

**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

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

Texas

- Anderson
- Andrew s
- Angelina
- Aransas

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
Age Group:	All Ages
Gender:	Both Genders
	"All Ages" includes a small number of deaths of unknown age

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**.

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

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.

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

Frequencies only
 Frequencies and Percents By Column
 Frequencies and Percents By Row
 Frequencies and Rates
 Crude Rates Age Adjusted Rates

Age Adjustment Standard:

Confidence Intervals:

Sort Results: No Sort 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- Select Optional Table Parameters)

ICD-10 Death Statistics for the State of Texas					
Sex: Female					
<u>Intentional Self-Harm (Suicide) (X60-X84, Y87.0)</u>					
Race					
	White	Black	Hispanic	Other	All Races
Year	Number	Number	Number	Number	Number
2002	414	28	53	9	504
<u>Rotate</u>			<u>Download</u>		

Figure 2: (Output Table for Step 5- Select Row and Column)

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	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
<u>Rotate</u>		<u>Download</u>	

Figure 3: (Output Table for Step 5-Select Row and Column)

ICD-10 Death Statistics for the State of Texas					
<u>Intentional Self-Harm (Suicide) (X60-X84, Y87.0)</u>					
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
<u>Download</u>					

Figure 4: (Final Output Table for Step 6: Frequencies only)

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	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
<u>Rotate</u>		<u>Download</u>	

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					

Sources:

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

Texas Health Care Information Council. <http://www.thaic.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>

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, PhD
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 this type of 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 coalition-building, 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/pubfiles/af/44/afpam44-160/afpam44-160.pdf>

Results

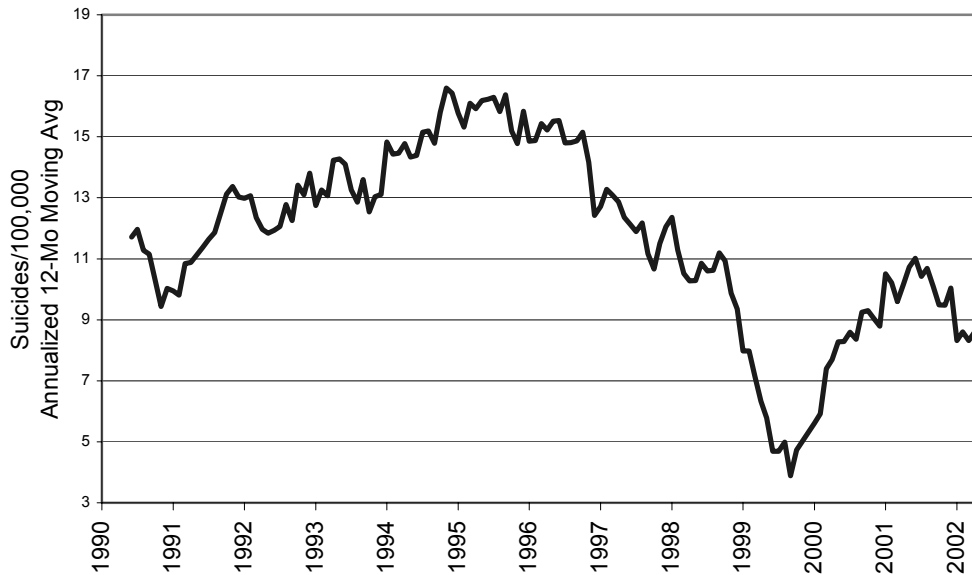
When the project began in 1995, suicide was the second leading cause of death among the 350,000 Air Force members, occurring at an annual rate of 15.8/100,000. Since then, the suicide rate declined statistically significantly over three consecutive years, and for the first six months in 1999 the annualized 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, PhD. 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:
 - Requirements for action to ensure the safety of the suicidal person and referral to treatment before leaving the scene
 - Evaluation of imminent and future risk factors
 - Controlling or seizing weapons
 - Evaluation of the ability of the family or others to help
 - Requirements for two officers to respond, including specially trained officers such as MHPOs
 - 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, MD
Chief of Psychiatry, Ben Taub General Hospital, Houston*

“Suicide is an ever present concern for counselors. The greatest danger for mental health/treatment professionals is to assume that our clients/patients will never commit suicide. On this count we are helpless. Equally dangerous is the belief that we are not personally and negatively impacted by such a death and/or suicide attempt. My client really died and I felt it and my feelings were negative. I found out how important it is to get help for myself at that time in my life.”

