REPORT OF THE
VIRGINIA DEPARTMENT OF HEALTH

A STUDY OF SUICIDE IN THE COMMONWEALTH

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 16

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH of VIRGINIA

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December 15, 1999

TO: The Honorable James S. Gilmore, III

and

The General Assembly of Virginia

The report contained herein is pursuant to Senate Joint Resolution 382, agreed to by the 1999 General Assembly.

This report constitutes the response of the Virginia Department of Health (VDH) to study the issue of suicide in Virginia.

The cost to VDH to conduct this study was $4,250. The study involved 300 staff hours of time.

Respectfully Submitted,

E. Anne Peterson, M.D., M.P.H.
State Health Commissioner

AUTHORITY

As per Senate Joint Resolution 382 (SJR 382), the Virginia Department of Health (VDH) with the assistance of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) studied the issue of suicide in the Commonwealth and has prepared the following study report with recommendations for the Governor and the General Assembly.

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ACKNOWLEDGMENTS

The Virginia Department of Health acknowledges the assistance of all the various organizations, groups and state agencies that participated in this study, especially the individuals listed in Appendix B. A special thanks goes out to all of the survivors of suicide in Virginia who gave their time, energy and support to this study and to Ari Karpf, a graduate student who assisted with the research.

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B. Process and Methodology

A core-working group was developed to conduct this study with representation from VDH and DMHMRSAS. Activities coordinated by this working group included analyses of data and literature on suicide, surveys of local mental health service personnel on existing suicide prevention programs and activities and focus groups with survivors of suicide (either lost a spouse or other family member). In addition a meeting was held to elicit recommendations from survivors and professionals who are working in the field of suicide prevention in Virginia.

C. Summary of Findings

Many fail to realize that more Virginians die from suicide than from homicide. On average, 2 Virginians die from suicide every day. In 1997, suicide was the 9th leading cause of death in the Commonwealth and the third leading cause of death for young people. Furthermore the suicide rate for children and adolescents in Virginia ages 10 to 19 has increased 32% since 1975. Also disturbing are the findings of a study of child and adolescent hospitalizations commissioned by VDH in 1998. Depression, which is a significant risk factor for suicide, was the leading cause of hospitalization for 10 to 14 year old children and the second leading cause of hospitalization for adolescents ages 15-19.

During the course of this study, various groups and organizations were identified that are working to prevent suicide in different localities in Virginia. There is, however, limited coordination and collaboration among these programs. These programs implement various grass roots approaches to suicide prevention with minimal resources. It is also apparent that there is limited interagency collaboration and statewide coordination of activities in this important public health area.

D. Recommendations

To adequately address the issue of suicide, the following recommendations are made.

1. Appropriation of funding to VDH and DMHMRSAS to conduct comprehensive suicide prevention and intervention activities.

2. VDH to develop a statewide strategic plan working in conjunction with the Coordinating Council on Prevention.

3. VDH to coordinate suicide prevention activities, including research and data collection on suicide and depression, professional and public information efforts and training. Training will be provided for parents, teachers, counselors, coaches, clergy, police, and others who work with youth to enhance identification and referral of children and adolescents at risk for suicide and depression. These activities will be coordinated in conjunction with survivors, DMHMRSAS, Department of Education, local crisis centers, the PTA, and other community stakeholders.

4. VDH to convene an annual conference on suicide and depression prevention and intervention to provide a forum for national, state, and local level practitioners to interact and discuss recent

research and new strategies and programs that are effective in preventing suicide in conjunction with the Coordinating Council on Prevention and other stakeholders.

5. VDH to develop and implement an annual public awareness campaign in collaboration with DMHMRSAS on suicide prevention and intervention. This campaign will share the facts about suicide, depression and other risk factors, warning signals, referral and prevention strategies.

6. VDH to provide resources, information and grants to support school and community-based programs that are designed to foster peer relationships, anger management, self-efficacy, problem solving and other relevant coping and social skills among children and adolescents.

7. DMHMRSAS to coordinate efforts to improve the ability of primary care providers to recognize and treat depression, substance abuse and other mental illnesses associated with suicide risk.

8. DMHMRSAS to support community-based crisis intervention services and survivor support groups and develop and implement strategies to reduce the barriers associated with seeking help.

9. DMHMRSAS to develop and coordinate statewide suicide crisis intervention, including the expansion of hotline services, and improve related interagency communication and collaboration.

10. DMHMRSAS to disseminate successful strategies for suicide intervention programming

11. DMHMRSAS to implement systems for effective follow up of people discharged from psychiatric facilities and/or after previous suicide attempts.

12. DMHMRSAS to facilitate availability of care and support programs for family/friends of people who commit suicide or attempt suicide

I. PURPOSE AND METHODOLOGY

A. Purpose

Senate Joint Resolution (SJR) 382 required the Virginia Department of Health (VDH) with the assistance of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to study the issue of suicide in the Commonwealth and prepare a report with recommendations for the Governor and the General Assembly. As requested, the study examines whether the problem is growing, causative factors, factors that reduce risk and what can be done to prevent suicide (see Appendix A for full text of the resolution).

B. Process and Methodology

A core-working group was developed to conduct the study with representation from VDH and DMHMRSAS. Activities coordinated by this working group included analyses of data and literature on suicide, surveys of local mental health service personnel on existing suicide prevention programs and activities, and focus groups with survivors of suicide (either lost a spouse or other family member). In addition, a daylong meeting was held to elicit recommendations from survivors and professionals who are working in the field of suicide prevention in Virginia.

II. SCOPE OF THE PROBLEM

Suicide remains a tragic problem throughout the world. It is prevalent within all populations and in all regions of the United States as well as Virginia. In 1997, more than 30,000 people committed suicide in the United States (Centers for Disease Control and Prevention). More Virginians die each year from suicide than homicide, 743 and 509 respectively in 1997. In Virginia, an average of two people die from suicide every day. In 1997, suicide was the 9th leading cause of death in the Commonwealth and the third leading cause of death for young people. Virginia's suicide rate is similar to the national rate of 11.3 per 100,000. Males account for more than 80% of deaths and the highest rates occur in males over the age of 65. Firearms are the most common method and accounted for more than 60% of all deaths. Hanging and drug overdoses are the next most common methods. See Appendix B for data charts which were provided by the Virginia Center for Health Statistics.

Although the overall suicide rate has declined 27% since 1975, the rate for Virginians ages 10 to 19 has increased an alarming 32%. For the nonwhite population ages 10 to 19, the rate has steadily increased since 1975, up from less than one death per 100,000 population in 1975 to more than 5 deaths per 100,000 population in 1997. Although white teens still have the higher suicide rates, the gap between whites and nonwhites is narrowing.

It is important to note that many studies support the claim that the number of suicides is underreported. Estimates of underreporting vary from 1% to 80% (Phillips and Ruth, 1993). This underreporting can be a result of misclassification of cause of death in categories such as accidental barbiturate poisoning, accidental firearm injury, single-car collisions and pedestrian deaths by motor vehicles or trains.

For each suicide death, it is estimated that there are as many as 25 attempted suicides (Kachur et., al. 1995). The national Youth Risk Behavior Survey (YRBS) found, that in 1997, 2.6% of American high school students reported having seriously considered attempting suicide during the past 12 months. This data may not representative of the experience of Virginia's students since Virginia does not participate in the conduct of the YRBS.

Unfortunately, in Virginia there is no statewide system for reporting nonlethal suicidal behaviors. Virginia's hospital discharge data on self-inflicted injury may, however, be somewhat reflective of suicide attempts. From 1994 to 1997, there were more than 17,000 self-inflicted injuries resulting in hospitalization. The associated medical charges annually exceeded $23 million dollars. In that same time period, there were more than 3,000 self-inflicted injury hospitalizations to Virginia's children under the age of 20, resulting in charges of more than $3.1 million dollars per year.

Mental health problems, including depression, are significant risk factors for suicide and suicide attempts. According to the National Mental Health Association, mental health problems affect one in every five young people at any given time. Ninety percent of adolescent suicide victims have at least one diagnosable, active psychiatric illness at the time of death, most often depression, substance abuse, and conduct disorders (American Foundation for Suicide Prevention). According to the organization, Suicide Awareness Voices of Education (SA/VE), the number one cause of suicide is untreated depression.

Recent studies have shown that as many as one in every 33 children may have clinical depression at any given time. The rate of depression among adolescents may be as high as one in eight. Recent studies have also reported that greater than 20% of adolescents in the general population have emotional problems. One-third of adolescents attending psychiatry clinics suffer from depression (NAMH online). Furthermore, the findings of a study of child and adolescent hospitalizations commissioned by VDH in 1998 revealed that depression was the leading cause of hospitalization for 10 to 14 year old children in 1995 and the second leading cause of hospitalization for adolescents ages 15-19. This accounted for 4,684 hospitalizations and charges of more than $51 million dollars (Pestian, et. al).

Depression continues to impact people at all ages. This serious illness is estimated to affect 15 out of every 100 adults over age 65 in the United States (National Mental Health Association).

Fortunately, depression is very treatable. The majority (80-90%) of people, who receive treatment experience significant improvement, and almost all individuals derive some benefit form medical care (American Psychiatric Association).

III. FINDINGS

A. Literature Review on Risk and Protective Factors

An approach to suicide prevention that appears frequently in the literature is the "risk factor reduction/protective factor development" approach. This broadly accepted and well-researched approach is based on the assumption that in order to effectively prevent a problem, one must first learn what the risk factors that contribute to the problem are, and then

implement ways to reduce these risk factors (Hawkins & Catalano, 1992). Once risk factors are identified, the "risk factor reduction/protective factor development" approach works towards simultaneously reducing identified risk factors and promoting healthy development of protective factors for the targeted problem. The protective factors are thought to balance the presence of risk factors and serve a moderating role in attenuating the deleterious effects of risk exposure.

