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

[Graph showing the number of suicide deaths in Oklahoma for youth aged 15-19 from 1990 to 2000.]
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.

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.

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).

Process
- Hospital E-Coding
- Collect Data on Suicide Attempts
- Youth Risk Behavior Survey
- Universal
  - Community Resource Coordination / Infrastructure
  - Suicide prevention education
  - Media Competency
  - Public Education
- Selective
  - Training for Caregivers
- Screening
- School Crisis Teams
- Indicated
  - Support Groups
  - Counseling Services
- Policy Development
  - Facilitate, through policy, the implementation of the state plan

Short Term Objectives
- Improved quality of suicide-related data
- Identification of at-risk Youth
- Risk Estimation
- Risk Reduction
- Media Guidelines
- Improved Access to and Coordination with Mental Health Care Services
- Reduce Access to Lethal Methods
- Adopt-a-Doc / Nurse Model

Long Term Goals
- Improved ability to evaluate suicide prevention efforts
- Improved data for policy development
- Reduction in suicide attempts
- Referral to Local Services
- Reduction in Youth Suicides

Impact
- Assessment Efforts
- Assurance Efforts
- Policy Efforts
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](http://www.health.state.ok.us/program/ahd/index.html)
- National Strategy to Prevent Suicide:  
  [www.mentalhealth.org/suicideprevention/strategy.asp](http://www.mentalhealth.org/suicideprevention/strategy.asp)
- Suicide Prevention Advocacy Network:  [www.spanusa.org](http://www.spanusa.org)
- American Association of Suicidology:  [www.suicidology.org](http://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