SECTION J. SUICIDE PREVENTION

Historically in Washington State, most suicide prevention activities have originated in the Department of Health, and those efforts have focused on youth suicide. More recently, with the growing attention on the suicide rates of service members (e.g., recent reports indicate an upsurge in suicides out of Joint Base Lewis-McChord in Washington), and with older adults, there has been an interest in expansion of efforts for adult suicide prevention across the state. Because of the well-known co-occurrence of chemical dependency and suicide ideation and suicide, the Division has keen interest in this problem. With the advent of health care reform, and with our focus on the continuum of care, we will use this planning period to coordinate these approaches and to develop strategies to identify and fill service gaps. We intend to expand existing programs to cover these additional demographics rather than starting a separate initiative.

The youth suicide efforts offer a model of interagency collaboration. The Washington State Department of Health convened the Advisory Council on Youth Suicide Prevention in July 1994, and developed the state's Youth Suicide Prevention Program. In council work sessions, prevention strategies were identified, evaluated and prioritized. Fifteen focus groups were held statewide to gather the perspectives of multiple high-risk groups of youth. The resulting plan includes the following goals:

- *Suicide is recognized as everyone's business.*
- *Youth ask for and get help when they need it.*
- *People know what to look for and how to help.*
- *Care is available for those who seek it.*
- *Suicide is recognized as a preventable public health problem.*

Gaining widespread support for youth suicide prevention was facilitated by the excellent epidemiological data the state collects. From 2002 to 2006 Washington youth suicide rates were higher than national rates. 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. The suicide rate for 10−24 year-olds in Washington was 8.3 per 100,000.

Attempted suicide heightens the risk of eventual suicide, and is related to a variety of other problem behaviors such as substance abuse and delinquency. Prevention efforts are guided by the detailed self-report data collected in the statewide Healthy Youth Survey. In 2010, for instance, 15 percent of Grade 8, 18 percent of Grade 10, and 14 percent of Grade 12 students seriously considered attempting suicide. However, in that survey an alarming number of students felt that they did not have an adult to turn to for help when feeling sad or hopeless: 26 percent of Grade 6, 39 percent of Grade 8 and 10, and 31 percent of Grade 12 students.

The Importance of Cultural Competency in Suicide Prevention

Suicide relates to a number of problems including violence, psychiatric disorders, family conflicts, dating violence, sexual assault, and hopelessness. Youth 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 recognizing and responding to risk factors. Cultures also differ in religious and spiritual beliefs,

and in how distress is manifested and interpreted. People may suffer stress trying to balance assimilation into 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 people who complement the communities they serve, and should train all staff in cultural competency.

The Need for Better Epidemiological Data

While epidemiological data for youth suicide and mental health risk factors are routinely collected as part of the Healthy Youth Survey, other parts of the population are surveyed only at the state level. We will improve our collection of data as resources become available. For instance, we have added questions to the Behavioral Risk Factor Surveillance System, but the sample size can only be expanded with a great deal more funding and new survey methodologies. We will also increase the utilization of screening and assessment tools. With training and technical assistance, we could support the implementation of a screening tool in a wide variety of settings, including primary care settings.

Suicide Prevention Requires a Public Health Approach

A public health approach to suicide prevention will require a complex and sustained effort. Outside of screening, public awareness of the importance of identifying people at risk for suicide must be raised, and the public needs know what to do or who to call in order to help people they identify as at risk. On this we will work closely with our colleagues at the Department of Health. In the communities surrounding military bases we will work to coordinate our capacity to deliver mental health and prevention initiatives with our Department of Defense colleagues. We also need to have a detailed assessment of the resources that are available for people who need some sort of prevention intervention. Thus our planning for increasing suicide prevention capacity will have to work on multiple stages in the public health arena.

We are concerned that Washington state laws and county practices do not require the uniform designation of suicide on death certificates, as this makes effective suicide prevention research much more difficult. We will work with partners, especially the Department of Health, and see if this important data should be included. This information would assist our efforts to identify and address populations and groups at risk, and to measure the impact of our prevention/ intervention efforts.