Firearm Suicide Prevention Task Force 11/30/16

Agenda:

- Review of the documents
- Discussion of proposals
- Public comment

Meeting Schedule:

Meeting #	Date	Location	Time
Meeting 3	Friday, December 9th	House Hearing Room, Legislative Hall	10:00am – 12:00pm

Membership:

Membership	Name	Title/Organization
Chair	Lisa Goodman	Chair
Vice Chair	Rep. Valerie Longhurst	State Representative
Member	Rep. Trey Paradee	State Representative
Member	Rep. Kevin Hensley	State Representative
Member	Sen. Henry	State Senator
Member	Sen. Ernie Lopez	State Senator
Member	Byran Horsey	Member of the Public
Member	Pete Rudoff	Member of the Public
Member	Cyndi McLaughlin	Foundation for a Better Tomorrow
Member	Dr. Harvey Doppelt	Division of Prevention and Behavioral Health Services, DSCYF
Member	Sec. Rita Landgraf	Dept. of Health and Social Services
Member	Jeff Hague	Delaware State Sportsman Association
Member	Bill Farley	Commission on Veterans Affairs
Member	Sgt. John McDerby on behalf of Chief Drew Aydelotte	DNREC
Member	Emily Vera	Mental Health Association
Member	George Higgins	Delaware Coalition Against Gun Violence
Member	Amy Kevis	Division of Substance Abuse & Mental Health
Member	Scott Tese	Firearm Dealer
Member	Jim Beatty	Firearm Dealer
Participant	Rick Armitage	NRA
Staff	Lauren Vella	Delaware House of Representatives

Firearm Suicide Prevention Task Force

Tuesday, November 15, 2016
10:00 a.m. – 12:00 p.m.
Legislative Hall, Senate Hearing Room
411 Legislative Ave.
Dover, DE 19901

Meeting Attendees:

Task Force Members:

Present:	Title/Organization
Lisa Goodman	Chair
Rep. Valerie Longhurst	Vice-Chair
Rep. Trey Paradee	State Representative
Rep. Kevin Hensley	State Representative
Sen. Margaret Rose Henry	State Senator
Sen. Ernie Lopez	State Senator
Pete Rudoff	Member of the Public
Cyndi McLaughlin	Foundation for a Better Tomorrow
Dr. Harvey Doppelt	DSCYF
Sec. Rita Landgraf	Dept. of Health and Social Services
Jeff Hague	Delaware State Sportsman Association
William Farley	Commission on Veterans Affairs
Emily Vera	Mental Health Association

Absent:	
Bryan Horsey	Member of the Public
Chief Drew Aydelotte	DNREC

Attendees:	Organization:
George Higgins	Delaware Coalition Against Gun Violence
Amy Kevis	DHSS on behalf of Bryan Horsey
Sgt. John McDerby	DNREC on behalf of Chief Drew Aydelotte
Rep. Daivd Bentz	State Representative

Staff:	
Lauren Vella	House of Representatives
Kay Wilson	House of Representatives
Stephanie Mantegna	House of Representatives
Samantha Hemphill	State Senate

Chair of the Firearm Suicide Prevention Task Force, Lisa Goodman, called the meeting to order at 10:06 a.m. She provided an introduction to the group and the intentions of the Task Force. She shared her background as President of Equality Delaware noting the increased risk of suicide in the LGBTQ community. She also shared her personal experience with the suicide of her father by a firearm.

She then asked the task force members and the public to provide a brief introduction. Many members of the group shared personal stories of suicides in their families or among friends as well as their related work experience.

Vice-Chair of the Firearm Suicide Prevention Task Force, State Representative Valerie Longhurst shared her thanks for the members' participation and shared her work with suicide prevention efforts during her tenure as a legislator. She shared her work on House Bill 90 in 2015 which requires training for public school personnel on the warning signs of suicide and requires prevention and response plans as well as her work with veteran suicide prevention with the '22 in 22' initiative.

Sen. Henry acknowledged the distinction between those suffering from mental illness and from end of life decisions regarding ending physical pain. She wanted to make it clear that senior suicides need to be looked at carefully to not misidentify an end of life decision with a mental illness induced suicide.

Chair Goodman reviewed the text of the Executive Order 63 and the charge of the task force to do the following:

a. Examining the current outreach, education and training about suicide to firearm owners.
b. Reviewing models and data from other state and local governments on effective public strategies for suicide prevention among firearm owners.
c. Developing recommendations to reduce suicides by firearms in Delaware.
d. Reviewing ways to connect mental health resources with at-risk populations.
e. Engaging firearm advocates, dealers and clubs in suicide prevention efforts.

She discussed the importance of getting firearm dealers to the table to be a part of the discussion and noted the report due date is January 1st.

Dr. Harvey Doppelt reviewed the Center for Disease Control (CDC) data of suicides and firearms in Delaware from 1999 to 2014. The data shows that white men are much more likely than women or minorities to commit suicide by firearm. He discussed the youth clusters explaining that adolescents are more likely to commit suicide if other children have done so response to youth suicide needs to be very careful to address other children in the community. Women are more likely to use pills to attempt suicide and this is often not lethal, so intervention can be made. Dr. Doppelt noted that being widowed was a risk factor for white males. Firearm suicides are the most lethal method.

Jeff Hauge remarked on the aging retiree population in Sussex County. Dr. Doppelt reviewed the firearm suicide rates as compared to other states. New Jersey had a significantly lower rate than Delaware. New Jersey is the second lowest state for gun ownership.

Vice-Chair Longhurst asked for an explanation on why New Jersey has such a lower rate of firearm suicide. Sec. Rita Landgraf offered to reach out to her counterparts in New Jersey to see what they are doing from a mental health perspective.

George Higgins and Dr. Doppelt discussed Delaware's participation in the National Violent Death Reporting System (NVDRS) which will improve the data collection for suicide. Dr. Doppelt shared that the state received the grant and is working on additional paperwork. NVDRS will be connected with law enforcement and the medical examiner's office.

The committee reviewed the article and legislation from Washington State. Vice-Chair Longhurst explained that the widow of the man who committed suicide by firearm reached out to the National Rifle Association to find a way to prevent these kinds of suicides. Chair Goodman pointed out that the legislation in Washington established a system of partners with the points of contact for people to obtain lethal means of suicide. Washington developed intervention strategies and materials at these locations in order to educate and intervene.

Sen. Henry asked if there have been any results or outcomes from Washington. Since the law was signing in 2016, outcomes are not yet available.

Chair Goodman reviewed the article about Dr. Gould, a professor of epidemiology at Columbia University and her work with suicide at the George Washington Bridge. Chair Goodman remarked that a take away would be from Dr. Gould's work is that the press needs to be engaged about how to cover suicides properly to not insight a suicide contagion.

Vice-Chair Longhurst asked the task force member to do some homework and review the materials provided at this meeting carefully. She also inquired about the current training law enforcement and first responders receive to handle calls.

William Farley shared that the Commission of Veterans Affairs provided training for law enforcement on post-traumatic stress disorder (PTSD). It was a onetime training.

Amy Kevis shared her experience as a New Castle County police officer for 20 years. It is difficult for officers to be prepared in practical ways to handle these types of cases. She saw this as an opportunity to review the training continuum that exists.

Sgt. John McDerby shared that officers within DNREC receive training but it is not annual and that bigger departments tend to have specialized officers. He noted that some training programs provide just a checklist but it is hard to make them meaningful and translate to the actual real situations officers will be responding to.

Amy Kevis shared about the training Division of Substance and Abuse and Mental Health (DSAMH) provides to crisis intervention teams for 40 hours. She would like to see more people

participate in that training given its significant time commitment. Emily Vera explained the training that the Mental Health Association provides at the Wilmington Policy Academy.

Chair Goodman noted that suicides can run in families and how important it is to educate family members.

Sen. Henry suggested that a commission be created to implement this work and to establish a collaborative effort providing the Child Protection Accountability Commission as an example.

William Farley noted that the training component in Washington's legislation brought consensus among gun owners and dealers.

Rep. Hensley pointed to the wellness centers in all of the Delaware public schools as a place for education and intervention with youth.

Cyndi McLaughlin suggested that efforts be implemented in steps to improve compliance and ease any concerns about the large undertaking. She also suggested that any recommendation include methods to help build up data.

Pete Rudoff asked if there was existing data on the signs of suicide to help inform the interventions. Cyndi McLaughlin share information about a 90 minute online training, Signs of Suicide.

George Higgins asked if the CDC had looked at suicide in the scientific way they recently looked at Wilmington's gun violence problem. Sec. Landgraf did not believe that they did; they look at just homicides.

The group discussed their goals for the next meeting which included each member submitting two proposals and disseminating the "Signs of Suicide" training module.

Chair Goodman opened the conversation to the public. Rep. Bentz remarked on the gender divide in suicide method and suggested modeling the Washington approach by addressing a in a holistic suicide methods including prescription drug overdoses. Vice-Chair Longhurst suggested that that be a recommendation for a commission to look at all methods.

Sen. Henry expressed her appreciation for firearm owners for their participation. She made it clear that she is not looking to take guns away but that there can be better ways to reach out to those in distress.

William Farley asked if this is a component of gun safety training and noted that the phrasing is really important to make suicide prevention a component of being a responsible gun owner.

Chair Goodman agreed that providing materials at gun shops is important but the content is equally as important. The meeting was adjourned at 11:46 a.m.

Respectfully submitted by: Lauren Vella

Gun Shop Project:

https://www.hsph.harvard.edu/means-matter/gun-shop-project/

Suicide Prevention: A Role for Firearm Dealers and Range Owners

Means Matter began working in 2009 on a novel project in New Hampshire to reach out to gun shops on the role that they can play in suicide prevention. The work is guided by the NH Firearm Safety Coalition, a group of mental health and public health practitioners, firearm retailers, and firearm rights advocates. The project developed materials with and for firearm retailers and range owners on ways they can help prevent suicide. Its objectives are to:

- Share guidelines on how to avoid selling or renting a firearm to a suicidal customer
- Encourage gun stores and firing ranges to display and distribute suicide prevention materials tailored to their customers

Half of the gun shops in New Hampshire are disseminating the materials, according to visits to all shops in 2011/2. And the project is now nationwide:

The project disseminated materials aimed both at reducing suicides involving recently-purchased firearms as well as existing household firearms. (Materials below include a poster, brochure, and tip sheet, below.) Our role in the coalition has been as research partner to study the issue, to survey the gun shop owners before and after the campaign (to solicit input and measure impact– over half of the commercial gun shops in the state were interviewed beforehand, and all were visited afterward), and to develop the materials for the campaign (with the exception of the video, which others took the lead on). The campaign products (disseminated in August 2011) and related press coverage are available at www.nhfsc.org. 48% of commercial firearm retailers in NH are displaying at least one product developed by the coalition.

Discussions with gun owners in the coalition and dealers around the state were invaluable; we are seeking funding to provide technical assistance to other suicide prevention groups around the country who express interest in starting up similar projects. **For more information about this project including links to the poster and brochure shown below please visit www.nhfsc.org or contact us.**

Gun Shop Project FAQ:

https://www.hsph.harvard.edu/means-matter/gun-shop-faq/

A Q&A with the NH Firearm Safety Coalition

1. Won't a suicidal person just use something else if they can't get a gun?

Sometimes, yes. But almost every other method is less lethal than a firearm so there‟s a greater chance the person won‟t die in their attempt. Also, other methods allow time for rescue or give the ambivalent attempter some time to change their mind mid-attempt.

2. If a suicidal person substitutes another method and doesn't die, won't they eventually figure out a way to kill themselves later?

Suicidal feelings often pass over time. Studies that follow people over many years have found that roughly 90% of those who survive a suicide attempt do not go on to die by suicide, including those who made a very serious attempt, like jumping in front of a train.

3. Suicide is a sensitive subject—I'm concerned about offending my customers or making them feel uncomfortable.

It‟s true this is a difficult subject, but it‟s also true that thoughtful conversations about hard topics can produce good outcomes, in this case even save lives. A customer might see our poster or brochure in your store, for example, and talk to his newly-divorced brother about letting him hold onto his guns until his deep depression lifts. Your store may have just helped save a life without your even knowing it. That said, it is very important to us to ensure our materials share information in a respectful manner. Please let us know what you hear!

4. Suicide is a personal choice—it's your right to end your life. Who am I to intervene if someone doesn't want to live anymore?

Suicide is certainly a personal choice. Some people attempt suicide after a lot of deliberation and are virtually certain life is no longer worth living. But many attempt during a crisis and most are ambivalent. Over half of attempters report less than an hour passed between deciding on suicide

and making the attempt, according to a number of studies. Often people who have survived serious attempts say something like: “The moment I jumped I said to myself…What did I just do? I don’t want to die…‟” Also, thousands of people in their teens and twenties kill themselves each year in the U.S.—too young an age to give up on life.

5. Does relocating the guns for a while always work?

Reducing access to firearms and other lethal means is only part of a broader suicide prevention plan. Those considered actively suicidal are best protected by not being left alone until they are feeling better. Getting professional help and the support of other family and friends is strongly advised. The Suicide Prevention Lifeline is 1-800-273-TALK (8255) and is available 24/7.

6. I’m concerned I’ll be sued if I refuse to make a sale or rent a firearm to someone who passes the background check.

The two largest gun shops in NH and ME have never been sued for this reason. Stores and ranges are NOT violating 2nd amendment rights by refusing a purchase or rental if we suspect something isn‟t right; it is well within our legal rights to deny a transaction (as long as this denial is not simply based on a person‟s race, ethnicity, religious beliefs, or sex). In fact, there have been instances where store owners have been sued by the family of someone who purchased a firearm and killed themselves soon after.

7. Customers could be acting funny for other reasons besides suicide—first time customers in particular are often a little nervous and don’t know anything about guns.

It’s hard to know for sure if someone is suicidal. The Tip Sheet is meant to help your staff identify customers who exhibit some “red flags.” Usually new customers are eager to hear purchasing advice from staff, and will gladly respond to questions we may ask as we try to help them select the best firearm for their purposes. It‟s those who are reluctant to converse with staff about the purchase, or who seem to be troubled, who require extra caution. You should “go with your gut” and your experience.

8. The Tip Sheet says one in ten firearm suicides were with recently purchased guns. That sounds like a lot—I’ve been in business for many years and never thought a customer was suicidal.

It sounded like a lot to us, too. But that number comes straight from the office of the NH Medical Examiner. When the ME‟s office investigates a death, sometimes they‟ll find a receipt for the gun
in the victim‟s pocket or next to the gun, so they know it‟s a recent purchase. Hopefully you and your staff will never come across a suicidal customer, but being prepared should that unfortunate day come could save a life.

9. I have had a customer purchase a gun for suicide, and he didn’t exhibit ANY warning signs at all. You can’t always spot people who are really serious about killing themselves.

There’s no way all suicides can be prevented. But there have been occasions when a dealer asked a person who seemed shaky whether they should really be buying this gun and they admitted they were considering suicide. One family wrote our co-Chair (owner of Riley’s Sports Shop)

and said that his question saved their mother‟s life. The more ambivalent someone is about suicide, the greater the opportunity for intervention.

10. What do I say to a customer who keeps a gun at home for self-defense but is worried about someone at home who's going through a rough time?
It depends on how that gun is stored. If a customer‟s loved one at home (or with keys to their home) is going through a rough time, they may want to re-evaluate the accessibility of that firearm to that person. Suicide may be the bigger threat that your customer has to guard against in the short term until the situation improves.

OTHER QUESTIONS?
Contact co-Chair Ralph Demicco at (603)485-5000, ext. 101 or send an email to the New Hampshire Firearm Safety Coalition via our website: www.nhfsc.org. (Research assistance from meansmatter.org)

PROGRESS IN SAFETY

Unintentional gun deaths have **dropped by over 50% in New Hampshire** over the last three decades!

NEW HAMPSHIRE FIREARM ACCIDENTS

	Deaths	Injuries treated in the Emergency Department
1983–1987	17	NA
2003–2007	7	193

Still, with one or two deaths a year—and about 40 injuries treated in New Hampshire emergency departments every year from firearm accidents—we can do better.

The first step is to follow the 11 commandments of gun safety. The newest rule addresses suicide prevention. Suicides far outnumber homicides in New Hampshire (annually about 150–200 suicides vs. 20 homicides). Firearms are the leading suicide method in our state (about half of all suicides).

If a family member is going through a difficult period (like depression, a relationship break-up, or drug problem), make sure they can't get to your guns. To learn ways to get help for them, call the **National Suicide Prevention Lifeline: 1-800-273-TALK [8255]**.

ABOUT THE COALITION

The New Hampshire Firearm Safety Coalition brings together a broad range of individuals and organizations who share a concern with firearm safety. The group includes: gun shops and firing ranges, legislators, injury prevention and mental health advocates, researchers and committed volunteers.

Since the Coalition first formed in 1994, the group has produced a variety of public education materials initially geared towards young people: a brochure and other printed materials, Firearm Safety Display Kits available for use at health fairs and educational programs, and two videos entitled "Staying Safe Around Guns – What You DON'T Know Can Hurt You" for middle and high school students. Since then, more than 4500 copies of these have been distributed throughout NH, the US and abroad.

In 2009, the Coalition took on *Suicide Prevention: A Role for Gun Shops and Ranges* – a collaborative effort to engage gun shop and range owners, their employees and their customers on preventing suicide, the number one type of firearm death in the U.S.

For more information visit our website
www.nhfsc.org

GUN SAFETY RULES

~~10~~ 11 COMMANDMENTS OF GUN SAFETY

Look inside to see what's new!

