however, permission to commit suicide had to be obtained from a priest and the senate. With the advent of science as a force in human thought in the seventeenth century, suicide was discussed in relation to depression and that persons who committed suicide did so because of forces beyond their control.

During the eighteenth century, the Age of Enlightenment, the thinking that led to the writing of the Bill of Rights and the Declaration of Independence also led to a change in the laws that punished those who committed suicide or attempted it. It is during this period that the use of science to explain the mysteries of life and death led to the secularization of death and suicide. By the nineteenth century, the Industrial Revolution had brought with it some of the social blight, poverty and despair that is prevalent today. Hence, the use of statistics was introduced to support or refute theories regarding suicide (Hatton and Valente, 1984).

The study of suicide as a science, suicidology, began with the work of Emile Durkheim in 1897. Durkheim advanced the need to study society rather than single cases of suicide to understand the problem. He noted that suicides were composed of three groups: the anomics who commit suicide because of a lack of integration into society; the altruists who live in a primitive society of strict rules which cannot be broken; and the egotists who live in a modern society and commit suicide whenever there is a sudden change in their social status. The view of suicide changed again with the work of Freud and psychoanalysis, advancing the need to study the individual rather than society. Since the sociological and psychoanalytic theories proposed over the last century, still there is no understanding of why people commit suicide. Physicians now believe that the relationship between suicide and depression may have some biochemical basis, and that there is some indication of familial history in many cases of depression (Hatton and Valente, 1984).

The Process of Adolescence

Adolescence is that period of growth between childhood and adulthood characterized by biologic changes, psychological and social development, ego development, the achievement of personal independence and the attainment of more sophisticated cognitive skills. All of these characteristics are not achieved simultaneously. Physical maturation is the earliest and most visible evidence of impending adulthood. During this period, adolescents are very conscious of their body build and profoundly affected by the concept of the "ideal body build" as taught by the culture. The acceptance of and satisfaction with one's body image are related to one's self-esteem. Consequently, early or late physical maturation is significant to the psychological and social adjustment of the adolescent.

It is generally acknowledged that the adolescent functions cognitively at a level between the thinking characteristic of the pre-adolescent (the concrete operation stage) and that thinking characteristic of the adult (the formal operational stage) The thinking of the adolescent whose cognitive level is that of the pre-adolescent is limited to the "here and now" and directly experienced events are the primary focus of thought. The cognitive processes of the adolescent at this level do not include considering the future, the consequence of or the alternatives of behavior. For this individual, what one does is the only option for behavior that exists. The thinking characteristic of the adult is typified by the ability to make abstractions, to see the long-term consequences of behavior, to plan for the future and to "think about thinking." The transition from adolescent to adult thinking is gradual.

The adolescent's level of cognitive development is crucial to the individual's ability to reason and to analyze and process the relevant issues realistically.

The social development of adolescents is marked by an extreme concern for the way they are perceived by their peers. During this time, the adolescent is also moving toward greater self-sufficiency and self-direction which are major sources of conflict between adolescents and parents. Self-esteem is of considerable importance to the adolescent's attainment of competence in social relationships. How one perceives himself is inextricably related to his mental health, academic progress, vocational aspirations and success, and ability to become a socialized member of society. Nothing is more crucial for an individual than the development of a positive self-concept, as failure to do so affects all that he attempts to do and his relationship with others.

Self-esteem has been called the survival of the soul. It is the ingredient that gives dignity to human existence and grows out of human interaction in which the individual is considered important to someone. The adolescent who has a poor self-concept is vulnerable to criticism, rejection and any evidence in his daily life that testifies to his inadequacy, incompetence or worthlessness. Often this individual will develop a facade as a compensating mechanism or succumb to peer pressure or engage in deleterious activities to overcome a sense of worthlessness and to convince others that he is worthy (Joint Subcommittee Studying Teenage Pregnancy, 1987).

Theories of Adolescent Suicide

The study of suicide is a multidimensional problem. Suicide is defined as "the taking of one's own life intentionally and voluntarily" (James, 1984). "The basic causal theories of adolescent suicide are psychodynamic, developmental, cognitive, sociological and biological. One theory alone is not sufficient to explain as complex a phenomenon as suicide, and therefore each theory must be understood in an interactive context.

Psychodynamic Theory - emphasizes the influence of past events on the present and the future. Suicidal behavior develops from the loss of love, deprivation, and possible rejection by significant people. Anger and resentment result, followed by feelings of guilt, which culminate in self-destructive behavior.

Development Theory - emphasizes the stress of adolescence. The adolescent period is a time of change, crisis, pressure, and tendency to impulsive overreaction. The precipitating event is the culmination of a longstanding sense of entrapment and rage and is usually associated with moving, changing schools, romantic breakup, death of a loved one, or divorce of parents.

Cognitive Theory - emphasizes the meaning of death for the adolescent. The adolescent is seen as having a sense of immortality - that death is reversible, not final. The adolescent's perspective is limited as a result of incomplete intellectual development as well as cultural attitudes and media that support the unreality of death.

Sociological Theory - emphasizes anomie, alienation, withdrawal, isolation, and loss of social contact. Anomie is characterized by a sense of weakening or disappearance of social guidelines - a lack of norms and structure in one's existence. Suicide results when a once-secure society is perceived as disintegrating and no longer dependable (Tishler and Christman, 1980).

"Biological Theory - emphasizes the biochemical correlates of suicidal behavior and underscores the relationship of suicide behavior to effective disorders. Recent studies suggest there may be a deficiency in serotonin, a neurotransmitter, in people who commit suicide. Additional studies have found other biological abnormalities associated with suicidal behavior, which may prove to be helpful in the prediction and prevention of suicide" (NIMH, undated).

Within the theoretical framework, there is an established relationship between depression and suicidal behavior. A major symptom of depression is a "prominent and persistent loss of pleasure and interest in usual activities and pursuits. Feelings of sadness, hopelessness, and discouragement pervade the depressed individual" (APA, 1980). For adolescents and young adults experiencing depression and attempting suicide, "there is an increase in negative life events, self-undermining, and family stress and illness, especially psychiatric illness. There is a decrease in family supportiveness and one's ability to cope. Those persons completing suicide are characterized as being more active, aggressive, and impulsive than individuals experiencing depression or attempting suicide. There is a recurring and prevalent theme of confrontation over some event (e.g. poor grades, truancy, antisocial behavior), with subsequent humiliation. The number of females experiencing depression and attempting suicide is greater than that of males. The number of males succeeding at suicide is greater than that of females" (Hirschfeld and Blumenthal, 1982).

There is also a link between depression and low self-esteem as one of the characteristics of depression is a negative self-concept associated with self-reproach and self-blame (Beck, 1973). Low self-esteem, a negative estimate of one's worth, is characterized by obedience, passivity, helplessness, inferiority, powerlessness, timidity, self-rejection, self-hatred, conformity, self-doubting, submissiveness, unworthiness, and self-punishment.

Coppersmith cited four sources of self-esteem:

Power - the ability to influence and control others;
Significance - acceptance, attention and affection of others;
Virtue - adherence to moral and ethical standards; and
Competence - successful performance in meeting demands for achievement.

High self-esteem does not depend on success in all four sources as one may have high self-esteem by being competent without being virtuous, significant or powerful (Coppersmith, 1967).

Few studies have been conducted to identify the symptoms of depression in adolescence. However, the Face Valid Depressive Scale (FVDSA) for Adolescents, utilizes a number of items chosen from the Minnesota Multiphasic Personality Inventory (MMPI) which were determined to be symptoms specific to depression in adolescence. They are:

Sadness
Fluctuation between indifference and apathy and talkativeness
Anger and rage - typically expressed by verbal sarcasm and attack
Sensitivity with inclination to overreact to criticism
Feelings of insufficiency to satisfy ideals
Poor self-esteem
Feelings of helplessness and decreased peer support
Intense ambivalence between dependence and independence
Feelings of emptiness in life
Restlessness and agitation
Pessimism about the future
Death wishes; suicide ideas, plans, and attempts
Rebellious refusal to work in class or cooperate in general
Sleep disturbance
Increased or decreased appetite
Weight gain or loss
Somatic depressive equivalent, headache

When these MMPI items were applied to the records of several psychiatric patients and analyzed, the analysis revealed six core factors in depression:

1. Lack of self-confidence. Feelings of guilt, lack of energy, brooding, and sadness.

2. Social abandonment. Emptiness in life, death wishes, and social frustration.

3. Loss of interests. Difficulty in interpersonal communication.

4. Sadness. Weight change, grouchiness, frequent crying and feelings of hopelessness.

5. Somatic symptoms. Disturbed sleep, changes in eating habits, and feelings of loneliness.

6. Acting out. Desire to run away from home, and aggressiveness (Mezzick and Mezzick, 1979).

Risk Factors for Youth Suicide

Although there is no single compelling reason why youth commit suicide, the key to understanding the problem rests on the concept of the child's failure to develop a sense of identity and a positive self-concept. Children and youth at risk for suicide feel powerless, hopeless and believe that they have no control over their lives or over their immediate environment. The risk factors for children and youth for successful suicide are:

- male;
- a long history of poor academic and community performance;
- divorced or separated parents - marital discord;
- alcohol and drug abuse;
- alcohol and drug abuse in parents;
- mental illness in the family, especially among first and second degree relatives;
- a history of suicide in the family; and
- a history of depressive illness in the family.

