REPORT OF THE
VIRGINIA COMMISSION ON YOUTH

Youth Suicide Prevention Plan

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH of VIRGINIA

Commission on Youth

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January 10, 2001

TO: The Honorable James S. Gilmore, III, Governor of Virginia

and

Members of the Virginia General Assembly

The 2000 General Assembly, through Senate Joint Resolution 148, requested that the Virginia Commission on Youth be directed "to develop a comprehensive youth suicide prevention plan." The Commission received this request by way of letter from the Speaker of the House of Delegates.

Enclosed for your review and consideration is the report, which has been prepared in response to this request. The Commission received support from all affected agencies and gratefully acknowledges their input into this report.

Respectfully submitted,

Phillip A. Hamilton

Phillip A. Hamilton
Chairman

L e L. Karen Darner
Senator R. Edward Houck
Delegate Jerrauld C. Jones

Delegate Robert F. McDonnell
Senator Yvonne B. Miller
Delegate John S. Reid
Senator D. Nick Rerras

Delegate Robert Tata
Mr. Steven V. Cannizzaro
Mr. Douglas F. Jones

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Authority For Study

§ 9-292 of the *Code of Virginia* establishes the Commission on Youth and directs it to "...study and provide recommendations addressing the needs of and services to the Commonwealth's youth and their families." § 9-294 provides the Commission the power to "...undertake studies and gather information and data in order to accomplish its purpose...and to formulate and present its recommendations to the Governor and members of the General Assembly."

The 2000 General Assembly conveyed Senate Joint Resolution 148 to the Commission by way of letter from the Speaker of the House of Delegates. The Resolution directed the Commission to develop a comprehensive youth suicide prevention plan. In fulfilling its legislative mandate, the Commission undertook the development of this plan.

Members Appointed to Serve

The authorizing legislation required the Commission on Youth to develop a comprehensive youth suicide prevention plan. The Commission received briefings and presentations during the summer and fall of 2000. Members of the Commission on Youth are:

The Hon. Phillip Hamilton, Chair, Newport News
Mr. Gary Close, Vice Chair, Culpeper
The Hon. L. Karen Darner, Arlington
The Hon. Jerrauld C. Jones, Norfolk
The Hon. Robert F. McDonnell, Virginia Beach
The Hon. Yvonne B. Miller, Norfolk
The Hon. R. Edward Houck, Spotsylvania
The Hon. John S. Reid, Chesterfield
The Hon. D. Nick Rerras, Norfolk
The Hon. Robert Tata, Virginia Beach
Mr. Steve Cannizzaro, Norfolk
Mr. Douglas Jones, Alexandria

Executive Summary

Senate Joint Resolution 148 directed the Commission on Youth, with the assistance of the Departments of Health, Education, and Mental Health, Mental Retardation, and Substance Abuse Services, to develop a comprehensive youth suicide prevention plan. The study resolution recognized suicide as the third leading cause of death among adolescents, as well as the significant increase in the rate of suicide among Virginia youth aged 10-19 since 1975. With the support of the departments identified above and significant input from survivors, service providers, and other stakeholders, the Commission undertook development of the plan.

A variety of methodologies were employed in this effort. Suicide prevention plans from other states were reviewed and analyzed. Suicide data were gathered at both the state and national level, including national data on suicide attempts and suicidal thinking. A large body of research was reviewed and analyzed, and workgroups were developed to provide guidance and feedback throughout the process.

In 1998, 30,575 people ended their own lives. More than 4000 were under 25 years of age. Three hundred seventeen (317) were children aged 10-14.[1] The number of adolescent deaths from suicide has increased dramatically during the past few decades. From 1950 to 1990, the suicide rate for adolescents in the 15-19 year-old age group has increased by 300%.[2] From 1980 to 1996, the rate of suicide among younger adolescents (10-14 years of age) has increased by 100%. Suicide is the third leading cause of death for children in these age groups and the ratio of attempted suicides to completed suicides is estimated to be 50:1 to 100:1.[3]

Over 800 Virginians died by suicide in 1998. The suicide rate for young Virginians, aged 10 to 19, has increased an alarming 32% since 1975. In 1998, seven Virginia children, aged 5-14, were reported to have died from suicide. Another 50 children, aged 15-19 ended their lives. Recent statistics show that teenage (15-19 years of age) deaths related to suicide range from 53 to 57 per year in Virginia. Approximately one Virginia teenager every week takes his or her own life.

Reducing and ultimately preventing youth suicide in Virginia will require substantial, long-term, system-wide changes, which expand and enhance services for youth. Over time, a coordinated approach to implementation of the recommendations described in this plan should significantly reduce the rate of youth suicide and contribute to improving the overall health of Virginia's youth.

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[1] National Center for Health Statistics Vital Statistics System. 1998 Leading Cause of Death Reports.
[2] Centers for Disease Control and Prevention. Programs for the prevention of suicide among adolescents and young adults. *Morbidity and Mortality Weekly*. 1994:43:1-7.
[3] Hussain, SA. Current perspective on the role of psychological factors in adolescent suicide. *Psychiatric Annual*. 1990:20:122-27.

Findings

Consistent with the recommendations of the Virginia Department of Health Study of Suicide in the Commonwealth, the Commission on Youth recommends that the Virginia Department of Health take responsibility for developing, implementing, and monitoring a coordinated suicide prevention strategy. The Department of Education and the Department of Mental Health, Mental Retardation, and Substance Abuse Services should partner with the Virginia Department of Health in the development and implementation of some specific components, but statewide coordination by one agency is critical.

Recommendation 1

Amend §32.1 of the *Code of Virginia* to designate the Virginia Department of Health (VDH) as the lead agency for youth suicide prevention in Virginia and require reporting to the Governor and General Assembly on the status of suicide prevention initiatives.

Findings

Youth suicide is a complex problem; therefore, efforts must be designed to provide for broad-based dissemination of information to all citizens of the Commonwealth. This information includes:

- *Prevalence and causes of suicide*
- *Need to talk to youth about suicide*
- *Services / supports available for youth and families.*

Community-wide education programs reach families, students, youth in the work force, hard-to-reach youth in other sectors, and media personnel. Research has shown that youth facing depression and other difficult times are unlikely to contact a mental health professional. Rather, friends, family, and teachers are most likely those in a position to observe the youth's despair and to respond. This, and the fact that early intervention with depressed youth is essential, compels the organization of public awareness campaigns which address the warning signs and appropriate approaches for helping. As a result of increased knowledge, skills, and interest, suicidal youth are more likely to be recognized and assisted in seeking appropriate mental health care.

Recommendation 2

Increase funding for the VDH and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) for their development and/or adoption of materials and dissemination of youth suicide prevention information throughout the Commonwealth.

Findings

Suicide contagion is a major concern among service providers and policy makers. Suicide acts following another's suicide have been linked with reporting practices in which the completed suicide was glorified or romanticized. Since media reports may affect the incidence of youth suicide, state and local policy makers should work together to influence media reporting practices regarding youth. Responsible reporting of suicide can have several direct benefits.

Community efforts to address the problem can be strengthened by news coverage that describes the help and support available; as well as provides information about how to access assistance; that explains how to identify persons at-risk for suicide; or presents information about risk factors.

Recommendation 3

VDH should make available to media professionals throughout the Commonwealth information about the responsible reporting of suicide (including specific guidelines developed by the U.S. Centers for Disease Control and Prevention) in order to reduce the risk of subsequent suicides.

Findings

School-based suicide prevention strategies involve a coordinated effort, reaching all levels of school staff. The purpose of school-based education efforts is to provide instructional content that parallels the community-wide public education campaign, so that youth, parents, teachers, and other adults are sensitized simultaneously to the issues and concerns, and to the knowledge and skills for preventing youth suicide. School-based programs are an effective method of disseminating information about suicide to large segments of the youth population.

Recommendation 4

The Department of Education (DOE) should revise the Suicide Prevention Guidelines to include criteria for follow-up with parents of students expressing suicidal intentions after initial contact is made.

Findings

Gatekeeper Training is designed to teach youth and significant adults specific strategies for recognizing and responding to suicide-risk youth and connecting them with persons capable of providing crisis intervention and support services. Gatekeeper Training is designed to prepare a broad spectrum of community members throughout Virginia to serve the protective functions of identifying and responding to youth with a high potential for suicide. Gatekeepers are trusted individuals who routinely have significant contact with youth and who are likely to observe high-risk behaviors. These Gatekeepers include:

- *Health care providers*
- *School personnel*
- *Clergy*
- *Youth service workers*
- *Law enforcement and Court Service personnel*

Gatekeepers do not replace professional mental health care providers, but are, more often, "natural helpers" in a youth's social network. Gatekeeper Training is a process by which these frontline persons acquire the skills necessary to accurately screen and refer high-risk youth.

Recommendation 5

VDH and DMHMRSAS should develop and deliver Gatekeeper Training to designated audiences throughout the Commonwealth.

Recommendation 6

The Board of Health Professions and all state agencies responsible for licensing or certification of youth-serving personnel should require suicide prevention education as a requirement for licensure or certification.

Findings

Youth suicide prevention is necessarily linked to mental health and emotional well-being. While it is recognized that youth in crisis and at-risk of suicide need immediate access to crisis intervention services, research also shows that early intervention and prevention services help to avoid the onset of crisis.

Comprehensive mental health services for children, adolescents, and their families include prevention, early identification and intervention, screening and evaluation, and a continuum of both non-residential and residential treatment services. A critical component of an effective system is an appropriate balance between more restrictive and less restrictive services.

To reduce suicidal behaviors and prevent suicide, high-risk youth, their friends and family members need immediate, 24-hour access to crisis intervention. Local crisis centers should be supported in their efforts to expand their service capacity, particularly in the implementation of 24-hour crisis hotlines.

Recommendation 7

DMHMRSAS should continue to develop and implement the plan to provide comprehensive mental health services for children, adolescents, and their families.

Recommendation 8

DMHMRSAS and VDH should increase the capacity of local communities to provide community-based crisis intervention and support services for children, adolescents, and their families.

Findings

Skill-building support groups are designed to provide a safe, comfortable environment in which vulnerable youths can learn and practice life skills to increase resiliency, strengthen protective factors and reduce risk factors. The target population for these groups is made up of youth who have been identified as being at-risk for suicide through screening, self-referral, or referral by parents, gatekeepers, and/or mental health professionals.

Increasing the availability of prevention and early intervention services for depressed youth are priority goals of the youth suicide prevention plan.

Providing school-linked mental health services will help to ensure that youth who need these services have access to them. Lack of social support, particularly family support, has been shown to increase the risk of youth suicide. Family support should include education about ways to support youth as well as teaching skills for family members. Youth should be served within the context of their families. A family-systems approach to mental health services will increase opportunities for successful prevention and intervention.

Recommendation 9

DMHMRSAS should continue to expand the availability of comprehensive mental health services for children and youth at-risk for suicide, particularly helping localities to offer skill-building and support groups, school-linked mental health services, and family support / survivor services.

Findings

If professionals are to work effectively with youth at-risk for suicide, continuing training opportunities must be provided to support these professionals. Expected outcomes of clinician training include:

- *Increased knowledge of the interpersonal and intrapersonal dynamics of youth at high-risk for suicide, psychosocial indicators of suicide, and necessary supports for these youth;*
- *Increased skill in the assessment of youth at-risk;*
- *Increased skill in individual therapeutic methods for youth at-risk and their families; and*
- *Prevention of worsening condition of youth and decreased risk and incidence of suicide.*

Recommendation 10

DMHMRSAS and VDH, in cooperation with university medical centers, health science centers, and professional organizations should develop, implement, and evaluate curriculum and training plans to increase the knowledge and skills of clinicians and others who work with youth at-risk for suicide and their families.

Findings

Currently, Virginia has no system for monitoring suicide attempts among youth. A suicide attempt data system will provide a comprehensive surveillance instrument for understanding suicide attempters who are present in Virginia hospitals. Monitoring suicide attempts in Virginia is necessary to better understand the occurrence of attempts by youth in the Commonwealth. Data gathered will help planning of activities and evaluation of the success of suicide prevention activities.

Recommendation 11

VDH should design and implement an adolescent suicide attempt data collection system to determine the magnitude of the problem, as well as the following

characteristics of youth who attempt suicide: demographics, service access, and behavioral characteristics.

Recommendation 12
VDH should improve the system for reporting external cause of injury (e-codes) by providing training to designated reporters and by requiring e-code reporting for emergency room admission in selected sites around the Commonwealth.

Findings
Both process and outcome evaluation of all components of Virginia's plan are critical to ensuring its success. The Department of Health may wish to contract with a university partner to conduct certain aspects of the comprehensive evaluation.

Recommendation 13
VDH should coordinate comprehensive evaluation of all aspects of the suicide prevention program.

Recommendation 14
The General Assembly should appropriate funds to the Department of Health, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Education to implement the youth suicide prevention initiatives described in this plan.

