REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES

Suicide Prevention Across The Life Span Plan for the Commonwealth of Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

COMMONWEALTH of VIRGINIA

Office of the Governor

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MEMORANDUM

TO: The Honorable Mark R. Warner, Governor
The General Assembly of Virginia

FROM: Jane H. Woods
Secretary of Health and Human Resources

DATE: October 26, 2004

RE: Senate Joint Resolution 312 (2003)
Suicide Prevention Across the Life Span for the Commonwealth

The 2003 General Assembly, through Senate Joint Resolution 312, requested that the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, formulate a comprehensive Suicide Prevention Across the Life Span for the Commonwealth.

Enclosed for your review and consideration is the report prepared in response to this request. All affected stakeholders listed in the legislation were involved in the development of this plan.

P.O. Box 1475 • Richmond, Virginia 23218

Preface

Authority
Senate Joint Resolution 312 (2003) requests the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention across the Life Span Plan for the Commonwealth.

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Executive Summary

Introduction

In 2003, the General Assembly agreed to Senate Joint Resolution 312 requesting the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention across the Life Span Plan for the Commonwealth. The General Assembly directed the Department of Health (VDH) and the Department for the Aging (VDA) to develop the plan, with participation from the Departments of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; and any other state agency with an interest, responsibility, or role in suicide prevention.

The Suicide Prevention across the Lifespan Plan was developed with the input of stakeholders from around the Commonwealth, through research into national and state resources, and with guidance and review by an Interagency Committee. The goals from the National Strategy for Suicide Prevention (National Strategy), developed by the United States Department of Health and Human Services in 2001, were adapted to Virginia and form the basis for the Virginia goals. One of the National Strategy's objectives is to "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." This plan, with emphasis on the entire lifespan, responds to this objective.

Epidemiology of Suicidal Behaviors

In 2002, there were 792 suicides in the Commonwealth, or about two suicides per day, for an age-adjusted rate of 10.8 suicides per 100,000 people.[i] It was the eleventh leading cause of death among all Virginians and the third leading cause of death for youth. Twice as many people died from suicide in Virginia as compared to homicides. Suicides occur in all areas of Virginia. The highest rates are in rural areas, primarily in the Southwest and West Piedmont areas. Firearms are the major means chosen by those who die by suicide; suffocation (mostly by hanging) is the second most common method, followed by drugs and gases.[a] For every suicide, there are about 25 suicide attempts; suicide attempts are three times more common in women than in men.[b] In the U.S., about 90 percent of people who completed suicide had a mental illness, including alcohol and/or substance use disorders and some had multiple diagnoses.[c] Therefore, in this country, the problem of suicide is inextricably linked to the issue of mental health and substance abuse.

[i] Age-adjusted rates are standardized to a common population age distribution, in this document, the Year 2000 U.S. population. This allows for comparison among populations in spite of differing age distributions.

The Institute of Medicine, in its landmark report, Reducing Suicide: A National Imperative, summarizes risk factors for suicide succinctly:

> Risk factors associated with suicide include serious mental illness, alcohol and drug abuse, childhood abuse, loss of a loved one, joblessness and loss of economic security, and other cultural and societal influences. Resiliency and coping skills, on the other hand, can reduce the risk of suicide. Social support, including close relationships, is a protective factor.[d]

and

> Converging evidence across disciplines indicates that suicide is related to stress: developmental and adult trauma; cumulative stressors, including multiple morbidities; acute and chronic social and cultural stressors; and capacity to cope with stress. Suicide can be considered an expected outcome of a significant subgroup of mentally ill patients who experience accumulative life stresses, just as cardiac infarction is an expected outcome of untreated high blood cholesterol.[e]

Effective Strategies

In the field of suicide prevention, a widely used model for grouping strategies is the Universal, Selective, and Indicated prevention model. ***Universal*** strategies are designed to reach all the members of a community or population. ***Selective*** strategies are targeted for the population groups at higher risk for becoming suicidal, for example, those with undiagnosed and untreated mental health conditions and aim at preventing the onset of suicidal behaviors. ***Indicated*** strategies are intended to prevent suicide among those most at risk for suicide and showing early signs of suicide potential, such as people who have attempted suicide.

Integrated programs combine universal, selective and indicated strategies. Program evaluations have indicated the effectiveness of this approach; there is also compelling logic to this strategy. Why increase public awareness without having adequate services and community support to help those most in need? Strengthening mental health services is valuable when coupled with actions that reduce barriers toward utilization of services.

Summary of Plan

Leadership Development and Infrastructure

Goal 1: Develop broad-based support for suicide prevention.
Objectives:

- Establish state-level oversight and leadership by assigning the Department of Mental Health, Mental Retardation and Substance Abuse Services as the lead agency.
- Identify and support strong regional and/or local coalitions.
- Identify sustainable and reliable funding for basic suicide prevention functions.
- Increase awareness of and support by state and local leaders.

Goal 2: Improve and expand surveillance systems.
Objectives:

- Systematically collect, analyze and disseminate data measures and reports to constitute the Virginia Suicide Prevention Surveillance System.
- Increase the number of localities regularly conducting suicide follow-back studies.
- Promote and support national efforts to standardize data collection methods.

Goal 3: Promote and support research, including evaluation, on suicide and suicide prevention.
Objective:
- Increase applied research in Virginia on suicide prevention.

Awareness

Goal 4: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
Objective:
- Increase the percentage of the population who recognize the importance of disclosing mental health symptoms to family, friends, or health care professionals and obtaining care for these problems.

Goal 5: Promote Awareness that Suicide is a Public Health Problem that is Preventable.
Objective:
- Conduct a public information campaign on the problem of suicide.

Intervention

Goal 6: Develop and implement community-based suicide prevention programs.
Objectives:
- Reduce the suicide rate in those planning districts with high male suicide rates.
- Establish effective programs aimed at population groups at high-risk for suicide.
- Integrate suicide prevention components in more community programs.

Goal 7: Promote efforts to reduce access to lethal means and methods of self-harm.

Objective:
- Reduce the rate of self-inflicted suicide firearm deaths.

Goal 8: Implement training for recognition of at-risk behavior and delivery of effective treatment.
Objectives:
- Increase the number of trained gatekeepers.
- Increase the number of education programs for family members and others in close relationships with those at risk for suicide.

Goal 9: Develop and promote effective clinical and professional practices.
Objectives:

- Increase the proportion of primary care practices with systems to assure accurate diagnosis, effective treatment, and follow-up for suicidal behaviors, depression, substance misuse, and other mental health conditions.
- 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.
- Increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.
- Increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.
- Increase the proportion of institutional settings that apply guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior.

Goal 10: Increase access to and community linkages with mental health and substance abuse services.
Objectives:

- Increase the proportion of the population with insurance coverage for mental health and substance abuse services.
- Expand local mental health services, especially in areas with high suicide rates.
- Improve integration and coordination among organizations/agencies including health, mental health, and spiritual.

Goal 11: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.
Objective:

- Identify and inform the media of inappropriate portrayal of or reporting on suicides, suicidal attempts, and mental illness.

Financial and Staffing Resources Envisioned for Plan Implementation

In an attempt to quantify the additional resources that would be necessary for implementation of the Suicide Prevention across the Life Span Plan for the Commonwealth, input was solicited from the members of the Interagency Committee. Committee members were asked to review the plan and estimate the amount of resources their agency would need to address the objectives that were relative to their agencies' work. Responses were received from Virginia Department of Health's Center for Injury and Violence Prevention and Office of the Chief Medical Examiner, Virginia Department for the Aging and Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. In total, the preliminary estimate of the additional resources needed to implement the objectives listed in the Suicide Prevention across the Life Span Plan for the Commonwealth is $307,470 in fiscal year 2006 and $4,814,633 in fiscal year 2007.

Introduction

In 2003, the General Assembly agreed to Senate Joint Resolution 312 requesting the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth (Appendix A). The General Assembly directed the Department of Health (VDH) and the Department for the Aging (VDA) to develop the plan, with participation from the Departments of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; and any other state agency with an interest, responsibility, or role in suicide prevention. The General Assembly expected the plan to:

- Address suicide prevention across the life span.
- Place special emphasis on effective strategies to prevent suicide among adolescent and elderly Virginians and other high-risk populations.
- Integrate applicable goals, objectives and strategies from the National Strategy for Suicide Prevention as well as previous planning efforts in Virginia and other states.
- Establish the Commonwealth's public policy regarding the prevention of suicide.
- Identify the lead agency responsible for carrying out that policy.
- Propose the creation of a permanent oversight body to monitor the implementation of the plan.
- Propose initiatives and interventions to effectively implement that policy.
- Identify the sources and amounts of resources to implement those initiatives and interventions.

The Suicide Prevention Plan was developed with the input of stakeholders from around the Commonwealth, through research into national and state resources, and with guidance and review by an Interagency Committee.

Input was first obtained through the **Third Annual Virginia Suicide Prevention, Intervention and Healing Conference**, held in May 2002. At that conference, approximately 125 individuals from around the Commonwealth participated in regional planning sessions (Appendix C). Participants, who were divided into five groups by Health Planning Region, were asked to identify priorities for each region, using the National Suicide Prevention Strategy and Virginia Youth Suicide Prevention Plan as a basis.

In the fall of 2003, the Virginia Department of Health contracted with Virginia Commonwealth University to hold focus groups to obtain input on critical issues in suicide prevention and recommendations for action (Appendix C). Participants in the focus groups included representatives from law enforcement agencies, public school systems, mental health agencies, community services boards, health departments, hospitals, nonprofit organizations, a variety of community services agencies, and the Interagency Suicide Prevention Coordinating Committee. In addition, two sessions were

held with college and university staff and a faith-based group to gain information on specific training needs.

The goals from the National Strategy for Suicide Prevention, developed by the United States Department of Health and Human Services in 2001, were adapted to Virginia and form the basis for the Virginia goals. The plan also addresses outcome objectives from the national objectives, the Healthy People 2010 Objectives, and the corresponding Virginia Healthy People 2010 Objectives (Appendix H). Healthy People 2010 is the prevention agenda for the nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

One particularly valuable resource was the Institute of Medicine's landmark review, Reducing Suicide: A National Imperative, published in 2002.[g] This comprehensive review of the literature and knowledge-base on suicide prevention relied on the analysis of many national experts in the field, both in the medical and social sciences. Additionally, Virginia suicide prevention plans, studies, grant applications, legislation, data, and published literature were resources used for the development of the plan.

History of Statewide Suicide Prevention Efforts in Virginia

In 1987, in response to the growing problem of suicide among youth, the General Assembly established a Joint Subcommittee to study the causes of suicide among children and youth and to develop strategies to implement effective youth suicide prevention programs. A report was completed in 1988 and was followed in 1989 by a similar report, this time focusing on suicide among the elderly. In 1990, the Department for the Aging presented a Suicide and Substance Abuse Prevention Plan for the Elderly. It was not until 2001 that a Youth Suicide Prevention Plan was prepared by the Virginia Commission on Youth. A key recommendation of this plan was the designation of the Virginia Department of Health as the lead agency for youth suicide prevention. The *Code of Virginia* was modified that same year to reflect the recommendation and the new biennium budget included an appropriation, for each year, of $150,000, to the Departments of Health and Mental Health, Mental Retardation and Substance Abuse Services. Staff was hired at each agency to initiate youth suicide prevention activities: statewide training, development and distribution of materials, and organization of statewide conferences. Major funding, in the form of a grant from the Centers for Disease Control and Prevention, was secured by VDH.

Also in 2001, the National Strategy for Suicide Prevention: Goals and Objectives for Action was released which examined the problems and provided national goals and objectives to prevent suicide across the lifespan. One of its objectives is to "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." This plan, with emphasis on the entire lifespan, responds to the national objective.

Major Suicide Prevention Accomplishments since 1988 in Virginia and Significant National Events

1988

- Report by the Joint Committee Studying Youth Suicide Prevention in response to the growing problem of youth suicide.

1989

- Report by the Virginia Department for the Aging (VDA) on suicide and substance abuse among the elderly.

1990

- Statewide Suicide and Substance Abuse Prevention Plan for the Elderly by the Department for the Aging.

1994

- Local child death review teams established in the Piedmont Region, Fairfax County, and Hampton Roads.

1995

- Virginia State Child Fatality Review Team was established by the General Assembly. The multidisciplinary review team systematically analyzes, among other fatalities, child suicides to determine if the deaths could be prevented and to make recommendations for education, training, and prevention.

1999

- Surgeon General's Call to Action to Prevent Suicide.
- Virginia legislation passed directing the Board of Education, in cooperation with the DMHMRSAS and the VDH, to develop guidelines for licensed school personnel to use in contacting parents or, if conditions warrant, the local or state services agency when they believe a student to be at imminent risk for attempting suicide.
- Suicide Prevention Guidelines written and disseminated to school personnel by the DOE.

2000

- Appropriation of $75,000 each to VDH and DMHMRSAS for each year of the 2000-2002 Biennium for activities to be conducted in response to the Youth Suicide Prevention Plan.
- A Study of Suicide in the Commonwealth by the Virginia Department of Health.
- Report on *Suicide Fatalities among Children and Adolescents in Virginia 1994-95,* by the State Child Fatality Team.
- Healthy People 2010, national goals and objectives, by the U.S. Department of Health and Human Services.

2001

- National Strategy for Suicide Prevention: Goals and Objectives for Action.
- Youth Suicide Prevention Plan by the Virginia Commission on Youth, with the assistance of the VDH; DMHMRSAS and the Department of Education. The plan recommends, among other items, amending the *Code of Virginia* to designate the Virginia Department of Health as lead agency for youth suicide prevention and increasing funding for both VDH and DMHMRSAS for youth suicide prevention activities.
- Report by the Virginia State Crime Commission on personalized handguns.
- VDH is designated as lead agency for youth suicide prevention in the Commonwealth, by amendment to the *Code of Virginia* (§32.1-73.7). VDH is mandated to report annually to the Governor and the General Assembly on its youth suicide prevention activities.
- DMHMRSAS initiated the proclamation of Childhood Depression Awareness Day, declared by the Governor on May 8, 2001.
- Interagency Youth Suicide Prevention Coordinating Committee formed by VDH with representation from DMHMRSAS, DOE, community services boards, and local health departments.
- Virginia Youth Suicide Prevention Advisory Committee established to advise DMHMRSAS on mental health recommendations from the Youth Suicide Prevention Plan.

- The Virginia Suicide Prevention Council is established as a public private partnership.
- Position of Youth Violence Prevention Consultant filled by the Center for Injury and Violence Prevention at VDH.
- Applied Suicide Intervention Skills Training (ASIST) and Question, Persuade, Refer (QPR) training initiated by VDH and DMHMRSAS.

2002

- Suicide prevention award of $966,992 over three years to VDH by the Centers of Disease Control and Prevention. VDH's efforts focus on training and distribution of materials to promote early recognition of the warning signs of depression and suicide in order to provide active intervention and referral of those who may have a tendency toward suicide.
- Third Annual Virginia Suicide Prevention, Intervention and Healing Conference held, sponsored by DMHMRSAS, Virginia Suicide Prevention Council, and VDH.
- Senate Joint Resolution No. 108 directs the Joint Commission on Behavioral Health Care, in cooperation with DMHMRSAS and VDH, to develop a plan and strategy for suicide prevention in the Commonwealth.
- Funding received to implement the National Violent Death Reporting System in Virginia, which will link information on violent deaths from sources such as forensic pathology, law enforcement, forensic science and vital records.
- DMHMRSAS initiated the proclamation of Childhood Depression Awareness Day declared by the Governor on May 7, 2002.
- Website on suicide prevention created by VDH (www.preventsuicideva.org).
- Report on *Suicide Associated Deaths and Hospitalizations, Virginia 2000*, by the Center for Injury and Violence Prevention, VDH.
- Report on *Child Death in Virginia: 2001*, by the Virginia State Child Fatality Review Team.

2003

- Developing a Plan and Strategy for Suicide Prevention in the Commonwealth by the Joint Commission on Behavioral Health Care. Main recommendation is to charge the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to lead an interagency and cross-secretarial effort to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth.
- Senate Joint Resolution 312 was passed by the General Assembly. It requests the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth.
- Suicide Prevention Guidelines revised to include criteria for following up with parents of students expressing suicidal intentions after initial contact has occurred.
- Interagency Youth Suicide Prevention Coordinating Committee's name is changed to Interagency Suicide Prevention Coordinating Committee and is expanded to cover the lifespan and representation broadened to include the Virginia Department for the Aging, the Virginia Commission on Youth, and the Department of Corrections.
- Regional Planning Sessions for Suicide Prevention held in Abingdon, Lynchburg, Arlington, Prince William County, and Norfolk and with representatives of faith-based organizations, higher education institutions, and with the Interagency Suicide Prevention Coordinating Committee.

Epidemiology of Suicidal Behaviors in Virginia

In 2002, the latest year for which data are available, there were 792 suicides in the Commonwealth, or about two suicides per day, for an age-adjusted rate of 10.8 suicides per 100,000 persons.[i] It was the eleventh leading cause of death among all Virginians and the third leading cause of death for youth. Twice as many died from suicide in Virginia as compared to homicides.[h] In 2001, Virginia's suicide rate ranked 31st highest in the nation.[i] The national target is 5.0 suicides per 100,000 by the year 2010.[j]

For every suicide, there are about 25 suicide attempts; thus there were about 19,800 suicide attempts in 2002 in Virginia. Suicide attempts are three times more common in women than in men. Also, each suicide intimately affects at least 6 other people.[k]

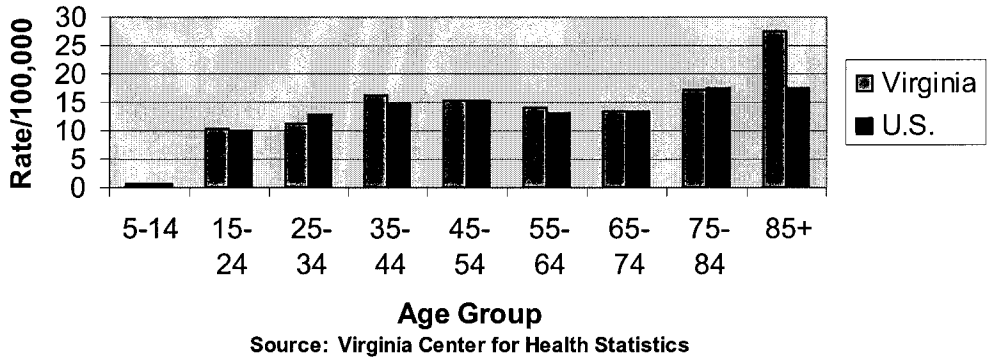
In 2002, the 792 suicides can be broken down as follows:

- 617 (78%) were suicides by males
- 535 (68%) of the suicides were by 25 - 64 year olds
  - 341 (64%) of these suicides were by white males
- 490 (62%) were deaths by firearms
  - 422 (86%) of the suicides by firearms were by males

Comparisons with National Rates

Suicide rates for Virginia in 2001 were very similar to those for the U.S., with the exception of the elderly aged 85 and over (Figure 1). The 2000-2002 average for this age group in Virginia was 37% higher than the national rate for 2001.

Figure 1: Age-Specific Suicide Rates, Virginia and U.S., 2001



Source: Virginia Center for Health Statistics

[i] Age-adjusted rates are standardized to a common population age distribution, in this document, the Year 2000 U.S. population. This allows for comparison among populations in spite of differing age distributions.

