2015

New Jersey Youth Suicide Report

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Data Overview and Recommendations on Youth Suicide in New Jersey

Suicide's impact reverberates through families, friends, and communities. It does not discriminate, touching all ages, genders, and racial and ethnic backgrounds. Suicide remains the third leading cause of death for New Jersey youth between the ages of 10 and 24.

The New Jersey Department of Children and Families (DCF), collaborating with state, local and community partners, is committed to preventing adolescent suicide by reducing youth suicide risk factors and increasing youth suicide protective factors.

This report is a compilation of data focused on suicide and suicide attempts for New Jersey youth between the ages of 10 and 24.

> The National Violent Death Reporting System Web Coding Manual defines suicide as, "death resulting from the intentional use of force against oneself. A preponderance of evidence should indicate that the use of force was intentional."[1]

New Jersey continues to have a lower rate of suicide than the nation. Low firearm access, seamless access to behavioral and mental health resources through DCF's Children's System of Care (CSOC), extensive gatekeeper training, and public awareness contribute to the lower rate.

New Jersey must continue to deploy strategies offering help and hope to individuals and families in need.

Data collection and analysis helps determine who is at risk and why. It helps set goals and measure prevention effort effectiveness. DCF collaborates with the New Jersey Department of Health (DOH), Center for Health Statistics and Informatics (CHSI) to collect suicide data for youth age between the ages of 10 and 24.

Through DOH, New Jersey is one of 32 states participating in a cooperative agreement with the Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control (NCIPC) to collect and provide suicide data. New Jersey suicide data is collected by the New Jersey Violent Death Reporting System (NJVDRS), which is part of the National Violent Death Reporting System (NVDRS). New Jersey collects data on suicides, homicides, legal intervention deaths, unintentional firearm injuries, and injury deaths of undetermined intent.

In addition to the NJVDRS data, this report includes data from the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services' (DMHAS) *2012 New Jersey Middle School Risk and Protective Factor Survey*. The survey documents risk and protective factors among New Jersey youth in seventh and eighth grades. The Edward J.

Bloustein School of Planning and Public Policy, Center for Survey Research (BCSR), at Rutgers University administered the survey.

This report also includes data from the New Jersey Department of Education's (DOE) *New Jersey Student Health Survey.* This survey addresses the prevalence of behaviors highly related to the causes of preventable premature illness and death, including suicide, among youth and young adults.

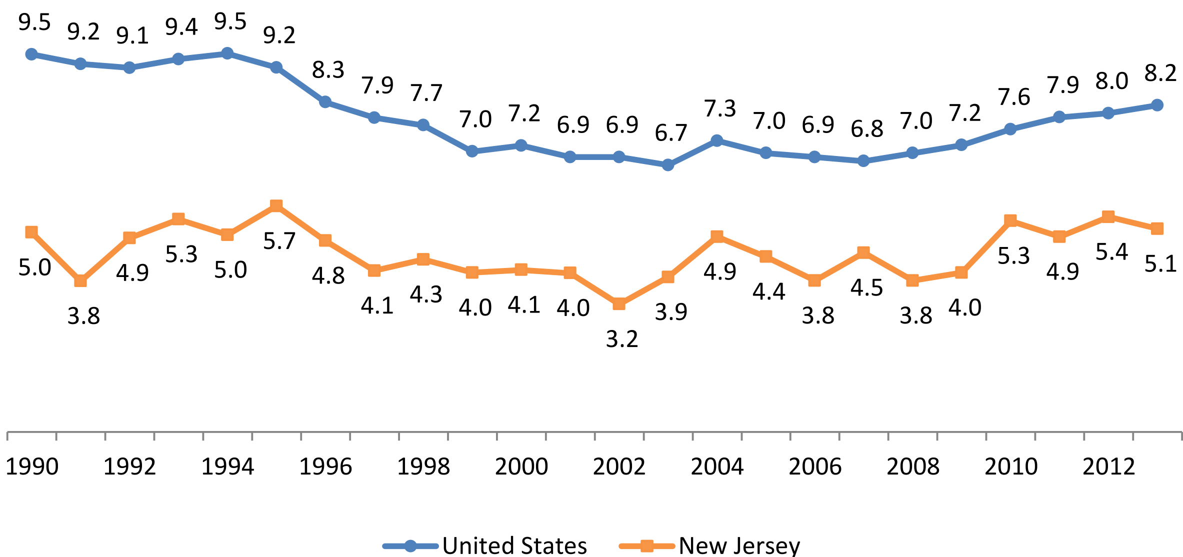
Analysis of all of these reporting tools shows New Jersey's rate of youth suicide remains low compared to the nation. However, over the last three years there has been a slight increase in New Jersey's overall rate of youth suicide. The most recent data reveal:

Suicides for 2012-2014:

- Suicide is the third leading cause of death for youth age 10 to 24 in New Jersey.
- There were 265 suicides in New Jersey involving youth age 10 to 24.
- The NJVDRS data reveal in 2014, 80 youth age 10 to 24 died by suicide, a rate of 4.6 per 100,000. This is a decrease from 5.2 in 2013.
- According to the Web-based Injury Statistics Query and Reporting System (WISQARS) data, in 2013 New Jersey had a suicide rate of 5.1 in comparison to 8.2 for the nation.
- Male youth continue to complete suicide at a higher rate (7.9) than female youth (2.2).

Chart 1:

Rates of Total Deaths by Suicide Among 10 to 24 Year Olds are Consistently Lower in New Jersey than the United States Overall



According to CDC, in 2013 suicide was the third leading cause of death for New Jersey youth age 10 to 24 , and the second leading cause of death for youth age 10 to 24 nationally (WISQARS Data online).

Suicide Attempts for 2012-2014:

- Mercer County's total rate of non-fatal suicide attempts/self-inflicted injuries (resulting in either hospitalization or emergency room treatment) was 196.2 per 100,000 youth ages 10 to 24. This was the highest of all New Jersey counties.
- Statewide, more non-fatal suicide attempts/self-inflicted injuries are treated in the emergency department (53.9) than in the hospital (38.7).
- Mercer County had the highest rate of youth (143.3 per 100,000) treated in the emergency department for non-fatal suicide attempts/self-inflicted injuries, while Warren County had the highest rate (74.5) of attempts resulting in hospitalization.
- Over 1600 youth age 10 to 24 used poisoning as the primary method for suicide attempts treated in the emergency room department.

