

# POLICY BRIEF

## *A Public Health Priority: Teen Suicide in Idaho*



### NATIONAL DATA AND TRENDS

Suicide is a leading cause of mortality in the United States of America, and the third cause of death for persons in the age range of 15 to 24. With approximately 4500 completed suicides annually in this age cohort, suicide accounts for more deaths among young people than cancer, heart disease, AIDS, birth defects, stroke and chronic lung disease combined.

Perhaps most alarmingly, the frequency of suicides for Americans under the age of 25 increased nearly threefold in the years between 1952 and 1995. This increase occurred at a disproportionate rate for younger people, with increases of 11 percent among those 15 to 19, and 109 percent for those below the age of 14 years old. A full 60 percent of the overall increase is statistically linked to the self-destructive use of firearms in the years between 1980 and 1997.

However, all statistics regarding suicide attempts and completions must be taken with a large grain of salt, given inconsistencies in coroner training, investigation and reporting techniques, and pressure from families to avoid reporting an ambiguous death as a suicide. Several states employ medical examiner systems, while others rely on pathologists, law enforcement officials or a system of mixed death investigators. The relative high costs of autopsies and blood level screenings also mitigates against fully accurate reporting of self-inflicted deaths. Finally, if more single-vehicle traffic crashes and unattended elderly over-medication deaths were categorized as intentional self-harm, absolute suicide numbers and rates would climb appreciably.

### HIGHLIGHTS

#### Research Shows:

Suicide is a leading cause of mortality in the U.S.

Idaho ranks second in terms of per capita rates of adolescent suicide deaths

Rural regions in Idaho lead the state in the number of suicide deaths

Approximately 80% of Idahoans live in Health Professional Shortage Areas or Medically Underserved Areas

Idaho is one of 21 states with a drafted statewide suicide prevention plan

Idaho KIDS COUNT



## STATE DATA AND TRENDS

The relatively high rate of suicide in Idaho stands in contrast to the overall positive health rates enjoyed by the state in comparison to the rest of the nation. While Idahoans do relatively well in terms of heart disease, cancer, diabetes, kidney and liver ailments, and cerebrovascular and chronic pulmonary diseases, rates for death due to accident and suicide exceed the national average by far. According to Idaho Vital Statistics, the state's per capita rate of death by suicide (16.4 per 100,000) exceeds the national rate (10.8 per 100,000) by more than one-third. This places the state at the seventh highest ranking in the United States (year 2001), but number two in terms of per capita rates of adolescent suicide deaths.

This disproportionate level of risk comes into sharp contrast when one examines suicide rates among all males ages 15 to 17 (22.5 per 100,000), and especially Native American males in this age category (115.8 per 100,000). At the same time, the 2001 Idaho Youth Behavior Risk Survey determined that 9<sup>th</sup> grade female students had attempted suicide nearly twice more often than males. This instrument also found that a full 15 percent of all Idaho high school students entertained thoughts about how to actually kill themselves, while one in four reported behavioral symptoms associated with clinical depression.