SHOOTING A GUN

1. **Seek proper instruction.** Attend a reputable firearms safety handling course or seek private instruction before attempting to use a firearm. Before handling a new gun, learn how it operates. This includes knowing its basic parts, how to safely open and close the action, and how to safely remove any ammunition if loaded. Remember, a firearm's mechanical safety device is never foolproof. The safety device can never replace safe firearm handling.

2. **Wear eye and ear protection as appropriate.** Firearms are loud. They can also emit debris and hot gases that can cause injury. For these reasons, safety glasses and ear protectors are recommended.

3. **Be sure your gun and ammunition are compatible.** Only cartridges or shells designed for a particular gun can be safely fired by that gun. Most guns have their cartridge or shell type stamped on the barrel. Ammunition can be identified by information printed on the box and stamped on each cartridge. Do not fire the gun if there is any question about the compatibility of the gun and ammunition.

4. **Carry only one gauge/caliber of ammunition when shooting.** Smaller ammunition can be accidentally placed in a gun chamber designed for larger ammunition, creating an obstruction and a very hazardous situation. Remove unfired ammunition from clothing when you are through shooting to avoid accidentally mixing different ammunition next time you go shooting.

5. **Be sure of your target—and what's beyond.** Be absolutely sure you have identified your target without any doubt. Equally important, be aware of the area beyond your target. This means observing your prospective area of fire before you shoot. Never fire in a direction where there are people or any other potential for mishap. It's simple: *think first, shoot second.*

6. **Don't mix alcohol or drugs with shooting.** Alcohol, as well as any other substance likely to impair mental or physical functions of the body, should not be used before or while handling firearms.

OWNING & HANDLING A GUN

7. **Keep your finger off the trigger until you are ready to shoot.** There's a natural tendency to place your finger on the trigger when holding a gun. Avoid it! Your trigger finger should be extended, pointing forward, pressed against the side of the firearm, above the trigger area.

8. **Keep the action open and the gun unloaded until ready to use.** Whenever you pick up any gun, immediately check the action and check to see that the chamber is unloaded. If the gun has a magazine, make sure it is empty. Even if the magazine is empty or removed, a cartridge may still remain in the firing chamber. If you do not know how to open the gun's action, leave it alone or get help from someone who is knowledgeable.

9. **Always point the muzzle in a safe direction.** Whether you are shooting or simply handling your gun, never point the muzzle at yourself or at others. Common sense should dictate which direction is safest depending on your location and various other conditions. Generally speaking, it is safest to have the gun pointed upward or towards the ground.

10. **Store your guns safely and securely when not in use.** Hiding guns where you think children or others will not find them is not enough. Always store your guns unloaded and locked in a case or gun safe when not in use, with ammunition locked and stored in a separate location.

11. **Consider temporary off-site storage if a family member may be suicidal.** When an emotional crisis (like a break-up, job loss, legal trouble) or a major change in someone's behavior (like depression, violence, heavy drinking) causes concern, storing guns outside the home for a while may save a life. Friends as well as some shooting clubs, police departments, or gun shops may be able to store them for you until the situation improves.

New Hampshire Firearm Retailers:

Your vigilance could save a life!

Close to one in ten firearm suicides in New Hampshire occur with guns purchased within that same week, usually within *hours*. While not all suicides are preventable, you could reduce the odds that a gun bought at your store today is used in a suicide tomorrow.

Signs that a potential buyer could be suicidal

Note: None of these signs clearly indicate someone is suicidal, but if any are present (especially if more than one is present), use extra caution in deciding whether to proceed with the sale.

- No knowledge about guns AND no interest in learning; asks no questions
- Doesn't care which gun s/he purchases or seem responsive to your questions about the purchase
- Gives unconvincing response when asked what s/he intends to use the gun for
- No interest in firearm maintenance or safety
- Mentions recent crisis, such as a divorce, job loss, or other setback
- Makes comments that could suggest suicidality (e.g. "I don't need a lot of ammunition, I won't have the gun for long.")
- Looks anxious, avoids eye contact
- Appears distraught (shaking, fighting back tears)

Options for responding to a potentially suicidal buyer

- Notify store owner or manager (if applicable) if at all uncomfortable with a prospective sale
- Urge customer with little firearm experience to seek training before buying
- Ask the customer why s/he wants a firearm and how and where s/he plans to use it
- Suggest the customer take some more time to think it over before buying
- If s/he claims to be buying for self-defense, offer to sell pepper spray instead
- Ask person directly if s/he is suicidal; if yes, offer National Suicide Prevention Lifeline number (1-800-273-TALK [8255])
- Notify nearby dealers that someone you denied a sale to may go to their store; notify police
- Trust your instincts; you are under no obligation to sell a gun to anyone

"What else can I do?"

- Display a suicide prevention hotline poster in your store
- Distribute firearm safety brochures to buyers that include information about recognizing suicide warning signs and keeping firearms away from suicidal or depressed family members
- For more information on suicide prevention in NH visit www.theconnectproject.org
- Spread the word! Ask other dealers you know to visit our website to request our materials

Poster

CONCERNED ABOUT A FAMILY MEMBER OR FRIEND?

ARE THEY SUICIDAL?

- Depressed, angry, impulsive?
- Going through a relationship break-up, legal trouble, or other setback?
- Using drugs or alcohol more?
- Withdrawing from things they used to enjoy?
- Talking about being better off dead?
- Losing hope?
- Acting reckless?
- Feeling trapped?

SUICIDES IN NH
far outnumber homicides

FIREARMS ARE THE LEADING METHOD

ATTEMPTS WITH A GUN ARE MORE DEADLY
than attempts with other methods

HOLD ON TO THEIR GUNS

— Putting time and distance between a suicidal person and a gun may save a life.

— For other ways to help, call the National Suicide Prevention Lifeline: **1-800-273-TALK (8255)**

NH FSC

www.nhfsc.org

Washington State Suicide Prevention Plan Summary

Strategic Direction

Goals

Short-term and Long-term Recommendations

Contents

Strategic Direction 1: Healthy and Empowered Individuals, Families and Communities

Goal 1: The general public considers suicide a public health issue requiring public participation.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Create common language about suicide as a public health problem in messages from public agencies.	• State agencies (Department of Health; Health Care Authority; Department of Social and Health Services (DSHS), etc.) • Local and tribal governments • Local health agencies • Higher education institutions • Suicide prevention organizations • Journalists • General public
Create a statewide health promotion campaign about protective factors, using culturally competent and adaptable messages to reach all communities.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
• Perform research on how public health approaches to suicide prevention affect public conversation and program design.	• Suicide researchers • Suicide prevention organizations

Goal 2: Individuals, families and institutions understand that they have a role in improving community behavioral health and preventing suicide.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Make and publish a short list of action steps that everyone can take to help prevent suicide. Include suggestions for distribution in media, at community events, etc.	• State agencies • Suicide prevention organizations • Local and tribal governments • Educational institutions • Journalists • Faith community leaders • Policymakers • Health professionals • Private funders • Suicide prevention coalitions • People with positive stories • Military • Youth-serving and youth-led groups • Mental health consumer groups
Host public awareness events that dispel suicide myths and encourage new people to participate in prevention. Publicize respectful, positive personal stories showing that community support prevents suicide even for people at high risk.	
Expand peer-to-peer suicide support, education and prevention programs.[45]	
Create and distribute a toolkit for starting suicide prevention coalitions and initiatives.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Build a diverse[46] and skilled suicide prevention workforce to create suicide prevention coalitions and build their capacity for action, focusing resources on high-need communities.	• Suicide prevention coalitions • Suicide prevention organizations • Lawmakers and taxpayers • Private funders

Goal 3: News media report responsibly on behavioral health and suicide.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Post guidelines for appropriate and culturally competent suicide reporting on websites of behavioral health and suicide prevention organizations. Train spokespeople on these guidelines and encourage them to explain the guidelines to journalists who request interviews.	• Behavioral health professionals • Suicide prevention organizations • People and organizations consulted by media on behavioral health issues • Spokespeople for communities at elevated risk of suicide • Journalists and news organizations • People with a positive story • Schools of journalism • High school journalism programs
Media follow guidelines for safe messaging when reporting on suicide and behavioral health. Consult experts for guidance on best practices.	
Pitch and publish stories on suicide prevention in news media outside the context of an immediate crisis, including non-English-language and tribal news media.	
Identify news organizations with appropriate behavioral health and suicide reporting policies, and assist others in adopting similar guidelines.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Create a curriculum module on appropriate suicide and behavioral health reporting for use in high school, college and graduate journalism classes.	• Schools of journalism • High school journalism programs • Suicide prevention organizations

Goal 4: Social media spread appropriate, supportive messages about behavioral health and suicide.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Create a statewide, culturally flexible social marketing campaign to raise suicide awareness and promote crisis line resources.	• State agencies • Local health agencies • Suicide prevention organizations • Social media users • Mental health bloggers • Public figures on social media • Youth • K-12 and higher education institutions
Widely distribute tips for safely dealing with behavioral health and suicide to social media users, suicide prevention organizations and others.	
Include Washington-based mental health bloggers, tweeters and other public figures on social media in trainings on suicide recognition and referral.	

Short-term Recommendations (1–3 years)	Who Plays a Role?
Use social media videos, public service announcements and other creative approaches to spread messages of hope and support about suicide prevention.	• Social media companies • Online suicide resources
Commit to appropriately discussing suicide and safely responding to suicide threats on social media.	
Track reports of suicide threats on social media that originate from Washington. Track clicks to crisis resources from Washington-based social media campaigns.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Create youth-appropriate training on how to address suicide on social media for use by youth, suicide prevention coalitions, educators and others.	• Suicide prevention organizations • Youth • Educators • Other social media users • Department of Health and contracted evaluator
Evaluate the effect of social marketing and social media campaigns for suicide prevention.	

Goal 5: Social and emotional health education is integrated into early learning programs, community programs and K-12 schools.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Establish state benchmarks for social and emotional health education.	• Legislature • Office of the Superintendent of Public Instruction (OSPI) and workgroup • Educational Service Districts • School districts • Department of Health • Department of Early Learning • Washington State Arts Commission
Survey Washington schools to learn which teach social and emotional health education, and assess district capacity.	
Develop a rigorous training program on the effect of adverse childhood experiences, and promote schools' use of trauma-informed practices to lessen the effects.	
Re-introduce HB 1900 (2015), legislation clarifying the roles of school counselors, social workers and psychologists in supporting students' behavioral health.	
Increase social and emotional development promotions in Child Profile health mailings. Create suicide prevention and behavioral health mailings for families of adolescents.	

Short-term Recommendations (1–3 years)	Who Plays a Role?
Promote social and emotional development skill-building programs for families in high-need communities.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Create a compendium of research-based resources promoting social and emotional health for infants, toddlers and K-12 students for daycare centers, early childhood programs and schools.	• OSPI • Department of Early Learning • Legislature • Early childhood programs • Educational Service Districts • School districts • School nurses, counselors, psychologists, social workers
Amend the staffing allocation for basic education to fully staff school nurses and counselors in all K-12 schools.	
Train Educational Service District personnel to train educators on the Compassionate Schools curriculum.[50] Identify students affected by adverse childhood experiences, and promote behavioral health and wellbeing for all students.	

Goal 6: Connectedness (the connections a person has among family, friends, peers, and community; how connected people are to health and social services; and how well services collaborate) is promoted as a protective factor to prevent suicide, and includes community-wide interventions and programs for marginalized and at-risk populations.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Promote connectedness programs in neighborhoods, communities and among cultural groups and high-risk populations.[51]	• Local and state government agencies • Tribal governments and programs • Community-based organizations • Private funders • Department of Veterans Affairs and other veterans organizations • Department of Corrections • Mental health consumer groups • Suicide prevention organizations • Schools and school districts • Behavioral health professionals • Faith communities • OSPI
Use media, community leadership and training to increase suicide prevention competence in connectedness initiatives.	
Maintain programs promoting family connectedness for people at risk of suicide, including LGBTQ youth, older adults and people experiencing behavioral health problems.[52]	
Improve connectedness to community behavioral health resources and schools' family referral practices in ongoing legislation implementation (House Bill 1336, Laws of 2013).	
Fund and evaluate programs maintaining connectedness for people at high risk of suicide during transitional periods.[53]	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Establish comprehensive programs to increase connectedness among isolated residents of the same geographic area.	• Suicide researchers • Local and state government agencies • Tribal governments and programs • Community-based organizations • Community leaders • General public • Behavioral health professionals
Pursue health equity initiatives to reduce racism, homophobia, ageism, gender bias, mental illness stigma, and other prejudices that create isolation and discourage help-seeking.	
Research and design campaigns to help middle-aged men in their 40s and 50s feel comfortable seeking help for crises and behavioral health needs.	

Strategic Direction 2: Clinical and Community Preventive Services

Goal 1: Tribal, state, local and institutional systems adopt comprehensive suicide prevention programs.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Acknowledge the relationship between childhood trauma and suicide risk, and integrate adverse childhood experiences prevention[55] and trauma-informed care into community governance and planning.	• State agencies, including Department of Corrections, Juvenile Rehabilitation Administration (JRA) and Employment Security Department • Labor unions, including law enforcement unions • Professional associations
Distribute comprehensive suicide prevention toolkits and encourage institutions to modify materials for their use, particularly in communities with elevated suicide rates.	

Short-term Recommendations (1–3 years)	Who Plays a Role?
Support tribes in replicating evidence-based programs and tribal best practices through funding and technical assistance, if requested.	• Suicide prevention organizations • Washington employers • County governments and correctional systems • Tribal governments and correctional systems • Bureau of Indian Affairs • Northwest Portland Area Indian Health Board • Foster care agencies • WorkSource sites • Legislature
Develop comprehensive suicide prevention programs within higher education institutions, including community and technical colleges.[56]	
Partner with a Washington-based employer to start a model comprehensive suicide prevention program.	
Help K-12 schools comply with state requirements on crisis plan development.	
Use death certificates and emerging violent death (WA-VDRS) data to identify groups most in need of suicide prevention support.	
Coordinate communication among Washington's military installations about suicide prevention, and create a network of suicide prevention coordinators to share resources and knowledge.	
Create a network of correctional system suicide prevention coordinators to share resources and knowledge.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Encourage unions and professional associations in occupations at high suicide risk[57] to develop comprehensive prevention programs.	• State agencies • Labor unions • Professional associations • Suicide prevention organizations • Washington employers • Department of Corrections • Tribal jails • County governments • Tribal governments • Bureau of Indian Affairs
Consider legislation requiring staff training and comprehensive suicide prevention programming in Washington's child welfare, juvenile justice and unemployment services systems, modeled on House Bill 1336 (Laws of 2013).	
Promote workplace behavioral health supports and Crisis Intervention Training (CIT) in law enforcement systems, and improve cooperation among state, local and tribal law enforcement agencies.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Encourage all-staff CIT in correctional facilities to improve inmate care and support accreditation standards.	• Northwest Portland Area Indian Health Board • Foster care agencies • JRA • Other juvenile justice programs • Employment Security Department • WorkSource sites • Legislature • Police unions • County and tribal corrections systems

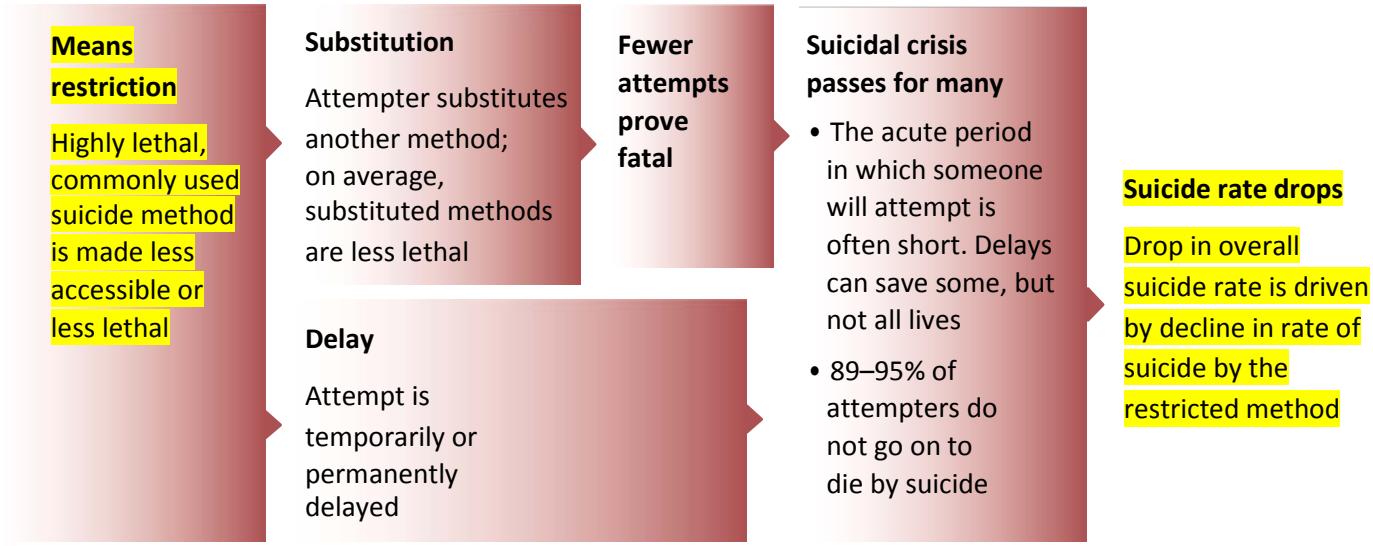
Goal 2: High-quality suicide recognition and referral trainings are widely available.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Inventory effective recognition and referral (R&R) trainings available in Washington, including those focused on marginalized and at-risk groups, weaving together cultural and evidence-based practices.	• Professional Educator Standards Board • Department of Health • All stakeholders named in Goal 1 • Suicide prevention organizations • Social service systems and peer support groups • Suicide researchers • Private foundations
Ensure R&R training is available as part of comprehensive suicide prevention programming at the tribal, state, local and institutional levels.	
Offer R&R trainings tailored to family members and caregivers of people at elevated risk of suicide, including older adults, people with substance abuse disorders, people receiving nonclinical services in medical and correctional facilities, and people experiencing stressful transitions.	
Fund and staff high-quality R&R trainings in neighborhoods and communities. Tailor training to community profiles and needs.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Build R&R training into orientation and continuing education for first responders (law enforcement, fire, EMTs, victim service providers, child and adult protective services investigators, etc.) and workers who come in contact with the public.[60]	• State agencies • Private employers • Human resources staff members • OSPI • Issues of Abuse trainers • Suicide prevention organizations • Training curriculum developers • Department of Corrections • Healthcare companies • Suicide researchers
Improve and standardize R&R content in the Issues of Abuse course required for new teachers.	
Require system-specific R&R training for all staff members working with older adults, including Meals on Wheels drivers, residential facility staff, family caregivers, Medicaid-funded transportation providers and medical translation interpreters.	