INTRODUCTION

DCF's Family and Community Partnerships (FCP), in collaboration with DOH, compiled this report's data, which includes aggregate demographic information about youth ages 10 to 24 who have attempted or completed suicide.

The annual Youth Suicide Report is presented to the Governor, the New Jersey State Legislature and New Jersey Youth Suicide Advisory Council (NJYSPAC) by DCF, pursuant to N.J.S.A. 30:9A-27.

DATA SOURCE OVERVIEW

New Jersey Violent Death Reporting System
The New Jersey Violent Death Reporting System provides the most comprehensive accounting of all deaths from violence throughout the state. Data is collected from several sources to provide an accurate picture of all violent deaths by linking data from death certificates, medical examiners reports, and law enforcement agencies at the state, county, and local levels. Multiple data sources help fill incident gaps. If there are conflicting concerns around the manner of death, specially trained data abstractors review death certificate, medical examiner and law enforcement reports to settle the manner of death. The abstractors review reports to:

- Reconcile definitional differences in cause and manner of death to standardize case-inclusion criteria across all states;
- Code situational circumstances to identify risk factors and incident characteristics, again according to CDC definitions;
- Write concise, detailed incident narratives without identifiers;
- Link related deaths and suspects as part of a single incident.

New Jersey Student Health Survey
In spring of 2015, the New Jersey Student Health Survey (the state's Youth Risk Behavior Surveillance) was conducted per CDC guidelines by DOE. DOE administers this survey every odd year to ascertain the health behaviors of high school students within the state. This report sought to include results from the most recent survey, but the survey's results were not approved by CDC for further analysis due to insufficient survey responses.

Instead of the 2015 New Jersey Health Student Survey, the 2015 Annual Suicide Report references the 2013 New Jersey Health Student Survey. That survey revealed "… bullying victimization is associated with depression, suicidal ideation, self-injury, suicide attempts. During the past year, 21% of students had been bullied at school and 15% had been

electronically bullied. In the same time frame, 15% had bullied someone else at school and 10% had bullied someone electronically."[2]

The survey also revealed "female students were more likely to report being bullied and experiencing suicidal ideation, while males were generally more likely to report violence."

New Jersey Middle School Risk and Protective Factor Survey

Though the 2012 New Jersey Middle School Risk and Protective Factor Survey questionnaire did not have specific questions related to suicide, suicide attempts or suicidal ideation was still an important data resource. The questionnaire did include questions related to risk and protective factors that are associated with suicide attempts and completions. These results showed a strong correlation to drug use, including feelings about school and their neighborhood; self-reported and perceived peer use of tobacco, drugs, and alcohol; and the availability of such substances. These are all risk factors and warning signs for suicide. The report revealed:

- More 8th grade than 7th grade students reported annual use of the following substances:
  - Alcohol (23.1% vs. 13.7%)
  - Cigarettes (7.9% vs. 3.6%)
  - Marijuana (7.8% vs. 2.0%)
- Females were slightly more likely than males to report annual alcohol use (18.5 vs. 15.8%)
- Hispanic students reported a much higher rate of annual alcohol use than White, African-American, and Asian students (27.4% vs. 16.5%, 15.0% and 5.4%, respectively)
- More Hispanic and African-American students reported annual marijuana use than White and Asian students (8.4% and 6.2% vs. 3.9% and 1.2%, respectively)
- Within the past 30 days of students completing the survey, Passaic County had the highest alcohol use rate (20.8%), more than 5 times higher than the findings for the county with the lowest reported rate, Monmouth County (4.1%).

Data Observations

The data analyzed for this report yielded several noteworthy observations.

- Mortality data reporting is delayed for New Jersey residents completing suicides in and out of state.
- Standard policies and procedures to collect, investigate, define, and certify suicide attempt and completions are not in place.
- Active parental consent established by state law N.J.S.A. 18A:36-34 for student surveys and student state tests hindered DOE's ability to reach CDC's minimum participation rate for state analysis.
- Prevention strategies would be effective in schools before 8th grade, as supported by data from the DHS administered Middle School Survey and NJVDRS preliminary data.
    a. Eighth grade students had a higher risk factor mean score (0.29) than 7th grade students (0.19) for Perceived Availability of Drugs, indicating that alcohol, tobacco, and other drugs were easier for 8th grade students to get.
    b. Eighth grade students had higher risk factor mean scores than 7th grade students on Laws and Norms Favorable to Drug Use (0.36 vs. 0.29), Friends Use of Drugs (0.12 vs. 0.05), and Favorable Attitudes Toward Drug Use (0.12 vs. 0.06), which suggests older students believe their community and friends are more favorable to drug use.
    c. New Jersey students are more likely to be protected from negative behaviors by factors in the school domain, which include: School Opportunities for Prosocial Involvement and School Rewards for Prosocial Involvement.
    d. The NJVDRS Preliminary 2014 data indicate a marked increase in death due to suicide among females ages 10 to 18, but there does not seem to be a specific pattern in terms of county of residence or specific age of the victim. More than half of the deaths in that age group were due to hanging or suffocations.

Confirmed Suicides

Table 1A: The New Jersey Violent Death Reporting System (NJVDRS) v.09/25/2014 Data

Year	New Jersey (WISQARS)						New Jersey (NJVDRS)					
	10-18		19-24		Total		10-18		19-24		Total	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
2003	17	**	48	8.0	65	3.9	17	**	47	7.8	64	3.8
2004	32	2.9	52	8.6	84	4.9	31	2.8	51	8.4	82	4.8
2005	20	1.8	55	9.0	75	4.4	17	**	61	10.0	78	4.6
2006	18	**	47	7.6	65	3.8	19	**	49	8.0	68	4.0
2007	20	1.8	57	9.2	77	4.5	22	2.0	51	8.2	73	4.2
2008	20	1.8	46	7.3	66	3.8	23	2.1	42	6.7	65	3.8
2009	22	2.0	46	7.2	68	4.0	22	2.0	59	9.2	81	4.7
2010	27	2.5	65	10.0	92	5.3	25	2.3	62	9.5	87	5.0
2011	27	2.5	58	8.8	85	4.9	27	2.5	52	7.9	79	4.6
2012	20	1.9	73	11.0	93	5.4	20	1.9	76	11.4	96	5.6
2013	21	2.0	67	9.9	88	5.1	21	2.0	68	10.0	89	5.2
2014*	Data not available yet						27	2.6	53	7.8	80	4.6
Total	244		614		858		271		671		942	

* 2013 NJVDRS data are preliminary and subject to change. **Rates not calculated for fewer than 20 observations.

