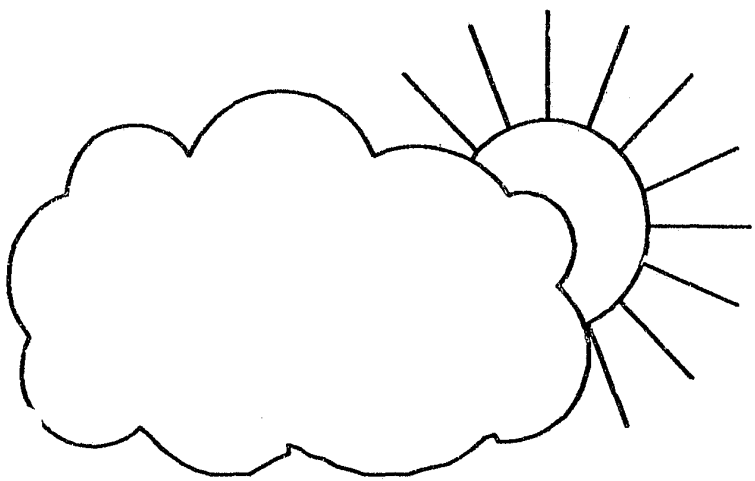
FOR A BETTER TOMORROW:

A Plan For Youth Suicide Prevention in Maryland



Gubernatorial Task Force on Child, Teenage and Young Adult Suicide and Other Associated Mental Health Problems
(Governor's Task Force on Youth Suicide Prevention)
July 1987

GUBERNATORIAL TASK FORCE ON CHILD, TEENAGE, AND YOUNG ADULT SUICIDE
AND OTHER ASSOCIATED MENTAL HEALTH PROBLEMS
c/o Mental Hygiene Administration
201 West Preston Street, Room 414
Baltimore, Maryland 21201
(301) 225-6649

July 29, 1987

The Honorable William Donald Schaefer
Governor of Maryland
301 West Preston Street - 15th Floor
Baltimore, Maryland 21201

Dear Governor Schaefer:

The Gubernatorial Task Force on Child, Teenage, and Young Adult Suicide and Other Associated Mental Health Problems (Governor's Task Force on Youth Suicide Prevention) appreciates the opportunity to develop *For a Better Tomorrow: A Plan for Youth Suicide Prevention in Maryland.* We believe our work was the beginning of a process which needs to continue in a structured manner with ongoing input from caring and well informed individuals who will help protect the lives of our children and grandchildren. Therefore, we ask that you:

- **Establish, through Executive Order, a focal point in State government to coordinate youth suicide prevention, intervention, and postvention activities by creating a Maryland Council for Youth Suicide Prevention in the Executive Department.**

What could we possibly do that would be more important than saving the life of a young person? Creating a Maryland Council for Youth Suicide Prevention would help save valuable lives. This Council would be a model program coordinating the efforts and resources of many State agencies and private organizations. Maryland would become a leader in the United States in youth suicide prevention.

We also request that in the development of your budget you give special consideration to agencies which have requested funding for youth suicide prevention programs by providing authorization and funding for them to:

- **Implement a Continuum of Youth Suicide Prevention, Intervention, and Postvention Resources in Maryland.**

Lastly, the Task Force hopes you will utilize your demonstrated leadership skills in identifying and mobilizing human and fiscal resources to:

- **Develop a community/school partnership to provide prevention, intervention, and postvention services utilizing local, State, federal and private sector resources and funding.**

The causes of youth suicide and the strategies to prevent them are similar to other problems of youth including: self-destructive behavior, substance abuse, emotional problems, eating disorders, teen pregnancy, and running away. Therefore, implementation of the Task Force's recommendations will have a beneficial impact on other problems and would enhance the quality of life for youth and their families. The Task Force appreciates your support and urges you to take action to prevent the tragedy of youth suicides and attempts which impacts thousands of Maryland families each year.

Sincerely,

Bruce L. Regan, M.D., Chairperson
Gubernatorial Task Force on Youth
Suicide Prevention and Other
Associated Mental Health Problems

110520

FOR A BETTER TOMORROW:

A Plan For Youth Suicide Prevention in Maryland

State of Maryland
William Donald Schaefer, Governor

Gubernatorial Task Force on Child, Teenage and Young Adult Suicide and Other Associated Mental Health Problems
(Governor's Task Force on Youth Suicide Prevention)
July 1987

Report Design and Typesetting: David Neubauer and Betty McGarvie Crowley

Printing: Work Adjustment Program
Mental Health Association of Montgomery County

Copies Available: Mental Hygiene Administration
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EXECUTIVE SUMMARY

Recognizing that legislative actions can save valuable lives, the 1986 Session of the General Assembly passed SJR 7 and HJR 47 (Joint Resolution 1 and Joint Resolution 6), creating the Gubernatorial Task Force on Child, Teenage, and Young Adult Suicide and Other Associated Mental Health Problems (Governor's Task Force on Youth Suicide Prevention). In accordance with these resolutions, the Governor appointed the Task Force in October 1986. A final report was requested by October 1, 1987, and an interim report (Appendix G) was submitted to the Governor and General Assembly on December 31, 1986. The Task Force's major responsibility was to develop a comprehensive plan designed to combat child, teenage, and young adult suicide and associated mental health concerns.

To address this charge, the Task Force met eight times, created seven committees, conducted key informant interviews, held a public hearing to gain citizen input, and identified needs which are addressed in this Plan.

For A Better Tomorrow: A Plan for Youth Suicide Prevention in Maryland is a resource document that can be used as a catalyst for action, for future planning, and for creating a comprehensive and coordinated system of services to prevent youth suicides. Included in the Plan is a statistical analysis of youth suicide trends in Maryland which presents data collected and compiled by the Task Force. A summary of the analysis, which highlights its most salient points, is also included. Three overall recommendations have been selected by the Task Force and 16 priority recommendations have been organized into these three areas. Rationales and implementation steps are presented for each recommendation. Additional background is provided in the Introduction, Conclusion, and Appendices.

There is a desperate need in Maryland for resources to be devoted to helping distraught parents, troubled youth, and others who are touched by the turmoil of youth suicide. The Task Force strongly believes that Maryland has the ability to help youth "hold on for a better tomorrow" and to save valuable young lives.

Therefore, the Task Force recommends that the Governor and the General Assembly:

I. Provide authorization and funding to implement a Continuum of Youth-Suicide Prevention, Intervention, and Postvention Resources that is accessible to all youth in Maryland.

II. Establish, by an Executive Order, a focal point in State government to coordinate youth suicide prevention, intervention, and postvention activities by creating a Maryland Council for Youth Suicide Prevention in the Governor's Office for Children and Youth which would:

A. Implement the Task Force's recommendations by coordinating and monitoring private and public youth suicide prevention, intervention, and postvention efforts in the State.

B. Serve as a clearinghouse for information and resources to provide technical assistance, training, consultation, public awareness, and educational programs including conferences with a particular emphasis on reaching gatekeepers.

C. Develop a coordinated statewide toll-free 24 hour Hotline number to provide immediate linkages with local resources, crisis intervention services, and information and referral.

D. Advise and report to the Governor and General Assembly on the status of youth suicide prevention activities in Maryland.

E. Require State agencies serving youth to have trained personnel, particularly at the local and institutional levels, to provide accessible prevention, intervention, and postvention services to respond to suicide crises.

F. Develop administrative and legislative initiatives to coordinate the collection, analysis, and dissemination of accurate and complete data on youth suicide completions and attempts in Maryland.

G. Study ways of improving health and mental health insurance coverage and removing barriers for individuals at-risk of suicide.

H. Encourage the counties and Baltimore City to develop and support Youth Suicide Prevention Councils or Task Forces to coordinate local efforts.

I. Coordinate annually, preferably in the fall, a Youth Suicide Prevention Week as a mechanism to educate the public on what can be done to prevent suicides and what resources are available to all.

III. Develop a community/school partnership to provide prevention, intervention, and postvention services utilizing local, State, federal and private sector resources and funding to:

A. Implement the Maryland State Department of Education's Youth Suicide Prevention School Program including the establishment of school/community crisis intervention teams and peer helper/facilitator programs.

B. Implement, through the Maryland State Department of Education, comprehensive health education programs (prekindergarten through grade 12) which include a mental health unit that addresses youth suicide prevention and development of life skills.

C. Ensure continuation and expansion of the Maryland State Department of Education's Student Assistance Program which includes a component on youth suicide prevention.

D. Establish programs within the Continuum of Resources for youth at high risk of suicide including youth who have a history of depression, suicide attempts, family suicides, substance abuse, child abuse and/or neglect, out-of-home placements, running away, sexual exploitation, teen pregnancy, AIDS or fear of it, identification with a sexual minority, eating disorders, and other special risk factors.

E. Explore educational and legislative interventions which may limit access to the lethal means of suicide, particularly firearms, for youths at high-risk of suicide.

F. Provide funding for local crisis intervention, training, and community education programs mandated by HB 1221 in 1986 (Chapter 122) through contracts with Youth Services Bureaus and/or existing suicide prevention programs.

G. Expand and fund the Mental Hygiene Administration's *Five Year Plan for Children and Adolescents* and the *Emergency Services Chapter* to include the implementation of the Continuum of Youth Suicide Prevention Resources which relate to mental health agencies.

As with most forms of human violence, the problem of youth suicide is fraught with immense resistance to action due to the emotional impact of the issue on others. The recommendations presented are starting points for further planning and the development of implementation strategies and actions. This Plan provides the foundation and framework of a system that can respond to the crisis of youth suicide. It is essential that the impetus gained by the Task Force in the short period of time that it functioned be maintained and augmented.

DATA SUMMARY

- From 1970 through 1985 there were 1,520 documented suicide deaths among Maryland youth aged 10 through 24.

- Suicide remains the third leading cause of death (after accidents and homicides) of young people in Maryland. There have been approximately 100 documented suicide deaths among youth aged 10 through 24 annually. Estimates indicate that for every completed suicide, as many as 100 youths attempt suicide.

- The suicide rate for youth aged 15 through 24 increased 180% in Maryland from 1950 to 1980.

- The following percentages pertain to the 1,520 completed suicides by individuals under age 25 from 1970 through 1985 in Maryland.

Ages 10-14	4%
15-19	31%
20-24	65%
Male	82%
Female	18%
White	83%
Non-white	17%

- For Maryland, and the United States in general, the youth suicide rate reached a peak in the late 1970's, and has remained fairly stable since then. The following are the 1982 suicide rates per 100,000 for demographic groups of Maryland residents aged 15 through 24.

White Male	25.3
Non-white Male	10.8
White Female	4.9
Non-white Female	1.7

- Firearms were used in 54% of all suicides by Maryland youth from 1970 through 1985. The use of firearms was the most common method selected by white males, white females, non-white males, and non-white females in the 10 through 24 age group.

- Since 1970 the Maryland suicide rate for 15 through 24 year olds by all methods except the use of firearms has remained relatively stable. However, the trend of increased suicide in this age group directly parallels the increase in the rate of firearm suicide by 15 through 24 year olds.

ACKNOWLEDGEMENTS

The Task Force appreciates Governor William Donald Schaefer's proclaiming Youth Suicide Prevention Week (Appendix H), agreeing to participate in a Public Service Announcement on youth suicide, adding to the supplemental budget $50,000 for the Maryland State Department of Education's Youth Suicide Prevention School Program, and assigning Martha Pedroni as his representative to the Task Force. We also wish to acknowledge the assistance of Lieutenant Governor Melvin A. Steinberg.

The Governor's Task Force on Youth Suicide Prevention was fortunate to have knowledgeable, dedicated, and hard working members. The Committees devoted countless hours to developing committee recommendations. An Executive Committee was created to consolidate the recommendations and develop the Plan. Michael Armiger, Geneva Cannon, Patricia D. Hawkins, Russell G. Henke, Jay N. Mossman, and Bruce L. Regan served on the Executive Committee. David Nelson Neubauer and Marylou Knapp were responsible for the section on Youth Suicide in Maryland: A Statistical Analysis.

Liaison and Resource individuals listed in Appendices C and D were invaluable and provided extensive consultation and assistance. The Mental Hygiene Administration provided the resources and the staff assistance of an Executive Director, Betty McGarvie Crowley, and a Secretary, Cheryl Boykin, for the Task Force.

A special note of appreciation is extended to Susan White-Bowden and Channel 2, WMAR-TV, for producing a Public Service Announcement, which will be copied for the other television stations in Baltimore and Washington, to air beginning September 1987.

Thank you to the Office of the Governor, the President of the Senate, the Speaker of the House, the Anne Arundel Board of Education, the Maryland Automobile Insurance Fund, the Mental Hygiene Administration, the Maryland State Department of Education, Manor Care, Inc., the Department of Budget and Fiscal Planning, and the Mental Health Association of Prince George's County for providing meeting spaces for the Task Force and Committees.

The following individuals were members of the Governor's Task Force on Youth Suicide Prevention which developed this plan. The names of individuals who served as Chairpersons of Task Force Committees are preceded with an asterisk.

* Bruce L. Regan, M.D., Chairperson
Maryland Department of Health and Mental Hygiene

– Judi Alden
Maryland Congress of Parents and Teachers

* Michael S. Armiger
General Public - Parent Survivor - Maryland Chapter of the National Committee on Youth Suicide Prevention

* Honorable Stewart Bainum, Jr.
Maryland State Senate

– Annette Elizabeth Barkley
Maryland Association of Student Councils

– Susan White-Bowden
General Public - Parent Survivor - Media

* Geneva Cannon
General Public - Worcester County Board of Education

- Sharon Carpenter
  General Public
- Leon E. Coleman
  School Principal
- Honorable Michael J. Collins
  Maryland State Senate
- Carole N. Coss
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- David Joseph Goldman
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* Patricia D. Hawkins, Ph.D.
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  Compassionate Friends - Maryland Chapter of the National Committee on Youth Suicide Prevention - Parent Survivor
- David Nelson Neubauer, M.D.
  Psychiatrist
- Alan Bruce Seward
  School Guidance Counselor
- Sgt. Charles H. Skuhr
  Maryland State Police, Maryland Center for Missing Children

INTRODUCTION AND BACKGROUND

Governor William Donald Schaefer urged Maryland citizens to "work to prevent youth suicide" in his May 17, 1987 Proclamation declaring Youth Suicide Prevention Week as May 17-23, 1987, (Appendix H). He stated that, "Youth suicide is one of the most disruptive and tragic events a family and a community can experience." The Governor has further challenged Maryland citizens to become directly involved in the *Schaefer Challenge* to improve the lives of children and youth in Maryland by donating time to a volunteer cause or event, working in the community, or contributing time and energy to assist children. This Plan is a challenge to commit resources to prevent youth suicides and suicide attempts in Maryland. The assistance of the public and private sectors working together with a unified agenda is needed to respond effectively to this challenge.

From 1970 through 1985 Maryland lost 1520 of its youth to suicide. Each of these deaths left countless family members, friends, and acquaintances devastated and at a loss to explain or understand why a young person who meant so much to them could have felt that his or her life was too painful or worthless to pursue. It has been estimated that for each tragic youth suicide, up to 100 other young people have attempted to take their own lives. Suicides by youth aged 15 through 24 have increased 180% from 1950 to 1980. This ultimate form of self-destructive behavior will not be prevented unless Marylanders respond to the challenges of this Plan so that youth can hold on *For a Better Tomorrow.*

The Maryland General Assembly recognized the need to address the epidemic of youth suicide by passing Senate Joint Resolution 7 and House Joint Resolution 47 (Joint Resolution 1 and Joint Resolution 6) requesting the Governor to establish a Gubernatorial Task Force on Child, Teenage, and Young Adult Suicide and Other Associated Mental Health Problems (Appendix A). The purpose of the Task Force was "to develop a comprehensive plan designed to combat child, teenage, and young adult suicide, and associated mental health concerns." The resolutions stated "peer pressure, family-related conflict, educational demands, and other youthful concerns can be extremely burdensome and oftentimes difficult for today's children, teenagers, and young adults to cope with." Furthermore, they pointed out that suicide, bulimia, anorexia, and other mental health disorders are becoming an increasingly serious problem among youth. The resolution spoke to the need for an organizational framework to focus State and local efforts to combat youth suicides.

Governor Harry Hughes began making appointments to the Task Force in the latter part of October 1986. Among the Task Force members were elected officials, parents of youth who had committed suicide, school personnel, mental health professionals, police, leaders of self-help groups, and a student. An Interim Report (Appendix G) was submitted to the Governor and General Assembly on December 30, 1986.

The Task Force began meeting on January 12, 1987, and adopted this Plan on July 29, 1987, at its eighth and final meeting. The Task Force shortened its official name to the Governor's Task Force on Youth Suicide Prevention for ease in communicating. Liaisons and Resources were recruited to assist the Task Force in its work (Appendices C and D). Numerous individual contacts were made with key informants by Task Force members and staff. Approximately 1,000 press releases were sent announcing a Public Hearing to collect information, suggestions, and recommendations for this Plan (Appendix I). This Hearing was held at the State House on the afternoon and evening of May 6, 1987.

Task Force members were represented at major local, State, and national programs and meetings addressing youth suicide and were interviewed by local media. A Letter to the Editor from the Chairperson was published in the *Baltimore Sun* in response to media coverage of a cluster of youth suicides. A representative of the Task Force testified at the Governor's

Commission on Children and Youth. A letter was sent to each state requesting information on their activities related to youth suicide prevention. State agencies and county police departments were surveyed to ascertain what training was taking place to deal with suicide attempters and survivors.

Committees were formed to address the components of the plan as outlined in the Joint Resolution in Appendix A. Six committees were created composed of Task Force members assisted by Liaisons and Resources; they were: Mental Health Resources, Data Collection, Program/Curriculum Design and Training, Informational Products and Presentations, Hotlines, and Public Hearing. An Executive Committee of Chairpersons met five times to develop, coordinate, and edit this Plan.

There was $60,000 allocated to the Mental Hygiene Administration to provide resources for the work of the Task Force. The Mental Hygiene Administration transferred $15,000 to the Maryland State Department of Education to assist in the development and implementation of the Youth Suicide Prevention School Program for the Public Schools of Maryland which was authorized by House Bill 1221 in the 1986 session (Chapter 122 of the *Laws of Maryland*, 1986). These funds were used to provide regional training sessions to present the School Program to local education agencies and other key personnel involved with local youth suicide prevention programs (Appendices E and F).

Maryland follows national patterns of youth suicides. The United States Office of the Inspector General's report, *Youth Suicide - National Program Inspection* states: "The actual number of deaths may be two times higher than the reported incidence because (a) there is no common definition of suicide among medical examiners/coroners, (b) the social stigma attached to suicide encourages underreporting, and (c) some suicides are masked, such as car accidents." This report also pointed out that: "a few trends surfaced among respondents' descriptions of youth at risk of suicide. The most frequently mentioned were (a) an increase in younger attempters (ages 5 to 10), (b) an increase in ideation and open discussion among all youth, (c) an increase in seriously disturbed youth (including chronically mentally ill), (d) an increase in multiple forms of self-destructive behavior, and (e) an increasing sense of futility among youth which leads them to live only for the moment."

