



October 2004

SAVING TOMORROWS TODAY

**North Carolina's Plan
to Prevent Youth Suicide**

Saving Tomorrows Today

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**North Carolina
Department of Health and Human Services**

Division of Public Health

October 2004

“This project was supported by Federal Formula Grant #160-1-02-001-J-179, awarded by the Bureau of Justice Assistance, U.S. Department of Justice through the North Carolina Department of Crime Control and Public Safety/Governor’s Crime Commission. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.”

Project administered by the **North Carolina Youth Suicide Prevention Task Force**.

North Carolina Department of Health and Human Services

Messages from the Secretary, State Health Director and Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services

When an epidemic occurs, North Carolina agencies mobilize their resources in a rapid response to prevent death and disabilities. But we have failed to recognize a silent epidemic that is taking place. North Carolina is losing an average of 127 children and youth per year as a result of suicide. Not to diminish the deaths of our children from any cause, but eight times as many children die from suicide as they do from influenza each year.

While acknowledging the complexity of the personal and situational factors associated with suicidal behavior, a public health approach is regarded as the one most likely to reduce suicide attempts and deaths. An integrated and coordinated effort with multiple partners is a keystone of public health. An organized collaboration among public health, mental health, medical, social services, law enforcement, political and other community stakeholders is crucial to prevent youth suicides.

North Carolina's youth suicide prevention plan, *Saving Tomorrows Today*, was developed by a task force comprised of volunteers and staff from numerous agencies. This plan establishes six goals for North Carolina to initiate state prevention activities. The fact that suicides are preventable calls for mobilizing our resources to address the goals and objectives in this plan to stop these tragic deaths.

The Department of Health and Human Services, Division of Public Health and Division of Mental Health, Developmental Disabilities and Substance Abuse Services are committed to the full implementation of the goals and objectives of *Saving Tomorrows Today*. Recognizing that suicide is a serious public health and mental health problem, we commit our divisions to lead the efforts to prevent these tragic deaths.



Carmen Hooker Odom

Carmen Hooker Odom, Secretary
NC Department of Health and Human Services



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Dedication

This document is dedicated to North Carolinians who have experienced the tragic loss of a loved one by suicide.

May this document serve to inspire individuals, organizations and communities to implement strategies needed to protect our state's greatest resource – our young people.

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Organizational affiliations are those at the time of the individual's involvement.

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Special Acknowledgment for Design and Layout of Plan: Jean Stafford, State Center for Health Statistics

Endorsements

The following agencies and organizations have recognized that youth suicide is a public health issue that requires collaborative intervention and stated their support by endorsing *Saving Tomorrows Today*

Association of North Carolina Boards of Health
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Mental Health Association in North Carolina
North Carolina Association of Local Health Directors
North Carolina Child Fatality Task Force
North Carolina Council of Community Programs
North Carolina Medical Society
North Carolina Pediatric Society
North Carolina Public Health Association
North Carolina School Counselor Association
North Carolina School Psychology Association
North Carolina State University
Office of Minority Health and Health Disparities, Department of Health and Human Services
Office of the Chief Medical Examiner, Department of Health and Human Services
School Nurse Association of North Carolina
School of Nursing, University of North Carolina at Chapel Hill
Stokes County Suicide Prevention Alliance
Survivors of Suicide: Self-Help Support Group (Wake County)
UNC Hospitals
UNC Physicians and Associates
Wake Forest University Baptist Medical Center
Youth Advocacy and Involvement Office, Department of Administration

A NORTH CAROLINA TRAGEDY: YOUTH SUICIDE

Suicide is the hidden killer of North Carolina's young people. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, influenza, and pneumonia *combined*. With suicide rates 17 percent higher than the national average, North Carolina loses approximately 127 of its young people to suicide each year, making it the third leading cause of death among those aged 10 to 24.¹ From 1995-1998, North Carolina's medical and productivity costs of fatal suicides for persons 24 years of age and younger were \$158,233,767. Hospitalized suicide attempts of North Carolina youth for 2001 cost \$31,890,264.² This figure does not include the immeasurable cost of the pain, suffering, and diminished quality of life experienced by the victims, their families, and their friends. This cost is poignantly described by Johns Hopkins University psychologist Kay Redfield Jamison:

*The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.*³

Who's at risk for suicide?

The death of a young person from suicide is tragic and a potentially preventable public health problem. It should be treated as a sentinel event that calls for an immediate response. North Carolina is losing its most precious resource – our young people – at a rate that is higher than the national average for those between the ages of 10 and 24. (NC =8.20/100,000, US=7.26/100,000). In this age group for the years 1999-2001, suicide was the third leading cause of death in North Carolina.⁴ Older teenagers

and young adults are particularly vulnerable.⁵ The suicide death rate increased sharply from age 10 to age 24. The rate for ages 15-19 was 4.2 times the rate for ages 10-14, and the rate for 20-24 was 1.6 times the rate for ages 15-19.⁶

“Suicide in your family is just one of the most horrible things you could ever imagine. There is no way around the guilt, there's no way around the why and the what if.”

– Nayo, surviving mother of 16 year old son

Data for 10-24 year old North Carolina residents indicate that the annual number of deaths from self-inflicted injuries, although fluctuating, has declined over the past 15 years (1988-2002). Although the number of deaths per year began to increase in 1989 – jumping from 98 deaths in

1988 to 145 deaths in 1989 and reaching a high of 179 deaths in 1994 – deaths by suicides have declined to 128 deaths in 2000, 140 deaths in 2001 and 95 deaths in 2002.¹ Suicide rates are widely accepted as under representing the true magnitude of the problem. Under reporting of suicides can be attributed to the stigma of suicide as well as the uncertainty of intent for incidents such as drug overdoses, car crashes and drownings. Suicide deaths represent the “tip of the iceberg”. Research indicates that thousands more will require medical care as a result of a suicide attempt or sustain an injury for which no

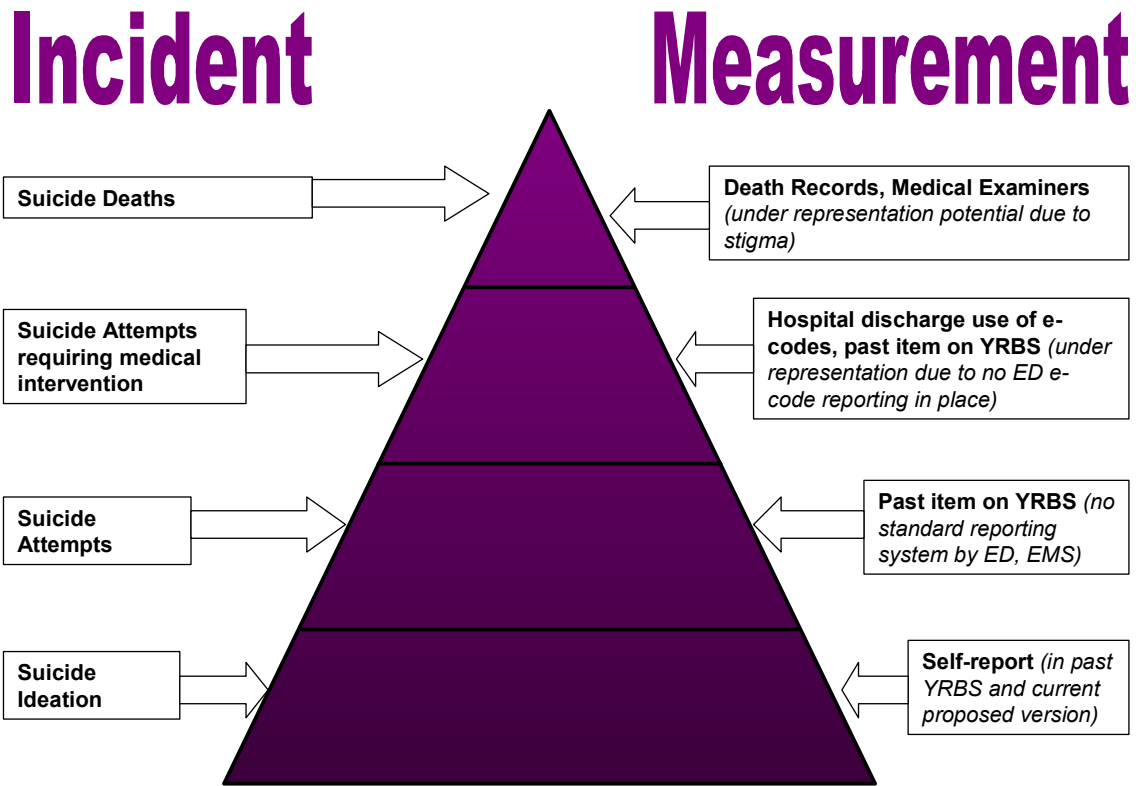


Figure 1

medical care is sought. Figure 1 depicts a proportional representation of levels of suicidal behaviors. Certain segments of the population have higher non-fatal to fatal ratios including women and youth. It is estimated that for every youth suicide in the United States, there are as many as 100-200 attempts.⁷

The North Carolina Youth Risk Behavior Survey (YRBS) is an anonymous written questionnaire supported by the Centers for Disease Control and Prevention (CDC) that is administered every other year to middle and high school students.* To gain valuable insight into suicide ideation in our school-age children, the survey identifies how many students seriously contemplate suicide. Although in North Carolina for 2003, representative data from the YRBS is only available for high school students, prior YRBS data indicate that for the past decade (i.e., since 1993) about 20 percent of students in both middle school and high school have seriously **considered** killing themselves. For the years 1995 through 2003, the percentages ranged from 21 to 27 percent for middle school children and from 18 to 24 percent for high school students. In 1997, the latest year that information was collected regarding **attempted suicide**, about one in twelve high school

*YRBS questions posed to middle school students and high school students about suicidal ideation differed. Middle school students were asked if they ever had seriously considered killing themselves whereas high school students were asked if they seriously considered attempting suicide in the past twelve months.

students (8.8%) reported having attempted suicide during the last twelve months prior to the survey. In the youngest high school students, ninth graders, the percentage of those reporting attempting suicide increased about 40 percent, from 8.5 percent (1995) to 12.0 percent (1997) (See Appendix A for a more detailed report). Suicide rates often vary by geographical regions, age and other demographic characteristics. Understanding these differences is essential in identifying populations at risk and developing prevention strategies targeted for these groups.

Females tend to attempt suicide more frequently than males, however males' attempts are more likely to be fatal. Nationally among 15-19 year olds, five males died by suicide for each female counterpart and about six males aged 20-24 years died by suicide for each female counterpart.⁸

North Carolinians reflect the national data for youth suicides, more males than females died by suicide. During the 15 years between 1988-2002 for the 10-24 year old population, there were almost eight times as many suicides in males (1,712) than females (218).¹

In North Carolina during the years 1988-2002, whites between the ages of 10-24 experienced more deaths from suicide than minorities of the same age. As depicted in more detail in figures A8-10 in Appendix A, during this 15 year period, the numbers of suicides among young white males peaked in 1994 and have since declined. A similar trend occurred in African American males. Although the number of suicides among young African American males has been consistently lower than that for young white males, there have been yearly variations in the number and rates of suicides in the African American male population. When data from 1984-88 was compared with data from 1994-98, an unexplained increase in suicide rates was observed for African American males – 138 percent increase for 15-19 year olds and 153 percent increase for 20-24 year olds. Current information indicates a decline in the number of suicides in African American males ages 15-24 since the mid 1990s from a high of 40 deaths in 1994 to 20 deaths in 2001 and 10 deaths in 2002.¹ A study in 1998 postulated that slight declines in suicide rates among adolescents could be a reflection of lowered substance abuse rates and the increase in prescribing antidepressants.⁹ However, recent studies have questioned the safety of antidepressant usage in the child/adolescent population. Of specific concern is whether some antidepressants actually increase suicidal behavior in youth. Researchers are continuing to study the effects of various antidepressants on children and adolescents and have formulated medication administration recommendations and warnings.^{10, 11, 12}

Did you know that more young males die by suicide than females?

Did you know that there are racial differences in youth suicides?

