Colorado

A History of Suicide Prevention, Intervention and Postvention Efforts in Colorado

produced by

Suicide Prevention Coalition of Colorado
and
Colorado Office of Suicide Prevention

written by Sara Miller

Colorado Department of Public Health & Environment
Office of Suicide Prevention

March 2012

Dear Readers,

We are very pleased to share this account of suicide prevention, intervention and postvention in Colorado, which chronicles the rich history and passion of the suicide prevention movement in our beautiful state. As the following pages detail, many individuals and organizations have contributed to some groundbreaking and innovative work over the last 60 years. Many initiatives began with the tragic loss of a loved one to suicide, followed by tireless advocacy of those left behind. All of the initiatives relied on the generous contributions of individuals and organizations throughout Colorado to raise awareness, create change, and save lives.

It is impossible to list the individuals and organizations that helped shape suicide prevention efforts over the last 60 years. This report highlights many of the critical initiatives that have influenced our history as recalled and reported directly by more than 40 of the individuals who played key roles in the success of suicide prevention in Colorado. It is our hope that this history allows readers, both those that have worked in suicide prevention for many years and those new to the movement, to more clearly understand the incredible work that has been done to date in Colorado and its importance to the work we will continue to do over the next 60 years.

This project would have been impossible without the commitment and time of its many contributors. The author, Ms. Sara Miller, spent months meeting with stakeholders, compiling notes, checking references, and writing a compelling document that provides a chronological snapshot of suicide prevention in Colorado. Countless individuals met with Ms. Miller to share their insight and experiences, and their knowledge was paramount to the success of this history. Members of the Suicide Prevention Coalition of Colorado Board reviewed drafts of the document and provided Ms. Miller with invaluable suggestions and filled gaps in the timeline.

While suicide continues to be a critical public health issue in Colorado that requires ongoing contributions from individuals and agencies statewide, it is imperative that future efforts acknowledge and learn from the rich history of suicide prevention and intervention in Colorado.

Jarrod Hindman

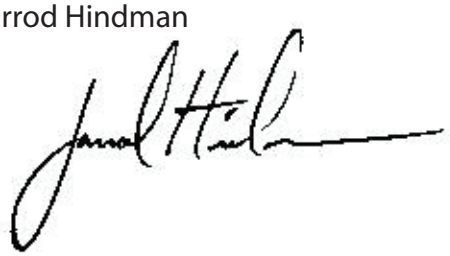

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TABLE OF CONTENTS

AUTHOR'S NOTE

Colorado has a history of suicide prevention that spans over 60 years. Some of the events documented in this project took place specifically in the realm of suicide prevention, while many others occurred in the broader spectrum of mental health and public health work. For this reason, it is impossible to reach everyone who has contributed to Colorado's suicide prevention efforts. Please know that whether or not your work is directly represented in this project, we are forever grateful for your dedication.

To those individuals with whom I *did* speak–community advocates, mental health professionals, parents and friends, academics and public policy workers, the hours of interviews for this project were priceless. We shared tears, we laughed and you answered my difficult and oftentimes redundant questions about the "whys" of suicide. I am forever grateful that you chose to share your stories with me. It is my honor to bring your words to life in this account of Colorado's suicide prevention, intervention and postvention history.

Monhandas Gandhi once said: "A small body of determined spirits fired by an unquenchable faith in their mission can alter the course of history." *You* are those determined spirits and *you* have altered the course of Colorado's history forever.

This is dedicated to my dear friends, Casey and Mike, who are greatly missed, and to Jill, who I will never know, but will always hold a place in my heart.

INTRODUCTION

Nine hundred forty people died by suicide in Colorado in the year 2009[1]. That is 475 more than died by motor vehicle accidents[2] and 162 more than died due to diabetes[3]. The most staggering fact is that those 940 deaths were preventable.

Researching this project for the better part of a year, I came into contact with many individuals. There were those who lost a loved one to suicide and committed their lives to preventing another tragic loss of life so their loved ones' lives were not lost in vain. Many have focused their careers even further upstream than suicide-specific prevention—helping the youth of Colorado build resiliency through analysis of risk factors and pinpointing personality traits (or lack thereof) that could eventually lead to suicide. Plus there were countless people who have dedicated their time to helping others recover from the loss of their loved ones who died by suicide—providing hours of support in the darkest days of someone's life**.** I spent time in communities that have assembled to scrutinize the continuum of suicide prevention and intervention, concentrating resources on every piece of that public health puzzle in the hopes that no stone goes unturned in the fight against suicide. It is all of these individuals—those about which this project is written—who *know* the statistics from above. It is these people who live with the statistics every day and continually redouble their efforts to ensure that those 940 lost to suicide, stay alive in years to come.

What struck me as most surprising, were the vast numbers of Colorado residents who *do not know* these statistics. Last month, my dentist asked me about my latest work. He was shocked to hear that Colorado's fight against suicide is so long enduring and necessary. "But we have so much sunshine…it's so beautiful here…people exercise more regularly. You would think that people here are happier and we would have less suicide than other states." Two friends, a pediatrician and a family physician specializing in Colorado's older population, asked a myriad of questions. Both are surprised to hear of the need for a project documenting Colorado's suicide prevention efforts. Both are saddened that in spite of efforts so far-reaching that they can fill a book, our state still has the sixth highest rate of suicide deaths in the country[4].

Many people have asked what the need for this project is. The reasons are many. Most important, is the need to validate and commemorate those who have been fighting tirelessly to prevent suicide for half a century. This includes volunteers and community advocates, mental health professionals, researchers and suicidologists, parents and educators, in Colorado.

In the midst of fighting such a daily battle, facts and figures can be lost. Some of the individuals who we commemorate are nearing retirement age, and it is important to capture their stories before they move on to other parts of life. Oftentimes, telling these stories has been a bit like playing detective:

- one person remembers a fact,
- which leads to a dusty box filled with notes,
- which leads to a long-forgotten article,
- which culminates in an "a-ha!" moment, and
- fills in the blanks of the institutional memory.

While this information treasure hunt is satisfying, it can be frustrating for those trapped in the archives searching for one last fact. This project is by no means comprehensive, but with the voices of more than 40 individuals and facts gleaned from articles, books and news sources a plenty, the hope is that a clear picture of Colorado's suicide prevention efforts will prevail.

However, creating this picture is not enough. Winston Churchill once said: "Those that fail to *learn* from history are doomed to repeat it." In the field of suicide prevention, we do repeat ourselves time and again—redoubling the fight, saying the same words and spreading the same message every day. With a thoroughly documented history, it is the hope that we can learn from the stories and take on the fight in a more organized, streamlined and informed manner. Rather than recreating the wheel, we can perhaps design a slightly different wheel whose function might better serve the purposes of our community, state or nation in the fight against suicide.

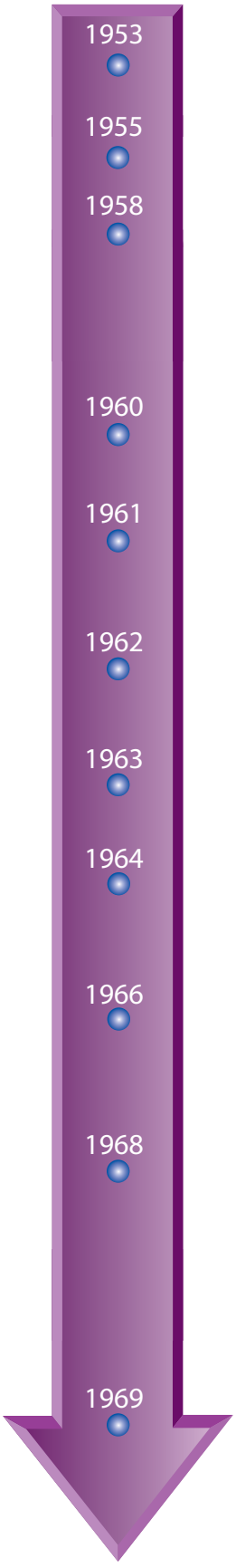
Finally, this project is about communication and awareness. There is a need to educate those in the suicide prevention community about what is being done across the state. At times, Colorado's fight against suicide has seemed "Denver-centric," given the access to more heavily concentrated resources in a metropolitan area. However, our far-reaching communities serve as microcosms of the greater population. Some of these communities have created comprehensive suicide prevention and intervention safety nets thanks to their collaborative efforts. These efforts should be validated and serve as models for larger and more broad-reaching geographies.

This need for education also extends to the general public—those who do not live with the statistics about suicide in Colorado. The aim of this project is to reveal the hard truth that suicidal ideation touches each of us in some form and that *all of us* can help prevent it from becoming reality.

One cannot adequately tackle the history of suicide prevention in Colorado without going back to the beginning of mental and public health in our country. Although this project only documents suicide prevention efforts in Colorado as far back as 1953, the story begins long before that date. Alongside Colorado, national and global suicide prevention movements were growing. In this chronological retelling, one can see that these state and national efforts are inextricably tied to one another. Colorado is home to leaders in suicide prevention who have furthered our state's work while at the same time contributing to and altering the national conversations about prevention, intervention and postvention.

Along the way, readers will meet these leaders—those who have influenced the national agenda and those who have made a difference in their own communities. Thus far, the majority of reports and plans focusing on suicide prevention in Colorado have been data-driven and strategic. While it is undeniably important to analyze the figures and to document best practices that further successful prevention efforts, it is also important to remember the stories. The stories of influential people and events documented in these pages are what put the skin and bones on Colorado's skeleton of facts and figures. These stories of passion and informed discovery are what keep the suicide prevention movement alive when the data seems bleak. These stories are what will continue to inspire Colorado's citizens to make the statewide plans a reality.

THE BEGINNINGS OF COMMUNITY MENTAL HEALTH IN COLORADO 1950s and 1960s



1953 - Mental Health America Colorado is incorporated.

1955 – Arapahoe Mental Health Center is founded. (Now known as Arapahoe/ Douglas Mental Health Network)

1958 – Jefferson Center for Mental Health is founded. (JCMH)

1958 – Los Angeles Suicide Prevention Center opens.

1960 – Suicide and Crisis Control hotline is operating in Denver.

1960 – International Association of Suicide Prevention (IASP) is founded in Vienna, Austria.

1961 – Britain's Parliament adopts the Suicide Act of 1961, which decriminalizes suicide in the UK, but makes assisting in a suicide punishable by up to 14 years in jail.

1962 –Spanish Peaks Mental Health is founded.

1963 – President John F. Kennedy passes the Community Mental Health Centers Act that funds construction and staffing for comprehensive, community-based mental health centers.

1964 – Center for Mental Health (in Montrose) is opened. (Now known as Midwestern Colorado Mental Health Clinic, Inc.)

1966 - Center for the Study of Suicide Prevention (renamed the Suicide Prevention Research Unit) is established at the National Institute of Mental Health. (NIMH)

1968 – Pueblo Suicide Prevention Center is incorporated.

1968 – American Association of Suicidology is founded. (AAS)

First National Conference on Suicidology is held in Chicago by AAS.

Robert Schuller founds New Hope, the first Christian 24-hour suicide prevention center, in California.

1969 – Four mental health centers are created in Denver: Bethesda Community Mental Health Center; Denver Center for Mental Health Services; Park East Comprehensive Mental Health Center; and Southwest Mental Health Center.

ORGANIZED SUICIDE PREVENTION IN COLORADO BEGINS 1970-1984

1970 - COMITIS Crisis Center begins operation to provide assistance to youth with substance abuse problems. They establish two 24-hour crisis helplines.

1974 – Eleanor Hamm joins the Pueblo Suicide Prevention Hotline.

1976 – Pueblo Suicide Prevention Center (PSPC) becomes a member of AAS.

The Gay, Lesbian, Bisexual, Transgender (GLBT) Community Center of Colorado is formed. (Now known as The Center)

1978 – Three students at Cherry Creek Schools take their lives.

1979 – LaRita Archibald attends the first AAS Conference held in Denver. (Only one session is offered for the bereaved.)

AAS requests that PSPC become the Region 8 Coordinator for Colorado, Wyoming, Montana, Utah, and North and South Dakota.

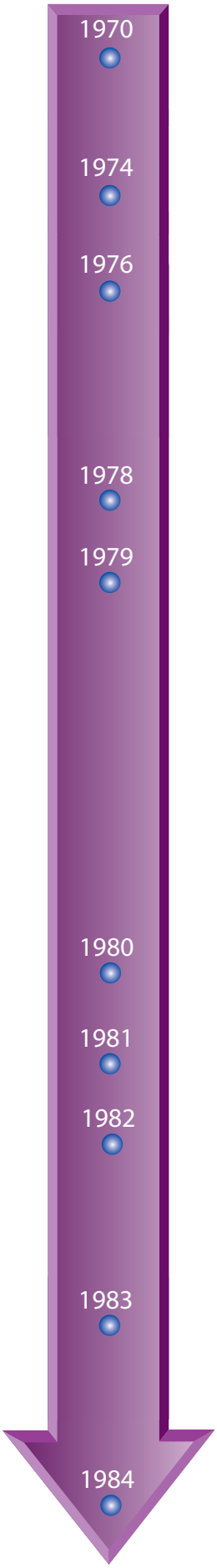
1979-1984 – Governor Richard Lamm creates the Colorado Commission on Children and Their Families. Suicide prevention is one of the commission's priorities.

1980 – LaRita Archibald founds HEARTBEAT and holds the first meeting on November 1.

Julie Perlman becomes the Executive Director of AAS (based in Denver).

1982 – *Intervention/Prevention Seeking Solutions to Self Destructive Behavior in Children* is published by Barrett and Horsfall. The impetus for this report was the 1978 Cherry Creek Schools' suicides.

1983 – Suicide Prevention Allied Regional Effort (S.P.A.R.E.) begins to organize.



1976 – AAS begins accrediting crisis centers nationwide.

1979 – 11th Annual AAS Conference is held for the first time in Denver.

National Alliance on Mental Illness (NAMI) is founded. NAMI is dedicated to improving the lives of individuals and families affected by mental illness.

1980 – Offices of American Association of Suicidology (AAS) move to Denver

1981 – Survivors after Suicide support group is founded in Los Angeles.

1983 – Centers for Disease Control (CDC) Violence Prevention Unit is created. This unit is later incorporated into the National Center for Injury Prevention and Control. One goal is to focus public attention on an increase in the rate of youth suicide.

1984 – AAS founds the National Survivor Committee. LaRita Archibald is one of the founders.

COALITIONS ARE FORMED ACROSS THE STATE 1985-1989

1985 – Pueblo (PSPC) is certified as an AAS Crisis Center.

S.P.A.R.E. formally organizes.

Youth Suicide Prevention Coalition, Columbine/Chatfield area is founded.

1986 – S.P.A.R.E. officially holds its first meeting.

S.P.A.R.E. holds first suicide prevention conference in Colorado.

1987 – Mental Health Center of Denver (MHCD) was incorporated as a private, not-for-profit 501(c)3 corporation.

Weld County Suicide Prevention Coalition is founded. (Now known as Suicide Education and Support Services [SESS])

S.P.A.R.E. receives funding from an Alcohol and Drug Abuse Divison (ADAD) grant.

1989 – AAS/AFSP hold inaugural Healing After Suicide Conference in Denver. The conference is chaired by LaRita Archibald.

Suicide Resource Center of Larimer County is founded.

Parents Surviving Suicide support group is started by Vivian Epstein in Denver.

1985

1986

1987

1989

1985 – Secretary's Task Force on Youth Suicide is established by the U.S. Secretary of Health and Human Services to review the problem of youth suicide and recommend actions.

1986 – CDC establishes the Division of Injury Epidemiology and Control.

AAS offers first half-day survivors' workshops as part of AAS national conference

The Secretary of Health and Human Services' Task Force publishes "Assessment and Documentation of Youth at Risk for Suicide."

Diane Ryerson-Peake writes Adolescent Suicide Awareness Program, which later becomes SafeTEEN.

1987 – American Foundation for Suicide Prevention (AFSP) is founded.

The United Nations releases a statement that "concerned people from around the globe recognized that suicide and suicidal behaviors are public health problems that affect the health and welfare of families, communities, and entire nations."

1989 – AAS/AFSP hold inaugural Healing After Suicide Conference in Denver.

AAS publishes first issue of *Surviving Suicide*, the national survivors' newsletter.

CITIZEN ADVOCACY GARNERS GOVERNMENT ATTENTION 1990-1995

1990 – Bob and Jan Burnside found HEARTBEAT support group at Lutheran Hospital.

Shaka Franklin Foundation for Youth is founded by Les Franklin.

S.P.A.R.E. gracefully disbands.

Doris Walker starts *Parents Surviving Suicide* newsletter.

1993 – LaRita Archibald co-founds Suicide Prevention Pikes Peak.

HEARTBEAT is incorporated.

Article in the *Denver Post* dubs 1993 the "Summer of Violence."

In response to the murders that spurred the *Denver Post* article, Governor Roy Romer establishes a statewide Committee on Youth Violence Prevention.

1994 – Yellow Ribbon Youth Suicide Prevention Program is founded.

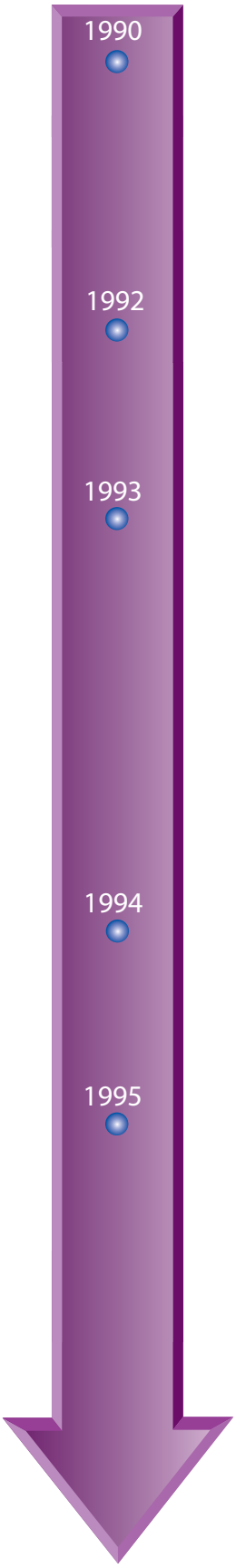
1995 – "Youth Risk Behavior Survey" is published by Colorado's State Health Department Survey Research Unit.

Community advocate, Deanna Rice, writes a letter to Gov. Roy Romer and his wife Bea, urging them to take action regarding the need for suicide prevention in Colorado.

Weld County Suicide Prevention Coalition becomes SESS (Suicide Education and Support Services).

Suicide Prevention Pikes Peak founds Suicide Prevention Hotline – now the Kevin and Mark Graham Hotline.

Jennifer Gamblin of Mental Health America Colorado (MHAC) organizes a meeting of likeminded professionals and advocates to discuss the lack of suicide resources in Colorado.



1990 – Suicide Awareness Voices of Education (SAVE) is incorporated, with Adina Wrobleski as the first Executive Director.

1992 – Scott and Leah Simpson form a statewide citizens group in Washington State to expose teenage suicide and find solutions. Washington State lawmakers fund a new, $2 million prevention program.

1993 – The United Nations (UN) and the World Health Organization (WHO) convene the first Interregional Expert Meeting on the Formulation of National Strategies for the Prevention of Suicide in Calgary.

1994 - Short-film, *Trevor*, wins an Academy Award. The film is a comedy/drama about a gay 13-year-old boy, who when rejected by friends because of his sexuality, makes an attempt to take his life.

1995 – Washington is the first state to launch a plan to prevent suicide.

AAS moves Central Office to Washington D.C. after 14 years in Denver. Alan (Lanny) Berman is appointed Executive Director.

Question Persuade Refer (QPR) is created by Dr. Paul Quinnett. QPR is developed in a joint venture between Spokane Mental Health and the Department of Health, Spokane County, Washington.

COLORADO'S ORGANIZED STATEWIDE EFFORTS BEGIN 1996-1998

1996 – Members of the group organized by Jennifer Gamblin attend a suicide prevention conference in Washington State.

Gamblin organizes a press conference on the steps of the Capitol in conjunction with the inaugural National Suicide Awareness Day.

1997 – 3rd Bi-Regional Adolescent Suicide Prevention Conference is held in Breckenridge. (Sponsored by the Health Resources & Services Administration of the Maternal & Child Health Bureau)

A series of articles is published by Bill Briggs in the *Denver Post* highlighting the chronic suicide prevention problem in Colorado.

Talks begin with Gov. Roy Romer, who tasks Jillian Jacobellis, Division Director of Emergency Medical Services and Prevention Division at the Colorado Department of Public Health, and Patti Shwayder, executive director of the Colorado Department of Public Health and Environment, to gather funds to create a Suicide Prevention Advisory Commission.

Colorado Lifekeeper Quilt is created.

1998 – Gov. Romer allocates $61,000 to fund the Suicide Prevention Advisory Commission, a state commission to investigate how other states combat suicide.

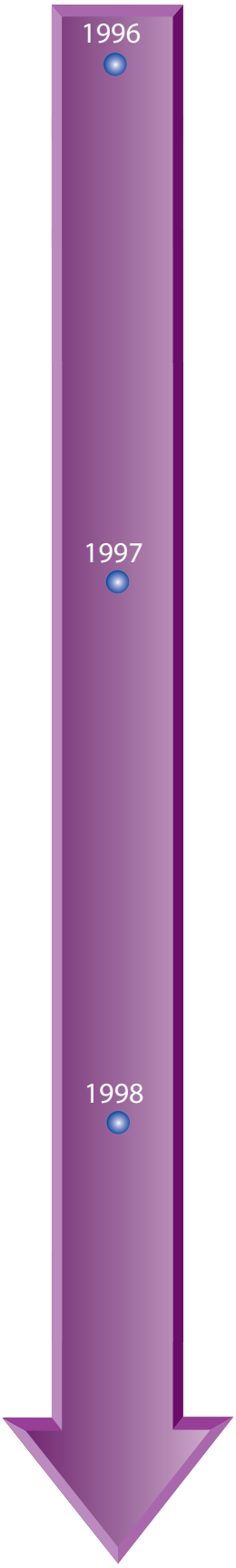
Suicide Prevention Advisory Commission is created on with Executive Order B 002 98.

Dr. Tom Barrett, Mental Health Director of Colorado, makes a presentation to the Governor's Commission regarding the link between mental illness and suicide.

The Citizens' Advisory Panel on Suicide Prevention is formed.

The work of the Blue Ribbon Suicide Prevention Advisory Commission officially begins.

Work on Colorado's state suicide prevention plan begins.



1996 – AFSP Citizens' Roundtable is formed on Suicide Prevention.

Suicide Prevention Action Network (SPAN) USA is founded by Elsie and Jerry Weyrauch, with the goal of preventing suicide through public education, community action and advocacy.

AFSP holds inaugural National Suicide Awareness Day event.

Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies is published by the World Health Organization and the United Nations.

1997 – SPAN petitions the federal government for action with regard to addressing suicide as a national problem.

Senate Resolution 84 (105th Congress) calls for suicide to be recognized as a national problem.

The Trevor Project is founded

National Organization for People of Color Against Suicide is founded. Colorado's Les Franklin is a co-founder and member of the Board of Directors.

The Jason Foundation is founded.

1998 – SPAN hosts a National Suicide Prevention Conference in Reno, Nevada, as a response to the WHO/UN publication *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*. (October)

U.S. House of Representatives House Resolution 212 passes "recognizing suicide as a national problem" and "declaring suicide prevention a national priority."

COLORADO'S SUICIDE PREVENTION PLAN IS COMPLETED 1998-1999

1998 (cont.) - *Suicide Prevention and Intervention Plan: The Report of the Governor's Suicide Prevention Advisory Commission* is released.

Gov. Roy Romer leaves office. Bill Owens becomes Colorado's 40th Governor.

Rainbow Alley is created at The Center to serve Colorado's GLBT and questioning youth.

1998

1999 – Members of the Blue Ribbon Commission and the Citizens' Advisory Panel personally deliver copies of the state plan to all heads of departments and legislators in Colorado.

1999

Citizens' Advisory and Governor's Blue Ribbon Commission continue to meet and become the Suicide Prevention Coalition of Colorado (SPCC).