Study Goals and Objectives

In developing goals for the Youth Suicide Prevention Plan, Commission staff reviewed the authorizing legislation and the most recent Virginia studies related to suicide in the Commonwealth. Other state plans were examined and a review of the literature was conducted. The following goals for the Plan were drafted, presented and approved by the Commission in June 2000:

I. Prevent suicidal behavior among youth in Virginia;

II. Reduce the impact of suicide and suicidal behavior on individuals, families, and communities; and

III. Improve access to and availability of appropriate prevention services for vulnerable individuals and groups of youth.

In order to ensure the development of a plan that met the stated goals, the following activities were undertaken:

- Coordination with the Virginia Department of Health, the Department of Mental Health Mental Retardation and Substance Abuse Services, the Department of Education and the State Child Fatality Review Team;
- Review of suicide prevention plans from other states;

- Review of literature, including existing data, reports, and research;
- Convening of stakeholders' group;
- Determination of components of youth suicide prevention plan;
- Development of a plan in cooperation with designated state agencies and stakeholders; and
- Recommendation of policy, legislative, and/or budget initiatives.

Methodology

In developing the Youth Suicide Prevention Plan, the Commission employed several distinct research and analysis activities. Each activity is described briefly below.

A. Review and analysis of suicide prevention plans from other states

A number of states around the nation have developed suicide prevention plans. Many others have identified suicide prevention as a state priority and are in various stages of development of such plans. In all, Commission staff reviewed completed, draft, or proposed plans from 11 states: Washington, Maine, Oregon, Maryland, Vermont, Colorado, Arizona, New Jersey, Minnesota, Texas, and Florida.

B. Suicide data collection and analysis

Suicide data from both U.S. and Virginia sources were gathered and analyzed. The National Center for Health Statistics, the U.S. Centers for Disease Control and Prevention, and the American Association of Suicidology provided national data on suicide, reported suicidal ideation, and suicide attempts in the U.S. The Virginia Department of Health, the Virginia Center for Health Statistics, and the Center for Pediatric Research provided valuable Virginia data.

C. Research and literature review

Much has been written in the last decade about the epidemic of youth suicide and strategies for prevention. An extensive search through both Internet and library sources was conducted and a large body of research was reviewed. In addition, previous Virginia studies of suicide were reviewed and analyzed.

D. Workgroups

As directed in SJR 148, the Commission identified a large group of stakeholders to provide guidance in the development of the Plan. Stakeholders included suicide survivors, service providers, representatives of affected state agencies, and other interested individuals. Stakeholders met as a large group on two occasions to provide guidance and feedback. Four smaller workgroups were formed to develop specific components of the plan. Each workgroup met at least twice during the summer of 2000. Workgroup membership lists are found in the Appendix.

Background

A. The Problem of Youth Suicide

In 1998, 30,575 people ended their own lives. More than 4000 were under 25 years of age. Three hundred seventeen (317) were children aged 10-14.[4] The number of adolescent deaths from suicide has increased dramatically during the past few decades. From 1950 to 1990, the suicide rate for adolescents in the 15-19 year-old age group increased by 300%.[5] From 1980 to 1996, the rate of suicide among younger adolescents (10-14 years of age) increased by 100%. Suicide is the third leading cause of death for children in these age groups and the ratio of attempted suicides to completed suicides is estimated to be 50:1 to 100:1.[6] The Substance Abuse and Mental Health Administration has declared adolescent suicide a national mental health problem.

Recently, the Office of the Surgeon General issued a "Call to Action to Prevent Suicide." This call recognizes the advantages in understanding the potential precursors and risk factors for youth suicidal behavior, specifically mental health and substance use disorders. The decision by the United States Department of Health and Human Services to include suicide as one of the leading indicators of health status in Healthy People 2010,[7] the call for prevention issued by the Surgeon General, and increasing attention from Congress, indicate that research related to the understanding, prevention, and treatment of suicidal behaviors is a high priority on a national level.

Many elements, both individual and societal, contribute to a youth's likelihood of attempting or completing suicide. The American Academy of Pediatrics identifies a number of factors, which may explain the dramatic increase in youth suicide in recent years:

- It is easier to get the tools for suicide (Boys often use firearms to kill themselves; girls usually use pills.)
- The pressures of modern life are greater
- Competition for good grades and college admission is stiff
- More violence is seen in the media
- Parents may be less involved in their children's lives.[8]

Youth suicide is a complex problem, involving multiple factors. However, research shows it is neither random nor inevitable. Addressing the problem requires recognition of the signs and symptoms of depression in children and understanding risk factors for suicide. In its report, *Suicide Fatalities among Children and Adolescents in*

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[4] National Center for Health Statistics Vital Statistics System. 1998 Leading Cause of Death Reports.
[5] Centers for Disease Control and Prevention. Programs for the prevention of suicide among adolescents and young adults. *Morbidity and Mortality Weekly.* 1994;43:1-7.
[6] Hussain, SA. Current perspective on the role of psychological factors in adolescent suicide. *Psychiatric Annual.* 1990:20:122-27.
[7] U.S. Department of Health and Human Services. Leading indicators for Healthy People 2010: A report from the HHS working group on sentinel objectives. *Washington, D.C.: U.S. Government Printing Office.* 1998.
[8] American Academy of Pediatrics. Some things you should know about preventing teen suicide. *Child Health Monthly.* 2000.

Virginia from 1994-95, the Virginia State Child Fatality Review Team found that more than 40% of the children who took their lives had told someone about their intent to die.[9] According to the report, the opportunity to intervene with these children was lost for a variety of reasons: the signs were not recognized, the magnitude of the problem was not understood, firearms and medications were not removed or secured, peers and family thought they could handle the problems themselves, they did not know where or how to get help, or help was not available.

B. Depression in Children and Adolescents

Depression in children and adolescents is strongly associated with an increased risk of suicidal behaviors. This risk may rise, particularly among adolescent boys, if the depression is accompanied by conduct disorder and alcohol or other substance abuse.[10] Researchers supported by the National Institutes of Mental Health found that, among adolescents who develop major depressive disorder, as many as 7% may commit suicide in the adult years.[11]

One study found that 90% of suicidal adolescents believed that their families did not understand them.[12] These teens reportedly felt alone and anonymous and believed that their parents either denied or ignored their attempts to communicate feelings of unhappiness, frustration or failure. Suicidal teens often feel that their emotions are played down, not taken seriously, or met with hostility by the people around them.

A number of epidemiological studies have reported that up to 2.5% of children and 8.3% of adolescents in the U.S. suffer from depression. In addition, research indicates that depression onset is occurring earlier in life today than in past decades.[13] Adolescent depression creates significant costs to society. In addition to the increased risk for suicide, depressed youth are at increased risk for substance abuse, school failure and eventual dropout. Further, as depicted in *Figure 1*, depression was the second leading cause of child and adolescent hospital admission in Virginia in 1995, at a cost of $51.5 million. When combined with substance abuse and manic depression, the costs of treating children at-risk for suicide approached $60 million in one year.

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[9] Office of the Chief Medical Examiner. Suicide Fatalities Among Children and Adolescents in Virginia 1994-95. Richmond, VA: January 2000.

[10] Shaffer, D. and Craft, L. Methods of suicide prevention. *Journal of Clinical Psychiatry*, 1999: 60:70-74.

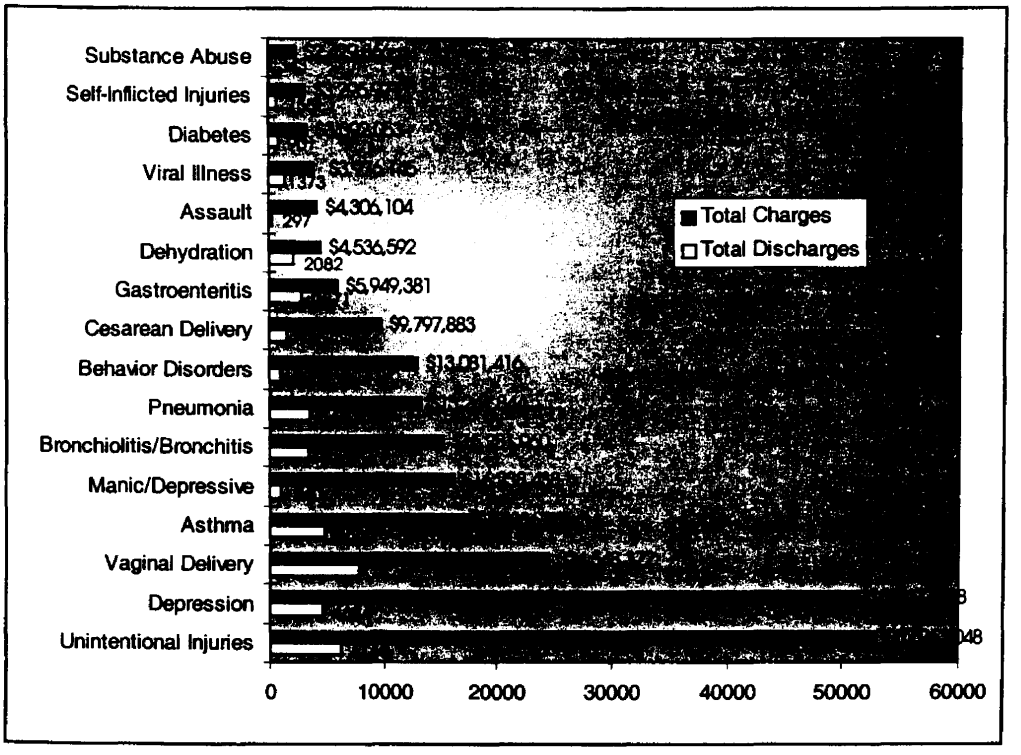
[11] Weissman, M.M., Wolk, S. and Goldstein, R.B. Depressed adolescents grown up. *Journal of the American Medical Association*, 1999: 281:1701-1713.

[12] American Academy of Pediatrics. Surviving: Coping with adolescent depression and suicide. *American Academy of Pediatrics On-line resources*. 2000.

[13] Birmaher, B., Ryan, N.D. and Williamson, D.E. Childhood and adolescent depression: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 1996: 35(11):1427-39.

Figure 1

Child and Adolescent Admission in Virginia, 1995



Source: Pestian, JP, Sheppard, VB, et al., *Child and Adolescent Hospitalizations in Virginia,* Center for Pediatric Research, 1997

Although the scientific literature on the treatment of children and adolescents with depression is less extensive than that concerning adults, a number of studies have confirmed the efficacy and safety of treatments for depression in youth. Early diagnosis and treatment are critical to the healthy emotional, social, and behavioral development of children and adolescents. The availability of comprehensive, appropriate mental health services for youth and families is discussed later in this report as a critical component of youth suicide prevention.

C. Youth Suicide: National Data

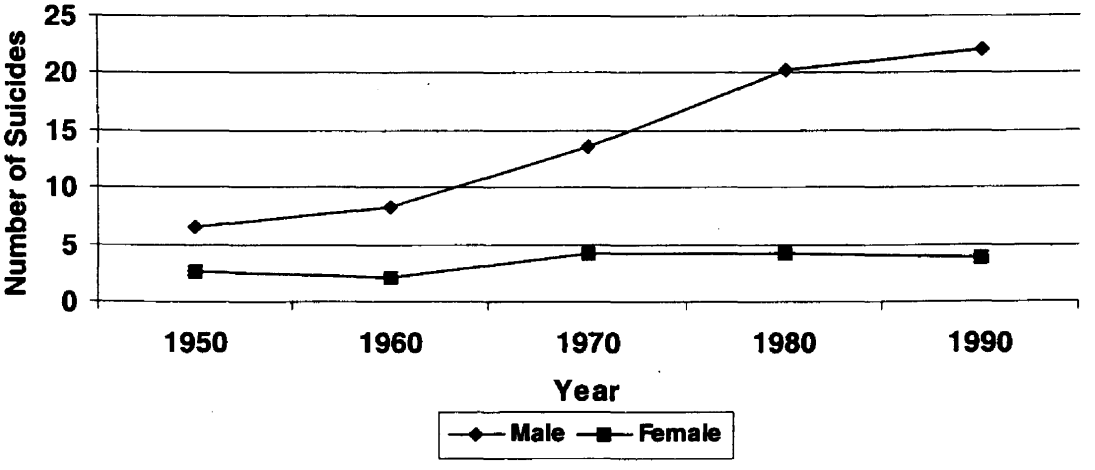
There has been an alarming increase in the rates of both completed suicide and suicide attempts among adolescents and young adults over the last three decades.[14] The adolescent suicide rate increased 200% compared with a 17% increase in the general population.[15] Suicide is the second leading cause of death among 15-19 year olds in the United States, and is closely associated with the disturbing trend of youth violence in our culture.[16] In 1998, there were 1737 suicides among individuals 15-19 years old. An additional 317 suicides were reported among children younger than 15.

[14] Washington State Department of Health. Youth Suicide Plan for Washington State. 1995.
[15] Garland, A.F. and Zigler, E. Adolescent suicide prevention: Current research and social policy implications. *American Psychologist*, 1993: 48;169-182.
[16] Andrews, J.A. and Lewinsohn, PM. Suicide attempts among older adolescents: Prevalance and co-occurrence with psychiatric disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 1992: 32, 655-662.