It is a common misconception that the most brilliant and gifted youth commit suicide. However, suicide is most often related to poor academic performance rather than to I.Q. Suicide is related also to social class as white middle to upper class males have the highest rate of suicide as compared to lower class white and black males. Societal contributions to the problem of youth suicide include: the glamorization of suicides of important persons by media coverage; the availability of firearms and medication; youth anxiety due to environmental threats such as nuclear war or floods; the denial of the possibility of youth suicide; the lack of positive alternatives; and the prevailing perception that youth are expendable in today's society. Pressure to achieve from parents, society, school, and peers may also exert overwhelming expectations on youth who are or feel unable to meet them. Certain youth are at higher risk than others. These include individuals who are different or perceive themselves so: American Indians, the learning disabled, the physically handicapped, psychotic youths, those with chronic diseases, the drug abuser, the sexually abused, the runaway, the delinquent youth, the young pregnant female, and those with repeated suicidal behavior (Breindel, 1985).

The Joint Subcommittee was advised that suicide may be underreported as there may be a reluctance to classify the deaths of children and youth as suicide because the survivors are stigmatized when children commit suicide, and that there also remains some question as to whether children really understand the finality of death to the extent that they choose to die.

Prevention, Intervention and Treatment

Efforts at prevention have primarily centered on the early recognition and identification of depression in children and adolescents, public awareness and education, and the implementation of youth suicide prevention programs in the public schools. The latter proposal has received considerable attention given the rapid increase in teen suicides, the highly publicized mass suicides of four New England teenagers in 1986 and the increased concern for copy cat suicides. Public attention is centered on the schools as the compulsory school system in this nation may provide a viable location for intervention and postvention work (Hill, 1984). It is the position of some that crisis hotlines, crisis intervention centers and psychiatrists and psychologists will not solve the problem of youth suicide, and for this reason parents, peers, teachers and adults who work with children, the school and in the community must be "educated on the warning signs of suicide in order that they may intervene before a tragedy occurs (Strother, 1986).

Consequently, many states are developing suicide prevention programs and some have mandated public awareness and education programs in the public schools, i.e. Maryland, New York, Illinois, California, Colorado. Several measures regarding suicide prevention were also introduced during the 99th Congress due to the increase in youth suicides in the nation. The U.S. Department of Health and Human Services has established the following specific health objective and has given to the Centers for Disease Control and the National Institute of Mental Health the responsibility for monitoring and promoting progress toward the objective:

> "By 1990, the rate of suicide among young people 15 - 24 years of age should be below 11 per 100,000 (compared with 12.1 per 100,000 in 1978)" (DHHS, 1986).

"A variety of issues and recommendations regarding intervention and treatment for the suicidal adolescent have been proposed. However, there are no empirical data related to the effectiveness of treatment programs for parasuicidal children and adolescents" (Kenley, et al., 1986). "The initial foci of treatment are to evaluate the potential for another suicidal attempt and to identify the reasons for it. The resources available to protect the child must be identified and mobilized, and the strengths and weaknesses of the family assessed. The intervention program must quickly increase the family's realization of the seriousness of the child's suicidal behavior, and during the early treatment phase the family is encouraged to share perceptions and feelings regarding the suicide attempt and responsibility for the adolescent's behavior" (Kenley, et al., 1986; Husain, 1984). If hospitalization is deemed necessary, a multidisciplinary team works collaboratively to individualize the daily treatment approach. The hospital setting allows the individual to receive support, protection and care, relieves the pressure that culminated in the suicide attempt, (Husain, 1984) and may promote a therapeutic change in the family (Kenley, 1986).

The purpose of therapy is to help the individual re-establish adequate relationships and permit the rebuilding of hope and healthy family ties (Husain, 1984). Therapeutic modalities may include individual therapy, family therapy, group therapy and drug therapy. Treatment must focus on both the adolescent and the family (Kenley, 1986). Talk of suicide should be taken seriously, as suicide does not occur on the spur of the moment but is the final outcome of serious emotional disorders which, in most cases, were not recognized or not treated (Shafii, 1985). As the successful child or adolescent suicide often occurs two years after the first attempt, a suicidal attempt should be viewed as a crisis and comprehensive mental health services should be engaged immediately (Kenley, 1986).

The Legal Issues

The legal questions inherent in any discussion of suicide have received scant attention. Although an individual's desire to die is a personal decision, it is affected by the state's interest in protecting life and ensuring its perpetuation. The individual's personal decision to die and the state's interest in protecting life create a dilemma that includes both ethical and moral issues which are difficult to resolve.

"Suicide or self-murder, was a felony at English common law, attended by a forfeiture of the felon's property and an ignominious burial. In some jurisdictions in this country suicide is considered to be a crime, but these courts are not agreed as to whether it is a felony or a misdemeanor. Many courts, however, take the view that it is not a violation of the criminal law for a person to take his own life, unless so declared by statute. This is the case in those jurisdictions where common-law crimes have not survived. In the absence of statute, many authorities hold that suicide is not an offense.

Although an attempt to commit the act may be held to be criminal, there is excellently reasoned authority which asserts that in the absence of statute, an attempted suicide is not an indictable offense. Some states' statutes have provided that a person who, with intent to take his own life, commits upon himself any act which would be dangerous to human life, or which, if committed upon another person and the consequence is death and such act would render the perpetrator chargeable with homicide, is guilty of attempted suicide and punishable as for a felony. Consequently, in some jurisdictions whether attempted suicide is a crime remains in doubt" (40 Am. Jur. 2d §§ 583-584). In Virginia, there is no law prohibiting suicide or attempted suicide.

The inconsistency in the law raises several difficult yet important questions: Is there a right to suicide? By whom and to what extent should intervention extend? Does one have an obligation to refrain from committing suicide? Are third parties obligated to honor the suicide's rights or to intervene? What is the basis of the state's authority in intervention?

Over the last decade, suicide has received considerable attention as a responsible alternative and discussions about suicide have focused on a "right to die." More recent cases have involved the rights of terminally ill or comatose patients. The legal issues therefore center on an individual's right to self-determination and privacy (Sullivan, 1970; Battin, 1970), the doctrine of informed consent, and in the case of minors, the mature minor rule and the definition of legal custody (Harris, 1985). The courts have not treated suicide or its close variants in a thorough fashion. Judicial decisions on suicide usually weigh the state's interest in preserving life or in policing the crime of self-destruction against any of several constitutional rights of the individual involving principles of self-determination or religious belief. However, modern courts have not explained the reasons for the government's interest in preventing self-destructive acts by competent people, and courts have only recently begun to identify with care the scope of a person's right to a death of his own choosing (Sullivan, 1970).

The issue of self-determination and the concept of the right to privacy as developed by the United States Supreme Court (Griswold v. Connecticut, 381 U.S. 479 (1965) generate questions regarding the limits of an individual's right to privacy relative to suicide. Do such rights attach only to those intimate relationships having a "claim to social protection," such as marriage and the family, or does the right protect from government interference the person's choice to do with his body

what he will, so long as that choice does not affect the rights of others? The Court's decisions anchoring privacy to the guarantees of 'liberty' in the Due Process Clauses of the Fifth and Fourteenth Amendments imply two important propositions: (1) the right to privacy belongs to individuals and does not necessarily flow from relationships sanctioned by society; and (2) the right protects personal choices in areas historically screened from the state's interference (Sullivan, 1970). Of the two most frequently used meanings of privacy, the right of selective disclosure and personal autonomy, the right to make certain personal choices concerning one's destiny free from government interference, it is the latter which is involved in suicide.

"The words, life, liberty and property, in the Fourteenth Amendment were borrowed from the English common law and the thirty-ninth article of the Magna Carta. As such, personal liberty meant no more and no less than the power of locomotion, of changing situation, or moving one's person to whatever place one's inclination may direct, without imprisonment or restraint, unless by due course of law" (Sullivan, 1970). However, modern courts in this nation have extended the concept of personal liberty to the individual's freedom from unconsented interference with choices concerning his body. This reasoning is at the heart of the Supreme Court's decision in Griswold wherein the Court held unconstitutional a state criminal statute that prohibited the use of contraceptives. The Court, in Griswold, acknowledged the existence of a fundamental right protecting the marriage relation from government intrusion when it opined that the First Amendment's "right of association," the Fourth Amendment's "right to be free of unreasonable searches and seizures," and the Fifth Amendment, which according to the Court, "enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment." In Eisenstadt v. Baird, 405 U.S. 438 (1971), the Court extended the privacy right to choices outside the marriage relation and held unconstitutional a statute proscribing distribution of contraceptives to unmarried persons. In addition, the Court has upheld the right of privacy centered upon the home, Stanley v. Georgia, 394 U.S. 557 (1969), holding unconstitutional a state statute proscribing the private possession of obscene material, and in relation to this case, cited Brandeis's dissent in Olmstead v. United States, 277 U.S. 438, 478 (1928), "the Constitution conferred, as the against the Government, the right to be let alone - the most comprehensive of rights and the most valued by civilized man." Roe v. Wade, 410 U.S. 113 (1973) is one of the most celebrated of right to privacy decisions. Here, the Court implicitly acknowledged that a person's control of her body, irrespective of any relation in which she may be engaged, is a fundamental right under the Constitution. However, the Court has not chosen to extend such rights to all matters of intimate personal discretion or to all important decisions affecting the individual's destiny. It is argued that the "Fourteenth Amendment's protection of the right to self-determination in significant matters of personal choice manifestly rests upon a belief in the primacy of personal responsibility. The law cannot consistently protect the right to decide while permitting official interference with choices that it deems to be foolish or morally wrong, unless important interests of others would be jeopardized by those choices. This decision is significant as it relates to the intrinsic questions generated by the issue of suicide" (Sullivan, 1970).

