



THE
COLORADO
TRUST



PREVENTING SUICIDE IN COLORADO

Progress Achieved & Goals for the Future

ACKNOWLEDGMENTS

The findings and recommendations of this report were developed collaboratively by researchers, advocates and experts in the field of suicide prevention. The report process and development of recommendations were conducted by Mental Health America of Colorado, under the leadership of Jeanne Rohner. Data analyses and report content were prepared by Jean Demmler, PhD of Heartland Network for Social Research, Anita S. Coen, MSW, LCSW of Focus Research & Evaluation and Jenny Shaw and Deb Kupfer, MHS of the Western Interstate Commission on Higher Education Mental Health Program.

The authors would like to thank the following individuals for providing consultation and advice over the course of this project:

- Dr. Holly Hedegaard, Director of the Colorado Violent Death Reporting System, Colorado Department of Public Health and Environment
- Ellen Susman, Professor, Department of Psychology, Metropolitan State College of Denver
- Stacey Freedenthal, Assistant Professor, University of Denver Graduate School of Social Work
- Diane C. Patrick
- Dr. Lawrence E. Adler, Director, Mental Health Illness Research, Education and Clinical Centers of the VA Rocky Mountain Network
- David L. Shern, President and CEO, Mental Health America
- Cindy Wakefield, Principal Consultant, Colorado Department of Education
- Hope Wisneski, Deputy Executive Director, Rainbow Alley

Thanks also to Denver freelance writer and editor Suzanne Weiss, who crafted the final report, and to Hanna Design for the graphic design of this report.

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TABLE OF CONTENTS

Suicide Prevention in Colorado: 1998-2008..... 1-2

Key Facts and Figures..... 3-14

Notable Programs, Partnerships and Assets 15-18

Strategic Goals and Objectives for the Next 10 Years and Beyond 19-24

Endnotes 25-26

Appendices 27-42

Appendix A: Number of Colorado Suicide Deaths by County

Appendix B: Population-Weighted and Age-Adjusted Mean Suicide Death Rates by County

Appendix C: State and Local Suicide-Prevention Organizations, Coalitions and Resources

Appendix D: Suicide-Prevention Education and Training Programs

Appendix E: Steering Committee and Advisory Council Members

*Appendix F: Suicide Prevention Resources and Needs Survey: Public Middle
and High Schools in Colorado, Report Summary*

DEAR READERS,

We are pleased to share with you this report on the evolution and progress of the state's suicide-prevention efforts. Much has been learned and accomplished over the last decade, when Colorado became one of the first states in the nation to craft a comprehensive strategy for mitigating and preventing suicide.

Today, a variety of individuals, organizations and constituencies throughout the state are working together to promote mental health literacy and educate diverse populations about suicide and suicide prevention. Among Colorado's key assets is a growing infrastructure of collaborative, community-based outreach, education and training, intervention, treatment and support programs. These community-based efforts have further benefitted from a stable core of leadership at the state level, as well as vital support from federal agencies and foundations.

But considerable challenges and much hard work lie ahead. While the state's average annual suicide rate has declined 6.5% since 1998, it remains significantly above the national average – and, as of 2005, sixth-highest among the states.

Together with information about progress achieved, prevention efforts and data on the incidence of suicide in Colorado, this report offers a set of strategic goals and objectives informed by experts and community stakeholders across the state. These goals are designed to help guide and advance Colorado's ongoing suicide-prevention agenda over the next decade and beyond.

We offer our appreciation to everyone involved in the preparation of this report – mental health professionals and practitioners, consumers, families, educators, researchers, advocacy groups, service providers, suicide survivors, community members and other key partners. Special recognition goes to the Colorado Office of Suicide Prevention and the Suicide Prevention Coalition of Colorado for their contributions to this report and for their ongoing dedication to ending the devastation of suicide.

It is our hope that the information and ideas presented in this report provide both a heartfelt thanks for the significant progress achieved by the many dedicated individuals and organizations working to prevent suicide in Colorado, as well as an understanding of how our state can continue to build on this firm foundation to further address this critical public-health problem.



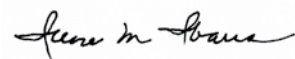
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SUICIDE PREVENTION IN COLORADO: 1998-2008

In spring 1998, Governor Roy Romer signed an executive order declaring suicide a major public health problem in Colorado that warranted systematic investigation and analysis, wide discussion and concerted action at the state and local levels.

Within months, Colorado became one of the first states in the nation to craft a strategic plan for mitigating and preventing suicide – across the life span, from childhood to old age.

The Colorado Suicide Prevention and Intervention Plan, issued in November 1998 by a 30-member advisory commission appointed by Governor Romer, was based on a comprehensive analysis of data from state and county agencies, health care providers, educational institutions, employers and other sources. The advisory commission and its staff also sifted through more than 400 reports and studies on suicide prevention and conducted hearings, small-group discussions and interviews in communities across the state.

The plan took the form of an in-depth report that included an overview of the suicide problem in Colorado, a statement of principles and goals, and several dozen “implementation tasks.”

In transmitting its findings and recommendations to Governor Romer in 1998, the advisory commission described the document as “a starting point, a template for action ... a fluid plan that should be tested regularly and evolve in light of new knowledge.”

A major step forward was the passage of legislation in spring 2000 establishing a new state agency – the Office of Suicide Prevention (OSP) – to lead and coordinate the implementation of the advisory commission’s recommendations. Their efforts are further aided by the Suicide Prevention Coalition of Colorado, which serves as the board of directors to this agency.

Over the years, OSP has been instrumental in the development of a growing infrastructure of community-based outreach, education and training, intervention and treatment programs. It has developed strong working relationships with other executive-branch agencies; nonprofit state, regional and community suicide-prevention coalitions; and funders ranging from local foundations to the federal Centers for Disease Control and Prevention (CDC).

Additionally, The Colorado Trust has invested \$4.1 million in suicide prevention over the past six years, supporting research, strategic planning and a range of activities and programs in 31 counties across the state. Multi-year federal grants also have enabled Colorado to expand its ability to collect, analyze and report suicide-related data, and fueled development of innovative prevention and intervention models on college campuses in Boulder, Denver and Trinidad. Today, across Colorado – in rural, urban and suburban communities alike – partners are working together to promote mental health literacy and suicide prevention among diverse populations.

But Colorado’s progress toward its goal of preventing suicide has been limited and uneven. While the state’s average annual suicide rate has declined 6.5% over the past decade, it remains significantly above the national average and, as of 2005, sixth-highest among the states. In a given year, more Coloradans die by suicide than in motor-vehicle accidents or from illnesses such as diabetes, pneumonia or breast cancer. And thousands of other young

people and adults are hospitalized or treated in emergency rooms following suicide attempts.

In 2007, Mental Health America of Colorado (MHAC) and Heartland Network for Social Research received support from The Colorado Trust to undertake a review of the original state plan and to update the 2002 Trust report, *Suicide in Colorado*, with a focus on:

- Assessing the relative strengths and shortcomings of the state’s approach to suicide prevention from a variety of standpoints and perspectives
- Identifying unmet or previously undetected needs; emerging issues, trends and priorities; and opportunities to build on what has been learned and accomplished thus far.

The 10-member steering committee created to coordinate this effort gathered, analyzed and shared data from a variety of sources; conducted hearings, small-group discussions and interviews in communities across the state; and reviewed the current knowledge base on suicide and suicide prevention.

The work of the steering committee and its team of researchers and suicide-prevention experts culminated in the development of a set of strategic goals and objectives designed to guide and advance Colorado’s suicide-prevention efforts over the next 10 years and beyond. They include:

- Developing the full potential of the state Office of Suicide Prevention as a mechanism for cross-system information sharing, partnership building and resource development
- Promoting mental health literacy in a variety of settings and formats, with an emphasis on increasing knowledge and changing attitudes about suicide
- Expanding and equalizing access to mental health care, substance abuse treatment and crisis intervention services
- Using data to guide planning, investment and changes in policy and practice.

This report is the product of sustained leadership and effort on the part of many individuals, organizations and constituencies – mental health professionals and practitioners, educators, advocacy groups, suicide survivors, social-service providers and state and local leaders.

Their collective contributions and hard work over the past year are a powerful affirmation of the state’s continuing commitment to increasing recognition of suicide as a public health problem that must be strategically addressed across a broad spectrum of agencies, institutions, systems and sectors.

About Rate vs. Numbers

The rate of suicide in a specific population can be high while the actual number of deaths can be low, and vice versa. For example, between 1999 and 2007, about 400 males aged 75 years or older died by suicide compared with more than 2,000 males between 35 and 54 years of age over the same time period. The suicide rate for the older men (58 per 100,000 older men in Colorado’s population), however, far exceeds the rate of the younger men (33 younger men per 100,000) and that of any other age-gender group. In other words, although the number of deaths may seem comparatively low for this elderly male population, the risk for suicide, as indicated by the rate of suicide, is very high. The knowledge of the number of deaths in any given age group allows service providers to plan for the level of suicide prevention services that may be needed, while understanding suicide death rates pinpoints the groups most at risk. Given the potentially different uses of such data, both the rates and numbers of death by suicide are presented in this document.

KEY FACTS AND FIGURES

Suicide and suicide attempts are a major public health problem in Colorado.

There are no definitive research findings that explain the higher rates of suicide in Western mountain states or in Colorado. Using general knowledge about risks for suicide and Colorado's demography, culture and mental health services, Colorado Department of Public Health and Environment staff and Colorado's suicide prevention stakeholders suggest a combination of factors have likely resulted in an above-average state suicide rate. Lower population density as well as a high rate of migration into the state promotes social and geographical isolation that can contribute to greater suicide risk for Colorado residents. There is also some evidence that high rates of gun ownership may contribute to the higher rates of suicide. Other factors may be higher levels of stigma about the use of mental health services and less availability of such services in Colorado than states in other regions.³

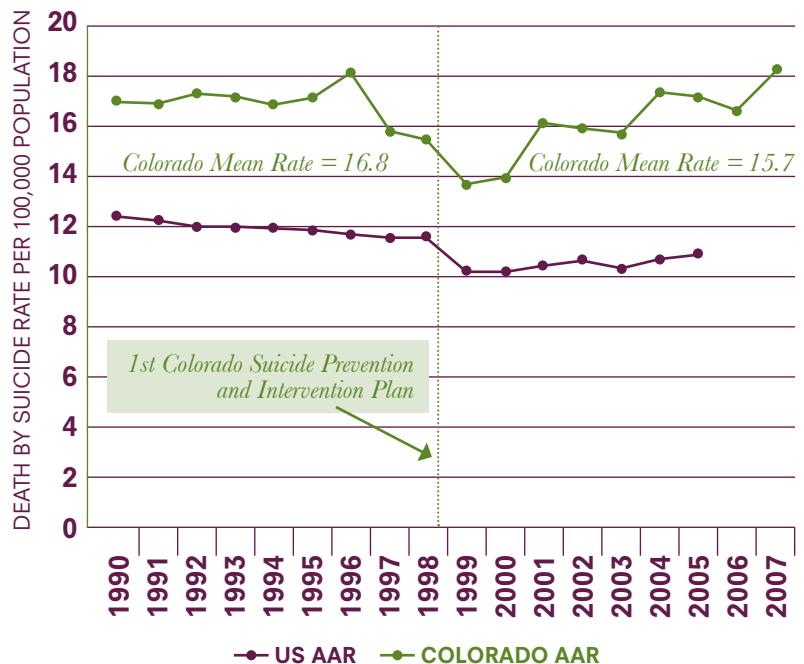
In 2007, more Coloradans died by suicide – 805 – than in motor-vehicle accidents or from illnesses such as diabetes, pneumonia or breast cancer.¹

While the state's average annual suicide rate has declined 6.5% subsequent to 1998, with 15.7 deaths by suicide per 100,000 persons in Colorado, it remains significantly above the national average of 11 deaths per 100,000 persons – and, as of 2005, sixth-highest among the states.² (See Figure 1 and Table 1)

Of the estimated 12,800 suicide attempts in the state each year⁴, roughly one-fourth result in hospitalization.⁵ There are, however, no statewide data about the estimated thousands of suicide attempters who are treated in emergency rooms and released or treated in primary-care offices, or who receive no medical attention.

