New Jersey Department of Children and Families

New Jersey Youth Suicide Report

2016

Introduction

In accordance with N.J. Statute. 30:9A-27, the New Jersey Department of Children and Families (DCF) presents this annual report of attempted and completed youth suicide in New Jersey.

This report is issued to the New Jersey Youth Suicide Prevention Advisory Council (Council), the Governor, and the Legislature. In accordance with statute, this report contains a summary of aggregate demographic information about youth who attempt or complete suicide.

Data Overview and Legislation on Youth Suicide in New Jersey

Suicide is a nationwide public health problem, but research shows it is preventable. In promoting the work of suicide prevention, collaboration with state, local, and community partners is essential. New Jersey's suicide and suicide prevention efforts are impactful through the partnership of the Traumatic Loss Coalition (TLC), 2NDFLOOR Youth Helpline, Perform Care, Mobile Response, NJ Hopeline, New Jersey Department of Health (DOH), New Jersey Department of Human Services (DHS), New Jersey Department of Education (DOE), Juvenile Justice Commission (JJC) and the public members of the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC).

Legislation

On August 1, 2016, Governor Chris Christie signed the Madison Holleran Suicide Prevention Act, N.J.S.A. 18A:3B-72, which requires all New Jersey colleges to provide students around the clock access to health care professionals trained in mental health. Supporters hope the law hope will prevent students from attempting suicide, the leading cause of death on college campuses[1].

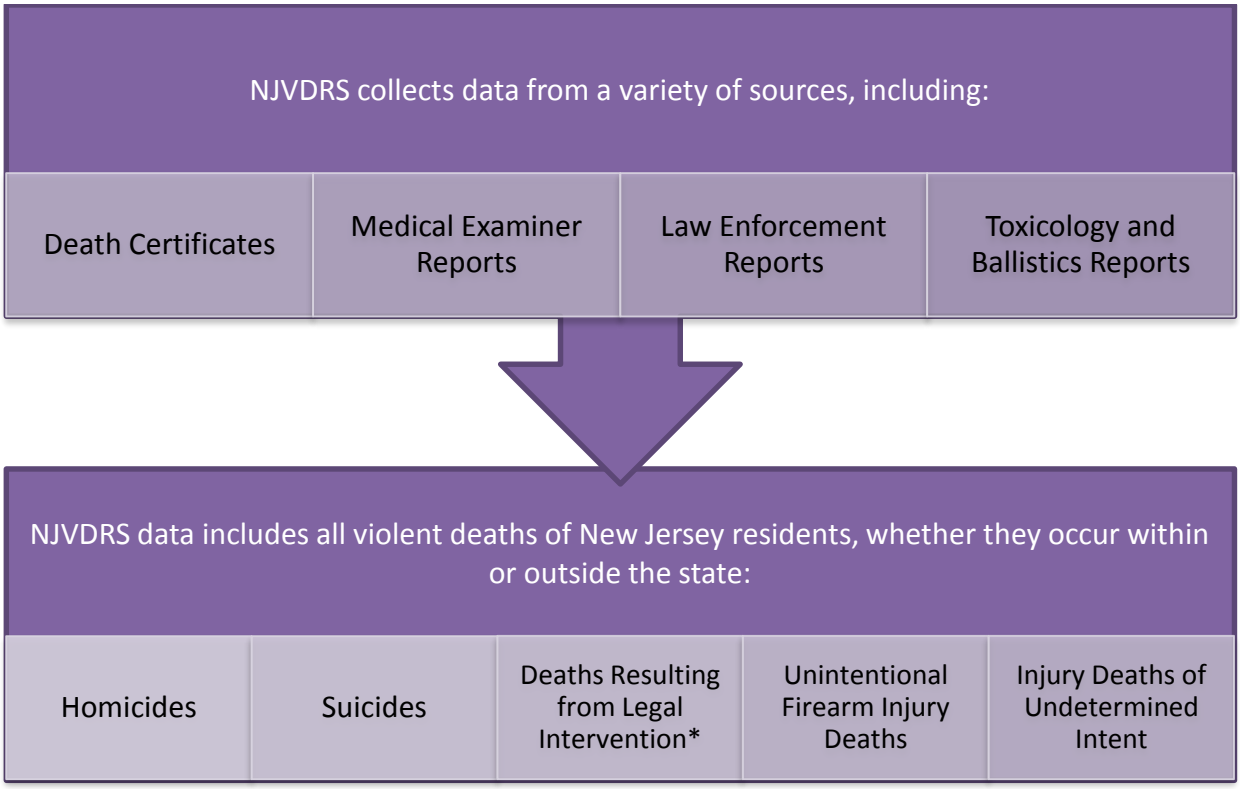
Data Collection System

New Jersey is one of 42 states and territories participating in the National Violent Death Reporting System through a cooperative agreement with the Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control (NCIPC). As a result, New Jersey can analyze timely and accurate suicide data using the New Jersey Violent Death Reporting System (NJVDRS). The source of this report's data, NJVDRS is a more comprehensive reporting system than the national (WISQARS) data, which is solely based on death certificates.

[1] http://www.phillymag.com/news/2016/08/01/madison-holleran-suicide-prevention-act/#BsJCYYmt81QVjt4u.99

NJVDRS is incident-based, and related victims and suspects are grouped into one incident. NJVDRS staff abstract and code incidents using CDC standard variable definitions, which enables comparable data analysis across multiple participating states.

Data on non-fatal suicide attempts/self-inflicted injury comes from the New Jersey Department of Health's hospitalization and emergency department visit billing data set, which includes information on discharge disposition, including whether the patient lived or died. NJVDRS provides data only on fatalities.



* individuals are killed by law enforcement personnel in the line of duty.

A "violent" death is defined as a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community. NJVDRS links data from multiple sources into a single standardized record of a violent death incident.

What's going on?

According to Medical Daily (October 2016) youth suicide trends provides insight into the epidemiology of suicide, especially the younger age group. According to an interview with the lead author of one of these studies (Sheftall, et al, *Pediatrics*, October 2016) posted by Medical Daily in September 2016, "*Children who died by suicide were more likely to have relationship problems with family members or friends…These differences tended to fall along developmental lines given elementary school-aged children are more likely to spend time with family and friends and less likely to engage in romantic relationships, which become more common during adolescence.*"

Postdoctoral research fellow Arielle Sheftall, PhD and her team at the Center for Suicide Prevention and Research at Nationwide Children's Hospital examined suicide deaths between 2003 and 2012. The team used data from the National Violent Death Reporting System in 17 states and separated them according to age group. Their analysis showed that *33 percent of the deceased had mental health issues at the time of their deaths. A diagnosis of Attention Deficit Hyperactivity Disorder was found to be common among children who committed suicide, compared to early adolescents who had depression or dysthymia (persistent mild depression)… We also found that 29 percent of children and early adolescents disclosed their intention for suicide to someone prior to their death*."

The study sheds tremendous light on the importance of educating pediatricians, primary health care providers, school personnel and families on how to recognize the warning signs of suicide and what steps to take when suicidal intent is disclosed.

New Jersey considers research and national trends in its suicide awareness and prevention efforts. Nationally, the rate of suicide for White non-Hispanic youth aged 10-24 is substantially higher than Black non-Hispanic youth aged 10-24. According to the Centers for Disease Control and Prevention, National Center for Health Statistics CDC WISQARS Online Database, from 2012 – 2014 the overall rate of suicide among 10 – 24 year old white youth is 10.0 per 100,000 and for 10 – 24 old black youth the rate is 5.7 per 100,000. However, in New Jersey, the three-year average rate of suicide among Black, non-Hispanic youth (5.2 per 100,000) is almost equal to that of White non-Hispanic youth (5.4 per 100,000).