## HIGHLIGHTS

### High Risk Populations in Idaho

■ Elderly males

■ Teenage males

■ Working age males

■ Young Native American males

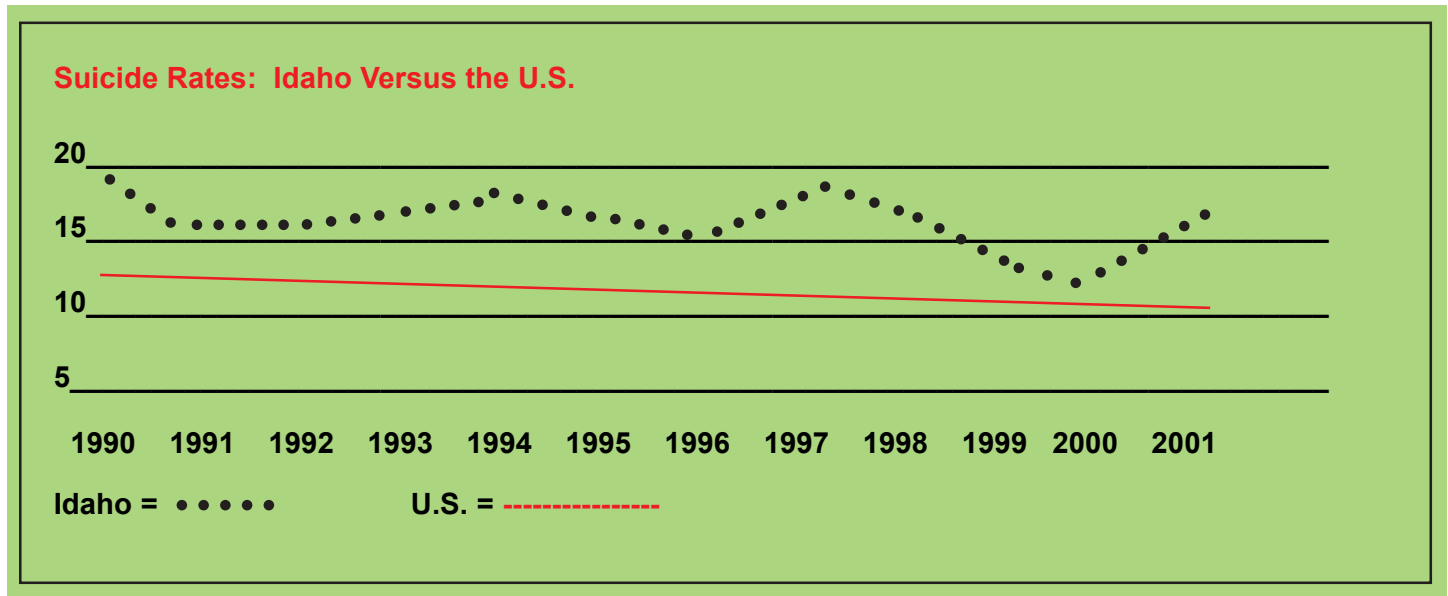
In terms of geography, rural counties lead the state. In 2002, Idaho Health District 2 (North Central) experienced the highest per capita rate of 24.0 per 100,000, followed by District 1 (Panhandle) at 20.6, District 5 (South Central) with 20.0, and District 6 at (Southeastern) 14.3. District 4, which include the capital city of Boise and its surrounding metropolitan area, witnessed 17.1 suicides per 100,00 residents, with most of those deaths occurring in sparsely populated Valley, Boise and Elmore counties. Unfortunately, current databases do not readily permit age-specific, county-by-county analyses.

## SURROUNDING AND/OR SIMILAR STATE DATA

Historically speaking, the Intermountain West (New Mexico, Montana, Nevada, Wyoming, Colorado, Idaho) and Alaska suffer from considerably higher suicides rates than eastern and midwestern states. In the year 2001 each intermountain state exceeded the U.S. national rate by at least a third, with an aggregate total of 3,027 deaths and a 16.2 per 100,000 suicide rate. Median ages in these states tend to be lower, by several years, than the national median of 35.3, and the region is also characterized by higher rates of unwed teenage pregnancy rates as well as lower ages for first marriages and higher fertility rates among the younger age cohorts. In recent decades these states have also undergone rapid urbanization, with consequent impoverishment of their outlying rural districts. All these factors mitigate against stable social networks and emotional support systems.

In terms of access to primary physical and mental health care, the federal government estimates that some 80 percent of Idahoans live within what it describes as either Health Professional Shortage Areas (HPSA) or Medically Underserved Areas, or within Medically Underserved Populations, a figure consistent with the frontier nature of the Intermountain West.

## HIGHLIGHTS



## THE IDAHO SITUATION - CAUSAL FACTORS

Elevated rates of suicide among younger people can be categorized in terms of four inter-related sets of risk factors: biological, psychological, social and cultural. Biological elements include genetic tendencies towards debilitating mental illnesses such as unipolar and bipolar depression and other mood disorders, schizophrenia, anxiety disorders, and certain personality disorders which may elevate tendencies towards suicidal thoughts and actions. Alcohol and other substance use or abuse tends to increase impulsiveness and impair emotional steadiness as well. The most recent Idaho State Police annual reports indicate anywhere from 800 to 1000 arrests per year of juveniles for drug and/or narcotics related felonies, during the majority of which alcohol or drugs were being taken during the commission of some serious crime. Anecdotal evidence suggests that alcohol remains the primary entry drug for teenagers, followed by marijuana, and Idaho adolescents are exposed to hard drug availability as well. Idaho's college campuses have all had to address the issue of undergraduate binge drinking.

