WASHINGTON STATE'S PLAN FOR

Youth Suicide Prevention

2009

Data updated 2011

“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.

Washington State's Plan for
Youth Suicide Prevention
2009

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This publication is also available on the Department of Health website:
http://www.doh.wa.gov/hsqa/emstrauma/injury/

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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Washington State Department of Health

DOH 971-001 September 2011

Acknowledgements

Youth Suicide Prevention Steering Committee

Washington State's Plan for Youth Suicide Prevention came together through the active involvement of the Washington State Youth Suicide Prevention Steering Committee, a group of committed individuals representing survivors as well as organizations (public and private) whose work directly affects youth.

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STATE OF WASHINGTON

September 18, 2009

Dear Fellow Community Member:

We, the Washington State Youth Suicide Prevention Steering Committee, represent families and organizations committed to the well-being of youth.

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. Thanks to their efforts, youth suicide gained public attention and some funding for prevention work.

While new programs brought progress, suicide among youth in Washington persists. Our youth suicide rates remain higher than the national average. In the five-year period 2004–2008, 540 Washington youth ages 10–24 died by suicide. There were another 4,446 hospitalizations because of a suicide attempt.

Now is the time for renewed commitment to the prevention of youth suicide in Washington. We urge you to step forward with us in support of *Washington State's Plan for Youth Suicide Prevention 2009* by putting it to work in your communities and organizations. As you read this plan, take time to think about what you can do to take action, to help make the goals and objectives become real and alive.

Washington State's Plan for Youth Suicide Prevention does not belong to any one organization or community; it is written in a way that there is a place for everyone who wants to participate in youth suicide prevention.

Sincerely,

Washington State Youth Suicide Prevention Steering Committee

Deanne Boisvert

Leigh Manheim

Jeff Soder, M.ED

Sue Eastgard

Laura Porter

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September 18, 2009

Dear Washingtonians:

Suicide is the second leading cause of death for Washington State young people between the ages of 10 and 24. The attached plan describes our state's effort to combat this tragic problem.

Washington State's Plan for Youth Suicide Prevention (2009) is the result of hard work by citizens dedicated to the well-being of youth and the prevention of suicide. It is a guide for all Washingtonians to use no matter where they work or live. Suicide is both a community and personal tragedy that deserves our attention.

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.
We know that:

- Each week, on average, two Washington youth kill themselves.
- Each week, 17 more are hospitalized because of a suicide attempt.
- Nine percent of the 10th grade respondents to the 2008 Washington Healthy Youth Survey, or about 7,500 students, reported making a suicide attempt in the prior 12 months.
- Seventeen percent of 10th grade respondents, or about 14,000 students, reported thinking seriously about committing suicide.

This plan was written for everyone who wants to help our youth feel valued, find hope for the future, and succeed in life. As you read it, take time to think about what you can do to help us turn this plan into action. Together, we can make a difference when we prevent youth suicide.

Sincerely,

Mary C. Selecky
Secretary

Attachment

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“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

Executive Summary

Suicide is the *second* leading cause of death for Washington youth between the ages of 10 and 24.

On average, *each week in Washington:*[1, 2, 3]
Two youth kill themselves.
There are 17 hospitalizations of youth because of a suicide attempt.

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.

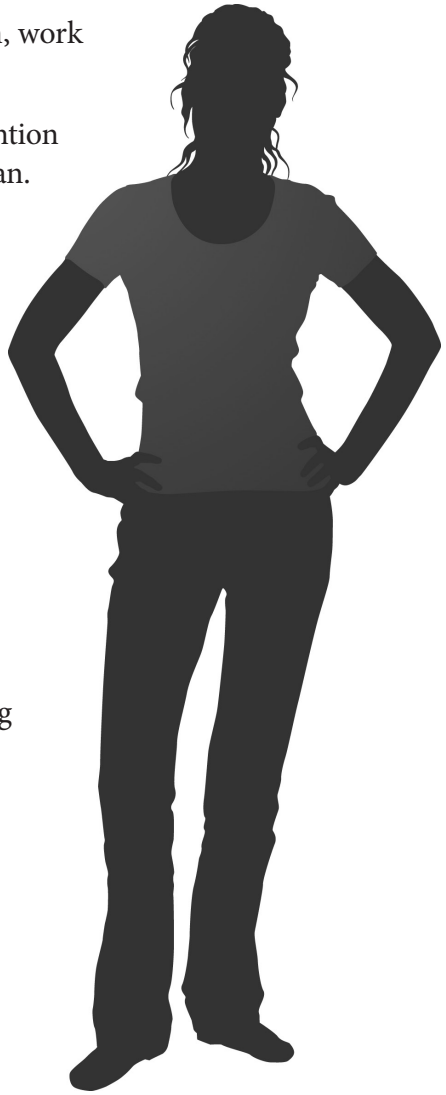
Preventing suicide takes many forms – from building strong, capable youth who are connected to families, friends and their communities, to teaching individuals to recognize suicide warning signs. It also includes increasing access to the medical-mental health treatment system.

