

Adolescent Suicide in New Jersey: Data Overview and Prevention Activities

Department of Children and Families

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Commissioner

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This report on suicidal behavior among New Jersey adolescents, current prevention efforts, and recommendations for future activities is presented to Gov. Jon S. Corzine, the State Legislature, and the New Jersey Youth Suicide Prevention Advisory Council by the Department of Children and Families under NJ 30:9A-27. It was prepared by the Department of Children and Families and the Department of Health and Senior Services.

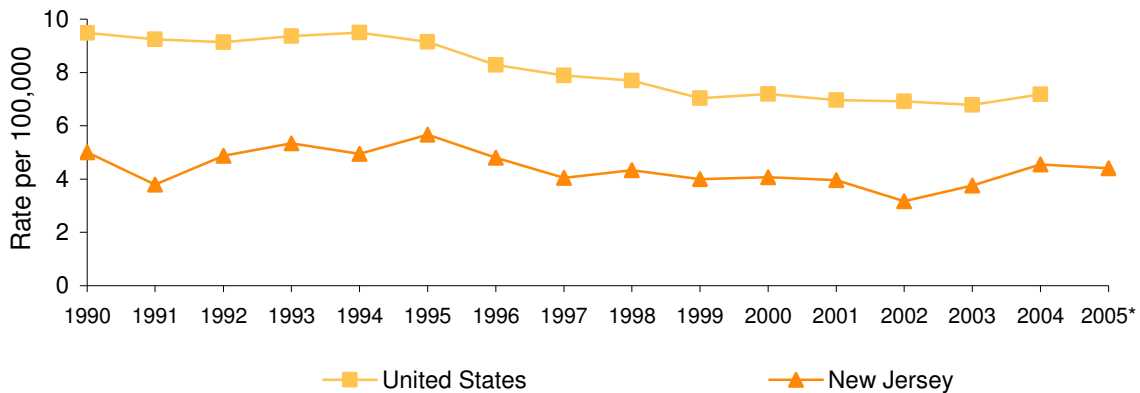
Introduction: It is vital that any effort by the state of New Jersey to provide information about youth who attempt or complete suicide be driven by solid data. In addition, any prevention or public education efforts resulting from the collection of data on youth at risk of suicide and the resources available for those youth, professionals in contact with youth and the general public must be guided by evidence-based practices. Under those guidelines, the intent of the Department of Children and Families and the Department of Health and Senior Services is to collect information about youths who attempt suicide; improve the information available to both professionals who are in contact with youth at risk of suicide and families at risk; identify and provide suitable intervention services to reduce the incidence of suicide; and educate youth and families at risk about the resources available for suicide prevention and intervention.

Data

Note: All tables and figures in this report provide information on New Jersey resident deaths and New Jersey resident hospital admissions to in-state hospitals. The New Jersey Violent Death Reporting System (NJVDRS) is a CDC-funded surveillance system, a collaborative effort of the Center for Health Statistics and the Violence Institute of New Jersey at the University of Medicine and Dentistry of New Jersey. The project seeks to help researchers determine the circumstances and risk factors associated with suicide and other violent deaths by linking timely data from multiple detailed sources. Hospitalization data is from the New Jersey Discharge Data Collection System, commonly known as UB-92 data, and includes only inpatient hospitalizations. Information on the New Jersey Student Health Survey can be found at the New Jersey Department of Education website: <http://www.state.nj.us/njded/students/yrbs/>.

Suicide among adolescents and young adults is rare when compared with other age groups, yet it is extremely costly in terms of both years of life lost and the impact on survivors. Over the last several decades, adolescent suicide rates have fallen, largely due to a decline in firearm suicides. New Jersey has a very low gun ownership rate (11% as compared with 35% nationally). This helps to prevent adolescent firearm suicides, where most of the time the gun used belongs to a family member. As an example, New Jersey, with a population of 2.3 million youth between the ages of 5-24 years in 2003 had 17 firearm suicides, while Arizona, with a higher gun ownership rate but only 1.6 million youths, had 76 firearm suicides in same year.

Figure 1. Suicide rate, United States and New Jersey, ages 10-24 years, 1990-2005



During the past five years there have been approximately 65 suicides annually in New Jersey among those aged 10-24 years, although this number fluctuates considerably from year to year. Data from 2004 shows an increase in the number of adolescent suicides, particularly among males aged 10-19 years. The rate of non-fatal suicides requiring hospitalization increased as well in 2004. The adolescent suicide rate increased more than did the rate of non-fatal injury. It is too soon to say whether this represents a temporary fluctuation or the beginnings of a reversal in a relatively long lasting trend. (Preliminary figures show the rate went down slightly in 2005.)

Table 1. Suicide and hospitalizations for self-injury among youth ages 10-24 years, New Jersey, 1999-2004

Year	Fatal		Non-fatal	
	<i>N</i>	<i>Rate</i>	<i>N</i>	<i>Rate</i>
1999	63	4.0	763	48.5
2000	65	4.1	821	51.4
2001	65	4.0	883	53.9
2002	53	3.2	845	50.9
2003	64	3.8	853	50.1
2004	79	4.6	926	53.4

Rates are per 100,000 age-specific population.

