Promising Practices to Prevent Adolescent Suicide: What Can We Learn from Florida?

Prepared by:
Priscilla A. Guild, M.S.P.H
Victoria A. Freeman, R.N., Dr.P.H.

February 7, 2006
(revised February 14, 2006)

Support for this project came from contract number 04-5240-0044 from the
Maternal and Child Health Bureau, Health Resources and Services Administration
U.S. Department of Health and Human Services

BACKGROUND

The Federal Maternal and Child Health Bureau (MCHB) administers the Title V program, a federal program devoted to improving the health of children and mothers. Each state receives funds from MCHB annually to support activities to meet the goals of Title V. Through the block grant application process, by which funds are allocated, each state describes its program structure and specific activities to accomplish the Title V goals.

Since the mid-1990s block grant applications must also include indicators of how well states are accomplishing their goals to improve the health of mothers and children. MCHB requires that all states report on a core set of performance and outcome measures. In addition, individual states select state performance and outcome measures by which to assess their progress in areas of particular concern to that state. States are given instructions regarding measurement of each performance or outcome measure. There is some latitude, however, in the reporting of these data in order to avoid costly and/or time-consuming efforts to produce reports that to a great extent replicate others being prepared by the state for other purposes.

The Title V Information System (TVIS) was developed by MCHB to compile, among other data, the states' reports for the national performance and outcome indicators as well as state-negotiated indicators. These data are available on the World Wide Web at https://performance.hrsa.gov/mchb/mchreports/index.asp and, when definitions are consistent, allow examination of individual state performance and comparison of performance across states. Data are available for 2000 through 2004 for most states and indicators.

In 2002, MCHB looked at the accumulated data on Performance Measure #16: "the rate (per 100,000) of suicide deaths among youths aged 15 through 19" for a group of "urban" states with the largest populations and identified New Jersey as the state with the lowest teen suicide rate over the past decade.[1]

The Child Health Program at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill was initially asked to look more closely at the experience of New Jersey to determine what was and is happening that might contribute to their notable performance related to the reduction of adolescent suicide in the hope that New Jersey's experience could benefit other states that are still working to meet their adolescent suicide goals. Staff at the Sheps Center used multiple methods to collect information for the study including a more detailed analysis of data for the indicator, a literature review to discover interventions that have been shown to be effective, and a visit to New Jersey to interview key informants. A copy of this report, published in December 2004, can be found on the Cecil G. Sheps Center's website http://www.schsr.unc.edu/publications.html.

In the Fall of 2004, MCHB requested that the Sheps Center do a similar report for Florida. The same general methods were used for Florida as were used for New Jersey, although the literature review was not redone. The information on the interventions to prevent adolescent suicide in Florida was collected from an extensive review of relevant websites, phone conversations with key informants, and a site visit that took place September 20-21, 2005.

---

[1] State vital records are the recommended source of data for this indicator. (USDHHD/MCHB, 2000)

REVIEW OF THE LITERATURE

Although a number of articles were reviewed, this summary of the literature draws heavily from two reviews of the literature done by Madelyn Gould and colleagues at Columbia University and the Institute of Medicine (IOM)'s book on *Reducing Suicide: A National Imperative*.

Suicide, A Leading Cause of Death for Adolescents (Age 15-19) in the United States

Table 1 shows how suicide ranks as a leading cause of death for various sex, race, and ethnic groups for 15 to 19 year olds in the U.S. for the year 2002 using the most recent Centers for Disease Control and Prevention (CDC) Web-based Injury Statistics Query and Reporting System (WISQARS) data available. (NCIPC, accessed 6/10/05) Suicide is the third leading cause of death overall. It is the second leading cause of death for Whites and American Indian/Alaskan Natives and the third leading cause of death for Blacks and Hispanics. The suicide rankings for males follow the same pattern as seen for combined sexes. The pattern is slightly different for females. For females, suicide is the fourth leading cause of death overall. It is the second leading cause of death for American Indian/Alaskan Natives, the third leading cause of death for Whites, the fourth leading cause of death for Hispanics, and the sixth leading cause of death for Blacks.

Table 1
Suicide: A Leading Cause of Death for Adolescents Age 15-19
Rank by Sex, Race, and Hispanic Origin
UNITED STATES 2002

	Total	White	Black	American Indian/AK Native	Hispanic
Total	3rd	2nd	3rd	2nd	3rd
Male	3rd	2nd	3rd	2nd	3rd
Female	4th	3rd	6th	2nd	4th

Data Downloaded from WISQARS on 6/10/05

Risk and Protective Factors

There are many ***risk factors*** that have been shown to be related to adolescent suicide in the literature although their independent effect cannot always be demonstrated. Risk factors are grouped here into personal characteristics, family characteristics, adverse life circumstances, and socioenvironmental and contextual factors as was done by Gould and colleagues. (Gould et al., 2003) Personal characteristics include:

- psychopathology, which includes psychiatric conditions such as depressive disorders (most prevalent) and substance abuse (especially among older adolescent males);

- history of a prior suicide attempt (one of the strongest predictors of a completed suicide);
- cognitive and personality factors, including hopelessness (which may be due to its relationship with depression) and poor interpersonal problem-solving ability;
- homosexual orientation, although the association has been shown to be reduced when depression, alcohol abuse, family history of attempts, and victimization are controlled; and
- biological factors, primarily related to abnormalities in serotonin function. (Gould et al., 2003)

Family characteristics include:

- family history of suicidal behavior;
- higher rates of parental psychopathology, particularly depression and substance abuse (may not be a factor when the youth's psychopathology is controlled);
- coming from nonintact families (the association decreases when parental psychopathology is controlled); and
- impaired parent-child relationships (the relationship has been shown to no longer exist when youth psychopathology is controlled). (Gould et al., 2003)

Adverse life circumstances include:

- stressful life events, such as interpersonal losses (romantic difficulties are most common for older adolescents), legal or disciplinary problems, and bullying;
- childhood physical abuse (even after controlling for other risk factors); and
- sexual abuse (effect greatly reduced after controlling for potential confounding factors). (Gould et al., 2003)

Finally, socioenvironmental and contextual factors include:

- difficulties in school, neither working nor being in school, and not going to college; and
- impact of the media supporting the notion of suicide contagion. (Gould et al., 2003)

There is little evidence of an association between socioeconomic status (SES) and suicide. (Gould et al., 2003)

It can be seen that youth psychopathology is a very important risk factor that, in many cases, mitigates the effect of the other risk factors. In material published on the *Healthy People 2010* objectives it was reported that in a given year one in five children and adolescents between 9 and 17 years of age have a diagnosable mental disorder that can lead to school failure, alcohol or illicit drug use, violence, or suicide. Of these children and adolescents, 20 percent have a diagnosable disorder; 9-13 percent have a serious emotional disturbance with substantial functional impairment; and 5-9 percent have a serious emotional disturbance with extreme functional impairment. (USDHHS, 2000)

Although the understanding of suicide risk factors among youth is highly developed when compared to what is known about other age groups, few data are available to specifically discriminate those who will try (or have tried) to kill themselves from those with similar problems who are not suicidal or who have suicidal ideas but do not act. (URMC, 2001, accessed March 31, 2003)

Several ***protective factors*** have also been identified. As might be expected, most of these are the antithesis of the risk factors. They include:

- family cohesion; (Gould et al., 2003)

- religiosity; (Gould et al., 2003)
- resiliency, self esteem, direction, mission, determination, perseverance, optimism, and empathy; (Goldsmith et al., 2002)
- coping and problem solving skills, insight, and intellectual competence; (Goldsmith et al., 2002) and
- social support and close relationships, availability of caring adult, and participation and bond with school. (Goldsmith et al., 2002)

Suicide Prevention Interventions

Youth suicide prevention strategies are grouped into three domains as was done by Gould and colleagues—school, community, and health care system. (Gould et al., 2003)

School-Based Suicide Prevention Programs:

The underlying rationale of **school-based suicide awareness curricula** is based on findings from Kalafat and others that teenagers are more likely to turn to peers than to adults in dealing with suicidal thoughts, and that a large proportion of teens know a suicidal peer yet they do not respond appropriately. While several controlled studies by Kalafat and others have reported modest increases in knowledge, attitudes, and help-seeking behaviors, others have reported no benefits or no detrimental effects. In light of these findings, efforts have now shifted toward programs that emphasize the following alternative school-based strategies. (Gould et al., 2003)

Based on the premise that some adolescents have poor problem-solving, coping, and cognitive skills, **skills training programs** emphasize the development of these skills. Although several evaluations have shown promising results, additional research is needed to refine this type of intervention. (Gould et al., 2003)

A few studies that examined the clinical efficacy of **school-based screening** programs have shown promising results related to identifying teens at risk for suicide. In the few studies that examined the efficacy of these programs, the sensitivity of the screening instruments ranged from 83 to 100 percent and the specificity ranged from 51 to 76 percent; therefore, although there were few false negatives, there were many false positives. This promising strategy also has some problems associated with it. Since suicide risk is not a constant and the urge comes and goes over time, multiple screenings are necessary. In addition, school-wide screening programs have been reported to be unacceptable to high school principals although few have personal experience with this type of program and the success of the program ultimately depends on effective referral for treatment. (Gould et al., 2003) The Columbia TeenScreen Program is one example of a screening program that has been used in schools and other facilities serving youth. This program is described later in this report along with findings from several evaluations.

Gatekeeper training involves training school personnel to identify students at risk of suicide, determine their level of risk, and make appropriate referrals. It is based on the premise that suicidal youth are under-identified at schools, and, with the appropriate knowledge, this could be corrected. Research on its effectiveness is limited but encouraging. (Gould et al., 2003)

Peer helper programs are based on the premise that suicidal youth are more likely to confide in a peer than an adult. The roles peers play vary by program and empirical evaluations are limited. Even though this approach is widely used, there is little evidence documenting the efficacy or safety of peer helpers. (Gould et al., 2003)

Postvention or crisis intervention programs have been developed on the premise that a timely response to a suicide is likely to reduce subsequent suicide attempts and completed suicides in fellow students. Here again, there is little research on the efficacy of these programs. (Gould et al., 2003)

Community-Based Prevention Programs:

Crisis centers and hotlines were developed to provide timely services outside of usual office hours to persons at risk for suicide. Unfortunately there is little evidence of their efficacy in serving teenagers. (Gould et al., 2003)

Since the use of firearms is the most common method for committing suicide nationally, it is felt that **restriction of firearms** may reduce suicides. Literature on the effect of restricting firearms on suicide has been mixed with some studies showing an effect and others showing none. In addition, a comparison of states that did and did not pass the 1994 Brady Bill that imposes a delay on the purchase of handguns showed no impact except for elderly males. For youth, a less controversial approach may be parent education about the means of restricting the availability of firearms to high-risk youth; however, one study found that parents of depressed adolescents were frequently noncompliant. There is some evidence that method substitution exists but the other methods used are usually less lethal. (Gould et al., 2003)

Given the lack of evidence in the literature of the effectiveness of media campaigns (Goldsmith et al., 2002) and the substantial evidence for suicide contagion (Gould et al., 2003; Goldsmith et al., 2002), a recommended suicide strategy involves **education of the media** (reporters, editors, film and television producers, etc.) about their role in appropriately producing media stories to reduce this harm.

Health Care-Based Prevention Programs:

There is evidence of the need for **training pediatricians and other primary care physicians** in the U.S. regarding suicide risk and prevention. Among 600 pediatricians and family practitioners in North Carolina who prescribed a Selective Serotonin Re-uptake Inhibitor (SSRI) antidepressant for a child or adolescent patient, only 8 percent felt they had received adequate training in the treatment of childhood depression and only 16 percent indicated they felt comfortable in treating children with depression. In addition, although many suicidal young people between 15 and 34 years of age sought medical care in the month before their suicidal behavior, fewer than half of the physicians surveyed reported that they routinely screened for suicidal risk. A study from Australia found that a 1-day training session for primary care physicians can significantly increase their identification of suicidal patients. (Gould et al., 2003)

There is little evidence in the literature of **treatment programs** that have been systematically evaluated and shown to have an impact on reducing suicidal ideation and behavior in children and adolescents, mainly because suicidal adolescents are usually excluded from studies of these programs. Procedures for the acute care treatment for suicidal adolescents were published by the American Academy of Child and Adolescent Psychiatry in 2001, but they are largely based on common sense approaches and expert clinician consensus. In addition, no-suicide contracts, which are commonly negotiated at the start of treatment, have not been empirically evaluated. (Gould et al., 2003)

The effectiveness of **inpatient care or partial hospitalization** in reducing rates of suicide ideation, non-lethal attempts, or completed suicides among adolescents has not been shown in the literature. **Outpatient treatment** has also been shown to not be effective because the low rates of compliance for adolescents makes these programs difficult to implement. (Gould et al., 2003)

Very few randomized controlled trials of **psychotherapy** have included adolescents in their samples. Although cognitive-behavioral therapy has been successfully used to treat adolescents with depression, no studies have been published on its use with suicide attempters. (Gould et al., 2003)

Until recently, there have been no studies of **psychopharmacological interventions** targeted at adolescents, although the rate of prescribing antidepressants to teenagers is extremely high and almost certainly includes adolescents who have attempted suicide. (Gould et al., 2003) Using prescription data from a large pharmacy benefit management organization, national suicide mortality files from CDC, regional geographic characteristics from the Census Bureau, and the geographic distribution of physicians using the Area Resource File, a cross-sectional study by Olfson and colleagues showed an inverse relationship between an increase in regional antidepressant medication treatment and the regional rates of suicide when data from 1990 were compared to 2000. Significant inverse trends were seen for older adolescents (age 15-19) and males but not for younger adolescents (age 10-14) and females. Although the study has some limitations, it is a first step in looking at the relationship between antidepressant use and adolescent suicide. (Olfson et al., 2003)

Lessons Learned by the Systematic Review of Suicide Prevention Programs Nationally:

Using the snowball sampling technique, O'Carroll and colleagues at CDC contacted suicide prevention experts in the U.S. and Canada. These individuals were asked to identify and describe suicide prevention programs for adolescents and young adults that they felt were effective based on their experience and assessment. Once the results were compiled, representatives of the identified programs were contacted and asked to expand the descriptions of their programs and to identify other programs they felt were exemplary. Representatives from the second wave of programs were contacted and asked to describe their programs. The list was further supplemented by contacting program representatives who participated in a national meeting of the American Association of Suicidology and by soliciting program contacts through their newsletter, *Newslink*. These programs were then categorized as follows: school gatekeeper training, community gatekeeper training, general suicide education, screening programs, peer

support programs, crisis centers and hotlines, restriction of access to lethal means, and intervention after suicide. After doing this categorization, an expert group at CDC reviewed the list to identify recurrent themes across the various categories and make suggestions for future research. The following were among the findings:

- Links between suicide prevention programs and existing community resources are frequently inadequate.
- Some potentially successful strategies (i.e., restricting access to firearms and drugs and peer programs) are applied infrequently yet other less proven approaches (school-based education) are applied commonly.
- Many programs with potential for reducing suicide among adolescents and young adults (i.e., alcohol and drug-abuse treatment programs or programs to help provide services to runaways, pregnant teenagers, and/or high school dropouts) are not considered or evaluated as suicide prevention programs.
- The effectiveness of suicide prevention programs has not been systematically evaluated. (O'Carroll et al., 1994)

Barriers to Effective Interventions:

The IOM Report, *Reducing Suicide: A National Perspective*, identified a number of barriers to effective treatment and intervention including stigma and discrimination, financial barriers, mental health system barriers, managed care barriers, clinician barriers, and patient barriers.