Washington State's Plan for Youth Suicide Prevention describes a multi-layered approach to the problem. It details what individuals, organizations, and community or state agencies can do to prevent youth suicide.

Youth Suicide Prevention–1995 to 2009

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, funding 25 percent of the estimated cost of carrying out the full plan. In 1999, that funding was reduced to $250,000 per year and in 2009 to $175,000 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.
- In 1998, Washington State's Juvenile Rehabilitation Administration strengthens policies, practices and training for suicide prevention and intervention with youth served by JRA.
- 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.



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 attempt[4-8] or complete[9-13] suicide have a diagnosable mental illness. Many youth cannot get needed mental health care due to 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 10–24 (data from 2004–2006).[1]
- Forty-eight percent of all suicides by 10–24 year olds took place with a firearm (data from 2004–2006).[1]
- Responses to the 2010 Washington Healthy Youth Survey showed that 18 percent of 10th graders (about 15,000 students in the state) seriously thought about attempting suicide during the 12 months prior to the survey and that 7 percent of 10th graders (about 6,000 students in the state) made 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) had ever seriously considered killing themselves and that 5 percent (almost 4,000 students in the state) had ever tried to kill themselves.[14]
- In 2006, the suicides of 120 Washington youth ages 10–24 cost an estimated $231 million in medical costs and lost future productivity. The 892 hospitalizations due to attempted suicides cost $18 million in medical care and lost short-term productivity. [15]

The Goals of Washington State's Plan for Youth Suicide Prevention will guide our work in Washington during the next five years. They represent the best thinking of the Youth Suicide Prevention Steering Committee, reflect national research and experiences of other states, and use 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 10–24 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 others 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 and mental health treatment systems.

Youth suicide prevention includes bringing communities together to address the many factors that lead individuals 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 suicide rates.

There is a place for everyone in suicide prevention. For example: an individual may look at this plan and see how he or she can learn the warning signs of suicide and help a youth; 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 cannot stop suicide from happening. The *Spectrum of Prevention* (see Appendix E) 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 individuals.

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 (YSPP), a private, non-profit organization, was founded. In addition to its many other activities, YSPP recently developed, implemented, and evaluated two courses that teach students to cope with stress, 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 10–24, 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 attempted[4-8] or completed suicide[9-13] 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.

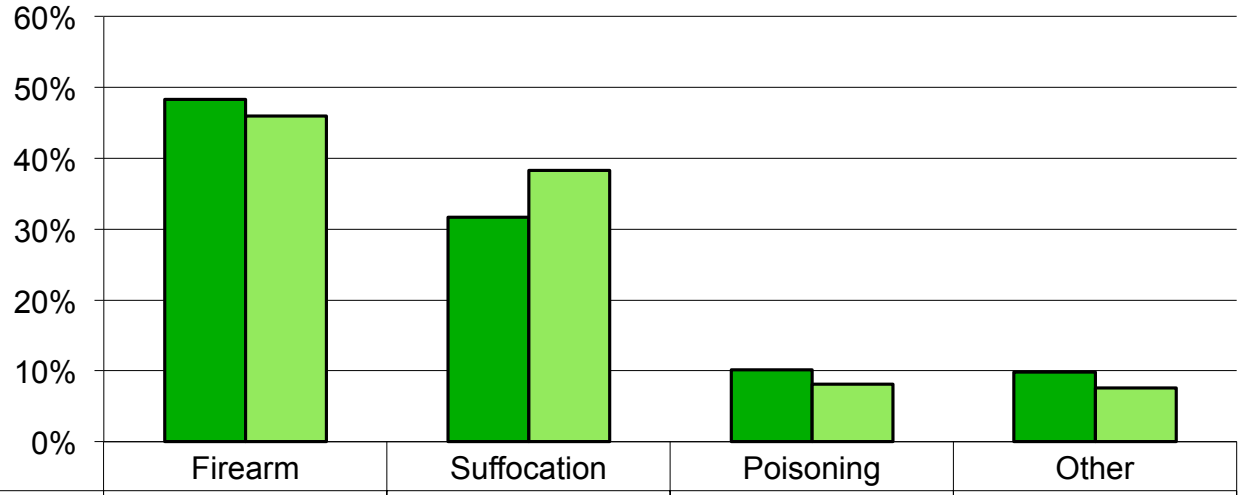
Youth Suicide Patterns in Washington

n Washington State and the United States there was no significant change in the rate of suicides (for youth 10–24) from 1999 to 2008.

