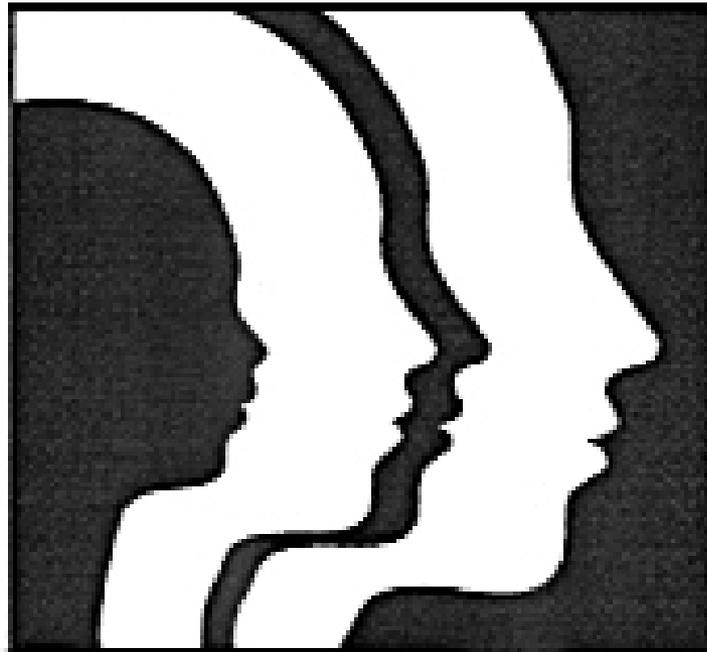


Youth Suicide Prevention

Facts and Statistics for Oklahoma



Adolescent Health

Suicide Among Adolescents

- ◆ Suicide is the 3rd leading cause of death for young people 15-24 years old.
- ◆ In 1996, more teenagers and young adults died of suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease *combined*.
- ◆ Males under the age of 25 are much more likely to commit suicide than their female counterparts. The 1996 gender ratio for people aged 15-19 was 5:1 (males to females), while among those aged 20-24 it was 7:1.
- ◆ Among persons aged 15-19 years, firearm-related suicides accounted for 63% of the increase in the overall rate of suicide from 1980-1996.

- Surgeon General's Call to Action to Prevent Suicide, 1999

Suicide Among Adolescents

- ◆ In the U.S., roughly one young person age 24 or younger dies of suicide every 2 hours.
- *American Association of Suicidology*
- ◆ More than half of young people who commit suicide abuse substances.
- *American Psychiatric Association*
- ◆ Males *complete* suicide more often than females, yet females *attempt* suicide more often than males.
- *Gould, Kramer: Columbia University School of Public Health*
- ◆ It is estimated that as many as 25 suicide attempts are made for every suicide completion.
- *National Institute of Mental Health*

