

Coming Together to Care

A Suicide Prevention and Postvention Toolkit for Texas Communities

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

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Spanish translations of selected sections of this toolkit are available online at
www.TexasSuicidePrevention.org.

If You Need Help Now

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.

<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 Appendices section of this toolkit.

- Call your doctor or other health care provider for a referral to someone who provides suicide prevention and intervention services.

On the Web

- http://txcouncil.com/crisis_numbers.aspx The Texas Council of Community MHMR 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, Community Mental Health Services 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.
- <http://www.befrienders.org>. An international, multilingual, 24-hour confidential service operated by the Samaritans.
- <http://www.metanoia.org/suicide>. A source of potentially life-saving advice for anyone who is feeling suicidal.
- <http://suicidehotlines.com/texas.html>. A web-based listing of Texas crisis hotlines with links to other resources.

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

Introduction and FAQs

This suicide prevention toolkit for Texas communities is organized in two parts. The first section covers the basic knowledge that people need to have in order to act effectively on this issue, and the second covers actions they can take once they have that basic knowledge. The goal is to make this a very practical resource that community leaders can easily use in efforts to prevent suicide deaths in Texas. Updates to the toolkit are posted periodically on the Texas Suicide Prevention Council website, <http://www.TexasSuicidePrevention.org>.

The development, research and training for the original toolkit were supported by a grant from the Texas Department of Mental Health and Mental Retardation in 2004. The 2006 and 2008 update to the toolkit, translations of initial sections into Spanish, and the development of a Texas Suicide Prevention website is supported by the Texas Youth Suicide Prevention Project funded by the Garrett Lee Smith Memorial Act, Substance Abuse and Mental Health Services Administration, through the Texas Department of State Health Services. (A grant overview is provided in Appendix A.)

Ten 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 11,256 residents to suicide in the five year period from 2000-2004. This is a loss of close to 2,300 Texans per year and slightly more than 6 Texans who die by suicide each day. (Note: 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 Part I, Chapter 1, “An Overview of Suicide in Texas.”)
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. (Note: Individual risks factors and protective factors are outlined in Part I, Chapter 2, “Understanding Suicide, The Basics.”)
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 guidelines for QPR gatekeepers (QPRInstitute.org) and concerned family members and friends: Ask the person if they are feeling suicidal; Persuade them to get help; and Refer them to an appropriate mental health provider. Do not leave them alone if they are suicidal but ideally go with them to your nearest hospital emergency room, call 911 and ask for a mental health deputy or police officer to come to his/her location to escort them to help, or call his/her family doctor and tell them the person is suicidal and ask for a referral for help. The 1-800-273-TALK national suicide prevention lifeline will connect you to the nearest crisis center for help or you can go to Appendix B for a list of Texas crisis centers.
4. **Question: If you talk about suicide, are you encouraging people to do it?**
Answer: This is one of the main myths about suicide. 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. On the other hand, media coverage about suicide should be done according to national guidelines so that suicide is not sensationalized, the specific means of death is not discussed, and pictures of the individual are not put on the front page. (Note: Media guidelines are provided at the end of Section I, Chapter
5. **Question: Are there research-based programs which can be implemented in our local areas to help prevent suicide?**
Answer: Yes, there are a number of best-practice programs for suicide prevention for your consideration. You can go to SPRC.org to get more information about these programs and to find out what programs states are implementing under their Youth Suicide Prevention SAMSHA grants. (Note: Section II, Chapters 5 and 6 give information on some of the best practice programs.)
6. **Question: There has been a recent suicide in our area. What do we do now?**
Answer: It is important to get advice from mental health and public health officials, not to have permanent

memorials in schools and to identify and provide counseling to those at risk. In addition, follow “postvention” (after suicide) guidelines in order to prevent copycat, cluster or contagion effects and try to follow media guidelines. (Note: There are some general suggestions for memorials or funerals following a suicide in Section II, Chapter 5 from a variety of religious traditions as well as some brief postvention guidelines. A complete postvention toolkit will be posted on TexasSuicidePrevention.org in the future.)

7. 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 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. Go to the end of this introduction to find a list of other groups in Texas who have joined the Texas Suicide Prevention Council and to Appendix A to obtain a copy of the statewide organization letter of agreement. If you want to get involved (or start) a community effort to prevent suicide, your community can also be a member of the Council. You can also find a list of community coalition contacts at the end of this introduction and a copy of the community coalition letter of agreement in Appendix A. For more information about joining the Council, contact suicideprevention@mhatexas.org.

8. Question: Where can I find a copy of the Texas State Plan for Suicide Prevention and a 1 or 2-page fact sheet about suicide in Texas?

Answer: The plan and several state fact sheets are in Appendix A.

9. Question: Where can I find a list of organizations, books, and web-based resources for suicide prevention?

Answer: Extensive resources for suicide prevention including organizations, books and web-based resources are listed in Appendix B, and books are listed in Appendix C.

10. 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 statewide 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) non-profit, serves as the fiscal agent for this organization and can accept donations in memory of a loved one or general donations to support the cause.

Send Memorial Contributions to:

Texas Suicide Prevention Council
c/o Mental Health America of Texas
1210 San Antonio Street, Suite 200
Austin, Texas 78701

In addition, **Appendix B** has a list of various statewide and national groups and non-profits involved in mental health and suicide prevention, most of which accept donations/memorials to further the work of their organizations.

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.

Toolkit Workgroups

Coming Together to Care Toolkit 2008 and 2009 Updates

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Special Thanks

Members of the Texas Suicide Prevention Council for their
ongoing work and dedication to suicide prevention in our
state, and to staff at the Texas Department of State Health
Services and the national Substance Abuse and Mental Health
Services Administration for their support of this project.

*Contacts for the Texas Suicide Prevention Council follow at
the end of this section as well as key contacts at the Texas
Department of State Health Services and the Youth Suicide
Prevention Project.*

*denotes person is a survivor of the loss of a friend or family
member to a death by suicide.

2006 Toolkit Update

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Special Thanks to – Members of the Texas Suicide
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members of Mental Health America of Texas and staff at
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national Substance Abuse and Mental Health Services Ad-
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also extended to the American Association of Suicidology,
American Foundation for Suicide Prevention, National

Suicide Prevention Resource Center and the Suicide Prevention
Advocacy Network-USA for providing national contacts,
research and tools for communities in Texas.

*denotes person is a survivor of the loss of a friend or
family member to a death by suicide

*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.*

Contact List: Suicide Prevention Stakeholder Groups in Texas

Texas Suicide Prevention Council

Charged with the implementation of the Texas State Plan for Suicide Prevention.

Executive Committee

**denotes person is a survivor of the loss of a close friend or family member to a death by suicide.*

Co-Chairs:

Gary Kesling, Texas Association for Marriage and Family Therapists and the Governor's EMS & Trauma Advisory Council, gkesling@utmb.edu 409-747-7345

*Patty Williams, Southeast Texas Suicide Prevention Coalition, pattyw3166@sbcglobal.net 409-832-1146 or cell 409-790-1595.

Immediate Past Chair

*Merily Keller, Austin/Travis County Suicide Prevention Coalition and founding board member, Texas Suicide Prevention Council, mhkeller@onr.com or hodgekeller@yahoo.com 512-327-8689

Secretary/Treasurer

* Margie Wright, Dallas Suicide Prevention Coalition, MargieW@sccenter.org 214-824-7020

Vice Chairs, Local Coalitions

* Merily Keller, Austin/Travis County Suicide Prevention Coalition, mhkeller@onr.com or hodgekeller@yahoo.com 512-327-8689

Troy Bush, Houston Suicide Prevention Coalition, troydidinato@yahoo.com or houstonareasuicideprevention@gmail.com 832-355-4939

Vice Chairs, Statewide Partner Organizations

Gary Kesling, Texas Association for Marriage and Family Therapists and the Governor's EMS & Trauma Advisory Council,

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*Amanda Summers-Fox, representing the Texas Department of State Health Services, amanda.summers-fox@dshs.state.tx.us 512-419-2231

*Erin Espinosa, representing the Texas Juvenile Probation

Commission, erin.espinosa@tjpc.state.tx.us 512-424-6728
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Vice Chair, Nominations

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Liaisons, Texas Youth Suicide Prevention Project

Joshua Martin, Texas Department of State Health Services, project director for the Youth Suicide Prevention Grant Joshua.Martin@dshs.state.tx.us 512-419-2255

*Mary Ellen Nudd, Youth Suicide Prevention Project partner, Mental Health America of Texas menudd@mhatexas.org, 512-454-3706 x 206

Linda Lopez, Youth Suicide Prevention Project partner, Center for Health Care Services, LLopez@chcsbc.org 210-731-1300 x 415

Texas Suicide Prevention Council Members from Statewide Organizations

Members of statewide organizations have signed a letter of agreement to support one or more of the goals and objectives of the Texas State Plan for Suicide Prevention and work to implement suicide prevention within their constituent member organization.

Statewide Organization Members

If you are a member of a statewide organization and you would like to help support suicide prevention in Texas, please contact one of the members of the Texas Suicide Prevention Council below for more information.

The meetings are convened at the offices of the Mental Health America of Texas and via conference call two to four times annually. **If your statewide organization, local community group or college campus is interested in joining the Council, contact Mary Ellen Nudd at menudd@mhatexas.org to obtain a copy of the letter of agreement. A sample letters of agreement is also included in the appendix.**

Advocacy, Inc.

Monica Thyssen, Advocacy, Inc., 7800 Shoal Creek Blvd., Austin, Tx 78757 #171-E, 512-454-4816 (V/TDD), mthyssen@advocacyinc.org. Web: www.advocacyinc.org/

American Association of University Women-Texas

Ann Berasley, President, berasley@swbell.net

Depression & Bipolar Support Alliance-Texas

DBSA- Texas, 3710 Cedar St. #22, Austin, TX 78705, 512-407-6676 or 866-327-2839, fax (512) 451-3110 dbsatexas@sbcglobal.net. Web: www.dbsatexas.org

Governor's EMS & Trauma Advisory Council

Gary Kesling, University of Texas Medical Branch at Galveston, School of Medicine - Departments of Surgery; Preventive Medicine and Community Health, Galveston, Texas 77555 -1173 (409)747-7345 gkesling@utmb.edu. Web: <http://www.dshs.state.tx.us/emstraumasystems/governor.shtm>

Texas Department of State Health Services, Office of EMS/Trauma Systems Coordination

PO Box 149347, Austin, TX 78714-9347. (512) 834-6700. Web: www.dshs.state.tx.us/emstraumasystems/about.shtm

Halliburton Foundation

Vanita Halliburton vanita@halliburtondallas.com. Halliburton Communications, (214) 676-4072 Cell and Voice Mail

Jason Foundation

Terri McBryde, Jason Foundation, c/o The Oaks Treatment Center, 1407 W. Stassney Lane, Austin, Tx 78745. 877-778-2275. 512-565-5184 cell terri.mcbryde@psysolutions.com. Michele Beaupre, 5120669-1187 cell. Web: <http://www.jasonfoundation.com/locations.html>

Mental Health America of Texas

*Mary Ellen Nudd, Mental Health America of Texas, 1210 San Antonio Street, Suite 200, Austin, Tx 78701. 512-454-3706 x 206, menudd@mhateexas.org Web: <http://mhateexas.org>

Montrose Counseling Center

(Representing gay, lesbian, bisexual, and transgender youth statewide) Ann Robison, PhD, 401 Branard, 2nd Floor, Houston, TX 77006. 713-529-0037. mcc@montrosecounselingcenter.org. Deb Murphy, HATCH - GLBT teen support program. 713-529-3590. Web: <http://www.montrosecounselingcenter.org>.

NAMI Texas

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National Association of Social Workers, Texas

Vicki Hansen, 810 W. 11th Street · Austin, TX 78701-2010 Phone: 512-474-1454, Fax: 512-474-1317. vhansen@naswtx.org. Web: <http://www.naswtx.org>

Texas Association for Marriage and Family Therapists

Gary Kesling, University of Texas Medical Branch at Galveston, School of Medicine - Departments of Surgery; Preventive Medicine and Community Health, Galveston, Texas 77555 -1173 (409)747-7345 gkesling@utmb.edu or TAMFT State Office, 1005 Congress, Suite 470, Austin, TX 78701. (800) 270-4320 · (512) 708-1593; (512) 476-7297. Web: <http://www.txmft.org/index.cfm>.

Texas Council of Community MHMR Centers

Joe Lovelace, TCCMHMR Centers, jlovelace@txcouncil.com. 8140 N. Mopac Expy, Westpark Bldg 3, Suite 240, Austin, TX 78759. Phone 512/794-9268 Fax 512/794-8280. Email: office@txcouncil.com; Web: <http://www.txcouncil.com>

Texas Department of Family & Protective Services

Carrie Harris, Volunteer Coordinator, Youth & Runaway Hotline, TDFPS P.O. Box 149030, Austin, TX 78714-9030, (512) 821-4746 fax (512) 821-4766. carrie.harris@dfps.state.tx.us 512-929-6877

Texas Department of State Health Services

*Amanda Summers-Fox, Texas Department of State Health Services, 909 W. 45th, PO Box 12668, Austin Tx 78711 amanda.summers-fox@dshs.state.tx.us. Web: <http://www.dshs.state.tx.us/mentalhealth.shtm> and John Hellsten, John.Hellsten@dshs.state.tx.us, Epidemiologist, Environmental & Injury Epi (T713). Texas Dept of State Health Services, 1100 W. 49th Street, Austin, TX 78756. 512.458.7269 12.458.7222 fax

Texas Health and Human Services Commission

Sherri Hammack, Texas Health and Human Services Commission, 4900 N. Lamar, Austin, TX 78751, 512 424-6964. sherri.hammack@hhsc.state.tx.us. Web: <http://www.dshs.state.tx.us>

Texas Juvenile Probation Commission

*Erin M. Espinosa, Federal Programs, Texas Juvenile Probation Commission, PO Box 13547, Austin, Texas 78711-3547. Phone: (512) 424-6728 Fax: (512) 424-6717 email: erin.espinosa@tjpc.state.tx.us. Web: <http://www.tjpc.state.tx.us>

Texas PTA

*Jan Wilkerson, President, Board, Texas PTA, janwpta@consolidated.net or Texas PTA State Office, Kyle Ward, Executive Director, kwad@txpta.org, 512.476.6769, 408 W. 11th St., Austin, TX 78701-2113 Web: txpta@txpta.org

Texas Psychological Association

Bonny Gardner, 4131 Spicewood Springs, #C-3, Austin, TX 78759 512-338-0201 gardnerb@swbell.net
Or TPA State Office, 1005 Congress Ave, Suite 410, Austin, TX 78701. 12-280-4099 (888) 872-3435 Web: <http://www.texaspsyc.org/>

Local Suicide Prevention Coalition Members

(Note: contact name listed first under each coalition for schedules & agendas)

If you want to get involved in an existing Texas Suicide Prevention local coalition, please contact the coalition facilitators and conveners listed below. If you want help to start a new coalition in Texas, please contact Merily Keller, mhkeller@onr.com or hodgekeller@yahoo.com, or Troy Bush, troydidonato@yahoo.com, Co-chairs of the Local Coalitions. The Texas Suicide Prevention Council has people and tools to help you organize your community to prevent suicide including sample local suicide prevention plans and a letter of agreement for local coalitions and college campuses to sign to join the Council.

1. **Austin/Travis County Suicide Prevention Coalition**
*Elizabeth Roebuck nroebuck@ix.netcom.com, 512-249-2317; or *Merily Keller mhkeller@onr.com or hodgekeller@yahoo.com, 512-327-8689
2. **Dallas-Area Suicide Prevention Coalition**
Margie Wright, MargieW@sccenter.org, 214-824-7020; or Jennifer Mootz, jenniferm@sccenter.org
3. **Fort Worth/Tarrant County Suicide Prevention Coalition**
April Mitchell, aprilmm@mhac.org, 817-335-5405
4. **Heart of Texas Suicide Prevention Coalition (Waco)**
Larry Becker, larry.becker@hotmhm.org
5. **Houston/Harris County Suicide Prevention Coalition**
Troy Bush, troydidonato@yahoo.com or houstonarea-suicideprevention@gmail.com 832-355-4939. Jennifer Battle, 713-970-8240, Jennifer.battle@mhmrahharris.org
6. **Highland Lake Suicide Prevention Coalition(Marble Falls/Burnet County)**

Cari Foote, cfoote@pgrb.com, 830-693-0530 or Sandra Galyon, Sgalyon@Seton.org, 512-715-3078, 512-715-3078. Fax: 512-756-9438. Pager: 512-604-0945

7. **Hill Country Suicide Prevention Coalition (Fredericksburg/Kerrville)**
Contact Merily Keller for more information, mhkeller@onr.com or hodgekeller@yahoo.com, 512- 327-8689
8. **San Antonio Suicide Prevention Coalition**
Jeannie Von Stultz, jvonstultz@bexar.org, 210-531-1015 or Susan Mercado, smercado@nixhealth.com, 210-842-3313
9. **Southeast Texas Suicide Prevention Coalition (Beaumont)**
*Patty Williams Pittman, patty3166@sbcglobal.net, 409-832-1146, cell 409-790-1595 or Jayne Bordelon, mhaje@eonet.net, 409-833-9757
10. **Bastrop Suicide Prevention Coalition**
*Debra Boyd, debra.boyd@dshs.state.tx.us; Laura Menn, laura.menn@bluebonnettmhm.org or *Sarah Maness, rebel_mimi@yahoo.com
11. **San Marcos Suicide Prevention Coalition**
Donna Murphree, dmurphree@ahss.org or Polly Robertson, 512-392-7151, probertson@hillcountry.org
12. **Brazoria County Suicide Prevention Coalition**
Chase Burgin, charles_burgin@hotmail.com

In addition, community volunteers and leaders in **Amarillo, Lubbock, and Montgomery County** have also expressed interest in developing a community coalition to prevent suicide in their areas. The Texas Suicide Prevention Council has volunteers to help these communities and other areas or college campuses that want to start their own coalition.

Texas Youth Suicide Prevention Officer for the State:

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Texas Youth Suicide Prevention Project,

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Texas Youth Suicide Prevention Project, Partner in San Antonio

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Question, Persuade & Refer (QPR) Suicide Prevention Gatekeeper Training

The Texas Suicide Prevention Council has instructors who are certified to give workshops in your area or statewide through the Texas Youth Suicide Prevention Grant, contact:
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**Part 1: What You Need to Know
About Suicide Deaths in Texas**

Chapter 1

An Overview of Suicide in Texas

“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

Suicide as a Preventable Public Health Problem

“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 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. Suicide in Texas is a serious public health concern - and one that might be addressed successfully through a coordinated and comprehensive approach aimed at prevention.

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. But consider the toll it is taking on our state:

- Suicide is the 10th leading cause of death for Texans and the third leading cause of death among youth ages fifteen to twenty-four and the second leading cause of death for college-age students.
- In 2004, on average, slightly more than six Texans died from suicide each day.
- Regardless of age, males were more likely to die because

of suicide than females. In fact, in 2004, 1,793 males and 497 females died of suicide in Texas.

- Suicide rates are highest among Texans seventy years and older. The highest reported suicide rate was among the seventy-five plus age cohort, which reported a rate of 19.9 per 100,000 in 2004.
- Among women, the highest suicide rate in 2004 occurred among those in the age group of 45-54. The suicide rate for this group was 7.9 per 100,000 women.
- Adolescents are a particularly vulnerable group. In 2004, 335 adolescents and young adults ages fifteen to twenty-four died as a result of suicide. Of these, 283 were boys and 52 were girls.

Hope for Prevention

We find among adolescents both a very high risk for suicide and a source of hope for preventing suicide. The Centers for Disease Control (CDC) recently reported a twenty-five percent drop in the suicide rate among American children and teens between 1992 and 2001. While the CDC did not report a reason for these changes, it may be instructive to note that the drop reflected a dramatic decrease in the rate of gun suicides, perhaps indicating that education about the need to restrict children's access to firearms might be helping to prevent some suicides in this group. And while the overall suicide rate dropped among children and teens, it must also be pointed out the number of suicides by hanging or other forms of suffocation actually rose among young people in that decade. So while the report indicates that suicide is preventable, it also points to the complexity of the problem.

There is much to be learned about suicide prevention. Suicide has many different causes that involve biological, psychological, social, and environmental factors. Because suicide is complex, there is a need to address it utilizing a multidisciplinary approach that draws on expertise in not only public health, but also mental health, substance abuse, aging, and many other areas.

The Public Health Model for Suicide Prevention

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 to

prevention involves five steps:

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

This type of well-coordinated, comprehensive response to suicide has been absent in Texas. Legislation regarding suicide prevention has traditionally targeted a narrow population, schoolchildren, and from a limited perspective. While this is necessary and laudable, an effective statewide plan requires greater scope. The Texas State Plan for Suicide Prevention endeavors to bring this larger perspective to the issue, as described in the following material.

The Texas State Plan for Suicide Prevention

In 2001-2002, a multidisciplinary coalition developed a statewide suicide prevention plan for Texas based on the national strategy for suicide prevention that was initiated by the US Surgeon General in 1999. The Texas Suicide Prevention Plan focuses on three primary areas identified by the Surgeon General's Call to Action:

- Awareness – broadening the public's awareness of suicide and its risk factors
- Intervention – enhancing services and programs
- Methodology – advancing the science of suicide prevention.

The specific goals of the plan are to:

1. Promote awareness that suicide is a public health problem and that it is preventable.
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.

4. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
5. Develop and implement community-based suicide prevention programs.
6. Promote efforts to enhance safety measures for those at risk of suicide.
7. Implement training for recognition of at-risk behavior and delivery of effective treatment.
8. Develop and promote effective clinical and professional practices.
9. Increase access to and community linkages with mental health and substance abuse services.
10. Promote and support research on suicide and suicide prevention.
11. Improve and expand surveillance systems.

In 2008 an expert panel of the Texas Suicide Prevention Council reviewed the original state plan and updated it to reflect the current state environment. The Texas Suicide Prevention Council approved the 2008 plan and a copy can be found in the Appendices section of this toolkit and at www.TexasSuicidePrevention.org

Sources:

"Public Health Approach to Suicide Prevention," Suicide Prevention Resource Center. <http://www.sprc.org>

The Surgeon General's Call to Action to Prevent Suicide, 1999.
<http://www.surgeongeneral.gov/library/calltoaction/default.htm>

The Texas Department of Health, Bureau of Vital Statistics, 2000-2004. *Death Tables* [Data file].
<http://www.tdh.state.tx.us/chs/vstat/latest/t18.htm>

Texas Youth Risk Behavior Surveillance System (YRBSS), 2005, 2007

US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, WISQARS, 2008. <http://www.cdc.gov/ncipc/wisqars>

A Brief History of Suicide Prevention Efforts in Texas

2001 - 2003: Toward a State Plan for Suicide Prevention

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. More than 100 people participated in this grassroots effort. Their suggestions led to 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. Sub-committees developed strategies for Texas in the areas of suicide awareness, intervention, and methodology, and soliciting community input from throughout the state, and the group released a proposal addressing suicide from a public health perspective. 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. A copy of the plan (as updated in 2008) can be found in the Appendices section of this toolkit and is posted under the www.TexasSuicidePrevention.org website.

In 2001 the Texas House Human Services Interim Committee was charged by the Speaker of the House to study the issue of suicide prevention in Texas. The committee spent the summer and fall creating a report for the upcoming legislative session recommending the establishment of a Suicide Prevention Council. A bill was drafted, and although it did not reach the floor for a vote during the 2003 session, it served to raise awareness among the members of the state legislature of the need for suicide prevention and cited the Texas Suicide Prevention Plan.

2003: The Texas Suicide Prevention Community Network of Locally Based Suicide Prevention Coalitions

In August 2003, the steering committee that published the Texas State Plan for Suicide Prevention met to dissolve itself, having accomplished the work with which it was charged. In the fall of 2003, after a series of community listening sessions, ten Texas communities organized as the Texas Suicide Prevention Community Network. The initial goals of the network were to prevent needless suicides by accomplishing the following tasks:

- Create, support, and empower suicide prevention coalitions in communities, counties, and regions

throughout Texas.

- Advance educational efforts in suicide prevention through local and statewide change.
- Implement community-based priorities based on 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.

The ten communities that initially organized the network are Austin, Burnet County, Dallas, Fort Worth, Fredericksburg, Houston, Longview, San Antonio, Victoria, and Wichita Falls. Some of these coalitions are being redeveloped and new ones have emerged.

2004: The Texas Suicide Prevention Partnership of Statewide Groups & Organizations

In 2004, the Texas Suicide Prevention Partnership was formed to partner with established agencies and organizations in Texas that deliver services or who can partner with each other to carry out a suicide prevention program in the state. This organization became a subgroup of the Mental Health Work Group of the Texas Strategic Health Partnership. An Interim Executive Committee met in 2004 to continue the development of this partnership.

2005-2007: The Texas Suicide Prevention Council Formed by Merging the Local Coalition Network and Statewide Group Partners.

SUICIDE PREVENTION IN TEXAS:

Overview of the Texas Suicide Prevention Council's Collaborative Effort to Implement the Texas Suicide Prevention Plan

Guiding Principle: All groups are responsible to the **Texas Suicide Prevention Plan**, developed for the people of Texas and belonging to the people of Texas. Each statewide organization signed a letter of agreement by which they agreed to support one or more of the goals and objectives of the Texas Suicide Prevention Plan. Each local coalition also signed a letter of agreement indicating that they have formed a local coalition to address suicide prevention at the community level, 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 the end of 2008, there were 18 statewide partners and 11

local coalitions and Mental Health America of Texas agreed to serve as the fiscal agent for the Texas Suicide Prevention Council. Sample letters of agreement are given in Appendix A for local groups, college campuses or statewide groups that want to join the Council to help prevent the tragedy of suicide in Texas.

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

The United States loses over 30,000 citizens per year to death by suicide. Suicide has become the third leading cause of all deaths nationally in the 10-24 year old age group. The State of Texas lost 11,563 residents to suicide in the five year period from 2001-2005.

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. The less than complete figures available at this time point to suicide as a major health problem in the United States where it is the eleventh leading cause of death, and world-wide where it is the thirteenth leading cause of death.

United States

In order to grasp the sheer size of the suicide problem in the United States, picture a Major League Baseball (MLB) game where the stadium is nearly full. The average attendance for an MLB game in 2004 was 31,112 baseball fans. In 2005, more than 32,000 people died by suicide in the United States. That same year, 162,359 people were hospitalized following suicide attempts and 372,722 were treated in emergency rooms. That hospitalization figure is more than eight times the number of people present in the stadium at an average MLB game. Picture at least nine stadiums full of baseball fans for an illustration of the number of people who attempt or die by suicide each year in the United States alone.

Suicide is the eighth leading cause of death for men in the United States and male Americans are four times more likely than female Americans to die by suicide. White males are particularly at risk, with a suicide rate of 19.6 per 100,000 population in the year 2005. However, American women are three times more likely than men to attempt suicide, often resulting in debilitating or disabling injuries.

Adolescents, young adults, and the elderly are age groups that appear to be at high risk for suicidal behavior. Suicide is the third leading cause of death nationally for young people from 10 to 24 years of age, and the second leading cause of death for college-age youth. The highest rate of suicide is in senior groups with 5,404 Americans over the age of 65 who died by suicide in 2005. Discharge of a firearm is the leading cause of death by suicide for most age groups. In Texas, among youth 10 to 14 years, suffocation has surpassed gunshot wounds as the most common method.

The American military has recognized that active-duty soldiers and veterans are at high risk for suicide. In addition to Suicide Prevention Programs, the Pentagon also has been working to encourage troops to seek mental health care by reducing the stigma associated with getting help. Suicide is one of the three leading causes of death in the Army with a yearly rate of 10.0-11.0 per 100,000 soldiers. At the end of August 2008, there were 62 confirmed suicides among active duty soldiers and National Guard and Reserve troops called to active duty. An additional 31 deaths are being investigated. If the high death numbers continue, they would eclipse the 115 in 2007 which was the highest number of deaths by suicide since the Army began keeping records in 1980.

Source: <http://www.buffalonews.com/260/story/431004.html>

Texas

The state of Texas, with a large resident population, contributes a considerable amount of data to the national figures. In fact, Texas has a number of counties where the suicide rate is at or above the national 90th percentile rank, and suicide ranks in the top ten causes of injury death for all ages in Texas (Figure 1, Table 1). Suicide by discharge of firearm is the most common cause of injury death for Texans overall, the second most common cause of injury death for Texans 45-74 years of age while the highest rate for this type of death is found among the elderly who are over 74 years of age (Table 3 & Figure 5). Furthermore, suffocation suicides are the most common cause of injury death for preteens and adolescents 10-14 years of age (Table 3, Figure 5 & Figure 6). Overall, the suicide rate in Texas has increased from 10.4 in 2000 to 11.0 in 2003 and 10.6 in 2004 for an average rate of 10.8 over this time period, (Table 3, Figure 3).

The raw number of suicide deaths in each Texas county for 2001 - 2004 is presented in Table 9. Due to disparities in population sizes, these numbers must be converted to county-specific rates in order to discern the actual incidence of suicide deaths for these areas. However, there were **942** suicide deaths recorded in the counties containing the

largest metropolitan areas (Bexar, Dallas, Harris, Tarrant, and Travis) during 2004. In Texas overall, the number of suicide deaths from 2000-2004 (11,256 deaths) was larger than the number of homicide deaths (7,068). Travis County has had the highest suicide rate of major Texas metropolitan areas for the past 5 years for which there is statewide county data (Table 2, Figure 2.)

Increasing Knowledge

The 2010 National Health Objectives call for a reduction in the overall suicide rate and in the number of suicide attempts by adolescents (Numbers 18-1 and 18-2.) Current data support the need for these reductions and provide insight into categories of people who may be at risk for self-harm or death by suicide. More sophisticated data-gathering efforts that include a real estimate of the number of suicide

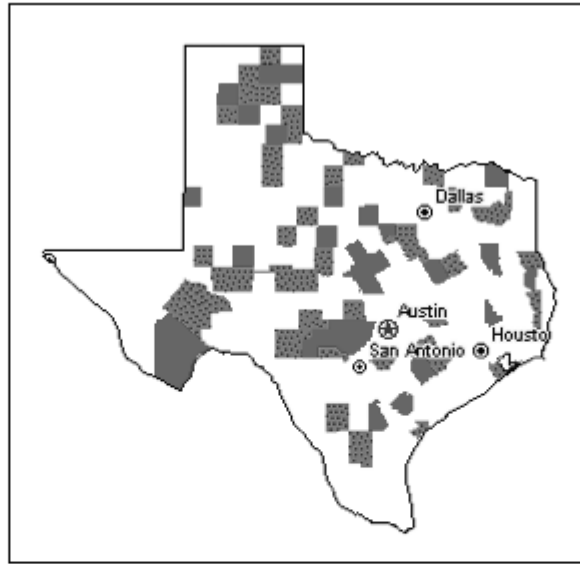
attempts that occur each year and the proximate circumstances surrounding self-harm are necessary to uncover the full picture of suicide in our nation. Data from the Youth Risk Behavioral Surveillance Survey (YRBSS) also indicates that Texas youth suicide attempts are increasing. Texas YRBSS data for 2005 compared with data from 2001 indicates that in 2005 more Texas youth felt sad and hopeless, more Texas youth actually attempted suicide and more Texas youth surveyed had an attempt that necessitated treatment by a doctor or nurse. This does not follow national trends. In fact, more Texan youth surveyed attempted suicide with a rate of (9.4) compared to the overall U.S. rate of youth attempts of (8.4) in 2005. (Table 4.) The following map, charts, and tables illustrate the depth of suicidality in Texas and the patterns that suicide deaths take across demographic categories of people.

Table 1.
Suicide Deaths in Texas 2000-2005. 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.)

Year	2000		2001		2002		2003		2004		2005		2000-2005	
Age	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
5 to 14	33	1	28	0.8	24	0.7	23	0.7	20	0.6	22	0.7	150	0.8
15 to 24	346	10.9	321	9.8	322	9.6	348	10.2	335	9.7	366	10.4	2,038	10.1
25 to 34	371	11.7	380	11.8	401	12.2	370	11.1	395	11.7	414	12.1	2,331	11.8
35 to 44	456	13.7	483	14.4	530	15.7	504	15	451	13.4	482	14.2	2,906	14.4
45 to 54	397	15.2	428	15.6	435	15.4	526	18.1	449	15.1	496	16.2	2,731	15.9
55 to 64	188	11.8	225	13.6	242	13.7	253	13.5	275	14	283	13.8	1,466	13.4
65 to 74	135	11.8	157	13.6	164	14	158	13.3	164	13.7	158	13.0	936	13.2
75 and over	167	18	191	20.1	183	18.9	172	17.4	200	19.9	179	17.5	1,092	18.6
All Ages	2,093	10.4	2,214	10.8	2,304	11	2,355	11	2,290	10.6	2,400	10.5	13,656	10.7

Figure 1.

*Map Data is from 1989-1998, Centers for Disease Control
and Prevention Injury Mapping Web Page*



Legend




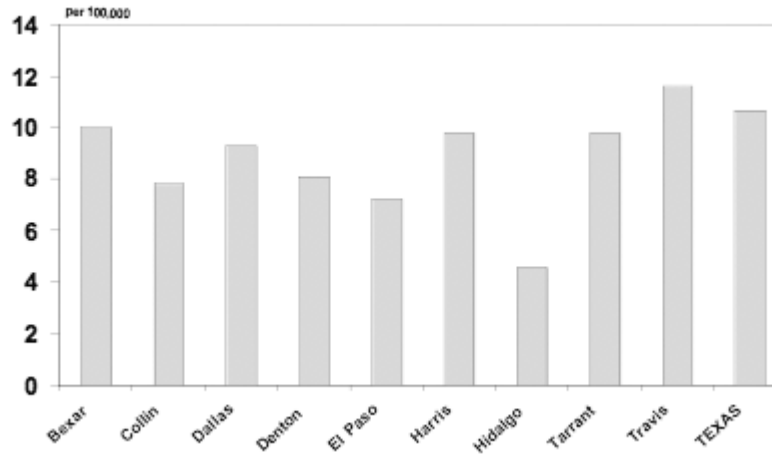
-  Rate is at or above the national 90th percentile per 100,000 people
-  Rate is at or above the national 75th percentile per 100,000 people but less than the 90th
-  Rate is less than the national 75th percentile per 100,000 people

Table 2.

**Comparison of Suicide Death Rates (Numbers per 100,000)
of Major Texas Metropolitan Counties from 2000-2005 (from Texas-DSHS)**

Place of Residence	2000		2001		2002		2003		2004		2005	
	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths
Bexar Co.	10.5	146	10.4	147	9.5	137	10	146	8.9	132	10.7	160
Collin Co.	8.3	41	6.9	37	7.4	42	6.9	41	8.2	51	9.2	61
Dallas Co.	8	178	10	224	10.1	230	9.5	217	8.9	203	9.2	216
Denton Co.	7.4	32	6	28	9.4	46	8.2	42	9	48	8.8	50
El Paso Co.	8.4	57	6	41	7.6	53	6.5	46	7.6	54	6.8	50
Harris Co.	9.5	322	9.6	334	10.9	387	9.7	348	10	364	9.3	343
Hidalgo Co.	4.2	24	3.7	22	4.1	25	5.3	34	4.1	27	5.3	36
Tarrant Co.	9.3	135	9.6	143	7.9	121	10.6	166	9.6	152	11.8	189
Travis Co.	11	89	12.2	102	13.1	110	10.7	92	10.4	91	12.4	107

Figure 2.
Suicide Death Rates of Texas Metropolitan Counties
2000 - 2005



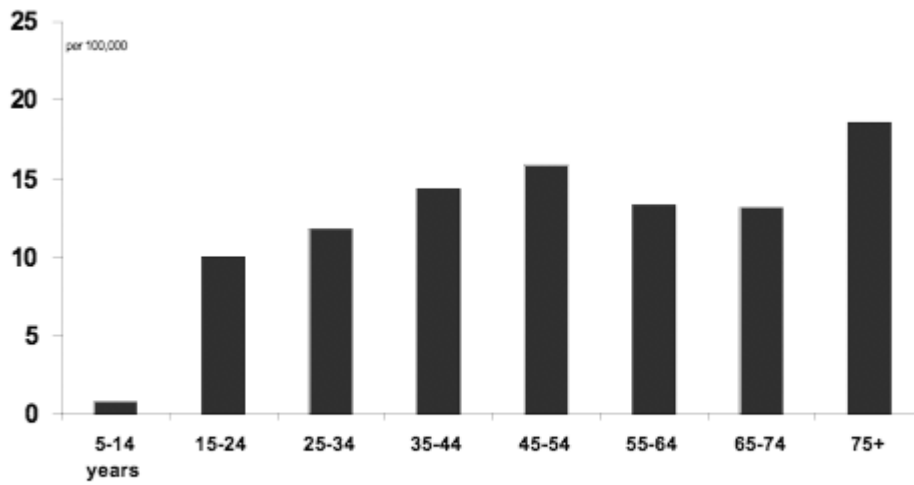
Source: Texas Department of State-Health Services

**DSHS death data for 2005, indicates that Travis County continues to have the highest rate of death by suicide for major metropolitan areas in Texas with a rate of deaths per 100,000 in 2005 which is higher than the rates for Bexar, Dallas, Harris and Tarrant (9.6). The average suicide death rate for which we have data for Travis County is 11.5 compared with the overall Texas average of 10.4.*

Table 3.
Overall Texas Suicide Death Rates for 2000-2004

Suicide Death Rates in the State of Texas – 2000-2004	
Year	Rate (Numbers per 100,000 population)
2000	10.4
2001	10.8
2002	11.0
2003	11.0
2004	10.6
2000-2004	10.8

Figure 3:
Texas Suicide Death Rates by Age Group
2000 - 2005



Source: Texas Department of State Health Services

Firearm Deaths in Texas for 2005

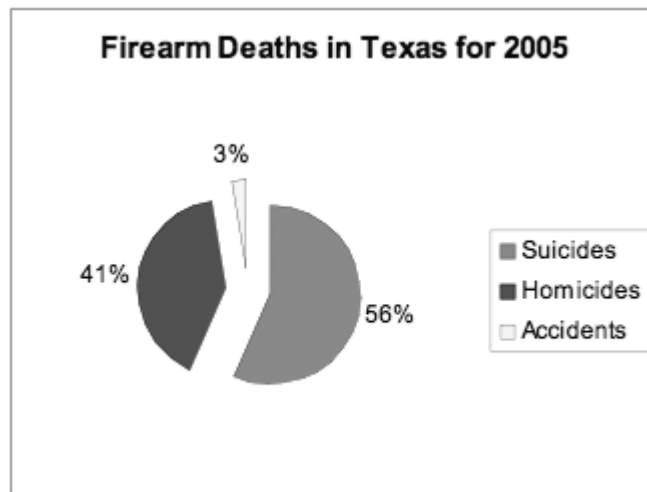


Table 4.
Comparison of Suicides vs Homicides for 2004

2004 Death Statistics for the State of Texas Comparison of death rates for homicide vs suicide	
County	Rate (numbers per 100,000)
Bexar County	6.8 for homicide vs 9.2 for suicide
Dallas County	11.3 for homicide vs 9.5 for suicide
Harris County	9.4 for homicide vs 10.7 for suicide
Tarrant County	5.3 for homicide vs 10 for suicide
Travis County	3.3 for homicide vs. 11.4 for suicide
Total for Texas	6.1 for homicide vs 10.6 for suicide

Texas overall and all major Texas metropolitan areas have higher death rates of suicide by all means than by homicide except for the Dallas area. (Data from TDSHS)

ICD-10 Death Statistics for the State of Texas		
	Year	
	2004	
Cause of Death	Number	Rate
<u>Intentional Self-Harm (Suicide) (X60-X84, Y87.0)</u>	2,290	10.6
<u>Assault (Homicide) (X85-Y09, Y87.1)</u>	1,403	6.1
Total for Selection	3,693	16.6

ICD-10 Death Statistics for the State of Texas		
<u>Assault (Homicide) (X85-Y09, Y87.1)</u>		
	Year	
	2004	
County	Number	Rate
Bexar County	103	6.8
Dallas County	275	11.3
Harris County	366	9.4
Tarrant County	81	5.3
Travis County	31	3.3
Total for Selection	856	8.2

ICD-10 Death Statistics for the State of Texas		
<u>Intentional Self-Harm (Suicide) (X60-X84, Y87.0)</u>		
	Year	
	2004	
County	Number	Rate
Bexar County	132	9.2
Dallas County	203	9.5
Harris County	364	10.7
Tarrant County	152	10.0
Travis County	91	11.4
Total for Selection	942	10.1

Table 5.
10 Leading Causes of Death by Age Group in Texas for 2005. 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	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 548	<u>Unintentional Injury</u> 172	<u>Unintentional Injury</u> 102	<u>Unintentional Injury</u> 121	<u>Unintentional Injury</u> 1,295	<u>Unintentional Injury</u> 1,110	<u>Unintentional Injury</u> 1,295	Malignant Neoplasms 3,484	Malignant Neoplasms 6,551	Heart Disease 31,319	Heart Disease 40,152
2	Short Gestation 319	<u>Homicide</u> 48	Malignant Neoplasms 54	Malignant Neoplasms 52	<u>Homicide</u> 399	<u>Suicide</u> 416	Malignant Neoplasms 1,082	Heart Disease 2,783	Heart Disease 4,696	Malignant Neoplasms 22,584	Malignant Neoplasms 34,291
3	SIDS 216	Congenital Anomalies 36	Congenital Anomalies 18	<u>Homicide</u> 25	<u>Suicide</u> 368	<u>Homicide</u> 394	Heart Disease 940	<u>Unintentional Injury</u> 1,265	Diabetes Mellitus 979	Cerebra-vascular 7,792	Cerebra-vascular 9,366
4	Maternal Pregnancy Comp. 161	Malignant Neoplasms 36	<u>Homicide</u> 10	<u>Suicide</u> 22	Malignant Neoplasms 154	Malignant Neoplasms 286	<u>Suicide</u> 489	Liver Disease 726	Chronic Low. Respiratory Disease 833	Chronic Low. Respiratory Disease 6,784	<u>Unintentional Injury</u> 8,598
5	<u>Unintentional Injury</u> 99	Heart Disease 11	Heart Disease 8	Congenital Anomalies 18	Heart Disease 94	Heart Disease 260	HIV 369	Cerebra-vascular 514	Cerebra-vascular 775	Alzheimer's Disease 4,571	Chronic Low. Respiratory Disease 7,988
6	Placenta Cord Membranes 97	Septicemia 10	Chronic Low. Respiratory Disease 5	Heart Disease 13	Congenital Anomalies 38	HIV 144	<u>Homicide</u> 290	Diabetes Mellitus 506	<u>Unintentional Injury</u> 747	Diabetes Mellitus 3,882	Diabetes Mellitus 5,605
7	Bacterial Sepsis 80	Perinatal Period 9	Benign Neoplasms 3	Cerebra-vascular 8	Complicated Pregnancy 20	Diabetes Mellitus 49	Liver Disease 260	<u>Suicide</u> 500	Liver Disease 644	Influenza & Pneumonia 3,077	Alzheimer's Disease 4,629
8	Respiratory Distress 59	Influenza & Pneumonia 8	Cerebra-vascular 3	Influenza & Pneumonia 6	Cerebra-vascular 17	Cerebra-vascular 42	Cerebra-vascular 201	HIV 289	Nephritis 322	<u>Unintentional Injury</u> 2,379	Influenza & Pneumonia 3,654
9	Neonatal Hemorrhage 54	<u>Three Tied</u> 4	Septicemia 3	Septicemia 4	HIV 14	Septicemia 37	Diabetes Mellitus 176	Chronic Low. Respiratory Disease 274	Septicemia 302	Nephritis 2,128	Nephritis 2,729
10	Necrotizing Enterocolitis 50	<u>Three Tied</u> 4	<u>Two Tied</u> 2	Chronic Low. Respiratory Disease 3	Septicemia 14	Influenza & Pneumonia 34	Septicemia 72	Viral Hepatitis 221	<u>Suicide</u> 285	Septicemia 1,885	Septicemia 2,542

Figure 4.
2005, Texas
Suicide
Ages 10-14, All Races, Both Sexes
Total Deaths: 22



WISQARS™

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

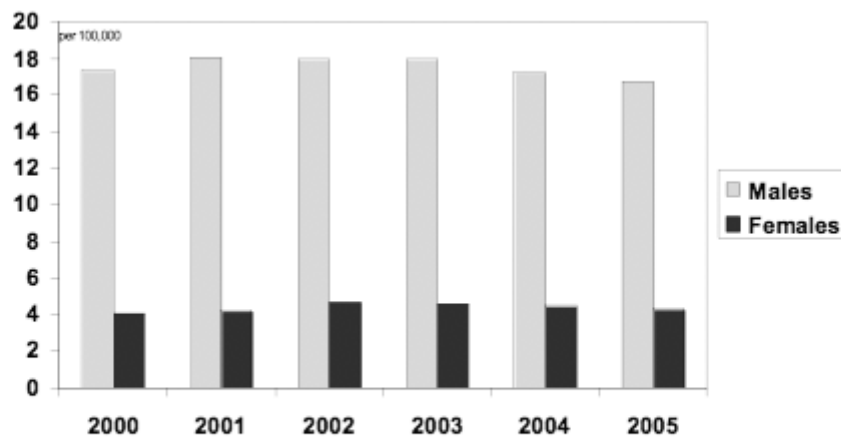
Table 6:
Suicide Deaths by Method and Age Group
2000-2005 (Data provided by Texas DSHS)

Table 6: Suicide Deaths by Method and Age Group												
2000-2005 (Data provided by Texas DSHS)												
	(Suicide) by		(Suicide) by		(Suicide) by		(Suicide) by		(Suicide) by		(Suicide) by	
	Firearm		Exposure to Drugs and Other Substances		Exposure to Other Gases and Vapors		Hanging, Strangulation and Suffocation		Jumping from a High Place		All Other and Unspecified Means and their Sequelae	
Ages	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate
5-14 years	49	0.3	4	<0.1	0	---	93	0.5	2	<0.1	2	<0.1
15-24	1,107	5.5	131	0.7	18	0.1	675	3.3	36	0.2	64	0.3
25-34	1,179	5.9	262	1.3	67	0.4	668	3.4	39	0.2	101	0.5
35-44	1,440	7.2	502	2.5	114	0.6	648	3.2	35	0.2	150	0.8
45-54	1,553	9	510	3	103	0.6	398	2.3	32	0.2	110	0.7
55-64	1,000	9.2	181	1.7	39	0.4	145	1.3	18	0.2	72	0.8
65-74	729	10.3	65	0.9	18	0.3	71	1	6	0.2	45	0.6
75+	933	15.9	32	0.5	16	0.3	67	1.2	7	0.1	32	0.6
All Ages	7,990	6.4	1,688	1.3	375	0.3	2,769	2.1	176	0.1	586	0.5

Figure 5.

