

## **SEMINARS ON ADOLESCENT HEALTH: PREVENTION OF ADOLESCENT SUICIDE (Webcast Date: June 25, 2003)**

>>TRINA ANGLIN: Welcome to the Maternal and Child Health Bureau Office of Adolescent Health WebCast, Seminars on Adolescent Health: Prevention of Adolescent Suicide

This WebCast is the second in a series of four.

The topics were selected with the state health coordinators.

Technical support for the WebCast is provided by the Center for the Advancement of Distance Education, from the University of Illinois at Chicago. I'm Trina Anglin from the Bureau's Office of Adolescent Health and will be the moderator.

I would like to review technical information.

You'll see Power Point slides on your computer screens and hear the voices of our panel.

Slides will appear in the central window and should advance automatically.

The slide changes are synchronized with the speaker's presentations.

You don't need to do anything to advance the slides.

You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to ask the speakers questions at any time during the presentation.

Simply type your question in the white message window on the right of the interface, select question for speaker from the drop down menu and hit send. Please include your state or organization in your message so we know where you are participating from.

The questions will be relayed to the moderator periodically throughout the broadcast.

The panel will respond to your questions during the discussion period, which follows the three presentations.

If we don't have the opportunity to respond to your question during the broadcast, we'll email you an answer afterwards.

Again, we do encourage you to submit questions at any time during the broadcast.

On the left of the interface is the audio control.

You can adjust the volume by using the slider clicking on the loudspeaker icon. Those of you who asked for accessibility features will see text captioning under the audio control window.

At the end of the broadcast, the interface will close automatically and you'll have the opportunity to fill out an online evaluation.

Please take a couple of minutes to do so.

Your responses will help us to plan future broadcasts in this series and improve our technical support.

So with this information in mind, we are ready to roll.

Our first speaker is Dr. Howard Adelman who is professor of psychology in the Department of Psychology at UCLA.

He's the co-director of the school mental health project supported by the Maternal and Child Health Bureau.

Howard will discuss youth suicide prevention, mental health and public policy perspectives.

He's prerecorded his presentation and join us live during the discussion period to answer questions.

Remember that you can type in questions at any time during his presentation. We're now ready for Howard's voiceover.

>>HOWARD ADELMAN: Hi.

The following presentation on youth suicide prevention, mental health and public health perspectives was presented by the staff for the center of mental health schools at UCLA.

It's designed as a training aid that you can download and adapt for local use.

Slide two, please.

As can be seen in the presentation overview, seven topics are covered, including discussion of the nature and scope of the problem.

What prevention programs try to development the framework for a public health approach.

Guides to programs and more.

Slide three, please.

Topic one focuses on the nature and scope of the youth suicide problem in the United States.

Slide four, please.

Here are some frequently cited statistics.

Take a minute or two to read them over.

As the data indicate, among youngsters age 15 to 24 in the U.S. suicide ranks as the third leading cause of death just behind homicide.

Of course, the figures don't include all those deaths that actually were suicides but were classified as a homicide or an accident.

Slide five, please.

Persons under the age of 25 accounted for 15% of all suicides with older adolescents more likely than younger ones to commit suicide.

Among persons age 15 to 19 years, firearm-related suicides accounted for 62% of the suicide rate over the last couple of decades.

The risk for suicide is greatest among young white males.

However, American Indian and Alaskan native adolescents have the highest rates.

From 1980 through the 1990's suicide rates increased most rapidly among young black males.

While youth suicide has plateaued in recent years the problems remains at what are almost historically high levels.

Slide six, please.

The economic costs to society continue to be debated.

There is no debate, however, that concern for suicide prevention is an indicator of a humane society.

That is any society that doesn't seriously attend to suicide prevention has too limited a commitment to the well-being of young people and ultimately pays a significant price for this lack of concern.

Slide seven, please.

Efforts to prevent youth suicide must confront the basic question, why is it that so many young people end that your lives?

The search for answers inevitably take us into the realm of psychopathology and the arena of depression.

But we must not only go in that direction.

As we become sensitive to symptoms of depression it is essential to differentiate common place periods of unhappiness from the syndromes that indicate clinical depression.

We must also remember that not all who commit suicide are clinically depressed and that most persons who were unhappy or even depressed don't commit suicide.

Moreover as the surgeon general's report on suicide stresses, various problems experienced by young people are linked.

This is a matter that has been raised frequently over the years yet its implications are widely ignored.

A pervasive factor linking youth problems is life dissatisfaction.

For any youngster among any group of youngsters the satisfaction with current life circumstances arises from multiple factors and can significantly affect emotions, thoughts and behavior.

When large numbers are affected in a neighborhood or school the problem is exacerbated.

In some cases the need is not just to address the mental health problems but to develop public health approaches.

This, of course, involves developing things including family and peer factors.

In such interventions they must not only affect an appreciation of the overlapping nature of the many risk factors associated with youngsters emotional, learning and behavior problems they must also be a range of protective efforts to help alleviate problems.

Slide eight, please.

Moving on to topic two, let's look more specifically at what prevention programs try to do.

From a public health perspective a logical first emphasis is on enhancing awareness and increasing awareness of about young people and their families, those who work with young people and the general public.

Also from a public health perspective a primary focus for prevention is on factors in the environment that are major contributors to problems.

Thus, any sound preventive approach to youth suicide, depression and violence must encompass efforts aimed at systemic changes with particular concern for how well diversity is accommodated.

For example, many aspects of schools and schooling have been identified as possible contributors to youngsters' alienation and sense of despair.

Such school-related factors should be major targets for change.

Of particular concern are changes that can enhance a caring and supportive climate and reduce unnecessary stress throughout a school.

Such changes not only can have a positive impact on current problems, they can prevent subsequent ones.

At the same time efforts must focus on appropriately identifying those at risk and building the capacities of schools, families and communities to help.

Note that the emphasis is on appropriate identification.

This is because of concerns that have arisen about large scale screening as well as concerns about the lack of availability of programs to help when referrals are made.

Concerns about large-scale screening are discussed later in this presentation.

With respect to the problem of program availability, it's essential to remember that many youth problems are linked.

With this in mind, it is important to avoid thinking too narrowly about youth suicide prevention.

Most programs for high-risk youth are concerned about many of the same risk factors and protective buffers.

Thus, treatment programs for alcohol and drug abuse, programs that provide help and services to runaways, pregnant teens or school dropouts address factors relevant to preventing suicide.

We can enhance program availability for a variety of problems by reversing the trend that creates so many separate categorical programs.

By ending unneeded specialization, resources can be redeployed and steps taken to establish comprehensive multi-faceted and cohesive approaches.

Concern about countering tendencies to overemphasize personal deficits has led to greater appreciation of the importance of designing approaches and ways that foster resilience and protective buffers.

As a result the strong movement has emerged for enhancing youngsters assets for emotional and problem solving, teaching stress management and much more.

Slide nine, please.

Moving on to the topic three.

Let's look at a framework for a public health approach.

Slide ten, please.