According to NJVDRS, in 2014 the number of completed suicides by youth age 10 to 18 increased from 21 to 27, while the number of youth age 19 to 24 who completed suicide decreased from 68 to 53. Since the decrease in older youth was larger, the overall total rate for New Jersey decreased from 2012 to 2013.

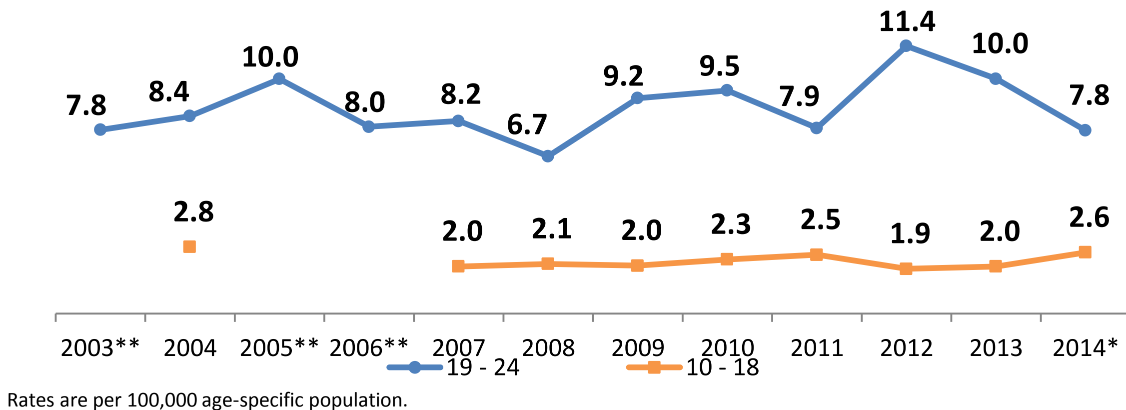
Table 1B: Comparison of Changes in NJVDRS Data as of 9/25/14 to 9/8/15

Year	New Jersey (NJVDRS) as of 9/25/14						New Jersey (NJVDRS) as of 9/8/15					
	10-18		19-24		Total		10-18		19-24		Total	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
2003	18	**	47	7.8	65	3.9	17	**	47	7.8	64	3.8
2004	31	2.8	51	8.4	82	4.8	31	2.8	51	8.4	82	4.8
2005	17	**	61	10.0	78	4.6	17	**	61	10.0	78	4.6
2006	19	**	49	8.0	68	4.0	19	**	49	8.0	68	4.0
2007	22	2.0	51	8.2	73	4.2	22	2.0	51	8.2	73	4.2
2008	23	2.1	41	6.5	64	3.7	23	2.1	42	6.7	65	3.8
2009	22	2.0	59	9.2	81	4.7	22	2.0	59	9.2	81	4.7
2010	24	2.2	57	8.7	81	4.7	25	2.3	62	9.5	87	5.0
2011	27	2.5	52	7.9	79	4.6	27	2.5	52	7.9	79	4.6
2012	17	**	63	9.4	80	4.6	20	1.9	76	11.4	96	5.6
2013*	21	2.0	52	7.7	73	4.2	21	2.0	68	10.0	89	5.2
Total	241		583		824		244		618		862	

The chart above captures some changes (see red font) to the NJVDRS data since this report was published in 2014. The total number of deaths by suicide for 10 to 18 year olds changed by 3 (2003 decreased, while 2010 and 2012 increased). The total for 19 to 24 year olds increased by 35. With the exception of 2003, these increases are due to New Jersey residents who completed suicide out of state. These suicides were not included in the New Jersey Medical Examiner's files, and a New Jersey death certificate was not issued because these deaths occurred out of state. These new cases are added to NJVDRS through the interstate certificate exchange program, which may take several years. The changes are part of the normal data updating process. New Jersey and the Office of Vital Statistics at the Department of Health are working to improve the process.

Chart 2

Rates of Deaths by Suicide are Higher Among Older Youths



Rates are per 100,000 age-specific population.

Youth ages 19 to 24 were three times more likely to die by suicide than youth age 10 to 18. However, this gap is narrowing. Recent years show death by suicide among 10 to 18 year olds is increasing while death by suicide among 19 to 24 year olds is decreasing.

Age and Gender

Table 2: Suicides by age group and gender, New Jersey, 2012-2014

	Age Group					
	10 to 18		19 to 24		Total (10 to 24)	
Gender	N	Rate	N	Rate	N	Rate
Male	52	3.2	157	15.0	209	7.9
Female	16	**	40	4.1	56	2.2
Total*	68	2.2	197	9.7	265	5.1

*Total includes 1 youth of unknown gender. **Rates are not calculated for fewer than 20 observations. Rates are per 100,000 age-specific population.

Table 2 above captures the age and gender of the 265 youth suicides in New Jersey over the last three years. The data reveals that 74% (197) of these deaths by suicide involve youth ages 19 to 24. In this same age category, young men complete suicide at a rate approximately 3.6 times higher (15.0) than young women (4.1). The rate of death by suicide among male youth age 10 to 18 is 3.2, which is also higher than female youth in this same age category. The actual rate of suicide among female youth age 10 to 18 is not calculated because there were fewer than 20 deaths in this group. These trends are consistent with what New Jersey has seen in prior years.