How, where and why do suicides occur?

Firearms were the most commonly used suicide method for both sexes between 1999-2001. Of the 404 youth suicides that occurred in North Carolina during that time period, 264 of these deaths, nearly 65 percent, were by firearm. In contrast to the misconception that women rarely use firearms as a suicide method, half of the young women who died by suicide in North Carolina used a firearm as a suicide method. While young females attempt suicide more often than young males, male attempts are more likely to be fatal because they are more likely to use firearms. National research indicates that 78 percent to 90 percent of all suicide attempts made by a firearm are fatal. Suicide by firearms is more frequent in North Carolina than the United States average for ages 10-24. (NC 5.11/100,000 US 3.89/100,000).¹³

Did you know that most North Carolina youth suicides are by firearms?

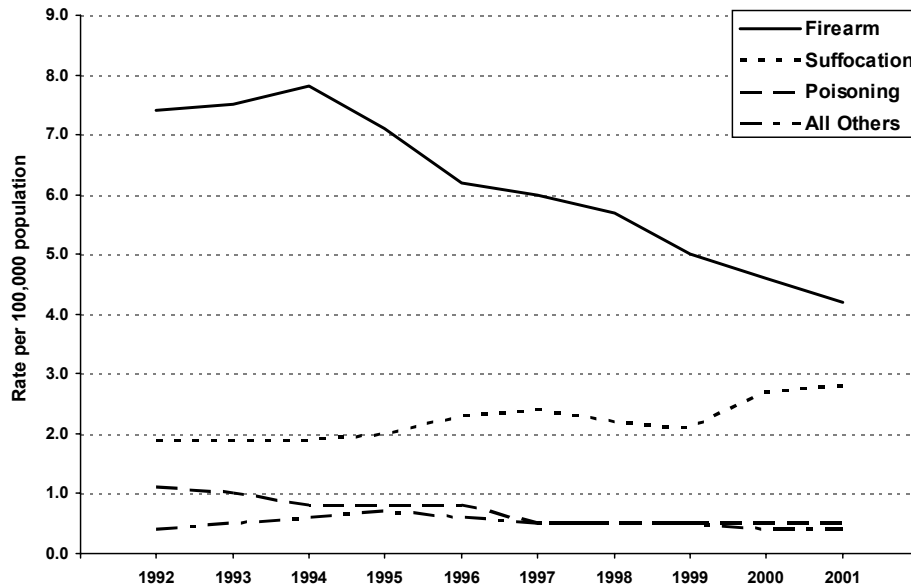
During the decade from 1992-2001, a national trend in suicidal behavior among youth was documented. There has been a decline in suicides by firearm for 10-14 year olds and for 15-19 year olds as depicted in Figure 2. Suicides of North Carolina youth in these age groups have followed the same trend. In North Carolina there are few suicides among 10-14 year olds, but the pattern of declining deaths by firearm looks similar to that of the nation. The annual number of suicides in this youngest age group clearly decreased during this period from seven deaths by firearm in 1992 to two deaths by firearm in 2002. The numbers and rates of suicides by firearm for 15-19 year olds in North Carolina clearly declined between 1992 and 2002 as Figure 3 illustrates. For this older adolescent age group, suicides by firearm declined from a rate of 4.27 (per 100,000) in 1992 to 1.66 (per 100,000) in 2002. The reasons for the changes in suicide methods are not fully understood, but demonstrate that rapid changes in youth suicidal behavior can occur.^{1,14}

According to the North Carolina Office of the Chief Medical Examiner's data between the years 1996-2000, 80 percent of children under the age of 18 inflicted their fatal suicidal injuries within the property limits of a home residence.

Did you know that most youth under the age of 18 inflicted their fatal injury in the home?

Generally suicide occurs when several risk factors are present, but there are no easy answers as to why suicides occur in children and adolescents. Improved surveillance systems and more research are needed. However, some of the characteristics of youth may contribute to their susceptibility such as the ability to be influenced, their risk taking behavior, and their impulsiveness.

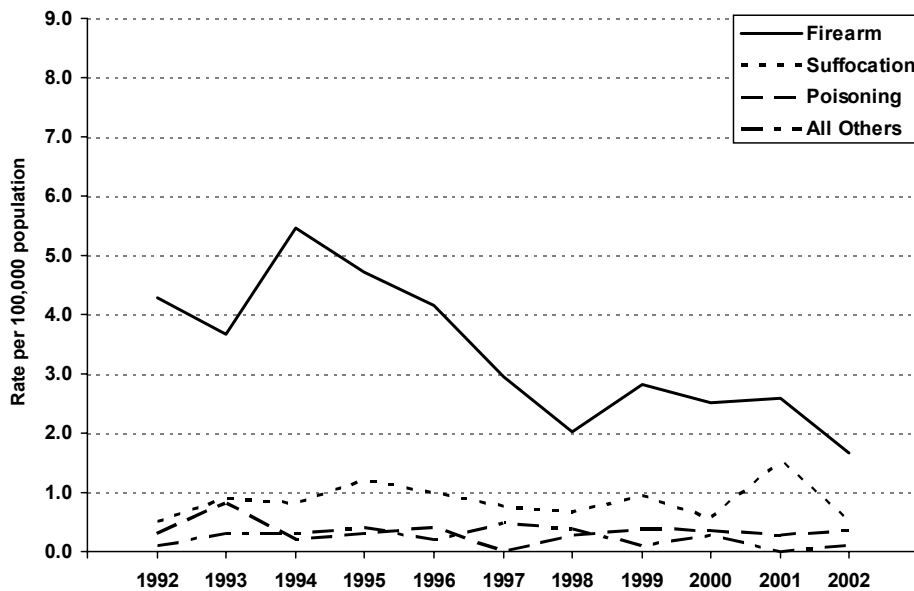
Annual suicide rates among persons aged 15-19 years, by year and method – United States, 1992-2001



Source: Centers for Disease Control and Prevention. *Methods of Suicide Among Persons Aged 10-19 Years -- United States, 1992-2001*. MMWR 2004;53 page 473.

Figure 2

Annual suicide rates among persons aged 15-19 years, by year and method – North Carolina, 1992-2002



Source: State Center for Health Statistics Public Use Mortality Data and State Demographer Population Estimates, 1992-2002.

Figure 3

While some suicides are carefully planned, others are impulsive acts of desperation. Youth tend to fall in this latter category. The influence of alcohol and the availability of lethal means are associated with increased risk. Youth who are isolated from family and friends are at higher risk, especially those who are in out-of-home care, such as group homes or correctional facilities.

At least 90 percent of those who take their own lives have mental health problems such as depression, anxiety and other disorders. Although most people who suffer from depression do not end their lives by suicide, depression is the mental disorder most often associated with suicide.^{15,16} Studies have revealed that up to 80 percent of people who took their lives by suicide had several depressive symptoms.¹⁷

Signs and symptoms of depression among children and adolescents differ from those of adults. *Depressed young people tend to exhibit more “acting out” – such as truancy from school, declining grades, bad behavior, violence and abuse of alcohol and drugs – and to also sleep and eat more.*¹⁷ Eating disorders and anorexic behavior are frequently found in combination with depression in young people, particularly among girls, and severe eating disorders are themselves associated with an increased risk for suicide.¹⁷

Research over many years has found that media representations of suicide may increase suicide rates, especially among youth.^{18,19} “Cluster suicides” and “suicide contagion” have been documented^{20,21} and studies have shown that both news reports (especially those involving celebrities) and fictional accounts of suicide in movies and television can lead to increases in suicide.^{22,23} There is stronger evidence for the negative impact of media reporting practices than positive effects. However, it is acknowledged that the media could have a positive effect if they depict the consequences of suicidal behavior.²⁴

Suicidal intent is a state of mind but often there are verbal and behavioral clues of depression and impending suicidal actions that knowledgeable adults and peers can detect. See examples on the next page.

Did you know that youth who have friends or family members who have died by suicide are at much higher risk?

Symptoms of depression in children and adolescents

- Missed school or poor school performance
- Changes in eating and sleeping habits
- Withdrawal from friends and family and activities once enjoyed
- Persistent sadness and hopelessness
- Problems with authority
- Indecision, lack of concentration or forgetfulness
- Poor self-esteem or guilt
- Overreaction to criticism
- Frequent physical complaints, such as headaches or stomachaches
- Anger and rage
- Lack of enthusiasm, low energy or motivation
- Drug and/or alcohol abuse
- Thoughts of death or suicide

–List courtesy of the Mental Health Association

Verbal Clues of Suicide

- "I shouldn't be here."
- "I'm going to run away."
- "I wish I were dead."
- "I'm going to kill myself."
- "I wish I could disappear forever."
- "If a person did this or that ... would he/she die?"
- "The voices tell me to kill myself."
- "Maybe if I died, people would love me more."
- "I want to see what it feels like to die."

Behavioral Clues

- Talking or joking about suicide.
- Giving possessions away.
- Pre-occupation with death/violence; TV, movies, drawings, books, at play, music.
- Risky behavior; jumping from high places, running into traffic, self-cutting.
- Having several accidents resulting in injury, "close calls" or "brushes with death".
- Obsession with guns or knives.
- Previous suicidal thoughts or attempts.

–List courtesy of SAVE (Suicide Awareness Voices of Education)

A PREVENTABLE PROBLEM: YOUTH SUICIDE

A Call to Action

National and state data and the strong grass roots efforts by surviving family members of suicide victims have helped focus attention on the issue of suicide. The nation's foremost authorities have recently highlighted suicide as a public health problem requiring every state's attention.

In 1998, during the first national suicide conference held in Reno, Nevada, the United States Surgeon General, Dr. David Satcher, declared suicide a national public health problem. The conference participants comprised of researchers, clinicians, suicide survivors and community leaders discussed the impact of suicide and possible public health prevention strategies. Following the conference, the Surgeon General issued a *Call to Action to Prevent Suicide in 1999*.²⁵ Since that time the US Department of Health and Human Services published the *National Strategy for Suicide Prevention: Goals and Objectives for Action* (2001), a landmark document that lays out a framework for action

for states and communities in the form of 11 national goals.²⁶ The national plan challenged states to develop their own comprehensive state suicide prevention plans that coordinate

efforts across government agencies, involve the private sector, and support the development, implementation and evaluation of suicide prevention activities at the state and local level. Numerous states have adapted the broad goals of the National Strategy into state specific ones for their individual plans. This federal blueprint was followed by an Institute of Medicine report, entitled *Reducing Suicide: A National Imperative*.²⁷ This comprehensive description of the epidemiology of suicide and current efforts to prevent or

treat suicidality also emphasizes that suicide is a public health problem, especially among our young, where it claims an inordinate number of lives. The recommendations include: increased monitoring and surveillance of completions and attempts; better training and tools for primary care providers to increase screening and recognition of suicidal thinking; partnerships among federal, state, and local agencies to implement effective suicide prevention programs, especially among at-risk populations; and the restriction of access to lethal means (including firearms, drugs and poisons, bridges, high buildings, etc.)

