

**A Suicide Prevention Framework
For Rhode Islanders Ages 15-24**

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Created by the Rhode Island Suicide Prevention Planning Team

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This document supports the health education standards referenced in the "Rules and Regulations for School Health Programs," (R16-21-SCHO)--Rhode Island Health Education Framework: Health Literacy for All Students, Appendix C, Comprehensive Health Instructional Outcomes for Mental and Emotional Health (See current document, Appendix A) as amended in December 2000 and supports the health objectives for Rhode Island as established in "Healthy People 2000: Rhode Island."

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**The Mission of the Rhode Island Suicide Prevention Planning Team is:
To prevent suicide and suicide attempts among Rhode Islanders by: Increasing awareness in communities, assuring appropriate and timely help, and reducing the stigma of mental illness.**

BACKGROUND

Preface

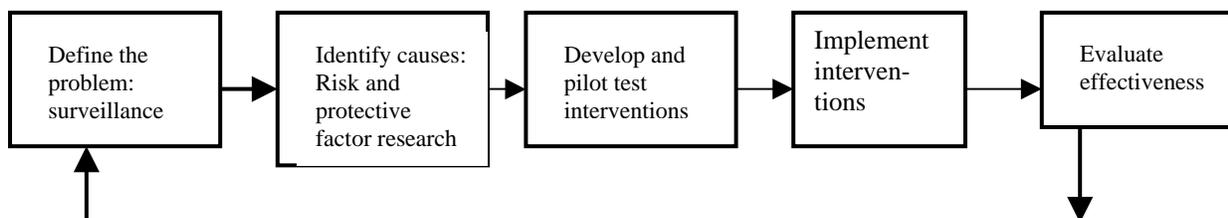
"The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description."

Kay Redfield Jamison, Author & Suicide Attempter

The suicide prevention framework provides guidance for professionals and individuals interested in suicide prevention planning among Rhode Islanders ages 15-24. The age group 15-24 was chosen as a starting point for what should become a larger suicide prevention strategy for Rhode Islanders across the life span. The Suicide Prevention Planning Team will continue with its work in the coming months to address suicide prevention among Rhode Islanders ages 25-64 and ages 65+, provided that adequate support and resources are available. We invite you to participate in the continuation of this important work; input from the community and interested individuals is always welcome.

Goals and objectives for prevention planning are outlined here without prioritization and focus on the general population of young people 15-24 as well as those people who are at increased risk for suicide. The goal of this document is to encourage the movement from suicide prevention planning to action by government, public health, education, human services, religion, voluntary organizations, and the advocacy and business communities in Rhode Island.

Specific steps for carrying out the action plan have purposefully been left out to allow for as much flexibility and creativity in program implementation as possible. However, in keeping with the *National Strategy for Suicide Prevention*, a public health approach is recommended as measurable goals and activities are implemented. The public health approach consists of the following five steps:



Surveillance entails collecting, analyzing, and interpreting information such as incidence rates of suicide over time. **Identifying risk factors**, those factors leading to, or associated with, suicide **and/or protective factors**, those factors that reduce the likelihood of suicide, inform the development of effective interventions. For example, knowing that depression is a risk factor for suicide informs the **development and testing of interventions** for depressed people. Effective interventions reduce risk factors or promote protective factors. The most effective interventions often include multiple strategies. Once deemed effective, interventions are **implemented** more widely with ongoing **evaluation** through continued surveillance and research.

Section I: History

A Brief History: From the World Health Organization to Rhode Island: 1996-2001

In its 1996 document "*Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*"ⁱⁱ, the World Health Organization recognized suicide as a growing problem throughout the world. The result of this document led to a collaborative effort between the U.S. Department of Health and Human Services and the grassroots advocacy organization, the Suicide Prevention Advocacy Network (SPAN) to design a national suicide prevention strategy for the United States.

In October 1998, four divisions of the United States Department of Health and Human Services-- the Centers for Disease Control and Prevention (CDC), the Health Resources Services Administration (HRSA), the Maternal and Child Health Bureau (MCHB), and the Substance Abuse and Mental Health Services Administration (SAMHSA)-- and SPAN convened the National Suicide Prevention Conference in Reno, Nevada. State teams consisting of representatives from the fields of injury prevention, mental health, and maternal and child health were invited to participate. The Rhode Island Department of Health's (HEALTH) Injury Prevention Program and the Rhode Island Department of Education's, Safe & Drug Free Schools program sent representatives to this historic conference.

The goal of the conference was to begin developing a national strategy for suicide prevention. By the end of the weeklong conference over 400 participants developed 81 recommendations for a national suicide prevention strategy. These 81 recommendations became the basis for 15 final recommendations published in *The Surgeon General's Call to Action to Prevent Suicide*ⁱⁱⁱ published in 1999 and ultimately, the 11 objectives of the *National Strategy for Suicide Prevention* (see Appendix B) released in May 2001^{iv}.

In January 1999, the Massachusetts Department of Health, on behalf of the Northeast Injury Prevention Network (NEIPN), a group of state Injury Prevention Directors from northeastern states, received conference support funds from the CDC to follow-up on the Reno meeting and the *Surgeon General's Call to Action*. Held in Byfield, MA in June 2000, this conference brought together state representatives from the Health Resources and Services Administration's (HRSA) regions one and two for three days. The conference supported both the formation of multi-disciplinary state suicide prevention teams and the development of state suicide prevention plans.

Suicide Prevention in Rhode Island:

The responsibility for suicide prevention has historically rested almost entirely with the Samaritans of Rhode Island. Specifically, in the mid-1980's, the State General Assembly mandated suicide education and prevention in Rhode Island public schools by The Samaritans, Inc.^v Funded in part by the State Department of Education, Safe & Drug Free Schools program, the Samaritans education resources include a daylong school suicide awareness and prevention program for health educators, school nurse teachers, school psychologists, social workers, guidance counselors, administrators, and parents. After receiving training, school staff integrate suicide prevention into the health curriculum, and are able to recognize suicide-warning signals

in students more effectively. A detailed teacher's manual is available upon request. Other resources provided by the Samaritans include a 24-hour prevention hotline, other community education services, and postvention (support to survivors after a suicide).

