REPORT OF THE
JOINT COMMISSION ON
BEHAVIORAL HEALTH CARE

Developing a Plan and Strategy for Suicide Prevention in the Commonwealth (SJR 108)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 19

COMMONWEALTH OF VIRGINIA
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EXECUTIVE SUMMARY

In the Commonwealth, suicide is the second leading cause of death for people aged 10-35. On average, two adults a day and one teenager a week died through suicide.[1]

Over the past 14 years, attention in the Commonwealth has been focused on suicide prevention among the elderly and youth. In 1990, the Virginia Department for the Aging developed a Statewide Suicide and Substance Abuse Prevention Plan. In 2001, the Commission on Youth developed a Youth Suicide Prevention Plan. In May 2002, the Third Annual Virginia Suicide Prevention, Intervention and Healing Conference was held, focusing on regional suicide prevention planning.

Meanwhile, at the national level, in 1999, the Surgeon General's Call to Action to Prevent Suicide recommended completion of the National Strategy for Suicide Prevention. Published in 2001, the National Strategy for Suicide Prevention has prompted a number of states to develop plans for suicide prevention across the life span, from youth to old age.

While some suicide prevention activities in the Commonwealth are directed primarily at youth and the elderly, there is no overall suicide prevention strategy across the life span. No single agency acts as a clearinghouse or coordinator of activities related to suicide prevention. In order for the Commonwealth to address the issue of suicide prevention across the life span, the following recommendations are proposed.

1. Building on the momentum from the May 2002 Virginia Suicide Prevention, Intervention and Healing Conference, the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, should lead an interagency and cross-secretarial effort to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth. Agencies that should participate in this effort include the Departments of Health; Mental Health, Mental Retardation and Substance Abuse Services; Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; and Corrections; the Department for the Aging and any other state agency that has a specific interest, responsibility or role in the development of the plan.

2. The Department of Health and the Department for the Aging should be the agencies responsible for actually developing this plan, supporting the Secretary's efforts. The Departments of Mental Health, Mental Retardation and Substance Abuse Services; Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; and Corrections should provide assistance to the Department of Health, the Department for the Aging, and the Secretary's Office in the development of this plan.

3. All affected stakeholders should be involved in the development of this plan. Stakeholders include public and private service providers (e.g., suicide crisis hotlines, mental health services agencies), local correctional facilities, family members and survivors, advocacy groups, the faith community, medical professionals, the media, and first-line responders (e.g., emergency medical technicians). Public hearings should be conducted around the

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[1] See "Leading Causes of Death, Virginia" Chart on page 3.

Commonwealth to solicit input from and participation by stakeholders and other interested parties.

4. The plan should be completed by October 1, 2004, and presented to the Governor and the General Assembly for their consideration and possible action during the 2005 legislative session.

5. The plan should address suicide prevention across the life span with a special emphasis on effective strategies to prevent suicide among adolescent and elderly Virginians and all other identified high-risk populations.

6. In developing the plan, previous planning efforts in Virginia and in other states, as well as the National Strategy for Suicide Prevention, should be reviewed and applicable recommendations, goals, objectives, and strategies should be integrated into this new comprehensive plan.

7. The plan should identify workable and effective organizational structures at the state and regional or local levels to implement the recommendations in the plan.

8. The plan should establish Virginia's public policy regarding the prevention of suicide, identify the lead agency responsible for carrying out that policy, propose initiatives and interventions to effectively operationalize that policy, and identify the sources and amounts of resources to implement those initiatives and interventions.

9. Finally, the plan should identify a permanent oversight body to monitor the implementation of the plan. This oversight body should report annually on December 1 to the Governor and the General Assembly on the prevention of suicide in the Commonwealth. This report should identify any new initiatives or interventions and the resources necessary to implement them to enhance the Commonwealth's efforts to prevent suicide.

Leading Causes of Death, Virginia
1999, All Races, Both Sexes

	Age Groups											
Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+ *	All Ages**
1	Short Gestation 136	Unintentional Injury 27	Unintentional Injury 21	Unintentional Injury 30	Unintentional Injury 134	Unintentional Injury 154	Unintentional Injury 270	Malignant Neoplasms 487	Malignant Neoplasms 1,221	Malignant Neoplasms 2,349	Heart Disease 12,376	Heart Disease 15,329
2	Congenital Anomalies 111	Malignant Neoplasms 14	Malignant Neoplasms 12	Malignant Neoplasms 17	Homicide 55	Homicide 64	Suicide 150	Heart Disease 381	Heart Disease 857	Heart Disease 1,569	Malignant Neoplasms 9,134	Malignant Neoplasms 13,365
3	SIDS 55	Congenital Anomalies 11	Heart Disease 3	Suicide 6	Suicide 42	Suicide 45	Homicide 94	Unintentional Injury 348	Unintentional Injury 247	Cerebro-vascular 272	Cerebro-vascular 3,606	Cerebro-vascular 4,110
4	Maternal Pregnancy Comp. 37	Homicide 9	Congenital Anomalies 2	Chronic Low. Respiratory Disease 5	Heart Disease 15	Malignant Neoplasms 23	Malignant Neoplasms 91	Suicide 172	Suicide 147	Chronic Low. Respiratory Disease 269	Chronic Low. Respiratory Disease 2,315	Chronic Low. Respiratory Disease 2,699
5	Respiratory Distress 26	Heart Disease 5	Homicide 2	Congenital Anomalies 5	Malignant Neoplasms 15	Heart Disease 21	Heart Disease 81	HIV 111	Cerebro-vascular 138	Diabetes Mellitus 212	Influenza & Pneumonia 1,456	Unintentional Injury 2,214
6	Placenta Cord Membranes 23	Cerebro-vascular 4	Septicemia 2	Heart Disease 5	Congenital Anomalies 5	Cerebro-vascular 6	HIV 56	Homicide 94	Diabetes Mellitus 123	Unintentional Injury 183	Diabetes Mellitus 1,087	Influenza & Pneumonia 1,594
7	Bacterial Sepsis 19	Influenza & Pneumonia 4	Benign Neoplasms 1	Homicide 3	Nephritis 3	Anemias 5	Influenza & Pneumonia 18	Cerebro-vascular 65	Liver Disease 109	Liver Disease 129	Alzheimer's Disease 902	Diabetes Mellitus 1,486
8	Unintentional Injury 19	Six Tied 1	Chronic Low. Respiratory Disease 1	Influenza & Pneumonia 2	Diabetes Mellitus 2	Septicemia 5	Cerebro-vascular 14	Liver Disease 59	Chronic Low. Respiratory Disease 72	Septicemia 117	Nephritis 864	Septicemia 1,092
9	Circulatory System Disease 18	Six Tied 1	Diabetes Mellitus 1	Septicemia 2	Influenza & Pneumonia 2	Congenital Anomalies 4	Diabetes Mellitus 14	Diabetes Mellitus 43	HIV 68	Suicide 97	Septicemia 854	Nephritis 1,035
10	Atelectasis 17	Six Tied 1		Two Tied 1	Seven Tied 1	Influenza & Pneumonia 4	Congenital Anomalies 12	Septicemia 35	Septicemia 60	Nephritis 85	Unintentional Injury 781	Alzheimer's Disease 917
11	Intrauterine Hypoxia 16	Six Tied 1		Cerebro-vascular 1	Seven Tied 1	Diabetes Mellitus 3	Chronic Low. Respiratory Disease 11	Influenza & Pneumonia 27	Nephritis 48	Influenza & Pneumonia 46	Pneumonitis 450	Suicide 791

* Suicide was the 18th leading cause of death for the age group 65+, accounting for 131 deaths. ** One suicide death was of undetermined age.

Prepared by Center for Injury and Violence Prevention, Virginia Department of Health. Data Source: National Center for Health Statistics (NCHS) Vital Statistics System.

I. AUTHORITY FOR THE STUDY

Senate Joint Resolution No. 108 (2002) directs the Joint Commission on Behavioral Health Care, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Department of Health, to develop a plan and strategy for suicide prevention in the Commonwealth. SJR 108 is included in Appendix A.

II. SUICIDE IN THE COMMONWEALTH

Suicide is a serious, preventable health problem affecting people of all ages throughout the United States and in Virginia. Suicide and suicide attempts exact an enormous toll in terms of loss of life, physical impairment and medical costs, grief and suffering, and disruption of families and communities.