The **stigma** of mental illness deters patients from seeking treatment. If they seek it, adolescents and certain ethnic minorities are less likely to complete treatment. Stigma of mental illness is also a barrier to insurance coverage and adds to housing and employment discrimination. Stigma may deter people from disclosing suicidal thoughts to their physician and family members may conceal problems for fear of blame. (Goldsmith et al., 2002)

There is evidence that the use of mental health services falls as the costs rise. In addition, there are insurance restrictions on mental health coverage. Legislative efforts are needed to remove some of the **financial barriers**. (Goldsmith et al., 2002)

There are several barriers related to the **mental health care system**. Mental health services are fragmented, especially if co-occurring conditions are involved such as drug abuse. Linkages between specialty mental health care and primary care, or emergency room care and substance abuse care are weak. Specifically for adolescents, many school-based programs are not linked with mental health or substance abuse care. Linkages between inpatient and outpatient care are also missing. Successful modes of care involve wrap-around services with multi-system treatment for adolescents with severe emotional problems. There is a lack of availability of "state-of-the-art" programs and a lack of any services in rural areas. In addition, there are problems with adapting programs for new settings. (Goldsmith et al., 2002)

Primary care settings have become critical to the detection of depression and alcohol disorders. Seventy-five percent of those seeking help for depression would rather stay in the primary care setting. Screening in the primary care setting is inadequate, only 30-50 percent of adults with diagnosable depression are accurately diagnosed in the primary care setting. Only 58 percent of

a random sample of 3375 primary care clinicians directly questioned patients about suicide during a routine depression evaluation even though suicidal thought should be queried. Family physicians (65%) and general internists (52%) were more likely to ask direct questions about suicide than obstetricians (48%). Even if diagnosed, only a minority of patients receive adequate treatment for depression mainly due to a lack of provider knowledge and time with the patient. Substance abuse disorders are second to mood disorders as the most common risk for suicide and are an especially important risk factor for young adults. In recent surveys, 40 percent of primary care physicians did not perform routine screening for substance abuse reportedly due to lack of time or fears of spoiling the relationship with the patient. Thirty-four (34) to 38 percent of persons who are suicide victims visited a primary care provider one month prior to the event. This is even more common for adults less than age 35. This suggests that patients are motivated to seek help but are reluctant to bring up suicide, yet they usually tell their physician if asked. Since suicide is a rare event in the primary care provider's practice (1 suicide every 3-5 years), they have little incentive to assess asymptomatic patients. (Goldsmith et al., 2002)

Suicidal patients are frequently seen in the **emergency department** (ED). The barriers to care in this setting include: covert symptoms that are not recognized, lack of assessment guidelines, and lack of training of ED staff. Once diagnosed, it is important that patients get into treatment promptly. Suicide attempters are at risk for re-attempt or completed suicide, but they often do not receive follow-up care. Nearly half of all adolescents who attempted suicide and were seen in the ED did not receive subsequent care after their ED visit. (Goldsmith et al., 2002) In addition, stigma, denial, and avoidance on the part of the adolescent may be reasons why the diagnosis of the problem is missed in the ED.

A significant percent of suicide completers had made recent contact with a **specialty mental health care** provider either in the community or hospital. Problems here are similar to those in the primary care setting including failure to assess for suicide risk. An additional barrier to treatment of patients of racial, ethnic, and cultural minorities is the substantial under-representation of these groups among providers. (Goldsmith et al., 2002)

Managed care programs now cover almost 72 percent of Americans with health insurance and there is an emphasis on providing mental health treatment as part of primary care. This is of particular benefit for minorities and older persons who are less likely to go for specialty care. However, the quality of care might not be as good, there could be a denial of needed care, and under-treatment can occur. Managed care has lowered the cost of mental health services but may have lowered access and quality too, and the impact of these reductions on suicide has been largely unstudied. It is recommended that quality care/utilization management guidelines for effective response to and treatment of individuals at risk for suicide be developed by managed care organizations and health insurance plans. (Goldsmith et al., 2002)

For the **clinician** an overarching **barrier** is the lack of assessment and treatment guidelines. Suicide assessment tools are infrequently used by practicing psychologists, psychiatrists, and clinical social workers because they do not find the current scales (i.e., Hopelessness Scale and Suicide Intent Scale) to be very useful. In a survey of 600 patients, 69 percent indicated that they were misdiagnosed and frequently had to consult four physicians before a correct diagnosis was made. Across all settings, only about 22 percent of suicide victims communicate their intent to

physicians. There are no clinical guidelines for the treatment of those who attempt suicide. This is probably due to the lack of power and rigor in research designs for suicide attempt treatments. Psychological autopsy studies have found a large percentage of suicide victims with depression were not receiving adequate treatment. Substance abuse is also often under-treated in suicidal patients. (Goldsmith et al., 2002)

Major **patient barriers** to treatment are stigma, cost, and fragmentation of services, which have been previously discussed. Fear of being hospitalized, lack of medication adherence, and lack of spontaneous reporting by the patient are additional barriers. Barriers for the adolescent (also previously discussed) are low access to care (especially for those who have dropped out of school and are unemployed), low help seeking behavior, low utilization, problems with clinician detection of suicidality, and problems with referral and adherence to care. Only nine percent of teachers and 1/3 of high school counselors thought they could recognize a student at risk for suicide. (Goldsmith et al., 2002)

Summary of the Literature Review

For suicide in general and adolescent suicide in particular, there is little well documented information on risk factors that have an independent effect on the event or on effective prevention interventions. There are three risk factors that have been documented to have a major effect independently of other factors and include psychopathology, including depression and substance abuse; childhood physical abuse; and history of a prior attempt. Interventions that show documented promise in the schools are awareness curricula; problem-solving, coping, and cognitive skills training; screening programs; and gatekeeper training. Within the community, firearms restrictions and media training show the most promise. For the health care community, physician training in the detection of suicide risk and treatment of depression using SSRI antidepressants is needed. A number of the interventions already discussed will work toward removing the barriers that prevent adolescents from seeking the suicide prevention services they need. Stigma, cost, and fragmentation of services are not being addressed by the preventive strategies described in the literature and need to be considered in order to have a comprehensive approach to this problem.

Although O'Carroll and colleagues' work at CDC was completed in 1994, after review of more recent articles on adolescent suicide, the following recommendations from their work are still valid:

- Ensure that suicide prevention programs are linked as closely as possible with professional mental health resources in the community.
- Avoid reliance on one prevention strategy.
- Incorporate promising, but underused strategies (e.g., restricting access to lethal means) into current programs where possible.
- Incorporate evaluation efforts into suicide prevention programs. (O'Carroll et al., 1994)

TRENDS IN ADOLESCENT SUICIDE IN THE UNITED STATES[2]

In 2002, the national suicide rate for 15-19 year olds was 7.4 per 100,000. (NCIPC, accessed 6/14/05) Although not high, when suicide attempts and suicidal ideation are taken into account, the magnitude of the problem increases. Since 1993, CDC has conducted the Youth Risk Behavior Survey (YRBS) every two years. This is a school-based survey of a representative sample of high school students in grades 9-12 throughout the country. Within this survey there is information on suicide attempts and ideation. By self-report in the 2003 survey, 16.9 percent of high school students seriously considered attempting suicide, 16.5 percent made a specific plan for suicide, 8.5 percent had attempted suicide at least once in the 12 months preceding the survey, and 2.9 percent made a suicide attempt that had to be treated by a doctor or nurse. (Grunbaum et. al., 2004)

Table 2 summarizes adolescent suicide rates for the U.S. by race and Hispanic origin using WISQARS data. (NCIPC, accessed 6/14/05) It should be noted that WISQARS data uses International Classification of Diseases (ICD)-9 codes (E950-E959) for 1991-98 and ICD-10 codes (X60-X84, Y87.0) beginning in 1999. Although ICD-10 uses a completely different coding system than ICD-9, it has been determined that the comparability ratios for overall intentional self-harm (suicide) are very close to 1.0 and thus the revision does not substantially affect the rates and they can be compared over these two time periods. (Anderson, et al., 2001) Overall there has been a 33 percent reduction in the adolescent suicide rate between 1991 and 2002 (11.0 in 1991 to 7.4 in 2002). The rates for Whites decreased 31 percent between 1991 and 2002 (11.8 in 1991 to 8.2 in 2002). Black rates went from a high of 9.5/100,000 in 1994 to 4.0/100,000 in 2002, a 58 percent reduction. American Indian/Alaskan Native rates fluctuated, but since the high in 1996 of 24.6/100,000, they dropped to 14.4 in 2002 (44% reduction). Finally, Hispanic rates went from a high of 8.9/100,000 in 1993 to 5.2/100,000 in 2001, a 42 percent reduction, with a 10 percent rise in 2002 to 5.7/100,000. (NCIPC, accessed 6/14/05) The adolescent suicide rates have also shown some consistency over time when comparing race and ethnicity with American Indian/Alaskan Natives having the highest rates and Blacks the lowest rates. The rates for Whites and Hispanics fall in between these two groups. In 2002, the national suicide rate for American Indian/Alaskan Natives was 14.4, followed by Whites (8.2), Hispanics (5.7), and Blacks (4.0). (NCIPC, accessed 6/14/05)

---

[2] There are a few problems with suicide data that should be noted. Suicide rates and methods only capture data on completed suicides. In addition, data can vary for the following reasons:

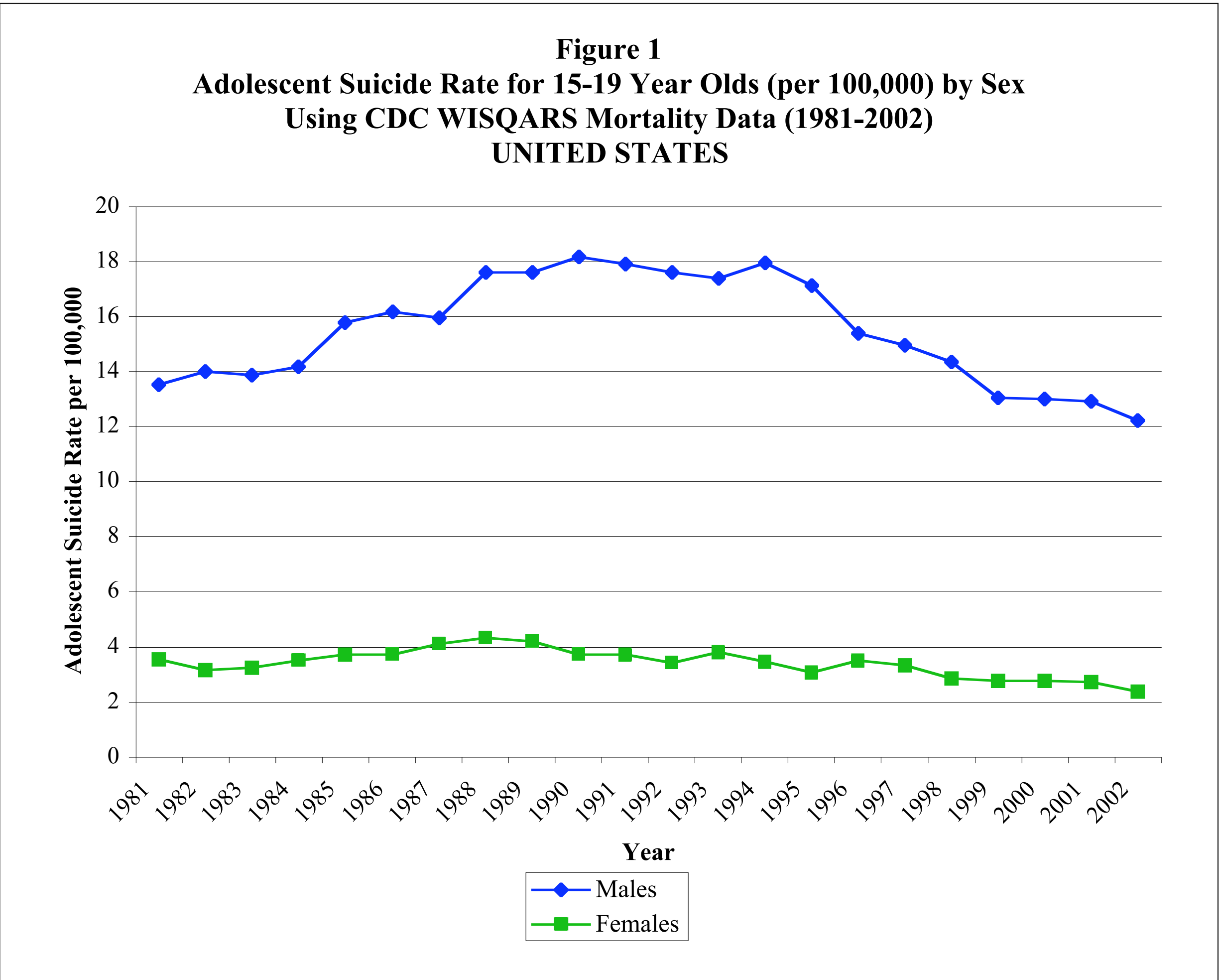
- differences in definition and how ambiguous cases are classified,
- differences in training and background for coroners and medical examiners,
- differences in the extent to which cases are investigated, and
- differences in quality of data management. (Goldsmith et al., 2002)

Table 2
Adolescent Suicide Mortality Rates for 15-19 Year Olds (per 100,000)
by Race and Hispanic Origin
Using CDC WISQARS Mortality Data (1991-2002)
UNITED STATES

Year	Total	White	Black	American Indian/AK Native	Hispanic Origin
1991	11.0	11.8	6.9	22.8	7.7
1992	10.7	11.1	8.4	18.8	8.1
1993	10.8	11.4	7.9	15.7	8.9
1994	10.9	11.2	9.5	22.3	8.5
1995	10.3	10.9	8.0	12.4	8.4
1996	9.6	10.2	6.6	24.6	7.9
1997	9.3	9.8	7.0	18.4	7.2
1998	8.8	9.2	6.2	20.0	6.1
1999	8.0	8.5	5.8	19.2	5.7
2000	8.0	8.5	5.5	15.5	5.6
2001	8.0	8.6	4.3	18.0	5.2
2002	7.4	8.2	4.0	14.4	5.7

Data Downloaded from WISQARS on 6/14/05.

Historically, suicide rates have been higher for males than females. After nearly a threefold increase in the adolescent male suicide rate between 1964 and 1988, the consistent increase ceased and the rate has been declining since the mid-1990s. (Gould et al., 2003) Figure 1 shows the adolescent suicide rates for the U. S. by sex from 1981 (the first year WISQARS data are available) to 2002. In 2002, the rate per 100,000 for males was 12.2/100,000, 5.1 times the female rate of 2.4/100,000. The suicide rate for males dropped from a high of 18.2 in 1990 to 12.2 in 2002, a 33 percent decrease. The rates between 1999 and 2001 remained relatively stable, dropping again in 2002. The suicide rate for females rose slightly between 1982 and 1988 when it began to fall to its lowest rate in 2002. Although based on smaller numbers, between 1988 and 2002 the female adolescent suicide rate decreased 44 percent, dropping from 4.3/100,000 in 1988 to 2.4/100,000 in 2002. Between 1998 and 2001 the rates have remained relatively stable, dropping again in 2002.



Tables 3 and 4 summarize data from the 2003 YRBS by sex, race, and ethnicity. In Table 3, although females have lower suicide rates than males, they have higher rates than males for feeling sad and hopeless (35.5% vs. 21.9%), considering suicide (21.3% vs. 12.8%), and unsuccessful suicide attempts (11.5% vs. 5.4%). Whites also had higher rates of considering suicide than Blacks (16.5% vs. 12.5%) but Blacks had higher rates for suicide attempts (8.4% vs. 6.9%). Hispanic and White females had the highest rates for considering suicide (23.4% and 21.2% respectively) and attempting suicide (15.0% and 10.3% respectively). Black males had the lowest rate of considering suicide (10.3%), while white males had the lowest rate of attempted suicides (3.7%). (Grunbaum et. al., 2004)

Table 3
Percent of High School Students Who Felt Sad or Hopeless, Seriously Considered Attempting Suicide or Attempted Suicide in the 12 Months Preceding the Survey by Sex, Race, and Ethnicity
CDC's Youth Risk Behavior Surveillance System
UNITED STATES 2003

Felt Sad or Hopeless	Females	Males	Total
Total	35.5% (±2.5)	21.9% (±1.4)	28.6% (±1.7)
Whites	33.3% (±3.8)	19.6% (±1.6)	26.2% (±2.1)
Blacks	30.8% (±3.1)	21.7% (±3.3)	26.3% (±2.5)
Hispanics	44.9% (±4.0)	25.9% (±3.0)	35.4% (±3.1)
Considered Attempting Suicide	**Females**	**Males**	**Total**
Total	21.3% (±1.1)	12.8% (±1.0)	16.9% (±0.7)
Whites	21.2% (±1.8)	12.0% (±1.4)	16.5% (±1.0)
Blacks	14.7% (±2.5)	10.3% (±2.1)	12.5% (±1.7)
Hispanics	23.4% (±2.6)	12.9% (±2.2)	18.1% (±1.7)
Attempted Suicide	**Females**	**Males**	**Total**
Total	11.5% (±1.4)	5.4% (±1.0)	8.5% (±1.1)
Whites	10.3% (±1.8)	3.7% (±0.8)	6.9% (±1.0)
Blacks	9.0% (±1.8)	7.7% (±3.0)	8.4% (±1.7)
Hispanics	15.0% (±2.3)	6.1% (±1.9)	10.6% (±1.3)

Table 4 shows that in 2003 males had higher rates than females of carrying a weapon (26.9% vs. 6.7%) or a gun (10.2% vs. 1.6%) in the past 30 days. This is true for Blacks, Whites, and Hispanics.

