NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

Updated 2012 Adolescent Suicide Report:

A Data Overview and Prevention Activities Report on Youth Suicide in New Jersey

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COMMISSIONER
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Executive Summary

In June 2012, the New Jersey Department of Children and Families issued its , *Adolescent Suicide Report: A Data Overview and Prevention Activities Report on Youth Suicide in New Jersey*[1] which included New Jersey suicide data for 2007 – 2009 and attempted suicide data for 2005 - 2009 This current, updated report includes data concerning suicides and attempted suicides for 2009-2011. This report also focuses on the prevention efforts outlined in the June 2012 report, as well as new initiatives undertaken since that report was issued.

Although New Jersey has had the lowest state-level adolescent suicide rate for more than a decade[2], this reality provides little consolation to friends and family who may have lost a loved one to suicide. The suicide and attempted suicide data for the 2009-2011 revealed the following:

Suicides

- There were 234 total suicides from 2009-2011.[3]
- 162 (69%) of the 234 suicides were young people ages 19-24.
- The New Jersey suicide rate per 100,000 youth ages 10-24 for 2010 was 5.3. The rate for 2011 was 4.2.
- The primary method of suicide for ages 10-24 during 2009-2011 was hanging/strangling/suffocation.

Attempts

- The attempted suicide rate per 100,000 youth ages 10-24 resulting in hospitalization was approximately 46.
- The attempted suicide rate per 100,000 youth ages 10-24 resulting in emergency department treatment was 49.
- As is the norm, the attempted suicide rate for females (resulting in either hospitalization or in emergency department treatment) was significantly higher than the rate for males.

Since the publication of the June 2012 report, there have been ongoing prevention and public awareness efforts undertaken by the Department of Children and Families (DCF). Those efforts include:

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[1] New Jersey Department of Children & Families Adolescent Suicide Report: A Data Overview and Prevention Activities Report on Youth Suicide in New Jersey. Available online at: http://www.state.nj.us/dcf/families/csc/prevention/.

[2] Guild PA, Freeman VA, Shanahan, E. Promising Practices to Prevent Adolescent Suicide: What We Can Learn from New Jersey. Cecil G. Sheps Center for Health Services Research. University of North Caroline at Chapel Hill.

[3] Please note, the June 2012 report also included 2009 data (suicide data for the years 2007-2009; and attempt data for the years 2005-2009). Therefore, there is one year of overlap in the data discussed in this report and the June 2012 report.

- The U.S. Department of Health and Human Services' Substance Abuse Mental Health Services Administration (SAMHSA) awarded a Garrett Lee Smith youth suicide prevention grant to the Traumatic Loss Coalition (TLC), a unit of the University of Medicine and Dentistry of New Jersey (UMDNJ) - University Behavioral HealthCare (UBHC), the lead youth suicide prevention program for DCF.
- The "Jersey Voice" website, a collaborative effort involving TLC that uses social media to reach youth and young adults in the channels in which they communicate, was launched in 2012. The website provides peer-to-peer support, suicide prevention, intervention, and postvention.
- In November 2012, DCF and the New Jersey Department of Human Services (DHS) are issuing a joint report reviewing the effectiveness and sufficiency of services provided by the New Jersey-based suicide prevention hotlines.
- In September 2012, the Mental Health Association in New Jersey and UMDNJ-UBHC both became certified members of the *National Suicide Prevention Lifeline Network* (*Lifeline*) in order to provide in-state crisis line backup coverage to help ensure that more crisis calls made to *Lifeline* by New Jersey residents are answered in New Jersey.

The Department continues to enhance and build upon its adolescent suicide prevention efforts, as evidenced by the recent award of the Garrett Lee Smith adolescent suicide prevention grant.

Introduction

This report on suicidal behavior among New Jersey adolescents is presented to Governor Christie, the New Jersey State Legislature, and the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC) by the Department of Children and Families (DCF) pursuant to *N.J.S.A. 30:9A-27*. This report contains a summary of the data compiled by the DCF-Division of Children's System of Care (CSOC). It includes aggregate demographic information about youth who attempt or commit suicide, current prevention efforts and recommendations for future activities. This report also focuses on the prevention and postvention efforts outlined in the June 2012 report, as well as new initiatives undertaken since that report was issued.

Data Overview

As reported in the June 2012 report, there are inherent challenges in data reporting for suicides. Nationally, medical examiners, hospitals, police, emergency service personnel, and similar entities are required to report deaths from suicide. However, there are no consistent criteria, definition or data elements that must be reported. At the local and state levels, this is reflected in differences in the definition of suicide, how cases are

classified, how they differ in terms of the extent to which potential suicides are investigated and how accurately they determine cause of death.