When one puts suicide prevention into a public health perspective it is essential to use a comprehensive multi-faceted and cohesive framework that highlights the systems necessary for meeting the complex needs of our youth. As the figure illustrates, the desired interventions can be conceived along a continuum, including universal, selective and indicated interventions. Because this figure will be difficult to read on your screen, we recommend downloading it and looking at the details later. A few points will help to clarify it.

Slide 11, please.

Such a continuum must be woven into three overlapping systems. A system for positive development and prevention of problems, which includes a focus on wellness or competence enhancement, a system of early intervention to address problems as soon as after their onset as is feasible and a system of care with those with chronic and severe problems.

Slide 12, please.

The continuum has a developmental emphasis that encompasses individuals and families where they live, work and play.

It provides a framework for adhering to the principle we should use the least restrictive forms of intervention needed to accommodate diversity and respond to problems.

Given the likelihood that many problems are not discrete the continuum can be designed to address root causes there by minimizing tendency to develop programs for each problem.

Most importantly, full development of the overlapping systems is essential to stemming the tide of referrals for specialized assistance.

Currently the only one of these systems that is even marginally in place is the system of care.

This has resulted in what has been described as a waiting for failure approach. Until the other systems are well developed, we will continue to inappropriately flood deep end services and make it virtually impossible for them to do their work effectively.

Slide 14, please.

Ultimately the framework enhances mapping and analyzing community and school resources with a view to increasing coordination and integration, enhancing the way the interventions are connected, and evaluating impact and cost effectiveness.

In turn this provides a solid basis for redeploying resources to fill gaps and strengthen existing interventions.

Of course, the developing such a systemic framework requires extensive community and school collaborations to build capacity to enhance policy,

refine infrastructure and expand training for leadership personnel and a wide range of primary care providers.

All this is essential to increasing the availability of programs for youth and evolving them into an effective continuum of integrated systems.

Slide 15, please.

Topic four brings us to a set of resources that are designed to guide decision makers to model programs.

Slide 16, please.

Decision makers need ready access to information on how to approach suicide prevention.

Each of the documents cited are major works from well-respected sources.

They contain discussions ranging from national strategies to model programs and best practices for addressing risks and promoting healthy development.

They provide basic references and links to other resources.

Included on the list are the national strategy for suicide prevention from the surgeon general's office and a major review of the field from the National Academy of Sciences Institute of Medicine.

Also cited is the 1992 guide to youth suicide programs and a more up to date major review published in 2003 in a peer review journal.

Slide 17, please.

Finally, two resources to overviews of social and emotional and youth development programs are listed.

All but the journal article can readily be accessed on the Internet.

Slide 18, please.

Topic five brings us to the matter of what role schools can play.

Slide 19, please.

Obviously at the Center for Mental Health in Schools we're very concerned with this aspect and developed a lot of resources and materials you can draw upon.

Let's look at the role schools can play.

First of all, it's important to make the case for why schools should play a role.

There are several major reasons.

First and foremost, schools cannot achieve their mission of educating the young when students' problems are major barriers to learning and development.

As the Carnegie task force in education has so well stated, school systems are not responsible for meeting every need of their students, but when the need directly affects learning, the school must meet the challenge.

A second reason schools must play a role is that they are at times the source of the problem and they need to take steps to minimize factors that lead to student alienation and despair.

Schools also are in a unique position to promote healthy development and protective buffers, offer risk prevention programs and help identify and guide students in need of special assistance.

Slide 20, please.

With respect to such identification there are a variety of checklists designed to help schools, staff and parents when they have reasons to fear a youngster is suicidal.

Checklists help to highlight key points but they're only guides.

For example, the suicide assessment checklist on the screen outlines matters that might be covered with a student and/or parent.

As you can see, it covers concerns about the youngster's past attempts, current plans, view of death, reactions to precipitating events, history of risk taking behavior and available psychosocial supports.

Take a minute to read over the specific questions related to each area.

Slide 21, please.

Now look at the next checklist which covers follow through steps.

Again, this is a slide you may want to download later in order to read more carefully.

Outlined are concerns ranging from assisting the youngsters, contacting and following up with parents and report child endangerment if necessary.

As you can see, the points on such checklists have relevance for anyone confronted with a youngster that may be suicidal.

Other checklists outline procedures for schools to follow in the aftermath of a youth suicide and these are available in resource aids by the center and readily download from our website.

Slide 22, please.

At this point a few cautions are in order.

Clearly, any indicators of unhappiness are reasons for concern.

However, even well-trained professionals using the best available assessment procedures find it challenging to determine whether an individual is suicidal.

The dilemma is to attend to potential problems without overreacting.

This dilemma is exacerbated when large scale screening programs are put into practice.

The type of first level screens that are often advocated tend to produce too many false positives.

This leads to over-referrals and results in an unfortunate misuse of scarce resources.

Another concern arises when school suicide prevention efforts involve students and looking for and reporting problems among their peers.

While the intent may be to foster a climate of social support and caring, too often what is created is an atmosphere of surveillance and overreaction.

The strategy can run efforts designed to promote empathy and a sense of community.

Obviously we want students to be concerned with each other and certainly to look for and help when youngsters are having trouble. At the same time, we don't want them to be put into the position where they have to feel like they must report on others or that they are no longer concerned with the youngsters' well-being but mainly are looking for problems.

Slide 23, please.

We hope this presentation has provided you with a useful beginning overview to the topic of youth suicide prevention and given you some insights into how schools can work with these problems.

You are free to download and use it as a training aid in your work.

It can be accessed either from the Maternal and Child Health Bureau archives or from our center's website.

For ready access to more on this topic the general resources displayed on your screen can be accessed.

These include SAMHSA's National Mental Health Information Center, CDC's information resources, and the Bright Futures resources developed with support from HRSA.

Slide 24, please.

And, of course, our center and our sister center at the University of Maryland provide a range of training and technical assistance resources.

Slide 25, please.

Our center also has developed a set of specific aids on this topic.

Each of the resources listed on the screen can be downloaded from our website at no cost.

In addition, many documents and links can be accessed through our center web sights quick find menu.

To bring this presentation to a conclusion, let me just summarize a few points that are worth underscoring.

It's essential to approach youth suicide from both a mental health and public health perspective.

It's on enhancing awareness and increasing awareness among young people and their families, those who work with young people and the general public.

A primary focus for prevention should be on factors in the environment that are major contributors to problems.

Efforts also must focus on appropriately identifying those at risk in building the capacity of schools, families and communities to help.

We've also stressed that it's essential to imbed prevention programs into a comprehensive, multi-faceted and cohesive framework.

We stress that schools have an important role to play in suicide prevention and they're in a unique position to promote healthy development and protect the buffers to offer risk prevention programs and to help to identify and guide students in need of special assistance.

As we all know, promoting healthy development and addressing barriers to youth well-being requires the best efforts of families, schools and communities working together in the best interests of all children.

We wish you well in your work.

And thank you for taking the time today to enhance your understanding of youth suicide prevention.

