A Call to Action

THE OREGON PLAN FOR

YOUTH SUICIDE **PREVENTION**

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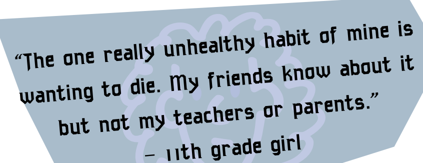

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EXECUTIVE SUMMARY

Approximately 75 Oregon youths die by suicide each year, making it the second leading cause of death among those aged 10 to 24. In 1998, the suicide rate among Oregonians in that age group was 10.6 per 100,000. From 1995 to 1997, this state's teen suicide rate was 29% higher than the national average.

Even greater numbers of youth are treated in Oregon's emergency rooms for attempts they survive. Over 750 suicide attempts are reported each year. In the 1999 Oregon Youth Risk Behavior Survey, 16% of the state's youth - an estimated 26,000 individuals - reported seriously considering suicide.

These data provide a shocking wake-up call to communities that have not yet recognized youth suicide as one of Oregon's silent epidemics. The Department of Human Services, as part of its mission to help people become independent, healthy, and safe, seeks to end that silence with a call to action.

This plan outlines an initiative through which Oregonians can help break through denial and cultural taboos about death, help end the shame associated with suicide, help foster the conviction that not even one youth has to die by suicide, and help take responsibility by openly and honestly joining with other Oregonians to reduce suicide among our youth.

The 15 strategies for state and community-based action require a commitment to partnership and shared responsibility among state agencies, between state and local governments, and between public and private sectors. Implementation of the strategies will require coordinated and comprehensive planning that fosters integration of services.

THE 15 STRATEGIES

1. **Develop and implement public education campaigns** to increase knowledge about symptoms of depression and suicide, response skills, and resources; increase help-seeking behavior; and decrease stigma associated with treatment for behavioral health problems.
2. **Promote efforts to reduce access to lethal means of self-harm**
3. **Educate youth and young adults about suicide prevention**
4. **Reduce harassment in schools and communities**
5. **Provide media education to reduce suicide contagion**
6. **Provide education for professionals** in health care, education, and human services
7. **Provide gatekeeper training** to create a network of people trained to recognize and respond to youth in crisis
8. **Implement screening and referral services**
9. **Increase effectiveness of crisis hot lines**
10. **Enhance crisis services**
11. **Establish and maintain crisis response teams**
12. **Improve access to affordable behavioral health care**

"I think our school needs a health center. I am trying to help a friend that is suffering from depression and troubles at home. I believe he is not getting everything he needs or doing the right thing because of lack of supervision."
an Oregon Youth

13. **Provide skill-building support groups** to increase protective factors and involve families
14. **Support suicide survivors** by fostering the development of bereavement support groups
15. **Improve follow-up services for suicide attempters**

The plan emphasizes three key prevention approaches: (1) community education, (2) integration of systems serving high risk youth, and (3) access to a full range of health care that includes mental health and alcohol and drug treatment services.

> "My whole life has been real bad since I was 8 years old. I have tried to commit suicide. Who can I talk to? Who can help me? What should I do?"
> – An Oregon youth

Our challenge and responsibility are to create communities where our youth won't choose to end their lives as a solution to a temporary problem, and communities where adults believe that suicide is preventable and that not even one child should die by suicide.

SECTION 1: INTRODUCTION

THE NEED FOR A CALL TO ACTION

"I feel we should have someone come and talk about suicide here. It's very important."
- an Oregon Youth

The United States Surgeon General, Dr. David Satcher, has declared suicide a serious public health concern and has issued a call to action for each state to implement suicide prevention strategies.[1]

Although Oregonians in every age group die by suicide, the upward trend in rates over the past few decades has been driven principally by suicide among adolescents and young adults (OHD, 1998). The grim facts speak for themselves:

- Suicide is the second leading cause of death among Oregonians aged 10 to 24
- Oregon's 1997 suicide rate among youth aged 10 to 24 was 17th highest in the nation
- Oregon's suicide rate among youth aged 15 to 19 increased from 2.8 per 100,000 during 1959-1961 to 13.4 per 100,000 during 1995-1997
- In 1998, the emergency room suicide attempt registry reported 761 attempts among youth under 18
- In 1998, 373 Oregonians aged 10 to 24 were hospitalized for suicide attempts
- In 1999, 16% of Oregon youth surveyed reported seriously considering suicide.[2] (See Appendix A for an epidemiologic profile of suicide among Oregon youth.)

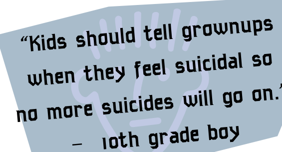
Suicide prevention is a statewide responsibility that affects the community as a whole. The purpose of The Oregon Plan for Youth Suicide Prevention: A Call To Action is to prevent suicide among Oregon youth by providing a multidisciplinary framework that calls for:

- communities to select, implement, and monitor youth suicide prevention strategies
- state agencies to integrate the coordination of technical assistance and resources
- collaboration between community-based organizations, state and local agencies, advocacy groups, professional associations, businesses, educational institutions, and foundations to implement prevention strategies

The strategies outlined in this call to action have built upon efforts that began in 1997 with recommendations from the Governor's Task Force on Youth Suicide. The 1997 Oregon Legislature established a Youth Suicide Prevention Coordinator position at the Health Division. The task primary of that coordinator is to facilitate the development of a statewide strategic plan addressing youth suicide. More than 500 Oregonians participated in the community assessment and planning process that resulted in this plan.

Efforts to reduce suicide rates show the most promise when multiple strategies are implemented simultaneously. There are many paths to suicidal behavior. Risk and protective factors and their interactions form the scientific base for suicide prevention. Risk factors are associated with a greater potential for suicide and suicidal behavior, while protective factors are associated with reduced potential.[3, 4, 5] The presence of multiple risk factors in adolescents is linked to a dramatic increase in the probability of having made a suicide attempt.[6] Significant reductions in Oregon's youth suicide rate will require integrated efforts to

produce long-term, system-wide changes. This plan outlines how to achieve that effort at the state and local levels.



COMMUNITY ASSESSMENT, PLANNING, AND MOBILIZATION

This plan contains tools to help communities assess their needs, plan to meet them, and mobilize for action. Because every Oregon community is unique, the implementation of suicide prevention strategies is best determined by community members who know local needs, resources, and possibilities. Community mobilization for youth suicide prevention requires that each community:

- identify an existing group or form a community team of stakeholders in youth suicide prevention
- assess the community's needs, resources, gaps in service, and readiness for addressing youth suicide
- determine strategies to be implemented and develop an implementation plan
- coordinate strategy implementation with local, state, and national partners and resources
- implement and monitor strategy implementation
- evaluate the effectiveness of strategy implementation

Because youths have a unique perspective and role to play in prevention, communities are encouraged to involve them when appropriate to advise adults on the planning, implementation, and evaluation of local youth suicide prevention strategies. Communities should also recruit and invite members of minority populations to join planning processes. This will help to assure that activities are culturally appropriate.

BUILDING STATE AND LOCAL CAPACITY THROUGH A MULTI-AGENCY TEAM

State agencies have expertise and resources that can support community activities by:

- providing technical assistance to communities in planning, implementing, and evaluating youth suicide prevention strategies.
- coordinating statewide efforts and resources in establishing youth suicide prevention and intervention strategies.
- monitoring the implementation of the statewide plan for youth suicide prevention.

This role can be accomplished through the formation of a multi-agency State Team for Youth Suicide Prevention. The core state agencies will include: Divisions and Offices of the Department of Human Services (the Health and Mental Health Divisions, Office of Drug and Alcohol Abuse Programs, State Office of Services to Children and Families, Adult and Family Services), the Commission on Children and Families, the Department of Education, and the Oregon Youth Authority.

Other organizations, and special interest groups should be identified as partners of the state team. These may include such entities as the Indian Health Board, Tribal Health Services, the American Foundation of Suicide Prevention Northwest Chapter, the Oregon Family Support Network, and the National Alliance for the Mentally Ill.

SECTION 2: YOUTH SUICIDE PREVENTION STRATEGIES

ABOUT THE 15 STRATEGIES

The prevention strategies presented below are derived from evidence-based research, public input on draft strategies, and recommendations from the Governor's Task Force on Youth Suicide Prevention.[7]

STRATEGY 1: DEVELOP AND IMPLEMENT PUBLIC EDUCATION CAMPAIGNS

OBJECTIVE

Develop and implement public education campaigns that will:

- increase knowledge about symptoms of depression, suicide risk and protective factors, indicators of possible suicidal behavior, skills for responding to a suicidal individual, and community resources
- increase help-seeking behavior by decreasing the stigma associated with behavioral health care

AUDIENCE

General public.