Concerning suicide prevention and intervention, the tort law doctrine of "informed consent" merits consideration, as well as the "mature minor rule." The basis of informed consent is related to the Fourteenth Amendment's guarantee of personal liberty, therefore acknowledging that the individual has a fundamental right to do with his body what he pleases, so long as neither the rights of others nor the public interest is threatened in the process. The law's acknowledgement of the right to decide entails acceptance of the consequences of choice. Therefore, the choice of a person to take affirmative steps to end his life is not legally different from the choice of a person to order termination of artificial means to prolong his life. Arguments that support the right to die in this instance, but not in the instance of suicide, ignore the profoundly personal nature of the decision in both instances" (Sullivan, 1970).

The state derives its authority to prevent and to intervene in suicide from its police powers and its role as parens patriae, a sovereign right and duty to care for and protect a child when his parents cannot or will not. Although the term "police power" cannot be fully defined, it can be said that it is the "whole power of government, the due regulation and domestic order of the kingdom, where members of the state are bound to conform their general behavior to the rules of propriety, good neighborhood, and good manners, and to be decent, industrious, and inoffensive in their respective stations, finds support in judicial decisions. It is that authority that resides in every sovereignty to pass all laws for the internal regulation and government of the state which is not surrendered by the terms of the Constitution to the federal government" (16A Am. Jur. 2d § 363). Two maxims undergird the doctrine of police power. They are "sic utere tuo ut alienum non laedas" (so use your own that you do not injure that of another), and "salus populi suprema lex est," (the welfare of the people is the highest law). It is upon this maxim that the rights enjoyed by the public are subject to the paramount right of the state to modify them to conserve the public welfare. Although constitutional guaranties cannot be transgressed, the police power of the state includes such reasonable conditions as may be essential to the safety, health, peace, order, and morals of the community. Police power extends not only to things intrinsically dangerous, but to those that may be so used as to be injurious or dangerous to life (Leisy v. Hardin, 135 U.S. 100); hence, everything inimical to public policy or to the public interest is the subject of the exercise of police powers. Thus, it is on this principle that the state has an interest in preventing suicide. It is in the state's interest to have strong, healthy citizens to preserve the strength and vigor of the race and to be capable of self-support. The welfare of its citizens is of such primary importance to the state and has such a direct relationship to the general good as to make laws to promote that object proper under the police power (16A Am. Jur. §§ 368-417).

The state, as parens patriae, has a wide range of power for limiting parental authority and freedom concerning a child's welfare. This power is based on the state's duty to protect those citizens who because of infancy are unable to care for themselves, the right of the child to its protection, and the state's interest in its own perpetuation. Therefore, the state, as parens patriae, in a proper case, may interfere to ensure that the child is given medical treatment necessary to continue and to protect his life.

FINDINGS OF THE JOINT SUBCOMMITTEE

The increase in youth suicides is a state and national crisis. The Joint Subcommittee held several public hearings throughout the Commonwealth and reviewed considerable data concerning youth suicide. The following represents the Subcommittee's findings on the magnitude and prevalence of youth suicide in Virginia, the needs in the areas of prevention, intervention, treatment and postvention.

The Joint Subcommittee received testimony from professionals in the areas of child psychology, mental health, psychiatry, social services, education, law-enforcement, and from the clergy, parents, youth, business and industry, various community organizations and other interested parties. Testimony presented to the Joint Subcommittee centered primarily on associative risk factors for youth suicide, the need for public awareness of the severity of the problem, the need for preventive and interventive strategies, treatment of the clinically depressed, the need for greater child mental health services and increased funding for such services, the need for school-based youth suicide prevention programs, proper training and utilization of school pupil services personnel, community involvement, and improvements in the reporting mechanism for suicides.

It was noted that it is the State Medical Examiner's responsibility to determine the cause of death, and that his decision is made objectively in keeping with the medical information and other data at his disposal. The medical examiner's office is a division of the State Health Department and its work is performed by 350 licensed physicians who serve as local medical examiners. They are supported by four regional offices to which each is assigned two Board-certified forensic pathologists. In reaching a decision as to whether the manner of death was by suicide, the medical examiner talks with physicians, psychiatrists, police and others to gather data on the decedent. After gathering the facts and the medical evidence, the medical examiner must rule upon the cause and manner of death. The ruling is dictated solely by the facts in each case. The manner of death in some cases are difficult to determine as in car accidents and other risk-taking behavior. On occasion, the Medical Examiner's ruling on the manner of death is challenged. In such instances, an insurance policy is usually in question and the suit is against the insurance carrier and peripherally against the medical examiner. Representatives of the Medical Examiner's office stated that assistance would be welcomed from other professionals who could approach each possible suicide rationally and objectively, and who could aid in the compilation of a social history and other relevant information about the decedent and the manner of death.

The Medical Examiner's Office stated that the single most effective action to enhance its capabilities in the investigation of suicide would be the employment of a well-qualified former homicide investigator who could be trained in the medicolegal aspects of the medical examiner's work to investigate and follow up on data obtained from medical investigation and law enforcement agencies. The substantiation of the evidence would provide adequate documentation needed to affirm the Medical Examiner's ruling on the manner of death when such rulings are litigated.

The rate of suicide for the age group 5-10 has not increased, but the rate for the age group 15-24 has increased dramatically. For every recorded successful suicide, there are a hundred or more suicide attempts. Deaths of children below the age of ten are not recorded as suicide in the nation. It would be helpful for statistical purposes to have this procedure corrected. One group of children and youth that is lost in the gross statistics on suicide are those who attempt suicide but are saved via the sophisticated expertise of medical science and technology. The number of such individuals who are left with permanent brain damage, neurological and other physical disorders which require long-term, expensive medical and rehabilitative care is steadily growing.

Testimony submitted to the Joint Subcommittee indicates that some accidents are believed to be suicide but that in some instances it is difficult to determine whether the cause of death was by accident or by suicide. Physicians sometimes record the cause of death as accidental for various reasons. It is possible that a percentage of deaths recorded as accidental should be categorized as suicide and that some of the lethal elements of the highway system, as well as the role of drugs and alcohol in suicide, should be considered when attempting to determine the cause of death.

The Joint Subcommittee also received testimony from the various school divisions. It was noted that the youth suicide prevention program used in the Fairfax County Public Schools was begun as a response to the need to combat the youth suicide problem in the county. Students who committed suicide in Fairfax County were among two groups, the high achievers and low achievers, specifically those students determined to be learning disabled. The Joint Subcommittee determined that generalizations cannot be made in assessing who is most at risk for suicide, as the geographical area and the social characteristics of the area may contribute to the problem. It was noted that the Fairfax area was characterized as one of intense pressure and competition and high academic standards and expectations.

The Prince William County Community Services Board reported that the Board was funded to conduct a model youth suicide prevention program. The program is focused on the use of community resources to provide preventive services. A national study of high achieving students who were selected for Who's Who in 1986 found that most of the students had thought about suicide at some time and some students had attempted suicide. Although there are a combination of factors why youth commit suicide, as it is thought that some gifted students place tremendous stress on themselves to be successful, most mental health professionals agree that more research on the factors which contribute to youth suicide is needed.

Several factors that are often overlooked or ignored when discussing youth suicide, particularly in the mass media, include the following:

1. It is the opinion of many experts in the field of children's mental health that some accidents that result in death or serious injury to young people are disguised suicides and suicide attempts.

2. Reported statistics on youth suicide seldom account for the serious, permanent injuries that may result from an unsuccessful suicide attempt.

3. Reported statistics usually do not reflect the enormous psychological harm to children who attempt suicide, to their families, friends and the impact of suicide or parasuicide on the suicidal behavior of peer groups.

4. Statistics on youth suicide usually do not reflect the large monetary costs of hospitalization, residential care and outpatient treatment for youth who attempt or complete suicide and their families.

The Joint Subcommittee, after reviewing data on youth suicide and the testimony submitted to it, acknowledges the need for the development and implemention of youth suicide prevention and treatment programs statewide and it urges that certain facts be seriously considered in the development of such programs.