Suicide Death Rates by Gender in Texas -2000-2005

Note: In Texas and nationally, Males die by suicide 4 times as often as females. Females attempt suicide more often than males.



Sources: Texas Department of State Health Services

Table 7.

**Youth Suicide Attempts in Texas Compared to the U.S.
As Reported by Youth Behavioral Risk Surveillance Survey for 2005**

TEXAS vs. UNITED STATES ALL YEARS PERCENTAGE OF STUDENTS WHO ACTUALLY ATTEMPTED SUICIDE ONE OR MORE TIMES DURING THE PAST 12 MONTHS					
YOUTH RISK BEHAVIOR SURVEY					
		Sex	T	F	M
Year	Site				
2005	TX		9.4 (±1.1)	12.5 (±1.9)	6.1 (±1.5)
2003			—	—	—
2001			9.0 (±1.1)	12.7 (±1.7)	5.3 (±1.0)
1999			—	—	—
			—	—	—
2005	US		8.4 (±0.9)	10.8 (±1.1)	6.0 (±1.2)
2003			8.5 (±1.1)	11.5 (±1.4)	5.4 (±1.0)
2001			8.8 (±0.8)	11.2 (±1.0)	6.2 (±1.1)
1999			8.3 (±1.0)	10.9 (±1.8)	5.7 (±1.2)
1991			7.3 (±0.9)	10.7 (±1.3)	3.9 (±0.9)
Legend:		'—'=No data available TX=Texas US=United States Sex T=Total F=Female M=Male			

Table 8:
On an Average Day In Texas 2004

- The Population Increased by 626 Persons. [The rate of natural increase (Births - Deaths)]
- There were 1,042 Resident Births
 - o 20 babies had no prenatal care
 - o 84 low birth weight babies were born (less than 2,500 grams or less than 5 lbs. 9 oz.)
 - o 53 babies were born to teenage mothers (less than 18 years of age)
 - o 333 babies were delivered by C-section
- There were 416 Resident Deaths
 - o 110 of these deaths were due to heart disease
 - o 92 of these deaths were due to cancer
 - o 23 of these deaths were due to accidents
 - o 7 of these were infant deaths
 - o 6 of these were deaths by suicide
 - o 4 of these were deaths by homicide

Table 9.
Suicide Death Numbers (No) and Rates (numbers per 100,000 population) for Texas Counties 1999-2004, ICD 10 death statistics for the State of Texas, provided by TDSHS (<http://soupfin.tdh.state.tx.us/cgi-bin/death10a>).

Suicide Statistics for the State of Texas for Suicide - 1999-2004

1999	2000		2001		2002		2003		2004		1999-2004			
County	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate
Anderson County	10	@. @	11	@. @	9	@. @	12	@. @	9	@. @	9	@. @	60	17.2
Andrews County	0	@. @	1	@. @	1	@. @	1	@. @	2	@. @	0	@. @	5	@. @
Angelina County	9	@. @	10	@. @	11	@. @	10	@. @	11	@. @	7	@. @	58	12.2
Aransas County	7	@. @	5	@. @	8	@. @	5	@. @	0	@. @	6	@. @	31	21.5
Archer County	0	@. @	1	@. @	0	@. @	0	@. @	0	@. @	2	@. @	3	@. @
Armstrong County	1	@. @	0	@. @	0	@. @	0	@. @	0	@. @	0	@. @	1	@. @
Atascosa County	7	@. @	10	@. @	4	@. @	5	@. @	5	@. @	4	@. @	35	15.5
Austin County	3	@. @	4	@. @	2	@. @	3	@. @	5	@. @	5	@. @	22	15.4
Bailey County	0	@. @	1	@. @	0	@. @	1	@. @	1	@. @	0	@. @	3	@. @
Bandera County	1	@. @	5	@. @	2	@. @	4	@. @	10	@. @	3	@. @	25	23.0
Bastrop County	11	@. @	4	@. @	10	@. @	13	@. @	12	@. @	5	@. @	55	14.7
Baylor County	2	@. @	1	@. @	0	@. @	0	@. @	0	@. @	0	@. @	3	@. @
Bee County	4	@. @	4	@. @	5	@. @	4	@. @	6	@. @	3	@. @	26	13.7
Bell County	24	12.3	33	14.0	24	11.0	25	11.5	27	11.7	23	9.3	156	11.6
Bexar County	139	10.8	146	10.8	147	10.7	137	9.6	146	10.2	132	9.2	847	10.2
Blanco County	1	@. @	2	@. @	0	@. @	3	@. @	1	@. @	0	@. @	7	@. @
Borden County	0	@. @	0	@. @	0	@. @	0	@. @	0	@. @	0	@. @	0	@. @
Bosque County	1	@. @	1	@. @	3	@. @	2	@. @	6	@. @	8	@. @	21	19.8
Bowie County	7	@. @	11	@. @	12	@. @	9	@. @	16	@. @	8	@. @	63	11.8
Brazoria County	24	11.5	34	15.0	38	16.1	29	11.9	32	12.7	33	12.5	190	13.2
Brazos County	8	@. @	7	@. @	10	@. @	10	@. @	8	@. @	10	@. @	53	7.7
Brewster County	2	@. @	2	@. @	3	@. @	2	@. @	0	@. @	1	@. @	10	@. @
Briscoe County	0	@. @	1	@. @	0	@. @	0	@. @	0	@. @	1	@. @	2	@. @
Brooks County	1	@. @	1	@. @	0	@. @	3	@. @	3	@. @	1	@. @	9	@. @
Brown County	2	@. @	5	@. @	4	@. @	5	@. @	1	@. @	9	@. @	26	11.6
Burleson County	1	@. @	5	@. @	2	@. @	0	@. @	3	@. @	2	@. @	13	@. @
Burnet County	4	@. @	5	@. @	3	@. @	6	@. @	7	@. @	7	@. @	32	14.3
Caldwell County	5	@. @	4	@. @	6	@. @	3	@. @	5	@. @	2	@. @	25	12.5
Calhoun County	3	@. @	4	@. @	0	@. @	2	@. @	3	@. @	3	@. @	15	@. @
Callahan County	0	@. @	3	@. @	0	@. @	1	@. @	1	@. @	2	@. @	7	@. @
Cameron County	11	@. @	22	7.8	20	6.4	25	7.7	17	@. @	19	@. @	114	6.2
Camp County	0	@. @	1	@. @	3	@. @	1	@. @	3	@. @	5	@. @	13	@. @
Carson County	0	@. @	1	@. @	1	@. @	2	@. @	1	@. @	0	@. @	5	@. @
Cass County	5	@. @	6	@. @	1	@. @	6	@. @	3	@. @	2	@. @	23	12.7
Castro County	1	@. @	0	@. @	0	@. @	2	@. @	0	@. @	1	@. @	4	@. @

Chambers County	2	@.@	4	@.@	2	@.@	1	@.@	4	@.@	5	@.@	18	@.@
Cherokee County	5	@.@	9	@.@	8	@.@	9	@.@	12	@.@	8	@.@	51	18.4
Childress County	2	@.@	2	@.@	1	@.@	2	@.@	1	@.@	0	@.@	8	@.@
Clay County	2	@.@	0	@.@	2	@.@	0	@.@	0	@.@	2	@.@	6	@.@
Cochran County	1	@.@	2	@.@	1	@.@	0	@.@	0	@.@	1	@.@	5	@.@
Coke County	0	@.@	0	@.@	1	@.@	0	@.@	0	@.@	0	@.@	1	@.@
Coleman County	1	@.@	2	@.@	1	@.@	0	@.@	0	@.@	3	@.@	7	@.@
Collin County	46	11.4	41	9.2	37	7.2	42	7.7	41	7.4	51	8.7	258	8.4
Collingsworth County	0	@.@	0	@.@	3	@.@	2	@.@	0	@.@	0	@.@	5	@.@
Colorado County	2	@.@	1	@.@	2	@.@	3	@.@	2	@.@	3	@.@	13	@.@
Comal County	8	@.@	5	@.@	7	@.@	10	@.@	9	@.@	8	@.@	47	9.2
Comanche County	3	@.@	1	@.@	1	@.@	0	@.@	2	@.@	2	@.@	9	@.@
Concho County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	2	@.@	2	@.@
Cooke County	9	@.@	2	@.@	1	@.@	3	@.@	6	@.@	11	@.@	32	14.5
Coryell County	6	@.@	10	@.@	6	@.@	12	@.@	6	@.@	7	@.@	47	10.9
Cottle County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
Crane County	0	@.@	0	@.@	1	@.@	1	@.@	0	@.@	1	@.@	3	@.@
Crockett County	1	@.@	0	@.@	0	@.@	1	@.@	2	@.@	0	@.@	4	@.@
Crosby County	1	@.@	3	@.@	0	@.@	0	@.@	0	@.@	0	@.@	4	@.@
Culberson County	0	@.@	0	@.@	0	@.@	1	@.@	0	@.@	1	@.@	2	@.@
Dallam County	1	@.@	0	@.@	0	@.@	1	@.@	0	@.@	4	@.@	6	@.@
Dallas County	205	10.7	178	8.4	224	10.8	230	10.7	217	10.3	203	9.5	1,257	10.0
Dawson County	0	@.@	1	@.@	0	@.@	3	@.@	1	@.@	0	@.@	5	@.@
Deaf Smith County	3	@.@	3	@.@	3	@.@	1	@.@	1	@.@	3	@.@	14	@.@
Delta County	0	@.@	1	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@
Denton County	37	10.3	32	8.4	28	6.5	46	10.3	42	9.1	48	9.5	233	9.0
DeWitt County	3	@.@	3	@.@	2	@.@	3	@.@	3	@.@	2	@.@	16	@.@
Dickens County	0	@.@	2	@.@	1	@.@	0	@.@	0	@.@	0	@.@	3	@.@
Dimmit County	0	@.@	2	@.@	0	@.@	0	@.@	1	@.@	1	@.@	4	@.@
Donley County	1	@.@	2	@.@	0	@.@	1	@.@	0	@.@	1	@.@	5	@.@
Duval County	0	@.@	1	@.@	0	@.@	0	@.@	2	@.@	3	@.@	6	@.@
Eastland County	2	@.@	1	@.@	2	@.@	2	@.@	4	@.@	1	@.@	12	@.@
Ector County	17	@.@	12	@.@	13	@.@	17	@.@	10	@.@	11	@.@	80	11.2
Edwards County	1	@.@	0	@.@	1	@.@	0	@.@	0	@.@	0	@.@	2	@.@
Ellis County	8	@.@	11	@.@	15	@.@	16	@.@	11	@.@	15	@.@	76	10.8
El Paso County	33	5.4	57	9.2	41	6.4	53	8.3	46	7.2	54	8.2	284	7.5
Erath County	3	@.@	1	@.@	7	@.@	2	@.@	4	@.@	0	@.@	17	@.@
Falls County	5	@.@	2	@.@	3	@.@	0	@.@	3	@.@	4	@.@	17	@.@
Fannin County	6	@.@	2	@.@	9	@.@	3	@.@	5	@.@	8	@.@	33	16.3
Fayette County	3	@.@	3	@.@	2	@.@	1	@.@	3	@.@	3	@.@	15	@.@
Fisher County	0	@.@	1	@.@	1	@.@	0	@.@	1	@.@	1	@.@	4	@.@
Floyd County	1	@.@	3	@.@	0	@.@	0	@.@	0	@.@	0	@.@	4	@.@
Foard County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
Fort Bend County	22	7.2	21	6.0	35	9.7	35	9.5	37	10.3	33	8.7	183	8.5
Franklin County	2	@.@	0	@.@	2	@.@	0	@.@	0	@.@	2	@.@	6	@.@
Freestone County	7	@.@	6	@.@	3	@.@	7	@.@	1	@.@	1	@.@	25	20.4
Frio County	0	@.@	1	@.@	0	@.@	0	@.@	1	@.@	2	@.@	4	@.@
Gaines County	0	@.@	1	@.@	1	@.@	2	@.@	1	@.@	2	@.@	7	@.@
Galveston County	22	9.1	37	14.9	41	16.5	41	15.9	28	10.8	28	9.7	197	12.8
Garza County	1	@.@	1	@.@	2	@.@	0	@.@	1	@.@	0	@.@	5	@.@
Gillespie County	1	@.@	3	@.@	4	@.@	4	@.@	5	@.@	1	@.@	18	@.@
Glasscock County	1	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@
Goliad County	0	@.@	0	@.@	0	@.@	2	@.@	1	@.@	0	@.@	3	@.@
Gonzales County	1	@.@	5	@.@	2	@.@	2	@.@	0	@.@	5	@.@	15	@.@
Gray County	0	@.@	5	@.@	7	@.@	4	@.@	3	@.@	6	@.@	25	18.5
Grayson County	19	@.@	17	@.@	26	22.4	8	@.@	13	@.@	15	@.@	98	14.5
Gregg County	17	@.@	12	@.@	21	19.2	20	17.5	21	18.1	22	19.2	113	16.8

Grimes County	1	@.@	6	@.@	5	@.@	3	@.@	7	@.@	2	@.@	24	16.7
Guadalupe County	7	@.@	9	@.@	11	@.@	10	@.@	9	@.@	11	@.@	57	10.5
Hale County	0	@.@	2	@.@	3	@.@	1	@.@	1	@.@	3	@.@	10	@.@
Hall County	0	@.@	0	@.@	0	@.@	1	@.@	1	@.@	0	@.@	2	@.@
Hamilton County	2	@.@	1	@.@	1	@.@	2	@.@	2	@.@	3	@.@	11	@.@
Hansford County	0	@.@	1	@.@	0	@.@	0	@.@	1	@.@	0	@.@	2	@.@
Hardeman County	0	@.@	1	@.@	0	@.@	0	@.@	2	@.@	0	@.@	3	@.@
Hardin County	5	@.@	11	@.@	6	@.@	7	@.@	4	@.@	10	@.@	43	14.7
Harris County	307	10.1	322	10.0	334	10.3	387	11.6	348	10.4	364	10.7	2,062	10.5
Harrison County	7	@.@	5	@.@	10	@.@	8	@.@	7	@.@	9	@.@	46	12.0
Hartley County	1	@.@	0	@.@	0	@.@	2	@.@	0	@.@	1	@.@	4	@.@
Haskell County	0	@.@	2	@.@	2	@.@	0	@.@	2	@.@	1	@.@	7	@.@
Hays County	1	@.@	10	@.@	15	@.@	10	@.@	11	@.@	10	@.@	57	10.3
Hemphill County	0	@.@	1	@.@	0	@.@	1	@.@	0	@.@	0	@.@	2	@.@
Henderson County	7	@.@	15	@.@	13	@.@	12	@.@	17	@.@	11	@.@	75	16.9
Hidalgo County	18	@.@	24	4.8	22	4.1	25	4.6	34	6.1	27	4.9	150	4.8
Hill County	6	@.@	3	@.@	3	@.@	7	@.@	8	@.@	8	@.@	35	19.3
Hockley County	6	@.@	1	@.@	1	@.@	0	@.@	2	@.@	2	@.@	12	@.@
Hood County	5	@.@	7	@.@	3	@.@	8	@.@	7	@.@	4	@.@	34	13.7
Hopkins County	5	@.@	5	@.@	1	@.@	5	@.@	5	@.@	3	@.@	24	12.5
Houston County	3	@.@	5	@.@	3	@.@	5	@.@	4	@.@	1	@.@	21	15.0
Howard County	7	@.@	5	@.@	6	@.@	5	@.@	6	@.@	8	@.@	37	18.0
Hudspeth County	0	@.@	0	@.@	0	@.@	1	@.@	0	@.@	1	@.@	2	@.@
Hunt County	14	@.@	10	@.@	14	@.@	11	@.@	10	@.@	10	@.@	69	15.0
Hutchinson County	3	@.@	3	@.@	3	@.@	1	@.@	4	@.@	1	@.@	15	@.@
Irion County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@	1	@.@
Jack County	1	@.@	0	@.@	2	@.@	0	@.@	0	@.@	1	@.@	4	@.@
Jackson County	1	@.@	1	@.@	1	@.@	2	@.@	1	@.@	1	@.@	7	@.@
Jasper County	4	@.@	4	@.@	7	@.@	6	@.@	5	@.@	5	@.@	31	14.8
Jeff Davis County	1	@.@	0	@.@	0	@.@	0	@.@	1	@.@	0	@.@	2	@.@
Jefferson County	29	11.3	30	11.9	31	12.2	17	@.@	32	12.9	25	10.2	164	10.9
Jim Hogg County	1	@.@	0	@.@	1	@.@	0	@.@	0	@.@	0	@.@	2	@.@
Jim Wells County	1	@.@	3	@.@	4	@.@	1	@.@	3	@.@	6	@.@	18	@.@
Johnson County	14	@.@	11	@.@	16	@.@	16	@.@	16	@.@	19	@.@	92	12.0
Jones County	5	@.@	3	@.@	3	@.@	4	@.@	5	@.@	1	@.@	21	16.5
Karnes County	3	@.@	2	@.@	3	@.@	0	@.@	2	@.@	1	@.@	11	@.@
Kaufman County	7	@.@	9	@.@	12	@.@	16	@.@	15	@.@	9	@.@	68	15.4
Kendall County	6	@.@	1	@.@	4	@.@	6	@.@	3	@.@	2	@.@	22	14.8
Kenedy County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
Kent County	0	@.@	0	@.@	1	@.@	0	@.@	0	@.@	0	@.@	1	@.@
Kerr County	6	@.@	7	@.@	10	@.@	7	@.@	6	@.@	13	@.@	49	15.2
Kimble County	2	@.@	1	@.@	0	@.@	1	@.@	1	@.@	0	@.@	5	@.@
King County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	2	@.@	2	@.@
Kinney County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
Kleberg County	3	@.@	1	@.@	2	@.@	2	@.@	4	@.@	1	@.@	13	@.@
Knox County	1	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@
Lamar County	7	@.@	12	@.@	3	@.@	9	@.@	13	@.@	5	@.@	49	17.3
Lamb County	1	@.@	1	@.@	0	@.@	2	@.@	3	@.@	2	@.@	9	@.@
Lampasas County	2	@.@	1	@.@	7	@.@	3	@.@	0	@.@	2	@.@	15	@.@
La Salle County	1	@.@	1	@.@	0	@.@	0	@.@	0	@.@	0	@.@	2	@.@
Lavaca County	1	@.@	3	@.@	4	@.@	1	@.@	1	@.@	0	@.@	10	@.@
Lee County	1	@.@	0	@.@	0	@.@	2	@.@	4	@.@	1	@.@	8	@.@
Leon County	5	@.@	5	@.@	5	@.@	4	@.@	1	@.@	3	@.@	23	26.0
Liberty County	18	@.@	5	@.@	10	@.@	8	@.@	15	@.@	14	@.@	70	16.5
Limestone County	1	@.@	3	@.@	2	@.@	3	@.@	1	@.@	7	@.@	17	@.@
Lipscomb County	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@	2	@.@	3	@.@
Live Oak County	2	@.@	0	@.@	0	@.@	2	@.@	0	@.@	1	@.@	5	@.@

Llano County	2	@.@	2	@.@	4	@.@	7	@.@	0	@.@	4	@.@	19	@.@
Loving County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
Lubbock County	21	9.0	29	12.0	36	15.3	30	12.1	27	10.8	22	8.4	165	11.3
Lynn County	1	@.@	1	@.@	0	@.@	2	@.@	1	@.@	0	@.@	5	@.@
McCulloch County	1	@.@	1	@.@	1	@.@	2	@.@	1	@.@	1	@.@	7	@.@
McLennan County	26	13.2	14	@.@	22	11.0	20	9.1	18	@.@	29	13.3	129	10.3
McMullen County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
Madison County	1	@.@	0	@.@	2	@.@	4	@.@	1	@.@	4	@.@	12	@.@
Marion County	1	@.@	1	@.@	2	@.@	0	@.@	4	@.@	0	@.@	8	@.@
Martin County	0	@.@	0	@.@	1	@.@	0	@.@	0	@.@	1	@.@	2	@.@
Mason County	2	@.@	0	@.@	1	@.@	0	@.@	0	@.@	0	@.@	3	@.@
Matagorda County	4	@.@	4	@.@	5	@.@	5	@.@	6	@.@	1	@.@	25	11.5
Maverick County	4	@.@	4	@.@	0	@.@	1	@.@	3	@.@	0	@.@	12	@.@
Medina County	4	@.@	3	@.@	6	@.@	1	@.@	4	@.@	2	@.@	20	8.6
Menard County	1	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@
Midland County	20	19.0	14	@.@	14	@.@	10	@.@	19	@.@	10	@.@	87	12.6
Milam County	2	@.@	2	@.@	1	@.@	5	@.@	5	@.@	3	@.@	18	@.@
Mills County	1	@.@	0	@.@	1	@.@	1	@.@	1	@.@	0	@.@	4	@.@
Mitchell County	0	@.@	2	@.@	0	@.@	3	@.@	3	@.@	0	@.@	8	@.@
Montague County	4	@.@	2	@.@	3	@.@	5	@.@	7	@.@	3	@.@	24	19.0
Montgomery County	34	12.6	41	15.1	41	14.0	50	16.0	59	16.9	39	11.4	264	14.3
Moore County	5	@.@	1	@.@	2	@.@	0	@.@	0	@.@	0	@.@	8	@.@
Morris County	1	@.@	2	@.@	6	@.@	3	@.@	2	@.@	0	@.@	14	@.@
Motley County	1	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@
Nacogdoches County	8	@.@	7	@.@	3	@.@	1	@.@	7	@.@	8	@.@	34	10.5
Navarro County	6	@.@	5	@.@	6	@.@	11	@.@	6	@.@	7	@.@	41	15.2
Newton County	2	@.@	2	@.@	1	@.@	1	@.@	2	@.@	1	@.@	9	@.@
Nolan County	3	@.@	0	@.@	1	@.@	0	@.@	1	@.@	3	@.@	8	@.@
Nueces County	30	10.0	34	11.1	28	9.1	41	13.2	29	9.2	27	8.7	189	10.3
Ochiltree County	0	@.@	2	@.@	3	@.@	2	@.@	1	@.@	1	@.@	9	@.@
Oldham County	1	@.@	0	@.@	0	@.@	0	@.@	2	@.@	0	@.@	3	@.@
Orange County	15	@.@	9	@.@	5	@.@	12	@.@	15	@.@	11	@.@	67	13.3
Palo Pinto County	5	@.@	4	@.@	10	@.@	4	@.@	2	@.@	5	@.@	30	17.6
Panola County	3	@.@	1	@.@	4	@.@	0	@.@	3	@.@	4	@.@	15	@.@
Parker County	17	@.@	9	@.@	10	@.@	11	@.@	14	@.@	17	@.@	78	14.1
Parmer County	1	@.@	2	@.@	1	@.@	0	@.@	2	@.@	1	@.@	7	@.@
Pecos County	4	@.@	1	@.@	0	@.@	1	@.@	1	@.@	2	@.@	9	@.@
Polk County	8	@.@	11	@.@	7	@.@	10	@.@	4	@.@	11	@.@	51	18.9
Potter County	14	@.@	11	@.@	19	@.@	27	24.9	17	@.@	15	@.@	103	15.9
Presidio County	1	@.@	1	@.@	0	@.@	0	@.@	1	@.@	1	@.@	4	@.@
Rains County	0	@.@	1	@.@	3	@.@	2	@.@	3	@.@	1	@.@	10	@.@
Randall County	15	@.@	11	@.@	19	@.@	13	@.@	18	@.@	13	@.@	89	14.0
Reagan County	1	@.@	1	@.@	0	@.@	0	@.@	2	@.@	0	@.@	4	@.@
Real County	1	@.@	1	@.@	0	@.@	0	@.@	0	@.@	1	@.@	3	@.@
Red River County	2	@.@	5	@.@	2	@.@	3	@.@	1	@.@	1	@.@	14	@.@
Reeves County	2	@.@	1	@.@	1	@.@	1	@.@	1	@.@	4	@.@	10	@.@
Refugio County	1	@.@	0	@.@	1	@.@	1	@.@	0	@.@	0	@.@	3	@.@
Roberts County	0	@.@	0	@.@	0	@.@	1	@.@	1	@.@	0	@.@	2	@.@
Robertson County	0	@.@	3	@.@	3	@.@	3	@.@	1	@.@	3	@.@	13	@.@
Rockwall County	7	@.@	9	@.@	6	@.@	2	@.@	8	@.@	7	@.@	39	13.8
Runnels County	2	@.@	2	@.@	0	@.@	0	@.@	2	@.@	2	@.@	8	@.@
Rusk County	6	@.@	8	@.@	4	@.@	7	@.@	7	@.@	13	@.@	45	15.6
Sabine County	2	@.@	2	@.@	0	@.@	1	@.@	3	@.@	4	@.@	12	@.@
San Augustine County	1	@.@	1	@.@	0	@.@	3	@.@	2	@.@	2	@.@	9	@.@
San Jacinto County	1	@.@	8	@.@	1	@.@	7	@.@	4	@.@	3	@.@	24	18.4
San Patricio County	7	@.@	6	@.@	3	@.@	11	@.@	5	@.@	12	@.@	44	11.4
San Saba County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@	1	@.@

Schleicher County	1	@.@	1	@.@	0	@.@	1	@.@	1	@.@	0	@.@	4	@.@
Scurry County	3	@.@	1	@.@	3	@.@	1	@.@	1	@.@	2	@.@	11	@.@
Shackelford County	0	@.@	0	@.@	2	@.@	0	@.@	0	@.@	0	@.@	2	@.@
Shelby County	2	@.@	1	@.@	1	@.@	0	@.@	7	@.@	4	@.@	15	@.@
Sherman County	0	@.@	1	@.@	0	@.@	2	@.@	0	@.@	0	@.@	3	@.@
Smith County	21	12.4	10	@.@	22	12.7	21	11.4	40	23.0	29	15.3	143	13.5
Somervell County	1	@.@	1	@.@	1	@.@	1	@.@	3	@.@	0	@.@	7	@.@
Starr County	2	@.@	4	@.@	3	@.@	3	@.@	3	@.@	0	@.@	15	@.@
Stephens County	1	@.@	1	@.@	1	@.@	1	@.@	3	@.@	3	@.@	10	@.@
Sterling County	1	@.@	0	@.@	0	@.@	0	@.@	0	@.@	1	@.@	2	@.@
Stonewall County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@
Sutton County	1	@.@	1	@.@	1	@.@	1	@.@	2	@.@	1	@.@	7	@.@
Swisher County	1	@.@	0	@.@	2	@.@	2	@.@	2	@.@	1	@.@	8	@.@
Tarrant County	118	9.0	135	9.6	143	9.9	121	8.3	166	10.7	152	10.0	835	9.6
Taylor County	13	@.@	17	@.@	11	@.@	11	@.@	15	@.@	13	@.@	80	11.0
Terrell County	0	@.@	0	@.@	0	@.@	1	@.@	0	@.@	0	@.@	1	@.@
Terry County	1	@.@	0	@.@	0	@.@	2	@.@	1	@.@	1	@.@	5	@.@
Throckmorton County	0	@.@	0	@.@	1	@.@	0	@.@	1	@.@	0	@.@	2	@.@
Titus County	4	@.@	3	@.@	2	@.@	4	@.@	7	@.@	2	@.@	22	13.6
Tom Green County	9	@.@	16	@.@	14	@.@	16	@.@	19	@.@	13	@.@	87	14.0
Travis County	71	9.8	89	11.1	102	12.8	110	13.6	92	12.2	91	11.4	555	11.9
Trinity County	6	@.@	2	@.@	3	@.@	2	@.@	2	@.@	3	@.@	18	@.@
Tyler County	2	@.@	1	@.@	3	@.@	4	@.@	5	@.@	4	@.@	19	@.@
Upshur County	4	@.@	6	@.@	6	@.@	6	@.@	5	@.@	11	@.@	38	17.7
Upton County	0	@.@	0	@.@	0	@.@	0	@.@	0	@.@	2	@.@	2	@.@
Uvalde County	1	@.@	3	@.@	1	@.@	3	@.@	2	@.@	3	@.@	13	@.@
Val Verde County	1	@.@	4	@.@	6	@.@	2	@.@	5	@.@	2	@.@	20	8.3
Van Zandt County	7	@.@	9	@.@	10	@.@	13	@.@	8	@.@	9	@.@	56	20.0
Victoria County	7	@.@	7	@.@	12	@.@	11	@.@	9	@.@	12	@.@	58	11.7
Walker County	3	@.@	5	@.@	11	@.@	12	@.@	9	@.@	14	@.@	54	15.1
Waller County	3	@.@	3	@.@	3	@.@	8	@.@	2	@.@	3	@.@	22	11.7
Ward County	2	@.@	2	@.@	1	@.@	0	@.@	0	@.@	4	@.@	9	@.@
Washington County	2	@.@	2	@.@	3	@.@	1	@.@	2	@.@	6	@.@	16	@.@
Webb County	8	@.@	8	@.@	12	@.@	5	@.@	20	9.2	18	@.@	71	6.1
Wharton County	3	@.@	5	@.@	3	@.@	3	@.@	7	@.@	8	@.@	29	11.8
Wheeler County	2	@.@	0	@.@	2	@.@	1	@.@	1	@.@	1	@.@	7	@.@
Wichita County	19	@.@	13	@.@	14	@.@	20	15.5	16	@.@	17	@.@	99	12.9
Wilbarger County	0	@.@	1	@.@	0	@.@	4	@.@	2	@.@	1	@.@	8	@.@
Willacy County	0	@.@	1	@.@	0	@.@	1	@.@	0	@.@	1	@.@	3	@.@
Williamson County	21	9.9	24	9.1	20	7.3	23	8.9	23	7.9	22	7.5	133	8.3
Wilson County	3	@.@	4	@.@	2	@.@	3	@.@	3	@.@	6	@.@	21	10.2
Winkler County	1	@.@	1	@.@	5	@.@	1	@.@	2	@.@	2	@.@	12	@.@
Wise County	9	@.@	7	@.@	8	@.@	7	@.@	3	@.@	6	@.@	40	13.3
Wood County	6	@.@	3	@.@	7	@.@	4	@.@	11	@.@	6	@.@	37	15.1
Yoakum County	1	@.@	0	@.@	0	@.@	1	@.@	2	@.@	1	@.@	5	@.@
Young County	2	@.@	7	@.@	1	@.@	0	@.@	3	@.@	3	@.@	16	@.@
Zapata County	1	@.@	0	@.@	0	@.@	0	@.@	1	@.@	1	@.@	3	@.@
Zavala County	2	@.@	0	@.@	0	@.@	0	@.@	3	@.@	0	@.@	5	@.@
Total for Selection	2,002	10.5	2,093	10.4	2,214	10.8	2,304	11.0	2,355	11.0	2,290	10.6	13,258	10.7
Footnote	<p align="center">Rates Per 100,000 .@ indicates numerator too small for rate calculation Age Adjustment Uses 2000 Standard Population</p>													

Note: Due to disparities in population sizes, these numbers must be converted to county-specific rates in order to discern the actual incidence of suicide deaths for these areas. Travis County has higher rates than the other major Texas metropolitan areas. Rates for counties with populations < 100,000 are listed as @.

Chapter 2

Understanding Suicide: The Basics

“Because of my long history with mental health issues, I thought I understood suicide. But it was not until I lost extended family members to suicide, and then was trained in suicide prevention, that I gained vital information to help save lives. Everyone should have easy access to suicide prevention information.”

Mary Ellen Nudd, Vice President, Mental Health America of Texas

Knowing the Facts about Suicide

Suicide is a subject surrounded by myths and misunderstanding. Perhaps because suicide is rarely talked about freely and openly, there are a lot of misconceptions about issues such as who is at risk, why, under what circumstances, and about how to get help. But knowing the facts is critical to taking action – and essential to saving lives. The following information describes the facts about suicide prevention based on current research as they pertain to adults and young people.

Suicide Facts for Adults

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 something subtle.
Do people always leave a note behind when they complete a suicide?	Actually, 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.
Are people who are suicidal intent on dying and feel there is no turning back?	Most people who are suicidal are actually of two minds about it. Part of them wants to die, but part of them doesn’t. The main thing they want is to stop their pain.
Are people who attempt suicide once likely to try it again?	Eighty percent of people who die from suicide have made at least one other 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 device.
If you mention suicide to someone who seems depressed, are you just planting the idea in his or her mind?	Discussing it openly can actually help, not hurt.

Suicide Facts for Youth

QUESTION	FACT
Do young people who talk about suicide ever attempt or complete suicide?	Many young people who attempt suicide talk about it first. It's an important warning sign.
If you know a young person who is talking about suicidal thoughts or feelings, should you just say "cheer up"?	Telling someone to "cheer up" can make it seem like you don't understand. It's better to listen and don't discount their feelings.
Is it better not to talk about suicide with someone who's feeling down or hopeless? Does it make things worse?	The first step in encouraging a suicidal person to live comes from talking about feelings. Fears that are shared are more likely to diminish.
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.
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/about_us/contact.html

Mental Health Library, Royal Park Hospital, Parkville, Victoria, Canada

Risk Factors and Protective Factors for Suicide

(From the *National Strategy for Suicide Prevention: Goals and Objectives for Action*, 2001, US Department of Health and Human Services)

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. Protective factors, on the other hand, reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. Risk and protective factors may be biopsychosocial, environmental, or sociocultural in nature. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives.

Understanding the interactive 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). Some of the most important risk and protective factors are outlined below.

Protective Factors for Suicide

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

- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self preservation

However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

Risk Factors for Suicide

Biopsychosocial Risk Factors

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

Environmental Risk Factors

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

Sociocultural Risk Factors

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

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).

References

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Source:

National Strategy for Suicide Prevention: Goals and Objectives for Action. <http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp>

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.

Ten Warning Signs of Suicide

1. Preoccupation with death and dying
2. Drastic changes in behavior or personality
3. A recent severe loss (such as a relationship) or threat of a loss
4. Unexpected preparations for death such as making out a will
5. Giving away prized possessions
6. A previous suicide attempt
7. Uncharacteristic impulsiveness, recklessness, or risk-taking
8. Loss of interest in personal appearance
9. Increased use of alcohol or drugs
10. Sense of hopelessness about the future

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 that it will happen. Find out if he or she has thought about how and when to do it and if the means are available. If there's a plan for what to do and when and how to do it, the risk of suicide is very high. Consider the San Francisco Suicide Prevention crisis line's "PlaidPals" list of things to watch for:

Plan – Do they have one?

Lethality – Is it lethal? Can they die?

Availability – Do they have the means to carry it out?

Illness – Do they have a mental or physical illness?

Depression – Chronic or specific incident(s)?

Previous attempts – How many? How recent?

Alone – Are they alone? Do they have a support system?
Are they alone right now?

Loss – Have they suffered a loss? Death, job, relationship, self-esteem?

Substance abuse (or use) – Drugs, alcohol, medicine?
Current? Chronic?

Get an agreement. If it seems likely that the person could act on thoughts of suicide, do not leave the person alone and try to get their verbal agreement to get help from a mental health professional. You can also call 911 for a mental health deputy or officer to transport a person if danger is imminent and/or take the person to the nearest hospital emergency room. Many local MHMRAs also have crisis mental health mobile outreach teams that may be available to provide help wherever you are.

Call for help. Get in touch with your local crisis line for resources and immediate help. Nationally, **Call 1-800-273-TALK (8255)** to be connected to the nearest crisis center or go to the Texas Department of State Health Services Web page at <http://www.dshs.state.tx.us/mhservices/default.shtm> to search by county to find the crisis center in your area or to the Texas Council of Community Mental Health Centers web site at <http://www.txcouncil.com/crisis.html> to find the crisis number for your area.

Source:

San Francisco Suicide Prevention crisis line. <http://www.sfsuicide.org>

"Understanding and Helping the Suicidal Individual," American Association of Suicidology. <http://www.suicidology.org>

Chapter 3

An Introduction to Taking Action

“Mental Health America of Texas has learned the importance of a community approach to bringing together diverse groups to address mental health issues. With the social, physical and mental aspects of suicide, this is even more important for prevention.”

*Lynn Lasky Clark, President,
Mental Health America of Texas*

The Importance of a Community-Based Approach

Part 2 of this toolkit provides practical tools and tips for organizing your community to take action to prevent suicide. A community-based approach is important. Because community-wide efforts bring together diverse groups, such an approach may have the best chance of addressing the multi-factorial nature of the problem of suicide. In addition, because all communities are different, a community approach enables each specific community to assess its own unique assets and challenges to find ways to increase protective factors and decrease risk factors for those at risk. And finally, community-driven efforts provide a visible, organized means by which those who care about preventing suicide can become involved in doing just that.

Working together, community groups can help to ensure that people in communities understand the issues associated with suicide, are able to recognize the warning signs, and know how to respond to those signs responsibly and effectively. By working to organize your community to prevent suicide, you are taking steps that will ultimately save lives.

“Gatekeeper” programs such as the QPR Institute’s suicide prevention training program, and the Applied Suicide Intervention Skills Training (ASIST) program are used in communities around the world. The programs are built on the idea that people in positions of trust - educators, faith community, volunteers - can learn to intervene to prevent suicide. You will learn more about programs like these as well as those offered by the Jason Foundation and Yellow Ribbon in part 2 of the toolkit.

The Suicide Prevention Resource Center has a number of tools to help develop a community approach to suicide prevention and to build suicide prevention coalitions. In addition, part 2 of this toolkit includes a useful community assessment tool and more information on coalition-building.

Sources:

Suicide Prevention Resource Center, library resources.
<http://library.sprc.org/browse.html?path=%2Fpartnerships+and+coalitions>
QPR Institute Inc. <http://www.qprinstitute.com>
Living Works Education, Inc.
<http://www.livingworks.net/ASISTAwrnssFcts.htm>

Targeting Populations within the Community

Within the larger community many populations exist that may be at special risk for suicide, such as women in certain age groups, men, the elderly, people from different ethnic groups, youth and people who are gay/bisexual/lesbian/transgendered. Understanding their needs and reaching out to them is critical in community efforts to prevent suicide. Targeting at-risk populations with suicide prevention efforts is addressed in Part 2 of this toolkit.

Sources:

Centers for Disease Control press releases,
<http://www.cdc.gov/od/oc/media/pressrel/r040610.htm>
Fact sheets on African American suicide, elderly suicide and youth suicide, American Association of Suicidology.
<http://www.suicidology.org>
“Older Adults: Depression and Suicide Facts,” National Institute of Mental Health, 2003.
<http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm>
The Texas Department of Health, Bureau of Vital Statistics, 2002. Death Tables [Data file].
<http://www.tdh.state.tx.us/chs/vstat/latest/t18.htm>
The Texas Department of Health, Texas Health Data Death of Texas Residents. <http://soupsfin.tdh.state.tx.us/death10.htm>
Townsend, Jeremy, “Articles Relating to Suicide by GLB Youth: 5 population-based studies, and 4 studies on uniquely GLB youth samples,” <http://www.jeremyt.org/gay/gaysuic.htm>

Working with the Media in the Community

The media can be of tremendous assistance in community initiatives to prevent suicide. They can help educate people about the preventability of suicide, how to recognize the warning signs, how to get involved in their community’s efforts, and many other aspects of this issue, effectively contributing to decreases in suicide rates in communities with good media coverage of the issue. But media coverage can have a double edge. Depending on how stories about suicide are reported, media coverage may play a role in phenomenon such as “suicide contagion” or “copycat” suicide. Part 2 of this toolkit contains information about how to work with the media to avoid negative effects, how to achieve the best possible results from press coverage, and a copy of the complete national media guidelines.

Sources:

Media Guidelines for 2004, American Association of Suicidology.
<http://www.suicidology.org>
“Reporting on Suicide: Recommendations for the Media,” The American Foundation for Suicide Prevention.
<http://www.afsp.org/education/newrecommendations.htm>

**Part 2: What You Need to Do
To Help Prevent Suicide in Texas**

Chapter 4

Taking Steps to Organize Your Community

Community Assessment: Starting with the Statistics

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 completed 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.

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 1999-2002.

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*

DEATH OF TEXAS RESIDENTS

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.

Select One or More Years

☐ 1999 ☐ 2000 ☐ 2001 ☐ 2002 ☐ 2003 ☒ 2004

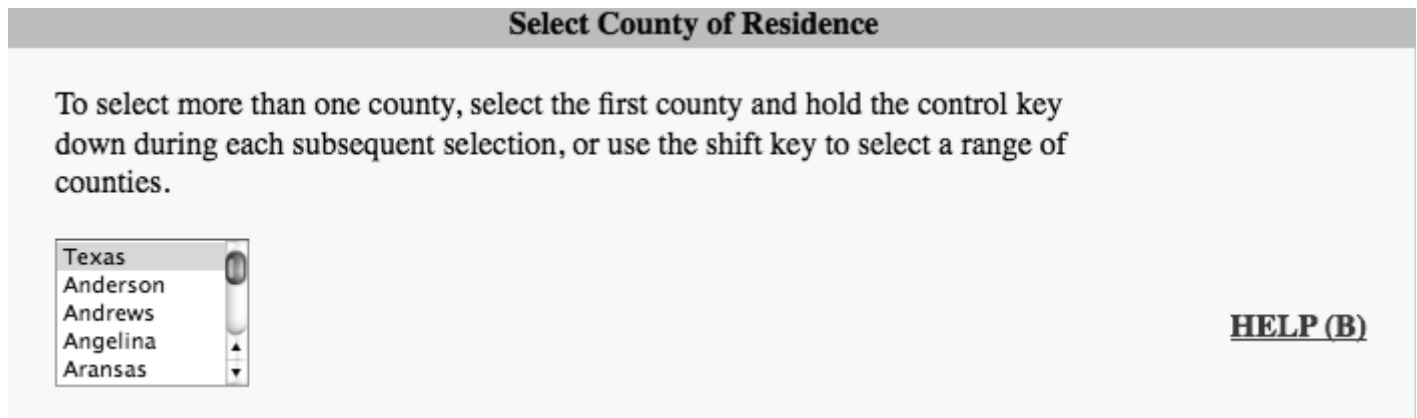
Step2: Causes of Death. Select from the dropdown box the cause of death. For suicide, select **Intentional Self-Harm (Suicide)** (x60-x84, y87-0).



All Causes
Salmonella Infections (A01-A02)
Shigellosis and Amebiasis (A03, A06)
Tuberculosis (A16-A19)
Whooping Cough (A37)
Scarlet Fever and Erysipelas (A38, A46)
Meningococcal Infection (A39)

[HELP \(A\)](#)

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.



Select County of Residence

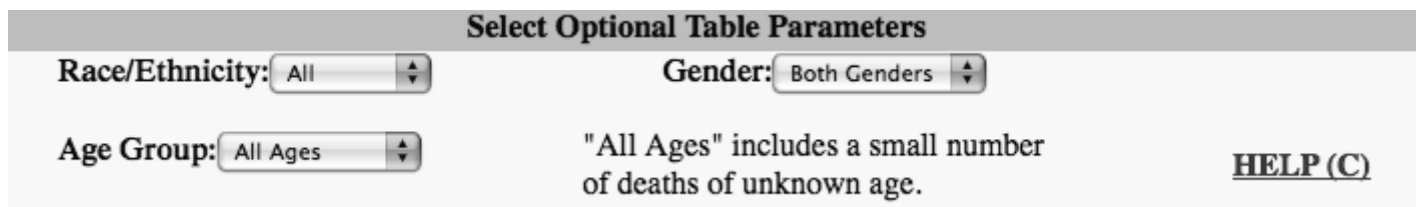
To select more than one county, select the first county and hold the control key down during each subsequent selection, or use the shift key to select a range of counties.

Texas
Anderson
Andrews
Angelina
Aransas

[HELP \(B\)](#)

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're interested in looking at suicide rates only in women or only in people aged 55 to 64.