Of note is a suicide rate of 5.9 per 100,000 among New Jersey Asian/Pacific Islander youth aged 10-24, which reflects a 42% increase in the suicide over the previous three-year period (2012-2014), going from 19 to 27 completed suicides. (NJVDRS, CHSI, NJDOH)

Brief Synopsis for 2013-2015 Data for New Jersey

- The 2014 national rate of suicide is used to do a comparison for NJ's rate. However, it should be noted that NJ's rate is clustered across a 3 year span. For the most recent one year period available on a national level, 2014 - the rate of suicide in New Jersey for youth age 10-24 remains lower (5.5 per 100,000) than the national rate (8.5 per 100,000). Suicide remains the third leading cause of death for youth aged 10-24 in New Jersey.

Suicide Attempts/Self-Inflicted Injuries, Age 10-24, 2013 - 2015

- 2,731 youth treated by hospital emergency rooms
  - 1660 (61%) female
  - 1,071 (39%) male
- Mercer, Warren, and Ocean counties have the three highest rates of suicide attempts/self-inflicted injuries seen by emergency rooms.

Suicide Deaths, Age 10-24, 2013 - 2015

- 269 youth
  - 196 (73%) male
  - 73 (27%) female
- Bergen County has the highest number of completions (26).
- Salem County has the lowest number of completions (4).

DCF's Family and Community Partnerships (FCP), in collaboration with DCF's Office of Research, Evaluation, and Reporting (ORER), and the New Jersey Department of Health (DOH), compiled this report's data, which includes aggregate demographic information about youth ages 10 to 24 that have been treated in New Jersey hospitals and emergency departments for attempted suicide and self-inflicted injuries, or have died by suicide.

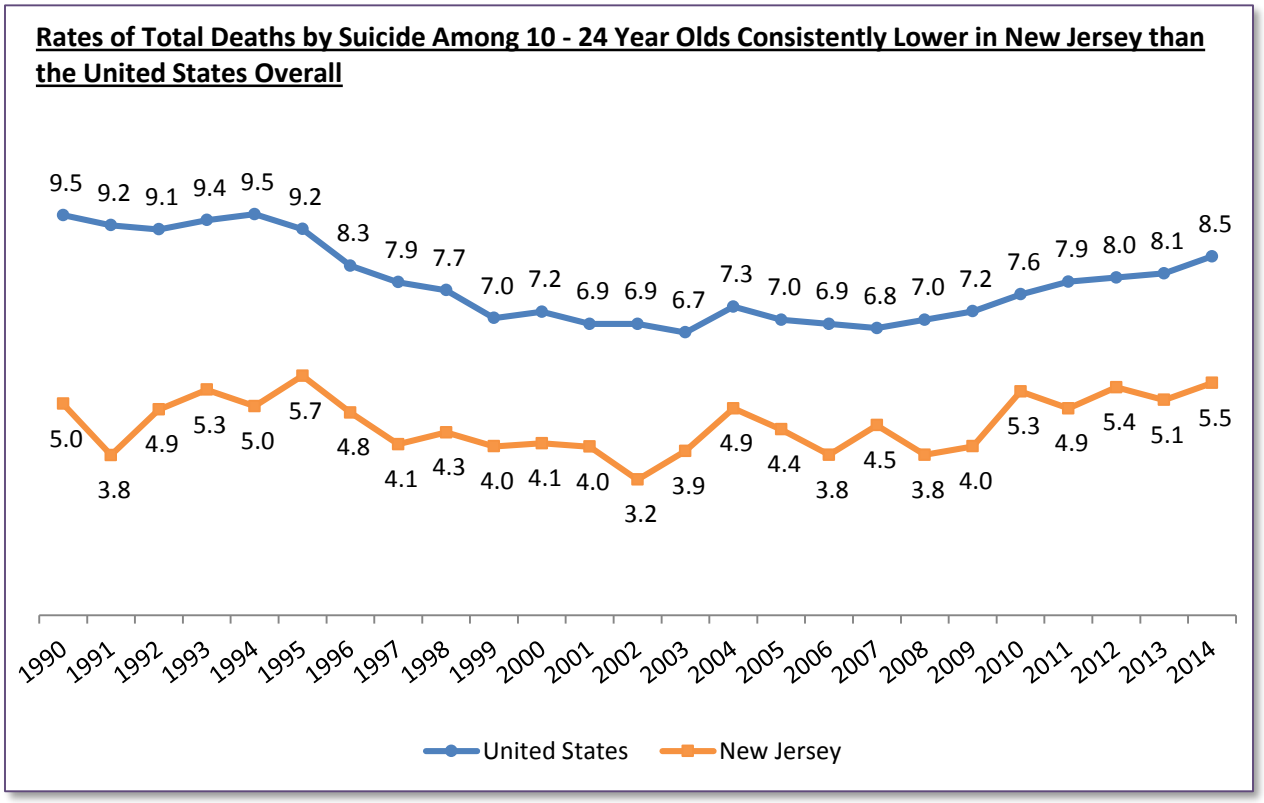
In presenting data for tables, graphs, and trends, the Center for Health Statistics and Informatics follows the conventions of the National Center for Health Statistics.

Rates are not calculated for fewer than 20 observations due to high standard errors associated with the statistic.
Estimates based on a random sample of a population are subject to error due to sampling variability, known as the "standard error". Rates and percentages based on a full population count may also be considered estimates, and as such also have a standard error that describes the variation of the estimate from the true or "underlying" rate. This error may be substantial when there are fewer than 20 observations; combining multiple years is a common way to minimize this effect.
Two or more years of data may be combined to increase the number of observations and thereby reduce the standard error to produce a more stable estimate.
For this report, as in previous years, annual figures are provided when the number of observations is 20 or more, and in the case of small numbers, 3 years are combined to produce a three-year average rate.
Cell sizes of fewer than 5 observations (and complimentary cells) may be suppressed in order to reduce the chance of unintentionally identifying an individual.

For more information, please contact the Center for Health Statistics and Informatics at chs@doh.nj.gov.

