

Oklahoma State Youth Suicide Prevention Plan

For further information regarding this document, please contact the Child and Adolescent Health Division of the Oklahoma State Department of Health at (405) 271-4471.

Dedicated to the memory of Carol King, suicide survivor and advocate for
youth suicide prevention in Oklahoma

Youth Suicide Prevention Task Force

Chairs:

Jerry Nida, MD (October 1999 – June 2000)
Commissioner of Health
Oklahoma State Department of Health

Michael Fuller, M.Ed. (June 2000 – December 2000)
Licensed Professional Counselor
Licensed Marital and Family Therapist

Members:

James Allen, MPH, CHES
Child and Adolescent Health Division
Oklahoma State Department of Health

Lana Bolhouse, Ph.D.
Associate Professor of Nursing
Oklahoma Baptist University

Michael Brose, MSW
Executive Director
Mental Health Association in Tulsa

Senator Bernest Cain
Oklahoma State Senate

Melinda Campbell, MSW, LCSW
Associates in Counseling

Gordon Deckert, MD
Oklahoma State Board of Health

Julie Geddes
TEENLINE Coordinator
Oklahoma Department of Mental Health
and Substance Abuse Services

Ronny Greenberg
Suicide Awareness Coordinator
CONTACT Crisis Helpline

Representative Joan Greenwood
Oklahoma House of Representatives

Teri Haney
Shawnee, OK

Senator Enoch Kelly Haney
Oklahoma State Senate

Jan Hardwick
Director of Prevention
Oklahoma Department of Mental Health
and Substance Abuse Services

The Rev. Tom Hoffmann
Minister of Discipleship
St. Luke's United Methodist Church

Lissa James, MS
Regional Administrator
Grand Lake Mental Health Center

Carol King
Staff
Oklahoma House of Representatives

Marilyn Lanphier, RN, MPH, FSAM
Child and Adolescent Health Division
Oklahoma State Department of Health

Valerie Littlecreek
Shawnee, OK

Keith Pirtle
Oklahoma Department of Mental Health
and Substance Abuse Services

Beverly Smallwood
Coordinator of Children's Services
Oklahoma Department of Mental Health
and Substance Abuse Services

John Smith, MD
Oklahoma City, OK

Michael Snyder
Attorney at Law

Shelli Stephens-Stidham
Injury Prevention Service
Oklahoma State Department of Health

Representative Dale Wells
Oklahoma House of Representatives

Steve Nedbalek, M.Ed.
Archdiocese of Oklahoma City
St. Eugene's Catholic School

Karen Scheel, Ph.D.
Department of Psychology
University of Oklahoma

Betty Smith
Suicide Survivor
Member, Suicide Prevention Advocacy
Network (SPAN)

J.C. Smith, Ph.D.
Director of Counseling
Oklahoma State Department of Education

Representative Barbara Staggs
Oklahoma House of Representatives

Richard Sternlof, Ph.D.
Child Psychologist

Senator Kathleen Wilcox
Oklahoma State Senate

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Executive Summary

Outline of the Oklahoma State Youth Suicide Prevention Plan

I. Assessment

- a. Data collection on suicide attempts and completions
- b. Implementation of External Cause of Death Coding (E-Coding) in hospitals

II. Policy Development

- a. Media guidelines for reporting suicide attempts and completions
- b. Improved access to and coordination of mental health care services
- c. Reduce access to lethal methods for suicide attempt and completion
- d. Implement an “Adopt a Doc / Adopt a Nurse” model with a focus on mental health

III. Assurance of Services

- a. Universal Prevention
 - i. community resource coordination and development
 - ii. media education
 - iii. public education
- b. Selective Prevention
 - i. suicide intervention training program for community caregivers
 - ii. screening programs
 - iii. technical assistance to school crisis teams
- c. Indicated Prevention
 - i. support groups
 - ii. network with local counseling services
- d. Evaluation

IV. Implementation

- a. Oklahoma Youth Suicide Prevention Council
- b. Oklahoma Turning Point Council

Youth Suicide Prevention Task Force Specific Recommendations:

Assessment

- ?? The standard definitions of “suicide” and “suicide attempt” presented in this state plan be applied by all data reporting entities.
- ?? Urge all Oklahoma hospitals and minor emergency centers to utilize External Cause of Death (E-Coding) reporting practices and make E-Coding a licensing requirement.
- ?? Mechanisms for reporting suicide completions be coordinated among all reporting entities and information provided to the Oklahoma State Department of Health for statistical analysis.
- ?? The Oklahoma State Department of Health develop and implement a statewide data collection system of suicide attempts with funding from the Oklahoma State Legislature.
- ?? The Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma State Department of Health provide technical assistance to communities on using data to inform changes in service delivery and health policy.
- ?? Urge the State of Oklahoma to adopt the statewide implementation of the Youth Risk Behavior Survey in Oklahoma High Schools.

Policy Development

1. Public and Media Education regarding suicide:
 - ?? Health officials must explain the carefully, established, scientific basis for their concern about suicide contagion and how responsible reporting can reduce contagion.
 - ?? Clinicians and researchers need to acknowledge that it is not news coverage of suicide *per se* but certain types of news coverage that may promote contagion.
 - ?? Education for the media in the responsible reporting of suicides.
 - ?? Public officials need to explain the potential for suicide contagion associated with certain types of reporting and suggest ways to minimize the risk for contagion.⁹
 - ?? The guidelines developed by the Centers for Disease Control and Prevention and the American Association of Suicidology be used as an overarching framework for the development and implementation of media reporting education and training efforts. (These guidelines are found in Appendix A)
2. Increase accessibility of the health care system:
 - ?? Substantially decrease the number of uninsured individuals, particularly children and youth.
 - ?? Increase coverage for mental illnesses in both public and private sectors.
 - ?? Expand and improve public health services to the uninsured.

- ?? Urge the Oklahoma Legislature to continue to pass meaningful mental health parity laws.
 - ?? Urge the Oklahoma Legislature to adopt a resolution asking Congress to open Medical Savings Accounts (MSA) to all public and private employees to provide funds for mental health services without increasing financial burden on businesses or government.
3. Reduce access to lethal methods:
- ?? Parents take responsibility for safe handling and storage of firearms and other lethal means in the home ensuring that these items are accessible only to their owners.
 - ?? Parents, law enforcement, school personnel and community business leaders take measures to ensure that alcohol remains inaccessible to youth under the age of 21.
 - ?? The support of local and state-wide programs which provide awareness, provision and distribution of external mechanical gun safety devices.
 - ?? Legislation mandating trigger locks for all new handguns sold, offered for sale, rented or transferred in the State of Oklahoma.
4. Coordination of community – public and private – mental health centers and county health department clinics:
- ?? Community mental health centers and county health department clinics coordinate services together so that appropriate referrals can be made.
 - ?? Both public and private mental health centers coordinate with physicians and other health professionals of all disciplines and hospitals to increase identification and referral of at risk youth.
 - ?? Referral protocols be established to delineate responsible parties, action time lines and follow up responsibility.
5. Develop and implement a statewide “adopt a doctor” / “adopt a nurse” program with schools focusing on mental health.
- ?? An Adopt a Doctor/Adopt a Nurse program be implemented statewide that connects schools with mental health professionals who can provide technical assistance to schools, school counselors and parents concerning youth mental illness and suicide ideation. These programs can also promote mental health fitness along side physical fitness as a comprehensive wellness program.

Assurance of Services

- ?? Urge the Oklahoma State Department of Health and the Oklahoma Department of Mental Health and Substance Abuse Services to coordinate efforts at all levels.
- ?? The Governor and the Cabinet Secretary for Health and Human Services increase coordination among state agencies within HHS (Departments of Health, Mental Health and Substance Abuse Services, Human Services, Health Care Authority, Office of Juvenile Affairs and the Oklahoma Commission on Children and Youth).

- ?? Urge the Oklahoma Legislature to fund the implementation of a suicide intervention training program for community caregivers across the state.
- ?? Urge the Oklahoma Health Care Authority to decrease the number of those without insurance coverage for mental health services.
- ?? Urge the Oklahoma Insurance Department to address coverage for addiction and mental illness.
- ?? Urge the Oklahoma Legislature to continue to pass meaningful mental health parity laws.*
- ?? Urge the Oklahoma Legislature to adopt a resolution asking Congress to open Medical Savings Accounts (MSA) to all public and private employees to provide funds for mental health services without increasing financial burden on businesses or government.*

* Cross referenced with Policy Development

Executive Summary Narrative

This document is the result of the work of the Oklahoma Youth Suicide Prevention Task Force, created in 1999 by the passage of House Joint Resolution 1018.