Goal 3: Designated health professions are trained in suicide assessment, treatment and management.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Inventory effective suicide assessment, treatment and management trainings available in Washington, including those focused on marginalized and at-risk groups and weaving together cultural and evidence-based practices.	• Stage agencies • Suicide prevention training experts from healthcare fields • Legislature • SEIU • Training Partnership • Community-based organizations • Local governments • Tribal governments and agencies • Private foundations • Suicide prevention organizations • Suicide researchers
Ensure best practices for supporting patients at discharge from services, including creating self-management and safety plans, are part of health professionals' mandated training.	
Explore benefits and costs of requiring additional health professions to have suicide prevention training for certification. Add training mandates as appropriate.	
Fund and staff high-quality suicide assessment, treatment and management training. Tailor training to community profiles and needs.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Require content on suicide assessment, treatment and management in health science and social service courses taught in higher education in Washington.	• Higher education institutions • Legislature
Convene stakeholders to explore the feasibility of adding suicide prevention training as part of the basic training and/or 12-hour continuing education requirement for home care aides, and consider whether it should be required or recommended.	

Goal 4: Screening for and limiting access to lethal means is conducted to reduce suicide risk for people in crisis.



Many suicidal crises are brief. Research shows that the time between deciding on suicide and an attempt is often less than an hour, sometimes as short as 10 minutes. If a lethal method is not immediately available, the crisis will often pass, and the person may never attempt suicide. Others may still make an attempt but use a less deadly method. A suicide attempt using a gun leads to death in 85 to 90 percent of cases; an attempt by medication overdose or a sharp instrument leads to death about 1 to 2 percent of the time.[63] It is important to understand that most people who attempt suicide once and survive never attempt again. Putting time, distance and other barriers between a person at risk and the most lethal means can make the difference between life and death.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Develop a statewide social marketing campaign around safe firearm storage in partnership with firearm owners and retailers.[64]	• State agencies • Rural health providers • Firearm owners • Firearm retailers • Injury prevention advocates • Suicide prevention organizations • Employers • Department of Fish and Wildlife • Hunter education curriculum developers and instructors • Healthcare companies and providers • Local governments and health agencies • Tribal governments and programs • Agency Medical Directors' Group • Legislature • Local law enforcement • Suicide researchers • Washington State Pharmacy Association • Pharmacy educators
Design a best-practice recognition and referral training for firearm owners. Offer training in partnership with firearm owner organizations, firearm retailers, occupations that require firearm use, and in communities where hunting is a cultural practice or social norm.	
Integrate suicide prevention training[65] into instructor training for the state-approved hunter education course, and improve the course content on safe storage and suicide prevention.	
Train primary care and behavioral health professionals to integrate lethal means counseling into routine and acute care and discharge procedures.	
Include or encourage the purchase of effective safe storage devices with every firearm purchase.	
Implement the Washington State Agency Medical Directors' Group's 2015 guidelines on prescribing and managing opioid medications.[66]	
Consider legislation giving families and/or law enforcement a process to temporarily prohibit an at-risk person from purchasing or possessing a firearm during a crisis.	

Short-term Recommendations (1–3 years)	Who Plays a Role?
Consider legislation that establishes a process for voluntary, temporary safekeeping of a person at risk's firearms with law enforcement or family members. Consider legislation imposing consequences on adults who leave or store a loaded firearm where a child can obtain it, causing injury or death. Provide safe medication disposal programs. Convene a short-term workgroup to examine strategies for preventing suicide through pharmacy policies and practices.	• State agencies • Rural health providers • Firearm owners • Firearm retailers • Injury prevention advocates • Suicide prevention organizations • Employers • Department of Fish and Wildlife • Hunter education curriculum developers and instructors • Healthcare companies and providers • Local governments and health agencies • Tribal governments and programs • Agency Medical Directors' Group • Legislature • Local law enforcement • Suicide researchers • Washington State Pharmacy Association • Pharmacy educators
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Offer educational materials encouraging recognition and referral of other gun owners at risk of suicide at the point of firearm purchase. Encourage development and use of new safety technologies to reduce access to lethal means.[67]	• Firearm retailers and owners • Suicide prevention organizations • Department of Transportation • Department of Corrections • Pharmaceutical companies • Legislature • Firearm manufacturers

Goal 5: Community members are aware of local resources, including behavioral health services and crisis lines.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Widely market existing local behavioral health resource guides and databases, and how to find and use them.[68]	• Local governments and health agencies • Local crisis clinics and resource lines • 211 referral system • Healthcare companies and providers • Tribal behavioral health providers • Retail store owners • Advertising companies • State agencies • Public transit agencies • Media outlets • Higher education institutions • School districts • School health clinics • WIC locations • Hospital social workers • Suicide prevention organizations • General public • Twelve-step programs • Faith-based organizations
Explore creation of a specifically staffed crisis line, similar to the Veterans Lifeline, for tribal members.	
Prominently display local crisis line and National Suicide Prevention Lifeline numbers and messages encouraging help-seeking in public and private locations (examples include liquor stores, public transportation, billboards and public service announcements in multiple media).	
Raise awareness of crisis resources in K-12 schools and higher education.[69]	
Display crisis line information and suicide prevention materials in primary care, behavioral health and emergency department settings. Give them to patients and their supporters at appointments or interventions relevant to suicide, including discharge after a suicide attempt.	
Encourage attendees at meetings, trainings and events relevant to suicide prevention to save a 24-hour crisis line number in their cell phones.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Engage local celebrities and public figures as ambassadors of suicide prevention.	• Suicide prevention organizations • Event organizers • Local celebrities • Suicide researchers • Program evaluators • Liquor and Cannabis Board • Legislature
Evaluate how publicity campaigns change crisis resource use.	
Recognize the link between alcohol intoxication and suicide risk, and explore the feasibility of including suicide crisis resources on alcoholic beverage labels and packaging.	

Strategic Direction 3: Treatment and Support Services

Goal 1: Access to mental healthcare, substance abuse treatment and crisis intervention services is expanded.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Organize a workgroup to identify and promote best practice models for clinic-to-community linkages between providers of physical and behavioral healthcare, community-based organizations and other systems to increase access to timely and appropriate screening, referral, care and follow- up. Educate mental health and crisis service providers about interacting with systems serving their clients, such as community corrections, child welfare and military systems.	• Physical and behavioral health professionals • Behavioral healthcare consumers • Community-based organizations • Correctional systems • Health researchers • State agencies • Higher education institutions • Tribal governments and programs • Military programs • Hospital discharge planners, case managers, health record managers • EHR system vendors • County and tribal corrections systems • Legislature • Screening, Brief Intervention and Referral to Treatment (SBIRT) rollout sites
Encourage new partnerships among community-based organizations serving populations disproportionately impacted by suicide.[73]	
Use systems approaches (such as case management, electronic health record alert systems and patient care coordinators) to improve timely and effective care for patients at risk.	
Improve county correctional facilities' ability to meet inmates' mental healthcare needs through staff training, system-level changes and mental health service funding.	
Support *New Blue H* report[74] telehealth and telemedicine recommendations, including supporting payment and coverage of telehealth/telemedicine services in Medicaid and commercial plans.	
Ensure Section 1115 Medicaid waiver allows Washington to design and finance patient-centered medical home services.	
Expand the Screening, Brief Intervention and Referral to Treatment (SBIRT) pilot at Division of Behavioral Health and Recovery (DBHR) in the Washington State Department of Social and Health Services.[75]	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Assist programs for populations disproportionately affected by suicide in developing evidence-based and best practice behavioral health services.	• Behavioral health professionals • Healthcare companies and providers

Short-term Recommendations (1–3 years)	Who Plays a Role?
Develop a health literacy campaign to educate the public about behavioral health services covered by the Affordable Care Act.	• Suicide and health researchers • Tribal governments and programs • Correctional systems • Military programs • State agencies • Community-based organizations • Educational institutions
Expand and coordinate multi-disciplinary care teams and wraparound services statewide using the patient-centered medical home model.	

Goal 2: Emergency departments and inpatient units provide for the safety, well-being and continuity of care of people treated for suicide risk.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Convene a Continuity of Care Workgroup including mental health acute and outpatient care providers, diversion and crisis teams to: • Recommend evidence-based and best practices for continuity of care after a suicide attempt, including the use of patient safety plans and ongoing assessment; • Help local health agencies, healthcare systems, community service organizations and educational institutions build these protocols into their services; • Evaluate patient-centered medical homes and managed care plan case management to improve continuity of care for patients frequently at risk of suicide; • Recommend best practices for educating patients and their supports about lethal means restriction as part of discharge and continuity of care; • Evaluate mobile crisis team services and make recommendations for funding and increasing their role as a post-discharge support.	• Continuity of Care workgroup • Community crisis providers • Correctional systems • Local health agencies • Tribal health agencies • Behavioral health organizations • State agencies • Legislature • Private and government funders
Fund and staff peer support specialists to assist in follow-up care after a hospital or acute care discharge or crisis service encounter.[78]	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Evaluate brief screening models for suicide risk in acute care settings (similar to SBIRT) and continuity of care services.	• Suicide researchers • Department of Health • Aftercare workgroup

Goal 3: Families and concerned others are involved, when appropriate, throughout a person at risk's entire episode of care.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Develop and evaluate model protocols for safely involving a self-defined care network in treatment, planning for discharge and self-management.	• State agencies • Private funders • Suicide researchers • Health professionals • Advocates against sexual and domestic violence • Mental health consumer groups • Suicide prevention organizations
Educate health and social service providers on involving a self-defined care network in suicide-related treatment.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Add to Washington's evidence base and tribal best practices for suicide interventions involving a patient's self-defined care network.	• Those using model protocols • Suicide researchers • Tribal governments and programs • State agencies

Goal 4: Effective suicide postvention-aftercare programs (programs providing care and support for the community and loved ones after a suicide) are in place to provide support after a suicide loss.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Convene a postvention/aftercare workgroup to: • Survey and evaluate Washington's existing aftercare services, and assess resource gaps; • Assess the need for appropriately trained[82] suicide loss support group facilitators; • Pull together a statewide network of suicide loss support groups; • Increase the state's capacity to provide technical assistance in applying best practices to postvention/aftercare programs; • Create a bereavement toolkit with community-specific content, to be distributed by law enforcement, medical examiners, coroners, emergency departments, funeral directors, funeral services counselors or medical investigators and available to the general public online; • Develop a strategic plan to evaluate, design and deploy postvention programs in schools, workplaces, faith communities, reservations, social service agencies and correctional facilities.	• State agencies • Postvention workgroup
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Use the Washington-Violent Death Reporting System (WA-VDRS), as appropriate, to identify suicide clusters and needed resources.	• Department of Health • Tribal governments • Suicide researchers
Evaluate evidence-based programs and tribal best practices for postvention/aftercare.	

Strategic Direction 4: Surveillance, Research and Evaluation

Goal 1: Effective suicide and behavioral health data surveillance systems are in place to guide prevention.

Data Source	Purpose (related to suicide)	Key Data	Limitations
Death certificates	Provides information about how many people die of suicide and characteristics of those people	Age, race, sex, ethnicity, residence, occupation, education	Missing circumstances surrounding the death, including substance use; gender identity not identified
Violent Death Reporting System (WA-VDRS)	Provides a clearer understanding of circumstances around suicide details	Demographics, mental health problems, recent life stressors	Data collection began in 2015 in 9 counties; analysis report will be available in 2017
Hospitalization data (CHARS and the Trauma Registry)	Provides data on how many people are hospitalized for a suicide attempt or self-injury	Age, sex, place of residence	Race and ethnicity data incomplete; no data on gender identity; does not reflect non-hospitalized suicide attempts; does not clearly distinguish non-suicidal self-injury from suicide attempt
Healthy Youth Survey	Provides prevalence of depressive feelings, suicidal thoughts and behaviors for students in grades 6, 8, 10 and 12	Age, race, ethnicity; health risk behaviors, such as alcohol and drug use and suicidal behavior	Occurs every other year; reaches only youth in school
Behavioral Risk Factor Surveillance System	Collects information from adults on mental health status, and firearm ownership and storage	Age, sex, race, ethnicity, gender identity	No data on suicide thoughts, plans, attempts; mental health data collected are not broadly distributed
Emergency department visits	Provides data on how many people are seen in an emergency department for a suicide attempt	Age, sex, date of visit	Data not yet collected statewide; does not include patient names, limiting ability to link with other data
National Survey on Drug Use and Health	Provides data on mental health status, suicidal thoughts and plans among adults	Age, state, access to mental health services	Not all data analyzed at a state level, such as suicide attempts

Data Source	Purpose (related to suicide)	Key Data	Limitations
Department of Defense Suicide Event Report	Provides information about how many in the armed forces die of suicide or attempt suicide	Based on postmortem information gathered retrospectively	Not available outside DoD
Suicide Prevention Application Network – Department of Veterans Affairs	Compiles all suicide events and deaths from VHA providers	Demographics, suicide safety plan in place, circumstances	Does not include veterans who get care outside the VHA system
Electronic health record data from healthcare companies	Patient tracking, quality control, identification of trends	Depending on provider, partial or full list of health services the patient has received	Not required to share publicly; confidentiality concerns; does not include care at another facility
Insurance company claims data	Tracking patient use of covered services, quality control	Full list of care paid for by the insurer	Does not include clinical detail
Child Death Review reports	Informing suicide prevention efforts for those under 18 years old	Circumstances, modifiable risk factors and recommendations for prevention	Limited number of counties; timing varies by county and could be far after the event
Washington Emergency Medical Services Information System (WEMSIS)	The latest version allows coding of EMS calls involving suicide attempts and people at risk of suicide	Details of EMS contact, including impressions, injuries, symptoms and treatment provided	

Short-term Recommendations (1–3 years)	Who Plays a Role?
Improve the state agencies' capacity to analyze, advise on collection of and make publicly available mental health and suicide-related data.	• Stage agencies • Healthy Youth Survey Planning Committee • Legislature • Hospital staff • Emergency departments • Department of Veterans Affairs
Make WA-VDRS data publicly available, where appropriate.[84]	
Monitor the completeness of race and ethnicity data for people hospitalized for self-inflicted injuries, and analyze when data are available.	

Short-term Recommendations (1–3 years)	Who Plays a Role?
Propose adding or expanding more detailed demographic questions for groups at high risk of suicide to the Healthy Youth Survey. Analyze suicidal behavior questions for these groups and make data publicly available.	• Department of Defense • Suicide researchers • Local governments and health agencies • Tribal governments and programs • Private funders • County Health Officers
Ensure the terms *sex* and *gender* are reported correctly in state data reports to increase reporting accuracy and inclusion of trans and gender-nonconforming people.	
Mandate reporting by emergency departments to the syndromic surveillance system, including completing external cause International Classification of Disease codes for suicidal behaviors. Analyze and make appropriate aggregate data publicly available.	
Promote broader distribution of existing state-level military suicide data.	
Encourage linkage of DoD/VA and American Indian/Alaska Native data sets to state-based data sets to enhance knowledge base and improve prevention efforts.	
Dedicate funding for local health agencies to conduct Child Death Reviews and disseminate data and recommendations.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Develop recommendations for the system built to query comprehensive medical record data to identify suicidal behaviors.	• State agencies • County crisis clinics • Suicide prevention organizations • Correctional systems • Child welfare systems • Students • Academics • Policymakers • Trainers • Senior service systems • Other appropriate service systems
Investigate the usefulness and cost of a centralized crisis clinic surveillance system.[85]	
Improve data collection by training service system staff members to conduct psychological autopsies or fatality reviews in cases of suicide and make aggregated data available to researchers and the public.	
Build and maintain a centralized, easily accessible online clearinghouse of Washington suicide data. Field questions and data requests through the clearinghouse.	

Goal 2: Researchers and state agencies collaborate on suicide prevention research and evaluation.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Create collaborations among state agencies, training providers and academic researchers to and analyze the effect of suicide prevention training. Improve the range of evidence- based trainings and tribal best practices available in Washington as needed.	• State agencies • Suicide prevention training providers and publishers • Suicide researchers • Professional Educator Standards Board • Academic institutions
Create a research guidance document to move the Washington State suicide prevention plan forward, including focus on populations most affected by suicide.[86]	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Create a competitive research fellowship for innovative projects using state suicide data, aligned with the guidance document.	• State agencies • Suicide researchers • Private funders
Create a virtual suicide research institute for researchers to share ideas and use state suicide data.	

Goal 3: Suicide prevention activities are evaluated and improved.

