

2011

Based on recommendations of the Oklahoma Suicide Prevention Council



OKLAHOMA STRATEGY FOR
SUICIDE
PREVENTION

ACKNOWLEDGEMENTS

Many individuals have dedicated time and energy to the development of the Oklahoma Strategy for Suicide Prevention.

The Oklahoma Suicide Prevention Council acknowledges the following member and participating organizations for their commitment and support.

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Aging Network

HeartLine

Indian Health Services

Long Term Care Authority

Minco Public Schools

Muscogee Creek Nation-Children's Mental Health Initiative

Oklahoma Commission on Children and Youth

Oklahoma Department of Mental Health and Substance Abuse Services

Oklahoma Department of Veterans Affairs

Oklahoma Faith Communities

Oklahoma Mental Health and Aging Coalition

Oklahoma Office of Juvenile Affairs

Oklahoma State Department of Education

Oklahoma State Department of Health

Minco Public Schools

Survivors of Suicide

Tulsa Public Schools

University of Oklahoma

Youth Services for Oklahoma County

Youth Services of Tulsa

The Oklahoma Strategy for Suicide Prevention is purposefully and closely aligned with recommendations of the National Strategy for Suicide Prevention, therefore the developers of this plan would like to acknowledge the use of the National Strategy text throughout the document.



COLLABORATION
EFFORT
RESILIENCE

INTRODUCTION

Background

Resilience, strong will, collaboration, and effort are part of the fabric of our state's history and citizenry. These characteristics were the driving force when a group of concerned Oklahomans first began gathering in 1997 to discuss the urgency and need to address the prevention of suicide.

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In 2001, the U.S. Department of Health and Human Services released the National Strategy for Suicide Prevention, a comprehensive and integrated approach to reducing suicide and suicidal behaviors across the life span. The national strategy is a culmination of efforts including the 1999 Surgeon General's Call to Action to Prevent Suicide and the landmark Mental Health: A Report of the Surgeon General (1999).

During the same time, a state plan to prevent youth suicide in Oklahoma was developed at the direction of the Oklahoma Legislature. The plan was developed by a state task force created in 1999 by House Joint Resolution No. 1018. Representatives from the task force presented on the development of the Oklahoma plan at a public hearing in Atlanta, Georgia in 2000. The State Plan on Youth Suicide Prevention was adopted in 2001 and the Oklahoma Youth Suicide Prevention Act was enacted, tasking a new Youth Suicide Prevention Council to implement the plan.

Since 2001, the Oklahoma Youth Suicide Prevention Council has actively pursued opportunities to act on the recommendations included in the state plan. The Council, comprised of suicide survivors, youth, educators, mental health professionals, and state agencies, achieved two significant outcomes to advance suicide prevention in the state. The first was making suicide a reportable injury so that hospitals reported suicide attempts, greatly enhancing the state's understanding of the scope of the problem. The second major achievement was the state's award of funds for youth suicide prevention and early intervention. The Oklahoma Department of Mental Health and Substance Abuse Services was awarded federal Garrett Lee Smith Youth Suicide Prevention and Early Intervention grant funding from the Substance Abuse and Mental Health Services Administration for years 2005 to 2008, and then re-funded in 2008 through 2011. This funding allowed the state to begin implementation of several recommendations in the state's 2001 state suicide prevention plan, including statewide and community-based suicide prevention training, suicide screening for youth and improved referral networks for youth at risk for suicide.

In 2008, the Council achieved another significant milestone when the Oklahoma Youth Suicide Prevention Act was amended by Senate Bill 2000 to become simply the Oklahoma Suicide Prevention Act, broadening the scope of the Council and the state plan to prevent suicide among Oklahomans of all ages. The Council and state Legislature recognized the need for a comprehensive strategy for Oklahoma citizens.