Suicide Among Adolescents – Oklahoma Statistics

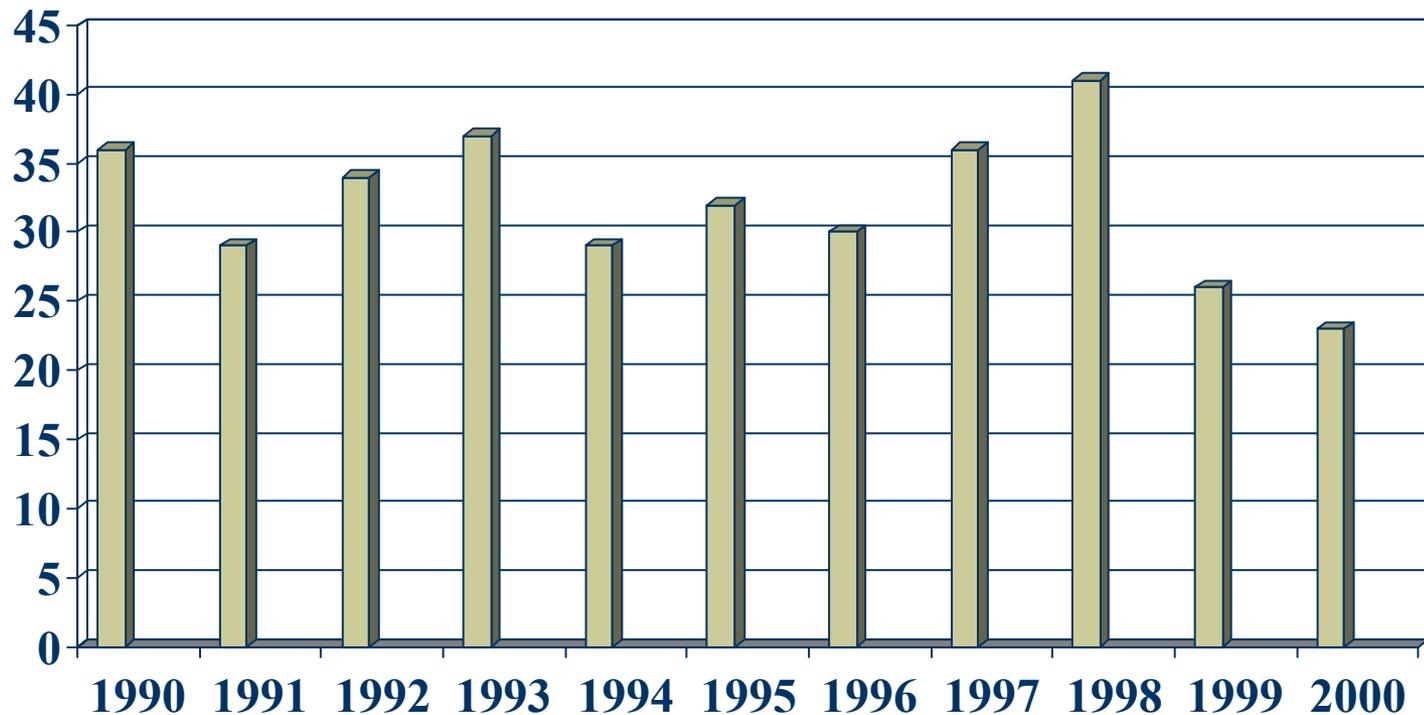
- ◆ Between the years 1976-2000, suicides outnumbered homicides 72% of the time for youth ages 15-19 (18 out of 25 years).
- ◆ In the year 2000, 29 adolescents under the age of 20 committed suicide – 6 of whom were under the age of 15.

- Oklahoma Vital Statistics

- ◆ Suicide rates are slightly higher in rural counties.
- ◆ 1 out of 3 suicides among persons 14 years of age or older involves alcohol.
- ◆ Whites have the highest rate of suicide among persons over age 15; for children less than 15 years of age, Native Americans have the highest suicide rate.

- OSDH, Injury Prevention Service

Suicide Deaths in Oklahoma / Youth Aged 15-19



Financial Costs to the State of Oklahoma

- ◆ Cost of completed and medically treated youth suicide acts (under age 20) in 1996:
 - Medical Costs: \$17,000,000
 - Loss of Future Earnings: \$50,000,000
 - Quality of Life: \$208,000,000

*-Children's Safety Network / National Injury and Violence
Prevention Resource Center*

Risk Factors

◆ Biological Factors

- Mental disorders, particularly mood disorders (depression), schizophrenia, anxiety disorders and certain personality disorders.
- Alcohol and other substance abuse

◆ Psychosocial Factors

- Poor interpersonal problem-solving ability
- Poor coping skills
- Impulsive and/or aggressive tendencies
- Legal / disciplinary problems
- History of trauma or abuse
- Previous suicide attempt
- Family history of suicide

- National Strategy for Suicide Prevention

- Gould, Kramer: Columbia University School of Public Health

Risk Factors, cont.

