



STATE OF
COLORADO

Suicide Prevention
and Intervention
Plan

*The Report of the Governor's
Suicide Prevention Advisory
Commission*

November 1998

GOVERNOR'S SUICIDE PREVENTION ADVISORY COMMISSION

Dear Governor Romer and Fellow Coloradans:

Suicide is not difficult to define: It is the intentional termination of one's own existence. Still, suicide is difficult to explain. It is a complex and tragic act, one that is often unpredictable, inexplicable, seemingly motiveless and intensely personal. Experts say that, among all living species, human beings are the only ones who ever consciously take their own lives.

Colorado's rate of suicide is too high. Suicide is Colorado's seventh leading cause of death; it is the second leading cause of death in every age group from 10 to 34 years of age. In the past three years 136 children and teens, ages 10-19—at least four classrooms full—took their own lives. More people died last year from suicide than from motor vehicle crashes, diabetes, homicides or AIDS.

These numbers are disturbing—but they are not new. Our rate of suicide has exceeded the national average since at least 1910, when suicide data were first collected. The time has come to address the suicide problem in Colorado; we can wait no longer. Therefore, it is fitting that on March 5, 1998 the Governor appointed the Suicide Prevention Advisory Commission. It is also fitting that suicide prevention now occupies the thoughts of the Governor and the Governor-Elect, members of the General Assembly, public health officials, teachers, employers, health care providers, suicide survivors and citizens throughout our state.

The charge to the Governor's Suicide Advisory Commission was straightforward: Develop a statewide suicide prevention plan for Colorado. The plan was to be "evidence-based," reflecting scientific research about which suicide prevention interventions are safe, effective, feasible and necessary. In other words, Colorado should have a plan that works.

The Commission felt that Colorado's suicide prevention plan must also meet several other goals. First, it must respect Colorado's diverse populations. Second, it must address suicides and suicidal behavior among Coloradans of all ages. Third, while the Commission would come to an end, suicide prevention efforts must not. Suicide must remain a state priority.

Fourth, Colorado's plan must involve many sectors of our society, including state government, local public health, mental health, nursing, medicine, social services, religious groups, schools and local community services. No agency, profession, service group or foundation can solve this problem alone.

The Commission reviewed more than 400 scientific studies and papers about suicide prevention. The studies covered a wide variety of interventions, including public information campaigns, school-based programs, gatekeeper training programs, training for health professionals, suicide hot lines, crisis centers and strategies to decrease access to firearms and other lethal means of suicide. The literature reviews provided some basic information; however, it is clear that no one has discovered an easy or complete solution to the problem of suicides.

At the same time, the Commissioners recognized that the recommendations could not be based solely on the published literature. Many suicide interventions have never been studied or published. In Colorado there are many suicide prevention experts, program leaders, advocates and suicide survivors who have wisdom and experience to share. Therefore, the Governor's Suicide Prevention Advisory Commission was joined at the table by a group of more than seventy other experts and stakeholders, called the Citizens' Panel. The Citizens' Panel was led by the Mental Health Association of Colorado. The Advisory Commission and the Citizens' Panel met, debated and studied suicide prevention together, and both groups contributed to this plan. We are convinced that the joint efforts of the Governor's Commission and the Citizens' Advisory Panel helped to integrate evidence and practice and provided a more complete answer to the question, "*What works in suicide prevention?*"

The enclosed report includes recommendations in four principal areas: 1. *State capacity- building*, including designation of a responsible state agency and development of key public- private partnerships; 2. *A public information and education campaign*, to inform citizens about suicide risks, warning signs and interventions, and also to help reduce the fears, superstitions, prejudices and misunderstandings about suicide and mental illness; 3. *Training*, aimed at a range of key people, from teachers and coaches, to clergy and substance abuse counselors, to doctors and nurses. The

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Commission recommends development of “Best Practices” guidelines, to improve the manner in which health professionals recognize and treat patients who have mental illnesses or who are at risk for suicide. 4. *Community-based planning*, including efforts to encourage innovative suicide prevention strategies that are designed by, and designed for, hard-to-reach populations. The Commission’s four broad recommendations are accompanied by concrete, action-oriented implementation steps, that the Commission believes can help reduce the number of suicides in Colorado.

In many areas, key partnerships are essential, particularly among state government agencies, between state and local governments, between medicine and public health and between the public and private sectors. The Commission has also identified priorities for data collection, including improved surveillance of nonfatal suicides and scientific research to determine, at long last, why Colorado suicide rates are so high.

The work of developing a suicide prevention plan is not complete. Suicide prevention is an ever-changing discipline. As science and practical experience grow, new prevention strategies will be proposed and tested. The Colorado plan for suicide prevention is a dynamic one; it should be evaluated regularly and modified to strengthen its impact. Even after the Commission’s extensive study, many questions remain: Who will carry out the recommendations of the Commission and Citizens’ Panel? Who will evaluate the efforts? And, who will pay?

For the past eight months the Governor’s Suicide Prevention Advisory Commission and the Citizens’ Advisory Panel have met, debated and studied suicide prevention. We have reviewed Colorado’s suicide data. Yet, we all recognize that the numbers and graphs do not tell us about the sadness, pain and suffering that surrounds a suicide. More than 100 years ago a prominent physician wrote to Florence Nightingale and asked, “What are your statistics worth, if they do no good to body or soul?” What good are our charts and graphs, if the rates of suicide do not come down?

Thank you for reading the report of the Governor’s Suicide Prevention Advisory Commission. Thank you for your interest, support and commitment to reducing suicides in Colorado.



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FOR ADDITIONAL COPIES AND INFORMATION, PLEASE CONTACT:

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*This report is dedicated to anyone
touched by suicide.*



The National Lifekeepers Memory Quilt began from a dream envisioned by Sandy Martin, a mother in Georgia who lost her son to suicide. The purpose of the quilt is to place a "Picture on Suicide", that will bring awareness and serve as a visual image of the huge number of suicides that occur in America today (32,000 annually). It is compassionately aiding the healing of the survivors by providing an opportunity to honor loved ones lost to suicide. The Colorado Lifekeeper Memory Quilt was organized in December 1997 by Teresa Helgeson who lost her mother to suicide on May 17, 1994. Survivors of suicide across the State of Colorado placed pictures of their loved ones with personal messages of love and fond memories on squares of material. They were stitched together piece by piece by the loving hands of Linda Buerger who is also a survivor of suicide.

On April 17, 1998 the Colorado Lifekeeper Memory Quilt was escorted to the 3rd Annual National Suicide Awareness Event in Washington D.C. and displayed on the steps of the United States Capitol Building along with Lifekeeper Quilts from 28 other states. The names of the loved ones lost to suicide were then read out loud one by one, state by state in a ceremony of remembrance. The Colorado Lifekeepers Memory Quilt was the largest quilt displayed and it was accordingly displayed at the Colorado State Capitol Building May 4th through May 8th, 1998. On September 20, 1998 the quilt was displayed at the "Walk for Life", a 5K walk for Suicide Awareness. A second Colorado Lifekeeper Memory Quilt is currently being created for display in Washington D.C. next April.

EXECUTIVE SUMMARY

“I have felt the pain and wanted it all to end.” – Nickole Rucker, 15 year old member of the Governor’s Suicide Prevention Advisory Commission Diversity Work Group

Reaching out to Nickole and to thousands of people like her, Governor Roy Romer created the Governor’s Suicide Prevention Advisory Commission (GSPAC) on March 5, 1998. Citing the staggering statistics related to suicide in Colorado, Executive Order B 002 98 assembled the Commission to study suicide prevention and intervention strategies and to create a statewide plan to reduce suicides. This document reflects the efforts of the Commissioners, members of the Citizens’ Advisory Panel and many other Coloradans who believe that we must address this complex issue before more lives are lost.

Suicide touches people of all ages in every geographic region of Colorado. It knows no boundaries – religion, ethnicity and socioeconomic status provide no safety net. In Colorado, suicide is the seventh leading cause of death. There were 692 suicides reported in Colorado in 1996, more than 55 deaths each month. Suicide was the second leading cause of death among Colorado children, teenagers and young adults in every age category between ages 10 and 34. Eighty-one percent of all suicides are men. Whereas males die from suicide five times more frequently than females in Colorado, females make more non-fatal attempts. According to some estimates non-fatal attempts occur 25 times more often than fatal suicides.

Over the course of the past eight months, the Governor’s Suicide Prevention Advisory Commission has reviewed the latest research, the efforts of other states, and the practical experience related to suicide prevention and intervention. More study is imperative. Unfortunately, the problem is complex, suicides are often unpredictable and many potential solutions are untested.

This report should be a catalyst for action, a template for future planning and a guide for creating a comprehensive and coordinated system of programs and services for suicide prevention and intervention.

In addition to the executive summary, this report includes: introduction and background; risk factors and predictors of suicide; Colorado rates and trends; review

of other state plans; evidenced-based research on prevention and intervention; GSPAC recommendations; fact sheet; and a service directory.

The Commission voted unanimously on November 11, 1998 to present the following four recommendations (along with specific implementation tasks) to Governor Roy Romer, Governor-Elect Bill Owens and to the Colorado Legislature.

1. *Develop a “lead entity” to assume responsibility for the development of an ongoing system to ensure integrated, coordinated and effective information and services for prevention of suicide.*
2. *Develop a statewide, ongoing and comprehensive public information and education campaign.*
3. *Train individuals involved in the identification, screening, referral, treatment and follow-up of people at risk for suicide.*
4. *Facilitate the design and implementation of “Community Suicide Prevention Resource Plans” that includes all community stakeholders interested and/or involved in suicide prevention and intervention.*

These recommendations and specific implementation tasks are based on the belief that for strategies to be successful, efforts must be implemented on both the community and the statewide level. “Community” is used to mean any group of people who share specific geographic, biological, or social factors. A “one-size fits all” approach will be ineffective. The framework presented in this plan encourages individual communities to utilize customized strategies and to implement them in a manner that fits the community.

Suicide is difficult to discuss because of its intense emotional impact. However, we need to go beyond talking about suicide - we need to take action. With adequate planning and resources, we can reduce suicides in Colorado and make a difference in the lives of Colorado families.

INTRODUCTION

“I have felt the pain and wanted it all to end.” – Nickole Rucker, 15 years old member of the Governor’s Suicide Prevention Advisory Commission Diversity Work Group

Reaching out to Nickole and to thousands of people like her, Governor Roy Romer created the Governor’s Suicide Prevention Advisory Commission on March 5, 1998. The Commission was the outgrowth of the concerns of the Governor and Patti Shwayder, executive director of the Colorado Department of Public Health and Environment, over the lack of state programs in place to deal with issues relating to suicide. Barbara McDonnell, executive director of the Colorado Department of Human Services, and the leadership of the Mental Health Association of Colorado also were instrumental in prioritizing this significant problem. Support was also provided by the Departments of Correction and Public Safety.

Citing the staggering statistics related to suicide in Colorado, Executive Order B 002 98 (Appendix A) assembled the Commission and give it four main charges:

- Review the rates, trends, demographics, risk factors, predictors, methods and other characteristics of suicides in Colorado;
- Conduct a critical scientific review of existing literature on effective suicide prevention strategies, including programs that recognize and respond to people who are at risk for or who have attempted suicide;
- Review and analyze suicide prevention plans from other states; and
- Prepare and submit a written report by November 30, 1998.

The Commission (Appendix B) was composed of experts and policy makers from throughout the state. These thirty individuals began their work together on April 8, 1998. They met monthly as a Commission and actively participated in the work groups that developed. Many other individuals throughout the state assisted the

Commission, adding their interest, energy, experience and hard work.

In May, 1998, the Citizens’ Advisory Panel (Appendix C) was created to work collaboratively with the Commission. Facilitated initially by Jennifer Gamblin and later by Patti Thompson of the Mental Health Association of Colorado, it was comprised largely of consumer advocates, organizational representatives from local, community-based programs, and individuals who have been personally affected by suicide. The Citizens’ Advisory Panel began immediately working to help accomplish the tasks of the Commission.

The Commissioners initially developed and a set of “Guiding Principles” by which to operate. With the direction of the Co-Chairpersons, Dr. Tom Barrett and Dr. Steven Lowenstein and the facilitation of Danelle Young, the structure for the Commission’s was developed. Work began immediately on studying suicide data and trends, risk factors and predictors, other state plans and evidenced-based research on prevention and intervention. Dr. Carolie Coates was hired to conduct the literature research and the study of other state plans.

In addition, seven work groups, comprised of Commissioners, Citizens’ Advisory Panel members and staff, met to explore the complex issues related to suicide prevention. The work groups included: system and policy level issues; public information and education; best practices – diagnosis and treatment; training for gatekeepers – 1st responders; prevention and intervention services; spiritual resources; and diversity. Written documentation from these work groups was utilized in the development of the recommendations, specific implementation tasks and other parts of this report.

The conclusions reached by the work groups were complementary to each other and to the evidenced-based research.

It is appropriate to note that integration of spirituality and diversity issues was a high priority for the work groups. Tasks generated from these work groups are noted throughout the recommendations. For example, the participants recognized the importance of spirituality and faith in a holistic view of individuals and

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community. However, people have very personal views on matters of spirituality and faith in their lives. To assist others in exploring these issues, copies of reports from the diversity and spirituality work groups are included (Appendix D and E).

On October 9, 1998, the United States House of Representatives “recognized suicide as a national problem and declared suicide prevention to be national priority”. House Resolution 212 (Appendix F) is important and we support national (and international) efforts to address this important issue. Interestingly, however, suicide prevention and implementation efforts often begin at the governmental level. In Colorado, we have seen examples of the phenomenal efforts by many grassroots groups, including the Light for Life Foundation International-Yellow Ribbon Program and the Shaka Franklin Foundation.

Given this grassroots experience, one clear decision of the work groups was that efforts must occur simultaneously on both the system (statewide) and local (community) level. To address the diverse needs of people in our state, we must support endeavors by communities to address their own needs. The concept of community must be viewed very broadly. For purposes of this report, *community denotes any group of people who share specific geographic, biological or social factors*. It is imperative that the suicide prevention and intervention strategies implemented have the greatest possible impact. Parallel efforts at the system and community level are a desirable approach to achieve desired goals.

A *community* may be: students of a particular school; members of a church, synagogue or parish; employees in a work place; residents of a specific town or locale; members of a specific organization; teens who are homeless; individuals who are experiencing particular medical problems; older persons who are about to retire; any other group of Colorado citizens.

The Commission met on November 11, 1998 and approved unanimously the recommendations included in this report. Members of the Commission and Citizens’ Advisory Panel are committed to maintaining the momentum gained through this process and will continue to work to prevent suicides in Colorado!

Touched by suicide

❖ Jan M. McKinnis ❖ Jeff A. McKinnis ❖ Louann Dicus ❖ Deanna Rice ❖ Jerry R. Rice ❖

Touched by suicide

RISK FACTORS

Despite the attention given to the topic of suicide the prediction of suicide remains problematic, and the prevention of suicide extremely complicated.

About 200 symptoms, diagnoses, traits and characteristics have been studied as possible factors in the prediction of suicide. Yet, no factor or set of factors have ever come close to predicting suicide with any accuracy.

The main reasons for identifying the so-called “risk factors” is that:

1. The more risk factors that one has may indicate a higher risk for suicide, especially when certain ones are combined, e.g. double abuse alone or in combination with freedom from responsibility for a child, a current episode of affective cycling and severe hopelessness.
2. To identify the risk factors that can be diminished,

resolved or otherwise intervened with, e.g.: anxiety, hopelessness/worthlessness, psychosis and family conflict (decreasing the number of risk factors may decrease the risk of suicide).

3. To use as a guide for evaluation.
4. To ensure that the community standard of care is attained and to protect against legal liability.

Table 1 summarizes some of the risk factors for predicting suicidal behavior. Knowing how much to weigh each one in performing a suicidal evaluation of an individual is extremely difficult, because the risk factors have been determined from many different studies, with an equal number of different study designs. Nonetheless, they serve as a clinical guide, and have proven over time to have some utility.

TABLE 1. RISK FACTORS REGARDING SUICIDE

Based on the research of John J. Kluck, M.D.

