Coming together to Care

A Suicide Prevention and Postvention Toolkit for Texas Communities

MHA Mental Health America of Texas

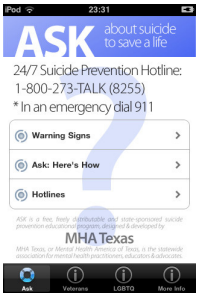
Texas Suicide Prevention Council
Texas Youth Suicide Prevention Project

TEXAS Department of State Health Services

eResources for Suicide Prevention in Texas

Virtual Hope Box App (coming soon)

The Virtual Hope Box app will provide an electronic version of the Hope Box concept: a place to store important images, notes, memories, and resources to promote mental wellness. The app will be free for teens and young adults, and available for both Android and iPhone users. For up-to-date information on the Virtual Hope Box, please see: http://www.TexasSuicidePrevention.org or http://www.mhatexas.org.



ASK & Prevent Suicide App (now available)

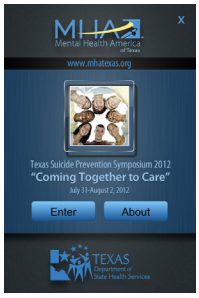
ASK & Prevent Suicide is a suicide prevention smartphone app for Android and iPhone users. This free app is filled with useful information about warning signs, guidance on how to ask about suicide, crisis line contact information, and other resources. To download this app, search "suicide prevention ASK" in iTunes or Google Play.

True Stories of Hope and Help (videos online now)

A series of short videos featuring youth and young adults from Texas sharing their stories of hope and help. These are true stories of high school and college age students who have either reached out for help or referred a friend for help. These videos can be found at: http://www.TexasSuicidePrevention.org or on YouTube (http://www.youtube.com/user/mhatexas).

FREE At-Risk Online Training for Public Schools and Colleges (now available)

The At-Risk interactive training simulation is now available for high school and college educators. Watch for the middle school training scheduled for release in the fall of 2012. Texas educators can access this training at: http://www.TexasSuicidePrevention.org or http://www.mhatexas.org.

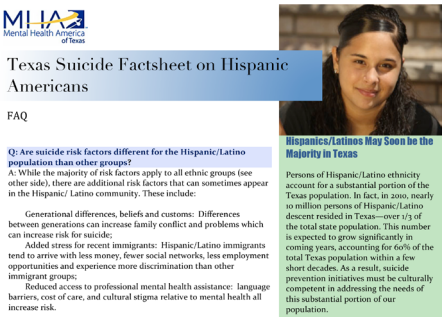


Texas Suicide Prevention Symposium App (now available)

Available for the 2012 Texas Suicide Prevention Symposium: Coming Together to Care, this iPhone and Android app features information and handouts presented at the Symposium. Also included is information about the Texas State Plan for Suicide Prevention, Texas statues and regulations related to suicide, and other state and national resources. To download the app, search "Texas Suicide Prevention Symposium 2012" in iTunes or Google Play.

FREE Mental Health Fact Sheets (now available)

See http://www.TexasSuicidePrevention.org or http://www.mhatexas.org for updated fact sheets on a variety of topics related to mental health, including the *Texas Suicide Fact sheet on Hispanic Americans* shown here.



NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

National Suicide Prevention Lifeline: www.suicidepreventionlifeline.org • 1-800-273-Talk (8255)

This toolkit was developed [in part] under a grant number SM059174 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS) and the Texas Department of State Health Services (DSHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA, HHS or DSHS.

2012

Dear Texas Suicide Prevention Supporters:

On behalf of the Texas Suicide Prevention Council, we are pleased to announce the 2012 edition of the Texas Suicide Prevention and Postvention Toolkit made available by the generous support of Texas State Department of Health Services and Mental Health America of Texas. This document provides a wealth of information, data and resources related to suicide prevention, intervention and postvention across a wide range of topics important in our quest to reduce deaths by suicide in Texas.

The 2012 edition of this toolkit was designed with both the print reader and digital reader in mind; the layout has been altered to make it easy to read in any format, whether online, on a mobile device, or in print. Additionally, you will find that copies of paper documents, fact sheets and handouts have been replaced with direct hyperlinks embedded within the online version (and visible in the print version). By providing electronic access to these resources, the 2012 Texas Suicide Prevention and Postvention Toolkit facilitates the ability to access critical, most current information, tools and research efficiently and effectively.

This year's edition also incorporates best practices resources, training and education materials made available from leading national organizations such as:

American Association of Suicidoloy
American Foundation for Suicide Prevention
Centers for Disease Control and Prevention
Mental Health America
National Alliance on Mental Illness
National Institutes of Health
National Institute of Mental Health
National Suicide Prevention Lifeline
Suicide Awareness Voices of Change
Suicide Prevention Resource Center
Substance Abuse and Mental Health Service Administration

As we are all aware, suicide is a public health issue. By working together to facilitate change in our communities, we are confident we can make Texas a healthier and happier state for all.

Sincerely,

Margie Wright and Jennifer Battle
Co-Chairs, Texas Suicide Prevention Council

A Suicide Prevention and Postvention Toolkit For Texas Communities

Texas Suicide Prevention Council
Texas Youth Suicide Prevention Project
Website: TexasSuicidePrevention.org

TEXAS Department of State Health Services

MHA Mental Health America of Texas

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Dedication

In memory of the Texans who have died by suicide.

In honor of the families, friends and associates they left behind as suicide survivors.

In hope of bringing Texas communities together to care about suicide prevention.

If you feel suicidal or you need to help someone else who does, put down this toolkit and call for help immediately.

On the Phone

Call 1-800-273-TALK (8255) to be connected to a suicide and crisis center in your area.

The **National Suicide Prevention Lifeline** is the only national suicide prevention and intervention telephone resource funded by the federal government. The Lifeline provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a 24-hour, toll-free telephone number **1-800-273-TALK (8255)**.
Veterans' hotline: 1-800-273-8255 +1. http://www.suicidepreventionlifeline.org

- Call the local crisis center listed in the first few pages of your local phone directory.
- Call 911 and ask for the mental health crisis team of your local law enforcement agency.
- Call or go to the nearest hospital emergency room in your area.
- Call one of the Texas crisis centers listed in the Chapter 3 of this toolkit.
- Call your doctor or other health care provider for a referral to someone who provides suicide prevention and intervention services.

Find Help Online at:

- http://www.dshs.state.tx.us/mhsa-crisishotline/ The Texas Council of Community Centers has a list of Texas crisis lines supported by local mental health authorities on a county-by-county basis.
- http://www.dshs.state.tx.us/mhservices/default.shtm The Texas Department of State Health Services, Mental Health and Substance Abuse division maintains an easy to use listing of local mental health authorities and their 24/7 crisis lines. You are able to search by county, city or zip code to find the one nearest you.
- www.suicidepreventionlifeline.org The National Suicide Prevention lifeline website will provide you with further information about using their 24/7 hotline.

For Smartphone Users:

Please take a minute to download the free **ASK & Prevent Suicide app** for your smartphone. With this app, you will always have a list of crisis hotlines and local health centers at your fingertips, as well as crucial information that will help you identify the warning signs of suicide, ask the difficult questions, and take the necessary steps to save a life.

Versions of this app are available for all mobile web browsers, including iOS and Android. For iPhone users, go to: http://itunes.apple.com/us/app/ask-prevent-suicide/id419595716?mt= to download this app from the iTunes store, or visit the App Store from your phone and search "ASK." For Android users, you can also find a version of this app at Google Play (https://play.google.com/store?hl=en), or in the Android Market from your phone at: market://details?id=com.mhatexas.askaboutsuicide.

You have made the right choice to look for help. We hope you will contact someone right away.

Contributors

Coming Together to Care, Texas Suicide Prevention and Postvention Toolkit 2012 Update

Project Coordinator: Lisa Sullivan, INFUSE Corporation-Consultant
Editors and Contributors from the Texas Suicide Prevention Council: Merily Keller, Consultant; Jenna Heise, Texas Department of State Health Services; Margie Wright, Dallas Suicide and Crisis Center of North Texas; Jennifer Battle, MHMRA of Harris County; Mary Ellen Nudd, Mental Health America of Texas.
Additional Contributors: Donna Barnes, Shina Bharadwaja, Anousha Lakhani, Sofia Kahn, Mario Gonzalez, Shayna Barksdale, Craig Bryan, Tony Salvatore, Dianna Groves, Connie Wilson, Corey Huston-Liter, Patrick Hunt.

Editors and Contributors to Previous Versions of the Texas Suicide Prevention Toolkit

Laurie Alexander, Debra Boyd, Sr. Helen Brewer, John Burruss, Lynn Lasky Clark, Allan Hugh Cole, Doris Rhea Coy, Sally Daguer, Sharon Derrick, Patrick Eberhardt, Saundra Gilfillan, Dave Gray, Lauralee Harris, John Hellsten, Polly Hughes, Kisla Jimenez, Merily Keller, Milissa Kennedy, John P. Keppler, Gary Kesling, Lorinda Lonie, Florastine Mack, Mary Chapman McIntosh, Charles Monney, Mary Ellen Nudd, Jasmin Paikattu, Traci Patterson, M. Scott Poland, Julian Rivera, Elizabeth Roebuck, Claire Sabatier, Liliana Santoyo, Skip Simpson, Judie Smith, Ben Sternman, Melissa Stratton, Mary Summerall, Amanda Summers-Fox, Molly Wilkins, Patty Williams, Frank Vega, Charles Vorkoper and Margie Wright.

Disclaimer: Membership on these workgroups or contribution to the toolkit as a writer, editor, researcher, supporter or reviewer does not imply agreement or endorsement of the plan by the respective agencies or organizations. In addition, this toolkit is to be used as an educational tool only and not as a substitute for consultation with a health, mental health or substance abuse provider. Research in this field is developing and changes on an ongoing basis.

Table of Contents

Understanding Suicide: The Basics

Chapter 1

Sections in this Chapter	
Section Name	**Page**

This suicide prevention and postvention toolkit focuses on safe suicide care related topics as well as Texas specific information. The goal is to make this a practical resource that community leaders can use in efforts to prevent suicide deaths in Texas and provide action steps to take in the event of a suicide. This chapter provides a high level overview of key information about suicide, the facts surrounding suicide, the risk and protective factors associated with suicide, and what to look for and what to do if someone is presenting suicidal behavior.

Updates will be posted at:
Texas Suicide Prevention Council: http://www.TexasSuicidePrevention.org

Frequently Asked Questions about Suicide Prevention

Listed are a few of some of the most frequently asked questions about suicide prevention in Texas, and where you can find the answers in this toolkit:

1. **Question: How many suicides are there in Texas and in my particular city or county?**
   Answer: The State of Texas lost over 2,800 residents to suicide in 2010. Over the past five years, Texas averaged a rate of approximately 11.3 per 100,000 residents. (County by county statistics and instructions on how to use a web-based search engine to generate specific statistics for your area can be found in this toolkit in Chapter 4.)

2. **Question: What are the risk factors for suicide?**
   Answer: Suicide is considered to be multi-factorial or a combination of various biological, psychological and social risks. As such, there is generally no "one cause" for suicide. There are risk factors associated with suicidal tendencies and, conversely, protective factors that aid in prevention. These factors are discussed in this chapter.

3. **Question: I have a family member or friend who I think may be suicidal. I'm worried about him/her. What do I do?**
   Answer: Follow the ASK guidelines located below. These guidelines are also available through a set of free smartphone apps (for iPhone and Android based devices), called "ASK." Please download this app so you will always have access to this important information.

The ASK steps are:

Ask about suicide.
Seek more information.
Know where and how to refer

ASK https://play.google.com/store/apps/details?id=com.mhatexas.askaboutsuicide&feature=search_result#?t=W251bGwsMSwyLDEsImNvbS5taGF0ZXhhcy5hc2thYm91dHN1aWNpZGUiXQ

ASK http://itunes.apple.com/us/app/ask-prevent-suicide/id419595716?mt=

In Addition:

- Call 911 and ask for a mental health deputy or police officer to come to his/her location to escort them to help.
- Call his/her family doctor and tell them the person is suicidal and ask for a referral for help.
- Call **1-800-273-8255.** The National Suicide Prevention Lifeline will connect you to the nearest crisis center for help.

Also, some communities have Mobile Crisis Outreach Teams that offer mobile mental health services to community residents. For more information, contact the local behavioral health center in your area, listed in Chapter 3 of this toolkit.

http://www.mhatexas.org/ask/

4. **Question: If you talk about suicide, are you encouraging people to do it?**
   Answer: This is one of the main myths about suicide. Not addressing the warning signs directly and promptly leads to more suicides, not less. Research in public health has demonstrated that you cannot address a public health issue if do you do not talk about it, or there is no awareness of the problem. The key to discussing suicide is to do so in a manner that supports suicide prevention, not sensationalizes it. There are best-practice guidelines for these discussions for all target populations, including media, which are located in Chapter 5 and Chapter 6 of this toolkit.

5. **Question: Do suicide hotlines and counselor follow-up really work?**
   Answer: YES. Follow-up calls are calls placed by the counselor to a previous caller into a crisis hotline in distress. The Substance Abuse and Mental Health Services Administration research found that when people were asked to what extent the counselor's follow-up call stopped them from killing themselves, 53.7% indicated "a lot" and 25.1% indicated "a little," meaning that counselors who placed follow-up calls made a difference in nearly 80% of these cases. Furthermore, when people who had previously used a hotline were asked to what extent the counselor's follow-up call kept them safe, 60.8% said "a lot," and 29.3% said "a little," meaning that 90% of calls placed by counselors were effective to some degree. Finally, 59.8% of people who were receiving follow-up calls indicated that just getting or anticipating the calls—knowing that someone cared—was helpful to them.

6. **Question: Are there research-based programs that can be implemented in our local areas to help prevent suicide?**
   Answer: Yes, there are a number of best-practice programs for suicide prevention available to implement at the

local level. These proven programs will support your community's prevention and postvention efforts. Many of these are being implemented at the state level as part of Youth Suicide Prevention SAMHSA grants (Substance Abuse and Mental Health Services Administration). These effective resources and programs are located in Chapter 3 of this toolkit, with direct hotlinks to the various providers.

7. **Question: There has been a recent suicide in our area. What do we do now?**
   Answer: There are a number of immediate and longer-term strategic steps that should be undertaken following a suicide to ensure the event is contained and does not spread to other vulnerable individuals in the sphere of influence of the person who died by suicide. Many of these steps may appear counter-intuitive at first, so it is important to involve qualified mental health professionals and/or public health officials when facing this challenge. Preventing suicide clusters, copycat, or contagion events is a top priority for postvention efforts. **Guidelines for all stakeholders, including media and social media are located in Chapter 6 of this toolkit.**

8. **Question: How can I get involved in suicide prevention in Texas? Are there statewide and regional groups to join in this effort?**
   Answer: This toolkit was named "Coming Together to Care," because Texans have a long history of joining together as communities to find answers and fix problems. If you are a member of a statewide organization/agency and your group agrees to support one or more of the goals and objectives of the Texas state plan for suicide prevention, your agency can become a member of the Texas Suicide Prevention Council. You can find a list of community coalition contacts in Chapter 3 and a copy of the community coalition letter of agreement in Appendix C.

   For more information about joining the Council, contact suicideprevention@mhatexas.org.

   In addition, each of the 37 Local Mental Health Authorities in Texas has designated suicide coordinators. These are listed at the Texas Council of Community Center's website: http://www.txcouncil.com.

9. **Question: Where can I find a copy of the Texas State Plan for Suicide Prevention?**
   Answer: The Texas Suicide Prevention Council has developed the *Texas State Plan for Suicide Prevention: Guidelines for Suicide Prevention in Texas;* the most recent version was adopted in 2011. The comprehensive plan outlines key goals, objectives, strategies, and actions in the areas of Awareness, Intervention and Methodology and can be found at: http://www.texassuicideprevention.org/ and in Appendix B of this toolkit. The Texas State Plan for Suicide Prevention is aligned with the National Plan for Suicide Prevention, which can be found at:

   http://store.samhsa.gov/product/National-Strategy-for-Suicide-Prevention-Full-Report-/SMA01-3517

10. **Question: Where can I find a list of organizations, books, and web-based resources for suicide prevention?**
    Answer: There is a wealth of print and web-based resources available. A list of resources can be found at the American Association of Suicidology's website at: http://www.suicidology.org/web/guest/stats-and-tools. Additionally valuable resources can be found at the Suicide Prevention Resource Center's website: http://www.sprc.org

    Additional resources are also listed in Chapter 3 of the toolkit.

11. **Question: I have lost a friend or family member to suicide and would like to contribute to suicide prevention in his/her name. Where can I contribute to Suicide Prevention in Texas?**

Answer: The Texas Suicide Prevention Council serves as the administrative body for stewarding state-level efforts and organizations addressing suicide and local suicide prevention coalitions. It is charged with implementing the Texas State Plan for Suicide Prevention. Mental Health America of Texas, a statewide 501c (3) nonprofit, serves as the

fiscal agent for the Council and can accept donations in memory of a loved one or general donations to support the cause.

Knowing the Facts about Suicide

Suicide is a subject surrounded by misconceptions and misunderstanding. As a result of the stigma attached to death by suicide, the subject is not freely and openly discussed. As such, understanding who is at risk, why, and under what circumstances is often based on inaccurate conjecture instead of fact. The following information describes research-based facts about suicide prevention as they pertain to adults and young people.

Question	Fact
Are there warning signs prior to a suicide?	Eight out of ten people who kill themselves give some sort of a warning or clue to others, even if it is something subtle.
Do people always leave a note behind when they complete a suicide?	In most cases, there is no suicide note.
Is someone who talks a lot about suicide just trying to get attention?	It's just the opposite. More than seventy percent of people who kill themselves have previously threatened to do so or actually attempted to do so. When someone says they feel this way, take it seriously. Follow the ASK steps.
Are people who are suicidal intent on dying and feel there is no turning back?	Research show that most people who are suicidal are conflicted. Part of them wants to die, but part of them doesn't. The main thing they want is to stop their pain.
If someone is determined to die by suicide, is there really anything that can be done to prevent it from happening?	As indicated by the previous answer, people who are suicidal are actually conflicted about wanting to die; therefore, following the proper steps and knowing how to refer someone who is suicidal (as outlined above in question three) is crucial.
Are people who attempt suicide once likely to try it again?	80% of people who die from suicide have made at least one previous attempt.
Is someone who survives a suicide attempt not serious about it?	Any suicide attempt should be treated as though the person intended to die, and not simply dismissed as an attention-getting action. As stated above, 80% of people who die from suicide have made at least one previous attempt. A previous attempt is a significant risk factor for future attempts
If you mention suicide to someone who seems depressed, are you just planting the idea in his or her mind?	Research shows that discussing suicide openly can actually help, not hurt.
Source: CrisisLink. http://www.crisislink.org/suicide-information/ Mental Health Library, Royal Park Hospital, Parkville, Victoria, Canada	

Knowing the Facts about Youth Suicide

Question	Fact
Do young people who talk about suicide ever attempt or die by suicide?	Many young people who attempt suicide talk about it first. Talking about suicide is an important warning sign and should trigger the receiver of this information to follow the ASK steps.

If you know a young person who is talking about suicidal thoughts or feelings, should you just say "cheer up"?	If you know that a young person is having thoughts of suicide, your first steps should be to persuade to them to get help and refer them to a mental health provider. (Follow the ASK steps discussed above in Question 3)
Is it better not to talk about suicide with someone who's feeling down or hopeless? Does it make things worse?	The first step to encourage a suicidal person to live is to let them know that someone cares and is willing to support and talk with them.
If someone tells you about suicidal feelings and asks you to keep it a secret, should you respect their wishes?	That could literally be a deadly secret to keep. It's more important to get help, even if that means revealing a secret. NEVER KEEP A DEADLY SECRET. SEEK ASSISTANCE from trusted adults.
When someone is really suicidal, is there anything you can do to help?	You can help by offering your support and the hope that they can find a way to end the pain without attempting suicide.
Are depressed people the only ones who attempt suicide?	You can have suicidal feelings or even attempt suicide whether you are clinically depressed or not.
Have you done your part if you can get someone to promise to get help?	It's important to follow through and be sure the person stays safe until you can put him or her in contact with a responsible adult.
Source: CrisisLink. http://www.crisislink.org/suicide-information/ Mental Health Library, Royal Park Hospital, Parkville, Victoria, Canada	

Risk Factors and Protective Factors for Suicide

According to the Centers for Disease Control and Prevention, there are a number of risk and protective factors that aid in increasing or decreasing the risk of suicide. Risk factors may not always be direct causes of suicide, but research indicates that these factors may contribute to the likelihood of suicide. Oftentimes, there may be a combination of factors involved.

Conversely, the protective factors may not directly stop a suicide. These protective factors may decrease the likelihood of suicide and may "buffer individuals from suicidal thoughts and behavior." For additional discussion on risk and protective factors see:

http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html

Risk Factors for Suicide

Risk factors may be thought of as leading to or being associated with suicide; that is, people "possessing" the risk factor are at greater potential for suicidal behavior. According to The Centers for Disease Control and Prevention's Injury Center, these factors are:

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▪ Family history of suicide ▪ History of mental disorders, particularly clinical depression ▪ Impulsive or aggressive tendencies ▪ Isolation, a feeling of being cut off from other people ▪ Physical illness ▪ Family history of child maltreatment ▪ Previous suicide attempt(s) ▪ History of alcohol and substance abuse	▪ Feelings of hopelessness ▪ Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma) ▪ Local epidemics of suicide ▪ Barriers to accessing mental health treatment ▪ Loss (relational, social, work, or financial) ▪ Easy access to lethal methods ▪ Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

Protective Factors for Suicide

Protective factors are the positive conditions, personal, and social resources that promote resiliency and reduce the potential for suicide as well as often high-risk behavior. Protective factors are critical to prevention because research indicates that the presence of just one protective factor decreases the chances of dying by suicide. Furthermore, as the number of protective factors increase, the likelihood of suicide attempts or deaths decrease.

▪ Effective clinical care for mental, physical, and substance abuse disorders ▪ Support from ongoing medical and mental health care relationships ▪ Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes.	▪ Easy access to a variety of clinical interventions and support for help seeking ▪ Family and community support (connectedness) ▪ Cultural and religious beliefs that discourage suicide and support instincts for self-preservation ▪ Restricted access to highly lethal means of suicide

Understanding the dynamic relationship between risk and protective factors in suicidal behavior and how this interaction can be modified are challenges to suicide prevention (Móscicki, 1997). Unfortunately, scientific studies that demonstrate the suicide prevention effect of altering specific risk or protective factors remain limited in number. However, the impact of some risk factors can clearly be reduced by certain interventions such as providing lithium for manic-depressive illness or strengthening social support in a community (Baldessarini, Tando, Hennen, 1999). Risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance use disorder or following a significant stressful life event (Oquendo et al., 1999). Protective factors are quite varied and include an individual's attitudinal and behavioral characteristics, as well as attributes of the environment and culture (Plutchik and Van Praag, 1994).

Warning Signs and What to Do About Them

People who attempt suicide often send out warning signs before they actually make an attempt. These signs may be loud and clear, or low-key and subtle. Knowing how to recognize these signs is the first step in taking action that could save someone's life.

The *Warning Signs for Suicide Prevention* were developed through an expert consensus working group administered by the American Association of Suicidology. Warning signs are different than risk factors in that the group defined warning signs as the "earliest detectable signs that indicate heightened risk for suicide in the near-term (within minutes, hours or days)." These are different than "risk factors," which often indicate longer-term

risk (a year or more). They also noted that, aside from "direct statements or behaviors threatening suicide, it is often a constellation of signs that raises concern, rather than one or two symptoms."

http://www.sprc.org/sites/sprc.org/files/bpr/AASWarningSigns_factsheet_edit.pdf

There are two other warning signs lists based on best practices and expert clinical consensus statements. One is from the Suicide Prevention Resource Center and the other from the American Association of Suicidology and are listed below:

American Association of Suicidology: The AAS follows the mnemonic to assist users in remembering the key warning signs:

IS PATH WARM?

"IS PATH WARM?" helps to identify key warning signs associated with suicide. These warning signs are critical, as they manifest differently in different people. It is important to remember that not all warning signs are verbal and it is often a combination of indicators that are present; ***if observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-8255 (1-800-273-TALK) for a referral.***

I Ideation (threatening to hurt themselves, talking, writing about death)
S Substance Abuse (increased substance use)

P Purposelessness (perception of no reason for living, no sense of purpose)
A Anxiety (agitation, unable to sleep or sleep extraordinary amount so time)
T Trapped (feeling like there's no way out of their situation)
H Hopelessness (no sense/perception the future will be better)

W Withdrawal (from friends, family, work and society in general)
A Anger (uncontrollable rage/anger, seeking revenge)
R Recklessness (engaging in risky behavior, activities, seemingly without thought)
M Mood Changes (dramatic, unpredictable mood changes)

http://www.suicidology.org/web/guest/stats-and-tools/suicide-warning-signs

Suicide Prevention Resource Center

A second resource, the Suicide Prevention Resource Center's Best Practice Registry contains two levels of warning signs, high risk and chronic/ongoing risk. Both sets of warning signs should trigger action by the observer by ***contacting a mental health professional or calling 1-800-273-8255 (1-800-273-TALK) for a referral.***

High Risk (activity in the following areas):
Threatening to hurt or kill oneself
Talking of wanting to hurt or kill oneself
Looking for ways to kill oneself by seeking access to firearms, drugs (prescription or illicit) or other means
Talking, writing or posting on social media about death, dying and suicide

Chronic/Ongoing Risk: feelings and behavior that is experienced over an extended period of time. The five key feelings and behaviors are:

Feelings:	Behavior:
▪ No reason for living, or no sense of purpose in life ▪ Feeling trapped, like there's no way out ▪ Hopelessness ▪ Dramatic mood changes ▪ Anxiety/agitation	▪ Increased substance use ▪ Withdrawal from friends, family and/or society ▪ Rage, anger, revenge-seeking behavior ▪ Reckless or risky decision making and actions ▪ Unable to sleep or sleeping all the time

http://www.sprc.org/sites/sprc.org/files/event_materials/3B%20AAS%20Warning%20Signs.pdf

What to Do if You Spot the Signs

Ask directly. Asking someone directly if they ever think of suicide lets them know that you take the situation seriously and want to help. It may be a real relief to someone to know that it's all right to talk about it openly.

Evaluate whether the danger is imminent. If someone admits thinking about suicide, follow through by asking questions that can help you determine how high the risk is. Find out if he or she has thought about how and when to do it and if the means are available. If there is a plan—WHAT, WHEN, and HOW—the risk of suicide is very high.

Consider the San Francisco Suicide Prevention Risk Assessment tool: "P.L.A.I.D.P.A.L.S. PlaidPals is a checklist of things to watch for when assessing the potential risk of suicide:

P **P**lan – Do they have one?
L **L**ethality – Is it lethal? Can they die?
A **A**vailability – Do they have the means to carry it out?
I **I**llness – Do they have a mental or physical illness?
D **D**epression – Chronic or specific incident(s)?

P **P**revious attempts – How many? How recent?
A **A**lone – Are they alone? Do they have a support system? Are they alone right now?
L **L**oss – Have they suffered a loss? (Death, job, relationship, self-esteem?)
S **S**ubstance abuse (or use) – Drugs, alcohol, medicine? Current? Chronic?

http://www.sfsuicide.org/prevention-strategies/warning-signs/p-l-a-i-d-p-a-l-s/

ACTIONS (what to do if you spot the warning signs):

If the threat is imminent:

- ✓ Call 911 for a mental health deputy or officer to assist in transportation.
- ✓ Transport the person to the nearest hospital emergency room.
- ✓ Contact your local Mental Health or Behavioral Health Center. These are listed in Chapter 3 of this toolkit. Many have a local mobile outreach team to assist in these circumstances.
- ✓ Get an agreement to get help from a mental health professional.

- ✓ Call for help; contact the national crisis line at 1-800-273-8255 (1-800-273-TALK) to be connected to your local crisis center.
- ✓ Call your local crisis hotline, which can be found at: http//www.dshs.state.tx.us/mhsacrisishotline/

There are also crisis lines for specific needs, such as:

The National Suicide Prevention Hotline number for individuals who are deaf, hard of hearing, and for those with speech disabilities who use a TTY 1-800-799-4TTY (4889)	**Lesbian, Gay, Bi-Sexual, Transgender Youth Suicide Hotline** (866) 4-U-TREVOR
Military and Veterans Suicide Hotline (800) 273-8255 (Press 1)	**Suicide Hotline in Spanish** (800) 273-8255 (Press 2)

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Texas Suicide Prevention eNews

To receive a quarterly suicide prevention eNewsletter with information about suicide prevention issues, free trainings and materials, contact: suicideprevention@mhatexas.org .

Key Terms and Definitions

Chapter 2

From the ASK About Suicide to Save a Life *training manual*

Term	Definition
Contagion	A Phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts. The CDC specifies that a contagion occurs when the deaths and/or attempts are "connected by person, place, or time.
Cluster	The CDC specifies that a cluster has occurred when attempts and/or deaths occur at a higher number than would normally be expected for a specific population in a specific area.
Gatekeepers (suicide prevention gatekeepers)	Individuals trained to identify persons at risk of suicide and refer them to treatment or support services as appropriate.
Resilience	Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.
Risk Factors	Factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.
Screening	Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.
Self-Harm	Confirmed or suspected: injury or poisoning resulting from a deliberate violent act inflicted on oneself with the intent to take one's own life or with the intent to harm oneself. This category includes suicide, suicide attempt, and other intentional self-harm.
Suicidal Behavior	Spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.
Suicidal Ideation	Thoughts of engaging in suicide-related behavior.
Suicide Attempt	A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Additional Terms

Act	The performance of any function or the bringing about of any effect. Example: A suicidal act may result in death (suicide), injuries, or no injuries.
Death of undetermined intent	A death whose manner is unclear when all available information is considered.

Direct	Pertaining to an association between a factor and a condition where the factor occurs prior to the condition, the change in the factor is correlated with a change in the condition and the correlation is not itself the consequence of the factor and the condition being correlated with some prior factor.
Distal risk factor	The underlying vulnerability that potentiates a characteristic, variable, or hazard which increases the likelihood of development of an adverse outcome which is measurable and precedes the outcome.
Episode	A developed situation that is integral to but separate from a continuous narrative.
Explicit	Fully revealed or expressed without vagueness, implication, or ambiguity; leaving no question as to meaning or intent.
Fatal	Causing death.
Immediate cause of death	The final disease, injury, or complication directly causing death.
Implicit	Being without doubt or reserve, implied though not directly expressed; inherent in the nature of something.
Impulsivity	Cognitive Impulsivity –The intellectual or mental process which results in an act performed without delay, reflection, voluntary direction or obvious control in response to a stimulus. Behavioral Impulsivity – An act performed without delay, reflection, voluntary direction or obvious control in response to a stimulus.
Indirect	Pertaining to an association between a factor and a condition because both are related to some common underlying condition.
Inferred	To derive as a conclusion from facts or premises.
Injury	A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological harm is excluded in this context.
Institution	An established organization or corporation, such as a hospital/urgent care center (emergency facility), mental health facility, clinic.
Intentional self-harm	Purposefully self-inflicted poisoning or injury.
Non-fatal	Not causing death.
Physical injury	A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological harm is excluded in this

	context.
Precipitating event	Factors associated with the definitive onset of a disease, illness, accident, behavioral response, or course of action. Examples include exposure to specific disease; circumstance, condition or agent.
Proximal risk factor	A measurable characteristic, variable, or hazard that increase the likelihood of development of an adverse outcome and is more immediately antecedent to the outcome, acting as a precipitant.
Rescueability	A term used in assessing a suicide act that indicates that the situation allowed for the possibility of intervention by others to prevent death.
Self-Harm Behavior/self-inflicted/ self-injurious	The act of injuring oneself intentionally by various methods such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness but with no intent to die.
Self- harm ideation	Any thought or communication regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of intent to die.
Suicidal ideation	Thoughts of engaging in suicide-related behavior.
Suicidal intent	There is evidence (explicit and/or implicit) that at the same time of injury the individual intended to kill self or wished to die and that the individual understood the probable consequences of his or her actions.
Suicidal plan	A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt this will often include an organized manner of engaging in suicidal behavior such as a description of a time frame and method.
Underlying cause of death	The disease, injury or complication, if any, that gave rise to the immediate cause of death.
Undetermined injury incident	Events where available information is insufficient to enable medical or legal authority to make a distinction between unintentional, self-directed and assault.
Victim-precipitated assault or homicide	An act in which a person engages in actual or apparent danger to others in an attempt to get oneself killed or injured.

Resources and Contacts

Chapter 3

Sections in this Chapter	
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Suicide Prevention Resource List

National Crisis Hotlines	
Boys Town National Hotline http://www.boystown.org/ 800-448-3000	The Boys Town National Hotline is a 24-hour crisis, resource and referral line. Accredited by the American Association of Suicidology, the Hotline is staffed by trained counselors who can respond to your questions every day of the week, 365 days a year. Over the past decade, more than 5 million callers have found help at the end of the line.
National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org 1-800-273-TALK (8255)	This hotline is staffed by trained counselors, available 24 hours a day, 7 days a week. Provides information about support services that can help you.

General Mental Health Advocacy, Information, and Referrals	
American Psychological Association http://www.apa.org publicinterest@apa.org	This site contains resources including journal articles, books, book chapters, reports, and general information for older adults and their families.
Depression and Bipolar Support Alliance http://www.dbsatexas.org	The Depression and Bipolar Support Alliance (DBSA) is a patient-directed organization focusing on the most prevalent mental illnesses: depression and bipolar disorder. The organization fosters an understanding about the impact and management of these life-threatening illnesses by providing up-to-date, scientifically-based tools and information written in language the general public can understand.
Depression Screening http://www.mentalhealthamerica.net/llw/depression_screen.cfm	Mental Health America has a Depression Screening site as part of their Campaign for America's Mental Health. The webpage educates people about clinical depression, offers a confidential way for people to get screened for symptoms of the illness, and guides people toward appropriate professional help if necessary.
Disability Rights Texas http://www.disabilityrightstx.org	Disability Rights Texas is a nonprofit corporation funded by the United States Congress. Its mission is to protect and advocate for the legal rights of individuals with disabilities in Texas.
Mental Health America http://www.mentalhealthamerica.net/	Mental Health America is a nonprofit organization addressing all aspects of mental health and mental illness. Includes an online locator by state of providers of free depression screening. Mental Health America of Texas is the state affiliate of MHA, www.mhatexas.org., 512-454-3706.
National Alliance on Mental Illness http://nami.org	A nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders. NAMI has state and local affiliates across Texas. NAMI Texas, www.namitexas.org, 800-633-3760, 512-693-2000
National Association of Social Workers (NASW) http://www.socialworkers.org	NASW is the largest national membership organization for social workers, with fifty-six chapters across the country and nearly 145,000 members. Their aim is to "enhance the well-being of communities through social work." (Contact information for the Texas chapter is located in State Agency Resources below.)
National Institute of Mental Health http://www.nimh.nih.gov	Part of the National Institutes of Health (NIH), the principal biomedical and behavioral research agency of the United States Government, NIMH's mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior.
National Mental Health Information Center http://www.mentalhealth.samhsa.gov	Sponsored by SAMHSA, this center provides information about mental health at the local, state and federal level to a vast audience, including Spanish materials, recent news items, an events listing and a mental illness services locator.
Substance Abuse and Mental Health Services Administration (SAMHSA) http://www.samhsa.gov/	A division of the U.S. Department of Health and Human Services, SAMHSA provides leadership in promoting quality behavioral health services to local communities throughout the country, through grants and funding for research and programs.
Screening for Mental Health, Inc http://www.mentalhealthscreening.org	This is a nonprofit organization developed to coordinate nationwide mental health screening programs and to ensure cooperation, professionalism, and accountability in mental illness screenings. All are community-based programs whose screenings are free and anonymous. Local health professionals conduct all the community-based programs with materials provided by Screening for Mental Health. The Interactive Screening Programs provide customized referrals to mental health professionals.

Texas Suicide Prevention Council http://www.texassuicideprevention.org/	The Texas Suicide Prevention Council is a group of over 20 statewide organizations and over 30 local coalitions that provide planning and support for implementation of the Texas State Plan for Suicide Prevention. Contact: Merily Keller, hodgekeller@yahoo.com
International Resources	
Befrienders International http://www.befrienders.org/	Befrienders International is a gateway to 1,700 suicide and emotional help lines worldwide and on the Internet. Offers 24-hour befriending services to those in emotional distress. They offer telephone, mail, and face-to-face befriending.
International Association for Suicide Prevention (IASP) http://www.iasp.info/	IASP is dedicated to preventing suicidal behavior, to alleviate its effects, and to provide a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors.
Programs and Resources Targeting Youth	
Adolescent Wellness, Inc www.AdolescentWellness.org	The website offers a free download of a manual suitable for schools. Several items for parents are also listed on the Parent Resources page.
AFSP – Teen Suicide Prevention Message http://www.afsp.org/	Look under "Education Resources, Teen Suicide Prevention Campaign." A public service message for distribution to schools by the American Foundation for Suicide Prevention.
Columbia University TeenScreen Tool-kit www.teenscreen.org	A widely used screen created at Columbia University that is research based and available to communities for efficient screening for suicide prevention.
Crisis Communication Guide and Toolkit http://www.neahin.org/educator-resources/school-crisis-guide.html	Created by the National Education Association and provides resources to empower members facing crises that guide school communities toward hope, healing, and renewal. This approach combines response to crisis and suicide prevention.
Jason Foundation, Inc. http://www.jasonfoundation.com	The Jason Foundation, Inc. (JFI) provides education programs and resources for parents, educators, youth and others for the prevention of youth suicide. JFI targets the triangle of prevention model: youth, educators, and parents.
National Youth Violence Prevention Resource Center (Now STRYVE: Striving To Reduce Youth Violence Everywhere) http://www.vetoviolence.org/stryve/	The National Youth Violence Prevention Resource Center (NYVPRC) was established as a central source of information on prevention and intervention programs, publications, research, and statistics on violence committed by and against children and teens. The resource center is a collaboration among the Centers for Disease Control and Prevention and other federal agencies. Together, the NYVPRC Website, www.safeyouth.org, and call center, 1-866-SAFEYOUTH (723-3968), serve as a user-friendly, single point of access to federal information on youth violence prevention and suicide.
Response, Second Edition http://www.columbiacare.org/Page.asp?NavID=99	Created by Columbia Care Services Inc., Response is a suicide prevention program designed for high school administrators, parents, and students. The program is delivered as a school kit that includes an implementation manual for administrators, lesson plans for students, and videos and powerpoint presentations for classroom training.
S.O.S (Signs of Suicide) http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/ Screening for Mental Health,	SOS is a school-based prevention program that incorporates two prominent suicide prevention strategies into a single program, combining a curriculum that aims to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors. The educational component is expected to reduce suicidality by increasing middle or high school students' understanding of and promoting more adaptive attitudes toward depression and suicidal behavior. The self-screening component enables students to recognize depression and suicidal thoughts and behaviors in themselves and prompts them to seek assistance.
Safe2Tell http://www.safe2tell.org	Safe2Tell is designed to help students, teachers, and parents anonymously report anything scaring or endangering youth, their friends, or family.

Stories of Hope and Help www.texassuicideprevention.org	Features short videos of youth sharing their stories of hope and help. The Videos feature the National Suicide Prevention Lifeline number and follow their guidelines. These true stories are from youths in high school and college who have either reached out for help themselves or referred a friend. A video discussion guide will be available in the fall of 2012.
Technical Assistance Sampler on: School Interventions to Prevent Youth Suicide http://www.smhp.psych.ucla.edu	From the Mental Health in Schools Center and created under the auspices of the School Mental Health Project, Department of Psychology, University of California at Los Angeles. This sampler presents an outline of a full program for school suicide prevention.
Teen Suicide Fact Sheet American Academy of Child and Adolescent Psychiatry (AACAP) http://www.aacap.org	Description: The AACAP developed Facts for Families to provide concise and up-to-date information on issues that affect children, teenagers, and their families. The AACAP provides this important information as a public service and the Facts for Families may be duplicated and distributed free of charge as long as the American Academy of Child and Adolescent Psychiatry is properly credited and no profit is gained from their use.
Texas Youth Suicide Prevention Project http://www.texassuicideprevention.org/	The Texas Youth Suicide Prevention Project provides public awareness, outreach and training in suicide prevention, the program is funded through the Texas Department of State Health Services and Garrett Lee Smith Memorial Act/SAMHSA.
Yellow Ribbon Youth Suicide Prevention Program/School-Based Guide http://www.yellowribbon.org http://theguide.fmhi.usf.edu	Developed by the Louis de la Parte Florida Mental Health Institute at the University of South Florida and other groups, this school-based guide provides a framework for schools to assess their existing or proposed school prevention efforts.
Youth Suicide Prevention Programs: A Resource Guide Center for Disease Control, et al. http://www.cdc.gov/ncipc/pub-res/youthsui.htm	This resource guide was developed to describe the rationale and evidence for the effectiveness of various youth suicide prevention strategies and to identify model programs that incorporate these different strategies. The guide is for use by persons who are interested in developing or augmenting suicide prevention programs in their own communities.
Research and Recommendations on Suicide and Suicide Prevention	
International Academy of Suicide Research. http://iasr.mcgill.ca/	Publishers of Suicide Studies, formerly Archives of Suicide Research. The objectives of the Academy include promoting high standards of research and scholarship in the field of suicidal behavior by fostering communication and cooperation among scholars engaged in such research.
Charting the future of suicide prevention: A 2010 progress review of the national strategy and recommendations for the decade ahead http://www.sprc.org/sites/sprc.org/files/library/ChartingTheFuture_Full book.pdf	This document reviews developments in the field of suicide prevention since the National Strategy for Suicide Prevention was published.
National Library of Medicine http://www.nlm.nih.gov/	Creator of MedLine/PubMed. PubMed provides access to over 12 million MEDLINE citations back to the mid-1960's and additional life science journals. PubMed includes links to many sites providing full text articles and other related resources.
National Strategy for Suicide Prevention http://www.mentalhealth.org/suicideprevention	The National Strategy for Suicide Prevention creates a framework for suicide prevention for the Nation. The Goals and Objectives for Action articulate a set of 11 goals and 68 objectives, and provide a blueprint for action. The National Strategy was published by the U.S. Department of Health and Human Services in May 2001 with the leadership from the Surgeon General.

NIMH Suicide Research Consortium	Coordinates program development in suicide research, identifies gaps in the scientific knowledge base on suicide across the life span, stimulates and monitors extramural research on suicide, keeps abreast of scientific developments in suicidology and public policy issues related to suicide surveillance, prevention and treatment, and disseminates science-based information on suicidology to the public, media, and policy makers.
Oxford University Centre for Suicide Research http://cebmh.warne.ox.ac.uk/csr/	Conducts research investigations on suicidal behavior, disseminates research finds, collaborates with other major centers, and provides training opportunities for researchers and students.
Reporting on Suicide: Recommendations for the Media http://reportingonsuicide.org/	The media play a powerful role in educating the public about suicide prevention. Stories about suicide inform readers and/or viewers about the likely causes of suicide, warning signs, trends in suicide rates, and recent advances in treatment. Media are able to reach multiple audiences about ways to prevent suicide. These recommendations will help guide the media to educate readers and viewers about the steps they can take to prevent suicide.
SharpTalk http://sharptalk.part.icipate.net/node/102	Sharp talk is a is an online self-harm support forum for both young people with experience of self-harm and health professionals (students and recently qualified). The forum is part of a study designed to test whether a discussion group can serve as an effective means for health professionals and young people to learn from one another.
Suicide Care in Systems Framework http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf	Recommendations of the Clinical Care and Intervention Task Force to the National Action Alliance on Suicide Prevention.
Suicide Information and Education Centre (SIEC). http://www.siec.ca	A special library and resource center providing articles on suicide and suicidal behavior.
Special Programs	
Air Force Suicide Prevention Program http://afspp.afms.mil	This website offers an Air Force description of their suicide prevention program and offers communities a model with elements that can be adapted for communities.
National Association of Social Workers For veterans and military families: http://www.socialworkers.org/military.asp	NASW provides information and resources for social workers who work with veterans and military families.
National Strategy for Suicide Prevention: Goals and Objectives for Action. http://store.samhsa.gov/product/SMA01-3517	Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.
Suicide Prevention Training — On your Watch - California Board of Corrections http://www.bdcorr.ca.gov/stc/Suicide_Prevention_Training/suicide_prevention_training.htm	This course provides the tools to develop a comprehensive suicide prevention agency. These courses were carried out in California.
SuicidePrevention and Crisis Intervention in Jails http://www.cdcr.ca.gov	A course that can be ordered from the state of California that offers training to trainers. For implementation help, agencies in California can be contacted.

Texas Veterans Project http://www.texvet.com/	TexVet, short for the Texas Veterans project, is the collaborative effort of federal, state and local organizations that focuses on bringing our military members and those that care about them a wealth of resources. The Central Texas Veterans Health Care system is launching a suicide prevention campaign, aligned with the VA's national suicide prevention efforts, including Operation S.A.V.E.
State Organization and Agency Resources	
National Association of Social Workers Texas Chapter http://www.naswtx.org	The National Association of Social Workers/Texas (NASW/Texas) is the major professional social work organization in the state of Texas. NASW seeks to advance professional social work practice and the profession, to promote human rights, social and economic justice, and access to services for all.
Texas Association for Marriage and Family Therapy http://www.tamft.org	The mission of the Texas Association for Marriage and Family Therapy is to use the power of the TAMFT organization to protect the integrity of the professional practice in the marketplace.
Texas Counseling Association http://www.txca.org	The Texas Counseling Association (TCA), a diverse community of counseling professionals, provides education and advocacy for the understanding and delivery of effective counseling.
The Texas Council of Community Centers http://www.txcouncil.com	The Texas Council of Community Mental Health Mental Retardation Centers is an organization under which the community MHMR centers of Texas can work together to improve and expand services to their local communities. The Council also provides accountability to their sponsoring government entities, funding sources, and State government. Website lists up-to-date suicide and crisis hotlines.
Texas Department of State Health Services www.dshs.state.tx.us	Suicide Prevention Coordinator, Jenna Heise Jenna.Heise@dshs.state.tx.us
Texas Parent Teacher Association http://www.txpta.org/	PTA is a grassroots organization made up of parents, teachers and others around the state that have a special interest in children, families and schools.
Texas Psychological Association http://www.texaspsyc.org	The Texas Psychological Association (TPA) represents and enhances the profession of Psychology in Texas, promoting human health and welfare through education, science and practice. TPA promotes the public policy interests of psychologists through the PYS-PAC, the Texas Psychology Political Action Committee.
Texas Society of Psychiatric Physicians http://www.txpsych.org	TSPP promotes the interests of mental health consumers, advances psychiatric service and facility standards, furthers cooperation between all parties concerned with medical, psychological, social, and legal aspects of mental health and illnesses, increases psychiatric knowledge among other medical practitioners and the public. The TSPP website includes a section on mental illnesses and warning signs.
Suicide Prevention Programs and Resources Targeting Special Populations	
Administration on Aging http://www.aoa.gov/	This site contains general information on aging, but through a search, you can find information on suicide and the elderly, below are the specific URLs to the information) http://www.aoa.dhhs.gov/prof/notes/note s_mental_health.asp http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/index.aspxhttp://www.aoa.dhhs.gov/eldfam/healthy_lifestyles/mental_health/mental_healthdep.asp
It Gets Better Project http://www.itgetsbetter.org/	The It Gets Better Project was created to show young LGBTQI2-S people the levels of happiness, potential, and positivity their lives will reach—if they can just get through their teen years.
Jed Foundation http://www.jedfoundation.org	The Jed Foundation is a nonprofit public charity committed to reducing the young adult suicide rate and improving mental health support provided to college students nationwide.

Montrose Counseling Center http://www.montrosecounselingcenter.org	Provides in-person and telephone support for gay, lesbian, bisexual, transgender, questioning, intersex, and two-spirit youth in Texas. HATCH – LGBTQI2-S teen support program, 713-529-3590.
National Association of Social Workers SHIFT Project http://www.naswdc.org/practice/adolescent_health/shift/default.asp	This toolkit provides a new, step-by-step, online resource to help you make the case and make the shift to evidence-based programs in your practice, agency, or community.
National Organization for People of Color Against Suicide (NOPCAS). http://www.nopcas.org	A non-profit organization, NOPCAS's goals are to bring suicide and depression awareness to minority communities that have historically been discounted from traditional awareness programs.
Reach Out http://us.reachout.com/	Reach out is an information and support service using evidence-based principles and technology to help teens and young adults facing tough times and struggling with mental health issues.
Texas Mental Health and Aging Coalition http://www.dads.state.tx.us/services	The coalition is a diverse group of state agencies, public and private organizations and individuals. It provides opportunities for professional, consumer, and government organizations to collaboratively improve the availability and quality of mental health preventive and treatment strategies through education, research, and increased public awareness.
The Trevor Helpline http://www.thetrevorproject.org/helpline.aspx 1-866-488-7386	This is a national 24-hour, toll-free suicide prevention hotline aimed at gay and questioning youth. Calls are handled by highly trained counselors and are free and confidential.
Suicide Prevention Toolkits	
Coming Together to Care, A Suicide Prevention Toolkit for Texas Communities http://mhatexas.org or http://www.texassuicideprevention.org/	Suicide Prevention toolkit covers the basic knowledge that people need to have in order to act effectively related to suicide prevention, and actions they can take once they have the basic knowledge. The toolkit also discusses sucide prevention resources, assessing your community, best practices, and prostvention..
Helping Others Prevent and Educate about Suicide (HOPES) http://www.hopes-wi.org	A web-based toolkit that includes prevention strategy and articles and ideas about survivor response.
Preventing Suicide: A Toolkit for High Schools http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669?WT.ac=EB_20120622_SMA12-4669	A comprehensive toolkit for high schools incorporating the best available evidence and expert opinion on suicide prevention among high school students. Provides schools with recommended steps in creating and implementing strategies and programs.
QPR for Communities: A Suicide Risk Reduction Program http://www.qprinstitute.com/	Presents an approach to community-based suicide prevention planning that can lead to the implementation of community-wide suicide risk reduction programs and practices. This program is intended to build community competence via a systems approach to gatekeeper training. Has links to many resources.
Suicide Prevention Resource Center (SPRC) http://www.sprc.org 1-877-438-7772	The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and information based on strengthening suicide prevention networks and advancing the National Strategy for Suicide Prevention. SPRC is funded by an agreement between Substance Abuse and Mental Health Services Administration (SAMHSA) and Education Development Center, Inc. (EDC), and the goal of SPRC is to both support and increase the ability of states and communities to implement and evaluate suicide prevention programs.

Suicide Prevention Training Resources

Adolescent Wellness www.adolescentwellness.org	School training manual and toolkit to promote awareness and early recognition of adolescent depression, written by McLean Hospital and Children's Hospital of Boston. They offer print materials, curriculum, workshops and parent resources.
ASK (About Suicide to save a Life) http://www.texassuicideprevention.org	**Mental Health America of Texas** coordinates 2-hour suicide prevention gatekeeper workshops in selected communities and schools. If you would like to learn how to identify and appropriately respond to someone who is feeling suicidal, or if you would like a presentation for your organization or school, email suicideprevention@mhatexas.org. A 90 minute workshop video will be available in the fall of 2012.
At-Risk For High School Educators (Texas State Version) https://txarht.kognito.com/loginpage.php	Free one-hour, interactive online suicide-prevention training for public high school educators in Texas. Participants will need school ID code from Texas Education Agency, and school zip code.
At-Risk For Texas Public Middle School Educators www.TexasSuicidePrevention.org	Free one-hour, interactive online suicide-prevention training for public middle-school educators in Texas to be launched in the fall of 2012.
Glendon Associates http://www.glendon.org/	The Glendon staff conducts educational and training seminars and workshops. These workshops are presented in an interactive style, intermixing lecture, discussion, and video demonstrations. They are designed to give participants the opportunity to discuss the theory and methods presented and their application to clinical practice. Glendon workshops have been conducted at universities, mental health facilities and hospitals throughout the country.
Kognito www.kognito.com	Developer of online role-playing simulations, where users build interpersonal skills to manage challenging conversations in the area of health and mental health, including suicide prevention.
Living Works http://www.livingworks.net	Developed the Applied Suicide Intervention Skills Training (ASIST) workshop (formerly the Suicide Intervention Workshop), a workshop for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Other trainings are also available.
National Center for Suicide Prevention http://training.sprc.org/	Provides educational resources to help public officials, service providers, and community-based coalitions develop effective suicide prevention programs and policies. Also provides a resource database composed of suicide prevention articles and information.
QPR Institute http://www.qprinstitute.com/	Over 1,000 trainers of suicide prevention throughout the United States. Offers a variety of training opportunities and materials (including self-study courses) to improve suicide risk detection, assessment and management skills. Also offers suicide risk management inventories and protocols available for those working with adults of all ages, those working with children and adolescents and those treating suicidal people in inpatient and residential settings. Training programs are also available for those who work with survivors of suicide and other trauma.
Suicide Information and Education Center http://www.suicideinfo.ca/	Contains suicide information and educational resources as well as suicide prevention training programs. Supports downloadable pamphlets, cards and information kits on a variety of subjects (some resources include a cost).
Training Institute for Suicide Assessment and Clinical Interviewing http://www.suicideassessment.com	Offers trainings and courses on suicide assessment, suicide prevention, violence assessment, risk assessment, crisis intervention, clinical interviewing, diagnostic interviewing, and methods for engaging clients and transforming resistance.

Yellow Ribbon Youth Suicide Prevention Program http://www.yellowribbon.org	The Yellow Ribbon Youth Suicide Prevention Program is dedicated to increasing youth awareness, reducing stigma associated with asking for help, and preventing youth suicide through peer group awareness.
Suicide Information and Education Center http://www.suicideinfo.ca/	Contains suicide information and educational resources as well as suicide prevention training programs. Supports downloadable pamphlets, cards and information kits on a variety of subjects (some resources include a cost).
Youth Suicide Prevention Education Program http://www.yspp.org	Wahington State's Program of awareness, education, prevention, intervention, postvention, community building, collaboration, replication & sustainability. Be-A-Link Gatekeeper Presentations and Trainings are available to youth and adults, separately and jointly. Curriculums are designed for professional and lay people, EMS/fire and law enforcement.

Suicide Prevention Information and Resources

Active Minds http://www.activeminds.org	Active Minds is the nation's only peer- to-peer organization dedicated to raising awareness about mental health among college students.
American Association of Suicidology (AAS) http://www.suicidology.org	AAS is a nonprofit organization dedicated to the understanding and prevention of suicide. AAS is a resource for anyone concerned about suicide, including AAS members, suicide researchers, therapists, prevention specialists, survivors of suicide, and people who are themselves in crisis
American Foundation for Suicide Prevention (AFSP) http://www.afsp.org	The American Foundation for Suicide Prevention (AFSP) is dedicated to advancing the knowledge of suicide and the ability to prevent it by supporting research and education needed to prevent suicide.
Centers for Disease Control and Prevention www.cdc.gov	Department of Health and Human Services website contains information on health and safety, publications and products, and data and statistics.
Community Toolbox (University of Kansas) http://ctb.ku.edu/en/default.aspx	6,000 pages of practical information to support work in community health and development. In addition, this is an interactive website access to multiple supports, a "WorkStation" (for a fee), online documentation, Customized Learning Communities (forums), and more.
Healing Self Injury http://healingselfinjury.org	A newsletter/blog website dedicated to help understand and prevent self-inflicted injuries.
Healthy People 2020 –Selected Resources for Injury, Violence, and Suicide Prevention. http://www.healthypeople.gov/2020/default.aspx	A listing of basic government and related websites.
Mental Health America of Texas http://www.mhatexas.org	On the Mental Health America of Texas website you will find mental health and suicide prevention information. The nonprofit organization also hosts www.TexasSuicidePrevention.org, which provides information and national resources, publications, links to Texas crisis and suicide hotlines, Texas suicide prevention trainings and programs, and information about Texas suicide prevention organizations and activities.
National Action Alliance for Suicide Prevention http://actionallianceforsuicideprevention.org/	The National Action Alliance is the public–private partnership advocating the National Strategy for Suicide Prevention.
National Center for Injury Prevention http://www.cdc.gov/injury/index.html	The Centers for Disease Control and Prevention website offers data, information and resources on suicide and suicide prevention.
Recovery International http://www.lowselfhelpsystems.org/index.asp	Recovery, Inc. is a nonprofit mental health organization established in 1937. There are over 600 weekly groups that offer self-help to anyone 18 years or older. There is no charge to attend meetings, although a voluntary contribution is requested.

Safe USA http://www.cdc.gov/ncipc/factsheets/suif acts.htm	The Centers for Disease Control and Prevention website offers data, information and resources on suicide and suicide prevention.
Texas Suicide Prevention Council www.texassuicideprevention.org	The Texas Suicide Prevention Council, facilitated by Mental Health America of Texas, is composed of representatives from state and local agencies. Council organizations provide leadership in promoting and implementing the National Strategy and the Texas State Plan for Suicide Prevention
Suicide Prevention Resource Center See info above.	

Suicide Statistics

CDC – WISQARS www.cdc.gov/injury/wisqars/facts.html	Web-based Injury Statistics Query Reporting System (WISQARS) provides fatal and nonfatal injury, violent death, and cost of injury data from a variety of trusted sources.
National Center for Health Statistics Fast Stats http://www.cdc.gov/nchs/fastats/suicide.htm	The Centers for Disease Control's National Center for Health Statistics compiles statistical information to guide public health actions and policies. This particular page displays statistics about self-inflicted injury/suicide in the U.S.
National Injury Data Technical Assistance Center http://www.injuryprevention.org/info/data.htm	Charts of injury mortality trends for each state with the mechanism of suicide for age groups. Each chart links to a downloadable Excel workbook containing the data that generated the chart and a high definition version of the chart suitable for inclusion in a printed reproduction.
The National Violent Injury Statistics System (NVISS) http://www.nviss.org http://www.hsph.harvard.edu/hicrc/nviss/about_main.htm	The NVISS is working to establish ongoing, national data systems on violent injuries. Gathering uniform data will assist efforts to understand and prevent homicide, suicide, and other violent injuries. NVISS's current major project is to pilot-test a prototype for the Centers for Disease Control and Prevention's proposed National Violent Death Reporting System.
Texas Department of State Health Services http://soupfin.tdh.state.tx.us/deathdoc.htm	This site allows you to find death statistics for Texas and create tables based on the variables and parameters that you select, including year, county, race, gender, and other options.
The World Health Organization Statistical Information System (WHOIS) http://www.who.int/whosis/en/	Offers statistical information on other countries as well the United States.

Survivor Support

(See also Table of Survivors of Suicide Support Groups in Texas on page 148)

Survivors of Suicide (SOS) http://www.survivorsofsuicide.com/index.html	Provides a variety of links, information, and a directory of local support groups for those who have lost a loved one through suicide.
Compassionate Friends http://www.compassionatefriends.org/home.aspx	A national non-profit, the mission of The Compassionate Friends is to assist families toward the positive resolution of grief following the death of a child of any age and to provide information to help others be supportive. Has 575 chapters throughout the U.S
Friends for Survival http://www.friendsforsurvival.org/ Phone: (916) 392-0664	A national nonprofit organization of people who have been affected by a death caused by suicide. Friends for Survival is dedicated to providing a variety of peer support services that comfort those in grief, encourage healing and growth, foster the development of skills to cope with a loss, and educate the entire community regarding the impact of suicide.
LOSS Team http://www.lossteam.com	LOSS Team is a volunteer organization of trained survivors dedicated to providing outreach and resources to families bereaved by suicide.
Resources for Clinicians Who Have Lost a Patient to Suicide http://www.suicidology.org/suicide-clinician-survivors	This is part of a website created and maintained by the American Association of Suicidology's Clinician Survivor Task Force.

SAVE: Suicide Awareness/Voices of Education http://www.save.org	An organization dedicated to education about suicide and mental illness, and to speaking for suicide survivors.