A review of studies has shown that factors which may influence youth who commit suicide include:

- drug and alcohol use
- previous attempts (including family history of suicide or attempt)
- availability of lethal means (particularly firearms)
- depression (mental illness)
- family conflict
- problems with the juvenile/criminal justice system
- eating disorders
- identification with a sexual minority

Recognizing and responding to these danger signs is a role which frequently falls on peers and gatekeepers who are often not adequately trained to help youth considering suicide. Irrational impulsive actions are not unusual especially for adolescents. It is important to recognize that when the pressures of life are too intense, they can lead to self-destructive or suicidal behavior. Therefore, it is necessary to provide training sessions to assist individuals to respond appropriately to youth who feel hopeless and helpless.

There are excellent school programs which can be replicated to train youth to serve as peer helpers and facilitators to respond to cries for help. There are also model programs

which could be replicated to train gatekeepers to improve their prevention, intervention, and postvention knowledge and skills. The Task Force found most gatekeepers who come regularly in contact with youth do not have adequate training opportunities or technical assistance available to know how to provide first line intervention to identify a troubled youth, render initial psychological first aid, and/or obtain the necessary help for youth suicide crises.

The Youth Suicide Prevention School Program for the Public Schools of Maryland provides a framework for many gatekeepers and students within the public school systems. Local Advisory Boards for the program are being set up to involve other sectors in the community such as community mental health centers, clergy, and youth services bureaus. The Governor's Task Force endorsed this Program and requested the Governor to include funding in the supplemental budget for FY 1988. There was $50,000 added to the Maryland State Department of Education's FY 1988 budget to commence the implementation of this program.

Youth suicides affect all youths, including those in public and private schools, colleges, work settings, and institutions as well as those who may be unemployed and/or out of school. In fact, national estimates indicate 44% of youth ages 15-24 are not in the educational systems. Consequently, it is important to have broad based youth suicide prevention activities. Programs, such as employee assistance programs, are needed to address youth in the workplace. This fact does not negate the need for services in the schools for children and teenagers. How many lives would have been saved if young adults had learned better problem solving skills, stress management techniques, options available, and where to go for help? If problems such as depression and substance abuse had been addressed at the first signs of difficulty, the option of suicide may have never surfaced.

Youth at higher risk of suicide are the ones who most need the help of gatekeepers. Because high risk youth are not the primary responsibility of one State agency, there needs to be a focal point in State government to coordinate youth suicide prevention, intervention and postvention activities. For example, youths could be receiving services from the Department of Health and Mental Hygiene, Juvenile Services Agency, Department of Human Resources, Maryland State Department of Education, and/or Department of Public Safety and Correctional Services in a State, local or regional program. Youths also could receive multiple services from these large agencies, such as the Department of Health and Mental Hygiene, which provides mental health, substance abuse, and other health services locally and regionally.

The types of resources needed in Maryland to specifically address this problem are included in the Continuum of Youth Suicide Prevention Resources in Maryland which is included in Recommendation I of this Plan. Unfortunately, there are not enough suicide prevention centers, crisis intervention services, hotlines, community mental health center programs, and other community resources to intervene promptly and appropriately 24 hours a day, seven days a week. Cries for help from suicidal youth are not always responded to in an appropriate and timely manner. Additional public and private resources must be obtained to expand and coordinate existing services as well as to develop new ones.

Not all youth who commit suicide or attempt suicide are suffering from a major mental illness. However, youth suicide is an issue that is a fundamental concern of the Mental Hygiene Administration, other mental health service providers, and human service organizations. There are not adequate mental health services in local jurisdictions to provide the needed services.

Youth suicide prevention strategies must be incorporated into school curricula. The newly developed Youth Suicide Prevention School Programs can provide the framework to develop and expand school programs. The problem of youth suicides will be reduced only

by collaborative efforts of many disciplines, gatekeepers, planners, families, youth, policy makers, and the community.

Four volumes summarizing current information on youth suicide are being published in August 1987 by the Department of Health and Human Services (HHS) Task Force on Youth Suicide (which was created in 1985) to "access and consolidate information which currently exists and recommend or initiate activities which will attack head-on the youth suicide dilemma and to generate research on the factors which place young people at risk of suicide." Task Force members and staff participated in a conference in November which was part of the development of the HHS report. They were briefed on the preliminary findings, and shared information throughout the process through a HHS liaison. This Report will be a valuable resource in helping to develop public policy strategies and administrative actions to implement *For A Better Tomorrow*.

YOUTH SUICIDE IN MARYLAND: A STATISTICAL ANALYSIS

From 1970 through 1985 there were 1,520 completed suicides committed by Maryland youths (ages 10-24). This is approximately 100 deaths each year. There has been a great increase in youth suicide since the 1950's, and presently suicide is the third leading cause of death (following accidents and homicides) of young people in Maryland. This trend by young people in Maryland follows the national pattern of the youth suicide rate. This rate has nearly tripled over the past three decades. Consequently, youth suicide has received considerable public attention. A wide variety of proposals on the national and local levels aims at reducing this disturbing trend. While general prevention programs should be designed to reach all youth, more specific services must be developed for those individuals determined to be at greater risk. Only through an understanding of the patterns and trends in suicide that have evolved to the present, can progress be made.

This study reviews the recent history of completed suicides by young people in Maryland. Table 1 presents the number of cases per county. The analysis focuses on the relationship of suicide to age, sex and race. Suicide method selection is analyzed with reference to the above variables. Finally, trends over time are considered.

The primary time focus is 1970 through 1985, since adequate data is available for analysis. Statistics regarding the 15 to 24-year-olds have been emphasized because suicides by individuals under age 15 are very rare, and data for this category frequently are not separated in published form.

In this report suicide refers to deaths attributed to intentional self-inflicted injury. Suicide attempts are not reflected in this data, and they may represent a different population of individuals. No mechanism for recording suicide attempts currently exists and no central agency accumulates information on non-lethal suicidal behavior. Limited research does suggest that attempts are many times more frequent than completed suicides. Recommendations have been formulated by the Task Force to improve data collection for attempted and completed suicides.

Effects of Age

A significant relationship between age and the frequency of suicide exists. Figure 1 shows the number of suicides for each age from 10 to 24 years covering all Maryland suicides (1,520) in this age group from 1970 through 1985. No suicides by children ten years or younger were recorded. For 11 and 12 year olds, five and six cases, respectively, were recorded. Frequency increased dramatically with age and then leveled off somewhat in the 20's age group. The peak age was 24, with 215 cases in this time period.

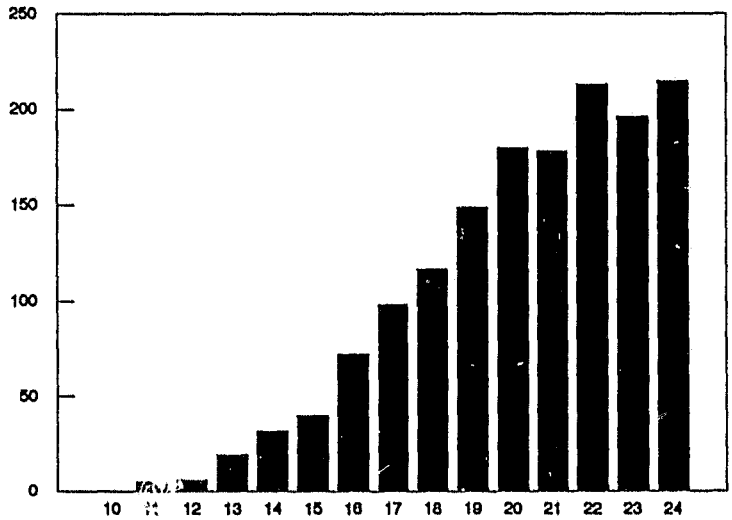


Fig. 1: Suicide cases by age in Maryland 1970-1985

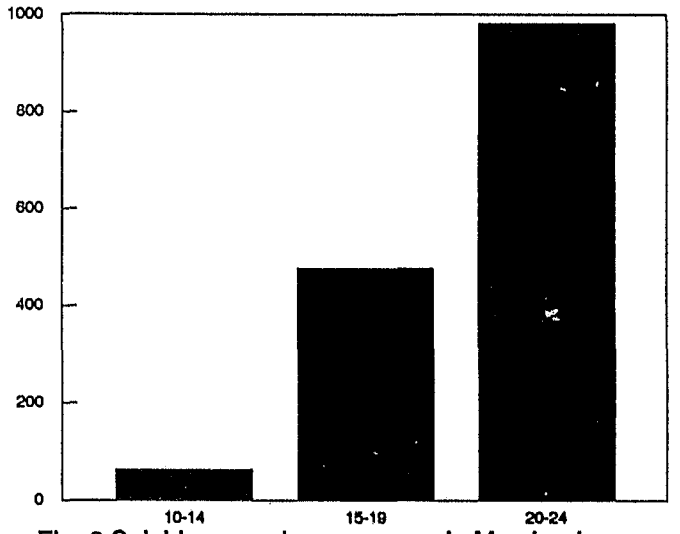


Fig. 2 Suicide cases by age group in Maryland 1970-1985.

The same data is collapsed into three age groups in Figure 2. There were 62 cases by those aged 10-14; 476 cases by ages 15-19; and 982 cases by ages 20-24. This data strongly indicates that frequency of suicide increases with age, and that ages 20-24 are responsible for the majority of suicides in youths.

The rate of suicide by children and young adolescents (under age 15) has remained very low since the 1950's. However, from 1950 to 1980 there was a marked increase in the suicide rate for those aged 15-24 in Maryland. While the rate for individuals of all ages was stable at about 11 suicides per 100,000 population, the rate for those aged 15-24 increased from 4.4 to 11.6 per 100,000 during this time. Figure 3 presents this data. The change in the suicide rate for different age groups is presented in Figure 4. This chart shows the percent change in the rate from 1950 to 1980 for eight age groups. The 1950 rate for each age group is provided for reference. Note that the rate increased only in the 15-24 and 25-34 age groups. All of the older age groups showed a decrease in their suicide rate during this same time.

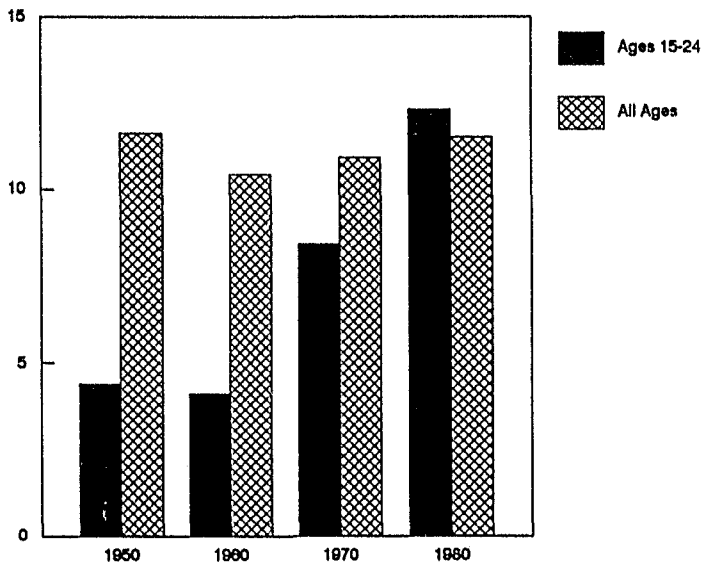


Fig. 3: Maryland suicide rate per 100,000 by age group.

The general trend of increased suicide among young people in Maryland is typical of the national pattern. Suicide rates in both Maryland and the U.S. rose steadily, culminating in 1977. The rate then decreased slightly and has remained relatively stable. Figure 5 compares the Maryland and U.S. rates for those aged 15-24 from 1970 to 1984. In Figure 6 this data is broken down to reflect the ages 15-19 and 20-24 rates for Maryland and the U.S. during this time. Rates for both age groups increased, but the rate for those aged 15-19 consistently has been much lower. For Maryland 15-19-year-olds, the increase was from 3.6 to 8.2 per 100,000. The maximum rate was recorded at 10.8 in 1976. For 20 to 24-year-olds in Maryland the change was from 13.5 to 16.6. The 1977 peak was 21.2 per 100,000.

Fig. 4: Percent rate change by age group from 1950 to 1980.

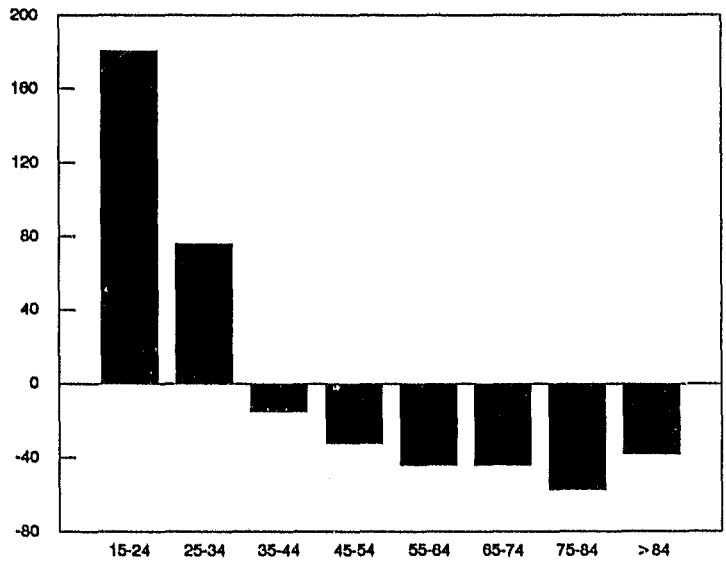
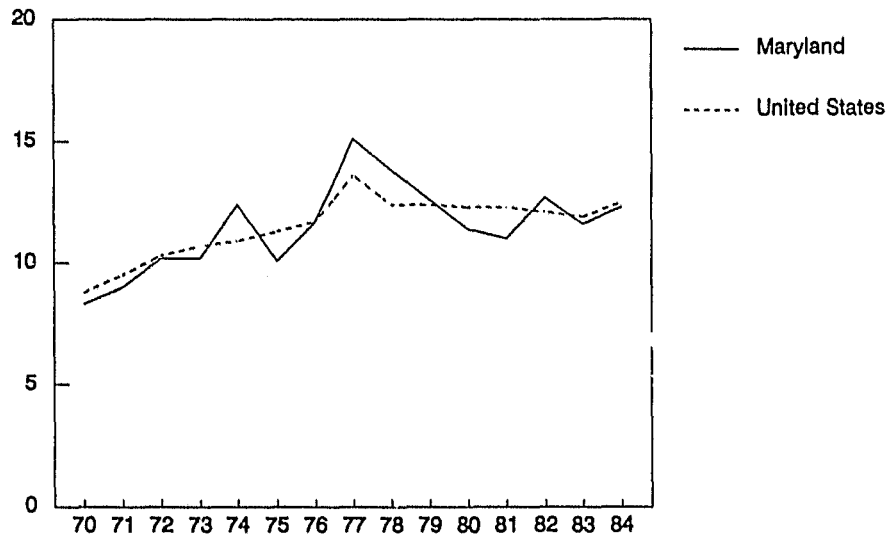


Fig. 5: Suicide rates for ages 15-24 from 1970 to 1984.



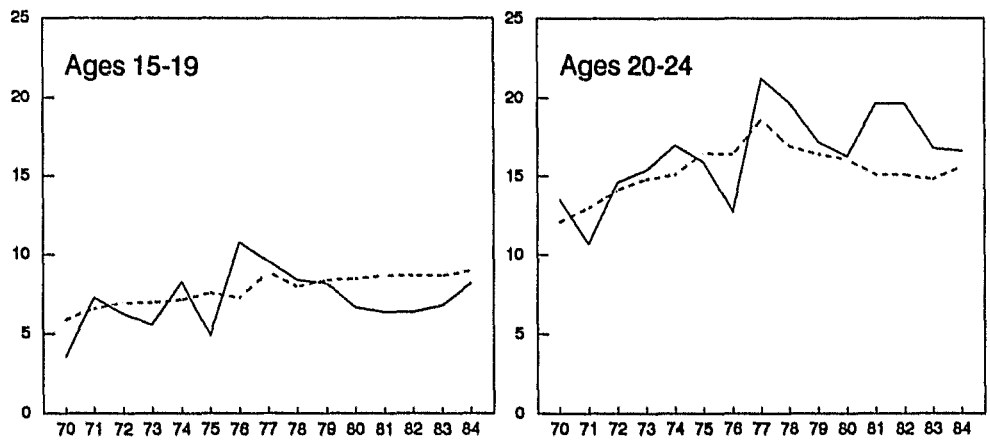


Fig. 6: Maryland and United States suicide rate per 100,000 for ages 15-19 and 20-24 for 1970-1984.

Effects of Race and Sex

Race and sex both have an enormous influence on suicidal behavior. In Maryland, as well as nationally, the suicide rate is much higher for males and for whites. Furthermore, the disparity in the male-to-female ratio has widened greatly in recent decades. The following data refer to those aged 15-24. Among whites, there were 1.8 male suicides for every female suicide in 1950. By 1982, this ratio increased to 5.2 males for every female. By that year, rates for white females had increased by 36%, while the rates for white males increased by 295%. Although the rates among non-white males consistently have been much lower than those for white males, they also increased markedly between 1950 and 1982. Starting at 3.3 per 100,000, the figures rose 227%. The male to female disparity among non-whites has changed even more than among whites. This is largely because the non-white female suicide rate in this age group has steadily declined in recent decades.

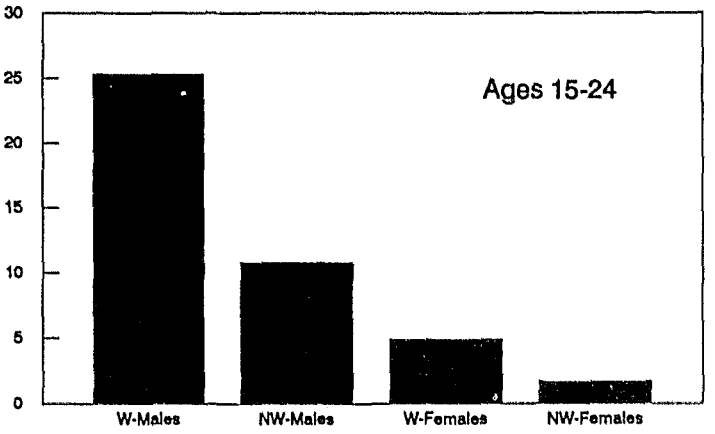


Fig. 7: Maryland 1982 suicide rate by sex and race.