Suicide is affected by complex biological, psychological, social, cultural, and societal factors (Heikkinen, Aro, and Lonnqvist, 1993). Suicide risk reduction and health promotion prevention strategies can be categorized into four broad areas: 1) promotion of healthy development, 2) early identification and intervention for people at risk for suicide, 3) provision of help to individuals in need during a crisis, and 4) provision of help to survivors and/or witnesses of suicide. Comprehensive suicide prevention initiatives should include an array of service components represented in all four of these categories. Programs that also include a focus on the individual, social context, and availability of means may further enhance the effectiveness of the prevention strategy.

Risk factors are not clear-cut or easily identified. They are very complex. It is also important to note that not all people who experience one or more of the listed risk factors are suicidal. Suicide and suicidal behavior are not normal responses to the stressors experienced by most people. The presence and interaction of multiple risk factors does, however, increase the individual risk of suicide. Important risk factors for suicidal behavior include:

- A family history of violence (including physical or sexual abuse), suicide, mental illness or substance abuse.

- Psycho-social and environmental factors: physical or sexual abuse, decreased familial or social supports, parental loss, exposure to suicidal behavior, negative life events, chronic physical illness, pregnancy in adolescent females, or being a runaway.

- Personality traits including aggressive behaviors, impulsiveness, hopelessness, cognitive rigidity and antisocial behaviors.

- A history of mental or addictive disorder and mood disorders.

- Biological correlates, including certain hormonal factors, and/or deficiency in the neurotransmitter serotonin.

- High-risk epidemiological and demographic factors: being male; being between the ages of 15 and 24 or over the age of 65; or being single, recently widowed, separated or divorced.

- Access to firearms or other lethal means.

(Bingham, et al., 1994; Blumenthal et. al, 1989; Gould et. al, 1998; Garber et al., 1998; Henry et. al, 1993; Tsuang et. al, 1992; for additional references, refer to attached bibliography)

Suicide appears to occur when multiple overlapping risk factors are present in the absence of protective factors. Research indicates certain protective factors that appear to prevent suicide including:

- Strong family and social support
- Cultural and religious beliefs that discourage suicide
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Hopefulness
- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal means of suicide
- Support from ongoing medical and mental health care relationships

(Busch, et al. 1993; Conwell, et al., 1995; Donahue et al. 1995; American Foundation of Suicide Prevention 1998/9, for additional references, refer to attached bibliography)

Despite the fact that there are more suicides than homicides, the barriers associated with discussing and addressing suicide have resulted in the individual suicide making limited public impact. This provides limited opportunity to base educational and preventive efforts on these tragedies. In 1996, the World Health Organization (WHO) recognized the magnitude of the problem and the need to develop suicide prevention strategies. A document entitled *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies* was produced by W.H.O. Furthermore, several states such as Colorado, Washington, Maine, Utah, and South Dakota have begun studying the issue of suicide and produced suicide prevention plans which are currently being implemented. In October 1998, the Center for Disease Control and Prevention, the Health Resources and Services Administration and the National Institutes of Mental Health, and many other groups and organizations, jointly convened a national conference of leading experts in the field to develop a public health model to prevent suicide. The recently released report entitled, *The Surgeon General's Call to Action to Prevent Suicide 1999*, is a culmination of these efforts. It introduces a blueprint for addressing suicide and contains 15 key recommendations for prevention that include broadening the public's awareness of suicide and its risk factors, enhancing services and programs (both population-based and clinical care), and advancing the science of suicide prevention.

B. Survivor Focus Groups

In June of 1999, focus groups were conducted with family members who had survived the loss of loved ones to suicide. In the research literature and amongst themselves, individuals in this unfortunate category are commonly called suicide "survivors". The term is confusing to many, as it is often misinterpreted as depicting an individual who has survived an unsuccessful suicide attempt. Nevertheless, in this study and the body of scientific literature, a suicide 'survivor' is defined as a family member or close associate of a suicide victim. Across the nation, informal survivor support groups have developed for survivors to talk with others who have experienced similar traumatic lifetime events. Across Virginia there are groups that meet and provide support to each other at regular discussion sessions in churches, hospitals or other donated public spaces.

Several themes recurred in the discussions about prevention (See Appendix C for a summary of these discussions). Participants identified public education and awareness concerning suicide as critical needs. They unanimously called for training on the prevention of suicide. The group emphasized the importance of highlighting the warning signs and long term consequences of suicide.

C. Stakeholder Meeting

On July 21, 1999, a work group representing various organizations who work in the field of suicide prevention and individuals who have experienced the suicidal loss of a loved one was convened to discuss suicide and make recommendations for prevention (See Appendix D and E for additional information on this meeting). Participants identified various groups and organizations working to prevent suicide in different localities in Virginia. There is, however, limited coordination and collaboration among these programs. These programs implement various grass roots approaches to suicide prevention despite minimal resources.

During the course of the day, the work group was subdivided into two smaller groups, one to address child and adolescent suicide and another to address adult suicide. Each group used a nominal group process that allowed each participant to select five priority recommendations. The recommendations receiving the most votes were presented to the entire group and consensus was attained that these would be the recommendations to be highlighted in the study.

The group recommended that VDH be designated as the lead state agency in suicide prevention efforts and the establishment of two state level positions, one at VDH and one at DMHMRSAS, to coordinate a statewide suicide prevention and intervention program. Additional priority recommendations called for research, a centralized resource on state, local and community efforts, increased parity and equity in mental health services, establishment of a statewide advisory group to develop a plan for suicide prevention, a public awareness campaign about suicide risk factors, prevention and intervention strategies and resources, and the provision of a minimum level of resources dedicated to prevention at the state and local level.

D. Community Service Boards Survey

A survey of local, public supported, mental health and substance abuse services professionals, also known as Community Service Boards (CSB's), was conducted in July 1999. Information was requested on the availability of suicide prevention programs, gaps and barriers to programs, and prevention recommendations. A qualitative summary of the survey reveals that all Community Services Boards are providing 24-hour crisis intervention services to their localities. This is a requirement of the *Code of Virginia*. In addition, most of the CSBs are providing some type of prevention education, after-school, and/or mentoring programs that includes information about suicide and suicide prevention. However, very few CSBs are providing specific programming targeting suicide prevention. Major barriers to service delivery that were identified include funding restrictions, and inadequate training and access to at-risk individuals (especially youth). The stigma of discussing suicide was also identified as a significant barrier to service development and provision. The primary recommendations made for suicide prevention programs were for increased targeted funding

for suicide prevention, training in suicide prevention for professional and non-professional staff, interagency collaboration/communication protocols for suicide prevention/intervention programs, culturally specific training, and the placement of mental health counselors in the schools.

IV. RECOMMENDATIONS

The key activities to prevent suicide fall into the following continuum: 1) promotion of healthy development, 2) early identification and intervention for people at risk for suicide, 3) provision of help to individuals in need during a crisis, and 4) provision of help to survivors and/or witnesses of suicide. In order to comprehensively address the issue of suicide in Virginia along this continuum, this study makes the following recommendations. These recommendations resulted from the literature reviews, focus groups, and surveys conducted for the study. Significant emphasis was given to the input from key stakeholders at the July 21 meeting.

1. Appropriation of funding to VDH and DMHMRSAS to conduct comprehensive suicide prevention and intervention activities.

2. VDH to develop a statewide strategic plan working in conjunction with the Coordinating Council on Prevention.

3. VDH to coordinate suicide prevention activities, including research and data collection on suicide and depression, professional and public information efforts and training. Training will be provided for parents, teachers, counselors, coaches, clergy, police, and others who work with youth to enhance identification and referral of children and adolescents at risk for suicide and depression. These activities will be coordinated in conjunction with survivors, DMHMRSAS, Department of Education, local crisis centers, the PTA, and other community stakeholders.

4. VDH to convene an annual conference on suicide and depression prevention and intervention to provide a forum for national, state, and local level practitioners to interact and discuss recent research and new strategies and programs that are effective in preventing suicide in conjunction with the Coordinating Council on Prevention and other stakeholders.

5. VDH to develop and implement an annual public awareness campaign in collaboration with DMHMRSAS on suicide prevention and intervention. This campaign will share the facts about suicide, depression and other risk factors, warning signals, referral and prevention strategies.

6. VDH to provide resources, information and grants to support school and community-based programs that are designed to foster peer relationships, anger management, self-efficacy, problem solving and other relevant coping and social skills among children and adolescents.

7. DMHMRSAS to coordinate efforts to improve the ability of primary care providers to recognize and treat depression, substance abuse and other mental illnesses associated with suicide risk.

8. DMHMRSAS to support community-based crisis intervention services and survivor support groups and develop and implement strategies to reduce the barriers associated with seeking help.

9. DMHMRSAS to develop and coordinate statewide suicide crisis intervention, including the expansion of hotline services, and improve related interagency communication and collaboration.

10. DMHMRSAS to disseminate successful strategies for suicide intervention programming

11. DMHMRSAS to implement systems for effective follow up of people discharged from psychiatric facilities and/or after previous suicide attempts.

12. DMHMRSAS to facilitate availability of care and support programs for family/friends of people who commit suicide or attempt suicide.

APPENDIX A:
SENATE JOINT RESOLUTION 382:
A STUDY OF SUICIDE IN THE COMMONWEALTH

SENATE JOINT RESOLUTION NO. 382

Requesting the Department of Health, with the assistance of the Department of Mental Health, Mental Retardation and Substance Abuse Services, to study the incidence of suicide in the Commonwealth.