Race and Ethnicity

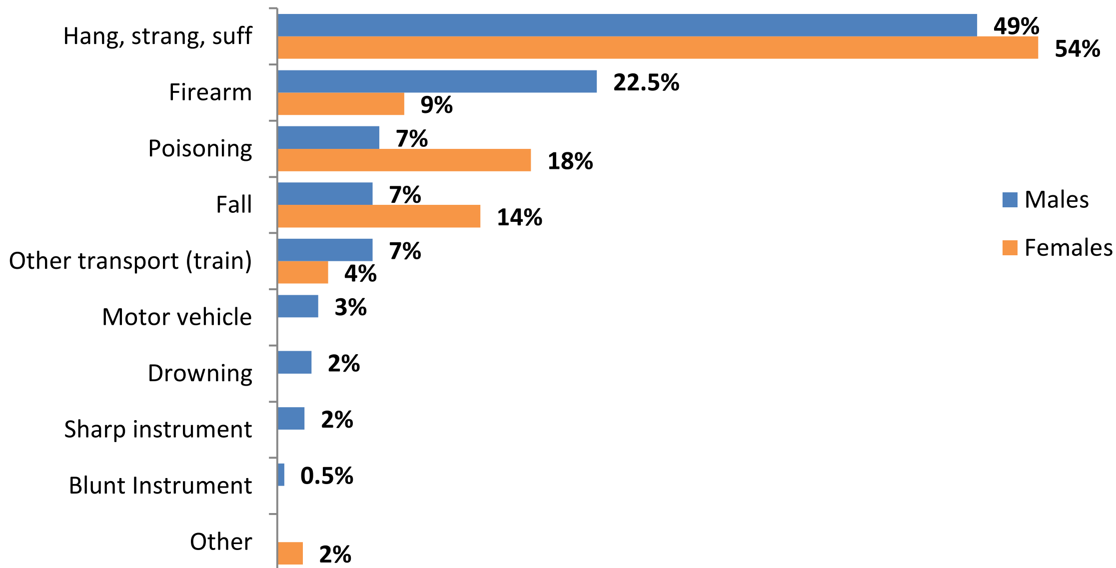
Table 3: Suicides by age group and race/ethnicity, New Jersey, 2012-2014

Race/ethnicity	Age Group					
	10-18		19-24		Total 10-24	
	N	Rate	N	Rate	N	Rate
White Non-Hispanic	35	2.1	109	10.7	144	5.3
Black Non-Hispanic	8	**	34	9.9	42	5.1
Hispanic	16	**	29	5.9	45	3.8
Asian/Pacific Islander	6	**	13	**	19	**
Other Race	3	**	12	**	15	**
Total	68	2.2	197	9.7	265	5.1

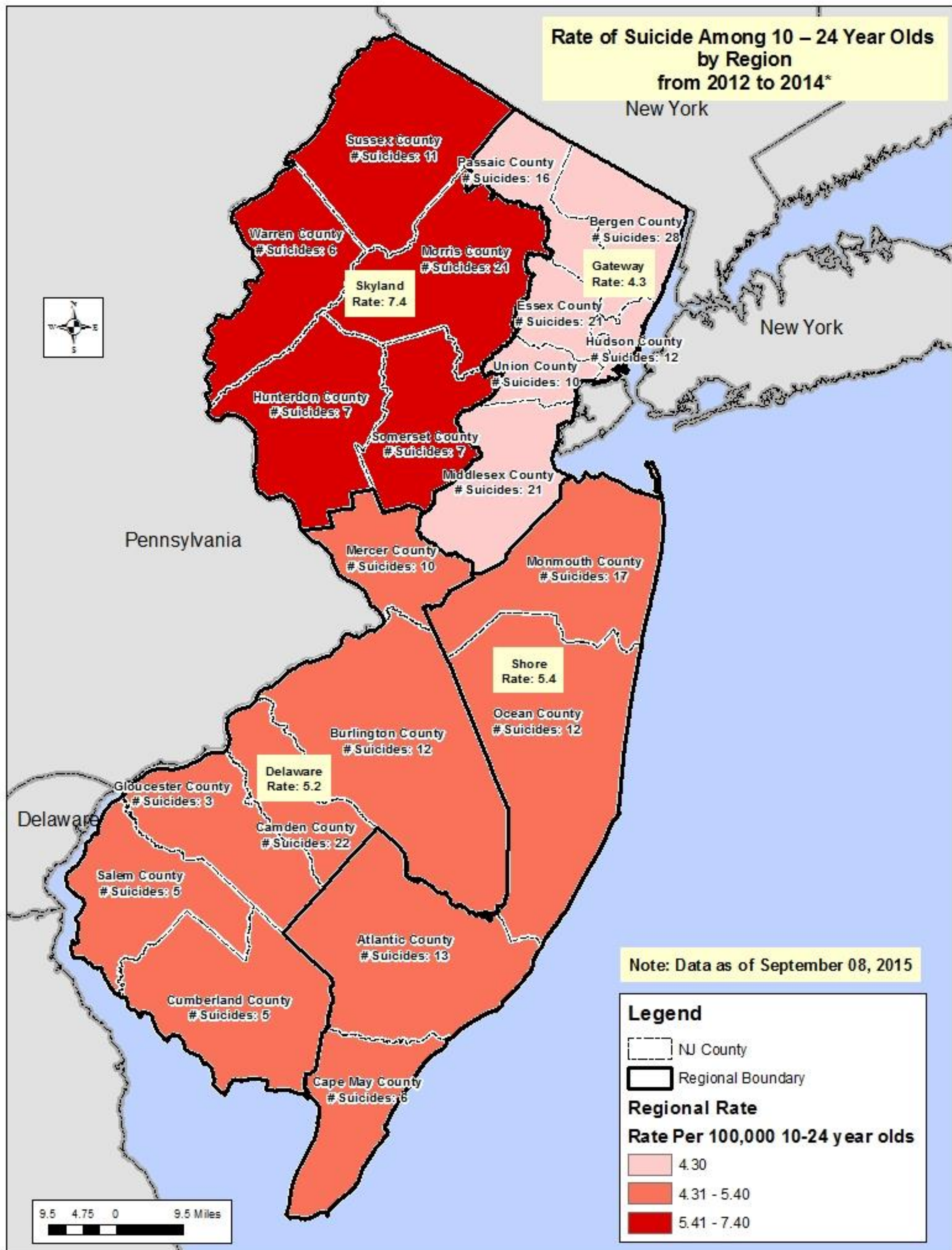
Table 3 above captures the race and ethnicity of the 265 youth suicides in New Jersey over the last three years. Race and ethnicity data should be interpreted with caution because Hispanic youth are often reported as “Other Race” or “White Non-Hispanic.” Based on current data, among those age 10 to 24, non-Hispanic White and Black youth complete suicide at nearly the same rate, with White Non-Hispanic youth just slightly higher. In comparison, for Hispanic youth age 10 to 24, the rate of death by suicide is 25% lower than the overall statewide rate (5.1). Again, this trend is consistent with prior reports.