More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease **combined**. During the past decade, there have also been dramatic and disturbing increases in reports of suicide among children. In Oklahoma, suicide is the third leading cause of death for youth aged 15-19.¹ In 1996, medical costs for completed and medically treated youth suicide acts for youth under 20 years old in Oklahoma totaled \$17,000,000. In that same year, the loss of future earnings (future economic productivity) for youth under 20 who successfully completed a suicide totaled \$50,000,000.² On an individual level, a 1980 U.S. study revealed that each youth suicide resulted in an average loss of 53 years of life and \$432,000 of economic productivity³.

The Oklahoma Youth Suicide Prevention State Plan works to address this problem by introducing multi-level strategies that communities can customize based on available resources and experience. At the base of this plan is the development of community infrastructure and resources for youth. Community infrastructure refers to the resources (financial, organizational, social) and the coordination of these resources that a community uses to help it address the needs of its citizens.

At the next level of this plan are specific prevention activities that communities can implement using their established resources and ambition that will help strengthen

infrastructure and provide the necessary supports and interventions that youth need to prevent a crisis or to address needs after a crisis occurs.

The final level of this plan involves crisis management and counseling services following a suicide death or attempt (postvention). This will address the needs of those directly affected by the event and reduce the likelihood that additional suicides will follow (suicide contagion). Specific components are listed in the outline below:

I. Community Infrastructure

- A) Create community awareness of the youth suicide problem, including overcoming denial and learning the myths and facts surrounding youth suicide.
- B) Organize local resources (health/mental health providers, counselors, ministers, teachers, etc.) into a network that is available to provide assistance to youth in need and who are identified through prevention activities.
- C) Build on the resources that youth have - both coping skills / problem-solving strategies within themselves and supportive surroundings within their environments. This will help them learn life-skills and give them a population of adults that care about them and take an active interest in their lives (this is something that every person in the community can take part in, regardless of background or education).

II. Prevention Activities

- A) Suicide Intervention Training for Community Caregivers

- a. Provide training for adults in suicide intervention, identifying at-risk youth, estimating risk, talking with them and referring them to appropriate local resources.
- b. Provides a community network of individuals who can serve as a safety net for youth.

B) School and Community-Based Education –

- a. Provides education for youth on the warning signs and risk factors for suicide and teaches them how and where to get help for themselves or their peers.
- b. Trains youth to tell an adult if they know of someone at risk of committing suicide.
- c. Provides education for the community regarding how to reduce suicide risk through involvement with youth and reducing access to lethal means.
- d. Provides community support for prevention activities.

C) Screening Programs

- a. Provide identification of youth at risk by testing for mental illnesses that are known to be risk factors for suicide.
- b. Provide referrals and counseling, using local resources, for youth who are identified as having high lethality (increased likelihood of carrying out suicidal ideations).

III. Postvention Activities

- A) Enhancing a school crisis team’s ability to interact with students and staff after a suicide death.
- B) School-based support groups
- C) Family support training for parents and guardians
- D) Network with local counseling services

The components identified in this state plan will be coordinated by at statewide Oklahoma Youth Suicide Prevention Council. This council will oversee the development of different stages of the state plan, and provide assistance to communities in identifying which of the plan’s activities their community is ready for and how to implement them. The council will also help communities move “up to the next level” of suicide prevention so that they can build on what they have put into place.

The Council will work with the Oklahoma Turning Point Council, an existing initiative that is focused on the development of public health infrastructure in Oklahoma communities. Partnering with Turning Point will assist the Youth Suicide Prevention Council in assuring that communities are able to assemble the resources they need in order to implement suicide prevention activities and address the needs of their youth.

Oklahoma State Youth Suicide Prevention Plan - Narrative

Introduction

More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease *combined*. During the past decade, there have also been dramatic and disturbing increases in reports of suicide among children. In Oklahoma, suicide is the third leading cause of death for youth aged 15-19.¹ In 1996, medical costs for completed and medically treated youth suicide acts for youth under 20 years old totaled \$17,000,000. In that same year, the loss of future earnings (future economic productivity) for youth under 20 who successfully completed a suicide totaled \$50,000,000.²

According to the Office of the Chief Medical Examiner's 1999 Annual Report, 85 individuals under age 25 committed suicide that year, 6 of those being under 15 years of age.

The *Surgeon General's Call to Action*, issued in 1999, introduces an initial blueprint for reducing suicide and the associated toll that mental and substance abuse disorders take in the United States. As both evidence-based and highly prioritized by leading experts, the 15 key recommendations listed below serve as a guide for the Oklahoma State Plan. The recommendations are categorized as **Awareness, Intervention, and Methodology**, or **AIM**.

Awareness: Appropriately 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

Awareness: Appropriately broaden the public’s awareness of suicide and its risk factors

- ?? Promote public awareness that suicide is a public health problem and, as such, many suicides are preventable. Use information technology appropriately to make facts about suicide and its risk factors and prevention approaches available to the public and to health care providers.
- ?? Expand awareness of and enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment.
- ?? Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeking help for such problems.

Intervention: Enhance services and programs, both population-based and clinical care

- ?? Extend collaboration with and among public and private sectors to complete a **National Strategy for Suicide Prevention**.
- ?? Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate.
- ?? Eliminate barriers in public and private insurance programs for provision of quality mental and substance abuse disorder treatments and create incentives to treat patients with coexisting mental and substance abuse disorders.
- ?? Institute training for all health, mental health, substance abuse and human service professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions.
- ?? Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to, and refer people showing signs of suicide risk and associated mental and substance abuse disorders. Natural community helpers are people such as educators, coaches, hairdressers, and faith leaders, among others.
- ?? Develop and implement safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention and incorporate peer support for seeking help.
- ?? Enhance community care resources by increasing the use of schools and workplaces as access and referral points for mental and physical health services and substance abuse treatment programs and provide support for persons who survive the suicide of someone close to them.

- ?? Promote a public/private collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of suicide and its associated risk factors including mental illness and substance abuse disorders and approaches to prevention and treatment.

Methodology: Advance the science of suicide prevention

- ?? Enhance research to understand risk and protective factors related to suicide, their interaction, and their effects on suicide and suicidal behaviors. Additionally, increase research on effective suicide prevention programs, clinical treatments for suicidal individuals, and culture-specific interventions.
- ?? Develop additional scientific strategies for evaluating suicide prevention interventions and ensure that evaluation components are included in all suicide prevention programs.
- ?? Establish mechanisms for federal, regional, and state interagency public health collaboration toward improving monitoring systems for suicide and suicidal behaviors and develop and promote standard terminology in these systems.
- ?? Encourage the development and evaluation of new prevention technologies, including firearm safety measures, to reduce easy access to lethal means of suicide.

Framework for Youth Suicide Prevention -

It is the purpose of this state plan to identify the various factors associated with youth suicide and to provide strategies for communities to address this significant public health issue. This state plan is structured around the core public health functions of assessment, policy development and assurance of services as it applies recommendations from the Surgeon General's Call to Action as well as the recommendations made by the members of the Youth Suicide Prevention Task Force.

Because various communities across Oklahoma will be at different levels of readiness and capacity for the implementation of a youth suicide prevention program, this plan is written in such a way as to provide a mechanism for determining which of the components to be described the community will be able to implement at a given point in time. There are no "magic bullets" in suicide prevention, and there is a wide variation

among the communities that make up our state. Thus, different forms of prevention strategies will be presented. Definitions for the terminology used throughout this plan are given below:

?? **Youth:** Individuals between the ages of 10 and 24. This category is classified into the following subgroups:

Early Adolescence (10-14 years)

Late Adolescence (15-19 years)

Older Youth/Young Adults (20-24 years)

?? **Suicide:** a) Voluntary and intentional taking of one's own life.
b) A conscious intent of self-destructive action that ends in death. (Youth Suicide Prevention Association, 1992)

?? **Suicide Attempt:** a) Voluntary and intentional injury to one's own body with the goal of ending one's own life.
b) Engaging in a self-destructive act that one believes will cause death. (Youth Suicide Prevention Association, 1992)

?? **Assessment:** The systematic collection on injury-related data from a statewide level that provides information regarding youth suicide trends and implications for prevention.

?? **Assurance of Services:** The provision of services, implementation of programs and development of supports that increase the capacity of communities to address the youth suicide problem.

?? **Policy Development:** The development of policy that is supportive of community and statewide efforts to reduce youth suicide and enhance their effectiveness.

?? **Universal Prevention:** Prevention efforts that target and benefit the state population as a whole by providing needed information and education.

