



State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES

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To the Residents of New Jersey,

We are pleased to present you with the *New Jersey Youth Suicide Prevention State Plan 2011-2014*. This plan was developed by the Department of Children and Families (DCF) - Division of Child Behavioral Health Services (DCBHS) with input provided by the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC).

DCF would like to take this opportunity to thank the NJYSPAC for their work and ideas on the development of our Youth Suicide Prevention Plan. While this plan was edited and published by DCF and not all of the recommendations made by the NJYSPAC were utilized, the NJYSPAC deserves much credit for their dedicated work to present a quality draft plan to DCF. We thank you.

This plan has been developed to guide the State's efforts to prevent youth suicides. While New Jersey has a comparatively low rate of suicide, consistently ranking one of the fourth lowest in the United States, youth suicide remains the fourth leading cause of death for New Jersey's youth. We are dedicated to continuing to work to prevent youth suicides in New Jersey and this plan helps provide guidance for this important work.

Although New Jersey had not adopted a formal State plan for youth suicide prevention until now, for many years New Jersey has provided resources to suicide prevention in many ways including funding the Traumatic Loss Coalition for Youth (TLC). The TLC is a state-wide suicide prevention program funded by DCBHS and led by the University of Medicine and Dentistry of New Jersey (UMDNJ)-University Behavioral Health Care (UBHC). This program remains a strong initiative in our suicide prevention efforts. More information and the most recent TLC state report can be found at <http://ubhc.umdj.edu/brti/TLC.htm>.

Preventing youth suicide is a collaborative effort and we look forward to working in partnership with our communities to move this plan forward. We welcome your comments or questions at cbh_dcf@dcf.sate.nj.us.

Sincerely,

A stylized, dark ink signature of Jeffrey J. Guenzel.

Jeffrey J. Guenzel, MA, LPC
DCBHS Director

A cursive ink signature of Allison Blake.

Allison Blake, Ph.D., L.S.W.
Commissioner



New Jersey Youth Suicide Prevention Plan 2011 – 2014

**New Jersey
Department of Children and Families
Allison Blake, Ph.D., L.S.W
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Introduction

In 2008, sixty-eight individuals aged 24 years and younger completed suicide (New Jersey Office of the State Medical Examiner). This number places youth suicide as the fourth leading cause of death for New Jersey's youth (National Center for Injury Control and Prevention, Centers for Disease Control).

The New Jersey Department of Health and Senior Services, reports:

- Every month seventy New Jersey youth make a suicide attempt serious enough for hospitalization.
- Over forty percent of the suicide attempts by minors are subsequent to previous suicidal behaviors.
- Suicide attempts result in significant medical and non-medical costs and include physical, emotional, and psychological damage to the victims as well as to their families and friends.
- Clusters of suicide attempts and deaths of youth have been reported in New Jersey.

NJ Suicide Statistics Relative to Other States

Relative to other states, New Jersey has low suicide rates at all ages. New Jersey has ranked as one of the four lowest states for suicide rates in the country (Thomson Healthcare). The reasons for New Jersey's relatively good standing can be attributed in part to the implementation of state regulations, policies, guidance, and resources identified in the professional literature to successfully prevent youth suicide (Cecil G. Sheps Center).

NJ's Suicide Prevention Activities

There are many factors and actions that have aided the suicide prevention efforts in New Jersey. New Jersey has had strict laws restricting minor's access to guns. The State has mandated staff training in schools for suicide prevention and the detection of warning signs. New Jersey has mandated the establishment of psychiatric screening centers in every county that include crisis hotlines staffed 24 hours a day, seven days a week. In addition, beginning in 2001, New Jersey has developed a state-wide Mobile Response and Stabilization System (MRSS) for youth available in every county in the State. This program provides 24/7 in community crisis intervention in situations where there may not yet be suicidal gestures, but there are often significant risk factors. The MRSS program is also able to provide up to eight weeks of immediate in-home/in-community therapeutic interventions.