During that same year, 15% of deaths in the 15-24 year-old age group were attributable to suicide. An average of one young person every two hours took his own life.[17] The true number of suicide deaths may be higher, because some of the deaths may be recorded as accidental.

Graph 1

U.S. Suicide Rates* for Persons 15-24 Years Of Age



* Per 100,000 persons.
Source: American Association of Suicidology, 2000.

Nationwide, suicide attempts significantly outnumber completed suicides. The National Youth Risk Behavior Survey, a school-based survey conducted biennially by the Centers for Disease Control and Prevention, indicated that 19% of high school students surveyed felt sad or hopeless for a significant period of time; 14.5% seriously considered suicide; and 8.3% of students in grades 9-12, actually attempted suicide in 1999.[18] Of particular note is the relatively high rate of potential risk among 10th grade girls in each category. (See Table 2)

[17] National Center for Health Statistics. Vital Statistics System: Leading Causes of Death. 1998.
[18] Centers for Disease Control and Prevention. Youth risk behavior surveillance: United States, 1999. *Morbidity and Mortality Weekly Report.* 2000: 49 (SS-5): 49.

Table 2

Percentage of U.S. high school students who seriously considered and who attempted suicide, 1999.

Category	Felt Sad or hopeless*			Seriously considered attempting suicide⊗			Attempted Suicide§		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Race/Ethnicity									
White¶	23.2	12.5	17.6	15.5	9.5	12.4	9.0	4.5	6.7
Black¶	18.8	11.7	15.3	13.7	9.5	11.7	7.5	7.1	7.3
Hispanic	26.1	13.6	19.9	23.3	12.1	17.7	18.9	6.6	12.8
Grade									
9	24.4	11.9	18.1	20.1	9.3	14.6	14.0	6.1	10.0
10	30.1	13.7	21.9	22.7	12.7	17.7	14.8	6.2	10.6
11	23.0	13.7	18.3	15.7	11.5	13.6	7.5	4.8	6.1
12	21.2	15.6	18.4	13.0	9.9	11.4	5.8	5.4	5.6
Total	**24.9**	**13.7**	**19.3**	**18.3**	**10.9**	**14.5**	**10.9**	**5.7**	**8.3**

Source: Commission on Youth Analysis of Youth Risk Behavior Surveillance System data, CDC 2000.

* Almost every day for > 2 weeks in a row.
⊗ During the 12 months preceding the survey.
§ One or more times.
¶ Non-Hispanic.

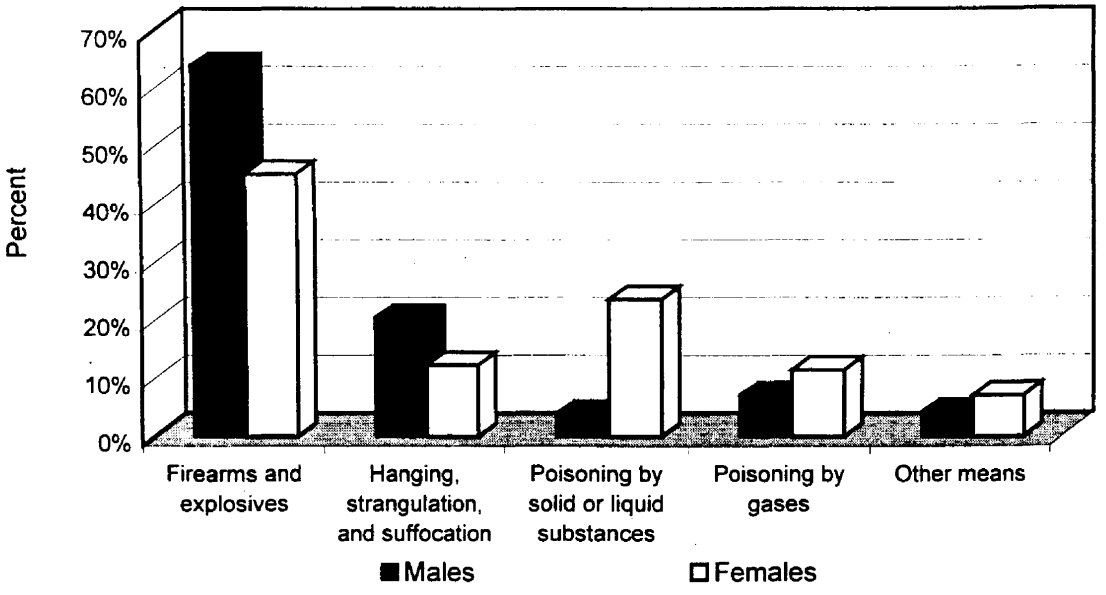
Suicide affects young people from all races and socioeconomic groups, although some have higher rates than others. White and Native American males have the highest suicide rate; African American females the lowest, although suicide rates among African American and Latino inner city youth have increased dramatically over the last decade.[19]

Ingestion of pills is the most common method among adolescents who attempt suicide but do not die. Firearms, used in approximately 67% of completed suicides, are the leading method for youth who commit suicide.[20] More than 90% of suicide attempts involving a firearm are fatal because there is little chance for rescue. Firearms in the homes of youth at-risk of committing suicide, whether they are kept unloaded or stored and locked, are associated with a higher risk for adolescent suicide.[21]

[19] Garland and Zigler.
[20] Kachur, SP, Potter, LB, James, SP, Powell, KE. Suicide in the United States: 1980-1992: Violence Surveillance. *Atlanta, GA: National Center for Injury Prevention and Control; Summary Series 1.* 1995:12
[21] American Academy of Pediatrics, Committee on Injury and Poison Prevention. Firearm injuries affecting the pediatric population. *Pediatrics.* 1992: 89:788-790.

Table 3

Suicide Methods for 15 to 24 Year Olds in the United States (1988)



Source: National Center for Health Statistics, 2000.

Many researchers claim that the number of suicides is underreported. Despite all of the data, the picture of youth suicide is considered incomplete because accurate assessment of suicide rates is difficult. Reasons for this difficulty include: [22]

- Non-standardized reporting of suicide
- Stigma associated with declaring death a suicide
- Concern that insurance may not cover a death by suicide
- Limited requirements for reporting of suicide attempts
- Deaths reported as accidental

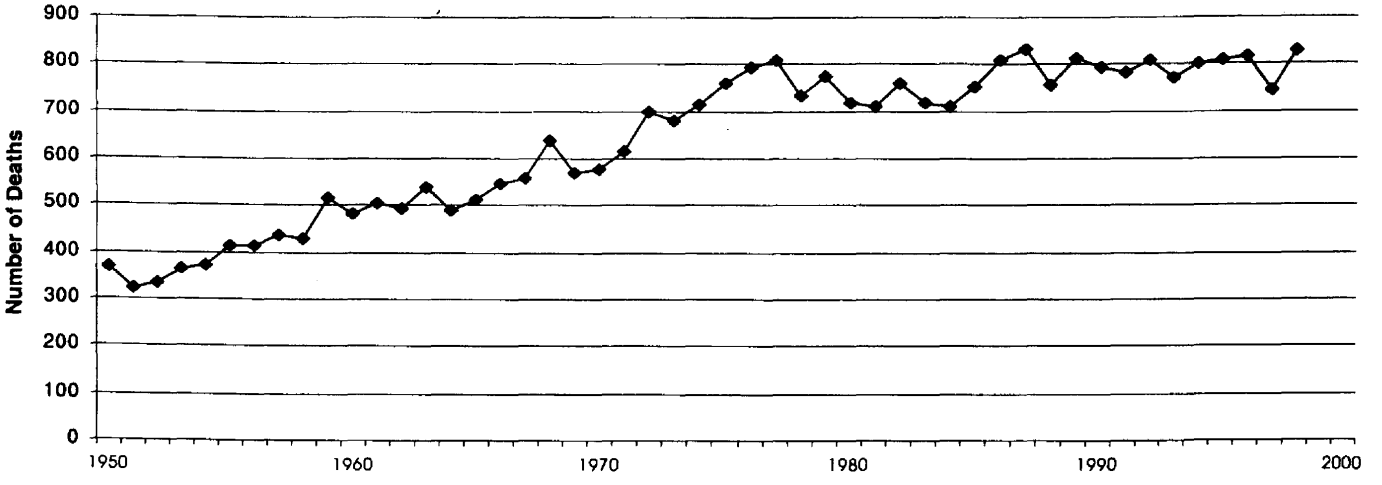
The extent of the problem of youth suicide and suicidal behaviors is likely underestimated.

D. Youth Suicide: Virginia Data

Although the suicide rate in Virginia demonstrated a slight decline in 1997, the overall rate has increased in the last three decades. Over 800 Virginians died by suicide in 1998.

[22] Washington State Department of Health. Youth Suicide Prevention Plan for Washington State. 1995.

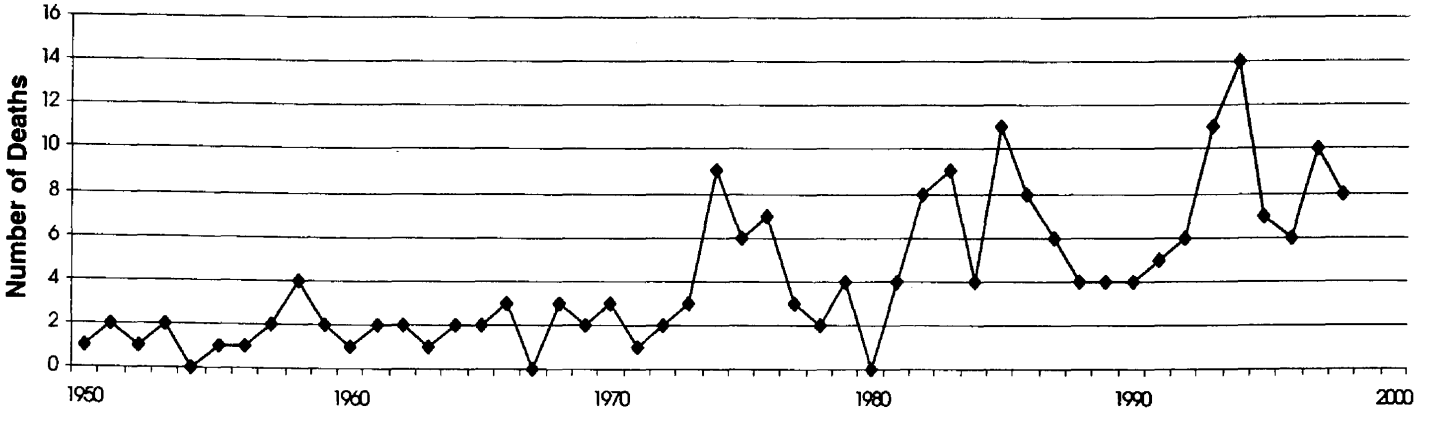
Chart 1
Total Virginia Deaths from Suicide 1950-1998
All Ages



Source: Virginia Center for Health Statistics, 2000.

The suicide rate for young Virginians, aged 10 to 19, has increased an alarming 32% since 1975.[23] In 1998, seven Virginia children, aged 5-14, were reported to have died from suicide. Another 50 children, aged 15-19 ended their lives.

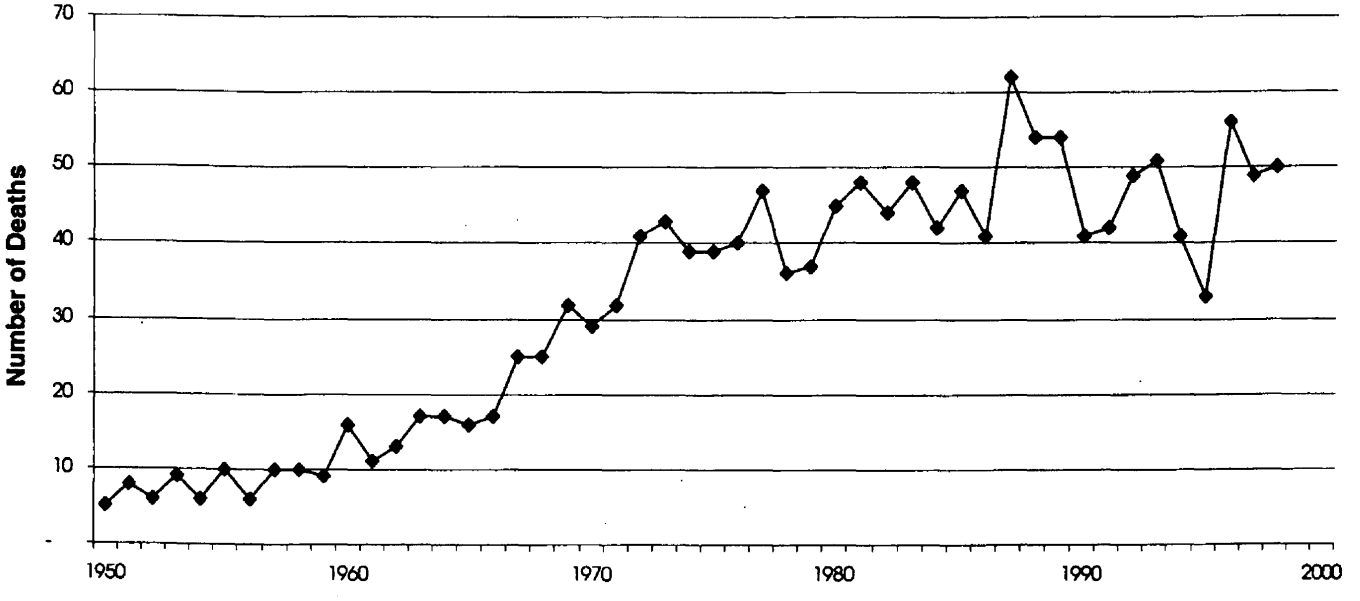
Chart 2
Virginia Deaths from Suicides 1950-1998
Ages 5-14



Source: Virginia Center for Health Statistics, 2000.

