

saving

lives



Ohio's Suicide Prevention Plan

one

person



Prepared by the Ohio Department of Mental Health
in collaboration with the Ohio Coalition for Suicide Prevention

at a

time



May 2002



“Still the effort seems unhurried. Every seventeen minutes in America someone commits suicide. Where is the public concern and outrage?”

Kay Redfield Jamison,
Author of *Night Falls Fast: Understanding Suicide*

For additional copies of this Plan, or for information about suicide prevention programs, please contact:

Ohio Department of Mental Health
30 E Broad Street, 8th Floor
Columbus OH 43215-3430
614-466-1984
www.mh.state.oh.us

or

Ohio Coalition for Suicide Prevention
50 W Broad Street, Suite 1915
Columbus OH 43215
614-228-0402

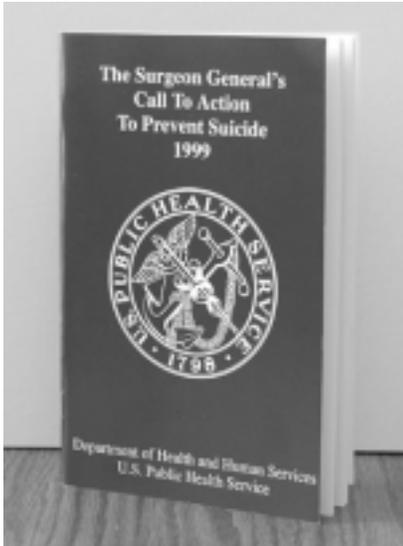
Dedication

Ohio's Suicide Prevention Plan is dedicated to Kirk "Crunch" Knick, son of Linda Whittle of Sidney, Ohio, an organizer of the Suicide Prevention Advocacy Network (SPAN), and to all other Ohioans touched by suicide.

Kirk "Crunch" Knick
November 29, 1979 - March 27, 1995



Introduction



More than 1,200 Ohioans die by their own hand every year. The impact of suicide does not stop with the lost lives. For every suicide death, it is estimated that six individuals will be profoundly affected for the rest of their lives. These deaths and their effects are even more tragic as suicide is largely preventable.

As the ninth leading cause of death in Ohio, suicide remains an ongoing challenge for healthcare policymakers, providers of care, schools, faith communities and law enforcement. Ohio statistics continue to mirror national trends where suicide rates are increasing among particular areas of the population. Adolescents, young adults, men 25 to 44 years of age and the elderly are among those at the highest risk in Ohio. Economic downturns and the inability to effectively problem solve and cope with challenges increase the risk for these priority groups, making the development of suicide prevention policies even more essential.

In October 1998, at the request of the U.S. Surgeon General and in collaboration with the Suicide Prevention Advocacy Network (SPAN), the Substance Abuse and Mental Health Services Administration (SAMHSA) convened a national suicide prevention conference. The Ohio Department of Mental Health (ODMH) appointed an eight-member team to attend the conference and assist in drafting the Surgeon General's *Call to Action to Prevent Suicide*, which was released in 1999.

ODMH Director Michael F. Hogan, Ph.D., was appointed to a national committee that assisted in the development of the National Goals and Objectives for Suicide Prevention 2000-2005. These National Goals serve as the framework for Ohio's state plan that utilizes Awareness, Intervention and Methodology, or AIM strategy to reduce the prevalence of suicide.

In January 2001, the Report of Ohio's Mental Health Commission, *Changing Lives, Ohio's Action Agenda for Mental Health*, included a recommendation that Ohio should build an initiative to reduce suicides. Ohio's Suicide Prevention Plan is the next step in saving lives and reducing suicidal behaviors by developing a comprehensive strategy in response to a very complex set of issues.

To develop a statewide plan, the Ohio Department of Mental Health established a partnership with the Ohio Coalition for Suicide Prevention, a grassroots organization of medical, mental health, and public health professionals, faith-community members and advocates who are dedicated to preventing suicide by raising awareness and promoting well-being.

In addition to the Ohio Coalition for Suicide Prevention, a number of various constituencies assisted in developing a coordinated statewide strategy and commitment. The following organizations were represented: SPAN; American Foundation for Suicide Prevention - Northeast Ohio Chapter; People of Color Suicide Support Group; Ohio General Assembly; Ohio Departments of Aging, Alcohol and Drug Addiction Services, Education, Health, Job and Family Services; The Ohio State University; the Ohio Public Health Association; local public health agencies; local crisis centers and suicide prevention hotline services; local mental health boards; medical and mental health professionals in public health, adolescent medicine, psychiatry, psychology and geriatrics; the Catholic Diocese of Columbus; the United Presbyterian Church; the West Ohio Conference of the United Methodist Church; and the Ohio Federation of Community Planning.