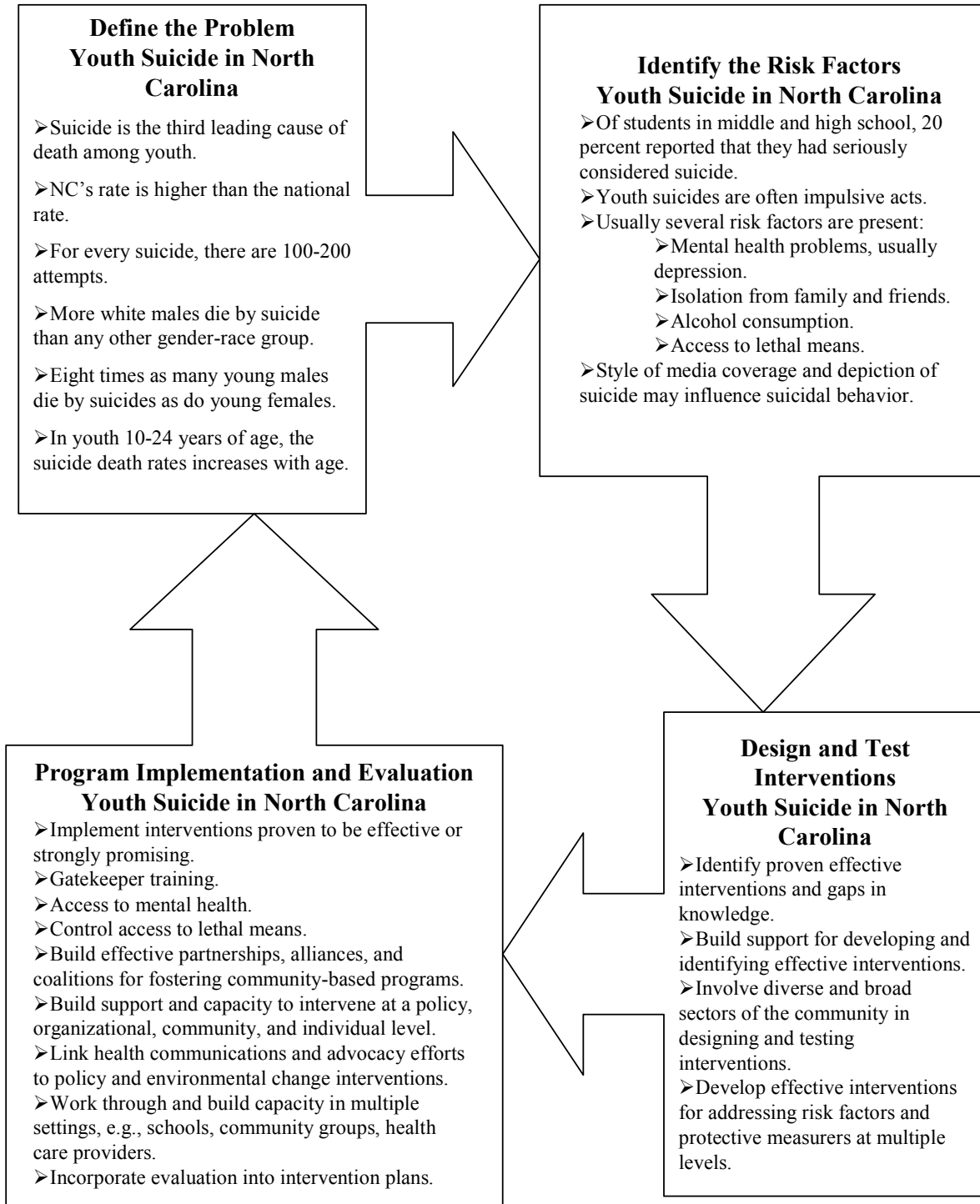
"In society, we tend to stay away from mental health issues and hush it down. But it's a national public health crisis, it's nondiscriminatory and it hits everybody."

– Nayo, surviving mother of 16 year old son

A Public Health Approach

The public health approach is widely regarded as the one most likely to produce significant and sustained reductions in suicide. This systematic approach uses four steps that are applicable to any health problem that substantially threatens a group or population. This approach is detailed in the following graphic.

Public Health Model for Suicide Prevention



NORTH CAROLINA'S STRATEGIES FOR THE PREVENTION OF YOUTH SUICIDE

The North Carolina Youth Suicide Prevention Task Force, led by staff from the North Carolina Department of Health and Human Services, Division of Public Health (NCDHHS/DPH), Injury and Violence Prevention Branch, has provided a forum for studying the problem of youth suicide in North Carolina, collaboratively conducting activities, and developing a state plan. This work has been particularly challenging due to the complexity of the problem, the needed involvement of agencies, organizations and individuals with diverse roles and perspectives, and the emotional pain that this issue evokes.

The Task Force members selected six goals from the *National Strategy for Suicide Prevention* as priorities for North Carolina. In concert with other key stakeholders from across the state, these goals have been discussed and specific objectives developed for launching a coordinated effort to prevent youth suicide in North Carolina. The goals and objectives of this plan provide a focused and strategic approach for North Carolinians to take the steps necessary to reduce the number of North Carolina youth who complete or attempt suicide.²⁶

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

Suicide is a major public health problem. Increasing awareness of the problem of youth suicide in North Carolina and the fact that it is preventable is the first step for mobilizing the social and political support needed for prevention initiatives and provides a founda-

tion for implementing this plan's other goals and objectives. Increased awareness that suicide is a serious public health problem will bring about improved knowledge which in turn may influence beliefs and behaviors including decreasing stigma associated with suicide and life-threatening behaviors.²⁵ In addition, a better informed public may be more motivated to invest in suicide prevention efforts at the local, state, regional, and national level.

"There is a killer on the loose, it is quiet and invisible, because we are not acknowledging its presence, and are scared to say its name."

– Kathy, surviving mother of 15 year old son

North Carolina Objectives

- a) Launch a statewide public awareness campaign with components that focus on the general public and decision-makers, and incorporate targeted messages for special populations at risk as determined by race, ethnicity, and sexual orientation.

- b) Provide information resources to community groups for promoting awareness through existing channels of communications and for local awareness campaigns.

ACTION IDEAS

Individuals

- Increase own personal knowledge about the problem of youth suicide, characteristics, risks, resources and treatments
- Increase awareness of campus resources among parents of college age students

Schools/Communities

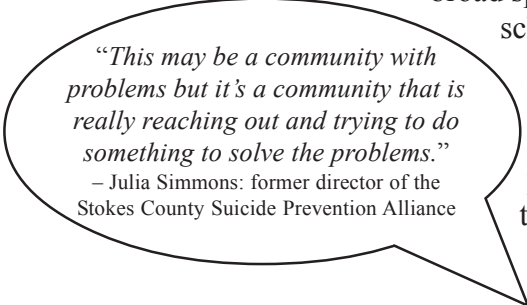
- Sponsor a suicide awareness event at school, church, a civic group, parent group, professional organization, etc.
- Promote awareness of the problem of youth suicide to the community, reaching out to racial and ethnic groups
- Distribute materials and promote support services on college campuses
- Post lists of recommended readings at public schools, university libraries and on web sites

GOAL: Develop and implement community based suicide prevention programs.

Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources. Programs may be specific to one particular organization or may encompass the entire state. A special emphasis of this goal is ensuring a range of interventions that together represent a comprehensive and coordinated approach.

For any preventive action to go forward, there must be public support for change.²⁸

Suicide risk factors cut across multiple disciplines – psychological, biological, and social – suggesting that successful prevention efforts must reflect collaborative efforts across a broad spectrum of agencies, institutions, and groups, including schools and faith-based organizations. Broad-based support for suicide prevention may also lead to additional funding, through governmental programs as well as private philanthropy and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed it. Currently knowledge about effective programs is sparse; nevertheless, some interventions have proven effective and others



appear promising, but are in need of evaluation.²⁹ Because effective prevention efforts may take years to show true benefits, instituting plans in 2- to 5-year increments may not permit prevention efforts to come to fruition. In addition, suicide prevention goals and

objectives must be woven into the fabric of community and local human services, training, and education. Standing alone, suicide prevention efforts fail to benefit from the resources, experience and community acceptance of established programs and services.²⁶

North Carolina Objectives

- a) Identify evidence-based best practices and facilitate their dissemination and implementation.
- b) Identify existing programs and services that are evidence-based and support and expand their availability.
- c) Increase applied research for developing effective evidence-based interventions.
- d) Engage key partners/stakeholders in a participatory process in all phases of youth suicide prevention from research design through dissemination, implementation, and evaluation.

ACTION IDEAS

Individuals

- Be an active community member by becoming involved in local programs that promote suicide prevention activities

Schools/Communities

- Increase the ratio of school nurses to students to 1:750
- Promote integration of mental health services in schools
- Increase availability of school guidance counselors to provide counseling to "at risk" students by decreasing their role in administering tests
- Incorporate comprehensive suicide prevention, intervention and postvention (suicide aftermath) strategies into school crisis plans
- Form networks/coalitions of youth-serving organizations that address youth suicide prevention
- Form coalitions of faith based organizations that offer education and support to parishioners about mental health disorders

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

Evidence from many countries and cultures indicates that limiting access to lethal means of self harm may be an effective strategy to prevent self-destructive behaviors. Although in North Carolina firearms are the most commonly used fatal suicide method by youth, for young women, the second most commonly used suicide method is poisoning that includes drug overdoses, followed by suffocation which includes hanging. For males, the pattern is reversed, the second most common method is suffocation, followed by poisoning.

Research has shown that limiting access to lethal means and methods of self-harm is an effective strategy to prevent self-destructive behaviors in certain individuals.^{30, 31, 32} This approach to prevention is based on the emerging evidence that a small but significant number of suicidal acts are impulsive,³³ especially in suicides among youth. Education on restriction of access to lethal means is seen as one of the most promising and economical strategies for preventing youth suicide.³⁴ Education can be provided by many professionals, including law enforcement and health care providers, and should focus on parents and other adults who can control access to firearms, drugs, and other lethal means. Educational strategies should instruct about effective methods of restricting access, and can be most effective when supportive policies are in place, e.g., laws requiring the safe storage of firearms.

North Carolina Objectives

- a) Develop and implement an effective multi-media safe storage campaign focused on increasing awareness of the relationship between firearm availability and suicide.
- b) Expand North Carolina's firearm safe storage law to include a clear and specific definition of safe storage.
- c) Increase the numbers of health care professionals who provide counseling to parents of children and adolescents about safe storage of lethal means (drugs and firearms).
- d) Collect and analyze information about the lethal means of suicide in a state-wide data system, including where the agents were obtained and how they were stored.
- e) Implement a prescription drug monitoring system in North Carolina.
- f) Identify evidence-based interventions to reduce the use of over-the-counter medication for suicide attempts.

ACTION IDEAS

Individuals

- Understand and apply Child Access Protection law and methods for safely storing firearms, medications (prescription and over the counter) and poisons in households with minor children and/or households where children visit

Schools/Communities

- Restrict roof access to multi-story buildings on campuses
- Adopt and enforce on-campus alcohol and firearm possession policies at community colleges, universities, and college campuses
- Sponsor firearm safety education in communities

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

Despite increased awareness of youth suicide as a public health problem, studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients and clients, or know how to make referrals for specialized assessment and treatment.^{35,36,37,38} Key gatekeepers – adults who are regularly in contact with youth at risk of suicide – need training in order to be able to recognize factors that place youth at risk for suicide and to appropriately intervene. Key gatekeepers can include teachers and school personnel, clergy, police officers, primary health care providers, mental health care providers, correctional personnel, and emergency health care personnel.

Nationally 70 percent of adolescents visit a primary health care provider at least annually. Youth may not readily self-disclose emotional/psychological symptoms. This provides an opportunity for health care providers to assess for mental health issues during the visit³⁹.

Recognizing risks for suicide and attempts by adolescents, and the necessity of detecting such risk, the American Academy of Pediatrics adopted a policy on suicide and suicide attempts by adolescents that states that *Pediatricians...should talk with their adolescent patients about depression, suicidal thoughts and other risk factors and need to inquire about availability of firearms in the home and discuss the increased risks with parents. They should recognize the medical and psychological needs of the adolescent and work closely with the family and health care professionals involved.*⁴⁰

“Suicide is a process, and if we teach people how to intervene in the process then we can save lives. ... Part of us died when she did but I thought if I can save one child, my daughter’s life will not have been in vain. And I’ve managed to reach hundreds so far.”
– Fred, surviving father of 15 year old daughter

Identifying individuals at risk and engaging them in early and aggressive treatments is effective in reducing the personal and situational factors associated with suicidal behaviors (e.g., depressed mood, hopelessness, helplessness, agitation, alcohol and drug abuse, among others). Another way to prevent suicide is to promote and support the presence of protective factors such as skills in problem solving, conflict resolution, and nonviolent handling of disputes. By promoting effective clinical practices in the assessment, treatment, and referral for youth at risk for suicide, the chances are greatly improved for preventing young people from acting on their despair and distress in self-destructive ways.

