

Issue Brief



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Youth Suicide Prevention: Strengthening State Policies and School-Based Strategies

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Summary

Every year almost 30,000 Americans complete suicide. More than 10 times as many are hospitalized or treated following a suicide attempt. Although the overall suicide rate has declined over the past 20 years, from 12.1 per 100,000 in 1979 to 11.3 per 100,000 in 1998, the suicide rate increased by more than 100 percent for adolescents 10 to 14 years old, and by six percent for teens 15 to 19 years old, during that time period.¹ Today, suicide is the third leading cause of death of Americans aged 15 to 24—surpassing unintentional injury and homicide. States spend more than \$900 million annually on medical costs associated with suicides and suicide attempts by youths up to 20 years of age.²

Increasingly, state policymakers are looking for ways to strengthen suicide prevention efforts. Governors in states such as **Colorado, Florida, Kansas, Maine, and Montana** have raised awareness about suicide as a public health concern and initiated the development of state suicide prevention policies. Other states—**Maine, Virginia, and Washington**—have created model statewide suicide prevention plans and funded prevention programs.

While schools and other youth-serving institutions often find themselves on the front lines of the battle against youth suicide, states have an important role to play by providing resources, training, and strategic planning assistance. Actions for Governors and other state policymakers to consider include:

- **Increasing public awareness**—using the gubernatorial bully pulpit to raise awareness of suicide as a leading cause of death among adolescents and young adults.
- **Crafting state prevention plans**—designing a statewide suicide prevention (or injury prevention) plan that spans all age groups, but includes a youth-specific component.
- **Establishing school-based prevention programs**—giving schools a larger role in suicide prevention efforts, including education and awareness training, mental health screenings/evaluations (which can be controversial), mental health services, and referral systems.
- **Dedicating resources**—funding a state suicide prevention office, a suicide/injury prevention coordinator, and “gatekeeper” training for teachers and other youth-serving professionals.
- **Stimulating multi-agency and multi-sector collaboration**—fostering collaboration among key state agencies (i.e., education, health, human services, and public safety) and between government and

community partners to target youth in a variety of settings (including schools) through multi-faceted and comprehensive injury prevention strategies.

Background

Among all age groups in the United States in 2001, suicide was the 11th leading cause of death. For every two homicides, there are three suicides. The incidence of suicide among adolescents and young adults tripled between 1952 and 1995 (although it has declined slightly since the mid-1990s). Today, suicide is the third leading cause of death for Americans aged 15 to 24. Suicide deaths are four to six times more prevalent among males than females in that age group, but females are more likely to attempt—and not complete—suicide.

WHAT IS SUICIDE?

Suicide is a fatal, self-inflicted, destructive act of an individual with explicit or inferred intent to die. Suicide is the 11th leading cause of death in the United States.

- Nearly 30,000 deaths a year, or 85 deaths a day, occur as a result of suicide.
- Suicide is 33 percent more prevalent than homicide (3 to 2 ratio).
- Risk factors for suicide are:
 - *Biopsychosocial*: Mental and substance abuse disorders, history of trauma/abuse, major physical illness, previous attempt, impulsive/aggressive tendencies, family history, and/or hopelessness.
 - *Sociocultural*: Lack of support, barriers to access of care, cultural/religious beliefs, sense of isolation, and/or stigma.
 - *Environmental*: Financial, job, or relational loss, and/or local suicide clusters.

WHO IS IMPACTED?

- Suicide is the third leading cause of death for people aged 15 to 24.
- Men are four times more likely to die as a result of suicide, but women are more likely to attempt suicide.
- White men account for 73 percent of all suicides.
- Native Americans have a higher incidence of suicide than other groups.
- The elderly have a higher incidence of suicide due to depression, chronic illness, and social isolation.
- Gay, lesbian, and bisexual youth are two to three times more likely to attempt suicide.
- Youth who report using alcohol or illicit drugs evidence a higher likelihood of committing suicide.
- Ninety percent of persons that attempt or commit suicide suffer from a diagnosable mental disorder.