Data sources: WISQARS (1999-2002), New Jersey Violent Death Reporting System (2003-2004), New Jersey Uniform Billing (UB-92) Discharge Data; Bridged Race Estimates for population.

Adolescents differ from others in their greater propensity to engage in non-fatal suicidal behavior. In New Jersey, there are more than ten non-fatal suicide attempts resulting in hospitalization for each completed suicide among those aged 10-24 years. Even more non-fatal attempts result in Emergency Department, outpatient, or home treatment.

The ratio of attempted to completed suicide is highest among young adults, and lowest among adults aged 65 years and over, for whom there are three attempts for each completion. For the population as a whole, the ratio is approximately seven to one.

Table 2. Suicide and hospitalizations for self-injury among youth ages 10-24 years, New Jersey 1999-2005

	Age 10-19		Age 20-24	
	<i>N</i>	<i>Rate</i>	<i>N</i>	<i>Rate</i>
Total suicides	113	2.0	198	8.2
Male	93	3.2	149	12.0
Female	21	0.8	47	4.0
Total Hospitalizations	2,469	42.9	1,696	70.2
Male	663	22.5	725	58.6
Female	1,806	64.5	971	82.3

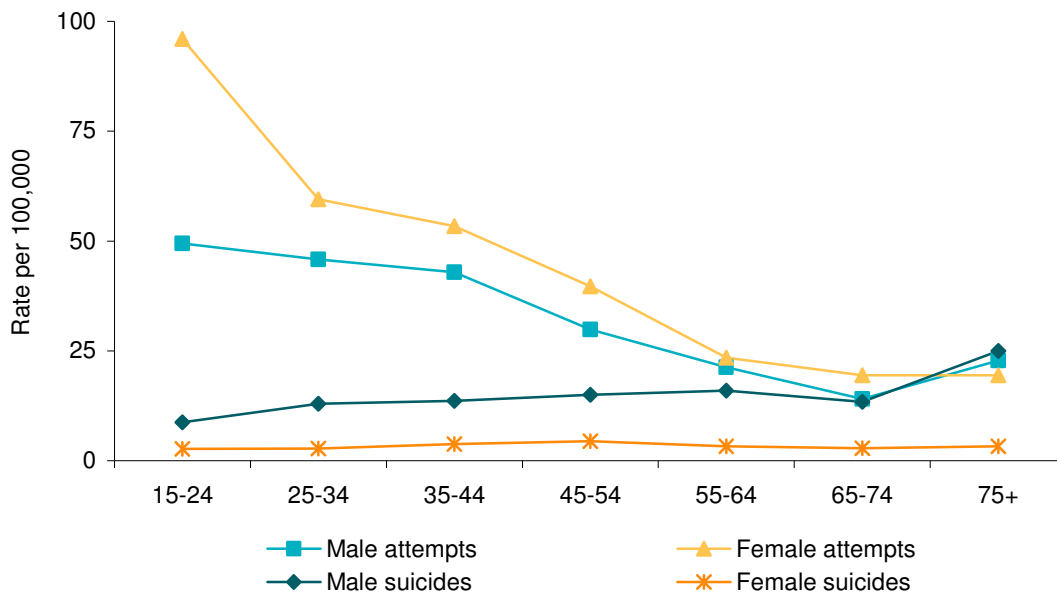
Rates are per 100,000 age-specific population.

Data sources: WISQARS (1999-2002), NJVDRS (2003-2004), New Jersey Uniform Billing (UB-92) Discharge Data; Bridged Race Estimates for population.

Even within the ages 10-24 years, the ratio of attempted to completed suicide declines with age. Among those aged 10-19 years, there are over

twenty hospitalizations for each completed suicide. Among those aged 20-24 years, the ratio had declined to less than ten. Suicide rates quadruple in the older age group, while hospitalization rates less than double.

Figure 2. Age-specific rates of fatal and non-fatal self-injury, New Jersey, 1999-2003



Data Sources: WISQARS; New Jersey Uniform billing (UB-92) Discharge Data; Bridged Race Estimates for population.

While most completed suicides are preceded by one or more non-fatal attempts, the vast majority of suicide attempters do not ultimately complete suicide. This is especially true in the case of adolescent females. The ratio of non-fatal to fatal attempts is highest for young females, who have both the highest rate of non-fatal attempts and the lowest rate of completed suicide when compared to the rest of the population. As females age, suicide rates remain relatively stable while attempt rates decline sharply. Yet even in the oldest age groups, the ratio for females well exceeds that for males.

Table 3. Completed suicides by age group, sex, New Jersey residents, 1999-2006

Completed suicides, 10-19 year-olds, by year								
	1999	2000	2001	2002	2003	2004	2005*	2006*
Males	17	29	13	17	17	30	22	18
Females	3	4	9	0	5	8	3	8
Total	20	33	22	17	22	38	25	26

Completed suicides, 20-24 year-olds, by year								
	1999	2000	2001	2002	2003	2004	2005*	2006*
Males	31	25	29	29	35	34	45	28
Females	12	7	14	7	7	7	7	6
Total	43	32	43	36	42	41	52	34

Source: WISQARS for 1999-2002; NJVDRS for 2003-2006. *2005 and 2006 NJVDRS data are preliminary.