Ed Perlmutter helps pass Senate Joint Resolution 99-031 concerning suicide prevention with SPCC's encouragement.

Tom Barrett presents a Suicide Prevention Panel at the 1999 Legislative Education Day.

Murder/suicide occurs at Columbine High School in Littleton and adds to the need for suicide prevention in Colorado.

SPCC has conversations with the NRA on safe storage of weapons. Steve Lowenstein calls for more aggressive screening of handgun owners.

Safe2Tell concept is presented in Colorado Springs.

Community advocate Deanna Rice sends a letter to Gov. Bill Owens and his wife Frances, requesting that he act on implementing the state suicide prevention plan.

Gov. Owens asks Jane Norton, Executive Director of Colorado's Department of Public Health and Environment, to "make prevention and intervention a state priority."

Members of SPCC send a letter of request to testify in front of Colorado's Joint Budget Committee.

1999 – National Council for Suicide Prevention is formed.

1-800-SUICIDE is launched by Reese Butler.

Former U.S. Surgeon General, Dr. David Satcher, dedicates the national crisis hotline network (1-800-SUICIDE).

The U.S. Surgeon General releases the *Call to Action to Prevent Suicide* report.

National Survivors of Suicide Day is changed to International Survivors of Suicide Day by U.S. Senate resolution.

International Yellow Ribbon Suicide Awareness and Prevention Week is created by U.S. House Resolution 286.

WHO launches a global initiative for the prevention of suicide.

COLORADO'S OFFICE OF SUICIDE PREVENTION IS ESTABLISHED 2000-2001

2000 – Gov. Bill Owens requests $166,000 from the state Joint Budget Committee (JBC) to launch a two-person Office of Suicide Prevention.

Three members of SPCC testify before the JBC in favor of Owens' proposal.

Columbine Review Commission is appointed by Gov. Owens.

Colorado House of Representatives approves House Bill 00-1432 mandating the creation of a State Office of Suicide Prevention.

Gov. Bill Owens signs the establishment of Colorado's Office of Suicide Prevention (OSP) into law with an annual budget of $157,800 from a general fund appropriation.

Colorado's State Office of Suicide Prevention (OSP) opens in the Colorado Department of Public Health and Environment.

Stephannie Finley is appointed acting interim director. Finley conducts a roadtrip to meet with those who have lost people to suicide and prepares a report for state lawmakers listing what types of suicide prevention programs are active in Colorado.

Shannon (Breitzman) Anderson is selected as Director of Colorado's Office of Suicide Prevention.

Colorado Trust partners with United Way to fund Mental Health America of Colorado's Colorado LINK school based teen-suicide prevention program.

OSP begins awarding one-year grants for suicide prevention to communities in Colorado.

Colorado receives a two-year, $378,000 grant from SAMHSA for Partners for Teen Suicide Prevention Project.

2001 – OSP launches a multi-poster graphics campaign aimed at public awareness and education.

Columbine Review Commission releases report.

2000

2001

2000 – The Jed Foundation is founded.

2001 – Surgeon General David Satcher unveils the *National Strategy for Suicide Prevention* by the Department of Health and Human Services.

GRANT FUNDING EXPANDS SUICIDE PREVENTION EFFORTS 2001-2003

2001 (cont.) - Suicide Prevention Intervention Network (SPIN) becomes a 501(c)3. SPIN is the brainchild of Bob and Jan Burnside.

Four students take their lives at Green Mountain High School in Lakewood, Colo.

Eagle River Youth Coalition is founded in Eagle County.

OSP coordinates a statewide "training the trainers" event using Applied Suicide Intervention Skills Training. (ASIST)

2002 – The Colorado Trust and OSP release *Suicide in Colorado*.

In response to *Suicide in Colorado*, the Colorado Trust creates a 4-year (2002-2006) $2.5 million Preventing Suicide in Colorado Initiative (PCIS), which funds 10 community initiatives.

Members of the Joint Budget Committee mistakenly think the Colorado Trust is going to fund the OSP. Community advocates rally to ensure that JBC maintains OSP funding in the state general fund.

Second Wind Fund holds first walk in response to suicides at Green Mountain High School.

HEARTBEAT founding chapter becomes a 501(c)3.

SPCC hosts Wings of Hope, the inaugural statewide suicide prevention summit.

2003 – Suicide & Crisis Intervention Lifeline Coalition is created in Routt and Moffat counties.

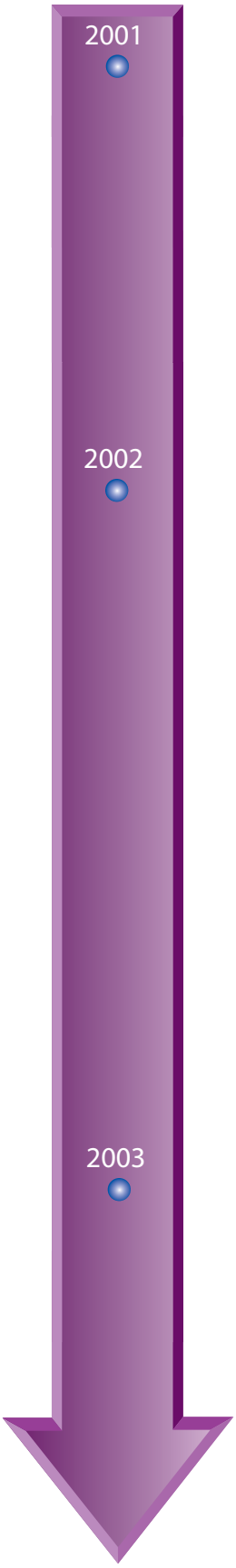
Colorado Trust funds Safe2Tell based in Colorado Springs.

Colorado receives funding from CDC to participate in National Violent Death Reporting System (NVDRS).

First Second Wind referral is made by Jay Lang at Green Mountain High School.

Active Minds is incorporated in Colorado.

SESS introduces the Hispanic Youth Suicide Prevention Project.



2001 (cont.) - The tragic events of September 11, 2001, cause a shift in the U.S. economy

The University of Michigan Depression Center is founded as the nation's only comprehensive center devoted to patient care, research, education and public policy in depression and related disorders.

2002 – Suicide Prevention Resource Center (SPRC) establishes the Education Development Center, Inc. with funding from SAMHSA.

Reducing Suicide: A National Imperative is published by the Institute of Medicine of the National Academies of Science.

The National Violent Death Reporting System is launched in six states.

Shannon (Breitzman) Anderson presents on behalf of OSP at the AAS national conference.

2003 – *Achieving the Promise: Transforming Mental Health Care in America* is published by the President's New Freedom Commission on Mental Health.

SPRC/AFSP Evidence-Based Practices Project (EBPP) is launched to identify and disseminate information about evidence-based suicide prevention programs.

Inaugural World Suicide Prevention Day is held. This is an IASP initiative in collaboration with WHO.

SUICDE PREVENTION FOCUSES ON NEW POPULATION GROUPS 2004-2005

2004 – Safe2Tell begins accepting calls.

Voz y Corazon is established at the Mental Health Center of Denver (MHCD).

Shannon (Breitzman) Anderson is invited to participate on the steering committee for the National Suicide Prevention Lifeline to provide consultation from a state perspective on crisis lines.

2005 – SPCC Speakers Bureau is formed.

Mariette Hartley is keynote speaker at the Wings of Hope Conference.

OSP hosts four town hall meetings across the state.

Rural Solutions in Sterling, creates the Life Source Training Project with funding from the Colorado Trust.

Reaching Everyone Preventing Suicide (REPS) is created under the auspices of Steamboat Mental Health with funding from the Colorado Trust.

The Montelores Suicide Prevention Coalition is created under the auspices of The Piñon Project with funding from the Colorado Trust.

Boulder County Suicide Prevention Coalition is formed. (Now known as HOPE Coalition of Boulder County)

Colie's Closet is formed in Boulder to provide funding for treatment of depression.

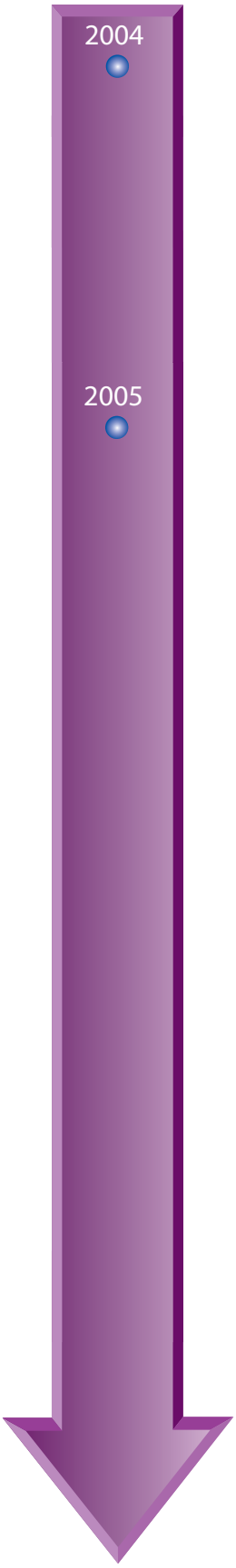
The Carson J. Spencer Foundation is formed.

The Veterans Administration awards a Mental Illness Research Education and Clinical Center to VISN 19 in Colorado to conduct research, educational activities, and clinical work focused on addressing suicidality in the Veteran population.

The 38th Annual AAS Conference is held in Broomfield, Colorado.

Karen Mason becomes director of OSP.

AFSP hosts first Out of Darkness Walk in Colorado.



2004 – The National Violent Death Reporting System expands to include 17 states.

A Secret Best Not Kept is released.

2005 – 1-800-273-TALK (National Suicide Prevention Lifeline) is launched with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Garrett Lee Smith Memorial Act is passed by the U.S. Congress creating a grant program at SAMHSA to help states, tribes and colleges/universities to develop and implement youth, adolescent and college-age early intervention and prevention strategies to reduce suicide.

The Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 2006, which appropriates $30 million for suicide prevention, is signed into law.

SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) begins reviewing and listing suicide prevention and intervention programs.

The Veterans Administration awards a Mental Illness Research Education and Clinical Center (MIRECC) to Veterans Integrated Service Network (VISN) 19 in Colorado with the direction to conduct research, educational activities, and clinical work focused on addressing suicidality in the Veteran population.

The 38th Annual AAS Conference is held in Broomfield, Colorado.

GARRETT LEE SMITH GRANTS CREATES PROJECT SAFETY NET 2006-2007

2006 – SPCC members testify in support of HB 06-1098 concerning teachers professional development.

Jarrod Hindman takes over as director of OSP.

Peter Gutierrez moves to Colorado and begins work at the VA. He is the acting president of AAS. (2006-2008)

Comcast makes *Student Voices: Teen Suicide*.

Substance Abuse and Mental Health Services Administration (SAMHSA) awards the Office of Suicide Prevention a Garrett Lee Smith grant in the amount of $400,000 per year for three years to conduct youth suicide prevention efforts in five Colorado counties and at the University of Colorado at Boulder.

Project Safety Net begins (2006-2009) with funding from Garrett Lee Smith grant.

OSP changes its format to a three-year funding cycle for all community grants.

Project HOPE is created at the Southeast Mental Health Center in Lamar to focus on education and awareness, gatekeeper training, screenings and appropriate referrals.

The Triage Project begins as a series of inter-agency and interdisciplinary discussions, convened and sponsored by Mental Health America of Colorado. (This project will become Metro Crisis Services.)

2007 – Kathy Cronkite is the keynote speaker at SPCC's Prisms Fundraiser.

Analysis of Colorado's Suicide Prevention and Intervention Plan is written by students at the University of Colorado at Denver Health Science Center Graduate School of Public Affairs.

MHAC and the Heartland Network receive support from the Colorado Trust to review state plan and update the 2002 Colorado Trust report, *Suicide in Colorado*.

2006

2007

2006 – The SAMHSA Program Priority Matrix is updated to include suicide prevention as one of the matrix priorities.

The Federal Working Group on Suicide Prevention is established.

The United States Air Force Suicide Prevention Program (AFSPP) is launched.

Signs of Suicide (SOS) is launched.

2007 – The Joshua Omvig Veterans Suicide Prevention Act is signed.

Best Practices Registry for Suicide Prevention (BPR), is launched by SPRC and AFSP to identify, review and disseminate information about best practices for suicide prevention.

The VA's Suicide Prevention Hotline becomes operational.

CONFERENCES, CAMPAIGNS AND COALITIONS: AN ACTIVE TIME 2007-2008

2007 (cont.) – Passage of Senate Bill 36 ensures expanded mental health insurance coverage to include nine additional disorders: post-traumatic stress disorder; drug and alcohol disorders; anorexia nervosa and bulimia nervosa; social phobia; panic disorder; general anxiety disorder; agoraphobia; and dysthymia and cyclothymia (both depressive disorders).

The Carson J. Spencer Foundation establishes the Rising Star Scholarship.

OSP partners with AFSP to research, design and implement a statewide public education campaign targeting men ages 35-54.

The Office of Suicide Prevention is invited to lend expertise to a prevention conference in Rapid City, S.D. The focus is suicide prevention among Native Americans in Colorado, Arizona, Wyoming, Nebraska, South Dakota, North Dakota, and Montana. Over 250 Native Americans attend the conference, which addresses the unique cultural and spiritual aspects of suicide among Native Americans.

2008 – The inaugural Bridging the Divide: Suicide Awareness and Prevention Summit is hosted by Regis University.

OSP and the Injury Community Planning Group at the Colorado Department of Public Health and Environment begin development of a training for first responders (emergency medical service providers and law enforcement), who are at an increased risk for suicide.

The Shaka Franklin Foundation goes international with expansion to Africa.

The "Don't Erase Your Future" campaign takes place at the University of Colorado Boulder.

The Depression Center at the University of Colorado Denver School of Medicine opens. This is the first step in a national effort to link centers focused on depression and bipolar disorder.

Trinidad State Junior College receives a Garrett Lee Smith grant for campus suicide prevention.

2008 – *Long Way Home* is produced by Outreach Arts.

A National Network of Depression Centers (NNDC) is launched with the opening of the Colorado Depression Center.

2008 (cont.) – The Interfaith Network on Mental Illness is founded by NAMI Boulder.

The Colorado School Safety Resource Center (CSSRC) is created by Senate Bill 08-001.

2009 – *Preventing Suicide in Colorado: Progress Achieved & Goals for the Future* is released by the Colorado Trust, MHAC and OSP. This document is an update to the 1998 state plan.

An announcement is released by the Colorado Department of Public Health and Environment regarding the highest suicide rate ever in Colorado.

Fort Logan closes its first inpatient beds.

Sue Klebold publishes an article about her son Dylan and the tragedy at Columbine High School in *O* Magazine.

Sue Klebold is asked to join the AFSP National Survivor Council.

Fort Carson becomes a Suicide Prevention laboratory for the military. Fort Carson's suicide rates are half the previous year's.

Second Wind Fund flagship affiliate is established.

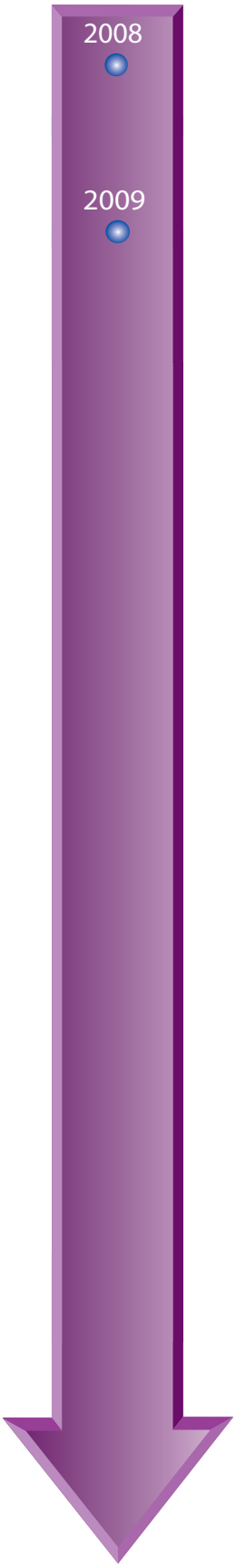
The Kirwin-Carr Foundation is established.

The Working Minds Toolkit is released by the Carson J. Spencer Foundation.

Suicide Education & Support Services (SESS) becomes a program of North Range Behavioral Health.

Garrett Lee Smith grant is renewed. (2009-2012)

OSP extends Project Safety Net funding.



2009 – The Army Suicide Prevention Task Force is established.

AFSP and SPAN merge.

Department of Veterans Affairs (VA) and Lifeline launch an online chat service for veterans in emotional distress.

THE FACE OF MENTAL HEALTH IN COLORADO IS CHANGING 2010-2011

2010 - Fort Carson hosts a Suicide Prevention Forum.

Metro Crisis spins off from MHAC; Metro Crisis Call center is opened.

Carson J. Spencer Foundation's Working Minds Toolkit is accepted into the Best Practices Registry.

The Military Suicide Research Consortium (MSRC) Department of Defense, through the Military Operational Medicine Research Program is founded in Denver.

SPCC hosts a Town Hall of Hope in Genesee, Colo.

SPCC launches an online statewide suicide prevention calendar.

Carson J. Spencer Foundation establishes the Working Minds award.

Denver Public Schools proudly launches the DPS Health Agenda 2015, outlining district health priorities for the next five years.

2011 - Fort Logan shuts the doors to its adolescent unit.

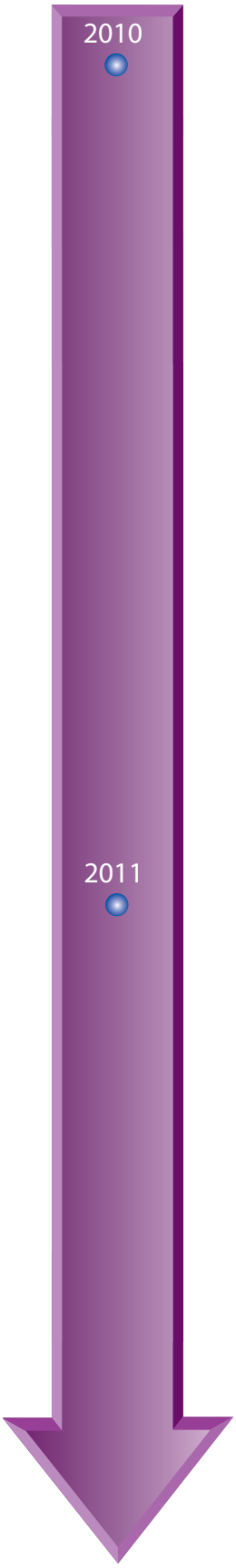
Metro Crisis begins working toward accreditation with AAS.

The House Education Committee begins work on Bill 1254, a bill designed to re-assess the anti-bullying guidelines in Colorado public schools.

The Center for Dependency, Addiction and Rehabilitation at the University of Colorado hosts "Confronting Addiction and Suicide: A Forum of Interfaith Community Leaders."

SafeSchools hosts a Youth Suicide Prevention and Intervention Symposium with OSP.

SPCC hosts a Regional Convocation on Suicide Prevention in conjunction with a meeting of the Depression Center Scientists Suicide Research Workgroup.



2010 - The Military Suicide Research Consortium (MSRC) Department of Defense, through the Military Operational Medicine Research Program is founded in Denver.

A study is released by the University of Utah Brain Institute, Salt Lake Veterans Affairs and Case Western University linking altitude and suicide rates.

The National Network of Depression Centers (NNDC) announces the passage of the ENHANCED Act of 2009 as part of the Patient Protection and Affordable Care Act.

The National Action Alliance for Suicide Prevention is established. Colorado's Sally Spencer-Thomas is named Executive Secretary.

Lifeline honors its 2 millionth call.

The history of mental and public health throughout the United States sets the stage for what is to come concerning suicidal individuals and the rich history of suicide prevention in Colorado. Colorado became the 38th state of the Union in 1858. Just two years later, in 1860, the state's first hospital, the City Hospital, was established in a log cabin near the corner of what is now 8th Avenue and Lawrence Street[5].

In 1879, Colorado enacted legislation establishing the state's first public mental health hospital, the Colorado Insane Asylum, now named the Colorado Mental Health Institute Pueblo. Ten years after its founding, Colorado's asylum recorded its first suicide. A columnist from the *Rocky Mountain Sun* was quoted as saying, "Someone is paid to care for these unfortunates, and the salary should be sufficient to make them vigilant. The inmates of the asylum are entitled to much more care and consideration than the 200 or 300 people confined in the penitentiary…"[6] It was apparent, even then, that suicide was a problem that could not be fixed by simple confinement within a psychiatric facility.

The asylum's residency grew until it reached capacity. This overcrowding led to patient neglect and additional tragedies within the facility. By 1898, newspapers from Aspen, Cripple Creek and San Juan County were all reporting on the need for major reform at the Pueblo asylum.[7] Throughout the next 10 years, psychiatric institution populations skyrocketed to more than 100,000 patients. Although many private citizens, community advocates and journalists complained about abject conditions, it was not until 1908 that Clifford W. Beers sparked a mental health reform movement in the United States.

In his autobiography, *A Mind That Found Itself*, Beers traced his childhood as a New Haven native to the privileged life of a Yale-educated gentleman to the inhuman deprivations of some turn-of-the-century insane asylums to the stature of mental health crusader. Beers' story was the most vivid autobiographical account of mental illness in the United States to date. It described his commitment to a mental hospital in 1900 followed by his leap out of a fourth-floor window in a failed suicide attempt.

Beers' book recounted in remarkable detail the 798 days of depression that followed his jump. He imagined his attempt at suicide to be a crime for which he would soon be arrested. He became convinced that his attendants and fellow patients were part of a conspiracy to gather evidence against him. He even believed his own brother to be an imposter.[8]

A Mind That Found Itself described the brutal abuse that Beers and his fellow patients suffered in the violent ward of a state institution. His account shed light on the unacceptable conditions occurring in the mental institutions throughout the country. Beers garnered support from the medical profession to reform the treatment of the mentally ill in the United States. He went on to found the National Committee for Mental Hygiene (the predecessor to the National Mental Health Association), which later became Mental Health America on November 16, 2006.[9] Mental Health America was founded with the goals of "improving attitudes toward mental illness and the mentally ill; improving services for the mentally ill; and working for the prevention of mental illness and to promote mental health."[10]

The national organization known as Mental Health America would eventually form state chapters, and Colorado's own Mental Health America of Colorado (MHAC) was founded in 1953.[11] MHAC not only

advocated to change mental health conditions, programs and legislation in Colorado, but the leadership of MHAC would be instrumental in developing and supporting suicide prevention efforts, as well.

As mental health reform garnered public attention and support, the United States was broadening its vision of healthy people and healthy communities from treatment alone to prevention. A study of pellagra, a vitamin-deficiency disease, conducted by Joseph Goldberger and Edgar Sydenstricker, revealed that a complex mix of environmental, social and biological interactions could be responsible for the occurrence and distribution of such diseases.[12] Physical and mental health was no longer about simply treating the symptoms; it was about encouraging a more holistic model of prevention—a model known as "public health."

Charles-Edward A. Winslow, an American bacteriologist and public health expert, drafted the first definition of "public health" as "the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health."[13]

By 1930, Mental Health America's advocacy efforts helped convene the First International Congress on Mental Hygiene in Washington D.C., bringing together more than 3,000 individuals from 41 countries[14] to discuss the improvement of mental health processes from a public health view. The ideas generated from this International Congress led to 16 years of research and work culminating in the passage of the "National Mental Health Act" in 1946. This act led to the creation of the National Institute of Mental Health (NIMH) whose mission was "to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure."[15]

From its inception, NIMH collaborated extensively with the World Health Organization (WHO), which used Charles-Edward Winslow's definition of public health as the basis for its belief that public health was, "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[16] With WHO's declaration and the ongoing complaints about the treatment of patients in mental health facilities, the NIMH pushed for a deinstitutionalization throughout the United States. The plan was set into motion by the Community Mental Health Act, passed by Congress in 1955, mandating the appointment of a Commission to make recommendations for "combating mental illness in the United States."[17] Deinstitutionalization was the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with mental disorders or developmental disabilities.