?? **Selective Prevention:** Prevention efforts that target and benefit specific high-risk groups by providing more intensive programs and services.

?? **Indicated Prevention:** Prevention efforts that target and benefit identified high-risk individuals who may be in immediate danger of attempting suicide.

Assessment

ASSESSMENT

Introduction –

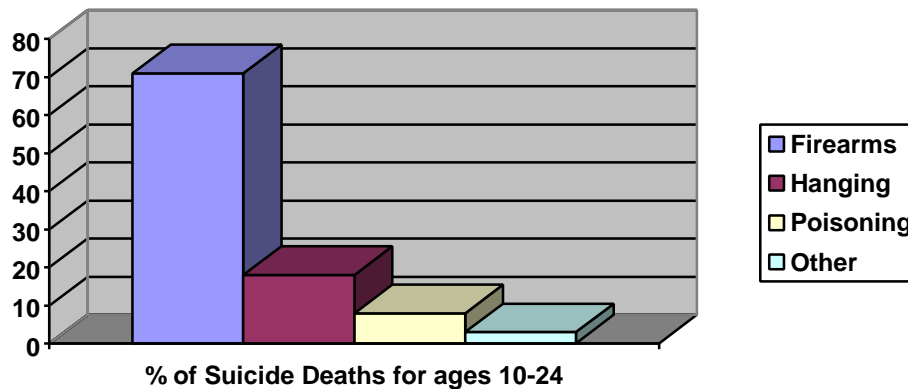
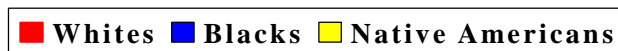
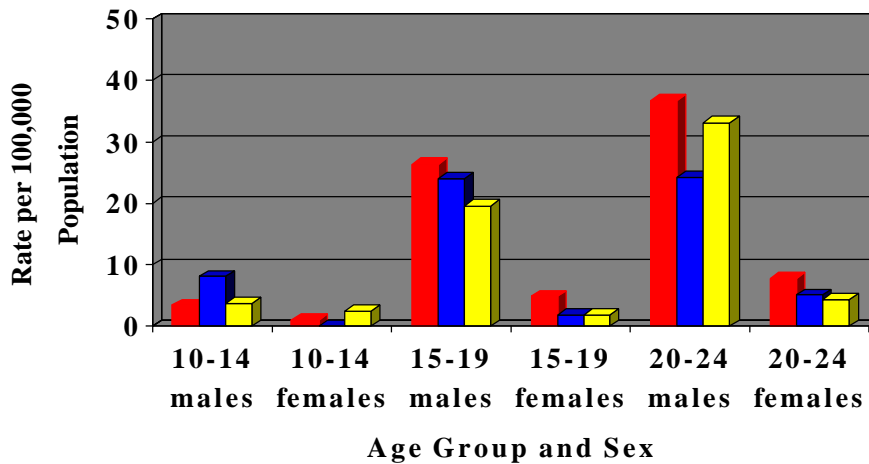
The foundation of a solid statewide prevention plan is quality data. The successful assessment of the youth suicide problem, as well as the effective planning, implementation and evaluation of a state plan, requires that a sound system of data collection be in place. Data is needed to assess how many suicides and suicide attempts are occurring among young people in the state. This will provide the ability to determine a baseline and thus, determine what effects this state plan has had. This will also help determine priority areas for prevention efforts in the state.

Suicide in Oklahoma –

According to Oklahoma State Department of Health Vital Statistics data, 846 Oklahoma youth 10-24 years of age committed suicide from 1989 to 1998, for an average of 85 suicide deaths each year.

The average annual rate for males (21.2/100,000 population) in Oklahoma was more than 5 times greater than the rate for females (4.1/100,000 population). The rate for whites (13.4/100,000 population) was more than the rate for blacks (10.8/100,000 population) and Native Americans (10.2/100,000 population). The age specific incidence rate was highest for white and Native American males 20-24 years of age (36.8/100,000 population and 33.1/100,000 population, respectively) (Figure 1). Suicide rates varied by county of residence with Woodward, Roger Mills, Blaine, Jefferson, Marshall, Haskell, and Delaware counties having rates 68% above the state rate.

Figure 1. Incidence Rate of Youth Suicide by Age Group, Sex, and Race, Oklahoma, 1989-1998



Methods for completing suicide among persons 10-24 years of age included firearms (71%), hanging/strangulation (18%), poisoning (8%), and other methods (3%). Firearms were the leading cause of suicide for both males and females and among all ages. However, youth 10-14 years were more likely to use hanging/strangulation (32%)

than persons 15-24 years (18%). Additionally, females were more likely to use poisoning as a means of completing suicide (18%) than males (6%).

According to State Medical Examiner data from 1989 through 1998, 86% of suicide victims 15 years of age and older were tested for blood alcohol. Of those tested, 32.5% had detectable levels of blood alcohol. Thirty-four percent of males had a positive blood alcohol concentration (BAC) compared to 24% of females. More than half of Native Americans (51%) had a positive BAC compared to 32% of whites and 20% of blacks.

Nationally, from 1980 to 1996, the rate of suicide among persons ages 15-19 years increased by 14%. Among persons ages 10-14, the rate increased by 100%. For African American males aged 15-19, the rate increased by 105%.²

Barriers and Limitations to Current Data Collection -

No Suicide/Attempt Data Collection System Currently in Oklahoma

Suicide is an important public health problem in the United States and Oklahoma, yet the public health database for suicide is limited in accuracy and reliability.

Information about suicide *attempts* is sketchy and incomplete because there is no national or state system of data collection to determine the number of suicide attempts. Suicide statistics based on death certificate data may not convey the true problem. In a survey of medical examiners, most thought the reported number of suicide deaths is probably less than the actual number.^{4,5} Some medical examiners may be pressured by family and friends of the victim not to record a death as suicide to avoid stigmatizing themselves or the victim. Suicide deaths may also be underreported because some suicide deaths are

never recorded;⁶ it is suspected that many single motor vehicle crashes may be suicide deaths.⁷

It is imperative that accurate, timely, and valid data on suicide and suicide attempts be available. The ability to identify specific areas or populations at risk, or to conduct an evaluation of the state's suicide prevention efforts, is dependent on having a sound data collection system. Any data collection system for these events needs to define a suicide and suicide attempt so that reporting is uniform. In 1989, the Report of the Secretary's Task Force on Youth Suicide recommended: 1) training programs for Coroners, Medical Examiners, and other officials whose judgment can affect the classification of a death by suicide; 2) the creation of a uniform definition of suicide (the definition adopted and proposed by this Task Force is as follows: Voluntary and intentional taking of one's own life, and a conscious intent of self-destructive action that ends in death); and 3) the development of a community-based data collection system for suicide attempts.

In 1992, the Oklahoma State Department of Health in the *Oklahoma State Strategic Plan for Injury Prevention and Control* recommended that a statewide data collection system for suicide and suicide attempts be established, and that funding be obtained to train Medical Examiners and other officials who are involved in the classification of a death by suicide.

Lack of E-Coding Among Hospitals

As stated above, one of the keys to an effective injury prevention program is a clear understanding of the injury problem. While medical and emergency medical services data can provide information about the injuries, information about the causes and

circumstances is often missing. E-codes are a supplemental code for use with the International Classification of Diseases (ICD). These four-digit codes provide a systematic way to classify diagnostic information that has been entered into the medical record. They are standardized internationally; allow consistent comparisons of data among communities, states, and countries; and are easily used in computerized data systems. E-codes in medical records enable health researchers and other healthcare officials to analyze the incidence, cost, and sociodemographic patterns of various types of injuries. If E-codes are included in hospital records, the medical and financial consequences of injuries can be examined. However, in 1999 only 39% of hospitals in Oklahoma use E-codes. This task force recommends that a statewide data collection system of suicide attempts be created within the Department of Health which utilizes E-coding data and data from the Youth Risk Behavior Survey (see below). An epidemiologist position would be required in order to coordinate the statewide data collection system, as current resources within the Department are not sufficient.

Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is an instrument developed by the Centers for Disease Control and Prevention that measures health risk behaviors established during youth that result in the most significant morbidity and mortality during both youth and adulthood. The six categories of the survey are: 1. Intentional and unintentional injury (including suicide ideation and attempts) 2. Tobacco use 3. Alcohol and other drug use 4. Sexual activity that can result in HIV infection, other STD's and unintended pregnancies 5. Dietary behaviors and 6. Physical activity.

The survey is supported by the American Association of School Administrators, the American Medical Association, the National Association of State Boards of Education, the National School Boards Association, the Association of State and Territorial Directors of Health Promotion and Public Health Education, the American School Health Association, and others.