Trends

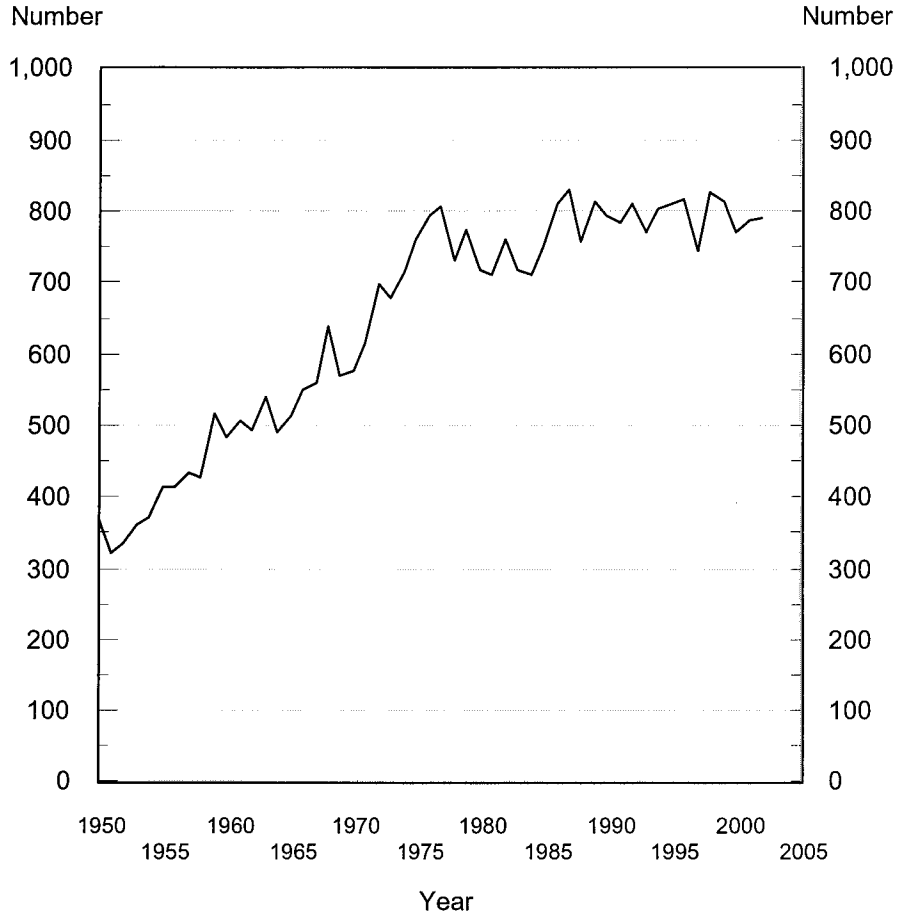
While the number of suicides in Virginia has risen by a third since 1970, it has stabilized since 1990 (Figure 2). Suicide death rates rose rapidly between 1950 and the mid-70s but have since declined by about 30% such that in 2002, the rate was similar to that of the mid-1950s (Figure 3). The suicide rate to 45-64 year olds has declined dramatically: since 1975, the rate has halved. Suicide rates for 20-44 year olds and 65-74 year olds have each declined since 1975 by 31%. The suicide rates of 15-19 year olds has remained relatively stable, however the rate for 2002 (5.8/100,000) is the lowest since 1975 – this rate will have to be monitored to see whether it indicates the beginning of a downward trend. The rate for the elderly ages 75 and over fluctuates greatly but both the rates for 75-84 year olds and for those 85 and over do not appear to have changed much during the past 28 years (Charts 1 to 10 in Appendix E)[1]. Rates for white males and females have declined since 1975 but for non-white males and females show little change (Figure 4).

Geographic Distribution

Suicides occur in all areas of Virginia. The highest rates are in rural areas, primarily in the Southwest and West Piedmont areas. For the most recent four-year period (1999-2002), Appendix F shows the cities/counties and planning districts with at least 20 suicides over a four-year period and rates at least as high as the Virginia rate. In descending order, the counties of Buchanan, Scott, Russell, Wise, Lee, Dinwiddie, Pulaski, and Tazewell had suicide rates at least 1.75 times the state rate and accounted for 232 suicides (7% of total) over a 4-year period. Lenowisco (Planning District 1) and Cumberland Plateau (Planning District 2) had rates at least twice as high as the state rate and the rate of West Piedmont (Planning District 12) was at least 1.5 times the state rate. Mount Rogers (Planning District 3) and the Roanoke Area (Planning District 5) had rates that were 1.25 times higher. Outside of these Planning Districts, Dinwiddie, Louisa, Culpeper, Isle of Wight, Shenandoah and Warren counties had similarly high rates. Together, the suicides in these areas accounted for 25% (786 suicides) of the total during those four years. Fairfax County had the highest number of suicides, at 274 over a 4-year period, but with a rate well below the state rate (7.0/100,000).

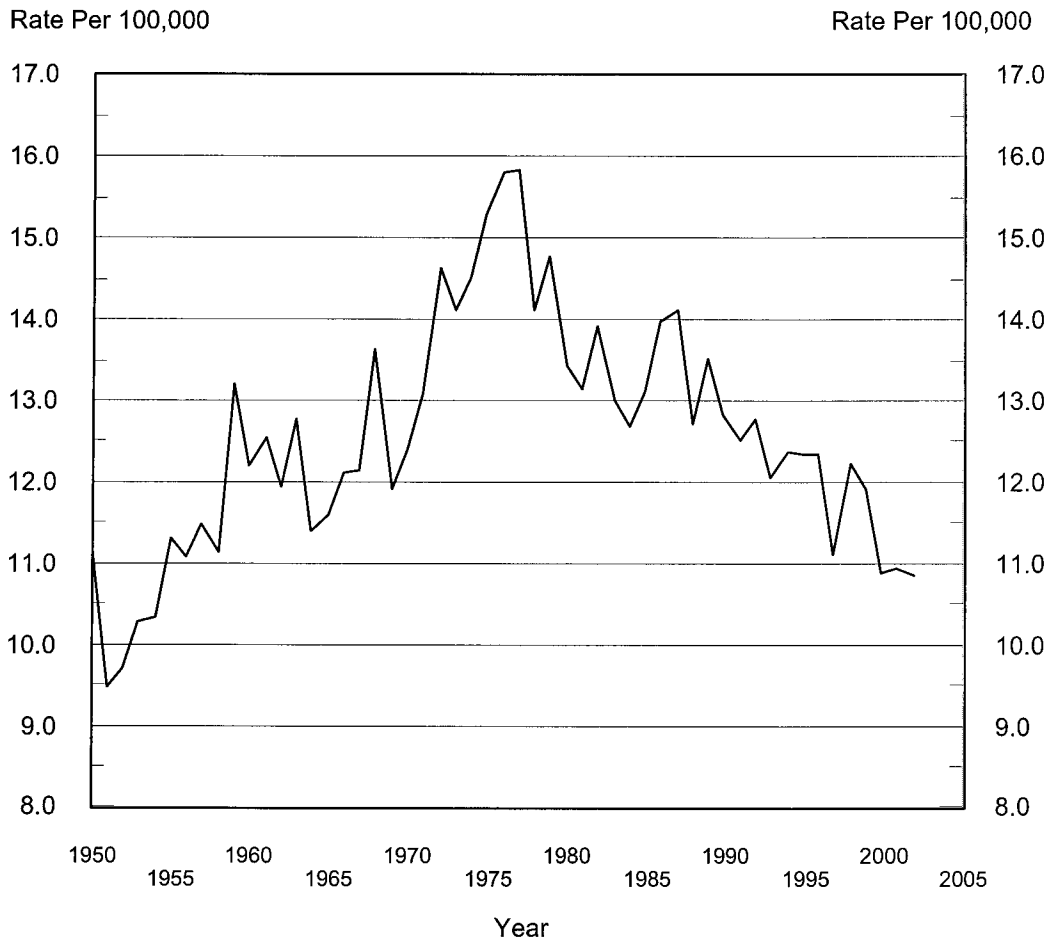
[1] Rates for ages 85 and over, 1975 – 2002: The straight-line descriptor of the rates has a slight positive slope: it rises from 18.9/100,000 in 1975 to 22.9/100,000 in 2002. However, it fails conventional probability tests as a descriptor, indicating no increase during those years.

Figure 2
Total Resident Deaths From Suicide
Virginia, 1950-2002



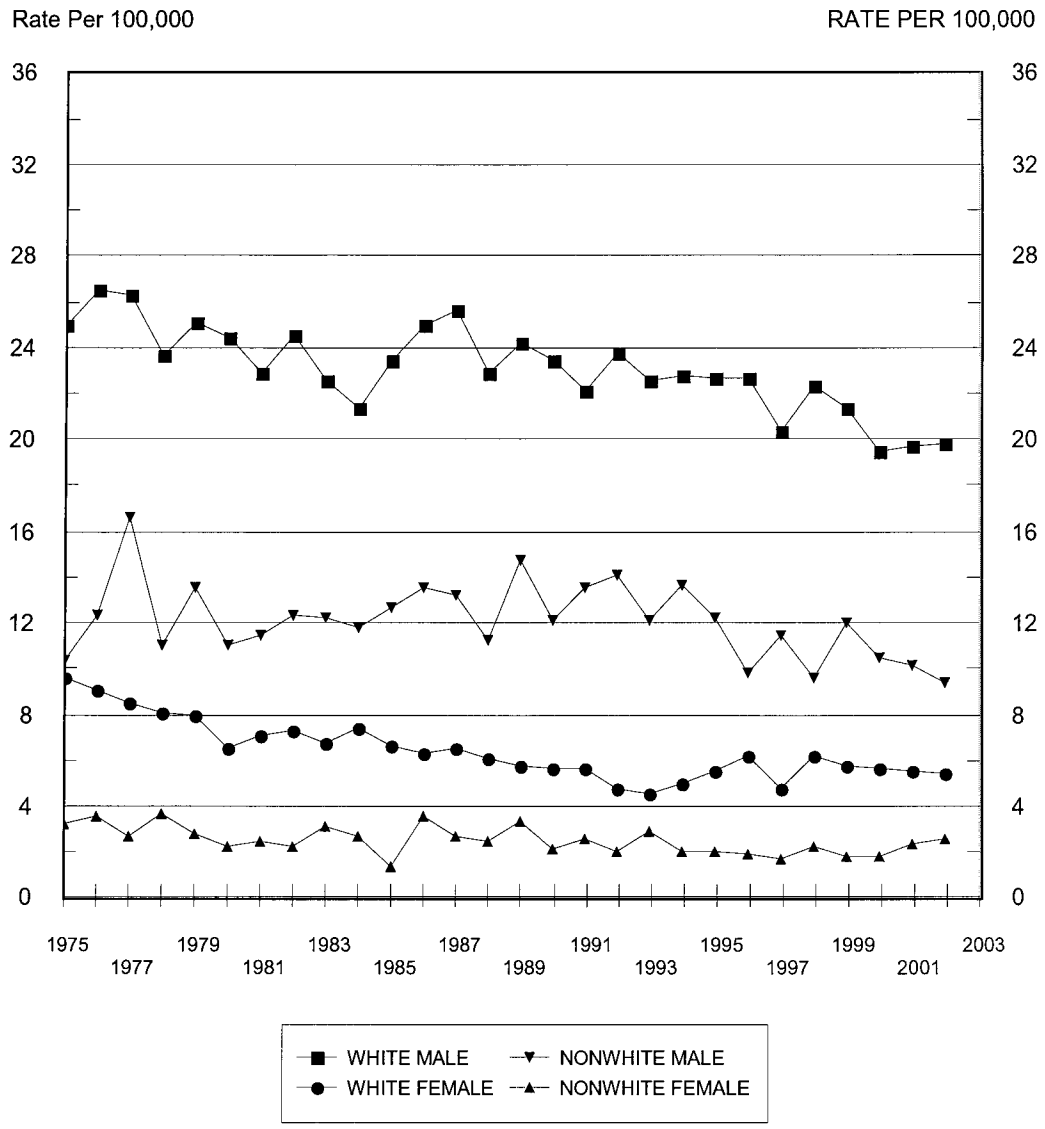
SOURCE: Virginia Center For Health Statistics

Figure 3
Total Resident Death Rates From Suicide
Virginia, 1950-2002



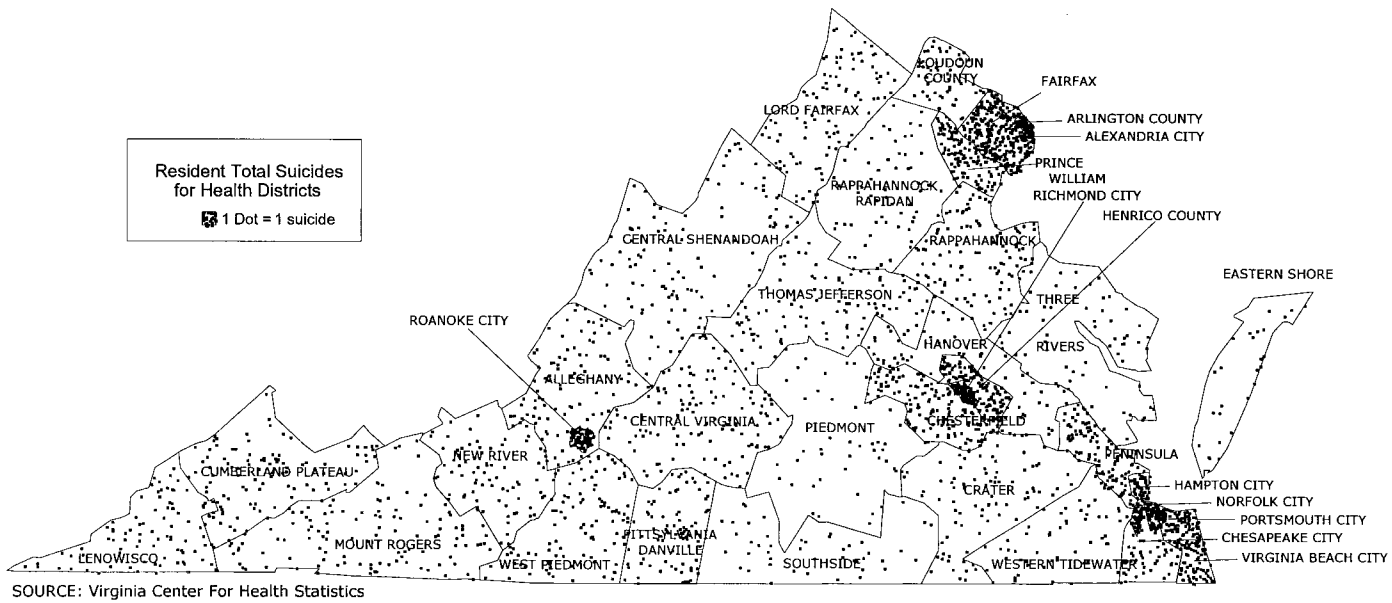
The Rates Are Per 100,000 Population of the U.S. Census and the VA State Data Center
SOURCE: Virginia Center For Health Statistics

Figure 4
Resident Suicide Death Rates By Race And Sex
Virginia, 1975-2002



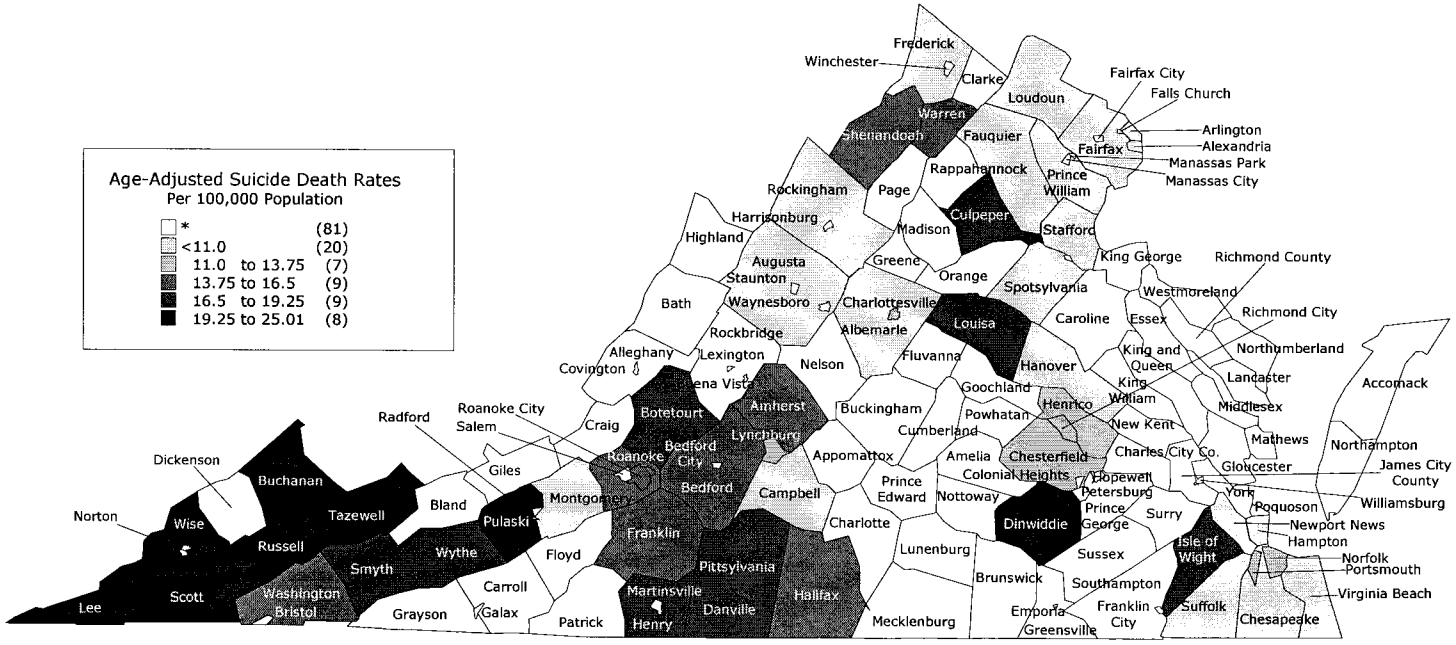
SOURCE: Virginia Center For Health Statistics

Figure 5: Resident Total Suicides for Health Districts in Virginia, 1999-2002



SOURCE: Virginia Center For Health Statistics

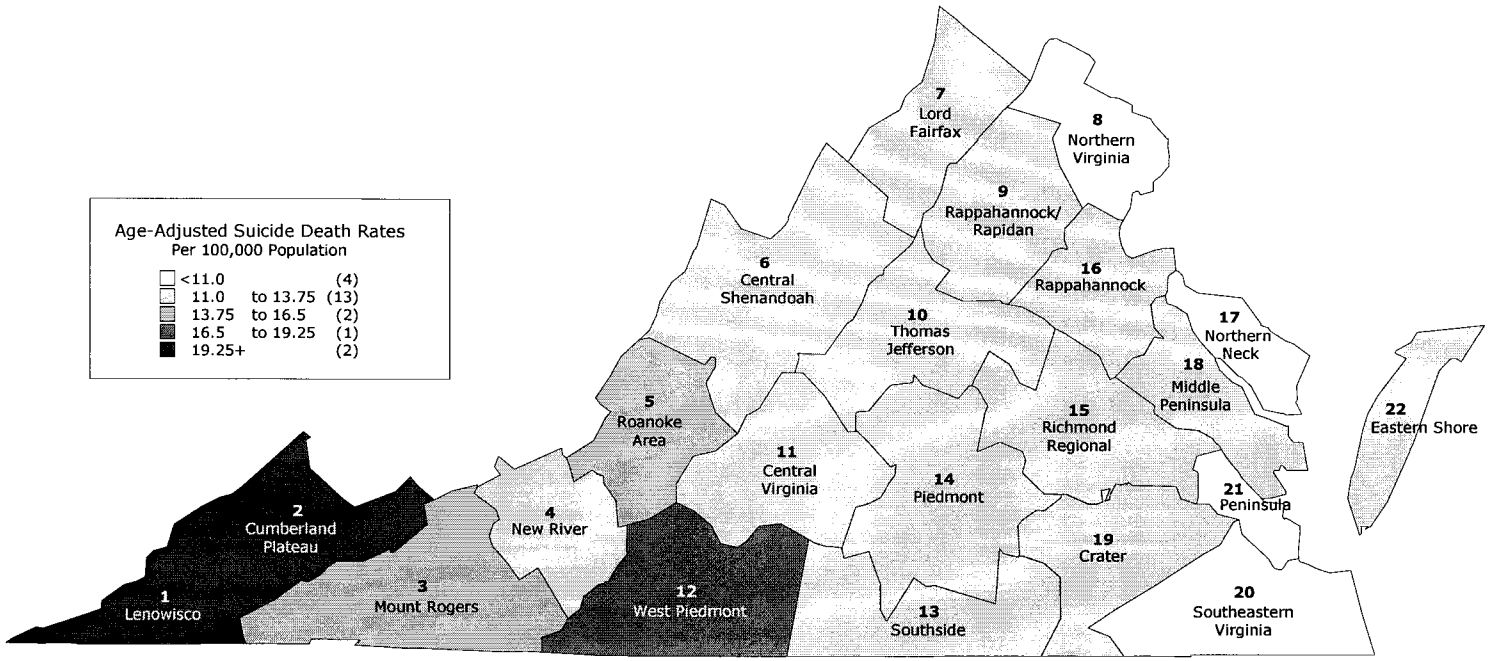
Figure 6: Resident Age-Adjusted Suicide Death Rates Per 100,000 Population By City and County Virginia, 1999-2002