FIGURE 1

Trends in U.S. and Colorado Annual Suicide Rates



Sources: Colorado Department of Public Health and Environment (CDPHE); Centers for Disease Control (CDC)
AAR = Age Adjusted Rate

TABLE 1

CDC WISQARS* Suicide Death Data: 2001-2005

STATE	# OF DEATHS	AGE-ADJUSTED RATE	STATE	# OF DEATHS	AGE-ADJUSTED RATE
Alaska	644	19.99	Alabama	2,623	11.52
Montana	920	19.85	New Hampshire	752	11.33
Nevada	2,164	19.43	South Carolina	2,375	11.33
New Mexico	1,752	18.91	Louisiana	2,495	11.22
Wyoming	475	18.84	Iowa	1,646	11.06
Colorado	3,774	16.54	Georgia	4,713	11.01
Idaho	1,093	16.33	Virginia	4,098	10.95
Utah	1,722	15.85	Delaware	452	10.9
Arizona	4,318	15.61	Texas	11,617	10.87
Oregon	2,730	14.89	Ohio	6,240	10.74
West Virginia	1,368	14.48	Pennsylvania	6,797	10.68
Oklahoma	2,520	14.42	Michigan	5,392	10.66
South Dakota	534	13.99	Nebraska	917	10.65
Arkansas	1,894	13.83	Minnesota	2,545	9.95
Tennessee	3,899	13.1	Hawaii	610	9.56
Florida	11,685	13	California	16,030	9.28
Kentucky	2,728	13	Maryland	2,394	8.63
North Dakota	416	12.97	Illinois	5,409	8.52
Vermont	418	12.97	Connecticut	1,404	7.85
Washington	3,978	12.78	Rhode Island	414	7.49
Kansas	1,717	12.6	Massachusetts	2,200	6.63
Missouri	3,539	12.27	New Jersey	2,862	6.49
Mississippi	1,720	12.12	New York	6,026	6.15
Maine	810	11.84	District of Columbia	173	5.6
Indiana	3,643	11.73			
North Carolina	4,974	11.67			

Source: Colorado Office of Suicide Prevention

* Centers for Disease Control and Prevention Web-based Inquiry Statistics Query and Reporting System

As a leading cause of death and injury in Colorado, suicide behavior is costly to Colorado's economy. Estimates of direct and indirect economic burden to our state combine to more than \$1 billion annually. Direct costs include health care expenses, autopsies and criminal investigations. Indirect costs include work lost primarily by younger persons who complete suicide.⁶

The risk of suicide and attempted suicide varies by gender, age group, race and ethnicity.

From adolescence on, males are at significantly higher risk of death by suicide than females.

The largest number of suicide deaths – roughly one-third in a given year – occur among men ages 35 to 54. By contrast, women in the same age group account for 10% of all suicide deaths each year.⁷

While men are more likely to die by suicide, women are more likely to attempt suicide. A major reason for this difference is that women who attempt suicide typically choose less lethal means and therefore do not die from their attempts.⁸ Fifty-six percent of males in Colorado who die by suicide use a firearm; 33% of women who die by suicide use a firearm. (See Figure 2) The risk of suicide increases among men as they age; for men 75 years and older, the suicide death rate (57.9) is about four times the statewide average of 15.7 per 100,000 persons.⁹ (See Figure 3)

FIGURE 2

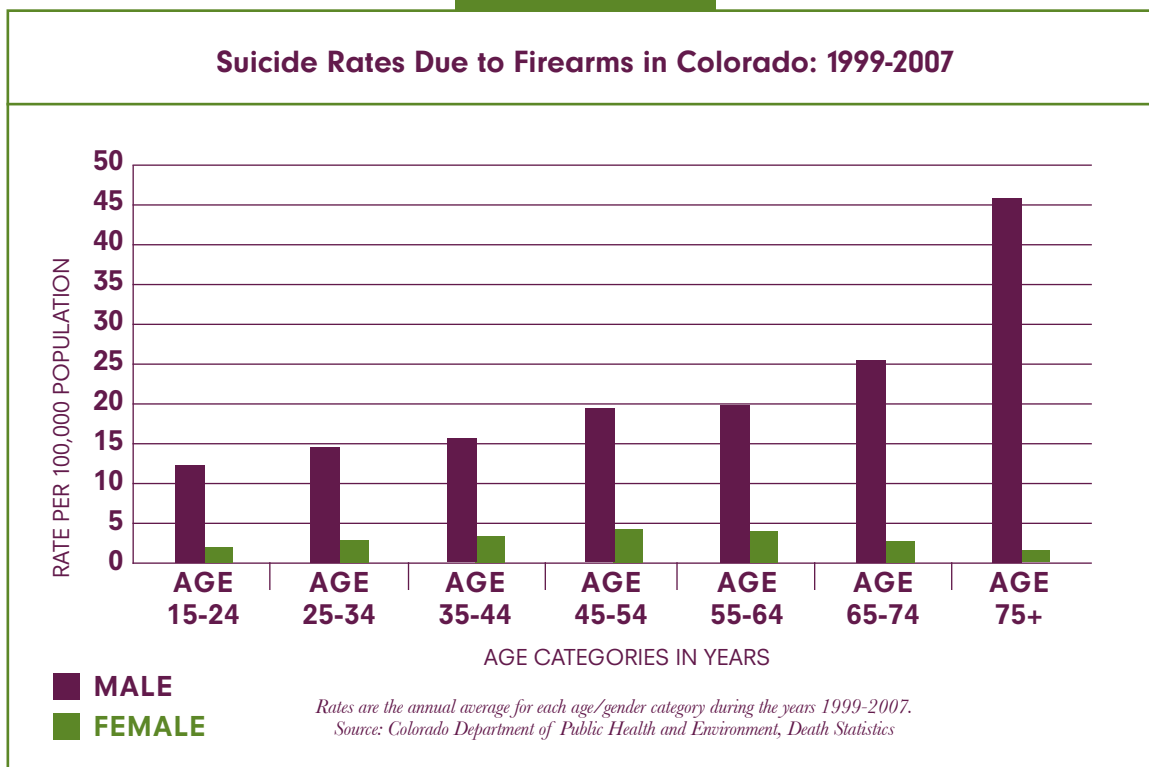
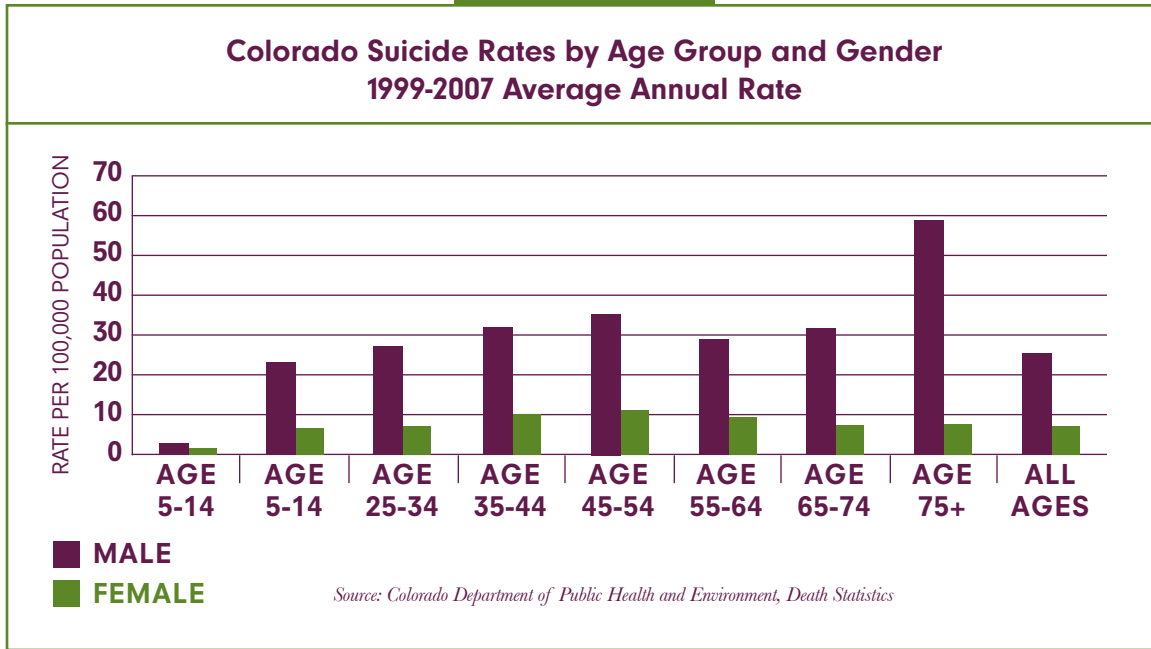


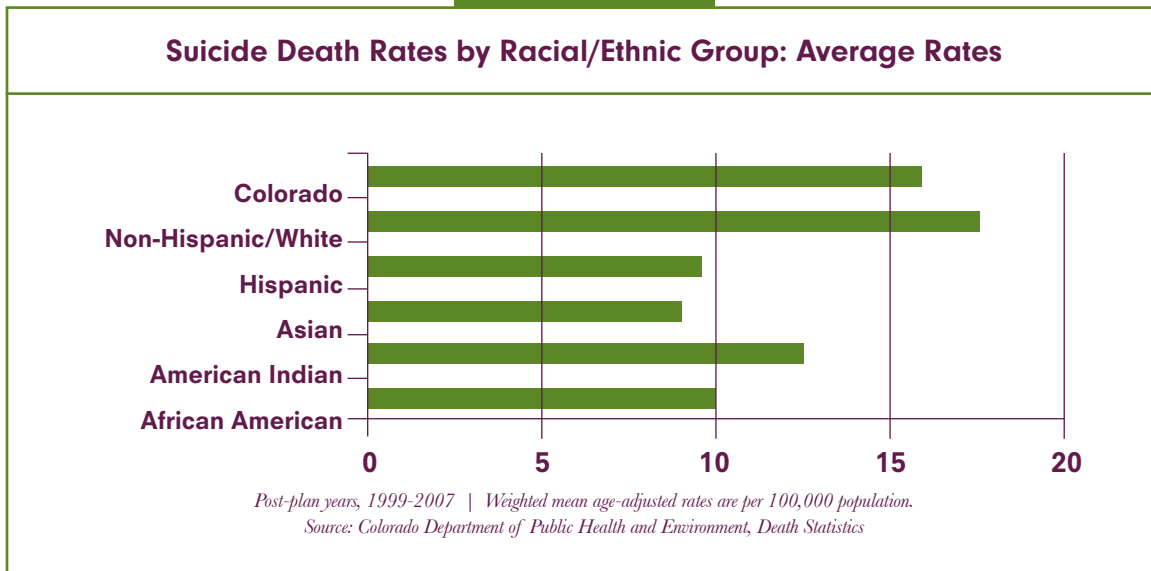
FIGURE 3



Among Colorado's racial and ethnic populations, whites have the highest rate of death by suicide.

The annual average suicide rate among white residents (17.4 per 100,000 persons) is significantly higher than the rates for African-American (10.1), Hispanic/Latino (9.7), Asian (9.0) and Native American (12.7) Coloradans.¹⁰ (See Figure 4)

FIGURE 4



Cultural norms, beliefs and traditions can serve as protective factors against suicide behaviors and contribute to the lower suicide rates among some racial and ethnic populations. For example, “the strong sense of family as support and obligation protects against suicide” among Asian Americans.¹¹ Religion has been identified as a protective factor among Latino/Hispanic Americans and African-American women.