In states that conduct the survey on a statewide level, high schools are randomly selected for participation in the survey (conducted every 2 years). Parental permission is obtained in accordance with the policies and procedures of each school district, and copies of the survey are made available to parents to preview if requested. The survey is anonymous, meaning that students do not use their name or any type of identifier. The survey is also voluntary, meaning that no student is required to participate, and students may also refuse to answer any of the questions. In addition, no individual school's data is released without the school's consent. Only statewide data is reported.

The YRBS asks questions regarding feelings of depression / hopelessness, suicide ideation, and attempt behavior. By collecting this information at a statewide level, in a scientifically randomized fashion, statewide data regarding suicide attempts could be obtained on a regular basis at no cost to communities and minimal cost to the state. Cost effectiveness and amount of useful data obtained make the YRBS a highly recommended option.

Oklahoma is one of only 16 states that have not participated in the YRBS on a statewide level. At present, individual schools contact Department of Health for implementation of the survey. Because this present setup is not a randomized selection of schools, statewide data regarding suicide ideation and attempts cannot be obtained.

Therefore, this task force urges that the State of Oklahoma adopt the statewide implementation of the Youth Risk Behavior Survey in Oklahoma high schools.

Summary of Assessment Recommendations –

This Task Force recommends the following:

- ?? The standard definitions of “suicide” and “suicide attempt” presented in this state plan are applied by all data reporting entities.
- ?? Urge all Oklahoma hospitals and minor emergency centers to utilize External Cause of Death (E-Coding) reporting practices and make E-Coding a licensing requirement.
- ?? Mechanisms for reporting suicide completions be coordinated among all reporting entities and information provided to the Oklahoma State Department of Health for statistical analysis.
- ?? The Oklahoma State Department of Health develop and implement a statewide data collection system of suicide attempts with funding from the Oklahoma State Legislature.
- ?? The Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma State Department of Health provide technical assistance to communities on using data to inform changes in service delivery and health policy.
- ?? Urge the State of Oklahoma to adopt the statewide implementation of the Youth Risk Behavior Survey in Oklahoma High Schools.

Policy Development

POLICY DEVELOPMENT

1. Public and Media Education regarding suicide.

Fact: Suicide contagion among youth is a major concern. There are several aspects of news coverage that can promote this contagion, including:⁸

1. Presenting simplistic explanations for suicide.
2. Engaging in repetitive, ongoing, or excessive reporting of suicide in the news.
3. Providing sensational coverage of suicide.
4. Reporting a “how-to” description of suicide.
5. Presenting suicide as a tool for accomplishing certain ends.
6. Glorifying suicide or persons who commit suicide.
7. Focusing on the suicide completer’s positive characteristics and ignoring the problems.

Therefore, we recommend:

- ?? Health officials must explain the carefully, established, scientific basis for their concern about suicide contagion and how responsible reporting can reduce contagion.
- ?? Clinicians and researchers need to acknowledge that it is not news coverage of suicide *per se* but certain types of news coverage that may promote contagion.
- ?? Education for the media in the responsible reporting of suicides.
- ?? Public officials need to explain the potential for suicide contagion associated with certain types of reporting and suggest ways to minimize the risk for contagion.⁹
- ?? The guidelines developed by the Centers for Disease Control and Prevention and the American Association of Suicidology be used as an overarching framework for the development and implementation of media reporting education and training efforts. (These guidelines are found in Appendix A)

2. Increase accessibility of the health care system.

Fact: 90% of those who commit or attempt suicide have a diagnosable mental illness.¹⁰

Therefore, we recommend:

- ?? Substantially decrease the number of uninsured individuals, particularly children and youth.
- ?? Increase coverage for mental illnesses in both public and private sectors.

- ?? Expand and improve public health services to the uninsured.
- ?? Urge the Oklahoma Legislature to continue to pass meaningful mental health parity laws.
- ?? Urge the Oklahoma Legislature to adopt a resolution asking Congress to open Medical Savings Accounts (MSA) to all public and private employees to provide funds for mental health services without increasing financial burden on businesses or government.

3. Reduce access to lethal methods.

Fact: Choice of method for suicide is based on access, knowledge and familiarity.¹¹

Fact: Firearms are the most common method of suicide among youth.⁹

Fact: 55 of the 85 suicides in 1999 among youth and young adults aged 25 and under in Oklahoma were committed using a firearm.¹²

Fact: There is a positive association between the accessibility and availability of firearms in the home and the risk for youth suicide.¹³

Fact: Among homes with both children and firearms, 43% had at least 1 unlocked firearm.¹⁴

Fact: Drinking alcohol increases the impulsive nature of adolescents. When this is coupled with easy access to firearms, the risk of suicide increases dramatically.¹⁵

Therefore, we recommend:

- ?? Parents take responsibility for safe handling and storage of firearms and other lethal means in the home ensuring that these items are accessible only to their owners.
- ?? Parents, law enforcement, school personnel and community business leaders take measures to ensure that alcohol remains inaccessible to youth under the age of 21.
- ?? The support of local and state-wide programs which provide awareness, provision and distribution of external mechanical gun safety devices.
- ?? Legislation mandating trigger locks for all new handguns sold, offered for sale, rented or transferred in the State of Oklahoma.

4. Coordination of community - public and private - mental health centers and county health department clinics.

Fact: 1/3 of those who commit suicide visit a physician in the week before they die. 1/2 of those who commit suicide visit a physician in the month before they die.¹⁶

Therefore, we recommend:

- ?? Community mental health centers and county health department clinics coordinate services together so that appropriate referrals can be made.
- ?? Both public and private mental health centers coordinate with physicians and other health professionals of all disciplines and hospitals to increase identification and referral of at risk youth.
- ?? Referral protocols be established to delineate responsible parties, action time lines and follow up responsibility.

5. Develop and implement a statewide “adopt a doctor”/”adopt a nurse” program with schools focusing on mental health.

Fact: The Schools for Healthy Lifestyles program has been evaluated as a successful model for connecting schools with health care providers.¹⁷

Fact: Most schools are not equipped to address mental health issues in and of themselves, nor is that their primary mission. Many schools are already overburdened with other issues concerning students.

Therefore, we recommend:

- ?? An Adopt a Doctor/Adopt a Nurse program be implemented statewide that connects schools with mental health professionals who can provide technical assistance to schools, school counselors and parents concerning youth mental illness and suicide ideation. These programs can also promote mental health fitness along side physical fitness as a comprehensive wellness program.

Assurance of Services

Assurance of Services

Assurance of Services consists of three components: Universal Prevention, Selective Prevention and Indicated Prevention. This prevention model was first proposed by Gordon in *An Operational Classification of Disease Prevention*.¹⁸ and was adopted by the Institute of Medicine (IOM)¹⁹. The Youth Suicide Prevention Plan for Washington State, one of the first states to develop a statewide plan, has utilized this framework successfully for their prevention strategies.

Universal Prevention

Universal prevention includes prevention efforts that target and benefit the state population as a whole by providing needed information, resources and education. The components within the Universal Prevention Framework include building community infrastructure, building supportive structures for youth, public education, school-based education, means restriction education, media reporting guidelines and school crisis team training.

Build Community Infrastructure and Assets for Youth

The goal of a problem-focused approach to suicide is to reduce or control risky behavior through prevention or intervention strategies. This approach is indeed very important in reducing and preventing youth suicide. Another approach that must be a focus is that of challenging communities to tap the caring, creative energies of families,

neighborhoods, schools, congregations, workplaces, youth organizations and groups of people to transform communities into united, healthy environments committed to youth. It is identifying what young people need to navigate successfully through infancy, childhood and adolescence to become productive, happy adults. This approach is identified by a number of terms: resiliency, behavioral assets, and promoting healthy families and youth.

Some people like to think of this approach as being like a set of "inoculations" that protect against illnesses. Assets pump up a young person's natural ability to tackle the risks and challenges to his or her well-being. Of course, just as booster shots are needed to preserve the benefits and staying power of inoculations, it's essential to keep on building assets to keep children and youth healthy. Assets infuse youth with the power to be resilient, competent, and responsible. An asset-building community, parents, schools, businesses, organizations, youth workers, and neighbors all work together to provide kids with a safe and supportive environment.

Both internal and external factors are necessary for youth to achieve this healthy state. Internal assets are those characteristics that youth obtain to assist them in making positive choices in their lives. These include developing a commitment to learning, having positive values, social competencies, and obtaining a positive identity. External factors refer to the positive developmental environments and experiences that surround young people. These assets accumulate through formal and informal interactions with parents and other caring adults, neighbors, educators, congregations, co-workers and peers. Examples of these factors are support, empowerment, boundaries and expectations, and constructive use of time.