"Many teenagers hide their true feelings, they need to know what to do and where to go."
- an Oregon Youth

RATIONALE AND EFFICACY

Many adolescents report that embarrassment, stigma, and fear are the main reasons they do not seek help for their problems. Studies show also that most adolescents do not seek help for suicidal ideation even when it is identified as the most pressing problem they are experiencing.[8]

Recognizing and responding appropriately to such troubled youth can prevent suicides. In addition, wider public understanding of the science of the brain and behavior can reduce the stigma associated with seeking help for behavioral health problems, and consequently may contribute to reducing the risk of suicidal behavior.

Knowing the signs of depression and suicide, and what to do can save lives.

A community-wide public education campaign can be an effective way to provide useful information on these subjects to all citizens. Evaluation of such a campaign recently conducted in Washington state indicates that it increased: (1) awareness of information about youth suicide prevention, (2) recognition of indicators of suicidal behavior, and (3) willingness to use suicide intervention skills in helping distressed youth.[9]

IMPLEMENTATION CONSIDERATIONS

Greater public awareness and knowledge about youth suicide prevention may expand the need for mental health and crisis intervention services. Providers should anticipate this possibility with contingency plans for managing the increased demand.

Public education campaigns about suicide prevention must be sustained efforts in order to maintain a necessary level of awareness.

SAMPLE IMPLEMENTATION ACTIVITIES

- Secure agreements from television broadcast stations to air public service announcements.
- Work with local print media to publish feature articles on adolescent depression and youth suicide prevention.
- Create, produce, and disseminate information through a variety of sources, including: grocery bags, book marks, slides at movie theaters, milk cartons, and local public access televised media.
- Disseminate informational flyers, brochures, and other materials to identified groups.
- Organize a community-wide Youth Suicide Prevention Week.
- Create, produce, and post informational posters in youth centers, health centers, employee assistance offices, and other places with high visibility to the general public.
- Create and distribute wallet cards to youth in and out of school, parents, and the general public that contain information about warning signs, how to help, and local /state/national resources.
- Create a speaker's bureau of professionals, survivors, youth, etc., for community presentations.

STRATEGY 2: PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS OF SELF-HARM

OBJECTIVE

Energize Oregonians to restrict youth access to means of suicide by educating them about such vital issues as:

- the link between lethal means in the home and completed suicide
- safe firearm storage (locked and stored separately from ammunition)
- the importance of removing lethal means (firearms, poisons, medications, alcohol, etc.) from homes with a youth at high risk of suicidal behavior

AUDIENCE

All Oregonians, particularly parents/ guardians, firearm owners, community gatekeepers (Strategy 7), young people - especially those aged 10 to 24, behavioral health care providers, teachers, school administrators, law enforcement, clergy, juvenile justice workers, physicians, public health practitioners, and legislators.

Removing or restricting access to lethal means of self harm is an effective suicide prevention strategy that can decrease suicide.

RATIONALE AND EFFICACY

Increased public awareness of the role of firearms in youth suicides and knowledge about safe firearm storage can save young lives. Here are some pertinent facts: Firearms are used in fully two-thirds of youth suicides in Oregon.[10] During the last three and one-half decades, the rate of suicide by firearm increased 4.3 times faster than did the rate of suicide by other methods. An estimated 16% of Oregon households with children under 18 have firearms that are loaded and unlocked.[11] During 1994-1997, 71% of firearm suicides among Oregon youth aged 10 to 24 occurred at home. The American Academy of Pediatrics advises that parents of depressed or suicidal adolescents remove firearms and ammunition from the home.[12]

Education on the restriction of access to lethal means is seen as one of the most promising and economical strategies for preventing youth suicide.[13] Removing or restricting access is an effective suicide prevention strategy that can decrease suicide.[14, 15] Among parents whose children visited an emergency department for a mental health assessment or treatment, those who received injury prevention education from hospital staff are significantly more likely to limit access to lethal means of self-harm than are families who did not receive such education.[13]

"No one loves me. I don't want to go on." 10th grade boy

IMPLEMENTATION CONSIDERATIONS

The safety of Oregon's young people is a serious concern both of gun owners and of those who do not own guns. Messages on restricting access to means of suicide should be crafted collaboratively by both groups to achieve community-wide support. Public education campaigns aimed at preventing youth suicide should incorporate messages on reducing access to lethal means of self harm as well (see Strategy 1).

SAMPLE IMPLEMENTATION ACTIVITIES

- Select and/or create media to educate the public about the role of firearms in youth suicide, safe storage, and firearm disposal.
- Conduct a public information campaign(s) designed to reduce the accessibility of lethal means of self harm (including firearms) in the home.
- Solicit help from community gun owners and sellers to support campaigns for safe storage.
- Conduct public forums for parents, guardians, and media on strategies for securing weapons (gun boxes, trigger locks, etc.) and medications, particularly prescription drugs and those stored in large quantities.
- Train professionals and other adults who provide services to youth at risk for suicide about firearm access issues.
- Increase the proportion of primary care and other health care providers who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate patients about actions to reduce risks.
- Conduct a local community assessment to determine the extent to which firearms and other lethal means are stored safely in homes with children and adolescents.

STRATEGY 3: EDUCATE YOUTH AND YOUNG ADULTS ABOUT SUICIDE PREVENTION

OBJECTIVE

Increase suicide prevention awareness, knowledge, and skills of youth and young adults. The underlying benefit is the creation of school communities in which all members accept responsibility for each other's safety and can provide a competent initial response to those at risk.

All youth and young adults need to be able to help suicidal peers seek professional care.

AUDIENCE

Middle and high school-age youth in school and vocational training settings. Youth and young adults in higher education, job corps centers, youth shelters, military installations, detention facilities, and other community settings. Staff responsible for supervising youth in school and community settings.

RATIONALE AND EFFICACY

About one-half of adolescent females and about one-third of males report having talked to someone who was definitely or potentially suicidal, and yet only about 25% told an adult about their suicidal peers.[17] It is important that all youth and young adults have the knowledge, attitudes, and skills to help suicidal peers get professional help.

Evaluation studies indicate that suicide prevention education programs increase the knowledge of students about suicide warning signs and about sources for help and referral.[18] Students who participated in such programs were found to be more likely to refer other students to hotlines and crisis centers than students who did not participate.[19] Students who participated in a school-based suicide prevention campaign in Washington state demonstrated increased awareness of information about youth suicide prevention, increased ability to recognize indicators of potential suicidal behavior, and a greater likelihood of offering advice to others about how to get help.[9]

IMPLEMENTATION CONSIDERATIONS

There is no evidence that school-based prevention programs increase the likelihood of suicidal behavior.[16] Nevertheless, care should be taken in selecting, designing, and presenting the information to avoid sensationalizing, normalizing, or inadvertently offering how-to instructions for committing suicide.[20] As with any sensitive classroom topic, teachers of suicide prevention education should anticipate and plan for the possibility of negative reactions, particularly on the part of students who have had some personal experience with suicide.

Some of the highest risk youth are not in conventional schools. Efforts to reach these youth are especially important to consider.

Classroom curricula should focus on basic knowledge, attitudes, and skills that help students become more confident and competent in helping troubled peers. The curricula should be implemented as part of a comprehensive school program that also includes administrative policies and procedures for dealing with suicide situations; training for all school personnel; three to five classroom lessons for students in health

and/or family life studies; presentations to parents; and possibly such other components as school crisis teams, training of community gatekeepers, and or/media campaigns.[21]

Strategies 7 (Gatekeeper Training), 8 (Screening and Referral), and 13 (Skill-Building Support Groups) are appropriate complements to suicide prevention education programs and consideration of simultaneous implementation is encouraged.1

"I think school would be better if it had a teen group for lonely students."- an Oregon Student

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify existing suicide prevention education activities and venues within communities where youth aged 10 to 24 receive suicide prevention awareness, information, and skills. Document gaps in services.
- Select safe, age-appropriate suicide prevention curricula, materials, and programs for use in schools and other community settings.
- Conduct suicide prevention education and outreach in community venues that serve out-of-school, street, and homeless youth and young adults.
- Work with school boards, educators, and parents to get suicide prevention education taught to students, supported with training for school staff and parents.

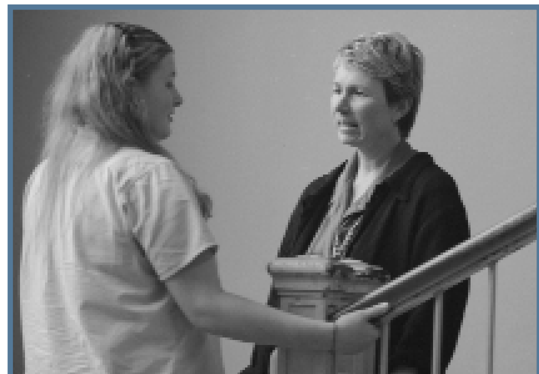
STRATEGY 4: REDUCE HARASSMENT IN SCHOOLS AND COMMUNITIES

OBJECTIVE

Reduce harassment in schools and communities through the creation and implementation of inclusive anti-harassment school policies, staff training, and school curricula.

AUDIENCE

All staff and students in schools.