In New Jersey, which has a county medical examiner system, practices from county to county can differ and ensuring that uniform forensic investigatory policies and procedures are consistent with the recommendations of the National Association of Professional Medical Examiners is challenging.[4]

The quality of data on suicide attempts is even more tenuous than that of suicides.[5] At the Federal level there is no systematic or mandatory reporting of nonfatal suicidal behavior. Estimated suicide attempt rates uses only the data for individuals who received medical treatment.[6] This results in significant underestimates of true rates as research indicates that over 50% of individuals who engage in suicidal behavior never seek health services.[7] Data collection is further complicated for adolescents, as they exhibit more non-fatal suicidal behavior than any other age group.[8]

The Youth Risk Behavior Surveillance System Survey (YRBSS), which is administered periodically to New Jersey middle and high school students, asks about depression, thoughts of suicide, suicide plans and attempts.

There is also no systemic uniform practice for first responders to speak with family members about the mental health history and recent behaviors of an individual who committed suicide or who may have made an attempt.[9]

Data, tables and figures in this report have been obtained from the following sources:

- The New Jersey Violent Death Reporting System (NJVDRS) 2009-2011[10]. New Jersey Department of Health, Center for Health Statistics, Office of Policy & Strategic Planning.
- The Hospital data is from the New Jersey Discharge Data System, Inpatient data and Emergency Department data 2009-2011. New Jersey Department of Health, Center for Health Statistics, Office of Policy & Strategic Planning.
- The Centers for Disease Control (CDC) 2011 Youth Risk Behavior Surveillance System Survey (YRBSS).

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[4] New Jersey Child Fatality & Near Fatality Review Board 2010 Annual Report. Available online at: http://www.state.nj.us/dcf/documents/about/commissions/fatality/CFNFRBAnnualReport2010.pdf

[5] Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, editors Reducing Suicide A National Imperative (2002).

[6] Ibid.

[7] Crosby AE, Cheltenham MP, Sacks JJ. Incidence of suicidal ideation and behavior in the United States, 1994. Suicide and Life - Threatening Behavior.1999; 29:131-140.

[8] National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available online at: www.cdc.gov/ncipc.

[9] Ibid.

[10] Please note, the June 2012 report also included 2009 data (suicide data for the years 2007-2009; and attempt data for the years 2005-2009). Therefore, there is one year of overlap in the data discussed in this report and the June 2012 report.

- The N.J. Gay, Lesbian & Straight Education Network (GLSEN) 2007 and 2009 reports.[11,12]
- DCF's Adolescent Suicide Report: A Data Overview and Prevention Activities Report on Youth Suicide in New Jersey.[13]
- The New Jersey Hotline Survey.
- Rates are not calculated for fewer than 20 observations.
- Rates are per 100,000 individuals for the age-specific population.
- Percents are not calculated for fewer than 5 observations.

Scope of the Challenge

Of the 234 suicides from 2009-2011, 162 or approximately 69%, were by college-aged youth 19-24. This is nearly identical to the percentage of suicides this age group accounted for between 2007-2009. The New Jersey suicide rate for 2010 and 2011 was 5.3 and 4.2, respectively.