In response to the Community Mental Health Act, mental health centers began to spring up throughout Colorado. Arapahoe Mental Health Center, now known as Arapahoe/Douglas Mental Health Network (ADMHN), opened in 1955. In the next 14 years, eight more mental health centers were established including Jefferson Center for Mental Health in 1958; Spanish Peaks Mental Health in 1962; the Center for Mental Health in Montrose (now known as Midwestern Colorado Mental Health Clinic, Inc.) in 1965;

and four mental health centers in Denver in 1969 (Bethesda Community Mental Health Center, Denver Center for Mental Health Services, Park East Comprehensive Mental Health Center, and Southwest Mental Health Center). Thanks to the passage of President John F. Kennedy's Community Mental Health Centers Act that "funded construction and staffing for comprehensive, community-based mental health centers, and several federal grants,"[18] these Comprehensive Community Mental Health Centers could offer inpatient, outpatient, home-based, school and community-based programs to individuals and families. The "reliance on the cold mercy of custodial isolation [was] supplanted by the open warmth of community concern and capability."[19]

While this mental healthcare transformation was sweeping the country, Doctors Norman Farberow and Edwin Shneidman discovered suicide notes in the basement of the Los Angeles County Coroner's office. The team of psychologists, which also included Dr. Robert Litman, conducted the first psychological autopsy with an interview of a suicide attempt patient. The team's research and interest in the area of suicide prevention and intervention grew, and in 1958, they published *Clues to Suicide* and received an NIMH grant to start the Los Angeles Suicide Prevention Center, the first suicide prevention center in the United States. The Center established a suicide crisis hotline and soon began offering training in suicidology to local professionals such as doctors and nurses.[19]

Dr. Farberow, long considered the first suicidologist in the United States, joined forces with Professor Erwin Ringel, an Austrian physician who built the world's first suicide prevention center in Vienna, Austria, in 1955. Professor Ringel founded the center in cooperation with the Catholic Church and the Catholic welfare organization, Caritas. A team of psychiatrists, doctors, social workers, psychotherapists, psychologists, lawyers and pastoral workers was established and the center was given the name "Lebensmüdenfursorge," or "The Centre for Care of those Tired of Living." It was arranged that those who had attempted suicide would be admitted to the detoxification ward of the University Psychiatric Clinic, and that aftercare would be provided by Lebensmüdenfursorge.[20]

Farberow spent a sabbatical year in Vienna where he and Ringel shared their concerns about the growing international suicide trends, and went on to found the International Association of Suicide Prevention (IASP) in Vienna in 1960. IASP is the key Non-Government Organization (NGO) in official relations with the World Health Organization (WHO) in addressing suicide. Today, IASP has membership from more than 50 countries and works to bring global attention to the unacceptable loss of approximately 1 million people worldwide who die by suicide each year.[21] Farberow served as president of the organization from 1973 to 1979. Today, Alan (Lanny) Berman, the Executive Director of the American Association of Suicidology, serves as IASP's president.

It was especially fitting that the IASP was founded in Europe, because one year later, in 1961, Britain's Parliament adopted the Suicide Act of 1961, which decriminalized suicide in the United Kingdom. Suicide and attempted suicide had historically been treated as a criminal matter in many parts of the world.[22] Prior to the Suicide Act of 1961 it was a crime to commit suicide, and anyone who attempted and failed could be prosecuted and imprisoned, while the families of those who succeeded also could potentially be prosecuted. These judgments reflected the complicated religious and moral objections to suicide as

self-murder, which continues to add to the enigma today. Britain's Suicide Act was the first step in removing the stigma and fear that had bubbled up surrounding suicide.

Meanwhile, the National Institute of Mental Health had turned its attention to suicidology. Suicidology is defined as "the science dedicated to the understanding of suicide (taking one's own life). Many fields of study are brought together under suicidology including psychology, psychiatry, physiology and sociology."[23] In 1966, the Study of Suicide Prevention Unit was established at the National Institute of Mental Health (NIMH). The Unit, which was later renamed the Suicide Prevention Research Unit, championed the risk factor approach to suicide prevention, a central tenet in the public health model of prevention embodied in the National Strategy for Suicide Prevention (NSSP).[24] Norman Farberow's partner, Dr. Edwin Shneidman, was appointed the co-director of this Center for Suicide Prevention based in Bethesda, Md. It was there that Shneidman had the opportunity to closely observe the limited available knowledge base regarding suicide. Disturbed at this lack of research and knowledge, Shneidman organized a meeting of several world-renowned scholars in Chicago under the auspices of NIMH. The group determined a need for a national organization devoted to research, education, and practice in "suicidology" and advancing suicide prevention. Thus, the American Association of Suicidology (AAS) was founded, and the first national conference on suicide was held in Chicago in 1968.[25]

After eight years directing the nation's only suicide prevention center and the first suicide hotline, Shneidman was quick to recognize a rapid expansion of the crisis center/hotline movements across the United States. Shneidman's newly established charge, the American Association of Suicidology, embraced these centers as sources of research information on suicidal clients. "AAS became the central clearing house for support and the hub of a many-spoked wheel, networking these centers to common needs, training materials, and goals."[26]

CRISIS HOTLINES IN COLORADO

In Colorado, several of these crisis center/hotlines were springing up—mirroring the efforts of Farberow and Schneidman in Los Angeles. Bill Anderson, a Denver-based minister, had been working in hospitals for many years and recognized a coverage gap for people who were in crisis or suicidal. These individuals needed an immediately available hotline that could be accessed before a person's mental health or suicidal crisis landed them in the hospital. Anderson rented a house at 2459 S. Ash Street in Denver and began operating the Suicide and Crisis Control Hotline to provide a local number at which those in crisis could receive help.[27]

Three more hotlines were founded within the next five years. Dr. Jim Selkin, the director of the Violence Research Unit at Denver General Hospital and a team leader in the Department of Psychiatry, started a hotline at Denver General (now known as Denver Health). The tiny log-cabin "hospital" that was founded on the banks of Cherry Creek all those years before, finally had a suicide and crisis prevention hotline.

Across town in Aurora, Richard E. Barnhill and a group of 50 concerned citizens (the vast percentage under the age of 21) opened the doors to Comitis Crisis Center. Comitis opened with the mission of

providing "paraprofessional alternative assistance to youth with substance abuse problems."[28] The original service offered by Comitis was the operation of two 24-hour crisis help lines, which were financed by the Centennial Kiwanis Club of Aurora. Comitis has expanded its services for the past 40 years, now offering a "comprehensive program of services providing crisis intervention, short term treatment, aftercare, outreach and education and prevention public forums to initially any person requesting aid. Comitis offers full-service, including emergency housing, to persons ranging from infants to senior citizens."[29] Comitis is recognized as a "Model Program" by the Federal Government in the area of runaway and youth services. The State Department of Human Services also licenses the Program Service that houses troubled youth as a residential childcare facility. Comitis' crisis hotlines are still in existence and going strong today.

PUEBLO SUICIDE PREVENTION CENTER AND HOTLINE

Perhaps the biggest step for Colorado in the arena of crisis hotlines came with the incorporation of the Pueblo Suicide Prevention Center in 1968. That year, a group of 23 citizens, comprising Colorado State Hospital Physicians and community leaders banded together to form the Pueblo Suicide Prevention Center (PSPC). PSPC was established as Colorado's first 24-hour emergency *suicide intervention* hotline. "These citizens came together in response to a need, identified through the Colorado State Hospital [previously known as the Colorado Insane Asylum], to offer an intervention system that would diffuse potential high-risk situations with an immediate and easily accessible method."[30] This response was viewed as a direct preventive measure to decrease suicide attempts and actual suicide related deaths.

Eleanor Hamm joined the PSPC hotline in 1974. Hamm had finished her degrees and was searching for a job in mental health. With each interview, she was told that she needed more experience. At the urging of a friend, Hamm decided to volunteer for the Pueblo Crisis hotline. With staffing changes on the horizon, Hamm, at the age of 24, interviewed for and took over as the director of PSPC.

Hamm's drive to make the PSPC successful was both professional and personal. During her last year of high school, Hamm lived in Florida with her mother, who struggled with a drinking problem. Upon applying to colleges, Hamm learned that her test scores were 10 points below the minimum requirements for acceptance to Florida State University.

"It had been a bad year. Over time, I had taught myself that if I could live through all of this, I could make it to the age of 18 when I could move out. Now it looked like I was going to have to go to a community college and still live at home. That thought was more than I could bear.

"At the time, we lived in an area of Florida that had canals at the end of every street. I jumped into my car and was going to drive it as fast as I could into the canal. On my way, I drove past the house of a co-worker of my mom. Something made me pull into the driveway, and the porch lights came on. I don't even remember exactly what this relative stranger said to me, but he listened and he told me that he would help. He wasn't a mental health worker; he was just some person that worked with my mom—but his support at that moment was what I needed."[31]

Hamm found a college to attend and hoped to pursue work in juvenile probation. Her career path took a turn, and she ended up studying behavioral counseling. After college, Hamm decided to follow her friend's advice and pursue volunteerism to get her foot in the door of mental health work. This led her to the Pueblo Suicide Prevention Center.

"I have never forgotten that night. It proves that it doesn't take a PhD for somebody to listen and help those in crisis. Validating a person is the most important thing you can do. Sometimes you can't change the situation, but you just validate it and keep them talking until you can connect them with the right resources. That's what we do on our hotline."

Hamm took over the Director position and pushed for proper training of all volunteers. Dr. Norman Farberow trained many of the original hotline workers. Given the American Association of Suicidology's interest in hotlines and crisis centers as a way to collect research information on suicidal callers, Pueblo was of prime interest, being the only suicide crisis hotline in the mid-West states. PSPC became a member of AAS in 1976.

"AAS started holding meetings so that anyone who was doing research and publication about suicide could come together to share information. The crisis centers started attending these meetings. However, we were often seen as the underlings in suicidology because our workers were all volunteers," says Hamm.

For this reason, the American Association of Suicidology established a process and set of guidelines to certify suicide prevention centers in the United States. AAS' mission was to ensure the use of best practices, policies and programs. Later this mission expanded to include a standardized set of understandings and basic crisis worker skills to help volunteer hotline staffers with their charge. In 1985, the Pueblo Suicide Prevention Center was certified as an AAS crisis center. According to Hamm, of the 112 certified centers in North America, PSPC was the smallest.

According to AAS, certified centers must provide three services to their constituents.

- Prevention: PSPC provides community education and awareness training to law enforcement, mental health workers, forestry professionals, dispatch officers, etc. Hamm has also traveled all over the world training military officers, business leaders and community advocates in suicide prevention.
- Intervention: The PSPC hotline is available 24 hours per day to intervene in any kind of crisis. The adult hotline has operated continuously since 1969. In 1991, PSPC started the only teen helpline in Colorado, staffed by teen volunteers. In 2000, as an AAS certified center, PSPC joined with the national 1-800-SUICIDE hotline and contracted to take all of the incoming Colorado calls. In 2005, PCPS also began taking calls for the National Lifeline (1-800-273-TALK).[32]
- Postvention: PSPC assists survivors in dealing with the aftermath of suicide with grief support through HEARTBEAT chapters and other monthly support groups.

Today, the Pueblo Suicide Prevention Center is still the only certified center in the State authorized to take calls from Colorado callers on the National Hotline.

MENTAL HEALTH BEGINS CONSOLIDATING

Although the Pueblo Suicide Prevention Center was successful, other areas of mental health assistance were struggling. Resulting from strict language in the Federal Community Mental Health Center Act, residents of Denver did not have proper access to care for mental health services. The Federal Act mandated catchment areas not to exceed populations of 200,000 people. Consequently, Denver was segmented into four areas covered by Bethesda Community Mental Health Center, Denver Center for Mental Health Services, Park East Comprehensive Mental Health Center and Southwest Mental Health Center. Although these centers operated quite well autonomously, "residents of each were able to utilize the services of the community mental health center in their area only, thus, specialized services were not available to individuals residing out of the catchment area boundaries. Despite efforts by the four mental health centers in Denver to provide quality care for their citizens, problems stemming from city fragmentation were difficult to remedy. Issues of client mobility, homelessness, program and administrative duplications, and other operational inefficiencies affected clinical and fiscal opportunities."[33]

In 1982, after much public outcry and two failed mental health reform attempts, Swanee Hunt, a Colorado native and a local and international public policy expert, began a campaign to "integrate [Denver's] four mental health 'catchments.' It would be tough: each of the quasi-private centers had its own administration, board of directors and program specialties. Turf battles were legendary. On a yellow legal pad [she] mapped the current mental health system and listed probable allies or detractors. Jean Demmler [of Mental Health America of Colorado] and [Hunt] then made appointments with about thirty stakeholders."[34]

Denver was one of nine cities awarded a $2.5 million grant by the Robert Wood Johnson Foundation Program on Chronic Mental Illness. The planning process kicked into high gear, and over a two-year period, individuals, corporations and organizations planned a restructuring of mental health programs and services in Denver. Finally in December of 1987, under an executive order from the Mayor of Denver, Federico Peña, the Mental Health Center of Denver (MHCD) was founded—bringing together the four disparate "catchments" and allowing individuals more open access to mental health care. As of 1989, MHCD was designated the community mental health authority for the City and County of Denver.

Today, MHCD specializes in the treatment of serious and persistent mental illness and has more than 5,000 active cases. This consolidation, led by a committed group of community advocates, was a watershed moment in Colorado's mental health reform, which would pave the way for the establishment of new governmental offices and priorities specifically concerning suicide prevention in the future.

THE GAY COMMUNITY CENTER OF DENVER

Mental health efforts were on track to assist Denver's general population, but certain target populations began to emerge—groups, which due to their struggle for social acceptance, needed resources and services to call their own. One such group was the gay, lesbian, bi-sexual and transgendered community in Denver. In 1976, community advocates recognized a gap in public health support for the GLBT

citizens of Denver. Phil Nash and a group of community activists founded the Gay Community Center of Colorado (now known as The Center). Initially, The Center's main service was to provide education and support that would help people struggling with their sexual identity to "come out" and receive support. The Center ran as a drop-in facility for six days per week for 12 hours each day on volunteer support.

The Center was the first organization in Colorado to respond to the AIDS crisis in the 1980s. "Due to stigma and fear, people infected with this new and unknown disease were deemed practically untouchable." The Center began a limited food pantry, hired a part-time case manager and a created a "buddy" program for those suffering from AIDS. These programs would eventually become what is today The Colorado AIDS Project. [35]

After the anti-gay Amendment 2 was passed in Colorado in 1992, The Center created a legal program to fight it in the courts. The Supreme Court eventually ruled that Amendment 2 was unconstitutional in 1996. In the late 1990s, Rainbow Alley, a drop-in center for teens, was formed to serve Colorado's LGBT and questioning youth.

"Rainbow Alley has a longstanding history of providing services to youth who are disenfranchised or may be homeless. Our motto is to connect with LGBT identified youth and their allies as well. We wanted to cover all classes of youth—those who were in schools, those who might be living on the streets, those who might be in suburban areas and not have access to the resources the LGBT community has in Denver,"[36] says Corey Barrett, Director of Rainbow Alley.

Today, in addition to its drop-in center programs, Rainbow Alley collaborates with youth organizations and school districts. Barrett, who serves on the LGBT advisory committee for Denver Public Schools, has assisted with both suicide prevention and broader solutions such as Colorado's anti-bullying initiative. In addition, The Center remains the third-oldest LGBT community center in the country. Its staff engages and empowers the community through statewide advocacy and nationally recognized cultural and educational programming.

ADDRESSING THE PROBLEM OF SUICIDE IN SCHOOLS

Suicide and bullying in schools are not just issues of concern today; they have been concerns for over 40 years in Colorado and the Denver-metro area. During the 1978-79 school year, three students at Cherry Creek Schools took their lives. "These three incidents within 18 months were really in all honesty, the first time that we took notice of suicide as a pervasive problem in our schools,"[37] says Dr. Bill Porter who was a school psychologist and the head of student mental health services for 26 years in the Cherry Creek Schools (CCS).

With growing concern on the part of the CCS mental health team about the incidence of suicide and self-destructive behavior in students, Porter and his team conducted a survey of adolescent suicide issues during the 1979-80 school year. The results revealed that many people underestimated the scope of the problem on a national and local level. This information, together with overwhelming support for the development of a program, led Cherry Creek Schools to embark on the task of creating a process that would effectively deal with the acute problem of self-destructive behavior. Porter teamed up with

Thomas C. Barrett, a Cherry Creek School psychologist, to develop "Intervention/Prevention: Seeking Solutions to Self-Destructive Behavior." This training program consisted of crisis intervention training; teacher in-service trainings; parent trainings; a student curriculum to teach students about the causes, symptoms and resources for help concerning suicide; and strategies addressing the adjustment problems of students moving into a new school system.

The project was conducted over a two-year period (1980-82) in the Cherry Creek School District and was directed by Barrett. This comprehensive school-based program was the first suicide intervention and prevention program of its kind in Colorado.

During the course of the two years of the project operations:

- In excess of 200 staff members were directly made aware of the issues surrounding the identification, referral and treatment of self-destructive behavior.
- In excess of 700 students were directly exposed to a curriculum designed to provide them with information necessary to identify and refer potentially self-destructive peers.
- The majority of the counseling and psychology staff of the Cherry Creek District received in-depth in-service training in the intervention and prevention of self-destructive behavior.
- During the last nine months of the project operation, 191 potentially self-destructive students were identified for referral.
- The validity of referrals to outside sources were extremely high. External professionals concurred with the assessment of the Cherry Creek Mental Health team in 96% of these cases.

> In summary, the Intervention/Prevention project appears to have had a significant impact on the Cherry Creek School District. The groundwork has been laid for a successful ongoing program to minimize what must be considered an intolerable situation in our schools. It is strongly hoped that this program will continue in Cherry Creek and spread to other schools across the country.[38]

Porter, Barrett and many other mental health professionals and community advocates, including Eleanor Hamm, would spend the next decade delivering presentations across the country about youth suicide.

"A lot of the emphasis was on increasing awareness and student engagement. The presentations were on youth suicide, but I remember my opening line was, 'I'm not here to talk about youth suicide. We're going to move a little bit upstream and talk about how to engage kids and help people feel comfortable in identifying it.' It's ironic that here we are, years later, and the issues our teens face are a little bit different, but the problem is still the same," [39] says Bill Porter.

HEARTBEAT: THE FIRST SURVIVOR SUPPORT GROUP

During the first year of Porter and Barrett's program in Cherry Creek School, LaRita Archibald lost her son to suicide in Colorado Springs. Archibald embarked on a campaign to educate herself about the issue of suicide, learning everything she could about the topic through books, while searching for suicide support groups with whom she might share her grief. On May 11 of 1979, the American Association of Suicidology hosted its 11th Annual Conference in Denver. Archibald attended:

"At that point, [AAS] was only about 10 years old. I went to the conference much against my family's wishes. I hoped that I would find out why my son had taken his life. Since that year, I have been a member of [AAS] and participated on a variety of levels and have had tremendous amount of learning and growth as a result of it," says Archibald.[40]

Archibald learned a great deal about suicidology at the conference, but did not find much in the way of a survivor support system. At the time, AAS only offered one session at its annual conference for the bereaved. However, while on a break, Archibald met another mother who had also lost her son to suicide.

"We spent hours at the remainder of the conference talking about what had happened. I came away from that meeting feeling very inspired and greatly comforted knowing that I wasn't the only mother in the world who had lost a child to suicide. I came home and told my husband, 'I want to offer a place where people can come and talk about their loss.'—at the time I didn't know that they were called support groups," says Archibald.

Archibald was also gaining knowledge, growth and experience as a respondent on a local hotline talking with survivor callers who asked for help in coping with the suicide of a family member. She realized the need for a safe place in which people could connect with others who had experienced a similar loss. Archibald contacted her local mental health association in Colorado Springs. The director offered Archibald a meeting place and the use of her staff to develop brochures to advertise the support group. On November 1, 1980, Archibald hosted the first meeting of HEARTBEAT, a survivors of suicide support group. According to Archibald, HEARTBEAT was the one of the first support groups for suicide bereaved in the country. That same year, two more were founded, in Delaware and Houston, and in 1981 the Survivors of Suicide support group was founded at the Los Angeles Suicide Prevention Center.[41]

The first meeting in November was attended by Archibald, her husband and two other individuals. "By the spring of 1981, people were driving miles and miles to come for that two-hour meeting once a month. Within the first year, we were having 40-50 people per meeting. People were starved to be with someone else and to talk about their loss without judgment and see that others were moving along and finding peace of mind and happiness again." In the summer of 1981, a second chapter of HEARTBEAT was started in Denver. Soon chapters were established in northwest Kansas and Central Nebraska, and in Greeley, Boulder and Pueblo. Today more than 50 chapters meet monthly throughout the United States and in places as far away as Newfoundland, Canada and New Zealand. Over the years, many of the community advocates who have become involved in suicide prevention in Colorado attended HEARTBEAT meetings after their own loss. These include Les Franklin, Jan and Bob Burnside, Joyce and Craig Rupp and many more.

Archibald based the philosophy of HEARTBEAT on *The Big Book* for Alcoholics Anonymous. "It was the only self-help group that I could find anything out about. I didn't want this to be a sob group. I wanted it to be positive, constructive, empathetic and gentle. I wanted to promote the growth and healing of these people."[42] The name, HEARTBEAT, is an initialism with each letter standing for a different part of Archibald's founding philosophy.

H – healthy coping techniques through

E – empathy and understanding reinforced by

A – acceptance without judgment and affirmation of self-worth,

R – resolution of conflict and reinvestment in life

T – truth ....responsibility for this death must be allowed to rest with the one who made the choice.

For those wishing to pursue further goals

B – be a "reach out" to new survivors

E – effect public prevention education and

A – acknowledgement of suicide as a health problem of considerable proportion within our community

T – transforming our recovery into positive action that will diminish the number of these deaths.[43]

Archibald began to advocate for support and information for survivors on the national front, as well. She went on to become one of the founders of the Survivor Division of the American Association of Suicidology. She served on the AAS school education committee, the *Surviving Suicide* newsletter editorial staff and is certified as an AAS Crisis Worker. In 1995, Archibald was honored with the first AAS Survivor of the Year award.

AMERICAN ASSOCIATION OF SUICIDOLOGY PLANTS ROOTS IN COLORADO

When LaRita Archibald first became involved with the American Association of Suicidology, which began in 1976, the organization was still operating as a small non-profit. "A woman was running the AAS office out of her apartment while she was going to social work school in Houston."[44] Bill Anderson of the Suicide and Crisis Control Hotline suggested that AAS move the offices to Denver and offered space for an office at the Crisis Center on Ash Street in Denver. Julie Perlman had just finished her social work degree and had been volunteering with the Suicide and Crisis Control Hotline since 1970.

"The woman who was running AAS was working very part-time. I was fascinated with suicide prevention and the whole process. When she resigned and they had no one else, I stepped up. I had the time, I came cheap and they gave me a free room in the Ash Street house."[45]

During Perlman's tenure as Executive Director of AAS (1980-1995), the organization tripled its membership. Concern over adolescent suicide had spread nationwide. The Centers for Disease Control (CDC) Violence Prevention Unit began focusing public attention on an increase in the national rate of youth suicide. With a staff person working more hours, AAS was able to secure its position as a clearinghouse for information on adolescent suicide as well as suicidology in general. Perlman also developed the first AAS newsletter, *Surviving Suicide*, a national survivors' newsletter. Her interest in the survivor community led to the establishment of AAS' National Survivor Committee in 1984. Perlman

worked closely with LaRita Archibald and others who had lost loved ones to suicide in developing the Committee. Archibald co-chaired the committee and the Survivor Division of AAS from 1993-1994.

ASAP and SafeTEEN: SCHOOL-BASED PROGRAMS

AAS and the CDC were expressing more frequent and public concern about youth suicide with each passing day. Across the country from Denver, Diane Ryerson-Peake, a psychiatric social worker was collaborating with her colleagues on a new school-based program in suicide education and prevention in the hopes that it might stem this rising teen suicide rate.