Across the United States, someone dies of suicide approximately every 18 minutes. This amounts to nearly 30,000 suicide deaths per year.[2]

In 1999, the suicide rates in Virginia were higher than the national rates for all age groups except for the age group 20 to 24 years old (Figure #1). In Virginia, suicides reflect the following characteristics:[3]

- Suicide is the second leading cause of death for people aged 10-35.[4]
- The age group of 65 and above has the highest suicide rate (20/100,000).
- The age group of 15-19 has the highest rate of self-inflicted injury hospitalizations (suicide attempts).
- Males (17.3/100,000) are more than 3 times more likely than females (4.7/100,000) to die by suicide.
- Females are 73% more likely to be hospitalized due to suicide attempts (69/100,000) than males (40/100,000).
- Suicide by firearm is the most common method for both men and women, accounting for 63% of all suicide deaths.
- Poisoning is the most common method used in suicide attempts that result in hospitalization, accounting for 83% of these self-inflicted injury hospitalizations.
- Whites (13/100,000) are more than twice as likely as blacks (6/100,000) and other races (3/100,000) to die from suicide.
- Races other than white and blacks have a higher rate of self-inflicted injury hospitalizations (73/100,000) than whites (56/100,000) or blacks (39/100,000).
- When categorized by gender and marital status, widowed males have the highest suicide rate (76/100,000).

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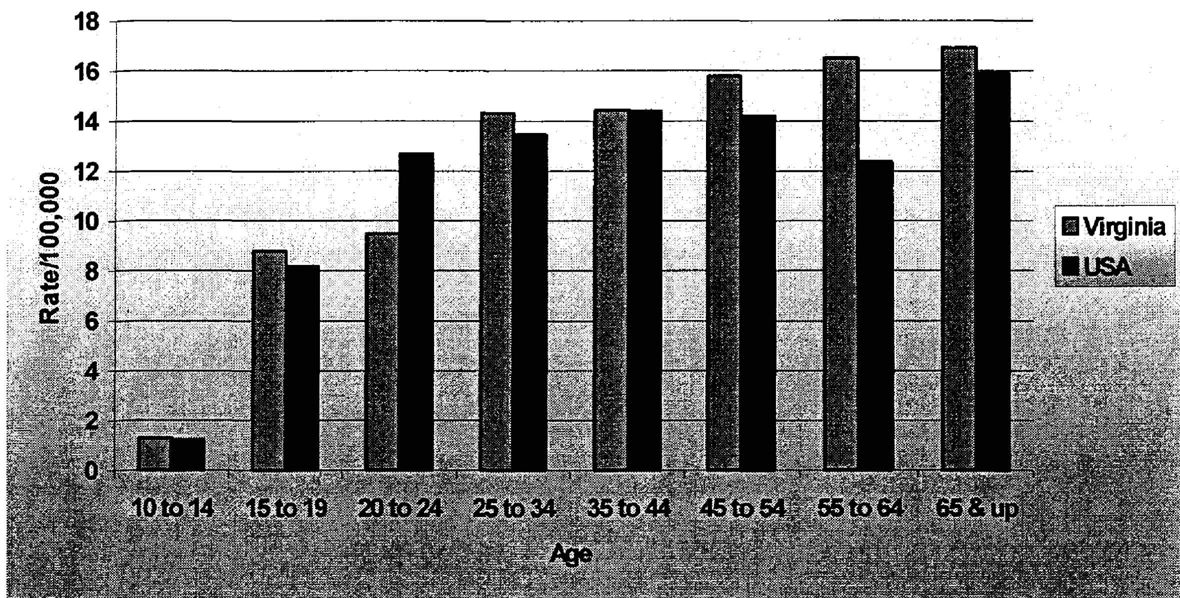
[2] Anderson, R. (2002). Deaths: Leading causes for 2000. *National Vital Statistics Reports.* 50 (16).

[3] Excepted as noted, statistics and figures from:
Hanna, R. (2002). *Suicide Associated Deaths and Hospitalizations, Virginia 2000.* Richmond, VA: Center for Injury and Violence Prevention, Virginia Department of Health.

[4] 1999 data. Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, http://webapp.cdc.gov/sasweb/ncipc/leadcaus.html. Data source: National Center for Health Statistics (NCHS) Vital Statistics System.

- Virginia's overall suicide rate (10.9/100,000 population) is slightly higher than the national average (10.7/100,000).
- Suicide claimed the life of 770 Virginians in 2000.
- 76% more Virginians died from suicide (770) than from homicide (437).[5]
- The total annual cost for hospitalizations due to suicide attempts was $25,028,032.
- On average, Virginia loses two adults a day and one teenager a week to death by suicide.

Figure 1: Suicide Rates by Age, Virginia vs. USA, 1999



Research suggests that social stigma leads to inaccurate reporting (underreporting of suicide). Thus, despite a medical examiner system that promotes more accurate reporting than is possible in some other states, these figures are unlikely to indicate the full extent of suicide attempts and completions in the Commonwealth. Added to the loss of life from completed suicides and the financial burden that results from suicide attempts is the effect on the health and functioning of families and communities caused by the special suffering that takes place when a person takes his or her own life.

Suicide presents an important health challenge across the Commonwealth. While the number of deaths from suicide is highest in some of the most populated areas of the State, the rate of suicide when adjusted for population has been highest in some of Virginia's least populated counties.

[5] Hanna, R. (2002). *Injury in Virginia 2000: A Report on Injury Related Death and Hospitalization.* Richmond, VA: Center for Injury and Violence Prevention, Virginia Department of Health.

III. OVERVIEW OF SUICIDE PREVENTION STUDIES IN VIRGINIA

In the past 14 years, Virginia has focused its efforts on suicide prevention on the Commonwealth's younger and older residents.

A. VIRGINIA'S ELDERLY AND SUICIDE

In 1988, the Virginia General Assembly, in House Joint Resolution No. 156, requested the Virginia Department for the Aging (VDA) to study suicide among the elderly. This study was conducted for the Department by researchers, including Nancy J. Osgood, Ph.D., Professor of Gerontology and Sociology, Virginia Commonwealth University. The study used a comprehensive methodology that involved a review of the relevant literature; an analysis of official mortality statistics on suicide from the National Center for Health Statistics for the period 1968 through 1985; case by case examinations of 74 percent (249 cases) of all suicides of individuals 60 and older occurring in Virginia from January 1, 1987, through August 31, 1988, recorded in the Medical Examiner's regional offices; a quantitative analysis of all suicides (338 cases) of individuals 60 and older recorded in the Office of the Chief Medical Examiner; and a public comment period and two public hearings. This study, House Document No. 32 (1989), identified the following characteristics of suicide among older Virginians.

- Virginia loses an elderly individual to suicide every 2.9 days. For the most recent time period studied (1983-1985), older Virginians committed suicide at a rate of 21.7 per 100,000 elderly compared to the national statistic of 19.8 per 100,000.
- Virginia's elderly have a 68% higher suicide rate than the general population of the state.
- Virginia's elderly have a 76% higher suicide rate than Virginia's youth.
- A consistent finding in studies of suicide is that women and the young attempt and men and old people complete suicide more frequently (using more violent and lethal methods).
- The profile of a person most "at risk" to commit suicide is a white male who is over 65, widowed and depressed, with no strong religious beliefs and who has some chronic illness and a history of alcohol abuse.
- The suicide rate is generally higher among older men than older women.
- Older men, nationally and in Virginia, tend to use firearms to commit suicide. Older Virginians of both sexes use firearms to commit suicide in noticeably higher proportions than the elderly people in the nation as a whole. For the period 1983-1985, in Virginia, elderly used firearms to kill themselves 80.3% of the time. This compares to a national average of 64.9%.
- The suicide rate among white persons increases with age. The suicide rate among non-whites peaks in their twenties and then decreases with age.
- Those who have had a marriage disrupted by death or divorce are most at risk. Those who have never been married are the next most vulnerable. Those who are married are at the least risk.
- Religion seems to have an impact on lessening the potential for suicide.
- Suicide rates differ in regions within the Commonwealth. In the Shenandoah-North-Central Area (excluding Northern Virginia), the suicide rate for the 1978-1982 period was 29.4 per 100,000, compared to 23.1 per 100,000 for the entire Commonwealth.

The researchers concluded that "the effect of life changes which often are associated with the aging process, including chronic illness, intermittent depression, widowhood and loss, and feelings of being a burden to others, can cause suicidal behavior in older adults." They cited lack of (i) public awareness, (ii) data that provide substantive reasons for the high rate of suicide among Virginia's elderly, and (iii) treatment and they recommended that the VDA, in conjunction with the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), Area Agencies on Aging, and Community Services Boards, develop a suicide prevention plan that includes education of the elderly, their families and services providers; a system for early detection and treatment; and development and expansion of psychosocial services.