Source: Virginia Center for Health Statistics

* Number of cases too small (<20) to calculate reliable rate
Note: 11.0/100,000 is the age-adjusted rate for Virginia

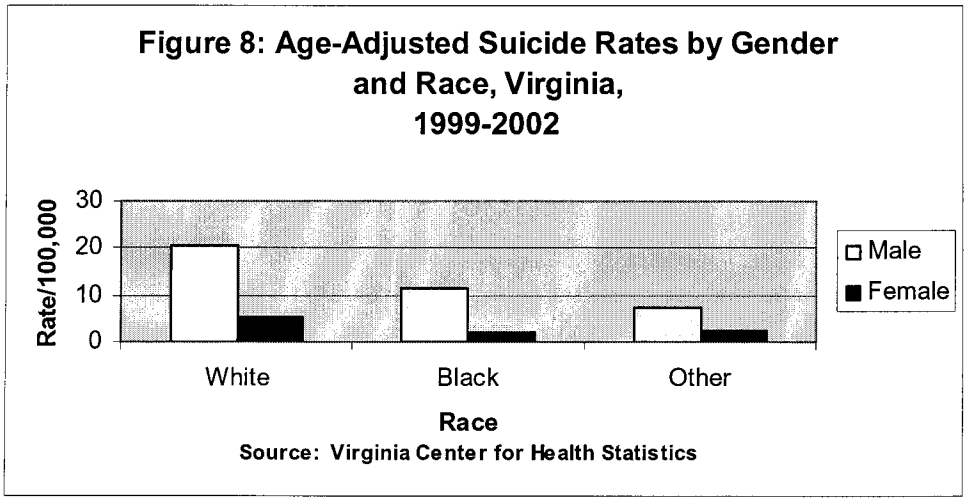
Figure 7: Resident Age-Adjusted Suicide Death Rates Per 100,000 Population By Planning District Virginia, 1999-2002



Source: Virginia Center for Health Statistics
Note: 11.0/100,000 is the age-adjusted rate for Virginia

Gender and Race

In 1999-2002, males in Virginia had age-adjusted suicide rates that were four times higher than those of females (18.6 and 4.6 respectively). The rate for white males was highest, 20.7 as opposed to 11.4 for black males. Black females had the lowest rates, at 2.1 and the rate for white females was 5.4 (Figure 8).



The pattern of suicide over the lifespan is strikingly different among the four major race/gender categories[i]. Among white males, the suicide rates rise steadily through age fifty-four; thereafter they rise dramatically and peak for those ages 85 and over. By contrast, the suicide rate peaks twice for black males: between 20 and 34 years and then again among those ages 85 and over. Between the ages of 5 and 34, the rates for both white and black males are similar. The rates for females are relatively low throughout the lifespan but reach the highest point between the ages of 35 - 44 for white females and 35 - 54 for black females. The rates for black females are very low: the highest rate for any age group is 4.1/100,000 (Figure 9).

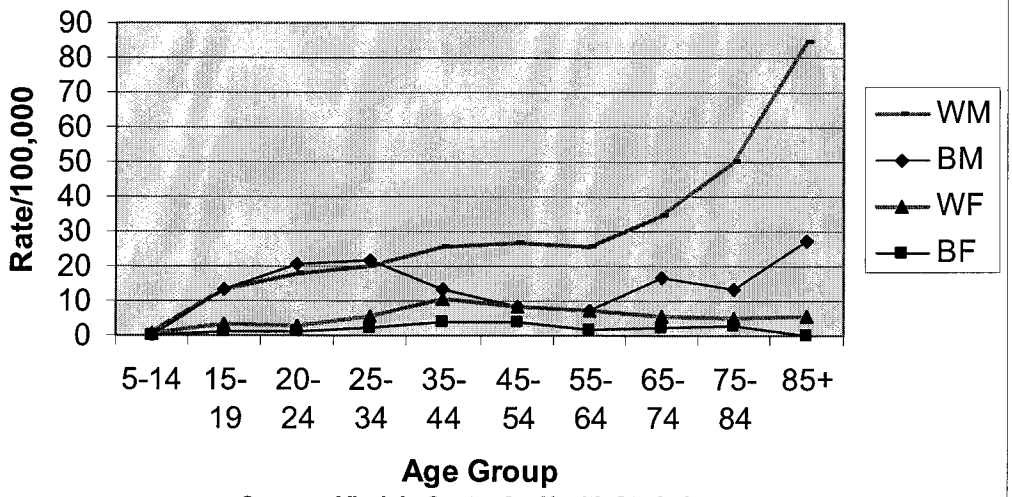
Mechanism of Suicide

In all age groups, firearms are the major means chosen by those completing suicide. Most recently, suffocation (mostly hanging) has become a more common means among 10-14 year olds nationally.[1] In Virginia, suffocation (mostly by hanging) is the second most common method, followed by drugs and gases (Figure 10).

[i] Rates for other race categories are available, but the numbers are so small that they are not deemed reliable.

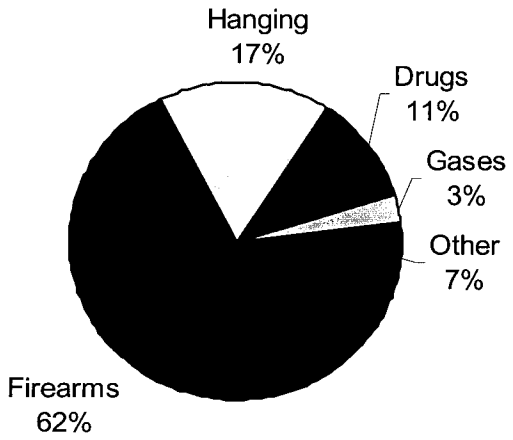
Since 1988, the suicide rate by firearms and gases has declined by 23% and 64% percent, respectively. The rate of suicide by suffocation, though, has risen during this same period. Suicide by drugs has fluctuated (Figure 11).

Figure 9: Age-Specific Suicide Rates by Race and Gender, Virginia, 1999 - 2002



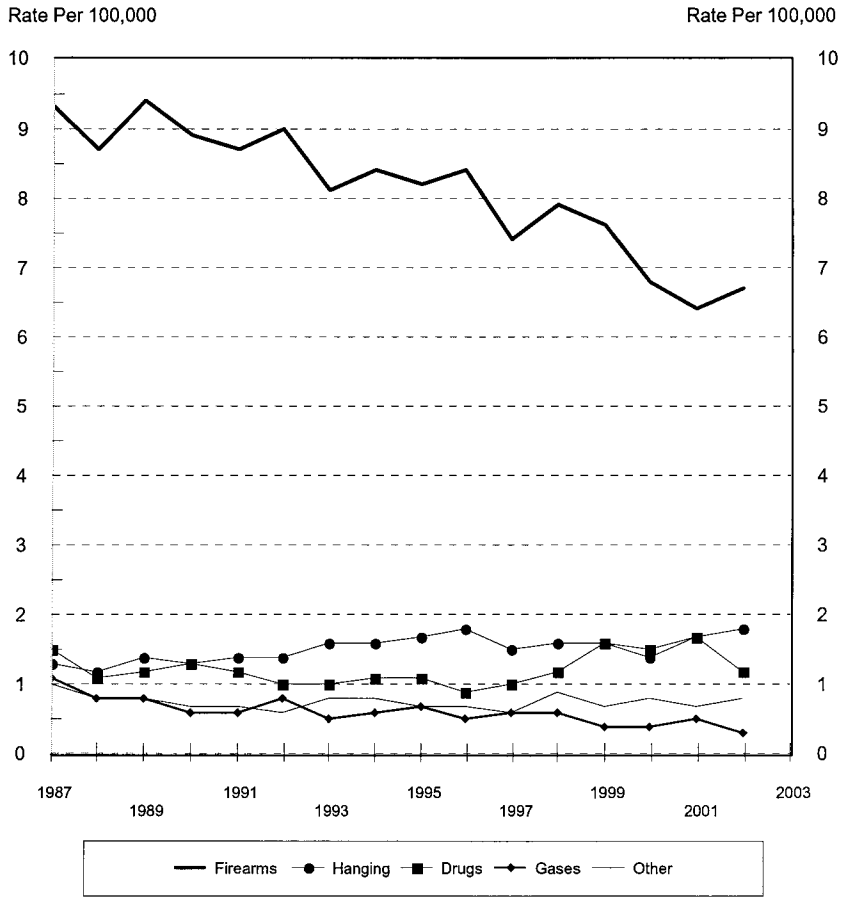
Source: Virginia Center for Health Statistics

Figure 10: Mechanism of Suicide, Virginia, 2002



Source: Virginia Department of Health

Figure 11
Resident Suicide Death Rates By Method
Virginia, 1987-2002



SOURCE: Virginia Center For Health Statistics

Suicidal Behaviors

For the first time in 2003, the Virginia Department of Health, in collaboration with the Centers for Disease Control and Prevention, included questions on suicidal behavior in the annual Behavioral Risk Factor Surveillance System, a random telephone survey of adults ages 18 and older. Table 1 shows the percentage of respondents reporting various suicidal behaviors and the estimated number of adults in Virginia who would expect to exhibit these behaviors based on the reported percentages.

Table 1: Estimated Prevalence of Self-Reported Suicidal Behaviors, Among Adults Ages 18 and Over in Virginia, 2003

Suicidal Behavior	Frequency (%)	Estimated No. of Adults in Virginia with Behavior, 2003
Seriously considered attempting suicide	**3.0**	**166,802**
Serious plan to attempt suicide	**1.4**	**77,841**
Attempted suicide	**0.5**	**27,800**
Suicide attempt that required medical attention	**0.2**	**11,120**

Source: Behavioral Risk Factor Surveillance System, Virginia Department of Health, 2004

In addition, nearly 2% of the surveyed adults reported suffering from depression, anxiety, or an emotional problem that limited their activities. Of those women who had a baby in the past year, 12.7 percent said they had felt sad or blue before pregnancy, 30.4% reported this feeling during pregnancy, and 38% after pregnancy.[m]

The Centers for Disease Control and Prevention conducts a national survey of youth in grades nine through twelve in public and private schools. This survey includes questions to determine risk behaviors, including questions about sadness, hopelessness, and suicidal thoughts and behaviors. Data specific to Virginia is unavailable from this study. Results from most questions are available since 1991 and indicate[n]:

- Nearly 30% of youth have felt sad and hopeless for two weeks or more during the past year, such that they have stopped some usual activities. This feeling is higher among females (33%) than males (20%). Among Hispanic females, this percentage is particularly high – 45% in 2003.
- Overall, 17% of youth seriously considered attempting suicide in 2003, with a higher percentage among females (21%) than males (13%), although the rate for black females is lower (15%).
- Fewer youth seriously considered suicide in 2003 (17%) as compared to 1993 (24%). This finding is consistent among all females and white males. Among minority males there appears to be a decline, but it may not be significant.
- Close to 9% of youth attempted suicide during the past year. The percentage was over twice as high among females (11.5%) than males (5%) and was lowest among white male youth (4%) and highest among Hispanic females (15%).
- Three percent of youth reported attempting suicide in the past twelve months and required medical attention as a result. These attempts appear to be somewhat higher among minority youth.
- Although data for youth of other (neither white, black nor Hispanic) are available, the rates are based on small numbers and are generally not reliable.

Data on suicidal behaviors is also available from Virginia Poison Centers and from hospital discharge reports. In 2003, 5,705 (called suicidal poison exposures) were reported to Virginia Poison Centers, for an average of 16 calls per day. Two-thirds of the callers were female and one-fourth were children and youth under the age of twenty. Ninety-three percent of callers were exposed in their own residences. Among 6-19 year olds, the most common types of exposures among callers were to analgesics (37%), antidepressants (15%), sedatives/antipsychotics/hypnotics (10%), cough and cold preparations (6%), and antihistamines (5%). Among adults 20 years or older, the most common exposures were to sedatives/antipsychotics/hypnotics (22%), analgesics (22%), antidepressants (16%), alcohols (9%), and antihistamines (4%)[o].

Self-inflicted injuries resulted in 4,210 hospitalizations in Virginia in 2002 and accounted for 11.4% of all injury-related hospitalizations. Self-inflicted injuries accounted for 13.6% of the injury hospitalizations for females and 9% of the injury hospitalizations for males. When considering age, certain patterns of hospitalization occur. The 15-34 year age group experienced the highest percentage of all injury hospitalizations attributable to self-inflicted injuries (Appendix G). For example, 12.7% of all those hospitalized for injury in Virginia were 15-19 year olds who were hospitalized for self-inflicted injuries, while only 3.3% of all those hospitalized for injury were those 65 years of age and older who were hospitalized for self-inflicted injuries. Similar conclusions can be drawn when analyzing the proportion of injury hospitalizations within a particular age group that were attributable to injury. About a quarter of all injury hospitalizations experienced by those 15-44 were due to self-inflicted injury (Appendix G) in comparison to the elderly for whom self-inflicted injuries are an insignificant percentage (1%) of injury hospitalizations.

Risk and Protective Factors[i]

In the U.S., about 90 percent of people who completed suicide had a mental illness, including alcohol and/or substance use disorders and some had multiple diagnoses. About 50% of those who completed suicide were not in treatment. Those who were in treatment often were not adequately medicated, sufficiently followed after acute treatment, and/or did not adhere to treatment. However, over 95% of those with mental disorders never attempt or complete suicide. Among those who attempt suicide, 30-90% have a depressive disorder and up to two-thirds are intoxicated with alcohol. Therefore, in this country, the problem of suicide is inextricably linked to the issue of mental health and substance abuse.

About 28-30% of the US population has a mental or addictive disorder, but only about a third of those with mental illness receive treatment. In 1997, a national survey found that in children and adolescents ages 6 to 17 years with mental health problems severe enough to indicate a clinical need for mental health evaluation, 79% did not receive a mental health evaluation or treatment in the past year.[p] Barriers to receiving treatment include

[i] Unless otherwise noted, the source of information for this section from Institute of Medicine. 2002. *Reducing Suicide: A National Imperative.* Washington, D.C.: National Academy Press.

stigma, limited insurance coverage, fragmentation of services, and low availability of services, especially in rural areas and communities with large minority populations.

Care to people with mental health problems is provided by mental health providers but also primary care practitioners and the clergy. Older adults, African Americans, and Hispanic Americans more often seek help for mental health issues, including suicide, from clergy rather than from mental health professionals. About half of people with depression and other mental disorders obtain mental health treatment in primary care settings. Nearly 75% of persons dying by suicide see a medical professional within their last year of life. About 40% of these people had contact with a primary care provider within a month of their death; 20% within a week before suicide. Among older people, 70% saw a health professional within a month of the suicide.

Researchers have identified patterns of high risk for suicide during certain periods of treatment, such as immediately after discharge from a hospital and early in treatment, before consistent drug and therapy treatments have been established.

Specific diagnoses associated with suicide attempts include:

- 30-90% with depressive disorder. As compared with the population as a whole, those with major depressive disorder have a 40 times higher risk of suicide.
- 30% with a personality disorder, in particular borderline personality (BPD) and antisocial personality disorders. Although BPD affects 2% of adults; 40-90% of people with BPD have attempted suicide.
- 25% with an alcohol abuse disorder. As compared to a psychiatrically healthy population, those with this disorder have 115 times greater risk of suicide.
- 20% with anxiety disorders, including post-traumatic stress disorder
- 5% with schizophrenia; they have 40 times greater risk of suicide than the population as a whole.
- 5% with bipolar disorder. This condition affects about 1.2% of the population but 25-50% of those with this disorder will attempt suicide at least once.
- Mood disordered individuals with impulsive aggression are at much greater risk for suicidal behavior than are those without this characteristic.

However, not all suicides or persons who attempt suicide have a mental health condition. A recent study found a significantly higher likelihood of suicide attempts, independent of effects of mental disorders, among people suffering from lung disease, ulcer, and AIDS with the number of physical illnesses related to an increased odds of suicide attempt.[q]

Specific protective and risk factors associated with suicide are presented in the charts below. Of particular note is the relationship between childhood trauma and suicidal behaviors. In a review of multiple studies, it was found that adults with a history of childhood physical and sexual abuse were 1.3 to 25 times more likely than adults without a past history to attempt suicide. Conversely, from 20-49 percent of child sexual abuse victims do not exhibit noticeable symptoms. The most common outcomes of sexual or physical abuse are depression and post-traumatic stress disorder but also include impaired social attachments, low self-esteem, substance abuse, and delinquent behavior. In

particular, childhood sexual abuse is a risk factor in about 9-20 percent of suicide attempts. This abuse is more likely when parents are depressed or substance abusers.

New biological research is showing a link between chronic stress, impulsivity, genetic inheritance and suicidal behaviors. Eventually, this research could help practitioners identify and follow patients who may be at most risk for suicidal behaviors. For example, irregularities of the hypothalamic-pituitary-adrenal axis, one of the body's primary stress response systems that becomes dysfunctional after trauma, such as abuse or chronic stress, are associated with suicide, independent of psychiatric diagnosis. Low levels of the neurotransmitter serotonin, associated with increased impulsive aggression, have been found in the brains and cerebrospinal fluid of serious suicide attempters and suicide victims.

Risk factors vary across the lifespan. For example, youth are more likely to exhibit irritability, acting out behaviors, and anger rather than exhibiting sad and depressed affect. Suicide victims under 30 are more likely to have problems with substance abuse, impulsive aggressive personality disorders, and precipitants such as interpersonal and legal problems than those over 30. Among the elderly, widowhood, serious medical illness, and social isolation are risk factors. In the U.S., the highest suicide rate is among bereaved elderly white men.

The Institute of Medicine, in its landmark report, Reducing Suicide: A National Imperative, summarizes risk factors for suicide succinctly:

> Risk factors associated with suicide include serious mental illness, alcohol and drug abuse, childhood abuse, loss of a loved one, joblessness and loss of economic security, and other cultural and societal influences. Resiliency and coping skills, on the other hand, can reduce the risk of suicide. Social support, including close relationships, is a protective factor.[r]

and

> Converging evidence across disciplines indicates that suicide is related to stress: developmental and adult trauma; cumulative stressors, including multiple morbidities; acute and chronic social and cultural stressors; and capacity to cope with stress. Suicide can be considered an expected outcome of a significant subgroup of mentally ill patients who experience accumulative life stresses, just as cardiac infarction is an expected outcome of untreated high blood cholesterol.[s]

Protective Factors

- Effective clinical care for mental, physical and substance use disorders.
- Easy access to a variety of clinical interventions and support for help-seeking.
- Restricted access to highly lethal means of suicide.
- Strong connections to family and community support.
- Support through ongoing medical and mental health care relationships.
- Skills in problem solving, conflict resolution and nonviolent handling of disputes.
- Cultural and religious beliefs, including those that discourage suicide and support self preservation.