Local Coalition Members of the Texas Suicide Prevention Council

Central		
Austin/Travis County Suicide Prevention Coalition	Merily Keller	hodgekeller@yahoo.com
	Renee Collins	rhcollins@seton.org
Bastrop County Suicide Prevention Coalition	Debra Boyd	debra.boyd@dshs.state.tx.us
	Laura Menn	laura.menn@bluebonnetmhmr.org
Central Texas Veterans Health Care Services (locations in Temple and Waco)	Linda Methvin	linda.methvin@va.gov
Heart of Texas Suicide Prevention Coalition (Waco)	Larry Becker	larry.becker@hotmhmr.org
Highland Lake Suicide Prevention Coalition (Marble Falls/Burnet County)	Cari Foote	cfoote@tstar.net
	Sandra Galyon	sgalyon@seton.org
Milam County Suicide Prevention Coalition	Pam Kaufmann	pkaufmann@rockdaleisd.net
	John Anderle	johnanderle@hotmail.com
	Michelle Morgan	mmorgan@txfb-ins.com
Pick with Austin, Inc.	Jeff Curley	jeffc@pickwithaustin.com
San Marcos Suicide Prevention Coalition	Donna Murphee	dmhrphree@ahss.org
	Polly Robertson	probertson@hillcountry.org
	Ann Taylor	ATaylor@mail.hillcountry.org
University of Texas at Austin	Erin Espinosa	erin.espinosa@mail.utexas.org
	Marian E. Trattner	mtrattner@austin.utexas.edu
North		
Dallas Area Suicide Prevention Coalition	Margie Wright	margiew@sccenter.org;
	John Dornheim	Dornheim@hcahealthcare.com;
	Jennifer Mootz	Jenniferm@sccenter.org
CONTACT Crisis Line	Benaye Y. Rogers	brogers@contactcrisisline.org
	Amy Stewart	astewart@contactcrisisline.org
Fort Worth/Tarrant County Suicide Prevention Coalition	Lee LeGrice	llegrice@mhatc.org
	Monica Kintigh	monica.kintigh@att.net
I AM HERE Dallas Youth Suicide	Diana Weaver	dweaver@GrantHalliburton.org

Prevention Coalition/Grant Halliburton Foundation		
Veterans Affairs North Texas	Annie Joseph	annie.joseph@va.gov
Northwest		
Lubbock Suicide Prevention Coalition	Matthew Jordan	mjordan@co.lubbock.tx.us
	Sharron Davis	sharron@contactlubbock.org
Panhandle Suicide Prevention Coalition (Amarillo)	Esther Quine	estherq7217@gmail.com
	Stacy Sandorskey	stacy.sandorskey@TPMHMR.org
	Jolie Person	jolie.person@dshs.state.tx.us
Plainview Suicide Prevention Coalition	Belinda Nails	belinda@clplains.org
South		
Bexar County Suicide Prevention Coalition (San Antonio)	Jeannie Von Stultz	jvonstultz@bexar.org
	Susan Mercado	smercado@nixhealth.com
Laredo Suicide Prevention Coalition	Manuel Sanchez	msanchez@ci.laredo.tx.us
	Arturo Diaz	adiaz2@ci.laredo.tx.us
South Texas Veteran Healthcare System/Veterans Affairs Region 17 (San Antonio)	Larry Stokes	Larry.Stokes3@va.gov
	Susan Mercado	smercado@nixhealth.com
Valley Suicide Prevention Coalition	Stephanie Contreras	stephcontreras11@gmail.com
University of Texas at Brownsville	Eugenia Curet	eugenia.curet@utb.edu
Southeast		
Houston Area Suicide Prevention Coalition	Troy Bush	troydidonato@yahoo.com
	Melba Hamilton	Melba.Hamilton@uhsinc.com
Mental Health America of Greater Houston	Traci Patterson	tpatterson@mhahouston.org
	Susan Fordice	sfordice@mhahouston.org
Mental Health Task Force of Brazoria County	Beverly Bernzen	bernzenfrc@hotmail.com
Southeast Texas Suicide Prevention Coalition (Beaumont)	Jayne Bordelon	mhaset@earthlink.net
	Patty Pittman	pj.pittman@yahoo.com
East		
East Texas Suicide Prevention Coalition (Tyler)	Tracy Williams	twil@tjc.edu
Veterans Administration, VISN 17	Steve Holliday	Steve.Holliday@va.gov
	Ludi McAuley	Ludi.McAuley@va.gov
Save A Life Today – S.A.L.T. (Carthage)	Diana Bonds	Chris3206@sbcglobal.net

West		
Abilene Suicide Prevention Coalition	David Jefferies	davidwjefferies@WTXS.net
	Susan Stuckey	sstuckey@acadiahealthcare.com
El Paso Suicide Prevention Coalition	Yolanda Canava	ycanava@EPMHMR.org
	Donna Juarez	djuarez@ESC19.NET

Texas Youth Suicide Prevention Officer for the States	Jenna Heise, Suicide Prevention Officer- Texas Department of State Health Services: Suicide Prevention,	jenna.heise@dshs.state
Texas Youth Prevention Project, Public Awareness Partner	Mary Ellen Nudd, Project Director & Vice President- Mental Health America of Texas,	*menudd@mhatexas.org*
	Merily Keller. Project Trainer & Suicide Prevention Consultant- Mental Health America of Texas	hodgekeller@yahoo.com
ASK (Ask about Suicide to Save a Life) - Gate Keeper Training	The Texas Suicide Prevention Council has instructors who are certified to give workshops in your area or statewide through Texas Youth Suicide Prevention Grant, contact: Merily Keller, ASK Instructor/Mentor, hodgekeller@yahoo.com	

Texas Suicide Prevention Council – 2012

American Association of University Women	Ann Berasly	berasley@swbell.net
American Foundation for Suicide Prevention - Texas	Molly Robbins	MRobbins@afsp.org
Army One Source – Texas	Isaac Hinojosa	Isaac.Hinojosa@serco-na.com
Depression and Bipolar Support Alliance	Marilyn Nolin	marilyn.nolin@sbcglobal.net
Disability Rights Texas (Formerly Advocacy Inc.)	Representatives Pending	
GLBT Montrose Counseling Center	Deb Murphy	info@hatchyouth.org
Governor's EMS and Trauma Advisory Council	Representatives Pending	
Jason Foundation at Texas NeuroRehab Center	Terri McBryde	terri.mcbryde@psysolutions.com
Mental Health America of Texas	Mary Ellen Nudd	menudd@mhatexas.org
	Merily Keller	hodgekeller@yahoo.com
National Alliance on Mental Illness Texas (NAMI)	Robin Peyson	rpeyson@namitexas.org
National Association of Social Workers Texas (NASW)	Vickie Hansen	vhansen@naswtx.org
Suicide Prevention Resource Center	Gayle Jaffe	gjaffe@edc.org

	(liaison to Suicide Prevention Council)	
Texas Association of Marriage and Family Therapists	Gary Kesling	gkesling@gmail.com
Texas Council of Community Centers	Jennifer Battle	Jennifer.Battle@mhmraharris.org
Texas Counseling Association	Jan Friese	Jan@txca.org
Texas Department of Family and Protective Services	Carrie Harris	Carrie.harris@dfps.state.tx.us
Texas Department of State Health Services	Jenna Heise	jenna.heise@dshs.state.tx.us
Texas Education Agency	Representatives Pending	
Texas Health & Human Services Commission	Sherri Hammack	sherri.hammack@hhsc.state.tx.us
Texas Juvenile Justice Department	Tracy Levins	Tracy.Levins@tjjd.texas.gov
Texas Psychological Association	Bonny Gardner	gardnerb@swbell.net
Texas PTA	Kyle Ward	kward@txpta.org

Texas Crisis Hotlines

City	Center	Counties served	Suicide Prevention Coordinator
Abilene	**Betty Hardwick Center 800-758-3344**	Callahan, Jones, Shackelford, Stephens, Taylor	Theron Cole tcole@bhcmhmr.org
Amarillo	**Texas Panhandle MHMR 806-359-6699 • 800-692-4039**	Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Ptter, Randall, Roberts, Sherman, Wheeler	Anna Isom Anna.Isom@tXPAN
Austin	**Austin Travis County Integral Care** Behavioral Health & Developmental Disabilities Services **512-472-4357**	Travis	James Van Norman, M.D. Jim.vannorman@atcic.org
Beaumont	**Spindletop MHMR Services 409-838-1818**	Chambers, Hardin, Jefferson, Orange	Garrett craver garrett.craver@stmhmr.org

Big Spring	**West Texas Centers for MHMR** **800-375-4357**	Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, Yoakum	Lisa Yates lisa.yates@wtcmhmr.org
Brownwood	**The Center for Life Resources** **866-558-4357**	Brown, Coleman, Comanche, Eastland, McCulloch, Mills, San Saba	Johnathan Harvey jonathan.harvey@cflr.us
Bryan	**MHMRAuthority of Brazos Valley 800-282-6467**	Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington	Shane DeLosSantos sdelossantos@mhmrabv.org
Conroe	**Tri-County MHMR Services 800/659-6994 "only from calling area"**	Liberty, Montgomery, Walker	Charlotte Jensen CharlotteJ@tricountyservices.org
Corpus Christi	**MHMR Center of Nueces County** **887-767-4493**	Nueces	Victoria Perez vperez@ncmhmr.org
Dallas	**CONTACT Crisis Help Line** 972-233-2233	Dallas	N/A
	Suicide & Crisis Center of North Texas **214-828-1000** **Toll free 1-866-672-5100**	Dallas, Tarrant, Collin, Ellis, Johnson, Rockwell, Denton, Hunt	N/A
	Dallas Metrocare Services 214-330-7722	Dallas	N/A
Denton	**Denton County MHMR Center** **800-762-0157 (Call center)** **ICARE Call Center Crisis referral, in- take hotline**	Denton Tarrant, Bosque, Falls, Freestone, Hill, Limestone, McLennan, Summerdale, Hood, Palo Pinto, Parker, Johnson	Tammy Weppelman tammyw@dentonmhmr.org
Edinburg	**Tropical Texas Behavioral Health** **877-289-7199** "Only from calling area"	Cameron, Hidalgo, Willacy	Dan Trussell dtrussel@ttbh.org
El Paso	**Emergence Health Network** El Paso center for Mental Health/Intellectual disabilities **915-887-3410**	El Paso	Yolanda Canava ycanava@epmhmr.org
Fort Worth	**MHMR of Tarrant County** 817-335-3022	Tarrant	James Turnage james.turnage@mhmrtc.org
Galveston	**The Gulf Coast Center** **866-729-3848**	Brazoria, Galveston	Dawn Caron-Roberts dawnc@gcmhmr.com

Houston	**MHMR Authority of Harris County** **866-970-4770**	Harris	Jennifer Battle jennifer.battle@mhmraharris.org
Jacksonville	**ACCESS** **800-621-1693**	Anderson, Cherokee	Dennis Phillips dphillips@accessmhmr.org
Kerrville	**Hill Country Community MHMR Center** **830-792-3300**	Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kenney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde, Val Verde	Anne Taylor ataylor@hillcountry.org
Laredo	**Border Region MHMR Center** **800-687-4239** Starr **800-287-4240** Zapata **800-643-1102** Webb	Jim Hogg, Starr, Webb, Zapata	Jacqueline Villanueva JacquelineG@borderregion.org
Longview	**Sabine Valley Center (Community HealthCore)** **800-832-1009**	Gregg, Harrison, Marion, Panola, Rusk, Upshur	David Deel david.deel@communityhealthcore.com
Lubbock	**Lubbock Regional MHMR Center** **Crisis Line: (806) 740-1414** **Toll Free: (800) 687-7581**	Cochran, Crosby, Hockley, Lubbock, Lynn	Kathy Irwin kirwin@lubbockmhmr.org
Lufkin	**Burke Center** **800/392-8343**	Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler	Terry Reeder terryr@burke-center.org
Lytle	**Camino Real Community MHMR Center 800-543-5750**	Atascosa, Dimmit, Frio, Karnes, La Salle, Maverick, McMullen, Wilson, Zavala	Daniel Ascencao daniela@caminorealcs.org
McKinney	**ADAPT Community Solutions** **866-260-8000**	Collin, Dallas, Rockwall, Navarro, Hunt, Ellis	N/A
Midland	**Permian Basin Community Centers for MHMR** **432-570-3300**	Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos, Presidio	Todd Luzadder tluzadder@pbmhmr
Plainview	**Central Plains Center** **800-687-1300**	Bailey, Briscoe, Castro, Floyd, Hale, Lamb, Motley, Parmer, Swisher	Belinda Nails belinda@clplains.org
Portland	**Coastal Plains Community MHMR Center** **800-841-6467**	Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak and San Patricio Counties	Barbara Giovannone bgiovann@cpmhmr.org
Rosenberg	**Texana MHMR Center** 800-633-5686	Austin, Colorado, Fort Bend, Matagorda, Waller, Wharton	Larry Frame larry.frame@texanacenter.com

Round Rock	**Bluebonnet Trails Community MHMR Center** 800-841-1255	Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, Williamson	Leo DelaGarza leo.delagarza@bluebonnetmhmr.org
San Angelo	**MHMR Services for the Concho Valley** **325-653-5933**	Coke, Concho, Crockett, Irion, Reagan, Sterling, Tom Green	Charles Vandiver cvandiver@mhmrcv.org
San Antonio	**The Center for Health Care Services** **800-316-9241** 210-223-7233 (SAFE)	Bexar	Aaron Diaz adiaz@chcsbc.org
Sherman	**MHMR Services of Texoma** **877/277-2226**	Cooke, Fannin, Grayson	Brent Phillips bphillips@mhmrst.org
Stephenville	**Pecan Valley MHMR Region** **800-772-5987**	Erath, Hood, Johnson, Palo Pinto, Parker, Somervell, Tarrant, Bosque, Falls County, Limestone, McLennan, Freestone, Hill	Phil Phillips pphillips@pvmhmr.org
Temple	**Central Counties Center for MHMR Services** **800-888-4036**	Bell, Coryell, Hamilton, Lampasas, Milam	Patricia Roy-Jolly pat.roy-jolly@cccmhmmr.org
Terrell	**Lakes Regional MHMR Center** **877-466-0660** **Noth Star Crisis Hotline:** **866-260-8000**	Camp, Delta, Ellis, Fannin Franklin, Grayson, Hopkins, Hunt, Kaufman, Lamar, Morris, Navarro, Rockwall, Titus	Robert Johnson robertj@lrmhmrc.org
Texarkana	**Northeast MHMR Center** **800-832-1009**	Bowie, Cass, Red River	N/A
Tyler	**Andrews Center** **903-597-1351**	Henderson, Rains, Smith, Van Zandt, Wood	Laura Newsome lnewsome@andrewscenter.com
Victoria	**Gulf Bend MHMR Center** **877-723-3422**	Calhoun, DeWitt, Goliad, Jackson, Lavaca, Refugio, Victoria	Judith Tyler jtyler@gulfbend.org
Waco	**Heart of Texas Region MHMR** **866-752/3451 (press 1**	Bosque, Falls, Freestone, Hill, Limestone, McLennan	Jana Fleischhauer jana.fleischhauer@hotrmhmr.org
Wichita Falls	**Helen Farabee Regional MHMR Center** **800-621-8504**	Archer, Baylor, Childress, Clay, Cottle, Dickens, Foard, Hardeman, Haskell, Jack, King, Knox, Montague, Stonewall, Throckmorton, Wichita, Wilbarger, Wise, Young	Charlie Martin MartinC@helenfarabee.org

Assessing Your Community

Chapter 4

Sections in this Chapter	
Section Name	**Page**

In order to effectively address a threat to the health and well-being of a community, there must first be an in-depth understanding of that threat. Self-harm injuries and suicide deaths are the multi-faceted results of a series of events. Each person who hurts herself, each person who kills himself, is a product of human biology and the physical and cultural environments in which that individual lives. Collection of detailed local data over time can provide the epidemiologist with a clearer picture of what types of prevention and intervention efforts will be successful in reducing the suicide rates for that community.

Sharon M. Derrick, PhD, Medical Anthropologist/Epidemiologist, Houston

Using a Public Health Model to Prevent Suicide

Suicide is a national problem... Suicide prevention is a national priority.
Senate Resolution #84 and House Resolution #212, unanimously passed during the 105th Congress

In 1999, The Surgeon General's Call to Action to Prevent Suicide identified suicide as a serious public health problem in the United States. In that year in Texas, suicide claimed the lives of 2,002 people. In 2005 there were 2,400 Texans who died as a result of suicide—more than the homicides that occurred in Texas that year and significantly more than the Texans who died from HIV.

By 2010, deaths by suicide reached over 2,800. Suicide in Texas is a serious public health concern, one that might be addressed more successfully through a coordinated and comprehensive approach aimed at prevention.

http://www.sprc.org/sites/sprc.org/files/library/surgeoncall.pdf

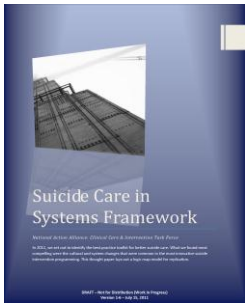
Suicide is a leading cause of death that carries a huge social cost, yet because of complex issues such as the stigma associated with mental illness and the lack of adequate research and surveillance dedicated to suicide, it is seldom recognized as a significant public health problem.

Public health refers to society's organized and coordinated efforts to prevent health problems. According to the Suicide Prevention Resource Center, a public health approach is essential to reducing the risk of suicide. This public health model involves the following five-step process.

1. Define the problem.
2. Identify the causes.
3. Determine methods of intervention.
4. Implement the methods.
5. Evaluate the effectiveness of the approach.

National Action Alliance's National Suicide Prevention Strategy

To this end, The National Action Alliance is working to define and implement a national suicide prevention strategy. The National Action Alliance is a national private and public partnership committed to advancing evidence based suicide prevention using this collaborative public/private partnership.



There are several task forces that make up the National Action Alliance; among them is the Clinical Care and Intervention Task Force, which recently released its most current recommendations in their report *Suicide Care in Systems Framework*. In this report, an environmental scan identified a few key agencies that have implemented specific strategies for suicide prevention. In each of these initiatives, according to this report, "dramatic successes were achieved in reducing suicide attempts, deaths, and in reducing costs associated with unnecessary hospital and emergency department care. Most importantly, these initiatives have demonstrated the capacity to save lives."

One of the cornerstones of the National Action Alliance's Suicide Prevention Strategy is the goal of "Zero Suicide." According to this report, "The National Action Alliance for Suicide Prevention (Action Alliance) will ensure a sustained, nationwide public health effort, as it implements the National Strategy for Suicide Prevention, to accomplish the ultimate goal of eliminating the tragic experience of suicide."

http://actionallianceforsuicideprevention.org/

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf

Texas' Commitment to the Zero Suicide Philosophy

Texas is committed to advancing the mission and work of the National Action Alliance for Suicide Prevention and its strategy to attain a zero suicide outcome for the State. To that end, the Texas Department of State Health Services is working to bring a care system that embraces a goal of zero suicides to Texas. According to Jenna Heise, Texas State Suicide Prevention Coordinator, DSHS in the midst of transformational changes to "truly put into practice the commitment of and core values necessary to support suicide being rendered a 'never event.'" DSHS is building an infrastructure throughout the community mental health system where there is a trained and skilled workforce that has the capacity and confidence to intervene in a suicidal situation.

Furthermore, DSHS is working to ensure that the skills and tools necessary to assess suicide risk and the ability to use best practices and evidence-based strategies for suicide care are in place throughout Texas. By collaborating at the local, state, and national levels, DSHS is working to make sure that the core capabilities are in place to set up treatment plans that support each person for the elimination of suicidality. In a truly suicide safe care site, such agencies will also be supported by quality policies and procedures about suicide care with a system for continuous improvement.

History of Suicide Prevention Efforts in Texas

Developing a Texas State Plan, 2001 to Present:

In 2001, in response to *The Surgeon General's Call to Action to Prevent Suicide* and the *National Strategy for Suicide Prevention*, the Texas Department of Health and the Governor's Emergency and Trauma Council organized an open Texas Suicide Prevention Forum, which was followed by the formation of a steering committee of 25 volunteers representing both the public and private sectors in Texas. The committee's mission was to draft a proposal for reducing the risk for suicide in Texas and increasing protective factors across the lifespan.

Soliciting community input from throughout the state, the group released a proposal addressing suicide from the public health perspective outlined earlier in this chapter. Closely following the US Surgeon General's *National Strategy for Suicide Prevention*, the Texas State Plan for Suicide Prevention was completed in the summer of 2003.

Following the completion of the first plan, ten Texas communities organized the Texas Suicide Prevention Network. The goals of this Network were to:

- Create, support and empower suicide prevention coalitions in communities throughout Texas
- Advance suicide prevention educational efforts through local and statewide policy changes
- Implement community-based priorities outlined in the Texas Suicide Prevention Plan
- Enlist the support of local groups, associations and businesses in suicide prevention
- Support state agency and legislative action for suicide prevention

By 2007, this loosely coupled group collaborated to form the Texas Suicide Prevention Council through the merging of the Texas Suicide Prevention Network and other statewide group partners.

In 2008, an expert panel of the Texas Suicide Prevention Council reviewed the original state plan to amend and approve a revised plan in September of that year.

In 2011, the *Texas State Plan for Suicide Prevention* was most recently amended and adopted by the Texas Suicide Prevention Council on September 29, 2011 and can be found in the appendix of this toolkit, or through the following link:

Texas State Plan for Suicide Prevention:
Guidelines for Suicide Prevention in Texas
http://www.texassuicideprevention.org/pdf/TexasStatePlanforSuicidePrevention2011-30apr2012.pdf

Role of State Agencies in Suicide Prevention

We are moving from a workforce where people think suicide is someone else's job to intervene and take care of to the assurance that everyone working in our community mental health system is ready and willing to intervene and has the tools and skills to do so. Imagine, you or someone you care about has the courage to seek help and reach out. It is our goal to ensure that the staff who you or your loved one will encounter are committed to doing everything they can to help you and, more than that, they are trained and ready to do so. That is the outcome of a care system that truly embraces the goal of no more deaths by suicide, not on my watch.

Jenna Heise, MA, NCC, BC-DMT State Suicide Prevention Coordinator, Department of State Health Services.

The state of Texas plays a significant role in coordinating and implementing suicide prevention efforts throughout the state. Managed by the Department of State Health Services, suicide prevention initiatives throughout the Texas Suicide Prevention project focus on best practice education, outreach, and training. In 2007, Texas created the position of State Suicide Prevention Coordinator to manage and coordinate a wide range of training and public awareness initiatives implemented through over 30 local coalitions, and over 20 statewide groups and other organizations. In addition to the State and local efforts listed below, The Texas State Suicide Prevention Coordinator also serves as a vital link between Texas and national and international suicide prevention activities. The Statewide Suicide Prevention Coordinator also plays a critical role in the development and deployment of the Texas State Suicide Prevention Plan, policy issues, technical assistance, training, and infrastructure.

Additionally, the State Suicide Prevention Coordinator also provides public awareness support and tools through bilingual brochures, Public Services Announcements, Prevention and Postvention toolkits, videos, State and Regional summits, newsletters, apps, and websites.

http://www.dshs.state.tx.us/mhsa/suicide-prevention

Texas Suicide Prevention Council (Statewide Groups and Local Coalitions)

The Texas Suicide Prevention Council was formed by statewide organizations and by local suicide prevention coalitions, who all agreed to support one or more of the goals of the Texas State Plan for Suicide Prevention. The statewide membership includes state agencies, statewide nonprofits, foundations and universities.

The Texas Suicide Prevention Council provides statewide leadership in suicide prevention based on the recommendations in the *Texas State Plan for Suicide Prevention*. Activities include:

- Update the *Texas State Plan for Suicide Prevention*
- Support the Texas Department of State Health Services (DSHS) suicide prevention grant efforts
- Work with state agencies to incorporate suicide prevention in their plans and protocols
- Provide statewide leadership in mental health and suicide prevention public policy, including information and data to legislators related to sharing of timely death data, declaring Texas Suicide Prevention Week, and school district policies and training related to suicide prevention
- Technical assistance to local suicide prevention coalitions
- Trainings in suicide prevention, including ASK about Suicide to Save a Life, ASIST, QPR, online At-Risk Suicide Prevention training for Texas public school educators
- Train Instructors at the local level to provide suicide prevention workshops
- Texas Suicide Prevention Symposium
- Public outreach and awareness, such as www.TexasSuicidePrevention.org, media releases, press conferences, smartphone app—ASK suicide prevention, presentations, and videos
- Free suicide prevention materials distributed statewide
- Postvention assistance to communities and schools
- Texas Suicide Prevention Toolkit, *Coming Together to Care*
- Promote the National Suicide Prevention Lifeline number on agencies' websites
- Support for DSHS crisis services redesign and certification of crisis centers by the American Association of Suicidology

As the above indicates, state agencies play a vital leadership role in suicide prevention efforts.

Role of Local Agencies and Coalitions in Suicide Prevention

Local agencies and coalitions play a vital role in suicide prevention as well through a variety of strategies. These public, nonprofit, and private agencies, mental health and medical practices provide needed services in public awareness, training, intervention and surveillance.

Texas' local community mental health or behavioral health centers each have a designated suicide prevention officer who leads their local efforts. Many of the centers will be conducting ASIST gatekeeper trainings with their staff in 2012-2013.

Local community suicide prevention coalitions in Texas universities and communities have formed in the past decade and are a part of the Texas Suicide Prevention Council. Coalitions focus on local priorities and have conducted a number of different activities, such as:

- Regular meetings, workshops and involvement in public awareness outreach and media
- Serving on general mental health and education committees
- Hosting or encouraging gatekeeper training, and/or screening such as support for ASK About Suicide, At-Risk for Texas High School Educators, ASIST, QPR, Jason Foundation, Yellow Ribbon, SOS, Teen Screen and others
- Assisting and/or promoting survivor of suicide support groups and/or provided postvention assistance
- Are involved with surveillance and/or data collection projects either by the coalition or in collaboration with other community groups

State of Texas and National Suicide Statistics: A Current Assessment

Statistics from the Texas Department of State Health Services and the US Centers for Disease Control and Prevention

The United States loses approximately 37,000 persons per year to death to by suicide, ranking as the tenth leading cause of death in this country. While the overall national rate of suicide in 2009 was 12.0 per 100,000 population, the following chart shows that by gender, there is great disparity in this statistic. The male rate of suicide is substantially higher than for females, with males outpacing females nearly 4:1 (see Table 4-1below).

Table 4-1

Suicide Data by Gender, Per 100,000 Population:[1]

Sex	Number of Suicides	Population	Rate
Males	29,089	148,094	19.2
Females	7,820	153,388	5.0
Total	36,909	301,482	12.0

Injury and death caused by intentional self-harm constitute a significant and highly preventable threat to the public health that has not historically received complete and accurate representation in published data sets. Epidemiologists and other professionals who conduct injury research are currently working to improve the quality of suicide and suicide attempt data-gathering methods in order to provide a clearer picture of intentional self-harm and the risk factors associated with it.

[1] Figures from the America Association of Suicidology and United States Census Bureau for the year 2009 for U.S.

National Suicide Statistics

Figure 4-1

From 2000–2006, the western US counties, including Alaska, had predominantly high suicide rates. Suicide rates were also high in certain Appalachian counties of Kentucky and West Virginia, southern Oklahoma and northern Florida.

Footnote: *All rates are age-adjusted to the standard 2000 population. Rates based on less than 20 deaths are statistically unreliable and are suppressed (see legend above).

Source: http://www.cdc.gov/ViolencePrevention/suicide/statistics/suicide_map.html

Smoothed, Age-adjusted Suicide Rates* per 100,000 population, by County, United States, 2000-2006

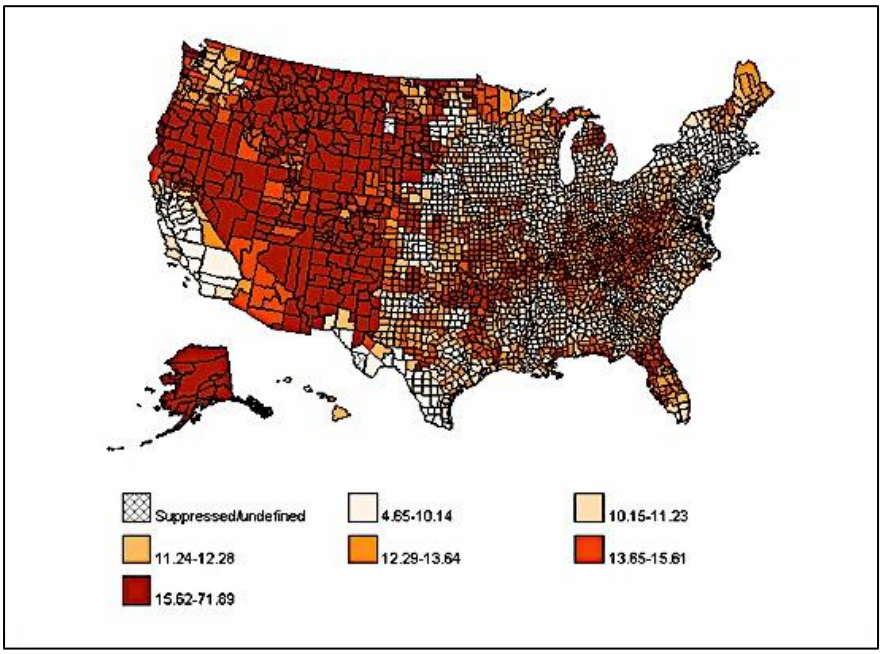
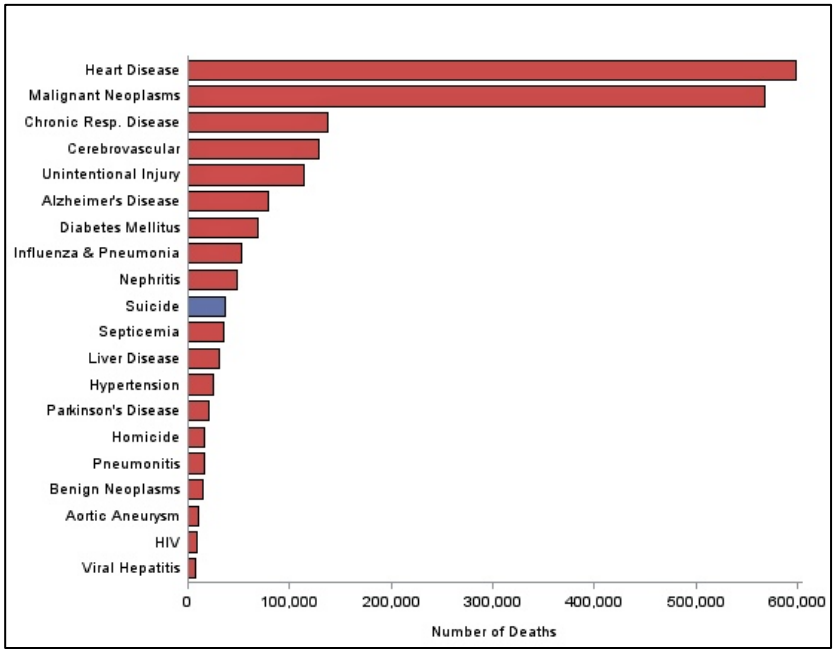


Figure 4-2

Twenty Leading Causes of Death Among Persons Ages 10 Years or Older, United States, 2009

According for the Centers for Disease Control and Prevention's Surveillance for Violent Deaths—National Violent Death Reporting Systems (NVDRS), suicide ranks as the 10th leading cause of death in the U.S.

Source: http://www.cdc.gov/ViolencePrevention/suicide/statistics/leading_causes.html



In 2009, suicide ranked as the 10th leading cause of death among persons ages 10 years and older, accounting for 36,891 deaths.

:

Table 4-2

1. State of mental health is a key indicator: Of the persons who died by suicide:	▪ 74.9% had been diagnosed with depression. ▪ 14.5% had been diagnosed with bipolar disorder. ▪ 8.1 % had been diagnosed with anxiety disorder. ▪ 4.6% had been diagnosed with schizophrenia. ▪ 1.7% had been diagnosed with Post Traumatic Stress Disorder (PTSD).
2. Firearms play a pivotal role in suicide completions:	▪ Over 50% of all suicides reported to NVDRS involved firearms. ▪ 23% involved some form of asphyxiation (hanging, strangulation, suffocation. ▪ 18% involved poisoning.
3. Many suicides are precipitated by a life crisis within two weeks preceding the suicide:	▪ More than 1 in 4 persons who died by suicide experienced a major life stressor within that timeframe.
4. Drugs and/or alcohol play a role in the majority of suicides:	▪ Over a third of those who died by suicide who were tested for alcohol, tested positive. ▪ Over a third of those who died by suicide who were tested antidepressants, tested positive. ▪ Nearly 25% of those who died by suicide who were tested for opiates, tested positive.
5. Previous attempters account for nearly one in five completed suicides:	▪ Just under 20% of persons who died by suicide had a history of attempts.

http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5904a1.htm

Texas Suicide Statistics

To put suicide in context of the daily life of Texans, the Department of State Health Services provides the following data for 2009.

Table 4-3

An Average Day in Texas, 2009:	
▪ The population increased by 654 persons.	
▪ There were 1100 resident <u>births.</u>	
○ 94 low birth weight babies were born (less than 2500 grams or less than 5 lbs. 9 oz.).	○ 51 babies were born to teenage mothers (less than 18 years of age).
▪ There were 446 resident <u>deaths</u>	
○ 104 of these deaths were due to heart disease.	○ 97 of these deaths were due to cancer.
○ 26 of these deaths were due to accidents.	○ 8 of these were deaths by suicide.
○ 7 of these were infant deaths.	○ 4 of these were deaths by homicide.

Source: http://www.dshs.state.tx.us/chs/vstat/vs09/data.shtm

The state of Texas, with a large resident population, contributes a considerable amount of data to the national figures. In fact, in the five-year period from 2005-2009, Texas lost over 12,000 persons to suicide, ranking suicide as a top cause of injury death for all ages in Texas with a suicide rate of 10.8 per 100,000 population.

In 2010, suicide was the 9th leading cause of death in Texas. In the youngest demographic groups, suicide has become the third leading cause of all deaths. Additionally, there has been a statistically significant increase in suicide attempts between 2009 and 2011 for high school students in Texas, from 7.4% of the high school population to over 10% in 2011.

http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5104a1.htm\

Over half of all suicides in Texas occur in Metropolitan counties; these nine counties (Bexar, Collin, Dallas, Denton, El Paso, Harris, Hidalgo, Tarrant and Travis) accounted for 6,300 suicides between 2005-2009 (see Figure 4-3). What is further startling is that the suicide rate in several of these counties outpace the homicide rate, meaning a person is more likely to die from suicide than from homicide (Bexar, Dallas, Harris, Tarrant and Travis Counties, see Table 4-6).

Table 4-4

Suicide Deaths in Texas 2005-2009.
ICD 10 data provided by the Texas Department of State Health Services. (Rates are per 100,000 people)
All categories are group specific, except for totals, which are age adjusted

ICD-10 Death Statistics for the State of Texas												
Intentional Self-Harm (Suicide) (X60-X84, Y87.0)												
	Year											
	2005		2006		2007		2008		2009		2005&2006&2007&2008&2009	
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Under 1	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
1 to 4	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
5 to 14	22	0.7	23	0.7	11	0.3	13	0.4	27	0.8	96	0.6
15 to 24	366	10.4	344	9.5	356	9.7	337	9.1	411	11.0	1,814	9.9
25 to 34	414	12.1	401	11.4	430	12.0	456	12.4	450	12.0	2,151	12.0
35 to 44	482	14.2	459	13.3	482	13.8	493	14.1	506	14.3	2,422	13.9
45 to 54	496	16.2	470	14.8	531	16.3	580	17.5	634	18.8	2,711	16.8
55 to 64	283	13.8	317	14.6	337	14.9	359	15.3	389	15.9	1,685	14.9
65 to 74	158	13.0	142	11.3	154	12.0	188	14.1	199	14.4	841	13.0
75 to 84	127	16.7	130	16.8	114	14.6	139	17.7	120	15.2	630	16.2
85 and over	52	19.9	46	16.8	55	19.5	53	18.4	57	19.2	263	18.7
All Ages	2,400	10.8	2,332	10.2	2,470	10.5	2,618	11.0	2,795	11.4	12,615	10.8

Source: http://soupfin.tdh.state.tx.us/death10.htm

Figure 4-3

Comparison of Suicide Death Rates (Numbers per 100,000) of Major Texas Metropolitan Counties from 2005-2009 (from Texas-DSHS)

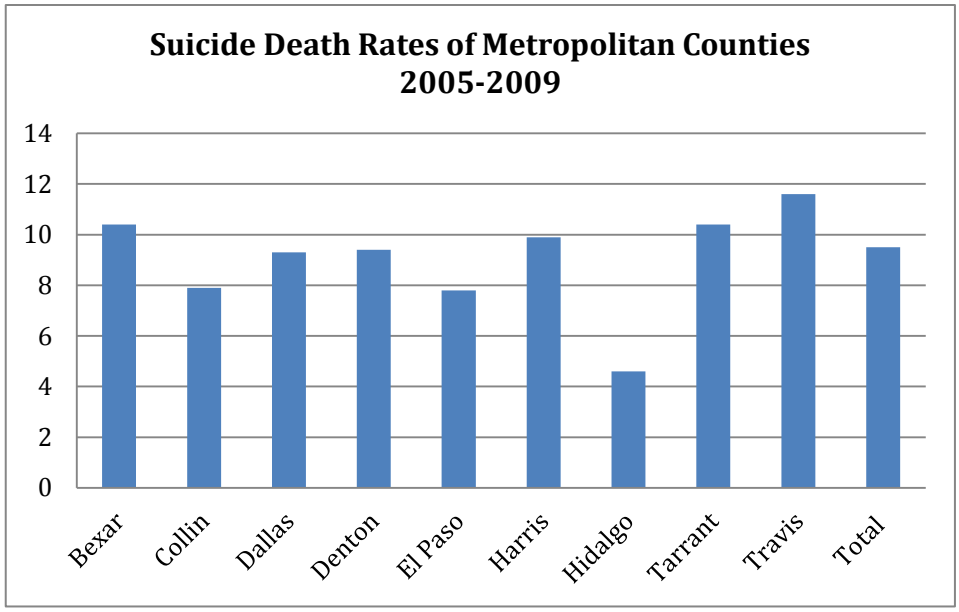


Table 4-5

Overall Texas Suicide Death Rates for 2005-2009	
Year	**Rate** (Numbers per 100, 000 population)
2005	10.8
2006	10.2
2007	10.5
2008	11.0
2009	11.4
2005-2009 Total	10.8
Source: http://soupfin.tdh.state.tx.us/death10.htm	

Table 4-6

Comparison of Suicides vs. Homicides for 2009	
Bexar County	7.2 for homicide vs **12.0 for suicide**
Dallas County	8.5 for homicide vs **10.6 for suicide**
Harris County	10.6 for homicide vs **11.6 for suicide**
Tarrant County	3.8 for homicide vs **9.6 for suicide**
Travis County	2.7 for homicide vs **11.7 for suicide**
Total for Texas	7.8 for homicide vs **11.1 for suicide**
Source: http://soupfin.tdh.state.tx.us/death10.htm	

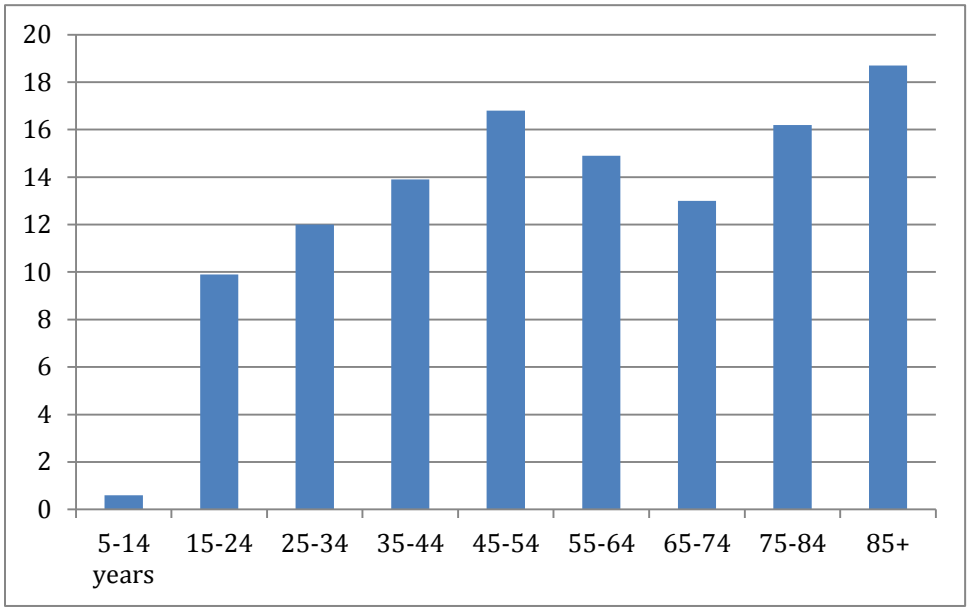
Figure 4-4

Texas Suicide Death Rates by Age Group 2005-2009

Deaths per 100,000 population

Age Distribution of Suicide Deaths in Texas

Death by suicide affects all ages, as this chart indicates. The highest rates of suicide in Texas are occurring in the 45-54 and in the elderly population over 85 age categories.



Source: http://soupfin.tdh.state.tx.us/death10.htm

Table 4-7

ICD-10 Death Statistics for the State of Texas		
	Year	
	2009	
Cause of Death	Number	Rate
Intentional Self-Harm (Suicide) (X60-X84, Y87.0)	2,795	11.4
Assault (Homicide) (X85-Y09, Y87.1)	1,494	5.9
Total for Selection	4,289	17.3

ICD-10 Death Statistics for the State of Texas		
Assault (Homicide) (X85-Y09, Y87.1)		
	Year	
	2009	
County	Number	Rate
Bexar County	123	7.2
Dallas County	214	8.5
Harris County	452	10.6
Tarrant County	70	3.8
Travis County	29	2.7
Total for Selection	888	7.8

ICD-10 Death Statistics for the State of Texas		
Intentional Self-Harm (Suicide) (X60-X84, Y87.0)		
	Year	
	2009	
County	Number	Rate
Bexar County	197	12.0
Dallas County	245	10.6
Harris County	447	11.6
Tarrant County	170	9.6
Travis County	113	11.7
Total for Selection	1,172	11.1

Texas overall and all major Texas metropolitan areas have higher death rates of suicide than by homicide. (Data from Texas Department of State Health Services), as the above table indicates.

Source: http://soupfin.tdh.state.tx.us/death10.htm

Suicide as a Leading Cause of Death in Texas:

Suicide in Texas is a significant factor in loss of life. In fact, between the ages of 10 and 54, suicide is a Top Five cause of death for Texans. In the age group of 25-34, suicide is the second leading cause of death; behind unintentional injury and ahead of homicide, malignant neoplasms and heart disease. See Table 4-8 below.

Table 4-8

10 Leading Causes of Death by Age Group in Texas for 2007. All Races, Both Sexes
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System
Produced By: WISQARS Program, Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 569	Unintentional Injury 192	Unintentional Injury 96	Unintentional Injury 111	Unintentional Injury 1,361	Unintentional Injury 1,245	Unintentional Injury 1,300	Malignant Neoplasms 3,632	Malignant Neoplasms 6,958	Heart Disease 29,783	Heart Disease 38,912
2	Short Gestation 327	Congenital Anomalies 56	Malignant Neoplasms 46	Malignant Neoplasms 41	Homicide 400	Suicide 424	Malignant Neoplasms 1,034	Heart Disease 2,850	Heart Disease 4,966	Malignant Neoplasms 22,883	Malignant Neoplasms 35,074
3	SIDS 259	Homicide 45	Congenital Anomalies 25	Homicide 17	Suicide 353	Homicide 416	Heart Disease 899	Unintentional Injury 1,508	Diabetes Mellitus 970	Cerebro-vascular 8,087	Cerebro-vascular 9,796
4	Maternal Pregnancy Comp. 115	Malignant Neoplasms 29	Homicide 11	Suicide 12	Malignant Neoplasms 155	Malignant Neoplasms 288	Suicide 471	Liver Disease 747	Unintentional Injury 924	Chronic Low Respiratory Disease 6,842	Unintentional Injury 9,392
5	Placenta Cord Membranes 86	Heart Disease 14	Heart Disease 9	Heart Disease 9	Heart Disease 92	Heart Disease 252	HIV 356	Suicide 524	Cerebro-vascular 916	Alzheimer's Disease 4,758	Chronic Low Respiratory Disease 8,107
6	Unintentional Injury 86	Influenza & Pneumonia 10	Influenza & Pneumonia 7	Congenital Anomalies 8	Congenital Anomalies 41	HIV 133	Homicide 279	Cerebro-vascular 522	Chronic Low Respiratory Disease 872	Diabetes Mellitus 3,432	Diabetes Mellitus 5,109
7	Bacterial Sepsis 84	Cerebro-vascular 7	Benign Neoplasms 6	Influenza & Pneumonia 7	HIV 16	Diabetes Mellitus 55	Liver Disease 213	Diabetes Mellitus 479	Liver Disease 673	Influenza & Pneumonia 2,674	Alzheimer's Disease 4,814
8	Necrotizing Enterocolitis 68	Perinatal Period 7	Chronic Low Respiratory Disease 5	Septicemia 4	Septicemia 15	Cerebro-vascular 49	Cerebro-vascular 187	HIV 332	Septicemia 377	Nephritis 2,577	Nephritis 3,291
9	Circulatory System Disease 58	Benign Neoplasms 6	Septicemia 4	Four Tied 3	Influenza & Pneumonia 14	Influenza & Pneumonia 41	Diabetes Mellitus 157	Chronic Low Respiratory Disease 286	Nephritis 364	Unintentional Injury 2,564	Influenza & Pneumonia 3,230
10	Neonatal Hemorrhage 57	Chronic Low Respiratory Disease 6	Cerebro-vascular 3	Four Tied 3	Diabetes Mellitus 11	Liver Disease 29	Septicemia 89	Viral Hepatitis 226	Suicide 329	Septicemia 2,094	Septicemia 2,094

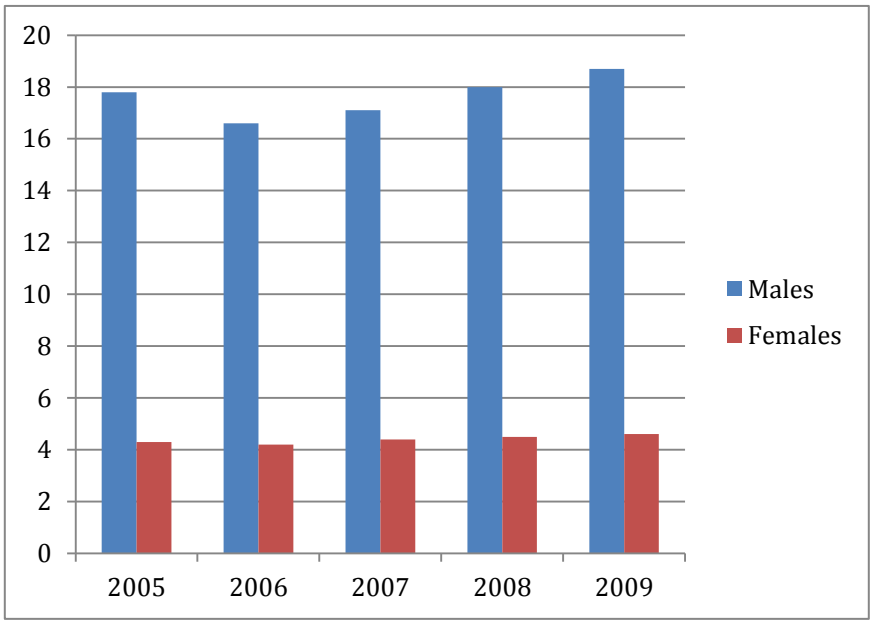
Source: http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html

Figure 4-5

Suicide Death Rates by Gender in Texas: 2005-2009

Suicide by Gender:

As with the national suicide trend, Texas also experiences a significant difference between male and female deaths by suicide rates. The male to female ratio of deaths by suicide in Texas actually outpaces the national average, as illustrated by this chart (Figure 4-5). In fact, in certain age groups, the elevated male to female ratio is even greater; according to the American Foundation for Suicide Prevention, in 2007, young adult males aged 15-24 outpaced female suicide in this same age group at a rate of nearly 6 to 1.



Foundation for Suicide Prevention's Youth Fact Sheet at: http://www.afsp.org/files/College_Film/factsheets.pdf

What is important to note is that although males die by suicide at over a 4:1 ratio to females, females actually make more attempts. This is true at both the national and state level. According to the American Foundation for Suicide Prevention, females attempt suicide at a rate of 3:1 to males, but it is believed that males use more lethal means, translating into a higher death rate for males.

Youth Specific Suicide Data:

According to data reported by the Texas Youth Behavior Risk Surveillance Survey, youth suicide attempts have consistently outpaced national high school suicide attempts for a ten-year period between 2001-2009. (See Table 4-9 below).

Table 4-9

Youth Suicide Attempts in Texas Compared to U.S.
As Reported by Youth Behavioral Risk Surveillance Survey for 2001-2009

Texas Source: http://www.dshs.state.tx.us/chs/yrbs/

U.S. Source: http://www.cdc.gov/HealthyYouth/yrbs/index.htm

Attempted Suicide One Or More Times
(during the 12 months before the survey)
Texas, High School Youth Risk Behavior Survey

Find out if there is a statistical difference between two years. Select two, then click the button. COMPARE TWO >>

Sex \ Year	2001	2005	2007	2009
Total	9.0 (7.9–10.2) 6,186†	9.4 (8.3–10.6) 3,565	8.4 (7.1–9.9) 2,749	7.4 (6.3–8.7) 3,079
Female	12.7 (11.1–14.5) 3,288	12.5 (10.7–14.6) 1,908	11.8 (10.0–14.0) 1,381	10.4 (8.3–13.1) 1,482
Male	5.3 (4.3–6.4) 2,877	6.1 (4.7–7.8) 1,648	4.9 (3.3–7.3) 1,367	4.3 (3.3–5.7) 1,595

Footnotes

† Percentage, confidence interval, cell size

Attempted Suicide One Or More Times
(during the 12 months before the survey)
United States, High School Youth Risk Behavior Survey

Find out if there is a statistical difference between two years. Select two, then click the button. COMPARE TWO >>

Sex \ Year	2001	2003	2005	2007	2009
Total	8.8 (8.0–9.7) 11,959†	8.5 (7.4–9.6) 13,150	8.4 (7.6–9.3) 12,427	6.9 (6.3–7.6) 12,484	6.3 (5.7–7.0) 14,609
Female	11.2 (10.2–12.3) 6,213	11.5 (10.1–13.0) 6,666	10.8 (9.8–12.0) 6,486	9.3 (8.2–10.4) 6,338	8.1 (7.2–9.0) 7,475
Male	6.2 (5.2–7.5) 5,715	5.4 (4.4–6.6) 6,433	6.0 (4.9–7.4) 5,892	4.6 (4.0–5.2) 6,138	4.6 (3.9–5.5) 7,082

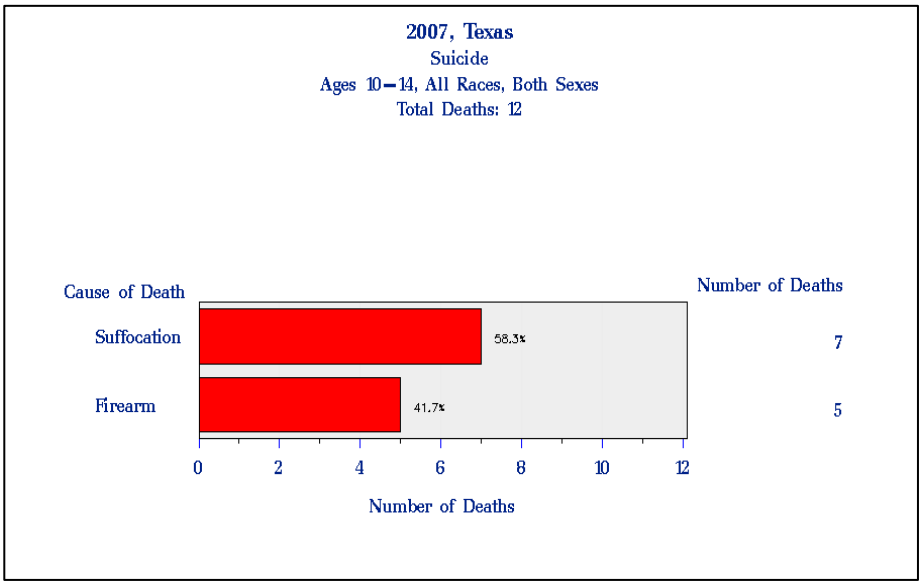
Footnotes

† Percentage, confidence interval, cell size

Younger youth are not immune to suicide: In 2007, Texas lost twelve youths under the age of 15 to suicide, with suffocation being the leading method of suicide in this age group. (See Figure 4-6 below.)

Figure 4-6

Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System



Source: http://webappa.cdc.gov/cgi-bin/broker.exe?_service=v8prod&_server=app-v-ehipwisq.cdc.gov&_port=5081&_sessionid=k85EatRdM52&_program=wisqars.details10.sas&_service=&type=S&prtfmt=STANDARD&age1=10&age2=14&agegp=10-14&deaths=12&_debug=0&lcdfmt=lcd1age&ethnicty=0&ranking=10&deathtle=Death

Navigating State Suicide Statistics

While it is important to understand the current statistics related to suicide at the national and state level, it is important for those working in the areas of suicide prevention at the local level to gain insight and understanding of their region-specific situation and needs. Prior to developing and/or implementing changes in suicide prevention initiatives, analyzing local data is vitally important to understand where limited resources may be able to have the most significant and leveraged impact.

Community Assessment: Starting with the Statistics for Your Community

One of the first steps in a community-based approach to suicide prevention is becoming aware of the numbers, rates, demographics, and trends in your community. The medical examiner's (ME) autopsy reports are an excellent source of this data for suicides. These reports are in the public record. Most MEs make a serious effort to determine a cause of death, but not all have investigators who work on suspected cases of suicide. Even in the best of ME offices suicides may be undercounted, especially if the death could possibly be viewed as accidental, such as with many drug-related deaths and auto crashes. Not all of the information included in the ME reports is captured in the state database. Information such as age, gender, race/ethnicity, mode of suicide, date and time of suicide, address or zip code of residence, and toxicology reports can be obtained and formatted into a report for the community. Zip code incidence maps can be very helpful in identifying school districts or areas that may benefit most from prevention efforts. The county department of health can be an excellent partner in analyzing raw data.

Suicide attempt data can be obtained through the Texas Health Care Information Council (THCIC). THCIC maintains a database of hospital discharge codes, including suicide attempts, which can be sorted by community. This is public information, but there may be a fee associated with some reports. A university or hospital in your community may be a subscriber to the system and be able to provide a report. In some communities, hospital personnel may not have the necessary data to determine a discharge diagnosis of a suicide attempt, so the report may seriously undercount this statistic. A discussion with the hospitals in your community may reveal if efforts are being made to ascertain if an injury is a suicide attempt or not. If so, these attempts are coded and easy to obtain as statistics.

The Texas Health Care Information Council's website is located at: http://www.dshs.state.tx.us/thcic/

Keep in mind as you collect data that suicide and attempt rates may vary from year to year, and a multiple-year study is best to observe trends. This is especially important information to have prior to beginning prevention efforts in order to determine both short- and long-term effects of prevention programs.

Collecting Suicide Data for Your County

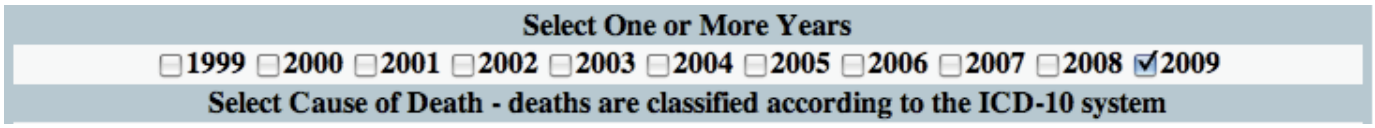
To access the data from the Texas Department of Health:

1. Go to the Texas Department of Health Center for Health Statistics web page at: http://www.dshs.state.tx.us/chs/default.shtm.
2. Under the Health Data by Topic menu, select Death Data - customized queries.
3. Select between the two Death Table options. Death data are available in two modules, one for the years 1990-1998 and one for the years 1999-2009,

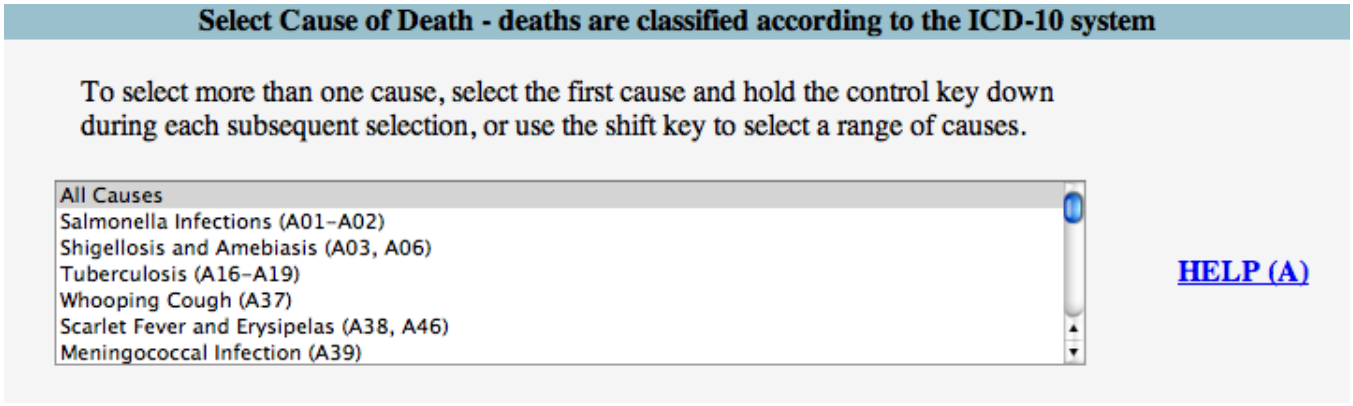
Congratulations! You are now ready to form tables of your own by following these next steps. The Web page that you are on should be titled TEXAS HEALTH DATA*

Working with the Data

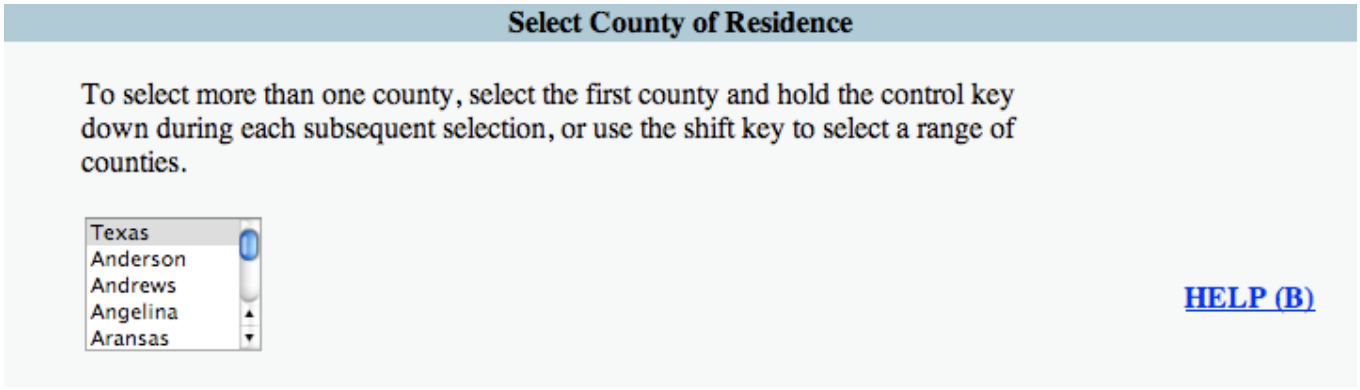
Step 1: Year. Select the year for which you want to collect data. If you need data for more than one year mark the box next to each year.



Step2: Causes of Death. Select from the dropdown box the cause of death. For suicide, select **Intentional Self-Harm (Suicide) (x60-x84, y87-0)**.

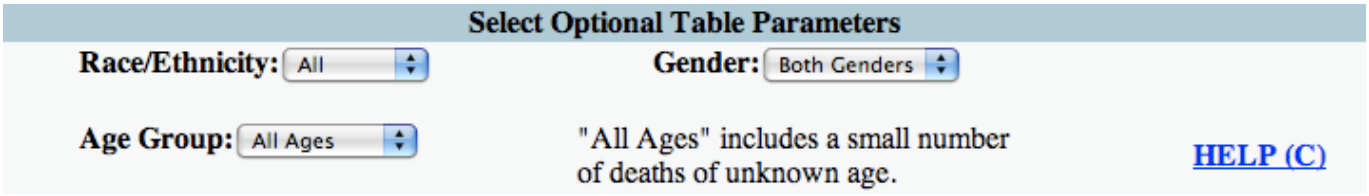


Step 3: Select County of Residence. Select the county that you want to generate data for. Select Texas if you want to gather data statewide.



Step 4: Select Optional Table Parameters. Optional parameters are used to limit the data you want to look at. For example, you would use this option if you were interested in looking at suicide rates only in women or only in people aged 55 to 64.

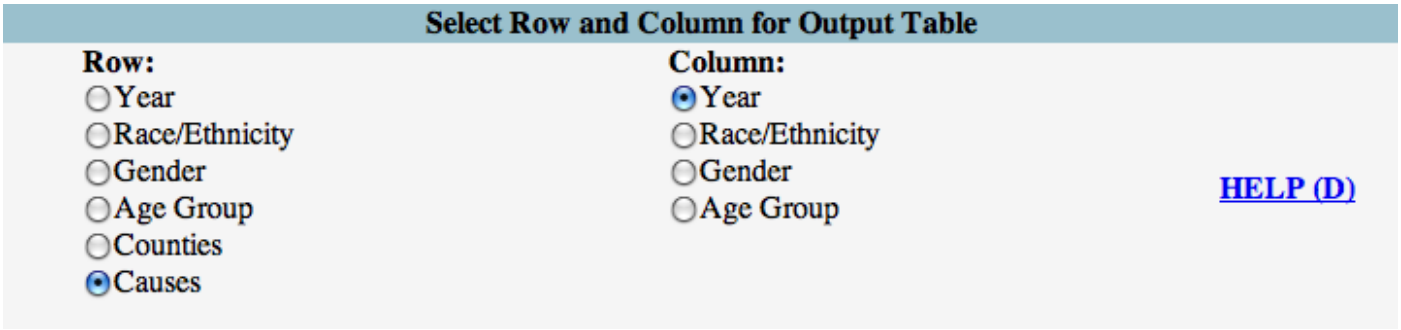
If you want to limit your data in this manner, select the group you want to look at from one of the dropdown boxes. For example, if you want to look at suicide rates only in women, you would select **female** from the **gender** dropdown box.



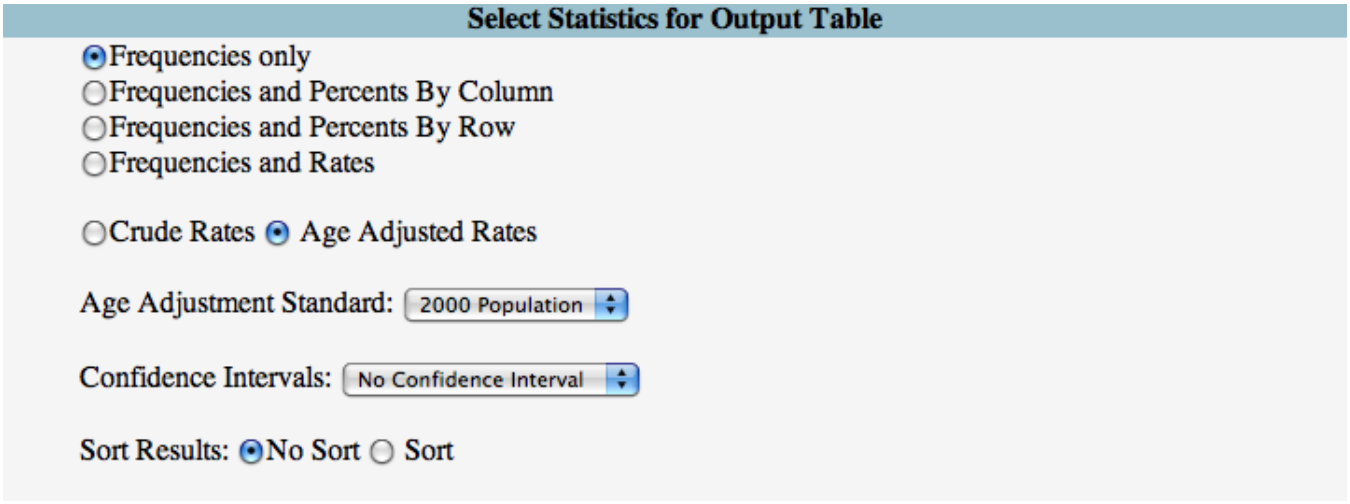
For an example using these Optional Table Parameters, please see Figure 4-7, Table 1. This table provides you with an example of what the table should look like if you select the value **female** for the variable **gender**. As explained in the next step, in this example the "row" variable is the year and the "column" variable is race/ethnicity.

Step 5: Select Row and Column for Output Table. This option allows you to select how you would like your data to be displayed. You can choose to break the data down by year, race/ethnicity, and other variable. By selecting a variable as a **Row** variable or a **Column** variable, you are selecting where on the table those variables will appear. For example, if you would like your data table to show the suicide rates broken down by male versus females across the top of your table and by age group down the left side of your table, you would select **Gender** under **Row** and **Age Group** under **Column**.

Tables 2 and 3 of Figure 4-7 provide you with examples of the different ways that you can display your data. Table 2 provides you with an example of what the table would look like if you chose the **Race/Ethnicity** variable for the **Row** and the **Gender** variable for the **Column**. Table 3 rotates those two variables and places **Gender** as the variable for the Row and **Race/Ethnicity** as the variable for the Column.