The plan's recommendations range from projects already under way to aspirational goals. Everyone has a role in putting the plan into action. Many people reading this plan already do suicide prevention work, but some of us are getting involved for the first time. Here is what you can do to get started.

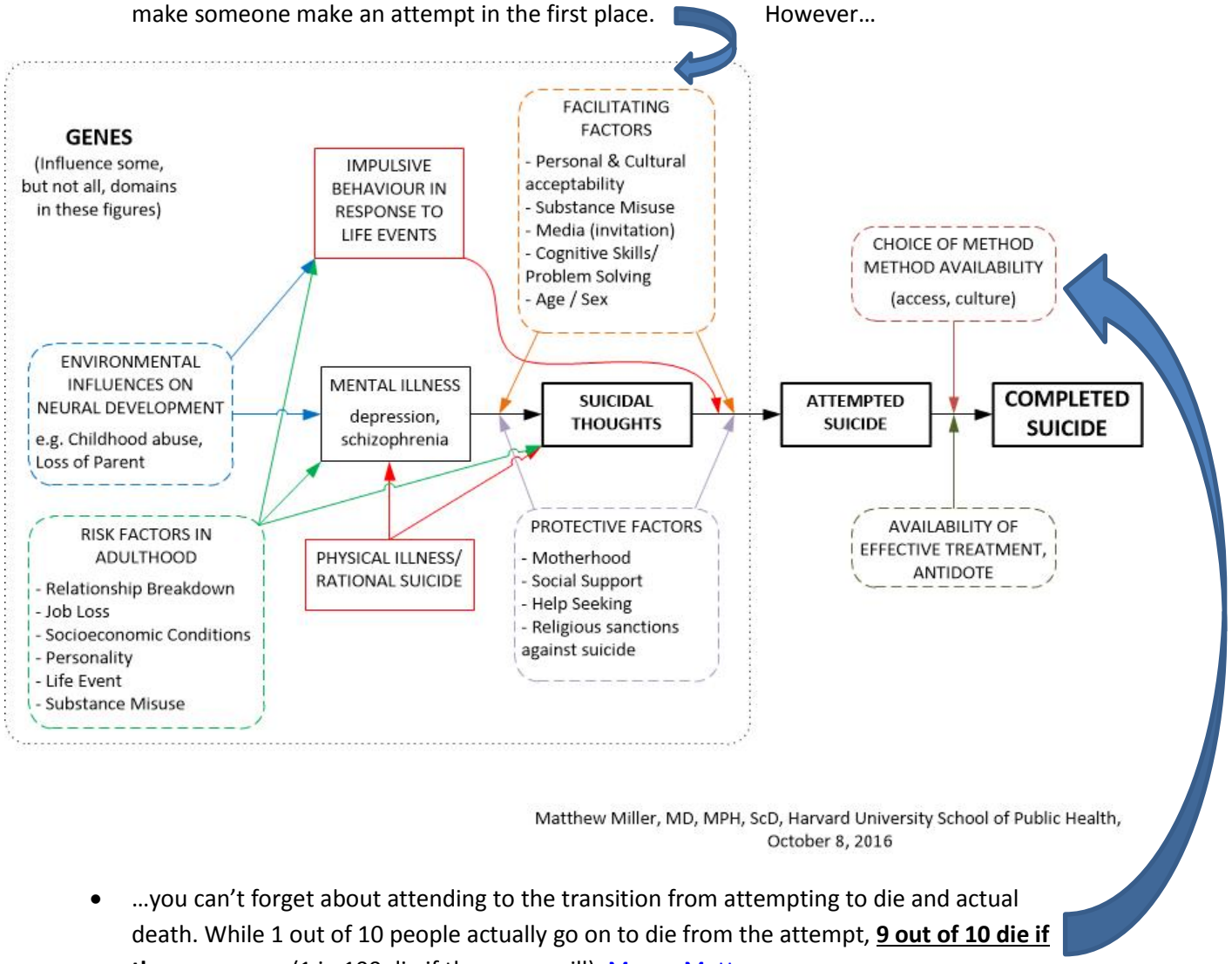
1. **Decide what you'll do.**
   First, find the recommendations that apply to you by searching the *Who Plays a Role?* column. Then choose the recommendations that make the most sense for you.
2. **Make an action plan.**
   Think about putting that recommendation into action. Will you need money? Volunteers? Access to researchers? A change in policy? (You can use the form in Appendix E to organize your plans. Every strategic direction has a list of resources and evaluation tools at the end.)
3. **Do your project.**
4. **Evaluate your project.**
   If you have the resources to work with a professional evaluator, use their services here. If not, a free and easy-to-use evaluation tool for suicide prevention programs is available here: http://www.rand.org/pubs/tools/TL111.html
5. **Tell us about it!**
   The Department of Health is interested in learning about any programs or initiatives you've developed and implemented to prevent suicides in your community or organization. Send a note to SuicidePreventionPlan@doh.wa.gov about what you did and how it went.

George Higgins
Sunday, November 27, 2016

Firearm Suicide Prevention Task Force Discussion Proposal

Findings from review of Washington State and New Jersey material and topic of Suicide and Firearm Suicide:

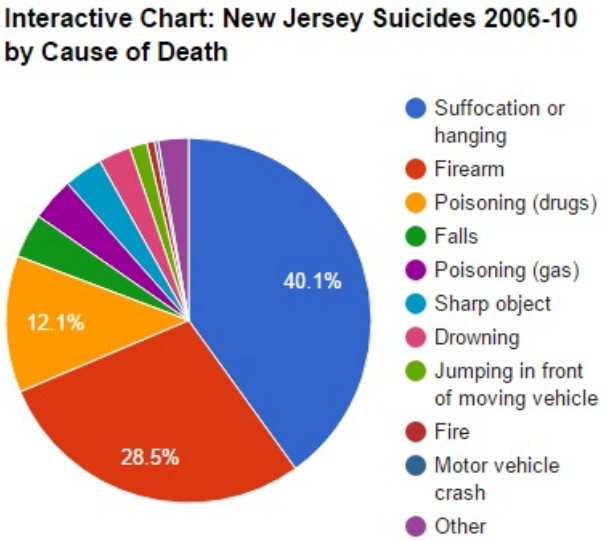
- There are a lot of things that leave people so aggrieved they end up trying to kill themselves – mental illness, existential problems – roughly **one in ten people who attempt suicide, die by suicide**.
- If you want to actually prevent deaths by suicide you have to focus on all these complicated factors that make someone make an attempt in the first place. However…



Matthew Miller, MD, MPH, ScD, Harvard University School of Public Health, October 8, 2016

- …you can't forget about attending to the transition from attempting to die and actual death. While 1 out of 10 people actually go on to die from the attempt, **9 out of 10 die if they use a gun** (1 in 100 die if they use a pill). Means Matter.
- So if you can **make it harder for somebody to use a gun in a suicide attempt**, they're much more likely not only to survive – but to not go on to die at their own hand thereafter, because **fewer than 10% of people who survive a suicide attempt actually go on to die by suicide**.

- How do you save someone from suicide? **You can prevent them from making the attempt** or **you can prevent them from dying in the attempt**. We're really lousy at preventing people from making an attempt, but we do know how to prevent people from dying in the attempt.
- New Jersey's [suicide] data also differs from the national [suicide data] in terms of the primary method used, in large part because of the state's tough gun-control laws. Nationally, just over half of all suicides are by firearm, with suffocation or hanging ranking second, responsible for about a quarter of self-inflicted deaths. In New Jersey, 4 in 10 suicides were by suffocation or hanging, while a little less than 30 percent were from self-inflicted gunshots.



States with highest gun death rates

Rank	State	Household gun ownership	Gun death rate per 100,000
1	Louisiana	45.60%	18.91
2	Mississippi	54.30%	17.8
3	Alaska	60.60%	17.41
4	Wyoming	62.80%	16.92
5	Montana	61.40%	16.74
States with lowest gun death rates			
50	Rhode Island	13.30%	3.14
49	Hawaii	9.70%	3.56
48	Massachusetts	12.80%	3.84
47	New York	18.10%	5.11
46	New Jersey	11.30%	5.46

Source: Violence Policy Center

- When we're talking about 1 in 3 homes having guns, we need to discover what message is persuasive to gun owners to remove access by those who are at risk of harming themselves and others (see attachment A).

Recommendations:

1. Review *Washington State Suicide Prevention Plan* to determine elements most pertinent to Delaware (see attached summary).
2. From *WS Plan, Direction 2, Goal 4*: Screening for and limiting access to lethal means is conducted to reduce suicide risk for people in crisis – ACTION: Determine most urgent interventions to put into practice now (see attachment B).
3. From *WS Plan, Direction 4, Goal 1*: Effective suicide and behavioral health data surveillance systems are in place to guide prevention – ACTION: Enhance the Delaware Behavioral Risk Factor Survey (BRFS) with meaningful Household gun ownership related survey questions to inform intervention assessment.
4. From *WS Plan, Direction 4, Goal 2*: Researchers and state agencies collaborate on suicide prevention research and evaluation – ACTION: Engage Matthew Miller, MD, MPH, ScD, Harvard University School of Public Health, to bring credible research and analysis and consultation to the issue of firearm suicide prevention in Delaware (see attachment C).
5. Acknowledge terminal physical illness and excruciating pain without hope of recovery as factors that – absent a death with dignity solution – do lead to firearm suicide (see attachment D provided with author's written permission) – ACTION: Investigate Delaware physician-assist options as illustrated by six states, including Washington, that provide such alternatives by law. (see attachment E).

Proposals provided by the committee:

Emily Vera:

1.) Create an ongoing firearms suicide prevention task force to work as a subcommittee of, or in conjunction with, the Delaware Suicide Prevention Coalition which includes representatives from the firearms industry, the NRA, suicide prevention organizations, suicide survivors, law enforcement, veterans affairs, DSAMH and DPBHS.
2.) Task force would work on expanding online and in-person trainings to include more law enforcement, gun safety classes, etc.
3.) Task force would work on expanding distribution of safe storage devices (VA and DNG are already doing this as part of their prevention efforts)
4.) Task force would work on messaging in the firearms owning community that suicide is preventable, marketing the crisis call and text line, etc. through pamphlets, posters, etc. that could be distributed or displayed at gun shops, DNREC visitor centers, gun ranges, etc.

Pete Rudoff:

- Any data on if there is a "type" of white males that commit suicide? Economic status? Education level? Sexual orientation? Drug/ alcohol use?
- Any data on how many of these suicides are happening immediately (24-48 hours) after purchasing a firearm?
- What life patterns have been identified that put white males at risk?
  Examples:
  - Divorce?
  - Work demotion/ firing?
  - Terminal sickness? (physical)
  - Loss of or sickness of a spouse or child?
  - Mental sickness? Depression etc.
- SOS module was good but I think it will miss the mark on our targeted group of white males. How do we reach them? Without overstepping of course.

Delaware Suicide Prevention Plan

http://mhainde.org/wp/suicide-prevention/state-of-delaware-suicide-prevention-plan/

July 2013 to July 2018 — A Five-Year Strategy

Approved by Delaware Suicide Prevention Coalition on Monday, June 17, 2013

Download the Delaware Suicide Prevention Action Plan (pdf format)

Overview

Goal 1 : Integrate and coordinate suicide prevention activities across multiple sectors and settings

Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors

Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery

Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide

Goal 5: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors

Delaware Suicide Prevention Coalition

The Suicide Prevention Coalition began efforts in 2004 and enlisted multiple state, private and nonprofit organizations to participate in the effort.

Our ultimate mission is to:

- Raise awareness that suicide is a preventable public health problem
- Enable the behavioral and social changes necessary to reduce suicidal ideation and attempts

DE Suicide Prevention Coalition MEMBERS

Chabereth Ministries, Inc.
mysite.verizon.net/vzeuvkdf

Christiana Care Health System
www.christianacare.org

ContactLifeline, Inc.
www.contactlifeline.org

DE Child Death, Near Death, Stillbirth Commission
courts.delaware.gov/childdeath/who.htm

DE Department of Corrections
www.doc.delaware.gov

DE Department of Education
www.doe.k12.de.us

DE Department of Health and Social Services
dhss.delaware.gov/dhss

- Division of Aging and Adults with Physical Disabilities

- Delaware Crisis Intervention Services
- Division of Public Health
- Division of Substance Abuse and Mental Health

DE Department of Services for Children, Youth and Their Families

- Division of Prevention and Behavioral Health Services
  kids.delaware.gov/pbhs/pbhs.shtml

DE Department of Veterans Affairs
www.veteransaffairs.delaware.gov

DE National Guard
www.delawarenationalguard.com

DE River & Bay Authority
www.drba.net

Delaware State University
www.desu.edu

MeadowWood Hospital
www.psysolutions.com/facilities/meadowwood

Mental Health Association in DE
www.mhainde.org

Mid Atlantic Behavioral Health
www.midatlanticbh.com

NAMI – DE
www.namide.org

Rockford Center
www.rockfordcenter.com

Steps for Steph
www.stepsforsteph.com

University of Delaware

- Center for Counseling and Student Development
  www.udel.edu/Counseling
- Center for Drug and Alcohol Studies
  www.udel.edu/cdas

Wilmington University, Community Counseling
www.wilmu.edu/behavioralscience/mscc.aspx

For more information, contact Emily Vera at: (302) 654-6833

evera@mhainde.org

Lifelines Awareness Presentation

Workshop Details:

45 minutes to **one hour** general awareness presentations are available through the Mental Health Association in Delaware (MHA). These workshops are ideal for parents & families, clergy, educators, and others. During the presentation, participants will learn about the problem of suicide in Delaware and on a national level, basic myths and facts about suicide, warning signs of suicide, and practical ways to help someone with thoughts of suicide. The presentations can be customized to address the needs of a specific community or organization.

Did you know?

- More than 90% of those who die by suicide have a diagnosable mental illness.
- Suicide deaths also outnumber homicide deaths worldwide each year.

To schedule a training, contact:
Mental Health Association in Delaware:
Phone: (302) 654-6833 or (800) 287-6423
Email: jseo@mhainde.org

safeTALK

safeTALK: suicide alertness for everyone

safeTALK: a **3 hour** training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources. As a safeTALK-trained suicide alert helper, you will be better able to:

- move beyond common tendencies to miss, dismiss or avoid suicide;
- identify people who have thoughts of suicide;
- apply the TALK steps (Tell, Ask, Listen and Keep Safe) to connect a person with suicide thoughts to suicide first aid, intervention caregivers.

Why should I come to safeTALK?

In only a few hours, you will learn how to provide practical help to persons with thoughts of suicide. Expect to leave safeTALK more willing and able to perform an important helping role for persons with thoughts of suicide.

Why is safeTALK for everyone?

Most persons with thoughts of suicide go unrecognized—even though most all are, directly or indirectly, requesting help. Without safeTALK training, these invitations to help are too rarely accepted, or even noticed. With more suicide alert helpers, more people with thoughts of suicide will get connected to the intervention help they need.

ASIST

ASIST (Applied Suicide Intervention Skills Training) is a **two-day** training for anyone who wants to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over one million caregivers have participated in this evidence based two-day, highly interactive, practical, practice-oriented workshop. ASIST is the most researched suicide prevention skills training world-wide, and evaluations have shown that interventions skills learned at ASIST are retained over time and put to use to save lives.

The Outcome

The emphasis of the ASIST workshop is on suicide first aid, on helping a person at risk stay safe and seek further help. Attendance at the full two days is essential. 15 CEU's are offered for completing the training.

Learn how to:

- recognize invitations for help
- reach out and offer support
- review the risk of suicide
- apply a suicide intervention model

*All MHA Suicide Prevention Gatekeeper Trainings are offered at no cost! Minimum number of participants for each training is 10 people.

The suicide rate is soaring in N.J., study finds

By Paul Milo | NJ Advance Media for NJ.com
http://www.nj.com/news/index.ssf/2016/04/njs_suicide_rate_soars_was_2nd-highest_in_2014_rep.html
on April 26, 2016 at 7:10 AM, updated April 26, 2016 at 8:42 AM

Correction: A previous version of this story incorrectly listed where New Jersey ranked nationally in suicides in 2014.

A study released Friday shows that the suicide rate has risen sharply among virtually all age groups across the United States while growing even faster in New Jersey.

Citing data from the U.S. Centers for Disease Control and Prevention, the Record of Woodland Park reported that New Jersey's suicide rate, which was the lowest in the country among all states in 2012, had risen by 13 percent two years later.

With 8.8 self-inflicted deaths per 100,000 people, New Jersey dropped into a tie with Massachusetts for the second-lowest suicide rate in the country in 2014, the year with the most recent data available.

Experts quoted by the Record attributed the spike in suicides to the lingering effects of the 2008 economic downturn, which continued to play out in New Jersey in the form of higher unemployment and foreclosure rates years after the recovery took root more firmly in other states.

The CDC study, which looked at a 15-year period beginning in 1999, found that the suicide rate rose nationwide by 24 percent, from 10.5 deaths per 100,000 people to 13 per 100,000, with the sharpest annual increases coming after 2006. The suicide rate rose among all groups except people aged 74 and older.

Girls aged 10 to 14 saw the largest increase in suicide over the study period, rising 200 percent, although the suicide rate remains lowest in this age group. Women aged 45 to 64 saw the second-largest increase between 1999 and 2014, increasing 63 percent during that time.

The sharp increase in suicide this century follows a steady decline in self-inflicted death during the 1980s and 1990s, the study also shows.

Paul Milo may be reached at pmilo@njadvancemedia.com.