Adapted from Risk and Protective Factors for Suicide, Suicide Prevention Resource Center, www.sprc.org

Risk Factors for Suicide

Biopsychosocial Risk Factors:

- Mental disorders, particularly mood disorders, especially depression, and schizophrenia, anxiety disorders and certain personality disorders.
- Alcohol and other substance use disorders.
- Hopelessness.
- Impulsive and/or aggressive tendencies.
- History of trauma or abuse, in particular sexual abuse.
- Some major physical illnesses.
- Previous suicide attempt.
- Family history of suicide.

Environmental Risk Factors:

- Job or financial loss; low socio-economic status.
- Relational or social loss, such as divorce or death.
- Easy access to lethal means.
- Local clusters of suicide that have a contagious influence.

Sociocultural Risk Factors:

- Lack of social support and sense of isolation.
- Stigma associated with help-seeking behavior.
- Barriers to accessing health care, especially mental health and substance abuse treatment.
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma).
- Exposure to, including through the media, and influence of others who have died by suicide.

Adapted from USDHHS National Strategy for Suicide Prevention: Goals and Objectives for Action, 2001. Public Health Service, Rockville, MD.

High Risk Populations

High-risk populations are those that are known to have a higher than average suicide rate or rate of suicidal behaviors and risk factors. Based on the research, high-risk populations include:

For suicide

- Men
- Elderly men, in particular widowers
- Rural residents
- Unemployed youth who have dropped out of school
- Incarcerated populations – most often young white males arrested for non-violent offenses and intoxicated upon arrest, frequently within 24 hours of incarceration.
- Dentists, physicians, and nurses
- Mathematicians and scientists, artists and social workers
- Homosexual/bisexual males

Note: Although police have been cited as having higher risk for suicide, studies have shown inconsistent results.

Suicidal thoughts or attempts

- Women
- Youth, in particular females, especially Hispanic females

Effective Strategies[i]

In the field of suicide prevention, a widely used model for grouping strategies is the Universal, Selective, and Indicated prevention model. ***Universal*** strategies are designed to reach all the members of a community or population and include public education campaigns, changes in laws or policies to improve access to care or reduce access to means, strategies aimed at improving the reporting of suicides, and initiatives to improve student wellness, such as sports programs. ***Selective*** strategies are targeted for the population groups at higher risk for becoming suicidal, for example, those with undiagnosed and untreated mental health conditions, the elderly, victims of abuse, unemployed persons, and depressed youth. These initiatives aim at preventing the onset of suicidal behaviors. Examples include the training of those persons in positions of responsibility who are most likely to come into contact with the higher risk population (also referred to as "gatekeeper" training), screening and treatment for depression or substance abuse, and developing supportive networks for elderly widowers. ***Indicated*** strategies are intended to prevent suicide among those most at risk for suicide and showing early signs of suicide potential, such as people who have expressed an intent or attempted suicide. Effective treatment, follow-up and support are considered "indicated" strategies.

The Institute of Medicine report, Reducing Suicide: A National Imperative recognizes that, while the indicative strategies target the groups at highest risk for suicide, these initiatives are limited in their impact on reducing the incidence of suicide because of the low prevalence of many of the high-risk conditions, such as unipolar depression. In comparison, universal and selective strategies have the potential for influencing a larger percentage of the population, including those at high risk, and therefore have a higher chance of reducing suicides.

Demonstrating the effectiveness of suicide prevention initiatives is difficult. Suicides are rare events, so establishing program effectiveness demands very large numbers of participants or very long-term studies and similarly high funding levels. Suicide ideation can be used as an alternate measure, but it is unclear whether suicide ideation is a strong predictor of suicide. Definitional problems plague this area too as researchers use different definitions and tools to identify suicidal intent. Researchers also have shied

[i] Unless otherwise noted, the source of information for this section from Institute of Medicine. 2002. *Reducing Suicide: A National Imperative.* Washington, D.C.: National Academy Press.

away from conducting studies with individuals at risk for suicide because of liability concerns.

Selecting a particular strategy involves evaluating its appropriateness for the intended audience as well as the effectiveness as demonstrated by a rigorous evaluation. Negative effects can occur if adapting the intervention to a population other than the one for which it was designed. Moreover, when evaluating or designing a strategy for a particular group, the cultural norms, beliefs and behaviors or the group must be taken into account.

This section summarizes effective strategies in preventing suicide, suicidal behavior or risk factors that may be targeted to the population as a whole or to specific groups. It does not include a summary of effective medications or therapies that may be prescribed to individuals by clinicians, such as anti-depressants, lithium, or psychotherapy. This is not to minimize the effect of such methods; rather, summarizing such methods is beyond the scope of this document.

Integrated Programs

Integrated programs combine universal, selective and indicated strategies. While examples cited below demonstrate that such approaches can be effective, there is also compelling logic to the integrated approach. Why increase public awareness without having adequate services and community support to help those most in need? Strengthening mental health services is valuable when coupled with actions to reduce barriers toward utilization of those services. Common elements of effective integrated programs are an assessment of the problem that identified the particular risk factors of the community, an integrated program specifically designed to address that problem, and a high level of involvement by leadership.

United States Air Force Program After first conducting a comprehensive assessment of the suicide problem in the United States Air Force, a program was developed with the help of the Centers for Disease Control and Prevention. The program consisted of:

- Involving the Air Force leadership in raising the awareness of mental health and removing the stigma of seeking help for a mental health or psychosocial problem.
- Training personnel at all levels on skills and knowledge of basic suicide and violence risk factors intervention skills, and referral procedures and resources.
- Changing policies to promote help-seeking behaviors.
- Establishing a seamless system of human services and strengthening preventive mental health services.
- Establishing multidisciplinary teams to improve response to traumatic events.

The program evaluation was a quasi-experimental design comparing suicide rates before and after intervention, and controlling for changes in demographic variables. The researchers found a 33% decline in suicide rates and an 18-54% reduction in rates of moderate and severe family violence after program implementation. The authors cite the

possible application of this program to other controlled environments such as workplace settings, larger corporations, and schools and universities.[t]

Integrated Programs on U.S. American Indian Reservations Several integrated interventions to reduce high suicide rates have been used effectively in U.S. American Indian reservations. In one, after an assessment to identify the most predominant risk factors, a program was initiated involving the active and enthusiastic participation of the local tribal members, social and economic improvements, traditional Indian cultural enhancement programs, and increasing mental health services. The suicide rate fell from 173/100,000 in 1972-76 to 45/100,000 in 1981-84. In another community, the suicide rate fell from 267/100,000 to 26.7/100,000 after a program was put into place consisting of suicide awareness, prevention strategies, and a counseling program.

In summary, the Institute of Medicine report states:

> Programs that integrate prevention at multiple levels are likely to be the most effective. Comprehensive, integrated state and national prevention strategies that target suicide risk and barriers to treatment across levels and domains appear to reduce suicide.[v]

Reducing Access to Means

Universal strategies such as technological and legislative measures to reduce access to the means of suicide are considered to have the greatest potential impact because they do not rely on human compliance for their success. For example, introducing blister packs for storing acetaminophen was associated with a 21 percent decrease in overdoses and a 64 percent decline in severe overdoses, whereas overdoses due to benzodiazepines, which were not similarly packaged, remained stable.[w]

In three case-control studies, firearms were found to be between 31.1 and 107.9 times more likely to be used for the suicide if a gun was already in the home than if they were not in the home.[xy] It would seem logical to promote measures to restrict access to lethal means, or at least promote the safe storage of such means in the home, particularly in those where residents have severe mental health conditions.

Quasi-experimental studies have shown a relationship between enactment of gun control legislation and the suicide rate. Counseling by physicians on the removal of guns in the home has limited effectiveness. In one study, only 27% of parents who reported having guns in the home had removed the guns by a follow-up visit after counseling by a physician.[z]

Identifying those At Risk for Suicidal Behavior

Several instruments have been developed and evaluated to assess risk for suicidal behavior. In one, the most widely used Scale for Suicide Ideation (SSI), patients with a score above a 3 were about 6.5 more likely to complete suicide than those whose score

was below this level. Some scales work with some populations better than others so care must be made to select an instrument that is appropriate for the intended purpose and the particular cultural background, age, and gender of the patients.

Follow-up Care

The time immediately after a suicidal patient is discharged from a hospital is one of high risk for suicidal behavior. This may be due to poor adherence to medication but other factors include isolation, access to means, or loss of contact with a health professional. Some institutions have initiated and evaluated follow-up care by a health care provider. Several of these initiatives show promise, with demonstrated reductions in suicidal behavior as compared to a control group.

Programs Aimed at Preventing Youth Suicide

This section summarizes a number of programs or initiatives aiming to prevent youth suicide that have shown some effectiveness in changing knowledge, attitudes or behavior. Several other programs, for example, comprehensive school programs to address youth violence, are being evaluated but final results are not available.

Universal Strategies

Programs and policies that appear effective include:

- Increase in the legal drinking age. Between 1970 and 1990, in states with a minimum legal drinking age of 18 years, the suicide rate among 18-20 year olds was 8 percent higher than states where the minimum legal drinking age was 21.[aa]
- Broad school-based programs promoting mental health and resiliency that target multiple risk and protective factors and which include skills training in an environment with trained, supportive adults.
- Longer-term programs for youth that raise awareness of suicide prevention, develop skills to act on new attitudes and intentions, and include access to services.

Worth noting here is a conclusion reached in the Institute of Medicine report on universal strategies for youth:

> Given that many schools in the United States employ short-term, school-based suicide awareness interventions that may be ineffective and even potentially harmful, evaluation of various models and dissemination of those found safe and effective emerges as a priority. The most effective United States and international programs integrate suicide prevention into a competence-promotion and stress-protection framework, suggesting closer examination of health promotion as a prevention strategy. The evidence reviewed here supports carefully designed, science-based programs, particularly longer-term approaches couched in a broader context of teaching skills and establishing appropriate follow-through and services, as part of an effective armamentarium against

suicide. Brief, didactic suicide prevention programs with no connection to services should be avoided.[cc]

Selective Strategies

Effective strategies include:

- Skill-based, action-oriented training of motivated, responsible adults who come into regular contact with youth (gatekeeper training) can be effective in demonstrating appropriate helping competencies in simulations with youth at risk for suicide. Whether or not more suicidal youth are receiving treatment as a result of gatekeeper training has not been systematically evaluated.
- Youth at risk for suicide who were given personal competency training experienced a reduction in suicide-risk behaviors. For example, one program, Reconnecting Youth, trained youth at risk for school failure and found declines in depression, hopelessness, anger, and stress and significant gains in self-esteem and personal control.
- Early treatment for child abuse victims and early family-based interventions to reduce child abuse can be expected to reduce suicide since childhood sexual abuse is a risk factor in 9 – 20 percent of suicide attempts. Nurse home visitation programs to high risk mothers during pregnancy and infancy have been found to be effective in reducing childhood abuse and neglect when contrasted with a comparison group.
- Treatment for suicide risk factors such as depression and substance use, however it is not known if they specifically reduce suicide.

The American Academy of Pediatrics recommends that pediatricians screen adolescents for a history of sexual assault and potential sequelae[ee]. If effective, screening and treatment could potentially prevent incidents of suicide attempts and other negative consequences.

Indicated Strategies

Strategies falling under this grouping include family support training; case management and skill-building for high-risk individuals; and referrals resources for crisis intervention and treatment. Among high-risk youth, individualized assessment and counseling as well as small-group skills training were successful in reducing depression, hopelessness, and suicidal behaviors compared to a control group.

Programs Aimed at the Elderly

Primary care clinicians can play a key role in preventing suicide among the elderly, particularly as a high percentage of elderly suicide victims see their primary care physicians in the month prior to death. Major depression is the most common psychiatric disorder among elderly who have completed suicide. It follows that interventions promoting the screening and treatment of depression in the elderly by primary care clinicians should be evaluated. Results from one such indicated program, called

PROSPECT, tested the use of Health Specialists working with physicians as care managers to help them recognize depression, recommend treatment, and encourage adherence to treatment. Outcomes of two groups of elderly depressed patients were compared. The intervention was found to be effective, as compared to a control group, in reducing suicidal ideation and depression.[ff]

Programs Aimed at Detainees

A number of initiatives have been implemented in jails and prisons including staff education and skills training, changes in housing practices, changes in supervision, improved follow-up and reporting. However, these initiatives have not been evaluated.

Programs Aimed at Clinicians

Clinicians have an elevated risk for suicide. Since some of these clinicians would be expected to identify and treat or refer those with severe mental health conditions, it follows that reducing help-seeking barriers by clinicians is essential. A consensus statement recently published in the *Journal of the American Medical Association* recommends "transforming professional attitudes and changing institutional policies to encourage physicians to seek help."[gg]

The Suicide Prevention Plan for Virginia

The aims of the plan are to:

1. Prevent deaths due to suicide across the lifespan.
2. Reduce occurrence of other self-harmful acts.
3. Increase recognition of risk factors and improve access to care.
4. Promote awareness of suicide and reduce stigma of mental health.
5. Promote healthy community development, enhancing interconnectedness, resources, and resilience.

Leadership Development and Infrastructure

Goal 1: Develop Broad-based Support for Suicide Prevention.

Objective 1.1: **By 2006, establish state-level oversight and leadership for suicide prevention planning, implementation, monitoring, and evaluation by assigning the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) as the lead agency.**

Recommended Action

- Amend the *Code of Virginia* to assign leadership for the statewide suicide prevention initiative across the lifespan to the Department of Mental Health, Mental Retardation and Substance Abuse Services.
- Amend the *Code of Virginia* to assign oversight to the Joint Commission on Health Care concerning the *Virginia Suicide Prevention Plan across the Lifespan.*
- The Department of Mental Health, Mental Retardation, and Substance Abuse Services (lead agency) should form a Private/Public Suicide Prevention Steering Committee (hereafter referred to as the Steering Committee) to support the agency in implementing, monitoring, evaluating, and revising the *Plan* by coordinating strategies and promoting collaboration at the state, regional and local levels.
- The Department of Health should continue to provide leadership in implementing the *Youth Suicide Prevention Plan.*

Notes

The Department of Mental Health, Mental Retardation and Substance Abuse Services shall have responsibility for leading the implementation of the Virginia Suicide Prevention across the Lifespan Plan and for continuously monitoring implementation as well as evaluating and revising the plan. DMHMRSAS is recommended as the lead agency for this effort because a majority of the objectives of this plan address the issue of mental health services. While it is recommended that DMHMRSAS take the lead for implementing this plan, the sole responsibility for implementing the objectives of this plan does not fall solely on DMHMRSAS. This responsibility shall be coordinated with public and private agencies and organizations with missions related to the prevention of suicide, to include, at a minimum the Departments of Health, Aging, Education, Social

Services, Juvenile Justice, Criminal Justice Services, State Police, Corrections, Community Services Boards, health professional associations, colleges/universities, faith organizations, the Virginia Suicide Prevention Council, and representatives of local/regional coalitions. The Department of Health (VDH) has had the lead responsibility for youth suicide prevention since 2000. The Center for Injury and Violence Prevention at VDH is recommended to continue its leadership regarding youth suicide prevention due to its documented success in addressing the prevention of suicide among youth through its gatekeeper training and media campaigns. The collaborative relationships in the communities and other agencies that have been built by VDH are strong. By retaining the lead in youth suicide prevention and training, VDH will continue to build on its achievement as an established leader in Virginia for youth suicide prevention. The Joint Commission on Health Care shall annually review a report by the lead agency documenting the progress toward meeting plan goals, objectives, and recommended action; utilization of resources; need for additional resources; and other systems or legislative needs. The Joint Commission on Health Care shall submit an annual report to the Governor and General Assembly.

Objective 1.2: **By 2007, DMHMRSAS will identify and support strong regional and/or local coalitions to prevent suicide across the lifespan, particularly in areas with high rates and numbers of suicides.** Such coalitions will:

- Develop local/regional strategies, develop partnerships, seek funding, promote collaboration, coordinate services, and promote a seamless service delivery system.
- Convene regional and statewide training and networking events or conferences to help build awareness and increase networking opportunities.

Recommended Action

- Based on available data, DMHMRSAS and Steering Committee should identify areas where local coalitions and interventions are most needed.
- Leaders and organization representatives in each specified region/locality should form or identify a coalition to take on the leadership for suicide prevention.

Objective 1.3: **By 2008, the state and local/regional lead agencies will have identified and received sustainable and reliable funding for basic, ongoing suicide prevention functions.**

Recommended Action

- DMHMRSAS should seek designation of state and federal funds for basic staff functions in suicide prevention.
- The state and local/regional lead agencies should seek new and varied sources of funding such as government and foundation grants, and corporate support.

Objective 1.4: **By 2008, state and local leaders will be aware and supportive of suicide prevention efforts.**

Recommended Action

- State and local agencies and their partners should educate state, regional and local leaders on the problem of suicide and its prevention.

Goal 2: Improve and expand surveillance systems.

Objective 2.1: **By 2007, DMHMRSAS, in collaboration with the Steering Committee, will identify and begin systematically collecting, analyzing and disseminating data measures and reports that will constitute the Virginia Suicide Prevention Surveillance System.**

Recommended Action

- DMHMRSAS, in collaboration with the Steering Committee, should develop a surveillance plan for suicide prevention, to include the measures, frequency of collection and analysis, resource needs, and data sources. Such measures and data sources may include:
  - Time trends and geographical and population-specific patterns of suicides.
  - Awareness of the problem of suicide, its symptoms, and prevention strategies through population-wide surveys.
  - Attitudes about mental health and substance abuse conditions and care-seeking.
  - Suicidal behaviors, ideation and related attitudes, risk and protective factors, knowledge and behaviors through adult and youth risk behavior surveys
  - Assessment of the service system and usage through surveys of providers, such as hospitals, crisis lines, community service boards, and police.
  - Cost of suicides and suicide attempts and years of productive life lost.
- DMHMRSAS, in collaboration with Steering Committee member agencies, should regularly disseminate accurate local suicide data that is aggregated geographically or by time period to provide stable rates.
- DMHMRSAS, in collaboration with agencies represented by the Steering Committee, should produce and disseminate a comprehensive report every three years on suicide and suicide attempts, integrating data from multiple data systems.

Objective 2.2: **By 2008, increase the number of localities regularly conducting suicide follow-back studies or death reviews.**

Recommended Action

- DMHMRSAS should identify those localities or population groups that could most benefit from such studies.
- Consider modifying the *Code of Virginia* to establish a mechanism for local/regional suicide review/follow-back study, with appropriate representative membership.
- The Office of the Chief Medical Examiner should provide technical support to localities wishing to conduct suicide follow-up studies.

Notes

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. They can be used to increase understanding of the causes of suicide and to refine prevention strategies. Virginia currently allows for Family Violence Fatality Review Teams to review deaths that occur as a result of abuse between family members or intimate partners.

Objective 2.3: **By 2007, DMHMRSAS and the Virginia Department of Health will promote and support national efforts to improve and standardize data collection methods.**

Examples of such methods include:

- Increasing the proportion of hospitals using standard external cause of injury coding for suicidal behaviors.
- Using standardized protocols for death scene investigations.

Goal 3: Promote and support research, including evaluation, on suicide and suicide prevention.

Objective 3.1: **By 2008, increase applied research in Virginia that will allow for better targeting of scarce resources.**

Recommended Action

- DMHMRSAS should identify researchers in Virginia universities with an interest in suicidology and promote the conduct of applied research, including evaluation, on initiatives and populations in Virginia.
- Member agencies of local coalitions should conduct comprehensive needs assessments in localities with high suicide rates to identify specific local problems and gaps in services. Needs assessments can include:
  - Comprehensive, confidential case studies of suicides and suicidal attempts in the localities, including assessment of systems barriers.
  - Assessment of local agency policies and procedures; availability of and access to services; and social and economic factors.

Awareness

Goal 4: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.

Objective 4.1: **By 2010, increase the percentage of the population who recognize the importance of disclosing mental health symptoms to family, friends, or health care professionals and obtaining care for these problems.**

Recommended Action

- DMHMRSAS, in collaboration with member organizations of the Steering Committee, should launch a public education campaign to improve awareness of mental health and substance abuse issues and the importance of disclosing symptoms and obtaining care with the aim of reducing stigma, myths, and denial of mental health conditions and substance abuse.

