

Washington State's Plan for
Youth Suicide
Prevention

2009

Data updated 2011

Data and goals updated 2014



DOH 971-013 September 2014

“I had a friend die of suicide...it’s a permanent solution to a temporary problem.....Suicide prevention can prevent sorrow and loneliness and more suicides from happening. To put a hand out for help may be the one thing that shows someone that life is worth living, and they don’t have to die.”

Homeless youth, age 19, in and out of foster care since age 11.

“Suicide is not simply a personal tragedy but a tragedy for the entire community. The reason that suicide is a public health issue is because resources needed to successfully prevent suicide are beyond the reach of individuals and families alone.”

Local public health professional

Washington State's Plan for Youth Suicide Prevention

2009

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Note: When state and national data are released each year, the electronic version of Washington State's Plan for Youth Suicide Prevention will be updated.

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Executive Summary

Washington state youth complete suicide in numbers that make this the second leading cause of death for people between the ages of 10 and 24.

On average, each week in Washington:^{1,2,3}

Two youth kill themselves

Seventeen youths are hospitalized because of suicide attempts

Many more youth have a plan or think about suicide.

Preventing suicide takes many forms – from building strong, capable youth who are connected to families, friends and their communities, to teaching people to recognize suicide warning signs. It also includes increasing access to the medical-mental health treatment system.

Youth Suicide Prevention–1995 to 2014

In 1995, Washington created its first Youth Suicide Prevention Plan. Since then, work has begun on some of its recommendations:

- The 1995 Legislature allocated \$500,000 per year for youth suicide prevention work, providing 25 percent of the estimated cost of carrying out the full plan. In 1999, funding was reduced to \$250,000 per year.
- The Youth Suicide Prevention Program, a private, non-profit organization, was founded to provide support and leadership in suicide prevention across the state.
- A statewide public awareness campaign conducted in 1996 reached about 500,000 people in Washington.
- Since 2006, the Office of the Superintendent of Public Instruction has provided \$100,000 per year for suicide prevention curriculum.
- A three-year federal grant has funded local activities at seven sites serving higher-risk youth, has encouraged people engaged in youth suicide prevention to share their knowledge and experiences, and has supported the completion of this state plan.
- The 2012 Washington State Legislature passed Engrossed Substitute House Bill 2366 requiring certain health professionals to complete training in suicide assessment, treatment, and management, and tasking the Department of Health with conducting a study to evaluate the effect of suicide assessment, treatment, and management training on licensed health care professionals to effectively treat suicidal clients.

In 2014, the Washington State Legislature passed Engrossed Substitute House Bill 2315, expanding the suicide assessment, treatment, and management training to more groups of licensed health professionals and requiring the Department of Health to develop a life-span suicide prevention plan by November 2015.

We Still Have Far to Go

- Suicide among youth in Washington State persists. Suicide rates among Washington youth remain higher than the national average.¹
- Suicide remains a difficult, often taboo subject to talk about.

- Overall, few communities and organizations address suicide and suicide prevention in a regular and routine manner.
- Research shows that at least 80 percent of youth who attempt⁴⁻⁸ or complete⁹⁻¹³ suicide have a diagnosable mental illness. Many youth cannot get needed mental health care because of limited public resources.
- The estimated cost of fully implementing the 1995 plan was \$2 million per year. Without that level of funding, many recommendations in that ambitious plan were not addressed.

The Picture of Youth Suicide in Washington State Today

- There were nearly twice as many suicides as homicides of youth ages 10 to 24 (data from 2006–2010).¹
- Forty-four percent of all suicides by 10- to 24-year-olds took place with a firearm (data from 2006–2010).¹ Responses by the 10th graders on the 2010 Washington Healthy Youth Survey show that 18 percent of the respondents (about 15,000 students in the state) in 10th grade seriously thought about attempting suicide during the 12 months prior to the survey, and that 7 percent (about 6,000 students in the state) reported making a suicide attempt in the 12 months prior to the survey.¹⁴
- In 2010, the suicides of 121 Washington youth ages 10 to 24 cost an estimated \$224 million in medical costs and lost future productivity. The 909 hospitalizations because of attempted suicides cost an estimated \$27 million in medical care and lost short-term productivity.

“Washington State’s Plan for Youth Suicide Prevention” guides our work in Washington. The plan represents the best thinking of the Youth Suicide Prevention Steering Committee, reflects national research and experiences of other states, and uses a variety of approaches to get the best results.

- Goal 1 — Suicide is recognized as everyone’s business.
- Goal 2 — Youth ask for and get help when they need it.
- Goal 3 — People know what to look for and how to help.
- Goal 4 — Care is available for those who seek it.
- Goal 5 — Suicide is recognized as a preventable public health problem.

To implement the new plan, we will use our partners across the state to identify existing tools and to develop new ones for preventing youth suicide at all levels. We will move from paper to practice by designing action plans for use in local communities, as well as local and statewide organizations. We will invite individuals, agencies, and policy makers to learn more about what they can do to prevent youth suicide.

Introduction

We have a significant youth suicide problem in Washington. The number of our youth completing suicide makes it the second leading cause of death for 10- to 24-year-olds. Many more youth think about it or actually have a plan. The pain experienced by parents and friends who have lost a child to suicide, or who have experienced the near loss because of an attempt, is immense.

Preventing suicide is up to all of us. When young people die by suicide, they leave behind those who love them. Society loses what those people would have achieved if they had lived full adult lives.

Why is Suicide a Public Health Issue?

At its core, the mission of public health is to improve the health of communities. One important part of that is reducing premature death. Because suicide is one of the leading causes of premature death in Washington, preventing it improves the overall health of communities.

For each person who kills himself or herself, there are families, friends, and people in schools, businesses, and communities whose lives are affected. It affects them emotionally, socially and financially. Preventing suicide is more than mental health treatment for at-risk youth. Prevention takes many forms – from building strong, capable youth connected to family, friends and community to teaching awareness of suicide warning signs. It also involves increasing access to the physical-mental health treatment system.

Youth suicide prevention includes bringing communities together to address the many factors that lead people to consider suicide.

How Can People Use This Plan to Help Prevent Youth Suicide?

This plan is only one step in the work of youth suicide prevention. Our hope is that as this plan is presented to Washington residents, it is seen as a guide and a framework for preventing youth suicide. It is not any one agency's plan, but a plan in which anyone working on youth suicide prevention can find a place.

The goals and objectives were chosen by the Department of Health Youth Suicide Prevention Steering Committee, a small group of leaders in a variety of areas who are committed to the well-being of young people. Their intent is to have everyone be able to see how they can be a part of the solution to youth suicide. By targeting our work and addressing hard issues together, we hope to see the continued downward trend in the suicide rates.

