FLORIDA STATE
METROPOLITAN AND NON-METROPOLITAN COMMUNITY
YOUTH SUICIDE PREVENTION PROTOTYPE PROGRAM

EXECUTIVE SUMMARY REPORT
YEAR ONE

Institute for Child Health Policy
Nova Southeastern University

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Annual Report

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Executive Summary

I. Introduction

About the National Problem

Suicide continues to be the 3rd leading cause of death among teenagers and young adults.[12] Suicide prevention is a predominant theme in the national dialogue about mental health, as suicide is often the end result of many types of untreated mental and behavioral disorders. Psychiatric disorders affect a significant number of youth across the United States, yet many children and adolescents with these problems do not receive care. According to the Surgeon General's Report on Mental Health (1999), about 21 percent of U.S. children, 9 to 17 years of age, have a diagnosable mental or addictive disorder with at least minimum impairment. A study of 46,000 children and adolescents, conducted by the RAND Corporation, indicates that seven out of ten adolescents with mental health problems do not get care.[3]

Although the number of deaths from suicide remains unacceptably high, mortality reflects only a small portion of suicidal behavior, particularly among youth. The majority of children and adolescents who engage in suicidal behavior do not die. Recent estimates from a nationally representative sample of U.S. emergency departments suggest that, among 15-19-year-olds, for every suicide death, 32 were treated for self-inflicted injuries.[4] In self-report studies, nearly 1 in 5 U.S. high-school students disclose seriously considering suicide in the past year and 1 in 13 report having engaged in at least 1 nonfatal suicidal act. [5] Furthermore, though youth are less likely to die as a result of suicidal behavior than are older adults, children and adolescents account for far more nonfatal behaviors and suicidal ideation.[6]

Florida's Response to the Problem

In 1984, the Florida State Legislature required the Department of Health Rehabilitative Services, in cooperation with the Florida Department of Education (DOE) and the Florida Department of Law Enforcement (FDLE) to develop a state plan for youth suicide prevention. The Task Force concluded that while a number of service components existed in many districts, coordination and supplementation of these services was needed in order to establish a starting point for the development of a full continuum of services, including prevention, intervention, and treatment coordinated to address children's needs in a holistic way. In June 2000 the Florida Adolescent Suicide Prevention Plan Task Force submitted a report to the Florida Department of Health Bureau of Emergency Medical Services. The findings in this report provide information to better understand the problem of youth suicide and recommends methodologies for evaluation of prevention and intervention efforts targeting families and professionals.[7] Also in 2000, the creation of Florida State Task Force, convened by the Florida Office of Drug Control Policy Director on Suicide Prevention in conjunction with representatives from numerous state agencies and advocacy groups, released a white paper titled *Preventing Suicide in Florida: A Strategy Pape*r.[8] *The Florida Metropolitan and Non-Metropolitan Community Youth Suicide Prevention Prototype Program* was developed in response to the guidelines that were set forth in that document.

II.Youth Suicide Prevention Prototype Program: Five-Year Plan 2002 – 2007

The Youth Suicide Prevention Prototype (YSPP) program takes a broad-based approach, which considers the entire continuum of a community-based youth suicide prevention, intervention, and postvention. The overall goal is to decrease the incidence of youth suicidal behavior (fatal and non-fatal) by one–third in Alachua and Broward Counties. Specific objectives are to examine the epidemiology and potential risk and protective factors related to youth suicide in a combined population base of 1.8 million residents; describe the epidemiologic characteristics and design choices of different intervention strategies for preventing suicide; and evaluate the impact of these interventions on youth suicide.

While the plan includes objectives and action steps to be pursued through the Institute for Child Health Policy, the improvements in suicide prevention envisioned here can only be accomplished through the systematic, coordinated efforts of many key agencies, organizations, and benefits from the commitment of various consumer groups. Therefore, the prototype should be considered a strategic plan for both the state and the nation.

III. Communities Selected as Pilot Sites

Alachua and Broward Counties were selected to pilot this program as non-metropolitan and metropolitan counties respectively. Commonalities exist between both counties relative to their community resources, which could be used to leverage capacity building in advancement of the YSPP program. One such partnership would be the Drug-Free Communities Program. The Drug-Free Communities Act of 1997 is a catalyst for increased citizen participation in efforts to reduce substance use among youth, and it provides community anti-drug coalitions with much-needed funds to carry out their important missions. Drug-Free Communities Program in Alachua has partnerships between the University of Florida Center for Cooperative Learning and the Alachua County Schools. Broward County has various youth drug prevention initiatives such as the United Way Drug Free-Community partnership with South Florida High Intensity Drug Trafficking Area, the Miami Coalition for a Safe and Drug-Free Community, the Drug-Free Youth In-Town program, the Florida Department of Juvenile Justice, the local school board, and other public and private substance abuse-related initiatives.

Alachua County is classified as a non-metropolitan community of 217,955 residents. Twenty percent of the residents are Black and five percent are Hispanic. Twenty-four percent of children between the ages of 5 and 17 reside in families at or below 100% of the federal poverty level (FPL).[9] There are 65 schools in Alachua County with a total enrollment of 29,684 students. Alachua County schools include 25 elementary, 8 middle, and 6 senior high schools.[10]

Broward County is a culturally diverse area in South Florida classified as a metropolitan community. It is the second most populous county in the state with 1,623,018 residents. The median age is 37.8 years and the average family size is 3.1. An estimated 18% of Broward County related children ages 5 – 17 years reside in families at or below 100% of the federal poverty level (FPL). Twenty percent of the county population is Black and seventeen percent is Hispanic. There are 3,667 Native American Indians and 36,158 Asian county residents. Enrolled in the Broward County School District are 260,916 students. [11]

IV. Project Objectives

The program plan was designed to span a five-year period. The ***overarching goal*** is to decrease the incidence of youth suicide by one third in the pilot communities - Alachua and Broward County - a benchmark set by Governor Jeb Bush. The ***objective of program activities*** is to promote the widespread adoption of programs and policies that prevent suicide. In Year 1, this objective was pursued through the following ***specific aims***:

> Aim 1 - Support state and local agencies, community-based organizations, and academic institutions to develop, implement, and evaluate suicide prevention interventions and data tracking systems.
>
> Aim 2 - Integrate the strategic plan across agencies and organization.
>
> Aim 3 - Train healthcare professionals, law enforcement, and school staff to recognize the early risk signs for suicide, and respond appropriately.

V. Project Activities

The Florida State Task Force on Suicide Prevention's *Preventing Suicide in Florida: A White Paper*[12] identified two primary reasons for failing to prevent suicides:

- a failure to recognize the risk factors and signals that indicate a higher probability of suicidal acts; and
- a diminished ability to get an identified suicide risk to timely, efficient, and affordable treatment.

The ***Youth Suicide Prototype Prevention Project*** aims to respond to these identified gaps through education and public awareness; by increasing access to readily available information; integrating efforts across agencies, organizations, and facilities; and promoting evaluation of prevention programs.

The program activities are divided into three general aims:

- Research and Resources,
- Training and Education; and
- Communication and Coordination

Research and Resources

Under ***Research and Resources***, the main activity has been the development of a Pilot Suicide Surveillance System starting in Broward County. The system will include data from the county's crisis hotline, the medical examiner, hospital discharge reports, and fire rescue. Inclusion of data from the emergency departments is still under discussion due to Health Insurance Portability and Accountability Act (HIPAA) concerns. In addition to the development of a pilot surveillance system, the Institute for Child Health Policy (ICHP) partnered with Covenant House Florida in Broward County, a crisis center that offers residential services to runaway, homeless, and at-risk youths in Broward County. This organization uses the Columbia TeenScreen® Program[13] to identify youth at risk for suicide and other mental health conditions. A total of 738 records of the combined screening data were analyzed from this high-risk group. While these data represent a unique and relatively small population of teens, they provide a useful source on non-fatal suicidal behavior among youth in Broward County and serve as a potential source of non-fatal data for the developing surveillance system.

Training and Education

As part of ***Training and Education***, the project contracted with researchers at the Florida Mental Health Institute to develop a Youth Suicide Prevention School Readiness Planning Guide. The guide was created based on existing research and input from community focus groups. At the start of Year 2, pilot testing will take place in Alachua and Broward schools. The other important component of this aim was to provide useful tools to primary care providers who may encounter children at risk for suicide in their practice. In order to provide materials that responded to their perceived needs, a survey was conducted to assess current practices, needs, and barriers regarding screening and referral for mental health problems.

Communication and Coordination

Communication and Coordination activities include participation in public awareness and advocacy events, media partnerships, and promotion of the program and/or presentation of data findings through publications and abstracts. These include meetings with the three advisory committees that oversee the governance of this project, as well as formal and informal presentations in a variety of settings. Many of the Communication and Coordination efforts were centered on promoting the School Readiness Planning Guide. Among these activities were a television program, newsletters, and display tables devoted to the Youth Suicide Prevention Prototype Project and/or the School Readiness Planning Guide.

VI. Preliminary Results and Next Steps

While the Youth Suicide Prevention Prototype Project is not a research project, the first year was devoted to planning and assessing the environment in which the activities will unfold. Below are some of the findings of the assessment stage and the next steps some of which will take place in Year 2 in response to these findings.

Suicide Surveillance

Results and Issues Identified:

- Epidemiologic surveillance is the first step to prevention in the public health model. Systematic collection, coding and tracking of youth suicide data is key to planning prevention strategies and monitoring program effectiveness. This important step is lacking in the area of preventing youth suicide attempts.

- Data-sharing partners have taken initial steps toward the development of the surveillance system. Data has been received from the Broward Medical Examiner, First Call for Help, and Agency for Health Care Administration (AHCA).

- Schools are an untapped source of data on suicidal behavior. The schools in the pilot communities do not currently collect this information.

- There is interest and willingness from the community to develop a surveillance system of non-fatal suicidal behavior; however these data are not recorded in a consistent manner. Improving coding and recording of suicidal behaviors among Emergency Medical Systems (EMS), Emergency Department (ED), and mental health inpatient computer systems must be part of this effort.

Next Steps:

- HIPAA issues are being worked through to obtain data from the Broward Fire Department and the Hospital Districts.

- Project staff is working with partner agencies to educate stakeholders about the importance of epidemiologic surveillance for program planning.

- Existing data sources will continue to be explored including schools, mental health, and medical providers.

- A manual will be created to assist other counties in developing a youth suicide surveillance system using existing data sources.

Training and Education

Results and Issues identified:

- Practitioners in the field (teachers, physicians, EMS personnel) need practical tools they can incorporate into their routine activities.

- Schools have considerable independence in implementing suicide prevention programs; school administrator and teacher buy-in to the process will determine adequate implementation, not a state mandate.

- Primary care physicians have limited knowledge of mental health referrals for children and adolescents.

Next steps:

- YSPP will work with professional organizations to provide continuing professional education of pediatricians, family practitioners, and ED and EMS personnel in the area of mental health emergencies and screening for chronic mental health conditions.

- The School Readiness Planning Guide will be rolled out in six Broward schools and three Alachua schools in the fall of 2003.

- Over 300 information packets were sent to pediatricians and family practitioners in Broward and Alachua Counties including a validated tool for office-based screening, suicide prevention information, and resource guides to make referrals in each county.

System Issues

Results and Issues identified:

- There is a significant time delay (due to lack of resources) for child/adolescent evaluations for medication and other community-based support for kids seen in the primary care provider offices with mental health concerns. Waits of six to eight weeks are common.

- There are limited resources for children/adolescents with dual diagnosis for mental health issues and alcohol/substance abuse. Due to lack of other facilities, the emergency department is used as a place of last resort for children and adolescents.

- There is a lack of clarity about the physician's role in identification of non-acute mental and behavioral health concerns.

Next Steps:

- Through the coalition building and awareness-raising activities, these issues will be discussed with policymakers and service providers to determine appropriate steps to address insufficient services.

- This issue is further complicated by the uncertainty of the impending transition to Medicaid capitation for mental health services. The Broward county Network for Children with Serious Emotional Disturbances (SEDNET) has created a workgroup to look at this issue.

- Through active collaboration with community mental health providers, local and state medical associations, and providers of continuing medical education, primary and emergency physicians' roles and responsibilities vis-à-vis mental health will be discussed and clarified.

VII. Lessons Learned and Conclusions

Youth suicide prevention strategies have primarily been implemented within three domains—school, community, and health care systems—and generally have one of two general goals: case finding with accompanying referral and treatment or risk factor reduction. The link between these three domains must be strengthened to ensure optimal collaboration. Based on the work of the Youth Suicide Prevention Prototype Project in Year One, we report the following lessons learned:

Research and Resources

- Coding and recording of suicidal behaviors among EMS, ED, hospital, and mental health service computer systems must be improved to capture the true incidence of suicidal behavior that requires medical care or law enforcement intervention.

- HIPAA considerations must be part of the surveillance system design and may result in less than optimal data due to inability to track duplicates.

Training and Education

- The dissemination of all education and prevention materials has to be well planned and framed within the context of a larger community suicide prevention effort to increase likelihood of implementation in diverse settings.

- Implementation guidelines for the school planning guide and other prevention tools must be flexible to meet the diverse needs of Florida schools.

- Before universal screening occurs, resources have to be in place to respond to the service needs that will arise. Formal relationships with community service providers are necessary parts of a suicide prevention plan.

- Primary care providers who work with youth need standard age-appropriate screening tools for use during routine examinations. Screening tools must be culturally competent due to the multi-ethnic composition of Florida residents. This is an area of research that has not been adequately translated into practice, and is especially relevant when dealing with families in crisis.

Communication and Community Awareness

- It is necessary to raise awareness about the significance of non-fatal suicide attempts and promote reporting of such attempts within HIPAA guidelines.

- Although community awareness increases public buy-in and political will to fund programs, awareness alone will not prevent suicide.

In its first year, the *Florida Metropolitan and Non-Metropolitan Community Youth Suicide Prevention Prototype Program* was successful in meeting its objectives and made significant progress toward developing a practical and replicable prototype for community-based suicide prevention in Florida counties. The process is long and must be implemented thoughtfully to increase likelihood of stakeholder buy-in and project sustainability. Throughout the duration of the five-year pilot program we will build a blueprint for counties to incorporate youth suicide prevention in all systems that serve youth, while implementing methods to collect and track data on youth suicidal behavior.

Introduction

Scope of the Problem

Youth suicide is the third leading cause of death among teenagers and young adults[14]. It accounts for more deaths in the United States than all natural causes combined among 15-24 years olds according to the Center for Health Statistics (2000). Each year, there are 30,000 deaths from suicide, compared with 17,000 homicides. Until 1999, when it dropped to 11th, suicide ranked among the ten leading causes of death for nearly a quarter-century. Persons under age 25 accounted for 15% of all suicides in 2000.[1] From 1952-1995, the incidence of suicide among adolescents and young adults nearly tripled. From 1980-1997, the rate of suicide among persons aged 15-19 years increased by 11% and among persons aged 10-14 years by 109%. From 1980-1996, the rate increased 105% for African-American males aged 15-19.[15]

Mental health has become a focus of national attention from federal health officials, professional, consumer, and constituency groups. Suicide prevention is a predominant theme in the national dialogue about mental health services as suicide is the end result of many types of untreated mental and behavioral disorders. In the pediatric arena, most of the emphasis has been on the adolescent age group. It is estimated that most of the reported 6-9 million children and adolescents in the U.S. with serious emotional disturbances are not getting adequate help.[16]

Psychiatric disorders affect a significant number of youth across the United States, yet many children and adolescents with these problems do not receive care. According to the Surgeon General's Report on Mental Health (1999), about 21 percent of U.S. children, 9 to 17 years of age, have a diagnosable mental or addictive disorder with at least minimum impairment and 5% - 9% are estimated to have an extreme functional impairment. Yet, a study of 46,000 children and

adolescents by the RAND Corporation indicates that seven out of ten adolescents with mental health problems do not get care.[17] This may play an important role in preventing suicides and suicide attempts that result from untreated mental health conditions.

Although the number of deaths from suicide remains unacceptably high, mortality reflects only a small portion of suicidal behavior, particularly among youth. The majority of children and adolescents who engage in suicidal behavior do not die. Recent estimates from a nationally representative sample of U.S. emergency departments suggest that, among 15-19-year-olds, for every suicide death, 32 were treated for self-inflicted injuries.[18] In self-report studies, nearly 1 in 5 U.S. high-school students disclose seriously considering suicide in the past year and 1 in 13 report having engaged in at least 1 nonfatal suicidal act. [19]Furthermore, though youth are less likely to die as a result of suicidal behavior than are older adults, children and adolescents account for far more nonfatal behaviors and suicidal ideation.[20]

In Florida, suicide is a serious problem. Florida's overall suicide rate is higher than the national average, ranking 11th in the nation among all age groups. In number of suicides, Florida ranked second after California, and ranked fifth in number of youth suicides (age 5-19).[21]

In 2002 and 2001, suicide was the ninth leading cause of death for all age groups in Florida. Suicide was the third leading cause of death for children 5-19 years of age. Between 1999 and 2000, Florida lost 145 children to suicide. The two youngest were 9 years old. In 2001 suicide claimed the lives of 209 of Florida's youth under the age of 24, an average of 4 suicides per week.[22]

Suicide accounted for 10% of all child (ages 5-19) injury deaths in Florida between 1999 and 2000, and the third leading cause of injury death in children, after motor vehicle crashes and homicide. Nine out of ten of youth suicide victims in Florida in 2001 were males, and 73% of them were non-Hispanic-Whites.[23] It is important to consider that the rate of suicide among African-American males and Hispanic females has increased nationwide. Thus these are groups that require special attention to avoid sharp increases in completed suicides.

According to the Youth Risk Behavior Survey, over 15 percent of high school students in Florida "seriously considered attempting suicide" and over 8% actually attempted suicide in 2001. Teen girls are nine times more likely than boys to attempt suicide. However, males are four times more likely to complete a suicide[24] because teen boys tend to use more deadly methods, such as guns or hanging. Girls who attempt suicide or self-harm tend to use overdoses of medications or cutting.

Although we have some knowledge about the scope of the problem and we attempting to address the absence of consistent data on suicide attempts, our current knowledge base for the prevention of suicide is inadequate. Whatever the response, it must include buy-in from communities and commitment from state leaders and policymakers. Such a commitment has allowed Florida to progress relatively rapidly in its suicide prevention efforts.

Florida's Response to Youth Suicide

The Youth Suicide Prevention Prototype was developed in the wake to two influential state level measures. The first measure was the creation of The Florida State Task Force on Suicide Prevention, and the release of a white paper titled, *Preventing Suicide in Florida: A Strategy Paper*.[25]

The second state-level action is section 1006.07(6) of the Florida Statutes,[26] which endeavors to develop a safety and security program that would include plans and measures to promote the safety and security of students and staff, ensure that school facilities and equipment are safe and in good condition, and address the safe transportation of students.[27]

Both measures were the culmination of multiple efforts to address safety, mental health, and suicide in the state. These state-level initiatives have resulted in a variety of community-based research and intervention strategies, such as the Youth Suicide Prevention Prototype project. The progression of suicide prevention activities in Florida is described below.

Evolution of Suicide Prevention in Florida

In 1984, the Florida State Legislature required the Department of Health and Rehabilitative Services, in cooperation with the Florida Department of Education (DOE) and the Florida Department of Law Enforcement (FDLE) to develop a state plan for youth suicide. The Task Force concluded that while a number of service components existed in many districts, coordination and supplementation of these services was needed in order to establish a starting point for the development of a full continuum of services, including prevention, intervention, and treatment coordinated to address children's needs in a holistic way.

In 1990, Florida mandated that, as a component of teacher certification, a life-management skills class is taught in the secondary education level and includes suicide awareness. In 1999, the DOE introduced the SAFE School Action Planning and Preparedness Program. School Critical Incident Response Plans incorporate suicide threats and gestures at all levels. In that same year, the Youth Suicide Prevention Study funded through the Department of Children and Families, described the state of affairs in Florida's programs for children, youth and their families addressing suicide prevention, knowledgeable intervention strategies, and promising practices that have been successful in reducing the risk factors associated with incidence of child and youth suicide. [28]

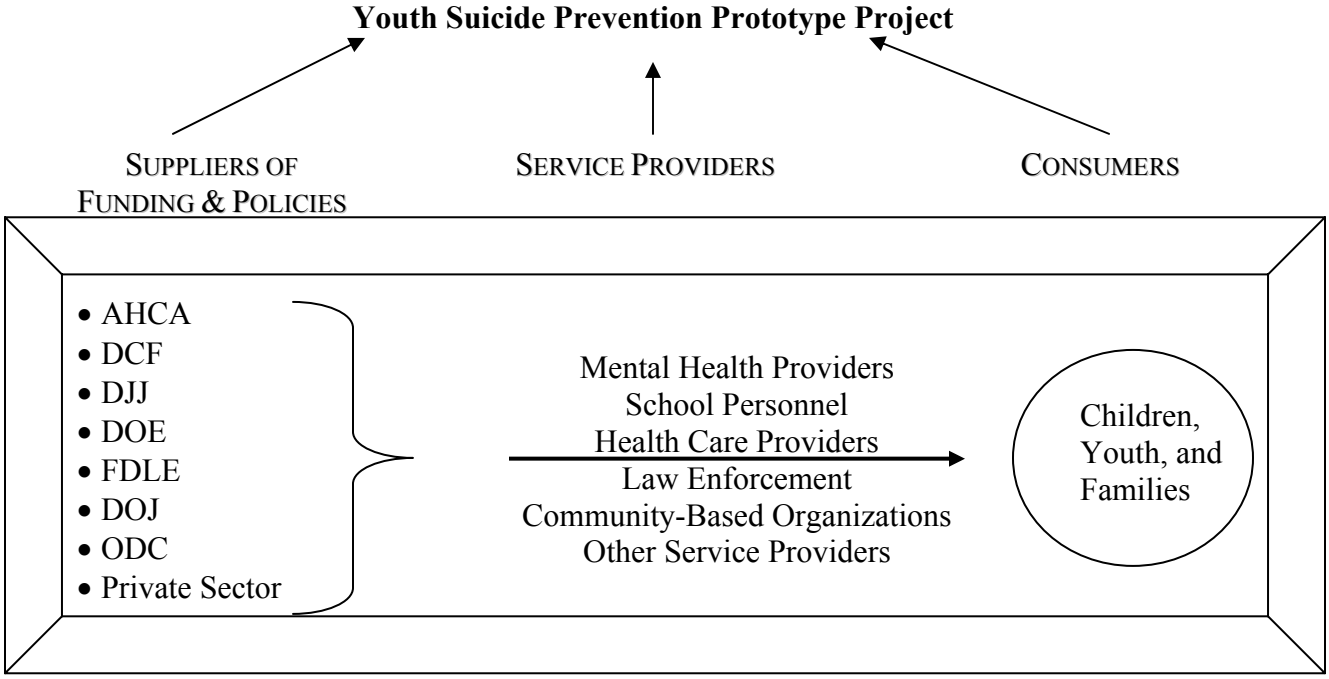
The Florida Commission on Mental Health and Substance Abuse was created in 1999 by legislation to conduct a systematic review of the state's mental health and substance abuse system. The January 2001 Commission Report finds that mental health and substance abuse services are fragmented, uncoordinated, and ineffective in many Florida communities across health, human services, educational, and correctional settings.

In June 2000, the Florida Adolescent Suicide Prevention Plan Task Force submitted a report to the Florida DOH/BEMS. The findings presented in this report provided information to better understand the problem of youth suicide and recommends methodologies for evaluation of prevention and intervention efforts targeting families and professionals. [29]

On November 16, 2000, at the request of the Florida Office of Drug Control Policy Director, representation from the American Foundation for Suicide Prevention, Florida Division - now known as Florida Initiative for Suicide Prevention Inc., Department of Children and Families (DCF), Department of Commerce (DOC), Department of Juvenile Justice (DJJ), Department of Education (DOE), Department of Health (DOH), Florida Medical Association (FMA), and Suicide Prevention Action Network (SPAN) convened at the Governor's Office to begin establishing an infrastructure for a State Suicide Prevention Task Force. The task force would provide the leadership, networking opportunities, expertise, and coordination necessary to build a comprehensive and accessible continuum of youth suicide intervention, prevention, and postvention with resources to address this problem.

Stakeholders Involved in the Youth Suicide Prevention Prototype Project

The figure below explains the interaction between agencies directly or indirectly involved in the structure of the Youth Suicide Prevention Prototype project. This graph illustrates the inter-relationships among the many factors that are to be considered in the development of such a program: suppliers of funding and policies, service providers, and input from individuals. These factors continuously shape research strategies and efforts to provide effective services to the intended population: youth at risk of suicide.