Goal 5: Promote awareness that suicide is a public health problem that is preventable.

Objective 5.1: **By 2010, a greater proportion of the population in Virginia will receive public information on the problem of suicide, i.e., that it is preventable, common signs and symptoms, and what the public can do.**

Recommended Action

- DMHMRSAS should:
  - Create an identifiable symbol for use in all public outreach, education, training, and programs.
  - Launch a public education campaign to educate the public about the problem of suicide, its cost, warning signs, causes, available resources, and what the public can do.
  - Expand, strengthen, and publicize the Virginia Suicide Prevention Website (www.preventsuicideva.org) to cover the lifespan.
  - Improve design and distribution of suicide prevention pamphlets.
  - Local coalitions should hold special outreach and community events, speakers and training to local religious, civic, leaders and organization representatives.

Notes

Specific methods of a public awareness campaign can include identifying a well-known personality to champion the cause of mental health, substance abuse, and suicide prevention; billboards; public service announcements; local television infomercials; and posters. Distribution sites include schools, faith organizations, senior centers, hospital emergency departments and clinics, physicians' offices, civic and community organizations, employers, unemployment agencies; bars; and barbers/hair salons. A community assistance section of the website would include funding information; slideshows and handouts for community events; speakers' bureau, trainers, downloadable brochures and other resources; and local resources, comprehensive referral lists, speakers, statistics, and links.

Intervention

Goal 6: Develop and implement community-based suicide prevention programs.

Objective 6.1: **By 2010, reduce the suicide rate in those planning districts with high male suicide rates.** (*Baseline: 36.8/100,000 (66 male suicides) for Lenowisco (Planning District 1), 38.2/100,000 (88 male suicides) for Cumberland Plateau (Planning District 2), and 33.6 (160 male suicides) for West Piedmont (Planning District 12) in 1999-2002; Target: 17.8/100,000).*

Recommended Action

- DMHMRSAS should provide education for regional/local coalition members and other leaders on the problem of suicide and its prevention.
- DMHMRSAS should, in collaboration with a local university, request technical assistance from the Centers for Disease Control and Prevention to:
  - Assess and define the problem of suicide in these areas.
  - Develop an intensive, comprehensive strategy for these areas with a strong evaluation component that is patterned after effective strategies in other rural areas (e.g. programs for rural American Indian communities that promoted social and economic improvements, leadership involvement, traditional culture enhancement programs, and increasing mental health services).
  - Seek financing for such an intervention from a major funding organization.

Objective 6.2: **By 2010, effective programs that address risks and protective factors of population groups at high-risk for suicide will be established.**
Recommended Action
DMHMRSAS should work with state-level representatives/leaders to design or promote programs with demonstrated effectiveness in reducing suicide, suicidal behaviors or associated risk factors. These programs should have strong evaluation components. Examples:

- *Childhood Trauma:* Promote effective home-visiting programs to prevent trauma and suicide risk.
- *Employers:* Promote the application of comprehensive suicide prevention programs such as the Air Force Suicide Prevention Program.
- *Youth:* Develop effective programs such as those summarized under Effective Strategies.
- *Elderly*: Program could include strategies, in collaboration with Area Agencies on Aging, to raise awareness of this problem and promote connectedness and reduce isolation, particularly among men after a traumatic loss such as death of a loved one. This could be done in conjunction with a replication of the PROSPECT program, as described under Effective Strategies.
- *Colleges/Universities/Technical Centers:* This is the time of onset of many psychiatric disorders and young people typically have lost parental health insurance coverage so this group would seem to be particularly vulnerable to undiagnosed mental health conditions.
- *Health Professionals:* A suggestion would be to provide burnout prevention services to and encourage help-seeking behavior by dentists, physicians, and other at-risk clinical providers.
- *Detainees*: Develop integrated programs, aimed at detainees, particularly within twenty-four hours of arrest, with a strong evaluation component.

Objective 6.3: **By 2010, increase the proportion of family, youth, elderly, and other community service organizations with integrated suicide prevention components as part of their programs.**
Recommended Action

- DMHMRSAS and Steering Committee members should meet with state representatives/leaders of family, youth, elderly, and other community service organizations to educate them on the problem of suicide, and provide materials for and promote the integration of suicide prevention components into their programs.

Goal 7: Promote efforts to reduce access to lethal means and methods of self-harm.

Objective 7.1: **By 2010, reduce the rate of self-inflicted firearm deaths.** (*Baseline: 6.7/100,000 in 2002; Target: 4.1/100,000).*
Recommended Action
DMHMRSAS and State Police should:

- Identify geographical areas and other population groups with high rates of firearm deaths implicated in suicides and homicides.

- In areas with high firearm death rates, educate the public about local firearm fatality statistics and the safe storage and handling of firearms.
- Train health professionals and other gatekeepers about firearm fatality statistics and the safe storage and handling of firearms.
- Train health professionals and other providers about the importance of discussing the safe storage and handling of firearms and other lethal means with family members or close contacts of individuals who are in crisis or have mental disorders, substance abuse problems, or suicidal thoughts.

Notes

The American Academy of Pediatrics states that "during routine evaluations, pediatricians need to ask whether firearms are kept in the home and discuss with parents the risks of firearms as specifically related to adolescent suicide. Specifically for adolescents at risk of suicide, parents should be advised to remove guns and ammunition from the house.[hh]"

Goal 8: Implement training for recognition of at-risk behavior and delivery of effective treatment.

Objective 8.1: **By 2008, increase the number of trained gatekeepers.**

Recommended Action

- Members of the Steering Committee should meet with leaders of statewide professional organizations,[i] state agency/organization personnel,[ii] and regional organizations[iii] representing gatekeepers for populations at high risk for suicide, to:
    - Explain the problem of suicide, areas and populations at high risk, risk and protective factors, and what can be done to prevent them.
    - Promote the availability of suicide prevention training (such as currently offered QPR and ASIST training) or identify other suitable training.
    - Explore the possibility of obtaining continuing education credits for such training or requiring such training for recertification, and
    - Explore the possibility of co-sponsorship of and charges for training.
- Meet with regional/local coalition leaders to provide the tools for and request their promotion of suicide prevention training to local leaders, including business, educational, religious, media, human services, foundation, and civic leaders.

Objective 8.2: **By 2010, increase the proportion of counties in which education programs are available to family members and others in close relationships with those at risk for suicide.**

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[i] Including professional organizations for physicians, dentists, providers of nursing care, physician assistants, emergency personnel, psychologists, social services personnel, clinical social workers, counselors, clergy, educational faculty and staff, adult and juvenile correctional workers, divorce and family law and criminal defense attorneys, bartenders, hairdressers and barbers.

[ii] Including mental health, Comprehensive Services Act, health department, social services, unemployment services, senior centers, and corrections personnel.

[iii] Including Area Agencies on Aging and Area Health Education Centers.

Recommended Action
The Department of Mental Health, Mental Retardation and Substance Abuse Services should work to:

- Assess the availability of family education programs, in collaboration with the Virginia chapter of the National Alliance for the Mentally Ill and the Community Services Boards.
- Promote establishment and utilization of family education programs through the regional/local coalitions, community service boards, local foundations, civic groups, and major employers.

Goal 9: Develop and promote effective clinical and professional practices.

Objective 9.1: **By 2009, increase the proportion of primary care practices that have systems to assure accurate diagnosis, effective treatment, and follow-up for depression, substance misuse, and other mental health conditions.**
Recommended Action
DMHMRSAS should work with Virginia primary care provider associations (medical, osteopathy, nurse and other allied health professionals) and graduate schools, as appropriate, to:

- Promote the screening or assessment, with effective tools, for depression, substance abuse, and other mental health conditions as recommended by the U.S. Preventive Services Task Force (USPSTF) and the American Academy of Pediatrics (AAP).
- Promote the establishment of linkages and practices to assure proper follow-up of patients following screening for depression and substance abuse.
- Incorporate depression, substance abuse, and other mental health assessment, prevention and referral as part of graduate training.

Notes
The National Strategy has several objectives to increase the screening for depression, substance abuse, and suicide risk by primary care providers. However, the USPSTF issued a report (May 2004) that states the evidence is insufficient to recommend screening office patients for risk of committing suicide[ii]. The USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and followup.[jj] The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. Such screening practices are not recommended for adolescents.[kk] As for drug abuse, the USPSTF takes a neutral stance on routine screening but does state that clinicians should be on the alert for signs and symptoms of drug abuse and ask about their use within the context of a trusting, nonjudgemental and confidential relationship.[ll] The AAP recommends that: 1) Pediatricians screen adolescents for a history of sexual assault and potential sequelae[mm]; 2) Pediatricians ask questions about depression, suicidal thoughts, and other risk factors associated with suicide in routine history-taking thoughout adolescence[nn]; 3) Pediatricians discuss the hazards of alcohol and other drug use with their patients as a routine part of risk behavior assessment[oo].

Objective 9.2: **By 2009, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to effectively assess suicide risk, intervene to reduce suicidal behaviors among their patients, and provide follow-up to prevent further suicidal behaviors.**

Recommended Action

The Licensing Office of the Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Assure that licensing regulations require written policies and procedures to effectively assess suicide risk, intervene to reduce suicidal behaviors among their patients, and provide follow-up to prevent further suicidal behaviors.
- Assess the proportion of such specialty centers that have these policies and procedures.

Objective 9.3: **By 2009, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.**

Recommended Action

The Department of Mental Health, Mental Retardation and Substance Abuse Services should work with local/regional coalitions, especially those in areas with high suicide rates, to:

- Assess the barriers patients and providers face in assuring completion or regular maintenance of treatment.
- Reduce these barriers through increased funding, training, or policy changes.

Objective 9.4: **By 2009, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.**

Recommended Action

The Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Promote the application of effective follow-up policies and practices among hospital emergency departments, particularly in areas with high suicide rates.

Objective 9.5: **By 2009, increase the percentage of institutional settings that apply guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior.**

Recommended Action

The Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Meet with leaders of institutional settings to promote application of guidelines, once national guidelines have been developed.
- Monitor the application of such guidelines.

Goal 10: Increase access to and community linkages with mental health and substance abuse services.

Objective 10.1: **By 2010, increase the proportion of the population with expanded benefits for mental health and substance abuse services.**
Recommended Action
The Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Work with insurance companies and the legislature to expand benefits for services to improve mental health.
- Work with the Department of Medical Assistance Services to explore the expansion of Medicaid eligibility for mental health services.

Objective 10.2: **By 2010, expand and improve local mental health services, especially in areas with high suicide rates.**
Recommended Action
The Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to expand and improve local mental health services, in accordance with the Comprehensive State Plan, 2004 – 2010[pp] and in response to the President's New Freedom Commission on Mental Health[qq], with special emphasis on areas with high suicide rates.

Objective 10.3: **By 2010, improve integration and coordination among organizations/agencies including physical health, mental health, and spiritual health.**
Recommended Action
DMHMRSAS and Steering Committee should:

- Conduct a study to identify policies at the state level that prevent integration and coordination of services at the local level and recommend changes or develop new policies to promote such integration and coordination. Such policy analyses and changes should be promoted by local coalitions as well.
- Promote integration of suicide prevention activities into existing programs targeting populations at high risk for suicide. Examples include:
  - Incorporate mental health and suicide risk assessment and referral into health and/or social services outreach and home-visiting programs for high-risk populations.
  - Incorporate screening for depression into substance abuse prevention and treatment programs.

Local/regional coalitions should:

- Convene community leaders to identify and implement collaborative opportunities for more effective service.

Goal 11: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.

Objective 11.1: **By 2008, identify the extent to which there is inappropriate portrayal of or reporting on suicides, suicidal attempts, and mental illness and inform the media of the problem.**

Recommended Action

DMHMRSAS should:

- Examine the News Clipping Service results for indications of the extent of inappropriate reporting on or portrayal of suicides, suicidal attempts, and mental illness.
- In collaboration with local/regional coalitions, meet with representatives of the radio, TV, news media and journalism schools, in each of the major media markets, to inform them on suicide risk in their geographical area, risk factors, solutions, and discuss the use of the American Foundation for Suicide Prevention's guidelines: Reporting on Suicide: Recommendations for the Media[i].

Notes

While the Reporting on Suicide: Recommendations for the Media focuses on news reporting, there are apparently no similar consensus recommendations formulated for the entertainment media.

[i] Developed in collaboration with the Office of the Surgeon General, the Centers for Disease Control and Prevention, the National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, the World Health Organization, the National Swedish Centre for Suicide Research, and the New Zealand Youth Suicide Prevention Strategy.

Financial and Staffing Resources Envisioned for Plan Implementation

In an attempt to quantify the additional resources that would be necessary for implementation of the Suicide Prevention across the Life Span Plan for the Commonwealth, input was solicited from the members of the Interagency Committee. Committee members were asked to review the plan and estimate the amount of resources their agency would need to address the objectives that were relative to their agencies' work. Below are the responses received from Virginia Department of Health's Center for Injury and Violence Prevention and Office of the Chief Medical Examiner, Virginia Department for the Aging and Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. In total, the preliminary estimate of the additional resources needed to implement the objectives listed in the Suicide Prevention across the Life Span Plan for the Commonwealth is $307,470 in fiscal year 2006 and $4,814,633 in fiscal year 2007.

Department of Mental Health, Mental Retardation and Substance Abuse Services

In a letter from the Commissioner of DMHMRSAS (Appendix I), Dr. Reinhard states:

> the Department of MH, MR and SA Services has no staff or other resources devoted to suicide prevention across the lifespan, and would need significant new funding to implement the *Suicide Prevention Across the Life Span Plan for the Commonwealth.* Funding is needed to support suicide prevention staff, research and data collection infrastructure, direct services by community services boards, public awareness initiatives, training, and support for coalition-building with local and regional entities.

Below are the costs associated with implementation of the plan as estimated by DMHMRSAS. A full cost breakdown through FY2010 is included as Appendix J.

	FY2006		FY2007	
	FTEs		FTEs	
Suicide Prevention Manager (Pay Band 6)	1.0	$94,500	1.0	$97,335
Suicide Prevention Specialist (Pay Band 5)	- -	- -	5.0	$405,000
Research Coordinator (Pay Band 5)	- -	- -	1.0	$81,000
Admin / Office Specialist III (Pay Band 3)	- -	- -	0.5	$54,000
Equipment	- -	$3,000	- -	$21,500
Travel	- -	$2,500	- -	$18,750
Office / Supplies	- -	$1,500	- -	$11,250
Research Infrastructure	- -	- -	- -	$30,000
Contractual Services - Public Awareness	- -	- -	- -	$82,500
Contractual Services - Training	- -	- -	- -	$85,000
Contractual – Community Leadership	- -	$40,000	- -	$80,000
CSB Direct Services - $50,000 per CSB	- -	- -	- -	$2,000,000
Yearly total	**1.0**	**$141,500**	**7.5**	**$2,966,335**

Department of Health Center for Injury and Violence Prevention

The Center for Injury and Violence Prevention currently addresses the issue of youth suicide prevention through statewide coordination of prevention, surveillance, public awareness and training. This work is supported through a $300,000 grant from the Centers for Disease Control and Prevention. The bulk of the funds go towards training gatekeepers in recognizing and responding to people at-risk of suicide. During the first two years of the grant, 450 presentations and 72 two-day skills trainings have been provided to over 24,000 people through a statewide network of trainers. However, the funds will be unavailable after October 2005. Therefore, CIVP would need an additional funds to continue to offer training in accordance with the plan.

	FY2006*	FY2007
1 FTE to coordinate trainings	$50,100	$68,804
Contractual Services	$74,246	$98,995
Supplies and Materials	$38,474	$51,299
Continuous Charges	$3,150	$4,200
Total	**$165,970**	**$223,298**

* FY2006 numbers represent 75% of a fully-funded year.

Department of Health Office of the Chief Medical Examiner

While the OCME conducts suicide surveillance, it lacks personnel with suicide follow-back study expertise and the fiscal resources for this activity. Given the inextricable link between suicide, mental health and substance abuse, the OCME would need additional resources to undertake this challenging task. Below are the costs associated with implementation of the plan as estimated by OCME.

	FY2006	FY2007
3 FTEs to coordinate follow-back studies	--	$275,000
1 FTE to provide technical assistance to localities	--	$100,000
Total	--	**$375,000**

Department for the Aging

In order for each local Area Agency on Aging (AAA) to incorporate suicide prevention activities into current health promotion/disease prevention activities, additional funding is needed as estimated by the Department for the Aging.

	FY2006	FY2007
1 FTE in each of the 25 AAA	--	**$1,250,000**

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APPENDICES

Appendices

A. Senate Joint Resolution No. 312

B. Item 305 of 2003 Appropriations Act

C. List of Attendees at Suicide Prevention Conference and Focus Groups

D. Virginia Youth Suicide Prevention Plan Summary of Recommendations

E. Trends in Suicides by Age, Virginia, 1975 – 2002

Chart 1: Resident Suicide Rates, Ages 5 - 14, Virginia, 1975 - 2002
Chart 2: Resident Suicide Rates, Ages 15 - 19, Virginia, 1975 - 2002
Chart 3: Resident Suicide Rates, Ages 20 - 24, Virginia, 1975 - 2002
Chart 4: Resident Suicide Rates, Ages 25 - 34, Virginia, 1975 - 2002
Chart 5: Resident Suicide Rates, Ages 35 - 44, Virginia, 1975 - 2002
Chart 6: Resident Suicide Rates, Ages 45 - 54, Virginia, 1975 - 2002
Chart 7: Resident Suicide Rates, Ages 55 - 64, Virginia, 1975 - 2002
Chart 8: Resident Suicide Rates, Ages 65 - 74, Virginia, 1975 - 2002
Chart 9: Resident Suicide Rates, Ages 75 - 84, Virginia, 1975 - 2002
Chart 10: Resident Suicide Rates, Ages 85 and Over, Virginia, 1975 - 2002

F. Adjusted Suicide Rates by City/County and Planning District, 1999-2002

G. Hospitalizations due to Self-Inflicted Injury, 2002

H. Suicide-Related Healthy People 2010 Outcome Objectives

I. Letter from Commissioner Reinhard at Department of Mental Health, Mental Retardation and Substance Abuse Services

J. Resource Requirements by Fiscal Year for Phased Implementation of Plan

K. Proposed Legislation

2003 SESSION

Appendix A

ENROLLED

SENATE JOINT RESOLUTION NO. 312

Requesting the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth. Report.

Agreed to by the Senate, February 4, 2003
Agreed to by the House of Delegates, February 13, 2003

WHEREAS, suicide is the second leading cause of death for people aged 10-35 in the Commonwealth; and

WHEREAS, over the last 14 years, attention in the Commonwealth has focused on suicide prevention among the elderly and youth; and

WHEREAS, at the national level, the National Strategy for Suicide Prevention, published in 2001, has prompted a number of states to develop plans for suicide prevention across the life span, from youth to old age; and

WHEREAS, to implement more extensive youth suicide prevention activities and begin initiatives across the life span, the Virginia Department of Health applied in 2002 to the Centers for Disease Control and Prevention and was awarded $967,000 over three years to expand the Commonwealth's suicide prevention efforts; and

WHEREAS, 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 and no single agency acts as a clearinghouse or coordinator of activities related to suicide prevention; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, be requested to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth. Agencies that shall 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; 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. The Department of Health and the Department for the Aging shall be the agencies responsible for actually developing the plan, supporting the Secretary's efforts. All affected stakeholders shall be involved in the development of this plan. The plan shall 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. In developing the plan, previous planning efforts in Virginia and in other states, as well as the National Strategy for Suicide Prevention, shall be reviewed and applicable recommendations, goals, objectives, and strategies shall be integrated into this new comprehensive plan. The plan shall establish the Commonwealth's public policy regarding the prevention of suicide, identify the lead agency responsible for carrying out that policy, propose initiatives and interventions to effectively implement that policy, and identify the sources and amounts of resources to implement those initiatives and interventions. Finally, the plan shall propose the creation of a permanent oversight body to monitor the implementation of the plan.