RISK FACTORS	STATISTICS	COMMENTS
1. Age	Older age accounts for 39% of suicides. Rates of young people 15-24 has soared to almost rival the older group.	Perhaps due to overall increased stress levels.
2. Race	90%+ are Caucasians.	Rates are increasing in young black males.
3. Gender	Men comprise 75% of suicides. Women have three times as many suicide attempts.	Men tend to use more violent means, although there is a sharp increase in firearms with young people in general.
4. Sexual Orientation	Bisexual: Sexually active Homosexual: Not sexually active	Several surveys of teens and young adults indicate an increase in suicide attempts

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RISK FACTORS	STATISTICS	COMMENTS
5. Psychiatric diagnosis	<p>Percent of suicides:</p> <p>Major depression - 40-60% (of all suicides)</p> <p>Chronic alcoholism - 20%</p> <p>Schizophrenia - 10%</p> <p>Borderline personality - 5.4% - 18.5%</p> <p>Anti-social personality disorder - 5% (46% attempt)</p>	<p>>90% of suicides have at least one major mental illness diagnosis.</p> <p>Any co-morbidity increases risk. Co-morbidity of affective disorder and/or substance abuse increases risk, especially with anti-social personality, borderline personality disorder and substance abuse.</p>
6. Major affective disorder	<p>15% with affective disorder will commit suicide in their life-time. Suicidal thinking is a symptom. Bipolar suicide is poorly researched, probably because of methodological problems. Best guess is 15-19% suicide. Probably decreased rate in mania and hypomania, but may be increased at the switch and in mixed states.</p> <p>Incidence of suicide in pure mania is quite low.</p>	<p>Few are adequately diagnosed.</p> <p>Tranquilizers are over prescribed.</p> <p>ECT is underutilized.</p> <p>Anti-depressants are prescribed in inadequate doses and with inadequate monitoring</p> <p>Outpatient follow-up is inconsistent.</p>
Psychotic depression	<p>Psychotic depression has 5-6x > risk than non-psychotic depression. This is controversial as more recent studies show no difference with the presence or absence of depression.</p>	<p>Menstrual periods may correlate with suicidal behavior since affective disorders may be precipitated at this time.</p>
Seasonal affective disorder		<p>SAD may help account for bi-modal pattern for suicides - a very high peak in May, and a lower peak in October.</p>
7. Substance Abuse	<p>Alcohol is involved in 25-50% of adult suicides and up to 70% in adolescent suicides.</p> <p>With drug abuse, the incidence of suicide is 20x greater than general population.</p> <p>Double abuse (alcohol plus one other substance) increases the risk of suicide tenfold</p>	<p>Most alcohol suicides occur late in the illness, associated with rejection, interpersonal loss, and medical complications of the illnesses.</p> <p>Alcohol may potentiate drug overdose and contribute to fatal accidents.</p> <p>Alcohol worsens depression and contributes to disruption of interpersonal relationships.</p> <p>Possible explanation of increase of suicide in drug abuse include, having dismal life circumstances, certain personality vulnerabilities, lack of social supports, and certain biological factors.</p>

Touched by suicide

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Suicide Prevention and Intervention Plan

RISK FACTORS	STATISTICS	COMMENTS
8. Schizophrenia	15% suicide in their life-time	<p>Profile = Young, male, unemployed, with history of pre-morbid higher functioning.</p> <p>Risk factors = depression, hopelessness, suicidal ideation, fear, mental disintegration, a history of previous suicide attempts, a chronic relapsing course, use or abuse of alcohol or drugs and are not compliant with treatment.</p> <p>May have <i>akasthesia</i></p>
9. Attempters vs completers	<p>A previous attempt is one of the most powerful predictors of suicide.</p> <p>About 1% of attempters will commit suicide each year and 10-20% will in their life-time</p>	<p>Attempters = younger, female, impulsive, ambivalent, personality disorder, chemical dependency, situational disorder.</p> <p>Completers = older, male, use lethal means, with a high percentage of diagnoses of major affective disorder, alcoholism, and schizophrenia.</p> <p>In general, the more serious attempts, the more likely a patient is to suicide.</p> <p>Patients who threaten suicide have higher rates of completed suicide.</p>
10. Suicidal ideation	Caution: do not over rely in suicidal ideation	<p>Factors include:</p> <p>Degree of preoccupation - occasional to continuous.</p> <p>Degree of intent - the more determined and more immediate the intent, then the greater the risk.</p> <p>Having a plan - the more violent the method, then the more suicidal.</p> <p>Access to plan, weapons, automobile, etc.</p>

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RISK FACTORS	STATISTICS	COMMENTS
11. Suicidal behavior		<p>One useful instrument is Beck's Suicide Intent Scale that examines circumstances related to an attempt, the patient's self report, and the degree of risk of the attempt.</p> <p>It has been validated as a measure of seriousness of intent of a suicide attempt.</p> <p>Pierce found it best used in para-suicides and suicides over time.</p>
12. Hopelessness	Up to 90% of suicides have scores about 9 on Beck's Hopelessness Scale in both inpatients and outpatients.	<p>Hopelessness is treatable, especially by cognitive therapy.</p> <p>Beck's Hopelessness Scale asks 20 questions about thoughts of the future, feelings about the future, and motivation.</p>
13. Personality traits		<p>The following personality traits have correlated with suicide: being aggressive, being impulsive, being socially withdrawn, having more interpersonal difficulties and lower self-esteem, to be less trusting, being negative and having negative expectations, and being an excessive risk taker.</p> <p>There is little evidence that histrionic characteristics correlate with suicide.</p>
14. Cognitive traits and distortions		<p>The following cognitive traits have correlated with suicide: rigidity field dependence, helplessness, hopelessness, powerlessness, and experiencing control as being external</p> <p>Beck's "negative triad" of depression in relation to suicide is that the individual patient's thinking becomes distorted, in that the person has a negative view of himself, the future and the world.</p>

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RISK FACTORS

STATISTICS

COMMENTS

15. Psychosocial and environmental factors

The following have correlated with suicide: recent bereavement, separation or divorce, early loss, having an inadequate support system, loss of a job, impending disciplinary crisis, threat of incarceration, knowing someone who committed suicide, and exposure to media coverage of a suicide.

For older people, death of loved ones, especially spouses, retirement, one's own physical decline when associated with a history of poor adaptation to life stress, vulnerability to loss and disruptions, loss of mastery and control, and cognitive impairment caused by organic disease

16 Psychodynamics

- A. Affective State
 - 1. Rage (violence)
 - 2. Hopelessness, despair, and desperation
 - 3. Guilt
 - a. Deeds done or fantasized
 - b. Survivors guilt
- B. Loss
 - 1. Recent history of loss, real or perceived
 - 2. Psychodynamic meaning of the loss
 - 3. Capacity for grief
 - 4. Support in grieving
- C. Meaning of Suicide
 - 1. As a method of gaining control over their lives
 - 2. Reunion
 - 3. Rebirth
 - 4. Retaliatory abandonment
 - 5. Revenge
 - 6. Punishment or atonement

Touched by suicide

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Suicide Prevention and Intervention Plan

RISK FACTORS	STATISTICS	COMMENTS
17. Medical illness	Prevalence of physical illness in suicides is 25-70%	Medical illness may precipitate depression or other psychiatric illness, and/or produce an OBS. Almost always, a psychiatric disorder is present.
Cancer	Cancer several times controls, highest right after diagnosis, and those receiving chemotherapy.	There may be an association of other risk factors for suicide with specific types of cancer (for example, the association of alcoholism with gastrointestinal cancer). Some cancers such as pancreatic tumors, are associated with depressive symptoms before overt signs of cancer are apparent.
Huntington's disease	Huntington's disease = 6x increase over controls (same rate in family members who have not yet developed the disease)	People with a morbid fear of cancer are at higher risk.
Epilepsy	Epilepsy 4x controls, TLE 25x	
Peptic ulcer disease		PUD usually associate with alcoholism and history of surgery for PUD.
Renal dialysis	Renal dialysis 10-100x incidence to controls	Renal dialysis suicides are usually depressed.
Musculoskeletal disorders Spinal cord injuries Multiple sclerosis Cushing's disease Thyroid disorders Hyperparathyroidism		Medications used to treat can cause depression.
AIDS	167/100,000 99% male 87% caucasian 12% black Median age 36	Incidence is probably under reported because AIDS may not be listed on death certificate unless the coroner suspects AIDS as a direct cause of the suicide.
	There was a reduction in the rate of about a third from 1987 to 1989.	Perhaps the introduction of new treatments brought renewed hope.

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RISK FACTORS	STATISTICS	COMMENTS
18. Consultation with a physician	<p>80% of people with a first psychiatric complaint seek medical treatment.</p> <p>25-30% of ambulatory medical patients, have a psychiatric diagnosis.</p> <p>50% who commit suicide have seen a medical physician in the past month and 75% have seen a medical physician in the past six months.</p>	<p>Few are correctly diagnosed and even fewer are adequately treated.</p> <p>>60% who saw a physician, directly or indirectly expressed suicidal ideation.</p> <p>Many kill themselves with medication prescribed during those visits.</p>
19. Genetics and family history	<p>50% of persons with a family history of suicide, attempt suicide.</p> <p>6% of completers, also had a parent who committed suicide - 88x higher than expected.</p> <p>24 of 26 Amish who have suicided over a 100 years belong to one of four family pedigrees.</p> <p>Twin studies show up to a 20% concordance rate for suicide in identical twins.</p> <p>A Danish adoption study revealed 6 fold higher incidence of suicide in biological relations than in adoptees.</p>	<p>Possible familial mechanisms: identification with imitation, family stress 2° to the suicide or mental illness, and contagion.</p> <p>There may be separate genetic transmission for suicidality and psychiatric disorder.</p>
20. Other Factors		Increased with:
Marital status		Recently separated, divorced, or widowed.
Living situation		Alone
Occupation Employment status		High stress, unemployed
History of early parent loss		Present

SUICIDE IN COLORADO

This chapter reviews the epidemiology of suicide in Colorado: Who is committing suicide? When, where, and how? This chapter is filled with charts, tables and numbers. Even as we present them, however, we recognize that they do not begin to measure the magnitude of the suicide problem. The charts and numbers do not measure the suffering or the sadness. Nonetheless, it is essential to collect and analyze epidemiologic data, in order to develop state priorities, compare suicide to other pressing health and injury problems and identify high risk groups and risk factors for suicide. Epidemiologic data are also essential in order to develop, implement and evaluate prevention and control efforts and to set the agenda for suicide prevention research. Epidemiologic data provide “the information upon which public health decisions should be made.”¹

SOURCES OF DATA

Suicide deaths in Colorado are recorded on death certificates, maintained by the Vital Statistics Division of the Colorado Department of Public Health and Environment (CDPHE). Death certificates contain information about age, gender, race, marital status, education, county of residence and place and manner of death. Suicides for the total population and for subgroups (for example, teens or white males) are measured by the age-adjusted suicide death rate, expressed as deaths per 100,000 residents of Colorado.

Death certificates have several important limitations. First, death certificates do not provide information about many demographic, social and behavioral factors, such as employment, length of residence in Colorado, family structure, exposure to violence or recent stresses in school, marriage or social life. Clinical histories are also absent, including physical and mental illness and alcohol and substance abuse.

Another important limitation is under-reporting of suicides.² To classify a death as suicide, coroners or medical examiners need evidence, such as a recent period of despondency, a prior suicidal threat or attempt or a suicide note or warning. Often, information about intent is lacking. In a recent study of 984 suicide deaths in

Colorado, only 22 percent had made a previous attempt, and only 37% had a history of a previous suicide threat or gesture.³ Only 36% left a suicide note. When information about mental illness, despondency or suicidal behavior is absent, suicides may go unreported, and deaths may be misclassified as having a natural or “undetermined” cause.⁴ Deaths from drugs, medicines and poisons may be especially difficult to classify. Suicides may also be misclassified because of a lack of standardized definitions for reporting suicides, or because of a lack of adherence to those standards.⁵ And in some cases, suicides may be misclassified because of religious principles, taboos, fears or even “deliberate attempts [by the deceased or by survivors] to conceal a culturally unacceptable form of death.”⁶

No one knows the true extent to which suicides are under-counted. In one study of 446 deaths, the cause of death listed on death certificates was compared to that determined after an independent review of medical and legal evidence by a panel of experts. Ninety percent of suicides were recorded correctly on the original death certificates.⁷ However, a study from Allegheny County, Pennsylvania found that, among 10-19 years olds, suicide was under-reported by 24 percent.⁸

SUICIDE IN THE UNITED STATES

Each year about 30,000 Americans commit suicide. In 1996 suicide was the ninth leading cause of death, according to the National Center for Health Statistics.⁹ There were 30,903 suicides reported in 1996, for an age-adjusted rate of 10.8 per 100,000 population. This rate of suicide is about the same as death rate from human immunodeficiency virus (HIV) infection (11.1) and pneumonia and influenza (12.8), and it is higher than the death rate from homicide (8.5) or liver disease and cirrhosis (7.5).⁹

The national suicide death rate has remained stable during the past fifty years. The age-adjusted suicide rate in 1950 was 11.0 per 100,000 population, about the same as the rate in 1996 (10.8 per 100,000).⁹

Touched by suicide

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Touched by suicide

Age, Gender and Race

Age, gender and race are important risk indicators for suicide. The rate of suicide is 4.5 times higher in men (18.0 per 100,000 persons) than in women (4.0 per 100,000). The rate of suicide is highest in Native Americans (13.0) and Whites (11.6) and lowest in Hispanics (6.7), Blacks (6.6) and Asian/Pacific Islanders (6.0). All told, white men have the highest rates of suicides, followed by men of other races (especially Native Americans), white women and women of other races.⁹

In general, suicide rates rise with advancing age. People age 65 and older account for about 13 % of the population but almost 20% of all suicides. The group with the highest rate of suicide is elderly men. In 1996 the rate of suicide in men over 65 years of age was 35 suicide deaths per 100,000 population. For men age 85 and over, the suicide rate was 60 deaths per 100,000 population, 5 1/2 times the rate in the population-at-large and 13 times the rate of white women of the same age.

Suicide rates in adolescents, teens and young adults are also of special concern. Suicide is the third leading cause of death in persons 15-24 years of age, after unintentional injuries and homicides. Even among adolescents (between 10 and 14 years of age), suicide ranks fourth, after unintentional injuries, cancer and homicide. Suicide is the sixth leading cause of "premature" death in the United States, as measured by Years of Potential Life Lost before age 75.⁹

For young people 15-24 years of age, the suicide rate *increased three-fold* between 1950 and 1980. Most of this increase occurred in young men, where the suicide rate tripled from 6.5 to 20.0 per 100,000. Since 1980, the overall rate and the rate for males in this age group have remained relatively stable.

A striking increase in suicides has occurred among young black males.¹⁰ Although black youth have had, historically, a low rate of suicide, during 1950-1995 the rate for black males aged 15-24 years increased more than three-fold, from 4.9 to 16.7 per 100,000 population. Today, the rate of suicide among young black males is almost as high as that of young white males.⁹

Among children and adolescents (10-14 years of age), the rate of suicide is low. But even in this young age group, a rising trend is apparent. Between 1980 and 1992 the rate of suicide increased 120 percent among 10-14 year olds, from 0.8 to 1.7 per 100,000 persons.¹¹

Suicide Risk Factors

Numerous demographic, social and clinical variables emerge as "risk factors" for suicide.^{12,13} Suicide rates are higher among widowed, divorced or single persons, compared to married persons. Periods of unemployment correlate with higher suicide rates. And, except among the elderly, suicide rates are higher among persons with fewer years of education. Mental illness, especially depression, schizophrenia, alcohol and substance abuse, panic disorder and antisocial personality disorders, sharply increase the risk for suicide. Epidemiologic data also suggest that the risks of suicide are increased among persons with prior suicide attempts, chronic medical illnesses, family histories of suicide or mental illness, family violence and household ownership of guns.

Methods of Suicide

Most suicides in the United States are committed with a firearm. Throughout the 1980's and 1990's firearms were used in about 60 percent of suicides, followed by poisoning (18%), strangulation, hanging or suffocation (15%), and cutting or piercing (1%). "Other" or unspecified means account for about 6% of completed suicides.¹² Firearms are the leading means of suicides in men and women, whites, blacks, Hispanics and Native Americans, and in every age group from adolescence through old age.

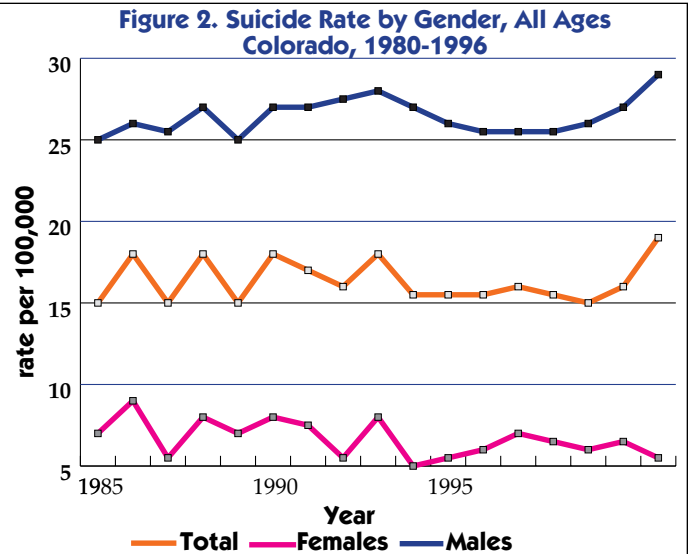
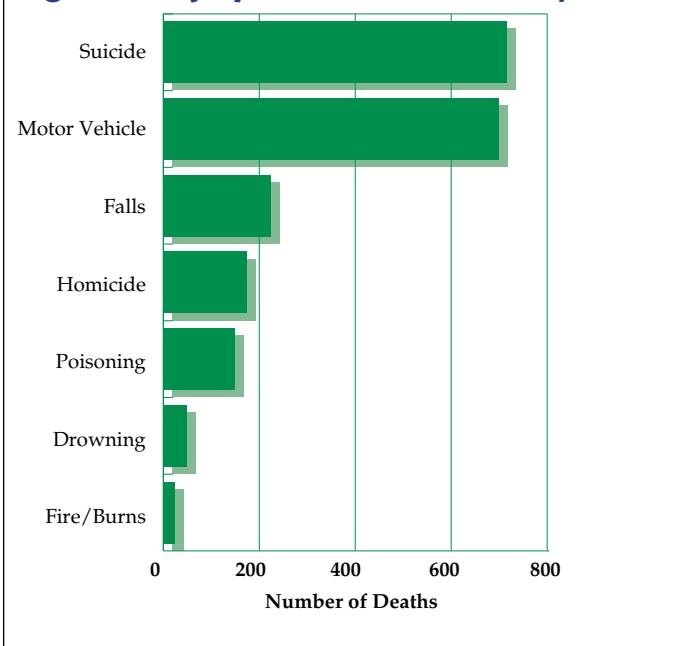
SUICIDES IN COLORADO

Suicide is Colorado's seventh leading cause of death.¹⁴ There were 692 suicides reported in Colorado in 1996, more than 55 deaths each month. In 1996 there were more deaths from suicide than from motor vehicle crashes (667), diabetes (552), homicides (213) or AIDS (244).

As shown in Figure 1, suicide is the leading cause of injury-related death, surpassing motor vehicle crashes, homicide, falls, poisoning, drowning and burns.

The rate of suicide in Colorado has remained relatively constant over the past 16 years (Figure 2). The current (1996) rate of suicide is 16.6 per 100,000, about the same as it was in 1980 (15.7). During this period the suicide rate for females has declined by 22 percent, while the rate for males has increased by 13 percent.¹⁴

Figure 1. Injury Deaths in Colorado, 1996



Comparing Colorado to Other States

In 1995 Colorado ranked fifth in the nation in suicide.¹⁵ In 1996 Colorado's age-adjusted rate of suicide was 16.6 per 100,000 resident population, compared to the national average of 10.8. Even after adjusting for variables such as age, gender, race and Hispanic origin, Colorado's rate of suicide is almost forty percent higher than the national average.¹⁶ What's more, Colorado's suicide rate has exceeded national averages at least since 1910, when suicide data were first collected.

Even today, there is no satisfactory explanation for Colorado's high rate of suicide. Suicide rates are, in general, higher in Western states than in the South, Midwest or Northeast. The reasons are unknown. Population density, family structure, education, employment and isolation could play significant roles. There is some evidence that migration patterns are associated with suicide rates; studies suggest that suicide rates are highest in states with large numbers of persons who migrate in from other regions.