Data from the New Jersey Violent Death Reporting System on suicide circumstances suggest that compared to other age groups, suicides among adolescents are often preceded by some kind of recent crisis. This crisis could be an argument with family members, a break-up of a relationship, an arrest, or some other type of sudden problem. Especially in the case of males, the crisis may be very recent, often less than 24 hours before the suicide. Adolescents were five times as likely as others to have had some type of “relationship problem,” usually a conflict with family members. Approximately forty percent of adolescents in New Jersey who complete suicide have some history of mental illness; slightly over thirty percent are currently being treated for a mental health problem. This is similar to suicides overall.

The Department of Children and Families is working to collect additional data on suicide attempts and ideations by children in New Jersey’s behavioral system of care. The next contract with the contracted system administrator, which provides a single point of contact that registers, tracks and coordinates care for children who are screened – at any level - into its Children's Behavioral Health Service System of Care, will collect additional data as part of the effort to improve system performance and enhance the delivery of care to children and families.

Table 4. Youth suicide, ages 10-24 years, by gender and mechanism, New Jersey, 1999-2004

	Males		Females	
	<i>N</i>	%	<i>N</i>	%
All suicides	306	100.0	83	100.0
Suffocation	155	50.7	38	45.8
Firearm	85	27.8	11	13.3
Poisoning	26	8.5	20	24.1
Falls	15	4.9	2	2.4
Cut/pierce	5	1.6	1	1.2
All other mechanisms	20	6.5	11	13.3

Data source: WISQARS (1999-2002), New Jersey Violent Death Reporting System (2003-2004).

Table 5. Hospitalizations for self-injury by youth ages 10-24 years, by gender and mechanism, New Jersey, 1999-2004

	Males		Females	
	<i>N</i>	%	<i>N</i>	%
All hospitalizations	1,712	100.0	3,379	100.0
Poisoning	1,499	87.6	3,294	97.5
Cut/pierce	111	6.5	46	1.4
Suffocation	25	1.5	8	0.2
Falls	18	1.1	13	0.4
Firearm	18	1.1	5	0.1
All other mechanisms	41	2.4	13	0.4

Data source: New Jersey Uniform Billing (UB-92) Discharge Data.

The primary method of suicide for adolescents is suffocation, or hanging. Firearms are the second most frequently used mechanism among males, followed by poisoning. For females, poisoning is the second most frequently used mechanism. Almost all non-fatal suicide attempts involve poisoning, usually an overdose of a prescription or non-prescription medication.

Table 6. County-level self-inflicted injuries, ratio of attempts to completions, New Jersey, 1999-2003

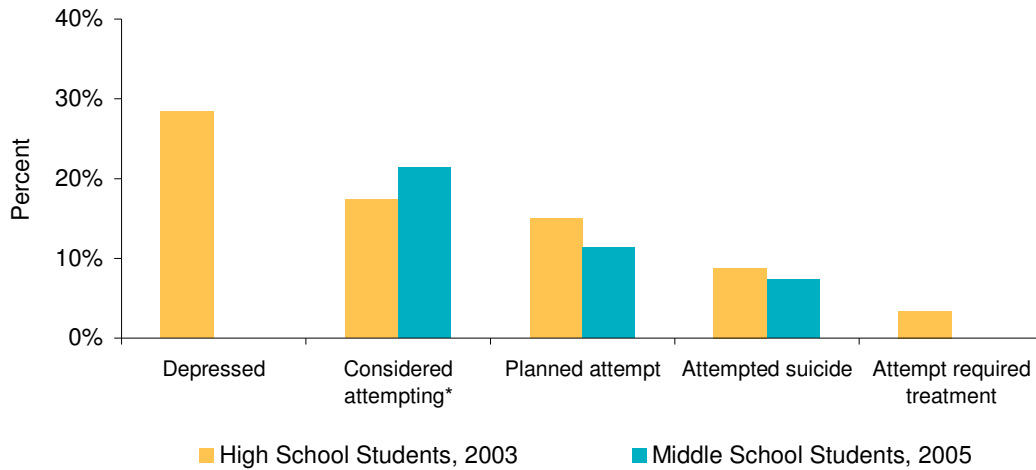
	Self-injury hospitalizations (H)	Completed suicides (S)	Ratio H:S
Atlantic	136	10	13.6
Bergen	330	26	12.7
Burlington	192	15	12.8
Camden	291	27	10.8
Cape May	47	6	7.8
Cumberland	102	9	11.3
Essex	387	22	17.6
Gloucester	127	12	10.6
Hudson	303	17	17.8
Hunterdon	59	2	29.5
Mercer	231	20	11.6
Middlesex	406	31	13.1
Monmouth	317	30	10.6
Morris	148	16	9.3
Ocean	235	21	11.2
Passaic	337	10	33.7
Salem	42	3	14.0
Somerset	129	13	9.9
Sussex	101	5	20.2
Union	180	13	13.8
Warren	63	3	21.0
NJ Youth Total	4,165	311	13.4

Total includes 2 hospitalizations where county of residence is unknown.
Data source: WISQARS, New Jersey Uniform Billing (UB-92) Discharge Data.

