MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

4032

2007 SENATE HUMAN SERVICES

SCR 4032

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SCR 4032

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 2-26-07

Recorder Job Number: 3850, 3889

Committee Clerk Signature Mary K Morson

Minutes:

Chairman Senator J. Lee opened the hearing on SCR 4032 directing the Legislative Council to study ways in which schools and school districts can better identify high-risk students and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts.

Senator Dever (District #32) introduced SCR 4032 which concerns itself with a study of behaviors that lead to suicide attempts by young people. He had a constituent who had a son who committed suicide. This is simply a call for the legislature to study this issue. A lot of good things are happening through the school systems and other organizations. If there are things the legislature could do to put policies or programs in place that would help alleviate that, it would be a good thing.

Mark LoMurray testified as a private citizen in support of SCR 4032. He has thirty years of professional work working with teens, about 20 years working with suicide prevention in ND. He helped draft a first national suicide prevention plan and is a co-founder of the suicide prevention task force in 1998. (Attachment #1)

Senator Warner was excited to hear about training the ancillary staff in schools. He asked him to comment a little on the effectiveness of training students to monitor each others behavior. Is it counter productive or is it an important part of the process?

Mr. LoMurray said they've trained approximately 8,000 teens. The approach to that is not that they are responsible for their friends but, what has been found is in about 80% of the teen suicides the peer group knew. They knew about warning signs and didn't tell any adult about it. The code of silence is pretty significant. They have found that when they train groups of teens for an hour, they are not able to make a dent in that code of silence. If they can get them for four hours and ask a group of teen leaders to go out and do some hands on tangible things they have a better chance to break the code of silence. (Meter 16:00) He continued talking about training teen groups.

Senator Dever said he has heard that there is a difference between adults and teenagers, that if an adult threatens to commit suicide they may or may not be serious and if a teenager does you better take them serious.

Mr. LoMurray said they see a lot more impulsive suicides with teens. He continued talking about reasons for suicide.

Senator Erbele asked what the reason the west is so high.

Mr. LoMurray said there are a lot of theories. One is rural states – areas with fairly long winters. Rural areas are considered a mental health low resource area. There are some ethnic issues.

Senator Heckaman – If we were to put some money out to increase these programs in our state, where would we direct the money to?

Mr. LoMurray – Wait till the study is back. It would look at what you are trying to target.

A suggestion in schools would be to train everybody but have more lengthy additional training for the highly empathetic school staff that the teens are already going to go to.

Stephanie Sauers testified on her own behalf in support of SCR 4032. (Attachment #2)

Connie Hildebrand (National Association of Social Workers) testified in support of SCR 4032. (Attachment #3)

Dorcas Kunkel (Director, Suicide Prevention Program, ND Dept. of Health) testified in support of SCR 4032. (Attachment #4)

Senator Dever said he had attended a workshop at United Tribes and they said the best thing that could happen to prevent suicides is to develop a sense of community within the community. Is that the best kind of approach to addressing this situation?

Ms. Kunkel said the broadest suicide prevention efforts would probably be the best. It's a very complex issue and many factors play into it.

Senator Dever – It really comes down to a sense of belonging in the community.

Ms. Kunkel – A sense of belonging and taking away that isolation.

LeAnn Nelson (Director, Professional Development, NDEA) testified in support of SCR 4032. The study is important, not only for the safety of the particular child but also the safety of others in the path of the child.

Chuck Pulver (Mental Health Association of ND, Public Policy Assistant and Community Education Coordinator for the 211 Health Information and Crisis Line) --The mental health association of ND supports this study resolution. One thing this study can really do is look at all the components that are out there.

There was no opposing or neutral testimony.

Senator J. Lee asked Dorinda Olson (DPI) if they would be able to provide any information about what is currently in place.

Ms. Olson replied that the one comment that comes to her mind over and over again is that even, as humans, when we don't know what to do, we often don't do anything. That is often what happens within a school system as well as in the communities. We don't know what to say, therefore, we say nothing. Silence is often probably the most negative thing that we could do.

The hearing on SCR 4032 was closed.

JOB #3889

Senator J. Lee opened SCR 4032 for discussion.

Senator Warner moved a Do Pass on SCR 4032.

Senator Erbele seconded the motion.

Roll call vote 6-0-0. Carrier is Senator Dever.

Date: 2-23

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1032

Senate **Natural Resources** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Adopt Amendment

Motion Made By Triplett Seconded By Freborg

Senators	Yes	No	Senators	Yes	No
Sen. Stanley Lyson, Chairman			Sen. Joel Heitkamp		
Sen. Ben Tollefson, ViceChairman			Sen. Jim Pomeroy		
Sen. Layton Freborg			Sen. Constance Triplett		
Sen. Herbert Urlacher					

Total (Yes) No

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-26-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 4032

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Sen. Warner Seconded By Sen. Erbele

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SCR 4032: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SCR 4032 was placed on the Eleventh order on the calendar.

2007 HOUSE EDUCATION

SCR 4032

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **SCR 4032**

House Education Committee

☐ Check here for Conference Committee

Hearing Date: **14 March 2007**

Recorder Job Number: **5048**

Committee Clerk Signature	Jan Prindle

Minutes:

Chairman Kelsch opened the hearing of SCR 4032.

Senator Dick Dever, District 32, sponsor, introduced the bill. I was asked to sponsor this resolution by a constituent. SAMSA is a national organization that surveys high school and middle school students. The results of their survey show what students think about themselves and for purposes of this resolution: suicide. It is concerning to me. I brought this resolution to call for a study of risk behaviors that lead to suicide. In 2005, 15% of high school students and 14% of 7th and 8th graders reported that they had considered suicide, 12% of high school students and 8% of 7th and 8th graders reported that they had planned a suicide, 6% of high school students and 5% of 7th and 8th graders reported that they had attempted suicide. I know that there are a lot of things being done on a lot of different levels to address this issue particularly in our schools, but I don't think the Legislature has ever really considered it. I am the sole sponsor of this resolution for a couple of reasons. One, I was up against the deadline, but the other is that to emphasis the point that I think a lot of people think of suicide to be singular act and the person who does it is responsible for the action and nobody else is involved. If we are talking about an adult suicide that's probably true; but when we talk about teenagers there are relationships or other people that are aware of the thoughts going through somebody else's mind. We see kind of an epidemic; we see copy cat kinds of activities and I

think it's something that we should as a Legislature take a good look at and see how we can improve situations in our school system.

Stephanie Sours, testified in favor of the bill. (Testimony Attached.)

Chairman Kelsch: Just a comment. I didn't know your son Chance, but we see plenty of vehicles around that have a little memorial to Chance and I even saw one or two in Fargo so I'm very familiar with what you are talking about. Thank you for sharing your story.

Mark LoMurray, testified in favor of the bill. (Testimony Attached.)

Representative Mueller: We have among the highest teen suicides in the country. Is there any explanation for that?

LoMurray: There are a lot of theories about that. I think what we see when we look at the fact that we have a high binge drinking rate in ND—there's strong correlation between drug and alcohol use and teen suicide impulsivity. We're an extremely rural state. Ninety percent of our state is considered a mental health shortage area so getting access to services is one thing. We have long winters. We have some seasonal affect from that. If we would look at 80 – 85% of fatalities tend to be males and we would look at some of our ethnic groups and that would be Scandinavian, German and Northern Plains Tribes. Men in that group tend to be a pretty reserved group and tend to hold things in sometimes. I think there are a lot of issues there. I don't think anyone has the magic answer. I would say that what we've found is it takes more than the mental health folks—it takes community involvement. Where we feel that we have made a dent it's been in getting schools involved, in getting faith communities and cultural groups and teen leaders and parents and those efforts that involve communities seem to be fairly effective and hopeful.

Representative Mueller: Miss Sours spoke of a group that her son unfortunately became involved in. Is there any mechanism in the system to follow up on that group to go in a try to

find out what's happening with a group like that because obviously there were some pretty destructive results from Chance's involvement with that group?

LoMurray: Quite honestly that differs from region to region and from community to community. Almost always I would say the follow up is dependent on how active a post prevention crisis team is and how aggressive they are willing to be about going after a group like that. In a lot of communities we find key individuals and it doesn't necessarily mean somebody in a hospital setting or a mental health worker. A lot of times it might be some pastors or youth ministers or some street outreach type workers that might really pursue a group like that. Quite often the reality is a lot of times that's left a pretty hidden mess. A group like that would be considered very much a concern and very high risk and you certainly would want to activate and see if you can get people to have some caring conversations at the very least and maybe some very interventions. The systems are really not in place to be quite honest.

Representative Wall: I support your very important work. Do you meet resistance in some communities with suicide education? They would rather not talk about it because it would bring it to light and there would be an increase. Is that something?

LoMurray: We have a lot of taboos around suicide particularly in school systems. As we talk with administration on the superintendent level we have a conversation in that they want to make sure we're not going to do more harm. Lots of time there is an underlying belief that let's just not have to talk about this too much because it might put that idea. I think there are some significant things there and we want to make sure that if we are doing suicide prevention issues, it really needs to be in a healthful, hopeful way. We need to be talking about where help comes from and where you get resources in a very, very positive way. You can do damage if you come in and go at this in the wrong way. I do think we have learned a lot and

that is the thing that we want to make sure that we are doing education and using models that are effective, that are safe and that are going to make a difference.

Representative Hunskor: Do you know if at the collegiate level in training teachers is there any emphasis in the curriculum that would address this? Secondly, is there anything being done in in-service in schools to help teachers prepare to recognize this?

LoMurray: We have talked to a variety of colleges and universities as to how they train on suicide, particularly for teachers. Our group has done a fair amount of teacher in-service training. I think almost always they really appreciate that especially if you can break it down to nuts and bolts and here are some things to watch for; but not just for suicidal youth, but if you see a youth in distress being able to make a connection and helping schools think through some ways to do that and also how we can partner and develop teen leaders in a way that is going to be effective. Those teens who will hear about friends in distress before any of the teachers will and they are the ones that will link up with the strong and supportive teachers. You are going to go to folks you have a relationship with and then those adults help make a connection to the system.

Vice Chairman Meier: Let's take for example, Bismarck School District. In the tragedy of a suicide of one of their students, what do they do at the school?

LoMurray: They have a crisis team in place made up by school system staff as well as some of folks outside of the schools system. There usually is some response to that. They decide how large a crisis they have and bring folks into the school to sit and talk with students. Many times I've been part of the situation where we come in and not only talk to students but after school or during school we're talking to staff as well if they have been affected or traumatized and are struggling with what's happened. It's very hard for the teachers and staff if they lose

one of their students as well so many times they need support in talking about this and what they should be doing to handle things in their classroom or after school.

Vice Chairman Meier: Is there a team that does initial and long term follow up?

LoMurray: That's one of the issues that traditionally with post intervention is there is a lot of activity within that first week. One of the things that we have certainly encouraged is a little bit more long term follow up especially with deeply affected friends, family and other youth that maybe don't know that person that well but they have been through some things that all of sudden that triggers a lot of issues for them. We really try to promote a model that encourages some of those folks that are already in some relationships with them to keep following up, doing some mentoring, having some conversations and making those referrals to mental health services so they know who and where to go with that.

Representative Hanson: Suicides are quite high on the reservations. Are there any ongoing studies on the reservation now by the federal government?

LoMurray: There's a variety of things that are happening. Standing Rock and Islaws (?) as well as the ND Health Department have received SAMSA grant through Garret Lee Smith and Dorcas Kunkal the project director is here and will probably speak to that. Built in to that there is some evaluation and that's going to be a bit more on a community wide level. They are using some wraparound strategies and some tracking strategies that they are trying to take a look at that I know of and they are trying to take a look at say at Standing Rock. We have some different things. Some things seem to be fairly hopeful. They have done some effective work with some screening tools as well as following up with small support groups any referrals they get when they screen. I think they screen 5th through 12th graders twice a year. They seem to use that fairly effectively at Four Winds. They would be one model to take a look at.

Dorcas Kunkel, director of the Suicide Prevention Program for the ND Department of Health, testified in support of the bill. (Testimony Attached.)

Chet Pulver, public policy assistant with the ND Mental Health Association, testified in favor of the bill. (Testimony Attached.) I am also involved in the crisis line—the community education coordinator. It's run by the mental health association. In 2006 we received 327 calls related to suicide. That was folks were in the act, folks who were contemplating, or folks that were concerned about family members. Having just lost a family member to suicide I've also seen what it does to families.

Vice Chairman Meier: When you receive a call you are concerned about do you send somebody out, or track the call or ??

Pulver: We're certified with the American Association of Suicide __?__ and there are protocols and policies that we follow. It depends on some indicators in the call and we can through the state radio do a track and trace and we have done that to call law enforcement to welfare check on someone. There is a confidentiality issue and there are protocols.

Connie Hildebrand, representing the National Association of Social Workers, ND Chapter, testified in favor of the bill. We testified in favor of this bill on the Senate side and we also offer our support on the House side as well. In addition to the risk factors we find out there are a number of skill techniques that can be taught and be helpful to young people in terms of being able to prevent these kinds of things. One of the things I would mention is conflict management skill teaching.

Nancy Sands, ND Education Association, testified in favor of the bill. We too are in support of this. NDEA takes this issue very seriously. We have provided workshops for our members and school support people on this. A number of years ago AAEW, put out a publication that talked about harassment. The students reported that it most often takes place

in the hallways. They need to be comfortable in reporting to people that can do something about it. We know that there is a tremendous amount of pressure on young people to belong and to feel they are part of a group. When that is lacking, then some of these issues come forward and we have results that we don't want. I hope this resolution will pass and we'll be happy to be part of the study group.

Mary Wahl, representing the ND Council of Education Leaders, testified in favor of the bill. During the testimony you heard this morning I know there have been at least 100 students who have been in the room and rotated through the room. If the information as provided you in this study is accurate, 15 of those 100 students would have considered suicide and 12 of those 100 students would have planned a suicide. That's assuming that they are typical of those that were in this study. When you think of it like that, it really does hit home. We all need to do a better job of taking care of our kids and this one area where we can focus and hopefully make a difference. We think this study will help and as a by product of the study, we would like to think that school environment in general may improve. Even for kids who are not necessarily driven to suicidal tendencies, life is not always as good as it could be for them in the school environment and we'd like to think that even as study the issue of suicide that we may improve our school environment for all of our kids.

Representative Mueller: Mary, the resolution that we have before us specifically speaks to teachers and counselors. If I'm hearing the testimony correctly, I wonder if we ought not to amend in "all school staff and personnel." Does that make sense?

Wahl: I think that would be a good addition. We've heard some testimony with regard to training of cooks and janitors because kids have relationships with those people too. Those people can be very sensitive to changes that they perceive happening in their kids. That would be an excellent addition.

Jim Bartlett, executive director of the Home School Association, testified in favor of the bill. I'm also on a group called the Bottineau Area Christian Ministerial Association and we first learned of the youth health risk survey results a year ago we began meeting each month to discuss what the clergy could do for the Bottineau area schools. We also met with the school principals and superintendents last September to discuss these results including suicide results and I have a few comments that came out of our discussions. One of them from the Bottineau HS principal mentioned that when he was in school, the peer pressure was 20% bad and 80% good and the way he summarized it today he said it was 80% bad and 20% good. He was open to ideas that would help. As a parent and a person concerned about education of children in general I want to mention something that hasn't been brought up. That is the idea that actions come from thoughts and philosophies that drive those thoughts. In our public schools today we have some guiding principals that are operating in our school system that are not generally looked at as a cause of the actions or the problems. Secondary humanism is a defined world view of defined origin. That is the only religion taught in the public schools today and that essentially promotes theological atheism. Atheism is where you have no God. If you have no God you have no accountability so suicide becomes an option. It also promotes philosophical naturalism—an idea that all is here is what you see and there is no such thing as a spiritual world. Biological, spontaneous generation, evolution ideas are promoted so some people say we came from you to you by way of the zoo. Basically it takes out a personal God and the creation process and leaves people without hope. Also, moral relativism so that what is good for you is good for you but I have a different idea and my truth is my truth and your truth is your truth. This relativism is also a reason for the hopelessness of children today. Legal positivism where you make laws based what you can do and basically produce the freedom that we had in America. We see very little suicides in the home school

movement. In talking with other folks here, we couldn't think of any examples of suicide in home school families. We would like to support the study because I think it needs to be studied—it's important. I would like to encourage you to include a philosophical discussion besides the practical. That's really at the root of the issue.

Vice Chairman Meier closed the hearing of SCR 4032.

Representative Haas: We had a brief discussion about adding on line 18 "all school staff"

I so move.

Representative Hanson: I second.

A voice vote was taken: The amendment was accepted.

Vice Chairman Meier: I Move Do Pass as Amended and Place on the Consent Calendar.

Representative Herbel: I second.

A voice vote was taken: Passed Unanimously.

Representative Meier will carry the bill.

Date: 14 March 07
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 4032

House Education Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Line 18 add "all Reg of Ctrl staff"

Motion Made By Haas Seconded By Hanson

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch			Rep Hanson		
V Chairman Meier			Rep Hunskor		
Rep Haas			Rep Mueller		
Rep Herbel			Rep Myxter		
Rep Johnson			Rep Solberg		
Rep Karls					
Rep Sukut					
Rep Wall					

Total **Yes** No

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Carried

Date: 1/4/Jan 07
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1032

House Education Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amend + Place on Consent

Motion Made By Meier Seconded By Herbel

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch			Rep Hanson		
V Chairman Meier			Rep Hunskor		
Rep Haas			Rep Mueller		
Rep Herbel			Rep Myxter		
Rep Johnson			Rep Solberg		
Rep Karls					
Rep Sukut					
Rep Wall					

Total **Yes** 13 **No** 0

Absent 0

Floor Assignment Meier

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SCR 4032: Education Committee (Rep. R. Kelsch, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SCR 4032 was placed on the Sixth order on the calendar.

Page 1, line 18, replace the first "and" with a comma and after "counselors" insert ", and all other school staff"

Renumber accordingly

2007 TESTIMONY

SCR 4032

Attachment # 1

Public Testimony for Senate Concurrent Resolution No. 4032
Sixtieth Legislative Assembly of North Dakota
Introduced by Senator Dever

Testimony by Mark LoMurray, LSW
15506 Sundown Drive
Bismarck, ND 58503
outreach@btinet.net
701-471-7186

I would like to provide testimony in support of Senate Concurrent Resolution No. 4032 directing the Legislative Council to study ways in which schools and school districts can better identify high-risk students and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts.

I am testifying as a private citizen with thirty years experience working with teen's professionally in North Dakota and over twenty years experience in the field of suicide prevention. I was one of 14 North Dakotans involved in the development of the first national suicide prevention plan and am the co-founder of the North Dakota Adolescent Suicide Prevention Task Force founded in 1998, and co-chair of this group from 2000-2005. I've been the project director with the Mental Health Association for the North Dakota Adolescent Suicide Prevention Project from 2000-2006, which has trained over 50,000 North Dakotans. In 2005 the project was chosen as the national winner of the Public Health Practice award by the American Public Health Association, Epidemiology Section. I began working primarily on teen suicide prevention through crisis intervention, when as the Director of the Police Youth Bureau in the mid-1990 I attended over 30 teen funerals in less than three years, half of which were teen suicides. I left the Police Youth Bureau convinced that we could do better and get in front of this growing danger of teen suicide. For the past nine years, twenty some grants later, I continue to work on teen suicide and teen risk issues, with the majority of my time spent in partnership with tribal and rural communities.

I consider this resolution an extremely important one for the health of North Dakota teens for the following reasons. The need is clearly stated by the statistics in the resolution taken from the 2005 Youth Risk Behavior Survey for North Dakota, but needs to be highlighted by the following longstanding fact.

- Suicide is the #2 cause of death for young people ages 10-24 years old in North Dakota.

In 1998, when in North Dakota we began our first efforts on a state suicide prevention plan, North Dakota was ranked the #2 highest state per 100,000 rate for suicide fatalities for 10-14 year olds, #6 highest state per 100,000 rate for suicide fatalities for 15-19 year olds. We had strong evidence closely linking teen suicide with other risk factors particularly depression, substance abuse, exposure to traumatic events, harassment

(racial, sexual, bullying, sexual orientation), intense conflict, and aggressive-impulsive behavior.

North Dakota has demonstrated some hopeful and promising trends in its ability to impact and reduce teen suicide behavior and fatalities. A 47% reduction in 10-19 year old suicide fatalities during 2000-2004 compared to the average of the 1990's. Also a 20%-29% reduction in three of four Youth Risk Behavior Survey markers associated with 9-12th grade suicide comparing 1999 with 2003 North Dakota YRBS data. From 2000 – 2004 the project began an extensive adolescent suicide prevention effort throughout North Dakota using 10 different grants to average approximately $40,000 per year for statewide efforts. At $40,000 per year the project did not have sufficient resources to adequately study, evaluate, or research the impact, but the prevention activities along with the dramatic reduction in teen suicide fatalities drew national attention from many groups. The project received the prestigious national Public Health Practice award from the American Public Health Association, Epidemiology Section in 2005.

The project focused on a variety of strategies, many that partnered with schools around updating protocols and policies, gatekeeper training, professional training, early screening and referral strategies, developing teen led strategies, mentoring, and developing small support groups.