"In New Jersey and throughout the East there had been a major concern about teen suicide prevention due to the high numbers in the late 1970s. We were constantly being called in to give classroom presentations or to help schools deal with a completed suicide," says Ryerson-Peake.

"The school personnel and the parents in the community weren't properly prepared to deal with these events, and neither were the students. We started a program in one school by pitching our ideas to the principal and the superintendent. Soon we were training all the freshman students—raising knowledge and awareness levels of youth suicide in the schools. We asked for feedback, and we were hearing that the parents were upset that we hadn't trained the seniors also. This was the first affirmation that we were on to something effective."[46]

The initial trainings evolved into a comprehensive school-based program for communities, known as Adolescent Suicide Awareness Program (ASAP).

ASAP consists of three interrelated segments:

- The Educators' Seminar: A three-hour awareness and skill-building workshop for faculty, administration and support staff.
- The Parents' Program: An informational program that can vary from a 30-minute overview to an intensive two-hour workshop.
- The Students' Workshop: A workshop at which specially selected school personnel are trained to teach the ASAP student curriculum to 9th or 10th graders.

The program incorporates education about the warning signs of suicide and appropriate help-seeking behaviors into the regular physical education or related curricula. This resulted in students' increased knowledge about suicidal behavior, more positive attitudes about talking to friends they believe to be suicidal, and seeking of help from adults.[47]

Within months, the implementation and institutionalization of this comprehensive, school-based youth suicide prevention program had reached 5,000 students. "Ten years after the program dissemination was begun, the extent of implementation and institutionalization was assessed utilizing a survey of the 46 public high schools, together with in-depth interviews with informants from the first 11 schools that had adopted the program. All but one of the 31 survey respondents and nine of 11 interviewees had retained the student lessons that were the core of the program."[48]The success of ASAP and Ryerson-Peake's passion about suicide education in schools pushed the program into a national spotlight. ASAP

would eventually become the program known as SafeTEEN, which is utilized in many Colorado schools today.

SPARE: COLORADO'S FIRST STATE SUICIDE PREVENTION COALITION

By early 1983, Dr. Bill Porter, Tom Barrett and other educational professionals had formalized the Cherry Creek School District's Suicide Prevention Program and, similar to Ryerson-Peake, had expanded their quest to address adolescent suicide in all schools. Porter and Barrett were asked to join Colorado Governor Richard Lamm's Child/Adolescent Suicide Prevention Committee of the Colorado Commission on Children and Their Families. They met a strong group of survivors who had lost loved ones to suicide. Craig and Joyce Rupp were two of these survivors, having lost their daughter to suicide. Rupp, Eleanor Hamm, LaRita Archibald and other community advocates and survivors were asked to join Lamm's Commission.

One of the Commission's goals was to increase awareness regarding the impact of child/adolescent suicide on families, friends and community. John Sadler, Jr., MD and Diane Rich were the co-chairpersons of the 21 person, all-volunteer committee. With the aid of a Region 8 Family Services Grant of $1,000, the committee scheduled and conducted workshops during late 1983 and early 1984 aimed at accomplishing their goals and objectives. The last meeting of the committee, as a part of the Colorado Commission on Children and Their Families, was held in July of 1984. The Commission's charter expired in mid-1984 and was not renewed by the state legislature.

Although there was no parent organization to sponsor them, the members of the committee, under the leadership of Dr. Bill Porter, continued to meet monthly for the purpose of carrying out the goals and objectives of the original Commission Committee. At the January 1985 meeting, Craig Rupp made a verbal proposal to the committee to develop an organization aimed at implementing the actions needed to solve the problems associated with the dynamics of suicide. The committee finalized the proposal in April 1985 and named itself SPARE, the Suicide Prevention Allied Regional Effort.

The group solicited the fiscal sponsorship of the Colorado Mental Health Association and the Grief Education Institute. However, when these groups declined in June of 1985, SPARE members decided to develop an independent organization to carry out their goals and objectives. The Bronco Youth Foundation agreed to grant SPARE $4,500 through the Alpine Institute and K.T. Enterprises for the purpose of assisting the committee to formally organize SPARE as a non-profit, tax-exempt organization. The committee did not view itself as a crisis intervention organization, but rather a connecting and educating coalition.[49]

That year the U.S. Secretary of Health and Human Services Margaret Heckler convened a departmental-level task force to address the seriousness of the adolescent suicide problem throughout the United States. This interagency council was located at the Public Health Service of Office of the Assistant Secretary for Health, staffed by the Alcohol, Drug Abuse, and Mental Health Administration. The task force, known as the Secretary's Task Force on Youth Suicide or the National Committee on Youth Suicide Prevention, was charged with investigating what could be done to prevent youth suicide. Tom Barrett of the Cherry Creek Schools Prevention Project, and a member of SPARE, was invited to serve as the

Colorado liaison to this National Committee. By February of 1986, the Committee requested that SPARE become a Chapter of the National Committee.

Boosted by their newfound national credibility, SPARE had attained its 501(c)3 status and was holding regular meetings in the Holly Ridge Center. The coalition began applying for grants with the intention of providing suicide education to more than 35,000 Colorado students, teachers and parents in 60 schools and communities within five high-incident Front Range counties (Boulder, El Paso, Jefferson, Larimer and Pueblo) during the 1986-87 school year.[50]

Beyond these educational objectives, SPARE hoped to develop a network of suicide prevention resources across Colorado. A memo written by SPARE President Craig Rupp from February of 1986 states: "There are numerous organizations in the State of Colorado involved in some facet of suicide prevention, intervention and public awareness. Their individual efforts are appropriate, well intentioned, and properly motivated. However, for the most part these efforts are uncoordinated. The lack of coordination tends to result in duplication of effort (and cost), conflicting activities, confusion, frustration and partially effective community service. By reasonably coordinating the efforts of the various organizations, more effective use can be made of their resources to reach the common goal of suicide prevention. SPARE is the logical vehicle to provide the desirable networking among the various organizations to accomplish the needed coordination."[51]

Through these networking opportunities, SPARE members hoped to empower local communities in organizing their resources to effectively understand the dynamics of suicide, to confront it as a preventable health problem and to conduct critically-needed research on the causes of suicide.

Amidst a heavily scheduled program of school and community-group appearances and lectures, SPARE members organized quickly. Members including LaRita Archibald and Eleanor Hamm answered requests from all over the country to speak about suicide education and prevention. With a 20-member Board of Directors and general coalition members attending meetings, within a few short months, the Board voted to hire a part-time employee to staff the office at Holly Ridge. Libby Gentholts-Purdy was the first Executive Manager of SPARE. The coalition became a member of AAS, and with the help of Naurice Wheat, a survivor and member of Compassionate Friends, began producing a monthly newsletter, *Suicide Prevention Network News*.

In February 1986, two representatives from the U.S. Department of Health and Human Services attended the SPARE meeting on a fact-finding mission. Later that year, the Secretary of Health and Human Services published *Assessment and Documentation of Youth at Risk for Suicide*. The document was the third in a series of three reports reflecting the findings of a national program inspection on youth suicide conducted at the request of the Secretary's Task Force on Youth Suicide.

The report described a qualitative national program inspection of youth suicide. The primary focus of the inspection was to (a) assess the extent to which the programs are involved in efforts to prevent youth suicide; (b) review how states and selected communities were responding to the problems associated with youth suicide; and (c) identify barriers and gaps that hindered delivery of services to

suicidal youth and/or their families.[52] The Task Force was investigating the need for a comprehensive screening tool to identify youth at risk of committing suicide.

According to the report, "Some respondents have developed their own tools for use within their agencies. The OIG inspection team did not systematically inventory or evaluate all of the screening tools currently in use. However, the following were identified." Of the eight screening tools mentioned, two were developed in Colorado. "Screen developed by Tom Barrett, psychologist involved with the Suicide Prevention Allied Regional Effort (SPARE) and Cherry Creek School District in Colorado and Screen developed by Eleanor Hamm, Suicide Prevention Center, Pueblo, Colorado."[53]

On November 6 and 7, 1986, the first statewide suicide prevention conference in Colorado took place. Mariette Hartley, the star of the made-for-television move, *Silence of the Heart,* was the guest speaker for the event. The conference was "designed to focus on ways in which individuals and communities of individuals can do that 'something' that will prevent suicide."[54] This event was hosted by SPARE and sponsored by 9KUSA-TV, the University of Colorado Health Sciences Center, The American Association of Suicidology and The Denver Broncos Youth Foundation.

After the successful event, Craig Rupp sent a memo to the SPARE membership that stated, "The snowball is beginning to roll. How big it gets and how useful it will be depends on how far in front we can stay and how we can control its path."[55]

The snowball continued to roll for another four years, but not without obstacles. With the rapid expansion of suicide prevention efforts across the state, the Board members of SPARE would get a taste of a problem that continues to challenge Colorado today. An all-volunteer board comprised of many people working in suicide prevention presented several challenges. Fundraising conflicts of interest, lack of volunteer time and an overlap of services, created tension among the coalition. In a memo published on January 13, 1989, SPARE Secretary LaRita Archibald stated:

> "Dear Fellow SPARE Board Members:
>
> SPARE survived 1988 although it was a year of painful transition fraught with discouragement, disagreements, frustration, some mistakes and disillusionment; lots of testing, challenge, sacrifice, soul-searching and a tremendous amount of hard work.
>
> SPARE suffered disappointments of losing valuable Board members, but has been revitalized by the enthusiasm, energy and expertise of valued new ones. We had error, doubt and failure but we also had successes, accomplishment and progress. SPARE experienced trials that confront, discourage and defeat many new organizations and, still, we endured.
>
> But, SPARE experienced more than mere survival and endurance in 1988. From discouragement and dispute we gained understanding, tolerance and unity; from mistakes and failure…learning, reassessment and direction; from testing and challenge…recognition and adjustment of weaknesses, appreciation of strengths; and from sacrifice, doubt and soul-searching we gained renewed determination and reaffirmed confidence of purpose. SPARE achieved some critical, necessary change and growth in 1988."[56]

SPARE continued to work together for several more years but eventually disbanded in the early 1990s.

"At that point, there was a lack of leadership to keep the organization going. However, the things that SPARE did achieve were tremendous and unprecedented in Colorado. The group was founded by professionals working in suicide prevention, but more importantly, it was founded by survivors. And the energy of survivors is remarkable."[57]

YOUTH SUICIDE PREVENTION COALITION OF COLUMBINE/CHATFIELD: DISPARATE RESOURCES COORDINATED FOR A COMMON CAUSE

While SPARE was taking on a statewide coalition role, the Youth Suicide Prevention Coalition of Columbine/Chatfield, was adopted as a community-focused model in Jefferson County. Within a three-year period, several events prompted Jefferson County residents to become concerned about teen violence and suicide. In 1982, 14-year old Jason Rocha shot and killed fellow student, 13 year-old Scott Darwin, at Deer Creek Middle School in Littleton, Colo. That same year, the American Psychiatric Association released a report about the neuropsychiatry of carbon monoxide poisoning in attempted suicide and the devastating result. Finally, in 1985, ABC released a full-length television movie titled *Surviving: A Family in Crisis*, which dealt with the aftermath of two teenagers who successfully completed a suicide pact.

"With all of these events and publicity surrounding violence and suicide, we realized that we needed to take these issues seriously and we needed to know what we were doing – we needed to have a plan,"[58] says Dina Robke-O'Shea, a licensed Adult, Adolescent, and Family Therapist who was working in the Jefferson County Public Schools at the time.

Robke met with a community-minded group, which included Jeanne Oliver from the Jefferson Center for Mental Health, and Dr. Donald Bechtold, a renowed psychiatrist and highly-respected expert on child issues, who was the Clinical Director in the Division of Child and Adolescent Psychiatry at the University of Colorado. Bechtold went on to become the Medical Director of the Jefferson Center for Mental Health.

"We brought together the school counselors and the administration from Chatfield, Ken Caryl, Deer Creek and Columbine. We called ourselves the Youth Suicide Prevention Coalition, Columbine/Chatfield area."[59]

The coalition began networking in the community, posing questions to one another such as "What things do we need to know in the event of a suicide? How do we intervene? What are the things as a community that we need to do to start preventing suicides?" In addition to educators and school staff, the Coalition involved paramedics, first responders, the faith community and more, to discuss what worked in the area of suicide prevention.

"We put on workshops for the community, and we brought in professionals to talk about suicide prevention. We were a resource for people in the schools, for parents. This organized movement was unique in that it allowed coordination of resources and information across the community—it was the whole community working together for a common cause," says Robke. [60]

In May of 1985, the Youth Suicide Prevention Coalition of Columbine/Chatfield was awarded the "Best Program" by the Mental Health Association of Colorado, and this grassroots suicide prevention effort is still in existence today.

At the end of 1985, the National Academy of Sciences published *Injury in America*, a report that documented serious inadequacies in the understanding of and approach to injury as a public health problem, and recommended the establishment of a central agency to coordinate research efforts in injury prevention and control. In response, Congress authorized funding for the establishment of a national injury prevention research effort, and the Division of Injury Epidemiology and Control was founded at the Centers for Disease Control. The CDC's programs for violence and alcohol as risk factors for injury and potentially suicide became part of this division.

SUICIDE EDUCATION AND SUPPORT SERVICES: ANOTHER COMMUNITY-MODEL

The Denver-metro area was not the only place in which citizens were banding together against suicide. In 1987, a group of concerned citizens in Greeley joined forces to form the Weld County Suicide Prevention Coalition. Now known as Suicide Education and Support Services (SESS), the Coalition consisted of community advocates, business people and health professionals who met regularly under the wing of the Weld County Department of Public Health.

Weld County/SESS's first step was to start a HEARTBEAT chapter which has met on an ongoing basis ever since. Beyond the monthly HEARTBEAT meetings, the coalition also founded Heart-to-Heart, an eight-week program for survivors with a structured curriculum. After the in-depth program, survivors can attend a speaker-training program to learn how to spread awareness about suicide prevention at schools and service groups. Heart-to-Heat also arranges for special HEARTBEAT groups, which are often support groups for kids who have lost a friend at school.

In 1995, the coalition changed its name to Suicide Education and Support Services (SESS). The next several years were paramount in the development of the community coalition. SESS developed a partnership with the Greeley Police Department's Victim Assistance; the Weld County Department of Public Health awarded the Coalition $25,000 to be used for suicide public awareness activities throughout the county; and Diane Ryerson-Peake became a SESS Board member. Ryerson-Peake had relocated to Colorado and eventually introduced the ASAP/SafeTEEN program to the Coalition. SafeTEEN is still being used in Weld County schools today.

In 2009, SESS became a program of North Range Behavioral Health, allowing the sharing of information between agencies with regard to suicidal youth to be even more streamlined. Kristen Jernigan, a program director at North Range Behavioral Health in Greeley, shepherded the incorporation of SESS of Weld County into her operation. SESS had been providing excellent training programs, support groups and presentations for years, but the board decided to merge with North Range for financial reasons.[61]

SUICIDE RESOURCES CENTER OF LARIMER COUNTY: TWO DEFINITIONS OF "SURVIVOR"

A series of teen suicides in Larimer County galvanized Fort Collins, Loveland and outlying communities, and was the impetus for the creation of a countywide task force. The group formed an all-volunteer coalition with the intention of providing two basic services: suicide grief support groups and community education/awareness programs. After several years the task force formed a 501(c)3, and called themselves the Suicide Resource Center of Larimer County. The group operated as an all-volunteer organization until 2000, when the Board of Directors hired Bev Thurber as the Center's Executive Director.

"At the time, there were two parallel movements in the 'traditional' suicide prevention field. The term 'survivors' has been used for those who have lost loved ones to suicide. There is another group of 'survivors,' too—those who have struggled with suicidal thoughts or perhaps unsuccessfully attempted to take their lives. In Larimer County we had a need for support services on both sides of the 'survivor' spectrum,"[62] says Thurber.

"We had a very influential volunteer who was a dealing every day with a mood disorder. He served as an informal voice for those who were perhaps struggling with suicidal ideation stemming from their depression, bipolar and other mood disorders. We developed an entire peer support system for people struggling with mood disorders."

The Board dubbed the program the Timberline Project. The named referenced the image of traveling from the darkness of a thick forest to a spot above timberline where the canopy of trees diminishes and the darkness becomes light.

In addition to the Suicide Resource Center's HEARTBEAT grief support group, the Timberline support groups continue to meet today. The Timberline Depression Support Group is a peer support group for those dealing with depression and bipolar disorder. The Timberline Family Group provides educational support in the form of month-long classes for families of individuals with depression or thoughts of suicide.

In addition to the community support groups offered, in 1996 the Suicide Resource Center developed a school-based educational program known as Raising Awareness of Personal Power (RAPP). RAPP teaches students signs of depression, suicidal warning signs, and how to help themselves or a friend. The Resource Center's staff offers the program free of charge for middle school and high school students in Larimer County and currently speaks with over 4,000 students each year.

Given its location near Fort Collins, Colo., the Suicide Resource Center of Larimer County was in a unique position to tap into the resources of Colorado State University (CSU). In 2008, the Resource Center collaborated with CSU on a data-driven evaluation of the RAPP program. The resulting article, "Investigation of the effectiveness of a school-based suicide education program using three methodological approaches," was published in *Psychological Services*.

Seven hundred seventy-nine high school students in seven public high schools participated in the study, which examined the effectiveness of RAPP. The article's authors found "that the RAPP program was effective not only in producing positive change in participants' knowledge, attitudes, and self-efficacy

about suicide and suicide prevention, but also in reaching predetermined levels of knowledge and positive reactions to the program."[63]

THE AMERICAN FOUNDATION FOR SUICIDE PREVENTION: FUNDING A COMMUNITY APPROACH TO SUICIDE PREVENTION

Globally, people from every country in the world were growing more concerned at the rising suicide rates. To put a face to this concern, in 1987, the United Nations released a statement which stated "concerned people from around the globe recognized that suicide and suicidal behaviors are public health problems that affect the health and welfare of families, communities, and entire nations."[64]

This statement was representative of the global community's concerns and an indication that although many programs and organizations were focused on the area of suicide prevention, there was still much to be accomplished. While AAS centered on the science of understanding suicide, there was a need for a national organization dedicated to funding the research, education and treatment programs necessary to prevent suicide.

A team of leading experts on suicide came together with business and community leaders and survivors of suicide to answer this call and form the American Foundation for Suicide Prevention (AFSP). These experts believed that only a combined effort would make it possible to fund the research necessary for progress in the prevention of suicide. They modeled their hopes and plans on high-profile physical health problems such as heart disease, cancer and diabetes. Just as public awareness campaigns had led to massive fundraising efforts for research into these diseases, AFSP hoped that a similar scenario might be created in approaching depression and suicide.[65]

AFSP worked in conjunction with the American Association of Suicidology.

> To fully achieve its mission, AFSP engages in the following five core strategies:
>
> - Funds scientific research
> - Offers educational programs for professionals
> - Educates the public about mood disorders and suicide prevention
> - Promotes policies and legislation that impact suicide and prevention
> - Provides programs and resources for survivors of suicide loss and people at risk and involves them in the work of the Foundation[66]

After only two years in existence, AFSP was walking arm-in-arm with AAS. The two organizations jointly hosted the inaugural Healing After Suicide Conference in Denver in 1989. With 235 attendees, this conference was the first of its kind—dedicated specifically to the psychological and emotional needs of the survivor community. LaRita Archibald proudly co-chaired this event.

PARENTS SURVIVING SUICIDE: THE FIRST PARENT SUPPORT GROUP FOR SURVIVORS

This Healing After Suicide Conference took place three months after Vivian Epstein and her husband lost their son to suicide. Epstein spent these three months educating herself—reading more than 60 books

on the topic of suicide and depression. She felt it was helpful for her to gain knowledge through the books, and she decided to attend the Healing After Suicide conference in the hopes that it would give her additional answers—the same answers for which Archibald began searching 10 years before.

"I learned a lot in the two-day session. A woman who sat next to me in one of the sessions had lost her son to suicide also. Several of the things that she said resonated with me: 'I can't live; I can't work; I can't breathe.' We got together for coffee. She knew three other mothers who all felt the same way. We decided to meet at my house for coffee. We met for a good year or two, and that is how Parents Surviving Suicide was formed,"[67] says Epstein.

Eventually the group grew too large to meet in Epstein's living room. Bethany Lutheran Church in Denver opened its doors to the group, which continues to meet monthly at that location. Epstein has been told that Parents Surviving Suicide is the only parent support group of its kind in the United States.

"I attended several other suicide support groups, but as a parent who has lost a child, you have a different perspective. You are a caretaker of this person who is gone. Consequently, you feel much more responsible for their decision."

Epstein structured the meetings to include an educational component and group support and talking. "I always offer a question of the month. This usually gets people talking—and one of the most important things that helps parents process these tragedies is to do their own talking."[68]

Epstein invited speakers to attend the group meetings. Dr. Robert Freedman, the Chairman of the Department of Psychiatry and Pharmacology at University of Colorado Denver, spoke to the group about the psychological motivation behind suicide. The group also viewed educational videos and spent each month discussing any new research on suicide or depression, which Epstein and other group members had found.

"Books help me so much. One of our group members, Karen Johnson, donated a lot of books that she had read, and we decided to create a lending library. Another member has been our librarian for years. Each month she carries her little suitcase of books to the meeting. We offer these on loan to our members."[69]

Seeing how effective literature can be to the healing process, the group began collecting money to give books to high school counselors in Adams and Jefferson counties. As this project progressed, Epstein applied for a grant from the Office of Suicide Prevention to provide books on the Parents Surviving Suicide reading list to libraries throughout Colorado. With the help of an ongoing grant from OSP, Parents Surviving Suicide has supplied educational and prevention-based books on suicide to all but eight libraries in the state of Colorado.

"We've received thank you letters from tiny rural libraries. The letter will say something to the effect of: 'There has been suicide in our community. Your books have been very helpful for everybody.' Oftentimes, these might be the only resources that a remote community has. We're happy to provide as much knowledge as we can through books."[70]

Parents Surviving Suicide has been a much-needed resource for bereaved parents throughout Colorado. In its 21 years of existence, the group has only missed one meeting due to a ravaging snowstorm. Group member, Doris Walker and her husband Don braved the snow and went to the church that night in case others came for the meeting. Doris lost her son, Michael, to suicide in 1989 and was one of the original members of Parents Surviving Suicide.

"That night, a couple came whose adopted son had taken his life. They came all the way from Nebraska to attend the meeting. It just so happened that the other four people who showed up that night also had adopted children. It was such a coincidence that all of those people with adopted children came to the group on the very same night. It's almost as if it was meant to be that Don and I opened the doors that night."[71]

From early on, Walker took on the responsibility of sending information to group members about upcoming meetings and dates. This regular correspondence eventually evolved into the *Parents Surviving Suicide* newsletter. For over 20 years, Walker has published a monthly newsletter filled with educational articles, remembrances of special dates such as lost loved ones birthdays or anniversaries, and essays from parents who have lost children to suicide.

"I never intended to start a newsletter; it just sort of happened. The newsletter became another way to get information for our members. For some, it even became another lifeline—something to look forward to each month. Something to keep them going,"[72] says Walker.

Walker remained involved in the survivor community serving on the Citizens' Advisory Panel which worked alongside the Governor's Blue Ribbon Commission and helping to plan several statewide suicide prevention conferences in the early 2000s. In 2006, Doris and Don Walker were honored by AAS with the Survivor(s) of the Year award.

"We got our strength by starting things like the newsletter and the conference. At the very beginning of your grief, there are no words to describe how you feel about yourself. You finally get to the point down the road where you start working toward something. You have an idea to educate or help others in a similar situation, and you make it happen. That's where the growth and the healing come from."[73]

SHAKA FRANKLIN FOUNDATION

Les Franklin, also an attendee of Parents Surviving Suicide, found his strength by starting something positive for kids, the Shaka Franklin Foundation. Franklin created the foundation in 1990 after his youngest son, Shaka, died by suicide.

Within weeks of the memorial services for Shaka, Franklin had convened his original board members. "I never asked any of my closest friends to serve on the board. They were all too close to the matter. I selected professionals from all walks of life,"[74] says Franklin.