North Carolina Objectives

- a) Identify and review existing evidence-based gatekeeper training for suicide prevention and intervention.
- b) Develop and implement a plan for the provision of training for youth suicide prevention.

- c) Develop and implement curricula about suicide prevention for students entering the fields of social work, allied health services, nursing, medicine, mental health services and related careers.
- d) Incorporate gatekeeper training as part of professional development.

ACTION IDEAS

Individuals

- Advocate to administrators that gatekeeper training be provided within your youth service agency

Schools/Communities

- Sponsor “gatekeeper” training within organizations whose staff work directly with youth
- Institutionalize training as a component of a competent work force
- Provide social skills building and conflict resolution education to students in order to increase personal resiliency
- Develop policies to address bullying and violent acts occurring in schools

GOAL: Improve access to and community linkages with mental health and substance abuse services.

Suicidal behavior is strongly associated with mental illness and/or substance abuse in all age groups. While both of these conditions can be successfully treated, many adolescents report that embarrassment, fear, and stigma are the main reasons

they don’t get help for their problems, even when they identify suicidal ideation as the most pressing problem in their lives.⁴¹ The stigma of mental illness and substance abuse has resulted in the establishment of separate systems for physical health and mental health care; one consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems.²⁶

“If I had realized my son was depressed when he was living, I know I would have gotten him help, but I probably would have been ashamed to tell anyone.”

– Kathy, surviving mother of 15 year old son

Services to prevent suicide must be available when and where people need them. Thus a variety of services must be provided in many locations throughout the state. Barriers of access to mental health and substance abuse services that must be addressed include structural barriers such as lack of health care professionals to meet the need for services and financial barriers such as not having health insurance. Outreach activities can address personal barriers, such as not knowing what to do or when to seek care, or concerns about confidentiality or discrimination.

There is substantial evidence that many youth who suffer from psychological, behavioral, and substance abuse disorders do not get the care they need.^{42, 43, 44} For adolescents, barriers to obtaining treatment or services include availability, transportation, cost and social stigma. Access to treatment can be increased by providing affordable and confidential services in schools, shopping centers, churches, and other community venues that are frequented by youth.⁴⁵ Financial barriers include inadequate health insurance or not having the ability to pay for services not covered by a health plan or insurance program.

De-stigmatizing mental illness and substance abuse, increasing access to treatment by reducing financial barriers and integrating care will increase the willingness of individuals to seek treatment.

North Carolina Objectives

- a) Assure that community mental health services in North Carolina include adequate suicide prevention and intervention services for youth.
- b) Inform traditional community services providers of potential risk for suicide in their youth populations (e.g., youth corrections, victims of abuse) and how to link those at risk to appropriate mental health services.
- c) Increase the use of non-traditional community resources, e.g., school counselors, faith communities, boys and girls clubs, recreation programs, to link youth at risk for suicide to mental health services.
- d) Improve access to insurance for youth and require that insurance plans cover mental health care on par with physical health care.

ACTION IDEAS

- Establish suicide prevention protocols in state and local institutional settings
- Increase funding of Health Choice – the state's low cost/no cost health insurance for working families – in order to continue coverage of current enrollees and in order to increase the poverty level limit to make more children eligible for services
- Train personnel in community programs serving youth
- Advocate for mental health insurance parity

GOAL: Improve and expand surveillance systems.

Suicide is the third leading cause of death for youth and young adults in North Carolina. However, the number of suicide attempts are unknown. Suicide is a complex issue. Establishing a system of ongoing surveillance of suicides and attempts will aid in understanding risk factors and circumstances surrounding suicide; which, in turn will enable the development of effective prevention interventions for those at greatest risk. There are existing and developing databases in North Carolina that can provide the data needed to improve the monitoring of suicides and attempts. These data can be accessed, analyzed, monitored and reported in a timely manner to produce a better understanding of youth suicide in this state.

Nationally, suicide surveillance data come from death certificates, yet this database obviously does not include those suicide deaths that are misclassified as homicides, accidents, or from natural causes. Information from death certificates also may be limited and incomplete. Prevention efforts would be enhanced by more comprehensive information about the circumstances of death such as will be available with the new National Violent Death Reporting System. Better data are also needed on suicide attempts. The State of Oregon is unique in that a 1987 law requires hospitals treating a child under the age of 18 for injuries resulting from a suicide attempt to report the attempt to the Oregon Health Division.⁴⁶ This data source provides important information for youth suicide prevention programming in Oregon. Information about risk factors for suicide can be critical for intervention because many prevention strategies are based on risk reduction. Information about depression, suicide ideation and planning, and other risk factors can be collected from population based surveys such as the Youth Risk Behavior Survey. Existing databases including the hospital databases should be explored for data variables that can document risk. Information about risk factors can be collected from available sources, analyzed and used to guide planning for prevention.

North Carolina Objectives

- a) Include the surveillance of suicide and associated risk factors in the North Carolina Violent Death Reporting System and produce annual reports of suicides in the state.
- b) Provide estimates of suicide attempts using data from the North Carolina Hospital Emergency Surveillance System (NCHESS).
- c) Develop a mandated reporting system that identifies all minors who receive emergency department treatment/evaluation for self-inflicted injuries.
- d) Analyze, interpret and distribute suicide surveillance data to inform research, program, and policy development in our state.

ACTION IDEAS**Individuals**

- Advocate that local school boards approve the administration of the Youth Risk Behavior Survey (YRBS) to anonymously collect from school age adolescents information on suicide etiology in children and youth

Professional groups/Communities

- Promote provision of standardized reporting forms through training and community support of state and local law enforcement
- Investigate the source and means of acquisition of the lethal mechanism used in youth suicides and document it (them) in the case report prepared by law enforcement
- Promote the investigation of suicide by law enforcement officials including how the youth obtained the lethal means
- Promote the consistent and standardized collection of information through training of medical examiners and the provision of reporting forms
- Reinforce the state-mandated reporting any firearm wounds by emergency departments and physicians in private practice to local law enforcement
- Recommend legislation that any medical provider report to their local health department director and/or child fatality review team confirmed or suspected intentional poisonings in children and adolescents under the age of 25

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APPENDIX A Data

- Statistical Table
- 1999-2001 Mortality Tables
- Youth Risk Behavior Survey Results
- Youth Risk Behavior Survey in the Juvenile Justice System
- Graphs
- Suicides by County (map)

Table A-1

North Carolina Resident Suicides

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Total	Total for Age Group
10-14 Male	2	9	3	5	6	3	9	3	4	5	8	7	6	5	3	78	129
White	2	0	0	1	4	2	3	3	2	4	0	2	2	1	1	27	
Black	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2	
Other	0	2	1	0	3	0	2	2	1	1	4	0	2	0	1	19	
Female	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	3	
White	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	0	
Black	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
15-19 Male	24	35	41	34	35	31	41	40	32	29	19	27	20	31	19	458	729
White	8	9	4	7	10	9	16	18	11	7	8	9	7	6	4	133	
Black	1	1	0	2	2	1	1	2	2	0	2	1	2	3	1	21	
Other	3	5	6	3	3	12	9	4	13	5	4	7	9	7	6	96	
Female	2	2	0	1	1	3	0	2	0	1	1	0	2	1	0	16	
White	0	0	1	0	0	0	0	0	0	1	1	1	0	1	0	5	
Black	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
20-24 Male	41	59	58	48	53	55	66	50	61	45	34	57	48	54	49	778	1138
White	6	11	10	14	15	8	24	10	12	20	12	9	16	14	6	187	
Black	2	2	0	0	2	1	4	2	2	2	1	3	3	5	1	30	
Other	4	9	22	6	9	5	3	10	5	10	4	7	7	11	2	114	
Female	2	1	2	1	1	3	0	1	1	3	1	6	2	1	1	26	
White	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	3	
Black	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total	98	145	148	122	144	133	179	148	146	134	100	136	128	140	95	1996	

Source: Injury and Violence Prevention Branch/State Center for Health Statistics, July 2004

Table A-2

NC Resident Suicide Deaths, Ages 10-24 by Sex, Race and Mechanism – 1999-2001

	White				Non-White			
	Females (N) Rate		Males (N) Rate		Females (N) Rate		Males (N) Rate	
Poisoning	(11)	0.66	(23)	1.33	(4)	0.52	(3)	0.39
Suffocation	(7)	0.42	(37)	2.14	(4)	0.52	(16)	2.09
Firearm	(30)	1.81	(171)	9.89	(8)	1.05	(58)	7.56
All Other	(2)	0.12	(12)	0.69	0	0	(6)	0.78
All Suicides	(50)	3.02	(243)	14.06	(16)	2.09	(83)	10.82

Table A-3

NC Resident Suicide Deaths, Ages 20-24 by Age Group and Mechanism – 1999-2001

	Age 10-14 (N) Rate		Age 15-19 (N) Rate		Age 20-24 (N) Rate	
	Poisoning	(1)	0.06	(11)	0.68	(23)
Suffocation	(19)	11.52	(33)	2.03	(37)	2.14
Firearm	(7)	0.43	(86)	5.29	(171)	9.89
All Other	0	0	(4)	0.25	(12)	0.69
All Suicides	(27)	1.64	(134)	8.24	(243)	14.06

Table A-4

NC Resident Suicide Deaths, Ages 10-24 by Sex and Mechanism – 1999-2001

	Females (N) Rate		Males (N) Rate	
	Poisoning	(15)	0.62	(20)
Suffocation	(11)	0.45	(78)	3.03
Firearm	(38)	1.57	(226)	8.78
All Other	(2)	0.08	(14)	0.54
All Suicides	(66)	2.72	(338)	13.13

Source: Injury and Violence Prevention Branch/State Center for Health Statistics. January 2004

Table A-5

2001 YOUTH RISK BEHAVIOR SURVEY RESULTS
North Carolina Middle School Survey
Summary Table – Weighted Data

	TOTAL			MALES			FEMALES		
	Percentage	95% confidence interval	N	Percentage	95% confidence interval	N	Percentage	95% confidence interval	N
Q15. Percentage of students who ever seriously thought about killing themselves									
Total	20.8	(18.6 - 23.0)	2,167	17.9	(15.7 - 20.2)	1,056	23.8	(20.2 - 27.3)	1,108
Age									
11 or younger	19.2	(13.5 - 24.8)	210	-	-	86	20.7	(12.8 - 28.7)	124
12	18.3	(14.7 - 22.0)	610	17.8	(13.3 - 22.3)	272	18.8	(14.2 - 23.4)	338
13	20.4	(18.1 - 22.7)	816	17.2	(13.8 - 20.6)	412	24.1	(19.3 - 28.9)	402
14 or older	25.7	(20.6 - 30.8)	531	19.5	(13.1 - 26.0)	286	33.3	(25.7 - 41.0)	244
Grade									
6th	20.3	(16.6 - 24.1)	512	18.8	(14.9 - 22.8)	251	21.9	(15.5 - 28.3)	261
7th	19.2	(15.7 - 22.6)	871	16.8	(12.4 - 21.1)	424	21.5	(16.6 - 26.5)	445
8th	22.8	(18.4 - 27.2)	769	18.6	(12.9 - 24.3)	373	27.2	(21.6 - 32.7)	395
Race/Ethnicity									
African American	22.4	(19.3 - 25.5)	625	29.5	(16.0 - 23.0)	286	25.1	(20.7 - 29.5)	339
Hispanic/Latino	25.6	(19.4 - 31.7)	119	-	-	53	-	-	66
White	19.5	(15.9 - 23.1)	1,184	17.4	(13.7 - 21.0)	595	21.9	(16.6 - 27.2)	589
All other races	-	-	85	-	-	43	-	-	41
Multiple races	25.0	(17.3 - 32.7)	146	-	-	75	-	-	69

Note: There were 30 students who did not provide usable data for Q15.
 N = Number of unweighted observations.
 - = Fewer than 100 observations.

Source: Department of Public Instruction: Public Schools of NC, Youth Risk Behavior, Middle School 2001 Results.