In addition to lower rates than whites, there also are differences in some characteristics among the Hispanic/Latino population who complete suicide compared to Colorado’s white population. Hispanic/Latinos who die by suicide are less likely to have had a diagnosed mental health problem, perhaps because they did not access mental health services. Also, they are less likely to have had a chronic physical problem because of their younger age at the time of death. The average age of Hispanic/Latino persons who die by suicide is 33, much younger than the average 46 years for Colorado’s white population.¹²

While the suicide rate for the Hispanic/Latino population in Colorado is lower than for non-Hispanic/Latino, white persons, the rate among Colorado’s Hispanic/Latino population is almost twice the suicide rate of the U.S. Hispanic/Latino population (5.79).

Additionally, national data indicate that even though suicide may be less frequent among some racial and ethnic groups than among whites, there is concern about the high rate of risk for suicide attempts among Latina youth. The Center for Disease Control’s Youth Risk Behavioral Surveillance has consistently documented the higher rates of attempted suicide among Latina school girls.¹³ There is no reason to believe that Colorado’s Latina youth have less risk for suicide behavior than the respondents in the national survey. Rather, the national findings have assisted in the identification of this subpopulation in need of attention to prevent suicidal behaviors.

Finally, although the number of suicides among Colorado’s American Indian population is too low to analyze and draw definitive conclusions about, the high rate of suicide among this population is congruent with national information. In the U.S., American Indians and Alaska Natives have the highest suicide rates of all ethnic groups, and suicide is the second leading cause of death for American Indian and Alaska Native youth.¹⁴

Suicide is the second-leading cause of death among teenagers and young adults in Colorado.

Analysis of the suicide rate among Colorado teenagers (15-19 years) shows no significant change since 2000. While the rate fluctuates from year to year, it has averaged 13.4 per 100,000, well above the U.S. average of 8.4 per 100,000 for this age group.^{15,16}

In a 2005 survey conducted at selected Colorado high schools, 10% of students reported having made a suicide plan, 6.7% reported having attempted suicide and 1% reported having received medical treatment following a suicide attempt.¹⁷

Young adults (20-24 years) in Colorado are at an even higher risk for suicide than adolescents. The average suicide rate for this group between 1999 and 2005 was 17.8 per 100,000, compared with the national average of 12.3 per 100,000.^{18,19}

Suicide rates and characteristics vary across and within regions of the state.

While the greatest number of deaths by suicide each year occur in metropolitan Denver-area counties, the highest rate of deaths by suicide occur in areas across the state. (See Figure 5 on page 9)²⁰

Counties with the lowest average annual suicide death rates are scattered across the state, too, and range from sparsely populated San Miguel in western Colorado; to Summit, in the central Rockies; to fast-growing Douglas and Weld counties.

Analysis of county-level data suggests that three factors are strongly related to the rate of death by suicide: higher levels of unemployment; higher proportions of people living in social isolation; and lower proportions of Hispanic/Latino residents, whose cultural norms and traditions may serve as protective factors against suicidal behavior.²¹

Personnel in urban school districts report the problem of suicide to be more serious than do school district personnel in rural areas. This difference may result from the larger number of youth who complete or attempt suicide in urban and suburban settings, compared to the lower numbers of suicidal youth in rural areas. Even so, personnel in urban areas report that they have more support to develop and expand suicide prevention services in their districts than do rural district personnel.²²

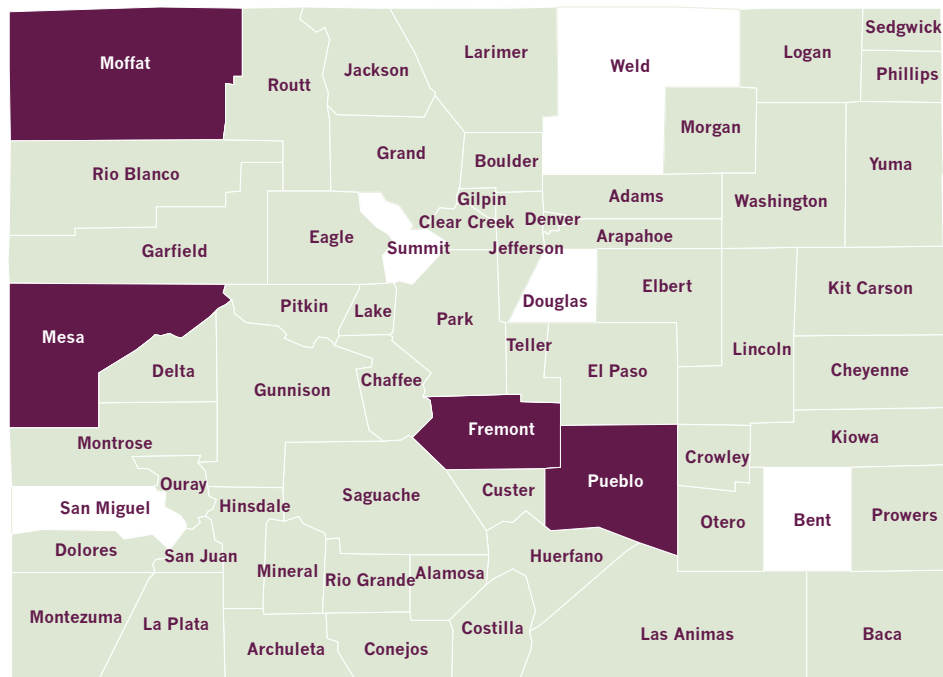
On the whole, an analysis of Colorado Violent Death Reporting System (COVDRS) data from 2004 through 2006 shows the following differences between urban and rural areas:

- The percentage of older adults, non-Hispanic whites and married persons who die by suicide is higher in rural areas compared to urban areas.
- Rural residents who die by suicide are more likely to use a firearm than are urban residents.
- A disproportionate share of suicide deaths in jails occurs in rural areas.
- Employment, financial or noncriminal legal problems are more prevalent among urban residents who die by suicide than among rural residents.
- Urban residents who die by suicide are more likely than rural residents to have been identified as having depression or previously attempting suicide.²³

Cultural norms, beliefs and traditions can serve as protective factors against suicide behaviors and contribute to the lower suicide rates among some racial and ethnic populations.

FIGURE 5

Colorado Suicide Rates by County: 1999-2007



For years 1999 to 2007, the average suicide rate in Colorado was 15.7 and ranges across the counties from 7.2 to 42.1 per 100,000 residents.

- Above the CO mean suicide rate
- Below the CO mean suicide rate
- Not statistically different than the CO mean suicide rate

Source: Colorado Department of Public Health and Environment, Death Statistics

Suicide risk in Colorado is strongly correlated with depression, other mental disorders and substance abuse.

While the correlation of suicide risk with depression, other mental disorders and substance abuse is acknowledged in suicidology literature, these risk factors can now be documented in Colorado. Data from the Colorado Violent Death Reporting System (2004 to 2006) confirm findings in suicidology literature about common precipitating factors for suicidal behavior among various age and gender groups. Specifically:

- Nearly half of Colorado teenagers who died by suicide had experienced a personal crisis within the two weeks prior to their death, including intimate relationship conflicts or losses, disciplinary problems and other stressful life events. Suicidal youth are also likely to be depressed, abuse alcohol and have a history of aggressive and antisocial behavior.

- In 45% of deaths by suicide among 20- to 24-year-olds, there was evidence of a problem with an intimate partner. Seventy percent of the young adults who died by suicide had experienced a depressed mood prior to their death.
- More than two-thirds of men ages 25 to 54 who died by suicide experienced depression in the days prior to their death, and the large majority had not sought or received professional help. Nearly one-third of the men in this age group had a problem with alcohol. Other factors that can exacerbate suicide risk in middle age, for men and women alike, include the loss of a spouse or child, deteriorating health, downward job mobility and social isolation.²⁴

Risk Factors for Suicide²⁵
BIOLOGICAL, PSYCHOLOGICAL and SOCIAL RISK FACTORS
Mental illness, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
Alcohol and other substance abuse
Feelings of hopelessness
Impulsive or aggressive tendencies
History of trauma or abuse
Major physical illnesses
Previous suicide attempt
Family history of suicide
ENVIRONMENTAL RISK FACTORS
Job or financial loss
Relational or social loss
Easy access to lethal means (examples: large quantities of medications, firearms)
Local clusters of suicides that have a contagious influence on others' plans
SOCIAL and CULTURAL RISK FACTORS
Lack of social support and sense of isolation
Stigma associated with seeking help
Barriers to accessing health care, especially mental health and substance abuse treatment
Certain cultural and religious beliefs
Exposure to and influence of others who have died by suicide

Veterans of the U.S. Armed Services have been identified as a population with multiple risk factors, including: male gender, elderly, diminished social support, medical and psychiatric conditions, and knowledge of — and access to — lethal means of suicide.

Military veterans, the elderly and sexual-minority individuals have been identified as at particularly high risk for suicide.

U.S. military veterans

There are more than 425,000 U.S. Armed Services veterans living in Colorado, with about 22% of these veterans having served during the Gulf War period (1990 or later.)²⁶ U.S. Armed Services veterans have been identified as a population with multiple risk factors for suicide, including: male gender, elderly, diminished social support, medical and psychiatric conditions associated with suicide, and knowledge of and access to lethal means of suicide.²⁷ Although there are no data about the rate of death by suicide among discharged members of the U.S. Armed Services in Colorado, there is national evidence that points to the higher risk for suicide among veterans.

- A recently published national study of males based on survey data from 1986-94 found that over time veterans in the general population were twice as likely to die by suicide as non-veterans, regardless of whether they sought care with the Department of Veterans Affairs.²⁸ Risk factors (predictors of suicide) included being white, having a 12th grade or higher education, and having activity limitations. Veterans who died by suicide were also more likely than their non-veteran counterparts to own firearms and to use firearms to complete suicide.
- A study of suicide mortality of veterans being treated for depression in the Veterans Affairs Health System reported that “unlike the general population, older and younger veterans are more prone to suicide than are middle-aged veterans.”²⁹

Recent military conflicts have also served to bring attention to the complex array of symptoms of traumatic brain injuries (TBI) and post-traumatic stress disorder that challenge military, veteran, and community-based professionals from both a diagnostic and treatment perspective. The combination of post-traumatic stress disorder, which is an increasingly more common diagnosis among veterans, and TBI, may make treatment difficult and the risk of suicide higher. Finally, the increased risk of alcohol abuse further complicates both treatment and coping upon their return.³⁰

Older adults

The highest rates for death by suicide in Colorado are among older adults. Among all age-gender groups, males over the age of 75 have the greatest risk of dying by suicide.³¹

Depression has been documented in more than 60% of people 65 years and older who die by suicide. Unlike young and middle-age adults who die by suicide, older people are more likely to have had a physical health problem (almost 80%) and less likely to have abused alcohol or drugs. Older people also face the increased potential of their aging spouse, family members and friends dying, resulting in their increasing social isolation and contributing to their increased risk for suicide.³²

Over the next decade, the number of older Coloradans will substantially increase:

- The number of Coloradans 65 years to 74 years and older will increase by 96%.
- The number of persons 75 years and older will increase by 28%.

The high rate of suicide among older adults combined with the projected increase in the number of older Coloradans points to a high risk population in the next decade.

Sexual-minority youth and adults

Because neither sexual orientation nor gender identity is recorded on death certificates, knowledge about the incidence of suicide among sexual-minority individuals is limited to information about suicide attempts.

University of Calgary Professor Richard A. Ramsay's recently published synthesis of more than 100 studies on reported suicide attempts, for example, found that individuals self-described or identified as sexual minorities are at higher risk for attempted suicide than are heterosexuals.³³

There are some Colorado data available regarding sexual-minority youth. In a 2003 youth risk behavioral survey conducted among high school students in the Boulder Valley and St. Vrain Valley school districts, 44% of sexual-minority respondents reported having attempted suicide, compared to 13.5% of their heterosexual counterparts.³⁴

More recently, an analysis of data on adolescents served by the Gay, Lesbian, Bisexual and Transgender Community of Colorado's Rainbow Alley program found that suicide risk factors included hopelessness, victimization by bullies, methamphetamine use and homelessness.³⁵

The high rate of suicide among older adults combined with the projected increase in the number of older Coloradans points to a high risk population in the next decade.

