NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

Adolescent Suicide Report:

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

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Executive Summary

Every life cut short by suicide is a tragedy. New Jersey has had the lowest state-level adolescent suicide rate for more than a decade.[1] An average of 72 young people between ages 10 and 24 were lost to suicide each year between 2007 and 2009 totaling 218 for these three years. Suicide is the fourth leading cause of death for New Jersey's youth, with male rates almost five times higher than females. While New Jersey has a comparatively low rate of youth suicide, youth suicide prevention remains a priority for the Department of Children and Families because even just one youth suicide is too many.

Of the 218 suicides from 2007-09, 151 or 69%, were by young people ages 19-24. Adolescent suicides are more common in densely populated areas, with six counties, Camden, Passaic, Monmouth, Hudson, Middlesex and Bergen, accounting for almost 50% of the suicides from 2007-2009. The primary method of suicide for ages 10-24 during 2007-2009 was suffocation/hanging, with white/non-Hispanic youth, representing 70% of those who committed suicide in New Jersey. Suicide crosses all lines in terms of geography and income level.

The attempted suicide rate for females is greater than the rate for males (38.5 vs. 22.4 per 100,000). Slightly over 60% of known suicide attempts resulting in hospitalization involved poisoning, usually an overdose of a prescription or non-prescription medication.

In New Jersey there have been continuous prevention and public awareness efforts across various agencies including the following:

- The Department of Children and Families - Division of Child Behavioral Health Services contracts with the University of Medicine and Dentistry of New Jersey (UMDNJ) to serve as the lead youth suicide prevention program. UMDNJ continues to expand the services offered and the network of traumatic loss experts that are available throughout New Jersey. In addition, UMDNJ continues to increase the promotion and use of evidence-based approaches to suicide prevention.
- The Department of Children and Families funds a 24 hour youth helpline named "2nd Floor." 2nd Floor recently earned accreditation by the American Association of Suicidology, as a suicide hotline. Over the last year, 2nd Floor has received more calls from youth than the national Lifeline suicide hotline did for individuals of all ages from New Jersey. The hotline is used by thousands of youth every year.
- The Department of Health & Senior Services, Division of Family Health Services continues to fund the Mercer County Traumatic Loss Coalition.
- All school teaching staff must complete at least two hours of suicide prevention instruction as part of their continuing education requirement.
- The Department of Law and Public Safety's Juvenile Justice Commission (JJC) established screening standards for suicide & mental health in county detention facilities and opened a Mental Health Unit at the Juvenile Medium Security Facility in Bordentown, NJ.

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

- The Department of Children and Families released New Jersey's first State Youth Suicide Prevention Plan in February, 2011 to guide the youth suicide prevention efforts in New Jersey.
- The Department of Children and Families continues to offer an annual statewide Youth Suicide Prevention Conference coordinated by UMDNJ for mental health professionals, school personnel, and others who work closely with youth.

A significant component of the Department of Children and Families' focus in its suicide prevention efforts is providing "postvention" following a youth suicide. Suicide contagion is a well documented phenomenon that can occur in a community following an initial suicide. Throughout New Jersey, the Traumatic Loss Coalition for youth focuses a portion of its prevention efforts following a youth suicide by working with the school and community to respond in a manner that will help reduce the risk of suicide contagion. New Jersey has sadly experienced this phenomenon in Monmouth County over the last several years with multiple youth who attended or were connected to Manasquan High School committing suicide.

The Department of Children and families has renewed its focus on youth suicide prevention over the past year. We are dedicated to working diligently with all of our partners in the State including the Youth Suicide Prevention Advisory Council, mental health professionals, law enforcement, addiction treatment professionals, school personnel, activists, community representatives, families, youth, and others to prevent youth suicides.

Introduction

This report on suicidal behavior among New Jersey adolescents is presented to Governor Chris Christie, the New Jersey State Legislature, and the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC) by the Department of Children and Families (DCF) pursuant N.J.S.A. 30:9A-27.

This report contains a summary of the data compiled by DCF's Division of Behavioral Health Services (DCBHS) that includes aggregate demographic information about youth who attempt or commit suicide, current prevention efforts and recommendations for future activities.

Data Overview

There are inherent challenges in data reporting for suicides. Nationally, there is mandatory reporting of suicide, though there are no consistent criteria, definition or data elements required. This is reflected in differences in the definition of suicide, how cases are classified, how they differ in terms of the extent to which potential suicides are investigated and how accurately they determine cause of death. For example, the classification of a cause of death as being "from undetermined causes" results in inaccurate data. It is estimated that most, if not all, of the undetermined cases are actually suicides.[2] While we believe New Jersey's progressive healthcare system may improve the accuracy of data reported, this remains an issue for New Jersey as well.

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

The quality of data on suicide attempts is even more tenuous than that of suicides.[3] At the Federal level there is no systematic or mandatory reporting of nonfatal suicidal behavior. Estimated suicide attempt rates are calculated based on the number of individuals who receive medical treatment.[4] This results in significant underestimates of true rates as research indicates that over 50% of individuals who engage in suicidal behavior never seek medical treatment.[5] This is further complicated for adolescents specifically, as they exhibit more non-fatal suicidal behavior than any other age group.[6] There is a need to collect, "data related to suicidal behaviors that result in death, hospitalization, or outpatient medical treatment, as well as those where no medical care is sought."[7] These challenges make it difficult to compare or view changes over time, across regions, and populations. It is also difficult to monitor the impact of legislation, policies and social changes.

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

- The Web-based injury Statistics Query and Reporting System (WISQARS) (US and NJ 1990-2009).
- New Jersey Violent Death Reporting System (NJVDRS). The NJVDRS is a collaborative effort the of New Jersey Department of Heath & Senior Services (NJDHSS), Center for Health Statistics, and the Violence Institute of New Jersey at the University of Medicine and Dentistry of New Jersey (UMDNJ) is funded by the Centers for Disease Control (CDC) and Prevention. Data is for 2007-2009.
- The Centers for Disease Control (CDC) Youth Risk Behavior Surveillance System Survey (YRBSS). The YRBSS is used nationally by CDC and provides information about the self-reported prevalence of behaviors that are highly related to the most important causes of preventable premature illness and death among youth and young adults. These surveys are conducted every two years, usually during the spring school semester. The survey provides data representative of 9th through 12th grade students in public and private schools.[8] The YRBSS data contained in this report is from the New Jersey 2007 survey.
- Hospital data is from the New Jersey Discharge Data Collection System. The hospital data reflects known attempts that resulted in medical treatment or hospitalization. Data is for 2005-2009.
- The National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Data is for 2005-2009.
- The Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS) is an interactive online database.
- Census data used to calculate rates were obtained from the U.S. Census Bureau American Factfinder website and are population estimates.
- **Please note, the most current complete national and New Jersey data set for suicides and suicide attempts is available through 2009. In some cases, quality preliminary data exists for 2010 and has been included in this report. It is important to note that while the most current complete national and state youth suicide data set is available through 2009, this**

[3] Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, editors Reducing Suicide A National Imperative (2002)
[4] Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, editors Reducing Suicide A National Imperative (2002)
[5] Crosby AE, Cheltenham MP, Sacks JJ. Incidence of suicidal ideation and behavior in the United States, 1994.Suicide and Life- Threatening Behavior.1999; 29:131-140.
[6] National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available online at: www.cdc.gov/ncipc
[7] Crosby AE, Ortega L, Melanson C. Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011
[8] Centers for Disease Control. Youth Risk Behavior Surveillance System Survey. Available online at http://www.cdc.gov/HealthyYouth/yrbs/pdf/system_overview_yrbs.pdf . Accessed 4/28/2011.

department is able to utilize more recent preliminary data to inform current operations and respond to emerging trends.

- Rates are calculated per 100,000 youth and are not calculated for fewer than 20 incidents.
- The categories of Black or African American and Hispanic or Latino are used as presented in the footnoted material and correspond to the Federal Standards for the Classification of Federal Data on Race and Ethnicity.

Scope of the Challenge

In New Jersey, a total of 218 young people between ages 10 and 24 committed suicide between 2007 and 2009, an average of 72 youth each year. According to the National Center for Injury Control and Prevention, Centers for Disease Control, suicide is the fourth leading cause of death for New Jersey's youth.

The New Jersey Department of Health and Senior Services reports:

- Every month 70 New Jersey youth make a suicide attempt serious enough to require hospitalization.
- Over 40% of the suicide attempts by minors are subsequent to previous suicidal behaviors.
- Suicide attempts result in significant medical and non-medical costs and include physical, emotional and psychological damage to the victims as well as to their families and friends.
- Clusters of suicide attempts and deaths of youth have been reported in New Jersey.[9]

National studies indicate that juvenile justice-involved youth may experience two to four times the rate of suicide of their peers in the general population.[10] With an overrepresentation of children of color in the child welfare systems and higher rates of trauma, this population is also of particular concern for suicide risk.[11]

Approximately one in four suicide victims, associated with a private or public school in the U.S., injured or killed someone else immediately before their suicide. This suggests an overlap between risk for committing school-associated homicide and risk for suicide.[12]

The 2007 Youth Risk Behavior Surveillance System Survey (YRBSS) found that 11.6% of New Jersey high school students reported having seriously considered suicide, 9.9% reported having made a suicide plan, and 7.2% reported attempting suicide. With over 400,000 high school students in the state and close to 55,000 college students, over 129,000 youth may have seriously considered or attempted suicide. Our college-aged youth are completing suicide at a higher rate than our high school population.

Rates of reported suicide attempts are two to seven times higher among high school students who

[9] New Jersey Youth Suicide Prevention State Plan 2011-2014.
[10] Justice Policy Institute. (2006). The dangers of detention: The impact of incarcerating youth in detention and other secure facilities. Available at: http://www.justicepolicy.org . Accessed 1/21/11.
[11] Suicide Prevention Resource Center. What foster parents can do to prevent suicide. Available online at: http://www.sprc.org/featured_resources/customized/FosterParents.asp . Accessed on 1/21/11.
[12] Methods of Suicide Among Persons Aged 10-19 Years – United States, 1992-2001," Morbidity and Mortality Weekly Report, Center for Disease Control and Prevention, 2004

identify as lesbian, gay, and bisexual, compared to their heterosexual peers.[13] LGBTQ youth reporting high levels of family rejection were 8.9 times more likely to attempt suicide than their heterosexual peers.[14]

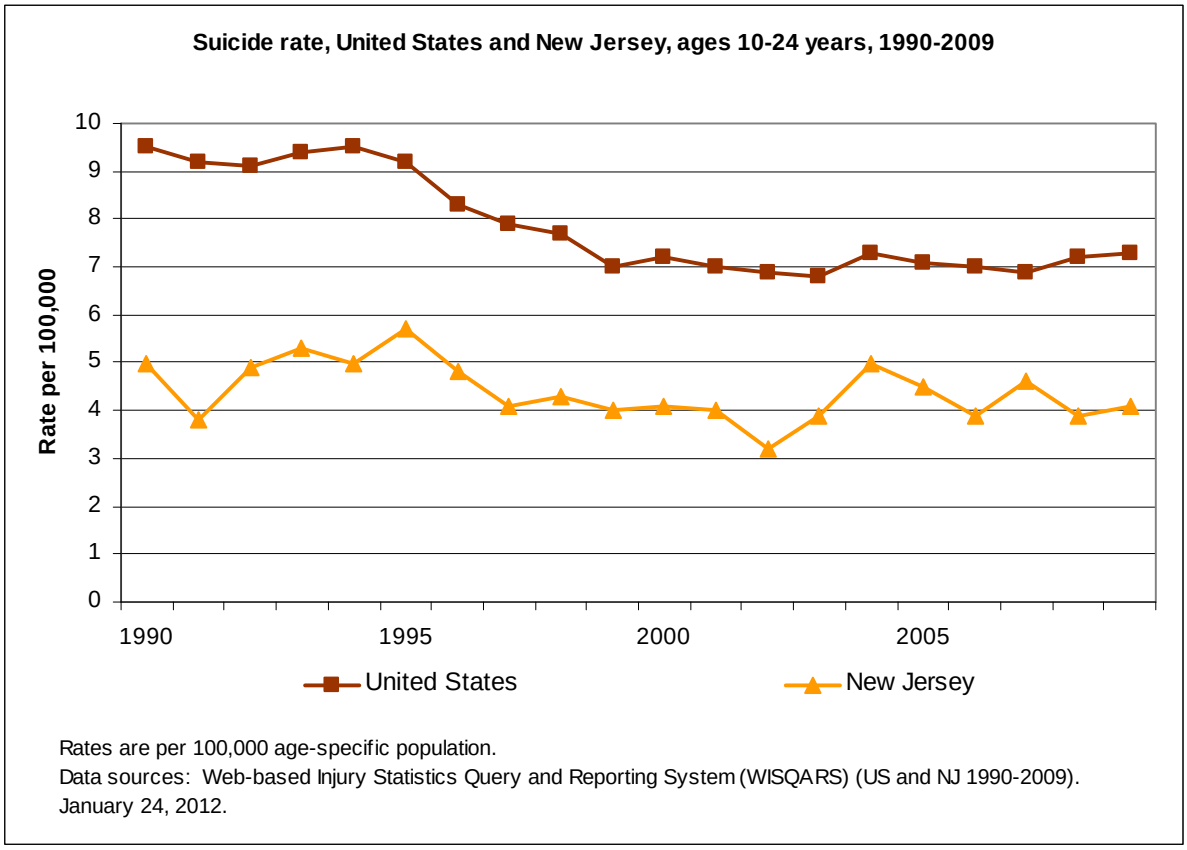
Findings from the 2007 National School Climate Survey demonstrate New Jersey secondary schools were not safe for LGBT students. The survey reported 87% of LGBT students were verbally harassed, 42% of LGBT students were physically harassed, and 24% of LGBT students were physically assaulted. A more detailed summary can be viewed at:

http://www.glsen.org/cgi-bin/iowa/all/library/record/2235.html?state=research&type=research

Confirmed Suicides

As reflected in Figure 1, New Jerseys' 2009 adolescent suicide rate, for ages 10-24, remains significantly lower than the national average. New Jerseys' average rate of suicide per 100,000 has consistently remained below the national average. From 2007-2009 the suicide rates for New Jersey are 4.6, 3.9 and 4.1 versus 6.9, 7.2 and 7.3 nationally.