Psychological elements may include cognitive distortions such as tendencies to globalize or see the entire world in terms of black and white, and personalization or identification with special victimhood. Childhood exposure to trauma such as sexual abuse and domestic violence, all too common in the state, are also contributing factors to low self-esteem, as well as a sense of hopelessness, isolation and despair.

Socially, traditional family and community-based support systems are currently under financial and other strains. Population mobility and rapid urbanization may lead to fragmented neighborhoods and the sense of temporary social relationships. Idaho's marriage and divorce rates both exceed the national average, implying greater instability in child and adolescent social life. The boom-and-bust economic patterns that distinguish the state's agriculture, mining and computer industries also place pressures on social stability.

And in times of financial restraint, Idaho’s legislators often chose to cut the kinds of after-school programs that offer adolescents opportunities to express themselves while congregating with their peers.

Culturally the geographic, ethnic and religious diversity of the state contributes to a unique level of richness but can amplify tensions as well. The majority of victims of religious, ethnic, sexual and racial hate crimes in Idaho are under the age of 20 years old, and victimization in such assaults is a recognized contributor to low self-esteem, depression and self-destructive behavior.

Religious taboos against suicide appear to function as protective factors, but may also inhibit young people from seeking help in time of heightened stress. Contemporary youth culture, immersed in commercialized celebrity status and ‘life style’ advertising, appears to undermine traditional, conservative values and heighten the sense of rootlessness diagnosed by the sociologist Emile Durkheim using the term *anomie*. And culturally-imposed time frames of so-called “normal” or “healthy” periods of mourning following a death by suicide often impede adequate child and adolescent healing from loss and grief.

Finally, stigmas surrounding mental illness, death, trauma, and help-seeking behavior cut across many ethnicities and subcultures. Native Indians, Hispanics, Asians, immigrant and refugee groups, as well as Anglo-Europeans assign different meanings to suicide, as do males and females. The presumption that standard pharmaceutical and psychotherapeutic treatments should work equally well with every type of population can lead to further alienation and discouragement unless applied with cultural sensitivity as well.

## HIGHLIGHTS

Idaho Suicide Rates by Race: Ethnicity			1999 - 2001
RACE	NUMBER		RATE
White	537		14.3
Black	2		8.8
American Indian/Alaska Native	13		21.0
<b>ETHNICITY</b>			
Hispanic	17		5.6
Non-Hispanic	542		15.2
			<b>Overall = 14.4</b>

## WHAT CAN BE DONE

In November of 2004, the Idaho Department of Health and Welfare released the first-ever document titled “Idaho’s Suicide Prevention Plan.” Available as a download on the Department of Health and Welfare’s web site, the plan acknowledges the state’s funding constraints and the key role of “non-traditional providers such as faith-based organizations” and mental health consumers interest groups. The plan calls for the creation of a local community-based infrastructure, greater awareness, implementation of best practices and materials, and consistent use of outcome and performance measurements. It also envisions how these changes might be accomplished.

## **NATIONAL REMEDIES**

In 2001 Dr. David Satcher, then Surgeon-General of the United States issued a “National Strategy for Suicide Prevention: Goals and Objectives for Action,” citing suicide prevention as a public health priority. The list of major goals includes greater awareness of the preventability of suicide death, broad-based support for suicide prevention, reduction of the stigma surrounding suicide and mental illness, development and implementation of effective suicide prevention programs, lethal means restriction, training for early recognition of warning signs, development of more effective clinical and professional practices, enhanced access to mental health and substance abuse services, more positive and realistic portrayals of mental illness in the mass media, better data collection systems, and greater support for research on suicide and suicide prevention. Objective 4.1 of the National Strategy specifically requires the creation of individual statewide suicide prevention plans. Idaho fulfilled this objective in November of 2003.

## **STATE POLICES THAT WORK**

As of this writing, twenty-one states (including Idaho) have drafted statewide suicide plans, while another fourteen have initiated the process towards formulating one. Most plans are based on a public health model, address the needs of specific populations, and include cost/benefit analysis and evaluation components.