RATIONALE AND EFFICACY

Students must feel safe in school and other learning environments if they are to achieve their maximum potential. Lack of physical and emotional safety can result in negative educational outcomes linked to risk behaviors.

Students may be marginalized for a wide variety of reasons, including physical characteristics, disability, medical conditions, religion, gender, race, ethnic/cultural identity, sexual orientation, and gender identity.

Studies have established a link between victimization at school with an elevated risk of suicidal ideation and behavior in adolescents.[22, 23, 24] Nearly one-third of Oregon high school students responding to the 1997 Youth Risk Behavior Survey (YRBS) reported being harassed at school during the previous 30 days. These students were three times more likely to report a prior suicide attempt. At greatest increassed risk were victims of sexual harassment and those who were perceived to be gay, lesbian, or bisexual.[25]

IMPLEMENTATION CONSIDERATIONS

Communities differ in the extent to which they accept individual and group differences and schools tend to reflect the attitudes of the community. It is important to work with all aspects of the community in finding agreement about what constitutes safe and supportive learning environments for all youth and young adults.

There is a strong link between victimization at school and an elevated risk of suicidal ideation and behavior.

Staff training should clearly define inappropriate student behavior and empower staff to intervene effectively.

Teaching students tolerance is best done within the context of other risk and protective factors that affect student health and safety.

SAMPLE IMPLEMENTATION ACTIVITIES

- Assess school district policy with regard to non-discrimination, student protection from harassment and violence, user-friendly grievance procedures, and the existence of clearly stated consequences that are consistently enforced.
- Work with school boards and school districts to identify gaps and address needs in school policy language and enforcement to increase safety in school learning environments.
- Utilize local YRBS data or other student survey information to assess needs and implement action plans to address needs.
- Train school staff to identify harassing behavior and effectively intervene.
- Train school staff to teach tolerance.
- Implement tolerance education in classroom curricula.

STRATEGY 5: PROVIDE MEDIA EDUCATION AND GUIDELINES

OBJECTIVE

Reduce suicide contagion through communications media by providing editors with guidelines for reporting youth suicide and suicide prevention resource information.

AUDIENCE

Editors in all communications media, including newspapers, radio, and television.

RATIONALE AND EFFICACY

There is persuasive evidence that outbreaks of suicide - i.e., "suicide contagion" - occurs, and adolescents and young adults are particularly vulnerable.[26] Studies show that mass media coverage of the suicide of a youth can influence others to engage in suicidal behavior.[27, 28] The more networks carry a story about suicide, the greater the increase in suicides thereafter.[27]

The manner of reporting a suicide may increase or decrease the possibility of contagion. Media guidelines recommend that excessive reporting of suicide, how-to descriptions, glorification of persons who commit

suicide, and simplistic explanations be avoided.[29] When suicide is reported, prevention information and community resources should also be provided.

IMPLEMENTATION CONSIDERATIONS

On an issue as sensitive as youth suicide, it is important that communities work with the media to achieve a balance between the mission of the news media and the need for responsible coverage.

Media guidelines should be regularly updated, repeated, and reinforced to reflect new developments in suicide reporting and to ensure that both new and experienced editors stay informed.

Media approaches to reporting suicide can increase or decrease the possibility of additional suicidal behavior in a community.

SAMPLE IMPLEMENTATION ACTIVITIES

- Collaborate with media representatives in developing youth suicide reporting guidelines using the media guidelines recommended by the Centers for Disease Control as a model.[29]
- Provide guidelines to local media personnel in a position to report youth suicide.
- Provide the guidelines to key partners in youth suicide prevention, such as mental health professionals, community leaders, survivors, and gatekeepers.
- Present/distribute guidelines at media association meetings.
- Identify someone to collect and analyze local news articles, television/radio news coverage, and other media on how youth suicide is reported and whether reports include crisis lines and other local/ state/ national resources for help.

STRATEGY 6: PROVIDE EDUCATION FOR PROFESSIONALS

OBJECTIVE

Increase training and education specific to health care professionals, educators, and human service providers who work with youth and families.

Many professionals are inadequately prepared to address suicide issues with youth and families.

AUDIENCE

Professionals and those in professional training programs who work with children, youth, young adults, and families. This audience includes but is not limited to: physicians, nurses, mental health providers, juvenile justice personnel, counselors, teachers, school administrators, crisis response providers, psychologists, social workers, alcohol and drug treatment providers, volunteers with organizations serving youth, and religious/spiritual leaders.

RATIONALE AND EFFICACY

Health care professionals, educators, and human service providers are in key positions to identify, assess, intervene, and refer youth and young adults who are at risk of suicidal behavior. Unfortunately, a number of studies indicate that many professionals are inadequately prepared in these areas.

A survey of pediatric residency programs in the United States found that topics least often cited as adequately covered included psychological testing and violence prevention.[30] Another study found that continued education for adolescent medicine physicians was associated with increased competence in addressing suicide.[31] A survey of graduate schools in psychology found that only 40% had some training on suicide.[32] In a survey of high school health teachers, only 9% believe they would recognize a student at risk for suicide. Suicide prevention education programs for teachers increase their ability to recognize warning signs for suicide, their knowledge of treatment resources and willingness to make a treatment referral.[33] Teachers who attended an in-service program on adolescent suicide, or who have experience teaching about youth suicide, or who work on a school-based crisis intervention team reported a higher level of confidence in being able to recognize a student at risk for suicide.[34]

IMPLEMENTATION CONSIDERATIONS

Training for professional groups should be tailored to reflect the focus and service delivery model of each profession. Champions in each discipline should be recruited to work within their field to promote interest in and support for youth suicide prevention education.

Educational strategies for professionals and service providers will require sustained implementation to keep pace with new developments in the field of suicide prevention and to adjust for the attrition of personnel.

SAMPLE IMPLEMENTATION ACTIVITIES

- Assess what is currently being taught about youth suicide prevention within identified course work, in-service training, and continuing education for professionals.
- Identify audiences and training opportunities.
- Recruit and train individuals to conduct youth suicide prevention education for specific professional groups.
- Conduct and evaluate in-service training for professionals.
- Advocate for the inclusion of youth suicide prevention education in relevant graduate/undergraduate programs as a requirement for certification/licensure and for certification/licensure renewal.

"Just because you haven't attempted suicide doesn't mean you're not depressed. I think the way students feel about things is just as important as what they do."
- an Oregon Student

STRATEGY 7: PROVIDE GATEKEEPER TRAINING

OBJECTIVE

Establish a network of adults and youth in every community who can recognize and respond to youth exhibiting signs of suicide risk and can assist them in getting professional help.

AUDIENCE

Gatekeeper training should be provided to adults who have regular contact with youth and their families. This includes but is not limited to: health care professionals, mental health providers, substance abuse counselors, law enforcement officers, juvenile corrections workers, protective service workers, family planning staff, school personnel (nurses, social workers, psychologists, counselors, teachers),

tribal leaders, clergy, peer helpers, crisis line workers, emergency room personnel, and others who have significant contact with youth between 10 and 24.

RATIONALE AND EFFICACY

Gatekeeper training for adults who work with youth builds their competence and confidence to:

- recognize risk factors associated with youth suicide
- identify at risk youth
- communicate with youth at risk for suicide
- make referrals to connect at-risk youth with skill-building and/or crisis intervention services
- implement policies to guide interventions with at-risk youth (e.g., never leave a suicidal youth alone)
- facilitate a 30- to 45-minute awareness program on the topic of youth suicide
- serve on a school/community prevention team and/or crisis response team

Gatekeeper training for youth builds their competence and confidence to:

- recognize the risk factors associated with youth suicide
- increase positive communication with youth at risk for suicide
- tell an adult of their concerns about a peer
- connect a peer at risk with an adult capable of helping

Adults and youth can be trained to identify youth at risk, show they care and connect youth with services.

Adults who are community gatekeepers interact with youth in a variety of school and community settings. Once trained, they're in a position to recognize youth at high risk of suicide and to intervene with them.[16]

Youth are more likely to talk with peers than with adults about suicidal feelings, ideation, plans, and behaviors.[21] Gatekeeper training for youth offers more in-depth training than general suicide awareness education and provides a cadre of youth with a high level of awareness and skill in intervening with and referring high-risk peers to professional help.

Results from Washington state gatekeeper training programs indicate that trained adults and youth are significantly more likely than the general public to: (1) believe they would act to prevent youth suicide, (2) demonstrate greater confidence in suicide assessment and intervention knowledge, and (3) report higher levels of comfort, competence, and confidence in helping at-risk youth. Youth who participated in a 2-day gatekeeper training were significantly more likely to know warning signs for suicide and more likely to respond with effective suicide prevention steps than non-participating peers.[9] Gatekeeper training programs in Colorado and New Jersey have shown similar results.[35]

IMPLEMENTATION CONSIDERATIONS

A public education campaign (Strategy 1) is adequate for the majority of parents.

Gatekeeper training is not generally designed for parents of youth identified as high-risk for suicide. Those parents should be contacted and referred to professional help.

