

THE VERMONT SUICIDE PREVENTION PLATFORM

TABLE OF CONTENTS

INTRODUCTION.....4
GOALS OF THE PLATFORM.....4
SCOPE OF THE PROBLEM.....4
RISK AND PROTECTIVE FACTORS.....5-8
STATE PLATFORM FOR SUICIDE PREVENTION.....9-16
RESOURCES FOR SUICIDE PREVENTION.....17-18
ATTACHMENT A: REPORTING ON SUICIDE
RECOMMENDATIONS FOR THE MEDIA.....19-23
REFERENCE.....23-24

MANY INDIVIDUALS HAVE DEDICATED TIME AND ENGERGY INTO THE DEVELOPMENT OF THE VERMONT SUICIDE PREVENTION PLATFORM. A SPECIAL THANKS TO THE FOLLOWING GROUPS FOR THEIR COMMITMENT TO THE PLATFORM AND FOR THE WORK THAT WILL FOLLOW IN ADVOCATING FOR THE IMPLENTATION OF THE PLATFORM.

THE VERMONT COALITION FOR SUICIDE PREVENTION
THE DIVISION OF MENTAL HEALTH
THE DIVISION OF HEALTH IMPROVEMENT
THE DIVISION OF COMMUNITY PUBLIC HEALTH
THE DIVISION OF ALCOHOL AND DRUG ABUSE PROGRAMS
DEPARTMENT OF EDUCATION

THE VERMONT SUICIDE PREVENTION PLATFORM

Introduction

In 2001 the US Department of Health and Human Services released the *National Strategy for Suicide Prevention*, a comprehensive and integrated approach to reducing suicide and suicidal behaviors across the life span. The national strategy was a culmination of efforts including the 1999 *Surgeon General's Call to Action to Prevent Suicide* and the landmark *Mental Health: A Report of the Surgeon General* (1999).

The Department of Health recognizes suicide as a significant public health problem and has included goals related to suicide deaths, suicide attempts, substance abuse and mental health as health priorities in *Healthy Vermonters 2010*, the department's blueprint for improving the health of Vermonters.

The Department of Health including the Division of Mental Health has been working with a suicide prevention planning team in conjunction with an advocacy group, *Vermonters for Suicide Prevention*, to develop a prevention platform for Vermont. Members of the team and group represent various state agencies, legislators, and interested individuals. The *Vermont Suicide Prevention Platform* is the result of this effort. This platform will involve regular ongoing review and revision. This review will involve tracking progress and achievement of goals.

Goals of the suicide prevention platform:

1. Reduce the rates of suicide attempts and other suicidal behaviors.
2. Prevent suicide deaths across the life span
3. Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends.
4. Improve mental health of Vermonters through early intervention, crisis treatment, and continuing care.

Scope of the Problem

Suicide is the 8th leading cause of death in Vermont and the 11th leading cause in the U.S. More people die from suicide than homicide in this country. On average, 78 Vermonters die by suicide each year and 14 are victims of a homicide

Suicide is a serious problem among Vermont's young people. In 2002, suicide was the third leading cause of death for 10-14-year-olds and the second leading cause of death for 15-34-year-olds. According to the 2003 *Vermont Youth Risk Behavior Survey*, 13% of students in grades 8-12 had made a plan about how to attempt suicide, 7% had actually attempted suicide, and 2% had made a suicide attempt that required medical treatment. In addition, students who used cigarettes, alcohol and marijuana were twice as likely to make a plan, attempt suicide and make an attempt that required medical treatment than students who did not engage in these behaviors. According to national figures, gay and lesbian adolescents are two to three times more likely to attempt suicide than their heterosexual peers.

Equally troubling is the incidence of suicide among adults and older adults, especially men. Nationally, and in Vermont, suicide rates are highest among persons 65 and older. Because the elderly are the fastest growing segment of the population, the number of elderly suicides is projected to increase significantly. Reasons for higher suicide rates among the elderly include:

- Older people may be less likely to survive self-inflicted injuries due to weaker physical conditions.
- Older people may be more isolated and therefore less likely to be rescued after a suicide attempt.
- Suicidal acts of older people tend to be more planned and determined, with fewer warnings to others, and use of more violent methods.

White males aged 25-54 constitute the greatest numbers of suicide deaths in Vermont. Studies show that this group is the least likely to have sought mental health treatment prior to death. Of particular concern are individuals with careers that expose them to high levels of stress, violence and/or threats of violence. For military personal, both male and female, risk is high.

Females are twice as likely as men to attempt suicide, although men are nearly five times as likely to die in an attempt. Whereas, the most common method of suicide attempt is poisoning, followed distantly by cutting/piercing injuries, firearms are the most common method for suicide fatalities, followed by poisoning and suffocation/hanging for all individuals, and for individuals under 20 firearms are still most common yet suffocation/hanging follows with poisoning last. Vermont has the highest firearm-related suicide death rate of all six New England states.