The general public, parents and youth workers need to be aware:

- of the seriousness of the problem
- of the early signs of depression
- of the specific behavior cues that often precede a suicide attempt
- of what they can do to help depressed or suicidal relatives or friends, and where they can go for help
- that depression is a very treatable illness in most cases

The essential components of an effective suicide prevention program include:

Prevention - education and skill building for teens to facilitate their knowledge of the effect of psychological developmental changes of adolescence; how to recognize and cope with stress, anxiety and depression; where to go for help, how to build a support system and how to help a depressed or suicidal friend; education programs for school personnel, parents, professionals and the community on how to recognize the warning signs and how to access appropriate assistance.

Intervention - accessible and staffed by qualified persons in child and family interventions; readily available crisis and emergency services and immediate crisis intervention and stabilization services.

Postvention - assist schools and communities in their reaction to a suicide.

Community plan - multi-agnecy and an integrated multidisciplinary plan to combat and reduce the risk factors for youth suicide.

The implementation of such programs will involve significant costs, however, the tremendous costs in the loss of productive human lives may be quite small by comparison.

Promising approaches for combatting youth suicide include:

- a system of planning for the early identification and referrals between public schools, pediatricians and mental health persons;

- the combined training of education and mental health personnel;

- the use of peer group counseling;

- the improved skills and qualifications of mental health professionals and an increase in the number of child psychiatrists in community mental health centers;

- the training of alcohol and drug abuse counselors of adults of the signs for which they should be alert in the children of such adults;

- the improvement in the job skills, particularly for the 19-24 year old age group; and

- further research to determine any biological factors associated with suicide and depressive illness.

It is the position of the Department of Education that the problems of drug and alcohol abuse, school dropout, teen pregnancy, depression and youth suicide are inseparable and should be addressed simultaneously in the schools and in the community. The creation of healthy psychological environments for young people should begin early in life and continue throughout the life span. Initiatives outlined by the Department that have been implemented to address youth suicide include:

Curriculum - a comprehensive unit on suicide prevention is included in health education at grade ten. Strategies to promote the development of a positive self-concept and coping skills are included in the mental health unit at all grade levels. Information on suicide has been provided to local school divisions since 1985. A Task Force on At-Risk Youth has been appointed to coordinate independent prevention efforts and to review methods of intervention. Youth suicide has been addressed at the annual conference for school nurses for the last three years.

Preparation of School Personnel - Some schools in Virginia have a documented plan of action in a suicide crisis. Fairfax County and Chesapeake have suicide prevention programs and postvention procedures which are broader and can apply to any crisis in the schools. Information is now being compiled on suicide prevention and postvention procedures in various schools and school divisions. This information will be provided to local school divisions.

Mechanisms for Resources and Referrals - Some schools have a mechanism for resources and referrals for students at-risk for suicide, but there is no official policy to require it. This information will be collected by the Department and will be made available to local school divisions.

Initiatives Taken to Combat Youth Suicide and Increase Public Awareness - The Department of Education is represented on the Virginia Health Care Council's Youth Suicide Prevention Task Force, which is an interagency cooperative effort to advocate suicide prevention services, to serve as a clearinghouse for information and resources, and to coordinate existing suicide prevention/treatment activities.

Model Program - The Virginia Health Care Council is developing a list and description of model prevention programs statewide.

Needs - The Department identified the following needs:

- Guidelines for dealing with the growing problem of suicide.

- An organized data collection and reporting procedure for suicide and suicide attempts.

- The training of guidance counselors and other support personnel in dealing with suicide.

RECOMMENDATIONS

1. *It is recommended that school-based youth suicide prevention programs be required in all public schools in the Commonwealth and that such services be delivered in cooperation with appropriate community mental health providers.*

Discussion: Data presented to the Joint Subcommittee indicated a need to provide information to youth on the warning signs of suicide, and to provide opportunities to help students develop positive-self concepts and coping and decision-making skills. The school offers an appropriate site for the delivery of these services as this approach would provide the greatest accessibility to students at one time. Prevention services and postvention services could be incorporated into the existing health education and family life education curriculum and outreach activities could be used to apprise parents and the community of the problem and involve them in the development of solutions. Equipping guidance counselors, teachers and other instructional and administrative staff to appropriately respond to children in crisis or in imminent danger of committing suicide was cited as an important aspect in addressing the problem of youth suicide. Several school divisions have initiated school-based youth suicide programs in response to the growing problem of suicide within their communities. Many of these school divisions have entered into cooperative arrangements with community mental health agencies and other community resources for the delivery of prevention services on the premises of the school grounds. The fact that such services would be delivered by an entity outside of the public school setting reduces the likelihood of the need for increased educational appropriations to provide prevention services. The Joint Subcommittee was advised that the Superintendent of Public Instruction has already begun to plan for the reorganization and coordination of pupil personnel services, e.g. school guidance counselors, school social worker, visiting teacher, school psychologist, in order to improve the delivery of needed support services to students.

2. *It is recommended that course work in the identification of the warning signs of suicide and suicide prevention be required of all pupil personnel services staff as a condition of professional certification.*

Discussion: It is essential that core personnel for the delivery of pupil personnel services be knowledgeable of the warning signs of suicide and the prevention modalities and services available in the community in order that appropriate intervention and treatment might be instituted.

3. *It is recommended that the Board of Education, together with the Departments of Health, MHMRSAS, and Social Services, develop a mechanism to enhance public awareness and disseminate information to students, parents and the public on the warning signs of suicide, medical and community resources, and public and private prevention services available within the localities.*

4. *It is recommended that prevention programs recognize the relationship of depression and suicide and that such programs provide opportunities for youth to learn appropriate coping skills and the symptoms of depression.*

Discussion: A broad definition of suicide should include depressive disorders. It is estimated that three to six million children in this nation are clinically depressed and that between six and ten percent of children aged six to twelve have already suffered an episode of clinical depression. One pressing need in reducing the high rate of youth suicide is greater public awareness of the severity of the problem, the associative causes of suicide, its warning signs, and the availability of prevention services. These simple yet critical measures would increase the likelihood that more young lives will be saved.

5. *It is recommended that hot lines for teens be established throughout the Commonwealth.*

Discussion: Crisis hot lines provide readily accessible, confidential counseling services for youth at risk. There are some hot lines already in use, but such services are not available across the state and they provide counseling services for many problems in addition to suicide prevention. A collaborative effort should be employed by the Departments of Health, Social Services, the Children, and Mental Health and Mental Retardation and Substance Abuse Services to assist localities in the implementation of crisis hot lines in order that such first line interventive services might be available throughout the state.

6. *It is recommended that existing policies, directives and programs of all state agencies be reviewed to determine the availability of youth suicide prevention programs in order to facilitate coordination of such existing programs and reduce the duplication of services.*

7. *It is recommended that localities in Virginia develop an integrated plan for the delivery of youth suicide prevention programs which would include multiple resource agencies.*

8. *It is recommended that youth suicide prevention activities, public and professional education, resource development and technical assistance to localities be coordinated at the state level.*

Discussion: The Joint Subcommittee was advised that there are on-going youth suicide prevention services and other initiatives to provide such services throughout the state. In order to prevent fragmentation and duplication of efforts on the part of affected state agencies and localities in the delivery of these programs and services, the Joint Subcommittee believes that a review of various prevention programs in the state would aid in the coordination of effective and essential programs and services, the elimination of duplicative services, and facilitate the efficient and cost-effective delivery of state supported programs and services. It is the Joint Subcommittee's position that the cooperation and integration of multidisciplinary programs and services at the community level, involving all segments of the community, provides the best means of addressing a multifaceted program in as wholistic a manner as possible. The Joint Subcommittee recommends that the Council on Coordinating Prevention be charged with these responsibilities.

9. *It is recommended that the Department of Education encourage public schools to utilize peer counseling as a means of providing prevention services.*

Discussion: Testimony presented to the Joint Subcommittee at its public hearings throughout the state indicate that youth are more likely to seek a peer with whom to discuss their problems. On a number of occasions, youth who are suicidal or who have successfully committed suicide first sought a friend with whom to share their problems and to receive counseling. Several young people testified that had they been adequately prepared to direct their friends to appropriate school professionals, community resources, or professional help, it is very possible that many lives might have been saved and unnecessary and prolonged suffering might have been avoided. Youth who have been adequately trained as peer counselors can be an effective deterrent to youth suicide.

10. *It is recommended that a mechanism be developed to determine the number and nature of attempted suicides in the state.*

Discussion: In Virginia, there is no mechanism in existence for monitoring and reporting attempted suicides. It is estimated that for every successful suicide there are twice as many attempts. Suicidology indicates that many failed attempts are these persons' cries, for help. Too often, such cries having been ignored, result in successful suicides. Therefore, to meet the needs of such individuals and to reduce the high rate of youth suicide, information about attempted suicides is essential. It aids in gauging the number of youth at risk for suicide, and in planning prevention, intervention and postvention programs.

11. *It is recommended that the State Council of Higher Education, State Board of Community Colleges, and the Departments of Health and MHMRSAS conduct a joint study to determine the magnitude of the problem of clinical depression and suicide at public colleges and universities, and*

the availability and accessibility of prevention, intervention, treatment and postvention programs and services offered by the institutions and within the surrounding communities.