Agreed to by the Senate, February 22, 1999
Agreed to by the House of Delegates, February 18, 1999

WHEREAS, suicide is the ninth leading cause of death in the U.S. with over 31,000 deaths recorded in 1995; and

WHEREAS, this approximates one death every seventeen minutes and accounts for more deaths each year than from homicide; and

WHEREAS, from 1952 to 1992, the incidence of suicide among teens and young adults tripled and today is the third leading cause of death for teenagers aged 15 to 19 after motor vehicle accidents and unintentional injury; and

WHEREAS, for every completed suicide it is estimated that as many as 25 suicide attempts are made; and

WHEREAS, while females attempt suicide three times more often than males, males are three to five times more likely to complete suicide; and

WHEREAS, the lifetime cost for adolescent suicide is $2.3 billion each year and health care costs for attempted suicides average $116.4 million a year; and

WHEREAS, there are many risks and contributing factors for suicides and attempts, including depression, anxiety, chemical imbalance, a family history of suicide, stressful life events, high risk behaviors, availability of a weapon, and alcohol; and

WHEREAS, the Commonwealth has a vested interest in examining the incidence, causes, and methods of prevention of suicide to offer protection to our citizens who may be at risk; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the State Department of Health, with the assistance of the Department of Mental Health, Mental Retardation and Substance Abuse Services, be requested to study the incidence of suicide in the Commonwealth. The study shall examine whether the problem is growing; what the causative factors are; which factors, such as family, social, cultural and religious factors, may reduce the risk of suicide; and what can be done to prevent suicide. This study shall also recommend initiatives which may reduce the incidence of suicide and which would aid survivors of suicide attempts.

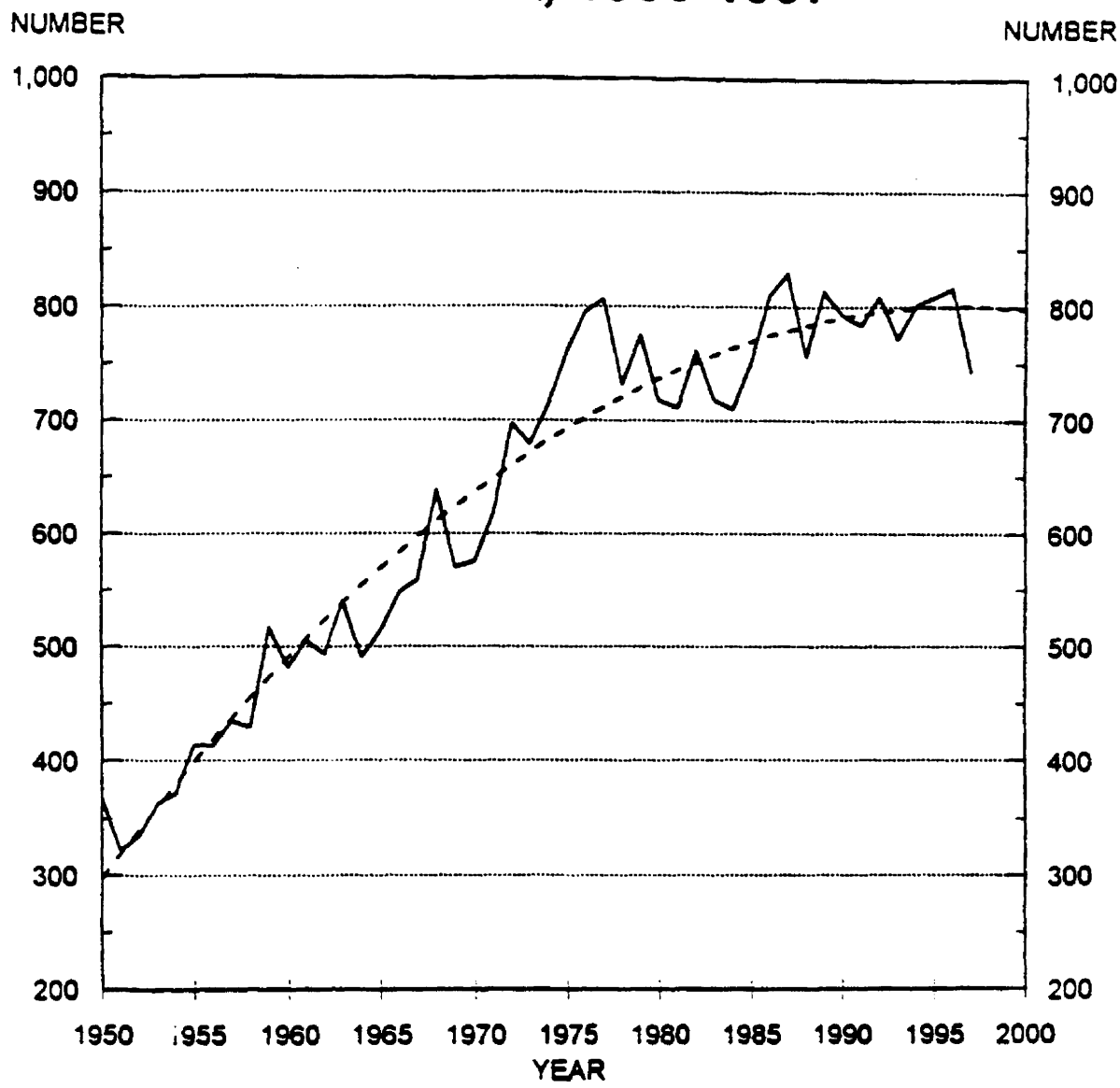
All agencies of the Commonwealth shall provide assistance to the Department for this study, upon request.

The State Department of Health shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B:

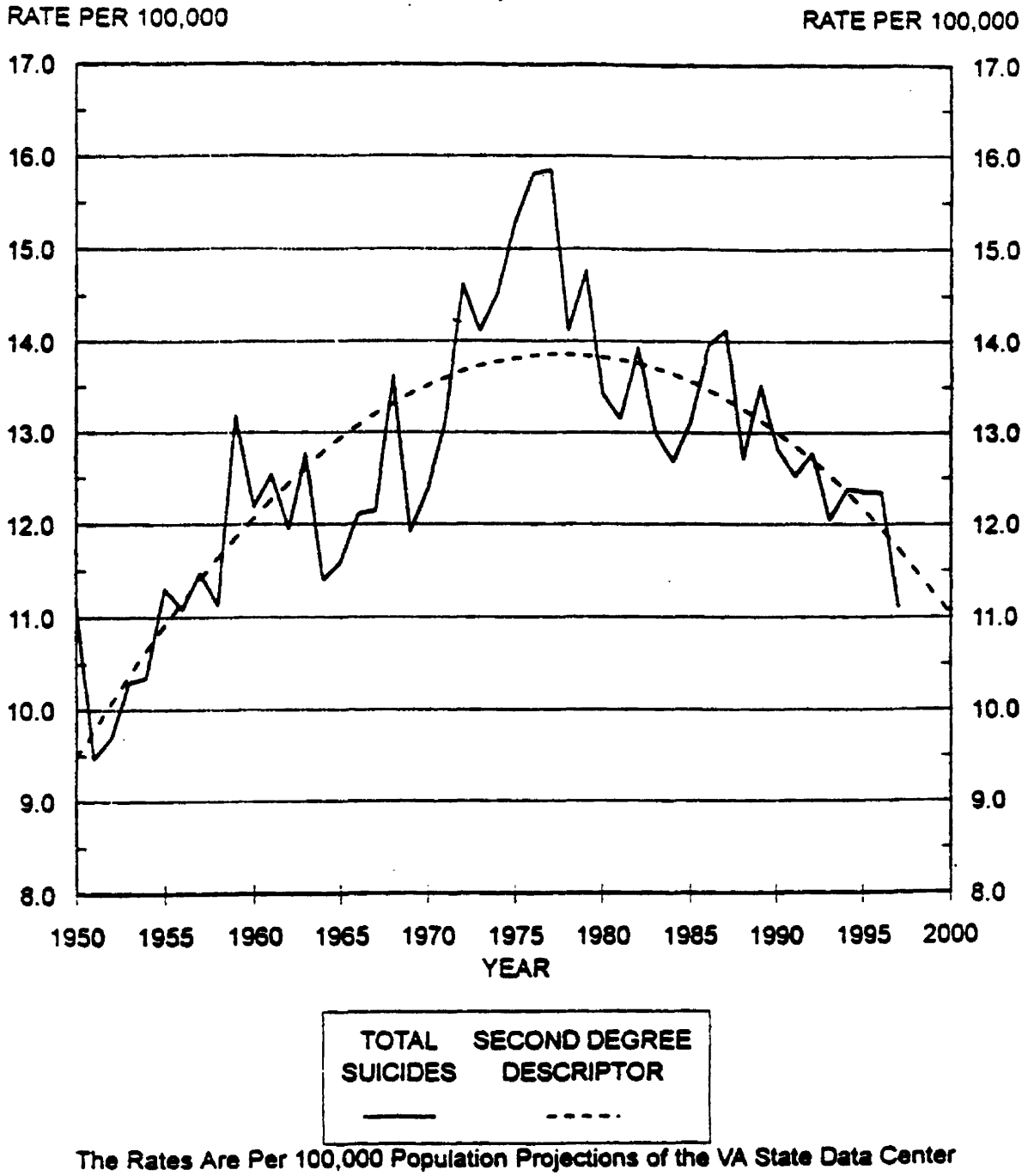
DATA CHARTS

CHART 1
TOTAL RESIDENT DEATHS FROM SUICIDE
VIRGINIA, 1950-1997



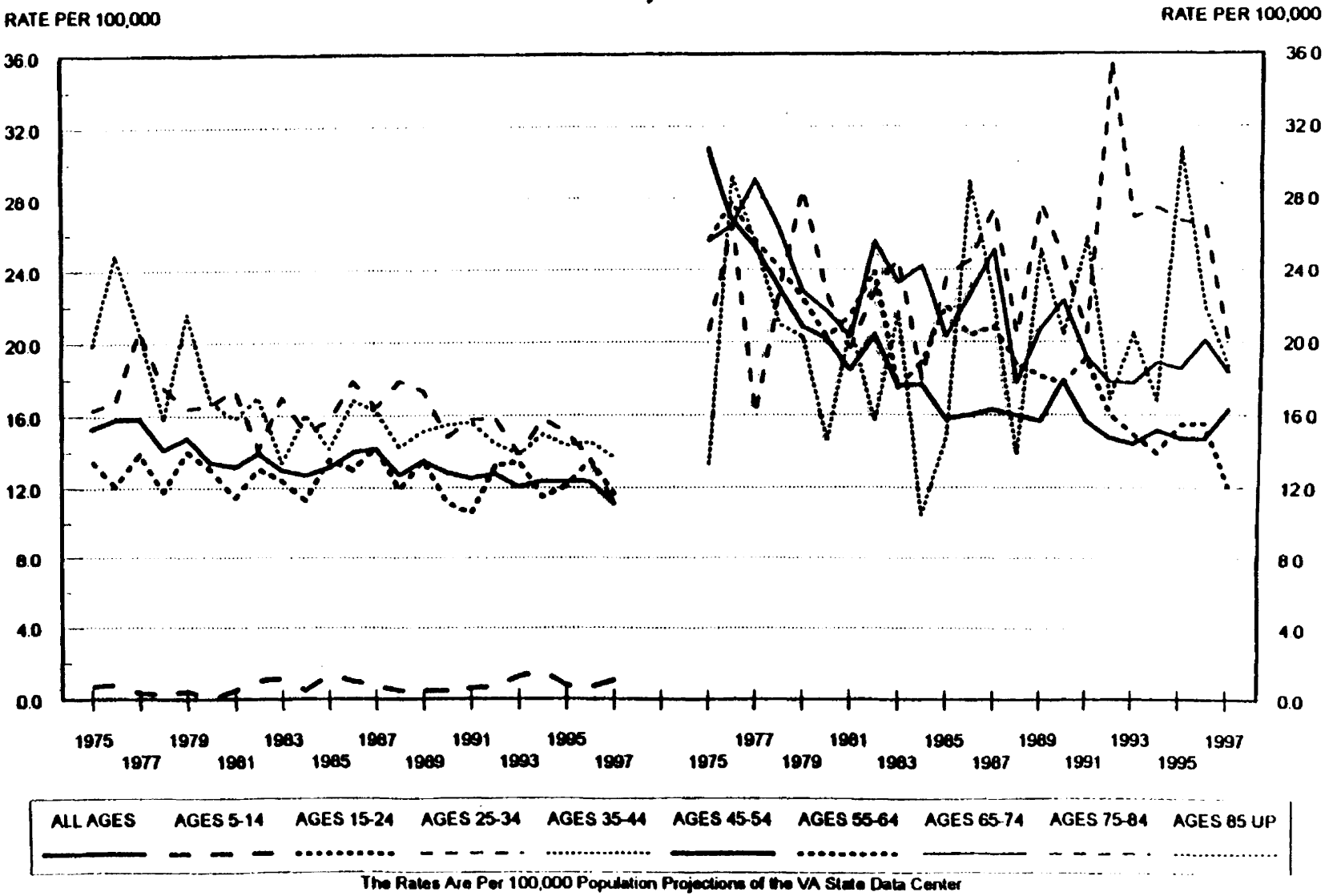
The Broken Curve is a Least-Squares Descriptor for the Period
SOURCE: Virginia Center For Health Statistics

CHART 2
TOTAL RESIDENT DEATH RATES FROM SUICIDE
VIRGINIA, 1950-1997



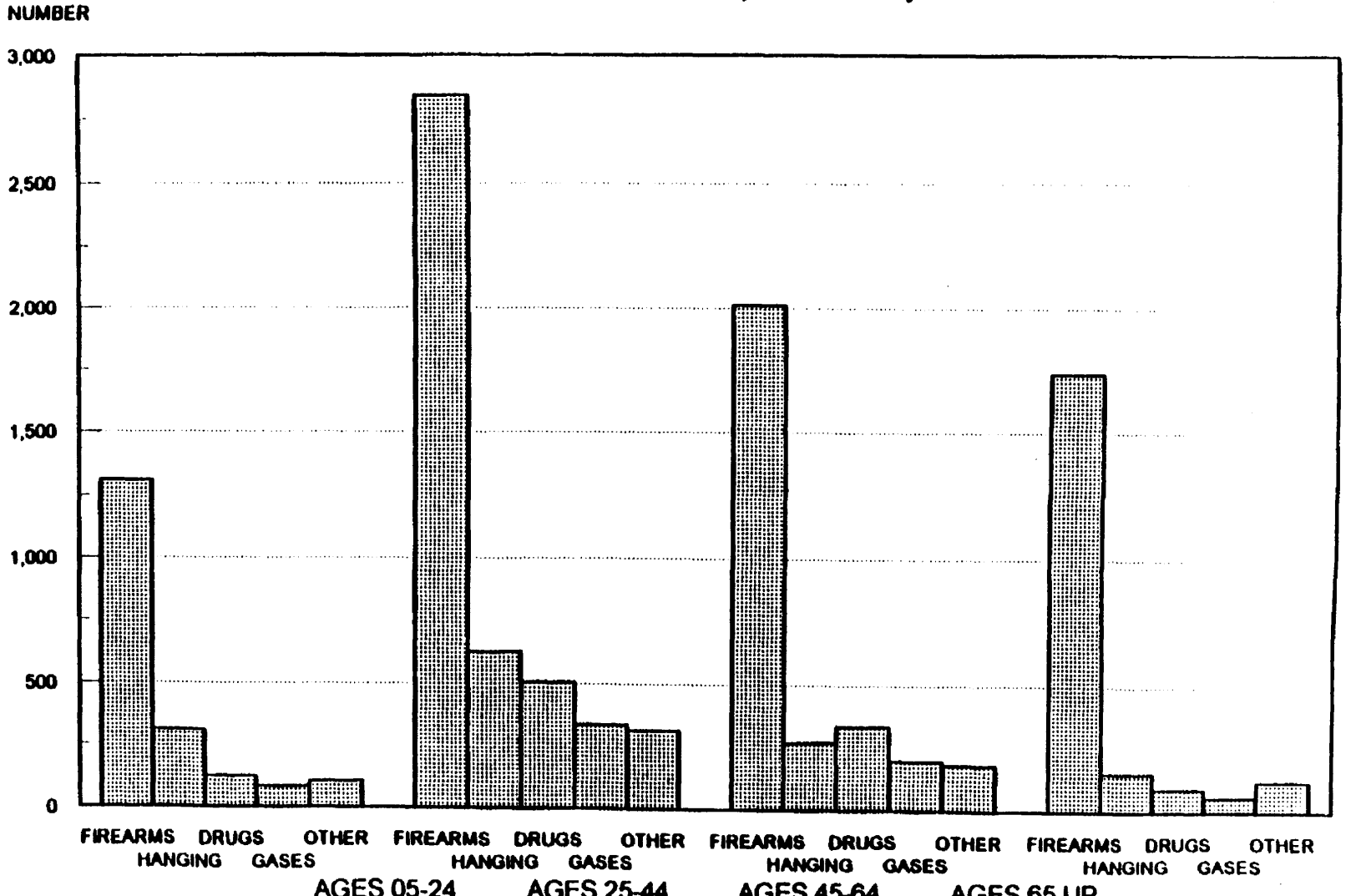
The Rates Are Per 100,000 Population Projections of the VA State Data Center
The Broken Curve is a Least-Squares Descriptor for the Period
SOURCE: Virginia Center For Health Statistics

CHART 3
RESIDENT DEATH RATES FROM SUICIDE BY TEN-YEAR AGE GROUPS
VIRGINIA, 1975-1997



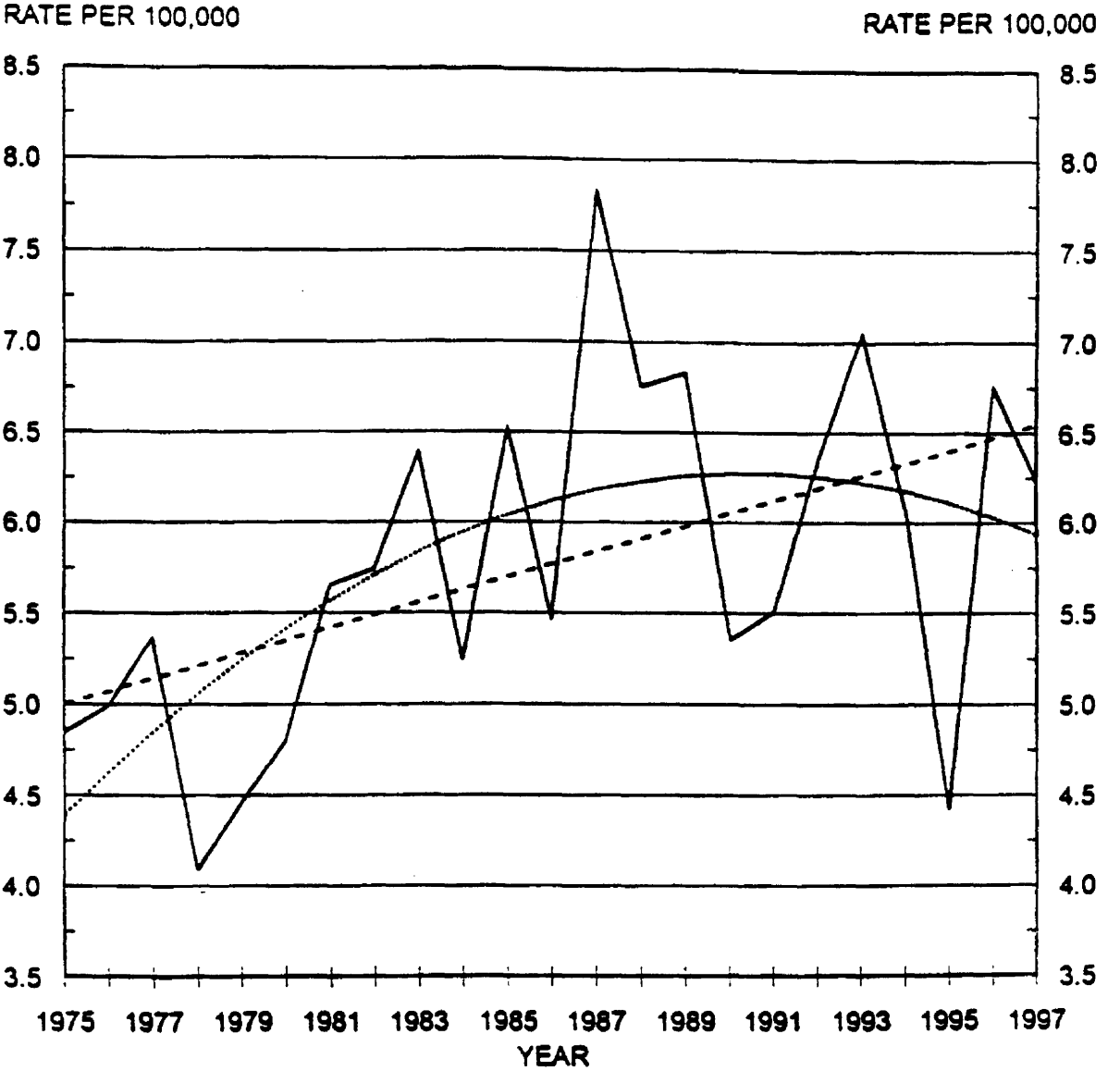
The Rates Are Per 100,000 Population Projections of the VA State Data Center
The Higher Age Groups Are Plotted To The Right Scale Of The Chart
SOURCE: Virginia Center For Health Statistics