Confirmed Suicides

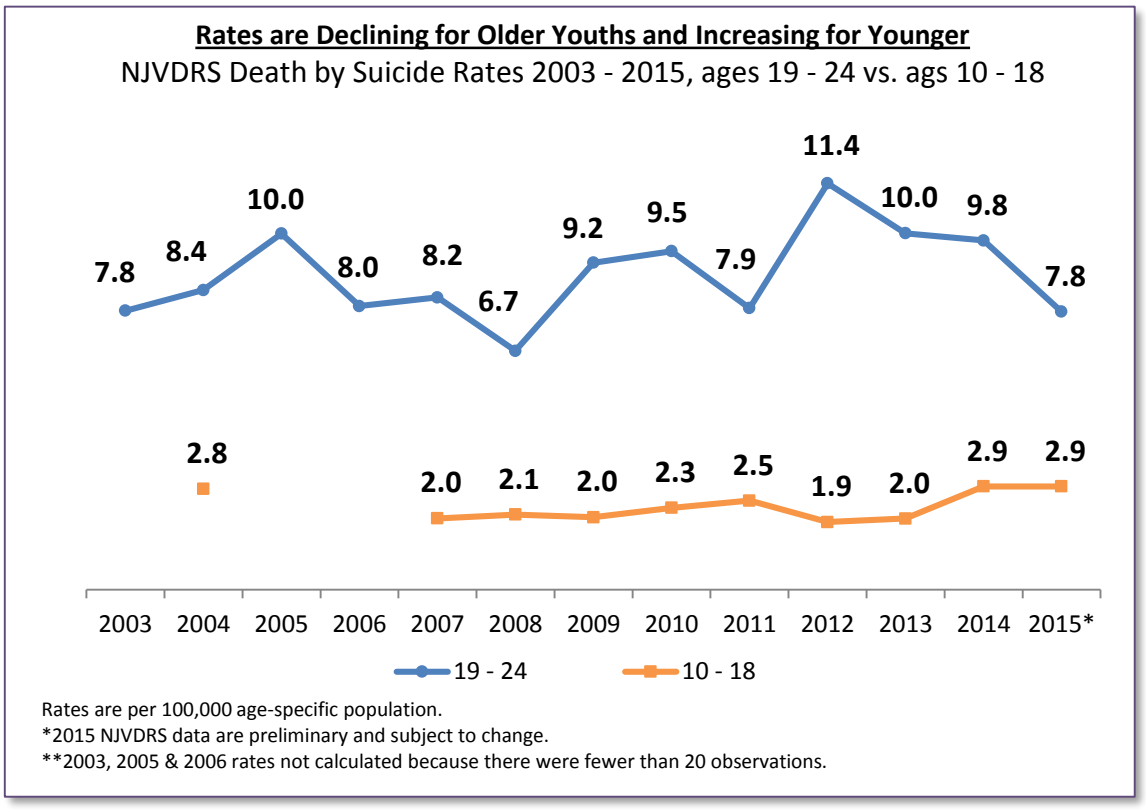
Chart 1:



Source: WISQARS, CDC (August 2016). Rates are per 100,000 population.

New Jersey rates are increasing compared to the last decade; a trend similar to the United States rates. The rate of suicide for both New Jersey and the United States has slightly increased from last year. The rate for suicide in New Jersey continues to remain lower than the national average.

Age and Gender - Chart 2



Source: New Jersey Violent Death Reporting System v.08/12/2016, NJDOH. Rates are per 100,000 population.

Youth ages 19-24 continue to complete suicide at a higher rate than youth ages 10-18. However, 2013-2015 statistics reveal an upward trend of youth aged 10-18 completing suicide, and a downward trend for older youth.

Male youth continue to die by suicide at a much higher rate than female youth, which is consistent with the national rate.

However, there has been a slight decrease in the rate of male youth from the 2015 Youth Suicide report (2012-2014) to this year. The 2012-2014 rate was 7.9 per 100,000, driven by a decrease in youth ages 19 to 24, and while 10 to 18 year-olds stayed the same for female youth, there was a rate increase from 2.2 to 2.9 per 100,000 for 2013-2015.

The rate increased for females within the ages of 10-18 and 19-24. The number of completions among females between the ages of 10-18 nearly doubled from 16 in 2012-2014 to 30 in 2013-2015.

Table 1. Suicides by age group and gender, New Jersey, 2013-2015

	Age Group				Total	
	10-18		19-24		10-24	
Gender	N	Rate	N	Rate	N	Rate
Male	51	3.2	145	13.8	196	7.4
Female	30	2.0	43	4.3	73	2.9
Total*	81	2.6	188	9.2	269	5.2

***Total includes 1 youth of unknown gender.**

Source: New Jersey Violent Death Reporting System v.08/12/2016, NJDOH. Rates are per 100,000 population.

Race and Ethnicity

Table 2. Suicides by age group and race/ethnicity, New Jersey, 2013-2015

	Age Group				Total	
	10-18		19-24		10-24	
Race/ethnicity	N	Rate	N	Rate	N	Rate
White Non-Hispanic	40	2.4	105	10.2	145	5.4
Black Non-Hispanic	11	**	31	9.0	42	5.2
Hispanic	18	**	23	4.7	41	3.4
Asian/Pacific Islander	8	**	19	**	27	5.9
Other/Unknown Race	4	**	10	**	14	**
Total	81	2.6	188	9.2	269	5.2

Source: New Jersey Violent Death Reporting System v.08/12/2016, NJDOH. Rates are per 100,000 population.

Consistent with prior reports, among those ages 10-24, New Jersey's non-Hispanic White and Black youth complete suicide at nearly the same rate, with White Non-Hispanic youth just slightly higher. Nationally, researchers have noted that blacks in general tend to have significantly lower rates of suicide than whites (Bridge, et al, *JAMA Pediatr.* 2015; Sheftall, et al, *Pediatrics*, 2016).

New Jersey's Hispanic population had a slight suicide rate decrease from 3.8 per 100,000 (45 completions) in 2012-2014 to 3.4 per 100,000 (41 completions) in 2013-2015.

Most notably, there has been an increase in the suicide rate for Asian/Pacific Islanders from 19 completions in 2012-2014 to 27 completions for 2013-2015, resulting in a rate of 5.9 per 100,000, which is higher than White Non-Hispanic.

Note: Race and ethnicity data should be interpreted with caution because Hispanic youth are often reported in other categories.

Completions by Region (Map 1)

Counties with Highest Suicide Rates for Youth

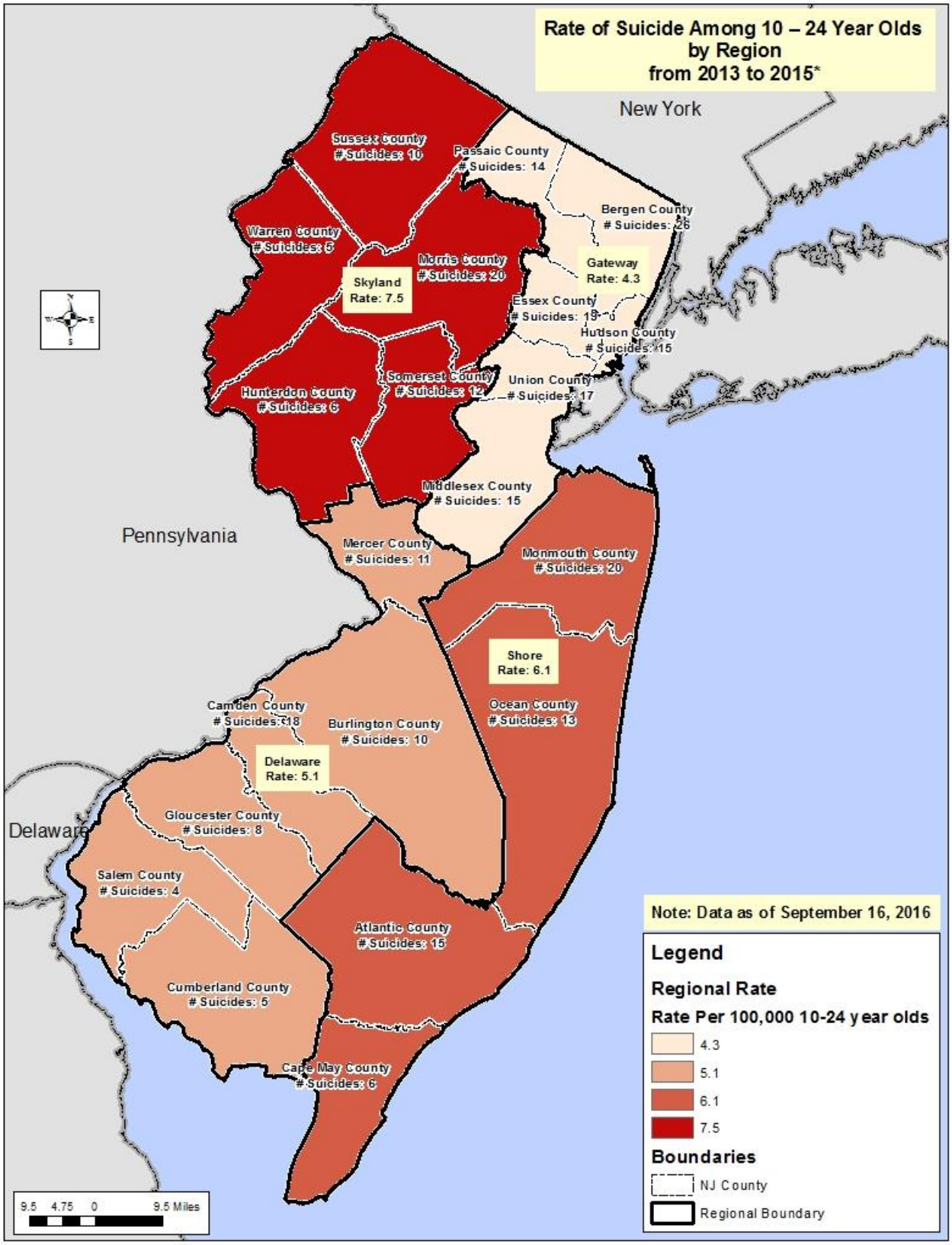
- **Morris – 6.8 per 100,000**
- **Monmouth – 5.5 per 100,000**
- **Bergen – 5.0 per 100,000**