Purpose of Oklahoma's Suicide Prevention Strategy

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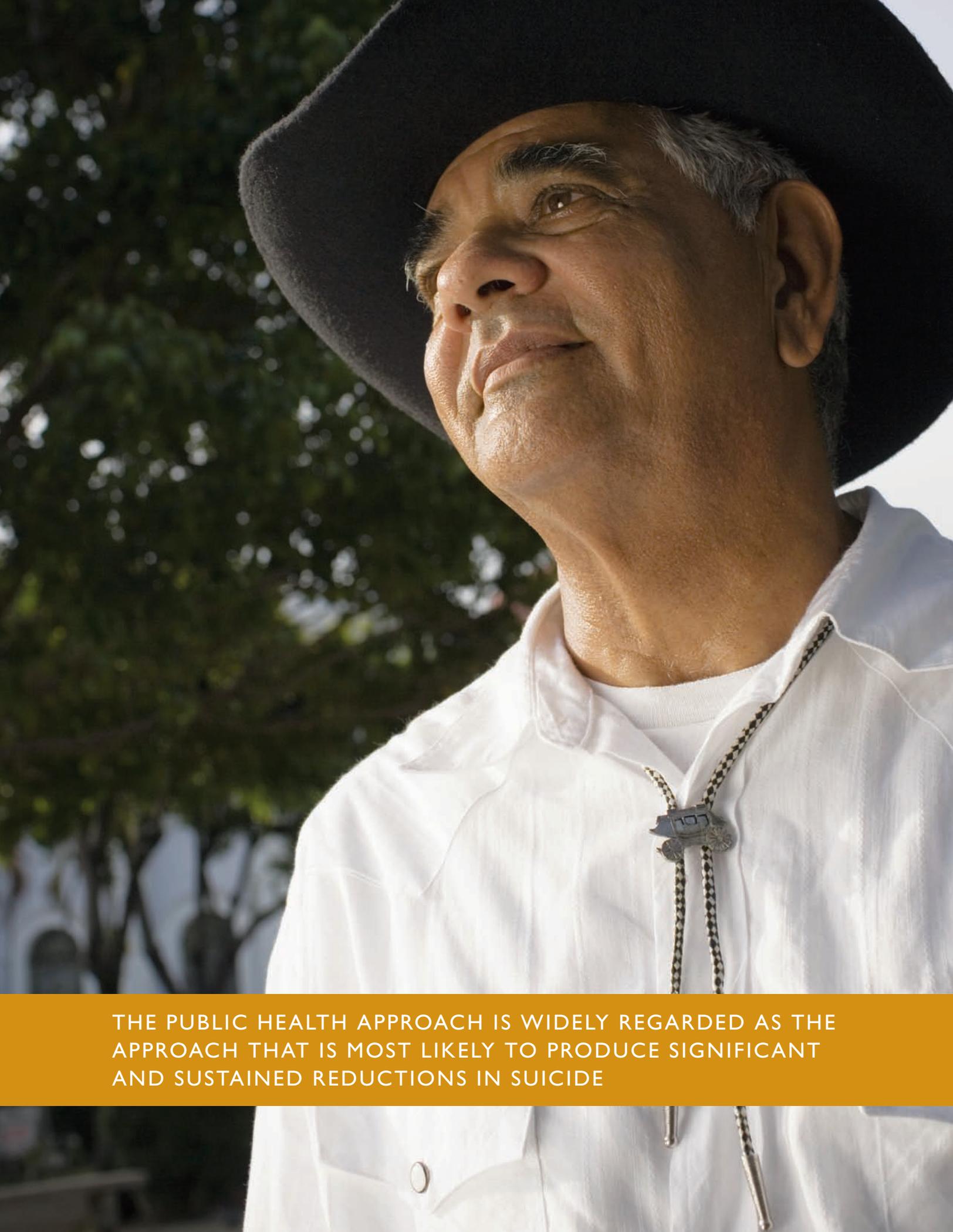
The Oklahoma Suicide Prevention Council recognizes suicide as a public health problem and proposes strategies based on public health methods as recommended by the National Strategy for Suicide Prevention. The public health approach is widely regarded as the approach that is most likely to produce significant and sustained reductions in suicide using a system of defining the problem, identifying causes, and implementing and evaluating evidence-based prevention and early intervention strategies. As such, the Oklahoma Strategy for Suicide Prevention is closely aligned with the goals outlined in the National Strategy with objectives tailored to address the specific needs of Oklahomans.

The components identified in this state plan will be coordinated by the Oklahoma Suicide Prevention Council. This council will oversee the development of different stages of the state strategy over a five-year period through 2015, and provide assistance to communities in identifying which of the plan's activities their community is ready for and how to implement them. Members of the council are legislatively appointed and represent various state agencies, survivors of suicide, legislators, and interested individuals. This state strategy will involve regular ongoing review and revision. This review will involve tracking progress and achievement of goals as well as annual reporting on progress to the state Legislature.

It is the purpose of the Oklahoma Strategy for Suicide Prevention to prevent suicide attempts, suicidal behaviors, and suicide deaths across the lifespan through the achievement of the following goals:

1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention.
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
4. Develop and implement community-based suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Develop and promote effective clinical and professional practices.
7. Increase access to and community linkages with mental health and substance abuse services.
8. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
9. Promote and support research on suicide and suicide prevention.
10. Improve and expand suicide surveillance systems.
11. Provide support for survivors of suicide.

The Oklahoma Strategy is comprehensive and ambitious. To achieve these goals it will be necessary for Oklahomans at the state and local levels to take action. The strategy calls upon schools, state agencies, tribes, faith communities, media, health care providers, community coalitions, just to name a few, to implement portions of the plan. Through continued collaboration and commitment to the strategy, lives will be saved.



THE PUBLIC HEALTH APPROACH IS WIDELY REGARDED AS THE APPROACH THAT IS MOST LIKELY TO PRODUCE SIGNIFICANT AND SUSTAINED REDUCTIONS IN SUICIDE



RECOGNITION
INTERVENTION
IMPACT

SCOPE OF THE PROBLEM

What Causes Suicide?

The causes of suicide are complex and vary among individuals and across age, cultural, racial, and ethnic groups. The risk of suicide is influenced by an array of biological, psychological, social, environmental, and cultural risk factors.

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Many people who attempted or completed suicide had one or more warning signs before their death. While warning signs refer to more immediate signs or symptoms in an individual, risk factors for suicide are generally longer-term factors that are associated with a higher prevalence of suicide in the population. Recognition of warning signs has a greater potential for immediate prevention and intervention when those who are in a position to help know how to appropriately respond.

Feelings of hopelessness and an inability to make positive changes in one's life are two consistent psychological precursors to suicidal behaviors. Many of those who die by suicide are described by family or friends as having been depressed or as having problems with a current or former intimate partner.

Trauma has a significant impact on suicide risk across the life span. A survey of over 17,000 people found that a history of adverse childhood experiences was associated with a significant increase in the prevalence of attempted suicides. For example, individuals reporting that their parents had separated or divorced were twice as likely to have attempted suicide, and those who were emotionally abused as children were five times as likely to have attempted suicide. For each additional adverse experience, the risk of attempted suicide increased by about 60 percent. This study also found a high prevalence of depression and substance abuse, suggesting that a history of adverse childhood experiences is associated with a host of negative outcomes.

Risk Factors for Suicide

BIOPSYCHOSOCIAL RISK FACTORS

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

ENVIRONMENTAL RISK FACTORS

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

SOCIAL/CULTURAL RISK FACTORS

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution to a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

What Protects Against Suicide?