Based on these results, in 1990 the Virginia General Assembly, in House Joint Resolution 365, requested the VDA to develop a Statewide Suicide and Substance Abuse Prevention Plan (Plan). The planning process focused on the need for additional research, education of physicians and other health professionals, and public awareness efforts among the elderly and their caregivers. The Plan was designed to complement and enhance the 1990-1992 Comprehensive Prevention Plan for Virginia, "especially the objective related to reducing the incidence of suicide in Virginia."[6] The suicide prevention portions of the Plan called for the following goals, objectives and strategies (House Document No. 38 (1990)):

- **Goal:** Learn more about the problem and causes of elderly suicides in Virginia.
  Objective: To investigate the causes for the high rates of suicide and the prevalence of the use of firearms by older Virginians.
  Strategy: The Virginia Department of Health (VDH), Office of Vital Statistics will analyze and summarize available data on the demographics of older Virginians who commit suicide. Contingent upon funding, the Virginia Commonwealth University will investigate the experience of family members who have experienced the death of a loved one through suicide, the DMHMRSAS will investigate the experience of older persons who are survivors of suicide attempts, and the Medical College of Virginia will investigate the prevalence, incidence and distribution of depression among older Virginians in the different areas of the Commonwealth.
- **Goal:** Improve the ability of citizens in the Commonwealth to help with prevention of elderly suicide.
  Objective: To educate the elderly in the responsible use of drugs and ways to deal with stress, depression, changes and loss so they can avoid suicidal tendencies.
  Strategy: VDA will work with the Area Agencies on Aging to send out public education materials to senior citizens through newsletters and presentations to senior groups. Another strategy included public education by VDA of the following groups: American Association of Retired Persons, National Association of Retired Federal Employees, unions in Virginia, corporate retirement programs, Virginia Council of Senior Citizens, and Virginia's Senior Citizen Clubs and Centers. VDA and DMHMRSAS were charged with preparing and distributing a brochure on warnings signs and available resources to help with the prevention of elderly suicide. Finally, the Governor's Advisory Board on Aging, with the Virginia Council of Churches, was charged with disseminating public educational materials on suicide prevention and educating members of the churches and other religious organizations.

[6] The Virginia Council on Coordinating Prevention published the 1992-2000 Comprehensive Prevention Plan for Virginia in 1992. A target to decrease death from firearms, including suicide, is included in this plan. The Council was repealed in 2001.

Objective: To educate family members and friends of the elderly to assist the elderly to cope with changes, loss and depression in a positive way to avoid suicide.

Strategy: VDA will work with corporations and businesses to train "gatekeepers" (e.g. personnel directors, retirement specialists, employee assistance program staff and employees who are caring for elderly relatives) in ways to help with prevention of elderly suicide and substance abuse. The Virginia Department of Health will make information available on the topic in local clinics and will include appropriate instruction in the recognition and treatment of mental health problems in continuing medical education programs for the medical staff of the Department. VDA will work with the Virginia Medical Society to make available in the offices of physicians and other health professionals public educational materials on prevention of elderly suicide. The Governor's Advisory Board on Aging, with the Virginia Council of Churches, will send out information on the issue to churches and religious organizations and various support groups that assist with prevention and treatment.

Objective: To educate professionals about the problem of elderly suicide including contributing factors, warning signs and available resources.

Strategy: VDA and DMHMRSAS will work with the Virginia Medical Society to conduct special outreach to Virginia physicians with an emphasis on need for referral for mental health treatment. The Virginia Health Care Association, the Virginia Home Care Association, and the Virginia Association of Homes for Adults will hold training sessions on the issues of suicide among the elderly at their annual meetings and conferences. VDA and DMHMRSAS will work with Area Agencies on Aging and Virginia Community Services Boards to conduct special training to educate state and local staff of their agencies on (a) the extent of the problem of elderly suicide, (b) how to access needed mental health, substance abuse, and supportive services, and (c) how to cope with the stress of serving older persons and their families who are victims of suicide. The Department of Social Services, the Virginia Association for Home Care, the Virginia Association of Homes for Adults, the Virginia Association of Non-Profit Homes for the Aging, and the Virginia Health Care Association will recommend that information on this issue be made a part of staff training curricula. VDA will work with statewide housing agencies and organizations to distribute public education materials to managers and staff of housing facilities for senior citizens. VDA will distribute information on the issue to diverse other groups, including other state agencies, other professional associations, and volunteer groups.

- **Goal:** Increase the ability of selected health and human resources professionals to screen for conditions that may lead to suicidal tendencies and refer such identified individuals for treatment with appropriate resources.

  Objective: To improve the ability of health services personnel, especially physicians, to recognize and treat physical and psychological conditions that contribute to suicide or substance abuse among the elderly.

  Strategy: VDA will work with the medical institutions of Virginia universities and with the Virginia Medical Society to continue the development of training that qualifies for Continuing Medical Education credits and that addresses the issues of suicide by the elderly. DMHMRSAS and VDA will provide physicians with information on available sources of mental health services counseling for older persons.

  Objective: To train professionals in the fields of aging, mental health, and substance abuse services in the early detection, screening, and treatment of substance abuse by the elderly.

  Strategy: Contingent upon funding, DMHMRSAS will provide funds for one half-time staff member in each community services board who will be a source of technical assistance to local health and human resources professionals. Such assistance shall include strategies for prevention and for treatment of elderly persons with suicidal tendencies. The Virginia

Association of Community Services Boards and the Virginia Association of Area Agencies on Aging will develop strategies to improve coordination of services at the local level targeted to older persons.
The Virginia Long-Term Care Council will disseminate information to local long-term care coordinating committees to encourage a coordinated response to this problem among local health and human resource agencies.

- **Goal:** Evaluate the effectiveness of the Elderly Suicide Prevention Plan.
  Objective: To monitor progress in achieving the goals of the Elderly Suicide Prevention Plan.
  Strategy: VDA will convene the Suicide and Substance Abuse Advisory Council annually to review progress on the plan. VDA and DMHMRSAS will review the plan quarterly and will annually submit a review of the progress of the plan to the Governor and the General Assembly.
  Objective: To review the rate of elderly suicides in Virginia.
  Strategy: VDH will review available data annually to determine changes in the rate of suicide of older Virginians

B. SUICIDE ACROSS THE LIFE SPAN

In 1999, the Virginia General Assembly, in Senate Joint Resolution No. 382, requested VDH, with the assistance of DMHMRSAS, to study the incidence of suicide in the Commonwealth. The study addressed whether the problem is growing, causative factors, factors that reduce risk, and what can be done to prevent suicide. An extensive study effort, including a review of the clinical literature, was undertaken by VDH with an expanded focus on suicide across the life span. In Senate Document No. 16 (2000), VDH reported that many people fail to realize that more Virginians die from suicide than homicide, 743 and 509 respectively in 1997. Males account for more than 80% of suicide deaths and the highest rates occur in males over the age of 65. Firearms are the most common suicide method and accounted for more than 60% of all deaths. Hanging and drug overdoses are the next most common methods. VDH noted that many studies support the claim that the number of suicides is underreported and that in Virginia there is no statewide system for reporting non-lethal suicidal behaviors.

In 1997, suicide was the ninth leading cause of death in the Commonwealth and the third leading cause of death for young people. The rate of suicide among Virginia youth, ages 10-19, has increased 32% since 1975. In 1998, VDH commissioned a study of child and adolescent hospitalizations that found depression, which is a significant risk factor for suicide, was the leading cause of hospitalization for 10-14-year-old children and the second leading cause of hospitalization for adolescents ages 15-19.