From 2013 – 2015, only three counties had 20 or more deaths by suicide: Bergen (26), Monmouth (20), and Morris (20). In last year's report, Camden, Essex, and Middlesex also had 20 or more, indicating a slight decline in these counties.

In accordance with National Center for Health Statistics standards, rates are not calculated for fewer than 20 observations. Such small numbers are considered statistically unreliable because of a large standard error. Due to this limitation, New Jersey's 21 counties are grouped into four regions to determine what areas of the state have higher rates of deaths by suicide.

The map on the following page shows:

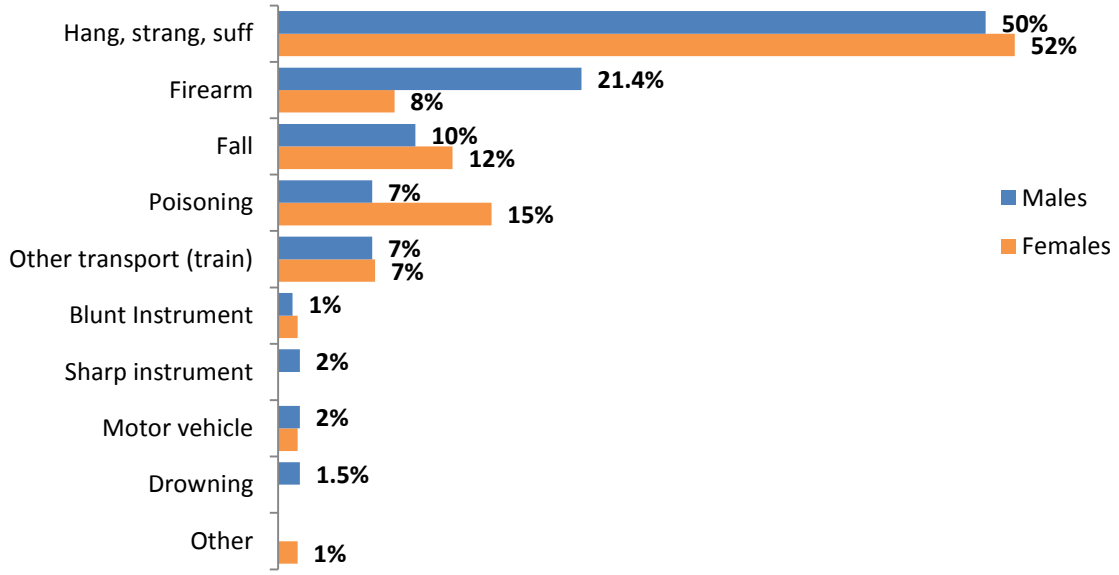
- Skyland Regions (7.5 per 100,000) has the highest rate of youth suicide.
  - Skyland's rate increased from 7.4 per 100,000 in 2012-2014 to 7.5 per 100,000
- Shore Regions (6.1 per 100,000)
  - Shore's rate increased from 5.4 per 100,000 in 2012-2014 to 6.1 per 100,000 in 2013-2015
- Delaware Regions (5.1 per 100,000).
  - Delaware decreased from 5.2 to 5.1 per 100,000
- Gateway Regions (4.3 per 100,000) has the lowest rate of youth suicides.
  - Although the Gateway region has a greater number of youth suicides, fewer youth die by suicide per capita than in New Jersey's less densely populated regions.


Rate of Suicide Among 10 – 24 Year Olds by Region from 2013 to 2015*
New York
Sussex County # Suicides: 10
Passaic County # Suicides: 14
Bergen County # Suicides: 26
Warren County # Suicides: 6
Morris County # Suicides: 20
Skyland Rate: 7.5
Gateway Rate: 4.3
Essex County # Suicides: 19
Hudson County # Suicides: 15
Somerset County # Suicides: 12
Union County # Suicides: 17
Hunterdon County # Suicides: 6
Middlesex County # Suicides: 15
Pennsylvania
Mercer County # Suicides: 11
Monmouth County # Suicides: 20
Shore Rate: 6.1
Ocean County # Suicides: 13
Camden County # Suicides: 18
Burlington County # Suicides: 10
Delaware Rate: 5.1
Delaware
Gloucester County # Suicides: 8
Salem County # Suicides: 4
Atlantic County # Suicides: 15
Cumberland County # Suicides: 5
Cape May County # Suicides: 6
9.5 4.75 0 9.5 Miles
Note: Data as of September 16, 2016
Legend
Regional Rate
Rate Per 100,000 10-24 year olds
4.3
5.1
6.1
7.5
Boundaries
NJ County
Regional Boundary

Primary Method

Chart 3

Hanging/Strangulation/Suffocation was the Method Used Most Often by Males and Females Age 10 - 24 in New Jersey 2013 - 2015



Source: New Jersey Violent Death Reporting System v. 08/12/2016, NJDOH

Hanging, strangulation, and suffocation are the most common means of suicide among male and female youth age 10-24. Consistent with prior years, males are more likely to use firearms and females are more likely to use poisoning.

Overall, jumping/falling continued to increase this period as compared to 2012 - 2014, overtaking poisoning as the third most common means.

There were also some differences between the younger and older age groups.

For youth age 10-18, the top three methods were:
- Hanging, Strangulation, Suffocation – 65%
- Other Transport (Train) - 10%
- Firearm – 9%

For youth age 19-24, the top three methods were:
- Hanging, Strangulation, Suffocation - 44%
- Firearm – 24%
- Fall- 12%

Table 3. Suicides by age group and method/weapon used, New Jersey, 2013-2015

10-18				19-24		
Method/Weapon	#	%		Method/Weapon	#	%
Hang, strangulation, suffocation	53	65%		Hang, strangulation, suffocation	83	44%
Other transport (train)	8	10%		Other transport (train)	10	5%
Firearm	7	9%		Firearm	46	24%
Fall	5	6%		Fall	23	12%
Poisoning	5	6%		Poisoning	14	7%
Other	3	4%		Other	12	6%
Unknown Weapon	0	0%		Unknown Weapon	0	0%
Total	81	100%		Total	188	100%

Source: New Jersey Violent Death Reporting System v.08/12/2016, NJDOH

Death by train was more frequently used by older individuals, but was the second most common method for 10-18 year olds.