The Secretary of Health and Human Resources shall submit to the Division of Legislative Automated Systems an executive summary and report of its progress in meeting the request of this resolution no later than the first day of the 2005 Regular Session of the General Assembly. The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B

ITEM 305.	Item Details($) First Year FY2003	Item Details($) Second Year FY2004	Appropriations($) First Year FY2003	Appropriations($) Second Year FY2004
Department of Health (601)				
305. Administrative and Support Services (44900)			~~$13,981,441~~ *$13,288,802*	~~$13,985,163~~ *$10,725,674*
General Management and Direction (44901)	~~$4,086,689~~ *$3,978,280*	~~$4,090,411~~ *$4,383,936*		
Computer Services (44902)	~~$5,085,646~~ *$4,810,622*	~~$5,085,646~~ *$1,770,440*		
Accounting and Budgeting Services (44903)	~~$1,730,868~~ *$1,593,819*	~~$1,730,868~~ *$1,590,119*		
Personnel Services (44914)	~~$1,763,258~~ *$1,663,169*	~~$1,763,258~~ *$1,713,565*		
Procurement and Distribution Services (44918)	~~$1,314,980~~ *$1,242,912*	~~$1,314,980~~ *$1,267,614*		
Fund Sources: General	~~$12,819,526~~ *$12,161,951*	~~$12,823,248~~ *$9,563,759*		
Special	~~$1,161,915~~ *$1,126,851*	$1,161,915		

Authority: §§ 3.1-530.1 through 3.1-530.9, 3.1-562.1 through 3.1-562.10, 32.1-11.3 through 32.1-11.4, 32.1-16 through 32.1-23, 35.1-1 through 35.1-7, and 35.1-9 through 35.1-28, Code of Virginia.

A. Out of this appropriation, $912,609 from the general fund the second year is provided toward the costs of the required relocation of the agency's central office staff to the James Madison Building. General and special fund appropriations in this item that are unexpended at the end of the first year shall be reappropriated to offset the impact of second year funding reductions in this item.

B. As part of the Department's ongoing suicide prevention efforts, the Department of Health, in cooperation with the Departments of Mental Health, Mental Retardation, and Substance Abuse Services; Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; Aging and other state agencies shall lead an effort to formulate a comprehensive suicide prevention plan. The plan shall address suicide prevention across the life span with an emphasis on adolescents, the elderly, and high-risk populations. The plan shall 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, identify the sources and amounts of resources to implement the initiative, and propose the creation of a permanent oversight body to monitor implementation. The plan should be completed by June 30, 2004, and presented to the Governor and General Assembly for their consideration and possible action during the 2005 legislative session.

List of Attendees at Suicide Prevention Conference and Focus Groups

2002 Suicide Prevention Conference

Keith Acosta
Virginia Beach Police Department

Faye Adams
Dept. of Rights of Virginians with Disabilities

Paige Akin
Richmond Times-Dispatch

Evol Alexander
Central Virginia Community Services Board

Sheree Alston
MPNN-CSB

Donald Anderson
Newport News Public Schools

Suzanne Augustine
Highlands Juvenile Detention Center

Mary Azoy
CrisisLink

Robin Bailey
Roanoke City Dept. Of Social Services.

Willnette Bailey
Va. School. For the Deaf, Blind & Multi-Disabled

Kathryn A. Baker
Valley CSB

Sheilah Benjamin
Middle Peninsula-Northern Neck

April Bennett
Valley CSB

Scott Bishop
Virginia Beach Police Department

Samiya Blakey
Plaza Middle School

Richard Boothe
Central Virginia Community Services Board

Gretchen Bousman
Roanoke City Dept. Of Social Services.

Janet Boyce
Probation & Parole - District #23

Anna L. Briley
Tidewater Child Development Clinic

John Brinkman

Charles S. Broadfield
Broadfield-Janus Assoc., Inc.

Heidi Buckner
Loudoun County Public Schools

Reese Butler
Hopeline

Linda Sierra Carey
The Choice Group

Wendy Carria
Arlington County Public Schools

Joan K. Carter
Community Services Board, District 19

Lenny Carter

Kelley Elaine Caspary
Virginia Beach Psychiatric Center

Sharon Christenenbury
Southside Community Services Board

H. Carlyle Church
Jerusalem Baptist Church

Warren Clark
Catawba Hospital

James Clemons

Jessye Cohen

Veronica Coleman
Pleasant Grove Baptist Church

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Glenda Collins
Lonesome Pine Office on Youth

Maryann L. Contreras
Life Coach Sentara Mental Health

Pamela Fitzgerald Cooper
Va. Dept. of MHMRSAS

Brandi Creasy
Central Virginia Community Services Board

Derek Creekmore
Portsmouth Police Department

Penny Crone
Middle Peninsula-Northern Neck Community Services Board

Margaret Nimmo Crowe
Virginia Alliance for Family and Children

Stephen Louise Cunningham
Virginia Beach Psychiatric Center

Derek Curran
Hampton-Newport News CSB

Neil Curtis
Waynesboro City Schools

Mary Herbert Daly
Children's Hospital of the King's Daughters

Paulette Daniel
Richmond Behavioral Health Authority

Patricia Davenport
Virginia School for the Deaf and Blind

Cecile A. Davis
Crisis Center

Doreen E. Davis
Alleghany Highlands CSB, Mental Health

Rebecca J. Davis
Virginia Rural Health Resource Center

Wanda G. Davis
Halifax County Dept. of Social Services

Sam Desai
Central Health, Rivermont School

Amanda DiGirolamo
Virginia Alliance for Family and Children

Delores Dodson
Eastern Shore Coalition Against Domestic Violence

Melinda Dooley
Central Virginia Community Services Board

Ellen R. Dotas
Valley CSB

Donzaleigh Douglas
Newport News Public Schools

Betsy Draine
DMHMRSAS

Sandy Dunahay
Pidemont Community Services Board

Jerry Earnhardt
Crisis Line of Central Virginia

Debra Echtenkamp
Loudoun County Public Schools

Barbara Eden

Jack Eden

Laurie Edmond
Arlington County Mental Health

Rachel Edmunds
Stafford County Schools

Jill H. Farrell
CSB Colonial Services Board

Jeri Fields
Prince William County Schools

Ann Fierstos
Alexandria Community Services Board

Heather Fisher
Virginia Beach Psychiatric Center

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Page Moss Fletcher

Ralfella C. Folston
Emergency Services

Judith Forsythe

Fred Fox
AFSP, AAS, ECF, VaSPC

Gail Fox
James Madison University

Miriam Friedland

J. Kevan Frye
Northwestern Regional Juvenile Detention Center/ City of Winchester

Beth Gibson
Virginia School for the Deaf and Blind

Carolyn E. Glover
Newport News Public Schools

Shelia Gresham
Chesapeake Community Services Board

Jupie Hamilton
U.S. Navy Family Advocacy Program

Agustus Harper
Crossroads Community Services Board

Stacy Harper
Valley CSB

Annette Harris
Emergency Services

Vickie V. Hawkins
First Home Care

Ginger Hendricks

Karen Hicks
Valley CSB

Kim P. Hicks
Culpeper County High School

David Hillis
Norfolk Garden Baptist

Judie Hogendorf

William Hogewood

Peggy Holmes
Lynnhaven Middle School

Shirley Hopkins
Sexual Assault Victims' Advocacy Serv.

Eileen Horan
Suffolk Public Schools

Patti Horgas
Johns Hopkins University

Crystal Horning
Mennonite Mutual Aid

Margie S. Howell

Jim Iman
Va. Beach Police Dept., 1st Prec.

Brenda Jackson
Crossroads Community Services Board

Debra Jefferson
Central Virginia Community Services Board

David A. Jobes

Deborah Johnson
Arlington County Mental Health

Karen Johnson
Blue Ridge Behavioral Healthcare

Natalie Johnson
Middle Peninsula-Northern Neck Community Services Board

Randy Jones
MPNN-CSB

Tisha Jones-Diggs
Arlington County Mental Health

Ronnie Kahn
People Places of Charlottesville

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Patricia Marie Kellam
Shore Memorial Hospital

Suzanne K. Keller
Virginia Department of Health

Fred Kelly
Community Services Board, District 19

Kathy Kiser
Prince George Public Schools

Arlene Krohmal
CrisisLink

Mary Douglas Krout
Healing After Suicide - Compassionate Friends

Rose Marie Larsen
Virginia Beach Schools

Jennifer Lasam
Valley CSB

Lori Lattarulo
Va. Dept. of MHMRSAS

David Lawless
Prince William Group Home For Girls

Sarah Lawman
Virginia Beach Schools/Kempsville High

Kjersh Lee
City of Virginia Beach MHMRSA

Frank J. Leonardi
U.S. Navy Family Advocacy Program

Lynda Leslie
Commonwealth Catholic Charities

Christy Letsom
The Planning Council

Patrick Lipsky
The Planning Council

David Litts

Mark Long
Navy Environmental Health Center

Theresa Long
Pleasant Grove Baptist Church

William Longstreet

Keri M. Lubell
CDC

Barbara Lucas
Lynnhaven Middle School

Maria Luna-Wolfe
New Life Metropolitan Community Church

Marty Luna-Wolfe
New Life Metropolitan Community Church

Michelle Lynch
Valley CSB

Nicole Lynch
Virginia Commonwealth University

Karen Marshall
Hopeline

Majoria Martin
Senior Connections Capital Area Agency on Aging

Kathy Maurer
Ocean Lakes High School

Barbara McCall
Dept. of Mental Health

Janet McCoy
Emergency Operation Center

Jamie Fiore McFarland

Staria Mitchell
Lynchburg City Schools

Adriene Montgomery

Susan Moon
Central Virginia Community Services Board

Regina Morales
Arlington County Child and Family Services
(Mental Health & SA Services)

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

John Morgan
Chesterfield Community Services Board

Andrea Morris

James Moseley
Pleasant Grove Baptist Church

Van Mullis
Virginia Beach Probation Office

Vance Mullis
Hampton Adult Probation

Mary Murray
Virginia School for the Deaf & Blind

Patricia Neiger
MPNN-CSB

Tom Neiger
MPNN-CSB

Bob Paul Newman
Virginia Beach Psychiatric Center

Sabina O. Newton
Middle Peninsula-Northern Neck Community Services Board

Cathie Niemann
Virginia Beach City Schools

Rebecca K. Odor
Virginia Department of Health

Christine O'Malley
Sexual Assault Victims' Advocacy Serv.

Erin Overby

Cindy Pannullo
St. Nicholas Catholic Church

Kathryn Perrin
Prince William Youth Suicide Prevention Coalition

Desaline Perry
Hamptom Roads Regional Jail

Dorothy Peterson
Carroll County Schools

Marie Pierce
Pleasant Grove Baptist Church

Jody Poggendorf
Richmond Behavioral Health Authority

Kate Stokely Powell
CONTACT Crisis Line of Danville Pittsylvania Co.

Tony Powell
Central Virginia Community Services Board

Anne Priode
UVA Medical Center - Psychiatry

Paul Quinnett
QPR Institute

Shani C. Reams
Va. Aligned Against Sexual Assault VAASA

Jerry Reed

Wava Reigel
The Crisis Line

James S. Reinhard
DMHMRSAS

Blair Rhodes
Central Virginia Community Services Board

Susan Rieves-Austin
Blue Ridge Behavioral Healthcare

Heidi Rist
Valley CSB

Jenny Roberts
Roanoke City Dept. Of Social Servs.

Megan Robinson
Christopher Newport University

Sharon Robinson
Schiffert Health Center Virginia Tech

Calvin Rogers
Pleasant Grove Baptist Church

Mozell Rogers
Pleasant Grove Baptist Church

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Candace Saban
New River Valley Community Services (NRVCS)

Stephanie Samuels

Rick R. Sanders
Community Corrections Hampton Probation and Parole

Delores Sartor
Eastern Shore Coalition Against Domestic Violence

Agatha Savage
Maryview Behavioral Medicine

Nancy Scagel
Schiffert Health Center Virginia Tech

Christian Schweiger
Concern Hotline

William Darryl Scott, Sr.
Pleasant Grove Baptist Church

Melba Scudder
Virginia Beach City Public Schools

Linda B. Sibley
Middle Peninsula-Northern Neck Community Services Board

Alice Sink
Middle Peninsula-Northern Neck Community Services Board

Robert Sipe
Middle Peninsula-Northern Neck Community Services Board

Rebecca H. Sitnik
Valley CSB

Robert Sizemore
Alexandria Community Services Board

Cecily Slasor
Virginia Department for the Aging

Lois D. Smith
F. W. Cox High School

Sandra Smith
Va. Dept. of Corrections

Sharon Smith
SMHM

Susan D. Smith
Middle Peninsula-Northern Neck Community Services Board

L. L. Spivey

Cathi Stallings
Arlington County Department of Human Services

Karen Stark
Middle Peninsula-Northern Neck Community Services Board

Dona Sterling-Perdue
Hampton-Newport News CSB

Bob Storer

Marie Strang
The Crisis Line

Bill Sullivan
Virginia Chapter of American Academy of Pediatricians

Christine G. Sutherland

Michael Taylor
Rural Virginia United Coalition (MPNNCSB)

Angela L. Tegeler
Planning Council

Beth Tolley
DMHMRSAS

Sara Townsend
RAFT Crisis Hotline

Domenica Vest
Roanoke City Dept. Of Social Services.

Jim Vetter
Virginia Department of Health

Robert Vogl
Messiah Lutheran Church

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

H. L. Wade
Staunton City Schools

Dennis Waite

Kathleen Wakefield
I Need A Lighthouse, Inc.

Kathleen Walker
Green Run High School

Amanda Ware
Valley CSB

Gloria J. Warren
Community Corrections Hampton Probation and Parole

Tisha Washington
Richmond Behavioral Health Authority

Bob Watson

Wendy Webb
Roanoke City Dept. Of Social Services.

Jonathan M. Wells
Central Virginia Community Services Board

Dan West
Central Virginia Community Services Board

Christine Westendorf

Henry Westray

Elsie Weyrauch
SPAN USA

Jerry Weyrauch
SPAN USA

Jane Wiggins
Rockingham County Public Schools

Gina Wilburn
Blue Ridge Behavioral Healthcare

Denise Willey
The Crisis Line

Brennetta Williams
Pleasant Grove Baptist Church

Lorraine Williams
CSB

Sara Jo Williams
Center For School Community Collaboration

Lisa Carter Williams
U.S. Navy Family Advocacy Program

Linda Williamson
Hampton-Newport News CSB

Joyce Willis
Southside Community Services Board

Carolsue Wyland
Contact Peninsula

Andy Young
Cape Henry Collegiate School

Paula Zo
Beech Acres

2003 Abingdon Focus Group

Patty Arthur
Bristol Police Department

Nadalyn Baker
Bristol Crisis Center

Cari Braddock
Wise County Schools

Lee Brannon
Washington County Schools

Curtis Burkett
Washington County Schools

Tom Casteel
Washington County Department of Social Services

Bob Craig
Bristol Crisis Center

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Tammy Francisco
Washington County Department of Social Services

Laurene Hogans
Bristol Crisis Center

Ramonda Jackson
Scott County Sheriff's Office

Melinda Keesy
Bristol Regional Counseling Center

Susan Murray
Bristol Family Resource Center

Brian Mutter
Bristol Police Department

Israel O'Quinn
Attorney General's Office

Jim Quesenberry
Bristol Crisis Center

Karen Riner
Bristol City Schools

Becky Sensky
Bristol Youth Services

Allen Slagle
Bristol Sheriff's Office

Denise Smith
Johnston Memorial Hospital

James Sproles
Bristol Crisis Center

Kim Sturgill
Smyth County Schools

Vicky Welsh
Wise County Schools

2003 Arlington Focus Group

Mary Azoy
CrisisLink

Ellie Barnes
Fairfax County Public Schools

Wendy Carria
Arlington County Public Schools

David Clayton
Child & Family Counseling Group

Teresa Fein
Arlington County Police

Grover Foehlinger
Fairfax County Public Schools

Fran Gatlin
Fairfax County Public Schools

James Gillespie
Fairfax Partnership for Youth

Jane Ashley Heavey
Center for Well Being

Jennifer Heffron
Fairfax Partnership for Youth

Linda Hutchinson
Yorktown High School

Jim Kelly
Fairfax County Emergency Services

Arlene Krohmal
United Way of National Capital Area

Kathy Persson
Northern Virginia Hospice

Karen Scudder
Fairfax/Falls Church Community Services Board

Jan Siegel
Arlington County Public Schools

Christian Storn-VanLeeuwen
City of Alexandria Public Schools

Rachel Thompson
Madison Senior Center

Dan Zeeman
Fairfax/Falls Church Community Services Board

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

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2003 College Focus Group

Michelle Alexander
College of William and Mary

Jim Grigsby
Germanna Community College

Kendrick Kelly
Virginia State University

Marjorie Kinnaman
Northern Virginia Community College

Pat Lient
Northern Virginia Community College

Barbara Wagar
Mary Washington College

Inaa Woodward
College of William and Mary

2003 Lynchburg Focus Group

Van Avery
Pittsylvania Mental Health Association

Darlene Callands-Younger
Pittsylvania County Jail

Larry Dockery
Pittsylvania County Sheriff's Office

Jerry Earnhardt
Crisis Line of Central Virginia

David Edmonston
Child & Family Community Service Board

Carol England
Lynchburg College

Lenore Holbrook
Alliance

Eileen Houston
Danville/Pittsylvania Community Services Board

Sylvia Lantz
Central Health EMH

Vicki Sandifer
MHA of Central Virginia

Kate Stokely Powell
Contact Danville

Ellen Trappey
Crisis Line of Central Virginia

Vic Vann
Council of Community Services

Elizabeth Webb
MHA of Central Virginia

Faye Whaley
Central Health EMH

2003 Norfolk Focus Group

Kim Birdwell
YWCA Response Sexual Assault Support Services

Julie Dixon
The Planning Council

Maravia Ebony
Norfolk Police Chief's Office

Barbara Gockel
Western Tidewater Community Services Board

George Harden
The Planning Council

Christy Letsom
The Planning Council

George McCormic
City of Virginia Beach Police Department

Sabina Neuten
Middle Peninsula Community Services Board

Margo Perry
Norfolk Public Schools

Jaqueline Schaete
Norfolk Community Services Board

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Rosemary Thompson
Chesapeake

Kathy Wakefield
I Need a Lighthouse

Linda Williamson
Hampton-Newport News Community Services Board

2003 Prince William Focus Group

Det. Beth Benham
Fairfax County Police

Linda Bergold
Prince William County Schools

Lt. Meg Carroll
Manassas City Police

Evalee Cluca
Survivor Group Facilitator

Phyllis Fullove-Reid
Emergency 911

Vicki Graham
Helpline

Julie Granahan
Domestic Violence Children's Program

Dan Harris
Prince William County Police

Beth Lewis
Domestic Violence Program

Appendix D

Virginia Youth Suicide Prevention Plan Summary of Recommendations

(Report of the Virginia Commission on Youth, House Document No. 29, 2001)

Leadership

1 – VDH Lead Entity for Youth Suicide Prevention in Virginia

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

Universal Prevention Strategies

2 – Statewide Public Awareness

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

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

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

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

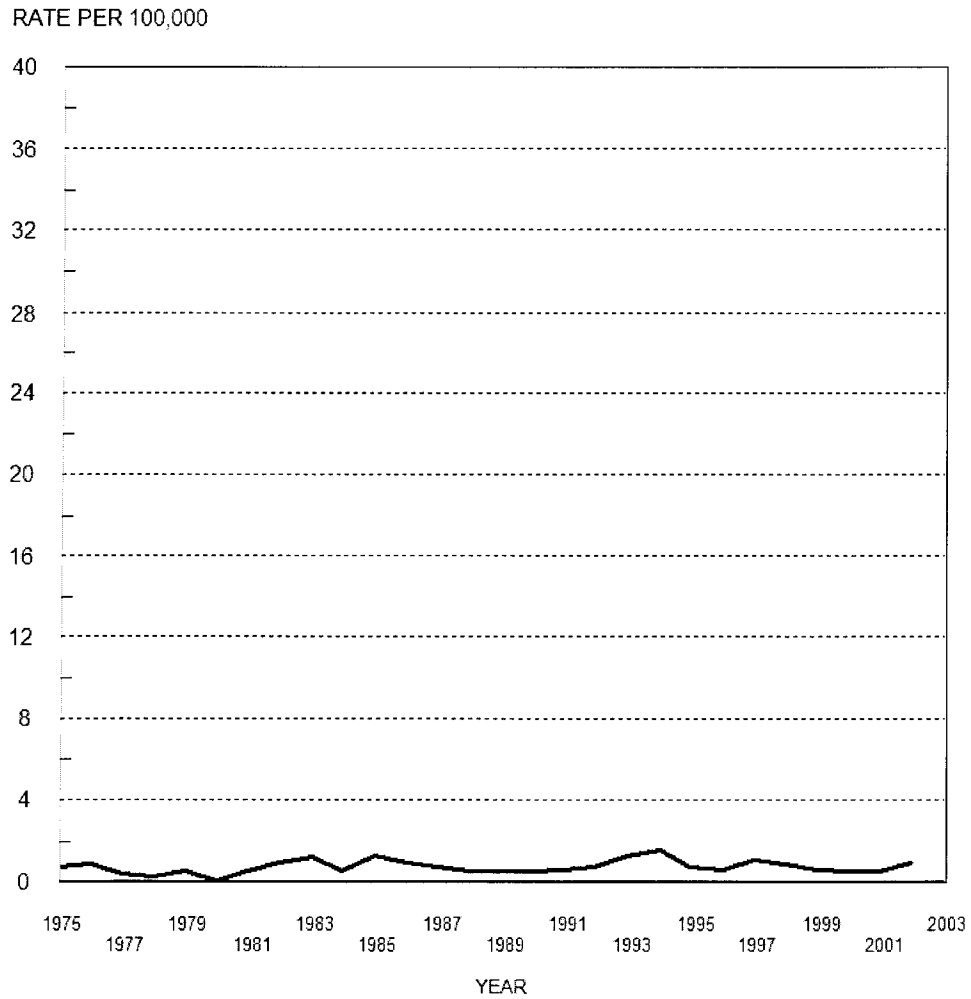
VDH should coordinate comprehensive evaluation of all aspects of suicide prevention program.