Investigation of a Youth Suicide Cluster in Kent and Sussex Counties – Delaware, 2012

Final Report

Prepared By:

Katherine A. Fowler, PhD, EIS Officer
Alexander E. Crosby, MD, MPH, Medical epidemiologist
Sharyn E. Parks, PhD, Epidemiologist
Asha Z. Ivey, PhD, EIS Officer

Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

February 19, 2013

Submitted to:
Dr. Paul Silverman
Delaware Department of Health and Social Services
Division of Public Health

Introduction

Between January 11 and March 22, 2012, eight adolescents and young adults (aged 13-21 years) were known to have died by suicide in Kent and Sussex counties, Delaware. These events attracted a great deal of local concern for two primary reasons: First, the number of suicide deaths in the first quarter of 2012 exceeded the number of suicide deaths typically reported in this two county area in an entire year; for example, from 2009-2011, the average annual number of deaths by suicide among persons aged 12-21 years was four. Second, four of these deaths occurred among students attending the same high school, over a period of about 2 months, increasing the perception that the deaths were part of a youth suicide cluster. Of the other four known decedents, one was a middle school student, one was a student at another high school, one was a young adult who had graduated from an area high school and was still living in Sussex County, and one was a young adult whose education status was unknown.

Suicide and nonfatal suicidal behavior are important public health concerns for adolescents and young adults. While the onset of suicidal behavior is observed at ages as young as six years, rates of death and rates of nonfatal injury resulting from suicidal behavior treated in hospital emergency departments (EDs) are relatively low until age 15[1,2]. In 2010, (the most recent national data available) in the United States, suicide was the 3rd leading cause of death among youth aged 10-14 and 15-19 years, and it was the 2nd leading cause of death among persons aged 20-24 years (Web-based Injury Surveillance Query

and Response System (WISQARS)[3]). During 2011, there were an estimated 174,030 hospital emergency department visits for self-inflicted injury among those aged 10-24 years (WISQARS[3]). In a 2011 nationally representative sample of students in grades 9-12, 7.8% (1 out of 13) reported having made a suicide attempt one or more times in the 12 months preceding the survey[4].

In epidemiology, clusters are defined as a closely grouped series of events, or cases of disease or other health-related phenomena, with well-defined distribution patterns in relation to time, space, or both. This framework has been extended to groupings of suicidal behavior[5]. Studies have found that suicide clusters occur almost exclusively among adolescents and young adults aged 15-24 years[1]. Though suicide clusters are relatively rare events, accounting for fewer than 5 percent of the total suicides among that age group, they can have dramatic and devastating effects on families and communities[6,7].

The Delaware Department of Health and Social Services (DHSS), Division of Public Health requested the assistance of the Centers for Disease Control and Prevention (CDC) in conducting an epidemiological study of this cluster of youth suicides in Kent and Sussex counties to determine the frequency of fatal and nonfatal suicidal behaviors in the first quarter of 2012, examine risk factors, and make recommendations about potential strategies that might be used by community and state leaders to prevent future suicides.

The objectives of the investigation were to: 1) characterize the fatal and non-fatal suicidal behaviors among youth occurring between January 1, 2012 and May 4,2012 (when the CDC visit would conclude), in Kent and Sussex

counties, Delaware; 2) describe trends in fatal and non-fatal youth suicidal behaviors over the past 4 years (2008 - 2012) in these counties to determine the degree to which the current suicide deaths demonstrate an increase over prior years; 3) identify, where possible, individual, family and community risk and protective factors; and 4) identify relevant prevention strategies for youth suicide.

Timeline of Activities

- 3/12/12 – CDC initially contacted by Jim Lafferty, Director of the Mental Health Association in Delaware at the request of Rita Landgraf, Secretary of DHSS. At this point there were 6 known suicide deaths (3 at High School A) among young people in Kent and Sussex counties since January 11, 2012. A conference call was scheduled for 3/26 to further discuss the possibility and scope of CDC assistance.
- 3/22/12 – Another suicide death occurs. Decedent is a student at High School A. Delaware Governor's office becomes involved. CDC receives a call directly from Rita Landgraf, Secretary of DHSS, requesting CDC assistance.
- 3/26/12 – First conference call with stakeholders in Delaware. Discussion includes immediate crisis response activities and process of initiating a formal request for CDC assistance.
- 4/2/12 – 4/22/12 - Multiple conference calls to discuss scope of the investigation and logistics regarding trip and activities.

- 4/24/12 – 5/4/12 – CDC Epi-Aid team travels to Delaware. Trip activities include:
    - Opening session with key stakeholders
    - Further consultation with stakeholders about potential sources of data
    - Finalized itinerary, confirmed meetings
    - Data review and collection
    - Key informant interviews (2 individual, 3 group) with High School A officials and local mental health crisis workers
    - Preliminary analysis of findings
    - Debriefing with stakeholders
- 5/7/12 – 5/18/12 – Continuing correspondence with DHSS staff assisting with additional data collection, and receipt of additional data.
- 5/21/12 – Data analysis and drafting of Epi-2 report begin
- 5/24/12 – Key informant interview with principal of High School B & interviews with staff (guidance counselor & health clinic) from High School B (3 individual interviews)
- 7/18/12 – Presentation of exit briefing to Delaware behavioral health and school board personnel.
- 7/25/12 – Briefing with DHSS Secretary Rita Landgraf about results to be presented in trip report
- 8/2/12 – Trip report issued to State of Delaware by CDC
- 8/3/12-present – Further analyses and drafting of the extended report.

Methods

This investigation consisted of the following phases:

- Development of case definitions
- Data gathering
  - Quantitative: Existing data on fatal and non-fatal suicidal behaviors from federal, state, and local sources
    - Medical examiner files
    - Emergency room medical records
    - Law enforcement reports
    - Survey data
  - Qualitative: Key informant interviews
    - Superintendent of School District A
    - Principal of High School A
    - Select teachers from High School A
    - Guidance counselors at High School A
    - Select crisis workers from area counseling service agency
    - Principal of High School B
    - Guidance counselor at High School B
    - Staff member from wellness center health clinic at High School B
- Data analysis
  - Quantitative
    - Descriptive findings
    - Case-control analyses
  - Qualitative
- Reporting results
  - Scientific report
  - Community debriefings

Phase 1: Case Definitions:

a) A **fatal case** (i.e., a youth who died by suicide) was defined as a resident of Kent or Sussex County, aged 12-21 years, whose death was classified in medical examiner records as being caused by intentional self-harm, and occurred between January 1, 2012 and May 4, 2012. For the case-control analysis, this window of time was expanded to include fatal cases occurring from January 1, 2009 to May 4, 2012 in order to improve the statistical power of the analyses.

b) A **non-fatal case** (i.e., a youth who attempted but did not die by suicide) was defined as resident of Kent or Sussex County, aged 12-21 years, whose records (medical record and/ or police report) indicated suicidal behaviors during the time period between January 1, 2012 and May 4, 2012. Nonfatal cases met the following criteria**:**

- Chief complaint that contained the word 'suicide' or variations of the word suicide (e.g., suicidal); psychiatric evaluation (for the ER only) or related terms (e.g., depression); or overdose or related terms (e.g., OD, ingestion, intentional overdose), OR
- Circumstances in the clinical narrative that indicated suicidal behavior, AND
- The record indicated that suicidal behavior occurred, either by explicitly stating that suicide was attempted or describing behavior consistent with a suicide attempt. Cases involving suicidal ideation

and threats that were not accompanied by suicidal behaviors were excluded.

c) A **control** (for purposes of a case-control analysis in which the above-defined fatal suicides constitute 'cases') was defined as a resident of the state of Delaware, aged 12-21 years, whose death was attributed to causes other than intentional self-harm (e.g., unintentional drug overdose, motor vehicle crash, natural causes) by the medical examiner, and occurred in the time period between January 1, 2009 and May 4, 2012 (the expanded time window was also used for the cases in the case control analysis).

Phase 2: Data Gathering:

Quantitative Data

Data sources were identified that could be used to determine the frequency of and risk factors for fatal and nonfatal suicidal behaviors in Kent and Sussex counties, as follow:

Fatal suicidal behaviors and controls: Medical examiner records were the primary source of information about the fatal suicide cases. These records typically included a lengthy narrative about the cause of death, circumstances surrounding the death, and personal histories of the decedents, as assessed by the investigators. These files included toxicology results per our request. Information about the controls represented in the case-control analysis also came from the medical examiner.

Law enforcement records served as a secondary source of information for the fatal cases. At times, law enforcement records were included in the medical examiner file. Law enforcement officials also made the records accessible to us through the Delaware health department. The investigator's notes provided information about the circumstances, setting, and methods used, and at times, the decedent's history of interactions with law enforcement. Witness statements added information about the circumstances and the personal history of the decedents.

Nonfatal suicidal behaviors: There were two primary sources and one secondary source of information about the nonfatal cases. Hospital emergency department data (ED) was one primary source. We collected data from the four EDs in Kent and Sussex counties that attend to the highest volume of patients. ED records included detailed information about the method of suicide attempt, , extent of injuries, level of medical treatment required, and toxicology results; circumstances surrounding the attempt; and disposition (i.e., recommended venue for aftercare).

The second primary source of information about nonfatal cases was inpatient psychiatric/behavioral health records. Youth typically remain at these facilities long enough for clinicians to conduct interviews, assessments, and thus compile detailed social and psychiatric histories. These records served as a comprehensive source of information about mental health, social functioning, circumstances leading up to the attempt, prior attempts, life history, and many other aspects of the youth's life and wellbeing.

Law enforcement records either included within inpatient behavioral health records or directly from law enforcement officials), served as a source of additional information about some youths' prior legal troubles.

Survey data: Delaware and national Youth Risk Behavior Survey (YRBS) Data for 2011 was used to examine bullying victimization at school and suicidal thoughts and behaviors for Delaware youth relative to U.S. youth in general.

National Suicide Prevention hotline reports for the state of Delaware and the nation were also examined to assess the possibility of an increase in suicidality across age groups in Delaware relative to the U.S. in general. We used the following data: Delaware call volume January 01, 2005 - March 31, 2012, the most recent time period available at the time of the investigation; year-to-date call volume report from December, 2011; and the March 2012 monthly report, the most recent report available at the time of the investigation.

Active case-finding methods were used for all data collection: We asked data providers to pull all files that potentially met our case definitions. Our team then reviewed each case to determine whether it should be included, and all information included in each record, abstracting the information into the database we created for this study.

Quantitative data were used to determine: (1) The frequency of fatal and non-fatal suicidal behaviors occurring between January 1 and May 4, 2012 in Kent and Sussex counties, Delaware, (2) Risk factors associated with the fatal and nonfatal suicide behaviors, (3) The descriptive epidemiological profile of the

cases, including demographics of the decedents/patients, methods used to attempt or complete suicide, and circumstances surrounding the suicidal behavior.

Comparisons were made with the frequency of fatal suicidal behaviors in the same counties in previous years (see Figure 1).

Qualitative Data

Seven key informant interviews (5 individual and 3 group) were conducted in Kent and Sussex counties. (See description of interviewees on p.5).

The purpose of the interviews was to talk to adults who regularly interacted with young people, particularly the youth affected by the recent suicide deaths in the community. The interview questions were designed to: 1) assess whether participants believed suicide was a problem in the Kent and Sussex county area; 2) ask participants what they thought was contributing to the problem; 3) determine awareness of available resources in the community; 4) inquire about barriers to accessing resources, and 5) ask participants what they thought could be done to prevent suicide in their community (see Appendix A).

Phase 3: Data Analysis:

Quantitative Data Analysis

Data were abstracted by the CDC team. An electronic data abstraction spreadsheet was prepared prior to the visit and updated throughout the investigation. A subset of cases were coded by two raters so that inter-rater

reliability could be calculated. Reliability was found to be sufficiently high for all variables (□□□□□ >.60).

Multiple variables were used to identify cases duplicated across sources. Duplicate cases were only counted once (e.g., if the same person had an ED and an ME record, they were only counted once among fatal cases

Descriptive statistics were calculated using the overall dataset. A case-control analysis of youth fatalities was conducted to identify unique preventable or treatable risk factors for suicide among Delaware youth. The timeframe of the case definition was expanded to encompass January 1, 2009-May 4, 2012 for this analysis to increase statistical power. All available cases and controls were included in the analyses. We conducted a series of binomial logistic regression analyses to generate unadjusted (crude) odds ratios, with case/control status as the dependent variable, and risk factor variables as independent or "exposure" variables. T-tests and chi-squared tests of independence were used to test case and control group demographic differences. Data were analyzed using Predictive Analysis SoftWare 18 (PASW/SPSS).

Additionally, we compiled two sets of survey data: (1) 2011 YRBS Kent and Sussex county data with state and national data on bullying (a topic of expressed local interest) and suicidal thoughts and behavior, and (2) a summary of National Suicide Prevention hotline national reports and report for the state of Delaware of suicide hotline calls from October 2011-March 2012. This time period was selected because it includes several months preceding the onset of the youth suicide cluster (October-December, 2011), and the timeframe in which

the cluster occurred (January-March, 2012). These two time periods were examined to investigate the possibility of a recent increase in overall suicidality in the area.

Qualitative Data Analysis

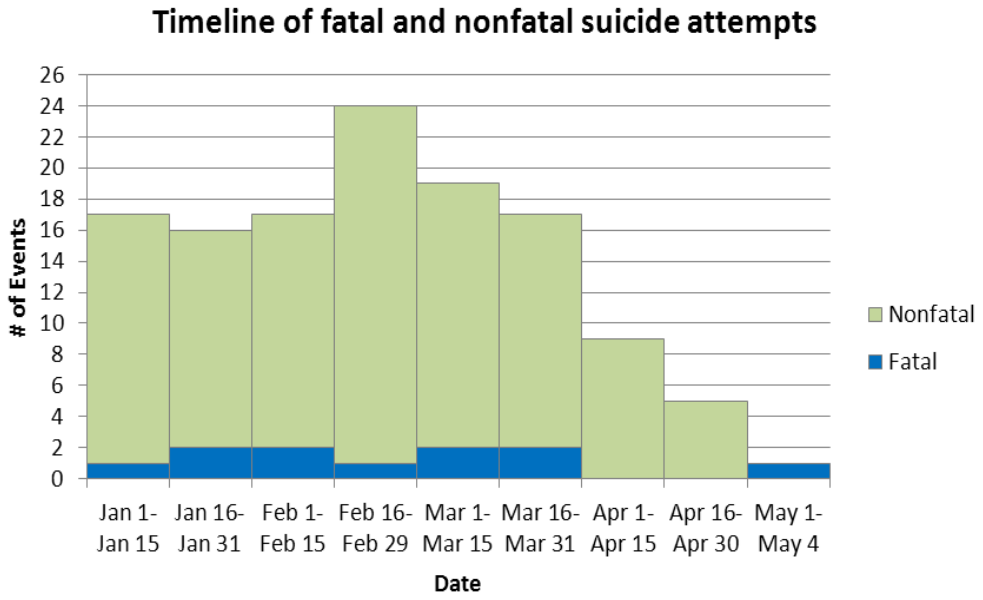
All scheduled key informant interviews were completed. Despite the sensitive nature of the discussions, participants expressed thoughts/feelings and shared their perspectives freely.

Key informant interview data preparation and analysis consisted of several steps. During the group sessions, there were a minimum of two note taker/observers present. To prepare the qualitative dataset, we converted the observer notes from each focus group into text files and made necessary modifications to correct inconsistencies among observer notes.

Next, the team identified the overall patterns and themes of responses across the focus groups on similar questions. Lastly, the team prioritized the qualitative findings and identified opportunities to compare and contrast the qualitative and quantitative findings in the report.

Results (Phase 4)

A timeline of the fatal and nonfatal suicidal behaviors in Kent and Sussex counties for the first quarter of 2012 was constructed:



Fatal cases

There were 11 deaths by suicide among youths aged 12-21 years in Kent and Sussex counties, Delaware between January 1 and May 4, 2012. This included one death that occurred during the course of our investigation (May 2). It excludes one death that occurred just prior to our cutoff date (death occurred on 11/20/11; body of decedent found 12/6/11). This case is notable not only due to its temporal proximity to the other cases, but also because the decedent was an adult education student at High School A. It is unclear whether this decedent knew any of the high school students from High School A who died by or attempted suicide in the months that followed.

Seven of 11 (64%) of the decedents were male, and 10 out of 11 (91%) were 16 years of age or older (see Table 1). These findings are consistent with national trends for suicide deaths[3].

Of the 11 decedents, 4 were students at High School A, 2 were students at other area high schools (2 different schools), 1 was a middle school student, 2 were graduates of area high schools still living in the area, 1 had dropped out of high school, and 1 was a young adult with an unknown education status.

Hanging (64%) was the most frequently used method of self-injury among the decedents, followed by self-inflicted gunshot wound (see Figure 2). This is consistent with the national pattern for this age group [3].

The most commonly found circumstances surrounding the suicides in this cluster were as follows: mental health problems (e.g., depression, anxiety, prior suicidal ideation); recent problem between decedent and parent(s); recent legal problems; recent problem with boyfriend or girlfriend; and substance use (see Table 2). These circumstances are consistent with the scientific research literature regarding the most commonly identified precipitating factors associated with youth suicidal behavior [8]. All decedents' cases included two or more of these circumstances; over half of the decedents were found to have experienced 5 or more (see Figure 3). This is consistent with research literature that indicates that youth who complete or attempt suicide usually have multiple risk factors for suicide[1,9].

Toxicology results were available for 10 out of 11 of the decedents. The following substances were detected at the time of death for these decedents: amphetamines (n=2), marijuana (n=2), prescription drugs other than antidepressants (n=2), antidepressants (n=1), cocaine (n=1), opiates other than heroin (n=1).