There is a place for everyone in suicide prevention. For example: People may look at this plan and see how they can learn the warning signs of suicide and help a youth, or an agency may see how it can change organizational practices to better support the youth it works with. It is also a plan that has a multi-layered approach. We know from research and experience that one thing alone – one area of focus by itself – cannot stop suicide from happening. The “Spectrum of

Prevention” (see Appendix F) gives us a way of organizing our work so we can address a particular goal on many levels, ranging from the individual change we want to see to the policies that support those people.

As stated before, this is a start. Action will be needed on many levels – from the individual level to the community, organization, and societal levels. We encourage the readers to think about what role they can play in prevention and how they can be part of a larger effort across Washington.

Our hope is that this Plan for Youth Suicide Prevention will provide inspiration and information that lead:

- Parents, caregivers, and other adults to learn risk factors, support youths’ changing needs as they grow and promote protective factors in youth.
- People in the public and private sectors who work with youth to offer the resources they need to thrive.
- Policy-makers such as school administrators, legislators, tribal elders, and state agency leaders to create responsible laws, rules, and regulations that ensure the health and safety of our young people.

Looking Back: Youth Suicide Prevention in Washington State

In 1995, under the joint leadership of the Department of Health and the University of Washington School of Nursing, a dedicated group of advocates and people who lost family and friends to suicide created the 1995 “Washington State Plan for Youth Suicide Prevention.” Many other people contributed their knowledge, experience and passion to develop the plan.

Four Key Areas in the 1995 Plan

1. Universal Prevention – raising awareness about the problem and giving information everyone should know.
2. Selective Prevention – teaching people to identify a youth at risk of suicide, learn where to turn for help, and promote a crisis response to suicidal youth.
3. Indicated Prevention – offering family support and building skills in suicidal youth so they can make different choices to cope with their stress.
4. Evaluation – measuring the success of prevention programs and activities as they are implemented.

Organizations have started programs and awareness campaigns. They evaluated and revised these projects to carry out the intended goals and meet local needs. Youth and adults have come together in schools and communities in Washington to learn about the problem of suicide and to receive training in youth suicide prevention. A 1996 statewide public awareness campaign

reached about 500,000 people in Washington. Local survivor groups have provided support to those who have lost a loved one to suicide.

Over time, the momentum for suicide prevention has grown in Washington. People who lost friends and family by suicide have become advocates with a strong voice. Programs that support youth and families have supported suicide prevention. In addition, research began showing how best to implement suicide prevention programs. This work is highlighted in the Milestones section of the appendix.

The 1995 State Plan recommended creating a statewide organization to focus on preventing youth suicide. In 2001, the Youth Suicide Prevention Program, a private, non-profit organization, was founded. In addition to its many other activities, YSPP developed, implemented, and evaluated several courses that teach students to cope with stress, to support friends who need help, and where to find help.

In 2006, the Department of Health received a three-year federal grant to support and evaluate youth suicide prevention and intervention activities with higher-risk populations (Native American youth, college enrolled youth, and youth who are homeless or involved in the social service system).

The grant has encouraged an assessment of the progress we have made since 1995 in local and statewide suicide prevention efforts. It has also brought people together to learn from each other and from experts through activities such as a September 2008 statewide conference on suicide prevention for sexual minority youth, youth in the juvenile justice and foster care systems, homeless youth, and Native American youth.

Challenges in Carrying Out the 1995 Youth Suicide Prevention State Plan

- Suicide is a difficult subject to talk about. Few people, communities, and organizations address suicide and its prevention in a regular and routine manner.
- Suicide is the second leading cause of death in Washington state for youth ages 10 to 24, but financial resources to support prevention and early intervention programs are inadequate. Originally, the work outlined in the 1995 state plan was funded at 25 percent of the proposed cost. This was later reduced to 12.5 percent of the proposed cost.
- Public resources are limited. It is difficult for people without insurance or other means to get into the mental healthcare system. It is very hard for youth to get into the system unless they are actively suicidal. Few resources exist for other forms of help. Because research indicates that at least 80 percent of youth who have attempted¹⁻⁵ or completed suicide⁶⁻¹⁰ have a diagnosable mental illness, adequate health services are critical. Some of the common diagnosable mental illnesses include depression, substance use, and anxiety disorders.

The Picture of Youth Suicide Today

Many researchers believe that because of inaccurate reporting, the number of attempted and completed suicides is understated.

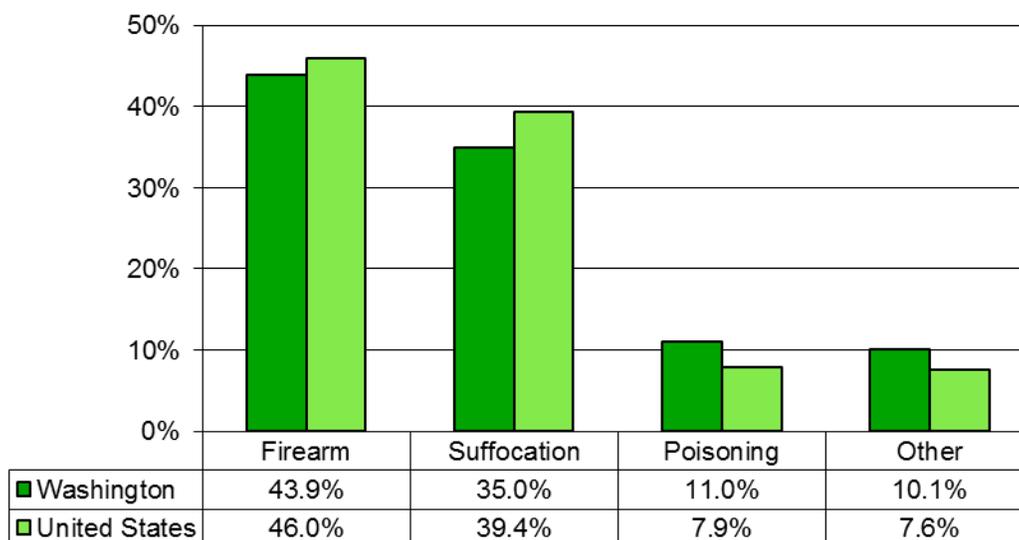
Factors that affect accurate reporting include: 1) stigma associated with declaring a death a suicide; 2) concern that insurance may not cover a death by suicide; 3) limited requirements for reporting suicides; and, 4) unknown intent, leading to suicides mistakenly classified as unintentional injury. The problem of suicide is likely more serious than the numbers indicate.