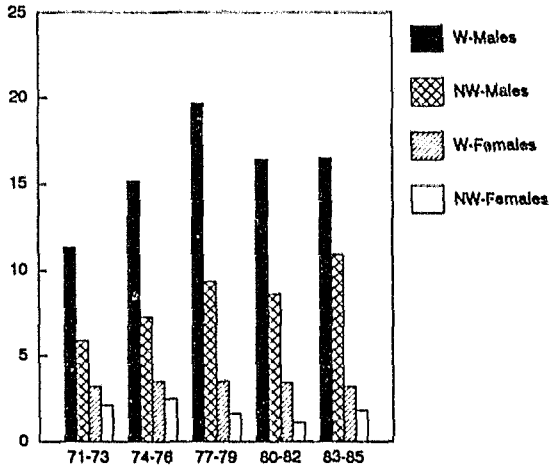


Fig. 8: Maryland suicide rate per 100,000 for 1971-1985 by sex and race for ages 10-24.

Suicide rates in 1982 among 15 to 24-year-old white males, white females, non-white males, and non-white females (depicted in Figure 7) are typical of recent years. Markedly higher suicide rates among white males are evident.

Figure 8 shows suicide rates for all individuals under 25 in each of four demographic groups from 1971 to 1985. For white males, the late 1970's rate peak and subsequent stabilization is shown. Non-white males, however, continued to increase their rate. Rates for white females and non-white females have remained below five per 100,000 throughout the time studied.

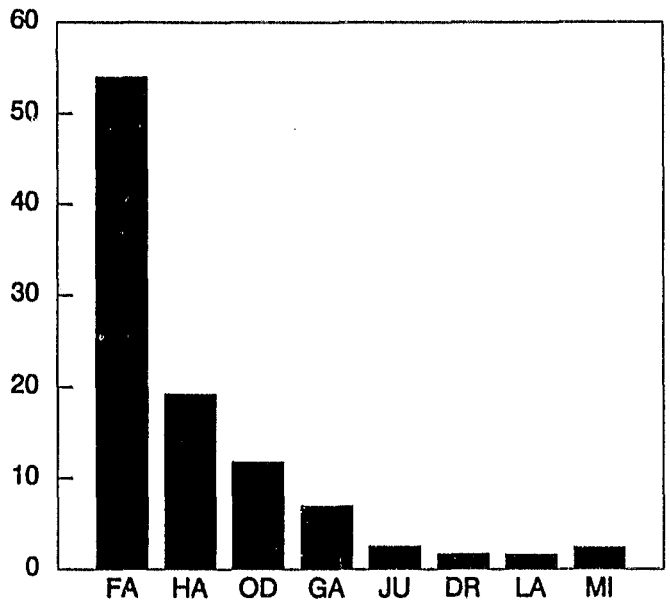
Suicide Methods

For this report, suicide methods have been categorized into eight groups: firearms, hanging, overdose and poisoning, jumping from height, gaseous inhalation, drowning, laceration and miscellaneous (which includes rare choices such as electrocution and burns). Figure 9 represents the 1,520 Maryland suicides by individuals under 25 from 1970 through 1985. Percentages of this total by choice of method are shown. In the later charts, gaseous inhalation is included with the overdose and poisoning category.

Fifty-four percent of all of the suicide deaths (in this age range) resulted from the use of firearms. Hangings accounted for the next most frequent cause of death at 19 percent of the

Fig. 9: Percent of total Maryland suicide cases (ages 10-24) from 1970 through 1985 for each method.

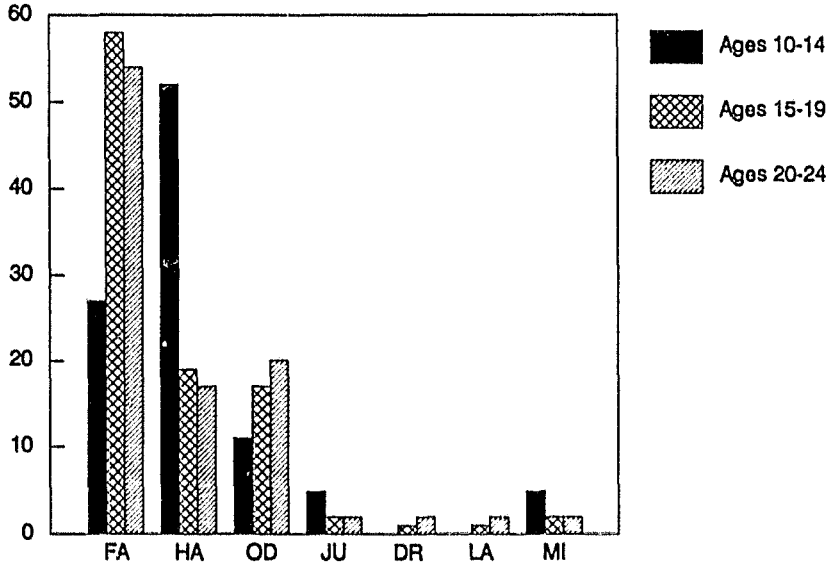
FA	Firearms
HA	Hanging
OD	Overdose/Poisoning
GA	Gaseous Inhalation
JU	Jumping
DR	Drowning
LA	Laceration
MI	Miscellaneous



cases. The overdose and poisoning category and gaseous inhalation (mostly carbon monoxide) together accounted for another 19 percent. Jumping from height, drowning, laceration, and miscellaneous each were responsible for less than 2.5 percent of documented deaths.

The relationship of method selection and age can be seen in Figure 10. Percentages of individuals in each age group by choice of method are indicated. The majority of those aged 10-14 committing suicide involved hanging. Firearms were the next most common method. Both the 15-19 and the 20-24 age groups employed firearms in greater than 50 percent of their suicides. Hanging was the second most common choice for those aged 15-19, while overdose and poisoning was the second for 20-24-year olds. The percent of individuals choosing the overdose and poisoning method increased with age.

Fig. 10: Percent of Maryland suicide cases from 1970 through 1985 for each method by age group



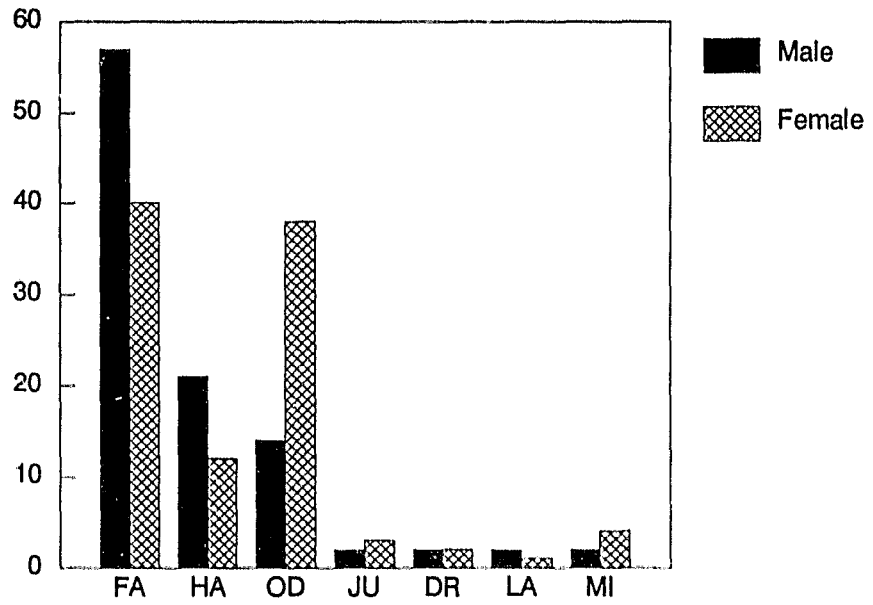


Fig. 11: Percent of Maryland suicide cases (ages 10-24) from 1970 through 1985 for each method by sex.

Method selection for males and females is graphically depicted in Figure 11. Clearly, firearms represent the primary method used by males. Similarly, females were also most likely to choose firearms as their method of suicide. This is important as it represents a change from the traditional female first choice of overdose and poisoning.

Both whites and non-whites were most likely to choose firearms as the primary suicide method , as shown in Figure 12. The second choice for whites was overdose and poisoning, while for non-whites it was hanging. Non-whites were more likely than whites to choose jumping from height, drowning, laceration and miscellaneous methods of suicide.

Percentages for selection of each method for all four primary demographic groups are shown in Figure 13. It is striking that white males, white females, non-white males, and non-white females each were most likely to choose firearms as the primary method of suicide.

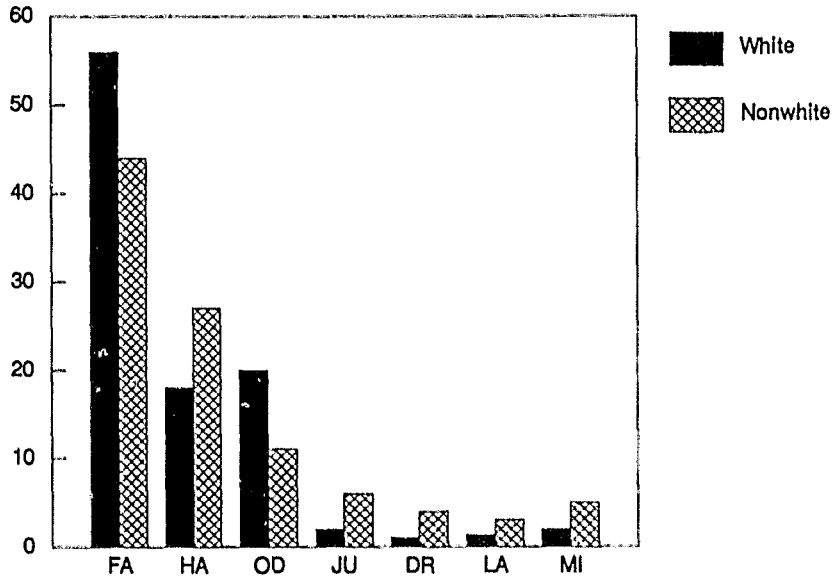
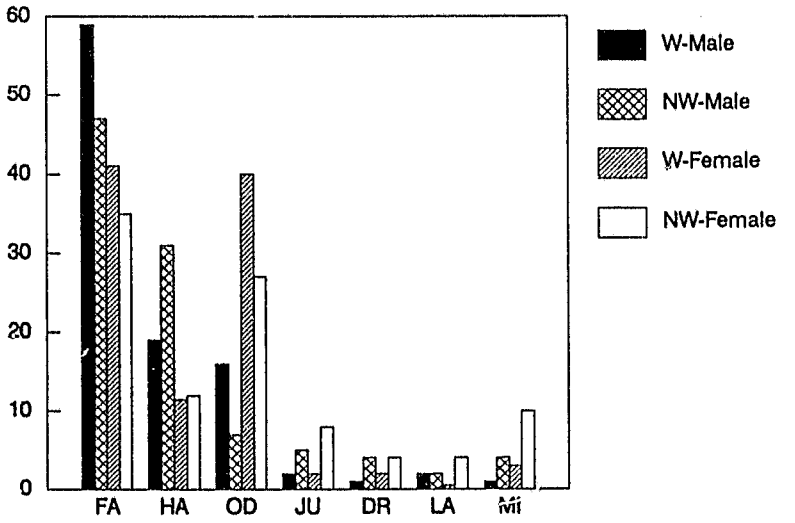


Fig. 12: Percent of Maryland suicide cases (ages 10-24) from 1970 through 1985 for each method by race.

Fig. 13: Percent of Maryland suicide cases (ages 10-24) from 1970 through 1985 by race and sex.

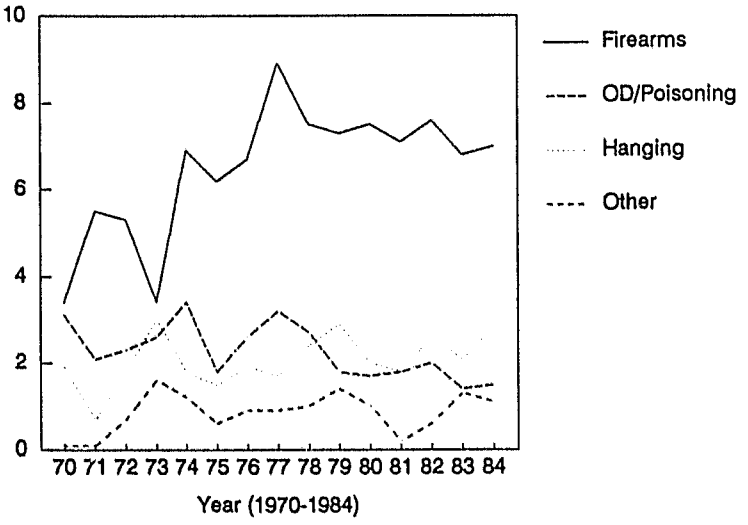


Method selection can be examined alternately by considering the degree to which each demographic group utilized individual methods. Hanging, for instance, was most likely selected by non-white males, while overdose and poisoning was most commonly selected by white females. Non-white females were the most likely to select less common methods such as jumping from height, laceration and miscellaneous.

Suicide Method Selection Trends

The literature on suicide demonstrates that method selection often is influenced by demographic and time factors. Different population groups seem to have methods of choice, which can change over time. The above review of method selection demonstrates that (in this population) the majority of youth suicides involve firearms. Analysis of the Maryland suicide rate by those aged 15-24 from 1970 through 1984 reveals that the trends regarding firearm suicide have increased markedly. Figure 14 shows the rate for selected methods for this population and time period. Rates for firearms, overdose and poisoning, hanging, and all other causes are shown for the years 1970 through 1984. The firearm rate increased and remained high, while the three other method rates remained stable or declined.

Fig. 14: Maryland youth (ages 15-24) suicide rate per 100,000 for selected methods for the years 1970 through 1984.



The significance of the increased rate of firearm suicides in relation to the increased Maryland youth suicide rate is indicated in Figure 15. This graph presents linear regression lines for all 15 to 24-year-olds and their suicide rates, the rate of suicide by firearms in this age group, and the rate of suicide by all other methods combined. The bottom dotted line shows that the rate for all other methods has not changed much during this time. In contrast, the firearm suicide trend has increased in a manner that directly parallels the overall youth suicide rate. This data, therefore, suggests that the increase in the suicide rate among Maryland youth aged 15-24 between 1970 and 1984 is due largely to the increase in firearm suicides.

Summary

This demographic and temporal review of youth suicides in Maryland during recent decades demonstrates several important trends. These are presented by statistics on the Data Summary page included in the Executive Summary. This type of analysis is critical to the understanding of patterns of suicidal behavior. With this knowledge, individuals at higher risk for suicide can be identified more effectively. Resources for prevention and intervention can be focused where needs are greatest. This type of information can be used to stimulate new legislative initiatives, in addition to support necessary mental health services and educational activities. Ideally, further research will be able to consider additional variables, thereby enhancing our ability to identify young people most likely to benefit from suicide prevention services.

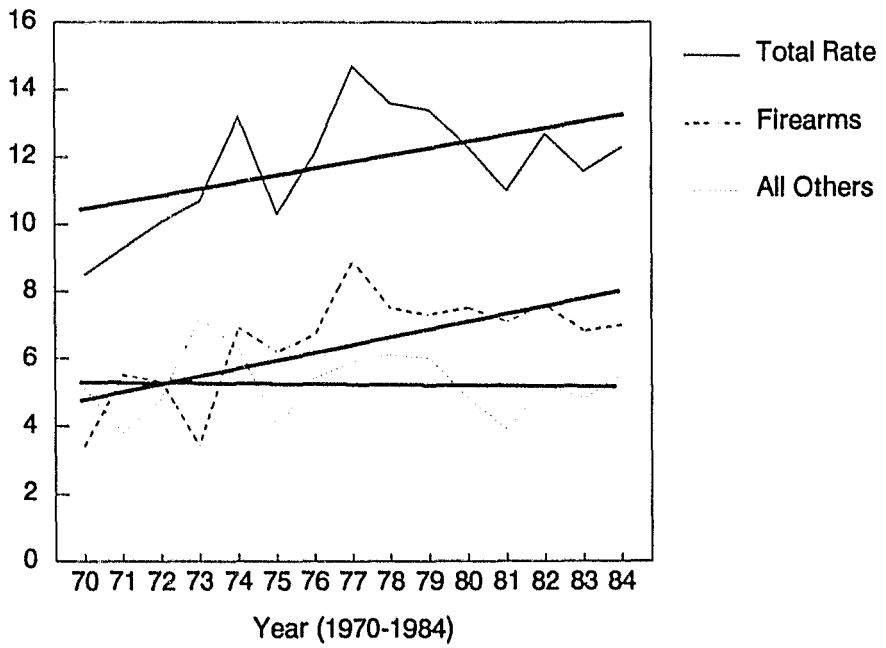


Fig. 15: Regression lines of rate per 100,000 for total Maryland youth (ages 15-24) suicide, youth firearm suicide, and all other youth suicide for the years 1970 through 1984.

TABLE 1

Number of Maryland Youth Suicide Deaths by County of Residence (1970-1985)

County of Residence	Cases (ages 10-24)
Allegany	14
Anne Arundel	139
Baltimore City	311
Baltimore	249
Calvert	14
Caroline	8
Carroll	36
Cecil	22
Charles	16
Dorchester	9
Frederick	42
Garrett	5
Harford	42
Howard	42
Kent	3
Montgomery	208
Prince George's	254
Queen Anne's	8
Saint Mary's	27
Somerset	4
Talbot	8
Washington	27
Wicomico	21
Worcester	11
Statewide	1520

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TASK FORCE RECOMMENDATIONS: AN OVERVIEW

The Committees of the Task Force formulated recommendations based on their research, review of over 150 documents, and key informant interviews. The full Task Force reviewed and analyzed the Committee reports and information submitted for the Public Hearing. The Executive Committee, composed of the Committee Chairpersons, took all of this information and combined it into suggested recommendations. The Task Force and Liaisons met in an all day workshop to finalize the recommendations, rationales, and implementation steps. The recommendations are organized into three overall recommendations with 16 priority recommendations organized under them. Rationales and implementation steps are provided for each recommendation and fiscal implications are included for selected initiatives that focus on youth suicide issues.

The recommendations presented are starting points for further planning and the development of implementation strategies and actions. Recommendation I describes what youth suicide prevention services are needed in Maryland. To develop this Continuum, the Task Force believes it is essential to have a focal point in the State to coordinate fragmented services and develop additional ones. Recommendation II is for a Maryland Council for Youth Suicide Prevention to be the focal point. The Council would report to the Governor and General Assembly and direct the implementation of this Plan. In Recommendation III, the Task Force describes the need for partnerships and collaborative actions by local, State, and federal governments with the private sector.

I. CONTINUUM OF YOUTH SUICIDE PREVENTION RESOURCES

RECOMMENDATION: Provide authorization and funding to implement a Continuum of Youth Suicide Prevention, Intervention, and Postvention Resources that is accessible to all youth in Maryland.