Case-control analysis

Twenty-nine deaths by suicide among Delaware youth aged 12-21 years between January, 2009 and May, 2012 were identified (see Table 3). A description of the case decedents follows: The median age of the case decedents was 18 years of age. Two (7%) were aged 12-14, 14 (48%) were aged 15-18, and 13 (45%) were aged 19-21. Twenty-two (76%) were male, and 7 (24%) were female. Twenty-two were White (76%), 4 were Black (13%), 2 were Hispanic/Latino (7%), and one was Asian (3%). The greatest number of deaths occurred in March, 2012: 4. Firearms (n=13, 45%) and hanging/strangulation (n=13, 45%) were the most common methods, followed by overdose/poisoning (n=2, 7%), and drowning (n=1, 3%).

Thirty-four control decedents were identified. The median age of the control decedents was 19 years. Twenty-two were male (65%), and 12 were female (35%). Twenty-eight were non-Hispanic White (82%), and 6 were non-Hispanic Black (18%). The causes of death for the control group were as follows: Overdose/poisonings (n=14, 41%), motor vehicle crash (n=11, 32%), adverse drug reactions (n=5, 15%), assaults (firearm, cut/pierce) (n=2, 6%), and natural causes (n=2, 6%).

Demographic and risk factor variables were compared using Chi-squared tests of independence for suicide decedents in the cluster spanning the time period between January 1 and May 4, 2012 (n=11) vs. suicide decedents whose deaths occurred in 2009-2011. Only one variable significantly differed between the two groups: Suicide death of a friend or family member was higher among

decedents in the cluster spanning January 1-May 4, 2012 (χ^2 = 6.57(1), p = .01). For this reason, case-control analyses were conducted with all suicide decedents from January 2009-May 2012 as one group.

The results of our case-control analyses provided additional information about risk factors associated with youth suicide in Delaware. There were no statistically significant differences between case and control group in their demographic characteristics (see Table 3). Potential relationships between case/control status and risk factors such as decedents' mental and physical health, life events, and environment were tested (see Table 4).

Cases were significantly more likely than controls to have a history of depression [odds ratio (OR) = 9.7, 95% confidence interval (CI) 2.4-38.8], a history of suicidal ideation/self-injurious behavior (OR = 8.4, CI = 2.1-33.8), and a history of injuries/hospitalizations (OR = 3.1, CI = 1.0-9.5). Cases were also more likely to have a history of arrest/incarceration (OR = 4.0, CI = 1.1-14.4), and were more likely to have a recent conflict or breakup with a romantic partner documented in the events preceding their death (OR = 10.5, CI = 1.2-91.4).

Controls were significantly more likely than cases to have a history of substance abuse (OR = 3.5, CI = 1.2-9.9), and toxicology results that indicated recent drug or alcohol use at the time of death (OR = 14.7, CI = 4.3-49.9). In particular, controls were much more likely to have a history of prescription drug abuse (OR = 4.4, CI = 1.2-15.4), and/or a positive screen for prescription drugs at the time of death (OR = 7.2, CI = 1.8-29.2), particularly opioids (e.g., oxycodone, morphine, oxymorphone; OR = 11.3, CI = 2.3-56.8).

Nonfatal cases

We identified 116 nonfatal suicide attempts among youths aged 12-21 years in Kent and Sussex counties, Delaware between January 1 and May 4, 2012. Although this estimate likely includes the majority of cases, it should be noted that we were unable to obtain data from every facility that might have attended a patient who had attempted suicide, and that there are often other persons who do not seek medical attention after making a suicide attempt and go undetected in official records. Sixty-five of 116 nonfatal cases were female (56%). Thirty-one (27%) were 14-15 years of age, 45 were 16-18 years of age (39%), and 32 (28%) were 19-21 years of age (see Table 1). These findings are consistent with national trends for nonfatal suicide attempts [10].

Method and history of attempts

Overdose was the most frequently used method of nonfatal suicide attempt (n=41, 35%). The majority of overdose attempts involved prescription and/or over-the-counter drugs (n=36, 87%). In many of these cases (n=18, 44%) it was unknown where the youth obtained the drugs used in the attempt. However, for those cases where it was known (23 out of 116 cases), 91% were obtained in the patient's own home (n=21) rather than from a source outside the home (n=2). The second leading method of attempt was cutting. These two leading methods are consistent with the methods recorded for this age group at the national level[10]. Forty-three nonfatal cases (37%) had a recorded previous

suicide attempt; of those, 15 (35%) were known to be attempts by the same method as the current attempt.

Lethality of current attempt

A Risk-Rescue rating[11] was calculated for n=114 of the nonfatal suicide attempts (the other 2 cases had no data about the circumstances surrounding the attempt). This rating system describes and quantifies the lethality of suicide attempts, and has been validated on a large sample of suicide attempts at a state general hospital. 'Risk' calculation takes into account several factors related to the method used and actual physical damage sustained in the course of the attempt, while 'Rescue' accounts for factors related to the availability of life-saving resources at the time of the suicide attempt (e.g., location, probability of discovery, whether the patient gave any indication of suicidality to others). The results were:

- Forty-three (38%) of nonfatal suicide attempts in this cluster were classified as low risk, 64 were low moderate risk (56%), and the remaining 7 were moderate risk or higher (6%).
- Fifty-five (48%) were classified as most rescuable, 46 were high moderately rescuable (40%), and the remaining 13 were moderately rescuable or lower (12%).

See Figure 4 for a histogram depicting the combined risk-rescue rating, which reflects the ratio of the two factors.

Influence of peer suicide attempts/completed suicide

Twenty-eight of the youth in our study who engaged in nonfatal suicide attempts had information in their medical record that indicated a personal connection with another young person in the community who died by or attempted suicide. Twenty-five of the 116 youth who attempted suicide indicated that a peer or friend had attempted or died by suicide; another 3 youth were currently attending a school where another student had attempted or completed suicide in the time since January 1, 2012 and therefore could also reasonably be counted among those although it was not specifically mentioned in their record

For a diagram that depicts the connections that we were able to determine among the individual nonfatal attempts and fatal attempts over time, aggregated within schools which had several nonfatal attempts, see Figure 5. Note that this diagram does not depict all nonfatal attempts that may have been influenced by peer suicidal behavior: Those that were not part of a subcluster of more than n=3 within a school, and/or that occurred at a school where the only known linkage was to other nonfatal attempts, are not depicted.

Risk factors and circumstances

Risk factors taken from the personal history described in the records of the nonfatal cases, and circumstances surrounding the nonfatal suicide attempts were also examined (see Tables 5 and 6).

Risk factors

Several of the most common mental health risk factors among the nonfatal cases were related to prior suicidal thoughts and behaviors: 42% of nonfatal

cases (n=49) had a history of suicidal ideation prior to the current attempt, and 41% (n=47) had a history of self-injurious behaviors. In addition, 41% of nonfatal cases (n=47) had a history of depression prior to the current attempt, and 47% (n=55) had received mental health treatment in the past.

In aggregate, 20% (n=23) of nonfatal cases had a history of some type of substance abuse. Alcohol was the most commonly abused substance (n=15), followed by marijuana (n=13). Twenty-three percent (n=27) had a history of law-breaking behavior, with consequences including arrests (n=21) and incarceration (n=5).

Thirty-four percent of nonfatal cases (n=40) had a history of violent victimization or abuse, most commonly sexual violence. Nineteen percent of nonfatal cases (n=22) had a history of engaging in violence or aggression toward others.

Circumstances

The most commonly identified circumstances surrounding the suicide attempts in this cluster were as follows: school problems (n=47; 41%); conflict with a parent (n=39, 34%); a recent change in home/family/caregiver (n=39, 34%); problems with a peer or peers (n=34, 29%); and problems with a boyfriend or girlfriend (n=26, 22%). The median number of circumstances per nonfatal case was 2 (range: 0-6). The majority of nonfatal cases (n=75, 65%) included 1 to 3 of these circumstances, while an additional 24% (n=27) included 4 or more.

These findings are again consistent with research literature that indicates that youth who complete or attempt suicide usually have multiple risk factors (both past and current) for suicide[1,9].

Toxicology results

Toxicology screens were conducted by the facilities attending to the youth presenting with nonfatal suicide attempts (n=102 youth). The following results are therefore based on these 102 cases (also (see Table 7). Among these, thirty percent of cases (n=31) showed a positive toxicology result for drugs or alcohol at the time of the suicide attempt. The most common substances detected were marijuana (n=14; 14%), antidepressants (n=11; 11%), and amphetamines (n=5; 5%). Less frequently detected substances included alcohol (at the level of intoxication), cocaine, and heroin. Five percent (n=5) of cases had a positive toxicology result for a substance other than the ones listed above, including barbiturates, and opiates other than heroin.

Qualitative results

The following themes about barriers to suicide prevention and accessing community resources emerged from the key informant interviews:

- Limited activities for youth outside of school
- Limited mental health resources, particularly for children and adolescents; long wait lists
- Lack of transportation to mental health appointments and activities

- Lack of parent/community education (mental health, substance use, suicide prevention, parenting skills)
- Resistance to seeking mental health treatment (parents and kids)
- Unsupervised access to firearms
- Limited student education on substance use, mental health, and suicide
- Limited ongoing staff training specific to substance use, mental health, crisis response, available resources

Other perspectives that emerged from the structured key informant interviews as well as through informal interviews with other adults who interact with youth in the community included the following:

- Although social media was not perceived to play a direct role in the suicide events in the community, it was often a source of information about suicidal behavior, including false rumors. Adults in the community expressed frustration with the degree to which social media is of intense interest among young people, and at the same time provides a virtually unchecked forum for rumors, gossip, and derisive comments.
- Adults generally agreed that the recent suicidal behaviors represent a perceived increase in the frequency of such behaviors among youth in the community. No one could recall another time when they observed a series of fatal or nonfatal suicide behaviors like this among young people in the community even though some had lived or worked in the community for more than 20 years.

- The clinical personnel at medical and mental health facilities reported impressions of an increase in patients hospitalized for nonfatal suicidal behaviors in the past few months. One provider hypothesized that some of this increase may be due to increased community sensitivity to suicidal ideation among young people, perhaps lowering the threshold for bringing a young person to the hospital. Other providers added that even though this is true, they perceive an increase in serious attempts as well.
- The suicides since January have taken an emotional toll on students in the community, and staff at local schools, particularly High School A.
- The death of the first decedent in the cluster at High School A was reported by the local media in a way that many people found sensationalistic. Namely, the reporter drew quotes and pictures from Facebook, and implied that bullying played a role in the student's death. Several key informants voiced disagreement that bullying was a circumstance in this decedent's suicide, and said that this was sensationalism.
- Several key informants reported that in addition to a lack of many other activities in the community, many young people engage in the use of illicit drugs and alcohol, and abuse prescription drugs.

Survey data

2011 Youth Risk Behavior Survey (YRBS) data regarding youth suicidal behavior and youth bullying were examined. The incidence of self-reported suicidal behavior among youth in both Kent and Sussex Counties was

approximately equal to the U.S. average (~8%). Youth in both counties reported a slightly lower prevalence of suicidal thoughts (~10-11%) than the U.S. average (~16%), although it is unknown if this represents a statistically significant difference. Youth in Kent County reported a slightly lower incidence of bullying victimization than the US average (~17% vs. ~20%) while those in Sussex County reported experiencing bullying at approximately the same rate as the US average. Again, it is unknown if this difference is statistically significant (see Figure 5).

State suicide hotline calls for October 2011-March 2012 did not show an overall increase in calls across age groups for the state during this time (see Figure 6).

Discussion and Recommendations

We identified 11 cases of youth aged 12-21 years who died by suicide and 116 youth who made nonfatal suicide attempts in Kent and Sussex counties, Delaware between January 1 and May 4, 2012. This is more than the eight fatalities originally identified. The number of nonfatal attempts (n=116) is approximately ten times the number of fatalities, which is consistent with the rate of hospitalizations vs. deaths attributed to suicidal behavior in this age group derived from large national surveillance systems, such as the most recent data from the CDC National Vital Statistics System[1, 8,10].

Case-control analyses revealed that a history of mental health problems such as depression and suicide attempts were significantly more likely among

Delaware youth who died by suicide than among control Delaware youth who died by other means in the same time period. This is consistent with findings from numerous studies that point to depression as an important risk factor for suicide[1,12]. Conversations with local informants revealed that a lack of training/ education about youth mental health and substance abuse problems is considered a significant barrier to suicide prevention in the community. Further, community informants expressed concern about scarcity of providers of youth mental health resources, and long wait-lists for services. Additionally, informants mentioned that few positive after-school activities are available and readily accessible to community youth.

The first two points are relevant because depression may go unrecognized or untreated in suicidal youth, creating a missed opportunity for intervention. Further, the finding that many case decedents had previously attempted suicide, almost always by less lethal means, shows that there may have been particularly concerning warning signs in some cases.

Although depression is an important risk factor for suicide, not all adolescents who engage in suicidal behaviors suffer from depression, as was seen in this cluster. Additionally, a subset of suicide attempts has been found to be unplanned and more impulsive in nature. Life stressors such as those seen in this cluster and discussed elsewhere in the literature also may precipitate suicide attempts (e.g., conflicts or breakup with a romantic partner, conflict with parents). Therefore, outreach to youth who are struggling with these and similar life

stressors is extremely important, even if they do not exhibit outward signs of depression or other mental distress.

In the process of quantifying and describing the nonfatal attempts that occurred in the same timeframe as the cluster of fatal cases, our analyses revealed two notable things: One, that the most common method of nonfatal suicide attempt was by overdose of an over-the-counter or prescription drug. This is important because it illustrates that drugs used in an overdose attempt are often of the type that are readily available, and that even youth who have no prior history of drug abuse may overdose in a suicide attempt. Additionally, the finding that when the source of the drugs used in the overdose was known, it often came from the youth's own home. This suggests that it may be productive to encourage parents to take enhanced precautions regarding substances in the home, particularly when a child is experiencing a period of poor emotional health or increased stress.

We linked a subset of nonfatal attempts to the fatalities in this cluster and to one another, and we observed that there were 5 schools that had more than 3 nonfatal attempts linked to fatal cases by students in this period. This further demonstrates the effect that youth suicides can have on other youth in the community, contributing not only to further deaths but to further injuries as well. Although the lethality index we calculated (the Risk-Rescue rating) indicated that most attempts were of relatively low lethality, this does not indicate that these attempts should be minimized or not taken seriously. As stated previously, those who die by suicide have often made prior attempts involving less lethal methods.

This was also seen in our sample, where 34% (n=10) of the decedents had a previous suicide attempt, with 80% of those (n=8) involving means of lower lethality. Despite the small numbers (n=7 and 13, respectively), it is important to consider the small number of suicide attempts that were of moderate and high lethality. Several of these involved methods or situations that easily could have been lethal.

Although not the focus of this study, our case-control analysis reflected something of public health interest about the controls: Youth who died by means other than suicide were significantly more likely to have a history of and/or postmortem toxicology result indicating drug use, particularly prescription drugs. This was also seen in our descriptive findings, where a large proportion (41%) of the controls died by accidental overdose/poisonings, and where a portion of the remainder of the control sample were involved in motor vehicle crashes that involved an alcohol or drug-impaired driver, or suffered from an adverse drug reaction due to ingestion of a prescription drug in a non-medically prescribed manner. These findings echo recent CDC reports on the dramatically rising incidence of prescription painkiller overdose[13], and overdose/poisonings as one of the top causes of fatal unintentional injuries among 15-19 years of age[14]. Although recommendations regarding this finding were not the focus of the present study, this supports the inclusion of information about prescription drug abuse in the recommended trainings about youth mental health and substance abuse.

Limitations

The findings described in this report are subject to several limitations. First, we did not speak directly with students or other young people in the community. It is possible that they may have differing or additional impressions about suicide, and its prevention and response in the community. As a related limitation, although we reviewed posted activity on High School A school social media accounts, we were unable to thoroughly investigate other social media activity (such as that between individual students) that could be related to the suicides in this cluster or suicidal behavior in the community. Taken together, this leaves open the possibility of events or dynamics that we were not aware of among the youth in the community. Still, our key informant adults had interviewed hundreds of youth during the immediate crisis period following several of the youth suicides, and there was no mention of social media as a relevant factor.

Second, although we canvassed the hospitals in the area that would have most likely received patients who had engaged in suicidal behaviors, and focused on those that would have received the majority of cases, we were unable to visit every facility.

Third, due to ambiguity of circumstances, suicidal behavior is sometimes misclassified. Therefore, there are cases that may have been missed during this investigation (e.g., single occupant motor vehicle crashes; poisonings, other injuries that appear to be unintentional). We addressed this by reviewing all cases classified as overdoses (which would likely be the most frequently misclassified) in the age group and time period of interest at all EDs visited to

determine whether narratives suggested suicidal intent. Some overdose cases were subsequently classified as suicide attempts in our analyses. As a check on misclassifications of other injuries, we reviewed all trauma cases in the age group and time period of interest at one ED. This review did not yield any additional cases. Still, it is always possible that some additional cases could have been missed because of the way they were classified in the hospital records systems.

Finally, there were some limitations to our case-control methodology, such as our use of deceased controls. Studies have shown that some exposure variables associated with an increased risk of premature death are overrepresented among deceased controls compared with living controls, possibly lowering the estimation of risk in the case group. Additionally, our analysis was limited to the information contained in medical examiner and law enforcement reports. It is possible that certain variables of interest in these analyses were not the subject of inquiry, particularly in cases that involved unintentional injury. Nevertheless, for most risk factors and circumstances there was a percentage of control decedents for whom each was indicated, leading us to conclude that where information was known it was recorded even for controls. It should also be noted that the case-control analysis was performed on a relatively small sample, and that many of the results include wide confidence intervals. Therefore, the results should be interpreted with caution, and may have limited generalizability.