[23] Virginia Department of Health. A Study of Suicide in the Commonwealth. *Senate Document No. 16.* Richmond, VA. 2000.

Chart 3
Virginia Deaths from Suicide, 1950-1998
Ages 15-19

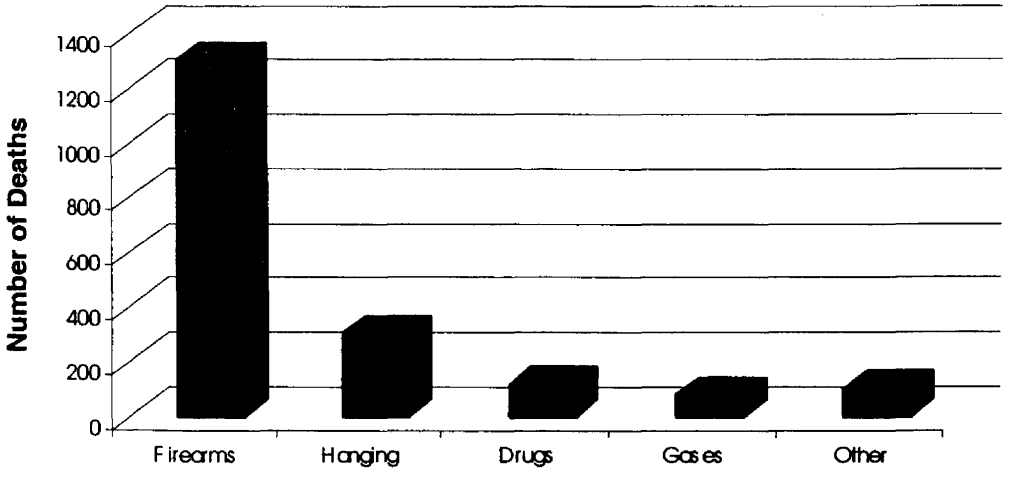


Source: Virginia Center for Health Statistics, 2000.

Recent statistics show that teenage (15-19 years of age) deaths related to suicide range from 53 to 57 per year in Virginia. Approximately one Virginia teenager every week takes his or her own life.

Virginia's young people seem to choose the same methods for suicide as their peers around the country. As shown in Chart 4, of the 1926 young Virginians who died by suicide between 1983 and 1997, the overwhelming majority chose to use firearms.

Chart 4
Virginia Completed Suicides by Method of Injury, 1983-1997
Ages 5 - 25



Source: Virginia Center for Health Statistics, 1999.

E. Previous Attention to the Problem of Youth Suicide in Virginia

Youth suicide and the concern about its increasing incidence are not recent phenomena. In response to what was seen as a growing problem, the 1987 General Assembly 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...".[24] The joint subcommittee heard testimony from state agency heads, community leaders, youth, parents, law enforcement, clergy, clinicians, educators, and others during three public hearings. They also received briefings and research data from staff. Upon completion of the study, the subcommittee reasoned that a "multifaceted program to provide prevention, intervention, and postvention services would be the most appropriate response," and recommended that:

1. 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;
2. 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;
3. The Board of Education, together with the Departments of Health, Mental Health, Mental Retardation and Substance Abuse Services, and Social Services, develop a mechanism to enhance public awareness and disseminate information to students, parents, and the public on the warning

[24] Report of the Joint Subcommittee Study of Youth Suicide Prevention. *Senate Document 30.* Richmond: Virginia General Assembly, 1988.

signs of suicide, medical and community resources, and public and private prevention services available within localities;

4. 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;
5. Hotlines for teens be established throughout the Commonwealth;
6. Existing policies, directives and programs be reviewed to determine the availability of youth suicide prevention programs in order to facilitate coordination and reduce duplication;
7. Localities in Virginia develop an integrated plan for the delivery of youth suicide prevention programs;
8. Youth suicide prevention activities be coordinated at the state level (by the Council on Coordinating Prevention);
9. The Department of Education encourage public schools to utilize peer counseling as means of providing prevention services;
10. A mechanism be developed to determine the number and nature of attempted suicides in the state; and
11. 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 the availability and accessibility of services.

The 1987 joint subcommittee concluded that each Community Service Board in the Commonwealth should have identified children's service units with prevention and treatment specialists and access to other related health, social services, and education professionals.

Twelve years later, the 1999 General Assembly passed Senate Bill 1250, directing the Board of Education, in cooperation with the Department of Health and Mental Health, Mental Retardation and Substance Abuse Services to develop guidelines for licensed school personnel to use when they believe a student is in imminent risk of attempting suicide. Components of these guidelines were clearly specified in the legislation and they were required to be disseminated to school personnel in October 1999.

The Suicide Prevention Guidelines[25] were developed and disseminated as directed. They specifically describe school personnel's responsibility to identify and report students at-risk of suicide, as well as guidelines for assessment and for contacting parents or Department of Social Services personnel as appropriate. They also direct each school division to develop and maintain a current list of public and private assessment and treatment facilities in order to facilitate the referral of students and families for assistance as needed. A list of selected readings is accompanied by a description of specific strategies for assessing suicide risk and responding to suicidal students.

[25] Board of Education, Commonwealth of Virginia. Suicide Prevention Guidelines. Richmond. 1999.

Local school divisions are responsible for disseminating the guidelines and determining how they will be used. A number of local school divisions have developed their own procedural guidelines to use in cooperation with those provided by DOE. These include:

- Documentation checklists
- Procedures regarding threatened suicide
- Suicide lethality index
- Crisis intervention procedures

In December 1999, the Virginia State Child Fatality Review Team completed an examination of 58 records of children younger than 18 years old who died as a result of suicide in 1994 and 1995. Their review was designed to:

- Gain a broader understanding of the circumstances surrounding child and adolescent suicide;
- Obtain a profile of the children who commit suicide; and
- Generate recommendations for prevention, intervention, education, and investigation of child death due to suicide.

As reported earlier, the Team determined that more than half of the suicides were preventable. Most of the children had threatened to commit suicide or had made a previous attempt, and 40% had told either a friend, parent, counselor, or school employee of their intent. Based on their comprehensive review of the circumstances and events that culminated in children taking their own lives, the Team developed a number of recommendations. The recommendations fall primarily into three categories and include:[26]

1. **Prevention and Intervention**
   - Identification of children with mental health needs as a priority population for services from DMHMRSAS and appropriate funding to support services;
   - Improved identification, assessment, treatment, and follow-up of children at-risk for depression and suicide;
   - Appointment by the Court of guardians ad litem for children involved in custody disputes;
   - Funding to support recommended school nurse ratios in all school divisions;
   - Securing all firearms and medications, and removing firearms when children at-risk are in the home; and
   - Appropriate prevention strategies to address gender and cultural differences, and peer resistance to reporting threats made by others.

2. **Education and Training**
   - Major public awareness campaign regarding signs and symptoms of depression and risks for suicide among children and youth;

[26] Office of the Chief Medical Examiner. Suicide Fatalities Among Children and Adolescents in Virginia 1994-95. Richmond: *Virginia State Child Fatality Review Team.* 2000.

- Continuing medical education, including risk assessment for depression and suicide and safety planning for children at-risk; and
- Training for all school personnel and clinical staff of Community Services Boards.

3. **Death Investigation**
   - Toxicology screens on all suicides;
   - Development of a protocol for child suicide investigations; and
   - Investigations of child suicides to support prosecution under §18.2-56.2 regarding access to firearms.

Senate Joint Resolution 382 (1999) required the Virginia Department of Health to study the issues of suicide in the Commonwealth and to prepare a report to the Governor and the General Assembly. Study activities included analyses of data and literature on suicide, surveys of local mental health service personnel, and activities and focus groups with survivors of suicide. At the conclusion of the study, the Department of Health offered 12 recommendations:[27]

1. Appropriation of funding to VDH and DMHMRSAS to conduct comprehensive suicide prevention and intervention activities;
2. Statewide strategic plan;
3. VDH coordination of suicide prevention activities to include research and data collection, public information and training;
4. Annual conference on suicide and depression prevention and intervention;
5. Annual public awareness campaign;
6. School and community-based programs designed to foster peer relationships, anger management, self-efficacy, problem solving, and other coping and social skills among children and adolescents;
7. Efforts to improve the ability of primary care providers to recognize and treat depression, substance abuse and other mental illnesses;
8. Community-based crisis intervention services and strategies to reduce the barriers to seeking help;
9. Statewide crisis intervention, expansion of hotline service, and improved interagency communication and collaboration;
10. Dissemination of successful strategies for suicide intervention programming;
11. Systems for effective follow-up of people discharged from psychiatric facilities and/or after previous suicide attempts; and
12. Care and support programs for families of those who attempt/commit suicide.

As a result of this study, the 2000 General Assembly directed the Commission on Youth to develop the comprehensive youth suicide prevention plan.

A number of localities around Virginia have initiated local suicide prevention efforts. While many of these programs involve multiple agencies within a locality and represent a great deal of citizen involvement, there is limited coordination and

[27] Virginia Department of Health. A Study of Suicide in the Commonwealth. *Senate Document 16.* Richmond: Department of Health. 2000.

collaboration across programs and little statewide coordination of activities. Public awareness, training, materials, and resource referrals may be a part of these efforts. A list of these local resources is provided in the Appendix.

F. Suicide Prevention Strategies - Review of Research

In 1992, the Centers for Disease Control and Prevention published a resource guide to describe the rationale and evidence for effectiveness of various youth suicide prevention strategies in place around the country.[28] The guide also identified model programs that incorporated these strategies. Both similarities and differences among the identified programs were noted and no single suicide prevention strategy was recommended over another. The authors did make some general recommendations for policy makers and planners:[29]

- **Ensure that new and existing suicide prevention programs are linked as closely as possible with professional mental health resources in the community.** Strategies designed to increase referrals of at-risk youth can only be successful to the extent that there are appropriate services to which referrals can be made.
- **Avoid reliance on one prevention strategy.** Most programs integrate several strategies, although some have limited evidence of their effectiveness.
- **Incorporate promising but underused strategies into current programs where possible.** The restriction of lethal means by which to commit suicide was identified as one important strategy. Peer support groups were also seen as promising.
- **Expand prevention efforts for young adults, aged 20-24 years of age.** The suicide rate for this group is twice that of adolescents.
- **Incorporate evaluation efforts into all new and existing suicide prevention programs**, preferably based on outcome measures such as the incidence of suicidal behavior. Evaluation measures should also be designed to identify unforeseen negative consequences, should they occur.

Additional research on specific prevention strategies was reviewed and is presented for each component of the plan in Section VII: Findings and Recommendations.

G. Suicide Risk and Protective Factors

Experts agree that there is no single cause of suicidal behavior among children and adolescents. The problem is complex and its causes are multidimensional. However, specific factors known to increase a youngster's risk for suicide have been identified. Conversely, there is agreement that some known protective factors support and buffer youth and reduce the risk of suicide. A greater understanding of the factors related to youth suicide is critical in planning prevention and intervention strategies.

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[28] Centers for Disease Control and Prevention. Youth Suicide Prevention Programs: A Resource Guide. *Atlanta: Centers for Disease Control.* 1992.
[29] Ibid. p 8.