On July 28, 2001, the Ohio Coalition for Suicide Prevention hosted a daylong strategic planning session with 40 participants representing a broad range of stakeholders. This group developed a list of preliminary recommendations and made plans to obtain further input in the formulation of a statewide plan.

The Department, along with the Ohio Coalition for Suicide Prevention, launched the plan of action for suicide prevention during a Statehouse press conference on October 10, 2001. Director Hogan released the Executive Summary that included the preliminary recommendations. A symposium, *A Call to Action: A Suicide Prevention Strategy for Ohio*, convened later that day for policy makers, providers, advocates, and survivors of suicide. Dr. David Litts, USAF, Special Advisor on Suicide Prevention to the U.S. Surgeon General, and Lucy Davidson, M.D., Clinical Associate Professor of Psychiatry at Emory University, addressed the participants on the opportunity for Ohioans to take action in preventing suicide.

In the fall of 2001, the Ohio Coalition conducted a series of six regional forums across Ohio to identify and convene local leadership in the public health, mental health, academic, faith, and survivor communities. The following organizations sponsored the regional forums:

| | |
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| The University of Toledo | Children's Hospital, Columbus |
| The Health Improvement Collaborative of Greater Cincinnati | The Ohio Federation for Community Planning (Held at the Visiting Nurses Association in Cleveland) |
| The Mahoning County District Board of Health (Held at the Ursuline Center in Canfield) | The Southern Consortium for Children (Held in Athens) |

More than 300 participants at these forums provided invaluable input in culling the best recommendations, developing goals, and recommending strategies to be used over the next three to five years. Their work has formed the framework for this state plan. These important partners will also be leaders in the implementation of the plan.

Recognizing that suicide is a public health problem that requires an evidence-based approach to prevention, the regional forum participants outlined the following characteristics of an effective statewide suicide prevention strategy. Ohio's strategy must be:

- Prevention-focused
- Public health focused
- Culturally competent
- Appropriate for a community-based mental health system
- Focused on adolescents and young adults first, then on other priority groups (middle-aged white males and the elderly)
- Built on data, research and best practices
- Able to address statewide needs

The plan's goals and objectives account for three levels of prevention strategies: universal, selective and indicated. Research supports the recognition that, as vulnerability and suicide potential increase, so does the need for stronger prevention interventions.

Universal prevention is focused on providing needed interventions to keep communities healthy. These programs benefit everyone in a community universally by providing general awareness information and education.

Selective prevention is dedicated to prevent the onset of suicidal behavior in priority risk groups. These strategies may include screening and assessment, training of natural community “gatekeepers,” and community-based mental health treatment.

Indicated prevention strategies identify priority groups known to be at high-risk for suicide. This may be done through skill building and services and treatment that reinforce protective factors.

To determine the best approach for creating a blueprint for Ohio’s suicide prevention plan, the following assumptions were used to guide the process and planning:

- The final action planning and execution must occur at the local level.
- All tools and protocols will be appropriate for the local community and its diverse members.
- There will be uniform messages and language across all activities, across all locations, and across all priority groups.
- Gatekeepers are anyone who has contact with individuals in need of help.
- The list of key gatekeepers will vary by local area.
- All interventions will be delivered in appropriate ways given the community and its diversity.
- Development of the capacity to achieve plan goals will be community-based.

In addition to being tailored to the needs and resources available within Ohio, strategies to prevent suicide must be part of strong collaborative and creative partnerships at all levels. By working together to raise awareness, reduce stigma and encourage Ohio’s citizens to seek help, we can save many lives that would otherwise be lost to suicide.

Priority Groups

- More teens and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.
- Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled.

Source: The Surgeon General's Call to Action to Prevent Suicide

The Young

The 1999 Ohio Youth Risk Behavior Survey shows that nearly 20 percent of all high school students in Ohio seriously contemplated suicide during the 12 months preceding the survey. Significantly more females (25 percent) than males (16 percent) seriously considered suicide.



Young women are more likely to attempt suicide than young males by about 6 to 1, but completed suicide is more common in adolescent males than in females by about 3 to 1. While some clinicians believe that psychiatric illness, such as clinical depression, underlies all suicide among the young, some think it is more complex than that, pointing to developmental factors that influence behavior. Certainly, all agree that substance and/or alcohol abuse significantly increases the risk of suicide in young people, as does anxiety or impulsivity, sexual identity issues – including being gay, lesbian or bisexual – and sexual abuse.