Step 6: Select Statistics for Output Table. This is the final step. This option menu allows you to select how your data will be displayed statistically in your final output table. Suicide data can be presented in various forms. Below are the definitions for the terms used in this section. Make your selection according to your individual information needs.



We have included two examples of final output tables. Table 4 displays data using frequencies only, and Figure 5 displays both frequencies and rates.

Glossary of Statistical Terms

Frequency. Simplest measure; refers to the raw number of cases of a disease or deaths. **Ex.:** 250 people out of 425 came down with the Norwalk virus while on a cruise. The frequency is 250.	**Percent.** Count relative to the size of the group; requires a meaningful denominator. Ex.: 250 people out of 425 came down with the Norwalk virus while on a cruise. 250/425 = 58.8% The percent is 58.8%
Rates. Frequencies that have been converted to numbers that share a common denominator, usually frequency of occurrence per 100,000 people in the population. Crude death rate = (# of deaths in a given year / Total # in population) X 100,000. Either 1,000 or 100,000 is used as the multiplier. Ex: In 1998, in Harris County: (382 deaths from motor vehicle accidents / 3,204,720 total population) X 100,000 =11.92 deaths per 100,000 (From Motor Vehicle Traffic Accidents and Texas HealthData Population Estimates)	**Age Adjusted Rates.** Also called "age standardization." Reduces the confounding effects of age on morbidity and mortality rates. For example, the crude death rate in the United States was 852.2 per 100,000 in 1979 and 880.0 in 1995. However, there was also an increase in proportion of the number of older people. Based on an age-adjusted rate, the rate actually dropped from 577.0 per 100,000 to 503.9. Many tables use an age-adjusted rate; be careful not to confuse your data by quoting an age-adjusted rate alongside a crude death rate. Also, if you are comparing data, make certain the data use the same standard, i.e. don't compare data that uses the 1940 Standard with data that uses the 1970 Standard.
Confidence Intervals. A confidence interval gives an estimated range of values that is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data. The width of the confidence interval gives us some idea about how uncertain we are about the unknown parameter. A very wide interval may indicate that more data should be collected before anything very definite can be said about the parameter.	**(Definitions are derived from the Charting Health Information in Texas Web site produced by the University of Texas Health Science Center in Houston, http://www.sph.uth.tmc.edu/library/chartinghealthinfo.htm**

Figure 4-7

1. Output for Steps 4-6

ICD-10 Death Statistics for the State of Texas					
Sex: Female Intentional Self-Harm (Suicide) (X60-X84, Y87.0)					
	Race				
	White	Black	Hispanic	Other	All Races
Year	Number	Number	Number	Number	Number
2009	439	28	68	36	571
Rotate			Download		

Select Optional Table Parameters

2. Output Table for Step 5

ICD-10 Death Statistics for the State of Texas			
Intentional Self-Harm (Suicide) (X60-X84, Y87.0) Year: 2009			
	Sex		
	Male	Female	Both Sexes
Race	Number	Number	Number
White	1,623	439	2,062
Black	112	28	140
Hispanic	414	68	482
Other	75	36	111
All Races	2,224	571	2,795
Rotate		Download	

3. Output Table for Step 5: Select Row and Column

ICD-10 Death Statistics for the State of Texas					
Intentional Self-Harm (Suicide) (X60-X84, Y87.0) Year: 2009					
	Race				
	White	Black	Hispanic	Other	All Races
Sex	Number	Number	Number	Number	Number
Male	1,623	112	414	75	2,224
Female	439	28	68	36	571
Both Sexes	2,062	140	482	111	2,795
Rotate			Download		

4. Final Output Table for Step 6: Frequencies only

ICD-10 Death Statistics for the State of Texas					
Intentional Self-Harm (Suicide) (X60-X84, Y87.0) Year: 2009					
	Race				
	White	Black	Hispanic	Other	All Races
Sex	Number	Number	Number	Number	Number
Male	1,623	112	414	75	2,224
Female	439	28	68	36	571
Both Sexes	2,062	140	482	111	2,795
Rotate			Download		

5. Final Output Table for Step 6: Frequencies and Rates

ICD-10 Death Statistics for the State of Texas										
Intentional Self-Harm (Suicide) (X60-X84, Y87.0) Year: 2009										
	Race									
	White		Black		Hispanic		Other		All Races	
Sex	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Male	1,623	27.7	112	8.0	414	9.6	75	13.1	2,224	18.7
Female	439	7.2	28	1.8	68	1.4	36	6.2	571	4.6
Both Sexes	2,062	17.2	140	4.8	482	5.5	111	9.6	2,795	11.4
Rotate					Download					
Footnote	Rates Per 100,000 @.@ indicates numerator too small for rate calculation Age Adjustment Uses 2000 Standard Population									

Texas Health Data Death of Texas Residents.

http://soupfin.tdh.state.tx.us/death10.htm

High Risk Populations

As you develop your community profile, it is important to note that different demographic groups have differing rates of suicide and, often, different underlying causes. Prior to discussing high risk populations it is important to consider the significant risk of suicide associated with severe mental illness, regardless of one's demography or ethnicity. In fact, people with severe mental illnesses are twelve times more likely to die by suicide than those unaffected by mental illness. Populations within a community often face different levels of risk for suicide across their lifespan with some groups at greater risk. The following material is intended to help in your efforts to reach out to those who may be at high risk. These high-risk population groups are:

- Military
- African American
- Elderly
- Latino/Hispanic
- Youth and Students
- LGBTQI2-S
- Men
- Women

The Military

As stated previously, military service had been considered a "protective factor" from suicide prior to 2004. Since that time, the number of suicides by service members has been growing; suicide rates among Army Soldiers and Marines have doubled in recent years and the Department of Defense and the Department of Veterans Affairs have worked aggressively to improve access to mental health services. Veterans are not immune to this growth trend: Dr. Richard McKeon, Branch Chief of Suicide Prevention at the Substance Abuse and Mental Health Services Administration indicates that one in five suicides in the United States involves a former military service member. He estimates that 950 veteran suicides are attempted each month and that Lifelines VA Hotline receives approximately 10,000 calls each month from current or former military service members. For additional information about Dr. McKeon's research please see the link below.

http://www.nciom.org/wp-content/uploads/2012/02/SAMHSA-Suicde-Prevention-Strategies.pdf

According to *Understanding and Preventing Military Suicide* (Bryan,C, et.al, 2012), "Never before have we seen a more sudden and dramatic increase of suicide in a population that has historically had meaningfully lower rates of suicide when compared to their civilian cohorts." This statistic is more compelling when compared to military history: until war operations in Afghanistan and Iraq, the military suicide rate typically decreased during wartime, not increased.

This unique population requires special awareness and programs surrounding suicide. It is essential to understand some of the compelling forces underlying the military environment and culture experienced by military personnel. At its core element, "The military is the only organization sanctioned by the U.S. society to be explicitly trained to kill other people," (Bryan, et.al, *Understanding and Preventing Military Suicide, 2012)*. The authors further indicate several of the underlying forces impacting service members:

- Use of aggression and violence as part of the service member's job responsibilities
- Cultural values of "strength, resilience, courage and personal sacrifice" in the face of adversity
- Managing stress and physical pain to continue performing when injured
- Suppressing fear, anger, grief, self doubt to remain calm and focused during combat
- The concept of "collectivism," that the cohesion of your team comes before everything else
- Fearlessness about death
- Self-sacrifice and self-reliance

Finally, the expectation that service members can "handle it,"—whatever "it" is—by deploying learned strategies embedded in years of training for combat effectiveness listed above (avoiding and/or deferring pain mentally and physically) further compound the mental health environment of the military.

These forces combine to create a culture entrenched in mental health stigma: that by seeking out help service members are "weak;" that the individual is letting their group down; and a distrust of "outsiders" which may indicate why service members are three times more likely to ask another service member for help for a mental health issue than access professional services.

"Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lessons Learned from the Defender's Edge Program," Bryan, C. et.al,
http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2011-04544-003
"Understanding and Preventing Military Suicide," Bryan, C, et.al,
http://www.tandfonline.com/doi/abs/10.1080/13811118.2012.667321?journalCode=usui20#preview

African-American Populations

Suicide is the 3rd leading cause of death among African Americans between the ages 15–24, after homicides and accidents. The rate of suicide among this age group is higher than that of older African Americans. Because the rate of homicide is higher than the rate of suicide in most African American communities—it is imperative to examine those homicides that may be certified erroneously. According to Donna Barnes, Cofounder and President of the National Association of Persons of Color Against Suicide, it may be easier to put oneself in a risky position that could lead to death than to actually take their own life:

> Within many US Cities with majority African American populations (>50%), homicide rates are considerably higher than suicide rates (i.e., District of Columbia, Gary, IN, Detroit, MI, Baltimore, MD). Whereas these statistics may be interpreted as African-Americans being more likely to engage in homicidal behavior than suicidal, we must be cautious to consider the social and psychological conditions in which these deaths take place. Due to the cultural stigma regarding suicidal behavior and mental illness within African American communities, one may engage in risky criminal or even homicidal behavior with the ultimate goal of bringing harm to themselves. African American females have the lowest rate of suicide among any population but have very high suicide attempts rates—just as high as their white counterpart.

The website for the National Organization for People of Color Against Suicide is located at:
http://www.nopcas.org

According to the American Association of Suicidology's (AAS) *African American Suicide Fact Sheet*, there are several factors that provide the backdrop for the outcomes discussed above:

- The perception that suicide is an unforgivable sin in the context of the predominant religions within the African American community
  - The perception that African-American men are macho and do not take their own lives
  - The perception that African-American women are always strong and resilient and never crack under pressure
- The behavioral component of depression in African Americans is more pronounced than for other sectors of the population
- African Americans are less likely to use drugs during a suicide crisis
- Some indication that African Americans express little suicide intent or depressive symptoms during suicidal crises

For more information see American Association of Suicidology's *African American Suicide Fact Sheet*:
http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-241.pdf

Elderly

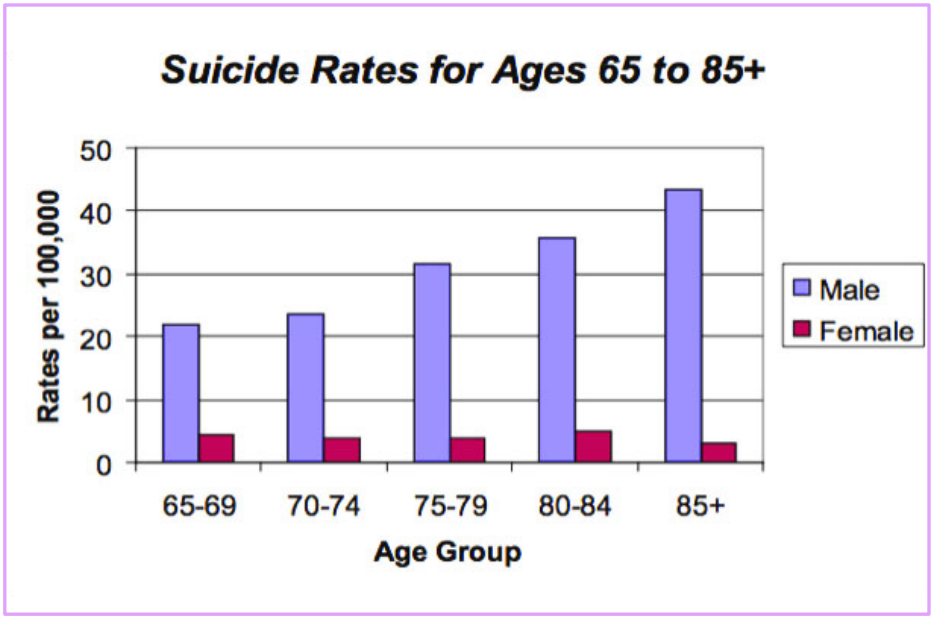
Elderly make up only twelve percent of the US population, yet they account for almost sixteen percent of the suicides in the United States. According to the American Association of Suicidology's *Elderly Suicide Fact Sheet*, 14.3 of every 100,000 Americans aged 65 and over died by suicide in 2004, higher than the general population rate. Most significantly, Non-Hispanic white males aged 85 and older died by suicide at a rate over three times the general elderly population; over 49.8 per 100,000.

American Association of Suicidology**,** *Elderly Suicide Fact Sheet*, Suicide Rates for Age 65-85+
http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-242.pdf

Figure 4-8

Because of the high relationship between depression and suicide in older Americans, the ability to identify and treat depression is essential. According to National Institute of Mental Health's Fact Sheet, *Older Adults: Depression and Suicide Factors*, it is estimated that up to 75% of elderly people who die by suicide visited a physician within the month preceding their death.

Because of the high relationship between depression and suicide in older Americans, the ability to identify and treat depression is essential.



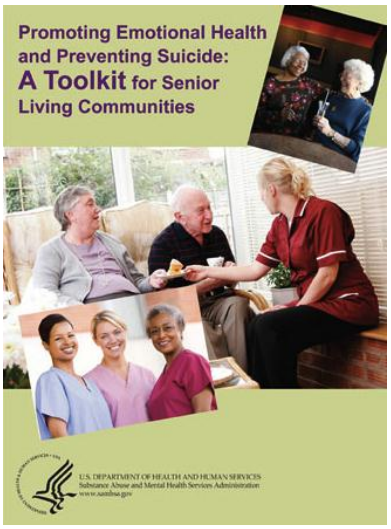
According to National Institute of Mental Health's Fact Sheet, *Older Adults: Depression and Suicide Factors*, it is estimated that up to 75% of elderly people who die by suicide visited a physician within the month preceding their death.

For more information, see the National Institute of Mental Health: Older Adults: Depression and Suicide Factors: Fact Sheet: http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts-fact-sheet/index.shtml

In Texas, the highest reported suicide rate in 2009 was among people 65 and older, which reported a rate of 14.9 deaths from suicide per 100,000 people, according to the American Association of Suicidology's report *USA State Suicide Rates and Rankings Among the Elderly and Young, 2009,* using data from the Centers for Disease Control and Prevention's data from the WISQARS Fatal Injury Reports website http://www.cdc.gov/injury/wisqars/index.html; downloaded 18 January 2012.

Risk factors for suicide among older persons differ from those among the young. Older persons have a higher prevalence of depression, a greater use of highly lethal methods, and social isolation. For more information about resources for seniors, contact:

- Your local Area Agency on Aging (AAA) at: http://www.dads.state.tx.us/providers/AAA/index.html
- National Suicide Prevention Resource Center at: http://www.sprc.org.
- Texas Department of Aging and Disability Services at: http://www.dads.state.tx.us/index.cfm



In addition to these resources, a toolkit for senior living communities is available from SAMHSA, titled *Promoting Emotional Health and Preventing Suicide.*

http://store.samhsa.gov/product/SMA10-4515

Youth and Students

According to the National Institute of Mental Health, suicide was the third leading cause of death among youth in 2007. One of the primary considerations is the use of illicit drugs. 2009 data suggests a correlation between illicit drug use and elevated suicide risk. Youths and students who use alcohol or tobacco are at an elevated risk and illicit drug use further compounds the risk. Research suggests that cocaine or heroin use increase suicide risk by a factor of 12. For each 100,000 population in this cohort:

Children age 10-14: 1 in 100,000 die by suicide;
Child age 15-19: about 7 per 100,000 die by suicide;
Young Adults age 20-24: nearly 13 in 100,000 die by suicide.

To put it in context, according to the U.S. Department of Health and Human Services (HHS) report *Youth Mortality in the United States, 1935-2007,* **suicide accounted for more youth loss of life than cancer, birth defects, diabetes, HIV/AIDS, pneumonia, influenza and stroke *combined.***

For more information about HHS report, go to:
http://www.hrsa.gov/healthit/images/mchb_youthmortality_pub.pdf

The Texas Department of State Health Services data for 2005-2009 reports that Texas lost nearly 2,000 youths to suicide in this timeframe, supporting the contention that adolescents are a particularly vulnerable group.

Youth populations have unique characteristics that present challenges in the areas of suicide and suicide prevention. The prevalence of a 24/7 culture enabled by advances in communication technologies such as social media, smartphones, and the use of technology for instructional purposes, youths are often faced with a wide variety pressures from peers and society in general.

Developments such as cyberbullying, suicide chat rooms, and other forms of communication are penetrating into this population rapidly. These are challenges not generally encountered by adult populations at this time. For instance, according to Biddle, L, et.al, "Suicide and the Internet," their research found that a systematic internet search designed to replicate a typical search engine by a person seeking information on suicide methods found that in the first ten sites listed for each search conducted, approximately half of the resulting websites were "pro suicide" sites that provided accurate information on these methods.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2292278/

Although this field is relatively new, current research indicates that cyberbullying victims are 1.9 times more likely and cyberbullying offenders were 1.5 times more likely to have attempted suicide than those who were not cyberbullying victims or offenders. (Hinduja S, et.al, "Bullying, Cyberbullying and Suicide").

http://www.touro.edu/EDGRAD/EAC/docs/Hinduja_Article_2010.pdf

In March 2011, the White House held the first-ever conference on Bullying Prevention; an indication of the growing concern of the impact the combined effect of bullying behavior and technological advances are having on our youth after several high profile youth suicides related to cyberbullying.

Youth are the only demographic group that can generally predict their environment for their foreseeable future. The majority of youth spend twelve years with a relatively stable peer group, representing up to 90% of their living years in some cases. This cocooning effect can magnify positive experiences and negative experiences alike; a special consideration when dealing with youth. Couple their physical reality with recent technical advances such as "pro-suicide" chat rooms, insult rooms and other online information that is only one search engine away creates an increasingly vulnerable youth population.

Texas youth are not immune. The 2011 Texas Youth Risk Behavior Surveillance System survey results highlight several important data points. Of the high school students surveyed within the past twelve months:

- 29.2% felt so sad or hopeless almost everyday for two or more weeks in a row that they stopped doing some usual activities
- 15.8% seriously considered attempting suicide
- 13.2% made a plan about how they would attempt suicide
- 10.8% actually attempted suicide one or more times
- 3.5% made a suicide attempt that required medical treatment

Further information about the Texas Youth Risk Behavior Surveillance System can be found at:
http://www.dshs.state.tx.us/Layouts/ContentPageNoNav.aspx?pageid=36131

Latino/Hispanic Populations

Although Hispanic suicide rates are lower than the general U.S. population rates, Texas plays a pivotal role in this area. According to the Centers for Disease Control and Prevention in their 2011 study *Morbidity and Mortality: Suicidal Thoughts and Behaviors Among Adults Aged ≥ 18 Years,* Texas ranks 2nd in Hispanic suicide attempts in the United States, accounting for just under 20% of total Hispanic attempts nationally.

http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm

There are several factors that are unique to the Hispanic population. The American Association of Suicidology's (AAS) *Hispanic Suicide Fact Sheet* has identified several factors that may be related to suicide attempts in Texas for this demographic group. These include: affluence, cultural assimilation, mobility, and divorce among others. AAS also found that immigrant Hispanics had a slightly elevated rate of suicide than non-immigrants.
American Association of Suicidology *Hispanic Suicide Fact Sheet*:

http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-243.pdf

One portion of this demographic group that warrants special attention is the suicide rate among the Latina population. According to Dr. Luis Zayas, Dean of the School of Social Work at the University of Texas at Austin, a leading expert in the area of Latina suicide, the younger Latina population is particularly vulnerable, with a near doubling of the rate of suicide attempts than non-Hispanic youth and young adult females. His research finds that one in seven Hispanic girls attempt suicide in the United States. Not only is this rate higher than other U.S. non-Hispanic rates, it is also higher than Latina rates in Hispanic countries. Socio-cultural conditions unique to Latinas may contribute to this elevated risk in the United States. These include:

- Cultural traditions and values
- Immigration
- Lower access to health care
- Absence of extended family.
- Intimate family dynamics
- Poverty
- Language barriers

For additional information about the Latina suicide research see:
"Why Do So Many Latina Teens Attempt Suicide? A Conceptual Model for Research," Zayas,L.H., et.al, *American Journal of Orthopsychiatry* 2005, Vol 75, No2, 275-287,
http://cathexa.com/uploads/Latina_Suicide.pdf
"Is Culture to Blame for High Latina Suicide Attempts?"
http://www.newstaco.com/2010/08/29/is-culture-to-blame-for-high-latina-suicide-attempt-rates/

Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Two-Spirit (LGBTQI2-S)

Writing poetry about death and suicide in junior high, took herself off anti-depressants, upcoming anniversary of losing first boyfriend, raped by a co-worker, loss of interest in school, moving out of town for college, questioning her sexuality and just broke up with her girlfriend—all of these factors were in place. I lost my only child, Wendi, to suicide a week after her 19th birthday. If I had only known all these factors and understood suicide prevention, maybe I could still have my daughter with me!

Elizabeth Roebuck
Suicide survivor, Austin

The LGBTQI2-S community, particularly its youth, is at exceptionally high risk for suicide. A number of studies have shown a significant difference in suicide rates between the LGBTQI2-S population as a whole relative to increased suicide risk. A 2011 report by The National Gay and Lesbian Task Force and the National Center for Transgender Equality cited data that indicate upwards of 41% of the transgender population surveyed reported attempting suicide at some point in their life. This report, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, also found that these attempts occur more frequently when other indicators are factored in, such as loss of a job or housing due to discrimination or victimization due to bullying.

An online version of this report can be found at:
http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf

Additionally, *Suicide and Suicide Risk in Lesbian, Gay, Bisexual and Transgender Populations: Review and Recommendations,* a recent study by the American Foundation for Suicide Prevention, found similar patterns in the LGBTQI2-S community:

- Significantly elevated rates of lifetime suicide attempts among LGBTQI2-S youth and adults compared to similarly aged heterosexual populations.

- Although there is a higher rate of depression, anxiety and substance use among LGBTQI2-S compared to heterosexual populations, these rate differences do not solely account for the elevated suicide attempts.

A copy of this report can be found at: http://www.tandfonline.com/doi/abs/10.1080/00918369.2011.534038

Because of the role bullying plays for youth generally, LGBTQI2-S youth are particularly vulnerable to this behavior. Recognizing this particularly vulnerable part of our population and, after several high profile youth suicides with apparent links to anti-gay bullying behavior, the American Foundation for Suicide Prevention convened a round-table discussion targeting this issue. High profile initiatives such as the Trevor Project and It Gets Better are also assisting in addressing these concerns.

The Trevor Project

The Trevor Project offers a wide array of programs, training and services targeting LGBTQI2-S-specific needs including such as:

- The Trevor Lifeline (1-866-488-7386): a 24/7 crisis intervention lifeline for LGBTQI2-S youth for suicide prevention, "Ask Trevor;" an online Q&A forum surrounding sexual orientation and gender identity.
- TrevorChat: a secure, confidential online messaging system that provides live assistance real time. (TrevorChat is NOT intended for suicide-related inquiries.)
- TrevorSpace: TrevorSpace.org is an online social network community for LGBTQI2-S youth.
- Youth Advisory Council: YAC serves as a liaison between youth and The Trevor Project, especially in issues such as suicide, sexuality and gender identity. YAC provides feedback and recommendations to The Trevor Project for programs, products and services to more effectively and efficiently meet the needs of the LGBTQI2-S community.

More information about The Trevor Project is located at: http://www.thetrevorproject.org/

It Gets Better

Another high profile program that was launched in 2010 is called "It Gets Better." According to its website, the It Gets Better project was "created to show young LGBT people the level of happiness, potential and positivity their lives will reach—if they can just get through their teen years. The It Gets Better Project wants to remind teenagers in the LGBT community that they are not alone—and it WILL get better." Through a wide-ranging campaign of videos that have been viewed more than 50 million times, It Gets Better is incorporating new media to reach some of the most vulnerable portions of our society through Facebook, You Tube, and Twitter. It Gets Better currently has over 2500 videos posted ranging from high profile celebrities, politicians, athletes, activists and others who have created inspiring messaging for LGBTQI2-S youth dealing with social issues such as bullying as a result of their sexual orientation or gender identity.

http://www.itgetsbetter.org/pages/about-it-gets-better-project/

Men

Prior to discussing gender, it is important to also consider age as a component of suicidal behavior and that appears to be changing. Historically, older Americans were the largest cohort of suicide. Data released by the CDC for 2006 and 2007 indicate that middle-aged Americans died by suicide at a rate surpassing any demographic cohort, including the elderly.

Although age is a risk factor, gender disparity in relation to suicide is important to identifying high risk factors that aid in suicide prevention initiatives. According to data from the Centers for Disease Control and Prevention, males complete suicide at a rate four times higher than females and represent 79.4% of all U.S. suicides, yet female attempt suicide at three times the rate of males. It is assumed that the higher male completion rate comes in part because of the male tendency to use more lethal means. Firearms are the most commonly used method of suicide among males (57.6%).

Among some of the statistics associated with male suicide:

- According to *Morbidity and Mortality: Suicidal Thoughts and Behavior Among Adults ≥ 18 years 2008-2009,* a report published by the Centers for Disease Control and Prevention in 2011, Texas ranks first in male suicide attempts nationally (http://www.cdc.gov/mmwr/PDF/ss/ss6013.pdf).
- Men are a statistically vulnerable group, representing a 2007 aggregate suicide completion rate of 18.4 per 100,000/population in the United States. Among males, non-Hispanic elderly males age 85 or older had a staggering rate of 43.9 per 100,000/population in 2007, followed by men aged 75-84 at a rate of 35.8. Men 65 and older account for about 10 percent of the U.S. population, but more than 33% of suicides are among men in this age group.
- However, as a portion of the male population dying by suicide in 2007, men ages 30-64 account for 50% of all male suicides, representing a growth in middle-aged deaths from suicide. Part of the reason for men's higher rate of suicide may be that they are less likely to talk about their feelings or to seek treatment for mental illness because of the stigma attached to mental illness. Some men may not recognize their irritability, sleep problems, loss of interest in work or hobbies, and withdrawal as signs of depression. Men may also try to mask their feelings with alcohol or drugs, or to work excessively long hours.

The Centers for Disease Control and Prevention data cited above can be found at:
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5904a1.htm - tab4

Women

A woman takes her own life every 90 minutes in the U.S., but it is estimated that one woman attempts suicide every 78 seconds.

American Foundation for Suicide Prevention

According to the Centers for Disease Control and Prevention's report *Morbidity and Mortality: Suicidal Thoughts and Behavior Among Adults ≥ 18 years 2008-2009,* Texas women account for the highest number of suicide attempt rates in the United States, tying for 7th place as a percentage of population. The higher rate of attempted

suicide in women is attributed to the elevated rate of mood disorders among females. According to the Women's Health Council of Rhode Island's article titled "High Risk Mood Disorders: Depression and Suicide," it is estimated that twice as many women as men will be diagnosed with a major depressive disorder in their lifetime. The same article cites a World Health Organization prediction that by 2020, the leading disability among women worldwide will be depression; who experience more severe symptoms than men.

This article can be found at**:** http://www.womenshealthcouncil.org/new-ideas-2/clinical-care/high-risk-mood-disorders-depression-and-suicide

Suicide is more common among women who are single, recently separated, divorced or widowed. The precipitating life events for women who attempt suicide tend to be interpersonal losses or crises in significant family or social relationships. Sixty to 80 percent of women experience transient depression and 10 to 15 percent of women develop clinical depression during the postpartum period following childbirth. In fact, the American Foundation for Suicide Prevention points out that many women who suffer from manic-depressive illness experience their first episode in the postpartum period.

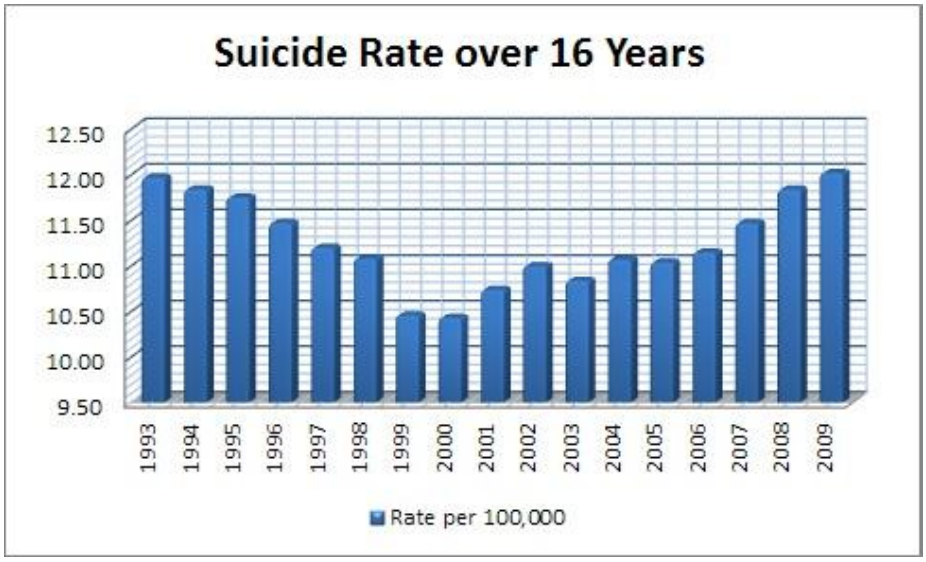
The suicide rates for women in the U.S. peaks between the ages of 45-54 and again after age 75.

Summary

There are many populations that are vulnerable to suicidal thoughts and tendencies. A summary from the home page of the American Foundation for Suicide Prevention is located below and at:

http://www.afsp.org/index.cfm?page_id=04EA1254-BD31-1FA3-C549D77E6CA6AA37

Figure 4-9



The latest data available from the Centers for Disease Control and Prevention indicates that 36,909 suicide deaths were reported in the U.S. in 2009. This latest rise places suicide again as the tenth leading cause of death in the U.S. Nationally, the suicide rate increased 2.4 percent over 2008 to equal approximately 12.0 suicides per 100,000 people. Also, the rate of suicide has been increasing since 2000; making it the highest rate of suicide in fifteen years.

Additionally:

- Every 14.2 minutes someone in the United States dies by suicide.
- Nearly 1,000,000 people make a suicide attempt every year.

- 90% of people who die by suicide have a diagnosable and treatable psychiatric disorder at the time of their death.
- Most people with mental illness do not die by suicide.
- Data indicates that yearly medical costs for suicide at nearly $100 million (2005).
- Men are nearly 4 times more likely to die by suicide than women. Women attempt suicide 3 times as often as men. Click here to view or see: http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_ID=04ECB949-C3D9-5FFA-DA9C65C381BAAEC0
- Suicide rates are highest for people between the ages of 40 and 59. Click here to view or see: http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_ID=04EB7CD1-9EED-9712-89C9540AFCB44481
- White individuals are most likely to die by suicide, followed by Native American peoples. Click here to view or see: http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_ID=D5A38B52-D93A-35D9-B8FAC9B6687929BE

Source: American Foundation for Suicide Prevention, http://www.afsp.org/

Additionally, it is important to note that suicide is a preventable condition. The underlying causes of suicide can be treated. Depression and suicide are treatable and preventable conditions with a significant prevalence in children and adolescents between the ages of 10 to 24 years. 90% of the suicides that occur are due to undertreated or untreated mental illness with the most prominent being depression. Over the previous two decades, mental health conditions, particularly major depressive disorder, are occurring at increasing rates, where most studies indicate a rate as high as 20 percent in the general population. Youth are not immune to mental illness.

War and related outcomes such as deployments, absences of spousal support, wounded soldiers, and geographic relocations have an effect on children, spouses and service members. Military conflicts have placed burdens on military families, placing family members at high risk for depression, which can lead to suicidal behaviors.

Rapid assessment with mental health and suicide screening tools can assist primary care providers in identifying struggling Americans of all ages with mental health conditions.

High Risk Factors

Coupled with high-risk populations are factors that are indicative of increased risk. Alcohol and substance use, bio-psychosocial, and sociocultural factors all play into the risk equation for suicide.

As stated previously, The Centers for Disease Control and Prevention estimates that up to 90% of persons attempting or completing suicide have an underlying form of mental illness that can be treated. Therefore, it is imperative that improved awareness, understanding, and treatment methods are developed in order to preempt the development of suicidal tendencies. As surveillance techniques identifying high risk factors become more prevalent and improved, suicide prevention outcomes will also improve.

http://www.cdc.gov/

According to American Association of Suicidology and the Suicide Prevention Resource Center, there are several high risk factors that increase the likelihood of suicide. These generally can be thought of in three inter-related Factor Categories: Bio-psychosocial, Environmental, and Sociocultural.

http://www.suicidology.org/home
http://www.sprc.org/

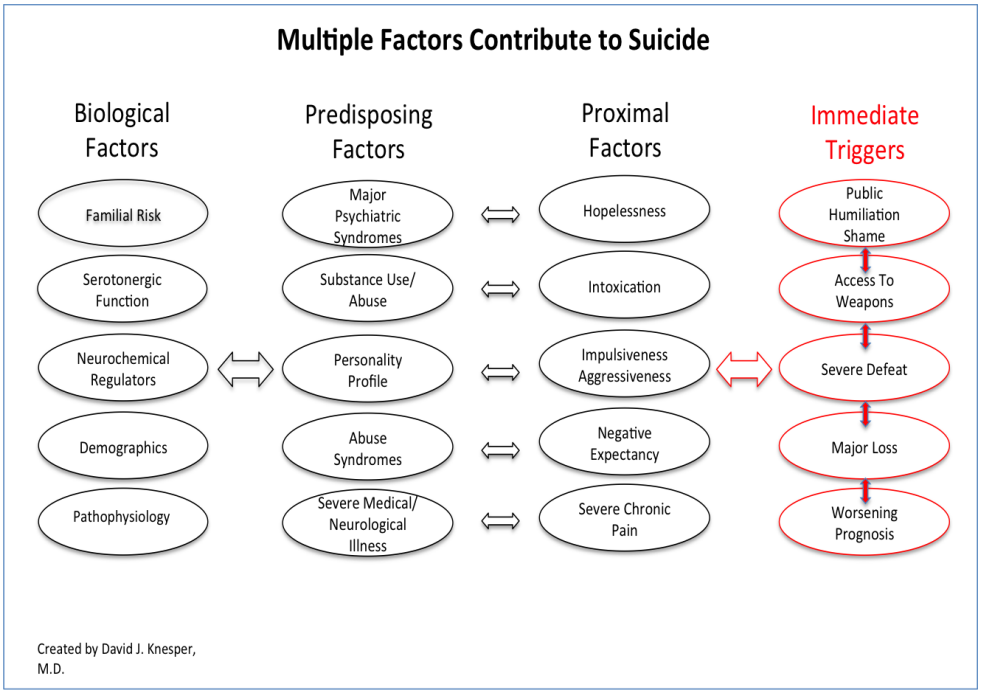
Bio-psychosocial Risk Factors	
▪ Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders ▪ Hopelessness ▪ History of trauma or abuse	▪ Previous suicide attempt ▪ Alcohol and other substance use disorders ▪ Impulsive and/or aggressive tendencies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

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

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

Figure 4-10

Another risk factor model, available through the Substance Abuse and Mental Health Services Administration's (SAMSHA) Suicide Fact Sheet, identifies multiple contributing factors as indicating factors and triggers associated with suicidal tendencies. Developed by Dr. David J. J. Knesper, M.D, at the University of Michigan, this model can be thought of as a four-pronged approach to key suicidal factors, the final of which serves as immediate "triggers."



http://psy.psych.colostate.edu/CICRC/summit2011/presentations/Rodgers_Philip.pdf

Information about risk and protective factors for attempted suicide is more limited than that on suicide. One problem in studying non-lethal suicidal behaviors is a lack of consensus about what actually constitutes suicidal behavior (O'Carroll et al., 1996). Should self-injurious behavior in which there is no intent to die be classified as suicidal behavior? If intent defines suicidal behavior, how is it possible to quantify a person's intent to die? The lack of agreement on such issues makes valid research difficult to conduct. As a result, it is not yet possible to say with certainty that risk and protective factors for suicide and non-lethal forms of self-injury are the same. Some authors argue that they are, whereas others accentuate differences (Duberstein et al., 2000; Linehan, 1986).

Additional Sources:

August 2012 Duberstein, P.R., Conwell, Y., Seidlitz, L., Denning, D.G.,
Cox, C., and Caine, E.D. (2000). "Personality traits and suicidal behavior and ideation in depressed inpatients 50 years of age and older." *Journal of Gerontology*, 55B, 18-26.
Linehan,.M.M. (1986). "Suicidal people: One population or two?" Annals of the New York Academy of Sciences, 487, 16-33.
Moscicki, E.K. (1997). Identification of suicide risk factors using epidemiologic studies. Psychiatric Clinics of North America, 20, 499-517.
O.Carroll, P.W., Berman, A.L., Maris, R.W., Moscicki, E.K., Tanney, B.L., and Silverman, M.M. (1996). Beyond the tower of Babel: A nomenclature for suicidology. Suicide and Life-Threatening Behavior, 26, 237-252."

Source: National Strategy for Suicide Prevention: Goals and Objectives for Action.
http://www.samhsa.gov/prevention/suicide.aspx

Best Practices for Community-Based Prevention and Intervention

Chapter 5

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Goals of Prevention

The ultimate goal of any suicide prevention program is to prevent suicide. To accomplish this, however, there are numerous underlying components that can aid or hinder our success in achieving suicide prevention. When developing suicide prevention initiatives, it is important to keep these in mind as we move our communities towards our ultimate goal.

In 2001, the *National Strategy for Suicide Prevention* was developed through a collaborative effort of SAMHSA, CDC, NIH, NRSA, and HIS, and is scheduled to be updated in 2012. These eleven goals serve as a blueprint for developing community-based programs in Texas though the *Texas State Suicide Plan for Suicide Prevention*. These goals are:

Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable
Goal 2: Develop Broad-based Support for Suicide Prevention
Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services
Goal 4: Develop and Implement Suicide Prevention Programs
Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm
Goal 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment
Goal 7: Develop and Promote Effective Clinical and Professional Practices
Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services
Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media
Goal 10: Promote and Support Research on Suicide and Suicide Prevention
Goal 11: Improve and Expand Surveillance Systems

The *Texas State Plan for Suicide Prevention*, adopted in September 2011 by the Texas Suicide Prevention Council, provides local and state level objectives and strategies for suicide prevention in the state. Texas Suicide Prevention Council members are actively working towards their implementation. The Texas plan will be updated following the release of the new National Plan.

The *Texas State Plan for Suicide Prevention* can be found in the appendix of this toolkit and online at: http://www.TexasSuicidePrevention.org/pdf/TexasStatePlanforSuicidePrevention2011-30apr2012.pdf

The *Texas State Plan for Suicide Prevention*, utilizing the eleven goals of the national plan, has Texas-specific action steps for implementation, which are contained in the document described above. Additionally, this plan has incorporated recent recommendations prepared by the Suicide Prevention Resource Center (SPRC) and Suicide Prevention Action Network USA (SPAN USA), a division of American Foundation for Suicide Prevention, dated August 2010.

Currently, the Texas Suicide Prevention Council is responsible for the successful implementation of the *Texas State Plan for Suicide Prevention*. Statewide organizations participating in its implementation have signed a letter of agreement by which they agree to support one or more of the goals contained in the plan.

Local coalitions have also signed a Letter of Agreement indicating they have formed a local coalition to address suicide prevention in their community or on a college campus, will support the *Texas State Plan for Suicide Prevention*, will work to develop a local suicide prevention plan and will meet at least four times per year. At

present there are 22 statewide partners and 21 local coalitions. Mental Health America of Texas serves as the fiscal agent for the Texas Suicide Prevention Council. Samples of these agreements are contained in Appendix C of this toolkit.

Coalition Building: Coalitions are Key to Successful Prevention

The key to lowering our community suicide rates are to have prevention, intervention, and postvention programs linked between schools, community agencies, and state systems. We need everyone to be at the table.

Scott Poland
Past President, National Association of School Psychologists

As the above quote indicates, collaboration is a key aspect of successful suicide prevention at the local, state and national levels. By utilizing a partnership approach, suicide prevention initiatives can be better coordinated, leveraged and enhanced by sharing lessons learned, resources, expertise, and most importantly, communications. The value of these exchanges made available by collaborative partnerships is improved by orders of magnitude contrasted to independent "islands" of effort. There is so much to learn, share, and build from; coalitions and other forms of collaboration are essential and vital to improving suicide prevention outcomes.

Coalitions are groups of people and organizations that join together to accomplish goals that no one organization or individual could do alone. Building and sustaining collaboration is essential to a community-based approach to suicide prevention. But it can also be challenging, because it often involves coordinating the efforts of a wide range of interests. Fortunately, there are many resources available to assist in this process. As you begin or enhance your community's suicide prevention initiatives, leveraging the power of community-based coalitions is essential to this effort.

The Prevention Institute's *Developing Effective Coalitions: An Eight Step Guide* can serve as a valuable resource in your efforts at coalition-building, even though it was not developed specifically for suicide prevention, but for more general injury prevention coalition-building. The guide details these key steps to coalition building:

- **Analyze objectives.** This is a necessary step to deciding whether to even form a coalition, depending on the program objectives and the resources available.
- **Recruit members.** It's important to recruit the right people with the appropriate interests and skill sets relative to your goals.
- **Determine objectives and activities**. This involves bringing together the objectives of all the member groups of the coalition.
- **Convene the coalition.** The first meeting of potential members of a coalition is critical to making sure that everyone involved agrees on the coalition's goals, structure, mission and membership.
- **Anticipate resource needs.** Resources don't necessarily mean financial resources; you must also anticipate what the coalition will need in terms of members' time spent on operational tasks and other activities.
- **Define the coalition structure.** Determining when the coalition will meet, how it will make decisions and set agendas for meetings, and how it will be active in between formal meetings is vital to achieving success.
- **Maintain coalition vitality.** Coalition leaders must work diligently to keep up the enthusiasm of the coalition members and thereby ensure the effectiveness of the coalition.
- **Evaluate and improve.** Evaluation is one of the most important aspects of coalition work, since it is the only way to determine whether your efforts are paying off and what you can do to improve them if they are not. The Prevention Institute's guide details the types of evaluation that can be employed to measure your coalition's effectiveness.

Air Force Suicide Prevention Program: Example of Best in Class Coalition Building

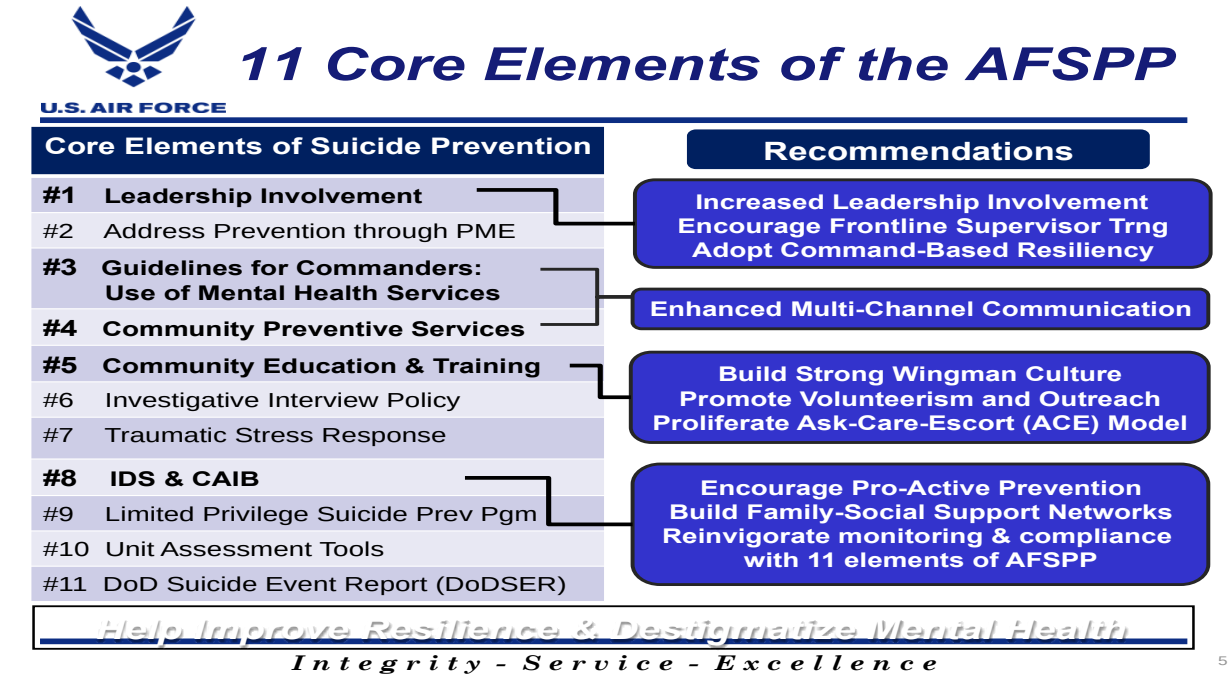
This population-based prevention program enlisted involvement over several years by a broad coalition of community agencies, both inside and outside the health care sector, to significantly reduce suicide among Air Force personnel. Now recognized as a best practices program by the Substance Abuse and Mental Health Services Administration, it serves as a model for successful community-based programs within and external to the military. This discussion is based on a presentation titled "AF Suicide Prevention Program," delivered by Major Michael McCarthy, former assistant deputy chief of staff, Air Force Prevention Program, and can be found at:

http://afspp.afms.mil/idc/groups/public/documents/webcontent/knowledgejunction.hcst?functionalarea=AFSuicidePreventionPrgm&doctype=subpage&docname=CTB_018094&incbanner=0

Background

From 1990-1995, suicide rates were rising at a statistically significant pace among Air Force personnel overall, and among both African-American and Caucasian enlisted male subgroups. By the end of the period, the overall rate was reaching all time record high levels for the Air Force, though it remained comparatively lower than that of the US population overall when corrected for age, gender, and race. Early in 1996, the Air Force Chief of Staff commissioned the Surgeon General to lead a systematic study of the issue and recommend a prevention strategy. The team included representatives of fifteen Air Force functional areas and experts from Centers for Disease Control and Prevention and academia. Employing a data- driven prevention model to guide its search of extant community data, it identified eleven core elements essential to effective suicide prevention. Stigma, cultural norms, and beliefs that combined to discourage help-seeking behavior were identified as major hurdles to successful suicide prevention. These eleven elements are interwoven aspects of policy and education related to suicide prevention. Figure 5-1 below lists the core elements and subsequent recommendations.

Figure 5-1



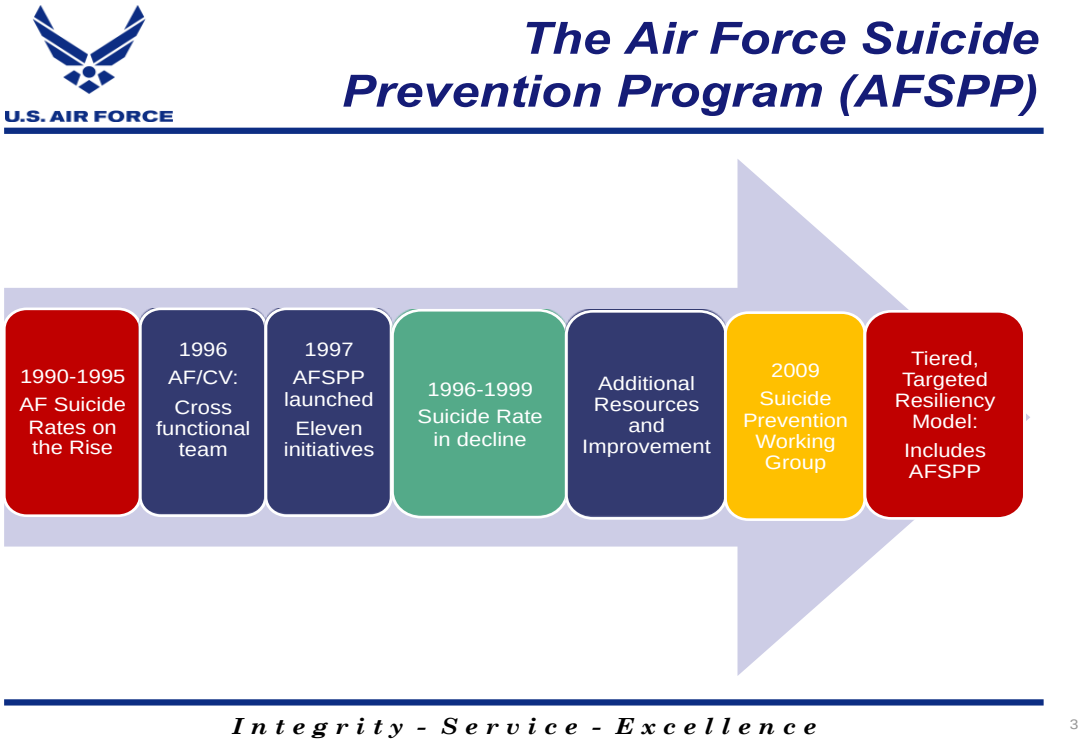
Implemented in 1997 through this task force team, the Air Force embraced suicide prevention as an organizational priority through an atmosphere of responsibility and accountability. This program was designed upon the existing infrastructure and culture within the Air Force, utilizing the core elements listed above.
Further, the work of this effort clearly articulated that suicide prevention was a community responsibility and that was demonstrated through the early and active involvement of leadership.

Since the initial implementation of the Air Force Suicide Prevention program, the Air Force has adopted a "continuous improvement" model to adapt and adjust to changing realities, situational needs resulting from new operating norms (multiple deployments, for instance) and improving technology. For instance, in 2007, computer-based training programs were integrated into the program, displacing a portion of the face-to-face trainings that were occurring prior to that time. As will be discussed shortly, the Air Force is re-establishing more face-to-face trainings in light of lessons learned.

The following chart from Major McCarthy's presentation provides an excellent overview of the timeline associated with the development, implementation, and enhancement of the Air Force Suicide Prevention Program (AFSPP):

Timeline of the Air Force Suicide Prevention Program 1990-2010

Figure 5-2



Initial Implementation: Lessons for Success

Starting a program of this nature requires considerable forethought to the intricate workings of a community's unique culture and needs. The following discussion provides some of the early-stage considerations particularly relevant to initiating a new program. It is hoped that by understanding the breadth and depth of the strategic thinking in the planning process, the learning curve to implementation within a new community can be shortened considerably.

Leadership is Essential

With the strong and visible support of the Air Force Chief of Staff, the cross-functional team began the work of implementing eleven recommendations aimed at mitigating risk factors and strengthening the protective factors for suicide. According to MAJ Michael McCarthy, leadership support—whether it is in military or civilian programs—is essential for success.

Know Your Risk Factors

Understanding the needs unique to your community is paramount to successfully designing a suicide prevention program. For the Air Force, the risk factors identified included problems with the law, finances, intimate relationships, mental health, job performance, and alcohol and other substance abuse. These were often further complicated by social isolation and poor coping skills. The team identified three key protective factors: a sense of

social support, effective coping skills, and policies and norms that encourage effective help-seeking behaviors.

Changing Social Norms: Promoting Social Support and Help-Seeking Behavior

Through a series of hard-hitting messages, the Air Force Chief of Staff repeatedly and unequivocally communicated the urgent need for Air Force leaders, supervisors, and frontline workers to support each other during the inevitable times of heightened life stress. Whether encountering the break-up of an intimate relationship, financial difficulties, legal problems, or frequently some combination of these, Air Force personnel were encouraged to personally offer assistance where possible and to promote use of community resources when necessary.

He specifically encouraged airmen to seek help from mental health clinics and pointed out that when airmen seek help early it is likely to enhance their career rather than hinder it. Further, he instructed commanders and supervisors to support and protect those who responsibly seek this kind of help. Finally, he removed policies that acted as barriers to mental health care for those being charged with violations of military law.

Today, the underlying premise of the 11 Core Elements is to improve resilience and de-stigmatize mental health. To do so takes a coordinated effort across a wide range of education, training, human resource, social systems, and communications systems:

- Increased leadership involvement
- Adopt Command-Based Resiliency
- Build Strong Wingman Culture
- Proliferate Ask-Care-Escort Model
- Build Family-Social Support Networks
- Encourage Frontline Supervisor Training
- Enhanced Multi-Channel Communication
- Promote Volunteerism and Outreach
- Encourage Pro-Active Prevention
- Reinvigorate Monitoring and Compliance with the 11 Elements

Educating a Wide Range of Community Members

The team established policy requiring all Air Force personnel to receive annual instruction on suicide risk awareness and prevention. A curriculum outline was provided at the inception of the program, calling on instructors at each Air Force installation to innovatively develop their presentations. In 2000, the best of the "home-grown" programs were carefully reviewed with the help of nationally recognized experts to produce a best practice tool kit for community education. Visit the website http://afspp.afms.mil for this resource.

Career officers and enlisted members typically complete three professional development courses over the span of their careers. Each of these academic courses is infused with appropriately targeted curricula on suicide prevention to augment their annual training. Students are tested on the curricula.

Further, as the program was implemented and new tools became available, these were incorporated into the training program, such as the implementation of computer-based tools described previously.

Improving Surveillance Through Tools and Communication

The importance of ongoing communication cannot be underestimated in a community-based suicide prevention program. In the Air Force, this communication extends up and down the command chain. Senior Leadership is actively involved in this process by receiving weekly updates on suicide incidents or threats, leaders are notified immediately on all suspect cases that are Air Force affiliated and a policy is in place that requires local review of each suicide and that lessons learned are shared throughout the Air Force command channels.

In early-stage implementation, a web-based epidemiological database was established to capture demographic, risk factor, and protective factor information pertaining to individuals who attempted or completed suicide. Highly secure to protect privacy, this tool allows leaders to quickly detect suicide clusters or changes in patterns in suicidal behavior that could inform needed change in policies and practices across the Air Force community.

Commanders were given a unit-based survey tool to assess aggregate risk among their subordinates, to inform leadership of the unit's current assessment as well as to compare and contrast an aggregate Air Force population. Based upon these results, a cross-functional team was able to suggest interventions tailored specifically to the needs of each community.

Critical Incident Stress Management: Intervening Real Time

By understanding the risk and protective factors unique to the Air Force, Critical Incident Stress Management teams were established to serve personnel at every installation with deployable teams available to provide additional resources to installations should events warrant. These teams respond to events such as combat deployments, serious aircraft accidents, and natural disasters as well as suicides within the military unit.

Suicide Prevention Does Not Occur in a Vacuum: The Importance of an Integrated Approach to Health Care

The Chief of Staff required the principle agencies at each geographical location to work together to assess the needs of the population they serve, develop a consolidated plan targeting their collective resources to a prioritized list of those needs, collaboratively market the resources to the community, and evaluate the effectiveness of their plan. Several of the agency's headquarters functions contributed funding for training in support of this new initiative. Leaders from the Chapel programs, mental health services, Family Support Centers (providers of financial counseling, career counseling, support services for families of deployed service members, and others), Child and Youth Programs, Family Advocacy (domestic violence prevention), and Health and Wellness Centers are involved on each installation. As a result, this 360° approach envelopes the entire community with tools, education, processes, leadership, communication and surveillance to improve suicide outcomes in the Air Force.

Each of these initiatives are described in detail in Air Force Pamphlet 44-160, The Air Force Suicide Prevention Program, and is available online at:
http://www.e-publishing.af.mil/shared/media/epubs/AFPAM44-160.pdf

The Importance of Continuous Improvement

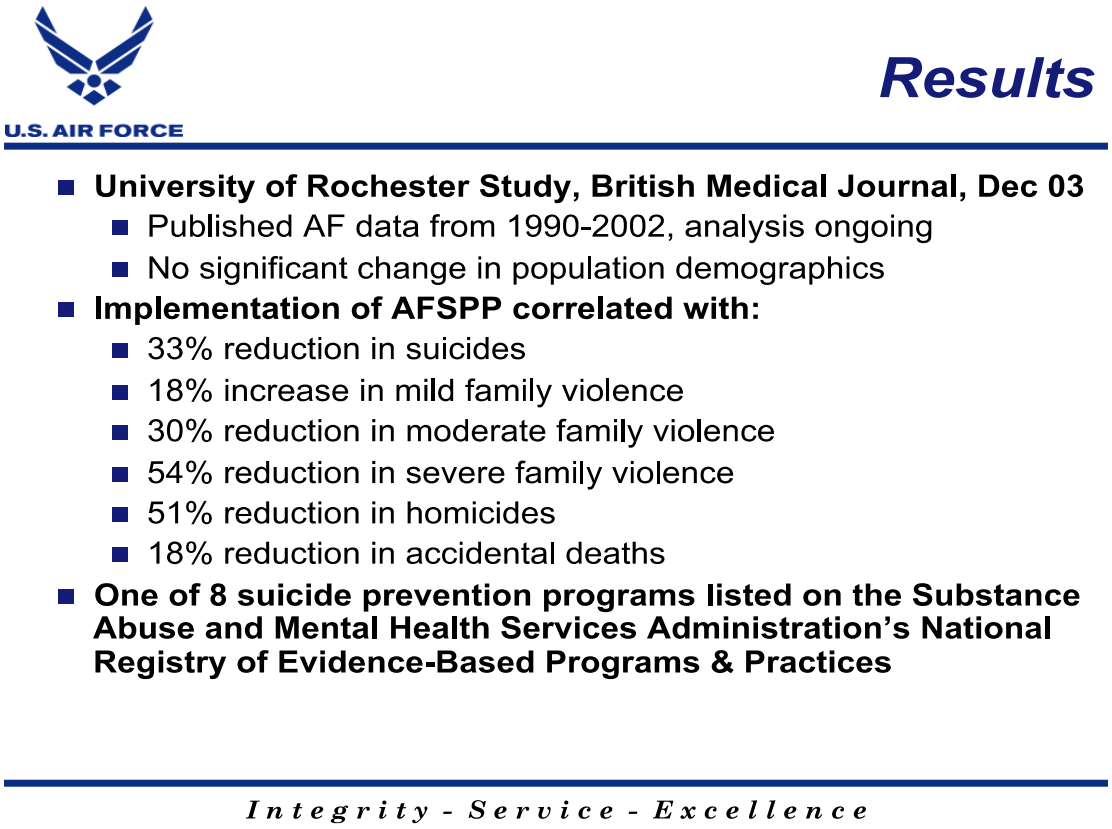
In addition to establishing a culture that is receptive to proactive management of suicide, so too is the Air Force embedding into this program the concept of continuous improvement. As lessons are learned, new tools, techniques and knowledge become available, the Air Force Suicide Prevention Program is adopting new methods for achieving its suicide prevention goals. Some of the recent changes include:

➲ Revised Leaders Guide for Managing Personnel in distress ➲ Increased access to mental health care/ decreasing stigma ➲ Revising AFI 44-154 Suicide and Violence Prevention Education and Training, to improve training of civilian employees and new accessions ➲ Updated Air Force Suicide Prevention website ➲ Renewed line leadership emphasis on program execution ➲ Developing new Training Tools ➲ Review all professional Military Education Curricula	➲ Enhanced tracking to include Air National Guard, civilian employee and family member suicides Mandatory Frontline Supervisor Training for at-risk career fields ➲ Developing Multimodal Strategic Communication Plan ➲ Research collaboration efforts ➲ Expanded use of Multimedia Suicide Prevention Efforts ➲ Initiated Suicide Event Review Boards for improved data collection ➲ Return to live, small group training ➲ Revising policy to improve program performance

Results

The outcomes resulting from the comprehensive, community-based approach implemented by the Air Force have shown to be substantial, not only in reducing the occurrence of suicide, but also other violence categories, such as homicides and family violence.

Figure 5-3



Is the Air Force Program Transferable to Civilian Communities?

Conceptually? Yes. Literally? No.

Suicide prevention does not subscribe to a one-size-fits-all solution. The Air Force community shares many characteristics with other American communities, and yet in some ways is quite distinct, so while many of the concepts are applicable to other environments, it is not possible to precisely replicate this program. For instance, the Air Force, like other communities, has identifiable leaders that can influence community norms and priorities. Human services, including health care, are delivered through a labyrinth of community agencies and organizations that are not always well connected.

The Air Force community has elements of a common identity, but at the same time is a collection of widely diverse individuals. There is an established network of gatekeepers—people who open gates to helping resources for individuals in need. The Air Force is distinct in that its leadership authority is especially concentrated and hierarchical, all members are employed by the same employer, housing and health care—including mental health care—is universally available, the population is pre-screened for serious brain disorders, and the gatekeeper network is unusually well organized.

These distinctions have likely sped the implementation of the program and increased its penetration. Nonetheless, the over-arching principles, such as leveraging community leaders to change cultural norms, engaging and training established networks of gatekeepers, improving coordination of broadly diverse human services, and providing educational programs to community members should be transportable to any civilian community with some minimal level of organization and cohesion.

For more information about the Air Force Suicide Prevention Program, please visit their public website located at:
http://afspp.afms.mil/idc/groups/public/documents/webcontent/knowledgejunction.hcst?functionalarea=AFSuicidePreventionPrgm&doctype=subpage&docname=CTB_018094&incbanner=0

Developing a Suicide Prevention Action Plan: The Importance of a Community-Based Approach

A community-based approach is important because community-wide efforts tend to bring together diverse groups for a common purpose. As a result, the outcomes of your plan will be enhanced by involving a wide variety of community interests early. In addition, because communities are different, especially across a state as diverse geographically, ethnically, culturally and socioeconomically as Texas—it requires close attention to the specific needs and characteristics of each community in order to develop and execute an effective suicide prevention program.

Working together, community groups can help to ensure that their citizens understand the issues associated with suicide, are able to recognize and respond to the warning signs effectively, and promote a community culture that de-stigmatizes mental health and suicide based on their community's needs.

There are multiple considerations when developing a community-based suicide action plan, two of which are the concept of coalitions and the community assessment discussed above. Because resources for initiatives in the area of mental health generally and suicide prevention specifically are so limited, it is important build off existing

efforts to maximize the impact of your suicide prevention action plan. Be careful to consider existing initiatives in an effort to expand and enhance them to reach a broader portion of your community more successfully. By using a coalition-based approach, it is more efficient and effective in gathering essential information about the state of the current level of training and experience in your community. As you recruit members to this coalition, be mindful of the expertise you need not only in understanding suicide prevention, but resources that can reach into key constituent groups to gather information in this area.

One area in which this approach can be particularly helpful is in understanding the level, reach (how many people have been trained) and type of training that has already been conducted in the area of suicide prevention for your community for each stakeholder group. These stakeholder groups are commonly referred to as "gatekeepers;" community resources that serve as a first line of defense against suicide. These groups are:

- First Responders
- Mental Health Professionals
- Healthcare Professionals
- School-based Professionals
- Pastoral Professionals
- Media-Specific (prevention)

Take inventory within these groups to determine:

- The current level of suicide prevention training;
- The key personnel responsible for suicide prevention initiatives
- How suicide prevention plays a role in their day-to-day activities.

Identify training and resource gaps and incorporate these findings into your planning process, even if the resources aren't yet available to solve these issues. It is important to know the total scope and magnitude of need in order to make informed decisions on how best to use limited resources at the community level.