Franklin, who was working as the State Director for Job Training under Governor Roy Romer, used his free time to educate himself about the topic of suicide. "The Governor never inhibited me from going

out and giving talks in schools, church groups…anywhere that people would listen. People needed to be educated about the tragedy of suicide."

In the first 10 years following his son's death, Franklin spent at least 100 days per year giving speeches—sometimes up to six speeches per day. He traveled to Canada and to every state in the United States except Alaska and Hawaii. The talk show host Montel Williams was a friend and invited Franklin to appear on two different occasions on his show. He also appeared on The Phil Donohue Show, the NBC Special "Images, Realities" with Lou Gossett, Jr., and the 700 Club moderated by Ben Kichlow. In each of these presentations, Franklin spoke about the loss of youth through self-destructive behavior. For several years, Franklin broadcasted a monthly radio program on Denver's KDKO and spoke on KUVO radio, as well.[75]

"People needed to know that suicide is something that affects everyone. A lot of blacks, especially, thought that this was just a white man's problem. But it was my goal to inform everyone about the dangers of self-destructive behavior."[76]

In offering up talks in schools, at boys and girls clubs and other local organizations, Franklin discovered that many civic and educational organizations were not addressing the topic of suicide with children and teens. Franklin began collecting materials from all of these organizations and created his own brochures and collateral that complemented the existing literature, while directly dealing with the topic of suicide. The brochures titled "Understanding Depression" and "Coping with Grief," were geared toward youth. Franklin also created "Purple Ribbon Cards," pocket-sized cards to hand out to students and their parents with the warning signs of suicide printed on them. "We knew that kids would put the cards in their pockets and forget to clean them out. We figured that parents might see the messages while doing laundry and be included in the conversation even if their children weren't including them."[77]

Franklin realized that prevention went well beyond education—prevention needed to start further upstream. "We needed to create a diversion to this self-destructive behavior that we were seeing in teens all around us. I was a single parent and my kids were latchkey kids. I knew that kids need things after school and on weekends. Activities to keep them active. Activities to make them feel as though they belong."[78]

Franklin approached Denver Public Schools and was given permission to operate the Shaka Franklin Center in the gymnasium at an empty school. His original staff consisted of Dr. Maurice Brooks, a certified therapist; Damani Kumar, a certified counselor; Efly Brooks who was in charge of youth programming; and Franklin's eldest son, Jamon. The Center was open after school and on weekends. It was structured as a drop-in facility and had separate rooms in which at-risk youth could receive counseling or support from the Foundation's staff.

The Foundation eventually purchased its own building and the Center became Shaka's Place Youth Technology Center located at 5929 E. 38th Avenue in Denver. The Center became the hub for the Foundation's educational and creative projects. At 5,000-square feet, The Center had 18 computer stations, a 21-seat theater, a conference room that doubled as a classroom, a video editing room, open

production studio and two music/audio studios. The resources are still available for youth ages 3 through 18 to learn and enjoy.[79]

The Shaka Franklin Foundation offered extra-curricular activities for youth as well. Franklin's staff would transport busloads of youth to Steamboat or Winter Park to ski for the weekend. Efly Brooks took the students on fishing trips for which the Division of Wildlife provided free fishing poles. The Foundation began hosting an annual fundraiser golf tournament, and soon had youth learning golfing, as well.

"We were always looking for enriching activities to engage these kids. I was reading *Ebony* magazine one night and spotted an article about an ice hockey team in Harlem. I grew up playing hockey and loved it. We got the kids started with in-line skates and then started busing them out to the Foothills Ice Arena to play ice hockey,"[80] says Franklin.

The program evolved and became SHAKA I.C.E.(Inner City Edge), a development program for ice hockey and figure skating for at-risk youth. A capital campaign is in the works today to fund the construction of an ice rink at 51st and Broadway in Denver.

In 1997, Franklin joined forces with Doris Smith and Donna Holland Barnes to form the National Organization for People of Color Against Suicide (NOPCAS). Franklin and his wife, Marianne, assisted with the founding of NOPCAS and Franklin became a member of the Board of Directors. After suffering from the loss of her son in 1990 and feeling very isolated, Barnes wanted to reach out to families of African-American descent who had also lost a loved one to suicide. Barnes contacted Les Franklin and Doris Smith from Atlanta, Georgia to conduct a forum called "Sharing the Pain." Shortly after the forum, the trio co-founded NOPCAS in an effort to unite black suicide survivors and teach them how to better understand living with the loss. Since that time, NOPCAS has held two-day conferences in Atlanta, New York, St. Louis, Durham, Denver and Washington, D.C. NOPCAS is the only national organization of its kind addressing the issue of suicide prevention and intervention, specifically in communities of color.[81]

In the year 2000, tragedy struck again, and Les Franklin lost his only remaining son, Jamon, to suicide. Stunned that his 31-year old son would follow in the footsteps on his 16-year old brother, Franklin temporarily put aside his work in suicide prevention.

"I didn't do anything for a year. I was angry and I was devastated. I sat on the floor in my bedroom and watched television,"[82] says Franklin.

After a time, however, Franklin returned to the fight that had become his life's mission. In 2007, the Shaka Franklin Foundation established an international branch in Johannesburg, South Africa, feeding 540 students daily. Franklin also established a partnership with Streets On Fire School of Fine Arts & Technology and with InsituDesign Architecture and the University of Colorado Graduate School of Architecture to re-build Tarlton Intermediate School in South Africa.

SUICIDE PREVENTION INTERVENTION NETWORK: SURVIVORS OFFERING RESOURCES TO OTHERS

In 1986, Bob and Jan Burnside lost their 17-year old daughter, Robin, to suicide. Not able to find a suicide support group in their own community of Littleton, Colo., the Burnsides began attending a

support group where they met many of the previously mentioned survivors in this document, including Joyce and Craig Rupp of Golden, Colo.

"The Rupps mentored us after the loss of Robin. We've always tried to emulate that support that we received. We try to help survivors get back on their feet after a loss. We make it well known that we're not professionals; we're survivors who have been through the pain and can perhaps offer suggestions and resources to help people recover from a suicide loss,"[82] says Jan Burnside.

The Burnsides eventually founded their own support group, the South Metro Denver chapter of HEARTBEAT, which they continue to facilitate monthly at Littleton Adventist Hospital. "Bob and I are both caregivers. We naturally started falling into the caregiver role when it came to helping other people cope with suicide."[83]

The Burnsides did not stop their caregiving efforts with the facilitation of a HEARTBEAT chapter. They took part in a local ASIST training to learn suicide first-aid and identify at-risk persons and how to prevent the immediate risk of suicide. The Burnsides began offering ASIST trainings to others and eventually founded the Suicide Prevention Intervention Network (SPIN) in 2001.

SPIN was founded on the principles of:

- Postvention: The HEARTBEAT support group facilitated by the Burnsides
- Intervention: The ASIST trainings offered by the Burnsides throughout their community, and
- Prevention: Education and Consultation[84]

The Burnsides began making presentations in local schools about suicide awareness and prevention. "We would go into classrooms and students would be slouched down in their chairs—disinterested in our visit. About 10 minutes into our presentation, after we told them that we had lost our daughter to suicide, the mood changed. Students began sitting up in their seats, leaning forward and hands started to go up. The students were very open to this topic because they all knew someone who had been touched by suicide. Our presentations were about opening up students' eyes to the problem of suicide and providing them with clear messages about the warning signs,"[85] says Jan Burnside.

The Burnsides were asked to conduct trainings and educational presentations throughout Denver. They spoke to a variety of groups including a meeting of Colorado's coroners, at an annual booth at the 9 News Health Fair, at churches and on radio and television programs. Along with public presentations, the Burnsides became a resource for families who had lost their loved ones to suicide.

"We started our second life after we lost our daughter. If someone needed to talk at 3 o' clock in the morning, we could take that phone call. We knew the aftermath of suicide and could help survivors find comfort and resources when they needed them the most. We meet people for coffee, visit people in the hospital and make house calls after a suicide. I always say, we meet people where the rubber meets the road. We're going to do whatever we can to get people talking and help them begin healing."[86]

After the incorporation of SPIN, the Burnsides received several awards for their tireless work in suicide prevention and postvention. Jan received a Congressional Record Award in 2001 for being at the

"forefront of the administrative, legislative and social push to reduce the specter of suicide in Colorado." The Burnsides were recognized by the Office of the District Attorney in the 18th Judicial District serving Arapahoe, Douglas, Elbert and Lincoln Counties for the "standard of excellence [SPIN] established in supporting the rights of crime victims." Finally, in 2005, the Burnsides were awarded the Survivor(s) of the Year award by the American Association of Suicidology to honor their "inspiring dedication to saving lives through suicide education, intervention, and survivor aftercare."[87]

In 2006, the Burnsides were featured on the Emmy-award-winning documentary, *Student Voices: Teen Suicide,* a 60-minute show made by MetroBeatTV, a division of Comcast. The show's introduction describes how the "Burnsides [took] the tragic loss of their only child and turned it around to help save others. Because Robin reached out to two friends before taking her own life, they want teens to know that if a friend tells you they are going to commit suicide, it's a cry for help and that you need to tell a parent or adult, even if you promised you wouldn't tell anyone."[88]

SURVIVOR PASSION DRIVES THE NATIONAL AGENDA: FIRST STATE PLAN CREATED IN WASHINGTON

Although many non-profit organizations like SPIN were formed throughout the United States thanks to the passion of survivors, Scot and Leah Simpson of Washington State were the first to acquire government attention and funding to create a statewide campaign for suicide prevention.

In 1992, the Simpsons lost their son Trevor to suicide. In the months following Trevor's death, the Simpsons formed a statewide citizens group in Washington State to expose teenage suicide and find solutions. This coalition convinced Washington's lawmakers to fund a new, $2 million prevention program. In 1995, under the joint leadership of the Department of Health and the University of Washington School of Nursing, a dedicated group of advocates and people who lost family and friends to suicide created the 1995 *Washington State Plan for Youth Suicide Prevention*. This plan was the first of its kind in the country and paved the way for Colorado's own statewide suicide prevention planning efforts.[89]

SUICIDE PREVENTION PARTNERSHIP OF THE PIKES PEAK REGION: TARGETING AT-RISK POPULATIONS

By 1993, LaRita Archibald was collaborating with concerned citizens in the Colorado Springs area to form the Suicide Prevention Partnership Pikes Peak Region (SPPPPR). Archibald's co-founders were Janet Perreault and Susan Golden. Prior to moving to Colorado, Golden worked for a psychiatric facility in California and knew many people involved in suicide prevention. She was also the survivor of her son's suicide and his father's suicide. Perreault was a mental health professional and worked at Peterson Air Force Base in Colorado Springs.

"The three of us talked about prevention and education possibilities for the Colorado Springs area. Finally, we each contributed $20 for a rented post box for the organization, and the rest was history. We got some interest from the director of the local health association. We formed a very successful hotline and had volunteers come up from Pueblo to train our volunteers,"[90] says Archibald.

One of the earliest accomplishments of the organization was the creation of a training manual made possible by a grant from the Colorado Department of Health. The manual caught the eye of a local Air Force chaplain. Given the high concentration of military families in the Colorado Springs area, SPPPPR representatives were enthusiastic about the opportunity to help with suicide prevention in military settings.

"One of our Board members was a young Air Force chaplain, and he was very interested in suicide prevention. He encouraged us to talk to the Commander at Schriever Air Force Base about our training manual. The Commander took quite an interest and asked us what they could do to deal with the risk of suicide. We told him about this idea of developing teams among volunteer personnel to respond to emergency or crisis situations among their own. We eventually gave four-day trainings at Peterson and Schriever Air Force Bases."

"We taught the airmen about rape, assaults, family violence and divorce. Often these issues can be triggers for a suicidal situation. If there was a suicide or a domestic incident, the chaplain would activate the volunteer teams that we had trained. They would mobilize in the Air Force community and do what close neighbors and friends do in their own neighborhoods: provide childcare, transportation, anything that family needed for a period of time. Because we have five military installations in the Colorado Springs area, we had a lot of contact with the military community."[91]

The SPPPPR trainers also traveled to Ramstein, Germany, to develop and train volunteer crisis support teams there. This cooperative relationship with the military has continued over time. Major General Mark Graham and his wife, Carol, lost their second son to suicide in 2003, just months after their oldest son was killed by a roadside bomb in Iraq. Since their son's suicide, the Grahams have been outspoken advocates for suicide prevention.

"We are grateful to Major General Graham who has brought suicide in the military to national attention. He was able to say, 'It's time to look at this issue and to say the word 'suicide' out loud. Last year the men and woman at Fort Carson Army Base, where Graham is commander, decided to participate in our walk-run fundraising event. We were able to do some suicide prevention trainings on-base for the military spouses,"[92] says Janet Karnes, the Executive Director of SPPPPR. The original hotline, which was founded in 1993, in still going strong and was recently dedicated as the Jeffrey & Kevin Graham Memorial Hotline.

Karnes and her Board and staff at Suicide Prevention Partnership of the Pikes Peak Region have targeted other at-risk populations in the Colorado Springs area, as well. In 2008, SPPPPR began working with the gay, lesbian, bisexual and transgender (GLBT) population. SPPPPR partnered with InsideOut Youth Services, a youth group for teenagers who are part of the GLBT community.

"[Janet] Karnes led a suicide prevention training at Inside/Out and learned that while teens were reluctant to call suicide hotlines, they often did call each other when they were contemplating suicide. 'A lot of them were fielding phone calls that normally professionals would handle,' she said. 'So we trained them in the warning signs, the risk factors, how to know when they are in over their heads. We taught them things that normally we would teach adults.'" [93]

"Out of those weekly conversations came the idea to film a video. The Suicide Prevention Partnership obtained an $8,000 grant from the Colorado Department of Public Health and Environment to do something around teen violence prevention in the GLBT community. The teens who volunteered to participate met weekly for six weeks."

"The first night the kids came, we spent time having them write their stories, what their experiences had been with violence. It turned out to be all different kinds of violence," said Joy Yeakley, a graduate student in social work who did her internship at SPPPPR. "Some of the kids were part of the GLBT population. Some were straight but had seen gay friends encounter violence. After that first night, we didn't spend a lot of time talking about their experiences with violence, because it's traumatic. Instead we got together to focus on self-care, on holistic health."[93]

After the trainings, the film's director turned on the camera and let the teens tell their stories unscripted. The footage became the 24-minute film, *You Are Not Alone*, which debuted in June of 2010. The stories tell of suicidal ideations, abusive relationships, domestic violence and many other issues, which can be prevalent in the lives of youth.

Karnes hopes to use the video in presentations at schools, churches and other venues where teen suicide prevention is taught, or where teen violence is discussed. "In 2009, we lost 10 youth in Colorado Springs to suicide, the youngest being 12," says Karnes. "And that's 10 too many."

SPPPPR is also reaching out to children and youth who are dealing with the aftermath of suicide. The Partnership is sponsoring a newly formed support group called "Children Left Behind by Suicide" for children or teens who have lost a loved one to suicide. In addition to the standard talk-format of bereavement groups, the young people have adult leaders who assist with the exploration of grief through art, journaling and relaxation/coping exercises.

DENVER'S "SUMMER OF VIOLENCE" DIRECTS ATTENTION TO SELF-DESTRUCTIVE & VIOLENT BEHAVIORS

In the summer of 1993, shortly after the founding of SPPPPR, a series of murders threw the city of Denver into an uproar. The concern started, when a 5-year-old boy took a stray bullet to the head in a drive-by shooting. A 10-month-old child was hit by an errant shot while visiting the Denver Zoo, and a young boy was shot in the arm as he played on his aunt's porch. A young man was murdered and his wife abducted on their way to the neighborhood grocery. The usual gang violence had become random, with strangers being caught in the crossfire. Nearly half of the murders that took place that summer were of teenagers. Many of them were drive-by shootings. Governor Roy Romer called the senselessness of such acts "an abandoning of our moral code."[94]

Former Colorado Governor Bill Ritter (who was Denver's District Attorney in 1993) said unpredictability bred anxiety. "The violence we are seeing has, to some extent, a random nature, and while it has a gang dynamic, we have innocent people who are not gang-involved who are being injured and killed—and that is something new."[95]

An article published in the *Denver Post* by Steve Lipsher dubbed 1993, "Denver's Summer of Violence." This increased media coverage led to public outcry demanding that Governor Roy Romer do something to prevent these random acts of violence. Romer responded by establishing a statewide Committee on Youth Violence Prevention and called a special session of the legislature in September to deal with youth violence. The special session lasted 10 days and led to a strict reform in the treatment of juvenile offenders. The Committee on Youth Violence Prevention continued as a special task force after the September reform.

On an international level, the United Nations and the World Health Organization took action regarding their concerns about suicide and convened the first Interregional Expert Meeting on the Formulation of National Strategies for the Prevention of Suicide in Calgary. This meeting was a follow-up to the 1987 meeting of Ministers responsible for Social Welfare in Vienna. The experts gathered to develop national strategy guidelines for the prevention of suicide that could be used by member countries around the world. The gathering and subsequent international policy guidelines were crucial in influencing the grassroots movement on public opinion, which led to the formulation of the U.S. National Suicide Prevention Strategy.[96]

YELLOW RIBBON FOUNDATION: A COLORADO PROGRAM WITH GLOBAL REACH

Two parents who would become integrally involved in the creation of the U.S. National Suicide Prevention Strategy lost their son to suicide shortly after the Interregional Meeting. In 1994, Darlene and Dale Emme suffered the loss of their youngest son. As Mike's friends gathered at their home to mourn the loss of the boy with the bright yellow Mustang, the Emmes found themselves repeating the same sentiments again and again: "Please don't do this. Learn how to ask for help for yourself or your friends. There are people who care."

One of the Mike's friends wrote the words down, and the Emmes decided that this was the message that they needed to spread to others. They printed the words on yellow paper (in reference to Mike's beloved yellow Mustang). Mike's friends began tying ribbons to the papers and brought them to his funeral service. By the end of the service, all of the ribbons were gone. The message of the Yellow Ribbon program had started to spread without the Emmes even realizing it.

"Most adults don't talk about suicide, but teens are faced with it—the sadness, the unsurety, the ideation—everyday. *We* didn't start the yellow ribbon program; the teens started the yellow ribbon program,"[97] says Dar Emme.

Three weeks after Mike's funeral service, a high school teacher from Casper, Wyo., called the Emmes. A student who had reached her emotional breaking point had given the teacher the Yellow Ribbon card as a cry for help. The teacher wanted to know how she could bring the Yellow Ribbon program to Casper. What the Emmes did not know was that these cries for help were happening frequently thanks to Mike's friends who had mailed the cards to places all over the country.

By February of 1995, the Yellow Ribbon Program was incorporated. The Emmes began making phone calls in Colorado to discover resources that were available concerning suicide. "We were mad that we

were never told how to help Mike. Dale called every local and national hotline. Many of them were disconnected or went to a voice mailbox. Colorado had a Violence Prevention Committee, and we went to a meeting to ask what resources were available that could have helped Mike. The response was that there was some sort of resource manual, but it wasn't clear as to how you acquired one. There were things going on in several counties, but the public didn't know much about any of it,"[98] says Emme.

The Emmes met others involved in similar prevention programs and were introduced to Les Franklin. Franklin took the Emmes under his wing when he saw their bent for advocacy and community action. Franklin asked the Emmes to bring their cards to one of his speaking engagements. "Five minutes after he got up on stage, he introduced us and gave up the rest of the time for us to tell our story. We talked to almost 700 kids that on that February day—just four months after Mike died."

The Emmes published their story in the popular book *Chicken Soup for the Soul* and were inundated with thousands of letters from youth who thanked them and their Yellow Ribbon card for saving their lives.

"We put a Board together, but we had no money and no marketing skills. We often tell people it was like being kicked out of a plane, and by the grace of God we had a parachute. And that parachute has been dragging us all over the world. We kept saying that we would get through Christmas and then we would organize and rebuild, but after *Chicken Soup* launched, the rest was history," says Dar Emme.

The Emmes began collaborating with churches and other faith-based communities. They taught about the warning signs of suicide and provided their Yellow Ribbon Ask4Help cards. "People wanted curriculums, tools for their schools, because they wanted a seamless program in a community. We created a school-based curriculum and a suicide prevention training piece," says Dale Emme.

The school-based program was initially met with concern. "Teachers and parents thought that exposing kids to conversations about suicide might put them more at risk. But that just isn't true. Our society allows kids to be advocates for other things, so why not the topic of suicide. Becoming advocates allows these kids to turn anger and hopelessness into something constructive," [99] says Dar Emme.

Today, Yellow Ribbon has two trademarked programs that are part of the Suicide Prevention Resource Center's National Best Practices Registry. The "Ask 4 Help!" Program gets cards to youth with instruction on how to ask for help for themselves or friends and informs adults about what the cards are and how to respond to a request for help. The "Be A Link!" Program is an adult gatekeeper-training program implemented in schools, workplaces and community groups. The training provides participants with knowledge to help them identify youth at risk for suicide and refer them to appropriate help resources. [100]

As Yellow Ribbon has become a nationally recognized program, almost 70 chapters have been established in schools and communities in the United States and five other countries. The local chapters are often founded by parents, students, healthcare professionals and community members in response to the question, "What can we do?" which arises at the end of a Yellow Ribbon training.

In 1999, the Emmes created the international Yellow Ribbon Suicide Awareness and Prevention Week—observed internationally the third week of September. U.S. House Resolution 286 was passed to recognize Yellow Ribbon week across the country in 1999.

The Yellow Ribbon offices are filled with letters from teenagers who have asked for help because of the Yellow Ribbon Ask4Help card. This grassroots program has affected thousands of people around the world. In the year 2000, Australian Prime Minister John Howard said, "The Yellow Ribbon Suicide Prevention Program is a valuable and timely contribution to the fight against youth suicide. Young people are our most valuable asset. A Yellow Ribbon Card in itself is a simple and inexpensive thing. This program can help to restore in individuals the feeling that they are valued."[101]

Programs like Yellow Ribbon made great strides in educating the country's youth about suicide and providing them with tools to ask for help. Shortly after the founding of the Yellow Ribbon Program, a short-film called *Trevor* won an Academy Award. The film is a dramedy about a gay 13-year-old boy, who when rejected by friends because of his sexuality, attempts to take his life. Although many films had been made with suicide as the subject matter, the filmmakers, James Lecesne, Peggy Rajski and Randy Stone treated the topic with enough emotional honesty and humor to be awarded with the highest filmmaking award in the United States.[102]

When *Trevor* was scheduled to air on HBO in 1998, the filmmakers realized that some of the program's young viewers might be facing the same kind of crisis as Trevor, and began to search for a support line to be broadcast during the airing. They discovered that no such helpline existed, and decided to dedicate themselves to forming what was, in their view, a much-needed resource: an organization to promote acceptance of LGBTQ youth, and to aid in crisis and suicide prevention among that group. The Trevor Lifeline was established and became the first nationwide, 24-hour crisis and suicide prevention helpline for LGBTQ youth. The Lifeline's umbrella organization, The Trevor Project also provides online support to young people through the organization's website, as well as guidance and resources to educators and parents.[103]

COMMUNITY ADVOCATES CALL FOR ACTION IN COLORADO REGARDING YOUTH RISK BEHAVIORS

1995 was the first year Colorado participated in the High School Youth Risk Behavior Surveillance Survey (YRBSS). The national YRBSS committee speculated "priority health-risk behaviors that contribute to the leading causes of mortality, morbidity and social problems among youth and adults often are established during youth, extend into adulthood and are interrelated." The studies began in 1993, and by 1995, 39 states were participating. By 2009, 47 states contributed data to the study's results.[104]

YRBSS monitored six health-risk behaviors among youth and young adults that contribute to intentional injuries. YRBSS included a national school-based survey conducted by the Centers for Disease Control and Prevention and state, territorial, tribal and district surveys conducted by state, territorial and local education and health agencies and tribal governments.[105]

The results indicated that in the United States, 72% of all deaths among school-age youth and young adults result from four causes: motor vehicle crashes, other unintentional injuries, homicide, and

suicide. In 1995, nearly one-fourth **(**24.1%) of students nationwide had seriously considered attempting suicide during the 12 months preceding the survey. More serious ideation was observed among the 17.7% of students nationwide who, during the 12 months preceding the survey, had made a specific plan to attempt suicide.[106]

These alarming statistics regarding youth suicide translated to the local stage as well. In 1994, Golden resident Deanna Rice lost her 14-year-old son to suicide. After her son's death, Rice joined the Board of Directors of Golden's Tying Neighborhoods Together to Build a Generation at the Golden Family Resource Center. The organization's goal at the time was to open a youth center in Golden, Colo., with programming to benefit youth ages 12-16 years old. Rice's research had shown a programming gap in inclusive programs for 13+ year olds. She was able to find Boy's Club programs in Denver, but the suburbs and surrounding communities outside of the urban center were lacking in after-school latchkey options for students with two-parent working families.