Youth Suicide Patterns in Washington

From 2006–2010, Washington youth suicide rates were higher than national rates: ¹

- Suicide was the second leading cause of death in the state of Washington for youth 10 to 24 years of age and the third leading cause of death nationally (see Figure A in Appendix B).
- The suicide rate for 10- to 24-year-olds in Washington was 8.2 per 100,000. This is above the national average of 6.9 per 100,000.
- Forty-four percent of all suicides among 10 to 24 year olds in Washington State, and 46 percent nationally, were completed with a firearm (see Figure 1).
- In Washington, firearms were the leading method of suicide for both males and females. Firearms were used in 54 percent of male suicides and in 37 percent of female suicides (see Figure B in Appendix B).

**Figure 1. Method of Suicide, Ages 10 to 24
Washington State and United States: 2006-2010**

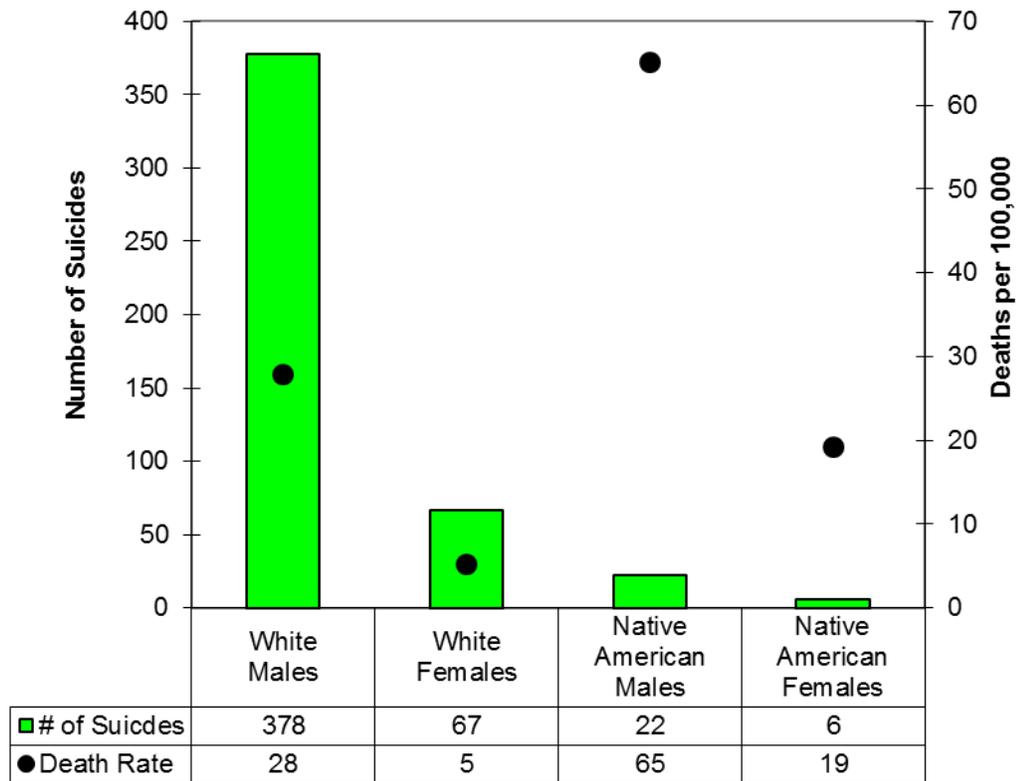


Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2013) Available from URL: www.cdc.gov/injury/wisqars

More Facts About Youth Suicide in Washington

- There were twice as many suicides as homicides among youth ages 10 to 24 (data from 2006-2010).¹
- In Washington State, females are hospitalized for attempted suicide more frequently, yet males died by suicide more often by a ratio of 5:1.^{2, 3}
- Responses to the 2010 Washington Healthy Youth Survey showed that 18 percent of the 10th graders (about 15,000 students in the state) seriously thought about attempting suicide during the 12 months prior to the survey. Further, 7 percent of the 10th graders (about 6,000 students in the state) reported making a suicide attempt in the 12 months prior to the survey.¹⁴
- Responses by sixth-graders on the 2010 Washington Healthy Youth Survey showed that 14 percent (about 11,000 students in the state) reported they had “ever” seriously considered killing themselves and that 5 percent (almost 4,000 students in the state) had reported “ever” trying to kill themselves.¹⁴
- In Washington and nationally, white males and females accounted for the highest number of suicides, while Native American males and females accounted for the highest rates of suicide (see Figure 2).¹

Figure 2. Comparing Native American and White Youth Suicide Death Rates for Washington State



Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2013) Available from URL: www.cdc.gov/injury/wisqars

Economic Costs of Suicide

Nationally, suicide and attempted suicide cost as much as \$33 billion annually. This includes \$32 billion in lost productivity and \$1 billion in medical costs.¹⁶

Based on these national estimates, the average cost per each completed suicide for youth between the ages of 10 and 24 is about \$1.9 million in future work loss and \$5,000 in medical costs. The estimated cost of a non-fatal suicide attempt, including those resulting in hospitalization or those seen by a medical care provider in an emergency department, hospital outpatient, or provider’s office, is about \$11,000 in work loss and \$9,000 in medical costs.

The estimated costs for suicide and attempts that result in hospitalization in 2010 for youth 10 to 24 years old are as follows:

- With 121 youth suicides, there was an estimated \$224 million lost in medical costs and lost future productivity.
- With 909 hospitalizations because of suicide attempts, there was an estimated \$27 million in medical costs and lost short-term productivity.¹⁵

Contributing Influences on Youth Suicide

Youth suicide relates to a number of problems including violence, psychiatric disorders, family conflicts, dating violence, sexual assault, and hopelessness. Adolescent developmental changes may also interact with other risk factors. Suicide risk is greater among certain groups of youth, such as Native Americans, whites, males, and gay, lesbian, bisexual, transgender and questioning youth (GLBTQ).

Cultures differ in their attitudes toward suicide, and toward the role of community and family in a youth's life. Cultures also differ in religious and spiritual beliefs, and in how distress is manifested and interpreted. Furthermore, young people may suffer stress trying to balance assimilation to the majority culture while maintaining their cultural heritage. They may feel misunderstood or stigmatized when using majority culture services.

Because of such influences, prevention work must be culturally relevant and community-based. A suicide prevention approach may be effective in one culture but not in another. One size does not fit all. It is the responsibility of everyone in the suicide prevention field to recognize their own cultural biases, to understand the culture of the youth with whom they work, and to use local communities as guides to design effective programs. Suicide prevention programs should hire staff members who reflect the communities they serve, and should train all staff members in cultural competency.