Program Objectives and Specific Aims

The Youth Suicide Prevention Prototype Project was designed to span a five-year period. The ***overarching goal*** is to decrease the incidence of youth suicide by one third in the pilot communities - Alachua and Broward County - a benchmark set by Governor Jeb Bush. The ***main objective of program activities*** was to promote the widespread adoption of programs and

policies that prevent suicide. In Year 1, this objective was to be pursued through the following ***specific aims***:

Year 1 Aims

Aim 1 - Support state and local agencies, community-based organizations and academic institutions to develop, implement, and evaluate the suicide prevention prototype program with a focus on community-based interventions. This aim included development of a suicide surveillance system to determine the type and frequency of youth suicidal behaviors.

Aim 2 - Integrate the strategic plan across agencies and organization. Strategies included establishing county advisory groups to improve organization of local service systems.

Aim 3 - Train health care professionals, law enforcement, and school staff to recognize the early risk signs for suicide and respond appropriately. This aim includes development of school readiness guide and distribution of educational materials for primary care physicians.

Evolution of Project Aims

As a prototype for a community-based prevention model, the Youth Suicide Prevention Prototype project needed to be flexible so that it could be adapted by local communities to fit their context. Therefore, the specific aims that guided the project in Year 1 were adapted into three concise aims grouped into three general areas with suggested strategies that can be implemented in all counties, although at different levels depending on available resources.

Year 2 Aims

Aim 1- Education and Training: Provide professional and community education on suicide/self harm.

Aim 2- Communication and Community Awareness: Develop and Pilot-Test Suicide Prevention Tool Kit to stakeholders.

Aim 3- Research and Resources: Develop suicide/self-harm surveillance system integrating existing data.

Project Oversight

This project is overseen by formal entities at the state and local levels. Furthermore, two advisory panels have been convened to provide expert technical consultation to program staff and sub-contractors.

State level: The Florida State Task Force on Suicide Prevention is composed of members appointed by the Executive Offices of the Governor (EOG) and managed by the Office of Drug Control (ODC). The Principal Investigator of the Youth Suicide Prevention Prototype Project makes routine presentations to this group to ensure compliance and accountability.

Local community level: Local advisory boards were created in Alachua and Broward Counties. These boards meet with program staff and/or subcontractors at least on a quarterly basis in order to facilitate implementation of the program and to ensure that they respond to community issues and needs.

Expert advisory panels: Two different advisory panels of experts provide guidance in design of the prototype research program and School Readiness Planning Guide. Both panels will play an important role during Year 2 of the program.

This oversight structure ensures that the activities of the Youth Suicide Prevention Prototype Project are in line with other suicide prevention efforts across the state and respond to the needs of the pilot communities. The expert panels and local advisory boards have assisted project staff and consultants in implementation of certain aspects of the project and have provided feedback on the school readiness planning guide and the research protocols.

Organization of This Report

This report outlines the accomplishments, challenges and lessons learned from the first planning year of the Youth Suicide Prevention Prototype project. Based on the project's objectives, this report is divided into the following sections: Training and Education; Coordination and Communication; Research and Resources with a conclusion drawn at the end, highlighting major findings and lessons learned.

Research and Resources

The Suicide Prevention Prototype Project team has conducted a variety of research activities to inform the work of the Youth Suicide Prevention Prototype Project. This section will describe the evolution of the pilot suicide surveillance system. Each participating agency and the data over which they have custody will be described. Also, an analysis of data from Covenant House Florida resulting from partial implementation of the TeenScreen® program will be presented as an example of a psychometrically validated tool to identify youth at risk for suicide.

I. Building a Pilot Suicide Surveillance System

An important part of suicide prevention and intervention is the collection and analysis of epidemiological data about the problem, to fully understand whom it affects, when and where attempts are occurring, what risk factors are at play, and to define and understand the circumstances typically leading to youth suicide. To this end, a suicide surveillance system is being developed in Broward County to pilot test as a model of using existing data sources to shed light on the problem of youth suicide. The data-sharing partners include: First Call for Help Crisis Hotline, County Hospital Districts, County Emergency Medical Services, County Medical Examiners, Florida Agency for Health Care Administration and Florida Department of Health. Preliminary data results are listed below. To see letters of cooperation, please see Appendix A.

A. First Call For Help Crisis Hotline

First Call for Help is a 24-hour free, confidential telephone Helpline for crisis/suicide counseling, and community information and referrals for health and human service resources in Broward County. This resource is an important front door for suicidal individuals to seek services. Helpline services assist residents to cope with their crises or problems, which may include mental health concerns, substance abuse, family violence, stress, financial problems, hunger, shelter needs, healthcare access, relationship issues, depression, and suicide. They have agreed to share data on suicide and other teen mental health issues for the Youth Suicide Prevention Prototype Project.

Below are two figures based on suicide-related calls between 2000 and 2002. The first shows that there has been no exceptional variation in number or type of suicide calls in the three years. The second shows that the ability to intervene over the telephone decreases as the level of suicidality increases.

Figure 1

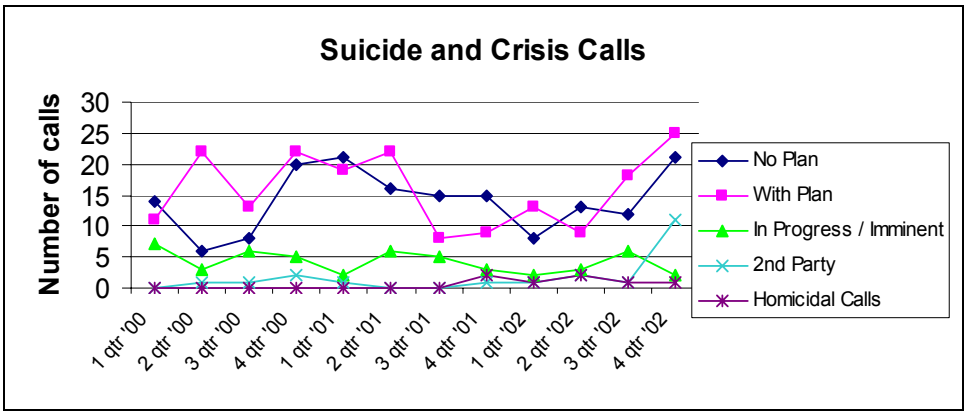
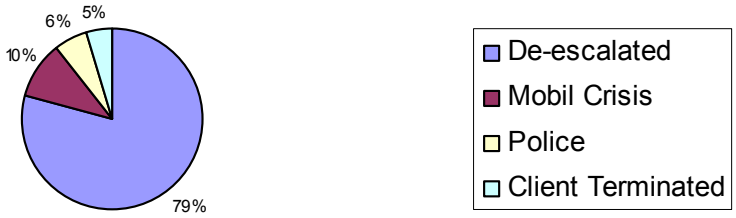


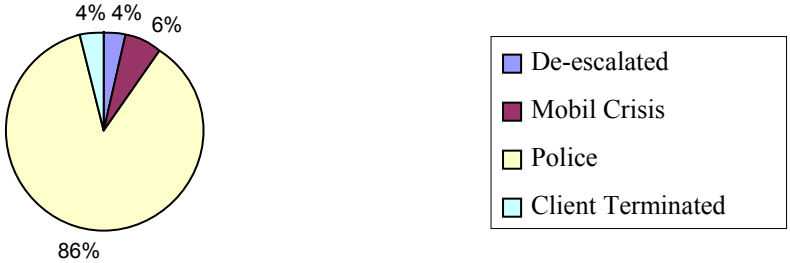
Figure 2

Call outcomes for callers with no Suicide Plan



Call outcome for callers with Suicide Plan

Call outcomes for callers in progress of attempting suicide



B. Medical Examiner

There is an agreement with the Alachua and Broward County Medical Examiners to share detailed information about youth suicide deaths stripped of identifiers to better understand the circumstances, toxicology, and contributing factors associated with youth suicide.

Suicides:

Broward County Medical Examiner & Trauma Services Division of Broward County 2000 Annual Report Summary on Youth Suicide

In the period studied 1999-2002, there were no youth suicide deaths in Alachua County. There were 208 suicides in the year 2000 in Broward County. Data are available by age group, gender, and race/ethnicity. Out of the 208 suicide cases investigated by the Medical Examiner's Office in 2000, six were youth suicides ranging from 5-18 years of age. White males accounted for all the reported youth suicide deaths. Out of the six white males that committed suicide, one was 5 to 9 years of age, and five were 15-18 years of age.

Data from 2001 indicate that there were a total of four suicides among children 10-19 years of age. As with 2000, all youth suicides were among Whites; two (50%) were male and two (50%) were female. Of the four suicide deaths, one was in the 10-14 age group and three were 15-19 years of age.

In 2002, there were nine suicide deaths of which seven were male and two were female. The victims ranged in age from 13 to 20 years old. Four out of these nine deaths were firearm related. For most of the cases (six), the place of incidence was a residence.

Drug related deaths:

In each year, deaths due to drug overdoses that were not ruled as suicides were also reported. In 2002 there was one drug overdose not ruled as a suicide death, in 2001, there were three drug-related non-suicide deaths and in 2000, there were also three drug-related deaths not ruled as suicide. This is an interesting group to track because in the case of drug overdoses where there is insufficient evidence to determine manner of death, there is no systematic definition and the determination is often left to the medical examiner's discretion

The graphs below illustrate the race/ethnicity, cause of death and place of incident in the nine youth suicides deaths in Broward in 2002.

Figure 3

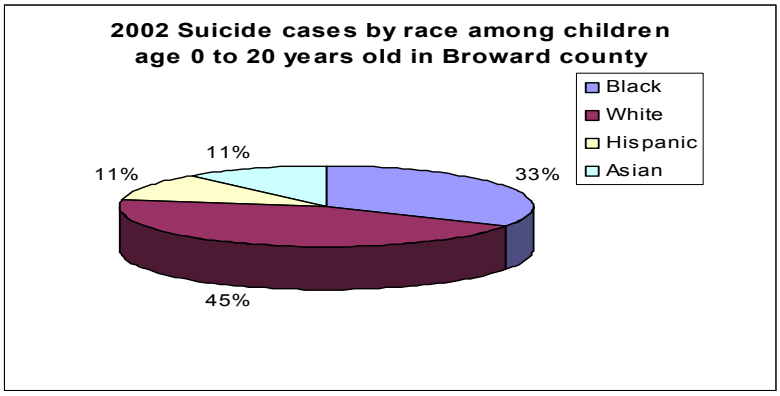


Figure 4

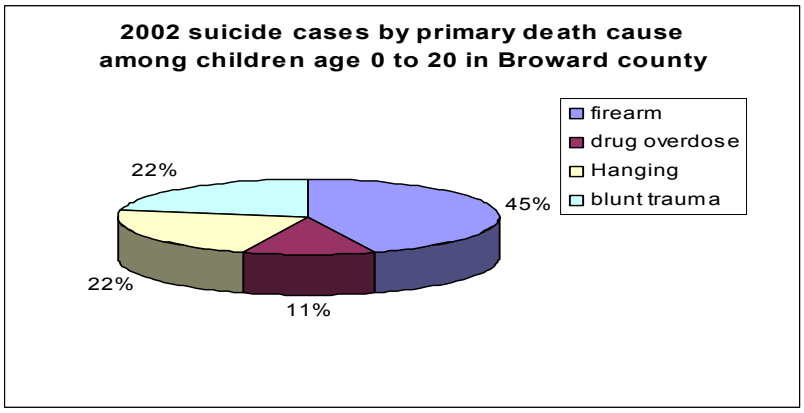
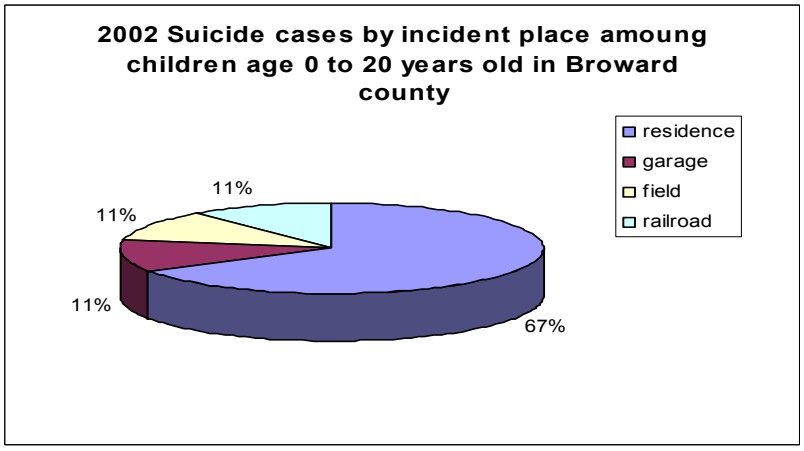


Figure 5



C. Hospital Discharge Data

State health agencies rely on injury surveillance to assess specific needs for injury prevention programs and policies, and to monitor their effectiveness. Injury surveillance is the ongoing process of tracking and monitoring incidence rates, causes, and circumstances that result in fatal and non-fatal injuries, and disseminating this data in order to prevent these injuries in the future. Death certificates and other sources are useful for surveillance of fatal injuries. To monitor non-fatal injuries, however, other sources of data are required. One common and important source for monitoring non-fatal injuries is hospital discharge data. An advantage of Florida State hospital discharge data, unlike some national surveillance data sets, may be stratified at state, county, city, and even community levels of analysis, making these data useful for monitoring the effects of injury interventions, where the interventions are implemented.

CI. Broward County

a. Mental health diagnoses among primary discharge diagnoses

Annual data for Broward County for 1999-2001 indicate that among children less than 15 years of age, mental health disorders consistently rank 3rd among 23 primary diagnoses codes. Injury was ranked 7th for 1999 and 2000 and 6th in 2001. A total of 3,046 mental health discharge diagnoses were reported among children less than 15 years of age during this time period, which represents 8.8% of the total discharge diagnoses reported in this age group. A total of 2,130 injury discharge diagnoses were reported, representing 6.1% of the total. As shown in **Table 1**, mental health disorders were between 8.6 and 9% of the total discharge diagnoses among children less than 15 years of age from 1999-2001; injury diagnoses were between 5.8and 6.3%.

Table 1. Broward County: Mental Disorders and Injury as Primary Hospital Discharge

Diagnoses for <15 year olds 1999-2001

Diagnosis	Year		
	1999	2000	2001
	n (%)*	n (%)*	N (%)*
Mental Disorders	949 (8.6)	1041 (9.0)	1056 (8.7)
Injury	638 (5.8)	720 (6.2)	772 (6.3)
TOTAL Diagnoses Reported	11010	11528	12177

*The number of specified discharge diagnoses reported and the percent of the total discharge diagnoses reported for that year among children <15 years of age.

b. Racial/ethnic distribution

During the three year period, a total of 3,046 discharge diagnoses of mental disorder were reported among children less than 15 years of age, which represents 8.8% of the total hospital discharge diagnoses reported in that period. By race ethnicity, the majority of mental health discharge diagnoses were among Whites (59.7%) followed by African-Americans (27.8%) and Hispanics (8.9%). The same pattern is revealed for 2130 injury diagnoses (6.1% of total discharge diagnoses). The greatest percentage of the reported injury diagnoses were among Whites with 47.2% (n=1006), followed by African–Americans with 34.2% (n=728), Hispanics with 13.6% (n=289), and "Other" with 3.4% (n=72).

For mental health disorders, white youths were significantly more likely than black youths to have a mental disorder discharge diagnosis ($p < 0.001$, Odds Ratio= 1.96; 95% confidence interval: 1.80-2.14). White youths were also significantly more likely than Hispanic youths to have a mental health discharge diagnosis ($p < .001$; Odds ratio=2.62, 95% confidence interval: 2.29-2.99). There was no difference between white youths and Hispanic youths in the proportion of mental health discharge diagnoses. Further, white youths were significantly more likely than black youths ($p<.001$; Odds ratio=1.20; 95% confidence interval:1.09-1.33) and Hispanic youths ($p < .001$; Odds ratio=1.27; 95% confidence interval:1.11-1.44) to have an injury discharge diagnosis.

c. Gender

Of the 3,046 mental health discharge diagnoses among children <15 years of age the majority were among males; (55.9%, n=1351among males versus 44.1%, n=1344 among females. For injury diagnoses (n=2130), the majority was also among males (63.4%, n=1351 among males versus 36.5%, n=779 among females). The results on injury diagnosis are consistent with other reported data in the literature, which suggest that males are more likely than females to experience injury related incidents.

CII. Alachua County

a. Mental health diagnoses among primary discharge diagnoses

Annual data for Alachua County for 1999-2001 indicate similar results as in Broward. Among children less than 15 years of age, mental health disorders ranked as the 3rd primary diagnosis reported for each year. Similarly to Broward County, injury ranked 7th in 1999 and 2000 and jumped to 6th in 2001.

During the three-year period, a total of 312 discharge diagnoses of mental disorder were reported among children less than 15 years of age, which represents 9.5% of the total hospital discharge diagnoses reported in that period. A total of 240 injury discharge diagnoses were reported, representing 7.3% of the total discharge diagnoses among children less than 15 year of age. As shown in **Table 2**, mental health disorders were between 9.1% and 10% of the total discharge diagnoses among children less than 15 years of age from 1999-2001; injury diagnoses were between 6.5% and 8.2%.

Table 2. Alachua County: Mental Disorders and Injury as Primary Hospital Discharge Diagnoses for <15 year olds 1999-2001

Diagnosis	Year		
	1999	2000	2001
	n (%)*	n (%)*	n (%)*
Mental Disorders	84 (9.1)	117 (10.0)	111 (9.2)
Injury	60 (6.5)	81 (7.0)	99 (8.2)
TOTAL Diagnoses Reported	923	1165	1202

*The number of specified discharge diagnoses reported and the percent of the total discharge diagnoses reported for that year among children <15 years of age.

b. Race/ethnicity

By race/ethnicity, the large majority of mental health discharge diagnoses were among Whites (67.9%, n=212) followed by African-Americans (25.0%, n=78), and then Hispanics (3.5%, n=11). The same pattern is revealed for the 240 injury diagnoses (7.3% of total discharge diagnoses). The greatest percentage of the reported injury diagnoses were among Whites with 55.8% (n=134) followed by African–Americans with 39.2% (n=94), Hispanics with 1.7% (n=4) and "other" with 3.3% (n=8). There was no statistically significant difference by race/ethnicity in the proportion of injury-related deaths among discharge diagnoses. For mental health disorders, white youths were significantly more likely than black youths to have a mental disorder discharge diagnosis ($p < 0.001$, Odds Ratio= 2.21; 95% confidence interval 1.67-2.92). There was no difference between white youths and Hispanic youths in the proportion of mental health discharge diagnoses.

For all discharge diagnoses among white adolescents (N=1752), injury represented 7.6% (n=134) of the diagnoses and mental health disorders were 12% (n=212) of the diagnoses. For all discharge diagnoses among African-American adolescents (N=1331), injury represented 7.0% (n=94) of the discharge diagnoses and mental disorders represented 5.9% (n=78). Among Hispanics, injury accounted for 4.2% (4/95) of primary discharge diagnoses and mental disorders accounted for 11.8% (11/95).

The data suggest that white and Hispanic adolescents are more likely, to receive a discharge diagnosis of mental disorder. For injury diagnoses, rates were similar among blacks and whites, and less common among Hispanics.

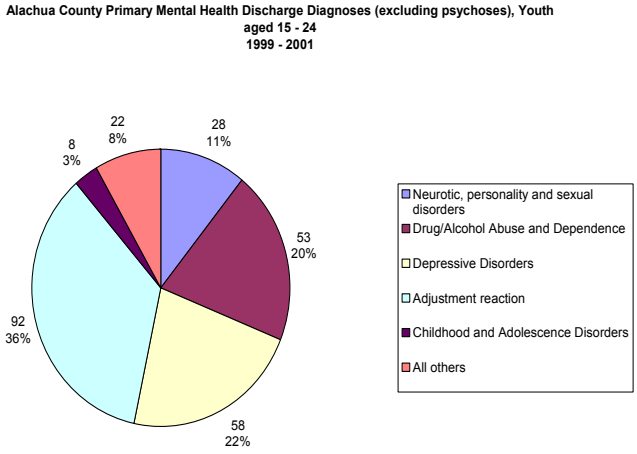
c. Gender

The majority of mental health discharge diagnoses (n=312) were among males; (58.3%, n=182 among males versus 41.7%, n=130 among females. For injury diagnoses (n=240), the majority was also among males (62.9%, n=151 among males versus 37.1%, n=89 among females). These results are consistent with results for Broward County.

Types of Mental Health Diagnoses

The figures below illustrate preliminary findings for pediatric mental health diagnosis in Alachua County and pediatric mental health and injury diagnoses using diagnosis codes and codes for external causes of injury in Broward County. The data for Alachua was not accessible to researchers at the time of this report.

Figure 6



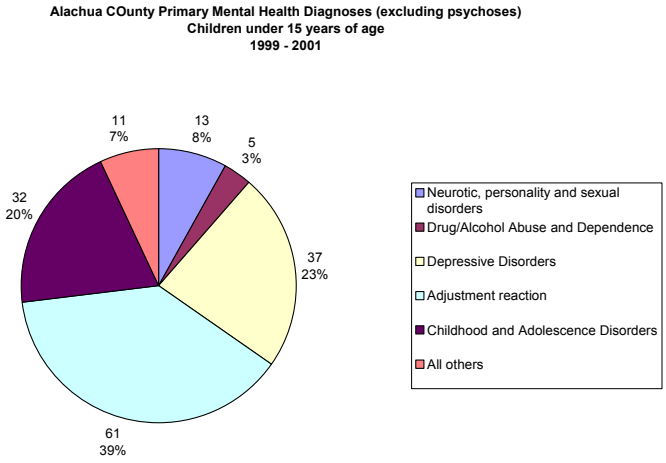
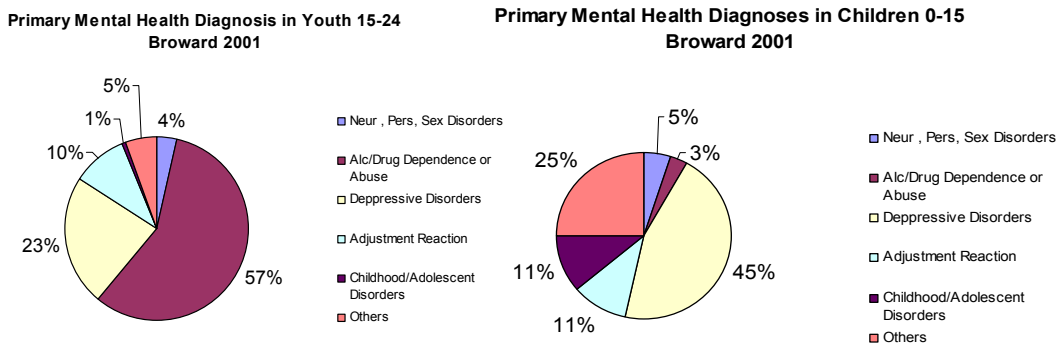


Figure 7

Leading mental health diagnoses in children

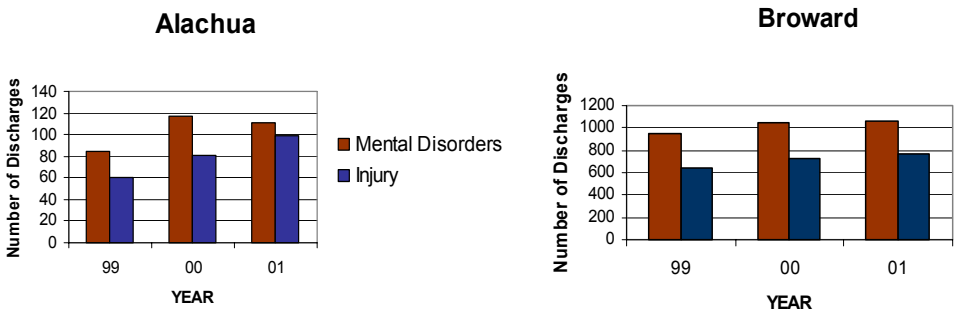


After psychoses, the leading mental health diagnoses among children are associated with suicide risk: depressive disorders in younger children and substance abuse or dependence among older youth.

Figure 8

Mental Disorders and Injury in Children

Mental Health and Injury as Primary Hospital Discharge Diagnoses
for <15 year olds 1999-2001

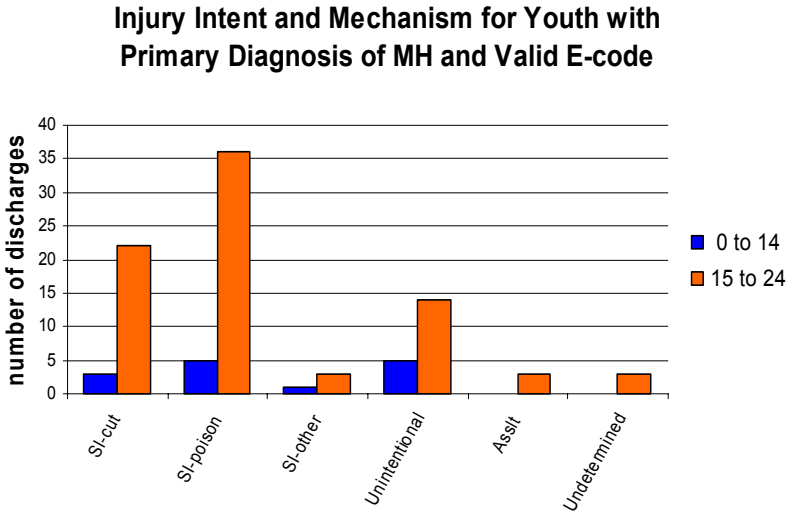


Hospitalizations for pediatric injuries and mental health disorders are on the rise.