--“Suicide Backgrounder,” NGA Center for Best Practices, 2003

The Centers for Disease Control and Prevention’s (CDC) 2003 Youth Risk Behavior Survey reports that 17 percent of high-school students had seriously considered attempting suicide during the previous 12 months, 16.5 percent had made a suicide plan, and 8.5 percent had actually attempted suicide.³ Risk factors for suicide include previous suicide attempts, mood disorders, substance abuse, geographic relocation, and proximity to a stress event (such as disappointment, rejection, or a disciplinary action).

The Children’s Safety Network estimates that the medical cost of suicide for Americans aged 0 to 20 approaches \$1 billion a year. Estimating lost future earnings and impacts on quality of life brings the total annual cost to more than \$15 billion.⁴ Suicide-related costs are borne disproportionately by rural states, particularly those in the West. For instance, from 1999 through 2001, states with the highest incidence of suicide deaths among those aged 15 to 24 included (in ranking order): Alaska, South Dakota, New Mexico, Wyoming, Idaho, Montana, Colorado, Nevada, and Arizona.⁵

The first National Suicide Prevention Conference was held in 1998, followed by the Surgeon General’s *Call to Action to Prevent Suicide*. In 2001, the U.S. Department of Health and Human Services (HHS) published a *National Strategy for Suicide Prevention*, offering 11 goals and associated objectives for action. The strategy

outlines a three-pronged suicide prevention model consisting of universal, selective, and indicated interventions. By definition, universal interventions, such as public education programs, are designed to expose everyone in a defined population to suicide prevention. Selective interventions, which might include suicide education programs, target specific subgroups at particular risk for suicide. Indicated interventions are intended for specific individuals who have evidenced a risk factor or condition that puts them at high risk for suicide. These interventions include screening and treatment for depression.⁶

The *National Strategy for Suicide Prevention* recommends that the education community become more involved in preventing suicide by:

- Participating in public-private partnerships to develop broad-based support for suicide prevention and incorporate suicide prevention activities into the mission of schools.
- Increasing the number of evidence-based suicide prevention programs in schools and at colleges and universities.
- Providing awareness training to key gatekeepers, such as teachers, school nurses, and resident assistants on college campuses, to enable them to identify and recognize factors that place students at risk for suicide and learn appropriate interventions.⁷

These recommendations are echoed by the President’s New Freedom Commission on Mental Health final report on mental health care in America, issued in 2003. Its recommendations include a call to implement and enhance the *National Strategy for Suicide Prevention* to serve as “a blueprint for communities and all levels of government.” The report also points to a larger role for schools in identifying and preventing mental health problems.

The Role of Schools in Suicide Prevention

Schools, as part of a community team, must play a larger role in suicide prevention. Many simply do not have the capacity or the resources to address this issue, and most educators and school officials do not have the skills to recognize the warning signs of suicide. A July 2004 poll by the Annenberg Public Policy Center of the University of Pennsylvania found that only one-third of high school staff members believed that their schools had a “clearly defined and coordinated process for identifying students who may have a mental-health condition.” And a recent National Household Survey on Drug Abuse found that only 36 percent of young people at risk for suicide had received mental health treatment or counseling during the past year.⁸

In addition, too few schools educate students about suicide. The CDC’s 2000 School Health Policies and Programs Study found that less than half the states require suicide prevention to be taught in at least one school grade.⁹

Last year’s report from the President’s New Freedom Commission on Mental Health underscores the increasing impact of students’ mental health problems on schools. It notes 5 to 9 percent of school-aged children suffer from serious emotional disorders, and only 42

Gatekeepers

A cornerstone of effective suicide prevention programs is the use of “gatekeepers” to spot at-risk youth. According to the *National Strategy for Suicide Prevention*, “Gatekeepers, those people who regularly come into contact with individuals or families in distress, must be trained to recognize behavioral patterns and other factors that place individuals at risk for suicide and be equipped with effective strategies to intervene before the behaviors and early signs of risk evolve further.” States such as **Virginia** have drafted guidelines for schools to use in developing gatekeeper-training programs. Virginia’s guidelines include allowing the use of Safe and Drug-Free Schools funding to participate in research-based gatekeeper-training workshops. The program first educated school-nurse coordinators as trainers, who now provide training to other school nurses in recognizing and assessing at-risk youth.