And we hope that you'll feel free to contact our center as you identify needs for technical assistance and training related to concerns about mental health in the schools.

>>TRINA ANGLIN: That's Dr. Howard Adelman from UCLA who will joining us live for our discussion period.

Our next speaker is Dr. Lloyd Potter, director of several important activities relative to the prevention of suicide at the education development center in Massachusetts.

These activities include the Children's Safety Network violence and prevention center.

The youth suicide prevention workshop series which some of you may have participated in and the project of developing indicators for suicide prevention.

He also directs the National Suicide Prevention Resource Center.

He will discuss planning to prevent youth suicide with a focus on states.

And remember that you can type in questions at any time during his presentation.

Dr. Potter.

>>LLOYD POTTER: Thank you, it's a pleasure to be here and I thoroughly enjoyed the background that Dr. Adelman gave us.

I will be focusing today on I guess a couple of topics, but I want to spend a little bit of time going over the background of suicide prevention just a little bit of time.

And then also talking more about planning for prevention of suicide.

And I want to try to put that in the context of the role that you all as adolescent health coordinators can play in state activities in suicide prevention and where -- emphasizing where you may be able to partner with people and organizations within your states.

First of all, I wanted to talk a little bit about the performance measures in the Title V block grant because I think this has been one of the, I suppose, bureaucratic decisions that has really helped move suicide prevention forward dramatically.

And some of you -- I assume most of you are familiar with the Title V block grant which Title V is the Social Security act which goes almost -- I guess all states and territories receive block grant money.

There are a number of performance measures in there.

It's to reduce the rate of suicide in age 15 to 19.

It led to a lot of states where they weren't really doing anything in the area of suicide prevention, taking a fairly active role, if not a very significant, putting on a very significant effort, to prevent youth suicide and it's resulted in the development of plans and a lot of activities in the area.

I think this is one of the first among a number of other things, one of the first things that really led to activity in the states around suicide prevention. And that, I think, then kind of fed into some partnering between a number of federal agencies that led to a conference in 1998 in Reno, Nevada that resulted in the Surgeon General's call to action to prevent suicide. And then that subsequently led to the national strategy for suicide prevention which Dr. Adelman referred to. And now we're at a stage where both federal agencies and state and local government are using the national strategy to begin to implement suicide prevention efforts across the country.

So I now want to give you a framework of public health approach framework which some of you I'm guessing many of you are familiar with so I won't spend much time on it.

And Dr. Adelman referred to it briefly as well.

But I want to present it as though the idea is that suicide prevention and prevention in general involves a fairly comprehensive effort and that starts with assessing the problem.

Obviously before you can mount an effort you need to figure out what the nature of the problem is.

And in order to focus your prevention effort.

But also to be able to organize around prevention.

So that involves having good data systems in place.

Surveillance systems.

Regular reporting and dissemination of information about the problem.

And in the case that we're talking about now, youth suicide and suicidal behavior or injuries related to suicidal behavior.

Once you have a good understanding of the problem, obviously then frequently causes are just suggested but it involves doing either research or really trying to understand the causes of the problem and trying to understand why it happens.

And that then leads to I was thinking about how can we break the causal chain? We need to then identify strategies for intervening, implement those and evaluate them and then once we find effective strategies for prevention, we implement those and disseminate those and facilitate implementing them with a fair amount of fidelity.

And obviously if we have good data systems in place we're able to then monitor our progress and make changes as we go along to improve the efficacy of our prevention efforts.

It's a cyclical process, the public health approach.

I'm fairly briefly going to go through a little of the epidemiology which many of you are familiar with.

I put up a map of the United States with suicide rates for ages 15 to 19. You can see from that, that the mountain west and Alaska are the states with the highest youth suicide rates.

But that doesn't really diminish the problem for those states say in the northeast or Florida where suicide is still a significant public health issue among youth.

I think in almost all states it's the third leading cause of death and in many of the states with high rates it's the second leading cause of death.

Moving to the next slide, I put this slide in here to illustrate the point that we tend to look at the tip of the iceberg of suicide, which are deaths.

And again there are relatively few even though it's a leading cause of death. But the real significant problem of suicidal behavior are hospitalizations and acute care.

Now, the slide that I show just represents the total population and doesn't really illustrate the problem among youth.

In fact, among youth there is probably the proportion of death to attempted suicides is greater than in the general population.

But there is a huge public health burden associated with suicidal behavior, non-fatal suicidal behavior.

It's the point I want to illustrate.

And there are very significant implications for that suicidal behavior for the families of kids that are attempting suicide and then obviously important the public health system as well just to be able to respond to the acute care needs of youth that are attempting suicide.

I also, I think, ought to illustrate this point as well.

Put the next slide, which is from the Massachusetts youth risk behavior survey. And in that -- in Massachusetts they have asked questions in 1997 about sexual orientation.

This just illustrates something about one risk factor associated with suicidal behavior on this slide but also illustrates this continuum of severity from having, among gay and lesbian youth in Massachusetts more than 50% reporting they had thoughts of suicide.

But I think the thing that I find in the general population that is somewhere in the neighborhood of 20% of youth in high school are reporting they've had thoughts of suicide.

When you think one in five kids are thinking about suicide and you kind of follow that through to making attempts that require medical attention, it's a very significant public health problem.

Moving to the next slide, I wanted to illustrate, I think, a point that Dr.

Adelman made very well which is that there are many areas where -- that influence the potential suicidal behavior of an individual. Obviously a child is born into the world and they have their own genetic makeup and there are all kinds of things that influence their own biological and mental development. But there are very strong influences, both of their physical environment but their social environment as well. And certainly family and peers have some of the strongest influences on an individual and their potential risk for suicidal behavior. And then the community. There is a lot of evidence that some communities have higher rates of suicide than other communities. And then there are also more broadly speaking social influences on suicidal behavior as well. I'm illustrating these points because when we think about prevention it's very important to think about prevention efforts that -- that are focused on trying to change something about the influences on the individual at these different levels.

The next slide I wanted to illustrate the point that suicidal behavior happens also within a broader context of violent behavior. And there is a growing body of literature that finds that suicidal behavior is related to exposure or experience of other types of violent behavior.

And that's further illustrated by the next slide which is listing of a number of the multiple death school shootings that have occurred in the United States, thankfully some time ago. But when you think about the -- many of the youth that were involved in those events, again we think about -- have a tendency to think about those as youth violence but very much the perpetrators in many of those cases had a lot of the risk characteristics of suicidal youth. Some of the youth even reported to be suicidal -- were suicidal. So there is this whole mix of suicidal behavior. Again I think Dr. Adelman did a great job illustrating that our prevention efforts need to take that into consideration. It is not just suicide that we're trying to prevent but there is a whole range of risk behaviors also that we want to focus on.