Figure 9

Mental Health diagnosis and self-inflicted injury

The majority of injuries among children with primary diagnoses that were mental health related were self inflicted. (SI = Self inflicted)



Of the 2,644 primary diagnoses for Broward 15-24 year olds, only 3% contained a valid e-code (external cause of injury). Therefore, this graph may under-represent the number of patients with both an injury and a mental health diagnosis.

D. Emergency Department Data

This increase in mental health disorders has caused tremendous stress and malfunction in today's healthcare system. This crisis is most obvious in the emergency care arena. Findings across the United States suggest that mental health emergencies in the Emergency Department (ED) suffer from a lack of adequate resources and linkage to definitive mental health evaluation and intervention.

The North and South Broward Hospital Districts are in the process of developing electronic emergency department data systems that include primary complaint, clinical procedures, diagnosis codes, and demographic data on all ED visits. This data will complement existing information about suicide attempts that do not result in hospitalization or death and thus are not captured in hospital discharge and medical examiner data. Permission has been granted by Joe Wagner, director of Information Systems within North Broward Hospital District, to review and collect data on youth ED visits. Currently, the proposed data sharing protocol has been submitted to the North Broward Hospital District Institutional Review Board and compliance with HIPAA must be ensured. The protocol was presented to the board on September 10th, 2003, and we are awaiting a response.

The State Comprehensive Health Information System Advisory Council (CHIS) 408.05(8) Florida Statutes established within the Agency for Health Care Administration (AHCA) the

CHIS to assist the agency in reviewing the comprehensive health information system and to recommend improvements for such system. The Agency for Health Care Administration Emergency Department Data Advisory Panel (EDDAP) has proposed a rule for emergency department patient data, which will be an amendment to the ambulatory patient data rule. The proposal defines emergency department visits for reporting purposes to include all visits in which emergency department registration occurs that do not result in an inpatient stay. It is anticipated that the rule promulgation process will be completed by the end of 2003. The proposed start of emergency department patient data collection will be for emergency department visits occurring on or after January 1, 2005. Both daily and quarterly reporting requirements will commence January 1, 2005.

E. County Emergency Medical Services

To improve emergency access and treatment for mental health disorders, we must first understand and characterize the scope of the problem and capture the essence of the need. It is particularly difficult to determine the incidence of pediatric mental health emergencies, presenting through the Broward County EMS system or to the emergency departments, as this information has not been gathered in any standardized fashion.

The Youth Suicide Prevention Prototype Project is collaborating closely with Broward County Fire Rescue to find ways to better document and report suicidal behavior and other mental health emergencies. The data sharing agreement is being reviewed by Broward County Fire Rescue authorities to ensure HIPAA compliance.

The LIFE program is a newly developed Emergency Medical Services data reporting and tracking system that uses computer-aided dispatch (CAD) information. Therefore, any application or use of data will be limited to the information extracted from fire department CAD systems. While not comprehensive, this is an important source of information about self-inflicted injuries that require medical attention. The initial data now being prepared covers the past two years. We will be reviewing cases of suicidal behavior, self-inflicted injuries, and other mental health-related primary complaints as they relate to children and youth. We are in the process of familiarizing ourselves with SunPro, the existing electronic file system used by Broward Fire Rescue (BCFR). The BCFR Assistant Fire Chief has authorized initial discussions about developing a data sharing agreement. The YSPP research team is in contact with the Broward Fire Rescue database manager and a HIPAA-compliant data-sharing protocol is being determined.

Box 1 Mental Health Problems in the Emergency Medical Systems

The true occurrence of pediatric and adolescent mental health emergencies encountered by EMS personnel is unknown, but some studies have attempted to identify this population. Currently, only 32 states maintain state-wide databases on EMS runs and most of those do not adequately track EMS runs for mental health-related emergencies.

Recent studies have attempted to look at the number of EMS transports for pediatric mental health issues. Sapien, et al., found that 4.2 %, 3.2 % and 1.6% of EMS transports for patients age 0-years to 20-years were for drug abuse, alcohol intoxication and suicide attempt respectively. This study looked at 17,722 transports in Albuquerque, New Mexico and the surrounding area from 1992 to 1995. It is not surprising that such transports were more common in older (11-20 years) children.

We do know that a substantial number of adolescents with mental health problems make their first connection to medical treatment through the Emergency Medical Services system. In 1991, Seidel et al. studied over 10,000 EMS ambulance runs, adolescents were found to access pre-hospital care through EMS most commonly for trauma and behavioral emergencies such as suicide, overdoses and psychiatric problems. The number of psychiatric emergencies encountered by EMS crews is not insignificant, in fact, because most studies rely on pre-hospital complaint and not final diagnosis to classify patients, the actual number of psychiatric emergencies is likely underestimated. The presentation of children to EMS emphasizes the need for first responders to be familiar with the identification and treatment of children with such wide-ranging mental health needs as violent behavior, suicidal ideation, sexual or physical abuse, neglect, depression, psychoses, autism, or substance abuse.

II. Covenant House

The Covenant House of Broward County is a crisis center that offers residential services to youths in Broward County. This organization uses the Columbia TeenScreen® Program to identify youth at risk for suicide and other mental health conditions at the time of intake. Our efforts to learn more about TeenScreen® led us to collaborate with Covenant House through a collaborative research agreement. The Institute for Child Health Policy at Nova Southeastern University conducted statistical analysis of the screening data obtained from 2001 to 2003.

Data Analysis

A total of 738 records of the combined screening data were analyzed using SAS (Statistical Application Software). There were 737 children screened (one refused to be screened) for suicide risk factors with questionnaires completed on paper from 2001 to March 2003. Among them, 356 (48%) were female and 381 (52%) were male. The age range for the screened children is from 11 to 20 years old, with 74.5% of those screened aged 17 years and older. The race distribution of the screened population is as follows:

Table 3: Race and Ethnicity

Race/Ethnicity	%	N=
White	33%	240
Black	40%	293
Hispanic	17%	125
Asian	1%	4
Other	9%	69

Suicide risk factors

There were 549 (75%) children who screened positive for at least one of the four main risk factors identified by TeenScreen®: depression (D), health problems (H), suicidal acts (S), and substance abuse (SUB). There were 187 (25%) children who screened negative for these risk factors.

Among children who were positive for these factors, 216 (39%) had suicidal risk factor, 192 (35%) had the risk factor of depression, 95 (17%) had the risk factor of substance abuse, and 46 (8%) had physical health problems. Of those that screened positive, 283 (52%) were female and 266 (48%) were male. There were 132 (19%) children that had a history of either suicide ideation or suicide attempt but not both. There were 90 (13%) children that had both suicide ideation and suicide attempt. Sixty-eight percent (n=478) of the children screened had no history of suicide attempt or suicide ideation.

Figure 10: Suicide Ideation Among Children Screened

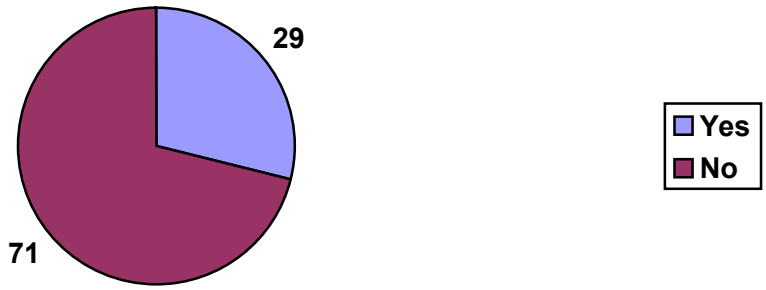
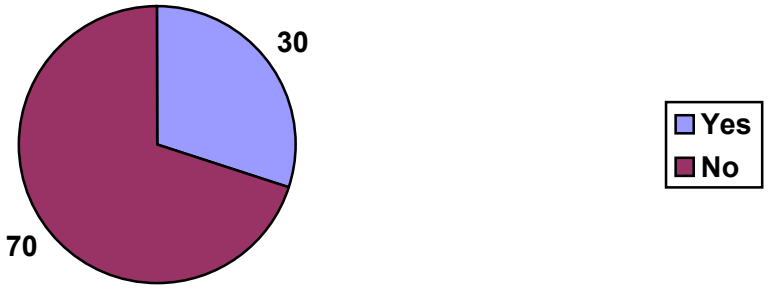


Figure 11: History of Suicide Attempts among Children Screened



Additional Screening with Diagnostic Interview Schedule for Children (DISC)

Computerized screening was done depending on the results of the paper screening. Children showing a high risk for committing suicide were further screened using National Institute Mental Health DISC. Over one quarter (28%; n=207) of the children were screened on computer using the DISC. The electronic screening results were not available at the time of this report.

Risk Factors by Gender

Further analysis revealed that there is a significant difference in proportion on suicide ideation and suicide attempt between children of different gender. While 31% of the girls who answered the question (N=105, out of 336) had thought about suicide, only 13% of the boys (N=47, out of 364) had suicide ideation. This difference in percentage is statistically significant ($p<0.0001$).

The same holds true for suicide attempts. While 32% of the girls who answered the question (N=108, out of 336) had suicide attempts, only 14% of the boys (N=52, out of 364) had suicide attempts in the past.

Among the 549 children who screened positive for those risk factors, risk patterns differ by genders. While the numbers of females and males are roughly the same, the risk proportions are not equal:

- Among those that screened positive for substance abuse, 81% were boys and only 19% were girls.
- Among those that screened positive for suicidal acts, 66% were girls and 34% were boys.
- Among those that screened positive for health related problems, 59% were girls and 41% were boys.
- There was no gender difference in depression distribution, each sex counted for 50%.

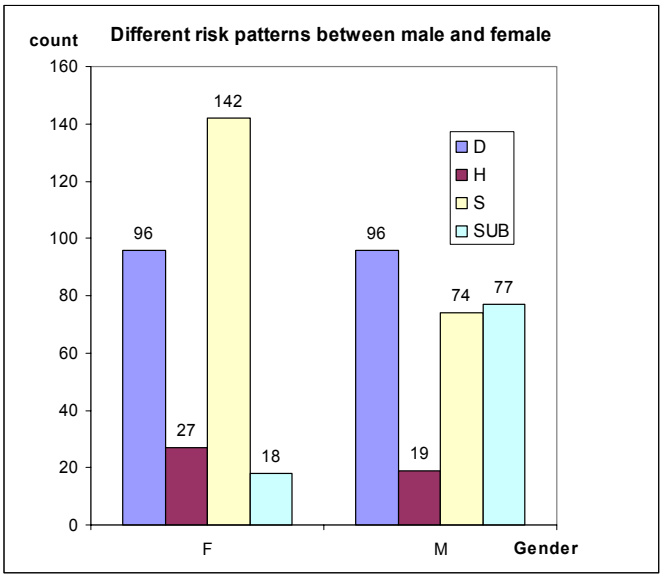
The table 4 shows the type of risk factor by gender. Chi square analysis shows a statistically significant association between gender and type of risk factor.

Table 4: Risk Factor by Gender

	Depression	Health problems	Suicidal behavior	Substance Abuse	TOTAL
Female	96 (50%)	27 (59%)	142 (66%)	18 (19%)	283
Male	96 (50%)	19 (41%)	74 (34%)	77 (81%)	266
TOTAL	192	46	216	95	529

Lastly, there was no significant difference in risk pattern between younger children (11-16 yrs) and older children (17-20 yrs).

Figure 12



Legend
D= Depression
H= Health Problems
S= Suicide risk
SUB = Substance use

While these data represent a relatively small population of teens, and a particularly high-risk group, it provides a unique data source on non-fatal suicidal behavior among youth in Broward County. These data would provide a profile of kids in shelter and incorporate non-fatal data to the proposed surveillance system. Further, they may be useful to promote universal screening of all high-risk teens receiving services in Broward and Alachua counties.

Training and Education

Preventive measures cannot solely a priority to elected officials and agency professionals. Representation from the entire community must also be engaged, from school staff, to health care workers, to support service providers to youth and their families.[30]

In its first year, the Youth Suicide Prevention Prototype Project has focused its training and education activities on school readiness for prevention and response to youth suicide, and assessing primary health care providers' training needs in this area. The main activities involve the development of the School Readiness Planning Guide, and a survey of primary care providers' perceptions and practices to identify mental health problems in children. These initiatives are described below.

I. Youth Suicide Prevention School Readiness Planning Guide

A Joint Statement from the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association to the US Senate Children and Families Subcommittee of the Health, Education, Labor and Pensions Committee (2001) submits that school-based mental health programs are the first line of defense for identifying children and adolescents with emotional or behavioral problems.

The *Youth Suicide Prevention School Based Planning Guide* project involves the development and pilot testing of a planning guide that will allow school administrators to assess the adequacy of their suicide prevention and response program. The kit will also provide tools to increase the scope and enhance the effectiveness of existing school suicide prevention plans. The tool kit is not intended to collect data on suicide in schools. It is a resource that schools can use and adapt to their context as appropriate. It will provide general information on school-based suicide prevention and response; and it will direct school staff to useful materials.

The project was built on the preliminary work of the American Academy of Suicidology Task Force.[31] The Louise de la Parte Florida Mental Health Institute was subcontracted to develop this portion of the Prototype. This included the following steps:

- Identifying and defining the elements of a comprehensive, school-based program;
- Examining the scientific literature to determine which of these elements have been proven to work in reducing the incidence of suicide;
- Developing a self-assessment instrument that may be completed by schools/school districts to evaluate the adequacy of their suicide prevention programs;
- Developing a tool kit to help school administrators add program elements that would result in more comprehensive programs and/or would replace unproven strategies with proven strategies;

- Conducting a limited initial field test (checklist plus guidelines) in four schools in two areas of Alachua and Broward counties (see Appendix B to see the invitation letter for the initial field test of the Planning Guide); and

- Revising the tool kit based on reviews of the material by a national expert consensus panel and the results of the initial field test.

The Florida Youth Suicide Prevention Prototype program operates in coordination with the office of Safe Schools. During the first year, the school readiness-planning guide completed different activities such as literature and material reviews, focus groups, and the expert panel meeting. All these activities were necessary for the development of the planning guide.

A. Literature and Material Reviews

The purpose of the annotated bibliography is to provide a compiled resource of a variety of publications to support the development of the School-Based Suicide Prevention Planning Guide. The collection and analysis of resources related to adolescent suicide prevention, intervention and postvention in a school context began on January 1, 2003. The first phase consisted of using high-probability data bases for literature searches, reviewing, evaluating and summarizing research, acquiring state-level materials relevant to Florida and other exemplary state-level plans and approaches (e.g., Colorado, Maine, Washington) and assessing the evidence available for some existing school-based screening and more comprehensive suicide prevention programs.

A number of programs and materials have been reviewed during Year 1. Some approaches reviewed by FMHI include:

- J. David Hawkins**.** Communities that Care. http://www.seattleschools.org/area/ctc/CTCworks.xml
- Guo's and Harstell's *Efficacy of Suicide Prevention Programs for Children and Youth*, through the Alberta Heritage Foundation for Medical Research;

- Kalafat's *A Systems Approach to Youth Suicide Prevention and School Approaches to Youth Suicide Prevention*;

- Garland's and Zigler's Adolescent Suicide Prevention: Current Research and Social Policy Implications; and

- Berkowitz's *The Social Norms Approach: Theory, Research and Annotated Bibliography, through the Higher Education Center for Alcohol and Other Drug Prevention*.

Box 2: Communities that Care

Unlike a number of programs identified to date (i.e., Columbia Teen Screen, SOS, etc.), the "Communities that Care framework is an operating system, not a program."[32] The Communities that Care operating system "uses the prevention science research base to match local profile of risk and protection with tested, effective actions; provides local control and flexibility to build ownership, maintain support and increase sustainability; and, focuses on outcomes to ensure accountability for resources."

Overall, one of the first steps to our Development of a School-Based Suicide Prevention Planning Guide was to begin to review the current literature available related to suicide prevention and school-based prevention programs. By its nature, the annotated bibliography is necessarily incomplete. It should be noted that we anticipate continuing to add to our knowledge base through updating this annotated bibliography as we find and review additional relevant research. For a list on the literature methodology searches and revised books, manuals and websites, please see Appendix C.

B. Focus Groups

The purpose of the focus groups was to obtain input from students, teachers and parents of children who may be exposed to the program once it is launched. Focus group questions were centered on prevention and education, support and intervention, and timely access to help and information.

Due to the topic of the focus group and involvement of vulnerable populations (students), the University of South Florida Institutional Review Board (IRB) required a full Board review rather than an expedited review. Following IRB approval, adult focus groups and middle school focus groups were conducted in the spring for both Alachua and Broward Counties. Focus groups findings suggest that:

- Schools have considerable independence in how they deal with suicide prevention;
- Children typically do not talk to adults about suicide; however, some youth participants who had a significant relationship with an adult reported they would tell that particular adult.

To see a complete report of the focus group findings, please see Appendix D.

C. Expert Panel Meeting

As suggested by the Florida State Task Force on Suicide Prevention, there is a need to turn to university studies and professional experts for their contribution to this field of knowledge. Based on this, the Youth Suicide Prevention Prototype Project decided to create a forum of approximately twelve experts in different aspects of suicide prevention programming. They will provide initial guidance in implementing the project and assist with the revision of the School Planning Guide. With respect to the Planning Guide, the expert panel will review and interpret research and assumptions underlying the Planning Guide and its application; review the

organization of the Planning Guide as a user-friendly tool; and identify dissemination strategies for the Planning Guide. For a list of panel of experts' members, please see Appendix E.

D. The Youth Suicide Prevention School Based Planning Guide and Pilot Testing

The Current status for the Youth Suicide Prevention School Based Planning Guide is as follows:

- The first draft of the Youth Suicide Prevention School Based Planning Guide will be on October 7th. The expert panel "teacher review" will be held on Friday, October 17th, 2003.

- The tentative date for the final product is November 7th, 2003.

- Initial pilot testing will first be implemented in six Broward County schools and will be rolled out on November 13, 2003.

II. Primary Care Provider Mental Health Practices Survey and Needs Assessment

According to an April 2000 report on children's mental health from the Agency for Healthcare Research and Quality (AHRQ), entitled *Children's Mental Health: The Changing Interface Between Primary and Specialty Care*,[33] the landscape for children's mental health has changed dramatically over the past decade, due to the influence of several factors:

- The emergency of managed care has shifted children's mental health care from specialists to primary care providers. Community surveys indicate that in some areas, two-thirds of children with psychiatric disorders do not receive specialist care.

- Epidemiological research has documented the under-recognition of mental health problems, and resulting unmet needs of children in primary care. Roughly one in five children attending pediatric practices has significant mental health problems. It is estimated that 60% of them do not receive services that they need.

- The decade of the brain has witnessed the increased use of psychotropic medication and further development of biological psychiatry. Advances in psychopharmacology have led to many breakthrough treatments, particularly in mood disorders among adults. Psychotropic medications are now being used in children as well, although extrapolation for safety and efficacy data from adults is not always valid.

Primary care providers in community-based practices are often caught as the only source of psychiatric medication management for many children who are not eligible for public aid and/or whose private health insurance does not cover mental health services. This places pediatricians and family practitioners in the position of having to decide whether to prescribe medications for disorders that are not within their area of expertise, or let the child's mental health needs go uncared for.

The need for training primary care physicians and pediatricians in the United States is highlighted by the finding that while 72 of 600 family physicians and pediatricians in North Carolina had prescribed a psycho pharmaceutical agent for a child or adolescent patient, only

eight said they had received adequate training in the treatment of childhood depression and only sixteen reported that they felt comfortable treating children for depression.[34] The Youth Suicide Prevention Prototype Project primary care providers' survey was developed as an instrument to measure awareness among Alachua and Broward County primary care providers in suicide-related issues, since they are instrumental in the early intervention for mental health conditions – including suicide ideation. One of the aims of the Florida State Youth Suicide Prevention Prototype Project is to facilitate the role of primary care providers as access and referral points for mental health services.

A. Methods

The survey instrument was designed based on existing literature and input from County Advisory Board members, survey design experts from the University of Florida Survey Center, and University of Utah National EMSC Data Analysis Research Center. The Nova Southeastern University Institutional Review Board for the protection of human subjects in research deemed the study to be exempt as it was an anonymous survey with minimal to no risk to the participant. The survey was complemented by a series of qualitative key informant-focused interviews to assist in the interpretation of survey results.

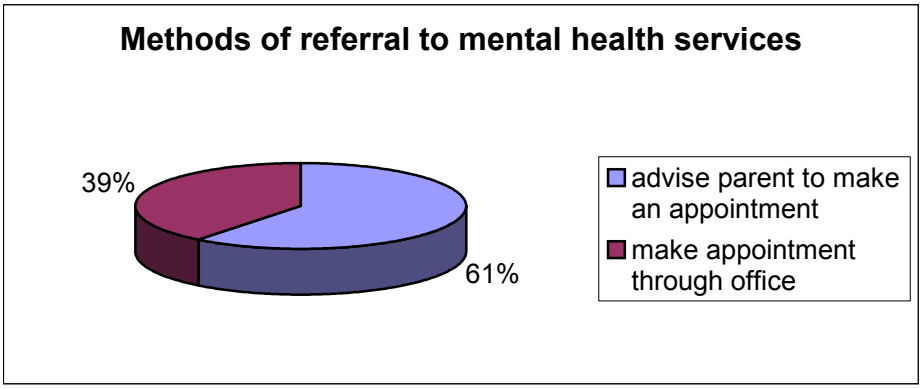
The final survey tool was distributed to primary care providers in Alachua and Broward Counties to identify current perceptions, practices, barriers, and issues related to youth suicide, mental health screening and referral services (see Appendix F for survey tool). Potential participants were identified through County Medical Associations and publicized in professional meetings and via e-mail. Surveys were faxed and emailed to primary care providers throughout both counties. The sample size was composed of 240 primary care physicians from Alachua and Broward Counties. There were 84 respondents to the faxed and/or e-mailed survey with a resultant response rate was 35%.

B. Results

Survey respondents were mainly pediatricians (86%) practicing in Alachua and Broward. Respondents practiced primarily in private practice settings (79%). Participants' gender was evenly distributed, composed of 50% women and 50% men. The average years of practicing medicine was 15 years, with a range from 1 to 48 years.

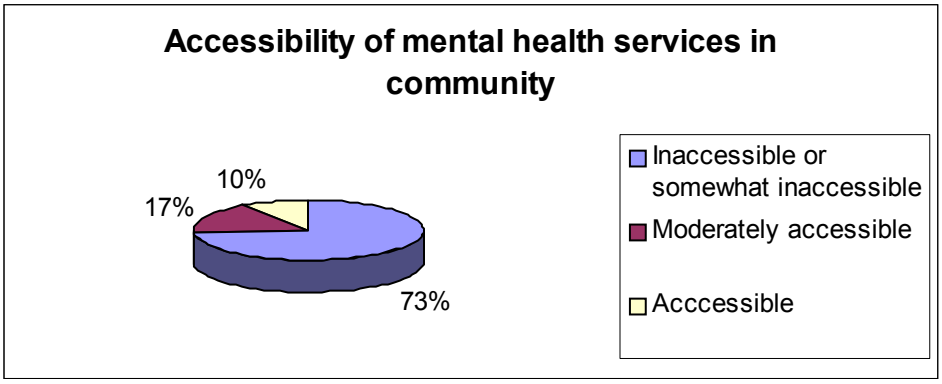
Over three quarters (78%) of respondents perceived patient mental health-related problems as moderately or very prevalent. However, the majority (76%) reported they do not use a standard mental health screening procedure in their routine practice. Additionally, only 46% reported using a follow-up procedure for youth patients they refer to mental health services. Please see below for common methods used of referral to mental health services.

Figure 13: Methods of referral to mental health services



The most common facilities where primary care physicians refer youth patients with mental health problems are private mental health clinics (54%) and community mental health centers (66%).

Figure 14: Accessibility of mental health services in the community



Furthermore, 26% of primary care providers rated themselves as moderately aware of existing youth mental health resources available in their communities, while 42% rated awareness as poor. Based on their referral experiences, most rated overall accessibility of youth mental health services in their community as poor (73%) or moderate (17%). Approximately half (44%) of primary care providers who responded perceived cultural diversity issues as having a moderate or great impact on mental health diagnoses and treatment among youth patients.