From 2004–2008, 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 10–24 years of age and the third leading cause of death nationally (see Figure A in Appendix B).
- The suicide rate for 10–24 year-olds in Washington was 8.0 per 100,000. This is above the national average of 6.9 per 100,000.
- Forty-eight percent of all suicides among 10–24 year olds in Washington state, and 46 percent nationally, were completed with a firearm (see Figure 1).
- In Washington, firearms were used in 54 percent of male suicides and in 37 percent of female suicides (see Figure B in Appendix B). Nationally, firearms were used in 52 percent of male suicides and 29 percent of female suicides.

Figure 1 Method of Suicide, Ages 10 – 24 Washington State and United States: Years 2004 – 2008



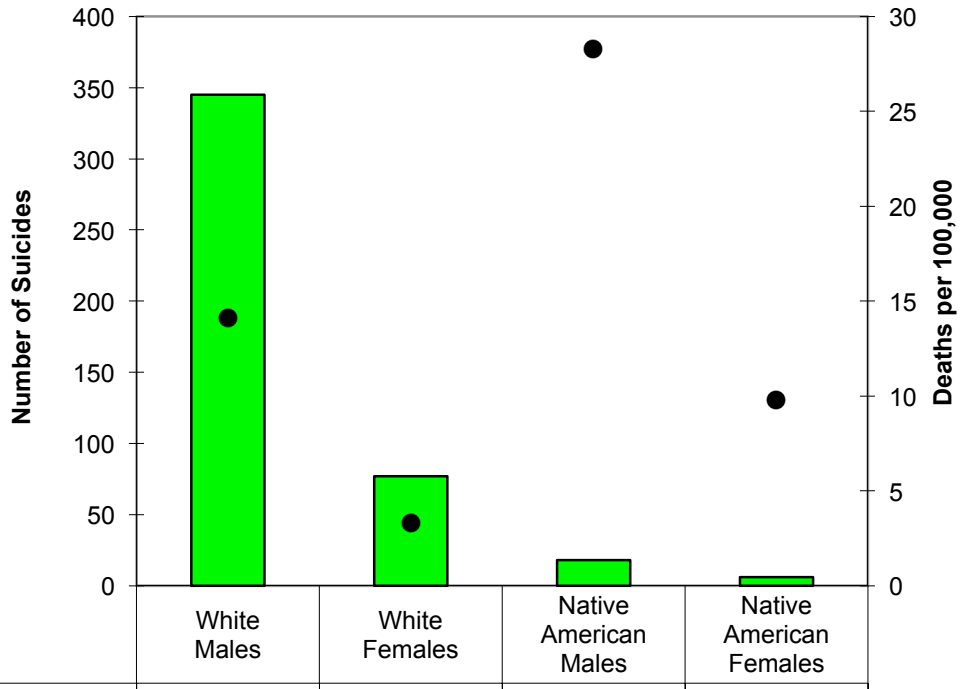
	Firearm	Suffocation	Poisoning	Other
Washington	48.3%	31.7%	10.2%	9.8%
United States	46.0%	38.3%	8.1%	7.6%

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2009) Available from URL: www.cdc.gov/injury/wisqars

More Facts About Youth Suicide in Washington:

- There were nearly twice as many suicides as homicides among youth ages 10–24 (data from 2004–2008).[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 10th graders (about 15,000 students in the state) seriously thought about attempting suicide during the 12 months prior to the survey and that 7 percent of 10th graders (about 6,000 students in the state) made 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) had ever seriously considered killing themselves and that 5 percent (almost 4,000 students in the state) had ever tried 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



	White Males	White Females	Native American Males	Native American Females
# of Suicides	345	77	18	6
Death Rate	14.1	3.3	28.3	9.8

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2009) 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 adjusted to Washington State, the average cost for 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 that results in hospitalization 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 Washington State in 2006 for youth 10-24 years old are as follows:

- With 120 youth suicides, there was an estimated $231 million in medical costs and lost future productivity.
- With 892 hospitalizations due to suicide attempts, there was an estimated $18 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 who reflect the communities they serve, and should train all staff 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.