Risk and Protective Factors

The influences linked with completed and attempted suicide are called risk factors. The influences known to protect against suicide attempts are called protective factors. Limiting risk factors and supporting protective factors, particularly among higher-risk groups, are valuable prevention strategies.

Key Risk Factors – Researchers have identified many demographic, psychological and environmental influences as risk factors for suicide attempts.¹⁷⁻²³

The following are the most important:

- Previous suicide attempt.
- Past or current psychiatric disorder (e.g., a mood disorder such as depression).
- Alcohol and/or drug abuse.
- History of sexual or physical abuse.
- Access to firearms.

Key Protective Factors – As with risk factors, research shows certain influences to be protective against suicide attempts.²⁴⁻³⁰

The following are the most important:

- Positive school experiences.
- Family harmony and support.
- Cultural and religious beliefs that discourage suicide.
- Well-developed coping skills.
- A strong sense of self-esteem and self-worth.

Developmental Issues

Moving from childhood to young adulthood is complex and difficult. It involves changes in several areas of life. Finding one's way through this maturing period is especially stressful, and may put youth at risk for suicidal thoughts and behaviors.

Stressful changes may include:

Physical changes. Puberty and sexual maturation lead to changes in a youth's body that can affect the way others treat that person.

Cognitive changes. These affect the way in which youth think about themselves and others. They may see strengths and limitations in themselves and others they have not seen before. They may come to understand the presence of stress-creating factors for their families and their inability to affect these elements.

Social changes. Demands from family, peers, teachers, and society can lead to increased stress and suicidal behaviors. These new challenges often have to do with succeeding in school, responding to bullying, taking part in relationships, and fulfilling financial obligations to those who rely on them.

Emotional changes. The stress of the physical, cognitive and social changes may lead to emotional changes. Youth who do not effectively cope with these factors may become depressed, abuse alcohol or other drugs, or become hopeless. These are all risk factors for suicide.

Implications of Risk and Protective Factors for Prevention

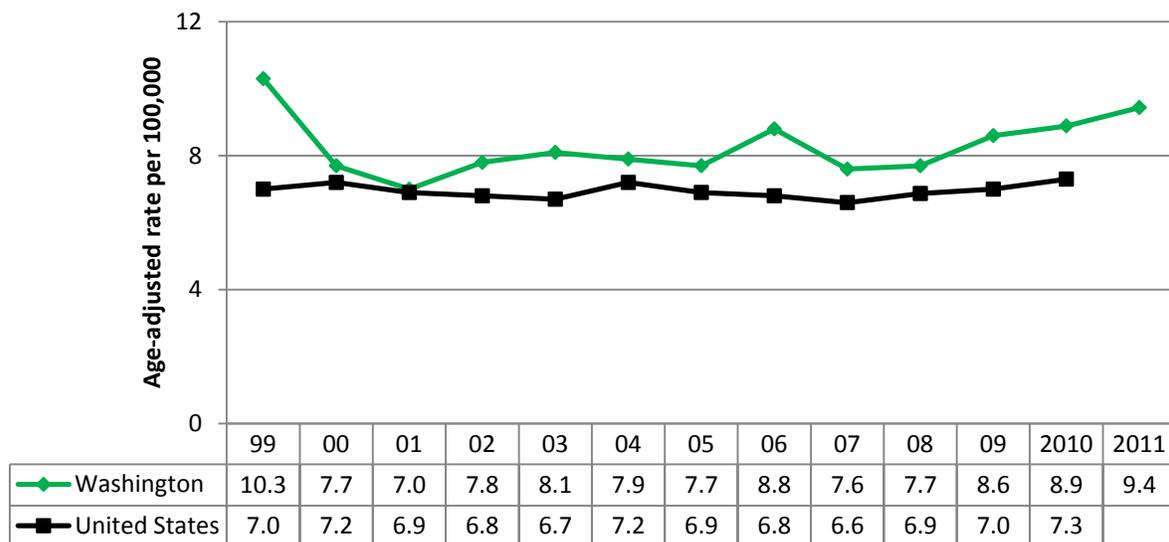
Based on this research, suicide prevention activities should alleviate risk factors and boost protective factors in the lives of Washington youth.

Warning signs for suicide do exist (see Appendix C). For example, expressing hopelessness and withdrawing from family and/or friends are two warning signs. These behaviors may indicate other problems -- but listening to and talking with youth exhibiting these warning signs are important first steps.

Looking Forward: Youth Suicide Prevention 2014

We hope we can reverse the upward trend, and that we can decrease youth suicide and suicidal behaviors. Suicide rates for Washington youth remain higher than the national average and have increased in recent years (see Figure 3).

**Figure 3. Comparison of Suicide Rates,
Washington State and United States: 1999-2011**



Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2013) Available from URL: www.cdc.gov/injury/wisqars

We must keep up our prevention efforts, learn from what we have done so far, and build momentum across Washington. As we put this 2014 plan into action, we reflect on the past 19 years and what we have learned about suicide prevention in Washington:

- We need to develop and implement community-based suicide prevention programs.
- We need to promote help-seeking for at-risk youth and to reduce the stigma of mental health and substance abuse treatment.
- We need to increase awareness of and competency in suicide prevention, treatment, and management.
- We need to increase access to clinical services.
- We need to build a statewide structure to support and sustain suicide prevention and intervention.

There is now national leadership and resources to support suicide prevention work. The U.S. Department of Health and Human Services has provided leadership to help guide and motivate suicide prevention efforts across the country. In 1999, the “Surgeon General’s Call to Action to

Prevent Suicide³⁷” was released. In 2001, the “National Strategy for Suicide Prevention³⁸” was developed to guide work in many states and communities. Both of these documents (Appendix G) informed the strategies, objectives, activities and outcomes developed in Washington’s 2009 Plan. The “2012 National Strategy for Suicide Prevention” is the basis for this amended 2009 plan.

We have tapped the wisdom of many national organizations to develop the current plan. These include the Substance Abuse Mental Health Services Administration, the Centers for Disease Control and Prevention, the Suicide Prevention Resource Center, the American Foundation for Suicide Prevention, and the American Association of Suicidology.

What We Want to Accomplish

The goals and objectives that follow will guide our work to reduce youth suicide over the next five years. They represent the best thinking of the Youth Suicide Prevention Steering Committee. They are based on national research and experiences of other states, and use a variety of approaches to get the best results.

The Youth Suicide Prevention Steering Committee looked at several models for presenting the objectives and chose the “Spectrum of Prevention.³³” (For an explanation of the Spectrum model, see Appendix E.) This framework recognizes that preventing youth suicide requires simultaneous work by many people, in many settings, using many different approaches. It defines six areas for action, each of which must be addressed for prevention work to be effective:

- Policy
- Organizational practices
- Coalitions and networks
- Professional education
- Community education
- Individual knowledge and skills.