- ◆ Environmental Factors
 - Difficulty in school
 - Neither working nor going to school (“drifting”)
 - Relational or social loss
 - Easy access to lethal means
 - Local clusters of suicide that have a contagious influence (contagion)
- ◆ Sociocultural Factors
 - Lack of social support and sense of isolation
 - Stigma associated with help-seeking behavior
 - Barriers to accessing health care
 - Certain cultural and religious beliefs (such as a belief that suicide is a noble resolution of a personal dilemma)
 - Exposure to (including through the media) and influence of others who have died by suicide.

- *National Strategy for Suicide Prevention*

- *Gould, Kramer: Columbia University School of Public Health*

Protective Factors

- ◆ Effective clinical care for mental, physical and substance use disorders
- ◆ Easy access to a variety of clinical interventions and support for help-seeking behaviors
- ◆ Restricted access to highly lethal means of suicide
- ◆ Strong connections to family and community support
- ◆ Support through ongoing medical and mental health care relationships
- ◆ Skills in problem-solving, conflict resolution and nonviolent handling of disputes
- ◆ Cultural and religious beliefs that discourage suicide and support self-preservation

- National Strategy for Suicide Prevention

Warning Signs

- ◆ Change in eating and sleeping habits
- ◆ Withdrawal from friends, family and regular activities
- ◆ Violent actions, rebellious behavior or running away
- ◆ Drug and alcohol use
- ◆ Unusual neglect of personal appearance
- ◆ Marked personality change
- ◆ Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- ◆ Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- ◆ Loss of interest in pleasurable activities
- ◆ Not tolerating praise or awards

- American Academy of Child and Adolescent Psychiatry

Additional Warning Signs

- ◆ Complaints of being a bad person or feeling “rotten inside”
- ◆ Giving verbal hints with statements such as: “I won’t be a problem for you much longer”, “nothing matters”, “It’s no use” or “I won’t see you again”
- ◆ Putting his or her affairs in order, such as giving away favorite possessions, cleaning his or her room, throwing away important belongings, etc.
- ◆ Becoming suddenly cheerful after a period of depression
- ◆ Having signs of psychosis (hallucinations or bizarre thoughts)

-American Academy of Child and Adolescent Psychiatry

Common Misconceptions Regarding Suicide

- ◆ People generally commit suicide without warning.
- ◆ Sometimes a minor event will push an otherwise normal person to suicide.
- ◆ Only mentally ill people commit suicide.
- ◆ People who talk about suicide do not commit suicide.
- ◆ People who want to commit suicide will find a way regardless of efforts to help them prevent it.
- ◆ Suicide is primarily genetic and, therefore, inevitable from generation to generation.
- ◆ Talking about suicide will push a person to commit suicide by planting the idea.
- ◆ Suicides occur most often around the Christmas and Thanksgiving holidays.

- *Silverman: National Expert Panel
Recommendations – Reno Conference, 1998*

Common Misconceptions Among Clinicians

- ◆ Improvement following a suicidal crisis means that the risk is over.
- ◆ If someone survives a suicide attempt, the act must have been a manipulative gesture.
- ◆ The clinician should not reinforce pathological behavior by probing vague references to suicide.
- ◆ Most of those who attempt suicide will go on to make multiple attempts.
- ◆ Persons with multiple attempts are demanding attention but unlikely to die.
- ◆ If someone is talking to a therapist about suicide, he or she will keep talking and not act on it.
- ◆ Truly suicidal people hide their intent from those who might stop them.
- ◆ Someone who makes a suicide attempt with a high chance of rescue is not serious about dying and will not be at high risk of suicide.