These efforts regarding New Jersey's suicide prevention activities were noted as a "promising practice" in a 2004 report by the Cecil G. Sheps Center at the University of North Carolina at Chapel Hill. The report also indicated that New Jersey has a high degree of collaboration among state and local organizations as exemplified by the makeup of the New Jersey Youth Suicide Prevention Council (NJYSPAC) which includes representatives from the New Jersey Department of Health and Senior Services, the Department of Children & Families, the

Department of Education, the Department of Human Services, the Division of Mental Health Services, and the Juvenile Justice Commission.

New Jersey's lead State agency for youth suicide prevention is the Department of Children and Families (DCF). As of the writing of this plan, DCF's lead youth suicide prevention program is the Traumatic Loss Coalition for Youth at the University of Medicine and Dentistry – University Behavioral Health Care. This program is funded by the Department of Children and Families – Division of Child Behavioral Health Services.

The Traumatic Loss Coalition (TLC) has operated as a county-based collaborative since the year 2000. Each county employs a Coordinator who conducts meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agencies, child welfare workers and many others who work closely with youth. The meetings are effective forums for reviewing traumatic loss events, identifying service needs, and providing professional development through the inclusion of an educational component. Speakers for the educational component are experts in topics related to the needs of youth. The Coordinators often collaborate with other agencies in their respective counties to co-sponsor workshops and conferences focused on issues pertinent to the mental health of the youth.

The Coordinators also work within their counties to direct a Lead Response Team (LRT) to assist schools when needed following a traumatic loss event, or as in the case of several counties, support the director of an existing team. Post Traumatic Stress Management (PTSM) training is provided for members of these teams.

The State report completed by TLC in 2010 indicated that in the 18 month period ending March, 2010:

- **3,991** individuals received on-site trauma response assistance to schools and communities including postvention after a death by suicide, homicide, accident or illness, and other critical incidents;
- **9,740** individuals attended training programs on mental health disorders and suicide prevention for youth-serving individuals and groups; and
- **2,448** individuals attended training programs for school and community personnel who must respond to the needs of youth in the aftermath of suicide, homicide, accidental death, and other critical incidents such as a natural disaster or terrorist strike (postvention).

The Traumatic Loss Coalitions for Youth Program has created an expanding statewide network that effectively works to prevent suicide and promote healing and resiliency in the aftermath of traumatic loss (UBHC, UMDNJ, Traumatic Loss Coalitions for Youth, 2010).

NJ Youth Suicide Prevention Advisory Council

In January of 2004 due to an overwhelming concern about youth suicide, The State of New Jersey created through legislation (N.J.S.A. 30:9A-22 et seq.) the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC). This purpose of the NJYSPAC is to examine existing needs and services and make recommendations to the Department of Children and Families for youth suicide reporting, prevention, and intervention; advise the Department of Children and Families on the content of informational materials to be offered to persons who are required to report attempted or completed suicides; and to advise the Department of Children and Families on the development of regulations pursuant to the act which created the NJYSPAC.

Everyone is affected by suicide. Council members are dedicated to youth suicide prevention and give freely of their time and commitment to developing strategies for suicide prevention and intervention.

***This plan is dedicated to the youth and families
whose life has been touched by suicide.***

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New Jersey’s Youth Suicide Prevention Plan

In 2001, the U.S. Department of Health and Human Services released a report entitled, “National Strategy for Suicide Prevention: Goals and Objectives for Action.” This report described suicide as a serious public health problem throughout the United States, and introduced a blueprint for addressing suicide prevention. The Surgeon General also recommended that each state adopt a youth suicide prevention plan that would incorporate the national recommendations.

This New Jersey Youth Suicide Prevention Plan seeks to build on the existing efforts in New Jersey by remaining focused on the risk and protective factors associated with the prevention of suicide in children, youth, and young adults. The plan outlines goals, rationale, and objectives for increasing the prevention effort throughout the state. Achieving these goals will require the continued partnership and collaboration among all stakeholders. Accountability for the goals will necessitate that all stakeholders work in concert with each other focused upon the needs of our children, youth, young adults, their families, and support networks.