Other suicide prevention efforts in Rhode Island include: research on suicide prevention, treatment of suicidal youth, public awareness such as HEALTH's "Talk to Teens" youth development campaign, annual National Depression Screening Day sponsored by the Mental Health Association, 24-hour emergency services, and support programs through the Department of Corrections. While these services are necessary, expanded prevention programming and services are needed to adequately address the problem of suicide in RI.

Section II. The Problem of Suicide

National Suicide Data

Suicides per Day	Attempts per Day	Suicides per Year	Attempts per Year
86	1,500	30,000	500,000 (approx)

According to the *National Suicide Prevention Strategy* (NSPS), 86 people take their own lives and another 1,500 people attempt suicide everyday. This means that in a year, over 30,000 people will die by suicide and approximately another 500,000 people will make an attempt. For every two victims of homicide in the U.S., there are three deaths from suicide. Overall, suicide rates increase with age, with peaks during adolescence and early adulthood.^{vi} More teenagers and young adults die by suicide each year than from deaths by cancer, AIDS, birth defects, and pneumonia combined^{vii}. Each suicide marks just the tip of the iceberg however. Beneath each death are dozens or hundreds more suicide attempts that are not completed. In fact, the number one risk factor for suicide is a previous suicide attempt. This means that prevention efforts must be ongoing and comprehensive.

National Data, Ranking of the leading causes of death for ages 15-24, 1998

Rank for ages 15-24	Cause of death, ages 15-24	Number of deaths	Rank for all ages
1	Unintentional Injury	13,349	5
2	Homicide	5,506	>10th
3	Suicide	4,135	8
4	Cancer	1,699	2
5	Heart Disease	1,057	1

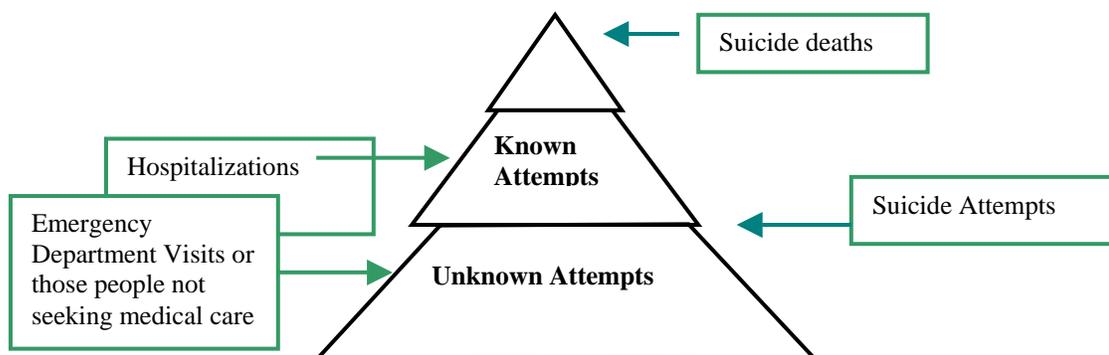
In comparison to other leading causes of death, in 1998, suicide was the 8th leading cause of death in the United States. For young people ages 15-24, suicide was the 3rd leading cause of death after unintentional (accidental) injuries and homicide^{viii}.

Rhode Island Suicide Data

In 1993, an objective to reduce suicide and suicide attempts in Rhode Island was introduced into the document *Healthy People 2000: Rhode Island* which sets forth 25 priority health objectives for the state and that is based on the national initiative, *Healthy People 2000*. The suicide objective sought to reduce the number of suicides by the year 2000 by 10% to no more than 9.2 suicides per 100,000 people and to reduce the incidence of suicide attempts that lead to hospitalization by 15%^{ix}. Over the past 7 years, substantial improvement in these goals has been noted and new goals are being set for *Healthy People 2010*^x.

According to the American Association of Suicidology, in 1998, the year for which the most recent data is available, Rhode Island ranked 45th out of 50 states and the District of Columbia in suicide deaths. In the prior year, 1997, RI ranked 49th in the U.S. While these rankings seem to indicate that suicide is not a problem in Rhode Island, this is not the case since even one suicide is too many.

Estimates of the number of attempts per suicide range from 25-200.^{xi} In 1998, there were 11 suicides among Rhode Islanders ages 15-24. Even using the most conservative estimate of 25 attempts per suicide, this means there would have been 275 attempts (11 x 25) and yet only 132, less than half, were recorded from hospitalization data. The number of attempts that resulted in an emergency department visit (without hospitalization) or that did not require medical attention is unknown. This highlights the need for improved public health surveillance (tracking) of suicide attempts.



Suicide is the second leading cause of death for youth 15-24.^{xixiii} The cost of suicide and suicide attempts among youth in Rhode Island is estimated at over 6 million dollars^{xiv}. This includes the costs of medical care and lost wages. Suicide is preventable.

Top 3 Leading Causes of Death for Rhode Islanders 15-24, 1998

Ranking	Cause of death
1	Unintentional Injury (Accidents)
2	Suicide
3	Homicide

Suicide Risk Factors

Partial list of risk factors	
◆ Previous suicide attempt	◆ Easy access to lethal means
◆ Mental disorders	◆ History of trauma or abuse
◆ Job or financial loss	◆ Hopelessness
◆ Alcohol and other substance abuse disorders	◆ Lack of social support / isolation

A primary risk factor for suicide is the presence of a mental illness, particularly mood and anxiety disorders. As many as 90% of suicidal individuals have a mental illness or substance abuse problem, often untreated, at the time of death^{xv}. In Rhode Island, Community Mental Health Centers (CMHCs) are the primary source of public mental health treatment services. As of December 31, 2000, 12% of the 4,451 children treated at the CMHCs were treated for depressive disorders^{xvi}. During the 1999-2000 school year, 2/3 of visits to the state's school-based health centers, were for mood or anxiety-related problems^{xvii}. Increased attention to mental health services for Rhode Island students is vitally important.