Although some experts have postulated that differences in firearm ownership, access or use could explain regional differences, recent studies by the Centers for Disease Control and Prevention (CDC) suggest otherwise. In a recent report the CDC noted that firearms are the leading method of suicide in all sections of the country; during the years 1990-1994 firearms accounted for more than half of all suicides in every geographic region of the U.S. except the Northeast (45%).¹⁶ The CDC also found that suicide rates in Western states were 70

Suicide Prevention and Intervention Plan

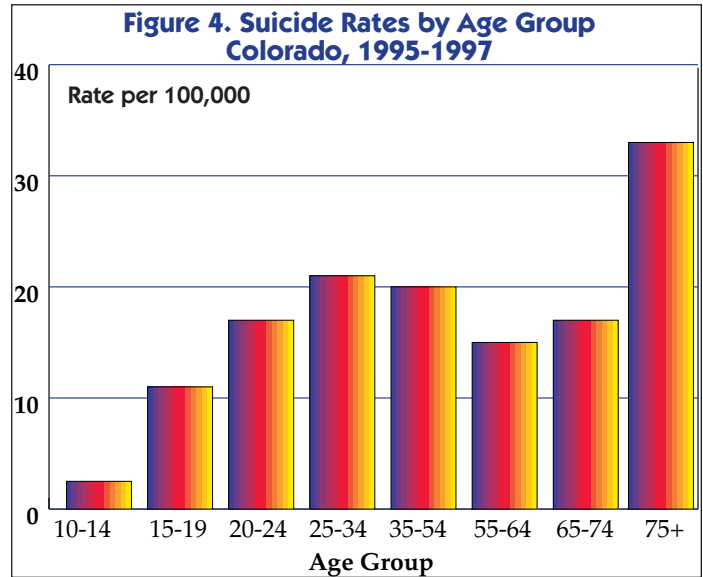
percent higher than in the Northeast and 25% higher than the national average. However, when suicide rates were stratified by method, rates were highest in the West for all methods *except firearms*. Firearm-related suicides were highest in the South; overdoses were disproportionately high in the West.

Clearly, additional research is needed to understand regional differences in suicides and to help develop focused strategies for prevention and control. The Governor's Suicide Prevention Advisory Commission lists "additional research to determine the reason(s) for Colorado's high suicide rate" as a top priority.

An Overview of Suicides in Colorado

There is no single rate of suicide in Colorado; rates vary according to age, gender, race and other factors. During the three-year period 1995-1997 there were 1965 suicides reported in Colorado (an average of 655 suicides each year). Of these suicides:

- Eighty-one percent of all suicides occurred in men (Figure 3).
- White males (including Hispanics and non-Hispanics) accounted for 77% of all suicides in Colorado; white females accounted for 19 percent.
- In order, the highest rates of suicide occurred in white men (28 per 100,000), Native American men (19), black men (15) followed by white women (7).
- Suicide rates increased with advancing age (Figure 4). The highest rates were in the elderly (75 years and



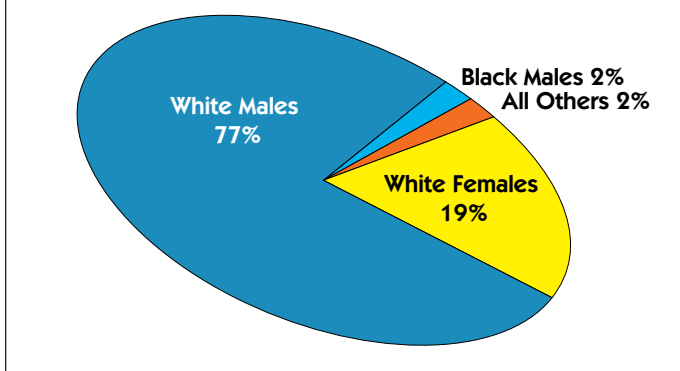
older). For men in the "oldest old" age category (age 85 and over), the suicide rate was 106 per 100,000, more than 6 times the rate in the population -at- large.

- In 1996 suicide was the second leading cause of death among Colorado children, teenagers and young adults in every age category between ages 10 and 34.
- In the past three years (1995-1997) 136 children and teens, ages 10-19 years old, took their own lives.

Methods of Suicide

In Colorado, as in the rest of the nation, the most common method of suicide is use of a gun. During 1995-1997 there were 1,965 suicides reported in Colorado. Of these, firearms accounted for 55%, followed by hanging/strangulation/suffocation (16%), motor vehicle exhaust and other gases (12%), drug overdose/poisoning (12%), cutting or piercing (2%) and "other" or "unspecified" means (2%) (Figure 5 next page).

Figure 3. Distribution of Suicides by Race and Gender Colorado, 1995-1997

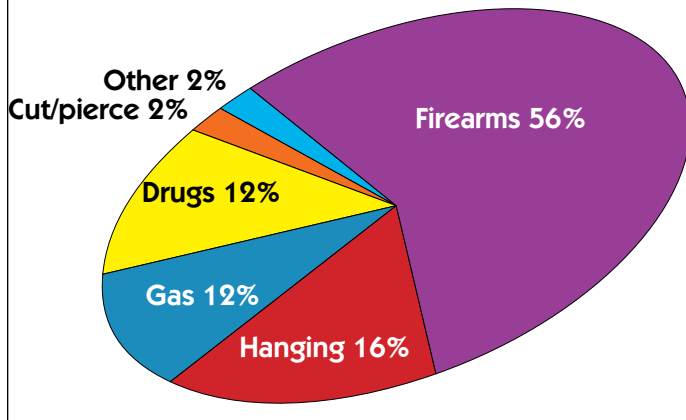


Touched by suicide

❖ Cliff Wink ❖ Jim Wink ❖ Jen Wink ❖ Kim Kort ❖ Barbara Van Zuiden ❖

Touched by suicide

**Figure 5. Method of Suicide
Colorado, 1995-1997**



Characteristics of People Committing Suicide in Colorado

In 1994 CDPHE, along with 9 county coroners, conducted a detailed analysis of 984 suicides that occurred during 1990-1993.³ The study consisted of a series of “psychological autopsies;” that is, coroners gathered information about each victim’s medical and mental health, suicides notes, recent periods of loss or despondency, and precipitating causes and events just prior to death.

Among the 984 victims, 17 percent had been hospitalized previously for a mental illness. Twenty-two percent had made at least one previous suicide attempt, while 37 percent had a history of previous suicidal threats. Other features of the suicide cases included: Death of a family member or friend in the preceding year (10%); suicide or suicide attempt in a family member or friend in the preceding year (11%); recent loss of a spouse, relative or friend (29%); and, a recent period of despondency (62%).

Almost two thirds of all persons had at least one diagnosed medical or psychiatric condition at the time of their death. Psychiatric and substance abuse conditions were the most common, including depression (29%), alcohol abuse (18%), “other mental illness” (10%), and drug abuse (8%). Heart disease (6%), cancer (6%), chronic obstructive lung disease (4%), and HIV infection or AIDS (3%) were present less often. Half of all victims had alcohol detected in their blood at the time of their death.

The county coroners also attempted to determine the principal reason for each suicide, based on information provided by family members, friends and other survivors. The leading reasons were illness in the victim (22%) and relationship problems (21%). Marital, financial and disciplinary problems were also common precipitants.

Finally, the coroners made inquiries about recent visits to health providers. Information was available only for 216 (22%) of the 984 suicide victims. Of these, 60% had visited a health care provider in the month preceding their death; 54 % had visited a provider within the week. Of the 216 suicide victims, 14 (6%) had visited a health care provider on the day of their death.

Handgun Ownership and Suicide Risk

National studies have indicated that household ownership of guns increases the risk of suicide, even after considering other factors, such as age, race and income and medical and mental illnesses.¹⁷ Similar results have been found in Colorado. In 1994 CDPHE conducted a case- control study to investigate whether household access to firearms was a risk factor for adolescent suicide.¹⁸ The study involved Colorado youth, less than 18 years of age, who committed suicides in the three year period 1991-1993. The presence of a gun in the home increased the risk of suicide four-fold, even after accounting for other key risk factors, such as impulsive behavior, mental health treatment and drinking.

Teen Suicide

No one is sure why teens choose to take their lives. Clearly, psychiatric diseases, especially depression, mood and conduct disorders and alcohol and substance abuse, contribute to the risk of teen suicide. At the same time, according to the report, *Violence in Colorado*, of the 44 teenagers who committed suicide in Colorado in 1990, “most were impulsive, with little or no planning.”¹⁹ Other factors may contribute to a teen’s risk of suicide: Poor impulse control; the physical and sexual changes and pressures of adolescence; family discord or violence; school-related or social events that bring shame, humiliation or rejection; and trigger factors, such as alcohol or access to firearms.²⁰ The television and print media may also add to the risk of suicide; teens appear

to be particularly susceptible to glorified portrayals of suicides by other teens, leading to well-documented “outbreaks” of teen suicides, sometime described as a contagion effect²¹

NONFATAL SUICIDAL BEHAVIOR IN COLORADO

It is more difficult to obtain information on nonfatal suicidal behaviors (suicidal ideation, plans and nonfatal attempts). Unlike the vital records system for death certificates, no uniform tracking system exists for nonfatal suicidal behaviors.

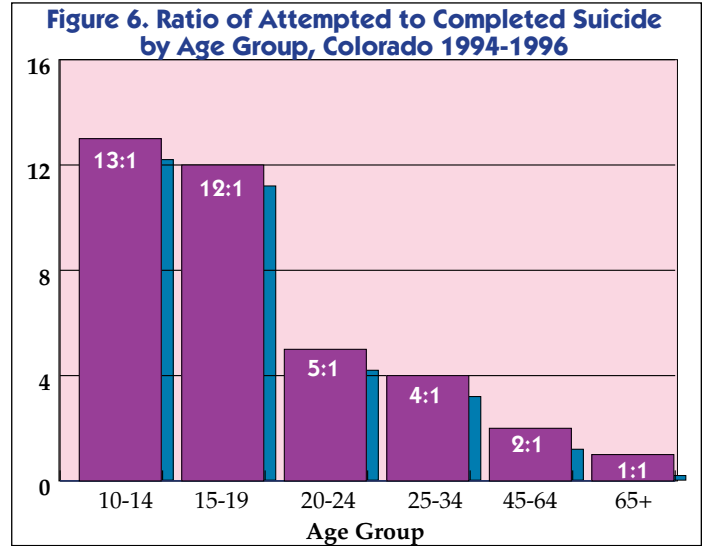
Some experts consider fatal and nonfatal suicides as separate entities, affecting different populations. Indeed, there are important epidemiologic differences between the two. Whereas males commit suicide five times more frequently than females in Colorado, females make more nonfatal attempts. Most fatal suicides are committed using guns, whereas most nonfatal attempts are made using drug overdose or other methods.

Despite these differences, a consideration of nonfatal suicidal behavior (often referred to as “attempts”) is warranted, for several reasons. First, according to some estimates, nonfatal attempts occur *25 times more often* than fatal suicides.¹³ Second, a suicide attempt is a strong risk factor for later suicide. And third, nonfatal suicide attempts add significantly to the emotional burden, medical morbidity and overall costs of suicidal behavior.

Hospitalizations

One measure of nonfatal suicidal behavior is the Colorado Hospital Association (CHA) discharge data set, which tracks all admissions to acute care hospitals throughout Colorado. The CHA discharge data set includes patients hospitalized for 24 hours or longer; patients who do not seek medical attention, and those who are treated in offices, clinics and emergency departments, are excluded. In addition, to be included in the data set as a suicide, the hospitalization must be recognized as a suicide and coded properly.

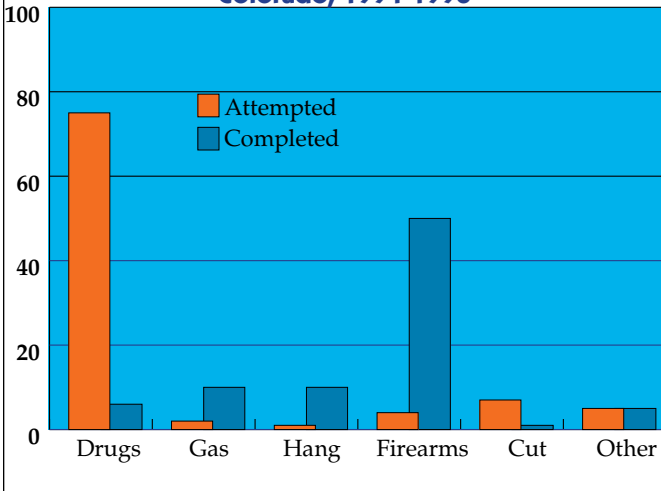
In one 3-year period (1994-1996), during which 1,939 fatal suicides were reported and coded on Colorado



death certificates, there were 7,800 persons who were hospitalized in Colorado because of suicide attempts, for an annual average of 2,600 admissions. A high proportion (60%) involved women. In the general population, suicide attempts leading to hospitalization outnumbered fatal suicides by a ratio of four to one.

The ratio of hospitalized attempts to completed suicides varied across age groups (Figure 6). For example in the age group 10-14 years, there were 13 children hospitalized for a suicide attempt for every child who died from suicide. This ratio declined with advancing age. In the oldest age group (65 and older) the ratio was one to one. The difference in lethality corresponds to differences in methodologies used. Most hospitalized suicide attempts result from drug overdoses, while completed suicides are more likely to involve guns (Figure 7 next page).

Figure 7. Completed and Attempted Suicide by Method Colorado, 1994-1996



Surveys of Nonfatal Suicide Attempts and Behaviors

Youth suicide ideation and attempts have also been measured by the Colorado Youth Risk Behavior Survey (YRBS), a biennial survey of adolescents and teens enrolled in grades 9 through 12 in public and private schools.²² The YRBS was developed by the CDC to identify critical, health-endangering behaviors among youth. The survey includes data about suicidal ideation, plans and attempts. In 1995, 8% of Colorado high school teens had made one or more suicide attempts in the previous year. Of these, one-fourth were serious enough to require medical attention. Among all high school students surveyed, 22% had seriously considered, and 17% had planned, a suicide attempt in the previous year. Suicidal thoughts, plans and attempts were reported significantly more often by females.

Another survey, the Colorado Behavioral Risk Factor Surveillance System (BRFSS), provides information about the behaviors and preventive health practices of Colorado adults. Using random digit dialing techniques, approximately 150 Colorado adults (age 18 and over) are interviewed each month. In 1996 questions regarding suicidal behavior were added to the survey. When asked, "In the past year have you ever seriously thought about trying to hurt yourself in a way that might result in your death?" 3% of the respondents said, "Yes." Of these, 19% had actually made one or more suicide attempts.

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Touched by suicide

❖ Rose Appio ❖ Marcy Balogh ❖ Sandy Fleischer ❖ April Fleischer ❖ *Michael Jess ❖

Touched by suicide

REVIEW OF OTHER STATES

Introduction: Do State Plans Help Prevent Suicide?

This section is a review of suicide prevention plans from other states. It begins by considering a broad, but important question: Is there any evidence that state plans — including Governors' Commissions, Conferences, Blue Ribbon panels, and the like — reduce the numbers or rates of suicide?

Lester (1992) examined the effects of state government initiatives from 1980 to 1987 for their effects on teenage suicide rates. Of the nine activities (legislation, government involvement, commission task force, manuals and brochures, school curriculum, training conferences, priority policy plans, direct services and special studies), only three activities—legislation, commission task forces, manuals or brochures showed any statistically significant, positive impact. Student participation in school-based suicide prevention programs was associated with a detrimental effect on absolute state teenage suicide rates (but not on percentage increases in youth suicide rates).

In a more recent study Metha, Weber and Webb (1998) reported on state initiatives directed at youth suicide prevention since 1980. Governors were surveyed during 1992 and 1996 with respect to their state's efforts in suicide prevention. Questions were asked about legislation, mandated or recommended school-based suicide prevention curricula, funding, special advisory councils, state plans, development and dissemination of materials, and assessment. These data were compared to the number of suicides, suicide rates and percentage change in suicide rates for 15-29 year olds for the periods 1979-1981 and 1992-1994. There was no significant relationship between changes in suicide rates and any of the state variables studied.

While the results of these "macro" studies are somewhat discouraging to planners of state initiatives, it may be that correlational studies such as these are simply not sensitive enough. No accommodation was possible for the characteristics of the various programs in terms of duration, intensity, quality or evaluation. The message is to build in careful program evaluation of every state initiative proposed in order to track its short- and long-term efficacy in reducing suicides. It should also be

pointed out that the studies were limited to effects on youth suicide rates; other at-risk populations were not studied.

States Involved In Suicide Prevention Initiatives

In a recent survey Metha et al (1998) obtained information about current state plans in adolescent or youth suicide. Nineteen states said they had adopted legislation regarding youth suicide prevention. Only four states have mandated or recommended suicide prevention programs, but other states have it required as a component in a required health education program. One state teaches it as part of a mandated life-management skills program. In other states, the curriculum on suicide prevention has been recommended, but not required. Only Arizona, Iowa, and Rhode Island reported they had ear-marked funds for the support of a suicide prevention curriculum. Twenty-four states reported they have, or have had, an advisory council, commission or task force on adolescent suicide prevention.

Based on the Metha study, only nine states reported they had state-initiated or state-supported programs for screening of youths for suicide risk. Almost all states have been involved in development and dissemination of youth suicide prevention materials. However, it was interesting to note that few states sponsored public education campaigns to restrict access to lethal means of suicide. A number of states have used federal or local funding to assess the extent of the problem on youth suicide in their state and to evaluate some programs. Several states have urged schools and community health centers to develop crisis intervention or emergency response plans. Over half of the states reported they were involved in school and community gatekeeping. Several states stressed their emphasis on cultural diversity and inclusion of the needs of special populations.

Metha et al mentioned omissions in the materials provided by the states in terms of lack of adequate funding to evaluate and disseminate information about successful programs, and the lack of state plans which

addressed long-term change. One exception is the Youth Suicide Prevention Plan for Washington State (Washington State Department of Health, 1995) which incorporates youth suicide programs which have been researched, and the Washington State plan outlines a rigorous plan for program evaluation and surveillance of new initiatives.

West (1998) reported on new developments since the survey conducted by Metha et al. Diverse partnerships, including family survivors of youth suicide, medical examiners, and health providers, have been instrumental in the passage of state legislation. Partnerships have also helped to gain funding for youth suicide prevention in Oregon and Washington and to support a Utah research study profiling youth suicides.

West (1998) notes the recent accomplishments of the western states, including legislation and state support for youth suicide prevention, and newly formed state task forces in Colorado and North Dakota. Colorado is implementing Child Fatality Reviews for all youth suicide deaths. Alaska is establishing community-based suicide networks. Utah is completing its research study, and Idaho is conducting training for gatekeepers. Washington state has implemented parts of its state plan including a media campaign, training of gatekeepers and increasing capacity of community crisis response groups.

Other State Plans and Initiatives— Colorado Survey

Seven states have developed or are in the process of developing, state plans for suicide prevention. These states are Arizona, Maryland, Oregon, Texas, Vermont, Washington, and Wisconsin (Metha et al, 1998). The Governor's Suicide Prevention Advisory Commission administered a faxed survey to State Health Departments in other states in the spring of 1998, which brought a response from an additional state, Maine. To the best of our knowledge, with the addition of the Colorado plan, the number of states with systematic plans to prevent suicide now numbers nine.