*- Silverman: National Expert Panel
Recommendations – Reno Conference, 1998*

Surgeon General's Call to Action (1999)

- ◆ Called for the Development of a National Suicide Prevention Strategy and Recommended the Following Format:
- ◆ AIM – Awareness, Intervention and Methodology
 - Awareness – Broaden the public's awareness of suicide and its risk factors
 - Intervention – Enhance services and programs, both population-based and clinical care
 - Methodology – Advance the science of suicide prevention

The National Strategy for Suicide Prevention (2001)

Created in response to the Call to Action – solicited input from nationally known experts, statewide initiatives and suicide survivors.

- ◆ Goal 1: Promote awareness that suicide is a public health problem that is preventable
- ◆ Goal 2: Develop broad-based support for suicide prevention
- ◆ Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
- ◆ Goal 4: Develop and implement suicide prevention programs
- ◆ Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm
- ◆ Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment

The National Strategy for Suicide Prevention, cont.

- ◆ Goal 7: Develop and promote effective clinical and professional practices
- ◆ Goal 8: Improve access to and community linkages with mental health and substance abuse services
- ◆ Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media
- ◆ Goal 10: Promote and support research on suicide and suicide prevention
- ◆ Goal 11: Improve and expand surveillance systems

Oklahoma State Plan for Youth Suicide Prevention

- ◆ Created by the Youth Suicide Prevention Task Force as a result of House Joint Resolution 1018 (1999)
- ◆ Implemented by the Youth Suicide Prevention Council created by the passage of HB 1241 (2001)
- ◆ Technical assistance in development and implementation provided by the University of Washington, University of Calgary/Living Works Education, Health Resources and Services Administration (HRSA), Suicide Prevention Advocacy Network (SPAN USA)
- ◆ Available for download at www.health.state.ok.us/program/ahd/index.html
or contact the Child and Adolescent Health Service, Oklahoma State Department of Health at (405) 271-4471

Oklahoma State Plan for Youth Suicide Prevention (cont.)

- ◆ Addresses youth suicide prevention through the core public health functions of assessment, policy development and assurance of services.
- ◆ Focuses on underlying issues surrounding suicidal behavior (substance abuse, mental health, social support)
- ◆ Incorporates a positive youth development approach.
- ◆ Links with the Oklahoma Turning Point Council to address community infrastructure and partnership development.