Conclusions and Recommendations

Youth who die by or attempt suicide typically have multiple risk factors for suicide before an attempt is made. A precipitating event then often prompts the attempt in an already vulnerable person. Therefore, it is possible to detect risk factors and prevent suicidal behaviors in vulnerable young persons. With this in mind, our preliminary recommendations included the following:

(1) Mental health awareness training (including training on suicidal behavior and substance abuse) for persons in the community (e.g., staff in youth-serving organizations, families, peers), to help identify at-risk youth and guide them to appropriate services[15].

(2) Development of partnerships among community institutions in different sectors (e.g., education, faith-based organizations, recreation) so that resources may be combined to help address the needs of youth through programs and other activities. CDC has articulated a strategic direction in suicide prevention that emphasizes the importance of connectedness among individuals, families, their communities and social institutions[16]. Such partnerships could help foster connectedness as a protective strategy against youth suicide.

(3) Creation of additional partnerships (such as with primary care providers and pediatricians) that could strengthen the infrastructure of youth mental health primary care, so that signs of depression and other mental and behavioral health problems can be effectively recognized and treated.

(4) Review and implement evidence-based primary prevention strategies that address the associated risk factors for youth suicide. Examples specific to youth suicide prevention include strategies outlined in the Substance Abuse and

Mental Health Administration (SAMHSA) Suicide Prevention Resource Center's recently released toolkit "Preventing Suicide: A Toolkit for High Schools" (http://store.samhsa.gov/shin/content/SMA12-4669/SMA12-4669.pdf), and programs listed in the National Registry of Evidence-Based Programs and Practices (NREPP) searchable database (http://www.nrepp.samhsa.gov/). Some common themes in these programs include: training school staff, parents, and youth to be "gatekeepers" by recognizing warning signs of suicide and learning what to do when someone is at risk for suicide; and understanding of risk factors such as depression.

Evidence-based programs that focus on positive youth development by strengthening youths' social/emotional and behavioral competencies or enhancing family functioning or other supportive relationships could also be implemented. These programs often have broad prevention aims, such as prevention of substance abuse, unplanned pregnancies, and other-directed violence. Although they are not specific to suicide prevention, these programs target risk factors for youth suicide found in this investigation and other studies (e.g., emotional problems, family problems, lack of supportive relationships, substance abuse) and could be useful for youth experiencing a wide range of problems. NREPP searches yield several examples of programs of this type using terms such as 'positive youth development' and 'youth skills.'

Further, information on how to take what we know about suicide and make it more actionable for prevention can be found at: http://www.cdc.gov/ViolencePrevention/ASAP.html

(5) Continue to monitor trends in youth suicidal behaviors through local resources (e.g., health department, medical examiner, hospitals). Monitoring fatal and nonfatal suicidal behavior in the community over time can provide one measure to evaluate the effectiveness of programs or interventions, or may reveal new strategies for prevention and intervention;

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Table 1. Fatal and nonfatal suicide behaviors in youths aged 12-21 in Kent & Sussex Counties, Delaware, by age group and sex, January 1-May 4, 2012.

	Fatal		Nonfatal	
	n	*%*	*n*	*%*
Age Group				
12-13 years	1	9	8	7
14-15 years	0	0	31	27
16-18 years	8	73	45	39
19-21 years	2	18	32	28
Total	11	100	116	100
Sex				
Female	4	36	65	56
Male	7	64	51	44
Total	11	100	116	100

Table 2. Circumstances indicated in deaths by suicide among youths aged 12-21 in Kent & Sussex Counties, Delaware, Jan 1-May 4, 2012.

	Fatal	
	n	%
Circumstance		
Mental health problem(s)	7	64
Recent conflict w/parent	5	46
Recent legal problem	5	46
Recent problem w/boyfriend or girlfriend	4	36
Substance use	4	36
Academic problem	3	27
Left note, called or texted about suicide	3	27
Concerns regarding sexual orientation	2	18
Recent peer problem	2	18

Table 3. Demographic Information and Cause of Injury for Cases and Ccontrols

	Cases n (%)	Controls n (%)	Differences Between Groups
Age			
12-14	2 (7)	2 (6)	
15-18	14 (48)	12 (35)	
19-21	13 (45)	20 (59)	
Mean age in years	18.1	18.62	*t (61)* = -1.01, *ns*[1]
Sex			
Female	7 (24)	12 (35)	
Male	22 (76)	22 (65)	χ^2 (1) = .93, *ns*[2]
Race/ethnicity			
White	22 (76)	28 (82)	
Black	4 (13)	6 (18)	
Hispanic/Latino	2 (7)		
Asian	1 (3)		
			χ^2 (2) =3.73, *ns*[2]
Cause of injury			
Hanging/strangulation	13 (45)		
Firearms	13 (45)		
Drowning	1 (3)		
Overdose/poisoning	2 (7)	14 (41)	
Motor vehicle crash		11 (32)	
Adverse drug reaction		5 (15)	
Assault		2 (6)	
Natural causes		2 (6)	

[1]*ns* = not significant

[2]Pearson chi-square

Table 4. Logistic regression analysis of risk factors for youth suicide

Potential risk factor	Cases N=29 (n, %)	Controls N=34 (n, %)	Direction of effect	Odds ratio	95% CI	p-value[1]
History of mental health problems						
Depression	14 (48%)	3 (9%)	Cases>Controls	9.6	2.4-38.8	**<.001**
Anxiety	6 (21%)	2 (6%)		4.2	0.8-22.6	ns
Suicidal ideation/self-injury	13 (45%)	3 (9%)	Cases>Controls	8.4	2.1-33.8	**<.005**
History of violence						
Victim of violence	4 (14%)	2 (6%)		2.6	0.4-15.1	ns
Violence toward others	5 (17%)	0 (0%)				
History of legal problems						
Arrest/incarceration	10 (34%)	4 (12%)	Cases>Controls	4.0	1.1-14.4	**<.05**
History of medical problems						
Injuries/hospitalizations	13 (45%)	7 (21%)	Cases>Controls	3.1	1.0-9.5	**<.05**
Chronic illness/defects	6 (21%)	4 (12%)		2.0	0.5-7.8	ns
History of substance abuse						
Any substance	10 (34%)	22 (65%)	Controls>Cases	3.5	1.2-9.9	**<.05**
Alcohol	5 (17%)	9 (26%)		1.7	0.5-5.9	ns
Marijuana	4 (14%)	6 (18%)		1.3	0.3-5.3	ns
Cocaine	1 (3%)	2 (6%)		1.8	0.2-20.4	ns
Prescription drugs	4 (14%)	14 (41%)	Controls>Cases	4.4	1.2-15.4	**<.05**
Substance use detected by toxicology[2]						
Any substance	7 (32%)	28 (85%)	Controls>Cases	14.7	4.3-50.0	**<.001**
Alcohol	0 (0%)	8 (24%)				
Cocaine	1 (5%)	2 (6%)		1.4	0.1-15.9	ns
Heroin	0 (0%)	2 (6%)				
Antidepressants	2 (9%)	12 (34%)	Controls>Cases	5.5	1.1-27.4	**<.05**
Amphetamines	2 (9%)	5 (16%)		1.9	0.3-10.5	ns
Cannabis	3 (14%)	13 (41%)	Controls>Cases	4.3	1.1-17.7	**<.05**
Opioids (other than heroin)	2 (9%)	17 (53%)	Controls>Cases	11.3	2.3-56.6	**<.005**
Prescription drugs	3 (14%)	17 (53%)	Controls>Cases	7.2	1.8-29.2	**<.01**
Other circumstances						
Romantic conflict/breakup	9 (31%)	1 (3%)	Cases>Controls	10.5	1.2-91.4	**<.05**

[1]ns = not significant
[2]Overall ns for toxicology results; Case overall n=22, Control n=33 due to a small number of decedents who were not screened

Table 5. Risk factors indicated in nonfatal suicide attempts among youths aged 12-21 in Kent & Sussex Counties, Delaware, Jan 1-May 4, 2012.

	Nonfatal cases	
	n	*%*
Risk factor		
Mental and behavioral health history		
Past mental health treatment	55	47
Suicidal ideation	49	42
Depression	48	41
Self-injurious behaviors	47	41
Previous suicide attempt	43	37
ADHD/LD or developmental delay	23	20
Bipolar disorder	17	15
Anxiety	15	13
Family history of mental illness	15	13
Psychotic symptoms or disorder	9	8
Conduct disorder/ODD/PD	5	4
Violence history		
Victim of interpersonal violence	40	34
Sexual violence†	23	58
Non-sexual violence†	17	43
Engaged in violence or aggression toward others	22	19
Legal history		
Law-breaking behavior§	27	23
Arrests	21	18
Incarceration	5	4
Medical history		
Chronic health condition	47	41
Injuries/hospitalizations	19	16
Substance abuse history		
Alcohol	15	13
Marijuana	13	11
Cocaine	6	5
Prescription drugs	5	4
Other	11	9
History of abusing any drug or alcohol	23	20

†Percentage within those who were victims of interpersonal violence. Also note that many individuals were victims of multiple forms of abuse. When categorized that way, 35% of the total victims of interpersonal violence (n= 14) had experienced sexual violence only, 35% had experienced multiple forms of abuse, and 23% (n=9) had experienced only one form of non-sexual abuse.

§ Diverse category including: Assault, battery, breaking and entering, burglary, possession of drugs/paraphernalia, rape, criminal mischief, DUIs, auto theft, possession of weapons on school property, running away, truancy, cruelty to animals, and probation violation

Table 6. Circumstances indicated in nonfatal suicide attempts among youths aged 12-21 in Kent & Sussex Counties, Delaware, Jan 1-May 4, 2012.

	Nonfatal cases	
	n	*%*
Circumstance		
School problems	47	41
Conflict w/parent	39	34
Change in home/family/caregiver	39	34
Peer problems	34	29
Problem w/boyfriend or girlfriend	26	22
Suicide of friend or peer	25	22
Disclosed intent	22	19
Other family conflict	18	16
# of circumstances per patient		
0	14	12
1	24	21
2	27	23
3	24	21
4	10	9
5	15	13
6	2	2
Total	116	100

Table 7. Toxicology results for youth aged 12-21 in Kent & Sussex Counties, Delaware who engaged in nonfatal suicide attempts between Jan 1-May 4, 2012.

	Nonfatal cases	
	n	*%*
Positive toxicology result		
Any substance	33	28
Marijuana/THC	14	12
Antidepressants	13	11
Amphetamines	7	6
Other	6	5
Elevated blood alcohol content†	4	3
Cocaine	4	3
Heroin	1	1

†Defined as BAC ≥.08 g/dL

Figure 1. Number of deaths by suicide among Kent and Sussex County youth aged 12-21 from 2009 to May 2012, by year

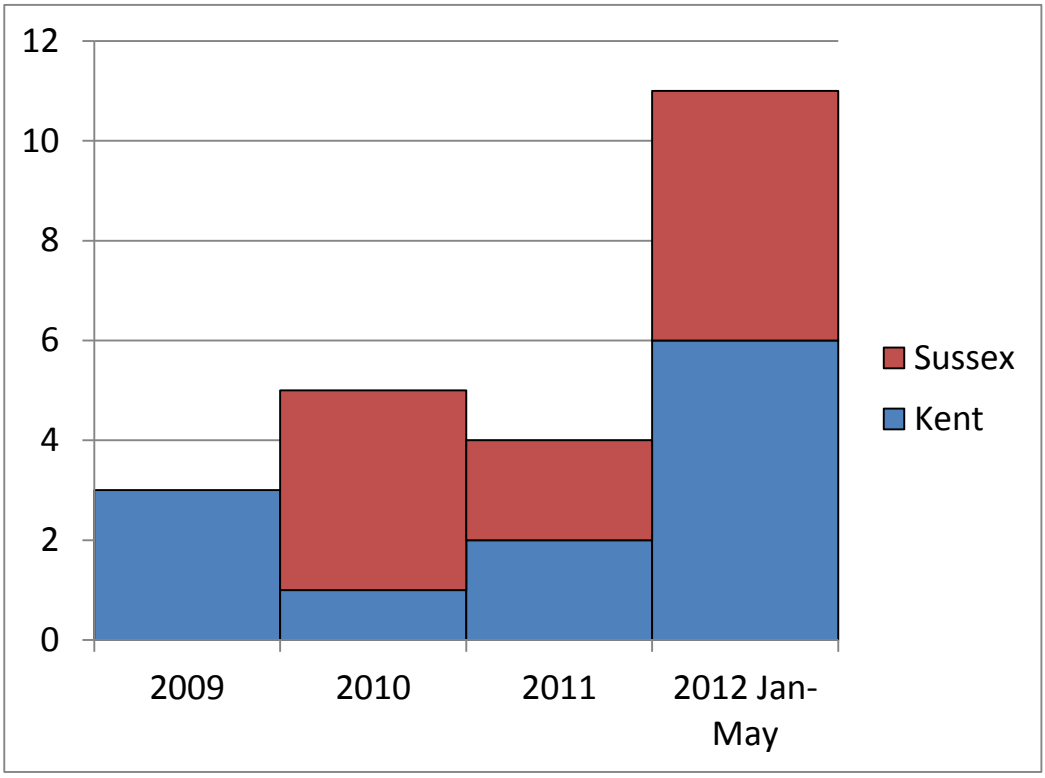
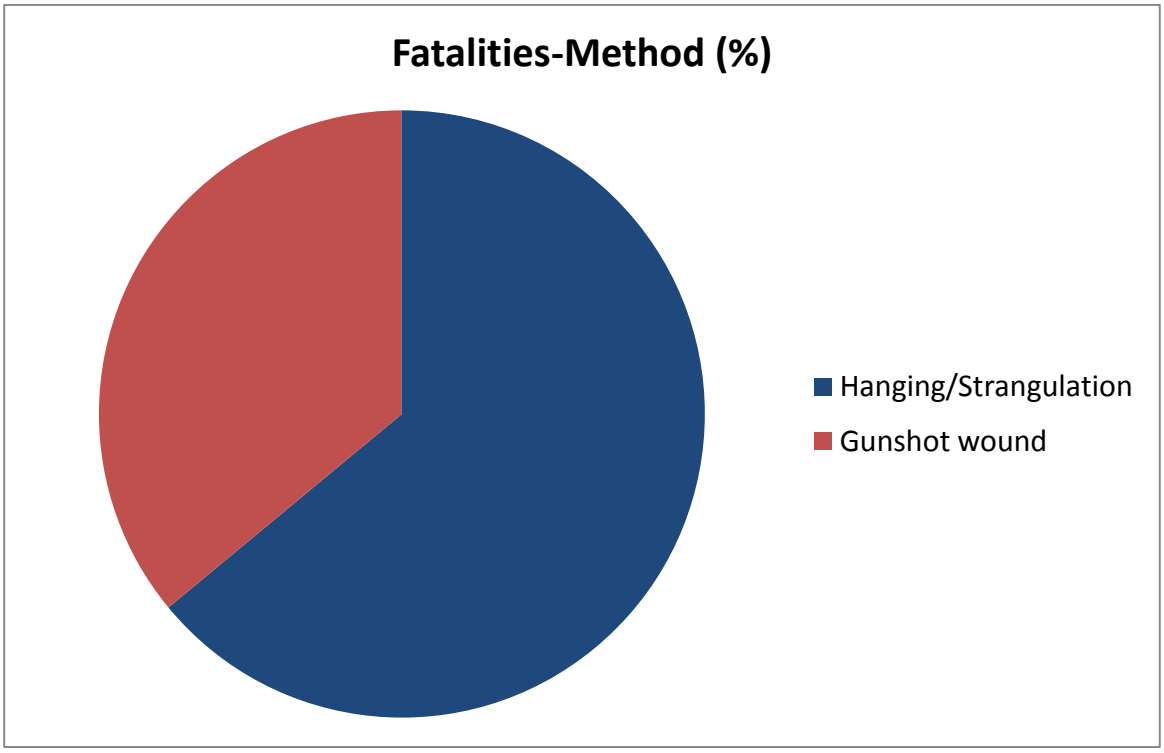


Figure 2. Method of suicide attempt or death by suicide for fatal and nonfatal cases among Kent and Sussex County youth aged 12-21 from January 1 - May 4, 2012



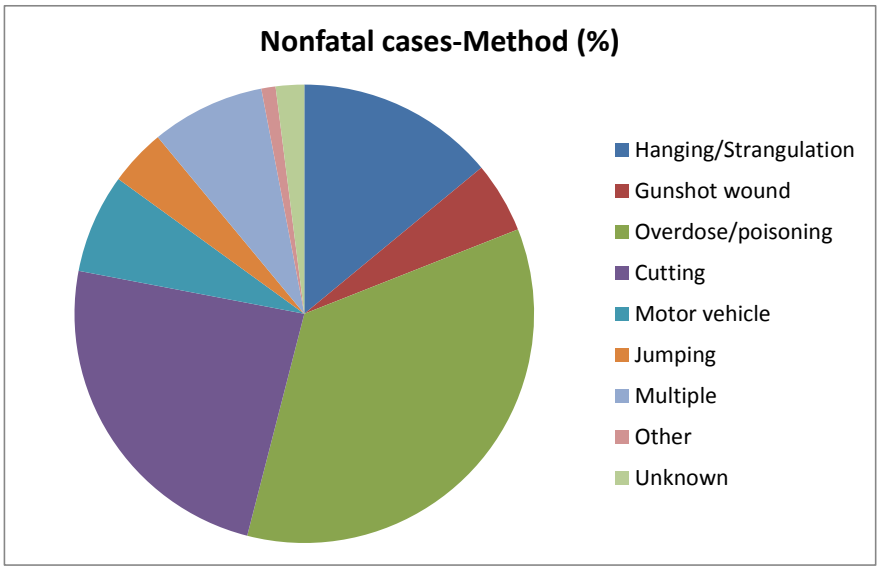


Figure 3. Number of circumstances per decedent in Kent and Sussex County youth suicide cluster January 1- May 4, 2012