Nearly all of the state's community mental health centers — which each year serve roughly 75,000 Coloradans who are uninsured or underinsured — consistently report having a waiting list for routine clinical care.

Access to mental health care varies regionally and is often limited for low-income Coloradans.

The mental health care needs of Coloradans and shrinking public resources have been well documented.³⁶ Given the risk factors of depression, personality disorders and other mental illness with regard to both suicide deaths and attempts, it is important to report that more than half of Colorado counties are designated by the federal government as “manpower shortage areas” for psychiatrists and other mental health professionals. (See Figure 6)

In addition, Colorado’s per-capita expenditures for mental health are well below most states’ – \$74, compared with the national average of \$100.³⁷ Nearly all of the state’s community mental health centers – which each year serve roughly 75,000 Coloradans who are uninsured or underinsured – consistently report having a waiting list for routine clinical care. Individuals who are judged to be in immediate danger of suicide receive crisis services, but follow-up or subsequent routine care may not be available when the service system is at capacity.

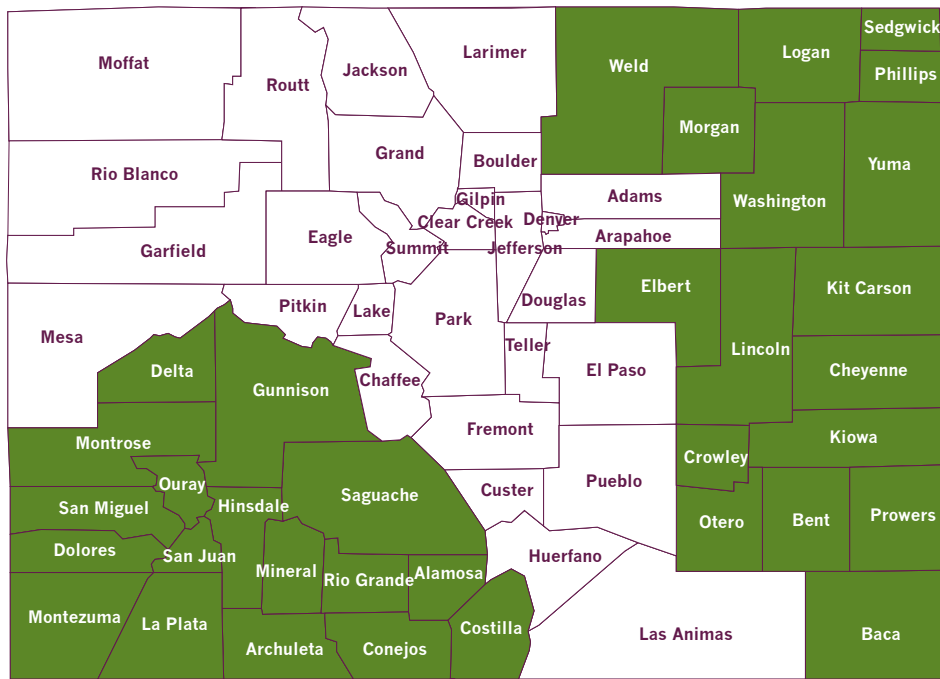
The limited access to public mental health and substance care is a challenge in the effort to promote suicide prevention. For example, school district personnel perceive that community mental health facilities may be unable to accept increased mental health referrals from schools if schools are able to identify increasing numbers of youth who indicate suicidal behavior.

Given this perceived challenge of access to mental health professionals, school personnel identified the need for increased mental health services and counseling within schools as their districts’ most compelling need to serve youth at risk for suicide. This finding suggests the need for further integration of mental health and school services as a strategy to promote suicide prevention among youth. One example is the availability of mental health clinicians located in school-based health clinics.²²

Additionally, it is estimated that three-quarters of U.S. veterans receive their health care from non-military service providers. Since previous studies of suicide among veterans have relied solely on data from veteran-based samples, little has been known about this unique population to whom a significant amount of services have been provided in the general health, mental health, education and other sectors in Colorado.

FIGURE 6

Counties Designated as Mental Health Professional Shortage Areas



Counties shaded in green are designated as shortage areas.

Source: Health Professional Shortage Area Data, Health Resources and Services Administration. Available at <http://datawarehouse.hrsa.gov/HPSA>.

Access to service providers may be difficult because of the shortage of particular specialists and because the most common insurance for military families, TriCare, is often not accepted by non-military mental health professionals or health care delivery systems.

NOTABLE PROGRAMS, PARTNERSHIPS AND ASSETS

Across Colorado – in rural, urban and suburban communities alike – a variety of partners are working together to promote mental health literacy and suicide prevention among diverse populations. Over the past 10 years, these community-based efforts have had the benefit of a strong, stable core of leadership at the state level, including:

- Colorado’s last two governors – Roy Romer and Bill Owens – and current Governor Bill Ritter, together with Colorado’s First Lady, Jeannie Ritter, who has made mental health care – including suicide prevention – her signature issue*
- The Colorado General Assembly, which in 2000 created the state Office of Suicide Prevention (OSP), and over the years has enacted mental-health insurance parity requirements and other legislation related to suicide prevention.*
- The state’s Office of Suicide Prevention at the Colorado Department of Public Health and Environment, Division of Behavioral Health and other executive-branch agencies involved in suicide-prevention efforts.*

Statewide organizations, networks and advocacy groups have actively promoted suicide prevention in Colorado. Mental Health America of Colorado has provided technical assistance to communities that are developing suicide prevention programs and initially sponsored the Suicide Prevention Coalition of Colorado. The Pueblo Suicide Prevention Center provides statewide suicide prevention, intervention and postvention services in response to calls to the 1-800-273-TALK and 1-800-SUICIDE national hotlines.

Foundations and federal agencies also have provided vital funding and technical assistance for suicide-prevention efforts in Colorado. For example:

- The Western Colorado Suicide Prevention Foundation, based in Grand Junction, has funded a range of suicide-prevention programs and activities in six Western Slope counties.
- Colorado is one of 17 states that has been awarded funding from the Centers for Disease Control and Prevention to develop the National Violent Death Reporting System, which provides a clearer picture of suicide-death characteristics and trends (e.g., methods used, locale and precipitating events or circumstances).
- With the support of three-year grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Denver’s Regis University and Trinidad State Junior College in southern Colorado are working to enhance services for students with mental health or substance abuse problems that place them at risk of suicide.

- Colorado is one of more than 30 states receiving funding from SAMHSA to implement suicide prevention programs to youth statewide.
- The Colorado Trust's \$4.1 million Preventing Suicide in Colorado initiative has supported a variety of activities in 31 of the state's 64 counties over the past six years – from community suicide-prevention training; to partnership and capacity building; to outreach, counseling and therapy programs.

Colorado enters its second decade of suicide-prevention efforts with a major asset: a growing infrastructure of collaborative, community-based suicide prevention programs and services. A sampling of the numerous suicide prevention efforts within Colorado are listed below. Though not a full listing, the following programs provide examples of the types of strategies recommended by stakeholders in the process of developing this plan as important to suicide prevention efforts in the next decade (See also Appendix C).

A focus on subpopulations at high risk for suicide: Civilians for Veterans Campaign

Colorado First Lady Jeannie Ritter is heading a campaign aimed at expanding access to mental health services for military veterans living in rural areas of the state.

The Civilians for Veterans campaign, launched in July 2008 with a \$50,000 grant from the Firefly Fund, is a collaborative effort of several mental-health groups, the Colorado Behavioral Healthcare Council and the U.S. Department of Veterans Affairs. The campaign will raise money to support the extension of existing VA services into rural areas, focusing initially on the San Luis Valley, Montrose County, La Junta and Lamar.

A focus on culturally competent suicide prevention: Voz y Corazón

Latina teens are at higher risk of suicide attempt than other teens. Important efforts have been made to address this suicide behavior using a culturally competent approach. This program, established under the auspices of the Mental Health Center of Denver, was designed by Latina leaders and teens to help Latina teens develop healthy identities through suicide prevention trainings. A key component of the program is regularly scheduled mentoring and art groups that result in an annual Art Gallery of works illustrating creative expression of the lives, emotions and hopes of the Latina teenagers.

Colorado enters its second decade of suicide-prevention efforts with a major asset: a growing infrastructure of collaborative, community-based suicide prevention programs and services.

A focus on integration of primary health and mental health care: Northern Colorado Health Alliance (NCHA)

NCHA, which serves low-income residents in Weld County, is an example of integrated physical and mental health care. This partnership of a behavioral health center, primary care clinics and a hospital system is structured so that an individual who enters the project from any "door" can easily access the services of other partner providers. Fundamental to integrated care is co-location of physical and mental services as well as staff trained to work collaboratively across health sectors. A medical chart system that includes information and treatment for both physical and mental health care practitioners is under development.

A focus on cross-system suicide prevention: Project Safety Net

Project Safety Net, coordinated by the Office of Suicide Prevention at the Colorado Department of Public Health and Environment, is a three-year initiative launched in October 2006 that involves five counties, the University of Colorado at Boulder and the Suicide Prevention Coalition of Colorado (SPCC). The goal is to build a safety net for adolescents and young adults who are at a heightened risk for suicidal behavior.

In the five counties (El Paso, Larimer, Mesa, Pueblo and Weld), adults working with adolescents ages 15-18 in the juvenile justice and child welfare systems, and the adolescents' parents or caregivers, are receiving suicide intervention and referral skills training. At the University of Colorado, similar training is offered to faculty, athletic department staff, resident advisors, Greek system representatives and others who work with students.

Project partners are working together to create and disseminate cross-system referral protocols for care and treatment of suicidal individuals and reach out to potential suicide intervenors through campus and community awareness campaigns.

A focus on community-based comprehensive efforts: Reaching Everyone Preventing Suicide (REPS)

Suicide prevention stakeholders in Moffat and Routt counties joined forces in April 2004 to create Reaching Everyone Preventing Suicide. As one project among a number of community-based comprehensive projects that received support from The Colorado Trust's Preventing Suicide in Colorado Initiative, this comprehensive program includes education and training of residents in the Yampa Valley and screening, risk assessment, referral to mental health services, emergency and on-going treatment for individuals at-risk of suicide and their families. Postvention services to families and friends of individuals who have completed suicide are also provided as a component of the comprehensive effort toward suicide prevention.

A focus on increased mental health treatment: Second Wind Fund

The Second Wind Fund was established by Green Mountain Presbyterian Church following the suicide deaths of four Jefferson County high school students during the 2001-02 school year. Its goal is to decrease the incidence of teen suicide by removing financial and social barriers to treatment for at-risk youth.

Over the past several years, the Second Wind Fund has raised more than \$600,000 through its annual Walk/Run/Ride event, which drew nearly 3,000 participants in 2008.

The money is used to subsidize professional therapy (up to 20 sessions) for economically disadvantaged high school students who are identified as at least moderately at risk for suicide. Referrals are initiated by school counselors or administrators, with the involvement and consent of a student's parents.

Since 2003, the program has served more than 1,200 students in Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson and Park counties.

Students can choose from a list of 60 state-licensed therapists who have experience with teens at risk for suicide, and who have agreed to see Second Wind clients at a reduced hourly rate.

A focus on education of Colorado's media: Suicide Prevention Coalition of Colorado's Annual Media Award

In 2008, the Suicide Prevention Coalition of Colorado honored Denver television station KUSA-Channel 9 for its commitment to promoting mental health and preventing suicide. Over the past two years, KUSA has broadcast dozens of pieces focusing on salient issues in the field, ranging from the suicide risk among combat veterans, the elderly and other vulnerable populations, to the connection between incarceration and mental health.