Funding

14 – Appropriating Funds

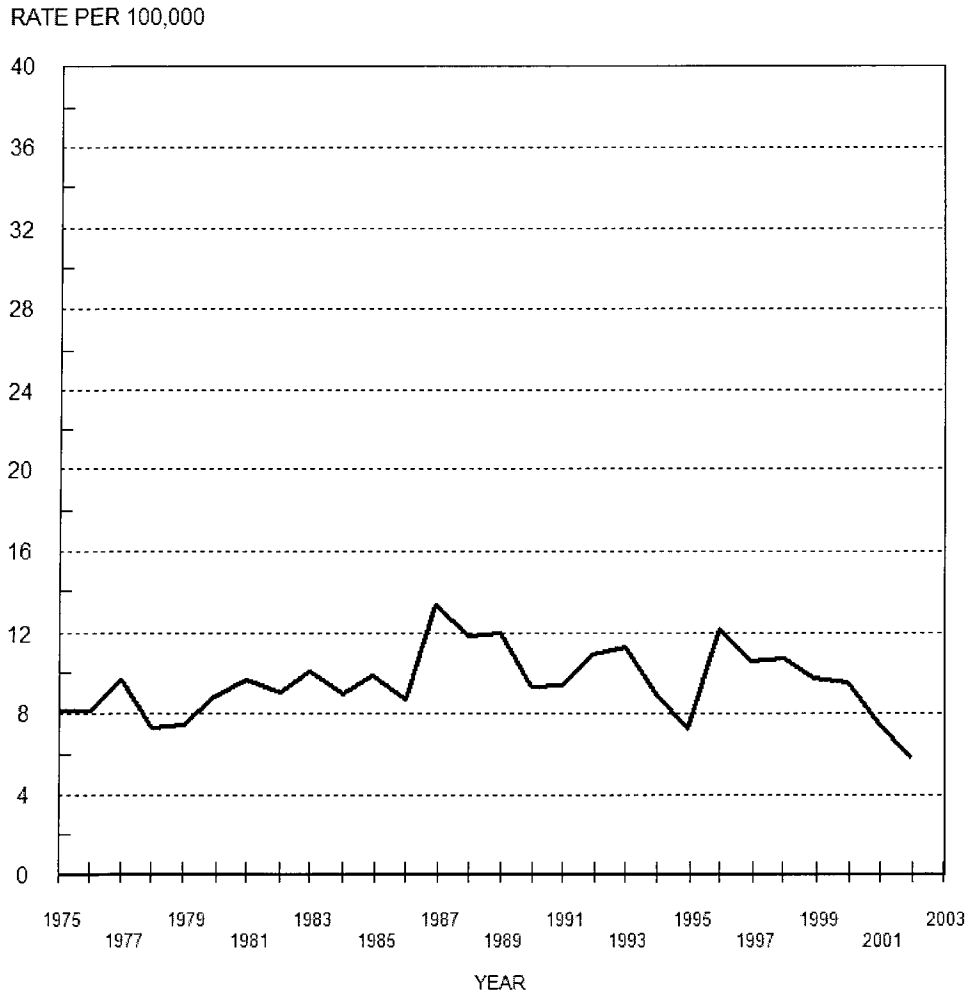
The General Assembly should appropriate funds to the Department of Health, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Education to implement the youth suicide prevention initiatives described in this plan.

CHART 1
RESIDENT SUICIDE RATES, AGES 5-14
VIRGINIA, 1975-2002



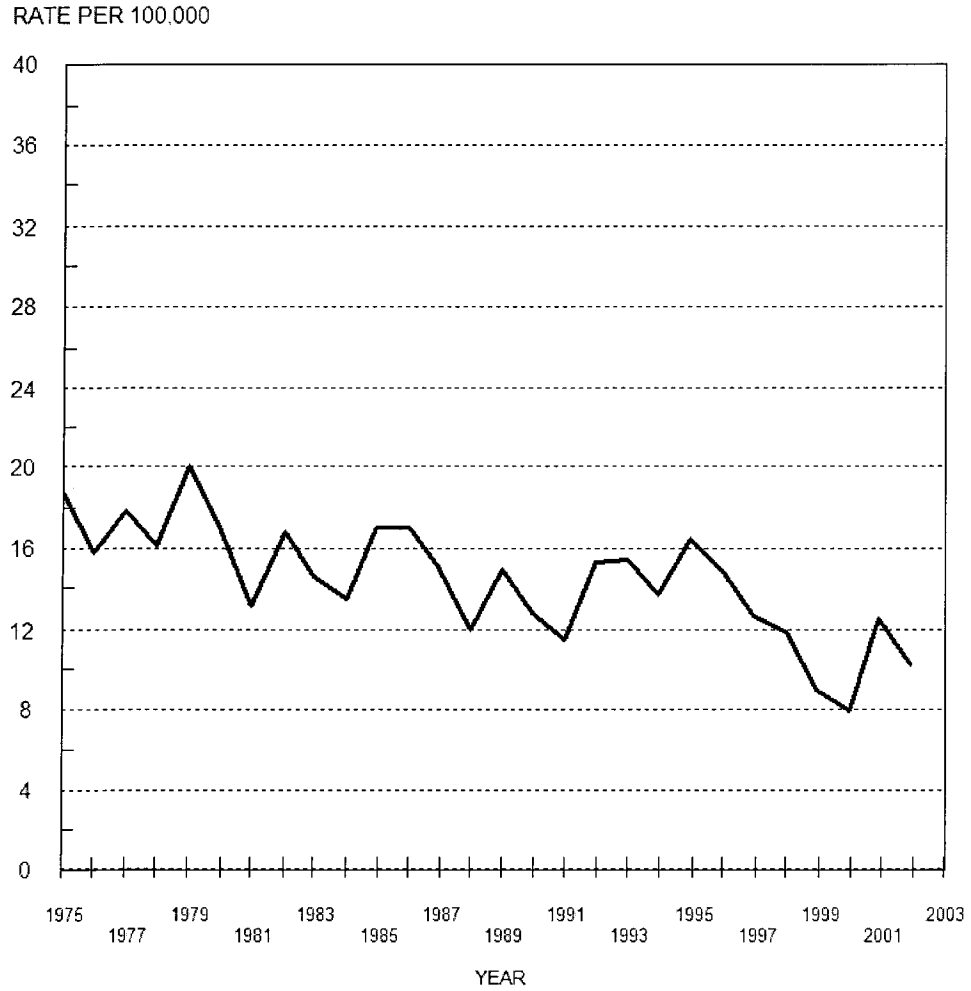
SOURCE: Virginia Center For Health Statistics

CHART 2
RESIDENT SUICIDE RATES, AGES 15-19
VIRGINIA, 1975-2002



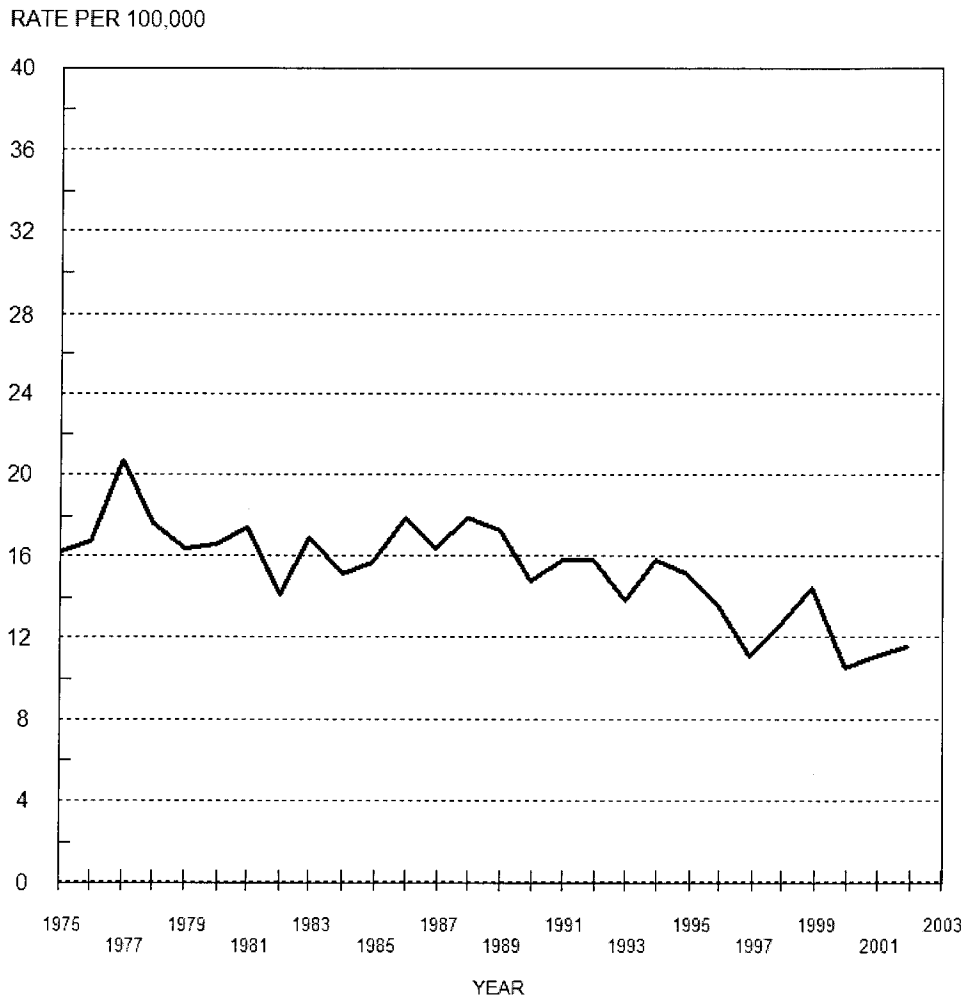
SOURCE: Virginia Center For Health Statistics

CHART 3
RESIDENT SUICIDE RATES, AGES 20-24
VIRGINIA, 1975-2002



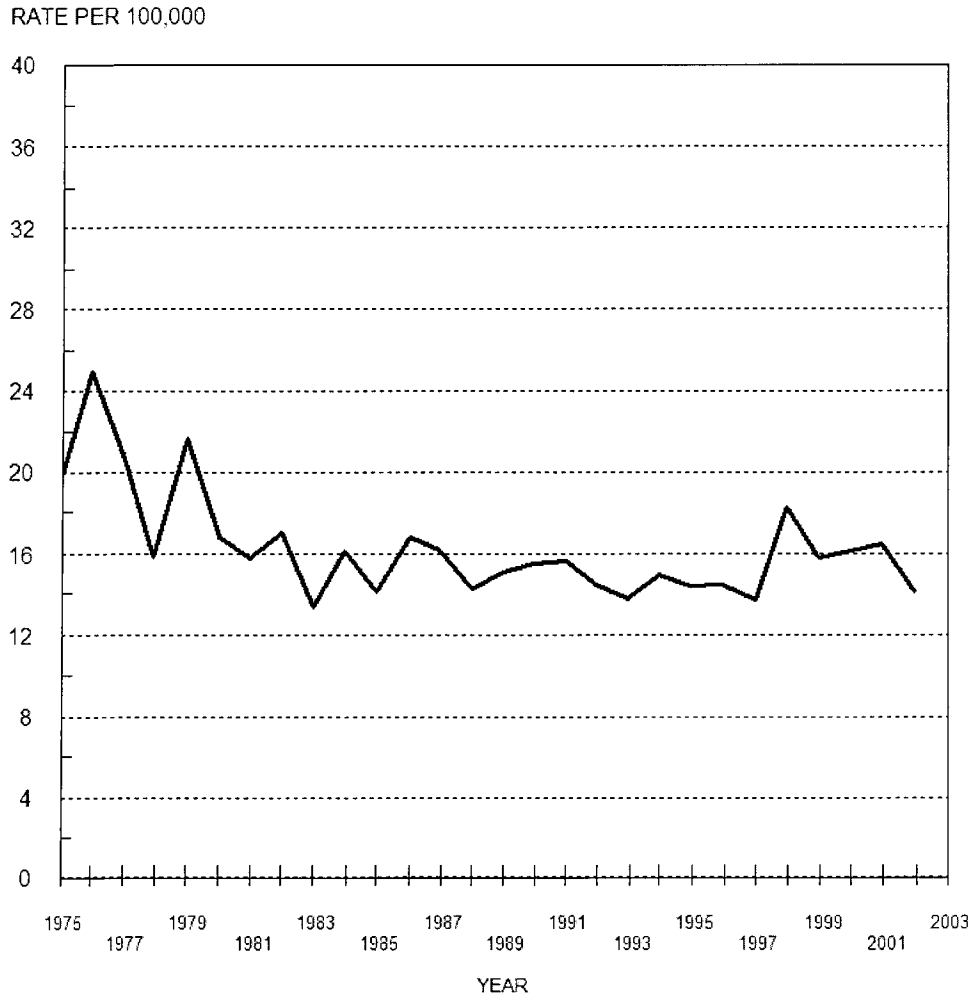
SOURCE: Virginia Center For Health Statistics

CHART 4
RESIDENT SUICIDE RATES, AGES 25-34
VIRGINIA, 1975-2002



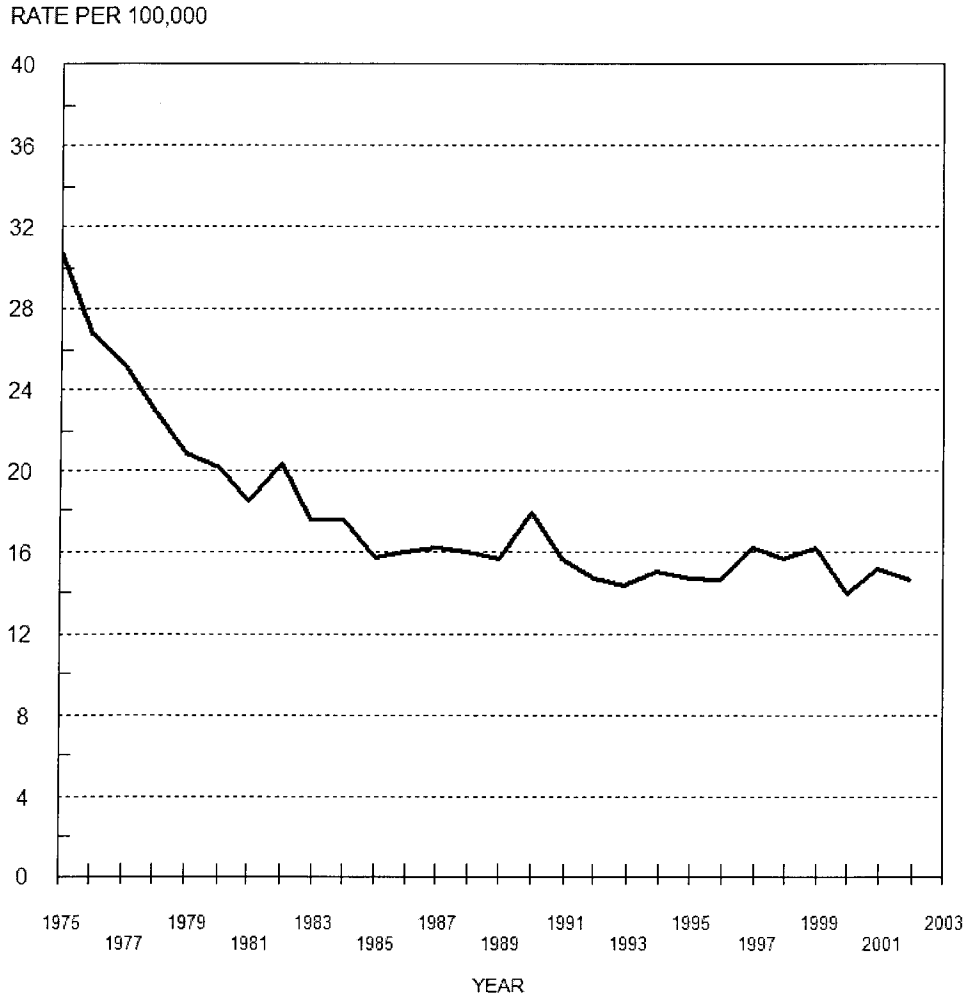
SOURCE: Virginia Center For Health Statistics