A number of gatekeeper training methodologies are commercially available. Two train-the-trainer models currently in use in the Pacific Northwest are LivingWorks and Question Persuade and Respond (QPR) for Suicide Prevention.[36, 37]

Adult gatekeeper training should take place before youth training to ensure that the trained youth gatekeeper will have adult support and follow-up when reaching out for help for themselves or friends.

Gatekeepers - especially youth gatekeepers - should receive ongoing supervision, debriefing, and training to help ensure that suicide intervention activities do not increase the risk of suicidal behavior by gatekeepers themselves.

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify community members who are already trained gatekeepers.
- Assess the need for additional gatekeepers.
- Utilize trained gatekeepers to provide youth suicide awareness education and serve on local prevention/crisis response teams (Strategy 11).
- Conduct a training to increase the number of gatekeepers.
- Provide support and ongoing training for current gatekeepers and for those seeking to become gatekeepers.

STRATEGY 8: IMPLEMENT SCREENING AND REFERRAL SERVICES

OBJECTIVE

Screen youth and young adults for suicide risk and refer identified individuals for further evaluation and intervention.

AUDIENCE

Screening and referral is appropriate for youth in any setting but may be particularly warranted for those in subgroups known to be at higher risk for suicide. These include: incarcerated youth, youth with history of juvenile justice and/or protective service involvement; American Indians; white males; depressed youth; substance abusers; high-striving, perfectionist youth; potential dropouts; runaways; gay and lesbian youth; victims of assault and/or abuse; and pregnant teens.[38]

> Screening can identify which youth need assessment and care.

RATIONALE AND EFFICACY

Screening can identify youth with symptoms of depression, suicidal ideation, and behavior, thus providing a means to determine which of them are in need of further assessment and care.

Screening using a three step process that reduces the number of false positives has been shown to be efficient and cost effective when used with both individual youth and large populations.[39]

IMPLEMENTATION CONSIDERATIONS

Screening programs can be characterized as **focused or broad.** Focused screening would select youth known to be at increased risk who present in settings such as juvenile corrections, foster care, alcohol and drug treatment, mental health, youth shelters, and family planning programs. Broad screening programs screen every youth in a population.

One focused approach is to screen high risk youth in settings where they appear for protective services, detention, or health care. Screening can be accomplished by trained paraprofessionals at service delivery sites administered by state and local agencies and community-based organizations.

Suicide-risk screening instruments are still in the developmental stage, with evaluation a priority research area. Some promising screening instruments that have been used include: Suicide Ideation Questionnaire; Evaluation of Imminent Danger of Suicide; Emergency First Aid; Measure of Adolescent Potential for Suicide; Columbia Teen Screen; and the National Institute of Mental Health Diagnostic Interview Schedule for Children.[40, 41, 42, 43, 44, 45]

Settings in which screening should occur include: juvenile corrections centers, homeless shelters, crisis centers, family planning clinics, mental health centers, alternative schools, recreation centers, homeless shelters, crisis centers, employee assistance offices, and alcohol and drug treatment programs.

Periodic screening of high-risk youth should be conducted, since an individual's risk for suicide may change over time.

"I think that teachers and staff members need to pay more attention to kids who are depressed. When they get in these depressions, many become violent and may harm others or attempt suicide." - an Oregon Student

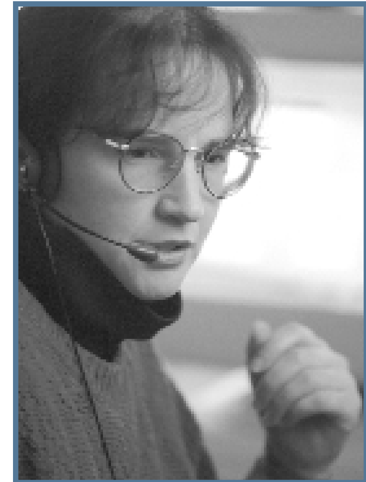
SAMPLE IMPLEMENTATION ACTIVITIES

- Assess current efforts and gaps in screening youth and young adults for suicide risk in school and community settings.
- Identify screening approach, either focused or broad.
- Identify environments where high-risk groups appear and where screening should occur.
- Identify screening instrument.
- Train staff to administer screening process.
- Ensure that clinicians are available to assess and treat referred youth.

- Conduct screening and document implementation processes.
- Refer youth at high risk to clinicians for further assessment and intervention.
- Assist youth at imminent danger of attempting suicide with immediate crisis intervention.

STRATEGY 9: INCREASE EFFECTIVENESS OF CRISIS HOTLINES

OBJECTIVE



Improve the effectiveness of 24-hour local, state, and national crisis hotlines by helping youths to increase their knowledge about how, when, and why to use them.

AUDIENCE

The primary audience is youth and young adults aged 10 to 24, especially those at high risk for suicide. A secondary audience includes community members who are especially concerned with youth suicide and for whom hotlines can be a helpful, readily available resource. These include family members, peers, and trained community gatekeepers (Strategy 7).

RATIONALE AND EFFICACY

There is evidence that hotlines: (1) are preferred by youth over mental health centers, especially if they are known to cater to youth and provide peer counselors; (2) provide a service for individuals troubled by suicidal ideation; (3) succeed in attracting populations they are designed to help; (4) are associated with decreases in suicide rates among white females under 25, the most frequent users of hotline services; and (5) reach otherwise underserved populations in the community.[16]

On the other hand, Shaffer notes that research on the effectiveness of crisis hotlines suggests that they have little impact on suicide rates in a community.[39] He concludes, however, that their impact may be improved if enhanced by appropriate advertising and if hotline personnel are trained in how to respond more specifically to callers regardless of the caller's problems.

IMPLEMENTATION CONSIDERATIONS

Immediate help is as close as a telephone.

Providing youth-friendly hotline response and outreach is important in facilitating the use of hotlines by young people.

Implementation efforts should include plans for anticipating and dealing with an increase in crisis hot-line use. Without such preparation, hotline workers and other care providers may be overwhelmed by public response.

Hotline workers should receive regular supervision from a mental health clinician.

Hotline workers should receive training in crisis response and management.

Hotline workers should have latest information to assist in linking to emergency resources.

A system for tracking the frequency and type of calls is an important tool for documenting and monitoring changes in crisis line use.

Publicity should include national youth hotlines for youth who may, for a variety of reasons, choose not to contact a local crisis line.

Some communities may find it more efficient and cost effective to implement this strategy as part of a regional collaboration with surrounding communities or counties.

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify the number of crisis hotlines, number of calls received from youth aged 10 to 24, the nature of hotline calls, and gaps and coordination issues in the local service area.
- Develop a plan to track calls to collect data as an aid to monitoring effectiveness.
- Develop and implement strategies for making crisis hotlines more user friendly to youth.
- Use a variety of media to publicize availability of crisis lines and crisis services to community members, families, and youth, especially youth at high suicide risk.
- Monitor, evaluate and improve standards for crisis line services.

STRATEGY 10: ENHANCE CRISIS SERVICES

OBJECTIVE

Enhance existing community-based crisis services to accommodate the growth in demand for these services resulting from successful implementation of youth suicide prevention strategies.

AUDIENCE

Crisis hotline staff and other crisis service providers.

> Effective community response after a suicide crisis depends on the education of responders and coordination specific to suicide built into a community's crisis response plans and protocols.

RATIONALE AND EFFICACY

Implementation of the youth suicide prevention strategies in this plan is likely to increase the demand for crisis services; crisis service staff should anticipate and plan for this increased workload.

When an action plan for enhancing crisis services was implemented in Washington state in 1996, crisis services staff reported increases in awareness of suicide prevention, visibility of crisis services, interest from school counselors and others, and helpful resources for improving crisis service staff competencies and for conducting community presentations.[9]

IMPLEMENTATION CONSIDERATIONS

Standards for certifying crisis workers and crisis agencies have been established by the American Association of Suicidology http://www.suicidology.org www.suicidology.org.

SAMPLE IMPLEMENTATION ACTIVITIES

- Document the frequency, type, and nature of crisis events involving youth and young adults and the crisis service provided in order to monitor delivery of services and provide a data base for continuous improvement.
- Ensure that crisis hotline staff have adequate training to respond to at-risk youth callers.
- Identify barriers to the delivery of crisis services to at-risk youth and make recommendations for ways of improving those services.
- Involve crisis service providers in the selection, implementation, and evaluation of community youth suicide prevention strategies.
- Survey crisis service providers about their needs.

STRATEGY 11: ESTABLISH AND MAINTAIN CRISIS RESPONSE TEAMS

OBJECTIVE

Establish and maintain trained, responsive, school and community crisis response teams (CRT) to help minimize the likelihood of suicide contagion in schools.

> Quick and appropriate response from crisis workers can minimize the negative impact of a suicide in a community.

AUDIENCE

The primary audience is current and prospective school and community CRT members. A secondary focus is other community members who play an important role in facilitating the work of a school CRT. These include: school administrators, school counselors, teachers, social workers, psychologists, mental health providers, religious/ spiritual leaders, bereavement counselors, hospital representatives, trained gate-keepers, parent groups, survivor groups, media representatives, crisis service providers, treatment providers, law enforcement, and emergency medical personnel.