Table A-6
2001 YOUTH RISK BEHAVIOR SURVEY RESULTS
North Carolina Middle School Survey
Summary Table – Weighted Data

	TOTAL		MALES		FEMALES	
	Percentage	95% confidence interval	Percentage	95% confidence interval	Percentage	95% confidence interval
		N		N		N
Q83. Percentage of students who ever felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months						
Total	26.1	2,136	21.7	1,030	30.6	1,102
Age						
11 or younger	30.4	212	-	86	25.9	125
12	23.2	601	20.1	265	26.0	336
13	25.1	805	18.7	400	32.2	403
14 or older	29.1	518	21.3	279	39.0	238
Grade						
6th	27.8	505	26.7	243	28.9	262
7th	23.8	854	19.1	412	28.6	440
8th	26.1	762	18.5	366	33.9	394
Race/Ethnicity						
African American	30.6	612	25.0	276	35.7	336
Hispanic/Latino	45.8	116	-	52	-	64
White	22.6	1,168	19.6	583	25.8	585
All other races	-	85	-	42	-	42
Multiple races	29.3	145	-	74	-	69

Note: There were 61 students who did not provide usable data for Q83.
 N = Number of unweighted observations.
 - = Fewer than 100 observations.

Source: Department of Public Instruction: Public Schools of NC, Youth Risk Behavior, Middle School 2001 Results.

Table A-7
2001 YOUTH RISK BEHAVIOR SURVEY RESULTS
North Carolina High School Survey
Summary Table – Weighted Data

	TOTAL 95% confidence interval		MALES 95% confidence interval		FEMALES 95% confidence interval	
	Percentage	N	Percentage	N	Percentage	N
Q23. Percentage of students who, during the past 12 months, ever felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities						
Age						
Total	29.3	2,518	20.8	1,243	38.0	1,270
15 or younger	29.8	1,054	20.3	508	38.5	545
16 or 17	28.2	1,202	21.4	600	35.5	599
18 or older	32.4	261	20.1	135	45.5	126
Grade						
9th	30.1	853	20.4	443	40.7	409
10th	28.7	643	20.6	325	37.0	317
11th	27.5	613	17.3	280	37.5	333
12th	30.3	395	25.1	187	35.0	206
Race/Ethnicity						
African American	30.3	600	22.3	299	39.0	301
Hispanic/Latino	27.5	114	-	65	-	49
White	28.8	1,564	19.6	760	37.6	802
All other races	-	90	-	53	-	35
Multiple races	30.4	141	-	61	-	80

Note: There were 30 students who did not provide usable data for Q23.
 N = Number of unweighted observations.
 - = Fewer than 100 observations.

Source: Department of Public Instruction; Public Schools of NC, Youth Risk Behavior, High School 2001 Results.

Table A-8
2001 YOUTH RISK BEHAVIOR SURVEY RESULTS
North Carolina High School Survey
Summary Table – Weighted Data

	TOTAL			MALES			FEMALES		
	Percentage	95% confidence interval	N	Percentage	95% confidence interval	N	Percentage	95% confidence interval	N
Q24. Percentage of students who seriously considered attempting suicide during the past 12 months									
Age									
Total	18.1	(16.1 - 20.0)	2,486	14.3	(12.0 - 16.5)	1,221	21.8	(19.0 - 24.7)	1,262
15 or younger	19.6	(16.9 - 22.3)	1,039	14.7	(11.2 - 18.1)	496	24.0	(19.9 - 28.1)	543
16 or 17	16.1	(13.8 - 18.4)	1,192	13.3	(11.0 - 15.6)	595	19.2	(15.7 - 22.6)	595
18 or older	20.8	(13.7 - 27.9)	254	17.0	(8.3 - 25.8)	130	24.6	(14.5 - 34.7)	124
Grade									
9th	19.3	(15.3 - 23.3)	839	14.4	(10.3 - 18.6)	432	24.5	(18.6 - 30.3)	406
10th	15.8	(12.8 - 18.9)	634	11.3	(7.8 - 14.9)	317	20.3	(16.3 - 24.3)	317
11th	17.7	(15.0 - 20.4)	613	15.2	(12.0 - 18.4)	282	20.1	(16.2 - 24.1)	331
12th	19.0	(14.7 - 23.3)	387	16.8	(10.9 - 22.6)	183	21.0	(15.2 - 26.9)	203
Race/Ethnicity									
African American	13.4	(10.8 - 16.0)	586	10.9	(7.8 - 14.0)	287	16.0	(11.5 - 20.4)	299
Hispanic/Latino	17.4	(9.6 - 25.1)	107	-	-	61	-	-	46
White	20.1	(17.8 - 22.4)	1,556	15.8	(12.7 - 18.8)	756	24.3	(21.0 - 27.6)	798
All other races	-	-	88	-	-	52	-	-	36
Multiple races	19.1	(12.2 - 26.1)	141	-	-	61	-	-	80

Note: There were 62 students who did not provide usable data for Q24.
 N = Number of unweighted observations.
 - = Fewer than 100 observations.

Source: Department of Public Instruction; Public Schools of NC, Youth Risk Behavior, High School 2001 Results.

Table A-9
2003 YOUTH RISK BEHAVIOR SURVEY RESULTS
North Carolina High School Survey
Detail Table – Weighted Data

OVERALL		AGE						GRADE			RACE/ETHNICITY			
		15 or younger	16 or 17	18 or older	9th	10th	11th	12th	African American	Hispanic/Latino	White	All other races	Multiple races	
Yes	%	18.1	19.3	11.9	17.2	21.5	18.9	14.2	15.7	21.4	18.8	16.3	21.3	
	N	481	204	43	195	139	83	63	91	32	298	28	26	
No	%	81.9	80.7	88.1	82.8	78.5	81.1	85.8	84.3	78.6	81.2	83.7	78.7	
	N	2,019	833	204	835	495	376	303	514	96	1,213	108	87	
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
	N	2,500	1,037	247	1,030	634	459	366	605	128	1,511	131	113	
MALES		AGE						GRADE			RACE/ETHNICITY			
		15 or younger	16 or 17	18 or older	9th	10th	11th	12th	African American	Hispanic/Latino	White	All other races	Multiple races	
Yes	%	13.2	14.8	11.3	10.4	14.7	16.8	12.0	7.9	-	15.2	-	-	
	N	178	83	25	58	49	40	31	28	7	118	14	10	
No	%	86.8	85.2	88.7	89.6	85.3	83.2	88.0	92.1	-	84.8	-	-	
	N	1,045	429	120	441	257	186	158	277	49	617	49	49	
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	-	100.0	-	-	
	N	1,223	512	145	499	306	226	189	305	56	735	63	59	
FEMALES		AGE						GRADE			RACE/ETHNICITY			
		15 or younger	16 or 17	18 or older	9th	10th	11th	12th	African American	Hispanic/Latino	White	All other races	Multiple races	
Yes	%	23.0	23.6	12.8	24.4	28.6	20.9	16.4	23.3	-	22.6	-	-	
	N	302	121	18	136	90	43	32	63	25	180	14	16	
No	%	77.0	76.4	87.2	75.6	71.4	79.1	83.6	76.7	-	77.4	-	-	
	N	971	403	84	393	238	189	145	236	47	596	54	36	
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	-	100.0	-	-	
	N	1,273	524	102	529	328	232	177	299	72	776	68	52	

Note: There were 53 students who did not provide usable data for Q24.

N = Number of unweighted observations.

- = Fewer than 100 cases.

Source: Department of Public Instruction: Public Schools of NC, Youth Risk Behavior, High School 2003 Results.

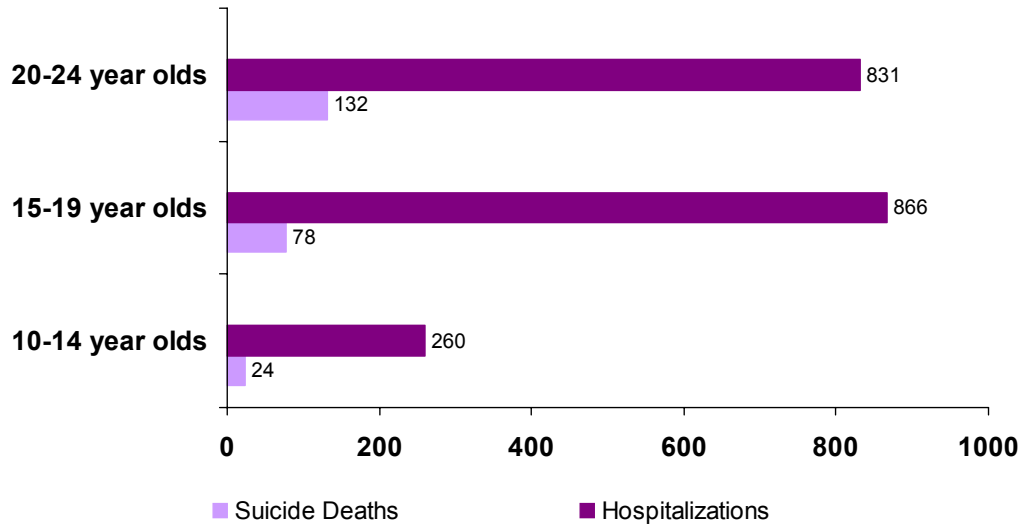
Table A-10
2002 YOUTH RISK BEHAVIOR SURVEY RESULTS
North Carolina (Alternative) High School Survey
Summary Table – Weighted Data

	TOTAL		MALES		FEMALES	
	Percentage	N	Percentage	N	Percentage	N
Q24. Percentage of students who seriously considered attempting suicide during the past 12 months						
Total	23.7	332	22.0	289	-	36
Age						
15 or younger	23.3	152	22.4	121	-	26
16 or 17	23.5	176	21.7	165	-	9
18 or older	-	4	-	3	-	1
Grade						
9th	-	0	-	0	-	0
10th	-	0	-	0	-	0
11th	-	0	-	0	-	0
12th	-	0	-	0	-	0
Race/Ethnicity						
African American	16.6	182	14.7	162	-	19
Hispanic/Latino	-	18	-	12	-	2
White	-	71	-	63	-	7
All other races	-	32	-	28	-	3
Multiple races	-	26	-	21	-	5

Note: There were 21 students who did not provide usable data for Q24.
 N = Number of unweighted observations.
 - = Fewer than 100 observations.

Source: Department of Public Instruction: Public Schools of NC, Youth Risk Behavior, Alternative High School 2002 Results (Juvenile Justice).