Washington State’s Plan for Youth Suicide Prevention has five goals. Every goal in the plan has six objectives, one for each of the areas of action described above. The goals are:

- Goal 1 – Suicide is recognized as everyone’s business.
- Goal 2 – Youth ask for and get help when they need it.
- Goal 3 – People know what to look for and how to help.
- Goal 4 – Care is available for those who seek it.
- Goal 5 – Suicide is recognized as a preventable public health problem.

Goal 1

Suicide is Recognized as Everyone's Business

Develop and Implement Community-Based Suicide Prevention Programs

Area of action	What Washington can do 2014 – 2015 objectives
Policy	1. Establish effective, sustainable, and collaborative suicide prevention programs at the state, tribal, and local levels.
Organizational practices	2. Integrate and coordinate suicide prevention activities across multiple sectors and settings and leverage work by joining existing programs.
Coalitions and networks	3. Develop and sustain public-private partnerships to advance suicide prevention.
Professional education	4. Promote efforts to reduce access to lethal means of suicide among youth with identified suicide risk.
Community education	5. Strengthen and expand community capacity to develop and implement suicide prevention programs.
Individual knowledge and skills	6. Increase the number of people who know where to join youth suicide prevention efforts in their community.

Goal 2

Youth Ask for and Get Help When They Need It

**Promote Help-Seeking for Those in Need
and Reduce the Stigma of Mental Health and Substance Abuse Treatment**

Area of action	What Washington can do 2014 – 2015 objectives
Policy	1. Increase the number of middle schools, high schools, and colleges that teach about coping with stress, that teach staff how to identify at-risk youth and how to refer them to services, and that have policies for connecting students to mental health and substance abuse services.
Organizational practices	2. Increase the number of organizations that include the number of the National Suicide Prevention Lifeline in their print and web materials.
Coalitions and networks	3. Increase the number of youth-focused groups that join together to promote mental health and suicide prevention.
Professional education	4. Promote responsible media reporting of suicide.
Community education	5. Promote the understanding that recovery from mental and substance abuse disorders is real and possible for all.
Individual knowledge and skills	6. Increase the number of youth who have the skills to seek help for themselves and others.

Goal 3

People Know What to Look for and How to Help

Increase Awareness of and Competency in Suicide Assessment, Treatment, and Management

Area of action	What Washington can do 2014 – 2015 objectives
Policy	1. Increase the number of licensed and certified health professions that acquire knowledge and skills in suicide assessment, treatment, and management.
Organizational practices	2. Improve public health capacity to collect, analyze, report, and use suicide-related data to implement prevention efforts.
Coalitions and networks	3. Increase the number of local coalitions with community education programs.
Professional education	4. Increase the number of Washington colleges and universities that have courses in suicide risk assessment and intervention.
Community education	5. Increase knowledge of the warning signs of suicide and how to connect people in crisis with assistance and care.
Individual knowledge and skills	6. Increase awareness of the role of crisis lines, such as the National Suicide Prevention Lifeline.

Goal 4

Care is available for those who seek it

Increase Access to Clinical Services

Area of action	What Washington can do 2014 – 2015 objectives
Policy	1. Promote timely access to assessment, intervention, and effective care for youth at high risk for suicide.
Organizational practices	2. Implement a post-crisis suicide prevention program for youth discharged from hospital emergency departments or inpatient psychiatric hospitalization.
Coalitions and networks	3. Establish linkages between providers of mental health and substance abuse services, and community-based and peer support programs.
Professional education	4. Promote continuity of care for youth treated for suicide risk after discharge from emergency departments and inpatient psychiatric units.
Community education	5. Create and distribute information to assist community members in promotion of suicide prevention and intervention services.
Individual knowledge and skills	6. Educate people on how to advocate for their own and their family’s mental health care.

Goal 5

Suicide is Seen as a Preventable Public Health Problem

Build a Statewide Structure to Support and Sustain Suicide Prevention and Intervention

Area of action	What Washington can do 2014 – 2015 objectives
Policy	1. Involve suicide attempt survivors and their families in all stages of suicide prevention planning and implementation.
Organizational practices	2. Evaluate the effectiveness of suicide prevention and intervention activities.
Coalitions and networks	3. Create and maintain a state coalition that advances the goals and objectives of Washington State’s Youth Suicide Prevention Plan.
Professional education	4. Create school crisis plans to include suicide prevention strategies that ensure rapid response to suicidal youth and their families.
Community education	5. Increase public knowledge of suicide and suicide prevention through a public awareness campaign.
Individual knowledge and skills	6. Create opportunities for people to learn about youth suicide prevention and to be willing to become involved in suicide prevention activities.

Next Steps

- We will work with our partners across the state to develop and employ tools to prevent youth suicide at all levels. We will move from paper to practice by designing action plans for use at the local and organizational level.
- We will look at location and approach when implementing strategies. For example, not all people between the ages of 10 and 24 are in school. Many over the age of 16 are out of school and are difficult to reach. Knowing this, we need to identify strategies that are location-specific and can be implemented in a variety of settings.
- We will continue to look at the factors that contribute to suicide, and at the various populations that need special help. As new research and information become available, we will review the validity of our approach, the target audience and the partners.
- There is emerging concern and information about suicides and suicidal behavior in our veterans from the Iraq and Afghanistan wars. A large number of these veterans fall within the age range targeted by this state plan.
- We are learning that the criminal justice system – especially local jails and juvenile detention centers – is experiencing suicide attempts and deaths even when inmates are on official suicide watch. Even though criminal justice agencies have policies and procedures to prevent inmate suicide and to intervene early, there is more to be done.
- Recent research and experience have taught us a great deal about the “how” of suicide. This research has shown that restricting the lethal means — firearms, prescription and non-prescription medications, and alcohol³⁴ — from suicidal youth can prevent fatalities. We will incorporate this information into our action planning.
- We need to learn what suicide prevention efforts are occurring in separate youth-serving organizations and communities around the state. Through collaboration and coordination, partnerships can greatly expand our influence.

Local ownership of prevention efforts is vital to prevent suicide among our youth. In 2014, we will convene a broad, statewide coalition to provide the leadership needed to move prevention forward in our state.

We invite individuals, agencies, and policy makers to learn more about what part they can play to prevent youth suicide.