RATIONALE AND EFFICACY

Exposure to the suicides of family members, friends, or others may increase the risk for youth and young adults already at high risk of self-destructive behavior. Suicide clusters (groups of suicides occurring closer in space and time than would normally be expected) and copycat suicides are rare events, but adolescents and young adults seem particularly vulnerable to such contagion. Estimates indicate that the percentage of adolescent suicides identified as cluster-related may range from less than 1% to 13%.[46] Schools and communities should be prepared to respond quickly to minimize the likelihood of suicide contagion following one or more youth suicides.

The advisability of a crisis response plan to manage the risk of multiple youth suicides is widely accepted by experts. In the absence of a crisis, it is difficult to evaluate the adequacy of response plan interventions.

Unfortunately, no evaluations exist on the effectiveness of crisis response team interventions on youth suicide behavior.[16]

IMPLEMENTATION CONSIDERATIONS

No matter how well developed a CRT plan might be, it will not work effectively if community stakeholders are not aware of the content of the plan or supportive of it. To ensure a coordinated, cooperative response in the event of a tragedy, school staff and community members should be educated about the role of crisis response teams in suicide prevention.[16]

CRT plans should specify a process for helping team members reduce stress resulting from interventions that prevent a suicide. Team members report significant benefits from participating in these critical incident debriefings.[47]

In addition to school-based and school/community-based CRTs in many communities, Oregon counties have access to National Office of Victim's Rights (NOVA) teams to respond to crises. An informal survey by the Oregon Department of Education in the fall of 1998 showed that most Oregon school districts have a crisis response plan that includes post-suicide intervention. However, many of the plans had not been updated within two years, and only about 25% of school districts had provided any kind of annual staff training in crisis response and crisis response planning. These two types of training were identified as the areas of greatest need.[48]

Suicidal behavior among high-risk youth may also be precipitated by accidental death or homicide or by other significant losses in schools and communities. The use of CRTs after these events should therefore be considered.

"We need to open our eyes and face reality. We have problems here and need to look at them."
- an Oregon Student

SAMPLE IMPLEMENTATION ACTIVITIES

- Establish CRTs in areas without existing teams.
- Incorporate CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters into new and existing CRT plans.[49]
- Involve local CRT members in community youth-suicide prevention efforts.
- Educate community stakeholders about the role of a CRT in the aftermath of youth suicide and solicit their support and utilization of a CRT when appropriate.
- Coordinate crisis response activities with existing community resources.

STRATEGY 12: IMPROVE ACCESS TO AFFORDABLE BEHAVIORAL HEALTH CARE

OBJECTIVE

Improve access to affordable behavioral health care for youth and young adults by:

- taking information and services (education, screening, treatment, consultation) to youth in places where they gather (schools, youth centers, events, youth-serving agencies, churches, athletics, shopping malls, etc)

- increasing the number of school-based health centers that provide behavioral health services
- improving linkages and collaborative relationships between schools and community providers of behavioral health services
- advocating for low-cost or no-cost services and more behavioral health treatment insurance coverage

AUDIENCE

The key audience consists of administrators of institutions that serve youth and young adults, insurance providers, and legislators. An important secondary audience includes public and private entities that provide behavioral health services, school-based health centers, parents, youth, business leaders, suicide survivors, and professional organizations and associations affiliated with health, mental health, and substance abuse issues.

> Mood disorders and alcohol abuse and other drug abuse are strongly linked to suicidal behavior.

RATIONALE AND EFFICACY

Barriers to obtaining treatment for behavioral health conditions in adolescents include availability, transportation, and cost - as well as the social stigma often associated with behavioral health problems (Strategy 1).[50] Oregon youth cite ease of access as the single most important reason why they use a school- based health center.[51] Access to treatment can be increased by providing affordable and confidential services in schools, youth centers, shopping malls, churches, and other places in the community frequented by youth. In addition, access may be facilitated by increasing parental knowledge of mental health services (Strategy 1) and assisting adolescents to initiate contact with a service provider.[52]

There is ample evidence that many youth suffer from a mental, emotional, or behavioral disorder, and many of them do not receive the care they need.[53, 54, 55] Teens who abuse alcohol or drugs are more likely to progress from suicidal ideation to suicide attempts.[56] Mood disorders, conduct disorder, and/or substance abuse are the conditions commonly linked to suicidal behaviors among teenagers.[57, 54] Various therapies and medications have been shown to be effective in the treatment of depression in children and adolescents.[53] Increasing access to effective treatment provides more opportunities for addressing the unmet behavioral health needs of children, adolescents, and young adults.

IMPLEMENTATION CONSIDERATIONS

Implementation of other strategies in this plan, such as screening and referral (Strategy 8) and gatekeeper training (Strategy 7), are likely to increase the need for community behavioral health treatment resources. It is important to anticipate this possibility so individuals with identified treatment needs can access existing resources in a timely manner.

School and community providers should collaborate to coordinate delivery of behavioral health care to youth and families.

The Health Division Center for Child and Family Health has published state and community based strategies for improving adolescent access, availability, and utilization of behavioral health services which can be found at: www.ohd.hr.state.or.us/ccfh/cfhna.htm

SAMPLE IMPLEMENTATION ACTIVITIES

- Involve youth and families in planning improvements in access to care.
- Inform adolescents of their right to health care access and confidential health services
- Perform outreach to enroll adolescents eligible for Children's Health Insurance Program or the Oregon Health Plan.
- Identify ways to decrease barriers and increase access to services and treatment.
- Create an outreach action plan for the delivery of behavioral health information and services in places where young people gather.
- Conduct focus groups with youth and young adults to identify barriers to utilizing local behavioral health services.
- Increase the number of school-based health centers providing behavioral health services that match needs and are planned to supplement local community resources.
- Advocate for affordable behavioral health treatment that achieves parity with medical insurance coverage on local, state, and national levels.

STRATEGY 13: PROVIDE SKILL-BUILDING SUPPORT GROUPS FOR YOUTH

OBJECTIVE

Provide skill-building support groups for identified at-risk youth in school and community settings that work to reduce the impact of multiple-risk factors, enhance protective factors, and involve families in supporting youth involvement and success.

AUDIENCE

The primary audience is young people who have multiple risk factors linked to suicidal behavior. The strategy should concentrate on school and community locations where at-risk young people are found. These include, but are not limited to, high schools, teen health clinics, college counseling/ health centers, youth activity centers, community health centers, juvenile detention facilities, youth shelters, and Job Corps centers.

> Skill building that includes learning to set goals, make decisions, reduce anger, solve problems, and abstain from alcohol and other drugs is a promising approach to reduce suicidal behavior.

RATIONALE AND EFFICACY

Skill-based support groups offer an opportunity to intervene with troubled youth and young adults short of the clinical intervention necessary for those at high risk of suicidal behavior. One feature that often characterizes at-risk youth is the challenge of facing multiple problems at the same time. Risk factors such as emotional distress, family strain, school strain, drug involvement, poor school performance, and low levels of personal and social support may overwhelm a young person's coping abilities. Conducting skill-based support groups for identified at-risk youth can be an effective prevention strategy.[58]

Studies show that youth with suicidal thoughts and behaviors are more likely to use emotion-based coping strategies and less likely to use problem-solving strategies than non-suicidal youth.[59, 60] Deficiencies in such functions as goal setting, decision-making, anger management, problem-solving, and drug use control compound a youth's sense of hopelessness. Social and family support combined with skill development in these areas shows promise in reducing youth suicidal behaviors.[61, 62, 63] Cognitive and behavioral experiences that increase feelings of competency and mastery will increase protective factors that offset risk factors of hopelessness and poor self esteem.

Talking with at-risk youth about their suicidal thoughts, combined with the support of caring adults in the youth's social network, appears to significantly reduce critical risk factors linked to suicidal behavior.[62] Several programs have shown to be effective for depressed youth and youth at risk for suicidal behavior, including the Coping with Depression Course, Group Problem-Solving/Support Interventions, and Reconnecting Youth.[64, 65, 61] Each of these programs has developed curricular materials for program planning and implementation.

IMPLEMENTATION CONSIDERATIONS

Young people in need of mental health services beyond the scope of skill-building support groups should be referred to mental health providers. Adults working with youth identified to be at high suicide risk should contact parents immediately and refer the family to a behavioral health care provider.

Lack of parental or family support is associated with youth suicidal behaviors.[66] The family component of skill-building groups focuses on parent involvement and linking youth and their families to sources of support. Collaboration between each youth, the program manager, and a parent/guardian (or adult friend or family member for a young adult) is important for involving at least one caring adult in a young person's life.[58]

It is important to select an evidence-based model that offers a multi-component prevention approach. It is also important to assess existing groups according to the model followed and to what extent they are skill based, they provide a family support component concurrent with the youth's group involvement, and they are effective in reducing depression and suicidal ideation/behavior.