Suicide Circumstance:

Table 4. Suicide circumstances by age group, New Jersey, 2013-2014

***Percentages in red font are explained below the chart**

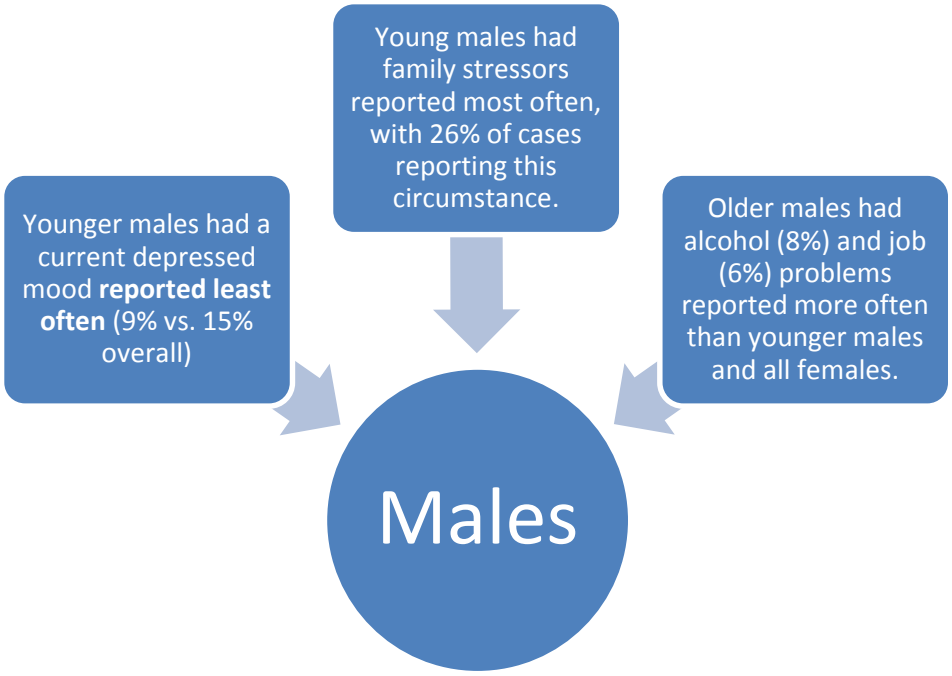
Age Group & Gender														
	Male						Female						Total	
	10-18		19-24		10-24		10-18		19-24		10-24		10-24	
Suicide Circumstance	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**	*N*	*%**
Other suicide circumstance	16	46%	41	39%	57	41%	5	31%	14	47%	19	41%	76	41%
Current mental health problem	12	34%	26	25%	38	27%	5	31%	13	43%	18	39%	56	30%
History of mental health treatment	11	31%	26	25%	37	26%	5	31%	13	43%	18	39%	55	30%
Crisis within 2 weeks	11	31%	32	30%	43	31%	5	31%	5	17%	10	22%	53	28%
Suicide note	11	31%	24	23%	35	25%	5	31%	7	23%	12	26%	47	25%
Current mental health treatment	7	20%	17	16%	24	17%	5	31%	8	27%	13	28%	37	20%
Current depressed mood	3	9%	18	17%	21	15%	4	25%	5	17%	9	20%	30	16%
Substance abuse problem	3	9%	21	20%	24	17%	0	0%	4	13%	4	9%	28	15%
Disclosed intent	6	17%	8	8%	14	10%	5	31%	5	17%	10	22%	24	13%
Family stressors	9	26%	11	10%	20	14%	3	19%	0	0%	3	7%	23	12%
History of suicide attempts	1	3%	10	10%	11	8%	4	25%	7	23%	11	24%	22	12%
Intimate partner problem	3	9%	13	12%	16	11%	1	6%	3	10%	4	9%	20	11%
School problem	6	17%	6	6%	12	9%	4	25%	1	3%	5	11%	17	9%
Recent criminal legal problem	1	3%	15	14%	16	11%	0	0%	1	3%	1	2%	17	9%
Alcohol problem	0	0%	8	8%	8	6%	0	0%	1	3%	1	2%	9	5%
Job problem	0	0%	6	6%	6	4%	0	0%	1	3%	1	2%	7	4%
Other relationship problem	1	3%	2	2%	3	2%	2	13%	0	0%	2	4%	5	3%
Eviction, loss of home	1	3%	4	4%	5	4%	0	0%	0	0%	0	0%	5	3%
Recent death of friend or family	0	0%	3	3%	3	2%	1	6%	0	0%	1	2%	4	2%
Physical health problem	1	3%	2	2%	3	2%	0	0%	1	3%	1	2%	4	2%
Legal problem	0	0%	4	4%	4	3%	0	0%	0	0%	0	0%	4	2%
Perpetrator of interpersonal violence	1	3%	1	1%	2	1%	0	0%	0	0%	0	0%	2	1%
Recent suicide of friend or family	0	0%	1	1%	1	1%	0	0%	0	0%	0	0%	1	1%
Financial problem	0	0%	1	1%	1	1%	0	0%	0	0%	0	0%	1	1%
Other addiction	0	0%	1	1%	1	1%	0	0%	0	0%	0	0%	1	1%

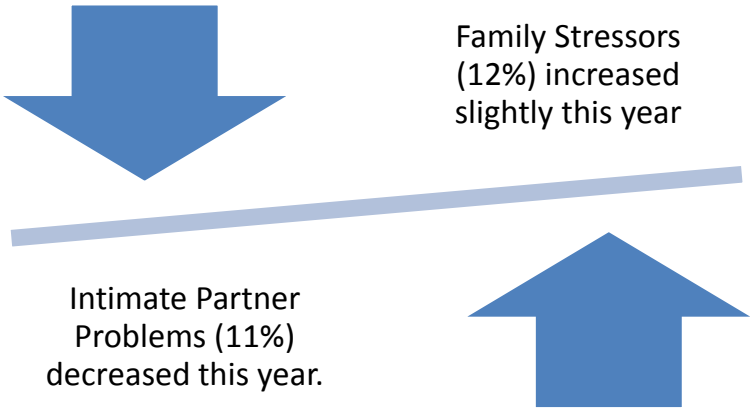
Anniversary of a traumatic event	0	0%	1	1%	1	1%	0	0%	0	0%	0	0%	1	1%
History of childhood sexual abuse	0	0%	0	0%	0	0%	1	6%	0	0%	1	2%	1	1%
Number of suicides in age group	35		105		140		16		30		46		186	
Number of suicides w/ known circs	28		71		99		13		21		34		133	
% of suicides w/ known circs		80%		68%		71%		81%		70%		74%		72%

Source: New Jersey Violent Death Reporting System v.08/12/2016, NJDOH

Table 4 highlights data captured to understand the circumstances associated with a youth who died by suicide from 2013 to 2014. The process of collecting and analyzing the circumstances associated with any one youth is laborious. The 2014 circumstance results are minimum estimates because investigation of the circumstances related to all deaths to be coded in NJVDRS are still pending At the time this report was being prepared, circumstances were known for 72% of youth suicides. Multiple circumstances may be involved with a single youth. Available data for 2013-2014 circumstance shows consistency with last year's annual suicide report.

Approximately one third of the youth (30%) were reported as having a current mental health problem, and only 20% were receiving treatment. The number who reported receiving treatment continued to decline from prior reports.