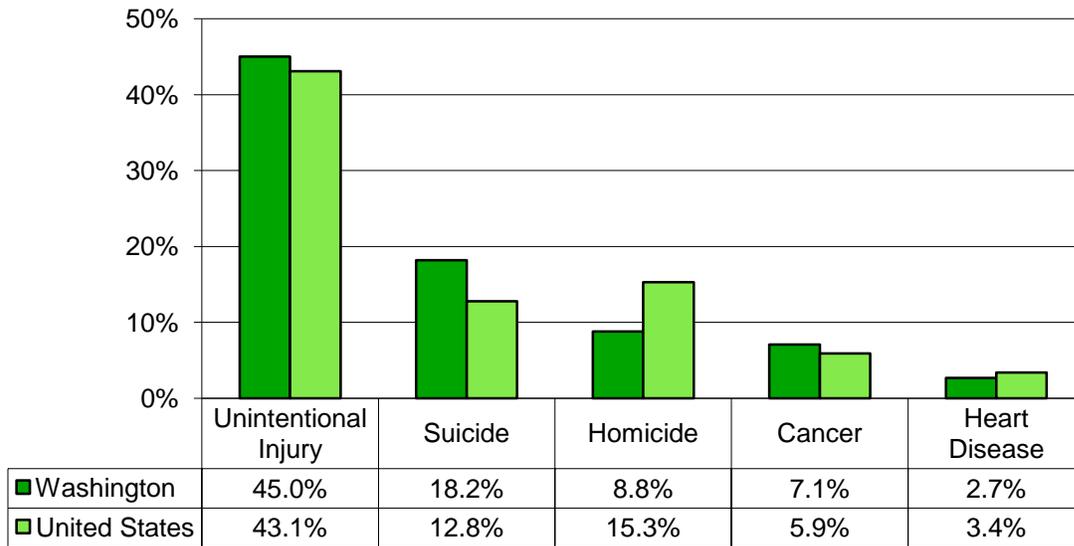
Appendix A: Citations

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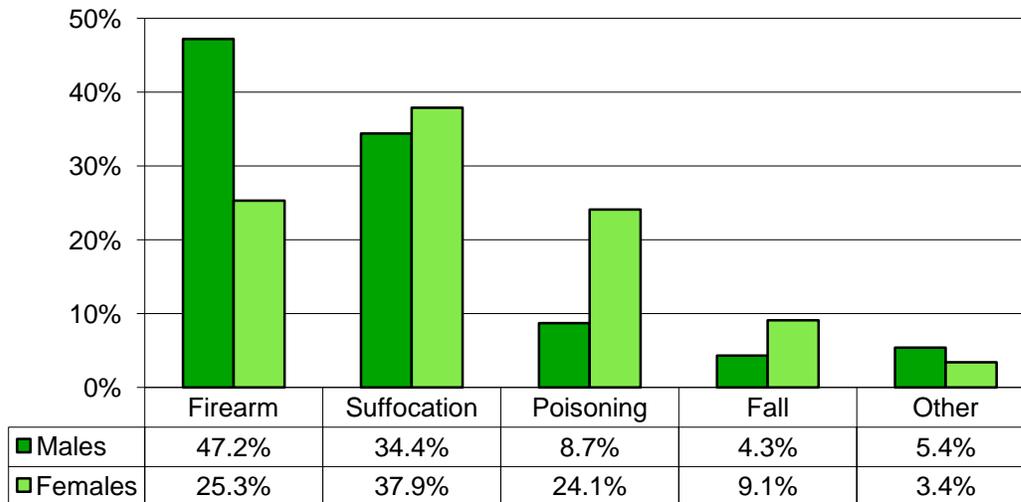
Appendix B: Youth Suicide Data Charts and Tables

Figure A. Leading causes of death for 10- to 24-year-olds Washington State and the United States: 2006-2010



Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2013) Available from URL: www.cdc.gov/injury/wisqars. Accessed January 25, 2013

Figure B. Leading methods of suicide for males and females in Washington State 2006-2010



Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2013) Available from URL: www.cdc.gov/injury/wisqars. Accessed January 25, 2013

Figure C - County Suicide Death and Hospitalization Data for 10- to 24-Year-Olds

Suicides Washington Residents Ages 10-24 By county by descending rate per 100,000 population Years 2006-2010			Non-Fatal Hospitalizations due to Attempted Suicide Washington Residents Ages 10-24 By county by descending rate per 100,000 population Years 2006-2010		
County	Count	Rate	County	Count	Rate
Stevens	6	14.3	Cowlitz	123	121.7**
Yakima	38	13.4**	Ferry	8	110.1
Clallam	7	11.9	Spokane	469	90.8**
Pierce	94	11.0**	Walla Walla	64	90.7**
Kitsap	29	11.0	Clark	374	85.5**
Thurston	26	10.4	Yakima	237	83.7**
Walla Walla	7	9.9	Kitsap	210	79.3**
Island	7	9.4	Skagit	93	81.7
Lewis	7	9.3	Grays Harbor	51	72.9
Benton	17	9.3	Pierce	597	69.9
Grant	9	8.8	Mason	36	68.8
Whatcom	21	8.6	Clallam	40	68.0
WA State	572	8.3	Okanogan	26	67.9
Clark	36	8.2	Benton	124	67.5
Spokane	42	8.1	State Total	4537	66.1
Skagit	9	7.9	Thurston	163	65.1
Snohomish	51	7.1	Snohomish	455	63.7
Chelan	5	6.8	Island	47	63.4
Franklin	6	6.7	Jefferson	12	60.2
King	117	6.5	Adams	13	57.6
Cowlitz	6	6.0	Whatcom	135	55.5
Asotin	4	*	Pend Oreille	6	54.2
Douglas	4	*	King	957	53.1
Grays Harbor	4	*	Douglas	20	50.2
Okanogan	3	*	Chelan	37	50.1
Pacific	3	*	Franklin	41	46.0
Ferry	2	*	Stevens	18	42.9
Mason	2	*	Lewis	32	42.6***
Pend Oreille	2	*	Grant	41	40.3***
Skamania	2	*	Asotin	7	35.1
Adams	1	*	Whitman	31	32.7***
Columbia	1	*	Klickitat	5	28.1
Kittitas	1	*	Kittitas	8	12.5***
Klickitat	1	*	Pacific	4	*
Wahkiakum	1	*	Lincoln	4	*
Whitman	1	*	San Juan	2	*
Garfield	0	*	Columbia	1	*
Jefferson	0	*	Skamania	1	*
Lincoln	0	*	Garfield	0	*
San Juan	0	*	Wahkiakum	0	*

*Rate not calculated for values < 5

Data Sources:

Washington State Department of Health, Center for Health Statistics, Death Records - 2012

Population source: Washington State Office of Financial Management with DSHS/Department of Health

Adjustments

Appendix C: Warning Signs of Suicide

Most suicidal young people don't really want to die; they just want their pain to end. About 80 percent of the time, people who kill themselves have given definite signals or talked about suicide. The key to prevention is to know these signs and what to do to help.