I've put in here a slide about -- from the national strategy and again I think Dr. Adelman mentioned, and I did earlier, but I think it's something that is useful in terms of providing a lot of guidance to think about prevention efforts and who should be involved. And I also want to emphasize one of the objectives in there is for all states to develop suicide prevention plans. And so that really leads me to the next slide which is important to think about developing a comprehensive approach and in some states or in some local areas

where one program is identified as -- as a strategy and it's put into place, it's difficult to really think that there is much of a chance of just one program being put into place as being successful.

And when we think about what needs to happen and again at the state level that there are a number of factors that need to be in place.

And one of the things that we've seen with states that have really advanced in their suicide prevention efforts is that they have a person who is identified as a coordinator.

They've been successful in getting funding either from an appropriation in the state or there is maybe private funding or grants from the federal government. There is very frequently a grass roots advocacy effort that leads to there being suicide prevention support in the state legislatures but also in terms of being a group of people that can help to implement and disseminate information about prevention.

There is a need to have a needs assessment.

I had talked earlier about the first step in the public health approach is identifying the problem and really figuring out where is the problem and where do we need to change systems, where do we need to implement programs and so on?

And there is always this issue of data.

That especially I think in suicide prevention, that if you don't have good information it's very difficult to gather the support that you need to mount an effort.

When you look at the numbers, it's usually quite convincing in terms of the need to mount a suicide prevention effort.

Planning is important.

And then again states working with local grass roots organizations or local government having evaluation components, and then the point that I really want to emphasize today, and I'll talk about again later is the issue of collaboration.

State government can't do it by itself and public health can't do it by itself but there is a need to work with mental health and a need to work across agencies, within government and across into the private sector.

So the next slide I've kind of listed a whole number of possible partners.

Again, this comes from experience working with different states and we've seen different configurations.

Sometimes some of these are present, sometimes there are others that aren't listed.

But that's just to give you some framework for possibilities for people to work with in planning and implementing suicide prevention efforts.

Then the next slide looks -- it's just kind of a planning model.

This is actually something that you've heard about a little bit earlier.

Some of the workshops that HRSA has developed that we're developing, intervention workshops.

The next workshop that we're preparing to implement sometime probably in the late summer or early fall is one that's focused on planning, implementation and evaluation and this slide comes from one of the activities that we have in there.

Where it really kind of gives you a step-wise process for planning.

We've spent -- in the next slide I want to talk a little bit about some state plans.

We've spent a little bit of time looking at state plans and Deb Stone who I have working with me here at EDC has been the one helping to develop these workshops.

She spent some time working for the centers with disease control.

There is a woman there that made an effort to gather suicide prevention plans from states.

So we collaborated with her and got copies of those and reviewed them to kind of get some sort of summary information.

So here is a listing of the states that we looked at.

And if you look at the next slide, we just looked at it using the national -- the state plans as a national strategy as kind of a framework and looked at some of the more commonly-stated objectives that the state plans had.

You can see that public education was very commonly stated.

And the model of gate keeper training in schools.

Doing screening or assessment in primary care.

Screening and referral.

Doing media education and improving surveillance.

Again, if you look at these, they probably fall within -- nicely within a public health approach.

Looking at the next slide on observations from them, there was a real -- generally speaking when states develop plans they took a comprehensive approach which I think is a very positive development given that in the past I think many states have just kind of taken one or two programs and tried to implement them.

But on the down side, I think when we looked at them, they tended to be overly ambitious.

Like it wasn't very realistic to think that states were going to achieve all the objectives that they had set out.

There is a real evidence that there was collaboration.

But the problem was, we found that there wasn't much in terms of evaluation happening, at least within the context of the plans we reviewed.

And there wasn't really -- many of the states hadn't kind of gotten to the level of implementation yet.

There was also developing a crisis response capability was very common in the state plans as well.

And it's not mentioned that much in the national strategy.

So again I could talk a lot more about these plans and I would be happy to answer questions about them.

But moving on, I felt as though Dr. Adelman did a very good job describing about school planning and school preparedness so I'll kind of skip over that slide and just go to the next slide which talks about programs for prevention among adolescents and young adults.

These all come from the document -- one of the documents that Dr. Adelman had listed, the CDC's resource guide for youth suicide prevention where CDC had reviewed the different types of programs that were out there.

And without making any real assessment for whether or not they were effective, in fact we could go through these, which I don't really have time to do now, and talk about each of them in terms of the evidence for their effectiveness in preventing suicide.

But again, one of the most commonly implemented strategies have to do with gate keeper training and that's both in schools and communities.

There has been -- there was a real emphasis for a while doing suicide prevention education.

That was slowed down a little bit when a study, I think David had found there may be some untoward effects if the programs weren't implemented correctly so a lot of schools have shied away from that strategy.

Screening programs that we'll be talking about here in more detail shortly.

Peer support programs.

Crisis centers and hot lines.

Efforts to restrict access to lethal means.

This usually refers to firearms but it may also refer to prescribing large doses of drugs that may be used in suicide attempts.

And then the whole issue of aftercare as well, which again Dr. Adelman mentioned.

Looking at the next slide I wanted to emphasize this idea that there is a lot of room -- I think Dr. Adelman made this point very ably, that there is a lot of room to implement suicide prevention in different types of programs.

And in a lot of programs, they've been implemented for purposes of drug abuse prevention or substance abuse prevention or treatment.

And they haven't been evaluated for their outcomes on suicidal behavior.

And that kind of brings me to the next slide where I have kind of listed in the rows of the different strategies of youth suicide prevention and then the column are just these different violence outcomes.

And I somewhat unscientifically said for suicide prevention efforts do they use gate keeping as a strategy.

Intimate partner violence I was able to identify a couple of examples and child abuse prevention as well.

Training people to recognize when somebody is at risk and then to make a referral as appropriate.

So just kind of going through this, somewhat again I unscientifically put these check marks here but my point in illustrating this is the tremendous potential for integrating suicide prevention efforts into existing programs where there may be some flow of either federal or state dollars for programming and in an environment where there may be little or no resources really directed for suicide prevention.

So again, I think there is tremendous potential to integrate suicide prevention into existing programs.

And here I've just listed those related to violence prevention.

But I might come -- I know many of you are involved in pregnancy prevention and H.I.V. aids prevention.

There is great potential for implementing suicide prevention efforts.

So coming to my last slide, which is I want to emphasize, I think, doing very discrete suicide prevention kind of taking a program and calling it suicide prevention is just the tip of the iceberg.

And that suicide prevention can be incorporated into many places.

And that it's disguised as in many cases as other types of programs that are focused on promoting positive youth development.

But again, we haven't really assessed those types of programs for their potential for preventing suicide.

Suicide prevention involves collaboration and planning and partnerships.

And again, we've seen -- the states where we've seen that have made the most progress, there is strong collaboration, strong partnerships and there are plans.

The next slide I have just listed a few of the resources that were mentioned earlier.

And again these aren't -- aren't meant to scare you away in any stretch of the imagination from the Center for Mental Health and Schools or from the Center for Schools and Mental Health Assistance because they have excellent resources on both of those web sites and provide excellent technical assistance.