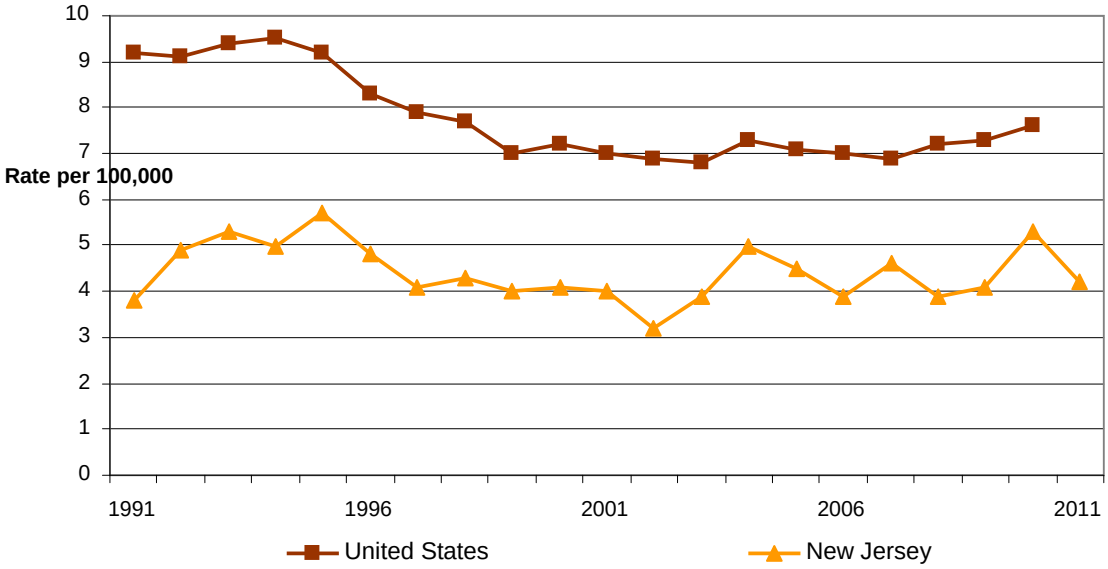
As noted in the June 2012 report, there are those youth who are at an increased risk for suicide. Those youth include Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth, Latina adolescents, African-American males, college and university students, juvenile justice-involved youth, and youth in out-of-home placements.

Confirmed Suicides

Figure 1, below, provides the New Jersey and the national suicide rates for youth ages 10-24 since 1991. For New Jersey, the adolescent suicide rate for 2011 was 4.2. That figure represents a decrease from the 2010 rate of 5.3. While the national suicide rate was not available for 2011, New Jersey's rate remains significantly lower than the national average of 7.6 for 2010, the most recent year for which data is available.

[11] GLSEN 2007 National School Climate Survey. Available online at: http://www.glsen.org/cgi-bin/iowa/all/news/record/2340.html.
[12] GLSEN 2009 National School Climate Survey. Available online at: http://www.glsen.org/cgi-bin/iowa/all/news/record/2624.html.
[13] New Jersey Department of Children & Families Adolescent Suicide Report: A Data Overview and Prevention Activities Report on Youth Suicide in New Jersey. Available online at: http://www.state.nj.us/dcf/families/csc/prevention/.

Figure 1
Suicide rate, United States and New Jersey, ages 10-24 years, 1991-2011



Rates are per 100,000 age-specific population.
Data sources: Web-based Injury Statistics Query and Reporting System (WISQARS) (US and NJ 1991-2011). November 26, 2012.

Age, Gender, County of Residence

Of the 234 youth suicides in New Jersey from 2009-2011, 162 or 69%, were by young people age 19-24. Males accounted for 191 (approximately 82%) of all suicides and of that number, 132 (approximately 69%) were males age 19-24.

Bergen and Monmouth were by far the counties with the highest incidence of adolescent suicide for 2009-2011. Of the 23 suicides in Bergen for the period, 15 were males age 19-24. For Monmouth, 13 of the 23 suicides for the period were males age 19-24. Camden County, which had the highest incidence of adolescent suicide for 2007-2009 (21), had a significant decrease in adolescent suicide for 2009-2011 (9). Please see Table 1 below.

Table 1. Suicides by age group, gender and county of residence, New Jersey, 2009-2011

	Age Group & Gender						
	Male			Female			Total
County of residence	10-18	19-24	10-24	10-18	19-24	10-24	10-24
Atlantic	0	4	4	1	1	2	6
Bergen	4	15	19	1	3	4	23
Burlington	2	9	11	1	2	3	14
Camden	2	4	6	2	1	3	9
Cape May	1	1	2	0	0	0	2
Cumberland	3	9	12	0	1	1	13
Essex	3	8	11	1	3	4	15
Gloucester	4	6	10	0	2	2	12
Hudson	5	12	17	0	2	2	19
Hunterdon	1	2	3	0	1	1	4
Mercer	1	8	9	2	3	5	14
Middlesex	4	7	11	2	2	4	15
Monmouth	8	13	21	2	0	2	23
Morris	3	3	6	0	2	2	8
Ocean	4	6	10	0	2	2	12
Passaic	4	7	11	0	3	3	14
Salem	0	1	1	0	0	0	1
Somerset	4	5	9	0	0	0	9
Sussex	2	2	4	0	0	0	4
Union	2	4	6	1	2	3	9
Warren	2	5	7	0	0	0	7
Unknown	0	1	1	0	0	0	1
Total	**59**	**132**	**191**	**13**	**30**	**43**	**234**

**Rates are not calculated for fewer than 20 observations. Rates are per 100,000 age-specific population.
The New Jersey Violent Death Reporting System v.11152012. Center for Health Statistics, Office of Policy and Strategic Planning

Suicide Rates by Age Group and Gender

As Table 2 illustrates, the male suicide rate for the period 2009-2011 was 7.2 per 100,000. The female rate for the same period was 1.7. The respective rates are consistent with research that shows that males commit suicide at a much higher rate than females.