Figure 1



Preliminary data for 2010 indicates there were 80 suicides for youth ages 10-24 years in New Jersey with a rate of 4.6.[15]

[13] Haas AP., Eliason M, Mays VM., Mathy RM, Cochran SD, et. al. Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. Journal of Homosexuality. 2011;58(1):10-51.
[14] Ryan C. Engaging families to support lesbian, gay, bisexual and transgender youth: The family acceptance project. *Prev Res*. 2010;17(4):11-13.
[15] Preliminary 2010 death data. New Jersey Violent Death Reporting System v.01/24/2012 (2003-2010) for deaths.

Age and Gender

Of the 218 youth suicides in New Jersey from 2007-09, 151 or 69%, were by young people age 19-24. Males accounted for 83% (182) of all suicides and of that number, 69% (126) were males age 19-24. As Table 1 reflects, the number of male suicides was almost five times higher than the number of female suicides.

Table 1. Suicides by age group and gender, New Jersey, 2007-2009

	Age Group		
Gender	**10-18**	**19-24**	**10-24**
Male	56	126	182
Female	11	25	36
Total	67	151	218

Data are from the New Jersey Violent Death Reporting System

Race and Ethnicity

For 2007-2009, New Jersey Asian/Pacific Islander youth represented 8% of the total youth 10-24 and represented 5% of total suicides (Table 2). Black youth represented 15% of the total youth 10-24 and were 13% of total suicides. White youth were significantly overrepresented with 70% of total youth ages 10-24 who committed suicide. Although Hispanic youth make up a significant portion of New Jersey's youth population at 22%, they accounted for only 9% of all suicides.

Table 2. Suicides by age group and race/ethnicity, New Jersey, 2007-2009

	Age Group		
Race/ethnicity	**10-18**	**19-24**	**10-24**
Asian/Pacific Islander	2	8	10
Black Non-Hispanic	7	23	30
White Non-Hispanic	52	101	153
Other Race	0	5	5
Hispanic	6	14	20
Total	67	151	218

Data are from the New Jersey Violent Death Reporting System

Circumstance

Suicides among adolescents are often preceded by a recent crisis. Examples of a recent crisis could have been an intense argument with family members, a relationship breakup or an arrest/involvement with the law. The 2007 report found, especially in the case of males, the crisis may have been very recent, often less than 24 hours before the suicide. Adolescents were five times as likely as others to have had some type of "relationship problem," usually a conflict with family members.[16] Research supports that suicides by adolescents are usually preceded by a recent crisis.[17]

For the period 2007-2009, the data indicates that many youth were identified to have mental health challenges (Table 3). Of those New Jersey adolescents with an identified circumstance who committed suicide, approximately 45% had a current mental health problem, 25% were in treatment, 43% had a history of mental health treatment and 28% of adolescents had experienced a crisis within the previous two weeks (2007-2009 data for a crisis occurring within 24 hours is unavailable). It should be noted

[16] New Jersey Violent Death Reporting System, v.02/13/2007 for 2003-2005
[17] New Jersey Violent Death Reporting System, v.02/13/2007 for 2003-2005

the numbers in Table 3 may total more than 100%, as there may be more than one reported circumstance for any given youth.

Table 3. Suicide circumstances by age group, New Jersey, 2007-2009

	Age Group					
	10-18		19-24		10-24	
Suicide Circumstance	*N*	**%***	*N*	**%***	*N*	**%***
Crisis within 2 weeks	12	25%	33	29%	45	28%
Current depressed mood	11	23%	24	21%	35	22%
Current mental health problem	18	38%	54	48%	72	45%
Current mental health treatment	11	23%	29	26%	40	25%
History of mental health treatment	19	40%	49	44%	68	43%
Substance abuse problem	6	13%	24	21%	30	19%
Alcohol problem	1	2%	15	13%	16	10%
History of suicide attempts	7	15%	29	26%	36	23%
Disclosed intent	10	21%	18	16%	28	18%
Suicide note	15	31%	24	21%	39	24%
Recent death of friend or family	3	6%	6	5%	9	6%
Recent suicide of friend or family	2	4%	3	3%	5	3%
School problem	9	19%	4	4%	13	8%
Financial problem	1	2%	3	3%	4	3%
Physical health problem	0	0%	4	4%	4	3%
Recent criminal legal problem	6	13%	9	8%	15	9%
Intimate partner problem	10	21%	26	23%	36	23%
Job problem	0	0%	8	7%	8	5%
Legal problem	1	2%	1	1%	2	1%
Other relationship problem	16	33%	12	11%	28	18%
Perpetrator of interpersonal violence	0	0%	2	2%	2	1%
Victim of interpersonal violence	0	0%	1	1%	1	1%
Number of suicides in age group	67		151		218	
Number of suicides w/ known circs	48		112		160	
% of suicides w/ known circs		72%		74%		73%

Data are from the New Jersey Violent Death Reporting System
Numbers will add to more than 100% as a youth may have multiple circumstances.

Primary Method

The primary method of suicide for New Jersey male and female adolescents in the 2007 DCF Adolescent Suicide Report was suffocation, or hanging. Firearms were the second most frequently used method among males, followed by poisoning. For females, poisoning is the second most frequently used method.

The data contained in the 2007 DCF Adolescent Suicide Report considered youth ages 10-24 years specifying gender and method. The data for 2007-2009 specifies age and method, but does not include gender. Hence, any comparison or discussion is restricted to youth ages 10-24 years and the method of suicide.

The primary method of suicide for adolescents during 2007-2009 remains suffocation/hanging; with firearms still the second most frequently used method followed by poisoning (Table 4).

For comparison, nationally, the use of firearms is the most prevalent method of suicide, accounting for 46% of suicide deaths among youth (CDC 2009). The second and third most prevalent methods of youth suicide are hanging and poisoning, respectively.

Table 4. Suicides by age group and method/weapon used, New Jersey, 2007-2009

	Age Group		
Method/Weapon	**10-18**	**19-24**	**10-24**
Firearm	11	23	34
Sharp instrument	0	1	1
Poisoning	5	22	27
Hang, strangle, suffocation	36	80	116
Fall	3	6	9
Drowning	2	4	6
Fire or burns	1	1	2
Motor vehicle	2	4	6
Other transport (train)	6	9	15
Other	0	1	1
Unknown	1	0	1
Total	67	151	218

NA* = not available
Data are from the New Jersey Violent Death Reporting System

Geographical Patterns

The geographical pattern of adolescent suicides in New Jersey continues to differ from that of older adults. Adolescent suicides are more common in densely populated areas; suicide rates among older adults are highest in rural counties in Southern and Northwestern New Jersey.

The six counties with the highest incidence of youth/young adult suicides for 2007-2009 are Camden, Passaic, Monmouth, Hudson, Middlesex, and Bergen. These six counties accounted for almost 50% of youth suicides.[18] [19]

- Camden County, with 21 suicides, had the highest rate per 100,000 youth of 19.88 from 2007-2009. The county has a population that is 20% African-American and a significantly higher poverty rate (11.2%) than the state average (8.7%).
- Passaic accounted for 16 youth suicides and a rate per 100,000 youth of 15.90 from 2007-2009. Passaic is very diverse, and nearly 36% of its population is Latino. 42% of families speak a language other than English. It has a higher than state average poverty rate at 13.9%.
- Monmouth County had twenty suicides and a rate per 100,000 youth of 15.55 among youth from 2007-2009. It is a predominantly white (85%), suburban county with 5.9% of its population living below the poverty level. This county is currently experiencing an identified suicide contagion and has been in consultation with the Centers for Disease Control (CDC) regarding prevention.
- Hudson County with a rate per 100,000 youth of 14.20 is home to Jersey City, the state's second largest city, which experienced nine of the 15 total suicides in the county from 2007-2009, the highest of any municipality. Eight of these deaths were college-aged youth. The county has a 40% Latino population, and 56% of its households speak a language other than English.
- Middlesex County with 16 youth suicides and a rate per 100,000 youth of 10.55 from 2007-2009 is the second most populated county in the state and is also highly diverse, with 19%

[18] New Jersey Violent Death Reporting System. (2011). Office of Injury Surveillance and Prevention, Center for Health Statistics, New Jersey Department of Health and Senior Services, Trenton, NJ, 2008. Accessed on 1/21/11.
[19] Census data used to calculate rates were obtained from the U.S. Census Bureau American Factfinder website and are population estimates.

Asian, 18% Latino, and 11% African-American. Seven percent of residents live below the poverty level.

- Bergen accounted for 14 youth suicides, with a rate per 100,000 youth of 8.60 from 2007-2009. Bergen County is predominantly suburban and enjoys a relatively low level of poverty (5.3%). Fifteen percent of its population is Asian and 15% is Latino.

Table 5. Suicides by age group and county of residence, New Jersey, 2007-2009

	Age Group		
County of residence	**10-18**	**19-24**	**10-24**
Atlantic	0	5	5
Bergen	7	7	14
Burlington	4	8	12
Camden	10	11	21
Cape May	1	2	3
Cumberland	2	10	12
Essex	1	9	10
Gloucester	2	6	8
Hudson	3	12	15
Hunterdon	2	1	3
Mercer	2	4	6
Middlesex	5	11	16
Monmouth	5	15	20
Morris	4	9	13
Ocean	3	8	11
Passaic	5	11	16
Salem	1	2	3
Somerset	5	5	10
Sussex	2	3	5
Union	1	8	9
Warren	2	3	5
Unknown	0	1	1
Total	67	151	218

New Jersey Violent Death Reporting System

Attempted Suicides[20]

It is important to note the vast majority of New Jersey youth who attempt suicide do not ultimately commit suicide.[21] Table 6 provides county-level ratio of attempts to completions for 2003-2010.

[20] For a discussion on the data, please refer to the Data Section of this report.
[21] National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available online at: www.cdc.gov/ncipc

Table 6. County-level self-inflicted injuries, ratio of attempts to competitions, New Jersey 2003-2010

	Self-injury hospitalizations (H)	Completed suicides (S)	Ratio H:S
Atlantic	190	15	12.7
Bergen	540	41	13.2
Burlington	343	32	10.7
Camden	533	55	9.7
Cape May	65	8	8.1
Cumberland	134	19	7.1
Essex	476	33	14.4
Gloucester	227	24	9.5
Hudson	389	34	11.4
Hunterdon	70	5	14.0
Mercer	322	29	11.1
Middlesex	662	48	13.8
Monmouth	566	59	9.6
Morris	348	28	12.4
Ocean	371	39	9.5
Passaic	437	34	12.9
Salem	75	13	5.8
Somerset	225	26	8.7
Sussex	177	9	19.7
Union	265	23	11.5
Warren	94	13	7.2
NJ Youth Total*	6509	592	11.0

*5 deaths have unknown county of residence. Note data time period 2003-2010.
Death data from New Jersey Violent Death Reporting System. 2010 death data is preliminary.
Self-injury data from New Jersey Hospital Discharge Data System for hospitalizations.

Age and Gender

National research indicates female adolescents have a higher rate of suicide attempts compared to adolescent males.[22] In New Jersey, there were 5,034 suicide attempts resulting in emergency department treatment from 2005-2009; of that number 4,020 (almost 80%) required hospitalization. As Table 7 indicates, the attempted suicide rate for females (38.5 per 100,000) is greater than the rate for males (22.4 per 100,000).

Table 7. Suicide attempts resulting in emergency department treatment, by age group and gender, New Jersey, 2005-2009

	Age group					
	10-18		19-24		10-24	
Gender	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**
Male	913	16.8	999	32.1	1912	22.4
Female	2085	40.5	1037	35.0	3122	38.5
Total	2998	28.4	2036	33.5	5034	30.3

Note data time period 2005-2009.
Data are from the New Jersey Hospital Discharge Data System.

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

The New Jersey 2007 Youth Risk Behavior Surveillance System survey (YRBSS) indicates within the previous 12 months, 14.0% of females had considered suicide vs. 9.2% of males and 11.9% of females had made a plan for suicide vs. 8.0% of males. Of the students who reported attempting suicide one or more times in the previous 12 months, 7.6% were female and 6.8% were male.

Race and Ethnicity

As reported by the New Jersey Hospital Discharge Data System for 2005-2009 (Table 8) the data indicates there were 5,034 suicide attempts resulting in treatment in an emergency department. Of that total number 3,031 (60%) were white, 781 (15%) were black and 794 (15%) were Hispanic.

Table 8. Suicide attempts resulting in emergency department treatment, by age group and race/ethnicity

	Age group					
	10-18		19-24		10-24	
Race/ethnicity*	N	Rate	N	Rate	N	Rate
White, non-Hispanic	1822	28.8	1209	36.1	3031	31.3
Black, non-Hispanic	452	26.1	329	32.3	781	28.4
Native American	11	**	11	**	22	62.7
Asian/Pacific Islander	67	9.5	45	10.6	112	9.9
Hispanic	472	26.5	322	25.5	794	26.1
Other race	60	-	37	-	97	-
Multiracial	3	-	1	-	4	-
Unknown race	111	-	82	-	193	-
Total	2998	28.4	2036	33.5	5034	30.3

*Rates are based on the 5 race categories used with death data, so they are just an estimate and should be used with caution.
Note data time period 2005-2009.