Young people need:

- ?? to experience support, care and love from their families and many others
- ?? to be valued by their community
- ?? opportunities to contribute to others
- ?? need to be safe and feel secure
- ?? to know what is expected of them
- ?? constructive, enriching opportunities for growth
- ?? to develop a lifelong commitment to education and learning
- ?? to develop strong values that guide their choices
- ?? skills and competencies that equip them to make positive choices, to build relationships
- ?? skills to succeed in life
- ?? a strong sense of their own power, purpose, worth and promise.

See Appendix C for specific things that communities and individuals can do for youth that will assist in developing their assets.

Build Supportive Structures for Youth – *(based on recommendations from the National Adolescent Health Information Center, University of California, San Francisco²⁰)*

1. *Build strong public support for investment in youth.*

- ?? Educate policymakers about youth issues by providing information, encouraging legislators and agency heads to meet with youth in their own communities, and conducting youth focus groups.
- ?? Increase public understanding of and support for teens.
 - Work at the community level (through faith-based organizations, businesses, and organizations of older adults such as the AARP) to bridge the gap between youth and older generations.

- Educate community members about the needs of youth, the contributions they can make to the community, and ways that communities can better support teens.

?? Use the media to promote balanced images of youth.

- Present images of family and community that include adolescents.
- Encourage media outlets to form youth advisory councils
- Create media awards and/or report cards for coverage of youth issues.

2. *Involve youth in the policy process.*

?? Provide youth with the skills needed to influence policy by training youth in leadership, policy advocacy and media.

?? Create opportunities for youth to shape policy.

- Include youth on boards and commissions at the state and local levels.
- Engage youth in asset mapping projects in their communities to identify community resources and needs from a youth perspective.
- Requiring and funding grantees to involve youth in program planning for state and foundation initiatives.

3. *Ensure access to comprehensive, youth-friendly health services.*

?? Ensure an adequate supply of services and providers.

- Establish parity between mental and physical health services.

- Increase the availability of inpatient services for youth who have a combination of medical and mental health disorders.
- Provide adequate capitation rates to cover preventive services.

4. *Create communities that offer youth positive life options.*

- ?? Expand community opportunities for teens by promoting activities for youth during non-school hours, community service and service learning, internships for youth within city and county departments, and incentives for employers to employ school-age youth.
- ?? Create positive social connections for youth by expanding mentoring programs, developing peer-to-peer mentoring, and fostering mutual understanding between teens and other community sectors.
- ?? Create community conditions that promote safe, healthy choices.
 - Facilitate community asset mapping and planning.
 - Build social networks.
 - Create channels for information dissemination.
 - Decrease youth access to firearms and alcohol/drugs.
 - Increase transportation safety and opportunities for healthy eating and physical activity.
- ?? Improve the ability of adults in the community to work with and support teens.
 - Provide professionals, parents and other adults with information, training and referral protocols to help them

identify and handle issues that affect adolescent health and development.

?? Increase the connection between schools and community by promoting the use of school facilities for youth and community activities during non-school hours and increasing parent and community involvement in schools.

Public Education -

State-wide public education campaign to help the general public and parents of youth:

- ?? Become aware of the increasing problem of youth suicide and suicidal behaviors.
- ?? Remove the stigma associated with mental illness in youth.
- ?? Recognize the common warning signs of suicidal thoughts and intent.
- ?? Learn how to respond to youth who exhibit warning signs.
- ?? Know when and where to go for accurate assessments and professional help.
- ?? Utilize “town meetings”, or focus groups, to understand the needs of each community setting.

The public education campaigns will be implemented using donated air time on local television and radio, as well as local print media. This coverage will be in addition

to public service announcements that are also run using these media. The material for these educational campaign messages will be developed and provided by the Oklahoma Youth Suicide Prevention Advisory Council (to be discussed at the close of the Assurance of Services Section) using research-based messages and material from organizations such as the American Association of Suicidology, the Suicide Prevention Advocacy Network and the Office of the Surgeon General.

School-Based Education -

Educational programs in schools and universities that serve youth aged 10-24.

- ?? Complement the public education campaign to achieve the same objectives.
- ?? Teach young people the warning signs of suicidal intent, how to respond, and how/where to get help for friends who exhibit these signs.
- ?? Educate school faculty and staff of warning signs and instruct them on how to access services.
- ?? Create awareness of local training opportunities that will further enhance skill in recognizing and addressing suicidal youth.

These educational services will be provided through materials developed as a part of the public education campaign, as well as through school-based suicide prevention programs developed and implemented by local suicide prevention organizations. Student

Development Centers will house these efforts in the university setting, and will work through Resident Advisors in dormitories, house parents in fraternities and sororities and through health clinics located on college campuses. It is key that school-based educational programs emphasize the availability of resources and how/when to access them. Evaluated curricula are also available that help at-risk youth improve their school achievement, reduce drug involvement and decrease their depression, aggression and suicidal behaviors. The coordination of educational services (including materials and providers) will occur through the Oklahoma Youth Suicide Prevention Council.

Means Restriction Education -

Statewide public educational campaign to reduce access to firearms and other lethal means of suicide, particularly in homes where a suicidal young person resides.

These educational messages will:

- ?? Focus on firearm safety and responsible use and storage of guns.
- ?? Promote the use of gun locks to prevent access by suicidal youth.
- ?? Utilize firearm safety educational materials developed by the National Rifle Association, the American Academy of Pediatrics, the Maternal and Child Health Bureau, Oklahoma Safe and Drug Free Schools, the Oklahoma SAFEKIDS Coalition and others (resource listings are provided in appendix B). Directories of local community resources within Oklahoma will be developed through the Oklahoma State Youth Suicide Prevention Council.

As with the Youth Suicide Public Awareness Campaign, this campaign will be implemented using donated airtime on local television and radio, as well as local print media. This coverage will be in addition to public service announcements that are also run using these media. Materials will be coordinated and provided to media outlets by the Oklahoma Youth Suicide Prevention Council.

Media Reporting Guidelines -

Training of media personnel in reporting practices as outlined in the media guidelines published by the American Association of Suicidology. A complete list of these guidelines is provided in appendix A. Policy statements regarding media reporting guidelines are discussed in the policy development section of this document. Training and technical assistance will be provided to media personnel by local suicide prevention/mental health professionals and organizations coordinated by the Oklahoma Youth Suicide Prevention Council.

School Crisis Team Training -

Technical assistance regarding youth suicide prevention provided to Oklahoma's existing school crisis teams.

?? These teams are already in existence in Oklahoma's Public Schools.

?? These teams will receive the above mentioned education regarding the identification of suicidal warning signs in youth and how to respond.

?? School crisis team trainings will enhance school crisis teams with training in dealing with the aftermath of a death of a student. This will address prevention of the suicide contagion effect, which is characterized by an increase in incidence of suicidal risk, ideation or behavior as the result of a suicide.

?? Trainings will also enable crisis teams to take a preventive approach by being able to identify students who may be at risk and identifying any issues that the student body may be facing as a group. A model program, funded by the Substance Abuse and Mental Health Services Administration, is currently being pilot tested in two Oklahoma schools.

Selective Prevention

Selective prevention includes prevention efforts that target and benefit specific high-risk groups by providing more intensive programs and services. The components within the Selective Prevention Framework include First Response training, Community and State Resource Networks, and Screening Programs.

I. Suicide Intervention Program for Community Caregivers -

?? Will provide adults who work with high-risk populations with up-to-date scientific knowledge about effective estimation of at-risk behaviors, warning signs and ideations.

- ?? Will increase skills in assisting youth to use help-seeking behaviors with parents, other adults in their social network and in promoting appropriate use of the health and mental health care system.
- ?? Will increase competencies in post-suicide interventions to prevent further suicides due to the contagion effect.
- ?? A similar component has been used in Washington State, Canada, and Australia. Recommended as the best approach for community-based prevention initiatives.

