**Domain Group: Adolescent**

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 **Lead Staff: Kelsee Torrez Recorder: Sarah Fischer**

**Focus Area:** *Provide brief responses to the following questions related to the focus area/issue.*

| **Discussion Questions** | **Comments** |
| --- | --- |
| 1. What is the problem/focus issue?
 | This will be an action alert calling on everyone to get involved and take action around impactful efforts, solutions and improvements around suicide prevention. Focus on what each person/role/sector can do right now—small but potentially very impactful strategies (parents, youth, schools, government, providers, communities, etc.). NOTE: Review the [CDC Technical Package](https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf)\* strategies for suicide prevention—can we align with something and draw from what to do? What other key resources and recommendations can we draw from? FYI: There is a highly collaborative group of state agencies and suicide prevention partners that has been convening for months. They are currently working on an awareness initiative with joint messaging and “call to action” that will involve the media.**\*** <https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf> |
| 1. Who is the target audience for the message(s)?
 | Audience is all (youth, parents, caregivers, families, physicians, school personnel, communities, etc.)  |
| 1. What type of document/product related to outreach/messaging are you preparing (what is the purpose) and why? (action alert, infographic, bulletin, etc.)
 | **Action Alert/Call to Action****(Use data, strategies, tips, and reminders to send the messages to impact behavior; intent is to mobilize and activate/create and drive action across sectors – we are all a part of the solution and can do something now.)** |
| 1. What MCH performance measure does this aim to address/support?
 | NOM 16.1 - Adolescent mortality rate, ages 10 through 19, per 100,000*Numerator: Number of deaths among adolescents ages 10 through 19 years Denominator: Number of adolescents ages 10 through 19 years***NOM 16.3:** Adolescent suicide rate, ages 15 through 19, per 100,000*Numerator: Number of deaths attributed to suicide among adolescents ages 15 through 19 years Denominator: Number of adolescents ages 15 through 19 years***Related: NPM 9: Bullying; NPM 10: Adolescent well visit** |
| 1. Outline the case for need:
* Data/negative trends
* Behaviors to target for change that are contributing to the issue
* System and/or policy issues and barriers contributing to the problem
* Other contributing factors
 | **Data:** State and local agencies rely on data to drive program implementation, policy decisions, and capacity building initiatives. These data sources tell us:* Vital Statistics (2013-2017)
	+ Suicide is the second leading cause of death for age groups 15-24 and 25-44; it’s the third leading cause for 5-14-year-old.
	+ There is an increasing trend over the last five years.
	+ 5.7% of all suicides are individuals less than 18 years old.
* Youth Behavioral Risk Survey (YBRS) (2017, males and females)
	+ 15.6% seriously considered suicide
	+ 11.8% made a plan to attempt suicide
	+ 7.1% attempted suicide
* Kansas Communities That Care (KCTC) (2019; 6th, 8th, 10th, and 12th grades)
	+ 18.7% of students reported thoughts of suicide
	+ 10.7% made a plan to attempt suicide
	+ 4.3% attempted suicide
* KS Violent Death Reporting System (KVDRS) (2015)
	+ Suicide made up 74% of all violent deaths (480/645)
		- 97% 18 years and older
		- 3% 10-17 years
* Total deaths due to violence for youth 10-17 years = 22; 73% due to suicide (rate = 5.01/100,000)
* Kansas Attorney General’s Office, Child Death Review Board (2018 Annual Report, 2016 Data)
	+ 35% of child/adolescent suicides in 2016 were age 14 or younger
	+ 40% of child/adolescent suicides in 2016 previously received or were receiving mental health services at the time of their death
	+ 35% of child/adolescent suicides in 2016 had a history of substance abuse

**NOTE: Refer to the KCTC Graphic that shows that less than 1% of students who reported a suicide attempt did so without a plan. The vast majority had a plan – which means there is time to intervene. Prevention strategies can be employed.****Behaviors to Target:****System and/or Policy Issues:** **Barriers to Address:** **Other Factors to Consider:**  |
| 1. What are the “asks” from the audience? What changes/actions can make a difference? Specifically, how should we move forward with this “issue” area that needs to be advanced?