Table 2. Suicides by age group and gender, New Jersey, 2009-2011

	Age Group				Total	
	10-18		19-24		10-24	
Gender	N	Rate	N	Rate	N	Rate
Male	59	3.6	132	13.1	191	7.2
Female	13	**	30	3.2	43	1.7
Total	**72**	**2.2**	**162**	**8.3**	**234**	**4.5**

**Rates are not calculated for fewer than 20 observations. Rates are per 100,000 age-specific population.
The New Jersey Violent Death Reporting System v.11152012. Center for Health Statistics, Office of Policy and Strategic Planning

Primary Method

As Table 3 below shows, the primary method of suicide for adolescents during 2009-2011 remained hanging/strangling/suffocation. Firearms remained the second most frequent method (especially for males who accounted for 34 out of 36 firearm deaths), followed by poisoning.

Table 3. Suicides by age group, gender and method/weapon used, New Jersey, 2009-2011

	Age Group & Gender						
	Male			Female			Total
Method/Weapon	10-18	19-24	10-24	10-18	19-24	10-24	10-24
Firearm	13	21	34	1	1	2	36
Non-powder gun	0	0	0	1	0	1	1
Sharp instrument	0	0	0	0	0	0	0
Poisoning	6	12	18	1	10	11	29
Hanging, strangulation, suffocation	28	78	106	8	15	23	129
Fall	3	3	6	0	1	1	7
Drowning	1	4	5	1	1	2	7
Fire or burns	0	2	2	0	0	0	2
Motor vehicle	3	3	6	0	1	1	7
Other transport (train)	5	8	13	1	1	2	15
Other	0	1	1	0	0	0	1
Unknown Weapon	0	0	0	0	0	0	0
Total	**59**	**132**	**191**	**13**	**30**	**43**	**234**

**Rates are not calculated for fewer than 20 observations. Rates are per 100,000 age-specific population.
The New Jersey Violent Death Reporting System v.11152012. Center for Health Statistics, Office of Policy and Strategic Planning

Race and Ethnicity

For the period 2009-2011, Asian/Pacific Islander youth 10-24 represented 5% of total suicides (Table 4) in New Jersey. Black youth represented 15% of total suicides for this age group. White youth accounted for nearly 62% of total youth suicides for the 10-24 age group. Hispanics accounted for 17% of all suicides. This represents a significant increase over the 9% of youth suicides for which Hispanics accounted during the 2007-2009 period.

Table 4. Suicides by age group and race/ethnicity, New Jersey, 2009-2011

	Age Group		Total
Race/ethnicity	10-18	19-24	10-24
White Non-Hispanic	46	99	145
Black Non-Hispanic	12	23	35
Hispanic	11	29	40
Asian/Pacific Islander	2	10	12
Other Race	1	1	2
Total	**72**	**162**	**234**

**Rates are not calculated for fewer than 20 observations. Rates are per 100,000 age-specific population.
The New Jersey Violent Death Reporting System v.11152012. Center for Health Statistics, Office of Policy and Strategic Planning

Attempted Suicides

As noted in the June 2012 report, fortunately, the vast majority of New Jersey youth who attempt suicide do not ultimately commit suicide. This section provides data concerning youth suicide attempts in New Jersey for the period 2009-2011.

Age Group, Gender, County of Residence

The data for New Jersey is consistent with the national research that indicates female adolescents have a higher rate of suicide attempts compared to adolescent males.[14] Table 5, below, provides the rate of non-fatal suicide attempts/self-inflicted injuries resulting in hospitalization.[15] Table 6, below, provides non-fatal suicide attempts/self-inflicted injuries resulting in Emergency Department treatment.

For the period of 2009-2011, there were 4,889 total suicide attempts resulting in either hospitalization or emergency department treatment. Of that number 2,360 (48%) required inpatient hospitalization and 2,529 (52%) resulted in Emergency Department treatment.

[14] Ibid.

[15] Inpatient hospitalization means at least one overnight stay.