Alcohol and other substance abuse disorders also put young people at risk for suicide. In 1998, 42% of 9th graders and 61% of 12th graders in Rhode Island used alcohol in the past month. Over 20% had used marijuana in the past month^{xviii}. These data indicate the widespread use of alcohol and other drugs in Rhode Island schools, which may further exacerbate the problem of mental illness and other age-specific factors such as impulsiveness and the need to fit in, that make adolescents particularly vulnerable, and point to the need for prevention services.

The *Youth Risk Behavior Survey* (1997), a national CDC survey administered to high school students, indicates that 10% of students in Rhode Island high schools self-reported having made a suicide attempt in the previous 12 months compared to 7.6% nationwide. Twenty-four percent (vs. 21% nationwide) self-reported having seriously considering suicide in the previous 12 months.^{xix} More recent data will be made available in Fall 2001.

Out of 203 primary and secondary schools responding to a statewide survey of violence prevention education, only 31% (n=62) reported suicide prevention programs^{xx}. While programs for substance abuse and anger management, also asked about on the survey, may contribute to suicide prevention, suicide and mental illness need specific attention in the classroom.

Understanding the stigma surrounding mental illness and help-seeking is very important to reducing rates of suicide attempts and deaths by suicide^{xxi}.

Other risk factors for suicide apart from mood disorders, prior suicide attempts, and substance abuse, include access to lethal means (e.g. guns, poison), family break-up, low attachment to school, problems with peer relationships (e.g. loss of an important relationship), (child) sexual and physical abuse/assault, and being gay or lesbian^{xxixxxiii}.

Suicide Protective Factors

In addition to risk factors, adolescents and young adults also display protective factors, factors that help support young people and prevent problems such as suicide. Important protective factors include strong interpersonal bonds with family, peers, and other adults; a strong sense of self-worth, high self-esteem, personal control, and strong beliefs in the meaning of life^{xxiv}. Other factors include support for seeking help for mental health problems, restricted access to lethal means, and non-violent problem solving skills, effective clinical care for mental, physical, and substance abuse disorders. Strong family dynamics, cultural factors, and participation in school, neighborhood, faith-based, and other supportive programs promote the development of protective factors.

Developmental Issues

The ages between 15 and 24 are vulnerable times for youth who are particularly susceptible to negative health behaviors, of which suicide is one extreme. The transition into young adulthood is marked by physical, cognitive, emotional, and social changes all of which can lead to depression, family conflict, school problems, and substance abuse, which are correlates of suicidal ideation among youth.

It is known that youth make more suicide attempts than adults, however, their intent is less clear, i.e., an actual wish to die versus a cry for help^{xxv}. Additionally, youth appear particularly vulnerable to suicide after having experienced the suicide or suicidal ideation of a peer. This can lead to what is frequently called suicide "contagion," a phenomenon exacerbated by media reports glamorizing suicide.^{xxvi}

To be effective, suicide prevention strategies for youth must be developmentally appropriate, taking into account the factors above. It is also important to recognize the need of adolescents to express their independence and their desire for peer approval.^{xxvii} Other important factors that impact on the occurrence of suicide and which must be addressed in prevention programs include gender, race, and sociocultural factors.

PLAN FRAMEWORK

Section III. Plan Framework

The Suicide Prevention Framework for Rhode Islanders Ages 15-24 is composed of two goals and seven objectives. Each objective is organized into six levels of prevention interventions (see Spectrum of Prevention on page 8) that need to be addressed in order to achieve the goal of suicide prevention. These interventions, like the objectives, are not prioritized. Agencies and organizations are encouraged to prioritize and adopt suicide prevention interventions consistent with their missions. Specific implementation plans, including measurable objectives can be further developed based on this broad framework. Examples of specific interventions for suicide prevention are included in Appendix E to facilitate plan development and implementation.

Plan Purpose:

To encourage the movement from suicide prevention planning to action by government, public health, education, human services, religion, voluntary organizations, and the advocacy and business communities in Rhode Island.

The suicide prevention framework for Rhode Islanders ages 15-24 is meant to guide:

- ❑ **Parents, caregivers, and other adults** to recognize risk factors, to support developmental needs, and to promote protective factors in youth.
- ❑ **Professionals** in the public and private sectors who work with individuals, groups, or populations at-risk for suicide.
- ❑ **Policy makers** including school administrators, legislators, heads of state agencies, and those people responsible for creating statutes, rules, and regulations ensuring the health and safety of young people.

Plan Goals and Objectives:

The goals of the framework are:

- ❑ To decrease the incidence of suicide among Rhode Islanders ages 15-24.
- ❑ To decrease the incidence of suicide attempts among Rhode Islanders ages 15-24.

Goals and objectives, along with the broad set of suggested interventions listed in sections IV-VI, were organized based on the *National Suicide Prevention Strategy* and the *Spectrum of Prevention*, a comprehensive prevention model that provides an array of strategies for individuals, the community, providers, and policy makers. Examples of specific interventions for implementation are found in Appendix E.

The National Suicide Prevention Strategy: A Public Health Approach

The seven objectives of the *RI Suicide Prevention Framework* are placed within three categories as defined in the *National Suicide Prevention Strategy*-- awareness, intervention, and methodology (AIM). Briefly, **awareness** entails educating individuals and the community that suicide and its risk factors are preventable. **Interventions** are strategies to improve positive

health outcomes and can include activities such as educational programs, screening, and identification. **Methodology** is the way intervention programs are evaluated or studied, and include activities such as data collection and research studies.

Spectrum of Prevention

The second part of the framework, a table of suggested ways to accomplish each objective, is organized via the *Spectrum of Prevention*. The Spectrum is a comprehensive prevention model created by Larry Cohen of the Prevention Institute in Berkeley, California and based on the work of Marshall Swift^{xxviii}. It includes six strategies or levels of prevention activity. Together, the six levels comprise a strategic prevention approach including interventions for individuals (at various levels of risk for suicide), providers, and the broader community. The need to change organizational practices, form networks, and create policy is also addressed in this model. The Spectrum of Prevention recognizes that it takes a combination of approaches to be effective. These levels should take place simultaneously whenever possible.