percent of those students eventually graduate from high school. The report argues that school-based mental health interventions can improve educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores. It recommends that schools take more proactive steps to identify students who are grappling with mental health problems. These efforts can include creating a state-level structure to drive collaboration between the education, public health, and mental health systems; providing mental health services in school-based health centers; and improving collaboration between schools and mental health agencies to help children with serious emotional disorders transition from school to work or to postsecondary education.¹⁰

One useful diagnostic tool for schools featured in the Commission's report is Columbia University's TeenScreen program. Currently operating in 36 states, the program's goal is to ensure that every student receives a mental health check-up prior to graduating high school. The centerpiece of the program is a screening tool that identifies teens who suffer from depression and are at risk for committing suicide.¹¹ Columbia University does not charge a fee to implement the program and is currently offering free, customized screening applications to states, including software, materials, training, technical assistance, and consultation. However, since there are a number of ways to conduct the program, costs to states (primarily for staffing and computers) vary widely. State officials in **Florida, Nevada, New Mexico, and Ohio** are currently partnering with TeenScreen to check high school students for mental health problems before they graduate.¹²

Another promising program is the Signs of Suicide (SOS) high-school suicide prevention program. It incorporates two successful suicide prevention approaches in a single program by raising awareness of suicide and screening for depression and other risk factors associated with suicide. According to Screening for Mental Health, the nonprofit organization that created SOS in conjunction with several school-based professional organizations, the program can be offered at a cost of 50 cents per student.

SOS is the first school-based suicide prevention program shown to reduce suicide attempts in a randomized controlled study published in the April 2004 edition of the *American Journal of Public Health*. The study found that SOS reduced suicide attempts by 40 percent in high school students exposed to the program, based on data from five high schools in Hartford, Connecticut, and Columbus, Georgia.¹³ SOS was also recently named as a "promising program" by the Substance Abuse and Mental Health Services Administration (SAMHSA).

State Support for Suicide Prevention Programs

Many states are already engaged in suicide prevention and have devoted significant resources to this issue. More than half of the states have developed suicide prevention plans, many of them in response to the Surgeon General's 1999 *Call to Action*. At least 12 states have prevention plans with a specific youth focus. **Maine** and **Washington** were early leaders in this effort. Seventeen states have a full-time suicide prevention coordinator. A handful of states, including **Minnesota** and **Ohio**, even have dedicated budget line items for suicide prevention programs.

States can assist schools by financing training for teachers, school nurses, and other gatekeepers to help them identify factors that place students at greater risk for suicide and teach them appropriate interventions. States can also require, fund, and craft design principles for suicide prevention programs. Effective programs—generally offered in high schools—strive to increase awareness of suicide, describe available treatment or counseling resources, and provide knowledge about suicide warning signs. However, because most programs assume that all teenagers are vulnerable to suicide, generally they do not target those truly at-risk.¹⁴

However, not all state plans are comprehensive or involve all key stakeholders, including schools and educators. Greater capacity is needed within state agencies to provide direction and technical assistance to

schools and school districts as they respond to this public health challenge. The National Suicide Prevention Resource Center (SPRC), established in October 2002, can help states build their capacity to develop, implement, and evaluate suicide prevention programs and promote partnerships. In collaboration with other leading national suicide prevention organizations, the center aims to provide technical assistance, training, and information to strengthen suicide prevention networks and advance the National Strategy for Suicide Prevention.¹⁵ The center is funded by HHS and SAMHSA and is located at the Educational Development Center in Newton, Massachusetts.