- Young males (17%) and young females (25%) were more likely to have reported school problems than older youth, and less likely to have reported substance abuse problems (males 9% and females 0%).
- 10 – 18 year olds were more likely to have been reported as having disclosed intent, with 17% of males and nearly a third (31%) of females disclosing intent.
- 31% of 10–18 year olds left a suicide note compared to 23% for 19–24 year olds.

Suicide Attempts/Self-Inflicted Injury

Table 5. Total Non-fatal suicide attempts/self-inflicted injuries by gender
New Jersey, 2013-2015

	10-24	
Gender	**N**	**Rate**
Male	1,737	65.3
Female	2,900	115.5
Total	4,637	89.7

Source: New Jersey Hospital Discharge Data System, NJDOH. Rates are per 100,000 population.

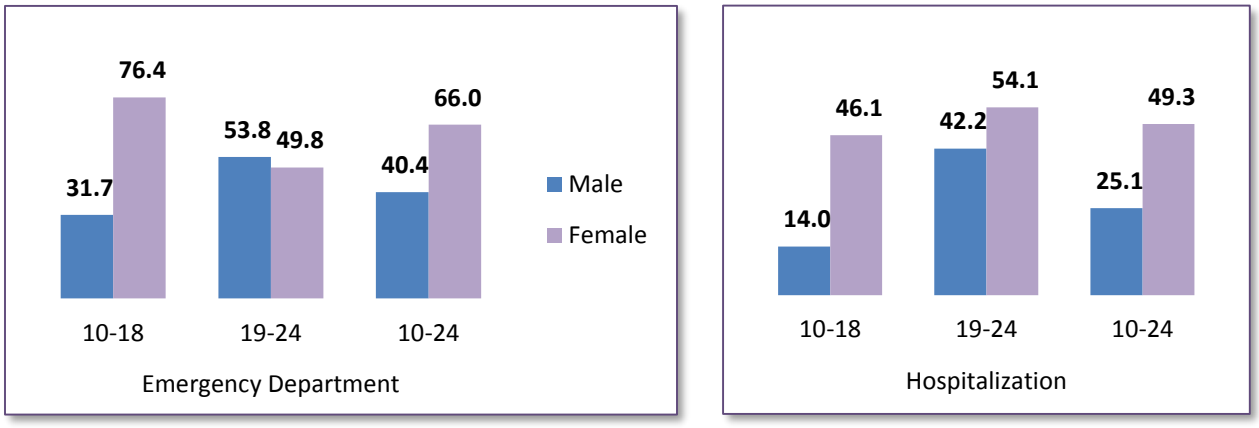
There were 4,637 non-fatal suicide attempts/self-inflicted injuries that resulted in either emergency room treatment or hospitalization in New Jersey from 2013–2015.

Females were substantially more likely to attempt suicide than males. This is consistent nationwide data that show females attempt suicide at a higher rate than males.

Emergency Department vs. Hospitalization

Age and Gender

Chart 4: 2013 – 2015 Rates of Non-fatal Suicide Attempts/Self-inflicted Injuries treated in the Emergency Department and Released versus Hospitalization



Source: New Jersey Hospital Discharge Data System, NJDOH. Rates are per 100,000 population.

Table 6. Rates of Non-Fatal Suicide Attempts/Self-Inflicted Injuries treated in Emergency Department vs. Hospitalization

	Age Group				Total	
	10-18		**19-24**		**10-24**	
	N	**Rate**	**N**	**Rate**	**N**	**Rate**
Emergency Dept	1674	53.5	1057	51.9	2731	52.9
Hospitalization	928	29.7	978	48.0	1906	36.9

Source: New Jersey Hospital Discharge Data System, NJDOH. Rates are per 100,000 population.

Overall, there were 4,637 encounters for non-fatal suicide attempts and self-inflicted injuries among youth ages 10-24 years treated in New Jersey hospitals and emergency departments from 2013-2015, with nearly 60% of patient treatment resulting in discharge from the emergency room without subsequent hospitalization.

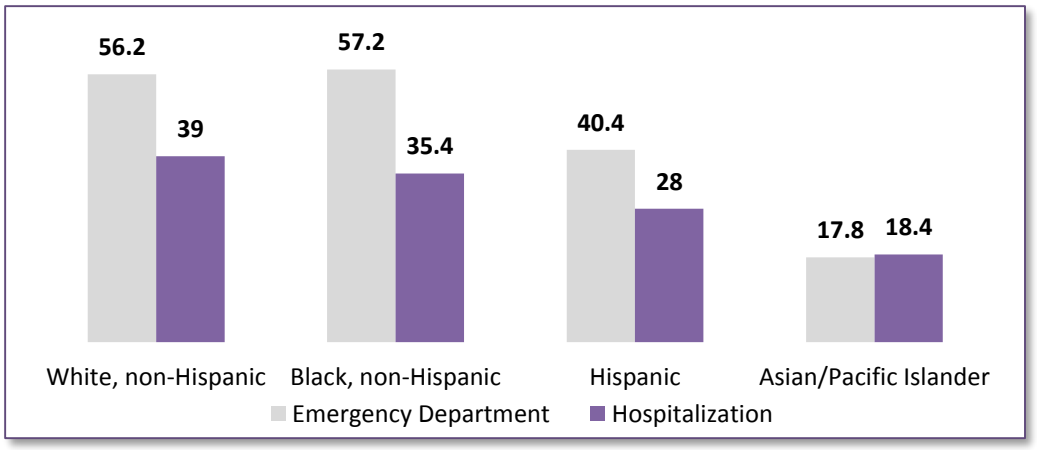
Emergency department discharge rates are highest among youth ages 10-18, and are slightly lower for youth ages 19-24.

There is a larger increase in hospitalization rates among youth ages 10-18 compared to youth ages 19-24. This may suggest that while the number of visits to hospitals or emergency departments overall declines with age, the level of injury becomes more serious as youth age.

Females ages 19-24 appear to drive the inpatient hospitalization rate for that age group. These findings are similar to those in DCF's 2014 Youth Suicide Report.

Race/Ethnicity

Chart 5. Non-fatal Suicide Attempts/Self-inflicted Injuries Resulting in Hospitalization versus Emergency Departments by Race/Ethnicity, 2013 to 2015



Source: New Jersey Hospital Discharge Data System, NJDOH. Rates are per 100,000 population.

There are distinct differences in the rate of nonfatal suicide attempts/self-inflicted injuries treated in emergency departments versus hospital inpatients when analyzed by race and ethnicity.

As noted in the past, the data indicates that White and Black youth have higher rates of suicide attempts than Hispanic and Asian/Pacific Islander youth.

Most demographic groups are more often treated in the emergency department, except those identified as Asian/Pacific Islanders. Asian/Pacific Islanders are admitted in the hospital at a slightly higher rate than in the emergency department.

County

Although more non-fatal attempts/self-inflicted injuries were treated in the emergency department statewide, Chart 6 shows this varies widely by county.