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Protective factors can reduce the likelihood of suicide by counterbalancing some of the risk factors. Examining populations with lower suicide rates can help understand potential protective factors and focuses for prevention strategies. Social, political, and economic factors may help explain different rates of suicide between countries and states. Differences in rates of depressive disorders, alcohol consumption, proportion of older adults, levels of social isolation, and religiosity may all play a role in the rate of suicide. In the United States, suicide rates among African American women, particularly in middle age, are very low. Sociocultural differences between population groups and between individuals, including social connectedness, family relations, marital status, parenthood, and participation in religious activities and beliefs (including negative moral attitudes toward suicide), may all be important underlying factors.

Protective Factors for Suicide

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for helpseeking
- 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

Suicide in Oklahoma

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Oklahoma is ranked 13th highest among all states for the number of suicide deaths per capita. Suicide was the most prevalent type of violent death in Oklahoma from 2004 to 2007, accounting for 2,057 deaths (14.4 suicides annually per 100,000 population), an average of 514 deaths per year. The rate of suicide was stable from 2004 to 2007. In 52 of the suicide deaths, the victim killed at least one other person before taking his/her own life, resulting in 65 homicide deaths.

TABLE 1.
Suicide by Year
Oklahoma, 2004-2007

Year	Number	Rate
2004	496	14.1
2005	517	14.6
2006	528	14.8
2007	516	14.3

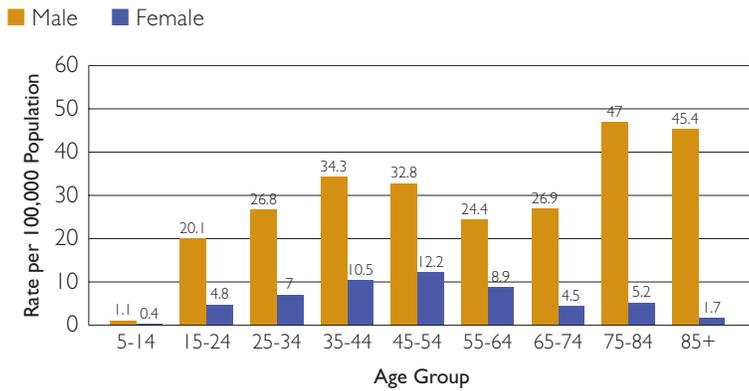
* Per 100,000 population.

Source: *Summary of Violent Deaths in Oklahoma, Oklahoma Violent Death Reporting System, 2004-2007, Injury Prevention Service, Oklahoma State Department of Health.*

SUICIDE WAS THE MOST PREVALENT TYPE OF VIOLENT DEATH IN OKLAHOMA FROM 2004-2007



TABLE 2.
Age and Gender Specific Rates of Suicide*
Oklahoma, 2004-2007



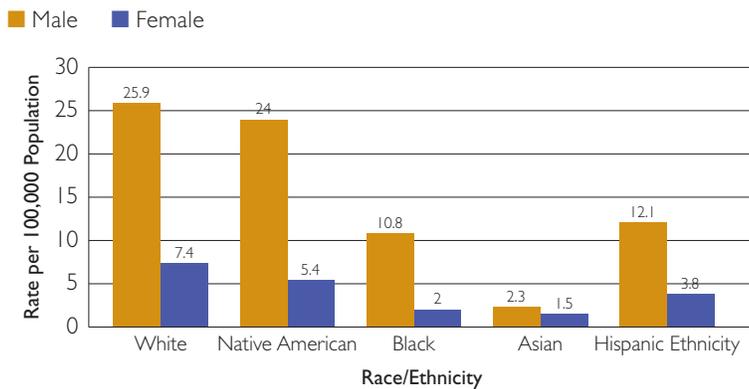
* Includes 2,057 persons.

Source: Summary of Violent Deaths in Oklahoma, Oklahoma Violent Death Reporting System, 2004-2007, Injury Prevention Service, Oklahoma State Department of Health.

Age

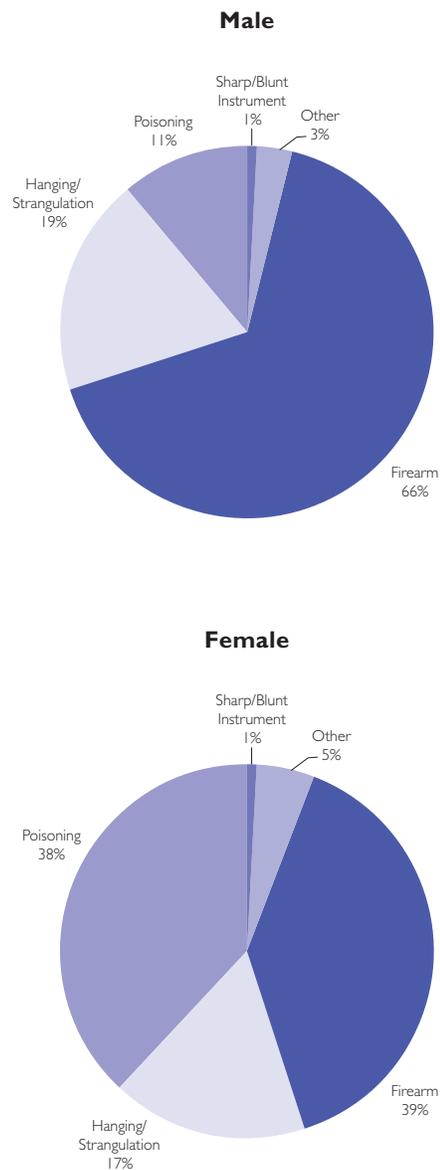
The youngest person to die by suicide was 12 years of age and the oldest person was 96 years. Seventy-eight percent of suicide victims were male and 22 percent were female. Males 75-84 years of age had the highest suicide rate among all ages. Among females, women 35-54 years were at greatest risk for suicide. White males had the highest suicide rate (25.9 percent), followed by Native American males (24.0 percent), black males (10.8 percent), and Asian males (2.3 percent).