1. Youth Suicide Risk Factors

Generally, suicide occurs when several risk factors converge and protective factors are absent.[30] Risk factors have been described within three categories:

- Direct suicide-risk factors
- Related risk factors
- Precipitating risk factors

Direct suicide-risk factors are those known to be most closely associated with suicidal behavior among youth.[31] These include:

- Prior suicide attempt
- Suicidal / homicidal ideation and threats
- Suicide of a friend or family member
- Detailed intentions for suicide attempt (plan)

Other factors, while not as clearly linked to suicidal behaviors, are associated with increased potential for suicide among youth by increasing vulnerability to suicidal thoughts.[32] These related risk factors include:

- Serious depression
- School performance problems
- Alcohol and/or other drug use and abuse
- Family disruption; serious family conflicts
- Isolation from family and/or peers
- Multiple serious stressful events, transitions, or losses in short time period
- Chronic or debilitating physical disorders or psychiatric illnesses
- Involvement in high-risk behaviors
- Living out of the home (correctional facility or group home)

Precipitating factors are events that immediately precede a suicidal act and seem to initiate or cause the suicidal behavior in an already-vulnerable youth.[33] Three types of precipitating factors have been identified:

- Opportunity
  - Access to a gun or other lethal means
  - Inadequate supervision
- Altered states of mind
  - Hopelessness
  - Rage
  - Intoxication
- Undesirable / stressful life events

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[30] Maine Department of Human Services, Bureau of Health. Maine Youth Suicide Prevention Plan. 1998

[31] Washington State Department of Health. Youth Suicide Prevention Plan for Washington State. 1995

[32] Lists compiled from multiple resources: Maine Youth Suicide Prevention Plan, Youth Suicide Prevention Plan for Washington State, American Academy of Pediatrics. Suicide and Suicide Attempts in Adolescents (RE9928), *Pediatrics*. 2000: 105: 871-874.

[33] Washington State Department of Health. Youth Suicide Prevention Plan for Washington State. 1995

- Conflict / disruption in interpersonal relationships
- Loss or death of friend or family member
- Loss of self esteem or negative anticipated outcomes
- Physical / sexual abuse

Research demonstrates that youth at greatest risk of suicide struggle with emotional / behavioral difficulties including[34]:

- Depression or mood disorder
- Conduct disorder
- Alcohol or other drug use
- Ultra-perfectionism or rigid behavior patterns.

Other groups that appear to be at especially high-risk include high-striving, high-achieving youth, high school dropouts and potential drop-outs, runaways, victims of abuse, and gay and lesbian youth.

Of particular note is the high-risk associated with the availability of firearms in homes of youth at-risk of committing suicide. Researchers in Tennessee and Washington found that having one or more guns in the home increased the risk for suicide almost 5-fold for those youth at-risk of committing suicide.[35] In a subsequent study of 67 consecutive youth suicides, researchers found that having a gun in the home increased suicide risk, even after correcting for a diagnosed mental disorder.[36]

2. Youth Suicide Protective Factors

Protective factors function to reduce potential risk for suicide and are generally grouped into two categories: social resources and personal resources.

Adolescent suicide has been consistently associated with family disruption and loss of social supports. Quality personal relationships with family, friends, teachers, and others in the community appear to support and protect a young person from the impact of serious life stresses. Important social resources include:[37]

- Strong interpersonal bonds, especially with family members or other caring adults
- Social support resources at home or in the community, including involvement in a faith community
- Attitudes and values prohibiting suicide

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[34] Shaffer, D., Garland, A., Gould, M., Fisher, P. and Trautman, P. Preventing teenage suicide: A critical review. *Journal of the American Academy of Child and Adolescent Psychiatry.* 1988: 27, 675-687.

[35] Kellermann, A.L., Rivara, F.P., Somes, G., Reay,D.T. Suicide in the home in relation to gun ownership. *New England Journal of Medicine*, 1992: 327(7), 467-472.

[36] Brent, D.A., Perper, J.A., Moritz, G., Baugher, M., Schweers, J., and Roth, C. Firearms and adolescent suicide: A community case-control study. *American Journal of Diseases of Children*, 147(10), 1066-1071.

[37] Eggert, LL, Thompson, EA, Herting, J.R,, and Nicholas, L.J. Measurement of Adolescent Potential for Suicide: Development and preliminary findings. *Suicide and Life-threatening Behavior.* 1994: 24 (4), 359-81.

Studies of resiliency indicate that youth with greater personal resources have lowered risk for suicide. Personal resources seem to empower youth and help them to manage life stresses. These personal resources include:[38]

- Strong sense of self-worth, self esteem
- Strong decision-making and coping skills
- Sense of personal control related to the use of above skills

H. Special Developmental Issues

Youth are particularly vulnerable to suicide, just by nature of their age. The transition to young adulthood is marked by multiple transitions and complex emotions. A youth's course of development is marked by changes in multiple spheres. [39]

- Physical or biological changes
  - Normal pubertal changes
  - Early or late sexual maturation
- Cognitive changes
  - Heightened self-consciousness
  - Increased awareness of limitations
- Emotional changes
  - High rates of depression
  - Sense of uncertainty and hopelessness
- Social changes

The correlates of high levels of suicide ideation among youth, (i.e. depression, family conflict, school problems, and substance use) are also the kinds of problems with which every youth struggles. Among youth, suicide is not only associated with severe mental illness. It is linked with everyday problems encountered in the transition from childhood to adulthood.

I. Implications For Prevention

Youth suicide is a public health problem of tremendous proportions. Youth suicide rates peaked in 1988 and have not yet begun to decline. Better identification of and intervention to reduce risk factors, along with efforts to enhance protective factors provide a means to reduce the suicide risk among youth in Virginia.

The Child Fatality Review Team recognized the need for greater awareness and response to these issues. They recommended that comprehensive, broad-based prevention efforts and appropriate resources be made affordable and accessible.

Suicide risk reduction involves improving society's ability to recognize and respond to high-risk youth, while reducing the number of personal and social risk factors experienced by our youth. In Virginia's Youth Suicide Prevention plan, this includes:

- Improved education about risk factors for parents, teachers, friends, and others

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[38] ibid.

[39] Lewinsohn, P.M., Rhode, P., Seeley, J.R., and Andrews, J.A., Adolescent psychopathology: Prevalence and incidence of depression and other DSM-III disorders in high school students. *Journal of Abnormal Psychology.* 1993: 102, 133-34.

- Improved identification and treatment for youth with emotional and behavioral disorders, including depression and substance abuse
- Increased resources to promote mental health
- Decreased access to lethal means

Enhancing resiliency means strengthening the protective factors for Virginia's youth, particularly for youth in high-risk groups and for those individuals identified as at-risk for suicide. Specifically, this includes:

- Increasing social supports for youth
- Teaching skills to increase sense of personal control
- Structuring opportunities for successful experiences

The remainder of this document provides a framework and specific strategies for reducing the risk of suicide for Virginia's youth. It is intended that the implementation of the plan be coordinated by the Virginia Department of Health, in collaboration with the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Education, and concerned citizens and community groups.

Findings and Recommendations

Youth suicide is a significant public health problem that demands attention. Because of the increasing rates of suicide among young people, the need for prevention planning and allocation of resources has become paramount. In its review of child and adolescent suicides in 1994 and 1995, the State Child Fatality Review Team found that over half of the suicides were preventable. Serious gaps were identified in programs, services, and responses to children at-risk for depression and suicide, and successful prevention efforts require the willingness to acknowledge the problem as well as create and fund programs and services to address it.

Reducing and, ultimately preventing youth suicide in Virginia will require substantial, long-term, system-wide changes, which expand and enhance services for youth. Over time, a coordinated approach to implementation of the recommendations described in this plan should significantly reduce the rate of youth suicide and contribute to improving the overall health of Virginia's youth.

In addition to implementing the recommended strategies, it is necessary to increase the availability of and access to mental health services for children, youth, and families throughout Virginia. While the strategies contained in this plan will positively impact the problem of youth suicide, enhancement and improvement of the comprehensive children's mental health system must be a top priority.

The specific components of the Youth Suicide Prevention Plan are described in the pages that follow. Rationales for each step, along with recommended strategies are described. As a result of extensive research and input from a variety of stakeholders and experts in the field, the following general principles were developed to guide prevention planning efforts:

- The goals of the Virginia Youth Suicide Prevention Plan are:

- To prevent suicidal behavior among youth in Virginia;
- To reduce the impact of suicide and suicidal behavior on individuals, families, and communities; and
- To improve access to and availability of appropriate prevention services for vulnerable individuals and groups.

- In 1990, the U.S. Congress mandated research on the prevention of youth suicide. This research has taken place on the federal level, as well as through the efforts of many other states. Virginia's plan should reflect this research, as well as the previous studies conducted in Virginia.
- The Institutes of Medicine and the National Institutes of Health recommend a prevention framework, which includes a continuum of *universal, selective* and *indicated* prevention approaches. Virginia's plan is an adaptation of this model.
- Effective and successful prevention efforts are comprehensive and require the collaboration of multiple agencies involved in services to youth.
- Effective prevention strategies are aimed at reducing risk factors, enhancing protective factors, or both.

A. Reducing Risk Factors

One step toward achievement of suicide prevention goals is to target strategies to known risk factors. These factors were identified in Section VI and may be individual or environmental. Prevention strategies should be designed to:

- Change direct suicide risk factors, including suicide attempts, suicidal thoughts, and exposure to suicide
- Change related risk factors including depression, alcohol, and drug use
- Change the environment in which risk factors occur through education of parents, others who have contact with youth, and the general public

B. Enhancing Protective Factors

Resiliency factors offer protection to youth against suicidal thought and behaviors. Protective factors, described in Section VI may be social or personal. Social or environmental protective factors include:

- Strong interpersonal bonds, especially with family members or other caring adults
- Social support resources at home or in the community, including connections to school and faith communities
- Attitudes and values prohibiting suicide

Personal protective factors seem to empower youth and help them to manage life stressors. These personal resources include:

- Strong sense of self-worth, self esteem
- Strong decision-making and coping skills
- Sense of personal control and ability to handle one's problems.

C. Suicide Prevention Model

The Commission on Youth model for Virginia's Youth Suicide Prevention Plan was adapted from the model developed by the Institute of Medicine and the National

Institutes of Health. Stakeholders and experts in the field of suicide prevention contributed to the adaptation and agreed that this model presents the important components of a comprehensive plan for Virginia. The prevention scheme includes three levels of prevention strategies: *universal, selective*, and *indicated.* Research supports the recognition that, as vulnerability and suicide potential increases, so does the need for stronger prevention interventions.

Universal prevention is focused on providing needed interventions to keep communities healthy. These programs target and benefit everyone by providing general awareness information and education. The mission of *selective prevention* is to prevent the onset of suicidal behavior in targeted risk groups. These strategies include screening and assessment, training of "gatekeepers," and community-based mental health treatment. Finally, *indicated prevention* strategies target individual youth known to be at high-risk for suicide, in order to provide skill building and supportive services and treatment.

The Virginia Youth Suicide Prevention Strategies and Activities Model is presented in Figure 1. Surveillance, monitoring and evaluation are built in at each level, as are necessary crisis intervention services. Specific components of the plan are described as Recommendations below.

Universal Prevention Strategies

Universal prevention targets everyone. Features of effective universal prevention and criteria for services, as defined in other models include:[40]

- Interventions are aimed at large groups of low-risk individuals
- Content raises public awareness of key facts
- Interventions are brief
- Per person costs are low
- Benefits outweigh costs and risks

The following universal prevention strategies are recommended as part of Virginia's Youth Suicide Prevention Plan:

Recommendation 1

Amend §32.1 of the *Code of Virginia* to designate the Virginia Department of Health (VDH) as the lead entity for youth suicide prevention in Virginia and require reporting to the Governor and General Assembly on the status of suicide prevention initiatives.