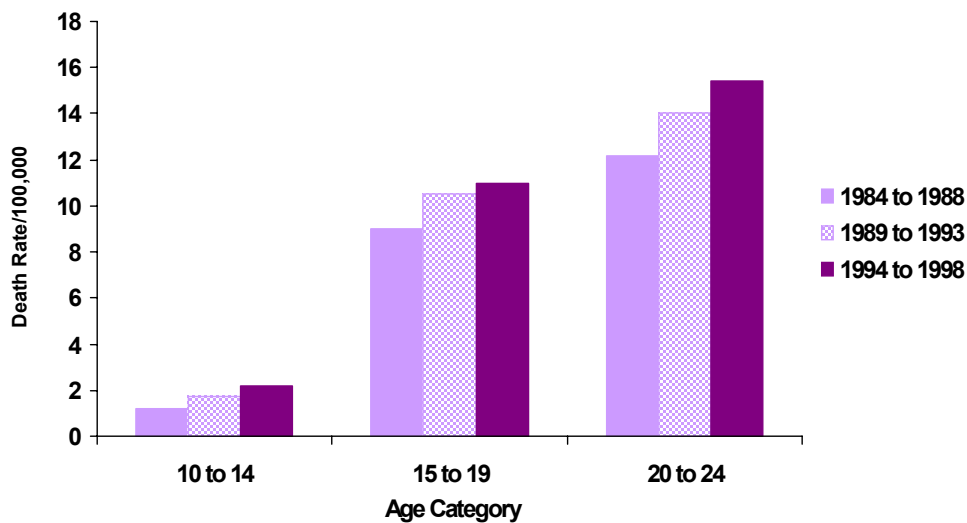
North Carolina Youth Suicide Deaths and Hospitalizations for Suicide Attempts, 1997-1998



Source: IVPD Hospitalization Discharge Data Books NC 1997-1999

Figure A-1

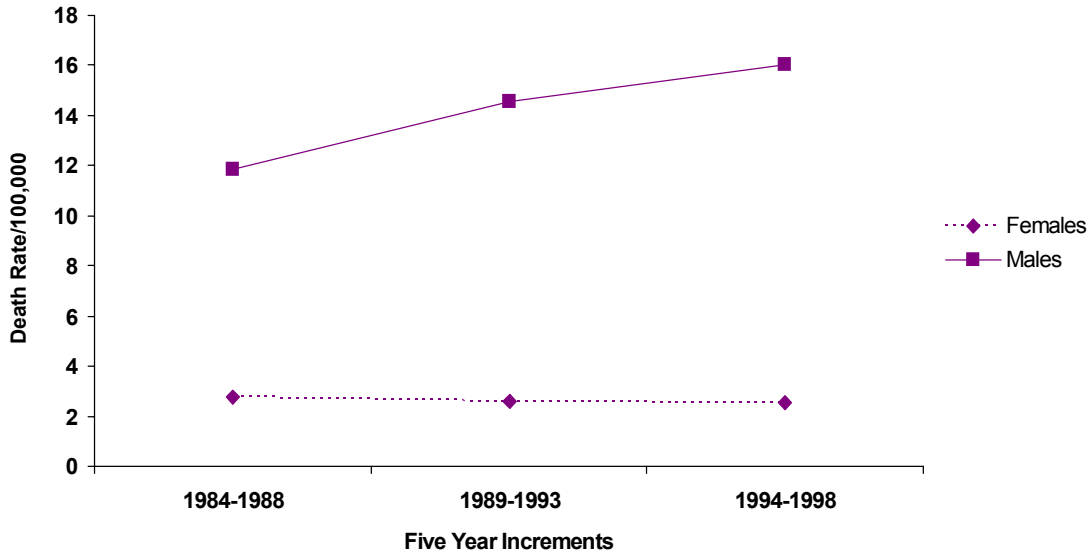
North Carolina Crude Suicide Death Rates in Five Year Increments (1984-1998) by Three Age Categories



Source: CDC WISQARS

Figure A-2

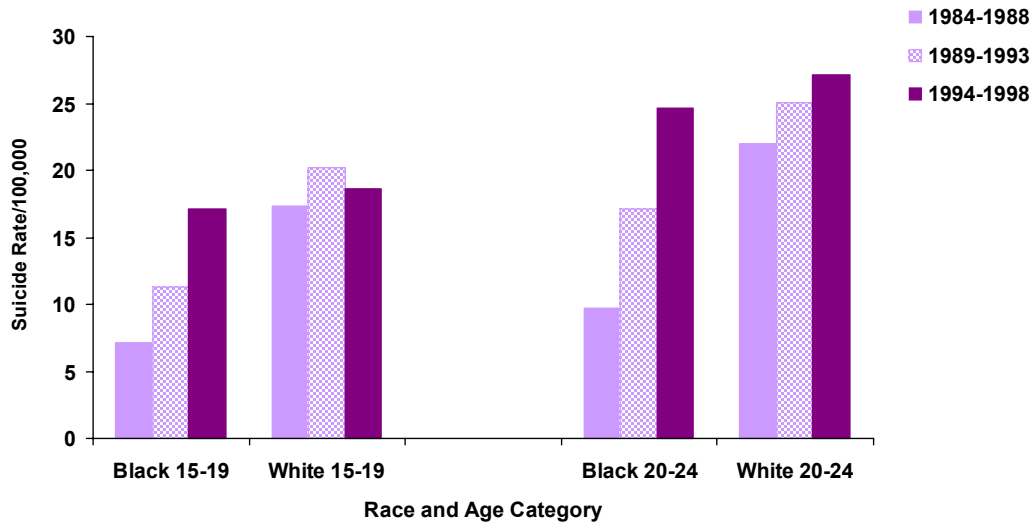
North Carolina Crude Suicide Death For Males and Females Ages 10-24 in Five Year Increments (1984-1998)



Source: CDC WISQARS

Figure A-3

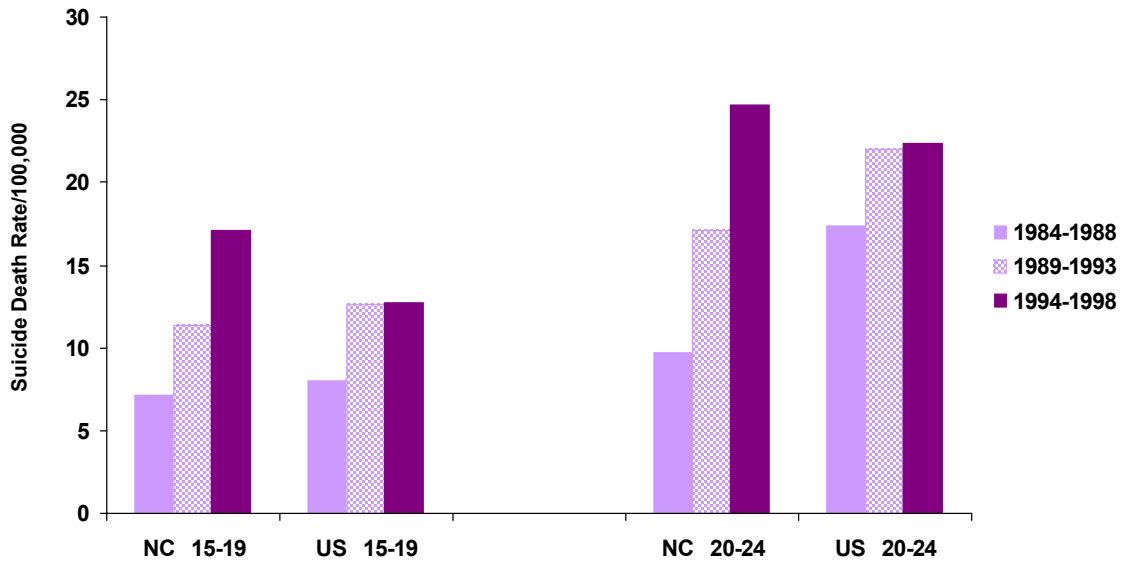
North Carolina Suicide Mortality Rates for Males by Race and Age Category (1984-1998)



Source: CDC WISQARS

Figure A-4

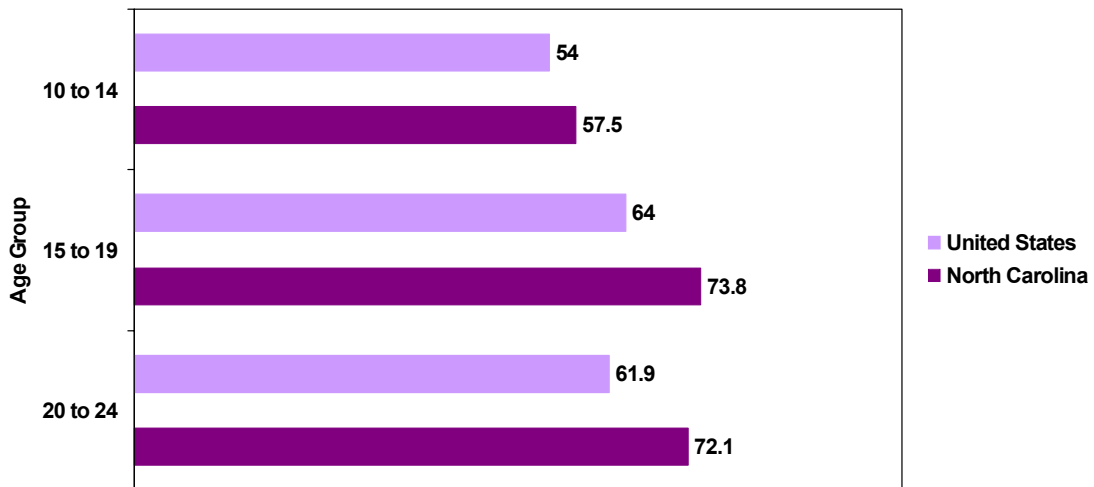
North Carolina and United States Suicide Death Rates for Black Males by Age Group



Source: CDC WISQARS

Figure A-5

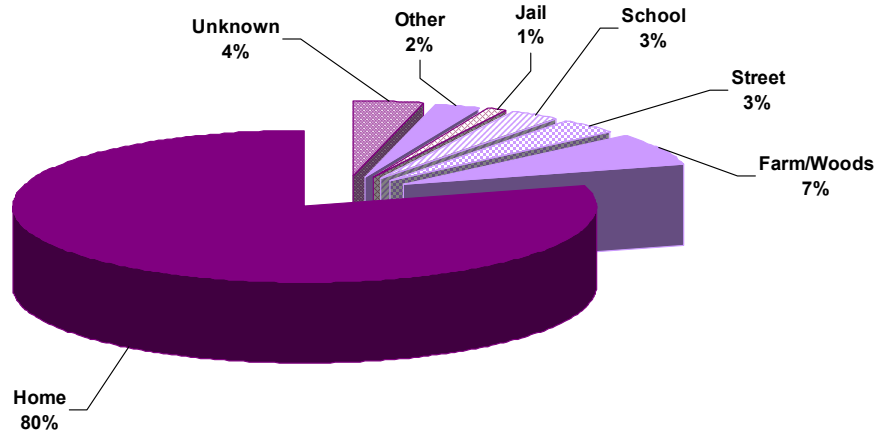
Percent of Suicides by Firearms for the United States and North Carolina by Three Age Groups (1984-1998)



Source: CDC WISQARS

Figure A-6

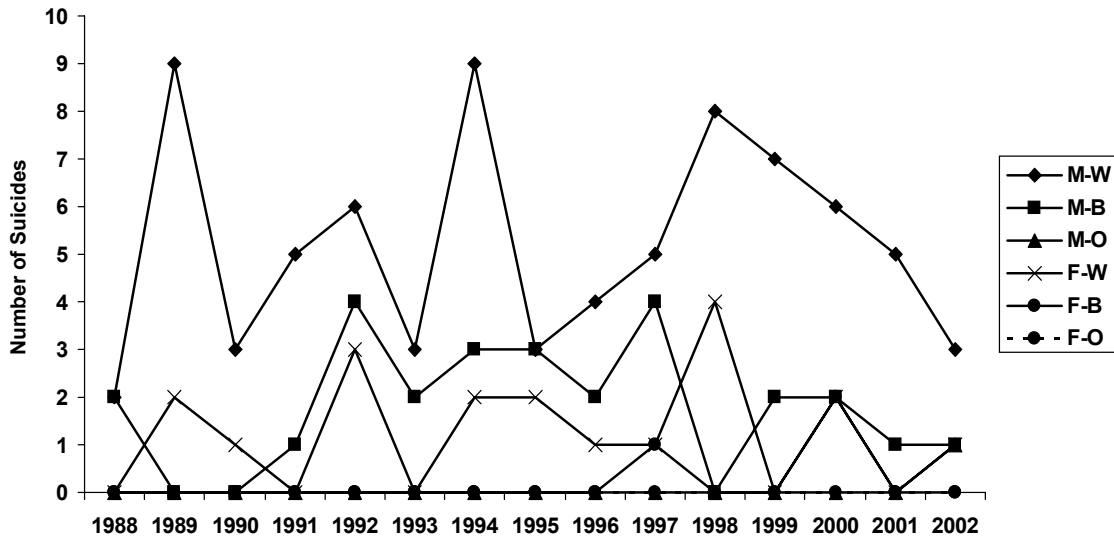
Location of Fatal Suicidal Injury for North Carolina Youth Under Age Eighteen: 1996-2000