Most of the plans have established goals, objectives, timetables and actions to be taken that emphasize prevention, intervention, and postvention activities (Metha et al, 1998). Almost all plans were developed to address only youth suicide. Some of the more recent state plans are recommending systematic evaluation of the interventions.

The Maryland plan is the original state effort and has received attention as a model program over the years. The plan which includes media campaigns and school components, was dramatically effective in that the state of Maryland had the fifth highest rate of suicide in the U.S. in 1989. After implementing their state prevention and awareness program, Maryland now ranks 45th. A more recent plan developed by the state of Washington has been cited as among the most comprehensive.

Appendix G reviews the responses of representatives from state health departments that received a faxed survey from the Colorado Department of Public Health and Environment. The survey, conducted in the Spring of 1998, inquired about whether there was a state plan or other initiative to prevent suicide. Appendix G presents more details about the information received, plus an analysis of information on state initiatives already on file at the Colorado Department of Health and Environment and the Mental Health Association of Colorado. The faxed survey responses may be biased, because we received responses from only 19 of the 50 states.

Summary

Lester (1992) found limited correlational evidence for the effectiveness of three state-level suicide prevention initiatives, and Metha et al (1998), in a more recent study, found no evidence for the effectiveness of state programs in reducing suicide rates. Despite the lack of comprehensive evidence of state plans in suicide prevention many states continue to view this as an important step in addressing suicide prevention (West, 1998). To date, nine states have developed state plans. Almost all of them have focused on youth suicide, and the more recent ones such as Washington State's plan, have stressed the importance of a research base and systematic program evaluation. These new initiatives will likely result in research and evaluation findings which will guide states and communities in their planning and implementation of programs to prevent suicide.

PREVENTION AND INTERVENTION

To answer the question, “What works in suicide prevention?”, an evidence-based review of research studied and published since 1983 was conducted. The original pool of 397 potential articles was pared down by including only data-based studies.

Studies were assessed using a 6-level scale for research rigor: 1) Systematic reviews; 2) Randomized pre-test and post-test studies with a control group; 3) Nonrandomized pre-test and post-test studies with a convenience sample for comparison studies; 4) Weaker, quasi-experimental studies; 5) Correlational studies; and 6) Descriptive studies.

The evidence was organized into 12 emergent program categories:

- I. School-based programs
- II. Suicide Prevention Centers
- III. Telephone crisis lines and hotlines
- IV. Limiting access to lethal means
- V. Training of professionals
- VI. Training of community gatekeepers
- VII. Media and public information/Cluster suicides
- VIII. Postvention followup of suicide/Programs for suicide survivors
- IX. Spiritual and ethical issues
- X. Mental health programs for attempters
- XI. Suicide prevention in correctional facilities
- XII. Promising programs for special at-risk populations

Many, but not all, of the studies focus on adolescent suicide. In general, more information was available for programs higher on the above list.

The following is a summary of the conclusions that were drawn after a critical review of the available research literature. A full report is available through the Colorado Department of Public Health and Environment.

I. School-based Programs

Conclusions. A number of well researched literature reviews are available on the topic of school-based programs (Level 1 evidence). The most recent one by Mazza (1997) is particularly useful. The reviewers universally present opinions that the school-based programs are not justified in terms of what they deliver. It should be noted that most programs offer only brief intervention sessions of a few hours. The label “curriculum” is misleading, because most of the programs are “one-shot”, brief training sessions without followup. This does not mean that better designed school-based interventions might not be effective. For studied programs the rather trivial outcomes of increases in knowledge and changes in attitude have been documented by experimental and quasi-experimental studies (Levels 2 and 3). However, there is evidence from several studies that some programs may negatively affect males and attempters. Correlational data (Level 5) at the state level has not substantiated effectiveness of school-based programs in reducing suicide rates. In fact, student participation in school-based suicide prevention programs was the only factor associated with a detrimental effect on state teenage suicide rates! One study (Vieland et al., 1991) that followed students 18 months after a program did not find significant effects of suicide rate reduction. While reviewers have suggested that schools can be a good access point to reach youth, programs need to be redesigned. Based on the evidence reviewed, the programs at best only appear to affect student self-reports of knowledge and attitudes. There are some harmful influences for some subgroups for programs that target all youth. Further research is needed to see if newly designed programs affect the crucial outcome variables of reduction of suicide ideation or suicide rates—or increase student’s skills in coping with distressed peers (being good peer gatekeepers).

Another limitation of the studies is that almost all of the programs targeted high school students, and a few targeted junior high school or middle school populations. Two recent policy articles (Bushong, Coverdale, & Battaglia, 1992; Potter, Rosenberg, & Hammond, 1998) suggest school-based interventions should be very different for these two populations and that the transition from middle school/junior high to high school is a stressful time that needs programmatic attention. Bushong et al. (1992) suggests that school-based programs cannot exist in isolation but need the contextual support of community and state agency policy and programs.

Only a few studies addressed programs for college students. The evidence on campus-based suicide prevention programs is sparse and represents only levels 4 and 6 (quasi-experimental and descriptive), evidence; no systematic conclusions can be drawn. More research is needed in this area.

II. Suicide Prevention Centers

In 1997, Lester et. al performed a review of 14 independent studies of the effects of suicide prevention centers. The findings were mixed. Seven studies provided some support for a preventive effect; one found an increase in the suicide rates where there were more suicide prevention centers, and six failed to find any significant effects. The meta-analysis of the 12 studies with sufficient data found a preventive effect from suicide prevention centers, although the effect was small and not statistically significant. However, one needs to interpret the result with caution because the absolute correlation was so small. Even with the mixed results, the reader needs to keep in mind that all of these studies were correlational in nature, and no causal conclusions can be drawn.

Conclusions. There is mixed support for the effectiveness of suicide prevention centers in reducing suicide rates. Lester (1997) suggests that the use of number of centers in a region may be too crude a measure, and other measures such as number of people providing services, or volume and type of clients using centers may prove to be more informative when the data becomes available.

III. Telephone Crisis Lines and Hotlines

There are no recent, methodologically strong studies on the effectiveness of suicide prevention hotlines. Reviews conducted in the mid-1980's suggest there is no credible evidence that hotlines prevent suicides; however, there is some evidence that they may be useful for information and referral purposes. Albers and Foster (1995) suggest there is some evidence that while many crisis centers were established with the primary purpose of suicide prevention, in actuality suicide related calls only represent about a tenth of the calls. Women tend to be more frequent callers than men. The remaining research studies reviewed on hotlines were descriptive in nature and described specific crisis lines and samples of callers.

IV. Limiting Access to Lethal Means

Restriction of lethal means, in almost all cases in the literature translates to study of some form of firearms control or presence/absence of firearms in the home and the relationship to suicide rates. Given that research studies on restriction of means other than guns are relatively few (e.g., car exhaust, poisons, drugs), they were excluded from this review. Obviously, gun control is a politically explosive issue. This review sets political issues aside and attempts to look only at the evidence on restricting access to guns and suicidal behaviors.

Conclusions. Many correlational studies have linked suicide and firearms availability. The results are mixed as to whether this contributes to reducing the overall suicide rate, or that individuals merely seek other means (displacement). Studies conducted before and after legislation restricting firearms generally document a decreased rate of suicides with firearms after the legislation. The more recent case-controlled studies with adolescents document that having a firearm in the home is associated with greater rates of adolescent suicide, suggesting a clear recommendation to remove firearms from homes of at risk adolescents. While in the past suicide by means of firearms has been linked with males and with adolescents, there is a growing trend for older women to use this method as well. Despite this strong evidence that stricter gun control is associated with lower suicide rates, very few states have sponsored public education campaigns to restrict access to lethal means (Metha et al., 1998, p. 160).

V. Training of Professionals

Professionals are defined here as medical or mental health care professionals. The literature can be divided into educational programs for professionals in training or programs offered to practicing professionals.

Conclusions. The research literature on the need for training and type of training needed for health and mental health providers is sparse and fragmented. There appears to be a lack of knowledge about the degree to which suicide prevention is a part of the curriculum of professional schools of medicine, nursing, social work, and psychology. Several studies have documented that contacts with professionals prior to suicide attempts have resulted in professionals being unable to detect the potential risk of suicide. While logically, one would conclude that better training for professionals would result in fewer suicides, no data supporting this proposition could be found except the Gotland study in Sweden (Rihmer, Rutz, & Philgren, 1995; Rutz, von Knorring, Philgren, Rihmer, & Walinder, 1995; Rutz, von Knorring, Walinder, 1989; Rutz, von Knorring, Walinder, 1992; Rutz, et al., 1989) which resulted in fewer female suicides with improved intervention training for general practitioners.

VI. Training of Community Gatekeepers

Community gatekeepers are individuals who might serve as the first line of recognition and referral for a distressed individual at risk for suicide. Gatekeepers include peers, teachers, clergy, parents, foster parents, and other community contacts who are in a position to serve in this role. Most of the literature on gatekeepers is from the school context of gatekeepers for adolescents—whether they be peers, teachers, or parents.

Conclusions. Gatekeeper training is a popular state preventive effort, with over half the states reporting they engage in this (Meetha et al., 1998); however, the effort is lacking in systematic evaluation of the outcomes. The research studies on effectiveness of community gatekeepers for prevention of youth and young adult suicide are eclectic and do not form a coherent body of evidence. Studies of youth suggest that they are not likely to tell an adult if a suicidal peer confides in them. A promising intervention study with positive self-report results used a form of peer contracting. Results on the effectiveness of gatekeeper training for teachers remains inconclusive. Little is known about the effectiveness of

gatekeeper training targeted for at risk populations other than youth.

VII. Media and Public Information \ Cluster Suicides

There is correlational evidence at the state level that media campaigns reduce increases in youth suicide rates (Lester, 1992), and almost all states have some form of suicide prevention media campaign (Metha et al. 1998). The CDC (O'Carroll & Potter, 1994) has developed guidelines based on research and practice for communities and the media regarding suicide. Evidence on the effects of the media with regard to cluster suicide have been inconclusive, but the CDC offers recommendations; there is consensus that followup is needed after a cluster suicide situation has emerged, particularly with at-risk individuals. This followup, called postvention, is reviewed in the following section.

VIII. Postvention Followup of Suicide/Programs for Suicide Survivors

Postvention is a term used to describe community followup after a crisis, particularly a series of adolescent suicides (cluster suicides) or a traumatic death. Prevention practices are designed to eliminate suicide contagion, the application of social learning theory that other individuals—particularly adolescents—might imitate suicide behavior if they identify with the characteristics of the individual committing suicide and if they see some rewards in the act (e.g., media attention). Postvention programs are designed to prevent or contain suicide clusters and to facilitate grieving of the survivors.

Conclusions. Study of suicide survivors (friends, siblings, and parents of suicide victims) and the effectiveness of offering them postvention, crisis and intervention services is a relatively new prevention area. Brent et al. (1996a, 1996b), in three-year follow up studies, finds survivors suffer from distress but are not at increased risk for suicide. While some follow-up studies suggest postvention programs are effective in reducing experience of symptoms like depression and that they might reduce suicide contagion among adolescents, others show no effect. The research is too incomplete to draw firm conclusions. Experts in the area are calling for

more research by partnerships of clinicians and researchers.

IX. Spiritual and Ethical Issues

While this is a very significant area for persons concerned about suicide, probably the most important writing in this area was not captured in the review of research articles addressing spiritual or ethical issues. Theological and law journals were not included in this review.

Conclusions. The research literature appears to be inadequate to the task of delineating spirituality and ethical issues with regard to suicide. More informative treatises may be found in the theological and legal literature. Ethical issues such as physician-assisted suicide and laws regarding the reporting of suicide that might conflict with religious beliefs abhorring suicide, were not pursued in this limited review. No research study could be located on the effects of an intervention such as prayer on suicide prevention or on assisting the survivors.

X. Mental Health Programs for Attempters

While clinical best practices and treatment interventions using drugs or individual therapy were excluded from this review, more recent and rigorous research on macro programs addressing followup outpatient programs for suicide attempters were reviewed for possible model programs. Much of the research studies the effectiveness of outpatient follow-up treatment with adolescent attempters.

While the research on the effectiveness of followup programs for adolescent attempters is relatively recent, it is of relative high quality. Several quasi-experimental studies have evaluated programs which tried to improve compliance with emergency department recommendations for followup outpatient care for attempters. While compliance was increased, a significant reduction in suicides could not be demonstrated in all of the studies. One randomized controlled study found a special followup program for attempters was effective, while another was unsuccessful. It appears that despite the promising new studies, the research remains conflicted on the effectiveness of followup outpatient treatment for adolescent attempters.

XI. Suicide Prevention in Correctional Facilities

It should be noted that corrections and law journals were not searched for information on suicide in correctional facilities; only the data bases listed at the beginning of the chapter were searched.

Suicides occur at higher rates in correctional facilities than in the general population. Standards have been developed to reduce the incidence. New York and Texas have published the most information on the effectiveness of these programs, which have demonstrated reductions in jail suicide rates despite increases in inmate populations. More research is needed on programs to reduce suicides in jails and juvenile detention centers.

XII. Promising Programs for Special At-Risk Populations

This section looks at some promising intervention programs targeted for special at risk populations. Many studies were excluded from review that only identified risk factors and recommended potential programs that could be developed based on risk factors. In most cases an article had to present an intervention strategy and have some type of evaluation component or data analysis to be included.

More research has been conducted on suicide prevention strategies for Native Americans than for other ethnic minority groups. However, the evidence is so sparse and of poor quality, that no meaningful generalizations can be drawn about what type of intervention is successful with different ethnic minority groups. Research on gender suggests that suicide prevention and treatment efforts need to be tailored differently for men and women. Although the research on sexual orientation is relatively new, there is evidence, particularly for adolescents, that gay adolescents are more at risk for suicide than are their heterosexual peers, but no prevention or treatment program has been suggested and evaluated. There has been a flurry of research on elder suicide in the past few years, but careful studies of proposed interventions are still lacking. Only one study from Finland could be found on differences among rural and urban suicides, so more research is definitely needed in this area. Thus, in summary more research is needed for programs targeted for special groups at risk for suicide.

GSPAC RECOMMENDATIONS

Governor’s Suicide Prevention Advisory Commission Recommendations

We believe that the number of Coloradans dying from suicide can be reduced. This section presents four major recommendations for preventing suicide in Colorado. For each recommendation, specific implementation tasks are included.

We base our recommendations on three key principles. First, suicide prevention strategies should be chosen only after a careful review of the scientific evidence. Unfortunately evidence-based research is limited. Therefore, our recommendations are based on both the scientific literature and on the critical experience of suicide prevention experts. The published literature and the practical experience of members of the Governor’s Suicide Prevention Advisory Commission and the Citizens’ Advisory Panel point to a number of promising interventions that are likely to lower suicidal behavior, with little risk of harm.

The second principle is that suicide prevention strategies must be implemented at both the state and the community levels. As discussed in greater detail in the introduction and background section, the term “community” refers not only to geographic locals but to *any group of people who share specific biological, social and/or geographic characteristics*. The benefits of focusing on both system changes and prevention and intervention services, are supported by the literature on system change. The United States General Accounting Office (GAO) reviewed the experience of several states that had made efforts to effect improvements in human services. The GAO audit found that improved outcomes were minimal unless there were parallel efforts to improve or re-engineer services at both the system (statewide) and community service levels.

The third principle is that suicide prevention is ever-changing. The Colorado Plan for Suicide Prevention includes concrete recommendations and specific implementation tasks. At the same time the Plan is only a starting point, a template for action. In the future, scientific knowledge and practical experience will grow, and new suicide prevention strategies will be proposed and tested. The Colorado Plan for Suicide Prevention is a fluid plan, one that should be tested regularly and should evolve in light of new knowledge.

The members of the Governor’s Suicide Prevention Advisory Commission approved the recommendations and specific implementation tasks on November 11, 1998.

Recommendation #1

Develop a “lead entity” to assume responsibility for the development of an ongoing system for ensuring integrated, coordinated and effective information and services for prevention of suicide.

We begin with a recommendation that provides the framework to carry out suicide prevention and intervention efforts. This “lead entity” will serve as the central point of responsibility for coordination, development and evaluation of all aspects of this plan. From public information to best practice guidelines, we believe it is vital that a “lead entity” be created.

Specific Implementation Tasks:

- ❖ Create a “lead entity” to be composed of a partnership between state and private agencies/organizations (including suicide survivor organizations) to assume responsibility

Suicide Prevention and Intervention Plan

for development of a comprehensive plan for suicide prevention including long-term resource development.

- ❖ Define the structure of this entity. Options include it taking the form of a 501(c)(3) or a combined state and private agency council, such as the Housing and Homeless Coordinating Council.
- ❖ Ensure the “lead entity” structure is composed of diverse groups and communities from throughout the state. Participants must include faith, religious and spiritual leaders, mental health consumers, community-based organizations, and survivors.
- ❖ Identify a single point of responsibility for coordinating services at the state level. Participation from many state agencies will be needed, including but not limited to, the Colorado Departments of Corrections, Education, Human Services, Public Health and Environment, Public Safety, and Regulatory Agencies.
- ❖ Create a diverse funding base for this entity that includes a combination of government and private resources. Obtain seed money from the legislature to begin start-up operation. Private foundation and federal grants should be pursued aggressively. Adequate resources must be generated to ensure that staff are allocated to complete needed activities.
- ❖ Develop a system for evaluating short- and long-term effectiveness of interventions and services to maximize consumer outcomes, measure improvement in the identification of at-risk persons, reduction in suicidal behavior and reduction in suicides.
- ❖ Support strategies to ensure that all Coloradans have access to appropriate mental health and substance abuse services. These include full parity for mental health coverage, access to mental health and substance abuse services for the uninsured, and programs targeting individuals not traditionally reached (e.g.: elderly; ethnic minorities; youth; gay and lesbian; and the homeless).
- ❖ Participate fully in, and support, national efforts to develop and implement a National Strategy for Suicide Prevention that will assist our state, as well as others, in accomplishing our goals.
- ❖ Integrate suicide prevention programs and strategies with other public and private systems, including behavioral and physical health, education, juvenile justice and corrections, social services, child welfare, substance abuse and domestic violence.
- ❖ Conduct research and studies of the relationship between access to lethal means (e. g: firearms, poisons) and suicide.
- ❖ Engage in a dialogue with the Colorado Chapter of the National Rifle Association, Ducks Unlimited and the Coalition Against Handgun Violence about our shared concern over firearm safe storage of firearms.
- ❖ Fund and implement the Colorado Youth Risk Behavior Surveillance system in a representative statewide sample. Additional questions should be added to the survey that are designed to measure emotional distress among youth, suicidal behavior, access to firearms, impulsiveness and access to, and utilization of, mental health services. Maintain Child Fatality Review process.
- ❖ Identify a state with a suicide rate less than the national average and a demographic/economic profile similar to Colorado’s. Engage in a collaborative study to determine why Colorado’s suicide rate is high and the other state’s suicide rate is low.
- ❖ The state or local health agencies should conduct studies of people who have seriously attempted suicide to determine what factors contribute to a non-fatal outcome.