Table 4
Percent of High School Students Who Carried a Weapon (i.e., gun, knife, club,) or Carried a Gun on One or More of the Past 30 Days by Sex, Race, and Ethnicity
CDC's Youth Risk Behavior Surveillance System
UNITED STATES 2003

Carried a Weapon	Females	Males	Total
Total	6.7 (±1.2)	26.9 (±2.6)	17.1 (±1.8)
Whites	5.5 (±1.4)	27.1 (±2.9)	16.7 (±1.9)
Blacks	9.8 (±2.6)	24.9 (±5.0)	17.3 (±3.5)
Hispanics	8.5 (±1.9)	24.3 (±4.9)	16.5 (±2.6)
Carried a Gun	**Females**	**Males**	**Total**
Total	1.6 (±0.6)	10.2 (±1.7)	6.1 (±1.1)
Whites	1.5 (±0.8)	10.0 (±2.2	5.9 (±1.3)
Blacks	1.4 (±0.8)	10.6 (±2.4)	6.0 (±1.5)
Hispanics	2.6 (±1.6)	8.2 (±2.3)	5.4 (±1.4)

Throughout the world suicide rates are found to be higher in rural versus urban areas. When suicide rates are mapped by county in the U.S., they are higher in the counties in the western, less populated states. This relationship holds even when rates are controlled for age, sex, and race. Looking at urbanization, suicide rates are highest in less populated areas as compared to densely populated cities. (Goldsmith et al., 2002) Much of this observed difference may be more appropriately attributed to various policies and programs implemented in densely populated areas.

Table 5 looks at method of adolescent suicides (age 15-19 years) in the U.S. between 1991 and 2002 for males and females using WISQARS data. (NCIPC, accessed 6/14/05) Firearms were used more by males than by females as a primary method of suicide. Firearms were the most frequently used method for both groups until 2001 when suffocation surpassed firearms as the method of choice for females. The rate of use by males has been decreasing since 1994 from a high of 73.0 percent to a low of 52.2 percent. The rates for females increased between 1992 and 1994 and then decreased in most years to a low of 31.8 percent in 2002. Suffocation is the second most common method used by adolescent males and females (35.4% for males and 41.6% for females in 2002). As the rate of firearm use as a method has decreased, the use of suffocation has increased for both groups. Poisoning was used as a method more by females (18.5% in 2002) than males (5.9% in 2002), although overall the use of this method has decreased for both groups. Since female teens tend to use less lethal methods (i.e., suffocation and poisoning) more than males, this is most likely one of the reasons for their lower adolescent suicide rates.

Table 5
Percent Distribution of Method of Suicide by Gender and Year
Using CDC WISQARS Mortality Data (1992-2002)
United States 15-19 Year Olds

MALES	Firearms	Poisoning	Suffocation	Other Method
1991	70.9%	7.1%	17.6%	4.4%
1992	71.5%	6.8%	18.0%	3.7%
1993	70.7%	6.4%	18.4%	4.5%
1994	73.0%	4.1%	18.2%	4.7%
1995	69.3%	5.0%	19.8%	5.9%
1996	66.3%	5.7%	22.7%	5.2%
1997	65.4%	3.4%	25.7%	5.4%
1998	64.9%	4.5%	24.9%	5.7%
1999	64.4%	4.2%	25.8%	5.7%
2000	58.7%	5.2%	30.6%	5.5%
2001	55.2%	4.9%	33.7%	6.2%
2002	52.2%	5.9%	35.4%	6.6%
FEMALES	**Firearms**	**Poisoning**	**Suffocation**	**Other Method**
1991	49.5%	29.6%	16.1%	4.8%
1992	47.4%	30.0%	18.1%	4.5%
1993	52.6%	24.1%	16.4%	6.8%
1994	57.9%	21.4%	14.7%	3.0%
1995	53.6%	20.1%	18.6%	8.0%
1996	48.3%	14.6%	29.3%	7.8%
1997	51.3%	14.1%	28.8%	5.8%
1998	50.4%	13.5%	28.5%	7.7%
1999	40.3%	17.5%	32.5%	9.7%
2000	38.5%	15.2%	37.0%	9.3%
2001	35.7%	19.2%	36.8%	8.3%
2002	31.8%	18.5%	41.6%	8.2%

Death Data Downloaded from WISQARS on 6/14/05

ADOLESCENT SUICIDE: THE CASE FOR FLORIDA

WISQARS data were used to examine adolescent suicide rates by year and state for the states with the largest populations. (NCIPC, accessed 2/11/05) Since the rates fluctuate looking at them yearly, five-year rates have been calculated (1983-97, 1988-1992, 1993-97, and 1998-2002). Figure 2 presents overall adolescent suicide mortality for a set of "urban" states selected for comparison by MCHB (California, Florida, Illinois, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas). Although New Jersey and New York have had the lowest adolescent suicide rates for the past 20 years, all of the other urban states followed the national trend, showing an increase in the adolescent suicide rate between 1983-87 and 1988-92 and then showing a decrease (improvement) in the past 10 years. By visiting one of these states it might be possible to learn more about what has caused this decline

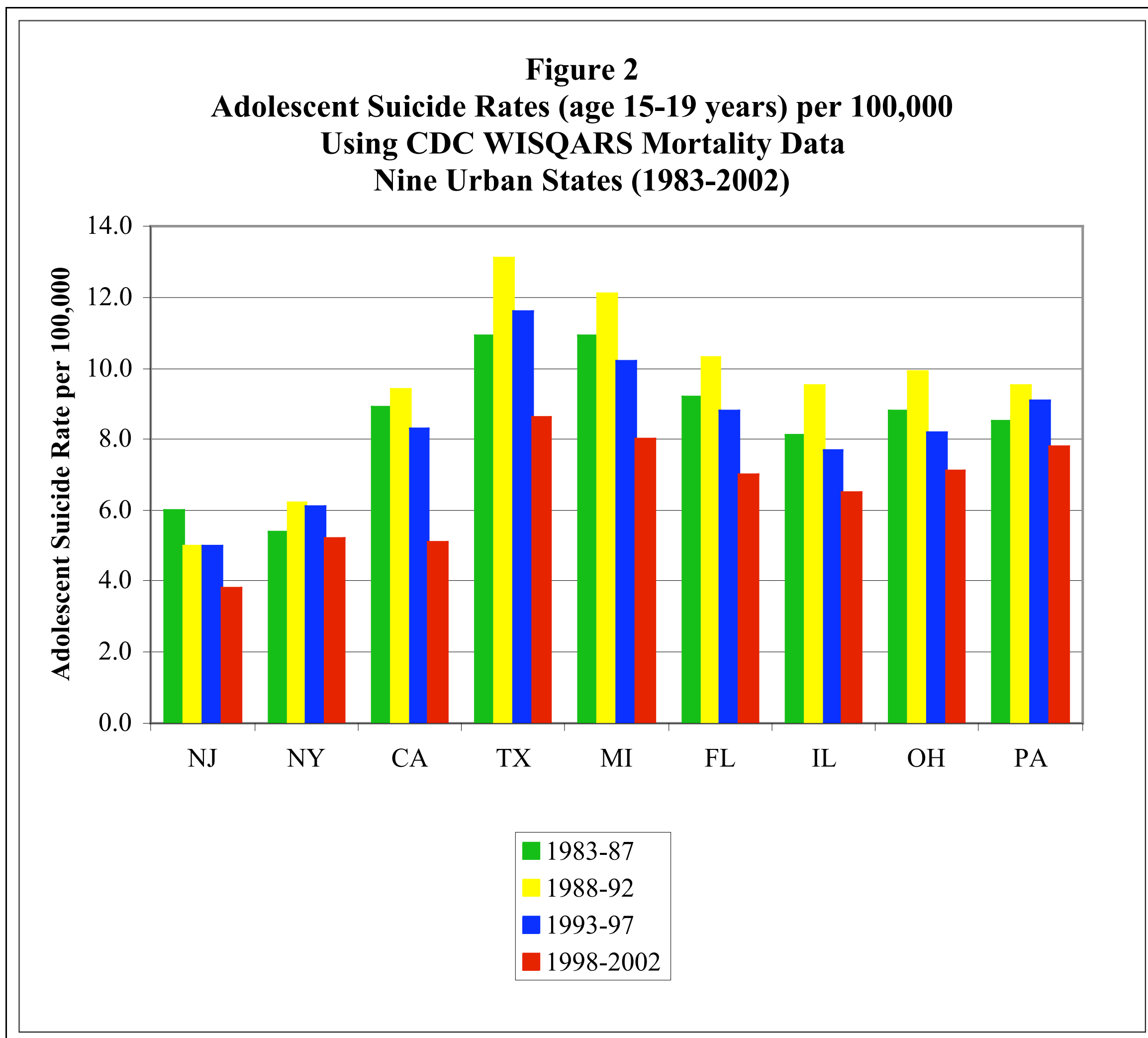


Table 6 summarizes the percent change in adolescent suicide rates for the selected "urban" states between the four time periods in Figure 2. With the exception of New Jersey, all states showed an increase in the adolescent suicide rates between 1983-87 as compared to 1988-92 and then declines in the next two time periods (1993-97 and 1998-2002). Texas, Michigan, and Florida

had the highest rates in 1988-92 and all showed a steady decline after that. Florida was selected for study because of its close proximity to the study team and because the study team had been working with the maternal and child health program in Florida for over 20 years.

Table 6
Percent Change in Overall Adolescent Suicide Rates (age 15-19 years) per 100,000
Using CDC WISQARS Mortality Data
FLORIDA AND COMPARISON STATES

	PERCENT CHANGE		
STATE	**83-87 vs. 88-92**	**88-92 vs. 93-97**	**93-97 vs. 1998-2002**
NJ	16.7% ↓	24.0% ↓	24.0% ↓
NY	14.8% ↑	16.1% ↓	14.8% ↓
CA	5.8% ↑	45.7% ↓	38.6% ↓
TX	20.2% ↑	34.4% ↓	25.9% ↓
MI	11.0% ↑	33.9% ↓	21.6% ↓
FL	*12.0%* ↑	*32.0%* ↓	*20.5%* ↓
IL	17.3% ↑	31.6% ↓	15.6% ↓
OH	12.5% ↑	28.3% ↓	13.4% ↓
PA	11.8% ↑	17.9% ↓	14.3% ↓

Data Downloaded from WISQARS on 2/11/05

ADOLESCENT SUICIDE IN FLORIDA

According to WISQARS data, in 2002 suicide was the third leading cause of death for adolescents 15-19 years of age in Florida. It was also the third leading cause of death for males and females. Looking at cause of death by race, adolescent suicide is the second leading cause of death for Whites, the fifth leading cause of death for Blacks, and the third leading cause of death for Hispanics. (NCIPC, accessed 7/5/05)

Because, in most years, the adolescent suicide rates for Florida by sex are based on 20 or fewer deaths, two-year rates were calculated between 1981 and 2002 using WISQARS data. Figure 3 shows two-year rates by sex. Although there is some fluctuation, after a slight increase in the 1980s there has been an overall decline in the adolescent suicide rates since 1989-90 for both males and females with the exception of the increase for males in 1993-94. The slight increase for both sexes in 2001-02, needs to be watched to see if this is the beginning of an increasing trend or just a random fluctuation due to small numbers of deaths. In 2001-02 the rates for males was four times greater than the rate for females. (NCIPC, accessed 2/11/05)

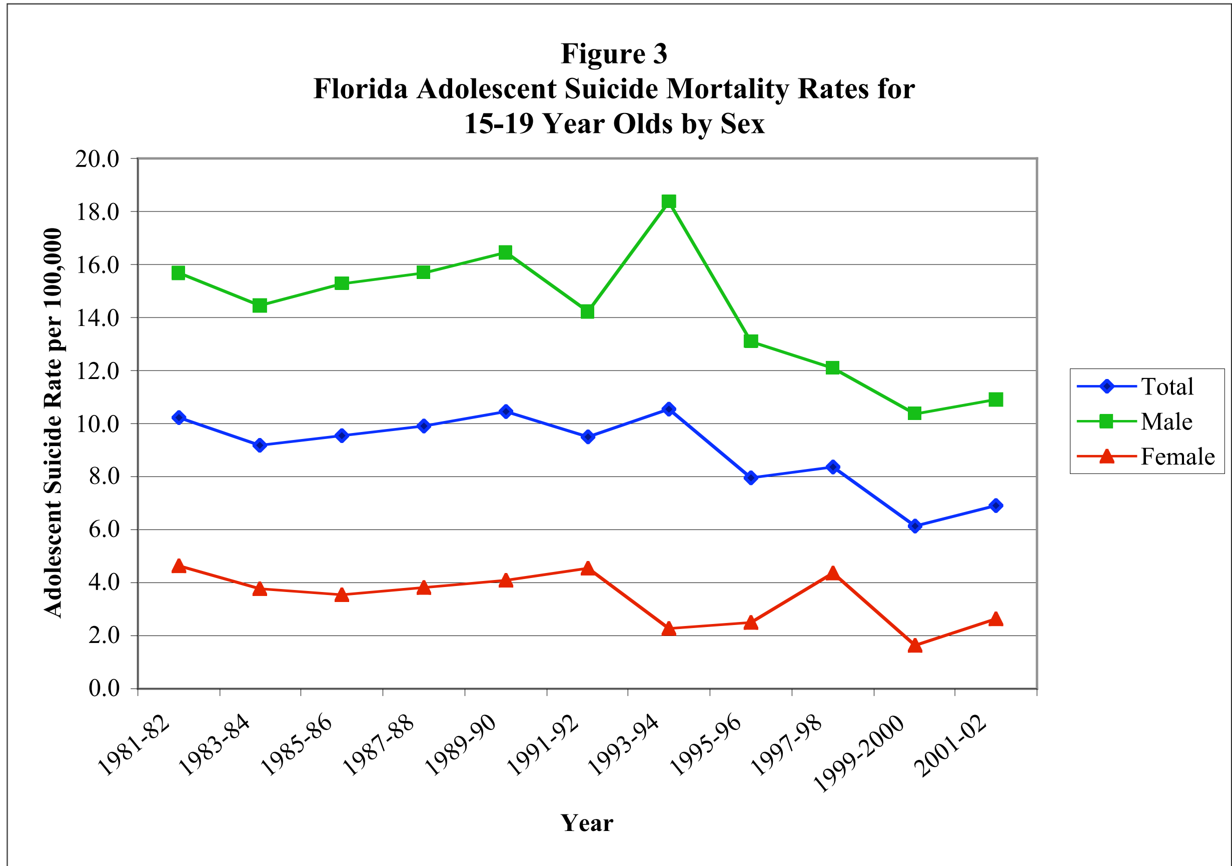


Figure 4 compares two-year rates for Whites, Blacks, and Hispanics. There are not enough deaths among the American Indian and Asian populations in Florida (only 7 and 15 respectively between 1988 and 2002) to include rates for these groups. Again, although the white two-year rates are based on greater than 20 deaths, most of the Black and Hispanic two-year rates are based on less than 20 deaths and thus could be very unstable. In addition, Hispanic data are only available starting in 1990. White rates were the highest, followed by Black and Hispanic rates. In general the rates have been declining since 1993-94 for Whites and Hispanics and 1995-96 for Blacks. After a large drop between 1993-1998, the trend for Hispanics is rising again and should be watched. The White rate also went up in 2001-02 and should be watched. In 2001-02 the White rate was 2.6 times as high as the Black rate and 1.8 times the Hispanic rate. (NCIPC, accessed 2/11/05)

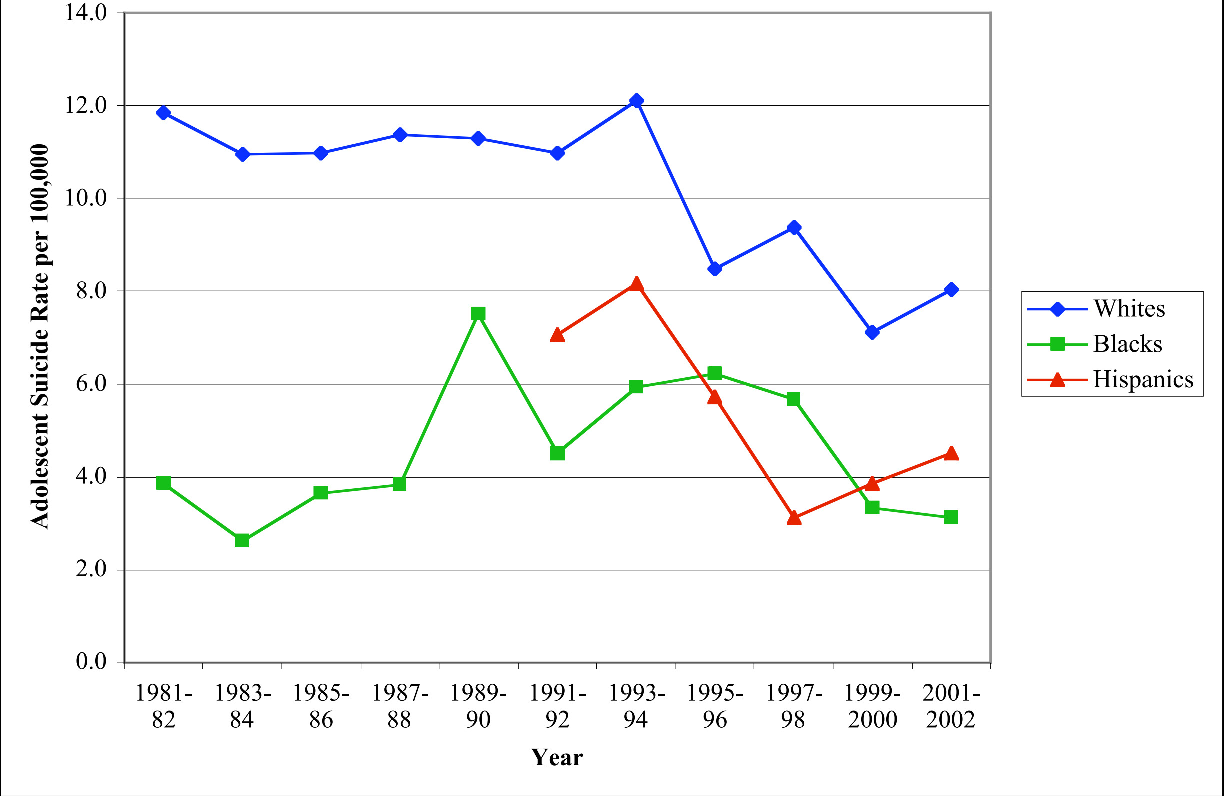


Table 7 looks at method of suicide by gender using CDC's WISQARS mortality data. (NCIPC, accessed 2/15/05). Again, since the overall number of suicide deaths in Florida is so low, two 11-year rates (1981-1991 and 1992-2002) are compared. Firearms are the most common method of suicide for both males and females, although the rate is declining more for females (17%) than males (6%). In 1992-2002, suffocation was the next most common method for suicide for both males and females and the rates are increasing. Poisoning was used as a method more for females than males and is declining for both males and females. For both males and females, suffocation and "other" methods appear to be replacing firearms and poisoning as methods of suicide.