Middle-aged Men

At particular risk of suicide are Ohio men, 25 to 44 years of age. According to the Ohio Department of Health, white men between the ages of 25 to 34 have the highest rate of this group. From 1996 to 1998, men between the ages of 25 and 34 had a suicide death rate of 23.7 per 100,000 and men between the ages of 35 to 44 had a suicide death rate of 23.0 per 100,000.



Men are generally more successful at completing suicide than women because they choose violent, more lethal means. However, the impulse to take one's own life is rooted in problems far more complex than the actual vehicle for death. Men who are 25 to 44 years of age are under enormous stress to perform, achieve, and provide. This oftentimes overwhelming stress coupled with a tendency to not seek help in times of need may actually describe why men of this age are at higher risk for suicide.

The Elderly

While the young are at particular risk for suicide, the group at greatest risk for suicide is the elderly. The suicide risk for Ohioans above the age of 80 is three to four times higher than for the average Ohioan.



Some of the factors that make the elderly more vulnerable to suicide are social isolation, significant losses (death of spouse, loss of home, family, and friends) illness, disability, chronic pain, depression, and oftentimes, hidden alcoholism. While many of these factors may be unique to the aging process, their presence and influence should not be fatal.

- Males are four times more likely to die from suicide than females.
- White males account for more than 75 percent of Ohio's suicides.
- In the month prior to their suicide, 75 percent of elderly suicide victims had visited a physician.

Sources: The Surgeon General's Call to Action to Prevent Suicide; Ohio Department of Health, Center for Public Health Data and Statistics

Goals and Objectives

Awareness

Appropriately broaden the public's awareness of suicide and its risk factors.

The Ohio Department of Mental Health, the Ohio Department of Health and the Ohio Coalition for Suicide Prevention believe that the number of Ohioans dying from suicide can be reduced through implementation of prevention strategies. The *Surgeon General's Call to Action to Prevent Suicide* introduced an initial blueprint for addressing suicide prevention. Goal areas for Ohio's prevention strategy are categorized as Awareness, Intervention and Methodology, or AIM, as were set forth in the Surgeon General's report.

Awareness Goal:

Increase awareness that suicide is a public health and mental health problem in order to reduce stigma and increase people's ability to seek help.

Awareness Objective 1:

Develop local, broad based support for suicide prevention.

Create or enhance a suicide prevention coalition in each Ohio county to develop a prevention plan based upon local needs and resources available. Coalition partners should include, but not be limited to, representatives of the Child Fatality Review Board, school districts, health department, crisis response teams, Area Agency on Aging, local news media, hospitals, human services providers, faith-based organizations, health care professional organizations, local service organizations (Kiwanis, Sertoma, Lions, Jaycees, Grange, etc.), mental health and addiction services boards, survivor groups, and human resources offices or employee assistance programs from local employers.

Awareness Objective 2:

Partner with Ohio's media to advance effective prevention efforts.

Educate the broadcast and print media (including but not limited to the entertainment industry) about the powerful role suicide-related coverage can play in future suicide prevention. Provide information about suicide, its warning signs, depression and other mental illnesses and substance abuse. Collaborate with media partners to ensure responsible media policies and practices are utilized in coverage related to suicide and suicide prevention.

Awareness Objective 3:

Increase awareness of policy makers.

In collaboration with public and private organizations, increase education and awareness of state and county policy makers about suicide and its warning signs. Educate officials on the impact that suicide, depression and other mental illnesses, and substance abuse have on other policy areas such as criminal justice, law enforcement and health care.

Awareness Objective 4:

Develop and implement a public awareness campaign.

Create a statewide media campaign to increase public awareness of available resources. Partnerships should be engaged to produce public service announcements, news articles, billboards, public speaking opportunities and other ventures that will reduce the stigma surrounding suicide and increase Ohioans' willingness to seek help.

Awareness Objective 5:

Encourage effective use of evidence-based prevention and awareness programs in educational settings.

Direct students, faculty and staff of Ohio's colleges and universities to available resources to encourage help-seeking behavior. One fourth of all persons age 18 to 24 in the United States are full or part-time college students, suggesting that a large proportion of young adults could be reached through college-based suicide prevention efforts.