Actions for Governors and State Policymakers

There are five broad areas in which Governors and other state officials can take action to address suicide prevention. These are: increasing public awareness of the problem; initiating, supporting, or participating in a statewide suicide prevention planning effort; giving schools a greater role in identifying youth at risk for suicide and in providing needed education, referrals, and services; appropriating dedicated funding for suicide prevention leadership, planning, and training; and fostering state-level collaboration between agencies with a role in prevention efforts.

Increasing public awareness—using the gubernatorial bully pulpit to raise awareness of suicide as a leading cause of death among adolescents and young adults.

Governors have a unique ability among state policymakers to focus public attention on policy issues. Simple steps such as declaring a state suicide awareness week can raise the profile of this issue among the public and key policymakers. Even better, Governors can use such a declaration as a launching pad for a larger effort to quantify the state's suicide problem and begin to develop policy responses to address it. In addition, seed money can help state agencies to disseminate information about suicide and jump start the state planning process.

Crafting state prevention plans—designing a statewide suicide prevention (or injury prevention) plan that spans all age groups but includes a youth-specific component.

More than 25 states have suicide prevention plans in place; others have plans in development. Some states have created youth-specific prevention plans, and some have incorporated strategies for youth suicide prevention within a broader plan that addresses all age groups. Gubernatorial leadership can be useful in convening a committee or task force to initiate this process and subsequently providing momentum to enact and implement recommended policies. State plans generally include public education, mental health evaluation and treatment, gatekeeper training programs, specialized curricula for out-of-school youth and those at-risk of becoming dropouts, and reduced access to lethal means of self-harm (such as safety wrapping on pill containers). It should be noted that communities must have the appropriate infrastructure (referrals and available services) in place before instituting an evaluation program.

Establishing school-based prevention programs—giving schools a larger role in suicide prevention efforts, including education and awareness training, mental health evaluations, mental health services, and referral systems.

Across the nation, nearly one in five high-school students consider suicide every year, and more than one in 12 attempt it. Within communities, schools are a major point of contact for this age group and must play a central role in efforts to identify and prevent suicide among those students at greatest risk. Several federal reports and academic studies have identified and recommended a number of promising suicide prevention strategies, including gatekeeper training, suicide awareness education (including identifying suicide risks and warning signs), and mental-health evaluations. These publications have also articulated the effectiveness of a school-based suicide prevention strategy.

A number of states already partner with providers of some of these school-based suicide prevention services, encourage the integration of suicide prevention into comprehensive health education, and have state suicide prevention plans that speak to the importance of involving schools in these efforts. States already ask much from the education system, but well-structured suicide prevention efforts can relieve some of the burden by providing training to educators and administrators and adding capacity and systems to assist at-risk students.

Suicide prevention programs such as *Yellow Ribbon* provide a toolkit that helps:

- educators and administrators to review, update, and develop written policies and procedures for responding to suicidal warning signs, threats, attempts, and completions;
- educators and administrators to develop written policy and procedures for supporting school staff after a suicide completion;
- communities to understand and reduce the threat of contagion and cluster (or copycat) suicides; and
- schools and communities to incorporate and address the ethnic culture for successful suicide prevention.¹⁶

Dedicating resources—funding a state suicide prevention office, a suicide/injury prevention coordinator, and “gatekeeper” training for teachers and other youth-serving professionals.

States with model suicide prevention approaches have invested in building institutional capacity and developing a knowledge base within government, both to comprehend how suicide impacts the state’s youth and to assist and support schools and communities in responding to this crisis. Most states have charged a specific agency or body with responsibility for coordinating suicide prevention activities and carrying out the state plan. In many states, authority rests with the state health agency or a suicide prevention office within the agency. Other states have created independent suicide prevention councils or prioritized suicide prevention as part of the work of the Governor’s Children’s Cabinet. But dedicated funding can ensure that this issue is a priority for the responsible state entity and that resources are available for needed investments and interventions.