Although nationally, rates of suicide among Hispanic youth are lower than those for Non-Hispanics, school-aged Hispanic youth self-report higher rates of feeling sad or hopeless, of thinking about suicide and of attempting suicide.[23]

The New Jersey 2007 YRBSS reports the following for Hispanic adolescents and suicidal ideation and attempts:

- A greater proportion of Hispanic and Black students (15.9% and 15.7%, respectively) than White students (9.1%) reported having considered suicide in the last 12 months.
- This trend was similar for those who reported having made plans to commit suicide, with Hispanic students most likely (13.4%) and White students least likely (8.0%) to have made plans.
- A greater proportion of Hispanic and Black students (11.7% and 9.1%, respectively) than White students (4.8%) reported attempting suicide in the last 12 months.

For comparative purposes, the national 2007 YRBSS reports the following for Hispanic adolescents and suicidal ideation and attempts:

[23] American Association of Suicidology. Hispanic Suicide Fact Sheet. Available online at http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-243.pdf

- 18% of Hispanic adolescents reported seriously considering attempting suicide in the last 12 months - a proportion higher than reported by their Non-Hispanic classmates.
- Hispanic female high school students reported a higher percentage of suicide attempts (14%), than White Non-Hispanic (7.7%) or Black Non-Hispanic (9.9%) female students.

Primary Method

The primary method used in suicide attempts was poisoning followed by cutting/piercing. The vast majority of suicide attempts involved poisoning (60.4%), most often an overdose of a prescription or non-prescription medication. A recently released report from the Drug Abuse Warning Network (DAWN) reinforces the need to continue to monitor drug-related suicide attempts and the need to develop strategies. DAWN is a US Health and Human Services, Substance Abuse and Mental Health Administration (SAMSHA) public health surveillance system that monitors drug-related emergency department visits in the United States. The national data reported for 2008 found that 95.4 percent of drug-related suicide attempts among adolescents involved pharmaceuticals and female adolescents accounted for almost three-fourths of drug-related suicide attempts that were seen in emergency departments.[24]

In New Jersey for 2005-2009 time period (Table 9), 3,041 (over 60%) of suicide attempts resulting in *emergency department treatment* involved poisoning, usually an overdose of a prescription or non-prescription medication. For that same time period, 3,793 (94%) of suicide attempts resulting in *hospitalization* also involved poisoning, usually an overdose of a prescription or non-prescription medication.

Table 9. Suicide attempts resulting in emergency department treatment, by age group and method/weapon, New Jersey, 2005-2009

	Age group					
	10-18		19-24		10-24	
Method/weapon	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**
Cut/pierce	646	6.1	508	8.4	1154	6.9
Drown	2	**	0	-	2	**
Fall	12	**	11	**	23	0.1
Fire/Flame	17	**	6	**	23	0.1
Firearm	2	**	4	**	6	**
MV Traffic	5	**	1	**	6	**
Poisoning	1893	17.9	1148	18.9	3041	18.3
Suffocation	26	0.2	19	**	45	0.3
Other Spec	3	**	1	**	4	**
NEC (not elsewhere classifiable)	317	3.0	260	4.3	577	3.5
Not spec	73	0.7	74	1.2	147	0.9
Unknown weapon	2	**	4	**	6	**
Total	2998	28.4	2036	33.5	5034	30.3

Note data time period 2005-2009.
Data from the New Jersey Hospital Discharge Data System

[24] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (May 13, 2010). The DAWN Report: Emergency Department Visits for Drug-related Suicide Attempts by Adolescents: 2008. Rockville, MD.

Prevention Activities

During the past 20 years, New Jersey has been at the forefront in its approach to implement a wide variety of policies and programs in focusing critical attention to the importance of actively addressing teen suicide.[25] Since the 2007 DCF Adolescent Suicide Report, New Jersey has continued to enhance, update and promote existing and new policies and programs for children's mental and behavioral health. Information about the State's prevention efforts across various agencies is presented below.

NJ Department of Children and Families (DCF)

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

New Jersey Youth Suicide Prevention Plan

The *New Jersey Youth Suicide Prevention State Plan 2011-2014* was developed by the Department of Children and Families with input provided by the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC). The plan was developed to guide the State's efforts to prevent youth suicides, focusing on the associated risk and protective factors of suicide and suicide attempts.

The following goals are outlined in the plan:

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

The full plan can be viewed at:

http://www.state.nj.us/dcf/behavioral/prevention/preventionplan.pdf .

[25] Promising Practices to Prevent Adolescent Suicide: What We Can Learn from New Jersey. Cecil G. Sheps Center for Health Services Research. Available online at http://www.shepscenter.unc.edu/publications/suicidepreventionNJ.pdf

DCF - Division of Child Behavioral Health Services

DCF's Division of Child Behavioral Health Services (DCBHS) serves children and adolescents with emotional and behavioral health care challenges and their families. DCBHS is committed to providing these services based on the needs of the child and family in a family-centered, community-based environment.

DCBHS believes that the family or caregiver plays a central role in the health and well being of children. DCBHS involves families throughout the planning and treatment process in order to create a service system that values and promotes the advice and recommendations of the family, a system that is friendly to families and one which provides them the tools and support needed to create successful life experiences for their children with emotional and behavioral problems.

Traumatic Loss Coalition for Youth (TLC)

The Traumatic Loss Coalitions for Youth Program (TLC) at the University of Medicine and Dentistry-University Behavioral Health Care is the state's primary youth suicide prevention and postvention program. The TLC is funded by the Department of Children and Families – Division of Child Behavioral Health Services and has operated as a county-based collaborative since the year 2000. The dual mission of the TLC is to decrease the number of suicide attempts and completions and provide a coordinated mental health response to a death of a youth or young adult by suicide, homicide, accident or illness.

Each county employs a TLC Coordinator who conducts meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agency personnel, child welfare workers and many other youth serving individuals. The purpose of the meetings is to provide a forum for networking, education and collaboration centered on issues of mental health and suicide prevention as they pertain to youth and young adults.

The TLC has continued to build a statewide infrastructure that enables school and community stakeholders access to conferences and trainings focused on mental health issues, and suicide prevention intervention, and postvention. These programs are consistently well attended and yield excellent evaluation results. (Please refer to data below and the appendix for further information.)

This infrastructure has historically served those that serve all school-age youth. The Division of Child Behavioral Health Services and the TLC understand that mental health needs and suicide risk does not end when a youth reaches 18 years of age. Many mental health disorders emerge during the young adult years and risk for suicide is higher in the 18-24 year old demographic. This understanding has prompted the TLC to increase its efforts to outreach young adults and those that serve them in colleges and universities throughout the state. TLC Newsletters and conference and training information is sent electronically to college counseling staff throughout the state. The Coordinators also outreach these individuals in their respective counties. This has resulted in increasing representation of counselors and clinicians from schools of higher education at the coalition tables and at TLC sponsored conferences and training programs as well as calls for consultation and onsite postvention assistance in the aftermath of a traumatic death.

The TLC infrastructure has exponentially increased the postvention capacity for youth and young adults. The TLC believes that those most impacted by a suicide or other traumatic loss event should have the opportunity to play a major role in the process of recovery and healing. The Coordinators work within their counties to direct a Lead Response Team (LRT) to assist the local crisis and mental health teams in schools, colleges and universities, and communities following a traumatic loss event of a youth or young adult. Postvention assistance is critical in the aftermath of a suicide to assist in the grieving process, provide accurate information about suicide, address common feelings and reactions, decrease blame and scapegoating, encourage help-seeking and identify and refer youth at-risk for imitative behavior. The TLC recognizes that appropriate suicide postvention steeped in best practice and evidence-based principles is tantamount to good suicide prevention.

The TLC continues to work in partnership with national leaders in the field of suicidology and with national organizations such as the American Foundation for Suicide Prevention (AFSP), and the Suicide Prevention Resource Center (SPRC). A recent product of this collaborative work with AFSP and SPRC is: *After a Suicide: A Toolkit for Schools*, a free, online resource to assist schools and communities in the aftermath of a death by suicide. This toolkit has been receiving national and international acclaim and has been added to the AFSP/SPRC Best Practice Registry. The TLC also collaborates with programs at University Behavioral HealthCare such as Cop 2 Cop and Vet 2 Vet, providing suicide prevention and postvention assistance.

In addition to ongoing county, regional, statewide and onsite staff development training for gatekeepers, counselors and clinicians, the TLC has recently begun a new evidenced-based Peer Leader initiative – Sources of Strength. The Sources of Strength Peer Leader Program was initiated in March and May, 2011 in five New Jersey schools.

Sources of Strength is a comprehensive wellness program that works to use peer leaders to change norms around codes of silence and seeking help. The core principals of Sources of Strength include: train both peer leaders and adults – one without the other lacks prevention power; use peer leaders to break down codes of silence and increase peer help seeking; core emphasis on strengths that move beyond a singular focus on risk and suicide warnings; multiple sources of support are encouraged – including but moving beyond a singular focus on mental health referrals; Hope, Help, and Strength messages delivered by peer leaders using local faces and voices.

Three new schools will be added in January 2012. In addition several community programs will be added that serve youth and young adults deemed to be at higher risk for attempts and completions by the National Action Alliance for Suicide Prevention. These groups will include LGBT youth, young adults in colleges and universities, Juvenile Justice and young adult military personnel and children of veterans.

TLC Summary of activities April 2010 to June 2011:

- 4,320 individuals attended training on mental health disorders and suicide prevention for youth-serving individuals and groups
- 1,036 individuals attended training for school and community responders
- 6,859 individuals received on-site trauma response assistance to schools and communities

More information on trainings offered, TLC County Coordinator Contact Information, links to other resources and the most recent TLC state report can be found at http://ubhc.umdnj.edu/brti/TLC.htm . The above text and information is from the TLC State report for April, 2010 – June, 2011.

DCBHS's Children's System of Care for Mental & Behavioral Health

Services encompassed within the Department of Children and Families (DCF), Division of Child Behavioral Health's (DCBHS) System of Care are

- Care Management Organizations (CMO)/Unified Care Management Organizations (UCM)
- Youth Case Management (YCM)
- Screening/Emergency Services
- Mobile Response Stabilization Services (MRSS)
- Family Service Organizations (FSO).
- Contracted System Administrator

New Jersey is renowned for its development and implementation of a Statewide culturally competent behavioral health System of Care that provides a comprehensive continuum of child centered/family focused and community-based resources. New Jersey's hope and goal is that by producing a 'wraparound continuum of care' for families and their child in need of mental and behavior health, this will aid in the family's health and positive growth, providing them with more informed choices that will lead all to a future of more happiness, unity and togetherness.

The Division of Child Behavioral Health Services (DCBHS) administers Mobile Response Stabilization Services (MRSS) as a key component to adolescent suicide prevention. MRSS provides in-home and community crisis intervention and intensive follow up, including clinical services on-site for up to eight weeks, as well as linkage to additional longer term services. Crisis plans are developed with each youth and family/caregiver, which assist in avoiding more restrictive services; avoiding disruption of the youth's living situation and decreasing stressors that may place youth at additional risk.

In 2010, state-contracted Mobile Response and Stabilization Services performed 19,825 Crisis Assessments for youth and children ages 5-18. Of these assessments, 1645 or over 8% rated at elevated risk for suicide.

DCBHS's Contracted Services Administrator (CSA) for the NJ System of Care

PerformCare is the gateway for New Jersey families and children in crisis, in order to obtain mental & behavioral health case management, advocacy or residential care, treatment and resources.

PerformCare utilizes advanced information technology within the electronic medical record (CYBER) to identify youth presenting with sustained high risk factors, such as depression, suicide ideation, self mutilation and other self harm, danger to others, and sexual aggression. These risk factors are assessed at regular intervals as part of the Strength & Needs Assessment for the associated service planning cycle. Through the anomaly management functionality in CYBER, youth meeting this high risk criteria are identified and the responsible treatment provider is then notified, triggering a more comprehensive review for follow up by the provider and as necessary, inclusion in the care treatment plan of the child and his/her family.

JJC Detention Center Services

New Jersey's Youth Detention Centers use the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2). The MAYSI-2 is a brief screening tool designed to assist juvenile justice facilities in identifying youth 12 to 17 years old who may have special mental health needs, which includes youth who may be at risk of suicide. For screenings that fall within "Warning Ranges" the DCBHS receives bi-annual reports summarizing these screenings. (See below under Juvenile Justice Commission).

More information on the services and resources available through DCBHS can be found at http://www.nj.gov/dcf/behavioral/help/index.html

Division of Prevention and Community Partnerships

The Division of Prevention and Community Partnerships' (DPCP) goal is to build a continuum of child abuse prevention and intervention programs that are culturally competent, strengths-based and family-centered, with a strong emphasis on primary child abuse prevention. Services and programs funded through the DPCP promote culturally-sensitive, strengths-based, positive outcomes for children, youth and families in the following areas: child cognitive development; child social and emotional development; child physical health development; prevention of child injury, abuse and neglect; parenting behavior, attitudes and knowledge; parents' mental health or risk behaviors; family functioning/resources, including economic self-sufficiency; empowerment and increased safety for domestic violence victims and their children.

School-Based Youth Services Program (SBYSP)

Through DPCP, the New Jersey School-Based Youth Services Program is available at high schools, middle schools, and elementary schools around the state. Many teenagers have multiple problems that call for different services. SBYSP was designed with input from teens, to provide employment, health and social services that are available to all youth based on a strengths-based positive youth development model. This program allows students to receive social and wraparound services right on campus.

2nd Floor Youth HELPLINE

The NJ 2nd Floor Youth HELPLINE is a Statewide, 24-hour, interactive telephone line for youth and young adults (ages 10-24), staffed by counseling professionals and specially trained volunteers. The overall goal of this initiative is to promote healthy youth development by providing immediate interactive, respectful, professional helpline services, with linkage to information and services that address the social and health needs of youth.