C. Qualitative findings from key informant interviews

Qualitative findings indicate that pediatricians consider mental health within the scope of their practice although they are frustrated with the gap between medical and mental health services, especially due to time constraints and reimbursement barriers. Other issues that arose in the key informant interviews include the need for sustained feedback from mental health providers, lack of services for parents with mental health issues, the increase of stressors in children's lives such as high academic and extracurricular expectations, family problems, and behavioral issues. Pediatricians recognize the distinction between psychological and psychiatric problems, but are often unclear about how to respond to different issues. There is a demand for training and

information about best practices for office based screening and referral resources in the community. Awareness about mental health varied widely among interviewed doctors, as did awareness about the importance of culture on the ability to discuss mental health issues. Findings of the key informant interviews will be presented in a separate document.

D. Conclusions from Primary Care Provider Surveys

The constraints of primary care practice (13 minutes allotted per visit on average), and the limited availability of mental health specialists, make it difficult for pediatricians and family practitioners to implement systematic screening procedures of diagnostic assessments. The apparent demand among primary care physicians for simple tools to identify and respond to patient's non-acute mental health needs calls for a brief, valid standard screening tool that can be administered within the timeframe of a routine examination. Primary care providers often lack the information or resources necessary to act on the results. Further, pediatricians require a broad array of referral options to fit the needs and insurance status of diverse patients necessitating ongoing partnerships between primary care and mental health services at all levels of health care delivery. Since the ability to access mental health services is largely dictated by insurance coverage, children often have irregular interactions with mental health professionals; communication between mental health providers and primary care physicians is crucial to ensure continuity. This communication needs to be improved and standardized.

III. Distribution of Educational Materials to Primary Care Providers

In July 2003, 100 information packets were mailed to all listed primary providers in Alachua County. The materials included provided information on prevalence of suicide, suicide prevention and Alachua County resources. The packets were sent in appreciation for the completion of the Primary Care Provider Mental Health Services Survey to all providers whether they had completed the survey or not.

Three hundred packets were sent to listed Broward County primary providers in September 2003. The materials included presented information on prevalence of suicide and the Primary Care Provider Mental Health Survey. To see documents included in the package mailing, please refer to Appendix G

IV. Training and capacity building among program staff

As a measure to respond to all needs identified by the primary care provider survey's outcomes, program staff has engaged in a variety of capacity building and training activities.

- *Children Services Council of Broward County Presents the Broward Training Collaborative*, *Crisis and Suicide Prevention*, July 24, 2003.

- *Planning and Evaluation for Youth Suicide*, July 7, 2003-August 1, 2003. This web-based training is sponsored by the National Center for Suicide Prevention Training (NCSPT). The program helps participants learn about planning and evaluation for youth suicide research, program implementation and advocacy.

Communication and Coordination

The availability of training and education is not enough to create change. These resources must be not only available, but also accessible, coordinated, and publicized. The purpose of the communication and coordination component of the Youth Suicide Prevention Prototype Project is to promote access, adoption of programs and policies that prevent youth suicide. Public awareness and advocacy, media partnerships, and publications will be described in this section.

I. Public Awareness & Advocacy

The following table shows the different public awareness and advocacy activities conducted during Year 1. The purpose of these activities was to increase awareness about the program, promote access and adoption of suicide prevention tools, guide the development of the Youth Suicide Prevention Prototype Project, and disseminate findings of research activities. For meeting agendas, please see Appendix H.

A. General

Activity	Date	Purpose	Results
Youth Suicide Prevention Prototype Program Advisory Council	2.26.2003	-To provide an opportunity for legislators to interact with researchers, advocates, service providers, and community residents.	To exchange thoughts on youth suicide and the need for timely mental health services-This meeting was held in conjunction with the Second Annual Broward County Legislative Breakfast on Suicide Prevention. Over 50 persons attended including legislative delegation members or their representatives
State Suicide Prevention Task Force Meeting	3.26.2003	- To present the School Suicide Prevention Resource Kit to legislators and their staff	-Presented documents were included in the Florida Suicide Prevention Coalition Legislative Packet as a source of promoting the YSPP as a model for future projects statewide. To see documents included in this packet, please see Appendix I
Florida DOH Injury Prevention Strategic Plan Task Force Meeting	7.28-29.2003	-To participate in the development of the 5-year Injury Prevention Strategic Plan process	Creation of a statewide injury prevention plan based on the Safe States Initiative developed by STIPDA.
Nova Southeastern University Family Faculty Institute Task Force	7.10.2003	-Initiate the design of a interdisciplinary course	- The curriculum would focus on family-centered care issues including but not limited to: families and advocacy, the powerful partnership of parents and providers, health care and cultural diversity, and family-centered versus systems-focused care.
Activity	**Date**	**Purpose**	**Results**
Pediatric Associate Monthly Physician Meeting	06/03/2003	-ICHP staff presented on the research and activities related to youth suicide and mental health.	-Physicians were urged to fill out the primary care survey and get involved with the Youth Suicide Prevention Prototype Project
Second Annual Legislative Breakfast	02/26/03	To explore policies and community resources that support local mental health system reform	Dr. Mulligan Smith presented an update of the Youth Suicide Prevention Prototype Project

B. Communication and Coordination with Oversight Committees

Advisory Boards

The purpose of the advisory board meetings is to facilitate the evolution of the program and to guide staff members in the adaptation of the program to meet the community's needs. In addition to determining what programs are currently in place statewide, all advisory board representatives provide suggestions for sustaining the program; identify new areas of interest and potential resources. Please see acknowledgements page for a list of advisory members for Alachua and Broward Counties.

Florida State Task Force on Suicide Prevention

The purpose of the Florida Task Force on Suicide Prevention is to increase public awareness that suicide is a state public health problem that is preventable. As an oversight committee, the Florida Task Force on Suicide Prevention, the State Task oversees the project to ensure compliance and accountability. (See Appendices K and L)

C. Participation in Community Networks

Project staff participate actively in a variety of networks to ensure that suicide prevention is included in the overall children's agenda. These networks include:

- Broward County Network for Children with Severe Emotional Disturbances (SEDNET), which meets monthly with consistent attendance by the executive leadership of all community-based mental health service providers.
- Children Services Council of Broward Training Collaborative, which sets the agenda for professional and community training for all children service-related issues. The Children Services Councils across Florida counties could become an important network across the state for inserting suicide prevention within their local strategic plans and a place for funding resources.
- Cultural Competence Workgroup, a coalition of service providers and community representatives working to ensure that mental health services for children are family centered and culturally inclusive.
- One Community Partnership, a federally funded initiative to coordinate services for children with mental health needs in Broward County.
- The Florida Institute for Suicide Prevention (FISP) is a not-for-profit organization based in Broward County. The organization, recognized by the Surgeon General's Office and the Center for Disease Control for its work in suicide prevention, is a founding member of the State Suicide Prevention Task Force and the Florida Coalition for Suicide Prevention. FISP has been instrumental in bringing the school-based SUN (Solutions Unlimited Now) Program, a problem solving group process for teens and pre-teens, to Broward and Miami-Dade Counties. FISP provides suicide prevention training for and works in collaboration with many community organizations including Nova Southeastern University Institute for Child Health Policy in providing educational conferences and legislative events.

D. Maintaining Relationships with Related Programs

The staff of the Youth Suicide Prevention Prototype Project is encouraged to learn from other local and national suicide prevention projects. This task is extremely important since it provides tools for exchanging information and making connections for future collaborations. Such agencies include Covenant House Florida, Children's Home Society, Broward and Alachua County School Boards, SUN Program, SUPERB program (Box 3) and Boys and Girls Club of Broward and (Box 4)

Box 3. SUPERB Program[35]

SUPERB Program

Research suggests that suicide and interpersonal violence share a number of important risk and protective factors across multiple domains of influence. These include problem-solving and coping skills, characteristics of school and community environments such as bullying, intolerance, and prejudice. Taken together, this evidence suggests that prevention approaches can integrate suicide and violence prevention by focusing on shared influences, in particular, strategies that promote good general coping skills and family functioning, have potential to increase both the effectiveness and efficiency of prevention efforts. While several programs have demonstrated evidence of reductions in suicidality or in youth interpersonal violence, there have been few attempts to achieve the benefits that could come from an integrated violence prevention approach.[36] (Ref: Lubell & Vetter, 2003).

Problem-solving and coping skills have emerged as fundamental protections against the development of suicidality and violent behavior. Having these skills decreases the likelihood that youth will turn to suicidal or violent behavior to resolve conflicts or gain relief from emotional stressors (Ref: DuRant *et al.*, 2001; Eggert *et al.*, 1994; U.S. Department of Health and Human Services, 2001). The reverse is also true, that is, that social and coping skill deficits, in the face of stressful events or chronic strains, increase the risk of suicidality and violence (Ref: Pollack & Williams, 1998; Maris et al., 2000;).

Comprehensive programs to prevent interpersonal violence and suicide should ideally start as early as pre-school or elementary school and continue, increasing in developmental sophistication, throughout the school years. Nova Southeastern University along with Broward School Board of Education has created the Students United with Parents and Educators to Resolve Bullying- SUPERB. The goal of SUPERB is to teach students to work together to resolve incidents of bullying and interpersonal violence in schools by educating students, teachers and parents that teasing and tormenting peers cannot be tolerated as an acceptable part of the school community.

SUPERB curriculum was developed in conjunction with Broward Schools Superintendent Frank Till, the Broward County School Board, and experts from the community including: Christopher F. Burnett, Psy.D., Director of Doctoral Programs in Family Therapy in the Graduate School of Humanities and Social Sciences (GSHSS), Anne Rambo, Ph.D., Associate professor of Family Therapy and a child and family therapist for over 20 years, and doctoral students in Family Therapy and Conflict Analysis and Resolution at NSU. For further information, please visit their website at www.nochildfearschool.org

Box 4: Diagnostic Screening at a Broward County Boys and Girls Club: A Descriptive Study

Diagnostic Screening at a Broward County Boys and Girls Club: A Descriptive Study

Villa M., Sas A., Levant R., Reitman D.

The benefit of using the electronic DISC Predictive Scales (DPS) is that it requires little staff time. Diagnostic evaluation with structured interviews is often lengthy and expensive. The DPS identifies children who could possibly benefit from further diagnostic inquiry in a particular diagnostic area, including suicidality, but a screening diagnosis will overestimate the actual number of problems identified.

Sixty-four out of the 272 children enrolled at a Broward County Boys & Girls Club participated in the study (53.1% Male, 46.9% Female). The average age of the participants was 8.75 ($\pm$1.18), ranging from 7 to 11 years. The median family income was $30,000 - $40,000 per year. One fifth of the participants identified themselves as Hispanic, 70% were white non-Hispanic, 3% were African-American, and another 3% identified as "Other."

Parents of children age 7-11 were asked to complete the DPS self-report questionnaire at the time of enrollment. A $10 membership reduction fee was offered for participation in the study. Graduate students were available to assist parents in filling out the questionnaire.

Conclusions

- 25% (n=16) of the children screened met criteria for two or more problems.
- Only two children are currently receiving psychological services for family-related problems, suggesting that there may be a strong need for additional mental health services for B&G Club children.
- Using the DPS, researchers were able to identify children who may need psychological services.
- The Hispanic population may have been underrepresented due to the late introduction of the DPS Spanish version.
- In the future, a shorter diagnostic measure could be used to increase participation rate.

II. Media Partnerships

The Florida State Task Force on Suicide Prevention encourages a unified media campaign to develop and advance suicide prevention efforts and to provide the public with sources to turn to when suicide ideations have been manifested. As part of these efforts, The Youth Suicide Prevention Prototype Project has taken on the task to promote the media's positive role in educating the public about risks for self-harming behavior and shaping attitudes about suicide. Moreover, given the substantial evidence for suicide contagion, a recommended suicide prevention strategy involves educating media professionals about contagion, in order to yield stories that minimize harm.

Several media-related activities took place with the purpose of increasing public awareness about youth suicide as a preventable problem, and to market the Youth Suicide Prevention Prototype Project, its activities and products. The media activities are outlined below.

Dateline Health Cable Television Show
February, 2003

Summary

A new medical program shown on cable television, Dateline Health is hosted by Nova Southeastern University Provost and Vice-Chancellor Fred Lippman, EdD. The Child Advocacy segment aired throughout the month of February focused on the Youth Suicide Prevention Prototype and Child Mental Health. Community resource contact information was provided to the viewing audience. Guests included Dr. Deborah Mulligan-Smith and Parent Advocate JoAnn Finkelstein. This cable television program is aired through Broward Education Communication Network (BECON) ITV. BECON produces a variety of finished programs each month. BECON possesses the administrative, production, programming and broadcasting capabilities to serve as a significant communication tool for a number of public service announcements and programs that are aired over commercial stations.

2-1-1 Day in Broward County
February 11, 2003

Summary

Broward County Mayor Diana Wasserman-Rubin proclaimed February 11, 2003 to be "2-1-1 Day in Broward County" following a unanimous vote by county commissioners. The day recognizes the significant benefits First Call For Help has provided residents in the year since it adopted the easy to remember 2-1-1 phone number, an important resource for individuals seeking help to deal with suicidal thoughts. Assistance is available in numerous languages, including English, Spanish, and Creole. First Call For Help has logged nearly 100,000 calls during the past year from residents unsure of where to turn for assistance. First Call For Help maintains a database of over 3,300 programs that are available at little or no cost to assist with a variety of issues. (See **Research and Resources** for more information).

SunSentinel article
February 23, 2003

Summary

A special article was published on the Florida Initiative for Suicide Prevention efforts, a close collaborator on the Youth Suicide Prevention Prototype Project.

Florida and Broward County Suicide Prevention Day Proclamations
March 26, 2003

Summary

The Presentation of the School Board Resolution and County Commissioners Proclamation were televised live through BECON on the South Florida Public Service Television network.

- Broward County Board of Commissioners Proclaims March 26, 2003 as Suicide Prevention Day.

- Broward County School Board Resolution Proclaims March 26, 2003 as Youth Suicide Prevention Day.

III. Publications and Presentations

Academic presentations and publications are another venue to increase knowledge about suicide prevention efforts. Toward this goal, the following abstracts were submitted to professional organizations

- *Exploring the Link Between Mental Health and Suicide*, The Florida Pediatrician Newsletter of the Florida Pediatric Society, May 2003.

- *Mental Health, Suicide Prevention: Within the Scope of Practice for the Pediatrician*. Deborah Mulligan-Smith MD FAAP FACEP, Greta Costa MS, and Maria Elena Villar MPH. American Academy of Pediatrics 2003 National Conference and Exhibition October 31-November 5, 2003 in New Orleans, LA. Please see Appendix M

Contributions by Related Staff:

- Maria Elena Villar is a Research Scientist with the Institute for Child Health Policy at Nova Southeastern University and is collaborating on the development of the surveillance system. Below is a sample of a relevant publication:

  Are 'Accidental' Gun Deaths as Rare as They Seem? A Comparison of Medical Examiner Manner of Death Coding with an Intent Based Classification, J Schaechter, I Duran, J De Marchena, G Lemard, ME Villar, PEDIATRICS Vol. 111 No. 4 April 2003, pp. 741-744

- Dr. Deborah Mulligan Smith was a lead author on a joint statement released by the American Academy of Pediatrics regarding child deaths in emergency departments.

  Death of a Child in the Emergency Department: Joint Statement by the American Academy of Pediatricians and the American College of Emergency Physicians, Pediatric Emergency Medicine Committee. PEDIATRICS Vol.110 No.4 October 2002-

Lessons Learned

Youth suicide prevention strategies have primarily been implemented within three domains—school, community, and healthcare systems – and generally have one of two general goals: case finding with accompanying referral and treatment or risk factor reduction.

Training and education

Only through recognizing who is at risk for suicide, and knowing how to prevent suicidal behavior and provide treatment for suicidal individuals will gatekeepers, mental health practitioners, primary care providers, educators and those designing educational and public health prevention programs prove proficient to successfully combat this major public health and clinical problem in youths.

- Considering focus group findings that schools have considerable independence in implementing suicide prevention programs, we need to find ways to engage school administrators and teachers to buy-in to the school readiness tool kit and work with them on the implementation.

- The guide dissemination has to be well planned and framed within the context of a larger community suicide prevention effort to increase likelihood of implementation.

- Implementation guidelines for the planning guide must be flexible to meet the diverse needs of Florida schools.

- It must be stressed that before universal screening occurs, resources have to be in place to respond to the service needs that will arise. Formal relationships with community service providers are necessary parts of a suicide prevention plan.

- Primary care providers that work with youth need standard age-appropriate screening tools for use during routine examinations. Screening tools must be culturally competent due to the multi-ethnic composition of Florida residents. This is an area of research that has not been adequately translated into practice, and is especially relevant when dealing with families in crisis.

Research and Resources

- Data-sharing partners have taken initial steps for the development of the surveillance system.

- There is interest and willingness from the community to develop a surveillance system of non-fatal suicidal behaviors. However, these data are not recorded in a consistent manner. Improving coding and recording of suicidal behaviors among EMS, ED, and mental health inpatient computer systems must be part of this effort. Schools are an untapped source of data on suicidal behavior. The schools in the pilot communities do not currently collect this information.

- HIPAA considerations must be part of the surveillance system design and may result in less than optimal data due to inability to track duplicates.

Communication and Community Awareness

- Although community awareness increases public buy-in and political will to fund programs, awareness alone will not prevent suicide.

- Practitioners in the field (teachers, physicians, EMS personnel) need practical tools they can incorporate into their routine activities.

- Marketing of these materials is important.

Health Care Specific Concerns

- There is a shortage of mental health case managers and/or social workers available in hospitals, and particularly in emergency departments.

- Primary care providers and hospital emergency department providers have limited knowledge of mental health referrals for children and adolescents.

- Lack of emergency department mental and primary care behavioral health screening tools exist for children/adolescents.

- There is a lack of clarity about the primary care and emergency department personnel's role in identification of non-acute mental and behavioral health concerns.

System wide Concerns

There appears to be a significant lack of mental health services for children and adolescents. The following issues were identified by primary care providers. There is a:

- There is insufficient access to mental health services to support a community-based model of mental health care for children and adolescents with severe mental health issues (e.g., respite care).

- Significant time delay (due to lack of resources) for child/adolescent evaluations for medication and other community-based support for kids seen in the primary care provider offices with mental health concerns. Waits of six to eight weeks are common.

- There is a scarcity of private mental health providers for children and adolescents.

- There are limited resources for children/adolescents with dual diagnosis for mental health issues and alcohol/substance abuse. Due to lack of other facilities, the emergency department is used as a place of last resort for children and adolescents.

Conclusions

It would be inappropriate to draw conclusions based on the activities of a planning year. However, through the various planning activities, we identified areas for opportunity and growth to increase the likelihood of reaching the Governor's objective of reducing youth suicide by one third.

The identified areas can be placed within a process continuum of planning and implementing the proposed activities to achieve the overall objective. Below are some reflections to consider in planning the future of YSPP.

YSPP Process

State Level policies	→ Planning Interagency collaboration Capacity Building	→ Implementation YSPP	→ Reaching the objective: **Reduce Youth Suicide by one third**

Policy-making perspective: mental health as a public health issue

Research demonstrates that mental health is the key to overall physical health. Emotional and behavioral problems in childhood have a predictive effect on health in adulthood, including implications for mental health and personality disorders. [37](Power, Manor and Fox 1991). Because of this, there is an obligation to integrate mental health into the public health priorities of the state, as well as local communities and the nation as a whole. This commitment must be backed by research-based programs reaching the communities that would benefit from them.

Community perspective: interagency collaboration?

Communities can play an important role in promoting and supporting for the health of children and youth. To be effective, prevention efforts must be comprehensive, involve wide participation and build on the strengths of the community. Collaboration across a broad spectrum of agencies, groups, organizations and institutions encourages the sharing of resources and facilitates learning from other related projects. In multi-sectoral or multi-agency prevention efforts, there must be a clear delineation of responsibilities for services where there is the potential for overlap.

A truly effective pediatric mental health system encourages broad-based interagency collaboration at the child/youth and family level as well as at the systems level. This requires building on a shared definition of the problem and developing a methodical, inclusive process for effectuating change.[38]

During the first year of the initiative, devoted primarily to identifying resources and planning, we identified and worked with community leaders from the healthcare sector, both public and private, as well as individuals representing research and practice experience in suicide prevention, public health, mental health, substance abuse, child development, program implementation and evaluation with community service providers and volunteer organizations. County level Advisory Boards are an objective source of information and guidance made up of community leaders. The active participation of these boards has proven an invaluable resource to provide feedback and connect the YSPP efforts more closely to the community. Through a

series of one-on-one meetings and interviews, we captured these individuals' particular concerns and areas of interest and developed a sense of their community culture, marketplace dynamics, and cross-sector relationships. The Alachua and Broward County Advisory Boards focused on collectively defining specifics of the problem of youth suicide and identified practical next steps that they were willing to undertake in their respective communities.

The Youth Suicide Prevention Prototype Project has rallied together many organizations around the goal of reducing youth suicide. Organizations that work together grow and change practices by learning from each other. Traditionally in our communities, the bulk of mental health services and funding are concentrated within a small number of providers. The process of establishing relationships for these countywide community-based initiatives opened the door to new collaborative partnerships and new service providers that may not have been included in countywide projects in the past. By engaging schools, community residents, and smaller more culturally oriented agencies, as well as large traditional providers, the program may be in a better position to offer support services and obtain community buy-in.

Practice Perspective: Identifying unmet needs

The first year of the Youth Suicide Prevention Prototype Program was devoted to identifying resources and needs. The YSPP Primary Care Provider Survey revealed the constraints faced by primary care providers in their practice (13 minutes allotted per visit on average), and the limited availability of mental health specialists, which make it difficult for pediatricians and family practitioners to implement systematic screening procedures of diagnostic assessments.

There is a demand among primary care physicians for simple tools to identify and respond to patient's non-acute mental health needs within the timeframe of a routine examination. Primary care providers often lack the information or resources necessary to act on the results. Further, pediatricians require a broad array of referral options to fit the needs and insurance status of diverse patients necessitating ongoing partnerships between primary care and mental health services at all levels of health care delivery.

In response to this need, resource packets were provided to ensure that all primary care providers understand the issues and experience of children with mental health needs, the impact of social determinants on direct health, and the health implications of inequities and have the knowledge, attitude, and skills to deal with them. Primary care providers have been linked to existing county mental health agency resources. Direct communication continues between primary and mental health providers through the venue of county medical society meetings.

Primary Care Providers have begun to advocate outside their office practice for the mental health needs of children and families. A case in point is the introduction and approval of mental health resolutions heard at the 2003 Florida Medical Association (FMA) Annual Legislative Delegation Conference Physicians, which develops effective grassroots activities and education about the impact of legislation on physicians and patients.

Research perspective: community-based culturally competent approaches

Studying the relationship between the organizations involved in the distribution of health services and child mental health services is needed before restructuring current systems. For interventions to successfully engage the intended recipients they must relate to their cultural

beliefs and attitudes, whether that culture has to do with race, ethnicity, age, geographical area, or family customs. We know that interventions are likely to fail if they do not have the appropriate buy-in from policy-makers, or if they do not meet the needs of the staff charged with delivering it. Once put into practice, the chances for continued sustainability are minimal unless there is a sound evaluation mechanism in place. All of these pieces must be in position for any community-based intervention to thrive. As soon as the period of planning an intervention has concluded, implementation of the proposed project may begin.

As with many important public health issues, there is the problem of limited resources for implementing data systems and for conducting the actual prevention activities. There are significant challenges in creating data systems appropriate for assessing the impact of suicide community wide suicide prevention efforts. During the initial phase of the YSPP, the objective of identifying youth at risk for suicide in Alachua and Broward County led to the implementation of the described surveillance system to collect epidemiological data about the problem. Improved data collection on local, state and national levels is critical for tracking trends, identifying risk and protective factors and targeting resources. Additional supporting information on mental health and contributory and/or co-occurring disorders were collected from available sources: Florida Governor's Office, Health Data Source Book (includes Census data), Vital Statistics, Statistical Abstract, Public Health Indicators Data System, Department of Children and Families Economic Services, Department of Education, Discharge Data, Behavioral Risk Factor Surveillance Survey, Alcohol/Drug and Mental Health Program Office and Medical Examiner Morbidity Statistics. However, most of these data are aggregated and do not allow us to analyze specific risks.

A population-based surveillance system will allow us to identify unrecognized risk factors that may be intervened upon in ways that we have not been able to conceive thus far. The community-based pilot surveillance system in Alachua and Broward Counties will facilitate the meaningful analysis of existing data sources to support intervention and health systems research. Development of accurate data systems on youth suicidal behavior (fatal and non-fatal) will serve as a basis for future enhancements to Florida's public health surveillance efforts and as a possible tool for evaluating impact of the prototype program.