The plan presents the overall goals for the prevention of suicide and is broken down into ten sections. Found within each section are specific objectives. The sections and format of the plan were not arbitrary. Rather the plan was modeled in content and in form after the 2001 National Strategy for Suicide Prevention and the joint Suicide Prevention Resource Center and SPAN USA 2010 Progress Review of the National Strategy.

New Jersey’s Youth Suicide Prevention Plan Goals

	Goals
1	Improve and expand surveillance systems;
2	Promote awareness that suicide is a preventable public health problem;
3	Develop broad-based support for youth suicide prevention;
4	Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services;
5	Strengthen and expand community-based suicide prevention and postvention ¹ programs;
6	Implement professional training programs for those who are in regular contact with youth at-risk for self-injury or suicide;
7	Develop and promote effective clinical practices to reduce suicide attempts and completions;
8	Promote access to mental health and substance abuse services;
9	Improve reporting and portrayals of suicide, mental illness, and substance use in the electronic and print media; and
10	Promote and support research on youth suicide and suicide prevention, its dissemination and incorporation into clinical practice and public health efforts.

¹ A strategy or approach that is implemented after a crisis or traumatic event has occurred

Goal # 1: Improve and expand surveillance systems.

Rationale

The quality of surveillance data on completed suicides is relatively high in New Jersey due to our state's participation in the CDC-funded National Violent Death Reporting System. The New Jersey Violent Death Reporting System (NJVDRS) is a detailed surveillance system of all violent fatalities, which integrates medical examiner, death certificate, and law enforcement data to provide accurate and timely data on all suicides. Additionally, the NJVDRS provides detailed information about suicide circumstances, and how they differ for adolescents as compared with those in other age groups. Despite this, death certificates sometimes fail to correctly identify suicides as the cause of the death. Information on completed suicides is obtained from the New Jersey Department of Health and Senior Services, Vital Records, as coded by medical examiners on death certificates. A problem arises in those ambiguous youth deaths where suicide is suspected, but no clear evidence is available to make a definitive statement of this specific cause. In those cases, the medical examiners will enter another code based on secondary circumstances surrounding the death (e.g., substance abuse, motor vehicle accident, undetermined, unintentional). This problem leads to potential under-reporting of youth suicide.

Data on suicide attempts or ideation are lacking and are similarly affected by some of the same surveillance challenges noted above. These data are expected to be collected by mental health providers, screening centers, and emergency room personnel. But there are gaps in how these data are collected and made available for further review by prevention initiatives.

A related issue is the extent to which information on youth suicide from schools is utilized regarding broad-based prevention efforts. The New Jersey Board of Education requires public middle and high school students to complete the New Jersey Student Health Survey, which is administered periodically to middle and high school students in the state. This survey asks about depression, suicide plans, ideation, and attempts. However there is an enormous discrepancy between the prevalence of self-reported attempts and the prevalence as captured by hospital discharge data, suggesting that the majority of these self-reported attempts are relatively low in terms of lethality. As adolescents age, their rate of reporting suicidal plans and attempts declines, while the rate of actual attempts increases. This is a serious problem as a 2009 nationwide survey of youth in grades 9-12 in public and private schools in the United States (U.S.) found that 13.8 % of students reported seriously considering suicide, 10.9 % reported creating a plan, and 6.3 % reported trying to take their own life in the 12 months preceding the survey (CDC Youth Risk Behavior Surveillance).

Objectives:

- 1.1 The Department of Children and Families will publish an annual report on suicide in New Jersey that integrates data from multiple state data management systems.
- 1.2 Improve coordination of data collection regarding suicide investigations with state, local agencies, and their partners.

1.3 Establish surveillance mechanisms across entities that track the use of mental health services as well as suicide attempts.

1.4 Establish a mechanism for systematic collection and analysis of suicide attempt data.

Goal # 2: Promote awareness that suicide is a preventable public health problem.