If you want to limit your data like this, 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.



Select Optional Table Parameters

Race/Ethnicity: All Gender: Both Genders

Age Group: All Ages

"All Ages" includes a small number of deaths of unknown age.

[HELP \(C\)](#)

For an example using these Optional Table Parameters, please see Figure 1. Figure 1 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**. Figures 2 and 3 provide you with examples of the different ways that you can display your data. Figure 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**. Figure 3 rotates those two variables and places **Gender** as the variable for the Row and **Race/Ethnicity** as the variable for the Column.

Select Row and Column for Output Table	
Row: <input type="radio"/> Year <input type="radio"/> Race/Ethnicity <input type="radio"/> Gender <input type="radio"/> Age Group <input type="radio"/> Counties <input checked="" type="radio"/> Causes	Column: <input checked="" type="radio"/> Year <input type="radio"/> Race/Ethnicity <input type="radio"/> Gender <input type="radio"/> Age Group

HELP (D)

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.

Select Statistics for Output Table
<input checked="" type="radio"/> Frequencies only <input type="radio"/> Frequencies and Percents By Column <input type="radio"/> Frequencies and Percents By Row <input type="radio"/> Frequencies and Rates <input type="radio"/> Crude Rates <input checked="" type="radio"/> Age Adjusted Rates
Age Adjustment Standard: <input type="text" value="2000 Population"/>
Confidence Intervals: <input type="text" value="No Confidence Interval"/>
Sort Results: <input checked="" type="radio"/> No Sort <input type="radio"/> Sort

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

Glossary of Statistical Terms

(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>)

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 Health Data 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.

Figures 1-5

Figure 1: (Output Table for Step 4 -

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
2002	414	28	53	9	504
Rotate			Download		

Select Optional Table Parameters)

Figure 2: (Output Table for Step 5 -

ICD-10 Death Statistics for the State of Texas			
Intentional Self-Harm (Suicide) (X60-X84, Y87.0)			
Year: 2002			
Sex			
	Male	Female	Both Sexes
Race	Number	Number	Number
White	1,357	414	1,771
Black	106	28	134
Hispanic	314	53	367
Other	23	9	32
All Races	1,800	504	2,304
Rotate		Download	

Sources:

Select Row and Column)

“Suicide in Tarrant County,” Mental Health Association in Tarrant County. <http://www.mhatc.org>

Texas Health Care Information Council. <http://www.thcic.state.tx.us>

Texas Department of State Health Services, Center for Health Statistics. <http://www.dshs.state.tx.us/chs/default.shtm>

Texas Health Data Death of Texas Residents. <http://soupfin.tdh.state.tx.us/death10.htm>

Figure 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: 2002					
Race					
	White	Black	Hispanic	Other	All Races
Sex	Number	Number	Number	Number	Number
Male	1,357	106	314	23	1,800
Female	414	28	53	9	504
Both Sexes	1,771	134	367	32	2,304
Download					

Figure 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: 2002			
Sex			
	Male	Female	Both Sexes
Race	Number	Number	Number
White	1,357	414	1,771
Black	106	28	134
Hispanic	314	53	367
Other	23	9	32
All Races	1,800	504	2,304
Rotate		Download	

Figure 5: (Final Output Table for Step 6 -
Frequencies and Rates)

ICD-10 Death Statistics for the State of Texas						
<u>Intentional Self-Harm (Suicide) (X60-X84, Y87.0)</u>						
Year: 2002						
	Sex					
	Male		Female		Both Sexes	
Race	Number	Rate	Number	Rate	Number	Rate
White	1,357	24.1	414	7.0	1,771	15.2
Black	106	9.6	28	2.2	134	5.6
Hispanic	314	9.5	53	1.6	367	5.5
Other	23	6.0	9	@.@	32	3.9
All Races	1,800	17.9	504	4.7	2,304	11.0
<u>Rotate</u>			<u>Download</u>			
	Rates Per 100,000					
Footnote	@.@ indicates numerator too small for rate calculation Age Adjustment Uses 2000 Standard Population					

For information on how to interpret data generated from the tables shown in this section tables, refer to the guide, “What is Wrong with this Data?” from The University of Texas Health Science Center. http://www.sph.uth.tmc.edu/library/charting_caveats.htm

For information on other sources you can use to collect data on suicide, consult the Suicide Prevention Resource Center. <http://www.sprc.org/library/datasources.pdf>

Coalition-Building: Power in Numbers

“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*

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 these efforts.

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:

1. **Analyze objectives.** This is a necessary step to deciding whether to even form a coalition, depending on the program objectives and the resources available.
2. **Recruit members.** It’s important to recruit the right people with the appropriate interests and skill sets relative to your goals.
3. **Determine objectives and activities.** This involves bringing together the objectives of all the member groups of the coalition.
4. **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.

5. **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.
6. **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.
7. **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.
8. **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.

Sources:

“Collaboration Math: Enhancing the Effectiveness of Multidisciplinary Collaboration,” The Prevention Institute. http://www.preventioninstitute.org/pdf/collabmath_1S.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://www.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://www.stanford.edu/~davidf/GTO_Volume_1.pdf

“The Tension of Turf: Making It Work for the Coalition,” The Prevention Institute. http://www.preventioninstitute.org/pdf/TURF_1S.pdf

Example of a Successful Community-Based Effort: The US Air Force Suicide Prevention Program

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.

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 nine factors that were frequently associated with victims of suicide and three factors it concluded were protective. Stigma, cultural norms, and beliefs that combined to discourage help-seeking behavior were identified as major hurdles to successful suicide prevention.

The Intervention

“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. 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 to the force, 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.

Educating 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 were infused with appropriately targeted curricula on suicide prevention to augment their annual training. Students are tested on the curricula.

Improving Surveillance

“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.

“Additionally, commanders were given a unit-based survey tool to assess aggregate risk among their subordinates. Anonymously administered, the Behavioral Health Survey assesses risk along several validated scales and tells the commander how his or her unit compares with the Air Force as whole. A cross-functional team on each base suggests interventions tailored to specifically address areas of elevated risk.

Critical Incident Stress Management

Critical incident stress management teams were established to serve personnel at every installation, with deployable teams available to provide additional resources to installations hard hit by potentially traumatizing events. These teams respond to events such as combat deployments, serious aircraft accidents, and natural disasters as well as suicides within the military unit.

Integrated Delivery System for Human Services

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 agencies' headquarters 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.

Each of these initiatives are described in detail in Air Force Pamphlet 44-160, The Air Force Suicide Prevention Program, and is available on the World Wide Web at: <http://www.e-publishing.af.mil/shared/media/epubs/afpam44-160.pdf>

Results

When the project began in 1995, suicide was the second leading cause of death among the 350,000 Air Force members, occurring at an annual rate of 15.8/100,000. Since then, the suicide rate declined statistically significantly over three consecutive years, and for the first six months in 1999 the annualized rate fell below 3.5/100,000. This is more than fifty percent less than the lowest rate on record prior to 1995 and an eighty percent drop from the peak rates in the mid-1990s.

The suicide rates increased in '00 and early '01, but have declined again since April '01 and have remained much lower than rates prior to 1995. Statistically significant declines in violent crime, family violence, and deaths due to unintentional injuries have also been measured concurrently with the intervention. Air Force leaders have emphasized community-wide involvement in every aspect of the project. The providers of community-based human services have made significant progress in coordinating their resources for the purpose of building stronger individuals and more resilient communities.

The suicide rates in the United States also declined in the second half of the decade of the 1990s. This decline, however, is extremely small compared to that measured in the Air Force. Explanations commonly advanced for the national declines have included a robust economy with historically low unemployment, declines in hard drug use, and increased utilization of the most commonly prescribed anti-depressant medications.

Although the first two would not be expected to have been a factor for the special population in the Air Force, it would be useful to study the influence the third may have had in the context of attempting to de-stigmatize seeking help for mental health problems. An independent, retrospective evaluation of the Air Force suicide prevention program was recently completed and is under review at the time of this writing. A five-year study to prospectively evaluate each of the program's components is now underway.

Is the Air Force Program Transferable to Civilian Communities?

The Air Force community shares many characteristics with other American communities, and yet in some ways is quite distinct. 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 well connected.

The 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. None-the-less, 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."

Suicide Rate – US Air Force Members 1990-2002



Source:

Litts, David A., USAF, Office of the Surgeon General, (301) 443-4000

Chapter 5

Best Practices for Community-Based Prevention and Intervention

Model Prevention Programs

For one hundred years suicide prevention in the U.S. has been guided by the question – ‘Why do people kill themselves?’ Yet, most everyone living today has experienced at least one of the known suicide risk factors; previous experience with suicide, depression, failure, loss, etc. We have an opportunity to re-frame suicide prevention efforts based on an understanding of ‘Why do people stay alive?’ Answers to this question will generate primary prevention efforts addressing individual, social, and cultural issues; the key to reducing suicidal behaviors.

John Hellsten

Epidemiologist & suicide survivor, Austin

The Evidence-Based Practices Project (EBPP) for Suicide Prevention, a collaborative effort of the Suicide Prevention Resource Center (SPRC) and the American Foundation for Suicide Prevention (AFSP), began work in 2004 to implement a cross-disciplinary framework to review and identify effective suicide prevention programs. You will in the future be able to find on the SPRC Web site evaluations of the effectiveness of different programs, with the evaluation criteria based on guidelines developed by the National Registry of Effective Prevention Programs (NREPP).

Source:

“Evidence-Based Practice Project (EBPP) for Suicide Prevention,”
Suicide Prevention Resource Center.
http://www.sprc.org/library/ebpp_announce.pdf

Professional Education for Community Organizations

First Responders

Law enforcement officers are often called to the scene when there is a serious suicide threat. 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:
 - o Requirements for action to ensure the safety of the suicidal person and referral to treatment before leaving the scene
 - o Evaluation of imminent and future risk factors
 - o Controlling or seizing weapons
 - o Evaluation of the ability of the family or others to help
 - o Requirements for two officers to respond, including specially trained officers such as MHPOs
 - o 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.

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.

Health and Mental Health 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

Chief of Psychiatry, Ben Taub General Hospital, Houston

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 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:
 - American Psychiatric Association, <http://www.psych.org/>
 - The American Foundation for Suicide Prevention, <http://www.afsp.org>
 - American Psychological Association, <http://www.apa.org>
- The limited effectiveness of “suicide contracts”
- 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

A local mental health provider should be recruited to serve as, or to work with, the community’s media spokesperson in the event of a suicide. This professional will need to understand the effect of media portrayal of the suicide on the survivors and develop the skills to craft media accounts to avoid untoward outcomes such as suicide contagion. This practitioner should work closely with print, radio, and television outlets on an ongoing basis to help convey the

potential risks of poorly handled public service announcements and event coverage.

Pastoral Community

“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.

- 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.
- 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.
- 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.
- 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.

- 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.
- 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)
- 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 the 1-800-273-TALK hotline as well as local hotlines. You might also suggest that they consider attending one of the survivor of suicide support groups if there is one available in your area. * 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.
- 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.
- 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.
- If the family grants permission, clergy conducting the

funeral service may chose 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.

- 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.
- 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.
- 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.
- 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. The appendices of this toolkit have a number of resources for professionals in the faith communities.

Sources:

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“The Criminal Justice/Mental Health Consensus Project Report,” Council of State Governments/Police Executive Research Forum/ National Association of State Mental Health Program Directors, et al., 2002. <http://www.consensusproject.org>

“Suicide & Liturgical & Homiletical Resources and Faith-based Statements Regarding Mental Illness,” OASSIS Interfaith Resources, <http://www.oasis.org/interfaithrcrs.html>

Texas Council on Law Enforcement Officer Standards and Education, providing courses on special needs populations and peace officer certification and training. <http://www.tcleose.state.tx.us>

Outreach to Populations at Risk

Different populations within the community 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.

Resources for Assisting Targeted Populations

African Americans

Suicide is the third leading cause of death among black youth, after homicides and traumatic injury, and the rate of suicide is growing faster among African American youth than among Caucasians. It is critical to help remove the stigma about suicide that suggests, among other things, that masculine men do not take their own lives and that strong women never crack under pressure. It is also important to take steps to improve access to mental health treatment for African Americans and to provide better access to such treatment.

- For more information, contact the National Organization for People of Color Against Suicide at <http://www.geocities.com/nopcas>

Alcohol & Substance Abuse

“It has long been known that alcohol abuse is a risk factor for suicide (Murphy, 2000). Recent research indicates that such a relationship also exists between suicidal behavior and the abuse of other drugs. Consider the following facts:

- The literature indicates that alcohol abusers have higher rates of both attempted and completed suicide than non-abusers (Lester, 2000).
- Twenty to 50 percent of the people who die by suicide had alcohol or drug abuse problems. Depression is the only psychiatric problem with a more pronounced association with suicide (Murphy, 2000).
- Youth who used alcohol or illicit drugs during the past year were more likely to be at risk of suicide than other youth. Youth who used any illicit drug other than marijuana were almost three times more likely to be at risk of suicide (Substance Abuse and Mental Health Services Administration, 2003).

- Fifteen percent of all alcohol-dependent people die by suicide. This is a loss of 7,000 to 13,000 people every year (Sadock & Sadock, 2002).

The information above came from the customized information sheets at [SPRC.org](http://www.sprc.org) for alcohol and other drug abuse counselors. For the references cited above and for more information about resources for alcohol and substance abuse issues, contact the Suicide Prevention Resource Center at <http://www.sprc.org> or by calling 877-GET-SPRC (877-438-7772)

Elderly

Older adults have the highest suicide rates compared to any other age group, yet this population is often overlooked in suicide prevention efforts. Suicide prevention is just as important among the older adult population as it is for the young. Older adults offer meaningful contributions to family, community, business, government, education, entertainment, and other aspects of society. Death by suicide of older adults involves not only the personal loss of a loved one, but it also deprives society of talent, skills, and knowledge.

*Liliana Santoyo
Austin*

- While the elderly make up only 12.6 percent of the US population, they account for almost 18.1 percent of the suicides. In Texas, the highest reported suicide rate in 2004 was among people 75 and older, which reported a rate of 19.9 deaths from suicide per 100,000 people. That is considerably higher than the national rate of 16.3 percent for people aged 75 and older for that same year. 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), the National Suicide Prevention Resource Center at [SPRC.org](http://www.sprc.org), or the Texas Department of Aging and Disability Services at dads.state.tx.us. *

Gay/Lesbian/Bisexual/Transgendered (GLBT)

“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 GLBT community, particularly its youth, is at exceptionally high risk for suicide. A number of studies have shown a significant difference in suicide rates between GLB youth and non-GLB youth, for example. One study indicates that as many as 41.7 percent of sexually active GLB youth reported suicide attempts compared with 28.6 percent of sexually active non-GLB youth.

- In Houston, a 24-hour gay and lesbian switchboard staffed by volunteers is available at (713) 529-3211. The Montrose Counseling Center offers professional counseling services and also operates a youth program. Learn more at <http://www.montrosecounselingcenter.org>
Help in other Texas cities is available from:
Resource Center of Dallas, <http://www.resourcecenterdallas.org>
Diversity Center of San Antonio, <http://www.causesincommon.org/coalition-partners/diversity-center-san-antonio>
OutYouth Austin at, <http://www.outyouth.org/index.html>
Waterloo Counseling Center, Austin, <http://www.waterloocounseling.org>

Hispanic Americans

In 2000, SAMHSA's National Household Survey on Drug Abuse in 2000 asked youths whether they had thought seriously about killing themselves or tried to kill themselves during the 12 months before the survey. Hispanic females aged 12 to 17 were at higher risk for suicide than other youth. Adding to the risk was the factor that only 32 percent of Hispanic female youth at risk for suicide during the past year received mental health treatment during this time period. Hispanic female youth born in the United States were at higher risk than Hispanic female youth born outside the United States although rates of suicide risk were similar among Hispanic female youth across regions and ethnic subgroups (e.g., Mexican, Puerto Rican, Central or South American and Cuban).

The 2005 Youth Risk Behavior Surveillance Survey (YRBSS) pointed out increased risk for Hispanics in Texas. Data from youth surveyed in Texas in 2005 compared to those surveyed in 2001 indicated an increased risk for suicide attempts among Hispanic teen youth. In 2007, the YRBSS highlighted an additional increased risk of attempting suicide for Hispanic female teens. Of great concern is the fact that Texas has a higher percentage of Hispanic female teen suicidal ideation and suicide attempts than that of the U.S. overall. Because Hispanic-Americans are the fastest growing cultural group in Texas, prevention efforts targeted to this population are critical.

Men

"Males complete suicide at a rate four times that of females and represent 79.4% of all U.S. suicides," according to the CDC. It is assumed that this higher 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%). However, females attempt suicide three times more often than males.

In 2005, 25,907 men died by suicide in the United States accounting for 71 male deaths by suicide per day for an overall suicide death rate of 17.7. The American Association of Suicidology points out that firearms remain the most commonly utilized method of completing suicide by essentially all groups. More than half (52.1%) of the individuals who took their own lives in 2005 used this method.

Among males, non-Hispanic white men age 85 or older had the highest rate of suicide (rate of 17.8 per 100,000 population) for 2004 in the U.S. overall. Men 65 and older account for about 10 percent of the U.S. population. But more than 33 percent of suicides are among men in this age group.

The National Institute of Mental Health also points out that there were gender differences in suicide among young people for 2004, as follows:

- Almost four times as many males as females ages 15 to 19 died by suicide.
- More than six times as many males as females ages 20 to 24 died by 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. 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.

By Gender

Sex	Number of Suicides	Population	Rate (age adjusted)
Males	25,907	145,973,538	17.96
Females	6,730	150,533,523	4.37
Total	32,637	296,507,061	11.01(crude rate)

Figures from the National Center for Health Statistics for the year 2005 for U.S.

All rates are per 100,000 population.

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.

The higher rate of attempted suicide in women is attributed to the elevated rate of mood disorders among females. 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. The suicide rates for women in the U.S. peaks between the ages of 45-54 and again after age 75.

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. In addition, 60 -80 percent of women experience transient depression, and 10 percent to 15 percent of women develop clinical depression during the postpartum period.

Protective factors for women include the fact that they are more likely than men to have stronger social supports, to feel that their relationships are deterrents to suicide, and to seek psychiatric and medical intervention, which may contribute to their lower rate of completed suicide.

For more information about risk and protective factors for women, contact the American Foundation for Suicide Prevention: http://www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id=04ECB949-C3D9-5FFA-DA9C65C381BAAEC0

Youth

"I was seventeen when Jeff committed suicide right after I told him I wouldn't marry him. Shock and confusion combined with guilt were the most memorable and long-lasting emotions I felt. I think teenagers today are no different than I was. There is a need to be educated to know that they need to go to get help from an adult."

*Amber Poole
Suicide Survivor, Houston*

"Recently graduated from law school at U of T, and I still think about two of my close friends who died by suicide in high school. Looking back, I see that their suicides had a domino effect making it more possible and more respected among young people, and serving to be the impetus for many

in our school to turn to alcohol and drugs to cope. The common sentiment is one of abandonment, confusion and fear. If the best and the brightest chose to jump ship, what does this then say about us? Save my generation and the generations after us from ever having to experience the world we have."

*Melissa Stratton
UT-law graduate, suicide survivor, Austin*

Each year, there are approximately twelve suicides for every 100,000 adolescents in the U.S. Statistics from the Texas Department of Health support the contention that adolescents are a particularly vulnerable group. In 2004, 355 adolescents aged ten to twenty-four died as a result of suicide. This reflects a larger trend reported by the Centers for Disease Control (CDC), whose recent findings indicate that suicide is the third leading cause of death among young people in the United States and a major public health problem for youth both in this country and abroad. The findings also indicated that Hispanic youth account for one fourth of all Hispanic suicide deaths. Texas data for 2005 compared with data from 2001 from the 2005 Youth Risk Behavior Surveillance Survey indicates that in 2005 more Texas youth felt sad and hopeless, more Texas youth actually attempted suicide and more Texas youth surveyed had an attempt that necessitated treatment by doctor or nurse.

- The National Center for Suicide Prevention Training (NCSPT) provides Web-based workshops on developing effective programs for youth. More information is available at <http://www.ncspt.org/workshops/default.asp>
- The American Association of Suicidology offers a School Suicide Prevention Accreditation Program for school psychologists, social workers, counselors, nurses, and all others dedicated to or responsible for reducing the incidence of suicide and suicidal behaviors among today's school-aged youth. Go to <http://www.suicidology.org/> for more information and an online application.
- A number of videos focusing on suicide prevention among youth are recommended by the American Association of Suicidology at <http://www.suicidology.org/displaycommon.cfm?an=1&subarticlebr=25> and by the American Foundation for Suicide Prevention at <http://www.afsp.org>

“Gatekeeper” Programs to Reach Out to At-Risk Populations

“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, Dallas

ASIST

Developed by Living Works Education, ASIST (Applied Suicide Intervention Skills Training) is based on the premise that suicide can be prevented through the actions of prepared caregivers. The program consists of a two-day, highly interactive, practical, practice-oriented workshop designed to help participants and caregivers become more comfortable, confident, and competent in helping to prevent the immediate risk of suicide.

ASIST is designed to help all caregivers become more ready, willing, and able to help persons at risk. Just as “CPR” skills make physical first aid possible, training in suicide intervention develops the skills used in suicide first aid. The workshop is for all caregivers (any person in a position of trust). This includes professionals, paraprofessionals, and lay people. It is suitable for mental health professionals, nurses, physicians, teachers, counselors, youth workers, police and correctional staff, school support staff, clergy, and community volunteers. ASIST programs are currently in place in Texas in Houston, San Antonio, and selected other communities.

JASON FOUNDATION

The Jason Foundation provides a range of programs that include parent and youth seminars, staff development training, and a school-based curriculum unit for grades seven through twelve. The foundation’s school based curriculum is a unit of study about the awareness and prevention of youth suicide presented so that teens learn how to help a friend in need. The Jason Foundation parent programs, presented by The Jason Foundation staff, gives the staggering statistics associated with youth suicide to enhance parental awareness of the problem. This program provides information about signs of concern that are unique to the parent-child relationship. Parents are also given helpful resources and information on what to do if they suspect their son or daughter is at risk. For more

information on other Jason Foundation programs and seminars, go to the Jason Foundation web site at <http://www.jasonfoundation.com/seminars.html>.

Note: The Jason Foundation is a member of the Texas Suicide Prevention Council.

QPR

The QPR Institute provides suicide prevention training and education to organizations in communities across the country. It delivers training both to professionals and to citizen “gatekeepers” whose role is to identify suicidal people and do everything possible to help them until they can receive professional care.

The QPR approach relies on gatekeepers and professionals working closely with each other. Because gatekeepers cannot be expected to have the skills to evaluate degrees of risk and the type of treatment needed, professionals must be there to support their efforts.

Actions by QPR-trained gatekeepers may have different possible outcomes including:

- No suicidal threat and no professional intervention needed
- Refusal of gatekeeper contact by someone believed to be suicidal, requiring further action by a professional.
- Acceptance of a referral on the part of the suicidal person.
- Acceptance of a referral, but also a refusal to travel to an appointment, requiring further professional action such as a home visit.
- Ambivalence about accepting a referral, requiring professional intervention (the level of which will depend on whether the person is clearly lethal).

QPR programs are currently available in Texas in Austin, Houston, San Antonio, College Station, and selected other communities. One of the goals of the Texas Youth Suicide Prevention Project is to expand the list and training of certified QPR instructors across Texas. A list of certified QPR Texas trainers is available by contacting the QPR Institute at <http://www.qprinstitute.com>. The Texas Suicide Prevention Council can also help find a QPR instructor for your community, or if you are interested in becoming an instructor, contact Merily Keller, mhkeller@onr.com.

Yellow Ribbon International

Yellow Ribbon International is a comprehensive, community-based suicide prevention program of the Light for Life Foundation. Designed specifically for outreach to youth, it provides gatekeeper training to schools and communities and is in use throughout the United States and in 47 countries.

Yellow Ribbon curriculums are available for lay people as well as professional people, including law enforcement. They include an elementary-age module and a physician's module. The program stresses:

- Awareness
- Education
- Prevention
- Intervention
- Postvention
- Collaboration and community building
- Replication and sustainability
- Helping save lives
- Helping survivors heal

There are a number of Yellow Ribbon programs throughout Texas. For more information about availability in your community, visit the Yellow Ribbon International Web site at <http://www.yellowribbon.org>

Tools for Screening for Suicide Risk

If you believe that someone may be at risk for suicide, there are screening tools available to evaluate the risk that can be implemented on a community basis. Two programs, Teen-Screen and SOS have been evaluated and are considered to be "best practice" child and adolescent screening programs by many researchers.

- More information about screening for suicide risk in adults is available at <http://www.ahrq.gov/clinic/3rduspstf/suicide/suicidesum.htm#AppFig1>.
- TeenScreen is a computer-based program developed by Columbia University that can be used to screen young people for depression and suicide ideation. More information is available at <http://www.teenscreen.org>.
- The Signs of Suicide program is a nationally recognized, cost-effective program of suicide prevention and mental health screening for secondary school students. SOS is the only school-based suicide prevention program that has been shown to reduce suicidality in a randomized, controlled study (March 2004, American Journal of Public Health). More information about this program is available at http://www.mentalhealthscreening.org/sos_highschool/.

Sources:

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

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http://www.ChildrensSafetyNetwork.org/MonthlyBulletins/MonthlyBulletin_May_2004.htm

Fact sheets on African American suicide, elderly suicide, and youth suicide, American Association of Suicidology.
<http://www.suicidology.org>

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"Risk of Suicide Among Hispanic Females," Substance Abuse and Mental Health Services Administration,
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Yellow Ribbon International. <http://www.yellowribbon.org>

Youth Risk Behavior Surveillance System,
<http://www.cdc.gov/healthyyouth/yrbs/>

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 Williams

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 they may hold meetings in person. A professional mental

health provider and a survivor of suicide usually facilitate them. The list of resources in the appendix section of this toolkit will help you identify support groups in Texas and connect you with information to help you if you would like to start a group in your area.

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 also.
- Wait at least three months before allowing someone to start a group. Those that start too soon often do not finish or do not benefit as much as they might if they waited. In the interim, arrange for survivors who have completed the program to call and offer support to those who are waiting.
- There should be at least one person who is clinically trained facilitating the group. A combination of a clinical professional and a survivor is ideal. The facilitators should be prepared to meet regularly to provide continuity of leadership for the group.

Sources:

“Locate Survivor Support,” Suicide Prevention Resource Center.
<http://www.sprc.org/survivors/survlocate.asp>

“Survivor Groups,” American Foundation for Suicide Prevention.
<http://www.afsp.org/index-1.htm>

School-Based Programs

Prevention

“When school campuses (counselors, teachers, administrators and nurses) are well trained in QPR 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
 Student Intervention Specialist,
 Department of Student Support
 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 QPR 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 year 2 and 3, the AISD QPR instructors offered suicide prevention training to all of the high school and middle school counselors, nurses and nursing assistants. Then, in year 3, they began to reach out to school administrators, teachers and selected student groups. For the past two 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 (one in 2000-2001 and one in 2007-2008), the coalition is currently in the process of working to develop postvention protocols. Postvention is what you do AFTER a suicide to help prevent

Synopsis of Suicide Prevention & Postvention Key Steps Austin Independent School District

1. Suicide Action Plan approved by AISD General Counsel and Cabinet
2. Suicide Action Plan and QPR training presented to:
 - ~ Counselors and Social workers
 - ~ Nurses
 - ~ Assistant Principals/Administrators
 - ~ SRO (School Reserve Officers on AISD campuses)
 - ~ Parents/Parent organizations
 - ~ PAL summer institute (Peer Assistant Leadership)
3. Coordinated with community groups for prevention training with Mayor’s Mental Health Task Force Monitoring Committee for protocols
4. Suicide postvention national trainer made presentations to parents, teachers, and staff members about best practices for prevention and postvention.
5. Best practices information for postvention given to principals/administrators
6. Worked with local coalition on community partnerships for postvention protocol: funeral directors, nurses, doctors, hospitals, mental health professionals, educators, law enforcement
7. Postvention protocol given to schools for implementation

more deaths by suicide and avoid a contagion process among youth. To develop protocols, the coalition is working 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. The postvention protocols should be available by Spring 2009 through www.TexasSuicidePrevention.org for other communities to view as a model.

A Postvention Guide for School Communities

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.

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 you are all free to have your 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. Approximately 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 Poland, S. handouts & articles

Sources:

Mental Health Association in Tarrant County. <http://www.mhatc.org>

Poland, S., and Lieberman, R., “NEAT Supports Nebraska Schools Following Suicide Cluster,” *Communiqué*, 32(8), 21-22.

“Signs of Suicide” prevention kit for youth, Screening for Mental Health. <http://www.mentalhealthscreening.org>

Tarrant County Public Health Department.
<http://health.tarrantcounty.com>

Yellow Ribbon Suicide Prevention Program.
<http://www.yellowribbon.org>

Note: A Postvention Toolkit will be available at www.TexasSuicidePrevention.org in the spring of 2009.

Chapter 6

Guidelines for Community Education and Communication

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 follows this section.

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 that can link the community to both 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

Holding Community Listening Sessions

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.

Tips for Organizing a Community Listening Session

Orchestrating 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 and cable stations. Be sure to include a telephone number 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.
- Follow-up after sending the media advisory.

Planning Guide

Logistics

- Form a Working Committee. Divide responsibilities among members to help the session run more efficiently. Consider appointing the following positions:
 - o Planning Coordinator to coordinate meetings, monitor progress on session plans and see that deadlines are met.
 - o Local Host/Moderator to conduct a pre-hearing meeting of panelists and facilitate the session.
 - o 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.
 - o Panelist Recruiter to identify key groups/individuals to screen speakers and recommend and manage panelists.
 - o Presentation Coordinator to refine the session agenda and define issues for discussion.
 - o 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 chapter asking them to do two things:
 - o Recommend potential speakers
 - o 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.

Getting the Word Out: Using Brochures to Promote Your Efforts

A brochure can give interested people in your community basic information on the subject of suicide prevention and point them toward additional information or help. You can create a simple brochure fairly easily with some help from your local copy shop and the guidelines below. You can also order brochures from many of the state and national organizations listed in the appendix and add local contact information.

Developing an Effective Brochure

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. (see appendix for complete list.) 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.

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.

Many of the federal and state agencies and national and state associations listed in the appendices offer easy to use downloadable brochures or offer web-based ordering for brochures, books, and outreach materials. These include:

<http://www.mhatexas.org>

Mental Health America of Texas has a number of brochures on all aspects of mental health including suicide prevention which can be downloaded or ordered from the website. Most of their brochures are in both English and Spanish, side-by-side.

<http://www.sprc.org/>

The National Suicide Prevention Resource Center has extensive downloadable information on suicide prevention on its web site including fact sheets for specific targeted and high risk groups.

<http://www.suicidology.org/storeindex.cfm>

The American Association of Suicidology has an online bookstore as well as fact sheets and outreach materials for professionals and survivors.

<http://www.afsp.org>

The American Foundation for Suicide Prevention has a number of brochures for professionals and survivors as well as films, videos, and training tools for community and professional education.

<https://www.save.org/>

The Suicide Awareness Voices of Education offers brochures on & books on suicide, teenage depression, and a complete community action kit on suicide prevention. Look up under menu options for brochures and books available.

<http://spanusa.org>

SPAN-USA, the Suicide Prevention Advocacy Network has a downloadable brochure, as well as downloadable maps of suicide rates by states and counties, and other suicide prevention tools for community outreach.

Working with the Media

Utilizing the Media to Promote Community Awareness

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

The Suicide Prevention Advocacy Network has a complete list of major media outlets in the United States for easy dissemination of news releases about suicide prevention. Their web site allows you to search for media outlets by zip code.

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 Part 1 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 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).
 - o 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.
 - o 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."

The national recommended media guidelines are listed below as well as guidelines for online and social network media websites.

Sources:

"Frequently Asked Questions About Suicide," National Institute of Mental Health, <http://www.nimh.nih.gov/suicideprevention/suicidefaq.cfm>

Media Guidelines for 2004, American Association of Suicidology. <http://www.suicidology.org>

"Media Relations," American Public Health Association, <http://www.apha.org/ppp/science/mediare12.htm>

"Reporting on Suicide: Recommendations for the Media," American Association of Suicidology. <http://www.suicidology.org/displaycommon.cfm?an=9> and American Foundation for Suicide Prevention <http://www.afsp.org/education/newrecommendations.htm>

"Find Sources of Your Local Media By Zip Code," Suicide Prevention Advocacy Network, <http://spanusa.org/>

Media Guidelines: Print & Broadcast

At-a-Glance: Safe Reporting on Suicide (reprinted from sprc.org)

Research indicates that the way suicide is reported in the media can contribute to additional suicides and suicide attempts. Conversely, 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. The following recommendations have been developed to assist reporters and editors in safe reporting on suicide.

For Reporters

What to Avoid

- Avoid detailed descriptions of the suicide, including specifics *of the method and location*.
Reason: Detailed descriptions increase the risk of a vulnerable individual imitating the act.
- *Avoid romanticizing someone who has died by suicide. Avoid featuring tributes by friends or relatives. Avoid first-person accounts from adolescents about their suicide attempts.*
Reason: Positive attention given to someone who has died (or attempted to die) by suicide can lead vulnerable individuals who desire such attention to take their own lives.
- *Avoid glamorizing the suicide of a celebrity.*
Reason: Research indicates that celebrity suicides can promote copycat suicides among vulnerable people. Do not let the glamour of the celebrity obscure any mental health or substance abuse problems that may have contributed to the celebrity's death.
- *Avoid oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable.*
Reason: Research shows that from 60-90 percent of suicide victims have a diagnosable mental illness and/or substance use disorder. People whose suicide act appears to be triggered by a particular event often have significant underlying mental health problems that may not be readily evident, even to family and friends. Studies also have found that perpetrators of murder-suicides are often depressed, and that most suicide pacts involve one individual who is coercive and another who is extremely dependent.
- *Avoid overstating the frequency of suicide.*
Reason: Overstating the frequency of suicide (by, for example, referring to a "suicide epidemic") may cause vulnerable individuals to think of it as an accepted or normal response to problems. Even in populations that have the highest suicide rates, suicides are rare.
- *Avoid using the words "committed suicide" or "failed" or "successful" suicide attempt.*
Reason: The verb "committed" is usually associated with sins or crimes. Suicide is better understood in a

behavioral health context than a criminal context. Consider using the phrase “died by suicide.” The phrases “successful suicide” or “failed suicide attempt” imply favorable or inadequate outcomes. Consider using “death by suicide” or “non-fatal suicide attempt.”

What to Do

- *ALWAYS include a referral phone number and information about local crisis intervention services.*

Refer to: The National Suicide Prevention Lifeline toll-free number, 1-800-273-TALK (273-8255), which is available 24/7, can be used anywhere in the United States, and connects the caller to a certified crisis center near where the call is placed. More information can be found on the National Suicide Prevention Lifeline website: www.suicidepreventionlifeline.org

- *Emphasize recent treatment advances for depression and other mental illness. Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.*

Refer to: Suicide Prevention Resource Center’s research and news briefs: www.sprc.org/news/research.asp

- *Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.*

Refer to: The American Foundation for Suicide Prevention’s “Talk to the Experts” page: www.afsp.org, view About Suicide, click on For the Media to locate the Talk to the Experts section

Suicide Prevention Resource Center www.sprc.org

1-877-GET SPRC (1-877-438-7772)

**Education Development Center, Inc. 55 Chapel Street,
Newton, MA 02458-1060**

Reporters may also contact the Suicide Prevention Resource Center at 1-877-GET-SPRC (438-7772), the American Association of Suicidology at (202) 237-2280, or the Suicide Prevention Action Network USA at (202) 449-3600.

- *Emphasize decreasing trends in national suicide rates over the past decade.*
Refer to: CDC’s (Centers for Disease Control and Prevention) WISQARS (Web-based Injury Statistics Query and Reporting System): www.cdc.gov/ncipc/wisqars/ or talk with an expert (see previous recommendation).
- *Emphasize actions that communities can take to prevent suicides.*

Refer to: CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters: wonder.cdc.gov/wonder/PrevGuid/p0000214/p0000214.asp

Best Practices Registry for Suicide Prevention:
www.sprc.org/featured_resources/bpr/index.asp

- *Report on activities coordinated by your local or state suicide prevention coalition.*

Refer to: Your state suicide prevention contact will be able to tell you if there are local groups or organizations providing suicide prevention training in your community. See the Suicide Prevention Resource Center’s State Suicide Prevention webpages: www.sprc.org/stateinformation/index.asp

For Editors

What to Avoid

- *Avoid giving prominent placement to stories about suicide. Avoid using the word “suicide” in the headline.*

Reason: Research shows that each of the following lead to an increase in suicide among media consumers: the placement of stories about suicide, the number of stories (about a particular suicide, or suicide in general), and dramatic headlines for stories. Using the word “suicide” or referring to the cause of death as “self-inflicted” in headlines increases the likelihood of suicide contagion.

- *Avoid describing the site or showing pictures of the suicide.*

Reason: Research indicates that such detailed coverage encourages vulnerable people to imitate the act.

What to Do

- *Suggest that all reporters and editors review Reporting on Suicide: Recommendations for the Media.* These guidelines for responsible reporting of suicide were developed by a number of Federal agencies and private organizations, including the Annenberg Public Policy Center.

Refer to: www.afsp.org, view About Suicide, and click on For the Media section

- *Encourage your reporters to review examples of good and problematic reporting of suicide.*

Refer to: The American Foundation for Suicide Prevention’s website: www.afsp.org, view About Suicide, click on For the Media section

- *Include a sidebar listing warning signs, or risk and protective factors for suicide.*

Refer to: American Association of Suicidology’s warning

signs: www.sprc.org/library/helping.pdf {May use my list of signs and risk factors}
National Strategy for Suicide Prevention's risk and protective factors: www.sprc.org/library/srisk.pdf
National Institute of Mental Health, Suicide Prevention: www.nimh.nih.gov/topics/suicide-prevention.shtml

The recommendations in this reprint of the sprc publication were adapted in 2005, from Reporting on Suicide: Recommendations for the Media, a 2001 report by the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center. www.afsp.org, view About Suicide, click on For the Media section. We would like to acknowledge Madelyn Gould of Columbia University for her many contributions to this document. Additionally, we thank Lanny Berman, Lidia Bernik, Ann Haas, Karen Marshall, and Dan Romer for their input.

SOCIAL NETWORKING

Online Postvention Recommendations: What to Do After A Suicide To Help Prevent More Suicides

"For postvention to work, we must include online media and social networking websites. We cannot reach today's youth and young adults with old media."

*Christopher Gandin Le
Suicide Postvention Consultant, Austin*

In 1988, the CDC released a document entitled "Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters" that said, "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." Twenty years later, we now need to expand our definition of community, with the understanding that we must include online communities like MySpace, Facebook, and other social networking websites.

Not everyone on a social networking site is an expert in suicide prevention, but they are experts on their community. Users read their friends' updates, blog posts, comments, and more, and they know when something is not right. Part of the culture of the internet has become sharing your life with others, how you're feeling one moment, what you're doing

later that day, who your friends are or even who you're angry with. This information flow can serve as a powerful tool as we look to save lives. Given the proper training, these tight-knit communities can become gatekeepers for suicide prevention and postvention.

ABOUT SOCIAL NETWORKING SITES:

MySpace: <http://www.myspace.com/>

MySpace now has over 100 million users. Their demographic ranges from kids under 14 (using fake birthdates) to adults 65 and up. The largest subset of these users is 16-35. MySpace doesn't require any real contact information apart from a working email address; because of this lax registration policy, users will sometimes have multiple MySpace accounts, representing themselves in different ways. Some MySpace features include comments, photo comments, private messages, and blog posting.

Facebook: <http://www.facebook.com/>

Facebook has over 62 million users. Their core demographic is a bit older than MySpace (21-45). Facebook is more of a social connection tool than MySpace. People present more of their real life information on Facebook and use it to connect to real-life friends and extended community. Facebook features include wall posts (public messages left for friends), private messages, instant messaging, and status updates. The format of the status updates is: "Chris is... 'fill in the blank'." (For example, "Chris is feeling really sad.") Therefore, these status updates are often where those in distress will post their feelings or intent.

Help.com: <http://www.help.com/>

Help is an interesting service where users ask questions and other users can answer those questions. Users can identify tags, or keywords, that they'd like to discuss (such as depression), and when someone posts a question about depression, users looking for that tag will receive a notification email. This essentially creates self-defined 'content experts.' Emotion Technology recommends training Help.com users in a local area to answer questions about suicide and suicidal behavior in an informed way.

WHAT CAN WE PROVIDE TO USERS OF SOCIAL NETWORKING SITES?

- Access to the National Suicide Prevention Lifeline through 1-800-273-TALK
- Access to resources in their community (MHMRAs in TX).
- Language to post on pages of deceased users (see below).
- Development of online gatekeeper training on suicide prevention and postvention protocols.
- A safe place to talk about their feelings of grief.

- Monitoring of comments to ensure user safety in the case of a contagion concern.
- Direct access to crisis support and information through MySpace. This would require more research on providing effective crisis support online, technology development time, and certainly funding to support staff being available 24/7.

WHAT TO DO ONLINE IN CASES OF YOUTH SUICIDE

After a suicide, a person's MySpace page or Facebook profile will stay online – often becoming a memorial for that person. While this can be a good place for friends and family to express their sorrow, we know that left unchecked, these pages can also become areas where further suicidal ideation can occur. Below we outline steps that should be taken after a suicide.

1. Identify the moderator of the person's online accounts (usually parents or friend of the deceased).
2. Provide the letter below to explain how social networking sites can impact further suicidal ideation
3. Someone in the community should monitor the comments posted after the suicide - watching out for any red flag language (e.g. "I am going to join you soon," "I can't take life without you.") and be prepared to contact those users if necessary.
4. Work with school counselors and principals to help them understand the impact a person's online presence can have.

LETTER TO GIVE TO PARENTS/FRIENDS

Dear parents and family members of [insert person's name]

Thank you for this chance to work together to help prevent suicide. We are so sorry to hear about the recent losses in your community, high school, and homes. While there is nothing we can do to erase these tragedies, it is our hope that we can help other families in your community from experiencing a similar situation. Please have a look at the message crafted for your children's Facebook or MySpace (or other social-networking) pages below, and let me know if you have any questions or need further assistance.

LANGUAGE FOR SOCIAL NETWORKING PAGES

The message posted on a Facebook page and/or group (or MySpace page or in any public space) regarding suicide is an important part of preventing further deaths. While the language should honor the person and comfort those left behind, it is important to make sure that those reading the page see suicide as preventable. For this very reason, we are providing the following language for posting:

With help, this loss of life might have been avoided. The best way to honor (person's name) is to seek help if you or someone you know is struggling. If you're feeling lost, desperate, or alone - please call the National Suicide Prevention Lifeline: 1-800-273-8255. The call is free and confidential, and crisis workers are there 24/7 to assist you. To learn more about the Lifeline, visit their MySpace page:

<http://www.myspace.com/suicidepreventionlifeline> or their website: <http://www.suicidepreventionlifeline.org>

Chapter 7

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. Evaluation may answer certain questions that have been taken for granted but that have not been scientifically tested, especially those related to proving the effectiveness of a program. Evaluation may also be used to improve the functioning of a program. Both types of evaluation-sometimes referred to as outcome evaluation and process evaluation-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: Focusing an 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? Are other factors that could contribute to an outcome adequately controlled?
Cost-Benefit	What is the relationship between program costs and program outcomes (benefits) expressed in dollars?
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.

The second audience for evaluation is outsiders with an 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/MA01-3517/appendixb.asp>.