The Suicide Prevention Coalition of Colorado also cited KUSA for promoting National Depression Screening Day, sponsoring a suicide prevention helpline, and offering free mental health screenings as part of its 9Health Fair program, which reaches more than 87,000 Coloradans in 165 communities each year.

In spring 2008, KUSA co-sponsored and provided coverage of Mirrors and Metaphors: Reflections on Suicide, Mental Health and Healing, a month-long art exhibit at Access Gallery in west Denver.

Identified Promising and Evidence-based Strategies

Colorado suicide prevention stakeholders now have the benefit of a national registry of strategies with evidence or promise of effectiveness. These programs are classified as evidence-based (either effective or promising) by the Suicide Prevention Resource Center and the American Foundation of Suicide Prevention, and include: community-based, emergency-room, primary care, school-based health clinics and service delivery programs. Information about these programs may be accessed at www.sprc.org/bpr/ebpp.asp#list.

STRATEGIC GOALS & OBJECTIVES FOR THE NEXT DECADE AND BEYOND

In 2007-2008, Mental Health America of Colorado (MHAC) coordinated the gathering, analysis and sharing of data from a variety of sources, and conducted community meetings across Colorado in Cortez, Denver, Grand Junction, Greeley and Pueblo.

The work of MHAC, a steering committee and a team of researchers and suicide-prevention experts (see Appendix E) culminated in the development of the following set of strategic goals and objectives, which are designed to help guide and advance Colorado's suicide-prevention efforts over the next 10 years and beyond.

1. Develop the full potential of the Colorado Office of Suicide Prevention.

The top priority of the 1998 Colorado Suicide Prevention and Intervention Plan was to establish a state agency that would serve as a mechanism for:

- Enlarging awareness and acceptance of suicide prevention as a public health priority
- Connecting suicide prevention efforts across a broad spectrum of agencies, institutions, systems and sectors
- Promoting best practices in suicide prevention and intervention
- Using data to guide planning, policymaking and resource allocation at the state and local levels.

Since its creation in 2000 by the General Assembly, the state Office of Suicide Prevention (OSP) has developed strong working relationships with other executive-branch agencies; nonprofit state, regional and community suicide-prevention coalitions; and funders ranging from The Colorado Trust to the federal Substance Abuse and Mental Health Services Administration.

Over the years, OSP has developed vital resources – including informational and training materials, technical assistance and a speaker's bureau – for communities, counties, service providers, nonprofit organizations, school districts, postsecondary institutions and other key partners in suicide prevention. The OSP provides annual community grants to organizations at the local level to implement suicide prevention efforts. It has also co-sponsored a variety of events and activities, from town meetings to public information campaigns to the May 2008 Suicide Awareness and Prevention Summit at Regis University in Denver.

From the start, OSP's ability to carry out many of the tasks outlined in the state suicide-prevention plan has been constrained by a limited budget.

The importance of steadily augmenting OSP's resources and capacity over the next several years cannot be overstated.

If Colorado is to achieve the goals and objectives listed on the following pages, it must develop the agency's full potential as a mechanism for gathering and sharing data, building cross-system and cross-sector networks and partnerships, and promoting initiative, innovation and best practice-based prevention strategies.

High priority should be given to developing a funding stream that allows OSP to:

- Expand its website to include a wider array of reports, articles, research summaries, practice guidelines and other materials on suicide and suicide prevention
- Build its capacity to collect, analyze and report data, and track the progress and impact of state and local suicide-prevention efforts over time
- Work more closely with communities by designating local or regional liaisons to facilitate the sharing of information
- Develop new forms and sources of support for suicide-prevention efforts across the state
- Increase the level of funding it provides to communities and agencies throughout Colorado that are doing suicide prevention work at the local level.

2. Promote mental health literacy in a variety of settings and formats, with an emphasis on increasing knowledge and changing attitudes about suicide.

In 2001, under the leadership of former U.S. Surgeon General David Satcher, the federal government issued a landmark report on suicide prevention that concluded with a useful summary of challenges to be addressed:

The argument that prevention is a luxury and funds should be allocated instead to treatment. Prevention is often likened to the work of posting warnings and constructing protective railings at the river's edge, while treatment is seen as the work of pulling from the waters those who have fallen in and cannot swim. The reality is that both kinds of work are needed, and prevention efforts are especially important as treatment programs cannot always keep pace with the demand for services.

The institutional tendency toward short-term and isolated prevention planning. Suicide prevention plans that are implemented in two- to five-year increments fail to take into account that effective public-health initiatives may take years to yield demonstrable results. Prevention goals and objectives must be woven into the fabric of community and local human services, training and education. Stand-alone suicide prevention efforts fail to benefit from the resources and community acceptance of established programs and services.

The twin nemeses of stigma and disparity. The societal stigma associated with mental illness, substance abuse and suicidal behaviors, and the disparity in access to mental health and substance abuse care are formidable. Overcoming them requires engaging the energies, creativity and commitment of all members of society.

In the past, public information campaigns have proven to be of great value in decreasing the use of tobacco, decreasing the consumption of alcohol during pregnancy, increasing the use of seat belts and the installation of smoke alarms in homes, and increasing early detection of cancer symptoms. The success of such efforts points to the need for strategies focused on:

- Dispelling myths, expanding knowledge and changing attitudes about suicide
- Increasing the proportion of the public that views mental and physical health as equal and inseparable components of overall health
- Increasing the proportion of suicidal individuals with underlying disorders who seek assistance and treatment.

Over the past several years, Colorado has made considerable progress in terms of promoting mental health literacy in a variety of settings and formats, and educating diverse audiences about suicide prevention. To build on and expand these efforts, it is recommended that the Office of Suicide Prevention, the Suicide Prevention Coalition of Colorado and other key partners focus on the following objectives:

- Encourage and support media in responsibly covering the issues of suicide, suicide prevention and mental health to help raise the awareness of Coloradans about suicide as a public health problem, including an understanding of common warning signs and risk factors, and the availability of preventive care, treatment and support.
- Develop suicide-prevention messages targeting different age groups, various racial and ethnic populations, individuals of various faiths, people of different sexual orientation, and people from diverse socioeconomic groups and geographic regions.
- Increase the number of public- and private-sector employers whose employee-assistance programs incorporate suicide awareness and prevention.
- Increase the number of the following “gatekeepers” – community members who have received training in suicide risk identification, crisis intervention and referral:
 - Providers of primary and emergency health care
 - Providers of mental health care and substance abuse treatment
 - Teachers, counselors, nurses and other school staff
 - College health-care staff, counselors and resident advisors
 - Clergy
 - Police officers
 - Hospice and nursing home volunteers
 - Correctional facility personnel
 - Supervisors in occupational settings
 - Family law, divorce and criminal defense attorneys.
- Increase the proportion of emergency medical technicians, firefighters, law enforcement officers, funeral directors and clergy who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.
- Use a variety of strategies to reduce the likelihood that firearms, alcohol, prescription drugs, over-the-counter medications, and poisons such as bleaches, disinfectants and herbicides are used for self-destructive purposes.

3. Expand and equalize access to mental health care, substance abuse treatment and crisis intervention services.

The societal stigma associated with mental illness, substance abuse and suicide, together with inadequate funding for preventive services, low insurance reimbursements for treatment, and a lack of coordination among the physical, mental and behavioral health care systems means that only an estimated one-third of Coloradans who need mental health services each year actually receive care.³⁶

This inability or unwillingness to seek help is particularly common among adolescents, young and middle-aged men (particularly combat veterans) and the elderly; people living in poverty or social isolation; and members of certain ethnic or sexual-minority groups. Individuals also might not seek treatment because they don't perceive they need it; do not know of available, affordable care options; or are unaware that recovery is possible.

One of the reasons that so many problems associated with suicide risk go untreated is that employee benefit plans tend to provide more liberal coverage for physical illness (general medical and surgical services) than for mental illness or substance abuse treatment.

Colorado is among a growing number of states that have passed laws requiring that group health-insurance plans with 50 or more employees include coverage for treating certain mental disorders, and alcohol and drug addiction, and that benefits for mental health and substance abuse treatment be on a par with medical and surgical benefits. States' efforts on this front will be bolstered by recent federal legislation that extends the right to non-discriminatory mental health and substance abuse coverage to individuals enrolled in self-funded insurance plans regulated by the U.S. Department of Labor, and that ensures coverage for a broader range of mental health conditions.

Expanding access to mental health care, substance abuse treatment and crisis intervention services will require a variety of changes in policy, practice and resource allocation in the following areas:

Mental health parity

- Expand Colorado's mental-health insurance parity law to include individual plans and smaller group-health plans (fewer than 50 employees).
- Pursue rule changes in Medicare and Medicaid programs that:
 - Allow presumptive eligibility for individuals experiencing a mental health or substance abuse crisis
 - Make coverage available to greater numbers of individuals (on a par with other states' guidelines) and reduce the time it takes to receive coverage
 - Remove barriers to obtaining and keeping coverage (e.g., allow suspension of Medicaid, instead of termination, for individuals in institutions).

Cross-system linkages

- Increase co-location of physical and mental health services and incorporate screening for depression, substance abuse and suicide risk in:
 - Primary-care settings
 - Hospice programs
 - Assisted-living and long-term care facilities

Only an estimated one-third of Coloradans who need mental health services each year actually receive care.

- School and campus-based health clinics
 - Senior resource centers
 - Employee-assistance programs
 - Juvenile detention centers, jails and correctional facilities.
- Increase the proportion of the following that include training in the assessment and management of suicide risk and the identification and promotion of protective factors:
 - Educational and medical residency programs for primary-care physicians and physician assistants
 - Clinical social work, counseling and psychology graduate programs
 - Curricula for nursing care providers at all levels
 - Recertification and licensing programs for relevant professions.
 - Strengthen connections between community suicide-prevention programs and agencies or facilities serving veterans.
 - Increase the proportion of counties with health and/or social-services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.
 - Increase the proportion of suicidal individuals treated in hospital emergency departments who keep follow-up mental health appointments after being discharged.
 - Increase the proportion of hospital emergency departments that routinely provide post-trauma psychological support and mental health education for victims of sexual assault and/or physical abuse.

Capacity

- Provide sufficient funding for community mental health centers and substance abuse providers to reduce waiting lists for routine clinical care.
- Promote the development of technology-based services, mobile mental-health clinics and other innovative delivery systems to reach underserved populations (e.g., rural residents, the chronically ill, the poor and the homeless).
- Provide incentives for rural mental health and substance abuse professionals, such as payment of school loans for those working in mental health shortage areas.

4. Use data to guide planning, investment and changes in policy and practice.

A major obstacle to advancing the study and prevention of suicide is the lack of uniform, reliable data available to researchers, policymakers, practitioners, advocates and the public at large to:

- Assess the progress and impact of suicide-prevention initiatives
- Identify unmet needs, emerging or previously undetected problems, and opportunities to use resources more efficiently and strategically
- Determine the number of individuals who are treated in hospital emergency rooms, clinics or primary-care settings following suicide attempts.

With funding from the Centers for Disease Control and Prevention, Colorado is one of 17 states that has begun collecting, analyzing and reporting data on homicides and suicides – drawn from death certificates, police reports, coroners’ offices and crime laboratories. Additionally, the development of the Colorado Violent Death Reporting System is an important first step in expanding the state’s ability to develop a clearer picture of suicide-death characteristics and trends (methods used, locale and precipitating circumstances or events).

Recommended next steps are to:

- Develop statewide protocols to ensure accurate and consistent reporting of suicide deaths from first responders, law enforcement, medical examiners and child-fatality review teams.
- Require the consistent use of external-cause-of-injury codes in hospital discharge data and emergency department records. Additional data about attempted suicide could be obtained if Colorado were one of the states that participate in the Healthcare Cost and Utilization Project (HCUP) data collection effort by the Agency for Healthcare Research and Quality.^{38, 39}
- Require that new state and local suicide-prevention initiatives include an evaluation component to ensure their effectiveness.