Primary Method

Hanging/Strangulation/Suffocation was the Method Used Most Often by Males and Females Age 10 to 24 in New Jersey 2012 to 2014



Hanging, strangulation, and suffocation were again the most common means of suicide among females and males in New Jersey in 2012 to 2014. Males were 2.5 times more likely to use firearms, while females were about 2.5 times more likely to use poisoning. Falling increased during this reporting period, overtaking trains to become the fourth most common means. It is still noteworthy that suicide by train is a significant concern for both males and females in New Jersey. Compared to national statistics, New Jersey has a relatively high number of suicides by train. According to CDC's NCHS Vital Statistics System (retrieved from WISQARS), in the most recent comparable period available from 2011 to 2013, there were 122 suicides (both males and females age 10 to 24) by "other land transport," a rate of 0.06. From 2012 to 2014, New Jersey had 16 suicides by other land transport. Although the national rate has increased slightly (there were 80 in 2009 to 2011), New Jersey still has a disproportionate number of the nation's suicides by other land transport. While New Jersey has 3% of the nation's population, approximately 13% of the nation's suicides by train occur in New Jersey.


Rate of Suicide Among 10 – 24 Year Olds by Region from 2012 to 2014*
New York
Sussex County # Suicides: 11
Passaic County # Suicides: 16
Bergen County # Suicides: 28
Warren County # Suicides: 6
Morris County # Suicides: 21
Gateway Rate: 4.3
Skyland Rate: 7.4
Essex County # Suicides: 21
New York
Hudson County # Suicides: 12
Union County # Suicides: 10
Hunterdon County # Suicides: 7
Somerset County # Suicides: 7
Middlesex County # Suicides: 21
Pennsylvania
Mercer County # Suicides: 10
Monmouth County # Suicides: 17
Shore Rate: 5.4
Ocean County # Suicides: 12
Burlington County # Suicides: 12
Delaware Rate: 5.2
Gloucester County # Suicides: 3
Delaware
Camden County # Suicides: 22
Salem County # Suicides: 5
Atlantic County # Suicides: 13
Note: Data as of September 08, 2015
Cumberland County # Suicides: 5
Legend
NJ County
Regional Boundary
Regional Rate
Rate Per 100,000 10-24 year olds
4.30
4.31 - 5.40
5.41 - 7.40
Cape May County # Suicides: 6
9.5 4.75 0 9.5 Miles

County of Residence (Map 1)

From 2012 to 2014, only 5 of New Jersey's more populated counties had over 20 deaths by suicide: Bergen, Camden, Essex, Middlesex and Morris. In accordance with National Center for Health Statistics standards, rates based on fewer than 20 persons in the population are considered unreliable for analysis purposes. Due to this limitation, DCF grouped New Jersey's 21 counties into four regions to determine what areas of the state have higher rates of deaths by suicide. The above map shows the Skyland region (7.4) has the highest rate of youth suicides, followed by the Shore (5.4) and Delaware regions (5.2). Although the Gateway region has a greater number of youth suicides, the rate (4.3) shows it is a smaller proportion of their total population. In other words, in the Gateway region fewer youths die by suicide per capita than in New Jersey's more sparsely populated regions. The Shore region appears to have increased since the 2014 report, but it is unclear if this is due to the addition of out-of-state deaths, or a true trend.

Life Circumstance

NJVDRS collects data on circumstance/life condition of youth age 10 to 24 that have completed suicide. Each youth may have multiple circumstances applicable to them. Table 4 provides data captured from 2012 to 2013 for this *2015 New Jersey Youth Suicide Report*. There are notable changes from last year's report. The data in last year's report reflected early 2013 circumstance results and at that time, only 69% of 10 to 24 year olds had known circumstance details. As new information becomes available circumstances related to deaths reported are coded. Therefore, the data reported in this year's report are minimum estimates. Nevertheless, the available data shows among youth who completed suicide, mental health, relationships, and substance abuse were prevalent challenges.

- The number of youth who had a current mental health problem considerably declined in this year's *New Jersey Youth Suicide Report* period 2012 to 2013 compared to the *2014 Youth Suicide Report* period 2011 to 2012. This year only 29% of youth had a confirmed current mental health problem, while last year it was 44%. Almost all of these (52 out of 54) were actively receiving mental health treatment. Last year only a quarter of the youth were receiving treatment at the time of their suicide completion. However, it was still the most common circumstance overall, particularly among 19 to 24 year old females and males.
- Relationship problems were the second most important circumstance for New Jersey youth during this report period. Nineteen percent reported intimate partner problems. However, only 8% indicated an "other" relationship problem, down from 21% in 2011 to 2012.
- Substance abuse (18%) was a much higher problem than alcohol (4%) for New Jersey youths age 10 to 24. Females were more likely to have substance abuse as a circumstance (23%) than males (17%), the opposite of last year's observation.

- The circumstances for 10 to 18 year old males continue to differ from females and older youth. The circumstances for 10 to 18 year old males most likely involve school problems (26% vs. 8% overall) and are related to family stressors more than any other group (16% vs. 5% overall).

Fewer New Jersey youth who completed suicide over the last two years either left a note and/or disclosed in advance their intent to complete suicide compared to 2011-2012. In 2012–2013, 23% left a note compared to 2011-2012 (32%). Fifteen percent disclosed their intent in advance compared to 22% in last year's report. Ten to eighteen year old males were more likely than 19 to 24 year old males to disclose intent and leave a note.