It is helpful to think of suicide prevention efforts similar to efforts to reduce traffic fatalities. We will not be able to prevent every traffic fatality, but we have shown that we can significantly reduce the number of highway fatalities through a mixture of efforts – speed limits, how cars are built, how roads are designed and maintained, seat belt laws, DUI enforcement, graduated licensing, etc.

The same is true of suicide prevention. We will probably be unable to prevent or stop all suicides, but it clearly seems possible to reduce the unacceptably high number of suicides especially in our young.

The reduced funding for suicide prevention in 2005-2006 obviously resulted in a reduction of statewide prevention activity, which was then followed by a bounce back, or increase in teen suicide fatalities though not to the previous levels of the 1990's.

On many fronts I believe North Dakota is viewed as a creative leader in its strategies and techniques to address teen suicide. I have been asked to speak at over a dozen national conferences in the past year, sponsored by SAMHSA, Indian Health Services, National Tribal Chairman's Health Board, National Suicide Prevention Resource Center, the Centers for Applied Prevention Technologies, the National Mentoring Center, and Native Aspirations. There is strong interest in what the North Dakota project has accomplished as a potential model for other rural and tribal areas. There is specifically great interest in how to effectively and safely engage teen leaders in these efforts, as well as, the holistic intervention model that has developed via Sources of Strength or wrap a round model for blending institutional mental health/medical services with village-based supports and strengths.

Our dependence on outside funding, even for a project that has received national attention shows the significant need for the study recommended in this resolution. Unless the legislature has clear and convincing evidence – research, that provides us with some strong recommendations, I fear promising efforts will never be widely initiated.

This resolution is timely, focused, and strategic and has a good chance to result in some very practical application. I recommend the study include the following

1. A review to determine if secondary schools in North Dakota have adequate policy and protocol that guide and support staff in the proper effective handling and referral of suicidal students.
2. A review to determine if schools have adequate resources, partnerships, and staff to immediately handle and refer suicidal teens in a timely manner.
3. Recommendations for consistent ongoing gatekeeper training for school staff, to include teachers, support staff (aides, bus drivers, cooks, janitors, etc.) as well as, administration and school board training, to assist in both identification of youth with warning signs and to increase proven protective factors to youth that are in distress, but not suicidal.
4. Recommendations and review of effective practices that can be woven into the school climate that could reduce youth suicidality, including educational and skill based coping curriculums, school-based mentoring, support groups, teen-led prevention activities, and other strength-based school bonding efforts.
5. Protocols and recommendations around the use of suicide screening resources for both universal screening of many students and targeted screening of students identified as high risk.
6. Track identified suicidal students to see if they receive adequate support and services from medical/mental health services and village supports in a way those students and parents find helpful and meaningful.
7. Postvention protocols and training to respond effectively to traumatic deaths in a manner that reduces the likelihood of suicide contagion and clusters.

This resolution is timely and hopefully can partner with two other potential efforts around suicide prevention in North Dakota.

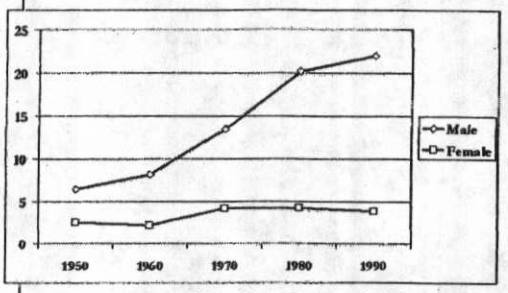
- The North Dakota Department of Health has just received a Garrett Lee Smith SAMHSA grant targeting 14 counties in North Dakota for adolescent suicide prevention efforts.
- Nationally recognized suicide prevention researchers (Wyman, Brown) recently completed a very comprehensive study of gatekeeper training on school staff in Georgia and spent several days in North Dakota this past December 2006 reviewing the efforts from the ND Adolescent Suicide Prevention Project and Sources of Strength. They are very interested in pursuing a large rural suicide prevention study and are interested in North Dakota as a core partner as part of this research effort.

Sources of Strengths
ND Adolescent Suicide Prevention Project

Mental Health Association in ND
701-255-3692

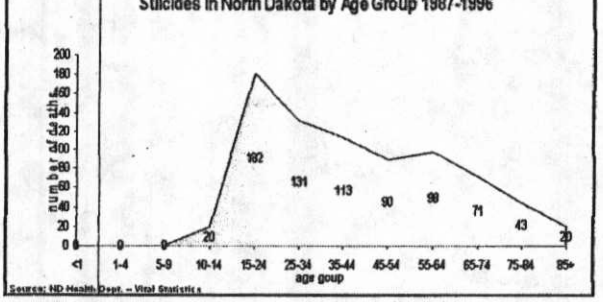
Mark LoMurray, LSW
701-471-7186
outreach@btinet.net

Past 50 Years
15-24 year old suicide rates

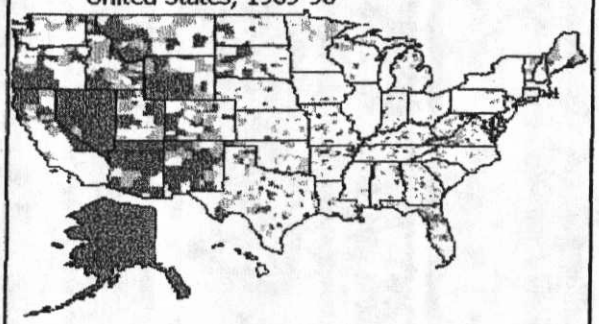


Source: National Center for Health Statistics, CDC

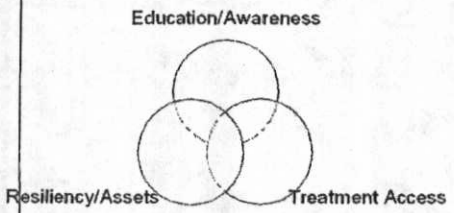
Teen and Young Adult Risk



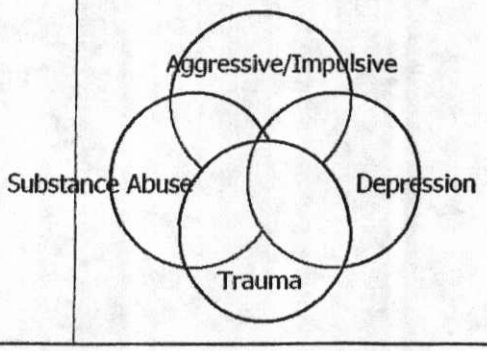
Suicides per 100,000 Population by County
United States, 1989-98



A Blended Approach



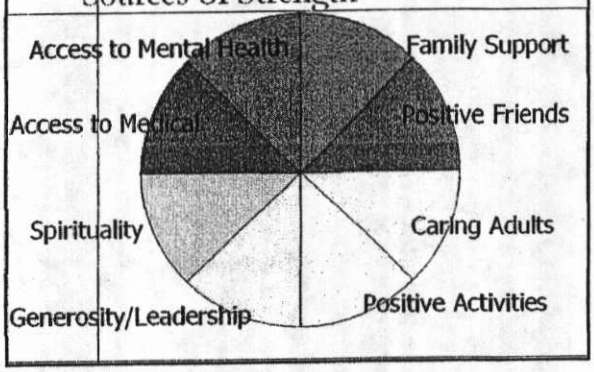
Key Adolescent Risk Factors



Behavioral Indicators for Suicide Attempt

- 6.2 (20+ cigarettes)
- 5.2 (Forced to have sexual intercourse)
- 4.6 (injected drugs, 4.1 inhalnts, 20+ alcohol)
- 4.3 (Psych. Cond.)
- 4.2 (Physical abuse)
- 3.9 (No caring adult)
- 3.9 (2+ sex partners)
- 3.2 (Don't eat with family)
- 3.2 (Threatened school, harrassed sexual comments, orientation)
- 2.9 Harrassed for Race
- 1.6 Physical Med. Cond

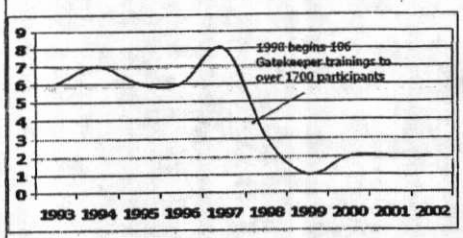
Sources of Strength



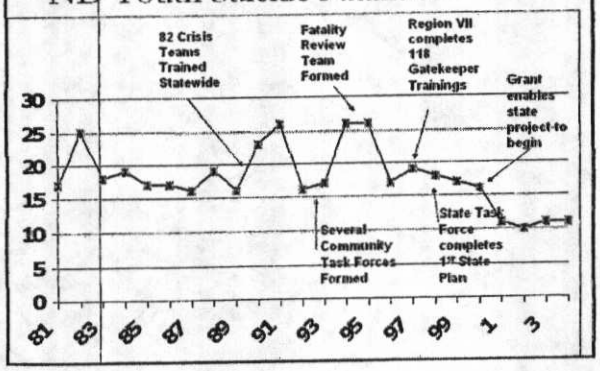
Sources of Strength – Teaching Points

1. These are common pathways to healing when hit by the big four
- The more you have the more protected when hit hard in life.
- Danger in one source interventions – no one strength keeps a suicidal person safe – this message goes to several groups.
- Need to have cross system referrals (institutions – village)
- Whole community has a role in suicide prevention
- Nothing works – I've tried everything, often means I've tried one or two sources
- Start with medical and mental health referrals, but activate four sources of strength during an intervention

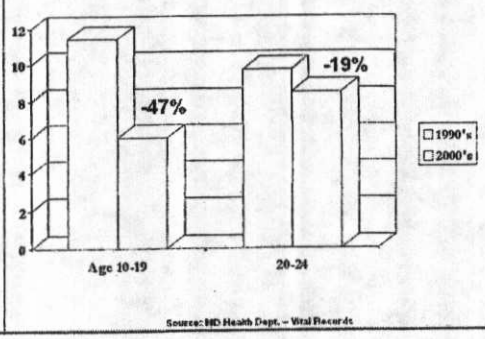
Region VII 10-24 year old Suicide Fatalities

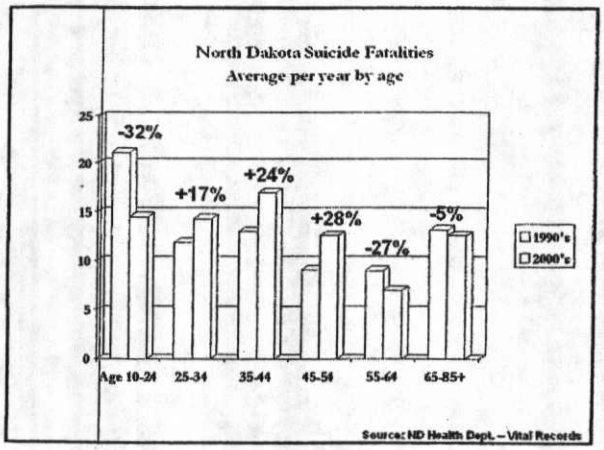


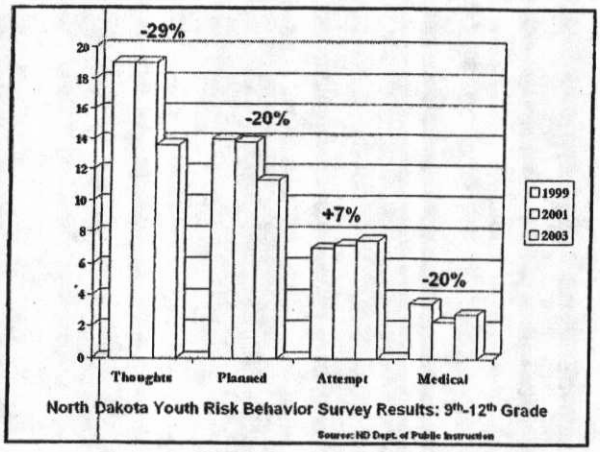
ND Youth Suicide Fatalities -



North Dakota Suicide Fatalities Average per year: Youth/Young Adults







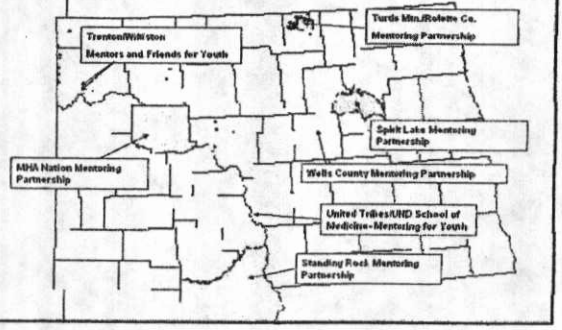
2006 Core Suicide Prevention Strategies for ND

- Sources of Strength Gatekeeper Training – school staff, teen leaders, parents, community caretakers
- Professional Education – medical, mental health, 1st responders, faith
- Resiliency efforts or community strengthening– mentoring, teen-led, small groups
- Early screening strategies
- Contagion response – community mobilization
- Home-tracking or mobile outreach using para's to follow suicide attempters
- Educate and activate stakeholders

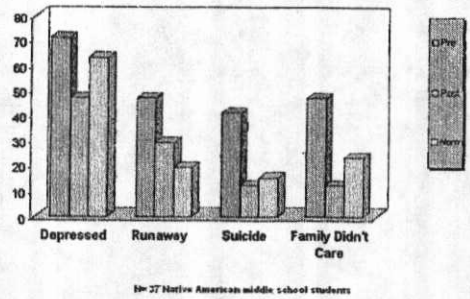
Recommendations for Schools

- In-service all staff every two years (include cooks, bus drivers, janitors)
- Provide Peer Gatekeeper Training and involve teen leaders
- Conduct quick screening for suicide/depression for all students
- Provide some form of support group/talking circle group within the school setting
- Encourage and participate in mentoring involving staff, community, faith-based groups
- Have intervention and referral protocol.
- Plan for a crisis response team for traumatic incidents

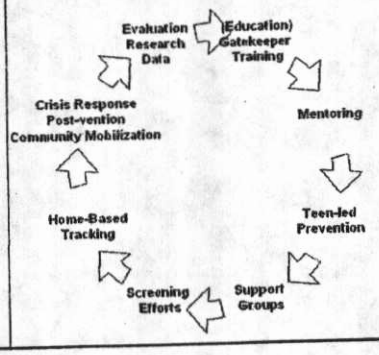
ND Tribal/Rural Mentoring Project



UND Mentoring: Mood Changes after 8 months



ND Adolescent Suicide Prevention Project: Action Strategies



Screening Efforts – Don't do unless you have some support in place

- Universal – avg. is 20%, tribal can be 40-60% of school
- Targeted – specific groups, key times,
- Must have partners/easy referral process
- Continuum from hospitalization – outpatient evaluation – community support groups - mentor

Support Groups – Creating Many Opportunities in a community

- Depression/Anger/Substance Abuse
- Grief/Survivor
- Talking Circles
- Cultural -
- Schools
- Faith-based
- Community – Boys and Girls Club

ND Mentoring Partnership Goals

- 80% of 400 matches spending at least one hour per week, lasting at least a year, and showing a measurable reduction in two risk behaviors and an increase in two protective factors
- 10% decrease in school truancy, 90% increase in academic performance, 10% decrease in school discipline

Mentoring Outcomes

- 83% avg. hour per week, 5.2 hrs per month average
- Average grade point went from 2.19 to 2.42 Year One – 2.6 to 2.7 Year Two with 49% having increase in grades
- Average discipline incidents went from 1.5 to .5
- Average days absent went from 10.5 days to 7 days Year One – with 35% increasing attendance in year two

Mentoring Outcomes

	Mentors	Parents	Teachers
Avoid legal	85%	63%	52%
Drinking/drugs	67%	58%	48%
Early parenting	86%	79%	52%
Families	86%	60%	44%
Pos. Activities	80%	80%	56%
Generosity	83%	74%	60%
Other adults	77%	56%	56%

Treatment

- Stigma reduction
- Home-based Tracking

"We must promote public awareness that suicides are preventable. We must enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment.

Dr. David Satcher
United States Surgeon General
July 28, 1999

Crisis Response

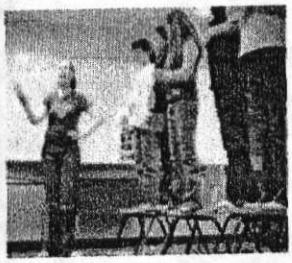
- Community/School Plans
- Beyond one time debriefing
- Rapid Community Mobilization
- Contagion Reduction

Teen Leaders: Partners in Prevention

- 7500 teens trained in Peer Gatekeeper
- 1000 teens present Peer to Peer message
- 36 new long-term teen-led prevention efforts started

Three Phases for using teen leaders in suicide prevention

1. Peer Gatekeeper Training
2. Peer to Peer message
3. Ongoing Youth-led Prevention Efforts



Teen-led Prevention Phases of Community Readiness

- Advisory Phase
- Role Model or Peer Helper Phase
- Focused Action Phase
- Saturation Phase

Top Five factors for success with Teen Leaders

- Clear team mission and goals
- Teen involvement in planning
- Provide adequate training
- Positive adult advisors - supervision
- Give recognition

www.ndsuicideprevention.org

2006 Update

North Dakota Suicide Prevention Project

www.mhand.org

A Mental Health Association in North Dakota Prevention Project
Mark LoMurray, Project Director
outreach@btinet.net
701-471-7186

2006 Targets

1. Raise funding – increase project visibility with policymakers
2. Implement newly updated ND suicide prevention plan for all ages
3. Release website ndsuicideprevention.org
4. Reach 5000 with targeted gatekeeper training – 20 certified trainers statewide
5. 1000 professionals to receive updated training
6. College campus campaign involving 15 tribal, community, university campuses
7. Community Strengthening
   - tribal-rural mentors increase from 350 to 500
   - teen/peer prevention from 50 groups to 80 groups
   -small support group saturation 50 new groups started in school, community, faith, or cultural settings
8. Develop statewide suicide contagion response team for tribal/rural areas.
9. Pilot home-based tracking or mobile outreach efforts for suicide attempters

National Award from American Public Health Association

The North Dakota Adolescent Suicide Prevention Project was named as the national award winner for the nation's largest public health organization, the American Public Health Association, epidemiology section. This award highlighted the North Dakota Adolescent Suicide Prevention Project as a project demonstrating measurable relevance to public health improvement. The award highlights a project using innovative and creative public health approaches with state, local and community-based public health action.

Project Outcomes

The project works closely with the North Dakota Suicide Prevention Task Force and dozens of tribal and rural partners throughout the state.

- Since the project's inception in year 2000, it has trained over 40,000 North Dakotans in suicide prevention strategies, including 7500 teen leaders, 8000 professionals, 1500 faith-based partners with 35% of the projects activities taking place in tribal settings.
- The five year trend since the start of the project shows a sustained 47% reduction in suicide fatalities ages 10-19 from 2000-2004 compared to the ten year average in the 1990's. Ages 10-24 suicide fatalities were reduced by 32% comparing 2000-2004 to the 1990's ten year average.
- North Dakota Youth Risk Behavior Survey comparing years 1999 to 2003, 9th -12th grade responses to suicide questions show the following: 29% reduction in teens having seriously thought about suicide, 20% reduction in teens having made a suicide plan, 20% reduction in teens having made suicide attempt needing medical attention.
- Every state and tribal region has initiated at least 3 of 7 recommended strategies:
  1. multi-targeted gatekeeper training
  2. professional training
  3. early screening and referral strategies
  4. teen-led or peer-led efforts
  5. mentoring
  6. increasing community level support groups, including survivor support
  7. increase access to treatment through development of home tracking, mobile outreach, school/community based mental health access, or tele-mentalhealth access.
- Besides the North Dakota Suicide Prevention Task Force, there have been six local, tribal, or regional coalitions/committees working on suicide prevention that have received training or technical assistance from the state project.

Project Outcomes (Continued)

- A *Sources of Strength* gatekeeper curriculum has been developed, implemented, and dispersed targeting four specific groups: teen leaders-college students, parents, school staff, and community caretakers. Participation satisfaction and usefulness ratings from these trainings have averaged 8.6 on a 1-10 scale with ten being the most useful. *Funding for independent evaluation is being pursued.*
- 35 new teen-led prevention projects received start-up training - 15 in tribal communities.
- 8000 professionals received updated training on suicide intervention and prevention strategies (physicians, nurses, pastors, law enforcement, EMT's, residential treatment and detention, school staff, recreation programs, and mental health specialists).
- 26 new schools and communities are implementing screening strategies - Prairie Screening Project partnership, National Depression Screening Day, plus targeted screening groups.
- North Dakota Tribal-Rural Mentoring Partnership was developed by the state project with 9 mentor coordinators working with 500 youth, 325 mentors in 20 tribal communities and 5 rural communities of North Dakota with funding from a Safe and Drug Free Schools Grant.
- Over sixty third year medical students from UND School of Medicine, fifty University of Mary nursing students, and thirty United Tribes nursing students have participated in year long mentoring to middle school adolescents and have received training on evidence-based suicide prevention efforts, substance abuse prevention, and a holistic model for suicide interventions.
- Adolescents involved in the medical student mentoring project showed a 35% reduction in suicidal ideation and 38% reduction in feelings that their families did not care about them.
- 2005 data from youth involved in the ND Tribal-Rural Mentoring Partnership showed an average contact of 5.2 hours per month, 65% increased academic grades, 60% were better able to avoid early drinking/tobacco, 80% better able to avoid early parenting- STD's, 63% better able to avoid legal trouble. Sixty percent of parents reported better home relationships, 80% reported more involvement in positive activities, 74% more helpfulness and generosity, and 71% improved relations with other adults.
- Over 95 tribal and rural entities have signed coalition agreements and belong to councils working on specified mentoring and suicide prevention activities.
- Over 50 Native American Injury Prevention students from United Tribes have been trained on suicide prevention strategies and are being placed in numerous tribal communities. Suicide prevention is becoming part of their core curriculum.
- Eight detention centers, attendant care sites, and residential centers have updated their suicide response protocol.
- Through training the trainer sessions over 20 gatekeeper trainers have been certified and provided training in North Dakota increasing capacity.
- The project's work has resulted in technical assistance training being provided to groups/individuals from 22 other states, including conference and curriculum planning with national and regional efforts including CSAP's Native American Prevention Sharing Conference, Native Lifesavers Conference, Aberdeen Area Tribal Chairman's Health Board, Region VIII US Public Health Services, West Denver Girls Project, and the National Suicide Prevention Resource Center.