Risk and Protective Factors for Suicide

Research shows us that there are identifiable risk and protective factors in suicidal behavior. Individuals possessing certain risk factors are thought to be at greater potential for suicidal behavior. Protective factors, on the other hand, reduce the likelihood of suicide. Risk and protective factor identification provides areas for intervention by reducing risk factors and enhancing protective factors.

Prevention is most effective when it focuses not only on identifying those people at imminent risk for suicide and facilitating rapid and appropriate interventions, but also to address early in a person's life those risk and protective factors, including the early identification and interventions in the mental illnesses associated with suicide, especially depression. Screening, gatekeeping and skill building such as the development of problem-solving, coping, mindfulness and cognitive skills, have particularly encouraging results in impacting suicidal behaviors. Media education and education of primary care physicians also has some evidence of helping with decreasing suicide.

Early intervention may occur at any stage of life, from childhood to old age. Clinical approaches for the identification, early intervention and prevention of several mental disorders for children and young people are available. They set out how to identify the signs and symptoms of an at-risk mental state for various mental disorders, and also how to provide an early intervention service approach that is effective and appropriate. Given the complexity of the mechanism of suicide, it seems likely that no one prevention/intervention strategy, by itself, is enough to combat this critical problem. Rather, a comprehensive, integrated effort, involving multiple domains-the individual, family, school, community, media, and health cares system-is needed.¹

² J.A.M. ACAD. Child Adolescent Psychiatry, 42:4, April 2003.

Risk and Protective Factors for Suicide

Table 1: Protective Factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)²

Individual factors	Family/Social factors	School context	Life events and situations	Community and cultural factors
<ul style="list-style-type: none"> • easy temperament • adequate nutrition • attachment to family • above-average intelligence • school achievement • problem-solving skills • internal locus of control • social competence • social skills • good coping style • optimism • moral beliefs • values • positive self-related cognitions 	<ul style="list-style-type: none"> • supportive caring parents • family harmony • secure and stable family • small family size • more than two years between siblings • responsibility within the family (for a child or adult) • supportive relationship with other adult (for a child or adult) • strong family norms and morality 	<ul style="list-style-type: none"> • sense of belonging • positive school climate • prosocial peer group • required responsibility and helpfulness • opportunities for some success and recognition of achievement • school norms against violence 	<ul style="list-style-type: none"> • involvement with significant other person (partner/mentor) • availability of opportunities at critical turning points or major life transitions • economic security • good physical health 	<ul style="list-style-type: none"> • sense of connectedness • attachment to and networks within the community • participation in church or other community group • strong cultural identity and ethnic pride • access to support services • community/cultural norms against violence

² Commonwealth Department of Health and Aged Care (2000), *Promotion, Prevention and Early Intervention for Mental Health—A Monograph*. (pp. 15) Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, Australia.

Table 2: Risk factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)³

Individual factors	Family/social factors	School context	Life events and situations	Community and cultural factors
<ul style="list-style-type: none"> • prenatal brain damage • prematurity • birth injury • low birth weight, birth complications • physical and intellectual disability • poor health in infancy • insecure attachment in infant/child • low intelligence • difficult temperament • chronic illness • poor social skills • low self-esteem • alienation • impulsivity 	<ul style="list-style-type: none"> • having a teenage mother • having a single parent • absence of father in childhood • large family size • antisocial role models (in childhood) • family violence and disharmony • marital discord in parents • poor supervision and monitoring of child • low parental involvement in child's activities • neglect in childhood • long-term parental unemployment • criminality in parent • parental substance misuse • parental mental disorder • harsh or inconsistent discipline style • social isolation • experiencing rejection • lack of warmth and affection 	<ul style="list-style-type: none"> • bullying • peer rejection • poor attachment to school • inadequate behavior management • deviant peer group • school failure 	<ul style="list-style-type: none"> • physical, sexual and emotional abuse • school transitions • divorce and family breakup • death of family member • physical illness/impairment • unemployment, homelessness • incarceration • poverty/economic insecurity • job insecurity • unsatisfactory workplace relationships • workplace accident/injury • caring for someone with an illness/disability • living in nursing home or aged care hostel • war or natural disasters 	<ul style="list-style-type: none"> • socioeconomic disadvantage • social or cultural discrimination • isolation • neighborhood violence and crime • population density and housing conditions • lack of support services including transport, shopping, recreational facilities

³ Commonwealth Department of Health and Aged Care (2000), *Promotion, Prevention and Early Intervention for Mental Health—A Monograph*. (pp. 16) Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, Australia.