*Charles Vorkoper, CMSW, LMFT
Counselor and Clinician, Suicide Survivor, Dallas*

“How many times have we looked into the face of a family or patient who is dealing with the issue of suicide or the attempt? Will that one's will to live be large enough make the journey from the dark side back to the possibility of hope? We wonder and we care for their physical wounding.... What can we say or do to help shine a glimmer of hope into their path? Choose to listen, touch, or hold them in the mist of the agony of treatment used to recover them from this dark place of hopelessness? Speak a kind word of comfort when all around is chaotic? Yes, and this is the nurturing of a nurse. It matters, please never stop.”

*Molly Wilkins RN, BSN, CEN, CCRN
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." Related, 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:

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<http://www.consensusproject.org>

Mental Health Association of Tarrant County, providing TCLEOSE-certified in-service training. mhatc@mhatc.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 2002 was among people age eighty to eighty-four, which reported a rate of 19.03 deaths from suicide per 100,000 people. That is slightly higher than the national rate of 17.7 percent for people aged seventy-five to eighty-four. 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 the local Area Agency on Aging (AAA) at (800) 252-9240.

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:
 - Waterloo Counseling Center, Austin, <http://www.waterloocounseling.org>
 - Resource Center of Dallas, <http://www.resourcecenterdallas.org>
 - Diversity Center of San Antonio, <http://www.diversitycentersa.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 also points out increased risk for Hispanics in Texas since data from youth surveyed in Texas in 2005 compared to those surveyed in 2001 indicated an increased risk for suicide attempts among Hispanic youth.

Because Hispanics are the fastest growing ethnic group in Texas, prevention efforts targeted to this population are needed.

Men

Males complete suicide at a rate four times that of females. It is assumed that this higher rate comes in part because of the male tendency to use more lethal means. However, females attempt suicide three times more often than males. Suicide by firearm is the most common method for both men and women, accounting for 57 percent of all suicides in 2000.

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 (54%) of the individuals who took their own lives in 2003 used this method. Males (58% firearms; 42% other method) used firearms more often than their female counterparts (33% firearms; 67% other method).” Nationally, the National Institute of Mental Health notes that white men accounted for 73% of all suicides and 80 percent of all firearm suicides in 2000. Older men are by far the single highest risk group for suicide. Men 65 and older account for about 10 percent of the U.S. population. But about 33 percent of suicides are among men in this age group.

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
Males	25,203	143,037,290	17.6
Females	6,281	147,773,499	4.3
Total	31,484	290,810,789	10.8

Figures from the National Center for Health Statistics for the year 2003 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.

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*

"Three years 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 student, 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 2002, 345 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>
- 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, R.N.
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 Partnership.

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 programming is 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 Grant 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>. In the spring of 2007, QPR instructors and community workshops will be listed on a new web site, www.TexasSuicidePrevention.org.

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, TeenScreen 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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Yellow Ribbon International. <http://www.yellowribbon.org>

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

Support Groups for Suicide Survivors

“There is much to be learned from books and support groups for parents who have lost a child. But parents who have lost a child to suicide have special and unique needs. Other parents who have survived the same tragedy understand the guilt and the pain of this tragic loss best. Support groups are not for everyone, but we often hear from parents who have survived the loss of a loved one to suicide that they find talking to each other and supporting one another is more important than therapy in going through the grieving process.”

Mary McIntosh

Suicide survivor and support group co-leader, Austin

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

“School counselors have a unique opportunity as well as a legal and ethical responsibility to identify, intervene, refer and support students who are experiencing a suicidal crisis. A well coordinated school suicide prevention program can play a major role in reducing the risk for suicide and thus prevent the tragic loss of lives.”

*Judie Smith, MA, LPC
Retired school crisis coordinator, and past board member
of the American Association of Suicidology (Dallas)*

“Training on suicide prevention is a necessary component of all school counseling training programs. All school counselors should present these programs to students, faculty, and parents each school year.”

*Doris Rhea Coy, PhD
Associate Professor, Department of Counseling,
Development and Higher Education, University of North Texas, Denton*

The Youth Suicide Prevention Coalition (YSP), in Tarrant County, Texas, is a good example of a public health approach to suicide prevention that focuses specifically on youth. Its vision is two-fold: 1) every middle and high school student to have regular training on suicide prevention and annual screening for depression, and 2) for the community, school staff, medical providers, and mental health professionals to have opportunities for regular education on youth suicide prevention strategies.

Youth Suicide Prevention consists of mental health professionals, school district staff, the local health departments (state, county, and city), parent survivors, mental health consumers, youth representatives, and advocacy groups. The coalition developed a Youth Suicide Prevention Toolkit that has integrated national materials and local resources including several outstanding youth-produced pieces from the Tarrant County Public Health Department’s Teen Videofest.