Table 7
Percent Distribution of Method of Suicide by Gender for Adolescents Ages 15-19 Years Using CDC WISQARS Mortality Data (1981-1991 and 1992-2002)
FLORIDA

Gender	Years	Firearms	Poisoning	Suffocation	Other Method
Males	**1981-1991**	69.0%	8.5%	18.0%	4.5%
	1992-2002	64.6%	5.1%	23.6%	6.7%
Females	**1981-1991**	61.7%	21.1%	7.4%	9.7%
	1992-2002	51.1%	17.5%	17.5%	13.9%
TOTAL	**1981-1991**	67.5%	12.1%	15.9%	4.5%
	1992-2002	62.3%	8.2%	22.6%	6.9%

Data Downloaded from WISQARS on 2/15/05

Tables 8 and 9 present data from CDC's YRBS on suicide attempts and related risky behaviors for 2003. (Grunbaum, 2004) As mentioned earlier, this is a survey of a representative sample of high school students in grades 9-12 throughout the country. It has been conducted every two years since 1993 with state and local components. In 2003, the overall response rate for Florida was 66%, which is a combined rate for the schools (95% responded) and the students (69% responded). The combined rate is obtained by multiplying the school response rate by the student response rate. CDC asserts that any state that obtains an overall response rate of ≥60 percent has a sample that is representative of the state and weights the state's data. Early surveys in Florida (1997 and 1999) had response rates too low for the sample to be considered representative of the state, so these results were not considered. Results are presented for the most recent year (2003).

Table 8
Percent of High School Students Who Felt Sad or Hopeless, Seriously Considered Attempting Suicide, or Attempted Suicide in the 12 Months Preceding the Survey
CDC's Youth Risk Behavior Surveillance System
FLORIDA 2003

Gender	Felt Sad or Hopeless	Considered Attempting Suicide	Attempted Suicide
Males	22.7 % (±1.6)	11.3% (±1.5)	6.2% (±1.0)
Females	37.6% (±1.9)	20.4% (±1.4)	11.8% (±1.5)
TOTAL	30.1% (±1.3)	15.8% (±1.1)	9.0% (±1.0)

Estimates of the percent of teenagers who felt sad or hopeless, considered suicide, or attempted suicide in the past year are summarized in Table 8 for the 2003 YRBS Survey. As with the U.S. data, more females (37.6%) than males (22.7%) felt sad or hopeless, considered attempting suicide (20.4% for females vs. 11.3% for males), and attempted suicide (11.8% for females vs. 6.2% for males) in the 12 months prior to the survey. (Grunbaum, 2004) Rates for 2001 were similar. (Grunbaum, 2002)

Table 9
Percent of High School Students Who Carried a Weapon (i.e., gun, knife, club,) or Carried a Gun on One or More of the Past 30 Days by Sex and Year
CDC's Youth Risk Behavior Surveillance System
FLORIDA 2003

Gender	Weapon	Gun
Males	26.7% (±2.5)	10.0% (±1.5)
Females	7.5% (±1.6)	2.1% (±0.8)
TOTAL	17.2% (±1.5)	6.1% (±0.9)

Table 9 summarizes estimates of the percent of respondents who carried a weapon or carried a gun specifically on one or more of the past 30 days in 2003. More males (26.7%) than females (7.5%) carried a weapon in the last 30 days. This same pattern is seen for carrying a gun, 10.0 percent of males as compared to 2.1 percent for females. (Grunbaum, 2004) These rates are up slightly from those reported in 2001. (Grunbaum, 2002)

ADOLESCENT SUICIDE PREVENTION ACTIVITIES IN FLORIDA

Initial contacts in Florida were with MCH Title V staff, Annette Phelps, Director of the Division of Family Health Services, FL Department of Health; Charlotte Curtis, Director of the MCH Child and Adolescent Unit; and Sylvia Byrd, Executive Community Health Nursing Director of the School Health Program. Quickly Lisa Vander Werf-Hourigan, Manager of the Injury Prevention Unit was identified as the person taking the lead on suicide prevention efforts for the Department of Health as its representative to the Florida Suicide Prevention Task Force. Discussions with Ms. Vander Werf-Hourigan then led quickly to James McDonough and Erin MacInnes, in the Governor's Office of Drug Control. In 1998 when Jeb Bush became Governor he formed the Office of Drug Control and appointed James McDonough as its Director. As part of his job Mr. McDonough was asked to take the lead on Suicide Prevention efforts in Florida in 2000. These individuals identified two websites for review, one for the Governor's Office of Drug Control (http://www.myflorida.com/myflorida/government/governorinitiatives/drugcontrol/suicide_prev. html) and the other for the Florida Suicide Prevention Coalition (http://www. floridasuicideprevention.org). These sites led to many other sites that described the various suicide prevention activities mentioned in this report. On September 21, 2005 a Suicide Prevention Symposium was held in Orlando with a meeting of the Florida Suicide Prevention

Task Force conducted before the Symposium. The site visit team was present for both events and met many of the suicide prevention leaders in Florida both at the agency and grassroots level. This report is based on information gathered from multiple sources, not just the Symposium and Task Force Meeting but also preliminary and follow-up phone calls and e-mails with Florida officials as well as extensive review of written materials (hard copy and web-based) about Florida's activities. A list of all persons in Florida who provided the information included in this report, a number of which assisted with its review, can be found in Appendix A.

I. Taking the Lead on Adolescent Suicide Prevention in Florida

The first group to take the lead on suicide prevention in Florida was the American Foundation for Suicide Prevention: Florida Division. It was started in 1991 by Carol Ullman after the death of her son in 1987 and was a not-for-profit statewide organization funded by private donations from individuals, foundations, and corporations. Its mission was to support research on the brain and the causes of suicide and support survivors of suicide. Initially most of the members were family members of someone who had committed suicide. In 2002, the group withdrew its affiliation with the American Foundation for Suicide Prevention Inc. and changed its name to the **Florida Initiative for Suicide Prevention (FISP)**. The new FISP is dedicated to providing support to survivors of suicide, educational programs and prevention training for the public and professionals as well as addressing legislative and advocacy issues at the state and national levels. "FISP supports and believes in a collaborative effort to address the risk factors that contribute to the incidence of suicide. We must support one another in our efforts, and work together …agency to agency…people to people… to address all facets of suicide, medical intervention and at risk behaviors." (quote from Rene Barrett, FISP, accessed 2/15/05) It is dedicated to changing those factors in the community that contribute to alienation, hopelessness, and helplessness and strongly advocates for public awareness. FISP, the Suicide Prevention Action Network (SPAN), and colleagues Pam Harrington and Laura Meyer worked with James McDonough on initiating of the Florida Suicide Prevention Task Force and were founding members of the Florida Suicide Prevention Coalition, both of which are described later in this report. (FISP, accessed 2/15/05) SPAN-USA is a national non-profit organization that works to increase awareness of the toll suicide takes on our nation and to ensure that government effectively addresses suicide. Survivors of suicide are its driving force. It works closely with state and national agencies and non-profits to advance the public policy response to suicide. SPAN-FL is the Florida affiliate of SPAN-USA.

In 1999, **House Resolution No. 9233** encouraging suicide prevention efforts and **Senate Resolution No. 2684** recognizing suicide as a state problem and declaring suicide prevention a state priority were passed. (GODC, 2005)

In January 2000, Governor Bush met with a group of grassroots suicide prevention activists who asked for his help in support of suicide prevention. In response, Governor Bush directed the Governor's Office of Drug Control to assist in decreasing the incidence of suicide in Florida. To this end in November 2000, James McDonough and the Governor's Office of Drug Control established the **Florida Suicide Prevention Task Force** (FSPTF). The Task Force included representatives from the Governor's Office of Drug Control, Florida Initiative for Suicide Prevention (FISP), Department of Children and Families, Department of Corrections,

Department of Juvenile Justice, Department of Education, Department of Health, Agency for Health Care Administration, Department of Elder Affairs, University of South Florida, The Beth Foundation, and Suicide Action Network of Florida (SPAN-FL). (GODC, 2005) Current members are listed in Appendix B.

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 Task Force included representatives from: Agency for Health Care Administration, American Child and Adolescent Psychology Association; American Foundation for Suicide Prevention; Child, Adolescent, and Family Therapy Services; Clearinghouse on Human Services; Florida Association of Medical Examiners; Florida College of Emergency Physicians; Florida Committee on Trauma; Florida Department of Education; Florida Division of Child and Family Services; Florida EMS Educators; Florida Poison Control Centers; Institute for Child Health Policy; Ministry Alliance of North Broward County; SPAN Florida; local PTA representative; local representative of the National Organization for Youth Safety; local providers from hospitals, emergency services, and public health; and national representatives from CDC and the Children's Safety Network. (ASPTF, 2000) The report provided information to better understand youth suicide and recommended evaluation methodologies for prevention and intervention efforts targeting families and professionals. (ICHP, 2004) The Office of Drug Control and the Florida Suicide Prevention Task Force have used information from this report in the development of their work on adolescent suicide prevention.

Founded in 2001, **The Beth Foundation, Inc**. is a non-profit organization dedicated to reducing the suicide rate in Florida through education and awareness. It was founded by Pam Harrington and Laura Meyer in memory of Elizabeth (Beth) Ann Harrington (7/25/81-6/7/97), as well as the other 2,000 Floridians who lose their lives each year to suicide and their families. Both women are active in the Suicide Prevention Action Network (SPAN). Much of their current work centers on gatekeeper training which will be discussed later in this report. (GODC, 2005; Beth, accessed 3/8/05)

To complement the Florida Suicide Prevention Task Force, James McDonough and the Governor's Office of Drug Control held a three-day meeting in October 2002 to learn about coalition building and to formalize the organization of the **Florida Suicide Prevention Coalition** (FSPC). The program was developed and administered through the Florida Counterdrug Training Academy. The FSPC is a volunteer, grassroots non-profit organization working with all groups, organizations, and state agencies to reduce the incidence of suicide in Florida. Its ***mission*** is to collaborate to develop and implement suicide prevention, intervention, and postvention strategies and programs. Its ***vision*** is that it is a coalition of Floridians for the elimination of suicide in their communities. The Board of Directors is made up of 15 members, one from each region, using the Department of Children and Families regions, and the elected officers. Each region also has a volunteer coordinator who is available to provide information on suicide prevention in his/her region. This strong grassroots movement works with and supports the FSPTF. (GODC, 2005; FSPC, accessed 9/9/05) The ultimate goal is to have local coalitions in each of the 15 regions. Currently the only local coalition is the **Suicide Prevention Coalition of Volusia and Flagler Counties**. This coalition was started in December 1999, prior to the statewide coalition, to focus on promoting community awareness, education, and support

regarding suicide prevention and intervention. It has been very active over the years, implementing a number of interventions. (GODC, 2005; SPCVF, accessed 3/14/05)

Since its inception, the Florida Suicide Prevention Task Force has been working diligently to formulate state policies to prevent suicide. In August 2002 they announced the *Statewide Suicide Prevention Strategy* to reduce suicide in Florida by one-third by 2005. In February 2004, when they realized that they were unlikely to meet this goal the Task Force had a retreat to brainstorm and develop a strategy for reducing suicide between 2005 and 2010. Participants included: Florida Office of Drug Control, FISP, FSPC, Department of Children and Families, Department of Juvenile Justice, Department of Education, Department of Health, Department of Elder Affairs, Florida Mental Health Institute of University of South Florida, University of Florida-Department of Psychology, The Beth Foundation, crisis centers, a school psychologist, and SPAN-FL. The goals and objectives in the ***Florida Suicide Prevention Strategy 2005-2010***, released in March 2005, were products of this retreat. This Strategy calls for an integrated, long-term approach to reducing suicide in Florida and offers a comprehensive framework on what needs to be done. It is to serve as both a guide and action agenda and, like the previous strategy, has three basic goals:

- To decrease the incidence of suicide in Florida by one-third between 2001 and 2010 (from 14.1/100,000 to 9.4/100,000).
- To decrease the incidence of teen suicide in Florida by one-third between 2001 and 2010 (from 9.5/100,000 to 6.3/100,000).
- To decrease the incidence of elder suicide in Florida by one-third between 2001 and 2010 (from 20.0/100,000 to 13.3/100,000). (GODC, 2005)

In August 2005, another retreat was held, this time to draw up a plan to move forward to address the issues identified in the Strategy. Eight focus areas were identified: public awareness and information, education and training, screening and intervention, treatment needs, creating safer environments, postvention, legislation, and research. With the exception of research, one priority and a number of strategies were identified for each. For each strategy, activities were specified that would impact on the strategy. For most activities, the persons who needed to be involved, where it would take place, the resources needed, how success would be measured, an implementation timeline, and a suggested lead were identified. Subcommittees of the FSPTF will be formed to work on each focus area.

In 2003, the **Office of Injury Prevention** was formed in the Florida Department of Health (DOH) to raise the level of awareness of the burden of injury in Florida and to establish injury as a priority for the Department. In 2004, the Florida Legislature passed a statute that required the DOH to "establish an injury prevention program with responsibility for the statewide coordination and expansion of injury prevention activities." The duties were to include "data collection, surveillance, education, and promotion of interventions." (DOH/DHATIP, accessed 7/13/05) Recognizing that:

- in 2002 there were 2,332 resident deaths in Florida due to suicide as compared to 1,714 for HIV and 1,004 for homicide and
- in 2001, suicide was the third leading cause of death for persons age 10-14 and 15-24, the second leading cause of death for person age 25-34, and the forth leading cause of death for persons age 35-44 and 45-54. It was the 8th leading cause of death for persons age 55-64 and the 9th leading cause of death overall,

in February 2004, the **Department of Health** established a **Suicide Prevention Committee**, chaired by Lisa Vander Werf-Hourigan, Manager of the Office of Injury Prevention and the Department of Health (DOH) representative to the Florida Suicide Prevention Task Force. The DOH Suicide Prevention Committee meets monthly and is composed of representatives from School Health, Family Health (adolescents, mothers, and young children), Sexual Violence, HIV/AIDS, Children's Medical Services, Injury Prevention, County Health Departments (CHD) Public Health Nursing Directors, CHD Administrators, and Community Health Centers. Discussion has focused on the role of the DOH and its activities related to depression and suicide prevention. There is agreement that the DOH role should relate to prevention and not treatment and that its focus should be on:

- promoting awareness of depression and suicide at community health professional conferences and meetings and
- identifying national, state, regional, and local organizations with available resources and reference materials on depression and suicide and provide this information to the community as requested.

Currently the Florida Suicide Prevention Task Force and the Florida Suicide Prevention Coalition, with support from James McDonough and Erin MacInnes in the Governor's Office of Drug Control, and Governor Bush are taking the lead in addressing suicide prevention in Florida, including adolescent suicide. They have been instrumental in getting the many organizations and groups in Florida who were working on suicide prevention activities to work together cooperatively. In support of suicide prevention activities, each year since 2003 the Governor has declared one day Suicide Prevention Day. The day is used to educate legislators, their staff, and visitors to the legislative building on suicide prevention. Grassroots organizations and state agencies have displays and visit their senators and legislators to encourage them to support legislation that would codify the Florida Task Force on Suicide Prevention and create a statewide office of suicide prevention. Such bills were introduced in both the House and the Senate in 2003, 2004, and 2005, none of which passed, initially for financial reasons and more recently for political reasons. Aggressive plans are currently underway to introduce bills again in 2006.