RATIONALE: A suicidal youth can be confronted with the harsh reality that there may not be appropriate, accessible services available to respond to his/her immediate and critical need for help. Youth suicide prevention resources in Maryland are fragmented and uncoordinated. There are too few resources devoted to youth suicide; thus, many youth and their families are unserved, underserved, or inappropriately served. Many gatekeepers who serve youth at risk of suicide and survivors are not adequately trained. The dramatic rise in suicides in youth aged 15-24 has not stimulated the development of adequate resources in Maryland. In fact, some resources, such as the State funding for local hotlines, have been cut back.

Youth suicide is a mental health problem; yet, there are not enough mental health resources to address this problem adequately. In many cases youth suicides can be prevented. Therefore, adequate prevention and mental health programs and services must be provided in local communities, schools, and institutions especially for high risk youth including substance abusers, depressed youth, and institutionalized youth. Youth suicide prevention services can be coordinated with or integrated into existing services of the Department of Health and Mental Hygiene (DHMH), Maryland State Department of Education (MSDE), Juvenile Services Agency (JSA), Department of Human Resources (DHR) and other appropriate public and private sector organizations.

The proposals for youth suicide resources in this Plan are not for the most part dependent on new laws and programs but are in many cases expansions or refinements of existing plans such as the *Interagency Plan for Children with Special Needs*, the Mental Hygiene Administration's *Addendum to the Five Year Master Plan for Deinstitutionalization of Chronically Mentally Ill Persons in Maryland - Chapter 8 - Emergency Services (Emergency Services Chapter)* and *Five Year Plan for Children and Adolescents*, and the Maryland State Department of Education's *Youth Suicide Prevention School Program*.

A continuum of resources can be used by State and local planners, advocates, and service providers to identify which mental health resources and treatment programs and centers already exist in local communities and which need to be developed. Existing State continuums do not specifically address youth suicide prevention. Therefore, the Task Force developed the following Continuum of Youth Suicide Prevention Resources which will be necessary if Maryland is to effectively address the issue of youth suicides.

A. EMERGENCY RESOURCES

1. TELEPHONE CRISIS HOTLINES – These must be available statewide on a 24 hour a day basis. The telephone number must be distributed widely, and the call should be free from any phone. They must be part of a 24 hour point of contact service. Services must include crisis counseling, connection to emergency services, information about mental health resources available, including how to obtain emergency evaluations, and referral to mental health clinics.
2. EMERGENCY ROOMS – These must be available 24 hours a day for acute crisis intervention and for the medical management of persons who have attempted suicide. Mental health professionals with suicide prevention training must be available for consultation 24 hours a day for evaluation and follow-up planning for potentially suicidal individuals. Suicidal youth should be seen in Designated Psychiatric Emergency Facilities.

3. MOBILE TREATMENT AND OUTREACH – There should be an interdisciplinary team that could travel to the scene of a crisis and offer active and immediate intervention.
4. TRANSPORTATION – Emergency transportation to a treatment facility, such as an emergency room, must be available. There should also be a mechanism for transporting the individual to an inpatient facility when this is necessary. This service should be available 24 hours a day.

B. COMMUNITY RESOURCES

1. PREVENTION – Services that seek to anticipate the occurrence of suicides and act to prevent them are an essential component of a comprehensive continuum of resources and must be available in each jurisdiction. Examples of prevention programs that can be provided by community, mental health, and educational organizations are: community education, health education, and life skills programs in the schools; a clearinghouse for information and resources; professional education; and parent education.
2. INFORMATION AND REFERRAL SERVICES – These provide basic information related to suicide prevention and intervention. These services provide formal or informal referrals to service providers and must be available throughout the State.
3. SCHOOL PROGRAMS – Schools must have suicide prevention curricula. Additionally, trained personnel must be available to manage suicidal individuals; and peer helper/facilitators must be available to channel these individuals into appropriate intervention and postvention services.
4. TRAINING AND CONSULTATION – The knowledge, skills, and attitudes of service providers must be improved so they can effectively and appropriately serve youth at risk of suicide and survivors. Gatekeepers who should have training and consultation include: professional and community members such as teachers, school counselors, other school personnel, child protective service workers, foster parents, staff of youth agencies, religious leaders, juvenile justice personnel, staff of domestic violence programs, substance abuse treatment personnel, funeral directors, college advisors, dormitory counselors, law enforcement personnel, emergency personnel, hospital personnel, medical examiners, community counseling center staff, HMO staff, media representatives, PTA members, social service staff, runaway shelter staff, personnel of institutions, day care personnel, health care personnel, employers of large groups of youth, and other individuals who may be of assistance in dealing with a crisis.
5. OUTPATIENT SERVICES – Community mental health centers, youth services bureaus, and other services providing care at no cost or with fees dependent on the individual's ability to pay must be available to serve all local jurisdictions. Private clinics and individual mental health professionals will exist in certain areas. Available services should include diagnostic assessments, medications, and a variety of psychotherapeutic approaches (e.g. family therapy). Outpatient care may be the primary referral for some individuals, or may represent follow-up treatment after a hospitalization.
6. GRIEF COUNSELING AND SURVIVORS' SUPPORT GROUPS – These types of resources can be very helpful for survivors in the positive resolution of their grief and the timely return to a productive life. Similar resources should be developed for the families of suicide attempters.

7. DRUG AND ALCOHOL PROGRAMS — Drug and alcohol abuse are significant risk factors in youth suicide. Help with these problems may reduce that risk. Addictions personnel dealing with these problems also must be trained to identify and manage suicidal youth.
8. CHILD PROTECTIVE SERVICES — Child abuse and unstable living situations may promote suicidal behavior. Protective services personnel must be trained to identify and manage suicidal youth.
9. DAY HOSPITALS — These types of services can be useful in lieu of hospitalization or as an intermediate step following a hospitalization and prior to dependence on less frequent outpatient therapy. They allow daily observation and treatment.
10. CASE MANAGEMENT/SERVICE COORDINATION — To assure that suicidal youths receive the most appropriate treatment, case management/ service coordination programs are needed. These services help youths and their families to obtain and coordinate the necessary services as the involvement of more than one agency is often needed for suicidal youths.
11. EMPLOYEE ASSISTANCE PROGRAMS — Employers provide these programs to assist employees in identifying and resolving personal problems which can affect their job performance. These programs can help employees confronted with the problems of youth suicide. More employers need to provide these confidential and professional programs.

C. OUT-OF-HOME/SUBSTITUTE CARE RESOURCES

1. GENERAL HOSPITALS — At a minimum, general hospital beds must be available locally to treat youth who have attempted suicide, or to help in the temporary management of potentially suicidal youth. Psychiatric and/or psychological consultants should be available. Twenty-four hour one-to-one supervision may be necessary for some patients.
2. ALTERNATE LIVING SITUATIONS — In some cases it is not therapeutic for the individual to return to the home living situation. A number of alternatives must be available for children and youth unable to return home. These include group homes, halfway houses, runaway shelters, emergency shelters, short-term evaluation sites, and foster care. Such placements may involve short-term or long-term crisis housing.
3. INSTITUTIONS SERVING YOUTH — There must be suicide prevention teams in these facilities since the population of institutionalized, detained, and committed youths represents a high-risk Additionally, there must be appropriate mental health evaluation and treatment available when potentially suicidal individuals are identified.
4. PSYCHIATRIC UNITS — There should be a specialized psychiatric unit in a general hospital or a separate psychiatric hospital. Facilities accepting involuntary patients must be available, as well as hospitals that are able to accept individuals who have no insurance. These units need not be present in all local jurisdictions; however, such facilities must be accessible to individuals from all areas.
5. CHILD AND ADOLESCENT PSYCHIATRIC UNITS — These types of facilities are appropriate for certain suicidal youths. Acute care facilities should be available for those children and youth who require this kind of intervention.

IMPLEMENTATION STEPS:

1. Develop a focal point in State government to coordinate youth suicide prevention resources and stimulate the development of new services.
2. Modify relevant State plans to incorporate an emphasis on resources for youth suicide prevention including the Mental Hygiene Administration's *Emergency Services Chapter* and *Five Year Plan for Children and Adolescents*, as well as the *Interagency Plan for Children with Special Needs*.
3. Identify which parts of the Continuum of Resources are currently available and which are needed in each county, Baltimore City, and/or region.
4. Involve private agencies in developing and coordinating youth service prevention resources.
5. Provide State funding for the Department of Health and Mental Hygiene, Maryland State Department of Education, Juvenile Services Agency, Department of Human Resources, and other State agencies serving youth to prioritize and expand youth suicide prevention resources appropriate to the populations they serve.

II. FOCAL POINT IN STATE GOVERNMENT

RECOMMENDATION: Establish, by an Executive Order, a focal point in State government to coordinate youth suicide prevention, intervention, and postvention activities by creating a Maryland Council for Youth Suicide Prevention in the Governor's Office for Children and Youth.

RATIONALE: There is a desperate need in Maryland for a central, accessible resource for distraught parents and troubled youth, as well as others in the community who are touched by the turmoil of youth suicide, to turn for immediate help and direction. Youth suicide prevention, intervention, and postvention resources in Maryland are fragmented and uncoordinated. Hundreds of youth routinely "fall through the cracks" and die by suicide while countless thousands are devastated and jeopardized as a result. As one parent survivor stated, "These are our children and grandchildren."

No State agency assumes primary responsibility for coordinating youth suicide prevention programs and activities. Public and private sector resources are being utilized for services that could be provided more efficiently and effectively as part of a comprehensive system of resources that are appropriate, accessible, and responsive.

If the State is to address the youth suicide issue in an effective, comprehensive, and coordinated manner, there must be a focal point in State government which will coordinate the many and varied resources necessary to save the lives of our youth. A Maryland Council for Youth Suicide Prevention, similar to the Governor's Council on Adolescent Pregnancy, is needed to provide an authoritative resource and source of information.

The Council would provide the organizational framework, requested in the Joint Resolutions in 1986, "to focus the efforts of State and local communities and mental health agencies, together with families, educational institutions, and others involved in programs geared to combat child, teenage, and young adult suicide." The Council would monitor and coordinate existing and future resources devoted to the problem of youth suicide and would stimulate and develop a viable partnership between the public and private sectors. It would be the catalyst for collaborative programs and activities by citizens, businesses, nonprofit organizations, and government throughout the State.

There needs to be a Maryland Council for Youth Suicide Prevention composed of caring, well-informed individuals who can continue to monitor the ongoing effort to save valuable young lives and ensure their future and ours. With a membership of individuals experienced in youth suicide issues and representative of the public and private sectors, the proposed Council would prove to be an invaluable resource to the Governor and the General Assembly in their efforts to address the issues of youth suicide. It is crucial to continue the momentum of the Task Force and to have a smooth transition. This could be facilitated by including individuals who served on the Task Force as initial members of a Council.

The Council would provide a clearinghouse, technical assistance, coordination of a Statewide toll-free 24-hour hotline, resources for local services and State agencies, coordination of data collection and dissemination, and training resources. A fuller description of the functions needed at a State level that could be best provided by a Council is included in Recommendations II A through I. The problem of youth suicide is not going to solve itself. The proposed Council is needed to help resolve the complex problem of youth suicide in Maryland.

IMPLEMENTATION STEPS:

1. Request that the Governor issue an Executive Order to create a Maryland Council for Youth Suicide Prevention.

2. Request that the Governor appoint Council members who have a demonstrated interest in youth suicide issues. Current members of the Governor's Task Force on Youth Suicide Prevention would be very effective in a transition to the Council because of their extensive knowledge of and involvement in the issue.

   To assure that Council members possess the necessary expertise, recommendations could be requested from organizations concerned with youth mental health and youth suicide. The Chairperson and Vice Chairperson would be appointed by the Governor. Equitable geographic representation on the Council could be achieved by selecting members in accordance with the four regions of the Mental Hygiene Administration.

   Included in the composition of the Council membership could be representatives of: the Senate (1); the House of Delegates (1); local youth suicide prevention and treatment services or coalitions (4); high school age youth (2); college-age youth and young adults up to age 24 (2); physicians (1); suicide survivor/support groups (1); mental health professionals (3); the clergy (1); personnel from public and private schools (3); police officers (1); fire department medical emergency teams (1); business and corporate sectors (2); media (1); advocacy organizations involved in youth suicide issues (3), and the general public (2).

3. Request that State government agencies appoint nonvoting ex officio members to the Council who would serve as liaisons. Among the agencies to be included are the: Maryland State Department of Education, Department of Health and Mental Hygiene, Office of the Chief Medical Examiner, Addictions Administration, Mental Hygiene Administration, Department of Human Resources, Juvenile Services Agency, State Board of Higher Education, Department of Public Safety and Correctional Services, and Attorney General's Office.

4. Require that Council meetings be convened at least quarterly or more frequently at the discretion of the Council.

5. Require the Council to report its findings to the Governor and General Assembly at least annually.

FISCAL NOTE: Based on the model of the Governor's Council on Adolescent Pregnancy which has a staff of five, the first full year of funding would be approximately $200,000, a cost of less than 15 cents per Maryland resident between the ages of 5 and 24. It is strongly urged that this staffing be phased in beginning in FY 1988.

A) RECOMMENDATION: Implement the Task Force's recommendations by coordinating and monitoring private and public youth suicide prevention, intervention, and postvention efforts in the State.

RATIONALE: There is no one state government body to coordinate and monitor both public and private resources which provide youth suicide prevention, intervention, and postvention services. A coordinated approach would save dollars and lives. Currently, there are not enough services. It is not unusual for youths and families to be confronted with inappropriate, fragmented, and inaccessible services. A Council would coordinate and monitor resources at a State level, which would facilitate the obtaining of appropriate, timely local services. There is a clear need for a sustained effort to develop an interagency, multidisciplinary approach to youth suicide prevention at the State and local levels. There is a need to involve youths, families, elected officials, representatives of business, professionals, gatekeepers, and concerned citizens in this coordination and oversight. This would be done by the proposed Maryland Council on Youth Suicide Prevention.

IMPLEMENTATION STEPS:

1. Set up a system to coordinate and monitor youth suicide prevention activities and programs by the proposed Maryland Council for Youth Suicide Prevention.
2. Promote cooperation of federal, State, and local youth suicide prevention programs.
3. Hold hearings and meetings to obtain information to assist the Council to effectively coordinate and monitor suicide prevention efforts.

B) RECOMMENDATION: Serve as a clearinghouse for information and resources to provide technical assistance, training, consultation, public awareness, and educational programs including conferences with a particular emphasis on reaching gatekeepers.

RATIONALE: If Maryland is to put forth a concerted effort to combat child, teenage, and young adult suicide and other related mental health disorders, the approach must be the combined efforts of all professionals and community members, from both the private and public sectors, working together to provide a comprehensive service delivery system. To ensure this collaborative effort, there needs to be a proposed Maryland Council for Youth Suicide Prevention to be responsible for providing coordination, technical assistance, training, consultation, public awareness, and educational programs on a statewide basis. An emphasis should be placed on providing gatekeepers with resources and recommended interventions.

The media is not always sensitive to the potential of imitative behavior and the contagion effect that can be caused by its portrayal of youth suicides. Guidelines need to be developed to limit sensationalism, romanticizing the circumstances, attention to violence, and creation of a celebrity status. A broad range of public information approaches needs to be developed to convey preventive information on potentially harmful or self-destructive behaviors. Existing informational products and presentations should be reviewed and appropriate ones selected for community organizations, groups, parents, individuals, children, teenagers, and young adults.

IMPLEMENTATION STEPS:

1. Collect, review, and distribute selected general information and educational materials for the public and media statewide.
2. Compile, analyze, and provide statistical information on the issue.
3. Establish a State training team responsible for providing technical assistance, training, and educational programs, including conferences, with particular emphasis on reaching gatekeepers, to provide them with resources and recommended interventions.
4. Work with the media to develop a variety of approaches and guidelines about how to communicate about potentially harmful or self-destructive behaviors including suicide as well as to develop programs which can help decrease suicide.

C) RECOMMENDATION: Develop a coordinated statewide toll-free 24 hour Hotline number to provide immediate linkages with local resources, crisis intervention services, and information and referral.

RATIONALE: Youths experiencing a suicide crisis and their families often do not know where to call for help. The citizens of Maryland do not have equal access to a well known crisis intervention service on a 24 hour basis. There is one toll-free statewide information and referral line located in Baltimore City. There are a number of hotlines scattered across the State

including six or seven 24 hour counseling services located in five of the 24 jurisdictions. There are over 150 services spread across the State providing a spectrum of assistance from strictly information and referral to trained telephone counseling by paid staff and volunteers. In spite of these resources, a recurring theme at the Task Force's Public Hearing concerned a lack of accessible telephone crisis intervention services.

Current resources are piecemeal and uncoordinated. Therefore, a well known telephone number, accessible from any phone at no charge to the caller, 24 hours a day, 7 days a week providing a crisis intervention hotline, must be made available to every citizen in Maryland. Some local jurisdictions do not have a hotline, whereas others have many. When there are local hotlines, it would be advantageous to utilize their expertise. Start-up costs and operating costs would be reduced if existing hotlines are used.

There are existing and proposed hotlines which do or could include services for suicidal youth and their families. These services need to be available in each local jurisdiction. Initially the Task Force proposes starting with six regional 24 hour hotlines which are certified to provide a variety of hotline services including youth suicide intervention services. This system would utilize one toll free phone number statewide so every caller would be immediately connected with the regional hotline nearest to the place from which the call was made. These regional hotlines would be tied into designated local hotlines so the caller could talk with a local service when one is needed and available. This 950 number should be publicized widely in public service announcements, prominent listings in telephone directories, educational materials, and through other means.

The Task Force believes a generic hotline can provide telephone services for a variety of target audiences such as the chronically mentally ill, pregnant teens, substance abusers, victims of domestic violence, and children who are abused. Generic hotlines could be funded from a variety of sources and could be the most cost efficient and effective way of providing hotline services to those in need in all local jurisdictions.

In reviewing options of an 800 number, 911, and 950 number which has seven digits such as 950-HELP, the 950 option appears to be the most feasible and cost effective means of meeting the needs of a suicide emergency call. This system would use the the C & P Telephone Company's Equal Access Tandem Technology. A caller could dial the number free from anywhere in the State and be connected automatically to a regional hotline tied in with resources from their local community and the Maryland Council for Youth Suicide Prevention. This 950 number could be a national model. This proposed network is adaptable for all communications enhancements such as call forwarding, automatic call distribution, automatic number identification, etc., if need is determined and additional funding is provided.

This proposed statewide network could be adopted more rapidly and economically by utilizing existing hotlines. Start-up time and costs as well as operating costs would be substantially decreased by taking advantage of existing expertise, resources, office space, and staff.