CHART 4
DISTRIBUTION OF 11,718 RESIDENT SUICIDES BY METHOD OF SUICIDE
SELECTED AGE GROUPS, VIRGINIA, 1983-1997



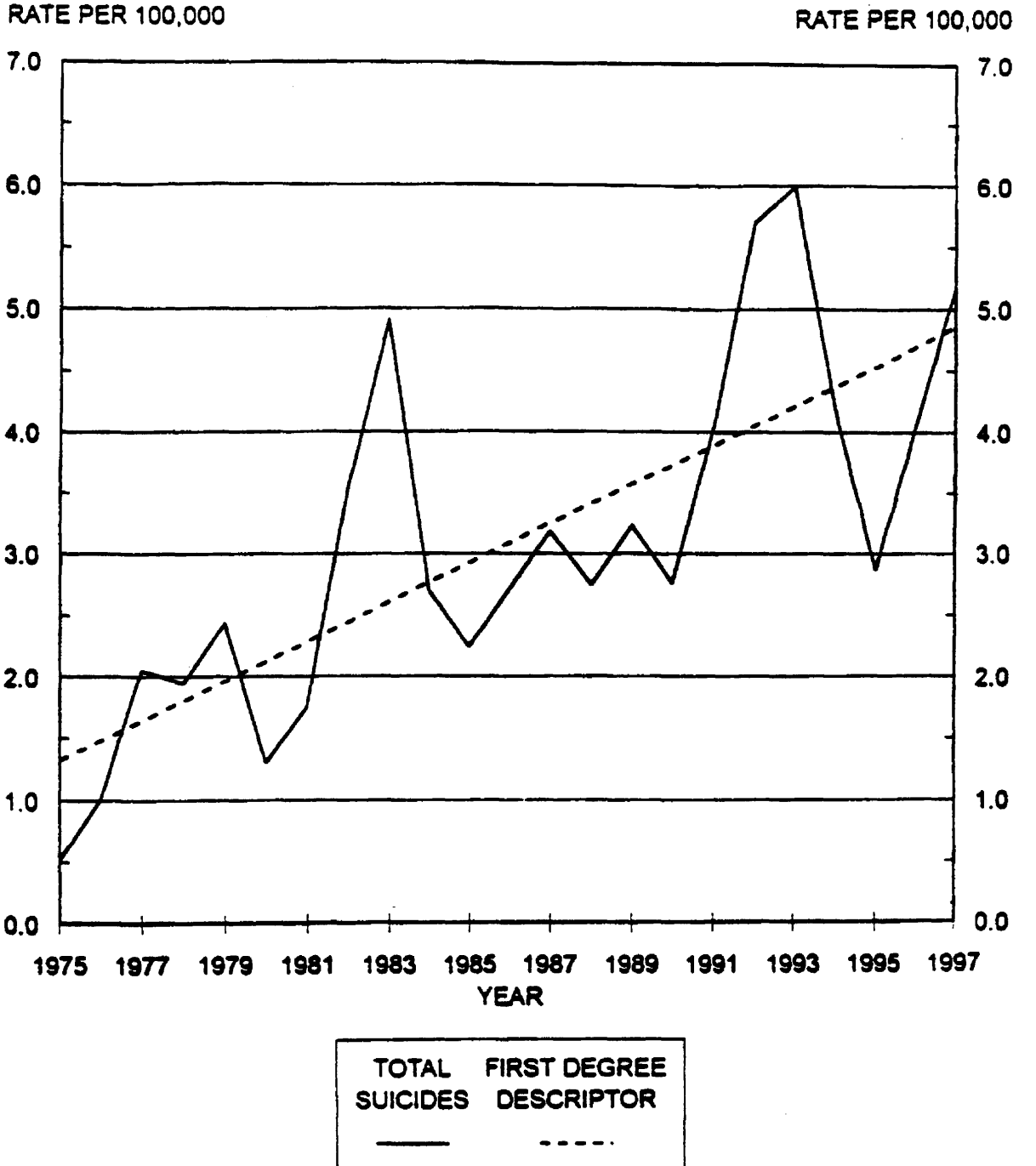
The Number Of Suicides In The Distributions Were 1,926, 4,627, 2,999, And 2,161
The Methods Totals Were 7,908, 1,356, 1,058, 676, And 720
SOURCE: Virginia Center For Health Statistics

CHART 5
RESIDENT DEATH RATES AGES 10-19 FROM SUICIDE
VIRGINIA, 1975-1997



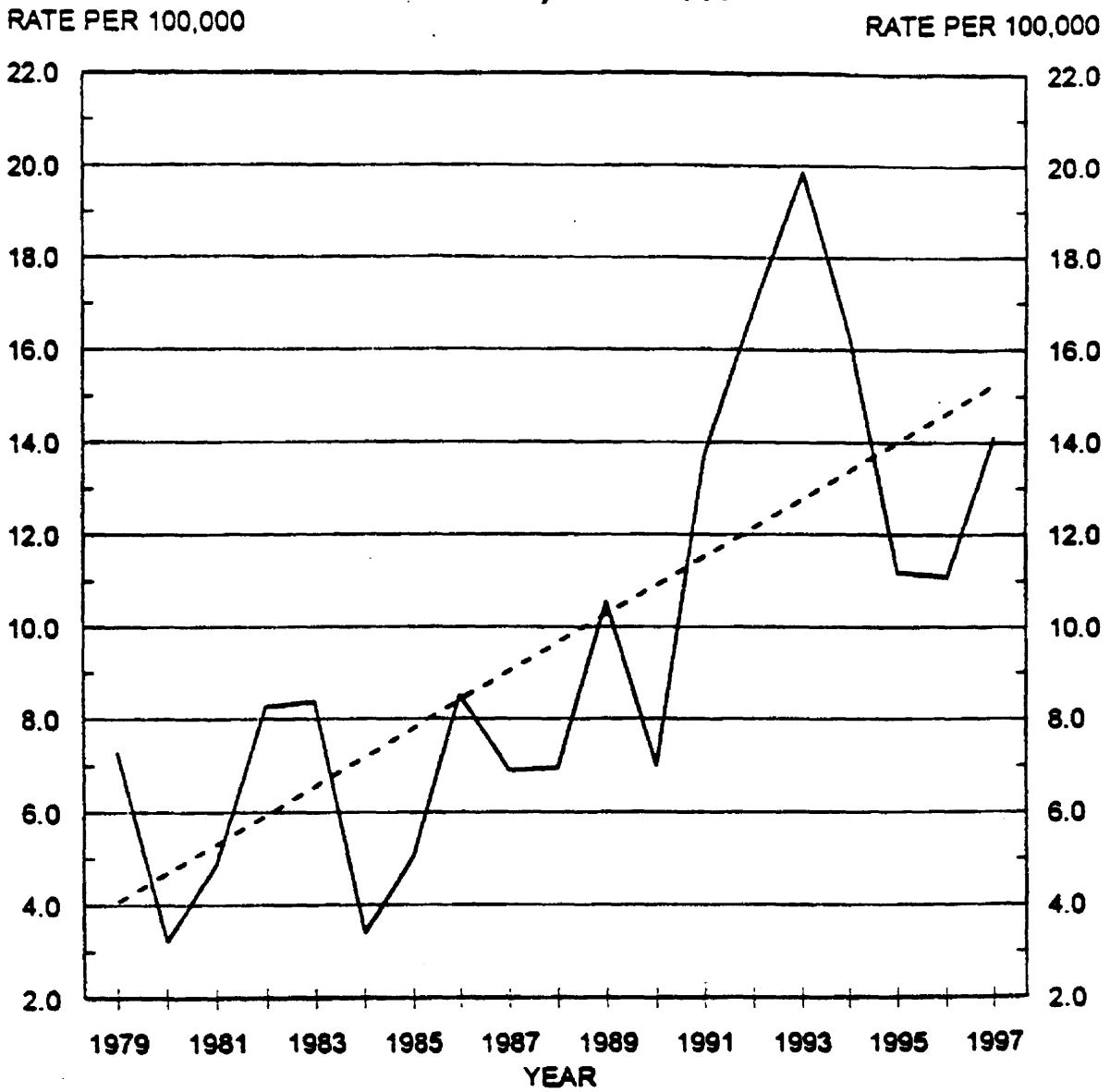
The Rates Are Per 100,000 Population Projections of the VA State Data Center
The Broken Lines Are Least-Squares Descriptors For The Period
SOURCE: Virginia Center For Health Statistics