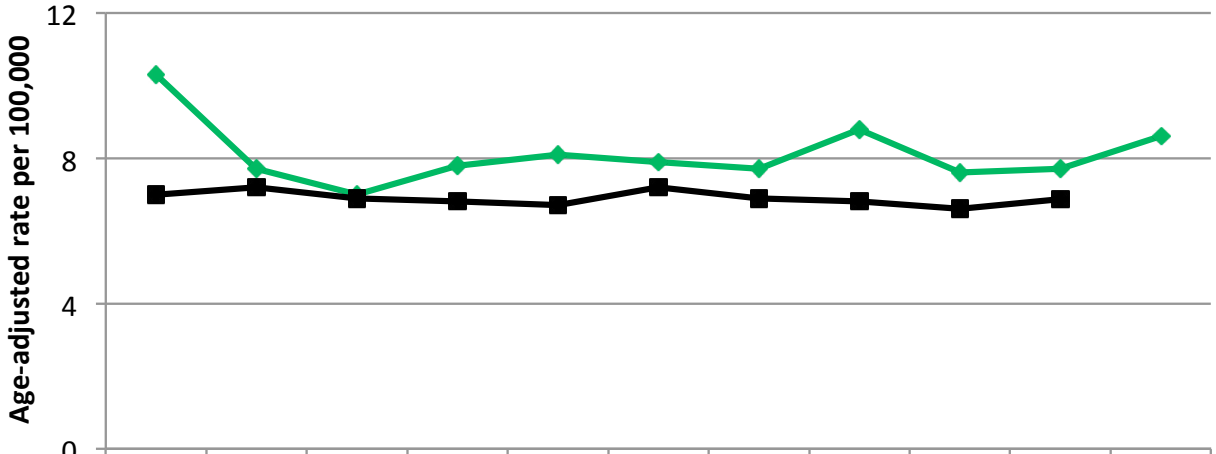
Warning Signs

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 2009

We hope we can continue on the downward trend and that we can decrease youth suicide and suicidal behaviors. Suicide among youth in Washington persists. Although lower than in 1995 when the first Youth Suicide Prevention State Plan was written, suicide rates for Washington youth remain higher than the national average (see Figure 3).

Figure 3 Comparison of Suicide Rates, Washington State and United States: 1999 – 2009



	99	00	01	02	03	04	05	06	07	08	09
Washington	10.3	7.7	7.0	7.8	8.1	7.9	7.7	8.8	7.6	7.7	8.6
United States	7.0	7.2	6.9	6.8	6.7	7.2	6.9	6.8	6.6	6.9	

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010) 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 2009 plan into action, we can reflect on the past 14 years and what we have learned about suicide prevention in Washington:

- We need to involve youth in suicide prevention activities, including public education. Young people often develop and promote some of the best messages.
- It takes strong leadership to successfully bring together people and resources – at the state, tribal, and community levels.
- Raising awareness about the problem of suicide is an on-going effort, not a one-time event.
- Providing local and state data and personal stories to describe the impact of suicide are essential. This makes it more real for people.
- Training adults to intervene early with youth who show the warning signs of suicide is effective.
- Adults, such as counselors, who we typically think have the skills to recognize and intervene with suicidal youth, too often do not get this training in their formal education.

- Teaching youth coping skills for the stress they face – and skills in how to help a friend and how to ask for help – is an effective prevention strategy.
- It is important that administration and leadership – at all levels – support agency, community and individual level prevention work.
- Youth look to various forms of media – including the Internet – for information. We need to respond through these media networks.
- Suicide prevention professionals cannot do this alone. The resources of other disciplines, such as education, mental health, victim services, substance abuse prevention, and community networks, must be involved if we are to effectively address suicide.

There is now national leadership and resources to support suicide prevention work. The United States 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 Suicide*[31] was released. In 2001, the *National Strategy for Suicide Prevention*[32] was developed to guide work in many states and communities. Both of these documents (see Appendix G) informed the strategies, objectives, activities and outcomes developed in Washington's 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:

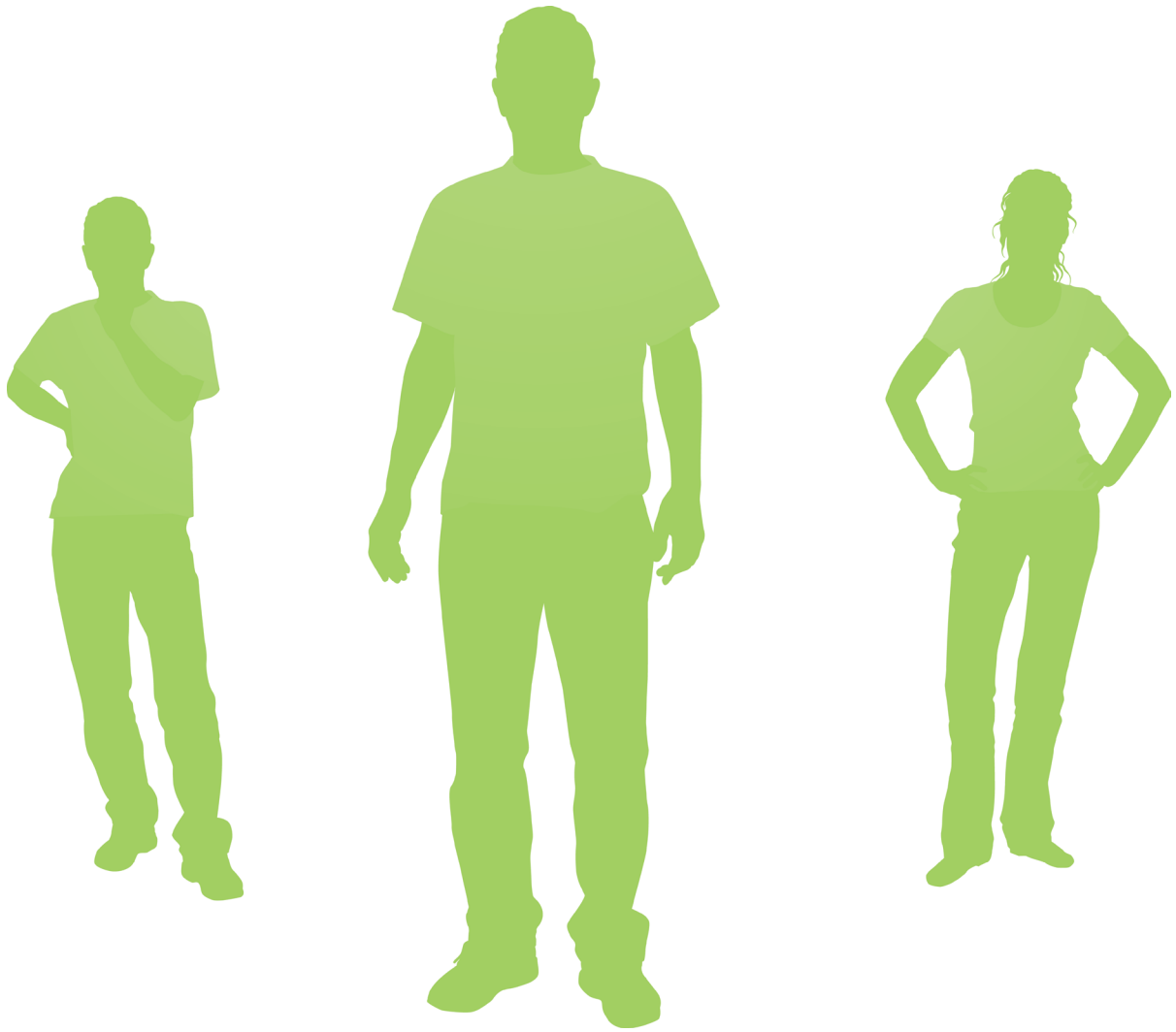
Goal 1— ***Suicide is recognized as everyone's business.***

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 Local Youth Suicide Prevention Programs

AREA OF ACTION	WHAT WASHINGTON CAN DO 2009 – 2014 OBJECTIVES
POLICY	**1.** Increase funding for suicide prevention programs.
ORGANIZATIONAL PRACTICES	**2.** Increase the number of local youth-focused groups who adopt programs that address suicide prevention and intervention.
COALITIONS AND NETWORKS	**3.** Increase the number of local coalitions, task forces, and networks that advance suicide prevention programs.
PROFESSIONAL EDUCATION	**4.** Increase the community mobilization skills of people who develop local suicide prevention programs.
COMMUNITY EDUCATION	**5.** Increase the availability of data and other information that local communities can use to show the need for youth 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 Treatment

AREA OF ACTION	WHAT WASHINGTON CAN DO 2009 – 2014 OBJECTIVES
POLICY	**1.** Increase the number of schools (high schools, middle schools, colleges) that teach about coping with stress, and that have policies for connecting students to mental health services.
ORGANIZATIONAL PRACTICES	**2.** Increase the number of social service organizations that include the 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.** Increase the knowledge and skills of people who work with youth so that they can encourage help-seeking behavior.
COMMUNITY EDUCATION	**5.** Increase the number of people who view mental health issues as problems that can be successfully treated.
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 Prevention and Intervention

AREA OF ACTION	WHAT WASHINGTON CAN DO 2009 – 2014 OBJECTIVES
POLICY	**1.** Increase the number of licensed and certified health professions that require knowledge and skills in suicide assessment and intervention.
ORGANIZATIONAL PRACTICES	**2.** Increase use of guidelines for assessment of suicidal risk in primary health care settings, emergency departments, and mental health and substance abuse treatment centers.
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 the number of education opportunities specifically for people who have close relationships with youth at risk for suicide.
INDIVIDUAL KNOWLEDGE AND SKILLS	**6.** Increase the number of people who report more knowledge and skills in recognizing and reaching out to those at risk of suicide.