Source: OCME, NC data 1996-2000

Figure A-7

15 Years of NC Resident Suicides in Children ages 10-14 by sex-race, 1988-2002

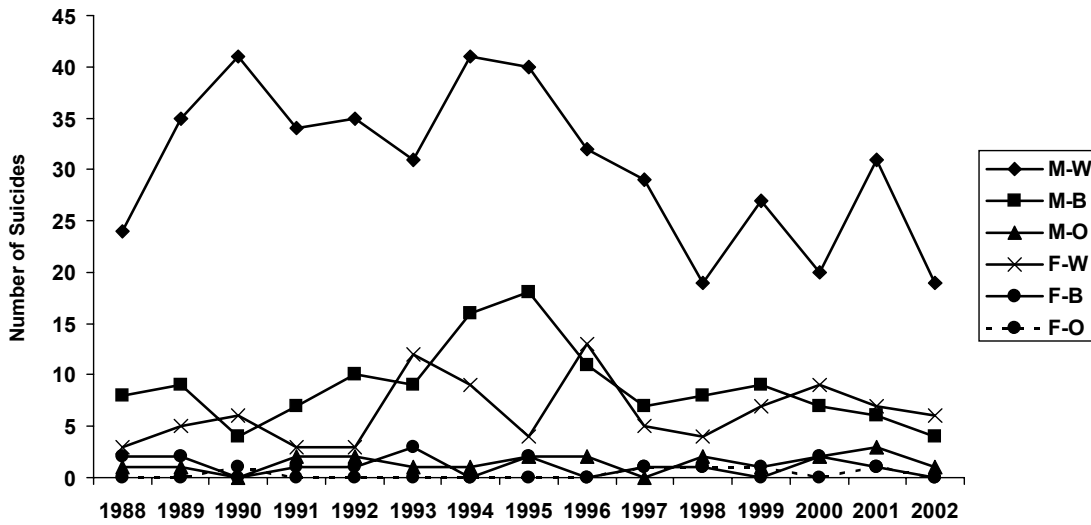


Source: North Carolina Division of Public Health, State Center for Health Statistics

M= male; F=female; W=white; B=Black; O=Other races

Figure A-8

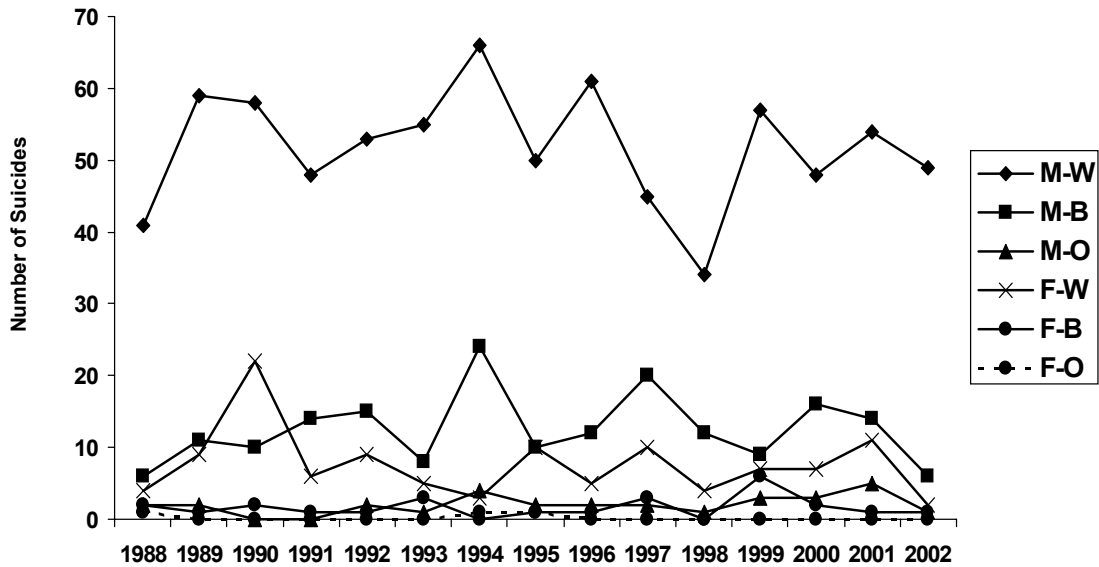
15 Years of NC Resident Suicides in Teens ages 15-19 by sex-race, 1988-2002



Source: North Carolina Division of Public Health, State Center for Health Statistics M= male; F=female; W=white; B=Black; O=Other races

Figure A-9

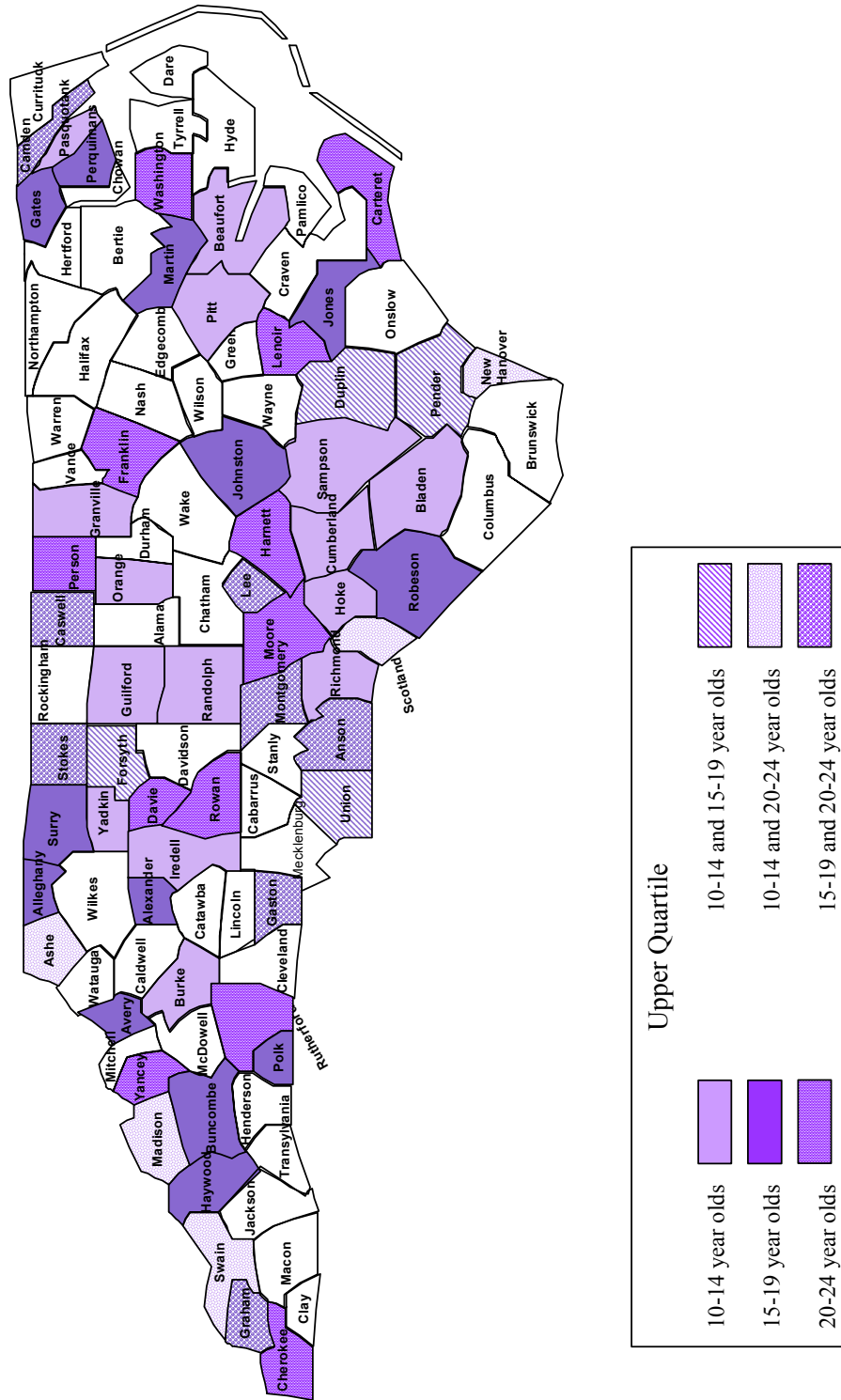
15 Years of NC Resident Suicides in Young Adults ages 20-24 by sex-race, 1988-2002



Source: North Carolina Division of Public Health, State Center for Health Statistics M= male; F=female; W=white; B=Black; O=Other races

Figure A-10

**Map A-1
North Carolina Counties with suicide rates within the upper quartile for the state, for ages 10-14, 15-19, 20-24 between 1989-1998**



Source: Injury and Violence Prevention Branch/State Center for Health Statistics. January 2004

APPENDIX B

Resources

Of Special Note: The information contained in the section *State/Local Examples and Resources* list local programs, organizations and individuals whose suicide prevention activities have become known to the North Carolina Youth Suicide Prevention Task Force either through directly serving as task force members or through community networking. This is not an exhaustive list. The North Carolina Youth Suicide Prevention Task Force acknowledges that other organizations and individuals, currently unidentified, have worked diligently in their communities to reduce youth suicide. A program's listing in this section does not necessarily indicate that it has been thoroughly researched and evaluated for effectiveness.

ACCESS RESTRICTION TO LETHAL MEANS

National Resources

Project Child Safe

- Program which promotes safe firearm handling and storage among firearm owners. The program provides safety education and free gun locking devices.

www.projectchildsafesafe.org/

PAX

- Promotes public awareness of firearm violence includes ASK (Asking Saves Kids) Campaign for parents. The campaign encourages parents to ask about the presence and storage patterns of firearms in homes where their children play and visit.

www.paxusa.org

HELP Network

- Network of medical and allied organizations which serves as a clearinghouse for firearm related information.

www.helpnetwork.org

American Academy of Pediatrics

- Information on children's and adolescent health topics including violence.

<http://www.aap.org/>

The Brady Center

- Information on firearm legislation and firearm safety programs.

<http://www.bradycenter.org/>

State/Local Examples and Resources

Child Access Protection Law

- Enacted 1993 stipulates that households with children under the age of 18 provide safe storage of their firearms.

Child Fatality Task Force

- Advocating efforts for closing gun show loopholes and expanding safe storage law to all households.

Contact: Cheryl.Waller@ncmail.net

North Carolina State University: Main Campus

- Campus residential building rooftops/balconies structurally modified to reduce risk of jumping. Also, restricted roof access at other campus buildings.
- Campus instituted zero tolerance gun and drug possession for students while on campus property.

Contact: Marie Baldrige
(919) 515-2423

Love our Kids, Lock your Guns

- Community based firearm safety education project which combines counseling and gun lock distribution conducted in Durham County.

Contact: Tamera Coyne-Beasley, MD, MPH
Assistant Professor of Pediatrics and Internal Medicine
University of North Carolina – Chapel Hill

Durham County Gun Safety Team

- In 2000, Healthy Carolinians/Durham Health Partners (a consortium of health-related organizations) published results of a poll taken of Durham citizens regarding their most pressing health concerns. Violence was rated third out of the five top concerns. During the same year, the Durham County Gun Safety Team developed its mission further to reduce death and injury related to firearms through broad based and preventive strategies that promote a safe (violence free) environment for children. The Durham Gun Safety Team has been active in the community educating citizens about ways to protect their children and families from gun violence.

Contact: Joanie Hoggard
Durham County Health Department
(919) 560-7765

North Carolinians Against Gun Violence Education Fund

- Mission is to make society safe from gun violence by educating North Carolinians about preventing gun violence, promoting the enforcement of existing gun laws, and encouraging the enactment of needed new laws.

Lisa Price, Director
(919) 403-7665

AWARENESS AND EDUCATION

National Resources

The American Association of Suicidology (AAS)

www.suicidology.org

American Foundation for Suicide Prevention (AFSP)

www.afsp.org

Suicide Awareness Voices of Education (SAVE)

www.save.org

Suicide Prevention Action Network (SPAN)

www.spanusa.org

National Organization of People of Color Against Suicide (NOPCAS)

www.NOPCAS.com

National Suicide Prevention Resource Center (NSPRC)

- Collaboration of AAS, AFSP and SPAN to provide technical assistance to state, local and non-governmental entities, provide suicide information, training and recommendations of best practices.

www.sprc.org

State/Local Examples and Resources

Mental Health Association in North Carolina

- The Campaign for America's Mental Health – MHA/NC's role in the community is one of advocate and educator. Provides educational materials on suicide prevention and depression (fact sheets, brochures, etc.) to the general public at health fairs, conferences, seminars, lectures.
- Provides information to the media on suicide prevention and depression.
- Prints brochures and fact sheets on the same topics in Spanish to be distributed to Latino organizations and at Latino venues such as health fairs as part of MHA/NC's Latino Outreach. Also in the process of developing a curriculum to set up support groups for Latina women experiencing post-partum depression.
- Has a faith-based African-American outreach, targeting African-American churches to help educate their members about depression and suicide prevention.