Understanding Best Practices Programs

Prior to developing or establishing a community based prevention program, project or materials, it is important to know whether the information and programs you are communicating to your community is safe and effective in preventing suicide. Because of the wide range and sheer volume of information on the topic of suicide and suicide prevention, in 2005, the Suicide Prevention Resource Center and the America Foundation for Suicide Prevention collaborated to develop the "Evidence-Based Practices Project." This process was expanded in 2007, when a new system launched that provided a comprehensive source to "identify, review and disseminate information about best practices for suicide prevention. Now called the National Registry of Evidence-Based Program and Practices (NREPP), as of 2010, this database also incorporates EBPP programs and more recent entries. This process is governed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of this program was to develop an online database of programs that meet criteria established to ascertain their effectiveness in meeting suicide and suicide prevention. This database delineates between those programs that have achieved an evidence-based classification and those that have not to date. This allows users of this system to make information choices prior to designing and/or implementing training and education in their communities.

As part of this discussion, it is important to know how a program becomes accepted as a "Best Practice." For the NREPP, there are two routes to becoming recognized in the registry. These are:

1. Registry Listing based on Expert Review
2. Registry Listing based on Application

The "Registry Listing based on Expert Review" process involves three steps: 1. Collection of relevant suicide prevention program evaluations; 2. Review program evaluations by at least three expert reviewers; and 3.

classification of each program into one of three categories: insufficient current support—meaning there isn't enough data to support to meet the thresholds established), promising—meaning there appears to be evidence of effectiveness given the thresholds established, and effective—meaning it meets the thresholds established by the expert review team. A comprehensive "scoring" system has been developed to access candidate programs by the expert panelists to assess each program utilizing a consistent framework for evaluation. A more complete discussion of the programs that meet the "promising" and "effective" categories of review, fact sheets are developed that contain the following information:

- Program title and description
- Cultural adaptions
- Evaluation design and outcomes
- Contact information
- Intervention activities
- Universal, selective, indicated populations
- Number/length of follow-up assessments
- Target population, age, gender, and ethnicity
- Urban, suburban, rural settings
- Resources required for implementation

The "Registry Listing based on Application" process provides programs that utilize proven, established methods that have already been developed but applied in a different manner. For programs evaluated under this process, the timeline for evaluation may be expanded to enable a more thorough evaluation that considers theoretically sound approaches additional time for consideration and assessment.

The Best Practices Registry (BPR), a product of the Suicide Prevention Resource Center, incorporates the evaluation and review process outcomes of the NREPP and EBPP in a searchable database format.
For additional discussions about the NREPP and BPR, please see the Suicide Prevention Resource Council's overview at:

http://www.sprc.org/bpr/section-i-evidence-based-programs
http://www.sprc.org/sites/sprc.org/files/bpr/ebpp_proj_descrip.pdf

For a current list of evidence-based suicide prevention programs, please visit the Best Practices Registry for Suicide Prevention (BPR) at the SPRC web site (www.sprc.org).

Texas Suicide Prevention Council as a Vital Resource

The Texas Suicide Prevention Council should be your first stop in developing a community suicide prevention plan. With over 30 community groups and over 20 statewide organizations, TSPC is charged with implementing the *Texas State Plan for Suicide Prevention*. Additionally TSPC also serves as the state's liaison to the national strategic plan.

The Texas Suicide Prevention Council offers a wide range of resources for communities embarking on the creation, implementation and management of suicide prevention efforts. Through its website, community members can find a number of useful documents, including information on hotlines related to suicide prevention. Other resources include: videos, fact sheets, reports, state suicide statistics, laws and statutes specific to suicide topics and other information related to suicide prevention. The website for the Texas Suicide Prevention Council is located at: http://www.texassuicideprevention.org/

In addition to the materials listed above, you will find information on how to join a coalition in your area. The current coalition members of the Council are located in Chapter 3 of this toolkit. These members are valuable

resources, often located nearby and would welcome your involvement in addressing suicide as a public health crisis.

Additionally, the Texas Suicide Prevention Council offers ongoing training, mobile apps, free brochures, conferences, symposiums, and other important resources for Texas communities.

For more information about the Texas Suicide Prevention Council, contact:
Mary Ellen Nudd, Mental Health America of Texas: menudd@mhatexas.org
Merily Keller, Vice-Chair, Local Coalitions: hodgekeller@yahoo.com

Designing, Developing, and Disseminating Information Via Community-Based Tools and Resources

Holding Community Listening Sessions

One powerful tool for coalition building is to hold community listening sessions to gain information and support for suicide prevention initiatives in your community. Community Listening Sessions are open-ended conversations designed specifically to hear the voices of everyone present. They provide excellent opportunities for the community—especially people most affected by suicide—and your organization to share ideas, thoughts, and concerns.

Sessions can be conducted in one or in a variety of community types. In addition, separate sessions can be held with target audiences like professionals, including representatives of families, courts, policy makers, program administrators and front-line staff.

Each participant in the listening sessions has an opportunity to respond to the issues raised and to express his or her opinion.

Developing the Program

- Prepare an agenda and define topics. It may be useful to begin with a general outline of what you would like to cover. Consider how the program will flow. Include an "open-mike" session that allows the audience to challenge opinions, ask questions or offer personal insights. It is recommended that the session last no longer than two hours to keep the presentation lively.
- Identify and screen potential speakers. Refine the perspective that each panelist will offer. Provide a general outline of key points you would like your speakers to address, which is often referred to as "talking points."

Building Participation in the Session

- Promote it to interested groups with a notification of the session to the leadership of key groups. Request that they inform their membership of the session through their newsletter, email, or mail. Enlist the audience participation of as many elected officials and their staff members as you can. Send a letter urging them to attend.
- Promote the session to families and others connected with your issues.

Gaining Visibility

- Encourage newspapers, radio, and television to promote the session in advance. Distribute community calendar announcements to local newspapers, TV, radio, blogs, and cable stations. Be sure to include a telephone number or email address where you can be reached for more information.
- Develop a list of all the media you would like to cover the event. Then, draft and distribute a "media advisory." It should be a brief document that clearly states the basics: who, what, where, when, why and how.
- Consider a media packet or handouts for the media who attend the session. (For free brochures contact: txsuicideprevention@mhatexas.org)
- Follow-up after sending the media advisory.

For more information on working with the media, follow the link below to reference *Recommendations for Reporting on Suicide*
http://texassuicideprevention.org/pdf/RecommendationsForReportingOnSuicide.2011.pdf

Planning Guide-Logistics

- Form a Working Committee. Divide responsibilities among members to help the session run more efficiently. Consider appointing the following positions:
    - Planning Coordinator to coordinate meetings, monitor progress on session plans and see that deadlines are met.
    - Local Host/Moderator to conduct a pre-hearing meeting of panelists and facilitate the session.
    - Site and Logistics Coordinator to manage all site logistics, including surveying and finding a location and arranging for audio/visual and other on-site requirements.
    - Panelist Recruiter to identify key groups/individuals to screen speakers and recommend and manage panelists.
    - Presentation Coordinator to refine the session agenda and define issues for discussion.
    - Media Relations Coordinator to generate media attendance and coverage.
    - Arrange all location needs. Consider holding sessions at a local library, hospital, or other public meeting place.
    - Identify key groups/individuals. First outline the types of individuals who could make a contribution to the session, such as health and mental health care professionals; representatives of advocacy groups; allied health professionals; representatives of community-based health programs; public health officials; candidates and elected officials; and families.
- The panelist recruiter should begin by sending a letter to all members in your working group asking them to do two things:
    - Recommend potential speakers
    - Identify families to include on the program
- Have a list of alternative speakers built into your planning process to prepare for scheduling conflicts and cancellations.

Community Assessment:

In addition to understanding the suicide history of your community through the data generated in the previous chapter, it is also important to assess some of the conditions and factors that are at work in your community. Some of these are social, economic, education, cultural, ethnic, accessibility to mental health and health care services and other important indicators. By gaining understanding into the unique composition of your community with suicide prevention as the context, an effective and efficient suicide prevention plan can be developed.

The Suicide Prevention Resource Center has developed a tool for assessing a community's risk profile, based on a community assessment tool developed by the Suicide Prevention Program at the Massachusetts Department of Public Health. Titled *Suicide Prevention Community Assessment Tool*, it is located at:

http://www.sprc.org/sites/sprc.org/files/library/catool.pdf

Gatekeeper Training

It is essential to identify and learn how to access resources before a crisis. Gatekeeper training in a mental health CPR is a valuable asset and the key to reaching those in need.

Debra Boyd
Public Health Nurse and Survivor, Bastrop

Suicide represents the most extreme state of personal crisis, and we must respond by helping people talk about their inner struggles instead of losing hope and destroying themselves and those that care about them.

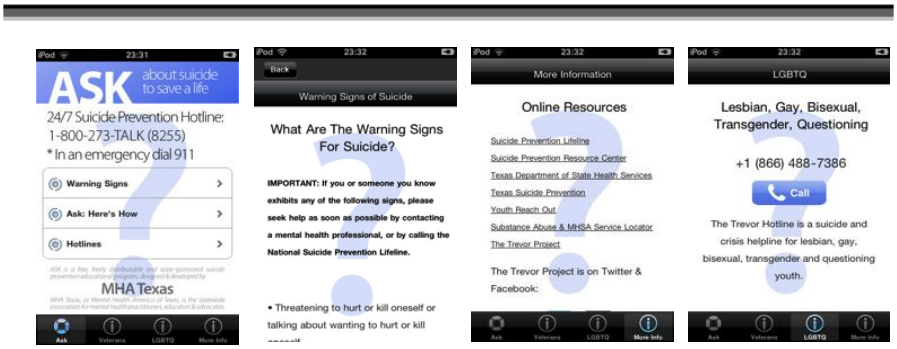
Margie Wright
Executive Director, Suicide and Crisis Center of North Texas, Dallas

Gatekeeper training is an essential component of any suicide prevention plan. Ensuring that persons and organizations with "front line" responsibilities are equipped with evidence-based programs, processes and information is key in suicide prevention and postvention, to limit any contagion, cluster or copycat suicide patterning.

One such training program, and companion smartphone app is ASK. The ASK gatekeeper training program was developed for Texas by the Texas Suicide Prevention Council.

Right: screenshots from the iPhone app.

Figure 5-4



There are numerous best practices programs targeting stakeholder and gatekeeper profiles that are proven effective. The following matrix, developed by the Suicide Prevention Resource Center, highlights several from the Best Practices Registry.

An online version of the following matrix can be found at:
http://www.sprc.org/sites/sprc.org/files/library/SPRC_Gatekeeper_Matrix.pdf

Table 5-1

Program	Audiences	Program Highlights
Applied Suicide Intervention Skills Training (ASIST)	▪ **Who is trained:** Caregivers (e.g., those seeking to reduce immediate risk of suicide), clergy, counselors, community volunteers, law enforcement ▪ **Who is helped:** Clients of caregivers; individuals at risk for suicide ▪ **Size of training group:** Groups of 15, 24, or 30 in 'training for trainers'; up to 30 in 'training for gatekeepers'	▪ Participatory work groups ▪ Mini-lectures, facilitated discussions, group simulation, and role play ▪ Training in suicide first aid *Also available in French; can be culturally adapted
Army's ACE Ask, Care, and Escort	▪ **Who is trained:** Soldiers and junior leaders ▪ **Who is helped:** Soldiers at risk for suicide ▪ **Size of training group:** Unspecified	▪ Encourages soldiers to directly and honestly question any battle buddy who exhibits suicidal behavior. ▪ The battle buddy should ask a fellow soldier whether he or she is suicidal, care for the soldier, and escort the soldier to the source of professional help
At- Risk for High School Educators	▪ **Who is trained:** High school educators ▪ **Who is helped:** High school students ▪ **Size of training group:** Unspecified (Note: a training for middle school educators is in development and will be available in the fall of 2012)	▪ One-hour, web-based training that teaches high school educators how to identify students exhibiting signs of psychological distress, approach and make a referral to school support services ▪ During the training, learners assume the role of a high school teacher concerned about two or three students, explore each students' profile and engage in simulated conversations with each student
At- Risk for University and College Faculty	▪ **Who is trained:** College and university faculty and staff ▪ **Who is helped:** College and university students ▪ **Size of training group:** Different site licenses are available	▪ Web-based simulation that allows learners to analyze profiles (include information on academic performance, behaviors, and physical appearance) of virtual students and interact with them ▪ Information on symptoms of mental distress (including depression, anxiety, and suicidal thoughts) ▪ Customizable features that allow incorporation of campus-specific resources and referral points
Be A Link!	▪ **Who is trained:** Adult community members (e.g., school staff/faculty, first responders, social workers, religious leaders, etc.) ▪ **Who is helped:** Youth at risk for suicide (10-18 years of age) ▪ **Size of training group:** Minimum of 10 participants in 'training for trainers' at Yellow Ribbon site; minimum of 20 in 'training for trainers' at local site (group can be mixed or by discipline); up to 90 in 'training for gatekeepers'	▪ Information on risk factors and warning signs for suicide, community referral points for help, and crisis protocols ▪ Training uses PowerPoint presentation (provided on a CD) and ▪ 'Be A Link' trainer's manual (includes talking points for each PowerPoint slide, program overview and outline, FAQ, preparation worksheet, and links to additional resources) ▪ Recommendations for safe and effective messaging

Program	Audiences	Program Highlights
Campus Connect	▪ **Who is trained:** College and university faculty, staff, and students ▪ **Who is helped:** College and university students at risk for suicide ▪ **Size of training group:** Up to 25 participants in 'training for trainers'; up to 30 participants in 'training for gatekeepers'	▪ Information on suicide statistics, risk/protective factors, warning signs, and referral sources ▪ Skills training on listening to, communicating with, and engaging at-risk students ▪ Final role play activity to practice skills
Connect/ Frameworks Community-Based Training for Gatekeepers and Key Service Providers *Prevention*	▪ **Who is trained:** Community members, professional service providers (schools, hospitals, police, mental health and/or other services, faith leaders, military) Note: Specific training modules for different professions ▪ **Who is helped:** Individuals at risk for suicide ▪ **Size of training group:** Up to 20 participants in 'training for gatekeepers'	▪ Training on coordination, communication, and connections among resources and stakeholders in the community ▪ Rehearsal of vignettes that demonstrate integrated community responses ▪ Information about stigma reduction, safe messaging, and promotion of help-seeking behavior ▪ Discussion/steps for lethal means restriction
Connect/ Frameworks Community-Based Training for Gatekeepers and Key Service Providers *Postvention*	▪ **Who is trained:** Community members, professional service providers (law enforcement/first responders, coroners, military, faith leaders, educators, mental health clinicians, social service agencies, funeral directors) ▪ **Who is helped:** Survivors and community members in the aftermath of a suicide ▪ **Size of training group:** Up to 20 participants in training for gatekeepers and professional service providers	▪ Enhances collaboration and coordination to provide the most effective intervention ▪ Assures outreach and prevention through rapid and comprehensive communication, including best practices, safe messaging, appropriate memorial services and media guidelines ▪ Engages resources to help survivors and the community with grieving and healing
EndingSui-cide.com	▪ **Who is trained:** Health professionals and school professionals ▪ **Who is helped:** At-risk clients ▪ **Size of training group:** Unspecified	▪ Modules range from the introductory-level materials for those without health training to more complex modules for practicing health professionals ▪ Each modules is based on a needs analysis, and includes educational objectives, need, goal, author bios, and disclosure information
Late Life Suicide Prevention Toolkit	▪ **Who is trained:** Front-line providers, medical and mental health care clinicians, and health care trainees ▪ **Who is helped:** Older adults ▪ **Size of training group:** Unspecified	▪ Toolkit focuses on how to identify suicide warning signs, establish rapport and assess suicide risk and resiliency factors, and manage immediate and ongoing risk for suicide among older adults ▪ Toolkits is based on Canadian Coalition for Seniors' Mental Health National Guidelines on the Assessment of Suicide Risk and Prevention of first ever interdisciplinary, evidence-based guideline on the topic.)
Let's Talk Gatekeeper Training	▪ **Who is trained:** Foster parents and adults who care for children ▪ **Who is helped:** At-risk youth ▪ **Size of training group:** Unspecified	▪ Training includes content about myths and facts about suicide, risk and protective factors for suicide, warning signs of suicide, and how to communicate with at-risk youth
Making Educators Partners in Youth Suicide Prevention	▪ **Who is trained:** Educators and school staff ▪ **Who is helped:** At-risk youth ▪ **Size of training group:** Unspecified	▪ Focuses on practical realities inherent in the school setting ▪ Uses informed commentary from experts in mental health and suicide prevention ▪ Training includes fifth module that allows viewers to email specific questions to a panel of experts

Program	Audiences	Program Highlights
More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel	▪ **Who is trained:** Teachers and other school personnel. The program is also suitable for parents and other adults who care for or work with youth ▪ **Who is helped:** Teens/youth ▪ **Size of training group:** Unspecified	▪ The program is built around two 25- minute DVDs intended for teens and to show adults how a potentially life- threatening mental health disorder can present in teens ▪ Also included are a 42 page instruction manual for program participants and slides for teacher trainers
Operation S.A.V.E.: VA Suicide Prevention Gatekeeper Training	▪ **Who is trained:** Veterans and those who serve veterans ▪ **Who is helped:** Veterans ▪ **Size of training group:** Unspecified	▪ Components of the S.A.V.E model include: Signs of suicide, Asking about suicide, Validating feelings, Encouraging help and Expediting treatment
QPR (Question, Persuade, Refer)	▪ **Who is trained:** Lay and professional gatekeepers ▪ **Who is helped:** Individuals at risk for suicide ▪ **Size of training group:** Minimum of 10 participants in a live training for trainers; up to 35 participants in a live training for gatekeepers	▪ Multimedia format ▪ Training uses "chain of survival" approach for recognizing and responding positively to warning signs and behaviors ▪ Training on questioning at-risk individuals in order to determine suicide intent/desire, persuading a person to agree to seek help, and referring a person to appropriate resources ▪ *Also available in other languages; can be culturally adapted
Student Support Network	▪ **Who is trained:** Campus student leaders ▪ **Who is helped:** Campus students ▪ **Size of training group:** Unspecified	▪ Core training components include knowledge of mental/behavioral health issues and campus/ community resources; intervention skills, including empathic responding and working with resistance; connecting identified students with a wide ranges of student helpers; promoting attitudes which de-stigmatize mental health help- seeking ▪ Students are actively recruited to participate in the SSN program based on their high level of involvement/leadership on campus and their desire to help others
Suicide Alertness for Everyone (safeTALK)	▪ **Who is trained:** Anyone ages 15+ years in a position to help (e.g., parents, students, teachers, front-line workers and supervisors, police, emergency responders, human resources personnel) ▪ **Who is helped:** Individuals at risk for suicide ▪ **Size of training group:** Groups of 15, 24, or 30 in 'training for trainers'; up to 30 in 'training for gatekeepers'	▪ Highly structured training that provides graduated exposure for practicing actions ▪ Six 60-90 second video scenarios, each with non-alert clips, are selected from a library of scenarios and strategically used throughout the training
Suicide Prevention Training for Gatekeepers of Older Adults	▪ **Who is trained:** Those who have regular contact with older adults ▪ **Who is helped:** Older adults ▪ **Size of training group:** 6 to 20 participants	▪ The training is organized into five sessions including, overview of aging, mental health, and suicide, risk and protective factors for suicide; working with older adults at risk for suicide; ongoing care and support of older adults at risk for suicide; self care

Program	Audiences	Program Highlights
Working Minds: Suicide Prevention in the Workplace	▪ **Who is trained:** Workplace administrators and employees ▪ **Who is helped:** Workplace employees ▪ **Size of training group:** Up to 40 participants	▪ Builds a business case for suicide prevention, creates a forum for dialogue and critical thinking, and promotes help-seeking and help-giving ▪ Interactive exercises and case studies help employers apply and customize the content to their specific work culture ▪ Three format options offered: 1-hour "lunchtime" presentation, 1.5-hour in-service workshop, 3.5-hour intensive training

However, as noted by the Suicide Prevention Resource Center, gatekeeper training is one—and only one—component of a community's suicide prevention strategy. While many of these programs can be implemented cost-effectively, it is done so only after your community's needs have been assessed to determine its needs and what role gatekeeper training can and should play.

Organizing a Speakers Bureau

There are numerous resources available in Texas to provide ongoing educational opportunities, to motivate people in your community, and to keep your focus on the task at hand while offering new perspectives on suicide prevention.

Locally, it is wise to be proactive in developing a range of speakers so that you are always prepared to address the needs of a variety of community organizations, such as parent-teacher organizations, civic groups, lay ministries, and others. It is also suggested that all speakers be trained and aware of the public health aspects of suicide prevention, intervention, and postvention and have a mental health professional review the speech outline ahead of time (if the speaker is not a mental health professional). A list of suggested topics is located below.

Keep in mind that for most organizations, there are certain times of year (such as in the summer) when scheduling may take place up to a year in advance. Some individuals are available to speak for free, others will need to have expenses covered, and others will expect a speaker's fee.

When seeking local speakers, identify individuals who are knowledgeable about the suggested topics and emphasize utilizing the information provided in the toolkit. Once you have identified some local resources, offer to listen to the material they plan to present and give them feedback before they present it to a group. Inexperienced speakers may benefit from these tips:

- Speak clearly and vary the pitch of your voice.
- Be precise in filling the time allotted by a group.
- Smile and make eye contact as you speak to the audience.
- Stand and move around a bit.
- Use visual aids if they are helpful, but avoid reading from them verbatim.
- Incorporate information that is relevant to specific groups and ages.
- Include a diversity of culture in your presentation.

When you have a speaker available, get the word out to the community by every available method. Start an email campaign, send public service announcements to the media, ask local television stations about getting coverage, and include the information in your own newsletter or web page. Ask the speaker to help by providing materials that you can use for publicity purposes such as a brief biography and a write-up on the program content and the

key points that will be covered. If you prefer, you can ask the speaker to let you interview him or her in order to get this information to use for these purposes.

At the event itself, assign one person to greet the media and introduce them to the speaker and other key individuals. Make sure the room is set up for the best effect, including temperature, lighting, and seating. See to it that the speaker has everything he or she needs, such as water. Be prepared to introduce the speaker using information he or she has provided to you.

When you are hosting a lecture about suicide, it is advisable to have both a mental health professional and a suicide survivor available in the back of the room in case their attention is required by anyone in the audience who might have personal concerns related to the content of the presentation. Be sure to identify these helping sources at the beginning of the presentation.

After the lecture, ask the attendees to fill out an evaluation that includes a suggestion section. Following the event, select some key quotes from attendees and photographs to include in a media opportunity so that you can continue to address the seriousness of this public health concern. Also, try to have an email contact list that can link the community to your organization, the speaker's, and national suicide prevention organizations. Always include the **1-800-273- TALK (8255)** lifeline number as well as any local hotline numbers in your presentation and handouts.

Topics to Consider

- Data-gathering and statistics
- Community and individual responses to suicide
- Survivorship
- Suicide as a public health problem
- Community organizing for suicide prevention
- Advocacy for suicide prevention
- Suicide prevention for at-risk groups: youth, elderly, men, women, minorities
- Starting support groups for survivors
- Spiritual concerns, memorials and ritual
- Suicide in the criminal justice system
- School-based suicide prevention programs
- Gatekeeper programs
- Professional training in clinical best practices
- Crisis hotlines

Brochures, Fact Sheets, Social Media, Websites, Apps and Other Communication Vehicles

There are a number of communication tools available to community coalitions to infuse your Suicide Prevention efforts into the community. This section talks about several of the most common and readily available forms for community coalitions to use in implementing their communications strategies. This section focuses on prevention; postvention communication will be discussed in a following chapter.

This section is designed to assist you in either developing an effective brochure or fact sheet, or evaluating one of the widely available ones that are available either through print or online. There is a wide range of materials already available from organizations such as:

- **Texas Suicide Prevention Council:** http://texassuicideprevention.org/resources.asp
  The Texas Suicide Prevention Council is the statewide coalition responsible for implementing the State's Suicide Prevention Strategic Plan. TSPC offers a wide range of suicide-related information, data, statistics and materials available to individuals and communities that are specific to Texas.

- **Texas Department of State Health Services:** http://www.dshs.state.tx.us/mhsa/suicide-prevention/

As the State's flagship resource for all health and mental health initiatives, TDSHS offers a variety of information tools (brochures, videos, online) to individuals and communities to assist Texans in meeting a range of vital health information needs.

- **Mental Health America of Texas:** http://www.mhatexas.org
  The State's oldest and largest mental health education and advocacy organization provides information and education tools on mental health issues in Texas. Many of these materials are available in English and Spanish.

- **Suicide Prevention Resource Council:** http://www.sprc.org/library_resources/sprc
  SPRC offers a comprehensive list of information products for download ranging from programs, high risk populations, types of underlying illnesses affecting suicide trends, setting-specific information and other considerations related to suicide, suicide prevention and suicide postvention.

- **American Foundation for Suicide Prevention:** http://www.afsp.org/
  AFSP offers a wide array of information on suicide, prevention and postvention (including surviving suicide). Additionally, there are standardized presentations for use in community discussions about this topic.

- **Substance Abuse and Mental Health Services Administration:** http://www.samhsa.gov
  SAMSHA offers numerous reports and fact sheets for prevention, intervention and postvention related to suicide. A key resource for suicide-related research and data, SAMHSA offers over 400 reports, fact sheets and other materials on its website.

- **American Association of Suicidology:** http://www.suicidology.org/home
  With a focus on the advancement of scientific research in the field of suicideology, AAS provides a wide array of fact sheets and statistics on current efforts to understand and prevent suicide.

- **SAVE:** http://www.save.org
  SAVE offers a variety of brochures, booklets, posters and wallet cards focusing on both suicide prevention and coping with loss, which can be customized to include logos, missions, and contact information of the organization requesting the materials.

- **National Institute of Mental Health:** http://www.nimh.nih.gov
  NIMH provides an extensive listing of statistics on a wide variety of mental health categories, in addition to booklets, brochures, and fact sheets on a variety of topics.

Developing an Effective Brochure or Fact Sheet

In the event you choose to develop your own brochure or fact sheet, this section has been designed to guide you in this process.

Educational or informational brochures must give the reader enough information to understand the issue and take action to prevent suicide. To do so effectively, they must present information in a clear, organized manner. Format is particularly important in achieving clarity. Presenting information in chronological order can be helpful. So can reducing complicated points down to their most important elements, leaving long, detailed explanations and descriptions for the books and research papers.

- Write down what you need to accomplish with your brochure. What are you trying to explain? What task is the reader able to accomplish after reading this brochure?

- Collect and review sample brochures that have a style or format you might like to imitate or borrow. See how much detail each type of brochure includes.
- Research your topic to see what materials are already available on local, state and national levels. Use the materials provided in the classroom or from other sources to gather more details about your topic. If you are explaining a process, decide what background information the reader will need. Are there steps to take in the process? Must the steps be completed in a certain order?
- Consider your target audience and what they know, understand, believe, care about, value, and appreciate. Consider how to appeal to their sensibilities dependent upon the profile you determine for them.
- Determine the major components of your brochure.
- Mark out any components you wish to omit from your brochure. Organize using headings and subheadings.
- Write the descriptive text using language that is appropriate for the audience of the brochure. Lengthy sentences are hard to follow and difficult to fit into the limited space each panel offers. Readers want to get information in a brochure, but they want to get it easily.
- Choose language that is not "slangy" or overly colloquial, and avoid jargon and abbreviations that are not familiar to the general public. Limit the use of acronyms. Spell out any acronyms used at least once and cite the acronym in parenthesis next to the text to convey the meaning. Example: Mental Health America of Texas (MHAT). Too many acronyms could result in the reader misunderstanding your message.
- Have another person not working on the brochure to edit the text. It should absolutely clear, concise, factual and error-free. This helps build credibility and professionalism.
- List your organization's contact information. If necessary, cite the contact information of other professional authorities or organizations that can offer additional resources that supports your message or issue.
- Determine the panel your reader will first view. This panel must make an immediate and accurate impact.
- The text should be enticing and inviting and suggest the general content of the interior of the brochure using limited graphics for this panel to enhance appeal and the overall attractiveness of the design sets a tone for the whole brochure.
- Draft how the brochure may look—including any graphics you think you want to include. Using page layout software, try different formats to fit your text, and edit your text to fit your layout. Some software packages have tools like clip art, websites, templates or wizards that can help you develop a professional tri-fold or single fold brochure.
- Color, graphics, and photos have a powerful impact. A photo or graphic can add interest, a sense of reality and persuasion to the brochure. Graphics and photos should be clear, obviously identifiable and meet your purpose. If budget allows, print using colored and/or select a colored paper to spruce up the brochure.
- Visit a local printing shop or copy shop to discuss your project and your printing needs. They can educate and guide you through the printing process, and work with you on ways to keep your costs within your printing or copying budget.
- Follow the guidelines outlined in *Recommendations for Reporting on Suicide* linked below.

http://texassuicideprevention.org/pdf/RecommendationsForReportingOnSuicide.2011.pdf

Evaluating the Brochure

Once a draft of the brochure has been developed, conduct a focus group comprised of individuals who were not involved in the writing process. Have them read the brochure and take a simple quiz (written or verbal) to determine how well the topic is presented and to gauge their perception and understanding of the material. If necessary, after the group's review, make modifications to the brochure based on the information gathered from your focus group and finalize your draft for printing. If most of the group can easily understand the content and actions listed, the publication will probably work well for the public. Not everyone will agree on the effectiveness

of a single brochure, but if you have done your job well, most readers will agree that your brochure gives them the information they want and need, and it is easy to follow.

Screening Resources

If you believe that someone may be at risk for suicide, there are a number of screening tools available to evaluate the risk that can be implemented within your community. Due to a variety of factors, costs being a major one, screening tools are in limited supply on the Best Practices Registry.

According to Dr. Gregory Brown at the University of Pennsylvania, there are at least two-dozen screening tools available to assess adults that have emerged within the last 10 years.

Table 5-2

Description of Suicide Assessment Measures in Adults

	Mode of Administration				Predictive	Study Settings				
Measure	Self-Report	Interview	Factors	Items	Validity	Psychiatric	Medical	College	Community	Other
Scale for Suicide Ideation		X	2	21	X	X	X	X	X	
Beck Scale for Suicide Ideation	X		3	21		X				
Modified Scale for Suicide Ideation		X	2-3	18		X		X		
Self-Monitoring Suicide Ideation Scale	X			3				X		
Suicide Intent Scale		X	2	15	X	X	X			
Parasuicide History Inventory		X	4	48+		X				
Suicide Behavior Questionnaire	X			4		X		X		
Suicide Behavior Questionnaire-Revised	X		1	34		X			X	
Suicide Behavior Interview		X		4						X
Suicide Probability Scale	X		6	36		X	X	X	X	
Positive and Negative Suicide Ideation Inv.	X		2	20				X		
Adult Suicide Ideation Questionnaire	X		4	25		X		X	X	
Suicide Ideation Scale	X			10				X		
Suicide Status Form	X	X	6	6				X		
Firestone Assessment of Self-Destructive Thoughts	X		3	84		X		X		

Table 1 (continued)

Measure	Mode of Administration		Factors	Items	Predictive Validity	Study Settings				
	Self-Report	Interview				Psychiatric	Medical	College	Community	Other
Risk-Rescue		X		10		X	X			
Self-Inflicted Injury Severity Form		X		7			X			
Lethality Scales		X		8		X	X			
Paykel Suicide Items		X		5					X	
Symptom Driven Diagnostic System for Primary Care (Suicide Items)	X			3			X			
Suicide Ideation Screening Questionnaire		X		4			X		X	
Hamilton Rating Scale for Depression (Suicide Item)		X		1	X	X				
Beck Hopelessness Scale	X		3	20	X	X	X	X		
Beck Depression Inventory (Suicide Item)	X			1	X	X	X	X		
Linehan Reasons for Living Inventory	X		6	48+		X	X	X	X	
Brief Reasons for Living Inventory	X		6	12						X
College Student Reasons for Living Inv.	X		6	46		X		X		
Suicide Opinion Questionnaire	X		5-15	100				X	X	X
Suicide Potential Lethality Scale	X			13					X	X
Quiz on Depression & Suicide in Late Life	X		12					X	X	X
Suicide Intervention Response Inventory	X		4	25					X	X

http://www.hawaii.edu/hivandaids/Review of Suicide Assess for Interven Res w Adults and Older Adults.pdf

Another tool, the Columbia-Suicide Severity Rating Scale (C-SSRS), developed in 2009 by Dr. Kelly Posner, New York State Psychiatric Institute is a recent addition to the available tool set. It is currently available in 103 languages and has been deployed in a variety of settings ranging from emergency rooms, military, college campuses, first responders, justice and juvenile justice, substance abuse, clinical, behavioral health environments. Further, the Centers for Disease Control and Prevention has adopted the Columbia definitions and is part of the new CDC surveillance document. Also, the National Institute of Mental Health recently published an article on its website concerning a study that was conducted on the C-SSRS that demonstrated efficacy in the November 8, 2011 publication of the *American Journal of Psychiatry*.

The C-SSRS has been demonstrated to show successful suicide attempt prediction in both adolescents and adults. According to the C-SSRS website, "It [C-SSRS] is the only screening tool that assesses the full range of evidence-based ideation and behavior items, with criteria for next steps." As a result, the C-SSRS can be useful in conducting initial screenings.

Information about the C-SSRS is located at: http://cssrs.columbia.edu/

In the National Registry of Evidence-Based Practices/Best Practices Registry lists the following as Section 1: Evidence Based Programs:

- *Columbia University Teen ScreenA:* A computer-based program to screen middle school and high school students for depression and suicide ideation. Further information is located at: http://www.teenscreen.org/

- *Signs of Suicide:* Another student-centered screening tool on the Best Practices Registry. SOS is a school-based intervention that includes screening for depression and suicide. SOS has been showed to be effective in reducing suicidality in a randomized, controlled study. Further information is located at: http://www.mentalhealthscreening.org/highschool/

- *Interactive Screening Program:* ISP provides an online mechanism to identify and encourage college students who are at risk for depression to seek treatment. Further information is located at: http://www.sprc.org/sites/sprc.org/files/bpr/ISP.pdf

- *Suicide Assessment Five-step Evaluation and Triage (SAFE-T) pocket card*: Designed for mental health clinicians, the pocket card provides protocols for conducting a suicide assessment, determining risk, identifying protective factors, and developing a treatment plan for patients. Further information is located at: http://www.sprc.org/sites/sprc.org/files/bpr/SuicideAssessmentFiveStep.pdf

Military Screening Tools

There are several screening tools related to military populations. These include the C-SSRS discussed above as well as tools made available by the Deployment Health Clinical Center (DHCC) that include screenings for:
Post Traumatic Stress Disorder (PTSD) for Military, https://www.pdhealth.mil/guidelines/appendix4.asp
Post Traumatic Stress Disorder (PTSD) for Civilians: https://www.pdhealth.mil/guidelines/appendix3.asp
Post Deployment Clinical Assessment Tool: https://www.pdhealth.mil/downloads/PDCAT_v7.pdf
Patient Health Questionnaire: https://www.pdhealth.mil/guidelines/downloads/appendix2.pdf

In addition to the above screening tools, additional information, including primers on each of the above listed assessment tools that include instructions and result interpretation material is located at:

https://www.pdhealth.mil/clinicians/assessment_tools.asp or
https://www.pdhealth.mil/guidelines/downloads/Suicide_Screening.pdf

Best Practices for Community Prevention and Intervention

Introduction

As with any community, different members play different roles, depending on their responsibilities, job descriptions, personal skill set, and community needs. As such, consideration should be given to each general category of community responder for specific training and education requirements unique to their position. Some of these categories are:

- First Responders and Law Enforcement
- Mental Health and Health Care Professionals
- School-based Professionals
- Pastoral Professionals

There are a number of best practices training programs available at the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices located at:

http://www.nrepp.samhsa.gov.

Additionally, the Suicide Prevention Resource Center offers a comprehensive listing of both best practices and "adherence to standards" programs located at:

http://www.sprc.org/bpr/section-i-evidence-based-programs - sec1listings
http://www.sprc.org/bpr/section-iii-adherence-standards - programs.

The American Association of Suicidology has developed and implemented two training programs particularly relevant to the community constituents listed above: *Recognizing and Responding to Suicide Risk* (RRSR) and *Assessing and Managing Suicide Risk* (AMSR). (An additional version of RRSR, called *RRSR-PC* is directed to Primary Care audiences, such as physicians, nurses, nurse practitioners, and physician assistants.)

Information about these programs is located at:
http://www.suicidology.org/web/guest/education-and-training

The American Association of Suicidology's RRSR training identifies 24 core competencies synthesized into eight topical areas. This outline provides an excellent overview of the critical components to training for any suicide prevention initiative. These are:

- Attitudes and Approaches for Working with Suicidal Clients
- Developing a Treatment and Services Plan
- Understanding Suicide
- Managing Care
- Collecting Assessment Information
- Documenting
- Formulating Risk
- Understanding Legal Issues Related to Suicidality

First Responders and Law Enforcement

The Suicide Prevention Resource Center has produced an excellent resource for first responder training titled *The Role of First Responders in Preventing Suicide*, which can be found at the link below. The following provides an overview of the content of this fact sheet and several of the key elements important to training first responders in suicide and suicide prevention.

The Role of First Responders in Preventing Suicide provides:

- Recognizing Warning Signs—(what to look for, questions to ask)
- Helping Suicide Attempters—(how to communicate with a person with self inflicted injuries and steps to take to ensure their safety immediately after an attempt)
- Helping Suicide Survivors—(preparing family members for next steps, dealing with the media, helping survivors to mobilize support networks)

Self Care of First Responders (dealing with stress, identifying warning signs in colleagues and what to do)

http://www.sprc.org/sites/sprc.org/files/FirstResponders_0.pdf.


The Role of First Responders in Preventing Suicide

If you are thinking of hurting yourself, or if you are concerned that someone else may be suicidal, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

Paul was part of a team that responded to an emergency call from a father whose daughter, age 17, had just fallen from the second-story porch of their house. When Paul arrived on the scene, the father was frantic. Paul assured the father that his daughter was in good hands and seemed to have survived the fall with only a broken arm and a bump on the head. He told the father that they would take his daughter to an emergency room for x-rays and a further evaluation just to make sure that she didn't have any other serious injuries. Paul was a bit puzzled as to how the girl could fall off a second-story porch surrounded by a waist-high railing.

Paul asked the father what had happened and if the girl had any medical conditions. The father said that his daughter had been treated for depression. Paul asked if the father thought that she might have jumped from the porch. The father said that his daughter had never tried to hurt herself-that while his daughter had problems, she wasn't the type of person who would try to kill herself.

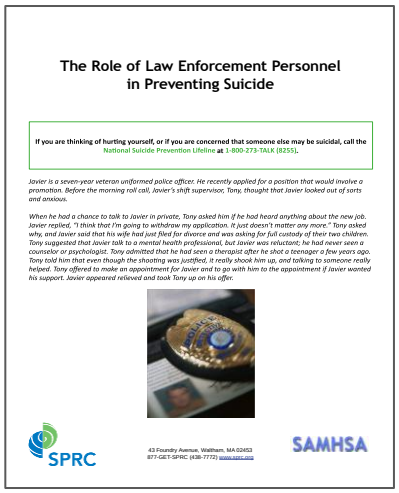
Paul spoke with the young woman in the ambulance on the way to the hospital, telling her what had happened, where they were going, and what would happen when they arrived at the hospital. Paul asked her what had happened before the fall. The young woman replied that she wasn't sure.

Paul spoke to the emergency physician at the hospital when they arrived and reported that this case could have been a suicide attempt. The doctor said that she would carefully assess the patient and thanked Paul for telling her about this possibility.

SPRC 43 Foundry Avenue, Waltham, MA 02453 877-GET-SPRC (438-7772) www.sprc.org SAMHSA

Law enforcement officers are often called to the scene when there is a serious suicide threat. As part of the first responder community, law enforcement has additional special considerations in the area of suicide prevention and play a critical part of the first responder component of their communities.

The Suicide Prevention Resource Center has also developed a fact sheet titled *The Role of Law Enforcement in Preventing Suicide*, which provides important information about suicide prevention. The following provides an overview of the content of this fact sheet.


The Role of Law Enforcement Personnel in Preventing Suicide

If you are thinking of hurting yourself, or if you are concerned that someone else may be suicidal, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

Javier is a seven-year veteran uniformed police officer. He recently applied for a position that would involve a promotion. Before the morning roll call, Javier's shift supervisor, Tony, thought that Javier looked out of sorts and anxious.

When he had a chance to talk to Javier in private, Tony asked him if he had heard anything about the new job. Javier replied, "I think that I'm going to withdraw my application. It just doesn't matter any more." Tony asked why, and Javier said that his wife had just filed for divorce and was asking for full custody of their two children. Tony suggested that Javier talk to a mental health professional, but Javier was reluctant; he had never seen a counselor or psychologist. Tony admitted that he had seen a therapist after he shot a teenager a few years ago. Tony told him that even though the shooting was justified, it really shook him up, and talking to someone really helped. Tony offered to make an appointment for Javier and to go with him to the appointment if Javier wanted his support. Javier appeared relieved and took Tony up on his offer.

SPRC 43 Foundry Avenue, Waltham, MA 02453 877-GET-SPRC (438-7772) www.sprc.org SAMHSA

The Role of Law Enforcement in Preventing Suicide includes:

- Recognizing the Warning Signs
- Helping the Public
- Helping Yourself and Your Fellow Officers
- Responding to the Warning Signs
- Role of the Department

http://www.sprc.org/sites/sprc.org/files/LawEnforcement_1.pdf

Because departments and individual officers can vary greatly in their response to a suicidal person, consistent training and departmental directives are crucial for ensuring the best outcome. Important training components include:

- Legal criteria for a warrantless arrest and for orders of protective custody, including what discretion and protections officers have
- Criteria that a hospital must meet for a seventy-two hour detention for evaluation
- Criteria that a judge must consider for an involuntary commitment
- Risk factors
- De-escalation techniques
- Information about the dynamics of serious mental illness, including psychosis, depression, and mania
- Training in alternatives to deadly force
- Recommended response protocol including:

- Requirements for action to ensure the safety of the suicidal person and referral to treatment before leaving the scene
- Evaluation of imminent and future risk factors
- Controlling or seizing weapons
- Evaluation of the ability of the family or others to help
- Requirements for two officers to respond, including specially trained officers such as mental health peace officers
- Alternatives when warrantless detention for treatment or transport to voluntary treatment is not possible (such as detention on outstanding warrants, with notification of jail staff of suicide potential)

In addition to responding to potential suicide attempts, law enforcement is called to the scene of completed suicides. It is important that those responding to these calls be aware that suicide of a family member or close friend may enhance the risk of suicide for survivors. Officers should be trained in how to notify and work with significant others at the scene. Suicide postvention will be discussed in the following chapter.

Collaboration among law enforcement, the public mental health system, advocacy groups, hospitals, and the courts can draft protocols for cooperative response and training for both law enforcement and hospital staff. Information cards that include mental health resources, commitment procedures, and crisis numbers can be provided to officers (and to the Justice of the Peace and the medical examiner's office) to distribute to families.

Mental Health and Health Care Professionals

It is critical for every physician in Texas to recognize the profound impact that suicide has on the well-being of a community and take steps to prevent this all-too-common killer of our loved ones, friends, and neighbors.

John W. Burruss
Former Chief of Psychiatry, Ben Taub General Hospital, Houston

In 2011, in its report *Suicide Care in Systems Framework,* the National Action Alliance: Clinical Care and Intervention Task Force identified key findings and recommendations for developing and delivering suicide prevention and postvention clinical care. This report provides a comprehensive model for clinicians targeting suicidality. This Task Force identified four components, described below:

Suicide Care in Systems Framework
National Action Alliance: Clinical Care and Intervention Task Force

http://www.actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf

While research has shown that over 90 percent of persons who die by suicide had a diagnosable mental health disorder and/or substance use disorder, empirical research has shown that it is insufficient to treat only the mental disorder. In contrast, the extant literature does show that targeting and treating suicidal ideation and behaviors, independent of diagnosis, hold the greatest promise for care of suicidal risk. It is vital that direct intervention and treatment be provided for potential suicidality. Care for persons at risk of suicide should be person-centered, where their personal needs, wishes, values, and resources become the foundation of developing a plan for their continuing care and safety. Where appropriate and practical, families and significant others should be engaged and empowered as well. Cultural values and preferences should be respected as much as possible. The Task Force has identified the following four components of care.

1. **Screening and Suicide Risk Assessment** – Universal screening for suicide risk should be routine in all Primary Care, Hospital Care (especially emergency department care), Behavioral Health Care, and Crisis Response settings (e.g., help lines, mobile teams, first responders, crisis chat services). Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, availability of means, presence of acute risk factors (including history of suicide attempts), and level of risk.

2. **Intervening to increase coping to ensure safety** – All persons identified as at risk of suicide by primary care practices and clinics, hospitals (esp. emergency departments), behavioral health organizations and crisis services should have a collaboratively designed safety plan prior to release from care. This should include inquiring about means access and planning to restrict access to lethal means (balanced with respect to other obligations, including legal and ethical requirements under federal and state laws).

3. **Treating and caring for persons at-risk of suicide** – Treatment and support of persons with suicide risk should be carried out in the least restrictive setting using research- guided practice techniques.

4. **Follow Up** – Persons with suicidal risk leaving intervention and care settings should receive follow-up contact from the provider or caregiver.

Additionally, every mental health training program includes some information about suicide risk and assessment, but few provide the kind of detailed, specific information necessary to help individuals and communities prevent and respond to this kind of loss. Part of organizing the community in suicide prevention efforts involves taking active steps to ensure that mental health and health care professionals who are involved in community efforts have the additional education they need to be effective. Supplemental education should address awareness of:

- The relationship between suicide and mental illness
- The need for mental health screening as a tool in suicide prevention efforts
- Existing treatment guidelines that will determine best practices, such as those of:
    a. American Psychiatric Association, http://www.psych.org
    b. The American Foundation for Suicide Prevention, http://www.afsp.org
    c. American Psychological Association, http://www.apa.org
- The limited effectiveness of "suicide contracts" and the use instead of "safety plans"
- The role of the mental health professional in helping to stop the spread of suicidal behavior in school and other group settings
- The need to work with the media to avoid glamorization of suicide, in order to limit any possible contagion effect
- The demographics of high-risk groups (as well as the limitations of demographic factors as predictors of behavior)
- Protective factors and the ability to maximize their influence within individuals and the community
- Drinking and drug use as precipitants for suicide
- The need for professionals to take an active stance about removing highly lethal agents from the home, especially firearms
- The under-appreciated risk of suicide among the elderly
- The need for age-appropriate intervention among children and adolescents, including professional guidance and availability to schools, in the aftermath of a suicide.

As stated previously, there are numerous training resources available through a variety of sources, many of which are gathered in the following websites:

- Suicide Prevention Resource Center located at http://www.sprc.org

- American Association of Suicidology located at: http://www.suicidology.org
- Please see Chapter 3 of this toolkit for a comprehensive list of available resources to guide the selection of training and education for your community.

Safety Planning

Safety planning is an important part of suicide prevention clinical care. According to Dr. Gregory Brown, "safety planning consists of a list of coping strategies that patients can use during a suicidal crisis. The key part of this treatment is for patients to identify the warning signs that indicate that they are in a 'suicidal mode' and then use coping strategies that were developed in therapy to deal with the crisis."

The Texas Department of State Health Services provides a Sample Safety Plan for Children and adolescents. This plan is based upon the recommendation of the American Association of Suicidology. A version for use with adults is currently under development.

Sample Safety Plan
For Children

Warning signs that tell me a crisis may be developing (these may include thoughts, situations, behaviors, images, etc.)

1. _____

2. _____

3. _____

Coping strategies that help me feel better (coping strategies may include listening to music, drawing, writing in a journal, going for a walk, etc.)

1. _____

2. _____

3. _____

Supportive people I have permission to contact and places I have permission to go that can provide a distraction or help me feel better (places may include a neighbor's house, library, backyard, etc.):

People/Phone Number:	Places:
1.	1.
2.	2.
3.	3.

Professionals I can contact during a crisis (this may include your counselor/case manager, a crisis hotline, school social worker/counselor, etc.):

Name:	Contact Information:
1.	
2.	
3.	
4. Local Crisis Line	
5. Suicide Prevention Lifeline	1-800-273-TALK (8255)

Steps to keep my environment safe:

1. _____

2. _____

Developed using recommendations from the American Association of Suicidology

Hope Box as a Component of Safety Planning

As part of safety planning, Dr. Brown's research has shown that the construction of a Hope Box is an effective part of a treatment plan. A Hope Box usually consists of a "shoebox, a folder, or a scrapbook where the patient includes pictures, letters, poetry, prayer cards, coping cards or other things that give them meaning in their life." More information about Dr. Brown's study is located at:

http://www.nimh.nih.gov/outreach/alliance/alliance-report-july-2006.pdf.

Building on this concept of a Hope Box, Mental Health America of Texas and the Texas Department of State Health Services are currently developing a Virtual Hope Box app that will be available for Android and Apple devices. This Virtual Hope Box will enable users to capture many of the above items that would be contained in a physical Hope Box on their phones. Please see Mental Health America of Texas or the Texas Suicide Prevention Council's websites for further updates on the availability of the Virtual Hope Box.

www.mhatexas.org
www.TexasSuicidePrevention.org

School-Based Professionals

When school campuses (counselors, teachers, administrators and nurses) are well trained in . . . suicide prevention, the school becomes a strong system for early identification of students who need supportive services for mental health problems. This type of system would be significant in reducing the risk of suicide completion among our young adolescents.

Dianna Groves, Department of Student Learning Support Services, Austin Independent School District

The Austin-Travis County Suicide Prevention Coalition is a good example of a public health approach to suicide prevention that has initially focused on youth (although their plan is to eventually reach all age groups). First, the coalition wrote a local suicide prevention plan modeled after the state plan. Second, it recruited community members and school representatives to be trained as Suicide Prevention gatekeeper trainers.

In Year One, the local coalition focused on the largest school district in the area, Austin Independent School District, and trained key district-wide and counseling staff. In years two and three, the AISD gatekeeper instructors offered suicide prevention training to all of the high school and middle school counselors, nurses and nursing assistants. Once completed, they began to reach out to school administrators, teachers and selected student groups. For the past few years, during the September National Suicide Prevention Week, the school district's athletic department makes announcements at half-time for major school games for the audience to "Save A Number to Save A Life," while they program the National Suicide Prevention Lifeline number into their cell phones (1-800-273-8255). Feedback from local counselors is that students have looked for the number on their cell phones during a crisis, and said they were relieved it was a quick link to help.

The local coalition helped to support the school district's efforts with regular monthly coalition educational meetings on suicide prevention involving key community groups. They worked with their coalition partners to offer gatekeeper training to faith-based groups, PTAs, community social service and mental health agencies, hospitals, and other stakeholder groups.

Because the Austin area had two youth suicide clusters (2000-2001 and 2007-2008), the coalition worked to develop postvention protocols. Postvention is what you do AFTER a suicide to help prevent more deaths by suicide and avoid a contagion process among youth. To develop protocols, the coalition worked with a broad-based group—public and private schools, local hospitals, the local community mental health center, first responders, and clinicians from health, mental health, and private facilities.

Schools offer unique challenges in suicide prevention and there is a wealth of information concerning suicide prevention and management of these efforts in educational environments. The Prevention Division of the American Association of Suicidology developed a set of guidelines, which has been reviewed by experts. The *Guidelines for School-based Suicide Prevention Programs* is available through the Suicide Prevention Resource Center in their Best Practices Registry Section II: Expert and Consensus Statements, which is located at:

http://www.sprc.org/sites/sprc.org/files/bpr/GuidelinesSchools.pdf

In Texas, recent legislation has been passed that directly affects suicide prevention initiatives in school environments. In June 2011, The Governor signed House Bill 1386 that amends the Health and Safety Code to require the Texas Department of State Health Services, in coordination with the Texas Education Agency, to provide a list of recommended best practice-based early mental health intervention and suicide prevention programs for implementation in public elementary, junior, middle, and high schools.

According to the Suicide Prevention Council's FAQs on HB 1386, the main tenets of the bill include:

HB1386. This is entitled, "AN ACT relating to the public health threat presented by youth suicide and the qualification of certain persons serving as marriage and family therapists in school districts."

HB1386 states that the Texas Department of State Health Services (DSHS) will coordinate with the Texas Education Agency (TEA) to provide and annually update a list of recommended early mental health intervention and suicide prevention programs for implementation in public elementary, junior high, middle, and high schools within the general education setting.

http://texassuicideprevention.org/pdf/HB1386-Final-12mar2012.pdf

The bill allows DSHS and TEA to consider any existing suicide prevention method developed by a school district. DSHS and TEA may also consider any Internet or online course or program developed in this state or another state that is based on best practices recognized by the Substance Abuse and Mental Health Services Administration or the Suicide Prevention Resource Center.

By September 2011, all school districts were required to have a Suicide Prevention Plan in place. By having this plan in place, schools can better anticipate, prepare and execute training programs that are relevant to their specific needs and, as a result, make informed decisions about training programs identified in the Best Practices Registry at SAMSHA or SPRC.

School districts in Texas are adopting policies related to mental health intervention and suicide prevention for students. These policies relate to training, identifying, and managing at-risk students. These policies relate to training, identifying, and managing at-risk students, reporting procedures, parent notification and medical screening procedures. To support school districts in this effort, the Texas Association of School Boards' Policy Service division has generated sample policy statements for school districts to use in guiding their district-specific policies for suicide prevention and mental health intervention. For specific information about TASB's policy recommendations and sample statements, please contact your district's TASB Policy Service consultant.

http://www.tasb.org/services/policy/index.aspx

In Texas, free online, interactive suicide prevention training for public high school educators is offered through www.texassuicideprevention.org. "At-Risk for High School Educators" is approved by the Texas Education Agency for one hour of continuing education. A middle school training program will be launched in the fall of 2012. Additionally, a ninety-minute gatekeeper video, "ASK About Suicide to Save a Life," will be available at www.texassuicideprevention.org in the fall of 2012.

Below, please find links to examples that have been implemented in the State:

- **Action Plan, Quick Reference Guide for Suicide Intervention (Austin ISD)** http://www.texassuicideprevention.org/pdf/AustinSuicideActionPlan-2010-2011-TexasSuicidePrevention-12apr2012.pdf
- **Confidential Positive Support Plan and Scaling Questions for Suicide and Self-Harm Risk Follow-up (Hays ISD)** http://www.texassuicideprevention.org/pdf/F32-B-Positive-Support-Plan-and-Scaling-Questions-TexasSuicidePrevention-11apr2012.pdf
- **Emergency Parent Notification of Suicide Thoughts (Hays CISD)** http://www.texassuicideprevention.org/pdf/Emergency-Parent-Notification-Suicide-11-121-TexasSuicidePrevention-11apr2012.pdf
- **Responding to Students in crisis: Training for PSS Staff and Counselors (Dallas ISD)** http://www.dallasisd.org/page/1387

Figure 5-5

Eanes ISD has implemented a 1-to-1 iPad program for its students, which will begin in the fall of 2012. Each iPad will be equipped with the ASK suicide prevention app to provide students and faculty with this important information.

Sample Action Plan from Austin Independent School District

ACTION PLAN
Quick Reference Guide for Suicide Intervention

Must complete 4 FORMS when working with High Risk Suicidal Students
(Forms are found in *CRISIS Notebook*)

1. *SAFETY CHECKLIST: YOUTH AT RISK FOR HARM* - - - - - - - - - - - - - - (copies: counselor & principal) V-3
2. *INDIVIDUAL SAFETY AGREEMENT* (former title *Stay Alive Contract*)- - (copies: counselor & principal) V-11
3. *EMERGENCY PARENT NOTIFICATION FORM*- - - - - - - - - - - - - - - - - - (copies: counselor & parent) V-12
4. *AISD CONSENT TO REQUEST STUDENT RECORD (S) FORM** - - - - - - (copies: counselor, parent, physician) V-14

*Inform parent that signing consent authorizes school to mail school records to physician/therapist and allows verbal communication between school and physician/therapist.
If parent signs, parent can deliver *CONSENT FORM* to physician/therapist or the counselor can mail *CONSENT FORM*.
If parent chooses **not** to sign, counselor must document "parent chooses not to sign" and date *CONSENT FORM*.

I. HIGH RISK - Student has a <u>specific plan</u> or <u>previous suicide attempt</u>. Must be seen immediately

- If student is **presenting imminent danger to self or others, contact SRO (School Resource Officer) or 911 immediately. Inform SRO that a Mental Health Officer is needed.**
- Inform Campus administrator.
- Contact parents immediately.
- If medical emergency is in progress, including a suspected drug overdose, dial **911, SRO** and contact **school nurse.**
- A Mental Health Officer has the authority to declare immediate need for voluntary or involuntary admission to hospital.
- Student should be monitored at all times – **do not leave alone,** even for a minute.
- Share your concern – communicate that you care and that you want him/her to be safe.
- Obtain commitment from the child/student not to harm self by completing the ***INDIVIDUAL SAFETY AGREEMENT*** (*CRISIS Notebook*, p. V-11).
- Principal Notification – verbal notification <u>and</u> a copy of the ***SAFETY CHECKLIST: Youth at Risk for Harm*** (*CRISIS Notebook*, p. V-3).
- Inform your School Nurse.
- **Do not release student from school at the end of the school day. Student must be released to a parent or guardian!** An ***INDIVIDUAL SAFETY AGREEMENT*** must be made with student, parent or guardian. If unable to contact parent or guardian, contact your SRO for assistance. **Student must be accompanied at all times.**
- **MCOT (Mobil Crisis Outreach Team) An additional crisis intervention resource available to provide assistance to trained professionals in school settings. MCOT: Extension of PES (Psychiatric Emergency Service) 472-HELP (4375) Available 24 hours a day.**

Assisting the Parent:

- Parent should immediately to contact physician/therapist, Hospital Emergency Room or PES.
- Complete ***EMERGENCY PARENT NOTIFICATION FORM*** and provide a copy to parent to share with physician/mental health professional (*CRISIS Notebook*, p. V-12).
- Request that parent/guardian complete and sign ***AISD CONSENT TO REQUEST STUDENT RECORD (S) FORM**** which will allow school to provide school records to physician/therapist and verbally communicate with physician/therapist.
- If parent chooses **not** to sign, counselor must document "parent chooses not to sign" and date *CONSENT FORM*.
- Families **with private insurance** should contact their Primary Care Physician.
- If student has therapist or psychiatrist, parent should contact immediately and schedule an appointment.
- Families **without private insurance** – will need to transport their child to Psychiatric **Emergency Services (PES) @ 56 East Ave. (Holly Street & I-35); Phone #: 472-HELP (4357) or Hospital Emergency Room.**

Follow Up:

- **Phone call home within 48 hrs**. to confirm parent followed through for medical/mental health assistance.
- If counselor suspects parent **did not** follow through, complete report to Child Protective Services (CPS) **Inform SRO.**
- If parent signed release, follow up by contacting physician or mental health provider.
- **Upon student's return to school, a transition meeting should take place between the student, parent, and counselor. Other staff might be included, at counselor discretion (i.e. SCL, campus administrator, school nurse, teacher). The *INDIVIDUAL SAFETY AGREEMENT* (*CRISIS Notebook*, p. V-11) should be reviewed and updated, as appropriate to student's needs**.
- Ensure student has understanding of **plan** and how to seek help both at school and home.
- Refer student to IMPACT Team. Monitor student closely.

09/01/10

II. MODERATE to LOW RISK (Student has vague or no plan.)

- Immediately contact parents.
- An ***INDIVIDUAL SAFETY AGREEMENT*** (*CRISIS Notebook*, p. V-11) must be completed with student.
- If unable to contact parent or guardian, contact SRO for assistance.
- Ensure student has understanding of the Safety Agreement and how to seek help at school and home. Establish a safe place to go when feelings of doom present themselves.
- Share your concern – communicate that you care and that you want him/her to be safe.
- Explore problem solving strategies and alternatives for staying safe.
- Increase counseling opportunity with focus on increasing coping skills, problem solving strategies, stress management.
- Inform Principal – verbal notification and provide a copy of the ***SAFETY CHECKLIST: Youth at Risk for Harm*** (*CRISIS Notebook*, p. V-3).
- Do not release student from school without prior notification and consent of an adult family member, preferably a parent or guardian.
- Inform school nurse.
- Inform SRO.

Assisting the Parent:

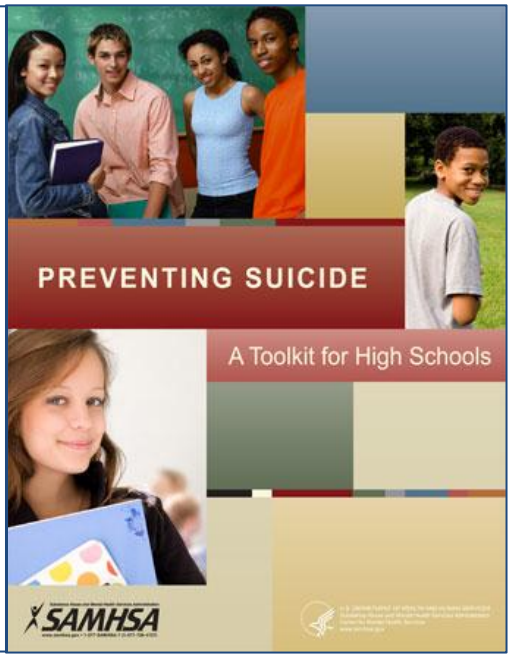
- Complete ***EMERGENCY PARENT NOTIFICATION FORM*** (*CRISIS Notebook*, p. V-12) and provide a copy to parent to share with physician or mental health provider.
- If parent is not able to come to school, inform the parent or guardian that an Emergency Parent Notification will be sent home with the student.
- Families **with private insurance** should contact their Primary Care Physician.
- If student has therapist or psychiatrist – parent should contact them immediately and schedule an appointment.
- Families **without private insurance** may contact **PES @ 472-HELP (4357)– PES-Psychiatric Emergency Service @ 56 East Ave (Holly Street & I-35)**.
- Refer student and family to outside counseling agency, if appropriate. May contact your School to Community Liaison (SCL) for assistance.

Follow Up:

- Phone call home within 24 to 48 hours.
- Monitor student closely. Review ***INDIVIDUAL SAFETY AGREEMENT*** (*CRISIS Notebook*, p. V-11). Continue to explore problem solving strategies and alternatives to staying safe. Ensure student understanding of plan and how to seek help.

Preventing Suicide: A Toolkit for High Schools, published by the Substance Abuse and Mental Health Services Administration, provides a comprehensive toolkit for schools. This useful guide provides school personnel with important information about planning, implementing, and evaluating suicide prevention (and postvention) initiatives at the district and campus level.

Chapter 1: Getting Started
Chapter 2: Protocols for Helping Students at Risk of Suicide
Protocols for Helping Students at Risk of Suicide Tools
Chapter 3: After Suicide
After Suicide Tools
Chapter 4: Staff Education and Training
Staff Education and Training Tools
Chapter 5: Parent/Guardian Education and outreach
Parent/Guardian Education and Outreach Tools
Chapter 6: Student Programs
Student Program Tools
Chapter 7: Screening
Screening Tools
Resources
Handouts
Contributors



This toolkit is available at:
http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669?WT.ac=EB_20120622_SMA12-4669

In addition to the previous toolkit, the *Research-Based Guidelines and Practices for School-Based Suicide Prevention* guide by Deborah Kimokeo, EdD, Teachers College-Columbia University, provides an excellent resource for developing a suicide prevention plan across all academic and administrative levels of planning. This guide provides an integrated and coordinated overview of suicide prevention initiatives, definitions, resources and other useful information to consider when constructing a suicide prevention plan for educational environments.