Through YSPP, which is a two-county pilot for the rest of the state, we have been able to identify data sources that are likely to exist in one way or another in all Florida counties.
While it is true that at this point the data reviewed raise more questions than answers, it is also true that until we systematically collect and understand what the data are saying, we will continue to use the same strategies we have been using with limited success. A system fed by local data from local agencies and service providers analyzed locally for each region would provide insight into understanding specific needs for planning data-driven community-based interventions.

Human perspective: hope for our youth?

Prevention and intervention strategies provide hope for the future in building healthier children with better coping skills such that they make better choices and never enter into a position where they may consider self-harm as an option. We need to continue collaborating on this matter to reduce suicidal attempts among our youth, without losing sight of the link between suicide and

mental health. As one survivor notes: "Suicide is not the result of a personal crisis or deliberate action, but most often the terminal result of an untreated, underrated or misdiagnosed psychiatric illness."[39]

At the conclusion of year-one and as we move forward into year-two this project will be modeled/expanded in several ways to:

1) Continue to build the population-based surveillance system
2) Continue to provide professional and community education on suicide/self harm
3) Continue development of and pilot test a suicide Prevention Tool Kit to stakeholders Evaluate achievements/challenges.
4) Build on the findings of year one to follow progress of linking agencies to existing resources; and/or
5) Increase/develop capacity to meet identified gaps/needs in existing system; and/or
6) Continue to reach out to all community-based organizations to become involved.

Appendix A
Letters of Supports

Letter of Support
First Call for Help
Sample

Deborah Mulligan-Smith, MD FAAP FACEP
Director and Professor
Institute for Child Health Policy
Nova Southeastern University
3200 S University Drive, Suite 1212
Fort Lauderdale, FL 33328

Dear Dr. Mulligan-Smith:

As Director of First Call For Help I am pleased to support the Institute for Child Health Policy (ICHP) at Nova Southeastern University research effort to establish a Suicide Surveillance System.

I am willing to share data from call logs for suicidal behaviors with ICHP in compliance with HIPAA requirements for the protection of privacy.

I look forward to a continued partnership with the Institute for Child Health Policy at Nova Southeastern University in our shared effort to decrease suicidal behaviors in Broward County.

Yours sincerely,

Ms. Susan R. Byrne
President and CEO First Call For Help.

Letter of Support
Broward County Fire Rescue
Sample

Deborah Mulligan-Smith, MD FAAP FACEP
Director and Professor
Institute for Child Health Policy
Nova Southeastern University
3200 S University Drive, Suite 1212
Fort Lauderdale, FL 33328

Dear Dr. Mulligan-Smith:

As Chief of Broward County Fire Rescue I am pleased to support the Institute for Child Health Policy (ICHP) at Nova Southeastern University research effort to establish a Suicide Surveillance System.

I am willing to share data received from 911 calls related to injuries and mental health emergencies with ICHP in compliance with HIPAA requirements for the protection of privacy.

Assistant Chief Todd J. LeDuc has agreed to the sharing of data between Broward County Fire Rescue and ICHP.

I look forward to a continued partnership with the Institute for Child Health Policy at Nova Southeastern University in our shared endeavor to decrease suicidal behaviors in the county.

Yours sincerely,

Chief Herminio Lorenzo

Annual Report

Letter of Support
Medical Examiners
Sample

Deborah Mulligan-Smith, MD FAAP FACEP
Director and Professor
Institute for Child Health Policy
Nova Southeastern University
3200 S University Drive, Suite 1212
Fort Lauderdale, FL 33328

Dear Dr. Mulligan-Smith:

As medical examiner for Broward County I am pleased to support the Institute for Child Health Policy (ICHP) at Nova Southeastern University research effort to establish a Suicide Surveillance System.

I am willing to share data from the Suicide Deaths Forensic Reports with ICHP research staff in compliance with HIPAA requirements for the protection of privacy.

I look forward to a continued partnership with the Institute for Child Health Policy at Nova Southeastern University in our shared endeavor to decrease suicidal behaviors in Broward County.

Yours sincerely,

Joshua Perper, MD

Appendix B
Invitation Letter for the Participation into the Pilot Test of the Youth Suicide Prevention School Based Planning Guide

September 10, 2003

Mr. Sam Smith, Principal
Sample High School
7777 N. 00th Avenue
Fort Lauderdale, FL 33020

Dear Principal Smith,

You are one of the select seven Broward County Public Schools being invited by the University of South Florida, Louis de la Parte Florida Mental Health Institute to have your school participate in the development and initial testing of a **School-Based Suicide Prevention Planning Guide**. The Planning Guide is a tool to help a school build an effective suicide prevention approach.

Last year Broward County was one of two counties selected to participate in the Florida Metropolitan and Non-Metropolitan Community Youth Suicide Prevention Prototype Program conducted by Nova Southeastern University. This is the next step in the process. The program is supported (funded?) by the State of Florida, Office of the Governor, Office of Drug Control.

We are able to provide a small stipend of $200 as an appreciation to the schools who participate in the Planning Guide project.

As a Planning Guide project participant your responsibilities will be:

- Attendance by your school guidance director/counselor, peer counseling coordinator and/or school suicide prevention designee to our local "expert panel" breakfast meeting for the **School-Based Suicide Prevention Planning Guide** that will be held from 8:00 am to 10:00 am on Friday, October 17th, 2003 at the Fort Lauderdale Marina Marriott, 1881 SE 17th Street, Ft. Lauderdale, 33316. This expert panel meeting will review the Planning Guide, share their expertise and offer recommendations for the refinement of the Guide. We will ask each participant to assist us prior to the meeting by reviewing a brief set of materials that will be sent prior to the meeting.

- In addition, your attendance and your school's "suicide representative" are requested for the "roll out" community meeting which will be held on November 13th. in the evening. The "roll out" meeting will bring together the seven select schools engaged in the initiative, local mental health providers, parents, advocates, student representatives, other "gatekeepers" and Broward County children's system partners.

Annual Report

We are asking you to respond to this request on the enclosed card and return it to us in the envelope provided by September 19, 2003. Please contact Steve Roggenbaum at 813/974-6149 should you have any questions.

We look forward to your school's participation in the **School-Based Suicide Prevention Planning Guide**.

Sincerely,

Stephen Roggenbaum
Project Director
and

Katherine J. Lazear
Principal Investigator

RETURN FORM FOR PARTICIPATION IN THE
School-Based Suicide Prevention Planning Guide

Thank you for selecting my school for participation in the development of the **School-Based Suicide Prevention Planning Guide.**

Please check one below:
_____ I would be pleased to have my school participate in this project.

_____ Thank you for selecting my school but we are unable to participate at this time.

If your school is able to assist us with this project, please list the name of the person(s) who you would select to attend the Expert Panel Breakfast on October 17, 2003 so that an invitation can be sent.

You can select up to three participants. We recommend that the guidance director/counselor, peer counseling coordinator and suicide prevention designee be included in those selected.

NAME	POSITION
_____	_____
_____	_____
_____	_____

Please return this form to Stephen Roggenbaum in the envelope provided by September 19, 2003 or you may also fax this form to Steve Roggenbaum at 813-974-7376. Please contact Steve Roggenbaum at 813-974-6149 should you have any questions.

Dear (Guidance, Peer Counseling Coordinator, Suicide Prevention Designee)name

Your principal has selected you to represent your school at a breakfast meeting of a local expert panel. Yours is one of seven select Broward County Public Schools who is participating in the **School-Based Suicide Prevention Planning Guide**. The intent of the
Planning Guide is a tool to help build an effective suicide prevention approach in your school and community.

As a Planning Guide project participant and representative of your school we request you attendance at:

- A breakfast meeting of the local "expert panel" meeting for the **School-Based Suicide Prevention Planning Guide** that will be held on Friday, October 17th, 2003 at the ------, Ft. Lauderdale. (TIME) The expert panel meeting will bring together a select, targeted group to review the Planning Guide, share their expertise and offer recommendations for the refinement of the Guide. We will ask each participant to assist us prior to the meeting by reviewing a brief set of materials that will be sent prior to the meeting.

- In addition, your attendance is requested for the "roll out" community meeting that will be held on November 13th (TIME) to be held at Nova Southeastern University. The "roll out" meeting will bring together the seven select schools engaged in the initiative, local mental health providers, parents, advocates, student representatives, other "gatekeepers" and Broward County children's system partners.

Last year Broward County was one of two counties selected to participate in the Florida Metropolitan and Non-Metropolitan Community Youth Suicide Prevention Prototype Program conducted by Nova Southeastern University. The planning guide is the next step in that process. The program is supported (funded?) by the State of Florida, Office of the Governor, Office of Drug Control. A major component of the project involves the development and initial testing of a school assessment planning guide that will allow school administrators to assess the adequacy of their suicide prevention programs and to improve their scope and effectiveness. The School-Based Suicide Prevention Planning Guide project is being conducted by the University of South Florida, Louis de la Parte Florida Mental Health Institute, through a subcontract with Nova Southeastern University.

Please contact Steve Roggenbaum at 813/974-6149 with an RSVP or should you have any questions.

We look forward to your participation in the Planning Guide Project and on the expert panel meeting in October. Your input will be invaluable to the development and success of a community response to youth suicide.

Sincerely,

Katherine J. Lazear
Principal Investigator

Stephen Roggenbaum
Project Director

Appendix C
Development of a School-Based Suicide Prevention Tool Kit
Annotated Bibliography

Introduction

The Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida under a subcontract from Nova Southeastern is working on a project to develop a School-Based Suicide Prevention Tool Kit with funding through the Drug Free Communities Program, Florida Office of Drug Control.

The following annotated bibliography is created as part of the process for the Development of a School-Based Suicide Prevention Tool Kit grant. This introduction describes the strategies for creating the annotated bibliography. The purpose of the annotated bibliography is to provide a compiled resource of a variety of publications to support the development of the School-Based Suicide Prevention Tool Kit.

One of the first steps to our Development of a School-Based Suicide Prevention Tool Kit was to begin to review the current literature available related to suicide prevention and school-based prevention programs. By its nature, the annotated bibliography is necessarily incomplete. It should be noted that we anticipate continuing to add to our knowledge base through updating this annotated bibliography as we find and review additional relevant research.

We began our search for current research with the following parameters and strategies:

- The review began by gleaning citations from the Surgeon General's Call to Action and the National Strategy,
- Recent literature – 1990 through current journals with one exception (see note below),
- Search terms used included:
    - youth/adolescent/teen
    - school/school based
    - suicide/suicidal/suicides
    - prevention
    - intervention
    - postvention
    - climate/environment
    - risk/protective/warning
    - universal/awareness
    - education
    - crisis
    - screening
    - programs/programming

- Searched the following data bases:
    - PubMed
    - Article First (OCLC)
    - PsychInfo
    - ISI Web of Science
    - Wilson Select
    - ISI Current Contents
    - Journals@Ovid Full Text
- included frequently identified citations in selected articles (this strategy expanded our review to include one article prior to 1990),
- included if they were extensively cited by other authors,
- written by noted experts in the field,
- addressed information not found elsewhere,
- evaluations of suicide prevention programs, and
- provided comprehensive information.

Although many resources were initially viewed and surveyed, the research team focused our efforts upon published research articles for this annotated bibliography. Other resource materials and resources (e.g., books, websites, state plans) are being kept on file as additional sources of information. A list of the additional resource material is included at the end of this introduction.

List of reviewed resources but not included in this annotated bibliography:

Books/Book Chapters

Underwood, M.M., & Dunne-Maxim, K. (1997). *Managing Sudden Traumatic Loss in the Schools: New Jersey Adolescent Suicide Project.* Piscataway, NJ: University of Medicine and Dentistry of New Jersey – University Behavioral HealthCare.

Hicks-Barrett, B. (1990). *Youth Suicide: A Comprehensive Manual for Prevention and Intervention.* Bloomington, IN: National Education Service.

Kalafat, J., & Underwood, M. (1989). *Lifelines: A School-Based Adolescent Suicide*

Response Program. Dubuque, IA: Kendall/Hunt Publishing Company.

Tiernay, R., Ramsey, R., Tanney, B., & Lang, W. (1991). Comprehensive school suicide prevention programs. In A.A. Leenaars (Ed.) & S. Wenckstern (Ed.), *Suicide Prevention in Schools* (pp. 83-98). New York, NY: Hemisphere Publishing Corporation.

Dyck, R. (1991). System-entry issues in school suicide prevention education programs. In A.A. Leenaars (Ed.) & S. Wenckstern (Ed.), *Suicide Prevention in Schools* (pp. 41-49). New York, NY: Hemisphere Publishing Corporation.

Kalafat, J., & Elias, M. (1991). Evaluations of school-based interventions. In A.A. Leenaars (Ed.) & S. Wenckstern (Ed.), *Suicide Prevention in Schools* (pp.231-241). New York, NY: Hemisphere Publishing Corporation.

Leenaars, A.A. (2001). Suicide prevention in schools: Resources for the millennium. In D. Lester (Ed.), *Suicide Prevention: Resources for the Millennium* (pp. 213-235). Ann Arbor, MI: Brunner-Routledge.

Poland, S. (1989). *Suicide Intervention in the Schools.* New York, NY: Guliford Publications.

Institute of Medicine (2002). Reducing suicide: A national imperative. Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board on Neuroscience and Behavioral Health: Washington, DC: The National Academies Press.

Manuals/Guidelines

Center for Mental Health in Schools at UCLA. (2003). A technical assistance sampler on school intervention to prevent youth suicide. Los Angeles, CA: Author. Retrieved February, 2003, from http://smhp.psych.ucla.edu/pdfdocs/Sampler/Suicide/suicide.pdf

Center for Mental Health in Schools at UCLA. (2000). A resource aid packet on responding to a crisis at a school. Los Angeles, CA: Author. Retrieved February, 2003, from http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

Dwyer, K., Osher, D., & Warger, C. (1998). *Early warning, timely response: A guide to safe schools.* Washington, DC: U.S. Department of Education.

Dwyer, K., & Osher, D. (2000). *Safeguarding Our Children: An Action Guide.* Washington, DC: U.S. Department of Education and Justice, American Institutes for Research.

Prevention Programs/Websites

Screening for Mental Health. SOS High School Suicide Prevention Program. Retrieved April, 2003, from http://www.mentalhealthscreening.org/sos_highschool/index.htm

University of Washington School of Nursing. Reconnecting Youth Prevention Research Program. Retrieved April, 2003, from http://www.son.washington.edu/departments/pch/ry/

Child and Adolescent Psychiatry at Columbia University & NYSPI. TeenScreen Program. Retrieved February, 2003, from http://www.teenscreen.org/resources/bib.html

National Center for Suicide Prevention Training

Retrieved from http://www.ncspt.org/default.asp

Hayden, D.C. (2003 updated). State Plans for Suicide Prevention Web Page.

Retrieved from http://www.ac.wwu.edu/~hayden/spsp/

Ryerson, D. SAFE:TEEN: A Comprehensive Suicide Prevention Program for Your School. Suicide Education and Support Services (SESS) of Weld County, Colorado.
Retrieved from http://www.safe-teen.com

The United States Air Force Medical Service (2002). Air Force Suicide Prevention Program: A Population-based, Community Approach.

Retrieved from http://www.osophs.dhhs.gov/ophs/BestPractice/usaf.htm

QPR Institute, Inc. QPR for Suicide Prevention.
Retrieved from http://www.qprinstitute.com

Appendix D
Development of a School- Based Suicide Prevention Tool Kit
Focus Group Summary

Deliverables in the initial subcontract called for conducting adult focus groups and middle school student focus groups in Alachua and Broward Counties. Due to the topic of the focus group and involvement of vulnerable populations (students), the USF Institutional Review Board process was required. A full Board review was required rather than an expedited review. The January 17th Board date was fully booked requiring us to wait for the February 21st full Board review. The Board then recommended changes in the informed consent procedures for the middle school students requiring a modification of the application with final IRB approval received on February 27th.

During the human subjects protection process we were made aware that Broward County has a separate review process. That process requires receipt of a separate application using Broward County forms, the inclusion of the USF IRB material and a copy of the USF letter of approval. All Broward County forms were completed and sent by Federal Express on March 10, 2003. The research team made frequent contacts with the School Board of Broward County Research Services Division (Naveen Iskanvar, Deidre Douglas, and Cary Sutton) in an attempt to answer questions, facilitate the application, and expedite the process. The project was approved for focus groups with students and school staff in the schools through the review process on April 22nd.

Due to the unavoidable delays related to IRB approval and the scheduling of FCAT in schools along with Spring Break it was not possible to conduct the focus groups during the first quarter. The project team worked with several individuals including the Alachua middle school principal (Jennifer Wise, Principal) and head guidance counselor (Dr. Linda Myrick) and with Alachua School District contacts (Joyce Daniels and Sharon Spreen) to schedule the student and adult focus groups, and assist in obtaining parental permission. The project team also contacted the local SEDNET Project Manager (Dana Huggins) and the Crisis Center Director (Marshal Knudsen) for assistance in securing meeting locations and feedback on scheduling.

The project team sent an introductory letter explaining the project with an invitation for participation in an adult focus group to each of the 15 middle and high school principals in Alachua County. Hard copies of the letters were mailed to each principal through the US Postal Service at the suggestion of Alachua School District contact Sharon Spreen since not all principals use email extensively. The project director attempted to contact each principal individually to answer questions and encourage participation. The project team also extended an invitation to participate in the adult focus group to several school district staff. The eight-grade focus group was held May 5th and two adult focus groups were scheduled on May 7th. A total of six youth attended and a total of five adults participated in the Alachua County focus groups.

Dr. Deborah Mulligan-Smith of Nova Southeastern University provided several Fort Lauderdale contacts to assist the research team in making connections with Broward County schools. Rene Barrett of the Florida Initiative for Suicide Prevention assisted the project team in connecting with a middle school to hold the eight-grade focus group. We continued to work with Mrs. Rhoda Gawlowski, Assistant Principal at New River Middle School to arrange the focus groups

and assist in obtaining parental permission. The middle school also provided space for the adult focus groups. For the adult focus groups, the project team made phone contact with individuals at about half (about 22 middle schools and 15 high schools). We followed up on each contact with a faxed copy of an introductory letter explaining the project with an invitation for participation in an adult focus group. The project team faxed copies of the introductory letter to the remaining middle and high schools (i.e., 16 middle schools, 13 high schools). The eight-grade focus group was held on May 27th and two adult focus groups were scheduled on May 27th and 28th. A total of seven youth attended and a total of two adults participated in the Broward County focus groups.

I. Middle School Focus Group Summary
Focus Group Facilitators: Karen Blasé and Steve Roggenbaum

General questions that were presented by focus group facilitators are followed by summaries of participant's responses.

Prevention and Education

What steps do you think need to be taken to prevent teen suicide?
What can schools do to help prevent school suicide?

- Talk to youth about teen suicide
- Be more open about suicide (Teachers don't realize it happens as much as it does)
- Teachers and guidance counselors could pay more attention to the issues and catch it earlier on
- Make sure kids know people care and about what kids think
- Teachers and guidance counselors should get more training to be able to monitor if kids are getting more depressed, deteriorating, outcasts, out on their own
- Have after school class
- Keep youth involved with extra curricular activities
- Keep youth around friends
- Foster opportunities for teens to develop good friendships
- Make sure there are a variety of activities adolescents can relate to
- Be careful that there is not too much stress
- Family support is important
- Don't push too much responsibility on young people, too much involvement can cause stress
- Everyone needs something or someone to live for and relate to
- Too much homework causes stress
- People wish it didn't happen so they ignore it.

What makes it comfortable for you to get information about suicide prevention?

- Some people feel uncomfortable in a group
- One on one with a psychologist might be better
- If lots of sources, need to think about the incentives
- Somebody to recognize they need help

- ❖ Teachers to notice and ask them
- ❖ Teach kids to be more open about thoughts and feelings
- ❖ Be open. Tell it to us straight out and include the consequences
- ❖ Use discussion, back and forth, not a lecture
- ❖ No real comfortable way. Let people know the risks.

Where do you get information/education about teen suicide and how to prevent it?

Some responses were mentioned more frequently or echoed and seconded by others in the groups when mentioned. The more frequent responses are at the top of the list with checks.

- ✓ TV (Education from TV shows, news, Public service announcements)
- ✓ Magazines
- ✓ Books (e.g., Chicken Soup for the Teenage Soul, Go Ask Alice)
- ✓ Parents
- ✓ Friends
- ✓ Movies

- ❖ Teachers come into class and speak about it, guest speakers (although more often about drugs and alcohol)
- ❖ Internet
- ❖ Common sense
- ❖ Biographies
- ❖ Church
- ❖ Posters/Signs
- ❖ Billboards
- ❖ Drug commercial/TV commercial

What information do you think students need about suicide and suicide prevention?

- ❖ Statistics
- ❖ If there are drugs involved
- ❖ Is it genetic or causal?
- ❖ What causes or triggers people to do this? (e.g., family, problems)
- ❖ Signs of suicide
- ❖ Why do kids try suicide, even if just once?
- ❖ At what age are kids at most risk?
- ❖ Why don't they get help?
- ❖ Can you tell how they are acting?
- ❖ How are the people close to the person affected?
- ❖ Does it cause others to commit suicide if around someone who has committed suicide?
- ❖ How you can prevent it?
- ❖ Why do kids go to some people for help and not others?
- ❖ If there are support groups or therapy groups to help them change and let them know they are not alone
- ❖ Available groups or clubs
- ❖ Suicide should be discussed at the same level of concern as drugs and alcohol, sometimes it's a bigger deal (kids can always get counseling for drugs or alcohol).
- ❖ Have phone lines

Why is suicide a solution for kids?

- Lots of kids think about suicide, maybe 75% of all 8th graders
- Don't have to deal with situation
- Easy way out
- Think nobody cares about them
- Fast way out of situation

Do you think students use the Internet to get information about depression and suicide prevention? Why or why not?

- May not use Internet because it is not private/confidential
- Poor people can't afford computers
- Could get access at a library-might be uncomfortable in a public setting
  - Need to get private info
  - Have someplace like Planned parenthood/confidential person to go to
  - Talking to someone you can trust
- Yes, definitely. Kids spend lots of time on the internet.
- Internet could be used to help prevent suicide.
  - Pop-ups about prevention
  - Use famous people on websites
  - Make it interesting to our eyes
  - Don't post negative song lyrics that encourage kids to hurt themselves.
  - More songs with positive lyrics and post lyrics on the Internet**.**
  -

Sometimes kids who are feeling depressed or suicidal don't tell anyone, why do you think they don't tell?

- Lack of trust
- Not normal to have these feelings. It's abnormal.
- Some kids may think it is a normal feeling and that "I'll get over it"
- Wouldn't go to someone they didn't know well
- Worried about someone seeing you go for help
- Don't think people will care if you do tell
- Don't feel like they understand (guidance counselor)
- Afraid to tell. For example, if in an abusive situation at home, it may get worse.
- Afraid it will get around school.
- If you tell, your parents may blame themselves.
- People may think you're crazy and you'll end up in a padded room.
- People will think you're suicidal. You'll develop a reputation.

Support and Intervention

Who/what do kids turn to when they are feeling depressed and suicidal?

Most kids indicated not telling an adult immediately unless a close personal relationship had been developed (e.g., working closely with one cool teacher for several years). Generally, adults seemed low on the list of who to tell.

- May write it down somewhere in a journal/diary
- Talk to someone their own age who would be sympathetic
- Talk to someone who has been through something similar or had the same feelings
- Talk to animals/pets
- Not my friends
- Not some parents
  - Over-react
  - Parents can emotionally abuse kids
  - Parents might blame the kid
  - Might blame themselves for not being a good parent
  - Might be suspicious of child
  - Might not take the problem seriously
  - Might take the problem too seriously if just asking for information
  - Uncomfortable being around them all the time

- Grandparents
- Mom/parents who listen
- Parents should share with kids/be open about it (like smoking and sex) patient
- Guys may share with other guys/gender may have something to do with it
- Boyfriends/girlfriends
- NOT teacher unless really cool
  - Will this effective my grades
  - Will she think differently of me

What do you think makes an adult "cool?" Why would you tell someone or a particular adult?

- Please define "cool"
  - Have their own opinions- not stuck in the 80s
  - Realized times have changed
  - Teachers who pay attention to you and notice if you need help
  - Wouldn't think you were weird afterward
  - Feel like it wouldn't change their opinion of you
  - Someone who likes kids
  - Wouldn't over react
- Kids would listen to younger adults who have survived suicide as guest speakers
- Should use guest speakers closer to our age
- Adults who are very open
- Teachers who make it fun, not boring
- Teachers who don't hide things from us, they show us how it really is.
- Adults who present both sides
- They don't get upset with us if we ask questions, will discuss with us.
- Don't judge us for asking questions
- Parents

What should schools do to help students who are feeling depressed or suicidal?

- Class for everybody
- A box students could check to ask for help and make it anonymous
- Ability to go to counselor's room
- Column in the newspaper to write into like an advice column
- Use instant messaging in a supportive way / "IM" for kids
- Provide a way for students to get advice anonymously
- Have people talk to students about suicide like kids who have been through similar situations.
- Have people available who will listen.