YSP offered toolkits and training to the superintendents of the eleven independent school districts in Tarrant County, and seven of accepted MHA’s offer to participate in the project, including the four largest districts. Following through on this involves the efforts of several coalition participants:

- The Mental Health Association in Tarrant County (MHATC) coordinates ordering and distribution of Toolkit materials and training for school staff.
- Resources are offered through other YSP members to the schools to assist with counseling on screening day and for referral to outside services.

- MHATC staff work with the schools to help design their suicide prevention programs and to assist with reporting of program statistics.
- YSP provides speakers for school programs, including parent education.

Each ISD has implemented its program using different methods. Ft. Worth ISD has required that every high school and all eighth-grade classes participate. Some ISDs have left participation up to each individual campus. Some schools have implemented the program school-wide, some by grade, and some in specific classes. YSP's goal is for all school districts to offer the program to all students in grades eight through twelve annually.

In the first semester of the project seventeen schools implemented the program and screened over 7,200 students. Thirteen percent of the students indicated serious symptoms of depression and five percent had recently experienced suicidal ideation. The rate varied between schools and between grades. Over 100 students requested counseling through the school staff during the first week after the program was presented. Evaluations of the program from the school staff have been very positive, with all of the schools indicating that they will continue to participate, and believe that the program has been beneficial to their students. YSP continues to offer periodic training for school staff and forums for mental health professionals and the general community.

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 feels 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>

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. When this toolkit is published on the Mental Health Association in Texas website, there will be a list of statewide speakers on suicide prevention who may be available to speak in communities across Texas.

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 lifeline number as well as any local hotline numbers in your presentation and handouts.

Topics to Consider

(Statewide speakers will be available on these and other topics)

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

Have a list of alternative speakers built into your planning process to prepare for scheduling conflicts and cancellations.

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 Association in 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>

The Mental Health Association 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.

<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/resources/order.html>

The Suicide Awareness Voices of Education offers brochures on & books on suicide, teenage depression, and a complete community action kit on suicide prevention.

<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
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. We recommend that this key message be part of the overall theme of any interview a survivor does. 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).

- For women, if you choose a skirt, make it long enough to cover the knee. When you are seated and the camera takes a wide shot, viewers' eyes will go to your thighs and distract from the power of your words.
- Non-flimsy shirts and blouses are preferable since you will likely have a microphone attached to your clothing and it will tug on thin or flimsy material.
- Jewelry and make-up: Any jewelry at the lapel should be small and non-shiny. Avoid metal bracelets or other “jangly” items. Make-up should include concealer for under the eyes, a neutral lipstick, and powder to even out skin tone and keep people focused on what you are saying. Use blush sparingly; the camera picks up red tones very easily.

Guidelines/Recommendations for the Media

The media can have a powerful effect after a suicide, both in the positive sense of helping to educate people that suicide is a preventable health problem and in the negative sense of potentially contributing to phenomena such as suicide contagion and worsening the problem. Both the American Foundation for Suicide Prevention and the American Association of Suicidology offer detailed recommendations for the media that address:

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

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

“Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors. Direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults.

The risk for suicide contagion as a result of media reporting can be minimized by factual and concise media reports of suicide. Reports of suicide should not be repetitive, as prolonged exposure can increase the likelihood of suicide contagion. Suicide is the result of many complex factors; therefore media coverage should not report oversimplified explanations such as recent negative life events or acute stressors. Reports should not divulge detailed descriptions of the method used to avoid possible duplication. Reports should not glorify the victim and should not imply that suicide was effective in achieving

a personal goal such as gaining media attention. In addition, information such as hotlines or emergency contacts should be provided for those at risk for suicide.

Following exposure to suicide or suicidal behaviors within one's family or peer group, suicide risk can be minimized by having family members, friends, peers, and colleagues of the victim evaluated by a mental health professional. Persons deemed at risk for suicide should then be referred for additional mental health services.”

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/mediarel2.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/>

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?
Descriptive	What happens in the program? (No "why" questions or cause/effect analysis)
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 stake-holders 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/SMA01-3517/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/tools/evaluateinitiative/index.jsp>

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/publications/TR/TR101/TR101.pdf>

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.wkkf.org/>

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

*For additional evaluation resources, visit the Suicide Prevention Resource Center's online library at: <http://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>

A Challenge to Texas Communities to Come Together To Care

Ten communities initially came together to form suicide prevention local coalitions in Texas. The current local suicide prevention coalition contacts are listed in the front of this toolkit. We would like to add other Texas communities as Texans continue to come together to care about suicide prevention. As you come together to address suicide, please contact the Texas Suicide Prevention Community Network, co-chairs, Troy Bush tbush@bcm.tmc.edu or Merily Keller, mhkeller@onr.com or hodgekeller@yahoo.com so that we can update the listing contacts.