This guide is located at: http://ican-ncfr.org/documents/SchoolSuicide.pdf

The *Research-Based Guidelines and Practices for School-Based Suicide Prevention* provides a comprehensive approach to suicide prevention planning for school district administrators and other staff including step-by-step planning process for:

- Planning of School-Based Primary Suicide Prevention Program
- School-Based Secondary Suicide Prevention Program
- School-Based Tertiary Suicide Prevention Program
- School-Based Suicide Prevention Program Evaluation Plan

For each grade level category (Primary, Secondary, Tertiary) a top-down planning process has been developed to navigate school personnel through this effort. Section VI of this report includes sample forms such as:

Research-Based Guidelines and Practices for School-Based Suicide Prevention **Section Outline Section VI. Useful Sample Forms, Checklists, Job Descriptions & Guidelines**

- Sample Policy from CA School Boards Relating to School-Based Suicide Prevention School District Crisis Response (Including Suicide): District Office Responsibilities District Crisis Guidance Manager Responsibilities & Responsibilities & Job Description District Crisis Support Team: Membership & Roles
- District Media Guidelines
- Establishing School Crisis Team: School Site Responsibilities
- School-Based Suicide Prevention Gatekeeper Training Checklist
- School-Based Suicide Prevention Program Recommendations
- School Crisis Immediate Response Checklist
- School Crisis Team Quick Checklist Following a Suicide
- Suicide Prevention Community Coordination.
- Sample Form Letters
- Parent/Guardian Letters (1) Sample parent/guardian letter inviting to Gatekeeper Training (2) Sample parent/guardian letter in death by accident (3) Sample parent/guardian letter in death by suicide (4) Sample parent/guardian letter in death by murder (5) Sample parent/guardian letter after a natural disaster (6) Sample parent/guardian informational evening guidelines
- Staff Letters/Announcements/Documentation/ Forms
- Sample staff letter advising of meeting to introduce Crisis and Suicide Prevention Handbook.
- Sample staff letter advising of schedule of mandatory gatekeeper meetings.
- Sample staff script to inform students of death of another student or staff member.
- Sample staff announcement of death of a staff member or his/her family.

Pastoral Professionals

Clergy and pastoral professionals often play an active role in suicide prevention. According to the Suicide Prevention Resource Center's fact sheet *The Role of Clergy in Preventing Suicide,* their literature review indicates that persons contemplating suicide often turn to their clergy for support rather than a mental health professional. In fact, according to the SPRC fact sheet, some research indicates that more than twice as many persons with diagnosable mental illness will seek counsel from their clergy rather than a psychotherapist.

As a consequence, the pastoral profession can be aided greatly by specific training in suicide prevention and the ability to identify and respond to warning signs associated with suicide.

- *Recognizing the Warning Signs* offers insight into the evidence-based warning signs associated with suicide.
- *Responding to the Warning Signs* provides guidance on clergy responses to identified warning signs, understanding the roles and distinctions between clergy and mental health professionals, legal, and confidentiality issues.

The Role of Clergy in Preventing Suicide factsheet is located at:
http://www.sprc.org/sites/sprc.org/files/Clergy.pdf

Media: A Critical Partner for Community-Based Initiatives

I always discuss the boundaries of an interview with media representatives ahead of time. Since my son was number five in a suicide contagion, I'm very sensitive to the fact that other young people may be watching or listening and be susceptible to a contagion effect, so I do not give details of his death, allow the media to film close-up pictures of him, or sensationalize his death. Instead, I focus on the loss as a tragedy that is preventable if society and our communities step up to the plate with time, energy, and money.

Merily Keller
Past Co-chair, Texas Suicide Prevention Council

Utilizing the Media to Promote Community Awareness about Suicide Prevention

The American Association of Suicidology provides a list of suggestions for using the media to promote your education and prevention efforts. The association suggests that community groups:

- Proactively establish media relationships
- Emphasize the warning signs and sources of help in the community
- Use real-life examples to make a point but without breaching any confidence
- Be aware of local, state, and national statistics to quote with the media
- Use everyday language that people will easily understand

The Suicide Prevention Resource Center and the Suicide Prevention Action Network offer a comprehensive guide for engaging the media across every platform (print, radio, television, op-ed, media advisories, press releases, etc). Their *Guide to Engaging the Media in Suicide Prevention* includes a wealth of information that provides a comprehensive strategy for all aspects of media relations. For more information, see:

http://www.sprc.org/sites/sprc.org/files/library/media_guide.pdf

The Table of Contents includes:

❖ Creating Suicide Prevention Messages	❖ Catching the Media's Attention with Your News
❖ How to Work with the Media	❖ Helping the Media Report on Suicide
❖ Conducting an Interview: Becoming an Effective Speaker	❖ "Bridge" to Your Key Messages
❖ Using Television to Tell Your Story	❖ Using Radio to Tell Your Story
❖ Using Print Media to Tell Your Story	❖ Informing the Media with a Press Release
❖ Advising the Media with a Media Advisory	❖ Writing an Effective Pitch Letter
❖ Controlling Your Message with an Op-Ed	❖ Reinforcing Your Message with Letters to the Editor
❖ Educating the Media with a Press Kit	❖ Identifying Appropriate Media Outlets
❖ Creating Media Lists	❖ Tracking Results.

Regardless of the platform employed, structured and strategic messaging is essential for effective utilization of the media in suicide prevention initiatives. This guide offers a three-pronged strategy in communicating suicide prevention information through media platforms. Called the "Message Triangle," SPRC outlines this approach:

Figure 5-6

Your organization should identify three core messages and diagram them as a "message triangle." The message triangle is a visual that can serve as a mental "safe harbor" when confronted by controversy or confusion during an interview by allowing the spokesperson to easily return to any one of three core messages. Like the equilateral triangle, all points are equally important. However, depending on the audience, you may want to customize the message by focusing on areas of specific concern, such as suicide and the elderly, or youth suicide prevention. For example, if you are being interviewed for a story in the AARP Magazine, you would focus on suicide and the elderly….

Outlined to the left is an example of a message triangle for a suicide prevention organization.

See: http://www.sprc.org/sites/sprc.org/files/library/media_guide.pdf

This model can and must be customized to meet the specific needs of your community and circumstances surrounding the media engagement. Hopefully, the reporters and editors will be following best practices guidelines outlined in this document in discussing and reporting on the topic of suicide.

Tips For Survivors Who Have Agreed To A Media Interview

Remember that your interview has the potential to save lives by making people aware that suicide is a preventable public health problem, educating them about the extent of the problem, and talking about the need for communities to work together to address the issue. These are key messages that should be included in any interview. With that in mind:

Be Prepared

- Go to Chapter 4 of this toolkit and memorize a few key facts about the extent of suicide in Texas. You might want to choose one of the statistics that matches the age of your loved one, i.e. if you lost someone who was older, you could say that my husband, wife, mother, father etc. was XX years old, and unfortunately statistics indicate that senior Texans have high rates of suicide. Conversely, if you lost a teenager, you could point out that suicide is one of the leading killers of adolescents in the state.
- Give some careful thought to how you want to celebrate the memory of your loved one in the interview. How do you want to portray the deceased? Prepare to describe the life of who your loved one was, and in a series of short sentences that portray their value and esteem. Take some time to decide what you are and are not

comfortable speaking about. Remember that giving details about the manner of death can not only be harmful to your equilibrium, but also to a potential viewer. The concern is two-fold, not only for you, but also that someone who is suicidal may be stimulated by the nature of what is being said.

- Consider partnering up with a mental health clinician in your community for all interviews. Most survivors have found it advantageous to have someone else next to them for the interview. Moral support is always a strength to draw on, and you can prearrange a non-verbal signal for your need of support, as well as to have them signal you if things seem to be going in the wrong direction. There is also great ease in having another person to deal with a question that you may not be completely comfortable answering. If a therapist or a support group has helped you, consider sharing that information. There might be someone days or weeks away from the suicide of a loved one that your process might touch.
- Remember that you have the right to ask beforehand what questions you will be asked and to deliver a list of questions that you are not willing to answer. You also have the right to stop the interview at any time.
- Don't forget to breathe! Take a few deep breaths before you get started to open up your voice and calm you down.

Keep the Focus on What Counts

- Have a transition line to use whenever you don't want to answer. For example, "You know, that is a very good question. Let me think about it and call you back after the interview."
- If you have a mental health professional with you, defer to the professional's expertise. For example, "That is your specialty; could you address that?"
- If you are asked a sensational question that would lead to a gory, detailed answer, simply say, "The details of my loved one's death are not the most important thing here. What matters is that communities can come together to address this tremendous mental health problem in Texas."

For Maximum Effectiveness on Television

- **Hands:** Remember, your hands will not be telling the story; your words will. If you have a tendency to use your hands for emphasis, feel free to clasp them together to allow your words to make your point for you.
- **Hair:** if you pull your hair back, the focus will be on your face, and your words, and not the style or length of your hair. Avoid wearing a hat. It detracts from the camera being able to see your face and focus on the message you are trying to convey with your words.
- **Clothing:** Stay away from all-white or all-black as well as large prints. Otherwise, solid colors are preferable to patterns or stripes. If you want people to hear your voice and see your heart, wear neutrals like grays or earth tones. For a compassionate presence, wear medium blue (rather than a dark navy or a light blue).
    - For women, if you choose a skirt, make it long enough to cover the knee. When you are seated and the camera takes a wide shot, viewers' eyes will go to your thighs and distract from the power of your words.
    - Non-flimsy shirts and blouses are preferable since you will likely have a microphone attached to your clothing and it will tug on thin or flimsy material.
- **Jewelry and make-up:** Any jewelry at the lapel should be small and non-shiny. Avoid metal bracelets or other "jangly" items. Make-up should include concealer for under the eyes, a neutral lipstick, and powder to even out skin tone and keep people focused on what you are saying. Use blush sparingly; the camera picks up red tones very easily.

Guidelines/Recommendations for the Media

While information concerning postvention messaging concerning the media will be covered in a later chapter of this toolkit, it is also important to consider how powerful (both positively and negatively) the media can be in a

prevention capacity after a suicide. The media can have a positive effect after a suicide by helping to educate their communities that suicide is a preventable health problem, helping to reduce stigma associated with mental illness in general and suicide specifically and encouraging vulnerable portions of the population to seek assistance and provide vital information to access this assistance. On the other hand, if not managed correctly, the media can also have a negative impact on its audience, by potentially contributing to phenomena such as suicide contagion and worsening the problem. Both the American Foundation for Suicide Prevention and the American Association of Suicidology offer detailed recommendations for the media that address:

- The risk of contributing to suicide contagion
- The relationship between suicide and mental illness
- Interviewing surviving relatives and friends
- The importance of choice of language
- Special situations such as celebrity deaths, homicide-suicides, and suicide pacts.

In addition, The National Institute of Mental Health stresses that suicide contagion is real and has the following recommendations to minimize suicide contagion:

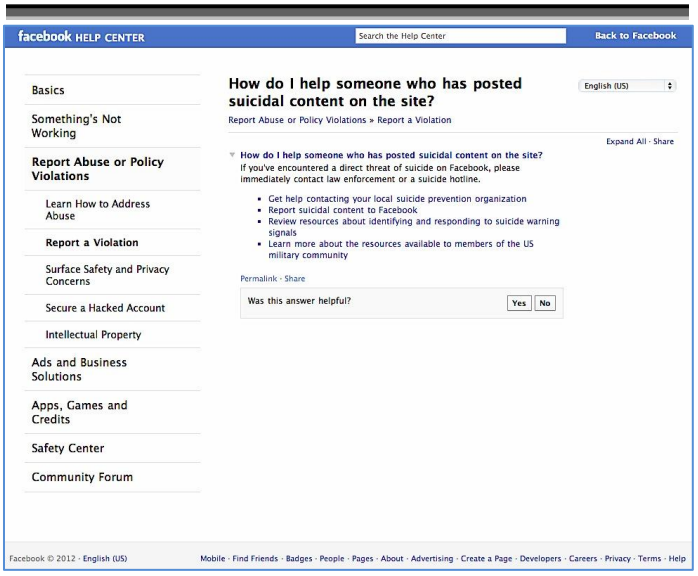
> Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors. Direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults.
>
> The risk for suicide contagion as a result of media reporting can be minimized by factual and concise media reports of suicide. Reporting should not be repetitive, as prolonged exposure can increase the likelihood of suicide contagion. Suicide is the result of many complex factors; therefore media coverage should not report oversimplified explanations such as recent negative life events or acute stressors. Reports should not divulge detailed descriptions of the method used to avoid possible duplication. Reports should not glorify the victim and should not imply that suicide was effective in achieving a personal goal such as gaining media attention. In addition, information such as hotlines or emergency contacts should be provided for those at risk for suicide.
>
> Following exposure to suicide or suicidal behaviors within one's family or peer group, suicide risk can be minimized by having family members, friends, peers, and colleagues of the victim evaluated by a mental health professional. Persons deemed at risk for suicide should then be referred for additional mental health services.

Using Social Media as a Prevention Tool

Social media deserves special attention as a tool to combat suicide. The advent of virtual communities and relationships play a powerful role in today's society. While most recent attention focuses on the negative aspects of social media's role in suicide, a recent post to a science and technology blog by Dr. David Luxton, a Research Psychologist and Program Manager at the National Center for Telehealth and Technology, pointed to several key points how social media is being leveraged to make a positive contribution to suicide prevention efforts:

- SAMHSA and National Suicide Prevention Lifeline Facebook and Twitter accounts
- Hundreds of support and prevention groups on Twitter
- Suicide prevention videos on YouTube offered by a variety of suicide prevention entities
- Facebook and Bebo provide 'panic button' mechanisms to report abusive activity that may raise the risk of suicide
- Department of Defense offers phone numbers for Twitter and Facebook accounts for suicide prevention in their populations

Figure 5-7



Because social media knows no geographic boundaries, assistance can come from any corner of the globe. For instance, according to an April 21, 2011 media report published on international newswires by *The Telegraph*, the UK news publication, a 16-year-old British youth sent a suicide message to another youth in the United States. The fast action by all involved prevented a suicide through the help of both governments to locate the British youth. A higher profile event involved actress Demi Moore in 2009, when a twitter follower of her account indicated their intention to die by suicide. Ms. Moore was able to elicit enough information to notify authorities of the follower's location to intervene.

Figure 5-8

In May 2012, Facebook also launched a partnership with the United States Department of Veterans Affairs and Blue Star Families to assist service members in crisis or at risk of depression. "The U.S. Military on Facebook" page lists a direct link for suicide and PTSD resources, which are captured in the screenshot to the left.

https://www.facebook.com/USMilitary/app_292564240827194

Emergency Reporting of Suicidal Content on Facebook:

In December 2011, Facebook launched the capability to contact support—either through Facebook or another suicide prevention resource—to assist Facebook users who encounter suicidal content. Facebook also developed guidelines as part of its Help Center to assist persons who come in contact with someone who has indicated suicidal tendencies. In addition to providing direction to contact local law enforcement or a suicide hotline,

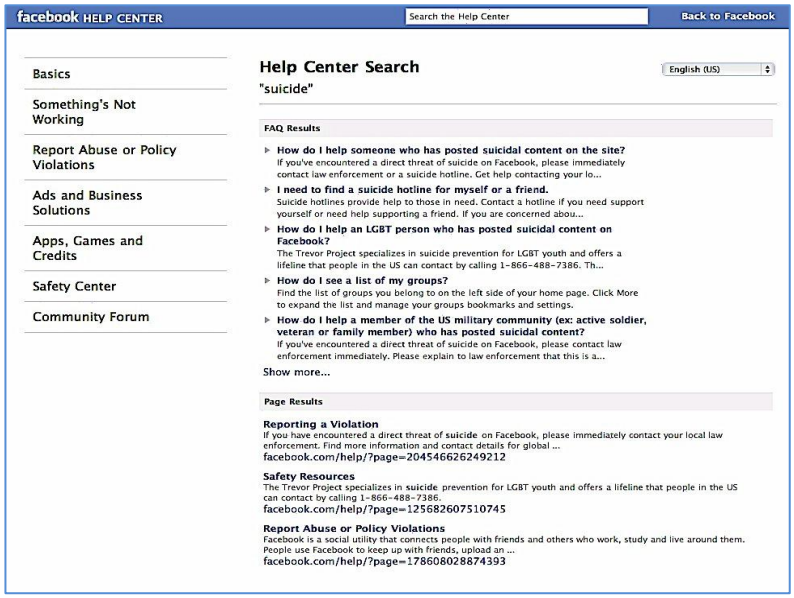
functionality has been deployed to gather information to submit directly to Facebook under its "Report Abuse or Policy Violation" help page located at:

https://www.facebook.com/help/?faq=216817991675637

Figure 5-9

A Facebook term search on the Help Center with the term "suicide" will find the following Question and Answer page which results in the following screen shot.

https://www.facebook.com/help/search/?q=suicide



Improved Facebook Functionality for Proactively Addressing Suicide Content on Facebook

Within the last year, Facebook has partnered with the National Suicide Prevention Lifeline to provide enhanced capabilities for users of Facebook to report and act upon suicidal content. The following is the fact sheet provided by the National Suicide Prevention Lifeline that describes the process steps for reporting such content.

The "How to Report Suicidal Users on Facebook" Fact Sheet, is located at:

http://www.texassuicideprevention.org/pdf/How-to-Report-Suicidal-Users-on-Facebook-28dec2011.pdf

Figure 5-10

NATIONAL SUICIDE PREVENTION LIFELINE

How to Report Suicidal Users on Facebook

We recently announced an innovative partnership with Facebook to offer crisis services via chat so that people in distress can more easily access the support that they need. This is part of our continued effort to expand our online crisis services to reach people where they are.

There are two ways to report a suicidal user to Facebook. You may either report it when you are scrolling on the suicidal user's comment or from the Facebook Help Center.

Reporting suicidal content while scrolling on the suicidal user's page

1) From your newsfeed, click on the user's name to go to their page. When you are on the suicidal user's page, click on the "Report/Mark as Spam" button in the upper right hand of the comment. It will only appear after you scroll over the X.

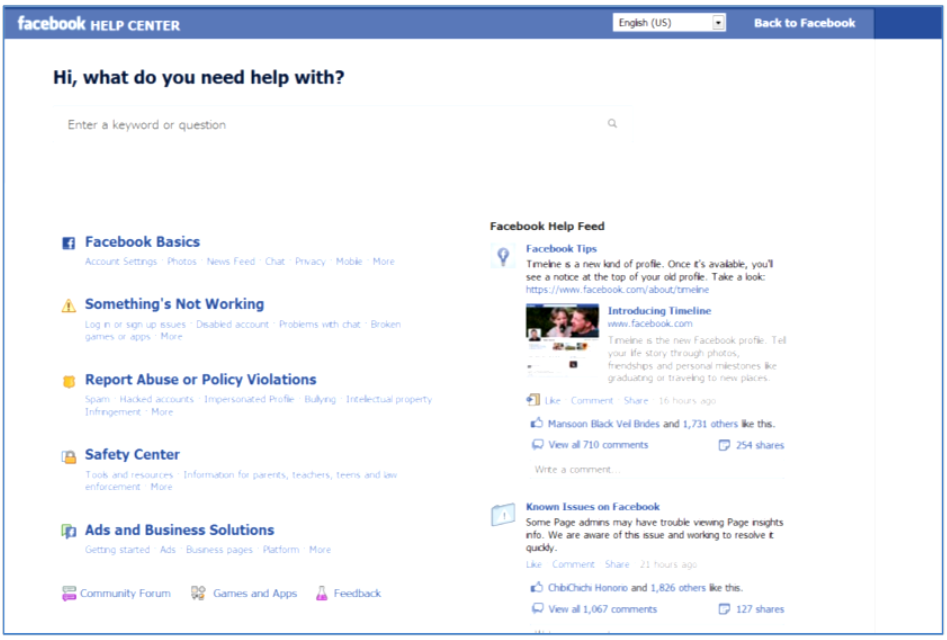
2) Click on the X and you will see a message that says, "Thanks for your feedback. You can undo this action or report it as abusive."

3) Click the option to report. The following screen will pop-up.

4) Check the "Violence or harmful behavior" field and scroll down to "Suicidal Content." Click continue. Your report will be sent to Facebook and reviewed by the Safety Team, who may send the person who posted the suicidal comment an e-mail encouraging them to call the National Suicide Prevention Lifeline 1-800-273-TALK (8255) or to click on a link to begin a confidential chat session with a crisis worker.

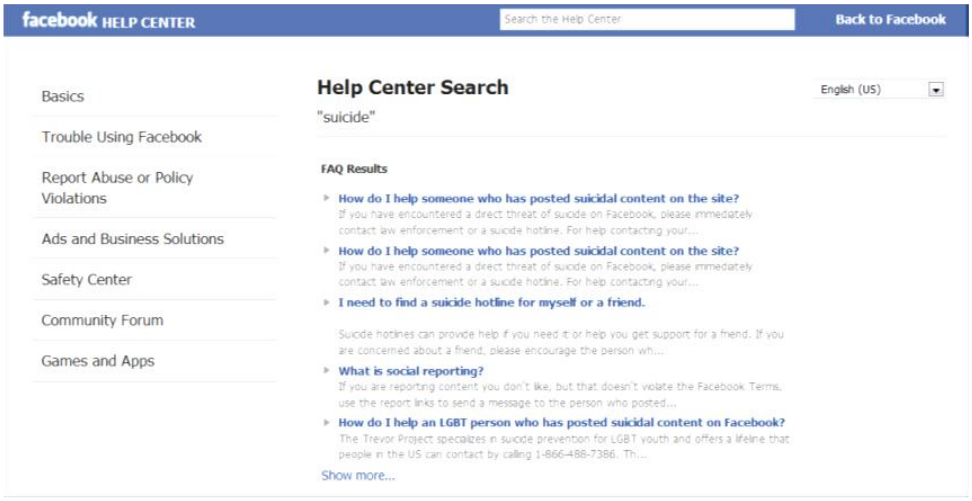
Reporting suicidal content from the Facebook Help Center

1) From any screen, click the downward arrow button which can be found on the upper right hand of the screen. Click on the "Help" option which will take you to Facebook's help page. The following screen will appear.

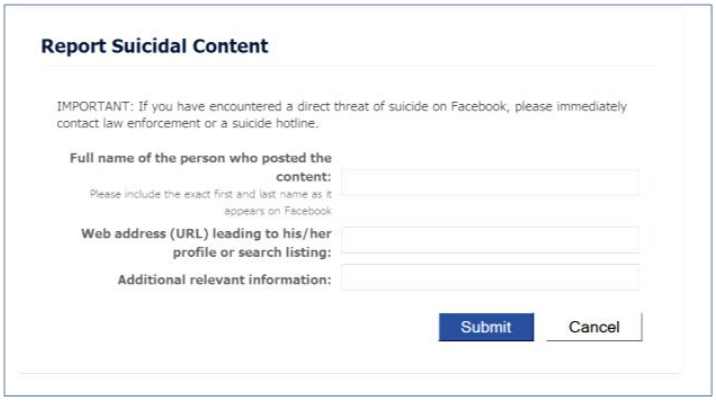


NATIONAL SUICIDE PREVENTION LIFELINE

2) Type the word "suicide" into the search box. The following screen will appear.



3) Click on the result, "How do I help someone who has posted suicidal content on the site?" An option will appear that says, "To report suicidal content to Facebook, click here." Click on the "click here" link to report and the following screen will appear.



4) Complete the form with the full name and web address of the user and click submit. Your report will be sent to Facebook and reviewed by the Safety Team, who may send the person who posted the suicidal comment an e-mail encouraging them to call the National Suicide Prevention Lifeline 1-800-273-TALK (8255) or to click on a link to begin a confidential chat session with a crisis worker.

Note: Please read the press release for more information about the new service.

Twitter:

Twitter also hosts numerous accounts with "suicide" and "suicide prevention" in its account name. No identifiable policies have been located specifically related to suicide or what to do if someone is posting suicidal tweets at this time. Twitter has not responded to requests for additional information at this time however, should more information become available, the online version of this document will be updated.

Websites:

Websites are an efficient and cost-effective way to both gather and disseminate information on suicide prevention. At present there are hundreds, if not thousands, of websites containing suicide prevention information and resources. Having said that, it is important to know many of these resources are not evidence-based, meaning there has been validation that the information contained within the site has been proven to be safe and effective. It is also important to check each and every website for content as some are masking as a prevention site when it is really a "pro-suicide" site. Prior to incorporating links to any suicide prevention online content, ALWAYS check with the Suicide Prevention Resource Center for a list of Best Practice programs, fact sheets, training and education products and other resources.

Questions to Consider When Contemplating Launching a Social Media, Website or other Online Resource Related to Suicide Prevention.

To Facebook or Not: Using Social Media as Part of a Community-Based Suicide Prevention Program.

Social media offers numerous valuable assets to its virtual communities, especially quick, easy-to-use, but effective methods to outreach into portions of your community. It is easy, on the conceptual level, to see the value of keeping our communities up to date on all the activities and initiatives surrounding suicide prevention. Keep in mind, however, with this open accessibility, there are significant obstacles, some of which may be very time-consuming and/or costly.

First: Remember Facebook is a two-way dialogue. It is difficult to manage content on Facebook if the public is allowed to post comments. Often, people who are searching Facebook may actually be vulnerable pockets of the population looking for support. Before launching a Facebook account, please be sure to check legal statutes in your area of liability and responsibility related to providing suicide prevention information in this manner. To monitor this 24/7 dialogue requires significant resources and individuals who have been effectively trained in handling such content.

Second: It is also important to consider whether or not Facebook is an effective means to reach the most vulnerable parts of your community. In many areas, the elderly are the highest at-risk population; in others there may be higher rates of suicide in the Hispanic community, who may not be effectively reached with an English only Facebook page.

Third: Consider the staff or volunteer time it takes to create and/or find relevant content to post and the dynamic nature of Facebook and other social media initiatives. For social media campaigns to be effective, there needs to be ongoing activity prompting your users. This takes a considerable amount of time, planning, and management to execute effectively.

Fourth: While your intent is to make a positive contribution to your community by using social media, consider that may not be everyone's goal. It's hard to anticipate on the front end, the things that can go wrong, but they can and will. Social media is exactly that: social. As part of your planning process, please refer to Facebook's best practices Social Media Crisis Guidelines to incorporate into your planning. These guidelines are located at:

http://www.facebook-studio.com/fbassets/media/753/FacebookSocialMediaCrisisGuidelines.pdf

Fifth: In order to utilize Facebook and other social media campaigns effectively, metrics are important. Be sure to incorporate these tools into your platform planning process. Facebook Insights offers a free tool to page developers to help track effectiveness of your social media campaign. There are numerous companies that offer these services as well.

Finally: If you do decide to move forward with a social media campaign, it is important on the front-end planning to consider how you will get the word out to your community that such a page exists. This can also be an expensive endeavor to customize a brand platform for communicating why your page is different and/or better than others in this content area. You may be more efficient in partnering with some of the existing resources already available rather than creating your own.

Websites: Create New or Use Existing?

Websites are also an invaluable tool for communicating with and informing communities about suicide prevention initiatives. However, many of the same considerations that apply for social media also apply to the development and deployment of websites. Developing and maintaining a website is a significant undertaking, one that requires careful technology, resource and market planning.

Again, there are a number of websites and other online resources already available. To maximize the effective use of your resources, carefully consider whether a new website is really necessary or if the existing resources are sufficient to meet your needs.

Social Media Strategy: Know the Basics

Social media platforms today offer stakeholder's constituents the chance to engage with the public in new ways. Efforts in suicide prevention are no exception. The general public has an interest in mental health, and they are using social media to seek, share, create, donate and participate. It benefits those responsible for suicide prevention activities to actively participate in the social media arena by contributing to the organization's official perspective or correcting errors. Hunt Adkins, a leading marketing, branding and social media firm based in Minneapolis, Minnesota, provides the following guidelines and best practices related to implementing social media in suicide prevention and mental health initiatives.

The Purpose of Social Media

Most importantly, Hunt Adkins advises, consider the overarching purpose of social media. Social media seeks to create a space of community between mental health practitioners, educators, advocates and the general public. Social Media sites such as Facebook, Twitter, and YouTube have become a primary mode of communication among many who are seeking information and guidance about topics related to mental health and suicide prevention. The general public can actively participate in the mental health discussion in a way that is flexible, thorough, and tailored to the needs of our constituents.

Best Practices for Social Media

The following Social Media Best Practices should be used as general guidelines in developing, implementing and evaluating strong social media practices. It is recommended that organizations considering social media should develop specific guidelines relevant to their organization's needs.

1. Make strategic choices.

- Social media communication should be a part of a larger communication effort and integrated into overall communication planning, activities, content development and data collection.
- Consider your overarching communication goals when setting up platform profiles, writing posts, responding to users, or sharing third party content. You may find that you will need different campaigns, messaging, or even platforms to meet specific communication goals and objectives.
- Remember that audiences, content, and behaviors can vary greatly from platform to platform.

2. Adopt low-risk tools first.

- Remember social media is first and foremost SOCIAL. Your audience will only actively engage with you if you are actively engaged, and social media success can only be as great as the time invested into the conversation.
- If resources are limited, consider adopting low-risk solutions and later building on these.
- Content such as articles, videos, and apps are easily downloadable and can be accessed from best practice organizations, credible third-party or partner sites, and support your website or social platform.
- Once you have an established "social rhythm," you may look to expand on tools for an enriched relationship.

3. Represent your organization. Be transparent.

- Identify yourself—name and, when relevant, role within suicide prevention. Make it clear if you are speaking on behalf of yourself, personally or professionally, or if you are speaking on behalf of your organization. If you are speaking on behalf of an organization, make sure that your online activities and content is consistent with your role and responsibilities.
- Be who you are. Be genuine. Show personality.
- Do not comment or edit anonymously in the public arena.
- Be the first to correct or comment on any mistakes made. If you are upfront about the mistake and correct it quickly, trust can more easily (and quickly) be restored with your audience.
- Remember that your actions reflect your organization. Support their mission, goals and positions on the topics important to your organization.

4. Add value.

Provide worthwhile information and perspective. Social media platforms and content represent the organization and the organizations providing the platform.

Does the content . . .

- Help stakeholders solve problems?
- Improve knowledge or skills?
- Contribute to the improvement of awareness and policies?
- Build a sense of community?

5. Make sure messages are fact or science based.

- Take the time to do your research whether developing original content or sharing content from a third-party. Is this party a credible third-party that we should be associated with? Has the content been proven or fact-checked? Will the content be considered credible within the professional suicide prevention community?
- If sharing option or editorial content, be sure to clearly identify it as such.

6. Identify supporting sources. Clarify endorsements.

- If a supporting source is online, be sure to provide linked or credited information so that others can access it too.
- Respect copyright and fair-use laws.
- Do not cite or reference people, associations, professionals, or other stakeholders without their approval. Be careful not to publish anything that might allow inferences to be drawn which would embarrass any person, association, professional, or other stakeholder.
- Be clear if content is or is not endorsed by your organization. Remember that users may infer that any content not accompanied by a source or disclaimer is coming directly from your organization. If an individual is endorsing content, point-of-view, product, or organization on behalf of themselves and a relationship outside of their organization, this needs to be clearly noted as well.

7. Protect nonpublic information.
Social media can blur the traditional boundary between internal and external content.
Be thoughtful of what you publish online. Do not:
- Disclose or use nonpublic information
- Disclose any personal information that could put yourself or others at risk. If you would not say something offline or include it in a written letter, do not post it online.

8. Respect your audience.
The mental health audience represents a diverse set of customs, values, and points of view.
Don't be afraid to be yourself, but do so respectfully. Don't create or share anything that may be considered obscene, objectionable, derogatory or inappropriate in the workplace or community your social media will reach.

9. Facilitate viral sharing and encourage participation.
- Make it easy for people to share your content, messaging, mission, and become advocates for suicide prevention.
- Use platforms that encourage sharing such as Facebook and Twitter among users.
- Use open-sourced social sharing tools such as Facebook Connect on blogs and websites.
- Openly ask your audience to join in the conversation, share with their friends and community and make a difference. Showcase participation and demonstrate that you've listened or made changes based on audience input and conversation. This will encourage active participation by users that may be currently only passive observers.

10. Provide multiple formats.
- Increase accessibility and reinforce messaging by providing multiple touch points and content formats. This will allow your audience to interact with you based on their level of engagement and access to media, and result in the most efficient and meaningful connections. Formats may include, but are not limited to, RSS feeds, articles, videos, infographics, surveys, pictures, downloadable content, blogs, comments, interviews, MP3s, podcasts, live streaming video and article shares.
- Consider mobile, only if appropriate for the message, content or desired audience action. Evaluate if any social content, delivery or call-to-action may need to change based mobile needs and technologies.

11. Monitor, evaluate, learn from metrics, and revise.
- Be prepared to make time and devote resources to monitoring all conversations surrounding your social media footprint. Be committed to reading every comment received and responding accordingly.
- Evaluate the success of an initiative using pre-determined metric goals. If something isn't working, don't be afraid to course-correct or modify what you are doing to better meet audience needs or internal resources. More often than not, social media communication is an iterative and evolving process

Guidelines for Evaluating Community Suicide Prevention Programs: An Evaluation Overview

Evaluation is the tool we use to ensure that programs, such as those that are designed to prevent suicide, accomplish what we intend.

The ultimate goal of evaluation is to provide the data necessary to assess effectiveness across relevant measures to improve the outcomes related to suicide prevention initiatives. Many of the evaluation and assessment tools are scientifically based to ensure that the outcomes are statistically relevant to the data they are evaluating. Generally, there are two types of methods available for evaluation—sometimes referred to as outcome evaluation and process evaluation—and both can help to ensure effective use of resources.

Weiss (1998) posits four defining elements of evaluation:

- Evaluation is concerned with either the operations or the outcomes of a program; a few evaluations may address both.
- Evaluation compares a program to a set of standards.
- The standards may be explicit, such as a statement of goals or objectives, or implicit, in which one must deduce the standard. Evaluation implies a judgment.
- Evaluation is systematic. It is conducted with rigor and thoroughness.
- Evaluation is purposeful. It is designed to provide information that can improve a program or document the effects of one or more aspects of it.

A **process evaluation** focuses on implementation. It describes how a program operates, how it delivers services, and how well it carries out its intended functions. By documenting a program's development and operation, a process evaluation can provide some understanding of the performance of the program and information for potential replication. The goal of a process evaluation may be to ensure that a project stays on course and is faithful to the initial model. It may also be designed to provide the opportunity to make midcourse corrections, to modify aspects of the program that are not working as originally intended, or to identify problems or gaps that need attention. Process evaluation can help a project ensure accountability by comparing its actual performance with expectations and explaining reasons for any differences. Such information can help program administrators understand why some activities were more useful than others, leading to improved services in the future.

An **outcome evaluation** employs a causal framework; that is, an intervention is assumed to cause a particular outcome. This type of evaluation is used to study the effectiveness of a program. It employs quantifiable data to determine whether or not a program had the desired effects. Examples might include a reduction in the suicide rate or in attempted suicides, changes in knowledge among primary care physicians of treatment resources, or changes in the number of depressed people taking antidepressants. While evaluation is often thought of in terms of measuring overall effectiveness, frequently less comprehensive questions can be asked. For example, an evaluation might address the ability of an outreach program to actually contact people at risk and it might assess the cost of doing so; another might examine the way in which health provider characteristics affect the ability and/or willingness of these individuals to effectively engage persons at risk of suicide.

Steps in Conducting an Evaluation

The key steps in evaluation are as follows:

1. Engaging staff and other potential stakeholders in the evaluation process.
2. Focusing the evaluation design.
3. Gathering evidence.
4. Justifying conclusions.
5. Ensuring use and sharing lessons learned.

1. Engaging Staff and Stakeholders: Involving staff and stakeholders in an evaluation ensure that their perspectives are understood. If they are not engaged, the evaluation might overlook important elements of the program. Stakeholders can also help to implement the evaluation. They can improve its credibility and help the project address any potential ethical concerns.

There are several ways to involve stakeholders in an evaluation. These include consulting with representatives from as many groups as possible; developing an evaluation task force and including representatives of the stakeholder groups; and providing timely feedback on the process of the evaluation. An advisory committee might be formed to function throughout the life of the project.

The provision of feedback to project staff and other relevant stakeholders on the ongoing progress of an evaluation is often overlooked, resulting in missed opportunities to improve the evaluation and ensure that the field ultimately uses its findings. Examples of ways to provide feedback include weekly meetings with program staff; monthly discussions or roundtables with a larger group; newsletters; and/or biweekly memos from the evaluator(s) on insights and reflections for response and comment. Ongoing dialogue and frequent communication are essential elements in ensuring that providers remain engaged in the project; such communication may also assist the evaluation team to refine the design and interpretations of the study.

2. Focusing the Evaluation Design: The evaluation question(s) drive the study. There are many potential questions that can be asked in an evaluation. Patton (1997) identifies 57 alternative ways of focusing an evaluation, each type with a different purpose and associated question—and these, he states, are illustrative only. Examples of ways to focus an evaluation and the types of questions relevant to each are shown in the table below.

Table 5-3: Evaluation

Focus of Evaluation	Defining Question or Approach
A. OUTCOME:	
Causal	What is the relationship between an intervention (as a treatment) and outcomes? Can the intervention be shown to have resulted in the observed outcomes?
Cost-Benefit	What is the relationship between program costs and program outcomes (benefits)
Effectiveness	To what extent is the program effective in attaining its goals? How can the program be more effective?
Social and Community Indicators	What social and economic data should be monitored to assess the impacts of the program? What is the connection between program outcomes and larger-scale social indicators, for example, unemployment?

B. PROCESS:	
Implementation	To what extent was the program implemented as designed? What issues surfaced during implementation that need attention in the future?
Context	What is the environment within which the program operates politically, socially, economically, culturally, and scientifically? How does this context affect the program?

After defining one or more important questions, the program and evaluation team must then determine whether or not it is possible to answer them. Perhaps a question cannot be clearly stated or its elements adequately defined. Or perhaps there is not a methodology that can be used to answer the question. Or, while it may be theoretically possible to design an evaluation study to answer a particular question, it may be quite expensive to conduct the study and sufficient funds may be unavailable. Determining whether or not a question can be asked clearly, whether there is a way to study it, and whether there is sufficient money to undertake an appropriate study is sometimes referred to as an "evaluability assessment."

Many people now use a "logic model" as a way to identify evaluation questions. A logic model is simply a diagram (perhaps a flow chart or a table) that shows the relationships between program elements and presumed outcomes; it represents the theory of how and why the program is assumed to work. By developing such a diagram, program stakeholders can sometimes clarify areas of particular interest for evaluation. An example of a completed logic model is included at the end of this discussion.

Once the questions for the evaluation have been determined, the project team must design the methodology. Decisions are made on issues such as the specification of groups that will be studied, the means by which groups will be selected, time intervals for study, the kinds of comparisons that are planned, and the form in which data are to be collected. Either qualitative or quantitative data may be collected, sometimes both. An evaluation question that addresses proving effectiveness, for example, will usually require a formal research design that includes a control group and the development of quantitative measures, but a question that is concerned with understanding a project's responsiveness to cultural issues will most likely employ methods such as interviews and focus groups.

3. Gathering Evidence: As a part of the study design, the evaluation team will need to decide on the instruments for collecting it. Survey questionnaires, interview protocols, and coding forms are examples of instruments. In some cases, it is possible to use preexisting instruments; in other cases, the evaluator will need to develop a new instrument. An advantage of existing instruments is that they are often (but not always) standardized (i.e., scores on particular items have been rated as "normal" and "non-normal"), and they may have been established as valid and reliable (valid means the instrument measures what it is supposed to measure and reliable means that responses are consistent over time). The disadvantage of using existing instruments is that they may not be appropriate for the particular program being evaluated. For example, an instrument may refer to services not provided through the program, or it may be inappropriate for the cultural or ethnic groups that make up a community.

4. Justifying Conclusions: In the data analysis phase of evaluation, the information is interpreted and a judgment made about the meaning of the data that has been collected. What are the answers to the questions that have been posed and what do these answers mean?

Generally, some standard will be used to judge the meaning of the findings. For example, if one of the desired outcomes of a program is the institution of or improvement in outreach services, a number by itself will have little relevance in the absence of a standard. Is an outreach program successful that reaches 15 percent of the population? The answer depends on what the program and the community defined as adequate and appropriate.

When diverse stakeholders have different standards, they may disagree on the conclusions that may be drawn from the data analysis.

5. Ensuring Use and Sharing Lessons Learned: Evaluation is only worth doing if it leads to improvements in knowledge and program operations. There is both a local and a universal component to utilization of evaluation findings. Evaluation should be important first of all to the stakeholders of the particular program that was evaluated; evaluation findings should inform programmatic decision-making and address questions that are important to program staff and service recipients. Engaging stakeholders throughout the evaluation process helps to ensure an evaluation that is relevant to the program and that may lead to changes in procedures and policies, if necessary, or to enhanced support for the program interest in the issue. Findings may help to improve the functioning of related projects, convince policy makers of the importance of the program, and generate wider support for the program. Evaluation findings presented in the media can increase public understanding.

Conclusion

This discussion has provided a very brief overview of some issues related to evaluation. It is intended to provoke thought and to suggest the importance of evaluation for suicide prevention. More detailed information on evaluation may be found on the Web sites and in the books listed below."

This section was adapted from the *National Strategy for Suicide Prevention: Goals and Objectives for Action*, "Appendix B: Evaluation of Suicide Prevention Programs," which is available at SAMHSA's National Mental Health Information Center.

http://www.mentalhealth.samhsa.gov/publications/allpubs/S MA01-3517/appendixb.asp.

Resources and Tools

Additional resources were added from the Suicide Prevention Resource Center at:
http://www.sprc.org/sites/sprc.org/files/library.

Useful Web Sites for Evaluation

- https://www.bja.gov/evaluation/
  This site, supported by the U.S. Department of Justice, Bureau of Justice Assistance, provides a primer on evaluation. While the examples are oriented to projects of the Department of Justice, the text is generic to evaluation of community-wide programs.

- http://www.cdc.gov/eval
  This site, supported by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, provides a description of the public health approach to evaluation in a clear and straightforward manner. It includes links to other Web sites with additional information on program evaluation, including numerous online publications that can be downloaded.

- http://ctb.ku.edu/en/services/ods.htm
  Part of the University of Kansas's Community Toolbox. This part of the toolbox provides a framework and supports for conducting a program evaluation. There are outlines, how-to materials, and links to other resources about evaluation.

- http://www.rand.org/pubs/index.html
  Incorporating traditional evaluation, empowerment evaluation, results-based accountability, and continuous quality improvement, this manual's ten-step process enhances practitioners' substance abuse prevention skills while empowering them to plan, implement, and evaluate their own programs.

- http://www.sprc.org/sites/sprc.org/files/library/catool.pdf
  Adapted from: Community Assessment Tool developed by the Suicide Prevention Program at the Massachusetts Department of Public Health. This assessment tool is targeted for "prevention networks," coalitions of change-oriented organizations and individuals working together to promote suicide prevention.

- http://www.sprc.org/sites/sprc.org/files/library/datadriven.pdf
  A suicide prevention-planning model by Richard Catalano and David Hawkins is outlined in five steps. The model assumes that a broad-based coalition has been formed and is sufficiently organized to support the infrastructure necessary for this plan.

- http://www.sprc.org/sites/sprc.org/files/library/swot.pdf
  Useful in conducting qualitative assessments, this document is a tool to identify Strengths, Weaknesses, Opportunities, and Threats (SWOT) of critical aspects of suicide prevention efforts. A bibliography is included.

- http://www.wkkf.org/
  This site includes a downloadable version of the excellent evaluation handbook developed by the W.K. Kellogg Foundation for its grantees. It provides much useful information for evaluating projects that are community-based.

- *For additional evaluation resources, visit the Suicide Prevention Resource Center's online library at: http://www.sprc.org/libraryresources/listing

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Additional Sources:

"Collaboration Math: Enhancing the Effectiveness of Multidisciplinary Collaboration," The Prevention Institute. http://ww.preventioninstitute.org/pdf/collab_math_web_020105.pdf

"Community Coalition Suicide Prevention Checklist," Suicide Prevention Resource Center. http://www.sprc.org/library/ccspchecklist.pdf

"Developing Effective Coalitions: An Eight Step Guide," The Prevention Institute. http://thrive.preventioninstitute.org/pdf/eightstep.pdf

"Getting To Outcomes: Methods and Tools for Program Evaluation and Accountability (Volume I)," SAMHSA Center for Substance Abuse Prevention. National Center for the Advancement of Prevention. http://gametlibrary.worldbank.org/FILES/309_Methods and tools for Program Evaluation.pdf

"The Tension of Turf: Making It Work for the Coalition," The Prevention Institute. http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=103&Itemid=127

Postvention

Chapter 6

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Postvention becomes prevention when, after each and every suicide people follow practical guidelines to prevent more deaths.

Jenna Heise, State Suicide Prevention Coordinator MHSA Program Services, Dept. of State Health Services

Introduction to Postvention

A death by suicide has potential complications for a community outside of the personal tragedy. National studies show that, in some cases, a death by suicide can lead to other deaths through a cluster effect mediated by contagion. According to the Centers for Disease Control and Prevention, "A suicide cluster may be defined as a group of suicides or suicide attempts or both, that occur closer together in time and space than would normally be expected in a given community."

Unfortunately, Texas is not insulated from these secondary effects of suicide. Over the last decade, there have been several suicide clusters among teenagers and young adults, who are the primary demographic to experience cluster and contagion events. Public concern and awareness has been elevated as a result, and schools and communities are incorporating the clustering and contagion phenomena into their postvention planning processes. The Centers for Disease Control and Prevention point to the following characteristics of suicide clusters:

- Clusters of completed suicides occur predominantly among adolescents and young adults.
- Such clusters account for up to 5% of all suicides in this demographic range.
- Suicide clusters appear to occur through a process of contagion with some evidence suggesting that in any given cluster, suicides occurring later in the cluster appear to have been influenced by earlier suicides.
- Ecologic evidence suggests that exposure of the general population to suicide through media may increase the risk for suicide in certain, high-risk individuals.

Due to the inherent vulnerability of many, especially youth, in response to suicidal behavior displayed by others, it is important that every school and community have a postvention response plan. As discussed in Chapter 5, Texas now requires that every school have a campus-based suicide prevention plan in place and HB 1386 requires the Texas Department of State Health Services and the Texas Education Agency to provide schools with lists of available resources that conform to best practices standards.

http://www.texassuicideprevention.org/pdf/HB1386-Final-12mar2012.pdf

While prevention is the key, and incorporating suicide prevention programs is the first level of preventative measures, once suicidal behavior has occurred, postvention protocols should be implemented immediately to prevent imitative behavior among other at-risk portions of the community.

Cluster and/or contagion can be the result of the lack of timely intervention. Postvention guidelines and protocols are developed in part to prevent cluster or contagion from developing. For the postvention protocols to be effective, training on both the purpose of the protocols and their effective implementation must be delivered. There are many key stakeholders in the community who touch the lives of youth and adults who are at risk for suicide and they play a role in postvention efforts. No single entity—not even a school—can orchestrate and implement a community-based approach to postvention independently. This community approach is consistent with postvention recommendations from the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration, among others.

This chapter will provide key information about postvention initiatives to assist you in developing and implementing these plans and related activities based on your community's needs.

What is Postvention?

According to the Suicide Risk and Assessment website, "Postvention," in relation to suicide, was first used in 1981 by Edwin Shneidman, who first coined the term. The American Association of Suicidology (1998) defines suicide postvention as "the provision of crisis intervention, support and assistance for those affected by a completed suicide". "Affected" individuals include classmates, friends, teachers, and family members, and are often referred to as "survivors" of suicide (Knieper, 1999). A discussion about the history of the term "postvention" is located at: http://sud.editme.com/Postvention-0. From a practical perspective, postvention is an intervention conducted after a death by suicide, primarily in the form of:

- Support for the bereaved (family, friends, associates, fellow students, fellow military service members and others).
- Outreach into the community to support others who may be vulnerable to suicide (who may now include the bereaved listed above).
- Careful communication and coordination with community stakeholders such as health and mental health providers, school officials, law enforcement and other first responders, faith communities, parents and social services agencies.

What are the Goals of Postvention?

While goals may be slightly different for each constituency, generally there is agreement to the following high-level goals related to postvention initiatives:

- Reduce the risk of further suicidal behavior.
- Avoid glorifying or sensationalizing the suicide.
- Avoid vilifying the decedent.
- Identify other members of the community that may represent a high risk for suicidal behavior.
- Connect high-risk community members with mental health resources.
- Identify/alter environmental factors that may be influencing the process of contagion.
- Provide long-term surveillance (data collection and analysis) across the spectrum of suicide related activities and outcomes.

Community-Based Postvention Planning

Postvention planning involves consideration to a wide-range of assets available in the community that are useful in postvention activities. A well-coordinated postvention plan, developed through the efforts of a multidisciplinary team of community stakeholders, may be pivotal in preventing the contagion process that contributes to the development of suicide clusters. No single agency or community organization has the resources or expertise to adequately develop a 360-degree response to an emerging suicide cluster; it takes everyone working together. Suicide is a complex issue, and as such, preventing suicide will require a well-planned and coordinated effort across many aspects of the community. Some of these include:

- Faith-based Members of the Community
- Law Enforcement
- Mental Health America of Texas and Local Affiliates
- Funeral Homes
- Primary Care Providers
- University Researchers in Education, School Psychology, Psychology and/or Social Work
- Texas Suicide Prevention Council
- Local Hospitals
- NAMI Texas and Local Affiliates
- Texas Medical Association
- Local Mental Health Authorities (LMHA)
- Suicide Prevention Coordinator from the LMHA (see Chapter 3)
- Parent Associations
- Local Suicide Prevention Coalitions
- Social Service Agencies
- School District resources (administration, counselors, nurses, school resource officers)

Postvention includes procedures to alleviate the distress of bereaved individuals, reduce the risk of imitative suicidal behavior, and promote the healthy recovery of the affected community. Postvention can also take many forms depending on the situation in which the suicide takes place. Schools and colleges may include postvention strategies in overall crisis plans. Individual and group counseling may be offered for survivors (people affected by the suicide of an individual). Since postvention works best when it is a community-wide process, checklists and outlines are provided in this toolkit for a community to use to bring key stakeholders together to develop a suicide postvention plan specific to their area.

As a general rule, community postvention efforts should be especially mobilized when:

1. Youth suicides or attempted suicides occur closer together in space and time than is considered usual for the community.
2. One or more deaths from trauma occur in the community (especially among adolescents or young adults) that may influence others to attempt or complete suicide.

Note: Although suicide clusters and contagion occur primarily in youth and young adults, Texas has had clusters of deaths by suicide in other age groups as well, however the prevailing research indicates that adolescents and young adults are at most risk for contagion and clustering outcomes.

Developing a Postvention Action Plan

There are several key postvention steps that should be incorporated into your community's postvention plan. *CDC Recommendations for A Community Plan for the Prevention and Containment of Suicide Clusters,* published by the Centers for Disease Control and Prevention, provides an excellent resource for postvention planning, especially as it relates to minimizing the risk of suicide clusters immediately after a suicide.

The CDC outlines the following high-level steps to consider when preparing a postvention plan for crisis management related to suicide:

I. A community should review these recommendations and develop its own response before the onset of a suicide cluster.

II. The response to the crisis should involve all concerned sectors of the community and should be coordinated by:

a. Coordinating Committee, which manages the day-to-day response to the crisis, and:

b. Host Agency, whose responsibilities would include "housing" the plan, monitoring the incidence of suicide, and calling meetings of the Coordinating Committee when necessary.
   i. The relevant community resources should be identified.
   ii. The response plan should be implemented under either of the following two conditions:
      a. When a suicide cluster occurs in the community, or
      b. When one or more deaths from trauma occur in the community, especially among adolescents or young adults, which may potentially influence others to attempt or complete suicide.
   iii. If the response plan is to be implemented, the first step should be to contact and prepare those groups who will play key roles in the first days of the response.
   iv. The response should be conducted in a manner that avoids glorification of the suicide victims and minimizes sensationalism.
   v. Persons who may be at high risk of suicide should be identified and have at least one screening interview with a trained counselor; these persons should be referred for further counseling or other services as needed. A timely flow of accurate, appropriate information should be provided to the media.

Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed. Long-term issues suggested by the nature of the suicide cluster should be addressed.

The complete document, including actionable information about each step above is located at:
http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm

Immediate Steps to Take Upon a Death by Suicide

Texas law provides specific guidelines for responding to an untimely or unattended death. The purpose of these laws is to improve understanding, efficacy, and access to suicide prevention efforts in Texas. As a result, there are significant reporting mechanisms in place for a number of state and local entities that often require the collecting and dissemination of key data when suicide is indicated. Some of these include:

- The deceased individual's date of birth, race or national origin, gender, and zip code of residence
- Any school or college the deceased individual was attending at the time of death
- The suicide method used by the deceased individual
- The deceased individual's status as a veteran or member of the armed services
- The date of the deceased individual's death.

For reporting purposes, this information can be shared across a wide spectrum of agencies and organizations for purposes related to suicide prevention provided the individual's name is not released. Please note this is distinct and different from the actual death certificate, which is a matter of public record. This usually includes the cause of death (i.e., overdose or gunshot) and the manner (accident, homicide or suicide). If the media or other qualified individual requests this information, it will normally be disclosed through the medical examiner's office.

For more information concerning Texas State statutes related to suicide, please see *Texas Statutes Regarding Suicide*, which is included in Appendix A or the Texas Suicide Prevention Council webpage on the subject, located at: http://texassuicideprevention.org/pdf/Texas_laws_suicide.pdf

What to Do if a Death by Suicide is Discovered:

Anyone who discovers a body of a person who died an untimely or unattended death must report the death to the office of the medical examiner or the police. Generally the medical director will make arrangements for transportation of the body and a funeral home may be requested to assist in this transport.

According to Texas State Law, a medical examiner's office must hold an inquest into the death of a person who dies in the county if the person completes suicide or the circumstances of the death indicate that the death may have been caused by suicide. If either of the above conditions are met, the death certificate must state the cause of death was suicide. In counties that do not have a medical examiner, the justice of the peace will be responsible for the conduct of the inquest. If the cause of death is determined to be suicide, by law, it must be reflected as such on the decedent's death certificate. In cases involving suspected overdoses, poisoning, drugs, alcohol, or other situations requiring toxicology test/report, the death certificate may not be finalized until test results are returned (often 6-8 weeks after the death).

Texas state law also authorizes Texas counties to establish "fatality review teams" to investigate unexpected deaths, which include deaths by suicide, and to use the information gathered from the investigations to engage in activities to prevent such deaths in the future—including "advising the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of unexpected deaths." As a result, pertinent personal information about the deceased is authorized to be collected, such as medical, dental and mental health records, birth certificates, law enforcement, juvenile court records, parole and probation information and records, and adult protective services information and records. Further, as part of their review, the fatality review team can request a closed meeting with persons who may have information regarding a fatality resulting from suicide.

Health care professionals are also required by law to report all adult deaths to the medical examiner (or a justice of the peace if in a county without a medical examiner) that are caused by suicide or that may be a result of suicide, or is suspected to be suicide. The cause (e.g. overdose or gunshot) and manner (e.g. suicide or accident) of death is subject to required public disclosure. If the media or qualified individuals request this information through an official public information request, it will normally be disclosed by the Medical Examiner's office.

To Obtain a Certified Copy of a Death Certificate in Texas:

The Texas Department of State Health Services Vital Statistics Unit governs the release of death certificates in Texas. If the death certificate has been issued within the past 90 days, it is likely the processing time will be longer while this newer data is entered into the system. There is now online access to ordering death certificates and death verification letters, which can expedite the process.

According to the Department's website, death records within the past 25 years are considered "protected records," meaning there are certain requirements that must be met in order to obtain a certified copy of a death certificate through the TexasOnline processing system. These are:

1. If you live in Texas, you can order the records of your immediate family members. If you live outside Texas, you must be the surviving spouse of the deceased, a parent of the deceased or the funeral director of the funeral home on the record.
2. You must have a valid state-issued driver's license or government-issued ID card.
3. You must be ordering a record that is to be delivered within the United States, to U.S. territories or U.S. commonwealths, or to U.S. military addresses (APO, FPO).

4. You must have a valid credit card.

Offline instructions for ordering a death certificate

5. Fill out an application for a certified copy of a birth or death certificate. For deaths that occurred 25 years ago to the present, only the immediate family members to the name on the death certificate are eligible to request a copy. If you are not an immediate family member, you must provide legal documentation, such as an insurance policy listing you as a beneficiary, that documents a direct and tangible interest in the record.
6. Send in the application with payment using one of the methods listed in the table below. If the death occurred within the last 25 years, you must include a photocopy of your valid photo government-issued ID. The following are acceptable forms of ID:

- State-issued driver's license
- State/city/county ID card
- Student ID
- Government employment badge or card
- Prison ID
- Military ID

If you do not have a photo ID, an alternative would be to send a copy of the photo ID of an immediate family member or copies of two documents with your name, such as a utility bill and your Social Security card. One of the documents must have your signature.

Applications where the death on the death certificate was within the last 25 years received without photo ID or the alternatives listed above will not be processed. The estimated response time is accurate for most requests, but will vary depending on the circumstances. Please note that death certificates for recent deaths may be delayed.

If you are paying by check, make checks payable to: DSHS.

For more information:
http://www.dshs.state.tx.us/VS/reqproc/deathcert.shtm

Obtaining a Death Verification Letter

The Texas Department of State Health Services Vital Statistics Unit also governs the release of Death Verification Letters for deaths that have occurred in Texas since 1903. A death verification letter simply states that a death certificate is on file with the State of Texas for the person indicated on the form. According to the Texas State Department of Health Services, a death verification letter is a letter that states whether or not a particular death was registered with the State of Texas. If the record is found, the verification letter will include the name of the deceased, the date of death, the county of death and the state file number.

The Texas death verification letter is not a replacement for a death certificate in most instances. At present, death verification letters requested within 90 days of the death certificate's issuance may not yet be available through its online services.

In order to use the Texas.gov online services for the ordering of a Death Verification Letter, the following criteria must be met:

- You must be ordering a record that is to be delivered within the United States, to U.S. territories or U.S. commonwealths, or to U.S. military addresses (APO, FPO).

- You must have a valid credit card.

If you do not meet the above criteria, the Texas Department of State Health Services has provided the following table (6-1) for ordering a death verification letter in Texas.

Table 6-1

Offline application methods	Instructions	Cost	Payment methods accepted	Processing time for most requests
In person at the Texas Vital Statistics Office (VSU) in Austin	Come to our office at 1100 W. 49th Street Austin, TX 78756 Monday-Friday 8 am - 5 pm	$22–Birth $20–Death	Cash Check Money order	A half-hour to 2 hours. If longer is needed, you will be given a pickup time for 3:30 that afternoon or 10:30 the following morning.
U.S. Postal Service regular mail Orders may be sent via mail and paid with a credit card, check or money order	Application–Word (58K) Application–pdf (28K)	$22–Birth $20–Death	Check Money order	6-8 weeks

For more information:
http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=35672&id=3633&terms=death+verification

Suicide Postvention for Family and Friends

When our 18-year-old high school senior died by suicide, he was number five in a suicide cluster. We were faced with our own personal grief complicated by the overwhelming needs of the community for appropriate postvention education. We not only faced the "what ifs," guilt, and grief as a family, but were haunted by the prospect of more teen suicide deaths. As grieving parents, we had to reach out and access support from mental health professionals for ourselves AND our community and youth at risk. We are grateful for family, friends, faith community and mental health professionals who provided postvention support, but wish that a postvention plan had been in place to help save lives of our youth. If only…

Merily H. Keller, Past Chair & Founding Board Member
Texas Suicide Prevention Council

Suicide postvention for family and friends involves balancing the overwhelming grief and loss of the individual involved with community needs for a public health postvention response to prevent even more tragic deaths. Often, these two needs are not completely aligned and, as the Austin-Travis County Suicide Coalition notes in its suggested postvention protocols, "in some cases, the suggested postvention response may be counter-intuitive or go against what you might normally do [under a different set of circumstances surrounding a death]." Therefore, postvention isn't an attempt "to tell someone or a community how to grieve—that's a very personal choice based on individual beliefs, culture, religion and tradition, but to inform all involved (family, friends, youth, first

responders, clergy, funeral homes, medical and mental health professionals)—that their response has the potential of adding to the risk of future deaths by suicide or helping to prevent future suicide tragedies."

http://www.nami.org/Content/Microsites140/NAMI_Austin/Home130/Advocacy11/Suicide-Prevention.pdf

As a result, postvention guidelines may help everyone in the aftermath of a suicide to successfully communicate and provide appropriate crisis response and long-term support of those immediately affected as well as the greater community.

Managing Survivor Grief

As with any sudden or unexpected death, those who have lost a loved one to death by suicide (often called survivors of suicide) have not had time to say goodbye. This suddenness, coupled with the violence of a death by suicide and common misunderstanding and stigma surrounding the death, can greatly intensify, complicate, and extend the time of the grief process. It is important to remember and know that it may be normal for survivors to face guilt about being unable to save the life of their loved one and spend time asking "why" their loved one took their own life before being able to move forward in the grief process.

It is also important to know that survivors may be at increased risk of death by suicide themselves so it is important to ensure that professional mental health support is readily available if needed. In fact, surviving a suicide event is considered a risk factor for heightened risk for suicide. Anyone who believes or suspects that they are facing Complicated Grief and/or Post Traumatic Stress Disorder is encouraged to get professional mental health support.

Different Types of Grief:

Generally there are three different types of grief related to suicide. These are:

Normal Grief: According to the Mayo Clinic, normal grief can be described as a period of sorrow, numbness, guilt and/or anger, followed by a gradual fading of these feelings as the loss grows and the person is able move forward.

Complicated Grief: Compounds the above and involves a more complicated, painful and debilitating process. The painful emotions are so intense and are so long lasting and severe that there is difficulty in accepting the death and returning to day-to-day activities.

Post Traumatic Stress Disorder: Survivors of a death by suicide, especially if they were the party that discovered the body of the deceased, may be at an increased risk for PTSD. The Menninger Clinic has defined PTSD as "a disorder that develops after traumatic stress. The hallmark of PTSD is re-experiencing the trauma in response to reminders through symptoms such as flashbacks and nightmares."

Postvention Goals for Family and Friends

Postvention involving friends or family members of someone who has died by suicide poses significant challenges in crafting a course through personal grief at the individual level with the need to reduce the likelihood of contagion and cluster suicide events at the community level. As a result, the goals for postvention in this area include:

- Provide support for normal grief process and minimize complicated grief and guilt reactions to the degree possible.
- Reduce the risk of further suicidal behavior (this may include efforts to remove firearms from the home and/or providing gun locks as well as removing or controlling access to lethal medications.)
- Connect family and friends to health and mental health resources in the community.
- Provide education and information about best practices related to funerals and memorial services for suicide decedents so that family and friends can help prevent suicide clusters and contagion in the immediate aftermath of a suicide.