The geographical pattern of adolescent suicides in New Jersey is different from that of older adults. While suicide rates among older adults are highest in rural counties in Southern and Northwestern New Jersey, adolescent suicides are relatively more common in densely populated areas.

The geographical pattern of adolescent suicides is similar to that of non-fatal suicide attempts, which are in general more likely in urban areas. Overall, the ratio of attempted to completed suicide seems highest in several of the rural counties in Northwestern New Jersey as well as several of the more urban counties near New York City. This may in part reflect geographical differences in hospital use, as hospitalization rates are higher in Northern New Jersey.

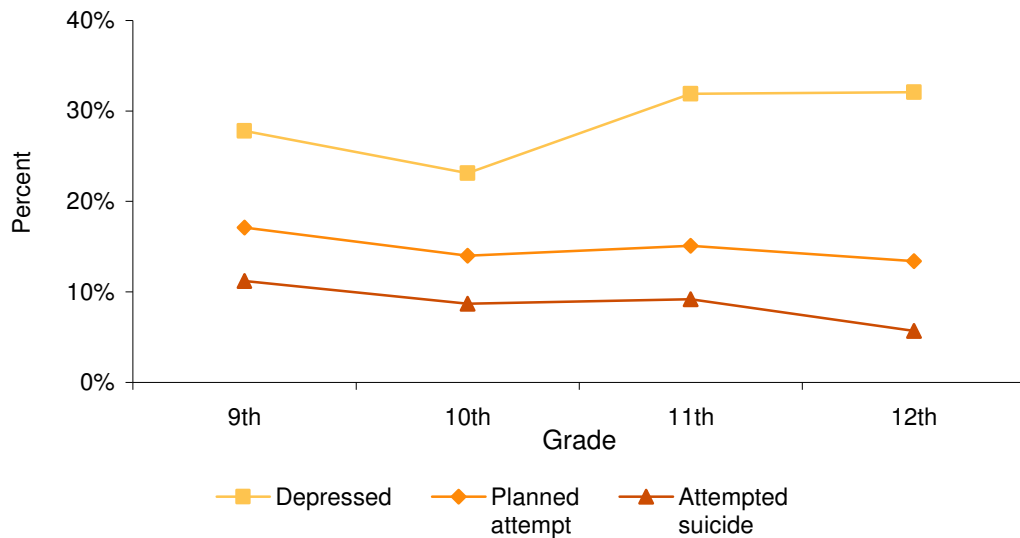
Figure 3. Self-reported depression and suicidal ideation among New Jersey middle and high school students



*Note: In the high school survey, the phrasing is “considered attempting”, in the middle school survey the phrasing is “seriously thought about suicide”.
 Data sources: New Jersey Student Health Survey of High School Students, 2003; New Jersey Student Health Survey of Middle School Students, 2005.

Nearly ten percent of middle and high school students in New Jersey report that they attempted suicide. This is consistent with national estimates. However, rates of hospitalization for self-injury in this age group are far lower – closer to fifty per one hundred thousand. This enormous discrepancy may result in part from the fact that many suicide attempts do not require hospitalization or even medical treatment. Approximately three percent of high school students reported that their attempt required treatment, but this figure still exceeds hospitalization rates for self-injury by a factor of roughly one hundred.

Figure 4. Self-reported depression and suicidal ideation by grade, New Jersey high school students, 2003



Data Source: New Jersey Student Health Survey of High School Students, 2003.

There appears to be a complicated relationship between suicidal thought and behavior among adolescents. As students age from 9th through 12th grade, the proportion who report feelings of depression rises, while at the same time the proportion reporting both suicidal plans or attempts declines. Yet rates of attempted and completed suicides actually rise as adolescents age. This discrepancy suggests that there is a rather significant difference between stated and actual suicidal behaviors that narrows as adolescents age.

Prevention

Introduction: This section contains descriptions of the major youth suicide prevention initiatives by the state of New Jersey. This state is the only one in the country that uses federal block grant money to create a statewide infrastructure by building a team in each county to prepare plans to respond to local crises. Bringing people in at a local level has led to the development of an indigenous capacity to support prevention efforts. New Jersey also has a pro-active children's mental health system that provides behavioral health care for families with children, youth and young adults with behavioral health challenges. Services that provide in-community assessment and treatment, essential components of the system of care, are virtually unprecedented in the nation.