TABLE 3.
Gender, Race, and Ethnicity Specific Rates of Suicide
Oklahoma, 2004-2007



Source: Summary of Violent Deaths in Oklahoma, Oklahoma Violent Death Reporting System, 2004-2007, Injury Prevention Service, Oklahoma State Department of Health.

FIGURE 1.
Method of Suicide by Gender
Oklahoma, 2004-2007



Source: Summary of Violent Deaths in Oklahoma, Oklahoma Violent Death Reporting System, 2004-2007, Injury Prevention Service, Oklahoma State Department of Health.

Suicide Method/Mean

Firearms were used in 59 percent of the suicide deaths, hanging/strangulation in 19 percent, poisoning in 17 percent, and other methods were used in 5 percent of suicides. Other methods used to complete suicide were sharp/blunt instrument (30), motor vehicle or other transportation vehicle (27), drowning (16), fire (16), fall (7), and unknown (2) methods. Firearms were used in male suicide deaths more often than in female suicide deaths, 66 percent and 40 percent, respectively. Poisoning was used more often in female suicide than male suicide, 38 percent and 11 percent, respectively.

Circumstances

A substantial number of suicides were associated with a current depressed mood, intimate partner problem, mental health problem, physical health problem, and/or crisis in the past two weeks. Circumstances associated with suicide varied by age. Physical health problems were more often associated with suicide among persons 65 years and older. Intimate partner problems were more often associated with suicides of persons less than 65 years of age. Almost one in five suicide victims had a history of suicide attempts. Thirty percent had stated their intent or expressed suicidal feeling to another person and 29 percent left a suicide note.

Seventy-six percent of persons who died by suicide with a current mental health problem were receiving mental health treatment, including 65 percent of persons 12-24 years, 77 percent of persons 25-44 years, 80 percent of persons 45-64 years, and 65 percent of persons 65 years and older.

TABLE 5. Selected Suicide Circumstances by Gender, Oklahoma, 2004-2007*

	Total (n=2,057)		Male (n=1,599)		Female (n=458)	
	Number	Percent	Number	Percent	Number	Percent
Current depressed mood	941	46	731	46	210	46
Intimate partner problem	682	33	551	34	131	29
Disclosed intent to commit suicide	614	30	463	29	151	33
Mental health problem	583	28	396	25	187	41
Depression/dysthymia	281	14	209	13	72	16
Bipolar disorder	76	4	34	2	42	9
Schizophrenia	35	2	26	2	9	2
Anxiety disorder	26	1	16	1	10	2
Post-traumatic stress disorder	5	0	4	0	1	0
Obsessive-compulsive disorder	2	0	2	0	0	0
Eating disorder	1	0	0	0	1	0
Other/unknown	217	11	136	9	81	18
Left a suicide note	601	29	458	29	143	31
Physical health problem	559	27	431	27	128	28
Crisis in past two weeks	505	25	413	26	92	20
History of previous suicide attempts	367	18	223	14	144	31
Substance abuse	278	14	194	12	84	18
Financial problem	241	12	188	12	53	12
Other relationship problem	222	11	161	10	61	13
Alcohol	188	9	155	10	33	7
Job problem	187	9	162	10	25	5
Recent criminal legal problem	179	9	160	10	19	4
Other death of friend or family	139	7	112	7	27	6
Non-criminal legal problem	85	4	70	4	15	3
Perpetrator of interpersonal violence within past month	49	2	44	3	5	1
Suicide of friend or family within past five years	34	2	20	1	14	3
School problem	14	1	11	1	3	1
Victim of interpersonal violence within past month	7	0	3	0	4	1

* More than one circumstance may have been associated with the death. Percentages were calculated using the total number of persons that committed suicide.
Source: *Summary of Violent Deaths in Oklahoma, Oklahoma Violent Death Reporting System, 2004-2007*, Injury Prevention Service, Oklahoma State Department of Health.

TABLE 6. Ten Most Common Circumstances* Associated with Suicide Deaths by Rank and Age Group, Oklahoma, 2004-2007*

Rank	12-24 Years	25-44 Years	45-64 Years	65+ Years
1	Current depressed mood (41%)	Intimate partner problem (47%)	Current depressed mood (49%)	Physical health problem (73%)
2	Intimate partner problem (38%)	Current depressed mood (43%)	Current mental health problem (31%)	Current depressed mood (49%)
3	Crisis in past 2 weeks (30%)	Current mental health problem (31%)	Physical health problem (31%)	Crisis in past 2 weeks (21%)
4	Current mental health problem (22%)	Crisis in past 2 weeks (28%)	Intimate partner problem (29%)	Current mental health problem (20%)
5	Relationship problem other than intimate partner (21%)	History of suicide attempts (21%)	Crisis in past 2 weeks (21%)	Death of family or friend (13%)
6	Substance abuse problem (19%)	Substance abuse problem (19%)	History of suicide attempts (20%)	History of suicide attempts (8%)
7	History of suicide attempts (19%)	Recent criminal/legal problem (13%)	Financial problem (16%)	Intimate partner problem (7%)
8	Recent criminal/legal problem (9%)	Financial problem (12%)	Job problem (13%)	Financial Problem (6%)
9	Job problem (8%)	Physical health problem (12%)	Substance abuse problem (11%)	Other relationship problem (5%)
10	Financial problem (6%)	Alcohol problem (12%)	Alcohol problem (11%)	Alcohol problem (3%)

*More than one circumstance may have been associated with the suicide.