GOAL 4

Care is Available for Those Who Seek It

Increase Access to Preventive Care
and Intervention Services

AREA OF ACTION	WHAT WASHINGTON CAN DO 2009 – 2014 OBJECTIVES
POLICY	**1.** Increase the number of individual and small-business health insurance plans that cover mental health and substance abuse care at the same level as physical health care *(mental health parity)*.
ORGANIZATIONAL PRACTICES	**2.** Adopt guidelines for screening of depression and suicide risk in primary health care settings, schools, and colleges.
COALITIONS AND NETWORKS	**3.** Increase the number of local groups that promote access to prevention and intervention services for the youth in their community.
PROFESSIONAL EDUCATION	**4.** Increase the number of health professionals who are skilled at recognizing and talking with youth about suicidal thinking and behavior.
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 individuals 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 2009 – 2014 OBJECTIVES
POLICY	**1.** Increase the number of reviews of youth suicide attempts and completions as a way of improving intervention and prevention services.
ORGANIZATIONAL PRACTICES	**2.** Create or revise school crisis plans to include suicide prevention and intervention strategies that ensure rapid response to suicidal youth and their peers.
COALITIONS AND NETWORKS	**3.** Create and maintain a state coalition that advances the goals and objectives of Washington State's Plan for Youth Suicide Prevention.
PROFESSIONAL EDUCATION	**4.** Increase the number of health care organizations that promote Washington State's Plan and that promote suicide prevention among their membership.
COMMUNITY EDUCATION	**5.** Increase the number of youth-serving programs that are aware of Washington State's Plan and that incorporate strategies from the implementation plan into their work.
INDIVIDUAL KNOWLEDGE AND SKILLS	**6.** Create opportunities for individuals to learn about youth suicide prevention, Washington State's Plan, and their role in prevention efforts.

Next Steps

- We will use 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. We need to promote and support institutional models, such as comprehensive training and screening implemented in the Juvenile Rehabilitation Administration.
- 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 alcohol[34] — 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. Overtime, 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.

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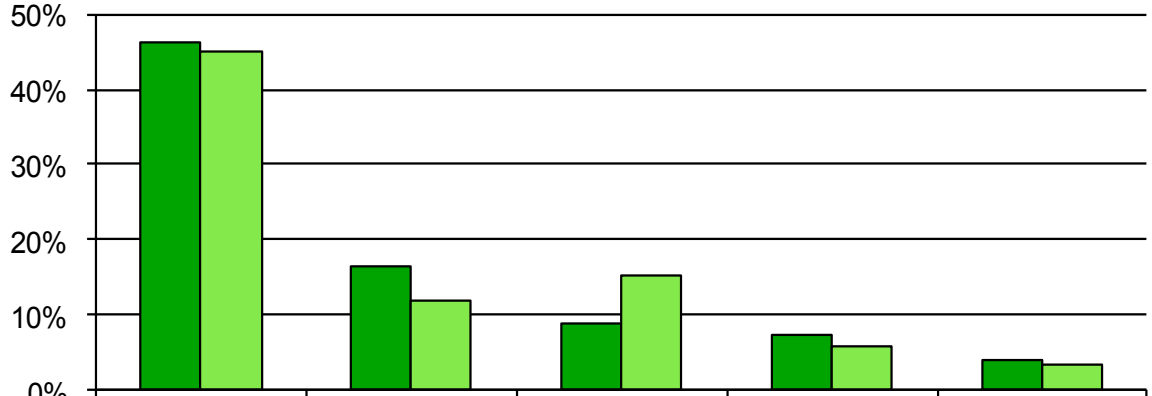
APPENDIX B: Youth Suicide Data Charts and Tables

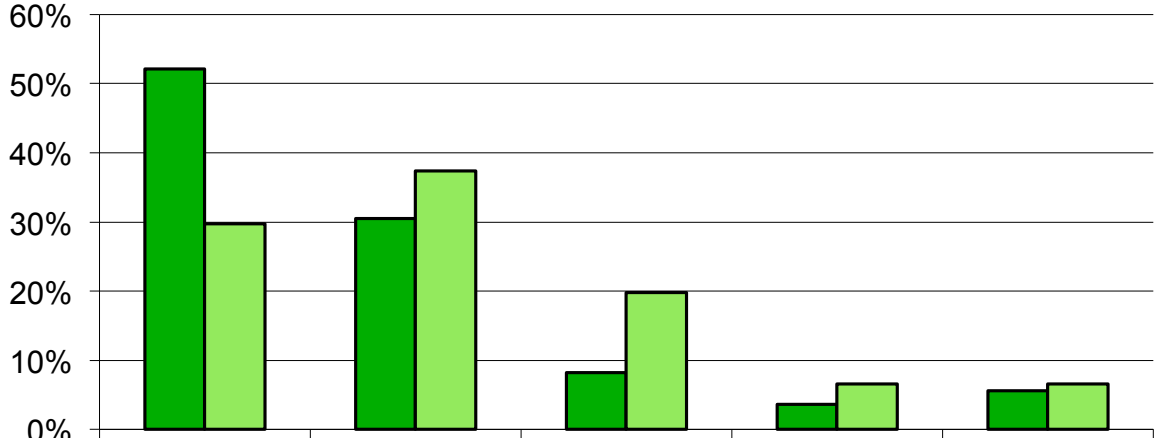
Figure A. Leading causes of death for 10–24 year olds Washington State and United States: 2004 – 2008