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

Useful Web Sites for Evaluation

<http://www.ojp.usdoj.gov/BJA/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 on-line 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/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/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/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.wkcf.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://library.sprc.org>

Evaluation Guidelines

1. Identify stakeholders – people or organizations that have something to gain or lose from what will be learned from the evaluation and what will be done with that knowledge. Include:
 - a. Those involved in the initiative or program operations, e.g. community members, sponsors, collaborators, staff
 - b. Those served or affected by the program or initiative, e.g. targets and agents of change in the community, community organizations, elected officials, residents
 - c. The primary intended users of the evaluation, e.g., grantmakers and funders, program or initiative staff, university-based researchers
2. Describe the program – create a summary explaining what the program or initiative is trying to accomplish and how it is trying to bring about the changes. It should include:
 - a. A statement of need – what is the nature of the problem or goal, who is affected, how big is it, and is it changing?
 - b. A statement of expectations – what are the intended results of the initiative or program, what has to be accomplished for success?
 - c. Activities identified or implemented to bring about change
 - d. Resources both needed and available to conduct activities – e.g., time, talent, equipment, information, money
 - e. The program or initiative's stage of development – Indicate how the program/initiative's stage of development (e.g., planning, implementation, maintenance) affects the goal of the evaluation
 - f. Context – Categorize environmental features that could potentially affect the initiative or program, such as community history, geography, politics, social and economic conditions
 - g. Logic model – Describe and provide a picture of how components of the program/initiative combine to bring about change and improvement
3. Focus the evaluation design – explicitly state what the evaluation of the program or initiative will address how it will do so, and how the findings will be used. Include a description of:
 - a. Purpose – what are the main things the program or initiative aims to accomplish in the evaluation and what has been done to accomplish them?
Purposes may include:
 - (1) Gaining insight
 - (2) Improving how things get done
 - (3) Determining effects of the program or initiative
 - (4) Affecting those who participate in the evaluation themselves
 - b. Users – those individuals who will receive the evaluation findings
 - c. Uses – what will be done with what is learned from the evaluation?
 - (1) Gain insight – e.g., assess needs and assets of the community, identify goals and barriers
 - (2) Improve how things get done – e.g., refine plans, improve intervention, enhance competence, reduce costs, enhance benefits
 - (3) Determine effects of the program – e.g., assess skill development of participants, document community (systems) change, examine behavior changes over time, document level of success in accomplishing objectives

- (4) Affect participants – e.g., teach evaluation skills, reinforce message of program, stimulate dialogue and awareness of community issues, improve individual outcomes
 - d. Evaluation questions – What information is important to stakeholders?
 - (1) How well was the program/initiative planned out and put into practice?
 - (2) How well has the program/initiative met its stated objectives?
 - (3) How much/what kind of difference has the program/initiative made for its targets of change?
 - (4) How much/what kind of difference has the program/initiative made in the community as a whole?
 - e. Methods – What type of study design was used to evaluate the effects of the program or initiative? Typical designs include experimental, quasi-experimental, and descriptive case studies. By what method will data gathered to help answer the evaluation questions? Some methods include:
 - (1) Documentation/monitoring and feedback systems
 - (2) Member surveys about the initiative
 - (3) Goal attainment reports
 - (4) Behavioral surveys
 - (5) Interviews with key participants
 - (6) Community-level indicators of impact
 - f. Agreements – Summarize and clarify the roles and responsibilities of those involved in the evaluation of the evaluation.
4. Gather credible evidence – Decide what is evidence, and what features affect credibility of the evidence
- a. Indicators – specify criteria used to judge the success of the program/initiatives translate into measures of indicators of success (capacity to deliver services, participation rates, levels of satisfaction, changes in behavior, community (systems) change or new programs, policies, and practices, improvements in community-level indicators (e.g., rates of adolescent pregnancy)
 - b. Sources of evidence – interviews/surveys with people, documents, or direct observation?
 - c. Quality – estimate the appropriateness and integrity of information gathered, its reliability, and how well relatedness to the evaluation questions
 - d. Quantity – estimate what amount of data is required to evaluate effectiveness, indicate how we will know when to stop
 - e. Logistics – identify methods, timing, and physical infrastructure for gathering/handling information
5. Justify conclusions – include the following elements based on the evidence gathered:
- a. Standards – the values held by stakeholders that provide the basis on which to judge the program or initiative’s success
 - b. Analysis & synthesis – methods used to summarize findings, how we detect patterns in the evidence
 - c. Interpretation – encapsulate what the findings mean, how this translates into practical importance of the results
 - d. Judgments – statements of worth or merit, compared to selected standards
 - e. Recommendations – identify actions to consider as a result of the evaluation
6. Ensure use and share lessons learned – Take steps to ensure that the findings will be used appropriately; include the following elements to help ensure that the recommendations are used:
- a. Design – how questions, methods, and processes are constructed
 - b. Preparation – steps taken to anticipate future uses of findings, how to translate knowledge into practice
 - c. Feedback – how communication will be facilitated among evaluation participants
 - d. Follow-up – support users needs during evaluation and after receiving findings, remind users of intended uses
 - e. Dissemination – communicating lessons learned to relevant audiences in a timely manner

The Evaluate the Initiative section is adapted from the Community Toolbox published by the University of Kansas.
<http://ctb.ku.edu/tools/evaluateinitiative/outline.jsp>

Part 3: What You Need To Know About Suicide Postvention

Suicide Postvention for Texas:

What You Do AFTER a Death By Suicide

To Help Prevent More Deaths

“Suicide is tantamount to an earthquake within a community. The ripple effect sends aftershocks throughout the community that can claim the lives of vulnerable, at-risk members. Postvention guidelines and protocols need to be regarded as important as community disaster prevention and preparedness protocols.”

Amanda Summers-Fox, Suicide Prevention Officer, Texas Department of State Health Services

Introduction

Due to the inherent vulnerability of many youth in response to suicidal behavior displayed by others, it is important that every school and community have a postvention response plan in place. Too many times a school has found its youth caught in a wildfire of suicidal behavior resulting in preventable deaths, injuries due to attempts and lives that are forever altered. Prevention is the key, and incorporating suicide prevention programs is the first level of preventive measures. Once suicidal behavior has occurred, postvention protocols should be implemented immediately to prevent imitative suicidal behavior among at-risk youth and other individuals in 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 occurring. For the postvention protocols to be effective, appropriate community staff and volunteers must receive training on both the purpose of the protocols and effective implementation. Since schools are a part of a larger community, and the lives of youths encompass both settings, the postvention guidelines need to be created by the community as a whole, although specific groups (such as schools) need to have their own policies, protocols and guidelines for their institutions.

There are many key stakeholders in the community who touch the lives of youth and adults who are at risk for suicide. Those stakeholders need to come together to create the postvention guidelines. This means each stakeholder will play a role in future postvention efforts. No single entity, including a school, can orchestrate and implement a community-based approach to postvention. This community approach is consistent with postvention recommendations by the Centers for Disease Control.

The suicide postvention chapters are organized in two parts. The first covers some basic knowledge that people need to have in order to act effectively on this issue and is presented primarily in an outline and checklist format. The second includes specific tools that communities can use to help them in their postvention protocol development and implementation. Because suicide postvention is a process that each school and each community has to develop to meet local needs, we have not included complete postvention plans or protocols but instead offer definitions, goals and steps to be covered for each key section.

Resources and postvention plans from other areas are also included for reference. The goal is to make this a very practical guide that community leaders and school leaders can easily use in efforts to prevent suicide deaths in Texas by acting effectively.

POSTVENTION BECOMES PREVENTION WHEN AFTER EACH AND EVERY SUICIDE PEOPLE FOLLOW PRACTICAL GUIDELINES TO PREVENT MORE DEATHS OF VULNERABLE, AT-RISK YOUTH.

In this way, **Postvention becomes Prevention.**

Updates to the toolkit will be posted periodically on the Mental Health America of Texas web site at <http://www.mhatexas.org/> and on the Texas Suicide Prevention Council web site at <http://www.TexasSuicidePrevention.org>.

Part 3A:

Saving Lives Through Community Postvention Planning

*“Suicide is a complex issue:
preventing suicide will require a coordinated community effort.*

No single community agency has the resources or expertise to adequately respond to an emerging suicide cluster. Collaboration and cooperation between agencies may well be the single most important element in stopping the contagion process and avoiding or stopping a suicide cluster.”

Lynn Lasky Clark, President/CEO, Mental Health America of Texas

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, “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 has seen a number of recent suicide clusters among teenagers and young adults, and public concern for this issue has grown as schools and communities reach out to help. Although research on the causes of suicide clusters is still ongoing, there are some suggestions for prevention.

The CDC cites studies, which indicate: (see complete CDC article in Part 4)

1. Clusters of completed suicides occur predominantly among adolescents and young adults.
2. Such clusters account for up to 5% of all suicides in this age group.
3. Suicide clusters are thought by many to occur primarily through a process of contagion with some evidence suggesting that in any given suicide cluster, suicides occurring later in the cluster appear to have been influenced by those occurring earlier.
4. Ecologic evidence suggests that exposure of the general population to suicide through television, movies and the internet may increase the risk for suicide for certain, high risk, susceptible individuals.

Definitions

A **postvention** is an **intervention** conducted **after a death by suicide**, primarily taking the form of:

1. Support for the bereaved (family, friends, associates, professionals and peers since family and friends of the suicide victim may be at increased risk of suicide themselves);
2. Outreach to at risk individuals in the community; and
3. Careful communication and coordination with community stakeholders including health and mental health providers, school officials, law enforcement, faith communities, parents and social service agencies.

Suicide postvention is a term that was first used by Shneidman in 1981, and has been defined by the American Association of Suicidology as “the provision of crisis intervention, support and assistance for those affected by a completed suicide.” Later definitions have expanded this to include those affected by a serious suicide attempt as well as a death by suicide.

The aim of postvention is to support and debrief those affected and reduce the possibility of suicide contagion. Interventions recognize that those bereaved by suicide may be vulnerable to suicidal behavior themselves and may develop complicated grief reactions.

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 given below for a community to use to bring key stakeholders together to develop a suicide postvention plan specific to their area.

Community Postvention Efforts Should Be Mobilized:

- 1. When youth suicides or attempted suicides occur closer together in space and time than is considered usual for the community
- 2. When 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

Definitions

- **Suicide Contagion:** The process by which one or more individuals, following the awareness of a recent suicide

threat, attempt or completion, or a fictional depiction of such behavior, initiate suicidal behavior.

- **Suicide Cluster:** A group of suicides or suicide attempts, or both, that occurs closer in time and space than would normally be expected in a given community.
- **Copy Cat Suicide:** When a person copies the manner of death of another person.

Note: Although suicide clusters and contagion occur primarily in youth and young adults, we have had clusters of deaths by suicide in Texas (and nationally) in other age groups.

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.”

Community Postvention Goals

- 1. Reduce the risk of further suicidal behavior.
- 2. Avoid glorifying or sensationalizing the suicide.
- 3. Avoid vilifying the decedent.
- 4. Identify youth that may represent a high risk for suicidal behavior.
- 5. Connect at-risk youth with mental health resources.
- 6. Identify/alter environmental factors that may be influencing the process of contagion.

(Note: These might include policies for all memorials to be held off school campuses; information and hotlines for suicide prevention provided at funerals; emphasis on prevention and non-sensationalizing in media coverage; care in whether and how youth are involved in memorials; monitoring and suicide prevention messages provided in internet memorials & postings; access to counseling; parent and youth awareness of local resources; normalization of help seeking behavior and emphasis to youth of importance of telling a responsible adult of any suicidal talk they hear from friends.)

- 7. Provide long-term surveillance (data collection and analysis).

(Note that at some point suicide postvention becomes suicide prevention but long term surveillance and monitoring of both the suicide attempts and deaths in a community and of that community’s suicide prevention and postvention plan is needed for that to happen effectively.)

Check List For Community Stakeholders to Develop & Implement Postvention Protocols:

(See CDC article listed in Part 4 of this toolkit)

<ol style="list-style-type: none"> 1. Select a Coordinating Committee to manage the day-to-day response to the crisis re postvention 2. Select a Host Agency or Co-Host Agencies to convene the meetings, house the plan, monitor the incidence of suicide attempts and completions and call meetings when needed 3. Identify community resources and stakeholder groups to be involved in a postvention planning process. <p>Stakeholder groups might include representatives from any or all of the following or other specific groups for an area: Faith Communities; Funeral Homes; Law Enforcement; Local Hospitals (administration, emergency department, social work department); Local MHMR Center; Medical Association; Mental Health America; School District (school administration, counseling departments, nursing departments, school police); Parent Associations; Primary Care Providers; Suicide Prevention Coalition, Social Service Agencies; Survivors of Suicide Group Facilitators, University Researchers in Education, School Psychology, Psychology and/or Social Work.</p> <p>Note: if postvention involves a college and/or university, appropriate university counseling center, administration and department representatives should be involved instead of the school district ones suggested.</p> <ol style="list-style-type: none"> 4. Implement the response plan when either: 	<ol style="list-style-type: none"> a. A suicide cluster occurs in the school or the community, or b. When one of more deaths from trauma occur in the community which may potentially influence others to attempt or complete suicide <ol style="list-style-type: none"> 5. Identify, contact & prepare groups who will prepare key roles in the initial response 6. Avoid glorification of the suicide victims and minimize sensationalism in all response outreach efforts 7. Identify persons who may be at high risk for suicide and enable them to have at least one screening interview with a trained mental health professional (refer for further counseling or other services as needed) 8. Provide appropriate information to the media along with media guidelines (if possible, arrange for a meeting with the editor or editorial review board ahead of time to avoid sensationalism in any coverage) 9. Identify elements in the environment such as stigma regarding help-seeking behavior, access to care, easy access to means of death, sensationalism in earlier memorials, lack of collaboration and cooperation between social service agencies and schools, etc. that might be changed to lower suicide risk for the future 10. Address any long-term issues which are suggested by the nature and course of the suicide cluster or potential cluster
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Brock, Steven E., "Suicide Postvention," National Association of School Psychologists, available online at <http://www.csus.edu/indiv/b/brocks/Workshops/NASP/Suicide%20Postvention%20Paper.pdf> and online slides from his workshop available at: <http://www.csus.edu/indiv/b/brocks/Workshops/NASP/NASP%20Suicide%20Postvention%20Slides.pdf>

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Zenere, Frank J, Ed.S. School Psychologist, National Emergency Assistance Team of the National Association of School Psychologists, "Prevention & Containment of Community Suicide Cluster's" workshop presented Jan. 10, 2008 in Austin, Texas. See PowerPoint in Part II.

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 at SPRC.org. Two toolkits with stakeholder specific postvention protocols include:

NAMI, New Hampshire Connect/Frameworks: Training Professionals & Communities in Suicide Prevention & Response available online at: www.TheConnectProject.org with protocols for specific stakeholders listed at: http://naminh.org/frameworks_community_protocols.php

The Maine Youth Suicide Prevention, Intervention and Postvention Guidelines developed by the Maine Youth Suicide Prevention Program can be accessed at <http://www.maine.gov/suicide/professionals/program/index.htm>.

Part 3B:

Suicide Postvention For Family & 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 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 for the 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 the lives of our youth. If only...”

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

Background

Suicide postvention for family and friends involves balancing the overwhelming grief and loss of the individuals involved with community needs for a public health postvention response to help prevent more tragic deaths. The Austin-Travis County Suicide Coalition stated in its introduction to suggested postvention protocols, “In some cases, the suggested postvention response may be counter-intuitive or go against what you might normally do. In these cases, it might help to consider the public health aspect of your response in addition to the inherent, intense personal grieving – i.e. how the personal expression might impact the larger community. ”

“This is not an attempt,” they said, “ to tell someone or some community how to grieve – that is a very personal choice based on individual beliefs, culture, religion and tradition. But this is an attempt to inform all those involved (family, friends, youth, first responders, clergy, funeral homes, medical and mental health community) that their response has the potential of adding to the risk of future deaths by suicide or helping to prevent future suicide tragedies.”

In this case, postvention guidelines may help everyone involved in the aftermath of a suicide successfully communicate and provide appropriate crisis response and long term support of those immediately affected as well as the greater community by offering suggestions and considerations to keep in mind for:

1. death notifications,
2. memorials,
3. funeral and gravesite services,

4. obituaries,
5. school and other institutional responses
6. news coverage
7. public awareness and
8. long term personal and community mental health.

Definitions

Survivors of Death by Suicide: those who have lost a loved one to death by suicide are often called “survivors” – used in this way, this designation refers to family members and/or friends and not to someone who has attempted suicide and “survived.”

Normal Grief & Complicated Grief: In the aftermath of a death by suicide, normal grief can become complicated. The Mayo Clinic explains it in this way: “Most people experiencing normal grief and bereavement endure a period of sorrow, numbness, and even guilt and anger, followed by a gradual fading of these feelings as they accept the loss and move forward. For some people, though, this normal grief reaction becomes much more complicated, painful and debilitating, or what’s known as complicated grief. In complicated grief, painful emotions are so long lasting and severe that you have trouble accepting the death and resuming your own life.”

PTSD: Survivors of a death by suicide, especially if they have found the body, may be at an increased risk for PTSD or Post Traumatic Stress Disorder. This is defined by the Menninger Clinic as “a disorder that develops *after* traumatic stress. The hallmark of PTSD is reexperiencing the trauma in response to reminders. Reexperiencing symptoms may include flashbacks and nightmares.”

Immediately Following the Death

Texas law provides specific guidelines for responding to an untimely or unattended death. 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. If the cause and manner of death is clear and there is no need for an autopsy, the death certificate will be issued. The medical examiner then will make arrangements for transportation of the body. Funeral directors may be requested to assist in the transport. If the medical examiner determines an autopsy is necessary, then it will generally be conducted within 24 hours and the body will be released to the funeral home or family.

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. In cases involving suspected overdoses, poisoning, drugs or 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).

To obtain a copy of the death certificate, contact the Texas Bureau of Vital Records at (512) 458-7111 or (888) 963-7111.

The Grief Process

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 that professional mental health support is readily available if needed. 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.

There are a number of resources including books and downloadable brochures in Part 4, which explain the grief process and offer support for family and friends in the immediate aftermath of a suicide death.

Self Care

Survivors of suicide may have to be reminded of the importance of self-care during the immediate period after a death. It is important for them to remember that they may be at increased risk for accidents and important to follow basic self-care steps such as:

- Get plenty of rest.
- Maintain proper diet and nutrition.
- Drink plenty of water.
- Exercise.
- Use relaxation skills, meditation and/or prayer.
- Be gentle with yourself/others.
- Seek out supportive people.
- Avoid use of (or increased use of) alcohol, caffeine, or other substances.
- Drive safely and be aware of increased risk for accidents during intense grief

Postvention Goals for Family & Friends

- Provide support for normal grief process and minimize complicated grief and guilt reactions.
- Reduce the risk of further suicidal behavior.
Note: this may include efforts to remove firearms from the home during the period of acute grief and/or providing gun locks as well as removing or locking up lethal medications.
- Connect family & friends to health and mental health providers if needed and to community resources.
- Education and information about steps family & friends can take to help prevent suicide clusters and contagion in the immediate aftermath of a suicide in the way that they approach funerals and memorial services and long term in community suicide prevention and postvention activities.

Check List For Postvention Support for Family and Friends:

<ol style="list-style-type: none"> 1. Help family and friends identify a support network and mobilize that network for the immediate aftermath of a death by suicide 2. Allow family and friends to share their grief openly and share remembrances of their loved one 3. 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.) 	<ol style="list-style-type: none"> 4. Connect them to Survivors of Suicide Support Groups and/or other local grief support resources and/or faith community resources. 5. 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). 6. 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.
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Check List For Community Postvention Concerns For Family and Friends to Consider (or for those assisting family and friends):

<p>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:</p> <ol style="list-style-type: none"> 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 	<p>practices and not being disrespectful of any family concerns or grief process.</p> <ol style="list-style-type: none"> 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 youth 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.)
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Requesting A Death Certificate. Information available online from Texas Department of State Health Services, Bureau of Vital Statistics, <http://www.dshs.state.tx.us/VS/reqproc/deathcert.shtm>

Texas Code of Criminal Procedures, Subchapter B. Duties Performed by Medical Examiners. Art. 49.25. [989A] Medical Examiners. A available online at: http://www.co.travis.tx.us/medical_examiner/code_crim_procedures.asp

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 at SPRC.org. Two toolkits with stakeholder specific postvention protocols include:

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The Maine Youth Suicide Prevention, Intervention and Postvention Guidelines developed by the Maine Youth Suicide Prevention Program can be accessed at <http://www.maine.gov/suicide/professionals/program/index.htm>.

See booklists for family and friends and online brochures for dealing with the aftermath of a death by suicide included in Section II. Downloadable brochures in English and Spanish on Youth Suicide Prevention for family members are also available online from <http://www.mhatexas.org> and <http://www.TexasSuicidePrevention.org>.

Part 3C:

Suicide Postvention in the Schools

The aftermath of a youth suicide is a sad and challenging time for a school. The major tasks for suicide postvention are to help your students and fellow 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%.

Scott Poland, National Association of School Psychologists, Past Chair

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. Sample policies from one Texas school district are included in Part 4.

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 Postvention Goals:

- Support the grieving process
- Prevent imitative suicides
 - Identify and refer at-risk students
 - Reduce identification with victim
- Reestablish health school climate
- Provide long term surveillance

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

The following guidelines and checklists for schools are meant as a summary to help school districts develop complete postvention plans. They came from points listed in the School Postvention Powerpoint presentation by Frank Zenere provided in Part 4. The Suicide Prevention Resource Center at <http://www.sprc.org> also has school prevention and postvention plans available in its library.

School Postvention Response Guidelines:

1. Verify the suicide death and/or attempt with first responders/medical examiner or law enforcement.
2. Contact the family of the victim within 24 hrs (if possible) to offer condolences.
3. Determine what and how information is to be shared
4. Mobilize the school and community crisis response team
5. Inform faculty and staff and parents
6. Assess the impact on the school
7. Identify at-risk students/staff and appropriate outreach for them

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 or have had a personal connection with the deceased
 - who have previously demonstrated suicidal behavior
 - who are known to have a mental illness
 - who are known to have a history of familial suicide
 - who have experienced a recent loss
 - 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 absences 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
 - student hospital visitors of suicide attempters
 - students who have a history of being bullied
 - students who are gay, lesbian, bisexual, transgender or questioning
 - students who are participants in fringe groups
 - students who have weak or troubled levels of

social/familial support

- (if school district policy allows) consider monitoring internet student social network sites for high risk statements and/or behavior and/or encouraging parents to monitor those sites

School Suicide Postvention Response Guidelines

1. Estimate level of response needed
2. Advise principal on how to proceed
3. Do not release information in a large assembly or over the intercom
4. Conduct small group notifications of students
5. Provide written information to parents who need to be notified
6. Visit victim's classes
7. Provide psychoeducation and/or psychological first aid services for impacted students and staff
8. Identify a school district media spokesperson to answer all questions from the media and refer media to media guidelines on reporting on a death by suicide (see Part 4).
9. Identify school district key contacts for victim family questions and concerns and for outreach to concerned parents of other students

School Suicide Postvention Student Psychoeducation Objectives

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

(See handout on answering student questions following a death by suicide in Part 4)

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 in Part 4 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.

(Note: The tracking tool in Part 4 provides a chart to input data and look at trends).

Tracking Check List

(See tracking form included in Part 4)

<ol style="list-style-type: none"> 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/Mean Used for Attempt and/or Death 6. Trigger=Issue or event that seemed to be “the last straw” or connected to the death. <i>(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.)</i> 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) 	<ol style="list-style-type: none"> 10. Diagnosis= Was there possible underlying mental illness, substance abuse, conduct disorder or learning disability? <i>(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.”)</i> 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)
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Sources:

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The Maine Youth Suicide Prevention, Intervention and Postvention Guidelines developed by the Maine Youth Suicide Prevention Program can be accessed at <http://www.maine.gov/suicide/professionals/program/index.htm>.

See booklists for family, friends, and youth and online brochures for dealing with the aftermath of a death by suicide included in Section II.

Downloadable brochures on Youth Suicide Prevention in English and Spanish are also available online from <http://www.Mhatexas.org> and <http://www.TexasSuicidePrevention.org>.

Part 3D: Suicide Postvention with Faith Communities & Funeral Homes

“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

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 in the “Coming Together to Care: A Suicide Prevention Toolkit for Texas Communities,” pages 102-103 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 and risks for suicide. (See “Understanding Suicide, The Basics,” in pages 30-33 and “Risk for Depression and Suicide Among Military Dependents and the Utility of Rapid Assessment,” pages 86-87 in [Coming Together to Care: A Suicide Prevention Toolkit for Texas Communities](#) available at <http://www.TexasSuicidePrevention.org>)

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 (some of the downloadable brochures available are given in Part 4 of this toolkit) 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-TALK (8255)** 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 online memorial pages.

Suggestions for Pastoral Care & Spiritual Support Following a Suicide

(Reprinted below from pages 45-46 in “Coming Together to Care: A Suicide Prevention Toolkit for Texas Communities” available at <http://www.TexasSuicidePrevention.org>)

Pastoral Community

“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

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.

- 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.
- 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.

- 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.
- 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.
- 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.
- 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)
- 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 the 1-800-273-TALK hotline as well as local hotlines. You might also suggest that they consider attending one of the survivor of suicide support groups if there is one available in your area.
- 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.

- 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.
- 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.
- 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.
- 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.
- 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.

- 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.
- 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. The appendices of this toolkit have a number of resources for professionals in the faith communities.

Sources:

"Behavioral Health," The Seton Cove: a non-profit, interfaith center for spirituality. <http://www.seton.net/Wellness/Spirituality5/Seton-Cove/index.asp>

"Suicide & Liturgical & Homiletical Resources and Faith-based Statements Regarding Mental Illness," OASSIS Interfaith Resources, <http://www.oasis.org/interfaithrcrs.html>

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 *continued on next page*)

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.

(**Note:** 30,000+ suicides in the US per year equals over a quarter of a million suicides in ten years. While survivors may not be aware of it, many friends, family, neighbors, and colleagues have experienced traumatic loss of loved ones by suicide. Being open about a death by suicide might end the rumor and misinformation that can accompany an untimely death – especially the death of a teen or young adult. It might also allow friends and families who are also suicide survivors to come forward and provide support from their own personal experience, and allow mental health counselors and others to begin postvention activities that may help prevent suicide contagion and reduce the possibility of future suicides.)

Sources:

Austin-Travis County Suicide Postvention Toolkit correspondence with coordinating committee. Toolkit will be available from the Austin Travis County Suicide Prevention Coalition in the fall 2009 from hodgekeller@yahoo.com and nroebuck@ix.netcom.com.

After a Suicide: Recommendations for Religious Services and Other Public Memorial Services, “SPRC, <http://www.sprc.org/library/aftersuicide.pdf>

Clergy Response to Suicidal Persons & Their Family Members, Author: David C. Clark, Ed., Exploration Press: Chicago, IL 1993

“Suggestions for Clergy,” from Compassionate Friends. Available online from. http://www.compassionatefriends.org/Other_Pages/Suggestions_for_Clergy.aspx

Frameworks Youth Suicide Prevention Project, June 2006 Version – Postvention Protocols, copyright NAMI NH, 2006, www.naminh.org

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

Texas Mental Health Association, and Texas Suicide Prevention Council websites provide general information on mental illness and a “toolkit” to assist community members in doing suicide prevention work. www.mhatexas.org and www.TexasSuicidePrevention.org.

Memorial Service and Funeral Guidelines

The Memorial Service Guidelines from After a Suicide: Recommendations for Religious Services and Other Public Memorial Services, “SPRC, <http://www.sprc.org/library/aftersuicide.pdf> 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, flag poles, 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.

Additional Resources

For more information about suicide and suicide prevention, including resources for faith-based communities in responding to and preventing suicide, please visit the Suicide Prevention Resource Center website at www.sprc.org.

Information on specialized grief support services and groups for survivors of a suicide are available from the following:

- American Association for Suicidology
www.suicidology.org
5221 Wisconsin Avenue, NW
Washington, DC 20015
(202) 237-2280
- American Foundation for Suicide Prevention
www.afsp.org
120 Wall Street, 22nd Floor
New York, NY 10005
(212) 363-3500
Toll-free: (888) 333-AFSP
- The Compassionate Friends, Inc.
www.compassionatefriends.org
P.O. Box 3696
Oakbrook, IL 60522-3696
(630) 990-0010
Toll-free: (877) 969-0010
- The Link's National Resource Center for Suicide Prevention and Aftercare
www.thelink.org/national_resource_center.htm
348 Mt. Vernon Highway, NE
Atlanta, GA 30328-4139
(404) 256-2919

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Part 3E: Suicide Postvention with Health and Mental Health Providers and Social Service Agencies

We know that suicide is the 3rd leading killer of adolescents overall, the 2nd leading killer of adolescent boys and the 2nd leading killer of college-age youth. This means that every Texas community is at risk for youth suicide attempts and deaths.

At risk-students are served by a variety of health and mental health providers and social service agencies. To reduce deaths by suicide with effective postvention, these providers and agencies HAVE to be informed, involved and made an integral part of the postvention planning and implementation process.

Patty Williams Pittman, Communities In Schools and Co-Chair Texas Suicide Prevention Council

Some of the factors in communities that have previously experienced suicide clusters are the following:

- Little community awareness of youth suicide.
- Rapid growth in the community
- Substance abuse problems.
- Massive schools.
- Lack of a sense of belonging.
- Material emphasis.
- No crisis center and/or limited community mental health services.

Health and mental health providers and social service agencies all have the capacity to positively affect these community factors. In addition, as provider of health and mental health services, they can serve a key role in their outreach to family members and high risk individuals and groups.

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.”

In addition, research indicates that the majority of adults who die by suicide have seen a primary health care provider in the weeks before their death, and we can assume that many youth have as well.

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:

- first steps, verification & notification
- self-care
- contact and support for family/immediate survivors
- 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 responding

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

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.

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.

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 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.

Support for Survivors & 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. Downloadable brochures for family members are also included in Part 4 of this toolkit.

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.

Sources:

Austin-Travis County Suicide Postvention Toolkit correspondence with coordinating committee. Toolkit will be available from the Austin Travis County Suicide Prevention Coalition in the fall 2009 from hodgekeller@yahoo.com and nroebuck@ix.netcom.com.

After a Suicide: Recommendations for Religious Services and Other Public Memorial Services, “SPRC, <http://www.sprc.org/library/after-suicide.pdf>

Frameworks-Connect Youth Suicide Prevention Project, June 2006 Version - Postvention Protocols, copyright NAMI NH, 2006, <http://www.naminh.org>

Gould, M.S., & Kramer, R.A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior*, 31 (Suppl.)

Poland, S. & McCormick, J.S. (1999) *Coping with crisis: Lessons Learned*. Longmont, CO: Sopris West.

Zenere, Frank J., Ed.S. School Psychologist, National Emergency Assistance Team of the National Association of School Psychologists, “Prevention & Containment of Community Suicide Clusters” presented Jan. 10, 2008 in Austin, Texas. See PowerPoint in Part II.

“Suggestions for Clergy,” from Compassionate Friends. Available online from: http://www.compassionatefriends.org/Other_Pages/Suggestions_for_Clergy.aspx

“Suggestions for Funeral Directors . . . When a Child Dies,” Compassionate Friends. Available online from: http://www.compassionatefriends.org/Other_Pages/Suggestions_for_Clergy.aspx

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 at SPRC.org. Two toolkits with stakeholder specific postvention protocols include:

NAMI, New Hampshire Connect/Frameworks: Training Professionals & Communities in Suicide Prevention & Response available online at: www.TheConnectProject.org

With protocols for specific stakeholders listed at: http://naminh.org/frameworks_community_protocols.php

The Maine Youth Suicide Prevention, Intervention and Postvention Guidelines developed by the Maine Youth Suicide Prevention Program can be accessed at <http://www.maine.gov/suicide/professionals/program/index.htm>.

See booklists for family, friends, and youth and online brochures for dealing with the aftermath of a death by suicide included in Section II.

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

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 & 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 website <http://www.dshs.state.tx.us/vs/default.shtm> to connect to link to order death certificates
<http://www.dshs.state.tx.us/mhservices/default.shtm> to find information on community mental health services (information presented in English and Spanish)

Part 4: Suicide Postvention Resources & Tools

Part 4A1:

Community Postvention Guidelines

Organization: Centers for Disease Control

Go to: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm>

CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters

From CDC MMWR

Supplements

August 19, 1988 / 37(S-6);1-12

OUTLINE

- 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.
- III. The relevant community resources should be identified.
- IV. 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.
- V. 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.
- VI. The response should be conducted in a manner that avoids glorification of the suicide victims and minimizes sensationalism.
- VII. 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.

- VIII. A timely flow of accurate, appropriate information should be provided to the media.
- IX. Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed.
- X. Long-term issues suggested by the nature of the suicide cluster should be addressed.

INTRODUCTION

Recent suicide clusters among teenagers and young adults have received national attention, and public concern about this issue is growing. Unfortunately, our understanding of the causes and means of preventing suicide clusters is far from complete. 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. A statistical analysis of national mortality data indicates that clusters of completed suicide occur predominantly among adolescents and young adults, and that such clusters account for approximately 1%-5% of all suicides in this age group (1). Suicide clusters are thought by many to occur through a process of "contagion," but this hypothesis has not yet been formally tested (2,3). Nevertheless, a great deal of anecdotal evidence suggests that, in any given suicide cluster, suicides occurring later in the cluster often appear to have been influenced by suicides occurring earlier in the cluster. Ecologic evidence also suggests that exposure of the general population to suicide through television may increase the risk of suicide for certain susceptible individuals (4,5), although this effect has not been found in all studies (6,7).

The Centers for Disease Control (CDC) has assisted several state and local health departments in investigating and

responding to apparent clusters of suicide and suicide attempts. These clusters created a crisis atmosphere in the communities in which they occurred and engendered intense concern on the part of parents, students, school officials, and others. In the midst of these clusters of suicides or suicide attempts, community leaders were faced with the simultaneous tasks of trying to prevent the cluster from expanding and trying to manage the crisis that already existed. Potential opportunities for prevention were often missed during the early stages of response as community leaders searched for information on how best to respond to suicide clusters.

The recommendations contained in this report were developed to assist community leaders in public health, mental health, education, and other fields to develop a community response plan for suicide clusters or for situations that might develop into suicide clusters. A workshop for developing these recommendations was jointly sponsored by the New Jersey State Department of Health and CDC on November 16-17, 1987, in Newark, New Jersey.* Participants in that workshop included persons who had played key roles in community responses to nine different suicide clusters. They were from a variety of different sectors including education, medicine, local government, community mental health, local crisis centers, and state public health and mental health. Also participating in this workshop were representatives from the National Institute of Mental Health (NIMH), the Indian Health Service (IHS), the American Association of Suicidology (AAS), and the Association of State and Territorial Health Officials (ASTHO).

These recommendations should not be considered explicit instructions to be followed by every community in the event of a suicide cluster. Rather, they are meant to provide community leaders with a conceptual framework for developing their own suicide-cluster-response plans, adapted to the particular needs, resources, and cultural characteristics of their communities. These recommendations will be revised periodically to reflect new knowledge in the field of suicide prevention and experience acquired in using this plan.

Certain elements of the proposed plan for the prevention and containment of suicide clusters are quite different from those of crisis-response plans for other community emergencies. These differences are primarily attributable to the potentially contagious nature of suicidal behavior and to the stigma and guilt often associated with suicide. Other elements of the proposed plan, however, are germane to crisis-response plans in general. Therefore, state and local health planners might consider whether the plan they develop from these recommendations should be integrated into existing guidelines for managing other emergencies or mental health crises.

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

Comment. When a suicide cluster is occurring in a community — or when such a cluster seems about to occur — several steps in our recommended response plan should be taken right away. If such a timely reaction is to be possible, the response plan must necessarily already be developed, agreed upon, and understood by all the participants at the onset of the crisis. The recommended response requires a great deal of coordination among various sectors of the community. Such coordination is sometimes difficult to establish at the best of times and may be even more difficult to establish in the face of a crisis.

In the early days of an evolving suicide cluster there has typically been a great deal of confusion. There is often a sense of urgency in the community that something needs to be done to prevent additional suicides, but there has usually been little initial coordination of effort in this regard. Moreover, community members often disagree about precisely what should be done to prevent a cluster from expanding. In almost every case, communities ultimately develop some sort of plan for responding to the crisis in a coordinated manner, but opportunities for prevention are often missed in the crucial first hours of the response.

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

- A. Individuals from concerned agencies — education, public health, mental health, local government, suicide crisis centers, and other appropriate agencies — should be designated to serve on a coordinating committee, which would be responsible for deciding when the response plan should be implemented and coordinating its implementation.
- B. One agency should be designated as the “host” agency for the plan. The individual representing that agency would have the following responsibilities:
 - 1. Call the initial meeting of the coordinating committee before any crisis occurs so that these recommendations can be incorporated into a plan that reflects the particular resources and needs of the community (see Section III, below).
 - 2. Establish a notification mechanism by which the agency would be made aware of a potentially evolving suicide cluster (see Comment, below).
 - 3. Convene the coordinating committee when it appears that a suicide cluster is occurring, or when

it is suspected that a cluster may occur due to the influence of one or more recent suicides or other traumatic deaths (see Section IV, below). At this initial meeting, the members of the coordinating committee could decide whether to implement the community response plan and how extensive the response needs to be.

4. Maintain the suicide-cluster-response plan. The coordinating committee should meet periodically to assure that the plan remains operational.
5. Revise the community plan periodically to reflect new knowledge in the field of suicide prevention, the community's experiences in using the plan, and changes in the community itself.

Comment. Every effort should be made to promote and implement the proposed plan as a community endeavor. During past suicide clusters, a single agency has often found itself “in the hot seat,” that is, as the focal point of demands that something be done to contain the suicide cluster. No single agency, however, has the resources or expertise to adequately respond to an evolving suicide cluster. Moreover, the emergence of one agency as the sole focus for responding to an apparent suicide cluster has several unfortunate consequences. The agency and its representatives run the danger of becoming scapegoats for a community's fear and anger over the apparent cluster. Such a focus can potentially blind a community to other valuable resources for responding to the crisis and to basic community problems that may have engendered the crisis.

The concept of a “host” agency was developed because—even though the response will involve a variety of different agencies and community groups—one person must necessarily take responsibility for establishing a notification mechanism, maintaining the response plan, and calling meetings of the coordinating committee as outlined above. Which agency should serve as the host agency should be decided by each community. In past clusters, for example, a school district, a municipal government, a mental health association, and even a private, nonprofit mental health center have taken the lead in organizing their community's response. State or local public health or mental health agencies might also serve as host agencies for the plan. The role of host agency might also be rotated among the various agencies represented on the coordinating committee.

The notification mechanism by which the host agency would be made aware of a potentially evolving suicide cluster would vary from community to community. In small communities, one death of a teenager by suicide might be unusual, and information about the death would be quickly transmitted to a county-level host agency. In some large

communities, however, there are many suicides each year among young persons. Clearly, a more formal system would be needed in such a county to notify the host agency when an unusual number of suicides had occurred in a particular high school or municipality.

Determining whether to implement the response plan is not an all-or-nothing decision. Indeed, an important function of the coordinating committee is to decide to what extent the plan will be implemented. In situations in which it is feared that a cluster of suicides may be about to start, for example, the implementation of the plan might be quite subtle and limited, whereas in the event of a full-blown community crisis the implementation should be more extensive.

III. The relevant community resources should be identified.

In addition to the agencies represented on the coordinating committee, the community should also seek to identify and enlist help from other community resources, including (but not limited to):

- a. hospitals and emergency departments
- b. emergency medical services
- c. local academic resources
- d. clergy
- e. parents groups (e.g., PTA)
- f. suicide crisis centers/hotlines
- g. survivor groups
- h. students
- i. police
- j. media
- k. representatives of education, public health, mental health, and local government, if not already represented on the coordinating committee

Comment. The roles of each of the above groups should be defined as clearly as possible in the response plan before any crisis occurs. These roles should be agreed upon and reviewed by persons representing those groups. Most of those involved in the response will already know how to perform their particular duties. However, appropriate training for the staff of these groups should be provided as necessary (8). For example, if it is deemed desirable to conduct surveillance for suicide attempts through hospital emergency departments, officials at the state or local public health department might help design the system and train the emergency department staff. Other potential resources for training and counseling include state and local mental health agencies, mental health and other professional associations, and suicide crisis centers.

It is particularly important that representatives of the local

media be included in developing the plan. In at least one community faced with a suicide cluster, the media collaborated in preparing voluntary guidelines for reporting suicide clusters. Although frequently perceived to be part of the problem, the media can be part of the solution. If representatives of the media are included in developing the plan, it is far more likely that their legitimate need for information can be satisfied without the sensationalism and confusion that has often been associated with suicide clusters.

The following example representing a composite of several actual suicide clusters illustrates the need for inclusion of and cooperation among many community organizations. Suppose that two high school students from the same school commit suicide in separate incidents on a weekend during the regular school year. The coordinating committee decides that these two deaths may increase the risk of suicide or attempted suicide among other students. The responsibilities of some of the relevant community resources might be as follows: School officials might be responsible for announcing the deaths to the students in an appropriate manner (discussed below, Section VI).

School counselors and teachers might assist in identifying any students whom they think are at high risk; students in the school might also help in this regard. The local mental health agency might provide counselors to work with troubled students, as well as supply training and support for the teachers. Emergency departments of community hospitals might set up a suicide-attempt surveillance system that would increase the sensitivity with which suicide attempters were identified and would ensure proper referral of the attempters for counseling. Hotlines might help identify potential suicide attempters, and police might assist in locating such persons when appropriate. Police may also help by identifying and maintaining contact with such high-risk persons as high school dropouts and those with a history of delinquency. Local government or public health authorities might help coordinate these various efforts, if so designated by the coordinating committee.

IV. The response plan should be implemented under either of the following two conditions:

- A. When a suicide cluster occurs in the community; that is, when suicides or attempted suicides occur closer together in space and time than is considered by members of the coordinating committee to be usual for their community;

OR —

- B. When one or more deaths from trauma occur in the community (especially among adolescents or young adults) which the members of the coordinating committee think may potentially influence others to attempt or complete suicide.

Comment. It is difficult to define a “suicide cluster” explicitly. Clearly, both the number and the degree of “closeness” of cases of suicide in time and space that would constitute a suicide cluster vary depending on the size of the community and on its background incidence of suicide. But when a community considers that it is facing a cluster of suicides, it is essentially irrelevant whether the incident cases of suicide meet some predefined statistical test of significance. With the suddenly heightened awareness of and concern about suicide in such a community, steps should be taken to prevent further suicides that may be caused in part by the atmosphere, or “contagion,” of the crisis.

In several clusters of suicides or suicide attempts, the crisis situation was preceded by one or more traumatic deaths — intentional or unintentional—among the youth of the community. For example, in the 9 months preceding one cluster of four suicides and two suicide attempts among persons 15-24 years of age, there were four traumatic deaths among persons in the same age group and community—two from unintentional injuries, one from suicide, and one of undetermined intentionality. One of the unintentional-injury deaths was caused by a fall from a cliff. Two of the persons who later committed suicide in the cluster had been close friends of this fall victim; one of the two had witnessed the fall.

The hypothesis that a traumatic death can kindle a suicide cluster regardless of whether it is caused by intentional or unintentional injuries has not yet been tested. Nevertheless, the available anecdotal evidence suggests that some degree of implementation of the response plan be considered when a potentially influential traumatic death occurs in the community — especially if the person who dies is an adolescent or young adult.

We should emphasize that the fear of a contagious effect of suicide is not the only reason to implement this plan. For example, suppose that in the wake of some local economic downturn a community noted an excess of suicide deaths among persons who had been laid off from work. This would be a suicide cluster, and it would be entirely appropriate for the coordinating committee to implement the response plan. It is irrelevant that the suicides are not apparently related to contagion from previous suicides but to a “common-source” problem, since there is an identified

population (laid-off workers) potentially at a suddenly increased risk of suicide. Whether and when to implement the response plan should be determined by the coordinating committee.

At this stage of our understanding of suicide clusters, we cannot specify that the response plan should be implemented only under a particular list of circumstances. Until further scientific investigation and experience with suicide clusters provides us with a more empirical basis for deciding when to implement the response plan, we must rely on prudent judgments by community leaders regarding the potential for further suicides in their communities.

V. If the response plan is to be implemented, the first step should be to contact and prepare the various groups identified above.

- A. Immediately notify those who will play key roles in the crisis response of the deaths that prompted the implementation of the response plan (if they are not already aware of them).
- B. Review the respective responsibilities and tasks with each of these key players.
- C. Consider and prepare for the problems and stresses that these persons may encounter—burnout, feelings of guilt if new suicides occur, and the like—as they carry out their assigned tasks.

Comment. Timely preparation of the groups involved is critical. In a past cluster that began with a scenario similar to that described in Section III above, the teachers and the students both heard about the suicide deaths at the same time over the school loudspeaker. The teachers were entirely unprepared to deal with the emotional response of the students and did not know what to say to them or where to refer those who were most upset. It would have been far preferable to have called a pre-school meeting with the teachers to outline the problem, discuss the appropriate roles of the teachers, and announce the various resources that were available (9). Support staff at the school—secretaries, bus drivers, janitors, nurses, and others—might also have been included at the meeting. Such preparation could have been of enormous help in several past suicide clusters.

VI. The crisis response should be conducted in a manner that avoids glorifying the suicide victims and minimizes sensationalism.

- A. Community spokespersons should present as accurate a picture as possible of the decedent(s) to students,

parents, family, media, and others (see Section VIII, below).

- B. If there are suicides among persons of school age, the deaths should be announced (if necessary) in a manner that will provide maximal support for the students while minimizing the likelihood of hysteria.

Comment. Community spokespersons should avoid glorifying decedents or sensationalizing their deaths in any way (9). To do so might increase the likelihood that someone who identifies with the decedents or who is having suicidal thoughts will also attempt suicide, so as to be similarly glorified or to receive similar positive attention. One community that had had several suicides among high school students installed a “memorial bench” on the school grounds, with the names of the suicide victims engraved on the bench. Although this gesture was undoubtedly intended to demonstrate sincere compassion, such a practice is potentially very dangerous.

Spokespersons should also avoid vilifying the decedents in an effort to decrease the degree to which others might identify with them. In addition to being needlessly cruel to the families of the decedents, such an approach may only serve to make those who do identify with the decedents feel isolated and friendless.

If the suicide victims are of school age, the deaths should be announced privately to those students who are most likely to be deeply affected by the tragedy—close friends, girl friends, boy friends, and the like. After the teachers are briefed (see Section V), the suicide deaths might be announced to the rest of the students either by individual teachers or over the school loudspeaker when all the students are in homeroom or some other similarly small, supervised groups. Funeral services should not be allowed to unnecessarily disrupt the regular school schedule.