TABLE II. Suicide Deaths of Veterans by Age, Oklahoma, 2004-2007

Age	Number	Percent
15-24	18	4%
25-34	30	6%
35-44	53	11%
45-54	77	17%
55-64	90	19%
65+	198	42%
Total	466	100%

Source: Summary of Violent Deaths in Oklahoma, Oklahoma Violent Death Reporting System, 2004-2007, Injury Prevention Service, Oklahoma State Department of Health.



**STRATEGY
GOALS
PREVENTION**

OBJECTIVES FOR ACTION

Goal 1

Promote awareness that suicide is a public health problem that is preventable.

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Rationale:

The stronger and broader the support for a public health initiative, the greater its chance for success. If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, the suicide rate can be reduced.

Objectives for Action:

- OBJECTIVE 1.1 Implement a minimum of one public information campaign, designed to increase public knowledge of suicide prevention, in all 77 counties of Oklahoma.

- OBJECTIVE 1.2 The state suicide prevention council will foster collaboration with stakeholders on prevention strategies across disciplines and with the public.

SUICIDE IS A PUBLIC HEALTH PROBLEM
THAT IS PREVENTABLE



Goal 2:

Develop broad-based support for suicide prevention.

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Rationale:

Collaboration across a broad spectrum of agencies, institutions, and groups is a way to ensure that prevention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than can these groups working alone. Broad-based support for suicide prevention may also lead to additional funding and to the incorporation of suicide prevention activities into organizations that have not previously addressed it.

Objectives for Action:

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| OBJECTIVE 2.1 | Sustain funding for an Office of Suicide Prevention within the Department of Mental Health and Substance Abuse Services to serve as an ongoing, centralized coordination of suicide prevention activities across the state. |
| OBJECTIVE 2.2 | Ensure that existing Oklahoma community coalitions have information about suicide, prevention strategies and training opportunities. |
| OBJECTIVE 2.3 | Ensure that state agencies have information about suicide, prevention strategies and training opportunities. |
| OBJECTIVE 2.4 | Ensure that institutes of higher learning have information about suicide, prevention strategies and training opportunities. |

Goal 3:

Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.

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Rationale:

Suicide is closely linked to mental illness and to substance abuse; and effective treatments exist for both. However, the stigma of mental illness and substance abuse prevents many persons from seeking assistance. The stigma of suicide itself—the view that suicide is shameful and/or sinful—is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. Family members of suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved one suffer not only the grief of loss, but often the added pain stemming from stigma. Stigma associated with mental illness, substance abuse, and suicide has resulted in the establishment of separate systems for physical and mental health care. One consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems. Destigmatizing mental illness, substance use disorders and suicide could increase access to treatment by integrating care and increasing the willingness of individuals to seek treatment.

Objectives for Action:

- OBJECTIVE 3.1 Increase the proportion of the public that views mental and physical health as equal, inseparable components of overall health.

- OBJECTIVE 3.2 Increase the proportion of Oklahomans with suicidal ideations or related conditions who seek mental health treatment services by promoting and increasing the capacity of Oklahoma's center for the National Suicide Prevention Lifeline and referrals to services.

THE STIGMA OF MENTAL ILLNESS AND
SUBSTANCE ABUSE PREVENTS MANY PERSONS
FROM SEEKING ASSISTANCE



Goal 4:

Develop and implement community-based suicide prevention programs.

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Rationale:

Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources. Effective prevention strategies may include:

- Training for key gatekeepers (people who regularly come into contact with individuals or families in distress) to recognize risk factors and intervene;
- Screening for suicide risk; and/or
- Promotion of coping and other life skills that develop help-seeking behavior and resilience.

The objectives established for this goal are designed to foster planning and program development work and to ensure the integration of evidence-based suicide prevention within key organizations and sectors of the community that have access to groups of individuals who otherwise might not receive the information.



EFFECTIVE SUICIDE PREVENTION PROGRAMS
REQUIRE COMMITMENT AND RESOURCES

Objectives for Action:

- OBJECTIVE 4.1 Increase the proportion of counties in Oklahoma with comprehensive suicide prevention plans. All 77 counties should have a plan in place.
- OBJECTIVE 4.2 Increase the proportion of school districts, private school associations, and tribal schools, with evidence-based strategies designed to address serious childhood and adolescent distress to prevent suicide.
- OBJECTIVE 4.3 Increase the proportion of colleges and universities with evidence-based strategies designed to address serious young adult distress to prevent suicide.
- OBJECTIVE 4.4 Increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.
- OBJECTIVE 4.5 Increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention strategies.
- OBJECTIVE 4.6 Increase the proportion of state aging networks that have evidence-based suicide prevention strategies designed to identify and refer for treatment elderly people at risk for suicidal behavior.
- OBJECTIVE 4.7 Increase the proportion of family, youth and community service providers and organizations with evidence-based suicide prevention strategies.
- OBJECTIVE 4.8 Increase the proportion of faith based organizations with evidence-based suicide prevention strategies.
- OBJECTIVE 4.9 Increase the proportion of primary health care organizations and providers with evidence-based suicide prevention strategies.
- OBJECTIVE 4.10 Increase the proportion of tribes with evidence-based suicide prevention strategies.
- OBJECTIVE 4.11 Increase the proportion of counties (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide.

Goal 5:

Promote efforts to reduce access to lethal means and methods of self-harm.