IMPLEMENTATION STEPS:

1. Establish a certification process for agencies acting as crisis hotlines.
2. Establish a single telephone number network which would be accessible by any citizen, from any phone, 24 hours a day, seven days a week using already existing Equal Access Tandem Technology of the C&P Telephone Company.
3. Integrate certified regional, State, and local hotlines by establishing and funding a statewide Network using existing generic hotlines in each of the Maryland Local Access Transport Areas (LATAS), which are shown on a map in Appendix J. The Baltimore and Washington LATAS are expected to require more than

one 24 hour point of contact. Therefore, six regional hotlines are proposed initially.

4. Request the Mental Hygiene Administration to include youth suicide hotline services in planning documents such as the *Emergency Services Chapter* and the *Five Year Plan for Children and Adolescents.*
5. Endorse and support the Association of Maryland Hotlines, Inc.
6. Publicize the 950 number throughout the State.

FISCAL NOTE: The C&P Telephone Company of Maryland estimates that calling within a LATA would be a "fraction" of regular long distance calling costs. They developed estimated costs for a 950 calling network with six regional hotlines based on 100 calls per day lasting 15 minutes with 1/2 of the calls transferred to other hotlines, and at no cost to the caller.

The cost for building the statewide telephone network of six regional hotlines would be a one time installation charge of $16,089. Ongoing costs are estimated at $19,126 monthly or $229,512 annually. The estimates do not include any on-site telephone equipment or additional staffing for the regional hotlines that may be necessary. The basic estimate would vary depending on actual calling volumes.

Funding for the installation, operating costs, staffing, and other expenses of hotlines connected to a 950 number must come from a variety of sources such as businesses, an additional charge added to telephone bills similar to funding for 911, and from State agencies with existing and planned hotlines.

D) RECOMMENDATION: Advise and report to the Governor and General Assembly on the status of youth suicide prevention activities in Maryland.

RATIONALE: There is no ongoing body to report regularly to the Governor and the General Assembly in Maryland on youth suicide prevention issues. Improved services are dependent on knowledgable elected officials. The proposed Maryland Council on Youth Suicide Prevention would be a valuable resource which would be responsible for regular reporting to the Governor and General Assembly on the status of youth suicide prevention activities in Maryland, the needs, and recommended actions.

IMPLEMENTATION STEPS:

1. Create a Maryland Council on Youth Suicide Prevention.
2. Require the Maryland Council on Youth Suicide Prevention to report regularly, at least annually, to the Governor and General Assembly on the status of youth suicide prevention activities in Maryland, the needs, and recommended actions.

E) RECOMMENDATION: Require State agencies serving youth to have trained personnel, particularly at the local and institutional levels, to provide accessible prevention, intervention and postvention services to respond to suicide crises.

RATIONALE: When a youth in crisis cries for help, personnel must respond with more than sympathy. Many adults who are responsible for and who interact with youths need to be better informed about the pressures faced by today's youth. It is essential that all persons who care for or come in contact with suicidal individuals be trained specifically to recognize the warning signs and utilize appropriate prevention, intervention, and postvention techniques and resources. This training must be comprehensive and systematic to ensure that the services are responsive to the needs of the recipients, whether they are attempters or survivors.

The Task Force conducted a survey of eight State agencies and local police departments to find out what types of training programs were being conducted presently. It was difficult to identify appropriate departments, individuals, and programs involved in youth suicide

prevention training activities. The programs were piecemeal, uncoordinated, and not comprehensive.

IMPLEMENTATION STEPS:

1. Involve the Department of Health and Mental Hygiene, Maryland State Department of Education, Juvenile Services Agency, Department of Human Resources, Division of Correction, and other State agencies which serve youth in the development, implementation, and evaluation of a comprehensive training curriculum for in-service training and refresher training of all personnel and volunteers.
2. Provide funding for the following:
   a. Development and reproduction of a comprehensive training package, including audio-visuals, trainers' guides, and trainees' workbooks for use statewide.
   b. Train-the-trainer sessions at regional and community levels.
   c. A statewide training team to provide ongoing technical assisance, monitor training activities, and assess agencies' progress and assurances.
3. Involve all direct and non-direct care staff at state institutions in a training program focusing on prevention, intervention, and postvention. Staff is to be trained in recognizing signs of potential suicidal behavior (prevention), making referrals (intervention), and dealing with resident survivors following an attempt/completion (postvention). Training should occur as an in-service requirement for all personnel.
4. Involve the Department of Human Resources, Addictions Administration, Juvenile Services Agency, Division of Correction, and Mental Hygiene Administration in the development and implementation of in-service training activities to educate gatekeepers including: foster care parents and workers, juvenile counselors, protective service workers, addiction counselors, and single parent service workers in recognizing at-risk factors connected with potential suicidal behavior. Training should also include appropriate referral responses/actions when a youth exhibits these signs and an awareness of appropriate referral sources in the community. Training can be done in partnership/consultation with existing resources such as youth services bureaus, community mental health centers, and mental health professionals.
5. Establish suicide intervention measures at the school, community and institutional level which provide and/or assure the delivery of the following services: the presence of a suicide intervention team with clearly defined procedures for handling any potential suicide including what action to take to ensure the optimum safety for the youth and his/her peers; how to make an immediate and appropriate referral to medical and/or psychological providers; and the implementation of a process for early identification and rapid intervention to prevent potential cluster suicides.
6. Implement suicide postvention procedures at the school, community, and institutional level to assure access to trained providers to work with survivors following an attempted or completed suicide to allow an appropriate grieving/healing time and facilitate a smooth transition back to the normal routine; and to establish a standard data collection protocol to document attempted and completed suicides.

F) RECOMMENDATION: Develop administrative and legislative initiatives to coordinate the collection, analysis, and dissemination of accurate and complete data on youth suicide completions and attempts in Maryland.

RATIONALE: Statistics with respect to the nature and extent of completed and attempted suicides are of vital importance in epidemiologic research, in determining health needs, and in evaluating health and human service prevention, intervention, and postvention programs.

In view of this importance, particularly with respect to the mortality and emotional casualty rates among our young, it is essential that valid and comprehensive data detailing the incidence and characteristics of youth suicide completions and attempts in Maryland be collected in such a manner that they are readily available for appropriate analysis and for rapid utilization in documenting service needs, generating casual hypotheses, and for developing and evaluating community-based prevention and intervention strategies. To assess the validity and efficiency of our existing system, an extensive analysis of youth suicide data from 1970 to 1985 and an intensive record review of a selected sample of autopsy records of youth deaths in Maryland in 1985 were undertaken. These studies led to the following recommendations with respect to improving the data collection and dissemination process so that the unmitigated tragedy of youth suicide can be addressed more effectively in our State.

IMPLEMENTATION STEPS:

1. Improve the investigation and reporting of youth suicide attempts through administrative and/or legislative initiatives to accomplish the following:
   a. Mandate Designated Psychiatric Emergency Facilities (DPEF) and request all other emergency rooms in the State, through administrative processes, to complete the current suicide-related aspects of the Department of Health and Mental Hygiene Administration (DHMH) Form 500 and provide sufficient funds to process, analyze, and disseminate this information in a timely manner.
   b. Revise and enhance DHMH Form 500 to include relevant demographic and other data involving mandatory follow-up information regarding referral and aftercare for attempters and survivors.
   c. Develop and implement a standard police investigation protocol, which would complement the revised DHMH Form 500, and which would include documented involvement in the investigation by designated mental health professionals who may be part of local suicide prevention teams.
   d. Develop a unique and untraceable identification code such as race, sex, date of suicide attempt, and/or date of birth to permit weeding out of duplicate reports with a minimum margin of error and no risk of tracing information back to individual identities.
   e. Develop and implement a standard form which would complement the revised DHMH Form 500 and which would document all suicide-related incidents with respect to the following special populations so that high-risk individuals can be identified, tracked, and monitored by confidential computerized management information systems within individual agencies. Cumulative descriptive data with respect to these special populations can be generated and forwarded to a central collection point.
      (1) For all children and youth in State custody including those in institutional placements, hospitals, RICA's, correctional facilities, group homes, foster care, etc.

(2) For all children and youth involved with State funded treatment and/or intervention programs including clients of the Mental Hygiene Administration, Addictions Administration, Developmental Disabilities Administration, Juvenile Services Agency, Department of Human Resources, community rehabilitation programs, youth services bureaus, hotlines, crisis intervention programs, etc.

(3) For all children and youth enrolled in public education programs.

2. Enhance investigation and accurate reporting of youth suicide completions through the Office of the Chief Medical Examiner.

a. Develop and implement a standard and expanded death investigative protocol for use by police which will involve designated mental health professionals, who may be members of local suicide prevention teams, in the investigation. A report will be forwarded with the body and/or telephoned to the Medical Examiner's Office. It will document demographic information, secondary causes of death, drug or alcohol use, mental health treatment history, specific type of weapon used, precipitating circumstances, etc.

b. Develop and implement a standardized protocol for youth suicide records at the Medical Examiner's Office which will include a fully completed death certificate to be forwarded to the Medical Examiner's Office for the files.

c. Expand the research capabilities of the Medical Examiner's Office with respect to identifying secondary causes of death and associated factors for youth suicides through the funding of appropriate equipment, supplies, and personnel to accomplish the following:

(1) Additional biochemical screening for biological markers of depression and aggression.

(2) Drug screens for all commonly abused drugs on all unnatural youth deaths.

(3) Pregnancy screens on female suicides and undetermined female youth deaths.

(4) AIDS/HIV screening on youth suicides or undetermined deaths.

d. Establish in the Medical Examiner's Office a confidential computerized management information system to facilitate the collection and analysis of descriptive statistics, which also can be forwarded to a central data collection point, so that emerging state or local trends with respect to the extent and nature of changes in youth suicidal behaviors and/or risk factors can be identified and disseminated rapidly.

e. Establish within the Medical Examiner's Office a Quality Assurance panel which could include representatives of the Medical Examiner's Office, law enforcement and emergency room personnel, mental health professionals, etc. involved in suicide prevention to routinely review a random sample of all unnatural youth deaths to accomplish the following:

(1) Confirmation of accuracy rate of death classification.

(2) Identification of rates of victim precipitated murders and subintentional suicides.

f. Improve initial and ongoing training of all personnel involved in the investigation and reporting of youth suicide deaths through mandating in-service training for deputy medical examiners; law enforcement personnel; emergency room, paramedic, and rescue squad staff; and local suicide prevention teams.

3. Enhance the collection, analysis, and dissemination of all data related to suicide attempts and completions.

   a. Establish a single data point within each major reporting State agency and within each local health department through the funding of appropriate equipment, supplies, and personnel to collect, analyze, and disseminate the relevant statistical data for that reporting unit. This will permit the tracking and monitoring of high risk individuals over time. Appropriate information can be forwarded to the central data point.

   b. Establish and fund a central data point within the State, preferably at the proposed Maryland Council for Youth Suicide Prevention, which will collect and coordinate data from all reporting sources, develop and disseminate appropriate descriptive statistics, and have the capability to develop functional linkages to academic institutions so that their equipment, expertise, and graduate student manpower can be utilized for more sophisticated analysis and dissemination of youth suicide information.

G) RECOMMENDATION: Study ways of improving health and mental health insurance coverage and removing barriers for individuals at risk of suicide.

RATIONALE: It has become commonplace in the field of suicide prevention to acknowledge the reality of underreporting of all suicide-related incidents. A review of the relevant literature as well as extensive interviews with key personnel from the Insurance Division of the Department of Licensing and Regulation and Office of the Chief Medical Examiner revealed that a variety of insurance barriers exist to full and accurate reporting. These include the following:

1. The potential for denial to a family of death benefits through suicide exclusion clauses.
2. The potential for losing psychiatric health care coverage because of previous treatment history through pre-existing conditions clauses.
3. The potential for losing health care benefits, both physical and psychiatric, as a result of "self-destructive" exclusion clauses.

It is particularly tragic that some of the language and exclusionary clauses found in current insurance policies are clearly archaic and do not take into account the biological basis for many serious mental disorders. In fact, we continue to perpetuate a double standard of life insurance and health care benefits where mental illness is treated as significantly different from physical illness, despite medical evidence to the contrary. Consequently, it is important that the whole issue of insurance-related barriers to accurate reporting and to preventive treatment be fully explored.

In addition, many educators and other professionals involved with youth appear reluctant to identify and/or refer individuals at-risk for the same reasons that substance abuse and/or child abuse often went unreferred and/or underreported for so many years. Legislative initiatives gave minors the right to seek assistance for substance abuse and strictly protected the confidentiality of all related information. Legislation also mandated reporting of child abuse with extensive procedural safeguards to protect the child and the reporter from unproductive parental reactions while ensuring that the child would get the needed assistance. It would appear that some type of similar legislative initiative, particularly with respect to any Task

Force recommendation involving treatment, prevention, and/or reporting activities should be explored so that all barriers to accurate reporting and treatment access would be removed.

IMPLEMENTATION STEPS:

1. Refer to other task forces and/or insurance commissions for definition and investigation of suicide related issues particularly with respect to the following:
   a. Definition and use of *insane*, *pre-existing*, *acute case*, and *self-destructive* as they apply to death benefits and health care.
   b. Apparent unjustified discrimination between physical and mental illness even through a biological basis for depression and schizophrenia is now well established.
   c. Malpractice liability issues which weigh against the treatment of high-risk suicidal individuals.
   d. Confidentiality protections related to computerization of data and central health care insurance data banks which mandate disclosure of previous treatment history with potential for inappropriate health benefit denial.
2. Explore the development of appropriate legislation to:
   a. Safeguard and strictly protect information and reports related to suicide attempts and/or completions.
   b. Establish guidelines with respect to a minor's right to consent to treatment with regard to suicide prevention and/or intervention services and the clarification of parental rights and obligations.

H) RECOMMENDATION: Encourage the counties and Baltimore City to develop and support Youth Suicide Prevention Councils or Task Forces to coordinate local efforts.

RATIONALE: One of the main themes of the Task Force's Plan is that the implementation of its recommendations must be accomplished in partnership between State government, local governments, and the community as a whole. The Councils would serve as the focal point for local jurisdictions to respond to this partnership arrangement. The Councils would also provide the avenue through which local input would be provided to the State level. Furthermore, they would provide the visibility and priority necessary at the local level to assure public awareness and support of these programs.

IMPLEMENTATION STEPS:

1. Create guidelines which could be used by local jurisdictions in establishing Councils or Task Forces.
2. Request that each county and the City of Baltimore to establish a local Council.
3. Make the availability of State funding for local youth suicide activities contingent upon the formation of a local Council or Task Force.
4. Regionalize the local jurisdiction in accordance with the four Mental Hygiene Administration regions.
5. Request that the local Councils within each Mental Hygiene Administration region collectively submit a name to the Governor for membership on the Maryland Council for Youth Suicide Prevention.

I) RECOMMENDATION: Coordinate annually, preferably in the fall, a Youth Suicide Prevention Week as a mechanism to educate the public on what can be done to prevent suicides and what resources are available to all.

RATIONALE: The successful implementation of a statewide youth suicide prevention program relies heavily on the broadest possible public awareness and support. The issues relating to youth suicide must have the highest priority and visibility. Programs need to be designed to educate students, families, gatekeepers, and the general public about youth suicide prevention.

One recommended strategy is for the Governor to proclaim annually a Youth Suicide Prevention Week. This was done in 1986 and 1987. Press releases, press conferences, press kits, public service announcements such as the one produced for the Task Force, proclamations, public education materials, and other public relations strategies should be pursued during the week and throughout the year.

IMPLEMENTATION STEPS:

1. Request the Governor to proclaim annually Youth Suicide Prevention Week.
2. Make Youth Suicide Prevention Week a part of an ongoing public relations strategy to prevent youth suicides in Maryland.
3. Involve the public and private sectors in youth suicide prevention activities.

III. COMMUNITY/SCHOOL PARTNERSHIP

RECOMMENDATION: Develop a community/school partnership to provide prevention, intervention, and postvention services utilizing local, State, federal, and private sector resources and funding.

RATIONALE: When a parent thinks his or her child is in danger of committing suicide, there is no time for red tape. A comprehensive system of youth suicide prevention, intervention, and postvention services needs to be accessible. A cooperative effort linking governmental and non-governmental service providers from a variety of disciplines is required to respond to at-risk youth and their families. Resources and funding are needed from local, State, and national governmental and non-governmental sources.

Mental health and education agencies would logically be primary participants and leaders in developing community/school partnerships. Mental health service providers would focus on intervention and postvention strategies while educational institutions would focus on prevention strategies. However, both systems, as well as others, such as the Department of Human Resources and Juvenile Services Agency, would have expertise in all three areas. Legislative and administrative policies need to be further studied to determine which ones need to be revised or developed to build a comprehensive, community-based, accessible system in Maryland. Examples of specific community/school programs and activities that are needed are included in Recommendations III A thru G.

IMPLEMENTATION STEPS:

1. Encourage agencies to request State funding to develop new programs or expand existing ones to provide needed resources.
2. Encourage local government agencies and private nonprofit organizations to include money in their budgets to address these recommendations.
3. Encourage private for-profit and private nonprofit service providers to develop or expand existing programs.
4. Encourage businesses, foundations, and individuals to make contributions to assist agencies to provide improved services.
5. Revise and/or formulate legislative and administrative policies to aid in the development of a comprehensive and accessible system for all youth and families in need of services.

A) RECOMMENDATION: Implement the Maryland State Department of Education's Youth Suicide Prevention School Program, including the establishment of school/community crisis intervention teams and peer helper/facilitator programs.

RATIONALE: In response to increased community concerns and the legislative imperatives expressed in HB 1221 passed in the 1986 General Assembly, the Maryland State Department of Education established the Interagency Committee on Youth Suicide Prevention. This Committee developed and introduced the Youth Suicide Prevention School Program to school systems throughout Maryland. This program has been well received; several school systems have begun the implementation of prevention, intervention, and postvention strategies. One of the key elements of this program is the school/community crisis intervention team which is designed to create a local network of specially trained individuals to address problems which may cause or be a result of youth suicide. Another key element is the peer helper/facilitator team that is comprised of students who have been trained in identifying signs of depression and personal stress in their classmates, and in providing information and help in seeking solutions to those problems. Both of these approaches have been found to be ef-

fective in preventing youth suicide, and they are two of the many key elements that make up the Youth Suicide Prevention School Program. (See Appendices E and F.)

IMPLEMENTATION STEPS:

1. Request that local school systems develop and implement the Youth Suicide Prevention School Program in all schools.
2. Support the implementation of the program and the training of personnel by continuing to include this item in the Maryland State Department of Education budget.
3. Request that local government agencies and support services join with the local school system to implement the Youth Suicide Prevention School Program.
4. Create a model school program which will identify those schools that have youth suicide prevention programs so that they can serve as examples for other schools.

FISCAL NOTE: Based on budgetary information submitted by the Maryland State Department of Education, the estimated cost for the first full year of program development and implementation would be $192,000.