(Carry to action alert worksheet.)NOTE: Break strategies/actions for change down by target population and provider or setting type |  |
| 1. What key message(s) or resources (phone numbers, websites, etc.) need to be communicated or promoted?

(Carry to action alert worksheet.)NOTE: Break message down by target population and provider or setting type, if appropriate. |   |
| 1. Sources/References
 |  |

**MCH State Action Plan Objectives & Strategies:**

* Increase access to programs and providers serving adolescents that assess for and intervene with those at risk for suicide.
	+ Develop follow-up protocols for families to be referred for behavioral health services and offer additional support as needed to assure services are received.
	+ Provide school-based access to confidential mental health screening, referral and treatment that reduces the stigma and embarrassment often associated with mental illness, emotional disturbances and seeking treatment.
	+ Partner with KU Pediatrics, Kansas Department of Aging and Disability Services, and Kansas Association for the Medically Underserved to provide mental health fellowship training opportunities to pediatric primary care providers through the REACH Institute.
	+ Promote the yellow ribbon initiative and accessible crisis services through school and out-of-school activities.

**What, if any recommendations, does the group have for the MCH State Action Plan related to this issue? Consider and discuss the following:**

|  |  |  |
| --- | --- | --- |
| Is the issue/need adequately addressed in the plan? Circle one (yes or no) and explain. | **Yes** | **No** |
| Does the group recommend any strategies to advance the work or improve the outcomes/measures?Circle one (yes or no) and explain. | **Yes** | **No** |

**Significance & Data:**

Bureau SIGNIFICANCE Suicide is the second leading cause of death for adolescents ages 15 through 19 years. In 2014, there were over 2,000 deaths due to suicide among adolescents ages 15 to 19 years, or 9.8 deaths per 100,000. Suicide and suicidal ideation is often indicative of mental health problems and stressful or traumatic life events. In 2015, 18 percent of high school students reported they had thought seriously about committing suicide in the past year. While females are more likely to report considering suicide, males are more likely to succeed in committing suicide. The suicide mortality rate for males is nearly three times that of females. Heron M. Deaths: Leading Causes for 2014. National Vital Statistics Reports. 2016 June 30. 65(5). https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65\_05.pdf Child Trends: Data Bank. Suicidal Teens-Indicators of Child and Youth Well-Being. 2016 December. https://www.childtrends.org/wp-content/uploads/2016/12/34\_Suicidal\_Teens.pdf

HEALTHY PEOPLE 2020 OBJECTIVE Related to Mental Health and Mental Disorders (MHMD) Objective 1: Reduce the suicide rate. (Baseline: 11.3 suicides per 100,000 in 2007, Target: 10.2 suicides per 100,000) Related to Mental Health and Mental Disorders (MHMD) Objective 2: Reduce suicide attempts by adolescents. (Baseline: 1.9 suicide attempts per 100 occurred in 2009, Target: 1.7 suicide attempts per 100) DATA SOURCES and DATA ISSUES National Vital Statistics System (NVSS) Population estimates come from the U.S. Census.

**NOM 16.1, 2, 3 Data Trends**

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**Additional Kansas Data**

* Vital Statistics (2013-2017) – See Table 1
	+ Suicide is 2nd leading cause of death for 25-44 and 15-24; 3rd leading cause for 5-14 years
	+ Increasing trend over the last five years
	+ 5.7% of all suicides are individuals less than 18 years
* Youth Risk Behavior Survey (YRBS) (2017, males and females)
	+ 15.6% seriously considered suicide
	+ 11.8% made a plan
	+ 7.1% attempted
* Kansas Communities That Care (KCTC) (2019; 6th, 8th, 10th, and 12th Grades)
	+ 18.7% of students reported thoughts of suicide
	+ 10.7% made a plan
	+ 4.3% made an attempt

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| Table 1. |
| Suicides of youth 17 and younger, by count |
| and percent of all suicides, Kansas residents |
| 2013-2017 |
|  | Suicides |  |
| Year | All ages | Under 18 | % Under 18 |
| 2013 | 426 | 15 | 3.5 |
| 2014 | 454 | 14 | 3.1 |
| 2015 | 477 | 17 | 3.6 |
| 2016 | 512 | 18 | 3.5 |
| 2017 | 544 | 31 | 5.7 |
| Total | 2413 | 95 | 3.9 |