From July 2009-June 2010 the 2nd Floor Youth HELPLINE, based upon the caller's presenting problem, over 33% of the calls received were in those areas identified as risk factors that are associated with suicidal behavior.

In July 2011 THE 2nd Floor Youth HELPLINE was accredited as a Suicide Prevention Hotline by the American Association of Suicidology. Their website is www.2ndfloor.org.

Brief Overview of Other NJ State Youth Suicide Prevention Efforts

NJ Department of Law and Public Safety - Office of the Attorney General

Juvenile Justice Commission (JJC) [26]

The JJC develops and implements strategies for the correction and rehabilitation of juvenile offenders. The commission is responsible for the planning, policy development and facility operations of the juvenile justice system. In addition, the agency provides a continuum of care services, including prevention, intervention, education and aftercare.

Detention Center Services

Under N.J.S.A. 52:17B-171.1 the New Jersey Juvenile Justice Commission was to establish standards for suicide and mental health screening in county juvenile detention facilities. Each county detention facility was to develop written policies concerning mental health screening, suicide screening, suicide prevention protocols and other mental and emotional health-related issues. It also required each county juvenile detention facility to make psychological or psychiatric services available to juveniles as needed.

New Jersey's Youth Detention Centers use the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2). The MAYSI-2 is a brief screening tool designed to assist juvenile justice facilities in identifying youth 12 to 17 years old who may have special mental health needs. Suicide is one area identified. The MAYSI-2 provides "cut-off scores" that automatically signal to staff a "decision to respond," while also identifying the appropriate next step(s). The protocol developed for use of the MAYSI-2 provides guidance to all staff involved in administering the MAYSI-2 and guide staffs in the interpretation of the risk factors for youth suicide and suicide attempts, including depression ratings, relationship ratings, school acceptance rating, bullying/harassment ratings.

The JJC submits a biannual report summarizing all screenings that fall within the "Warning Ranges" to DCBHS staff.

Mental Health Unit

In addition, in January 2010 a Mental Health Unit started operations, at the Juvenile Medium Security Facility in Bordentown, NJ. The Unit was created to serve committed youth identified as requiring Level 3 custody (highest security level), with persistent moderate to severe mental health pathologies and corresponding symptoms.[27] This includes youth at risk of suicide (suicide ideation).

[26] The Juvenile Justice Commission is in, but not of the Office of the Attorney General.
[27] Preliminary Assessment of the Juvenile Justice Commission's H-Wing Mental Health Unit, August 2010. Accessed 6/1/2011. Available from URL: http://www.nj.gov/oag/jjc/pdf/2010-Preliminary_Assessment_of_JJC_Mental-Health_Unit.pdf

NJ Department of Education

Suicide Prevention Awareness

The NJ Suicide Prevention Law, N.J.S.A. 18A:6-111. requires instruction in suicide prevention in public schools as part of the continuing education that public school teaching staff members must complete to maintain their certification. The NJ Core Curriculum Content Standards in Comprehensive Health and Physical Education include instruction on suicide prevention awareness. (maybe refer to the standard?)

NJ Department of Health and Senior Services (DHSS) - Division of Family Health Services

Federal Title V Funds

As previously stated, the Mercer County Traumatic Loss Coalition is the only county TLC funded through NJDHSS with Federal Title V funds. This Federal Block Grant requires State Maternal and Child Health programs to report on specific national performance measures. One of these measures is to reduce the rate (per 100,000) of suicide deaths among youths aged 15 through 19. To address this performance measure, the Title V Maternal and Child Health Program funds the Mercer TLC and a DHSS staff member from Office of Injury Surveillance and Prevention (OISP) in the Center for Health Statistics actively participates on the NJ Youth Suicide Prevention Council (NJYSPAC). The Office of Injury Surveillance and Prevention is a central source for injury and suicide statistics.

Recommendations

Based on the above data review, there is more work to be done to reduce the incidents of youth suicide completions and attempts. The New Jersey Youth Suicide Prevention Plan released by DCF in 2011 was informed by the above reviewed data. The NJ Youth Suicide Prevention Plan outlines this department's recommendations for future youth suicide prevention efforts in NJ. This includes the following: (The full detailed plan is attached as an appendix)

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

DCF is committed to working diligently to continue to address the needs and attain the goals outlined in the NJ Youth Suicide Prevention Plan. Over the last year we have already taken many steps towards these goals. For example, we have expanded the use of best practice and evidence-based approaches, we are implementing an innovative social media suicide prevention program, and we have increased training opportunities for professionals and communities. We look forward to working with NJ's residents in meeting these goals and ultimately reducing the youth suicide rates in NJ.

Appendices

- NJ Youth Suicide Prevention Plan 2011 – 2014
- UMDNJ Traumatic Loss Coalition State Report 2010 - 2011

New Jersey Youth Suicide Prevention Plan 2011 – 2014

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

Table of Contents

Introduction

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

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

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

NJ Suicide Statistics Relative to Other States

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

NJ's Suicide Prevention Activities

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

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

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

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

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

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

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

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

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

NJ Youth Suicide Prevention Advisory Council

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

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

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

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***Organizational affiliations are those at the time of the individual's involvement.**

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New Jersey's Youth Suicide Prevention Plan

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

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

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

New Jersey's Youth Suicide Prevention Plan Goals

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

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

Goal # 1: Improve and expand surveillance systems.

Rationale

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

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

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

Objectives:

1.1 The Department of Children and Families will publish an annual report on suicide in New Jersey that integrates data from multiple state data management systems.

1.2 Improve coordination of data collection regarding suicide investigations with state, local agencies, and their partners.

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

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

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

Rationale

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

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

Objectives

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

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

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

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

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

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

Rationale

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

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

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

Objective

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

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

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

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

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

Rationale

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

Objective

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

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

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

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

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

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

Rationale

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

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

Objectives

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

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

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

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

Rationale

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

Objectives

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

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

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

6.4 NJYSPAC will make specific recommendations to DCF:

> 6.4.1 That identifies who the "key gatekeepers" are; determine how they are organized across the state; recommend engagement strategies for each group; and suggests courses of action for engagement in youth suicide prevention efforts.
>
> 6.4.2 That identify preferred youth suicide prevention training strategies for key gatekeeper groups; training strategies will be cognizant of and sensitive to the particular mission, goals, needs, and organizational structures of each group.

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

Rationale

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

Objectives

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

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

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

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

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

Rationale

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

Objectives

8.1 Identify and address barriers to mental health and substance abuse services.

8.2 Increase community awareness of risk behavior and increase awareness of culturally competent and linguistically relevant services.

8.3 Work with all appropriate state departments to increase access to an integrated network of effective, efficient, culturally competent and linguistically accessible mental health and substance abuse services that include suicide prevention and counseling services.

8.4 Promote DCF's youth helpline, "2nd Floor." Continue to enhance this helpline's ability to respond to youth at risk and explore potential for this helpline serving as a National Suicide Prevention Lifeline networked hotline.

8.5 Increase the number of calls answered in New Jersey from New Jersey residents that call the National Suicide Prevention Lifeline. Identify, coordinate, and prepare New Jersey based hotlines to serve as a recipient of National Suicide Prevention Lifeline calls.

8.6 Encourage all DCF contracted agencies to promote NJ Mental Health Cares helpline as a resource for families seeking mental health services.

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

Rationale

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

Objectives

9.1 Disseminate information on nationally recognized guidelines for reporting about suicide with an effort to reduce the stigma and prevent future suicides.

9.2 Utilize the nationally recognized guidelines outlined in the Reporting on Suicide: Recommendations for the Media (Annenberg Public Policy Center 2001) for reporting on suicide and local experts on suicide and suicide prevention for consultation and training with the media and academic programs in journalism.

9.3 Work with New Jersey academic journalism programs to include guidance on the appropriate depiction and reporting of mental illness, suicide and self-injury in their curricula.

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

Rationale

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

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

Objectives

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

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

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

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

Next Steps

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

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

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TRAUMATIC LOSS COALITIONS FOR YOUTH

April 2010 – June 2011

UBHC
UNIVERSITY
BEHAVIORAL HEALTHCARE

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

UNIVERSITY BEHAVIORAL HEALTHCARE
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Traumatic Loss Coalitions for Youth Program
TLC Central Team and Coordinators

Donna Amundson, LCSW…Program Manager
Nancy A. Baird, MA…Resource Coordinator
Dotty Rodrick, DRCC…Resource Coordinator

County	Coordinator	Host Agency
Atlantic	Patty Weeks, LSW Laura Pelouze, MA	Richard Stockton College of NJ
Bergen	Sue Heguy, LCSW	Care Plus NJ, Inc.
Burlington	Elfrieda Francis, MSW	Board of Chosen Freeholders of the County of Burlington
Camden	Barbara Maronski, LSW	Community Planning and Advocacy Council
Cape May	Chris Miller, MA	Cape Counseling Services
Cumberland	Elvira Smith, MA, CSW	UMDNJ-UBHC
Essex	Arlene O'Connell, LPC	UMDNJ-UBHC
Gloucester	Barbara Maronski, LSW	Center for Family Services
Hudson	Silvana Gomez, MA	Liberty Health-Jersey City Medical Center
Hunterdon	Sherri Neville, MA	Hunterdon Medical Center
Mercer	Steve Olsen	Mercer County Funding
Middlesex	George Scott, EdS, MFT	UMDNJ-UBHC
Monmouth	George Scott, EdS, MFT	UMDNJ-UBHC
Morris	Mary Vineis, BA, DRCC	AHS Hospital Corp – Atlantic Behavioral Health
Ocean	Karen Bright, MA, LPC	Saint Barnabas Health Care-Kimball Medical Center
Passaic	Dan Silitsky, PhD	UMDNJ-UBHC
Salem	Joanne Comninos, MA, LPC	Robins' Nest, Inc.
Somerset	Melissa Callen, MA, LPC	Richard Hall Community Mental Health Center
Sussex	Dan Silitsky, PhD	UMDNJ-UBHC
Union	Pat Neary-Ludmer, PhD	Trinitas Regional Medical Center
Warren	Darrell Buckner, MSW, LSW	Family Guidance Center of Warren

Traumatic Loss Coalitions for Youth Program

is dedicated to excellence in suicide prevention and in providing a collaborative and coordinated mental health response to a global or community crisis affecting our school-age youth.

Executive Summary

The Traumatic Loss Coalitions for Youth Program (TLC) at the University of Medicine and Dentistry-University Behavioral HealthCare is the state's primary youth suicide prevention and postvention program. The TLC is funded by the Department of Children and Families – Division of Child Behavioral Health Services and has operated as a county-based collaborative since the year 2000. The dual mission of the TLC is to decrease the number of suicide attempts and completions and provide a coordinated mental health response to a death of a youth or young adult by suicide, homicide, accident or illness.

Each county employs a TLC Coordinator who conducts meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agency personnel, child welfare workers and many other youth serving individuals. The purpose of the meetings is to provide a forum for networking, education and collaboration centered on issues of mental health and suicide prevention as they pertain to youth and young adults.

The TLC has continued to build a statewide infrastructure that enables school and community stakeholders access to conferences and trainings focused on mental health issues, and suicide prevention intervention, and postvention. These programs are consistently well attended and yield excellent evaluation results.

This infrastructure has historically served those that serve all school - age youth. The Division of Child Behavioral Health Services and the TLC understand that mental health needs and suicide risk do not end when a youth reaches 18 years of age. Many mental health disorders emerge during the young adult years and risk for suicide is higher in the 18-24 year old demographic. This understanding has prompted the TLC to increase its efforts to outreach young adults and those that serve them in colleges and universities throughout the state. TLC Newsletters and conference and training information is sent electronically to college counseling staff throughout the state. The Coordinators also outreach these individuals in their respective counties. This has resulted in increasing representation of counselors and clinicians from schools of higher education at the coalition tables and at TLC sponsored conferences and training programs as well as calls for consultation and onsite postvention assistance in the aftermath of a traumatic death.

The TLC infrastructure has exponentially increased the postvention capacity for youth and young adults. The TLC believes that those most impacted by a suicide or other traumatic loss event should have the opportunity to play a major role in the process of recovery and healing. The Coordinators work within their counties to direct a Lead Response Team (LRT) to assist the local crisis and mental health teams in schools, colleges and universities, and communities following a traumatic loss event of a youth or young adult. Postvention assistance is critical in the aftermath of a suicide to assist in the grieving process, provide accurate information about suicide, address common feelings and reactions, decrease blame and scapegoating, encourage help-seeking and identify and refer youth at-risk for imitative behavior. The TLC recognizes that appropriate suicide postvention steeped in best practice and evidence-based principles is tantamount to good suicide prevention.

The TLC continues to work in partnership with national leaders in the field of suicidology and with national organizations such as the American Foundation for Suicide Prevention (AFSP), and the Suicide Prevention Resource Center (SPRC). A recent product of this collaborative work with AFSP and SPRC is: *After a Suicide: A Toolkit for Schools,* a free, online resource to assist schools and communities in the aftermath of a death by suicide. This toolkit has been receiving national and international acclaim and has been added to the AFSP/SPRC Best Practice Registry. The TLC also collaborates with programs at University Behavioral HealthCare such as Cop 2 Cop and Vet 2 Vet, providing suicide prevention and postvention assistance.

In addition to ongoing county, regional, statewide and onsite staff development training for gatekeepers, counselors and clinicians, the TLC has recently begun a new Evidenced-Based Peer Leader initiative – Sources of Strength. The Sources of Strength Peer Leader Program was initiated in March and May, 2011 in five New Jersey schools.