One way those who are supporting friends and family in the grieving process can assist them is to remind them about the importance of self-care during the stressful period immediately following a death by suicide. Self-care includes:

✓ Get plenty of rest ✓ Exercise ✓ Be gentle with yourself and others ✓ Avoid use of (or increased use of) alcohol or other substances	✓ Maintain proper diet and nutrition; drink plenty of water ✓ Use relaxation skills. ✓ Seek out supportive people ✓ Ask for help, when needed and have referrals for sources of help

The American Association of Suicidology (AAS) has developed a comprehensive fact sheet for how to support family and friends who have lost a loved one to suicide. *Helping Survivors of Suicide: What Can I Do?* provides a wealth of useful information to assist in guiding persons coming in contact with survivors of suicide.

This Fact Sheet is located at:
http://www.suicidology.org/c/document_library/get_file?folderId=257&name=DLFE-456.pdf

Figure 6-1: Helping Survivors of Suicide

Helping Survivors of Suicide: What Can You Do?

The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex and long term. Grief and bereavement are an extremely individual and unique process.

There is no given duration to being bereaved by suicide. Survivors of suicide are not looking for their lives to return to their prior state because things can never go back to how they were. Survivors aim to adjust to life without their loved one.

Common emotions experienced with grief are:

Shock	Denial
Pain	Numbness
Anger	Shame
Dispair	Disbelief
Depression	Stress
Sadness	Guilt
Rejection	Loneliness
Abandonment	Anxiety

The single most important and helpful thing you can do as a friend is listen. Actively listen, without judgment, criticism, or prejudice, to what the survivor is telling you. Because of the stigma surrounding suicide, survivors are often hesitant to openly share their story and express their feelings. In order to help, you must overcome any preconceptions you have about suicide and the suicide victim. This is best accomplished by educating yourself about suicide. While you may feel uncomfortable discussing suicide and its aftermath, survivor loved ones are in great pain and in need of your compassion.

Ask the survivor if and how you can help. They may not be ready to share and may want to grieve privately before accepting help.

Let them talk at their own pace; they will share with you when (and what) they are ready to.

Be patient. Repetition is a part of healing, and as such you may hear the same story multiple times. Repetition is part of the healing process and survivors need to tell their story as many times as is necessary.

Use the loved one's name instead of 'he' or 'she'. This humanizes the decedent; the use of the decedent's name will be comforting.

You may not know what to say, and that's okay. Your presence and unconditional listening is what a survivor is looking for.

You cannot lead someone through their grief. The journey is personal and unique to the individual. Do not tell them how they should act, what they should feel, or that they should feel better "by now".

Avoid statements like "I know how you feel"; unless you are a survivor, you can only empathize with how they feel.

August 20, 2004

Survivors of suicide support groups are helpful to survivors to express their feelings, tell their story, and share with others who have experienced a similar event. These groups are good resources for the healing process and many survivors find them helpful. Please consult our website (www.suicidology.org) for a listing of support groups in or near your community.

The American Association of Suicidology (AAS) offers a variety of resources and programs to survivors in an attempt to lessen the pain as they travel their special path of grief. These include:

- Survivors of Suicide Kit: an information kit consisting of fact sheets, a bibliography, and sample literature.
- *Survivors of Suicide: Coping with the Suicide of a Loved One* booklet and *A Handbook for Survivors of Suicide*.
- *Surviving Suicide*, a quarterly newsletter for survivors and survivor support groups.
- "Healing After Suicide", an annual conference held every April, for and about survivors.
- Suicide Prevention and Survivors of Suicide Resource Catalog: a listing of books, pamphlets, etc. which can be ordered from AAS. Includes resources for children and those who care for them.
- Directory of Survivors of Suicide Support Groups – print version available for purchase and an online version available at www.suicidology.org.
- Guidelines for Survivors of Suicide Support Groups: a how-to booklet on starting a support group.

Additional Resources

- Survivors of Suicide (www.survivorsofsuicide.com).
- Suicide Awareness: Voices of Education (SAVE) (www.save.org).
- American Foundation for Suicide Prevention (AFSP) (www.afsp.org).

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

American Association of Suicidology
5221 Wisconsin Ave. N. W.
Washington, DC 20015
(202) 237-2280
(202) 237-2282 (Fax)
Email: info@suicidology.org
Website: www.suicidology.org

As indicated above, there are numerous steps to take for those involved in supporting suicide survivors. Below, please find two checklists for use when providing such support.

Checklist for Postvention Support of Friends and Family

Help family and friends identify a support network and mobilize that network for the immediate aftermath of a death by suicide: 1. Allow family and friends to share their grief openly and share remembrances of their loved one 2. Provide information and support to family and friends by downloading some of the brochures and resources for dealing with the aftermath of a death by suicide (See downloadable brochures in Part 4.	3. Connect them to Survivors of Suicide Support Groups and/or other local grief support resources and/or faith community resources. 4. Advise them of the availability of professional mental health support for more intense or complicated grief that may accompany a death by suicide (facilitate and/or make referrals when needed). 5. Long term, help them to consider living memorials to their loved ones by giving them information about how to get involved in mental health and/or suicide prevention community education and outreach and/or fund raising for mental health and suicide prevention.

Checklist For Community Postvention Concerns For Family and Friends to Consider (or for those assisting family and friends)

Identify a family member, friend, faith community representative, funeral home advisor or mental health professional who might be able to gently and carefully share some postvention community concerns and suggestions with family and friends regarding:

1. Taking care of themselves, their family members and friends by limiting the access to a death by suicide for those in intense grief and storing guns away from their house and/or making sure that they are locked. Also limit access to and/or lock lethal medicine during the immediate grief period.

2. In the midst of intense personal trauma, being aware of community safety needs and taking care to not sensationalize the death by suicide of their loved one or publicize the specifics of the means of death by suicide. In fact, family may want to send media inquiries and questions to mental health or suicide prevention specialists who are informed about suicide prevention and postvention and aware of the best practice media guidelines.

3. Scheduling memorials off-campus instead of in a school setting. Recognition of many school policy limits regarding on-site memorials and that these schools are following suicide postvention best practices.

4. Being aware of how at-risk students might view any memorials and memorial services and seek community support for the provision of mental health providers who might attend to support at-risk attendees—especially youth.

5. Care to be taken in the selection of any youth to be involved in the memorial service so that at-risk youth are not further traumatized. (If youths are to be involved, appropriate counseling might be offered before and/or after the service by a mental health provider.)

6. If the family is comfortable and open about the death being a death by suicide, share the 1-800-273-TALK (8255) Suicide Prevention Lifeline Crisis Number in the memorial service or funeral bulletin and/or download the Lifeline Cards to have available at the service. Local suicide prevention and/or crisis hotline numbers might also be shared. Also consider sharing these resources on online funeral home memorial pages in memory of their loved one and on any social network site dedicated to their loved one. (See social network site recommendations in Part 4.)

Support for Survivors and The Community at Large

Share Resources for Help

Since survivors of the death of a close friend or loved one have an increased risk themselves, it is important to connect them to resources for additional mental health support. Because their ability to concentrate and remember new information may be affected by grief, give them written information on how to find mental health resources for themselves and for their children or teenagers, including information on how to access survivors of suicide support groups.

Referrals for Survivors & Community Members

You might also remind clients to contact their primary care physician to get referrals for mental health providers. Many local medical societies and mental health professional groups maintain and/or provide a database of area

mental health providers. Be prepared to share such a resource with family members and survivors of suicide.

Grief Counseling Outreach

If you are a social service agency with grief counselors or if you have access to other social service agencies with grief counselors, you may want to see if the agency would be comfortable providing counselors before and after the memorial service and/or partner with area schools to offer no-cost or low cost grief counseling after school hours. Be sure to let people know they will be available and how to connect with them.

Awareness of Potential Disorders

Sometimes following a death by suicide, the survivors, particularly if they witnessed the death or felt a sense of helplessness or horror, may develop symptoms of Acute Stress Disorder or Post Traumatic Stress Disorder (PTSD). Symptoms can include feelings of distress, anxiety and depression. If someone experiences these symptoms they should seek consultation with their medical or mental health provider as soon as possible.

Participating in Community Postvention Planning

Because a death by suicide affects the community as a whole and has the potential for a contagion effect, it is important for health providers, mental health providers and social service agencies to be a part of local planning teams to develop postvention guidelines. If those guidelines have been developed, be sure to follow them. If they have not been developed, consider being part of a community team charged with their development. In this way you can lower risk factors for future deaths by suicide and increase protective factors for the community as a whole.

More Information Available Online:

A number of states have produced suicide prevention and postvention toolkits, which can be accessed through the Suicide Prevention Resource Center. Two toolkits with stakeholder specific postvention protocols are included below.

NAMI, New Hampshire Connect/Frameworks: *Training Professionals & Communities in Suicide Prevention & Response* available online at:
http://www.theconnectprogram.org, with protocols for specific stakeholders listed at:
http://www.theconnectprogram.org/training/postvention-training-promoting-healing-and-reducing-risk-after-suicide

http://www.sprc.org/

The Maine Youth Suicide Prevention, Intervention and Postvention Guidelines developed by the Maine Youth Suicide Prevention Program, which can be accessed at http://www.maine.gov/suicide/professionals/program/index.htm.

Additional Postvention Information Online:

See booklists for family, friends, and youth and online brochures for dealing with the aftermath of a death by suicide included in Chapter 5.

Guide for Funeral Directors about Supporting Survivors: The Suicide Prevention Action Network USA (SPAN USA) and SPRC have released *Help at Hand – Supporting Survivors of Suicide Loss: A Guide for Funeral Directors.* The guide, available in PDF form only, provides funeral directors with practical information about working with suicide survivors.

http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_5/SurvivorsOfSuicideLoss.aspx

The Mental Health America of Texas website and the Texas Suicide Prevention Council website provide general information on mental illness, a toolkit to assist community members in doing suicide prevention work and an extensive appendix with reading lists for family, friends, and professionals as well as contact information for national and state organizations. Downloadable brochures are also available in English and Spanish. http://www.mhatexas.org or http://www.TexasSuicidePrevention.org

Survivors of Suicide (SOS) provides a variety of links, information, and a directory of local support groups. http://www.survivorsofsuicide.com/index.html

Texas Department of State Health Services provides information about ordering death certificates http://www.dshs.state.tx.us/vs/default.shtm. Information on community mental health services (information presented in English and Spanish) is available at: http://www.dshs.state.tx.us/mhservices/default.shtm.

Support Groups for Suicide Survivors

Support groups are a huge part of the healing process for those left behind by suicide. Some might say 'Why not just a grief group?' Although grief groups are good, they don't touch on the real issues left with survivors-the Whys, the Guilt, the Anger, the What-ifs and the Stigma that plague and often hamper recovery of a person reeling from a suicide completion. Support groups are not for everyone, but those who have come to ours say that they look forward to time spent with those who really know how they feel. They can express the feelings that overwhelm them without feeling guilty about what others may think.

Patty Pittman
Former Co-chair, Texas Suicide Prevention Council, Beaumont

Suicide survivor support groups can provide an opportunity for survivors to share their grief with others who have had similar experiences. These groups may be web-based or in person meetings. A professional mental health provider and a survivor of suicide usually facilitate them.

Support Groups in Texas:
The American Foundation for Suicide Prevention provides a regularly updated list of Texas-based survivor groups on their website, located at:
http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=AC806EDD-B491-7467-1CBA90887FBEABED

Table 6-2: Suicide Survivor Support Groups in Texas

City	Group Name	Contact Info
Amarillo	Survivors of Suicide	Kris Collins 806-457-4993, mailto:kris.collins@hillsidewired.com
Austin	Austin Survivors of Suicide	Linda Davis 512-560-6115, mailto:2005lindadavis@gmail.com
	For the Love of Christi-Loss of Loved Ones to Suicide	Christi Center 512-467-2600, mailto:info@christicenter.com
	My Healing Place	Khris Ford (512) 472-7878 khris@myhealingplace.org
Bellaire	Red Bird Center	Marjorie Kosoy 713-621-2700,

		mailto:redbird@redbirdcenter.com
Corpus Christi	Survivors After Suicide	Family Counseling Services 361-852-9665
Dallas	Suicide and Crisis Center of North Texas	Jenyce Gush 214-824-7020, mailto:jenyceg@sccenter.org
	Christian Survivors of Suicide	Dawn Anderson, 214-418-2728, mailto:skycase@yahoo.com
Denton	Touched by Suicide	Carol and Larry Walker, 940-367-1313, mailto:touchedbysuicidedenton@gmail.com
	I Survived: Suicide Survivors Support Group	Angela Powell, 940-395-0073, angelacounselor@gmail.com; mailto:ambercounselor@gmail.com
Flower Mound	Touched by Suicide	Bill Combest, mailto:touchedbysuicide_bc@yahoo.com
Ft. Worth	Survivors of Suicide	Sharon Walker, 817-335-5405, mailto:slwalkercsw@sbcglobal.net
	Suicide Survivors: The Healing Journey After Loss	Marti Lawrence 817-698-9955, mailto:suicidesurvivors@myfumc.org
Grand Prairie	Christian Survivors of Suicide	Dawn Anderson 214-418-2728, mailto:skycase@yahoo.com
Houston	Crisis Intervention of Houston-Survivors of Suicide	Brenda Fitch 713-527-9864 Ronda@crisishotline.org 24 hour crisis hotline: 713-468-5463
Kingwood	Survivors of Suicide Support Group-for Adults and Teens	Bryan Boyle and Jim Simon 713-481-2808, mailto:jim@wellsourcegroup.com
Lewisville	Touched by Suicide	Martha Giles and Kim Bremmer 972-420-7270, mailto:ouvcugmu@aol.com
Midland	Survivors of Suicide	Ron Ellison 432-686-6118, mailto:rellison@hospiceofmidland.org
San Antonio	Survivors of Loved Ones' Suicide	Tony Mata 210-885-7069, Pat O'Brian 210-695-9136 mailto:solossanantonio@gmail.com
San Marcos	CTMC San Marcos Survivors of Suicide	Joe Flores 512-754-0322, mailto:joe.floresjr@ahss.org

Starting a Survivor Support Group:

The Suicide Prevention Resource Center's Best Practices Registry Section II has identified Lifeline Australia's Program "Towards Good Practice: Standards and Guidelines for Suicide Bereavement Groups" as a best practice program for establishing and implementing a suicide bereavement support group. These standards are located at:

http://www.sprc.org/sites/sprc.org/files/bpr/TowardsGoodPracticeStandardsGuidelinesSuicideBereavementSupportGroups.pdf
or directly at the Lifelines' website located at:
http://www.lifeline.org.au/Find-Help/Preventing-suicide/Support-after-a-loss-by-suicide/Support-after-a-loss-by-suicide/default.aspx

Additionally, here are some tips for those starting a survivor support group:

- Have a structured program with a beginning, middle, and end, so that participants can see that there is a "light at the end of the tunnel."
- You may want to have monthly follow-up groups, but if you do, make those time-limited as well.
- Encourage new participants to wait at least three months before joining your group. Those that start too soon often do not finish or do not benefit as much as they might have if they had waited.
- There should be at least one person who is clinically trained in group facilitation. A combination of a clinical professional and a survivor is ideal. The facilitators should be prepared to meet regularly to provide continuity of group leadership.

Best Practices for Community Postvention

Response to suicide has a profound affect on family, friends, organizations, and the community. According to Tony Salvatore, Montgomery County Emergency Services, "it is estimated that every suicide leaves behind 6-8 survivors," (Suicide Loss FAQs located at: http://lifegard.tripod.com/ssfaqs.html). As such, the community's reach into the survivor community is essential to not only promote healing for these individuals and family members but to also reduce the risk of subsequent contagion or cluster events from occurring.

Therefore, how a community responds to a death by suicide plays a crucial role in preventing additional suicides through contagion or clusters. Regardless of the stakeholder or gatekeeper's role in the community, there are important steps that communities and organizations can take in the event of suicide. The Riverside Trauma Center in Needham, MA has developed *Postvention Guidelines for Communities*. The purpose of these guidelines is to assist community stakeholders in developing postvention guidelines to aid in the development of postvention planning and tasks based on individual organization and community needs.

Guidelines for Communities

According to these guidelines. The goals of organizational postvention (whether a business, school, community or other organization) are:

- At the organizational level, to help restore equilibrium and functioning within the school, agency, community or organization.
- At the individual and group level, to promote healthy grieving, and commemorate the deceased for all members of the community who have been impacted.
- At the individual level, to provide comfort to those who are distressed, minimize adverse personal outcomes (depression, PTSD, complicated grief), and reduce the risk of suicide imitation or contagion.
- At the individual level, to identify those most likely to need support. These are likely to include, but are not limited to, people who were psychologically close to the deceased (e.g., friends and family members), people who were already depressed and possibly suicidal themselves before the death, and those who might psychologically identify with the deceased as being similar in lifestyle, values, or life circumstances. After suicide, it is important to identify members of the community who may have felt responsible for the well-being of the deceased, and by extension, for preventing the suicide. For example, in a school setting, teachers, coaches, and counselors who were closely involved with an adolescent who has died of suicide are at risk. Likewise, in a workplace setting, supervisors and colleagues of a person who takes his or her life may feel particularly guilty and/or ashamed for not preventing the death.

The Riverside Trauma Center's Postvention Guidelines for Communities is located at:
http://riversidetraumacenter.com/documents/RiversideTraumaCenerPostventionGuidelines6_24_11.pdf

Trauma Center Postvention Guidelines for Communities

Document Outline

- Verification of death and cause
  - Crucial management of information dissemination, FERPA and HIPPA laws, family's wishes, etc.
- Coordination of external and internal resources
  - Quick mobilization of resources such as mental health professionals, human resource departments, clergy, Employee Assistance Programs that provide crisis support services for businesses.
- Dissemination of information
  - Provide factual information to dispel rumors and speculation; provide small group opportunities for gatekeepers to assess potential at-risk sectors of the community
- Support for those most impacted by the death
  - Support friends, colleagues, neighbors, team members and others who are closest to the situation
- Identification of those at risk and prevention of contagion
  - Crisis teams should keep close contact with persons identified as "at risk" based and monitor their healing process
- Commemoration of the deceased
  - It is important to note that the Centers for Disease Control and Prevention now recommends that a consistent memorial policy be in place, regardless of the cause of death. Focus on the personal attributes and accomplishments rather than the cause of death. CDC also discourages the establishment of permanent memorials on schools or places of business.
- Psychoeducation on grieving, depression, PTSD and suicide
  - Provide appropriate education based on the needs of the audience in order to disseminate best-practice information on what to expect during the grieving process, signs and symptoms of depression, PTSD and suicidality
- Screening for depression and suicidality
  - Postvention initiatives should have a provision to conduct screening for depression and other risk factors in communities following a death by suicide. This is especially important in situations where adolescents and young adults are a target population, as studies show the risk for contagion and cluster events are highest in these demographic groups.
- Provision of services in the case of a second or subsequent suicide
  - It is important to intervene quickly in the event of a second suicide event to contain the development of a suicide cluster. CDC and Riverside Trauma recommend forming a "Community Coordinating Committee" after a second suicide event to elevate the urgency of postvention and subsequent prevention activities across the community. It is essential that a wide range of stakeholders and/or gatekeepers be involved in this process.
- Linkage to resources
  - Provide timely, accurate and relevant information to community members for mental health and emergency mental health resources.
- Evaluation and review of lessons learned
  - As in the Air Force Suicide Prevention Program, continuous improvement should be built into the suicide prevention and postvention planning process that shares lessons learned.

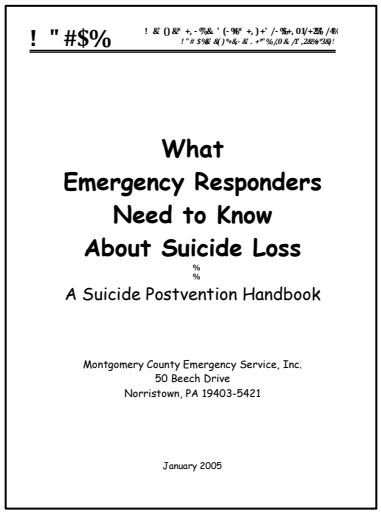
- Development of a system-wide prevention plan
  - This plan should include the ability to identify and promote protective factors and reduce the impact of risk factors and access to means (firearms, etc.) that contribute to suicide.

First Responders

Law enforcement and other first responders play a crucial role in suicide postvention initiatives. As such, first responders can greatly aid or hinder the grieving and recovery process for family and friends of those who die by suicide.

Law enforcement and other first responder personnel are often the first on the scene of a suicide. As such, these community members are often the first contact survivors of suicide will have after a death by suicide.

According to the Montgomery County Emergency Service Inc.'s handbook, *What Emergency Responders Need to Know About Suicide Loss: A Suicide Postvention Handbook,* there are a number of strategies and/or models for postvention initiatives in law enforcement and first responder organizations. These include:



- **Victim Services Model:** Utilizes existing Victim Services resources for postvention support.
- **Medical Examiners Office-based Model:** The Medical Examiner's office is involved in every suicide to some extent and in many instances already have established lines of communication to the family of the person who died by suicide.
- **Crisis Center Model:** By deploying a crisis-center model, communities are able to integrate resources across a wider range of service providers such as emergency medical staff and police.
- **Agency/Church Model:** By combining resources, social service agencies and religious groups can provide a comprehensive approach to postvention, including, in some cases, 24/7 support as well as longer term support than can be offered through the above models.

Additionally, this handbook provides guidance and information for first responders concerning a wide range of topics related to suicide postvention. The content of this handbook includes:

- 🕮 What is suicide postvention?
- 🕮 Why do suicides happen?
- 🕮 Who's dying and how?
- 🕮 Some misconceptions about suicide
- 🕮 What is different about suicide loss?
- 🕮 What are the immediate needs of suicide grievers
- 🕮 Postvention "First Aid"
- 🕮 Behaviors to avoid if possible
- 🕮 Some things best Not said
- 🕮 Questions that may come from family and friends
- 🕮 Suicide grief support source
- 🕮 Toward a proactive postvention model

This handbook is located at: http://lifegard.tripod.com/EMT_police_bookle_MCES.doc

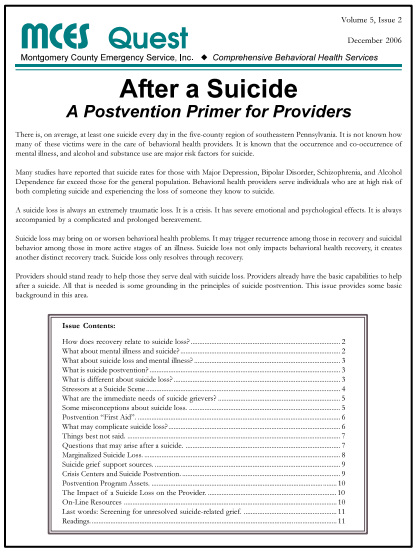
In addition, "Community-Based Suicide Postvention Guidelines for Wisconsin" identifies a number of steps for law enforcement and other first responders to suicide. This document discusses:

- **Protecting evidence:** Securing the scene of a suicide until the investigation can be completed in a professional manner while being respectful of the family's privacy and needs.
- **One step at a time:** Don't draw conclusions, take sides or debate the issue of the cause of death with family members.
- **Notifying next of kin:** Specialized training should be in place for department personnel who will be responsible for informing family members. Ensure a second resource is present, whether a mental health professional, another officer, someone from the faith-based community, or a family friend.
- **Exerting care conveying the messaging that someone has died:** Know to whom you are speaking; inquire if there are other people present in the home, especially children. Be prepared to answer probing questions about the death (how, where, when) of what occurred. Avoid getting into graphic details; be aware of HIPPA rules, etc.
- **Be prepared:** Be ready for a range of emotional reaction to the news of the death.
- **Explain what happens next:** Family members need to be informed on the next steps in this process. By providing these details, family members will be reassured by this knowledge. For questions you can't answer, assure family members you will find out and get back to them.
- **Stay with survivors until others arrive:** Assist the person with contacting other family members or friends for support.
- **Preventing the spread of rumors:** The best practice for law enforcement or emergency service personnel is to adhere to providing only basic facts. Designate one person inside the department to interact with the media. It is important to remember that how this information is shared within a community can greatly impact the ability to prevent contagion and/or cluster events.
- **Linking survivors with other resources:** Ensure that law enforcement and EMS personnel have accurate, timely information on community resources available to survivors of suicide. These resources should include mental health professionals, support groups, faith community. It is wise that first responders have access to business cards, brochures, or other materials to physically hand to survivors.
- **Keep your eyes and ears open:** Especially when dealing with youth. As stated previously, the risk for contagion and cluster suicide events peak in adolescents and young adults. Often youth will engage in high-risk behavior that will bring at-risk individuals in contact with law enforcement. Work with school liaison officers and counselors to identify at-risk portions of the population and potential outreach efforts.
- **Serving the community:** First responders may be asked to support visitation and/or funeral services.
- **Learn as much as you can about suicide:** Postvention training and information can greatly aid in the effectiveness of these efforts for survivors. Don't use the term "committed suicide" when referring to the death, for instance.
- **Take care of yourself:** supporting suicide survivors is difficult and consuming work. Ensure you have the support you need for self-care. Law enforcement officers are generally at a greater risk for suicide, due to the high stress environment of their jobs. Participate in debriefing sessions and other mechanisms your department has in place to alleviate some of this stress.

A copy of this handbook is located at: http://www.mhawisconsin.org/communitybasedguidelines.aspx

Mental Health and Healthcare Professionals

Health and mental health providers and social service agencies all have the capacity to positively affect these community factors in postvention situations. In addition, as provider of health and mental health services, they can serve a key role in their outreach to family members and at-risk individuals and groups.



MCES Quest

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Montgomery County Emergency Service, Inc. ◆ *Comprehensive Behavioral Health Services*

After a Suicide

A Postvention Primer for Providers

There is, on average, at least one suicide every day in the five-county region of southeastern Pennsylvania. It is not known how many of these victims were in the care of behavioral health providers. It is known that the occurrence and co-occurrence of mental illness, and alcohol and substance use are major risk factors for suicide.

Many studies have reported that suicide rates for those with Major Depression, Bipolar Disorder, Schizophrenia, and Alcohol Dependence far exceed those for the general population. Behavioral health providers serve individuals who are at high risk of both completing suicide and experiencing the loss of someone they know to suicide.

A suicide loss is always an extremely traumatic loss. It is a crisis. It has severe emotional and psychological effects. It is always accompanied by a complicated and prolonged bereavement.

Suicide loss may bring on or worsen behavioral health problems. It may trigger recurrence among those in recovery and suicidal behavior among those in more active stages of an illness. Suicide loss not only impacts behavioral health recovery, it creates another distinct recovery track. Suicide loss only resolves through recovery.

Providers should stand ready to help those they serve deal with suicide loss. Providers already have the basic capabilities to help after a suicide. All that is needed is some grounding in the principles of suicide postvention. This issue provides some basic background in this area.

Issue Contents:

According to research cited by the Suicide Prevention Resource Center, "Ninety percent of suicides that take place in the United States are associated with mental illness, including disorders involving the abuse of alcohol and other drugs. Approximately 50 percent of those who die by suicide were in treatment with a mental health professional at the time of their death. The suicide of a client has been called an 'occupational hazard' for psychologists and other mental health providers."

One document that offers a set of guidelines for postvention initiatives related to providers is *After a Suicide: A Postvention Primer for Providers*. Developed by the Montgomery County Emergency Service Inc., this document provides useful information related to crisis planning and postvention for those charged with serving survivors of suicide. The outline of this document is included below.

- How does recovery relate to suicide loss?
- What about mental illness and suicide?
- What about suicide loss and mental illness?
- What is suicide postvention?
- What is different about suicide loss?
- Stressors at a Suicide Scene
- What are the immediate needs of suicide grievers?
- Some misconceptions about suicide loss
- Postvention "First Aid"
- Things best not said
- Questions that may arise after a suicide
- Marginalized Suicide Loss
- Suicide grief support sources
- Crisis Centers and Suicide Postvention
- Postvention Program Assets.
- The Impact of a Suicide Loss on the Provider
- On-Line Resources
- Last words: Screening for unresolved suicide-related grief
- Readings

This document is located at: http://lifegard.tripod.com/After_a_Suicide.pdf

In addition, research by Luoma, J.B., et.al, published in the American Journal of Psychiatry (http://ajp.psychiatryonline.org/article.aspx?Volume=159&page=909&journalID=13, "Contact with Mental Health and Primary Care Providers Before Suicide") indicates that the majority of adults who die by suicide have seen a primary health care provider in the weeks before their death. In fact, according to research from the American Association of Suicidology, 20% of those who die by suicide visit their primary care provider within 24 hours of the event and up to 45% of inidividuals who die by suicide visit their primary care physicians within one month of their death. This figure grows to 73% among the elderly population.

For mental health providers, approximately 20% of adults have contact with mental health professionals in the month preceding suicide; this figure grows to 32% within a year. Clearly, mental health and primary care professionals have significant interest in postvention given their experience with those who die by suicide.

With this in mind, there are four key aspects of postvention that health, mental health providers and social services agencies face in the aftermath of a client's death by suicide:

1. First steps, verification & notification
2. Self-care
3. Contact and support for family/immediate survivors
4. Care for survivors and the larger community to help prevent suicide contagion and future tragic loss of life to death by suicide

First Steps

Because a death by suicide tends to be surrounded by misinformation and rumors, first steps should always involve making an attempt to verify information or obtain more facts without violating confidentiality. If there are other treatment providers involved (psychiatrists, primary care physicians, social service agency, etc.) and you have signed client/patient releases of information, contact them to share information and open the door to mutual support.

In the process of this verification, also keep in mind to:

- Seek consultation or professional support from other colleagues
- Develop and implement a self-care plan for yourself and/or your office/agency
- Secure the medical and/or mental health chart of your client/patient to the extent possible
- Decide if there is a need to contact other clients
- Familiarize yourself with best practice media guidelines

Do not respond to media queries until you are prepared and have consulted with your attorney or agency's legal department. Follow your agency's guidelines for responses to any media queries, and make sure that they have a copy of the media guidelines for reporting on suicide and that you, yourself, follow the media guidelines. Be brief, be factual, and orient your answers towards preventing suicide in the future and offering hope for others. Always give the national and local suicide prevention hotline numbers.

Confidentiality

Confidentiality does not end at death. You are not at liberty to disclose confidential information regarding the individual. You might want to consult with an attorney or your social service agency legal department to understand your obligations and limitations.

Contact With Other Clients

In situations where the client participated in group therapy or support groups, you may need to prepare yourself for how you will respond to client inquiries, while still respecting confidentiality.

Suggestions for contact with other clients when needed include:

- Be direct and factual about the cause of death with the information you have without breaking confidentiality and without giving details about the means of death or circumstances surrounding it.
- Don't speculate on what you don't know.
- Be aware of and pay attention to those who might be at increased risk as a result of this suicide.
- Be prepared to share resources and referrals, as needed, with clients who need more intensive support at this time.

Note: These same and/or similar steps may need to be taken if a death by suicide involves a physician or mental health provider or leader of a support group.

Self-Care

Be aware of the need for self-care for yourself and for survivors as well as the people caring for survivors. Talk openly about self-care and model the skills in your office or social service agency. Self-care skills include:

✓ Get plenty of rest ✓ Exercise ✓ Be gentle with yourself/others ✓ Avoid use of (or increased use of) alcohol or other substances	✓ Maintain proper diet and nutrition; drink plenty of water ✓ Use relaxation skills. ✓ Seek out supportive people ✓ Ask for help, when needed, and have referrals for sources of help

Family and Survivor Support might include (depending upon the circumstances and confidentiality considerations)

- Directly calling on the family to express sympathy and condolence
- Attending the funeral or memorial service
- Providing staff with time off to attend funeral service/memorial service
- Sending a personalized letter/card to the immediate family/next of kin
- Sending flowers or making a donation in memory of the person
- Providing the family with information/referral on available support groups
- Following up with the family to offer information/ referral for bereavement counseling and mental health support, if appropriate/indicated

Contact with the Family

Contact with survivors of a client or patient who has died by suicide may depend on a variety of circumstances. Prior to taking any steps in this area, seek consultation and legal advice, if indicated. Although there are no clear best practice directions for this type of situation, you might want to consider how you would react if it was a death due to another circumstance other than suicide (heart attack, stroke, cancer, etc.) If you would make a condolence call, send a condolence note, or attend the funeral in those cases, you might want to do so in this case as well.

Confidentiality considerations include:

Families do not necessarily understand the complexities of confidentiality, so it is also important to consider what you think the family expects of you. Many families appreciate the effort and compassion that health and mental health providers gave their loved ones and welcome them to attend services. Others may have had a discordant relationship with their loved one's treatment team or not even be aware that their loved one was in treatment.

- Is the family aware that the individual was in treatment and have you had previous contact with the family as part of the treatment?
- If the family was aware of prior treatment, what type of relationship, if any, did you or members of your health, mental health and/or social service agency have with family members?
- Does sending a note, flowers, etc. or attending a public event violate confidentiality by revealing to others that the individual was in treatment?

Some families rely on the advice of health and mental health providers when planning the memorial service, writing an obituary, and dealing with the community at large. Because of this, health and mental health providers need to be aware of best practices to reduce the potential of suicide clusters and contagions. Suggestions in these areas are included in other sections of this toolkit.

School-Based Professionals

Media Coverage Caution

Regarding media coverage of suicide deaths, Scott Poland warns:

> Well documented in the research is the fact that teens are the most susceptible to suicide contagion and that media coverage—especially front-page coverage—of a youth suicide, details of the method used, simplistic explanations of the cause of suicide, and printing photos of the suicide victim are key contributions to contagion. The literature also contains numerous references that once a community has experienced one youth suicide that the chances of a second occurrence increase greatly.

How a school responds to a death by suicide of a student or staff member can have far reaching effects for a school community. With this in mind, all schools are encouraged to have suicide prevention and postvention policies, guidelines, and plans in place as part of their overall crisis response.

It is important to understand that suicide clusters can exist where student deaths occur in a time and place at a higher incidence than normal and that suicide contagion is real and supported by the research literature. Research supports the fact that the occurrence of a single suicide in a community (especially an adolescent suicide) increases the risk of further suicides within that community and that the risk needs to be monitored long term. Anniversary dates related to the death can also be times for increased risk.

Key messages to share with students, staff and parents at this time are those related to the warning signs and risk factors for youth suicide. It is important to emphasize that no one thing or person is to blame and explain the mental health connection for the majority of deaths by suicide. Anger should be normalized, help-seeking behavior encouraged, and referral information and support services shared.

It is also important to not over romanticize or vilify the victim and to avoid sensationalizing the suicide event. Although the loss and grief has to be responded to in appropriate ways, researchers emphasize the need to avoid school disruption and to adhere to normal school schedules as much as possible.

School Memorial Activities Following A Death by Suicide

Do

- Provide opportunity for small group/individual discussion and opportunities for grief support (school/community mental health partners might help in this process.
- Encourage students to get involved in living memorials which may help prevent other suicide deaths such as raising funds for suicide prevention.
- Encourage impacted students (with parental permission) to attend the funeral or memorial service and provide them with an excused absence to do so.
- Encourage parents and clergy to avoid glorifying or sensationalizing the suicide act.

Don't

- Conduct on campus memorial services or close school for these services.
- Glorify the act of suicide or provide excessive details about the specific means and situation of the death.
- Establish permanent memorials to the victim on school property.
- Dedicate yearbooks, songs, or sporting events to the suicide victim.

School Postvention Goals

- Support the grieving process
- Provide long-term surveillance
- Reestablish healthy school climate
- Prevent imitative suicides
- Reduce identification with victim
- Identify and refer at-risk students

The following guidelines and checklists for schools are meant as a summary to help school districts develop complete postvention plans.

School Postvention Response Guidelines:

- Verify the suicide death and/or attempt with first responders/medical examiner or law enforcement.
- Contact the family of the victim within 24 hrs. (if possible) to offer condolences.
- Determine what and how information is to be shared
- Mobilize the school and community crisis response team
- Inform faculty and staff and parents
- Assess the impact on the school
- Identify at-risk students/staff and appropriate outreach for them

Suicide is a crisis event for any community, but school communities are particularly important in addressing postvention planning and crisis planning. Washington State's Youth Suicide Prevention Program (YSPP) has developed a list of planning questions for schools and districts to use in developing their Crisis Response Plans related to postvention.

This guide is located at: http://www.yspp.org/schools/crisis_response_planning.htm

Youth Suicide Prevention Program's Steps in Enhancing Crisis Response Plans

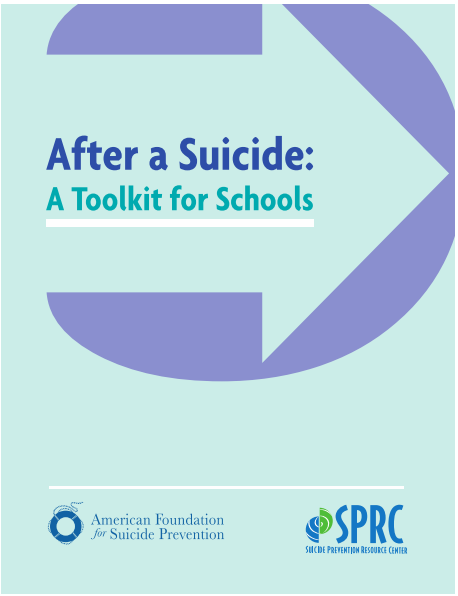
If it is decided that the focus should be on **postvention**, develop answers/strategies to the following checklist of tasks:

1. Who will be the contact for the bereaved family?
2. Will we utilize a building or district crisis team? If so, what training have they had?

3. Who will inform the faculty and staff of the student's suicide? How much information will they receive?
4. Who will develop a script that each faculty member will be asked to read at a specific time during the day? How much information will the students receive?
5. Who will inform the parents of the death? What information will they receive and how: email, letter home in US Mail or home via their student?
6. Where will we set up a "safe room" for students to gather? Who will staff that room?
7. Will substitutes be available if a teacher's grief interferes with teaching?
8. Will someone in the building or at the district handle media inquiries?
9. How will other "high-risk" students be identified and referred to counseling services?
10. How will we handle sticky situations, like a request for a memorial, or the student's locker, or a story in the school newspaper?

A Postvention Guide for School Communities

Because of the unique environment of schools and school-based communities, postvention planning in schools has special requirements. The American Foundation for Suicide Prevention and the Suicide Prevention Resource Center has issued a special postvention planning guide for schools titled *After a Suicide: A Toolkit for Schools,* published in 2011.



Summary of Table of Contents for SPRC's and AFSP's "After A Suicide: A Toolkit For Schools"

Introduction and Executive Summary

After a Suicide: A Toolkit for Schools includes an overview of key considerations, general guidelines for action, do's and don'ts, templates, and sample materials, all in an easily accessible format applicable to diverse populations and communities. Principles that have guided the development of the toolkit include the following:

- Schools should strive to treat all student deaths in the same way. Having one approach for a student who dies of cancer (for example) and another for a student who dies by suicide reinforces the unfortunate stigma that still surrounds suicide and may be deeply and unfairly painful to the deceased student's family and close friends.
- At the same time, schools should be aware that adolescents are vulnerable to the risk of suicide contagion. It is important not to inadvertently simplify, glamorize, or romanticize the student or his/her death.
- Schools should emphasize that the student who died by suicide was likely struggling with a mental disorder, such as depression or anxiety, that can cause substantial psychological pain but may not have been apparent to others (or that may have shown as behavior problems or substance abuse).
- Help is available for any student who may be struggling with mental health issues or suicidal feelings.

Get the Facts First

While it may not always be possible to immediately ascertain all of the details about the death, confirming as much information as possible is important because speculation and rumors can exacerbate emotional upheaval within the school. If the cause of death has not been confirmed to be suicide, if there is an ongoing investigation, or if the family does not want the cause of death disclosed, it can be challenging for a school to determine how to proceed.

Crisis Response

A suicide death in a school community requires implementing a coordinated crisis response to assist staff, students, and families who are impacted by the death and to restore an environment focused on education. Whether or not there is a Crisis Response Plan already in place, the toolkit contains information that can be used to initiate a coordinated response once the basic facts about the death have been obtained. Included are a Team Leader's Checklist (who does what), talking points for use with students, staff, parents, and the media; sample handouts; meeting guidelines; and links to additional resources.

Tools for Crisis Response

This toolkit provides links to sample documents for school administrators to use as a template for creating the necessary tools for use in crisis response.

Helping Students Cope

Most adolescents have mastered basic skills that allow them to handle strong emotions encountered day to day, but these skills may be challenged in the face of a school suicide. Moreover, adolescence marks a time of increased risk for difficulties with emotional regulation, given the intensification of responses that come with puberty and the structural changes in the brain that occur during this developmental period. Schools should provide students with appropriate opportunities to express their emotions and identify strategies for managing them, so that the school can return to its primary focus of education.

Working with the Community

Because schools exist within the context of a larger community, it is important that in the aftermath of a suicide (or other death) the school administrative team establish and maintain open lines of communication with community partners such as the coroner/medical examiner, police department, mayor's office, funeral director, clergy, and mental health professionals. Even in those realms where the school may have limited authority (such as the funeral), a collaborative approach allows for the sharing of important information and coordination of strategies. A coordinated approach can be especially critical when the suicide receives a great deal of media coverage and when the community is looking to the school for guidance, support, answers, and leadership.

Memorialization

School communities often wish to memorialize a student who has died, reflecting a basic human desire to remember those we have lost. It can be challenging for schools to strike a comfortable balance between compassionately meeting the needs of distraught students while preserving the ability of the school to fulfill its primary purpose of education. In the case of suicide, schools must also consider how to appropriately memorialize the student who has died without risking suicide contagion among those surviving students who may themselves be at risk. It is very important that schools strive to treat all deaths in the same way.

Social Media

Social media such as texting, Facebook, and Twitter are rapidly becoming the primary means of communication for people of all ages, especially youth. While these communications generally take place outside of school (and may therefore fall outside of the school's control or jurisdiction), they can nevertheless be utilized as part of the school's response after a student's suicide. By working in partnership with key students to identify and monitor the relevant social networking sites, schools can strategically use social media to share prevention-oriented safe messaging, offer support to students who may be struggling to cope, and identify and respond to students who could be at risk themselves.

Suicide Contagion

Contagion is the process by which one suicide may contribute to another. In fact, in some cases suicide(s) can even follow the death of a student from other causes, such as an accident. Although contagion is comparatively rare (accounting for between 1 percent and 5 percent of all suicide deaths annually), adolescents appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. If there appears to be contagion, school administrators should consider taking additional steps beyond the basic crisis response, including stepping up efforts to identify other students who may be at heightened risk of suicide, collaborating with community partners in a coordinated suicide prevention effort, and possibly bringing in outside experts.

Bringing in Outside Help

School crisis team members should remain mindful of their own limitations and consider bringing in trained trauma responders from other school districts or local mental health centers to help them as needed.

Going Forward

In the ensuing months, schools may wish to consider implementing suicide awareness program to educate teachers, other school personnel, and students themselves about the causes of suicidal behavior in young people and to identify those who may be at risk.

This toolkit is located at:
http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf and at:
http://www.afsp.org/files/Surviving/toolkit.pdf

A school's response after a youth suicide can have an impact on the risk of further suicides. Once a death has been verified, the immediate tasks are to assess the impact on the school, notify the district office and other affected sites (such as schools previously attended or schools that siblings attend), and contact the family of the victim to express sympathy and, if appropriate, provide referrals.

Working with the victim's parents or guardian, administrators must determine what information is to be shared in the school and what the limits of confidentiality are. The next step is to determine how information will be provided to students. If there is no reasonable chance that students will learn of a death by suicide, it is acceptable not to report it to them as a suicide. If the death is actually ambiguous then there should absolutely be no reference to suicide.

Finally, it is important to conduct screening to identify high-risk students and plan interventions. Look for students who may have:

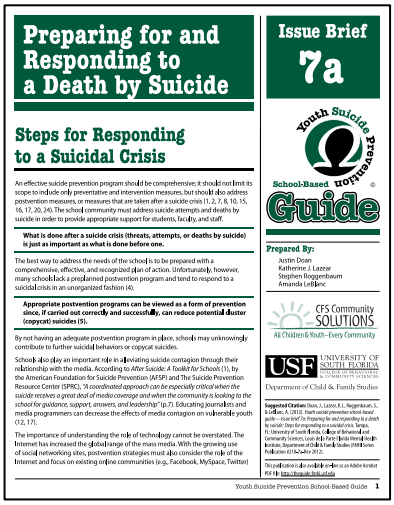
- Facilitated or otherwise been involved in the suicide
- Seen but not recognized warning signs
- Been close to the victim
- Identified closely with the victim, perhaps as a role model
- A previous history of suicide attempts of their own
- Suffered other significant losses

A staff meeting and debriefing should follow. There should be no plans for permanent memorials on campus.

Other Best Practice Postvention Resources for School Communities:

According to the State of Maine and the University of South Florida-College of Behavioral and Community Sciences each have programs and protocols on the Best Practices Registry. The University of South Florida's *Preparing for and Responding to a Death by Suicide, Issue Brief 7a: Steps for Responding to a Suicidal Crisis*, provides the educator community a comprehensive list of action items to consider when formulating a crisis plan for schools.

http://theguide.fmhi.usf.edu/pdf/2012PDFs/IB-7a.pdf


Preparing for and Responding to a Death by Suicide

Issue Brief 7a

Steps for Responding to a Suicidal Crisis

Youth Suicide Prevention School-Based Guide

Prepared By:
Justin Doan
Katherine J. Lazear
Stephen Roggenbaum
Amanda LeBlanc

CFS Community SOLUTIONS
All Children's Youth—Every Community

USF University of South Florida
Department of Child & Family Studies

An effective suicide prevention program should be comprehensive; it should not limit its scope to include only preventative and intervention measures, but should also address postvention measures, or measures that are taken after a suicide crisis (1, 2, 7, 8, 10, 15, 16, 17, 20, 24). The school community must address suicide attempts and deaths by suicide in order to provide appropriate support for students, faculty, and staff.

What is done after a suicide crisis (threats, attempts, or deaths by suicide) is just as important as what is done before one.

The best way to address the needs of the school is to be prepared with a comprehensive, effective, and recognized plan of action. Unfortunately, however, many schools lack a preplanned postvention program and tend to respond to a suicidal crisis in an unorganized fashion (4).

Appropriate postvention programs can be viewed as a form of prevention since, if carried out correctly and successfully, can reduce potential cluster (copycat) suicides (5).

By not having an adequate postvention program in place, schools may unknowingly contribute to further suicidal behaviors or copycat suicides.

Schools also play an important role in alleviating suicide contagion through their relationship with the media. According to *After Suicide: A Toolkit for Schools* (3), by the American Foundation for Suicide Prevention (AFSP) and The Suicide Prevention Resource Center (SPRC), "*A coordinated approach can be especially critical when the suicide receives a great deal of media coverage and when the community is looking to the school for guidance, support, answers, and leadership*" (p.7). Educating journalists and media programmers can decrease the effects of media contagion on vulnerable youth (12, 17).

The importance of understanding the role of technology cannot be overstated. The Internet has increased the global range of the mass media. With the growing use of social networking sites, postvention strategies must also consider the role of the Internet and focus on existing online communities (e.g., Facebook, MySpace, Twitter)

Suggested Citation: Doan, J., Lazear, K. J., Roggenbaum, S., & LeBlanc, A. (2012). *Youth suicide prevention school-based guide — Issue brief 7a: Preparing for and responding to a death by suicide: Steps for responding to a suicidal crisis.* Tampa, FL: University of South Florida, College of Behavioral and Community Sciences, Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies. (FMHI Series Publication #231-7a-Date-2012).

This publication is also available online as an Adobe Acrobat PDF file: http://theguide.fmhi.usf.edu

Youth Suicide Prevention School-Based Guide 1

University Of South Florida-College Of Behavorial And Community Sciences

Preparing for and Responding to a Death by Suicide Issue Brief 7a: Steps for Responding to a Suicidal Crisis:

Responding to a Suicidal Crisis: Steps for Schools

1. The school principal should contact the police or medical examiner in order to verify the death and get the facts surrounding the death. It is important to know the facts in order to reduce imitative behaviors and to place focus on means restriction strategies for parents, as well as the school.

2. The superintendent of the school district needs to be informed of the death. He or she should also be involved in the school's response to the suicide through information dissemination with other school districts and media contacts.

3. Prepare and activate procedures for responding to the media. Suicide is newsworthy and as such can be expected to attract the media. Utilize a designated media spokesperson and remind staff not to talk with press or spread rumors and if asked refer to media spokesperson. Media coverage of suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking. Encourage the media to refer to "Recommendations for Reporting on Suicide," (19) available at http://reportingonsuicide.org. For more information refer to *Issue Brief 7b: Responding to and Working with the Media.*

4. Notify and activate the school's crisis response team. (For more information on crisis response teams refer to *Issue Brief 6b: Crisis Intervention and Crisis Response Teams.)*

5. Contact the family of the deceased. Find out if the deceased has any siblings enrolled in other schools or school districts. If so, then notify the principals of those schools. Obtain permission to release the cause of death from the parents. If the parents do not give permission to release the cause of death as a suicide, respect for their wishes should be maintained.

6. Schedule a time and place to notify faculty members and all other school staff. This meeting should be arranged as soon as possible. After this has been done, staff can provide critical and appropriate support for students.

- Inform all staff about the facts behind the suicide and dispel rumors.
- Allow time for staff to ask questions and express feelings.
- Ensure that all staff have an updated list of referral resources.
- Review the process for students leaving school grounds and tracking student attendance.
- Announce to staff how the school will interact with the media and inform staff who will act as the school's media spokesperson. Remind staff not to talk with the press and refer any questions to the designated media spokesperson.
- Review planned in-class discussion formats and disclosure guidelines for talking to students. Prepare staff for student reactions.
- Compile a list of all students who were close to the deceased.
- Compile a list of all staff members who had contact with the deceased.
- Update and compile a list of students who may be at- risk for suicide (see Issue Brief 3a: Risk Factors for more information on risk factors).
- Remind staff about the risk factors and warning signs for adolescent suicide.
- Provide staff counseling opportunities and supportive services available to them.

7. Contact community support services. (See Issue Briefs 6a and 7c for additional information).

8. Arrange a meeting for parents/caregivers, however, avoid a large parent/caregiver meeting and try to the number of parents/caregivers at a minimum.

- Provide parents/caregivers with warning signs for children and adolescents who may be suicidal.
- Provide information about supportive services available to students at the school.
- Provide information about community resources, services, and family support organizations they may wish to utilize.
- Provide information about how to respond to their child's questions about suicide.
- Remind parents/caregivers of their child's special needs during this time.
- Communicate with other students' parents/caregivers through telephone or written notice.
- In a letter to parents or at a meeting, alert parents that their child and other students may choose to use social media and other online venues to communicate about the suicide, and encourage them to monitor their child's Internet use periodically following the death.

9. Meet with all students in small groups (classrooms)**.**

- Notify students as early as possible following the staff meeting.
- If parents/family of the deceased student give permission, make sure all teachers announce the death of the student to their first class of the day. It is preferable to describe the deceased as "having died by suicide," rather than as "a suicide," or having "committed suicide." The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
- Disclose only relevant facts pertaining to the student's death. Do not provide details, such as method or exact time and location of suicide.
- Allow students an opportunity to express their feelings. "What are your feelings and how can I help?" should be the mantra behind the structure of discussion.
- Explain and predict what students can anticipate as they grieve (e.g., feeling angry, guilty, shocked, anxious, lonely, sad, numb, or experiencing physical pain). Express to students there is no one right way to grieve. What is important is to recognize feelings and communicate them. Below are some age-appropriate signs of grief reactions in children (25):
    - Very young children may respond to a death or traumatic experience by reverting to earlier behavioral stages, and begin thumb sucking, wetting the bed, and clinging to parents again.
    - Children ages five through approximately eleven may withdraw from playgroups, compete for more attention from parents and teachers, become aggressive, and/or fear things they didn't use to. Their behavior may also revert to earlier stages.
    - Adolescents may complain about vague physical symptoms. They may become more disruptive at school and at home, and may become at risk for drug and alcohol use.
- Inform students of the available support services in the school (and outside the school, including family and peer support groups) and encourage them to use them.
- Re-orient students to ongoing classroom activities.
- Avoid assemblies for notification and do not use impersonal announcements over the public address system. Notify students in small, individual classrooms through faculty members or crisis team members.

10. Provide additional survivor support services, such as suicide bereavement support groups (see http://www.afsp.org). A school may want to invite friends of the deceased to join a support group so they can becounseled separately with more focused attention. Provide individual counseling to all students identified as at-risk.

11. Members of the school's crisis team should follow the victim's classes throughout the day providing counseling and discussion to assist students and teachers. This could also help to identify and refer students who may be at-risk.

12. Establish support stations or counseling rooms in the school and make sure that everyone including faculty, students, and other school staff members know where these are located. There should be more than one location and should be set up in small to mid-size rooms. Provide water, kleenex, fruit and information about follow-up contacts.

13. De-brief staff (including members of the crisis team) at the end of the day for approximately five days following the suicidal crisis. Provide post-action staff support to school staff involved in student support during the crisis. The staff included could be teachers, bus drivers, monitors, cafeteria staff, etc.

14. Reschedule any immediate stressful academic exercises or tests if at all possible, however, avoid changing the school day's regular schedule.

15. Avoid flying the school flag at half-mast in order to avoid glamorizing the death. Memorialization should be consistent with other types of deaths of students.

16. Memorialization should focus on prevention, education, and living. Encourage staff and students to memorialize the deceased through contributions to prevention organizations such as Mothers Against Drunk Driving, a suicide hotline, or a suicide survivors group.

17. Collaborate with students to utilize social media effectively to disseminate information and promote suicide prevention efforts. Social media can be used to disseminate important and accurate information to the school community, identify students who may be in need of additional support or further intervention, share resources for grief support and mental health care, and promote safe messages that emphasize suicide prevention and minimize the risk of suicide contagion. Some schools (with the permission and support of the deceased student's family) may choose to establish a memorial page on the school website or on a social networking site. Such pages should not glamorize the death in ways that may lead other at-risk students to identify with the person who died. Memorial pages should utilize safe messaging, include resources, be monitored by an adult, and be time-limited, remaining active for up to 30 to 60 days after the death, at which time they should be taken down and replaced with a statement acknowledging the supportive messages that had been posted and encouraging students who wish to further honor their friend to consider other creative expressions. School personnel should also join any student-initiated memorial pages so that they can monitor and respond as appropriate.

18. Inform local crisis telephone lines and local mental health agencies about the death so that they can prepare to meet the needs of students and staff.

19. Provide information about visiting hours and funeral arrangements to staff, students, parents, and community members. Funeral attendance should be in accordance with the procedures for other deaths of students.

20. The family of the deceased should be encouraged to schedule the funeral after school hours to facilitate the attendance of students.

21. Arrange for students, faculty, and staff to be excused from school to attend the funeral, if necessary.

22. Follow up with students who are identified as at-risk and provide on-going assessment and monitoring, including Internet use, of these students following the death. Follow-up should be maintained as long as possible.

Answering Students' Questions after a Suicide

Overview from handout distributed by Scott Poland:

The aftermath of a youth suicide is a sad and challenging time for a school. The major tasks for suicide postvention are to help students and faculty to manage the understandable feelings of shock, grief, and confusion. The major focus at this time should be grief resolution and prevention of further suicides. The research literature estimates that once a suicide occurs, the chances of another death by suicide increases approximately 300 percent. The following suggestions are intended to guide teachers during this difficult time. It is important to:

- Be honest with students about the scope of the problem of youth suicide and the key role that everyone (including the student) plays in prevention.
- Balance being truthful and honest without violating the privacy of the suicide victim and his or her family and to take care not to glorify his or her actions.
- Have the facts of the incident, be alert to speculation and erroneous information that may be circulating, and assertively, yet kindly, redirect students toward productive, healthy conversation.

How to Respond to Commonly Asked Questions

Why did this happen? We are never going to know the answer to that question. The focus needs to be instead on helping you with your thoughts and feelings and on working together to prevent future suicides.

What method did he or she use? Answer specifically with information as to the method (such as "she shot herself" or "he died by hanging," but do not go into explicit details such as what type of gun or rope was used or the condition of the body and so forth.

Why didn't God stop this? Different religions have different beliefs about suicide, and we are all free to have our own beliefs. However, many religious leaders have used the expression, "God sounded the alarm but could not stop the suicide victim from doing this. Now, this person is in whatever afterlife you believe in, and God is saddened that they did not stay on this earth and do God's work over a natural lifetime."

What should I say about him or her now? It is important to remember the positive things and to respect the family's privacy. Please be sensitive to the needs of close friends and family members.

Is it okay to be angry with him or her? You have permission for any and all your feelings in the aftermath of suicide and it okay to be angry with the person who died.

Isn't someone or something to blame for this? There is no one to blame. The decision to die by suicide involved every interaction and experience throughout this person's entire life up until the moment of death, and yet it did not have to happen. It is the fault of no one.

How can I cope with this suicide? It is important to remember what or who has helped you cope when you have had to deal with sad things in your life before. Please turn to the important adults in your life for help and share your feelings with them. It is important to maintain normal routines, proper sleeping and eating habits, and to engage in regular exercise. Please avoid drugs and alcohol. Resiliency, which is the ability to bounce back from adversity, is a learned behavior. We do best when surrounded by friends and family who care about us and when we view the future in a positive manner.

What is an appropriate memorial to a suicide victim? The most appropriate memorial is a living one such as a scholarship fund or contributions to support suicide prevention. The American Association of Suicidology cautions that permanent markers or memorials such as plaques or trees planted in memory of the deceased

dramatize and glorify their actions. Special pages in yearbooks or school activities dedicated to the suicide victim are also not recommended, as anything that glorifies the suicide victim will contribute to other teenagers considering suicide.

How serious is the problem of youth suicide? It is the third leading cause of death for teenagers and the eighth leading cause of death for all Americans. Over 30,000 Americans die by suicide each year.

What are the warning signs of suicide? The most common signs are the following: making a suicide attempt, verbal and written statements about death and suicide, fascination and preoccupation with death, giving away of prized possessions, saying goodbye to friends and family, making out wills, and dramatic changes in behavior and personality.

What should I do if I believe someone to be suicidal? Listen to them, support them, and let them know that they are not the first person to feel this way. There is help available and mental health professionals such as counselors and psychologists have special training to help young people who are suicidal. Do not keep a secret about suicidal behavior; you could save a life by getting adult help. That is what a good friend does, and someday your friend will thank you.

How can I make a difference in suicide prevention? Know the warning signs, listen to your friends carefully, do not hesitate to get adult help and, remember that most youth suicides can be prevented."

From Scott Poland's handouts and articles.

School Postvention Risk Identification Strategies

1. Review risk factors and warning signs with school faculty and support staff
2. Identify all students/staff:

- Who have had a personal connection with the decreased
- Who are known to have a mental illness
- Who have experienced other recent losses
- Who have previously demonstrated suicidal behavior
- Who are known to have a family history of suicide
- Who were present at the funeral or memorial service and seem troubled

3. Monitor:

- Student increases in visits to the nurse or health services following a suicide
- Student absentees in the days following a death by suicide
- The behavior of students who were involved in the funeral or memorial service including any student pallbearers
- Students who have a history of being bullied
- Students who are lesbian, gay, bisexual, transgender, questioning, intersex, or two-spirit
- Students who are participants in fringe groups
- Students who have weak or troubled levels of social/familial support
- Student hospital visitors of suicide attempters

If school district policy allows, consider monitoring student social network sites for high-risk statements and/or behavior and/or encouraging parents to monitor those sites.

School Suicide Postvention Student Psychoeducation Objective

1. Help students separate facts from rumors without disclosing specific details of the death, which may be private or undetermined and/or could lead to sensationalizing or imitative behavior.
2. Redirect guilt responses.
3. Ensure understanding that suicide is permanent.
4. Ensure acceptance of reactions as normal.
5. Express assurance that coping will occur with support.
6. Ensure student recognition of warning signs and help resources.
7. Ensure understanding of funeral and/or memorial expectations.

Postvention as One Component in a Comprehensive School Suicide Prevention, Intervention and Postvention Program

School suicide postvention protocols and response guidelines should be only **one** part of a **comprehensive** school suicide prevention, intervention and postvention program. The Maine Youth Suicide Prevention Program, for instance, recommends that schools implement all of the following:

1. **Administrative Protocols** to guide effective responses to suicidal behavior in troubled students, in those who threaten or attempt suicide, and others potentially at risk in the aftermath of a student death by suicide.
2. **Agreements with Crisis Service Providers** that outline prevention and intervention services to be provided to the school.
3. **Gatekeeper Training for all school staff** using a training of trainers, step by step model
4. **Designated school personnel to be available at each building** to help to intervene, screen, refer etc.
5. **Suicide prevention education for students.** This step is recommended **ONLY AFTER** all other steps are in place.
6. **A range of responsive support services** such as Student Assistant Team, substance abuse services, school based or linked mental health services, School Resource Officers.
7. **A school climate that promotes safety and respect for all.**

The Maine program is available online at: http://www.maine.gov/suicide/professionals/program/index. htm.

Surveillance: School Suicide Prevention Tracking of Student Attempts and Deaths

It is important to track past and current suicidal behaviors that have occurred within each school and school district as a whole. The tracking sheet/tool included below captures some of the important key elements that need to be tracked to assist in the identification of trends and commonalities, which can guide the selection of appropriate prevention and intervention measures. Proper use can also lead to the identification of subpopulations that may need immediate, intensive, targeted, or tailored response to suicidal activity. However, postvention efforts must also address the needs of the general student population.

When tracking student suicide attempts and completions, it is important to look at trends and connections related to any and all of the following. Please note that this information is to be considered confidential and used for suicide postvention only.

Tracking Check List:

1. Number Assigned (to protect confidentiality) & Date of Attempt and/or Death	**2. Outcome: Attempt and/or Death** If an attempt, and not a completion, this is a place to note the outcome of the attempt i.e. recovered or continued hospitalization.
3. Demographics (Age, Gender, Race/Ethnicity)	**4. Grade & School** (Or if former student, last school attended when a student in the school (private or public).
5. Method/Means Used for Attempt and/or Death	**6. Trigger**=Issue or event that seemed to be "the last straw" or connected to the death. *(Use information that has been obtained from family such as triggers. If family states that "he was depressed over the breakup with his girlfriend", then go with that as a trigger.)*
7. Home Environment = List what is known of the home environment. Was it stable? Did they move a lot? Was there a recent divorce or move? Was there suspected abuse or substance use among members?	**8. Social Status With Peers =** Were they an outcast? Were they popular? Were they average?
9. Social Network (Sports, Band, Clubs, Faith Community, Gaming, Online Community, Other)	**10. Diagnosis** = Was there possible underlying mental illness, substance abuse, conduct disorder or learning disability? *(Note: 90% of those who die by suicide have a diagnosable substance abuse and/or mood disorder. If a formal diagnosis is not known but staff suspected (based on behaviors) an underlying diagnosis, note "suspected X disorder.")*
11. Academic/Grades = How were they doing academically? Average, Below average or Above average	**12. Behavior**(s) = Warning signs or problematic behaviors
13. Connection to Others = Did they know any of the other students that died by suicide either directly or indirectly? Did they attend the funeral and/or memorial service of other students who recently died by suicide? Did they attend the same school or were former students of that school? Were they in the same extra-curricular activities? Did they live in the same neighborhood? Were they Facebook or MySpace friends?	**14. Media =** Was there media coverage of the death or attempt? Was it appropriate (list "G" for good and "B" for bad)? (See media guidelines.) Also put type of media (TV, Paper, Radio**)** and extent (Major coverage—all TV channels—or Minor coverage)

(Developed 3-09 by Amanda Summers-Fox with assistance from John Hellsten & Merily Keller for Texas School Districts & communities requesting technical assistance from TDSHS & Texas Suicide Prevention Council to use for tracking suicide attempts and deaths.)