Table 5. Non-fatal suicide attempts/self-inflicted injuries resulting in hospitalization, by age group, gender and county of residence, New Jersey 2009-2011

	Male		Female		Total	
	10-24		10-24		10-24	
County of residence	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**
Atlantic	23	27.1	43	52.5	66	39.6
Bergen	77	30.2	114	47.4	191	38.6
Burlington	49	35.5	86	69.9	135	51.7
Camden	84	52.6	123	80.4	207	66.2
Cape May	15	**	15	**	30	59.9
Cumberland	22	44.9	28	62.0	50	53.1
Essex	58	23.7	117	49.1	175	36.2
Gloucester	31	33.2	45	51.2	76	41.9
Hudson	49	26.7	89	52.5	138	39.1
Hunterdon	13	**	18	**	31	41.6
Mercer	41	34.3	83	71.4	124	52.6
Middlesex	75	29.0	133	55.3	208	41.6
Monmouth	92	48.1	122	67.9	214	57.7
Morris	41	28.7	76	57.0	117	42.4
Ocean	64	40.9	76	51.1	140	45.9
Passaic	41	25.1	114	71.7	155	48.0
Salem	21	104.7	16	**	37	95.3
Somerset	29	30.9	36	41.5	65	36.0
Sussex	41	88.9	36	84.8	77	86.9
Union	31	19.2	59	38.5	90	28.6
Warren	12	**	22	72.0	34	54.0
Total	**909**	**34.2**	**1,451**	**57.9**	**2,360**	**45.7**

*Race and ethnicity in hospital discharge data are known to be inconsistent, and these **data should be used with caution**. **Rates are not calculated for fewer than 20 observations. New Jersey Hospital Discharge Data System, Inpatient data. Center for Health Statistics, Office of Policy and Strategic Planning.

Table 6. Non-fatal suicide attempts/self-inflicted injuries treated in the Emergency Department and released, by age group, gender and county of residence, New Jersey 2009-2011

	Male		Female		Total	
	10-24		10-24		10-24	
County of residence	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**
Atlantic	18	**	35	42.7	53	31.8
Bergen	60	23.6	80	33.2	140	28.3
Burlington	30	21.7	57	46.3	87	33.3
Camden	48	30.1	94	61.4	142	45.4
Cape May	4	**	6	**	10	**
Cumberland	42	85.6	41	90.8	83	88.1
Essex	99	40.4	138	58.0	237	49.1
Gloucester	36	38.6	40	45.5	76	41.9
Hudson	48	26.2	74	43.6	122	34.6
Hunterdon	12	**	23	67.8	35	47.0
Mercer	81	67.8	134	115.3	215	91.2
Middlesex	121	46.7	146	60.7	267	53.4
Monmouth	92	48.1	87	48.4	179	48.3
Morris	24	16.8	43	32.2	67	24.3
Ocean	99	63.3	137	92.2	236	77.4
Passaic	38	23.2	81	50.9	119	36.9
Salem	14	**	16	**	30	77.2
Somerset	97	103.3	107	123.4	204	113.0
Sussex	19	**	40	94.2	59	66.6
Union	53	32.8	72	47.0	125	39.7
Warren	16	**	27	88.4	43	68.3
Total	**1,051**	**39.5**	**1,478**	**60.0**	**2,529**	**48.9**

*Race and ethnicity in hospital discharge data are known to be inconsistent, and these **data should be used with caution**. **Rates are not calculated for fewer than 20 observations. New Jersey Hospital Discharge Data System, Emergency Department data. Center for Health Statistics, Office of Policy and Strategic Planning.

Youth Risk Behavior Surveillance System Survey (YRBSS)