Touched by suicide

❖ Jeff Arens ❖ Shaawna Arens ❖ Derrick Arens ❖ Laycie Arens ❖ Evan Phillips ❖

Touched by suicide

Recommendation #2

Develop a statewide, ongoing, and comprehensive public information and education campaign.

We believe that informed individuals will assist themselves and others in reducing suicide of people of all ages in Colorado. Suicide is a difficult topic to discuss. However, other issues, like child abuse, breast cancer and depression, are also not easy. We believe that public information and education campaigns have proven that people will listen to these important public health/prevention and safety messages. Given the opportunity, people empowered with accurate information will make a difference.

Specific Implementation Tasks:

- ❖ Create a campaign (or augment an existing campaign) to meet the public information objectives identified by the “lead entity.” The campaign must strive to reduce ignorance, stigma and bias related to suicide and mental illnesses. Issues to address include: The seriousness and magnitude of suicide; common myths and realities surrounding suicide, depression and mental illnesses; common warning signs; high risk life events associated with suicide; and what to do, what not to do and where to get help.
- ❖ Address the diversity of the state and its population. Participation by youth, religious leaders, seniors, the homeless community, the gay and lesbian communities, and ethnic and racial minorities is needed to ensure relevance and appropriateness. Affiliation with a strong primary media partner and strong contacts with ethnic and community media (e.g., La Viz., The Catholic Register and Community Sentinels) is vital. All information and education materials must be available in multiple forms as needed (e.g., Braille and multilingual translations).
- ❖ Sponsor a suicide prevention and awareness week each year and designate one day for recognition and remembrance.
- ❖ Design the campaign to be multi-dimensional with a visible kick-off with the Governor, representatives from the legislature, mental health officials, clergy and individuals whose lives have been impacted by suicide.
- ❖ Create a clearinghouse of information, including a “library” of suicide information (books, articles, newsletters), speakers bureau and practice guidelines.
- ❖ Identify (or create) and publicize a “1-800” phone number to assist individuals and communities in accessing information and referrals.
- ❖ Assist media in sensitive and responsible reporting of suicide by designing a comprehensive press kit which includes reporting guidelines. Partner with Colorado media and Schools of Journalism to develop (or adopt) guidelines such as those of the American Association of Suicidology, and the Centers for Disease Control and Prevention.
- ❖ Integrate suicide prevention public information and education into other public information campaigns (e.g., depression, anxiety, emergency care, violence prevention) as possible.
- ❖ Expand and update regularly a statewide suicide prevention service manual, (see separate manual included with this report).

Recommendation #3

Train individuals involved in the identification, screening, referral, treatment and follow-up of people at risk of suicide.

As identified in Recommendation #2, we believe that information is imperative to assist in suicide reduction. However, information alone is not adequate. We must provide greater training related to detection, referral, treatment and follow-up of individuals who are depressed or at risk of suicide.

Specific Implementation Tasks:

Quality of Care:

- ❖ Develop “Best Practice” guidelines to improve recognition and treatment of suicidal and at-risk individuals by health care professionals. Guidelines should cover all individuals during routine health examinations, people being evaluated and treated for behavioral health disorders and/or significant social stresses (by internists, nurses, family physicians, pediatricians, mental health practitioners, gynecologists, emergency medical personnel), and persons with non-fatal suicide histories or suicide ideation. Guidelines may be created through the efforts of the Colorado Clinical Guidelines Collaborative, state and local medical and professional societies, or panels of experts, consumers and partners in the health care, human services and insurance industry.
- ❖ Establish culturally appropriate mental health screening at routine visits to physicians, such as adolescent school, camp and sports physicals, adult annual exams and geriatric patients upon admission to facilities for long-term care.
- ❖ Ensure high quality assessment, intervention, cross training, treatment and management for persons with alcohol and substance abuse disorders (as mental illnesses and suicidology often co-exist).

- Encourage routine and improved assessment, intervention and appropriate treatment of suicidal individuals in the criminal justice system – prisons, jails and correctional settings.
- ❖ Improve follow up efforts for individuals treated in emergency departments after suicide-related episodes.
- ❖ Develop clinical practices for health care professionals to utilize related to the safe storage of firearms and reduction of access to other lethal means for individuals at risk of suicide.
- ❖ Ensure needed intervention and support following suicides is in place for police, first responders, coroners, witnesses and survivors.

Collaboration:

- ❖ Ensure K-12 staff recognize and refer at-risk students for appropriate intervention and treatment. Support comprehensive school-based health services and training for staff, students, parents and other appropriate community members.
- ❖ Enhance consumer/provider partnerships, coordination and continuity of care to optimize treatment for those with serious mental illnesses and/or substance abuse.
- ❖ Foster collaboration among treatment sectors that address intimate partner violence and suicide intervention services.
- ❖ Develop guidelines for monitoring clinical services and continuous quality improvement for health insurers and health maintenance organizations in Colorado.
- ❖ Foster collaboration with community-based organizations that are providing services to, and are trusted by, communities.

Education:

- ❖ Encourage professional certification programs to include continuing education for health care and human service providers about depression and suicide prevention, including the demonstration

of current knowledge on these topics.

- ❖ Utilize forums for deans and faculty of the schools for health care and human services disciplines (e.g., medicine, nursing, psychology, social work, substance abuse) to improve the curriculum for professionals in recognition and treatment of suicidal behavior and mental illnesses.
- ❖ Develop “gatekeeper” training for communications, accompanied by outcome measures. Draw on existing gatekeeper training models and make adjustments for the needs of specific communities. *Gatekeepers is a term used in suicide prevention to denote persons in the “community” that have the opportunity to detect the conditions that lead to suicide and assist in obtaining the help that is required.* Examples of gatekeepers are school personnel, spiritual leaders, coaches, employers, home health workers and HIV/AIDS caseworkers. For a list of possible gatekeepers – see Appendix H.
- ❖ Support the “Comprehensive Health Education Act” to include suicide prevention as a part of the comprehensive approach to supporting reduction of risk behaviors in a community.

Recommendation #4

Facilitate the design and implementation of “Community Suicide Prevention Resource Plans” that include all community stakeholders interested and involved in suicide prevention and intervention.

To make these efforts work for everyone in Colorado, communities must choose the best possible approaches for their members. We recognize that every community has unique assets and resources. Needs and interests also vary. This recommendation is based on this belief.

Specific Implementation Tasks:

- ❖ Define the “community” (e.g., geographic (urban or rural), faith communities; ethnic communities; gay, lesbian, bisexual, and transgendered community) and include representation and input from all community members who have an interest in or are involved in suicide prevention and intervention (e.g.: mental health and substance abuse agencies, survivors, law enforcement, schools, community-based organizations).
- ❖ Design a process to explore issues and needs specific to each community by identifying opportunities and obstacles and then developing collaborative strategies for reducing suicide morbidity and mortality.
- ❖ Encourage non-traditional, innovative strategies that are responsive to the unique and diverse needs and issues identified within the community (e.g., gender, life phases such as youth and elderly, health status, socio-economic status, stability of living environment, and ethnicity) and utilize multiple sites and settings to implement them.
- ❖ Assist communities in determining where to nest suicide prevention services. Utilize existing resources (e.g., public health clinics, mental health centers, community-based organizations, parishes, churches or synagogues, and family centers) or newly created entities (non-for-profit coalitions or a suicide prevention collaborative).
- ❖ Consider strategies supported by research, best practice or experience. Include provisions for evaluation, to determine if the community’s needs and issues were effectively addressed. Develop mechanisms to share strategies among communities.
- ❖ Create suicide review teams to investigate, assess and collect data on suicides and people who have seriously attempted suicide in their community. Review teams should include the county coroner and representatives from local

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public health and mental health agencies. Each team should develop a method for collecting, storing, and analyzing the information which will then guide local suicide prevention efforts.

- ❖ Make available technical assistance and expertise to support the community planning process in the program and clinical arenas as well as community system development and integration. Resources should be available in clinical program development, injury prevention, epidemiology and health promotion, as well as in service delivery system change, coordination and integration.

Touched by suicide

❖ *Albert Gutierrez* ❖ *Nicole Leonard* ❖ *Kim Martin* ❖ *Paul Mattern* ❖ *Crystal Morgan* ❖

Touched by suicide

REMEMBERING ROBBY

I am telling Robby's story and the lessons that I believe I have learned from it in the hope that it may save another child's life.

Robby was 12 years old; two months and two days short of being a teenager, when he came home from school in April of 1997 and hung himself. He left no note. In the time since then, I have thought about this nearly every waking moment, and have made some realizations and come to a few conclusions. First, I don't think Robby's death was brought on by depression as so many are, but by a fixation with hanging that began after an older kid from our neighborhood hung himself a few months before Robby - a kid that Robby didn't even know.

Now, after all these months, I admit that I didn't listen to the voice inside my gut that said something was wrong, when months after the first kid did it, Robby was still asking, "What do you think hanging feels like?" I should've taken him to the school counselor or someone, but I trusted him when he promised me that he'd never try it himself. I do know that from now on, I will trust and act on my intuition. I also think there is a lesson to be learned from his friends who knew that he was going to try it, and didn't say anything to anyone until it was too late. They didn't think he'd really do it. Talk of suicide is not always direct, we need to be aware and to educate our kids that indirect talk of hurting oneself or engaging in a dangerous behavior is also a warning sign of suicide. Kids need to be schooled in how to be each other's first line of defense, to not be sworn to secrecy and to get help for a suicidal friend in the same way that they would run for help for a friend that was drowning in water.

I would also like to address the perception that I think is out there in the general public about the kids that we are losing to suicide. From what I've learned talking to many, many people since Robby's death is that we are losing our best and brightest kids. It is not only the so-called at-risk, problem kids from broken homes that are doing this. It is the middle-class, seemingly well-adjusted kids, the majority from two parent families. I wish I had a dollar for every person that said to me after Robby's death, "Robby was the last kid I ever would've thought was at risk of suicide." He was well-liked, bright, athletic, sensitive and artistic with a good sense of humor. All his teachers agreed that he was one of the most mature, well-adjusted kids in his class and he was rarely a discipline problem, either at home or at school. There is no way to predict who is most likely to commit suicide, we need to consider all kids as "at risk", and believe me parents, *if this can happen to my kid, it can happen to yours.*

Members of the Governor's Suicide Prevention Advisory Commission and the Citizens' Advisory Panel recognize that suicide can happen to anyone. Each of us in our own way must make a difference, so that another heartbeat is not silenced.

Touched by suicide

❖ Brian Muir ❖ Amber Pickard ❖ Lisa Ryder ❖ Nicole Sanchez ❖ Christi Santi ❖

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Suicide Prevention and Intervention Plan

FOR A COMPREHENSIVE BIBLIOGRAPHY , PLEASE CONTACT:

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
INFORMATION CENTER
303-692-2035



STATE OF COLORADO

EXECUTIVE CHAMBERS

136 State Capitol
Denver, Colorado 80203-1792
Phone (030) 866-2471



B 002 98

Roy Romer
Governor

EXECUTIVE ORDER

CREATING THE GOVERNOR'S SUICIDE PREVENTION ADVISORY COMMISSION

- WHEREAS; in 1995, Colorado had the fifth highest rate of suicide in the nation; and
- WHEREAS, in 1996, more than 600 persons in Colorado committed suicide, and suicide was the seventh leading cause of death in the state; and
- WHEREAS, suicide is the second leading cause of death among Colorado teenagers and young adults between the ages of 15 and 34 years of age, and in this group the rate of suicide has tripled since 1950; and whereas, in a 1995 survey, 22% of Colorado high school students had seriously contemplated suicide during the previous year; and
- WHEREAS, the suicide rates in Colorado rise with advancing age and are highest among persons above age 65; and
- WHEREAS, suicides cause extreme suffering, grieving and pain that affect families, schools and communities; and
- WHEREAS, suicides and suicide attempts impose large economic burdens in Colorado including medical and mental health care costs, lost productivity and lost years of productive life; and
- WHEREAS, many of the social, demographic, biologic, clinical and behavioral risk factors for suicide are known, and many promising strategies exist to prevent suicide; and
- WHEREAS, it is urgent that Colorado develop a statewide plan to prevent suicide, after a careful review and analysis of effective suicide prevention strategies.

NOW THEREFORE, I, Roy Romer, Governor of the State of Colorado, pursuant to the authority vested in me under the statutes and the Constitution of the State of Colorado, DO HEREBY ORDER THAT:

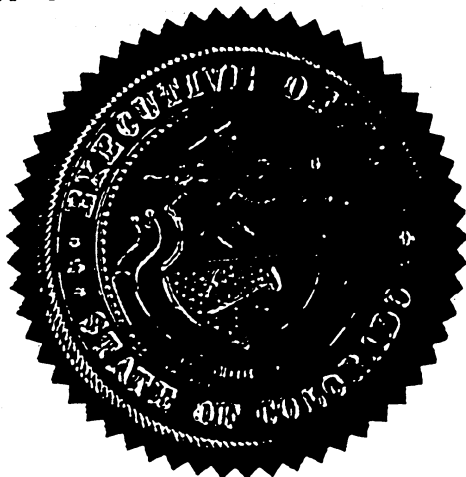
1. The Suicide Prevention Advisory Commission is hereby created. It shall consist of no more than 30 persons who shall be knowledgeable in the areas of suicide awareness, education and prevention. All members shall be appointed by the Governor and shall serve at the pleasure of the Governor. Members shall serve without compensation. The Governor shall designate a chair from among the Commission membership.

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❖ Adam Paul Leaf ❖ Will Wink ❖

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2. The Suicide Prevention Advisory Commission shall determine meeting times and places necessary to fulfill its responsibilities and shall have the following duties:
 - a. Review the rates, trends, demographics, risk factors, predictors, methods and other characteristics of suicides in Colorado.
 - b. Conduct a critical scientific review of the existing literature on effective suicide prevention strategies, including programs that recognize and respond to people who are at risk for and/or attempted suicide.
 - c. Review and analyze suicide prevention plans from other states.
 - d. Prepare and submit a written report no later than November 30, 1998, to the Governor and to the Executive Directors of the Colorado Departments of Public Health and Environment, Education, Public Safety, Human Services and Corrections.
3. The report shall include:
 - a. A summary of Colorado Suicide rates and trends.
 - b. A review of the risk factors and predictors of suicide.
 - c. An evidence-based summary of effective state suicide interventions.
 - d. Recommendations to the Governor and to the Executive Directors listed above for initiatives and intervention that will establish suicide prevention as a statewide priority and that will help reduce the number of suicides in Colorado.
4. Necessary staff and support shall be provided to the commission by the Colorado Department of Public Health and Environment and appropriate agencies.
5. The Commission shall be reviewed no later than December 31, 1998, to determine appropriate action for its continuance, modification or termination.



Given under my hand and
the Executive Seal of the State
of Colorado, this fifth day of
March, 1998.

A handwritten signature in cursive script, reading "Roy Romer".

Roy Romer
Governor

**Governor’s Suicide Prevention Advisory
Commission
Commission Members**

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Touched by suicide

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Touched by suicide

Citizens' Advisory Panel on Suicide Prevention

(We apologize to any person whose name was inadvertently omitted)

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Weld County Health Dept.

Jerald Adamek
Director
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Michael H. Allen, M.D.
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Kari Anderson

Deb Austin
Heartbeat

Scott Anthony
Weld County Coroner

LaRita Archibald
Heartbeat

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Marilynn Barrett
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Jefferson High School

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DIVERSITY WORK GROUP REPORT

The following sections have been extracted from a full report which is available through the Colorado Department of Public Health and Environment in the Information Center (303-692-2035).

Introduction

Suicidal behavior, like all behavior that takes place in a social context, is deeply affected by social and biological differences such as age, gender, sexual orientation, race and ethnicity, socioeconomic status, health status, and stability of living environment. Suicide rates, patterns of suicidal behavior, risk and protective factors, and even effective prevention strategies vary to a certain degree on the basis of these differences. While it is impossible to neatly categorize individuals, groups, or communities, the following discussion attempts, in relation to specific groups and communities, to identify some critical suicide prevention issues and effective suicide prevention strategies.

Gender, Age, and Socioeconomic Status

Gender is one of the best predictors of suicidal behavior in the United States. Females are more likely than males to report suicidal thoughts and to engage in suicidal behavior. Females, however, are less likely to die as a result of a suicidal act than males. Suicide prevention programs have tended to ignore these gender differences. A common error has been to define risk for suicidal behavior based on the experience of males. Concepts and programs appropriate for males do not always apply to females and issues relevant to both genders, that emerge through the study of females, have been overlooked.

Key gender issues in the different patterns of suicidal behavior of females and males are the gendered images and connotations associated with different kinds of suicidal behavior. Nonfatal suicidal behavior is considered feminine and less potent than fatal suicidal behavior. At the same time, suicide is seen as a masculine and relatively strong act. Killing oneself is considered more permissible for males. People are less critical of

those who die than of those who survive a suicidal act. Men who kill themselves are viewed as more well-adjusted than women who kill themselves, independent of the reason for the suicide.

During adolescence, females are at highest risk for suicidal ideation and behavior. Suicide mortality is a relatively rare event during adolescence. At no other time in the life-span is the ratio of non-fatal to fatal suicide behavior as high as it is during adolescence. However, adolescent males are at highest risk for suicide mortality. After adolescence, rates of nonfatal suicidal behavior decrease in both females and males. Rates of suicide mortality remain flat during adulthood for females, with a slight increase around mid-life (age 45-55), and a consistent decline through late-adulthood. Yet, even at mid-life, women's rates of death by suicide are less than half those of men. The risk of suicide mortality increases with age for males. The female to male suicide ratio for those age 65 and above is around 1:6.

Lower socioeconomic status is associated with increased risk for nonfatal suicidal behavior at all ages. Persons who engage in suicidal behavior tend to be less educated, to be from working class backgrounds, to be unemployed and to have financial problems. The relationship between socioeconomic status and suicide mortality is less clear. Suicide is more common among the relatively economically privileged white older adult males, rather than among socioeconomically disadvantaged older adults, such as women or ethnic minorities.

RECOMMENDATIONS:

- * Suicide prevention educational programs need to explicitly examine the participants' beliefs about gender and suicidal behavior specific to different cultural and socioeconomic-economic status groups and challenge the maladaptive aspects of these beliefs.
- * Suicide prevention educational programs should challenge the notion that nonfatal suicidal behavior is a feminine way to cope with problems, that killing oneself is a masculine, powerful act and that surviving a suicidal act is shameful and unmasculine.
- * Educators and researchers should reevaluate the meaning and implications of females' accepting, sympathetic attitudes towards suicidal persons and the

conclusions that females' positive response to educational programs means that they have acquired protection against suicidal behavior. They also should reconsider the conclusions that a critical or pessimistic reaction by males to a suicide prevention program means that it is not useful to them.