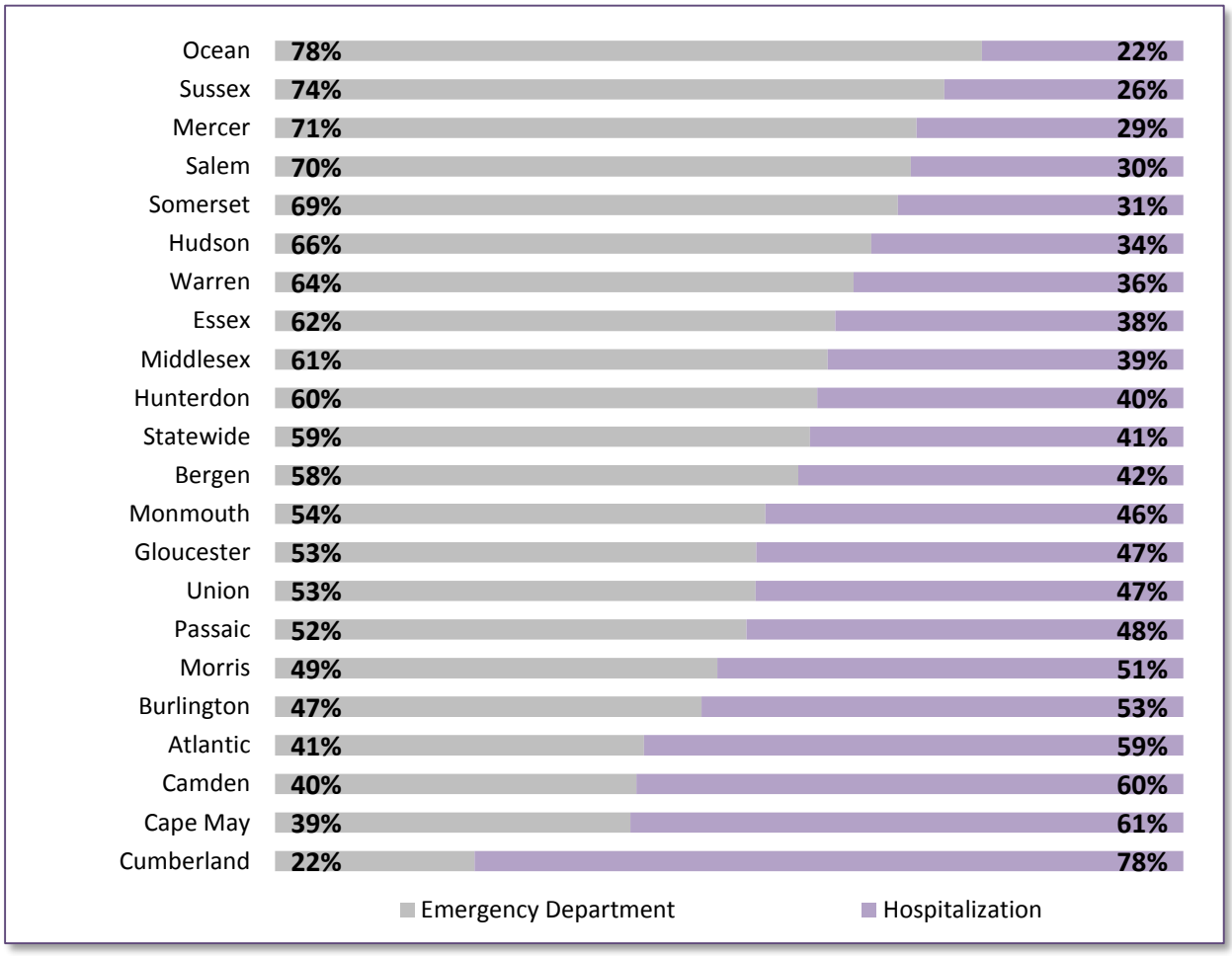
59% of non-fatal attempts statewide are treated in the emergency room

- Ocean County - 78% of non-fatal attempts were treated in the emergency room
- Cumberland County - 22% of attempts were treated in the emergency room

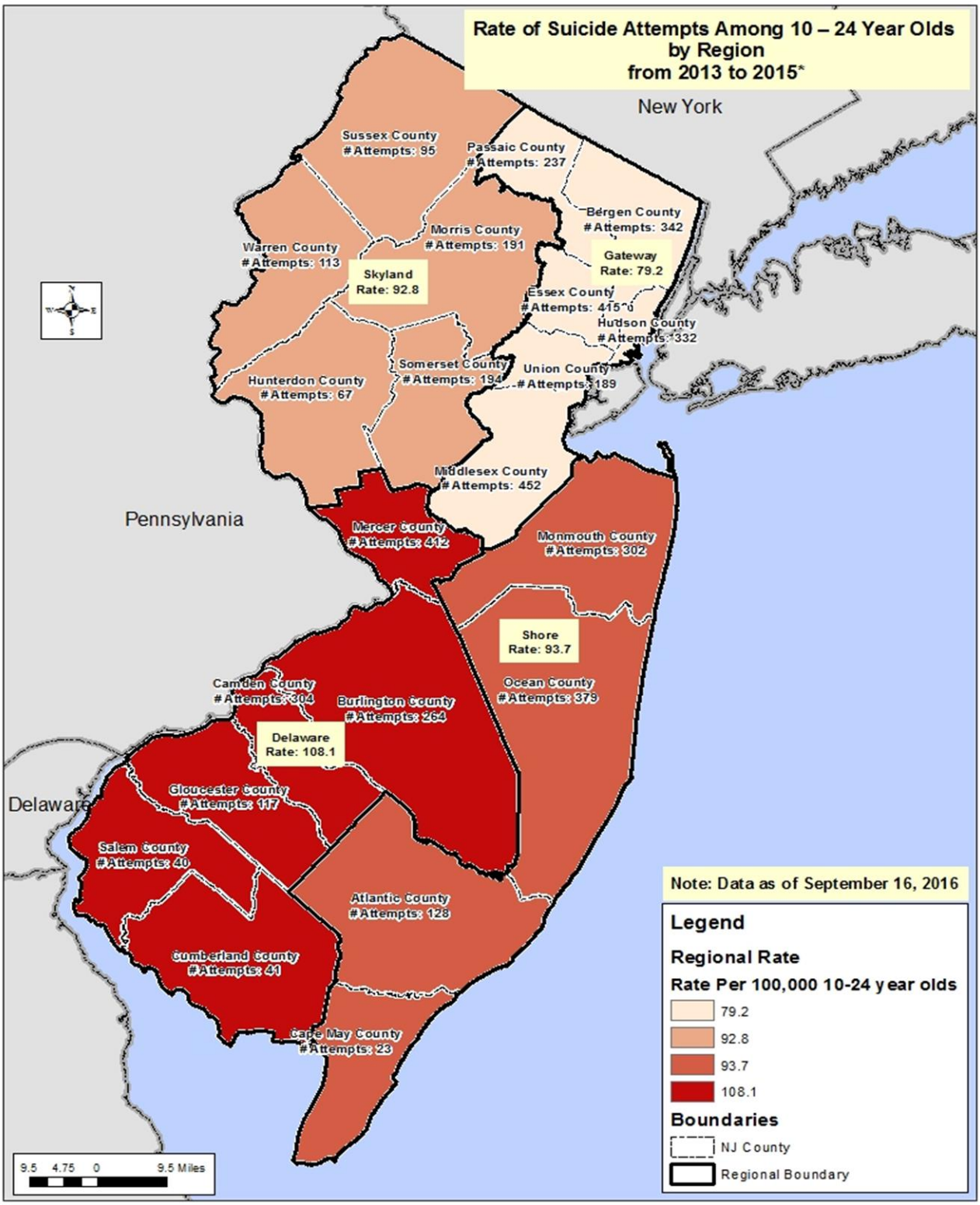
In six counties, a majority of attempts resulted in hospitalization