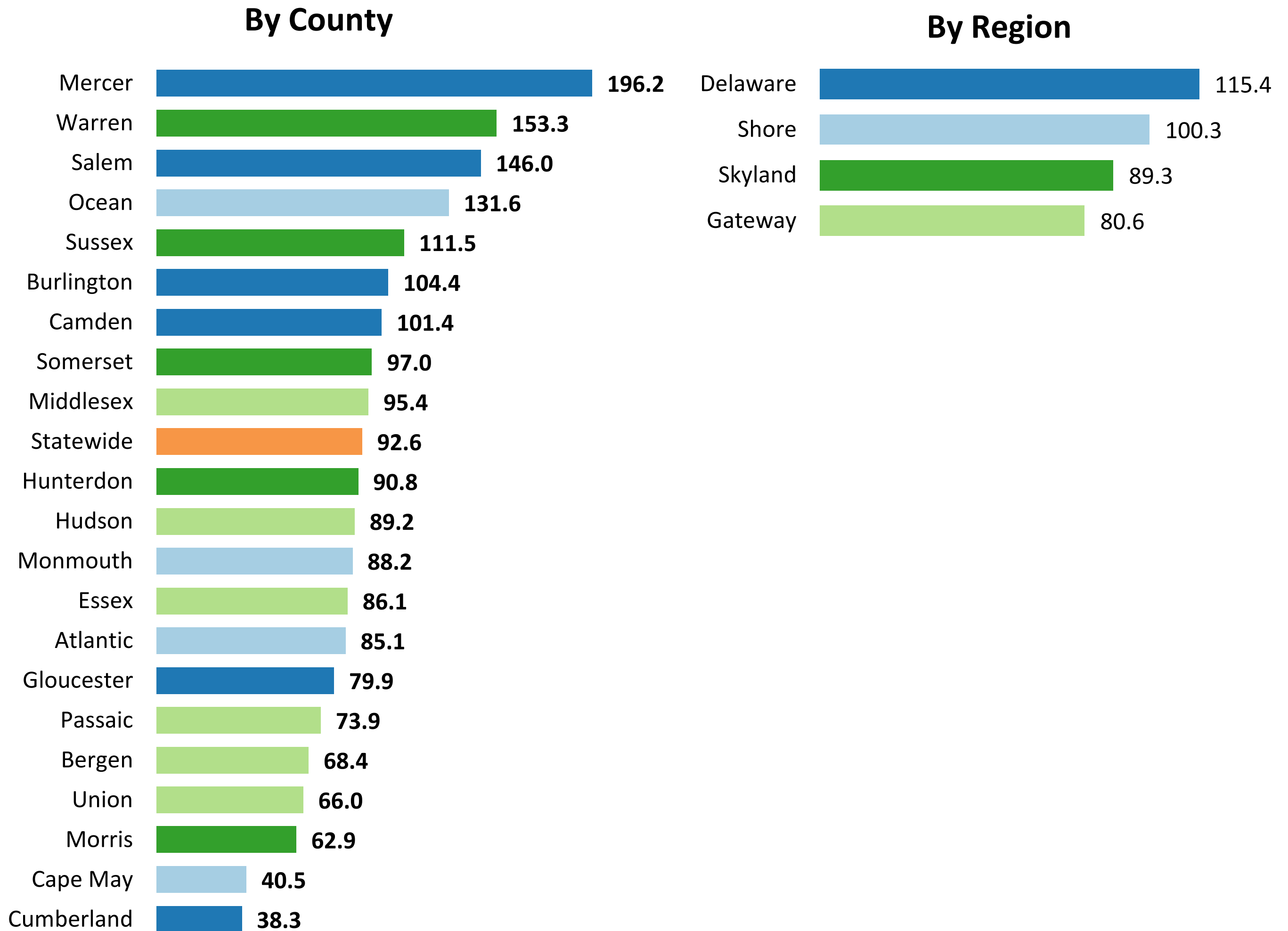
Table 4

	Age Group & Gender													
	Male						Female						Total	
	10-18		19-24		10-24		10-18		19-24		10-24		10-24	
Suicide Circumstance	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**
Current mental health problem	9	24%	32	27%	41	26%	0	0%	13	48%	13	43%	54	29%
History of mental health treatment	9	24%	32	27%	41	26%	0	0%	11	41%	11	37%	52	28%
Crisis within 2 weeks	13	34%	18	15%	31	20%	1	33%	6	22%	7	23%	38	21%
Current mental health treatment	6	16%	17	15%	23	15%	0	0%	7	26%	7	23%	30	16%
Substance abuse problem	7	18%	19	16%	26	17%	0	0%	7	26%	7	23%	33	18%
Current depressed mood	7	18%	17	15%	24	15%	2	67%	4	15%	6	20%	30	16%
Alcohol problem	0	0%	5	4%	5	3%	0	0%	2	7%	2	7%	7	4%
Suicide note	11	29%	22	19%	33	21%	1	33%	9	33%	10	33%	43	23%
Disclosed intent	10	26%	10	9%	20	13%	1	33%	6	22%	7	23%	27	15%
History of suicide attempts	3	8%	12	10%	15	10%	1	33%	9	33%	10	33%	25	14%
Other suicide circumstance	14	37%	33	28%	47	30%	1	33%	12	44%	13	43%	60	32%
Intimate partner problem	9	24%	19	16%	28	18%	1	33%	6	22%	7	23%	35	19%
Other relationship problem	7	18%	4	3%	11	7%	1	33%	2	7%	3	10%	14	8%
School problem	10	26%	4	3%	14	9%	0	0%	1	4%	1	3%	15	8%
Recent criminal legal problem	5	13%	12	10%	17	11%	0	0%	2	7%	2	7%	19	10%
Legal problem	0	0%	7	6%	7	5%	0	0%	0	0%	0	0%	7	4%
Perpetrator of interpersonal violence	1	3%	2	2%	3	2%	0	0%	0	0%	0	0%	3	2%
Job problem	0	0%	5	4%	5	3%	0	0%	2	7%	2	7%	7	4%
Financial problem	0	0%	2	2%	2	1%	0	0%	1	4%	1	3%	3	2%
Recent death of friend or family	1	3%	5	4%	6	4%	0	0%	0	0%	0	0%	6	3%
Physical health problem	0	0%	0	0%	0	0%	0	0%	2	7%	2	7%	2	1%
Victim of interpersonal violence	1	3%	0	0%	1	1%	0	0%	0	0%	0	0%	1	1%
Recent suicide of friend or family	0	0%	1	1%	1	1%	0	0%	0	0%	0	0%	1	1%
Other addiction	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Family stressors	6	16%	4	3%	10	6%	0	0%	0	0%	0	0%	10	5%
Eviction, loss of home	2	5%	5	4%	7	5%	0	0%	0	0%	0	0%	7	4%
Anniversary of a traumatic event	0	0%	1	1%	1	1%	0	0%	0	0%	0	0%	1	1%
History of childhood sexual abuse	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Number of suicides in age group	38		117		155		3		27		30		185	
Number of suicides w/ known circs	29		77		106		2		20		22		128	
% of suicides w/ known circs		76%		66%		68%		67%		74%		73%		69%