Discussion: During the course of its study, the Joint Subcommittee found that although youth suicide, for health statistical purposes, extends to age 25, emphasis is placed on the age group 15 to 18. However, the age group 20 to 25 has one of the highest suicides rates. Due to this emphasis, a large proportion of the population at risk for suicide is under-assessed and disregarded. It is estimated that four to ten percent of the American public now suffer from clinical depression and depressive symptoms. The data reveal a higher prevalence of such disorders among young adults between ages 18 and 44. This is noteworthy as persons with long-term clinical depression are at a high risk for suicide, and the economic costs associated with clinical depression and suicide are substantial. Depressive disorders are often related to lowered job performance and productivity, absenteeism, and alterations in career and job choices. Such disorders are often the precursors of a host of other related problems, such as family dysfunction, antisocial behavior, illness and death. It is the position of the Joint Subcommittee that a determination of the prevalence of clinical depression and suicide among students at institutions of higher education in the Commonwealth would facilitate better health planning, dissemination of critical information regarding the warning signs of suicide and the availability and delivery of prevention, intervention, treatment and postvention services. Such data would also enable efficient planning and utilization of mental health services and provide more accurate information on the magnitude of the problem among youth in Virginia.

CONCLUSION

Dr. Herbert Hendin of the Center for Psychosocial Studies noted in one of his published works that the marked increase in youth suicide has been accompanied by a rise in other serious problems such as drug and alcohol abuse, delinquency and crime among the same age group. These problems have become indicators of social stress. The emphasis of health promotion, prevention and treatment initiatives is to assist young people in understanding the stresses of life, to endow them with coping skills and to assist them in attaining knowledge to improve their prospects for the future.

Although the demand for mental health services for children and youth has increased dramatically, only 15 of the 40 CSBs have a full-time child and adolescent treatment specialist. Each CSB should have identified children's services units with adequate staffing of appropriate prevention and treatment specialists and access to other related health, social services and education professionals to serve children and youth as the caseload might warrant. The approach should be multidimensional, multidisciplinary, comprehensive, multi-agency and coordinated. Services that should be available in each locality include:

1. Public awareness, education and community involvement

2. Case management

3. Outpatient child and family counseling

4. Intensive in-home crisis intervention services

5. Day treatment and school-based youth suicide prevention programs

6. Inpatient hospitalization

Youth suicide is a multidimensional problem. It involves the family, the community, schools, mental health and substance abuse programs and other community organizations. The belief which must undergird all youth suicide prevention programs is that "suicide is preventable." This approach involves identification and mediation of many of the problems of youth. Effective suicide prevention efforts must address depression among youth, the role of low self-esteem, pressures to achieve, lack of problem solving and coping skills, family problems and dysfunction, increased stress and substance abuse. It is essential that a combined community approach utilized to address this problem include treatment, intervention and prevention service modalities. The responsibility for such programs should not be given to any one institution or organization in the community. Such programs must be a partnership between the local mental health agencies and all other facets of the community must be coordinated to provide crisis services systems that respond effectively, and with dispatch, to youth in crisis.

The Joint Subcommittee expresses it appreciation to all state agencies, school divisions, institutions of higher education, parents, youth, elected officials, civic organizations, community leaders, law-enforcement agencies, and interested citizens for their contributions to its study.

Respectfully submitted

Richard L. Saslaw, Chairman

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APPENDIX

A. Senate Joint Resolution No. 173
House Joint Resolution No. 312

B. Proposed Legislation

C. Tables: Virginia Death Rates Per 100,000 Age Specific, 1981-1985

APPENDIX A

SENATE JOINT RESOLUTION NO. 173

Requesting a joint subcommittee be established to study causes of suicide among children and youth and strategies to effect the implementation of youth suicide prevention programs.

Agreed to by the Senate, February 4, 1987
Agreed to by the House of Delegates, February 25, 1987

WHEREAS, the youth of society represent the hope for the future; and

WHEREAS, suicide is a significant national health problem affecting young people as demonstrated by the fact that suicide is currently the eighth leading cause of death in the United States, the third leading cause of death among adolescents, and the second leading cause of death among college and university students; and

WHEREAS, the rate of suicide in this country during the last twenty-five years among individuals fifteen to twenty-four years of age has increased threefold; and

WHEREAS, peer pressure, family-related conflicts, educational demands, and other youthful concerns can be extremely burdensome and oftentimes difficult for today's children and youth to cope with; and

WHEREAS, there is a need to identify the causes of suicide among children and youth so as to develop strategies and comprehensive plans to recognize, address and combat these suicides; and

WHEREAS, an organizational framework is needed to provide a forum in which state and local officials, together with youth, parents and educational institutions may focus their efforts to develop such plans and strategies after identifying suicide's causes; now, therefore, be it

RESOLVED by the Senate of Virginia, the Hosue of Delegates concurring, that a joint subcommittee be established to study the causes of suicide among children and youth and develop strategies to implement effective youth suicide prevention programs. The subcommittee is requested to ask local and state officials, as well as the public and educators, to participate in its study so as to emphasize a partnership between government and the public.

The joint subcommittee shall consist of seven members to be appointed as follows: three members from the Senate Committee on Education and Health to be appointed by the Senate Committee on Privileges and Elections; four members from the House Committee on Health, Welfare and Institutions to be appointed by the Speaker of the House.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and to the 1988 Session of the General Assembly.

The indirect costs of this study are estimated to be $13,500; the direct costs of this study shall not exceed $6,300.

GENERAL ASSEMBLY OF VIRGINIA -- 1987 SESSION

HOUSE JOINT RESOLUTION NO. 312

Requesting a joint subcommittee be established to study causes of suicide among children and youth and strategies to effect the implementation of youth suicide prevention programs.

Agreed to by the House of Delegates, February 8, 1987
Agreed to by the Senate, February 24, 1987

WHEREAS, the youth of society represent the hope for the future; and

WHEREAS, suicide is a significant national problem affecting young people as demonstrated by the fact that suicide is currently the eighth leading cause of death in the United States, the third leading cause of death among adolescents, and the second leading cause of death among college and university students; and

WHEREAS, the rate of suicide in this country during the last twenty-five years among individuals fifteen to twenty-four years of age has increased threefold; and

WHEREAS, peer pressure, family-related conflicts, educational demands, and other youthful concerns can be extremely burdensome and oftentimes difficult for today's children and youth; and

WHEREAS, there is a need to identify the causes of suicide among children and youth so as to develop strategies and comprehensive plans to recognize, address and combat these suicides; and

WHEREAS, an organizational framework is needed to provide a forum in which state and local officials, together with youth, parents and educational institutions may focus their efforts to develop such plans and strategies after identifying suicide's causes; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, that a joint subcommittee be established to study the causes of suicide among children and youth and develop strategies to implement effective youth suicide prevention programs. The subcommittee is requested to ask local and state officials, as well as the public and educators, to participate in its study so as to emphasize a partnership between government and the public.

The joint subcommittee shall consist of seven members to be appointed as follows: four members from the House Committee on Health, Welfare and Institutions to be appointed by the Speaker of the House; and three members from the Senate Committee on Education and Health to be appointed by the Senate Committee on Privileges and Elections.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and to the 1988 Session of the General Assembly.

The indirect costs of this study are estimated to be $13,500; the direct costs of this study shall not exceed $6,300.

1988 SESSION

LD2451132

SENATE BILL NO. 284

Offered January 26, 1988

A BILL to amend the Code of Virginia by adding a section numbered 22.1-253.8:1. relating to support services to include local suicide prevention programs.

Patrons–Saslaw. Miller, E. F., Scott and Miller, Y. B.

Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 22.1-253.8:1 as follows:

§ 22.1-253.8:1. Standard 2. Support services.—A. The General Assembly and the Board of Education believe that effective schools must provide and maintain adequate support services to ensure quality education.

B. The Board of Education shall provide to the local school divisions technical assistance in the delivery of those support services which are necessary for the operation and maintenance of the public schools. Such technical services shall include, but not be limited to, in-service training of staff, development of appropriate facility plans, specifications for equipment, technology updates, and inspections of school buses.

C. Each local school board shall provide those support services which are necessary for the operation and maintenance of its public schools including, but not limited to, administration, instructional support, student attendence and health, including suicide prevention programs, operation and maintenance of the buildings and management information systems.

D. Each local school board shall also provide a program of pupil personnel services for grades K through 12 which shall be designed to aid students in their education, social and career development.

E. Pursuant to the appropriations act, support services shall be funded from basic school aid on the basis of prevailing statewide costs.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

LD1604132

SENATE JOINT RESOLUTION NO. 15

Offered January 20, 1988

Requesting the Board of Education to encourage the establishment of school-based youth suicide prevention programs.