B) RECOMMENDATION: Implement, through the Maryland State Department of Education, comprehensive health education programs (prekindergarten through grade 12) which include a mental health unit that addresses youth suicide prevention and development of life skills.

RATIONALE: The Maryland State Department of Education has initiated a process to revise the Health Education Curriculum used in public schools. The Task Force that has been appointed by the State Superintendent of Schools is developing a curricular framework for prekindergarten through grade 12. The revised curricular framework will propose the implementation of comprehensive health education in all Maryland schools. Comprehensive health education addresses all health issues in a sequential format which is developmentally based and age appropriate. Such a curriculum would include mental health as an integral part of the program and would focus on the importance of students developing life skills. If the incidence of youth suicide is to be reduced, students must learn a variety of life skills including how to cope with stress and other strategies for preventing health problems. Implementation of comprehensive health education will assist students in developing the life skills which are essential for survival.

IMPLEMENTATION STEPS:

1. Request that the Maryland State Department of Education include a mental health unit that addresses youth suicide prevention and the development of life skills in the Health Education Curricular Framework.
2. Recommend that the State Board of Education implement the Health Education Curricular Framework by approving a bylaw which requires that all school systems include health education as part of the prekindergarten through grade 12 curriculum.
3. Support the implementation of a health education curriculum by providing curriculum improvement grants to local school systems in need of funding for such programs.
4. Request that the Maryland State Department of Education and the Department of Health and Mental Hygiene, as well as other State and local agencies, assist

local school systems in the development and implementation of a comprehensive health education curriculum.

C) RECOMMENDATION: Ensure continuation and expansion of the Maryland Department of Education's Student Assistance Program which includes a component on youth suicide prevention.

RATIONALE: The Maryland State Department of Education, with funding from the Masonic Charities of Maryland, has developed a Student Assistance Program which is designed to assist youth who are experiencing alcohol/drug abuse or related problems. The goal of this program is to train a team of school personnel to identify students who have drug/alcohol related problems or who may be at risk of developing such problems, and to refer them to appropriate community resources. This program has been proven successful in the early identification of and intervention in student alcohol and drug abuse problems, as well as in providing support for students returning to school from treatment programs. Research has shown that students who experiment with drugs/alcohol and develop problems related to drug/alcohol abuse are at high-risk of attempting suicide or developing other health problems. It has been estimated that from one- half to two-thirds of those young people who take their own lives have been known to use or abuse drugs and/or alcohol. A component of the Student Assistance Program trains school personnel in youth suicide prevention techniques.

IMPLEMENTATION STEPS:

1. Request that the Maryland State Department of Education expand the Student Assistance Program training currently available.
2. Provide funding to local systems to implement and maintain Student Assistance Program teams in all middle schools and high schools.
3. Support existing and future Student Assistance Program teams by providing continued technical assistance from State and local agencies which provide support services to youth.
4. Recommend that the Maryland State Department of Education increase the number of staff to support the Student Assistance Program training and implementation.

D) RECOMMENDATION: Establish programs within the Continuum of Resources for youth at high-risk of suicide including youth who have a history of depression, suicide attempts, family suicides, substance abuse, child abuse and/or neglect, out of home placements, running away, sexual exploitation, teen pregnancy, AIDS or fear of it, identification with a sexual minority, eating disorders, and other special risk factors.

RATIONALE: As programs are being designed to combat child, youth, and young adult suicide and related mental health disorders, special attention must be given to the needs of those in this age group targeted as high-risk. The Department of Human Resources, Juvenile Services Agency, Mental Hygiene Administration, Addictions Administration, and other agencies dealing with high-risk youth should establish a program of prevention, intervention, and postvention in each of their institutions serving children and adolescents. Institutions include detention centers, correctional facilities, in-patient facilities, and residential treatment centers. Community programs include community mental health centers, foster homes, group homes, halfway houses, runaway and emergency shelters, rehabilitation and psychosocial programs, day care centers, and other programs which serve youth. Youth, their parents, the schools, and social service agencies need to be involved in recognizing, addressing, and combatting the serious mental health disorders and other problems of high-risk youth. Studies linking suicide with high-risk youth were submitted to the Task Force including one

showing "gay youth are two to three times more likely to attempt suicide than other young people." Another states 15% of individuals with affective disorders, manic depression and severe depression commit suicide.

IMPLEMENTATION STEPS:

1. Involve child care facilities and other State agencies and programs which provide services to youth at high risk in instituting a program of prevention, intervention, and postvention with all staff and students. Where possible, the Maryland State Department of Education's Youth Suicide Prevention School Program should be used as a guideline. Assistance from the Maryland State Department of Education can also be utilized through consultation/ contractual arrangements.

2. Develop clearly defined procedures for handling any potential suicide cases. Procedures should include action to be taken by direct care staff in providing prompt prevention, intervention, and postvention services to clients, peers, and immediate family.

3. Expand and fully fund Recommendation III-G--Mental Health Plans.

4. Fully fund and implement Recommendation III-F--Youth Programs

E) RECOMMENDATION: Explore educational and legislative interventions which may limit access to the lethal means of suicide, particularly firearms, for youths at risk of suicide.

RATIONALE: Between 1970 and 1985 the majority of youth suicides in Maryland were committed with firearms. The suicide data for Maryland suggests that the increase in the suicide rate among Maryland youths aged 15-24 during this period was directly proportional to the increased use of firearms as the method of choice. Many suicides are impulsive acts and if access to firearms is restricted, the suicide rate for young people may decline. There is evidence that restricting gun availability, as well as other lethal means, reduces deaths.

IMPLEMENTATION STEPS:

1. Limit access to firearms by youth through legislative mandate.
   a. Enforce current laws regarding firearm sales to minors.
   b. Establish additional laws to restrict availability of guns to minors.
   c. Limit gun advertising directed to or involving minors.
   d. Require improved safety features which make guns safer (e.g. clear indicators that guns are loaded).
2. Limit access to firearms through educational programs.
   a. Develop an effective gun safety education program for youth and adults.
   b. Enlist the National Rifle Association, gun manufacturers and other weapon-related groups to develop educational programs to reduce the incidence of gun misuse.
   c. Provide educational and training programs for gatekeepers, families, and others who work with youths that highlight the importance of limiting the availability of lethal means.
3. Limit access to other lethal means of suicide.
   a. Limit access to bridges and high buildings through the use of protective screens and security.

b. Limit the number of pills and dosage of potentially lethal medications that could be filled at a single pharmacy visit.

F) RECOMMENDATION: Provide funding for local crisis intervention, training, and community education programs mandated by HB 1221 in 1986 (Chapter 122) through contracts with Youth Services Bureaus and/or existing suicide prevention programs.

RATIONALE: Youth Services Bureaus and suicide prevention programs require funding to provide crisis intervention, training, and community education programs which were mandated in 1986 by HB 1221 (Chapter 122 of the Laws of Maryland, 1986). No funds were appropriated for these mandated services. Funding should come from State and local sources, including the Juvenile Services Agency. Local jurisdictions need to identify which community-based organization is best able to provide these programs.

IMPLEMENTATION STEPS:

1. Obtain local and State funding.
2. Develop an equitable formula for the distribution of funds.
3. Implement the programmatic intent of HB 1221 throughout the State.

FISCAL NOTE: Based on the salary and benefits of a full-time professional position in each of the 24 local jurisdictions, it is estimated that the cost of this recommendation would be $480,000. Each jurisdiction should have the discretion to appropriate these funds to fulfill the intent of HB 1221.

G) RECOMMENDATION: Expand and fund the Mental Hygiene Administration's Five Year Plan for Children and Adolescents and the Emergency Services Chapter to include the implementation of the Continuum of Youth Suicide Prevention Resources which relate to mental health agencies.

RATIONALE: The Mental Hygiene Administration needs to provide youth suicide prevention services in accordance with the Continuum of Youth Suicide Prevention Resources. The Mental Hygiene Administration's *Five Year Plan for Children and Adolescents* and the *Addendum to the Five Year Master Plan for Deinstitutionalization of Chronically Mentally Ill Persons in Maryland-- Chapter 8-- Emergency Services Chapter* are the major public mental health planning documents which must address youth suicide issues and services. They delineate the plans for the allocation of Mental Hygiene Administration funds for community mental health services. Neither plan sufficiently addresses youth suicide issues. In the *Five Year Plan for Children and Adolescents* the specific recommendations for youth suicide prevention programs were omitted temporarily pending this Task Force's Plan. Both need to be amended to incorporate the Continuum of Youth Suicide Prevention Resources included in Recommendation I and other recommendations in this Plan.

The goal of the *Child and Adolescent Plan* is to assure equitable access to a continuum of care for children and adolescents manifesting or at risk for serious psychiatric illness with an emphasis upon serving each child in the least restrictive environment. Full funding for this comprehensive plan would help prevent youth suicides. Emergency services are scattered, piecemeal, and inadequate. *The Emergency Services Chapter* outlines the components of a comprehensive emergency service system for the chronically mentally ill. This system is also compatible with the needs of youth considering suicide, attempters, and survivors. Community mental health centers are not adequately funded to provide services including youth suicide prevention, intervention, and postvention services. For example, centers could provide additional consultation, treatment, education, and outreach services if resources were available. A staffing survey of child and adolescent specialists in early 1986 showed that centers were seriously understaffed with only 1/3 of the needed positions funded. Among the

gaps in the Continuum identified is the following example provided by psychiatric residents at the University of Maryland Hospital:

> A six-year-old boy was brought to the pediatric emergency room by his mother, after having made a suicide attempt by running in front of a car. His mother had saved him by pulling him out of the car's path. In the emergency room, he told the doctors he wanted to die, and would try again to kill himself. His mother did not feel she could continue to safely handle him at home.
>
> He had private medical insurance, but no child psychiatric unit in Maryland or the District of Columbia had a bed available. The State Hospital refused to accept the patient as well, on the grounds that they have no unit to treat children under the age of 12. After spending 24 hours in the Emergency Room, he was inappropriately admitted to an acute medical bed on a pediatric unit, then transferred to a private child psychiatric facility after one week.

Unfortunately, this case example is not an unusual one as there are only 21 acute psychiatric beds for children in Maryland and they are all located in the central region.

IMPLEMENTATION STEPS:

1. Amend the two Mental Hygiene Administration plans and any other relevant plans or proposals to incorporate the Task Force's recommendations including the following components of the Continuum of Youth Suicide Prevention Resources: telephone crisis hotlines, training of individuals who come regularly in contact with youth (e.g. gatekeepers), community and parent education, grief counseling and survivors support groups, information and referral services, prevention programs, case management/service coordination, and out-of-home resources.
2. Provide funding to expand Mental Hygiene Administration services, either directly or through contract with appropriate agencies, for youth at-risk of suicide and survivors. These services would include: community mental health outpatient services, in-home interventions, emergency services, hotlines (i.e. 24 hour points of contact), consultation and education, training, in-patient beds, and case management.
3. Provide sufficient funding for each community mental health center to have trained staff to provide suicide prevention, intervention, and postvention services.

CONCLUSION

For A Better Tomorrow presents a challenging Plan by which the State of Maryland can develop a comprehensive system for youth suicide prevention. This Plan can provide a starting point for making Maryland a model state in responding to the crisis of youth suicide.

It is essential to follow-up immediately on the work of the Task Force and build upon the momentum and knowledge gained during the short period of time in which the group has functioned. Therefore, the Task Force strongly recommends that a Council on Youth Suicide Prevention be created by Executive Order after this Plan is formally presented to the Governor and the General Assembly. As part of the Governor's Office for Children and Youth, the proposed Council would more fully develop, refine, and coordinate this Plan's recommendations.

The proposed Council would be able to provide the leadership, networking opportunities, expertise, and coordination necessary to build a comprehensive and accessible Continuum of Youth Suicide Prevention, Intervention, and Postvention Resources to effectively address the epidemic of youth suicides. The Council would be the most efficient vehicle to facilitate community/school partnerships utilizing government and private resources in the most cost effective manner. The proposed Council would provide mechanisms to enhance and effectively utilize the services now in existence as well as help develop other quality youth suicide prevention services.

Task Force members were asked why they felt a Council was needed. Susan White-Bowden replied, "I truly believe that if there had been such a State supported resource in 1977 when my 17-year old son, Jody, committed suicide, he would be alive today." She went on to further describe the proposed Council and why it is needed: "A place that is well publicized, a place where a parent, whose child is in crisis, could turn, without shame, for quick professional information and help...A place that perhaps my son might have contacted himself...It is too late to save Jody White, but it is not too late to save the children who now live in Maryland and the thousands who will in the future."

It is impossible to segregate out the complex problem of youth suicide from other interrelated problems that youths experience. Youth suicide prevention programs must be an integral part of other services for youth. Therefore, the Task Force recommends resources for a variety of agencies to better serve their target populations. The proposed Council would provide the leadership, expertise, and coordination to assure that services are more accessible and appropriate to better meet the needs of troubled youths and their families.

The Task Force strongly believes that it is time for Maryland to accept the challenges presented in this Plan to prevent the tragic and devastating physical, emotional, and economic consequences associated with youth suicides and attempts. These are our children and grandchildren. *For A Better Tomorrow,* we must all act today.

APPENDICES

SENATE JOINT RESOLUTION No. 7
(61r0731) F1

Introduced by Senators Bainum and ~~Berman~~, Dorman, and Della

Read and Examined by Proofreader:

_____
Proofreader.

_____
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____ M.

_____
President.

RESOLUTION NO. _____

A Senate Joint Resolution concerning

Gubernatorial Task Force - ~~Teenage~~ Youth *Child, Teenage, and Young Adult* Suicide and Other Associated Mental Health Problems

FOR the purpose of requesting the Governor to establish a task force to develop and implement a plan to combat ~~teenage~~ *child, teenage, and young adult* suicide and other associated mental health problems confronting today's youth; directing the task force to consider certain matters and involve certain State and local government agencies and institutions and other individuals in the development of its plan; providing for the membership and staffing for the task force; providing that the task force issue a report to the General Assembly and Governor by a certain date; and generally relating to establishing a task force to address ~~teenage~~ *child, teenage, and young adult* suicide and other associated mental health problems affecting ~~teenagers~~ youth *children, teenagers, and young adults*.

WHEREAS, Peer pressure, family-related conflicts, educational demands, and other youthful concerns can be extremely

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EXPLANATION:
Underlining indicates amendments to bill.
~~Strike-~~out indicates matter stricken by amendment.
Script denotes opposite chamber/conference committee amendments.

Appendix A

burdensome and oftentimes difficult for today's teenagers youth children, teenagers, and young adults to cope with; and

WHEREAS, ~~Teenage-suicide, bulimia, anorexia, and~~ other and associated Child, teenage, and young adult suicide, bulimia, anorexia, and other child, teenage, and young adult teenage mental health disorders are becoming an increasingly serious problem among youth in the State; and

WHEREAS, It is imperative that Maryland's teenage youth children, teenagers, and young adults, and the adults responsible for and who interact with them in their daily lives, be better informed about the pressures faced by today's teenagers youth children, teenagers, and young adults; and

WHEREAS, There is a particular need to involve ~~our communities, including~~ teenagers youth children, teenagers and young adults, their parents, and the schools, and ~~social service agencies both public and private agencies and providers~~ social service agencies in recognizing, addressing, and combating these serious mental health disorders; and

WHEREAS, An organizational framework is needed to focus the efforts of State and local communities and mental health agencies, together with families, educational institutions, and others involved in programs geared to combat teenage child, teenage, and young adult suicide among today's ~~teenagers~~ youth children, teenagers, and young adults; now, therefore, be it

RESOLVED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Governor is requested to establish a task force to develop and ~~implement~~ a comprehensive plan designed to combat teenage youth child, teenage, and young adult suicide and associated mental health concerns; and be it further

RESOLVED, That the task force be strongly encouraged to consider, as components of its recommended plan:

(1) the implementation of appropriate training programs for ~~teachers~~ all school personnel and volunteers and appropriate ~~institutions~~ institutional and residential care facilities' staff;

(2) the development of teenage youth child, teenage, and young adult suicide and mental health curriculum training programs for junior and senior high schools and appropriate institutions and residential care facilities;

(3) the development of informational products and presentations for community organizations and groups and for parents, either individually or in groups;

(4) the development of appropriate informational products or presentations for teenage ~~students~~ young people children, teenage students, and young adults;

(5) the identification of mental health resources and treatment programs and centers in local communities; and be it further

RESOLVED, That the task force be composed of ~~17~~ 18 members, appointed as follows:

(1) 2 principals, 1 from a senior high school and 1 from a junior high school in this State;

(2) 1 social worker, specializing in mental health concerns;

(3) 1 registered nurse specializing in school health;

~~(3)~~ (4) 1 psychologist;

~~(4)~~ (5) 1 psychiatrist;

~~(5)~~ (6) 1 police officer, specializing in juvenile matters;

~~(6)~~ (7) 2 school guidance counselors, 1 from a senior high school and 1 from a junior high school in this State;

~~(7)~~ (8) 1 representative from the State Department of Education;

~~(8)~~ (9) 1 representative from the State Department of Health and Mental Hygiene; ~~and~~

~~(9)~~ (10) ~~3~~ 2 parents, one of whom shall represent a parent-teacher association and one of whom shall represent Compassionate Friends;

~~(10)~~ (11) ~~2 members~~ 1 member of the Senate, selected by the President of the Senate; ~~and~~

~~(11)~~ (12) ~~2 members~~ 1 member of the House of Delegates, selected by the Speaker of the House of Delegates;

~~(12)~~ (13) 1 youth member chosen from a local group involved with peer counseling as support or otherwise close to the issue; ~~and~~

~~(13)~~ (14) 1 youth member selected from the Maryland Association of Student Councils or the Governor's Youth Advisory Council; and ~~be it further~~

(15) 1 representative of the Department of Human Resources; and be it further

RESOLVED, That the members of the task force not be paid a salary but may be reimbursed for travel and meal costs in accordance with the Standard State Travel Regulations; and be it further

RESOLVED, That the Governor appoint a chairperson and vice chairperson from the members of the task force; and be it further

RESOLVED, That the task force present a report to the Governor and the General Assembly by December 31, 1986; and be it further

RESOLVED, That staff for the task force be provided jointly by the Department of Education and the Department of Health and Mental Hygiene; and be it further

RESOLVED, That a copy of this Resolution be forwarded by the Department of Legislative Reference to the Honorable Harry Hughes, Governor of Maryland, the Honorable Melvin A. Steinberg, President of the Senate of Maryland, and the Honorable Benjamin L. Cardin, Speaker of the House of Delegates of Maryland; to David W. Hornbeck, State Superintendent of Schools, 200 W. Baltimore Street, Baltimore, Maryland 21201; and to Adele Wilzack, Secretary of Health and Mental Hygiene, 201 W. Preston Street, 5th Floor, Baltimore, Maryland 21201 *; and Ruth Massinga, Secretary of Human Resources, 1100 North Eutaw Street, Baltimore, Maryland 21201*.