The six levels of the Spectrum are:

Level I. Individual Skill Building and Client Services

- Transfers information and skills to individuals
- Changes attitudes and beliefs to enhance individuals' resources and ability to prevent suicide

Examples:

- ◆ Prevention tips and resources from providers given to patients and their parents
- ◆ Peer leadership training
- ◆ Violence prevention curricula
- ◆ Client counseling and treatment

Level II. Promoting Community Education.

- Reaches groups of people with information and resources for preventing suicide
- Provides information and builds support for healthier behavior, norms and policy change

Examples:

- ◆ Mass media and social marketing
- ◆ Community organizing for social and public policy change

Level III. Educating Providers

- Educates providers on the importance of prevention in order to motivate and communicate skills to patients, clients, and colleagues

Examples:

- ◆ Training for social workers on how to recognize signs of suicidality in their clients
- ◆ Educating primary care physicians about how to talk to their patients about suicide
- ◆ Interagency continuity of care

Level IV. Fostering Coalitions and Networks

Collaborative approaches:

- Bring together the participants necessary to assure an initiative's success
- Conserve resources by reducing duplication and sharing expenses
- Foster cooperation between diverse sectors of a community or society
- Increase the credibility and the impact of prevention efforts

Level V. Changing Organizational Practices

- Changes internal organizational regulations and norms to affect the health and safety of employees and to influence the broader community
- Enhances organizational credibility and improves the health of workers and their families

Examples:

- ◆ Adequate reimbursement for mental health services by private insurers and Rite Care/Medicaid
- ◆ Provision of early childhood development and parental support

Level VI. Influencing Policy Legislation

- Presents the opportunity for improvement in health outcomes via policies and laws

Examples:

- ◆ Media advocacy critical to development and implementation of policy
- ◆ Development of local ordinances and state and national laws
- ◆ Adoption of formal policies by boards, commissions, and institutions

Section IV. Awareness Objectives

People at-risk for death by suicide including those with mental illness, a substance abuse problem, and/or a family history of suicide. Seeking help is often stigmatized or discouraged. Without this help, young people may feel isolated, alone, or helpless, thereby exacerbating risk factors. Moreover, funding and reimbursement by the health care and insurance industries for suicide prevention services is inadequate and also a result of stigma.^{xxix} According to the *National Suicide Prevention Strategy*, "If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, the suicide rate can be reduced."^{xxx} Awareness includes community understanding of:

- ◆ Risk factors for suicide
- ◆ Warning signs of suicidal ideation
- ◆ Symptoms of depression
- ◆ Protective factors that enhance emotional competence
- ◆ Supportive resources available in the community
- ◆ Role of access to lethal means in suicidal behavior
- ◆ Role of the media in reducing suicide contagion or in not normalizing suicide as a problem solving strategy
- ◆ Social policies that encourage help-seeking and that promote tolerance of others^{xxxi}

Objectives 1 and 2 address ways to improve awareness among individuals, families, and the communities in which they live and interact, regardless of risk, in order to prevent suicide.

Objective 1: To support and affirm people at-risk for death by suicide.

Strengthening Individuals	Community Education	Educating Providers	Fostering Coalitions	Changing Organizational Practices	Influencing Policy
Provide information to young men and women at-risk that it's acceptable and important to seek help	Educate widely about who is at risk for suicide and how to respond	Provide training and staff development in suicide issues in after-school programs, to college residence assistants, and at school health services	Develop partnership with media to provide guidelines on suicide reporting that decrease likelihood of suicide contagion (see appendix D)	Assure development and adoption of an effective suicide prevention policy in all schools and universities	Increase funding to provide public awareness, school & college prevention, etc..
Provide information to families that it's good to seek help	Increase awareness of school & community resources for suicide prevention	Develop & promote use of common language and terminology around suicide prevention	Identify community agencies to promote suicide prevention through their networks	Assure implementation of school policy, assuring on-going awareness of policy	Provide fact sheets to legislators
Teach emotional competence. Encourage good academic skills and skills for the job market.	Develop & promote use of common language/terminology related to suicide prevention	Assist school peer helpers to understand how to respond to at-risk peers	Work with health care providers and insurers to improve access to services; i.e. RItE Care reimbursement, and private insurers	Develop criteria for an effective suicide prevention policy (including assessing situation, gun safety, etc.)	Lobby for adequate mental health service coverage
Provide support groups for attempters Encourage a safe and nurturing school environment	Raise awareness about the dangers of over-the-counter & prescription medications and other lethal means	Improve referral efficiency and effectiveness by school and college counselors	Work with community-based and voluntary agencies, and faith-based organizations to increase awareness of services to kids and families in need	Increase delivery of effective suicide prevention education programs in schools (see appendix C) and other organizations	
Build a sense of community through improved personal relationships	Raise awareness that suicide is a public health problem and that it is preventable	Improve referral knowledge and referral mechanism by primary care providers		Increase number of support groups in the community	

Objective 2: To reduce the stigma associated with seeking services for mental health, substance abuse, and suicide prevention

Strengthening Individuals	Community Education	Educating Providers	Fostering Coalitions	Changing Organizational Practices	Influencing Policy
Maintain the focus in objective 1.	Maintain the focus in objective 1.	Maintain the focus in objective 1.	Maintain the focus in objective 1.	Maintain the focus in objective 1.	Maintain the focus in objective 1.
Reduce stigma of asking for services	Conduct statewide campaign to reduce stigma				
Provide suicide prevention information on the web					
Provide education and information about the acceptability of seeking help, early and often via pediatricians, daycare providers, neighborhoods, health centers, and employers					

Section V. Intervention Objectives

Programs and services that focus on suicide prevention can be classified according to:

Population served- **Universal** interventions focus on people at average risk, **selective** interventions focus on people at higher than average risk, and indicated interventions focus on those people who have already made a suicide attempt or who exhibit warning signs of suicidal behavior^{xxxii}.