Timely Access to Help and Information

If a friend or family member indicated they were feeling like they wanted to harm themselves or commit suicide what would you do?
What would you encourage them to do or whom would you encourage them to contact?

- Be patient
- Ask them "what is the matter?"
- Not get scared or overwhelmed
- Feel pressure/don't force help for them
- May call hotline for them
- I would tell, even if they seem mad if you told someone, they may be grateful later
- Several students indicated that they would tell a particular teacher with whom they have developed a relationship with over several years. He would get the right help needed.
- Try to help them
    - Tell my parents anonymously about student
    - Find out why they want to
    - Ask them if they want to tell others
    - Connect them to a counselor because they are trained
    - Talk with them - not tell unless they wanted me to
    - Solve it first, and then if it doesn't help tell someone
    - May hold a grudge
    - May forgive you
    - Egos may get in the way of them getting help

Sometimes when kids tell a friend or family member that they feel like they want to hurt themselves or commit suicide, they ask that person to keep it a secret. Do you think that kids keep those kinds of secrets? Why or why not?

- Scared
- Don't want to be judged
- Don't think anyone would care
- Confidentiality
- Want to be normal
- Feel worse if it's not confidential/don't want people talking about them behind their back
- Not want school to know or talk about it

- I would tell someone
- I would tell them that I couldn't keep that a secret and would tell.
- I would try to convince them not to commit suicide.
- People might not take them seriously if they have an anger problem
- Religion and community might give hope and help
- Might not have support if person doesn't believe

What are some of the resources available to middle school students?

- Special groups/ambassadors (7th grade)
- Paper booklet at beginning of the year with special topics
- Peer helper/peer leader groups
- Pre/post testing
- Work out deal with psychologist
- Resource numbers for kids
- Screening to get help
- Prevention screening
- Schools should be open and honest with us about suicide.

II. School and School District Staff (Adult) Focus Group Summary
Focus Group Facilitators: Karen Blasé and Steve Roggenbaum

General questions that were presented by focus group facilitators are followed by summaries of participant's responses.

What is happening currently in your schools/district regarding suicide prevention?

Broward County has an individual identified at most middle and high schools that serves as a suicide prevention contact for the school.

- Life Management class in high school covers the topic of suicide
- Individual schools will do something as needed
- When someone is noticed
  - Assess risk level
  - Sign suicide prevention contract
  - Contact supervisor of guidance
  - Suicide risk level
  - Parent contact
- Means restriction- contacts
- Each new student in counseling to talk about boundaries of confidentiality
- Contact Crisis Center to do assessment
- School Resource Officer Assessment
- Have teachers stay and report to parent (since they are the ones who saw it)
- Give students crisis center numbers
- Providing information about Medicaid
- Teachers go to guidance
- Brief (30 minute) in-service for teachers at beginning of year at our school
- Peer Counseling programs available at some schools

- Some schools are sensitive to the issue of suicide but prefer not to deal with it.

What should be happening in your schools/district regarding suicide prevention?

- New training for teachers/new teacher session
  - Starts at the top
  - More support for training for teachers
  - Happens through team meetings, which is harder
  - Need training time and resources

- Risk factor education
  - Useful if lists could be neat, flashy, nice to look at
  - Time to talk about crisis each year
  - Addressed at pre-planning

- Yellow Ribbon Day
  - Flyer out to all teachers
  - Phone number of crisis center on flyer
  - Kids get involved
  - TV
  - Discuss in homeroom
- Need to have students engaged developmentally-prevention
- People have resources- kids have phone numbers of lifelines
- One teacher wanted to start Yellow Ribbon program but principal said no, didn't want to promote suicide by discussing it.

- Teen Talk audio tape program accessible by phone
  - Corner Drug Store
  - Tapes on many subjects
  - Anonymous information for Teen Talk
    - Now have more answers

- Some students know they are stressed out
  - Report "I think I need medication"
  - Report they are depressed

- Increase in cutting/self-mutilation in middles school
  - Cutting needs to be addressed
- Kids are turning to their friends
  - Friends may tell others
  - Notes from friends or "I have a friend"
- Journaling in almost all classes - teacher concerned about entry in journals
- Risk for suicide may come out in counseling session when referred for something else

- PAL Grant
  - Came out of Columbine situation
  - Target loners
  - Peer groups of leaders for the target groups of loners

- Weekly sessions
- Psychology interns to train the leaders
- Teacher recommendation at the high school level
- Two pilot projects—2 high schools, 2 middle schools

❖ Safe School coordinators have options for extra money
- Programs include Get Real about Violence
- Get Real about Drugs
- Get Real about Alcohol
- But don't think there is one about suicide.

❖ Work more with parents
- Parents are key component
- As responsible if not more so than teachers
- Difficult to gain perspective with them
- Teachers need support from parents on personal matters such as suicide.

❖ Suicide is a problem some schools address after it happens
❖ Some think that if you talk about it, you will promote it.
❖ Kids live in a fantasy world. There is no finality in it.
❖ Attention seeking kids will try suicide.
❖ Have survivors speak at schools.

What are the barriers related to implementing suicide and violence prevention programs?

❖ Need training for students on how to look out for their friends
❖ Smaller school- more contact with students and counselor
- Reports and referrals
  - Teachers
  - Peers
  - Students

❖ See changes and address them if you see them in a small school
❖ Not a lot for teachers to refresh on warning signs
❖ Difference: rural vs. urban and smaller vs. larger
❖ Suicide is not discussed
❖ Need public services announcements just like for drunk driving and drugs
❖ Myths
- Have them dispelled
- Contagion issues-how to deal with it
- Talking about suicide will put the idea in their head

❖ Good that newspapers don't publish it
❖ Sharon Bailey
- Principle at Prairie View Elementary (Alachua County)
- Gives talks on suicide

❖ Suicide/Homicide issues need to be covered
- Tell parent
- Sign agreement
- Refer to crisis center

- Need to link to community resources
- Target journal writing
- County should adopt Second Step Violence Prevention Program
- Finding time
- Picking the right class to discuss the issue of suicide
- If discussed, kids assume someone recently tried it.
- Teacher selection process, how to select presenters/teachers for subject
- Seems to be up to principals at each school on how to implement programs
- Maybe use a pilot test strategy so other schools can see success
- Fear of litigation
- Curriculum may need to be approved at district level.

- Kids like the medical students coming in to discuss smoking (may be use medical students to discuss issues of suicide prevention.
- Kids seem to like to interactive CD for preventing violence, maybe use similar format for suicide prevention.
- Could be hard to make a certain class that has suicide prevention required since there are different ways to fulfill district requirements for graduation.

Appendix E
Panel of Experts Participants

School-Based Suicide Prevention Program Toolkit

List of Expert Panel Members

July 30, 2003

Joe Brinales, M.A.
Department of Epidemiology and Biostatistics
College of Public Health, USF
Tampa, Florida

C. Hendricks Brown Ph.D.
Professor in Department of Epidemiology and Biostatistics
College of Public Health, USF
Tampa, Florida

Donna Cacciatore, MBA.
Director of the Suicide Prevention & Volunteer Services
Crisis Center of Tampa Bay, Inc.
Tampa, Florida

Dan Casseday
Children's Board of Hillsborough County
Tampa, Florida

Ellen Connorton, MSW, MPA.
Deputy Director for the National Suicide Prevention Resource Center (SPRC)
Newton, Massachusetts

Cliff Davis
Human Service Collaborative
Mt. Vernon, Ohio

Gail Flores, M.S.
Florida Department of Education
Tallahassee, Florida

William J. Goodman, Ed.S., LMHC
Supervisor of Guidance Services, School Board of Alachua County
Gainesville, Florida

Pam Harrington
Suicide Prevention Action Network (SPAN)
Pont Vedra, Florida

LaShante Keys
National Conference for Community and Justice (NCCJ)
Advisor to Youth Congress and AnyTown Programs

Keri M. Lubell, Ph.D.
Division of Violence Prevention at the National Center for Injury Prevention and Control,
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia

Tom Mueller
Director of Education Services
Crisis Center of Tampa Bay, Inc.
Tampa, Florida

David Shern, Ph.D.
Dean of The Louis de la Parte Florida Mental Health Institute
University of South Florida

Lisa VanderWerf-Hourigan, M.S.
Injury Prevention and Control Office of the Florida Department of Health
Tallahassee, Florida

Stephanie Weaver
Treatment Specialist Student Support Services
Prevention Program, School District of Broward County
Fort Lauderdale, Florida

Frank Zenere, Ed.S.
School Psychologist, Department of Crisis Management
Miami-Dade County Public Schools
Miami, Florida

Joseph Zolobczuk
Education Coordinator, Project YES
Miami, Florida

Keith Woods & Traci Bexley
c/o LaShante Keys
National Conference for Community and Justice (NCCJ)
St. Petersburg, Florida

Project Staff, School-Based Suicide Prevention Tool Kit

Katherine J. Lazear, M.A
Principal Investigator, School-Based Suicide Prevention Tool Kit
Louis de la Parte Florida Mental Health Institute
University of South Florida

Steve Roggenbaum, M.A.
Project Coordinator, School-Based Suicide Prevention Tool Kit
Louis de la Parte Florida Mental Health Institute
University of South Florida

Justin Doan
Graduate Assistant for School-Based Suicide Prevention Tool Kit
Louis de la Parte Florida Mental Health Institute
University of South Florida

Annual Report

Panel of Experts
Research
July 28, 2003

Susan Tucker
Department of Elder Affairs
Tallahassee, Florida

Gail Flores
Intervention and Prevention Services
Florida Department of Education
Tallahassee, Florida

Wayne Goodman, Ph.D
Professor and Chairman
Department of Psychiatry
University of Florida
McKnight Brain Institute
Gainesville, Florida

Steve Freedman, PhD
Emeritus Founding Director
Institute for Child Health Policy
University of Florida
Gainesville, Florida

Sue Ross, MS
Chief of Children's Mental Health
Department of Children and Families
Tallahassee, Florida

Charles Hendricks Brown, PhD
Professor
Epidemiology Department
University of South Florida
Tampa, Florida

Joe Brinales
Epidemiology and Biostatistics
College of Public Health
University of South Florida

Appendix F
Youth Mental Health Screening and Services Primary Physician Survey

Welcome. This survey is designed to gather information about youth mental health screening and services in the primary care setting. We'd appreciate if you take the time to answer the survey to the best of your abilities. For the purpose of this study we define "youth" as those who are 20 years old or younger. Please read instructions for each section. Thank you for your participation!

I. Mental Health Assessment/Screening
(Circle your response, check boxes and write down your responses where appropriate)

1. What is your perception of the prevalence of mental health related problems among your youth patients? Please rate prevalence on a scale of 1 to 9 (with 1 being not prevalent and 9 very prevalent).

_1_____2_____3_____4_____5_____6_____7_____8_____9

Not **Moderately** **Very**

Prevalent ***Prevalent*** ***Prevalent***

2. Do you routinely *use* a standard screening procedure to assess the mental health status of your youth patients?

1. Yes 2. No 3. N/A

(a) If your answer to 2 is YES, which one do you use:

1. Standardized tool, please specify:_____ 2. A self-developed tool
3. Other (please specify):_____

3. Are you aware if any of *your* patients have been determined to have a severe emotional disturbance in the past year?

1. Yes 2. None of my patients did 3. Not aware of any

(a) If Yes, how many in the past year? _____ Youth patients
(b) If Yes, were any of them diagnosed as a result of a referral from you?
1. Yes 2. No

4. Are you aware if any of *your* youth patients have attempted suicide or engaged in suicidal behavior the past year?

1. Yes 2. None of my patients did 3. Not aware of any

(a) If your answer to question 4 is YES, how many in the past year? _____ Youth
(b) patients

5. Are you aware if any of *your* youth patients have completed suicide in the past year?

1. Yes 2. None of my patients did 3. Not aware of any

(a) If your answer to question 5 is YES, how many in the past year? ____Youth Patients

6. Based on your experience, your location and your type of practice setting, please indicate how frequently do you encounter youths with the following risk factors, and indicate your screening practice for these risk factors? (Place a check in the appropriate boxes.)
For each risk factor select one answer from the first 4 columns ***and*** one answer from the last two:

RISK FACTOR	Very Frequently	Somewhat Frequently	Not Frequently	N/A	**Routinely Screen**	Do not routinely screen
a. Depression						
b. Family History of Depression						
c. Firearms in Home						
d. Alcohol Use or Abuse						
e. Prior Suicide Attempts						
f. Family History of Suicide						
g. Other Substance Use						
h. Family History of Substance Use						
i. Physical Abuse						
j. Sexual Abuse						
k. School Problems						
l. Fight with Significant Other						
m. Fight with Parent(s)						
n. Being HIV Positive						
o. Sexual Orientation						
p. Involvement with Juvenile Justice						
q. Delinquent behavior						
r. Conduct Disorder						
s. Other (please specify):_____						

7. When you identify youth patients with at-risk behaviors, do you provide additional information to youth and family members?

1. Yes 2. No

(a) If yes, what kind of information do you provide the youth and family members? (circle all that apply)

1. Written material in the office 2. Verbal information

3. Refer them to credible information via Web site addresses

4. Other (please specify):_____

II. Referral Practice & Accessibility
(Circle your responses and write down answers where appropriate.)

8. Do you have on-site mental health services available for your youth patients?
1. Yes 2. No

9. When you refer youth patients to mental health services, what is the most common method used in
your office? (circle all that apply)

1. Advise parents to make appointment 2. Make appointment through your office

3. Other (please specify):_____

10. To which of the following facilities do you refer youth patients who may be at risk for suicide?

(circle all that apply)

1. Private Mental Health Clinic 2. Community Mental Health Center 3. Mental Health ER

4. Pediatric ER 5. School-based services 6. Other (please specify):_____

11. To which of the following facilities do you refer youth patients who may be assessed as severely emotionally disturbed (SED)?" (circle all that apply)

1. Private Mental Health Clinic 2. Community Mental Health Center 3. Mental Health ER

4. Pediatric ER 5. School-based services 6. Other (please specify):_____

12. Do you have any follow-up procedure for patients you refer to mental health services?

1. Yes 2. No 3. NA

(a) If YES, Briefly describe follow up procedure: _____

13. Based on your referral experience, how would you rate the **accessibility** of youth mental health services in the community where you practice? Please rate overall accessibility of services on a scale of 1 to 9 (with 1 being not accessible and 9 very accessible)

_1_____2_____3_____4_____5_____6_____7_____8_____9
Not Accessible **Moderately Accessible** **Very Accessible**

14. How ***aware*** (or knowledgeable) would you say you are of the youth mental health services available in the community where you practice?

_1_____2_____3_____4_____5_____6_____7_____8_____9
Not aware at all **Somewhat Aware** **Completely aware**

15. As a primary care physician, what would you consider are the biggest barriers to effective mental health diagnosis, prevention/intervention with your youth patients?
(Please rank the following barriers by writing a 1 by the first most important barrier, 2 by the second most important barrier, and so on)

____ Inadequate insurance coverage for mental health problems
____ Inadequate reimbursement for screening for mental health
____ Not having enough [time] (resources) to screen for mental health problems
____ Lack of readily available information and resources about screening for youth mental health services
____ Unwillingness of young patients to trust doctors
____ Social stigma attached to mental health problems
____ Other (please specify):_____
____ Other (please specify):_____

16. Would you like to receive more information on youth mental health services in your area?

(a) Suicide prevention	1.Yes	2. No
(b) Severe emotional disturbance (SED)	1.Yes	2. No
(c) Other mental health services	1.Yes	2. No

(d) If YES to c, please specify: _____

(e) If you answered YES above, in what format would you like to receive the information (please check all that apply):

1. Electronic list of available mental health services 2. A list received via regular mail
3. Information posted on a Web site 4. Other (please specify):_____

17. How would you rate the impact of cultural diversity issues on mental health diagnoses and treatment among your youth patients? Please rate the impact on a scale of 1 to 9 (with 1 being no impact at all and 9 a great impact).

_1_____2_____3_____4_____5_____6_____7_____8_____9

No impact at all **Somewhat of an impact** **Great impact**

III. Physician and Practice Characteristics

(Circle your response and write down the answer where appropriate)

18. What is your gender? 1. Male 2. Female

19. What racial category do you belong to? (please circle only one answer)

1. American Indian or Alaskan Native 2. Asian or Pacific Islander

3. Black 4. White 5. Other (please specify)_____

20. What ethnic category do you belong to? (please circle only one answer)

1. Hispanic or Latino 2. Caribbean Islander 3. African-American 4. European

5. Multi-ethnic 6. Asian 7. Other (please specify):_____

21. What county is your primary office located in (please circle)? 1. Broward 2. Alachua

(a) What is the zip code for your primary office? Zip code:_____

22. Are you a Board Certified physician? 1. Yes 2. No 3. In Process

(a) Please specify specialty and/or training: _____

23. How long have you been practicing medicine? _____Years

(a) How many years (or months) have you been practicing in the county where your primary office is presently located? ____ Years _____Months

24. How would you categorize your primary practice? 1. Mainly Pediatrics

2. Pediatric subspecialty 3. Family/General Practice 4. Other, (please specify):_____

(a) If your answer to question 23 is Mainly Pediatric, up to what age are your pediatric patients?

____Years old

25. Please indicate or identify your primary practice setting: 1. University based Clinic

2. Health Department Clinic 3. Private Practice 4. Hospital based Clinic

5. HMO/ Managed Care Team 6. Other (please specify):_____

26. What is the approximate number of youth patients (ages 5-20) currently seen in your practice per week? _____ *Youth* Patients

Thank you again for your time in completing this survey.

Appendix G
Resource Package Mailing

Alachua County

March 19, 2003

Dear Doctor:

We would like to extend our appreciation to all who recently participated in a research study survey entitled "Primary Care Provider Survey of Youth Mental Health Services." Your responses helped us a great deal to better understand perceptions and practices of primary care physicians about youth mental health and mental health services in their respective communities. The survey results provide us with necessary information that will be used to plan awareness and education strategies to prevent youth suicide and improve services for children with severe emotional disturbances.

Whether you participated in the study or not, on behalf of the Institute for Child Health Policy and Nova Southeastern University we are sending this resource package in thanks for your support and dedication to your patients. This thank you package contains the Alachua County Resource Services Guide, the Pediatric Symptom Checklist (child psychosocial screening tool) and scoring guide, and the Florida Youth Suicide

This research is funded through a State of Florida "Drug Free Community" grant to the Institute for Child Health Policy at Nova Southeastern University. If you have questions about being a participant in this research study or about information contained in this thank you package, you may call us at 954-262-1932 or 1-800-541-6682 extension 1932.

Most sincerely,

Deborah Mulligan-Smith, MD, FAAP, FACEP
Director and Professor, Institute for Child Health Policy
Nova Southeastern University

Broward County

September15, 2003

Dear Doctor:

We would like to extend our appreciation to all who recently participated in a research study survey entitled "Primary Care Provider Survey of Youth Mental Health Services." Your responses helped us a great deal to better understand perceptions and practices of primary care physicians about youth mental health and mental health services in their respective communities. The survey results provide us with necessary information that will be used to plan awareness and education strategies to prevent youth suicide and improve services for children with severe emotional disturbances.

Whether you participated in the study or not, on behalf of the Institute for Child Health Policy at Nova Southeastern University we are sending this resource package in thanks for your support and dedication to your patients. The package includes:

- ✓ The Broward County *One Community Project* Mission and Vision Statement
- ✓ Introduction to *CCB 2003 Broward Community Resource Inventory Guide*
- ✓ *Connections for Kids 2003, A guide of services for the children of Broward County.*
- ✓ The *Florida Youth Suicide Fact Sheet*.
- ✓ *NSU Psychology Center* information brochure.
- ✓ The *Pediatric Symptom Checklist* (child psychosocial screening tool) and scoring guide.
- ✓ The *Primary Care Provider Survey of Youth Mental Health Services*

If you have questions about being a participant in this research study or about information contained in this thank you package, you may call us at 954-262-1942 or 1-800-541-6682 extension 1942.

Most sincerely,

Deborah Mulligan-Smith, MD, FAAP, FACEP
Director and Professor, Institute for Child Health Policy
Nova Southeastern University

Appendix H
Meetings

Second Annual Broward County Legislative Breakfast
On Suicide Prevention
Agenda

Prepared by: Florida Initiative for Suicide Prevention and Institute for Child Health Policy at Nova Southeastern University
Date: February 26, 2003

I. Opening Remarks:
Frederick Lippman EdD, Executive Vice-Chancellor and Provost

II. Introductions: **Harry M. Rosen**, **Esq**., FISP Chairman

III. Recent Federal Efforts in Suicide Prevention:
Keri Lubell, Ph.D. Behavioral Scientist
National Center for Injury Prevention and Control (CDC)

IV. Defining Key Issues Affecting Mental Health Service Providers:
Anita Godfrey, CEO, Mental Health Association of Broward County

V. Florida Youth Suicide Prevention Prototype Project:
Deborah Mulligan- Smith, M.D., Director, Institute for Child Health Policy

VI. Advocacy and Grassroots Initiatives: **Rene Barrett**, Executive Director, Florida Initiative for Suicide Prevention, Inc. (FISP)

Legislative Panel Discussion Chaired by:
State Senator Steven A. Geller, Chair, Broward Delegation

Annual Report

Florida Suicide Prevention Task Force
Agenda

Place: Tallahassee, Florida
Date: March 26, 2003

9:30 a.m. - 10:00 a.m.	Coffee and Greetings
10:00 a.m.- 10:10 a.m.	Opening Remarks and Introductions Dir. Jim McDonough, Office of Drug Control
10:10 a.m. – 10:40 a.m.	Florida Suicide Prevention Coalition Update Terry Smith and Pam Harrington • Mission Introduction • Overview of the "Florida State Suicide Prevention Plan" Draft • Discussion on Partnering with the Volusia County Suicide Prevention Coalition
10:40 a.m.- 11:00 a.m.	Nova Southeastern University Update Dr. Deborah Mulligan-Smith • School-Based Resource Kit Progress Update
11:00 a.m. - 11:10 a.m.	1-800- SUICIDE-Brief Marshall Knudson
11:10 a.m. – 11:15 a.m.	Volusia County Prevention Coalition and Florida Suicide Prevention Coalition Conference Pam Harrington and Laura Meyer
11:15 a.m. – 11:30 a.m.	Suicide Prevention Day Events Dir. Jim McDonough, Office of Drug Control

Annual Report

Youth Committee – Florida Task Force on Suicide Prevention

Minutes

Date: June 30, 2003

Members:

Chair – **Terry R. Smith** – Florida Suicide Prevention Coalition

Rene Barrett – Florida Initiative for Suicide Prevention

Mary Jo Butler – Department of Education

Cristal Cole – Governor's Mentoring Initiative

Belinda McClellan – Agency for Health Care Administration

Deborah Mulligan-Smith – Nova Southeastern University

Frank M. Platt, LCSW – Department of Children & Families

Bernard Warner, Asst Sec – Department of Juvenile Justice

Mae Waters, PhD, CHES – Department of Health

Steven Wiggins, Sr Psychologist – Department of Juvenile Justice

Frank Zenere, EdS – Miami-Dade Public Schools

Committee: (24 & under)

I present for your thoughts again these items. I will be out of the state for most of the rest of July. We have our presentation to the Task Force on Friday, August 1. Please post your thoughts for group discussion.

Possible Action Items:

q Evaluate suicide prevention programs currently in:

o K-12 - What is each school district currently doing to address suicide prevention, intervention and postvention?

o Community College

o College/University schools

q Develop and provide school districts statewide model suicide prevention "Policies and Procedures" program to be adopted by the local school boards.

q Evaluate the 1990 state mandate that suicide awareness be a component of teacher certification?

q Evaluate the 1990 state mandate that suicide awareness be a component of Life-Management Skills classes taught in secondary education level?

q Monitor and evaluate the goal of the Governor's "Preventing Suicide in Florida – A Strategy Paper" to decrease the incidence of teen suicide in Florida by one third (from 9.52 per 100,000 in 1998 to approximately 6.0 per 100,000 in 2005).

q Monitor the Community Based Youth suicide prevention program being conducted by Deborah Mulligan-Smith Pilot Programs in Alachua & Broward counties and the "School Based Suicide Prevention Tool Kit".

q Research and evaluate youth based suicide prevention programs that are currently available.

q Other items the Committee would like to explore?

Thank you all for your work with the Task Force and the Youth Committee.

Annual Report

Youth Committee – Florida Task Force on Suicide Prevention
Minutes

Date: August 1st, 2003

- Introductions

- Legislative Committee Update
  Keep the suicide prevention message concrete and not diluted with other issues. Legislation should be focused on schools and teaching in schools. Coordinate with other committees to determine the specifics related to a suicide prevention staff person.