- Cumberland
- Cape May
- Camden
- Atlantic
- Burlington
- Morris

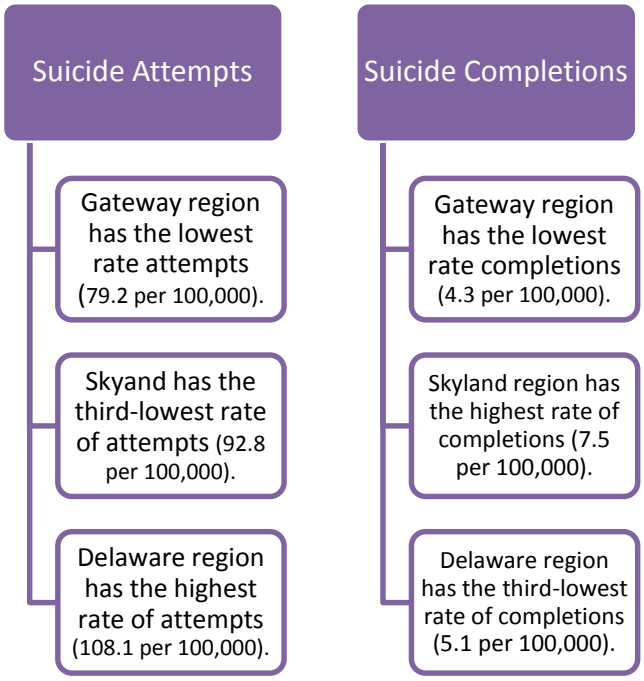
Chart 6:
Proportion of Non-fatal Suicide Attempts/Self-inflicted Injuries Treated in the Emergency Department and Released Versus Resulting in Hospitalization by County in New Jersey, 2013 - 2015


Ocean 78% 22%
Sussex 74% 26%
Mercer 71% 29%
Salem 70% 30%
Somerset 69% 31%
Hudson 66% 34%
Warren 64% 36%
Essex 62% 38%
Middlesex 61% 39%
Hunterdon 60% 40%
Statewide 59% 41%
Bergen 58% 42%
Monmouth 54% 46%
Gloucester 53% 47%
Union 53% 47%
Passaic 52% 48%
Morris 49% 51%
Burlington 47% 53%
Atlantic 41% 59%
Camden 40% 60%
Cape May 39% 61%
Cumberland 22% 78%
Emergency Department
Hospitalization

Suicide Attempts by Region (Map 2) Total rate of nonfatal suicides/self-inflicted injuries by region



There are notable differences between suicide attempts and suicide completions by region.

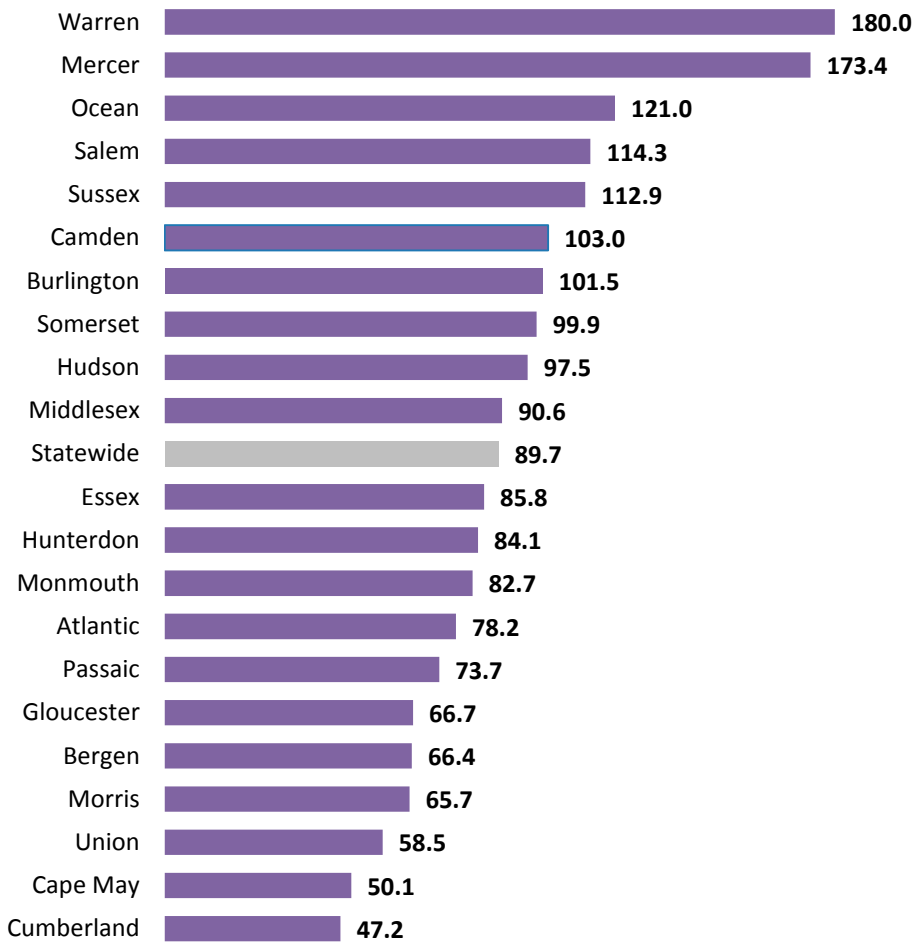


The Shore Region has the second lowest rate of attempts (93.7 per 100,000) and completions (6.1 per 100,000)

Note: The order of suicide rates by region did not change from 2015 youth suicide report. However, the rates did decline slightly for all regions except the Skylands, where there was a slight increase.

Chart 7:

2013 - 2015 County Rates of Non-fatal Suicide Attempts/Self-inflicted Injuries
10 - 24 year old youth



Source: New Jersey Hospital Discharge Data System, NJDOH. Rates are per 100,000 population.

Warren had the highest county rate of suicide attempts/self-inflicted injury even though it is part of the Skyland region, which has the third lowest rate of suicide attempts/self-inflicted injuries.

Cumberland had the lowest county rate suicide attempts/self-inflicted injury even though it is a part of the Delaware region, which has the highest rate suicide attempts/self-inflicted injuries.

Primary Means of Non-fatal Suicide Attempts/Self-inflicted injury

Table 7: Means of Non-fatal Suicide Attempts/Self-inflicted Injuries among 10 to 24 Year Olds in the Emergency Department versus Hospitalization, New Jersey, 2013 to 2015

	Emergency Dept.		Hospital	
Method/weapon	**N**	**Rate**	**N**	**Rate**
Poisoning	1,554	30.1	1,761	34.1
Cut/pierce	588	11.4	56	1.1
Other or not specified	548	10.6	40	0.8
Hanging/Strangulation/Suffocation	22	0.4	13	**
Fall	13	**	31	0.6
Firearm	6	**	5	**
Total	2,731	52.9	1,906	36.9

Source: New Jersey Hospital Discharge Data System, NJDOH. Rates are per 100,000 population.

Poisoning is the most common means of attempted suicide for youth in New Jersey in 2013-2015. Cutting or piercing was the second most common means.

Males are more likely to complete suicide because they use more lethal means, like firearms, while females attempt suicide more often but often use less lethal means, like poisoning.

Hospitals more thoroughly record the method of an attempted suicide when the patient is admitted to the hospital compared to only being treated by the emergency department. Emergency departments are more likely to report the method of an attempted suicide as "other" or "not specified". This is consistent with the 2014 and 2015 Youth Suicide Reports.

Suicide Prevention Activities

DCF is the lead state agency responsible for facilitating efforts 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.

2NDFLOOR Youth Helpline

www.2ndfloor.org; 888.222.2228

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

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