Type of interventions (Adapted from the Youth Suicide Prevention Programs: A resource Guide)^{xxxiii}

- *Gatekeeper training*- Adults in the community (e.g. teachers, clergy, providers, parents, law enforcement etc..) learn to recognize signs of suicidality and to provide appropriate and timely referral to mental health services
- *Screening*-appraisal of an individual's suicidality
- *Peer support programs*- designed to foster peer relationships and to enhance problem solving techniques and competency development
- *General suicide prevention education*- provides facts about suicide and information on how to seek help for oneself or others
- *Crisis centers and hotlines*- provide telephone counseling and referrals for suicidal people or people in crisis
- *Means restriction*- refers to advocating for restricted access to lethal means such as handguns or inappropriate use of prescription drugs
- *Postvention*- refers to services provided after a suicide or suicide attempt has taken place, e.g., counseling to prevent suicide contagion or clusters, or teaching skills to cope with loss
- *Youth development*- activities that strengthen protective factors in youth

These interventions are often used in conjunction with each other as one intervention is often not as effective as multiple strategies used together. Similarly, programs should be linked to create seamless service and coordinated services, for example school programs should be linked with community programs and vice versa, so that all people in the community are involved. Everyone can take part in prevention, from students to teachers, parents, businesses, police, etc..

Inpatient and outpatient mental health services should also be part of the interventions listed. Surgeon General, David Satcher, MD, MPH, states in his report on children's mental health that the nation is experiencing a crisis. According to this report, 1 in 10 children/adolescents suffer from a mental illness and yet less than 20% receive treatment. Dr. Satcher states that, "Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by the very institutions and systems that were created to take care of them."^{xxxiv}

Objectives 3, 4, and 5 focus on improving and expanding mental health service delivery, increasing screening and identification, and eliminating access to lethal means. The other intervention types listed above are suggested within the context of these three objectives. Again, interventions focus on universal, selected, and indicated populations as described above.

Objective 3: To improve and expand mental health services delivery

Strengthening Individuals	Community Education	Educating Providers	Fostering Coalitions	Changing Organizational Practices		Influencing Policy
Provide information to youth on what mental health services exist and how they can be accessed and paid for		Increase cross-training of clinicians related to risk assessment, recognition, treatment management, and aftercare (postvention) of suicidal youth	Develop partnership with DCYF to identify common areas of concern related to mental health service needs of people under their care	Assure the adoption of a suicide prevention policy in schools	Increase state-wide suicide prevention programming in schools, especially Central Falls, Pawtucket, Providence, & Woonsocket	Implement utilization management guidelines for suicidal risk in managed care and insurance programs
Promote mentor programs for youth		Train health care providers (HMOs, etc) on handling non-acute cases (i.e. people needing non-emergency mental health services)	Develop partnership with agencies that serve children and youth	Assist colleges and universities to attract, train and retain child psychiatrists and psychologists in RI	Develop programs that are culturally relevant, needs-driven, and family focused	Provide quality, effective, and affordable mental health services available and accessible to all Rhode Islanders 15-24
Develop other volunteer programs for young people as means of expanding mental health services		Provide continuing education for Student Assistance Counselors and other school-based pupil personnel (e.g. social workers)	Work with health care providers and insurers to improve access to services and reimbursement; i.e. RIte Care	Decrease disincentives and red tape for child psychiatrists and psychologists to practice	Strengthen resources for volunteer training	Ensure adequate reimbursement and coverage for universal, selected and indicated mental health services
Identify methods to strengthen individuals' emotional competency		Provide on-going training to college counseling centers	Work with community-based agencies to increase awareness of services to kids and families in need	Increase number of male clinical social workers	Provide seamless services for at least 3 months postvention (after an attempt)	Require suicide prevention education for all providers seeking licensure
		Educate providers about utilizing culturally appropriate interventions	Develop youth-led programs and activities	Increase hotline availability	Integrate mental health services into other social service delivery	Improve advocacy efforts

Objective 4: To increase screening and identification

Strengthening Individuals	Community Education	Educating Providers	Foster-ing Coalitions	Changing Organizational Practices		Influencing Policy
Support and educate peers to identify emergency situations and at-risk peers	Educate adults (teachers, counselors, coaches, clergy, primary care doctors ^{xxxv} (see appendix C), nurses, community-based programs etc) to identify at-risk youth	Provide resources (referral information) to providers who identify at-risk youth		Annually review data, and characteristics of completed and attempted suicides to improve screening tools	Provide street outreach (HIV, Travelers' Aid models, Boys & Girls Clubs, other community groups)	Lobby for coverage and reimbursement for routine screening services
Support peers who "tell" on their at-risk friends		Screen early and often via pediatricians, daycare providers, employers, health centers, etc.		Design instruments (prompts) for primary medical doctors to increase screening	Increase adoption of policy prioritizing, and supporting screening	
Provide educational programs for family members of persons at elevated risk				Promote screening at college level		
				Assess & evaluate validity of existing screening tools to make good choice of tools		

Objective 5: To promote efforts to reduce access to lethal means and methods of self-harm

Strengthening Individuals	Community Education	Educating Providers	Fostering Coalitions	Changing Organizational Practices	Influencing Policy
	Raise awareness during legislation season about gun control bills.	Develop school mental health protocol including questions re: guns at home, ask suicidal youth if they have a plan to kill themselves	Interagency collaborations around support for gun control and gun safety	Add gun issues to school policy criteria	Support gun control legislation with statement about waiting period & suicide
	Raise awareness through public education campaigns about gun deaths in RI.	Review/create school crisis plans	Improve communication among providers Include school personnel e.g. nurses, school psychologist, social worker, administrators	Address suicide attempts by over-the-counter medications with providers and pharmacists; e.g. warning labels for RXs	Examine gun-free schools law
	Raise awareness about gun safety measures	Put gun safety in suicide plan			Draft legislation
		Educate health care providers and health and safety officials on assessment of lethal means in the home			
	Educate providers re: connections between substance use and other high-risk behaviors & suicide				

Section VI. Methodology Objectives

Methodology refers to the advancement of Suicidology, the science of suicide prevention. Enhanced research on suicide risk and protective factors, effective prevention programs and interventions, improved monitoring systems for suicide and suicide attempts, and the development of new prevention technologies are all methodologies needing support. Sound scientific methodology ensures effective program components and services and links positive outcomes to specific interventions versus unknown external factors.