- MHA/NC's newsletter (3 times/year) with a circulation of 11,000.
- Annual Statewide Meeting and Conference – speakers present breakout sessions on mental health related topics.
- Conducts special events to highlight depression awareness and other mental health issues.
- Has conducted suicide awareness programs for parents and staff in middle schools.

Contact: Romaine Dougherty, Director of Community Outreach
919-981-0740 x225

The Mental Health Association in North Carolina has 41 affiliates in North Carolina.

www.mha-nc.org

Hopeline, Inc.

- Presentations to local community organizations, civic groups, businesses regarding mental health related issues (Wake, Durham, Orange counties).

Contact: (919) 832-3326

Parents Against Teen Suicide, Inc.

- Awareness and education prevention workshops for junior and high school youth (ages 12 to 20) and their parents.
- Promotion of suicide education to professional service provider groups : law enforcement, American Indian territories, medical groups.

www.teachhotline.org

North Carolina State University: Main Campus

- Informational materials on stress, depression and campus counseling center services distributed during new student orientation, placed in handbooks and mailings.

Parent orientation includes this information.

Contact: Marie Baldrige
(919) 515-2423

COMMUNITY BASED PROGRAMS

National Resources

Suicide Awareness Voices of Education (SAVE)

- Suicide Prevention Community Action Kits: contains public awareness materials, pre-printed and pre-recorded ads, organizing tips, etc. for groups wanting to become active in suicide prevention.

www.save.org

National Center for Suicide Prevention Training

- Provides educational resources to help public officials, service providers and community based coalitions. Offers on-line workshops.

www.ncspt.org

SOS High School Prevention Program

- Signs of Suicide is a nationally recognized program of suicide prevention and mental health screening for secondary school students. It provides school health professionals with education materials, a training video and implementation manual and can be blended into existing health curriculum.

http://www.mentalhealthscreening.org/sos_highschool/

Yellow Ribbon Program

- Created by the parents whose son died by suicide, the program promotes help seeking behavior in distressed youth. Utilizing instructional cards, the youth can non-verbally communicate to caregivers that they are in crisis.

<http://www.yellowribbon.org/>

State/Local Examples and Resources

Hopeline, Inc.

- Yellow Ribbon Program: provides education about how to start a program in a community.

Contact: (919) 832-3326

Durham Yellow Ribbon Program

Contact: Kathy Poole
(919) 544-7997

Working Against Violence Everywhere (WAVE)

- A toll free, 24 hour phone line available to all North Carolina schools. Students, parents, teachers and community members can call anonymously to report concerns of school safety, e.g., threats against self or others, weapons, drugs and alcohol. Program provides awareness campaign for implementation in school.

<http://www.waveamerica.com/waveline.html>

Healthy Carolinians of Stokes County

County wide effort to educate, coordinate and network local providers who can provide suicide prevention, intervention and post-vention services. Program formerly known as Stokes County Suicide Prevention Alliance.

Contact: Angie B. Cullen, RN, MBA/MHA
Healthy Carolinians Coordinator
336-593-5370
Cullenangie@aol.com

Triangle Suicide Prevention Consortium

- A newly formed group started by two survivors who are networking with community resources to address suicide prevention in the counties of Orange, Chatham, Durham and Wake.

Contact: Philip Morse
Pmorse@nc.rr.com

Healthy Wake Coalition

- A mental health subcommittee was formed to address suicide prevention in Wake County. The coalition is comprised of community partners and led by Wake County Human Services.

Contact: Karen Hartwell
Khartwell@co.wake.nc.us

Mental Health Association of North Carolina

- “Hope & Help” a depression awareness program for college women.
- In process of developing a school resource list of providers.
- Have compiled and printed a list of bi-lingual mental health providers across the state.
- The MHA/NC and the NC Primary Health Care Association are partnering to compile a list of bi-lingual providers in the area of behavioral health and primary care.

Contact: Romaine Dougherty, Director of Community Outreach
919-981-0740 x225

The Mental Health Association in North Carolina has 41 affiliates in North Carolina.

www.mha-nc.org

North Carolina State University: Main Campus

- Student Counseling Center, located on campus, screens students requesting counseling services for depressive symptoms and suicidal thoughts.
- Counseling center provides special risk population programs.
- “Fresh Start” program for students re-entering university after suspension or failure.
- Substance abuse relapse prevention program.
- Evaluation, short term treatment, support groups.
- Counselors, psychologist, psychiatrist on staff at campus based center. Appointments and walk-ins accepted. Counseling center located within general health services building so it lowers barriers to accessing care.
- Campus mental health services networked with:

The Women’s Center is a port of entry to the *Advocate’s Program* to assist students experiencing rape and sexual assault. Referrals are made to Interact counselors for those students.

Residential staff can require a resident to go to Student Health for a psychological evaluation to remain in student housing as part of their housing contract. Office of Student Conduct can also require an evaluation if a student is observed out of the campus residential facility exhibiting concerning behavior.

Health Care providers at Student Health readily refer symptomatic students or walk student into counseling area.

Contact: Marie Baldrige
(919) 515-2423

Hopeline, Inc.

- Teen Talkline for middle and high school students needing support and active listening within Wake, Durham and Orange counties.

Contact: (919) 231-3626

School based health centers

- Provides prevention, diagnosis and treatment services to students who have parental permission to receive care at a center. Comprehensive care includes physical, social, mental, and nutritional services. Students attending the centers complete an annual questionnaire, *Guidelines for Adolescent Preventive Services*, that contains questions regarding history of depression, current feelings of depression, suicide, alcohol use, abuse and weapons in the home. Licensed Clinical Social Workers and other mental health professionals provide one-on-one counseling and group sessions. The sessions include topics such as grief and anger management, improving self-esteem, establishing goals and life choices. When necessary, appropriate referrals are made from the center. There are approximately 45 centers across the state.

CRISIS INTERVENTION

National Resources

1-800-SUICIDE (National Hopeline Network)

- Connects crisis calls that originate within North Carolina to certified, networked centers and coordinates with local emergency responders and resources throughout the state in life threatening situations.

State/Local Examples and Resources

Community Crisis Centers

- “Hotline” telephone services for distressed individuals are located in several communities throughout the state. Centers can vary in hours of operation and staffing.

Refer to local telephone directory.

Examples include:

Hopeline, Inc.

- 24 hour crisis and referral phone line primarily covering Wake, Durham and Orange counties. Links callers to resources.

REAL Crisis

- 24 hour crisis and referral phone line covering Pitt County.

Teen Education and Crisis Hotline (TEACH)

- 24 hour crisis and referral line primarily covering the western counties in North Carolina.

Local Management Entities

The state's public mental health system is divided into regional coverage areas. Areas of service can be located at:

<http://www.dhhs.state.nc.us/mhddsas/dirbox.htm>

North Carolina State University

- Crisis Intervention 24 hour on call for students

Activation of 24 hour system can come from observations of campus public safety officer, residential staff, student's family, etc. Networked with local hospitals.

FAITH COMMUNITIES

National Resources

Organization for Attempters and Survivors of Suicide in Interfaith Services

- Supports message to faith based organizations about treatment of suicide as a health issue.

www.oassis.org

Evangelical Church

- Publication of an official statement/pamphlet on suicide.

http://www.elca.org/dcs/suicide_prevention.html

State/Local Examples and Resources

Sunshine Sunday

- Collaborative effort of Ashe County churches to annually devote a sermon to the issue of depression and suicide prevention. Endorsed by yearly proclamation of county commissioners.

Contact: Nancy Kautz, Ashe Memorial Hospital
Jim Weaver (336)246-4855 email at
awweaverj@fastransit.com

MEDIA GUIDELINES

National Resources

American Association for Suicidology

www.suicidology.org

American Foundation for Suicide Prevention

www.afsp.org

Suicide Awareness Voices of Education

www.save.org

SUICIDE PREVENTION/INTERVENTION TRAINING AND EDUCATION

National Resources

LivingWorks

- Canadian based organization that developed a training model for gatekeepers.
www.livingworks.net

QPR Institute

- Training model for gatekeepers and the general public.
www.qprinstitute.com

National Center for Suicide Prevention Training

- Provides on-line workshops designed to provide training to enhance suicide prevention practices and policies.
www.ncspt.org

State/Local Examples and Resources

The Mental Health Association in North Carolina

- Developing a curriculum for teachers and staff in identifying at-risk behaviors.
- Provides training to implement support groups in the schools.

Contact: Romaine Dougherty
Director of Community Outreach
919-981-0740 x225

The Mental Health Association in North Carolina has 41 affiliates in North Carolina.

www.mha-nc.org

Hopeline, Inc.

- Provides Question Persuade and Refer (QPR) training to local community groups.

Contact: (919) 832-3326

North Carolina State University: Main Campus

- Residential Housing staff including Greek Life provided with training to recognize depression/warning signs in residents.

- Campus Public Safety Officers and other health care providers and clerical staff located within the Student Health Services Center are provided with training to recognize warning signs.

LivingWorks certified trainers

- The LivingWorks Applied Suicide Intervention Skills Training (ASIST) model developed in Canada trains gatekeepers, individuals who work with or are in contact with at-risk individuals, to recognize suicide warning signs and intervene until professional help arrives.

Contact: Jane Ann Miller (919) 715-6452 for current list of trainers in the state.

Dr. David Goldston (Duke University)

- *Measuring Suicidal Behavior and Risk in Children and Adolescents*
Assessment of screening instruments
www.apa.org/books/4318001.html

SURVEILLANCE/DATA COLLECTION

National Resources

Centers for Disease Control

- Data reports and the Web-based Injury Statistics Query and Reporting System (WISQARS).
www.cdc.gov

State/Local Examples and Resources

North Carolina Death Certificates and North Carolina hospital discharge data

- Analysis requests submitted to the Statistical Services Unit at the State Center for Health Statistics, Department of Health and Human Services, Raleigh, NC. Contact Dr. Paul Buescher, 919-733-4728.

North Carolina Pre-hospitalization Medical Information System (PreMIS)

- Maintained by the DHHS North Carolina Office of Emergency Medical Services, PreMIS produces outcome reports through a web browser interface on trauma data, such as mechanism and risk, and medical record documentation, including situation, vital signs, assessment, treatment and disposition. Website is www.premis.net. Contact Dr. Sharon Schiro, 919-843-0201.

North Carolina Medical Examiner Data

- Maintained by the DHHS Office of the Chief Medical Examiner, the electronic database contains standardized information routinely collected on deaths requiring review by the state's medical examiners. Information on suicides in children and adolescents can be requested through Dr. Deborah Radisch, director of the Child Fatality Prevention Team, 919-966-2253.

National Violent Death Reporting System (NVDRS)

- The NVDRS is a relational database of deaths that occur from self-inflicted and other inflicted violence. Information is obtained from death certificates, medical examiner records, law enforcement reports and crime laboratory data on weapons. Beginning January 2004, North Carolina Violent Death Reporting System began collecting state data on all suicides, homicides, unintentional firearm deaths and legal interventions.

For more information contact Kay Sanford, Injury and Violence Prevention Branch, 919-715-6444. E-mail kay.sanford@ncmail.net

SURVIVOR INFORMATION/SUPPORT**National Resources****Suicide Prevention and Advocacy Network**

Includes information and state links.

www.spanusa.org

Survivors of Suicide

Includes information and state links.

www.survivorsofsuicide.com

Bibliography of survivor oriented books can be found at:

American Association for Suicidology

www.suicidology.org

American Foundation for Suicide Prevention

www.afsp.org

Suicide Awareness Voices of Education

www.save.org