In a July 1999 survey of community services boards (CSBs), VDH found that the CSBs are providing 24-hour crisis intervention services to localities as mandated by the Code of Virginia. Most of the CSBs are providing some type of prevention education that includes information about suicide and suicide prevention. However, very few CSBs are providing specific programming targeting suicide prevention. VDH also convened work groups representing various organizations that work in the field of suicide and individuals who have experienced the suicidal loss of a loved one. The study found that, while suicide prevention activities are occurring in the Commonwealth, there is limited funding and limited coordination and collaboration among both the grassroots and statewide prevention efforts. The following recommendations were made by VDH:

- Funds should be appropriated to VDH and DMHMRSAS to conduct comprehensive suicide prevention and intervention activities.
- VDH should develop a statewide strategic plan, working in conjunction with the Coordinating Council on Prevention.
- VDH should coordinate suicide prevention activities, including research and data collection on suicide and depression, professional and public information efforts, and training. Training should be provided for parents, teachers, counselors, coaches, clergy, police, and others who work with youth to enhance identification and referral of children and adolescents at risk for suicide and depression. These activities should be coordinated in conjunction with survivors, DMHMRSAS, Department of Education, local crisis centers, the PTA, and other community stakeholders.
- VDH should convene an annual conference on suicide and depression prevention and intervention to provide a forum for national, state, and local level practitioners to interact and discuss recent research and new strategies and programs that are effective in preventing suicide in conjunction with the Coordinating Council on Prevention and other stakeholders.
- VDH should develop and implement an annual public awareness campaign in collaboration with DMHMRSAS on suicide prevention and intervention. This campaign should share the facts about suicide, depression and other risk factors, warning signals, referral and prevention strategies.
- VDH should provide resources, information and grants to support school and community-based programs that are designed to foster peer relationships, anger management, self-efficacy, problem solving, and other relevant coping and social skills among children and adolescents.
- DMHMRSAS should coordinate efforts to improve the ability of primary care providers to recognize and treat depression, substance abuse, and other mental illnesses associated with suicide risk.
- DMHMRSAS should support community-based crisis intervention services and survivor support groups and develop and implement strategies to reduce the barriers associated with seeking help.
- DMHMRSAS should develop and coordinate statewide suicide crisis intervention, including the expansion of hotline services, and improve related interagency communication and collaboration.
- DMHMRSAS should disseminate successful strategies for suicide intervention programming.
- DMHMRSAS should implement systems for effective follow-up of people discharged from psychiatric facilities and/or after previous suicide attempts.
- DMHMRSAS should facilitate availability of care and support programs for family/friends of people who commit suicide or attempt suicide.

C. YOUTH SUICIDE PREVENTION PLAN

The sobering statistics on the prevalence of youth suicide identified in the VDH study prompted the 2000 General Assembly to direct the Virginia Commission on Youth (COY) to develop a comprehensive youth suicide prevention plan. The 2000 General Assembly authorized Senate Joint Resolution No. 148 by way of a letter from the Speaker of the House of Delegates. The COY study (House Document No. 29 (2001)) reported:

> In 1998, 30,575 people ended their own lives in the United States. More than 4,000 were under 25 years of age[;] 317 were children aged 10-14. 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%. 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 [from] 50:1 to 100:1.

COY found that in 1998, seven Virginia children, aged 5-14, were reported to have died from suicide. Another 50 children, aged 15-19, ended their lives. The report warns that the extent of the problem of youth suicide is likely underestimated because of the non-standardized reporting of suicide, the stigma associated with declaring a death to be a suicide, and the fact such deaths are often reported as accidental.

COY further reported that the American Academy of Pediatrics listed the following factors that 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; and
- Parents may be less involved in their children's lives.

In Suicide Fatalities Among Children and Adolescents in Virginia 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. Further, the Team reported that 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 unavailable. The Team made recommendations in the following areas:

Prevention and Intervention

- Identify children with mental health needs as a priority population for services from DMHMRSAS and appropriate funding to support services;
- Improve identification, assessment, treatment, and follow-up of children at risk for depression and suicide;
- Appoint guardians ad litem for children involved in custody disputes;
- Fund recommended school nurse ratios in all school divisions;
- Secure all firearms and medications, and remove firearms when children at risk for suicide are in the home; and
- Implement appropriate prevention strategies to address gender and cultural differences and peer resistance to reporting threats made by others.

Education and Training

- Institute a major public awareness campaign regarding signs and symptoms of depression and risks for suicide among children and youth;
- Provide continuing medical education, including risk assessment for depression and suicide and safety planning for children at risk; and

- Train all school personnel and clinical staff of CSBs.

Death Investigation
- Conduct toxicology screens on all suicides;
- Develop a protocol for child suicide investigations; and
- Implement investigations of child suicides to support prosecution under § 18.2-56.2 regarding access to firearms.

Senate Bill 1250 (1999) directed the Board of Education, in cooperation with the DMHMRSAS, to develop guidelines for licensed school personnel to use when they believe a student is at imminent risk of attempting suicide. The Suicide Prevention Guidelines were disseminated to school personnel in October 1999. The guidelines describe school personnel's responsibility to identify and report students at-risk of suicide, include assessment tools, and provide for contacting parents or Department of Social Services personnel, as appropriate. The guidelines 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.

The Youth Suicide Prevention Plan was adapted by the COY from the model developed by the Institute of Medicine and the National Institutes of Health. The prevention scheme includes three levels of prevention strategies: universal, selective, and indicated. Universal prevention is focused on providing needed interventions to keep communities healthy and they target everyone. Selective prevention strategies strive to prevent the onset of suicidal behaviors in targeted risk groups. 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 Youth Suicide Prevention Plan[7] contained the following recommendations.

Leadership
- Amend the Code of Virginia to designate VDH as the lead entity for youth suicide prevention in Virginia and require reporting to the Governor and the General Assembly on the status of suicide prevention initiatives.

Universal Prevention Strategies
- Increase funding for the VDH and the DMHMRSAS for their development and/or adoption of materials and dissemination of youth suicide prevention information throughout the Commonwealth.
- VDH should train media professionals throughout the Commonwealth to ensure responsible reporting of suicide in order to reduce the risk of subsequent suicides.
- The Department of Education should revise the Suicide Prevention Guidelines to include criteria for follow-up with parents of students expressing suicidal intentions after initial contact is made.

Selective Prevention Strategies
- VDH and DMHMRSAS should develop and deliver Gatekeeper Training[8] to designated audiences throughout the Commonwealth.

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[7] A summary of the Virginia Youth Suicide Prevention Plan recommendations is attached as Appendix E.
[8] Gatekeepers are trusted individuals who routinely have significant contact with youth and who are likely to observe and be in a position to accurately screen and refer youth at risk of suicide. These Gatekeepers include

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

Indicated Strategies

- 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.
- 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.

COY found that in order to adequately plan for the prevention of youth suicide and suicidal behavior, surveillance, data collection, and dissemination must be improved. Thus, the Youth Suicide Prevention Plan contains the following recommendations.

Surveillance and Evaluation Strategies

- 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.
- 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 admissions in selected sites around the Commonwealth.
- VDH should coordinate comprehensive evaluation of all aspects of [the] suicide prevention program.
- The General Assembly should appropriate funds to the VDH, DMHMRSAS, and Department of Education to implement the youth suicide prevention initiatives described in this plan.

In Senate Bill 1190 (2001), enacted in response to the recommendations of the Youth Suicide Prevention Plan, the Virginia General Assembly designated VDH as the "lead agency for youth suicide prevention." In § 32.1-73.7 of the Code of Virginia, VDH's responsibility includes, "coordination of the activities of the agencies of the Commonwealth pertaining to youth suicide prevention in order to .... [address] the promotion of health development, early identification, crisis intervention, and support to survivors." During the 2000-2002 biennium, the legislature made an initial budget appropriation of $75,000 per year each to VDH and DMHMRSAS for activities to be conducted during development of the Youth Suicide Prevention Plan. Section 32.1-73.7 requires VDH to provide an annual report to the Governor and General Assembly on

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health care providers, school personnel, clergy, youth services workers, and law enforcement and court services personnel.

youth suicide prevention activities. The first such annual report was House Document No. 22 (2002).

IV. CURRENT SUICIDE PREVENTION EFFORTS IN VIRGINIA

A. YOUTH SUICIDE PREVENTION ACTIVITIES

Working in collaboration with other public and private agencies, VDH prioritized and successfully implemented initial youth suicide prevention activities focused on strengthening leadership and coordination, increasing public awareness, providing training, supporting community-based crisis intervention, and increasing funding for suicide prevention.

1. Leadership

VDH has created and, as of July 25, 2001, filled a new full-time position of Director, of the Suicide and Youth Violence Prevention Program in the Center for Injury and Violence Prevention. VDH has consulted with representatives of DMHMRSAS, Department of Education, Aging, CSBs, and local health departments and formed an ongoing Interagency Suicide Prevention Coordinating Committee (see Appendix B). To support activities related to the mental health recommendations of the Plan, DMHMRSAS has formed its Virginia Youth Suicide Prevention Advisory Committee. In addition, VDH and DMHMRSAS actively participate in the Virginia Suicide Prevention Council, a public-private partnership designed to address issues of suicide prevention in the Commonwealth across the life span.

2. Public Awareness

VDH has worked with state and national suicide prevention practitioners to adapt or create public awareness brochure for teachers, parents, and students, and distributed them in collaboration with the Department of Education. During the first six weeks that these brochures were made available at the beginning of the 2002 school year, VDH received and filled requests from across the State for approximately 340,000 brochures. VDH also created an extensive website containing information on Virginia youth suicide prevention activities, as well as links to other national and international suicide prevention resources (www.preventsuicideva.org). DMHMRSAS used its funding to raise public awareness of childhood depression, a contributing factor to youth suicide, and worked with the Governor to declare May 8, 2001, and May 7, 2002, "Childhood Depression Awareness Day," which garnered media attention.