Patrons–Saslaw, Scott, Colgan, Miller, Y. B., Miller, E. F., Houck, Stallings, Holland, C. A., Walker, Gartlan, Joannou, Michie, Holland, E. M. and Macfarlane

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Referred to the Committee on Rules

WHEREAS, over the last thirty years in the United States, the suicide rate for youth fifteen to twenty-four years of age has increased dramatically, moving suicide from the fifth leading cause of death for this age group in 1960 to the third leading cause of death in 1980; and

WHEREAS, in Virginia, suicide among all ages has risen dramatically since 1950, and has become the second leading cause of death among youth fifteen to twenty-four years of age; and

WHEREAS, although the causes of suicide are multidimensional, major indicators of the risks for suicide are depression, a prominent and persistent loss of pleasure and interest in usual activities, feelings of sadness, hoplessness and discouragement; and

WHEREAS, youth at risk for suicide are those who experience an increase in negative life events, family stress and dysfunction, a history of suicide, depression or mental illness in the family, poor grades and recurring and prevalent confrontations with subsequent humiliation; and

WHEREAS, youth at risk for suicide demonstrate certain warning signs such as low self-esteem, withdrawal, sudden changes in physical appearance, disturbed sleep and eating habits, the increase in the use of alcohol and drugs, the giving away of personal possessions; and

WHEREAS, suicide is preventable if youth are assisted in developing appropriate coping and decision-making skills, understanding the nature of adolescent development and pressures of living; and

WHEREAS, instruction on the causes and warning signs of suicide, the development of coping and decision-making skills and a positive self-concept, access to competent, trained mental health and counseling professionals, and information on available community resources would enable youth to seek help in stressful times, thereby saving lives; and

WHEREAS, to ensure that youth receive this critical information, such instruction may be best provided through the required health education and family life education programs in the public schools, utilizing a multidisciplinary approach and community resources; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Board of Education is requested to encourage local school divisions to establish and implement school-based youth suicide prevention programs. The Board shall encourage local school divisions to provide information regarding youth suicide to parents and other community leaders, and seek the assistance of all facets of the community in the delivery of the programs.

LD1597132

SENATE JOINT RESOLUTION NO. 63

Offered January 26, 1988

Requesting the State Council of Higher Education to study the incidence of clinical depression and suicide among college students and the availability of suicide prevention services at institutions of higher education in the Commonwealth.

Patrons–Saslaw, Miller, E. F., Waddell and Miller, Y. B.

Referred to the Committee on Rules

WHEREAS, over the last thirty years in the United States, the suicide rate for youth fifteen to twenty-four years of age has increased dramatically, moving suicide from the fifth leading cause of death for this age group in 1960 to the third leading cause of death in 1980; and

WHEREAS, in Virginia, suicides among all ages have risen dramatically since 1950, and was the second leading cause of death among youth fifteen to twenty-four years of age and

WHEREAS, although the causes of suicide are multidimensional, major indicators of the risks for suicide are depression, a prominent and persistent loss of pleasure and interest in usual activities, feelings of sadness, hopelessness and discouragement; and

WHEREAS, persons at risk for suicide are those who experience an increase in negative life events, family stress and dysfunction, a history of suicide, depression or mental illness in the family, poor grades and recurring and prevalent confrontations with subsequent humiliation; and

WHEREAS, persons at risk for suicide demonstrate certain warning signs such as low self-esteem, withdrawal, sudden changes in physical appearance, disturbed sleep and eating habits, the increase in the use of alcohol or drugs, and the giving away of personal possessions; and

WHEREAS, it is estimated that four to ten percent of the American public now suffer from clinical depression and depressive symptoms show a higher prevalence among young adults between ages eighteen and forty-four; and

WHEREAS, persons with long-term clinical depression are at a high risk for suicide, and in Virginia in 1985, suicide was the second leading cause of death for age group fifteen to twenty-four and the fourth leading cause of death for the age group twenty-five to forty-four; and

WHEREAS, the increase of clinical depression and suicide is unknown among students at institutions of higher education in the Commonwealth, and services for the depressed or suicidal are not available statewide; and

WHEREAS, the economic costs associated with clinical depression and suicide are substantial, such disorders also related to lowered job performance and productivity, absenteeism, and alterations in career and job choices; and

WHEREAS, the social costs are immeasurable, and often are the precursors of a host of other related problems, such as family dysfunction, antisocial behavior, illness and death; and

WHEREAS, suicide is preventable if the individual is assisted in developing appropriate coping and decision-making skills, understanding the complexities and difficulties of living; and

WHEREAS, a determination of the prevalence of clinical depression and suicide among students at institutions of higher education in the Commonwealth would facilitate better health planning, dissemination of critical information regarding the warning signs of suicide and the availability of community resources, and the delivery of essential preventive, postventive and treatment services for this population; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the State Council of Higher Education is requested to study the incidence of clinical depression and suicide

among students at institutions of higher education in the Commonwealth. The Council shall ascertain the number of diagnosed clinical depression, parasuicides and suicides among this population, the availability of professional counseling and mental health services and the accessibility to adequately trained mental health prevention and treatment specialists at the institutions and within the immediate community. The Council shall also determine the needs of the student health services departments at the institutions in the provision of counseling, mental health services and other related health services.

The Board of the Virginia Community College System and the Departments of Health and Mental Health, Mental Retadation and Substance Abuse Services shall provide assistance to the Council as it may deem appropriate. Private institutions of higher education in the Commonwealth are requested to participate and cooperate with the Council in the conduct of this study.

The State Council of Higher Education shall submit a written report on its findings and recommendations to the Clerk of the Senate for the Senate Committees on Education and Health and on Finance and to the Clerk of the House of Delegates for the House Committees on Education, on Health, Welfare and Institutions and on Appropriations by December 1, 1988.

Official Use By Clerks	
Agreed to By The Senate	Agreed to By The House of Delegates
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

LD1603132

SENATE JOINT RESOLUTION NO. 64

Offered January 26, 1988

Requesting certain state agencies to assist in youth suicide prevention.

Patrons—Saslaw, Miller, E. F., Waddell, Scott and Miller, Y. B.

Referred to the Committee on Rules

WHEREAS, in Virginia, suicides among all ages have risen dramatically since 1950, and was the second leading cause of death among youth fifteen to twenty-four years of age in 1985; and

WHEREAS, although the causes of suicide are multidimensional, major indicators of the risks for suicide are depression, a prominent and persistent loss of pleasure and interest in usual activities, feelings of sadness, hopelessness and discouragement; and

WHEREAS, youth at risk for suicide are those who experience an increase in negative life events, family stress and dysfunction, a history of suicide, depression or mental illness in the family, poor grades and recurring and prevalent confrontations with subsequent humiliation; and

WHEREAS, youth at risk for suicide demonstrate certain warning signs as low self-esteem, withdrawal, sudden changes in physical appearance, disturbed sleep and eating habits, the increase in the use of alcohol and drugs, the giving away of personal possessions; and

WHEREAS, suicide is preventable if youth are assisted in developing appropriate coping and decision-making skills, understanding the nature of adolescent development and pressures of living; and

WHEREAS, the Joint Subcommittee Studying the Causes of Youth Suicide and Strategies to Implement Youth Suicide Prevention Programs determined that the greater the public's awareness of the problem of youth suicide and the availability of prevention services, the greater the likelihood that more young lives will be saved, and there is not a coordinated system of disseminating such vital information; and

WHEREAS, the Joint Subcommittee found that the availability of crisis hot lines would provide readily accessible, confidential counseling and information services to youth at risk or in crisis situations, and there is not adequate information on the extent of such services throughout the Commonwealth or a centralized point to obtain information on crisis hot lines and their varied services; and

WHEREAS, the Joint Subcommittee found further that suicide is not reported for children under the age of ten, that it is believed that many accidental deaths are indeed suicides, and that because there is a tendency to avoid the stigmatization of survivors, youth suicide may be under reported; and

WHEREAS, it was determined that the availability of suicide prevention services is essential to and instrumental in helping youth develop good coping and decision-making skills, fostering self-esteem, and enabling youth to gain a sense of hope and a desire to survive, but prevention specialists and related services are not available throughout the Commonwealth; and

WHEREAS, a mechanism to determine the number and nature of suicide attempts in the Commonwealth would facilitate effective health planning for the provision of prevention, intervention and postvention services, and a mechanism to coordinate existing policies, programs and services in these areas would result in saved lives and reduce the duplication and fragmentation of expensive services; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Departments of Health, and Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Council on Coordinating Prevention assist in youth suicide prevention.

The Department of Health is requested to develop a mechanism to determine the number and nature of attempted suicides and facilitate the reporting of suicides in youth

under age ten. The Department of Mental Health, Mental Retardation and Substance Abuse Services is requested to provide for prevention specialist positions and services at community services boards without such positions, determine appropriate means by which child mental health services may be made available and accessible throughout the Commonwealth, and together with the Virginia Council on Coordinating Prevention, provide for broader dissemination of information on the associative factors and warning signs and community resources for the prevention of suicide, the development of community youth suicide prevention programs, and crisis hot lines. The Virginia Council on Coordinating Prevention is requested to monitor and coordinate existing and the development of new programs and services to ensure that such initiatives are consistent with the objectives and goals of the Comprehensive Prevention Plan and to prevent the duplication and fragmentation of such services.

The Departments of Health, and Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Council on Coordinating Prevention shall submit a written report on the status of the implementation of their respective charges to the Clerk of the Senate for the Senate Committee on Education and Health and the Committee on Finance, and to the Clerk of the House of Delegates for the House Committee on Health, Welfare and Institutions and Appropriations Committee by December 1, 1988.