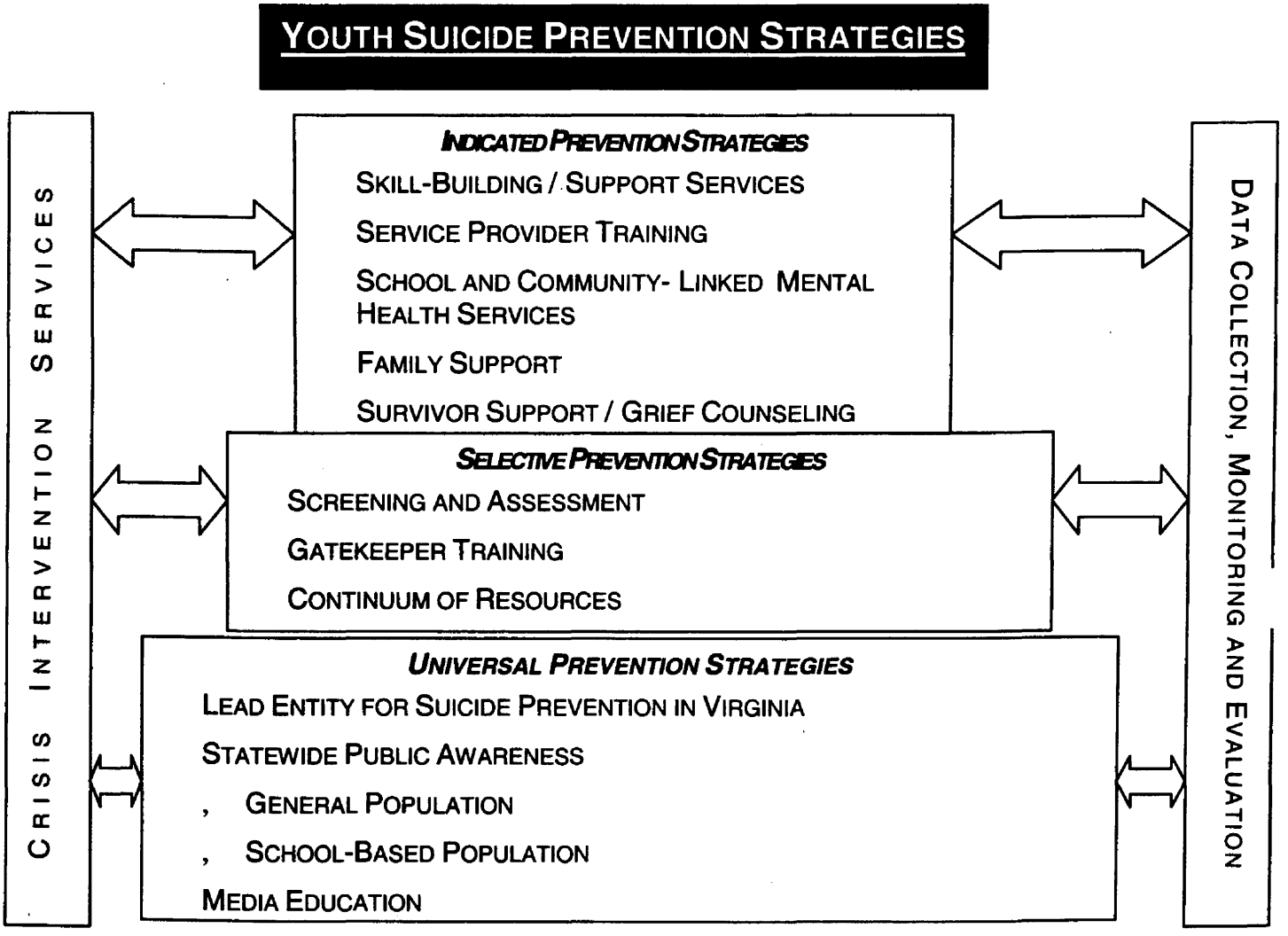
Findings

Consistent with the recommendations of the Virginia Department of Health Study of Suicide in the Commonwealth, the Commission on Youth recommends that VDH take responsibility for developing, implementing, and monitoring a coordinated suicide prevention strategy. The Department of Education and the Department of Mental Health, Mental Retardation, and Substance Abuse

[40] Washington State Department of Health. Youth Suicide Prevention Plan for Washington State, 1995.

Services should partner with VDH in the development and implementation of some specific components, but statewide coordination by one agency is critical.

Figure 2



Recommendation 2

Increase funding for the VDH and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) for their development and/or adoption of materials and dissemination of youth suicide prevention information throughout the Commonwealth.

Findings

Youth suicide is a complex problem; therefore, efforts must be designed to provide for broad-based dissemination of information to all citizens of the Commonwealth. This information includes:

- *Prevalence and causes of suicide*
- *Need to talk to youth about suicide*
- *Services / supports available for youth and families*

Community based education efforts are an effective method for disseminating information to large segments of the population. Such programs:

- *Increase awareness of suicide risk and protective factors*
- *Heighten awareness of community mental health resources*
- *Focus community sentiment toward help-seeking and use of resources*
- *Complement school-based programs*
- *Provide accurate information to wide communities*
- *Increase knowledge about depression among youth*

Community-wide education programs reach families, students, youth in the work force, hard-to-reach youth in other sectors, and media personnel. Research has shown that youth facing depression and other difficult times are unlikely to contact a mental health professional. Rather, friends, family, and teachers are most likely those in a position to observe the youth's despair and to respond. This, and the fact that early intervention with depressed youth is essential, compels the organization of public awareness campaigns which address the warning signs and appropriate approaches for helping. As a result of increased knowledge, skills, and interest, suicidal youth are more likely to be recognized and assisted in seeking appropriate mental health care.

The following activities are recommended as part of the general public awareness campaign:

A. *Development by VDH of a series of video and audio announcements to be presented as both public service announcements and paid prime time media.*
B. *Development and dissemination of suicide prevention materials (brochures, posters, bookmarks, inserts, etc.) for statewide distribution.*
C. *Implementation of Youth Suicide / Depression Awareness Day to draw attention to the issues of depression in children and*

youth and provide opportunities for dissemination of information about available resources.

Recommendation 3

VDH should train media professionals throughout the Commonwealth to ensure responsible reporting of suicide in order to reduce the risk of subsequent suicides.

Findings

Suicide contagion is a major concern among service providers and policy makers. Suicide acts following another's suicide have been linked with reporting practices in which the completed suicide was glorified or romanticized. Several factors have been identified as likely to increase suicide contagion.[41] *They include:*

- *Oversimplification of the causes of suicide; failure to recognize the complexity of the problem*
- *Highly visible and excessive reporting*
- *Emphasis that glorifies the suicide rather than mourning the loss*
- *Failure to acknowledge the serious problems experienced by the person who died and an overemphasis on the positive aspects*
- *Providing technical information on how the suicide was completed*

Since media reports may affect the incidence of youth suicide, state and local policy makers should work together to influence media reporting practices regarding youth suicide. The Centers for Disease Control and Prevention offered the following concerns and recommendations for public officials who provide information for the reporting of suicide:[42]

- ***Suicide is often newsworthy, and it will probably be reported.*** *Efforts to prevent news coverage may not be effective, so the goal should be to assist news professionals in their efforts toward responsible and accurate reporting.*
- ***"No comment" is not a productive response to media representatives who are covering a suicide story.*** *Refusing to speak precludes the opportunity to influence what will be contained in the report. Public officials should not feel obligated to provide an immediate answer to difficult questions, but should be prepared to provide a reasonable timetable for giving such answers.*
- ***All parties should understand that a scientific basis exists for concern that news coverage of suicide may contribute to the causation of suicide.***

[41] O'Carroll, P.W. and Potter, L.B. Suicide contagion and the reporting of suicide: Recommendations from a national workshop. *Morbidity and Mortality Weekly Report*, 1994: 43(RR-6), 9-18, April.

[42] Ibid.

- ***Some characteristics of news coverage of suicide may contribute to contagion, and others may help prevent suicide.*** *It is not news coverage, per se, but certain types of coverage that promote contagion.*
- ***Public officials should not try to tell reporters what to report or how to write the news regarding suicide.*** *If the nature and apparent mechanisms for suicide contagion are understood, the media are more likely to present the news in a manner that minimizes the likelihood of contagion. Officials should explain the potential for suicide contagion and suggest ways to minimize the risk.*
- ***Public officials and the news media should carefully consider what is to be said and reported regarding suicide.*** *Reporters generally present the information they are given. Impromptu comments by a public official can result in harmful news coverage.*

Responsible reporting of suicide can have several direct benefits. Community efforts to address the problem can be strengthened by news coverage that describes the help and support available and how to access help, explains how to identify persons at-risk for suicide, or presents information about risk factors. The Centers for Disease Control and Prevention recommends an ongoing dialogue between news media professionals and health and other public officials in order to facilitate the reporting of suicide information.

The following activities are recommended as part of the media education program:

A. Develop packets of information for dissemination to media outlets about the responsible reporting of suicide, including guidelines developed by the Centers for Disease Control and Prevention.

B. Educate community leaders about the effects of media coverage on subsequent youth suicides.

Recommendation 4

The Department of Education (DOE) should revise the Suicide Prevention Guidelines to include criteria for follow-up with parents of students expressing suicidal intentions after initial contact is made.

Findings

School-based suicide prevention strategies involve a coordinated effort, starting with the support of the Superintendent and reaching all levels of school staff. The purpose of school-based education efforts is to provide instructional content that parallels the community-wide public education campaign, so that youth, parents, teachers, and other adults are sensitized simultaneously to the issues and concerns, knowledge and skills for preventing youth suicide.

School-based programs are an effective method of disseminating information about suicide to large segments of the youth population. Studies of school-based programs have revealed some promising outcomes. Youth participating in these programs typically show:

- *Increased knowledge about depression and suicide warning signs*
- *Increased awareness of community resources and obtaining help*

Primarily, suicide awareness programs are received favorably by students, and students believe the information is helpful.[43] *There is no evidence that school-based prevention programs increase the likelihood of suicide ideation or suicidal behavior.*[44] *It is important, however, that school-based programs be coordinated with strategies for identifying and assisting high-risk youth through screening and Gatekeeper Training and with services designed to assist those youth identified to be at-risk.*

School-based programs should feature information about:

- *Depression symptoms and manifestation in adolescents, impact on decision-making and problem-solving abilities*
- *Suicide risk and protective factors*
- *Suicide warning signs*
- *Available community resources*

Youth who are experiencing problems may be more likely to confide in their peers than in adults or family members. Students may be the "first finders" of another youth with suicidal intentions and need to be taught skills for responding to their peers. Skill-building strategies should be taught to improve skills in:

- *Listening and communicating with a friend who is depressed and/or expressing suicidal thoughts or plans;*
- *Assisting a friend in seeking help, including appropriate and helpful responses, identifying a caring adult for assistance, and handling an immediate crisis; and*
- *Seeking appropriate professional help.*

Selective Prevention Strategies

Selective prevention targets known risk groups. Selective prevention strategies focus on reducing the risk factors that make certain young people more vulnerable for self-destructive and suicidal behavior. Selective strategies aim at building the personal and social resources of high-risk groups. These resources include developing relationships with caring adults, family support, and available support in the community

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[43] Shaffer, D., Garland, A., Vieland, V., Underwood, M., and Busner, C. The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child and Adolescent Suicide.* 1991: 30(4), 588-596.

[44] Metha, A., Chen, E.C., and Weber, B. Substance Abuse / Suicide: Research on Prevention. *American Association of Suicidology Annual conference.* 1993.

or school. Features of effective selective prevention programs and criteria for services are:

- Interventions are advantageous for specific groups, even though all youth in the group may not show evidence of need;
- Interventions target the typical range of risk factors and identify the protective factors characteristic of the group;
- Per person costs are greater; and
- Benefits outweigh costs.

Recommendation 5

VDH and DMHMRSAS should develop and deliver Gatekeeper Training to designated audiences throughout the Commonwealth.

Recommendation 6

The Board of Health Professions and all state agencies responsible for licensing or certification of youth-serving personnel should require suicide prevention education as a requirement for licensure or certification.

Findings

Gatekeeper Training is designed to teach youth and significant adults specific strategies for recognizing and responding to suicide-risk youth and connecting them with persons capable of providing crisis intervention and support services. Gatekeeper Training is designed to prepare a broad spectrum of community members throughout Virginia to serve the protective functions of identifying and responding to youth with a high potential for suicide. Gatekeepers are trusted individuals who routinely have significant contact with youth and who are likely to observe high-risk behaviors. These Gatekeepers include:

- *Health care providers*
- *School personnel*
- *Clergy*
- *Youth service workers*
- *Law enforcement and Court Service personnel*

Gatekeepers do not replace professional mental health care providers, but are, more often, "natural helpers" in a youth's social network. Gatekeeper Training is a process by which these frontline persons acquire the skills necessary to accurately screen and refer high-risk youth. It provides these adults with competencies to:

- *Recognize risk factors associated with youth suicide*
- *Screen high-risk youth*
- *Communicate with youth at-risk for suicide and intervene to prevent immediate harm*
- *Make referrals and connect high-risk youth with appropriate crisis intervention services*
- *Coordinate and deliver post-suicide interventions*

Youth also serve as gatekeepers and natural helpers for their peers. Gatekeeper Training for adults and youths differs in terms of content, research findings and expected outcomes. Youth training incorporates suicide prevention information into peer helper education. Teaching youth to connect a suicidal friend to an adult who can help is the most important behavioral objective of Youth Training.[45] *Program content helps youth to:*

- *Recognize the risk factors associated with youth suicide*
- *Communicate appropriately with youths at high-risk for suicide*
- *Tell an adult of their concerns about a high-risk youth*
- *Connect a high-risk youth with an adult capable of helping*

A number of gatekeeper and youth peer training programs have been developed, but limited evaluation data is available to demonstrate specific outcomes. The Virginia Department of Health is reviewing two of these and continued study is necessary to determine their appropriateness for Virginia. These include Living Works[46] *and QPR (Question-Persuade-Refer).* [47]

In general, Gatekeeper Training has shown positive results. Research has demonstrated that adults who receive Gatekeeper Training:[48]

- *Demonstrate increased knowledge about youth suicide*
- *Report increased confidence and competence in helping high-risk youth*
- *Express satisfaction with the experience*
- *Retain skills for a minimum of six months after training*

Additional outcomes resulting from Gatekeeper Training included:[49]

- *Increased recognition of sources of environmental stress that could be reduced or eliminated*
- *Team building among crisis centers, offices of education, mental health and social services*
- *Increased number of students referred for evaluation*
- *Decreased number of students referred for discipline problems*

Finally, as shown in Table 4, participants in school Gatekeeper Training demonstrated significant changes in knowledge after training. Of particular note, after receiving training, 68% of gatekeepers reported knowing where to refer a troubled student, compared with 45% who reported having this knowledge prior to training.