3. "Gatekeeper" Training

VDH and DMHMRSAS have worked collaboratively to provide "gatekeeper training" for trainers in two research-based models: Applied Suicide Intervention Skills Training (ASIST) and Question, Persuade, Refer (QPR). "Gatekeeper training" is designed to help concerned individuals and staff members recognize suicide warning signs, implement appropriate initial interventions, and provide effective referrals. According to VDH, while both training models provide participants with information on youth suicide prevention, the ASIST model provides more intensive training in assessing the level of suicide risk and crisis intervention, whereas QPR provides a less time-intensive training process that makes it appropriate for a general audience. In 2001, 46 trainers were provisionally certified as ASIST trainers through 5-day training sessions jointly sponsored by VDH and DMHMRSAS. DMHMRSAS is providing ongoing technical assistance for Virginia ASIST trainers. Additionally, VDH arranged for 128 trainers to

receive a one-day training session on delivering QPR. These trainers have agreed to be listed as local contacts for the QPR model. VDH provides ongoing support for these QPR trainers, including supplying a special Virginia-specific version of the QPR participant materials for all trainings that take place within the Commonwealth.

4. Community-based Crisis Intervention and Support

As noted earlier, the CSBs provide crisis intervention and support services. In addition, 13 Virginia agencies listed by the National Hopeline Network offer telephone crisis hotline services (see Appendix C). Five of these agencies, CrisisLink of Arlington, The Crisis Center (Bristol), ACTS, Inc. (Dumfries), The Crisis Line of Central Virginia (Lynchburg) and The Planning Council (Norfolk), received contracts of $5,000 each year during 2001 and 2002 from VDH to enhance their ability to offer crisis intervention and support services (including gatekeeper training and American Association of Suicidology certification of their telephone crisis lines) in their local areas. All five contractor agencies provide crisis hotline services available 24 hours a day, seven days a week. They also have qualified staff members who deliver ASIST and QPR training in their communities.

5. Funding

Recognizing that securing adequate funding is a significant key for Virginia's ability to address the problem of suicide, VDH applied for and, in early October 2002, was awarded $966,992 over the next three years from the Centers for Disease Control and Prevention (CDC) to expand the state's suicide prevention program. Virginia is one of only four states to receive this Targeted Injury Intervention Program funding and one of two states to receive this funding for suicide prevention (see Appendix D).

The funds will initially be used to promote and provide gatekeeper training for school personnel across the Commonwealth. Statewide work groups will plan additional suicide prevention training for colleges and universities, elder care workers, health care and mental health providers, and emergency first responders such as police, firefighters and emergency medical services staff. The expanded program will also improve coordination of prevention activities in the Commonwealth and increase its ability to analyze suicide data and evaluate suicide prevention activities. The new program will include a public awareness campaign directed at teens.

B. ELDERLY SUICIDE PREVENTION

In response to the 1990 Suicide and Substance Abuse Prevention Plan for the Elderly, VDA worked with staff from the Virginia Geriatric Education Center at the Virginia Commonwealth University to develop a brochure titled, "Suicide and Virginia's Elderly: Warning Signs and Resources." This brochure was distributed to Area Agencies on Aging, nursing homes, licensed assisted living facilities, AARP chapters, and a wide variety of organizations providing services to older Virginians. VDA has recently worked with VDH to update and distribute a revised brochure on suicide and the elderly. In addition to these efforts, VDA has kept the 25 Area Agencies on Aging updated on suicide and the elderly. At the local level, these Area Agencies on Aging provide information about suicide prevention to older citizens (as well as local health care and human services professionals) at health fairs and other local events. Area Agencies on Aging, through their outreach and care coordination activities, identify persons who are at risk for suicide and work with their local Adult Protective Services programs, local CSBs, and other

agencies to intervene. VDA reports that budget constraints limited its activities in relation to suicide prevention for the elderly.

However, VDA has recently received a grant from the federal Administration on Aging to fund three pilot programs to test the feasibility of identifying and intervening with male caregivers. Each of the three pilot programs received a grant of $50,000 to employ or designate a qualified individual to conduct outreach efforts to identify and provide information, referral, and services to male caregivers as needed.

Two of the pilot programs focus on retired military personnel: Senior Services of Southeastern Virginia (serving Norfolk, Virginia Beach, Chesapeake, Portsmouth, Suffolk, and the surrounding counties) and the Peninsula Agency on Aging (serving Hampton, Newport News, Williamsburg and the surrounding counties). One pilot program focuses on rural male caregivers: The Crater District Area Agency on Aging (serving Petersburg, Emporia, and surrounding counties).

The "typical" caregiver for a frail older adult is still perceived to be a woman, either a daughter, a mother, or a wife. However, men are increasingly becoming caregivers. Whether they are retired military or live in rural regions of the country, these male caregivers are reluctant to share their feelings with others and will often refuse to seek out resources that could help them with their caregiving responsibilities. Social isolation may result because the caregiver is reluctant to share his caregiving struggles with friends, neighbors, and other social contacts in the community. For some men, the stress of caregiving may lead to physical breakdown, psychological depression, and, in some instances, to abuse of their spouse or other care recipient. A study of homicide-suicides among older couples conducted by the University of Florida found that when an older man murdered his wife and then committed suicide, it was often a situation where the man had been caring for his sick or disabled wife for an extended period of time.[9] Outreach to male caregivers can help prevent this type of tragedy.

V. SUICIDE PREVENTION AT THE NATIONAL LEVEL

Virginia is one of the nation's leaders in developing a plan for addressing the serious public health threat of suicide among youthful and elderly Virginians. Meanwhile, a national strategy has been developed to move the country as a whole forward in designing and strengthening suicide prevention strategies that will inform the Commonwealth's plan for suicide prevention across the life span.

In 1996, the United Nations/World Health Organization led an international suicide prevention effort, which produced Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies. The 105th U.S. Congress recognized suicide as a national problem and declared suicide prevention a national priority (U.S. Senate Resolution 84 (5/6/97) and U.S. House Resolution 212 (10/9/98)). In October 1998, the CDC, the Health Resources and Services Administration, the National Institutes of Mental Health, and many other groups and organizations convened a National Suicide Prevention Conference of leading experts in the field to develop a public health model to prevent suicide. The Surgeon General's Call to Action to Prevent Suicide, published in July 1999, was a culmination of these efforts that recommended the completion of the National Strategy for Suicide Prevention. The National

[9] Lindsay Peterson, "Researcher explores homicide-suicide among elderly," The Tampa Tribune, July 20, 1998.

Strategy for Suicide Prevention: Goals and Objectives for Action (2001)(NSSP)[10] lays the foundation for confronting the serious public health problem of suicide across the life span.

> A national strategy to prevent suicide is a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course. It encompasses the promotion, coordination, and support of activities that will be implemented across the country as culturally appropriate, integrated programs for suicide prevention among Americans at national, regional, tribal and community levels.
>
> A broad public/private partnership is essential for developing and implementing a national strategy. Interwoven within a national strategy are three key ingredients for action to improve suicide prevention: a knowledge base, the public will to support change and generate resources, and a social strategy to accomplish change. Developing a national strategy provides an opportunity to convene public and private partners across many sectors of society--government, public health, education, human services, religion, voluntary organizations, advocacy, and business--to sustain a true national effort (NSSP, p. 21.).

The effective implementation of NSSP will play a critical role in reaching the suicide prevention goals in the nation's public health agenda, Healthy People 2010 (DHHS, 2000). The goals and objectives of the NSSP are listed below.

Goal 1: Promote awareness that suicide is a public health problem that is preventable.
Objectives:
- By 2005, increase the number of States in which public information campaigns designed to increase public knowledge of suicide prevention reach at least 50 percent of the State's population.
- By 2005, establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.
- By 2005, convene national forums to focus on issues likely to strongly influence the effectiveness of suicide prevention messages.
- By 2005, increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the World Wide Web.

Goal 2: Develop broad-based support for suicide prevention.
Objectives:
- By 2001, expand the Federal Steering Group to appropriate Federal agencies to improve Federal coordination on suicide prevention, to help implement the National Strategy for Suicide Prevention, and to coordinate future revisions of the National Strategy.
- By 2002, establish a public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy.
- By 2005, increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities.
- By 2005, increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.

Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
Objectives:
- By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.