40,000 North Dakotans Trained

Of these 7500 are teens

8000 professionals

1500 faith/cultural partners

From 2000-2004 there was a 47% drop in North Dakota suicide fatalities ages 10-19 compared to the average of the 1990's

1999-2003 Youth Risk Behavior Survey for North Dakota 9th -12th graders three teen suicide markers dropped 20-29%

Attachment # 2

Same given to House

I would like to address Chair Lady Judy Lee and members of the committee.

In 2005 fifteen males between the ages of ten and nineteen committed suicide in North Dakota. My nineteen year old son Chance was one of those males. What could have happened? Chance had turned in an application that Sunday for a bull riding school that was to be held the following week-end. You see Chance was full of hope for the future. His dreams were set on the Professional Bull Riders circuit. He and his dad had just bought some bulls and he wanted World Champion Bullrider Cody Custer to watch and critique his ride.

After turning in his application he went shopping for a Mothers Day present and bought himself a new cell phone case. We laughed about how jealous his Dad would be because it was camouflage. He eyed a lighted antenna for his phone and told the sales clerk he wanted one. She said they were out and would have more on Wednesday. He told her to hold one for him.

We parted ways and I talked to him by phone throughout the evening. Our last call was at 11:15 pm. I called him to tell him I was going to bed he said he would be there in a few. That was our last conversation. I tried reaching him all through the night. I was worried because he had never stayed out this late without checking in. I was sure the boys had gotten stuck somewhere because they had all been mudrunning that spring.

I only was called when it was all over Monday at 6:25 am. The Boy X who called me was very cool and collect. He just said that I needed to come. I never thought it was because Chance was dead.

I just couldn't understand his death. I thought we had all the bases covered. He had family support and love, mentors, positive activities, spirituality and even saw counselors who helped him with his reading comprehension disability. The autopsy came back with no drugs or alcohol. What could have went wrong for Chance?

We hired the services of a private investigator to look into his death. Chance became part of a new group that he normally did not hang out with because of interest in one of the girls. One of Chances close friends had this to say in his interview, "During the week before Chance died everything seemed to change. What had been the norm before was no longer the norm. Chance and Boy X suddenly became good friends, and he thought that Boy X was unlikely friend for Chance to have. He to felt that way because Boy X is such a controlling and negative person."

An unofficial psychiatric analysis of the mental state of Chance and his associates during the time leading up to Chances death was solicited by our investigator.

His finding was "Chances associates were playing a dark game when Chance came on the scene. Chance got brought into the game. He was straight, naïve and got caught up in the game. They didn't expect that Chance would take it to the next level and follow through, but he did."

Boy Xs'sixteen girlfriend who was part of this group and involved with Chance until he died had this to say in her interview, "She said that whole group of kids was seriously depressed on a regular basis and that Chances situation kind of spiraled out of control that night before they realized that was the case. She never really thought that Chance would commit suicide because that was not at all something he would do. No one who knew Chance ever would have suspected that he would do such a thing. They didn't

call friends because it was so late in the morning for them and they would all be asleep, and it was so early for everyone else."

It was shocking to our family that this group of kids could pull Chance down to the point of self destruction within one week. Reality is they did. I will never know what happened because as fast as these kids moved in they moved on. No remorse. No I'm sorry's. The loss of a child is with you every second. There are moments of comfort when someone writes special words. A young girl left this passage in a letter left at Chances grave:

"I had to smile when your Mom called your sister Chelsie when she was at my house, it reminded me of all the times your mom called to check on you. I wish my mom was like that, because you always knew your Mom cared."

This is why I am here today, because I care. Suicide needs to be addressed. We all think of victims as drug addicts, drunks, abused or depressed persons. That is not always the case these days. We are seeing good kids dying. Teenagers today are impulsive and suicide by teenagers is said to be an impulsive permanent solution to a temporary problem. Teens need to know to look to an adult when things get deep and not to another teen who does not have the life experience and maturity to know how to get the right help.

We should not limit this training of teachers and counselors to information we already know, but to recognize situations that don't fit the norm. We need to go beyond! In many instances we have only a narrow window of time for developing a plan from us noticing to them taking action. For Chance it was one week.

We have a responsibility to our youth. We are there PROTECTORS! We must do whatever we can to help them to achieve a healthy future. Suicide does not know age, wealth, race or sex. Everyone is at risk. It is the 2nd leading cause of death in our North Dakota youth and 3rd leading cause of death in the U.S. Our community needs to get educated to the realities of suicide.

I feel implementing programs in our schools would be beneficial in saving our youth now and for them to carry this education into adulthood.

I know hindsight is 20/20 but I can't help but wonder the outcome for Chance if all involved were educated in suicide prevention. If Chance had known how to get out of a moment so deep with company of those who want to bring harm. If his close friend would have known to alert an adult of Chance's unusual and seemingly unhealthy friendship. If Boy Xs' girlfriend knew it doesn't matter what time you call when it comes to saving a life. To his parents for knowing impulsive behavior is a high risk factor for suicide.

We have opened our home to our children's friends. We talk often and let me tell this world scares them. I believe we can help take some of these fears by letting them know we are here to help. One big way to help is to be educated in the dangers that may fall upon our youth. Just think about how much you have learned in the last five minutes and to think it may save a life.

Attachment # 3

NATIONAL ASSOCIATION OF SOCIAL WORKERS
NORTH DAKOTA CHAPTER

February 26, 2007

Testimony on Senate Concurrent Resolution 4032
Senate Human Services Committee

Chairman Lee and Members of the Senate Human Services Committee:

My name is Connie M. Hildebrand and I am the legislative chair of the North Dakota Chapter of the National Association of Social Workers. I'm providing testimony in support of SCR 4032, which directs the Legislative Council to study how school districts can identify high-risk students and access programs to reduce the incidence of high-risk behavior leading to suicide attempts.

In 2002 the President's Commission on Mental Health recognized youth suicide early intervention and prevention as an urgent public health priority. Although suicide accounts for 1.2% of deaths in the United States annually, suicide comprises 12.8% of all deaths among 15-24 year-olds. In this age group, suicide ranks as the third leading cause of death; in some states it's second. Suicide also ranks as the third leading cause of death in 10-14 year olds.

As in adult suicide, the causation of youth suicide is complex, multi-determined, and reflects the presence of "risk factors," the absence of "protective factors," and their interaction.

"Risk" factors may include a family history of suicide, childhood sexual abuse, exposure to domestic violence, or a mental health or substance abuse disorder. School-based, evidence-based, risk-screening tools can be utilized in the identification of at-risk youth, and NASW supports the administration of such tools by qualified mental health personnel.

In addition to the assessment of suicide risk factors however, it is critical schools recognize and implement "protective factors" that lessen risk. Protective factors can include teaching skills in problem-solving, impulse control, or conflict resolution. It can mean activating family support, obtaining access to mental health care, and reinforcing life-affirming cultural and religious beliefs that discourage suicide.

Testimony on Senate Concurrent Resolution 4032
Senate Human Services Committee
NASW-ND
February 26, 2007

The research on "risk and protective factors" suggests that a promising prevention strategy among school-age children is to reduce early risk-factors for depression, substance abuse, and aggressive behaviors and to implement programs that enhance resilience.

Attached to this testimony is the background paper prepared by NASW on youth suicide, 2005

Also, I have available the 2006 Kids Count Data Book which contains the ten key indicators of child well-being for North Dakota, along with a special section on American Indian children.

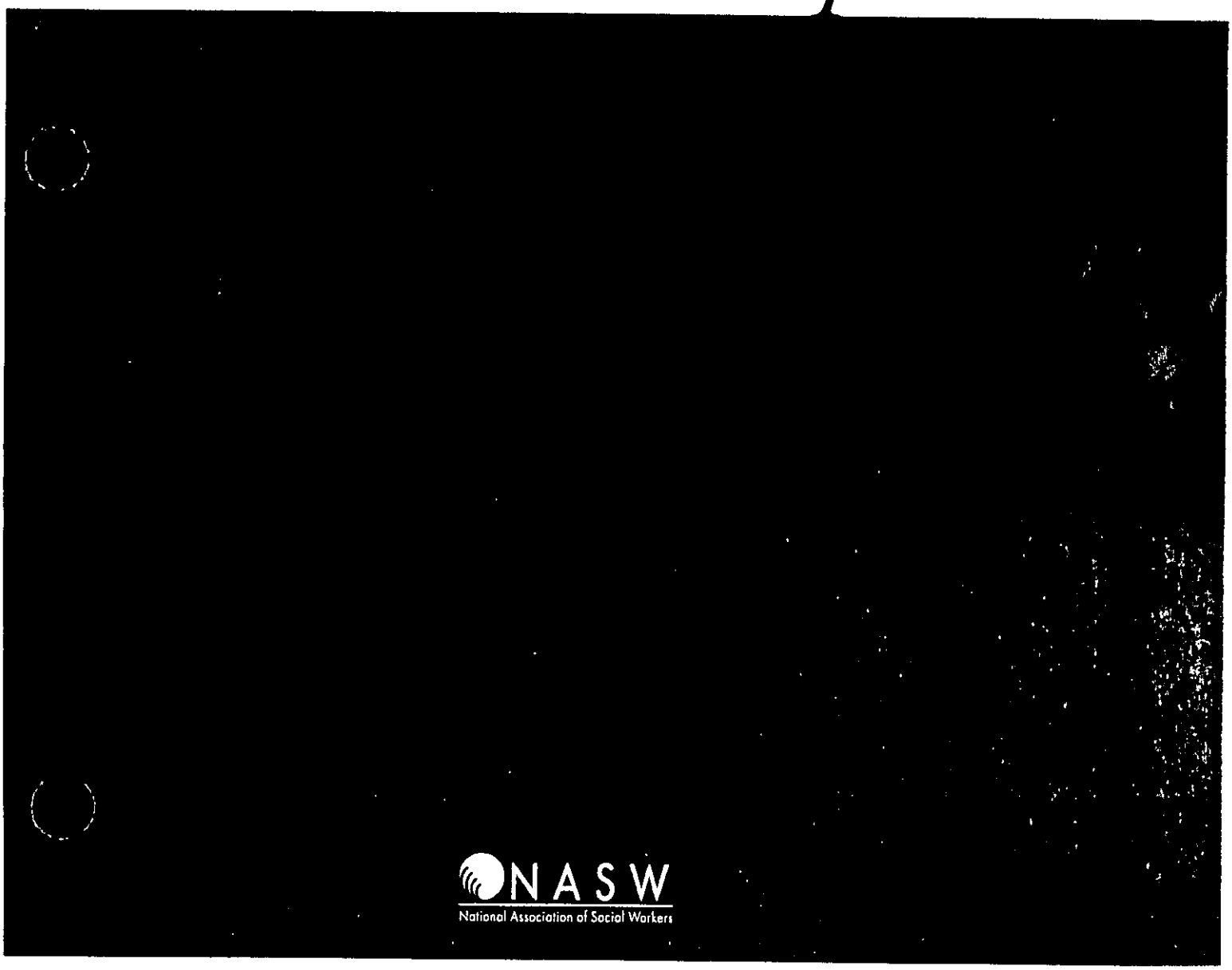
NASW welcomes this opportunity to offer support for this resolution, and commends the sponsor for helping focus community efforts on the issue of youth suicide.

We request a committee vote of DP on SCR 4032.

SEVENTH EDITION

2006-2009

Social Work *Speaks*



NASW
National Association of Social Workers

Youth Suicide

BACKGROUND

In 1999 former Surgeon General David Satcher, MD, PhD, released "The National Strategy for Suicide Prevention: Goals and Objectives for Action." This document, which reflected national awareness of suicide as a serious public health problem, was also designed to be "a catalyst for social change" by offering a comprehensive and integrated approach to suicide awareness and prevention. (U.S. Public Health Service [PHS], 1999). This approach was based on the growing body of knowledge about the biological and psychological factors that contribute to suicidal behaviors as well as recognition of the critical importance of trained, coordinated interdisciplinary resources for suicide prevention and intervention.

In 2002 the President's New Freedom Commission on Mental Health specifically recognized youth suicide early intervention and prevention as urgent public health priorities. Although suicides account for 1.2 percent of deaths in the United States annually, they comprise 12.8 percent of all deaths among 15- to 24-year-olds. In that age group, suicide ranks as the third leading cause of death, although in several states, particularly in western regions of the nation, suicide is the second leading cause of death in this age group (Centers for Disease Control and Prevention [CDC], 1999). Suicide also ranks as the third cause of death in 10- to 14-year-olds, which reflects a 99 percent increase between 1980 and 1997 (American Association of Suicidology, 2001; Children's Safety Network National Injury and Violence Prevention Resource Center, 2004). Although the suicide rate in this youth cohort remains highest for white males, the rate for African American males ages 15 to 19 is increasing rapidly and has more than doubled from 2.9 per 100,000 to 6.1 per 100,000 from 1981 to 1998. (CDC, 2000). The suicide rate for Native American youths is also exceedingly high compared with the overall rate for males ages 10 to 19 (19.3 per 100,000 versus 8.5 per 100,000) (CDC, 2000).

The rate for youth suicide attempts is difficult to estimate because many attempters may not be treated in a hospital or recorded as self-injury (Miller, Covington, & Jensen, 1998). The potential relationship among homicide, "suicide by cop" (youth intentionally escalates law enforcement into lethal use of force), excessive speed, and driving under the influence to suicide rates for youths warrants further research (Lindsay & Lester, 2004). Self-report data from 1999, however, indicate that 19.3 percent of high school students seriously considered attempting suicide, 14.5 percent made plans to attempt suicide, and 8.3 percent made an attempt in the year preceding the survey (CDC, 2000). This survey's data also indicated that Latino students, both male and female, were significantly more likely than white students to have reported a suicide attempt (12.8 percent versus 6.7 percent), with Latino females almost three times more likely than males (18.9 percent versus 6.6 percent) to have reported a suicide attempt. The most likely explanation for ethnic rate differences is variations in cultural norms related to suicide, including cultural views on adolescence and communication expectation among family members.

Firearms are the most common method for suicide completion by youths across sex, race, and age. More than 60 percent of suicides among youths between ages 10 and 19 in 1998 were firearm-related. The rate of youth suicides involving firearms increased 38 percent

between 1981 and 1994, and although there has been a slight decrease since 1994, these numbers remain critically high (CDC, 2000).

Just as in adult suicide, the causation of youth suicide is complex, multidetermined, and reflects an interaction of risk and protective factors (Berman, Jobes, & Silverman, 2005). Risk factors for completion include previous suicide attempts, a family history of suicide, childhood trauma, and a mental health or substance abuse disorder. Studies show that 90 percent of youths who completed suicide were suffering from a diagnosable mental illness at the time of their death (American Foundation for Suicide Prevention, http://www.afsp.org). Other risk factors include exposure to domestic violence, sexual abuse, impulsive and aggressive behavior, family instability, and a recent severe stressor. This stressor is rarely the cause of suicide, but often acts as a precipitating event or trigger for high-risk youths (Gould, Fisher, Parides, Flory, & Shaffer, 1996). A particularly significant trigger is incarceration. One study found that suicide in juvenile detention facilities was more than four times greater than the overall rate for youths in general (Hayes, 2000).

Exposure to the suicidal behavior of others, whether through personal experience or through real or fictionalized accounts in the media, has been shown to increase the suicide risk in vulnerable teenagers. There is also evidence that local epidemics of suicides, known as clusters, can have a contagious effect on youths who were only marginally connected to the suicide completer (Velting & Gould, 1997).

Although there is growing concern that gay and lesbian youths are at an elevated risk of suicide because of sexual orientation, no national statistics exist for completion rates in this group. Part of the challenge in assessing the implications of sexual orientation on suicide risk is that experts disagree about the best ways to measure sexual orientation; in addition, many adolescents may be reluctant to report issues related to sexual identity (National Institute of Mental Health, 1999). Clearly, this area requires further investigation.

Research indicates a positive association between the accessibility and availability of firearms in the home and the risk of youth suicide (Brent et al., 1993). The risk presented by guns is proportional to their accessibility and their number in the home (Kellerman et al., 1992).

In addition to the assessment of suicide risk factors, it is critical to recognize the protective factors that mitigate risk. Protective factors for youths include learned skills in problem solving, impulse control, skills in conflict resolution, family and community support, access to appropriate mental health care and support for help seeking, restricted access to lethal methods of suicide, and life-affirming cultural and religious beliefs that discourage suicide (PHS, 1999).

Despite national recognition of youth suicide as a major public health problem, there has been little systematic evidence on what is effective in regard to prevention (Briss et al., 2000). There has been, however, increasing awareness of the complexity of the problem as well as the implementation of scientific approaches to describing and monitoring youth suicide; understanding risk and protective factors; developing, implementing, and evaluating prevention strategies; and disseminating information about effective strategies (PHS, 1999).

The research on risk and protective factors suggests that a promising prevention strategy among school-age children is to reduce early risk factors for depression, substance abuse, and aggressive behaviors and to implement programs that enhance resilience. A confidential screening instrument has been developed to identify depression, substance abuse, and suicidal ideation among high school youths; subsequent evaluation by mental health professionals can then facilitate referral for appropriate treatment (Shaffer & Craft, 1999).

Other school-based interventions, such as general awareness programs, and dissemination of lists of "warning signs," have been less promising. These programs have sometimes had the unintended effect of suggesting that suicide is an option for many young people (PHS, 1999). Obviously, the need for carefully evaluated program development that is informed by existing research is essential.

ISSUE STATEMENT

The suicide rate has long been understood to correlate with cultural, social, political, and economic forces (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Because social work values are so intrinsically related to supporting the individual's right to self-determination in a societal context, it has both the responsibility and the opportunity to apply its expertise to the multifaceted, systemic challenges presented by youth suicide. Few professions have as ubiquitous a presence in systems that involve children, from the family and the school to child protective agencies and the juvenile justice system.

Unfortunately, social work education has been slow to include suicide assessment and prevention in graduate coursework or continuing education requirements. Feldman and Freedenthal (2003), in a recent national survey of social workers, reported that 78 percent of respondents felt that they were inadequately trained in suicide prevention in their MSW program. Only 55 percent had some classroom instruction in suicide intervention and of those, 78 percent reported they had received two hours or less of instruction. At the same time, 86 percent recommended required continuing education in suicide management.

The profession of social work is not alone in this oversight. Goal 6 in the National Strategy for Suicide Prevention states that "many mental health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients for specialized assessment and treatment" (PHS, 1999, p. 79). It also indicates that there is lack of awareness of the mental health issues faced by family members of loved ones who have died by suicide. The National Strategy for Suicide Prevention, therefore, recognizes that the training of community gatekeepers, including social workers, must be improved to provide proper assessment, treatment, and management of suicidal people (PHS). The accessibility of current epidemiological data and research information on nationally recognized Internet sites enhances this learning process and is a valuable educational resource.

Given that many social workers serve as community gatekeepers, social workers are in a unique position to address the stigma associated with mental illness, substance abuse, and suicide. Not only does this stigma inhibit help seeking, but it also has contributed to inadequate funding for preventive services and to low reimbursements for treatment (PHS, 1999). Transforming public attitudes requires broad-based support, and the systemic approach of social work can bring community linkage skills to this critical public education need. In fact, because the community is truly at the core of many youth suicide prevention and intervention initiatives, social work networking and community organization techniques can facilitate the coordination of interorganizational communication and service delivery related to youth suicide awareness and prevention.

Social work is also in a position to contribute to the increasing body of knowledge about prevention strategies, treatment interventions, and the enhancement of protective factors that mitigate risk, especially in school and community settings. As in all social problems, the profession plays a vital role in the development of public policy that is theoretically grounded in evidence-based research and is directed toward the development of comprehensive youth suicide prevention plans.

POLICY STATEMENT

NASW is in agreement with the surgeon general's recognition of youth suicide as a major public health problem. It is the position of NASW to address the social and mental health issues related to youth suicide, by supporting the following:

- undergraduate, graduate, and continuing professional education about the scope of youth suicide and the current evidence-based prevention and intervention strategies.
- provision of a range of prevention, intervention, and postvention services at the community level for families and others affected by the suicide of children and youths.