CHART 6
RESIDENT NONWHITE DEATH RATES AGES 10-19 FROM SUICIDE
VIRGINIA, 1975-1997



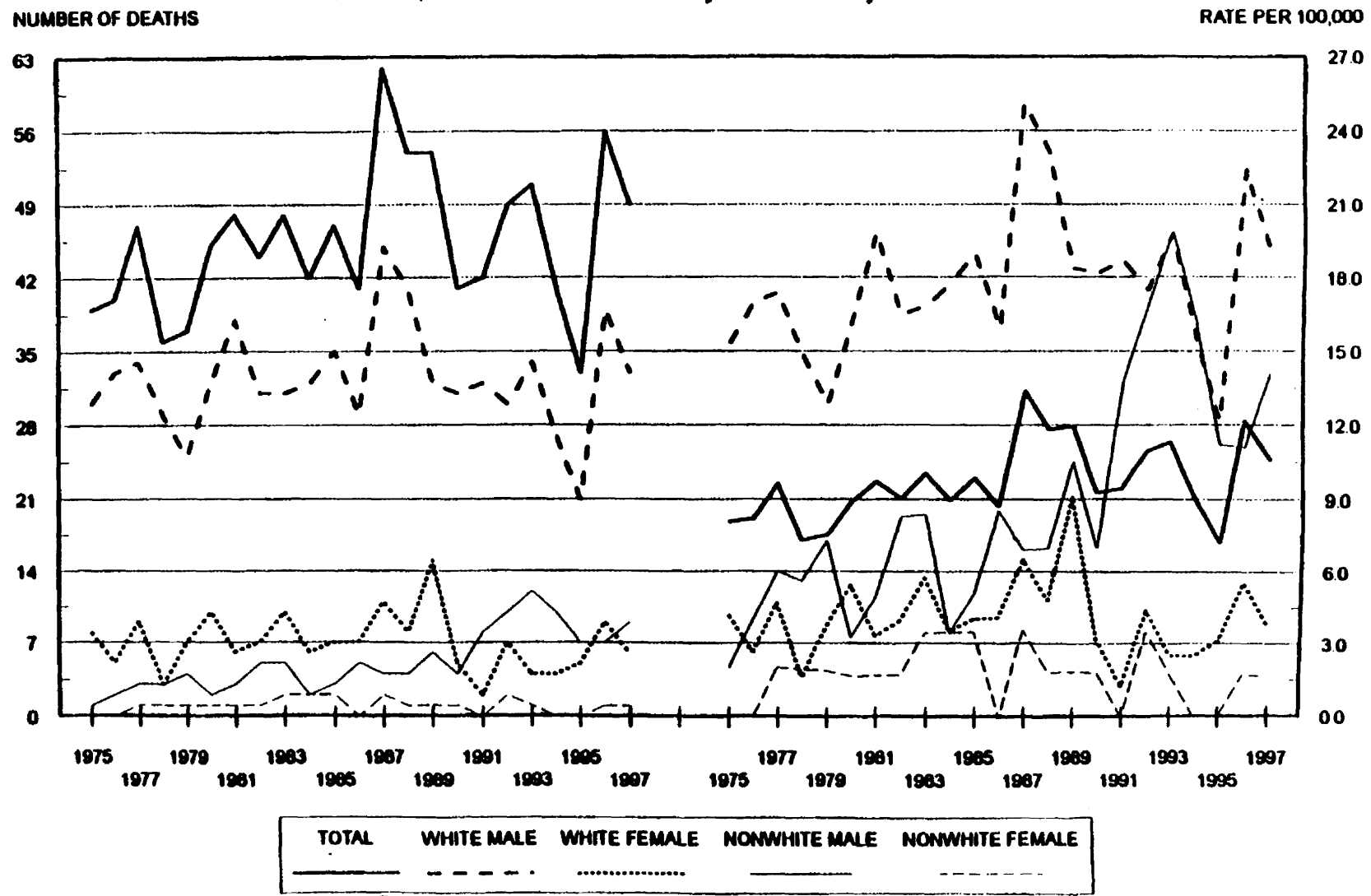
The Rates Are Per 100,000 Population Projections Of The VA State Data Center
The First Degree Curve Is The Best Least-Squares Descriptor For The Period
SOURCE: Virginia Center For Health Statistics

CHART 7
NONWHITE MALE DEATH RATES AGES 15-19 FROM SUICIDE
VIRGINIA, 1979-1997



The Rates Are Per 100,000 Population Projections of the VA State Data Center
The First Degree Curve Is The Best Least-Squares Descriptor For The Period
SOURCE: Virginia Center For Health Statistics

CHART 8
RESIDENT DEATHS AND DEATH RATES AGES 15-19 FROM SUICIDE BY GENDER AND RACE, VIRGINIA, 1975-1997



The Rates Are Per 100,000 Population Projections of the VA State Data Center
The Number Of Deaths Is Plotted To The Left, The Death Rates To The Right
SOURCE: Virginia Center For Health Statistics

APPENDIX C:

SURVIVOR FOCUS GROUP MINUTES

Suicide Survivor
Focus Group Discussion

Reported by Stephen Conley, PhD
September 1999

Introduction:

Senate Joint Resolution (SJR) 382 called for a study of suicide in the Commonwealth of Virginia. Some of the issues around suicide that the Virginia Department of Health (VDH) through its Center for Injury and Violence Prevention (CIVP) were directed by the study resolution to investigate included causative factors and successful preventive measures. The study also called for an assessment of family, social, cultural and religious factors that may reduce the risk of suicide.

One of the research strategies planned by the staff of the CIVP and the VDH Division of Child and Adolescent Health was to directly involve family members who had survived the loss of loved ones to suicide. In the research literature and amongst themselves, individuals in this unfortunate category are commonly called suicide 'survivors.' The term is confusing to many, as it is often misinterpreted as depicting an individual who has survived an unsuccessful suicide attempt. Nevertheless, in this study and the body of scientific literature, a suicide 'survivor' is defined as a family member who remains after the suicide of a spouse, child or other close relative.

Across the nation informal survivor support groups have developed for survivors to talk with others who have experienced similar traumatic lifetime events. In the Richmond area there are several groups who meet and support each other at regular discussion sessions in churches, hospitals or other donated public spaces. Since these individuals have the most knowledge and understanding of the impact of suicide, the study team decided to conduct qualitative research on the issue through a focus group with survivors.

Six research/discussion questions were selected to frame the focus discussion in keeping with the directives of SJR 382. Selected discussion points included the following:

What are the causative factors for suicide?
What are your experiences with accessing mental health services?
Does social stigma affect mental health problems in general and suicide in particular?
Are there family, religious and social factors that may decrease the risk of suicide?
What should be done to prevent suicide?
What should the policy makers keep in mind?

Recruitment:

Study participants were recruited through a letter of inquiry to the leaders of two local suicide survivor support groups. Volunteers were promised confidentiality for assisting with the research. During the recruitment phase, it was discovered that three adolescent children who had suffered the loss of a parent to suicide might join the study. Therefore, a separate discussion group for any youth survivors who might attend was arranged with a second group leader. On the scheduled evening for the focus groups, only one teenage woman arrived, so it was decided that she would be included in the adult discussion group.

Setting:

In June 1999 a large hotel on the south side of Richmond was secured for the focus group session. Participants were provided with dinner and then moved to a second room for the discussion. Participants were seated in a circle of chairs in a long narrow room with two noisy, but essential air conditioners. During the discussion one or two study participants would leave the room and return a few moments later. The formal discussion lasted approximately three hours. Informal discussions continued with the remaining participants for an additional hour.

Group description:

Twelve individuals participated in the focus group. All of them were women, with eight having lost children to suicide . Most surviving parents had lost sons, but one individual had lost a daughter. One woman had experienced the loss of her father and a child to separate suicidal events. In addition, two individuals had suffered the loss of their spouses, and one a fiancé. Two participants had lost fathers and one individual's brother had committed suicide. Most participants were adults, except for one sixteen year old high school student. Everyone in the group was Caucasian, and residents of Richmond or surrounding communities.

One participant noted during the recruitment phase how distinctly different the issues and recovery for survivors of suicide are between those who lose children and those who lose a spouse or parent. She related how support groups often deal with these varied needs for emotional support.

Nevertheless, participants were not recruited for this session by these categories. The intent was to offer the opportunity to participate in the research and to work with those who attended, whatever the relationship of their lost family members.

The study leader welcomed the participants and described the purpose of SJR 382 and the intent of the evening's focus group research. Simple ground rules were presented. These included a restatement of the respect of participants' confidentiality, planned anonymous listing of discussion contributions in the final report, permission to audio tape the session, and a request for one person to speak at a time. The discussion began with individual introductions. Each participant provided their name, place of residence and personal loss experience with suicide.

Causative factors:

The discussion opened by asking each participant to provide one-word or short descriptions of the causes they identified as factors in the suicidal death of their family members. The initial list generated by the group included:

Pain (fibromyalgia), depression, loss of function due to disability, alcohol, anti-depressants (Prozac), hypersensitivity, high IQ, excessive empathy, fear (to escape cult experiences), grief and loss of hope, self-destructive patterns, inability to cope, school pressures, early physical maturity, guns, low self-worth, men's inability to deal with emotional matters, poor body image, anger, child abuse, manic depression, attention deficit disorder, poor parenting and divorce.

In the discussion that followed specific comments expanded on the range of causative factors for suicide:

"Suicide is an attempt to stop pain, whether the suffering is physical or emotional "

"I believe Prozac had a lot to do with my son's death."