Oklahoma Youth Suicide Prevention Plan

Assumptions

There is no standardized data collection or reporting system for suicide deaths

80-90% of youth who commit suicide have a diagnosable mental illness

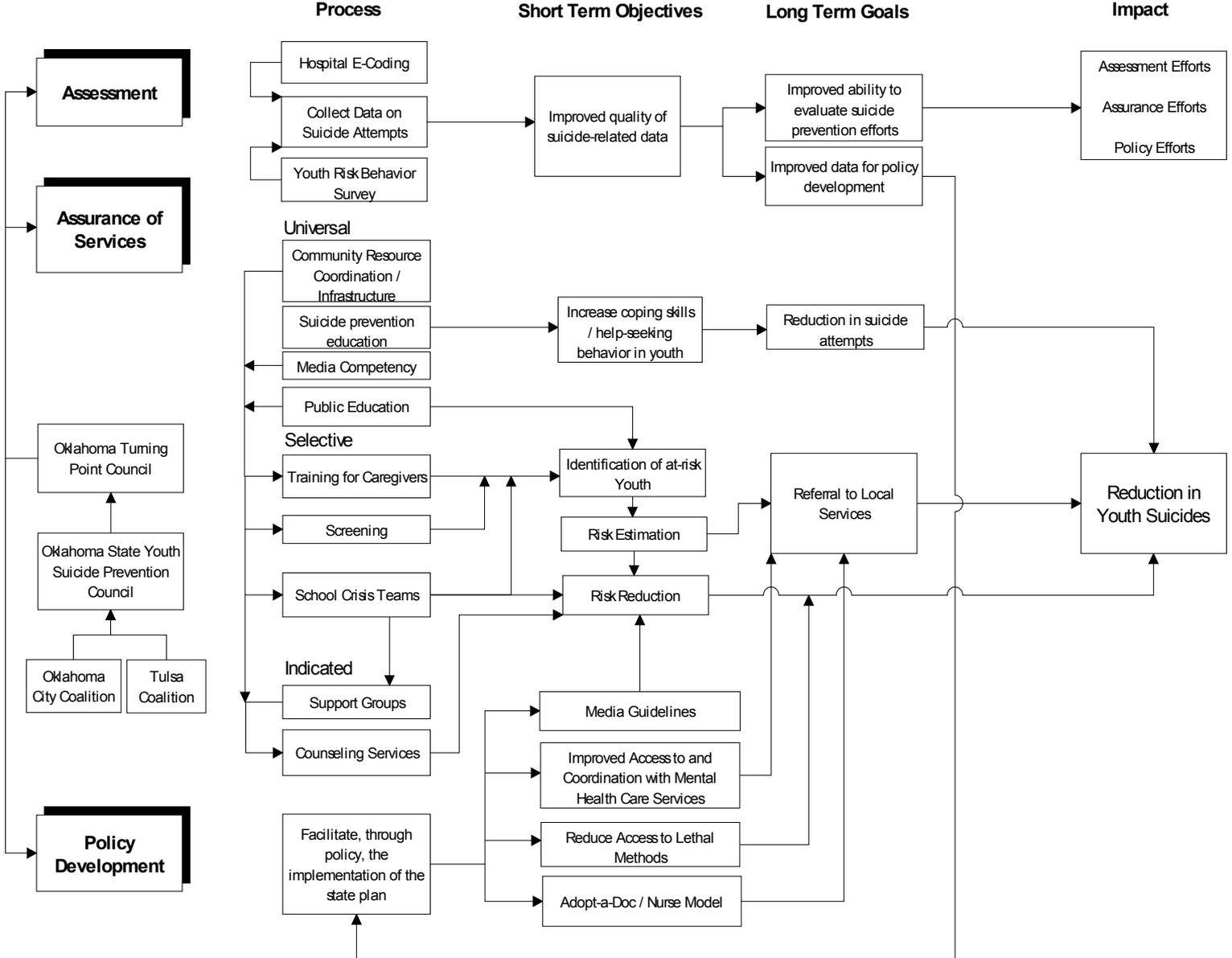
1/3 of those who commit suicide have seen a physician within one week before death: 1/2 in the month before

Choice of suicide method is based on access, knowledge and familiarity

Alcohol increases impulsivity in youth which is connected to suicide

Most schools are not equipped to address mental health issues, nor is that their primary mission

A completed suicide places those in close association at increased risk (contagion effect)



Community Partnerships

- ◆ Oklahoma Turning Point Initiative
 - Funded by the Robert Wood Johnson and Kellogg Foundations
- ◆ Local Turning Point Partnerships
 - Focus on population-based approaches to health
 - Develop a public health change process that can be replicated, adopted and sustained across communities
 - Utilize a “grass roots” approach in which public health change is aided and driven by the community.
- ◆ Oklahoma Turning Point Council
 - Consists of representatives from local partnerships along with representatives from state-level sectors.
 - The Youth Suicide Prevention Council serves as an ad-hoc committee.

Resources

- ◆ Oklahoma Youth Suicide Prevention State Plan online: www.health.state.ok.us/program/ahd/index.html
- ◆ National Strategy to Prevent Suicide: www.mentalhealth.org/suicideprevention/strategy.asp
- ◆ Suicide Prevention Advocacy Network: www.spanusa.org
- ◆ American Association of Suicidology: www.suicidology.org
- ◆ Teenline (Oklahoma Department of Mental Health and Substance Abuse Services) 1-800-522-TEEN (8336)
- ◆ CONTACT Crisis Helpline: 848-CARE / 1-800 SUICIDE
- ◆ Oklahoma State Department of Health, Child and Adolescent Health Service – (405) 271-4471