Sources of Strength are a comprehensive wellness program that works to use peer leaders to change norms around codes of silence and help seeking. The core principals of Sources of Strength include: train both peer leaders and adults – one without the other lacks prevention power; use peer leaders to break down codes of silence and increase peer help seeking; core emphasis on strengths that move beyond a singular focus on risk and suicide warnings; multiple sources of support are encouraged – including but moving beyond a singular focus on mental health referrals; Hope, Help, and Strength messages delivered by peer leaders using local faces and voices.

Three new schools will be added in January 2012. In addition several community programs will be added that serve youth and young adults deemed to be at higher risk for attempts and completions by the National Action Alliance for Suicide Prevention. These groups will include LGBT youth, young adults in colleges and universities, Juvenile Justice and young adult military personnel and children of veterans.

The TLC is pleased to present this State Report for April 2010 through June 2011. We have exceeded our goals which are a direct result of the support provided by the Department of

Children & Families, Division of Child Behavioral Health Services; UMDNJ-University Behavioral HealthCare; County Mental Health Administrators and Host Agency Directors. This program would not be as successful without the dedication and tireless work of the TLC Coordinators and the deeply committed efforts of the LRT responders.

We look forward to our continued work with the many stakeholders around the state in saving lives and bringing healing to those impacted by suicide and other traumatic loss.

TLC Goal Achievements Summary April 2010 to June 2011:

Goal # 1

Conduct training programs on mental health disorders and suicide prevention for youth-serving individuals and groups

TLC Central Team programs - number trained:	**1,754**
Coordinator sponsored programs - number trained:	**2,566**
Total trained during this report period:	**4,320**

Goal # 2

Conduct training programs for school and community personnel who must respond to the needs of youth in the aftermath of suicide, homicide, accidental death, and other critical incidents such as a natural disaster or terrorist strike (postvention)

TLC Central Team programs – number trained:	**120**
Coordinator sponsored programs – number trained:	**916**
Total trained during this report period:	**1,036**

Goal # 3

Provide on-site postvention assistance to schools and communities including postvention after a death by suicide, homicide, accident or illness, and other critical incidents

Number receiving postvention:	**6,859**
County LRT postvention hours: (# responders x # hours)	**1,658**
Coordinators postvention hours:	**792**
TLC Central Team onsite postvention hours:	**440**
LRT skill drilling meetings:	**79**

Goal # 4

Foster collaboration between youth-serving individuals and organizations

Number of attendees at Coalition meetings:	**1,835**
Number of Coalition meetings held:	**113**
Number of educational components provided:	**92**

Goal # 5

Design suicide prevention and postvention programs for schools and community-based organizations in collaboration with national experts and national organizations

After a Suicide: A Toolkit for Schools

Goal # 6

Disseminate information regarding suicide prevention, intervention, and postvention programs, guidelines, fact sheets, and resources

TLC Central Team disseminated information on Suicide Prevention Programs from the Suicide Prevention Resource Center Best Practice Registry and the SAMHSA National Registry of Evidence-based Programs and Practices (NREPP). These were included on information tables at the 8th Annual Suicide Prevention Conference, in the TLC Newsletter and continues to be posted on the TLC website. The programs included:

- ***More Than Sad-Teen Depression and More Than Sad-Preventing Suicide Programs***
- ***AFSP College Film***
- ***Lifelines Suicide Prevention Program***
- ***Signs of Suicide Program (middle and high school programs)***
- ***Signs of Self Injury Program***
- ***Sources of Strength***
- ***CASE Approach***
- ***Columbia Teen Screen***
- ***ASIST***
- ***AFSP Interactive Screening Program***
- ***Kognito***

TLC Central Team disseminated Fact Sheets, Guidelines, and Resources. These were included on information tables at the 8th Annual Youth Suicide Prevention Conference, the TLC Newsletter and continue to be posted on the TLC website. These include:

- ***A Safe Way to Memorialize a Death by Suicide: Guidelines for Schools***
- ***Youth Survivors of Suicide Information Fact Sheet***
- ***Reporting on Suicide: Recommendations for the Media***
- ***Information on World Suicide Prevention Week and World Suicide Prevention Day***
- ***Article highlighting the work of the American Foundation for Suicide Prevention***
- ***Information about AFSP Out of the Darkness Overnight and Community Walks***
- ***The National Suicide Prevention Lifeline Phone Number***
- ***Listing of Suicide Survivor Support Groups in New Jersey***
- ***Web addresses for National Suicide Prevention Organizations***
- ***Information about Second Floor – a NJ Youth Helpline***
- ***Comfort Zone Camp***
- ***Grief Speaks Program***
- ***Good Grief Bereavement Program for Youth & Families***
- ***The Sanctuary – Trauma & Loss Counseling Program***
- ***Suggested books***

Goal # 7

Develop and disseminate guidelines for youth and young adult-serving individuals following a local or global crisis

TLC Central Team developed and disseminated:

- ***Helping Children Cope in the Aftermath of the Haitian Earthquake***
- ***Understanding Childhood Grief and How to Help: A Guide for Adults***
- ***Guidelines for Helping Children Through Challenging Times***
- ***Helping Parents Help Their Children: Information about Coping with Trauma***
- ***Common Reactions Following Childhood Bereavement***
- ***Tasks of Grieving***
- ***Talking with Young Children about Death: Strategies for School Systems***

Goal # 8
Provide training, consultation and technical assistance for TLC Coordinators

Regional Coordinator meetings held:	**23**
All County Coordinator training meetings held:	**3**
Trainings held for Coordinators:	**8**
• **PTSM skill building workshops**	**4**
• **PTSM advanced training workshops**	**2**
• **TII/CBI training workshops**	**2**

TLC Comprehensive Training Program Listing April 2010 to June 2011:

Goal # 1
Conduct training programs on mental health disorders and suicide prevention for youth-serving individuals and groups

- ***Suicide Awareness Training Workshops for Educators*** **- Ongoing**
  TLC Training Team
  TLC provides a two-hour Suicide Awareness Training for Educators to fulfill the professional development requirement, per **N.J.S.A. 18A:6-11**. A team of clinicians experienced in the evaluation and treatment of children and adolescents with mental health disorders and suicidal behaviors provide this training. The content is customized to meet the needs of a single school or an entire school district, as well as mental health and social agency staff. On-site school counselors or administrators are included in the presentation to talk about the specific protocols outlined in their school's crisis plan for referring at-risk youth for further evaluation and treatment. This program includes information on mental health disorders that put youth at risk for suicide as well as risk factors, protective factors and warning signs for suicide. The training uses lecture, power point, video clips, and interactive discussion to enhance the learning.
  849 trained

- ***Chronological Assessment of Suicide Events - the CASE Approach*** **– April 2010-June 2011**
  Donna Amundson, LCSW, and George Scott, EdS, MFT
  Both trainers have been certified to teach the CASE Approach by Shawn Shea, MD, its originator and an internationally acclaimed innovator in the field of suicide assessment and intervention. The target audience included counselors and clinicians from a variety of settings throughout the state. The CASE Approach is a flexible, practical, and easily learned interview strategy for eliciting suicidal ideation, planning, behavior, desire, and intent. Helping suicidal individuals share valid information about this sensitive material while increasing their sense of safety with the interviewer can make the difference between life and death. The CASE Approach is appropriate to use with adolescents of normal cognitive development and adults. This training was offered to NJ Screeners, Rutgers' Graduate School of Applied and Professional Psychology students and individual clinicians.
  76 trained

  The TLC also partnered with University Behavioral HealthCare and Shawn Shea, MD to offer an experiential training in the CASE Approach called Pod Training. This training uses didactics and groups of 4 to highlight the learning experience. By the end of this full day training participants gained both a theoretical and experiential understanding of the CASE Approach providing them with advanced skills in the effective use of the techniques and strategies.
  Over a five day period
  140 were trained

- ***The Aftermath of Suicide: Working with Adult and Child Survivors*** **June 2010**
  Edward J. Dunne, PhD; Karen Dunne Maxim, RN, MSN; Donna Amundson, LCSW
  Edward Dunne and Karen Dunne-Maxim, who are themselves survivors of suicide, along with Donna Amundson presented to the audience on the specific needs of survivors of suicide. This conference focused on how to work with survivors in the immediate aftermath of the suicide and also techniques for working in longer term individual and family therapy and support group formats. This conference was attended by school counselors, social workers, psychologists and crisis counselors.
  148 trained

- **8th Annual Youth Suicide Prevention Conference – December 2010**
  Preventing and Responding to Adolescent Suicide-Focusing on Contagion
  Robert D. Macy, PhD; Madelyn S. Gould, PhD, MPH; Larry Berkowitz, EdD; James McCauley, LICSW; Christopher Gandin Le, MA
  The TLC annual conference, presented in the central region of the state, brought together experts from the International Center for Disaster Resilience, Columbia University; Riverside Trauma Center in Massachusetts and an expert in Social Media Suicide Prevention, Intervention and Postvention. This conference was co-sponsored by the American Foundation for Suicide Prevention – NJ Chapter.
  251 trained

- ***LGBT Youth: Family-Focused Approach to Reduce Risk for Suicide and Other Health Problems*** **January 2011**
  Caitlin Ryan, PhD, ACSW
  Stories of Substance-college troupe
  Dr. Ryan's research at the Family Acceptance Project at San Francisco State University was presented in this all-day conference.
  "Stories of Substance" acting troupe showcased their production that uses drama, humor and music in a creative, and powerful way to educate students about making healthy choices in life.
  170 trained

- ***Sources of Strength*** **– March-May 2011**
  Secaucus High School; Wall High School; Orange High School; Long Branch High School and Cinnaminson High School
  Donna Amundson along with Mark Lo Murray from Sources of Strength trained peer leaders and adult advisors in the above high schools. These schools are now implementing the Sources of Strength Peer Leader Program.
  205 trained

- ***Working with Resistant Teens: From Power Struggle to Partnership*** **– March 2011**
  Amy Jacob
  This training was provided to the Deron Schools in Union and Montclair
  30 trained

- ***Bullying* – April 2011**
  George Scott
  This training was provided to Monmouth Medical Center in Long Branch.
  25 trained

- TLC training programs offer continuing education contact hours, and therefore, must adhere to the high standards imposed by the licensing boards of the participating disciplines. University Behavioral HealthCare's Training and Consultation Resources Department issues these contact hours and mandates that participants complete an evaluation of the course.

  We are pleased to report that ratings for TLC sponsored programs are consistently high for both course content and speaker/trainer effectiveness as evidenced by evaluation results. We have included this information. **(Appendix 1).**

- The TLC Coordinators also personally provided or co-sponsored workshops and trainings in suicide prevention and mental health issues in their respective counties (**Appendix 2).**
  2,566 trained

Goal # 2
Conduct training programs for school and community personnel who must respond to the needs of youth in the aftermath of suicide, homicide, accidental death, and other critical incidents such as a natural disaster or terrorist strike (postvention)

To continue to build suicide postvention and trauma response capacity, the TLC has been training TLC Coordinators, Lead Response Team (LRT) members, school crisis teams and community mental health clinicians throughout the state in PTSM an evidence-based protocol. The following trainings were provided by Robert Macy, PhD, founder and director of the Center for Trauma Psychology (CTP) in Boston, Massachusetts. Attendees received certification in each of these trainings by the CTP.

- ***16 Hour Post Traumatic Stress Management (PTSM) and Psychological First Aid – With Ethnocultural, Gender and Developmental Specificity* – October 21, 22, 2010**
  Robert D. Macy, PhD
  The goal of this training is to enable trainees to respond to traumatic loss by suicide, homicide, accident or illness as well as large scale disasters with evidence-based public health/mental health intervention protocols incorporating ethnocultural, gender and developmental specificity so that the majority of survivors are stabilized and/or referred appropriately within the first 72 hours of the traumatic loss incident or disaster occurring. This training was held at Cumberland County College in Vineland.
  73 trained

- ***6.5 Hour Advanced PTSM Training in Suicide Postvention Protocols* – December 2010**
  Robert D. Macy, PhD
  The purpose of this training is to help those who have already been trained in the PTSM 16 hour certificate course to apply suicide-specific postvention protocols to PTSM group models. Content includes a review of the detailed literature regarding the epidemiology of suicide and the risk and protective factors associated with attempts and completions. It also includes identifying issues arising from deaths caused by suicide. This training was held at Cumberland County College in Vineland.
  47 trained

- The TLC Coordinators also personally provided or co-sponsored workshops and trainings in suicide postvention and trauma response in their respective counties **(Appendix 3).**
  916 trained

Goal # 3
Provide on-site postvention assistance to schools and communities including postvention after a death by suicide, homicide, accident or illness, and other critical incidents

Schools and communities can request suicide and other postvention assistance from the TLC at no cost. The Coordinators and their Lead Response Teams (LRTs) can assist schools in several different ways: lead the postvention response effort on site; work alongside the school's crisis management team; or provide behind the scene coaching on or off site.

The TLC follows an Incident Command System and the Lead Response Teams are activated by invitation only. TLC Coordinators often outreach an affected school to offer assistance. The Coordinator or their designee act as the leader of the Lead Response Team. During the initial phone contact the Coordinator conducts an assessment of the incident. The Coordinator and the Incident Commander (usually the school's principal) determine response objectives and the level of support or interventions needed. The Coordinator contacts the TLC Program Manager to outline the response plan. The plan is either approved or other suggestions are made, and the Coordinator deploys the Lead Response Team. Most of the time the Coordinators work on site with their teams. In a few counties with existing school crisis teams, the Coordinators work collaboratively with that team leader in providing the response.