Official Use By Clerks	
Agreed to By The Senate	**Agreed to By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the Senate	Clerk of the House of Delegates

APPENDIX C

RESIDENT SUICIDES BY AGE, BY RACE AND SEX
WITH RATES PER 100,000 POPULATION, VIRGINIA, 1985

Race/Sex	Total	Age Groups							
		Under 15	15-24	25-34	35-44	45-54	55-64	65-74	75 & Over
TOTAL	751	11	134	159	117	96	110	75	49
White male	516	7	97	103	83	51	78	53	44
White female	151	4	23	27	22	31	23	17	4
Nonwhite male	75		12	27	11	10	9	5	1
Nonwhite female	9		2	2	1	4			
TOTAL RATES*	16.6		13.6	15.7	14.1	15.8	22.0	20.3	21.8
White male	29.5		24.9	26.0	25.0	20.6	40.2	41.1	71.6
White female	8.1		6.3	6.8	6.6	12.4	10.7	9.8	3.2
Nonwhite male	17.2		10.2	25.2	14.5	19.7	21.9	17.3	7.2
Nonwhite female	1.9		1.7	1.8	1.2	6.8	0.0	0.0	0.0

*Rates for totals of Race/Sex groups based on ages 15 and over.

RESIDENT SUICIDES BY RACE, SEX AND METHOD
VIRGINIA, 1985

Method	Total	Race/Sex			
		White Male	White Female	Nonwh Male	Nonwh Female
TOTAL	751	516	151	75	9
Firearms and explosives (E955)	506	376	76	51	3
Hanging, strangulation, and suffocation (E953)	88	65	7	15	1
Poisoning by drugs and medicaments (E950.0-E950.5)	59	15	41	1	2
Poisoning by domestic and other gases (E951-E952)	41	30	8	3	
Cutting and piercing instruments (E956)	15	12	3		
Jumping from high places (E957)	14	7	5	1	1
Submersions (drownings) (E954)	12	3	5	3	1
Poisoning by other solid and liquid substances (E950.6-E950.9)	4	2	2		
Other and unspecified means (E958)	12	6	4	1	1

NOTE: Numbers in parentheses are from ICD, 9th Revision.

SOURCE: Virginia 1985 Vital Statistics Annual Report

DEATH RATES PER 100,000 AGE SPECIFIC
POPULATION FROM MOTOR VEHICLE ACCIDENTS,
HOMICIDE AND SUICIDE, 1981-85, VIRGINIA

AGE GROUPS	YEAR AND RATE/100,000 AGE SPECIFIC POPULATION					
15 - 19	1981	1982	1983	1984	1985	81-85
M.V. Accidents	34.57	30.25	30.16	28.35	26.47	30.00
Homicide	4.24	7.41	6.07	4.69	4.41	5.37
Suicide	9.70	9.05	10.05	8.95	9.87	9.53
10 - 14	1981	1982	1983	1984	1985	81-85
M.V. Accidents	5.89	5.49	4.11	3.92	6.06	5 10
Homicide	2.12	0.72	1.45	0.73	1.70	1.35
Suicide	0.94	1.91	2.17	0.98	2.67	1.73
5 - 9	1981	1982	1983	1984	1985	81-85
M.V. Accidents	6.16	5.15	5.67	3.73	2.51	4.60
Homicide	1.34	0.54	0.27	1.60	0.50	0.85

DEATHS FROM HOMICIDE, SUICIDE, AND MOTOR VEHICLE ACCIDENTS AND
5 YEAR RATES PER 100,000 CHILDREN
15-19 YEARS BY HEALTH SERVICE REGION
VIRGINIA, 1981-85

	M.V. ACCIDENTS Deaths (Rate)	HOMICIDE Deaths (Rate)	SUICIDE Deaths	(Rate)
HSA I	133 (39.97)	12 (3.61)	23	(6.91)
HSA II	139 (30.79)	11 (2.44)	49	(10.85)
HSA III	198 (35.28)	27 (4.81)	57	(10.16)
HSA IV	126 (29.53)	35 (8.20)	44	(10.31)
HSA V	125 (19.81)	44 (6.97)	56	(8.87)
Virginia	721 (30.00)	129 (5.37)	229	(9.53)

DEATHS FROM MOTOR VEHICLE ACCIDENTS
HOMICIDE AND SUICIDE AND 5 YEAR
RATES PER 100,000 CHILDREN 10-14 YEARS,
BY HEALTH SERVICE REGION, VIRGINIA, 1981-85

Region	M.V.ACCIDENTS Deaths (Rate)	HOMICIDE Deaths (Rate)	SUICIDE Deaths	(Rate)
HSA I	11 (4.06)	5 (1.84)	0	
HSA II	13 (3.02)	2 (0.46)	9	(2.09)
HSA III	27 (5.56)	3 (0.62)	11	(2.26)
HSA IV	27 (7.28)	7 (1.89)	12	(3.24)
HSA V	28 (5.37)	11 (2.11)	4	(0.77)
VIRGINIA	106 (5.10)	28 (1.35)	36	(1.73)

DEATHS FROM MOTOR VEHICLE ACCIDENTS AND
HOMICIDE AND 5 YEAR RATES PER 100,000 CHILDREN,
5-9 YEARS, BY HEALTH SERVICE REGION
VIRGINIA, 1981-85

Region	M.V. Accidents Deaths (Rate)	Homicide Deaths	(Rate)
HSA I	20 (8.30)	2	(0.83)
HSA II	10 (2.53)	7	(1.77)
HSA III	18 (4.20)	2	(0.47)
HSA IV	16 (4.89)	2	(0.61)
HSA V	23 (4.66)	3	(0.61)
Virginia	87 (4.60)	16	(0.85)

DMCH 11/86

DEATHS FROM SUICIDE TO CHILDREN AGED 10-14
WITH FIVE-YEAR RATES PER 100,000 CHILDREN IN THE AGE GROUP
VIRGINIA, 1981-1985

Planning District/ City or County	SUICIDE DEATHS TO CHILDREN AGED 10-14 1981	1982	1983	1984	1985	TOTAL DEATHS 1981-85	RATE PER 100,000 CHILDREN AGED 10-14
State of Virginia	4	8	9	4	11	36	1.7
District 1	0	0	0	0	1	1	2.3
Lee						0	0.0
Scott						0	0.0
Wise					1	1	5.2
Norton						0	0.0
District 2	0	0	0	0	0	0	0.0
Buchanan						0	0.0
Dickenson						0	0.0
Russell						0	0.0
Tazewell						0	0.0
District 3	1	1	1	0	1	4	5.7
Bland						0	0.0
Carroll						0	0.0
Grayson						0	0.0
Smyth			1			1	7.8
Washington	1				1	2	10.4
Wythe		1				1	9.7
Bristol						0	0.0
Galax						0	0.0
District 4	0	0	0	0	0	0	0.0
Floyd						0	0.0
Giles						0	0.0
Montgomery						0	0.0
Pulaski						0	0.0
Radford						0	0.0
District 5	1	0	0	0	1	2	2.1
Alleghany						0	0.0
Botetourt						0	0.0
Craig						0	0.0
Roanoke						0	0.0
Clifton Forge						0	0.0
Covington						0	0.0
Roanoke City	1				1	2	6.0
Salem						0	0.0
District 6	0	0	0	0	0	0	0.0
Augusta						0	0.0
Bath						0	0.0
Highland						0	0.0
Rockbridge						0	0.0
Rockingham						0	0.0
Buena Vista						0	0.0
Harrisonburg						0	0.0
Lexington						0	0.0
Staunton						0	0.0
Waynesboro						0	0.0
District 7	0	0	0	0	0	0	0.0
Clarke						0	0.0
Frederick						0	0.0
Page						0	0.0
Shenandoah						0	0.0
Warren						0	0.0
Winchester						0	0.0
District 8	1	3	0	3	2	9	2.1
Arlington				1	1	2	6.2
Fairfax	1	3		1	1	6	2.4
Loudoun						0	0.0
Prince William				1		1	1.3
Alexandria						0	0.0
Fairfax City						0	0.0
Falls Church						0	0.0
Manassas						0	0.0
Manassas Park						0	0.0
District 9	0	0	0	0	0	0	0.0
Culpeper						0	0.0
Fauquier						0	0.0
Madison						0	0.0
Orange						0	0.0
Rappahannock						0	0.0
District 10	0	0	0	0	0	0	0.0
Albemarle						0	0.0
Fluvanna						0	0.0
Greene						0	0.0
Louisa						0	0.0
Nelson						0	0.0
Charlottesville						0	0.0

DEATHS FROM SUICIDE TO CHILDREN AGED 10-14
WITH FIVE-YEAR RATES PER 100,000 CHILDREN IN THE AGE GROUP
VIRGINIA, 1981-1985