- Grant Research Committee
  Funding sources should be researched for organizational efforts, media efforts, training models, and studies. Follow up by the committee, "from where to what." Comments should be forwarded. Identifying a catalyst as a principle. What should organizations do and where should the money go. Come up with a matrix. Build a catalog of funding sources. Task Force members should e-mail to Mike Smith current grants and research being funded and pursued.

- University Research Committee Brief
  Florida has a unified medical examiners system; better than most states. Different ways should be devised to capture the data. Look to the vital records board and seek legislative support to do a study to determine specific statistics, in specific, relating to deaths per capita (taking into consideration a growing population). David Shern, Bruce Goldberger, and Wayne Goodman have been identified to initiate this. Deborah Mulligan-Smith should also coordinate on this effort as well. Look into ethnic breakdown of those who commit suicide.

- SUN Program Report

- Adult Committee Brief
  Target a message to the workplace or determine where there is a high rate of adult suicides. Isolate information and capitalize to reach those in need. Seek data from the University Research Committee. Break the age group down. Where are most of the deaths? Identify specific areas. Media campaign is imperative; advertise programs, 1800 Suicide, etc. Members from the Task Force should request to meet with the FMA during their board meetings. Look into the new corporate mental health-substance abuse board and put suicide prevention on the agenda.

- Elder Committee Report
  Combine efforts with a successful elders program in Broward County. Deborah Mulligan-Smith is willing to assist. Mike Smith will look into possible funding sources to implement elder suicide programs. Look into developing an assessment tool and distribute through the Department of Elder Affairs and the Department of Children and Families. Elders should be involved in mentoring programs.

- Youth Committee Report
  Dr. Goldberger can look into specific statistics related to youth. Committee emphasized the need for a full-time person to work on suicide prevention.

- Public Affairs Committee
  TeenScreen should be considered to fund the campaign. Jim McDonough will work with David Shern to bring this up to TeenScreen. One ribbon should be introduced as an identifier. Establish a website for suicide prevention. Identify a "poster person." All Task Force members should present ideas for a PR campaign.

- Government Committee Report
  Tie into the Agency for Workforce Innovation. This committee should make a map of efforts to be considered. All agency reps need to work with Lisa Vander-Werf Hourigan and give a great amount of support.

- Law Enforcement Report
  Data and reporting needs to be more specific. Law enforcement is involved in many suicides. Recommend that law enforcement have more assistance in training for Crisis Intervention Teams. Focus should be on educating law enforcement professionals. Law enforcement should be trained in intervention and prevention.

- Eliminating the Barriers Initiative
  National media campaign to target eliminating mental health barriers. There is a marketing plan and lead from each state.

Annual Report

NSU'S Interdisciplinary Patient and Family Faculty Program Task Force Agenda*

Date: July 10th, 2003

Room: HPD 1563

8:30 A.M.- 9:00 A.M.	Welcome Breakfast and Introductions
9:00 A.M.- 9:15 A.M.	Review of White Paper
9:15 A.M.- 10:30 A.M.	Keynote Speaker: Beverley H. Johnson, President/CEO Institute For Family-Centered Care
10:30 A.M.- 10:40 A.M.	Coffee Break
10:40 A.M.- 11:00 A.M.	Parents and Providers: A Powerful Partnership Shelley and Arthur Green
11:00 A.M.- 11:20 A.M.	A Pediatric Perspective Dr. Deborah Mulligan-Smith Director, Institute for Child Health Policy at NSU
11:30 A.M.- 1:30 P.M.	"Working Lunch" in Chancellor's Board Room- HPD 1509 Goal: Development of an Interdisciplinary Strategic Plan. Where are we now? Where do we want to be?

*Meeting facilitated by Shelley and Arthur Green
Dean: Human Development and Family Services
Fischler Graduate School of Education and Human Services
Arthur Green, J.D./NSU Adjunct Faculty

Annual Report

School-Based Suicide Prevention Tool Kit Project

Institute for Child Health Policy at Nova Southeastern University

Minutes

Date: May 27th, 2003
Venue: Telephone Conference
Time: 11:05 am

The aim of the conference was to ascertain the progress being made with regards to the School Suicide Prevention Tool Kit.

Welcome and apologies:

Dr. Mulligan-Smith welcomed the participants. Special welcome was extended to Kathy Lazear, newly appointed Project Coordinator for the School Suicide Prevention Tool Kit and Delphene Barrett new Administrative Assistant at the Institute for Child Health Policy at Nova Southeastern University. The participants were:

Delphene Barrett, Administrative Assistant

Kathy Lazear, Project Investigator

Maria Elena Villar, Research Scientist

Cheng Wang, Research Scientist

Apologies were given for the following individuals who were unable to participate due to prior engagement:

Karen Blasé, Former Project Investigator

Stephen Roggenbaum, Project Coordinator

Costa, Research Associate

Mary Armstrong, Consultant

Business Discussed:

This telephone conference was the first conference in which Ms. Lazear was participating as project investigator for the School Suicide Prevention Tool Kit. She stated that due to her newness to the position she would appreciate some background information about the "Tool Kit." Dr. Mulligan-Smith presented the background information as requested.

Dr. Mulligan-Smith emphasized the need for a distinction between suicide and substance abuse as it relates to this "Tool Kit." Ms. Lazear, who is now in charge of putting the "Tool Kit" together, endorsed the approach. Dr. Mulligan-Smith informed her that the "Tool Kit" should be ready by December 2003. Meeting this deadline was imperative, because the "Kit" should be signed off by the schools in the same month. Ms. Lazear confirmed her ability to meet the December 2003 deadline for completion of product.

As it relates to focus groups, Ms. Lazear expressed that she was "comfortable with the number of adults and children in the groups." In addition, she indicated that the focus groups would be finished by the end of June.

Dr. Mulligan-Smith raised questions about information presented in an annotated bibliography submitted recently by Mr. Roggenbaum. Ms. Lazear was unable to answer the questions raised. However, she stated that contact would be made with Ms. Francis and Mr. Roggenbaum for the answers.

Ms. Villar suggested that the Florida Mental Health Institute team investigate what is in the America Foundation for Suicide Prevention Social Marketing Tool Kit in order to avoid needless duplication of efforts and identify how best to build on what has already been done. In addition, she asked that they ascertain the role of the Columbia Depression Scale in Project SOS and Columbia Teen Screen, as well as assess other screening tools used in school settings.

Dr. Mulligan-Smith mentioned that social marketers were helpful in identifying what individuals were looking for in The Family Disaster Readiness Tool Kit. As a result, she suggested that social marketers be consulted early in the process to do the same for the School Suicide Prevention Tool Kit. She further added that, school based Life Skills Management and Values Classes are excellent avenues to disseminate the parts of the Tool Kit relevant to students.

Ms. Villar asked whether or not schools were contacted for their input as it relates to the method of dissemination that should be used. In response, Ms. Lazear stated that they were and in addition, students were asked by their teachers to make suggestions.

According to Dr. Mulligan-Smith, the tool kit should be designed in a manner that teachers can follow a step-by-step procedure when using it. Ms. Villar recommended that the kit encompass the wider community, which includes: families, primary care providers, volunteer groups and mental health providers in order to maintain a link between the school and the family. Dr. Mulligan-Smith, who also added that the kit should have a team approach, endorsed Ms. Villar's suggestion.

The date for the Expert Panel is confirmed for July 30, 2003.

In closing Ms. Lazear emphasized her enthusiasm to work on the "Tool Kit" project. The next meeting was tentatively scheduled for July 9, 2003 in Tampa. The telephone conference ended at 12:10 PM.

Comprehensive Health Information System Council (CHIS)

DRAFT

Date: August 20, 2003

Beginning Time: 10:30 am
Venue: Teleconference

Members Present: Mr. James Brodie substituting for Dr. Rhonda Medows, Ms. Kim Shafer substituting for Mr. Charles Bement, Ms. Diane Godfrey; Ms. Barbara Hawthorne, Mr. Scott Keller, Ms. Edith Orsini, and Ms. Kim Streit

AHCA Staff Present: Ms. Beth C. Dye, Ms. Beth Eastman, Ms. Katherine Holzer, Ms. Carolyn Turner, and Mr. Tom Warring

Members Absent: Ms. Pamela Adams, Mr. Perry Brown, Dr. Michael Howell, and Mr. Rich Robleto

Others Participants: Mr. Jim Bracher representing J. Bracher & Associates, Ms. Maritza Concha for Deborah Mulligan-Smith representing the Institute for Child Health Policy at Nova Southeastern University, Ms. Taryn Davis representing JMH Health Plan, Ms. Lisa Eaton representing Florida Healthy Kids Corporation, Ms. Kenna Holzen representing Tenet Healthcare, Mr. Larry McLaughlin representing HealthCare Research Associates, Mr. Wayne Schiefelbein representing Rose, Sundstrom & Bentley, LLP, Ms. Donna Slosburg representing the Florida Society of Ambulatory Surgical Centers, and Mr. Bob Wychulis representing the Florida Association of Health Plans, Inc.

Meeting Materials: Agenda, Minutes, and Ad Hoc Work Group on Complaint Data

I. Opening Remarks
James K. Brodie

Mr. James Brodie, Chief, Interagency Operations, Agency for Health Care Administration (AHCA), opened the meeting and welcomed members on behalf of the Secretary.

II. Review and Approval of Minutes from 6/4/03
All

Motion to approve the minutes: Mr. Scott Keller
Second the motion: Ms. Kim Streit
Motion carried.

III. Status of Membership Changes
Jim Brodie

Mr. Brodie noted that the State Comprehensive Health Information System Advisory Council (CHIS) is to have a total membership of 13 members per 408.05(8) Florida Statutes. Currently, there is one vacancy to be appointed by the Department of Education. There are four active members (Pamela Adams, Diane Godfrey, Scott Keller, Kim Streit) whose term of office will expire on the 31st of August.

Mr. Brodie indicated that the *Questionnaire for Secretarial Appointments* had been sent to the four members to return if they wish to be considered for a reappointment. Members were requested to return the questionnaire by August 25. Other applications may be received during this time.

Ms. Diane Godfrey asked about types of representation required by the statutes establishing the CHIS. Mr. Brodie read from the statutes:

8) STATE COMPREHENSIVE HEALTH INFORMATION SYSTEM ADVISORY COUNCIL.--

(a) There is established in the agency the State Comprehensive Health Information System Advisory Council to assist the center in reviewing the comprehensive health information system and to recommend improvements for such system. The council shall consist of the following members:

1. An employee of the Executive Office of the Governor, to be appointed by the Governor.

2. An employee of the Department of Insurance, to be appointed by the Insurance Commissioner.

3. An employee of the Department of Education, to be appointed by the Commissioner of Education.

4. Ten persons, to be appointed by the Secretary of Health Care Administration, representing other state and local agencies, state universities, the Florida Association of Business/Health Coalitions, local health councils, professional health-care-related associations, consumers, and purchasers.

Ms. Godfrey indicated that she supported the reappointment of Ms. Streit. She indicated that she was also willing to continue to serve either on the CHIS or through participation in work groups established by AHCA.

IV. Status of Emergency Department Data Development

Katherine Holzer

Ms. Holzer reported that a second rule development workshop on the proposed amendments to the ambulatory patient data collection rule is scheduled for August 25, 2003. The proposed amendments will incorporate emergency department patient data in the reporting requirements.

Ms. Holzer indicated that this workshop might be the last prior to the formal filing of the rule amendments.

Ms. Godfrey asked about whether hospitals had expressed concern about the costs or difficulty of retrieving and reporting the data. Ms. Streit indicated that hospitals gave comments at the first rule development workshop.

Ms. Shafer proposed a survey of hospitals regarding their ability to report the proposed data elements. Ms. Streit and Ms. Holzer noted that a survey was performed prior to the first rule workshop. The survey requested information about hospitals' capacity to report the data.

Ms. Holzer indicated that the current proposal excludes data fields that were not readily available as determined by the results of the survey and comments received at the workshop.

V. Status of Ad Hoc Work Group on Complaint Data

Carolyn Turner

Ms. Turner indicated that an ad hoc work group has been established. The purpose of the work group is to consider what types of complaint data might be published by AHCA for consumer information.

A meeting of the work group will be held in Tallahassee on September 9, 2003. Ms. Turner reported that the meeting has been noticed and materials have been sent to work group members and HMO Report Work Group members.

The Ad Hoc Work Group will report their findings at the November meeting of the CHIS.

VI. Status of Ambulatory Surgery Guide 2004

Carolyn Turner

Ms. Turner reported that the ambulatory surgery guide is on schedule for publication in 2004. As work is completed, additional materials will be sent to the Ambulatory Surgery Guide Work Group for review. The format will be similar to that of the *Florida Hospital Services Guide 2003*.

Ms. Turner noted that the hospital guide is now available in print and on www.FloridaHealthStat.com. The interactive version of the guide will be available on the web site soon. She encouraged CHIS members to look at the interactive version of the guide when available.

VII. Status of HMO Report 2003 & 2004

Carolyn Turner

Ms. Turner reported that *Choosing A Quality Health Plan: Florida HMO Report 2003* has been approved for publication. She expected that the report would be available on www.FloridaHealthStat.com by the end of the month. Printed copies will be available in September.

Data collection for the 2004 report is underway. Ms. Turner indicated that a memorandum had been sent to HMOs requesting member sample for the survey to commence October 1, 2003.

VIII. Next Meeting: November

All

The next CHIS meeting was scheduled for Tuesday, November 4, 2003 in Tallahassee starting at 11:00 a.m.

IX. Adjournment

The meeting adjourned at 11:00 a.m.

Appendix I
Capital Rotunda Display

A presentation on the School Suicide Prevention Resource Kit was provided by Principal Investigator, Dr.Mulligan-Smith.

Additionally, the Institute of Child Health Policy participated in the *Capitol Rotunda Display*. The Youth Suicide Prevention Prototype Program display included:

- *Youth Suicide Prevention Prototype Program* Information
- Florida's Response to Suicide by Children: Florida Youth Suicide Fact Sheet (Appendix 5)
- Broward Days at the Capitol: Health Care Committee Position Paper (Attachment 1)
- Broward County Board of Commissioners Proclamation declaring March 26, 2003 as Suicide Prevention Day.
- Broward County School Board Resolution declaring March 26, 2003 as Youth Suicide Prevention Day.

Appendix J
Task Force Members

FLORIDA SUICIDE PREVENTION TASK FORCE COMMITTEE MEMBERSHIP

*(nm) Not a member of the Task Force

PUBLIC AFFAIRS COMMITTEE

NAME	ORGANIZATION
Pam Harrington-Chair	SPAN USA
Rick Miller-Co Chair	Department of Community Affairs
Lisa VanderWerf-Hourigan	Department of Health
Liza McFadden	Governor's Mentoring Initiative
Natalie Kelly	Alzheimer's Association of Florida
Donna Cacciatore	Crisis Center of Tampa Bay
Laura Meyer	SPAN USA
David Shern	University of South Florida (FMHI)
Rene Barrett	Florida Initiative on Suicide Prevention
Phil Spooner	Agency for Workforce Innovation
Belinda McClellan	Agency for Health Care Administration

GRANT RESEARCH COMMITTEE

NAME	ORGANIZATION
Mike Smith-Chair	Florida State University
Rick Miller-Co Chair	Department of Community Affairs
Gene Cash	Fl. Assoc. of Florida School Psychologists
Wayne Goodman	University of Florida
Harry Smith (**nm**)	Department of Children and Families

UNIVERSITY RESEARCH COMMITTEE

NAME	ORGANIZATION
Wayne Goodman-Chair	University of Florida
Sheriff Donald Eslinger	Seminole County Sheriff's Office
David Shern	University of South Florida (FMHI)
Deborah Mulligan-Smith	Nova Southeastern University
Mike Smith	Florida State University
Marshall Knudson	Crisis Center of Alachua County
Steven Freedman	University of Florida
Paula Hoisington	Department of Corrections
Mary Jo Butler	Department of Education

YOUTH COMMITTEE

NAME	ORGANIZATION
Terry Smith-Chair	Florida Suicide Prevention Coalition
Steve Wiggins	Department of Juvenile Justice
Rene Barrett	Florida Initiative on Suicide Prevention
Frank Zenere	Miami-Dade Public Schools
Frank Platt (**nm**)	Department Children and Families
Cristal Cole (**nm**)	Governor's Mentoring Initiative
Mary Jo Butler	Department of Education
Deborah Mulligan-Smith	Nova Southeastern University
Mae Waters **(nm)**	Department of Health
Gail Flores **(nm)**	Department of Education

ADULT COMMITTEE

NAME	ORGANIZATION
Donna Cacciatore-Chair	Crisis Center of Tampa Bay
Laura Meyer	SPAN USA
Marshall Knudson	Crisis Center of Alachua County
Georgette Daniels	Office of Policy and Budget

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ELDERS COMMITTEE

NAME	ORGANIZATION
Ken McLeod-Chair	Department of Elder Affairs
Pam Harrington	SPAN USA
Natalie Kelly	Alzheimer's Association of Florida
Rene Barrett	Florida Initiative on Suicide Prevention
Carol Barr-Platt (**nm**)	Department of Children and Families
Dr. Schonfeld (**nm**)	Florida Mental Health Institute (USF)
Larry Dupree (**nm**)	Florida Mental Health Institute (USF)
Donna Cohen (**nm**)	Florida Mental Health Institute (USF)

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LEGISLATIVE COMMITTEE

NAME	ORGANIZATION
Natalie Kelly-Chair	Alzheimer's Association of Florida
Andrew Palmer	Office of Policy and Budget
Sheriff Donald Eslinger	Seminole County Sheriff's Office
Gene Cash	Fl. Assoc. of Florida School Psychologists
Pam Harrington	SPAN USA
Terry Smith	Florida Suicide Prevention Coalition
Rene Barrett	Florida Initiative on Suicide Prevention
Susan Latvala (**nm**)	County Commissioner (Pinellas County)

GOVERNMENT COMMITTEE

NAME	ORGANIZATION
Lisa VanderWerf-Hourigan-Chair	Department of Health
Liza McFadden	Governor's Mentoring Initiative
Paula Hoisington	Department of Corrections
Celeste Putnam	Department of Children and Families
Mary Jo Butler	Department of Education
Ken McLeod	Department of Elder Affairs
Belinda McClellan	Agency for Health Care Administration
Rick Miller	Department of Community Affairs
Andrew Palmer	Office of Policy and Budget
Phil Spooner	Agency for Workforce Innovation
Bernard Warner	Department of Juvenile Justice
Steven Wiggins	Department of Juvenile Justice

LAW ENFORCEMENT REPORTING COMMITTEE

NAME	ORGANIZATION
Sheriff Donald Eslinger- Chair	Seminole County Sheriff's Office
David Shern	University of South Florida (FMHI)
Wayne Goodman	University of Florida
Bruce Grant	Office of Drug Control
Mike Smith	Florida State University

Appendix K
Florida Task Force on Suicide Prevention: A White Paper

Preventing Suicide In Florida

A Strategy Paper By the Florida Task Force on Suicide Prevention

A. James McDonough, Chair, Director of the Office of Drug Control

►Purpose

The purpose of this strategy paper is to provide policy direction to Florida's state and community leaders in order to decrease the incidence of youth suicide in Florida. The authors comprise a task force brought together under the direction of the Governor of the State of Florida consisting of suicide victims' survivors, suicide prevention support groups, medical experts and government officials. Their intent is to provide programs and initiatives that will lead to progress toward stated goals and objectives ensuring lower suicide rates in general and appreciably lower numbers of youth and elder suicides in particular. The insights and recommendations offered herein are drawn from experts in the field dedicated to preventing the tragedy of suicide. The experts we have consulted or whose work we have drawn from include:

- Parents who have survived the tragic deaths of their own children and are passionately committed to preventing other families from experiencing the devastating effects of these self-destructive acts;
- The Office of the U.S. Surgeon General, whose detailed strategy and related papers on suicide have brought together the best information available nationwide;
- National researchers in this field, who have identified evidence-based prevention and intervention practices.
- Florida's child-serving and elder adults agencies, including the Departments of Health, Education, Children and Families, Elder Affairs and Juvenile Justice, each of whom can play a key role in addressing this serious problem;
- Associations and organizations at local, state, and national level known for their commitment and objectivity in informing the public as to the extent of the problem and in advancing methods to alleviate it.

The factors that contribute to a suicide are complex and diverse; accordingly the efforts to prevent suicide must incorporate multiple approaches. This paper is not offered as a conclusive answer to the tragedy of suicide. Instead, it is meant to be a start -- a statement of the extent of the problem, a summation of the available data, an identification of the information not available but necessary for a solution, a listing of available methods of mitigating suicide risk, and a call for specific actions to alleviate the problem. As such, its prime value is in: (1) formulating a base upon which further knowledge and information can be added as they become available, and (2) as a policy beginning to which can be added increasing numbers of programs, initiatives, and processes as they are developed.

►Background

Recognizing that statistics, trends, and facts are very important in the analysis of any issue, the authors of this paper have reviewed the latest data and research findings on suicide. What the data cannot show, however, is the overwhelming anguish felt by the family, friends, and the entire community when an individual dies from his or her own hand. Whenever a family loses a loved one, the grief is deep and painful, but when the death is by suicide, the hurt can be even more agonizing. Too often the surviving family members are stigmatized, adding to their burden of hurt and intensifying their isolation.

Parents, siblings, friends, and others who knew the deceased often feel that if only they had "done something" the person would still be alive. Parents especially can feel overpowering guilt for not realizing something was wrong in their child's life, or certainly nothing serious enough to end in death. Sadly, sometimes in hindsight it becomes apparent that the person was in distress but no one close knew how to assess the risk of suicide, leaving those who might have helped uninformed of the risk of suicide and what to do about it.

The reality is that not only are concerned individuals devoid of systemic ways to become aware of and respond appropriately to potential suicide, so too are health professionals. The latter face many challenges when caring for those with mental health problems related to high risk behaviors leading to suicidal ideation or actual suicide attempts. Already stressed emergency medical facilities are often overwhelmed by the need to provide emergency care or placement for patients that are considered a threat or harm to themselves or others. Identification of high-risk patients proves insufficient in and of itself. Without systems in place to follow-through on identification of a potential suicidal person, the worst may follow.

For example, it is not uncommon for a depressed, suicidal 15 year old to wait for hours or even days in an emergency department while efforts are made to find a mental health facility or hospital that has the space or expertise for care. During this time the patient and his or her family become increasingly stressed. Often parents become embarrassed or angry and try to convince the medical staff that their child can be treated as an outpatient. Even when admission for follow-through care does occur, it is often for only one or two days, insufficient time to address the problem.

Florida emergency medical facilities and physicians seeing high volumes of patients displaying risk factors of potential suicide report the following:

- Difficulty in determining the patients' insurance or funding status and assigned primary care physician. These problems are exacerbated in emergency department settings after regular business hours.
- Difficulty in determining what mental health facility or plan is contracted with the insurance company, HMO, or payer.

Delays in high risk patients being accepted for inpatient mental health or psychiatric care for a variety of reasons that included: proof of coverage; facilities having over-extended capacities; facilities not accepting children and/or adolescents;

- unavailability of medical personnel authorized to make decisions; and demands for inappropriate medical evaluations and tests at the emergency facility.
- Denial of inpatient mental health or psychiatric treatment if the patient is not actively suicidal despite any assurances that the patient will be adequately treated as an outpatient. Such denials were reported even after severe depression, and/or the patient having a very unstable home situation.
- Lack of mental health professionals willing to treat Medicaid patients (due to low reimbursements rates).

►Facts and figures

In recent years, Florida's suicides continue at a steady rate, showing a variation in the incidence per 100,000 from 14.26 in 1996 to 13.64 in 1998. These are unacceptable numbers that cannot be tied to any causality factors that would explain their failure to go down. Indeed, the ubiquity of suicide throughout the nation is shocking.

- In Florida in 1998, twice as many people died from suicide (2172 deaths) than died by homicide (1083 deaths). Nationwide there are approximately 31,000 suicides a year.
- In 1998, suicide was the second leading cause of deaths for Florida's youth aged 15-19
- For young people 15-24 years old, suicide is currently the 3rd leading cause of death, exceeded only by accidents and homicide.
- Suicide rates for women peak between the ages of 45-64, and do so again after 75.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease *combined*.
- Nearly 60% of all suicides are committed with a firearm.
- Not all deaths that are suicides are reported as such. For example, deaths classified as homicides or accidents, where individuals may have intentionally put themselves in harm's way, are not included in suicide rates.
- Suicidal individuals sometimes harm or kill other people before killing themselves.
- Recent studies show that 90% of teenagers who commit suicide have a psychiatric diagnosis, usually some form of depressive disorder, alcohol or substance abuse, or both.
- Medical costs in Florida for completed acts of suicide were estimated at $40 million in 1996; related costs were estimated at $662 million.
- Males commit suicide at a rate four times that of females. However, twice as many females as males attempt suicide.