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[10] Copies of this document are available from the Center for Mental Health Services' Knowledge Exchange Network by calling 1-800-789-2647, reference document number SMA 3517; and on the World Wide Web at www.mentalhealth.org/suicide prevention, or at http:///www.surgeongeneral.gov/library. A summary list of the NSSP Goals is attached as Appendix F.

- By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments.
- By 2005, increase the proportion of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health.

Goal 4: Develop and Implement Community-Based Suicide Prevention Programs.
Objectives:
- By 2005, increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector, and c) support plan development, implementation, and evaluation in its communities.
- By 2005, increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.
- By 2005, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide.
- By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.
- By 2005, increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention programs.
- By 2005, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.
- By 2005, increase the proportion of family, youth and community services providers and organizations with evidence-based suicide prevention programs.
- By 2005, develop one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs.

Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm.
Objectives:
- By 2005, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce risks.
- By 2005, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.
- By 2005, develop and implement improved firearm safety design using technology where appropriate.
- By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.
- By 2005, improve automobile design to impede carbon monoxide-mediated suicide.
- By 2005, institute incentives for the discovery of new technologies to prevent suicide.

Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment.
Objectives:
- By 2005, define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels.
- By 2005, increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk and identification and promotion of protective factors.
- By 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors.
- By 2005, increase the proportion of clergy who have received training in identification of and response to suicide risk and behaviors and the differentiation of mental disorders and faith crises.
- By 2005, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk of suicide.
- By 2005, increase the proportion of correctional workers who have received training on identifying and responding to persons at risk for suicide.
- By 2005, increase the proportion of divorce and family law and criminal defense attorneys who have received training in identifying and responding to persons at risk for suicide.

- By 2005, increase the proportion of counties (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide.
- By 2005, increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.

Goal 7: Develop and promote effective clinical and professional practices.
Objectives:
- By 2005, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.
- By 2005, develop guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings.
- By 2005, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.
- By 2005, develop guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.
- By 2005, increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.
- By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.
- By 2005, increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.
- By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers).
- By 2005, incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all Federally-supported health care programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare).
- By 2005, include screening for depression, substance abuse and suicide risk as measurable performance items in the Health Plan Employer Data and Information Set (HEDIS).[11]

Goal 8: Improve access to and community linkages with mental health and substance abuse services.
Objectives:
- By 2005, increase the number of States that require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.
- By 2005, increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.
- By 2005, define guidelines for mental health (including substance abuse) screening and referral of students in schools and colleges. Implement those guidelines in a proportion of school districts and colleges.
- By 2005, develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts.
- By 2005, increase the proportion of school districts in which school-based clinics incorporate mental health and substance abuse assessment and management into their scope of activities.
- By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers.
- By 2005, define national guidelines for effective comprehensive support programs for suicide survivors. Increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented.

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[11] HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.

- By 2005, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans.

Goal 9: Improve reporting and portrayals of suicide behavior, mental illness, and substance abuse in the entertainment and news media.
Objectives:
- By 2005, establish an association of public and private organizations for the purpose of promoting the accurate and responsible representation of suicidal behaviors, mental illness and related issues on television and in movies.
- By 2005, increase the proportion of television programs and movies that observe promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues.
- By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations.
- By 2005, increase the number of journalism schools that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.

Goal 10: Promote and support research on suicide and suicide prevention.
Objectives:
- By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates.
- By 2005, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice, and for training of researchers in suicidology.
- By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.
- By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.

Goal 11: Improve and Expand Surveillance Systems.
Objectives:
- By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions).
- By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides.[12]
- By 2005, increase the proportion of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by coding external cause of injuries utilizing the categories included in the International Classification of Diseases.
- By 2005, implement a national violent death reporting system that includes suicides and collects information not currently available from death certificates.
- By 2005, increase the number of States that produce annual reports on suicide and suicide attempts, integrating data from multiple State data management systems.
- By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior.
- By 2005, implement pilot projects in several States that link and analyze information related to self-destructive behavior derived from separate data systems, including for example law enforcement, emergency medical services, and hospitals.

The NSSP's goals and objectives are the framework for suicide prevention. They are sufficiently broad so that individuals and groups can select objectives that correspond to their responsibilities and resources. The next step is to develop workable and effective organizational activities at the state and regional or local levels to implement the objectives.

Development of specific activities provides the opportunity to address the particular needs of subgroups at high risk for suicide and particular cultural/ethnic/social contexts for implementation. For instance, the objective to "increase the proportion of family,

[12] Follow-back studies consist of the collection of detailed information about the victim, his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents....In some States, child death review teams analyze suicides of young people, and information from these reviews is used to assist in prevention programming (NSSP, p. 121.).

youth and community services organizations and providers with evidence based suicide prevention programs" can be achieved by different prevention activities appropriate for younger African-American males, the elderly, gay and lesbian youth, persons with major mental illnesses, or American Indians and Alaskan Natives.[13]

VI. SUICIDE PREVENTION PLANS IN OTHER STATES

According to the NSSP, nearly half of the states are engaged in suicide prevention and many have committed resources to implement programs.[14] A number of states have suicide prevention plans, yet few are comprehensive and the plans do not uniformly link public health, mental health and substance abuse programs. "Moreover, not all address the entire life span and few involve all key stakeholders, such as education, justice, social services, and the private sector."[15] Davis C. Hayden, Ph.D., of the Psychology Department at Western Washington University maintains a website that lists the status of states' progress in developing plans and that has links to a number of state sites containing their state's plans (http://www.ac.wwu.edu/~hayden/spsp/). In addition to Virginia, Dr. Hayden provides information about the following states and their state plans:

A. STATES WITH SUICIDE PREVENTION PLANS ACROSS THE LIFE SPAN

Colorado: Statewide suicide prevention efforts began in the 1980s. Governor Roy Romer, prompted by the efforts of concerned citizens, created the Governor's Suicide Prevention Advisory Commission on March 5, 1998. The Commission completed the state plan for suicide intervention and prevention in November 1998. A recommendation that a lead entity be created to coordinate statewide suicide prevention activities and programs was among the recommendations in the state plan. The Office of Suicide Prevention within the Department of Public Health and Environment was signed into law on June 2, 2000. In 2002, Colorado has received $378,000 from a federal planning and development grant from the Substance Abuse and Mental Health Services Administration (42%), $357,000 in state general funds (39%), and $170,000 in private grant support (19%) for its suicide prevention efforts.

Kansas: Following a Region VII U.S. Department of Health and Human Services conference in August 1999, Kansas formed a Statewide Suicide Prevention Steering Committee. Kansas adopted a state plan soon after the formation of the steering committee and held the first annual Suicide Prevention Conference in the fall of 2000, with 175 in attendance from across the state.

Minnesota: The Minnesota Suicide Prevention Plan includes 28 strategies recommended by a statewide advisory group and completed by the Minnesota Department of Health (MDH) for presentation to the legislature in January 2000. Working with multiple stakeholders and a biennial state appropriation of $2.2 million, MDH continues implementation of the plan. Support for implementing the entire plan is sought from both public and private sectors.

Missouri: In October 1999, Missouri held a statewide planning meeting about suicide prevention. Missouri has developed a state plan through a collaborative process among six state agencies and a wide variety of partners. Additionally, funds have been committed to support selected gatekeeper training and community-based activities in six targeted communities.

[13] NSSP, p. 24.
[14] NSSP, p. 1.
[15] NSSP, p. 64.

Montana: The Montana Department of Public Health and Human Services administers a five-year plan, the Montana Strategic Suicide Prevention Plan, dated January 2001.

Nebraska: Nebraska participated in the August 1999 Region VII conference and formed the state's first action groups in suicide prevention planning. Facing geographic and fiscal challenges, Nebraska has commenced suicide data collection statewide among two of the Native American tribes as well as farming families. Awareness activities have begun, most notably in the Omaha school district, as Nebraska works to equip communities with the means and tools to prevent suicide.

Ohio: In May 2002, the Ohio Department of Mental Health in collaboration with the Ohio Coalition for Suicide Prevention, a grassroots organization of medical, mental health, and public health professionals, faith-community members and advocates, published Ohio's Suicide Prevention Plan.

Tennessee: Regional workshops were held in 1999 to develop the Strategy for Suicide Prevention in Tennessee. This strategy was submitted at the statewide Tennessee Suicide Prevention Conference in October 1999, at which the Tennessee Strategy for Suicide Prevention was adopted. The Tennessee Suicide Prevention Network Advisory Council referred recommendations to the Governor for approval on September 26, 2001.