Risk and Protective Factors for Suicide , continued

Individuals with mental health and/or health problems are at markedly higher risk to die by suicide. Mental Health problems that relate to a higher suicide rate include depression, psychotic disorders and drug/alcohol misuse. Individuals with medical conditions such as HIV/AIDS, Epilepsy, Spinal Cord Injury, Brain Injury, Huntington's chorea and Cancer are also increase risk. Children and adolescents with more emotional and behavioral problems report substantially more suicidal ideation and behavior. Suicide rates are higher for people who are not receiving treatment or whose current treatment is not effective and there is strong evidence that appropriate pharmacological treatment can dramatically reduce the risk of suicide in depression, schizophrenia and bipolar disorder for adults. . Early intervention for mental health problems therefore clearly has the potential to reduce the incidence of associated suicides. Furthermore suicide is the final outcome of what is usually a complex, cumulative and interacting set of risk factors. The trajectory is different for each individual and it is not possible to predict individual suicide with any certainty, although there are a number of personal and environmental factors that place people at increased risk.

Often suicide prevention is best approached indirectly; many intervention programs do not address the issue of suicide itself, and instead address risk or protective factors, such as depression, alcohol and other drug use, school failure, delinquency, family conflict, gun control, exposure to media violence and building resiliency. Suicide prevention programs may also target younger children, many years before they are likely to attempt suicide, when the risk factors for suicide and mental health problems are beginning to develop.⁴

Vermont has been piloting a pediatric collaborative for the past five years and it has been an effective model for provision of preventative care, early screening, early intervention, and service coordination for children and their families at risk for mental illness and/or substance abuse disorders. The primary care office seems to be a less stigmatizing environment where parents and children are more likely to address health concerns including issues of social and emotional health.

The model co-locates a community mental health professional jointly trained in mental health and substance abuse in a pediatric or family practice office to screen, coordinate mental health and substance abuse treatment, provide short-term intervention, and provide staff consultation. In addition, the primary care office will have regular consultation with a child psychiatrist for two hours a week. Finally, the model provides immediate access to more intensive mental health and substance abuse treatment when necessary, and allows early interventions which result in the reduction of mental health and substance abuse related issues. This ultimately reduces suicidal ideation and attempts throughout an individuals lifetime.

⁴ Commonwealth Department of Health and Aged Care (2000), *Promotion, Prevention and Early Intervention for Mental Health—A Monograph*. Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, Australia, 16-112.

State Platform for Suicide Prevention

When considering the types of interventions to use in a state suicide prevention program, specific state needs based on an assessment of the suicide problem should be considered. Programs that are comprehensive and include multiple interventions are believed to have a greater likelihood of reducing the suicide rate than programs targeting only one risk or protective factor.

Preventing Suicide in Vermont – Objectives for Action (based on the National Strategy for Suicide Prevention)

1. Promote awareness that suicide is a public health problem that is preventable.

Objective:

- Develop and implement public education that will increase knowledge about symptoms of depression, suicide risk and protective factors, indicators of possible suicidal behavior, skills for responding to a suicidal individual, and community resources.

Rationale:

If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, many lives can be saved.

Recommended Strategies:

- Support a public information campaign designed to increase public knowledge of suicide prevention.
- Develop a website for dissemination of information on suicide prevention.
- Ensure crisis line phone numbers are accessible.
- Develop and distribute brochures to multiple community settings such as school nurse offices, doctor's offices, hospitals, town clerk offices etc...
- Ensure directories clearly indicate where to call for support concerning suicide
- Ensure 211 includes suicide response information
- Add prevention resources to statewide web sight

2. Develop broad-based support for suicide prevention.

Objective:

- Collaboration across a broad spectrum of individuals, agencies, institutions, and groups to ensure that suicide prevention efforts are comprehensive.

Rationale:

Prevention of suicide must address psychological, biological, and social factors if it is to be effective.

Recommended Strategies:

- Establish a committee to coordinate suicide prevention efforts and support local communities in implementing the Vermont Suicide Prevention Platform.
- Encourage professional, voluntary and other groups to integrate suicide prevention activities into their ongoing programs and activities.

3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.

Objective:

- Increase help-seeking behavior by decreasing the stigma associated with mental illness and substance abuse.

Rationale:

Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. The stigma of suicide itself is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. Embarrassment, stigma and fear are the main reasons people do not seek help for their problems. Recognizing and responding appropriately to such troubled people can prevent suicides. In addition, wider public understanding of the science of the brain and behavior can reduce the stigma associated with seeking help for behavioral health problems, and consequently may contribute to reducing the risk of suicidal behavior. A community-wide campaign can be an effective way to provide useful information on these subjects to all citizens.