ENDNOTES

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APPENDIX A

Number of Colorado Suicide Deaths by County

	1990-1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	TOTAL
Adams	489	35	55	65	61	60	75	78	60	71	560
Alamosa	21	*	4		*	4	4	*	*	5	26
Arapahoe	549	62	54	86	84	73	83	77	78	90	687
Archuleta	8	5	*	*	6	*		*	*	6	27
Baca	5	*	*		*	*		*	*		8
Bent	5			*	*		*			*	4
Boulder	312	30	47	45	38	37	40	49	48	43	377
Broomfield	NA			*	9	6	7	12	12	12	61
Chaffee	39	*	*	4	4	*	*	5	5	*	30
Cheyenne	4	*		*				*			*
Clear Creek	15	*		*	*	4	6	*	*	*	23
Conejos	11	*	*	4	*	*	*	*	*	*	17
Costilla	6		*	*	4	*			*		8
Crowley	5				*	*	*		*		6
Custer	*	*				*		*	*		5
Delta	49	9	7	8	5	8	4	*	*	6	52
Denver	885	67	87	73	80	79	89	94	76	100	745
Dolores	*	*			*		*			*	7
Douglas	87	10	16	22	20	17	28	15	28	31	187
Eagle	31	*	*	5	7	4	*	*	6	9	41
Elbert	21	*	*	*	4	*	*	*	4	*	27
El Paso	639	65	74	97	86	85	121	106	69	98	801
Fremont	75	7	9	10	15	13	12	20	14	12	112
Garfield	59	9	8	*	12	8	8	6	9	8	71
Gilpin	13	*	*	*		5	*	*			14
Grand	15	*	*	*	*	*	6	4	*		22
Gunnison	13	5	*	*	*	*	*		*	*	20
Hinsdale	*	*		*							*
Huerfano	12	*		*	*	*	4		5	4	19
Jackson	*		*	*	*			*			4
Jefferson	670	89	63	89	78	93	94	96	92	95	789
Kiowa	*						*				*

	1990-1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	TOTAL
Kit Carson	14	*		*	*		*	*	*		8
Lake	10	*	*		*	*		*	*	*	13
La Plata	67	7	5	10	9	13	8	6	8	8	74
Larimer	275	28	37	43	31	45	33	51	48	34	350
Las Animas	22	4	*	8	*	4	6	*	*	*	32
Lincoln	7		*	*	*	*		*	*	*	9
Logan	18	*	*	*	6	4	4	*	*	*	27
Mesa	188	24	30	18	30	26	29	27	23	40	247
Mineral	*	*			*						*
Moffat	15	*	4	4	5	*	*	6	8	*	35
Montezuma	43	*	4	11	4	4	6	7	6	8	51
Montrose	57	*	8	6	11	4	7	11	6	11	67
Morgan	41	*	4	5	5	4	*	*	*	4	31
Otero	32	5	*		5	*	*	4	4	*	25
Ouray	6				*			*			4
Park	15	*	4	*	5	*	4	*	6	4	33
Phillips	6	*	*	*			*		*		6
Pitkin	21	*	*	5	4	*		5		*	21
Prowers	14	4	*	*		*	*	*	*		16
Pueblo	213	22	24	33	28	32	32	26	22	34	253
Rio Blanco	9	*		*		4	*	*	4	*	17
Rio Grande	20	*	*		4	*	*	*	4		14
Routt	22	*	*	*	4	*	4	5	*	4	27
Saguache	6			*	*	*			*	*	10
San Juan	4						*				*
San Miguel	8					*	*	*		*	6
Sedgwick	5	*	*	*	*	*	*		*	*	11
Summit	15	*	5	*	*	*	4	*	4	*	24
Teller	43	*	4	*	5	5	5	8	7	4	43
Washington	6	*			*	*		*			4
Weld	208	24	19	22	18	31	29	27	28	29	227
Yuma	15		*		*	*	*	*	*		9
TOTAL	5469	567	612	717	724	718	792	795	724	805	6454

*Cells that have an asterisk are years in which there are less than three suicides in the county. The use of asterisks allows for confidentiality when the numbers are very small.

Source: Colorado Department of Public Health and Environment, Death Statistics

APPENDIX B

Population-Weighted, Age-Adjusted Mean Suicide Rates by County

	Pre-plan Rates 1990-1998	Post-plan Rates 1999-2007
Adams County	19.0	17.2
Alamosa County	18.0	20.3
Arapahoe County	15.0	14.8
Archuleta County	11.3	26.5
Baca County	13.3	19.2
Bent County	10.6	7.3
Boulder County	14.5	14.3
Chaffee County	28.5	18.6
Cheyenne County	21.1	7.2
Clear Creek County	18.4	25.9
Conejos County	16.0	24.6
Costilla County	20.3	27.6
Crowley County	13.8	11.1
Custer County	4.6	12.8
Delta County	21.9	19.7
Denver County	19.1	14.6
Dolores County	15.1	36.7
Douglas County	11.9	10.3
Eagle County	14.0	14.9
El Paso County	16.5	16.5
Elbert County	18.5	15.1
Fremont County	20.7	24.3
Garfield County	19.4	16.0
Gilpin County	38.4	30.8
Grand County	18.5	17.5
Gunnison County	12.0	15.8
Hinsdale County	66.2	28.7
Huerfano County	19.0	26.3
Jackson County	21.8	32.2
Jefferson County	15.8	16.0
Kiowa County	4.5	24.0
Kit Carson County	20.7	10.8

	Pre-plan Rates 1990-1998	Post-plan Rates 1999-2007
La Plata County	20.9	17.0
Lake County	16.7	22.2
Larimer County	14.6	14.4
Las Animas County	16.3	21.7
Lincoln County	12.8	14.8
Logan County	10.4	13.5
Mesa County	20.1	21.4
Mineral County	48.2	18.8
Moffat County	14.7	31.4
Montezuma County	23.6	23.7
Montrose County	23.1	20.8
Morgan County	18.6	12.9
Otero County	18.0	14.9
Ouray County	26.0	12.6
Park County	21.0	21.2
Phillips County	14.8	12.7
Pitkin County	19.4	13.4
Prowers County	11.8	12.9
Pueblo County	18.7	19.2
Rio Blanco County	16.5	30.9
Rio Grande County	20.2	12.8
Routt County	16.1	12.8
Saguache County	14.4	17.0
San Juan County	46.4	29.1
San Miguel County	29.9	7.7
Sedgwick County	21.3	42.1
Summit County	10.2	7.8
Teller County	30.8	23.2
Washington County	14.8	7.7
Weld County	16.1	12.3
Yuma County	17.2	10.3

Note: Broomfield County is missing because it was not created until 2001.

Source: Colorado Department of Public Health and Environment, Injury, Suicide and Violence Prevention Section, Colorado Health Information Dataset (CoHID online database). Available at: <http://cdphe.co.us/cohid>.

APPENDIX C

State and Local Suicide-Prevention Organizations, Coalitions and Resources

The following is a list of suicide prevention, intervention and treatment organizations and coalitions in Colorado as of the writing of this report.

ANDY ZANCA YOUTH EMPOWERMENT PROGRAM is a nonprofit organization dedicated to the empowerment of youth through media and the arts.
1344 Barber Drive, Carbondale, CO 81623

ANOTHER LIFE FOUNDATION in Colorado Springs is the nation's only consumer-run organization dedicated to helping individuals struggling with suicidal behaviors.
www.anotherlifefoundation.org

THE CARSON J SPENCER FOUNDATION in Westminster is a nonprofit organization dedicated to early intervention and effective treatment for people with bipolar disorder and suicidal ideation.
www.carsonjspencer.org

COLORADO DIVISION OF BEHAVIORAL HEALTH administers non-Medicaid community mental health services for people with serious emotional disturbance or serious mental illness of all ages, through contracts with six specialty clinics and 17 private, nonprofit community mental health centers.
www.cdhs.state.co.us/dmh/

COLORADO OFFICE OF SUICIDE PREVENTION (OSP) is the central and primary coordinator of suicide-prevention services in Colorado.
www.cdphe.state.co.us/pp/Suicide/index.html

COMMUNITY PRO-ACTIVE CRISIS TEAM (C-PACT) provides Sedgwick County residents with prevention, intervention and postvention services in any crisis, including suicide.
Contact Jenna Johnson, 311 W. Fifth, Julesburg, CO 80737

DOUGLAS COUNTY SUICIDE PREVENTION COALITION consists of representatives from Sky Ridge Medical Center, Douglas County School District, Douglas County Sheriff's office, Castle Rock Police Department, Castle Rock Police Department Victim Assistance, area mental health agencies and the Kiwanis Club of Castle Pines.
303-660-7505

EAGLE RIVER YOUTH COALITION is a nonprofit organization addressing suicidal behavior in youth of the Vail Valley by providing suicide intervention skills training to local community members and suicide awareness presentations via wellness events and parent forums.
www.eagleyouth.org

EL PASO COUNTY DEPARTMENT OF HEALTH AND ENVIRONMENT in Colorado Springs disseminates SAFE:TEEN training to El Paso County middle and high schools in partnership with the Suicide Prevention Partnership of the Pikes Peak Region.
www.elpasocountyhealth.org/

HIGH PLAINS COMMUNITY HEALTH CENTER in Lamar has developed an aggressive case management system to ensure coordination of services between its in-house mental health clinician and patients presenting to their primary care providers with symptoms of depression. www.highplainschc.net

JEFFERSON CENTER FOR MENTAL HEALTH has helped start many grassroots suicide-prevention efforts, including the Columbine/Chatfield Coalition for Youth. www.jeffersonmentalhealth.org

MENTAL HEALTH AMERICA OF COLORADO (MHAC), fiscal sponsor for the Suicide Prevention Coalition of Colorado, supports and implements programs and activities focused on advocacy, education, prevention and outreach. www.mhacolorado.org

MENTAL HEALTH CENTER OF DENVER provides a wide range of services including Voz y Corazon, an arts, enrichment and peer-support program targeting teenage Latinas at risk of suicide. www.mhcd.org/Services/VozYCorazon.html

MESA COUNTY SUICIDE PREVENTION COALITION/WESTERN COLORADO SUICIDE PREVENTION FOUNDATION comprises professionals and survivors of suicide working together to address suicide in Mesa County. health.mesacounty.us/suicide/coalition.cfm

MIDWESTERN COLORADO MENTAL HEALTH CENTER in Montrose educates the public on suicide prevention; provides screenings and referrals; and offers support programs to schools, senior centers, primary-care physicians; and sponsors postvention support groups. 970-249-0711

THE PIÑON PROJECT/MONTELORES SUICIDE PREVENTION COALITION in Cortez sponsors awareness, education, screening and postvention programs. 970-564-1195

PROJECT CASE in Brighton is a nonprofit organization dedicated to fighting the destructive result of depression and suicide through education, training and support programs. www.projectcase.org

PUEBLO SUICIDE PREVENTION CENTER provides comprehensive suicide prevention, intervention and postvention services in response to calls to the 1-800-SUICIDE and 1-800-273-TALK national hotlines. www.pueblospc.org

REPS (REACHING EVERYONE PREVENTING SUICIDE) is a broad-based community partnership in the Yampa Valley dedicated to educating the community on suicide and suicide prevention and offering help to those in need. The coalition is under the auspices of the Colorado West Regional Mental Health Center. www.justasknow.org/reps.html

RURAL SOLUTIONS in Sterling is a coalition of community health care providers, grassroots organizations, social services departments, domestic violence agencies, handicapped services, public health agencies and elected officials. www.rural-solutions.org

SAN LUIS VALLEY COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER, SUICIDE, SUBSTANCE ABUSE AND VIOLENCE EDUCATION COALITION in Alamosa has developed suicide awareness and education campaigns, training and school-based programs.
www.slvmhc.org

SECOND WIND FUND in Lakewood provides life-saving services for students in need of therapy for suicide-related issues who cannot access services because of a lack of insurance and financial hardship.
www.thesecondwindfund.org