	Unintentional Injury	Suicide	Homicide	Cancer	Heart Disease
Washington	46.3%	16.5%	8.7%	7.2%	3.8%
United States	44.9%	12.0%	15.1%	5.8%	3.3%

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2011) Available from URL: www.cdc.gov/injury/wisqars. Accessed September 21, 2011

Figure B. Leading methods of suicide for males and females in Washington State 2004 – 2008



	Firearm	Suffocation	Poisoning	Fall	Other
Males	52.1%	30.5%	8.2%	3.6%	5.6%
Females	29.7%	37.4%	19.8%	6.6%	6.6%

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

Suicides
Washington Residents Ages 10–24
Years 2004–2008
By county by descending rate per 100,000 population

County	Count	Rate
Stevens	7	16
Clallam	7	11.7
Yakima	32	11.6
Grant	11	11.2
Kitsap	28	10.6
Pierce	91	10.6
Spokane	49	9.8
Franklin	8	9.7
Thurston	24	9.7
Walla Walla	7	9.7
Whatcom	20	8.5
Cowlitz	8	8
Lewis	6	7.8
Island	6	7.8
Clark	30	7
Snohomish	47	6.7
Benton	11	6.1
King	108	6.1
Skagit	5	4.2
Garfield	1	*
Wahkiakum	1	*
Columbia	1	*
Ferry	2	*
Skamania	2	*
San Juan	2	*
Asotin	3	*
Lincoln	1	*
Pacific	2	*
Jefferson	2	*
Pend Oreille	1	*
Mason	4	*
Klickitat	1	*
Douglas	2	*
Kittitas	3	*
Adams	1	*
Grays Harbor	3	*
Chelan	2	*
Okanogan	1	*
Whitman	0	*
Washington State	540	8

Hospitalizations * due to Attempted Suicide
Washington Residents Ages 10–24
Years 2004–2008
By county by descending rate per 100,000 population

County	Count	Rate
Cowlitz	174	170.4
Ferry	9	123.3
Yakima	265	96.2
Spokane	456	89.7
Benton	161	89.6
Walla Walla	59	82.2
Okanogan	33	80.2
Kitsap	211	80.1
Adams	17	71.9
Chelan	53	71.2
Clallam	43	71.0
Franklin	57	69.6
Skagit	80	67.2
Pierce	562	65.3
Grays Harbor	46	63.0
Clark	261	61.3
Thurston	144	58.7
Whatcom	137	58.5
Snohomish	403	57.6
Mason	28	56.7
King	987	55.2
Grant	53	54.7
Douglas	20	52.2
Island	40	51.9
Jefferson	10	51.7
Stevens	19	49.9
Klickitat	9	46.1
Pacific	8	45.5
Pend Oreille	5	44.8
Lewis	35	44.6
Asotin	9	43.8
Whitman	33	37.1
Kittitas	9	15.1
Garfield	1	*
San Juan	4	*
Columbia	1	*
Skamania	2	*
Lincoln	2	*
Wahkiakum	0	*
Washington State	4,446	65.5

* Rate not calculated for values < 5

Data sources: Washington State Department of Health, Center for Health Statistics, Comprehensive Hospital Abstract Reporting System – 2011
Population source: Washington State Office of Financial Management with DSHS/DOH 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 http://www.yspp.org

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 themselves.
- 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 http://www.yspp.org *or* http://www.suicidepreventionlifeline.org

APPENDIX D: Best Practices for Suicide Prevention

The Best Practices Registry (BPR), managed by the Suicide Prevention Resource Center (SPRC), identifies, reviews, and disseminates information about best practices that address specific objectives of the 2001 National Strategy for Suicide Prevention.

The BPR has three sections that include different types of programs and practices reviewed according to specific criteria for that section. BPR listings include only materials submitted and reviewed according to the designated criteria and do not represent a comprehensive inventory of all suicide prevention initiatives. See listings at http://www.sprc.org/featured_resources/bpr/index.asp

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.

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 impact.
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 an individual's capability of preventing injury or illness and promoting safety.

Prevention Institute

APPENDIX F: Suicide Prevention Selected Milestones in Washington

1992
17 yr old Trevor Simpson (Edmonds) dies by suicide; parents become advocates for suicide prevention awareness and education.

1995
Youth Suicide Prevention State Plan completed. Legislature funds Dept of Health (DOH) youth suicide prevention work ($1M per biennium) – demonstration project begins.