VII. Persons who may be at high risk 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. Active measures:
 - 1. Identify relatives (siblings, parents, children) of the decedents and provide an opportunity for them to express their feelings and to discuss their own thoughts about suicide with a trained counselor.
 - 2. Similarly, identify and provide counseling for boy friends/girl friends, close friends, and fellow employees who may be particularly affected by the deaths.

- B. Strategies to identify associates of the decedents or others who may be at increased risk of suicide might include: identifying the pall bearers at the funeral services of the decedent(s); checking with the funeral director regarding visitors who seemed particularly troubled at the services; keeping a list of hospital visitors of suicide attempters; and verifying the status of school absentees in the days following the suicide of a student. 3. In the case of suicides among school-age persons, enlist the aid of teachers and students in identifying any students whom they think may be at increased risk of suicide. 4. Identify and refer past and present suicide attempters for counseling if these persons were substantially exposed to suicide (see below), regardless of whether they were close friends of the decedents.

- a. “Substantially exposed” persons would include, for example, students in the same high school or workers at the same job location as the suicide victims. In past suicide clusters, such persons have committed or attempted suicide even though they did not personally know the victims who had committed suicide earlier in the cluster.

Identify and refer persons with a history of depression or other mental illness or with concurrent mental illness who were substantially exposed to suicide (see Section VII.A.4.a, above). 6. Identify and refer persons whose social support may be weakest and who have been substantially exposed to suicide. Examples of such persons include:

- b. students who have recently moved into the school district
c. students who come from a troubled family
d. persons who have been recently widowed or divorced, or who have recently lost their jobs.

C. Passive measures:

1. Consider establishing hotlines or walk-in suicide crisis centers—even temporarily—if they do not already exist in the community; announce the availability of such hotlines/centers.
2. Provide counselors at a particular site (such as school, church, community center) and announce their availability for anyone troubled by the recent deaths.
3. If suicides have occurred among school-age persons, provide counselors in the schools if possible; announce their availability to the students.
4. Enlist the local media to publish sources of help—hotlines, walk-in centers, community meetings, and other similar sources.

5. Make counseling services available to persons involved in responding to the crisis as well.

Comment. The recommendations for active measures to identify persons at high risk of suicide are based largely on scientific evidence that certain factors increase the risk of suicide. For example, mental illness (especially depressive illness) (10) and a history of past suicide attempts (11) are both strong risk factors for suicide. Certain sociologic factors such as unemployment (12), being widowed or divorced (13,14), other bereavement (15,16), and mobility (17), also appear to be important risk factors for suicide.

The role of imitation or “contagion” is, as we noted above, less well-established than the risk factors listed above. Nevertheless, the anecdotal evidence from suicide clusters is quite compelling, and several of the specific suggestions made above regarding who should be considered for screening are based on such evidence. For example, in one high school-based cluster, two persons who committed suicide late in the cluster had been pall bearers at the funerals of suicide victims who had died earlier in the cluster. It is likely that persons who are exposed to one or more of the aforementioned risk factors—depression or recent loss, for example—may be more susceptible to a contagious effect of suicide.

VIII. A timely flow of accurate, appropriate information should be provided to the media.

- A. Make certain that a single account of the situation is presented by appointing one person as information coordinator. This person’s duties would include:
1. meeting frequently with designated media spokespersons (see Section VIII-B, below) to share news and information, and to make certain that the spokespersons share a common understanding of the current situation
 2. “directing traffic”—referring requests for particular types of information to selected media spokespersons or to others (e.g., academic resources)
 3. maintaining a list of local and national resources for appropriate referral of media inquiries
 4. scheduling and holding press conferences.
- B. Appoint a single media spokesperson from each of the relevant community sectors—public health, education, mental health, local government, and the like.
1. Each sector represented on the coordinating committee should have a spokesperson. This person is not necessarily the same representative who serves on the coordinating committee.
 2. Spokespersons from additional agencies or public groups may be designated as appropriate.

- C. These spokespersons should provide frequent, timely access to the media and present a complete and honest picture of the pertinent events. When appropriate, regularly scheduled press conferences should be held.
 - 1. Avoid “whitewashing”—that is, saying that everything is under control or giving other assurances that may later prove unwarranted. This practice would undermine the credibility of the community spokespersons.
 - 2. Discuss the positive steps being taken, and try to get the media to help in the response by reporting where troubled persons can go for help.
- D. The precise nature of the methods used by decedent(s) in committing suicide should not be disclosed. For example, it is accurate to state that an individual committed suicide by carbon monoxide poisoning. But it is not necessary—and is potentially very dangerous—to explain that the decedent acquired a hose from a hardware store, that s/he hooked it up to the tail pipe of a car, and then sat in a car with its engine running in a closed garage at a particular address. Such revelations can only make imitative suicides more likely and are unnecessary to a presentation of the manner of death.
- E. Enlist the support of the community in referring all requests for information to these spokespersons.

Comment. If some suicide clusters spread through “contagion,” the vehicle for such contagion is information, perhaps sensationalized information, about the suicides that have occurred. The role of the media in causing or exacerbating a suicide cluster is controversial, but some investigators will no longer even discuss an evolving suicide cluster with media representatives for fear that newspaper or television accounts will lead to further suicides. Although a definitive understanding of this issue must be left to future research, it is prudent in the meantime to try to prevent needlessly sensationalized or distorted accounts of evolving suicide clusters.

The media spokespersons should meet as a group and with the information coordinator regularly; under certain circumstances, they may need to check with each other several times a day. Gaining the cooperation of the community in referring requests to these spokespersons is a formidable task and will require early and ongoing efforts if it is to be accomplished. It may be helpful to assure community members that it is all right to say “no” to media phone calls or requests for interviews.

The cooperation of parents is especially essential in the context of a school-based suicide cluster. Interviews with students about the suicide of one or more of their peers can be very stressful. Parents who do not wish to have their

children interviewed may be able to prevent such interviews by refusing to sign a release statement. A handout addressing how media requests should be handled might be prepared and distributed to parents, students, and other appropriate persons.

Gaining the cooperation of media representatives in this regard is also a formidable task. In the midst of a crisis, the frequent presentation of accurate and credible information is the best means of establishing such cooperation. It is preferable, however, to develop a working relationship with local media representatives before a crisis occurs.

IX. Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed.

Comment. If a particular method or site was used in previous suicides or suicide attempts, modification efforts should be addressed to these methods or sites first. For example, if the decedent(s) jumped off a particular building, bridge, or cliff, barriers might be erected to prevent other such attempts. If the decedent(s) committed suicide by carbon monoxide poisoning in a particular garage, access to that garage should be limited or monitored or both. If the decedent(s) committed suicide with a firearm or by taking an overdose of drugs, then restricting immediate access to firearms or to potentially lethal quantities of prescription drugs should be considered. In the case of suicides committed in jail, belts and other articles that may be used to commit suicide by hanging should be removed, and vigilance over the jail cells should be increased. Some of these modifications can be accomplished directly through the efforts of the coordinating committee, while others (limiting access to drugs or firearms) can only be suggested by the committee for others to consider.

Although immediate environmental modifications may be suggested by methods used in previous suicides, the modifications need not be limited only to those methods. If there is concern, for example, that the risk of suicide for particular adolescents may have been increased because of the influence of previous traumatic deaths, then common methods of suicide—firearm injury, carbon monoxide poisoning, overdose—should be made temporarily unavailable if possible. The coordinating committee should consider a variety of potentially relevant environmental factors in developing this element of the response strategy.

X. Long-term issues suggested by the nature of the suicide cluster should be addressed.

Comment. Common characteristics among the victims in a given suicide cluster may suggest that certain issues need to

be addressed by the community. For example, if the decedent(s) in a particular suicide cluster tended to be adolescents or young adults who were outside the main stream of community life, efforts might be made to bring such persons back into the community. Or, if a large proportion of the suicide attempters or completers had not been suspected of having any problems, then a system should be developed (or the present system altered) so that troubled persons could receive help before they reached the stage of overt suicidal behavior.

Communities should consider establishing a surveillance system for suicide attempts as well as completed suicides. Suicide-attempt surveillance systems are almost nonexistent; yet the benefits of such systems are potentially great. In the context of a suicide cluster, such a system would allow persons who have attempted suicide in the past to be identified. Such persons are known to be at high risk of further suicide attempts. It would also allow for ongoing identification of high-risk persons during and after the current crisis. Communities should consider establishing suicide-attempt surveillance systems in their local emergency departments or wherever appropriate.

This plan should be modified according to the community's experience with its operation. Parts of the plan that have worked well in a given setting should be stressed in the updated plan, and parts that were inapplicable or that did not work should be excluded. Finally, the Centers for Disease Control requests that communities that use the plan notify us of their experiences with the plan to allow appropriate updating of this document. Please write to:
Chief, Intentional Injuries Section Mailstop F-36 Centers for Disease Control 1600 Clifton Road NE Atlanta, GA 30333

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PART 4A.2: Sample Postvention Announcement for Clinicians

SUICIDE ANNIVERSARY ALERT

AUSTIN AREA YOUTH SUICIDE PREVENTION

To Primary Care Practitioners & Mental Health Clinicians

At the start of last school year, Austin had more youth (age 15-19) die by suicide in a 6 month period than teens of this same age died by suicide in all of 2005.
Definitions from the Centers for Disease Control, qualify this as a youth suicide cluster.*

In order to help prevent any future suicide deaths associated with the anniversary dates of these tragedies, the Austin Suicide Prevention Coalition and the Seton Shoal Creek Hospital and The Seton Family of Hospitals are asking all primary care practitioners and mental health clinicians in our area to do four things:

- **Be ALERT** to possible warning signs youth may give about their emotional state and know the risk factors and warning signs for suicide which include:
-Suicide threats –Previous suicide attempts –Alcohol & drug abuse –Suicide ideation – Sudden changes in behavior –Prolonged depression –Making final arrangements or giving away possessions – Buying a gun or stockpiling pills
- **Increase your staff's AWARENESS** that Austin youth of middle school and high school age may be of increased risk of death by suicide because of last school year's cluster and the increased risk on anniversary dates
- **Increase ACCESS** to care by giving priority access in your medical and mental health practice to middle and high school youth and their parents who may have had contact with the youth who died or who have been distraught by accounts of their deaths
- **Always ASK** about any thoughts of suicide youth may have so that immediate and appropriate referrals may be made.

With this in mind, primary care physicians and their staff have a unique opportunity to intervene with youth since many who are thinking about suicide see their primary care physician. **Please note that the majority of last school year's youth deaths by suicide were in the Central and West Austin areas where families tend to see private physicians.**

Ninety percent of those who die by suicide have an underlying mental health condition or substance abuse condition (although that condition may not be diagnosed or adequately treated). Mental health clinicians in our area are advised to make sure that **ALL of the youth they treat** have safety plans that include how to access help in an emergency from their treatment team and available and concerned adults in their life.

We also urge you to have all youth in your practice and their parents to: **"Save A Number To Save A Life"** by programing their cell phones with the **National Suicide Prevention Lifeline 1-800-273-TALK (8255)** which provides 24 hour suicide prevention services. Two other important resources available here in the Austin area for teens in crisis are **ATCHMHMR Psychiatric Emergency Services and Mobile Crisis Outreach Team 512.454.3521 as well as Seton Shoal Creek Hospital 512.324.2029.**

For more information on youth suicide prevention & postvention, (what you do AFTER a suicide to help prevent more suicide deaths), please go to the following web sites:

www.setonshoalcreek.net and www.Texasuicideprevention.org

**= anecdotal information only since official death data for 2007-2008 has not been released or confirmed and 2005 is the last year for which we have official death information.*

This community service message is brought to you by Seton Shoal Creek Hospital.

Part 4B.1: Suicide Activity Tracking Sheet – Schools

(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)
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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)

Part 4B.2: After a Suicide: Answering Questions From Students

*Listed with permission from author - Scott Poland, Ph.D.,
National Association of School Psychologists and Member
of National Emergency Assistance Team*

Overview:

The aftermath of a youth suicide is a sad and challenging time for a school. The major tasks for suicide postvention are to help your students and fellow 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%. 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.
- It is important to balance being truthful and honest without violating the privacy of the suicide victim and his/her family and to take care not to glorify their actions.
- It is important to 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.

Commonly Asked Questions and Appropriate Responses:

Why did he /she die by suicide? We are never going to know the answer to that question as the answer has died with him/her. The focus needs to be on helping you with your thoughts and feelings and everyone working together to prevent future suicides rather than explaining “why”.

What method did they use to end their life? Answer specifically with information as to the method such as he/she shot herself or died by hanging but do not go into explicit details such as what was the type of gun or rope used or the condition of the body etc.

Why didn't God stop him/her? There are varying religious beliefs about suicide and you are all free to have your own beliefs. However, many religious leaders have used the expression “ God sounded the alarm but could not stop

him/her. God has embraced them yes, and he/she is in whatever afterlife you believe in, but God is actually saddened that he/she did not stay on this earth and do God's work over their natural lifetime.”

What should I say about him/her now that they have made the choice to die by suicide? It is important that we remember the positive things about them and to respect their privacy and that of their family. Please be sensitive to the needs of their close friends and family members.

Didn't he/she make a poor choice and is it okay to be angry with them? They did make a very poor choice and research has found that many young people who survived a suicide attempt are very glad to be alive and never attempted suicide again. You have permission for any and all your feelings in the aftermath of suicide and it is okay to be angry with them.

Isn't someone or something to blame for this suicide? The suicide victim made a very poor choice and there is no one to blame. The decision to die by suicide involved every interaction and experience throughout the young person's entire life up until the moment they died 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. Everyone does the best when surrounded by friends and family who care about us and by viewing 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. Approximately 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 and save a life by getting adult help as that is what a good friend does and someday your friend will thank you.

How does the crisis hotline work? We are very fortunate in (list your city) to have a certified crisis hotline that is available 24 hours a day. The number is (list your local number). There is also a national suicide hotline and that can be reached via 1-800-273-TALK (8255).

How can I make a difference in suicide prevention? Know the warnings signs, listen to your friends carefully, do not hesitate to get adult help and, remember that most youth suicides can be prevented. High school students can volunteer and be trained to answer the Teenline. Please, contact the Houston Crisis Hotline for more information. One person can make the difference and prevent a suicide!

Where can I go for more information about preventing suicide?* Contact the American Association of Suicidology at www.suicidology.org; the American Foundation for Suicide Prevention at www.afsp.org or the Jason Foundation at www.JasonFoundation.com or the Yellow Ribbon Program at <http://www.yellowribbon.org/> or the Suicide Prevention Resource Center at www.sprc.org.

Texas also has downloadable brochures and a toolkit available at www.TexasSuicidePrevention.org.
(* More contacts added by editor to the original list by Scott Poland.)

Part 4B-3: School District Policies To

Address Suicide Postvention

Descriptions and/or policies given below come from the websites of the organizations listed as of March 2009 or have been shared by the school listed as an example for this toolkit. The policy overview and/or guidelines are selected policies or guidelines only and do not reflect the overall policy of the school or school district. Individuals desiring complete school district guidelines regarding suicide postvention should contact their individual school district and/or private school administration, psychological services or counseling departments. Updated or changed information may be posted and/or adopted after this date. (Note: Policy & guidelines from other school districts will be added to the TexasSuicidePrevention.org website as available)

CRISIS RESPONSE GUIDE: DALLAS INDEPENDENT SCHOOL DISTRICT

Selected School District Policies related to suicide prevention and postvention are given below from the Crisis Response Guide of the Dallas Independent School District, (DISD) Psychological and Social Services Department.

Reprinted with permission from Psychological and Social Services Department, DISD.

Department phone: Phone 972-925-8050 • Fax 972-794-3525

Chapter 1 Purpose of Training

The goal of this manual is to provide Psychological and Social Services staff and school counselors the information necessary to effectively implement district policy regarding the handling of potentially suicidal or violent students. It will also provide an opportunity to learn skills in assessing the risk of suicide or violence of students who are brought to the attention of a primary caregiver.

Suicide Risk Assessment

Since 1987 Dallas I.S.D. has had a comprehensive school-based program that provides suicide prevention, intervention and post-vention services. The goal of the program is to foster the safety of students by reducing the risk of suicide attempts and completions among the students of the school district. The Psychological & Social Services (PSS) department has provided training over the years to help school personnel recognize the signs of potentially self-destructive behavior, respond appropriately, and refer promptly to the necessary services. The department also provides training to counselors and other caregivers to give them the necessary skills to assess the risk of suicide and assist the student in finding options other than suicide for the relief of emotional distress. The training includes information on school policy and procedures to follow during a crisis

and how to offer supportive follow-up services until the crisis has been resolved.

Should there be a completed suicide; the department provides short-term supportive services for the family and schoolmates of the deceased. The post-vention procedures include offering consultation and guidance to administrators, teachers, and other school personnel, providing group and individual counseling to the bereaved classmates, and assisting the school in returning to its normal educational routine. A secondary goal of post-vention services is to prevent other students from choosing suicide as an option by guiding the schools to respond appropriately to the completed suicide.

School District Policy

School board policy on suicide threats and attempts and completion states:

The various student services components shall provide personnel trained in crisis intervention and suicide prevention to offer assistance to local school building staff for students in crisis. Every campus shall have a designated primary caregiver who has received approved training in suicide and crisis intervention. No suicide threat shall be ignored. A suicide threat is defined as any spoken, written, or behavioral indication of self-destructive tendencies with the intent of taking one's own life. School personnel shall take all threats seriously and shall implement the following procedures:

1. Any person on the local campus aware of a suicide threat on the part of a student shall contact the primary caregiver designated in his or her building.
2. The primary caregiver shall provide immediate crisis counseling and may, upon receipt of written consent from the parent or legal guardian, complete a suicide risk assessment to assess the risk that the student will attempt suicide. The parent or legal guardian has the right to review the screening instrument prior to its administration and may withhold consent. Such refusal to consent shall not be used to deny any right or benefit to which the student is otherwise entitled.
(LEGAL) Family Educational Rights and Privacy Act, Protection of Pupil Rights Amendment, 20 U.S.C. § 1232(g).
The suicide risk assessment may not be used as a basis for disciplinary action. The refusal to consent to a suicide risk assessment may not be used as a basis for disciplinary action.
3. All dangerous substances and/or implements shall be removed immediately from the student and the area.
4. The student shall not be left alone or returned to class unsupervised until an adult family member, preferably a guardian, has been notified and an intervention plan agreed upon.
5. The primary caregiver shall inform the building administrator of the crisis situation.
6. The primary caregiver shall report the threat to the psychological services department.
7. The primary caregiver shall request services of specialized suicide and crisis personnel through the psychological services department if the student is determined to be at high risk to attempt suicide.
8. A parent, guardian, or relative is notified of the student's threat by the primary caregiver and/or specialized suicide and crisis intervention personnel. No student is released from school prior to notification and consent of an adult family member, preferably a guardian.
9. The primary caregiver or specialized suicide and crisis intervention personnel may not transport a suicidal student to a hospital or home but may accompany a parent who assumes responsibility for transportation.

All attempted suicides shall be treated initially as medical emergencies. A suicide attempt is defined as any life-threatening behavior or gesture on the part of a student with the intent of taking his or her own life. It is not left to the discretion of school personnel to determine the seriousness of the attempt. The management of cases involving attempted suicide shall follow the procedures for threatened suicide and include the following:

1. The student's parent, guardian, or relative shall be contacted immediately, and the principal or designee shall

require that the student receive medical treatment from a physician and/or counseling from a community mental health professional.

2. If the student has ingested medication, chemical agents, or has incurred physical injury, the emergency procedure described in the FFA (REGULATION) shall be followed.
3. The department of psychological services shall be notified of all suicide attempts. The primary caregiver shall be assisted by personnel specialized in suicide and crisis intervention.
4. When the student returns to school, professional clearance from the attending physician or community mental health professional must be provided to the principal, in consultation with health services central administration.
5. Upon the student's return to school, the primary caregiver shall convene a meeting with the parents or guardian, campus administrator, nurse, and a member of the crisis team, to make recommendations regarding supportive counseling and follow-up services.

When school personnel become aware of a completed suicide by a student or faculty member in their building, the following procedures shall be followed:

1. The department of psychological services shall be notified
2. The building administrator shall consult with the District crisis specialist regarding communication with the media and dissemination of information to students, faculty, and parents.
3. The crisis team shall provide prevention strategies for students and faculty.

School board policy on threats of violence states:

If a threat of violence has been made, the primary caregiver, usually a counselor, shall, upon receipt of written consent from the parent or legal guardian complete a threat of violence risk assessment. The parent or legal guardian has the right to review the screening instrument prior to its administration and may withhold consent. Such refusal to consent shall not be used to deny any right or benefit to which the student is otherwise entitled.

(LEGAL) Family Educational Rights and Privacy Act, Protection of Pupil Rights Amendment, 20 U.S.C. § 1232(g).

The caregiver shall, as follows:

1. For threats assessed as high-risk, the caregiver shall request assistance from psychological services to determine the need for additional services.
2. For threats assessed as low to medium, the primary caregiver:
 - a. Shall develop an action plan and confer with the parent.
 - b. May also obtain consultation from psychological services as needed.

In addition to the violence risk assessment, a behavior report form shall be completed. Copies of these forms shall be placed in the counselor’s file and shall be sent to psychological services. The violence risk assessment may not be used as a basis for disciplinary action. The refusal to consent to a violence risk assessment may not be used as a basis for disciplinary action. If the police charge the student with making a terroristic threat or other offense, the student may be taken into police custody. State law requires mandatory removal of the student to an off-campus disciplinary alternative education placement. Regardless of the level of risk, no student will be left alone, returned to class unsupervised, or released from school until a parent or guardian has been notified and an intervention plan agreed upon. Student access to all dangerous implements should be removed. Regardless of the level of risk, all students making threats shall receive follow-up through the local campus student support team.

by students and school personnel to ensure safety. All threats will be taken seriously.

Determining Degree of Risk

When a primary caregiver is notified that a student is expressing suicidal thoughts/intent or is a potential harm to others, the first response is to meet with that student as quickly as possible to determine the extent of the student’s distress, if any. After meeting with the student, the next step is to contact the parent to get written consent to conduct a Suicide Risk Assessment or complete the Risk of Violence Questionnaire (RVQ) Part B. When contacting the parent the counselor makes every effort to have the parent give written consent for an assessment. If the parent gives written consent, then continue with the student interview using the Suicide Risk Assessment or Risk of Violence Questionnaire Part B to determine the level of risk. (Focus: Inform the student about parent notification)

All threats of violence must be reported to the principal

**Risk Assessment
Decision Tree**

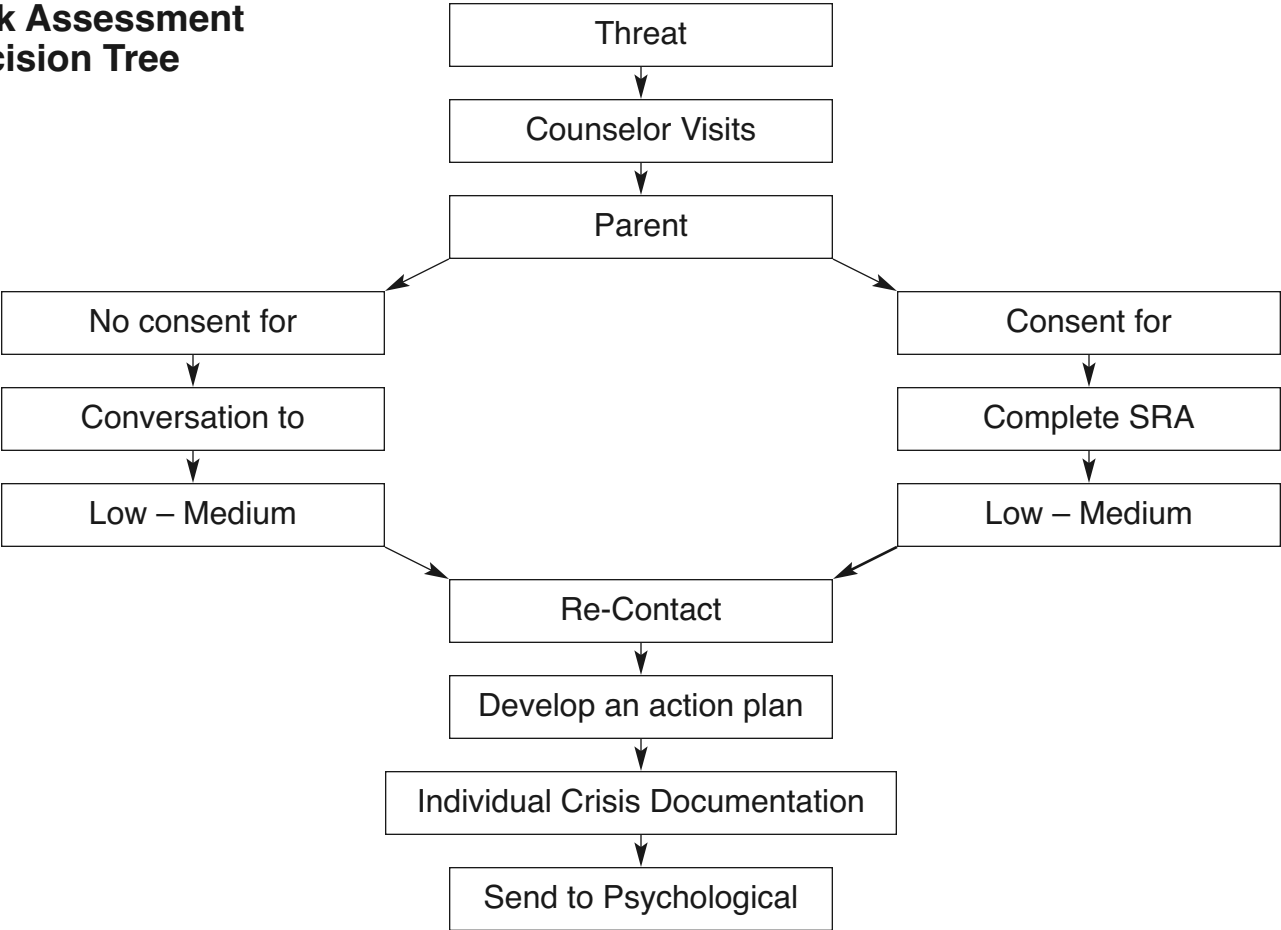


Figure 1: RISK ASSESSMENT PROCESS

Should the parent refuse the use of the SRA/RVQ instrument, then the counselor will continue the conversation with the student and determine level of risk based on their best clinical judgment. If the student is deemed to be at high risk, contact Psychological & Social Services for next steps and request that the parent transport student to an emergency care facility.

Referral to Agencies for Emergency Care

Referral to outside agencies should be made only after a risk assessment has been completed. The only exception would be if the student attempted suicide at school or prior to arriving at school. A suicide attempt on campus requires immediate referral to the nurse. Only the nurse can determine if a 911 call is necessary. Other referrals for emergency care are for students assessed as being at risk for suicide and only after consulting with Psychological & Social Services personnel. The Youth and Family Centers (YFC) are not an appropriate resource for emergency care. See procedures for referring students to YFC.

Many students who express suicidal thoughts are not at high risk for a suicide attempt. They do not need emergency services but they may need the mental health services provided by community agencies. A good rule of thumb is to give the parent at least three referral sources. Then allow the parent to choose the service that best meets the needs of their child. The parent is responsible for payment of such services.

Emergency Care of High Risk Students

The following psychiatric referral procedures are suggested for students who are assessed as high risk to attempt suicide.

1. A student who threatens suicide is referred to the primary caregiver (school counselor). The counselor conducts the initial risk assessment. If the risk for suicide is high, the counselor contacts the licensed specialist in school psychology (LSSP), visiting teacher or social worker assigned to the campus to assist with the case. Parents always have the option of choosing private or public care. The school district is not responsible for expenses incurred even if the school refers the family or takes the student to a hospital emergency room.
2. The action plan for high risk cases may include a request for further psychiatric evaluation. If the parents choose public care, refer suicidal students to the nearest psychiatric emergency room for evaluation.
 - Students 17 years or younger who are unfunded or lacking a social security number should go to Children's Medical Center emergency room.
 - Students 18 years and older should go to Parkland Hospital psychiatric emergency room.
- Provide the parent a copy of the suicide risk assessment so that they can provide it to hospital staff.
- Parents are responsible for transporting their child or adolescent to a hospital emergency room when a psychiatric evaluation is necessary. If the parents are not available the Dallas ISD police department or constable may provide transportation for a child with an APOWW (Peace Officer Application For Emergency Detention Without Warrant)
- The psychiatrist will make an assessment and will make further referrals when necessary. It is important to recognize that an evaluation by a psychiatrist is not a guarantee of hospitalization.
- The school should secure parent permission to obtain information regarding the disposition or treatment provided by the psychiatric facility by having the parent complete a release of confidential information form
3. If the student refuses treatment by a physician, or a parent cannot be located, and if there is potential danger to self or others, school officials should call Dallas ISD police at 214-932-5627 or Constable (214-415-8517 of-office hours are 11am-7pm) for assistance in transporting the student on an APPOW.
4. It is recommended parents or guardians be present at the hospital to assist with the crisis intervention process. However, under the Texas Family Code, a suicidal child or adolescent can be evaluated and treated without a parent or guardian present
5. Before sending the student and parent to the psychiatric emergency room consult with your school nurse to see if an additional medical referral is needed.
6. The *Adapt Mobil Crisis Team (1-866-260-8000)* will respond to calls from any school needing assistance with a student in an acute suicidal crisis. Reserve these requests for extreme situations when stabilization is needed.
7. If a mentally retarded student requires emergency psychiatric stabilization, the parent needs to be given a copy of the most recent Full and Individual Evaluation (FIE) and referred to Dallas Metrocare PATHWAYS 214-743-6188.
 - PATHWAYS see individuals needing emergency psychiatric evaluations Monday through Friday.
8. When the school is referring a student to the hospital, someone from the school (counselor, psychologist, visiting teacher or social worker) may accompany or meet the student and parents at the hospital.

Suicide Attempts

School policy requires that all suicide attempts be referred to the school nurse to decide if there is a medical necessity for treatment (i.e. overdose) and determine if an ambulance needs to be called. If there is no need for medical treatment the following steps should be taken:

- Either a physician or community mental health professional may see the student if there is no physical injury or medical necessity for treatment.
- Advise the parent that a signed clearance by the physician will be requested for the student to re-enter the school safely after being released from the hospital or a mental health professional after evaluation. The *Referral for Emergency Care* form should be given to the parent to take to the evaluator.

Referring High Risk Students to Youth & Family Centers

Use the following procedures when referring students who have threatened suicide or an act of violence against another student.

- Youth and Family Centers (YFC) are not an appropriate referral for emergencies. Send the suicidal or potentially violent student (and parent) to a hospital psychiatric emergency room if there is a concern for immediate danger.
- YFC may be an appropriate referral for follow-up services after the suicidal/potentially violent student has been treated on an emergency basis or for students who are assessed as low to medium risks.
- The school counselor will provide the initial crisis intervention assistance and conduct a risk assessment before sending the suicidal or potentially violent student to a Youth and Family Center.
- Referring staff (counselor, visiting teacher, social worker, or licensed specialist in school psychology) should call the appropriate YFC to see if the family can make a quick appointment. Quick is defined as within two or three days. It is not acceptable to ask a family to wait two to three weeks to be seen.
- If there is no opening on the psychiatrist's schedule, call the YFC central office at 972-502-4190. Ask for the Director. He/She will expedite an appointment in another YFC.
- Referring staff and treatment team should keep in touch to assist the school in supporting the suicidal student.

Conducting an Interview of a high risk student

Interviewing Students Threatening Suicide: Lethality = thought+ intent +plan + means

- ♦ It seems things have not been going so well for you lately. Tell me about it.
- ♦ Have you felt upset, maybe had some sad or angry feelings you have trouble talking about?
- ♦ Maybe I could help you talk about these thoughts and feelings?
- ♦ What are your thoughts about school?
- ♦ What are your thoughts about friends?
- ♦ What are your thoughts about family?
- ♦ Do you believe things can get better or are you worried things will just stay the same or get worse?

With young or withdrawn students, you may use drawings or other visual material

1. Thoughts, ideas, or intentions about suicide
 - a. Do you ever wish you were dead? Do you think about killing yourself? How often? How intense are your thoughts? Do you plan to do it or do you only think about it?
 - b. Are you thinking about suicide a lot lately?
 - c. If you killed yourself, what do you think will happen? To your family? What about to you? What do you think happens after death?
 - d. Are you the kind of person who acts quickly? Impulsively? Or, do you make plans?
 - e. What would have to happen to make you go ahead and kill yourself? Is that likely? When would that happen?
2. Plans and means to commit suicide.
 - a. Do you have an idea about how you would do it, if you kill yourself? (if the person says yes, ask more questions) What would you do? When would you do it?
 - b. Ask the person if the means are available to them. For example, do you have a gun, or pills, or a car? Do you have a way of getting a gun or pills or razor blades?
 - c. Do you think that a gun or pills or hanging would kill you?
 - d. Sometimes, when people think about dying, they make plans for their belongings or make a will. Have you done any of those things?
 - e. What do you think about death? Does it seem like a safe, comforting thing? Does death seem bad or scary?
 - f. What does your religion believe about suicide? Do you agree?
3. Personal factors and history
Some people have personalities and life histories that

make them more likely to kill themselves. To find out if someone has such a history, ask questions such as:

- a. Have you recently lost anyone or anything important to you? You may already know that the person lost a family member or possession. If not, be sure to inquire.
 - b. Have you felt like a failure lately? Has anything happened that hurt your pride?
 - c. Are you the kind of person who has to do everything right? When you don't do everything right, do you feel very bad about yourself? How are things going for you now?
 - d. Have you known anyone who killed himself or herself? Anyone who tried to? What do you think about his or her death/attempt?
 - e. Have you ever tried to kill yourself? Have you ever pretended to? Held a gun to your head or put a rope around your neck or thought about driving your car off the road into a tree?
 - f. Before you came to this school, did you ever see a doctor or go to the hospital because you were very sad? Heard or saw things others did not hear or see? Sometimes had too much energy? Did you ever feel like that – sad, or too energetic, or hearing or seeing things – without seeing a doctor?
 - g. Do you ever hear voices that tell you to do things? Do they ever tell you to hurt yourself? Kill yourself?
 - h. Has anyone in your family had those problems or seen a doctor for them?
 - i. When people drink, they often do things they wouldn't otherwise do. Find out how much the person drinks or uses drugs. When you feel very upset or sad what do you do to feel better? Sometimes, when people are very sad or nervous, they drink or use drugs to feel better? Do you ever do that? How often? Do you ever drink so much you can't remember what you did when you got high/drank?
 - j. Are you the kind of person who makes friends easily?
4. Feeling depressed and hopeless
- a. Do you ever feel that you have no reason to live?
 - b. Do you believe things will get better for you?
 - c. Do you feel you can take care of things? Make things better?
 - d. Do you think things will be better in the future?
 - e. What do you think your life will be like a year from now? Five years from now?
 - f. Do you feel good about yourself these days?

Interviewing Students Threatening Violence:

1. **Plan.** You have threatened to _____. How would you do it? What did you have in mind? What are you planning to do? When would you do it? What would you use to

do it? Who do you know that has a gun? Have you ever seen it? Do you know how to use it?

2. **Aggressive behavior.** When you get angry what do you do? Do people treat you fairly? Have you ever set a fire to things or a building?
3. **Discipline record.** Have you ever been suspended or expelled? Have your parents ever been called to school because of your behavior?
4. **Academic performance.** What grades are you making and how do you feel about them?
5. **Previous threat.** Have you ever threatened to harm anyone before?
6. **Exposure to violence.** Have you ever seen anyone killed or seriously hurt?
7. **Victim of abuse.** Has anyone ever intentionally hurt you?
8. **Cruelty to animals.** Do you have a pet or have you ever had a pet? Have you ever intentionally hurt an animal?
9. **Victim of harassment.** Has anyone ever teased or harassed you?
10. **Gang affiliation.** What gang are you a member of? Would you like to be a part of one? Do you see the gang as a source of protection?
11. **Family support.** Who in your family are you close to now? Who were you close to when you were younger?
12. **Empathy.** Is there anyone you feel sorry for? Do you ever wish you hadn't done something?
13. **Relationship skills.** Do you see yourself as having a lot of friends? Do you wish you had more? How would your friends describe you? Do you think others respect you?
14. **Preoccupation with violence.** What kind of movies or TV programs do you like to watch? Do you like to make up stories about violence or do you talk to your friends about violent stories much? Video games?
15. **Drugs.** How often do you use drugs or drink alcohol each week? How much each time?
16. **Emotional stability.** Do your moods swing from sad to happy? Describe it to me? How often?

Developing an Action Plan

The key to an effective action plan is an accurate risk assessment. Some parts of an action plan are mandated by Dallas I.S.D. policy, whereas other parts are determined by the specific needs of the student.

Mandated Components of the Action Plan: Suicide and Violence

- ◆ Parental notification
- ◆ Administrator notification: Each primary caregiver must decide upon a system of notification with their principal. For high risk students or those who have made a suicide attempt, the administrator will be

notified immediately and Psychological & Social Services (PSS).

- ♦ PSS consultation on all high risk cases involving suicidal and/or violent students, this includes suicide attempts and students who have completed suicides
- ♦ The counselor will meet with students who were referred to a community mental health facility (campus suicide attempts and high risk cases) upon their return to ascertain what continuing needs there might be.
- ♦ The counselor meets with parents to make recommendations regarding supportive counseling and follow-up services for high risk and “acting out” students
- ♦ Refer to Student Support Team (SST) all students with a violence risk referral

Optional Components of the Action Plan

- ♦ Refer to SST or other school based program
- ♦ Draft a “Safety Contract” or “No-Harm Agreement”
- ♦ Student identifies a support person at home and school
- ♦ Student checks in daily with the counselor at school
- ♦ Best practice would include a follow-up plan, even if it only entailed one additional meeting

Notification of Parents/Guardians by School Personnel

Sample opening of phone conversation: *I am calling to talk about a concern regarding your child. Today in school he/she did (Tell how the child was brought to your attention, in cases involving a violence risk the parent may already have been contacted by an administrator). In talking to him/her they disclosed that they wanted to harm themselves or someone else. District policy requires me to inform you of this threat/attempt and to ask you for written consent to further assess the risk of your son/daughter carrying out the threat. This assessment will allow me to give you a better idea of the level of risk (low – medium - high) that your child is experiencing at this time. It will also help us devise a plan to help your keep your student and other students and faculty safe.*

Additional information to give parents while on the phone depending on risk level: After talking briefly with your student it appears that he/she is at risk of carrying through on the threat. However these results are preliminary and I will need you to give me written consent to more accurately determine the level of risk. After a thorough assessment, the following may be shared.

Low Risk: Inform of risk level and suggest love, support and guidance in problem solving.

Medium Risk: Inform of risk level. Ask about how accessible weapons and other potentially lethal instruments/objects in the home are. If they are accessible, suggest that they get them out of the house or safely locked up. Give referrals for outside counseling if appropriate or requested.

High Risk: Consult with Psychological and Social Services staff if you determine the student threat to harm himself or others is imminent before re-contacting the parent. Inform the parent of risk level. Tell them that school policy requires they come up to the school at this risk level. Set up a time for them to meet you at school that same day.

Conference Tips For Counselors: It is helpful to have at the meeting two school staff members and both parents (if possible). Working in a cooperative effort to help the student should be emphasized. Parents should be made to understand the severity of the situation and provided with suggestions to increase supervision, reduce access to weapons and assist their child. Use the Student Safety Plan and Parent Conference and Agency Referral in the forms section of this document to assist in documenting this conference.

(NOTE: This is only the first chapter from the DISD Crisis Response Training manual and does not include the forms section listed below or subsequent chapters.)

FORMS:

Rapid Response Fact Sheet

Strategies for Dealing With Loss

PSS Response Team Summary Report

Principal Reminders

PSS Response Team Activity Tracker

Classroom Presentation

Sign-in Sheets

PSS Staff Script

Talking to Children about Death

For Family Members, Friends and Community

Part 4C.1: Postvention Information, Brochures, Booklists and Resources

Postvention Online

1. Information, Brochures, Booklists and Resources For Family Members Friends, and Community Members

There are roughly 32,000 suicides annually in the U.S. It is estimated that for every suicide there are 6 survivors. So, approximately 5 million Americans became survivors of suicide in the last 25 years!

Descriptions given below come from the websites of the six selected organizations listed below as of March 2009. Updated or changed information may be posted after this date, and other organizations, not listed here, offer additional resources.

1. Organization:American Association of Suicidology

<http://www.familyaware.org/brochure.php>

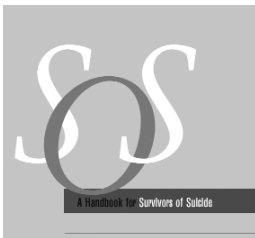
Go to: Coping after a Suicide brochure

Programs and/or Special Publications:

Survivors of Suicide Handbook

Surviving Suicide Newsletter

SOS: A Handbook for Survivors of Suicide



“The SOS Handbook is designed to be a pocket-sized, quick-reference booklet for suicide survivors. Written by fellow survivor Jeffrey Jackson, it is brief, clear, and packed with essential information covering nearly every aspect of the survivor ordeal — from the emotional roller-coaster, to the elusive quest for “Why?”, to how to find support groups in your area.”



Surviving Suicide

Surviving Suicide is a newsletter written by and for survivors of suicide. To subscribe without a membership, please the contact central office of American Association of Suicidology.

2. Organization: American Foundation for Suicide Prevention

<http://www.afsp.org/>

Go to: “Surviving Suicide Loss on the web site

Programs and/or Special Publications:

1. Survivors After Suicide Listserv (can sign up online)
2. Online Resources & Brochures for Survivors
3. Annual National Suicide Survivors Teleconference with past conference video presentations available on line

Surviving After Suicide Brochure

Clear, basic information on coping with suicide loss and survivor support.

Can be ordered from AFSP for \$0.25 each.

“Surviving a Suicide Loss: A Resource and Healing Guide is designed to help survivors navigate the experience of losing a loved one to suicide. The guide includes practical information about coping with suicide loss, personal survivor stories, articles on bereavement, resource listings and an extensive bibliography. This resource guide was designed and printed with grants from the Paul R. Blattberg Memorial Fund; Lisa Sallow, family and friends, in loving memory of her son, Josh Sallow; and Beverly Wool, family and friends, in loving memory of her daughter, Deborah Wool.”

Surviving a Suicide Loss—An Online Financial Guide

(can also be ordered as a brochure)

<http://www.afsp.org/financialguide/>

“As a survivor of suicide loss, you should know that you are not alone. Each year, approximately 30,000 people in the United States die by suicide—that’s about one every 18 minutes. Devastated family and friends are left behind to try to make sense of it.

As you try to make sense of your own loss, you face a complicated mix of emotional and practical issues. The load may seem overwhelming at times. The American Foundation for Suicide Prevention (AFSP) can help lighten that load. AFSP and its Survivor Council, in collaboration with the National Endowment for Financial Education, developed this Web site to help you with one of the most important practical matters survivors face—personal finances.”

Additional Resources Given in the Online Financial Guide include:

“Survivors Benefits,” Social Security Administration Publication No. 05-10084, August 2001. Available at www.socialsecurity.gov.

FirstGov for Consumers; www.consumer.gov.

Internal Revenue Service Taxpayer Advocate Service, 1-877-777-4778; www.irs.gov/advocate. This division assists

taxpayers who might suffer a significant hardship as a result of tax laws.

National Foundation for Credit Counseling, 801 Roeder Road, Suite 900, Silver Spring, MD 20910, 1-800-388-2227; www.nfcc.org.

National Endowment for Financial Education, 5299 DTC Boulevard, Suite 1300, Greenwood Village, CO 80111; www.nefe.org.

Social Security Administration, 1-800-772-1213; www.socialsecurity.gov. Benefits, depending on eligibility, may include a one-time death payment; widow/widower payments; child payments, which are made to a surviving spouse with dependent children; and dependent parent payments.

Description from website:

“AFSP reaches out to survivors of suicide with two goals in mind:

- To offer the support that is so vital, particularly to the newly bereaved; and
- To provide opportunities for survivors to get involved, through a wide variety of educational, outreach, awareness, advocacy and fundraising programs”

3. Organization: Families for Depression Awareness

<http://www.familyaware.org/brochure.php>

Go to: Coping after a Suicide brochure

Programs and/or Special Publications:

Coping after a Suicide brochure.

Information to help family and friends of a loved one who has taken their own life.

Descriptions from website:

“Coping After the Suicide of a Loved One”

“If you have lost a loved one to suicide, the first thing you should know is that you are not alone. Over 30,000 people take their own lives each year. This is devastating for the loved ones they leave behind. There are millions like you, known as “suicide survivors” and are trying to cope with this overwhelming loss. Your reactions and feelings to this sudden and terrible death are completely valid. Our resources below can help you through this difficult journey.



90% of people who take their life have a mental illness, usually a depressive disorder. And depression runs in families.

Our free brochure, *Coping after a Suicide* can provide you with important information to help you and your loved ones understand suicide, grief and depression.”

4. Organization: Centre For Suicide Prevention

<http://www.suicideinfo.ca/>

Go to: Book Lists

<http://www.suicideinfo.ca/csp/go.aspx?tabid=14>

Description from website:



What is SIEC?

The Suicide Information and Education Collection is the world's largest English language collection of materials on suicide and suicidal behaviours with more than 37,000 references to print and audiovisual resources on prevention, intervention,

and postvention.

