ASTHO
Association of State and Territorial Health Officials

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State Efforts to Prevent Youth Suicide

Each year in the United States, almost 30,000 people die by committing suicide. This problem is especially severe among America's young—suicide is the third leading cause of death for those ages 15 to 24, and the eleventh leading cause overall. While teenage boys die from suicide four times as often as girls, females attempt suicide twice as often.[1]

More than 4,300 American youths between the ages of 5 and 24 died by suicide in 2000. Findings of the 2001 Youth Risk Behavior Survey show that nearly one in five high school students have seriously considered suicide, with one in ten making an attempt.[2] While many factors contribute to suicidal behavior, the American Psychiatric Association estimates that 54% of teens that commit suicide also abuse substances. The Children's Safety Network determined that direct and indirect costs of youth suicide total $15 billion.[3]

Youth Suicide by the Numbers

- The teenage (15-19) suicide rate increased 11 percent from 1980 to 1997, and the rate for children ages 10-14 more than doubled.
- 15 percent of all American suicides are by persons under age 25.
- Caucasian teens account for 84 percent of all youth suicides, but Native American males, ages 10-19, are twice as likely to commit suicide as the rest of the male population.
- More teenagers die from suicide than cancer, heart disease, AIDS, and birth defects combined.
- Up to half of the teens who survive an attempt will try again. A male teen who has previously attempted suicide is 30 times more likely to eventually complete suicide.
- Suicide causes the loss of more years of potential life than all other causes, except cancer, heart disease, and premature birth.[4]

Prevention

Suicides do not just happen—warning signs are often apparent. Especially among youth, multiple prevention strategies can be put in place to reach the entire population, as well as those at highest risk. While the strongest predictor of a youth suicide attempt is a previous attempt, many prevention strategies aimed at youth are population based, designed to prevent the first suicide attempt. Suicide prevention strategies are divided into three categories: *universal, selective, and indicated.*

[1] Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) www.cdc.gov/ncipc/wisqars

[2] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). http://www.cdc.gov/nccdphp/dash/yrbs/results.htm

[3] Children's Safety Network. Youth Suicide Fact Sheet Packet. www.childrenssafetynetwork.org

[4] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. "Suicide in the United States." http://www.cdc.gov/ncipc/factsheets/suifacts.htm

Universal prevention employs population-based health promotion techniques to reach large numbers of people. These efforts include media campaigns and programs designed to raise awareness of the signs and symptoms of potential suicide attempts. For example, the Virginia Department of Health has distributed brochures at schools—*What Every Parent Should Know About Preventing Youth Suicide* and *What are Friends For?*—designed to help fellow students, parents, and teachers recognize the warning signs of suicidal behavior and what steps should be taken to prevent a potential suicide.[5]

Selective prevention intends to identify those youth with suicide risk factors through screening programs, and by training teachers, counselors and others to identify those who may be at risk**.** The Oklahoma Department of Health has provided technical assistance to school-based crisis response teams on how best to recognize and prevent suicidal behavior following traumatic events.[6]

Indicated prevention focuses on those persons who have been identified as high risk individuals and utilizes interventions that include support groups and treatment. The Alaska Suicide Prevention Plan includes a strategy that would require state mental health centers to provide ongoing care to suicide survivors, upon request. [7]

[5] Virginia Department of Health. Center for Injury and Violence Prevention. http://www.vahealth.org/civp/preventsuicideva/pubs.asp
[6] Oklahoma State Youth Suicide Prevention Plan. http://www.health.state.ok.us/program/ahd/spspex.pdf
[7] Alaska Suicide Prevention Plan. http://health.hss.state.ak.us/suicideprevention/StatePlan/DraftAlaskaSuicidePreventionPlan.pdf

State Efforts

Efforts to prevent youth suicides vary tremendously from state to state. Like other major public health concerns, resources available to states for prevention and education efforts are limited. However, because the potential for youth suicide attempts is affected by so many factors, prevention efforts can be addressed by a variety of agencies, including state health departments, state and local education agencies, mental health entities, juvenile justice agencies; and emergency services, and law enforcement entities at the state and local level.

State prevention plans or suicide prevention councils have been established in 49 states. However, unclear authority and accountability, resource constraints, and collaboration challenges are common factors limiting the implementation of these plans. Most often, state health departments are the conveners and provide leadership for such planning efforts. Public health expertise in data collection and analysis, public education, and population-based programs make state health departments a crucial player within state governments to address suicide prevention and effectively lead multi-agency and multi-sector approaches.

Despite the challenges associated with establishing and implementing plans, almost every state currently has some suicide prevention planning effort underway. Currently, 18 states are developing or implementing a suicide prevention plan specific to youth, while 31 other states are developing or implementing state plans focusing on suicide prevention across the entire lifespan.[8]

[8] Lubell, Keri. "State-Based Suicide Prevention from a National Perspective." CDC/NCIPC, March 17, 2004

Collaboration Around Youth Suicide Prevention

To provide assistance to states in developing and implementing their suicide prevention plans, the Association of State and Territorial Health Officials (ASTHO) began a series of roundtables in 2003, called *Collaboration Around Youth Suicide Prevention*. ASTHO and its partners convened state teams—comprised of key policymakers and programmatic staff—at two regional roundtables to strategize over prevention activities for their states. At these workshops, experts from both the public and private sectors highlighted key aspects of youth suicide prevention including the federal and state roles, economic analysis and funding options, and cultural factors to be considered. Participants also spent considerable time in state teams, identifying priority areas and challenges, ultimately crafting feasible action plans to be implemented upon their return home.