The Traumatic Loss Coalition

The Traumatic Loss Coalitions (TLC) for Youth Program is the focus of adolescent suicide prevention efforts in New Jersey. Overseen by the Department of Children and Family's Division of Child Behavioral Health Services and funded with \$500,000 from federal grants, the program has operated as a county-based collaborative for six years and is now in each county in the state. The Mercer County Traumatic Loss Coalition was started in 1995 as a result of several suicides (eight children and one teacher) that took place there. The coalition, which is comprised of members from various sectors of the community, widened its scope and provides a coordinated response to traumatic loss incidents. In addition, it seeks to address the prevention of destructive behaviors of Mercer County adolescents and their families. In 1999, the Traumatic Loss Coalitions for Youth Program was created to establish Traumatic Loss Coalitions in each of New Jersey's 21 counties and to provide ongoing technical assistance to communities in crisis. The mechanism for proactive planning was modeled after the first Traumatic Loss Coalition in Mercer County which is funded by the New Jersey Department of Health and Senior Services. The TLC County Coalitions provide trauma response following critical incidents affecting school age children, resiliency enhancement, professional development, and statewide training and conferences. Training includes Post Traumatic Stress Management and Managing Sudden Traumatic Loss in the Schools, which have provided school-based counselors and mental health clinicians with the skills needed to assist youth in their local districts with

the everyday unfortunate losses as well as equip them with knowledge to assist in a large scale event. (See Figure 5 for attendance at coalition meetings.)

Attendees of Coalition Meetings October 1, 2005 – September 30, 2006

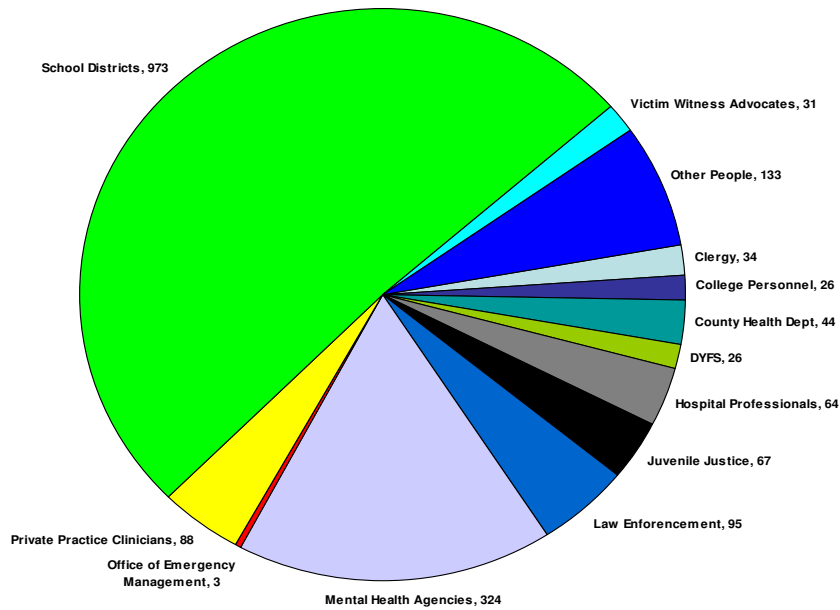


Figure 5

The TLC supports coalitions that bring together educators, mental health providers, law enforcement personnel, members of community agencies and faith-based organizations to share knowledge, ideas, and experiences and create trauma response networks and lead response teams in each county. Participants benefit from an interactive statewide network, youth suicide prevention awareness, critical incident consultation and assistance, resiliency enhancement, professional development, statewide training and conferences, technical assistance, and traumatic event data. In Fiscal Year 2006, the TLC network reviewed 160 traumatic events in various fatal and non-fatal categories. (See Table 7 on next page for events reviewed at coalition meetings.)

*Summary of Traumatic Loss Events Reviewed at County Coalition Meetings
October 1, 2005 – September 30, 2006*

Traumatic Loss Event	Fatal	Non-fatal	TOTALS
Accidents	52	26	78
Completed Suicide	19		19
Death by Natural Causes	14		14
Disease	3		3
Homicide	31		31
Suicide Attempts		3	3
Questionable Intent	2		2
Other	1		1
TOTALS	122	29	151

Table 7

The TLC County Coalitions also arrange for speakers to provide an educational component at the meetings. *(See Table 8 below for topics presented.)*

Date	Title	Attendees
01-Oct-05	Child Sexual Predators - Protecting Children Online	89
07-Oct-05	Gang Awareness	25
27-Oct-05	NIMS/ICS Training for Disaster Mental Health Responders	15
16-Nov-05	Tabletop Exercise with OEM Team Captains and MHA	20
01-Dec-05	Childhood Diseases / Dr. Andrew Peligrini / Local Pediatrician	13
01-Jan-06	Struggling with Stress	43
17-Jan-06	Methamphetamine Scourge	45
19-Jan-06	Non-Violent Crisis Intervention	20
25-Jan-06	Community Interventions in Suicide	65
03-Feb-06	Disaster Protocol RHCMHC	80
17-Feb-06	Psychological First Aid	12
24-Feb-06	SOS	7