In May of 1995, Rice wrote a moving letter to then Governor Roy Romer and his wife Bea, inquiring why more wasn't being done in Colorado to prevent suicide. The letter opened with the words: "I write to you as a desperate plea for your help in bringing the serious problems our youth are facing today to state and national attention."[107] Rice quoted 1990 teen suicide statistics from the CDC's Youth Risk Behavior Surveillance Survey. Her letter highlighted positive steps already taken in Colorado's fight for suicide prevention including Parents Surviving Suicide, the Shaka Franklin Foundation, the Yellow Ribbon Program, and the Larimer County Suicide Prevention Resource Center.

Rice closed with a call to action: "I don't expect you to have the answers; I just want to bring these matters to the attention of someone who has the authority to make an impact. We cannot ignore these problems any longer. Communities need to address these problems, but we can't do it alone. Let's look at what is effectively being done elsewhere and get some programs started for youth in Colorado."[108]

In August, Rice received correspondence from the Governor's office acknowledging her letter and assuring her that Romer had passed Rice's information on to Sally Vogler, "who is my point person on teen suicide."[109]

Sally Vogler, who began work for Governor Romer in 1988, was the Policy Director on children and family issues for the Governor's office. In this capacity, she advised the Governor on policy and programs related to early childhood and directed First Impressions, the Governor's early childhood initiative. Between 1988 and 1996, First Impressions successfully put in place a number of key educational and community supports that promoted the healthy development of young children and their families. This included the establishment of a statewide childcare resource and referral system; the creation of family development centers and the expansion of family literacy programs in the state. However, in 1995, there was no task force designated to deal specifically with suicide, teen suicide or otherwise.

That same year, the American Association of Suicidology moved its offices to Washington D.C., after 14 years in Denver. Alan (Lanny) Berman was appointed Executive Director and remains in this position today. Across the country in Washington State, a doctor named Paul Quinnett created a

groundbreaking program called Question Persuade Refer (QPR). QPR was developed in a joint venture between Spokane Mental Health, where Quinnett was the Director of Adult and Elder Services, and the Department of Health in Spokane County.

QPR was modeled after cardio pulmonary resuscitation practices. CPR was created as a simple emergency medical intervention for a cardio pulmonary crisis situation. In a similar vein, QPR is an emergency mental health intervention for suicidal persons. Individuals trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.[110]

Not only was Washington State leading the way in the development of intervention training, but the Washington's statewide citizens group published the first ever statewide suicide prevention plan in the United States, the *Washington State Plan for Youth Suicide Prevention*. The power of survivors and a focused, statewide examination of suicide prevention had proven effective. Perhaps, it was time for Colorado to harness the passion of its own professionals and survivors and follow Washington's example.

COLORADO'S COMMUNITY ADVOCATES BEGIN TO ORGANIZE

By early 1996, there were 11 published numbers for suicide/crisis hotlines operating in Colorado. Echoing the sentiments of Dar and Dale Emme, Jennifer Gamblin, a program director for Mental Health America Colorado (MHAC), was becoming concerned about the validity and usefulness of many of these hotlines.

"At MHAC we had an Information Network and Referral service line. We had one staff person whose full-time job was to receive calls on the line. People from the community called in looking for referrals for very specific kinds of services like suicide prevention hotlines. Our staff person was repeatedly hearing from people in the community that many of the numbers were not being answered or were being picked up by answering machines. We did not want to be referring people in crisis to numbers that weren't helpful. This felt like a huge hole in our safety net."[111]

When Gamblin asked the question, "What can be done?" she was met with a common response. "Does suicide fit in mental health or is it more of a public health issue?" Gamblin did not care where the topic fit; she simply knew that holes in a suicide/crisis prevention safety net were unacceptable. She gathered a group of likeminded professionals and advocates to discuss concerns about suicide/crisis services and to brainstorm about what could be done.

The group was small at first, but as word spread, the group grew quickly to include representatives from county health departments, the Division of Youth Corrections, the GLBT community, mental health centers, local school districts, the Catholic Pastoral Center, Jewish Family Services, hospitals, police and fire protection districts. Many of the group's original members knew each other from their work three years before on Gov. Romer's statewide Committee on Youth Violence Prevention. Gamblin's group also included community advocates, survivors who had lost loved ones to suicides, and representatives from existing suicide prevention organizations such as SPPPPR, the Suicide Resource Center of Larimer County

and Suicide Education and Support Services of Weld County. At its peak in 1998, the group included representatives from the media and government officials from the State of Colorado's Mental Health Services, Department of Human Services, Alcohol and Drug Abuse Division, and the Governor's office. Perhaps the most powerful voices on the committee were those of the survivors: Doris Walker, LaRita Archibald, Becca Emme, the daughter of Dar Emme, Diane Ryerson-Peake and Bob and Jan Burnside, among others.

This extensive group of survivors was anxious to be part of a more formalized effort to address the question that concerned many of them—Why wasn't more being done about suicide prevention in Colorado? Gamblin and several members of this original committee attended a suicide prevention conference in Washington State, shortly after the release of Washington's state plan on teen suicide prevention.

"We were seeking leadership, seeking information and taking advantage of other states' expertise to hopefully bring some of this information to Colorado. In hindsight, it was really very naïve of all of us to think that we could evoke change. This wasn't just a statewide problem. Our efforts were just a pebble that was thrown into a very large pond. But with every pebble thrown, you get these ripple effects. And that's exactly what happened. We just harnessed the passion that all of these people had toward this topic, and things began to happen,"[112] says Gamblin.

On the national front, the American Foundation of Suicidology had formed its own Citizens' Roundtable on Suicide Prevention. Elsie and Jerry Weyrauch, who had lost their daughter to suicide, founded the Suicide Prevention Action Network (SPAN) with the goal of preventing suicide through public education, community action and advocacy. AFSP and SPAN joined forces that May to hold the inaugural National Suicide Awareness Day event.

On May 10, in conjunction with National Suicide Awareness Day, Jennifer Gamblin organized her citizens group and held a press conference on the steps of the Colorado Capitol. The *Denver Post* published an article the next day, titled "'Suicide crisis' in state."

"Mental health advocates yesterday urged the creation of a statewide prevention and intervention plan to battle Colorado's 'suicide crisis.'…At a state Capitol press conference, families and friends displayed handmade signs with the names, birth and death dates, and photos of loved ones who have committed suicide."[113]

In the article, Barbara Beiber, the executive director for MHAC, offered three critical solutions to Colorado's "suicide crisis." "A coordinated statewide prevention and intervention plan must be implemented, a statewide toll-free hotline must be set up for people to get counseling and referrals, and a state agency, perhaps the Colorado Department of Public Health and Environment, must address suicide, such as by forming an intra-agency council."[114]

The press conference and subsequent article presented the first official media coverage addressing suicide as a "crisis-level" problem in Colorado. In the immortal words of Craig Rupp, the snowball was rolling.

Realizing the need for organization and careful planning, global representatives were following suit as well with the publishing of *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies* by the World Health Organization and the United Nations. This urging from such a globally recognized group "motivated the creation of an innovative public/private partnership to see a national strategy for the United States. This public/private partnership included agencies in the U.S. Department of Health and Human Services, encompassing the Centers for Disease Control and Prevention, the Health Resources and Services Administration (HRSA), the Indian Health Service (HIS), the National Institute of Mental Health, the Office of the Surgeon General, and the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Suicide Prevention Advocacy Network."[115]

Meanwhile, Gamblin's committee continued to meet. Hoping for additional media exposure following the Capitol press conference, the committee began supplying fact sheets, information and personal interviews to a *Denver Post* staff writer, Bill Briggs. Briggs did not need much prodding to run a series of articles about suicide in Colorado.

In a serendipitous turn of events, Briggs had his own personal story of loss by suicide. In 2011, Briggs published an opinion column titled "Suicide's legacy—finding the words to help," on the website HealthPolicySolutions, a source for unbiased, independent coverage of health policy issues in Colorado and the Rocky Mountain West.

The column states:

> Journalism runs in my family.
>
> So does suicide.
>
> Both are contained in the same DNA branch.
>
> My grandfather was a brilliant photographer. Some of his most content years were spent taking pictures for the Nashville Banner – an afternoon paper where, many decades later, I broke into the business.
>
> I am named after the man. I eventually was drawn to newspapers, to Nashville, to my grandfather's world. But I never had a chance to meet him. When my mother was a teenager, her dad took his own life. Clinically depressed for years, he ended his suffering one night with a bullet.
>
> I never mentioned any of this history to my Denver Post editors when I decided in 1997 and again in 2000 to write two series of stories on Colorado's historically high suicide rate. The pace of suicides per 100,000 Colorado residents had soared in the 1990s, peaking in 1996 at 17.7. The editors didn't need to know why I was personally interested in the topic. The high rate was a lingering enigma and a modern health crisis, crossing all age groups. They agreed that the Post should dig into the numbers, rummage through the demographics, talk to the experts, and sit with the survivors. My stories offered some insights and tossed out some theories. Several Colorado families shared their own terrible narratives with readers, hoping their experiences somehow might soothe, teach or maybe even prevent future deaths…
>
> I hoped that perhaps my work might have a small, tangible impact. Maybe, I thought, this can be part of my grandfather's revised legacy. After all, I had followed him into journalism.[116]

The September 1997, series mentioned by Briggs was titled "The Silent Crisis," and consisted of seven articles. One article quoted Joyce DeVaney, a Denver consultant to the federal Maternal and Child Health Bureau.

"For any state (agency), suicide is just a very painful issue to take on. It is part of the denial all of us feel," said DeVaney. "What a state does is look at the issues of concern (within its borders)—health issues, housing, whatever. Then they target those issues. (In Colorado) suicide has definitely been overlooked. We've certainly been aware of the data for a very long time...It's a serious, serious issue that all of us need to attend to, whether it's in the state legislature or in mental health... (But) we just sit there and watch it get worse."[117]

The weekend following publication of Briggs' series, DeVaney, co-hosted the 3rd Bi-Regional Adolescent Suicide Prevention Conference held in Breckenridge by the National Health Resources and Services Administration of the Maternal & Child Health Bureau. Members of the Citizens' Committee attended this conference and were provided with yet another opportunity to spread the word about the infancy of statewide organizational efforts. It was at the Breckenridge conference that Deanna Rice, a member of the Citizens' Advisory Panel, met Leah Simpson from Washington State. Inspired by the Simpson's advocacy, Rice chatted with Leah to learn how advocacy had led to funding for suicide prevention in Washington State.

All of the media coverage and public rumblings drew the attention of the Colorado Health Department (CHD).

"The *Denver Post* articles were pointing fingers at the Colorado Health Department, asking, 'What are you, CHD, going to do about this problem?' We knew that our approach needed to be well thought out and that the strategies that we employed to study the problem needed to be population-based,"[118] says Jillian Jacobellis, the Division Director of the Colorado Department of Public Health and Environment Prevention Services.

Jacobellis and her supervisor, Patti Shwayder, Executive Director of the Colorado Department of Public Health and Environment, began gathering funds to create a Suicide Prevention Advisory Commission.

"We gathered about $10,000, and got Governor Romer interested in the idea of a commission. We pulled together a group of professionals from public health, mental health, the universities and suicide prevention organizations," says Jacobellis.

The 29-member group was led by Dr. Steve Lowenstein, the Director of Emergency Medicine at the University of Colorado Health Sciences Center, and Dr. Tom Barrett, the Director of Mental Health Services at the Department of Human Services. [It should be noted that this Tom Barrett is not the same person as Dr. Tom Barrett, the school-psychologist from Cherry Creek Schools, previously mentioned in this document.] Several active members of the Colorado suicide prevention community, such as Dr. Bill Porter, Les Franklin, Eleanor Hamm and Dar and Dale Emme were also contributors to the committee.

As Jacobellis' committee was coalescing, SPAN petitioned the national government. Similar to Deanna Rice's plea that Gov. Romer take action with regard to Colorado's suicide crisis, SPAN demanded action from the national government "with regard to addressing suicide as a national problem." The U.S. government responded in May of 1997 with Senate Resolution 84 (of the 105th Congress) calling for "suicide to be recognized as a national problem."[119]

In March of 1998, Gov. Romer allocated an additional $61,000[120]to fund a suicide task force to investigate how other states combat suicide. Under Executive Order B 002 98, the Governor's Suicide Prevention Advisory Commission, also known as the Governor's Blue Ribbon Commission, was formed. The Executive Order mandated that the Commission should consist of no more than 23 persons "who shall be knowledgeable in the areas of suicide awareness, education and prevention."[121] All members were to be appointed by the Governor and serve as volunteers.

The Commission's task was to review the "rates, trends, demographics, risk factors, predictors, methods and other characteristics of suicide in Colorado." They were to "conduct a critical scientific review of the existing literature on effective suicide prevention strategies, including programs that recognize and respond to people who are at risk for and/or have attempted suicide."[122] The Governor's wish was for the Commission to review and analyze suicide prevention plans from other states. Finally, the Commission was to prepare a written report for the Governor and the Executive Directors of the Colorado Departments of Public Health and Environment, Education, Public Safety, Human Services and Corrections with recommendations for initiatives and intervention that would establish suicide prevention as a statewide priority and would help reduce the number of suicides in Colorado.

The Suicide Prevention Advisory Commission officially delved into its charge in April of 1998. After several meetings, Jacobellis realized that although the group was filled with vast amounts of knowledge, the sheer number of individuals from all walks of life could result in organized chaos.

The Executive Order demanded that the Commission's result be a congruent effort—a data-driven plan put together for the Colorado. However, no one knew exactly what format the final report should take. Dr. Carolie Coates was hired to conduct literature research and a study of other state plans.

In spite of the skilled co-chairs, the Commission members soon realized that they needed an accomplished facilitator—an objective party to vet all of the opinions and information and to keep the committee on task. "Jillian Jacobellis called me. At the time I had a consulting company called Solution Resources," says Marcie Balogh, now President of Ba-Lo Consulting. "Some group members were saying, 'Don't give us anything anecdotal—we only want the facts.' However, when you're dealing with suicide, there is an undeniable emotional tenor to the topic. The facts were very important to everyone, but the stories of attempts and survivors needed to be conveyed, too. We had people talking in every direction, and we needed to get them focused."[123]

Balogh took on the challenge, and with the co-leadership of Danelle Young, the Manager of the Office of Field Services in the Colorado Department of Human Services, guided the group for the next eight months.

Simultaneously, in May of 1998, Jennifer Gamblin's group of consumer advocates, organizational representatives and concerned citizens, officially became the Citizens' Advisory Panel. The Panel worked congruently with the Governor's Commission in fulfilling the tasks designated in the Executive Order.

"The Commissioners initially developed a set of 'Guiding Principles' by which to operate. In addition, seven work groups, comprised of Commissioners, Citizens' Advisory Panel members and staff, met to explore the complex issues related to suicide prevention. The work groups included system and policy level issues; public information and education; best practices—diagnosis and treatment; training for gatekeepers—1st responders; prevention and intervention services; spiritual resources; and diversity. In total, the Commission reviewed more than 400 scientific studies and papers about suicide prevention. After these studies and hours of discussion, the workgroups produced written documentation that was utilized in the development of the recommendations, specific implementation tasks and other parts"[124] of the Commission's final document.

"There were so many ideas at these Commission meetings. We quickly determined that we needed to create a statewide plan, and we needed to establish an office of suicide prevention. These goals drove the final report. We needed to present the data; we needed clear plans for all aspects of a state plan; and we needed a component dealing with prevention. We packed many hours of work into a relatively short period of time. It was also important to many of us that we put a face on suicide,"[125] says Balogh.

After all of the work group recommendations were synthesized and the final report written, Balogh and Young met with Elaine Huffman, a colleague of Young's from the Office of Field Services at the Colorado Department of Human Services.

"Elaine Huffman deserves all the credit for the visual 'look' of the report. The aesthetic feel of the document was just as important to this group as the facts and recommendations contained within. Elaine designed the quilt motif that we used on the cover and the banners that ran at the bottom of every page with the names of those lost to suicide,"[126] says Balogh.

The quilt graphic was used to honor the National Lifekeepers Memory Quilt designed by Sandy Martin of Georgia in 1994. The purpose of the quilt was to place a "'Picture on Suicide,' that will bring awareness and serve as a visual image of the huge number of suicides that occur in America today."[127] The Colorado Lifekeepers Memory Quilt was organized in December of 1997 by Teresa Helgeson who lost her mother to suicide. The quilt has been displayed across the United States.

The image of this quilt was used on the cover of the Commission's final report, *State of Colorado Suicide Prevention and Intervention Plan: The Report of the Governor's Suicide Prevention Advisory Commission,* which was completed in November of 1998. The report included recommendations on a public information and education campaign to inform citizens about suicide risks, warning signs and interventions and to reduce the stigma surrounding suicide; training aimed at gatekeepers such as teaches, coaches, clergy and medical professionals; and "state capacity building, including the development of a responsible state agency and development of key public-private partnerships."[128]

That October, an outgrowth of the public/private partnership spurred by the WHO/UN publication, *Prevention of Suicide: Guidelines for the Formation and Implementation of National Strategies*, gathered in Reno, Nevada for a national conference. Conference participants included researchers, health and mental health clinicians, policy makers, suicide survivors and community activists and leaders. They engaged in careful analysis of what was known and unknown about suicide and its potential responsiveness to a public health model emphasizing suicide prevention.

"Several of us from the Governor's Blue Ribbon Commission participated in that national planning conference. It's interesting that many of the things we were already doing in Colorado were discussed on a national level at the Reno conference. We already had our plan written, and the majority of the ideas that we presented in Colorado became what they used nationally,"[129] says Dale Emme.

When Emme and the others returned from the Reno Conference, the Commission's report, *State of Colorado Suicide Prevention and Intervention Plan: The Report of the Governor's Suicide Prevention Advisory Commission,* was completed and presented at a press conference on December 7, 1998. Less than three weeks later, Romer finished his term, and Governor Bill Owens took office as the 40th Governor of Colorado.

"We were petrified that with a changing of the guard, all of this work would be over—that our efforts would get swept under a rug. But we were pleasantly surprised that Gov. Owens owned this state plan as if it was his own piece,"[130] says Balogh.

With their main task achieved, the Blue Ribbon Commission and the Citizens' Advisory Panel did not want the statewide plan to become a document that would gather dust on lawmaker's shelves. Dedicated members of the two groups continued to meet to later become a statewide suicide prevention network known as the Suicide Prevention Coalition of Colorado (SPCC). "At this point, however, we were only a passionate few, determined that this plan be implemented. The original mission of SPCC was to get Gov. Owen's support,"[131] says Deanna Rice.

Rice and SPCC's original co-chairs, Diane Ryerson-Peake and Tom Barrett, urged SPCC members to write letters to editors of their papers, encouraging the new Governor to implement the recommendations of the state plan. A memo to SPCC members stated:

"This is a year of political transition. The new governor and the new state legislators need to be convinced that this effort is an important one. The effort to implement this well-crafted effort and report could stop. No one knows better than we suicide survivors the effect suicide has on our families, lives and souls. We are best equipped to keep the message in front of our communities and our state leaders."[132]

SPCC refined the language from the state plan and made a recommendation for the "development of a 'lead entity' to assume responsibility for the development of an ongoing system for ensuring integrated, coordinated and effective information and services for the prevention of suicide."[133]

"We knew that we needed to keep the momentum going in order for any of our recommendations to become realities,"[134] says Dale Emme. Emme published a letter to the editor in the *Denver Post* in January. Emme's letter requested the support of the new Governor and the legislature to establish a single state agency to coordinate the public-private campaign to fight suicide. Emme also mentioned SPCC's first act: "The commission has already worked locally with the National Rifle Association—not on gun control, but to promote safe storage of firearms—an early example of public-private cooperation."[135]

The members of the newly formed SPCC also hand-carried copies of the new state plan to all the heads of the departments and legislators in Colorado. This pavement pounding by SPCC members got the attention of Democratic Representative Ed Perlmutter. Perlmutter helped get Senate Joint Resolution 99-031 passed. This resolution stated that the "General Assembly recognizes the severity of the problem posed by suicide to the health and spirit of the citizens and communities of Colorado" and "the General Assembly is committed to encouraging and pursuing an integrated and coordinated approach to community-based solutions as recommended by the Governor's Suicide Prevention Advisory Commission and Citizens' Advisory Panel."[136]

Even after the passage of Senate Resolution 99-031, no action was taken by the Governor's office or the Colorado legislature to act upon the Commission's recommendations. In February, SPCC co-Chair Tom Barrett presented a Suicide Prevention Panel at the Legislative Education Day. Barrett's presentation drew strong connections between those who take their life by suicide and those who have diagnosable mental or substance abuse disorders. Barrett's presentation was intended to raise awareness amongst a broader group of legislators—not just those who had been part of drafting the joint Senate Resolution 99-031. Barrett ended his presentation with information about the four main recommendations made in the *Suicide Prevention and Intervention Plan* created by the Governor's Commission.

In April, SPCC members continued to knock on doors and write letters to the press. Deanna Rice wrote an op-ed piece published in the *Denver Post*. The article stated: "Last December, the Suicide Prevention Advisory Commission presented its recommendations to the state, yet no action has been taken. How many parents will the state have to tell they had a plan, but failed to act on it? It is finally time to take action."[137]

TRAGEDY AT COLUMBINE: HIGHLIGHTING A NEED FOR ADDITIONAL SUICIDE PREVENTION

Just 10 days after Rice's letter was published, the face of suicide in Colorado became even more complicated. On April 21, 1999, a murder/suicide occurred at Columbine High School in Littleton. Eric Harris and Dylan Klebold shot and killed 12 students and one teacher, wounded 24 others and took their own lives. The actions of Harris and Klebold highlighted the additional need for school safety protocol in Colorado. Much later, the Columbine tragedy also highlighted the urgent need for additional suicide prevention and screening in Colorado.

According to Dave Cullen, author of the *New York Times* best seller, *Columbine,* "Teen depression is the great unlearned lesson of Columbine. (Dylan [Klebold] was heavily driven by suicide.) The U.S.

Preventive Services Task Force estimates that 6% of U.S. adolescents suffer clinical depression. That's 2 million kids. It's time to act."[138]

In excerpts from a journal released by police after the Columbine shootings, Klebold wrote of his depression and social ostracism as early as 1997. Police said Klebold also wrote of obtaining a gun and committing suicide. However, in the face of multiple murders, it was not until months later that the topics of suicide, teen depression and bullying were addressed.

In the immediate wake of Columbine, the Jefferson Center for Mental Health printed and distributed more than 100,000 copies of a booklet designed to teach parents how to help their children cope with a tragedy like Columbine.

That summer, the Colorado General Assembly passed the Safe Schools Act (C.R.S. 22-32-109.1). The Act required each school district Board of Education to:

- adopt a mission statement and safe school plan that makes safety a priority in each public school.
- include a uniform and consistently enforced written conduct and discipline code in the safe schools plan.
- adopt a policy requiring school principals to report annually specified information concerning the learning environment in the school. These reports are submitted to the Department of Education.
- enter into agreements with law enforcement officials, the juvenile justice system, and social services to help maintain a safe school environment.
- have a written crisis management policy and procedures, and employee crisis management training adopt a policy requiring annual school building inspections for removal of barriers to safety
- adopt a policy to share and release information in accordance with state and federal guidelines related to a student in the interest of making schools safer
- adopt a policy to allow reasonable access of parents and board members to observe activities at a school with notice to administrative office
- adopt a policy for screening licensed and non-licensed employees
- establish a school response framework in compliance with the National Incident Management System – a model framework for responding to critical events
- adopt a policy for bullying prevention and education
- provide for immunity of school boards, teachers or others acting in good faith to comply with conduct and discipline codes[139]

The Colorado Trust, along with other partners, provided a $1 million grant to the Center for the Study and Prevention of Violence at the University of Colorado at Boulder. The grant, which was extended for six years (1999-2005), funded an initiative called "Safe Communities – Safe Schools." The program was directed toward comprehensive technical assistance for eight schools and eight school districts to help them design and implement safe school plans similar to those discussed in the Safe Schools Act.