Confidential – for suicide prevention and postvention response.

Number Assigned & Date (1)	Outcome	Age Gender Race	Grade School	Method/ Means	Trigger (2)	Home Environment (3)	Social Network (Sports, Band, Gaming, Gaming Online, Community, Other)	Social Status with Peers (4)	Diagnosis (MH, SA, LD) (5)	Academic (Grades) (6)	Behaviors (7)	Connection to Others (attempter/ died) (8)	Media Coverage Type/Extent (9)
00/00/00	Death Attempt												
	Death Attempt												
	Death Attempt												
	Death Attempt												
	Death Attempt												
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	Death Attempt												
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	Death Attempt												
	Death Attempt												

1. Num=Assign a number to the event to avoid using names and for referencing on other documents to protect confidentiality
2. Trigger=Issue or event that seemed to be "the last straw" or connected to the death.
   Use information that has been obtained from family such as triggers. If family states that "he was depressed over the breakup with his girlfriend", then go with that as a trigger.
3. Home Environment=List what is known of the home environment. Was it stable? Did they move a lot? Was there a recent divorce or move? Was there suspected abuse or substance use among members?
4. Social Status= Were they an outcast? Were they popular? Were they average?
5. Diagnosis= Was there possible underlying mental illness, substance abuse, conduct disorder or learning disability?
   Note: 90% have a diagnosable substance abuse and/or mood disorder. If a formal diagnosis is not known but staff suspected (based on behaviors) an underlying diagnosis, enter it as "suspected X disorder."
6. Academic=How were they doing academically? Average, Below average or Above average
7. Behavior(s)=Warning signs or problematic behaviors
8. Connection to Others=Did they know any of the other students that died by suicide either directly or indirectly? Did they attend the same school? Were they in the same band? Did they live in the same neighborhood?
9. Media=Was there media coverage of the death or attempt? Was it appropriate (list "G" for good and "B" for bad)? (See media guidelines) Also put type of media (TV, Paper, Radio) and extent (Major coverage-all TV channels or Minor coverage)

Pastoral Professionals and Funeral Care Providers

When we lost our daughter in 1997, we needed someone to offer support and understanding. There was such shock initially that it was very difficult to make immediate decisions regarding the memorial service and obituary. The faith community and funeral homes are in a position to offer guidance to survivors of suicide loss during this time of need and prevent a possible contagion, especially among young people. What I have learned is that many postvention guidelines are counter-intuitive and education is essential to create a safety net for those at risk of suicide in our communities.

Elizabeth Roebuck, American Foundation for Suicide Prevention – Central Texas Chapter and Austin-Travis County Suicide Prevention Coalition

Clergy and faith communities are often primary resources for care to family members, loved ones, and the extended community after a suicide. When clergy and faith communities provide thoughtful, sensitive, and supportive care, they facilitate mourning and obviate harm.

Allan Hugh Cole, Jr. Austin Presbyterian Theological Seminary

Suggestions for Pastoral Care & Spiritual Support Following Suicide

The manner in which clergy and faith communities respond to suicide will vary somewhat with respect to theological tradition and beliefs, social customs, cultural mores, and differences among individual personalities and persons. Even so, clergy and faith communities are often primary resources for care to family and loved ones, and to the extended community, after a suicide. The following are suggestions for how clergy and faith communities may provide thoughtful, sensitive, and supportive care that will facilitate mourning and obviate harm.

1. Focus primarily on being a supportive presence, sharing empathically in family members' and loved ones' profound feelings of loss, and on listening non-judgmentally to questions, concerns, expressions of pain, anger, confusion, guilt, and a myriad of other thoughts and feelings.

2. Avoid speaking excessively, being a "fixer" of the problem, an alleviator of the pain, or a provider of answers to questions of "why?" One experiencing profound grief is typically shocked and unable to comprehend what has happened, especially for the first several days following the loss. Moreover, when one asks "why" questions this is most often more an expression of one's deepest pain than a query seeking explanation. Most beneficial to the bereaved is the offer of presence, care, concern, and non-judgmental listening.

3. Do not suggest or otherwise indicate that suicide is somehow "God's will" or that it "fits into God's plan." Never suggest or affirm another's suggestion that a suicide is in some way "a test of faith." Not only are these responses theologically suspect, but they also have little to offer a bereaved person in the way of comfort or support. A better alternative is to express your belief that you and your community share some of their pain and are willing to stand by them.

4. Do not offer platitudes or pithy wisdom such as "God never gives us more than we can handle," "It's okay, he is with God now," "God needed her more than you did," "There is now another angel in heaven," "At least he is a peace now," or similar responses that minimize bereaved persons' loss and often contribute to their anger, confusion, and despair.

5. Be aware that family members, loved ones, and close friends often feel more angry, guilty, and even suicidal themselves following a suicide than is the case with other means of death. Family members may also be at risk for a post-traumatic stress condition (especially if they found the body). This is particularly true for adolescents. Pay close attention to, and check-in with, all of these persons regularly, enlisting the contributions of other supportive persons, groups, and resources within the faith community and beyond.

6. Be careful neither to condemn nor to glorify an act of suicide, but reassure family members, loved ones, and the larger community of faith that a death by suicide does not mean the deceased person is out of communion with God, cut off from eternal life, or otherwise compromised before God, making use of the language and beliefs that best fit within your own religious tradition. (Avoid the language "killed themselves" or "committed suicide" if possible.)

7. With time, invite but do not insist, upon family members and loved ones sharing their feelings concerning the suicide with clergy or spiritual leaders of their choice, helping professionals, or both. Since some research indicates that survivors of suicide may have a higher risk of suicide themselves, be sure and give them the names of local mental health professionals and the1-800-273-8255 (TALK) hotline as well as local hotlines. You might also suggest that they consider attending one of the survivors of suicide support groups if there is one available in your area.

8. With time, and as is consistent with one's religious faith and tradition, encourage the bereaved to believe that they will survive their loss as they rely on God and others to journey with them through their mourning. Continue to stress that the suicide survivor is not responsible for the death. Many faith traditions also believe that the person who died was not in their right mind at the time that they died, and they are also not responsible for their actions.

9. Offer your care and support but also be aware of and respectful toward bereaved persons' needs for solitude, privacy, and emotional "space" in which to mourn in their own way.

10. For longer-term care, make a note of the anniversary of the death, and perhaps the deceased person's birthday and wedding anniversary, which are often times of acute grief and which bring increased risk of depression and suicide. Convey your care and concern for family and loved ones more explicitly as those dates approach.

11. If the family grants permission, clergy conducting the funeral service may choose to speak of the suicide as a result of a disease called depression or a mood disorder, by which the deceased person was overcome. But in general, it is wise to avoid speaking of causes for the suicide. Their "why" is really unanswerable and is very internal and unique to them. Rather talk about the path ahead toward hope and life, acknowledging that this path will be painful.

12. Faith community leaders have an opportunity to help destigmatize mental illness and deaths by suicide while at the same time being aware that it is important to support families' wishes. Some families are uncomfortable with any mention or indication that the death was a suicide. Others want to help destigmatize suicide and want to mention it in either a direct or indirect way. Death by suicide may be used in the obituary or clergy may suggest that the suicide be described as "an untimely death" or a death "after a struggle with a mood disorder" or with similar language that omits stating specifically that suicide was the cause. Because the obituary is often an object of lasting importance, and meant to be a celebration of the person's life,

"softening" the language of suicide may be appreciated long term. Another way to address this indirectly is to suggest that the family add a statement at the end of the obituary about contributing to a local suicide and crisis hotline, survivors of suicide support group, or one of the national suicide prevention organizations.

13. Offer schools a space at your place of worship for children to memorialize a friend, parent, family member, or other significant person who has died by suicide in an ongoing way, meaning a "safe" space for children to find age-appropriate support and opportunities for expressing feelings, thoughts, questions, and concerns with trained pastoral or trained adult support.

14. When dealing with crisis situations such as a death by suicide, many people find it helpful to practice things like prayer, meditation, Tai Chi, or yoga.

15. Clergy, faith communities and spiritual centers should actively seek and access opportunities for educating themselves on how best to provide care and support following suicide with respect to immediate and longer term needs.

Support for and Care of Survivors

Funeral home representatives and faith community representatives are often the immediate advisors to survivors of the loss of a loved one to death by suicide. It is important that they be informed about some of the unique grief processes that survivors face and some of the unique challenges in acknowledging the death. It is imperative that newspaper announcements, writing an obituary, planning funerals and public memorial services are done in a way that both support the survivors and offers hope and help for the community at large.

In *After a Suicide: Recommendations for Religious Services and Other Public Memorial Services*, The Suicide Prevention Resource Center summarizes the steps a community can take to support survivors by emphasizing how important it is to support them in the same way others are supported who have lost a loved one.

- Extend gestures of kindness (such taking in meals)
- Reach out to intentionally draw them into the "fabric of that community's normal activities"
- Talk to survivors about the deceased with the same openness and sensitive way that they would discuss any other death in that community (this openness will help the surviving family and friends overcome any embarrassment or shame)

They also stress that grief for survivors can be different and emphasize that the community (and funeral homes) can also encourage survivors to seek specialized services for their grief either through survivors of suicide support groups (Texas Survivors of Suicide Support Groups are listed on page 148 of this toolkit, and are available at TexasSuicidePrevention.org) or through professional mental health services and grief counseling through someone who is experienced in working with survivors of suicide.

Faith communities and funeral home representatives also have the unique position of being able to help educate the community as a whole and correct some of the misinformation and myths about deaths by suicide so that "this is a time for healing, not judging." Although the individual act that caused the loss of life of the decedent cannot be undone, educated communities can help to recognize and reach out to members of who might be exhibiting signs of depression.

Both faith communities and funeral homes can also have brochures available to give to survivors about dealing with the aftermath of a death by suicide (see page 96 for a list of websites that offer a variety of materials) and can hand

out the wallet cards or insert the wallet card information in memorial service bulletins from the National Suicide Prevention Lifeline with the **1-800-273-8255 (TALK)** number along with numbers for local hotlines.

Funeral home representatives can help by recognizing the unique aspects of grief survivors of suicide may face. They also should be aware of the importance of memorial services and funerals to support survivors and help the community prevent future deaths by suicide by including postvention steps as they are being planned.

Faith communities and funeral homes can help support families and the community by encouraging families to list the 1-800-273-TALK (8255) National Suicide Prevention Lifeline in funeral home online and/or newspaper memorial pages.

Obituaries/Death Notices (from the Austin-Travis County Suicide Postvention Protocols)

One of the first decisions family and friends will have to make following a death by suicide is what to include in an obituary. In the past, suicide was never mentioned as the cause of death in an obituary (unless it was a very public person), but with mental illness being acknowledged more openly, some family and friends have recently chosen to mention that the person died by suicide. This is a very personal decision for survivors of the loss of a loved one to make. Following is a checklist of considerations for those writing an obituary following a death by suicide:

Checklist for Obituary Decisions

- The decision to include or not include the information in an obituary that the individual took his or her own life is a very personal decision. Each family will need to make this on their own in keeping with their own cultural and religious beliefs.
- The obituary is not the only opportunity to publicly disclose how the person died
    - The family may wish to do so privately with family/friends or not at all
    - The family may choose to do so in another circumstance such as in a memorial service
    - A family can indirectly acknowledge that the death was a suicide by asking for contributions to a mental health or suicide prevention organization

Note: If the family decides to disclose privately that the death was a suicide, it is OK to mention how (e.g. used a gun, hanging), but avoid providing specific/graphic details, which might traumatize others or add to a contagion or imitative process.

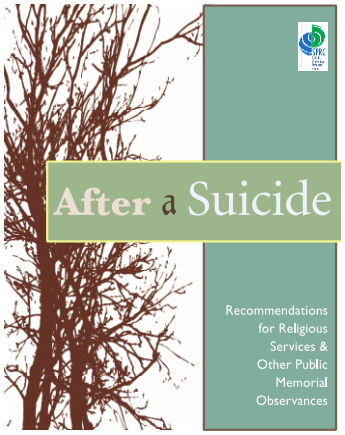
If the family chooses not to disclose the death as a suicide:

- Keep in mind that it is better to make no statement about the cause of death rather than stating something misleading.
- Be aware that if the cause and manner of death has been determined by the Medical Examiner, they are a matter of public record and can be accessed by media or others qualified individuals who request the death certificate.

Guide for Funeral Directors about Supporting Survivors: The Suicide Prevention Action Network USA (SPAN USA) and SPRC have released *Help at Hand – Supporting Survivors of Suicide Loss: A Guide for Funeral Directors.* The guide, available in PDF form only, provides funeral directors with practical information about working with suicide survivors (http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_5/SurvivorsOfSuicideLoss.aspx).

Mental Health America of Texas, and Texas Suicide Prevention Council websites provide general information on mental illness and this toolkit to assist community members in doing suicide prevention work.

www.mhatexas.org
www.TexasSuicidePrevention.org



Memorial Service and Funeral Guidelines

The Memorial Service Guidelines from *After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances* are reprinted below:

Recommendations for Memorial Services

Memorial services are important opportunities for increasing awareness and understanding of the issues surrounding suicide and thereby ridding the community of some of its unfounded stigma and prejudice (DHHS, 2001). The ultimate goal of a memorial service is to foster an atmosphere that will help survivors understand, heal, and move forward in as healthy a manner as possible. In preparing for memorial services, it is important to recognize that public communication after a suicide has the potential to either increase or decrease the suicide risk of those receiving the communication (Centers for Disease Control and Prevention [CDC] et al., 2001). The following recommendations can facilitate a community's healing in the aftermath of a suicide and, at the same time, reduce the risk of imitative suicides.

Comfort the Grieving

A death by suicide often leaves surviving family and friends with excruciating emotional pain, which may persist for an extended time. Help survivors find comfort within the context of their faith and their faith community.

Help Survivors Deal with Their Guilt

Survivors are almost invariably left with a sense of unwarranted guilt or an exaggerated sense of responsibility from not being aware of what was going on with their loved one, or not acting in time to prevent the suicidal death (Van Dongen, 1991). Others may feel unfairly victimized by the act of their family member or friend and by the stigma that society inappropriately places on them. Consequently, it is common for survivors to relive for weeks, months, and even years a continuous litany of "What if . . . ?," "Why did . . . ?," and "Why didn't . . . ?" Rehearsing or rehashing these questions, although a nearly universal experience, will not necessarily produce answers that satisfy the longing for understanding and closure. Once again, it is helpful to offer survivors solutions that can be found within their faith traditions. After sufficient time, a better understanding of why suicide occurs may provide the beginning of healing for some survivors.

Help Survivors Face Their Anger

Feelings of anger commonly occupy the minds and hearts of those mourning the loss of a loved one to suicide (Barrett & Scott, 1990). These feelings may take several forms: anger at others (doctors, therapists, other family members or friends, bosses, the deity, etc.), anger at themselves (because of something done or not done), and/or anger at the deceased (for abandoning the survivor, throwing away all plans for a future, and abrogating

responsibilities and obligations). Surviving family and friends should be assured that feeling or expressing their anger is often part of the normal grieving process. Even when their anger is directed toward the deceased, it does not mean they cared for their loved one any less.

Attack Stigma

Stigma, embraced by ignorance, can be the greatest hindrance to healing if it is not dealt with directly (Jordan, 2001). Take this opportunity to make as much sense as possible of what could have led to the person's tragic end. One approach is to disclose selected information about the context of the specific suicide, such as a mental illness from which the deceased may have been suffering. (Do not describe the suicidal act itself.) An alternative approach is to discuss the factors commonly associated with suicidal acts (e.g., psychological pain, hopelessness, mental illness, impulsivity) without mentioning the specifics of the person's death. At a minimum, dispel the common myths about moral weakness, character flaws, or bad parenting as causes (except in cases where parental violence or abuse was known to be a contributing factor). Recognition of the role of a brain illness may help community members understand suicide in the same way that they appreciate, for example, heart disease, another common cause of death.

Use Appropriate Language

Although common English usage includes the phrases "committed suicide," "successful suicide," and "failed attempt," these should be avoided because of their connotations. For instance, the verb "committed" is usually associated with sins or crimes. Regardless of theological perspective, it is more helpful to understand the phenomenon of suicide as the worst possible outcome of mental health or behavioral health problems as they are manifested in individuals, families, and communities (DHHS, 2001). Along the same lines, a suicide should never be viewed as a success, nor should a non-fatal suicide attempt be seen as a failure. Such phrases as "died by suicide," "took his life," "ended her life," or "attempted suicide" are more accurate and less offensive.

Prevent Imitation and Modeling

Public communication after a suicide can potentially affect the suicide risk of those receiving the communication (CDC et al., 2001). Some types of communication about the deceased and his or her actions may influence others to imitate or model the suicidal behavior. Consequently, it is important in this context not to glamorize the current state of "peace" the deceased may have found through death. Although some religious perspectives consider the afterlife to be much better than life in the physical realm, particularly when the quality of physical life is diminished by a severe or unremitting mental illness, this contrast should not be overemphasized in a public gathering. If there are others in the audience who are dealing with psychological pain or suicidal thoughts, the lure of finding peace or escape through death may add to the attractiveness of suicide. (Information about resources for treatment and support should be made available to those attending the observance.) In a similar way, one should avoid normalizing the suicide by interpreting it as a reasonable response to particularly distressful life circumstances.

Instead, make a clear distinction, and even separation, between the positive accomplishments and qualities of the deceased and his or her final act. Make the observation that although the deceased is no longer suffering or in turmoil, we would rather she or he had lived in a society that understood those who suffer from mental or behavioral health problems and supported those who seek help for those problems without a trace of stigma or prejudice. Envision how the community or society in general could function better or provide more resources (such as better access to effective treatments) to help other troubled individuals find effective life solutions. The goal of this approach is to motivate the community to improve the way it cares for, supports, and understands all its members, even those with the most pressing needs, rather than contribute to the community's collective guilt.

Consider the Special Needs of Youth

In a memorial observance for a young person who has died by suicide, service leaders should address the young people in attendance very directly, since they are most prone to imitate or model the suicide event (Mercy et al., 2001). The death of their peer may make them feel numb or intensely unsettled. Regardless of how disturbing this sudden loss may be, impart a sense of community to the audience, highlighting the need to pull together to get through this. Make specific suggestions that will unite the community around the purpose of caring for one another more effectively. Also, ask the young people to look around and notice adults on whom they can call for help in this or other times of crisis, such as teachers, counselors, youth leaders, and coaches. Consider pointing out specific adults who are known to be particularly caring and approachable. Note the desire of these adults to talk and listen to anyone who is feeling down or depressed or having thoughts of death or suicide. In the course of this discussion, endeavor to normalize the value of seeking professional help for emotional problems in the same way one would seek professional help for physical problems. Focus attention on the hope of a brighter future and the goal of discovering constructive solutions to life's problems—even when these problems include feelings of depression or other signs of mental or emotional pain. Encourage the youth to reach outside themselves to find resources for living their lives to the fullest and to talk with others when they are having difficulties. Additionally, it is critically important that the young people who are present watch one another for signs of distress and that they never keep thoughts of suicide a secret, whether those thoughts are their own or a friend's. Stress the importance of telling a caring adult if they even think one of their friends may be struggling with these issues.

Schools and faith communities may wish to organize individual classes or small discussion groups with prepared adult leaders in which youth can more comfortably discuss their thoughts and feelings regarding their loss and where questions may be more easily raised and addressed.

Consider Appropriate Public Memorials

There have been several cases where dedicating public memorials after a suicide has facilitated the suicidal acts of others, usually youth (CDC, 1988). Consequently, dedicating memorials in public settings, such as park benches, flagpoles, or trophy cases, soon after the suicide is discouraged. In some situations, however, survivors feel a pressing need for the community to express its grief in a tangible way. Open discussion with proponents about the inherent risks of memorials for youth should help the community find a fitting, yet safe, outlet. These may include personal expressions that can be given to the family to keep privately, such as letters, poetry, recollections captured on videotape, or works of art. (It's best to keep such expressions private; while artistic expression is often therapeutic for those experiencing grief, public performances of poems, plays, or songs may contain messages or create a climate that inadvertently increases thoughts of suicide among vulnerable youth.) Alternatively, suggest that surviving friends honor the deceased by living their lives in concert with community values, such as compassion, generosity, service, honor, and improving quality of life for all community members. Activity-focused memorials might include organizing a day of community service, sponsoring mental health awareness programs, supporting peer counseling programs, or fund-raising for some of the many worthwhile suicide prevention nonprofit organizations. Purchasing library books that address related topics, such as how young people can cope with loss or how to deal with depression and other emotional problems, is another life-affirming way to remember the deceased.

Media and Social Media Guidelines on Reporting Suicide

The media can play a powerful role in educating the public about suicide prevention. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual

deaths by suicide may be newsworthy and need to be covered, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates.

Recommendations for Reporting on Suicide

According to the Suicide Prevention Resource Center's document *Recommendations for Reporting on Suicide:*

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly described the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering a suicide carefully, even briefly, can change public misperceptions and correct myths that can encourage those who are vulnerable or at risk to seek help.

With these findings in mind, media, online, and social media coverage of a suicide is critically important in preventing more deaths through contagion and cluster events. Media, online, and social media suicide reporting should be developed using best practices and *Recommendations for Reporting on Suicide* is a set of guidelines developed for this purpose. Created in 2011 through collaboration across a broad range of expertise specializing in mental health and suicide policy, media policy, local, national and international organizations, these guidelines now serve as the standard for reporting on suicide.

Recommendations for Reporting on Suicide provides a wide range of information on suicide reporting including:

- Communicating the message that suicide is a public health issue
- Providing the causal relationship between reporting on suicide and the effect on contagion and cluster events
- Specific examples of "Do's" and "Don'ts" relative to examples of reporting methods
- How to avoid misinformation
- Useful information to include in sidebars about warning signs of suicide and available resources
- How to inspire hope
- Action steps readers can take if confronted with a suicidal situation
- ALWAYS include the National Suicide Prevention Lifeline number: 1-800-273-8255 (TALK)

Recommendations for Reporting on Suicide: http://reportingonsuicide.org/Recommendations2012.pdf

Finally, the SPRC website also provides specific examples of how media organizations have utilized the *Recommendations for Reporting on Suicide* to report on suicide safely and responsibly.

The following are examples that utilized the *Recommendation for Reporting on Suicide* to cover recent deaths or the overall issue of suicide safely and responsibly. Research has shown that safe and accurate reporting of suicide reduces risk of contagion and helps encourage help-seeking behavior:

- ⇨ "Suicide Rate Slowly Rising" – Philadelphia Inquirer
- ⇨ "Journalists at Tampa TV Station Use Skill, Care, Expertise to Cover Child's Suicide" – Poynter., St. Petersburg, FL
- ⇨ "Bullying a Red Flag for Depression" – Associated Press
- ⇨ "Temperance, Common Sense Required with Suicide Coverage" – Napa Valley Register

- ⇨ "People who attempted suicide as youths trace their recovery" – Toronto Star
- ⇨ "Bullying And Suicide: The Dangerous Mistake We Make" – the Huffington Post

Considerations for Social Media and Online Reporting

The majority of the recommendations found in the above document also apply to social media reporting. However, there are several distinct characteristics of social media that create unique circumstances in reporting on suicide.

According to www.reportingonsuicide.org, here are some of the unique needs of social media reporting relative to suicide:

Reporting On Suicide-Online Media Guidelines: http://reportingonsuicide.org/online-media/

The *Recommendations for Reporting on Suicide* also apply to online content including citizen-generated media coverage, social media sites, blogs, and online content from traditional media organization's websites. In fact, following the recommendations for online content is just as important since online articles, blogs, photos, and videos can be instantly shared with millions of people around the world. And we know from research that extensive media coverage of a suicide increases risk for contagion.

Here are some additional tips for online media coverage:

Include hyperlinks to resources, such as suicide warnings and risk factors, or to the National Suicide Prevention Lifeline to help inform readers and reduce risk of contagion.

Think about reporting on suicide as a health issue, not just in response to a recent death. For example you can report about:

- Effective suicide prevention programs
- New research on suicide prevention or mental illness
- Advocates working to reduce suicide
- Individual stories of people who have overcome suicidal ideations
- Stories on families bereaved by suicide loss who are helping others cope or working to prevent suicide in their community
- New treatments for depression or other mental illnesses that can lead to suicide
- Steps local/federal government agencies are taking to prevent suicide

Remember that most online stories also allow for public commentary. Websites and bloggers should develop policies and procedures for safe message board comments and monitor for hurtful messages or comments from posters who may be in crisis. It might be helpful for webmasters, bloggers, or messageboard moderators to post the National Suicide Prevention Lifeline information in the first comment box in any story about suicide.

Traditional media journalists who also blog either for their news organization or as an individual should follow the media recommendations and be consistent. Try not to be sensational in your online coverage just because there is more space or less oversight.

Additionally, there are other considerations related to social media after a death by suicide such as how to remove a Facebook page for someone who has died.

https://www.facebook.com/help/search/?q=deceased

The Facebook Help Center offers a number of links to questions such as:

- How do I report a deceased user or an account that needs to be memorialized?
- What does memorializing an account mean? Does it deactivate or delete it?
- A deceased persons account is appearing in "People You May Know" feed. How do I report this?
- The "Tag a friend" feature is asking me to tag a deceased friend in a photo

Managing a Facebook Page of Someone Who has Died by Suicide

Facebook has very specific policies concerning Facebook users who have died. These are located at the Facebook Help Center and are provided below:

Reporting a Death: https://www.facebook.com/help/search/?q=death+report

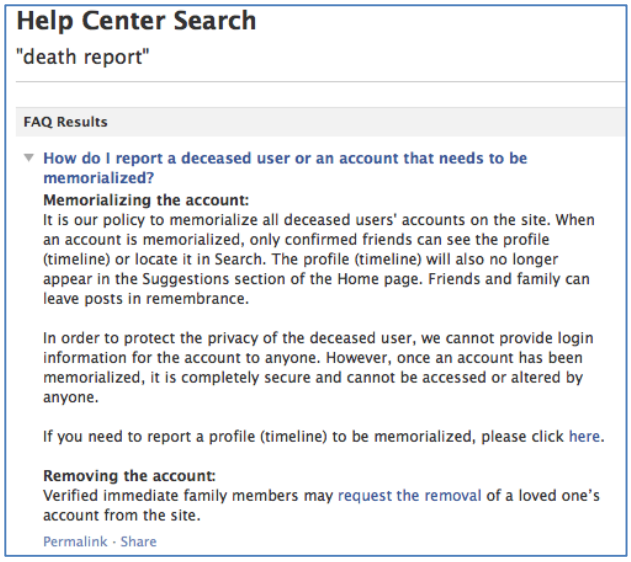


Figure 6-2

As indicated by this screenshot, after a death (whether by suicide or other means), Facebook policy is that the person's Facebook page will stay online and becomes a memorial site for the deceased. While this can be a good place for friends and family to express their sorrow, we know that left unchecked, these pages can also becomes areas where further suicidal ideation can occur.

Further, although immediate family members can request the removal of the site, the immediacy of social networking creates a critical lag time between the death and the removal of the site, which can have serious consequences relating to contagion and cluster activity. Therefore, it is crucial that the deceased's site be monitored until a final plan can be developed and executed on how to manage the Facebook page.

Below, please consider these steps for action relative to social media after a death by suicide.

- Immediate family should notify Facebook of the death. This is done by providing information through an online form located at the Facebook Help Center: https://www.facebook.com/help/contact/?id=305593649477238.
- Identify a moderator of the person's online accounts (usually parents or friend of the deceased).

- Provide information to explain how social networking sites can impact further suicidal ideation and request that people who are moved to post to this site, follow best practices guidelines for posting.
- Someone in the community should monitor postings for language and content; postings such as "I am going to join you soon," "I can't take life without you," should be taken seriously and these users should be followed up with appropriate steps.
- Work with school counselors and principals to help them address the unique needs of youth and social media.

Memorial Websites and Facebook Pages

In addition to personalized Facebook pages, there are general "memorial" or "tribute" sites that host a collection of memorials that survivors have posted pictures and postings related to friends and family who have died by suicide. These sites are easily located through simple Google searches or on the Facebook search screen using the search term "suicide memorial."

It is important to stress that some of these sites may not be following best practices related to safe social media and online reporting, and, as such, should be approached cautiously. Please use the guidelines above provided when visiting or interacting with these sites.

Special Considerations for Family and Friends Who Have Agreed to Public Interviews
http://www.sprc.org/sites/sprc.org/files/library/Best Practices for Presentations by Suicide Loss and Suicide Attempt Survivors - FINAL 2012.1.pdf

Special Considerations for Telling Your Own Story: Best Practices for Presentations by Suicide Loss and Suicide Attempt Survivors
Provided by: Suicide Prevention Resource Center

Sometimes when peoples' lives have been touched by suicide, they want to help others by sharing their experience. Sharing one's story with the public through presentations and media interviews is an important way to educate people about suicide. Research indicates that particular care needs to be taken when discussing suicide and here, a group of experts within the suicide prevention community offer the following best practices for you to think about prior to sharing your story.

Am I ready to speak? Have I healed enough to speak?

- Remember that if you don't want to tell your story, you don't have to. While some people feel it's important to share, that isn't true for everyone.

- Give yourself time to heal from your loss or your attempt in order to gain perspective from your experience. Know the difference between healing yourself and helping others. Allow yourself possibly several years after your own suicide attempt or loss before making public presentations.

- Consider seeking a consultation with a mental health or other clinician to assess whether it is an appropriate time for you to become a public speaker.

Am I prepared for my family's reaction to my going public?

- It is important to realize that not all of your family members may be accepting of your telling the story of a loved one's suicide or your own experience with a suicide attempt. They may be in different places emotionally or have different feelings about privacy.

- Before you go public, you may want to speak to your family members to learn their feelings. In the end, this is your story, not that of family members, and it is your decision to make. However, you may want to consider closely your comfort level and what impact telling your story publicly will have on them.

Am I prepared for the social ramifications of going public with my story?

Given the instant and widespread access to information through the Internet and social media, consider the long-term ramifications of going public with your story, such as the potential for loss of privacy in your future personal and business life. Remember, you always have the choice about how public you want to make your story. You are free to set limits on any recording that might take place at your presentation. Some people find it easier to present to groups they don't know due to the perceived level of anonymity it affords. Others prefer to speak only to people/groups they know as they feel more comfortable and assured they will receive support.

Do Your Research

Consider collaborating with local suicide prevention experts in your community to seek feedback about the content of your presentation (e.g. written speech, Powerpoint slides). They can also be a useful source of information about local resources and suicide prevention efforts. Consider inviting suicide knowledgeable mental health workers, guidance counselors, and public health workers to attend your presentation as they can be available to help provide support for you and your audience and also to field questions.

Resources

- It is very important for you to read and adhere to the *Safe Messaging Guidelines* that are referenced below. These guidelines are based on the best available research and address the complexities of talking publicly about suicide and the steps for doing so safely.

- Refer to the websites listed at the end of this document for resources, including statistics, warning signs, risk factors, media recommendations, and other related information. Provide and highlight affordable and/or free resources for audience members who might be in need of support. For example, mention (preferably at least twice) the National Suicide Prevention Lifeline, 800-273-TALK (8255) which is a national suicide crisis hotline; and emphasize that it is for those who need help *and* for those who care about someone who needs help. Also, be sure to mention that calling NSPL is free and it is available 24/7.

Other important suggestions:

- Help the audience understand that suicide results from multiple and interacting causes and is the result of a combination of factors including underlying depression and life circumstances. Statistics have shown that up to 90% of all people who die by suicide have a diagnosable and treatable psychiatric disorder at the time of their death (National Center for Health Statistics, 2005). Avoid contributing to the myths that suicide is inexplicable or the result of a single event such as losing a job.

- Avoid giving a message that focuses on the impact of suicide (e.g. pain/devastation to others). For example, although it's understandable for a grieving parent to want to implore the student body not to consider suicide because of the pain it will cause their families this is not a safe or effective suicide prevention message. It would be far preferable to focus on how to get help if they're concerned that they (or someone they know) might be at risk, and give specific information about available resources in the community.

- Although it's generally acceptable to mention the method (such as gunshot or overdose), further detail (especially any graphic description) should generally be avoided. Consider the composition of your audience. What is appropriate to reveal to mental health professionals may not be appropriate to reveal to youth. If you are going to mention the method, clearly identify and explain to the audience your purpose for doing so.

- Know your audience and adjust your presentation accordingly. It can be challenging to mix attempt and loss survivors in a single discussion because the dialogue can sometimes generate intense and even antagonistic emotions. For example, loss survivors may accuse attempt survivors of acting selfishly for not considering the pain that his/her suicide would cause. Conversely, attempt survivors may criticize loss survivors who focus on their own pain or culpability for not having somehow prevented the suicide rather than the pain the person who attempted was experiencing. On the other hand, mixing attempt and loss survivors can also produce meaningful insights that help each other heal.

- You might also remind the audience before you begin that it is an emotional topic and they can feel free to leave the room at any time. Coordinate with the mental health workers who are attending the presentation to look out for anyone who might become upset by the topic. Sometimes discussing suicide and loss can bring up unexpected emotions and feelings.

- If you're asked a question that you prefer not to answer, it is perfectly acceptable to decline to answer, saying something like, "I appreciate your interest/concern/curiosity, but I hope you understand that I don't feel comfortable discussing that publicly."

- And if you don't know the answer to a specific question, it's okay to tell the audience that. You can let that audience member know that you will attempt to get an answer and email a response at a later date.

Speaking to the Media

- Speaking to the media can be an opportunity to educate reporters about suicide. Read the media recommendations (referenced at the end of this document) and follow all the recommendations in this document when speaking to reporters.

- Also, be sure to provide media representatives with a copy of the media recommendations prior to speaking with them (don't assume they will already know about it). Utilize opportunities to educate them by providing them with websites that have links to the information.

- After you speak with a reporter you might second-guess something you said. If the piece hasn't been aired or written, you can contact the reporter and give additional clarification. You can request of a reporter that they validate with you that they captured your words appropriately before printing something on which they are quoting you. Not all reporters will agree to let you see the article before it is printed, but you can always ask for the opportunity to review it.

Self Care

Only by taking care of yourself can you help others. For example:

- Have a support system of your own in place following your presentation. This can include a mental health professional, family member, friend, clergy, or a colleague who is a fellow presenter who understands the nature and personal impact of your work as a public speaker.

- Utilize your own support system to de-brief following your presentation. It helps to "talk out" your feelings, the stories you've heard, and the heartache you may have been exposed to when you gave your speech. Sometimes you will encounter loved ones who are angry or who blame others. Yet others might want to share all the details of their loved one's suicide or attempt, or their own attempt with you. Be prepared that people may want to ask you additional questions or share additional time with you. This can exact a toll, but remember that you are always free to set limits.

- Following your presentation, schedule down time, rest, an activity, or a break from talking about the topics of mental health and suicide prevention. Maintaining a healthy balance in your own personal life is critical.

A Final Word

It is through the personal stories of the suicide bereaved and suicide attempters that public awareness about suicide moves forward. We encourage you to follow these recommendations to help strengthen the movement so that we continue to battle the stigma that surrounds suicide and help more people receive the support they need. You might consider ending your presentation with discussing the link between increased awareness about suicide and the need for the community to join the cause, volunteer, work with a non-profit, advocate, or join a local suicide prevention task force.

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This document was created through the collaboration of several organizations and experts in the suicide prevention community, including: the American Association of Suicidology, the American Foundation for Suicide Prevention, the National Suicide Prevention Lifeline, NAMI New Hampshire, Suicide Awareness Voices of Education, and several individual mental health advocates and public speakers.

Tips For Survivors Who Have Agreed To A Media Interview

I always discuss the boundaries of an interview with media representatives ahead of time. Since my son was number five in a suicide contagion, I'm very sensitive to the fact that other young people may be watching or listening and be susceptible to a contagion effect, so I do not give details of his death, allow the media to film close-up pictures of him, or sensationalize his death. Instead, I focus on the loss as a tragedy that is preventable if society and our communities step up to the plate with time, energy, and money.

Merily Keller
Past Co-chair, Texas Suicide Prevention Council

Remember that your interview has the potential to save lives by making people aware that suicide is a preventable public health problem, educating them about the extent of the problem, and talking about the need for communities to work together to address the issue. These are key messages that should be included in any interview. With that in mind:

Be Prepared

- Go to Chapter 4 of this toolkit and memorize a few key facts about the extent of suicide in Texas. You might want to choose one of the statistics that matches the age of your loved one i.e. if you lost someone who was older, you can say that my husband, wife, mother, father etc. was XX years old, and unfortunately statistics indicate that senior Texans have high rates of suicide. Conversely, if you lost a teenager, you could point out that suicide is one of the leading killers of adolescents in the state.
- Give some careful thought to how you want to celebrate the memory of your loved one in the interview. How do you want to portray the deceased? Prepare to describe the life of who your loved one was, and in a series of short sentences that portray their value and esteem. Take some time to decide what you are and are not comfortable speaking about. Remember that giving details about the manner of death cannot only be harmful to your equilibrium, but also to a potential viewer. The concern is two-fold, not only for you, but also that someone who is suicidal may be stimulated by the nature of what is being said.
- Consider partnering up with a mental health clinician in your community for all interviews. Most survivors have found it advantageous to have someone else next to them for the interview. Moral support is always a strength to draw on, and you can prearrange a non-verbal signal for your need of support, as well as to have them signal you if things seem to be going in the wrong direction. There is also great ease in having another person to deal with a question that you may not be completely comfortable answering. If a therapist or a support group has helped you, consider sharing that information. There might be someone days or weeks away from the suicide of a loved one that your process might touch.
- Remember that you have the right to ask beforehand what questions you will be asked and to deliver a list of questions that you are not willing to answer. You also have the right to stop the interview at any time.
- Don't forget to breathe! Take a few deep breaths before you get started to open up your voice and calm you down.

Keep the Focus on What Counts

- Have a transition line to use whenever you don't want to answer. For example, "You know, that is a very good question. Let me think about it and call you back after the interview."
- If you have a mental health professional with you, defer to the professional's expertise. For example, "That is your specialty; could you address that?"
- If you are asked a sensational question that would lead to a gory, detailed answer, simply say "The details of my loved one's death are not the most important thing here. What matters is that communities can come together to address this tremendous mental health problem in Texas."

For Maximum Effectiveness on Television

- **Hands:** Remember, your hands will not be telling the story; your words will. If you have a tendency to use your hands for emphasis, feel free to clasp them together to allow your words to make your point for you.
- **Hair:** if you pull your hair back, the focus will be on your face, and your words, and not the style or length of your hair. Avoid wearing a hat. It detracts from the camera being able to see your face and focus on the message you are trying to convey with your words.
- **Clothing:** Stay away from all-white or all-black as well as large prints. Otherwise, solid colors are preferable to patterns or stripes. If you want people to hear your voice and see your heart, wear neutrals like grays or earth tones. For a compassionate presence, wear medium blue (rather than a dark navy or a light blue).
  - For women, if you choose a skirt, make it long enough to cover the knee. When you are seated and the camera takes a wide shot, viewers' eyes will go to your thighs and distract from the power of your words.
  - Non-flimsy shirts and blouses are preferable since you will likely have a microphone attached to your clothing and it will tug on thin or flimsy material.
- **Jewelry and make-up:** Any jewelry at the lapel should be small and non-shiny. Avoid metal bracelets or other "jangly" items. Make-up should include concealer for under the eyes, a neutral lipstick, and powder to even out skin tone and keep people focused on what you are saying. Use blush sparingly; the camera picks up red tones very easily.

Guidelines/Recommendations for the Media

The media can have a powerful effect after a suicide, both in the positive sense of helping to educate people that suicide is a preventable health problem and in the negative sense of potentially contributing to phenomena such as suicide contagion and worsening the problem. Both the American Foundation for Suicide Prevention and the American Association of Suicidology offer detailed recommendations for the media that address:

- The risk of contributing to suicide contagion
- The relationship between suicide and mental illness
- Interviewing surviving relatives and friends
- The importance of choice of language
- Special situations such as celebrity deaths, homicide- suicides, and suicide pacts.

In addition, The National Institute of Mental Health stresses that suicide contagion is real and has the following recommendations to minimize suicide contagion:

> Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors. Direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults.
>
> The risk for suicide contagion as a result of media reporting can be minimized by factual and concise media reports of suicide. Reports of suicide should not be repetitive, as prolonged exposure can increase the likelihood of suicide contagion. Suicide is the result of many complex factors; therefore media coverage should not report oversimplified explanations such as recent negative life events or acute stressors. Reports should not divulge detailed descriptions of the method used to avoid possible duplication. Reports should not glorify the victim and should not imply that suicide was effective in achieving a personal goal such as gaining media attention. In addition, information such as hotlines or emergency contacts should be provided for those at risk for suicide.
>
> Following exposure to suicide or suicidal behaviors within one's family or peer group, suicide risk can be minimized by having family members, friends, peers, and colleagues of the victim evaluated by a mental health professional.
> Persons deemed at risk for suicide should then be referred for additional mental health services.

Additional Tips for Survivors Who Have Agreed to a Media Interview:

The American Association of Suicidology provides a list of suggestions for using the media to promote your education and prevention efforts. The American Association of Suicidology suggests that community groups:

- Proactively establish media relationships
- Emphasize the warning signs and sources of help in the community
- Use real-life examples to make a point but without breaching any confidence
- Be aware of local, state, and national statistics to quote with the media
- Use everyday language that people will easily understand

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"Suggestions for Funeral Directors When a Child Dies," Compassionate Friends. Available online from: http://www.compassionatefriends.org/Other_Pages/Suggestions_for_Clergy.aspx, 453- 457.

"Reporting on Suicide: Recommendations for the Media," American Association of Suicidology. http://www.sprc.org/sites/sprc.org/files/library/sreporting.pdf

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Online Resources and Suggested Reading:

American Association of Suicidology (www.suicidology.org)
American Foundation for Suicide Prevention (www.afsp.org)
National Suicide Prevention Lifeline, 1-800-273-TALK (8255) (http://www.suicidepreventionlifeline.org)
Suicide Awareness/Voices of Education (www.save.org)
Suicide Prevention Resource Center (www.sprc.org)

The Suicide Prevention Resource Center's Safe and Effective Messaging for Suicide Prevention, (http://www.sprc.org/library/SafeMessagingfinal.pdf)
Media Recommendations (http://reportingonsuicide.org
The) Entertainment Industries Council's Depicting Suicide Prevention and Depression in the Movies and on Television (www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf)

Appendix

Texas Statutes Regarding Suicide

Appendix

A

Information compiled by Denise Brady, JD, Austin, Texas
www.TexasSuicidePrevention.org
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The materials available on this website are for informational purposes only and not for the purpose of providing legal advice. You should consult with an attorney to obtain advice with respect to any particular issue, problem, or situation. Mental Health America of Texas and the Texas Suicide Prevention Council regret that we are unable to provide individual legal advice or further interpretations of these Texas statutes.

The following is a list of Texas laws (statutes) that relate to suicide prevention, services, or reporting.

The statutes are organized by subject, with a short explanation of what the law does and, when relevant, what suicide prevention advocates should know about that section of the law. The statutes are presented as excerpts, with only the section of the law that relates to suicide included. In many cases, the statute excerpts have been slightly edited and/or reformatted for clarity and ease of reading, but no content or meaning should have been affected. The reference to "suicide" will be underlined in most passages. The full citation is provided after each excerpt for those that want to see the entire section of the law.

This list is current as of June 6, 2011, and includes updates from bills that passed the 82nd Texas Legislature (2011 Legislative Session); the Governor has until June 19, 2011 to veto a bill, however.

The document does not contain references to several sections of statute that address suicide in the Texas Insurance Code or in the area of wills and estates, due to the complicated nature of those areas of law. Nor do we include references to the Texas Administrative Code (i.e., agency regulations) at this time, due to the length of the document.

Schools and School Personnel

What you should know: **Public schools in Texas must have a "district improvement plan," which must include strategies for suicide prevention. Advocates of suicide prevention should work with their school district's local committees and stakeholders to ensure the district's plan and training includes methods for addressing suicide prevention.**

Texas law: Texas Education Code - District-Level Planning and Decision-Making

- Each school district shall have a district improvement plan that is developed, evaluated, and revised annually, in accordance with district policy, by the superintendent with the assistance of the district-level committee established under Section 11.251 [of the Education Code]. The purpose of the district improvement plan is to guide district and campus staff in the improvement of student performance for all student groups in order to attain state standards in respect to the student achievement indicators adopted under Section 39.053 of the Education Code.
- The district improvement plan must include strategies for improvement of student performance that include methods for addressing the needs of students for special programs, including suicide prevention programs (in accordance with Health and Safety Code requirements regarding parental or guardian notification procedures) (NEW), conflict resolution, violence prevention, or dyslexia treatment programs.

Tex. Education Code §11.252 (a)(3)(B)

NEW Texas Law: Texas Education Code - Staff Development
School district staff development is authorized to include certain training, including training in preventing, identifying, responding to, and reporting incidents of bullying.

Tex. Education Code §21.451(d)

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What you should know: **School counselors should help ensure their school's counseling programs and services integrate best practices in suicide prevention.**

Texas law: Texas Education Code - Counselors

- The primary responsibility of a school counselor is to counsel students to fully develop each student's academic, career, personal, and social abilities.
- In addition to a school counselor's responsibility described above, the counselor shall participate in planning, implementing, and evaluating a comprehensive developmental guidance program to serve all students and to address the special needs of students who are at risk of dropping out of school, becoming substance abusers, participating in gang activity, or committing suicide.

Tex. Education Code § 33.006 (a) and (b)

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What you should know: **Parents may request that their child be transferred to another classroom or another school if their child is a victim of bullying.**

Texas law: Texas Education Code - Transfer of Victims of Bullying
For this and all other sections of the Education Code, bullying is now defined as "engaging in written or verbal expression, expression through electronic means, or physical conduct that occurs on school property, at a school-sponsored or school-related activity, or in a vehicle operated by the district and that: (1) has the effect or will have the effect of physically harming a student, damaging a student's property, or placing a student in reasonable fear of harm to the student's person or of damage to the student's property; or (2) is sufficiently severe, persistent, or pervasive enough that the action or threat creates an intimidating, threatening, or abusive educational environment for a student." (NEW DEFINITION)

Conduct described above is considered bullying if that conduct: exploits an imbalance of power between the student perpetrator and the student victim through written or verbal expression or physical conduct and interferes with a student's education or substantially disrupts the operation of a school. (NEW)

- Parents/guardians may request that their child be transferred to another classroom or another school if their child is a victim of bullying. It is the responsibility of the board of trustees or the board's designee to verify that the student has been a victim of bullying before the transfer may occur and "may consider past student behavior when identifying a bully." School districts are not required to provide transportation to a student who transfers to another school.
- A district may transfer the student who engaged in bullying to another campus at the campus to which the victim was assigned at the time the bullying occurred, or a campus other than that campus -- after consulting with the parent of the student who engaged in bullying. (NEW)

Tex. Education Code § 25.0342 and (NEW) § 37.0832

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What you should know: **Student Codes of Conduct must prohibit bullying and other harassing behaviors.**

Texas law: Texas Education Code - Student Code of Conduct:
Student codes of conduct, developed by the district board of trustees, must be posted and prominently displayed at each school or be made available at the principal's office. The code of conduct must:

- Specify circumstances under which a student may be removed from a classroom, school campus, or alternative education program;
- Specify conditions when a principal or administrator may transfer a student to an alternative education program;

- Outline conditions under which a student may be suspended or expelled; Address parent/guardian notification of code violations that result in suspension, removal to a disciplinary alternative education program, or expulsion;
- Prohibit bullying, harassment, and making hit lists and ensure that district employees enforce these prohibitions; and
- Provide methods for classroom management, student discipline, and "preventing and intervening in student discipline problems, including bullying, harassment, and making hit lists."

Defines "harassment" as "threatening to cause harm or bodily injury to another student, engaging in sexually intimidating conduct, causing physical damage to the property of another student, subjecting another student to physical confinement or restraint, or maliciously taking any action that substantially harms another student's physical or emotional health or safety."

Tex. Education Code § 37.001

What you should know: **Advocates should work with their local school boards in developing bullying prevention policies.**

NEW Texas law: Texas Education Code – Discipline, Law and Order; Bullying Prevention Policies and Procedures

The Board of Trustees of each school district must adopt a policy, including any necessary procedures, concerning bullying that:

- prohibits the bullying of a student;
- prohibits retaliation against any person, including a victim, a witness, or another person, who in good faith provides information concerning an incident of bullying;
- establishes a procedure for providing notice of an incident of bullying to a parent or guardian of the victim and a parent or guardian of the bully within a reasonable amount of time after the incident;
- establishes the actions a student should take to obtain assistance and intervention in response to bullying;
- sets out the available counseling options for a student who is a victim of or a witness to bullying or who engages in bullying;
- establishes procedures for reporting an incident of bullying, investigating a reported incident of bullying, and determining whether the reported incident of bullying occurred;
- prohibits the imposition of a disciplinary measure on a student who is a victim of bullying on the basis of that student's use of reasonable self-defense in response to the bullying; and
- requires that discipline for bullying of a student with disabilities comply with applicable requirements under federal law, including the Individuals with Disabilities Education Act.

The procedures adopted must be included annually in the student and employee school district handbooks and in the district improvement plan under Education Code Section 11.252 (District-Level Planning and Decision-Making). Also requires that the procedure for reporting bullying be posted on the district's Internet website to the extent practicable.
Tex. Education Code § 37.0832

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NEW Texas law: Texas Education Code – Essential Knowledge and Skills Curriculum

In addition to any other essential knowledge and skills the State Board of Education adopts for the health curriculum under another section of the Education Code , the board shall adopt for the health curriculum, in consultation with the Texas School Safety Center, essential knowledge and skills that include evidence- based practices that will effectively address awareness, prevention, identification, self-defense in response to, and resolution of and intervention in bullying and harassment.

Tex. Education Code §28.002 (s)

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What you should know: **Parents and guardians have certain rights pertaining to mental health issues, medications, and their children.**

Texas law: Texas Education Code - Health and Safety; Psychotropic Drugs and Psychiatric Evaluations or Examinations

(a) In this section:

(1) "Parent" includes a guardian or other person standing in parental relation.

(2) "Psychotropic drug" means a substance that is:

(A) used in the diagnosis, treatment, or prevention of a disease or as a component of a medication; and

(B) intended to have an altering effect on perception, emotion, or behavior.

(b) A school district employee may not:

(1) recommend that a student use a psychotropic drug; or

(2) suggest any particular diagnosis; or

(3) use the refusal by a parent to consent to administration of a psychotropic drug to a student or to a psychiatric evaluation or examination of a student as grounds, by itself, for prohibiting the child from attending a class or participating in a school-related activity.

(c) Subsection (b) does not:

(1) prevent an appropriate referral under the child find system required under the Individuals with Disabilities Education Act; or

(2) prohibit a school district employee who is a registered nurse, advanced nurse practitioner, physician, or certified or appropriately credentialed mental health professional from recommending that a child be evaluated by an appropriate medical practitioner; or

(3) prohibit a school employee from discussing any aspect of a child's behavior or academic progress with the child's parent or another school district employee.

(d) The board of trustees of each school district shall adopt a policy to ensure implementation and enforcement of this section.

(e) An act in violation of Subsection (b) does not override the immunity from personal liability granted in Section 22.0511 or other law or the district's sovereign and governmental immunity.

Tex. Education Code § 38.016

Texas Law: School-Based Health Centers - Parental Consent Required

- A school-based health center may provide services to a student only if the district or the provider with whom the district contracts obtains the written consent of the student's parent or guardian or another person having legal control of the student on a consent form developed by the district or provider. The student's parent or guardian or another person having legal control of the student may give consent for a student to receive ongoing services or may limit consent to one or more services provided on a single occasion.

- The consent form must list every service the school-based health center delivers in a format that complies with all applicable state and federal laws and allows a person to consent to one or more categories of services.

Tex. Education Code § 38.053 (a) and (b)

Identification of Health-Related Concerns

- The staff of a school-based health center and the person whose consent is obtained under Section 38.053 shall jointly identify any health-related concerns of a student that may be interfering with the student's well-being or ability to succeed in school.

- If it is determined that a student is in need of a referral for mental health services, the staff of the center shall notify the person whose consent is required under Section 38.053 verbally and in writing of the basis for the referral. The referral may not be provided unless the person provides written consent for the type of service to be provided and provides specific written consent for each treatment occasion.

Tex. Education Code § 38.057 (a) and (b)

Youth and Family Services

What you should know: **A minor generally may seek and receive counseling services from a doctor or a mental health professional without the professional having to obtain consent from the minor's parent or guardian, including counseling regarding suicide prevention. This assures youth they may seek confidential counseling in many situations.**

Texas law: Texas Family Code - Consent to Counseling

- A child may consent to counseling for:
  - suicide prevention;
  - chemical addiction or dependency; or
  - sexual, physical, or emotional abuse.

- A licensed or certified physician, psychologist, counselor, or social worker having reasonable grounds to believe that a child has been sexually, physically, or emotionally abused, is contemplating suicide, or is suffering from a chemical or drug addiction or dependency may:
  - counsel the child without the consent of the child's parents or, if applicable, managing conservator or guardian;
  - with or without the consent of the child who is a client, advise the child's parents or, if applicable, managing conservator or guardian of the treatment given to or needed by the child; and
  - rely on the written statement of the child containing the grounds on which the child has capacity to consent to the child's own treatment under this section.
- Unless consent is obtained as otherwise allowed by law, a physician, psychologist, counselor, or social worker may not counsel a child if consent is prohibited by a court order.
- A physician, psychologist, counselor, or social worker counseling a child under this section is not liable for damages except for damages resulting from the person's negligence or willful misconduct.
- A parent, or, if applicable, managing conservator or guardian, who has not consented to counseling treatment of the child is not obligated to compensate a physician, psychologist, counselor, or social worker for counseling services rendered under this section.

Tex. Family Code § 32.004

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What you should know: **The Texas state agency responsible for the public mental health system, the Department of State Health Services, must have a designated employee who will specialize in suicide prevention to liaison with public schools.**

Texas law: Texas Health & Safety Code - Services for Children and Youth

- The department shall ensure the development of programs and the expansion of services at the community level for children with mental illness or mental retardation, or both, and for their families.

- The department shall designate an employee as a youth suicide prevention officer. The officer shall serve as a liaison to the Texas Education Agency and public schools on matters relating to the prevention of and response to suicide or attempted suicide by public school students.

Tex. Health & Safety Code § 533.040 (a) and (c)

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What you should know: **The Department of State Health Services (in coordination with the Texas Education Agency) must provide and annually update a list of best- practice suicide prevention programs for consideration by public schools and report on implementation.**

NEW LAW: Texas Health & Safety Code – Public Health, Early Mental Health Intervention and Prevention of Youth Suicide

(a) Requires the Texas Department of State Health Services (DSHS), in coordination with the Texas Education Agency (TEA), to provide and annually update a list of recommended best practice-based early mental health intervention and suicide prevention programs for implementation in public elementary, junior high, middle, and high schools within the general education setting. Authorizes each school district to select from the list a program or programs appropriate for implementation in the district.

(b) Requires that the programs on the list include components that provide for training counselors, teachers, nurses, administrators, and other staff, as well as law enforcement officers and social workers who regularly interact with students, to:

(1) recognize students at risk of committing suicide, including students who are or may be the victims of or who engage in bullying;

(2) recognize students displaying early warning signs and a possible need for early mental health intervention, which warning signs may include declining academic performance, depression, anxiety, isolation, unexplained changes in sleep or eating habits, and destructive behavior toward self and others; and

(3) intervene effectively with students described by Subdivision (1) or (2) by providing notice and referral to a parent or guardian so appropriate action, such as seeking mental health services, may be taken by a parent or guardian.

(c) Requires DSHS and TEA, in developing the list of programs, to consider: (1) any existing suicide prevention method developed by a school district; and

(2) any Internet or online course or program developed in this state or another state that is based on best practices recognized by the Substance Abuse and Mental Health Services Administration or the Suicide Prevention Resource Center.

(d) Authorizes the board of trustees of each school district to adopt a policy concerning early mental health intervention and suicide prevention that:

(1) establishes a procedure for providing notice of a recommendation for early mental health intervention regarding a student to a parent or guardian of the student within a reasonable amount of time after the identification of early warning signs as described by Subsection (b)(2);

(2) establishes a procedure for providing notice of a student identified as at risk of committing suicide to a parent or guardian of the student within a reasonable amount of time after the identification of early warning signs as described by Subsection (b)(2);

(3) establishes that the district is authorized to develop a reporting mechanism and is authorized to designate at least one person to act as a liaison officer in the district for the purposes of identifying students in need of early mental health intervention or suicide prevention; and

(4) sets out the available counseling alternatives for a parent or guardian to consider when their child is identified as possibly being in need of early mental health intervention or suicide prevention.

(e) Requires that the policy prohibit the use without the prior consent of a student's parent or guardian of a medical screening of the student as part of the process of identifying whether the student is possibly in need of early mental health intervention or suicide prevention.

(f) Requires that the policy and any necessary procedures adopted under Subsection (d) be included in:

(1) the annual student handbook; and

(2) the district improvement plan under Texas Education Code Section 11.252 (District-Level Planning and Decision-Making).

(g) Authorizes DSHS to accept donations for purposes of this section from sources without a conflict of interest. Prohibits DSHS from accepting donations for purposes of this section from an anonymous source.

(h) Requires DSHS, not later than January 1, 2013, to submit a report to the legislature relating to the development of the list of programs and the implementation in school districts of selected programs by school districts that choose to implement programs.

(i) Provides that nothing in this section is intended to interfere with the rights of parents or guardians and the decision-making regarding the best interest of the child. Provides that policy and procedures adopted in accordance with this section are intended to notify a parent or guardian of a need for mental health intervention so that a parent or guardian may take appropriate action. Requires that nothing in this Act be construed as giving school districts the authority to prescribe medications. Provides that any and all medical decisions are to be made by a parent or guardian of a student.

Tex. Health & Safety Code § 161.325

What you should know: **The Department of State Health Services may be directed by the Texas Commissioner of Health and Human Services to monitor the quality of services provided through the Children's Health Insurance Plan (CHIP), in part by measuring suicide attempts of enrolled youth. This requirement can help ensure health plans will be aware of the importance of suicide prevention activities and services.**

Texas law: Texas Health & Safety Code - Texas Department of State Health Services

The Health and Human Services Commission may direct the Texas Department of State Health Services to monitor the quality of services delivered to enrollees through outcome measurements including the percent of adolescents reporting attempted suicide.

Tex. Health & Safety Code § 62.052 (a)(3)(D)

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What you should know: **Child care facilities licensed by the Texas Department of Family and Protective Services (which includes child care facilities, residential facilities, foster homes, and other facilities) must report to the agency any attempted suicide by a child in a regulated facility.**

Texas law: Texas Human Resources Code - Reporting of Incidents and Violations

In this section, "serious incident" means a suspected or actual incident that threatens or impairs the basic health, safety, or well being of a child. The term includes:

- the arrest, abuse, neglect, exploitation, running away, attempted suicide, or death of a child;
  - a critical injury of a child; and
  - an illness of a child that requires hospitalization.

- A person licensed under this chapter shall report to the department's statewide intake system each serious incident involving a child who receives services from the person, regardless of whether the department is the managing conservator of the child.
- An employee or volunteer of a general residential operation, child-placing agency, foster home, or foster group home shall report any serious incident directly to the department if the incident involves a child under the care of the operation, agency, or home.
- A foster parent shall report any serious incident directly to the department if the incident involves a child under the care of the parent.

Tex. Human Resources Code § 42.063

Medical Services to Minors in the Conservatorship of the State

What you should know: **A medical professional can provide care or services to a youth in the conservatorship of the state (i.e., a child in foster care) in emergency situations without having to obtain the usual consents in order to prevent a child from committing suicide.**

Texas law: Texas Family Code - Provision of Medical Care in Emergency

- Consent or court authorization for the medical care of a foster child otherwise required by this chapter is not required in an emergency during which it is immediately necessary to provide medical care to the foster child to prevent the imminent probability of death or substantial bodily harm to the child or others, including circumstances in which:

- the child is overtly or continually threatening or attempting to commit suicide or cause serious bodily harm to the child or others; or
- the child is exhibiting the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the child's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

- The physician providing the medical care or designee shall notify the person authorized to consent to medical care for a foster child about the decision to provide medical care without consent or court authorization in an emergency not later than the second business day after the date of the provision of medical care under this section. This notification must be documented in the foster child's health passport.
- This section does not apply to the administration of medication under Subchapter G, Chapter 574, Health and Safety Code, to a foster child who is at least 16 years of age and who is placed in an inpatient mental health facility.

Texas Family Code § 266.009 (a)-(c)

Providing Mental Health Services or Medication without Consent

What you should know: **An individual can be ordered by a court to receive inpatient or outpatient mental health services if the court finds that the person may cause harm to him or herself without treatment.**

Texas law: Texas Health & Safety Code - Court Ordered Mental Health Services

Note: This section of the Health & Safety Code contains extensive provisions regarding court-ordered mental health treatment which are too lengthy to be duplicated here. The following is one excerpt that outlines the standard for temporary inpatient court-ordered care.

- The judge may order a proposed patient to receive court-ordered temporary inpatient mental health services only if the judge or jury finds, from clear and convincing evidence, that the proposed patient is mentally ill and as a result of that mental illness the proposed patient:
  - is likely to cause serious harm to himself;
  - is likely to cause serious harm to others; or
  - is suffering severe and abnormal mental, emotional, or physical distress; experiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health, or safety; and unable to make a rational and informed decision as to whether or not to submit to treatment.

Tex. Health & Safety Code Chapter 574

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What you should know: **A medical professional can administer psychoactive medication to an individual who is under court-ordered mental health services without the individual's consent in certain emergency situations.**

Texas Health & Safety Code - Administration of Medication to Patient under Court-Ordered Mental Health Services

- A person may not administer a psychoactive medication to a patient who refuses to take the medication voluntarily unless:
  - the patient is having a medication-related emergency*;
  - the patient is under an order issued under Section 574.106 authorizing
  - the administration of the medication regardless of the patient's refusal; or
  - the patient is a ward who is 18 years of age or older and the guardian of the person of the ward consents to the administration of psychoactive medication regardless of the ward's expressed preferences regarding treatment with psychoactive medication.