- * Clinicians and researchers need to assess the impact and efficacy of secondary prevention programs based on their effect on gender-specific rates of suicidal behavior.
- * Secondary prevention training for care providers should include information on myths and facts of females/males and suicidal behavior.
- * Educational programs should be developed to target older adult males, a high-risk but neglected group in terms of primary prevention. Prevention programs targeting older adult males ought to include an outreach component, rather than the traditional crisis phone services.
- * Develop training programs for youth and those that work with youth (parents, teacher, law enforcement, etc.) on how to identify and prevent suicidal behavior in youth.

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Race and Ethnicity

In Colorado, from 1992–1996, the racial/ethnic category White had the highest suicide rate, followed by American Indian, Hispanic, African-American, and Asian. During this period 548 White individuals died by suicide, 4 American Indians, 55 Hispanic individuals, 15 African-Americans, and 6 Asians. When comparing suicide rates among racial and ethnic groups, it is important to recognize that, in some communities, suicidal behavior may be hidden in homicide rates and deaths through unintentional injuries. In the following discussion, it is important to acknowledge the complexity of racial, ethnic, and community identifications. The following represents a characterization of community issues and is not meant to pre-define the experiences or issues of specific individuals.

American Indians

American Indians in Colorado have the second highest rate of suicide, but because the population is small relative to the other groups, the number of deaths by suicide is also comparatively small. However, because the members of American Indian communities are so closely connected to each other by extended family ties, the loss of one individual affects the entire tribe.

In this population, adolescent and young adult males are at highest risk of fatal suicidal behavior. Risk factors for adolescents include: past physical or sexual abuse; substance use, especially hard liquor; risky sexual behavior; delinquency or truancy; frequent encounters with the criminal justice system; violence; family history of suicide; suicide of a friend; suicide clustering; frequent interpersonal conflicts; prolonged unresolved grief; chronic familial instability; depression; multiple home placements.

Suicide Prevention and Intervention Plan

* **BARRIERS:** History of oppression, prejudice, stripping away of culture, language, and religion; experiences of isolation, invisibility, and stigma; accurate diagnosis of depression may be difficult because of simultaneous occurrence of other significant physical and mental health problems, including grief and acculturative pressures; lack of culturally sensitive and appropriate mental health services; lack of respect for traditional methods of healing among mental health providers; history of negative experiences with health systems, including mental health systems.

RECOMMENDATIONS:

- * Focus on the education of all generations and build on the strengths and resources specific to each native community (elders, spiritual leaders, schools and educators, public safety officials, and trained mental health professionals based in the community).
- * Adopt culturally relevant prevention, intervention and treatment programs, with particular emphasis on traditional spirituality, values and practices, the strengthening of families, and implementation by American Indian staff, traditional healers, and peers.
- * Link public health outreach workers with mental health programs in the community, and include suicide prevention/intervention strategies.
- * Integrate suicide prevention/intervention strategies into substance abuse service programs.

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Hispanics/Latinos

The Hispanic/Latino population in Colorado has a suicide rate very similar to that of the American Indian population. This community also has the highest number of deaths by suicide after the White population. 1997 Colorado statistics show that, in the 15–19 year old age group, Hispanic males had a suicide rate almost twice that of White males; in the 20–34 year old age group, the suicide rate for Hispanic males was slightly higher than that of White males. According to national results of the 1995 Youth Risk Behavior Survey, high school-aged Hispanic females had higher rates of non-fatal suicidal behavior than White or Black females in the same age group.

A summary of findings from community-based studies found that immigrants from Mexico had higher rates of suicide than Mexicans, and Mexican American adults born in the United States had higher lifetime rates of suicide attempts than Mexican American adults born in Mexico. This may be due to the process of acculturation/deculturation eroding traditional protective factors and/or causing significant individual and intergenerational stress. There is evidence that suicides occur at a younger age for Latinos than for Anglos and that suicide rates for Mexican-Americans decline with age.

Risk factors for this community include the following: male, 25–44 years old, depression, substance use, lack of family support, inadequate coping skills, acculturative stress. Protective factors include family cohesion (both nuclear and extended), coping ability and a strong sense of self-identity within a cultural context.

BARRIERS: Lack of culturally competent mental health services; lack of respect within health care system for traditional healing and/or support systems; lack of services/outreach in Spanish, inconvenient times and locations of services; cultural values and norms that inhibit the use of mental health services; history of negative experiences with mental health systems; lack of eligibility for services or fear of legal ramifications of seeking help due to immigration status.

Touched by suicide

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RECOMMENDATIONS:

- * Support the integration of mental health services and culturally competent providers into existing community-based organizations and clinics where a level of trust is already established.
- * Provide peer-to-peer support.
- * Increase the number of Hispanic/Latino mental health providers and integrate traditional healers into treatment.
- * Recognize the differences among subgroups in the Hispanic/Latino community relating to country of origin or descent, acculturation level, etc.

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African-Americans

Although African Americans have a lower suicide rate than most other racial/ethnic groups in Colorado, according to national statistics, the suicide rate among Black males has increased between 1986 and 1991 at a faster rate than among White males. The highest rate for African Americans is in the 25-34 age group. Black males are four to six times more likely to commit suicide and to use more lethal means than Black females.

The following are risk factors for suicide among African-Americans: male; age 25-34; substance abuse (particularly cocaine); depression; family dysfunction, conflict, or violence; interpersonal discord/marital conflict; acting out/delinquency, psychiatric disorders/psychological symptomatology; homosexuality; AIDS. In some studies, there is an association between higher Black suicide rates, higher

education, higher income, and lower fertility rates. Among youth, self-reported depression and suicidal ideation is more frequently associated with suicidal attempts in Whites than in African-Americans. Protective cultural factors include the role of religion, the central role of elders, extended family and kin networks, and cohesive social environments.

BARRIERS: Stigma and negative judgments associated with mental health problems in general and especially with suicide; cumulative effects of daily experiences with racism; lack of community-based, culturally appropriate, mental health services.

RECOMMENDATIONS:

- * Strengthen the cultural competency of existing programs and increase the number of African American mental health service providers.
- * Address the stigma of seeking mental health services by offering them through community-based organizations that provide a variety of services.
- * Provide a variety of non-clinical interventions, including home visits and family mediation, using trained members of the community.
- * Implement early prevention/intervention programs that include peer counseling services and youth mentoring and career counseling programs that include mentoring and career counseling.

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Asian-Americans

Three groups of foreign-born Asian residents should be delineated. One is the group who has come over with "immigrant" status, where there typically has been some degree of choice and motivation to come to the U.S. Many of these individuals have come over as adults. Typical stressors among this group include: separation from support systems, isolation, lack of cultural navigational skills, increasing role diffusion, unemployment/underemployment, racism, and internalized oppression.

The second group is comprised of Southeast Asian residents who came over initially as refugees. In addition to the typical stressors experienced by immigrants, refugees often have been forced to leave their country of origin and been exposed to the traumatic effects of war, re-education camps, escape, refugee camps, and resettlement processes.

A third group are individuals who have immigrated or have come under refugee status, and who were quite young at the time of entry into the U.S. Typical stressors for this group include: conflicts with family stemming from differing values and expectations (loss of family as a source of support), an inability to effectively communicate with potential sources of support, a sense of alienation from both native and American culture, identity issues, isolation, racism, etc.

Data on suicidal behaviors in the Asian-American population is limited. In addition, non-fatal and fatal suicidal behaviors may be under reported among Asians for cultural reasons. Chinese- and Japanese-Americans have higher rates of suicide in the elderly than Caucasians. Among Asians, the gender difference in prevalence of fatal suicidal behavior is much smaller than among Caucasians.

It is particularly important to pay attention to the cultural meaning of suicidal thoughts and behaviors in Asian cultures, for instance, cultural acceptance of suicide and attitudes about outside intervention around suicidality.

BARRIERS: Lack of culturally competent mental health services and bilingual, bicultural mental health personnel; cultural values/expectations that tend to inhibit seeking mental health care (reliance on family, self and family-face, inhibition of expressing emotion); lack of understanding and knowledge of how to utilize mental health services; symptom manifestation/presentation that may differ significantly, leading to inaccurate diagnoses; and a multitude of linguistically and

culturally diverse groups encompassed within the term "Asian."

RECOMMENDATIONS:

- * Increase multicultural competency in existing systems, recognizing differences among subgroups relating to country of origin or descent, acculturation level and language.
- * Develop and enhance specialized programs and language-specific informational materials, taking into account cultural practices and beliefs.
- * Embed linguistically and culturally appropriate services in the local communities.
- * Educate physicians, who are usually the only health professions in contact with this population, to the possibility of suicide, especially among the elderly.

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Sexual Orientation and Gender Identity

In a random sample of high school students in Massachusetts, gay, lesbian, and bisexual (GLB) students were over three times more likely than non-GLB students to have engaged in non-fatal suicidal behavior in the last 12 months. Elevated rates of suicidal behavior were also found among male adolescents in Vermont who engaged in same sex sexual behavior compared to their sexually active peers. GLB youth have higher rates of risk behaviors known to be correlated with suicidal behavior, including substance use, fighting, and carrying a weapon in school.

Such adverse factors as rejection by family, friends, and community, stigma, school-based discrimination and harassment can overwhelm the coping abilities and resiliency of youth and young adults. Risk factors for young gay and bisexual males include self-identification

as homosexual at younger ages, substance abuse, cross gender identification, family dysfunction, interpersonal conflict regarding sexual orientation, and nondisclosure of sexual orientation to others.

BARRIERS: Traditional sources of support (family, community, religious organization, school) often are not available; suicide prevention programs and services (including mental health services) frequently overlook or avoid discussing sexual orientation issues and adverse experiences based on sexual orientation; fear of negative judgments may keep individuals from seeking mental health services or from disclosing information critical to receiving effective help.

RECOMMENDATIONS:

- * Train mental health staff, education professionals, and medical health personnel to work effectively with this population
- * Integrate culturally specific suicide prevention programs and mental health services into organizations that already serve the gay, lesbian, bisexual, and transgendered community.
- * Assist families in learning how to support their gay, lesbian, bisexual, and transgendered children.
- * Implement programs that address anti-gay harassment and violence in schools and colleges.

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Persons Living with Terminal and Chronic Illness

Persons living with terminal or chronic illness who are contemplating suicide are dealing with both psychic suffering and physical pain. Coping with terminal or chronic illness can include physical pain which is often

times not well controlled, or if controlled, may produce unwanted side effects. Disfigurement, loss of bowel and bladder control, impaired motor skills and cognitive abilities, and a variety of other conditions dramatically affect the quality of one's life. These impairments lead to a sense of hopelessness and helplessness.

Traditional support persons may not be physically or emotionally able to be present throughout the illness. Those who are able to provide support and care are vulnerable to the effects of prolonged stress and exhaustion. The financial impact of a chronic or life-threatening illness is monumental. Medical visits, hospitalizations, home care, medications and equipment are costly. Lost wages of the person that is ill and/or their caregiver contribute to a sense of guilt often felt by those in this life stage.

There is much debate about whether suicide to end living with a terminal or chronic illness, sometimes termed 'self-deliverance' (whether assisted or not), is acceptable or right in light of shortened life expectancy and these quality of life factors. Putting the moral discussion aside, the fact remains that suicide is an option considered by many during this stage of life and is often discussed with health care providers and support persons.

RECOMMENDATIONS:

Suicide prevention with this population becomes a matter of providing options. Allowing the individual to make decisions regarding their care, provides an invaluable sense of empowerment. Once options are explained and understood, it is important to allow the person to make decisions up to and including the point of refusing further treatment. At that point, rather than this decision being judged as 'giving up', it becomes the self guided choice of 'letting go'.

Access to and willingness to access these resources may vary dependent upon the person's gender, socioeconomic status, race, ethnicity and cultural norms. A partial listing of options is as follows:

- * Pain management which is a speciality care component in medicine tailored to the individual patient.
- * Special devices and training to accommodate physical impairments
- * Emotional support and counseling through peer counselors, mental health professionals and spiritual advisors.
- * Respite care for support persons.

- * Hospice care for the terminally ill which mandates a menu of services including medical, psychosocial and spiritual support.
- * Community support programs focused on specific illnesses such as multiple sclerosis, AIDS, cancer and Parkinson's disease.

People who are Homeless

- * For people who live without a stable, fixed residence, have little or no access to mental health services, and often have a history of mental illness, suicide can become a very real option. Studies of people who are homeless indicate that between one-third and one-half suffer from a major mental illness (Carter, 1998). Shelters and homeless service providers report a continuous concern about clients with suicidal ideation and histories of suicide attempts. Death certificates neither track a person's living status nor do they correlate the address to shelters. However, all of the shelters in Denver reported people who died from suicide this past year.

Shelters are designed for congregate living, do not have the ability to deliver extensive individualized care, and do not have the psychiatric services which many people who are homeless require. Most shelter care staff are not trained to administer or monitor medication, have minimal training in working with people with mental illness, and few resources for the person who is suicidal. When suicide attempts are made, the individual is hospitalized for a brief stay and returned to the streets. Generally this occurs without the benefit of a full psychological evaluation, medications, or provisions for on-going care.

RECOMMENDATIONS:

- * Increase access for the homeless to mental health centers
- * Train shelter staff in suicide prevention and mental health issues
- * Track the lack of stable, fixed residence on death certificates to better assess the rate of suicide in the homeless.

Reference:

Carter, Rosalynn. (1998) *Helping Someone With Mental Illness*, Random House.

APPENDIX E

SPIRITUALITY WORK GROUP REPORT

The charge of the Spiritual Resources Work Group of the Governor’s Commission on suicide prevention was to develop a mission statement, recommendations, and implementation strategies for Colorado religious communities for suicide prevention.

Spirituality must be a major element of any suicide prevention plan. It includes respect for religious traditions and individual values of people. The spiritual component addresses issues around healing the broken soul, the loneliness and pain that may be a part of a decision to attempt to take one’s life. It will emphasize the meaning and sanctity of human life, ultimately addressing the wholeness and holiness of every person. Spiritual elements of the plan will also address healing the fractured community in a compassionate and supportive manner.

For a suicide prevention plan to be effective and complete it must first be established as a long term commitment by the State either as a segment of the public health arena or in partnership with the public arena and private partnership. This committee further feels that merely implementing a plan or a set of strategies will not be effective unless the underlying essence of the value of human life is incorporated into the plan.

A great majority of Americans consider religion to be of great importance in their lives. During any given week, U.S. church and synagogue attendance exceeds total attendance at all U.S. sporting events by an estimated factor of 13 to one. U.S. faith communities also form the spiritual and institutional backbone of the nation’s sizable philanthropic and charitable sector. (*Institute for American Values, 1998*)

Religion is especially suited to the task of transmitting morals and values from generation to generation because it focuses our minds and hearts on obligations to each other that arise out of our shared createdness. Religion helps us to understand the sanctity and dignity of human life and to transmit those values to others. (*Institute for American Values, 1998*)

Suicide is always an act of absolute separation from the universe and other members of the human community, a violent rupture of those relationships that are the very

foundation of the human condition. He who commits suicide not only kills himself but in fact injures all life, since by his action he deprives it of his assistance. (*Lepp, 1968*) The religious communities are able to provide a spiritual resource that helps to heal those broken relationships. Pastoral and educational approaches can be useful in creating an atmosphere of support for individuals struggling with despair.

In order to address, (and reverse), the elevating suicide rate throughout the state the Spiritual Resources work group used the following questions to produce recommendations:

- How does spirituality become a relevant component to any suicide prevention plan that is implemented?
- What is the role of the State in conveying the importance of the dignity of life?
- How can recommendations on spirituality issues be carried out in a public arena?
- What training is available and can be implemented to train religious lay and ordained ministers, to assist people who attempt suicide or who are suicide survivors?
- What traditions address healing, wholeness, and holiness issues as related to suicide prevention in religious communities?

SUMMARY

The Spiritual Resources Group is adamant that to prevent suicide the value and dignity of every human life must be emphasized; the education of many to recognize warning signs and know what action to take imperative. Awareness of the pain and suffering of the survivors and a fractured community when a suicide happens is an important part of deterrence. “The test of every institution or policy is whether it enhances or threatens human life and human dignity.” (*A Century of Social Teaching, 1970*)

Touched by suicide

❖ Norma Waltz ❖ Robert L. Waltz ❖ Gary R. Severson ❖ Janet Bishop-Severson ❖

Touched by suicide



United States
of America

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No. 141

House of Representatives

RECOGNIZING SUICIDE AS A NATIONAL PROBLEM

Mr. BURR of North Carolina. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 212) recognizing suicide as a national problem, and for other purposes.

The Clerk read as follows:

H. Res. 212

Whereas suicide, the ninth leading cause of all deaths in the United States and the third such cause for young persons ages 15 through 24, claims over 31,000 lives annually, more than homicide;

Whereas suicide attempts, estimated to exceed 750,000 annually, adversely impact the lives of millions of family members;

Whereas suicide completions annually cause over 200,000 family members to grieve over and mourn a tragic suicide death for the first time, thus creating a population of over 4,000,000 such mourners in the United States;

Whereas the suicide completion rate per 100,000 persons has remained relatively stable over the past 40 years for the general population, and that rate has nearly tripled for young persons;

Whereas the suicide rate is rising among African American young men;

Whereas the suicide completion rate is highest for adults over 65;

Whereas the stigma associated with mental illness works against suicide prevention by keeping persons at risk of completing suicide from seeking lifesaving help;

Whereas the stigma associated with suicide deaths seriously inhibits surviving family members from regaining meaningful lives;

Whereas suicide deaths impose a huge unrecognized and unmeasured economic burden on the United States in terms of potential years of life lost, medical costs incurred, and work time lost by mourners;

Whereas suicide is a complex, multifaceted biological, sociological, psychological, and societal problem;

Whereas even though many suicides are currently preventable, there is still a need for the development of more effective suicide prevention programs;

Whereas suicide prevention opportunities continue to increase due to advances in clinical research, in mental disorder treatments, and in basic neuroscience, and due to the development of community-based initiatives that await evaluation; and

Whereas suicide prevention efforts should be encouraged to the maximum extent possible; Now, therefore, be it

Resolved, That the House of Representatives—

(1) recognizes suicide as a national problem and declares suicide prevention to be a national priority;

(2) acknowledges that no single suicide prevention program or effort will be appropriate for all populations or communities;

There was no objection.