Recommended Strategies:

- Co-locate mental health and substance abuse professionals with primary care providers to detect early warning signs of depression.
- Educate the public and providers that mental and physical healths are equal and inseparable components of overall health; and that mental disorder are real illnesses that respond to specific treatments.
- Normalize that suicidal thoughts are not uncommon for most people at some point in their life when they are sad, or have experienced a traumatic event.

4. Develop and implement effective suicide prevention programs.

Recommended Programs, based on literature:

A. Skills Training

Objectives:

- Increase problem-solving, coping, mindfulness and cognitive skills for all ages, these practices are most effective when initiated with children and youth.
- Ensure skill training continues throughout lifetime
- Reduce suicide risk factors, e.g. depression, hopelessness, and drug abuse.

Rationale:

90% of people completing suicide have a diagnosable emotional problem. Skill training/building is used to build generic social/emotional cognitive skills as a means to reduce psychopathology. This is usually most effective when provided earlier in multiple settings involving multiple people in an individual's life and is continued over the lifetime. There are several areas of prevention interventions where skills can be developed in order to address risk factors. There are many programs available that have proven records of reducing social/emotional issues through the development of skills (i.e.; Promoting Alternative Thinking Strategies, Second Step, ...).

Recommended Strategies:

- Provide skill building in school and community settings that works to reduce the impact of multiple-risk factors, enhance protective factors, and involve families.
- Emphasis continued skill development in adult settings, such as their work place.

B. Screening for Mental Illness

Objectives:

- Increase case finding through direct screening.
- Increase referrals of identified individuals for further evaluation and intervention.

Rationale:

Providing a quick screen to determine if further evaluation and assessment is needed to assess risk for mental illness is beneficial in the prevention of suicidal behavior and suicide. Since mental illness has a link to suicidal acts it is important to have the ability to identify risk as soon as possible. Screenings can be conducted by mental health professionals, physicians and some school personnel. Some examples of strategies include Teen Screen, the Diagnostic Interview Schedule for Children Predictive Scales which is a questionnaire that indicate likelihood of psychiatric diagnosis in young people 8-18 and “Ready 6+4.”

Recommended Strategies:

- Screen for suicide risk in a variety of settings.
- Assess current efforts and gaps in screening for suicide risk in school and community settings.
- Identify screening approach, either focused or broad.
- Identify environments where high-risk groups appear and where screening should occur.
- Identify screening instruments for all age groups
- Train professional staff to administer screening process.
- Ensure that clinicians are available to assess and treat referred individuals.

C. School-based Prevention Programs –

Objective:

- Increase knowledge of depression and suicide for all students, faculty, staff administration, and parents.

Rationale:

School-based universal programs are needed to complement community education efforts in order to reach youth and are an effective method of disseminating information about suicide to large segments of the youth population; the programs can be delivered within the existing educational context and directed toward the promotion of mental health. There is *no* evidence that school-based prevention programs increase the likelihood of suicide ideation or suicidal behavior. There is evidence, however, that some suicide awareness programs may have some negative outcomes for high-risk youth—e.g., white males and youth who have previously attempted suicide were less likely to seek help. Thus, school-based programs should only be implemented when they are coordinated with ways to *identify* and *assist* high-risk youth through screening programs and Gatekeeper training.

Recommended Strategies:

- Support school-based instructional content.

D. Gatekeeper Training

Objective:

- Establish a network of adults and youth in every community who can recognize and respond to individuals exhibiting signs of suicide risk and can assist them in getting professional help.

Rationale:

Adults and youth who routinely interact with others generally lack the critical skills for identifying people at high risk for suicide or suicidal behavior. Because suicides tend to occur during the early phase of depressive episodes, many family members and other significant people don't recognize warning signs. A gatekeeper training program is the process of teaching youth and significant adults specific strategies for recognizing, responding to, and connecting suicide-risk people to persons capable of crisis intervention.

Recommended Strategies:

- Encourage gatekeeper training (Suicide Intervention Training) *for adults* who work with youth to build their competence and confidence to:
 - recognize risk factors associated with youth suicide
 - identify at-risk youth
 - communicate with youth at risk for suicide
 - make referrals to connect at-risk youth with skill-building and/or crisis intervention services
 - implement policies to guide interventions with at-risk youth (e.g., never leave a suicidal youth alone)
 - facilitate a 30- to 45-minute awareness program on the topic of youth suicide
 - serve on a school/community prevention team and/or crisis response team
- Encourage gatekeeper training (Suicide Intervention Training) *for youth* to build their competence and confidence to:
 - recognize the risk factors associated with youth suicide
 - increase positive communication with youth at risk for suicide
 - tell an adult of their concerns about a peer
 - connect a peer at risk with an adult capable of helping
- Encourage citizen gatekeeper training (Suicide Intervention Training) *for community members* to train community gatekeepers to recognize suicidal communications and warning signs, of youth, adults and elderly, and steps that can be taken to help prevent a suicidal act.
 - recognize the risk factors associated with suicide
 - increase positive communication with individuals at risk for suicide
 - tell a professional about the concerns about an individual
 - connect a person at risk with an individual capable of helping

- Provide comprehensive suicide prevention training programs and educational and clinical materials for parents, family members, the general public, professionals, and institutes.