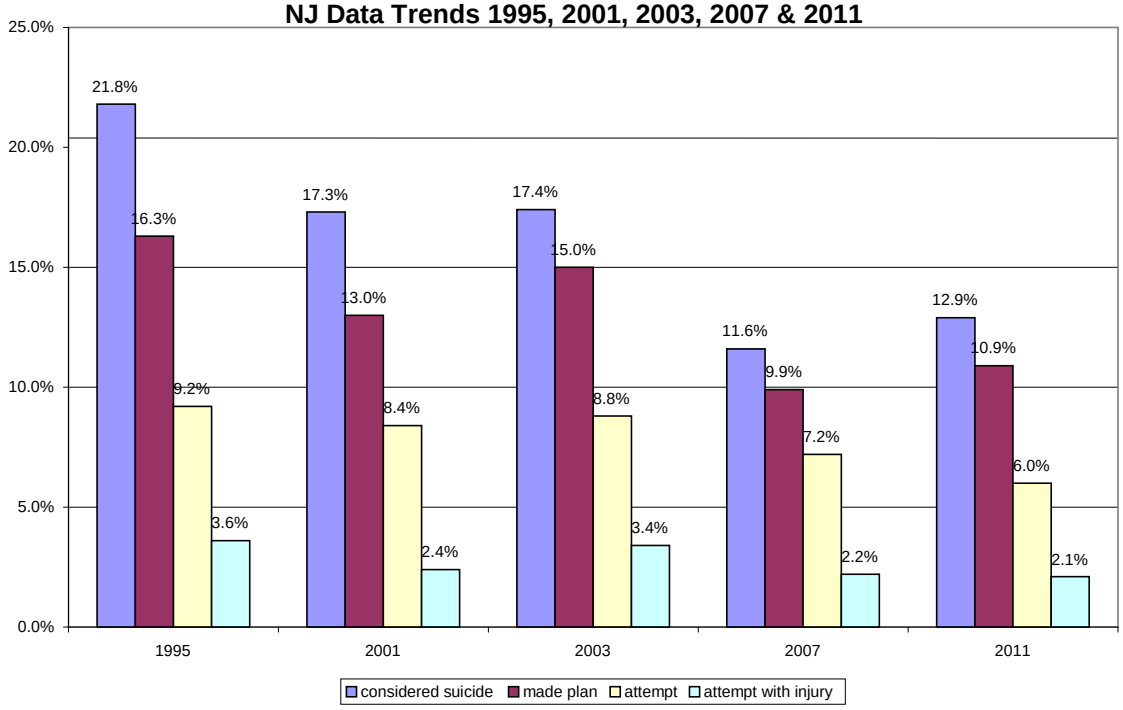
The Centers for Disease Control and Prevention (CDC), National Youth Risk Behavior Survey System (YRBSS) is a tool designed to monitor a wide range of priority health risk behaviors among representative samples of high school students at the national, state, and local levels. The YRBSS is conducted every two years. One area of focus is youth suicide risk behavior.

According to the 2011 YRBSS, approximately 13% of New Jersey high school students reported having seriously considered suicide, approximately 11% reported having made a suicide plan, and approximately 6% had attempted suicide. Over one quarter (26%) of students reported that within the previous 12 months they had felt so sad or hopeless almost every day for at least two weeks row that they stopped doing some usual activities.[16] In addition, a greater percentage of females than males, 16% vs. 10%, considered suicide; and, 12% of females had made a plan for suicide versus 10% of males. However, the frequency of reported suicide attempts did not vary by gender according to the respondents.[17] Please see Figure 2 below.

The number of students who self-reported considering and planning suicide increased slightly from the 2007 YRBSS. Conversely, the number of New Jersey students who self-reported a suicide attempt and being injured as a result of a suicide attempt dropped to their lowest levels in 2011. The 2005 and 2009 YRBSS surveys did not address suicide-related matters.[18] Data from 1997 and 1999 was not available.

[16] New Jersey 2011. Youth Risk Behavior Surveillance System Survey. Available online at www.nj.gov/njded/students/yrbs/index.html.
[17] Ibid.
[18] Ibid.

Figure 2.
Youth Risk Behavior Surveillance System Survey
NJ Data Trends 1995, 2001, 2003, 2007 & 2011