CHART 5
RESIDENT SUICIDE RATES, AGES 35-44
VIRGINIA, 1975-2002



SOURCE: Virginia Center For Health Statistics

CHART 6
RESIDENT SUICIDE RATES, AGES 45-54
VIRGINIA, 1975-2002



SOURCE: Virginia Center For Health Statistics

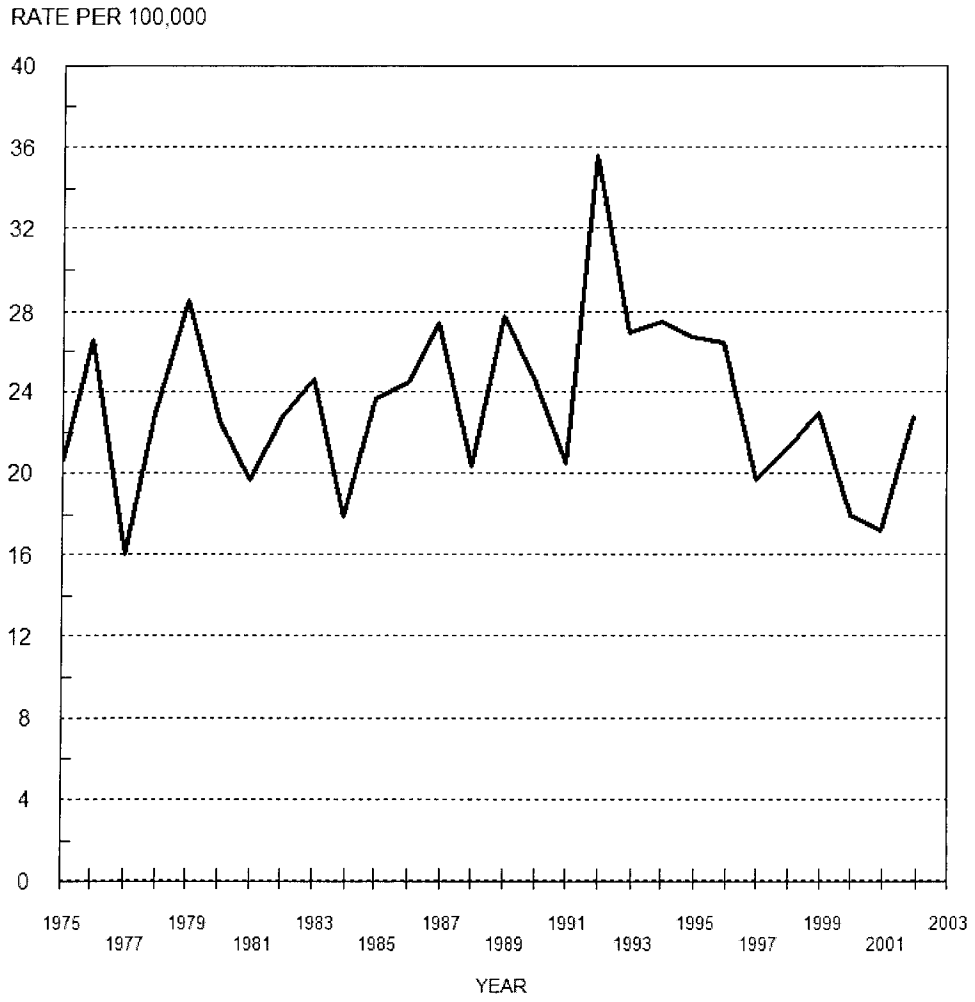
CHART 7
RESIDENT SUICIDE RATES, AGES 55-64
VIRGINIA, 1975-2002

SOURCE: Virginia Center For Health Statistics

CHART 8
RESIDENT SUICIDE RATES, AGES 65-74
VIRGINIA, 1975-2002

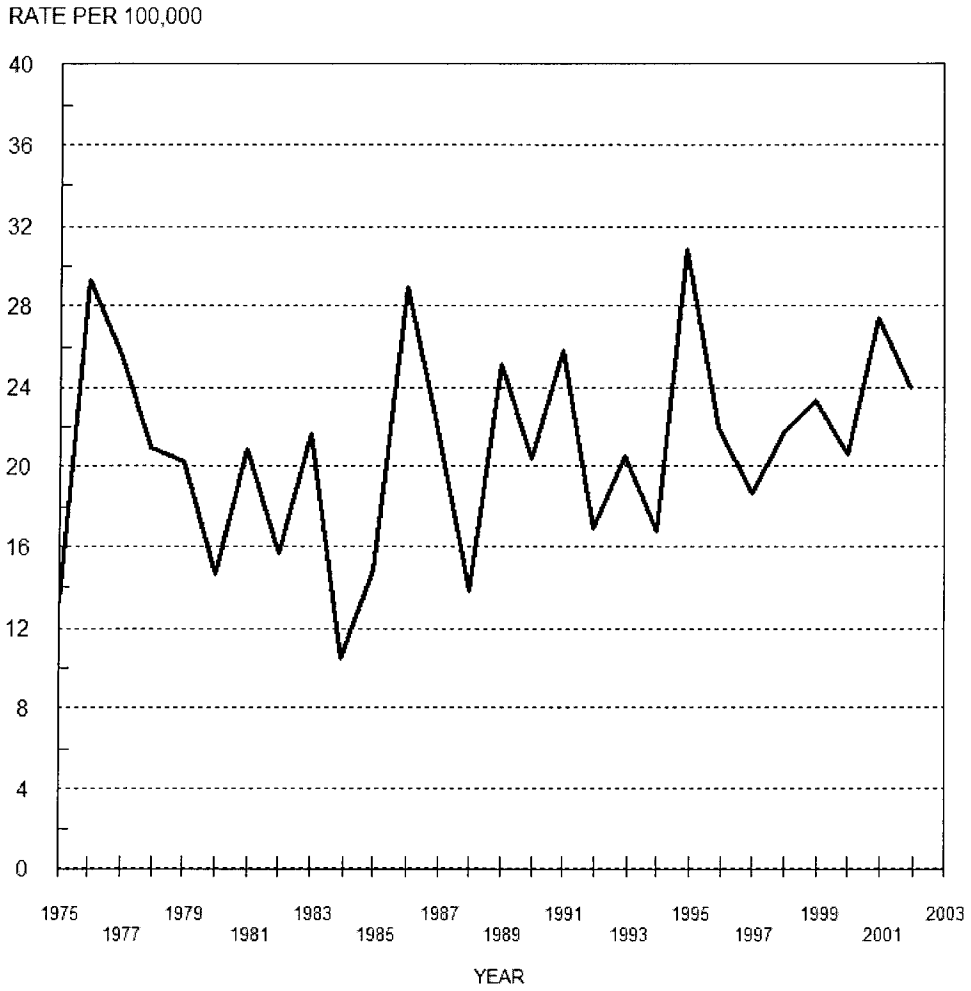
SOURCE: Virginia Center For Health Statistics

CHART 9
RESIDENT SUICIDE RATES, AGES 75-84
VIRGINIA, 1975-2002



SOURCE: Virginia Center For Health Statistics

CHART 10
RESIDENT SUICIDE RATES, AGES 85+
VIRGINIA, 1975-2002



SOURCE: Virginia Center For Health Statistics

Adjusted Suicide Rates by City/County and Planning District, 1999-2002[1]

1. Localities with a rate ≥ 22.0 (2 times state rate)

	No.	Rate
Buchanan	27	25.0
Scott	26	24.9
Russell	30	24.3
Wise	38	22.8
Planning District 1	87	23.2
Planning District 2	110	22.0

2. Localities with a rate ≥ 19.25 (1.75 times state rate)

	No.	Rate
Lee	20	21.9
Dinwiddie	22	21.0
Pulaski	29	20.3
Tazewell	40	20.2

3. Localities with a rate ≥ 16.5 (1.5 times state rate)

	No.	Rate
Danville	36	19.2
Louisa	20	19.1
Pittsylvania	47	18.4
Botetourt	24	18.1
Henry	43	17.1
Wythe	20	16.9
Isle of Wight	20	16.7
Smyth	21	16.6
Planning District 12	184	17.6

[1] This list includes only those localities with at least 20 deaths due to suicides during 1999-2002. Fewer deaths leads may result in unstable rates.

4. Localities with a rate ≥ 13.75 (1.25 times state rate)

	No.	Rate
Culpeper	23	16.8
Amherst	21	16.4
Shenandoah	24	16.0
Warren	20	15.5
Roanoke City	60	15.2
Bedford	37	15.0
Washington	32	14.4
Roanoke County	52	14.2
Henry	28	14.2
Halifax	21	13.9
Planning District 3	116	14.5
Planning District 5	160	14.4

5. Localities with a rate ≥ 11.00 (equal to state rate)

	No.	Rate
Charlottesville	20	13.1
Portsmouth City	49	12.3
Norfolk City	108	12.1
Chesterfield	121	12.0
Richmond City	96	11.9
Lynchburg	29	11.8
Henrico	123	11.6
Planning District 19	92	13.4
Planning District 22	26	12.4
Planning District 13	45	12.2
Planning District 18	42	12.1
Planning District 15	413	11.8
Planning District 14	45	11.3
Planning District 16	108	11.2

Adjusted Male Death Rates Due to Suicides by Planning District, 1999-2002

Planning Districts (P.D.) with Adjusted Rates ≥ 1.25 times the state rate for males.

	No.	Rate
State	**2,476**	**18.6**
P.D. 2(Buchanan, Dickenson, Russell, Tazewell)	**88**	**37.3**
P.D. 1(Lee, Scott, Wise, Norton)	**66**	**36.1**
P.D. 12 (Franklin, Henry, Patrick, Pittsylvania, Danville, Martinsville)	**160**	**32.7**
P.D. 3 (Bland, Carroll, Grayson, Smyth, Washington, Wythe, Bristol, Galax)	**98**	**26.2**
P.D. 5 (Alleghany, Botetourt, Craig, Roanoke City and County, Covington, Salem)	**120**	**23.9**
P.D. 22 (Accomack, Northampton)	**23**	**23.8**
P.D. 7 (Clarke, Frederick, Page, Shenandoah, Warren, Winchester)	**86**	**23.1**
P.D. 11 (Amherst, Appomattox, Bedford County and City, Campbell, Lynchburg)	**99**	**23.0**
P.D. 19 (Dinwiddie, Greensville, Prince George, Surry, Sussex, Colonial Heights, Emporia, Hopewell, Petersburg)	**75**	**22.9**
P.D. 10 (Albemarle, Fluvanna, Greene, Louisa, Nelson, Charlottesville)	**85**	**22.7**

Source: Virginia Center for Health Statistics

Appendix G

Hospitalizations due to Self-Inflicted Injury, Virginia 2002

Age Group	Frequency (Column %)	% of Age Group's Total Injury Hospitalizations
<1 Year	0	
1-4 Years	0	
5-9 Years	3 (.07%)	.5%
10-14 Years	143 (3.4%)	16.5%
15-19 Years	544 (12.7%)	25.9%
20-24 Years	522 (12.4%)	23.5%
25-29 Years	458 (10.9%)	25.8%
30-34 Years	507 (12.0%)	26.6%
35-39 Years	536 (12.7%)	23.6%
40-44 Years	549 (13.0%)	22.7%
45-49 Years	399 (9.5%)	17.3%
50-54 Years	234 (5.5%)	11.7%
55-59 Years	119 (2.8%)	7.0%
60-64 Years	68 (1.6%)	4.6%
65+ Years	139 (3.3%)	1%
Total	**4210 (100%)**	**11.4%**

Source: Virginia Department of Health

Appendix H

Suicide-Related Healthy People 2010 Outcome Objectives

1. By 2010, reduce the suicide rate to **5.0/100,000 (Healthy People (HP) 18-1).** (*Virginia 2002 Baseline:* **10.8**; *U.S. 2010 Target*: **5.0/100,000;** *U.S. Rate in 2001:* **10.7**)

2. By 2010, reduce the rate of suicide attempts by adults. (*Virginia 2003 Baseline:* **27,800,** *estimated; Target:* **14,000**)

3. By 2010, reduce the rate of suicide attempts by adolescents (**HP 18-2 and Virginia Healthy People 2010).** (*Virginia 2002 Baseline:* **not available**; *U.S. 1999 Baseline:* **2.6% of adolescents in 9th – 12th grades**; *U.S. 2010 Target:* **1%**)

4. By 2010, increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health **(HP 7-2 and Virginia Healthy People 2010).** (*Virginia Baseline:* **not available** *U.S. 1994 Baseline*: **58% of schools** providing education on suicide; *U.S. 2010 Target:* **80%**).

Related Objectives

1. By 2010, reduce the rate of firearm-related deaths **(HP 15-3 and Virginia Healthy People 2010).** (*Virginia 2002 Baseline:* **10.5/100,000 population** *U.S. 1998 Baseline*: **11.3/100,000**; *U.S. 2010 Target*: **4.1/100,000**)

2. By 2010, increase the proportion of children with mental health problems who receive treatment. **(HP 18-7)** (*Virginia baseline:* **not available** *Source of data:* **1997 National Survey of America's Families: 79% of children and adolescents aged 6 to 17 years with mental health problems severe enough to indicate a clinical need for mental health evaluation, did not receive a mental health evaluation or treatment in the past year**; *2010 Target*: **no target established**).

3. By 2010, increase the proportion of adults with mental disorders who receive treatment (**HP 18-9**). (*Virginia Baseline:* **not available**; *U.S. 1997 Baseline:* **23% of adults aged 18 and older with recognized depression**; *U.S. 2010 Target*: **50%**)

Appendix I

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

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Voice/TDD (804) 371-8977
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October 15, 2004

Robert B. Stroube, M.D., M.P.H., Commissioner
Virginia Department of Health
Post Office Box 2449
Richmond, Virginia 23218-2448

Dear Dr. Stroube:

Thank you again for the opportunity to participate in the development of the *Suicide Prevention Across the Life Span Plan for the Commonwealth.* The *Plan* is comprehensive and well-conceived, and this Department supports the goals and strategies of the *Plan*, as well as our new designation as the lead agency.

Attached please find draft legislation to formalize the designation of DMHMRSAS as the lead agency for suicide prevention, as proposed in Objective 1.1 of the *Plan*. These amendments also preserve the Department of Health's role with respect to youth suicide prevention, as envisioned in the *Plan*.

As you know, the Department of MH, MR and SA Services has no staff or other resources devoted to suicide prevention across the lifespan, and would need significant new funding to implement the *Suicide Prevention Across the Life Span Plan for the Commonwealth*. Funding is needed to support suicide prevention staff, research and data collection infrastructure, direct services by community services boards, public awareness initiatives, training, and support for coalition-building with local and regional entities. I have also attached a summary of these costs.

Again, I appreciate the Department of Health's vision and leadership on this *Plan*, and I look forward to working together to make these activities a reality.

Sincerely,

James S. Reinhard, M.D.

JSR:ibs

Pc: The Honorable Jane H. Woods

Attachment

Resource Requirements by Fiscal Year for Phased Implemention of the Plan

Department of Mental Health, Mental Retardation and Substance Abuse Services

	FY2006		FY2007		FY2008		FY2009		FY2010	
	FTEs		FTEs		FTEs		FTEs		FTEs	
Suicide Prevention Manager (Pay Band 6)	1.0	$ 94,500	1.0	$ 97,335	1.0	$ 100,255	1.0	$ 103,263	1.0	$ 106,361
Suicide Prevention Specialist (Pay Band 5)	0.0	$ -	5.0	$ 405,000	5.0	$ 417,150	5.0	$ 429,665	5.0	$ 442,554
Research Coordinator (Pay Band 5)	0.0	$ -	1.0	$ 81,000	1.0	$ 83,430	1.0	$ 85,933	1.0	$ 88,511
Admin / Office Specialist III (Pay Band 3)	0.0	$ -	0.5	$ 54,000	0.5	$ 55,620	0.5	$ 57,289	0.5	$ 59,007
Equipment	- -	$ 3,000	- -	$ 21,500	- -	$ 3,750	- -	$ 3,750	- -	$ 3,750
Travel	- -	$ 2,500	- -	$ 18,750	- -	$ 18,750	- -	$ 18,750	- -	$ 18,750
Office / Supplies	- -	$ 1,500	- -	$ 11,250	- -	$ 11,250	- -	$ 11,250	- -	$ 11,250
Research Infrastructure	- -	$ -	- -	$ 30,000	- -	$ 2,000	- -	$ 2,000	- -	$ 2,000
Contractual Services - Public Awareness	- -	$ -	- -	$ 82,500	- -	$ 82,500	- -	$ 82,500	- -	$ 82,500
Contractual Services - Training	- -	$ -	- -	$ 85,000	- -	$ 85,000	- -	$ 85,000	- -	$ 85,000
Contractual Svcs - Community Leadership	- -	$ 40,000	- -	$ 80,000	- -	$ 80,000	- -	$ 80,000	- -	$ 80,000
CSB Direct Services	- -	$ -	- -	$ 2,000,000	- -	$ 2,000,000	- -	$ 2,000,000	- -	$ 2,000,000
Yearly Total	1.0	$ 141,500	7.5	$ 2,966,335	7.5	$ 2,939,705	7.5	$ 2,959,399	7.5	$ 2,979,683

FTE Salary: Starting salary at mid-range plus fringe benefits plus 3.0% yearly cost of living adjustment

Equipment: $3,000 initial per FTE; $500 each subsequent year per FTE

Travel: $2,000 per FTE

Office/ Supplies: $1,500 per FTE

Department of Health Center for Injury and Violence Prevention

	FY2006		FY2007		FY2008		FY2009		FY2010	
Suicide Prevention Coordinator	1.0	$50,100	1.0	$68,804	1.0	$70,868	1.0	$72,994	1.0	$75,184
Contractual Services	- -	$74,246	- -	$98,995	- -	$98,995	- -	$98,995	- -	$98,995
Supplies and Materials	- -	$38,474	- -	$51,299	- -	$51,299	- -	$51,299	- -	$51,299
Continuous Charges	- -	$3,150	- -	$4,200	- -	$4,200	- -	$4,200	- -	$4,200
Yearly Total	1.0	$165,970	1.0	$223,298	1.0	$225,362	1.0	$227,488	1.0	$229,678

State funds are not requested for FY 2005 since the federal grant funding is available. One quarter grant funding will be available for FY 2006 therefore the request represents three quarters of funding only. Salary and fringe for coordinator: $50,100 in the initial year represents three quarters funding. Annual cost is $66,800 with a 3% annual salary increase thereafter.

Contractual Services: 50 ASIST Trainings @ $600/training ($30,000); 300 QPR trainings @ $50/training ($15,000), Annual trainer training ($27,000), Annual Radio Campaign ($18,000); Trainers' travel reimbursement @ 24,500 miles x .32/mile($7,963); Coordinator travel @3,225 miles x .32/mile ($1,032)

Supplies/ Materials: ASIST participant materials @$36/ participant x 1,200 participants ($43,200); 30,000 QPR cards ($5,699); general office supplies @$200/month ($2,400)

Continuous Charges: Phone ($1,200); Rent ($3,000)

Appendix K

Proposed Legislation: DMHMRSAS to be lead agency for suicide prevention

§ 32.1-73.7. Department to be lead agency for youth suicide prevention.

With such funds as may be appropriated for this purpose, the Department, in consultation with the Department of Education, the Department of Mental Health, Mental Retardation and Substance Abuse Services, community services boards, and local departments of health, shall have the lead responsibility for the youth suicide prevention program within the Commonwealth. This responsibility includes coordination of the activities of the agencies of the Commonwealth pertaining to youth suicide prevention in order to develop and carry out ~~a~~ comprehensive youth suicide prevention ~~plan~~ strategies addressing the promotion of health development, early identification, crisis intervention, and support to survivors. The ~~plan~~ strategies shall be targeted to the specific needs of children and adolescents. The Department shall cooperate with federal, state and local agencies, private and public agencies, survivor groups and other interested individuals in order to prevent youth suicide within the Commonwealth. The Department shall submit a status report ~~annually by December 1 of each year to the Governor and the General Assembly~~ on its youth suicide prevention activities to the Department of Mental Health, Mental Retardation and Substance Abuse Services annually for inclusion in the report on suicide prevention activities to the Governor and General Assembly pursuant to § 37.1-48.3.

§37.1-48.3 Department to be lead agency for suicide prevention across the lifespan.

With such funds as may be appropriated for this purpose, the Department, in consultation with the community services boards, the Department of Health and local departments of health, and the Department for the Aging shall have the lead responsibility for the suicide prevention across the lifespan program within the Commonwealth. This responsibility includes coordination of the activities of the agencies of the Commonwealth pertaining to suicide prevention in order to develop and carry out a comprehensive suicide prevention plan addressing public awareness, the promotion of health development, early identification, intervention and treatment, support to survivors and surveillance. The Department shall cooperate with federal, state and local agencies, private and public agencies, survivor groups and other interested individuals in order to prevent suicide within the Commonwealth. The Department shall report annually by December 1 of each year to the Governor and the General Assembly on its suicide prevention activities.

The provisions of this section shall not limit the powers and duties of other state agencies. The Department of Health shall continue to be responsible for youth suicide prevention strategies as provided in § 32.1-73.7 of the Code of Virginia.

10/14/04