Watch for these signs. They may indicate someone is thinking about suicide. The more signs you see, the greater the risk.

- A previous suicide attempt
- Current talk of suicide or making a plan
- Strong wish to die or a preoccupation with death
- Giving away prized possessions
- Signs of depression, such as moodiness, hopelessness, withdrawal
- Increased alcohol and/or other drug use
- Hinting at not being around in the future or saying goodbye

These warning signs are especially noteworthy in light of:

- a recent death or suicide of a friend or family member
- a recent break-up with a boyfriend or girlfriend, or conflict with parents
- news reports of other suicides by young people in the same school or community

Other key risk factors include:

- Readily accessible firearms
- Impulsiveness and taking unnecessary risks
- Lack of connection to family and friends (no one to talk to)

Courtesy of the Youth Suicide Prevention Program.

What to do if you see the warning signs?

- Seek immediate help by contacting 911 if you believe someone is in immediate danger of hurting himself or herself.
- Contact a mental health professional or call 1-800-273-TALK for a referral should you witness, hear or see anyone exhibiting any one or more of the above behaviors.
- For additional resources see these websites:
 - [Youth Suicide Prevention Program](#)
 - [National Suicide Prevention Lifeline](#)

Appendix D: Best Practices Registry for Suicide Prevention

The Best Practices Registry for Suicide Prevention reviews evaluates suicide prevention programs, classifies them according to their demonstrated evidence, and creates an online registry of fact sheets for programs determined to be evidence-based. New programs are added regularly.

This project was initiated in response to Objective 10.3 of the “National Strategy for Suicide Prevention,” which called for the development of a registry of prevention activities with demonstrated effectiveness for suicide and suicidal behaviors.

Section I: Evidence-based programs

This section contains programs that have demonstrated successful outcomes (generally, reductions in suicidal behaviors or risks) based on well-designed research studies.

Community-Based Programs:

- U.S. Air Force Suicide Prevention Program
- Reduced Analgesic Packaging
- Emergency Room Intervention for Adolescent Females
- ER Means Restriction Education for Parents
- Primary Care
- PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)

School-Based Programs:

- CARE (Care, Assess, Respond, Empower)
- CAST (Coping and Support Training)
- Columbia University TeenScreen
- Lifelines
- Reconnecting Youth
- SOS Signs of Suicide
- American Indian Life Skills Development/Zuni Life Skills Development

Treatment Programs:

- Cognitive Behavioral Therapy for Adolescent Depression
- Dialectical Behavior Therapy
- Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)
- Psychotherapy in the Home

Section II: Expert and consensus statements

This section lists statements that summarize the current knowledge in the field and provide "best practice" recommendations to guide program and policy development.

- *A Resource Guide for Implementing the Joint Commissions 2007 Patient Goals on Suicide*, Screening for Mental Health Inc.
- *Consensus Statement on Youth Suicide by Firearms*, Youth Suicide by Firearms Task Force and the American Association of Suicidology.
- *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student*, Jed Foundation
- *Guidelines for School Based Suicide Prevention Programs*, American Association of Suicidology.
- *National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide*, Canadian Coalition for Seniors' Mental Health
- *Reporting on Suicide: Recommendations for the Media*, Multiple Authors
- *Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline*, National Suicide Prevention Lifeline.
- *Suicide Prevention Efforts for Individuals with Serious Mental Illness*, National Association of State Mental Health Program Directors.
- *Warning Signs for Suicide Prevention*, American Association of Suicidology.

Section III: Adherence to standards

This section contains suicide prevention programs and practices that have been implemented in specific settings. These programs address specific objectives of the "National Strategy for Suicide Prevention." Their content has been reviewed for accuracy, likelihood of meeting objectives, and adherence to program design standards. Being listed in this section means that the program content meets the stated criteria; inclusion does not mean that the practice has been proven effective through evaluation (those programs are listed in Section I.) While this section does not include treatments, it does contain practices that support treatment such as case-finding, compliance, and aftercare.

Awareness Materials:

After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors, National Suicide Prevention Lifeline

After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department, National Suicide Prevention Lifeline

After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department, National Suicide Prevention Lifeline

Depression and Bipolar Wellness Guides for Parents and Teens, Families for Depression Awareness

Depression Wellness Guide for Adults with Depression and their Family and Friends, Families for Depression Awareness

"Is Your Patient Suicidal?" Emergency Department Poster and Clinical Guide, Suicide Prevention Resource Center

Educational and Training Programs:

Applied Suicide Intervention Skills Training (ASIST), LivingWorks
Ask 4 Help Suicide Prevention for Youth, Yellow Ribbon Suicide Prevention Program
Assessing and Managing Suicide Risk: Core Competencies (AMSR), SPRC Training Institute
Connect/Frameworks Suicide Postvention Program, NAMI New Hampshire
Connect/Frameworks Suicide Prevention Program, NAMI New Hampshire
Healthy Education for Life (HELP), Heartline Oklahoma
Helping Every Living Person (HELP) Depression and Suicide Prevention Curriculum,
Washington Youth Suicide Prevention Program
High School Gatekeeper Curriculum, Gryphon Place
Interactive Screening Program, American Foundation for Suicide Prevention
LEADS for Youth: Linking Education and Awareness of Depression and Suicide, Suicide
Awareness Voices of Education
Making Educators Partners in Youth Suicide Prevention, Society for the Prevention of Teen
Suicide
Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention, QPR Institute
Response: A Comprehensive High School-based Suicide Awareness Program, ColumbiaCare
Suicide Alertness for Everyone (safeTALK), LivingWorks

Protocols and Policies:

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), Screening for Mental Health
*Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School
Personnel*, Maine Youth Suicide Prevention Program
Youth Suicide Prevention School-based Guide Checklists, Louis de la Parte Florida Mental
Health Institute, University of South Florida

[The Suicide Prevention Resource Center has more information.](#)

Appendix E: Spectrum of Prevention

The Spectrum of Prevention is a systematic tool that promotes a multifaceted range of activities for effective prevention. It identifies multiple levels of intervention and helps people move beyond the perception that prevention is merely education.

The Spectrum is a framework for a more comprehensive understanding of prevention that includes six levels for strategy development. These levels, delineated in the table below, are complementary and when used together produce a synergy that results in greater effectiveness than would be possible by implementing any single activity or linear initiative. At each level, the most important activities related to prevention objectives should be identified. As these activities are identified they will lead to interrelated actions at other levels of the Spectrum.