Youth with multiple risk factors have a dramatically higher probability of having attempted suicide than youth with few risk factors.[54] Assessing youth who may benefit from participation in skill-based support groups depends on identifying those with risk factors linked to suicide or youth populations with an elevated suicide risk (Appendix A). Care should be taken to avoid including youth who do not need the group intervention and to assure that high suicide-risk youth receive more intensive clinical services.

The presence of risk factors or a combination of risk factors can be indicative of risk behaviors other than suicide.

A good question to ask would be: "When you felt depressed, did you have access to items which could have ended your life?"
- an Oregon Youth

SAMPLE IMPLEMENTATION ACTIVITIES

- Identify support/skill-building groups for youth and young adults that already exist in school and community settings, and identify gaps in services.
- Identify locations where high-risk youth are likely to be found as possible places to conduct groups.
- Train professionals to conduct skill-building groups for high-risk youth.
- Conduct group programs in coordination with screening programs and referral systems.
- Develop a plan for ongoing facilitator training, consultation and supervision services, and program evaluation.

STRATEGY 14: SUPPORT SUICIDE SURVIVORS

OBJECTIVE

Foster the development of bereavement support groups for youth and adult survivors of suicide (those who have lost someone by suicide).

AUDIENCE

Suicide survivors, including parents, other family members, and young people who have lost a friend.

RATIONALE AND EFFICACY

In 1998, 569 Oregonians died by suicide.[67] It has been estimated that six to eight people are directly affected by each suicide death, suggesting that at least 3,000 Oregonians each year face the emotional pain of losing a loved one or friend to suicide.[68] A survivor's own risk of suicide can increase as a result of cultural taboos and stigmatization, leading to criticism or condemnation of the survivor, social isolation, and loss of social support.[69] Young people who have lost a friend or acquaintance to suicide may be at increased risk of depression, post-traumatic stress disorder, and suicidal ideation and behavior. Social support should be provided for these potentially bereaved and depressed youth.[72]

Research on the effectiveness of supportive intervention with suicide survivors is limited. One study concluded that group interventions are initially worthwhile in helping adolescents cope with peer suicide, but that supportive intervention may be needed to offset a decrease over time in self-worth and academics.[71] Another study of bereavement support group outcomes for adult survivors produced significant reductions in overall depression, distress, and despair.[7]

Many survivors find that involvement with suicide prevention promotes healing, reduces stigma, and helps them cope with the grief of losing a loved one or friend.

Suicide survivors are at increased risk for suicide.

IMPLEMENTATION CONSIDERATIONS

The stigma often associated with suicide inhibits some survivors from risking public visibility; care should be taken in outreach efforts to protect their privacy. Collaboration with established survivor networks and/or local survivor leadership is recommended.

Bereaved youth and their families may need crisis intervention services, individual counseling, or participation in a peer support group or community-based bereavement support group. Parents of and adults working with bereaved youth should be knowledgeable about local services and should assist youth in getting the support they need.

SAMPLE IMPLEMENTATION ACTIVITIES

Annually, 3000 Oregonians loose a loved one or friend to suicide.

- Conduct outreach to suicide survivors and invite them to participate in implementing suicide prevention strategies.
- Assist survivors in organizing local bereavement support networks.
- Assist survivors in connecting with state, regional, and national organizations working to support survivor advocacy in preventing suicide.
- Support efforts to create community and regional events that increase survivor networking and involvement in suicide prevention activities.

STRATEGY 15: IMPROVE FOLLOW-UP SERVICES FOR SUICIDE ATTEMPTERS

OBJECTIVE

Improve emergency room and after-care services for youth suicide attempters and their families by:

- training emergency room staff in the use of a protocol to increase treatment adherence
- providing follow-up after-care for youth and their families

AUDIENCE

Emergency room personnel and after-care service providers.

A prior suicide attempt is the strongest predictor of a future attempt

RATIONALE AND EFFICACY

One of the strongest predictors of a future suicide attempt is a past attempt.[73] Follow-up studies have found that 31% to 50% of youth whose suicide attempts are serious enough to warrant medical care will make another attempt. As many as 11% will eventually take their own lives.[74, 75] Studies show that psychiatric intervention can have a positive effect in reducing subsequent attempts.[76] Yet, approximately half of all adolescents seen for suicidal behavior receive no mental health intervention after their emergency room visit, and of those who do receive follow-up, as many as 75% do not adhere to the recommended treatment.[75] Appropriate medical care and after-care for suicide attempters is important for preventing future attempts in this highly vulnerable population.

A specialized emergency room program for adolescent attempters has demonstrated increased adherence to treatment after-care.[77] In addition, a brief family therapy model has shown promise in reducing overall symptom levels in youth suicide attempters, but research following them over time is needed to evaluate the effectiveness of the model.[77, 78]

IMPLEMENTATION CONSIDERATIONS

Involvement of medical personnel, especially emergency room and critical care providers, is vital to the implementation of this strategy.

Model programs may need to be adapted for specific emergency room/critical care settings and staffing patterns to work in ways that do not compromise the program's demonstrated effectiveness.

SAMPLE IMPLEMENTATION ACTIVITIES

- Involve hospital personnel and critical care providers in community efforts to prevent youth suicide.
- Assess the number and frequency of youth in the community receiving medical care for suicide attempts.
- Assess emergency room and critical care provider protocols in responding to suicidal youth and the extent and nature of after-care provided to youth suicide attempters and their families.
- Work with medical providers in selecting appropriate emergency care protocols and after-care interventions.
- Facilitate the provision of training to emergency care and after-care service providers.

SECTION 3: MEASURING PROGRESS

Heightened community awareness about suicide can lead to a sense of urgency and a will to act. Tragic stories can win votes, can help get money appropriated to the cause, and can inspire volunteers to pour their heart and soul into prevention activities. But all that vigorous and heartfelt activity will be wasted unless it is harnessed to a program that works.

Plans for program evaluation should be part of any plan for the implementation of a suicide prevention program. The evaluation can help provide proof that the program is successful, and this is often important when looking to obtain financial or political support for the program. In addition, detecting the unintended effects of a program can lead to efforts to refine that program. Finally, documentation of how a program was implemented can also be useful to others if they choose to replicate a successful program.

In designing an evaluation plan it is often useful to explicitly and concretely specify the activities involved in the program, and the short-and long-term goals of the program. Once the activities and goals have been specified, at least two kinds of evaluation should be considered:

- Process evaluation: measuring the extent to which activities are implemented as planned
- Outcome evaluation: measuring the effectiveness of the program in achieving the program's stated outcomes.

The appendices to this plan contain information and tools that may be useful as you plan prevention activities and evaluation of those activities.

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APPENDICES

APPENDIX A: THE EPIDEMIOLOGY OF YOUTH SUICIDE IN OREGON

In order to develop and focus prevention strategies, it is essential to understand who is at risk, and when and where suicide occurs. This is a summary of what is known about the epidemiology of suicide and suicide attempts among Oregon youth aged 10 to 24.

SUICIDE DEATHS

Data Source and Limitations

This section summarizes information gathered from death certificates. In order to classify a death as a suicide, medical examiners must be aware of specific evidence that the decedent attempted to kill himself or herself. Such evidence might include a suicide note, a recent period of depression, or a prior suicide attempt or threat. Because of this requirement, the number of deaths classified as suicides on death certificates is almost certainly an underestimate.

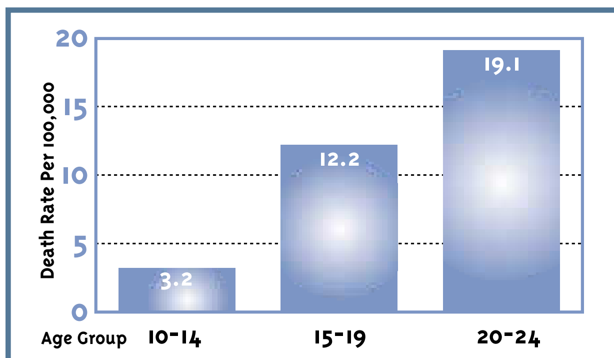
Overall Rates

Approximately 75 Oregon youth aged 10 to 24 commit suicide each year, making it the second leading cause of death for Oregonians in that age group. Oregon's 1997 suicide rate of 9.81 per 100,000 among youth aged 10 to 24 ranked 17th among states.

Age

The highest rate of suicide among youth occurs in those aged 20 to 24 (Figure1). Although the rate among youth aged 10 to 14 is low, national statistics show that from 1980 to 1992, this rate increased 120% from 0.8 to 1.7 per 100,000.[1]

Figure 1: Suicide Death Rates Among Youth Aged 10-24 Oregon, 1994-1998



Source: Oregon Death Certificates

Race

White youth account for the largest number of youth suicides in Oregon: 62 suicide deaths in 1998, representing 94% of total suicide deaths, at 9.1 deaths per 100,000 white population. Since the majority of Oregon's population is white, it is necessary to look at multiple years of data to make comparisons by race. From 1994 to 1998, suicide rates were highest among American Indian youth, and almost three times higher than for white youth: 15 deaths from 1994 to 1998, 4% of total suicide deaths, 24.5 deaths per 100,000 American Indian population. During this same time period, the figures for African American youth were: 10 suicide deaths, 3% of total youth suicide deaths, 12.3 deaths per 100,000 African American population. Asian youth manifested a significantly lower risk for suicide:[6] suicide deaths, 1% of total suicide deaths, 4.7 deaths per 100,000 Asian population.