1996
Spokane based Question, Persuade and Refer (QPR) training institute for suicide prevention established.

1998
Washington State's Juvenile Rehabilitation Administration strengthens policies, practices and training for suicide prevention and intervention with youth served by JRA.

1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998

Late 80's
Safe Schools Coalition: advocacy for sexual minority youth; prevention of bullying/ harassment.

1992
WA State Survey of Adolescent Health Behaviors includes questions about suicide.

1994
Suicide prevention becomes a priority for Family Policy Council & Community Network.

1995
17 yr old Craig Toribara (Spokane) completes suicide. Family starts *Students Mastering Important Lifeskills Education (SMILE)* - a non-profit organization that supports families who have lost a child to suicide and provides education about suicide prevention.

Additional Contributions to Youth Suicide Prevention in Washington State

1994	University of Washington School of Nursing develops Coping and Support Training (CAST) and implements in multiple school districts.
1994 - 2000	Spokane Regional Health District funds the new Spokane County Suicide Prevention Task Force – one of the earliest in the State.
1995	University of Washington School of Nursing develops and pilots a school-based suicide risk assessment tool – Measure Adolescent Potential for Suicide (MAPS).
1995 - 1999	University of Washington School of Nursing develops youth suicide prevention Media Campaign.
1996 - forward	Suicide prevention initiatives developed by Students Mastering Important Lifeskills Education (SMILE) – Spokane based non-profit suicide prevention organization: Self Acceptance is Life (SAIL) program for CampFire Inland Empire Council (1996-2002); Annual conferences began (2000); Starting Blocks CD on youth topics (2006); Grieving Resources booklet for families (2007).
1999	University of Washington School of Nursing expands MAPS tool to include young adults.

1999

Youth Suicide Prevention Program (YSPP) established to lead statewide effort to reduce youth suicide.

2002

WA State Survey of Adolescent Health Behaviors expands to become the Healthy Youth Survey. Suicide questions continue.

2006-2009

Office of Superintendent of Public Instruction (OSPI) funds school-based suicide prevention curriculum - Help Every Living Person (HELP) curriculum .

2006 – 2009

WA DOH receives 3 year youth suicide prevention grant from the federal Substance Abuse & Mental Health Administration. Grant is funded by the Garrett Lee Smith Memorial Act (GLSMA).

1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009

1999

State funding for Suicide Prevention eliminated but community advocacy results in $500,000 per biennium being restored.

2000

Family Policy Council begins regular education about suicide & suicide prevention for community coalition leaders.

2005

13 year old Paul Icenogle dies by suicide. Family advocates with legislators to fund bullying policy impact study.

2006

DSHS Div. of Alcohol & Substance Abuse (DASA) made suicide prevention a priority.

2007

Veterans Administration receives federal funding for suicide prevention.

2008

State Legislation on School Safety Plans implemented but lacks directive for suicide prevention and intervention.

1999	University of Washington School of Nursing conducts follow-up study to measure effectiveness of CAST training.
2001	University of Washington School of Nursing implements (CARE) intervention which uses the MAPS tool for individual student assessment. Parents involved.
2003	CeaseFire Organization's Washington chapter leads Asking Saves Lives (ASK) campaign to address the risks of having guns in the homes of children and youth.
2004	University of Washington School of Nursing works with Johns Hopkins University to study the use of civility and intent in decreasing bullying and dehumanization.
2005	Harborview Injury Prevention Research Center study shows that locking firearms reduces teen suicide. JRA develops a Suicide and Self-Harm Treatment training for case managers.
2006	University of Washington School of Nursing begins middle school suicide prevention project.
2007	JRA's Suicide Risk Assessment tool is revised in collaboration with Dr. André Ivanoff of Columbia University.

APPENDIX G: 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. The document can be found at www.surgeongeneral.gov/library/calltoaction/.

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 – DOH Publication No: 530-090
www.doh.wa.gov/hsqa/emstrauma/injury/pubs/icpg/default.htm

Northwest Suicide Prevention Tribal Action Plan 2009 – 2013

This plan 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. The complete document can be found at:
www.npaihb.org/images/healthissues_docs/suicide/NW%20Tribal%20Suicide%20Action%20Plan%202009.pdf

APPENDIX H: Glossary

Access— the ability to gain admittance to an array of treatments, services and supports; consumers know how and where to obtain 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 individuals 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 persons at risk of suicide and refer them to treatment or supporting services as appropropriate.

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 an individual's cognitive, emotional or social abilities; often used interchangeable.

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 well-being, and 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 individuals will develop a disorder. Risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening— use of an assessment tool to identify persons 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— individuals who have survived a prior suicide attempt.

Suicide Survivors— family members, significant others, or acquaintances who have experienced the loss of a loved one due to 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.

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