DEFINITIONS

This list of definitions is provided to assist the reader in understanding the meaning of the following words or phrases as they are used within the context of this plan.

GATEKEEPERS: Individuals who regularly come in contact with youth including both professional and community members such as teachers, school counselors, other school personnel, child protective service workers, foster parents, staff of youth agencies, religious leaders, juvenile justice personnel, staff of domestic violence programs, substance abuse treatment personnel, funeral directors, law enforcement personnel, emergency personnel, hospital personnel, medical examiners, community counseling center staff, HMO staff, media representatives, PTA members, social service staff, runaway shelter staff, personnel of institutions, day care personnel, health care personnel, employers of large groups of youth, and other individuals who may be of assistance in dealing with a crisis.

HIGH-RISK YOUTH: Young people who are more susceptible to suicidal behavior because of life circumstances which may include a history of: depression, suicide attempts, family suicides, substance abuse, child abuse and/or neglect, out of home placements, running away, sexual exploitation, teen pregnancy, AIDS or fear of it, identification with a sexual minority, eating disorders, and other special risk factors.

HOTLINE: A well-publicized single statewide telephone number network which is accessible by any citizen, from any phone, 24 hours a day, seven days a week, to provide information, referral, counseling and crisis intervention services.

INTERVENTION: Those coordinated services and activities that are directed toward all youth, but especially those youth who are identified as at-risk for suicide, to interfere with the chain of events that may lead to suicide.

POSTVENTION: Those coordinated services and activities that assist youth, their family, friends and the community in coping with the aftermath of a young person's attempted or completed suicide.

PREVENTION: Those coordinated services and activities that help young people, families, gatekeepers and the community to prevent suicides, to identify those youth who are at-risk for suicide, and to develop an awareness of and a plan of action for coping with the issues surrounding youth suicide.

SURVIVOR: A family member, peer, gatekeeper or any other individual who has been impacted by a completed suicide.

YOUTH: Any child, teenager, or young adult who is less than 25 years old.

LIAISONS

State agencies involved with youth suicide issues assigned the following ex officio liaisons to the Task Force. They participated in Task Force meetings and provided invaluable assistance in their respective areas of expertise.

- Eugenia Broumas
  Health and Human Services
  Task Force on Youth Suicide
- Darlind Davis
  Addictions Administration
  Department of Health and Mental Hygiene
- William Edwards
  Juvenile Services Agency
- Julia Irons
  Office of Governmental and Public Affairs
  Department of Health and Mental Hygiene
- Lori Klein
  Office of the Attorney General
  Department of Health and Mental Hygiene
- Marylou Knapp
  Mental Hygiene Administration
  Department of Health and Mental Hygiene
- Louri Larash
  Juvenile Services Agency
- Sandra Leichtman, Ph.D.
  Mental Hygiene Administration
  Department of Health and Mental Hygiene
- Michele Linck Prumo
  Maryland State Department of Education
- Martha Pedroni
  Office of the Governor
  Executive Department
- C. Frederick Ryland
  Office of the Attorney General
  Department of Health and Mental Hygiene
- Laura Steele
  Governor's Office for Children and Youth
  Executive Department
- Bill Thomas
  Juvenile Services Agency

RESOURCES

The following individuals provided valuable assistance to the Task Force by participating in Task Force meetings, committee meetings, the Public Hearing, and/or by providing resources:

- Mary K. Albrittain - Maryland State Department of Education
- Estelle Apelberg - Maryland Center for Health Statistics, Department of Health and Mental Hygiene (DHMH)
- Steven A. Cambell - Maryland Association of Youth Services Bureaus, Inc.
- Elsa Carlson - LIFE, Mental Health Association of Montgomery County
- Beverly Celotta, Ph.D. - Celotta, Jacobs and Keys Association, Inc.
- Linda Crawford - Office of the Governor, Executive Department
- Herb Cromwell - Mental Health Association of Maryland, Inc.
- William B. Crowley - Crowley and Associates
- Pat Hofmann Darden - Office of the President of the Senate, General Assembly of Maryland
- J . Raymond DePaulo, Jr., M.D. - Johns Hopkins Hospital
- Ann Dixon, M.D. - Office of the Chief Medical Examiner, DHMH
- Eric English, Ph.D. - Anne Arundel County Department of Health
- Betty Fuqua - C&P Telephone Company
- Perry Gaidurgis - OUT, Inc.
- Edward Gold, Psy.D. - Anne Arundel County Department of Health
- Rosalyn Goldner - Office of Governmental and Public Relations, DHMH
- Paulette Goodman - Federation of Parents and Friends of Lesbians and Gays, Inc.
- Mila Guandola - LIFE, Mental Health Association of Montgomery County
- Sue Hailman - Grassroots Crisis Intervention and Peer Counseling Center, Inc.
- Henry Harbin, M.D. - Mental Hygiene Administration, DHMH
- Faye Harmon - LIFE Crisis Center
- Robert Harrington - Montrose School, Juvenile Services Agency
- Laura Hendricks - Mental Health Association in Howard County, Inc.
- Linda Hosier - Mental Hygiene Administration, DHMH
- Thomas Krajewski, M.D. - Mental Hygiene Administration, DHMH
- Patricia Kramer - Equal Partners
- Ludwig Lankford - Office of Education and Training for Addictions Services, Addictions Administration
- Viola Lewis - Office of Governmental and Public Relations, DHMH
- John Light - C&P Telephone Company
- Mary Dunnigan Lochary - Proofreader
- Rose Marie Martin - Maryland Center for Health Statistics, DHMH
- Howard Max - Insurance Division, Department of Licensing and Regulation
- Ann McDermitt - Honorable Stewart Bainum's Office, General Assembly of Maryland

- Harry Meir - Outreach
- Regina Miller - Mental Hygiene Administration, DHMH
- Muriel Morgan - Mental Hygiene Administration, DHMH
- Oscar Morgan - Mental Hygiene Administration, DHMH
- Phyllis Mutlu, LCSW - Anne Arundel County Department of Health
- Dorothy Noble - Juvenile Services Agency
- Ronnie O'Branovich - Mental Health Association of Prince George's County Hotline and the Suicide Prevention Center
- Linda Oney - Office of Education and Training for Addictions Services, Addictions Administration
- Andrew Pearle - LIFE, Mental Health Association of Montgomery County
- Norene Pease - Office of Planning and Policy Analysis for Health, DHMH
- Pat Piston - Mental Health Association of Prince Georges County Hotline and the Suicide Prevention Center
- Carolyn Queener - RICA-Rockville, DHMH
- Jack Ramult - C&P Telephone Company
- Art Rosenbaum, LCSW - Family Division - Sinai Hospital
- Dick Rutherford - C&P Telephone Company
- Wendy Sherman - Special Secretary for Children and Youth and Director of the Office for Children and Youth, Executive Department
- Suzanne Sigona - Juvenile Services Agency
- John E. Smialek, M.D. - Office of the Chief Medical Examiner, DHMH
- Shane Spradlin - LIFE, Mental Health Association of Montgomery County
- Lieutenant Governor Melvin A. Steinberg - Executive Department
- Sandra J. Sundeen, R.N. - Mental Hygiene Administration, DHMH
- Roy Tansill - Maryland Center for Health Statistics, DHMH
- Delores H. Thomas - Employee Assistance, Department of Personnel
- Mary Kay Tierney - Mental Hygiene Administration ,DHMH
- Fran Tracy - Office of Governmental and Public Relations, DHMH
- Cindy Woodside - Mental Hygiene Administration, DHMH
- Eileen Zeller - Prince Georges County Community-Wide Task Force on Suicide Prevention

HOUSE OF DELEGATES

61r1669 No. 1221 F1

By: Delegates Collins, Hollinger, and Kirchenbauer
Introduced and read first time: January 31, 1986
Assigned to: Constitutional and Administrative Law and Ways and Means
Reassigned: Ways and Means and Constitutional and Administrative Law, February 7, 1986

Committee Report: Favorable
House action: Adopted
Read second time: March 22, 1986

CHAPTER _____

AN ACT concerning

Youth Suicide Prevention School Programs

FOR the purpose of establishing a youth suicide prevention school program administered by the Department of Education in cooperation with local education agencies and other appropriate community agencies; requiring the Department to establish a certain demonstration youth suicide prevention school program in certain political subdivisions by a certain date; requiring the Department to adopt certain regulations; providing a description of the services to be provided in a youth suicide prevention school program; requiring that certain funds be included in the budgets of certain agencies; requiring youth service bureaus to provide certain services to address youth suicide prevention; and generally relating to a youth suicide prevention school program.

BY adding to

Article - Education
Section 7-4A-01 through 7-4A-06 to be under the new subtitle "Subtitle 4A. Youth Suicide Prevention School Programs"
Annotated Code of Maryland
(1985 Replacement Volume and 1985 Supplement)

BY repealing and reenacting, with amendments,

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike-out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Article - Health - General
Section 6-122
Annotated Code of Maryland
(1982 Replacement Volume and 1985 Supplement)

Preamble

WHEREAS, The youth of society represents the hope for the future; and

WHEREAS, The rate of youth suicide has increased more than threefold in the last two decades; and

WHEREAS, Over 5,000 young Americans took their lives last year, including over 100 young people in Maryland, many more attempted suicide, and large numbers of families were affected; and

WHEREAS, Youth suicide is a phenomenon which must be addressed by a concerned society and which can only be solved through the combined efforts of individuals, families, community organizations, public officials, agencies, educators and community leaders; and

WHEREAS, The effort to prevent youth suicide has been initiated in several jurisdictions throughout the State; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Education

SUBTITLE 4A. YOUTH SUICIDE PREVENTION SCHOOL PROGRAMS

7-4A-01.

THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(1) A STATEWIDE YOUTH SUICIDE PREVENTION SCHOOL PROGRAM IS ESSENTIAL TO ADDRESS THE CONTINUING PROBLEM OF YOUTH SUICIDE THROUGHOUT THE STATE;

(2) THE YOUTH SUICIDE PROBLEM OFTEN EXISTS IN COMBINATION WITH OTHER PROBLEMS, INCLUDING DRUG ABUSE AND ALCOHOL USE;

(3) A SUICIDE PREVENTION PROGRAM FOR YOUNG PEOPLE MUST EMPHASIZE A PARTNERSHIP BETWEEN EDUCATIONAL PROGRAMS AT THE STATE AND LOCAL LEVELS AND COMMUNITY SUICIDE PREVENTION AND CRISIS CENTER AGENCIES.

(4) IT IS OF VITAL IMPORTANCE THAT A STATEWIDE YOUTH SUICIDE PREVENTION SCHOOL PROGRAM BE ESTABLISHED WITH SHARED RESPONSIBILITY AT BOTH THE STATE AND COUNTY LEVELS, AND THAT THIS

COOPERATION SHALL BE A MAJOR TOOL IN EFFORTS TO ACHIEVE THE SUCCESSFUL PREVENTION OF YOUTH SUICIDE.

(5) COUNTY SUICIDE PREVENTION AND CRISIS CENTER AGENCIES ALONG WITH LOCAL EDUCATION AGENCIES ARE BEST SUITED FOR DEVELOPING AND IMPLEMENTING PROGRAMS FOR STATEWIDE YOUTH SUICIDE PREVENTION.

7-4A-02.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "PROGRAM" MEANS A YOUTH SUICIDE PREVENTION SCHOOL PROGRAM ESTABLISHED UNDER THIS SUBTITLE.

(C) "YOUTH SERVICE BUREAU" MEANS A PROGRAM DEFINED UNDER § 6-122 OF THE HEALTH - GENERAL ARTICLE.

7-4A-03.

(A) (1) THERE IS A STATEWIDE YOUTH SUICIDE PREVENTION SCHOOL PROGRAM ADMINISTERED BY THE DEPARTMENT IN COOPERATION WITH:

(I) PARTICIPATING LOCAL EDUCATION AGENCIES;

(II) LOCAL COMMUNITY AGENCIES INVOLVED IN SUICIDE PREVENTION;

(III) LOCAL COMMUNITY MENTAL HEALTH PROGRAMS; AND

(IV) YOUTH SERVICES BUREAUS.

(2) ON OR BEFORE OCTOBER 1, 1986, THE DEPARTMENT MAY ESTABLISH A DEMONSTRATION YOUTH SUICIDE PREVENTION SCHOOL PROGRAM IN COOPERATION WITH LOCAL EDUCATION AGENCIES IN THE FOLLOWING POLITICAL SUBDIVISIONS:

(I) ANNE ARUNDEL COUNTY;

(II) BALTIMORE CITY;

(III) BALTIMORE COUNTY;

(IV) HARFORD COUNTY;

(V) HOWARD COUNTY; AND

(VI) MONTGOMERY COUNTY.

(B) ANY POLITICAL SUBDIVISION IN THE STATE MAY APPLY FOR ASSISTANCE OR GRANT FUNDS UNDER THIS SUBTITLE TO ESTABLISH A LOCAL YOUTH SUICIDE PREVENTION SCHOOL PROGRAM.

7-4A-04.

(A) (1) THE DEPARTMENT SHALL ADOPT REGULATIONS THAT SET ELIGIBILITY GUIDELINES FOR STATE FUNDING OF YOUTH SUICIDE PREVENTION SCHOOL PROGRAMS UNDER THIS SUBTITLE.

(2) THE REGULATIONS SHALL:

(I) ESTABLISH PROCEDURES FOR DEVELOPING LOCAL PROGRAMS, IN COOPERATION WITH LOCAL EDUCATION AGENCIES, YOUTH SERVICE BUREAUS, AND COMMUNITY MENTAL HEALTH CENTERS; AND

(II) ESTABLISH STANDARDS AND POLICIES FOR PROGRAMS TO OFFER:

1. INDIVIDUAL, FAMILY, AND GROUP COUNSELING RELATED TO YOUTH SUICIDE PREVENTION;

2. REFERRAL, CRISIS INTERVENTION, AND INFORMATION FOR STUDENTS, PARENTS, AND SCHOOL PERSONNEL; AND

3. TRAINING FOR SCHOOL PERSONNEL, AND OTHERS RESPONSIBLE FOR COUNSELING OR SUPERVISING STUDENT ACTIVITIES;

(B) A YOUTH SUICIDE PREVENTION SCHOOL PROGRAM ESTABLISHED UNDER THIS SUBTITLE SHALL PLAN, FUND, AND IMPLEMENT EDUCATIONAL PROGRAMS, WHICH MAY INCLUDE ANY OF THE FOLLOWING:.

(1) CLASSROOM INSTRUCTION DESIGNED TO ACHIEVE ANY OF THE FOLLOWING OBJECTIVES:

(I) ENCOURAGE SOUND DECISION MAKING AND PROMOTE ETHICAL DEVELOPMENT;

(II) INCREASE PUPILS' AWARENESS OF THE RELATIONSHIP BETWEEN DRUG AND ALCOHOL USE AND YOUTH SUICIDE;

(III) TEACH PUPILS TO RECOGNIZE SIGNS OF SUICIDAL TENDENCIES, AND OTHER FACTS ABOUT YOUTH SUICIDE;

(IV) INFORM PUPILS OF AVAILABLE COMMUNITY YOUTH SUICIDE PREVENTION SERVICES;

(V) ENHANCE SCHOOL CLIMATE AND RELATIONSHIPS BETWEEN TEACHERS, COUNSELORS, AND PUPILS; AND

(VI) FURTHER COOPERATIVE EFFORTS OF SCHOOL PERSONNEL AND COMMUNITY YOUTH SUICIDE PREVENTION PROGRAM PERSONNEL;

(2) SCHOOL OR COMMUNITY BASED ALTERNATIVE PROGRAMS OUTSIDE OF THE CLASSROOM, INCLUDING:

(I) POSITIVE PEER GROUP PROGRAMS;

(II) A 24-HOUR "HOTLINE" TELEPHONE SERVICE, STAFFED BY TRAINED PROFESSIONAL COUNSELORS;

(III) PROGRAMS TO COLLECT DATA ON YOUTH SUICIDE ATTEMPTS;

(IV) INTERVENTION AND FOLLOW-UP; AND

(V) PARENT EDUCATION AND TRAINING PROGRAMS; AND

(3) TEACHER TRAINING PROGRAMS.

(C) ANY PROGRAM ESTABLISHED UNDER THIS SUBTITLE SHALL:

(1) ASSIST IN INCREASING THE AWARENESS, AMONG SCHOOL PERSONNEL AND COMMUNITY LEADERS, OF THE INCIDENCE OF TEENAGE SUICIDE;

(2) TRAIN SCHOOL PERSONNEL IN INDIVIDUAL AND SCHOOL WIDE STRATEGIES FOR TEENAGE SUICIDE PREVENTION;

(3) DEVELOP AND IMPLEMENT SCHOOL-BASED TEENAGE SUICIDE PREVENTION PROGRAMS AND PILOT PROJECTS; AND

(4) THROUGH COOPERATIVE EFFORTS, UTILIZE COMMUNITY RESOURCES IN THE DEVELOPMENT AND IMPLEMENTATION OF TEENAGE SUICIDE PREVENTION PROGRAMS UNDER THIS SUBTITLE.

7-4A-05.

(A) THE DEPARTMENT SHALL:

(1) AS TO EACH PROGRAM RECEIVING STATE FUNDING:

(I) MONITOR ITS OPERATIONS; AND

(II) EVALUATE ANNUALLY ITS EFFECTIVENESS.

(2) REVIEW AND EITHER APPROVE OR DISAPPROVE THE APPLICATION FOR STATE FUNDING OF A PROPOSAL PROGRAM.

(B) (1) THE FUNDING OF AN ELIGIBLE PROGRAM SHALL BE A SHARED RESPONSIBILITY OF THIS STATE AND LOCAL EDUCATION AGENCIES.

(2) EACH ELIGIBLE PROGRAM SHALL SUBMIT TO THE DEPARTMENT A PROPOSED ANNUAL BUDGET FOR REVIEW AND APPROVAL, AT THE TIMES THAT THE DEPARTMENT SPECIFIES.

(3) THE PROPOSED BUDGET OF THE DEPARTMENT SHALL LIST THE ELIGIBLE PROGRAMS AND ESTIMATE THE AMOUNT OF STATE FUNDS TO BE ALLOCATED TO EACH.

(C) THE STATE FUNDS DESIGNATED FOR YOUTH SUICIDE PREVENTION SCHOOL PROGRAMS MAY BE INCLUDED IN THE BUDGETS OF:

(1) THE DEPARTMENT; AND

(2) THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

7-4A-06.

(A) THE LOCAL EDUCATION AGENCY AND THE LOCAL HEALTH DEPARTMENT SHALL IDENTIFY FUNDS FROM PUBLIC AND PRIVATE AGENCIES FOR DEVELOPMENT AND IMPLEMENTATION OF THE PROGRAM.