Rationale

Many individuals are not aware that suicide is the fourth leading cause of youth death in New Jersey. Therefore, enhanced awareness that suicide is a serious public health issue is expected to influence people to be more vigilant about identifying the risk of suicide in themselves, peers, and others.

Increased awareness should result in more caregivers of children, youth and young adults to seek assistance when there is a risk of suicide. Awareness among policy makers may result in efforts to modify policies and to allocate resources toward suicide prevention efforts.

Objectives

2.1 Develop and implement a public information campaign that explains that suicide in youth is preventable and is related to mental health, substance abuse and other at-risk behaviors.

2.2 Establish and enhance existing mechanisms and structures for suicide prevention designed to foster collaboration with stakeholders and the general public on prevention strategies across disciplines.

2.3 Increase the number and quality of both public and private institutions that are involved in collaborative and complementary dissemination of current suicide prevention information on the Internet.

2.4 Promote awareness of youth suicide as a public health issue in communities through community-based organizations.

2.5 Increase awareness of suicide risk and prevention strategies for all providers of DCF out-of-home services including resource homes, treatment homes, and various residential placements.

Goal # 3: Develop broad-based support for youth suicide prevention.

Rationale

Because youth suicide and attempts are the result of complex, multidimensional biological and psychosocial factors, the prevention of suicide requires an ecological, multidisciplinary approach. Similar collaborative efforts will be required at the state and local levels in New

Jersey. These collaborative efforts like NJYSPAC will need public and private partnerships at the local, state and national level to generate the greatest impact regarding suicide prevention.

The National Strategy for Suicide Prevention supports the development of collective leadership and of increasing the variety of groups working to prevent suicide. This effort applies to the state and local level. The development of broad-based support for suicide prevention will require ready access to information, research, literature resources, best practices, and program models. This effort will include the identification of multiple sites that can disseminate these resources.

Objective

3.1 Encourage agencies and organizations involved in suicide prevention to work within a collaborative framework at the state and local level.

3.2 Promote access to materials such as monographs, periodicals, videos, outreach posters, information pamphlets, electronic communication and related materials on suicide prevention in New Jersey.

3.3 Increase the number of state, local, professional, volunteer, and other groups that can integrate suicide prevention activities into their ongoing programs and activities.

3.4 Include suicide prevention information on the DCF website and encourage DCF contracted agencies to include suicide prevention information on their websites.

Goal # 4: Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse and suicide prevention services.

Rationale

Harris and Barraclough, 1997, found that sixty to ninety percent of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder (National Strategy for Suicide Prevention). The negative stigma of mental illness and substance abuse prevents many children, youth and young adults from seeking assistance and has contributed to the silence and shame associated with mental health problems and suicide. Family members of those surviving a suicide attempt often hide the behavior from those that could help or provide support, believing that it reflects badly on their own relationship with the suicide attempter or that attempting suicide is shameful or sinful (National Strategy for Suicide Prevention).

Objective

4.1 Increase coordination among state agencies and entities such as the Governor's Anti-stigma Council and DCF to decrease stigma.

4.2 Increase public knowledge that mental health and physical health are intertwined components of overall health.

4.3 Increase public knowledge that mental illness and substance abuse, similar to physical illness, respond to specific treatments.

4.4 Increase public knowledge that consumers of mental health, substance abuse, and suicide prevention services are pursuing fundamental care and treatment for their overall health.

4.5 Encourage professional groups, associations, and individuals to address the issue of stigma associated with using mental health and substance abuse services.

Goal # 5: Strengthen and expand community-based suicide prevention and postvention programs.

Rationale

Effective suicide prevention requires a broad-based community commitment. Although there is not any one “suicide type,” there are youth who are at a higher risk based on particular risk factors. To help youth in need, community professionals and organizations must mobilize resources, identify risk and protective factors, and bring focused attention to the issue of suicide.