The TLC Program Manager remains available for consultation and support throughout the response and also assists in deploying additional responders from other county LRTs when needed. Coordinators arrange for responders not involved in the postvention to provide Care for the Caregiver intervention at the conclusion of the response for the Lead Response Team and the school crisis team members. Care for the Caregiver services are routinely offered to any school's crisis team even if TLC response services are not provided. The TLC Coordinators also follow up with schools in the days, weeks and months following the postvention to provide a continuity of care to their consultancies during critical intervals and to advise about appropriate memorialization activities.

Due to requests from families, schools and community programs, the TLC Central Team has been increasing outreach to bereaved families following a death by suicide where youth have been affected. The TLC Team offers up to three home visits to assist the family in the hours and days after the loss to address issues prevalent in the aftermath of suicide. Families needing more intervention are referred to local resources. In several cases, families have recommended TLC services to others who are newly bereaved by suicide. In our estimation, that is the highest form of recognition for the value of the work being done.

All school, family and community responses are subsequently reviewed in the TLC monthly regional Coordinator meetings where lessons learned are discussed to help the Coordinators refine their skills. These follow-up discussions ensure that the tenets of the PTSM and CBI/TII models are adhered to.

The Coordinators hold five skill drilling/self-care meetings each year. These meetings are offered to LRT members and anyone in the county who has been PTSM/CBI/TII trained and would like an opportunity to practice the skills. The Coordinators use these meetings to increase competence and confidence, promote camaraderie and support, and teach self-care activities to prevent compassion fatigue and burnout.

- ***Suicide Postvention Consultation to Rutgers University staff*** **- September 2010**
  The TLC provided PTSM suicide postvention consultation following a highly publicized suicide of a Rutgers Student. TLC Central was called in by the staff at the Counseling and Psychological Services (CAPS) at Rutgers University, New Brunswick campus following the death of Tyler Clementi. In addition to postvention consultation, TLC offered Rutgers staff several training initiatives including: macro training in the CASE Approach for the supervisory staff and Pod training for their online clinicians. A conference on working with LGBT Youth featuring international expert, Caitlin Ryan was provided by TLC and co-sponsored by Rutgers University CAPS, the Graduate School for Applied and Professional Psychology, the NJ Chapter of the American Foundation for Suicide Prevention, and the NJ Family Therapy Institute. Students from Rutgers and other universities around the state were offered seats at a greatly reduced registration fee.

  In addition, CAPS personnel were invited to attend the next PTSM training planned for October 2011.

- ***Letters of Appreciation Following Postvention Assistance***
  Feedback from affected schools, communities and families consistently reflects gratitude for the TLC's assistance and highlights the knowledge, professionalism and compassion of the responders. Included are samples of letters received during this reporting period **(Appendix 4).**

Goal # 4
Foster collaboration between youth-serving individuals and organizations

The Traumatic Loss Coalition for Youth Program's unique, statewide infrastructure provides a mechanism for fostering collaboration between youth-serving individuals, agencies, and organizations. It also facilitates easy dissemination of information to a large number of stakeholders around the state. The TLC supports county coalitions headed by a Coordinator. The Coordinators receive ongoing training, consultation and technical assistance from the TLC Central Team.

- The TLC Central Team and County Coordinators work very closely with Prosecutors, Police Officers, Mental Health Administrators, County and District Superintendents, Principals, Medical Examiners, School - Based Counseling Program Administrators, the NJ Department of Education, and Juvenile Justice Personnel.

- In addition, the TLC Central Team works closely with the Division of Mental Health Services-Disaster and Terrorism Branch (DTB). TLC Lead Response Teams remain ready to assist the DTB when called upon. Many of the Lead Response Team members have received Disaster Response Crisis Counselor (DRCC) certification through the DTB. Additionally, PTSM training credits have been approved for use in DRCC recertification.

- The TLC Central Team works very closely with the American Foundation for Suicide Prevention; the Suicide Prevention Resource Center; the Training Institute for Suicide Assessment and Clinical Interviewing; the UBHC Center for Healthy Schools, Communities and Families, and the Multicultural Family Institute.

- The TLC Central Team also works closely with University Behavioral HealthCare's Cop 2 Cop program in providing postvention for children and families of police officers who have died by suicide, homicide, or accidents occurring in the line of duty.

- TLC Central Team has participated on the following councils and boards:
  - Governor's Council for Youth Suicide Prevention.
  - Monmouth County Youth Suicide Prevention Task Force

- TLC County Coalitions
  TLC Coordinators host county coalition meetings throughout the school year. Coalition membership includes but is not limited to educators, mental health providers, law enforcement and Juvenile Justice personnel, members of social service and community agencies, college and university personnel and leaders of faith-based organizations. The largest number of attendees represents school systems and mental health agencies. The purpose of these meetings is to provide a forum in which these often disparate groups of individuals can network, disseminate information, and review best practices in the areas of mental health, suicide prevention, intervention, postvention and trauma response.

The TLC Coordinators are mandated to provide at least three coalition meetings per year. Most coalitions have opted to meet more than this, and the mean number of meetings held is four per year. Several counties still meet once a month by popular demand. This indicates a continued need and interest in this type of collaboration among youth-serving individuals, agencies, and organizations. The coalition meetings include a one hour educational component and Educator Professional Development Credits are available for attending. The topics are chosen by the coalition members and reflect the unique and diverse needs of the communities in each of the counties **(Appendix 5).**

Goal # 5
Design suicide prevention and postvention programs with consultation from national experts for schools and community-based organizations

TLC Central Team staff was asked to join the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention's four person writing team that created the After a Suicide: A Toolkit for Schools. This document reflects consensus recommendations developed in consultation with a diverse group of national experts. It incorporates existing material and research findings as well as references, templates and links to additional information and assistance.

Goal # 6
Disseminate information regarding suicide prevention, intervention, and postvention programs that are considered Evidence Based (those that have been evaluated and proven effective) and Best Practice (those that have been reviewed for accuracy, safety, and adherence to current standards in the field)

The TLC infrastructure is ideal for disseminating suicide prevention, intervention and postvention information to a large number of individuals throughout the state. Each Coordinator has a county database, and the TLC Central Team has developed a database using UMDNJ's ListServ comprising of individuals in New Jersey, New York, Massachusetts, and Pennsylvania. Pertinent information is mailed or sent electronically to over 2,000 individuals.

The TLC publishes a Newsletter that is distributed electronically three times during the school year. Each edition contains a column highlighting the activities of each county coalition, as well as lists of upcoming training initiatives, suicide prevention and traumatic stress resources, and recommended books.

The TLC maintains a website that has been updated this reporting period to enable users to easily locate information and guidelines for schools and communities focused on suicide prevention and postvention, trauma and grief. The website also includes information about TLC trainings and has online registration capability. Additionally, the TLC Newsletter is posted on the website and is available as an adobe file for ease in downloading.

The After a Suicide: A Toolkit for Schools, the National Lifeline Hotline number and the 2nd Floor Helpline are all posted on the website for easy access and download.
Additional programs, guidelines and pertinent websites have been added to the TLC website and broken down into two major areas, **Guidelines for Educators, Parents, Youth & Young Adults and Suicide Awareness Programs**:

Suicide Awareness & Prevention

The TLC often receives calls from schools inquiring about suicide awareness programs for students and faculty in their desire to fulfill the professional development requirement, per N.J.S.A. 18A:6-11. We appreciate the caution that schools are demonstrating as care needs to be taken to choose programs that are effective and safe especially in regard to suicide awareness programs for students.

The TLC has disseminated information about appropriate and vetted programs as well as suicide prevention information and resources. These have been disseminated electronically in the TLC Newsletter and on the TLC website throughout the year.

Bullying Prevention

- Suicide and Bullying
- Olweus Bullying Prevention Program

LGBT Youth

- LGBT Suicide Prevention Recommendations
- Family Acceptance Project
- Preventing Suicide Among LGBT Youth
- Suicide Risk & Prevention for LGBT Youth
- Talking About Suicide & LGBT Populations

Media

- Reporting on Suicide

Programs for Schools

- National Registry for Evidenced Based Programs & Practices (NREPP)
- Best Practices Registry (BPR)
- College Student Depression and Suicide
- Interactive Screening Program for Colleges and Universities

Social Networking

- Lifeline Postvention Manual

Suicide Postvention

- After A Suicide: A Toolkit for Schools
- Lifeline Postvention Manual

Survivors of Suicide

- National Survivors of Suicide Day
- Out of the Darkness Walks
- Suicide Bereavement Support Groups
- New Jersey Support Groups
- Survivors of Suicide Fact Sheet
- Youth Suicidal Behavior Fact Sheet

Websites for Youth and Young Adults

- ReachOut.com
- The Trevor Project
- 2nd Floor Youth Helpline for New Jersey

Goal # 7
Develop and disseminate guidelines for youth-serving individuals following a local or global crisis

Parents, school personnel, and other caring adults are vitally important in supporting youth following a traumatic loss or other crisis event. They are, however, often at a loss as to how to best help. Guidelines that are practical, easy to understand and readily accessible can be extremely helpful to any adult who is faced with a grieving or traumatized child. During this report period, the TLC has created, organized and disseminated the following guidelines and included them on their website:

Guidelines for Educators, Parents, Youth & Young Adults

- Educators
    - Guidelines in Selecting Anti-Bullying Programs
    - ACES for Bullying Prevention
    - How The TLC Can Benefit Your School
    - How Teachers Can Help a Grieving Student
    - Talking With Young Children About Death: Strategies For School Systems
    - Tasks of Grieving
    - Coping in Hard Times: Fact Sheet for School Staff

- Memorialization After a Student Suicide
- A Lesson From Nature: Cold Penguins to the Middle

- Parents
  - Talking Points: Helping Children Following School Violence
  - Helping Parents Help Their Children: Information About Coping With Trauma
  - Understanding Childhood Grief and How to Help
  - Depression in Children and Adolescent Fact Sheet
  - Optimism: A Key Ingredient to Happiness (NASP)
  - Fostering an Attitude of Gratitude: Tips for Parents (NASP)
  - Self-Efficacy: Helping Children Believe They Can Succeed (NASP)
  - Back-to-School Transitions: Tips for Parents (NASP)
    HTML | Audio version
  - Stress in Children and Adolescents: Tips for Parents (NASP)
  - NJ Vet 2 Vet
  - Cop 2 Cop

- Youth & Young Adults
  - Coping in Hard Times: Fact Sheet for Youth-High School & College Age

- 9/11
  - 10 Years After 9/11/01: Stress, Trauma and Media Overload
  - Suggestions for Talking to Children About September 11th
  - Creating a Safe Space in the Classroom
  - The New School Year and September 11th Guidelines for Helping Children Navigate the Words and Images of 9/11
  - The 4 Action Initiative
  - Preparing for the 10th Anniversary of 9/11: Anticipating the Effects of Traumatic Stress Law Enforcement & Security Personnel
  - 10th Anniversary of September 11: Fostering Resilience and Optimism (NASP)
    English | Spanish | Arabic
  - 10th Anniversary of September 11: Tips for Parents and Caregivers (NASP)
    English | Spanish | Arabic
  - 10th Anniversary of September 11: Tips for Educators (NASP)
    English | Spanish
  - 10th Anniversary of September 11: Tips for Youth (NASP)
    English | Spanish | Arabic

- Natural Disasters
  - Helping Children Cope in the Aftermath of Hurricane Irene
  - Helping Children Cope in the Aftermath of the Haitian Earthquake
  - Psychological First Aid Guide

Goal # 8
Provide training, consultation and technical assistance for TLC Coordinators

Working in the field of suicide postvention and trauma response is important work, and it is very rewarding. It is also very demanding. Frequent exposure to trauma and loss can result in vicarious traumatization and compassion fatigue which can have physical and emotional repercussions. In addition to providing training and consultation, the TLC Central Team assists the Coordinators and their County Lead Response Teams in maintaining physical and emotional health by promoting good self-care habits and monitoring trauma exposure. This includes debriefing after a postvention and decreasing exposure to traumatic events when needed.

The TLC Central Team supports the work of the 21 Coordinators and meets with them regularly throughout the year. Regional meetings are held monthly. The purpose of these meetings is to share information, increase collaboration, review trauma responses provided, and practice PTSM skills and self-care.

In addition, there are two All County meetings held each year. One is scheduled at the beginning of the school year and another at the end of the year in June. These meetings are very helpful in bringing together all 21 Coordinators to receive training, share information and strengthen the statewide team through team building activities.

Coordinators also email their coalition and LRT meeting agendas to the Central Team. The agendas are then emailed to every Coordinator statewide. The purpose is to continue to strengthen the network and spark ideas for coalition meeting topics and speakers.