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Rationale:

Evidence shows that limiting access to lethal means of self-harm may be an effective strategy to prevent self-destructive behaviors. Often referred to as “means restriction,” this approach is based on the belief that a small, but significant minority of suicidal acts are, in fact, impulsive and of the moment; they result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, a self-destructive act may be prevented by limiting the individual’s access to the means of self-harm. Evidence suggests that there may be a limited time effect for decreasing self-destructive behaviors in susceptible and impulsive individuals when access to the means for self-harm is restricted. The objectives established for this goal are designed to separate the suicidal impulse from access to lethal means of self-harm.

Objectives for Action:

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| OBJECTIVE 5.1 | Increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks. |
| OBJECTIVE 5.2 | Initiate a targeted public awareness campaign for guns and medications safety to expose a larger proportion of households designated to reduce the accessibility of lethal means, including firearms and medications, in the home. |
| OBJECTIVE 5.3 | Initiate a gun lock or exchange your lock program in partnership with other state agencies. |
| OBJECTIVE 5.4 | Develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide. |



A SELF-DESTRUCTIVE ACT MAY BE PREVENTED BY LIMITING THE INDIVIDUAL'S ACCESS TO THE MEANS OF SELF-HARM

Goal 6:

Develop and promote effective clinical and professional practices.

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Rationale:

One way to prevent suicide is to identify individuals at risk and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g., depressed mood, hopelessness, helplessness, alcohol and other drug abuse, etc.). Another way to prevent suicide is to promote and support the presence of protective factors, such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes. By improving clinical practices in the assessment, management, and treatment of individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved. Moreover, promoting the presence of protective factors for these individuals can contribute importantly to reducing their risk. The objectives established for this goal are designed to heighten awareness of the presence or absence of risk and protective conditions associated with suicide, leading to better triage systems and better allocation of resources for those in need of specialized treatment.



ONE WAY TO PREVENT SUICIDE IS TO IDENTIFY
INDIVIDUALS AT RISK AND TO ENGAGE THEM IN
TREATMENTS THAT ARE EFFECTIVE

Objectives for Action:

- OBJECTIVE 6.1 Promote guidelines for assessment of suicide risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers.
- OBJECTIVE 6.2 Increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and training for all staff designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.
- OBJECTIVE 6.3 Encourage aftercare treatment and referrals for individuals exhibiting suicidal behavior and ideation (including those discharged from inpatient facilities and hospitals).
- OBJECTIVE 6.4 Train those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy, medical examiners) to address their own (the service provider) exposure to suicide in addition to the unique needs of suicide survivors.
- OBJECTIVE 6.5 Develop and disseminate informational materials to individuals and agencies that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse (e.g., law enforcement, hospital emergency departments, crisis intervention works, sexual assault nurse examiners, emergency shelter workers, etc).
- OBJECTIVE 6.6 Develop and disseminate information and materials providing education to family members and significant others of persons receiving care who may be at risk of suicide. Implement the guidelines in facilities (including those in general and psychiatric hospitals, community mental health clinics, and substance abuse treatment facilities).
- OBJECTIVE 6.7 Promote screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities.
- OBJECTIVE 6.8 Increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.
- OBJECTIVE 6.9 A legislative mandate shall be in place requiring all professional licensing agencies to require continuing education on suicide prevention each year for licensure.
- OBJECTIVE 6.10 Oklahoma shall have at least two certified suicide prevention trainers in each county at all times, the number required will be proportionate to the population size.
- OBJECTIVE 6.11 Oklahoma shall have a 24/7 aftercare and postvention team of personnel created and trained regionally to:
- Provide support after a death by suicide.
 - Prevent additional deaths among survivors and the immediate community.
 - Collect information regarding the proceeding circumstances to inform future suicide prevention practices.

Goal 7:

Increase access to and community linkages with mental health and substance abuse services.

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Rationale:

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside a health plan or insurance program. Structural barriers include the lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers include cultural or spiritual differences, language, not knowing when or how to seek care, or concerns about confidentiality or discrimination. Reducing disparities is a necessary step in ensuring that all Americans receive appropriate physical health, mental health, and substance abuse services. One aspect of improving access is to better coordinate the services of a variety of community institutions. This will help ensure that at-risk populations receive the services they need, and that all community members receive regular preventive health services. The objectives established for this goal are designed to enhance inter-organizational communication to facilitate the provision of health services to those in need of them.

Objectives for Action:

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| OBJECTIVE 7.1 | Develop and disseminate guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts. |
| OBJECTIVE 7.2 | Increase the number of school districts that have a formalized relationship with mental health and substance abuse providers. |
| OBJECTIVE 7.3 | Increase the number of mental health courts to one in every county in Oklahoma. |
| OBJECTIVE 7.4 | Increase the proportion of counties (or comparable jurisdictions) in which the guidelines for effective suicide survivor support programs are implemented. |
| OBJECTIVE 7.5 | Increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention. |
| OBJECTIVE 7.6 | Identify strategic locations and information to link people to services and offer referrals for crisis interventions. |
| OBJECTIVE 7.7 | Develop an active survivor of suicide support group in every county. |

Goal 8:

Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.