Spectrum of Prevention Level of Spectrum

Level of Spectrum	Definition of Level
Influencing Policy and Legislation	Developing strategies to change laws and policies to influence outcomes.
Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety.
Fostering Coalitions and Networks	Convening groups and individuals for broader goals and greater effect.
Educating Providers	Informing providers who will transmit skills and knowledge to others.
Promoting Community Education	Reaching groups of people with information and resources to promote health and safety
Strengthening Individual Knowledge and Skills	Enhancing a person's capability of preventing injury or illness and promoting safety.

[The Prevention Institute has more information.](#)

Appendix F: References

1995 Youth Suicide Prevention Plan for Washington State

The Washington State Legislature directed the Department of Health to develop a state plan for youth suicide prevention in 1994. Using the suicide prevention expertise of the University of Washington School of Nursing, the department contracted with the school to convene experts and stakeholders to assist in developing this plan. The plan continues to be a resource for Washington and is used across the United States as well as in several other countries as a guide for their own suicide prevention efforts. The 1995 plan was organized around a prevention framework developed by the Institute of Medicine. This framework and the strategies identified as action priorities were:

Universal Prevention

- Statewide educational campaign on suicide prevention
- School-based educational campaigns for youth and parents
- Public educational campaign to restrict access to lethal means of suicide
- Education on media guidelines

Selective Prevention

- Screening programs with special populations
- Gatekeeper training; statewide 1-800 line for consultation and education services
- Crisis intervention services

Indicated Prevention

- Skill building support groups
- Family Support Training

Evaluation and Surveillance

- Evaluation of prevention interventions in each component
- Surveillance of suicide and suicidal behaviors among youth 15-24 years

1999 Surgeon General’s Call to Action to Prevent Suicide

In July 1999, Tipper Gore and Surgeon General David Satcher unveiled a blueprint to prevent suicide in the United States. This document, titled “[The Surgeon General’s Call to Action to Prevent Suicide](#)” outlines more than a dozen steps that can be taken by individuals, communities, organizations and policymakers to prevent suicide.

2001 National Strategy for Suicide Prevention

One recommendation from the “Surgeon General’s Call to Action to Prevent Suicide” was the development of a national strategy for suicide prevention that included goals and objectives for

communities, states, and organizations. This would help build a cohesive effort toward suicide prevention in the United States. The “National Strategy for Suicide Prevention” has been a foundation document for many states and national organizations as they develop plans and begin their work in suicide prevention.

2008 Washington State Injury and Violence Prevention Guide

Washington produced the “Washington State Injury and Violence Prevention Guide” for those working on prevention programs. The guide consists of 12 injury and violence prevention chapters with four priority areas to prevent injuries and violence, disability, and premature death. It includes injury data, goals, evidence-based strategies, and promising or experimental prevention strategies for each injury area. The chapter on “Suicide” describes recommended prevention strategies:

Evidence-based strategies

- Treat and care for depressed older adults
- Reduce future risk among suicide attempters in emergency rooms
- Train gatekeepers who work with youth

Promising or experimental strategies

- Raise awareness that suicide is a preventable
- Promote education and training
- Promote access to mental health care
- Reduce access to lethal means of committing suicide
- Gain broad support for suicide prevention, and enhance and support surveillance systems

Washington State Injury and Violence Prevention Guide – Department of Health Publication No: 530-090. [This guide is available here \(PDF\)](#).

Northwest Suicide Prevention Tribal Action Plan 2009-2013

This [Northwest Suicide Prevention Tribal Action Plan 2009-2013 \(PDF\)](#) was developed by the Northwest Portland Area Indian Health Board in collaboration with tribal health representatives, Indian Health Service, state health departments, state departments of education, universities, and regional tribal planning groups. The plan’s mission is to reduce suicide rates among American Indians and Alaska Natives living in the Pacific Northwest by increasing tribal capacity to prevent suicide and by improving regional collaborations.

Appendix G: Glossary

Access — the ability to gain admittance to an array of treatments, services and supports; consumers know how and where to get them; and there are no system barriers or obstacles to getting what they need, when they need it..

Advocacy — active support of an idea or cause; activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes.

Assessment — comprehensive examination and evaluation of a person’s needs for psychiatric, developmental disability or substance abuse treatment, services and supports according to applicable requirements.

Best Practices — activities or programs that are in keeping with the best available evidence regarding what is effective.

Coalition — alliance of individuals and groups formed to pursue a common goal.

Community — group of people residing in the same locality or sharing a common interest (for example. a town or village, and faith, education and correction communities, etc.).

Culturally Appropriate — set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, and interpersonal styles.

Effective — prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Evaluation — systematic investigation of the value and impact of an intervention or program.

Evidence-based — systematic selection, implementation, and evaluation of strategies, programs and policies with evidence from the scientific literature that they have demonstrated effectiveness in accomplishing intended outcomes.

Gatekeepers — those people in a community who have face-to-face contact with large numbers of community members as part of their usual routine and are trained to identify people at risk of suicide and refer them to treatment or supporting services as appropriate.

GLBTQ — Gay, lesbian, bisexual, transgender or questioning

Goal — broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health Disparities — differences in a population’s health status that are avoidable and can be changed. These differences can result from social or economic conditions, as well as public policy.

Intervention — strategy or approach intended to prevent an adverse outcome or to alter the course of an existing condition.

Means — instrument or object used in a self-destructive act (i.e., firearm, poison, medication).

Means Restriction — techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Mental Disorder — diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with a person’s cognitive, emotional or social abilities

Mental Health — capacity of an individual to interact with others and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational)

Outcome — measurable change in the health of an individual or group of people that is attributable to an intervention

Prevention — strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Professional — somebody whose occupation requires extensive education or specialized training.

Rate — the amount of something expressed as a proportion of the total population.

Resilience — capacities within a person that promote positive outcomes, such as mental health and wellbeing, and that provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Resource — source of supply or support (e.g., technical assistance, training, funding, etc.).

Risk Factors — those factors that make it more likely that people will develop a disorder; risk factors may encompass biological, psychological or social factors in the person, family and environment.

Screening — use of an assessment tool to identify people in need of more in-depth evaluation or treatment

Stigma — object, idea, or label associated with disgrace or reproach.

Strategy — method or approach for achieving an end.

Suicidal Behavior — spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Suicidal Ideation — self-reported thoughts of engaging in suicide-related behavior.

Suicidality — term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide — death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person’s death.

Suicide Attempt — potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries

Survivors — People who have survived a prior suicide attempt.

Suicide Survivors — family members, significant others, or acquaintances who have experienced the loss of a loved one because of suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance — ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Vulnerable Youth — youth who have characteristics that may lead to future at risk behaviors.