Established in 1982, the Centre for Suicide Prevention can provide you with the information you need from the SIEC Library to develop suicide prevention, intervention and postvention programs. Statistical information, key resource people, computer literature searches, and document delivery are just some of the resources we can offer you.

The SIEC database is updated regularly. The Centre has a

prompt turnaround time for computer search and document delivery services.

Downloadable Book Lists for:

Books for Families and Friends:

Mental Health Issues and Suicide Prevention

- ➡ *Adolescent Suicide & Mental Health: Books for Parents*
- ➡ *After Suicide Attempt: Books for Attempters and Their Caregivers*
- ➡ *Books for Adolescents: Mental Health Issues/Suicide Prevention*
- ➡ *Information About Depression: Books for Families and Friends*
- ➡ *Mental Health Issues/Suicide Prevention: Books for Family and Friends*

Books for Families and Friends

Bereavement, Grief & Loss

- ➡ *Bereavement Grief & Loss: Books for Adolescents*
- ➡ *Bereavement Grief & Loss: Books for Children*
- ➡ *Bereavement, Grief & Loss: Workbooks for Children and Adolescents*
- ➡ *Child Bereavement, Grief and Loss: Books for Parents and Caregivers*
- ➡ *Child Loss: Books for Families and Friends*
- ➡ *Parental Loss: Books for Families and Friends*
- ➡ *Sibling Loss: Books for Families and Friends*
- ➡ *Spousal Loss: Books for Families and Friends*

5. Organization: National Alliance on Mental Illness, New Hampshire

http://www.naminh.org/frameworks_community_protocols.php

Go to: NAMI, New Hampshire <http://naminh.org/index.php>


and then to Connect: Frameworks, Protocols

http://www.naminh.org/frameworks_community_protocols.php


Programs and/or Special Publications:

“Learning how we can work together to prevent and respond to suicide has made us a stronger, more compassionate community.”

Connect is a designated national Best Practice developed by




NEW HAMPSHIRE



Training Professionals & Communities in Suicide Prevention & Response

15 Green Street, Concord, NH 03301

Non-Profit
101 Purpose
PAID
Concord, NH
Permit No. 2348



Training Professionals & Communities in Suicide Prevention & Response

It takes a community to prevent suicide

Connect is a designated national Best Practice developed by NAMI NH

recognize

Do you know how to respond to suicide thoughts, threats, attempts or deaths?

For comprehensive information
see www.ConnectProject.org or call
1 800 225 5359

Connect is designated as a national Best Practice Program that increases the competence and confidence of professionals and communities to respond to suicide incidents across the lifespan. This community-based approach focuses on prevention (education about early recognition), intervention (skills for responding to attempts, thoughts, and threats of suicide) and postvention (promoting healing and reducing risk after a suicide).

connect

1. Recognize.

Our training for key service providers, stakeholders and individuals promotes early recognition and intervention of mental illness, substance use and other conditions that increase the risk for suicide. Our community-based—i.e., town, campus, school system, faith groups or military—model improves understanding that each individual and community has unique risk and protective factors that impact suicide prevention, intervention and response.

connect

2: Connect.

Guided by best practice protocols, participants learn how to connect with individuals at risk and connect them to a qualified health care provider who can assess their risk.

They also learn how to connect with each other and work together on community risk and protective factors, coordination of services, and improved access to care to prevent suicide.

3. Communicate.

By strengthening relationships and enhancing communication among key service providers, our training programs encourage an integrated and coordinated response. The **Connect** approach promotes messages that improve attitudes toward mental health care and help-seeking behavior. It also stresses safe messaging guidelines to promote responsible media reporting of suicide and increases public awareness of suicide as a public health issue.

We can tailor training.

Specialized training and consultation is available to gatekeepers, educators, law enforcement, faith leaders, social service agencies, emergency departments, mental health and healthcare providers, military, and domestic violence groups.

Train-the-trainer services to expand the benefits of **Connect**, conference presentations, and customized training and consultation are available. Topics include suicide prevention—the media and communication technologies, age and cultural aspects of suicide prevention, and training survivors as speakers and advocates.

Connect: Framework Community Protocols Recognize, Connect! Frameworks Suicide Prevention Project

“The Frameworks Project has developed comprehensive **Best Practice** protocols targeted to community stakeholders in the following areas (as well as protocols for prevention and intervention). Although the protocols are copywritten and cannot be copied and distributed without an agreement with NAMI-New Hampshire, they can be viewed online and used to help inform an appropriate school and community response.”

“Postvention - Community Response to Suicide

- Law Enforcement
- Emergency Medical Services and First Responders (Fire/Ambulance)
- Medical Examiner
- Gatekeepers
- Immediate Family
- Students/Teens/Young Adults
- Clergy/Faith Communities
- Funeral Directors
- Mental Health/Substance Use Provider (Public and Private)
- Education
- Social Service Agencies
- Community Coordinators

Information on training packages based on these protocols can be found on the website or by contacting NAMI, New Hampshire, Frameworks directly edemello@naminh.org. Training packages tailored to meet the individual needs of your agency, organization, community, or state.

The Frameworks Protocols are copyrighted and may only be used as part of an approved Frameworks Training, or with permission from NAMI NH. New Hampshire residents interested in the protocols may contact NAMI NH for samples.”

6. Organization: Suicide Prevention Resource Center <http://www.sprc.org/>

Go to: “Select Your Role” at the pull down menu in upper right corner of the web site or search the library or best practice registry.

<http://library.sprc.org/>

Programs and/or special publications.

“The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention.” Extensive fact sheets are available from the pull down menu as well as a best-practice registry, online library and SPRC publications.

A “postvention” query to the SPRC library resulted in the following articles and links.

Managing sudden traumatic loss in the schools

URL: http://www.psych.com/pdfs/Loss_article.pdf

The following link is to an excerpt from Managing Sudden Traumatic Loss in the Schools by Maureen Underwood & Dunne-Maxim, K. It was written for school staff to facilitate their understandings of the complexities of grief that might be observed in school populations, which is why clinical language has been omitted. (Description from the PsyBC web site)

[Show details](#)

Suicide contagion

URL: <http://suicideandmentalhealthassociationinternational.org/suiconclust.html>

This article defines the terminology of suicide contagion and answers basic questions about the phenomena of suicide clusters.

[Show details](#)

Youth suicide prevention, intervention & postvention

guidelines: A resource for school personnel

URL: <http://www.maine.gov/suicide/docs/guidelines.pdf>

The intent of this document is to: a) understand the nature of youth suicide; b) establish school-based protocols for suicide prevention, crisis intervention and postvention; c) build connections within a community and among regional support services; and d) educate school personnel, parents and students about effective suicide prevention and intervention.

Please note: the PDF takes a minute or two to load.

[Show details](#)

Media guidelines for school administrators who may interact with reporters about youth suicide

URL: <http://www.maine.gov/suicide/professionals/program/mediaschool.htm>

Explores how media accounts can actually serve as a suicide prevention tool.

[Show details](#)

C.2: National Suicide Prevention Lifeline Wallet Card

Suicide Prevention and Postvention Wallet Card. Go to:

<http://www.suicidepreventionlifeline.org/media/pdf/NSPL%20Wallet%20Card.pdf>

Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Are you or
someone you love
at risk of suicide?

NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org



Get the facts and take
appropriate action.

Part 4D: Media Guidelines

Based on Best Practices for News Coverage

(Including sample news releases)

When communities need to answer media queries with a formal briefing because of a cluster or contagion in their community, it is best to discuss media guidelines with them prior to the news conference to enlist their support.

1. Media Guidelines

For the Media

Reporting on Suicide:



Recommendations for the Media

American Foundation for
Suicide Prevention
American Association of
Suicidology
Annenberg Public Policy Center

Suicide Contagion is Real

...between 1984 and 1987, journalists in Vienna covered the deaths of individuals who jumped in front of trains in the subway system. The coverage was extensive and dramatic. In 1987, a campaign alerted reporters to the possible negative effects of such reporting, and suggested alternate strategies for coverage. In the first six months after the campaign began, subway suicides and non-fatal attempts dropped by more than eighty percent. The total number of suicides in Vienna declined as well.^{1,2}

Research finds an increase in suicide by readers or viewers when:

- The number of stories about individual suicides increases^{3,4}
- A particular death is reported at length or in many stories^{3,5}
- The story of an individual death by suicide is placed on the front page or at the beginning of a broadcast^{3,4}
- The headlines about specific suicide deaths are dramatic³ (A recent example: “Boy, 10, Kills Himself Over Poor Grades”)

Recommendations

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.^{1,2}

- Certain ways of describing suicide in the news contribute to what behavioral scientists call “suicide contagion” or “copycat” suicides.^{7,9}
- Research suggests that inadvertently romanticizing suicide or idealizing those who take their own lives by portraying suicide as a heroic or romantic act may encourage others to identify with the victim.⁶
- Exposure to suicide method through media reports can encourage vulnerable individuals to imitate it.¹⁰ Clinicians believe the danger is even greater if there is a detailed description of the method. Research indicates that detailed descriptions or pictures of the location or site of a suicide encourage imitation.¹
- Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.⁶

Suicide and Mental Illness

Did you know?

- Over 90 percent of suicide victims have a significant psychiatric illness at the time of their death. These are often undiagnosed, untreated, or both. Mood disorders and substance abuse are the two most common.¹¹⁻¹⁵
- When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.^{14,15}
- Research has shown that when open aggression, anxiety or agitation is present in individuals who are depressed, the risk for suicide increases significantly.¹⁶⁻¹⁸

The cause of an individual suicide is invariably more complicated than a recent painful event such as the break-up of a relationship or the loss of a job. An individual suicide cannot be adequately explained as the understandable response to an individual’s stressful occupation, or an individual’s membership in a group encountering discrimination. Social conditions alone do not explain a suicide.¹⁹⁻²⁰ People who appear to become suicidal in response to such events, or in response to a physical illness, generally have significant underlying mental problems, though they may be well-hidden.¹²

Questions to ask:

- Had the victim ever received treatment for depression or any other mental disorder?
- Did the victim have a problem with substance abuse?

Angles to pursue:

- Conveying that effective treatments for most of these conditions are available (but underutilized) may encourage those with such problems to seek help.
- Acknowledging the deceased person's problems and struggles as well as the positive aspects of his/her life or character contributes to a more balanced picture.

Interviewing Surviving Relatives and Friends

Research shows that, during the period immediately after a death by suicide, grieving family members or friends have difficulty understanding what happened. Responses may be extreme, problems may be minimized, and motives may be complicated.²¹

Studies of suicide based on in-depth interviews with those close to the victim indicate that, in their first, shocked reaction, friends and family members may find a loved one's death by suicide inexplicable or they may deny that there were warning signs.^{22,23} Accounts based on these initial reactions are often unreliable.

Angles to Pursue:

- Thorough investigation generally reveals underlying problems unrecognized even by close friends and family members. Most victims do however give warning signs of their risk for suicide (see [Resources](#)).
- Some informants are inclined to suggest that a particular individual, for instance a family member, a school, or a health service provider, in some way played a role in the victim's death by suicide. Thorough investigation almost always finds multiple causes for suicide and fails to corroborate a simple attribution of responsibility.

Concerns:

- Dramatizing the impact of suicide through descriptions and pictures of grieving relatives, teachers or classmates or community expressions of grief may encourage potential victims to see suicide as a way of getting attention or as a form of retaliation against others.
- Using adolescents on TV or in print media to tell the stories of their suicide attempts may be harmful to the adolescents themselves or may encourage other vulnerable young people to seek attention in this way.

Language

Referring to a "rise" in suicide rates is usually more accurate than calling such a rise an "epidemic," which implies a more dramatic and sudden increase than what we generally find in suicide rates.

Research has shown that the use in headlines of the word suicide or referring to the cause of death as self-inflicted increases the likelihood of contagion.³

Recommendations for language:

- Whenever possible, it is preferable to avoid referring to suicide in the headline. Unless the suicide death took place in public, the cause of death should be reported in the body of the story and not in the headline.
- In deaths that will be covered nationally, such as of celebrities, or those apt to be covered locally, such as persons living in small towns, consider phrasing for headlines such as: "Marilyn Monroe dead at 36," or "John Smith dead at 48." Consideration of how they died could be reported in the body of the article.
- In the body of the story, 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.
- Contrasting "suicide deaths" with "non-fatal attempts" is preferable to using terms such as "successful," "unsuccessful" or "failed."

Special Situations

Celebrity Deaths

Celebrity deaths by suicide are more likely than non-celebrity deaths to produce imitation.²⁴ Although suicides by celebrities will receive prominent coverage, it is important not to let the glamour of the individual obscure any mental health problems or use of drugs.

Homicide-Suicides

In covering murder-suicides be aware that the tragedy of the homicide can mask the suicidal aspect of the act. Feelings of depression and hopelessness present before the homicide and suicide are often the impetus for both.^{25,26}

Suicide Pacts

Suicide pacts are mutual arrangements between two people who kill themselves at the same time, and are rare. They are not simply the act of loving individuals who do not wish to be separated. Research shows that most pacts involve an individual who is coercive and another who is extremely dependent.²⁷

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Reporting on Suicide: Recommendations for the Media

American Foundation for
Suicide Prevention
American Association of
Suicidology
Annenberg Public Policy Center

Developed in collaboration with:

Centers for Disease Control and Prevention
National Institute of Mental Health
Substance Abuse and Mental Health Services
Administration
Office of the Surgeon General
American Foundation for Suicide Prevention
American Association of Suicidology
Annenberg Public Policy Center

These recommendations were produced in the spirit of the public-private partnership recommended by the Surgeon General's National Strategy for Suicide Prevention. We would like to thank the many journalists and news editors who assisted us in this project. The Annenberg Public Policy Center's involvement was funded by the Robert Wood Johnson Foundation.

Resources: United States

- Centers for Disease Control and Prevention
- National Institute of Mental Health
nimhpress@nih.gov
- Substance Abuse and Mental Health Services
Administration

- Office of the Surgeon General
- National Strategy for Suicide Prevention
- American Association of Suicidology
- American Foundation for Suicide Prevention

International

- Canterbury Suicide Project (New Zealand)
- National Centre for Suicide Research and Prevention of Mental-III Health (Sweden)
- National Youth Suicide Prevention Project (Australia)
- Centre for Suicide Prevention
- World Health Organization



At-a-Glance: Safe Reporting on Suicide

Research indicates that the way suicide is reported in the media can contribute to additional suicides and suicide attempts. Conversely, 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. The following recommendations have been developed to assist reporters and editors in safe reporting on suicide.

For Reporters

What to Avoid

- *Avoid detailed descriptions of the suicide, including specifics of the method and location.*
Reason: Detailed descriptions increase the risk of a vulnerable individual imitating the act.
- *Avoid romanticizing someone who has died by suicide. Avoid featuring tributes by friends or relatives. Avoid first-person accounts from adolescents about their suicide attempts.*
Reason: Positive attention given to someone who has died (or attempted to die) by suicide can lead vulnerable individuals who desire such attention to take their own lives.
- *Avoid glamorizing the suicide of a celebrity.*
Reason: Research indicates that celebrity suicides can promote copycat suicides among vulnerable people. Do not let the glamour of the celebrity obscure any mental health or substance abuse problems that may have contributed to the celebrity's death.
- *Avoid oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable.*
Reason: Research shows that from 60–90 percent of suicide victims have a diagnosable mental illness and/or substance use disorder. People whose suicide act appears to be triggered by a particular event often have significant underlying mental health problems that may not be readily evident, even to family and friends. Studies also have found that perpetrators of murder-suicides are often depressed, and that most suicide pacts involve one individual who is coercive and another who is extremely dependent.
- *Avoid overstating the frequency of suicide.*
Reason: Overstating the frequency of suicide (by, for example, referring to a “suicide epidemic”) may cause vulnerable individuals to think of it as an accepted or normal response to problems. Even in populations that

have the highest suicide rates, suicides are rare.

- *Avoid using the words “committed suicide” or “failed” or “successful” suicide attempt.*
Reason: The verb “committed” is usually associated with sins or crimes. Suicide is better understood in a behavioral health context than a criminal context. Consider using the phrase “died by suicide.” The phrases “successful suicide” or “failed suicide attempt” imply favorable or inadequate outcomes. Consider using “death by suicide” or “non-fatal suicide attempt.”

What to Do

- *Always include a referral phone number and information about local crisis intervention services.*
Refer to: The National Suicide Prevention Lifeline toll-free number, 1-800-273-TALK (273-8255), which is available 24/7, can be used anywhere in the United States, and connects the caller to a certified crisis center near where the call is placed. More information can be found on the National Suicide Prevention Lifeline website: www.suicidepreventionlifeline.org
- *Emphasize recent treatment advances for depression and other mental illness. Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.*
Refer to: Suicide Prevention Resource Center's research and news briefs: www.sprc.org/news/research.asp
- *Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.*
Refer to: The American Foundation for Suicide Prevention's “Talk to the Experts” page: www.afsp.org, view *About Suicide*, click on *For the Media* to locate the *Talk to the Experts* section.

Continued ►►

Suicide Prevention Resource Center ♦ www.sprc.org ♦ 1-877-GET SPRC (1-877-438-7772)
Education Development Center, Inc. ♦ 55 Chapel Street, Newton, MA 02458-1060

For Reporters *(Continued)*

Reporters may also contact the Suicide Prevention Resource Center at 1-877-GET-SPRC (438-7772), the American Association of Suicidology at (202) 237-2280, or the Suicide Prevention Action Network USA at (202) 449-3600.

- *Emphasize decreasing trends in national suicide rates over the past decade.*

Refer to: CDC's (Centers for Disease Control and Prevention) WISQARS (Web-based Injury Statistics Query and Reporting System): www.cdc.gov/ncipc/wisqars/ or talk with an expert (see previous recommendation).

- *Emphasize actions that communities can take to prevent suicides.*

Refer to: CDC Recommendations for a Community

Plan for the Prevention and Containment of Suicide Clusters: wonder.cdc.gov/wonder/PrevGuid/p0000214/p0000214.asp

Best Practices Registry for Suicide Prevention: www.sprc.org/featured_resources/bpr/index.asp

- *Report on activities coordinated by your local or state suicide prevention coalition.*

Refer to: Your state suicide prevention contact will be able to tell you if there are local groups or organizations providing suicide prevention training in your community. See the Suicide Prevention Resource Center's State Suicide Prevention webpages: www.sprc.org/stateinformation/index.asp

For Editors

What to Avoid

- *Avoid giving prominent placement to stories about suicide. Avoid using the word "suicide" in the headline.*

Reason: Research shows that each of the following lead to an increase in suicide among media consumers: the placement of stories about suicide, the number of stories (about a particular suicide, or suicide in general), and dramatic headlines for stories. Using the word "suicide" or referring to the cause of death as "self-inflicted" in headlines increases the likelihood of suicide contagion.

- *Avoid describing the site or showing pictures of the suicide.*

Reason: Research indicates that such detailed coverage encourages vulnerable people to imitate the act.

What to Do

- *Suggest that all reporters and editors review Reporting on Suicide: Recommendations for the Media. These guidelines for responsible reporting of suicide were developed by a number of Federal agencies*

and private organizations, including the Annenberg Public Policy Center.

Refer to: www.afsp.org, view *About Suicide*, click on *For the Media* section

- *Encourage your reporters to review examples of good and problematic reporting of suicide.*

Refer to: The American Foundation for Suicide Prevention's website: www.afsp.org, view *About Suicide*, click on *For the Media* section

- *Include a sidebar listing warning signs, or risk and protective factors for suicide.*

Refer to: American Association of Suicidology's warning signs: www.sprc.org/library/helping.pdf

National Strategy for Suicide Prevention's risk and protective factors: www.sprc.org/library/srisk.pdf

National Institute of Mental Health, Suicide Prevention: www.nimh.nih.gov/topics/suicide-prevention.shtml

The recommendations in this publication were adapted in 2005, from *Reporting on Suicide: Recommendations for the Media*, a 2001 report by the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center. www.afsp.org, view *About Suicide*, click on *For the Media* section.

We would like to acknowledge Madelyn Gould of Columbia University for her many contributions to this document. Additionally, we thank Lanny Berman, Lidia Bernik, Ann Haas, Karen Marshall, and Dan Romer for their input.

www.sprc.org

Created 2005 - Updated 2007

Part 4D.2: Sample News Release on Community Postvention Effort

Youths and Families Get Community Support to Stop Travis County Teen Suicides

Contact: Mental Health America of Texas Communications Director, (512) 454-3706 x 218
Seton/Shoal Creek Marketing Outreach Coordinator, (512) 324-2063

AUSTIN, TX (February 11, 2008)—Austin area school, health and mental health officials are mobilizing community efforts to prevent a youth suicide cluster in Travis County. When youth suicides or attempted suicides occur closer together in space and time than is considered usual for the community, it is considered a suicide cluster. Clusters can put at-risk students in jeopardy of death by suicide because some youths may have a tendency to identify with destructive solutions adopted by the person who has attempted or has died by suicide.

“From July to November of 2007, anecdotal information on suicide deaths for youths aged 15-19 in Travis County indicates there were five deaths by suicide for youths of this age. There has also been another death within recent weeks and yet another youth has been hospitalized and is in critical condition from a suicide attempt only days ago. This anecdotal information compares with only four deaths for this age group in all of 2005, the last year for which we have official death data,” said Merily Keller, co-chair of the Texas Suicide Prevention Council.

“It is important to understand that a suicide cluster may involve not just children or adolescents who know one another. Young people who are far removed from or entirely unknown to suicide victims may identify with their behavior and resort to suicide as a result,” said David Evans, Executive Director of Austin-Travis County MHMR Center.

Representatives from Austin-Travis County MHMR, Austin Independent School District (AISD), Austin PTA Council, Austin-Travis County Suicide Prevention Coalition, Mental Health America of Texas, Seton Shoal Creek Hospital, A member of the Seton Family of Hospitals and St. David’s HealthCare are on heightened alert that a large number of young people are dying by suicide in the Austin area. These organizations are leading the charge to increase public awareness about suicide prevention in an effort to save the lives of young people in the Austin-Travis County area. They are preparing doctors, students, school staff, parents, faith leaders and others who work with young people how to identify symptoms of suicide, know what actions to take if a person is suicidal and where to get help.

“To help address and answer questions students may have about suicide and other mental health issues, Mental Health America of Texas, National Alliance on Mental Illness Austin and Depression Bipolar Alliance-Texas, Austin Area PTA and the Jason Foundation at The Oaks Treatment Center is creating Suicide Prevention/ Mental Health Wellness resource centers in AISD high school libraries,” said Mary Ellen Nudd, vice president of Mental Health America of Texas. “Students can access print copies of the materials during campus library hours. Many of the materials are also available through the provider organization’s websites.”

“These centers will have materials targeted to teens and their parents. The centers will include brochures, books, posters and bookmarks that highlight youth mental health and mental illnesses, depression and suicide prevention. The information will be readily accessible for students and family members to take with them,” said Charlotte Winkelmann, assistant director of Student Support Services at AISD.

“It is imperative for all parents, educators, youth leaders, faith leaders, medical and mental health clinicians to know the warnings signs for suicide and talk to young people about the importance of seeking help for themselves or friends who have suicidal thoughts—especially since a young person is often the first to know that another youth is considering death by suicide,” Sherry Blyth, Associate Director of Crisis Services at Austin-Travis County Mental Health Mental Retardation Center (MHMR).

Some Warning Signs That A Person May Be Suicidal:

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person
- Hopelessness or feeling no reason for living; no sense of purpose in life
- Increased irritability, rage, or uncontrolled anger

2-Sample News Release

- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there’s no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- The more “clues or warning signs,” a person exhibits, the higher their risk of suicide.

Some Ways to Be Helpful to Someone at Risk of Death by Suicide

- Be aware. Learn the warning signs.
- Ask the person if they are thinking about suicide. Talking about suicide does not cause someone to be suicidal.
- Be willing to listen. Allow for expression of feelings. Accept the feelings.
- Don’t be judgmental, lecture on the value of life or debate whether suicide is right or wrong.
- Don’t be sworn to secrecy. Seek support.
- Offer hope that alternatives and treatment are available.
- “Don’t leave them alone!” Take action! Remove means (weapons, pills, poison, etc.) and get help from individuals or agencies specializing in crisis intervention and suicide prevention.

Some People or Places Who Can Help in a Crisis

- A community MHMR or health center
- A school counselor
- A suicide prevention/crisis intervention center
- Psychiatrist, psychologist, or therapist, or other mental health professional
- A doctor
- A religious/spiritual leader

In January 2008, as officials recognized the possibility of a youth suicide cluster in Travis County, American Foundation for Suicide Prevention-Central Texas and Austin-Travis County MHMR with support from Seton Shoal Creek Hospital and other community groups brought in a national suicide postvention expert to work citywide with more than 300 mental health professionals and primary care doctors, AISD counselors and staff as well as parents and interested community members on suicide prevention methods to stop the cluster from becoming a contagion and postvention methods to address the current suicides in the community. Key stakeholders have continued to meet to develop postvention protocols based on national guidelines to share with area school, city, county, medical, faith and other groups since many of the recommendations are counter-intuitive but essential safety procedures.

“Postvention is an important intervention conducted after a suicide, largely to support and debrief those affected; and reduce the possibility of suicide contagion,” said Paul Whitelock, MD, medical director at Seton Shoal Creek Hospital. “Postvention procedures help to recognize those bereaved by suicide that may be vulnerable to suicidal behavior themselves and may develop complicated grief reactions. Postvention also helps alleviate the distress of bereaved individuals, reduces the risk of imitative suicidal behavior, and promotes the healthy recovery of the affected community.”

“Of those who die by suicide most have an underlying mental health or substance abuse condition,” said Keller. “The majority of suicidal individuals do not want to die; they just want their emotional pain to stop. Take all suicidal talk seriously and take action to get that person to help.

For more information on suicide prevention in Texas please go to www.TexasSuicidePrevention.org. If you or someone you know is in crisis and needs help, please call 1-800-273-TALK (8255), the National Suicide Prevention Lifeline. Locally, individuals can access help at Austin-Travis County MHMR Psychiatric Emergency Services/Mobile Crisis Outreach at 512-454-3521 or Seton Shoal Creek Hospital at 512-324-2029 or by calling 911.

2-Sample News Release

Interviews with the following individuals available:

(Note: They will speak at the news conference in the order in which they are listed below.)

1. **David Evans**, Executive Director of Austin Travis County MHMR will open the conference and discuss the national and local suicide statistics and discuss ATCMHMR's response to this suicide cluster.
2. **Merily Keller**, Co-chair, Texas Suicide Prevention Council and co-facilitator, Austin-Travis County suicide prevention coalition will discuss the need for a city-wide Postvention Plan and share media guidelines for reporting on suicide. She will explain postvention and why it could help prevent more teen suicides.
3. **Sherry Blyth**, Associate Director of Crisis Services at Austin-Travis County Mental Health Mental Retardation Center (MHMR) will discuss how Texans can access crisis suicide prevention help from their local MHMRs and how Psychiatric Emergency Services and mobile outreach works in Austin/Travis County.
4. **Paul Whitelock, MD**, Medical Director for Seton Shoal Creek Hospital will talk about Suicide warning signs and discuss how parents and teens can access help at Seton Shoal Creek.
5. **Charlotte Winkelmann**, Assistant Director, Student Support Services at Austin Independent School District (AISD), will share the district's response to suicide prevention and discuss how parents and youth can help prevent deaths by suicide.
6. **Mary Ellen Nudd**, Vice-President Mental Health America of Texas (MHAT) will talk about public awareness resources available on suicide prevention including web based resources and recognize the contributions that local organizations MHAT, NAMI, Austin PTA, The Jason Foundation and DBSA will make to help AISD with mental health resources for libraries.

Note: We will have some long term survivors of the loss of a youth family member to suicide available to talk to the press at the news conference, but we ask that you do not try to contact recent survivors of a suicide loss since that could add to their distress.

ADDITIONAL INFORMATION:

Suicide cluster vs. suicide contagion:

When youth suicides or attempted suicides occur closer together in space and time than is considered usual for the community, it is considered a suicide cluster. In a suicide contagion, the deaths are connected by person, place or time.

Suicide postvention community goals:

Reduce the risk of further suicidal behavior
Avoid glorifying or sensationalizing the suicide
Avoid vilifying the decedent
Identify youth that may represent a high risk for suicidal behavior
Connect at-risk youth with mental health resources
Identify/alter environmental factors that may be influencing the process of contagion
Provide long-term surveillance

Rationale for the development of a community postvention plan:

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 community agency has the resources or expertise to adequately respond to an emerging suicide cluster. Suicide is a complex issue; preventing suicide will require a coordinated community effort.

Resources for explanations given above: Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, August, 19, 1988, Vol.37, No.SU-06

Postvention: Community Response to Suicide. New Hampshire National Alliance for the Mentally Ill, 2005.

DEVELOPMENT OF A COMMUNITY POSTVENTION PLAN

(Media Handout for News Conference)

A postvention is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). Family and friends of the suicide victim may be at increased risk of suicide themselves.

The aim is to support and debrief those affected; and reduce the possibility of suicide contagion. Interventions recognize that those bereaved by suicide may be vulnerable to suicidal behavior themselves and may develop complicated grief reactions.

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).

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 community agency has the resources or expertise to adequately respond to an emerging suicide cluster.

**Suicide is a complex issue;
preventing suicide will require a coordinated community effort.**

COMMUNITY POSTVENTION EFFORTS SHOULD BE MOBILIZED:

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

DEFINITIONS:

- **Suicide Contagion:** The process in which suicidal behavior is initiated by one of more individuals, following the awareness of a recent suicide threat, attempt or completion, or a fictional depiction of such behavior.
- **Suicide Cluster:** A group of suicides or suicide attempts, or both, that occurs closer in time and space than would normally be expected in a given community.
- **Copy Cat Suicide:** When a person copies the manner of death of another person.

COMMUNITY POSTVENTION GOALS:

1. Reduce the risk of further suicidal behavior.
2. Avoid glorifying or sensationalizing the suicide.
3. Avoid vilifying the decedent.
4. Identify youth that may represent a high risk for suicidal behavior.
5. Connect at-risk youth with mental health resources.
6. Identify/alter environmental factors that may be influencing the process of contagion.
(Note: These might include policies for all memorials to be held off school campuses; sharing of information and hotlines for suicide prevention provided at funerals; emphasis on prevention and non-sensationalizing in media coverage; care in whether and how youth are involved in memorials; monitoring and suicide prevention messages provided in internet memorials & postings; access to counseling; parent and youth awareness of local resources; normalization of help seeking behavior i.e. emphasis to youth of importance of telling a responsible adult of any suicidal talk they hear from friends)
7. Provide long-term surveillance.
from: Frank J. Zenere, Ed.S., School Psychologist, National Emergency Assistance Team of the National Association of School Psychologists, “Prevention & Containment of Community Suicide Clusters” presented Jan. 10, 2008 in Austin, Texas.

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Part 4.D.3: Social Networking Guidelines for Postvention

Online Postvention Recommendations: What to Do After A Suicide To Help Prevent More Suicides. (Developed by Chris Le, 2008)

In 1988, the CDC released a document entitled “Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters” that said, “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.” Twenty years later, we now need to expand our definition of community, with the understanding that we must include online communities like MySpace, Facebook, and other social networking websites.

Not everyone on a social networking site is an expert in suicide prevention, but they are experts on their community. Users read their friends’ updates, blog posts, comments, and more, and they know when something is not right. Part of the culture of the internet has become sharing your life with others, how you’re feeling one moment, what you’re doing later that day, who your friends are or even who you’re angry with. This information flow can serve as a powerful tool as we look to save lives. Given the proper training, these tight-knit communities can become gatekeepers for suicide prevention and postvention.

About social networking sites

MySpace: <http://www.myspace.com/>

MySpace now has over 100 million users. Their demographic ranges from kids under 14 (using fake birthdates) to adults 65 and up. The largest subset of these users is 16-35. MySpace doesn’t require any real contact information apart from a working email address; because of this lax registration policy, users will sometimes have multiple MySpace accounts, representing themselves in different ways. Some MySpace features include comments, photo comments, private messages, and blog posting.

Facebook: <http://www.facebook.com/>

Facebook has over 62 million users. Their core demographic is a bit older than MySpace (21-45). Facebook is more of a social connection tool than MySpace. People present more of their real life information on Facebook and use it to connect to real-life friends and extended community. Facebook features include wall posts (public messages left for friends), private messages, instant messaging, and status updates. The format of the status updates is: “Chris is... ‘fill in the blank’.” (For example, “Chris is feeling really sad.”) Therefore, these status updates are often where those in

distress will post their feelings or intent.

Help.com: <http://www.help.com/>

Help is an interesting service where users ask questions and other users can answer those questions. Users can identify tags, or keywords, that they’d like to discuss (such as depression), and when someone posts a question about depression, users looking for that tag will receive a notification email. This essentially creates self-defined ‘content experts.’ Emotion Technology recommends training Help.com users in a local area to answer questions about suicide and suicidal behavior in an informed way.

What can we provide to users of social networking sites?

- Access to the National Suicide Prevention Lifeline through 1-800-273-TALK (8255)
- Access to resources in their community (MHMRAs in TX).
- Language to post on pages of deceased users (see below).
- Development of online gatekeeper training on suicide prevention and postvention protocols.
- A safe place to talk about their feelings of grief.
- Monitoring of comments to ensure user safety in the case of a contagion concern.
- Direct access to crisis support and information through MySpace. This would require more research on providing effective crisis support online, technology development time, and certainly funding to support the staff being available 24/7.

What to do online in cases of youth suicide

After a suicide, a person’s MySpace page or Facebook profile will stay online – often becoming a memorial for that person. While this can be a good place for friends and family to express their sorrow, we know that left unchecked, these pages can also become areas where further suicidal ideation can occur. Below we outline steps that should be taken after a suicide.

1. Identify the moderator of the person’s online accounts (usually parents or friend of the deceased).
2. Provide the letter below to explain how social networking sites can impact further suicidal ideation
3. Someone in the community should monitor the comments posted after the suicide – watching out for any red flag language (e.g. “I am going to join you soon,” “I can’t take life without you.”) and be prepared to contact those users if necessary.
4. Work with school counselors and principals to help them understand the impact a person’s online presence can have.

Letter to give to parents/friends

Dear parents and family members of [insert person's name]

Thank you for this chance to work together to help prevent suicide. We are so sorry to hear about the recent losses in your community, high school, and homes. While there is nothing we can do to erase these tragedies, it is our hope that we can help other families in your community from experiencing a similar situation. Please have a look at the message crafted for your children's Facebook or MySpace (or other social-networking) pages below, and let me know if you have any questions or need further assistance.

Language for Social Networking Pages

The message posted on a Facebook page and/or group (or MySpace page or in any public space) regarding suicide is an important part of preventing further deaths. While the language should honor the person and comfort those left behind, it is important to make sure that those reading the page see suicide as preventable. For this very reason, we are providing the following language for posting:

With help, this loss of life might have been avoided. The best way to honor (person's name) is to seek help if you or someone you know is struggling. If you're feeling lost, desperate, or alone – please call the National Suicide Prevention Lifeline: 1-800-273-8255. The call is free and confidential, and crisis workers are there 24/7 to assist you. To learn more about the Lifeline, visit their MySpace page:

<http://www.myspace.com/suicidepreventionlifeline> or their website: <http://www.suicidepreventionlifeline.org>

Part 4E: Postvention Powerpoint Presentation and Training for Schools, Clinicians and Concerned Community Members

Frank Zenere, a member of the National Emergency Assistance Team of the National Association of School Psychologists has assisted a number of Texas school districts & communities facing suicide clusters and/or a youth suicide contagion. Given below is one of three slide shows he shared with targeted stakeholders (schools, health and mental health providers, and community stakeholders) in Spring 2008 in Austin, Texas, following a suspected youth suicide cluster. This powerpoint is also available as a powerpoint slide show on the Texas Suicide Prevention website.

Another powerpoint available on the Texas Suicide Prevention.org website is a presentation given at the Texas Coming Together To Care symposium held in Austin, Texas, June, 2007, from Scott Poland, PhD. Poland is also a member of the National Emergency Assistance Team of the National Association of School Psychologists and has also assisted a number of Texas school districts & communities facing suicide clusters and/or a youth suicide contagion. Zenere and Poland and select other school suicide prevention and postvention trainers can be contacted through the The National Association of School Psychologists (NASP) National Emergency Assistance Team (NEAT) at: http://www.nasponline.org/resources/crisis_safety/NEAT.aspx In an emergency, NEAT members can be reached through NASP or directly through the phone numbers/emails posted at the site. To contact a team member through NASP during business hours, call 301-657-0270 and ask for the Executive Director.

Clinician training for suicide prevention and postvention is also available through both the American Association of Suicidology (School Suicide Prevention Accreditation Program), www.suicidology.org and the Suicide Prevention Resource Center Training Institute (Assessing and Managing Suicide Risks, for Mental Health Providers), www.SPRC.org or email: xyoung@edc.org.

A partial list of other publicly available workshops that aim to improve the clinical competence of mental health professionals in the assessment and/or management of risk for suicide was recently shared on the American Association of Suicidality ListServe, March 18, 2009 by Tony Pisani and Madelyn Gould.

Their partial list included:

Assessing and managing suicide risk (AMSR; SPRC/AAS)

Collaborative assessment and management of suicide (CAMS; Jobes)

Recognizing and responding to suicide risk (RRSR; AAS)

Question, persuade, refer, and treat (QPR-T; Quinette)

Skills training for managing people at risk of suicide (STORMS, Gask, et al)

SuicideCare: Aiding life alliances (ASIST, Living Works Ed)

The practical art of suicide assessment (includes CASE; Shea)

The Suicide Prevention Officer at the Texas Department of State Health Services and Suicide Prevention Consultant and Manager at Mental Health America of Texas can also be contacted for technical assistance for postvention needs. In some cases, they may be able to convene an advisory panel by phone to provide technical assistance to a school or community-based postvention team needing more information in a crisis. Contact: Texas Department of State Health Services Amanda Summers-Fox at Amanda.Summers-Fox@DSHS.STATE.TX.US or Mental Health America of Texas; Merily H. Keller at hodgekeller@yahoo.com or Mary Ellen Nudd at menudd@mhatexas.org.

SUICIDE POSTVENTION IN THE SCHOOL COMMUNITY

Frank J. Zenere, Ed.S., School Psychologist
Miami-Dade County Public Schools
National Association of School Psychologists
National Emergency Assistance Team

SUICIDE POSTVENTION

Definition:

"The provision of crisis intervention, support and assistance for those affected by a suicide."

American Association of Suicidology, 1998

SUICIDE POSTVENTION: GOALS

- Support the grieving process (Hazell, 1993; Underwood and Dunne-Maxim, 1997).
- Prevent imitative suicides (Hazell, 1993; Underwood and Dunn-Maxim, 1997).
 - Identify and refer at-risk survivors (Gould and Kramer, 2001)
 - Reduce identification with victim
- Reestablish healthy school climate (King, 2001).
- Provide long-term surveillance (Gould and Kramer, 2001).

SCHOOL SUICIDE POSTVENTION: RESPONSE PROTOCOL

- Verify suicide
- Contact family of suicide victim
- Determine what and how information is to be shared
- Mobilize the crisis response team
- Inform faculty and staff
- Assess the impact on the school
- Identify at risk students/staff

School mental Health Project, Dept. of Psychology, UCLA, 2003

SCHOOL SUICIDE POSTVENTION

"At some point suicide postvention evolves into a prevention response with emphasis being placed on recognition of risk factors and warning signs."

New Hampshire National Alliance for the Mentally ill, 2005

SCHOOL POSTVENTION GUIDELINES: RISK IDENTIFICATION STRATEGIES

SCHOOL POSTVENTION GUIDELINES: RISK IDENTIFICATION STRATEGIES

- Identify students known to have a mental illness
- Identify students known to have a history of familial suicide
- Identify students who have experienced a recent loss
- Monitor the behavior of student pallbearers
- Identify students at the funeral who are particularly troubled

SCHOOL POSTVENTION GUIDELINES: RISK IDENTIFICATION STRATEGIES

- Review risk factors and warning signs with school faculty and support staff
- Identify all students/staff that have or have had a personal connection/relationship with the deceased
- Identify students/staff who have previously demonstrated suicidal behavior
- Monitor student absences in the days following a student suicide

SCHOOL POSTVENTION GUIDELINES: RISK IDENTIFICATION STRATEGIES

- Identify students known to have a mental illness
- Identify students known to have a history of familial suicide
- Identify students who have experienced a recent loss
- Monitor the behavior of student pallbearers
- Identify students at the funeral who are particularly troubled

SCHOOL POSTVENTION STRATEGIES: RISK IDENTIFICATION STRATEGIES

- Monitor student hospital visitors of suicide attempters
- Monitor students who have a history of being bullied
- Monitor students who are gay, lesbian, bisexual, transgender or questioning
- Monitor students who are participants in fringe groups
- Monitor students who have weak levels of social/familial support

SCHOOL SUICIDE POSTVENTION: RESPONSE PROTOCOL

- Estimate level of response
- Advise principal on how to proceed
- Do not release information in a large assembly or over intercom
- Conduct small group notifications
- Visit victim's classes
- Provide psychoeducation and/or psychological first aid services for impacted students and staff

School Mental Health Project, Dept. of Psychology, UCLA, 2003

SUICIDE POSTVENTION: OBJECTIVES

- Help students separate facts from rumors
- Redirect guilt responses
- Ensure understanding that suicide is permanent
- Ensure acceptance of reactions as normal
- Express that coping will occur with support
- Ensure understanding that fleeting thoughts of suicide are not unusual
- Ensure student recognition of warning signs and help resources
- Ensure understanding of funeral expectations

Brock, S., 2002

SCHOOL SUICIDE POSTVENTION: KEY MESSAGES

- **Points to emphasize to students, parents, media:**
 - ✓ Prevention (warning signs, risk factors)
 - ✓ No one thing/person is to blame
 - ✓ Mental illness etiology
 - ✓ Normalize anger (Clark, 2001)
 - ✓ Stress alternatives
 - ✓ Help is available

SCHOOL SUICIDE POSTVENTION: RESPONSE PROTOCOL

- Notify parents of highly affected students
- Provide recommendations for community-based mental health services
- Conduct faculty planning session
- Hold evening meeting for parents
- Provide information on community-based funeral services/memorials
- Collaborate with media, law enforcement and community agencies

School Mental Health Project, Dept. of Psychology, UCLA, 2003

SUICIDE POSTVENTION: CAUTIONS

- Avoid romanticizing or glorifying event
- Avoid vilifying victim
- Do not provide excessive details
- Do not describe event as courageous or rational
- Do not eulogize victim or conduct school-based memorial services
- Address loss but avoid school disruption as best possible

School Mental Health Project, Dept. of Psychology, UCLA, 2003; Brock, S., 2002

SUICIDE POSTVENTION: CAUTIONS

- Providing postvention when not indicated may sensationalize the behavior
- Proper assessment will determine whether postvention services will be required

Brock, 2002

SUICIDE POSTVENTION: CAUTIONS

“Suicidal behavior is only contagious if other people know about it.”

Brock, 2002

SUICIDE: FACTORS THAT COMPLICATE THE GRIEVING PROCESS

- ❖ The act is accompanied by social stigma and shame
- ❖ The search for “why?” often leads to scapegoating or blaming
- ❖ The suddenness of the event allows no time for anticipatory mourning
- ❖ Investigations can increase guilt and stigma

SUICIDE: FACTORS THAT COMPLICATE THE GRIEVING PROCESS

- ❖ Guilt is exacerbated by the fact the death could have been prevented
- ❖ Feelings of rejection and desertion affect survivor's self-esteem
- ❖ Survivors may fear their own self-destructive impulses
- ❖ Cultural/religious attitudes (Ramsay, Tanney, Tierney & Lang, 1996)

MEMORIAL ACTIVITIES FOLLOWING SUICIDE

- ❖ Don't conduct on campus memorial services
- ❖ Provide opportunity for small group/individual discussion
- ❖ Don't glorify act
- ❖ Avoid mass assemblies focusing on victim
- ❖ Don't establish permanent memorials to victim
- ❖ Don't dedicate yearbooks, songs, or sporting events to the suicide victim

MEMORIAL ACTIVITIES FOLLOWING SUICIDE

- Do something to prevent other suicides
- Develop living memorials that will help students cope with feelings and problems
- Encourage impacted students, with parental permission, to attend the funeral
- Encourage parents and clergy to avoid glorifying the suicidal act

Brock, S. , 2002

SUICIDE POSTVENTION: SURVEILLANCE

RECOMMENDATIONS

- ❖ When addressing the friends of suicide victims, don't dismiss depressive symptomology as attributable to "normal grief."
- ❖ Postvention efforts for exposed peers should be focused upon short-term prevention of imitation and long-term followup and prevention of disability from depression, anxiety, and PTSD.
- ❖ Awareness should be directed at indicators suggestive of potential multiple suicides, including the formation of isolated small groups characterized by: depression, substance abuse, antisocial personality, or previous suicide exposure.

Brent, D. et al. (1996)

SUICIDE POSTVENTION: TEMPORAL CONCERNS

- The anniversary date of a suicide and/or the birthday of the deceased can serve as a trigger for the emergence of additional suicidal behavior among youth (Poland, 1989).
- School personnel, parents and the greater community need to be aware of this possibility and increase their surveillance/assessment of youth behaviors.
- Student support professionals and parents should acknowledge the significance of these dates with selected youth, who were significantly impacted by the suicide.