* * * * * * *

This report is respectfully submitted by the Traumatic Loss Coalitions for Youth Program Central Administrative Team:
Donna Amundson, MSW, LCSW, Program Manager
Nancy Baird, MA, Resource Coordinator
Dotty Rodrick, DRCC, Resource Coordinator

Appendix 1

Conference Evaluation Results

- ***The Aftermath of Suicide: Working with Adult and Child Survivors* – June 2010**
  Edward Dunne, PhD; Karen Maxim Dunne, RN, MSN; Donna Amundson, LCSW

Faculty	Knowledge of subject matter					Content consistent with objectives					Clarity of presentation				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Edward Dunne, PhD			1	14	82			5	15	108		1	8	20	95
Karen Dunne-Maxim, RN, MSN			4	13	106			8	18	96			6	22	87
Donna Amundson, MSW, LCSW			5	6	114			1	10	110			7	8	113

Faculty	Effectiveness of the presentation					Currency of information					Responsive to participant's questions				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Edward Dunne, PhD		3	10	24	57			4	16	103		2	2	16	104
Karen Dunne-Maxim, RN, MSN		2	11	22	86		1	8	17	96		2	6	14	100
Donna Amundson, MSW, LCSW			3	10	109			2	9	110			2	10	103

Faculty	Ability to utilize appropriate technology to support participant learning				
	1	2	3	4	5
Edward Dunne, PhD			6	27	89
Karen Dunne-Maxim, RN, MSN		1	6	31	84
Donna Amundson, MSW, LCSW			3	21	96

Content	1	2	3	4	5
Appropriate for participant's education level, experience and licensure level	1	2	4	28	83

Consistent with state objectives		**3**	**2**	**13**	**66**
Teaching Methods	**1**	**2**	**3**	**4**	**5**
Visual aids, handouts, and oral presentations clarified content			**9**	**21**	**90**
Teaching methods were appropriate for subject matter			**7**	**23**	**88**
Suitability and/or usefulness of instructional materials to topic			**5**	**24**	**89**
Relevancy	**1**	**2**	**3**	**4**	**5**
Information could be applied to practice		**1**	**4**	**22**	**91**
Information could contribute to achieving personal, professional goals		**1**	**8**	**20**	**89**

- ***Post Traumatic Stress Management Psychological First Aid Training-2 Day*** – **October 2010 –** Robert D. Macy, PhD

OBJECTIVES: This program met the stated objectives of:						
		1	**2**	**3**	**4**	**5**
1	Identify historical perspectives and responses to helping people who have experienced psychological trauma and the resulting traumatic stress including ethnocultural and gender variables effecting the traumatic stress response		**1**	**7**	**26**	**27**
2	Describe Psychological First Aid (PFA)				**6**	**56**
3	Analyze the PFA's 8 core functions				**9**	**54**
4	Differentiate theoretical models		**1**	**6**	**31**	**39**
5	Analyze the subjective experience of traumatic stress		**1**		**23**	**39**
6	Distinguish resiliency cascades of adults, children and diverse and resiliency in adults, children, and diverse groups in the US	**1**		**7**	**21**	**32**
7	Construct and assess active listening drill	**2**	**1**	**2**	**26**	**28**
8	Analyze physiological and biological reactions during a traumatic stress response with focus on ethnocultural variables			**4**	**18**	**42**
9	Analyze traumatic response psychological factors			**2**	**17**	**43**
10	Design and conduct PFA and PTSM continuum of care protocols sensitive to diversity, gender, and developmental stages as applied to TLC-PTSM Incident Command			**6**	**23**	**32**
11	Formulate self-care techniques			**1**	**16**	**35**
SPEAKER: (Robert D. Macy, PhD)						
1	Knowledge of subject matter				**1**	**60**
2	Content consistent with objectives			**1**	**10**	**52**
3	Clarity of presentation			**1**	**12**	**51**
4	Effectiveness of the presentation			**1**	**9**	**55**
5	Currency of information				**6**	**58**
6	Responsive to participant's questions				**6**	**57**
7	Ability to utilize appropriate technology to support participant learning				**10**	**52**

CONTENT:						
		1 Lowest	2	3	4	5 Highest
1	Appropriate for participant's education level, experience and licensure level				**10**	**56**
2	Consistent with stated objectives				**17**	**49**
TEACHING METHODS:						
1	Visual aids, handouts, and oral presentations clarified content			**1**	**14**	**51**
2	Teaching methods were appropriate for subject matter			**1**	**8**	**57**
3	Suitability and/or usefulness of instructional materials to session topic			**1**	**13**	**52**

RELEVANCY:						
1	Information could be applied to practice			**1**	**14**	**50**
2	Information could contribute to achieving personal, professional goals			**2**	**11**	**52**

- ***8th Annual – Preventing and Responding to Adolescent Suicide-Focusing on Contagion* – December 2010**
  Robert D. Macy, PhD; Madelyn S. Gould, PhD, MPH; Larry Berkowitz, EdD; James McCauley, LICSW; Christopher Gandin Le, MA

OBJECTIVES: At the end of this training the learner will:						
		1	2	3	4	5
1	Identify patterns of youth suicide clusters in the United States including criteria for a suicide cluster		**1**	**16**	**74**	**89**
2	Identify at least three factors that contribute to youth suicide clusters		**1**	**14**	**60**	**106**
3	Describe the relationship between psychological trauma and violence, including self injurious behavior	**2**	**6**	**26**	**58**	**87**
4	Explain how risk and resiliency interact within communities facing suicide contagion			**24**	**64**	**94**
5	Identify suicide postvention strategies and how common strategies may be used across settings such as schools and communities	**1**	**1**	**16**	**54**	**107**
6	Compare facilitating grief versus responding to trauma & contagion when conducting a postvention	**2**	**1**	**35**	**68**	**72**
7	Recognize indicators of a person in emotional or suicidal crisis on a social media site and available options once the person is identified		**2**	**19**	**66**	**84**

8	Assess steps to identify and prevent online suicide pacts or clusters; and strategies of action in the event of a suicide cluster		**6**	**23**	**68**	**72**

SPEAKER:		**Robert Macy**					**Madelyn Gould**					**Larry Berkowitz**				
		1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
1	Knowledge of subject matter		**1**	**1**	**8**	**170**		**1**	**2**	**12**	**158**			**4**	**29**	**138**
2	Content consistent with objectives	**1**		**5**	**27**	**152**		**4**	**10**	**24**	**137**	**1**	**1**	**8**	**39**	**121**
3	Clarity of delivery			**6**	**21**	**151**	**2**	**5**	**22**	**65**	**119**			**7**	**40**	**115**
4	Effectiveness of the presentation		**3**	**5**	**21**	**151**	**4**	**6**	**43**	**63**	**88**		**4**	**14**	**53**	**97**
5	Currency of information		**1**	**4**	**17**	**157**	**3**	**6**	**13**	**39**	**117**		**2**	**9**	**32**	**125**
6	Responsive to participants			**3**	**32**	**151**	**1**	**3**	**14**	**38**	**124**	**1**	**1**	**6**	**44**	**116**
7	Ability to utilize appropriate technology to support participant learning			**4**	**28**	**148**	**1**	**5**	**16**	**42**	**112**	**1**	**2**	**6**	**39**	**121**

SPEAKER:		**James McCauley**					**Christopher Gandin Le**				
		1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**6**
1	Knowledge of subject matter			**5**	**32**	**143**		**2**	**1**	**27**	**124**
2	Content consistent with objectives			**2**	**36**	**130**		**2**	**6**	**43**	**100**
3	Clarity of delivery	**1**		**17**	**38**	**120**	**3**	**5**	**20**	**43**	**82**
4	Effectiveness of the presentation		**5**	**15**	**48**	**107**	**1**	**4**	**16**	**41**	**87**
5	Currency of information	**1**	**1**	**10**	**30**	**133**		**2**	**4**	**27**	**122**
6	Responsive to participants	**1**	**1**	**8**	**39**	**119**		**1**	**3**	**36**	**111**
7	Ability to utilize appropriate technology to support participant learning		**1**	**7**	**38**	**121**		**1**	**5**	**29**	**119**

CONTENT:						
		1 Lowest Rating	**2**	**3**	**4**	**5 Highest Rating**
1	Appropriate to participant's education, experience and/or licensure level	**2**	**2**	**14**	**50**	**108**
2	Consistent with stated objectives	**1**	**1**	**8**	**50**	**113**

TEACHING METHODS:						
1	Visual aids, handouts, and oral presentations clarified content		**2**	**12**	**68**	**94**
2	Teaching methods were appropriate for subject matter		**5**	**10**	**62**	**101**

3	Suitability and/or usefulness of instructional materials		**3**	**16**	**59**	**107**
RELEVANCY:						
1	Information could be applied to practice	**3**	**2**	**10**	**52**	**106**
2	Information could contribute to achieving personal, professional goals	**3**	**3**	**12**	**49**	**107**

- ***Advanced PTSM Protocols for Response to Suicide* – December 2010**
  Robert D. Macy, PhD

OBJECTIVES: At the end of this training the learner will:						
		1 Lowest Rating	**2**	**3**	**4**	**5 Highest Rating**
1	Review the detailed literature by Madelyn Gould, PhD, regarding the epidemiology of suicide and the risk and protective factors.			**3**	**10**	**27**
2	Identify conditions and stigmatic issues arising from deaths caused by suicide.			**1**	**10**	**29**
3	Apply suicide-specific protocols to PTSM group models: orientations, stabilizations, and coping groups through small group practice.			**1**	**8**	**31**

SPEAKER: Robert D. Macy, PhD						
1	Knowledge of subject matter				**1**	**38**
2	Content consistent with objectives				**7**	**32**
3	Clarity of delivery				**6**	**33**
4	Effectiveness of the presentation				**9**	**30**
5	Currency of information				**4**	**34**
6	Responsive to participant				**6**	**33**
7	Ability to utilize appropriate technology to support participant learning			**1**	**5**	**33**

	CONTENT:	1 Lowest Rating	2	3	4	5 Highest Rating
1	Appropriate for participant's education, experience and/or licensure level				**4**	**35**
2	Consistent with stated objectives				**7**	**32**
TEACHING METHODS:						
1	Visual aids, handouts, and oral presentations clarified content			**2**	**6**	**31**
2	Teaching methods were appropriate for subject matter			**1**	**6**	**32**
3	Suitability and/or usefulness of instructional materials			**2**	**5**	**32**
RELEVANCY:						
1	Information could be applied to practice				**9**	**30**
2	Information could contribute to achieving personal, professional goals				**8**	**31**

- ***LGBT Youth-Family-Focused Approach to Reduce Risk for Suicide and other Health Problems* – January 2011**
  Caitlin Ryan, PhD, ACSW

OBJECTIVES: At the end of this training the learner will:						
		1 Lowest Rating	2	3	4	5 Highest Rating
1	Explain the importance of serving LGBT youth and young adults in the context of their families.		**1**	**2**	**18**	**101**
2	Identify specific supportive family reaction to an adolescent's LGBT identity.		**1**	**5**	**21**	**97**
3	Analyze ways of opening up the topic of sexual orientation/gender identity with youth and families	**2**	**6**	**21**	**43**	**51**
4	Describe the Family Acceptance Project's risk assessment tool to identity risk of family rejection.		**2**	**12**	**42**	**69**
5	Appraise barriers to family engagement.	**1**	**2**	**15**	**34**	**65**
6.	Evaluate one to three specific change(s) participants can make in their work with LGBT questioning and gender variant youth with regards to family assessment or engagement to help decrease the adolescent's risk for suicide and promote their well-being.	**2**	**1**	**10**	**41**	**67**

7	Assess protective measures schools can use to prevent or intervene in the victimization and harassment of LGBT and gender non-conforming students.	**2**	**7**	**10**	**42**	**58**
SPEAKER: Caitlin Ryan, PhD, ACSW						
1	Knowledge of subject matter				**3**	**115**
2	Content consistent with objectives		**3**	**3**	**13**	**99**
3	Clarity of delivery			**4**	**18**	**96**
4	Effectiveness of the presentation		**2**	**12**	**18**	**88**

5	Currency of information			**3**	**12**	**105**
6	Responsive to participant		**1**	**3**	**22**	**87**
7	Ability to utilize appropriate technology to support participant learning		**2**	**4**	**24**	**83**
	CONTENT:	**1 Lowest Rating**	**2**	**3**	**4**	**5 Highest Rating**
1	Appropriate for participant's education, experience and/or licensure level		**5**	**7**	**22**	**84**
2	Consistent with stated objectives		**5**	**4**	**24**	**82**
TEACHING METHODS:						
1	Visual aids, handouts, and oral presentations clarified content	**2**	**6**	**25**	**41**	**44**
2	Teaching methods were appropriate for subject matter	**1**	**3**	**9**	**34**	**67**
3	Suitability and/or usefulness of instructional materials	**1**	**2**	**20**	**32**	**61**
RELEVANCY:						
1	Information could be applied to practice		**5**	**10**	**25**	**78**
2	Information could contribute to achieving personal, professional goals		**3**	**11**	**20**	**83**

Appendix 2

Mental Health and Suicide Prevention Training
Provided or Sponsored by Coordinators

- Youth Conference on Fostering Resiliency in Children
- Mental Illness Awareness
- Suicide Assessment of Youth
- Dealing with Disruptive Behaviors in the Classroom
- Suicide Awareness
- Self Care
- Coping Skills and Resiliency
- Suicide Prevention
- The Pain Within: Understanding Trauma in Adolescents
- Psychiatric Disorders & Suicide Awareness
- Mental Health First Aid
- Understanding Self Harming Behaviors
- Suicide Prevention: Identifying Signs and Symptoms for Suicide and Depression
- Bullied: A Teaching Tolerance Documentary
- CIACC Education Subcommittee Behavioral Health Training
- More Than Sad Suicide Prevention
- Youth Depression and Suicide Awareness
- Suicide Assessment
- Understanding Cyberbullying Panel
- Suicide Prevention for Educators
- Things Children Want Their Parents to Know
- Suicide Prevention and Intervention
- Emotional Intelligence
- Relationship of Bullying and Suicide
- Understanding Bullying in Special Populations
- Bullying, Depression and Suicide and How It Affects High School and College Youth
- Warning Signs of Depression and Suicide

Appendix 3

Suicide Postvention and Trauma Response Training
Provided or Sponsored by Coordinators

- Crisis Response Protocols & Procedures, Debriefing & Lessons Learned
- Ethics in Disaster Response
- Psychological First Aid Overview
- Preparing for a Critical Incident in Schools
- Cultural Diversity in Disaster Response
- Community Resources: Crisis Intervention
- Trauma from a Faith Based Perspective
- Assisting Veterans and Their Families
- Introduction to Disaster Response-Mental Health and Crisis Counseling
- The Ethics of Trauma and Disaster Response
- Helping the Helpers
- Crisis Planning
- Suicide Protocols and Utilizing County Services
- Psychological First Aid and TLC Information
- Crisis Team Preparedness and Building Trauma Informed Schools
- Managing Sudden and Traumatic Loss
- Creating Trauma Informed Schools
- Postvention: Managing Sudden and Traumatic Loss
- Building a School Crisis Team
- Responding to a School Crisis
- Psychological First Aid in the Classroom
- Psychological First Aid for Nurses

Appendix 4

Appreciation Letters

For Responses:

Bergen County
To: Sue Heguy, Coordinator

It is with much respect that I write to express my sincerest appreciation for your professionalism and assistance.