Educate staff in Ohio school districts on the warning signs for suicidal youth and encourage schools to develop a plan of action for helping at-risk students. Researchers have found that suicidal youth are not likely to self-refer or seek help from school staff, so teaching youth to identify the warning signs of suicide may not be effective. However, researchers have also found that enhancing problem-solving and coping skills reduces suicidal ideation among young people who are facing difficult problems or life situations, so targeting risk and protective factors that occur earlier in the pathways to suicide is a necessary component of school-based efforts.

Intervention Goal:

Reduce factors that increase the risk of suicide.

Intervention Objective 1:

Strengthen crisis response and build community capacity to serve persons at risk and in need of treatment.

Identify gaps in available resources and services that create a barrier to suicide prevention. Encourage collaborations of community stakeholders to create a "safety net" by enhancing existing service delivery systems.

Intervention

Enhance services and programs, both population-based and clinical care.

Intervention

Enhance services and programs, both population-based and clinical care.

According to the National Strategy for Suicide Prevention, in the month prior to their suicide, 75 percent of elderly persons had visited a physician. With increased training in identifying risk factors in patients, fewer suicidal patients will go unrecognized.

Intervention Objective 2:

Through education and promotion, increase the number and quality of key gatekeepers in Ohio.

Gatekeepers are primarily individuals in the community who can effectively recognize life-threatening distress in individuals or families. Equipped with the appropriate knowledge and resources, these individuals can intervene when early signs of risk appear. Gatekeepers may include teachers and other school staff, school health personnel, clergy, police officers, correctional personnel, coaches, supervisors in the work environment, primary healthcare providers, hospice and nursing home providers and volunteers, mental health care and substance abuse treatment providers and emergency health care personnel, among many others.

Intervention Objective 3:

Increase the ability of healthcare professionals to intervene.

Identify or develop training curricula for physicians, psychologists, social workers, counselors, nurses and physician assistants to increase the ability of these individuals to effectively intervene. Identify health professional training programs that include assessment and management of suicide risk and identification and promotion of protective factors.

Intervention Objective 4:

Increase the ability of clergy to intervene.

Identify or develop resources to increase the proportion of clergy who have been trained to recognize signs of suicide risk and behaviors. Clergy often provide counseling and interventions for those in distress, and for some, may be the only individuals in a position to provide emotional support. Clergy and clinicians should work collaboratively to enhance treatment options for people in need of services.

Intervention Objective 5:

Promote and support the presence of protective factors.

Change policies and procedures and enhance risk-assessment tools in settings such as hospital emergency rooms, community mental health centralized access points and primary care offices where persons at risk of suicide often come for help.

Methodology Goal:

Gather more data about suicide attempts and evaluate the effectiveness of programs designed to prevent suicide.

Methodology Objective 1:

Develop a state and county surveillance system.

Developing a comprehensive suicide surveillance system to collect and link information related to suicide attempts and gestures would significantly enhance each county's efforts to prevent suicide. Improved surveillance, data collection and dissemination are essential for the development of effective suicide prevention efforts.

Methodology Objective 2:

Increase scientific knowledge.

Advancing research, outcome evaluations and knowledge transfer can increase the awareness of evidence-based programs which would work for the priority groups in Ohio.

Methodology Objective 3:

Promote a research agenda.

Establish partnerships and assist in securing funding, especially with colleges and universities, to increase the amount of research being done in Ohio related to risk and protective factors and effective prevention programs and treatments.

Methodology

Advance the
science of suicide
prevention.

Plan Contributors

Special thanks to the more than 300 Ohioans who provided input into this plan by attending the regional forums and conferences and completing the questionnaire related to suicide prevention needs in Ohio.