- evidence-based research into the unique risk factors of ethnically, sexually, and gender diverse youths.

- involvement of social workers in the development and implementation of youth suicide awareness and prevention (including continuing education programs for and consultation services to non–mental health staff) in schools, child welfare agencies (child protection teams), juvenile detention facilities, courts, and other settings where youths may be at elevated risk.

- media education for the general public and community gatekeepers (including clergy, police, hospital personnel, emergency personnel, and recreation staff) to minimize the risk of suicide contagion and encourage the dissemination of information on mental health resources for youth suicide prevention at the community level.

- interdisciplinary strategies developed in collaboration with professional associations and community agencies to decrease the stigma associated with mental illness, substance abuse, and suicide.

- research concerning posttraumatic stress syndrome and its impact on youth suicide.

- educational and legislative measures that restrict access of youths to firearms

- family, school, and community-based programs that enhance protective factors for families and youths.

- school-based, evidence-based, multifactored screening as an important tool in the identification of at-risk youths. Training on the use of this tool provided to the gatekeepers (including administrators, counselors, coaches, teachers, school social workers). NASW supports the administration of such tools only by qualified mental health personnel.

- development and funding of multidisciplinary research projects aimed at extending the knowledge base about youth suicide and demonstrating which interventions have proven efficacy.

- legislative efforts to provide grants to state and local governments and nonprofit organizations to help develop, coordinate, and expand early intervention and prevention strategies and community mental health services for at-risk youths.

- evaluation of the effectiveness and efficacy of youth suicide prevention and early intervention activities.

- social work involvement in the development of policies, procedures, and protocols that facilitate interdisciplinary collaboration with professional associations and community agencies in the provision of early identification, intervention, and postvention services.

- advocacy on state and local levels, to ensure an appropriate continuum of care, from least restrictive to most restrictive, is available for youths at risk of suicide.

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SUGGESTED READING

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Policy statement approved by the NASW Delegate Assembly, August 2005. This policy statement supersedes the policy statement on Youth Suicide approved by the Delegate Assembly in 1996 and referred by the 2005 Delegate Assembly to the 2005 Delegate Assembly, and the statement approved in 1987. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 700, Washington, DC 20002-4241. Telephone: 2002-408-8600 or 800-638-8799; e-mail: press@naswdc.org.

Attachment #4

Testimony

Senate Concurrent Resolution 4032

Senate Human Services Committee

Monday, February 26, 2007; 11:15 a.m.

North Dakota Department of Health

Good morning, Chairman Lee and members of the Senate Human Services Committee. My name is Dorcas Kunkel, and I am director of the Suicide Prevention Program for the North Dakota Department of Health. I am here to testify in support of Senate Concurrent Resolution 4032.

Senate Concurrent Resolution 4032 calls for the Legislative Council to study ways in which schools and school districts can educate teachers and counselors to better identify high-risk students and to identify ways in which schools and school districts can plan and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts.

Several studies have been conducted that look at risk factors for youth suicide. These risk factors include:

- Previous suicide attempts – Teens who have attempted suicide in the past are much more likely than other teens to attempt suicide again in the future. Approximately a third of teen suicide victims have made a previous suicide attempt.
- Depression and/or alcohol or substance abuse – More than 90 percent of teen suicide victims have a mental disorder, such as depression, and/or a history of alcohol or drug abuse.
- Family history of mental disorders, substance abuse, or suicide – Teens who kill themselves have often had a close family member who attempted or committed suicide. Many of the mental illnesses, such as depression, that contribute to suicide risk appear to have a genetic component.
- Stressful situation or loss – Teens who kill themselves almost always have serious problems, such as depression or substance abuse. When they experience losses or certain stressful situations, it can trigger a suicide attempt. Such stressful situations include getting into trouble at school or with the police; fighting or breaking up with a boyfriend or a girlfriend; and fighting with friends.[1]
- Exposure to other teenagers who have died by suicide – Teens are more likely to kill themselves if they have recently read, seen or heard about other suicide attempts.

I direct the Garret Lee Smith State and Tribal Youth Suicide Prevention Grant provided by the federal Substance Abuse and Mental Health Services Administration. This grant provides the North Dakota Department of Health $1.2 million over three years to focus on suicide prevention for North Dakota youth ages 10 to 24. The project period for this grant is from Sept. 30, 2006, to Sept. 29, 2009.

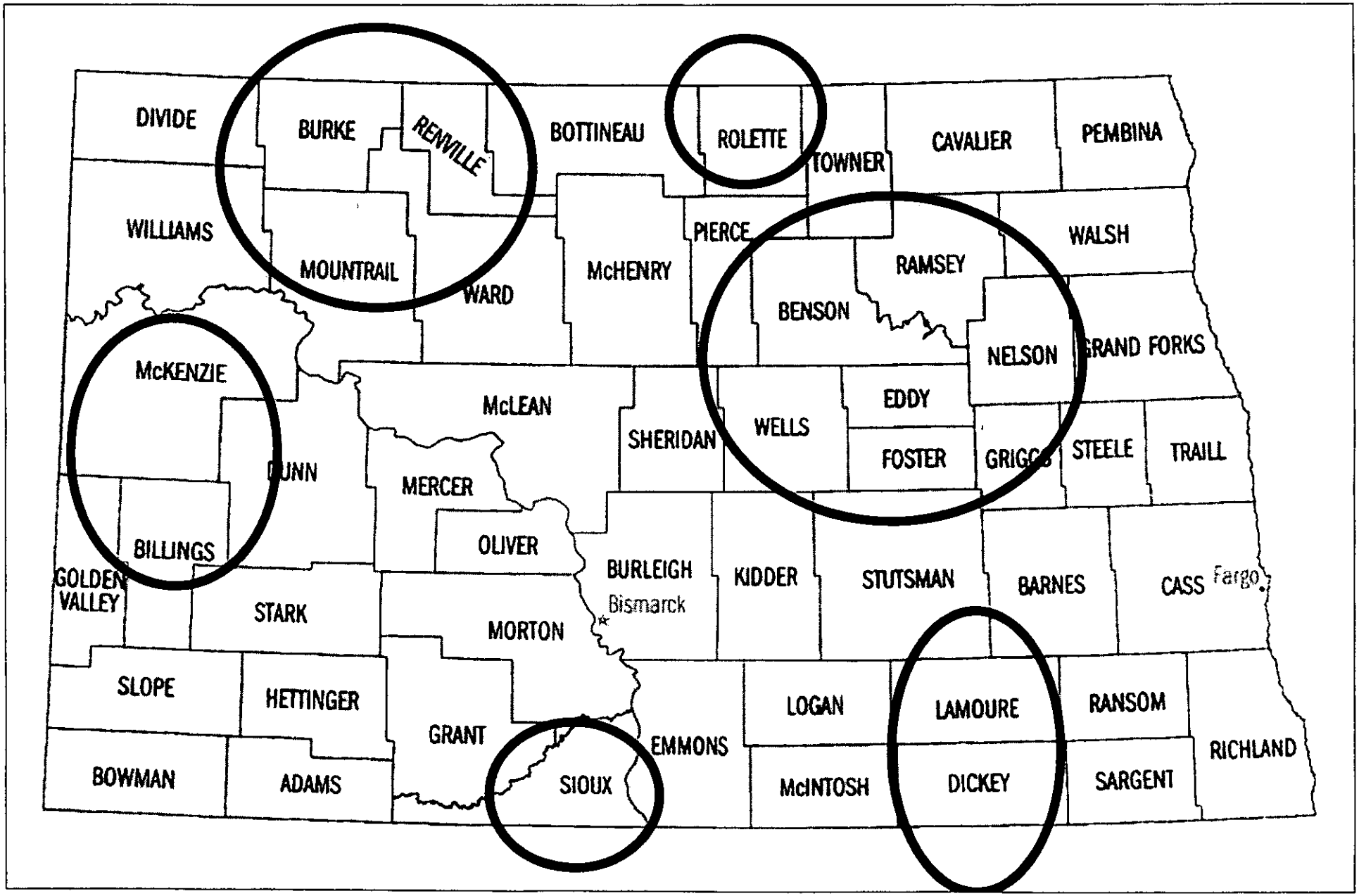
The purpose of the Youth Suicide Prevention Grant is to build on the foundation of prior suicide prevention efforts for youth in order to support states and tribes in developing and implementing youth suicide prevention and early intervention strategies. The grant requires public and private collaboration among institutions and agencies that serve youth, including schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other organizations.

The goal for this grant is to reduce youth suicide deaths in four of the six highest risk areas of North Dakota. The long-term goal of the Department of Health's Suicide Prevention Program is to develop a comprehensive, statewide suicide prevention program. In addition, a nationwide and statewide cross-site evaluation will be conducted during and at the completion of the grant to evaluate the effectiveness of suicide prevention programs in different settings and different areas of youth service. We would happy to share this data with the committee during your study.

The study called for in Senate Concurrent Resolution 4032 is timely and important. The Department of Health offers our assistance in meeting your goals.

This concludes my testimony. I am happy to answer any questions you may have.

Highest Youth Suicide Fatalities Areas of North Dakota
Focus of ND State GLS Grant



North Dakota KIDS COUNT

A Project of the Annie E. Casey Foundation

Part of Attachment 3: Connie Helgeland

Dr. Richard Rathge, *Executive Director* **Helen Danielson**, *Coordinator*

December 2006

Greetings from North Dakota KIDS COUNT. For the past 12 years, North Dakota KIDS COUNT has been tracking data and analyzing the well-being of our state's children. The *2006 Overview of Children's Well-Being in North Dakota: A Focus on American Indian Children* reflects a focus on a growing minority population in our state. Understanding the major trends within a cultural context provides meaningful discussion of both strengths and weaknesses and well-informed decisions that affect American Indian residents and citizens statewide. Some major trends and highlights include:

- The American Indian population in North Dakota grew considerably between 1990 and 2004.
- Children represent nearly half of all American Indians in our state.
- American Indian children in North Dakota benefit from strong extended family support.
- About three in seven American Indian children in North Dakota reside with a single parent.
- North Dakota has five tribal colleges within its borders with approximately 2,000 American Indians enrolled Fall 2005.
- American Indian children younger than 18 have poverty rates more than four times as high as white children in our state.
- Approximately one-third of all children enrolled in North Dakota Head Start programs are American Indian.
- Since 2000, there has been a significant drop in the infant death rate for American Indians in North Dakota.
- American Indian teens have higher suicide rates than do all teens in North Dakota.
- American Indian children comprise 9% of the state's children, but 29% of all children in foster care in North Dakota.

North Dakota KIDS COUNT is pleased to present you with this colorful file folder of NEW publications on Children's Well-Being in North Dakota. For ready access, you can place this folder in your filing system with the tab "North Dakota KIDS COUNT" easily visible. The folder contains:

- *2006 Overview of Children's Well-Being in North Dakota: A Focus on American Indian Children*. This publication sets the stage for American Indians' unique political and racial status and provides an appreciation of their cultural heritage. The focus is on North Dakota's American Indian population, family composition, economic conditions, education, health, and "at-risk" indicators. In addition, this publication strives to "put it all together" and provide resources for further information on American Indians in North Dakota.
- *2006 North Dakota KIDS COUNT Fact Book* cover. This sheet provides a reminder that the traditional Fact Book format continues to be readily accessible online with state, regional, and county profiles of child well-being in North Dakota. You may download the complete Fact Book or just the portions that you need.
- *2006 North Dakota KIDS COUNT ABRIDGED Fact Book* is a condensed version of the *2006 North Dakota KIDS COUNT Fact Book* and provides a quick comparison of state and county indicators.
- North Dakota KIDS COUNT Bookmark, reminding you to place www.ndkidscount.org among your online "favorites" for quick access to all the publications in this folder and other resources for information about children and families. If you have difficulties accessing the information you need, please contact our office at (701) 231-5931.

We hope that you will find the new publications helpful as you work to improve the well-being of our state's greatest resource, our children and families.

Sincerely,

Richard Rathge,
Executive Director

Helen Danielson,
Coordinator

Polly Fassinger,
Research Analyst

North Dakota State University, PO Box 5636, Fargo, ND 58105

Phone 701.231.5931 - Fax 701.231.9730 - ndkidscount@yahoo.com - www.ndkidscount.org

Mental Health Association in ND
1051 East Interstate Avenue
Bismarck, ND 58503
info@mhand.org
701-255-3692

Download this document at
www.ndsuicideprevention.org

Online depression screening
www.mhand.org

If you are in crisis in North Dakota call

2-1-1 Get Connected. Get Answers.

Or HELP-LINE 1-800-472-2911

National crisis Lifeline

NATIONAL SUICIDE PREVENTION LIFELINE

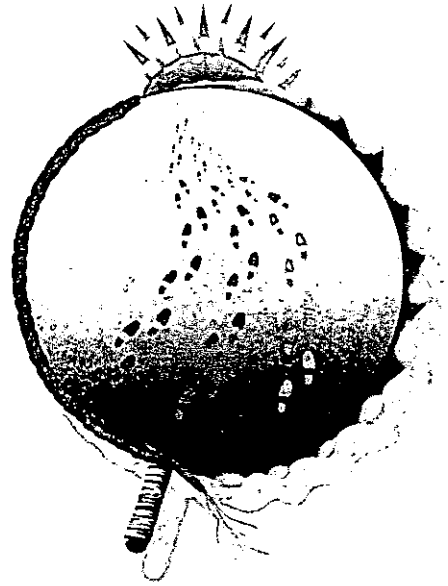
1-800-273-TALK

www.suicidepreventionlifeline.org

Sources of Strength

A Natural Helper Guide For Preventing Youth Suicide

For friends, parents, and community!



The North Dakota Suicide Prevention Project

A collaborative project between
Mental Health Association in North Dakota
North Dakota Adolescent Suicide Prevention Task Force
United Tribes Native American Injury Prevention Project
North Dakota Department of Health

Suicide

IS NOT ABOUT DEATH

Teens that attempt suicide do not want to kill themselves. They want to end their pain. Adults and friends can often dismiss a teen's "problems" as temporary without realizing that depression, drinking, grief, anger, or trauma can distort how a teen sees life. They can often feel that their unhappiness is permanent.

A teen can be left feeling that no one can help them or that they have no other choices left. The saying that suicide is a permanent solution to a temporary problem is true.

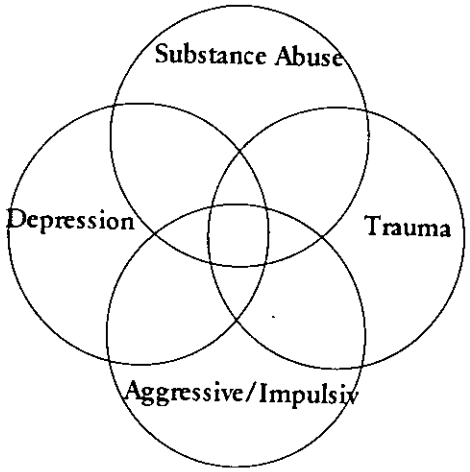
Friends are often in a good position to recognize teens at-risk of suicide. They can help by showing they care, listening, acknowledging the pain, showing them that they do have choices, and getting them to a counselor and other sources of healthy support.

Involve others.

Don't try to help all by yourself.

Facts About Suicide

- Teens that talk and threaten suicide often do it.
- About 80% of the time teens who kill themselves have given out signals, especially to friends and peers, but friends mistakenly keep this a secret.
- Most suicidal people do not want to die, but are feeling alone, stuck, hopeless, and want the pain to stop.
- Teens of all kinds, cultures, ages, and education levels end their own lives. Don't dismiss your concerns because they are not the type.
- Asking someone if they are suicidal will not cause someone to do it...
- Listen, have a caring discussion and connect teens with needed support. Don't handle it alone.
- Pay attention to anger, conflict, and impulsivity as a potential warning sign, as well as depression, substance abuse, and traumatic events.



Individuals struggling with…

- long-term depression
- with substance abuse addiction
- conflict or increasing levels of aggression
- trauma through abuse, rape, fight, harassment, an accident, or a death of someone close to them are often at increased risk of suicide.

Trauma, conflict, depression, or addiction can often make a person feel emotionally, mentally, spiritually, or even physically paralyzed. If feeling hopeless and suicidal, a person may often be feeling that nothing helps, nothing works. **The fact is that most suicidal individuals get better. Their stories to health and healing are reflected in the sources of strength.**

Risk Factors

There is no one suicidal type, but the presence of these factors makes it more likely a teen may have suicidal thoughts and attempts.

- Previous suicide attempts
- Depression, hopeless, helpless feelings
- Drinking, using drugs, or heavy nicotine usage
- Increased anger, conflicts, aggression, irritability
- Trauma incident – rape, abuse, harassment, fights
- Recent loss of family or friend by death or suicide
- Isolating behaviors toward friends, family, activities
- Risk taking behaviors – cars, weapons, sexually
- Injury or illness that disables even temporarily
- Gay or lesbian issues – sexual orientation harassment
- Talking or joking about suicide
- Doing poorly in school, skipping classes
- Death themes in music, writing, or art
- Losing interest in things they used to enjoy
- Personal care and hygiene changes
- Sleeping, eating, concentration problems, crying
- Males account for 85% of suicide fatalities, but females make 85% of suicide attempts
- Substance abuse is involved in over 65% of teen suicide attempts
- More suicides are attempted by middle school youth, but more fatalities occur in 17-24 year ages.

Building Multiple Strengths

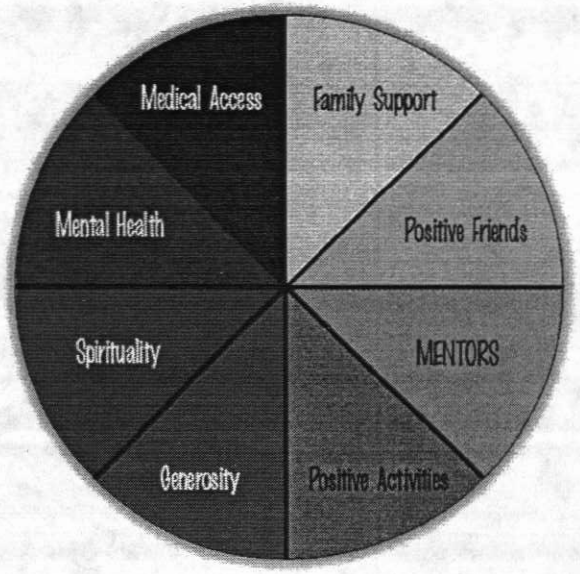
Healing, strength, resiliency, or protection comes from a wide range of supports and places. These eight sources of strength are areas that young people at-risk for suicide will most commonly mention as making a positive difference in their lives. If your child or friend is suicidal you should start by helping them get to appropriate mental health or medical services—they can be struggling with an untreated or undiagnosed medical or mental health problem. Remember - move beyond just one support. Develop a cluster of supports around a suicidal young person.

Your support as a parent, a friend, a mentor, a spiritual advisor, a counselor, or a physician is important, but your help alone is usually not enough to keep a suicidal young person safe.

The key is to build many of these sources of strength around our youth. Remember that most suicidal individuals do not wish to die, but are often feeling alone, isolated, and hopeless. Healthy supportive relationships are vital in helping a suicidal person through a crisis. Without some caring relationships in a suicidal person's life many of the other interventions lack effectiveness and intensity.

Think of suicide interventions and prevention as building a cluster of supports.

Many individuals struggling with depression, anger, trauma, and substance abuse find that spiritual support and seeking healthy beliefs is very healing and starts them on a new path in life. Others often find that becoming involved in positive activities, such as, sports, art, and music make a tremendous difference. Yet others find that reaching out and helping others, practicing generosity in their lives not only helps others, but acts as a powerful protector in their own lives. Some find that a specific medication, therapy, or a support group is key in finding their way through a difficult time. As a parent or friend remember to involve others in bring healing and support to someone feeling suicidal.



Sources of Strength Survey

On a 1-10 Scale (1 being very poor support – 10 be very strong support) how would you rate yourself in the following areas. Write your score in the box area.

☐ **Family Support.** (Feel cared for, loved, supported by my family, take time for me)

☐ **Positive Friends.** (Friends that care about me, help me stay out of trouble, help me make healthy decisions.)

☐ **Caring Adults.** (I feel I have strong friendships with adults that care about me other than my parents,)

☐ **Positive Activities.** (I feel I'm involved in healthy activities, such as sports, arts, music, etc.)

☐ **Generosity.** (I feel I have strong opportunities to help others, show leadership, make a difference through helping others.)

☐ **Spirituality.** (I feel I have healthy beliefs and practice my faith, spirituality, or culture.)

☐ **Mental Health.** (I feel I have good access to a counselor or support group if I, my friends, or family needed one.)

☐ **Medical Support.** (I feel I have good access to a doctor, nurse, clinic, or medication if I, my friend, or family needed it.)

Which sources of strength do you feel are strong in your life right now?

Which Sources of strength do you feel need to be strengthened? If you were going to pick one or two to strengthen in the next two weeks, which would they be?

Informal and Formal Supports

Young people will very seldom refer a friend to institutions, but often try to seek help through someone they know. If you had a suicidal friend, which adults would you contact to get help. List some names below.