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[45] Maine Department of Human Services, Bureau of Health. Maine Suicide Prevention Implementation Plan, 1998.
[46] Ramsay, R.F., Tanney, B.L., Tierney, R.J., and Lang, W.A. Suicide Intervention. *Calgary, AB, Canada: Living Works Education, Inc.*, 1994.
[47] Quinette, P.R. *Question, Persuade, Refer. Ask a Question, Save a Life.*
[48] Centers for Disease Control and Prevention. Youth suicide prevention programs: A resource guide. *Atlanta: U.S. Department of Health and Human Resources, Public Health Service*, 1992.
[49] ibid.

Table 4
Changes in Knowledge Among School Gatekeepers After Training

Issue	Before	After
Mean Number of Warning Signs Identified	**3.6**	**6.1**
Percentage of Gatekeepers Listing Specific Warning Signs		
Making Final Arrangements	24%	53%
Nonspecific Change	34%	50%
Specific Suicidal Threat/Warning	27%	50%
Depression	57%	49%
Social Withdrawal	46%	35%
Changed Eating Habits/Weight Gain or Loss	11%	31%
Decreased School Performance	20%	29%
Engaging in Risky Behavior	2%	29%
Apathy/Indifference	22%	22%
Knowledge of Treatment Resources		
Know where to refer a troubled student	45%	68%
Willingness to Make Treatment Referrals		
Believe that they should be responsible for contacting a mental health professional (outside school) about a student who may be at-risk for suicidal behavior	46%	62%

Note: Analyses are based on a sample of approximately 307 educators who completed questionnaires before and after the program. This represented 72% of educators who attended the program.

Adapted from: Shaffer, D., Garland, A., and Whittle, R. New Jersey Adolescent Suicide Prevention Project Final Project Report, pp. 28-29.

The following activities are recommended as part of Gatekeeper Training:

A. Clearly define all target audiences.

B. Evaluate Living Works, QPR, and other training and awareness programs to determine their appropriateness for use in Virginia.

C. Develop a continuum of Gatekeeper Training opportunities to be made available to each target group.

D. Plan and present an annual interdisciplinary children's mental health conference to draw attention to the issues of youth mental health, depression and suicide, and to offer opportunities for training of personnel.

E. Adapt/Develop training materials to support Gatekeeper Training. Materials should be available using a wide variety of media.

F. Evaluate training outcomes.

Recommendation 7

DMHMRSAS should continue to develop and implement the plan to provide comprehensive mental health services for children, adolescents, and their families.

Recommendation 8

DMHMRSAS and VDH should increase the capacity of local communities to provide community-based crisis intervention and support services for children, adolescents, and their families.

Findings

Youth suicide prevention is necessarily linked to mental health and emotional well-being. While it is recognized that youth in crisis and at-risk of suicide need immediate access to crisis intervention services, research also shows that early intervention and prevention services help to avoid the onset of crisis.

Comprehensive mental health services for children, adolescents, and their families include prevention, early identification and intervention, screening and evaluation, within a continuum of both non-residential and residential treatment services. Table 5 lists the categories of services generally agreed to be components of an overall system of care. Although they are listed individually, the service components cannot be operated in isolation. Only when the services are enmeshed in a coherent, well-coordinated system will the needs of youth and their families be appropriately and effectively met. A critical component of an effective system is an appropriate balance between more restrictive and less restrictive services.

Table 5

Mental Health Services

Nonresidential Services	***Residential Services***
Prevention	*Therapeutic foster care*
Early identification and intervention	*Therapeutic group care*
Assessment	*Therapeutic camp services*
Outpatient treatment	*Independent living services*
Home-based services	*Residential treatment services*
Day Treatment	*Crisis residential services*
Emergency Services	*Inpatient hospitalization*

Source: Stroul, B. and Friedman, R. (1986) A system of care for youth with severe emotional disturbances. Washington, D.C.: Georgetown University Child Development Center.

In August 1998, Governor Gilmore created the Hammond Commission on Community Services and Inpatient Care, with responsibility to advise the Governor as to how Virginia can best build a responsive, quality mental health, mental retardation, and substance abuse services system for the next century. In its interim report in December 1998 the Commission recognized the need for reforms in Virginia's mental health system and proposed a number of shared values to guide meaningful reform. Some of these values are listed below. [50]

[50] Hammond Commission. Crossroads of Reform: Positive Direction for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System. Richmond, VA: *Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.* 1999.

- *Purpose: The purpose of our services system is to improve the health and quality of life of our fellow citizens, whose special needs or disabilities make them eligible for publicly-funded care.*
- *Collaboration: The continued development of a successful services system... depends on meaningful collaboration among the people served, their families and advocates, care providers, payers, and ... governments.*
- *Community services: Virginians should strive to improve the possibilities for people with mental disabilities to lead independent lives in a community.*
- *Data: Accurate information on care and treatment practices, outcomes and results, satisfaction... and other quality indicators should be publicly maintained and used to improve the quality of services.*

In the Six-Year Comprehensive State Plan, the Department of Mental Health, Mental Retardation and Substance Abuse Services identified two major service components for Virginia's system of publicly-funded mental health, mental retardation, and substance abuse services.[51]

- *An expanded array of community-based short-term intensive intervention or safety net services... to all individuals who are experiencing a crisis... and*
- *A comprehensive array of longer-term services and supports that are available to... children and adolescents with or at-risk of serious emotional disturbance...*

Pursuant to House Bill 428, passed by the 1998 General Assembly, DMHMRSAS has identified priority populations, those groups of individuals, identified through uniform and consistently applied classification instruments, which have the most serious or severe disabilities. Such identification does not create any legal entitlement for services, but, rather, provides a framework for identifying who should have priority for receiving long-term services paid for with state-controlled funds. Mental health priority populations include, among others:

- *children and adolescents, birth through age 17, with a serious emotional disturbance; and*
- *children, birth through age 12, who are at-risk of developing serious emotional disturbance.*

In its Comprehensive Plan, the Department proposes to provide short-term intensive intervention services to anyone, whether or not a member of a priority population, who needs the services to:

- *Address an immediate crisis*
- *Prevent a further deterioration in functioning*
- *Improve ability to function independently, or*

[51] Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services. Comprehensive State Plan 2000-2006. Richmond, VA: 2000.

- *Prevent the onset of a mental disability.*

This final justification has broad implications in the area of suicide prevention. Specific prevention activities include:

- *Education and training*
- *Gatekeeper Training*
- *Screening and assessment*
- *Skill-building*
- *Establishment of referral networks*

To reduce suicidal behaviors and prevent suicide, high-risk youth, their friends and family members need immediate, 24-hour access to crisis intervention. More extensive screening and the presence of well-trained gatekeepers will increase the demand for crisis intervention services. Key features of crisis intervention services are timeliness, intensity, and accessibility.[52] *By definition, crisis services are available continuously and provided immediately. Such services should be community-based, in "youth-friendly" settings, and be easily accessible to youth. Crisis services, currently provided in some localities by Crisis Teams, should be available in every locality in Virginia, staffed by a combination of health-care professionals, mental health workers, and volunteers.*

Finally, local crisis centers should be supported in their efforts to expand their service capacity, particularly in the implementation of 24-hour crisis hotlines. Often, youth prefer anonymous hotlines to mental health centers, especially if they are known to provide peer counselors and are sensitive to youth issues. Further, research suggests that hotlines:[53]

- *Provide a service for individuals troubled by suicide ideation;*
- *Succeed in attracting populations they are designed to help;*
- *Are associated with a significant drop in the suicide rate among white females under 25 years of age, the most frequent users of the service; and*
- *Reach otherwise underserved populations, such as college students.*

Currently, two local crisis lines in Virginia are certified by the American Association of Suicidology and connected to 1-800-SUICIDE, a national crisis intervention and referral line. These local programs offer support and referrals when Virginians dial the toll-free number. There are 9 additional crisis centers located around the Commonwealth which, with adequate support and assistance, may become certified and connected to the network. It is recommended that such support be offered, so that Virginians throughout the Commonwealth may have access to services in their communities. (See Appendix for list of Crisis Centers in Virginia.)

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[52] Washington State Department of Health. Youth Suicide Prevention Plan for Washington State. Olympia, WA: Department of Health. 1995.

[53] Centers for Disease Control and Prevention. Youth suicide prevention programs: A resource guide. *Atlanta: U.S. Department of Health and Human Resources, Public Health Service.* 1992.

Indicated Prevention Strategies

Indicated prevention strategies target only those youth known to be at-risk for suicide, that is, those youth who have shown serious warning signs, such as suicidal thoughts, prior attempts, signs of depression, and alcohol or drug use. Features of effective programs and criteria for services include:

- Individual risk factors and deficits in protective factors are identified for high-risk youth;
- Specific interventions are aimed at these risk and protective factors;
- Intervention amounts are sufficient to have the desired effect; and
- Costs are greater per person than universal or selective strategies.

Recommendation 9

DMHMRSAS should continue to expand the availability of comprehensive mental health services for children and youth at-risk for suicide, particularly helping localities to offer skill-building and support groups, school-linked mental health services, and family support / survivor services.

Findings

Skill-building support groups are designed to provide a safe, comfortable environment in which vulnerable youths can learn and practice life skills to increase resiliency, strengthen protective factors and reduce risk factors. These small groups may be offered in schools, through Community Service Boards (CSB), and/or within other community organizations and are facilitated by trained adolescent mental health personnel. Evidence suggests that youth at-risk for suicide are reluctant to seek help. These same youth respond well to support and skill building peer groups delivered by a caring adult.[54] The target population for these groups is made up of youth who have been identified as being at-risk for suicide through screening, self-referral, or referral by parents, gatekeepers, and/or mental health professionals.

Increasing the availability of prevention and early intervention services for depressed youth are priority goals of the youth suicide prevention plan. Providing school-linked mental health services will help to ensure that youth who need these services have access to them. One 1996 study demonstrated that students who received behavioral health services through school-based health centers showed significant declines in depression and improvements in self-concept. [55]

The Roanoke Adolescent Health Partnership (RAHP) offers one example of school-linked mental health services. RAHP currently operates three Teen Health Centers, one at Patrick Henry High School, one at William Fleming /

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[54] Eggert, L.L., Thompson, E.A., and Hertig, J.R. Reducing suicide risk behaviors among high-risk youth. Suicide and Life-Threatening Behaviors. *American Association of Suicidology.* 1995.

[55] Weist, Paskewitz, and Warner. Treatment outcomes of school-based mental health services for urban teenagers. *Community Mental Health Journal.* 1996: 32, 149-157.

Ruffner Middle School, and the third in the Hurt Park Health Center, a local Health Department Clinic. Each Teen Health Center offers primary medical services and mental health counseling services. Mental health services at the Teen Health Centers are provided by a therapist who is licensed or license-eligible to provide psychotherapy in the Commonwealth of Virginia. Clinical and administrative supervision is provided by the local Community Services Board. The array of mental health services consists of a diagnostic evaluation/assessment, individual, family and group therapies, case management activities and crisis intervention services. The location of mental health services within the schools promotes increased mental health awareness by teachers and students, opportunities for on-site consults with a mental health professional, and the ability to serve youth where they are located, which improves attendance to therapy sessions and may ease barriers of transportation, scheduling, etc. Referrals may be made by school staff, parents, or other Teen Health Center staff members. Examples of issues that may result in a referral and subsequent treatment include: behavioral problems, conflicts within the school and/or family, adjustments, and/or more serious problems such as mood and anxiety disorders including suicidality, chronic behavioral problems, and/or severe family problems.

Lack of social support, particularly family support, has been shown to increase the risk of youth suicide. Family support should include education about ways to support youth as well as coping skills for family members. Youth must be served within the context of their families and a family-systems approach to mental health services which will increase opportunities for successful prevention and intervention.

Recommendation 10

DMHMRSAS and VDH, in cooperation with university medical centers, health science centers, and professional organizations should develop, implement, and evaluate curriculum and training plans to increase the knowledge and skills of clinicians and others who work with youth at-risk for suicide and their families.

Findings

If professionals are to work effectively with youth at-risk for suicide, continuing training opportunities must be provided to support these professionals. Expected outcomes of clinician training include:

- *Increased knowledge of the interpersonal and intrapersonal dynamics of youth at-high-risk for suicide, psychosocial indicators of suicide, and necessary supports for these youth;*
- *Increased skill in the assessment of youth at-risk;*
- *Increased skill in individual therapeutic methods for youth at-risk and their families; and*
- *Prevention of worsening condition of youth and decreased risk and incidence of suicide.*

Currently, such training is not regularly available and many Virginia clinicians report never having received such training. DMHMRSAS and VDH should develop a needs assessment process and target mental health clinicians, substance abuse clinicians, medical personnel, school guidance counselors, family preservation and child protective services workers, and crisis center personnel. Needs assessment should focus on both content-related needs and training process/methods which will be most effective. A training planning group should be developed to review research on clinician training, plan and implement the needs assessments, and provide recommendations for the implementation and evaluation of the training plan.