SUICIDE POSTVENTION: EVALUATION COMPONENT

- Identify areas in need of improvement
- Recognize effective postvention efforts
- Assess cost/benefit of response
- Consider relevant legal/ethical issues

Loe, 2001

CONTAGION IMPACT OF SUICIDAL BEHAVIOR

- ❖ **Suicide Contagion:** The process in which suicidal behavior is initiated by one or more individuals, following the awareness of a recent suicide threat, attempt or completion, or a fictional depiction of such behavior.
- ❖ **Suicide Cluster:** "A group of suicides or suicide attempts, or both, that occur closer in time and space than would normally be expected in a given community." (CDC, 1988)
- ❖ **Copy Cat Suicide:** When a person copies the manner of death of another person.

SUICIDE CONTAGION: RESEARCH FINDINGS

- ❖ Research suggests that the process of suicide contagion exists (Velting, D. & Gould, M., 1997).
- ❖ Considerable evidence supports that mass media coverage including newspaper articles, television news reports and fictional dramatizations have led to significant elevations in completed suicides (Gould, M.S., 2001).
- ❖ The influence of media reports of suicide and its impact on future suicides is most significant among adolescents (Phillips, D. & Carstensen, L.L., 1986).
- ❖ The occurrence of a single suicide in a community (especially an adolescent suicide) increases the risk of further suicides within that community (Gould, Wallenstein, Kleinman, O'Carroll & Mercy, 1990; & Phillips & Carstensen, 1988; Askland, Sonnenfeld, & Cosby, 2003)

YOUTH SUICIDE CLUSTERS: COMMUNITY CHARACTERISTICS

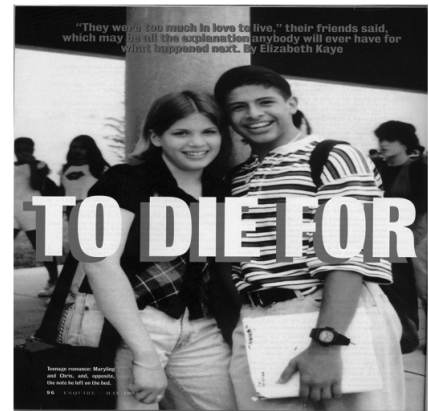
- Lack of integration and belonging
- Rapid community growth and large schools
- High rates of substance abuse
- Emphasis on material possession
- Lack of mental health services and little awareness of problem of youth suicide
- No 24-hour crisis hotlines
- Lack of networking and coordination among community agencies

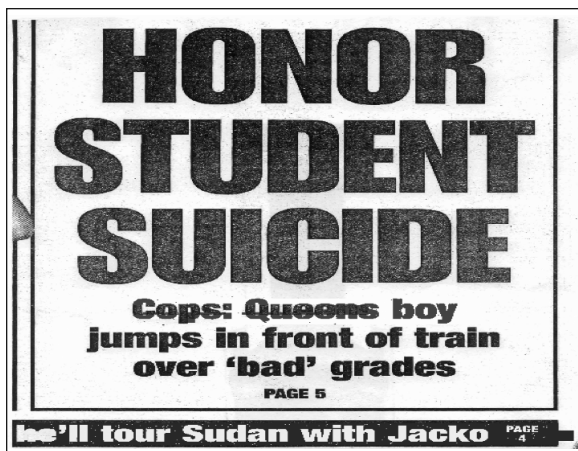
SUICIDE CLUSTERS: RESEARCH FINDINGS

- ❖ Clusters in the United States tend to occur among adolescents and young adults under the age of 24 years (Gould, Wallenstein, & Kleinman, 1990; Gould, Wallenstein, Kleinman, O'Carroll & Mercy, 1990).
- ❖ Similar results reported for clusters of suicide attempts (Gould, Petrie, Kleinman & Wallenstein, 1994).
- ❖ Between 1%-2% of annual teenage suicides occur in clusters (Gould, Petrie, Kleinman & Wallenstein, 1994).
- ❖ 100-200 teens die in clusters annually (CDC).

SUICIDE CONTAGION: FACTORS OF INFLUENCE

- Suicide clusters occur as a result of the process of contagion. The vehicle for such contagion is information, particularly sensationalized information regarding suicides that have previously occurred.
- Inappropriate media coverage of suicidal behavior can foster the development of the contagion process.





MEDIA REPORTING ON SUICIDE: GUIDELINES

What to avoid

- Avoid detailed descriptions of the suicide, including specifics of the method and location.
- Avoid romanticizing the victim.
- Avoid featuring tributes by friends or relatives.
- Avoid accounts of other adolescent suicide attempts.
- Avoid glamorizing celebrity suicides.

Suicide Prevention Resource Center (SPRC)

MEDIA REPORTING ON SUICIDE: GUIDELINES

- Avoid oversimplifying the causes of suicide and avoid presenting them as inexplicable or unavoidable.
- Avoid overstating the frequency of suicide.
- Avoid using the words "committed suicide" or "failed or successful suicide attempt."
- Avoid giving headline prominence to a suicide; also avoid using suicide in the headline.
- Avoid describing the site or showing pictures.

SPRC

MEDIA REPORTING ON SUICIDE: GUIDELINES

What to do

- Include referral phone numbers and information about local crisis intervention services
- Emphasize recent treatment advances for depression and other mental illnesses
- Emphasize actions taken that can prevent suicide

SPRC

RISK FACTORS FOR IMITATIVE SUICIDE

Facilitated suicide

- Involved in a suicide pact
- Helped write note
- Provided means
- Did not attempt to stop

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

Failed to recognize suicidal intent

- Did not take seriously/kept secret
- Observed warning signs
- Didn't respond to request for help

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

Believe they may have caused suicide

- Feels guilty about things said or done
- Recently punished or threatened to punish

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

Had relationship with victim

- Mentioned in note
- Boyfriend, girlfriend, friend
- Relatives
- Same social network
- Self-appointed therapist

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

Identify with the student victim

- Identifies with situation
- Views victim as a role model
- Believes life circumstances are similar

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

History of prior suicidal behavior

- Previous attempt
- Preoccupied with death/suicide
- Family history of traumatic death
- History of impulsive/violent behavior

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

History of psychopathology

- Poor baseline mental health
- Clinical depression
- Substance abuser
- Hospitalized for mental illness/substance abuse

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

Symptoms of hopelessness/ helplessness

- Desperate/ suicide seen as a solution
- Feels powerless to change life circumstances

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

Suffered significant life stressors

- Traumatic death of family member/friend
- Break-up in relationship
- Frequent changes in residence, schools, parental figures

Brock, S., 2002

RISK FACTORS FOR IMITATIVE SUICIDE

Lacks social resources

- Has few friends
- Lacks a supportive family

Brock, S., 2002

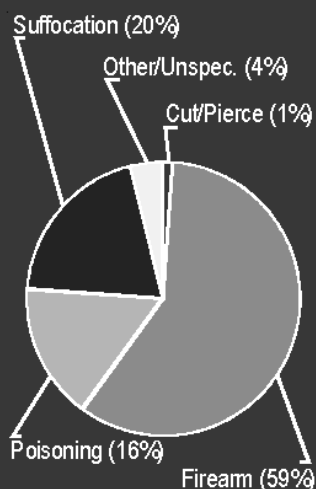
The journey through postvention begins and ends with an emphasis on prevention.

Appendix A

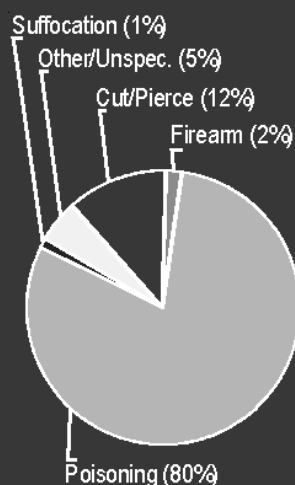
- 1. Texas Suicide Prevention Fact Sheet from the Suicide Prevention Resource Center (1999 - 2003)**
- 2. Hospitalized Attempts, 2003**
- 3. A Suicide Prevention Plan for Texas: History and Background**
- 4. Texas State Plan for Suicide Prevention**
- 5. Texas Youth Suicide Prevention Project, 2005 - 2008**
- 6. Risk for Depression and Suicide among Military Dependents and the Utility of Rapid Assessment, Center for Health Care Services and Brooke Army Medical Center**
- 7. Suicide Facts at a Glance, Summer 2008, Centers for Disease Control**
- 8. Letter of Agreement, Texas Suicide Prevention Council - Statewide Agencies**
- 9. Letter of Agreement, Texas Suicide Prevention Council - Local Coalitions and College Campuses**

Suicides, 1999-2005

Suicides by Method



Attempts by Method



Phone: 877-GET-SPRC
 877-438-7772
TTY: 617-964-5448
Web: www.sprc.org
Email: info@sprc.org
Mail: SPRC
 55 Chapel Street
 Newton, MA 02458-1060

Statewide

- 11th ranking cause of death
- Average of 2,238 residents died by suicide each year
- Suicide rate: 11.2 per 100,000
- Average of 6.1 suicides every day

Gender

- Males: 79% of suicides; rate 17.9 per 100,000; 7th ranking cause of death
- Females: 21% of suicides; rate 4.6 per 100,000; 14th ranking cause of death
- Male suicide rate 4.0 times the female rate

Race/ Ethnicity

- White Non-Hispanic (NH): 76% of suicides; rate 16.1 per 100,000
- Hispanic: 17% of suicides; rate 5.8 per 100,000
- Black NH: 6% of suicides; rate 5.8 per 100,000
- Other NH: 1% of suicides; rate 5.5 per 100,000
- White NH suicide rate 2.8 times the Black NH rate

Age

- 70+ years: highest suicide rate; 12% of suicides; rate 2.0 times the rate for 15 to 19 years

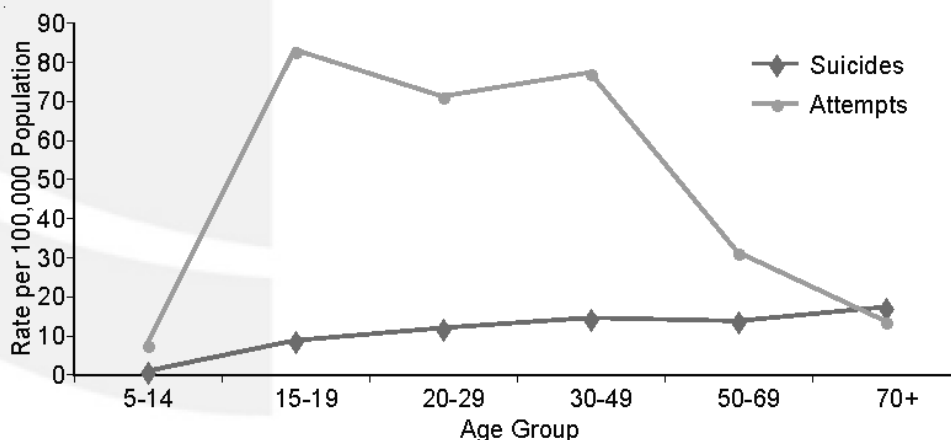
Method

- Firearm: leading method; rate 6.6 per 100,000; 2nd ranking cause of injury deaths
- Suffocation: 2nd leading method; rate 2.2 per 100,000; 6th ranking cause of injury deaths
- Poisoning: 3rd leading method; rate 1.8 per 100,000; 8th ranking cause of injury deaths
- If half of **undetermined intent** poisonings were self-inflicted, suicides in this state would be 2% higher

Costs

- Average medical cost per case: \$4,042
- Average work-loss cost per case: \$1,207,369

Average Annual Self-Inflicted Injuries by Age Group, Texas Residents



Estimated Hospitalized Attempts, 2005

Statewide

- Total of 10,807 hospitalized attempts per year
- Hospitalized attempt rate: 51.3 per 100,000
- Average of 29.6 attempts every day

Method

- Poisoning: leading method; 8,654 annual attempts; rate 41.1 per 100,000
- Cut/Pierce: 2nd leading method; 1,327 annual attempts; rate 6.3 per 100,000

Gender

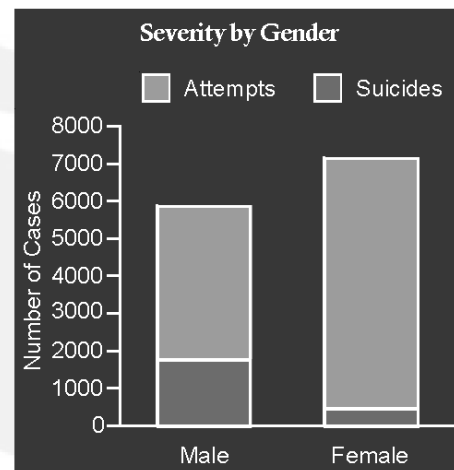
- Males: 38% of attempts; rate 39.2 per 100,000
- Females: 62% of attempts; rate 63.4 per 100,000
- Female attempt rate 1.6 times the male rate

Costs

- Average medical cost per case: \$8,849
- Average work-loss cost per case: \$10,285

Age

- 15-19 years: highest hospitalized attempt rate; 13% of hospitalized attempts



Self-Inflicted Injuries by Age Group, Gender, and Method, Texas Residents

	Suicides								Estimated Hospitalized Attempts							
	Male		Female		All		Avg Cost Per Case		Male		Female		All		Avg Cost Per Case	
	N	Rate	N	Rate	N	Rate	Medical	Work Loss	N	Rate	N	Rate	N	Rate	Medical	Work Loss
Age Group																
5-14	18	1.1	6	0.4	25	0.7	\$14,463	\$1,554,478	56	3.2	204	12.2	260	7.6	\$7,064	\$14,176
15-19	118	13.8	23	2.9	141	8.5	\$5,557	\$1,740,119	530	60.5	878	106.8	1,408	82.9	\$6,834	\$10,501
20-29	325	19.2	58	3.7	383	11.7	\$4,083	\$1,854,460	1,079	59.9	1,377	82.9	2,456	71.0	\$7,789	\$13,290
30-49	710	21.7	219	6.8	929	14.3	\$3,686	\$1,441,208	1,866	55.2	3,309	99.4	5,175	77.1	\$8,857	\$10,019
50-69	377	21.1	124	6.5	501	13.5	\$3,694	\$692,454	481	24.0	809	37.8	1,290	31.2	\$11,775	\$6,600
70+	225	36.9	36	3.9	260	17.1	\$4,072	\$102,612	87	13.3	131	13.6	218	13.5	\$14,865	\$2,001
Method																
Cut/Pierce	24	0.2	5	0.0	29	0.1	\$5,454	\$1,142,371	615	5.9	712	6.7	1,327	6.3	\$9,483	\$41,726
Firearms	1120	11.3	199	2.0	1319	6.6	\$3,214	\$1,126,436	131	1.3	28	0.3	159	0.8	\$56,950	\$56,620
Poisoning	185	1.9	166	1.6	351	1.8	\$5,971	\$1,140,279	2,927	28.0	5,727	54.1	8,654	41.1	\$7,355	\$1,465
Suffocation	377	3.8	73	0.7	449	2.2	\$3,280	\$1,491,071	73	0.7	25	0.2	98	0.5	\$26,841	\$205,752
Other/Unspecified	66	0.7	24	0.2	90	0.5	\$11,976	\$1,273,784	353	3.4	216	2.0	569	2.7	\$28,046	\$51,884
Total	1772	17.9	466	4.6	2238	11.2	\$4,042	\$1,207,369	4,099	39.2	6,708	63.4	10,807	51.3	\$8,849	\$10,285

Rates are per 100,000 population aged 5 and over. For table details and data sources, see Methods page. Rates based on 5 or fewer cases may be unstable, use with caution. Rows and columns may not add due to rounding. All costs are in year 2006 dollars. Not all self-inflicted injuries are suicide attempts.

This has been published by the Suicide Prevention Resource Center at EDC. It is the reader's sole responsibility to determine whether any of the information contained in these materials is useful to them. These materials are based upon work supported by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration under grant No. 1 U79 SM57392-02. Any opinions, findings and conclusions, or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

A SUICIDE PREVENTION PLAN FOR TEXAS: HISTORY AND BACKGROUND

A Suicide Prevention Plan for Texas is a part of a process that began in 1999 when the United States Surgeon General published a Call to Action to Prevent Suicide. This call declared suicide to be a national public health problem. The program proposed action in three areas: Raised Awareness, Enhanced Intervention Programs, and Improved Methodology for research and service evaluation.

The second phase ended in 2001 when the Surgeon General's office published: National Strategy for Suicide Prevention: Goals and Objectives for Action. One element of this strategy is the development of Suicide Prevention Plans in the states.

In June, 2001, a Texas effort began with a Texas Suicide Prevention Forum held in Austin and sponsored by the Governor's Emergency and Trauma Advisory Council and the Texas Department of Health. In the fall of 2001, a Steering Committee began meeting and completed a Draft Suicide Prevention Plan in June, 2002. The Texas Plan is closely modeled after the National Strategy.

In 2001, the Speaker of the Texas House of Representatives charged the House Human Services Interim Committee to study the issue of suicide prevention in Texas. In their report, the committee recommended that the Legislature establish a Suicide Prevention Council to design and implement a comprehensive statewide suicide prevention plan. The full text of their study report and recommendations can be read at the Texas House Web Site for Interim Reports (click on the Human Services) section below.

<http://www.house.state.tx.us/committees/reports/77interim/welcome.htm>

Beginning in January, 2002, Community Listening Meetings were held across the state to allow stakeholders, government officials, and citizens to be educated about the Draft Plan and to give input to this plan.

The Surgeon General's office released the National Strategy for Suicide Prevention: Goals and Objectives in May, 2001, calling on all states to develop a state plan following the national guidelines. This national call to action came from a private/public cooperative effort to address the critical public health issue of suicide. During this same time period, a group of concerned Texas citizens and professionals gathered from around the state to meet in Austin to discuss a coordinated, statewide effort for suicide prevention. This meeting resulted in a statewide private/public effort to begin to understand where we are

and where we need to go for suicide prevention in Texas.

The attendees of this meeting asked for a coordinated, comprehensive suicide prevention plan for our state.

In response to the state call to action, a multi-disciplinary group of professionals and survivors held a meeting in October, 2001, and created the Texas Suicide Prevention Plan Steering Committee. Members of the committee represented the mental health, medical, public health, aging, substance abuse, corrections, and education fields from a variety of perspectives, including state agencies, local school districts and universities, clinical providers, and suicide survivors. The committee charged itself with creating a plan. Based on the National Strategy from the Surgeon General, the Texas Plan for Suicide Prevention lists goals, objectives, and strategies to address the varied aspects of suicide.

The Steering Committee finished its work with the development of the Texas State Plan for Suicide Prevention and ceased as an ad hoc group. Work affiliations have changed for some of the individuals listed. Many of the original members remain involved in suicide prevention activities through the current Texas Suicide Prevention Council. Other individuals have become involved in forming local suicide prevention coalitions across the state.

Steering Committee Members Who Developed the Original 2002 Texas State Plan for Suicide Prevention: Judie Smith, Co-Convener, Irving Independent School District; John Hellsten, PhD, Co-Convener, Texas Department of Health; Donna Holland Barnes, Southwest Texas State University; Gloria Black, Texas Education Agency; Craig Crabtree, PhD, Texas Tech University; Melanie Gantt, Mental Health Association in Texas; Merily Keller, UT Houston Health Science Center MPH Graduate Student (survivor); John Keppler, M.D., Texas Commission on Alcohol and Drug Abuse; Molly L. Wilkins, Ben Taub General Hospital (survivor); Anne Lopez, Bexar County Juvenile Corrections; Florastine Mack, Texas Department of Health, Kate Martin, San Antonio Metropolitan Health District; Barbara Mathews Blanton, Texas Women's University; Mary Chapman McIntosh, Texas Department of Health (survivor); Kim McPherson, Mental Health Association in Texas; Scott Poland, PhD, Cypress Fairbanks Independent School District; Claire Sabatier, Crisis Intervention of Houston; Shawn Safarimaryaki, M.D., Sabine Valley MHMR Center; Lili Santoyo, Texas Department on Aging; Joe Thornton, M.D., University of Texas Health Science Center, San Antonio; Cristen Wall, M.D.,

Southwestern School of Medicine, Dallas; Frank Vega, Texas Department of Mental Health / Mental Retardation; Charles Vorkoper, Private Practice Counselor; David Zane, Texas Department of Health.

Contributors to the original 2002 plan: Gloria Black, Craig Crabree, Melanie Gantt, John Hellsten, Merily Keller, Florastine Mack, Kate Martin, Barbara Mathews Blanton, Mary Chapman McIntosh, Lili Santoyo, Judie Smith, Joe Thornton, Frank Vega, Charles Vorkoper, Cristen Wall, Molly L. Wilkins, David Zane.

The key underlying idea of the Plan is that it is intended to be community-based. Agencies, organizations, businesses, educators, health providers and individuals acting in a coordinated effort are most capable of assessing community needs regarding suicide prevention and implementing the necessary interventions at a local level with the support and coordination from the state.

Clarification of a few key terms and the distinctions made are included below. Contributors to the plan agreed that the three terms, 'mental health,' 'mental illness,' and 'mental disorder' are generally synonymous, with each term carrying its own connotation and implication. Therefore, the Texas Suicide Prevention Plan uses the terms in specific contexts. 'Mental health' is the general term to be used, except when addressing treatment issues or issues with treatment implications; 'mental illness' is used in these situations.

There were similar discussions regarding 'best practice' and 'evidence-based' interventions. By definition, programs or activities that are referred to as being one or the other must have evidence of effectiveness, with 'evidence based' requiring a more stringent level of scientific support (see glossary). While this higher level of scientific thoroughness

is desired, there are few current interventions that meet these criteria. Therefore, the Plan includes 'best practice' activities, with the understanding that these activities will now include a thorough scientific component to enable program effectiveness to be determined.

Implicit throughout the plan is the need for assessment and evaluation. While it may or may not be listed, the starting point for many of the strategies is to determine what materials and resources are already available. Because there is a need for more and better science about suicide prevention, intertwined throughout the strategies is the need to evaluate the process and the outcomes. Sound evaluation of programs will build the evidence base and ensure that the few and precious suicide prevention resources available will be directed toward those activities that can demonstrate effectiveness.

In 2008, the Texas Suicide Prevention Council Executive Committee reviewed and updated the Texas State Plan for Suicide Prevention which was then approved by the full Suicide Prevention Council. The updated plan continues to be modeled after the National Strategy and focuses on suicide prevention as a concern for all age groups. Members included: Erin Espinosa, Austin; Amanda Summers-Fox, Austin; Merily Keller, Austin; Gary Kesling, Galveston; John Hellsten, Austin; Isaac Martinez, San Antonio; Mary Ellen Nudd, Austin; Elizabeth Roebuck, Austin; Jeannie von Stultz, San Antonio; Patty Williams, Beaumont; and Margie Wright, Dallas. Membership on the committee or contribution to the plan does not imply agreement or endorsement of the plan by the respective agencies or organizations.

A copy of the updated plan follows, and it is also available as a separate document on www.TexasSuicidePrevention.org.

Texas State Plan for Suicide Prevention: GUIDELINES FOR SUICIDE PREVENTION IN TEXAS

Amended and Adopted by the Texas Suicide Prevention Council, September 2, 2008

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 STRATEGIES

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 the 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.

Strategies

- 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 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 health 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.

Texas Youth Suicide Prevention Project

2005-2009

The purpose of the Youth Suicide Prevention Project is to advance the Texas State Plan for Suicide Prevention through a public/private partnership that:

- o pilots a primary care initiative to identify, assess and provide referral and follow-up for youth in military families who are at-risk of suicide
- o trains health, school and community representatives to identify and refer at-risk youth
- o supports collaborative efforts to increase public awareness.

Funds are distributed through the Substance Abuse and Mental Health Administration from the Garrett Lee Smith Memorial State/Tribal Youth Suicide Prevention and Early Intervention Grant Program to the Texas Department of State Health Services. Strategies are implemented primarily by Mental Health America of Texas, the Center for Health Care Services in San Antonio, and the Texas Suicide Prevention Council. Activities are statewide, with a focus on areas with higher than national youth suicide rates - Austin, Houston, and San Antonio.

Texas Department of State Health Services Contact: Joshua Martin, 512-419-2255. Joshua.Martin@dshs.state.tx.us

Services for Children and Youth in Military Families

The Center for Health Care Services, San Antonio, facilitates a pilot program that provides direct suicide prevention and intervention services for youth in military families through health care and school settings. They also provide Question/Persuade/Refer (QPR) suicide prevention gatekeeper training and distribute bilingual English/ Spanish information.

Goals:

- Identify children and adolescents military dependents at risk for suicide in a setting where mental health conditions may otherwise go unrecognized
- Provide referrals for community support and mental health services to each participant whether they exhibit suicidal behaviors or not
- Identify the utility of instruments used in suicidal assessment for the present population of youth.
- Provide follow-up surveys to assess the effectiveness of the referral system for youth identified as having at-risk issues associated with depression and suicidality.

Child and youth participants include attendees to the Brooke Army Medical Center pediatrics or adolescent clinic and students in the Fort Sam Houston Independent School District, grades 5-12. Prior to screenings, all parents are asked if they would like to participate and a consent form is signed before any screening occurs. Participants receive questionnaires and if risk factors are indicated, a further assessment is completed. If suicide risk is determined, participants receive referral based on needs identified in further assessment, ranging from inpatient to outpatient services. Support services in the community are also made available to the family.

Referrals are made to mental health providers and community programs and follow-up is provided. Mental health based referrals include the Children and Adolescent Psychological Services at Brooke Army Medical Center, Center for Health Care Services, Private Tri-care Providers, Laurel Ridge, The Nix and Southwest Medical Center. Community based referrals include Army Community Services, Fort Sam Houston Child & Youth Services, and Inspire Fine Arts. Families are contacted at regular intervals for follow-up to identify types of services received the need for further services, and satisfaction with the screening, referral, and treatment.

As of June 2008, 70 youth required further assessment (35%) and four received inpatient treatment, 16 were already receiving outpatient treatment, and there were 47 referrals for outpatient treatment. Of those with risk factors, 18% reported having a parent currently in the military that is in rehabilitation or receiving medical care for an injury received in a recent conflict. 29% reported having moved 3 or more times in the past 5 years.

Services for Military Families Contact: Isaac Martinez, PhD, Center for Health Care Services, 210-299-8139 x 353. IMartinez@chcs.hhscn.org

Suicide Prevention Training

Mental Health America of Texas provides training to identify and refer at-risk youth using the evidence based Question/Persuade/Refer suicide prevention curriculum. The suicide prevention training centers on "QPR" - Questioning the person directly about their desire to end their life, Persuading the person to get help, and Referring the person for professional services.

Volunteer Instructors are trained and certified, and then they provide QPR workshops for their communities, schools and faith-based organizations. As of March 2009, 92 Instructors have been trained and certified in the QPR curriculum and they have conducted 184 workshops, training over 5,200 people statewide (2,100 in school settings and 3,100 in community settings.) QPR Instructors have provided suicide prevention training in 23 communities in Texas, with a focus on the Austin, Houston and San Antonio areas.

The Texas Juvenile Probation Commission and the Austin Independent School District have rolled-out the QPR suicide prevention training in their systems. The Juvenile Probation Commission, serving high-risk youth, has expanded the QPR training with information related to agency procedures. They have trained over 1,000 of their probation officers, with a goal of training all officers. The Austin school district has provided QPR training to over 900 school counselors, nurses, teachers and parents, and has a goal of providing training to all middle and high schools.

QPR Contact: Merily Keller, Mental Health America of Texas, mhkeller@onr.com or hodgekeller@yahoo.com. 512-327-8689.

Public Awareness

Mental Health America of Texas and the Texas Suicide Prevention Council (a collaboration of 18 statewide organizations and 12 local coalitions) provide a wide variety of suicide prevention public awareness activities across the state. Texas Suicide Prevention Council is charged with implementing the Texas State Plan for Suicide Prevention and serving as an Advisory Committee to the Texas Youth Suicide Prevention Project.

Public awareness activities as of March 2009 from Mental Health America of Texas and the Texas Suicide Prevention Council:

- statewide symposiums (2007 & 2008) with a focus on youth to educate community members, media, families and professionals in Texas on best practices in suicide awareness, intervention and methodology (340 participants)
- Texas Suicide Prevention Toolkit (1,550 distributed)
- English & Spanish public awareness information (379,400 distributed)
- Web site www.TexasSuicidePrevention.org
- Presentations (55) and Exhibits (40)
- Policy activities (90)
- Interviews and articles (127)
- Texas State Plan for Suicide Prevention updated and included in Toolkit

Public awareness activities of local Suicide Prevention Community Coalitions included media coverage, suicide prevention training, presentations to schools and community groups, distribution of bilingual suicide prevention information, and screening of film “Jumping Off Bridges.”

Public Awareness Contact: Mary Ellen Nudd, Mental Health America of Texas, 512-454-3706 x 206. menudd@mhatexas.org

Expanding the Texas Youth Suicide Prevention Project

The Texas Youth Suicide Prevention Project has been expanded and enhanced with public and private support, including the suicide prevention work by local suicide prevention coalitions and state agency partners in the Suicide Prevention Council. A grant from Noven Therapeutics to Mental Health America of Texas provided funding to train QPR Instructors and to develop and distribute the bilingual “Texas Suicide Factsheet on Hispanic Americans.” This grant also provided support to develop a training module “Culture, Ethnicity, Poverty and Violence: Risk or Protection among Latino Youth in Texas?” that has been added to the QPR Instructor training, and is available at www.TexasSuicidePrevention.org. Other supporters have funded conference registration scholarships, QPR Instructor training, and television and bilingual radio and television public service announcements.

What Does the Future Hold for Suicide Prevention in Texas?

The Texas Suicide Prevention Council partners are working to continue suicide prevention activities beyond 2008 by writing suicide prevention grant applications, investigating policy and funding opportunities, and including suicide prevention activities in general fund raising efforts. Local suicide prevention coalitions are volunteer-run, and plan to continue their efforts in the future with support from local volunteers, organizations and grant applications. Additionally, the Texas Department of State Health Services continues coordination of suicide prevention efforts through their Suicide Prevention Officer. The department’s activities include requirements for suicide prevention in provider contracts, an Injury and Violence Workgroup, suicide prevention training for health and mental health professionals and suicide prevention workshops at conferences.

Suicide Prevention Officer: Amanda Summers-Fox, Texas Department of State Health Services, 512-419-2231. Amanda.Summers-Fox@dshs.state.tx.us.

Risk for Depression and Suicide among Military Dependents and the Utility of Rapid Assessment

**Center for Health Care Services
Brooke Army Medical Center
San Antonio, Texas**

Isaac G. Martinez, PhD, Jeffery P. Greene, MD,
Angela B. Gurno, M.S., LPC, Deidre J. Carlson, BA
Joshua R. Avelar and Angela M. Chapa, BA
Data as of June 10, 2008

Background

- 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 occurred were due to undertreated or untreated mental illness with the most prominent being depression
- Worldwide, suicide is the 13th leading cause of death. In the United States, suicide is the eleventh leading cause of death overall and the third leading cause of death among children and adolescents ages 15-24 years.
- In Texas, it is the 10th leading cause of death. In 2005, the Youth Behavioral Surveillance Survey demonstrated that Texas has the highest percentage of attempted suicides in the United States.
- Over the previous 2 decades, mental health conditions, particularly major depressive disorder, are occurring at increasing rates, where most studies indicate as high as 20 percent. Youth in grades 9-12 have reported depressive symptoms.
- War and related outcomes such as deployments, absences of spousal support, wounded soldiers, and geographic moves has an effect on children. Military conflicts have placed burdens onto 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 children and teens with mental health conditions.

Method

Participants are military dependents aged 10-19 years and are recruited for participation from Fort Sam Houston School District and Brooke Army Medical Center (BAMC) Child and Adolescent Clinics.

Procedure. Parents are asked to indicate if they are interested in their child participating in the screening by receiving a letter from their child sent home from schools, or at

the clinic at BAMC while they are there for their child's regularly scheduled appointment.

- After the consent process is completed, participants complete screening measures. If risk factors are identified in measures, a further assessment is completed with a licensed clinician to assess for suicidality.
- Referrals are then given for both community and mental health based resources as identified as need in the further assessment. This includes inpatient and outpatient service referral.
- Demographic information is collected from parents.
- Follow up surveys are completed with participants/parents at intervals of 1 week, 3 weeks, 8 weeks and 3 months.

Results

- Total participants screened N=171.
- Of those, 36.3%, or 62 participants were identified as having risk factors.
- Of these 62, 45 received referrals for outpatient services, 4 received referrals for inpatient services and 13 reported already being involved in outpatient services prior to participating in the study.
- Preliminary analysis has been carried out to this date.
- An unadjusted prevalence estimate for depressive symptoms and/or risk factors for suicidal behaviors is provided.
- Future analyses will provide a prevalence estimate that is adjusted for any confounding variables such as gender, age and race/ethnicity as well as a weighted estimate to help control for selection bias.

Discussion

- This is a preliminary analysis of data.
- Some factors show self-selection bias with regard to participation in the study which may impact the results.
- More data needed to address hypothesis presented in the current study.
- Future studies will address issues related to number of participants, differences between screening sites and potential risk factors.
- Conclusions of the study will be used for future youth suicide prevention programs, screening efforts aimed at addressing military dependent populations, screening instruments utilized with younger populations, and implementation of mental health services designed to address the unique needs of the military dependent population.

Measures

1. Pediatric Symptom Checklist - Youth (PSC-Y)
General symptom questionnaire widely used by pediatricians to identify cognitive, emotional, and behavioral problems.
2. Patient Health Questionnaire - (PHQ-9M)
A nine question inventory used to identify the DSM-IV-TR criteria for depressive disorder.
3. Depressive Symptom Index Suicidality Subscale - (DSI-SS)
A four item questionnaire to assess suicidality.

Contact:

Isaac Martinez, PhD
IMartinez@chcsbc.org
210-731-1300 x 211

Suicide

Facts at a Glance

SUMMER 2008

Fatal Suicidal Behavior

In 2005:

- Suicide was the eleventh leading cause of death for all ages.¹
- Suicides accounted for 1.3% of all deaths in the U.S.¹
- More than 32,000 suicides occurred in the U.S. This is the equivalent of 89 suicides per day; one suicide every 16 minutes or 11.01 suicides per 100,000 population.¹
- The National Violent Death Reporting System examined toxicology tests of those who committed suicide in 13 states: 33.3% tested positive for alcohol; 16.4% for opiates; 9.4% for cocaine; 7.7% for marijuana; and 3.9% for amphetamines.²

Nonfatal Suicidal Thoughts and Behavior

- Among young adults ages 15 to 24 years old, there is one suicide for every 100-200 attempts.³
- Among adults ages 65 years and older, there is one suicide for every four suicide attempts.³
- In 2007, 14.5% of U.S. high school students reported that they had seriously considered attempting suicide during the 12 months preceding the survey. More than 6.9% of students reported that they had actually attempted suicide one or more times during the same period.⁴

Gender Disparities

- Males take their own lives at nearly four times the rate of females and represent 79.4% of all U.S. suicides.¹
- During their lifetime, women attempt suicide about two to three times as often as men.⁵
- Suicide is the eighth leading cause of death for males and the seventeenth leading cause for females.¹
- Among males, adults ages 75 years and older have the highest rate of suicide (rate 37.97 per 100,000 population).¹
- Among females, those in their 40s and 50s have the highest rate of suicide (rate 7.53 per 100,000 population).¹
- Firearms are the most commonly used method of suicide among males (57.6%).¹
- Poisoning is the most common method of suicide for females (39.1%).¹

Racial and Ethnic Disparities

- Among American Indians/Alaska Natives ages 15- to 34-years, suicide is the second leading cause of death.¹
- Suicide rates among American Indian/Alaskan Native adolescents and young adults ages 15 to 34 (21.7 per 100,000) are 2.2 times higher than the national average for that age group (10.0 per 100,000).¹
- Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts (14.0%) than their White, non-Hispanic (7.7%) or Black, non-Hispanic (9.9%) counterparts.⁴



www.cdc.gov/injury



Suicide Facts at a Glance

Age Group Differences

- Suicide is the second leading cause of death among 25-34 year olds and the third leading cause of death among 15- to 24-year olds.¹
- Among 15- to 24-year olds, suicide accounts for 12.3% of all deaths annually.¹
- The rate of suicide for adults aged 65 years and older was 14.7 per 100,000.¹

Nonfatal, Self-Inflicted Injuries*

- In 2005, 372,722 people were treated in emergency departments for self-inflicted injuries.⁶
- In 2006, 162,359 people were hospitalized due to self-inflicted injury.¹
- There is one suicide for every 25 attempted suicides.³

Suicide-Related Behaviors among U.S. High School Students

In 2007:

- 14.5% of students, grade 9-12, seriously considered suicide in the previous 12 months (18.7% of females and 10.3% of males).⁴
- 6.9% of students reported making at least one suicide attempt in the previous 12 months (9.3% of females and 4.6% of males).⁴
- 2.0% of students reported making at least one suicide attempt in the previous 12 months that required medical attention (2.4% of females and 1.5% of males).⁴

References

1. Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2005). National Center for Injury Prevention and Control, CDC (producer). Available from URL: www.cdc.gov/ncipc/wisqars/default.htm.
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3. Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, editors. *Reducing suicide: a national imperative*. Washington (DC): National Academy Press; 2002.
4. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance—United States, 2007. *Surveillance Summaries*, June 6. *MMWR* 2008; 57(No. SS-4).
5. Krug EG, Dahlberg LL, Mercy JA, Zwi A, Lozano R, editors. *World report on violence and health*. Geneva: World Health Organization; 2002.
6. McCaig LF, Nawar EN. National hospital ambulatory medical care survey: 2004 emergency department summary. *Advance data from vital and health statistics*. Hyattsville (MD): National Center for Health Statistics; 2006. Report no. 372.

**The term “self-inflicted injuries” refers to suicidal and non-suicidal behaviors such as self-mutilation.*

For more information, please contact:
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
1-800-CDC-INFO • www.cdc.gov/injury • cdcinfo@cdc.gov

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 2010.

___ 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.

Signed: _____ Date: _____

Appendix B

Suicide Prevention Resource List

National Crisis Hotlines

(See also Table of Suicide Hotlines by Texas City and County below)

National Suicide Prevention Lifeline

<http://www.suicidepreventionlifeline.org>
1-800-273-TALK (8255)

TTY number: 1-800-799-4TTY (4889)

The hotline is staffed by trained counselors, available 24 hours a day, 7 days a week. Provides information about support services that can help you.

Girls & Boys Town National Hotline

<http://www.girlsandboystown.org>
800-448-3000

TTY line: 800-448-1833

The Girls and 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.

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. They seem to have someone in every country from Argentina -Zimbabwe to help you. Befrienders listen to people who are lonely, despairing or considering suicide. They don't judge them or tell them what to do. They listen.

International Association for Suicide Prevention (IASP)

<http://www.med.uio.no/iasp>

IASP is dedicated to preventing suicidal behavior, to alleviate its effects, and to provide a forum for academicians, mental health professionals, crisis workers, volunteers and suicide survivors.

Survivor Support

(See also Table of Survivors of Suicide Support Groups in Texas below)

Survivors of Suicide, Inc. (SOS)

<http://www.sossd.org>

This is a nonprofit, nonsectarian, self-help support group for those who have lost a relative or friend through suicide. This site maintains links to other related sites, a quarterly newsletter and volunteer opportunities.

Compassionate Friends

<http://www.compassionatefriends.com>

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/>

P.O. Box 214463

Sacramento, CA 95821

Phone: (916) 392-0664

A national non-profit organization of people who have been affected by a death caused by suicide. Established in 1983, 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. All staff and volunteers have been directly impacted by a suicide death.

Organization for Attempters and Survivors of Suicide in Interfaith Services (OASSIS).

<http://www.oassis.org>

Founded in 1997, OASSIS is a 501(c)3 non-profit organization whose mission it to enrich the lives of those who have been and will be touched by suicide. OASSIS works to prevent suicide, increase awareness and remove the stigma on attempters and survivors. By facilitating educational programs, organizing systems-wide support, training professional caregivers, and offering consultative services, OASSIS works not only with religious communities, but also business and labor, health care providers, higher educational institutions, law enforcement, and

military personnel

Resources for Clinicians Who Have Lost a Patient to Suicide

<http://www.iusb.edu/~jmcintos/basicinfo.htm>

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.

Suicide Prevention: Information and Resources

Active Minds

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>

4201 Connecticut Ave. NW Suite 408
Washington, DC 20008

Phone: (202) 237-2280

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>

120 Wall Street, 22nd Floor
New York, NY 10005

Phone: (212) 363-3500

Fax: (212) 363-6237

1-888-333-AFSP (2377)

E-mail: inquiry@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.

Healing Self Injury

<http://healingselfinjury.org>

Sidran Institute Phone: 825-8888 ext. 206

A newsletter/blog website dedicated to help understand and prevent self-inflicted injuries.

Mental Health America of Texas

<http://www.mhatexas.org>

Phone: 512-454-3706

Fax: 512-454-3725

On the Mental Health America of Texas website you will find the online version of this toolkit. The 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 Center for Injury Prevention

<http://www.cdc.gov/ncipc/factsheets/suifacts.htm>

Mailstop K60

4770 Buford Highway

Atlanta, Georgia 30341-3724

Phone: (770) 488-1506

Fax: (770) 488-1667

E-mail: OHCINFO@cdc.gov

The Centers for Disease Control and Prevention website offers data, information and resources on suicide and suicide prevention.

Recovery International

www.recovery-inc.org

802 n. Dearborn Street

Chicago, Illinois 60610

312-337-5661

Email: inquiries@recovery-inc.org

Recovery, Inc. is a non profit 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/suifacts.htm>

National Center for Violence Prevention
Mailstop K60

4770 Buford Highway

Atlanta, Georgia 30341-3724

Phone: (770) 488-4362

Fax: (770) 488-4349

E-mail: DVPINFO@cdc.gov

The Centers for Disease Control and Prevention website offers data, information and resources on suicide and suicide prevention.

Suicide Prevention Action Network USA (SPAN USA)

<http://www.spanusa.org>

1025 Vermont Ave, NW, Suite 1066

Washington, DC 20005

Phone: (202) 449-3600

Fax: (202) 449-3601

Email: info@spanusa.org

SPAN USA's goal is to create a way for survivors of suicide to transform their grief into positive action to prevent future tragedies.

Suicide Prevention Resource Center (SPRC)

<http://www.sprc.org>

Education Development Center, Inc.

55 Chapel Street

Newton, MA 02458-1060

1-877-438-7772

E-mail: info@sprc.org

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 SAMHSA and 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

781-727-8617

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.

National Center for Suicide Prevention Training

<http://www.ncspt.org/>

SPRC

55 Chapel St.

Newton, MA 02458

1-877-GET-SPRC (438)-(7772)

TTY: 617-964-5448

ncspt@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 (Question, Persuade, Refer) Institute

<http://www.qprinstitute.com/>

P.O. Box 2867

Spokane, WA 99220

Phone: (509) 536-5100

1-519-536-5100 regular line

1-888-726-7926

qinstitute@qwest.net

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.

Glendon Associates.

<http://www.glendon.org/workshops/index.html>

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.

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.

Mental Health America of Texas

<http://www.mhatexas.org>

Phone: 512-454-3706

Email: suicideprevention@mhatexas.org

On the Mental Health America of Texas website you will find the online version of this toolkit. The website also has resources from the Suicide Prevention Toolkit Training Workshop that was held in 2004. The organization also hosts the website 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.

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.

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>

P.O. Box 644

Westminster, CO 80036-0644

Phone: (303) 429-3530 business office

E-mail: ask4help@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.

Youth Suicide Prevention Education Program

<http://www.yspp.org>

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 Toolkits**BASIC RESOURCES****Center for Disease Control**

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/tools/assess_community/index.jsp

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.

Healthy People 2010 - Selected Resources for Injury, Violence, and Suicide Prevention.

<http://www.health.gov/healthypeople/healthfinder/>

A listing of basic government and related websites.

Suicide Prevention and Resource Center

<http://www.sprc.org>

SPRC supports suicide prevention with the best of science, skills and practice. The Center provides prevention support, training, and informational materials to strengthen suicide prevention networks and advance the National Strategy for

Suicide Prevention. This website has a wide selection of information and is updated frequently.

TOOLKITS**Coming Together to Care, A Suicide Prevention Toolkit for Texas Communities**

<http://mhatexas.org> or 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.

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.

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 Awareness Voices of Education (SAVE)

<http://www.save.org/>

Using Minnesota as its example, this site presents a kit that provides the tools and resources to get involved and start efforts in communities.

Suicide Prevention Toolkit - Ministry of Health of New Zealand

www.moh.govt.nz

A toolkit that is available only on this website. Subjects include: Risk factors, intervention, planning, accountability indicators, the policy context for planning, interventions and more.

Yellow Ribbon Toolkit

http://www.yellowribbon.org/O-form_Info_ProgramToolkit.htm

This toolkit was produced by the Yellow Ribbon Youth Suicide Prevention Program, which is dedicated to increasing youth awareness, reducing stigma associated with asking for help, and preventing youth suicide through peer group awareness.