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Rationale:

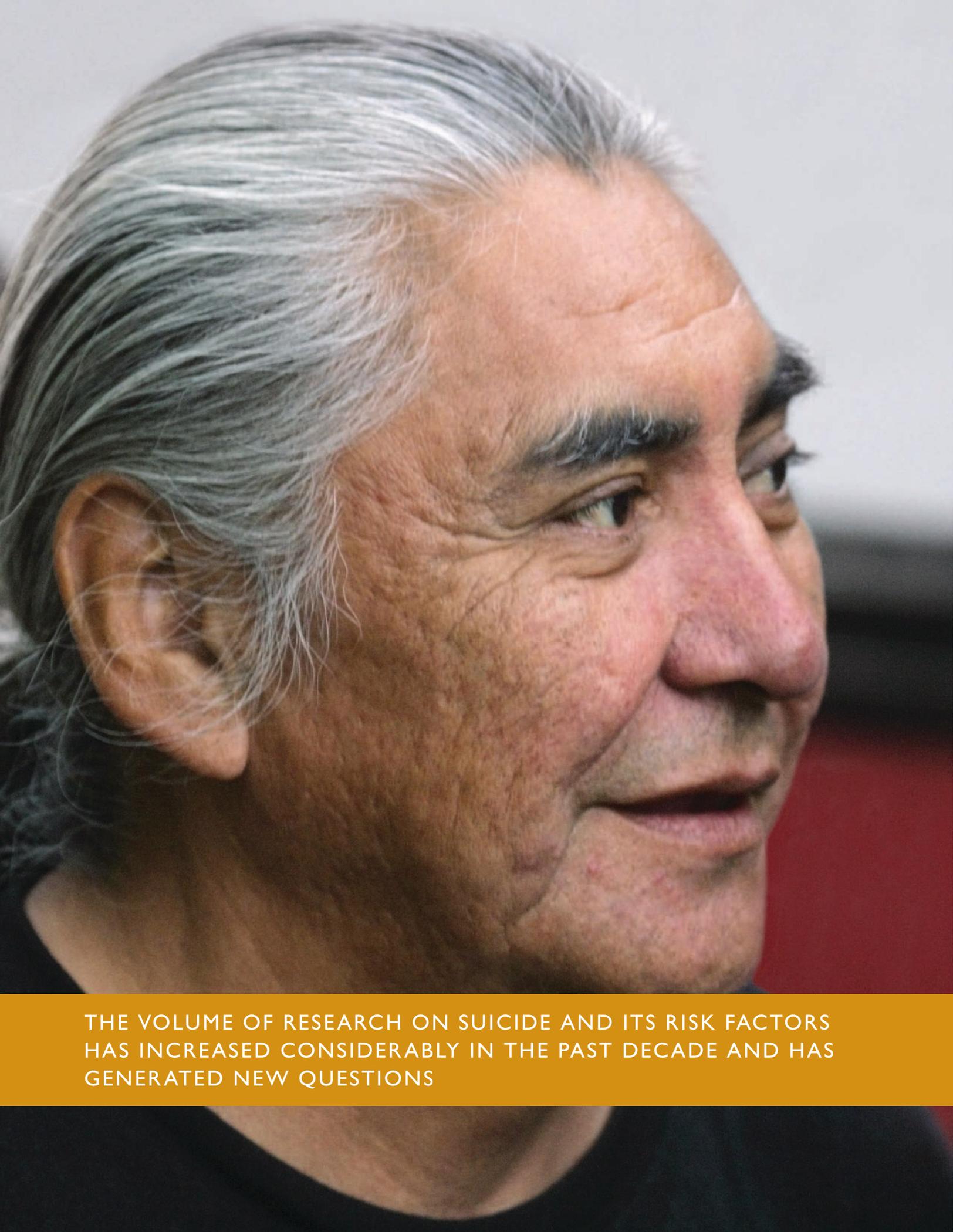
The media can have a powerful impact on perceptions of reality and behavior. Research over many years has found that media representations of suicide may increase suicide rates, especially among youth. “Cluster suicides” and “suicide contagion” have been documented, and studies have shown that both news reports and fictional accounts of suicide can lead to increases in suicide. On the other hand, it is widely acknowledged that the media can play a positive role in suicide prevention. The way suicide is presented is particularly important. Media portrayals of mental illness and substance abuse may also affect the suicide rate. Negative views of these problems may lead individuals to deny they have a problem or be reluctant to seek treatment—and untreated mental illness and substance abuse are strongly correlated with suicide. The objectives established for this goal are designed to foster consideration among media leaders of the impact of different styles of describing or otherwise depicting suicide and suicidal behavior, mental illness, and substance abuse, and to encourage media representations of suicide that can help prevent rather than increase suicide.

Objectives for Action:

- OBJECTIVE 8.1 Increase the number of journalism schools that include in their curricula guidance on the appropriate portrayal and reporting of mental illness, suicide and suicidal behaviors.
- OBJECTIVE 8.2 Increase the proportion of Oklahoma media outlets that actively participate in promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues.
- OBJECTIVE 8.3 Increase the number of Oklahoma media outlets that are following and have available the national guidelines for responsible reporting of deaths by suicide.

THE MEDIA CAN HAVE A POWERFUL IMPACT ON PERCEPTIONS OF REALITY AND ON BEHAVIOR





THE VOLUME OF RESEARCH ON SUICIDE AND ITS RISK FACTORS HAS INCREASED CONSIDERABLY IN THE PAST DECADE AND HAS GENERATED NEW QUESTIONS

Goal 9:

Promote and support research on suicide and suicide prevention.

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Rationale:

The volume of research on suicide and its risk factors has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. Important contributions of underlying mental illness, substance abuse, and biological factors, as well as potential risk that comes from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect an individual's risk for suicidal behavior is the next challenge. This understanding can contribute to the limited but growing information about how modifying risk and protective factors changes outcomes pertaining to suicidal behavior.

The objectives established for this goal are designed to support a wide range of research endeavors focused on the etiology, expression, and maintenance of suicidal behaviors across the lifespan. The enhanced understanding to be derived from this research will lead to better assessment tools, treatments, and preventive interventions.