Gender

In 1998, male youth were seven times more likely to commit suicide than female youth (11.0 per 100,000 vs. 1.6 per 100,000).

Method of Suicide

Firearms are the leading method of suicide. From 1994 to 1998, firearms were used in 64% of Oregon youth suicides. Self-hanging was the second most common method (21%).

SUICIDE ATTEMPTS

Data Sources and Their Limitations

The information in this section is based on data from Oregon's Adolescent Suicide Attempt Registry, Youth Risk Behavior Survey, and Hospital Discharge Index.

Emergency room personnel are required by law to report suicide attempts by adolescents to the Oregon Health Division, and these reports are compiled into the Adolescent Suicide Attempt Registry. Note, however, that the registry records only attempts by youth aged 0 to 17, and does not include any attempts that do not result in a visit to an emergency room..

Additional data on youth suicide attempts is available from the Youth Risk Behavior Survey (YRBS), which is administered each year to a sample of Oregon middle and high school students. A strength of this survey is that it collects information by self-report of students, so it includes all suicide attempts whether or not they resulted in a visit to a health care provider. However, as with suicides included in the Adolescent Suicide Attempt Registry, these data also are limited to middle school and high school students.

The Hospital Discharge Index is a compilation of billing records from Oregon inpatient and psychiatric hospitals. This data source includes suicide attempts by patients of all ages, and attempts that do not result in a hospitalization are not included.

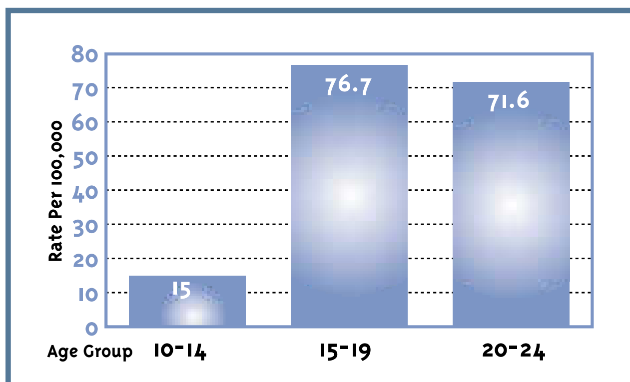
Overall Rates of Suicide Attempts

In 1998, a total of 761 suicide attempts were reported to the ER attempt registry. Among Oregon youth under age 18, approximately 44 attempts were reported to the registry for every death. Also in 1998, 366 youth aged 10 to 24 were hospitalized for suicide attempts.

Age

The highest rate of hospitalization for a youth suicide attempt occurred among those aged 15 to 19 (76.7 per 100,000) (see Figure 2).

Figure 2: Youth Suicide Attempts by Age Group Oregon, 1998

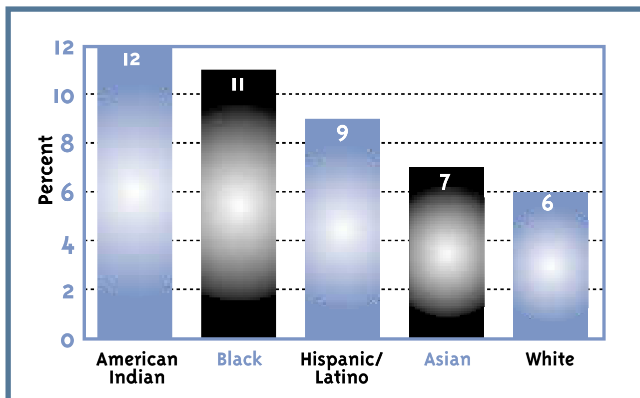


Source: Oregon Hospital Discharge Index

Race

Race information on suicide attempters is obtained from the adolescent suicide attempt registry (attempters under 18) and the YRBS. The 1998 registry reported the highest rate for American Indian youth under 18, at 103.2 per 100,000, followed by white youth at 100.6 per 100,000 and African American youth at 75.4 per 100,000. Asian youth had a lower rate of suicide attempts at 43.0 per 100,000. The YRBS also reported the highest prevalence of suicide attempts in American Indian students (Figure 3).

Figure 3: Percentage of Students Who Reported a Suicide Attempt in Previous year by Race/Ethnicity, Oregon, 1999



Source: Youth Risk Behavior Survey

Gender

Among adolescents (i.e., under 18) whose attempts led to an emergency room visit, females were 3.2 times more likely to attempt suicide than males (142.7 attempts per 100,000 females vs. 45.0 attempts per 100,000 males). This is a dramatic contrast to the predominance of males in deaths due to suicide.

Method of Suicide

Among youth whose attempt led to hospitalization, the most common was ingestion of drugs (94%). This is a dramatic contrast to the predominance of firearm use in completed suicides. Cutting or piercing injuries (3%), suffocation/strangulation (1%), and firearms (0.5%) were the next most common methods for this age group.

Risk Factors

In order to target prevention efforts, it is essential to understand what populations are most at risk and the characteristics of high-risk groups. Research data indicate that there are factors common to those who commit suicide and those who attempt suicide. The following table outlines some of the risk factors associated with youth suicide. The magnitude of the increased risk and the estimated prevalence of a particular risk factor vary from study to study; the elevated risk and the number of individuals with the factors might therefore be presented as a range. Through the identification of high-risk groups and the estimated size of a group with the particular characteristic, interventions can be more efficiently focused.

TABLE 1: RISK FACTORS FOR SUICIDAL BEHAVIOR

Risk Factor	Relative Risk	Estimated Population with Risk Factor in Oregon
Prior Attempt[2]	1.5-14.0	13,500-68,000
Past Depression[3]	3.4	30,500-34,000[4]
Major Depression[2]	11.9	20,000
Poly-Substance Abuse[3]	2.8-5.3	81,000[5]
Alcoholism[3]	5.3	210,000[6]
Drug Abuse[2]	14.8	156,000[6]
Family Hx of Suicide[7]	3.9-7.0	30,500[3]
Incarceration[8]	4.8	2,800[9]
Access to firearm[10]	4.8	40,000[11]
Homelessness[12]	2.8	34,000[13]

Suicidal Ideation and Previous Suicide Attempts

Sixteen percent of high school students surveyed in the 1999 Oregon YRBS reported "seriously considering suicide," 6% reported an attempt in the last 12 months, and 2% reported an attempt in the last six months that resulted in an injury requiring medical attention. Suicidal ideation appears to be a common experience among adolescents. Some risk factors may differentiate those who only contemplate suicide from those who proceed to actually attempting suicide. It is estimated that between 7% and 16% of adolescents and young adults (aged 10 to 24) have attempted suicide.[2] A previous suicide attempt has been identified as the most strongly associated risk factor for completing a suicide.[2] In 1998, one out of every three Oregon youth suicide attempters requiring an ER visit, (youth under 18) had made a prior attempt in the last 5 years. These facts support the need for appropriate follow-up care after a suicide attempt.

Major Depression and Other Mental Health Issues

A history of depression, mood disorder, or other mental health diagnosis is common in individuals who commit suicide. In fact, studies estimate that 90% of youth who commit suicide have at least one major psychiatric disorder.[2,4]

Substance Abuse

Substance abuse increases the risk both for suicide and attempts in youth. Studies indicate that approximately one-third of youth who commit suicide were under the influence at the time of their death.[7] Cross sectional studies using the Youth Risk Behavior Survey have observed that suicidal behavior often coexists with substance abuse.

History of Physical or Sexual Abuse

Thirteen percent of all Oregon high school students who took the 1999 YRBS said they had been purposely hit, kicked, or slapped by an adult family member in the last year. Six percent reported forced sexual intercourse, and 18% reported unwanted sexual touching. These youth were several times more likely to have made a suicide attempt than those students who did not report being abused.[14]

Incarceration

Suicide is the leading cause of death in jails and lock-up facilities. In Oregon juvenile detention facilities, 32% of the incarcerated youth reported a prior suicide attempt, compared to 9% of Oregon high school students.[9] In 1997-1998, there was a cluster of three suicides in an Oregon juvenile correction facility.