One means to measure effectiveness is through tracking trends in suicides and suicide attempts, called public health *surveillance*. Surveillance activities are needed "to assess public health status, to define public health priorities, to evaluate programs, and to conduct research. Surveillance data indicate where the problems are, who is affected, and where programmatic and prevention activities should be directed."^{xxxvi} Surveillance data of suicide and suicide attempts is often gathered from sources such as vital records/death certificates, hospital discharge data, the *Youth Risk Behavior Survey*, and emergency department data (not currently available in RI).^{xxxvii} Other sources of data can provide useful data and should be researched.

Research is a second means by which to measure program success and to expand upon information known about suicide. This may include research in many areas such as comparing one prevention intervention to another or looking at the retention of patients in treatment after a suicide attempt. Psychological autopsy studies, the collection of detailed information about a deceased individual's life from a relative or friend that provides detail on the circumstances surrounding the decedent's life, and other special research projects are useful to assess why someone may have taken his/her own life.

Research may also entail medical research looking, for instance, at brain chemistry or heredity factors in suicide or depression. Unfortunately research and data collection take time and money, both of which are often in short supply. Objectives 6 and 7 list recommended research and data collection activities for suicide prevention.

Note:

Objectives 6 and 7 are not amenable to the Spectrum of Prevention table. Data collection and research are on-going activities happening simultaneous with objectives 1-5. Additionally, the bulk of the activities for objectives 6 and 7 take place by doctors and scientists in research settings versus in the workplace or in the community. Results from research and data collection do, however, ultimately impact on spectrum of prevention; building individual strengths, informing community outreach efforts, interventions, and policy development.

Objective 6: To coordinate and expand public health surveillance of suicide and suicide attempts

Suggested Activities

- Establish objectives of a public health surveillance system for suicide and suicide attempts
- Develop case definitions for suicide and suicide attempts
- Determine utility and feasibility using CDC criteria of various data sources or data collection mechanisms for the surveillance of suicides and suicide attempts among Rhode Islanders 15-24 including:

Suicide Surveillance

- Child Death Review Team (CDRT) database
- Medical Examiner files

Suicide Attempt Surveillance

- Hospital Discharge Data
- Emergency Department data
- School-Based Health Center data
- Emergency Medical Service run reports
- Poison center data

- Develop data collection instruments if necessary (if not already developed)
- Field test methods
- Develop and test analytic approach
- Develop dissemination mechanism
- Assure use of analysis and interpretation

Objective 7: To promote and support culturally relevant research on suicide and suicide prevention

Suggested Activities

- Research and evaluate the potential role and effectiveness of conducting psychological autopsies in RI, given the other sources of data available
- Research the effectiveness of treatments for suicidal risk
- Do a literature review on the impact of emotional competency/character education etc. on suicide and suicide attempts or affiliated risk behaviors (e.g. dropping out of school, getting into trouble etc.)
- Evaluate the impact of existing primary prevention programs (e.g. emotional competency, character education, and social/emotional education) on suicide and suicide attempts
- Evaluate the accuracy of E-coding (categorizing of injuries and intent) suicide attempts at RI Hospitals
- Evaluate outcomes of students referred by counseling and support services
- Support molecular biology/genetics research and the potential link to suicide
- Conduct biopsychosocial research on causes and prevention of suicide
- Evaluate suicide prevention interventions
- Clarify risk and protective factors specific to different populations (demographics, SES, religion, participation in extra-curricular activities, etc.)

RECOMMENDATIONS & CONCLUSIONS

Section VII: Recommendations

The Rhode Island Suicide Prevention Planning Team recommends that comprehensive action takes place in the State to address suicidal behavior among people ages 15-24. Suicide is the second leading cause of death, after unintentional injuries (accidents) for this age group, but it doesn't have to be. Suicide is preventable. The Suicide Prevention Planning Team recommends:

- That agencies and community groups from the private and public sectors and from the profit and non-profit sectors partner together and seek resources to implement this plan.
- That agencies and organizations implement specific interventions now that are consistent with their missions and which utilize existing resources.
- That schools review and update their health education curricula to ensure that students' mental and emotional health is effectively addressed, as specified in the Rhode Island general laws (§16-21-7) that requires that all schools have a school health program providing for a healthy school environment, health education, and services. In order to help schools comply with the law and to ensure that schools provide quality health education instruction, a health education framework has been developed for grades K-12. One of the dimensions addressed in the health education framework is promoting good mental and emotional health. See the attached, *Rhode Island Health Education Framework Health Literacy For All Students, Appendix C, Comprehensive Health Instructional Outcomes for Mental and Emotional Health, Grades 9-10 and 11-12*.
- That state and community-based agencies, employers, medical/mental health facilities, businesses, and other groups review and update their mental health services or prevention activities in accordance with EXISTING agency/company policy.
- That state and community-based agencies, employers, medical/mental health facilities businesses, and other groups review and create NEW mental health policies where needed.
- That media utilize the new media guidelines released by the Department of Health and Human Services on how to report on suicide. See Appendix D.
- That surveillance efforts to track trends in suicides and suicide attempts around the State be improved.
- That all programs to prevent suicide consider cultural and developmental factors during program planning, implementation, and evaluation.
- That suicide prevention interventions focus on three levels: universal- average risk youth (the general youth population), selected-above average risk youth, and indicated- high risk youth.
- That suicide prevention policy be developed in coordination with the Governor and the Children's Cabinet and other state agencies.

Section VIII. Conclusions

The prevention framework described here will help reduce the impact of suicide and suicide attempts on our state. The framework includes a role for everyone from individuals working to enhance their emotional competence, to adults learning to recognize warning signs, to mental health providers appropriately assessing suicidal risk, and to policy makers legislating improved access to mental health services for all young people.

Suicide is related to many factors including drug abuse, mental illness, and histories of abuse. Suicide affects our schools and student success. It also affects our families and our work environment. State agencies, community-based organizations, schools, and the broader RI community working together have the opportunity to make a significant difference in the lives of youth and families.

One suicide is just the tip of the iceberg. Dozens or hundreds of attempts are made for every one completed suicide. With improved community awareness, training, services, and research, RI can strive toward reducing all suicides and suicide attempts in the state. Even one suicide is too many.