10-Mar-06	Adolescent Self-injury	250
17-Mar-06	Reducing the Risks: Managing Youth at Risk for Violence and Suicide	80
28-Mar-06	Start Talking Before They Start Drinking	75
01-Apr-06	Managing Stress	10
01-Apr-06	Up Close and Personal – Meg Kallman O’Connor	8
28-Apr-06	Teen Challenges – Self Injury and Bullying	53
01-May-06	Stress & Mental Health Issues	100
22-May-06	Up Close and Personal	36
01-Jun-06	Ethical Issues in Disaster Counseling	45
15-Jun-06	Suicide Prevention – Educators (2 trainings simultaneously)	190
16-Jun-06	Psychological First Aid	10
20-Jun-06	Suicide Prevention - Educators	125
05-Sep-06	Suicide Prevention - Educators	65
07-Sep-06	Suicide Prevention - Educators	60

Table 8

The TLC also offers training in evidence-based methodologies and skills to those who work closely with youth. For example, post-traumatic stress management training enables professionals to identify, stabilize and augment the psychosocial needs of children who have been exposed to life threatening events including traumatic loss. This model also enables those who work with children and adolescents to provide psychological first aid and psychosocial stabilization and to enhance resiliency and coping. The goal is a significant decrease of the negative effects caused by exposure to a traumatic event. The main purpose is to create a group of individuals who are well trained and fully prepared to respond to the unfortunate daily traumatic exposures that challenge the youth of New Jersey. These can include suicide, homicide, fatal accidents, drug overdoses, witnessing domestic violence and deaths resulting from illness.

Ongoing training provided by certified trainers through the Traumatic Loss Coalitions for Youth Program is increasing the number of Trauma Response Network members throughout the state. This increase creates a base of trained individuals specially trained in children’s trauma response.

They will have the knowledge and skills to provide a quality intervention following a critical incident.

The Traumatic Loss Interventions for Youth Project is dedicated to excellence in suicide prevention and to providing a collaborative and coordinated mental health response to a global or community crisis affecting New Jersey's school-aged youth. New Jersey is the only state that is pursuing the building and training of Trauma Response Networks and Lead Response Teams (LRT) for post critical incident response for children in schools and communities as a statewide initiative.

The county coordinators have identified trained individuals to become part of the LRT in their respective counties. These Lead Response Teams are called in when a school's capacity to respond to a traumatic event is either overwhelmed by the size and scope of the event or their local resources are in need of psychological first aid themselves. The Lead Response Teams can function in the capacity of lead responders, co-responders or consultants to the responders.

As an example of the collaborative efforts fostered by the TLC throughout the state, the Middlesex County Coalition Coordinator along with the County Mental Health Administrator and the County Superintendent partnered to obtain an Emergency Response Crisis Management Grant from the National Department of Education. This grant spans a three-year period and will enable the county to focus on increasing school safety and security as well as increasing the capacity of schools and communities to assist youth in the event of a large impact event caused by natural or man made disasters.

(See pages 16 and 17 for listing of county coordinators and page 18 for Figure 6 on Lead Response Team (LRT) Interventions.)