►Causes of suicide

According to the *1999 Florida Youth Suicide Prevention Study,* (produced by the Florida Mental Health Institute, University of South Florida, for the Department of Children & Families)

Research indicates that youth suicide is inextricably linked to depression and other mental health disorders, substance abuse, violence and access to lethal means, and negative life events. According to the literature, the most commonly identified primary youth risk factors include affective illness such as depression, substance abuse, a prior suicide attempt, antisocial or aggressive behavior, a family history of suicidal behavior, and availability of firearms.

In addition, research has identified precipitant factors in youth suicide. Stressful life events as well as substance use are two. Also, most completed youth suicides were often preceded by a shameful or humiliating experience or the fear of failure or rejection, acute disciplinary crisis, or interpersonal conflict with a romantic partner or parent.

Although psychiatric problems are probably the most significant risk factor for suicide or suicidal behavior, few suicide victims are in treatment at the time of their suicide. One researcher suggests, "proper assessment and treatment of these psychiatric conditions are likely to be the most effective mechanism for the prevention of youthful suicide."

Despite such findings, the number of facilities providing pediatric or adolescent mental health services has declined due to financial constraints, lack of trained staff and a challenging (often unto frustration) work environment. Emergency departments, outpatient clinics and primary care physicians are often unaware of the current mental health resources available in their community and are thereby hampered in their ability to find placement for in or outpatient treatment for their patients. The difficulty involved in determining a patient's financial eligibility for specific mental health programs or facilities is often overwhelming and can delay the provision of care. In turn, the lack of care threatens to increase the probability of suicide.

Suicides, therefore, remain unchecked because of two general shortfalls. The first is a failure to recognize the risk factors and signals that indicate a higher probability of suicidal acts. The second is a diminished ability to get an identified suicide risk to timely, efficient and affordable treatment. Both shortfalls are tragic, but they are not insurmountable. Both can be addressed by better education, access to readily available information, integration of effort across agencies, organizations and facilities, and appropriation direction and application of resources.

►Prevention resources

Although the Task Force recognizes that there is a shortage of necessary suicide prevention resources, the fact remains that there are a number of existing entities that seek to address the problem of suicide.

These include:

Public information and referral: The Department of Health, Education, Children and Families, Elder Affairs, and Juvenile Justice are able to direct family and friends to community organizations, such as "First Call for Help", to provide information about mental health abuse and substance abuse services in all regions of the state. These "Information and Referral" providers can help a parent, teacher or friend locate professional help for an individual with depression, anxiety, substance abuse or other high-risk condition. While such local referral avenues are helpful, it follows that an integrated statewide referral system would be a logical "next step". At national level there is a 1-800-Suicide line.

Resources for parents: The Department of Juvenile Justice funds a parent hotline through a contract with the Florida Network of Youth and Family Services. A toll-free number (888) 41-Family, is widely advertised and staffed 24 hours a day, seven days a week by trained staff who offer advice and services to families whose children exhibit troublesome behaviors, such as running away, habitual truancy, or ungovernable behavior.

School-based prevention: The Department of Health, through its county health departments, works intensively with the public schools to provide health education for students, including mental and emotional health, the effects of alcohol and other drugs, and the development of nonviolent conflict resolution skills. Additionally, its School Health Program has assisted the local school districts develop suicide intervention plans and screening protocols.

Public education campaigns: Several of the state child-serving agencies have public education campaigns that address specific issues that put children at risk of self-destructive behaviors. Examples include alcohol and drug abuse prevention, promotion of child health and wellness, and child abuse prevention and reporting. Some of these prevention campaigns can be coordinated or redesigned to reach a broader target audience, as we know that prevention of some problems can help to prevent others. Bottom line, however, is that a specific public awareness effort addressing the prevalence of suicide and what can be done about it is needed.

Literature: There is no dearth of literature on the subject of suicide, much of it well informed and documented. The National Strategy for Suicide Prevention, produced under the auspices of the Centers for Disease Control and Prevention, is an excellent compendium of goals and objectives that, if met, should lower the incidence of suicide. It also includes an extensive list of references to which the sender can refer for additional information on specific subjects. In addition to scientific studies, strategies, and research papers, various associations, such as the American Foundation of Suicide Prevention, put out newsletters that update their membership on developments and share insights on how to address the problem. Moreover, there are available bibliographies on specific areas of

the issue. The Florida Department of Education, for example, through its Clearinghouse Information Center, offers for loan or a supply of books, videos, and other material on adolescent suicide issues.

Medical Organizations: A number of professional medical organizations and associations contribute to the effort to reduce suicide. The American Psychiatric Association, for example, maintains an excellent web site [http://psych.org/public_info/index.cfm] that presents facts on mental illness and lists other available agencies that can offer help and advice, such as the American Association of Suicidology, the National Mental Health Association, and others.

Advocacy Organizations: Born of tragedy and loss and driven by a commitment to lower the incidence of suicide and suicide attempts, a number of citizens' advocacy groups have come forward from around the country. Having suffered the consequences of a lack of information on the presence of potential risk factors in their own loved ones or, unable to find adequate medical means with which to respond, individuals have banded together to mitigate for others their own difficulties. The Suicide Prevention Advocacy Network, [SPAN USA], Yellow Ribbon Suicide Prevention Plan, American Association of Suicidology [AAS], Suicide Awareness/Voices of Education [SAVE], the Florida Initiative For Suicide Prevention, Inc. [FISP], and the American Foundation of Suicide Prevention [AFSP] are some of the groups formed.

► Goals

Florida is determined to bring down the rates of suicide. The intent of this strategy paper is to do just that by initiating and advancing programs that result in more information available to those who can use it before the act of suicide is attempted and, at the same time, to integrate available resources so that, once identified, potentially suicidal individuals can receive the necessary help in a timely fashion. How we plan to do these two things is discussed below, but it is important for us to set the specific targets up front. Therefore, our stated goals are:

- **To decrease the incidence of suicide in Florida by one third,** (from 13.64 per 100,000 in 1998 to approximately 9.0 per 100,000 in 2005).
- **To decrease the incidence of teen suicide in Florida by one third,** (from 9.52 per 100,000 in 1998 to approximately 6.0 per 100,000 in 2005).
- **To decrease the incidence of elder suicide in Florida by one third,** (from 20.34 per 100,000 in 1998 to approximately 13.0 per 100,000 in 2005).

► Discussion

In a perfect world, we would set as our goals the elimination of all suicides. We do not live in a perfect world, however, and human psychology and interaction being what they are, we can, sadly, expect that there will always be some who -- for whatever reason -- see no alternative but to take their own life. Therefore, no matter how determined and resourceful we may be as a society, we would delude ourselves if we thought we could eliminate suicide once and for all. But just as clearly as we see that we cannot eliminate suicide from the human experience, we can deduce that there is no predetermined reason -- nor collection of reasons -- that dictate that the current high rate of suicide must be accepted. In the past ten years over 300,000 Americans died by their own hand.

In the past decade, the suicide rate among adolescents has declined by 25%, most likely an outcome of better treatment modalities for depression and anxiety. On the other hand, since the 1950s, the number of suicides among15-24 years old has tripled. We have to ask ourselves, why is that so? This is not an infectious disease we are talking about, but a human activity, an act of violence against the very person committing the act. At a time in our history when we are rightly concerned about an HIV/AIDS epidemic that is claiming unacceptably high numbers of American lives, the sad fact is that we are undergoing a suicide epidemic that is killing more than twice as many.

Such realities are obscured from those most vulnerable to their toll. Suicide receives little publicity and by and large is ignored as an issue by those not yet affected by it. Therein lies the rub. Only when suicide is manifest does the shocking reality get driven home. By then, it may be too late.

Our activities, therefore, must be:

First, to heighten awareness of the potential for suicidal activity before it occurs an;

Second, to offer immediate and appropriate resources to curtail such activity once the propensity for it has been identified.

Of this we can be sure: Whatever chain of events transpired to bring together a deadly mix of societal and human phenomena that resulted in an increase in suicides in the last half of the twentieth century can be resisted by countervailing efforts to reverse the trends. We are not predestined to see ever increasing rates of suicide; nor are we compelled to accept the excessive rates that exist today.

The purpose of a strategy is to mobilize resources toward achievement of specified goals. By its very nature, a strategy is dynamic. It offers a plan that when mobilized will bring to fruition the end state it seeks to achieve. But it understands that the plan must be adjusted along the way to maximize progress toward the desired outcomes. It must learn as it goes, reinforcing the programs and initiatives that work well, and modifying and adapting the others to allow them to work better. This is such a strategy.

► What is to be done

First do no harm, but advance the science: There is no room for error in the business of suicide prevention. Whatever programs are adopted they must not lead to an increased incidence of suicide, the opposite of our intention. The history of suicide prevention instructs us that there is a chance that misguided programs that are too explicit in detailing the circumstances surrounding incidences of suicide can lead disturbed individuals to identification with both the cause and effect. The result could be a suicide that otherwise might not have happened.

Conversely, we cannot allow the fear of unintended consequences to stymie efforts to find more effective means of suicide prevention. While inappropriate or overly broad and indiscriminate models are to be avoided, we can set standards for independent research and evaluation that can lead to more effective modalities to prevent suicide. Not to do so would leave us an unacceptable paradox. To remain fixed only on proven methods and to avoid research into yet unproven areas is likely to negate any possibility of progress toward our goals. If the different experiences of youth today compared to a generation ago have resulted in an alarmingly higher incidence of suicide, we must determine what new approaches we can take to roll the numbers back. Limited responses to evolving epidemics are usually not the best way to head off serious health concerns. The answer, therefore, may lie in careful research by qualified experts subject to peer review, with enough control mechanisms in place to ensure progress is made. That means we must be prepared to commit adequate resources to the development and proof of effective suicide prevention strategies. Risk must be mitigated, but progress must be achieved. This has always been the challenge of medical science. There is no reason to believe that it cannot be met in the specific field of suicide prevention.

Integrate across agencies and organizations: Suicide is not an isolated issue, a phenomenon so distinct that it holds no relationship to other factors. To a large degree suicide has become the silent epidemic of our times. In varying degrees it is related to health issues, substance abuse, financial insolvency, disappointing inter-social relationships, lack of knowledge, familial difficulties, social mores, and other parameters, any or all of which may be entwined with each other. It makes no sense, therefore, for those committed to alleviating the causes of suicide to compartmentalize their efforts. We have the capacity to make the total effect of our many resources greater than the sum of their parts. Integration is key. Schools can help identify children in danger so that health agencies can provide relief. Substance abuse prevention programs can target high-risk populations so that treatment programs can purchase a new lease on life for the troubled. Advocacy organizations can provide mutual support for families of at risk individuals. Juvenile Justice services can screen troubled youth and the Department of Children and Families can provide services. Across the board, faith-based groups can come to the help of individuals contemplating suicide and families shocked and terrified by their so doing.

Each must know how the other is capable of assisting. Teamwork builds with an active appreciation of skills and capacities of all of the players. Not only should each of us learn <u>what</u> the other can do, we must learn <u>who</u> can do it. Simple steps such as reference

lists (i.e., readily available names and phone numbers) can help move a troubled individual to a medical professional in time to get appropriate assistance and then back to a family aided by a suicide support group. Achieving such streamlined effective support need not await the breakthroughs of future technologies or treatment modalities. It is essentially a systems-engineering challenge that can be met by dedicated people who not only are expert in their own fields but who are also aware of the entire spectrum of the problem and familiar with the people and places that can contribute to its solution. That solution, therefore, lies in informational awareness, cross-training, and available communications. More critically, however, the solution lies in the hearts and minds of dedicated individuals who are savvy enough and motivated to reach out to others who can provide assistance. In short, what we need is an integrated team effort there and with the right approach we can get it.

Mount a Public Information Campaign: Knowledge is power, and in the case of suicide prevention, it can be life itself. A public awareness effort on the prevalence of suicide and what can be done about it is key to success. To a large degree, suicide has become the ignored epidemic of our times. It is inconceivable that a phenomenon killing twice as many people per year as either HIV/AIDS or drug abuse is ignored by virtually the entire population that has not been personally affected by it. Where are the champions of suicide prevention -- the public icons, sports figures, media celebrities, and academic leaders who would alert the public of the dangers and what can be done about it? Where are the central coordinating authorities of government that have the capacity to integrate responsive efforts? In a ten year span that equates to the length of the Viet Nam War, five times as many Americans will die by their own hand as lost their lives in that war. Yet the streets are calm, the airwaves devoid of messages, and the bully pulpits quiet on the subject of suicide.

At 30,000 plus dead a year, suicide has become the proverbial elephant in the living room; so obvious in its enormity that conscious effort has to prevail to avoid its mention. But silence is deadly in this regard. We must overcome the reluctance to address so sensitive a subject; we must take advantage of the grassroots organizations and the requisite public offices prepared to speak out on the subject. With a some effort, we can reach out to Florida's citizens and the American people with a strong, effective, and positive message that at one fell swoop can promise to remove the stigma on families wounded by suicide, heighten awareness to all on the danger signs and appropriate responses, and decrease the death rates borne up by ignorance, fear, and isolation. In an age where there is universal agreement as to the power of marketing, there should be little doubt that we can devise an effective public information campaign that will get us toward our goal of fewer suicide deaths.

Train for Success: The growing body of knowledge on suicide prevention indicates a need for specialty training. It is not enough to be well meaning; family members, law enforcement officials, teachers, health-care professionals, and potential suicides themselves must have the skill sets to avert suicidal tendencies.

We need to provide training for caregivers and community leaders. Research has shown that suicide is neither random nor inevitable. There are risk factors, warning signs and protective factors that all affect suicide. Training programs should include specific and

current information on how to access professional assessment and treatment resources in the local community. The Surgeon General recommends instituting training for all health, mental health, substance abuse and human service professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions. This strategy adds to the recommendation that training should be made available to parents, foster parents, and other adults who provide care or supervision for children and adolescents, (to include youths in colleges and universities), as well as the elderly.

Since the reservoir of proven training programs is limited, there needs to be a programmatic commitment to the development of responsible, well-targeted, innovative training models subjected to carefully constructed and independent research protocols. Early intervention is key and must include teachers and school personnel. The latter are likely to perceive early indicators of depression, self-destructive and/or violent tendencies, and withdrawal from social interactions. At the opposite end of the age spectrum, training for elderly care-givers (as well as family members) would be key.

No team can enter the field of play without training and expect to be victorious. Suicide presents a formidable -- but not insurmountable -- foe; the more we train in specific skills (e.g., recognition of signs of suicide risk, efficacious and timely interventions, emotional and systemic support for potential victims and their families, etc.) the more we can expect the requisite team effort to be effective. We need a training system thought through from start to finish, one that begins with research modalities, advances curricula and training programs to individuals and organizations throughout the chain of concern and care provision, and provides periodic refresher and update mechanisms.

Limit Access to Expeditious Means of Suicide: Suicide is an act of violence one whose execution is likely to inflict enormous physical pain upon the victims. Born of a psychological calculation clouded by depression, desperation, and confusion, its object is to remove oneself from the perceived cause of affliction. Pain, therefore, is merely a byproduct of the act, and in most instances, in the mind of the potential suicide victim, preferably avoided or at least mitigated. The net result is that the more one calculates that the duration or intensity of pain can be lessened; the more likely he or she will proceed with the act. Accordingly, it is not surprising that the majority of suicides are committed by means of a firearm.

It is axiomatic, therefore, that the more we can restrict access to expeditious means of suicide, the more successful we can be in reducing the act itself. As impulse gives way to contemplation of the stress of the action itself, as well as to its fatal consequences, the less likely will be the propensity to follow through. For youth and young adults, especially the less the immediate access to firearms, particularly when the risk factors are present, the less likely the act of suicide. Moreover, the probability of successful completion of the act goes down markedly when firearms are not used. For example, only 10 per cent of the self-poisoning attempts in 1999 were successful; 90 per cent of the firearm attempts succeeded. For older adults, supervising the dosages of legal but potent drugs could reduce suicide rates, especially when suicidal tendencies are evident.

Lower suicide rates can be realized with a combination of public information and caregiver and familial responses. The simple formula is to not make it easy for those so

inclined to kill themselves. While those determined to overcome any fear of pain and any obstacle in their path cannot be forever protected from themselves, we can increase the probability of deterrence by limiting access to expeditious means of self-destruction, thereby -- at the least -- buying time for healing to occur and reason to prevail.

Develop a Responsive Health Care System: We must enhance the ability of the medical community to support. Pediatricians, family practitioners, and physicians in the county health departments should be encouraged to routinely assess the emotional and behavioral health of individuals they see in their practices. Physicians who administer the early and periodic screening, diagnosis and treatment of children and elderly adults covered by Medicaid should be encouraged to use optional screening tools for identifying mental health and substance abuse issues and then refer those individuals for assessment and treatment. Training should be provided for physicians on the warning signs of depression in individuals and other conditions that present a high risk for suicidal behaviors.

We also need to expand mental health and substance abuse assessment and treatment for Florida's adults and children. Scientific research has shown that almost all people who kill themselves have a diagnosable mental or substance abuse disorder and the majority has more than one disorder. Clear progress has been made in the scientific understanding of suicide and mental and substance abuse disorders, and in developing effective interventions to treat these disorders. In order for treatment to work in preventing suicidal behaviors, however, family members, friends and other caregivers need to know where to go for advice and help. Barriers to accessing treatment -- such as waiting lists and non-availability of treatment resources -- must be eliminated.

We need to challenge and reward schools and communities to protect children from bullying and other forms of harassment and intimidation. A teacher in South Florida starts each school year by listing on the blackboard all the ugly, insulting terms the class can think of that children use against each other. He then erases the board and tells his class that those terms will not be tolerated in his classroom. We need to encourage adults to actively protect children from bullying, harassment and discrimination in the schools and in the broader community. Recognition and incentives should be provided to teachers, coaches, youth ministers, scout leaders and other community "gatekeepers" who exemplify the role that adults should play in protecting children.

Based upon specific feedback from medical professionals in Florida concerned about current deficiencies (see background discussion) among the immediate steps needed are:

- Training of healthcare professionals (EMTs, nurses, physicians), law enforcement and school staff to recognize the early risk signs for suicide.

- Development of community-based systems to identify mental health and other resources.

- Education regarding correct coding of mental health related diagnoses.

- Further study of issues related to funding of psychiatric and mental health care.

- Classification of all inpatient and mental health facilities in the state regarding contact information, ages accepted, insurance plans accepted, etc.

- Development of a "follow-up" system to assure that patients seen in an emergency setting receive counseling and treatment.

- Improved data collection systems, to include evaluation and reporting services.

Broaden Support for Suicide Prevention: Suicide prevention has long been an issue in search of leadership. Ironically, it has the potential to be just the opposite -- an issue so threatening to the general health of the public and so inherently amenable to progress once we organize for success as to naturally draw strong backing and viable leadership to its fore. The agenda listed in the preceding sections should go a long way toward publicizing the issue without undue concern for "suicide contagion" (a sort of copycat phenomenon triggered by sensationalized reporting, "how-to" descriptions, or romanticization of the victim or the act). It also lays out a formula for organizing for success. But we cannot rest there: We need to capitalize on such successes by ensuring long term public and private support for suicide prevention.

Political leadership is key. At national, state, and local levels, elected officials and legislatures have the ability to mobilize popular support, develop and manage effective policies and programs, and generate resources for the purpose of lowering the suicide rates. We can and should identify such leaders, provide them the information necessary to advance the issue, and simultaneously mobilize support groups to spread roots throughout communities that will allow the effort to take hold and grow.

Professional and community leadership must be integrated. While there are many associations and groups (both formal and informal) focused on suicide prevention as a primary or affiliated effort, they could benefit from umbrella organizations that both focus and link their activities. The outcomes could include a concerted and coordinated public media campaign with local emphasis, integrated crisis response systems, coordinated counseling services, mutually supporting research agendas, and interconnected support groups. Educators, medical experts, counselors, caregivers, law enforcement agents, faith-based institutions, and families need to join together in a series of cascading streams of information and responses that not only identify potential victims, but, at the same time, take them through a crisis period and beyond for long term recovery and health.

The media can also play a key role in broadening support for suicide prevention. The media's ability to inform and persuade is legion. At the very least, they could advance suicide prevention efforts by reporting on suicides with greater compassion and less sensationalism. They certainly would be key in advancing a public information campaign as outlined in this strategy paper.

The question is not how to do all this. Indeed, we must ask why it has not yet been done. The component parts are there; the information, the science, and the methodologies are available. What remains is for us to put together all of the pieces into a coherent whole,

advance the knowledge in deliberate and sound research modalities, and put at bay one of the deadliest killers in our land -- suicide.

►Conclusions

"There is an urgency to explicitly build into all prevention strategies the vital supports necessary for positive child and adolescent development." This was the first recommendation of the Florida Youth Suicide Prevention Study, based on the information gathered from community forums, focus groups, research literature, and discussions and testimonies from professional service providers, families and friends of youth that have or attempted to commit suicide. The study further recommended that, "while positive youth development is an essential ingredient to the healthy development of all children and youth, it is critical for those youth who are disproportionately at risk."

In 1985, the co-chair of the National Committee on Youth Suicide Prevention poignantly expressed the dilemma of youth suicide confronting communities across the country:

"When the bright promise of a teenager's life is sacrificed by suicide, we are haunted by an unequaled sense of loss, tragedy and anger. There is no greater pain that a parent, family and community can suffer."

"Parents who have lost a child to suicide express frustration in trying to warn others that suicide knows no geographic, economic or social barriers. It is not limited to "problem kids" and could strike your family tomorrow."

"Yet, we offer our kids little advice about what they should do when a friend talks of suicide. We offer little guidance to parents, fostering the attitude that "it won't happen to us" in our homes and schools. We go on speculating about the causes and solutions, rather than committing resources needed for research and prevention programs."

"Those who believe suicide is unstoppable are wrong – tragically wrong. We must look the problem straight in the eye and respond on behalf of those thousands of young people who will otherwise choose death over life. The more rapidly we act, the more lives we will save."

Compelling words. More compelling, though, is the tragic fact that since 1985 we have lost 3,198 of Florida's children and youth under the age of 24 to suicide.

The recommendations of the task force as codified in this strategy are only words on paper unless they result in action. Some of the recommendations can be implemented with existing resources; some may require additional resources. All will require political will and broad based cooperation and coordination. The net results, however, promises to be a safer environment for the residents of Florida. That is what they deserve and what we should be able to offer to them.

Appendix L
Presentations

American Academy of Pediatrics 2003 National Conference and Exhibition

Filename: 550538

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Primary Section Choice: Injury & Poison Prevention;

Secondary Section Choice: Emergency Medicine;

Presentation format: Please consider for either poster or oral presentation
AAP: AAP Fellow
AAP Section Affiliate member: Yes
Original Research/Case Report: Original Research
Consent: Yes, I give my consent
Prior publication: No.

IACUC or IRB approval number: Exempt.
Awards:
Disclosure: There are no relationships to disclose

Title: MENTAL HEALTH, SUICIDE PREVENTION

WITHIN THE SCOPE OF PRACTICE FOR THE PEDIATRICIAN

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Abstract:
Background
Over the past two decades, the rate of psychosocial problems identified in primary care increased as mental health services decreased. Pediatricians are

instrumental in early intervention for mental health conditions, including suicide ideation. An aim of the Florida State Youth Suicide Prevention Prototype is to facilitate the role of primary care providers as access and referral points for mental health services.

Methods

A survey was conducted to identify current practices, barriers and issues related to mental health screening and referral. Surveys were faxed and emailed to pediatricians in multi-ethnic, multi-cultural metropolitan and non-metropolitan communities. Potential participants were identified through County Medical Associations. Qualitative data from key informant interviews were used to complement survey findings.

Results

Preliminary results indicate 90% of respondents perceived patient mental health related problems as moderately or very prevalent. However, 76% reported they do not use a standard mental health screening procedure in their routine practice. Pediatricians rated themselves as moderately aware of existing resources, most rating overall accessibility of youth mental health services as poor (67%) or moderate (33%). Qualitative findings indicate pediatricians consider mental health within the scope of their practice though frustrated with the gap between medical and mental health services, especially due to time constraints and reimbursement barriers.

Conclusion

The apparent demand among pediatricians for simple tools to identify and respond to patient's non-acute mental health needs calls for a brief standard screening tool that can be administered within the timeframe of a routine examination. Further, pediatricians require a broad array of referral options to fit the needs and insurance status of diverse patients necessitating ongoing partnerships between primary care and mental health services at all levels of health care delivery.

Signature of Presenting Author:

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Deborah Mulligan-Smith

School Safety & Security Best Practices
With Their Associated Indicators
2002-2003 School Safety and Security Self- Assessment Form
Alachua County

*** Please visit the following website:**
http://www.firn.edu/doe/besss/safe_passage/2003pdf/2003alachua.pdf

School Safety & Security Best Practices
With Their Associated Indicators
2002-2003 School Safety and Security Self- Assessment Form
Broward County

Please visit the following website:
http://www.firn.edu/doe/besss/safe_passage/2003pdf/2003broward.pdf

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