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Appendices

Appendix A:

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Rhode Island Health Education Framework: Health Literacy for All Students, Appendix C, Comprehensive Health Instructional Outcomes for Mental and Emotional Health, Grades 9-10 and 11-12

Appendix B:

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National Strategy for Suicide Prevention- List 11 Objectives

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Contact information for obtaining copies of the:
Guidelines for School Based Suicide Prevention Programs, 1999
Guide to Clinical Preventive Services: Screening for Suicide Risk

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Reporting on Suicide: Recommendations for the Media

Appendix E

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Examples of Specific Interventions for Implementation

APPENDIX A
Health Education Standards for Mental and Emotional Health Instructional Outcomes
Grades 9-12

Standard 1: Students will understand concepts related to health promotion and disease prevention as a foundation for a healthy life.

Grades 9-10

Students will demonstrate the ability to:

1. Analyze how mental and emotional health can impact health maintenance and disease prevention (Required Topics: effect on judgment; anxiety and depression and susceptibility to disease)
2. Describe the interrelationships of mental, emotional, social, and physical throughout young adulthood (Required Topics: self-image- personal, social, ideal; personal qualities and characteristics; personal development over time; capacity and potential for personal growth and change; heredity and environment; fallacies regarding suicide; signs signaling suicide; eating disorders).
3. Analyze the impact of emotional expression on the functioning of body systems (Required Topics: anxiety; effect on performance, concentration, etc. depression as a common emotional response to distress; positive mental/emotional states and physical health).
4. Analyze how the family, peers, community and environment are interrelated with mental and emotional health. (Required Topics: peer pressure; violence in society).

Grades 11-12

Students will demonstrate the ability to:

1. Analyze interrelations of mental, emotional, social and physical health throughout life. (Required Topics: heredity and environment; depression and mental illness; maturation; key tasks in each stage of human growth and development).
2. Analyze how the family, peers, community, and environment influence mental and emotional health (Required Topics: victimization and abuse)
3. Describe how to delay onset and reduce risks of potential life-long health problems relating to poor mental and emotional health. (Required Topics: alcoholism, drug dependency and treatment, depression in young adults; appropriate identification and expression of emotions)

Standard 2: Students will demonstrate the ability to access valid health information and health-promoting products and services.

Grades 9-10

Students will demonstrate the ability to:

-
1. Analyze resources from home, school and community that provide valid mental health information (Required Topics: Different types of available assistance; elements and rationale of support systems).
 2. Access school and community resources and services for personal or family problems, and for treating alcohol.
 3. Analyze situations requiring professional health services (Required Topics: Seeking help in reaction to signs of suicide).

Grades 11-12

Students will demonstrate the ability to:

1. Evaluate resources from home, school and community that provide valid information about mental health and mental illness treatment for self and others.
2. Evaluate situations requiring professional health services (Required Topics: eating disorders, substance use, drug dependency, suicidal tendencies, depression and other mental illness; emotional, sexual, physical abuse).
3. Evaluate opportunities for career choices in field of mental health.
4. Analyze the educational requirements, demands, rewards and benefits of a career in the field of mental health.

Standard 3: Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks

Grades 9-10

Students will demonstrate the ability to:

1. Analyze the role of individual responsibility for healthy behaviors (Required Topics: Choices and consequences; effects of emotions on behavior, judgment, and reason).
2. Evaluate personal stress management habits to determine strategies for enhancing health and reducing risk. (Required Topics: sharing and facing a crisis with others and its effect on anxiety).
3. Analyze the short-term and long-term consequences of risky and harmful behaviors (Required Topics: personal feelings and attitudes about suicide; dealing with depression and/or anxiety).
4. Outline strategies for dealing with mental and emotional health emergencies and crises, including suicide.

Grades 11-12

Students will demonstrate the ability to:

1. Evaluate the effect of responsible behaviors on self, others and community. (Required Topics: Avoiding ATOD; setting personal goals)
2. Design a plan with recommended strategies to address a mental health issue in the local community which presents a threat to individual, family or community health. (Required Topics: Violence; impact of individual behaviors on family and society; suicide among youth).

-
3. Research and evaluate strategies to manage stress by individual and groups within a family, at school, at work, or in other social settings.

Standard 4: Students will analyze the influence of culture, media, technology & other factors on health.

Grades 9-10

Students will demonstrate the ability to:

1. Analyze how cultural diversity enriches and challenges appropriate emotional expression. (Required Topics: Cultural experiences, attitudes and practices).
2. Evaluate the effect of media and other factors on personal, family and community expressions of emotions).
3. Analyze how information from the community, peers and others influences behaviors in response to emotions. (Required Topics: Dealing with conflict; complex emotions).

Grades 11-12

Students will demonstrate the ability to:

1. Research a school or community mental health issue resulting from the influence of culture, media, technology and other factors (Required Topics: Violence and aggression on TV; gangs).
2. Develop and implement a solution to a researched mental issue.

Standard 5: Students will demonstrate the ability to use interpersonal communication skills to enhance health.

Grades 9-10

Students will demonstrate the ability to:

1. Apply skills for communicating effectively with the family, peers, and others. (Required Topics: Assertive behavior; listening skills; "befriending" skills to prevent suicide).
2. Analyze how interpersonal communication effects relationships. (Required Topics: conflict resolution).
3. Use healthy ways to express needs, wants, and feelings.
4. Communicate care, consideration and respect of self and others.
5. Apply strategies for solving interpersonal conflicts without harming self or others.
6. Apply refusal, negotiation; limit setting and collaboration skills needed to avoid potentially harmful situations.
7. Analyze the possible causes of conflict in schools, families and communities.
8. Apply healthy strategies used to prevent conflict.

Grades 11-12

Students will demonstrate the ability to:

1. Apply strategies to a selected situation that facilitate effective communication among individuals or groups. (Required Topics: suicide prevention "befriending skills"; negotiation; conflict resolution.

Standard 6: Students will demonstrate the ability to use goal setting & decision making skills to enhance health.