"I think I would help my mother to kill herself, when she decides the pain from her disease is too much to bear."

There was considerable discussion about the difficulty men have confronting their emotions. Several participants related their inability to successfully entreat their male relatives to seek counseling or medical attention. Some participants also described the inability of their husbands to seek support after the suicidal death of one of their children.

One participant informed to the group that before her fiancé killed himself, he gave no indication that anything was troubling him. *"Everything seemed to be going so well for us."*

The youngest reported suicide during the focus group session was the poisoning of an eight year old child. The surviving parent explained, *"at the age of eight my daughter told friends at school that she was going to kill herself. Later, I found a note in her diary that said, 'my father set the example.'"*

Another parent survivor discussed the torment her late son had endured. *"My son had been overweight as a child and felt ostracized by others his age. As a young adult he lost weight and developed a great physique, but he still thought of himself as overweight."*

Mental health services and access?

The initial discussion of this health care domain was not lengthy or active. The group provided a consensus attitude that mental health services had been personally difficult for most of them to obtain. In addition to the difficulty of getting male relatives in need of counseling to seek assistance, participants detailed their general frustrations with mental health services.

The group agreed that more counseling services should be available at an affordable cost. Several individuals reported difficulty obtaining mental health referrals from health maintenance organizations (HMOs). One participant suggested that services provided by social workers should cost considerably less than that provided by psychologists. There was considerable agreement that survivor support group participation had been the most helpful resource in their emotional recovery from personal loss.

Stigma of mental health problems?

The group agreed that a strong stigma is associated with both suicide and the receipt of mental health services in our society. Several participants described their frustration that seeking professional counseling services was, in itself, seen as a personal sign of "weakness."

At this point in the discussion, the general inability of men to discuss emotional issues was raised again. In a discussion of the female composition of the research group, it was generally agreed that more women than men attend survivor support groups. The experience of the participants showed that male survivors might come to a few meetings, and then drop out. One exception was a new spouse who attended group sessions in support of his wife, who had lost her teenage son from a previous marriage. This man would say his attendance was for her but once ,after a fight between the two, he attended in anger to get a better understanding of his wife's grief and suffering.

Specific comments about blame and social stigma included the following:

"His family shut down on us. They think it was my fault. They won't say it, but it's clear they blame me for his death."

"Survivors always get the blame."

"There's such a desire for blame in our society – society needs an answer as to WHY the family member committed suicide."

"There's an attitude in some families that there's no way the victim would have done something like that unless he was somehow driven to it."

One participant's contribution to this portion of the discussion may be paraphrased in this manner:

In the beginning everyone looks for the cause or individual to blame. There's a search for something to hang it on and absent a clearly identified cause, the closest relative is blamed, whether parent or spouse.

Another participant described the thought patterns people go through once they learn you are a suicide survivor: People try to imagine what it would take to force them justifiably to kill themselves. Then they project this situation to feel it could never happen to them or their family. For example, they rationalize that 'my son isn't artistic like yours, so were safe.'

Two stories of youth suicide:

At this point in the discussions, one participant provided the story of two very different reactions to the deaths of two youths.

There had been a suicide by a student from the neighborhood the previous day. One of the local school counselors who resided in the same area related the incident to one of the study participants, a known survivor of the loss of a spouse. While the counselor would discuss the case of the student's suicide with this surviving neighbor, she was very clear that school officials would not inform the other students that their fellow student's death was through suicide. The student was buried in a small private, family-only funeral.

This participant continued that a few months later a young girl from the same school died in a violent car crash. In her case the "*whole school*" went to the funeral. And everyone knew the details of this death. The participant concluded with the statement that "*there's an unnecessary fear that informing youth of the death of another student at his own hands will cause others to do the same.*" The group also agreed that if more students were educated about suicide, there would be fewer occurrences of 'copy cat' suicides.

A second participant, herself a teacher, then told about her son's suicide and the manner it was mishandled by her school. She detailed a story in which school officials intentionally provided an untrue depiction of the death of her son to the student body. It was depicted by the school leaders as a big secret. The student body was informed by a school guidance counselor that the teacher's (survivor's) son had died in an accident. On the other hand, during her personal leave to handle the funeral and burial of her child, the parent survivor planned to return to the school and, on her first day back, discuss her son's suicide with her students. The untruthful stories were provided to her students before she was able to discuss the issue with them. When the surviving teacher learned of the false statements, she was too emotionally devastated to relate the truth to her students. It was "*bizarre that the guidance counselor couldn't deal with the suicide, and our principal has never spoken with me about my son's death.*" Subsequently, when another student committed suicide, the school counselor once again refused to tell the students the truth about his death.

More personal experiences with suicide:

After the two participants had detailed their experiences with the stigma of suicide, these statements about personal loss were provided by other members of the group.

"You can use my name on anything you want related to my brother's suicide, because the worst thing that could happen to me has already happened.

"Cancer is a disease and so is suicide."

Several participants related uncomfortable interactions with medical professionals after the suicide of a family member. It was generally agreed that most professionals have not had the necessary training in this arena.

"A doctor told me three months after Monty died that I should be over it!"

Another physician told a participant that she would be okay about the death of her brother in a year.

The stigma of suicide is rampant in the beliefs of most of society. The difficulties friends and acquaintances and co-workers have was explained by several participants.

"People want to help, but they don't know what to say."

"Many people are aware of what you have experienced, but still don't ask you about it - why?"

Family, religious, and social factors that may decrease risk:

This question elicited considerable discussion, but mostly related to inadequate support and misunderstandings of congregations or ministers. Four of the participants described their churches as adequately supportive to them after a suicide. In fact, several had switched to new places of worship some time after their traumatic loss. Only one participant expressed strong support from her pastor. She was the first member of his congregation to lose a member of her family to suicide. She described his willingness to read research and other written materials that she offered. While it took him a while to fully address her about the loss, this minister used the materials along with information he gathered to develop a bereavement packet for others in the congregation, who may need support. He continues to add materials to the packet and has expressed considerable interest in the findings of the SJR 382 study.

The consensus was that ministers need considerable education on dealing with suicides and survivors' needs. In fact, the theme of greater public education and awareness for most professions was raised again.

Specific comments on this topic included the following:

"The ministers are afraid your child has gone to Hell and they don't want to talk to you, thereby , reminding you of that."

"I returned to work at our church three weeks after my son's suicide and my co-workers were gathered around me on that first day back. The minister, who had conducted my son's funeral, stuck his head in the door and said, 'oh, I see you're back.' He's never said another word to me about my son's death."

"It took our lay (Methodist) minister two months to call me after my father's suicide."

"Pastors need training and education, too."

"More Christian writing is needed on suicide."

"More information in general is needed."

"When my son died, Barnes and Noble had no materials on suicide available."

"[Suicide] is a 'way of life' that alters your course forever."

"Some churches stigmatize survivors, blaming them for the loss."

One of the two support group leaders told of her personal negative experience with her church of 47 years.

"Two weeks after the death of my son, the church asked me to stop teaching my youth class. They said, ' after what happened to your son, we think you don't have any business working with other youths.'"

In addition, despite support from the minister and congregation members at the time of her son's funeral, she was blamed for his death.

"None of my son's friends ever came to visit me after he died. I learned later from a few of them that their parents wouldn't allow them to visit."

What can be done to prevent suicide?

In the discussion of this portion, most participants referred to their personal experiences with suicide. Suggestions were offered, though, that showed considerable thought on this matter. The recommendations were broad and once again turned around increased public education on the matter of suicide.

At this point, one individuals regretted that everything she had tried had failed to save her son's life. *"[Son] passed away in a hospital after his fourth attempt, so even being in a safe place could not save him."*

"We need more public awareness and visibility of this issue."

"Provide clear education in the workplace, in the community and in our schools."

"List warning signs in more places, do a media campaign."

"Remove guns and/or medications from the seriously depressed."

"Media should encourage potential victims or significant others to call for help."

"Maybe when youth apply for their driver's permits, suicide could be addressed; safety and saving lives go hand in hand."

What should the policy makers keep in mind?

This question elicited some of the most lively discussion. Everyone in the group contributed suggestions. Several participants volunteered to assist in telling policy makers about suicide and they offered additional assistance with the study.

"There's a great need to educate the public. The stigma is alive and well and needs to be addressed with clear factual information."

"In high schools, suicide should be discussed just like other health issues."

"Schools should behave proactively, instead of fearing suicide clusters."

"Put [suicide] in health education now, not after an event happens."

"Warning signs are critical."

"Educate the public on what happens to survivors."

"Media campaigns with the statistics of suicide are needed."

"Survivors get depressed on key dates such as birthdays, anniversaries, and holidays."

"Police should follow-up with lists of support groups, and/or physicians, who have personal experience with family loss from suicide."

"Richmond has a team of counselors who visit families after murders; they should add a specialist on suicide and/or create a similar team for suicides or suicide attempts."

Other issues:

Several participants described their emotional paths after the death by suicide of their loved ones:

"Initially, one functions like a robot, but the real work for recovery begins months after the death."

"I knew I was getting better when I started making plans for the future. They had told me not to make any major decisions for at least six months and now I understand why."

"Not a day passes without a thought crossing my mind as to what could have been done differently."

A participant described suicide in history. She related how in early ages suicide was seen as a way to avoid paying taxes. *"Religious rules were [therefore] developed to prevent suicide."*

Conclusion:

Several themes recurred throughout the discussions. Participants identified public education and awareness concerning suicide as a critical need.

Training for professionals in all fields of work was called for.

Written descriptions from survivors:

"When I think of my son, Paul, I think of the happy times. I miss very much what could have been - his future hopes and dreams. I'll always remember his keen wit, personality and great sense of humor. A change took place and he went from highs to lows and never was the same. He took his life to find "peace" and it will have affect us forever."