II. Surveillance

The Governor's Office of Drug Control has the responsibility for releasing adolescent suicide rates to the Governor and Legislature. The Injury Prevention Unit within the Department of Health provides the data on suicide rates to the Office of Drug Control. There are no specific levels of the adolescent suicide rate that are regarded as sentinel events; however, swat team-like actions are taken whenever a suicide attempt or completed suicide is known.

Suicide data are part of the Florida Injury Surveillance Data System, maintained by the Office of Injury Prevention. It is modeled after the State and Territorial Injury Prevention Director's Association (STIPDA) *Consensus Recommendations for Injury Surveillance in State Health Departments*. (DOH/DHATIP, accessed 7/13/05) Vital records and hospital discharge data (initiated in 1997) are used to monitor completed and attempted suicides. In 2005, an emergency room data system was started to expand on information that could be obtained from the hospital discharge data. Data are summarized at the statewide and county-levels using three-year raw numbers and observed and expected rates. In addition, suicide death data are available on the

Internet as part of Florida's Community Health Assessment Resource Tool Set (CHARTS) at http://www. floridacharts.com/charts/report.aspx?domain=04&IndNumber=0116. Finally, data from CDC's Youth Risk Behavior Surveillance System are used to look at suicide risk factors and attempts in Florida high school students.

There is a district medical examiner system in Florida with 24 independent districts. All **medical examiners** are physicians, so the cause of death reporting is expected to be good.

Child death reviews are done at the county-level on all verified child abuse deaths. Using public health statutory authority, Palm Beach County is doing death reviews through age 19 for all deaths due to intentional or unintentional injury and a sample of deaths from natural causes. This would include suicide deaths for 15-19 year olds. There are no other counties known to be doing this level of review. The only statutory defined review of child deaths is for child abuse deaths.

Nova Southeastern University currently has a pilot project for the **Development of the Youth Suicide and Intentional Self-harm Surveillance System**. This project is using existing data sources (record systems from medical examiners, hospital emergency departments, EMS providers, crisis hot lines, physicians' offices, and schools) to collect information on youth suicide and self-harming behavior. Where possible, information is being collected on victim characteristics, mechanisms used, incident circumstances, and services providers. Using these data local leaders and policy makers can better identify trends in suicidal or self-harming behaviors at the county-level. (GODC, 2005)

III. Suicide Interventions

There are a number of ways to organize information on suicide prevention interventions. In this report, they will be organized by type of intervention using the same categories as the literature review (community, school or other facility serving adolescents, and health care system) and whether they are regulatory or non-regulatory.

Community-Wide Regulatory Interventions and Statutes:

There are no gun control laws in Florida and there is a considerable lobby against such controls.

In 1984, recognizing the critical need to suicide prevention, the Legislature passed the **Florida Youth Emotional Development and Suicide Prevention Act** (Chapter 84-317). It required the (former) Department of Health and Rehabilitative Services (HRS), in cooperation with the Florida Department of Education (FDOE) and Law Enforcement (FDLE) to develop a state plan for youth suicide. In 1985, a ***Comprehensive Plan for the Prevention of Youth Suicide*** was written. The plan provided a model that addressed detailed prevention, intervention, and treatment strategies and included a budget but it was never implemented. The Act also required the establishment of a Task Force, including representatives from HRS Program Offices for Children, Youth, and Families; Alcohol, Drug Abuse, and Mental Health; Developmental Services; Evaluation; and from the Departments of Law Enforcement and Education. The Task Force concluded that although many of the service components existed at the local level,

coordination of these services and supplementation was necessary to establish the full continuum of needed services (prevention, intervention, treatment). (GODC, 2005)

In 1999, 15 years after the Florida Youth Emotional Development and Suicide Prevention Act was passed, the Louis de la Parte Florida Mental Health Institute at the University of South Florida was funded by the Florida Department of Children and Families to do a study on the impact of this act. Data were collected from 10 regional community forums (5-30 participants per forum, total of 124 participants, mostly from professional agencies) and six focus groups throughout Florida (4-12 participants per group, total of 51 participants, included students with a serious emotional disturbance [SED] and personnel in SED Centers from middle and high schools, as well as college students from the University of South Florida [including a group with only African American students]). Within these groups, risk factors for youth suicide at the individual, family, and societal levels; protective factors; access to services and treatment; and gaps in services were identified. In ***Suicide Prevention Study: Report to the Florida Legislature*** these findings are summarized and a literature review to support them is provided. From these findings, the following 10 recommendations were made:

- Develop a framework for a comprehensive approach to positive youth development.
- Foster collaboration among schools, community organizations, and families.
- Make available high-quality after-school programs
- Develop mentoring programs as a mechanism for guidance, sharing, and support.
- Involve youth in program planning and implementation.
- Create an awareness and understanding of the communities in which we live.
- Acknowledge, support, and enhance existing advocacy groups.
- Increase research and evaluation activities.
- Identify, support, and disseminate promising practices.
- Review and revise as necessary *Florida's Youth Suicide Prevention: Guide for Trainers of Adult Programs* and the *State Plan for Prevention of Youth Suicide in Florida*.

In the Report's Appendices, tables were included that summarize the resources identified and the recommendations for Legislators that were identified at each of the community forums. An annotated bibliography is also included. (Lazear et al., 1999)

Non-Regulatory Interventions in the Community:

Crisis Hotlines and Centers: The National Suicide Prevention LifeLine and National Hopeline Network/Kristin Brooks Hope Center are both used statewide in Florida. These are both 24-hour/day, 7-day/week toll-free numbers. Both lines refer callers to the nearest available American Association of Suicidology (AAS) certified Suicide Prevention Crisis Center. Florida is very effectively covered by over 40 AAS Certified Crisis Centers that provide a 24 hour/day, 7-day/week suicide prevention resource. These centers offer immediate and free telephone access to the nearest available certified suicide prevention resources. This started in the 1960s when crisis hot lines were mandated for Community Mental Health Centers. The services provided by the centers are: information and referral, face-to-face counseling, and consultation. In addition, Florida has twelve 2-1-1 Call Centers that serve 36 of its 67 counties. This is a nationwide network of call centers that is being developed through the efforts of the United Way and accredited by the Alliance of Information and Referral System (AIRS). These call centers are connected on a community level to the phone number 2-1-1. Calls are answered, the callers'

needs are identified, and the caller is referred to the most appropriate provider. These centers that are blended (suicide prevention, information, and referral) may also be answering the two national hotlines. Besides these national hotlines and call centers, there is the LifeLine of Central Florida and numerous local hotlines listed on the internet at http://suicidehotlines.com/florida.htm. In general, these centers and hot lines are mainly used by 18-55 year olds, so they probably do not have a great impact on teen suicides.

Survivor Support Groups: There are numerous survivor support groups in Florida. They are listed by Florida Suicide Prevention Coalition (FSPC) region on the FSPC website. With the exception of two regions that have no groups listed, there is at least one, and for most regions several, of these groups listed.

YES Institute: Begun in 1996, the mission of the YES Institute is to "prevent suicide and ensure the healthy development of gay, lesbian, bisexual, transgender (GBLT) and all youth by initiating dialogue, providing education, and creating support systems." Staff works in partnership with traditional networks of support for youth (families, communities of faith, schools, youth service agencies, and peer groups) who have a commitment for creating a safe environment for youth. They offer, often for the first time, a forum for open, non-controversial discussion on gender, orientation and the needs of these youth. Education courses and workshops are offered and corporate and leadership trainings are done. They have worked with students and educators in a number of public and private schools in the Miami-Dade, Broward, and West Palm Beach areas. Parents are involved in their programs and are encouraged to avail themselves of the YES Institute services. This program was professionally evaluated and in June 1999 funded by the Ittleson Foundation for national replication. Although much of their work has taken place in the Miami-Dade, Broward, and West Palm Beach areas, they have traveled to other places in Florida and around the country and to meet these demands have developed a distance learning center. (Lazear, 1999; YI, accessed 11/1/05)

The Department of Children and Families (DCF) received funding from the Substance Abuse and Mental Health Services Administration in 2001 for a three-year pilot project, the **Eliminating Barriers Initiative** (EBI). The project was designed to reduce stigma and discrimination associated with mental illness. Model public relations materials (radio, Television, PSAs) were tested in Florida and seven other states (CA, MA, NC, OH, PA, TX, WI). Information gathered will be provided to others to use as best practices. (SAMHSAEBI, accessed 11/4/05) Vanguard Communication is developing the materials and the Gallup Organization is evaluating the media campaign. The evaluation results have not been released since the project just ended. Florida is trying to continue the campaign but since the funding ended activities have slowed.

Funded by the Florida Drug-Free Communities Grant Program to Nova Southeastern University, the **Youth Suicide Prevention Prototype (YSPP) Project** was established in 2002 and is slated to end in 2007. It considers the whole continuum of a community-based program (prevention, intervention, and postvention) and is being piloted in two counties, Alachua (non-metropolitan) and Broward (metropolitan). The overall goal of the YSPP Project is to reduce suicidal behavior (fatal and non-fatal) by one-third in each of these counties and its objectives are to:

- "examine the epidemiology and potential risk and protective factors related to youth suicide in the combined population of 1.8 million residents,
- describe the epidemiologic characteristics and design choices of different interventions for preventing suicide, and
- evaluate the impact of these interventions on youth suicide."

This will be accomplished "through the systematic, coordinated efforts of the many key agencies and organizations in the area and with the commitment of various consumer groups." In 2000 the Florida Task Force on Suicide Prevention produced *Preventing Suicide in Florida: A White Paper*. This paper identified the failure to recognize risk factors for suicide and the difficulty getting a person identified at risk timely, efficient, and affordable treatment as the main reasons suicides are not prevented. The YSPP Project is responding to these problems "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." (ICHP, 2004)

Social Marketing: Project 220: In 2005, the Governor's Office of Drug Control worked with the ACT Corporation and key legislative leaders to identify funding for a three-prong public awareness project. As part of this effort, the following three pilot programs are being developed:

- A program in northeast Florida with the Northeast Florida Education Consortium will address YOUTH suicide through the development of a program aimed at developing school-based training in coping skills, interactive peer-to-peer events, on-line links to approved resources and chat rooms, and a student produced video documentary.
- The "Roll Backup" program will be promoted and implemented statewide to address the needs of LAW ENFORCEMENT officers. It is based on a US Air Force model that has been tested and known to be effective and includes train-the-trainer programs, academy training sessions, public relations efforts, and a confidential helpline staffed by retired officers.
- Suicides among the ELDERLY will be addressed in the Sarasota area by a program where high school seniors will be paired with elders to document their history, insights, and wisdom to share with the next generations "life legacy."

In addition, a 3-4 hour "Social Marketing 101" training program will be developed that focuses on providing assistance earlier in the "life cycle" of suicide attempts, research will be conducted with prevention experts to identify trigger events and associated messaging channels, and a portfolio of recommended communication tactics tied to various trigger events will be developed.

There are a number of **family strengthening efforts** in Florida that are not aimed directly at suicide prevention but do address one of the protective factors for adolescent suicide, family cohesion. One example of this is designating September 26, 2005 as Family Dining Day. This is part of a national effort to encourage family togetherness at mealtime. The Department of Health supports these efforts and has established the "Because Family Matters" website to give ideas about how families can work together more effectively. Examples include "Valentine's Day Tips" from the American Academy of Pediatrics on 14 ways to love your child and the "ABCs to Strengthen Families." (DOH/BFM, accessed 1/9/06)

The **Council of Church-Based Health Programs, Inc**. is a statewide not-for-profit consortium of interfaith churches and church leaders in Florida concerned about the health and human services needs of the communities they serve. To date most of their work has been related to drug use prevention, a risk factor for suicide, and more general health education. (CCBHP, accessed 2/7/06) In the future they plan to expand into other areas of suicide prevention. This is felt to be important in the Black community because historically Blacks have had lower rates than Whites and Hispanics and the Black community does not always view suicide as a problem. The faith community can do a number of things that could impact on youth suicide including but are not limited to:

- providing a forum for youth to share feelings, concerns, and thoughts;
- building suicide prevention efforts into drug prevention programming;
- trying to learn more about issues around depression and stress that may serve as early indicators of suicide;
- training clergy, youth leaders, youth ministers, and missionaries on how to deal with youth mental health issues;
- refraining from viewing or dealing with suicide as a sin;
- listening more to young people, being a resource, and not being judgmental;
- being supportive of youth's ideas and concerns; and
- setting-up seminars, plays, dramatizations, and other special events to highlight the issues around suicide so that youth can receive the information in a non-threatening manner.

Regulatory Interventions in the Schools:

There are numerous laws and standards affecting school health programs. Only a few of those that relate to the provision of services that might effect adolescent suicide will be described here.

The mission of the **School Health Services Program** "is to appraise, protect and promote the health of students." "Services are provided in accordance with a local School Health Services Plan jointly developed by the county health department, the school district and the school health advisory committee." (SHSP, accessed 11/12/05) These services are an important component of the public health system. The following components of the School Health Program are established by statute:

- The **School Health Services Act**, authorized by s. 381.0056, Florida Statutes and passed in 1974, mandates that all public schools provide a basic package of services, including health record reviews; follow-up for mandated school entry physical examinations and appropriate grade-level immunizations against preventable communicable diseases; screening for vision, hearing, growth and development, and scoliosis; first aid; medication assistance; and emergency health services. (SHSP, accessed 11/12/05) These types of services have no direct focus on mental health or suicide prevention. Services similar to those described below as part of the CSHSP are also provided in schools with basic school health programs on an as needed and as feasible (money driven) basis, however they are not required to submit detailed reporting on these activities.
- **Comprehensive School Health Services Projects (CSHSP)** were authorized by s. 381.0057 Florida Statutes in 1990. In addition to the basic services provided under the School Health Services Act described above, the following enhanced services are provided: student health management, interventions and classes to reduce risk-taking

behaviors, violence and injury prevention, and services to reduce teen pregnancy and promote returning to school after giving birth. (SHSP, accessed 11/12/05) Most of the programs started between 1990 and 1995. CSHSP staff also refer students to services provided by community-based social service agencies. As of September 15, 2005, schools in 46 of Florida's 67 counties participate in the program, although not all schools in any of these counties would necessarily participate.

- In addition, in 1990, **Full Service Schools** were authorized by s. 402.3026, Florida Statutes. These schools focus on underserved students in poor, high-risk communities needing access to medical and social services. All basic health services are provided along with nutritional services, economic and job placement services, parenting classes, counseling for abused children, mental health and substance abuse counseling, and adult education for parents. (SHSP, accessed 11/12/05) These schools are located in each of the 67 counties. (SHSP, accessed 11/12/05)

In south and central Florida although middle and high school students speak English, their parents may not speak or read English. In this area many of the schools have Hispanic school nurses who can communicate with the parents if they identify a depressed or suicidal student.

Teacher suicide prevention training was made a requirement for certification at the secondary level in 1990. This was included in a life management skills class. The requirement has since been vacated. (GODC, 2005) Now all teachers get crisis management, including suicide prevention, as part of their orientation. There are crisis intervention teams all over Florida at three levels (school buildings, district, and state). Although not prevention focused, they do address suicide attempts and hopefully help prevent suicides.

The **Safe Passage Act** [s. 1006.07(6), Florida Statutes] was a product of the 2001 Legislature to ensure that all children have a safe passage through Florida's educational system. This act includes plans and measures to promote the safety and security of students and staff, ensures that school facilities and equipment are safe and in good condition, and addresses the safe transportation of students. Safety was to be considered in its broadest sense, including violence prevention. The Office of Program Policy Analysis and Government Accountability (OPPAGA), in conjunction with the Florida Department of Education, developed the first Best Practices for Safety and Security self-assessment in 2001 for use in the 2001-02 school year. This was revised for the 2003-04 school year. The Office of Safe and Healthy Schools, Florida Department of Education prepared a technical assistance paper to help school districts implement the assessment. Only district-level responsibilities are laid out in the statute, but each school within the district should have policies in place to adequately respond to a critical incident. In reviewing the self-assessment tool developed by the OPPAGA, there are a number of Best Practices Indicators (BPI) that address violence in the schools from the perspectives of having in place:

- a plan to handle violent attacks [BPI #8];
- a training manual for school staff on ways of handling violent situations [BPI #11];
- anti-harassment, anti-bullying, and anti-violence polices [BPI #13];
- systems to identify students that exhibit early warning signs for violent behavior [BPI #15];
- curriculum and programs to address pro-social skills, character education, conflict resolution, and peer mediation [BPI #17]; and

- an approved Safe and Drug-Free School Plan [BPI #18].

Best Practices Indicator #20 relates directly to suicide prevention and assesses such things as:

- training for school staff about the warning signs for suicidal behavior;
- facilities in place that encourage requests for assistance from students who pose risk for suicidal behavior;
- timely access to professional staff trained to evaluate students at risk for suicidal behavior;
- procedures in place for appropriate management of students at risk for suicidal behavior; and
- procedures in place to guide and support students re-entering the school environment following a suicide attempt or those surviving the suicide of a peer.