Successful suicide prevention, intervention and postvention strategies are based on the public health approach. Evidence-based methods are needed. Evaluations are also needed as programs are developed and implemented. The science of suicide prevention is still developing. Therefore, emerging strategies, promising practices, and other strategies with a foundation based in best practices may be used in addition to existing evidence-based strategies. These programs require an even more rigorous evaluation process to measure effectiveness.

Objectives

5.1 Expand and improve training efforts in suicide prevention to increase knowledge regarding best practices for suicide prevention, intervention and postvention for community-based organizations and schools.

5.2 Improve coordination with cultural and faith-based entities to share resources and information on issues of suicide.

5.3 Focus specific suicide prevention and postvention efforts towards higher risk populations such as adolescents, college students, gay/lesbian/bisexual/transgender youth, immigrants, non-English speaking youth, those addicted to and/or abusing substances, and youth in the correctional/juvenile justice system or other out-of-home settings.

Goal # 6: Implement professional training programs for those who are in regular contact with youth at-risk for self injury or suicide.

Rationale

There are many different settings where trained personnel can intervene with youth at-risk for self-injury or suicide. Pirkis & Burgess, 1998, found that approximately 45 percent of all individuals who die by suicide have had some contact with a mental health professional within the year of their death (National Strategy for Suicide Prevention). Trained personnel who come into contact with youth at risk for suicide are referred to as “key gatekeepers.” Key gatekeepers include, but are not limited to, teachers, clergy, police, resource parents, physicians, nurses, and therapists. Providing appropriate training for this broad array of key gatekeepers is an opportunity to enhance suicide prevention efforts.

Objectives

6.1 Maintain and expand key gatekeeper suicide prevention training programs in New Jersey to ensure adequate recognition and treatment of youth who are at-risk for suicide.

6.2 NJYSPAC will make concrete and specific recommendations to DCF about the adequacy of existing training for DCBHS and DMHS providers and about improvement, including specific curricula, which are preferable.

6.3 Maintain training programs in the recognition and treatment of risk factors associated with suicide across disciplines, including physical and mental health and substance abuse systems, legal systems, the education systems, and religious organizations. These trainings should include instruction on the identification of persons at risk, appropriate counseling, and referral to community-based services.

6.4 NJYSPAC will make specific recommendations to DCF:

6.4.1 That identifies who the “key gatekeepers” are; determine how they are organized across the state; recommend engagement strategies for each group; and suggests courses of action for engagement in youth suicide prevention efforts.

6.4.2 That identify preferred youth suicide prevention training strategies for key gatekeeper groups; training strategies will be cognizant of and sensitive to the particular mission, goals, needs, and organizational structures of each group.

Goal # 7: Develop and promote effective clinical practices to reduce suicide attempts and completions.

Rationale

For every youth who completes suicide there are many others who have made non-lethal attempts. Professionals in the health and mental health/substance abuse fields, clergy, education, and law enforcement are involved in the identification and referral of people at-risk for suicide. Service referrals should be made to programs evidencing high quality services, best practices and evidence based treatments when possible and appropriate. The quality of treatment for at-risk youth will be improved by the identification and implementation of these effective clinical practices. It is essential that all referral sources know how and where to locate providers whose practices are evidence based and reliant upon best practices. It is necessary that individuals at risk for suicide are engaged in prompt and effective treatment.

Objectives

7.1 DCF will facilitate interdepartmental collaboration to develop and promote best practice on the recognition of the antecedents of suicidal behavior.

7.2 Identify, disseminate and train the various provider groups on evidence-based and best practice guidelines in the diagnosis and treatment of suicide and self-injury. The primary audiences for this effort may include emergency care providers, primary care providers, mental health care providers, substance abuse providers, juvenile corrections personnel, school personnel, clergy, and other professionals who work with youth at-risk for suicide. Training should support providers efforts to treat youth at high-risk for suicide, youth that attempt suicide, and families, friends and those likely to be affected by a suicide or suicide attempts.

7.3 Promote, and support evidence-based and best practice guidelines for prevention and treatment of suicide or self-injury.

7.4 Facilitate the training of providers who treat children, youth, and young adults who are suicidal in best practices and evidenced based treatments.