The cost of implementing a school-based program varies widely. The level of involvement can range from establishing a point-of-contact in a school to a million-dollar, multi-faceted effort. Costs also vary among more expensive school-wide initiatives and less expensive programs limited to a certain grade level. The cost of hiring staff (if necessary) fluctuates demographically.¹⁷ Some national suicide prevention programs offer start-up services free of charge. Others, such as The Jason Foundation, offer student curriculum kits (overheads, handouts, teacher manuals, and other materials) for a certain fee per kit.¹⁸

Stimulating multi-agency and multi-sector collaboration—fostering collaboration among key state agencies (i.e., education, health, human services, and public safety) and between government and community partners to target youth in a variety of settings (including schools) through multi-faceted and comprehensive injury prevention strategies.

State suicide prevention strategies require a lead agency, but also should use broad partnerships involving a mix of state agencies and non-government partners. The Maine Suicide Prevention Program is perhaps one of the best models of a state initiative that involves a multitude of public and private partners and effectively disseminates best practices in suicide prevention to local officials. Such an approach is needed to reach youth in a variety of locations—schools, after-school programs, public-health agencies, juvenile detention facilities—and to maximize available public and private funding to build an effective state youth suicide prevention strategy.

Highlighted State Suicide Prevention Initiatives

The CDC and other suicide prevention experts have identified **Maine** and **Virginia** as two leading states that have developed comprehensive, streamlined approaches to suicide prevention. Other states have acted to establish statewide suicide prevention councils, and at least 25 states have developed statewide suicide prevention plans. Over the last several years, a number of Governors have also demonstrated leadership on suicide prevention. Their actions have furthered state efforts to raise awareness and take action on this important public health issue.

Maine

Maine has a history of placing a high priority on suicide prevention. In 1998, three years after then-**Governor Angus King Jr.** appointed a Task Force on Adolescent Suicide and Self-Destructive Behaviors, the Maine Youth Suicide Prevention Program was established in statute. It is administered by five state agencies as a priority initiative of the Maine Governor's Children's Cabinet. The program has focused on increasing public awareness of suicide, established a 24-hour suicide hotline, trained educators and others who work with youth in prevention strategies, and encouraged the integration of suicide prevention information into comprehensive school health education.¹⁹ In addition, the CDC has granted the state of Maine \$900,000 over three years to develop a comprehensive, statewide suicide prevention plan. Maine is using CDC funding to implement and evaluate school- and community-based intervention programs in 10 local high schools and the communities they serve.²⁰

Virginia

Virginia developed a comprehensive statewide youth suicide prevention plan in 2001. In response to the plan's recommendations, the state Legislature designated the Department of Health as the lead state agency for carrying out the plan. The Virginia Youth Suicide Prevention Plan's recommendations include public awareness campaigns, gatekeeper training, suicide education licensing and certification requirements for youth-serving professionals, comprehensive mental health services, improved data gathering, and school-based strategies for at-risk youth.²¹ The CDC provided the state of Virginia with \$967,000 over three years to further implement activities under the plan.²² In addition, the state has allocated \$75,000 a year, including \$5,000 a year to five crisis centers, for brochures and other materials, as well as the suicide hotlines at the centers. Funding has also allowed Virginia to complete 500 gatekeeper trainings over the past two years at middle and secondary schools.²³

Alaska

Alaska's Statewide Suicide Prevention Council released a suicide prevention plan in early 2003 for public comment. The publication outlines 10 state goals for preventing suicide. It argues that suicide prevention is more effective when programs are long-term, with repeated opportunities to reinforce targeted attitudes, behaviors, and skills in places where people normally spend their time, such as schools. In addition, the plan recommends that the state support and expand suicide prevention programs in schools by educating staff and helping schools develop their own plans.²⁴

Colorado

Through the leadership of **Governor Bill Owens**, the Colorado Office of Suicide Prevention was created in the state Department of Public Health and Environment in 2000. In February 2002, in collaboration with the Colorado Trust, the Office released *Suicide in Colorado*, a statewide needs and resources assessment of suicide prevention services and assistance and state suicide trends.²⁵ In addition to sponsoring a second statewide summit on suicide prevention in May 2003, the office is currently developing a strategic plan for adolescent suicide prevention and instituting a model prevention program in three pilot communities through a grant from SAMHSA. Other ongoing activities conducted by the office include public awareness campaigns and community training.