The Child Safety Network is part of the Maternal and Child Health Bureau and we work directly with states and will provide assistance on suicide prevention.

The National Suicide Prevention Resource Center was recently funded by SAMHSA.

Again the target audience for then, one of the target audiences for providing technical assistance are state health departments.

And then the National Center for Suicide Prevention Training is the website where we have our online training in suicide prevention with the public health approach.

Let me stop there and turn it back over to Dr. Anglin.

>>TRINA ANGLIN: Thank you so much, Dr. Lloyd Potter.

Our third panelist is Ms. Leslie McGuire.

The director of the Columbia University TeenScreen Program.

Leslie has a background in social work.

She'll discuss the TeenScreen Program and remember, that you can type in questions at any time during her presentation.  
We actually have already received several really good questions so keep them coming.  
Okay, Leslie.

>>LESLIE McGUIRE: Thank you.  
Good afternoon, everyone.  
What I'm going to talk to you about this afternoon is the Columbia TeenScreen Program.  
This is a program designed to identify kids who might be at risk for suicide or suffering from undiagnosed mental illness and get them into treatment.  
This is a national program going on now and may be something that you all can bring to your communities.

Next slide, please.  
Both of the previous speakers have done a great job at outlining really the great background information on teen suicide, the problem of it and its prevention so I'm not going to go into that.  
But this slide here gives a good idea about why we're doing what we're doing.  
First of all, it's estimated that 3/4 million teens are depressed at any one time and the vast majority go untreated.  
The problem is larger than that when you look at the whole scope of mental illness in kids.  
We estimate there are between 7 and 12 million kids who suffer from a psychiatric disorder, most not getting treatment.  
Also suicide is currently the third leading cause of death in 15 to 19-year-olds and an even greater problem when you take into account the number of kids who think of suicide and attempt it.  
The youth risk behavior survey done by the CDC shows us that 19% of U.S. high school students think about killing themselves.  
9% tell us they've made an attempt and 3% have made an attempt that requires medical attention.  
We're actually talking about millions of U.S. teens who are struggling with the problem of suicide.  
But yet we do have effective screening tools so we can identify these kids and we can also effectively treat them.  
We have improved medications and psychotherapies.  
There is something we can do about this crisis.  
We also know a lot about who the kids are who commit suicide.  
There have been a number of what we call psychological autopsy studies done both nationally and internationally showing us that approximately 90% of teens who commit suicide suffer from a psychiatric disorder at the time of their death.  
In addition, these are kids who have been struggling for some time.

In the study we did in the greater New York area 63% of the teens who committed suicide had been symptomatic for more than a year.

It also turns out it is a pretty limited range of psychiatric disorders that these kids are suffering from.

It's mood disorders like depression, bipolar disorder, drug and alcohol abuse is a particularly strong risk factor in boys and a past suicide attempt is also a strong risk factor.

In teens, 1/3 of boys and girls who commit suicide have made a past attempt. So we looked at the results of these autopsy studies and we looked at some of the other results showing how some of the other programs that are out there to prevent teen suicide aren't necessarily doing the job with that population and we thought why not try something different.

Let's screen kids for the risk factors of suicide and ask them if they're having these problems.

Hopefully if they tell us we'll be able to get them help and treatment.

Next slide, please.

We are now rolling out a national initiative to get every child in America a mental health checkup.

It's called positive action for teen health.

Our goal is to get this out there so that we believe this is something that every child in America deserves.

We do vision tests in school, hearing tests, if you want to play on a sports team you have to get a physical.

You know, when you look in the adult years women get an annual Pap smear. This is also something we believe should be an annual requirement or annual thing we all come to expect.

We also think that teen suicide is a public health crisis.

And so is the untreated rates of mental illness in kids so we're trying to promote this as a public health priority.

Another thing we're trying to do with this initiative is to take the research that has been out there and bring it into the communities.

Bring it into the hands of the people who are actually working with kids so everyone can be up to date on what has indeed been found to be evidence-based or effective.

And this isn't something that we can do alone.

Our one group isn't going to be able to ensure that every child in America gets a mental health checkup so we're creating partnerships with advocates, state departments of mental health, with school districts, education associations, service agencies and other places so that they can help us create this new initiative.

There are a number of organizations that have signed on and agree with our goal that every child in America should get a mental health checkup and this slide here lists some of those groups and we have other groups just coming in. The initiative we did just launch in January so this is still relatively new.

Screening kids for suicide risk and mental illness is not new and this is something that we've been doing at Columbia University for more than a decade now.

We began our TeenScreen Program, which is what we call our screening initiative, in 1991.

And we began it as a research study.

We wanted to, before we got this out there, we wanted to make sure that, first of all, you could indeed identify kids at risk for suicide.

If you ask some of these questions directly they would tell you.

So we tested the program out on almost 2,000 high school students in a number of schools in the greater New York area and we learned from that study that, indeed, you can identify these kids.

You can find kids who are at risk and aren't getting help.

From there we ran some of our own public service projects in the greater New York area and in that time refined our screening process and tools as well, making it more efficient and effective as we went.

We've done a follow-up study which I'll tell you a little bit about in a bit and in 1999 we launched our national initiative to get this program out there throughout the states so that other children outside of the New York area could be screened as well.

Since that time we have trained 70 different sites in 27 states.

The next slide is a map showing you where some of the TeenScreen programs are and it also shows you some other screening locations.

We have some colleagues at Columbia who are focusing on juvenile justice facilities.

The TeenScreen Program focuses primarily on schools.

Some clinical users and some other guidance counselor projects as well but you can see we're beginning to make a dent.

Hopefully you can see the slides.

The brown states are the ones that we don't have screening programs in yet.

The TeenScreen Program, as I said before, is designed or was designed to be used in schools.

That's mostly because that's where you can reach the largest number of kids at any one time.

It is a flexible program, though.

And that means that this is something that you can do really in any kind of facility where you've got groups of kids.

So most of our sites -- most of the 70 sites are in schools but we have some residential treatment facilities using our tools, some foster care programs, some drop-in centers, homeless shelters, clinics.

As I mentioned before we've got some colleagues working on this in juvenile justice.

And also a colleague here trying to get this worked into pediatric and family practices.

How does this work in the real community?

I'll explain in a moment how the actual screening program works.

But probably I would say that none of our 70 sites are doing screening the same way.

And that's also a benefit of what we offer that is not a one size fits all kind of thing.

Every community is different and has different needs and different resources. So we work with them to come up with a screening model that will fit those needs and resources.

So just to go over a few of these to give you a flavor for how this works, we've got a program in Tulsa, Oklahoma that was begun in response to a number of teen suicides that they had.

Some middle school girls who had shot themselves.

And they got -- they got the community to come together and work together to start a pilot program to do some screenings.

The pilot program was successful and they got funding from the united way to fund a full time screener and this person travels from school to school screening kids.

As I said before you can do this in school-based health centers.

In Alaska we have one that has a mental health clinician who is there six hours a week.

They have screening to determine which ones need to see the clinician and which ones don't.