This self-assessment instrument continues to be used and results as late as 2005 are available on the website. The majority of districts indicate they have procedures in place to address BPI #20, but the intensity and specifics are not known. (OPPAGA, accessed April 15, 2005)

Non-Regulatory Interventions in the Schools and/or Other Facilities Serving Adolescents:

Mendez Foundation, *Too Good for Drugs*: "For more than 20 years the Mendez Foundation has helped schools create safe and positive learning environments by providing award-winning drug and violence prevention curricula to teach students skills, consequences and confidence." (MF, accessed 10/9/05) Started in 1978, *Too Good for Drugs* is a school-based prevention program for grades K-12 designed to reduce risk factors and enhance protective factors related to alcohol, tobacco, and other drug use. There is a separate, developmentally appropriate curriculum for each grade level that builds on each other. The curriculum builds on five essential life skills: goal setting, decision-making, bonding with others, identifying and managing emotions, and communicating effectively. Topics are handled in a positive, age-appropriate manner using cooperative learning, role-playing, and other experimental teaching techniques. Their framework for prevention is school-based but involves families and the community as equal partners. It has been evaluated and designated a Model Program by the Substance Abuse and Mental Services Administration (SAMHSA). In order to achieve this status the program had to be implemented under scientifically rigorous conditions, demonstrate consistently positive results, be innovative and effective, and respond successfully to the needs of the target population. The program is being used in a very large number of school systems throughout Florida.

Suicide Prevention and School Crisis Management Program (SPSCMP): Started in 1989, this is a local program in the Dade County Public School System. To Reach Ultimate Success Together (TRUST) offers a curriculum to kindergarten to 5th graders on drug education that stresses the themes of making healthy and positive choices. The curriculum provided to 6th through 12th graders offers more developmentally appropriate themes for these ages. The topic of teen suicide is not formally introduced until the 10th grade in the Life Management Skills class. The program has been evaluated. Hotline data were analyzed between 1980 and 1994. Comparing data from 1989-94 (after the program) to 1980-88 (prior to the program):

- The average number of suicides per year decreased from 12.9 suicides per year (19 occurring in 1988) prior to the program to 4.6 suicides per year after the program.

- The rate of suicide attempts per 100,000 population decreased from 87 prior to the program to 31 after the program.
- The suicide ideation rate fluctuated and returned to previous levels in 1993-94. (Lazear et al., 1999)

The program is still in operation in the Dade County Public Schools. Parts of it are used in other schools is FL and around the country.

Started in 1992, the **Centers for Disease Control and Prevention (CDC) Coordinated School Health Program** (CSHP) is a cooperative venture between the Florida Department of Health and the Florida Department of Education to develop school health systems designed to provide a coordinated approach to the delivery of educational and health services to meet the diverse needs of Florida's youth. The CSHP model consists of eight interactive components: health education, health services, family and community involvement, environmental health, nutrition services, psychological and social services, health promotion and physical education. As of September 15, 2005, 57 schools in 20 counties participated in this program. (SHSP, accessed 11/12/05)

SAFE Schools: Critical Incident Prevention, Planning, and Preparedness Statewide Summit and Regional Meetings: In 1999, one of the goals of the Florida Department of Education (FDOE) was a safe learning environment, including preparing for critical incidents. The FDOE, in partnership with other state and local agencies and professional associations, conducted a statewide Summit and follow-up regional meetings focused on emergency planning and preparedness, and specifically, the development of critical incident responses plans. The Department of Education has a video and participant's guide from these trainings.

Columbia University TeenScreen Program: This is a national mental health and suicide risk screening program with the goal "to ensure that all parents are offered the opportunity for their teens to receive a voluntary mental health check-up." Its primary objective is "to help young people and their parents through the early identification of mental health problems, such as depression." (CUTSP, accessed 11/12/05) Screening can take place in schools, doctors' offices, clinics, youth groups, shelters, and other youth-serving settings and is funded by private foundations, organizations, and individuals. TeenScreen is not funded by any pharmaceutical companies. The screening involves the following steps:

- TeenScreen sites must obtain parental consent before offering screening to the youth. In addition to obtaining parental consent, youth must also provide written assent for participation in the TeenScreen Program.
- Participants complete one of three self-administered screening instruments: Columbia Health Screen (CHS), Diagnostic Predictive Scales (DPS), or Columbia Depression Scale (CDS). TeenScreen screens for depression, anxiety disorders, and substance abuse. TeenScreen focuses on these disorders because they are common and treatable conditions, and most youth who suffer from them go undiagnosed and untreated.
- Youth reporting no mental health problems are given a short debriefing by program staff. Program staff offer the youth the opportunity to speak with a mental health professional. If the youth has no concern, they are dismissed. If results indicate that the youth may be at risk for a mental health concern, the youth has a brief clinical interview with an on-site mental health professional.

- If the mental health professional decides a more complete evaluation would be beneficial, the parents are notified and offered assistance obtaining services in the community. (UCTSC, accessed 11/12/05)

As of October 25, 2005 there were a total of 460 active TeenScreen sites in 42 states and Washington DC. Florida is one of the larger initiatives. (UCTSC, accessed 11/12/05)

The program has been evaluated nationally and the following key research findings are reported on their website (UCTSC, accessed 11/12/05):

- "The TeenScreen Program is effective in identifying youth suffering from mental illness or at risk for suicide." (Shaffer et al., 2004)
- "The program may be the most effective way of finding teens at risk, many who do not display external signs of their depression or risk of suicide." (Shaffer and Craft, 1999; Scott and Schaffer, 2004)
- "The program identifies youth that are likely to have long-term mental health problems." (Shaffer et al., 1998)
- "Screening programs have resulted in reduced reports of suicide attempts." (Aseltine and DeMartino, 2004)
- "Evidence shows that screening for suicide is safe and does not cause teens to think about killing themselves." (Gould et al., 2005)

The first screening site in Florida was developed in 1999 in a youth homeless shelter. Currently Florida has 33 TeenScreen sites throughout the state located in a variety of settings (16 schools, 12 residential/ homeless shelters, 1 foster care provider, 1 juvenile assessment center, and 3 community mental health providers). Both the Governor's Office of Drug Control and the Louis de la Parte Florida Mental Health Institute at the University of South Florida have been instrumental in promoting the TeenScreen Program as well as supporting its efforts to build screening programs. The Program is working with the Florida Network of Youth and Family Services to systematically bring TeenScreen to youth homeless shelters throughout the state. The Network represents agencies which serve to strengthen the relationships between homeless, runaway, and troubled youth—ages ten and older—and their families. In February of 2004, they trained 6 shelters through the Network and plan to train up to 15 more in January 2006. The program has been pioneered in 13 cities throughout the state and continues to work with an additional 40.

The **Solutions Unlimited Now (SUNsm) Program**, developed by Judith S. Tellerman, Ph.D. at the University of Illinois at Chicago College of Medicine, is a ten-step structured early intervention and prevention group program designed to help participants enhance decision-making, social and coping skills, reduce impulsivity, and prevent self-destructive behaviors through a confidential support system in a safe, easily accessible environment. Participants learn the important concept that there are always many diverse solutions to the same problem, and how to determine and carry out the best solutions to their problems, thereby eliminating the frustration that often leads to antisocial behavior. They learn everything does not always happen immediately and that things do change if you give them time and learn to ask for help. The group teaches each other not to give up and to have patience with both themselves and others. The **FISP SUN Program** has expanded on the Tellerman program by including various modalities (i.e., drawing, charts, puppets, and role playing developed by FISP facilitators) to

involve children who find it difficult to express themselves. They have also adapted the program to meet the needs of the facilities, such as meeting each day for 10 days in a detention center instead of once a week for 10 weeks so that children are not lost. Starting in 2002, the FISP SUN Program is being offered to 10 to 17 year old participants in peer groups of 8 to 10 in cooperation with partner organizations at no cost to the teen or partner organization. The target population consists of teens who are in families with working or absent parents and at-risk family structures and who are attending an after school program, involved in the foster care system, local schools, or the juvenile justice system. This program is being used in the Metro-Dade, Palm Beach and Broward County School Systems' after school programs where several hundred counselors have been trained. In addition, Juvenile Judges in Broward County are mandating it for children on probation and it is being used by the YMCA after school program at Lauderhill Middle School. It has been used in the LEAF juvenile justice residential facility for girls that is now closed and Hispanic Unity in Hollywood, Florida, as well as the SOS Children's Village in Coconut Creek. Program supporters believe that success is demonstrated by participants in the after school programs telling their friends to join the groups so they too can experience for themselves the sense of safety and accomplishment gained by their bonding with peers and adults; staff and some of the most at-risk teen participants at LEAF requesting more sessions and repeat groups; and after offering the program to a group of girls at SOS Children's Village who were getting ready to leave asking for it to be offered to a group of boys in the same situation. Jackie Rosen, FISP Executive Director and CEO feels "the SUN Program is helping meet the problem solving development needs of the undeserved and at-risk teen population in Broward County. It greatly improves their self-worth and self confidence so they can succeed in today's society."

Gatekeeper Training: In 2002, the DCF funded The Beth Foundation to develop and implement a youth suicide prevention gatekeeper-training curriculum. Evidence-based training is provided to caregivers and gatekeepers throughout the state to help ensure that "someone" is always there who can help. The training enables participants (teachers, school nurses, school personnel, police officers, mental health care providers, and emergency health care personnel) to recognize those factors that place youth at risk for suicide and to learn appropriate interventions. The objective of the training is to establish a network of adults trained to recognize, respond appropriately and refer young people for help. The workshop is an interactive training experience with engaging exercises, small group discussions, videos, and role-playing. Ideally, the workshop consists of 25 participants with a willingness to commit to conducting gatekeeper training for others in their communities. The training workshop consists of 11 modules: Key Terms; Attitudes and Beliefs; Understanding Young People in Crisis; Recognizing Risk Factors, Warning Signs, and Clues; Protective Factors and Positive Emotional Development; Responding to Suicidal Behavior; Community Resources; Managing Suicide or Sudden Death; Helping Survivors; Featuring Suicide in the Media; and Gatekeeper Training Program Suggested Outlines. The training program provides two facilitators to conduct the one-day train-the-trainer workshop. In addition, a training support package has been developed to enhance the training efforts of certified trainers. Each workshop participant receives a training support package including a Trainers Guide, Information Booklet, numerous Power Point presentations, scheduling support and tips, handouts and a CD-ROM with all of the support materials to aid in the reproduction of the materials. (Beth, 2005)

Workshops have been conducted in a number of counties and numerous state conferences each year reaching a wide variety of audiences, including school staff, prevention specialists, law enforcement, youth, and others. The Louis de la Parte Florida Mental Health Institute's Department of Child and Families Studies and the Beth Foundation committed to evaluate the training. Between November 2003 and September 2004, 302 gatekeepers were trained of which 299 provided data for an evaluation. Trainees were primarily mental health providers, human services providers, students, and educators. Half (50%) had received some sort of prior training in suicide prevention or intervention and 40 percent had already referred at least one at-risk individual for professional assistance. Immediately following the training there were significant increases in the trainees' knowledge about suicide issues and their perceptions about their ability to intervene. These were maintained at three-month follow-up after the training. (Roggenbaum et al., 2004)

***Youth Suicide Prevention School-Based Guide*:** This *Guide* was developed by the University of South Florida, The Louis de la Parte Florida Mental Health Institute and was funded by the Institute of Child Health Policy at Nova Southeastern University through a Drug Free Communities Program Award. It provides a framework for schools to assess their existing or proposed suicide prevention efforts (through a series of checklists) and provides resources and information that school staff can use to enhance or add to their existing programs. The *Guide* can be used by school administrators, counselors, teachers, youth outreach programs, family and community partnerships, and caring adults. It is based on review of the current literature and exemplary programs and is produced in relatively short, separate Issue Briefs combined into a pocket folder. The *Guide* includes 7 topic-specific *Checklists* (Information Dissemination in Schools, School Climate, Administrative Issues, Suicide Prevention Guidelines, Intervention Strategies, Preparing For and Responding to Death by Suicide, Culturally and Linguistically Diverse Populations) that can be completed to help evaluate the adequacy of the school's suicide prevention programs, ability to deal with a suicidal youth, and ability to respond to a suicide or suicide attempt. It also includes 13 *Issue Briefs* with topic-specific references (Information Dissemination; School Climate; Risk Factors: Risk and Protective Factors, and Warning Signs; Risk Factors: How Can a School Identify a Student At-Risk for Suicide; Administrative Issues; Suicide Prevention Guideline; Intervention Strategies: Establishing a Community Response; Intervention Strategies: Crisis Intervention Teams; Intervention Strategies: Responding to a Student Crisis; Preparing for and Responding to a Death by Suicide: Steps for Responding; Preparing for and Responding to a Death by Suicide: Responding to and Working With the Media; Family Partnerships; and Culturally and Linguistically Diverse Populations) that offer a rationale for the importance of the topic with an overview of proven effective strategies. *References* include helpful links for further investigation into the specific topics. In addition, a sample of school-based suicide prevention programs, additional resources and links, statistics from the American Association of Suicidology, a true/false test about the myths of youth suicide, and sample school forms are included. (Lazear et al., 2003)

The *Guide* was completed in 2003 and released nationally at the December 2003 Suicide Prevention Resource Center Conference in New Orleans and is in use across the nation as well as in Florida. The Florida Department of Education is strongly encouraging schools to use this *Guide*. Initially 600-700 copies were distributed at no charge to Florida schools. Another 600-700 copies were purchased by Florida schools or school systems. It was put on-line in January

2004 and currently can also be obtained on CD. In 2005 a flier was prepared and sent with the overview of the *Guide* to school superintendents and secondary school principals. In addition, a number of presentations have been made at statewide education and school health conferences. There are links to the website from several Florida suicide prevention websites as well as being listed in the Suicide Resource Center Library. There is also a reference to this *Guide* and its website in the National Governor's Association Issue Brief on "Youth Suicide Prevention: Strengthening State Policies and School-Based Strategies."

Signs of Suicide (SOS) Program: This is a school-based suicide prevention program that combines a curriculum that aims to raise awareness of suicide and related issues with a brief screening for depression and other risk factors. The educational piece expects to reduce adolescent suicide by increasing knowledge and promoting adaptive attitudes toward depression and suicidal behavior. The self-screening piece enables students to recognize depression and suicidal thoughts and behaviors in themselves and prompts them to seek help. The program educates students to recognize suicide as being directly related to mental illness and depression and that it is not a normal reaction to stress and emotional upset. The program promotes the acronym ACT (Acknowledge, Care, and Tell), and hopes that it will become as well known as CPR. First a person must "acknowledge" the signs of suicide and take them seriously. Then one must let another person know you "Care" about them and want to help. Finally, youths are instructed to "Tell" a responsible adult. The program is aimed at high school students in urban, suburban, and rural areas and is suitable for a school setting. It includes a video "Friends for Life: Preventing Teen Suicide" and a discussion guide. A multi-state evaluation of the program shows that:

- The average number of youth seeking counseling for depression/suicidability in the 30 days following the training was significantly higher when compared to this average per month for the year prior to the program (9.59 vs. 3.93).
- There was a 70% increase in the average number of youth seeking counseling for depression/suicidability on behalf of a friend after the program in the 30 days following the training when compared to this average per month for the year prior to the program (3.79 vs. 2.25).
- The number of youth seeking counseling for depression/suicidability remained high in the 3 months following the program as well as those seeking help for a friend. (SAMHSAMP, accessed 11/12/05)

This program was introduced into the Orange County school system in Florida in September 2005, funded by the Michael Buonauro Foundation. This foundation was set-up by the parents of Michael Buonauro, who grew up and was educated in the West Orange area and committed suicide at age 25. It is co-sponsored by the county's SAFE Program and is offered in all Orange County Schools. The video is shown followed by a student-lead discussion and handing out the ACT card. The self-screening portion of the SOS Program is not included. No parental consent is required. West Orange High School was the kick-off school and now ambassadors are being trained in the other schools. The program is incorporated as part of the SAFE program, already in the schools. Each school has a SAFE Coordinator who watches students during the video and students can come to this person if they have concerns. There are also SAFE Ambassadors, who are students and wear bracelets to identify themselves. There is an initiative to put this program in law during the 2006 Legislative session.

Bullying Programs: The Florida Office of Safe and Healthy Schools, in the Bureau of Student Assistance, Florida Department of Education continues to make the community aware of the seriousness of the bullying problem with youth. The April 2005, *SDDFS Notes* produced by the office addressed bullying. In this publication the scope of the problem, types of bullies, role of "cyberbullies," the bullying cycle, and successful anti-bullying programs were described. In addition, anti-bullying legislation nationally, facts and statistics on bullying from national surveys, and anti-bullying efforts in Florida and nationally were summarized. "Bullying and Harassment in Our Schools: A Fact Sheet" was developed and initially distributed at a Congressional briefing on Bullying and Harassment led by Congressman John Shimkus on March 23, 2004. This fact sheet summarizes what currently is known about the problem from the literature, describes the differences and similarities between bullying and harassment, emphasizes the powerful role prevention can play, and decries the lack of federal legislation to address these issues.