Wisconsin: In May 2002, the Wisconsin Suicide Prevention Strategy was published. It was developed by the Wisconsin Department of Health and Family Services and the Division of Public Health and Division of Supportive Living. The Wisconsin Suicide Prevention Strategy lists goals and suicide intervention objectives based on scientific evidence. Currently, there is no funding for the suicide prevention initiative in Wisconsin.

B. STATES WITH YOUTH SUICIDE PREVENTION PLANS

Louisiana: The Louisiana Youth Suicide Prevention Plan is titled S.T.A.R. (S-Suicide Prevention for Louisiana Youth, T-Training of Gatekeepers, A-Awareness and Advocacy, and R-Resources, Recommendations and Resolutions) Plan. Through legislation, Louisiana established a program of suicide prevention in the public schools and proclaimed September 16-22 to be Yellow Ribbon Youth Suicide Prevention and Awareness Week.

Maine: The Maine Youth Suicide Prevention Program was developed using the recommendations of a grassroots-based gubernatorial task force and research literature. The task force included Commissioners and senior staff from the Departments of Human Services; Education; Mental Health, Mental Retardation and Substance Abuse Services; Corrections; and Public Safety. The Program was designed to work within existing systems in the schools and communities. Program goals are to reduce the incidence of suicide behavior among Maine youth aged 10-24 and to improve youth access to appropriate prevention and intervention services. In 2001, the Program had a budget of $250,000.

New Hampshire: New Hampshire formed the Youth Suicide Prevention Advisory Assembly and its projects have received funding primarily from the New Hampshire Department of Health and Human Services.

New Mexico: New Mexico's Department of Health initiated a Youth Suicide Prevention Plan in September 1999, which includes a School Mental Health Initiative on Suicide Prevention/Intervention. These Policies and Procedures for School Based Health Centers are designed to ensure the safety of students, to facilitate positive change in students' lives, and to assist schools in crisis management.

North Dakota: The North Dakota Adolescent Suicide Prevention Task Force and the North Dakota Department of Health completed the state plan in 2000. Implementation has been funded through state funds of $75,000 per year.

Oklahoma: Oklahoma completed its state plan and the legislature created the Youth Suicide Prevention Council in July 2001. The council oversees implementation of the state plan and provides technical assistance to communities in implementing and evaluating suicide prevention activities.

Oregon: Oregon developed a plan for youth suicide prevention based on national suicide prevention strategies, public input received at statewide community forums, and "best practices" research on suicide prevention that was made public in December 2000. The lead agencies in implementing the statewide plan are the Oregon Health Division and the Office of Mental Health Services. The Oregon plan will serve as a guide for communities in organizing, implementing, and monitoring the implementation of prevention strategies. Gatekeeper training, movie trailer public service announcements, depression screening and referral, and informational brochures for teachers on child and adolescent depression are examples of community initiatives and partnerships that were stimulated by the planning process.

Washington: Washington has a State Plan for Adolescent Suicide Prevention that is in its sixth year of funding and implementation. The program is supported through the Washington State Department of Health and receives state general funding in the amount of $500,000 for the 2001-2003 biennium.

VII. COMMUNITY ACTION

As noted by former Surgeon General David Satcher, "Most of these [state] plans recognize that much of the work of suicide prevention must occur at the community level, where human relationships breathe life into public policy. American communities are also home to scores of faith-based and secular initiatives that help reduce risk factors and promote protective factors associated with many of our most pressing social problems, including suicide."[16] Recognizing the importance of community action, the Third Annual Virginia Suicide Prevention, Intervention and Healing Conference was held on May 2-3, 2002, in Virginia Beach. The Virginia Suicide Prevention Council and DMHMRSAS with support from VDH sponsored the conference. Sponsors included Gail and Fred Fox, Solvay Pharmaceuticals, The October Center for the Study and Prevention of Youth Violence at VCU, Action Alliance for Virginia's Children and Youth, Friends of Loudoun County Mental Health, Kristin Brooks Hope Center, and the National Hopeline Network 1-800-SUICIDE (784-2433). Approximately 125 individuals from around the Commonwealth participated in regional planning sessions. The conference attendees were divided into groups representing the state's five health planning regions. The purpose of these sessions was to develop a plan to implement the NSSP and the Virginia Youth Suicide Prevention Plan on a regional level.

[16] NSSP, p. 2.

In preparation for the sessions, Margaret Crowe of the Action Alliance for Virginia's Children and Youth and James B. Vetter, Ed.M., of VDH distilled the elements of the NSSP and the State Plan into eight focus areas:

- Leadership
- Public awareness and public support (including the general public and media awareness)
- Specific population-based prevention strategies
- Community-based mental health services (including crisis intervention and ongoing services)
- Clinician training
- Access to lethal means
- Evaluation and research
- Funding

Members of the Virginia Suicide Prevention Council from the region facilitated each session. Participants discussed resources in their region and gaps in services for each of these eight focus areas.

Despite the differences among many of the regions, two common priorities emerged.

1. Public awareness was identified as a top priority in each of the regions. Reducing the stigma of mental illness to encourage people to seek help is a major goal of public awareness activities. The regions expressed interest in making use of the public education materials that are available at no cost at the national level.
2. Another priority was to develop regional leadership around the issue of suicide prevention. Some regions have existing task forces/coalitions in certain areas, but other areas are not currently included. Other regions wished to start regional coalitions. Maintaining communication among coalitions/leaders was an important goal; regions suggested starting regional listservs and creating a web page for each region on the VDH website. Developing a system to disseminate statewide goals and information about suicide prevention resources should be a priority for any statewide plan.

While each region included individuals from diverse organizations and backgrounds, each acknowledged that all necessary participants were not yet at the table. Some areas of the state were not represented (far southwest), and participants from some areas stated that they had no resources currently available for suicide prevention efforts (southside).

VIII. RECOMMENDATIONS

To address the issue of suicide prevention across the life span, the following recommendations are made:

1. Building on the momentum from the May 2002 Virginia Suicide Prevention, Intervention and Healing Conference, the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, should lead an interagency and cross-secretarial effort to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth. Agencies that should participate in this effort include the Departments of Health; Mental Health, Mental Retardation and

Substance Abuse Services; Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; and Corrections; the Department for the Aging; and any other state agency that has a specific interest, responsibility or role in the development of the plan.

2. The Department of Health and the Department for the Aging should be the agencies responsible for actually developing this plan, supporting the Secretary's efforts. The Departments of Mental Health, Mental Retardation and Substance Abuse Services; Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; and Corrections should provide assistance to the Department of Health, the Department for the Aging, and the Secretary's Office in the development of this plan.

3. All affected stakeholders should be involved in the development of this plan. Stakeholders include public and private service providers (e.g., suicide crisis hotlines, mental health services agencies), local correctional facilities, family members and survivors, advocacy groups, the faith community, medical professionals, the media, and first-line responders (e.g., emergency medical technicians). Public hearings should be conducted around the state to solicit input from and participation by stakeholders and other interested parties.

4. The plan should be completed by October 1, 2004 and presented to the Governor and the General Assembly for their consideration and possible action during the 2005 legislative session.

5. The plan should address suicide prevention across the life span with a special emphasis on effective strategies to prevent suicide among adolescent and elderly Virginians and all other identified high-risk populations.

6. In developing the plan, previous planning efforts in Virginia and in other states, as well as the National Strategy for Suicide Prevention, should be reviewed and applicable recommendations, goals, objectives, and strategies should be integrated into this new comprehensive plan.

7. The plan should identify workable and effective organizational structures at the state and regional or local levels to implement the recommendations in the plan.

8. The plan should establish Virginia's public policy regarding the prevention of suicide, identify the lead agency responsible for carrying out that policy, propose initiatives and interventions to effectively operationalize that policy, and identify the sources and amounts of resources to implement those initiatives and interventions.

9. Finally, the plan should identify a permanent oversight body to monitor the implementation of the plan. This oversight body should report annually on December 1 to the Governor and the General Assembly on the prevention of suicide in the Commonwealth. This report should identify any new initiatives or interventions and the resources necessary to implement them to enhance the Commonwealth's efforts to prevent suicide.

APPENDICES

SENATE JOINT RESOLUTION NO. 108

Directing the Joint Commission on Behavioral Health Care, or its successor in interest, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Department of Health, to develop a plan and strategy for suicide prevention in the Commonwealth.