When the clinician sees the kids they can do a much more efficient interview.

In Oregon, this is another community-wide effort.

Four of their community mental health agencies have donated a quarter of a person and those people all come together and work one day a week in different schools screening kids.

In Florida there is a homeless and run away shelter for kids.

They're using the screening tools to help identify who is most at risk immediately.

You can do this in alternative schools, school social workers can do this, school psychologists.

If there is a will we help you find the way.

So how does this work and how can people from different communities become part of the TeenScreen Program?

What we're doing is really creating partnerships with communities and schools from throughout the country to help them develop and implement their own custom-made screening programs.

We -- our goal, we have a big one.

We want every child in America to get a mental health checkup and also participate in the prevention of teen suicide and we are fortunate that we have funding from a benefactor that allows us to give our services away free.

The communities who qualify and want to do this and are interested, we're able to provide them with consultation training.  
Post training technical assistance and materials and other kinds of consultation all for free.

We do ask for a few things in return for that.

We need there to be one person in that community who is taking this on in some level as part of their responsibilities.

This is a person who is going to make sure the screening program actually gets implemented and that we can work with as the contact in that community.

We have a site application that needs to be filled out.

There is a letter of agreement that is signed that's basically just indicating that the process will be done as they've laid out.

It is going to be done safely, things like that.

We also ask that communities commit to screening a minimum of 200 kids per year.

And again, we're giving this away for free and we're looking for communities that are committed to doing this and want to make this part of what they routinely offer kids.

This year they'll do screening and next year it's asthma screening, we're looking for communities that really want to make this a permanent part of their practice for kids.

We do ask that communities share their screening results with us.

That's really just an aggregate set of results.

These results are not used for research purposes.

I'm going to explain now how the actual screening works.

We've got a few different instruments that people can pick and choose from.

There is a Columbia TeenScreen which is a paper and pencil survey plus a voice disk.

This is the model that people use if they want to specifically look at identifying kids who are at risk for suicide.

We've got another instrument called the D.P.S. which can be used for more broad mental health screenings and use the disk instrument alone for kids referred to a school social worker or psychologist.

So with the suicide risk model, this next slide shows you how the actual process works.

If you're -- if you're looking to identify kids at risk for suicide we recommend you screen kids in the high school years.

Suicide happens but it's really pretty rare before that age range.

It doesn't begin to go up significantly until about age 16.

That's about where we recommend you screen kids at that point.

An important part of this whole program is people's willingness to participate.

So we do require parental consent for the program and we also require participant consent so kids are volunteering to do this as well.

The kids who agree to do this and have parental consent go on to the Columbia TeenScreen which I'll tell you more about in a minute.

This screen enables us to identify which kids we need to look at more carefully and who can be screened out.

If nothing comes out they can be screened out and go back to class.

If something does come up they go on to a much more thorough computerized interview.

If nothing comes up on that we realize we know from our research that they're okay and can be screened out.

And if something does come up they go to the third stage where they're evaluated briefly by a mental health professional.

Let me explain to you these stages and the instruments a bit more thoroughly.

The Columbia TeenScreen is an instrument that we developed here at Columbia university and based on what we know are the risk factors of teen suicide.

We ask about symptoms of depression, substance abuse, current suicidal thinking and past suicide attempts.

A paper and pencil survey that is self-completion and takes about ten minutes for kids to complete.

It's not a diagnostic tool.

We don't know at the end who is definitely got these problems or who is definitely at risk but it enables us to screen some kids out and find out who we need to look at more carefully.

So each stage of the screening sort of acts like a funnel.

The kids who are positive on the teen TeenScreen where they go onto a computer.

The disk is a psychiatric tool that covers many disorders.

It was first developed in 1979 and the most widely used research tool of its kind.

The great thing about the DISC in terms of screening is that it's self-administered.

Kids sit at a computer, they put on headphones and the computer asks questions of them.

It acts like a child psychologist would when doing a physical assessment.

It will ask for more information when you say yes.

If you say no it will skip on to the next thing.

The entire DISC interview takes about an hour in a community sample.

But it is a modular program so you can also pick and choose which disorders you want to administer.

So again, if we're looking to identify kids only at risk for suicide we'll only look at a handful of the disorders.

We'll look at anxiety disorders, mood disorders, drugs and alcohol.

It is designed for 9 to 17-year-olds.

You can go a bit older than that.

The other great benefit of the voice DISC is that research shows us that kids are

willing to reveal a lot more to computers about high-risk behaviors than they are to us adults.

We end up getting a lot of information out of these kids about those things that we would be concerned about.

The next slide just shows you all of the disorders that the voice DISC covers.

You can see how very comprehensive it is.

So the kids who are positive for -- let me just back up one second.

The -- what happens with the voice DISC is at the end the computer prints out a summary report telling the clinician or whoever is evaluating it which psychiatric disorders the child meets.

It shows you which disorders they are sub threshold for.

Ones where they have a lot of symptoms and even some impairment but don't meet the full criteria and it tells you their answers to clinically significant questions.

What did they say if they were asked if they were thinking about suicide?

That is the print out the clinician gets.

By the time the child makes it to the third stage the mental health professional who will do a brief evaluation with them has a wealth of information.

It's also helped to break the ice between the child and the clinician.

Most of the kids that we end up screening have never been asked questions like this before.

It can be uncomfortable being asked these questions and talking about these kinds of issues but they know the computer has asked them, they've answered them.

They know we'll see the answers and it makes the conversations much easier.

So kids who come up with any kind of diagnosis or sub threshold diagnosis on the DISC and kids who tell us anything about suicide go on to the third stage where this brief clinical evaluation.

The purpose of this evaluation is to determine whether or not the child would benefit from further assessment or treatment or not.

And at this point this is where we're really screening out the false positives.

These kids have had a full battery.

There will be some kids who make it to the clinician who don't need to be referred out but the clinician can determine that at this point.

Another key element of our program is case management.

We've found that identifying these kids is easy but getting them into treatment is not always easy.

So we have a case management component and this involves calling parents to inform them of the screening results and helping the child and the family get the treatment or the assessment that they need.

The next slide shows you what happens in this model from one stage to the next.

We use an active consent procedure, so we sent out letters to over 3,000 kids. This is a number of years ago.

Got about 1/3 back from parents saying 14% back no and about half didn't come back.

Of the kids who took the TeenScreen, 64% were positive.

22% of the kids who took the TeenScreen said they had been thinking about suicide.

8% made an attempt.

Going down below you can see that almost half.

46% of the kids who went on to the DISC interview came up with something and then went on and saw the clinician and then the two bottom points are the most important here.

What you see is that we identified in our sample in the Bronx 25% of the kids we screened needed either further evaluation or treatment.

Only 9% of those kids were already getting any kind of help.

So the program really does a unique job of finding a lot of kids but specifically finding the kids who haven't been found already.

And I am running out of time so if you could skip the next two slides and go to the mental health checkup model slide.