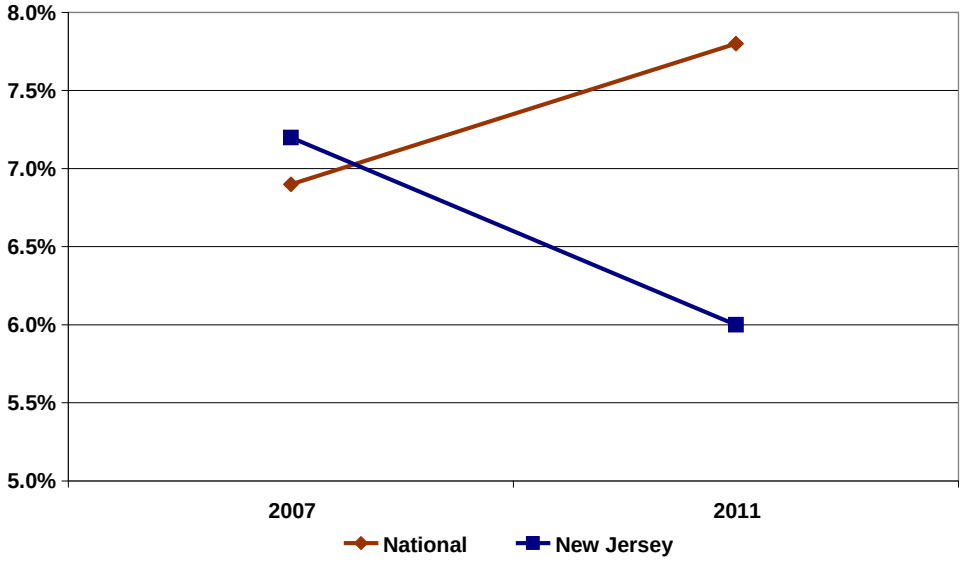


Nationally, all of the indicators identified in Figure 2 (considered suicide, made plan, attempt, and attempt with injury) reflected an increase since 2007. This may not be surprising in light of the fact that for the past several years the country has been experiencing economic challenges, and historical data suggests that economic downturns tend to increase the suicide rate.[19]

Figure 3 below is a comparison of the percentage of youth in New Jersey and the nation who reported attempting suicide in the 2007 and 2011 YRBSS.

[19] Centers for Disease Control and Prevention, Impact of Business Cycles on the U.S. Suicide Rates, 1928–2007, *American Journal of Public Health,* April 2011.

Figure 3. Youth Risk Behavior Surveillance System Survey
Attempted Suicide



While nationally the key measurements of suicide risk and suicide behavior in the YRBSS increased, New Jersey was one of only 12 states that showed a decrease in both reported attempts and reported attempts that required medical attention.

Prevention Activities

New Jersey has continued to enhance, update and promote existing and new policies and programs for children's mental and behavioral health. Some the State's key prevention activities initiated since the June 2012 report are discussed below.

NJ Department of Children and Families (DCF)

The Department of Children and Families (DCF) is focused on ensuring the safety and well-being of New Jersey's children and families. Together, the divisions within DCF work together to implement departmental initiatives including youth suicide prevention.

There have been significant developments since the June 2012 report was published, several of which are directly related to the *New Jersey Youth Suicide Prevention State Plan 2011-2014*. The State Plan was developed to guide New Jersey's efforts to prevent youth suicides, focusing on the associated risk and protective factors of suicide and suicide attempts.

The full plan can be viewed at: http://www.state.nj.us/dcf/families/csc/prevention/.

DCF-Division of Children's System of Care (formerly Division of Child Behavioral Health Services)

DCF's Division of Children's System of Care (CSOC) serves children and adolescents with emotional and behavioral health care challenges and their families; and children with developmental disabilities.[20] CSOC is committed to providing services based on the needs of the child and family in a family-centered, community-based environment.

Suicide Hotline Report

On January 5, 2012, Governor Christie signed into law, Public Law 2011, Chapter 166. Among the provisions of the law was a requirement that DHS and DCF jointly prepare a report reviewing the effectiveness and sufficiency of services provided by the New Jersey-based suicide prevention hotlines. The purpose of the legislation was to ensure that New Jersey has sufficient resources to address the needs of an extremely vulnerable population. The report provides an overview of existing crisis lines, suggestions for improving the crisis line system, and a commitment by DCF and DHS to continue collaborative efforts to ensure most – if not all – suicide related calls from New Jersey residents are answered in New Jersey. (The Suicide Prevention Hotline report is expected to be released at or about the same time as this youth suicide report.)

Traumatic Loss Coalition for Youth

The Traumatic Loss Coalition for Youth (TLC) is DCF's lead youth suicide prevention program. DCF was extremely pleased that a Garrett Lee Smith (GLS) youth suicide prevention grant from the U.S. Department of Health and Human Services' Substance Abuse Mental Health Services Administration (SAMHSA) was awarded to TLC, based upon the collaborative efforts of UMDNJ, TLC and DCF. The grant is currently being implemented under the name, *the New Jersey Youth Suicide Prevention Project* (NJYSPP). The project will focus on youth and young adults ages 10-24, with special attention paid to reaching youth at increased risk for suicide, including Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth, Latina adolescents, African-American males, college and university students, juvenile justice-involved youth, and youth in out-of-home placements.

The NJYSPP will also give priority attention to the six counties with the highest incidence of completed youth suicides for 2007 – 2009 according to the New Jersey Violent Death Reporting System data[21] including Camden, Bergen, Hudson, Middlesex, Monmouth and Passaic.