After the program's first year, which consisted of 60 statewide forums conducted by the Violence Prevention Center and Attorney General Ken Salazar, the funding groups realized the need for additional money and funding. Ultimately, the grant provided funding for statewide safe school planning efforts and yearly conferences, and supported 16 pilot sites across Colorado. The Center for the Study and

Prevention of Violence, the lead entity on the grant, is a research program of the Institute of Behavioral Science at the University of Colorado at Boulder. The Center was founded in 1992 to provide informed assistance to groups committed to understanding and preventing violence, particularly among adolescents.[140]

While widespread school safety reform was beginning in Colorado, Jefferson County was mired in the complicated investigations of the last days before the Columbine shootings and piecing together the events of April 20. After nine months of complex testimony and investigation, Governor Owens appointed the Columbine Review Commission in January 2000. The purpose of the Commission was to conduct an independent review of the tragedy and make recommendations to prevent further tragedies in the future

In May of 2001, this 14-member Commission published *The Report of Governor Bill Owens' Columbine Review Commission*. The 188-page document presented many recommendations with regard to law enforcement's handling of the crisis, the sufficiency of school safety protocols as used at Columbine, and identification of key factors that might have contributed to the tragedy. The report offers an interesting look at the student "code of silence," which may have been one contributing factor:

> "… authorities must devise means to encourage students, who are most likely to know about impending violence, to come forward to disclose their information to school authorities.
>
> Why have students failed to come forward with their information in advance of the many instances of school violence before and after Columbine? Often, that reluctance may stem from a culture that fosters and enforces a code of silence, under which students cannot be seen to 'rat' on their fellow students. Students may well not understand that even jokes about violence or indirect threats of violence may be significant.
>
> Another basis for student failures or refusals to report threats of violence, is a fear of repercussions should their worries about violence prove groundless. One way to encourage students to report their concerns about potential violence, without their having to worry about repercussions, is to put in place a mechanism through which students may report their concerns or worries anonymously.
>
> Before the events at Columbine High School, school authorities, law enforcement officials, juvenile authorities, and other persons with relevant information about a student were uncertain about whether they could share the information. Colorado has been endeavoring to clarify the matter, and recently-enacted legislation germane to the issue makes major advances toward its resolution. Conversely, the legislation permits law enforcement personnel to inspect a student's school attendance and disciplinary records under certain circumstances. Senate Bill 00-133 of course is not the final word in this area, but it constitutes a major improvement when compared to the uncertainty that had existed previously.
>
> The Commission has been considerably assisted in discharging those responsibilities by the approach to prevention of violence and school safety recommended by the Center for the Study and Prevention of Violence at the University of Colorado. The Center, directed by Professor Delbert Elliott, stresses the importance of viewing school safety in broad preventive terms: a safe school fosters a supportive school atmosphere, has strong links to the surrounding community, has in place both programs to prevent violence and mechanisms to allow students to confide to school administrators their concerns about

> violence and safety, has established a well-trained threat assessment team, and has adopted a strong crisis management plan for use in case of emergencies.[141]

Although the report offers incredible insight into many things that went wrong on the day of the tragedy, it fails to directly address mechanisms that could have been improved to ensure that students who were depressed, outcast or exhibiting potentially violent behavior did not fall through the cracks. It also did not specifically address the issue of suicide until page 157 of the 188-page report.

On this page, the topic of Suicide Prevention is finally covered:

> The subject of suicide is deeply entangled with Columbine. Obviously, the attack at Columbine High School can be viewed from one perspective as a double suicide by two deeply troubled young men. But the possibility of other suicides has become in Colorado a direct byproduct of the Columbine attack, engendered by its effect on persons other than the perpetrators. Victims of violent attacks often find it difficult to recover from them. Even persons whose lives have been spared frequently have trouble understanding why they were spared and why fate took the lives of others no different from them. Thus, the possibility that Columbine will harvest future victims is a legitimate matter of concern.
>
> Although efforts at suicide prevention have been launched, as a society we have far to go. Suicide traditionally has been something almost everyone is nervous about discussing. Parents have been encouraged by public health officials to talk to their children about sex and about drugs, but probably few parents talk with their children about suicide.
>
> Even though they remain in their infancy for the moment, suicide-prevention programs are being developed in our communities. In the Commission's view, therefore, suicide constitutes a very serious public health problem in Colorado, necessitating the continued promotion of public awareness of it, and the development of programs enabling teachers and school administrators to discuss with their students the subject of suicide before it occurs and not exclusively afterwards.[142]

Although the issue of suicide was addressed in the report, it was addressed from the perspective of the possibility of other suicide because of Columbine. The only reference to Dylan Klebold's and Eric Harris' (particularly, Dylan Klebold's) depressed states and cries for help comes in one line: "Obviously, the attack at Columbine High School can be viewed from one perspective as a double suicide by two deeply troubled young men." For Sue Klebold, Dylan's mother, the subject of depression as a risk factor for suicide and/or murder-suicides deserved a deeper look. After months of dealing with the aftermath of her son's final moments, the subject of suicide was what moved Klebold toward the acceptance of her son's death and ultimately, some form of healing.

Klebold and her husband were prevented from participating in suicide support groups after the Columbine tragedy because they were embroiled in lawsuits from 36 local families associated with the events of Columbine. "Our lawyers let us know that anyone that we spoke with at a support group could become a witness if we ended up in court. I didn't want to do that to anybody—in particular suicide survivors who have already been through their own pain of losing a loved one,"[143] says Klebold. Klebold, instead, turned to a private therapist and some close friends. One friend happened to be Sharon Wink. Wink lost her oldest son to suicide in 1995. Wink went on to be Chair of the Board of Directors of the Suicide Prevention Coalition of Colorado.

"It took me a number of years before I reached out to very many people. But in 2005, the AAS national conference was held here in Denver. One of my dear friends was Sharon Wink. We had worked at Arapahoe Community College together. Sharon was so helpful to me and was active in suicide prevention. She allowed me to put my toes in the water…making favors for events or conferences. I met Doris Walker, Jan Burnside and Jo Mosby—other survivors—through Sharon," says Klebold.

After her retirement, Klebold became more involved in suicide prevention. "After all of the suffering, I finally felt like I was home when I met these other survivors. I was finally among people who understood the loss and grief and humiliation. It was so comforting to be with people who were non-judgmental and allowed me to tell my story and be part of the prevention world."[144]

In 2006, Klebold was invited to speak at the Violence Goes to College Conference in Boulder, Colo. "It was my first speaking engagement, and I spoke on a panel with several other people about murder-suicides. I was terrified, but I did it, and then little by little, I started getting involved in other things," says Klebold.

In 2009, Klebold published her first public interview after Columbine in the November issue of Oprah's *O* Magazine. In the article, Klebold says:

> "Dylan's participation in the massacre was impossible for me to accept until I began to connect it to his own death. Once I saw his journals, it was clear to me that Dylan entered the school with the intention of dying there. And so, in order to understand what he might have been thinking, I started to learn all I could about suicide.
>
> Suicide is the end result of a complex mix of pathology, character, and circumstance that produces severe emotional distress. This distress is so great that it impairs one's ability to think and act rationally. From the writings Dylan left behind, criminal psychologists have concluded that he was depressed and suicidal. When I first saw copied pages of these writings, they broke my heart. I'd had no inkling of the battle Dylan was waging in his mind. As early as two years before the shootings, he wrote about ending his life. In one poem, he wrote, 'Revenge is sorrow / death is a reprieve / life is a punishment / others' achievements are tormentations / people are alike / I am different.' He wrote about his longing for love and his near obsession with a girl who apparently did not know he existed. He wrote, 'Earth, humanity, HERE. that's mostly what I think about. I hate it. I want to be free…free… I thought it would have been time by now. the pain multiplies infinitely. Never stops. (yet?) i'm here, STILL alone, still in pain….'
>
> I don't know how much control he had over his choices at the time of his death, what factors pushed him to commit murder, and why he did not end his pain alone. In talking with other suicide survivors and attempters, however, I think I have some idea why he didn't ask for help.
>
> I believe that Dylan did not want to talk about his thoughts because he was ashamed of having them. He was accustomed to handling his own problems, and he perceived his inability to do so as a weakness. People considering suicide sometimes feel that the world would be better off without them, and their reasons for wanting to die make sense to them. They are too ill to see the irrationality of their thinking.
>
> In raising Dylan, I taught him how to protect himself from a host of dangers: lightning, snake bites, head injuries, skin cancer, smoking, drinking, sexually transmitted diseases, drug addiction, reckless driving, even carbon monoxide poisoning. It never occurred to me that the gravest danger—to him and, as it

> turned out, to so many others—might come from within. Most of us do not see suicidal thinking as the health threat that it is. We are not trained to identify it in others, to help others appropriately, or to respond in a healthy way if we have these feelings ourselves.
>
> In loving memory of Dylan, I support suicide research and encourage responsible prevention and awareness practices as well as support for survivors. I hope that someday everyone will recognize the warning signs of suicide—including feelings of hopelessness, withdrawal, pessimism, and other signs of serious depression—as easily as we recognize the warning signs of cancer. I hope we will get over our fear of talking about suicide. I hope we will teach our children that most suicidal teens telegraph their intentions to their friends, whether through verbal statements, notes, or a preoccupation with death. I hope we come to understand the link between suicidal behavior and violent behavior, and realize that dealing with the former may help us prevent the latter. (According to the U.S. Secret Service Safe School Initiative, 78 percent of school attackers have a history of suicide attempts or suicidal thoughts.)[145]

Klebold believed that there was a connection between her son's depression and his final violent behavior that needed to be addressed. She decided to use this article as a vehicle to spread the word about suicide awareness.

"Columbine is perceived as a national tragedy. Everyone claims it as their own even though it occurred here in Colorado. Given the national interest in the event, I figured that some people might read the article out of sheer curiosity. I was hopeful that even if that was the case, readers could learn something about suicide prevention along the way,"[146] says Klebold.

Shortly after the publication of Klebold's article, she was invited to join the National Survivor Council of the American Foundation of Suicide Prevention, and in 2011 she co-chaired the "Healing After Suicide Conference," which originated so many years before in Colorado thanks to LaRita Archibald.

NATIONWIDE STEPS TO FURTHER SUICIDE PREVENTION

Throughout the United States, there was still concern about the lack of consistent and broad-reaching crisis hotlines as a means to suicide prevention. After the death of his wife, Kristin, prominent California businessman, Reese Butler, launched a personal crusade. Butler registered the number 1-888-SUICIDE, then networked it with crisis centers in his area. He subsequently added 1-800-SUICIDE and 1-877-SUICIDA, a Spanish-language hotline. In May of 1999, U.S. Surgeon General David Satcher dedicated this national crisis hotline network. The network connected people to AAS certified crisis centers 24-hours a day.

"While the idea of a suicide hotline is not a new one, the challenge of creating a national network and connecting our country's crisis centers under a single, easy-to-remember, toll-free telephone was a daunting task," says Butler.[147]

Not long after the national hotline dedication, David Satcher, released the *Surgeon General's Call to Action*. This document "introduce[ed] a blueprint for addressing suicide—Awareness, Intervention, and Methodology, or AIM—an approach derived from the collaborative deliberations of the conference participants in Reno the previous year. As a framework for suicide prevention, AIM include[d] 15 key

recommendations that were refined from consensus and evidence-based findings presented at the conference…These recommendations and their supporting conceptual framework are essential steps towards a comprehensive National Strategy for Suicide Prevention."[148]

In response to Satcher's Call to Action, the National Council For (for) Suicide Prevention was founded. Comprised of representatives from 11 national organizations, the Council worked for two years to help shape and deliver the *National Strategy for Suicide Prevention: Goals and Objectives* in May of 2001. Of those representatives at the table, one key Colorado citizen stood out, Dale Emme of the Yellow Ribbon Foundation. It was quite fitting that Colorado, whose own state plan recommendations had contributed significantly to the recommendations used in Satcher's AIM blueprint, was represented by Emme on the National Council.

THE GOVERNOR'S OFFICE TAKES NOTICE: COLORADO'S OFFICE OF SUICIDE PREVENTION IS CREATED

By September of 1999, Owens still had taken no action in support of the Commission's recommendations. Unwilling to accept silence as a final answer, SPCC encouraged its members to write letters to the Governor requesting his support.

"Louise Boris [an SPCC Board member] suggested that we write letters to Governor Owens. She also had the brilliant idea that we write to Frances, Governor Owens' wife,"[149] says Deanna Rice.

Rice's letter to Frances Owens requested that she "help make suicide prevention a priority during Governor Owens' administration by supporting the implementation of a suicide prevention plan in Colorado and the development of local programs to support suicide prevention efforts."

"Just like people with heart disease can die from a heart attack, people with depression can die from suicide. Colorado cannot afford to wait any longer to address this issue. We cannot ignore this silent epidemic any longer. And recently we have seen an increase in murder-suicides. I believe that if the suicides at Columbine could have been prevented, other lives would have been spared."[150]

Eleven days after Rice sent her letter, she received a personal response from Frances Owens saying that she had forwarded Rice's letter to Jane Norton, the Executive Director of Colorado's Department of Public Health and Environment, and a personal friend of Frances Owens. In a follow-up letter from Richard O'Donnell, Director of the Governor's Office of Policy and Initiatives, O'Donnell assured Rice that the "Governor has directed Jane Norton to vigorously pursue a suicide intervention program. She will be announcing several initiatives in the coming months."[151]

The members of the suicide prevention community were bolstered by the support from the Governor; however, a decision still needed to be made as to whether an Office of Suicide Prevention would be housed under the mental health or public health umbrella. Tom Barrett, the Director of Mental Health and a co-chair of SPCC, had tasked Louise Boris with compiling a budget. At the time, Louise was the Director of Program Quality at the State of Colorado, Mental Health Services. When Tom Barrett, originally became the co-chair of the Governor's Commission, he asked Boris to staff the process with him. Boris served on the Citizens' Advisory Panel and took an active staff role in the work of the Commission as well.

"It came time for budgeting for Mental Health Services, and Tom Barrett and I had a conversation about augmenting the division of Mental Health so that a part of it could do suicide prevention through a state office of the Colorado's government. Tom asked me to put together a budget and a plan to add suicide prevention to the Division of Mental Health,"[152] say Boris.

Colorado's Office of Suicide Prevention was initially proposed as part of Tom Barrett's department at the Department of Human Services. "Along the way it got switched to the Department of Public Health and the Environment. The Governor and many of the involved parties liked the idea of having suicide prevention fall under the realm of public health. This decision had pros and cons. From the standpoint of mental health, there were some disadvantages because the technical expertise, in terms of providing services to people who are at risk for suicide lies within the mental health community. The Division of Mental Health was responsible for contracts with community mental health centers. When the decision was made to house OSP under Public Health, we lost some of those connections with the mental health centers and we had to make a concerted effort to re-establish those connections,"[153] says Tom Barrett.

As Barrett stated, there were advantages to the placement of suicide prevention with the Public Health sector. In late-November, the members of SPCC were informed that Governor Owens had submitted a proposal to Colorado Joint Budget Committee requesting a special budget initiative in the amount of $161,000 at Colorado's Department of Public Health and Environment for funding of a suicide prevention and education program. The proposal would fund two positions at the Department of Public Health and Environment to coordinate the state's suicide prevention efforts. Members of SPCC were asked to testify in front of the JBC in support of Owen's proposal.

On January 6, 2000, three members of SPCC provided testimony before the Joint Budget Committee. The members were Diane Ryerson-Peake, Deanna Rice and Dale Emme. The three presented strong factual and anecdotal evidence that suicide had a disproportionate impact on the quality of Colorado's health. They offered the opinion that the state's lack of coordinated private-public partnership had contributed to the Colorado's remaining in the top 10 of the nation's worst suicide statistics.

Ryerson-Peake presented a fact-filled testimony derived from more than two decades spent designing and implementing the SafeTEEN program in New Jersey and throughout the world. Ryerson stated, "The Colorado Department of Public Health and Environment has been tasked by Governor Owens to lead the State public sector's efforts on suicide prevention. The Department's vision is 'Working Together to Make Colorado the Healthiest Place to Live.' Following up on that theme, the Coalition has been working closely with the Department and has been supported by them to take the private partnership role in suicide prevention."[154]

Emme and Rice addressed the deaths of their respective sons, the need for suicide awareness and prevention and provided a "face" to the survivors of suicide in Colorado. All three encouraged the JBC to support the Governor's proposal in their testimony. The six members of the JBC voted to support Gov. Owens' proposal. In March of 2000, JBC member Representative Gayle Berry, a Republican from Grand Junction, stepped forward to sponsor legislation to give CDPHE statutory authority to house a state office of suicide prevention. Berry played a pivotal role in the creation of the Office of Suicide

Prevention. House Bill 00-1432 mandating the creation of a State Office of Suicide Prevention. Finally in June, the Governor signed the bill into law mandating an adjustment to the 2000 long bill, to appropriate $157,846 from the general fund to the Department of Public Health and Environment.

An article by Bill Briggs titled "State prepares to battle suicide" ran in the *Denver Post* to inform the public that:

> Colorado, plagued for a century by one of the nation's highest suicide rates, will open its first suicide-prevention office Aug. 2 with early orders to cast a bright light on the shadowy tragedy.
>
> The new, two-person agency was signed into law Friday by Gov. Bill Owens, culminates almost four years of talking, plotting and planning by state government officials and grassroots suicide counselors.
>
> Owens quickly picked Stephannie Finley as a temporary chief to get the office off the ground—in part because of her organizational skills, but also because she has a personal vendetta against suicide. Finley has been touched by suicide twice within the past eight months.[155]

Finley was U.S. Representative Scott McInnis' first chief of staff and also spent time as the director of legislative affairs for Colorado Ski Country USA. At the time of her appointment, Finley was the Legislative Liaison for the Department of Public Health and Environment. She worked closely with Gayle Berry to help draft and pass House Bill 00-1432 which created the Office of Suicide Prevention.

"After the legislation was over with, the Governor and Jane Norton came to me and asked me to serve as the acting director to get the office off the ground. I drove all over the state talking to survivors and subject matter experts. The OSP was tasked with coordinating the hodgepodge of grass-roots prevention efforts already in place across the state. I don't believe that you can be if you don't go to the sources—the experts—to get insight and advice. There was already a framework to start from. The Commission had done a masterful job with the statewide report. My job was to figure out how to expand on the meaty stuff in their report and institutionalize it. I spent four months traveling all over the state, just listening and learning about active suicide prevention programs,"[156] says Finley.

This road trip drew national attention, and Finley flew to New York City and was interviewed by CBS reporters for *60 Minutes. "*It was interesting what kind of press all of this got on a national level—the founding of a state-funded office and this road trip. They wanted to know why Colorado was so focused on the issue of suicide prevention and awareness and what I was learning from my travels. Suicide efforts had been focused on big cities because many of the resources are in those large metropolitan areas. *60 Minutes* wanted to know what I was learning from my travels in places like Grand Junction, Julesberg, Limon and Durango,"[157] says Finley.

What Finley learned was that there were a wealth of small suicide prevention organizations and programs already operating in many Colorado towns. She also learned that there were qualified and passionate professionals who would be perfect to take on the open position of Director of the Office of Suicide Prevention.

THE OFFICE OF SUICIDE PREVENTION FINDS A LEADER

Shannon Anderson (now Shannon Breitzman) was a caseworker at the Weld County Department of Social Services, working with troubled adolescents. In a *Denver Post* article from October 20, 2000, Breitzman was quoted:

"I've had a lot of experience just being on the front line with kids who are showing the risk signs for suicide and suicidal behavior."[158]

Breitzman, along with three other finalists for the position, was scrutinized by a variety of experts including officials from the Colorado Children's Campaign, Colorado Mental Health Services and from Governor Owens' office. Jane Norton and a panel of prevention workers and suicide survivors interviewed the finalists.

Breitzman met with Finley to map out priorities for the future of the Office of Suicide Prevention. Finley had acquired a two-year, $378,000 grant from the Substance Abuse and Mental Health Services Adminstration (SAMHSA) to focus on teen suicide prevention. Both Finley and Breitzman were clear that although teen suicide prevention was a priority, Colorado had other target populations at risk, too. They were heartened by the fact that the SAMHSA grant would allow OSP to spend its additional $157,000 state-allocated budget toward other at-risk populations. The Partners for Teen Suicide Prevention project, which resulted from the SAMHSA monies, began in November of 2000. The project focused on children and youth ages 10 to 19 and addressed "the issue of youth suicide prevention and linking those efforts to related issues of youth substance abuse, mental health and violence.[159]

To fulfill the grant requirements, Breitzman convened a task force of key stakeholders. The task force reflected geographic and ethnic diversity, had representation from major youth-serving agencies at both the state and local level, schools, faith communities, and youth and family survivors. Subsequent goals included completing a statewide needs assessment regarding youth suicide; developing a statewide strategic plan to address youth suicide prevention (building upon the recommendations developed by the 1998 Suicide Prevention Advisory Commission; and reviewing best practices in youth suicide prevention to select a model program to be implemented in three communities.[160]

The Partners for Teen Suicide Prevention Task Force reviewed many different strategies and prevention programs and selected LivingWorks, adapted for youth, as the model program to use to create the foundation of teen suicide efforts in Colorado. Today, the LivingWorks suite of programs is the most widely used and the most recognized suicide prevention-intervention training program in the world. LivingWorks has more than 4,000 community-based trainers around the world who train over 60,000 participants annually.[161] Breitzman and the task force chose the Applied Suicide Intervention Skills Training (ASIST). ASIST workshops are for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide.

Breitzman's goal was to understand best practices—what core components made up a good prevention program. This philosophy drove the selection of the Living Works/ASIST (youth prevention) program for the SAMSHA grant.

"I did research on all of the Gatekeeper training programs available, but many weren't specific to youth. We felt like the Living Works ASIST training was the most evaluated and intensive training program. It walked you through risk assessment and intervention strategies to get somebody to help. "[162]

The Task Force then distributed more than 800 applications throughout Colorado to identify three communities to serve as pilot sites for the Living Works program. The three entities selected were the Jefferson Center for Mental Health in Jefferson County, the Mesa County Health Department and the San Luis Valley Comprehensive Mental Health Center. Each community received funding to implement the Living Works trainings for their community gatekeepers and to pay a facilitator to coordinate a community coalition for the planning and implementation of the training program.

"I did a lot relationship building and coalition building during that first year. There were quite a few grassroots prevention efforts going on, but nothing to that point had been formalized with government funding. I felt it was important to get to know all the players and understand their roles and their agendas,"[163]says Breitzman.

Breitzman used the remainder of the Colorado-budgeted money to create a grant program. Six grants were awarded to local entities for suicide prevention and education services. The grant program was "designed to support communities working on comprehensive suicide prevention programs, and to improve and expand suicide prevention at the local level. Each grant was a one-year award, and upon receiving news that the 2001-2002 budget for OSP was increased to $298,159, the office was pleased to announce that the increase would result in a 300 percent increase in the amount of the grant funding the following year."[164]

THE COLORADO TRUST: A PARTNER IN SUICIDE PREVENTION

The year 2000 marked the Colorado Trust's first foray into suicide prevention programming. "Carol Breslau, a Vice-President for Initiatives from the Trust, had just finished a study on guns and gun ownership as part of a violence prevention study. She was attending some of the SPCC meetings, and I felt like the Colorado Trust might be a good partner for OSP. At the time, The Trust didn't have open grant opportunities; their funding was very initiative driven. Knowing that the Trust's interest in violence prevention could translate to suicide prevention, too, I asked Carol to fund a cadre of trainers to help with our 'Train the Trainers' ASIST program," says Breitzman. This program was created with the goal of mobilizing a statewide suicide prevention infrastructure. By the end of the year, 26 individuals in 15 regions representing all 52 counties in Colorado and two representatives in the US Air Force had been trained as LivingWorks ASIST trainers.[165]

The Office of Suicide Prevention was not the only agency the Colorado Trust was funding for suicide prevention. That same year, the Trust partnered with United Way to fund Mental Health America of Colorado's Colorado LINK school-based teen-suicide prevention program.