I'll just show you briefly that the other model that we have, if people are more interested doing a broader screen or something briefer we have another instrument called the DISC predictive scales that you can use in place of the DISC screen.

It's a short screening version of the DISC.

It is on the computer and has the voice.

Instead of taking an hour it takes five to ten minutes and it tells you which disorders that child should be further evaluated for rather than saying which ones they meet the diagnostic criteria for.

33% of the kids who take the short version that covers social phobia, generalized anxiety, panic disorder, obsessive/compulsive disorder, drug use, 33% of them come up as positive for something.

So just to summarize, we've also done some research to see of the kids that we identify with certain problems, which ones are already known to have these problems or be of even concern to anyone in the school?

And only 31% of the kids who were depressed were known to someone in the school.

Only 26% of those who were thinking of suicide were known to have problems or, you know, of any concern to anyone in the school and only 50% of the kids who had made a past attempt were known to someone in the school.

We also did a follow up study on the TeenScreen Program and we looked at some of the original participants when they were young adults.

We followed them up six years later and reassessed them for depression and suicide.

What we found with that was that of the young adults who were depressed or suicide the vast majority of them had been identified through their high school screening.

That really then means by screening in the high school years you can actually identify most of the people who will go on to have significant or recurrent problems with either mental illness or suicide.

So let me skip that next one and just go to the last slide of how to learn more. So if anyone is interested, you've got our email address and 800 phone number and also our website.

We would love to work with any of you who might be interested in doing some screening in your communities.

So thank you.

>>TRINA ANGLIN: I would like to thank Leslie for her excellent presentation. We have about 15 minutes for our panelists to respond to your questions and perhaps for them to discuss some issues amongst themselves.

And even though we have received many excellent questions, if you do have any more, please type them in to your messaging center box in the lower right-hand corner of your screen.

I've organized the questions into three general areas.

And they don't necessarily correspond to our three speakers' presentations.

But one set is actually around the epidemiology and risk factors for suicide amongst young people.

Another set has to do with families.

Another set has to do really with the role of screening.

And the final set has to do with states and best practices.

So I thought that perhaps we might want to start with questions around risk factors for suicide.

And these questions include, so that anybody of our panelists can feel free to answer them, is the frequency of suicide in young or very young children.

I know that Leslie had addressed that a little bit.

I think perhaps the speaker was thinking about young people who are not even yet teenagers.

>>LLOYD POTTER: I could speak a little bit to it.

One, I think the rates are extremely low.

And this is Lloyd Potter.

And I think that what we've seen is that the -- there have been, even though the base rates are very low, there is some evidence that there have been some increases over the past ten years.

As of late I think that as with all suicide rates for all ages, there has been kind of a plateau.

But one of the things that you have to question when you look at rates again that are very low for completed suicides is any sort of influence that, for example, that medical examiners may have changed their practice in terms of being more likely to classify the death of a child as a suicide.

May actually -- in other words, that may not -- the increase in the rates that we've seen may not actually be an increase in suicidal behavior but it may be a change in how suicide is being reported.

In terms of suicidal -- non-fatal suicidal behavior.

Maybe the others would comment on that.

>>HOWARD ADELMAN: My knowledge is limited in terms of anything that says there is good data in that area.

The problem has been with young children we can pick up a lot of risk factors but we aren't getting them directly from them and we're also, of course, not seeing it in terms of the severe behavior.

The actual committing of suicide.

Obviously you do pick up a whole bunch of risk factors on the types of things that end up being precursors that we ought to be worried about and it gets us into the issue the Surgeon General pointed out so well.

We have to worry about the common factors here and not just narrow it in too quickly, that this is all about suicide, per se.

>>TRINA ANGLIN: Thank you.

The next one is a real specific one.

And that is, is gambling seen as a risk factor for suicide?

Have there been any studies that address this?

Maybe we can keep the answers brief because we have a lot of questions we need to address.

>>HOWARD ADELMAN: I believe I've seen a couple of things that associate -- I don't have any in mind any strong studies that have illustrated that.

But I do know that not gambling but kind of addictive behaviors or disorders are associated with suicidal behavior.

From that perspective I think it is an issue.

I don't know how big a problem it is with people with gambling disorders.

>>TRINA ANGLIN: And there is a question -- actually that two people asked and perhaps Leslie could answer this.

It's that youngsters who are like gay or lesbian or bisexual who might be more likely for suicide are you able to understand the issue?

>>LESLIE MCGUIRE: We don't yet have studies showing that gay and lesbian kids are at greater risk for completing suicide.

We do know from like the risk behavior survey that they have higher rates of suicide ideation and attempts but we don't know that they're completing suicide more often.

So it's a little bit tricky.

Most of those kids, though, also -- who are having problems with suicidality and are gay and lesbian are also having problems with depression and other mental illness things.

There is overlap.

We don't ask sexual orientation preferences but it is something that comes up often because of the nature of the program offering kids a safe and confidential way to talk about these more taboo topics.

>>LLOYD POTTER: One of the things, some of the risk for suicidal behavior among gay and lesbian youth is associated with having been victims of harassment or bullying.

So that certainly is a significant issue in terms of prevention.

And I know that the Maternal and Child Health Bureau is preparing an effort to roll out an awareness program and prevention efforts around bullying preventions.

I think that will be sometime in the fall as well which may have bearing for gay and lesbian youth.

>>TRINA ANGLIN: Thank you.

For people in the audience, if we don't quite get your question in this discussion, we promise we'll email you an answer specifically to it.

At this time I would like to move on to families.

There actually were several questions here.

How can we think of families as a resource for youngsters who might be at risk for suicide?

And then conversely, how can families -- what is the role of being a risk factor?

Somebody asked very specifically what is the relationship among youngsters who might be at risk for suicide if their own parents have a mental disorder?

Who would like to tackle that?

>>HOWARD ADELMAN: It's very clear that families are -- that the best area of support for young people is families.

And if you look at a number -- I know in -- I think in Oregon they had an MMWI that reported they had interviewed kids that had attempted suicide in the hospital and one of the more commonly-stated reasons that they gave for their suicide attempt was there was some sort of family discord.

So I think kind of from that -- I don't know if just from that, but there is no doubt that building strong family support and an understanding of the risk that kids may be in for suicidal behavior is important in trying to reach out to families and involve them in prevention efforts.

There is also the issue of having -- you talked about risk.

There is no doubt that there is kind of intergenerational -- a fair amount of evidence that there is enter generational risk associated with suicidal behavior and whether or not that's genetic or whether or not it's behavioral or environmental.

It may be all of them or some of them may have a stronger influence but that certainly is a consideration.

And I think having some knowledge about the family's history with mental health and suicidal behavior.

There was another part to your question as well.

>>LLOYD POTTER: I would echo the point about family support. There is a fairly strong growing literature showing the strong relationship between a mother's depression and children's depression. If you take it a step further you start looking at some of the associations with suicide.