Juvenile Justice Detention Facilities: An interagency agreement is in place between DCF and the Department of Justice to look into reducing suicide attempts in juvenile justice detention facilities. Facility checklists have been implemented to assess and decrease the means for suicide in these facilities (e.g., eliminate crossbars from which an inmate might hang him/herself).

Interventions to Impact the Health Care System:

Mental Health Services: The mission of the Department of Children and Families (DCF) is to "protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery." Strategies to do this address:

- children or adults who have been abused, neglected, exploited, or are at risk of abuse, neglect, or exploitation and their families;
- families and individuals in distressed/fragile health or circumstances; and
- individuals and families at risk of or challenged by substance abuse and/or mental illness. (DCF, 2005)

Mental health and substance abuse services are primarily contracted out to community mental health centers and crisis stabilization units, although there are still a few state hospitals. These contracts are handled by 14 district offices, which have authority for how services will be developed in their districts. As might be expected, those with the most resources are the most progressive. Most, if not all, of their materials are in Spanish as well as English and in south Florida the documents are also in Creole. In areas where Spanish is the primary language for many residents, such as Ft. Lauderdale and Miami, most staff are bilingual or a Spanish-speaking interpreter is available. The community mental health centers are private, not-for-profit organizations that take on many forms. Unfortunately due to a lack of funds, not much money is put into prevention, although something is going on related to prevention in the districts, it is just not very well organized or extensive. In some areas there is Assertive Community Treatment, where mobile crisis teams go out to the problem. There are efforts currently underway to see that these are linked better with the suicide prevention efforts in the communities they serve. Every district has at least one of these teams but in rural areas they may serve more than one county.

In addition, as mentioned earlier, some mental health providers have received gatekeeper training and the *Columbia TeenScreen Program* is being used by three community mental health providers.

Pediatricians and Other Primary Care Providers: Dr. Deborah Mulligan and her colleagues at Nova Southeastern University have done a great deal of work looking at primary care providers and the provision of mental health services primarily in Broward County, some of which will be highlighted in this report. Dr. Mulligan is the immediate past Chairperson of the Florida Academy of Pediatrics. A survey of pediatricians to identify current screening and referral practices, barriers and issues related to mental health screening, and barriers and issues related to mental health referrals has been conducted in Broward and Alachua counties, a multi-ethnic, multi-cultural metropolitan community in Florida. Surveys were faxed or e-mailed to 240 pediatricians identified by the County Medical Associations. Qualitative data from key informant interviews were used to complement the survey findings. The respondents were mainly pediatricians (86%) practicing in private settings (79%). The majority (78%) felt that patient mental health or related problems were moderately prevalent to very prevalent and about three-quarters (76%) reported that they do not use a standard mental health screening procedure in their routine practice. Less than half (31%) felt they were aware or very aware of the mental health services in their community and only forty-six percent (46%) had follow-up procedures for youth they referred for mental health services. Qualitative findings indicated that they felt mental health was within the scope of their practice but they were frustrated with the gap between medical and mental health services, especially due to time constraints and reimbursement barriers. After completing the survey, physicians were sent an information packet dealing with mental health screening and referral practices.

In response to the above survey on September 17, 2005 the Broward County One Community Partnership, Nova Southeastern University, and the Broward County Children's Services Council sponsored the *Fourth Annual Raising Healthy Children Seminar* that was free and designed for educators, physicians, nurses, and mental health professionals. It is rare that these groups have an opportunity to come together for joint continuing education. The seminar was designed to increase the knowledge and awareness of the incidence of child mental health disorders; acute and long-term care for children with mental health and behavioral disorders; quality of life of these children and their families; liability, insurance, and pharmacology needs; future directions for pediatric mental health; and strategies for communities and families to prevent violent injury resulting from mental health and behavioral disorders. It was well received by the 224 participants that represented all the target groups and has been nominated for a SAMHSA ECO Award. A professionally produced DVD will be made available for mass distribution to Broward County primary care providers and other targeted health/mental health professionals.

Another effort in this area is the *Health Professionals and Families United* project. This is a CATCH Implementation Grant funded by the Hasbro Children's Foundation. The project is helping families with children with severe emotional disturbances (SEDs) and a group of medical students at different points in their training at Nova Southeastern University gain advocacy skills. In addition, medical students learn about the lives of children with SED and the challenges they and their families face and families learn about the importance of a medical

home and access to primary care. Overall the project hopes to develop positive relationships between SED families, their community pediatrician, and the medical students.

Dr. Lisa Cosgrove, the Region IV representative to the Florida Pediatric Society, feels these problems are less of an issue in smaller, less urban areas because providers know their patients better and can more easily predict what children will have problems when they reach their adolescent years. The problem arises when there is a lack of time to spend with the patient to treat their mental health needs well.

Summary and Conclusions

Florida has implemented a wide variety of policies and programs identified in the professional literature as important in addressing teen suicide. These policies and programs have been at both the State and community level. Table 10 provides a chronology of relevant programs and policies implemented in Florida.

As can be seen from Table 10, although Florida had several efforts underway to address adolescent suicide prior to 1990, most of the efforts began in 1990 with statewide efforts in the schools. In 1990, the basic package of health services provided in schools was expanded in two ways by statute. *Comprehensive School Health Services Projects* were started in a number of schools that expanded the basic school health services to cover such things as interventions and classes on risk taking behaviors, violence and injury prevention, teen pregnancy prevention, and promotion of returning to school after giving birth. In the same year *Full Service Schools* were authorized by statute. These schools focus on services for underserved students in poor, high-risk communities needing medical and social services, including providing economic and job placement services, counseling for abused children, and mental health and substance abuse counseling. All of these services should impact on some of the risk factors for adolescent suicide, such as depression, substance abuse, and childhood physical abuse. In addition, suicide prevention training was made a requirement of teacher certification at the secondary level. Although this is no longer a requirement, crisis management, including suicide prevention, is part of the orientation for all teachers. In 1992 the Centers for Disease Control and Prevention's (CDC) *Coordinated School Health Program* was started in a number of schools. This program combines the delivery of education and health services to better address students' needs, including the provision of psychological and social services.

In 1999, the FDOE sponsored *SAFE School Critical Incident Prevention, Planning, and Preparedness Summi*t and regional meetings across the state, bringing leaders in the field to address critical incidents. In 2001, authorized by statute, the *Safe Passage Act's* self-assessment tool to assure all children have a safe passage through Florida's educational system addressed suicide prevention directly as well as addressing a number of the risk factors. In 2003, the Center for the Study of Children's Futures, Louis de la Parte Florida Mental Health Institute at the University of South Florida released the *Youth Suicide Prevention School-Based Guide* that provides a framework for schools to use to assess their existing and proposed suicide prevention efforts and promoted it extensively in all Florida school districts and school districts statewide continue to mount efforts in bullying and harassment prevention.

Finally, there are a number of programs that have been used in selected schools around the state that should impact adolescent suicide. These include the Mendez Foundation's *Too Good for Drugs*, the *Suicide Prevention and School Crisis Management Program*, the *Florida Initiative for Suicide Prevention's (FISP) SUN Program*, and the *Signs of Suicide (SOS) Program*. School-based programs have the potential for reaching many adolescents and may have contributed to the lowering of the adolescent suicide rates in Florida that began in the 1990s.

Two statewide efforts that are not only directed toward schools but other facilities serving adolescents that address suicide prevention are the *Columbia TeenScreen Program* and the *Beth Foundation's Gatekeeper Training*. Started in 1999, Florida now is one of five states in the country with more than 30 Columbia TeenScreen settings, including primarily shelters and schools but also several community mental health providers. The Beth Foundation began a gatekeeper train-the-trainer program in 2002. To date, trainings have taken place in a variety of settings around the state. Trainees have been primarily mental health providers, human services providers, students, and educators.

What may not be apparent from Table 10 is the recent exceptionally high degree of collaboration among the large number of state and local agencies and organizations involved in the effort to assist at-risk youth. This became a major focus in suicide prevention efforts in 2000 when, after meeting with a group of grassroots suicide prevention activitists, Governor Jeb Bush directed the Governor's Office of Drug Control to take the lead on coordinating efforts to reduce the incidence of suicide in Florida. That same year, James McDonough, Director of the Office of Drug Control, established the multi-agency/organization *Florida Suicide Prevention Task Force* (FSPTF). Following that, McDonough and the Office of Drug Control facilitated the formation of a complementary grassroots statewide organization, the *Florida Suicide Prevention Coalition* (FSPC). In addition, injury and suicide prevention were made a more prominent focus in the Department of Health with the formation of the *Office of Injury Prevention* in 2003 and the *Suicide Prevention Committee* in 2004.

Beginning in 2003, the Governor, FISP, FSPTF, and the FSPC have tried to raise awareness of suicide prevention in the Legislature. For the last three years, the Governor has declared one day in March as *Suicide Prevention Day*. During this day Task Force and Coalition members put up displays in the legislative building and lobbied their state legislators. Each year, bills have been introduced to codify an Office of Suicide Prevention with a statewide coordinator. To date, these efforts have not been successful, but will be a major focus again in 2006.

Since 1985 three strategy papers have been written related to suicide prevention in Florida. The first one, *Comprehensive Plan for the Prevention of Youth Suicide*, was never implemented but the fact that it was written may have raised awareness of youth suicide prevention activities. The second, *Preventing Suicide in Florida: A Strategy Paper*, was a product of the FSPTF and the Office of Drug Control and the third, *Florida Suicide Prevention Strategy 2005-2010*, was a product of FSPTF, FSPC, and the Office of Drug Control. A retreat was held in August, 2005 to plan strategies to address the issues raised in the third paper and subcommittees of the FSPTF have been given parts of the plan to move forward. It is hoped that these efforts will help in reaching the goals of reducing the suicide rates overall and for teens and elders by one-third between 2001 and 2010.

In summary, Florida has used a multi-agency/organization, multi-focused approach to addressing adolescent suicide prevention. If the effort has not already been evaluated, evaluation is a component in many instances. Interventions include awareness, problem solving and gatekeeper training programs as well as screening and anti-bullying and harassment programs. They have worked in schools as well as other facilities that serve troubled youth, such as homeless shelters and juvenile detention centers and have also worked with community mental health service providers. They have statewide crisis centers and hotlines and survivor support groups, although the literature does not support that hotlines would have a major impact on adolescent suicide. Through the *Eliminating Barriers Program*, model public relations material has been developed for radio and television to reduce the stigma and discrimination associated with mental illness. The *Florida Injury Surveillance Data System* makes data on both completed suicides and suicide attempts available at the county level on the Internet through the use of death and hospital discharge records. Starting with 2005, data on suicide attempts will be available from a new hospital emergency room visit data system. Information on suicide ideation and attempts is available every two years through *CDC's Youth Risk Behavior Surveillance System*. All of these data are made available to users through the Office of Injury Prevention in the Department of Health. Recently they have begun to address health care provider education and coordination through the *Annual Raising Healthy Children Seminar* and *Health Professions and Families United Project* in Broward County. With the inception of the *Governor's Office of Suicide Prevention* and the *Florida Suicide Prevention Task* in 2000 and the *Florida Suicide Prevention Coalition* in 2002, there is a much higher degree of coordination of suicide prevention efforts in the state. In order to assure this continues it is important that an Office of Suicide Prevention, with a statewide coordinator, be established by law at the Governor's Office level. Although it is difficult to evaluate the overall effect of multi-agency, multi-focused interventions like those seen in Florida, they should raise awareness and hopefully have a positive impact by reducing the adolescent suicide.

Table 10
Florida Adolescent Suicide Prevention Activities
TIMELINE

Date	Activity
1978	Mendez Foundation began offering *Too Good for Drugs*, a school-based prevention program for grades K-12.
1984	*Florida Youth Emotional Development and Suicide Prevention Act* passed that includes the development of a state plan for youth suicide and the establishment of a Task Force.
1985	*Comprehensive Plan for the Prevention of Youth Suicide* was written addressing prevention, intervention, and treatment strategies but it was never implemented.
1989	*Suicide Prevention and School Crisis Management Program* started in Dade County Public Schools.
1990	Suicide prevention training made a requirement for teacher certification at the secondary level. Requirement, but no longer in effect but all teachers now get crisis management, including suicide prevention, as part of their orientation.
1990	Statute passed establishing the *Comprehensive School Health Services Projects* to provide an expanded set of health services in a selected group of schools.
1990	Statute passed to authorize *Full Service Schools* to provide health services to students in poor, high-risk communities.
1991	Florida Division of the American Foundation for Suicide Prevention [now called the *Florida Initiative for Suicide Prevention (FISP), Inc*.] was started.
1992	*CDC's Coordinated School Health Program* started in selected Florida schools.
1996	*YES Institute* began providing services to prevent suicide in the gay, lesbian, bisexual, and transgender community in 3 southeastern Florida counties.
1999	*Suicide Prevention Study, Report to the Legislature* was released that evaluated suicide prevention in Florida since the passing of the Suicide Prevention Act in 1984. Ten recommendations were made based on the findings.
1999	Both houses on the state legislature passed *suicide prevention resolutions* (HR 9233 and SR 2684).
1999	The FDOE sponsored *SAFE School Critical Incident Prevention, Planning, and Preparedness Summi*t and regional meetings across the state, bringing leaders in the field to address critical incidents.
1999	First *Columbia TeenScreen* site was developed in a youth homeless shelter.
Dec. 1999	The *Suicide Prevention Coalition of Volusia and Flagler Counties* was started.

Jan. 2000	Governor Bush met with grassroots activists and directed the *FL Office of Drug Control* to assist in decreasing the incidence of suicide in FL.
June 2000	*Adolescent Suicide Prevention Plan, Task Force Report* to the Florida Department of Health, Bureau of EMS completed and submitted.
Nov. 2000	Governor directed the Director of the FL Office of Drug Control (Jim McDonough) to appoint the *Florida Suicide Prevention Task Force*.
2001	*Safe Passage Act* to assure that all children have a safe passage through Florida's educational system was passed by the Legislature.
2001	*The Beth Foundation, Inc*. was founded to reduce the suicide rate in Florida through education and awareness.
2001	*SAMHSA Eliminating Barriers Initiative* funded to reduce stigma and discrimination associated with mental illness.
2002	*FISP SUN Program* to teach 10-17 year olds problem-solving skills was started.
2002	The Beth Foundation, Inc. began its *Gatekeeper Training Program*.
2002-2007	*Youth Suicide Prevention Prototype Program* in Alachua and Broward counties.
Aug. 2002	*Preventing Suicide in Florida: A Strategy Paper* was written by the Florida Suicide Prevention Task Force that includes goals for 2005 and strategies to reach these goals.
Oct. 2002	*Florida Suicide Prevention Coalition* started (not-for-profit, organization working with groups at the grassroots level to reduce the incidence of suicide.
2003	*Youth Suicide Prevention School-Based Guide* released to help schools assess their existing or proposed suicide prevention efforts.
2003	*Office of Injury Prevention* formed in the Department of Health (DOH).
Mar. 2003	*First Suicide Prevention Day* declared by Governor Bush.
Nov. 2003	Bill drafted to codify the Suicide Prevention Coordinating Council and provide a full-time staff member to coordinate efforts. The bill did not pass.
2004	HB 0897 and SB 2042 introduced to create a statewide office for suicide prevention and create a position of Statewide Coordinator of Suicide Prevention was introduced but neither passed due to the fiscal impact.
2004	Anti-bullying and anti-harassment programming in schools continues to be addressed at the state and local levels.
Feb. 2004	*DOH Suicide Prevention Committee* was started to address the DOH role related to suicide prevention.
Mar. 2004	*Second Suicide Prevention Day* declared by Governor Bush.

2004-2005	The *Health Professionals and Families United Project* helps medical students at Nova Southeastern University learn about the lives of families of children with severe emotional disturbances and the challenges they face.
2005	Bills (SB 0210 and HB 0447) introduced into the 2005 Legislature to create a Statewide Office for Suicide Prevention, hire a coordinator, and continue the Suicide Prevention Coordinating Council. Neither bill passed for political reasons.
2005	Three pilot programs in social marketing started to foster suicide awareness.
Feb 2005	Broward County Children's Services Council sponsored the *Fourth Annual Raising Healthy Children Seminar* that was free and designed for educators, physicians, nurses, and mental health professionals.
Mar. 2005	*Third Suicide Prevention Day* declared by Governor Bush and the *Florida Suicide Prevention Strategy 2005-2010* was released.
Aug. 2005	Retreat held to plan strategies to address issues identified in the above strategy.
Sep. 2005	*Signs of Suicide (SOS) Program*, a school-based suicide prevention program was started in the Orange County school system.