Team members included:

- State health department leadership and staff members
- State education agency leadership and staff
- Mental health agency leadership and staff
- Legislators
- Governors' health policy advisors
- Survivors and advocates

ASTHO's partners included the National Association of State Mental Health Program Directors, the National Governors Association, the National Association of State Legislatures, and the Council of Chief State School Officers. CDC's National Center for Injury Prevention and Control and the Health Resources and Services Administration provided funding and other support for the effort.

The first roundtable convened in Seattle, Washington, January 23-24, 2003, and included teams from Alaska, Idaho, Montana, Oregon, Washington, and Wyoming.

The second roundtable took place in New Orleans, Louisiana, December 1-2, 2003, and included state teams from Alabama, Georgia, Kentucky, New Mexico, North Carolina, Oklahoma, and Texas.

Defining the Problem

During state team interactions, attendees at the two roundtable meetings identified key issues they faced, and how best to address them within the infrastructure currently in place in each particular state. While the participating states have been engaged in different stages of the policymaking process, several common challenges and themes emerged in both Seattle and New Orleans:

- States generally lack resources and the infrastructure to adequately implement statewide youth suicide prevention efforts;
- Suicide prevention requires a "home" or lead agency within state governments to ensure continuity of implementation and accountability;
- The notion of the preventability of suicide and suicide attempts needs greater public visibility and understanding;
- Workforce shortages and training challenges continue to be a barrier;
- Lack of coordination and awareness among relevant state agencies;
- The need to elevate the status of the issue, especially among high-level policymakers;
- Lack of access and coverage for mental health services;

- Challenges in focusing on youth at the highest risk—those with multiple risk factors;
- Difficulties in reaching and involving rural communities in planning and implementation; and
- Data must drive policy priorities, and be used to target interventions, but are often not available.

Outcomes

While acknowledging lack of resources and time, as well as competing interests, the participating state teams came away from these workshops with detailed state action plans to address the burden of youth suicide and the barriers identified. Examples of action items include:

- Develop and deliver "Suicide 101" presentations to educate policymakers.
- Strengthen efforts to increase cross-agency coordination and communication.
- Identify champions to assist in implementation of prevention strategies and policies.
- Hold statewide summits to strengthen and expand partnerships.
- Create an accessible clearinghouse of suicide prevention information and tools.

Signs of Progress

ASTHO conducted follow-up interviews with key members of each team approximately six months following the first roundtable, and after the states' most recent legislative sessions ended. A similar evaluation will take place with participants from the second workshop to gauge progress made and challenges encountered in the Southern states.

Six-month follow-up interviews with participants from the Seattle workshop indicated that although budgets remained tight, most of the teams had made some progress on their action plans. There were several states that described creative ways they overcame challenges:

1. The legislature from one state appropriated $15,000 to begin the state planning process and convene a task force for this process.
2. Several states have since drafted state suicide prevention plans and conducted strategic planning, however implementation has been delayed due to budget constraints.
3. Statewide conferences have been planned in several states.
4. One state completed a process to catalog available resources and gaps that need to be filled.
5. Participating legislators have worked to promote more legislative action among their colleagues on substance abuse and mental health issues.
6. Several state health department participants cited examples of reaching out to local health departments and community organizations to partner on state efforts.
7. One state published a prevention and intervention manual.
8. One state implemented the Safe Teens program.
9. Several states cited enhancements in information sharing capacity.
10. Many of the follow-up interviews mentioned that the enhanced relationships between public health and mental health agencies fostered at the roundtable had been maintained.

Challenges Continue

While the state teams have collaborated to make progress in their states, several significant challenges remain.

- State budget shortfalls continue to impact the sustainability of youth suicide prevention efforts.
- Minimal data collection infrastructure exists, especially in rural communities.
- A lack of broad-based legislative interest persists.
- Several states continue to lack the capacity and infrastructure to create a committee charged to draft a prevention plan.
- More involvement and input from non-governmental organizations is needed in the planning process.
- More training opportunities to identify signs and symptoms of suicidal behavior are needed for essential partners.
- Some instances of challenges in initiative, leadership, and coordination among state agencies involved in youth suicide prevention continue to exist.

Next Steps

While budget constraints, challenges of cross-agency collaboration and other challenges have inhibited full implementation of the action plans, the 13 participating states remain committed to reducing youth suicide and implementing their state action plans. ASTHO and its partners will continue to closely monitor each of the 13 states that participated in the two *Collaboration Around Youth Suicide Prevention* roundtables, and will provide technical assistance whenever possible and appropriate.

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The Association of State and Territorial Health Officials is the national nonprofit organization representing the state and territorial public health agencies of the United States, the U.S. territories, and the District of Columbia. ASTHO's members, the chief health officials in these jurisdictions, are dedicated to formulating and influencing sound public health policy, and assuring excellence in state-based public health practice.

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