Florida

Governor Jeb Bush declared Suicide Prevention Days in Florida in both 2003 and 2004²⁶ and serves as the honorary chairman of the Florida Suicide Prevention Coalition. In 2002, the Florida Office of Drug Control and the Florida Suicide Prevention Task Force published a strategy paper, *Preventing Suicide in Florida*, which details the extent of suicide in Florida, some of the most common causes of suicide, and programs in place to combat the problem.²⁷ Since then, the task force has expanded on the *Suicide Prevention Strategy Paper* and written the *Florida Suicide Prevention Strategy*, which will be rolled out in March 2005. The goal is to reduce suicide across the life span by one third by the end of 2010. The strategy's three basic goals are to:

- Decrease the incidence of suicide in Florida by one-third (from approximately 14.1 per 100,000 in 2001 to approximately 9.4 per 100,000 by the end of 2010).
- Decrease the incidence of teen suicide by one-third (from approximately 9.5 per 100,000 in 2001 to approximately 6.3 per 100,000 by the end of 2010).
- Decrease the incidence of elder suicide in Florida by one-third (from approximately 20 per 100,000 in 2001 to approximately 13.3 per 100,000 by the end of 2010).

To view the strategy, visit www.myflorida.com/drugcontrol,²⁸ and then click on suicide prevention.

The Florida Office of Drug Control and NOVA, which produced the *Youth Suicide Prevention School Based Guide*, have spent \$515,765 over the last two years.²⁹ The Office of Drug Control committed nearly \$300,000 of this funding to an ongoing project in two Florida counties that will identify suicide trends and publish a suicide prevention resource kit for school administrators. In addition, through a partnership with TeenScreen, SAMHSA, the University of South Florida, and the Hillsborough and Pinellas County Schools, the state is planning to implement a media campaign to encourage mental health screenings. This pilot program will be expanded throughout the state.³⁰

Idaho

In 2000, **Governor Dirk Kempthorne** unveiled a statewide campaign directed at parents to alert them of suicidal tendencies in teenagers. The Governor announced the airing of two commercial spots that would raise awareness of this issue across the state. While in office, he has also issued several proclamations declaring a Suicide Prevention Week in Idaho.³¹

Illinois

Governor Rod Blagojevich signed the Suicide Prevention, Education, and Treatment Act in August 2004, creating the Suicide Prevention Strategic Planning Committee to create a statewide prevention plan. The law requires the Illinois Department of Public Health (IDPH) to establish five suicide prevention pilot programs by September 2005, distribute suicide awareness materials to schools and community organizations, and make a depression and suicide screening system available statewide.³²

Kansas

Governor Kathleen Sebelius signed a proclamation in 2003 recognizing suicide as a statewide public health problem, designating suicide prevention as a state priority, and declaring the first week of May "Suicide Prevention Week" in Kansas. The Governor's proclamation called for the state to undertake initiatives based on the goals of the *National Strategy for Suicide Prevention*. It also recognized the efforts of the Kansas Suicide Prevention Statewide Steering Committee (comprised of five state agencies, 15 private organizations, and one state legislator).³³

Montana

In early 2004, **Governor Judy Martz** detailed how \$50,000 in federal funds she had set aside the previous year could be used to address suicide prevention in Montana. The Governor's plan calls for spending \$9,000 for each of three county- or municipal-based suicide prevention programs and \$9,000 on one program based on an American Indian reservation. Additional monies would be dedicated to suicide-risk identification training for teachers and school officials, an investigation of state suicide trends, an inventory of existing efforts, the establishment of suicide prevention hotlines, and an evaluation of state and local suicide prevention efforts.³⁴ The state also has a suicide prevention plan that is 100 percent federally funded with an Emergency Medical Services for Children Partnership Grant and a Family Community Health Bureau Block Grant. The key goals of the plan are to increase public awareness about suicide, dedicate funding and personnel for suicide prevention, and improve data capacity to track incidences of suicide.³⁵