The tragedy of a suicide death of an adolescent is disturbing and painful to our community, but the intervention with you and your fellow professionals with our young seasonal staff certainly made an impact on all of us. It was beneficial for the employees to have someone to share with; ease their pain and reassure them that although life brings difficult situations…there is a positive way to cope.

Your service is invaluable and I am grateful.

With good thoughts,

Nancy A. Bigos
Deputy Director of Parks and Recreation
Village of Ridgewood

To: Sue Heguy, Coordinator

I am writing on behalf of our counseling staff, administration, teachers and particularly on behalf of our students to thank you, sincerely, for the important assistance that you provided to Community High School yesterday helping us to deal with the loss of one of our beloved students.

Your guidance in helping us to navigate through this complicated time and your direction and suggestions pertaining to the steps that we should take were invaluable.

Your sensitivity in response to our loss clearly enabled our students and teachers to find comfort, within each other, through the school, and through the process that you prescribed – at a time when such comfort was most needed.

The excellent resource and services that you offer all of the students in Bergen County are so important, for all of us. We are genuinely grateful.

Thank you again.

Sincerely,
Dennis Cohen
Director of Program
Community High School, Teaneck

Camden County
To: Barbara Maronski, Coordinator

The week of 4-12 was a very difficult week for the students, parents and staff of Waterford Township Public Schools. As administrators, we certainly learned a great deal that week. Making decisions about appropriate planning and procedures was challenging to say the least. We would like to take this opportunity to thank you for your involvement the evening of 4-14-10.

Although we suspected that the parent meeting would be difficult, the high emotion and concern voiced at that time proved to be quite challenging. Although your actual role at the meeting was not what you expected it to be, your presence, patience and professionalism proved to be a great support for us and the other staff members, who were present. We were particularly impressed with the input that you provided following the meeting. Your kind words and knowledgeable advice were needed, and we approached the next day much better prepared.

The schools in Camden County are very fortunate to have organizations such as TLC and the Camden County Crisis Response Team. Your willingness to work and plan together is evident, and the result is an effective and desperately needed service.

Again thank you for your service and assistance. Please feel free to call on us at any time if we can help in any way.

Sincerely,
Gary L. Dentino
Superintendent of Schools

Kenneth I. Hall
Supervisor of Special Services
Waterford Township Public Schools

Essex County
To: Arlene O'Connell, LPC

I just wanted to thank you for the consultation yesterday. I appreciate your time as well as the referral information that you provided me for this family. The service and information provided by the coalition is such a valuable resource for our community. As always your response was immediate and greatly appreciated.

Thanks again.

Elizabeth Dunlea, MSW, LCSW
Bloomfield Middle School
Crisis Counselor

To: Arlene O'Connell, LPC (Postvention at Catholic Charities)

I really appreciate you and Arlene coming to our office and spend some time with the team. I think it was very important for us to have a moment to think and process what Nilsa is going through.

Please send me the information for Nilsa and her children to have some support.

Thanks.

Patricia Valdivia

Middlesex County
To: George Scott, Coordinator

On behalf of the Crisis Management Team, staff, students, and parents at North Brunswick Township High School, I want to thank you for all your professional advice and efforts during our time of need with the death of one of our students during the week of February 1-5, 2011.

Your ability to provide us with the proper preparation and your understanding personality was truly appreciated by all of us.

Sincerely,

Pete Clark
Principal
North Brunswick Township High School

To: George Scott, Coordinator (Death of a Youth Baseball Coach)

I would just like to say thank you for all your help with the baseball team the other night. This is such a hard time for them to have to go through at 8 years old. You gave us some great information & the video (I'm sure) will be a big help. It is so nice to have such caring people working in our town with the children. You made us feel at ease just knowing that everyone grieves differently & that it's ok no matter how we grieve. We appreciate you both taking the time to help us through such a difficult time. Tim was a wonderful person & he will be greatly missed.

Sincerely,
Lynne Fama

To: George Scott, Coordinator

Thank you for your time in speaking to the boys and the parents about the death of Coach Tim. For Teresa and me, it was helpful to know and understand that Michael's reaction to Coach Tim's death was normal for his age. We appreciate the materials that you provided particularly if this situation arises again the future.

Best regards,
Jeff and Teresa Reyes

To: George Scott, Coordinator

I just wanted to say "Thank You So Much" for coming out to speak with both the parents and the children from the South Brunswick U8 Baseball Travel Team on Friday Night, June 18, 2010. It was very informative and I thought it made a big impact on the children in this difficult time for them, it is great that there is such a program out there to help both the parents and children to deal with a loss of someone they care about.

Keep up the great work and thank you again it really meant a lot to us.

Sincerely,
Dawn and Matt & Kyle White

To: George Scott, Coordinator

Thank you for taking time to provide grief counseling to our 8 year old travel baseball team parents and players on Friday, June 18. The death of our head coach, Tim, was not easy to comprehend for both the adults and the children. Your words of support certainly helped us get

through this very difficult time when we were all in shock and didn't quite know or sometimes understand how we felt. I especially thank you for providing me with your insight and specific tools on how to help our 8 year old cope with this tragic event. Even when I thought I knew my son well and how he has dealt with this type of situation before, he has surprised me with some of his action and reaction and I now know how to better deal with it. Thank you, too, for providing us with the wonderful Sesame Street DVD.

Sincerely,
Frank and Liz D'Amato

Morris County
To: Mary Vineis, Coordinator

Thank you for coming to St. Cecilia School after the death of our dear Father Jean Claude St. Martin. You and your coworkers helped very much. We are at peace with Father's death and realize that we have a great intercessor at the throne of god. We are blessed to have known the wonderful priest.

Thank you for sharing your expertise with us and going the extra mile to help in this way. Please extend our deepest gratitude to the other two women that worked with you on that day.

The rest of our teachers and staff join in this expression of gratitude. May God bless you for all.

Sincerely yours,
Sister Marie Elise Briel SCC
Principal, Saint Cecilia School
Rockaway

To: Mary Vineis, Coordinator

Our school went through a very difficult crisis and emerged stronger as a result of the professionalism demonstrated by the Traumatic Loss Coalition. They guided us through each step of our response and provided a level of expertise that we needed to help our students in crisis.

Michael St. Pierre, President
Morris Catholic High School

Ocean County
To: Karen Bright, Coordinator

Thank you for your participation in the Manchester Township School District's annual orientation program. The information that you conveyed regarding the services that are offered

through the Traumatic Loss coalition of Ocean County and your role in same was very informative and helpful. The information shared will be reinforced at the school level in the near future as it is important that all district employees recognize signs of suicide ideation as well as the procedures that are in place to address a student or employee in crisis.

From comments heard, it is evident that the information shared was viewed as valuable and worthwhile to all in attendance. It is my hope that we may call upon your services once again next year, as an overview of the services available to students and employees alike is information that anyone might need to draw upon.

Thank you again.

Judith S. Nappi, Ed.D.
Director of Curriculum
Manchester Township School District

TLC Central
To: Donna Amundson, Program Manager

I cannot express how much having you all involved at our school has meant to our students, families and staff. Please forward this on as I did not collect all of your emails.

…Again, thank you for all the good,

Dr. Michelle Fenwick, SLP.D
Director of Special Services
Pompton Lakes Public Schools

For Training:

Monmouth County
To: George Scott, Coordinator

On behalf of the Monmouth County CIACC Education Initiative Committee and school liaisons we thank you for sharing your knowledge and expertise in the area of suicide prevention. The presentation on November 14, 2010 was invaluable to our over 100 school representatives from multiple disciplines.

"Outstanding, great presentation and excellent training and presenters," were just a few of the comments overheard as people were leaving. Our community is truly fortunate to have such devoted and compassionate individuals to address a difficult subject that has impacted our professional and/or personal lives.

We look forward to any input you may have to enhancing future presentations based on your experience and look forward to collaborating. Thank you again for your time.

Best Regards,

Karen Frumen
Education Initiative Advisory Board Chair
Monmouth County CIACC

To: George Scott, Coordinator
I can't thank you enough for the time you spent with our interns today. I've already heard from all of them…each found the presentation VERY helpful. They also commented on your relaxed style being helpful as well. I agree!

Looking ahead, I would love to have you come again next spring…when we have a new group of interns. Would this be a possibility? If you can't come, would it be alright with you if I use your handout to review key points? Or, can I create something new, using the important points. Of course I would be certain to acknowledge it as your work and/or Shea's.

Kindly let me know…I will be planning next year's training over the next few months.

Carol A. Evangelisto, MA, NCC
Licensed Professional Counselor
Coordinator of Clinical Training
Counseling and Psychological Services
The College of New Jersey

To: George Scott, Coordinator

Here are a few comments…the evaluations are on the way. Thanks again,

Thank YOU, Dennis, for bringing him to Voorhees. As I wrote on my comment sheet, I was dreading this two-hour session and it ended up being one of the best in-service sessions I have ever experienced. He really made me think about how we handle bullies and how important the school climate is. You never know when you take an extra minute or two to talk to a child, if you might really be helping him or her. Anyway, it's always good to see you and thanks, again, for arranging for George to come to Voorhees.

What a wonderful presentation of George Scott's. I never looked at my watch, until I saw him look at his!!! Thank you so much for arranging for him. I will look at my students a little different today.

The speaker was awesome. He was extremely interesting and I learned a lot. Thanks.

The workshop was very informative and worthwhile. I really enjoyed the information and the presenter. Thank you for a job well done!

Dennis A. Cesare, LPC
School Counselor
Voorhees Township School District

Morris County
To: Mary Vineis, Coordinator

On behalf of the Our Youth their Future Organization, we would like to take this opportunity to thank Morris County Traumatic Loss Coalition for supporting our first annual youth event. On Saturday, October 2, 2010, our organization sponsored a Youth Rally, wherein the youth of our community enjoyed food, music, dance performances, guest speakers and participated in a basketball tournament. It was a huge success!

It is our goal to provide monthly activities for our youth in an effort to educate and to encourage awareness in diverse areas which will help them build confidence and self-esteem.

Your contribution is greatly appreciated and we, again, thank you. As we strive to continue in our mission of "education and awareness," and as we look forward to planning additional events for our youth, we hope we can count on your further support and participation,

Very truly yours,

Our Youth Their Future Organization
Morristown

TLC Central
To: Amy Jacob, Consultant

Thank you so much for sharing your expertise and talents last night. Comments as the Advocates left were super positive both about the material and your warm way of presenting such a –for most- a disturbing topic. Your experience just shines through!

We appreciated your time and … .

Thanks again,

Denise Lang, Ed.S., LPC
Coordinator
Morris County Sexual Assault Center

To: Donna Amundson, Nancy Baird, Dotty Rodrick

I just wanted to thank you again for the tremendous effort, dedication and professionalism your program demonstrated in putting on such an outstanding conference. I emailed our dean of GSAPP about it yesterday, and he was thrilled. It was an exceptionally well organized and thoughtful conference; I attend quite a few conferences, and few are this well done. So hat's off to you folks!

…Warmly,

Monica J. Indart, Psy.D.
Graduate School of Applied and Professional Psychology Rutgers University

Appendix 5

Educational Components at Coalition Meetings

- Anti-Bullying
- Abusive Dating Relationships
- Bullying and Special Populations
- Internet Dangers
- Red Cross Disaster Action Team
- Grief and the Adolescent
- Dealing with Compassion Fatigue
- Working with Traumatized Children
- Working with Latino and Jewish Populations
- CBT Therapy Techniques
- Grief and Loss
- Assisting Military Families
- Grief and Rituals of the Jewish Faith
- Grief: what we should know
- Compassion Fatigue
- Good News About Grief
- Following Death: The Role of the Funeral Director
- Available Resources Within Monmouth County
- More Than Sad: Review of Video
- Childhood Mental Health Issues
- Understanding and Responding to Teen Self-Injury Behaviors
- Using Creativity in Schools and the Community
- Co-occurring Disorders in Youth
- How to Access Available Resources in Salem County
- Understanding and Working with LGBTQ Youth
- Professional Resource Assembly: How to access and make referrals
- Services by Division of Community and Youth Services
- Strides for Pride: Addressing GLBT Youth Issues
- Self Care for Providers
- Cultural Competency in a Clinical Setting
- Family Outreach
- FSO Services
- Autism and Dealing with the Educational System

- Grandparents Raising Grandchildren
- Choking Game and Other Risky Behaviors
- Self Care and Stress Management Techniques
- Angel Food Ministries
- Child Sexual Assault
- The Work of the County Medical Examiner's Office
- Self Care for Responders
- Working with Children in Foster Care
- Trauma and Its Aftermath, What to Expect
- Issues Faced by Today's Veterans
- Crisis Response in the School Setting
- Crisis Prevention and Preparedness for School Crisis Teams
- Critical Incident Stress Management
- African-American Males & Substance Abuse
- Helping Youth Survive their Most At-Risk Years
- Current Drug Trends in Cape May County and NJ High School Students
- Suicide Postvention
- QPR-Suicide Gatekeeper Training
- The Nurtured Heart Approach
- Working with Personality Styles
- GLSEN-The Gay, Lesbian, Straight Education Network
- Introduction to the Trevor Project
- Suicide Assessment
- Bullying and Suicide: What is the Connection
- Domestic Violence and the Effects on Children and Teens
- Gang Awareness
- Common Sense Parenting
- Introduction to Conducting a Risk/Threat Assessment