Curricula include: Assist- a two day workshop to provide participants with gatekeeper knowledge and skills in order to recognize warning signs and intervene with appropriate assistance, Signs of Suicide (S.O.S.) teaches students how to identify symptoms of depression and suicidality in themselves or their friends and encourages help-seeking. The program's primary objectives are to educate teens that depression is a treatable illness and to equip them to respond to a potential suicide in a friend or family member using the SOS technique and Question Persuade and Respond (QPR) people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

5. Promote efforts to reduce access to lethal means and methods of self-harm.

Objective:

- Reduce access to lethal means to completing suicide including guns, poisons and medications, and alcohol and other drugs.

Rationale: Choice of method for suicide is based on access knowledge and familiarity. Ready access to lethal weapons increases the likelihood that an individual will complete suicide. Individuals who are both suicidal and impulsive tend to be at greatest risk for death by firearms. Removing or restricting access to means of suicide is an effective prevention strategy. Individuals contemplating suicide tend to chose one type of method; limiting access to one method does not increase the probability that another method will be chosen.

Recommended Strategies:

- Train professionals and other adults that provide professional services to individuals at risk for suicide about firearm access issues and how to educate families about associated risk.
- Encourage primary care and other health care providers to routinely assess the presence of lethal means (including firearms, drugs and poisons) in the home and educate patients about associated risks.
- A Public Educational campaign of "Means-Restriction." The purpose is to reduce youth's access to lethal means of completing suicide including guns, poisons and medications, alcohol and other drugs. This entails:
 - Educating the public to increase awareness about the link between lethal means in the home and completed suicide.
 - Educating parents and guardians, health professionals and other adults about links between alcohol/drug use in suicide attempts.
 - Soliciting help from community gun owners and sellers to support campaigns for safe gun handling and storage.
 - Distributing flyers, public forums, and media coverage illustrating strategies for securing weapons in the home (gun cases, trigger locks, etc.) and safety methods, in general, within the context and responsibility of the parenting role, and methods for storing medication, particularly prescription medication and those that are dispensed in large quantities.
- Perhaps the most promising, economical and least-used strategy for preventing youth suicide is restricting access to lethal means.

- Choice of method for suicide is based on access, knowledge and familiarity. Removing or restricting access to means of suicide is an effective prevention strategy. Limiting access to lethal means can decrease suicide.
- Ready access to lethal weapons increases the likelihood that a youth will complete suicide.
- Youth who are both suicidal and impulsive tend to be at greatest risk for death by firearms.

6. Support training for recognition of at-risk behavior and delivery of effective treatment.

Objective:

- All professional training in the state will incorporate suicide prevention and intervention curricula.

Rationale:

Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients in need of specialized assessment techniques and treatment approaches. Key gatekeepers – people who regularly come into contact with individuals or families in distress – need training in order to be able to recognize factors that place individuals at risk for suicide, and to learn appropriate interventions. Key gatekeepers include teachers and school personnel, clergy, police officers, primary health care providers, child care centers, mental health care providers, correctional personnel, emergency health care personnel, and employers.

Recommended Strategies:

- Provide training for clergy, teachers and other educational staff, correctional workers, attorneys, employers and others on how to identify and respond to persons at risk for suicide.
- Improve suicide prevention training for nurses, physician assistants, physicians, social workers, psychologists and other counselors.
- Provide educational programs for family members of persons at elevated risk.
- Licensure requirements for relevant professions should specifically include suicide training.
- Ongoing training for education staff and administration.
- Ongoing support coordinated at the state level (DOE, VDH, etc.)

7. Develop and promote effective clinical and professional practices.

Objectives:

- Increase mental health follow up for patients who present with self-destructive behavior.
- Increase the number of patients who receive and maintain treatment, who experience a mood disorder and/or substance abuse.

Rationale:

By improving clinical practices in the assessment, management, and treatment for individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved

Recommended Strategies:

- Encourage hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings to assess suicide risk and intervene to reduce suicidal behaviors among patients.

- Incorporate screening for depression, substance abuse and suicide risk in primary care settings, hospice, skilled nursing facilities, home health agencies, private practice and Area Agencies on Aging.
- Encourage clinicians to provide ongoing depression inventories to their clients who present with suicidal ideation.
- Enhance crisis treatment.
- Ensure that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g. emergency medical technicians, firefighters, police, and funeral directors).
- Ensure that persons treated in emergency departments for trauma, sexual assault, or physical abuse receives mental health services.
- Foster the education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.
- Co-locate mental health and substance abuse professionals in primary care offices. These professionals also need to understand the nature of suicide and be skilled in postvention services in the event of a consumer death by suicide.
- Increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.