Surveillance and Evaluation Strategies

In order to continue to adequately plan for the prevention of youth suicide and suicidal behavior, surveillance, data collection and dissemination must be improved. Data and surveilance strategies are designed to answer, on a regular, ongoing basis, a number of specific questions:

- What is the magnitude of the youth suicide problem in Virginia?
- How many youth attempt suicide in Virginia?
- What are the characteristics of youth who attempt suicide in Virginia?
- What is the impact of the suicide prevention strategies implemented as part of the youth suicide prevention plan?

Recommendation 11

VDH should design and implement an adolescent suicide attempt data collection system to determine the magnitude of the problem, as well as the following characteristics of youth who attempt suicide: demographics, service access, and behavioral characteristics.

Recommendation 12

VDH should improve the system for reporting external cause of injury (e-codes) by providing training to designated reporters and by requiring e-code reporting for emergency room admission in selected sites around the Commonwealth.

Findings

Currently, Virginia has no system for monitoring suicide attempts among youth. A suicide attempt data system will provide a comprehensive surveillance instrument for understanding suicide attempters who present in Virginia hospitals. While research provides estimates on youth suicide attempts ranging from 8 to 100 attempts for every completed suicide,[56] monitoring suicide attempts in Virginia is necessary to better understand the occurrence of attempts by youth in the Commonwealth. Data gathered will help in planning of activities and evaluation of the success of suicide prevention activities.

[56] United States Department of Health and Human Services. Suicide Facts - NIMH Fact Sheet. (www.nimh.nih.gov) 1999.

External cause of injury (e-code) data are maintained and reported for hospital admissions throughout the Commonwealth. Improvement in the quality of the data may be attained by providing training to personnel responsible for reporting these data. In addition, it is recommended that selected emergency rooms be required to collect and report e-code data to determine the feasibility for requirement in emergency rooms statewide.

Recommendation 13

VDH should coordinate comprehensive evaluation of all aspects of suicide prevention program.

Findings

Both process and outcome evaluation of all components of Virginia's plan are critical to ensuring its success. Process evaluation should employ both qualitative and quantitative measures to determine if a program is being implemented as it was designed. Evaluation questions generally include: whether a program works, how it works, under what conditions, and for whom. Key features of process evaluation:

- *Process evaluation is ongoing. It is designed to ensure that programs are carried out in ways that are consistent with the overall intent and design.*
- *Process evaluation examines each step of program implementation.*
- *Process evaluation may measure:*
  - *Amount and range of content*
  - *Number and description of places where program is delivered*
  - *Consistency of implementation across agencies*
  - *Quality of delivery*

Outcome evaluation is the measurement and assessment of program effectiveness. It is concerned with determining whether the program produced change. Key features of outcome evaluation include:

- *Examining the effect of the total program and all of its components on desired outcomes:*
  - *Reduced rates of suicide and suicidal behavior among youth*
  - *Reduced impact of suicide on families and communities*
  - *Improved access to appropriate prevention services*
- *Measuring change as evaluated by several outcome indicators:*
  - *Reduction in youth suicide*
  - *Increase in key protective factors*
  - *Decrease in key risk factors*

Finally, measures used for both process and outcome evaluation must be valid, reliable, and sensitive with respect to measuring change in all outcome areas. The Department of Health may wish to contract with a university partner to conduct certain aspects of the comprehensive evaluation.

Recommendation 14

The General Assembly should appropriate funds to the Department of Health, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Education to implement the youth suicide prevention initiatives described in this plan.

The 2000 General Assembly appropriated $75,000 each to the Virginia Department of Health and to the Department of Mental Health, Mental Retardation, and Substance Abuse Services for suicide prevention initiatives. Each of the Departments presented plans for use of those funds in the area of youth suicide prevention to the Commission in the Summer of 2000. (See Appendix)

In order to fully implement this Youth Suicide Prevention Plan, additional funds from the State General Fund will be required. It is recommended that the General Assembly appropriate this funding. Anticipated funding needs are outlined below:

Virginia Department of Health

- Personnel and support to coordinate youth suicide prevention plan
- Research and development of public awareness materials
- Purchase of media time
- Development and implementation of Gatekeeper and clinician training programs
- Development and implementation of suicide attempt data collection system
- Comprehensive evaluation of youth suicide prevention initiatives

Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services

- Coordination of statewide Youth Depression Awareness Day Activities
- Production and distribution of Youth Depression Awareness Day materials
- Implementation of strategies to increase capacity for community-based crisis intervention and support services for children, adolescents, and families
- Development and implementation on clinician training programs

Virginia Department of Education

- Training for school personnel in use of Suicide Prevention Guidelines

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Suzanne Keller, Coordinator

Maryland Department of Health and Hygiene
Henry Westray, Youth Suicide Prevention Coordinator

Washington State Department of Health
Debbie Ruggles, Youth Suicide Prevention Coordinator

Arizona Department of Health
Barbara Olson

Oregon Department of Health
Ronald Bloodworth

U.S. Centers for Disease Control and Prevention
Alex Crosby

Maine Department of Health
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Appendix I: Crisis Centers in Virginia Localities

Alexandria
Alexandria Hotline - Mental Health Assoc.
4600 Duke St., Suite 301
Alexandria, VA 22304
Business Phones:
(703) 212-0010
Crisis Phones:
(703) 751-0169 TDD/V
(703) 751-0123 Voice only
8 a.m. - midnight

Arlington
Northern Virginia Hotline
P.O. Box 7563
Arlington, VA 22207-0563
Business Phones:
(703) 527-6603
Crisis Phones:
(703) 527-4077
24 hrs / 7 days
AAS Certified: Yes
AAS Member: Yes

Blacksburg
ACCESS Emer. & Asses. Services
700 University City Blvd.
Blacksburg, VA 24060
Business Phones:
Crisis Phones:
(540) 961-8400
24 hrs./ 7 days
AAS Certified: No
AAS Member: No

Bristol
Crisis Center
PO Box 642
Bristol, VA 24203
Business Phones:
(540) 466-2218
Crisis Phones:
(540) 628-7731
(540) 466-2312
24 hrs / 7 days
ttfadv55@usit.net
AAS Certified: No
AAS Member: No

Lynchburg
The Crisis Line of Central VA
PO Box 3074
Lynchburg, VA 24503
Business Phones:
(804) 947-5921
Crisis Phones:
(888) 947-7272
(804) 947-7273 Rape Companion Program
(804)/ (888) 947-7277 Teen Talk
(804)/ (888) 947-4357
(804)/ (888) 947-5437 Chatterline
24 hrs. / 7 days
AAS Certified: No

Martinsville
Contact Martinsville-Henry Co.
PO Box 1287
Martinsville, VA 24114
Business Phones:
(540) 638-8980
Crisis Phones:
(540) 632-7295 24 hours/day
(540) 634-5005 Teenline 5:30-9:30pm Sun-Thurs.
9:00 A.M. - 5:00 P.M.
AAS Certified: No
AAS Member: No

Portsmouth
Suicide-Crisis Center, Inc.
P.O. Box 7428
Portsmouth, VA 23707
Business Phones:
(757) 393-0502
Crisis Phones:
(757) 399-6393
24 hrs / 7 days
AAS Certified: Yes
AAS Member: Yes

Charlottesville
Madison House
170 Rugby Rd.
Charlottesville, VA 22903
Business Phones:
(804) 977-7051
Crisis Phones:
(804) 295-8255 Open House Hotline
Volunteer staffed.
AAS Certified: No
AAS Member: No

Danville
Contact Crisis Line Danville/Pittsylvania Cty
P.O. Box 41
Danville, VA 24543
Business Phones:
(804) 793-4940
Crisis Phones:
(804) 792-4357
8:30am-5pm & 6:00pm-10:00pm
AAS Certified: No
AAS Member: No

Dumfries
ACTS Helpline
P.O. Box 74
Dumfries, VA 22026
Business Phones:
(703) 368-4141
Crisis Phones:
(703) 368-6544 Spanish - M-F 6p.m.-10p.m.
(703) 368-8069 Teenline
(703) 368-4141 24 Hr. Helpline
24 hrs/7days
AAS Certified: No
AAS Member: Yes

Richmond
West End Behavioral Healthcare System
12800 W. Creek Pkwy.
Richmond, VA 23238
Business Phones:
(804) 819-4000
Crisis Phones:
(804) 643-5502 TDD
(804) 684-9224
AAS Certified: No
AAS Member: No

Roanoke
Trust: Roanoke Val Trouble Cnt
Administrative Office:
P.O. Box 2826
Roanoke, VA 24016
Business Phones:
(540) 344-4691
Crisis Phones:
(540) 344-1948
(540) 982-8336 Teenline, 6-10pm Daily
(800) 345-8336 Statewide Teenline
24 hrs. / 7 days
AAS Certified: No
AAS Member: No

Winchester
Concern Hotline, Inc.
PO Box 2032
Winchester, VA 22601
Business Phones:
(540) 667-8208
Crisis Phones:
(540) 667-0145 Winchester
(540) 743-3733
(540) 459-4742 Woodstock
(540) 635-4357 Front Royal
24 hrs / 7 days
AAS Certified: No
AAS Member: No

Woodbridge
Community MH, MR & Substance Abuse Services Board - Prev Division
15941 Cardinal Dr.
Woodbridge, VA 22191
Business Phones:
(703) 792-4900
Crisis Phones:
(703) 792-7800
(703) 368-8069 Teen Line, 3-7 pm
By Appointment
AAS Certified: No
AAS Member: No

Appendix II: SJR 148 - Youth Suicide Prevention Plan Stakeholders Group

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400 East Jackson Street
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1 800 Suicide
609 E. Main Street #112
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reese@value.net

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Purcellville, Virginia 20132
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Hopewell, Virginia 23860
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SJR 148 - Stakeholders Group Continued

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Appendix III: Virginia Department of Health Youth Depression/Suicide Prevention Initiative

Last year a joint resolution required a study of suicide in the Commonwealth to be undertaken by VDH and DMHMRSAS. This study resulted in Document No. 16, *A Study of Suicide in the Commonwealth.* Several recommendations of the study arose during the subsequent General Assembly session.

The suicide initiative instituted this legislative and budget session has three separate, but inter-related components. VDH received $75,000 for the initiative; DMHMRSAS received the same amount for the prevention of suicide. In addition, the Commission on Youth was charged with developing a state adolescent suicide prevention plan. VDH will collaborate with both groups with Stephen Conley, PhD, Director of Adolescent Health Programs, serving as the Director of Adolescent Depression/Suicide Prevention for VDH. Forty percent of his time and efforts are dedicated to the initiative.

Preliminary planning has included the following activities to reduce depression and suicide in the Commonwealth.

- VDH will focus on adolescent suicide prevention in the first year of the initiative.

- The Center on Injury and Violence Prevention will issue an RFF in July for five crisis centers in the state ($5,000 each) to collaborate with CIVP and conduct staff and community leader training on suicide prevention.

- Training will be conducted across the state for "gatekeepers" to learn to identify those youth at-risk for suicide. This likely will involve a contract with a Canadian organization, 'LivingWorks®.' We also may utilize the QPR® system from Spokane, Washington. This training teaches lay community workers to question, persuade and refer those at imminent risk of suicide. The expected audience for training will include guidance counselors, teachers, social workers, counseling therapists, school nurses, ministers, and anyone who comes into regular contact with youth.

- Instructional materials on suicide prevention will be purchased and distributed. Distribution may be through the crisis centers.

- Training will be offered for electronic and print media reporters and editors on the CDC *Guidelines for Reporting on Suicides.*

- Federal funds will be sought to enhance the scope of the initiative.

- VDH will work closely with the other two agencies to assure a coordinated effort for the state.

- The lead staff contact, Stephen Conley, Ph.D., has been approved by the Maternal and Child Health Bureau to receive technical assistance in Seattle, Olympia and Portland on effective prevention approaches used in the states of Washington and Oregon, a region with high rates of youth (and adult) suicide.

Preliminary Budget

$15, 000	public information materials
2, 000	travel
33, 000	training
25, 000	community RFF for local training
$75, 000	

Appendix IV: DMHMRSAS Suicide Prevention Initiative for Children and Adolescents

Amount: $75,000

Description: DMHMRSAS suicide prevention initiatives for children, adolescents, their parents and families.

Plan: The DMHMRSAS will use these funds to improve the ability of public and private mental health providers, foster care workers, and community program workers to recognize signs of childhood depression in children and adolescents and to provide appropriate intervention.

The DMHMRSAS Youth Mental Health Suicide Initiative will include:

- Training
- Coordinating activities with the Department of Health and the Commission on Youth
- Developing and promoting Childhood Depression Awareness Day in May 2001 (The National Mental Health Awareness Month) with accompanying materials
- Identifying resources currently available through the Community Services Boards to support families and loved ones of people who commit suicide or attempt suicide
- Development of resource materials and information links for DMHMRSAS website
- Hiring part-time staff to manage the initiative

Implementation Activities and Timetable:

- Collaboration and coordination with the Department of Health and the Commission on Youth regarding suicide initiatives for youth (ongoing)
- Hire part-time staff to manage and coordinate suicide prevention activities and intervention activities (August 1, 2000)
- Develop work plan for activities (September 15, 2000)
- Implement proposed activities (September 16, 2000 - June 30, 2001)