Suicide Attempts

Chart 4

Rates of Non-fatal Suicide Attempts/Self-inflicted Injuries among 10 to 24 Year Olds in 2012 to 2014



The above chart shows the total rate of nonfatal suicides/self-inflicted injuries by county and region. There are several notable differences with the map on p. 11 that shows suicide completions by county.

The Delaware region had the highest rate of nonfatal suicide attempts, but the second lowest rate of suicide completions. The Delaware region's Mercer County had the highest rate of suicide attempts statewide. Salem, Burlington, Camden, and Mercer all had non-fatal suicide/self-inflicted injury rates above the statewide average.

The Shore region had a slightly higher rate of deaths by suicide (5.4) than the Delaware region (5.2), but it was the opposite case for attempts. The Shore had a lower rate of attempts than the Delaware region. Only Ocean County had a rate of attempts above the state average, with Cape May, Atlantic, and Monmouth much lower.

The Skyland region had the highest rate of suicide completions, but a lower than average rate of attempts. Individually, Warren, Sussex, and Somerset were above the statewide average rate of attempts, but Hunterdon and Morris were lower. Hunterdon's attempts declined since the 2011-2013 reporting period, from 95.1 in last year's report to 90.8 in 2012 to 2014.

Consistent with the map on p. 11, the Gateway region had the lowest rate of nonfatal suicide attempts/self-inflicted injuries. Only Middlesex County was slightly above the statewide rate.

Emergency Room vs. Hospitalization

Age and Gender

Chart 5:

Rates of Non-fatal Suicide Attempts/Self-inflicted Injuries Treated in the Emergency Room and Released Versus Resulting in Hospitalization by Age Group and Gender in New Jersey, 2012 to 2014

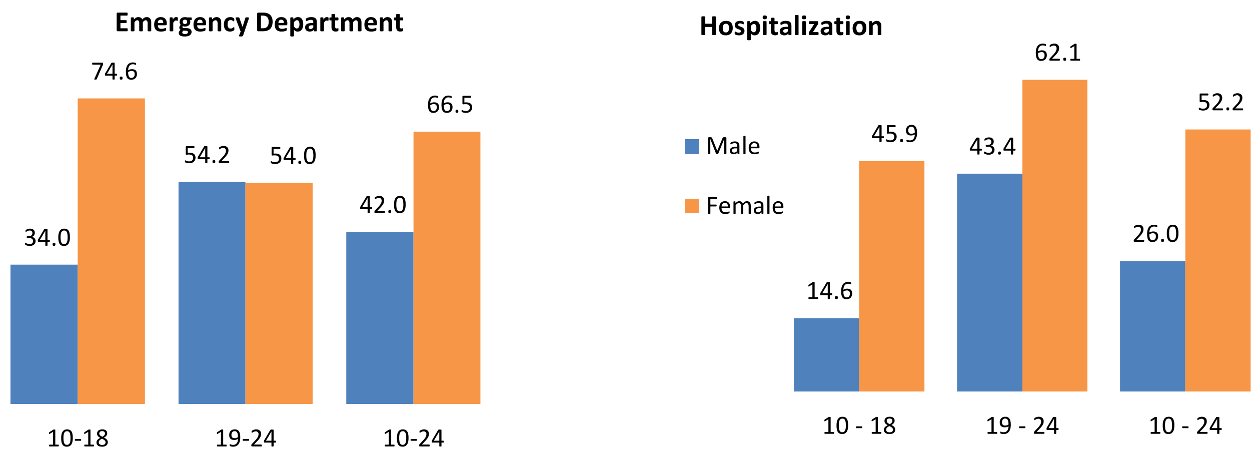


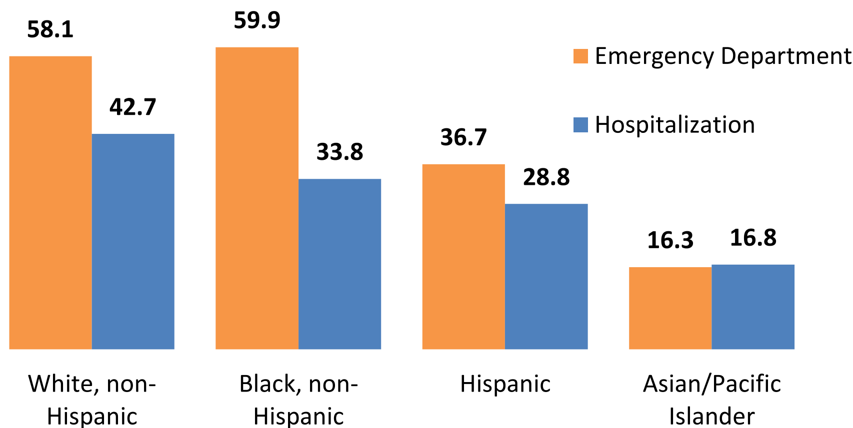
Table 5

	Age group				Total	
	10-18		19-24		10-24	
	N	Rate	N	Rate	N	Rate
Emergency Room	1,693	53.8	1,098	54.1	2,791	53.9
Hospitalization	941	29.9	1,064	52.5	2,005	38.7

Overall, youth ages 10 to 24 were more often treated for nonfatal suicide attempts in the emergency room from 2012 to 2014. However, this difference can be attributed to youth age 10 to 18, who are more likely to be treated in the emergency room. On the other hand, older youths ages 19 to 24 are treated in the hospital at a slightly higher rate than the emergency room. Females age 19 to 24 are the reason for this difference. This group is the only group being treated in the hospital at a higher rate than the emergency room. Overall, females have higher rates of non-fatal attempts than males. All of these trends are the same in DCF's 2014 Youth Suicide Report, for the period 2011 to 2013.