8. Improve access to mental health and substance abuse services and better coordinate services of the variety of community institutions.

Objective:

- All people in need will have timely and appropriate access to mental health and/or substance abuse services.
- Increase the knowledge of Employee Assistance Programs and Worker's Compensation programs that specific at risk population, certain professions, isolated elders, gay/lesbians youth, military returning home from active duty are at greater risk

Rationale:

Barriers to equal access and affordability of health care may be influenced by many factors. Reducing disparities is a necessary step in ensuring that all Vermonters receive appropriate physical health, mental health, and substance abuse services. One aspect of improving access is to better coordinate the services of a variety of community institutions. This will help ensure that individuals who are at high risk for suicide due to mental health or substance abuse problems receive the services they need.

Recommended Strategies:

- Encourage health insurance plans to cover access to mental health and substance abuse care on par with access to physical health care.
- Integrate mental health, substance abuse and suicide prevention into health and social services outreach programs for at-risk populations.
- Co-locating mental health and substance abuse professionals in primary care offices.
- Continue to build capacity for mental health and substance abuse treatment.

9. Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the news media.

Objective:

- Reduce suicide contagion through communications media by providing editors with guidelines for reporting suicide and suicide prevention resource information.

Rationale:

Research has found that media representations of suicide may increase suicide rates, especially among youth. Imitation plays a role in certain individuals engaging in suicidal behavior. The media, however, can play a positive role in suicide prevention even as they report on suicide or depict it and related issues. Media portrayals of mental illness and substance abuse may also affect the suicide rate. Negative views of these problems may lead individuals to deny they have a problem or be reluctant to seek treatment.

Recommended Strategies:

- Encourage news reports on suicide to observe recommended guidelines in the depiction of suicide and mental illness as outlined in Attachment B: *Reporting on Suicide: Recommendations for the Media*.
- Encourage journalism programs in schools and colleges to include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.
- Run articles on preventive measures.
- Review media recommendations regularly to incorporate latest information with recommendations.

10. Improve and expand surveillance systems.

Objective:

- Develop an information system that allows timely tracking of important suicide related information, such as trends and clusters, and allows for sufficient planning and intervention.

Rationale:

Data on suicide and suicidal behavior are needed to draw attention to the magnitude of the suicide problem and to examine differences in rates among groups and locales. Data helps establish program priorities and are necessary for evaluating the impact of suicide prevention strategies.

Recommended Strategies:

- Develop and implement standardized protocols for death scene investigations.
- Increase the number of follow-back studies on all completed suicides.
- Improve data collection on suicide attempts – via National Violent Death Reporting System, NVDRS
- Produce reports on suicide and suicide attempts, integrating data from multiple Vermont data management systems.
- Explore mandating reports on suicide attempts to Vermont Department of Health
- Distribute data via web sight to appropriate parties and professionals.

Resources for Suicide Prevention

National Strategy for Suicide Prevention website and document clearinghouse. The website/clearinghouse provides electronic linkages among partners involved in the NSSP and provides information and support for collaboration in achieving the NSSP.

<http://www.mentalhealth.org/suicideprevention>

National Mental Health Strategy, Promotion, Prevention and Early Intervention for Mental Health-Australia 2000

Vermont Crisis Intervention and Suicide Prevention Expertise

Addison County

Counseling Service of Addison County 388-7641

Bennington County

United Counseling Services 442-5491
Family Emergency Services 447-8270 or 442-1400
Manchester 362-3950

Caledonia County

Northwest Kingdom Mental Health Services
St. Johnsbury 748-3181

Chittenden County

Howard Center for Human Services
First Call Crisis Line for Children & Families 864-7777
Adult Crisis Services Hotline 863-2400

Franklin/Grand Isle

Franklin/Grand Isle Mental Health Services 524-6554

Lamoille County

Lamoille County Mental Health Services 888-49145026

Orange County

Clara Martin Suicide Hotline 800-639-6360

Orleans County

Northeast Kingdom Mental Health Services
Newport 334-6744

Rutland County

Rutland Mental Health Services, Family Focus Program (Children) 802-773-4225
Rutland Mental Health Services, Adult Crisis Services (Adults) 802-775-1000

Washington County

Washington County Mental Health Services 229-0591

Windham & Windsor Counties

Health Care & Rehabilitation Services 800-622-4235

Statewide Hotlines

Domestic Violence 1-800-228-7395

Sexual Assault 1-800-489-7273

Outright Vermont –support for lesbian, gay, bisexual, transgender and questioning youth ages 22 and under 10am-6pm 1-800-452-2428 (1-800-GLB-CHAT)

Parents Assistance Line 1-800-727-3687 (1-800-PARENTS)

211 information hotline

References

National Strategy for Suicide Prevention: Goals and Objectives for Action. US Department of Health and Human Services. Rockville, MD, 2001.