SHAKA FRANKLIN FOUNDATION FOR YOUTH in Denver focuses on addressing self-destructive behaviors among young people ages 12 to 21 years, and educates diverse audiences about the dangers and myths that surround suicide, depression and grief.
 303-337-2515

SOUTHEAST MENTAL HEALTH CENTER/PROJECT HOPE, which serves six rural southeastern Colorado counties, focuses on suicide-prevention awareness and education, screening and referrals.
ww.semhs.org

SUICIDE EDUCATION AND SUPPORT SERVICES (SESS) in Weld County is a nonprofit organization whose membership includes mental health professionals, faith community leaders and suicide survivors.
www.endsuicide.org

SUICIDE PREVENTION COALITION OF COLORADO, based in Denver, develops and implements suicide-prevention and intervention strategies, focusing on public awareness, education and advocacy through cooperation among organizations, agencies, individuals, surviving family members and government.
www.mhacolorado.org

SUICIDE PREVENTION INTERVENTION NETWORK (SPIN), based in the southern Denver metro area, focuses on prevention, intervention and education activities, including a HEARTBEAT Survivors Support Group, education and consultation services, Level 1 Training, and ASIST Intervention Workshops.
www.spinheartbeat.com

SUICIDE PREVENTION PARTNERSHIP OF THE PIKES PEAK REGION, based in Colorado Springs, is a nonprofit organization that addresses suicide by bringing together law enforcement, mental and public health, the military, government, business, the religious community, educators and local citizens.
www.sppppr.org

SUICIDE RESOURCE CENTER OF LARIMER COUNTY, based in Loveland, coordinates and develops suicide education, prevention, intervention and postvention in communities in Larimer County.
www.suicideresourcecenter.org

YELLOW RIBBON SUICIDE PREVENTION PROGRAM, based in Westminster, is an international community-based program using a universal public-health approach to empower and educate professionals, adults and youth.
www.yellowribbon.org

APPENDIX D

Suicide-Prevention Education and Training Programs

Targeting Multiple Audiences

APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST) is a standardized and customizable two-day, two-trainer workshop designed for members of all care-giving groups. The emphasis is on teaching suicide first-aid to help at-risk individuals stay safe and seek help as needed.

www.yspp.org/training/asist.htm

ASSESSING AND MANAGING SUICIDE RISK: CORE COMPETENCIES (AMSR) is a one-day workshop for mental health professionals aimed at helping them better assess suicide risk, plan treatment and manage the ongoing care of at-risk clients.

www.sprc.org/traininginstitute/amsr/clincomp.asp

DIALECTICAL BEHAVIOR THERAPY is a cognitive-behavioral treatment approach blending a problem-solving focus with acceptance-based strategies.

www.dbtselfhelp.com

HEARTBEAT is a peer-support program offering empathy, encouragement and direction following the suicide of a loved one.

www.heartbeatsurvivorsaftersuicide.org

PROJECT HOPE/SOUTHEAST MENTAL HEALTH CENTER, which serves six rural southeastern Colorado counties, focuses on suicide-prevention awareness and education, screening and referrals.

www.semhs.org

QUESTION PERSUADE REFER (QPR) is an emergency mental-health training program that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors.

www.qprinstitute.com

SUICIDE ALERTNESS FOR EVERYONE (SAFETALK) is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with sources of assistance.

www.livingworks.net/ST.php

U.S. AIR FORCE SUICIDE PREVENTION PROGRAM is a population-oriented approach to reducing the risk of suicide. The Air Force has implemented 11 interrelated initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors.

www.afspp.afms.mil

Targeting Adults

EMERGENCY ROOM MEANS RESTRICTION EDUCATION FOR PARENTS is a program that educates parents of youth at high risk for suicide about limiting access to lethal means. Education takes place in emergency departments and is conducted by department staff.
www.sprc.org/featured_resources/bpr/ebpp_PDF/emer_dept.pdf

MAKING EDUCATORS PARTNERS IN SUICIDE PREVENTION is an online training program for teachers and other school staff.
www.spts.pldm.com

PARENTS SURVIVING SUICIDE, sponsored by the Colorado Department of Public Health and Environment, is a support-group program for parents who have lost a child to suicide.
www.cdphe.state.co.us/pp/suicide/comprehensiveprogram.pdf

PREVENTION OF SUICIDE IN PRIMARY CARE ELDERLY: COLLABORATIVE TRIAL (PROSPECT) is a federally sponsored program aimed at preventing suicide among older primary-care patients by reducing depression and suicidal ideation.
www.nrepp.samhsa.gov/programfulldetails.asp

WORKING MINDS, developed by the Carson J Spencer Foundation, provides state-of-the-art training and other resources for workplace-based suicide prevention programs.
www.workingminds.org/about.html

Targeting Youth

AMERICAN INDIAN LIFE SKILLS DEVELOPMENT is a suicide-prevention curriculum designed for American Indian middle- and high-school students.
www.guide.helpingamericasyouth.gov/programdetail.cfm?id=635

CAMPUS CONNECT is a gatekeeper-training program for college and university faculty, staff and students.
www.sprc.org/featured_resources/bpr/PDF/CampusConnectfactsheet.pdf

CARE, ASSESS, RESPOND, EMPOWER (CARE) is a school-based suicide prevention program targeting high-risk youth by decreasing suicidal behavior, decreasing risk factors, and increasing personal and social assets.
www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=225

COGNITIVE BEHAVIORAL THERAPY FOR ADOLESCENT DEPRESSION is an adaptation of the classic cognitive-therapy model emphasizing collaborative empiricism, the importance of socializing patients to the cognitive-therapy model, and the monitoring and modification of automatic thoughts, assumptions and beliefs.
www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=92

COPING AND SUPPORT TRAINING (CAST) is a high school-based suicide prevention program for youth 14-19 years old focused on improving mood management, enhancing academic performance and decreasing involvement with drugs.
www.reconnectingyouth.com/cast/index.html

COLUMBIA TEEN SCREEN program focuses on identifying middle and high school-aged youth in need of mental health services due to risk for suicide and undetected mental illness. The program's main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals.

www.teenscreen.org

EMERGENCY ROOM INTERVENTION FOR ADOLESCENT FEMALES is a program for girls 12-18 years old who are admitted to the emergency room after attempting suicide. The intervention aims to increase attendance in outpatient treatment following discharge and to reduce future suicide attempts.

www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=168

LIFELINES is a school-based program that includes a suicide-prevention curriculum and lessons; model policies and procedures for responding to at-risk youth, suicide deaths and attempted suicides; and presentations and workshops for teachers and parents.

www.sprc.org/featured_resources/ebpp/pdf/lifelines.pdf

LINKING EDUCATION AND AWARENESS OF DEPRESSION AND SUICIDE (LEADS)

is an interactive three-day curriculum that can be integrated into high-school health courses.

www.save.org/index.cfm?fuseaction=home.viewPage&page_id=45DFBB66-7E90-9BD4-CEB81505D25E7ED1

RAISING AWARENESS OF PERSONAL POWER (RAPP) is a school-based suicide education and prevention program that teaches students about signs of depression and suicidal behavior, and how to help themselves or a friend.

www.cdphe.state.co.us/pp/suicide/comprehensiveprogram.pdf

RECONNECTING YOUTH is a school-based selective or indicated prevention program that targets young people in grades 9-12 who show signs of poor school achievement, potential for dropping out and risk for suicide.

www.reconnectingyouth.com/ry/index.html

RESPONSE is a comprehensive school-based program that increases awareness about suicide among staff, students and parents.

www.oregon.gov/DHS/ph/ipe/ysp/response.shtml

SUICIDE AWARENESS FOR EVERYONE (SAFE:TEEN) is a comprehensive suicide-prevention program for school staff, parents and students to help them recognize and respond to the warning signs of suicide.

SOS (SIGNS OF SUICIDE) is a two-day high school-based intervention that includes screening and education.

www.mentalhealthscreening.org/highschool/index.aspx

VOZ Y CORAZON is a teen-focused and teen-designed program that supports teenagers' efforts to develop solid identities through suicide prevention trainings and culturally appropriate activities.

<http://www.mhcd.org/Services/VozYCorazon.html>

YELLOW RIBBON SUICIDE PREVENTION PROGRAM is an international community-based program using a universal public-health approach to empower and educate professionals, adults and youth.

www.yellowribbon.org

APPENDIX E

Suicide Prevention in Colorado Steering Committee and Advisory Council Members

Steering Committee Members

- Jeannie Ritter**, Colorado First Lady, Honorary Chairwoman
Jeanne Rohner, Mental Health America of Colorado, Chairwoman
Amy Boymel, Mental Health America of Colorado
Lisa Carlson, The Centers, University of Colorado Denver
Jean Demmler, Heartland Network for Social Research
Jarrod Hindman, Office of Suicide Prevention,
 Colorado Department of Public Health & Environment
Stephen Kopanos, Mental Health America of Colorado
Deb Kupfer, Western Interstate Commission for Higher Education
Jenny Shaw, Western Interstate Commission for Higher Education
Susie Street and Laura VanDeusen, Mental Health America of Colorado,
 Project Coordinators

Advisory Council Members

- Ellen Berk**, Private Practitioner
Lacey Berumen, NAMI Colorado
Phyllis Bigpond, Denver Indian Family Resource Center
Louise Boris, Suicide Prevention Coalition of Colorado
Larry Botnick, National Association of Social Workers, Colorado Chapter
Anne Marie Braga, Colorado Department of Public Health and Environment
Sidney Brown, Denver Indian Family Resource Center
Diana Buza, Pinon Project Family Resource Center
Susan Dahl, Community Member
George Del Grosso, Colorado Behavioral Healthcare Council
Tom Dillingham, Federation of Families for Children’s Mental Health – Colorado Chapter
Vivie Duclos, Youth Advisor Council to Colorado Department of Public Health
 and Environment
Becca Emme, Yellow Ribbon Suicide Prevention Program
Dale Emme, Yellow Ribbon Suicide Prevention Program
Dar Emme, Yellow Ribbon Suicide Prevention Program
Lynn Fichtner, Suicide Education and Support Services
T. Kerry Flood, Community Member

Stacy Freedenthal, University of Denver, Graduate School of Social Work

P.J. Gage, Harrison School District Two

Jon Gordon, Advisory Group, 2002 “Suicide in Colorado,” Midwestern Mental Health Center

Eleanor Hamm, Pueblo Suicide Prevention Center

Jodee Hawkins, Pueblo Suicide Prevention Center

Holly Hedegaard, Colorado Department of Public Health and Environment

Janet Karnes, Suicide Prevention Partnership Pikes Peak Region

Jeff Lamontagne, Second Wind Fund

Flavia Lewis, Private Practitioner

Sheila Linwood, Western Colorado Suicide Prevention Foundation

Ed Lucero, The Colorado Trust

Petrea Mah, Private Practitioner

Sophie Marie, Youth Advisor Council to Colorado Department of Public Health and Environment

Susan Marine, Boulder Suicide Prevention Coalition

Jerod McCoy, Division of Behavioral Health

Isabelle Medcill, Denver Indian Family Resource Center

Jo Mosby, Suicide Prevention Advocate

Stan Paprocki, Division of Behavioral Health

Bill Porter, Suicide Prevention Coalition of Colorado

Natalie Portman-Marsh, Consultant

Jose Reyes, Cultural Competency Consultant

Deanna Rice, Suicide Prevention Coalition of Colorado

Tasha Russman, Youth Advisor Council to Colorado Department of Public Health and Environment

Zeik Saidman, The Centers, University of Colorado Denver

Ann Seanor, Division of Behavioral Health

Sally Spencer Thomas, Carson J Spencer Foundation

Nicole Sperekas, Private Practitioner

Diane Stone, Law Enforcement Consultant

Bev Thurber, Suicide Resource Center of Larimer County

Randy Van Landingham, Yellow Ribbon Suicide Prevention Program

Suzanne Villarreal, Stakeholder

Thomas Wanebo, Chief of Staff to Colorado First Lady

APPENDIX F

Summary – Suicide Prevention Resources and Needs Survey: Public Middle and High Schools in Colorado