Mr. BURR of North Carolina. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we are here today to address the House resolution that deals with recognizing suicide as a national problem. When I am back in my district, I spend a tremendous amount of time in our country's schools. It is very interesting to watch the children in elementary and middle and high school these days, as they talk about the problems that they hear their parents talk about around the dinner table, not the ones that influence us on the nightly news but the ones that truly affect their quality of life.

I cannot imagine a school child without hope, but, believe me, in our world today there are many children that go to bed at night without that hope. This is a reason that I cosponsored House Resolution 212 introduced by Mr. LEWIS, my colleague from Georgia.

I received a letter recently from a student in my district, and I want to share part of that letter with my colleagues here today. Her letter said:

This letter concerns my opinion on teen suicide. There are more and more teen suicides, and it is becoming more and more popular. I think that teen suicide could be prevented. There could be classes that teens could take, not for a grade, but for them to build their self-esteem. If they do not feel badly about themselves, they will not have a reason to kill themselves.

Let me read my colleagues some statistics. According to the Centers for Disease Control, despite a decrease in the number of overall deaths of children age 5 through 14 from 1980 to 1998, death itself due to suicide in that age group doubled. While the overall number of deaths age 15 to 24 also dropped during the same period, suicide increased 3 percentage points.

Mr. Speaker, any death leaves a hole in a family. A suicide not only leaves a hole, but many painful unanswered questions. It is my hope that by passage of House Resolution 212, fewer families will have to live with the pain, and more individuals will receive the help they desperately need.

House Resolution 212 states that, one, Congress recognizes suicide as a national problem and wants suicide prevention to be a national priority. Two, no single suicide prevention program or effort will be appropriate for

Mr. LEWIS of Georgia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am proud to join my colleagues in bringing to the floor today a resolution that addresses a common but often unrecognized problem, suicide. This resolution recognizes suicide as a national problem and declares suicide prevention to be a national priority.

While no single prevention program would be appropriate for all populations and communities, the point of this resolution is to create a climate for suicide prevention, to recognize as a Nation that we must become aware of the problem, that we are to address it and eventually solve it.

□ 1615

We must not remain quiet or silent on problems that cause us pain. Instead, we must bring the problems out from under the rug into the light where we can deal with them. If we begin to do that as a Nation, it is my hope that we will encourage individuals and communities nationwide to do the same.

I am pleased that more than 92 of my colleagues are joining me in this effort by becoming original cosponsors of this resolution. I want to thank my good friend from North Carolina (Mr. Burr) for managing the bill on the other side.

Suicide touches hundreds of American families every year. An estimated 750,000 people attempt suicide each year. Suicide claims the lives of more than 31,000 people annually, more than homicide. Suicide is the ninth leading cause of all deaths in the United States, and the third for young people age 15 to 24. It is on the rise for young people in general and for African-American young men in particular.

Only by talking about mental illness and encouraging treatment can we begin to address the painful issue that leads to suicide. We must tell our friends and our loved ones that it is okay to talk about feelings of despair, depression and hopelessness and suicide. For those who have the courage to get help, to seek treatment, we must

support them, and we must talk about suicide so that we can try to understand it and prevent it.

Too much shame surrounds feelings of depression and suicide. We can

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❖ Marietta T. Mosby ❖ Danelle Young ❖ Michael E. White ❖ James E. Perez ❖

Touched by suicide

Report on Colorado’s Progress in Obtaining Information about other State Suicide Prevention Plans

METHOD Preliminary information on state plans for suicide prevention was obtained from the Colorado Department of Public Health and Environment and the Colorado Mental Health Association. Some calls were made to other states with minimal success because of problems with lack of return calls. In the middle of April, 1998, to speed the information collection process a one page survey was faxed to all state health departments inquiring about their progress on state plans and other state initiatives. The current summary is a progress report of all information received to date.

I. STATES RESPONDING TO THE COLORADO FAXED SURVEY AS HAVING STATE PLANS

1. Washington Washington State Youth Suicide Prevention Plan for Washington State (Jan., 1995). Washington State Department of Health, Olympia, Washington.

The plan which is outlined below has been touted by many as the most comprehensive plan to date, the most research-based plan, and the plan most supportive of systematic program evaluation.

Structure of Washington Plan:

Section I. The Problem of Youth Suicide (e.g., U.S., Washington State, High-risk groups, Risk and Protective Factors)

Section II. Issues in Youth Suicide Prevention (e.g., Definitions, Goals, Prevention Model, Key Issues)

Section III. Universal Community-Wide Youth Suicide Prevention Approaches (Public Education Campaign, School-based Suicide Awareness Education, Restrict Access to Lethal Means, Media Education)

Section IV. Selective Youth Suicide Prevention Approaches (Screening, Gatekeeper Training, Community-based Crisis Intervention)

Section V. Indicated Youth Suicide Prevention Strategies (Support/Skill-building Groups for High-risk Individuals, Strengthening Family Support)

Section VI. Evaluation and Surveillance (e.g., Model for Evaluation of Youth Suicide Prevention Programs, Surveillance of Youth Suicide and Suicidal Behaviors)

Section VIII. Conclusions and Recommendations: A Plan for Action

(e.g., Plan Summary, Evaluation/Surveillance, Estimated Costs)

References

Figures

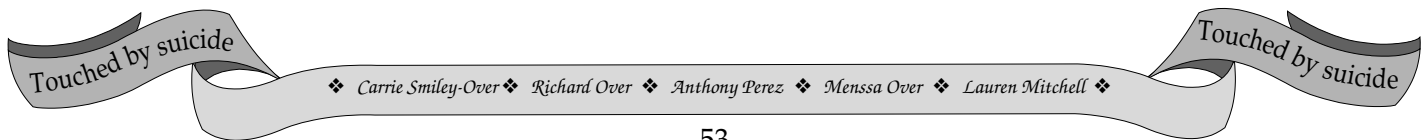
Tables

Funding update: 1995 and 97 legislative support to DOH—\$1 million per biennial for gatekeeper training, public education, community crisis intervention.

2. Maryland A Plan for Youth Suicide Prevention in Maryland (July 1987) Governor’s Task Force on Youth Suicide Prevention.

Task Force Recommendations: Describes Continuum of Youth Suicide Prevention Services needed in Maryland, for Maryland Council for Youth Suicide Prevention to be the focal point, need for partnerships and collaborative actions by local, State, and federal governments with private sector.

History: In 1986 legislators passed a bill creating Gubernatorial Task Force on Youth Suicide to develop a comprehensive plan to combat child, teenage, and young adult suicide. A State Coordinator for Youth Suicide in Dept. of Health and Mental Hygiene wa hired. In 1989 Governor appointed an Interagency Workgroup to review and implement the plan and proclaimed October as Youth Suicide Prevention Month; the first statewide conference was held. Since then have held annual conferences. A series of subcontracts (e.g., Automation of data collection and analysis for Statewide Hotline Information, Youth Suicide Prevention School Program, public service campaigns) have been completed to



Suicide Prevention and Intervention Plan

implement programs. Maryland model was selected as an exemplary suicide prevention plan by CDC.

Update: Ninth Annual Conference on Suicide Prevention, sponsored by Governor's Interagency Workgroup on Youth Suicide Prevention, dated October 30, 1997. Resource Manual for Maryland communities on youth suicide prevention. A summary of the Maryland Youth Crisis Hotline is available plus examples of material used in their recent media campaigns.

3. Maine Maine Youth Suicide Prevention implementation Plan, May, 1998, developed by Children's Cabinet, Information and Training Development Work Team, and Data and Evaluation Work Team.

The plan addresses youth suicide and describes 5 universal strategies (public education efforts, school-based programs, media education, education on restriction of access to lethal means, and youth suicide prevention education programs for wide audiences), 5 selective prevention strategies (gatekeeper training, screening, crisis hot line, school based crisis intervention teams, and outreach), 5 indicated prevention strategies (skill building support groups for youth, clinician training, increase access to behavioral health services, acute crisis intervention services, nonhospital/crisis beds, and strengthening family support), 3 strategies to improve data and surveillance, and an overall program evaluation plan.

4. Arizona A 1994 Arizona plan from their Adolescent Suicide Task Force: Report and Recommendations, Governor's Office for Children.

This plan we understand, was developed, but is yet to be implemented and funded. It includes recommendations from three subcommittees: Psychiatric diagnosis and risk factors, school-based prevention programs, and community-based programs.

5. Oregon Report on Youth Suicide in Oregon by Governor's Task Force on Youth Suicide Prevention (January, 1997). Working on full-blown plan to be developed by end of summer, 1998.

Structure of 1997 report:

Introduction

25 Recommendations

(Example: Every student should have access to

mental health resources 24 hours a day, seven days a week. Therefore:—list of funding and mandate recommendations.)

Narrative Report (including Purpose, Facts of youth suicide, It can happen, What do we know about youth suicide, What can we do, A starting point (recommend 8 areas for further study and process)

4/23/98 letter: In addition they are compiling a report on child fatality in Oregon for 1997 to be published by July, 1998. They are in the process of hiring a Youth Suicide Prevention Coordinator who will convene a group to develop a strategic plan. They hope to have a strategic plan and coalition formed to carry it out by August, 1998. Will be guided by the 25 recommendations.

II. STATES RESPONDING TO THE COLORADO FAXED SURVEY THAT THEY ARE IN THE PROCESS OF DRAFTING STATE PLANS

1. Connecticut (response to faxed survey 4/30/98) Report they are in the process of drafting a state plan focused on youth. They also report on three funded youth suicide prevention programs, as well as other initiatives with school college/university-based programs, and clinical and community agency programs.

2. New Mexico (response to faxed survey 4/16/98) Are planning a conference to create a strategic state plan for youth suicide prevention first meeting on May 11, 1998. Sponsorship by federal Maternal Child Health Bureau and New Mexico Department of Health. Currently working on education and awareness.

II. STATES THAT RESPONDED TO THE FAXED SURVEY OF HAVING NO STATE PLAN BUT SOME STATE INITIATIVES (INDICATED IN PARENTHESES AFTER STATE NAME)

1. Louisiana
2. Arkansas
3. South Dakota
4. California
5. Nebraska
6. Pennsylvania
7. Michigan
8. Montana
9. New York

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❖ Katarina Mitchell ❖ Meissa Anderson ❖ Joseph Mitchell ❖ Andrew A. Young ❖

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10. Wisconsin (Programs available through counties and schools. In 1985 had a grant to develop a suicide prevention curriculum but adoption was on a voluntary basis)
11. Texas (Have been using video for suicide prevention in public schools and are conducting a pre- and post-test)
12. Massachusetts (public education and crisis hotlines, training)

III. STATES THAT REPORT SOME INITIATIVES BUT NO SYSTEMATIC STATE PLAN —based on information received from the states and on file at the Colorado Department of Health and Environment or Colorado Mental Health Association files—(files reviewed April, 1998.)

1. Utah Utah Suicide Study (1995 or 1996?) Doug Gray, M.D., Child Psychiatrist, Primary Children's Medical Center, Assistant Professor, University of Utah Medical Center.

Outline of need to:

- 1) study youth suicide to develop a descriptive profile of youth suicide victims,
- 2) identify community contacts of deceased who recognized suicide victim had problems prior to suicide.
- 3) identify barriers that kept deceased from receiving professional help.

Research Instruments:

Structured interviews with community contacts to include intimacy scale, types of problems, barriers than prevented help.

Developing Youth Outcome Questionnaire to screen children and adolescents for psychiatric problems, developing profiles of at risk populations in Utah.

This baseline study supposed to be completed in spring, 1998.

2. Alaska EMSC Grant Task Force Prevention. Coordinators and community counselor, rural school crisis, community-based suicide prevention, screening. Conference held.

3. Idaho Have supported training of gatekeepers, MCH block grant. Suicide Task Force.

4. North Dakota Dept of Health funded statewide suicide prevention project by Mental Health Assoc.; Strategies included regional awareness conferences, training and supporting crisis response teams, hotline, and quarterly newsletters. Bismarck Public Schools developed crisis intervention manual. Suicide Prevention Task Force. Suicide Awareness Day. Involving Indian reservations, schools, churches. Supported from State MCH and Governor's Office. Pilot on Child Fatality Review project. Developing history for suicide victims.

(4/16/98 faxed survey indicated no further initiatives and no state plan to date)

5. Arkansas Attorney General founded and chaired Arkansas Youth Suicide Prevention Committee beginning in 1989. Proposed mode of school response to youth suicide crisis in 1989. Arkansas Youth Suicide Prevention Newsletter published quarterly by Outreach Div. of Attorney General's Office. Committee received input from Student Advisory Board of community leaders to provide additional insight about Arkansas youth.

6. Indiana Adolescent suicide identified as 1 of 13 public health priorities by Indiana State Dept. of Health. In 1995 the Health Dept. issued a manual, "Suicide—Students at Risk: Suicide Prevention Resource Guide for Schools; A Team Approach. Manual developed by Youth Suicide Prevention Advisory Committee."

7. New Jersey New Jersey Dept. of Health issued report, "Recommendations from a Workshop on Suicide Contagion and the Reporting of Suicide in 1991."

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❖ Alma A. Cook ❖ Roger Kent Archibald ❖ La Rita Archibald ❖ Sarah Anne Russell Crnkovich ❖

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Appendix H

Gate Keeper Training Examples of Gatekeepers

The following are some examples of gatekeepers:

Direct family members

School personnel including coaches, teachers, and other non-mental health professionals

Youth

Universities, including faculty, counselors, resident advisors, health clinics, campus police, and departments of Psychology, Social Work, Nursing, and others

Spiritual groups and leaders

Police/Law Enforcement

EMT

Fire Department

Recreation Centers/Activities (formal and non-formal, including YMCA/YWCA, public and private facilities

Day care

Senior Centers/Elder Care Workers

Nursing Facilities

Hospitals

Family Physicians/Physician Assistants

Nurse Practitioners

Visiting nurse associations

HMOs

Clinical Pharmacists

AIDS Caseworkers

Personal Services/Human Resources staff

Supervisors and managers

Correctional and juvenile detention staff

Government Technicians

Health educators

Red Cross Volunteers

Community Mental Health Centers

Crisis Clinics and Hotlines

Behavioral Health Clinics and Organizations

Mental Illness Advocacy Groups

Indian Tribes and Indian Health Services

Child/Adult Protective Services

Planned Parenthood

AA.NA and other 12 steps programs

Rape Crisis Centers

Domestic Violence Workers

Residential treatment staff

Bartenders/beauty parlors

Military Rank and File as well as Officers and Non-commissioned Officers

Health Line Telephone Operators

911 Staff

Camp Counselors

Parent/Teacher Associations

Service Clubs Government

Funeral Directors

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Suicide Prevention Fact Sheet

- ❖ 55 Coloradans die from suicide every month
- ❖ More people died in Colorado from suicide than from motor vehicle accidents in 1996 (692 suicide deaths)
- ❖ In 1996 suicide was the 2nd leading cause of death for Coloradans ages 10 through 34
- ❖ Colorado Hospital Association discharge data shows 7,806 attempted suicides between 1994 and 1996

MYTH: People who talk about committing suicide never attempt suicide.

FACT: Up to 3/4 of those who take their lives have talked about suicide before attempting.

MYTH: Once a person decides to commit suicide, nothing can stop them.

FACT: Most people who commit suicide appear to be ambivalent about their own deaths. For many people the suicidal crisis passes and they are grateful for having been prevented from self destruction.

MYTH: Never ask a deeply depressed or troubled person if he or she has suicidal thoughts. It may implant the idea.

FACT: A person may feel relief if another person asks if suicide has become an issue, thus actually giving permission to talk about things that are troubling

MYTH: Once a person is suicidal, he or she will always be suicidal.

FACT: Most people who become pre-occupied with suicidal thoughts are suicidal for only a limited time. Many can lead normal lives if they receive appropriate help for the issues and complexities in their lives.

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 than later
- ❖ Get them connected with professional help
- ❖ Dispose of pills, drugs and guns
- ❖ Do not worry about being disloyal to the individual; contact a reliable family member or close friend of the person

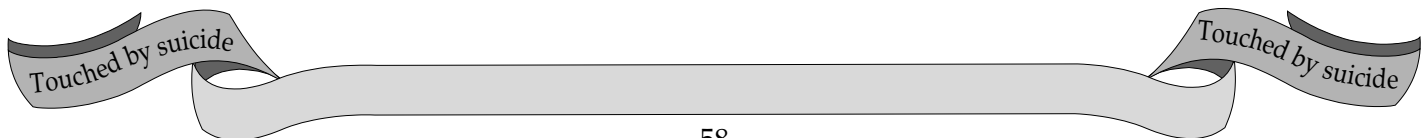
What Not To Do

- ❖ 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
- ❖ Avoid arguments
- ❖ Do not try and counsel the person yourself, GET PROFESSIONAL HELP!