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LRT Intervention

October 1, 2005 – September 30, 2006

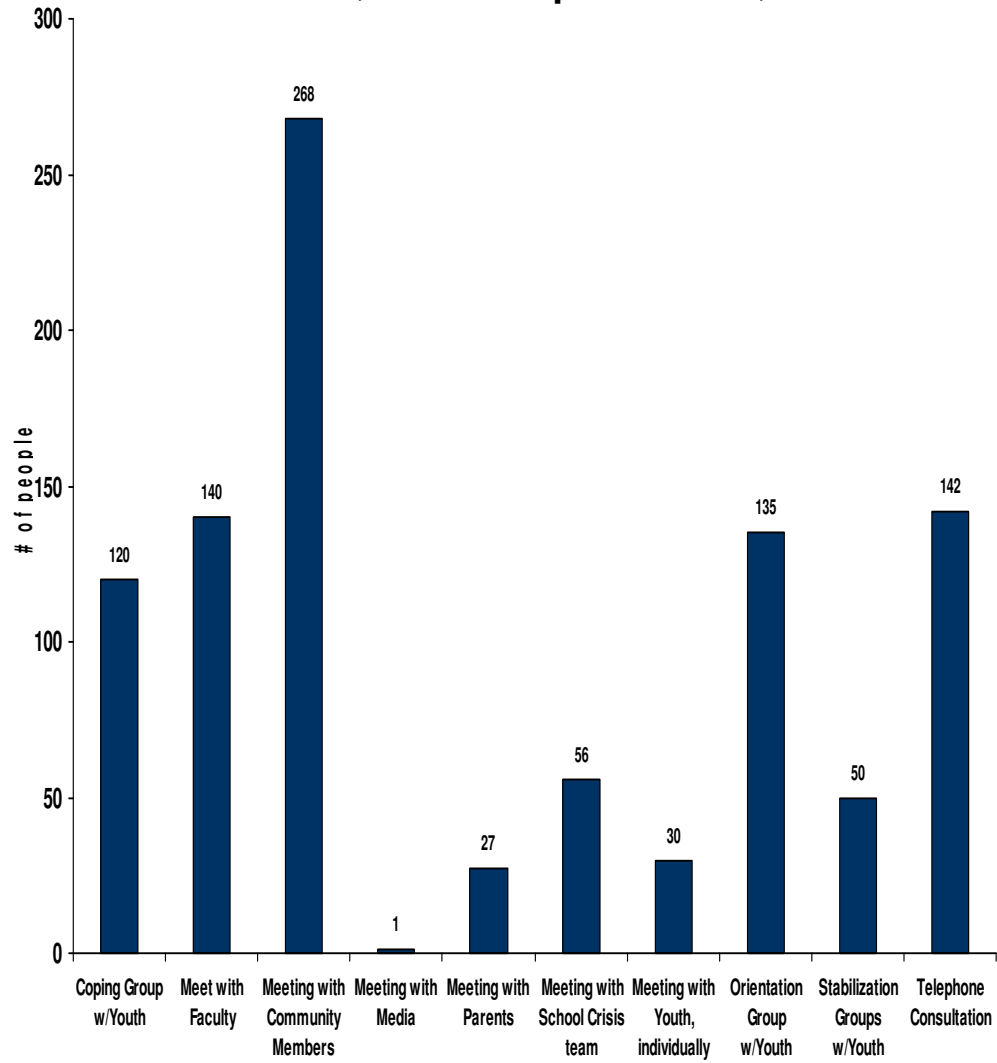


Figure 6

Education

In January 2006, Governor Cody signed into law legislation requiring the State Board of Education to include two hours of instruction in suicide prevention as part of professional development for public school teaching staff members and to revise the Core Curriculum Standards in Comprehensive Health and Physical Education to include suicide prevention instruction. This included teachers in youth suicide prevention efforts. The Traumatic Loss Coalition has been assisting schools in meeting the mandate by providing suicide prevention training for educators. This training program is being provided by coordinators who have experience in suicide prevention as well as assessment and treatment of at-risk youth. The two-hour curriculum covers mental health disorders that put youth at risk for suicide such as major depressive disorder, bipolar disorder, conduct disorder and substance abuse. It also covers risk factors for suicide, protective factors, warning signs and referral procedures.

This program was the result of a pilot training program that was initiated by the Traumatic Loss Coalition prior to the law. It was designed to include mental health disorders in the curriculum to increase the public's knowledge about the link between mental illness and completed and attempted suicides. The training provided through TLC follows a public health model. It is geared toward educating large numbers of people about a public health problem as well as focusing on reducing stigma which is a barrier to accessing life saving treatment. In the pilot phase there were 769 educators trained. Another 440 were trained through September 2006. The TLC also trained 2,294 educators in the months of October and November 2006. There continue to be many more requests for this training. In January and February 2007, there were 1,420 teachers trained. The total number of teachers trained in the Suicide Awareness Curriculum to date is 4,527. There are 16 additional trainings scheduled from March through November 2007 with a projected total to be trained of 1,475.

TLC has also provided information throughout the state on evidenced based student curriculum. There were regional informational workshops offered on the Signs of Suicide curriculum. These workshops were attended by over 400 school personnel, including administrators. Each TLC County Coordinator received a kit to assist schools in implementing the program. Information about the Columbia Teen Screen and other suicide prevention programs included in the Suicide Prevention Resource Center's National Registry of Evidence Based Programs and Practices was provided at the TLC's Fourth Annual Suicide Prevention Conference held in May 2006. It

featured Madelyn Gould, PhD, and David Schaffer, MD, and was entitled “Causes, Management and Prevention of Youth Suicide.” The conference was held in two locations to maximize accessibility. There 635 participants from schools, mental health centers, juvenile justice facilities and social service agencies.

The TLC has also added a second yearly statewide conference aimed at youth suicide prevention. A risk factor for developing maladaptive coping behaviors including suicide attempts and completions is the experience of physical and psychological trauma. The risk is greater when traumatic incidents are chronic or occur early in a child’s development. With this in mind, the TLC will be sponsoring a yearly conference focused on trauma and youth. In 2006, Eliana Gil, an internationally recognized expert in treating trauma in children, presented on The Art of Treating Traumatized Children and 518 attended the conference.

The TLC statewide conferences are popular and well attended. Evaluations are consistently excellent. Because of the growing number of participants, all of the conferences in 2007 will be offered in three locations throughout the state.

Further plans for youth suicide prevention in 2007 will focus on the training of clinicians in suicide assessment techniques. The targeted audience will be those clinicians in schools, mental health centers, private practice as well as those in screening centers and health care settings.

In February 2007, TLC Coordinator Donna Amundson, Somerset County TLC Coordinator Nicci Spinnazola and Middlesex County Coordinator George Scott were Macro Trained in the Chronological Assessment of Suicidal Events (CASE) Approach. This is a model created and taught exclusively by Dr. Shawn Shea. It is a highly refined and original approach that has evidence-based data, including expert face validity, clinician face validity (including quantitative data), and construct validity. The CASE Approach was designed to improve the accuracy of data collected during an interview with a potentially suicidal person, and to decrease errors of omission which may be the difference between life and death.