The public health model dictates that risk factors for suicide first be identified; that they be isolated from vulnerable populations; and that communities build resilience against further exposure. In the case of suicide, most risk factors have been identified in both the clinical and sociological literature, although the relative weight of each remains under dispute. As for isolating such factors, means restriction (firearms trigger locks, alcohol and substance control) generally proves to be uneconomic or unpopular, and incompatible with the ethos of absolute individualism found in the Intermountain West. Building resilience requires education on the warning signs of mental illness and suicide, knowledge of resources, and positive modeling of help-seeking and help-providing behaviors.

The states have also considered the requirements of various populations as well. All recognize the usefulness of heightening suicide prevention within the general public, using universal measures such as public and media education. Community gatekeepers are those who come into most frequent contact with suicidal persons, and include law enforcement and corrections officials, clergy and educators; they generally seek and require targeted or selected types of advanced knowledge and skill sets. And physical and mental health professionals who deal with the highest risk individuals, usually in hospital settings, must be given highly specialized education on symptomology and scientifically sound treatment methods.

The emphasis on cost/benefit analysis and internal as well as external evaluation components arises from a growing awareness concerning the importance of proven “best practices” or “gold standards” of diagnosis, treatment and follow-up care. The mental health field, like many others, is replete with well-meaning programs that have proven ineffective or even harmful in their applications. The Institute of Medicine of the National Academies publishes criteria for measuring efficacy and efficiency in suicide prevention programs. Among them are a firm commitment to long-term rather than short-term programs and an ecological instead of a pathology-driven approach to the problem.

## LOCAL BEST PRACTICES

Among the most successful youth surveillance programs currently operating in Idaho is Red Flags, sponsored by First Lady Patricia Kempthorne and administered through the National Alliance for the Mentally Ill and Idaho State University as a school-based awareness and destigmatizing program. Project Safe Place, currently operating in Idaho Falls, Pocatello and Coeur d'Alene, provides young people in crisis with a network of supportive sites providing immediate access to respite and help.

For its part, Boise State University offers the only Certified Crisis Worker preparation program in the United States, leading students to certification by the American Association of Suicidology. BSU's Department of Extended Studies provides regularly scheduled credit workshops on adolescent suicide prevention. Idaho Suicide Prevention Services, a non-profit volunteer organization, staffs the only state-wide 24/7 suicide prevention crisis hotline (1-800-564-2120) and is in the process of applying for national certification. And Idaho SPAN (Suicide Prevention Action Network) hosts annual statewide conferences designed to educate and energize professionals, legislators and government officials and the general public on all issues surrounding suicide prevention, intervention and postvention strategies.

## HIGHLIGHTS

### Strategies that Build Resilience Against Teen Suicide:

- Education on the warning signs of mental illness and suicide
- Positive modeling of help-seeking and help-providing behaviors
- Community gatekeepers with highly specialized knowledge of symptomology and scientifically sound treatment methods
- Awareness of resources
- Long-term rather than short-term treatment programs
- Ecological instead of pathology-driven approach

## SOURCES

Centers for Disease Control and Prevention; National Injury Prevention Center; Idaho Department of Education; Idaho Department of Health and Welfare, Bureau of Health Policy and Vital Statistics; Idaho State Police annual reports; Institute of Medicine of the National Academies; Office of the Surgeon-General of the United States, "National Strategy for Suicide Prevention: Goals and Objectives for Action."; Suicide Prevention Research Center; Suicide Prevention Action Network

## ABOUT THE AUTHOR

Beginning his career as a photojournalist and art writer, Peter Wollheim, Ph.D., received his M.A. from Simon Fraser University (1978) and Ph.D. in Communication from McGill University (1991). Dr. Wollheim has taught at Boise State University as an associate professor for the Department of Communication since 1989. His current academic research projects include the role of alcohol as a proximate factor in completed suicides and adolescent suicide prevention. Dr. Wollheim serves as the Executive Director of Idaho Suicide Prevention Services. He has presented papers and posters regarding suicide at several national and international conferences. He is a founding board member of the Idaho Suicide Prevention Action Network, and established the nation's first Certified Crisis Worker preparation program on the BSU campus. Dr. Wollheim's efforts have earned him a Jefferson Award for Public Service, a BSU Foundation Scholar Award for Service, and a commendation from the Idaho State Planning Council on Mental Health.