Silverman MM, Davidson L and Potter L (Eds.) National Suicide Prevention Conference Background Papers. Special Supplement. *Suicide and Life Threatening Behavior* 2001, 31.

Data Sources

VT Department of Health

- VT Vital Statistics System
- VT Hospital Discharge Data / Emergency Department Data
- VT Youth Risk Behavior Survey

National Hotline

Attachment A

Reporting on Suicide: Recommendations for the Media

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

Developed in collaboration with

World Health Organization • National Swedish Centre for Suicide Research • New Zealand
Youth Suicide Prevention Strategy

Suicide Contagion is Real

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

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

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

RECOMMENDATIONS

The media can play a powerful role in educating the public about suicide prevention. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy and need to be covered, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates.^{1,2}

- Certain ways of describing suicide in the news contribute to what behavioral scientists call "suicide contagion" or "copycat" suicides.^{7,9}
- Research suggests that inadvertently romanticizing suicide or idealizing those who take their own lives by portraying suicide as a heroic or romantic act may encourage others to identify with the victim.⁸
- Exposure to suicide method through media reports can encourage vulnerable individuals to imitate it.¹⁰ Clinicians believe the danger is even greater if there is a detailed description of the method. Research indicates that detailed descriptions or pictures of the location or site of a suicide encourage imitation.¹
- Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.⁸

SUICIDE AND MENTAL ILLNESS

Did you know?

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

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

Questions to ask:

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

Angles to pursue:

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

INTERVIEWING SURVIVING RELATIVES AND FRIENDS

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

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

Angles to Pursue:

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

Concerns:

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

LANGUAGE

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

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

Recommendations for language:

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

SPECIAL SITUATIONS

Celebrity Deaths

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

Homicide-Suicides

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

Suicide Pacts

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

STORIES TO CONSIDER COVERING

- Trends in suicide rates
- Recent treatment advances
- Individual stories of how treatment was life-saving
- Stories of people who overcame despair without attempting suicide
- Myths about suicide
- Warning signs of suicide
- Actions that individuals can take to prevent suicide by others

References

1. Sonneck, G., Etzersdorfer, E., & Nagel-Kuess, S. (1994). Imitative suicide on the Viennese subway. *Social Science and Medicine*, 38, 453- 457.
2. Etzersdorfer, E., & Sonneck, G. (1998). Preventing suicide by influencing mass-media reporting. The Viennese experience 1980-1996. *Archives of Suicide Research*, 4, 67-74.
3. Phillips, D.P., Lesyna, K., & Paight, D.J. (1992). Suicide and the media. In R.W. Maris, A.L. Berman, J.T. Maltzberger et al. (Eds.), *Assessment and prediction of suicide* (pp. 499-519). New York: The Guilford Press.
4. Hassan, R. (1995). Effects of newspaper stories on the incidence of suicide in Australia: A research note. *Australian and New Zealand Journal of Psychiatry*, 29, 480-483.
5. Stack, S. (1991). Social correlates of suicide by age: Media impacts. In A. Leenaars (Ed.), *Life span perspectives of suicide: Timelines in the suicide process* (pp. 187-213). New York: Plenum Press.
6. Fekete, S., & A. Schmidtke. (1995) The impact of mass media reports on suicide and attitudes toward self-destruction: Previous studies and some new data from Hungary and Germany. In B. L. Mishara (Ed.), *The impact of suicide*. (pp. 142-155). New York: Springer.
7. Schmidtke, A., & Häfner, H. (1988). The Werther effect after television films: New evidence for an old hypothesis. *Psychological Medicine* 18, 665-676.
8. Gould, M.S., & Davidson, L. (1988). Suicide contagion among adolescents. In A.R. Stiffman, & R.A. Feldman (Eds.), *Advances in adolescent mental health* (pp. 29-59). Greenwich, CT: JAI Press.
9. Gould, M.S. (2001). Suicide and the media. In H. Hendin, & J.J. Mann (Eds.), *The clinical science of suicide prevention* (pp. 200-224). New York: Annals of the New York Academy of Sciences.
10. Fekete, S., & Macsai, E. (1990). Hungarian suicide models, past and present. In G. Ferrari (Ed.), *Suicidal behavior and risk factors* (pp. 149- 156). Bologna: Monduzzi Editore.
11. Robins, E. (1981). *The final months: A study of the lives of 134 persons*. NY: Oxford University Press.
12. Barraclough, B., & Hughes, J. (1987). *Suicide: Clinical and epidemiological studies*. London: Croom Helm.
13. Conwell Y., Duberstein P. R., Cox C., Herrmann J.H., Forbes N. T., & Caine E. D. (1996). Relationships of age and axis I diagnoses in victims of completed suicide: a psychological autopsy study. *American Journal of Psychiatry*, 153, 1001-1008.
14. Brent, D.A., Perper, J.A., Moritz, G., Allman, C., Friend, A., Roth, C., Schweers, J., Balach, L., & Baugher, M. (1993). Psychiatric risk factors for adolescent suicide: a case-control study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32 (3), 521-529.