Remember organizations and individuals exist in your community that are trained to help with suicide – mental health professionals, school counselors, hospitals and clinics, and emergency services. If you are not sure who to contact call 2-1-1 in North Dakota or the National LifeLine at 1-800-273-TALK and they will assist 24 hours a day.

See It – Say It *From Minnesota Institute of Public Health*

When a friend or family engages in risky, unhealthy, or suicidal behaviors here is a simple caring, but assertive way to talk to them.

1. I care ... express your concern and care first
2. I see... describe what you see or noticed
3. I feel... use a feeling word - worried, concerned
4. Have you been thinking of suicide, hurting yourself?
5. I'm listening... what is going on for you?
6. I want... you to talk with someone else, involve your parents, talk to the school counselor, etc.
7. I will... go with you, make an appointment, give you a ride, call you tonight.

Remember if someone is actively suicidal get help immediately, do not leave them alone, and get medical or mental health assistance as a place to start the healing process.

A Deadly Barrier to Help –
Codes of Silence

Friends are often the first to notice signs of concern or even suicidal signs in their friends. In one study 80% of teen suicidal fatalities had peers that knew their friend was suicidal, but chose not to go to an adult.

The reasons for silence are many...

- Not taking threats seriously
- Thinking their friend will get in trouble
- Afraid their friend will be angry with them
- Not knowing or trusting adults to turn to
- Believing they can take care of their friend by themselves
- Thinking that their friend was suicidal for just that incident (most stay at-risk for up to six months)

Remember, tell someone. Get your friend, child, or family member to help and begin building multiple supports. Don't try to keep them safe by yourself.

If a suicidal person is joking about suicide or making suicide comments or threats while drinking alcohol or using drugs – this makes them significantly more at risk to harm themselves, not less. Many believe when an individual is drunk they do not know what they are saying – 65% of teen suicide fatalities happen when the individual is drunk or high.

L.E.A.D.E.R.

For natural helpers such as parents, mentors, teachers, and spiritual advisors think of LEADER as a guide during an intervention.

Listen—Take suicide indications seriously. Never mock or challenge a youth's statements about suicide.

Empathize—Your greatest strength in helping a suicidal youth is your relationship with them. Make every effort to be available, call periodically, and try to keep in touch with the youth's moods and progress.

Affirm—Don't contradict a youth's feelings of hopelessness or how bad everything is, but acknowledge the difficulties and affirm their worth as a person.

Direct—Build your relationship with the youth, foster communication, teach coping skills, focus on resources, and develop a plan of action.

Enlist—Involve the youth in a verbal "life agreement." Ask them to agree to keep trying and to call or make contact if overwhelmed. The adult should agree to take time if contacted by the youth.

Refer—If a youth has even passing thoughts of suicide, a medical or mental health assessment should be pursued. If the danger is serious, take them immediately to a clinic, hospital, or local mental health center. Always remove firearms and other identified means of harming themselves while the youth is suicidal.

ALWAYS
GET
HELP
FOR
THE
YOUTH

RISK = DANGER+AVAILABILITY+TIME FRAME

North Dakota Adolescent Suicide Prevention Task Force

Suicide Prevention

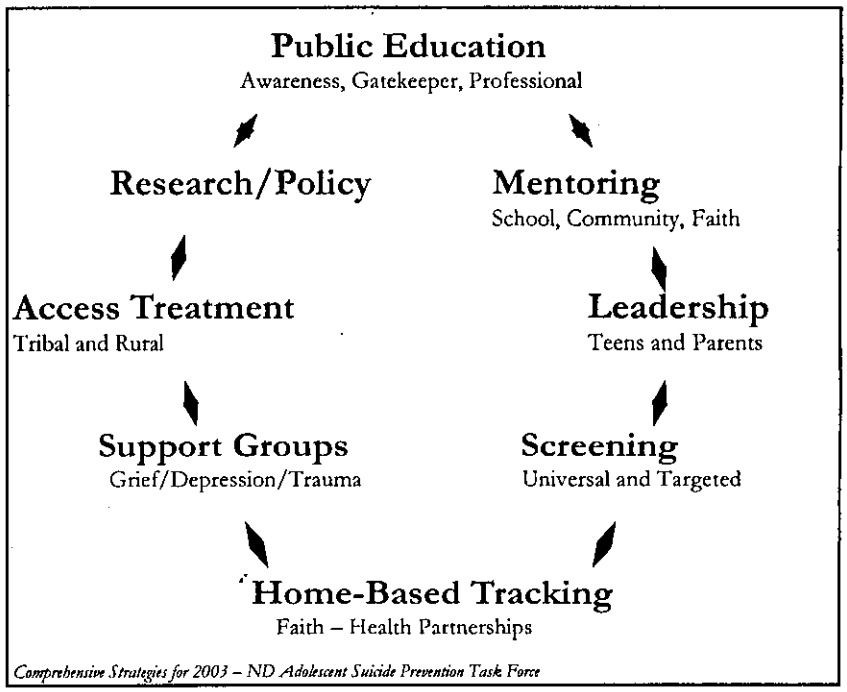
Increasing Protection for Your Community's Youth

50 Anniversary Celebration
Mental Health Association in North Dakota

INJURY PREVENTION PROGRAM
SPIRITUAL MENTAL EMOTIONAL PHYSICAL

United Tribes Technical College

ND Teen Suicide Deaths Reduced
Funding Needs are Critical



Comprehensive Strategies for 2003 – ND Adolescent Suicide Prevention Task Force

Statistically, it's not yet significant, but the 48% drop in North Dakota suicide fatalities among 10-24 year olds, from a ten year average of 21 youth suicides to 11 in 2001, comes as a hopeful sign in the midst of an aggressive three year youth suicide prevention campaign. Grants of $75,000 per year provided funding for the first three years; it is hoped that long term funding from state and local resources will continue to enable statewide leadership in 2003.

In the three year period, the following outcomes were identified.

- ◊ 325 workshops presented to 10,000 participants.
- ◊ 40% of the workshops were in tribal areas with over 30 Native American co-trainers used.
- ◊ 2500 teens trained as peer gatekeepers.
- ◊ 62 teen leadership prevention projects trained.
- ◊ 27 new teen led prevention projects started.
- ◊ 13 new mentoring projects started.
- ◊ A state-wide rural and tribal mentoring co-op received funding.
- ◊ 26 new schools began screening efforts.
- ◊ 3 suicide prevention coordinators hired in 3 state/tribal regions.
- ◊ 2 videos produced: *"Teen Leaders-Partners in Prevention"* and *"Sources of Strength-Native Americans"*.
- ◊ Pilot home-based tracking project started with Mercy Hospital in Valley City area.

Despite the success of the project, suicide issues remain a significant health risk to North Dakota teens and young adults.

Suicide remains the #2 cause of death for 10-24 year olds in North Dakota.

According to the results from the **2001 North Dakota Youth Risk Behavior Survey,** 9th – 12th graders reported the following:

- ◊ *13,800 ND teens (19%) reported thinking of suicide in the past year;*
- ◊ *5400 ND teens (7.5%) reported attempting suicide in the past year;*
- ◊ *1600 ND teens (2.3%) needed medical attention for a suicide attempt in the past year.*

"In the past three years 325 suicide prevention workshops by the ND Adolescent Suicide Prevention Project were held with over 10,0000 participants in North Dakota ."

2002 ND Adolescent Suicide Prevention Project Report

ND Adolescent Suicide Prevention Project

The North Dakota Adolescent Suicide Prevention Project and the Mental Health Association in North Dakota (MHAND) can help your community, school, faith group, or professional organization become involved in implementing effective suicide prevention activities. Here are some recommended strategies.

Public Education

- ◊ Increase community awareness through sponsored regional or tribal workshops (325 with over 10,000 participants in past three years.)
- ◊ Update training for medical, educational, emergency, justice, faith, residential, and other professionals.
- ◊ Provide community gatekeeper training for caring adults that addresses listening, assessing, and referral of suicidal teens.
- ◊ Provide key teen leaders with a proven Peer Gatekeeper Curriculum that addresses codes of silence and can be used to start other teen led prevention activities.

Mentoring Cooperative

- ◊ Start a small team of adult mentors in your community, school, or faith group for one of the most highly effective prevention strategies.
- ◊ MHAND has resources to help with recruitment, training, screening, matching, and supervising mentors in rural and tribal settings.

Teen Led Prevention

- ◊ Startup and ongoing training is provided to help get teens actively involved in effective prevention efforts.
- ◊ Get teens involved in proven focused prevention activities around mentoring, after-school programs, co-facilitating small groups, presenting prevention curriculum, multi-media messages on television, radio, drama, or print media.

Screening Strategies

- ◊ Use recommended quick screening tools to provide early identification of teens at-risk for suicide in your school or community.
- ◊ Tools and technical assistance are available for universal screening (all students) or toward targeted groups in schools, churches, or specified programs.

Support Groups

- ◊ Initial training and technical assistance is available for your community, school, or faith group to provide grief, depression, survivor, and addiction support groups.

Home-Based Tracking

- ◊ Technical assistance for developing a rural and tribal home-based tracking model for suicidal teens is available. This model would provide a partnership between local medical professionals and community or faith-based natural helpers that could provide a bridge to professional services for suicidal teens.

HELP-LINE: 1-800-472-2911
Answered 24 hours a day

- ◊ Use the statewide nationally certified crisis intervention and referral service for your community. Call and make sure your community resources are listed.
- ◊ Crisis response team models and protocols are available.

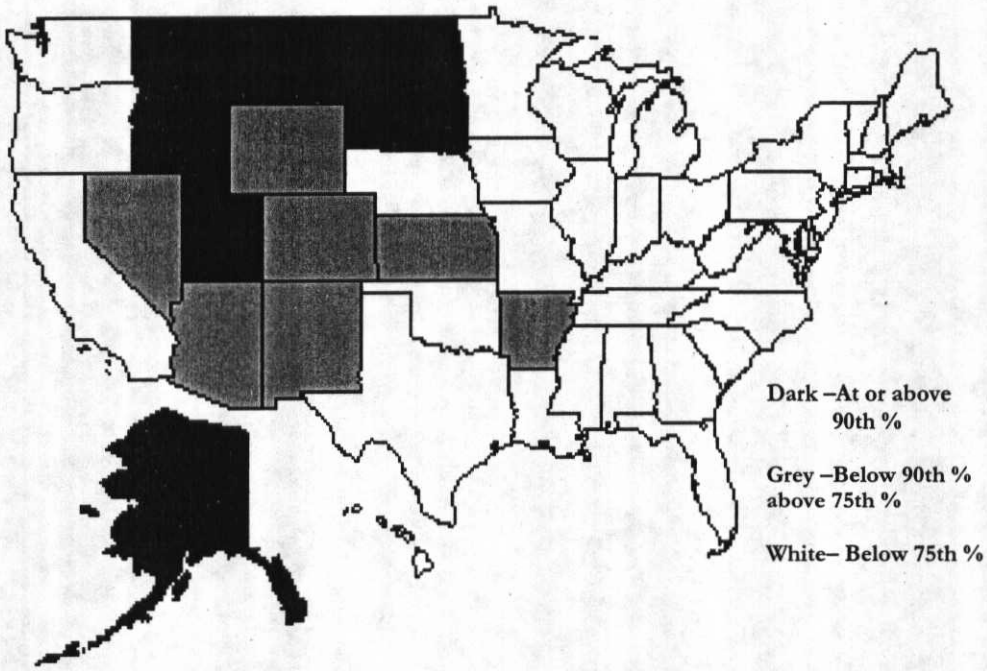
MHAND Resource Center

- ◊ Over 150,000 publications and handouts, and 650 videos related to mental health issues are available. 1-800-472-2911.

Community Capacity

- ◊ Collaborate with many other organizations on the ND Adolescent Suicide Prevention Task Force, Native American Injury Prevention Program and others, in promoting effective proven suicide prevention strategies.
- ◊ Training-the-trainer workshops for local suicide prevention coordinators.
- ◊ Technical assistance and grant writing assistance in developing regional and tribal suicide prevention plans and local prevention activities.

1996-1998 Suicide Fatalities (ages 10-19)



Source: National Center for Disease Control
Most recent national data available

CORE PREVENTION STRATEGIES

INCREASING PUBLIC EDUCATION AND AWARENESS

The U.S. Surgeon General's *Call to Action* in 1999 highlights the need to increase awareness of suicide as a public health issue:

- ◊ Twice as many teens die from suicide than homicide.
- ◊ More teens die from suicide than cancer, heart disease, AIDS, birth defects, strokes, pneumonia, influenza, and chronic lung disease **combined.**
- ◊ Lack of awareness and stigma toward mental health issues affect policy makers and hamper implementation of effective strategies such as universal screening in schools.

INCREASING ACCESS TO MENTAL HEALTH AND MEDICAL SERVICES

Reducing the stigma and barriers to treatment for mental health disorders remains a high priority:

- ◊ Updating professional training related to identification, treatment, and aftercare of suicidal individuals.
- ◊ Increasing mental health coverage and services in rural and tribal areas.
- ◊ Increasing early screening strategies.
- ◊ Increasing natural helpers ability to identify and refer through gatekeeper training.
- ◊ Enhancing community-based care models such as home-based tracking.

INCREASING RESILIENCY AND PROTECTIVE FACTORS

Preventative strengths that strengthen mental health:

- ◊ Increasing family support by encouraging time together, appropriate boundaries, and care.
- ◊ Building relational supports for all youth through adult mentoring and positive peer support.
- ◊ Building opportunities for bonding through healthy activities in sports, arts, and music.
- ◊ Helping teens feel they can contribute to a community through teen leadership efforts and growing skills of generosity.
- ◊ Increasing healthy beliefs through involvement in faith communities.

"More teens die from suicide than from cancer, heart disease, AIDS, birth defects, strokes, pneumonia, influenza, and lung disease combined."

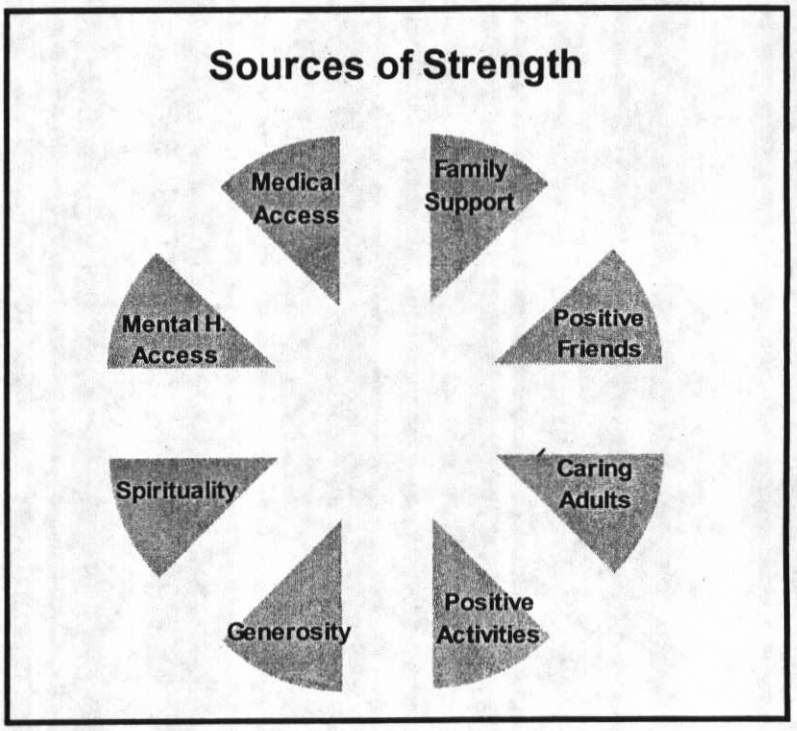
1999 U.S. Surgeon General's Call to Action

"It's important that professionals, natural helpers, and teen leaders understand where strength, healing, and resiliency come from. It's as important as knowing suicidal warning signs."

Mark LoMurray, Director of North Dakota Adolescent Suicide Prevention Project

Increasing Proven Protective Factors

Prevention research clearly points toward areas of resiliency, assets, or protective factors that keep teens safe. Unfortunately, traditional suicide prevention and intervention strategies have tended to focus on only three core protective factors (medical, mental health access, and family support), often at the exclusion of others. Yet the research seems clear, the more assets or strengths teens have, the healthier and safer they will be.



It's important that professionals, gatekeepers, and teen leaders understand where strength and healing come from. It's as important as knowing suicidal warning signs.

A clear suicide prevention message needs to increase clusters of protective factors, no one source of strength should be seen as adequately protective when dealing with suicide issues.

- Teen leaders need to know that positive friends are important, but other adults and areas need to be involved.
- Parents need to know that care, boundaries, and consistency are important, but other areas of support are needed.
- Physicians need to understand that medication can help, but other supports need to be pursued as well.
- Spiritual leaders and pastors need to know that prayer and faith can be powerful, but that other supports are important as well.

Our success in prevention should be measured by increases in areas of strength and reductions in injuries and fatalities.

Using Sources of Strength as part of a suicide intervention

Listening, determining risk, and making a referral is the first order of business during a suicide intervention. But, here are a few strength-based questions to ask...

- ◊ In your family who is most supportive and helpful to you? When did you talk to them last?
- ◊ Who tend to be your healthiest friends?
- ◊ Who are some healthy adults friends in your life? Have there been any in the past? Teachers?
- ◊ What activities such as sports, art, music, do you or did you enjoy?
- ◊ What opportunities have you had to help someone else recently?
- ◊ Where are you spiritually? With God? Prayer?
- ◊ Have you been to counseling or talked to someone about this before? What part was most helpful?
- ◊ Have you ever gone to a support group?
- ◊ Have you been on medication before? Did it help?
- ◊ Of these areas which two are strongest for you now?
- ◊ Which area would you most like to strengthen?

Decreasing Risk Factors for Teens

Adolescent Suicide Risk Factors Include:

Ongoing depression with an impact on eating, sleeping, mood, and interest in past activities.

* Most teens self-label ongoing depression as being lazy or stupid.
* Children of severely depressed parents are at elevated risk for suicide attempts suggesting the need for whole family assessments.

Increase in conflict and aggression is common prior to teen suicides that are often highly impulsive and triggered by anger.

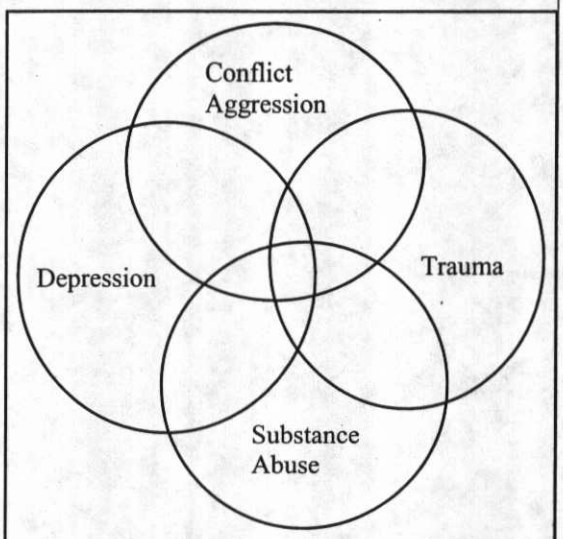
* Parent-teen conflict often causes parents to pursue punishment and reject counseling or treatment when addressing suicidal teens.
* Increased fighting, arguing, and anger are significant warning signs.

Increase in substance abuse is closely linked with the other core risk factors.

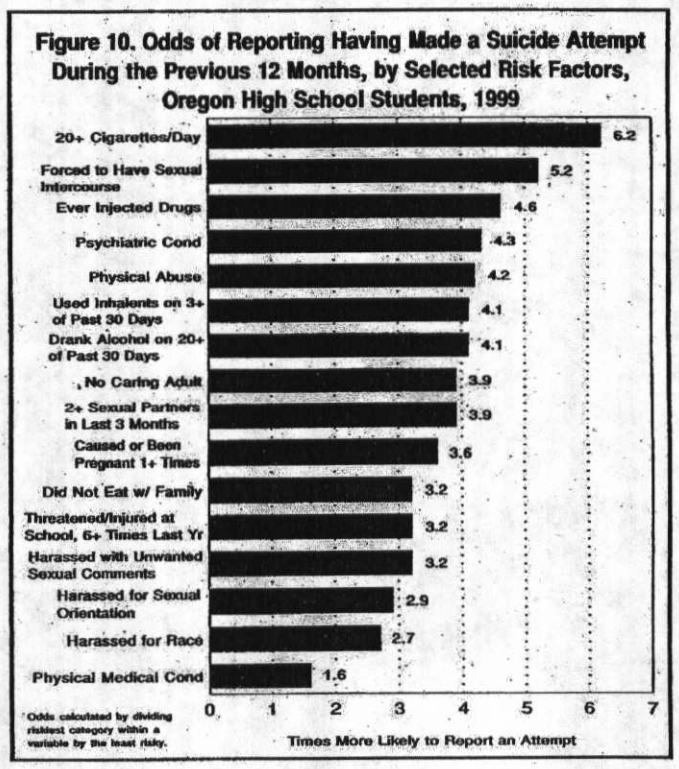
* In approximately 65% of teen suicides, the youth is drunk or high at the time of an attempt or fatality.