Grades 9-10

Students will demonstrate the ability to:

1. Analyze the ability to use different strategies when making decisions related to mental and emotional health needs. (Required Topics: Substance use; coping with stress; relationships; seeking help).
2. Analyze mental health concerns that require individuals to work together. (Required Topics: Suicide prevention; eating disorders; depression).
3. Predict immediate and long-term impact of emotional expression on the individual, family and community. (Required Topics: Factors and steps in decision-making; on-going nature of decision making throughout life.).
4. Describe how personal health goals are influenced by changes in information, abilities, priorities, and responsibilities.
5. Compare and contrast a variety of mental health strategies that address personal strengths, needs and risk. (Required Topics: Setting personal goals; self-contracts).

Grades 11-12

Students will demonstrate the ability to:

1. Evaluate different strategies when making decisions related to managing stress, and dealing with conflict. (Required Topics: Analysis of personal goals; self-contracts for personal growth).
2. Design, evaluate and implement a plan for attaining a personal mental health goal.
3. Analyze the essential skills and strategies needed by an individual to enable him/her to develop, modify and implement effective plans to achieve and maintain optimum lifelong health. (Required Topics: Communication skills; various decision-making models).

Standard 7: Students will demonstrate the ability to advocate for personal, family, community & environmental health.

Grades 9-10

Students will demonstrate the ability to:

1. Discuss accurate information about mental and emotional health issues, including suicide prevention and express opinions about them. (Required Topics: Effects of violence, self-destructive behaviors, misdirected emotions on individual, family and society).
2. Design methods for accurately expressing information and ideas about mental health promotion and suicide prevention.

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3. Utilize strategies to overcome barriers when communicating information, ideas, feelings and opinions about mental health issues.
 4. Influence and support others in making positive health choices. (Required Topics: Avoiding substances; seeking professional help/treatment; managing stress; changing unhealthy behaviors).
 5. Work cooperatively when advocating for healthy communities. (Required Topics: Identifying community resources; laws addressing violent behaviors).

Grades 11-12

Students will demonstrate the ability to:

1. Discuss accurate information and express opinions about mental health issues.
2. Adapt messages and techniques about mental and emotional health, including suicide prevention, to the characteristics of a particular audience.
3. Influence and support others in making positive choices regarding their mental and emotional health.
4. Work cooperatively when advocating for mental and emotional health promotion.
5. Evaluate community health services and systems in place relating to mental health, suicide prevention and make recommendations for improving those systems and services.

APPENDIX B:
National Strategy for Suicide Prevention:
Goals

1. Promote awareness that suicide is a public health problem that is preventable
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
4. Develop and implement suicide prevention programs
5. Promote efforts to reduce access to lethal means and methods of self-harm
6. Implement training for recognition of at-risk behavior and delivery of effective treatment
7. Develop and promote effective clinical and professional practices
8. Improve access to and community linkages with mental health and substance abuse services
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media
10. Promote and support research on suicide and suicide prevention
11. Improve and expand surveillance systems

For a full copy of this report access: www.mentalhealth.org/suicideprevention

APPENDIX C: Contact Information

Guidelines for School Based Suicide Prevention Programs

<http://www.afsp.org/index-1.htm>

American Foundation for Suicide Prevention

120 Wall Street, 22nd Floor

New York, New York 10005

Fax: 212-363-6237

TOLL-FREE: 888-333-AFSP

Phone: 212-363-3500

e-mail: inquiry@afsp.org

**Guide to Clinical Preventive Services, Second Edition
Screening for Suicide Risk**

<http://www.vnh.org/GCPS2/60.html>.

e-mail: cartographer@vnh.org

APPENDIX D: Contact Information

Reporting on Suicide: Recommendations for the Media

American Foundation for Suicide Prevention

1-888-333-AFSP

215-363-3500

American Association for Suicidology

Annenberg Public Policy Center

www.afsp.org/education/printrecommendations.htm

Appendix E: Examples of Specific Interventions for Implementation

Referral

- Referral to the national suicide prevention hotline which connects locally in RI. Call 1-800-SUICIDE
- Assess the feasibility of a statewide mental health services referral hotline for parents, teen, teachers, and other adults. May receive information from Connecticut which currently works with the United Way to provide this type of hotline via 211. Call 203-759-2014 for more information.

Provider

- Provide a continuing education course for physicians and residents on suicide prevention
- Develop a suicide prevention internship option for the Affinity program at Brown University

The Affinity Group Program is a longitudinal four-year program that links students with faculty and upper class medical student fellows, in small active learning groups to further students' personal and professional development. The program begins for students in the PLME with meetings during the sophomore year of undergraduate study and concludes at the end of the second year of medical school. As such, Affinity Groups provide a transition between the undergraduate and medical school years and offer orientation programs for students entering at the first year of medical school. In the context of MD 2000, the groups provide a vehicle for advising, mentoring, and peer support, while helping students to address key competencies and abilities and to pursue early clinical experiences. Active community involvement is encouraged.

- Develop suicide prevention training for providers of after-school and other youth programs (e.g. YMCA, Boys and Girls Club)
- Develop a teen resource guide that provides information and referrals for suicide prevention, HIV testing, Counseling services, etc., e.g. Teen Yellow Pages

A directory of resources created by United Way of Massachusetts Bay. Call 617-624-8000 for more information.

Parent

- Devote time at PTA meetings to discuss: mental illness, importance of mental health, mental health resources available in the community

College/University

- Include suicide prevention information in first-year college student orientation materials
- Research possibility for renewed Suicide Prevention Advocacy Network (SPAN) chapter at Brown and other colleges/universities; Call 1-888-649-1366 to begin a local chapter

Advocacy

- Talk to all state legislators about the importance of suicide prevention
- Work on legislation to require state prevention contracts require suicide prevention information be taught; similar to the tobacco requirement in the SAPT Block Grant.

-
- Plan a suicide prevention awareness day in May (to coincide with suicide prevention awareness month) with activities and awards at the State House
 - Begin a RI chapter of the Lifekeeper Memorial Quilt

The purpose of the Lifekeeper Memorial Quilt is to raise awareness and prevent suicide by placing a "Face on Suicide," a visual image of the approximately 32,000 suicides that occur in America every year. The goal is for all 50 states and any specialty group interested to be represented by displaying their quilt(s) as a joint effort at the annual National Suicide Awareness events in May. Call Sandy Martin for information on starting a RI chapter or to display the quilt, at 678-937-9297.