15. Shaffer, D., Gould, M.S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, 53 (4), 339-348.
16. Mann, J.J., Waternaux, C., Haas, G.L., & Malone, K.M. (1999). Toward a clinical model of suicidal behavior in psychiatric patients. *American Journal of Psychiatry*, 156 (2), 181-189.
17. Soloff, P.H., Lynch, K.G., Kelly, T.M., Malone, K.M., & Mann, J.J. (2000). Characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder: a comparative study. *American Journal of Psychiatry*, 157 (4), 601-608.
18. Fawcett, J. (1990). Targeting treatment in patients with mixed symptoms of anxiety and depression. *Journal of Clinical Psychiatry*, 51 (Suppl.), 40-43.
19. Gould, M.S., Fisher, P., Parides, M., Flory, M., & Shaffer, D. (1996). Psychosocial risk factors of child and adolescent completed suicide. *Archives of General Psychiatry*, 53, 1155-1162.
20. Moscicki, E.K. (1999). Epidemiology of suicide. In D.G. Jacobs (Ed.), *The Harvard Medical School Guide to suicide assessment and intervention* (pp. 40-51). San Francisco: Jossey-Bass.
21. Ness, D.E., & Pfeffer, C.R. (1990). Sequelae of bereavement resulting from suicide. *American Journal of Psychiatry*, 147, 279-285.
22. Barraclough, B., Bunch, J., Nelson, B., & Sainsbury, P. (1974). A hundred cases of suicide: clinical aspects. *British Journal of Psychiatry*, 125, 355-373.
23. Brent, D.A., Perper, J.A., Kolko, D.J., & Zelenak, J.P. (1988). The psychological autopsy: methodological considerations for the study of adolescent suicide. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27 (3), 362-366.
24. Wasserman, I. M. (1984). Imitation and suicide: A re-examination of the Werther effect. *American Sociological Review*, 49, 427-436.
25. Rosenbaum, M. (1990). The role of depression in couples involved in murder-suicide and homicide. *American Journal of Psychiatry*, 47 (8), 1036-1039.
26. Nock, M.K., & Marzuk, P.M. (1999). Murder-suicide: Phenomenology and clinical implications. In D.G. Jacobs (Ed.) *The Harvard Medical School guide to suicide assessment and intervention* (pp. 188-209). San Francisco: Jossey-Bass.
27. Fishbain, D.A., D'Achille, L., Barsky, S., & Aldrich, T.E. (1984). A controlled study of suicide pacts. *Journal of Clinical Psychiatry*, 45, 154-157.

Resources

United States

- Centers for Disease Control and Prevention
Phone: 1-800-311-3435
www.cdc.gov
- National Institute of Mental Health
Phone: 301-443-4513
www.nimh.nih.gov
- Substance Abuse and Mental Health Services Administration
Phone: 1-800-487-4890
www.samhsa.gov
- Office of the Surgeon General
National Strategy for Suicide Prevention
www.mentalhealth.org/suicideprevention
- American Association of Suicidology
Phone: 202-237-2280
www.suicidology.org

International

- Canterbury Suicide Project (New Zealand)
Phone: 64 3 364 0530
www.chmeds.ac.nz/RESEARCH/SUICIDE/Suicide.htm
- National Swedish Centre for Suicide Research
Phone: +46 08/728 70 26
www.ki.se/ipm/enheter/engSui.html
- National Youth Suicide Prevention Project (Australia)
Phone: 61 3 9214 7888
www.aifs.org.au/ysp
- Suicide Information and Education Centre
Phone: 403 245-3900
www.suicideinfo.ca
- World Health Organization
Phone: +00 41 22 791 21 11
www.who.int

American Foundation
for Suicide Prevention
Phone: 1-888-333-AFSP
Phone: 212-363-3500
Web: www.afsp.org

These recommendations were produced in the spirit of the public-private partnership recommended by the Surgeon General's National Strategy for Suicide Prevention.

We would like to thank the many journalists and news editors who assisted us in this project.

The Annenberg Public Policy Center's involvement was funded by The Robert Wood Johnson Foundation.