This training will enable the TLC to provide durable and sustainable training in the CASE approach throughout the state to clinicians in screening centers, behavioral health centers, juvenile justice facilities, school-based counseling programs, mobile outreach programs, and pediatricians and other primary-care physicians. These trainings will commence following the 5th Annual Suicide Prevention Conference in May 2007. Dr. Shea will be the presenter at the conference, “Unlocking Suicidal Secrets: New Approaches

to Assessment and Treatment Planning.” The conference will consist of four workshops taught by Dr. Shea, including “The Quest for a Resilient Happiness: Matrix Treatment Planning and Its Role in Suicide Assessment and Treatment Planning”; The Art of Spotting the Early Emergence Of Psychosis and Uncovering Dangerous Psychotic Process”; “Innovative Interviewing Techniques for Uncovering Sensitive Material: Suicidal Ideation to Antisocial Behavior”; and “The Delicate Art of Eliciting Suicidal Ideation: The Chronological Assessments of Suicidal Events.”

In addition to the statewide conferences, the TLC Coordinators also partnered in 2006 with other agencies in their respective counties to co-sponsor countywide conferences featuring national and international experts in their respective fields. These trainings focus on suicide prevention and include: “Adolescent Self-Injury,” presented in two counties with 200 and 250 attendees respectively; “Traumatic Effects of Bullying and Gang Culture: The Victim’s Perspective,” 100 attendees; “Substance Abuse and the Adolescent Brain,” 150 attendees; and “Adverse Childhood Experiences: Impact and Consequences for Our Youth,” 200 attendees.

Since its inception in 2001, the TLC has trained over 15,000 individuals throughout the state in mental health issues involving youth, suicide prevention, managing sudden traumatic loss in the schools, childhood grief, and post traumatic stress management through its coalition meetings, and county and statewide conferences.

Mobile Response Stabilization Services

The Division of Child Behavioral Health Services (DCBHS) also administers Mobile Response Stabilization Services as a key component to adolescent suicide prevention. In 2006, Mobile Response Stabilization Services served over 5,000 youth and successfully maintained their living situation over 90 percent of the time. MRSS provides in-home and community crisis intervention and intensive follow up, including clinical services on-site for up to eight weeks, as well as linkage to additional longer term services. Crisis plans are developed with each youth and family/caregiver and play a large role in avoiding more restrictive services as strategies are determined in advance of a recurrence so as to avoid disruption of the youth’s living situation that may increase stressors and place youth at additional risk.

DCBHS Data

It is vital that the services cited above and all those provided under the system of care are guided by evidence-based practices and driven by properly collected data, including data on suicide completions, attempts and ideations. The collection of additional data as part of the next DCF contract with the contracted system administrator will be an important part of ensuring that prevention or public education efforts and the resources available for those youth at risk of suicide are the best available to professionals and youth and their families.

Screening/Emergency Services

Children and youth experiencing a psychiatric crisis can access inpatient hospitalization through Screening /Emergency Services, which are available 24 hours a day, seven days a week typically within community hospitals' emergency service departments. Children's Crisis Intervention Services, located in community hospitals, are acute inpatient units which provide screening, stabilization, assessment and short-term intensive treatment. These units are licensed by the Department of Health and Senior Services following designation by DCBHS.

Detention Center Services

Through DCBHS, mental health services are also more accessible to youth in detention centers where immediate needs can be addressed. The most prominent services are the provision of clinical evaluations to youth who may never have had one. These are provided by licensed clinicians who follow a comprehensive template to assess a full scale of mental health issues which can then provide an entrée to appropriate and longer term care.

School-Based Services

Through the Division of Prevention and Community Partnerships, the New Jersey School-Based Youth Services Program is available at high schools, middle schools, and elementary schools around the state. This program allows students to receive social and wrap-around services right on campus. About 130,000 cases of one-to-one counseling or other services that promote healthy youth development were provided through the program in the 2005-06 school year.

Public Awareness Campaigns

The Department of Children and Families will work with the Traumatic Loss Coalition in outreach efforts to ensure careful planning so that any public awareness campaigns do not result in causing suicide ideations. DCF will also follow the policy and program parameters of the United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA.) The performance goals of SAMHSA's program are:

- Decrease in the number of persons of all ages attempting or committing suicide, particularly among high-risk groups.
- Provide effective suicide prevention, intervention, and treatment by health care professionals by increasing reach of SAMHSA-developed guidelines, protocols and best practices related to suicide prevention and early intervention.
- Increase rates at which individuals of all ages, genders, races and ethnicities seek treatment for clinical depression and other mental/substance abuse disorders that act as risk factors for suicide, including those who have made a suicide attempt.
- Fully implement the objectives of the National Strategy on Suicide Prevention through broad-based public/private partnerships.
- Increase awareness that suicide is a preventable public health problem.
- Better translation of new suicide prevention-related research to services and practices.

The Department of Children of Families will also work with SAMSHA on awareness and utilization of suicide prevention/early intervention messages, including SAMHSA/Ad Council Public Service Announcements.