Agreed to by the Senate, March 6, 2002
Agreed to by the House of Delegates, March 5, 2002

WHEREAS, the General Assembly of 1999 directed the Virginia Department of Health and the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the magnitude of the problem of deaths by suicide in the Commonwealth; and

WHEREAS, that study, reported to the General Assembly of 2000, resulted in the formation of a task force by both departments and a Youth Suicide Prevention Plan developed by the Commission on Youth; and

WHEREAS, that plan was partially funded by the 2000 General Assembly; and

WHEREAS, a subsequent study by the Virginia Department of Health found that from 1996 through 1998, 2,387 Virginians died by suicide and 13,992 Virginians were treated for self-inflicted injuries; and

WHEREAS, more than 179 of those deaths by suicide occurred among youth or people under age 20 and 2,208 suicides were completed by adults; and

WHEREAS, during the same years, 1,404 Virginians died by homicide and 5,594 were treated as a result of assault; and

WHEREAS, in July 1999 the United States Surgeon General released a Call to Action for Suicide Prevention followed by the National Suicide Prevention Strategy in May 2001; and

WHEREAS, Virginia is recognized as a leader in the fight to prevent youth suicide, and federal grants may be made available to Virginia and other states with approved suicide prevention plans; and

WHEREAS, the Youth Suicide Prevention Plan can be expanded to address the serious public health problem of suicide across the human life span and to develop a strategy for implementing these plans as recommended by the United States Surgeon General; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Behavioral Health Care, or its successor in interest, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Department of Health, be directed to develop a plan and strategy for suicide prevention in the Commonwealth.

The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Department of Health shall also provide technical assistance for the study. All agencies of the Commonwealth shall provide assistance to the entity directed to conduct this study, upon request.

The Joint Commission on Behavioral Health Care, or its successor in interest, shall complete its work by November 30, 2002, and shall submit its written findings and recommendations to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Interagency Youth Suicide Prevention Coordinating Committee

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Crisis Centers Operating Hotlines in Virginia Localities[12]

Contact Information	Hotline Services	AAS Membership/Certification
Arlington CrisisLink of Northern Virginia P.O. Box 7563 Arlington, VA 22207-0563 t)703.527.6603 f)703.516.6767 www.crisislink.org	Hotline 24 hours/7 days 703.527.4077 TTY & TTD	Certified *yes* Member *yes*
Blacksburg New River Valley Community Services-ACCESS Services 700 University City Blvd. Blacksburg, VA 24060 t)540.961.8400 f)540.961.8469	Hotline 24 hours/7 days 540.961.8400 888.717.3333 toll free	Certified *no* Member *no*
Bristol Crisis Center P.O. Box 642 Bristol, VA 24203 t)540.466.2218 f)540.466.5481	Hotline 24 hours/7 days 540.466.2312 540.628.7731 Washington Co.	Certified *no* Member *no*
Charlottesville Madison House 170 Rugby Rd. Charlottesville, VA 22903 t)804.977.7051 f)804.977.7339	Hotline 24 hours/7 days-school year 804.295.8255	Certified *no* Member *no*
Danville Contact Crisis Line Danville/Pittsylvania Cty P.O. Box 41 Danville, VA 24543-0041 t)804.793.4940 f)804.792.4359	Hotline 8am - 10pm 804.792.4357	Certified *no* Member *no*
Dumfries ACTS Helpline P.O. Box 74 Dumfries, VA 22026 t)703.368.4141 f)703.368.6544	Hotline 24 hours/7 days 703.368.4141 703.368.6544 Spanish M-F 6p-10p 703.368.8069 Teen Line	Certified *no* Member *yes*

[12] As of October 30, 2001. Sources: American Association of Suicidology, National Hopeline Network.

Contact Information	*Hotline Services*	*AAS Membership/Certification*
Fredricksburg Fredricksburg Area Hotline, Inc. P.O. Box 7132 Fredricksburg, VA 22404 t)540.371.1212	Hotline 24 hours/7 days 540.371.1212	Certified *no* Member *no*
Lynchburg The Crisis Line of Central VA P.O. Box 3074 Lynchburg, VA 24503 t)804.947.5921 f)804.947.5501	Hotline 24 hours/7 days 804.947.4357 888.947.9747 toll free 888.947.7277 teen talk 888.299.7277 teen talk	Certified *yes* Member *yes*
Martinsville Contact Martinsville-Henry Co. P.O. Box 1287 Martinsville, VA 24114-1287 t)540.638.8980 f)540.632.6133	Hotline 24 hours/7 days 540.632.7295 540.634.5005 teen line 540.694.2962 Patrick Co. 540.489.5490 Franklin Co.	Certified *no* Member *no*
Newport News Contact Peninsula P.O. Box 1006 Newport News, VA 23601 t)757.244.0594 f)757.245.4707	Hotline 24 hours/7 days 757.245.0041	Certified *no* Member *no*
Norfolk The Crisis Line of the Planning Counsel P.O. Box 3278 Norfolk, VA 23514-3278 t)757.622.1309 f)757.622.7259	Hotline 24 hours/7 days 757.622.1126	Certified *yes* Member *yes*
Roanoke Trust: Crisis Hotline & Shelter 404 Elm Ave. Roanoke, VA 24016 t)540.344.4691 f)540.344.4695	Hotline 7 days 540.344.1948 8a-12a 540.982.8336 teen line 6p-10p	Certified *no* Member *no*
Winchester Concern Hotline, Inc. P.O. Box 2032 Winchester, VA 22601 t)540.667.8208 f)540.667.8239	Hotline 24 hours/7 days 540.667.0145 Winchester Co. 540.459.4742 Shenandoah Co. 540.635.4357 Warren Co. 540.743.3733 Page Co.	Certified *no* Member *no*

Suicide Prevention Funding Allocations by Source, 2000-2005

Virginia Department of Health

Fiscal Year	General Funds	Federal Block Grant Funds	CDC Special TIIP Funds**
FY 2000	0	0	0
FY 2001	$75,000	0	0
FY 2002	$75,000	$115,000*	0
FY 2003	$75,000	unknown	$322,000
FY 2004	unknown	unknown	$322,000
FY 2005	unknown	unknown	$322,000

* One-time Title V Maternal and Child Health block grant carry-forward funds.
** Centers for Disease Control and Prevention Funds restricted to special Targeted Injury Intervention Program suicide prevention activities.

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

Fiscal Year	General Funds	Federal Block Grant Funds
FY 2000	0	0
FY 2001	$75,000	0
FY 2002	$75,000	$10,000*
FY 2003	$26,000	unknown
FY 2004	unknown	unknown
FY 2005	unknown	unknown

* One-time Substance Abuse Prevention and Treatment Block Grant Funds.

Virginia Youth Suicide Prevention Plan
Summary of Recommendations

Universal Prevention Strategies

1 – VDH Lead Entity for Youth Suicide Prevention in Virginia

"Amend the Code of Virginia to designate VDH as the lead entity for youth suicide prevention in Virginia and require reporting to the Governor and the General Assembly on the status of suicide prevention initiatives".

2 – Statewide Public Awareness

"Increase funding for VDH and DMHMRSAS for their development and/or adoption of materials and dissemination of youth suicide prevention information throughout the Commonwealth".

3 – Media Education

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

4 – School-based Strategies

"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".

Selective Prevention Strategies

5 – Gatekeeper Training

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

6 – Licensing/Certification Requirement

"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".

7 – Comprehensive Mental Health Services

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

8 – Community-based Crisis Intervention and Support Services

"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".

Indicated Strategies

9 – Comprehensive Mental Health Services for At-Risk Children and Youth

"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".

10 – Education for Clinicians/Other Working with At-Risk Youth and Their Families

"DMHMRSAS and VDH, in cooperation with university medical centers, health sciences 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".

Surveillance and Evaluation Strategies

11 – Adolescent Suicide Attempt Data Collection System

"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".

12 – External Cause of Injury Reporting

"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".

13 – Comprehensive Evaluation

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

14 – Appropriating Funds

"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."

National Strategy for Suicide Prevention:

Goals and Objectives for Action

Summary List

Awareness

1. Promote **awareness** that suicide is a public health problem that is preventable.

2. Develop **broad-based support** for suicide prevention.

3. Develop and implement strategies to **reduce** the **stigma** associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Intervention

4. Develop and implement suicide **prevention programs**.

5. Promote efforts to **reduce access to lethal means** and methods of self-harm.

6. Implement **training** for recognition of at-risk behavior and delivery of effective treatment.

7. Develop and promote effective **clinical and professional practices**.

8. Improve access to and community linkages with **mental health and substance abuse services**.

9. **Improve reporting and portrayals** of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.

Methodology

10. Promote and support **research** on suicide and suicide prevention.

11. Improve and expand **surveillance** systems

For more information on suicide prevention in Virginia, contact:
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