Tex. Health & Safety Code § 574.103 (a) and (b)(1)-(3)

* A "medication emergency" means a situation in which it is immediately necessary to administer medication to a patient to prevent imminent probable death or substantial bodily harm to the patient because the patient overtly or continually is threatening or attempting to commit suicide or serious bodily harm.

Tex. Health & Safety Code § 574.101 (2)(A)(i)

Note: all uses of the phrase "medication-related emergency" in subchapter G of Chapter 574 of Tex. Health and Safety Code includes suicide prevention. See subsequent sections of Chapter 574 for procedures related to administration of medication without an individual's consent.

Effect of Suicide Attempt on a Declaration for Mental Health Treatment

What you should know: **Medical personnel can disregard an individual's Declaration for Mental Health Treatment in emergency situations in order to prevent the individual from committing suicide.**

Texas law: Texas Civil Practice & Remedies Code - Disregard of Declaration for Mental Health Treatment.

- A physician or other health care provider may subject the principal to mental health treatment in a manner contrary to the principal's wishes as expressed in a declaration for mental health treatment only:
  - if the principal is under an order for temporary or extended mental health services under Section 574.034 or 574.035, Health and Safety Code, and treatment is authorized in compliance with Section 574.106, Health and Safety Code; or
  - in case of an emergency* when the principal's instructions have not been effective in reducing the severity of the behavior that has caused the emergency.
- A declaration for mental health treatment does not limit any authority provided by Chapter 573 or 574, Health and Safety Code:
  - to take a person into custody; or
  - to admit or retain a person in a mental health treatment facility.
- This section does not apply to the use of electroconvulsive treatment or other convulsive treatment.

Tex. Civil Practice & Remedies Code Sec. 137.008.

*"Emergency" means a situation in which it is immediately necessary to treat a patient to prevent:

- probable imminent death or serious bodily injury to the patient because the patient:
  - overtly or continually is threatening or attempting to commit suicide or serious bodily injury to the patient; or
  - is behaving in a manner that indicates that the patient is unable to satisfy the patient's need for nourishment, essential medical care, or self-protection; or
  - imminent physical or emotional harm to another because of threats, attempts, or other acts of the patient.

Tex. Civil Practice & Remedies Code § 137.001 (4)

Note: Because this section of the law defines "emergency" to include situations where there is an attempt to treat a patient to prevent death by suicide, all uses of the word "emergency" in Tex. Civil Practice & Remedies Code Chapter 137 would include suicide prevention.

Effect on Employment for Person Convicted of the Offense of Aiding a Suicide

What you should know: **A person who has been convicted of aiding a suicide may not be employed in certain state-regulated facilities, such as nursing homes, State Supported Living Centers, assisted living facilities, Home and Community Services Programs, local MHMR center programs, and others.**

Texas law: Texas Health & Safety Code - Convictions Barring Employment

A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense under Section 22.08, Texas Penal Code (aiding suicide).

Texas Health & Safety Code § 250.006

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What you should know: **A nurse's license will be suspended if he or she has been convicted of aiding someone's suicide.**

Texas law: Texas Occupations Code - Required Suspension, Revocation, or Refusal of License for Certain Offenses
The board of nursing shall suspend a nurse's license or refuse to issue a license to an applicant on proof that the nurse or applicant has been initially convicted of aiding suicide under Section 22.08, Penal Code, and the offense was punished as a state jail felony.

Texas Occupations Code § 301.4535 (a)(9)

Public Safety/Criminal Justice

What you should know: **The Texas Youth Commission must train juvenile correctional officers in suicide prevention.**

Texas Law: Texas Human Resources Code - Juvenile Correctional Officers The Texas Youth Commission shall provide each juvenile correctional officer employed by the commission with at least 300 hours of training, which must include on-the-job training, before the officer independently commences the officer's duties at the facility. The training must provide the officer with information and instruction related to the officer's duties, including information and instruction concerning the signs of suicide risks and suicide precautions.

Tex. Human Resources Code § 61.0356 (b)(4)

*********What you should know:*** **It is against the law to allow a child under 17 unsupervised access to a loaded firearm.**

Texas Law: Texas Penal Code - Making a Firearm Accessible to a Child

- A person commits an offense if a child gains access to a readily dischargeable firearm and the person with criminal negligence:
  - failed to secure the firearm; or
  - left the firearm in a place to which the person knew or should have
  - known the child would gain access.
- It is an affirmative defense to prosecution under this section that the child's access to the firearm:
  - was supervised by a person older than 18 years of age and was for hunting, sporting, or other lawful purposes;
  - consisted of lawful defense by the child of people or property;
  - was gained by entering property in violation of this code; or
  - occurred during a time when the actor was engaged in an agricultural enterprise.
- Except as provided by the subsection directly below, an offense under this section is a Class C misdemeanor.
- An offense under this section is a Class A misdemeanor if the child discharges the firearm and causes death or serious bodily injury to himself or another person.
- A peace officer or other person may not arrest the actor before the seventh day after the date on which the offense is committed if:
  - the actor is a member of the family, as defined by Section 71.003, Family Code, of the child who discharged the firearm; and
  - the child in discharging the firearm caused the death of or serious injury to the child.
- A dealer of firearms shall post in a conspicuous position on the premises where the dealer conducts business a sign that contains the following warning in block letters not less than one inch in height:

"IT IS UNLAWFUL TO STORE, TRANSPORT, OR ABANDON AN UNSECURED FIREARM IN A PLACE WHERE CHILDREN ARE LIKELY TO BE AND CAN OBTAIN ACCESS TO THE FIREARM."

Texas Penal Code § 46.13

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What you should know: **City or county jails may not be required to install fire sprinklers in jail facilities if a sheriff believes the sprinkler head might be used by an inmate in an attempt to commit suicide.**

Texas law: Texas Government Code - Fire Sprinkler Head Inspection

- On the request of a sheriff, the Commission on Jail Standards shall inspect a facility to determine whether there are areas in the facility in which fire sprinkler heads should not be placed as a fire prevention measure. In making a decision under this section, the commission shall consider:
  - the numbers and types of inmates having access to the area;
  - the likelihood that an inmate will attempt to vandalize the fire sprinkler system or commit suicide by hanging from a sprinkler head; and
  - the suitability of other types of fire prevention and smoke dispersal devices available for use in the area.
- If the commission determines that fire sprinkler heads should not be placed in a particular area within a facility, neither a county fire marshal nor a municipal officer charged with enforcing ordinances related to fire safety may require the sheriff to install sprinkler heads in that area.

Tex. Government Code § 511.0097

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What you should know: **A person won't be found guilty of certain crimes if the person was using force to prevent another person from committing suicide.**

Texas law: Texas Penal Code - Protection of Life or Health

- A person is justified in using force, but not deadly force, against another when and to the degree he reasonably believes the force is immediately necessary to prevent the other from committing suicide or inflicting serious bodily injury to himself.

- A person is justified in using both force and deadly force against another when and to the degree he reasonably believes the force or deadly force is immediately necessary to preserve the other's life in an emergency.

Texas Penal Code § 9.34

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What you should know: **It is against the law to aid or attempt to aid another person in committing suicide.**

Texas law: Texas Penal Code - Aiding Suicide

- A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide.
- An offense under this section is a Class C misdemeanor unless the actor's conduct causes suicide or attempted suicide that results in serious bodily injury, in which event the offense is a state jail felony.

Tex. Penal Code § 22.08 (a) and (b)

Reports and Data

What you should know: **The state Inspector General must report annually to a number of state executive and legislative officials the number of investigations in State Supported Living Centers (formerly called "State Schools") that involve the suicide of a resident**

Texas law: Texas Health & Safety Code - Annual Status Report

The inspector general shall prepare an annual status report of the inspector general's activities, which must include information that is aggregated and disaggregated by individual center regarding the number of investigations conducted that involve the suicide, death, or hospitalization of an alleged victim.

Tex. Health & Safety Code § 555.103 (a) and (b)(4)

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What you should know: **The Inspector General of the Texas Youth Commission (TYC) must report regularly to a number of state executive and legislative officials certain information, including the number of investigations they have conducted in TYC facilities that involve a youth's suicide.**

Texas law: Texas Human Resources Code - Office of Inspector General

- The chief inspector general shall on a quarterly basis prepare and deliver a report concerning the operations of the office of inspector general.
- A report prepared under this section is public information under Chapter 552, Government Code (i.e.," Open Records"), to the extent authorized under that chapter and other law, and the commission shall publish the report on the commission's Internet website. A report must be both aggregated and disaggregated by individual facility and include information relating to:
    - the number of investigations conducted concerning suicides, deaths, and hospitalizations of children in the custody of the commission.

Tex. Human Resources Code § 61.0451 (g) and (h)(3)

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What you should know: **Certain entities or agencies may share information about suicides with each other and release data for suicide prevention purposes.**

Texas law: Texas Health & Safety Code - Memorandum of Understanding on Suicide Data

- In this section, "authorized entity" means a medical examiner, a local registrar, a local health authority, a local mental health authority, a community mental health center, a mental health center that acts as a collection agent for the suicide data reported by community mental health centers, or any other political subdivision of this state.
- An authorized entity may enter into a memorandum of understanding with another authorized entity to share suicide data that does not name a deceased individual. The shared data may include:
    - the deceased individual's date of birth, race or national origin, gender, and zip code of residence;
    - any school or college the deceased individual was attending at the time of death;
    - the suicide method used by the deceased individual;
    - the deceased individual's status as a veteran or member of the armed services; and
    - the date of the deceased individual's death.
- The suicide data an authorized entity receives or provides under the above provisions is not confidential.
- An authorized entity that receives suicide data under a memorandum of understanding authorized by this section may periodically release suicide data that does not name a deceased individual to an agency or organization with recognized expertise in suicide prevention. The agency or organization may use suicide data received by the agency or organization under this subsection only for suicide prevention purposes.
- An authorized entity or an employee or agent of an authorized entity is not civilly or criminally liable for receiving or providing suicide data that does not name a deceased individual and that may be shared under a memorandum of understanding authorized by this section.
- This section does not prohibit the sharing of data as authorized by other law.

Texas Health & Safety Code § 193.011

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What you should know: **The law authorizes Texas counties to establish "fatality review teams" to investigate unexpected deaths, which include deaths by suicide, and to use the information gathered from the investigations to engage in activities to prevent such deaths in the future – including "advising the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of unexpected deaths."**

> **Texas law: Texas Health & Safety Code - Definitions**
> "Unexpected death" includes a death of an adult that before investigation appears:
> to have occurred without anticipation or forewarning; and to have been caused by suicide,
> family violence, or abuse.

Note: Because the definition of "unexpected death" includes suicide, all uses of the phrase "unexpected death" in this section of the Code, below, also include suicide.

Establishment of Review Team

- A multidisciplinary and multiagency unexpected fatality review team may be established for a county to conduct reviews of unexpected deaths that occur within the county. A review team for a county with a population of less than 50,000 may join with an adjacent county or counties to establish a combined review team.
- The commissioners' court of a county may oversee the activities of the review team or may designate a county department to oversee those activities. The commissioner's court may designate a nonprofit agency or a political subdivision of the state involved in the support or treatment of victims of family violence, abuse, or suicide to oversee the activities of the review team if the governing body of the nonprofit agency or political subdivision concurs.
- Members selected under this section should have experience in abuse, neglect, suicide, family violence, or elder abuse.

Purpose and Powers of Review Team

- The purpose of a review team is to decrease the incidence of preventable adult deaths by:
    - promoting cooperation, communication, and coordination among agencies involved in responding to unexpected deaths;
    - developing an understanding of the causes and incidence of unexpected deaths in the county or counties in which the review team is located; and
    - advising the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of unexpected deaths.
- To achieve its purpose [to decrease the incidence of preventable adult deaths], a review team shall:
    - meet on a regular basis to review fatality cases suspected to have resulted from suicide, family violence, or abuse and recommend methods to improve coordination of services and investigations between agencies that are represented on the team.

Duties of Presiding Officer

The presiding officer of a review team may send notices to the review team members of a meeting to review a fatality involving suspected suicide, family violence, or abuse.

Access to Information

- A review team may request information and records regarding adult deaths resulting from suicide, family violence, or abuse as necessary to carry out the review team's purpose and duties. Records and information that may be requested under this section include:
    - medical, dental, and mental health care information; and
    - information and records maintained by any state or local government agency, including:
    - a birth certificate;
    - law enforcement investigative data;

- medical examiner investigative data;
- juvenile court records;
- parole and probation information and records; and
- adult protective services information and records.

Meeting of Review Team
This section does not prohibit a review team from requesting the attendance at a closed meeting of a person who is not a member of the review team and who has information regarding a fatality resulting from suicide, family violence, or abuse.

Report of Unexpected Fatality
A person, including a health care provider, who knows of the death of an adult that resulted from, or that occurred under circumstances indicating death may have resulted from suicide, family violence, or abuse shall immediately report the death to the medical examiner of the county in which the death occurred or, if the death occurred in a county that does not have a medical examiner's office or that is not part of a medical examiner's district, to a justice of the peace in that county.

Procedure in the Event of Reportable Death

- A medical examiner or justice of the peace notified of a death under the above provision may hold an inquest under Chapter 49, Code of Criminal Procedure, to determine whether the death was caused by suicide, family violence, or abuse.
- Without regard to whether an inquest is held, the medical examiner or justice of the peace shall immediately notify the county or entity designated by the commissioner's court of:
  - each notification of death received under Section 672.012 (report of unexpected fatality);
  - each death found to be caused by suicide, family violence, or abuse; or
  - each death that may be a result of suicide, family violence, or abuse,
  - without regard to whether the suspected suicide, family violence, or abuse is determined to be a sole or contributing cause and without regard to whether the cause of death is conclusively determined.

Tex. Health & Safety Code Chapter 672

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What you should know: **A medical examiner's office must hold an inquest into the death of a person who dies in the county if the person commits suicide or the circumstances of the death indicate that the death may have been caused by suicide, and the death certificate must state if the cause of death was suicide.**

Texas law: Texas Code of Criminal Procedure - Medical Examiners/Death Investigations
Any medical examiner, or his duly authorized deputy, shall be authorized, and it shall be his duty, to hold inquests with or without a jury within his county when any person commits suicide, or the circumstances of his death are such as to lead to suspicion that he committed suicide.

Tex. Code of Criminal Procedure Art. 49.25 Sec. 6 (a)(5)

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What you should know: **In counties that do not have a medical examiner, a justice of the peace shall conduct an inquest into the death of a person who dies in the county if the person commits suicide or the circumstances of the death indicate that the death may have been caused by suicide**

Texas law: Texas Code of Criminal Procedure - Deaths Requiring an Inquest
A justice of the peace shall conduct an inquest into the death of a person who dies in the county served by the justice if the person commits suicide or the circumstances of the death indicate that the death may have been caused by suicide.

Tex. Code of Criminal Procedure Art. 49.04 (a)(5)

Texas law: Texas Health & Safety Code - Personal Information
A person conducting an inquest required by Chapter 49, Code of Criminal Procedure, shall complete the medical certification not later than five days after receiving the death or fetal death certificate; and state on the medical certification the disease that caused the death or, if the death was from external causes, the means of death and whether the death was probably accidental, suicidal, or homicidal, and any other information required by the state registrar to properly classify the death.

Tex. Health & Safety Code § 193.005(e)(1) and (2)

Public Safety Emergency Response Systems

What you should know: **9-1-1 systems may be used to transmit requests for suicide prevention services.**

Texas law: Texas Health & Safety Code - Transmitting Requests for Emergency Aid
A 9-1-1 system must be capable of transmitting requests for fire-fighting, law enforcement, ambulance, and medical services to a public safety agency or agencies that provide the requested service at the place from which the call originates. A 9-1-1 system may also provide for transmitting requests for other emergency services, such as poison control, suicide prevention, and civil defense, with the approval of the board and the consent of the participating jurisdiction.

Tex. Health & Safety Code § 772.112, .212, and .312

Effect of Suicide in a Civil Action or Lawsuit

What you should know: **A defendant in a civil lawsuit may be not liable for damages in the lawsuit in certain situations if the person suing (i.e., the plaintiff) was committing or attempting to commit suicide and suicide (or the attempt) caused the damages/injury.**

Texas law: Texas Civil Practice & Remedies Code - Assumption of the Risk: Affirmative Defense
It is an affirmative defense to a civil action for damages for personal injury or death that the plaintiff, at the time the cause of action arose, was:

- committing a felony, for which the plaintiff has been finally convicted, that was the sole cause of the damages sustained by the plaintiff; or
- committing or attempting to commit suicide, and the plaintiff's conduct in committing or attempting to commit suicide was the sole cause of the damages sustained; provided, however, if the suicide or attempted suicide was caused in whole or in part by a failure on the part of any defendant to comply with an applicable legal standard, then such suicide or attempted suicide shall

  not be a defense.

Note: The above does not apply in any action brought by an employee, or the surviving beneficiaries of an employee, under the Worker's Compensation Law of Texas, or in an action against an insurer based on a contract of insurance, a statute, or common law. In an action to which it does apply, this section of the law will prevail over any other law.

Tex. Civil Practice & Remedies Code § 93.001

Effect of Suicide on Property Transactions

What you should know: **A real estate broker or salesperson does not have to reveal information about whether any person who lived on the property they are brokering committed suicide.**

Texas law: Texas Occupations Code - Disclosure of Certain Information Relating to Occupants
A license holder is not required to inquire about, disclose, or release information relating to whether:

- a previous or current occupant of real property had, may have had, has, or may have AIDS, an HIV-related illness, or an HIV infection as defined by the Centers for Disease Control and Prevention of the United States Public Health Service; or

- a death occurred on a property by natural causes, suicide, or accident unrelated to the condition of the property. Tex. Occupations Code § 1101.556

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What you should know: **A person attempting to sell property does not have to reveal information about whether any person who lived on the property they are brokering committed suicide.**

Texas law: Texas Property Code - Seller's Disclosure of Property Condition A seller or seller's agent shall have no duty to make a disclosure or release information related to whether a death by natural causes, suicide, or accident unrelated to the condition of the property occurred on the property or whether a previous occupant had, may have had, has, or may have AIDS, HIV-related illnesses, or HIV infection.

Tex. Property Code § 5.008 (c)

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www.TexasSuicidePrevention.org
2011

ADDENDUM TO SUICIDE PREVENTION STATUTES

Texas Suicide Prevention Week

Sunday through Saturday surrounding World Suicide Prevention Day, September 10, each year

CONCURRENT RESOLUTION

WHEREAS, Suicide is a major preventable cause of premature death in the State of Texas; and

WHEREAS, According to the latest available figures, approximately 30 Texans attempt suicide every day, and on average, 6 attempts are completed; death by one's own hand stands as the 11th leading cause of mortality in the state overall, ranking 7th among men and 14th among women; and

WHEREAS, Suicide is the third leading cause of death for young Texans and the second leading cause of death for college-age youth; a large number of suicides occur among the middle-aged as well, while the elderly suffer the highest rate; veterans and active-duty military personnel in Texas are also at high risk for suicide; and

WHEREAS, In addition to the personal suffering involved, suicide entails significant social costs; the average medical expense associated with each suicide death is $4,000, while the medical cost of each suicide attempt averages nearly $9,000; in addition, the "work loss" cost per suicide death has been calculated at $1.2 million; and

WHEREAS, The causes of suicide are complex and include psychological, biological, and sociological factors; among those who die by suicide, 90 percent are suffering from an underlying mental health or substance abuse condition; the most common mental health problem affecting those who commit suicide is a depressive disorder; sadly, the stigma attached to mental illness often discourages individuals who are afflicted from seeking help; and

WHEREAS, Public health researchers, however, consider suicide to be one of the most preventable causes of death; opportunities for reducing the incidence of suicide continue to improve, thanks to advances in neuroscience, progress in diagnosing and treating mental illness, and the growing number of community-based suicide prevention initiatives; and

WHEREAS, September 10 is now recognized annually as World Suicide Prevention Day; within this country, the Substance Abuse Mental Health Services Administration, the U.S. Suicide Prevention Resource Center, the American Association of Suicidology, and the American Foundation for Suicide Prevention, together with Mental Health America of Texas and the Texas Suicide Prevention Council, have endorsed the week encompassing September 10 as a time to promote understanding about suicide and to highlight resources for addressing its precipitating causes; now, therefore, be it

RESOLVED, That the 82nd Legislature of the State of Texas hereby designate the Sunday through Saturday surrounding World Suicide Prevention Day, September 10, each year as Texas Suicide Prevention Week.

Texas State Plan for Suicide Prevention

Appendix

B

GUIDELINES FOR SUICIDE PREVENTION IN TEXAS

Amended and Adopted by the Texas Suicide Prevention Council Executive Committee
September 29, 2011

AWARENESS GOALS, OBJECTIVES AND STRATEGIES

Goal 1. Promote Awareness that Suicide is a Public Health Problem that is Preventable

Objective 1.1. Increase cooperation and collaboration between and among both public and private local and state institutions that have made a commitment to public awareness of suicide and suicide prevention.

Strategies

1.1.1. Establish a network of public and private local and state institutions who communicate regularly via internet and regular state meetings.

1.1.2. Provide culturally and linguistically appropriate material that promotes awareness of suicide as a preventable public health concern that can be distributed within communities by the network of public and private local and state institutions.

Objective 1.2. Establish regular state symposiums on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.

Strategies

1.2.1. Adopt a statewide legislative resolution to designate a Suicide Prevention Day within the National Suicide Prevention Week each September.

1.2.2. Coordinate an annual symposium to support awareness and/or prevention.

Objective 1.3. Increase the number of counties in which public information campaigns are designed to increase public knowledge of suicide prevention.

Strategies

1.3.1. Develop culturally and linguistically appropriate public service announcements and distribute to local communities through available media such as television, radio, billboards, and the web. Where possible, include local resource contact information.

Objective 1.4. Increase the number of both public and private local and state institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the world wide web as well as by other means.

Strategies

1.4.1. Develop a web site to disseminate suicide prevention activities and efforts which will include bilingual resources.

Goal 2. Develop Broad-Based Support for Suicide Prevention

Objective 2.1. Identify and support a management/leadership structure for oversight

of the Texas Suicide Prevention Plan.

Strategies.

2.1.1. Establish within the Texas Department of State Health Services positions of Director of Suicide Prevention, Program Specialist, Health Educator and Administrative or Public Health Technologist.

Objective 2.2. Sustain the Texas Suicide Prevention Council, a public/private partnership, with the purpose of advancing and coordinating the implementation of the Texas Suicide Prevention Plan.

Strategies

2.2.1. Blend resources of stakeholders to increase broad based support for suicide prevention.

2.2.2. Utilize broad based support to seek additional funding.

Objective 2.3. Increase the number of local, state, professional, voluntary and faith-based groups that integrate suicide prevention activities into their programs.

Strategies

2.3.1. Develop a plan to educate local, state, professional, voluntary and faith-based organizations about the importance of integrating suicide prevention activities into their programs.

2.3.2. Distribute specific suggestions and examples of integration.

Goal 3. Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse and Suicide Prevention Services.

Objective 3.1. Increase the proportion of Texans who view mental and physical health as equal and inseparable components of overall health.

Strategies

3.1.1. Increase the statewide availability of culturally and linguistically appropriate information (brochures, public service announcements, conferences, presentations) that includes and/or supports the message that mental health is fundamental to overall health and well being.

3.1.2. Target at-risk populations in all socio-economic groups for mental health public education and information campaigns.

Objective 3.2. Increase the proportion of Texans who view mental health issues as illnesses that respond to specific treatments.

Strategies

3.2.1. Use opinion editorials, public service announcements, and spokespersons to articulate the message that mental illnesses respond to effective treatment.

3.2.2. Educate health care professionals, particularly in primary care, to increase their ability to appropriately identify mental illness in their patients.

3.2.3. Encourage mental health professionals to promote strategies to impact citizen perception that mental health issues are illnesses that respond to specific treatments.

Goal 4. Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media.

Objective 4.1. Promote the accurate and responsible representation of suicidal behaviors, mental illness and related issues in the media.

Strategies

4.1.1 The Texas Suicide Prevention Council will acknowledge accurate and responsible representation of suicidal behaviors, mental illness and related issues in the media.

Objective 4.2. Increase the proportion of news reports on suicides in Texas that observe consensus reporting recommendations.

Strategies

4.2.1. Establish a process for the collection and analysis of news reports on suicide in Texas.

4.2.2. Encourage Texas journalism schools and media associations to adopt the recommendations for reporting suicide posted on the Suicide Prevention Resource Center web site, from the American Association of Suicidology and the American Foundation for Suicide Prevention, and develop a strategy for dissemination of the recommendations to key media.

Objective 4.3. Increase the number of journalism schools in Texas that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.

Strategies.

4.3.1. Convene meetings with Texas journalism schools and media associations to discuss reporting recommendations regarding suicide, as posted on the Suicide Prevention Resource Center web site, from the American Association of Suicidology and the American Foundation for Suicide Prevention, and develop a strategy for dissemination of the recommendations and their presentation in curricula.

INTERVENTION GOALS AND OBJECTIVES AND STRTEGIES

Goal 5. Develop and Implement Community-Based Suicide Prevention Programs.

Objective 5.1. Increase the proportion of public school districts and private school associations with promising or best practice based programs designed to address mental illness and prevent suicide.

Strategies

5.1.1. Survey districts for existing programs including: a) school policy or operating procedures, b) promising or best practice based training for counselors, social workers, psychologists, nurses and general staff and c) provision for post-suicide completion crisis counseling and procedures.

5.1.2. Revise and update guidelines for school suicide prevention and postvention programs and make them available to all Texas school districts, Regional Service Centers, and private school associations.

5.1.3. Include suicide prevention and postvention protocols in legal school policies disseminated by the Texas Association of School Boards, the Texas Education Agency, or other appropriate entities.

5.1.4. Promote early prevention programs within student support services including: a) mentoring, b) peer mediation and conflict resolution, c) anger management, d) bullying, e) life skills and character education, f) substance abuse, and g) parent involvement.

5.1.5 Promote the education of all campus personnel on identification, intervention and referral of early symptoms of mental distress in students and staff.

5.1.6. Support the inclusion of suicide prevention through the local school health curriculum.

5.1.7. Encourage school districts to request guidance for their suicide prevention programs from their local school health advisory committees.

Objective 5.2. Increase the proportion of colleges and universities with promising or best practice based programs designed to address mental illness and prevent suicide.

Strategies

5.2.1. Survey Texas colleges and universities for existing programs including: a)

policy or operating procedures, b) promising or best practice based training for physicians, psychiatrists, psychologists, counselors, social workers, nurses, campus police and general staff and c) provision for suicide prevention and postvention counseling and procedures.

5.2.2. Promote promising or best practice based guidelines for suicide prevention, intervention and postvention programs and make them available to all college and university counseling/student health departments, chaplains, etc.

5.2.3. Include suicide prevention and postvention protocols in legal school policies and in faculty handbooks.

5.2.4. Promote early prevention programs including provision of extensive student support services and comprehensive mental and physical health student and faculty-centered health promotion education strategies.

5.2.5. Promote the education of all campus personnel on identification, intervention and referral of early symptoms of mental distress in students and staff.

5.2.6. Test and promote programs to train faculty and resident staff to train students to identify and refer students at risk for suicide.

Objective 5.3. Increase the proportion of employers that ensure the availability of promising or best practice based prevention strategies for suicide.

Strategies

5.3.1. Promote promising or best practice based training through the appropriate professional organizations such as the Texas Workforce Commission, Employee Assistance Programs, Society for Human Resources, and the Chambers of Commerce.

5.3.2 Encourage development of prevention and postvention policies in the workplace.

Objective 5.4. Increase the proportion of adult correctional and/or juvenile justice agencies and institutions that have promising or best practice based suicide prevention and postvention programs.

Strategies

5.4.1 Identify promising or best practice suicide prevention and postvention programs specific to the needs of adult correction and juvenile justice systems.

5.4.2 Promote the implementation of promising or best practice suicide prevention and postvention programs throughout the adult correctional and juvenile justice systems.

5.4.3 Provide support and technical assistance to adult correctional and juvenile justice systems.

5.4.4 Encourage continued partnerships between adult correction and juvenile justice systems and mental health providers.

Objective 5.5. Increase the proportion of aging networks that have promising or best practice based prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.

Strategies

5.5.1. Promote the implementation of promising or best practice prevention programs throughout aging networks.

5.5.2. Provide support and technical assistance to the aging networks.

5.5.3. Increase outreach to older adults and encourage screenings for depression, substance abuse and suicide risk

5.5.4 Encourage continued partnerships between aging networks and mental health providers.

Objective 5.6 Promote promising or best practice training and technical assistance for suicide prevention and postvention programs through the Suicide Prevention Council utilizing promising or best practice guidelines.

Strategies

5.6.1. Promote promising or best practices education programs that can be implemented by community workers. Incorporate information specific to high-risk populations.

5.6.2. Promote promising or best practice based training for community providers in implementation of the educational programs.

Objective 5.7 Increase the proportion of family, youth and community service providers and organizations with promising or best practice based suicide prevention programs.

Strategies

5.7.1. Establish linkages among schools, local health departments, organizations, and providers who are trained and interested in assisting with the implementation of suicide prevention and postvention programs.

Objective 5.8. Ensure that an evaluation component is included in all suicide prevention programs.

Goal 6. Promote Efforts to Enhance Safety Measures for Those at Risk of Suicide.

Objective 6.1. Increase the proportion of health care providers, organizations, and health and safety officials who routinely assess safety practices and educate about actions to reduce associated danger for those at risk for suicide.

Strategies

6.1.1. Encourage Texas Medical Association, Texas Society of Psychiatric Physicians, Texas Department of Insurance and Mental Health/Mental Retardation Agencies as well as other medical societies to review the quality and increase the availability of mental health continuing medical education.

6.1.2. Survey current practices used by primary care physicians, health care providers, health and safety officials to assess the presence of lethal means in the home.

6.1.3. Promote safety assessment and education models that can be easily and quickly implemented. Disseminate the use of these models through conferences and publications.

Objective 6.2. Increase the proportion of households exposed to public information campaigns designed to enhance safety skills in the home where a resident is at risk for suicide.

6.2.1. Develop and distribute information on safety skills to individuals and families at risk of suicide, following attempts, or upon discharge.

Objective 6.3. Develop promising or best practice based guidelines and training for health care professionals for safer dispensing of medications in households with individuals at heightened risk of suicide.

Strategies

6.3.1. Support continuing medical education which assists physicians and other health care professionals in making appropriate clinical judgments when prescribing potentially lethal medications to patients at risk for suicide.

Goal 7. Implement Promising or Best Practice Based Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment.

Objective 7.1. Define recommended course objectives in identification and management of those at risk for suicide and promotion of protective factors in each of the following professions: medicine, nursing, dentistry, social work, physical, speech and occupational therapy, psychology, law enforcement, EMS, law, pastoral care, education, first response, and other fields as appropriate in both civilian and military communities.

Strategies

7.1.1. Review research and curricula materials available from the field of suicidology to establish a recommended standard for promising or best practice based training in suicidology relevant to the professional focus of existing programs.

Objective 7.2. Increase the number of re-certification or licensing programs in relevant professions which provide promising or best practice based training in suicide assessment, management and prevention, consistent with promising or best practices.

Strategies

7.2.1. Identify suicide prevention curricula mandated by licensing and certification boards in the above professions.

7.2.2. Form a small group of professionals from each of the relevant groups to advise, collect data for current suicide prevention curricula in current licensing criteria, and review and recommend needed updates.

Objective 7.3 Increase the number of colleges and universities that include the promising or best practice based suicide prevention and postvention course objectives. Encourage direct clinical experience in the application of suicide prevention and postvention strategies in pre-professional education or at the graduate and postgraduate or employee level.

Strategies

7.3.1. Survey all schools and colleges in the state to identify curricular threads teaching suicide prevention.

7.3.2. Review curricula materials available from the field of suicidology to establish a baseline standard for promising or best practice based training in suicidology relevant to the professional focus of existing programs.

7.3.3. Develop or promote existing promising or best practice based programs in a sample curriculum for suicide prevention education in undergraduate and graduate programs, with particular emphasis for returning veterans and their families.

Distribute to all relevant schools and colleges for both mental health and non-mental health faculty,

7.3.4. Promote implementation of a plan for increasing the proportion of health professionals trained in suicide risk management.

7.3.5. Survey all schools two years after the distribution of the curriculum to see if any modifications are needed in providing appropriate suicide prevention education.

Objective 7.4 Increase the number of promising or best practice based programs that train support personnel in civilian and military communities, including how to identify suicide risk factors, ideation, behaviors and appropriate referral strategies. These personnel include but are not limited to paraprofessionals and other health care support personnel such as: nurse's aides, food service workers, maintenance, teacher aides, dental technicians, paralegals, correction officers, social worker aides, funeral directors, “gatekeepers” such as hairdressers and bartenders, and workers from other agencies.

Strategies

7.4.1. Identify minimum course objectives in orientation and promising or best practice based training programs for support personnel and volunteers in the relevant specialties.

7.4.2. Develop recommended promising or best practice based guidelines for the minimum course objectives needed for each group.

7.4.3. Survey the certification and promising or best practice based training programs of paraprofessionals in their fields, including knowledge of identification and referral of suicidal clients.

7.4.4. Collaborate with the various boards that certify these workers to include objectives in suicide identification and referral in mandatory promising or best practice based training programs and continuing education.

7.4.5. Promote brief sample curricula to be used as an example for each group of caregivers and support personnel.

7.4.6. Recommend annual staff development on awareness of suicide warning signs, agency policy and operational procedures, and general principles of suicide prevention for other institutions that work closely with at risk persons.

7.4.7. Survey these promising or best practice based training programs in three years to assess the increase in the number of programs that are teaching these principles.

Objective 7.5 Increase the number of military installations that include promising or best practice based suicide prevention and postvention course objectives for key personnel.

Strategies

7.5.1. Survey military bases in the state to identify curricular threads teaching suicide prevention.

7.5.2. Review curricula materials available from the field of military suicidology to establish a baseline standard for promising or best practice based training in suicidology relevant to the professional focus of existing programs.

7.5.3. Develop or promote existing promising or best practice based programs for suicide prevention education in a sample curriculum and distribute to all Texas military installations.

Goal 8. Develop and Promote Effective Clinical and Professional Practices

Objective 8.1. Promote the use of promising or best practice based suicide prevention programs and mental health follow up for patients who present self-destructive behavior to hospital emergency departments

Strategies

8.1.1. Promote research studies comparing standard practices versus enhanced follow-up.
8.1.2. Promote promising or best practice based guidelines for follow-up plans.
8.1.3. Promote community based programs for mental health follow-up with emergency room patients.
8.1.4 Promote patient and family education which would include but not be limited to identification of warning signs, safety plan, appropriate crisis numbers, limiting access to lethal means and support resources.

Objective 8.2. Promote the development of promising or best practice based guidelines for assessment and management of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers.

Strategies

8.2.1. Promote the implementation of promising or best practice based guidelines for the assessment and management of suicide risk.

Objective 8.3. Increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behavior among their patients, consistent with promising or best practices.

Strategies

8.3.1. Collaborate with the appropriate licensing agencies to incorporate suicide management practices in facility assessments and report the results.

Objective 8.4. Promote and encourage suicide prevention promising or best practice based guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities.)

Strategies

8.4.1. Collaborate with the Joint Accreditation Commission for Hospital Organizations and the Texas Department of State Health Services on incorporating suicide management practices in facility assessments and reporting the results.
8.4.2. Promote aftercare service to individuals who are at risk for suicide or who maintain a significant level of suicidal ideation.
8.4.3. Promote aftercare procedures in promising or best practice based guidelines for licensed social service agencies serving individuals who are at risk for suicide.

Objective 8.5 Increase the number of implemented promising or best practice based training programs which will include appropriate screening, assessment and management of suicidal behaviors for professional staff/clinicians who serve at risk populations. These professionals include but are not limited to psychiatrists, psychologists, social workers, substance abuse counselors, etc.

Strategies

8.5.1. Identify promising or best practice minimum course objectives for orientation training for the relevant specialties and provider settings (outpatient/community, inpatient).
8.5.2 Identify promising or best practice minimum course objectives for annual training for the relevant specialties and provider settings (outpatient/community, inpatient).
8.5.3 Develop recommended promising or best practice guidelines for the minimum course objectives for each group.
8.5.4 Survey the certification and promising or best practice based training programs of professionals in their fields that include appropriate screening, assessment and management of suicidal clients.

8.5.5 Collaborate with the various boards that certify these workers to include objectives in screening, assessing and managing suicidal behaviors in mandatory promising or best practice based training programs and continuing education.
8.5.6 Promote brief sample curricula to be used as an example for each group of professionals.
8.5.7 Recommend annual training which will provide a review and update on evidence based assessment and management practices and agency policy and operational procedures.
8.5.8 Collaborate with professional associations to encourage the implementation of promising or best practice based training for all professionals/clinician providers who treat at risk populations.
8.5.9 Survey these promising or best practice based training programs in three years to assess the increase in the number of implemented programs containing recommended elements.

Objective 8.6. Increase the proportion of those who provide key services to suicide survivors (e.g. emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy, mental health professionals, health care professionals) who have received promising or best practice based training that addresses community postvention and the service provider's exposure to suicide and the unique needs of suicide survivors.

Strategies
8.5.1. Encourage the use of promising or best practice based materials and programs for service provided to survivors of suicide.
8.5.2. Develop a liaison between the Texas Critical Incident Stress Management Network and the Suicide Prevention Council to assure that the first responders are being debriefed and supported as survivors as well.
8.5.3. Work with the state professional organizations of clergy, funeral directors and health care providers to raise awareness of the danger of exposure to suicide.
8.4.4. Promote the use of best practice based community postvention protocols.
8.5.5. Develop and share a model curriculum for continuing education courses within each of the professional organizations.

Objective 8.6. Increase the proportion of patients with psychiatric mood disorders who complete a course of treatment or continue maintenance treatment as recommended.

Strategies
8.6.1. Promote continuing medical education which emphasizes the importance of treatment continuance and maintenance, as appropriate, to prevent mental illness relapse.
8.6.2. Advocate health plans to pay for continuous and maintenance treatments for mental health disorders as supported by the standards for promising or best practice.
8.6.3. Promote adherence to promising or best practice based standards for treatment of patients with mood disorders.
8.6.4 Promote patient and family education which emphasizes the importance of treatment continuance and maintenance, as appropriate, to prevent mental illness relapse.

Objective 8.7. Increase the proportion of hospital emergency departments that routinely provide post-trauma psychological support, risk assessment when appropriate, and mental health education for all at risk of PTSD including sexual assault and/or physical abuse, military veterans and active military.

Strategies
8.7.1 Promote funding for a conference on promising or best practices and disseminate findings.

Objective 8.8. Increase the number of implemented promising or best practice based guidelines for providing suicide prevention education to family members and significant others of persons receiving care for the treatment of mental health, substance abuse and victims of assault and trauma within critical settings such as but not limited to general hospitals, mental health hospitals, mental health clinics and substance abuse treatment centers.

Strategies
8.8.1 Identify essential core elements based on promising/best practices or research for inclusion in suicide prevention education guidelines for family members and significant others.
8.8.2 Collaborate with providers to promote implementation of suicide prevention education for family members or significant others based on the guidelines
8.8.3 Survey stakeholders annually for implementation status and evaluation purposes

Objective 8.9. Promote annual screening for depression, substance abuse and suicide risk in primary care settings, hospice, and nursing facilities for all heath care programs.

Goal 9. Increase Access to and Community Linkages with Mental Health and Substance Abuse Services

Objective 9.1. Require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.

Objective 9.2. Increase the proportion of rural and urban counties (or appropriate jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.

Objective 9.3. Promote and encourage promising or best practice based guidelines for mental health screening and referral of students in schools and colleges. Implement those guidelines in a proportion of public and private schools and colleges.

Strategies

9.3.1. Promote and encourage promising or best practice based inservice training of all faculty and staff on how to recognize the signs of a student in suicidal crisis and how to refer that student to the proper available facilities for intervention.

9.3.2 Promote and encourage promising or best practice based training of all college faculty and staff, especially those working in residential life, that includes how to recognize the signs of a student in suicidal crisis and develop a standard procedure on intervention, follow-up and reintegration into campus life.

9.3.3. Promote and encourage the use of a postvention promising or best practice based protocols for schools and colleges that illustrate how to work with students in crisis and students who have been affected by suicide.

Objective 9.4. Promote and encourage promising or best practice based guidelines for schools on appropriate and timely linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of schools.

Strategies

9.4.1. Refer all students who are assessed as high risk for attempting suicide or those who have made a suicide attempt to a health care professional for further evaluation and treatment.

9.4.2. Provide annual inservice promising or best practice based training on community referral resources for school and university staff, administrators, and other personnel such as school counselors, campus police, teachers and other mental health care-givers.

9.4.3. Foster a linkage between the schools and community resources.

Objective 9.5. Encourage school-based clinics to incorporate mental health, suicide, and substance abuse assessment and management into their scope of activities.

Strategies

9.5.1 Work through appropriate state agencies and organizations to encourage schools to provide mental health, substance abuse and physical health services through school based clinics in conjunction with local resources.

Objective 9.6. Promote promising or best practice based guidelines for adult and juvenile incarcerated populations for mental health screening, assessment and treatment of suicidal individuals.

Strategies

9.6.1. Encourage annual promising or best practice based training for all law enforcement personnel, to address intake screening, suicide assessment, and emergency procedures.

9.6.2. Promote policies which establish consistent suicide watch levels, supervision, intervention, and postvention.

Objective 9.7. Promote promising or best practice based guidelines for effective comprehensive support programs for suicide survivors.

Strategies

9.7.1. Promote promising or best practice based suicide survivor facilitator training.
9.7.2. Encourage annual reviews of survivor suicide groups by mental health professionals.
9.7.3. Support policies that require survivors providing peer to peer support be recommended by physician or mental health professional and be two years past the suicide death.

Objective 9.8. Promote quality care/utilization management promising or best practice based guidelines for effective response to suicidal risk or behavior and continuity of care guidelines.

Objective 9.9. Promote certification of crisis centers in Texas by the American Association of Suicidology.

Objective 9.10. Promote seamless linkage between crisis centers and public and private mental health and substance abuse services.

Strategies

9.10.1. Strengthen linkage through sharing information regarding services.
9.10.2. Encourage service provider coalitions and provider groups to enter into mutual understandings with community mental health and substance abuse services.
9.10.3. Encourage collaboration for provision of services to ensure comprehensive coverage.
9.10.4. Encourage the development of resource and referral guides for distribution, and promote the linkage and referral services.
9.10.5. Encourage annual promising or best practice based training of staff and volunteers of crisis centers on information regarding referral agencies and how to access them.

METHODOLOGY: GOALS, OBJECTIVES AND STRATEGIES

Goal 10. Promote and Support Research on Suicide and Suicide Prevention.

Objective 10.1. Develop evidenced-based suicide research

Strategies

10.1.1. Conduct detailed epidemiologic studies of suicide and suicide attempts.
10.1.2. Review scientific evaluation studies of new or existing suicide prevention, intervention and postvention efforts.
10.1.3. Encourage researchers to obtain input from survivors, practitioners, researchers, advocates and others in the community for research initiatives.
10.1.4. Collect, analyze and report annually on population-based information.

Goal 11. Improve and Expand Surveillance Systems.

Objective 11.1. Develop standardized protocols for death scene investigations and implement these protocols in all Texas counties.

Strategies

11.1.1. Assess and inventory current practices.
11.1.2. Develop a protocol model that is appropriate for persons of all age, gender, racial/ethnic groups.
11.1.3. Disseminate the protocol (which would include the identification of data to be collected) and arrange for promising or best practice based training.

Objective 11.2. Develop timely reporting systems to identify suicide behaviors connected by person, place or time in order to identify trends and prevent contagion.

Strategies

11.2.1. Assess the type and timeliness of data currently collected.
11.2.2. Determine data variables that need to be collected.
11.2.3. Conduct appropriate analyses and disseminate results.

Objective 11.3. Increase the proportion of hospitals (including emergency departments), EMS, medical examiners, and law enforcement departments that collect uniform and reliable data on suicidal behavior.

Strategies

11.3.1. Assess the type of information currently collected.
11.3.2. Determine the appropriate data variables to be collected.
11.3.3. Emphasize consistent coding of injury by utilizing the categories included in the International Classification of Diseases.
11.3.4. Provide rationale and incentives for utilizing specific methodologies for collecting uniform data.

Objective 11.4. Produce a biannual report on suicide and suicide attempts.

Strategies

11.4.1 Identify available and appropriate data sources.
11.4.2. Synthesize data from multiple data management systems including but not limited to law enforcement, emergency medical, public health departments, and hospitals.
11.4.3 Produce and disseminate a report to legislators, state agencies and public and private organizations.

AMENDMENT
to Texas State Plan for Suicide Prevention

The Executive Committee of the Texas Suicide Prevention Council voted to support and endorse the recommendations below from Charting the Future *and to add these recommendations to the Texas State Plan for Suicide Prevention, September 29, 2011*

Charting the Future of Suicide Prevention:
A 2010 Progress Review of the National Strategy
and Recommendations for the Decade Ahead

Prepared by the Suicide Prevention Resource Center (SPRC) and Suicide Prevention Action Network USA (SPAN USA), a division of American Foundation for Suicide Prevention, 8/ 2010.

Report Recommendations - Summary List

Recommendation 1: Develop and implement plans to increase the proportion of public awareness and education campaigns that reflect both the fundamental principles of health communication and the safe messaging recommendations specific to suicide.

Recommendation 2: Promote the importance of using public awareness and education campaigns as an adjunct to other interventions rather than as stand-alone initiatives. Whenever possible, health communications campaigns should have much more specific goals than simply "raising awareness."

Recommendation 3: Promote the development of public awareness and information campaigns that are tailored for and targeted toward specific audiences and that describe the actions those audiences can and should take to prevent suicidal behaviors.

Recommendation 4: Implement suicide related GPRA performance measures in government grant programs serving populations at increased risk for suicide, such as aging services; mental health, substance abuse, and healthcare; labor; education; and Tribal programs.

Recommendation 5: Promote more active and systematic state support of suicide prevention planning, implementation, and evaluation at the community level; systematically share successes across States.

Recommendation 6: Expand efforts to provide effective follow up care after emergency department discharge of suicidal persons.

Recommendation 7: Expand efforts to provide effective follow up care after inpatient discharge of suicidal persons.

Recommendation 8: Promote evidence-based and evidence-informed practices for reducing suicide risk among primary care patients.

Recommendation 9: Evaluate and assess practices being implemented in the VA for dissemination to the broader healthcare delivery system.

Recommendation 10: Evaluate and assess practices being implemented in the Department of Defense for potential dissemination for community-based suicide prevention efforts.

Recommendation 11: Promote collaboration between public and private partners to engage military families and veterans' families in suicide prevention efforts.

Recommendation 12: Increase efforts to integrate suicide prevention practices into substance abuse prevention and treatment services.

Recommendation 13: Evaluate the capacity of continuing education clinician training programs to produce behavioral outcomes that improve clinical practice and outcomes. On the basis of evaluation, make curriculum improvements if needed; promote mass dissemination of continuing education to practicing behavioral health providers.

Recommendation 14: Continue to evaluate and refine gatekeeper training in various contexts; modify curricula in a continuous quality improvement mode. Implement gatekeeper training in the context of comprehensive suicide prevention programs.

Recommendation 15: Develop and widely disseminate training on core public-health competencies, including strategic planning, to coalition members via the World Wide Web.

Recommendation 16: Convene organizations that establish standards of accreditation for professional and clinical training programs to develop and implement plans to ensure all training programs within specific professions include curricula on recognizing, assessing, and managing suicide risk and certification exams include questions on this content.

Recommendation 17: Incorporate extant curricula, or newly develop curricula content, to teach state of the art, evidence-based practices in professional training programs and continuing education offerings.

Recommendation 18: Evaluate the cost and effectiveness of statewide teacher training initiatives; use evaluation results to inform policy in States and Territories.

Recommendation 19: Conduct research to better determine the effects of suicide on the bereaved and to identify effective approaches to mitigate those effects.

Recommendation 20: Develop methodologies that are capable of providing preliminary estimates of suicide rates and rapidly detecting meaningful changes in rates for specific demographic groups at the national level.

Recommendation 21: Develop a system to collect reliable data on suicide deaths that occur in healthcare settings.

Recommendation 22: Support the development of a robust suicide research infrastructure that is commensurate with the magnitude of the public health burden.

Recommendation 23: Fast-track research to develop and evaluate effective therapies, as well as non-clinical suicide risk management techniques that take into account the widespread non-acceptance of mental health treatment modalities.

Recommendation 24: Convene a task force to address suicide among adults in mid-life.

Recommendation 25: Take steps to ensure evidence-based therapies discussed in the Intervention section of this report are available to more suicide attempt survivors.

Recommendation 26: Develop, evaluate, and disseminate other evidence-based clinical and non-clinical interventions for survivors of suicide attempts.

Letters of Agreement

Appendix

C

1. **Letter of Agreement/Commitment With Statewide Agencies**
2. **Commitment to the Texas Suicide Prevention Council**
3. **Texas Suicide Prevention of Agreement with Local Texas Suicide Prevention Coalitions and College Campuses**

LETTER OF AGREEMENT/COMMITMENT WITH STATEWIDE AGENCIES
Texas Suicide Prevention Council

The Texas Suicide Prevention Council is seeking public and private involvement from local and state organizations to address the crucial challenge of suicide prevention for fellow Texans. Your organization has been identified as one which could make a significant difference in the more than two thousand lives lost annually to suicide in Texas. By contributing to one or more of the goals of the Texas State Plan for Suicide Prevention, which follows the national goals and objectives for suicide prevention developed by the U.S. Surgeon General's Office, your organization will help save lives.

This letter of agreement is a commitment by your organization to assist in the reduction of the lives lost to suicide in Texas and the harm suicide brings to others, including families, communities, and helping professionals. The purpose of the Council is to support partners to develop suicide prevention programs with their constituent members and to interface with and support other partners. The Council is composed of representatives from state and local organizations with constituencies who have signed a Letter of Agreement/Commitment. Each partner organization agrees to act as an affiliate to initiate and continue to develop suicide prevention activities with and among their constituents. The Texas Suicide Prevention Council is not a legal partnership under the laws of the State of Texas.

Please review the full list of the Texas Suicide Prevention Plan goals below and put your commitment to the goals in written form to enable us to work together. (Complete goals & strategies of the Texas State Plan for Suicide Prevention are available online in the "Coming Together to Care: Suicide Prevention Toolkit, Appendix A at mhatexas.org).

Return this letter of agreement to the Texas Suicide Prevention Council c/o Mary Ellen Nudd, Mental Health America of Texas

Mary Ellen Nudd, menudd@mhatexas.org
fax: (512) 454-3725, or mail to: Mary Ellen Nudd
Mental Health America of Texas
1210 San Antonio, Suite 200, Austin, Texas 78701

Name of Organization _____

Contact Person Name & Title for the organization:

_____

Address: _____

Street or P.O. Box ,City, State, Zip Code:

_____

Phone & Fax, Email & Organization Website:

_____

Signature & Date: _____

Commitment to the Texas Suicide Prevention Council

Our organization commits to be a partner in protecting and promoting the health of Texans by contributing to carry out the specific activities outlined below under one or more goals of the Texas State Plan for Suicide Prevention and to continue to explore specific opportunities to address the goals.

This organization pledges to begin, improve, and/or expand activities related to these goals while seeking to strengthen Texas Suicide Prevention Council in order to facilitate reaching the goals. Annually, this organization will report its progress toward activities related to the below goals to the Texas Suicide Prevention Council.

Instructions: please check off the goals below that your organization will address & attach a brief (250 words or less) description of your organization's mission and purpose.

In addition, for each goal checked that your organization can help to address, please provide a short paragraph or a bulleted list outlining current, ongoing or anticipated future activities that your organization will do to help Texas reach this goal by
.

___Goal I: Promote awareness that suicide is a public health problem that is preventable.

___Goal II: Develop broad-based support for suicide prevention.

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

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

___Goal V: Develop and implement community-based suicide prevention programs.

___Goal VI: Promote efforts to enhance safety measures for those at risk of suicide.

___Goal VII: Implement promising or best practice based training for recognition of at-risk behavior and delivery of effective treatment.

___Goal VIII: Develop and promote effective clinical and professional practices.

___Goal IX: Increase access to and community linkages with mental health and substances abuse services.

___Goal X: Promote and support research on suicide and suicide prevention.

___Goal XI: Improve and expand surveillance systems.

Texas Suicide Prevention Council Letter of Agreement with Local Texas Suicide Prevention Coalitions and College Campuses

The importance of a comprehensive, community focus on suicide prevention is referenced in the 2001-2002, 77th Texas Legislative House Interim Study on suicide prevention:

> The local plan requires a coordinated, community-wide response across disciplines and levels involving diverse groups of all age levels in both the public and private sectors . . . Mental health and substance abuse issues must be interwoven with efforts in education, health care, social service, criminal justice, and faith-based professions among others. A comprehensive and coordinated response to this issue can save lives and reduce the tragedy of suicide for many.

As a community-based, suicide prevention coalition in Texas, the suicide prevention coalition has agreed to be a member of the Texas Suicide Prevention Council and commits to the following. We will:

1) Operate in a collaborative basis working towards implementing the goals of the Texas State Plan for Suicide Prevention and/or a local plan which we have developed based on the state plan.

2) Hold a minimum of four regular meetings per year open to individual and group stakeholders in order to implement the plan in our area.

3) Appoint a representative of our coalition/campus to send information about our activities to the Texas Suicide Prevention Council on a quarterly basis and send a list of members and member groups to be added to the Texas Suicide Prevention Council listserv or outreach list. (with their approval to do so)

4) Implement evidenced-based or best practice suicide prevention programs locally where possible.

5) Work with local media to follow the media guidelines as posted on the AAS, AFSP and SPRC web sites.

6) Keep the Texas Suicide Prevention Council informed about our coalition or campus facilitator/s contact information as well as regular meeting dates and places.

In addition, as part of the Texas Suicide Prevention Council, we will work with other local suicide prevention coalitions or campuses to:

7) Elect representatives (1 regular and 1 alternate) to represent our coalition/campus at meetings of the Texas Suicide Prevention Council, and serve as a liaison between our coalition/campus and the Council to support the work of the Texas Suicide Prevention Council.

8) Advocate for public policy which supports the goals of the Texas State Plan for Suicide Prevention, and

9) To protect member coalitions/campuses that have public employee representatives, a statement will declare on any documents that may be or may be construed to be an advocacy issue one from which public employees may abstain.

Substance Abuse and Mental Health Services Administration Suicide Fact Sheet

Appendix

D

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

SUICIDE THE FACTS

8.4 million adults had serious thoughts of suicide in 2009....**2.2 million** made a plan....**1.1 million** attempted suicide....**36,547** Americans died by suicide.

Women attempt suicide **TWO to THREE times** more than men.

Latina girls have the **highest rates** of feeling sad and hopeless, seriously considering suicide, making a suicide plan AND attempting suicide when compared to whites and blacks.

Men die by suicide at a rate of almost **FOUR times** greater than women.

For men over age 65, the rate is almost **EIGHT times greater** than women.

Working age males (20-64) makeup **60%** of those who have died by suicide.

Youth statistics

For youth between the ages of 10 and 24, suicide is the **third leading cause of death**. A nationwide survey of youth in grades 9-12 across the US found that **15%** of students reported seriously considering suicide, **11%** reported creating a plan, and **7%** reported trying to take their own life in the 12 months preceding the survey. **Over 40%** of surveyed gay or lesbian youth seriously considered attempting suicide. Suicide rates among American Indian/Alaska Native adolescents and young adults are **1.8 times** higher than the national average for that age group.

Missed Opportunities=Lives Lost

Individuals discharged from an inpatient unit continue to be at risk for suicide:

- 10% of individuals who died by suicide had been discharged from an Emergency Department within the previous 60 days.
- 8.6% hospitalized for suicidality are predicted to eventually die by suicide.
- 77% of individuals who die by suicide had visited their primary care doctor within the year....45% within the month.

The question of suicide was seldom raised.

Each year, approximately 149,000 youth between the ages of 10 and 24 receive medical care for self-inflicted injuries at emergency departments across the US.

Over 90% of those who die by suicide suffer from a significant psychiatric illness, substance abuse disorder, or both at the time of their death.

The Suicide and Substance Abuse Connection

Suicide is a leading cause of death among people who abuse alcohol and drugs.

Compared to the general population, individuals treated for alcohol abuse or dependence are at about **TEN times** greater risk to eventually die by suicide compared with the general population, and people who inject drugs are at about **FOURTEEN times** greater risk for eventual suicide.

MORE THAN 30% OF THOSE THAT DIE BY SUICIDE HAVE MEASURABLE BLOOD ALCOHOL LEVELS.

2005-2009: 55%↑ in emergency department visits for drug related suicide attempts by men 21 to 34
2005-2009: 49% ↑ in emergency department visits for drug related suicide attempts by women 50+

The Suicide and Mental Health Connection

50% of individuals who die by suicide suffered from Major Depressive Disorder (MDD). The risk of suicide in people with major depression is about 8 times that of the general population.

When addressing youth suicide, the prevalence of mental illness and/or substance use disorders is lower than with adults, falling within a range of 50-90%.

On average in the United States, 1 suicide occurs for every 30 attempts. In bipolar patients, it's 1 suicide for every 3 attempts, which confirms the increased risk of suicide in patients with bipolar disorder: their attempts are 10 times more lethal.

SUICIDE

Suicide Warning Signs

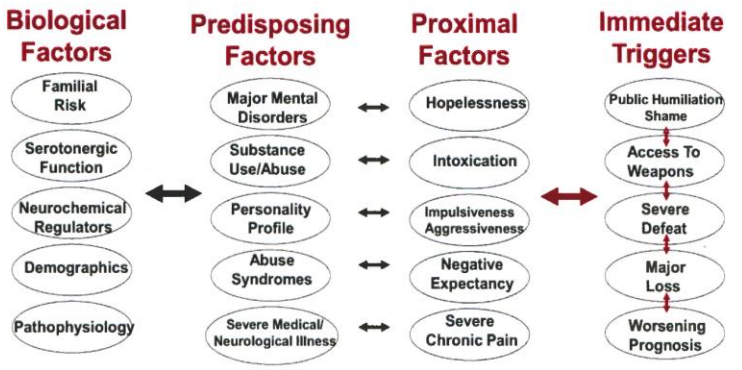
These signs may mean someone is at risk for suicide. Risk is greater for if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

If you are concerned for yourself or someone else, please call the National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**.

WHAT WE CAN DO

SUICIDE: MULTIPLE CONTRIBUTING FACTORS



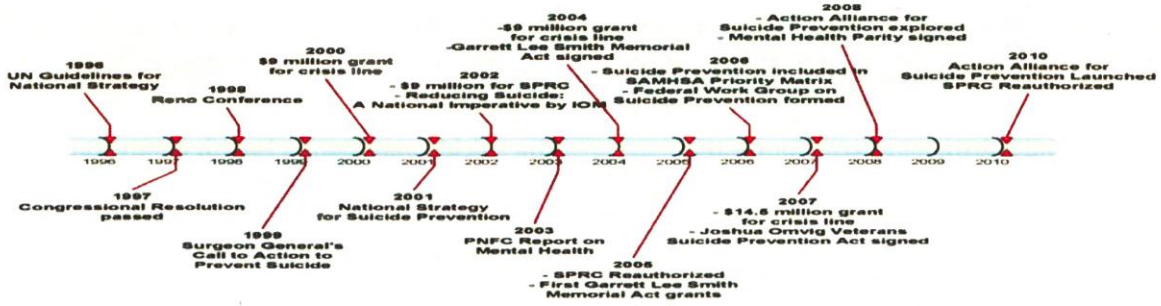
SUICIDE RISK ASSESSMENT WORKSHOP, University of Michigan
David J. Knesper, M.D. Available at www.med.umich.edu/depression/suicide_assessment/

FOLLOW UP WORKS!

SAMHSA funds a grant program which provides follow-up to people who have called a crisis center in distress. After the initial call, counselors call the individual to check in with them. Evaluation of this services found:

- When asked to what extent the counselor's call stopped them from killing themselves, ***53.7%*** indicated a lot, and ***25.1%*** indicated a little.
- When asked to what extent the counselor call has kept them safe, ***60.8%*** indicated a lot, and ***29.3%*** indicated a little.
- ***59.8%*** reported that just getting or anticipating the call(s)/knowing someone cared was helpful to them.

US Suicide Prevention Milestones



We've come a long way in suicide prevention....but we've still got far to go. Here are some resources to help:

National Suicide Prevention Lifeline (http://www.suicidepreventionlifeline.org/) (1-800-273-8255): a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress.

Suicide Prevention Resource Center(http://www.sprc.org/): assists organizations and individuals to develop effective suicide prevention programs and policies by providing prevention support, training and resources, including customized information, state information and an online library.

National Strategy for Suicide Prevention (http://store.samhsa.gov/product/SMA01-3517): The United States' framework for action around suicide prevention, guiding development of services and programs to reduce deaths due to suicide.

National Action Alliance for Suicide Prevention (http://actionallianceforsuicideprevention.org/): a public/private partnership to catalyze planning, implementation, and accountability for updating and advancing the National Strategy for Suicide Prevention.

SAMHSA Mental Health Services Locator (http://store.samhsa.gov/mhlocator): a facility locator that provides comprehensive information about mental health services and resources by State or U.S. Territory.

American Association for Suicidology (AAS) and American Foundation for Suicide Prevention (AFSP) Survivor Resources (http://suicidology.org/ and http://www.afsp.org): These organizations offer resources, support group directories and virtual networks for suicide loss survivors.

Behavioral Health is Essential To Health • Prevention Works • Treatment is Effective • People Recover

If you feel suicidal or you need to help someone else who does, put down this toolkit and call for help immediately.

Call 1-800-273-TALK (8255) to be connected to a suicide and crisis center in your area.

The National Suicide Prevention Lifeline is the only national suicide prevention and intervention telephone resource funded by the federal government. The Lifeline provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a 24-hour, toll-free telephone number: 1-800-273-TALK (8255).

Veterans' hotline: 1-800-273-8255 +1
Red Nacional de Prevención del Suicido: 1-888-628-9454
Website: http://www.suicidepreventionlifeline.org

For Additional Assistance:

- Call the local crisis center listed in the first few pages of your local phone directory.
- Call 911 and ask for the mental health crisis team of your local law enforcement agency.
- Call or go to the nearest hospital emergency room in your area.
- Call one of the Texas crisis centers listed on **page 38** of this toolkit.
- Call your doctor or other health care provider for a referral to someone who provides suicide prevention and intervention services.

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Veterans Crisis Line
1-800-273-8255
PRESS 1

RED NACIONAL de PREVENCIÓN del SUICIDIO
1-888-628-9454
prevenciondelsuicidio.org

Coming Together to Care

A Suicide Prevention and Postvention Toolkit for Texas Communities

TEXAS Department of State Health Services

Mental Health America of Texas

Mental Health America of Texas
1210 San Antonio Street, Suite 200
Austin, Texas 78701

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK (8255)

suicidepreventionlifeline.org

Electronic versions and updates to this toolkit will be posted at:
www.mhatexas.org
www.TexasSuicidePrevention.org