Exposure to trauma incidents such as child abuse, rape, harassment, accidents, and death of friends or family members increases risk of suicide.

* Ongoing harassment can be racial, sexual, sexual orientation, or bullying.
* Both bully and victims are at elevated risk.
* Gay-lesbian youth are at increased risk if subjected to anti-gay harassment.



Core Teen Suicide Risk Factors



Other Risk Factors

- ◊ Previous suicide attempts
- ◊ Smoking a pack of cigarettes a day
- ◊ Talking or joking of hurting themselves
- ◊ Giving away possessions
- ◊ Cutting or injuring self
- ◊ Death themes in writing, art, or music
- ◊ Significant negative changes in eating or sleeping habits
- ◊ Increased risk taking with cars, weapons, sex
- ◊ Increased isolation
- ◊ Gay or Lesbian youth, or youth harassed for sexual orientation
- ◊ Untreated mental illness
- ◊ Combinations of depression, substance abuse, aggression, conflict, or trauma incidents

"Impulsiveness with aggressiveness plays an important role in suicide, especially youth suicides."

Youth Suicide Prevention Programs, A Resource Guide, Centers for Disease Control

"Suicide and depression screenings should be likened to hearing and vision tests for grade school students."

Colombia Teen Screen Project

A Checklist for Long-Term Suicide Prevention

Prevention research and evaluation has grown considerably over the past ten years, but new studies increased our knowledge of what is effective in suicide prevention. A few prevention basics should be kept in mind when planning suicide prevention activities in your school, community, or faith-based group.

- ◊ Repeated contacts are important. Research consistently shows that one-time awareness talks, activity events, or conversations are not effective.
- ◊ Strategies should attempt to impact multiple areas, such as, family, peers, school, and community.
- ◊ Strategies should attempt to increase several protective factors and reduce specific risk factors.

Here are some recommended strategies to implement in your community.

Mentoring
Effective mentoring and relationship building should be a core component in any prevention effort. There are school, community, and faith-based mentoring programs, but the common ingredients are caring relationships and consistency of contacts. Set a community prevention goal of having a formal mentor for 10% of all K-12 students.

Peer Gatekeeper Training
Have key students from a variety of cliques attend a four hour training on risk factors, codes of silence, warning signs, protective factors, and referral strategies. The training curriculum is interactive with games, role plays, and ongoing discussion.

Teen Leadership Projects
Use the Peer Gatekeeper Training to jump-start ongoing teen led prevention efforts. There are a wide range of effective teen led prevention activities, but make sure teens receive training, have adult supervision, are involved in planning, have clear and focused missions, and receive recognition for their efforts. Set a prevention goal of actively involving 25% of 9th-12th grade students in teen led prevention efforts.

Staff and Adult Gatekeeper
All staff, including cooks, janitors, coaches, and bus drivers, and volunteer adults should know warning signs, protective and risk factors, basic risk assessment, and how to make appropriate referrals.

Student Education Efforts
Suicide education for all students should be built into curriculums with a minimum of ten sessions on topics such as stress, depression, social skills, coping skills, anger/conflict skills, substance abuse, and healthy peer supports.

Postvention Crisis Teams
A team of school and community helpers should be identified to help with traumatic death incidents. A plan should be in place. Remember that one-time debriefings are not as helpful as follow-up and support for a longer period of time by someone the students know and trust – natural helpers.

Screening Tools
Suicide thoughts have become extremely prevalent in middle school, high school, and college age students. **The 2001 ND Youth Risk Behavior Survey** showed that 19% of all high school students in North Dakota had thought of suicide in the past year. Suicide/depression screening for adolescents should be likened to hearing and vision tests for grade school students. It is recommended that all students receive at least a quick mood screening yearly with support from community, school, and parents.

Parent Education Efforts
Parent education on suicide generally needs to happen on multiple levels. Offering parent education classes will attract some, mailings and handouts will be read by others. Door to door campaigns using teams of parents, survivors, and teen leaders can be very effective in rural and tribal communities. When in conflict, parents of at-risk teens often need information in small doses. When families are in intense crisis there is about a four day window of opportunity to get 90% of an intervention done. Message or skills sheets designed to be placed on refrigerator doors is highly recommended.

Support Groups
Schools, communities, faith-groups, along with medical and mental health organizations, should collaborate to make sure depression, addiction, grief, and trauma support are available in your area.

Home-Based Tracking
Success in using natural helpers as a bridge to medical services has been successful in prenatal and postnatal, diabetes, and asthma. Get home-based tracking for suicidal teens and young adults started in your area.

A Checklist for Community Suicide Response – Short Term

If your community or tribal area has had a recent series of suicides, check the short term list first for activities in school, community, or faith-groups.

Community Gathering

If your community has experienced a suicide contagion or cluster of several youth suicide fatalities, it can be important to gather elders, spiritual leaders and pastors, teen leaders, community professionals, and parents together for a large gathering, ceremonial walk, or time of prayer. The style may vary by community, but the message from the whole community is clear– suicide is a poor choice and we wish to protect our teens and young adults mentally, spiritually, physically, and emotionally.

Parent Education

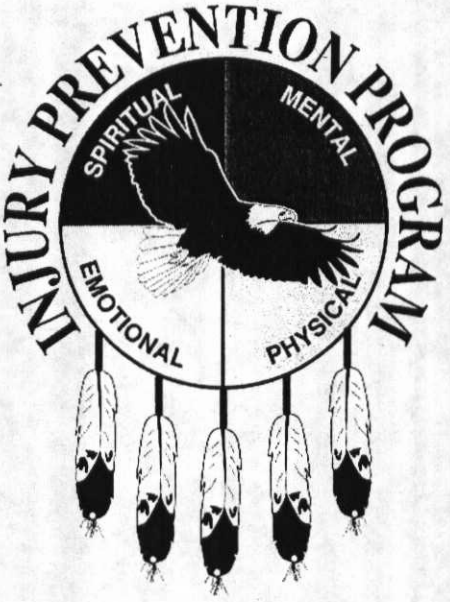
Often, a parent education campaign can be quickly conducted through door-to-door distribution of flyers, mailings, radio messages, and parent meetings in affected communities. The primary message is - know warning signs, take them seriously, know where to get help, and follow-up on support.

Crisis Response

Often communities with a suicide contagion lack mental health and crisis resources. Clearly identify key individuals who will assess suicide risk 24 hours a day. Make sure emergency responders, school personnel, and spiritual leaders are in agreement about handling crises. If no community or school crisis plan is in place, a model can quickly be obtained from the Mental Health Association in ND.

Support in Groups

Following traumatic deaths, students, parents, and even professional responders need a chance to deal with the grief and trauma, often on more than one occasion. Offering weekly support groups in schools, at churches, and through traditional ceremonial gatherings is important. Professionals should have an opportunity to debrief together at least weekly during a crisis.



Individual Supports

Sometimes relatives, close friends, and vulnerable individuals need extra support for many months after a traumatic death. These supports can come through counseling, spiritual leaders, and other professionals, but all high risk individuals should have at least one or two natural helpers who will provide support and caring contact. This mentoring style of support can come from relatives, caring adults, teachers, and friends, but all natural helpers should receive training on risks to watch for, strengths to encourage, and they should clearly know what professionals to contact in an emergency.

Teen Leadership Education

Following a suicide, most students receive a short suicide awareness or grief talk. In each school a smaller group of key teen leaders should receive a four hour training about handling peer suicide concerns, codes of silence, and how to partner with adults and refer friends. Curriculum is available from the Mental Health Association in ND.

Screening Tools

There are several effective pencil and paper quick screening tools that can be completed in a few minutes during school or community based screenings. Computer driven screening tools are also available. Make sure community professionals and natural helper supports are in place to handle the teens and young adults identified through a community wide screening effort.

Media

Radio, television, and print media can be powerful partners in reaching community members with important suicide prevention messages during a time of crisis. Studies have also shown that media can increase risk if the message comes across as hopeless, glamorizing, or highlights methods of suicide. Media messages should be hope based – giving positive information – who, what, how, and where help can be found.

"Holistic interventions need to provide emotional, mental, physical, and spiritual support."

Dennis Renville, United Tribes Injury Prevention Program

Risk and the Teenage Brain

Teenager's brains are in a "pruning" process and repeated exposure to aggressive behavior or nicotine changes the pathways and chemistry of their brain. Role modeling and mentoring help set those pathways as well.

Parents have long blamed hormones for many of the behaviors of adolescence, but new research suggests brain growth may explain many teen behaviors. Previously, most physicians thought that the brain stopped growing by age eight, but technologies like MRI or PET scanning have detected brain growth well into adolescence.

The scientific publication "Nature" recently featured a series of time lapse images of brain growth from ages 3-15. After puberty, a period of "pruning" takes place in the prefrontal cortex of the brain where most of the planning and impulse control functions take place.

Lynn Ponton, psychiatrist and author of "The Romance of Risk: Why Teenagers Do the Things They Do," states that teens are not good at assessing risk because their brain is still developing. That's why suicide, violence, HIV, etc. are often at most significant risk prior to age 24. Further studies with rats and hamsters verify teen brain growth. Teenage rats don't smoke cigarettes and drive cars too fast, but they do hang out with their peers and flip from one activity to the next.

Craig Ferris, of the University of Massachusetts Medical Center, studies golden hamsters that go through a two week period of adolescence. If the hamster is exposed to an aggressive adult hamster for even an hour a day during adolescence, they have found they will grow up to be bullies. This aggressive role modeling affects brain development through lower levels of vasopressin and more receptors for serotonin. Chemicals and pathways that lower impulse control create damage in the area of the brain associated with addiction.

Researchers have long known of the link between nicotine usage in teenagers and depression. Only recently has research shown that the nicotine usage appears to be causing depression in teens due to nicotine's impact on receptors and pathways in the brain. The recent Oregon Youth Risk Behavior Survey indicated a correlation between a pack-a-day cigarette habit and a suicide attempt by 9th—12th grade Oregon students.

Research indicates that it is important to reduce a teen's early exposure to violence, trauma, drugs, and nicotine as it can have permanent impact on how the brain develops and how receptors and pathways are "pruned" after puberty. Adolescent brain development appears to happen in the context of adult role modeling, which may explain the effectiveness of mentoring as a prevention tool. It may not only be the way to a teen's heart, but to a teen's brain as well.

EDUCATORS: SAVINGS KIDS FROM SUICIDE

The 2001 Youth Risk Behavior Survey of ND 9th –12th grade students found that:

- 13,800 ND teens (19%) had seriously thought about attempting suicide in the past year.
- 5400 ND teens (7.5%) reported attempting suicide in the past year.
- 1600 ND teens (2.3%) had made a suicide attempt that resulted in an injury needing medical attention.

Schools can make a difference. In a 1988 study of 229 youth that committed suicide, 76% experienced a significant decline in academic performance in the year before their deaths.

What do educators need to know?

- Schools are not held to confidentiality when a child is talking about suicide. Contact with helping agencies and parents can and should be made.
- Act immediately if a child discloses suicide thoughts – directly, through a friend, a writing assignment, or on the internet – report it right away. Don't wait until the end of the school day.
- Take any indication of suicide seriously. Check out ambiguous comments, joking comments, and suicidal threats reported in dating relationships. Don't overreact, but don't underestimate potential concerns.
- If possible, don't handle suicide interventions or suicide prevention alone. Use a team approach and community resources. Work with school

counselors, social workers, peer helpers, administrators, and natural helpers in the community.
- Help connect a student and parents with mental health or other community resources. Keep an updated list of agencies. Make community helpers an ongoing part of school education in all classes. Previous contact helps during a crisis situation.
- All school staff (cooks, janitors, and bus drivers included) should have knowledge of "150 Ways To Let Kids Know You Care" by Search Institute and should be aware of suicide warning signs.
- Warning signs are...
  - * drug and alcohol abuse
  - * moodiness
  - * thoughts about dying
  - * withdrawn behavior
  - * isolation
  - * impulsive/aggressive
  - * lack of interest
  - * hinting—not being here
  - * getting into trouble
  - * hopelessness
  - * guilty feelings
  - * worthless feelings

A clustering of warning signs merits an assessment.

A SCHOOL SUICIDE CURRICULUM?

The Center for Disease Control and Prevention warns that "not all curriculums are necessarily well conceived."

General education programs that teach the facts, warning signs, and risk factors associated with suicide do impart knowledge. But these programs often have little impact in changing attitudes about suicide and the importance of seeking help.

It's important not to sensationalize or romanticize suicide to adolescents. Suicide should not be normalized, but a hopeful, caring tone should be used to discuss coping with teen issues.

School wide symposiums or Channel One style videos are not recommended due to the impersonal settings.

Schools should use assessment tools and have an ongoing school-wide education effort that addresses suicide in the context of depression, stress, anger/conflict management, coping skills and risk factors.

Peer Gatekeeper Training should be conducted with a smaller group of key teen leaders representing a variety of cliques in the school. Mentoring programs should be encouraged and teen leaders should be active participants in any school prevention effort.

"Over 2.3%, or 1600 North Dakota teens reported making a suicide attempt that resulted in an injury needing medical attention in 2001."

North Dakota Youth Risk Behavior Survey 2001

The #1 question facing suicide prevention efforts is how to effectively reach adolescent and young adult males.

More Risk Factors & Warning Signs

Suicide warning signs include

- Ongoing depression
- Substance abuse
- Conduct problems
- Previous attempts
- Increase in conflicts
- Talking or joking about hurting themselves
- Increased isolation
- Increase in risk taking with cars, weapons, sex.
- Significant sleep and eating changes
- Giving away possessions
- Death themes in writing, art, or music
- Impulsive or aggressive behavior

* Males account for 85% of suicide fatalities, but females make 85% of suicide attempts.

* Substance abuse is involved in 50% of suicide fatalities, and over 65% of teen suicide attempts.

* More suicides are attempted by middle school youth, but more fatalities occur in 17-21 year ages.

* School suspensions and multiple arrests are common factors in suicide fatalities.

* Teens that have been traumatized or are experiencing post traumatic stress are higher risk.

* 65% of suicides involve firearms with many described by parents as highly impulsive incidents. 60% of Native American suicides involve hanging.

*Native American suicide rates vary dramatically from tribe to tribe. In ND, Native Americans are 6% of youth population, but make up 35% of teen suicide fatalities.

*Gay/lesbian youth or teens subject to anti-gay harassment are 5 times more likely to make a suicide attempt.

Assessment Questions

The following are some questions that can be used in a caring conversation to assess risk.

⇒ Are you thinking about hurting yourself or ending your life?

⇒ How often or how long have you been having these thoughts?

⇒ Have you thought about how you would do this? Is there a plan?

⇒ What has triggered the most recent suicide thoughts?

⇒ Is the method available? How close have you come to making an attempt?

⇒ Have you attempted in the past? How and when?

⇒ Have any friends or family members attempted suicide or passed away ?

⇒ Have you been using alcohol or drugs?

⇒ Are firearms available to you?

⇒ What has kept you from following through?

⇒ What are your support systems?

⇒ Who is a healthy support person for you?

L.E.A.D.E.R

For a natural helper such as a bus driver, coach, pastor, or teen leader think of "LEADER" as a guide for steps to use during and after an intervention.

- **Listen** – Take suicide indications seriously, and never mock or challenge a youth's statements about suicide thoughts.
- **Empathize** – Your greatest strength in helping suicidal youth is your relationship with them. Make every effort to be available, call periodically and try to keep in touch with the youth's moods and progress.
- **Affirm** – Don't contradict a youth's feelings of hopelessness or how bad everything is, but acknowledge the difficulties and affirm his/her worth as a person.
- **Direct** – Build your relationship with the youth, foster communication, teach coping skills, focus on resources, and develop a plan of action.
- **Enlist** – Involve the youth in a verbal or written "no suicide" contract. Ask him/her to agree not to stop trying. The adult should agree to take time if contacted by the youth.
- **Refer** – If a youth has even passing thoughts of suicide, a medical and mental health assessment should be pursued. If the danger is serious, take him/her immediately to a clinic or a hospital. Always get help for the youth.

ND Lessons Learned with Teens and Gatekeeper Training

Over 2500 teens have received Peer Gatekeeper Training with many of the 325 workshops over the past three years involved teens and adults being trained together.

Here are a few lessons learned:

- ◊ Teens are already intervening with their peers about suicide, usually without adult knowledge – teens need the training, information on codes of silence, and the message to involve and partner with adults.
- ◊ The four hour training often acts as a springboard for starting other ongoing teen led prevention efforts (26 new teen projects)
- ◊ We spend more time discussing Sources of Strength and protective factors than warning signs. It is important that teens know and can share stories of where strength and health come from.
- ◊ Teen groups can usually list the common warning signs and symptoms of depression, but are often unaware of the conflict, aggression, trauma, and substance abuse indicators.
- ◊ The "values debate" has been a powerful tool in bringing underlying beliefs and codes of silence into the open.
- ◊ Breaking referral resources into "informal resources – people they personally know and would go to" vs "formal resources – institutions or professionals designated to handle suicide" is important. Teens go to people they have relationships with. Acknowledging this gives us a chance to talk about what to do if an informal resource doesn't know what to do – go to plan B and contact a formal resource.
- ◊ Have teens name the adult they would refer to in front of the group. In rural and tribal communities it is often a natural helper, not a professional, and hearing the same name over several times helps with identifying and training those key natural helpers.
- ◊ Addressing boundary issues for teen leaders about suicide, violence, and child abuse is important, as well as stating day and nighttime adult advisor contacts.
- ◊ The curriculum has very little lecture in it. Most of the four hours involves activities, challenge games, group debates, role plays, and discussion.
- ◊ It is common for students to attend a training looking for assistance with their own depression or suicide issues. The Sources of Strength circle has been helpful in leading a discussion about what makes a difference when dealing with your own issues – whether it's depression, trauma, grief, substance abuse, anger, etc.
- ◊ Teens often follow-up with the Peer Gatekeeper training by distributing Yellow Ribbon cards or Mental Health Association tri-fold cards to other school students.

If a firearm is accessible to a suicidal youth, the chances of a fatality double.

National Centers for Disease Control

High Risk Screening: Eight Key Times For Caring Contacts With Youth At-Risk

When a young person is in trouble or having problems, he/she often needs a caring conversation with an adult about stressors. These conversations need to address on how "stuck" or hopeless a young person is feeling and what supports they have access to. These are eight key stress points to be aware of in a young person's life. These should be a "minimum" standard when adults reach out to youth.

- If out-of-school suspension or a 2nd school detention takes place
- Any placement out of the youth's home
- After a 2nd court incident
- Fired from a job
- Death of a friend or family member
- Intense dating breakup
- Any suicide gesture, attempt, or comments.
- During a fight or harassing incident for both aggressor and victim.

Access to a caring, supportive adult is listed by many youth as the key to getting through an intense crisis.

Suicide is preventable.

Like traffic fatalities, we can reduce the high rates of suicide among North Dakota's youth.

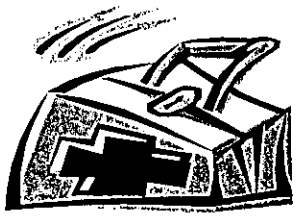
MEDICAL CHALLENGES IN SUICIDE INTERVENTION

Most suicidal individuals visit a doctor in the three months before a suicide attempt. In a managed care environment, it is not unusual for a physician to see a client every 12 minutes.

Suicide prevention advocates are in the midst of an intense national debate with managed care regarding adequate time and reimbursement for physicians to conduct suicide assessment with patients. Physicians play a key role in community assessment and intervention with patients. Adequately training physicians, nurses, and emergency medical personnel must be combined with a time frame sufficient enough to assess suicidal concerns.

In emergency room settings where the majority of suicidal adolescents are treated while under the influence of alcohol or drugs, it has been found that the tone set by the initial care provider often greatly influences a teenager or a parents attitude regarding follow-up services.

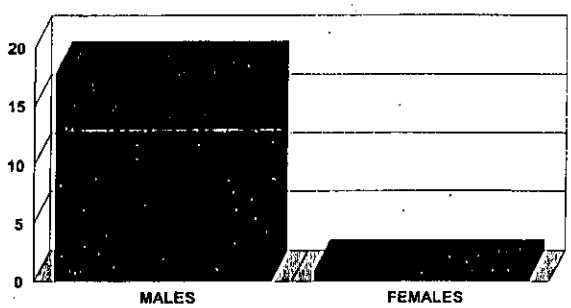
For many teenagers the four days following a suicide gesture is the primary window of opportunity to promote positive change. Most male adolescents will rarely follow a year long course of traditional therapy, but significant support can often be made through a series of contacts within the four day window of opportunity. Several community contacts within the four day window is often seen as more protective than a hospitalization with little community follow-up.



MALES AT RISK

Females account for 85% of all suicide attempts, but males account for the vast majority of suicide fatalities. Prevention efforts need to target adolescent and young adult males with an emphasis on healthy coping skills, positive ways to handle conflict, drug/alcohol abuse prevention, and relationship breakups skills. High risk ages include 16-20 year olds.

1997 ND SUICIDES BY GENDER
10-24 YEARS OLD



TREATMENT OR ROLE MODELING FOR MALES

When asked why 85% of all suicides are by males, a 9th grader recently blurted out, "Because they have the guts to do it." The combination of macho attitudes, unwillingness to reach out for help, and use of firearms, results in a suicide fatality in one out of every two attempts by males.