Objectives for Action:

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| OBJECTIVE 9.1 | Develop an Oklahoma suicide research agenda with input from survivors, practitioners, researchers, and advocates. |
| OBJECTIVE 9.2 | Establish funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice, and for training of researchers in suicidology. |
| OBJECTIVE 9.3 | Require Oklahoma suicide prevention efforts to include research-based prevention activities that have demonstrated effectiveness for suicide or suicide behaviors. |
| OBJECTIVE 9.4 | Conduct at least one scientific evaluation study on new or existing suicide prevention interventions. |
| OBJECTIVE 9.5 | Develop and measure the effectiveness of suicide prevention efforts in high-risk populations (e.g., older adults; veterans; rural Oklahomans; non-Hispanic White or Native American race; males; those in prison/jail; persons who are gay, lesbian, bisexual, transgender; persons who have experienced post-emergency situations.). |
| OBJECTIVE 9.6 | Conduct five cultural analyses, pilot studies, and/or qualitative studies to better understand the cultural scripts/processes for suicide and suicide prevention in Oklahoma's various cultural groups and populations. |

Goal 10:

Improve and expand suicide surveillance systems.

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Rationale:

Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. They are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions, and to assess the impact of prevention efforts. Accurate data on suicide and suicidal behavior are needed at the State and local levels. State and local data help establish local program priorities and are necessary for evaluating the impact of suicide prevention strategies. The objectives established for this goal are designed to enhance the quality and quantity of data available on suicide and suicidal behaviors and ensure that the data are useful for prevention purposes.

Objectives for Action:

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|-----------------|---|
| OBJECTIVE 10.1 | Refine standardized protocols for death scene investigations and implement these protocols in the 10 Oklahoma counties with the highest suicide rates. |
| OBJECTIVE 10.2 | Increase the number of psychological autopsy investigations on completed suicides. |
| OBJECTIVE 10.3 | Obtain 100 percent participation of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by accurately coding external cause of injuries, utilizing the categories included in the International Classification of Diseases. |
| OBJECTIVE 10.4 | Maintain participation in the National Violent Death Reporting System that includes suicides and collects information not currently available from death certificates (i.e., psychological autopsies). |
| OBJECTIVE 10.5 | Increase the number of jurisdictions that produce annual reports on suicide and suicide attempts, integrating data from multiple Oklahoma data management systems. |
| OBJECTIVE 10.6 | Explore mandating reports on suicide attempts to the Oklahoma State Department of Health. |
| OBJECTIVE 10.7 | Increase the number of surveys (e.g., across the lifespan, rural/urban/tribal areas, college students, emergency department patients, primary care patients, Veterans) that include questions on suicidal behavior. |
| Objective 10.8: | Develop user-friendly web site to distribute data to appropriate parties and professionals. |

Goal 11:

Provide support for survivors of suicide.

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Rationale:

Every year about 500 Oklahomans of all ages die by suicide. Each of these tragic deaths immediately affects five to eight close relatives. Friends and co-workers are also profoundly affected by each of these losses. Support to the survivors decreases the risk of the contagion effects of suicide or cluster events.

Objectives for Action:

- OBJECTIVE 11.1 Promote and support a network of support groups across the state.
- OBJECTIVE 11.2 Promote and support basic guidelines, curriculum and training as recommended by the American Foundation for Suicide Prevention.

EVERY YEAR ABOUT 500 OKLAHOMANS OF ALL AGES DIE BY SUICIDE.



Contagion

A phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts

Gatekeeper

Individuals trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate

Ideation

Thoughts of engaging in suicide-related behavior

Means

The instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication)

Postvention

A strategy or approach that is implemented after a crisis or traumatic event has occurred

Prevention

A strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors

Protective factors

Factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment

Risk factors

Factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment

Screening

Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment

Suicide

Death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death

Suicide attempt

A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries

Survivor

Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors

RESOURCES

OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

www.ok.gov/odmhsas/Prevention_Programs/

OKLAHOMA STATE DEPARTMENT OF HEALTH (OSDH)

www.ok.gov/health/

NATIONAL SUICIDE PREVENTION LIFELINE

www.suicidepreventionlifeline.org/

NATIONAL SUICIDE PREVENTION LIFELINE - VETERANS

www.suicidepreventionlifeline.org/Veterans/

SAVE | SUICIDE AWARENESS VOICES OF EDUCATION

www.save.org/

AMERICAN ASSOCIATION OF SUICIDOLOGY

www.suicidology.org/

AMERICAN FOUNDATION FOR SUICIDE PREVENTION

www.afsp.org/

SUICIDE PREVENTION RESOURCE CENTER (SPRC)

www.sprc.org/

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

mentalhealth.samhsa.gov/suicideprevention/

NIMH | NATIONAL INSTITUTE FOR MENTAL HEALTH

www.nimh.nih.gov

CDC | CENTERS FOR DISEASE CONTROL AND PREVENTION

www.cdc.gov/violenceprevention/suicide/

WHO | WORLD HEALTH ORGANIZATION

www.who.int/topics/suicide/

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF MENTAL HEALTH SERVICES (OMHS)

www.mentalhealth.va.gov/suicide_prevention/

SUICIDE.ORG

SPAN USA | SUICIDE PREVENTION ACTION NETWORK USA

www.spanusa.org/

ARMY G-I SUICIDE PREVENTION

www.preventsuicide.army.mil/

NAVY SUICIDE PREVENTION

www.suicide.navy.mil/



**OKLAHOMA DEPARTMENT OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES**

www.ok.gov/odmhsas/

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