References

Adolescent Suicide Prevention Task Force (ASPTF). *Adolescent Suicide Prevention Plan: Task Force Report*. Florida Department of Health, Tallahassee, Florida, June 2000.

Anderson RN, Minino AM, Hoyert DL, Resenburg HM. Comparability of Cause of Death Between ICD-9 and ICD-10: Preliminary Estimates. *National Vital Statistics Reports*. 2001;49(2):18.

Aseltine RH, DeMartino R. An outcome evaluation of the SOS suicide prevention program. *American Journal of Public Health*. 2004;94(3):446-451.

Columbia University TeenScreen Program (CUTSP). Available at http://www.teenscreen.org. Accessed November 11, 2005.

Council of Church-Based Health Programs, Inc. (CCBHP). Available at http://www.ccbhp.org. Accessed February 7, 2006.

Florida Department of Children and Families (FDCF). *2005-2008 Strategic Plan*. Tallahassee, Florida, September 2005.

Florida Department of Education (DOE), Safe Passage Act: District Safety and Security Assessments. Available at http://www.firn.edu/doe/besss/safe_passage/safe_passage.htm. Accessed November 21, 2005.

Florida Department of Health (DOH), Because Family Matters (BFM). Available at http://www.doh.state.fl.us/Family/familymatters/index.htm. Accessed January 9, 2006.

Florida Department of Health (DOH), Division of Health Access & Tobacco – Injury Prevention (DHATIP). Available at http://wwwdoh.state.fl.us/workforce/ InjuryPrevention/index.html. Accessed July 13, 2005.

Florida Initiative for Suicide Prevention (FISP). Available at http://www.fisponline.org. Accessed February 15, 2005.

Florida Substance Abuse and Mental Health Corporation (FSAMHC). *A Year of Change and Renewed Priorities*, Tallahassee, Florida, December 31, 2004.

Florida Suicide Prevention Coalition (FSPC). Available at http://www.floroidasuicideprevention.org. Accessed September 9, 2005.

Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, editors. *Reducing Suicide: A National Imperative*. Washington, DC: The National Academies Press; 2002.

Gould MS, Greenberg T, Velting DM, Shaffer D. Youth suicide risk and preventive interventions: a review of the past 10 years. *Journal of the American Academy of Child Adolescent Psychiatry*. 2003;42(4):386-405.

Gould M, Marrocco F, Kleinman M, Thomas J, Mostkoff K, Cote J, Davies M. Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *Journal of the American Medical Association*. 2005;293:1635-1643.

Governor's Office of Drug Control (GODC), Executive Office of the Governor. *Florida Suicide Prevention Strategy 2005-2010*. Tallahassee, Florida, January 2005. Available at http://www.myflorida.com/myflorida/government/governorinitiatives/drugcontrol/suicide_prev.html.

Grunbaum JA, Kann L, Kinchen S, Ross J, et al. Youth risk behavior surveillance--United States, 2003. *MMWR Surveillance Summaries*. 2004;53(SS-2):35-36, 45-48.

Grunbaum JA, Kann L, Williams B, Ross JG, et al. Youth risk behavior surveillance--United States, 2001. *MMWR Surveillance Summaries*. 2002;51(SS-4):26, 32.

Institute for Child Health Policy (ICHP), Nova Southeastern University. *Florida State Metropolitan and Non-Metropolitan Community Youth Suicide Prevention Prototype Program: Executive Summary Report Year Two*. Ft. Lauderdale, Florida, October 1, 2004.

Lazear KJ, Nations L, Vaughn D, Chambers K. *Florida Youth Suicide Prevention Study: Report to the Florida State Legislature*. University of South Florida, Louis de la Parte Florida Mental Health Institute: Department of Child and Family Services, Tampa, Florida, 1999. Available at http://www.floridasuicideprevention.org/state_history.htm.

Lazear K, Roggenbaum S, Doan J. *Youth Suicide Prevention School-Based Guide*. University of South Florida, Louis de la Parte Florida Mental Health Institute: Department of Child and Family Services, Tampa, Florida, 2003. Available at http://theguide.fmhi.usf.edu.

Mendez Foundation (MF). Available at: http://www.mendezfoundation.org. Accessed October 9, 2005.

National Center for Injury Prevention and Control (NCIPC), Center for Disease Control and Prevention, WISQARS. Available at: http://www.cdc.gov/ncipc/wisqars. Accessed at various times in 2005, dates indicated with the data.

O'Carroll PW, Potter LB, Mercy JA. Programs for the prevention of suicide among adolescents and young adults. *Morbidity and Mortality Weekly Report*. 1994;43(RR-6);1-18.

Office of Program Policy Analysis and Government Accountability (OPPAGA), School Safety and security Best Practices. Available at: http://www.oppaga.state.fl.us/school_districts/safety/schoolsafety.html. Accessed April 15, 2005.

Olfson M, Shaffer D, Marcus SC, and Greenberg T. Relationship between antidepressant medication treatment and suicide in adolescents. *Archives of General Psychiatry*. 2003;60(10):978-982.

Roggenbaum S, Makosky J, Hamilton C, Department of Children and Families. *The Evaluation of a Florida Suicide Prevention Gatekeeper Training Program*. Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies, Tampa, Florida, September 2004.

SAMHSA Elimination of Barriers Initiative (SAMHSAEBI). Available at: http://www.allmentalhealth.samsha.gov/aboutebi.html. Accessed November 4, 2005.

SAMHSA Model Programs (SAMHSAMP): Info on Promising Programs. Available at: http://modelprograms.samhsa.gov/template_cf.cfm?page=promising&pkProgramID=429. Accessed November 12, 2005.

School Health Services Program (SHSP). Available at: http://www.doh.state.fl.us/Family/school/services/sh_services.html. Accessed November 12, 2005.

Scott M, Shaffer D. The Columbia Suicide Screen: Does screening identify new teens at risk? Poster presented at the annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC, 2004.

Shaffer D, Craft L. Methods of Adolescent Suicide Prevention. *Journal of Clinical Psychiatry*. 1999;60(2):70-74.

Shaffer D, Restifo K, Garfinkel R, Wilcox H, Ehrensaft M, Munfakh J. Screening for youth-adult suicidality and moos disorders in high school. Poster presented at the annual meeting of the American Academy of Child and Adolescent Psychiatry, Anaheim, CA, 1998.

Shaffer D, Scott M, Wilcox H, Maslow C, Lucas C, Garfinkel R, Greenwald S. The Columbia SuicideScreen: validity and reliability of a screen for youth suicide and depression. *The Journal of the American Academy of Child and Adolescent Psychiatry*. 2004;43:71-79.

Suicide Prevention Coalition of Volusia and Flagler Counties (SPCVF). Available at http://www. suicideprevention–volusiaflagler.org. Accessed March 14, 2005.

The Beth Foundation, Inc. (Beth). Available at http://www.thebethfoundation.com. Accessed March 8, 2005.

University of Rochester Medical Center (URMC). Scientific Consensus Meeting on Suicide Prevention in Adolescents and Young Adults; 2001 June 13-14; Bethesda, Maryland. Available at: http://www.rochesterpreventsuicide.org/youth.html. Accessed: March 31, 2003.

U.S. Department of Health and Human Services (USDHHS/MCHB), Maternal and Child Health Bureau, Maternal and Child Health Services Title V Block Grant Program. *Guidance and Forms for the Title V Application/Annual Report*. April 30, 2000, pp. 164 and 173.

U.S. Department of Health and Human Services (USDHHS). Mental Health and Mental Disorders. *Healthy People 2010, Conference Edition*; 2000 January; Washington, DC.

YES Institute (YI). Available at http://www.yesinstitute.org. Accessed November 1, 2005.

Appendix A

Persons Providing Information for the Florida Adolescent Suicide Prevention Report

Lorraine Husum Allen
Director, Office of Safe and Healthy Schools
Florida Department of Education
Tallahassee, FL
(850) 245-0668
Lorraine.Allen@fldoe.org

Rene Barrett
Founding Executive Director and Honorary Board Member
Florida Initiative for Suicide Prevention (FISP)
Director/Broward County
Florida Suicide Prevention Coalition
Hollywood, Florida
(954) 257-4568
myadvocate@bellsouth.net

Jackie Beck, MSW
Department of Children and Families
Mental Health Program Office
Tallahassee, Florida
(850) 921-5699
Jackie_Beck@dcf.state.fl.us

Lidia Bernik
Program Coordinator
Suicide Prevention Action Network (SPAN) USA
Washington, DC
(202) 449-3600
lbernik@spanusa.org

Denise Bishop
State Consultant
Department of Education
School Psychology Student Support Services Project
University of South Florida
Tampa, Florida
(850) 922-3727
bishop@tempest.coedu.usf.edu

Sylvia Byrd, ARNP, MPH, NCSN
Executive Community Health Nursing Director
School Health Program
Tallahassee, Florida
(850) 245-4447
sylvia_byrd@doh.state.fl.us

Judy Cobb, RN, MSPH
Community Health Nursing Consultant/ Epidemiologist
Palm Beach County Health Department
Riviera Beach, Florida
(561) 514-5369
Judith_Cobb@doh.state.fl.us

Anne Compton, BS
Training Coordinator
Mendez Foundation
Tampa, Florida
(800) 750-0986 (ext. 205)
annec@mendezfoundation.org

Lisa Cosgrove, MD
Atlantic Coast Pediatrics
Merritt Island, FL
Region IV Representative to the Florida Pediatric Society
(321) 452-6115
lisacosgrove@usa.net

Charlotte M. Curtis, RN
Director, Child and Adolescent Health Unit
Family Health Services
Tallahassee, Florida
(850) 245-4496
Charlotte_Curtis@doh.state.fl.us

Ken DeCerchio
Assistant Secretary of Substance Abuse and Mental Health
Department of Children and Families
Mental Health and Suicide Prevention
Tallahassee, Florida
(850) 921-8461
ken_decerchio@dcf.state.fl.us

Martha Fugate
Director, YES Institute
Miami, Florida
(305) 663-7195
martha@yesinstitute.org

Michael L. Haney, PhD
Director for Prevention and Intervention
Children's Medical Services
Florida Department of Health
Tallahassee, Florida
(850) 245-4444 (ext. 4217)
mike_haney@doh.state.fl.us

Pam Harrington
Beth Foundation and SPAN USA
Ponte Vedra Beach, Florida
(904) 819-9431
r-harrington@comcast.net

Gregory J. Harris, MASS
Executive Director
Council of Church-Based Health Programs
Tallahassee, Florida
(850) 385-1205
hppi@ureach.com

Bettye Hyle
Team Leader, Student Support Services and
Shared Services Network
University of South Florida
Tampa, Florida
(850) 922-3727
bhyle@tempest.coedu.usf.edu

Marshall Knudson, PhD
Director, Alachua County Crisis Center
Gainesville, Florida
(352) 264-6792
mknudson@alachua.fl.us

Marjorie LaBarge
Safe and Drug Free Schools Coordinator
Orange County Schools
Orlando, Florida
(407) 317-3344
labargm@ocps.net

Michael Lo, MSPH
Epidemiologist, Office of Injury Prevention
Florida Department of Health
Tallahassee, Florida
(850) 245-4440 (ext. 2729)
Michael_Lo@doh.state.fl.us

Erin MacInnes
Chief, Suicide Prevention Efforts
CTI State Coordinator
Florida Office of Drug Control
Executive Office of the Governor
Tallahassee, Florida
(850) 922-0498
Erin.MacInnes@MyFlorida.com

James McDonough
Director
Florida Office of Drug Control Policy
Executive Office of the Governor
Tallahassee, Florida
(850) 488-9557
Jim.McDonough@MyFlorida.com

Laura Meyer
Florida Suicide Prevention Coalition
Deland, Florida
(386) 736-2446
dreamsicle#@msn.com

Joy Mills
Vice President of Strategy
CEO Service Bureau
Jacksonville, Florida
(904) 396-0230
joy@ceoservicebureau.com

Deborah A. Mulligan, MD, FAAP, FACEP
Director and Professor
Institute for Child Health Policy
Nova Southeastern University
Fort Lauderdale, Florida
(954) 262-1940
dams@ichp.nova.edu

Annette Phelps
Director, Division of Family Health Services
FL Department of Health
Tallahassee, Florida
(850) 245-4447
Annette_Phelps@doh.state.fl.us

Lauren Porter
Program Specialist
Office of Safe and Healthy Schools
Florida Department of Education
Tallahassee, Florida
(850) 245-0671
Lauren.Porter@fldoe.org

Stephen Roggenbaum
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida
(813) 974-6149
roggenba@fmhi.usf.edu

Jackie Rosen
Executive Director and CEO
Florida Initiative for Suicide Prevention (FISP)
Weston, Florida
(954) 384-0344
jrosenFISP@aol.com

Heather Scanlon, MSW
Senior Program Coordinator
Columbia University TeenScreen Program
(646) 443-8199
ScanlonH@childpsych.columbia.edu

Lisa VanderWerf-Hourigan, MS
Manager, Office of Injury Prevention
Florida Department of Health
Tallahassee, Florida
(850) 245-4440 (ext. 2776)
Lisa_VanderWerf-Hourigan@doh.state.fl.us

Leslie Wurster, MSW, MPA
Government Operation Consultant II
Family and Community Health
School Health Services (HSFFC)
Florida Department of Health
Tallahassee, Florida
(850) 245-4444, (ext. 2936)
Leslie_Wurster@doh.state.fl.us

Frank Zenere
Miami-Dade Public Schools
Miami, Florida
(305) 995-7319
fzen3@hotmail.com

Appendix B

Florida Suicide Prevention Task Force Members
September 2005

Rene Barrett
Florida Initiative for Suicide Prevention
(954) 257-4568
myadvocate@bellsouth.net

Denise Bishop
School Psychology Student Suport Services Project
University of South Florida
(850) 922-3727
bishop@tempest.coedu.usf.edu

Donna Cacciatore
Crisis Center for Tampa Bay
(813) 964-1964 (ext. 3043)
cicacciatore@crisiscenter.com

Gene Cash
Florida Association of School Psychologists
(954) 963-5363
gcash1@aol.com

Georgette Daniels
Office of Policy and Budget
(850) 488-7734
georgette.daniels@laspbs.state.fl.us

Ken DeCerchio
Department of Children and Families
Mental Health and Suicide Prevention
(850) 921-8461
ken_decerchio@dcf.state.fl.us

Donald Eslinger
Florida Sheriff's Association
(407) 665-6731
sseiple@seminolesheriff.org

Shan Goff
Department of Education
(850) 245-0509
shan.goff@fldoe.org

Wayne Goodman
Department of Psychiatry
University of Florida
(352) 392-3681
wkgood@psych.med.ufl.edu

Pam Harrington
Beth Foundation and SPAN USA
(904) 819-9431
r-harrington@comcast.net

Mark Helms
Department of Community Affairs
(850) 922-1723
mark.helms@dca.state.fl.us

Paula Hoisington
Department of Corrections
(850) 488-5602
hoisinfton.paula@mail.dc.state.fl.us

Natalie Kelly
Alzheimer's Association of Florida
(850) 942-0942
Natalie.Kelly@alz.org

Marshall Knudson
Alachua County Crisis Center
(352) 264-6792
mknudson@alachua.fl.us

Belinda McClellan
Agency for Health Administration
(850) 922-7324
mccleld@fdhc.state.fl.us

Lisa McFadden
Volunteer Florida
(850) 413-0908
lisa@volunteerflorida.org

Erin MacInnes
Florida Office of Drug Control
Executive Office of the Governor
(850) 922-0498
Erin.MacInnes@MyFlorida.com

Kenneth McLeod
Department of Elder Affairs
(850) 414-2307
mcleodk@elderaffairs.org

Laura Meyer
Florida Suicide Prevention Coalition
(386) 736-2446
dreamsicle#@msn.com

Deborah Mulligan
Nova Southeastern University
(954) 262-1940
debmsmi@aol.com

David Shern
University of South Florida
(813) 974-1990
shern@fmhi.usf.edu

Karen Shiver
Department of Community Affairs
(850) 922-1658
Karen.shiver@dcs.state.fl.us

Mike Smith
FloridaState University
(850) 644-4690
mpsmith@admin.fsu.edu

Terry Smith
Florida Suicide Prevention Coalition
(386) 446-4690
tvss@pcfl.net

Phil Spooner
Agency for Workforce Innovation
(850) 245-7177
phil.spooner@awi.state.fl.us

Lisa Vander Werf-Hourigan
Office of Injury Prevention
Florida Department of Health
(850) 245-4440 (ext. 2776)
Lisa_VanderWerf-Hourigan@doh.state.fl.us

Bernard Warner
Probation and Community Correctors
Department of Juvenile Justice
(850) 487-9575
berbard.warner@djj.state.fl.us

Steven Wiggins
Department of Juvenile Justice
(850) 487-4521
steven.wiggins@djj.state.fl.us

Frank Zenere
Miami-Dade Public Schools
(305) 995-7319
fzen3@hotmail.com