The NJYSPP will use a public health model to target multiple levels of service with evidenced-based and best-practice interventions. Planned activities will directly support several goals of the *New Jersey Youth Suicide Prevention State Plan 2011-2014*, including the following:

[20] DDD is currently the point of initial contact and intake in order to access services for children and youth with developmental disabilities.

[21] New Jersey Violent Death Reporting System. (2011). Office of Injury Surveillance and Prevention, Center for Health Statistics, New Jersey Department of Health and Senior Services, Trenton, NJ, 2008.

- Creation of County Youth Suicide Prevention Task Forces to expand local networks, promote awareness, and develop broad-based support for youth suicide prevention;
- A Mobile *Teen Screen* Team will be created to strengthen and expand community-based suicide prevention and postvention efforts;
- *Sources of Strength* training for youth peer leaders and adult mentors to help reduce stigma associated with needing mental health, substance abuse, and suicide prevention services;
- Connect Gatekeeper Training to provide professional training in identification, assessment and referral for those who are in regular contact with youth at-risk;
- *Assessing and Managing Suicide Risk* training for mental health professionals to promote effective clinical practices among clinicians; and
- A Statewide Social Media Campaign to promote access to mental health and substance abuse services among youth.

TLC also launched a peer-to-peer website, "Jersey Voice," for youth and young adults. The website is a platform where individuals can share their stories of hope, help and strength in getting through the difficult times in life. Messages can be shared using stories, poems, music, photography, posters, videos and other creative outlets. "Jersey Voice" is a partnership with Emotion Technology, a company that combines suicide prevention, intervention and postvention with social media to reach youth and young adults where they live and communicate. The web address is: www.jerseyvoice.net.

Division of Family and Community Partnerships (formerly Prevention & Community Partnerships)
The Division of Family and Community Partnerships (FCP) seeks to build a continuum of child abuse prevention and intervention programs that are culturally competent, strengths-based and family centered, with a strong emphasis on primary child abuse prevention.

2NDFLOOR Youth Helpline
The *2NDFLOOR* Youth Helpline is a statewide, 24-hour, interactive telephone line for youth and young adults (ages 10-24), staffed by counseling professionals and specially trained volunteers. *2NDFLOOR* is currently exploring additional ways to reach youth via social media. *2NDFLOOR* is accredited as a Suicide Prevention Hotline by the American Association of Suicidology. The web address is: www.2ndfloor.org.

NJ Department of Human Services (DHS)

DHS -Division of Mental Health and Addiction Services
DHS -Division of Mental Health and Addiction Services (DMHAS) serves adults with mental health challenges as well as individuals battling substance abuse.

Suicide Hotline Report
As noted above, pursuant to legislation, DHS and DCF prepared a joint report reviewing the effectiveness and sufficiency of services provided by the New Jersey-based suicide prevention hotlines to help ensure that New Jersey has sufficient suicide prevention resources. A survey of New Jersey based crisis lines revealed, among other things, that the New Jersey crisis lines have implemented texting and social media services to better reach youth and young adults.

National Suicide Prevention Lifeline Network Hotline
DCF and DHS have been working together to increase the number of calls answered in New Jersey that are made to the Lifeline Hotline by New Jersey residents. Currently, most calls originating in New Jersey are answered by suicide hotlines in other States. In September 2012, the Mental Health Association in New Jersey and UMDNJ-UBHC both became certified members of the *National Suicide Prevention Lifeline Network* (*Lifeline*) in order to provide in-state crisis line backup coverage to help ensure that more crisis calls made to *Lifeline* by New Jersey residents are answered in New Jersey.

Conclusion and Recommendations

While both nationally and in New Jersey the rate of youth suicide increased in 2010, we are pleased that the overall rate of youth suicide in New Jersey dropped in 2011 and that the results of the 2011 National Youth Risk Behavior Survey System indicates that students are attempting suicide less often. This decrease is a positive sign and possibly an indicator that the State's suicide prevention efforts are working. Through educating youth, teachers, and parents on warning signs, how to get help, as well as building positive supports for youth in their schools, New Jersey's youth suicide prevention programs offer support and hope.

Nevertheless, the work to continually improve our youth suicide prevention efforts is not over. Every life lost to suicide is a tragedy and DCF is committed to diligently work to decrease the rate of youth suicide in New Jersey.

The recommendations from the June 2012 report are still relevant and remain DCF's focus. DCF will continue to address the needs and attain the goals outlined in the *New Jersey Youth Suicide Prevention State Plan 2011-2014*. This plan will continue to guide our work for the next two years.