When a group of professionals were asked what percentage of 17 or 18 year old males would show up for even two sessions of traditional in-office therapy, almost all responded that fewer than 20% would follow through. Looking at promising approaches in suicide prevention for males means going outside of the traditional mental health field and using mentoring efforts, teaching coping skills, anger management skills, and providing healthy role models to the person in need. Helping responses need to be community based.

TEN MOST COMMON ERRORS DURING A SUICIDE INTERVENTION

Angela Pfeiffer and Robert Neimeyer conducted extensive testing on 215 medical students, master level counselors, addiction counselors, and crisis workers on their suicide intervention skills.

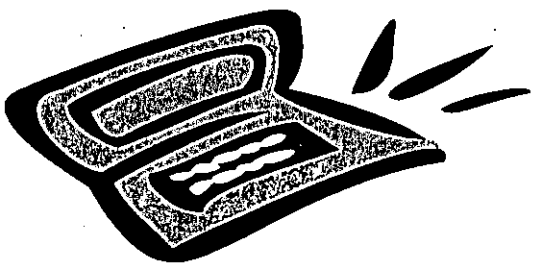
They found ten common errors:

1. Superficial Reassurance - Out of an intense desire to assist, some helpers offer reassurance that comes across as trivial to the person in crisis. "You're so young, how can you think of killing yourself." The response is intended to encourage, but they risk alienating a teen who feels they are not being heard and are misunderstood.

2. Avoidance of Strong Feelings - When confronted with intense depression, grief, or anger some helpers retreat into trivial reassurance, professionalism, advice giving, or passivity. When confronted with deep feelings of, "no one cares if I'm alive or dead," it's important not to move into an analytical discussion of their feelings. Establish empathy by putting feelings into words. For example, "With all the hurt you've been experiencing, it must be impossible to hold those tears in."

3. Professionalism - Given the intensity of some suicide interventions, it isn't surprising that some helpers insulate themselves with an air of professionalism. "You can tell me, I'm been trained to be objective." While intended to put the client at ease, it can come across as disinterested or hierarchical. A better response might be, "It sounds like some of your ideas are pretty frightening to you, and you think I might be shocked to know what you're really thinking.

4. Inadequate Assessment of Suicidal Intent. - Surprisingly, many helpers ignore suicidal statements. Pursue necessary questions about what clients have been thinking, for how long, and check out any specific plans or attempts.



Research helping with interventions.

5. Failure to Identify the Precipitating Event - Asking about key incidents and events can help move interventions toward necessary action plans. "It sounds like everything collapsed around you when your wife died three years ago, but what has happened recently to make you feel even worse—that dying is the only way out?"

6. Passivity - 25% of physicians and counselors took a passive stance when confronted with intense emotions. "Go ahead, I'm listening." It was not unusual for contact to be broken off. Early stages of suicide interventions need to be active, engaging, empathetic, with the helper structuring the interaction.

7. Insufficient Directness - A phone conversation with a suicidal person ends with, "Ok, but call back if you keep feeling suicidal." At a minimum get a verbal no suicide contract.

8. Advice Giving - At times helping may come across simplistic. "Try not to worry about it." or, "Focus on the positive." Concrete action ideas are often helpful, but only after the helper has established trust and a thorough understanding of the clients situation. Action plans should come from the clients tentative ideas, rather than from the authoritative advice of the helper.

9. Stereotypic Response -When trying to save time during a crisis intervention, a helper may fit the client into a category of diagnosis based on race, sex, age, class, etc. Focus on the individuality of each person and their emotional uniqueness.

10. Defensiveness - Suicidal teens can often be angry, aggressive, or rejecting of the helper's attempts. To react defensively, use sarcasm, or put- downs erodes the small trust that exists. "How could you ever help me, have you ever tried to kill yourself." A quick witted comment can come out as a put- down. Maintain a caring stance, and acknowledge fears and concerns. "It must be hard to seek help when it's tough to trust people." The helper has the responsibility to reach across a gulf and establish a working partnership.

"25% of physicians and counselors took a passive stance when confronted by intense emotions during a suicide intervention."

Pfieffer and Neimeyer

An effective mentoring team can be as small as 3 or 4 individuals and can come from work, community, or faith settings.

STEPS FOR SUCCESS
USING TEENS AS MENTORS

Mentoring programs come in a wide variety of formats, but one favorite has been to train a team of 5-15 teen leaders and match each teen with one younger student who could use a mentor. Here's a recommended step-by-step process.

1. Identify the lead agency, usually a school, but sometimes a church or a youth organization, that will work with the mentoring team.

2. Identify the adult(s) who will provide regular supervision for the teen mentors. (1 adult to 15 youth maximum).

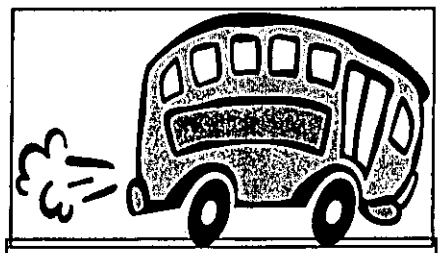
3. Provide an orientation session for school, church, or agency staff about undertaking a mentoring project. Get a group consensus from the staff before proceeding with the project; significant reservations should be addressed before proceeding.

4. Provide an orientation session for youth who may be interested in being mentors. Recruit teen leaders through announcements, word of mouth, flyers, etc.

5. Provide interested teen leaders with a simple screening and application process. Usually this requires that two or three adults recommend that a teen become a mentor.

6. Select a team of teens for ongoing training. If possible, choose teens from a variety of cliques and interest groups within the school.

7. Provide an initial training attended by both mentors and adult supervisors. The focus of the training is on communication skills, boundary issues, and team building with an emphasis on games and role playing. For a startup project, a two day, 16 hour training is suggested. Some projects provide a 32 hour, week long training for school credit during the summer.



Relationships in Action

8. Screen students during the training process. After the training, and through role plays, some students may be uncomfortable with one-on-one mentoring, but may have a role in group activities, organization, or helping with multi-media efforts.

9. Have teachers or other staff identify the youth to be mentored. Approach those youth and parents for permission to participate.

10. Identify a consistent time the mentors can meet with their younger students each week.

11. Begin matching students. Ask teen mentors about interests and ages of youth they'd like to mentor as a way to assist in making a good match. Often initial meetings can be as a group activity, with time for mentors and their young friends to talk alone for a few minutes.

12. Continue to have weekly one-on-one contact. This can be from 15 minutes to one hour in length, depending on the age and attention span of the student being mentored.

13. Provide monthly group activities. It's usually a good plan to provide a monthly group time for all teens mentors and their "littles." Games, food, and crafts make for good activities.

14. Provide a team supervision time. Two times a month is recommended for start-up programs, with lunch meetings common.

15. Provide recognition to the mentors. Make it fun and take time to celebrate.

YOUTH LEADERSHIP: A SUCCESS STORY

Awesome things are happening as youth become involved in prevention activities. Successful teen leadership efforts implement these core benchmarks:

- Provide adequate training to youth leaders.
- Provide adult supervision to youth leaders of no more than a 1-12 ratio.
- Include youth in planning, problem solving, and doing.
- Develop a team of youth leaders with a clear mission or goal.
- Give recognition to youth leaders through awards, media, personal thank you's, and public acknowledgement

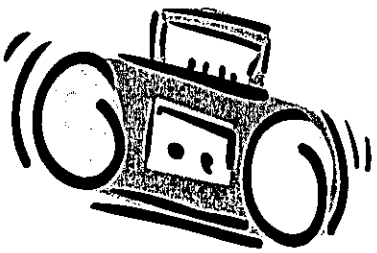
The following seven areas are common examples of teen led prevention efforts with a clear mission or focus.

- One-on-one mentoring
- Small group facilitators
- Leading alternative activities
- Mediating conflicts
- Prevention presentations
- After-school programs
- Multi-media efforts, through radio, tv, print, puppet and drama troupes.

There is an incredible success story unfolding throughout our state. It is a story of youth being valued and responding dramatically to opportunities to help strengthen their communities.

Youth leaders are responding in numbers that are keeping schools, churches, and agencies scrambling to keep up with a dynamic new energy in prevention.

This new energy is moving from a focus of fixing problems toward an attitude of developing strengths, from a prevention attitude of "doing to" youth, toward one of "working with" youth. This new approach moves from "at-risk" to "all youth," with all youth being valued and given opportunities to contribute.



Use youth to get prevention messages out on radio and television.

A change is happening that has communities discussing how to develop relationships with youth, not just how to start new programs. Rather than worrying about a duplication of services, the focus is about how to duplicate success and healthy messages throughout the community.

STAGES OF COMMUNITY READINESS TO USE TEEN LEADERS

As we've encouraged numerous communities, schools, and faith-based programs to begin partnering with teen leaders in prevention activities, we have noticed a four phase process or progression that often happens.

1. Advisory Council Phase

In this phase teens are involved on committees, boards, and task forces. While this allows a teen voice, and helps with some planning and implementation, few teens enjoy committee meetings any more than adults do. Teens need a voice and input in prevention decisions.

2. Role Model or Peer Helper Phase.

This phase involves training teens to be role models or helpers around schools or communities, and generally focuses on communication skills. While this is beneficial and extremely supportive for the trained teens, the overall school impact is often less than hoped for because of a lack of a focused mission or role.

3. Focused Action Phase

This phase has teams of teen leaders, trained and supervised, to work on specific efforts, such as weekly one-on- one mentoring, facilitating after-school groups, doing prevention presentations, etc. The school or community impact is often greater because the teens have a focused and clear mission.

4. Saturation Phase

This phase occurs when communities move beyond just one or two groups of teens active in a community, but begin to set and encourage the prevention goal of many teens being involved and contributing to the community. This saturation of teen leaders creates a "tipping point" where many good things begin happening in a variety of prevention areas.

We want to move a community's concept of teen leadership from a few kids on an advisory committee to one of setting prevention goals around saturation levels—25% of all 9th – 12th graders actively doing prevention.

North Dakota Adolescent Suicide Prevention Task Force

Put first things first. Every adult involved in treating, educating, preventing, and discussing youth problems, should spend at least one hour a week in a one-on-one relationship with a young person.

THE POWER OF RELATIONSHIPS: MEDICAL SCHOOL MENTORING

The UND School of Medicine: Bismarck Campus is in its 5th year of a community mentoring project in Bismarck.

Medical students provide caring adult mentors to middle school students, while learning about adolescent health and behavior.

Over the past five years, students from Theodore Jamerson, St. Mary's High School, Simle Middle School, and the ND Youth Correctional Center have met weekly with their medical students.

In annual evaluations all youth but one stated they would recommend this program to other students. That one student misunderstood the question and emphatically wrote, "No, he's my best friend." He thought they were going to give his mentor to someone else.

Pre and Post evaluation shows that an hour a week of mentoring time brings a reduction in 13 risk behaviors, but when contact is reduced to one half hour per week only 3 risk behaviors are reduced. Mentoring makes a difference.

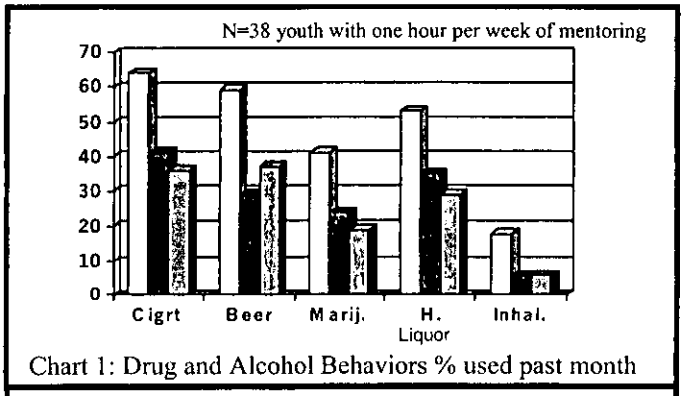


Chart 1: Drug and Alcohol Behaviors % used past month

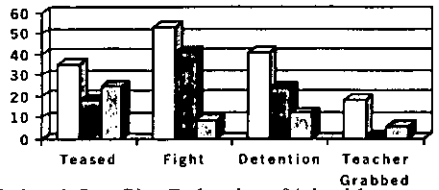


Chart 2: School Conflict Behaviors % incident past month.

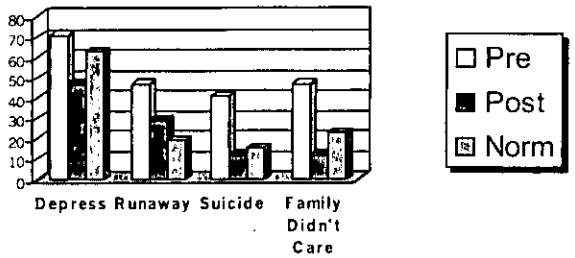


Chart 3: Mood/Attitude % felt like past month

NATIONAL BB/BS STUDY MOVES MENTORING TO MODEL PROGRAM

Public/Private Venture's evaluation of 959 youth in the Big Brother/Big Sister Program of America provided groundbreaking results that shed light on important benchmarks to successfully implement mentoring programs:

- The most successful mentoring relationship met frequently (weekly) with sufficient time.
- Mentors and youth were able to bridge significant differences in class and racial background when mentors placed top priority on making their relationship enjoyable and fun for both.
- Successful relationships were grounded in the mentors' belief that they were there to provide support and opportunities, while less satisfactory mentors believed their primary purpose was to guide the youth toward values and behaviors – to fix kids, etc. Successful mentors focused on building a fun caring relationship, not on reducing high-risk behaviors.
- Thorough screening of volunteers, training mentors in communication and limit setting skills, a matching procedure, and intensive supervision of each match by a supportive staff person were found to be keys for success.

The HOW of mentoring counts. Mentors need to be taken care of, trained, and supported.

GRANT ENABLES STATEWIDE TRIBAL/RURAL MENTORING PROJECT WITH MHAND

The Mental Health Association in North Dakota recently obtained a $182,000 a year grant for three years to develop a statewide mentoring infrastructure for tribal and rural communities. The US Dept. of Education grant will enable the hiring of part-time mentoring coordinators in all tribal areas and some rural areas of the state. This grant enables the ND Adolescent Suicide Prevention Project to move forward with tribal and rural mentoring.

The focus of this project will be:

- ◊ To start at least a dozen small mentoring teams of 4-20 mentors doing school, community, or faith-based mentoring.
- ◊ For MHAND to provide a state mentoring infrastructure for screening, matching protocol, training of mentors, and supervision by area coordinators.
- ◊ To provide weekly one-on-one time and monthly group recreational activities.

The vision of a statewide mentoring project is to allow rural and tribal communities to focus on recruitment and to spend time with youth, without the need to design a whole mentoring program.

If you are interested in starting a team of mentors in your community, school, faith group, or business, please contact the HELP-LINE at 1-800-472-2911. We can help you, with a step by step process, begin making a difference in the lives of youth in your community.

DEVELOPING YOUTH ASSETS: COMMUNITIES TAKING ACTION

As the tragic statistics of youth suicide become known, the focus quickly moves toward an urgent story in all towns and communities, that the developmental infrastructure is crumbling.

Too few young people grow up experiencing key ingredients for their healthy development—support from adults, relationships across generations, and healthy messages about values, coping, and boundaries. The real challenge in suicide, violence, and drug prevention is to begin rebuilding this developmental infrastructure, with a focus on all youth.

Rooted in research, the Search Institute has identified 40 building blocks or developmental assets that all youth need for growing up healthy. These assets are broken into seven types:

- ♦ Support
- ♦ Empowerment
- ♦ Boundaries and Expectations
- ♦ Constructive Use of Time
- ♦ Commitment to Learning
- ♦ Positive Values
- ♦ Social Competencies

Creating a community-wide commitment toward safety and building protective strengths in our youth is a vision for our whole community, not just for professional caretakers.

- ♦ Everyone has a role and contributes, including youth.
- ♦ Asset building never stops.
- ♦ The community is filled with consistent and healthy messages.

Suicide Attempts or Depression
Search Institute (30 Asset List)

0-10 Assets **21-25 Assets**
11-20 Assets **26-30 Assets**

Here are six key themes to promote in asset building:

- ♦ Assets are nurtured in all people, not just "at-risk" youth.
- ♦ Relationships, not programs, are the key.
- ♦ Duplication and repetition are valued. Positive actions and messages are repeated from a variety of directions.

Call the Mental Health Association in North Dakota for help in starting a mentoring team in your school, community, business, or faith group.

Make a difference.

Call the American Foundation for Suicide Prevention for a free youth suicide prevention packet and free public service announcements

1-888-333-AFSP

25 INTERNET RESOURCES

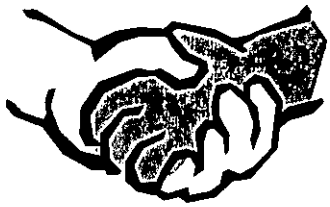
- www.preventiondss.org CSAP's comprehensive Decision Support System for substance abuse prevention planning–a vast website for community prevention.
- www.health.state.nd.us/ndhd/pubs/ The North Dakota Health Department web site–scroll to Community Health Section for the report "Suicide ND Children, Teenagers, and Young Adults–the North Dakota Response."
- www.mha-nd.org Mental Health Association in North Dakota home page with suicide prevention and crisis intervention clearinghouse.
- www.health.state.nd.us/ndhd/prevent The North Dakota Prevention Resource Center clearinghouse and reports.
- www.dpi.state.nd.us/health/index.shtm School Health and Drug Free Program page from the ND Department of Public Instruction which includes data on the ND Youth Risk Behavior Survey.
- www.cdc.gov The National Center for Disease Control report on the Youth Risk Behavior Surveillance System.
- www.spanusa.org Suicide Prevention and Advocacy Network sponsors national legislation and prevention efforts.
- www.surgeongeneral.gov The Surgeon General's call to action on suicide prevention and Mental Health Report on Youth.
- www.nida.nih.gov The National Institute of Drug Abuse has reports linking stress, suicide, and drug addiction.
- www.suicidology.org The American Association of Suicidology has a wide range of support information and prevention resources available at this site.
- www.nmha.org The National Mental Health Association has many resources on suicide and other mental health related topics.
- www.aap.org American Academy of Pediatrics has a wide range of materials for youth and parents including recent reports encouraging screening of teens for suicide.
- www.ac.wwu.edu/~hayden/spsp/ Western Washington University has a site listing all of the state's suicide prevention plans.
- www.ihs.gov/MedicalPrograms/InjuryPrevention Indian Health Services provides statistics, recommendations, and grant opportunities regarding suicide prevention.
- www.aacap.org American Academy of Child and Adolescent Psychiatry has many resources on teen suicide issues.
- www.nydic.org National Youth Development Information Center provides an extensive list of topics related to youth development and prevention.
- www.captus.org Centers for the Application of Prevention Technology have great sites bringing prevention research into practice.
- www.search-institute.org Search Institute provides a variety of materials on assets for youth and research information.
- www.peerhelping.org The National Peer Helpers Association provides leadership and promotes excellence in the peer resource field.
- www.healthycommunities.org Coalition for Healthier Cities and Communities including success stories in the field of prevention.
- www.health.org/multicul/index.htm NCADI Multicultural Prevention provides access to culturally relevant treatment and prevention with an emphasis on medical information.
- www.nimh.nih.gov National Institute of Mental Health supports a large website on a variety of mental illness and mental health issues.
- www.mentoring.org National Mentoring Partnership provides resources and support for mentoring for America's young people.
- www.yellowribbon.org Suicide prevention movement founded by the Light for Life Foundation.
- www.afsp.org American Foundation for Suicide Prevention with a free youth suicide prevention packet available.

A VISION FOR HOME BASED TRACKING

It is presently assumed that approximately 50% of teens and young adults making a suicide attempt serious enough to need an emergency medical contact are receiving no mental health services two weeks after the incident.

The reasons for this dramatic lack of contact are many - mental health stigma, lack of insurance coverage, lack of services in rural and tribal communities, or other co-existing mental and family conditions. The simple fact remains that many in North Dakota do not receive adequate help following self-inflicted injury.

The vision for North Dakota is to begin two pilot projects: one in rural and one in tribal communities that would allow a natural helper or paraprofessional to make a home-based contact shortly after a contact with EMS, emergency room, clinic, or psychiatric release. This Home-Based Tracking is being pursued in the six counties around Valley City through Mercy Hospital's Wellness in the Valley Program. Several tribal communities have expressed interest and funding is being pursued.



The Home-Based Tracking model has been successfully used with pre and postnatal supports, asthma, and diabetes follow-up resulting in significant reductions in hospitalizations.

Clients would sign home-base tracking agreements as part of the standard procedure as they leave a medical contact. The home-based tracker then can act as a natural support and assist in making necessary medical and mental health appointments as well as providing a caring, listening ear.

This bridge building model holds much promise for rural North Dakota and protecting our teens and young adults from further risk.

Home-based tracking has been proven very effective with a variety of health issues – it can provide a bridge for suicidal individuals to needed help.

SCREENING STRATEGIES

The **Colombia Teen Screen and the DISC** (Diagnostic Interview Schedule for Children) have been coordinated by partnerships with the Prairie Psychiatric Center out of Fargo. **The Colombia Teen Screen** is a quick screen tool for use in universal screening strategies, and the **DISC** is a comprehensive computer-driven tool used to identify and screen for a wide range of mental health disorders.