Suicide Intervention Training Program for Community Caregivers Implementation Strategy:

1. Funding will be provided for a training for trainers course component for those candidates selected to participate as trainers in the Suicide Intervention Training Program for Community Caregivers.
2. Participants - Workshop participants can include counselors, teachers and ministers; workers in health, welfare or justice; community volunteers; emergency service workers; mental health professionals. This includes professionals, para-professionals and lay people who come in contact with youth in front line positions.
3. Training for trainers course – This is typically a 5-day workshop that will be implemented in two stages: training 24 potential trainers, followed by another 24 trainers within 6-12 months. A minimum of two trainers from the same community or region will be working together as a team to present the Suicide Workshop for Community Caregivers.
4. An application process for candidacy to attend the training for trainers will be established. Contracts will be signed by those candidates selected to attend the training that they are obligated to hold a minimum of 3-6 workshops in their designated areas. Failure to complete the required number of workshops would result in the trainer having to reimburse the training fee (estimated at \$1,500) for attending the training for trainers.
5. Workshop Materials - Workbooks, certificates, handbook, etc. will be provided free for trainers through a central location such as the Department of Health or the Youth Suicide Prevention Council. Videos

used with the training will be available for checking out for workshop training purposes. Minimal fees (estimated at \$35) will be charged for the initial 3-6 required workshops. These funds will help pay for the required workshop materials and expenses.

6. Regional Areas - The state will be divided into regional areas with two trainers per area in order to not duplicate efforts in conducting workshops.
7. Cost Containment - After completion of all required free workshops, the cost will be kept low (estimated at \$65 per person for the two-day workshop) in order to encourage continued participation in the suicide workshop for as many persons as possible throughout the state.
8. Networking for trainers - Skill building, networking and support for trainers will be provided through a half-day summer program. This session will also include questions and answers along with role-plays for the trainers in order to maintain their skill levels.
9. Selection of the Suicide Training Program for Community Caregivers will need to have the following components:
 - a. Program in existence for at least 5-10 years;
 - b. Strong master trainers experienced at least 5 years in conducting training for trainers 5-day workshops;
 - c. On-going research/evaluation component of at least 5-10 years.

II. *Screening Programs* –

?? Identify mental illness in youth that are associated with suicide ideation.

?? Identify youth who are currently contemplating suicide or who have made a suicide plan or who have attempted suicide.

?? Refer identified at-risk youth to local professional services or provide services on-site if warranted.

Moving along the continuum from breadth to depth, screening programs provide a very focused, more intensive prevention strategy. The number of youth served by a screening program is relatively small, but the screen will provide a comprehensive check and detailed breakdown of suicide potential in those served. Screening programs will be offered to schools that request the service. A limited number of pilot sites will be involved initially, with the number of schools with the screening program increasing each year. In addition to schools volunteering to participate, permission would be obtained from both parents and youth before any screening instrument is given. A pilot screening program currently exists in the state, which could serve as a model.

Education concerning the screenings and logistics for implementation will be coordinated by the Oklahoma Youth Suicide Prevention Council through local resources. A key to the screening component, as with the others, is the coordination and participation of local community resources. Referrals will be made through the screening program based on screen results, and communities must be prepared to address the needs of those referred.

Funding for the screening software and equipment will be provided by the universities that develop the instruments as a means of replicating their programs, and through grant funding. Parental and student permission will be obtained for all students utilizing the screening instruments.

III. Development of Community Infrastructure for Addressing Youth in Need –

- ?? Will provide the resources necessary to address the needs of youth who are identified either through Community Caregivers, School and Community Crisis Teams or Screening Instruments.
- ?? Disseminate a comprehensive and customized community directory of resources and services to schools, churches, health care providers, community organizations, etc. The statewide directory will be compiled and disseminated by the Oklahoma Youth Suicide Prevention Council, and the council will provide technical assistance to communities in developing their own local versions.
- ?? Provide assistance to communities in mobilizing resources and creating community capacity to address the youth suicide issue.
- ?? Provide assistance to communities in creating community crisis teams, which will work in conjunction with school crisis teams.

Indicated Prevention

Indicated Prevention - Prevention efforts that target and benefit identified high-risk individuals who may be in immediate danger of attempting suicide.

Components within the Indicated Prevention framework are school-based skill and support groups, family support training and counseling services.

1. *High school and college based support / skill groups will:*

- ?? Utilize interactive educational small groups to enhance the amount and quality of social support for high-risk youth.

?? Provide support group opportunities for high-risk youth, identified through school staff (teachers, school counselors, school nurses, or other staff members), self-referred or referred by parents/guardians in which youth will:

- Learn and practice life skills for reducing suicide risk factors and enhancing protective factors.
- Increase network of support people and other resources in their lives.
- Learn about available resources and their accessibility.
- Develop self-management skills for reducing alcohol and drug use.
- Develop and implement life skills including depression and anger management, interpersonal communication, decision making, coping skills and other skills useful in building resiliency in youth.

2. Family support training for parents and guardians will enable them to:

- ?? Encourage participation in prevention efforts with their sons/daughters.
- ?? Better assist their at-risk sons'/daughters' progress toward success by remaining supportive and involved with them.
- ?? Link youth to additional sources of support.
- ?? Recognize early warning signs of suicidal ideation and know how to respond through participation in First Response Trainings.

3. *Counseling services will reduce contagion effects by:*

- ?? Providing an outlet for youth to express their reactions to a youth suicide.
- ?? Linking youth close to the victim to local resources that are ready to assist the youth and the school.
- ?? Providing positive mechanisms through which to work out the grief process.

4. *Counseling services will reduce youth suicides by:*

- ?? Addressing immediate safety needs of youth diagnosed as very high risk by screening programs and identified by first responders.
- ?? Assessing the lethality of youth identified by the aforementioned mechanisms.
- ?? Maintaining a working relationship with schools and colleges to keep them up to date on how to respond to crisis situations or to youth who have been receiving treatment for potentially violent tendencies or suicide ideation.

State Plan Implementation

The state youth suicide prevention plan will be implemented through two mechanisms working in partnership with one another: 1. The Oklahoma Youth Suicide Prevention Council and 2. The Oklahoma Turning Point Council.

Oklahoma Youth Suicide Prevention Council –

The coordination and implementation of the components of the Oklahoma State Plan for Youth Suicide Prevention will be provided by the Oklahoma Youth Suicide Prevention Council. This council will be composed of representatives from the Departments of Health, Mental Health and Substance Abuse, Education, Human Services, Juvenile Justice as well as school teachers, school counselors, Parent-Teacher Association members, mental health professionals, suicide survivors and community representatives from six state regions: Northwest, Southwest, Southeast, Northeast, Oklahoma City and Tulsa metropolitan areas. The Council will be chaired by a full time coordinator. The specific duties of the Council will be to:

- ?? Provide technical assistance to communities in the development and coordination of local resources and building community capacity to address the issue of youth suicide.
- ?? Coordinate first response trainings statewide.
- ?? Coordinate screening programs statewide.
- ?? Provide technical assistance to school and community crisis teams specific to best practices in youth suicide prevention.

- ?? Monitor the implementation of the various state plan components.
- ?? Coordinate the evaluation of the state plan components.
- ?? Promote the state plan in Oklahoma and serve as a resource to other states.

A subcommittee composed of youth will advise the Council on a regular basis. The council will meet once a month in addition to any meetings that are needed to address specific issues. Additional subcommittees may be formed based on the current needs of the state and current needs of communities in implementing the state plan.

Oklahoma Turning Point Council

The Oklahoma Turning Point initiative, funded by the Robert Wood Johnson Foundation and the Kellogg Foundation, is a partnership between communities and policy makers. It recognizes that true, sustainable change in local health systems can only come from the people who represent their communities. Interventions to improve health status, such as this state youth suicide prevention plan, will have to be initiated one step at a time by local communities, neighborhoods and families. Because the basic foundation of this state plan is the development of local community infrastructure, the Oklahoma Turning Point Council is a good fit.

Currently, Oklahoma county Turning Point Initiatives are found in Texas, Tulsa and Cherokee counties. Seven additional counties are currently in the process of joining these first three. The goal of the Turning Point Initiative is to have Turning Point Initiatives in each of Oklahoma's 77 counties within four years. This would provide a mechanism in which the state plan could be implemented in all 77 counties. Areas of the

state that do not currently have Turning Point Initiatives in place will be served by the Youth Suicide Prevention Council representatives in those areas. Technical assistance can be provided to these counties as well by neighboring county Turning Point Initiatives. The State Youth Suicide Prevention Council will serve as an ad-hoc committee on the Oklahoma Turning Point Council, providing a link between the two groups.

Existing Community Partners:

The Oklahoma Department of Mental Health and Substance Abuse Services administers 18 Area Prevention Resource Centers (APRC) across the state. These centers focus on specific catchment areas and address the development of life-skills in youth. The activities of the APRCs are a natural fit to the infrastructure development efforts of the state plan and the development of protective factors in youth.

69 of Oklahoma's 77 counties have local health departments that serve youth and can act as a resource in referring youth and families to other local services. Trainings could be provided to health department staff (public health nursing, child guidance) to assist in this coordination process.