(B) THE DEPARTMENT SHALL SUBMIT AN ANNUAL REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1312 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY REGARDING THE CURRENT STATUS AND EFFECTIVENESS OF THE PROGRAMS ESTABLISHED UNDER THIS SUBTITLE.

(C) THE GOVERNOR SHALL INCLUDE FUNDS IN THE BUDGET TO CARRY OUT THE PROVISIONS OF THIS SUBTITLE.

Article - Health - General

6-122.

(a) In this section, "youth services bureau" means a community based entity that is operated:

(1) To provide community oriented delinquency prevention, YOUTH SUICIDE PREVENTION, and youth development;

(2) To ameliorate conditions that breed delinquency, YOUTH SUICIDE, and family disruption; and

(3) To function as an advocate of youth needs.

(b) (1) The Administration shall adopt rules and regulations that set eligibility guidelines for State funding of youth services bureaus under this section.

(2) The rules and regulations shall require that each State aided youth services bureau provide, free of charge, at convenient hours:

(i) Individual, family, and group counseling;

(ii) Referral and information services;

(iii) Crisis intervention, INCLUDING INTERVENTION RELATING TO YOUTH SUICIDE PREVENTION;

(iv) Informal counseling; and

(v) In accordance with particular community needs:

1. Tutoring;

2. Alternative leisure activities;

3. Employment assistance;

4. Community education, INCLUDING TRAINING AND INFORMATION RELATING TO YOUTH SUICIDE PREVENTION; and

5. Other specialized services.

(c) The Administration shall:

(1) As to each youth services bureau receiving State funding:

(i) Monitor its operations;

(ii) Evaluate annually its effectiveness; and

(iii) Stop funding a youth services bureau that is ineffective or that, for 2 years, fails to meet the eligibility guidelines for State funding; and

(2) Review and either approve or disapprove the application for State funding of a youth services bureau or proposed youth services bureau.

(d) (1) The funding of an eligible youth services bureau shall be a shared responsibility of this State and of local governments. This State's share shall be 75 percent of the funding of an eligible youth services bureau, as provided in the State budget.

(2) Each eligible youth services bureau shall submit to the Administration a proposed annual budget for review and approval, at the times that the Administration specifies.

(3) The proposed budget of the Administration shall list the eligible youth services bureaus and estimate the amount of State funds to be allocated to each.

(4) At the option of the local governing body that provides the matching funds for an eligible youth services bureau, the State funds for the support of the eligible youth services bureau shall be paid directly to its private sponsor or to the local governing body. Before the State funds are paid, the fiscal officer of the local government shall certify, in writing, the source of the 25 percent local funds.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1986.

YOUTH SUICIDE PREVENTION SCHOOL PROGRAM

for the Public Schools of Maryland

Maryland State Department of Education
Division of Compensatory, Urban, and Supplementary Programs
200 West Baltimore Street
Baltimore, Maryland 21201

1987

Appendix F

YOUTH SUICIDE PREVENTION SCHOOL PROGAM

The rate of youth suicide has increased more than threefold in the last two decades, with more than 5,000 suicides among youth nationwide in the last year, including over 100 in Maryland. Youth suicide is a phenomenon that cannot be ignored. The prevention of this devastating phenomenon requires a concerted effort by the entire community: educators, social services, health care providers, the media, community leaders, parents, and youth.

Committee Rationale

In response to House Bill 1221 (Youth Suicide Prevention School Programs), which was passed in the 1986 legislative session, the Youth Suicide Prevention School Program Committee was established by the Maryland State Department of Education in cooperation with the local education agencies and other appropriate state and community agencies.

In following the intent of House Bill 1221, the Youth Suicide Prevention School Program Committee developed a framework for a program to address the following goals:

- Assist in increasing the awareness among school personnel and community leaders of the incidence of teen suicide;
- Train school personnel in individual and schoolwide strategies for teen suicide awareness/prevention;
- Develop and implement school-based preventive programs and pilot programs; and,
- Facilitate cooperative efforts to utilize community resources in the development and implementation of teen suicide prevention programs.

Design of the Youth Suicide Prevention School Program

The framework designed by this committee reflects the three components of a youth suicide prevention school program: prevention, intervention, and "postvention" (i.e., term used by health professionals indicating actions to be taken after suicide or suicide attempt). These components are presented in grid form (see pages 5-17) showing the phases of implementation and their related goals, objectives, and strategies. These phases are designed to be implemented sequentially, with regular formative evaluation and staff development. LEAs may use this framework to help evaluate the comprehensiveness of existing youth suicide prevention programs or as a guide in establishing a youth suicide prevention school program.

The framework developed by the Youth Suicide Prevention School Program Committee includes:

- Definition of terms;
- Description of the LEA Advisory Board;

- Phases of implementation of the program's components;
- Goals, objectives, and strategies relative to prevention, intervention, and postvention; and,
- List of resources.

Youth Suicide Prevention School Program: Definitions

The following are the definitions to be used throughout the development and implementation of the Maryland Youth Suicide Prevention School Program:

Prevention: Those coordinated services and activities that help the students, school, families, and community to

- develop an awareness of and a plan of action for coping with the issues surrounding youth suicide, and
- identify those students who are "at-risk" for suicide

Intervention: Those coordinated services and activities that are directed toward all students, but especially those students who are identified as "at-risk" for suicide, to interfere with the chain of events that may lead to suicide.

Postvention: Those coordinated services and activities that serve the students, school, family, and community in coping with the aftermath of a student's attempted suicide, or completed suicide.

Local Education Agency Advisory Board(s):

Each LEA should establish an Advisory Board to monitor and evaluate the Youth Suicide Prevention School Program. Suggested members for this board are supervisors of pupil services and/or guidance counselors from elementary, middle, and high schools; school health nurses; assistant superintendents; school psychologists; curriculum specialists; school administrators; teachers; parents; representatives from community mental health centers, youth services bureaus; law enforcement agencies, the clergy, the state senate and/or house; pediatricians; private practice therapists; a lawyer with juvenile law background; and students.

This advisory board will report to the local superintendent and/or the board of education.

Responsibilities of the board are to:

1. Establish, monitor, and evaluate youth suicide prevention school programs;
2. facilitate the establishment of LEA youth suicide prevention school policies and procedures;

3. Recommend to the superintendent that an LEA-wide committee be established to:

   a. Develop and implement the youth suicide prevention school program: prevention, intervention, and postvention

   b. Provide county-wide inservice training;

4. Audit results and make recommendations for the program;

5. Send total program to MSDE for evaluation;

6. Assure that data is collected and utilized;

7. Act as resource for school-based personnel; and,

8. If possible, have a representative from the Advisory Board serve on school-based crisis intervention team.

CONTINUUM OF THE YOUTH SUICIDE PREVENTION SCHOOL PROGRAM

Components	Component Goal 1	Component Goal 2	Component Goal 3	Component Goal 4	Component Goal 5	Component Goal 6
Prevention	* To educate local school personnel in youth suicide prevention concepts	* To educate parents, students, and community on Youth Suicide Prevention School Program	*** To develop an awareness of the issues surrounding youth suicide for students and to develop and implement student self help programs	***And*** To establish procedures for collecting, recording, reporting, interpreting, and evaluating data related to suicide attempts and completions	*** To develop and/or revise K-12 life skills curriculum	** To assure the quality of the School's program through the training and updating of the school's team annually and as needed
Intervention	** To establish and train a crisis intervention team in each school and LEA	**** To refer identified students to the appropriate school and community resources for comprehensive services	** To assure the quality of the School's program through the training and updating of the school's team annually and as needed	*** To create an information management center		
Postvention	*** To establish and implement a school-based plan that addresses the aftermath of a suicidal event	** To assure the quality of the school's program through the training and updating of the school's team annually and as needed				

Appendix F

* Meets Program Goal 1
** Meets Program Goal 2
*** Meets Program Goal 3
**** Meets Program Goal 4
(See page 1)

HARRY HUGHES
GOVERNOR

ADELE WILZACK, R.N., M.S.
SECRETARY

State of Maryland

MENTAL HYGIENE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • AREA CODE 301 • 225-
Henry T. Harbin, M.D., Director
M. Ellen Anderson, R.N., M.A., Deputy Director
TTY FOR DEAF: Baltimore Area 383-7555
D.C. Metro Area 565-0451

December 30, 1986

Honorable Harry Hughes
Governor
State of Maryland
State House
Annapolis, Maryland 21401

Dear Governor Hughes:

This Interim Report was prepared on the status of the Gubernatorial Task Force on Child, Teenage, and Young Adult Suicide and Other Associated Mental Health Problems in accordance with your request included in my appointment letter of October 17, 1986. This letter also extended the due date of the Final Report to October 1, 1987 from December 31, 1986. Attachments to the letter are: (A) Office of Children and Youth's newsletter on Youth Suicide, (B) Senate Joint Resolution 7 authorizing the Task Force, (C) House Joint Resolution 47 authorizing the Task Force, (D) House Bill 1221 authorizing Youth Suicide Prevention School Programs, (E) the Task Force list as of November 10, 1986, and (F) the Task Force agenda for the January 10, 1987 meeting.

SJR 7 and HJR 47 were enacted in July 1986 and became Joint Resolutions 1 and 6. The Resolutions authorized a Gubernatorial Task Force to develop a plan to prevent suicide by youth in Maryland. In the same Session H.B. 1221, Youth Suicide Prevention School Programs was also enacted.

There was confusion about whether the $60,000 included in the supplemental budget for the prevention of youth suicide was intended to implement SJR 7 and HJR 47 or H.B. 1221 (Chapter 122). This issue was clarified in September by a letter from you stating the $60,000 was to fund the Task Force and explaining the inconsistencies that arose between the supplemental budget language and other documents and statements. The Mental Hygiene Administration (MHA) is overseeing this funding. MHA staff have met with Maryland State Department of Education (MSDE) representatives regarding the funding confusion and have agreed to transfer $15,000 to MSDE for suicide prevention demonstration projects in schools authorized by H.B. 1221. A formal Letter of Agreement between MSDE and the MHA will be signed in the near future.

Appointments were made for most of the Task Force in mid October and we understand the remaining members will be confirmed in mid January when the House and Senate representatives are selected. A list of the members as of November 10, 1986 is attached. Betty McGarvie-Crowley, the Task Force Executive Director, began on November 18 and Cheryl Boykin has been hired as the Task Force Secretary.

I have contacted the Task Force members to provide background materials and to seek input in developing the agenda for the first meeting. A shorter name, the Governor's Task Force on Youth Suicide Prevention, will be utilized. Liaisons have been established and meetings held with individuals and organizations concerned about youth suicides. Task Force members and staff attended the National Conference on Strategies for the Prevention of Youth Suicide sponsored by the H.H.S. Task Force on Youth Suicide on November 18, 1986. Letters have been sent to all state mental health departments requesting information and experiences related to the charge of this Task Force. Many states have replied and other information has been gathered.

The first meeting of the Task Force will be held on Monday, January 12 from 11:00 a.m. until 3:00 p.m. at the Senate Reception Room of the James Senate Office Building. If you are available, you are, of course, welcome to attend.

We look forward to achieving the objectives of SJR-7 and HJR-47 and believe this Task Force can have a major impact on the third leading cause of death among teenagers. We believe there are strategies to help prevent needless deaths of youth such as we saw from 1970-1984 when at least 502 youths, ages 10-19, committed suicide in Maryland.

Sincerely,

Bruce L. Regan, M.D.
Chairman

BLR:cyb

Enclosures: (A) Office of Children and Youths newsletter on Youth Suicide
(B) Senate Joint Resolution 7
(C) House Joint Resolution 47
(D) House Bill 1221
(E) Task Force List
(F) 1/10/87 Task Force Meeting

cc: Governor-Elect William Donald Schaefer

The State of Maryland

Proclamation
from the
Office of the Governor

YOUTH SUICIDE PREVENTION WEEK
MAY 17 - 23, 1987

WHEREAS, *Youth suicide is one of the most disruptive and tragic events a family and a community can experience, and is occurring at a national rate of over 5000 youth suicides annually, close to 100 youth suicides in Maryland annually, and is the second-leading cause of death for people between the ages of 15 and 24 nationwide; and*

WHEREAS, *Maryland's "Schaefer Challenge" to our citizens seeks to call on every individual to get involved directly in improving the lives of children in Maryland, by donating his time to a volunteer cause or event, working in his community, or otherwise contributing with time and energy to a project which assists children; and*

WHEREAS, *Answering a suicide hotline, volunteering at a suicide prevention counseling center, or simply spending time talking to and helping a troubled and depressed youth are all ways in which citizens can rise to the Schaefer Challenge and address the problem of youth suicide directly; and*

WHEREAS, *The issue of youth suicide and how to prevent it is of extreme importance to youths, their families, communities, and the nation at large, and so must be recognized and handled with sensitivity... and Maryland is pleased to be at the forefront in leading these worthwhile efforts.*

NOW, THEREFORE, I, WILLIAM DONALD SCHAEFER, GOVERNOR OF THE STATE OF MARYLAND, do hereby proclaim May 17 - 23, 1987 as YOUTH SUICIDE PREVENTION WEEK in Maryland, and do urge all citizens to respond to the Schaefer Challenge and work to prevent youth suicide.

Given Under My Hand and the Great Seal of the State of Maryland, this 17th day of May One Thousand Nine Hundred and Eighty-seven

William Donald Schaefer
Governor

John D. Kelly
Secretary of State

Appendix H

Governor's Task Force on Youth Suicide Prevention
c/o Dr. Bruce Regan
Spring Grove Hospital Center
Wade Avenue
P.O. Box 3235
Catonsville, Maryland 21228

FOR IMMEDIATE RELEASE

CONTACT: Betty McGarvie Crowley
(301) 225-6649

The Governor's Task Force on Youth Suicide Prevention will hold a public hearing on Wednesday, May 6, 1987 from 3:00-5:00 p.m. and from 6:00-8:00 p.m. at the Calvert Room on the first floor of the State House in Annapolis, Maryland, according to Russell Henke, Chairperson of the Hearing Committee.

The Task Force was created to develop a plan to combat child, teenage, and young adult suicide and other associated mental health problems confronting today's youth. The purpose of the hearing is to collect information, suggestions, and recommendations for the Task Force to consider as they develop recommendations for their report to the Governor and General Assembly.

Those wishing to testify will sign up at the hearing room starting at 2:30 p.m. on May 6. There will be up to three minutes allocated for individuals and five minutes for organizations. One copy of the testimony is to be submitted to the Task Force Chairperson at the time of the hearing. Twenty-five copies are needed if those presenting testimony wish each member to have one.

If written testimony only is to be submitted, it must be received by May 8, 1987. A copy should be sent to Dr. Bruce Regan, Chairperson, Governor's Task Force on Youth Suicide Prevention, Spring Grove Hospital, Wade Avenue, P.O. Box 3235, Catonsville, Maryland 21228.

After 5:00 p.m., access to the State Capital is at the lower level under the stairs near the Governor's Mansion.

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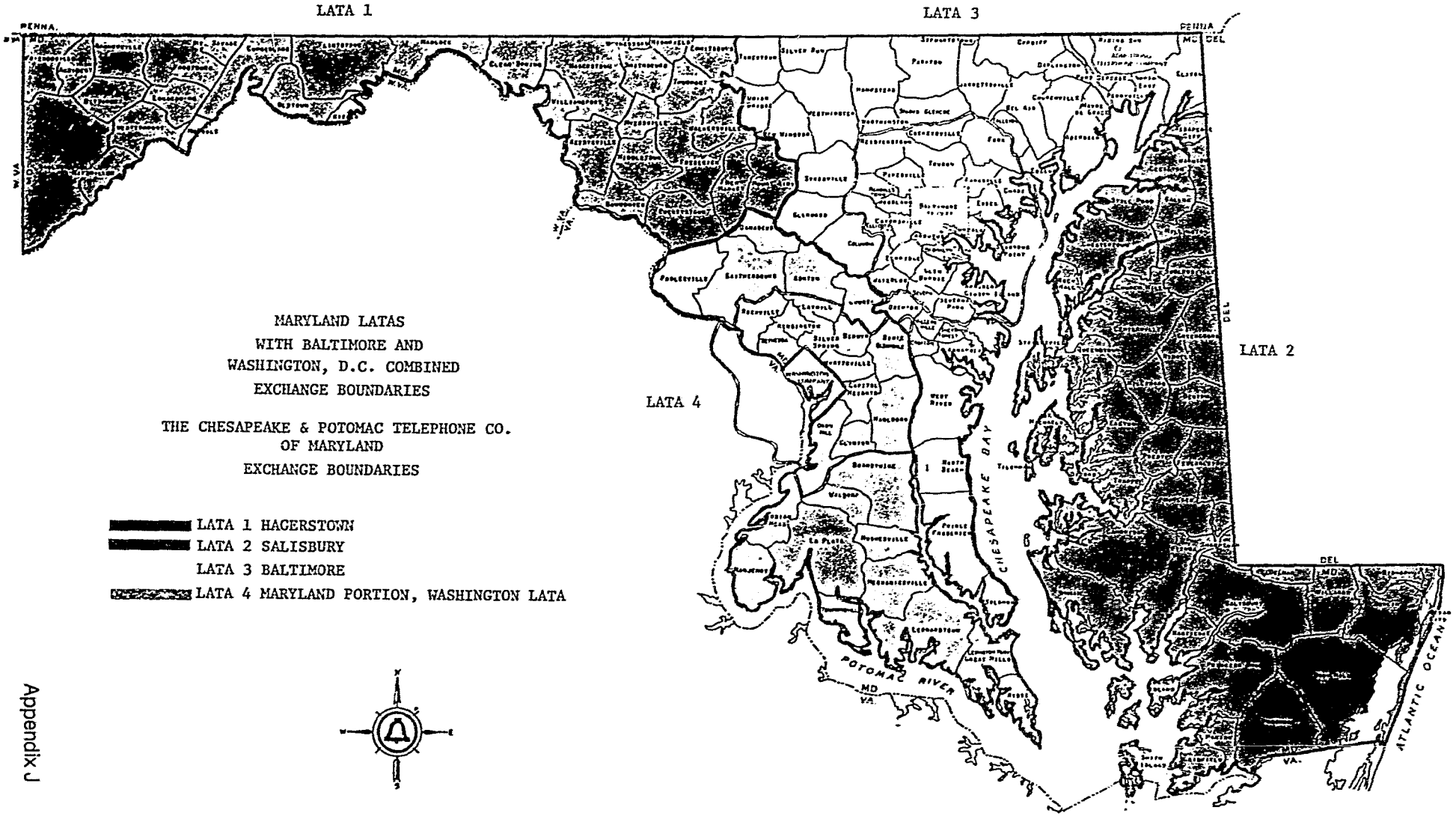

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Appendix J