Homelessness

Researchers have noted that homeless youth are at much greater risk of suicide than their domiciled peers. Studies of homeless youth in large urban areas found that 41% of their samples had considered suicide, and more than 25% had attempted suicide.[15] Greenblat found that almost half of homeless youth aged 13 to 17 had attempted suicide.[16] Ringwalt studied "throwaway" youth who were specifically told to leave home and found this sub-population to be at higher risk for suicidal behavior than homeless youth who were not told to leave home.[13]

Sexual Orientation

In an analysis of five studies involving representative samples of U.S. high school students Remafedi found higher rates of attempted suicide among homosexual youths compared to their heterosexual peers.[17] This higher risk has been shown to be significant, with homosexual youth ranging from 3.4 to 13.9 times more likely than heterosexual youth to engage in suicide attempts.[18,19] Safren and Heimberg found that gay, lesbian, and bisexual adolescents reported greater depression, hopelessness, and past and present suicide ideation than did heterosexual adolescents.[20] When accounting for other predictor variables, they concluded that environmental factors play a major role in predicting distress in this population.

Accessible Firearms

Firearms in the home, whether locked up or not, whether loaded or not, is associated with a higher risk for adolescent suicide, even after controlling for other psychological risk factors.[21] According to the 1999 Oregon YRBS, students who reported a suicide attempt in the last year were twice as likely to report carrying firearms.[22]

Multiple Risk Factors and Protective Factors

Research shows that the probability of adolescents having made a suicide attempt increases dramatically as a function of the number of risk factors they possess.[23] Nevertheless, it is the accumulation of risk factors and the absence of protective factors in a young person's life, rather than membership in or identification with a particular high-risk group, that increases the risk for suicidal behavior.[12] Results of the 1999 Oregon Youth Risk Behavior Survey indicate that as the number of environmental and behavioral risk factors increase, individuals are more likely to report a suicide attempt.[14]

DATA COLLECTION NEEDS

Death Scene Investigations and Manner of Death

Death by suicide is underreported, especially among youth, and the true prevalence of suicide attempts is unknown at this time. Law enforcement and medical examiner investigations of youth suicide often involve only immediate family members. However, relatives, friends, and adults who knew the deceased often have information that is not known to immediate family members. Improved investigations of youth suicide can improve the ability of local communities to evaluate how their systems of care respond to youth and families in crisis, and can assist them in developing community suicide prevention plans. Improved investigations would include an effort to correctly identify not just the mechanism of death (e.g., a firearm or ligature), but to determine a precipitating event, known factors that contributed to the death, and the underlying risk factor or reason the suicide occurred.

An additional benefit of n in depth investigation is the connection of bereaved families and friends to support services. Research indicates that those who have lost a loved one to suicide are at increased risk for suicide themselves. Complicated grief can also lead to depression that may need clinical care.

Suicide Attempt Registry

Little is known about the difference between attempters and suicide completers. Research into post-treatment follow-up care in emergency rooms is needed to better understand the differences between successful interventions and those that fail.

Accurate, comprehensive data are critical to the development, implementation, and evaluation of effective prevention strategies. In order to evaluate if prevention efforts begun at age 16 carry through into adulthood, it will be necessary to track health data across time. Such data are needed for tracking the rate of attempts in each age group as time passes. Expanding the age range for data collection to all attempters would assist in defining the magnitude of the problem and in evaluating activities to prevent suicide. Without expanded attempt data on young adults and adults as they age, it will not be possible to evaluate if efforts begun in adolescence continue to bring results later on.

Survey Work on Risk Behaviors

School participation in the risk behavior survey is necessary to accomplish the goal of creating a representative sample of Oregon youth in high school and middle school. Accurate, comprehensive data are critical to the development, implementation, and evaluation of effective prevention strategies. Data from this survey can provide communities with a rich source of information to use in community planning efforts to best determine use of resources.

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APPENDIX B: STATE AND LOCAL COMMUNITY DATA SOURCES ON RISK/PROTECTIVE FACTORS

Data can assist in the selection and implementation of local suicide prevention activities and assessment of their impact on local youth. Community-wide issues that impact the quality of life, such as poverty, crime, discrimination, limited access to services, and isolation, are also important considerations in planning for local suicide prevention efforts. The following data sources provide information on morbidity, mortality, and risk and protective factors among Oregon youth.

The Youth Risk Behavior Survey. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1997.

Suicidal Behavior, A Survey of Oregon High School Students, 1997. Center for Health Statistics, Health Division, Oregon Department of Human Services. 1998.

Youth Suicide, Results from the 1999 YRBS. Center for Health Statistics, Health Division, Oregon Department of Human Services. 2000.

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Office of Alcohol and Drug Abuse County Data Books: www.oadap.hr.state.or.us/2000db.html
Office of Services to Children and Families reports: www.scf.hr.state.or.us/abusereports.htm
Office of Mental Health Services reports: www.omhs.mhd.hr.state.or.us/dataonline/reports.cfm
Oregon Department of Education: www.ode.state.or.us/stats/

APPENDIX C: COMMUNITY ASSESSMENT

Communities are in the best position to assess local needs and resources, identify gaps, and make decisions about suicide prevention activities. The following questions can be used to identify local resources and to assess the gaps in services that should be addressed.

What **public education** has occurred in the community to increase awareness of youth suicide warning signs, intervention approaches, and local resources for help?

Do youth and young adults in and out of school receive any **suicide prevention education** in school and community settings? If so, when, where, what?

What percentage of community members understand **the role of firearms** in youth suicide? What percentage of community members own firearms? What percentage of community members store them safely?

Have all schools and school districts in the community created and implemented a **safe schools plan** that protects students from harassment and violence through the establishment and enforcement of school norms of tolerance and mutual respect?

Have the local **media** been educated about the appropriate reporting of suicide? If so, who, by whom, when, what education?

Is training on suicide awareness, prevention, and intervention provided to **educate professionals** who work with youth and families? If so, who, what, when?

How many community members are trained in youth suicide intervention skills **(gatekeeper training)** and prepared to intervene with youth at high risk for suicidal behavior?

Is there any kind of identification, **screening,** and referral of high-risk youth for suicidal ideation or behavior? Where is this done? Who does the screening? What screening tools are used? Where are the youth referred? What is the community's capacity for serving referred youth (hospitals, schools, mental health centers, private mental health practitioners, doctors, etc.)?

How do youth and young adults get information about access to the community 24-hour **crisis line?** How is the crisis line accessed? What is the response time? hours of operation? gaps in service?

Are **crisis service providers** in the community trained in suicide prevention? Are they integrated into community-wide suicide prevention efforts? Do crisis services meet American Association of Suicidology certification?

Does your community have a **crisis response team** with school and community professionals that coordinates the utilization of local resources in response to youth suicide? If so, what is the membership of this team?

Are individuals or groups working to increase **access to behavioral health care** services in your community? If so, who are they? If not, who may be interested? Are schools amd providers linked?

Are there any **skill building support groups** available to identified high-risk youth in school and community settings? If so, where, when, who supports?

Is there an organized network of **survivors of suicide** that provides support to those who lose a loved one or friend to suicide? Who are the network representatives and how are they contacted?

Is your community aware of the **sources of data** on youth risk behaviors, suicide attempts, and completions? Are these data used to understand and plan for reducing youth risk behaviors and increasing protective factors?

How do local **emergency rooms** respond to youth suicide attempts? Are referrals made, and what kind of follow-up is provided? Are ERs reporting attempts to Health Division?

APPENDIX D: PROJECT MANAGEMENT TOOL

Goal Statement: Reduce morbidity and mortality due to suicide among youth in Curry County, Oregon.

Strategy	Audience	Activities	Indicators	Monitoring Methods	Lead Person	Complete Date
#1 Public Education Campaign	All residents of Curry County	Secure PSAs to use in television, radio, & print media	Copies of PSAs obtained locally	Review Materials & document	Jane	February 00
		Secure agreements to broadcast & print media	Agreements with local editors & run dates & times	Announcement of agreements	Mark	March 00
		Work with print media to develop feature articles on adolescent depression & suicide	Draft copies of articles	Collect copies of feature articles published	June	April 00

Goal Statement: Reduce morbidity and mortality due to suicide among youth in ______________Oregon.

Strategy	Audience	Activities	Indicators	Monitoring Methods	Lead Person	Complete Date

APPENDIX E: THE INTERVENTION DECISION MATRIX

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Intervention Provide youth with crisis line number	**Option 1** Develop, print & distribute 2000 wallet cards	**Option 2** Develop, print & post posters	**Option 3** Develop, print & distribute brochures
Effectiveness	High...kids will carry small card in wallets but should laminate with plastic	Moderate, they won't have number with them	Low, kids won't read and carry
Feasibility	High	Moderate as design costs are high	High
Affordability	Moderate with plastic cost	High	Moderate
Sustainability	Moderate with changes in number	Moderate	Moderate with changes in number
Political Acceptability	High	High	Low
Unintended Consequences	Not sure	Not sure	Not sure
Final Priority (high, medium, low)	High to Moderate	Moderate to High	Moderate to Low

THE INTERVENTION DECISION MATRIX

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Intervention	**Option 1**	**Option 2**	**Option 3**
Effectiveness			
Feasibility			
Affordability			
Sustainability			
Political Acceptability			
Unintended Consequences			
Final Priority (high, medium, low)			

Compare options ranking each cell as "high, medium or low" priority. Which option is strongest? Is there a cell that sinks the idea?