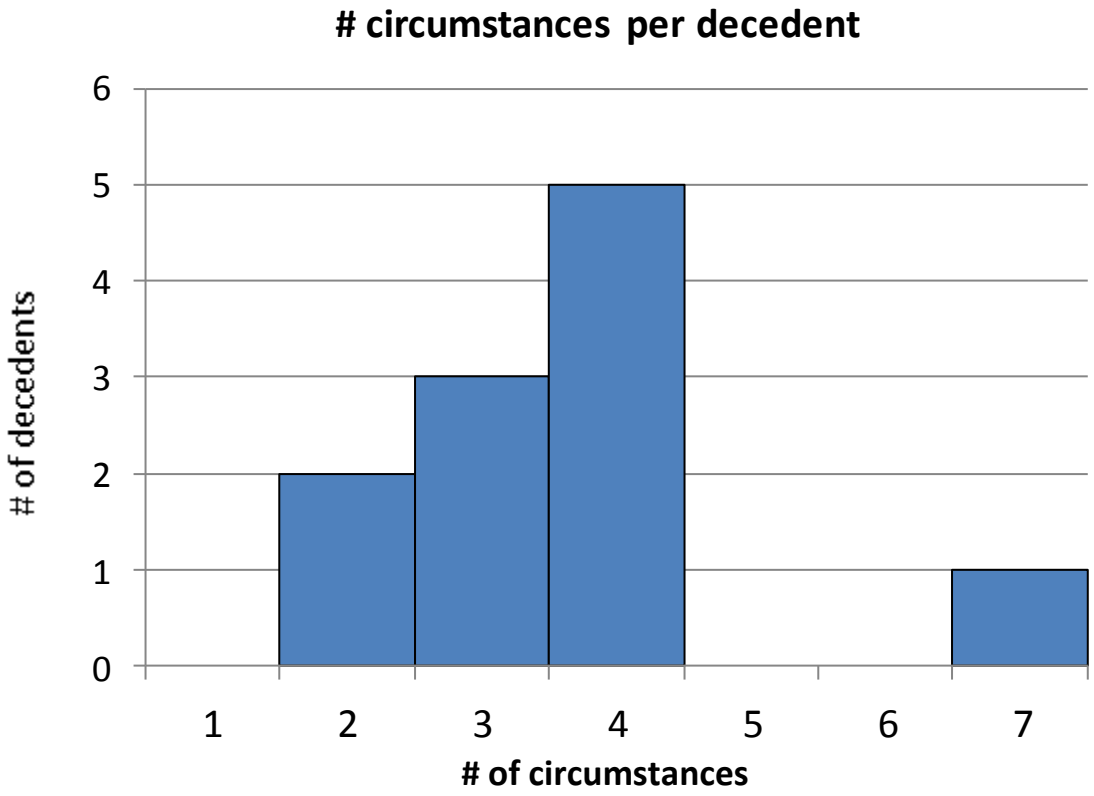
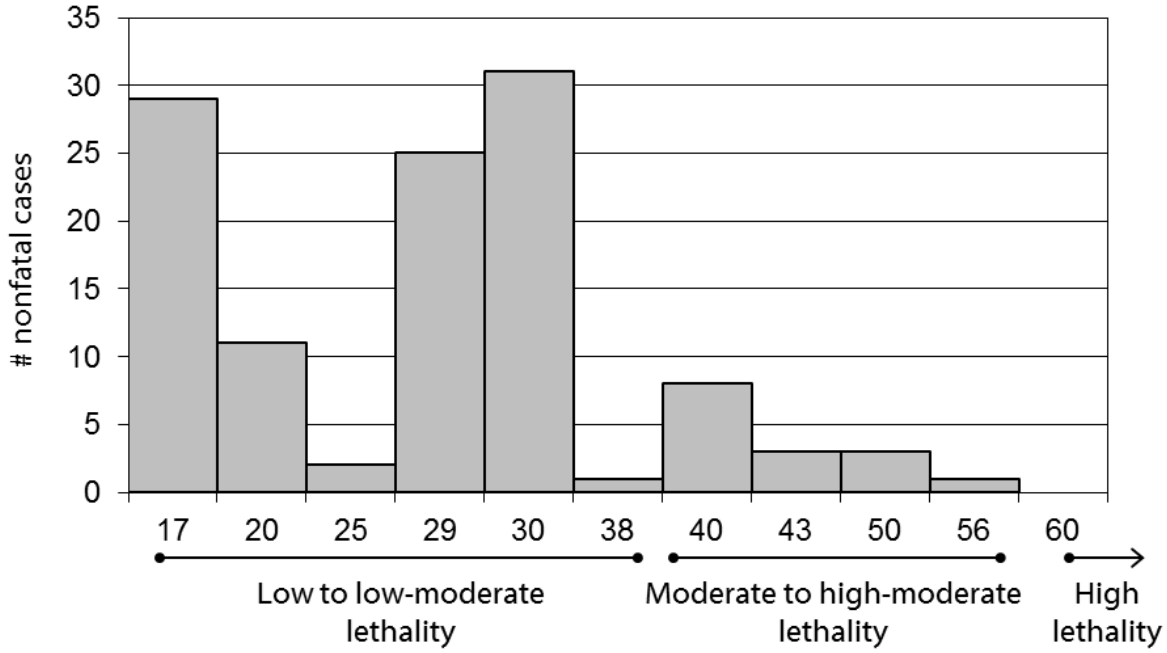


Figure 4. Distribution of risk-rescue combined rating of lethality†: Nonfatal suicide attempts among Delaware youth aged 12-21 years, January 1-May 4, 2012.



† 'Risk' accounts for lethality of methods used and severity of injuries sustained in the attempt; 'Rescuability' accounts for availability of life-saving resources at time of attempt (e.g., location, probability of discovery, disclosure of intent to commit suicide). The combined rating accounts for these two dimensions together.

Figure 5. Connections among fatal and nonfatal suicide events between January and May, 2012 among Kent and Sussex county youth, aggregated by schools with several nonfatal attempts

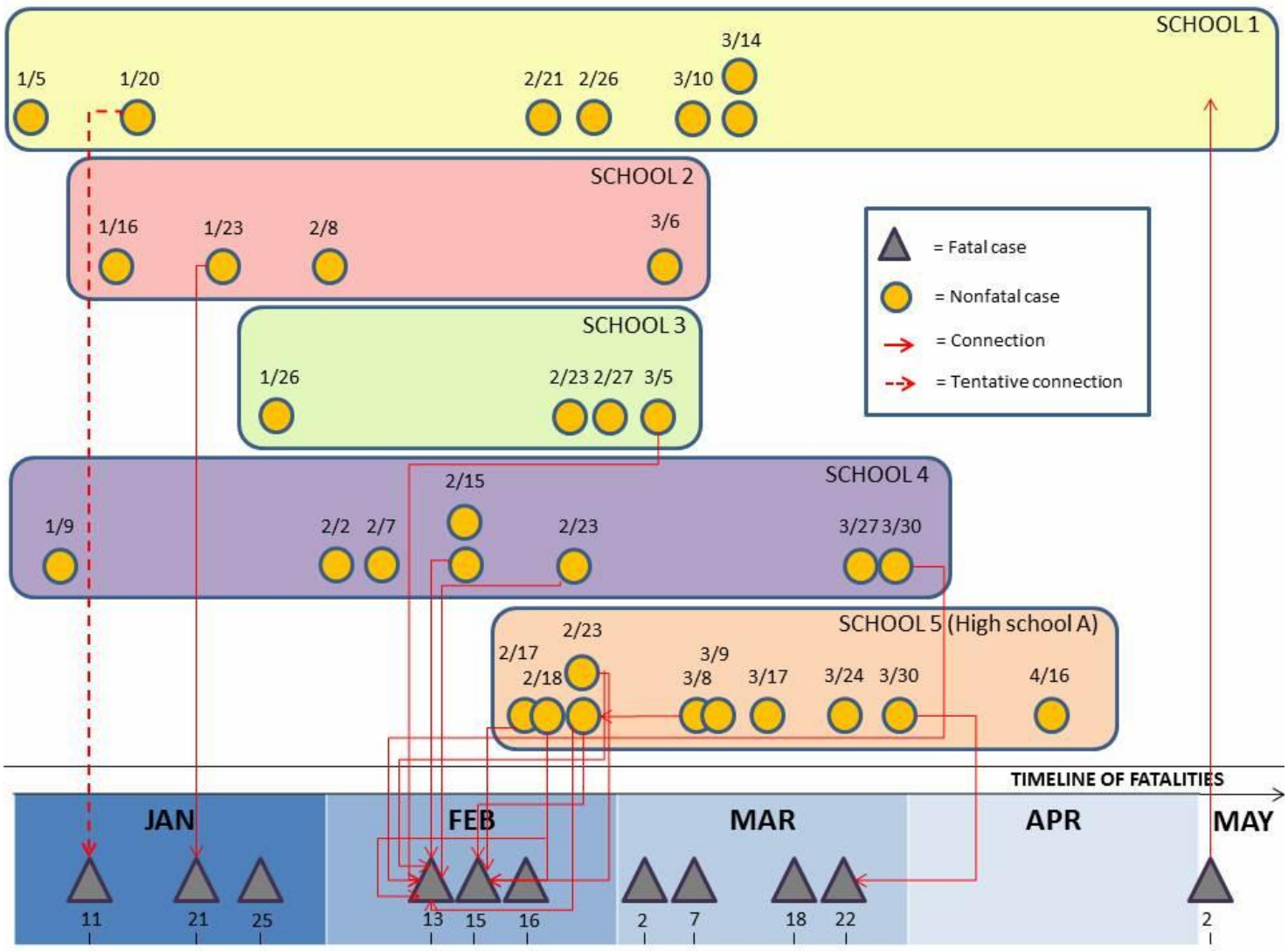
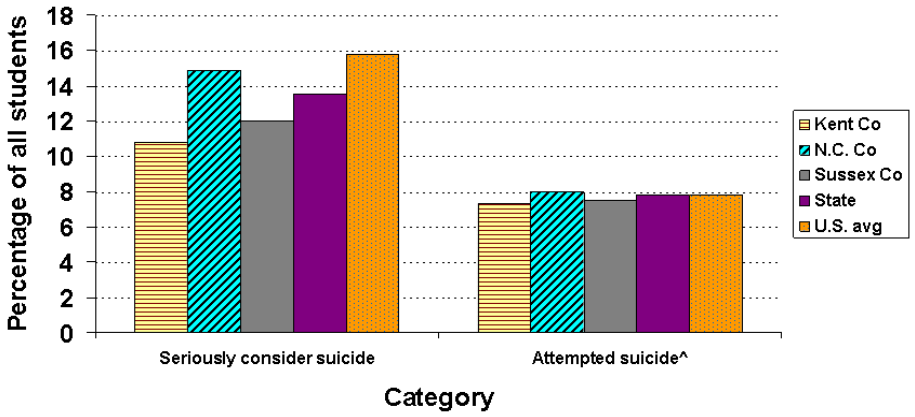


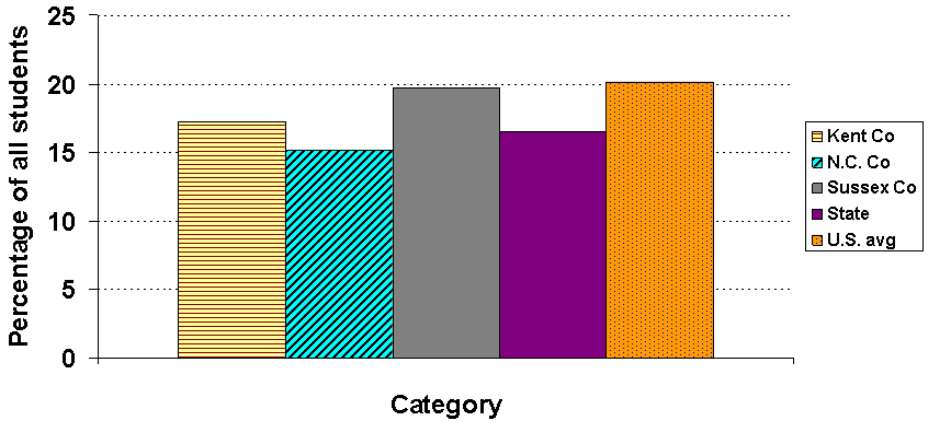
Figure 6. YRBS suicidal ideation and bullying data: Kent and Sussex counties, state of Delaware, and national data.

Suicidal ideation and behavior among high school students – Delaware and U.S., 2011



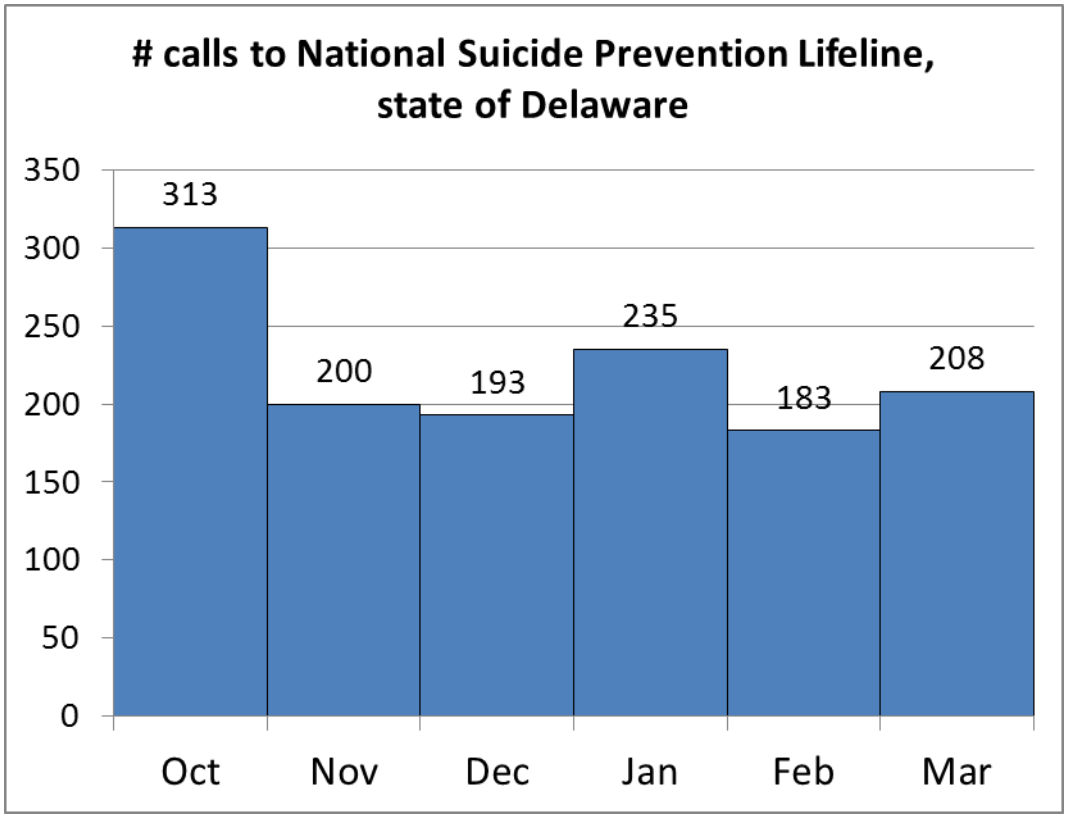
Source: CDC Youth Risk Behavior Survey
* During the 12 months preceding the survey
^One or more times

Ever bullied on school property among high school students – Delaware and U.S., 2011



Source: CDC Youth Risk Behavior Survey
* During the 12 months preceding the survey

Figure 7. National Suicide Prevention Lifeline calls for the state of Delaware from October 2011 – March 2012



Appendix A. Key informant interview

Introductory information

a) Title/position:

b) Role in the community

c) How long this person lived and/or worked in the community (is this person from the area or an "outsider". Does s/he remember any previous local cluster to current events?

Questions:

1. Do you think there is a suicide problem in this area? Why or why not?

    a) If yes, do they think it's specifically a youth suicide problem?

2. Do you personally know someone who died by suicide or attempted suicide?

3. Have you been affected by the recent suicides in the community? How?

4. How do people in this area respond when someone dies by suicide?
    a) How does the town respond?

    b) How do schools respond?

    c) How do parents respond?.

    d) How do young people respond?

5. Is there something about this community that affects the way people think about or respond to suicide?

6. What resources are available in the area for helping young people who might be feeling suicidal?

7. What kind of resources or people do you think might help prevent suicide?

a. Are those people currently involved?

b. If not, what might help them get involved?

8. When it comes to addressing the needs and problems of young people, what do you think the community needs most?

9. What are the barriers, if any, to seeking and accessing mental health care/resources?

   a. Any specific barriers among youth/young adults?

   b. In the community, in general?

10. Do you think or know of any role social media has played in the recent events (suicides)?

11. Is there anything else you think we should know?

Firearm Suicide Prevention Task Force

Meeting #2 Notice

Wednesday, November 30
9am to 11am
Legislative Hall, House Hearing Room
411 Legislative Ave,
Dover, DE 19901

Agenda

- Approval of minutes

TBD

Contact: Lauren CW Vella, 302-577-5190