Where to Get Help

Contact your community mental health center or other suicide prevention programs

Created by the Public Information and Education Workgroup of the Governor's Suicide Prevention Advisory Commission 9/98



SERVICE DIRECTORY

COLORADO MENTAL HEALTH CENTERS

Adams CMHC
8931 N. Huron Street
Thornton, CO 80221
303-853-3450

Aurora CMHC
14301 East Hampden Ave
Aurora, CO 80014
303-693-9500

Colorado West Reg MHC
P.O. Box 40
Glenwood Springs, CO 81602
970-945-2241

MH Corp Denver
P.O. Box 100726
Denver, CO 80222
303-504-6500

Pikes Peak MHC
220 Ruskin Avenue
Colo Springs, CO 80910
719-572-6100

North Range Behavioral Health
1306 11th Avenue
Greeley, CO 80631
970-353-3686

Arapahoe MHC
6801 South Yosemite Street
Englewood, CO 80112
303-657-3700

Centennial MHC
211 West Main Street
Sterling, CO 80751
970-522-4392

Jefferson Center for MH
5265 Vance Street
Arvada, CO 80002
303-425-0300

MHC of Boulder County
1333 Iris Avenue
Boulder, CO 80304
303-443-8500
Southeastern CO Fam. Gui. & MHC
711 Barnes
La Junta, CO 81050
719-384-5446

Southwest Colorado MHC
281 Sawyer Drive
Durango, CO 81301
970-259-2162

West Central MHC
3225 Independence Rd.
Canon City, CO 81212
719-275-2351

Larimer County MHC
P.O. Box 1190
Fort Collins, CO 80522
970-498-7610

Midwestern Colorado MHC
P.O. Box 1208
Montrose, CO 81402
970-249-9694

San Luis Valley CMHC
522 Alamos Avenue
Alamosa, CO 81101
719-589-3673

Spanish Peaks MHC
1304 Chinook Lane
Pueblo, CO 81001
719-545-2746

HEARTBEAT OF COLORADO

HEARTBEAT/Boulder, CO
Dr. Cheryl Clement
710 33rd Street
Boulder, CO 80303
303-444-3496

HEARTBEAT/Boulder, CO
Patricia Hanson
1587 Bradley Drive
Boulder, CO 80303
303-499-6773

HEARTBEAT/Canon City, CO
Cheryl Clement
Sangre de Cristo Hospice West
517 W. 3rd Street
Florence, CO 81226
719-784-4661

HEARTBEAT/
Colorado Springs, CO
LaRita Archibald
2015 Devon Street
Colorado Springs, CO 80909
719-596-2575

HEARTBEAT/Denver, CO
Narice Wheat
2956 S. Wolff Street
Denver, CO 80236
303-934-8464

HEARTBEAT/South Metro
Denver, CO
Robert and Jan Burnside
6491 S. Forest
Littleton, CO 80121
303-770-1859

HEARTBEAT/Durango, CO
Patricia Theis
701 Florita Road
Durango, CO 81301
970-247-0950

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Suicide Prevention and Intervention Plan

HEARTBEAT/Durango, CO
Paul Merry
5182 County Road #523
Bayfield, CO 81122
970-884-9843

HEARTBEAT/ERIE, CO
Gary and Kathy Bean
1760 Spruce Drive
Erie, CO 80516
303-828-3325

HEARTBEAT/Grand Junction, CO
Margy Palo
722 Centauri Drive
Grand Junction, CO 81503
970-243-2467

HEARTBEAT/Grand Junction, CO
Shirley Kalmbach
394 1/2 East Valley Circle
Grand Junction, CO 81503
970-243-5162

HEARTBEAT/Greeley, CO
Patty Lloyd
1915 25th Street
Greeley, CO 80631
970-356-1710

HEARTBEAT/Greeley, CO
Dr. Majel Martin
1115 23rd Avenue Court
Greeley, CO 80631
970-356-0995

HEARTBEAT/Montrose, CO
Glenda Fletchall
59215 Spring Creek
Montrose, CO 81401
970-249-2979

HEARTBEAT/Montrose, CO
Shelly Green
970-240-3348

HEARTBEAT/Pueblo, CO
Elaine Newton
85 Duke Street
Pueblo, CO 81005

HEARTBEAT/Wheatridge, CO
Jackie and Tom Johnson
6725 Pierce Way
Arvada, CO 80003
303-424-4094

HEARTBEAT/Wheatridge,
CO (TEENS)
Teresa Helgeson
11252 Clarmont
Thornton, CO 80233
303-252-7553

HEARTBEAT/East Central
Colorado
Emma Rose Pearce
26368 Road J
Kit Carson, CO 80825-9412

OTHER RESOURCES

Survivors Supporting Survivors
Dr. Kim Stahlmaker
9604 Collard Drive
Ft. Collins, CO 80525
970-635-9301

Parents Surviving Suicide
Vivian Epstein
212 S. Dexter Street
Denver, CO 80222
303-322-7450

OASOS
Open Affirming Sexual
Orientation Support
Christa Kriesel
3450 Broadway
Boulder, CO 80304
303-413-7504

Criminal Justice Center
2739 East Las Vegas
Colorado Springs, CO 80906-1522
719-390-2102
303-390-2000 (24 hour crisis line)

Emergency Psych Services
1333 Iris Avenue
Boulder, CO 80304
303-443-8500
303-447-1665 (24 hour crisis line)

Suicide Education & Support
Services of Weld Co.
1024 9th Avenue, Suite #7
Greeley, CO 80634
970-352-9111
303-353-3686 (24 hour hotline)

Pueblo Suicide Prevention
Center, Inc.
1925 E. Orman, Suite G-25
Pueblo, CO 81004
719-564-6642
719-564-5566 (M-F 5p-10p)

Lifeline of Colorado, Inc.
5742 Field Street
Arvada, CO 80002
303-421-6453

Comitis Crisis Center
9840 E. 17th Avenue
P.O. Box 913
Aurora, CO 80040
303-341-9160
303-343-9890 (24 hour crisis line)

LIS'N
Capitol Hill Community Center
Box 15, 1290 Williams Street
Denver, CO 80218
303-860-1200
303-860-1200 (Suicide/depression
hotline)
303-894-9000 (Youth support line)

Ft. Morgan Helpline
330 Meaker Street
Ft. Morgan, CO 80701
303-867-3411

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Suicide Prevention and Intervention Plan

Crisis & Info Helpline of Larimer
Co HELPLINE
2850 McClelland Drive, Ste., 1400
Ft. Collins, CO 80525
303-226-1122
303-229-0888 (8a-5p m-f)

Light for Life Foundation -
Yellow Ribbon Program
P.O. Box 644
Westminster, CO 80030
303-429-3530
303-429-3530(M-F 8a-5p MTN
time)

Suicide Prevention HOTLINE and
Prevention Education Programs
(PEP)
Suicide Prevention Partnership
3595 E. Fountain Blvd., Ste J-1
Colorado Springs, CO 80910
719-573-7447

Weld County Suicide Prevention
Program
Susy Ruof
Johnstown, CO
303-587-2336

Shaka Franklin Foundation
for Youth
Les Franklin
8101 E. Dartmouth Ave. #11
Denver, CO 80231
303-337-2515
Institute for Integration Therapy
Brian
5778 W. Ken Caryl Place
Littleton, CO 80128

303-979-0319

Suicide Prevention Coalition
of Erie
Barbara Van Zuiden
St. Scholastica Catholic Church of
Erie, CO
5476 Fir
Erie, CO 80516
303-828-4687

Suicide Prevention Partnership
Suicide Prevention HOTLINE
(719-596-LIFE [5433])
Professional and School-bases
Training
Clergy Roundtable
Community Task Force on Suicide
Prevention
Crisis Support Teams for the
military
3595 E. Fountain Blvd., Ste. B-1
Colorado Springs, CO 80910
719-573-7447

The Trevor Helpline
National 24-hour toll-free suicide
prevention hotline aimed at gay,
lesbian, bisexual, transgendered,
and questioning youth
800-850-8078

Touched by suicide

Touched by suicide

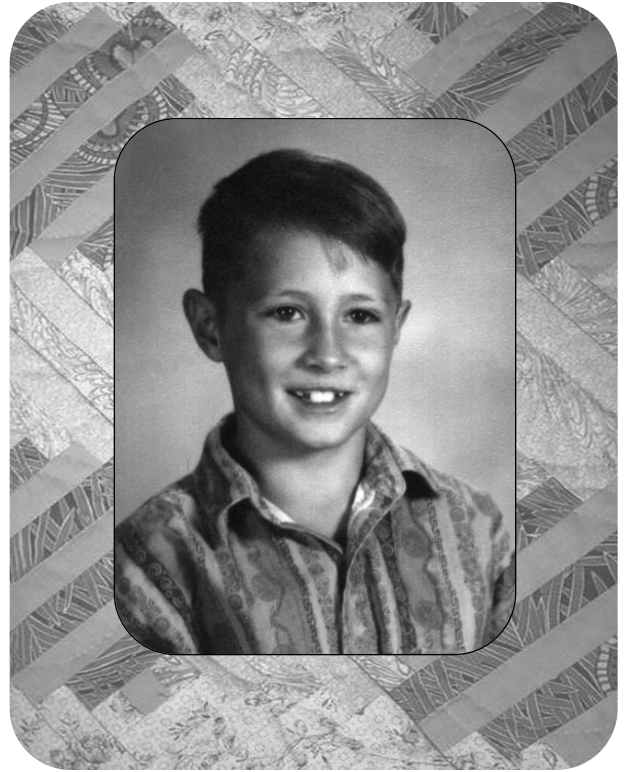
*“55 Coloradans die from
suicide every month.”*

*“More people die from suicide
than automobile accidents
in Colorado.”*

In 1996, 692 deaths were attributed to suicides, while 667 deaths were attributed to motor vehicle crashes.

*“According to some estimates,
nonfatal suicidal behavior occurs
25 times more often than
fatal suicides.”*





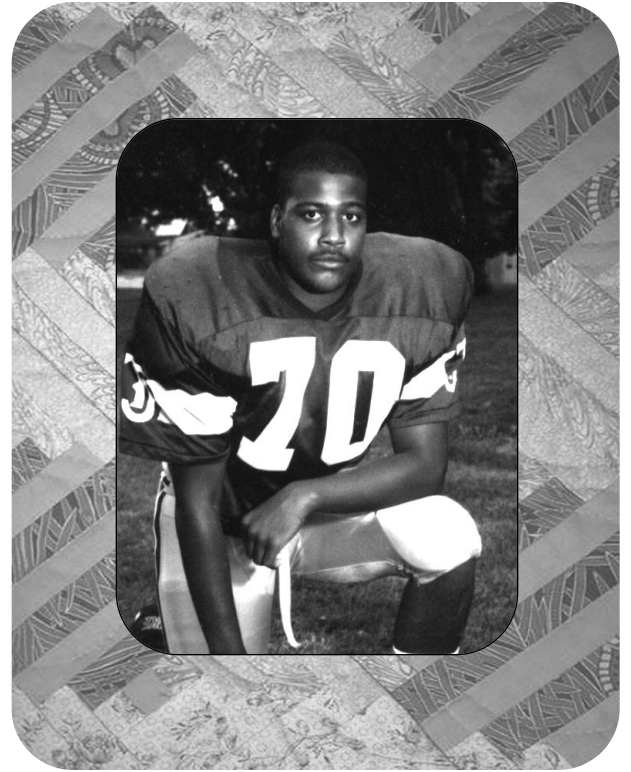
Derrick

March 23, 1985 - October 24, 1997

INTRODUCTION & BACKGROUND

My son, Derrick was a bright and beautiful child. I think one of his most endearing qualities was his wonderful sense of humor. He kept everyone around him laughing and you never knew what practical joke he'd be up to next.

He was energetic and loved sports. He played a lot of street hockey and was an avid fan of the Colorado Avalanche and Denver Broncos. He enjoyed fishing, camping and just being with his friends. He was very loving and kind hearted.



Shaka

August 17, 1974 - October 19, 1990

RISK FACTORS & PREDICTORS OF SUICIDE

Shaka was a young man who never gave his father any problems. He was a popular football star at Thomas Jefferson High School and a counselor for others in his school. Shaka was witty, loving and cared about everyone that came across his path. When Shaka took his life, he was sixteen years old.

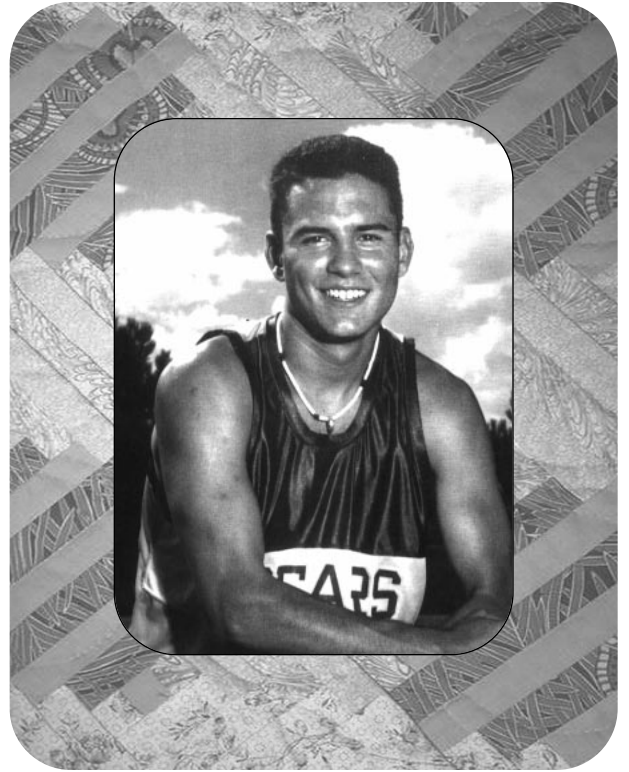


Vera

April 15, 1944 - May 17, 1994

COLORADO SUICIDE RATES & TRENDS

Vera had a heart of gold! She was a loving mother, sister, aunt, grandmother and wife. She opened her heart and home to everyone without judgement. Love is the best word to describe Vera. In her 50 years on this earth, she raised 4 children and had 6 grandchildren. She loved being a mother and grandmother most of all!

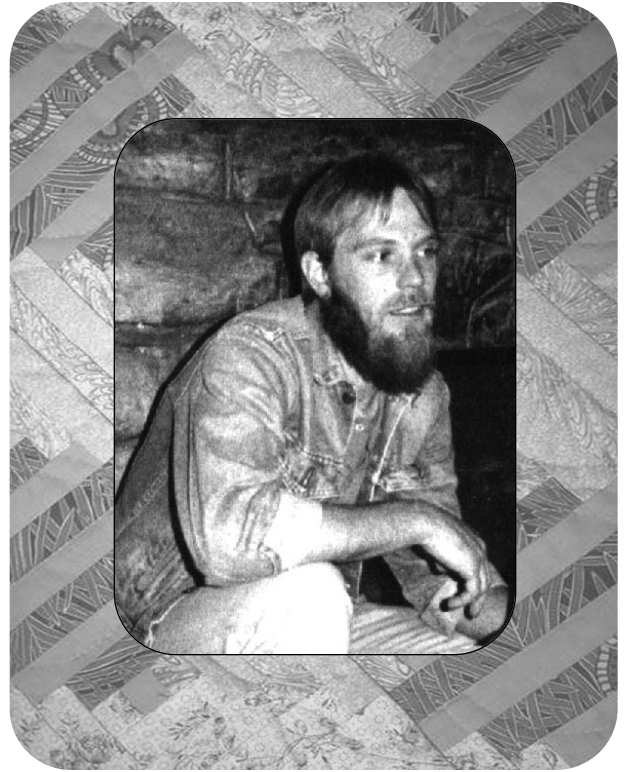


Marc

October 12, 1981 - March 8, 1998

REVIEW OF OTHER STATES

Marc was a gifted athlete. In every sport he attempted, he excelled. He especially enjoyed basketball and running. He was a great kid and had a great personality. He was fun to be around. Marc loved movies, music, sports camping, hiking and his family. Marc loved his dog. He was a sophomore in high school and had a wide variety of friends. He was always thoughtful of others...we miss his beautiful smile.

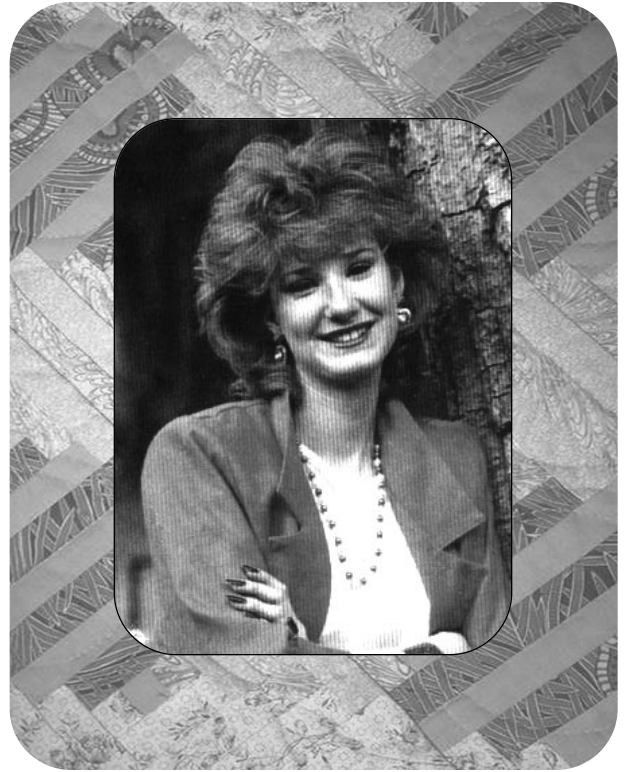


Michael

October 3, 1962 - October 21, 1989

EVIDENCED - BASED RESEARCH ON PREVENTION & INTERVENTION

Michael was our 4th of 5 sons. He was very bright and overly sensitive and giving. He was very skilled with his hands and made beautiful jewelry. He enjoyed listening to jazz and playing his guitar. Michael adored his 2 little nieces and they were delighted when he visited. Most of all, he loved his little dog and an old Bronco he drove. Our lives will never be the same without Michael.



Marla

November 5, 1969 - August 28, 1988

GSPAC RECOMMENDATIONS

Marla loved children and was always in demand for baby-sitting. She loved visiting with the elderly people in the neighborhood. She was always ready to help others. She liked reading in her room when she wasn't at work or at school. Marla was an honor student and always wanted to be at the top of her class. She had lots of friends. She was a caring daughter and a piece of my heart died when she died.

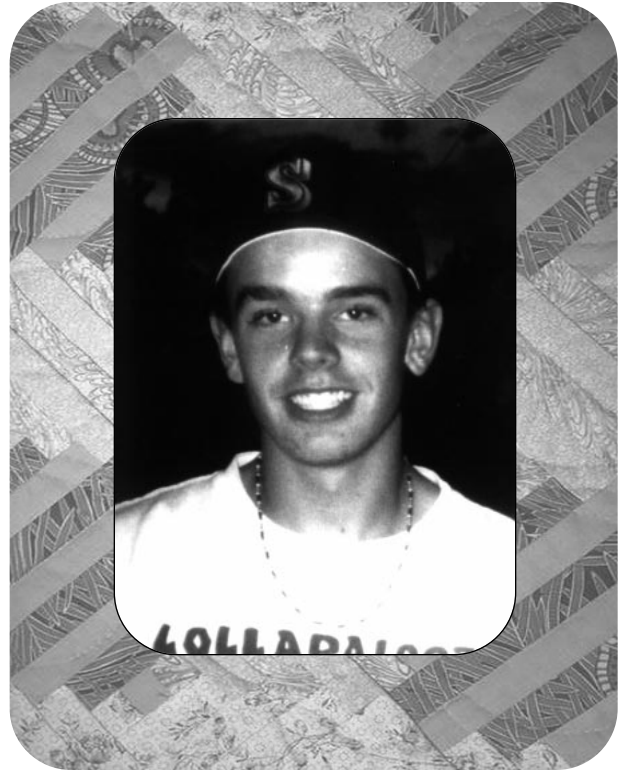


Marc

November 30, 1973 - August 12, 1996

BIBLIOGRAPHY

Marc was a beautiful, gentle, brilliant man (boy as well). Marc died at 23, years after graduating from CU Boulder with a BS in Aerospace Engineering. Marc will be forever missed by all of his relatives as well as his dog, Ender Wiggins



Mike

March 19, 1977 - September 8, 1994

APPENDICES

Mike was a loving son, brother and uncle. Recognized by his bright smile and yellow 1968 Mustang, he was a true friend to those in need as well as those he just met. Since Mike's death, the Yellow Ribbon Project has touched and saved the lives of teens around the world. We'll forever treasure his 17 years.