School-based screening efforts have been started throughout the state and several juvenile justice screening projects; detention and attendant care sites are using screening strategies to keep youth safe.

Four Winds Schools has conducted yearly screening for all students from 5th grade to 12th grade for depression, suicide, and substance abuse concerns for several years. **Theodore Jamerson school at United Tribes** have started using the easy to use **Burlison Mood Scale.** The **Zung Self-Rating Depression Scale** has been used for college and adult groups by the Mental Health Association in ND. The **Reynolds** is a nationally recommended tool. The **Williston area Mental Health Association** has conducted some of the most comprehensive community depression screening efforts in the nation.

Screening strategies have been well tested and found to be highly effective in identifying suicidal adolescents.

Almost 20% of 9th – 12th graders state they have had suicide thoughts in the past year. Think of suicide screening in adolescents as similar to hearing and vision screening for grade school children. Early identification of suicidality, depression, substance abuse, trauma, and other disorders can prevent loss of life, school failure, incarceration, and a wide range of injuries and accidents associated with teens and young adults.

Schools, communities, and faith-groups, all can be actively screening teens and adults for signs. Medical and mental health treatment services, support groups, and caring natural helpers should all be available to teens who have been identified through screening efforts.

North Dakota Adolescent Suicide Prevention Task Force

Mental Health Association in ND
1459 Interstate Loop
Bismarck, ND 58503
info@mha-nd.org

HELP-LINE 1-800-472-2911

ND Adolescent Suicide Prevention
Project Director
Mark LoMurray
Outreach Services, Inc.
PO Box 773
Bismarck, ND 58502
Phone/Fax 701-224-0097
outreach@btinet.net

MENTAL HEALTH ASSOCIATION
IN NORTH DAKOTA
1459 INTERSTATE LOOP
BISMARCK ND 58103

This project has been funded by grants from:

- *US Department of Education: Safe and Drug Free Schools*
- *ND Children's Services Coordinating Committee*
- *Ronald McDonald House Charities*
- *Office of Juvenile Justice and Delinquency Prevention*
- *ND Department of Health*
- *ND Department of Human Services*

ND ADOLESCENT SUICIDE PREVENTION TASK FORCE

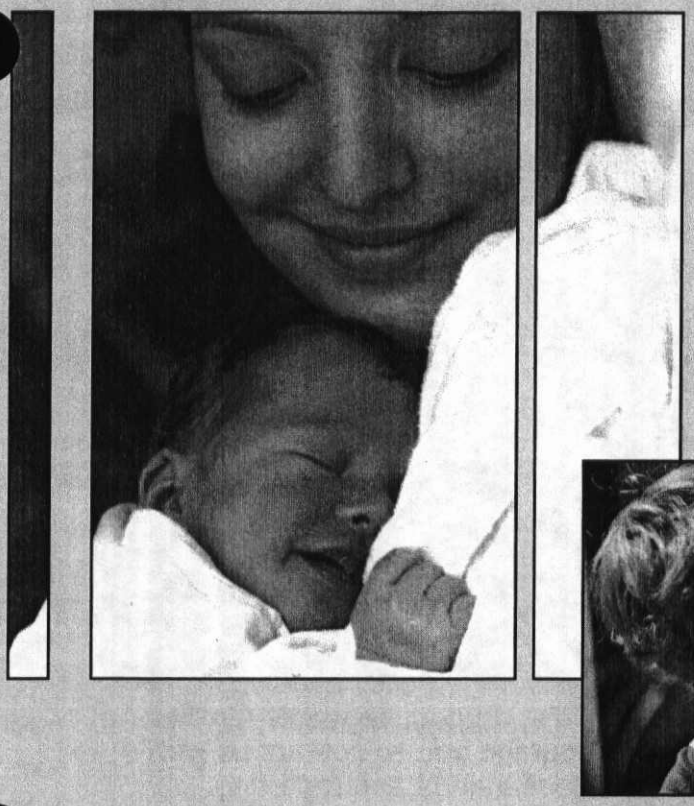
The following organizations have participated in the work of the task force.

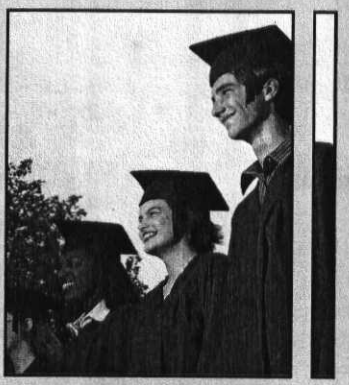
- ND Lt. Governor's Office
- ND Department of Health
- ND Department of Human Services
- ND Indian Affairs Commission
- ND Department of Public Instruction
- ND Attorney General Office
- ND Children's Services Coordinating Committee
- ND Division of Juvenile Services
- ND School Counselors Association
- Indian Health Services – Spirit Lake, Standing Rock, and Turtle Mountain
- Dr. Todd Twogood – Pediatrician
- Youth representatives
- ND Emergency Medical Services
- Family survivors
- Rick Heidt - Educator
- Outreach Services, Inc.
- Clergy and spiritual leaders
- Prairie Psychiatric Center
- Minot Suicide Prevention Task Force
- Williston Suicide Prevention Task Force
- Mental Health Association in ND
- United Tribes Injury Prevention Program

Remember:

The Mental Health Association in ND has a state-wide toll-free HELP-LINE : 1-800-472-2911.

If you need help, prevention materials, a listening ear, or just need to ask a question, feel free to call.





North Dakota KIDS COUNT

2006 ABRIDGED FACT BOOK

State and County Profiles of Child Well-Being in North Dakota
A condensed version of the 2006 North Dakota KIDS COUNT Fact Book

See following page for information on obtaining a copy of this document

www.ndkidscount.org

kids count north dakota

NORTH DAKOTA KIDS COUNT - OUR MISSION

North Dakota KIDS COUNT seeks to promote the well-being of North Dakota children through data-based public awareness activities encouraging policy decisions that enhance the capacity of communities to provide the support networks families need to successfully raise their children.

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Helen Danielson, Coordinator
Polly Fassinger, Research Analyst

Visit the
North Dakota KIDS COUNT
web site:

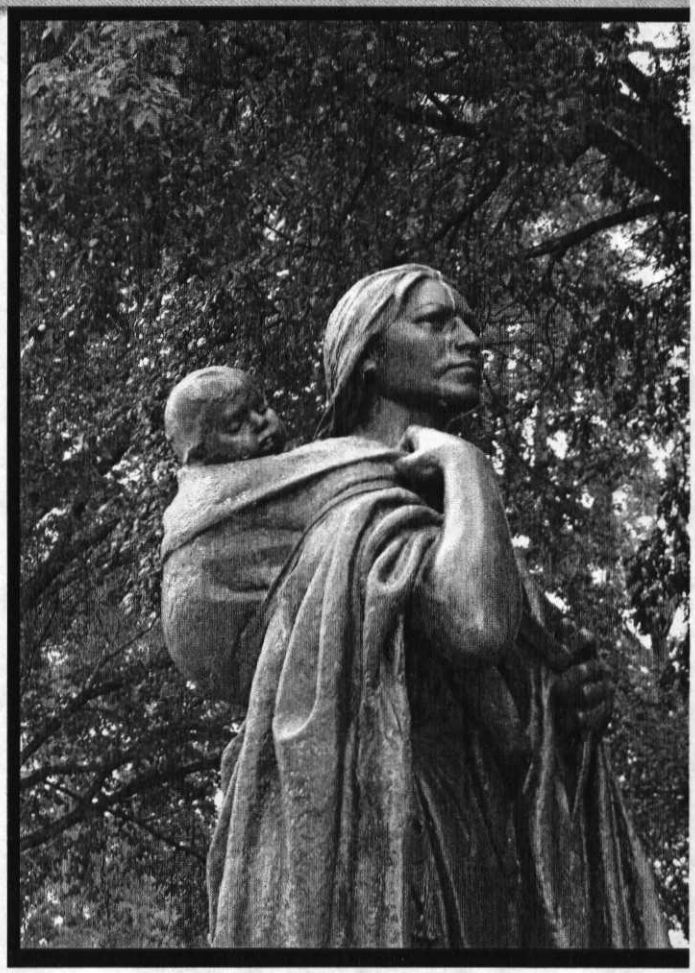
http://www.ndkidscount.org

where you can obtain this and other
North Dakota KIDS COUNT publications online.

kids count north dakota

2006 Overview of Children's Well-Being in North Dakota

A Focus on American Indian Children



Legislative Council Library has a copy or Contact ND Kids Count Office

Public Testimony for Senate Concurrent Resolution No. 4032
Sixtieth Legislative Assembly of North Dakota
Introduced by Senator Dever

Testimony by Mark LoMurray, LSW
15506 Sundown Drive
Bismarck, ND 58503
outreach@btinet.net
701-471-7186

I would like to provide testimony in support of Senate Concurrent Resolution No. 4032 directing the Legislative Council to study ways in which schools and school districts can better identify the high-risk students and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts.

I am testifying as a private citizen with the following experience...

- Thirty years professional experience working with teens in North Dakota
- Twenty years suicide prevention experience working with adolescent and young adult suicide prevention efforts in North Dakota.
- One of 14 North Dakotan's involved in the development of the first national suicide prevention strategy in 1998
- Co-founder of the North Dakota Adolescent Suicide Prevention Task Force founded in 1998, co-chair of the task force from 2000 – 2005.
- Project director for the Mental Health Association for the North Dakota Adolescent Suicide Prevention Project from 2000-2006 which trained over 50,000 North Dakotan's during that time – from teen leaders, school staff, community caretakers, parents, and a variety of professional groups
- Project director of the North Dakota Tribal – Rural Mentoring Partnership with almost 600 youth being mentored in North Dakota's largest mentoring project and one the nation's largest tribal mentoring efforts.

I consider this resolution an extremely important one for the health of North Dakota teens for the following reasons.

- Suicide is the #2 cause of death for young people ages 10-24 years old in North Dakota.
- In 1998, when North Dakota began it's first efforts on a state suicide prevention plan North Dakota was ranked the #2 highest state per 100,000 rate for suicide fatalities for 10-14 year olds, #6 highest state per 100,000 rate for suicide fatalities for 15-19 year olds.
- Adolescent suicide is closely linked with other risk factors particularly depression, substance abuse, exposure to traumatic events, harassment, intense conflict, and aggressive-impulsive behavior.
- From 2000 – 2004 the project began an extensive adolescent suicide prevention effort throughout North Dakota using 10 different grants to average approximately $40,000 per year for statewide efforts. The project focused on a

variety of strategies, many that partnered with schools around updating protocols and policies, gatekeeper training, professional training, early screening and referral strategies, developing teen led strategies, mentoring, and developing small support groups.

It is helpful to think of suicide prevention efforts similar to efforts to reduce traffic fatalities. We will not be able to prevent every traffic fatality, but we have shown that we can significantly reduce the number of highway fatalities through a mixture of efforts – speed limits, how cars are built, how roads are designed and maintained, seat belt laws, DUI enforcement, graduated licensing, etc.

The same is true of suicide prevention. We will probably be unable to prevent or stop all suicides, but it clearly seems possible to reduce the unacceptably high number of suicides especially in our young. We have seen some hopeful trends and know more about effective adolescent suicide prevention than we did ten or even five years ago.

At $40,000 per year the project did not have sufficient resources to adequately study, evaluate, or research the impact, but the prevention activities along with some hopeful trends drew national attention from many groups. The project received the prestigious national Public Health Practice award from the American Public Health Association, Epidemiology Section in 2005.

On many fronts I believe North Dakota is viewed as a creative leader in its strategies and techniques to address teen suicide. I have been asked to speak at over a dozen national conferences in the past year sponsored by SAMHSA, Indian Health Services, National Tribal Chairman's Health Board, National Suicide Prevention Resource Center, and the Centers for Applied Prevention Technologies, the National Mentoring Center, and Native Aspirations. There is strong interest in what the North Dakota project has accomplished as a potential model for other rural and tribal areas. There is specifically great interest in how to effectively and safely engage teen leaders in these efforts, as well as, the holistic intervention model that has developed via Sources of Strength or wrap a round model for blending institutional mental health/medical services with village-based supports and strengths.

Our dependence on outside funding, even for a project that has received national attention shows the significant need for the study recommended in this resolution. Unless the legislature has clear and convincing evidence – research, that provides us with some strong recommendations, I fear promising efforts will never be widely initiated. This is especially troublesome since many of these promising efforts have been designed and implemented in North Dakota and are being by many other states.

This resolution is timely, focused, and strategic and has a good chance to result in some very practical application. I recommend the study includes the following...

1. A review to determine if secondary schools in North Dakota have adequate policy and protocol that guide and support staff in the proper effective handling and referral of suicidal students.

2. A review to determine if schools have adequate resources, partnerships, and staff to immediately handle and refer suicidal teens in a timely manner.
3. Recommendations for a consistent ongoing gatekeeper training for school staff, to include teachers, support staff (aides, bus drivers, cooks, janitors, etc.) as well as, administration and school board training, to assist in both identification of youth with warning signs and to increase proven protective factors to youth that are in distress, but not suicidal.
4. Recommendations and review of effective practices that can be woven into the school climate that could reduce youth sociality, including educational and skill based coping curriculums, school-based mentoring, support groups, teen-led prevention activities, and other strength-based school bonding efforts.
5. Protocols and recommendations around the use of suicide screening resources for both universal screening of many students and targeted screening of students identified as high risk.
6. Track identified suicidal students to see if they receive adequate support and services from medical/mental health services and village supports in a way those students and parents find helpful and meaningful.
7. Postvention protocols and training to respond effectively to traumatic deaths in a manner that reduces the likelihood of suicide contagion and clusters.

This resolution is timely and hopefully can partner with two potential efforts around suicide prevention in North Dakota.

- The North Dakota Department of Health has just received a Garrett Lee Smith SAMHSA grant targeting 14 counties in North Dakota for adolescent suicide prevention efforts.
- Nationally recognized suicide prevention researchers (Wyman, Brown) recently completed a very comprehensive study of gatekeeper training on school staff in Georgia and spent several days in North Dakota this past December 2006 reviewing the efforts from the ND Adolescent Suicide Prevention Project and Sources of Strength. They are very interested in pursuing a large rural suicide prevention study and are interested in North Dakota as a core partner as part of this research effort.

Testimony

Senate Concurrent Resolution 4032

House Education Committee

Wednesday, March 14, 2007; 9 a.m.

North Dakota Department of Health

Good morning, Chairman Kelsch and members of the House Education Committee. My name is Dorcas Kunkel, and I am director of the Suicide Prevention Program for the North Dakota Department of Health. I am here to testify in support of Senate Concurrent Resolution 4032.

Senate Concurrent Resolution 4032 calls for the Legislative Council to study ways in which schools and school districts can educate teachers and counselors to better identify high-risk students and to identify ways in which schools and school districts can plan and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts.

Although suicide is preventable, 10 North Dakota children ages 10 through 19 completed suicide in 2006. A number of studies have identified risk factors for youth suicide. These risk factors include:

- Previous suicide attempts – Teens who have attempted suicide in the past are much more likely than other teens to attempt suicide again in the future. Approximately one-third of teen suicide victims have made a previous suicide attempt.
- Depression and/or alcohol or substance abuse – More than 90 percent of teen suicide victims have a mental disorder, such as depression, and/or history of alcohol or drug abuse.
- Family history of mental disorders, substance abuse, or suicide – Teens who kill themselves often have had a close family member who attempted or committed suicide. Many of the mental illnesses, such as depression, that contribute to suicide risk appear to have a genetic component.
- Stressful situation or loss – When teens experience losses or certain stressful situations, it can trigger a suicide attempt. Such stressful situations include getting into trouble at school or with the police; fighting or breaking up with a boy friend or a girlfriend; and fighting with friends.
- Easy access to guns – Teens are much more likely to kill themselves when they have access to guns. When teens shoot themselves, they most often do so in their own homes. Teens are at far greater risk for suicide when there are loaded and accessible guns in their homes.

- Exposure to other teenagers who have committed suicide – Teens are more likely to kill themselves if they have recently read, seen or heard about other suicide attempts.
- Other risk factors include a history of physical and/or sexual abuse, poor communication with parents, incarceration, and lack of access to or an unwillingness to seek mental health treatment.

One of the ways in which schools and school districts might help teachers and counselors better identify students at risk is to teach them to recognize the following warning signs:

- A suddenly worsening school performance
- A fixation with death or violence
- Unhealthy peer relationships
- Violent mood swings or a sudden change in personality
- Indications that the teen is in an abusive relationship
- Other risky behaviors such as promiscuous sexual behavior, driving recklessly or engaging in self destructive behaviors
- Signs of an eating disorder
- Difficulty in adjusting to gender identity
- Bullying
- Depression

I direct the Garret Lee Smith State and Tribal Youth Suicide Prevention Grant provided by the federal Substance Abuse and Mental Health Services Administration. This grant provides the North Dakota Department of Health $1.2 million over three years to focus on suicide prevention for North Dakota youth ages 10 to 24. The project period for this grant is from Sept. 30, 2006, to Sept. 29, 2009.

The purpose of the Youth Suicide Prevention Grant is to build on the foundation of prior suicide prevention efforts for youth in order to support states and tribes in developing and implementing youth suicide prevention and early intervention strategies. The grant requires public and private collaboration among institutions and agencies that serve youth, including schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other organizations.

The goal for this grant is to reduce youth suicide deaths in four of the six highest risk areas of North Dakota. The long-term goal of the Department of Health's Suicide Prevention Program is to develop a comprehensive, statewide suicide prevention program. In addition, a nationwide and statewide cross-site evaluation will be conducted during and at the completion of the grant to evaluate the effectiveness of suicide prevention programs in different settings and different areas of youth service. We would happy to share this data with the committee during your study.

The study called for in Senate Concurrent Resolution 4032 is timely and important. The Department of Health offers our assistance in meeting your goals.

This concludes my testimony. I am happy to answer any questions you may have.

MENTAL HEALTH ASSOCIATION IN NORTH DAKOTA

Works for a world free from discrimination against mental illness

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A private, non-profit 501(c) 3 agency. The [redacted] non-governmental organization concerned with all aspects of mental health for all citizens of North Dakota.

Testimony
Mental Health Association in North Dakota

SCR 4032- A concurrent resolution directing the Legislative Council to study ways in which schools and school districts can better identify high-risk students and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts.

House Education Committee

Representative Kelsch, Chairman

March 14, 2007

Chairman Kelsch and members of the Education Committee, my name is Chet Pulver, I am a Public Policy Assistant with the Mental Health Association in North Dakota(MHAND). Susan Rae Helgeland, our Executive Director has asked me to present testimony today.

MHAND is a nonprofit organization whose mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

MHAND supports this important study resolution. Madam Chairman and members of the committee we encourage you to give this resolution a do pass recommendation.

Thank you for allowing me to appear before you today and I would be glad to answer any questions.

NASW

NATIONAL ASSOCIATION OF SOCIAL WORKERS
NORTH DAKOTA CHAPTER

March 14, 2007

Testimony on Senate Concurrent Resolution 4032
House Education Committee

Representative Kelsch and Members of the House Education Committee:

My name is Connie M. Hildebrand and I am the legislative chair of the North Dakota Chapter of the National Association of Social Workers. I'm providing testimony in support of SCR 4032, which directs the Legislative Council to study how school districts can identify high-risk students and access programs to reduce the incidence of high-risk behavior leading to suicide attempts.

In 2002 the President's Commission on Mental Health recognized youth suicide early intervention and prevention as an urgent public health priority. Although suicide accounts for 1.2% of deaths in the United States annually, suicide comprises 12.8% of all deaths among 15-24 year-olds. In this age group, suicide ranks as the third leading cause of death; in some states it's second. Suicide also ranks as the third leading cause of death in 10-14 year olds.

As in adult suicide, the causation of youth suicide is complex, multi-determined, and reflects the presence of "risk factors," the absence of "protective factors," and their interaction.

"Risk" factors may include a family history of suicide, childhood sexual abuse, exposure to domestic violence, or a mental health or substance abuse disorder. School-based, evidence-based, risk-screening tools can be utilized in the identification of at-risk youth, and NASW supports the administration of such tools by qualified mental health personnel.

In addition to the assessment of suicide risk factors however, it is critical schools recognize and implement "protective factors" that lessen risk. Protective factors can include teaching skills in problem-solving, impulse control, or conflict resolution. It can mean activating family support, obtaining access to mental health care, and reinforcing life-affirming cultural and religious beliefs that discourage suicide.

Testimony on Senate Concurrent Resolution 4032
Senate Education Committee
NASW-ND
March 14, 2007

The research on "risk and protective factors" suggests that a promising prevention strategy among school-age children is to reduce early risk-factors for depression, substance abuse, and aggressive behaviors and to implement programs that enhance resilience.

Attached to this testimony is the background paper prepared by NASW on youth suicide, 2005

NASW welcomes this opportunity to offer support for this resolution, and commends the sponsor for helping focus community efforts on the issue of youth suicide.

We request a committee vote of DP on SCR 4032.

NASW
National Association of Social Workers
NORTH DAKOTA CHAPTER
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