Race and Ethnicity

Chart 6



When looking at the rates of nonfatal suicide attempts/self-inflicted injuries in emergency departments versus hospitals by race and ethnicity, we again see that, overall, Whites and Blacks have higher rates of suicide attempts than Hispanics and Asian/Pacific Islanders. Most groups are also more often treated in the emergency department. The only exception is Asian/Pacific Islanders, who are treated in the hospital at a slightly higher rate than in the emergency department. Non-Hispanic blacks have the greatest difference in emergency room and hospital use. The rate Blacks are treated in the emergency department is approximately 77% higher than the hospital. The Hispanic emergency department rate is 27% higher than the

hospital, and Whites use the emergency department at a 36% higher rate. These are the same trends reported in the 2014 Youth Suicide Report.

Note: Race and ethnicity in hospital discharge data are known to be inconsistent, and these data should be used with caution.

Primary Means of Non-fatal Suicide Attempts

Means of Non-fatal Suicide Attempts/Self-inflicted Injuries among 10 to 24 Year Olds in the Emergency Department versus Hospitalization, New Jersey, 2012 to 2014

Means/weapon	Emergency Dept.		Hospital	
	N	%	N	%
Poisoning	1625	58%	1867	93%
Cut/pierce	555	20%	53	3%
Other or not specified	567	20%	36	2%
Fall	19	1%	31	2%
Hanging/Strangulation/ Suffocation	22	1%	10	0%
Firearm	*	*	*	*
Unknown weapon	*	*	*	*
Total	2791	100%	2005	100%

*Cells with fewer than 5 observations are suppressed.

Poisoning is the most common means of attempted suicide for youth in New Jersey for this reporting period. Cutting or piercing was the next most common means of nonfatal suicide attempts. Emergency rooms record the method of attempted suicide less thoroughly compared to when a patient is hospitalized. As a result, there are a large percentage of attempted suicides reported by emergency rooms where the method of the attempted suicide is listed as “other or not specified.” These trends are nearly identical to the last reporting period and reflect the data discussed earlier in the report. Males are more likely to complete suicide because they use more lethal means than females, who attempt more often but use poison.

Suicide Prevention Activities

DCF is the lead state agency responsible for facilitating the work to prevent youth suicide. In this role, DCF recognizes this work cannot be accomplished by any one entity. DCF works through partnerships across all systems and communities, including but not limited to federal, state, county and local government, individuals and families, community service providers, private organizations, foundations, universities, and media.

Here is a list of suicide prevention activities within the state along with current legislation as it relates to suicide:

New Jersey Suicide Prevention Hopeline
1-855-654-6735 www.njhopeline.com

The Hopeline is New Jersey's dedicated in-state peer support and suicide prevention hotline staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week. The service is available to callers of all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. Crisis chat is also accessible through the website and the service can be reached by texting njhopeline@ubhc.rutgers.edu.

Screening and Screening Outreach Programs
Available in each county 24-hours a day, seven-days a week to individuals in emotional crisis needing immediate attention.

An individual may be seen without an appointment, or be brought to the screening center by a parent, friend, spouse, law enforcement official, mental health worker, or any other concerned individual.

For information visit the DHS Division of Mental Health and Addiction Services' website at www.state.nj.us/humanservices/divisions/dmhas/.

Perform Care
When a child is facing challenges to their functioning and well-being, finding the right services and support can be overwhelming. To access CSOC Perform Care and Mobile Response services please call 1-877-652-2764.

2ND Floor Youth Helpline
www.2ndfloor.org
Accredited by the American Association of Suicidology, 2ND Floor confidentially serves youth and young adults (ages 10 to 24). Youth who call are assisted with their daily life challenges by professional staff and trained volunteers.

Trevor Project

www.thetrevorproject.org

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13 to 24.

Traumatic Loss Coalitions for Youth Program

The dual mission of TLC is suicide prevention and trauma response assistance to schools following suicide, homicide and deaths that result from accidents and/or illnesses. Functioning as an interactive, statewide network, TLC offers collaboration opportunities and support to professionals working with school-age youth via education, training, consultation and coalition building to:

- reduce suicide attempts, suicide completions, and to promote recovery of persons affected by suicide and
- provide guidance and support in the response to a traumatic event

For more information and support related to suicide prevention visit http://ubhc.rutgers.edu/tlc/index.html

New Jersey Youth Suicide Prevention Advisory Council

Established in the New Jersey Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council is comprised of appointed New Jersey citizens and representatives from state departments. The purpose of the Council is to examine existing needs and services and make recommendations for youth suicide reporting, prevention and intervention; advise on the content of informational materials to be made available to persons who report attempted or completed suicides; and advise in the development of regulations required pursuant to N.J.S.A. § 30:9A-25 et seq.

For more information related to the council email dpcp@dcf.state.nj.us

References for Data, Tables, and Figures

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(2) New Jersey Department of Education, Division of Student Services and Career Readiness, Office of Student Support Services. (2013). New Jersey Student Health Survey. Retrieved from http://www.nj.gov/education/students/yrbs/2013/full.pdf

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(4) WISQARS data
Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005)
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Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

(5) NJVDRS data -New Jersey Violent Death Reporting System (NJVDRS) v.08/21/2015
Prepared by: The New Jersey Violent Death Reporting System
Center for Health Statistics and Informatics
Office of the Commissioner
New Jersey Department of Health
September 8, 2015

How We Calculated the Rates:
Numerator: Number of deaths due to suicide
Denominator: Total number of persons in the population

Note: *The rate refers to the number of cases occurring during a given time period divided by the population at risk during that same period, multiplied by a unit chosen for standardization (typically 100,000 for deaths). There may or may not be 100,000 people in the population of interest, but multiplying it by this standard unit allows comparison between bigger or smaller populations (counties, age groups, etc.). This is a standard way of calculating statistics in public health so comparisons can be made across different populations. By using rates instead of raw numbers, the occurrence of disease (or, in this case, suicide) in one group can be fairly compared with another.*