Nancy Bearor (Williamsport)
Charlotte Bell (Columbus)
Jamie Blair (Columbus)
John Borchard (Athens)
Debby Bourquin (Louisville)
Joy Bowers (Dayton)
Robert Brown, M.D. (Columbus)
Helen Cain Jackson (Columbus)
State Rep. Jamie Callender (Eastlake)
Tom Clemons (Bowling Green)
Russ Crabtree (Grandview Heights)
William "Bill" Cramer (Cleveland)
Gary Crum, Ph.D., MPH (Jackson)
Susan Culbertson (Zanesville)
Nancy Cunningham, Ph.D. (Columbus)
M. Meredith Dobyms, M.D. (Circleville)
Catherine Ferrer (Cleveland)
Amy Forrester (Oxford)
Pat Franz (Napoleon)
Cate Fopma (Cincinnati)
Lois Hall (Columbus)
Thomas Halpin, M.D., MPH (Columbus)
Judy Herendeen (Columbus)
William "Bill" Hill (Columbus)
Kim Hoffman (Findlay)
Mary Brennen-Hofmann (Columbus)
Cheryl Holton (Newark)
Judy Howard (New Albany)
Susan Iorio (Sylvania)
Jean Haefner, Ph.D. (Toledo)
Wanda Harewood-Jones (Columbus)
Robert Indian (Columbus)
Linda Karlovec, Ph.D. (Grandview Heights)
Miriam Keith (Marietta)
Barbara Klein (Lancaster)
Linda Krueger (Columbus)
Randi Love, Ph.D. (Columbus)
Melody Lozier (Mansfield)
Somers Martin (Columbus)
Doris Matheny (Cleveland Heights)
Cherie Mercer (Bryan)
Nan Migliozi (Columbus)
Beth Montgomery (Delaware)
Melinda Moore (Columbus)
Bayard Paschall, Ph.D. (Columbus)
Judith Peters (Cleveland)
Eric Poklar (Columbus)
Kay Rietz (Columbus)
Ann Robinson (Columbus)
Suzanne Robinson (Columbus)
Denise Rocklin (Cincinnati)
Jake Ryan (Columbus)
Mary Alice Sonnhalter (Canton)
Terry Southwick (Worthington)
Melvin Stallworth (Columbus)
Caryn Steerman (Akron)
Matt Stevanak (Youngstown)
Patricia Starr Upchurch (Worthington)
Councilwoman Charleta Tavares (Columbus)
Susan Thie (Cincinnati)
State Rep. James Trakas (Independence)
Steve Trout (Athens)
Sharon Wallar (Logan)
Betty Waugh (Gallipolis)
Laura Wentz (Columbus)
Linda Whittle (Sidney)
William "Bill" Wood (Mansfield)
Darlene Gonoz Zangara (Columbus)

Fact Sheet

Common Warning Signs

- Giving away favorite possessions
- A marked or noticeable change in an individual's behavior
- Previous suicide attempts and statements revealing a desire to die
- Depression (crying, insomnia, inability to think or function, excessive sleep or appetite loss)
- Inappropriate "good-byes"
- Verbal behavior that is ambiguous or indirect: "I'm going away on a real long trip. You won't have to worry about me anymore. I want to go to sleep and never wake up."
- Purchase of a gun or pills
- Alcohol or drug abuse
- Sudden happiness after long depression
- Obsession about death and talk about suicide
- Decline in performance of work, school, or other activities
- Deteriorating physical appearance, or reckless actions

High Risk Life Events Associated With Suicide

- Death or terminal illness of a loved one
- Divorce, separation, or broken relationship
- Loss of health (real or imaginary)
- Loss of job, home, money, self-esteem, personal security
- Anniversaries
- Difficulties with school, family, the law
- Early stages of recovery from depression

What To Do

- Take suicide threats seriously, be direct, open and honest in communications.
- Listen, allow the individual to express their feelings and express your concerns in a non-judgmental way.
- Say things like, "I'm here for you. Let's talk. I'm here to help."
- Ask, "Are you having suicidal thoughts?" A detailed plan indicates greater risk.
- Take action sooner rather than later.
- Get the individual who is at risk connected with professional help.
- Dispose of pills, drugs and guns.
- Don't worry about being disloyal to the individual; contact a reliable family member or close friend of the person.

What Not To Do

- Do not leave the person alone if you feel the risk to their safety is immediate.
- Do not treat the threat lightly even if the person begins to joke about it.
- Do not act shocked or condemn. There may not be another cry for help.
- Do not point out to them how much better off they are than others. This increases feelings of guilt and worthlessness.
- Do not swear yourself to secrecy.
- Do not offer simple solutions.
- Do not suggest drugs or alcohol as a solution.
- Do not judge the person.
- Do not argue with the person.
- Do not try to counsel the person yourself, GET PROFESSIONAL HELP!

Where to get help:

Contact your local Mental Health or ADAMH Board, or call a Crisis Hotline (look in the yellow pages under "Mental Health" or "Crisis Intervention") or call 1-800-SUICIDE.

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30 E Broad Street, 8th Floor
Columbus OH 43215-3430

Ohio Coalition for Suicide Prevention
50 W Broad Street, Suite 1915
Columbus OH 43215



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Bob Taft, Governor
Michael F. Hogan, Ph.D., Director

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