YOUTH PROGRAMS

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.nea.org/crisis/index.html>

Created by the National Education Association and provides resources to empower members facing crises that guides school communities toward hope, healing, and renewal. This approach combines response to crisis and suicide prevention.

Frameworks: Prevention, Intervention and Postvention

NAMI New Hampshire

http://www.naminh.org/frameworks_community_protocols_at_main_page.php

Protocols for recognizing and connecting with youth at risk for suicide - community response to suicide attempts and threats. Also postvention toolkit for community response to suicide.

New Zealand Youth Suicide Prevention Strategy

<http://www.moh.govt.nz/suicideprevention>

Created for the Maori youth of New Zealand this project is a research based program. It may offer communities clues to programs that offer wide cultural diversity in their programs.

QPR (Question Persuade, Refer) 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.

Mental Health America of Texas coordinates 2- hour suicide prevention gatekeeper workshops in QPR (Question Persuade, Refer) 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@mhateexas.org. Also check www.TexasSuicidePrevention.org for information.

Safe2Tell

<http://www.safe2tell.org>

Special Investigator
Department of Public Safety
PO Box 49296
Colorado Springs, CO 80949
719-520-7435

Safe2Tell is designed to help students, teachers and parents anonymously report anything scaring or endangering youth, their friends, or family.

S.O.S (Signs of Suicide)

<http://www.mentalhealthscreening.org>

Screening for Mental Health, Inc.
One Washington Street, Suite 304
Wellesley Hills, MA 02481
781- 239-0071

Email: smhinfo@mentalhealthscreening.org

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.

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.

TeenScreen Program

<http://www.teenscreen.org>

The Columbia University TeenScreen(r) Program works by creating partnerships with schools and communities and helping them to implement their own screening programs to identify at-risk teens and pre-teens. The program is used in high schools and other settings across the country. It was developed under the leadership of David Shaffer, M.D., the Director of the Columbia University's Division of Child and Adolescent Psychiatry.

Yellow Ribbon Youth Suicide Prevention Program

<http://www.yellowribbon.org>

P.O. Box 644

Westminster, CO 80036-0644

Phone: (303) 429-3530

E-mail: ask4help@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.

Youth Suicide Prevention - A School Based Guide

<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 is a school-based guide that provides a framework for schools to assess their existing or proposed school prevention efforts. It assists schools to work in partnership with community resources and families.

Youth Suicide Prevention Kit -
Parkville, Victoria, Australia

<http://www.aifs.gov.au/institute/pubs/ysp/bulletin1.pdf>

A content-based kit for youth programs from Australia.

SPECIAL PROGRAMS

Air Force Suicide Prevention Program

<http://sp.datausa.com/afspOverview/establishment.html>

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.

Suicide Prevention - a Resource Manual for the US Army

<http://chppm->

www.apgea.army.mil/dhpw/Readiness/suicide.aspx

Prepared for US Army, Chaplain Corps by the American Association of Suicidology. Also available are training facilitator kits. There is also a web-based version of the Navy Suicide Prevention program.

Suicide Prevention 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.

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.

National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001. <http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517>

Texas Veterans Project

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 resources identified through TexVet are meant for anyone who is serving or has served in any branch of the military, as well as the others who care about a service member. 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. <http://www.texvet.com/>

Suicide Prevention Programs and Resources Targeting Special Populations

Administration on Aging

<http://www.aoa.dhhs.gov>
U.S. Administration on Aging

Washington, DC 20001
1 Massachusetts Av. NW
Phone: (202) 619-0724
Fax: (202) 357-3523
AoAinfo@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/notes_mental_health.asp
http://www.aoa.dhhs.gov/prof/notes/notes_suicide.asp
http://www.aoa.dhhs.gov/eldfam/healthy_lifestyles/mental_health/mental_health_dep.asp

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.

Texas Mental Health and Aging Coalition

http://www.dads.state.tx.us/services/agingtexaswell/mental_health/index.html
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.

Montrose Counseling Center

<http://www.montrosecounselingcenter.org>
401 Branard, 2nd Floor, Houston, TX 77006. 713-529-0037.

HATCH – GLBT teen support program, 713-529-3590.

Provides in-person and telephone support for gay, lesbian, bisexual, and transgender youth in Texas.

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.

Postpartum Resource Center of Texas

<http://www.texaspostpartum.org>

info@texaspostpartum.org

A nonprofit organization that provides support and information to women dealing with postpartum depression and other postpartum mood disorders. Assistance to families and friends is also offered.

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.

The Trevor Helpline

www.thetrevorproject.org/helpline.aspx
(866)4.U.TREVOR (488-7386)

This is a national 24-hour, toll-free suicide prevention hot line aimed at gay and questioning youth. Calls are handled by highly trained counselors and are free and confidential.

Suicide Prevention Programs and Resources Targeting Youth

Adolescent Wellness, Inc

www.AdolescentWellness.org

103 Old Colony Road
Wellesley, MA 02481

The website offers a free download of manual, suitable for schools. Several items for parents are also listed on the Parent Resources page.

Experience Journal

www.experiencejournal.org

The website is safe, with writings by family members of all ages and reviewed by clinicians before posting. The topic of depression is addressed along with other diseases.

Jason Foundation, Inc.

<http://www.jasonfoundation.com>

116 Maple Row Blvd., Suite C
Hendersonville, TN 37075

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

<http://www.safeyouth.org>

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 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.

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.

TeenScreen Program

<http://www.teenScreen.org>

The Columbia University TeenScreen(r) Program works by creating partnerships with schools and communities and helping them to implement their own screening programs to identify at-risk teens and pre-teens. The program is now used in high schools and other settings in 26 states. It was developed under the leadership of David Shaffer, M.D., the Director of the Columbia University's Division of Child and Adolescent Psychiatry.

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.

Youth Suicide Prevention Programs: A Resource Guide

U.S. Department of Health and Human Services, Public Health Services, Center for Disease Control, National Center for Injury Prevention and Control

<http://www.cdc.gov/ncipc/>

pub-res/youthsui.htm

Description: Given the continued high rates of suicide among adolescents and young adults (15-24 years of age), it is more urgent than ever that our limited resources for prevention is applied in the most effective manner possible. 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.

Youth Suicide Prevention Education Programs

State Agency Resource

Texas Department of State Health Services

www.dshs.state.tx.us

Suicide Prevention Officer, Amanda Summers-Fox

909 West 45th Street

Austin, Texas 78756

512-419-2231

Fax 512-419-2675

Email: amanda.summers-fox@dshs.state.tx.us

dshs.state.tx.us

State Organizations

National Association of Social Workers / Texas Chapter

<http://www.naswtx.org>

810 W. 11th Street

Austin, TX 78701

Phone: (512) 474-1454

Fax: (512) 474-1317

E-mail: naswtex@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. NASW/Texas advocates for social workers and promotes public policy that furthers their goal that basic human needs are met.

Texas Counseling Association

<http://www.txca.org>

1204 San Antonio St.

Suite 201

Austin, TX 78701

Phone: 1-800-580-8144

Fax: (512) 472-3756

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 Mental Health Mental Retardation Centers

<http://www.txcouncil.com>

Westpark Building 3, Suite 240

8140 North Mopac Expressway

Austin, TX 78759

Phone: (512) 794-9268

Fax: (512) 794-8280

E-mail: office@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 Association for Marriage and Family Therapy

<http://www.tamft.org>

P.O. Box 49009 Austin TX 78765-9009

(800) 270-4320, 512-708-1593

Email: admin@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 Medical Association

<http://www.texmed.org>

401 West 15th Street, Austin TX 78701
Ph: (800) 880-1300, (512) 370-1300
The Texas Medical Association serves the people of Texas in matters of medical care, prevention and cure of disease, and the improvement of public health. With more than 40,000 physician and medical student members, TMA's vision is to improve the health of all Texans. TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

Texas Parent Teacher Association

<http://www.txpta.org/>
txpta@txpta.org
408 W. 11th St.
Austin, TX 78701-2113
1.800.TALK.PTA
512-476-6769

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>
1005 Congress Avenue, Suite 410
Austin, TX 78701
Phone: (512) 280-4099
1-888-872-3435

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>
401 West 15th Street, Suite 675
Austin, TX 78701
Phone: (512) 478-0605
Fax: (512) 478-5223
E-mail: TXPsychiatry@aol.com
Texas Society of Psychiatric Physicians (TSPP) is committed to "developing the highest quality of comprehensive psychiatric care for patients, families and communities." 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.

TSPP also assists the national chapter, The American Psychiatric Association, in the promotion of national goals. The TSPP website includes a section on mental illnesses and warning signs.

General Mental Health: Advocacy, Information, Referrals

Advocacy Inc.

<http://www.advocacyinc.org>
7800 Shoal Creek Blvd. #171-E
Austin, TX 78757-1024
Phone: 512-454-4816
Fax: 512-323-0902
1-800-252-9108
E-mail: infoai@advocacyinc.org
Advocacy, Inc. 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. Advocacy, Inc. focuses on protecting the rights of individuals with developmental disabilities, mental illnesses, and other physical disabilities. The advocacy priorities in mental health include: abuse, neglect, restraint, seclusion, discharge planning, consent to treatment, and access to records in state hospitals, and denial of access in community mental health services. Advocacy, Inc. programs supply information and advice, referrals to services, representation services in administrative and legal proceedings, political monitoring, advocacy training, and technical assistance for legal and private sector providers.

American Psychological Association

<http://www.apa.org/pi/aging/depression.html>
Office on Aging
American Psychological Association
Public Interest Directorate
750 First Street, NE
Washington, DC 20002-4242
Phone: (202) 336-6050
Fax: (202) 336-6040
TTY: (202) 336-6123
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

www.dbsatexas.org
P.O. Box 200369
Austin, TX 78770

866-327-2839
512-407-6676

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. DBSA Texas provides QPR (Question Persuade and Refer) suicide prevention gate-keeper workshops in some locales.

Depression Screening

<http://www.depression-screening.org>
National Mental Health Association (NMHA) has a Depression Screening site as part of their Campaign for America's Mental Health. The mission of this website is to educate people about clinical depression, offer a confidential way for people to get screened for symptoms of the illness, and guide people toward appropriate professional help if necessary.

National Alliance on Mentally Illness.

<http://www.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 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.
NIMH website on Suicide:
<http://www.nimh.nih.gov/suicide/prevention/index.cfm>

Mental Health America

<http://www.nmha.org>
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
Phone: (703) 684-7722

Fax: (703) 684-5968

The National Mental Health Association (NMHA) 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 NMHA, www.mhatexas.org, 512-454-3706.

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.

President's New Freedom Commission on Mental Health (2003). Achieving the promise: transforming mental health care in America.

<http://www.sprc.org/library/freedomcomm.pdf>

The New Freedom Commission on Mental Health was charged with studying the mental health service delivery system and making recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

Screening for Mental Health, Inc.

<http://www.mentalhealthscreening.org>

This nonprofit organization coordinates nationwide mental health screening programs and ensures cooperation, professionalism, and accountability in mental illness screenings. All are community-based programs and 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

The Texas Suicide Prevention Council is a group of 18 statewide organizations and 10 local coalitions that provide planning and support for implementation of the Texas State Plan for Suicide Prevention. Public awareness activities include a statewide symposium, suicide

prevention trainings, workshops, and providing information for www.TexasSuicidePrevention.org. Statewide agencies/organizations, campuses, and local communities are welcomed partners. Contact: Merily Keller, mhkeller@onr.com.

Suicide Statistics

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>

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.

The World Health Organization Statistical Information System (WHOIS)

<http://www3.who.int/whois/menu>

Offers statistical information on other countries as well the United States.

Research on Suicide

International Academy for Suicide Research.

<http://www.depts.ttu.edu/psy/iasronline/>

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.

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.

<http://mentalhealth.samhsa.gov/suicideprevention/research.asp>

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.

Suicide Information and Education Centre (SIEC).

<http://www.siec.ca>

A special library and resource center providing articles on suicide and suicidal behavior.

**Reporting on Suicide:
Recommendations for the Media**

<http://www.afsp.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.

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Survivors of Suicide

Texas Suicide Support Groups

AMARILLO

Survivors Group, Suicide & Crisis Center
P.O. Box 3250, Amarillo, TX 79116-3250
Paula Ryan (806) 359-6699; (800) 692-4039
(800# for those in the 806 area code only)
Meeting Place: Varies with each 6-week group
Meeting Day(s)/Meeting Time: Meets once a week for six weeks
Facilitated by: Peer and Professional
Charge: No
Newsletter: No
Counties Served: Upper 21 counties of Texas Panhandle area

AMARILLO

Texas Panhandle Mental and Health Mental Retardation Center
Libby Moore
PO Box 3250, Amarillo, TX 79116-3250
(806) 337-1000
Crisis# (806) 359-6699

AUSTIN

For the Love of Christi, Loss of Loved Ones to Homicide and Suicide / Violent Crime Victims
2306 Hancock Drive, Austin, Texas 78756
(512) 467-2600
Meeting Place: Christi Center Annex at above address
Meeting Day(s)/Meeting Time: 2nd Tues. of month 6:00-8:00 pm
Facilitated By: Staff and Peers
Charge: None
Newsletter: Yes
Counties Served: Travis and Williamson Counties

AUSTIN

Survivors of Suicide; Hospice Austin
4107 Spicewood Springs Rd., Austin, TX 78759
Bereavement Department (512) 342-4700
Meeting Place: Call for information
Meeting Day(s)/Meeting Time: 1st & 3rd Tuesday Call for info
Facilitated by: Peer and Professional
Charge: No
Newsletter: No
Counties Served: All are welcome

BEAUMONT

JEFFERSON, ORANGE, HARDIN COUNTIES

Survivors and Attempters Support Group
505 Orleans, Suite 301
Beaumont, TX 77701
Jayne Bordelon (409) 833-9657
Mental Health America of Southeast Texas
Meeting Place: Christ Community Church

415 S. 11th Street, Beaumont, TX 77726
Meeting Day(s)/Meeting Time: 4 times a year, 8-week sessions, please call
Attempters facilitated by: Alan Apperson, LPC
Survivors facilitated by: Christy Mellen., OPC
Charge: No
Newsletter: No
Counties Served: All counties in Southeast Texas

CORPUS CHRISTI

Survivors After Suicide
3833 Staples St. Corpus Christi, TX 78411
Family Counseling Services (361) 852-9665
Meeting Place: Family Counseling Services
3833 South Staples Street, Suite 206
Meeting Day(s)/Meeting Time: 1st Monday each month at 6:30PM
Facilitated by: Peer
Charge: No
Newsletter: No
Counties Served: All counties in South Texas

DALLAS SOS Groups

Suicide & Crisis Center of North Texas
2808 Swiss Avenue, Dallas, TX 75204
(214) 828-1000; Jenyce Gush (214) 824-7020, Toll Free 1-866-672-5100
Meeting Place: Various locations in the Metroplex area
Meeting Day(s)/Meeting Time: Structured eight week groups, with new groups starting nearly every month. Sessions are closed after the second week. Followup groups are available once a month.
Facilitated by: Peer and Professional
Charge: No
Newsletter: Yes
Counties Served: Dallas, Tarrant, Collin, Ellis, Johnson, Rockwell, Denton, Hunt

HOUSTON

Crisis Intervention of Houston, Inc., Survivors of Suicide
3015 Richmond Ave., Ste. 120, Houston, TX 77098
Contact: Brenda Fitch (713) 527-9864 x4508;
(713) HOTLINE (468-5463)
Meeting Place: N.W., S.E., S.W. Houston; call for details
Meeting Day(s)/Meeting Time:
N. - 1st & 3rd Tuesday 7:00PM
S.W. - 2nd & 4th Thursday 7:30PM
Clear Lake - 2nd & 4th Tuesday 7:00PM
Katy - 1st, 3rd Thursday 7:00pm
Facilitated by: Peer and Professional
Charge: No
Newsletter: Yes
Counties Served: All are welcome

FT. WORTH

MHA Tarrant City

For support group times contact: Amber Hughes
(817) 546-7802

LUBBOCK

Christian Ministry Suicide Prevention

P.O. Box 6477, Lubbock, TX 79493-6477

Contact: Sharron Davis., C.C.G.C.; (806) 765-7272 or (806)
765-8393 24 hr.; 800-886-4351 24 hr., Texas and New Mexico

LUFKIN

“Hospice in the Pines”

116 S. Raguet St., Lufkin, TX 75904

Contact: Demetress Harrell, LSW, 800-324-8557
(936) 632-1514

Meeting Place: Hospice In The Pines, Medford Conference
Room, 116 S. Raguet Street

Meeting Day(s)/Meeting Time: Varies; every other month

Facilitated by: Peer/Professional

Charge: No

Newsletter: No

Counties Served: Angelina, Nacogdoches, Cherokee, Shelby,
Polk, Houston, Trinity, Tyler, Sabine, San Augustine, Walker,
San Jacinto

www.hospiceinthepines.org

SAN ANGELO

Individual Survivor

3222 Southland Blvd., San Angelo, TX 76904

Contact: Shirley Grosshans (325) 944-1666

Counties served: Tom Green County and Surrounding area

SAN ANTONIO

Survivors of a Loved Ones' Suicide

8310 Ewing Halsell Drive, San Antonio, TX 78229

Contact: JoAnn Chavez (210) 616-0885 x313;

Pat O'Brien (210) 695-9136

Closed group for survivors only.

Meeting Place: Ecumenical Center for Religion & Health

Meeting Day(s)/Meeting Time: 1st and 3rd Wednesday

7:00 - 8:30PM

Facilitated by: Peer/Professional

Charge: No

Newsletter: Yes

Counties Served: Bexar, and everything to the Gulf of
Mexico up to Austin and Dallas

WACO

Support Group for Survivors of Suicide

2323 Columbus Ave.

Waco, TX 76701

Contact:

Mindy (254) 752-9330 Ext. 100

Meeting Place: Advocacy Center for Crime Victims and
Children

Meeting Day(s)/Meeting Time:

2nd and 4th Monday of every month from 5:30-7 pm - open
group

Facilitated by:

Charge: No

Newsletter: No

Counties Served: Bosque, Falls, Freestone, Hill, Limestone
& McLennan

TEXAS SUICIDE AND CRISIS HOTLINES

(NATIONAL SUICIDE PREVENTION LIFELINE (1-800-273-8225)

Source: <http://www.txcouncil.com/crisis.html>)

ABILENE

Betty Hardwick Center

Counties Served: Callahan, Jones, Shackelford, Stephens, Taylor
800/758-3344

AMARILLO

Texas Panhandle MHMR

Counties Served: Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Pter, Randall, Roberts, Sherman, Wheeler
806/359-6699 • 800/692-4039

AUSTIN

Austin Travis County MHMR Center
Counties Served: Travis
512/472-4357

BEAUMONT

Spindletop MHMR Services

Counties Served: Chambers, Hardin, Jefferson, Orange
409/838-1818

BIG SPRING

West Texas Centers for MHMR

Counties Served: Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, Yoakum
800/375-4357

BROWNWOOD

The Center for Life Resources

Counties Served: Brown, Coleman, Comanche, Eastland, McCulloch, Mills, San Saba
866/558-4357

BRYAN

MHMR Authority of Brazos Valley

Counties Served: Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington
800/282-6467

CONROE

Tri-County MHMR Services

Counties Served: Liberty, Montgomery, Walker
800/659-6994 “only from calling area”

CORPUS CHRISTI

MHMR Center of Nueces County

Counties Served: Nueces
368/886-6900

DALLAS

Dallas Metrocare Services

Counties Served: Dallas
214/330-7722

DALLAS

Suicide & Crisis Center of North Texas

Counties: Dallas, Tarrant, Collin, Ellis, Johnson, Rockwell, Denton, Hunt
214-828-1000
Toll free 1-866-672-5100

DENTON

Denton County MHMR Center

Counties Served: Denton
800/762-0157 (Call center)
ICARE Call Center Crisis referral, intake hotline - Tarrant, Bosque, Falls, Freestone, hill, limestone, McLennan, Summerdale, Hood, Palo Pinto, Parker, Johnson

EDINBURG

Tropical Texas Center for MHMR

Counties Served: Cameron, Hidalgo, Willacy
800/813-1233 “Only from calling area”

EL PASO

El Paso MHMR

Counties Served: El Paso
915/779-1800

FORT WORTH

MHMR of Tarrant County

Counties Served: Tarrant
817/335-3022

GALVESTON

The Gulf Coast Center

Counties Served: Brazoria, Galveston
800/729-3848

HOUSTON

MHMR Authority of Harris County

Counties Served: Harris
866/970-4770

JACKSONVILLE

ACCESS

Counties Served: Anderson, Cherokee
800/621-1693

KERRVILLE

Hill Country Community MHMR Center

Counties Served: Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kenney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde, Val Verde

CITY OF KERRVILLE:

800/833-5155 (no) “talk line ad”

Counties:

877/466-0660 - Crisis Hotline

LAREDO

Border Region MHMR Center

Counties Served: Jim Hogg, Starr, Webb, Zapata
800/687-4239 Starr
800/287-4240 Zapata
800/643-1102 Webb

LONGVIEW

Sabine Valley Center

Counties Served: Gregg, Harrison, Marion, Panola, Rusk, Upshur
800/832-1009

LUBBOCK

Lubbock Regional MHMR Center

Counties Served: Cochran, Crosby, Hockley, Lubbock, Lynn
806/740-1414

LUFKIN

Burke Center

Counties Served: Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler
800/392-8343

LYTLE

Camino Real Community MHMR Center

Counties Served: Atascosa, Dimmit, Frio, Karnes, La Salle, Maverick, McMullen, Wilson, Zavala
800/543-5750

MCKINNEY**ADAPT Community Solutions**

Counties Served: Collin, Dallas,
Rockwall, Navarro, Hunt, Ellis
866/260-8000

MIDLAND**Permian Basin Community Centers
for MHMR**

Counties Served: Brewster, Culberson,
Ector, Hudspeth, Jeff Davis, Midland,
Pecos, Presidio
432/570-3300

PLAINVIEW**Central Plains Center**

Counties Served: Bailey, Briscoe,
Castro, Floyd, Hale, Lamb, Motley,
Parmer, Swisher
800/687-1300

PORTLAND**Coastal Plains Community MHMR
Center**

Counties Served: Aransas, Bee,
Brooks, Duval, Jim Wells, Kenedy,
Kleberg, Live Oak and San Patricio
Counties
800/841-6467

ROSENBERG**Texana MHMR Center**

Counties Served: Austin, Colorado,
Fort Bend, Matagorda, Waller, Wharton
800/633-5686

ROUND ROCK**Bluebonnet Trails Community
MHMR Center**

Counties Served: Bastrop, Burnet,
Caldwell, Fayette,
Gonzales, Guadalupe, Lee, Williamson
800/841-1255

SAN ANGELO**MHMR Services for the Concho
Valley**

Counties Served: Coke, Concho,
Crockett, Irion, Reagan, Sterling, Tom
Green
325/653-5933

SAN ANTONIO**The Center for Health Care Services**

Counties Served: Bexar
210/223-7233 (SAFE)
800/316-9241

SHERMAN**MHMR Services of Texoma**

Counties Served: Cooke, Fannin,
Grayson
877/277-2226

STEPHENVILLE**Pecan Valley MHMR Region**

Counties Served: Erath, Hood,
Johnson, Palo Pinto, Parker, Somervell,
Tarrant, Bosque, Falls County,
Limestone, McLennan, Freestone, Hill
800/772-5987

TEMPLE**Central Counties Center for MHMR
Services**

Counties Served: Bell, Coryell,
Hamilton, Lampasas, Milam
800/888-4036

TERRELL**Lakes Regional MHMR Center**

Counties Served:
877/466-0660 Camp Delta, Ellis,
Franklin, Hopkins, Hunt, Kaufman,

Lamar, Morris, Navarro, Rockwall,
Titus

877/466-0660: Northstar Counties,
Collin, Dallas, Ellis, Hunt, Kaufman,
Navarro, Rockwall

TEXARKANA**Northeast MHMR Center**

Counties Served: Bowie, Cass, Red
River
800/832-1009

TYLER**Andrews Center**

Counties Served: Henderson, Rains,
Smith, Van Zandt, Wood
903/597-1351

VICTORIA**Gulf Bend MHMR Center**

Counties Served: Calhoun, DeWitt,
Goliad, Jackson, Lavaca, Refugio,
Victoria
877/723-3422

WACO**Heart of Texas Region MHMR**

Counties Served: Bosque, Falls,
Freestone, Hill, Limestone, McLennan
866/752/3451 (press 1)

WICHITA FALLS**Helen Farabee Regional MHMR
Center**

Counties Served: Archer, Baylor,
Childress, Clay, Cottle, Dickens, Foard,
Hardeman, Haskell, Jack, King, Knox,
Montague, Stonewall, Throckmorton,
Wichita, Wilbarger, Wise, Young
800/621-8504

Appendix C

A Reading List on Suicide Prevention and Recovery

Source: Website of the Suicide and Crisis Center of Dallas, Texas: www.sccenter.org/reading.htmlr.org, with additions from members of the Texas Suicide Prevention Council.

Disclaimer: 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.

Most of the following list was compiled by Susan Woram. At the end of most book descriptions, one or more letters signify the category of reader that may find the book most helpful.

C - Children

M - Mental health professionals and students

P - Parents and other adults

T - Teens

Alexander, V. (1998). *In the Wake of Suicide: Stories of the People Left Behind.*

The stories in this book chronicle individual journeys through grief after suicide - from the initial impact of the loss to its lace in the survivor's lives years later. The intent of this book is to help survivors give voice and meaning to their loss. **(P)**

American Association of Suicidology

<http://www.suicidology.org>

Materials and resources to help understand and prevent suicide.

Berman, A.L. & Jobes, D.A. (1991). *Adolescent Suicide: Assessment and Intervention.*

Reflects on what is current and promising in working with the suicidal adolescent and provides information relevant to theory, research, practice, and intervention. Provides practical guidance for the clinician. **(M, P)**

Baughner, B., Ph.D. & Jordan, J., Ph.D. (2001). *After Suicide Loss: Coping With Your Grief.*

This book is written specifically to help survivors during the first year after a suicide. It is organized around the first few days, few weeks, few months, etc. It is short, concise and very practical in its orientation to providing concrete suggestions and help for survivors. **(P)**

Bolton, I. and Mitchell, C. (1983). *My Son ... My Son ... A Guide to Healing After Death, Loss, or Suicide.*

As its title indicates, this book may hold special meaning for those searching for healing after the loss of a son. The author's hopeful message is just as helpful to those who have lost a daughter or brother. This is a simple and comforting book from a mother with firsthand knowledge. **(P)**

Buscaglia, Leo F. (1983). *The Fall of Freddie the Leaf: A Story of Life for All Ages.*

This is a book that deals with death on a level that children can begin to understand. Mr. Buscaglia does a good job explaining death as a natural part of the cycle of life. Beautifully illustrated with simple text. The book does not specifically address suicide. **(C)**

Clark, D.C. Ed. (1993). *Clergy Response to Suicidal Persons and Their Family Members.*

Interfaith resource book for the clergy and congregations. Provides basic knowledge about theology and suicide, recognizing suicidal risk, and referral to the appropriate caregivers. **(M)**

Dr. Clark, S. (1995). *After Suicide: Help for the Bereaved.*

This is a comprehensive handbook dealing with a specific area of bereavement after suicide - and fills the gap in the grief and suicide literature. It shows practical commonsense and careful guidelines to help people find their way through this time. It is an excellent resource for both those who have suffered and those who would support them. **(P)**

Colt, G. H. (1991). *The Enigma of Suicide.*

This encyclopedic volume on suicide is informative and thorough. It may be more helpful for those wanting an academic view of suicide than for those looking for comfort. It includes large sections on history, 'right-to-die' issues, prevention and survivors. **(M, P)**

Crenshaw, D. A. (1999). *Bereavement: Counseling the Grieving Throughout the Life Cycle.*

This is a book for the caregivers of those who are mourning. The age of a mourner will influence the type of support that may be most helpful. Different ages have different needs and that is the premise of this helpful book. The book breaks down the tasks of grieving and suggests particular ways to be supportive. This work is intended to aid any caretaker whether family member or professional counselor. **(M, P)**

Dower, L. (2001). *I Will Remember You: What to do When Someone You Love Dies: A Guidebook Through Grief for Teens.*

This is a book that is directed to teens but appropriate for all ages. It is written in clear, simple language that can help teens through the grieving process. It guides the adolescent reader through confusing feelings and helps them give words to the emotions they may feel. It includes a number of excellent writing and meditation exercises. The author also talks about grief through history and in other cultures. **(M, P, T)**

Durkheim, E. (1951). *Suicide: A Study on Sociology.*

This famous book was written in 1951 by a French sociologist and is still required reading for most serious students of sociology. Durkheim focuses on the social causes of suicide

rather than the internal workings of the mind. His work has immense historical value and shows the universal and timeless nature of human frailties. This work is recommended for the serious student of suicide only. (M)

Elliott, H. B., Brad. (1993). *Ripples of Suicide*.

Harold Elliott is a Baptist minister and the chaplain for a Texas police department. His book has a slightly academic feel to it and includes good historical information. Some readers may find the police angle of his real world work experiences a little difficult to handle. Some of the content is quite graphic. It includes helpful information on dealing with suicidal individuals and notifying families. (M, P)

Ellis, Thomas E. & Cory F. Newman. *Choosing to Live: How to Defeat Suicide Through Cognitive Therapy*.

A well written book for the general public. It is filled with practical advice but remains cautious of the limitations of a self-help approach to reducing suicide risk. (P)

Etkind, M. (1997). *... Or Not To Be: A Collection of Suicide Notes*.

Only a minority of those who die of suicide will leave a note. This book is a compilation of notes from a wide variety of people. They include celebrities and everyday people. They range in time from the 1700s to the present. These are interesting insights that may not be right for everyone. (M, P)

Emswiller, M.A. and J.P. Emswiller. (2000). *Guiding Your Child Through Grief*.

Backed by research in child psychology and filled with case histories, this title answers questions that parents and caregivers need to ask, such as: Is it normal for a child to act as if nothing has happened? Is an infant too little to understand the loss of a parent? Do children blame themselves for the death of a family member? Should I worry about a child committing suicide after a death in the family? (P)

Fawcett, J., M.D., Golden, B., Ph.D., Rosenfeld, N., and Goodwin, F.K. (2000). *New Hope for People with Bipolar Disorder*.

This book includes psychiatric findings and treatments in the author's multidimensional approach to expel the myths and fears surrounding bipolar disorder. Treatment options covered include drugs, nutrition, psychotherapy, diet, and lifestyle changes, which the authors address clinically and personally, offering compassionate and insightful suggestions for everyone affected by the disease. (M, P)

Fine, C. (1997). *No Time To Say Goodbye: Surviving the Suicide of a Loved One*.

Carla Fine has written about the loss of her husband to suicide. This book particularly addresses the social stigma that is still attached to suicide. Fine was so ashamed by her husband's suicide that she initially told others that his death was due to a heart attack. The author has spoken with many other survivors and passionately communicates their stories and experiences along with helpful information from mental health professionals. (M, P)

Fumia, M. (1992). *Safe Passage: Words to Help the Grieving Hold Fast and Let Go*.

This is a simple book of meditations written by women who

experienced the loss of her infant son. The meditations are progressive, that is the author follows the grieving process itself. The initial meditations are meant to deal with the "harsh beginnings" of unexpected loss. As the meditations continue, they focus increasingly on the process of recovery. (P)

Goldman, Linda. (1996). *Breaking the Silence*.

Provides a clear, concise, and informative guide to helping children with complicated grief issues and provides strategies and referral resources for child grief issues. The text is understandable and user-friendly for parents and laypersons, as well as experienced clinicians. (P, M)

Goldman, Linda. (1994). *Life and Loss: A Guide to Help Grieving Children*.

An information guide for helping children deal with general grief issues, as well as hands-on techniques for grief resolution. Useful for parents as well as clinical sessions by mental health professionals. (M, P)

Goldman, Linda and Jonathan P. Goldman. (1998). *Bart Speaks Out: Breaking the Silence on Suicide*.

Bart, a white terrier, narrates his story to losing Charlie to suicide. A workbook for young children to journal their feelings about the loss of a loved one to suicide, this is an ideal book to use with a parent or counselor who can assist the child in filling in the pages. (M, C)

Goldston, David B. (2003). *Measuring Suicidal Behavior and Risk in Children and Adolescents*.

This book offers practitioners and researchers practical, up-to-date information on a wide range of instruments used to evaluate suicidal behaviors in children and adolescents. In this critical and comprehensive reference book, the author first describes conceptual, definitional, and psychometric issues important in evaluating and comparing various assessment instruments and then focuses on available instruments that can be used for screening purposes or as adjuncts in detecting, describing, or estimating the risk of suicidal behavior. (M)

Goldsmith, Sara K. (2002). *Reducing Suicide: A National Imperative*.

A compilation and review of the state of the science in suicide prevention. This data driven review explores factors that raise a person's risk of suicide: psychological and biological factors including substance abuse, the link between childhood trauma and later suicide, and the impact of family life, economic status, religion and other social and cultural conditions. The authors review the effectiveness of existing interventions, including mental health practitioners' ability to assess suicide risk among patients. They provide a blueprint for addressing the problem, how to build infrastructure, conduct needed research, and improve our ability to recognize risk and effectively intervene. (M)

Grollman, E. A. and Malikow, M. (1999). *Living When a Young Friend Commits Suicide: Or Even Starts Thinking About It*.

In addition to addressing issues about suicide this book also discusses how to deal with others who may be suicidal. It has chapters on the stages of grief, common misconceptions about suicide, coping skills, helping suicidal individuals and religious

issues. This book is the collaborative work of a pastoral counselor and a grief counselor. (P, T)

Harris, M. (1996). *The Loss That is Forever: The Lifelong Impact of the Early Death of a Mother or Father.*

This book addresses the issues that can face an adult who experiences the loss of a parent early in life. This is not a work that is specific to suicide but still may be quite comforting to the adult who lost a parent at a young age. Written by clinical psychologist. (P)

Hewett, J. H. (1980). *After Suicide.*

A recommended and highly readable book. Its practical nature can help readers understand what to expect after a loved one dies by suicide and offer options for coping. It includes a very helpful chapter on suicide and faith. It also clarifies many of the misconceptions that we hold about suicide and religion. (M, P)

Hsu, Albert Y. *Grieving a Suicide: A Loved One's Search for Comfort, Answers & Hope* (2002).

Hsu relates his own coping with unexpected, violent death and compassionately examines the emotional and theological issues of suicide. Hsu's father died of suicide at 59. He had suffered a stroke and become depressed during the preceding weeks, yet his death was a great shock. The Christian way of grieving is Hsu's focus in the latter half of the book, where he surveys Scripture to deal with questions such as whether people who die by suicide can go to heaven, where God is when tragedy strikes and what can be learned from suicide. (M, P)

Jacobs, Douglas G. M.D. (1999). *Harvard Medical Guide to Suicide Assessment and Intervention.*

Clearly this is one of the most comprehensive guides available on suicide. It is a must read for every mental health professional and others devoted to helping people forced with a crisis. Provides a very clear and understandable approach to the phenomenology of suicide. (M)

James, J. W. and Friedman, R. (1998). *The Grief Recovery Handbook: The Action Program For Moving Beyond Death, Divorce, And Other Losses.*

Those who like the idea of following a 'program' for recovery will enjoy this book. The book addresses losses of all types not just those related to suicide. A small downside for some readers may be the book's insistence to strict adherence to their program and the offer of what seems like a "cure" for your grief. That being said, the book appears to have a wide following and is used as a springboard for many self-help groups. (M, P)

Jamison, K. R. (1999). *Night Falls Fast: Understanding Suicide.*

Kay Redfield Jamison has had her own personal struggle with manic-depressive illness and survived a suicide attempt. As a Johns Hopkins professor of psychiatry she is well equipped to clearly discuss the current epidemic rates of suicide and the myriad of causes. She also reminds us of the preventable nature of this epidemic. The book uses essays on individual suicides to poignantly illustrate the various forces at work in those that die by suicide. (M, P)

Joiner, Thomas Ph.D. (2005). *Why People Die by Suicide.*

In the wake of a suicide, the most troubling questions are

invariably the most difficult to answer: How could we have known? What could we have done? And always, Why? Drawing on extensive clinical and epidemiological facts and personal experience, Joiner brings a comprehensive understanding to seemingly incomprehensible behavior. (M,P)

Kleespies, Phillip M., Ph.D. (Ed.) (1997). *Emergencies in Mental Health Practice: Evaluation and Management.*

Focusing on acute clinical situations in which there is an imminent risk of serious harm or death to self or others, this practical resource helps clinicians evaluate and manage a range of mental health emergencies. (M)

Leenaars, A. & S. Wenckstern (Eds.) (1990). *Suicide prevention in Schools.*

Suicide prevention, intervention, and postvention in the schools are outlined in this edited book. (M, P)

Lester, D. (1993). *The Cruellest Death: The Enigma of Adolescent Suicide.*

This helpful book gives us a broad overview of the various factors that can contribute to suicide in adolescents. This book is an excellent primer for the mental health professional just beginning to study teen suicide. The book covers theory and research as well as epidemiology and intervention. (M, P)

Lester, David. (2001). *Suicide Prevention: Resources for the Millennium.*

Suicide Prevention presents an evaluation of the past, present, and future of suicidal behavior and efforts to prevent suicide. Authors from varying disciplines of psychology, sociology, and psychiatry analyze suicide in the opening chapters. Through the exploration of these roles of these disciplines, the roles of primary physicians, and the impact of suicide prevention education in schools, the contributors describe the history of suicidology and the changes necessary for improvement. The book concludes with a section detailing the goals and activities of organizations designed to prevent or facilitate suicide. (M, P)

Linn-Gust, Michelle. (2001). *Do They Have Bad Days in Heaven? Surviving the Suicide Loss of a Sibling.*

The first comprehensive resource for sibling suicide survivors. The author takes the reader through the personal experiences of losing her younger sister and weaves in the available research for sibling survivors. She explains suicide, the grief process, and how sibling death impacts the brothers and sisters left behind, and offers practical advice for surviving the loss of a sibling to suicide. (M, P, T)

Maris, R., Berman, A.L., Maltzberger, J.T., Yufit, R. (Eds.) (1992). *Assessment and Prediction of Suicide.*

Comprehensive reference volume of 32 chapters covering a range of specialized topics such as jail suicides, school suicide programs, hospital and clinic studies, economic and social factors, and the biology of suicide. (M)

McCracken, Anne & Mary Semel. (1999). *A Broken Heart Still Beats.*

This anthology of poetry, fiction, and essays compiled from the literature of loss and grief is remarkable. The authors have included pieces from everyone from William Shakespeare to Dwight D. Eisenhower whose works explore the shock, the

grief, and the search for meaning that come with the death of a child. Each piece is clearly introduced explaining the details surrounding the person's loss. (P)

McIntosh, John L., Santos, John F., Hubbard, Richard W., and James C. Overholser. *Elder Suicide: Research, Theory, and Treatment*.

This book presents epidemiological trends and identifies special high-risk factors for suicide among elders. It also examines sociological, psychological, biological, and other theories of suicide and provides an overview of clinical approaches to depressed and suicidal elders by identifying aspects unique to elder suicide, exploring assessment and intervention modalities, and specifying warning signs.

Mehren, Elizabeth. (1997). *After the Darkest Hour the Sun Will Shine Again*.

This helpful and inspirational book clearly helps bereaved parents deal with the many questions and issues that come up for them. It's both a guide and a meditation that offers support and comfort. It is written in a clear and simple style with short stories dealing with difficult issues. The advice and solace found in this small book is very valuable. (P)

Merman, A. L. & Jobes, D. A. (1999). *Adolescent Suicide: Assessment and Intervention*.

This book is published by the American Psychological Association and written with the mental health clinician in mind. Chapters include: The epidemiology of adolescent suicide, The theoretical context, The empirical context, Assessment of risk, Treatment, Prevention and postvention. The book presents current research findings and provides extensive references and case illustrations. (M)

Mishara, B.L. (Ed.) (1995). *The Impact of Suicide*.

A prestigious group of internationally known contributors, including Robert Kasienbaum, Alan Berman, and David Lester, take an incisive look at suicide's effects on family, friends, and professionals. Research data are supplemented by rich clinical experience. (M)

Osgood, N. (1992). *Suicide in Later Life*.

Discusses reasons for elderly suicide, describes the symptoms and warning signs, and proposes risk reduction strategies. Written for older adults, family members and caregivers, and all those who provide services for older clients/patients. (M, P)

Poland, S. (1989). *Suicide Intervention in the Schools*.

Provides step-by-step guidelines for setting up and maintaining a comprehensive crisis intervention program. (M, P)

Poland, S., & Lieberman, R. (2002). *Best practices in suicide intervention*. In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology* (Vol. 3, pp. 1151-1166).

Poland, S., & McCormick, J. (1999). *Coping with Crisis: Lessons Learned*.

Poussaint, Alvin F. (2002). *Lay My Burden Down: Unraveling Suicide and Mental Health Crisis Among African Americans*.

Risenhoover, C. C. (2004). *The Suicide Lawyers: Exposing Lethal Secrets*.

Texas attorneys share their experiences in suicide litigation and help readers know how to recognize, react, and intervene when a friend or loved one is at risk for suicide.

Robinson, R. (1989). *Survivors of Suicide*.

Originally published in 1989, this book was revised in 2001 and contains additional information on teen suicide. The book also reviews such areas as common suicide myths, depression, historical and religious perspectives and includes a resource directory. (P)

Rubel, B. (2000). *But I Didn't Say Goodbye: For Parents and Professionals Helping Child Suicide Survivors*.

This hands-on book benefits those who want to learn how to help a child after a sudden loss. The power of this book comes from the most frequently asked questions a bereaved child asks, and the honest, respectful, age-appropriate answers from caring adults. Caregivers get intervention strategies, complete with bereavement referrals and up-to-date recommended resources. Adults get a head start by the ready-to-copy, interactive, non-threatening questions and activities wherein the child's thoughts and feelings are shared. (M, P)

Shea, Shawn C. (1999). *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors*.

Shea provides a thorough introduction to the CASE (Chronological Assessment of Suicide Events) approach, using numerous case examples. The author moves the reader from suicidology theory and research to elicitation of suicide ideation to appropriate decision-making and treatment planning. This book would be equally useful for students, beginning clinicians, and seasoned veterans. (M)

Shneidman, Edwin, Ph.D., (2004). *Autopsy of a Suicidal Mind*.

With other Suicidology experts Dr. Shneidman discusses the special qualities of the mental content and mental qualities of a deeply suicidal person. A case is studied and discussed from a variety of perspectives.

Shneidman, Edwin, Ph. D. (1993). *Suicide as Psychache: A Clinical Approach to Self-Destructive Behavior*.

Dr. Shneidman's approach to treatment and response to suicidal people. This book offers a perspective for prevention and treatment that arises from his long reflection and clinical work as a Suicidologist. It is direct and readable and offers an effective approach to suicidal people that is being demonstrated in research by researchers like Israel Orbach, Ph.D. and others in Israel.

Smolin, Ann. (1993). *Healing After the Suicide of a Loved One*.

The authors address the special needs and emotions of the survivors - those affected by the suicide of a loved one — explore the natural grief, and the added guilt, rage, and shame that dealing with a suicide often engenders. Includes a directory of worldwide support groups.

SPRC Library

<http://library.sprc.org/>

A searchable collection of resource materials on various topics in suicide, suicide prevention and mental health.

Stimming, M.T. and M. Stimming (Eds). (1999). *Before Their Time: Adult Children's Experiences of Parental Suicide*. Before Their Time is the first work to present adult children survivors accounts of their loss, grief, and resolution following a parent's suicide. In one section, the book offers the perspective of sons and daughters on the death of mothers, in another, the perspective of sons and daughters on the death of fathers. In a third section, four siblings reflect on the shared loss of their mother. Topics such as the impact of the parent's suicide on adult children's personal and professional choices, marriages and parenting, sibling and surviving parent relationships are explored with sensitivity and insight. Various coping skills, including humor, are described. (P)

"Suicide and Life-Threatening Behavior" The Official Journal of the American Association of Suicidology. Morton M. Silverman, M.D., Editor-in-chief
This journal is published quarterly by The Guilford Press, 72 Spring Street, New York, NY 10012 - www.guilford.com

Treadway, David C. *Dead Reckoning: A Therapist Confronts His Own Grief*.
Chronicles his arduous year-long journey to come to terms with his mother's depression and suicide, which happened years earlier in the author's life.

Underwood, M.S. and Dunne-Maxim, K. (1997). *Managing Sudden Traumatic Loss In The Schools*.
This manual incorporates the basic principles of postvention as well as practical implementation techniques garnered in the hundreds of schools and communities where the authors have provided postvention services. The manual has been revised several times and over 20,000 copies have been distributed nationwide. In 1999, a series of videotapes was produced to accompany the manual. These tapes reinforce the principles outlined in the manual and are designed to provide support and direction during the initial days of the trauma. They have also been used by school systems for training of crisis management teams. (M, P)

White, T.W. (1999). *How to Identify Suicidal People: A Systematic Approach to Risk Assessment*.
This is an excellent reference for mental health professionals who work with potentially suicidal people. Discusses the author's new method, and actual system of conduction risk assessment. (M)

Wofalt, A., Ph.D. (2000). *Healing the Grieving Child's Heart - 100 Practical Ideas for Families, Friends, and Caregivers*.
Helpful to adults to understand grief and mourning in children. (P)