Nevada

The 2003 legislative session was a watershed for suicide prevention in Nevada—a state with one of the highest suicide rates in the nation. A bill signed by **Governor Kenny Guinn** established a Statewide Suicide Prevention Program in the Department of Human Resources and funds two positions, a State Suicide Prevention Coordinator and a Suicide Prevention Trainer and Network Facilitator. A separate bill, adopted in March 2003, authorized suicide prevention training for teachers and school administrators. The state Senate also passed two concurrent resolutions urging the formation of suicide prevention coalitions in each county.³⁶

Oregon

Former **Governor John Kitzhaber** established the Governor's Task Force on Youth Suicide Prevention by executive order in 1996. The following year the task force presented the Governor with 25 recommendations, immediately resulting in legislation addressing one recommendation—funding a youth suicide prevention coordinator in the Oregon Health Division.³⁷ The coordinator's initial task was to help implement the task force's recommendations, develop a statewide strategic plan to address youth suicide, improve outreach to at-risk youth, and provide technical assistance to state and local agencies. *The Oregon Plan for Youth Suicide Prevention*, completed in 2000, outlines 15 strategies for state- and community-level action, including public education, educator training, enhancing crisis services, reducing school harassment, and improving access to behavioral health care.³⁸

Washington

Washington State became one of the first states to formalize and fund a comprehensive statewide suicide prevention program in 1995. The State Health Department was given initial responsibility for administering the *Youth Suicide Prevention Plan*, developed by an advisory committee composed of citizens and professionals. The plan outlines universal, selective, and indicated prevention strategies. Universal prevention consists of statewide public education designed to reach youth aged 15-24. Selective prevention focuses on high-risk populations and consists of screening programs, gatekeeper training, and crisis intervention. Indicated prevention targets individual youth at high risk and uses skill-building support groups and family support training.³⁹ In 2001 the Youth Suicide Prevention Program incorporated as a nonprofit organization, but continues to receive financial support from the state. Current activities focus on public awareness, training, and helping communities to develop suicide prevention plans.⁴⁰

Conclusion

Suicide is an unrecognized killer of American youth. The limited publicity that suicide receives—especially compared to homicide—and the solitary nature of the act itself, contribute to a public health problem that is neither widely recognized nor well understood. Governors have an opportunity to exercise leadership on this

front. As this Issue Brief discusses, there are a variety of steps that Governors and other state policymakers can take to recognize and prevent suicide as a leading killer of young people.

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Selected Sources for Further Information and Guidance

- American Association of Suicidology: www.suicidology.org
- American Foundation for Suicide Prevention: www.afsp.org
- CDC's National Center for Injury Prevention and Control: www.cdc.gov/ncipc/default.htm
- Children's Safety Network: www.childrenssafetynetwork.org
- Columbia University TeenScreen Program: www.teenscreen.org
- The Jason Foundation: www.jasonfoundation.com
- National Suicide Prevention Resource Center: www.sprc.org
- National Strategy for Suicide Prevention: www.mentalhealth.org/suicideprevention
- National Youth Risk Behavior Survey: www.cdc.gov/yrbss
- Signs of Suicide Program: www.mentalhealthscreening.org/sos_highschool/index.htm
- Suicide Prevention Action Network (SPAN): www.spanusa.org
- Yellow Ribbon: www.yellowribbon.org
- Youth Suicide Prevention School-Based Guide: <http://theguide.fmhi.usf.edu/>

¹ Calculated from data provided by the Centers for Disease Control and Prevention in the *National Center for Health Statistics, Death Rates for 72 Selected Causes by 5-Year Age Groups, Race, and Sex: United States, 1979-98*, p.485.

² Children's Safety Network National Injury and Violence Prevention Resource Center, Education Development Center, Inc. *Costs of Completed and Medically Treated Youth Suicide Acts by State, 1996*. (2000); <http://notes.edc.org/HHD/CSN/csnpubs.nsf>.