CONTACT Crisis Helpline, TEENLINE and SAFECALL are statewide and local hotlines that are available to youth and can play a role in the coordination and implementation of the various components of this state plan as well. Coordination and collaboration can also take place with two local youth suicide prevention coalitions that exist in the Oklahoma City and Tulsa metropolitan areas.

Evaluation - Evaluation is critical in determining what components of a project or plan are working correctly and which ones are not. It provides information on how and why particular program components are performing the way they are, and if a project is successful, evaluation can determine which program components are responsible for that success (the same can apply to program components that are holding a project back). Program evaluation also provides the information used in developing strategies to improve program components.

There are three primary types of program evaluation: Process, Impact and Outcome. *Process evaluation* is designed to document the degree to which program procedures were conducted according to a written program plan. It answers the question, “How much of the intervention was provided, to whom, when, and by whom?” In clinical terms, process evaluation can be called a quality assurance review (QAR). A possible process evaluation question for the purposes of youth suicide prevention might be: “Did suicide prevention training participants attend all of the required sessions, and were all of the objectives in each training session covered?”

Impact evaluation (often called summative evaluation) is used to measure short-term impacts of program components. The primary domains measured here are changes in knowledge, attitude and behavioral intentions among the targeted population. A possible impact evaluation question could be “As a result of our program, do the participants have a greater knowledge of the warning signs of suicide in youth?”

Outcome evaluation is designed to assess the effectiveness of an intervention in producing long-term changes. A possible outcome evaluation question could be “Are local mental health providers seeing an increase in the number of adolescent clients?” or “Have the rates of suicides and suicide attempts gone down?” Outcome evaluation typically takes several years to conduct, particularly in the area of youth suicide due to the fact that any one particular location may have a very sporadic suicide completion rate to begin with. Nevertheless, a solid system of data collection can provide this data, and can provide it on the county and state level, allowing comparisons between rural and urban settings, gender, age, etc.

Finally, a logic model evaluation plan helps to put an entire program or plan into perspective. It categorizes each program component according to the type of evaluation (process, impact, or outcome) that is used to measure its completion, and then connects them according to how they effect other components (i.e. if one component needs to be completed before another one can be addressed). This helps to identify exactly which program components are affecting which outcomes, and it helps to identify the status of components in terms of progress toward completion.

It is helpful to think of a logic model like a road map that helps one identify where he/she is in terms of reaching an end point, and which roads will lead to which outcomes. A logic model for this state plan is included in appendix D. As the logic model shows, the various components of this state plan are interrelated (for example, school-based education, community caregiver networks and screening programs are tied to the infrastructure of communities).

Evaluation measures for this state plan are listed below according to their level of evaluation:

Process Evaluation –

Process evaluation for this state plan will primarily monitor the implementation of the state plan components. Serving as a checklist, the various steps involved in developing and implementing an improved data collection system, implementing First Response Trainings and screening programs, equipping school and community crisis teams for suicide prevention, providing technical assistance to the media concerning AAS media guidelines, implementing public education campaigns, coordinating community resources and establishing networks and building community capacity.

Impact Evaluation -

Specific impacts of interest for evaluation will be an increase in the number of referrals to local resources, perceived efficacy and effectiveness of adults who have received Community Caregiver Trainings measured by evaluation forms, increased understanding of levels of suicide ideation in school populations as a result of screening programs, measures of increased community capacity, higher quality suicide data as a result of statewide data collection efforts and changes in observed media coverage of suicides.

Outcome Evaluation –

Outcome evaluation markers will focus on measuring reduction of suicide ideation and attempts in youth (measured through the statewide data collection system and data from screening programs). Additional Impact and Outcome measures will be developed by the State Youth Suicide Prevention Council as the state plan is implemented.

Goal -

The overall goal of the Oklahoma State Plan for Youth Suicide Prevention is to reduce the suicide rate for youth aged 10-24 in Oklahoma. This will be measured through annual reports from the Office of the State Medical Examiner.

Budget Justification

Cost of Completed and Medically Treated Youth Suicide Acts in Oklahoma (ages 0-20) in 1996 (in 1998 dollars).²

Medical Costs - \$17,000,000

Loss of Future Earnings (Economic Productivity) - \$50,000,000

Quality of Life - \$208,000,000

TOTAL - \$275,000,000

Funding for the following can be provided through state appropriated dollars, grant funding and in-kind resources.

Training for Trainers Course	\$1500 per participant 48 participants in year 1
Total for Training for Trainers	\$72,000

2. *Youth Suicide Prevention Coordinator:*

The Coordinator will serve as chair of the Oklahoma Youth Suicide Prevention Council and oversee the implementation and evaluation of the state plan, providing technical assistance to communities.

1 Coordinator	Salary - \$29,159 + Fringe - \$10,907 (based on current salaries for Health Educator Level II Classification salary band L code X20B).
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3. *Epidemiologist:*

The Epidemiologist will be responsible for the collection and statistical analysis of suicide attempt data as presented in the state plan.

1 Epidemiologist	Salary \$31,500 + Fringe - \$9,053 (based on current salaries for an Epidemiologist Level II Classification code X27B).
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4. *Travel:*

Travel funding for Health Educator to provide technical assistance to communities across the state.

\$5,000

Totals:

Training for Trainers:	\$72,000
Health Educator:	\$40,066
Epidemiologist:	\$40,553
Travel:	\$5,000
Total state dollars requested:	\$157,599
Total FTE:	2

4. Screening Program:

Recommendations and estimations based on known screening programs for screening 900 individuals per year:

Full Time Coordinator	\$30,000
Start-Up Costs (equipment)	\$6,000
Estimated cost per student for 900 students (minus start-up costs)	\$35

Funding sources for the screening program, public education, and school-based education will be sought through suicide prevention community grants offered through such sources as the National Institutes of Mental Health, the Substance Abuse and Mental Health Services Administration, as well as local community foundations. The goal is to use as many existing sources (both in terms of funding and established community programs) as possible. Again, the focus of this state plan is the coordination of existing services as well as the implementation of programs. Considering the scope of this state plan, and the costs to the State of Oklahoma that youth suicide incurs (presented above), the expenses requested from the state are quite reasonable.

References

1. State of the State's Health Report, Oklahoma State Board of Health, 1999.
2. Children's Safety Network - National Injury and Violence Prevention Resource Center, U.S. Department of Health and Human Services. www.edc.org/HHD/csn
3. Weinstein, M.C. and Saturno, P.J. (1989). *Economic impact of youth suicide and suicide attempts*, 1989 Report of Secretary's Task Force on Youth Suicide, Vol 4, 1989.
4. Rosenberg M, Smith JC, Davidson LE, Conn JM. The emergence of youth suicide: an epidemiologic analysis and public health perspective. *Annu Rev Public Health* 1987;8:417-40.
5. Rosenberg ML, Davidson LE, Smith JC, Berman AL, Buzbee H, Gantner G, Gay GA, Moore-Lewis B, Mills DH, Murray D, O'Carroll PW, Jobes D. Operational criteria for the determination of suicide. *J Forensic Sci* 1988;33:1445-56.
6. *Suicide Surveillance Report: United States, 1970-1980*. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control. Washington, DC: U.S. Government Printing Office, 1985.
7. Worden, JW. *Methods as a Risk Factor in Youth Suicides: Report of the Secretary's Task Force on Youth Suicide*. Washington, DC: U.S. Government Printing Office, 1989;2:184-192.
8. Ramsey, Richard F and Tanney, Bryan L (Ed): *Global Trends in Suicide Prevention – Toward the Development of National Strategies*: TATA Institute of Social Sciences, 1996.
9. American Association of Suicidology – www.suicidology.org
10. Shaffer, D and Craft L, Methods of adolescent suicide prevention, *Journal of Clinical Psychiatry*. 1999;60 Suppl 2:70-74.
11. Berman, A.L. & Jobes, D.A. (1991) Adolescent suicide assessment and intervention. Washington, DC: American Psychological Association as cited in Youth Suicide Prevention Plan for Washington State, Washington Department of Health, 1995
12. Office of the Chief Medical Examiner Annual Report, 1999
13. Brent et al, 1993; Kellerman et al., 1992

14. American Journal of Public Health, Vol. 90 No. 4 p. 588.
15. Brent, D.A., Perper, J.A. and Allman, C.J. (1987). Alcohol, firearms, and suicide among youth: Temporal trends in Allegheny County, Pennsylvania, 1960-1983, *Journal of the American Medical Association*, 257(24), 3369-3372 as cited in Youth Suicide Prevention Plan for Washington State, Washington Department of Health, 1995.
16. Jamison, Kay Redfield, *Night Falls Fast: Understanding Suicide*: Knopp, New York 1999
17. Sobczyk, et al. (1995) *Health promotion schools of excellence: A model program for Kentucky and the nation*. *Kentucky Medicine*, April 1995 pp. 142-147.
18. Gordon, R. (1987). *An operational classification of disease prevention*. In J.A. Steinburg & M.M. Silverman (eds). *Preventing mental disorders* (pp. 20-26). Rockville, MD: Department of Health and Human Services. As cited in Youth Suicide Prevention Plan for Washington State, Washington Department of Health, 1995
19. Institute of Medicine (IOM) (1994). *Reducing risks for mental disorders: Frontiers for prevention intervention research*. P.J. Mrazek & R.J. Haggler (eds). Washington, DC: National Academy Press. As cited in Youth Suicide Prevention Plan for Washington State, Washington Department of Health, 1995
20. *Investing in Adolescent Health: A Social Imperative for California's Future*. A Strategic Plan by the California Adolescent Health Collaborative - National Adolescent Health Information Center, University of California, San Francisco
21. Douglas, S. Jacobs, (Ed): *Guide to Suicide Assessment & Intervention*, The Harvard Medical School: Jossey Bass, 1999.