Paul's Mom

"Ten years ago, on Labor Day evening, I talked twice with my 25-year old son on the phone. He was sad and crying...didn't feel like eating or working. It was such a beautiful day that I had no idea what was to happen next, nor could his older sister who also talked with him on the phone. He made five cyanide capsules with the cyanide he used in his business. He phoned his ex-girlfriend in another town and told her of his plan to consume the capsules. She phoned my nephew, who called his parents, who lived near my son.

They found him unconscious.

He lived two days in a coma."

APPENDIX D:

MINUTES OF STAKEHOLDER MEETING

Specific Findings

A. Child and Adolescent Workgroup

1. What resources are available and/or what is currently being done for youth who are at immediate risk of suicide? (think about services, programs, activities, etc.)

- General Assembly resolution directing the development of school guidelines for suicide prevention by the Department of Education.
- Various training and workshops for school staff on the prevention of violence, suicide, conflict resolution, substance abuse, etc.
- Comprehensive Services Act requires all youth that are referred and are in crisis to complete a screening and assessment survey.
- Requirement for comprehensive mental health screening when youth are admitted to juvenile jails and detention facilities.
- West Potomac High School (Fairfax) has a suicide prevention coalition.
- Prince William County has a suicide prevention coalition that provides education to parents and professionals on adolescent suicide, includes a hotline for youth staffed by peers at certain times.
- National suicide hotline.
- Richmond Organization for Sexual Minority Youth (ROSMY) has a hotline for at-risk youth (not specific to suicide).
- Some churches support grass root organizations with donation of space, funds and volunteers.
- Some funeral parlors have been expressing interest in obtaining information to help suicide survivors.
- State Child Fatality Review Team is conducting a retrospective review of youth and adolescent suicides.
- Various counties have conducted Youth Risk Behavior Survey (YRBS).
- Various mentoring programs across the state.

2. What programs, services activities and efforts exist in Virginia to strengthen youth at risk so that they do not become actively suicidal?

- Universities offer support services to students through counseling services.
- School based clinics at Roanoke City Schools have a universal release for health services that opens door for counseling in addition to physical health services.
- DARE and school resource officers.

3. What should be done to help those who are at immediate risk of suicide and what can be done to reduce risk factors and strengthen youth so that their risk of suicide is reduced?

Priority recommendations based on consensus vote:

- Research information on risk by instituting Youth Risk Behavior Survey (YRBS) in Va. and develop new research on contributing factors in populations where suicide is increasing
- Establish a statewide advisory group to develop a plan for suicide prevention
- Increase parity and equity in mental health treatment and coverage
- Establish two positions at the state level (preferably Virginia Department of Health) to develop and coordinate suicide prevention and intervention activities
- Establish a statewide advisory group to develop a plan for suicide prevention
- Increase awareness in general population to recognize risk factors for suicide.

Other recommendations:

- Improve channels of communication regarding suicide between educators, parents, media, clergy and other service providers.
- Identify suicide as a public health problem and distribute information through the standard medical care system.
- Increase access to mental health services.
- Improve research and ways to determine predictors and risk factors for suicide and improve treatment.
- Use research based information to identify successful suicide prevention programs.
- Centralize data collection and increase availability.
- Increase crisis intervention services and insure that all members of Commonwealth have access to crisis services.
- Insure that local resources are available, especially through Comprehensive Services Act.
- Reduce barriers to services (i.e. financial and procedural).
- Expand and improve postvention activities.
- Increase public education to faith communities to make them aware of services available to members.
- Increase conflict resolution and bullying reduction programs in schools
- Increase general education regarding primary prevention with less focus on at-risk kids, target general population.
- Increase avenues for support and help (mentoring, peer groups, etc.)
- Educate all who work with children, concerning questions to ask and where to make referrals
- Utilize best practices for public awareness and prevention learned from tobacco and HIV/AIDS programs.
- Need to develop common and more precise vocabulary regarding suicide terminology.
- Improve continuum of services- prevention to post intervention.
- Recognize the role of the family and develop strategies that improve family dynamics when developing prevention efforts.
- Increase the role of schools as location for assessment, identification and referral to access services.

B. ADULTS

1. What is currently being done and what resources are available for adults at immediate risk of suicide – adults in crisis?

- There are suicide crisis centers in at least 10 localities including Northern Virginia, Tidewater, Richmond, Martinsville, Lynchburg, and Bristol. They are small, with no formal federal or state funding. They are privately funded through the United Way, foundations, faith organizations, and rely heavily on volunteers. They are striving to meet a significant need - the Tidewater crisis center covers a five-city area and alone receives 24,000 calls per year.
- A National Hotline "1-800-SUICIDE" provides a switchboard that links caller's back to nationally accredited, available crisis lines in Virginia. It is not advertised and needs publicity.
- There is no central registry of suicide services other than through the national organization, the American Association of Suicidology.
- Police dispatchers receive special training in crisis response (certification is under discussion and consideration by the Department of Criminal Justice Services).
- Some state and local police officers are trained in suicide intervention, negotiation and crisis support.
- Community Service Boards provide crisis lines and crisis teams. By code CSB's must provide emergency intervention services but they vary in size and some close at 5 p.m.

- Support groups provide services to survivors after a suicide but only upon survivor request. They also produce and disseminate newsletters to survivors and treatment specialists.
- Enhanced "911" allows rapid location of people in crisis in some areas.
- There are on-campus hotlines and counseling services.
- Hospital emergency departments are another resource.
- Involuntary civil commitment via emergency departments and through magistrates is another option for protecting people in crisis.
- The state information and referral # connects people with resources.
- Faith organizations are another resource but the response is inconsistent.
- The military has family networks, ombudsmen, spouses support groups and other services for servicemen.
- Prison ministries provide counseling intervention.

2. **What programs, services, activities and efforts are currently in place to strengthen adults with risk factors so they do not become actively suicidal?**

- Programs like "Meals on Wheels" and the diversity of other types of support groups that exist that provide social contact, support, group and individual counseling for elderly and other at-risk groups.
- Community Service Boards.
- Disaster relief organizations such as the Red Cross.
- Employee Assistance Programs.
- Pastoral Counseling.
- The Mental Health Association of Virginia is working on a clinical depression campaign and conducting depression screening. Some local chapters work with hospitals and post-partum women.
- Professional associations such as police provide informal support to membership and the Boards of Nursing and Medicine have referral sources for professionals with confidential issues.
- The COPS (Concerns of Police Survivors) program address the needs of police who attempt or commit suicide and their families. Crisis intervention training and stress management training is provided to critical incident management teams and other "first responders"
- Prison ministries provide counseling in jails. Inmates are screened before they enter a correctional facility. Later on, however, the inmate would have to initiate a request for services.
- Area Agencies on Aging.
- Individual therapists who often volunteer their time
- The different types of crisis centers (e.g. rape, domestic violence, suicide response)
- Community based organizations like YMCAs and YWCAs that empower people, and provide Community services and safe haven.
- Shelters of all kinds.
- Alcohol and drug counseling groups.
- Various volunteer efforts occurring in state that offer "connectedness" and support
- The TRIAD program which is operated by law enforcement and the area agencies on aging – keep law enforcement in contact with elderly, identify at risk people and connect them with services they need.

3. **What should be done to reduce risk factors for suicide?**

Priority recommendations based on consensus vote:

- Public awareness campaigns about suicide risk factors, prevention and intervention strategies and resources. These campaigns should decrease the stigma associated with seeking help, encourage a public dialogue on depression and suicide and involve media outreach (including training of media representatives about available referral resources).
- Conduct research to determine the scope of the problem and to identify state, local and community resources and consolidate this data in one place.
- Establish a state coordinator of suicide services (DMHMRSAS or DOH)
- Provide a minimum level of resources dedicated to prevention at the state and local level

Other recommendations:

- Increase public education about resources such as the 1-800 suicide line, the state information and referral line and the upcoming 211 that can link people to services.
- Improve coordination between suicide crisis organizations as well as other crisis oriented organizations for a) public education and b) response when they receive calls or come into contact with those with suicide risk factors.
- Involve existing "crisis lines" in any newly developed public awareness initiatives.
- Provide training for medical professionals and other gatekeepers to increase awareness of signs of suicide/mental health issues. Continuing medical education credits should be offered.
- Outreach to the faith communities to raise awareness about suicide and needs of at-risk people, survivors, family and associates.
- Develop a uniform system of reporting for service agencies.
- Develop a statewide network of prevention services and provide resource and referral information on the Internet.
- Provide funding and positions to better support current efforts.
- Have the Commonwealth provide an expression of intent, to make it a priority, to do something about suicide.
- Insurance companies should offer and support a continuum of care (therapeutic and pharmacological) and revise current limits on length of stay and treatment that may place suicidal individuals at increased risk.
- Develop and distribute prevention resource guides.
- Endorse the attached national recommendations from the Suicide Prevention Advocacy Network (SPAN)

4. **What should be done to help those in crisis?**

Priority recommendations based on consensus vote:

- There should be a dedicated consistent level of funding for crisis centers and funded positions to support efforts already in place

Other recommendations:

- Funeral homes should disseminate information on survival groups.
- Suicide crisis teams should accompany police to scene of suicide or suicide attempt and assist families, observers.
- There should be minimum standards for emergency services for community service boards – e.g. 24 hour, easy access.

- There should be minimum, adequate training on suicide intervention for police/emergency dispatchers and law enforcement.
- Provide advertising budgets.
- Resource guides should be developed and distributed (e.g. how to cope).
- All public awareness efforts should be evaluated.
- There should be media outreach on where to refer people in crisis and what messages should be communicated when reporting on suicides.
- Hospitals should provide a crisis counselor or direct patient access to a crisis center or community services board.
- People in crisis should receive a rapid response in the emergency rooms or immediate access to affordable treatment.
- Develop standards for emergency services units of community services boards.

APPENDIX E:

STAKEHOLDER MEETING PARTICIPANT LIST

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APPENDIX F:
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