Goal # 8: Promote access to mental health and substance abuse services.

Rationale

Youth with untreated mental health and substance abuse problems are at high risk for suicide; therefore, access to high quality mental health and substance abuse services is critical. Barriers to access should be reduced and linkages among various community agencies, mental health, and substance abuse treatment programs need to be enhanced. Where possible, services should be integrated and coordinated to avoid conflicting policies from potential funding sources.

Objectives

- 8.1 Identify and address barriers to mental health and substance abuse services.
- 8.2 Increase community awareness of risk behavior and increase awareness of culturally competent and linguistically relevant services.
- 8.3 Work with all appropriate state departments to increase access to an integrated network of effective, efficient, culturally competent and linguistically accessible mental health and substance abuse services that include suicide prevention and counseling services.
- 8.4 Promote DCF's youth helpline, "2nd Floor." Continue to enhance this helpline's ability to respond to youth at risk and explore potential for this helpline serving as a National Suicide Prevention Lifeline networked hotline.
- 8.5 Increase the number of calls answered in New Jersey from New Jersey residents that call the National Suicide Prevention Lifeline. Identify, coordinate, and prepare New Jersey based hotlines to serve as a recipient of National Suicide Prevention Lifeline calls.
- 8.6 Encourage all DCF contracted agencies to promote NJ Mental Health Cares helpline as a resource for families seeking mental health services.

Goal # 9: Improve reporting and the depiction of suicide, mental illness, and substance use in the electronic and print media.

Rationale

Media representations of suicide can potentially influence the suicidal thoughts and actions of youth. The collaborative efforts of the American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center with support from the Centers for Disease Control, National Institute of Mental Health, Office of the Surgeon General, and Substance Abuse and Mental Health Services Administration have issued guidelines for reporting on suicide.

Objectives

- 9.1 Disseminate information on nationally recognized guidelines for reporting about suicide with an effort to reduce the stigma and prevent future suicides.
- 9.2 Utilize the nationally recognized guidelines outlined in the Reporting on Suicide: Recommendations for the Media (Annenberg Public Policy Center 2001) for reporting on suicide and local experts on suicide and suicide prevention for consultation and training with the media and academic programs in journalism.
- 9.3 Work with New Jersey academic journalism programs to include guidance on the appropriate depiction and reporting of mental illness, suicide and self-injury in their curricula.

Goal # 10: Promote and support research on youth suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Rationale

Suicide prevention is a growing field, with an expanding knowledge base. More youth suicide prevention programs have been evaluated and resources are available to help community-based programs evaluate their suicide prevention efforts. Additional research on suicide prevention efforts and information from an increased number of evidence-based practices needs further systematic replication and evaluation.

Suicide prevention efforts at the state and local program level can be strengthened by promoting research-based strategies, using research in program planning and development, collection of data on process and outcome and an evaluation component for each program. There is a need for more training in evaluating suicide prevention efforts.

Objectives

10.1 Promote ongoing dissemination of evidence-based suicide prevention models and use of research-based strategies for suicide prevention.

10.2 Encourage all New Jersey suicide prevention programs to review best-practice and evidence-based research and to include an evaluation component that demonstrates outcome effectiveness.

10.3 Increase the number of suicide prevention programs that conduct program-specific research or participate in research and evaluation efforts of others.

10.4 Establish and maintain a directory of suicide prevention programs with demonstrated effectiveness as recognized by best-practice.

Next Steps

This plan is a three (3) year plan; however it is designed to be a base for longer range planning as well. Not all of the objectives listed in this plan will be able to be met within three years and will carry over to future plans. It is the hope of DCF that the NJYSPAC will provide ongoing recommendations for suicide prevention and planning and this State plan may be amended as often as annually. At a minimum, the plan will be fully reviewed and updated every three (3) years.

DCF will continue to accept and review all advice and recommendations provided by the NJYSPAC. The NJYSPAC will meet on a regular schedule and DCF will provide a liaison to the NJYSPAC.

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