APPENDIX A

American Association of Suicidology Media Guidelines

CDC-AAS MEDIA GUIDELINES

Rates of suicide continue to increase among adolescents and teenagers. Younger age groups are thought to be more vulnerable to the phenomenon of "contagion" than other age groups. The recommendations for reporting of suicide printed below provide some guidelines to assist both public officials and media representatives in making decisions about how to report suicide. Generally, reporting of suicide should not be shunned when newsworthy. It is important that the public be aware of the nature and magnitude of the problem. Indeed, more than 34,000 people died from suicide in 1994, making it the 9th leading cause of death. While few of these suicides would be considered under the rubric of "contagion," those that are may be reduced by responsible reporting.

In November 1989, a national workshop that included suicidologists, public health officials, researchers, psychiatrists, psychologists, and news media professionals was held to address general concerns about, and specific recommendations for, reducing the possibility of media-related suicide contagion. These recommendations, which are endorsed by the Centers for Disease Control and Prevention and adopted by the American Association of Suicidology, outline general issues that public officials and health and media professionals should consider when reporting about suicide.

General Concerns and Recommendations

1. Suicide is often newsworthy, and it will probably be reported.

It is important to assist news professionals in their efforts toward responsible and accurate reporting.

- 2. "No comment" is not a productive response to media representatives who are covering a suicide story.**

Refusing to speak with the media does not prevent coverage of a suicide; rather, it precludes an opportunity to influence what will be contained in the report. It is not necessary to provide an immediate answer to difficult questions; however, be prepared to provide a reasonable timetable for giving such answers or provide a referral.

- 3. All parties should understand that a scientific basis exists for concern that news coverage of suicide may contribute to the causation of suicide.**

Health officials must explain the carefully, established, scientific basis for their concern about suicide contagion and how responsible reporting can reduce contagion.

- 4. Some characteristics of news coverage of suicide may contribute to contagion, and other characteristics may help prevent suicide.**

Clinicians and researchers need to acknowledge that it is not news coverage of suicide, per se, but certain types of news coverage, that may promote contagion.

- 5. Health professionals or other public officials should not try to tell reporters what to report of how to write the news regarding suicide.**

Instead of dictating what should be reported, public officials should explain the potential for suicide contagion associated with certain types of reporting and suggest ways to minimize the risk of contagion.

- 6. Public officials and the news media should carefully consider what is to be said and reported regarding suicide.**

Aspects of News Coverage that can Promote Suicide Contagion

In order to minimize the likelihood of suicide contagion, reporting should be concise and factual. The likelihood of suicide contagion may be increased by the following:

- 1. Presenting simplistic explanations for suicide.**

It is important to acknowledge that multiple factors may have contributed to a suicide attempt.

- 2. Engaging in repetitive, ongoing, or excessive reporting of suicide in the news.**

Alternative approaches for coverage of newsworthy suicide stories should be considered since repetitive coverage tends to promote suicide contagion.

3. Providing sensational coverage of suicide.

Sensationalism can be minimized by limiting morbid details of the suicide, decreasing the prominence of the news report, and avoiding the use of dramatic photographs, related to the suicide.

4. Reporting "how-to" description of suicide.

Technical details about the method of suicide is not recommended and may in fact facilitate imitation of the suicidal behavior by other at-risk individuals.

5. Presenting suicide as a tool for accomplishing certain ends.

Suicide should not be presented as an effective coping strategy because other potentially suicidal individuals may view suicide as an attractive solution.

6. Glorifying suicide or persons who commit suicide.

News coverage is less likely to contribute to suicide contagion when reports of community expression of grief (i.e., public eulogies and public memorials) are minimized.

7. Focusing on the suicide completer's positive characteristics.

It is important to report the suicide completer's problems in addition to the positive aspects of his/her life.

In addition to these guidelines, AAS recommends publication of potential warning signs in the article, or as a side bar, in addition to information on community resources for those who may be suicidal or who know people who are.

Reference: Centers for Disease Control. Programs for the prevention of suicide among adolescent and young adults; and Suicide contagion and the reporting of suicide: Recommendations from a national workshop. MMWR 1994; 43 (No. RR-6).

Copies of the MMWR are available at \$3.00 each from: Massachusetts Medical Society, C.S.P.O. Box 9120, Waltham, MA 02254-9120.

This summary has been prepared by the American Association of Suicidology, Suite 310, 4201 Connecticut Ave., NW, Washington, DC 20008. Telephone number (202) 237-2280; fax: (202) 237-2282.

APPENDIX B

Resources / National
Organizations

Resources / National Organizations

The American Academy of Child & Adolescent Psychiatry (AACAP)
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
(202) 966-7300
(202) 966-2891 Fax
www.aacap.org

The American Association of Suicidology (AAS)
4201 Connecticut Avenue, NW Suite 408
Washington, DC 20008
(202) 237-2280
(202) 237-2282 Fax
www.suicidology.org

The American Foundation for Suicide Prevention (AFSP)
120 Wall Street, 22nd Floor
New York, NY 10005
(212) 363-3500
(212) 363-6237 Fax
(888) 333-AFSP (toll free)
www.afsp.org

American Psychological Association (APA)
750 First Street, NE
Washington, DC 20002
(202) 336-5500
www.apa.org/psychnet

Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)
Division of Violence Prevention
Mailstop K60
4770 Buford Highway, NE
Atlanta, GA 30341-3724
(770) 488-4362 (770) 488-4349 Fax
www.cdc.gov/ncipc/dvp

Children's Safety Network (CSN)

55 Chapel Street

Newton, MA 02458-1060

(617) 969-7100 ext. 2207

(617) 244-3436 fax

www.edc.org/hhd/csn

General technical assistance on youth suicide prevention (617) 969-7100 ext. 2207 or
(202) 466-0540 (Washington, DC office)

For rural youth suicide issues: (715) 389-4999

For youth suicide data information: (619) 594-3691

For youth suicide economic and data information (301) 781-9891

Light for Life Foundation International

Yellow Ribbon Suicide Prevention Program

PO Box 644

Westminster, CO 80036-0644

(303) 429-3530

(303) 426-4496 Fax

www.yellowribbon.org

National Institute on Mental Health (NIMH)

NIMH Public Inquiries

5600 Fishers Lane, Room 7C-02, MSC 8030

Bethesda, MD 20892-8030

www.nimh.gov

The National Organization for People of Color Against Suicide

Dr. Donna Barnes, Founder and President

PO Box 125

San Marcos, TX 78667

(830) 625-3576

SAVE

PO Box 24507

Minneapolis, MN, 55424-0507

(612) 946-7998

www.save.org

Search Institute
700 South Third Street, Suite 210
Minneapolis, MN 55415
1-800-888-7828
www.search-institute.org

Suicide Information and Education Center (SIEC)
201-1615 10th Ave, SW
Calgary, Alberta Canada T3C 0J7
(403) 245-3900
(403) 245-0299 fax
www.siec.ca

Suicide Prevention Advocacy Network (SPAN)
5034 Odin's Way
Marietta, GA 30068
(888) 649-1366
(770) 642-1419 fax
www.spanusa.org

Suicide Prevention Resource Center
G. Thomas Shires, MD
Director, University of Nevada School of Medicine
Trauma Institute
2040 W. Charleston, Suite 501
Las Vegas, NV 84102
(702) 671-2276
(702) 385-2701 fax

Office of the Surgeon General
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202) 205-0463 fax
www.surgeongeneral.gov

APPENDIX C

Developmental Assets for Youth

APPENDIX D

Logic Model