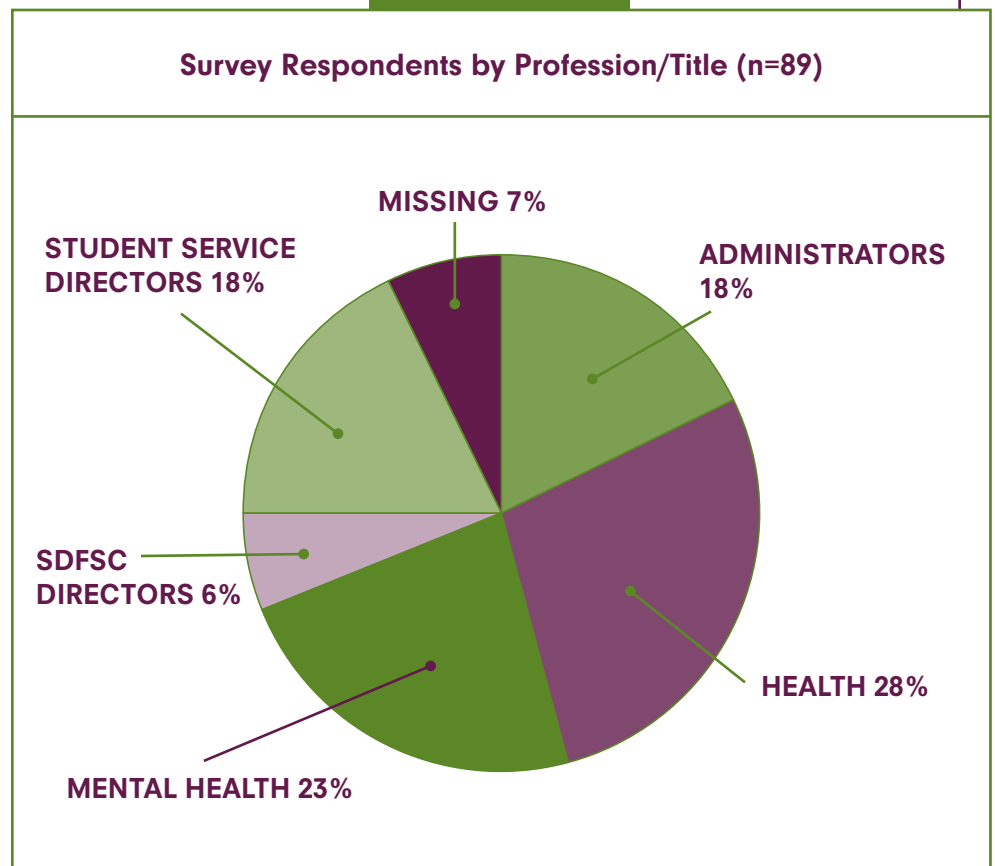
Prepared by Anita Saranga Coen, MSW LCSW, Focus Research & Evaluation

In order to learn more about the suicide prevention in Colorado’s public schools, public school districts were surveyed about several key components of suicide prevention.

- Strategic planning
- Awareness, education, gatekeeper programs conducted or planned to be conducted
- Funding for programs
- Judged seriousness of suicide problem and adequacy of services
- Support for and barriers to developing or expanding suicide prevention resources
- Additional services needed

The survey was mailed to the directors of Safe and Drug Free Schools and Communities (SDFSC), and Special/Exceptional Education and school nursing staff in each of Colorado’s 178 school districts. The survey was also made available for web-based completion. Respondents and districts were assured of confidentiality. Eighty-nine responses were received representing at least one response from 77 school districts (43.3%). Since a few large districts did not respond, these results should be viewed as exploratory. Several districts responded multiple times.

FIGURE 1



Each district was weighted equally; a composite record was created for each district by combining affirmative responses, averaging ratings, and compiling and entering all comments into the combined record.

Figure 1 shows the distribution of respondents by their profession or job title.

Geographic representation. The 76 districts represented 40 counties, 62.5% of Colorado's 64 counties, in regions throughout Colorado. With regard to population density, 52% of the districts were classified as rural or frontier and 47% as urban (1% were unknown).

District level suicide prevention planning. Two-thirds of the districts reported that there was no district-wide suicide prevention plan. About 35% of the districts reported that district approval was needed for schools within the district to conduct suicide prevention programs.

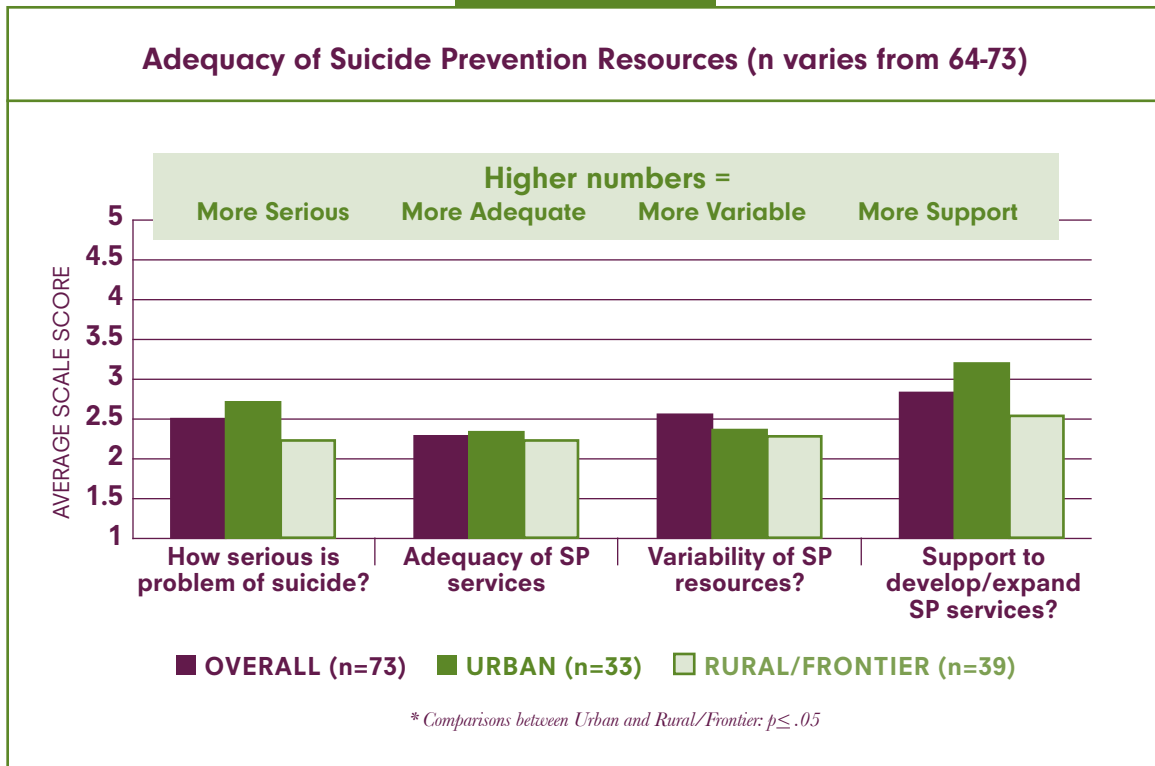
Suicide prevention programs conducted in the middle or high schools. Thirty-four (44.2%) of districts reported conducting at least one suicide prevention program during the 2007-08 school year, including, in decreasing order, Yellow Ribbon, Intervention Skills Training (ASIST®), Signs of Suicide, SAFE:TEEN, safeTALK®, Question, Persuade, Refer (QPR) and SuicideTalk®.

The remaining 43 (55.8%) of the responding districts reported they conducted no suicide prevention programs named on the list during the 2007-8 school year. One-third of these districts reported they conducted at least one Other suicide prevention activities, including, suicide education units within health or other classes, Safe2Tell, Columbia TeenScreen Program, Counselors, School Psychologist, Peer Counseling, Dialectical Behavior Therapy (DBT) and the use of Suicide Prevention Hotline posters.

Funding for suicide prevention programs. Most respondents (36.4%) indicated that their district is the most common source of funding for suicide prevention programming, followed by Other sources (16.9%), federal grants (13%), and finally by state and foundation grants, 3.9% each. Other sources of support included community mental health and a variety of community organizations, including free presentations.

The problem of suicide; adequacy of resources. Respondents were asked to rate their impressions of the seriousness of the problem of suicide in their district as well as three aspects of suicide prevention services: adequacy of available services; variability of the amount of resources from school to school within the district; and the amount of support available to develop or expand suicide prevention services. Figure 2 displays the average of responses for all respondents and for a breakdown of respondents by urban and the combined rural/frontier counties represented by participants. Respondents reported a mid-range average for all areas, with urban respondents reporting a statistically significantly higher level of seriousness of the problem of suicide and more support for developing or expanding suicide prevention services than rural/frontier areas of the state. Evaluators noticed that average ratings for support to enhance services tended to be slightly higher than the other ratings.

FIGURE 2



Support or advocacy to enhance suicide prevention resources within the districts.

Respondents were asked to review a list of 11 potential sources of support and identify those from which they perceived support for enhanced suicide prevention services. Table 2 below lists sources of support that were identified most frequently by respondents. Half or more of the respondents identified most of the support for enhancing suicide prevention resources in their district as coming from school-based mental health professionals and local community mental health centers, and school-based health professionals. District level health, administration, mental health professionals, teachers and school-based administration were identified by one-third or more of the respondents.

TABLE 2

Source of Support	Number of Respondents	%
School-based mental health professionals	42	54.5%
Community mental health centers	41	53.2%
School-based health professionals	38	49.4%
District-level health professionals	35	45.5%
District-level administration	32	41.6%
District-level mental health professionals	31	40.3%
Teachers	31	40.3%
School-based administration	30	39.0%

Other supports included parents, the Colorado Office of Suicide Prevention, the Colorado Department of Education, community-based suicide prevention coalitions (e.g., Rural Solutions, Piñon Project and the Mesa County Suicide Prevention Coalition, Suicide Resource Center of Larimer County) and local community groups and resource centers, including faith-based and other organizations.

Likely challenges to enhancing suicide prevention services within the districts.

Respondents were also asked to review a list of 12 potential challenges that would likely be faced if there was an effort to develop or expand suicide prevention services within the district.

Table 3 below lists the challenges that were identified most frequently by respondents. More than half of the respondents identified lack of time and funding as the most common challenges to developing or expanding suicide prevention strategies in their district. Lack of awareness, concerns about handling increased mental health referrals and uncertainty about the positive impact of such interventions were identified by one-third or more of the respondents. Lack of information about available programs and concerns about a potential increase in suicide attempts were identified by one-fourth or more respondents. Less than 8% of the respondents identified concerns about whether suicide prevention was an appropriate role for the schools.

TABLE 3

Challenges to Developing/Expanding Suicide Prevention Resources (N=77)		
Source of Support	Number of Respondents	%
Lack of time	49	63.6%
Lack of funding	47	61.0%
Lack of awareness	31	40.3%
Handling increased mental health referrals	28	36.4%
Uncertainty of positive impact	26	33.8%
Lack of information about what programs are available	24	31.2%
Concern about increase in suicide attempts	22	28.6%
Parental concerns	18	23.4%
Concern about legal liability	17	22.1%
Stigma	13	16.9%
Concern about cultural barriers	11	14.3%

Additional services needed for youth at risk of suicide. Respondents identified the need for increased mental health services and counseling within the schools as their districts’ most compelling need to serve youth at risk for suicide. A few indicated that suicide prevention or crisis specialists are needed. This was followed by the need for increased dollars and staff (and general resources) to acquire the materials needed and to provide training in suicide prevention.



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