³ National Youth Risk Behavior Survey Web site, <http://www.cdc.gov/yrbss>.

⁴ Children's Safety Network National Injury and Violence Injury Prevention Center, Education Development Center, Inc.; [http://notes.edc.org/HHD/CSN/csnpubs.nsf/0/1cbbc46173caa7fd85256bc0005ffdc9/\\$FILE/Suicide%20Fact%20Sheets%20Part%203.pdf](http://notes.edc.org/HHD/CSN/csnpubs.nsf/0/1cbbc46173caa7fd85256bc0005ffdc9/$FILE/Suicide%20Fact%20Sheets%20Part%203.pdf).

⁵ U.S. Center for Disease Control and Prevention, National Center for Injury Prevention and Control. *1999-2001, United States Suicide Injury Deaths and Rates per 100,000*. WISQARS™ (Web-based Injury Statistics Query and Reporting System); <http://webapp.cdc.gov/sasweb/ncipc/mortrate.html>.

⁶ U.S. Department of Health and Human Services. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. (Washington, D.C., 2001), 39.

⁷ *National Strategy for Suicide Prevention: Goals and Objectives for Action—Summary*, <http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3518/default.asp>.

⁸ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Steps to a Healthier US Prevention Report, Issue 1, Fall 2002*; <http://odphp.osophs.dhhs.gov/pubs/prevrpt/03Volume17/Iss1Lit.pdf>.

⁹ Centers for Disease Control and Prevention, Department of Health and Human Services. *School Health Policies and Programs Study 2000*: <http://www.cdc.gov/nccdphp/dash/shpps/index.htm>.

¹⁰ President's New Freedom Commission on Mental Health. *Final Report for the President's New Freedom Commission on Mental Health*. (Washington, D.C., 2003), 62-64; <http://www.mentalhealthcommission.gov/reports/reports.htm>.

¹¹ TeenScreen, "President Bush's Commission on Mental Health Endorses Screening Youth to Prevent the Development of Serious Mental Health Problems"; <http://www.teenscreen.org/newsroom/001.html>.

¹² NGA Center for Best Practices, "Columbia University Offers Mental Health Screenings to States"; http://www.nga.org/center/frontAndCenter/1,1188,T_CEN_HES%5ED_7092,00.html?hotOffThePress=1.

¹³ Robert H. Aseltine, Ph.D. and Robert DeMartino, M.D., "An Outcome Evaluation of the SOS Suicide Prevention Program," *American Journal of Public Health* Vol. 94, No. 3 (March 2001); http://www.mentalhealthscreening.org/sos_highschool/SOS_AJPH%20article_March2004.pdf.

¹⁴ Ibid.

¹⁵ National Suicide Prevention Resource Center, Education Development Center, <http://www.sprc.org>.

¹⁶ Presentation, Workshop, Inservice and Training information; www.yellowribbon.org.

¹⁷ Personal communications with Jerry Reed, Executive Director of SPAN USA and Stephen Roggenbaum, University of South Florida.

¹⁸ Personal communications with Angie Hypes at The Jason Foundation.

¹⁹ Maine Youth Suicide Prevention Program, <http://www.state.me.us/cabinet/suicideprevention.html>.

²⁰ *Preventing Suicide*, "CDC Awards to Virginia and to Maine for Suicide Efforts," November 2002.

²¹ Virginia Department of Health. *Annual Report on the Virginia Youth Suicide Prevention Plan* (2002); http://www.ac.wvu.edu/~hayden/spsp/states/Virginia%20HD22_2002.pdf.

²² *Virginia's Suicide Prevention Plan: Successes and Challenges*, a presentation by James B. Vedder, Ed. M., Virginia Department of Health, ASTHO Conference Call, December 16, 2002; <http://www.astho.org/pubs/18>.

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²⁴ Alaska Statewide Suicide Prevention Council. *Alaska Suicide Prevention Plan [Draft]* (2003).

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