>>TRINA ANGLIN: Thank you. I think that one of the issues that our state adolescent health coordinators are interested in is the role of families in a variety of contexts in adolescents' lives. This might be an area we want to explore further. There seems to be a little bit of tension between the concepts of screening specifically for the risk for suicide and then sort of the mental health checkup of TeenScreen. And a couple of -- several people had commented on that. So I was wondering perhaps if Howard and Leslie could address the issues of screening kids more specifically for suicide. More globally around mental health issues and how those two can relate. Maybe we can take a minute or so for each of you to talk about that.

>>LESLIE McGUIRE: Sure. In my mind they go hand in hand. They are separate models but they go hand in hand because the major risk factors for suicide are disorders. It can also incorporate that.

>>HOWARD ADELMAN: You get into some bigger issues here, I think. One major public health issue is just the whole issue of whether our money should be going toward screens or our money should be going toward enhancing services. And we haven't really touched upon that and need to get into that in more depth. The other issue has to do with whether we're talking about mental health and mental illness. Much of what we've gotten into in the check ups has been about mental illness check. It may not foster or promote the mental health side of it that we're all concerned about.

>>TRINA ANGLIN: Would you like to address, kind of respond to Howard briefly, Leslie?

>>LESLIE McGUIRE: Yeah. It's a tricky situation because there is a lot to fix. When you go back to the first slide I showed, there are big problems out there.

There is an issue in terms of there's many, many kids who suffer from mental illness or risk for suicide who don't get identified.

So we do need to put some resources there.

I am in complete agreement as well that we need to put some resources into the treatment arena.

I don't think there are really any easy answers here.

Unfortunately.

>>TRINA ANGLIN: Well, thank you.

It's a very, very, you know, a big issue that we -- I think that our society is struggling to address. I would like to move now.

This is a segue into the sets of questions about states.

And one of them looking actually at the scarcity of mental health professionals as a resource asks specifically which states have done a good job in engaging mental health in suicide prevention?

>>LLOYD POTTER: There are a number of states that have been very proactive in developing strategies and implementing them.

And some of them I'm more aware of and familiar with than others so I could talk about a few perhaps at the risk of excluding others that have done great things.

So--

>>TRINA ANGLIN: Before you go on with that, Lloyd, there were actually a couple of questions about which states have best practices, best policies.

And would it be possible for people to have access to individual states' plans? That can fold into your response to that question.

>>LLOYD POTTER: Okay.

I don't think -- one of the projects of the new national suicide prevention resource center is to go through and look at different strategies and actually with a subcontract to the American Foundation of Suicide Prevention where establishing a system to establish a number of criteria against which different strategies will be judged.

So the idea is to really summarize in one place information about the evidence of effectiveness of different strategies.

Because essentially that hasn't been done to date.

Systematically.

Again you can look at a case by case basis and -- but there hasn't been any sort of standard process to look at prevention efforts.

So looking at the states, I don't think any one of them really kind of has a list of best practices that have been developed.

Then I'll just kind of add onto that, one of the goals also as the website for the new website is being developed is to make materials like state plans broadly available.

So we're actively getting electronic copies and where those don't exist scanning in paper copies of plans.

I think sometime in the fall they will be available over the Internet.

In the interim if somebody is interested you would be able to contact me or somebody at the suicide prevention resource center and we'd be able to get you copies of plans that we have.

I'll refer you to the state and they can provide it.

There are a number of states that have made a lot of progress.

I think one of the first states to really move forward was the State of Washington.

And they had a fairly comprehensive -- still have a fairly comprehensive program for suicide prevention.

One that I've really been impressed with as well is the State of Maine.

They have a pretty good website that describes their program but they're doing multiple -- their focus in Maine is on youth also.

And they are doing multiple things in schools.

Have a good evaluation program.

They've been able, recently received a CDC grant to help build their capacity in that area.

Similarly, the State of Virginia has -- all three of these states have developed their plan somewhat -- the path by which they got to where they are has been slightly different.

But Virginia also recently received a CDC grant and in receiving those grants they had to make a case for the fact that they were kind of at a stage they had a plan and so on that they could move things forward.

So I think when I point to people, to model states I think those are three that I'm most familiar with that have done a lot of very good work and are very actively implementing programs and evaluating them.

And there are other states also, but with a limited amount of time I'll stop at those.

>>TRINA ANGLIN: Okay.

Thank you.

One other content area in which these questions have just come in.

That has to do with the relationship of child mortality review teams and suicide.

There have been two questions here.

One is, are members of our panel have any suggestions for how a child mortality review team could keep from missing as they review their cases of actually of a suicide?

And then secondly, are you aware of whether states might have active suicide review teams similar to the concept of child fatality or mortality review teams?

>>LLOYD POTTER: Again, this is Lloyd.

Feel free, Leslie or Howard to jump in.

I mean, there are a number of cases or states that have -- I don't know if I would call them they've developed the same thing as a child fatality review team but they've done follow-back work with suicides. Probably one of the most notable is the State of Utah which I think has done -- they did a fairly comprehensive follow-back study of suicides. They found that a large percentage of the completed suicides among youth had been in -- somehow involved in the juvenile justice system which led them to develop a collaborative effort with the juvenile justice system to prevent suicide among kids interfacing with that system. There are a number of other states that have done similar studies. But these tend to be somewhat limited in the time duration and again they are more studies rather than having a panel in place that's consistently or periodically meeting to review cases. And then I think most child death review teams actually suicide is one of the conditions for most of them where they would actually review them. Look at what sort of systems the kids had been in contact with and issues that - - where the case may have been prevented.

So I think most states do that.

And in terms of missing, again it depends on the criteria for the panel in terms of what would activate them to review a case.

Many suicides are masked as single occupant car crashes, accidental or unintentional poisonings and in most states or most child mortality review teams, those cases would activate external causes of death, the review would be activated as a function of cause of death.

Now, whether or not they would be able to uncover evidence that would suggest that it was a suicide rather than an unintentional death, that may be difficult.

But again they should -- almost all cases that may have been suicides would be reviewed by a child death review team.

>>TRINA ANGLIN: We got a nice comment in from New Hampshire.

They review youth suicides in a similar way through the youth suicide prevention assembly and the state medical examiner reviews on the monthly basis.

People from other states might want to contact the state adolescent health coordinator to learn about our activity.

This brings us to time to conclude our WebCast.

We hope you've found it to be a good learning experience as well as enjoyable.

Our next WebCast is scheduled for Wednesday, July 30th.

It will be part one of a two-part series on adolescent nutrition and physical activity.

Thanks to our panel.

We also appreciate the technical support of the University of Illinois at Chicago and finally we thank our audience for generation of important questions.

We invite you to spend a couple of minutes evaluating the WebCast.  
A link will appear automatically after the broadcast ends.  
Your responses will help us to plan future broadcasts.  
And to improve our technical support.  
And I would like to remind you, because there are multiple questions about this, is that the archive of this WebCast will be available for viewing within several days at the website [www.mchcom.com](http://www.mchcom.com).  
This concludes our presentation of Seminars on Adolescent Health: Prevention of Adolescent Suicide  
Thank you.