Planning District/ City or County	SUICIDE DEATHS TO CHILDREN AGED 10-14					TOTAL DEATHS 1981-85	RATE PER 100,000 CHILDREN AGED 10-14
	1981	1982	1983	1984	1985		
District 11	0	1	0	0	1	2	2.6
Amherst		1			1	2	17.4
Appomattox						0	0.0
Bedford						0	0.0
Campbell						0	0.0
Bedford City						0	0.0
Lynchburg							
District 12	0	1	0	0	1	2	2.2
Franklin					1	1	6.8
Henry						0	0.0
Patrick						0	0.0
Pittsylvania		1				1	3.8
Danville						0	0.0
Martinsville						0	0.0
District 13	0	0	1	0	1	2	6.3
Brunswick						0	0.0
Halifax					1	1	8.3
Mecklenburg			1			1	9.1
South Boston						0	0.0
District 14	0	0	0	0	0	0	0.0
Amelia						0	0.0
Buckingham						0	0.0
Charlotte						0	0.0
Cumberland						0	0.0
Lunenburg						0	0.0
Nottoway						0	0.0
Prince Edward						0	0.0
District 15	1	0	5	0	2	8	3.3
Charles City Co.						0	0.0
Chesterfield			1			1	1.4
Goochland						0	0.0
Hanover					1	1	4.5
Henrico			3			3	4.6
New Kent	1					1	25.9
Powhatan						0	0.0
Richmond City			1		1	2	3.1
District 16	0	0	0	0	0	0	0.0
Caroline						0	0.0
King George						0	0.0
Spotsylvania						0	0.0
Stafford						0	0.0
Fredericksburg						0	0.0
District 17	0	0	0	0	0	0	0.0
Lancaster						0	0.0
Northumberland						0	0.0
Richmond						0	0.0
Westmoreland						0	0.0
District 18	0	0	0	0	0	0	0.0
Essex						0	0.0
Gloucester						0	0.0
King and Queen						0	0.0
King William						0	0.0
Mathews						0	0.0
Middlesex						0	0.0
District 19	0	1	1	0	0	2	3.1
Dinwiddie						0	0.0
Greensville		1				1	18.4
Prince George						0	0.0
Surry						0	0.0
Sussex						0	0.0
Colonial Heights						0	0.0
Emporia						0	0.0
Hopewell						0	0.0
Petersburg			1			1	6.5
District 20	0	1	0	1	1	3	0.9
Isle of Wight						0	0.0
Southampton						0	0.0
Chesapeake		1				1	1.9
Franklin City						0	0.0
Norfolk						0	0.0
Portsmouth					1	1	2.6
Suffolk						0	0.0
Virginia Beach				1		1	0.8
District 21	0	0	0	0	0	0	0.0
James City Co.						0	0.0
York						0	0.0
Hampton						0	0.0
Newport News						0	0.0
Poquoson						0	0.0
Williamsburg						0	0.0
District 22	0	0	1	0	0	1	5.8
Accomack			1			1	8.5
Northampton						0	0.0

DEATHS FROM SUICIDE TO CHILDREN AGED 15-19
WITH FIVE-YEAR RATES PER 100,000 CHILDREN IN THE AGE GROUP
VIRGINIA, 1981-1985

Planning District/ City or County	SUICIDE DEATHS TO CHILDREN AGED 15-19					TOTAL DEATHS 1981-85	RATE PER 100,000 CHILDREN AGED 15-19
	1981	1982	1983	1984	1985		
State of Virginia	48	44	48	42	47	229	9.5
District 1	1	1	0	1	0	3	7.0
Lee	1	1		1		3	26.9
Scott						0	0.0
Wise						0	0.0
Norton						0	0.0
District 2	2	0	3	1	2	8	12.6
Buchanan	1				1	2	10.8
Dickenson			1			1	10.7
Russell	1		1			2	14.3
Tazewell			1	1	1	3	13.9
District 3	3	2	0	1	2	8	10.5
Bland						0	0.0
Carroll	1					1	9.0
Grayson						0	0.0
Smyth				1	1	2	14.6
Washington	1	1			1	3	14.4
Wythe	1	1				2	18.9
Bristol						0	0.0
Galax						0	0.0
District 4	3	1	1	0	2	7	8.2
Floyd						0	0.0
Giles						0	0.0
Montgomery	2				2	4	8.6
Pulaski	1	1				2	13.3
Radford			1			1	8.6
District 5	2	2	1	3	2	10	10.0
Alleghany						0	0.0
Botetourt						0	0.0
Craig						0	0.0
Roanoke				3		3	9.6
Clifton Forge						0	0.0
Covington						0	0.0
Roanoke City	2	2			2	6	16.7
Salem			1			1	9.8
District 6	0	0	1	2	2	5	5.0
Augusta					1	1	4.4
Bath						0	0.0
Highland						0	0.0
Rockbridge						0	0.0
Rockingham			1			1	3.9
Buena Vista						0	0.0
Harrisonburg				2		2	12.1
Lexington						0	0.0
Staunton						0	0.0
Waynesboro					1	1	16.0
District 7	1	0	0	1	1	3	5.4
Clarke						0	0.0
Frederick				1		1	6.5
Page					1	1	12.6
Shenandoah						0	0.0
Warren	1					1	11.1
Winchester						0	0.0
District 8	10	14	11	6	8	49	10.9
Arlington	1		2			3	7.6
Fairfax	6	9	4	2	7	28	10.7
Loudoun	1					1	3.7
Prince William	1	2	4	3	1	11	14.7
Alexandria		1	1			2	7.1
Fairfax City	1	1				2	23.6
Falls Church		1				1	36.5
Manassas				1		1	15.4
Manassas Park						0	0.0
District 9	1	1	3	0	2	7	17.0
Culpeper						0	0.0
Fauquier	1	1	3			5	29.6
Madison					1	1	23.1
Orange					1	1	12.7
Rappahannock						0	0.0
District 10	1	1	0	1	1	4	5.4
Albemarle	1	1		1	1	4	11.0
Fluvanna						0	0.0
Greene						0	0.0
Louisa						0	0.0
Nelson						0	0.0
Charlottesville						0	0.0

DEATHS FROM SUICIDE TO CHILDREN AGED 15-19
WITH FIVE-YEAR RATES PER 100,000 CHILDREN IN THE AGE GROUP
VIRGINIA, 1981-1985

Planning District/ City or County	SUICIDE DEATHS TO CHILDREN AGED 15-19 1981	1982	1983	1984	1985	TOTAL DEATHS 1981-85	RATE PER 100,000 CHILDREN AGED 15-19
District 11	2	1	1	1	2	7	7.9
Amherst				1		1	7.3
Appomattox		1				1	18.4
Bedford	1					1	6.8
Campbell			1		1	2	9.5
Bedford City						0	0.0
Lynchburg	1				1	2	6.4
District 12	4	1	4	5	0	14	13.3
Franklin			2			2	10.6
Henry			1			1	3.9
Patrick			1			1	14.1
Pittsylvania	1	1		3		5	17.0
Danville	2			2		4	23.3
Martinsville	1					1	14.5
District 13	0	0	1	0	0	1	2.9
Brunswick						0	0.0
Halifax						0	0.0
Mecklenburg			1			1	8.6
South Boston						0	0.0
District 14	0	1	2	0	3	6	14.6
Amelia					1	1	26.2
Buckingham		1	1			2	35.2
Charlotte					1	1	19.3
Cumberland			1		1	2	53.1
Lunenburg						0	0.0
Nottoway						0	0.0
Prince Edward						0	0.0
District 15	3	8	7	6	7	31	11.4
Charles City Co.			1			1	28.9
Chesterfield	2	2	1			5	6.8
Goochland						0	0.0
Hanover		1	1	1		3	12.0
Henrico		3	2	4	4	13	18.2
New Kent					1	1	26.1
Powhatan					1	1	14.3
Richmond City	1	2	2	1	1	7	8.4
District 16	0	0	1	3	0	4	6.6
Caroline						0	0.0
King George				1		1	20.3
Spotsylvania				2		2	11.9
Stafford			1			1	4.7
Fredericksburg						0	0.0
District 17	0	1	1	0	0	2	12.7
Lancaster						0	0.0
Northumberland						0	0.0
Richmond						0	0.0
Westmoreland		1	1			2	35.2
District 18	2	1	0	1	0	4	16.0
Essex	1					1	26.7
Gloucester		1		1		2	22.5
King and Queen						0	0.0
King William						0	0.0
Mathews						0	0.0
Middlesex	1					1	33.7
District 19	1	2	0	2	1	6	7.7
Dinwiddie				1		1	8.7
Greensville						0	0.0
Prince George					1	1	6.0
Surry				1		1	35.0
Sussex		1				1	20.7
Colonial Heights		1				1	13.2
Emporia						0	0.0
Hopewell	1					1	10.1
Petersburg						0	0.0
District 20	9	2	10	6	8	35	8.7
Isle of Wight		1				1	9.8
Southampton						0	0.0
Chesapeake	2		1		2	5	9.3
Franklin City		1				1	28.9
Norfolk	3		2	3	2	10	7.7
Portsmouth	1			1		2	4.6
Suffolk						0	0.0
Virginia Beach	3		7	2	4	16	11.9
District 21	3	4	0	2	4	13	7.8
James City Co.	1	1			1	3	28.9
York		1		1		2	10.6
Hampton					1	2	3.4
Newport News	1	2		1	2	6	9.2
Poquoson						0	0.0
Williamsburg						0	0.0
District 22	0	1	1	0	0	2	11.0
Accomack		1	1			2	16.6
Northampton						0	0.0