"My first job at the trust as a program officer was to develop an initiative. At the time we were an initiative-based grant making institution. This meant we identified specific issues that we felt we could

have an impact on. We crafted an evaluation strategy, developed our own program ideas and long-term tactics, and worked with grantees to transform these ideas into effective activities,"[166] says Breslau.

Breslau had recently completed a violence-based initiative with a study on youth and handgun violence. The Trust learned that guns were the weapon of choice for suicide among young men. Although this was not new news, it was a terrifying statistic in Colorado. The Trust was also investigating ways to begin work on mental health issues.

"We took this knowledge about suicide that we gleaned from our youth and handgun study and combined it with the obvious need to fund mental health programming, and the Colorado LINK program was born."

The Colorado Trust sought supplemental funding from Mile High United Way to develop a school-based program for suicide prevention administered at Denver Public Schools' North and East High Schools. The grantee team was comprised of Mental Health Association of Colorado, the Yellow Ribbon Suicide Prevention Program and Urban Peak, an organization providing services for homeless and runaway youth. What made Colorado LINK different from the Partners for Teen Suicide Prevention program directed by OSP was that Colorado LINK focused specifically on diverse youth populations (youth of color, Spanish-speaking students and homeless/runaway youth), and not only focused on awareness and education but on increasing access to mental health services among these traditionally underserved youth.

In spite of the apparent success of Colorado LINK, there were still many unanswered questions with regard to suicide in Colorado. In early 2001, the Trust expanded its partnership with OSP to conduct a statewide needs and resource assessment. The Center for Research Strategies conducted the assessment and the data-driven findings were eventually compiled into a final report published by the Colorado Trust in 2002 titled *Suicide in Colorado*. Colorado House Bill 00-1432, which ordered the founding of the Office of Suicide Prevention, identified gaining a full understanding of the suicide-related needs and resources of the state as one of the office's top priorities. The final report, *Suicide in Colorado*, built upon the Suicide Prevention Advisory Commission's work in the 1998 state plan and helped to create an even more thorough picture of suicide in Colorado and the resources available to address the problem.

A CALL TO ACTION

By January of 2001, the National Council for Suicide Prevention and the national advisory council had completed their two-year strategic planning process, and Surgeon General David Satcher unveiled the *National Strategy for Suicide Prevention with Goals and Objectives* by the Department of Health and Human Services. The advisory council conducted extensive research, and during 2000, held public hearings in Atlanta, Boston, Kansas City and Portland to provide a face-to-face forum for additional input and clarification.[167]

The resulting national strategy to prevent suicide was a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course. The document was comprised of 15 goals with concrete objectives to achieve each goal. The plan encompassed the promotion, coordination and support of activities to be implemented across the country as culturally appropriate, integrated programs for suicide prevention among Americans at national, regional, tribal and community levels.[168]

The document stressed the need for a broad public/private partnership in the United States to ensure that the strategy could be effectively carried out. This would require that public and private partners across many sectors of society come together to sustain a true national effort. These groups included, but were not limited to, government, public health, education, human services, religion, voluntary organizations, advocacy and business. Most importantly, the National Strategy sought to be an agent of "social change," working to transform attitudes toward mental illness, influence policies and direct resources to prevention services.[169]

In Colorado, the Office of Suicide Prevention launched a multi-poster graphics campaign aimed at public awareness and education. The idea for this campaign originated in Colorado's 1998 statewide suicide prevention plan and also supported the goals of the NSSP to transform attitudes toward mental illness. In 2000, OSP convened a public awareness work group to focus on public awareness materials and events. The group further developed a media campaign utilizing the messages from the 14 posters, as well as advertising the national hotline number. The campaign also included the creation and distribution of six new pieces of outreach material including booklet targeting family members of suicide attempter called *Suicide Prevention Resources for Your Family* and a booklet targeting suicide prevention among the elderly called *Got the Blues?* Six flyers and the Suicide Prevention Resource for Your Family were translated into Spanish.[170]

Then on September 11, 2001, the urgency to address the suicide crisis in our country was raised a notch. In the aftermath of the September 11 terrorist attacks, a dramatic shift in the United States' economy resulted in rising unemployment, and mental health experts began warning that the already alarming rate of suicide in the country could worsen.

SECOND WIND FUND: A PROVEN RESPONSE TO A NEED

Shortly after September 11, perhaps driven by the national stress of the event, or perhaps not, three students took their lives at Green Mountain High School in Lakewood, Colo. Jeff Lamontagne and Scott Fletcher both attended Green Mountain Presbyterian Church next door to the high school.

"I remember different people getting up during announcement time and saying 'There's been another suicide.' People in the community were becoming increasingly concerned,"[171] says Lamontagne.

Feeling helpless about the fear and insidious nature of suicide in the community, a committee at the church suggested doing something to help.

"Our immediate thought was some sort of walk/run. It would bring the community together; it would engage the kids outside of school. We began planning the event, not really knowing how we should spend any money raised or how it would be best used."[172]

The church went ahead with the planning, and with a fourth suicide at Green Mountain in July 2002, the group felt a renewed sense of urgency. Lamontagne, Fletcher and the rest of the planning committee were joined by Dr. Marjorie Laird, a licensed clinical social worker and marriage and family therapist.

"In the weeks before the walk, we talked about what we could use the fundraising money for. It was Marjorie's recommendation that it be used for counseling services for at-risk kids. The idea made a lot of sense. A lot of other organizations were doing suicide postvention or presenting about warning signs and risk factors. The common criticism was that everyone was doing the same thing—training, education and raising awareness. Although all of these are so important when dealing with the issue of suicide, we wanted to meet a different need."[173]

Marjorie sketched out an operational model. The group incorporated as the Second Wind Fund under the auspices of Green Mountain Presbyterian Church as a fiscal sponsor. The presented model would bridge the gap that was occurring at private therapists, community mental health agencies, and other counseling services for students targeted as at-risk for suicide.

The first walk/run event was held in Lakewood on September 8, 2002. Sixty-six people participated. "We didn't reach that many people. Only 12 people were from outside of the church and seven of those were friends of a church member. We drew a total of five people who weren't connected with the church—a family of four and one kid who said he saw our poster while getting his hair cut."[174]

In spite of the small number of attendees, the walk/run provided a fundraising opportunity. Several walkers raised $300 each; several attendees wrote donation checks at the event. These funds combined with walk/run participant fees allowed the Second Wind Fund to raise $4,000.

"We didn't think it would amount to much, but $4,000 was something to start with. Given that $500 was our goal, we were encouraged," says Lamontagne.

The committee approached Green Mountain High School with its proposals. Initially, there was hesitancy on the part of the school. As with most schools, district policies and a fear that talking about suicide could lead to a self-fulfilling prophecy, prevented the school from making a quick decision.

This gave the committee time to hone its system. Marjorie Laird had recruited three other therapists. Each provider was a licensed therapist who agreed to work with The Second Wind Fund at a reduced rate, and all were selected because of their experience working with at-risk youth. This is often a stumbling block in therapy within an educational, private community health setting. Given the lack of suicidal-tendency specific training for most mental health professionals, many shy away from working with suicidal patients. In many other instances, patients are not properly matched with therapists based on age, geographic location, etc. The Second Wind Fund overcame all of these problems.

Each student must be referred by a qualified referral source: school mental health staff, school psychologists, a principal—"anyone who is not related to the student and works with kids. These people also need very basic training in mental health or the warning signs around suicide," [175] says Lamontagne.

Traditionally, 96 percent of Second Wind referrals come from schools. A small number of referrals come from faith communities, hospitals, juvenile justice center, non-profits and rape assistance centers. Once a referral was made, Second Wind granted six counseling sessions to the student. The second year in operation, the number of sessions increased to eight. All of Second Wind Fund referral patients are uninsured or underinsured.

"Many of these uninsured kids might only have access to the community health system if they are at risk for suicide. However, the community mental health system is so bogged down with long wait times or the counselor may be geographically preventative for a student. With an underinsured student, the parents might be able to scrape together enough money for counseling, but the point is that a lot of these kids are already feeling isolated or burdensome to their families. Being the cause of a financial hardship like that might make things worse,"[176] says Lamontagne.

This brings Lamontagne to the reason for the Second Wind Fund's existence—access for kids at risk for suicide. If a child is thinking about suicide, the Second Wind Fund can provide a quick turnaround time for appointments. In many other cases, students might wait up to a month to get an appointment. As professionals in the suicide prevention field are aware, if help is not available during the suicidal crisis, it may be too late. The Second Wind Fund now provides eight sessions with a licensed therapist for each qualified student. In many cases, those with no insurance are limited to a maximum of four appointments in the community mental health system. Within its first year of operation, SWF created a tiered system in which a referral source and the therapist can collectively request additional sessions for a student with ongoing risk assessment. This number can be as high as 16 sessions with a licensed therapist. In the case of mental health facilities, students do not always see a licensed professional. Today, SWF contracts only with licensed therapists who have experience with adolescent mental health. Finally, Second Wind has created a model providing geographic access to all referred students. Second Wind Fund works with over 95 providers in the metro-Denver area and another 100 in other locations across the state. This ensures that no referred student needs to travel more than a few miles to see a provider.

With carefully-honed procedures in place, the Second Wind Fund received its first referral from Jay Lang, a counselor at Green Mountain High School, in December of 2002. After the first student received immediate access to care and started doing better, Lang's colleagues in the area also began calling to ask for referrals.

"Our original goal was the help the kids at Green Mountain High School. We were funding those students in need fairly well, but we got down to the last $400 from the walk/run and realized that we needed to raise more money if the Second Wind Fund was going to grow and continue. Over the course of about two week, I got calls from three others schools, the middle school that feeds into Green Mountain High School, Alameda High School and Bear Creek High School asking to refer kids to the

program. In spite of the fact that we were almost out of money, we said 'yes' to these schools. That was one of the big turning points of the program. We realized that suicide wasn't a Green Mountain issue; it was a universal issue, and we needed to keep our promise to help at-risk kids."[177]

The Second Wind Fund hosted a second walk/run in 2003 and began seeking corporate sponsorship and grants. To date, over 400 schools in Colorado have utilized the program, and SWF has raised over $3 million to provide counseling to 2,200 students.

"Out of 2,200 referred students, not one has gone on to take their own life. We've also seen the youth suicide rate go down in counties where we've served the most kids for the longest amount of time. The downturn always corresponds with the introduction of the Second Wind Fund program,"[178] says Lamontagne.

In 2005, the Second Wind Fund began an affiliate program, providing seed money to other communities throughout the state to establish local SWF chapters. By 2010, SWF had nine affiliates in Boulder County, Douglas County, the Eagle River Valley, El Paso and Teller counties, the Four Corners area, Northeast Colorado, the Uncompahgre Plateau and Weld County. These affiliates cover over 85 percent of youth under age 19 in Colorado.

In 2009, people began recognizing the value of the Second Wind Fund model on a national level. That year, the original Second Wind Fund became the Second Wind Fund of Denver, and the umbrella organization re-organized to begin developing affiliates throughout the country.

"People have told me that no one else is doing something like this in the country. Expanding the program nationally will ensure that more universal coverage is built in for at-risk youth. We are decreasing the incidence of teen suicide by removing financial and social barriers, so that these uninsured or underinsured youth who are struggling with real life-and-death thoughts now have professional help on a par with insured youth,"[179] says Lamontagne.

***SUICIDE IN COLORADO*: THE COLORADO TRUST'S FINDINGS**

Following the Colorado Trust's Colorado LINK collaboration with the Mental Health America of Colorado and its fact-finding partnership with the Office of Suicide Prevention to understand the suicide-related needs and resources in the state, the Trust released the report compiling and analyzing its findings since the year 2000 titled *Suicide in Colorado*. The report identified the target populations most at risk for suicide in Colorado, existing suicide-prevention resources and gaps that needed to be addressed. Two companion reports accompanied this report: the *Suicide Prevention and Treatment Programs in Colorado* report detailed suicide-related statistics and prevention resources for each Colorado county, and the *Suicide in Colorado Summary* served as an executive overview of the main *Suicide in Colorado* report. While the 1998 state suicide prevention plan provided a roadmap for the organization and mobilization of suicide prevention, postvention and intervention efforts in Colorado, *Suicide in Colorado* provided a thorough analysis of what was already happening in the state and areas in which inadequacies of services could be found.

The report deemed that populations in Colorado most at risk for suicide were youth (ages 13-18), middle-aged men (ages 35-54), and the older population (ages 65+). Analyzing 10 years of suicide death statistics compiled by the Colorado Department of Public Health and Environment, the Colorado Trust report determined that counties with the largest numbers of reported suicide deaths were urban metropolitan areas such as Denver, Adams, Arapahoe, Douglas and Jefferson counties.

The authors' main elements of concern regarding Colorado's suicide prevention efforts were:

- "Sixteen Colorado counties [were] formally recognized by the federal government as 'mental health manpower shortage areas,' that is, areas where there is a shortage of mental health professionals, including psychiatrists.
- Recent mental health needs assessment analyses prepared for Colorado's Map Mental Health Services indicate there continues to be substantial unmet needs for mental health services in Colorado for the seriously mentally ill population. Overall, 5.7% of Colorado's adult population is estimated to be in need of mental health services. Using the 2000 U.S. Census population figures, the estimated number of adults in Colorado in need of mental health services is 181,146. Roughly half of these individuals are estimated to be recipients of clinical services through some type of public mental health system, suggesting that there are many people in need of clinical services who do not receive such services in the public sector.
- Fourteen of 17 community mental health centers and clinics report there is currently a waiting list for routine clinical care. Typically, individuals placed on a waiting list have neither Medicaid nor private medical insurance. The fact that access to the public system can take some time indicates further that the amount of services available in Colorado is insufficient. Individuals judged by clinicians to be in immediate danger of committing suicide would receive crisis services, but follow-up or subsequent routine care for these people may not be available when the service system is at its capacity.
- Representatives from 52% of Colorado school districts responding to the survey indicated that written crisis plans exist in only 67% of these districts, suggesting that a substantial number of school districts should be encouraged to take steps to develop appropriate crisis planning strategies. School districts and individual schools in Colorado were found to offer a variety of suicide-related programs to their students. The most common of these are anti-drug programs (63%), antiviolence programs (58%), screening and referral services (52%) and general skill building (49%). However, even these more typical school-based programs are only available in roughly two-thirds of the responding districts, leaving ample opportunity for further program development."[180]

Using a stakeholder survey, the Trust determined that "suicide prevention resources are available in all Colorado counties, but stakeholders throughout the state have characterized these resources as minimally 'adequate' to meet the needs of those at risk for suicide-related behaviors."[181] When asked to identify the barriers that limit their ability to expand suicide-related programs, the overwhelming majority cited lack of available funding to develop, implement and support suicide prevention programs. "Eighty-five percent of the community stakeholders and 74% of school district representatives identified a lack of funding as the major barrier to suicide program expansion. Other major issues commonly recognized by the community respondents were a lack of community awareness (54%) and a lack of community mental health services (48%). For those in school districts, the second most-common barrier was a lack of time (68%), followed by a lack of community mental health services (38%)."[182]

One problems addressed was that need for population-based programs which address other types of at-risk behavior as well. Researchers know that there are strong associations between suicide and the presence of depression, other psychiatric disorders and substance abuse. Since suicide is often a symptom of other related problem behaviors, the assessment of suicidal thinking, planning and behavior, as reported in these studies, often occurs as part of a broader constellation of at-risk factors.

Suicide in Colorado served as a watershed moment in Colorado's history of suicide prevention. Although much of the information in the report was not new to suicidologists, mental health professionals or community educators working in suicide prevention, it was revealed through the Colorado Trust stakeholder survey that limited funding was a key barrier for access to care and prevention programs throughout the state. Not only did the Colorado Trust bring to light many of the inadequacies in Colorado's suicide prevention efforts, but the Trust also put "its money where its mouth was" in furthering the efforts. In response to the report, the Colorado Trust created a 4-year, $2.5 million initiative, the Preventing Suicide in Colorado initiative (PSIC). From 2002 to 2006, the Colorado Trust provided much-needed funds to assist 10 diverse communities throughout the state with creating or furthering comprehensive community-based suicide prevention initiatives.

"There were so many unanswered questions about access to care and prevention strategies at the time. Out of that report, the recommendations were very clear. We needed to gain buy-in from the communities. We wanted to launch a Gatekeeper model in those communities. We engaged the Mental Health America of Colorado (MHAC) and the University of Colorado at Denver: Center for Public-Private Sector Cooperation,"[183] says Carol Breslau.

"The Trust funded these two groups to work together. The Center's staff members were experts in community process, and at the time MHAC housed the Suicide Prevention Coalition of Colorado and had the knowledge of the content piece with regard to suicide."

The Colorado Trust also engaged the help of the Office of Suicide Prevention. Shannon Breitzman assisted with reviewing 53 letters of intent and 22 full proposals. She provided feedback to the selection committee, and 10 grantees were chosen from across the state.

MHAC and the UCD Centers partnered to work with the geographically diverse grantees. After one four-year round of funding the Trust determined that more funding was necessary to make the program self-sufficient, and granted an additional three years of funding to each group resulting in a project that spanned seven years from 2002-2009.

Zeik Saidman was the Associate Director for the Center for Public-Private Sector Cooperation at the University of Colorado Denver. The Center's mission was to assist with building and sustaining productive community collaborations and collaboration. Saidman specialized in meeting facilitation and task forces designed to address and resolve community issues. Lisa Carlson is the Director of the Center and specialized in collaborative problem solving and consensus building with diverse groups. Carlson, Saidman and Jeanne Rohner, retired CEO of Mental Health Association of Colorado, were the key facilitators in the PSIC initiative, meeting with stakeholders in each of the 10 grantee communities to achieve consensus and develop comprehensive strategic plans for suicide prevention efforts.

These community initiatives included:

- Hispanic Youth Suicide Prevention Project of Suicide Education and Support Services of Weld County
- The LifeSource Project sponsored by Rural Solutions in Northeast Colorado
- The Link for Life program in Mesa County sponsored by the Western Colorado Suicide Prevention Foundation in Grand Junction
- Project HOPE coordinated by Southeast Mental Health Services
- Tri-County Trust Project: Suicide Prevention in Jefferson, Gilpin and Clear Creek counties coordinated by the Jefferson Center for Mental Health
- REPS (Reaching Everyone Preventing Suicide) serving the Yampa Valley, in Moffat and Routt counties
- Montelores Suicide Prevention Initiative sponsored by The Piñon Project
- Midwestern Colorado Suicide Prevention/Intervention Coalition serving Montrose, Delta, Ouray, San Miguel, Gunnison and Hinsdale counties sponsored by Midwestern Colorado Mental Health
- Suicide Prevention and Advocacy Coalition serving El Paso and Teller counties sponsored by the Suicide Prevention Partnership Pikes Peak Region
- Voz y Corazon serving Hispanic girls between the ages of 11 and 17 in West Denver

HISPANIC YOUTH SUICIDE PREVENTION PROJECT: SESS

Zeik Saidman oversaw the grant administration for six of the 10 grantee projects. After working closely with Saidman, the Suicide Education and Support Services of Weld County (previously discussed as SESS, a program of North Range Behavioral Health) introduced the Hispanic Youth Suicide Prevention Project. The program was designed to reach Hispanic youth, in and out of school settings, who may be at-risk for suicide, as well as their families. The focus was on raising awareness about suicide within the Hispanic community, empowering youth gatekeepers, facilitating the connection between youth and the mental health services system, and coordinating data collection between agencies that interact with suicidal youth.[184]

Several youth from the Greeley's Latino community participated in a six-month planning process to develop a culturally appropriate suicide prevention program. In 2003, the planning group ranging in age from 14-17 years old, named the coalition Youth Ending Suicide (YES). YES is open to any youth in Weld County and meets at the three Boys & Girls Clubs in Greeley and Milliken. Group members range in age from 7 to 19, though most are in middle or high school. Some have begun to engage in self-destructive behavior, many know someone who has attempted or completed suicide, and others come just because they feel a sense of belonging when they are in YES. The group is free, and youth do not need to be members of the Clubs in order to attend.[185]

LIFESOURCE PROJECT: RURAL SOLUTIONS

Saidman also counseled Maranda Miller, the Suicide Prevention Coordinator of Rural Solutions, a coalition of community service providers in Northeastern Colorado. With the funds provided by the PCIS grant, Rural Solutions created the LifeSource Project in Northeastern Colorado.

Rural Solutions began as a grassroots collaboration in the early 1990s. The Director of Human Services for nine counties in northeast Colorado (Logan, Morgan, Cheyenne, Kit Carson, Lincoln, Phillips, Sedgwick, Washington and Yuma Counties) joined forces with Centennial Mental Health Center, the community mental health center in Sterling, Colo., mental health providers, social services departments, handicapped services, public health, the Area Agency on Aging and elected officials.

"The organizations came together with one common goal. All of them realized that our communities were too small to obtain grant funding for projects in the areas of family health and wellness, suicide prevention, and elder population needs,"[186] says Miller.

Using the representational power of a larger consortium, Rural Solutions could apply for funding on behalf of its member organizations. Rural Solutions obtained funding to hire a program coordinator who coordinated the diverse wellness efforts, and eventually obtained its 501(c)3 designation in 1994.

By 2002, Rural Solutions was poised to launch a comprehensive suicide prevention program. The first two years of the grant cycle were used for planning and analysis of prevention needs specific to northeastern Colorado. Miller was hired in February of 2005 and took over the program. The LifeSource program was designed to educate the citizens of Northeast Colorado about the availability of resources to help citizens make positive decisions concerning healthy living. It was proven that often these positive decisions assist with resolving issues of suicide. The project began with community gatekeeper training utilizing ASIST and QPR. LifeSource aggressively identified gatekeepers who worked specifically with the older adult population. According to the Colorado Trust's *Suicide in Colorado* report, social isolation is a driving force behind suicides in the older adult population. The small populations and large land area of Northeastern Colorado (which can contribute to feelings of isolation), combined with 25% of the population over the age of 54, pushed Rural Solutions to recognize the need for a community-driven initiative to reach this older population.

"Although we have a great relationship with Centennial Mental Health, people felt like a suicide prevention program should stand alone. Citizens in our area are all about relationships. Oftentimes when people are at risk for depression or other suicidal risk factors, they are resistant to seeking out counseling or other traditional mental health services." [187]

With Rural Solutions as the program coordinator, we could partner with the public and private mental health providers, but we could also partner with nursing homes, public health officials, school psychologists, counselors, law enforcement officials, coroners, EMTs, victim advocate coordinators and survivors of suicide,"[188] says Miller.

After the initial round of gatekeeper trainings, Miller began actively delivering suicide education and awareness program to any groups willing to listen in the nine-county area. Soon, Rural Solutions developed a resources directory. This 33-page directory can be accessed by county or by specific need

(mental health, school-based program, private therapist, etc.) and also provides a comprehensive religious and faith-based organization listing for the nine-county area.

"What we discovered in the creation of this directory is that people have a misconception that because we are comprised of rural communities, we don't have a lot of resources for those at risk for suicide. We did some good digging and found that we have a great list of mental health providers and organizations for those in need,"[189] says Miller.

The LifeSource and other suicide prevention programming at Rural Solutions, did not come to a halt with the end of the Colorado Trust grant funding. In the fall of 2009, Rural Solutions was awarded a three-year, $12,000-per-year grant to focus on suicide prevention in the elderly population and a three-year Project Safety Net grant to train those who work with at-risk youth (ages 10-17) and to develop protocols with agencies who interact with youth.

LINK FOR LIFE: WESTERN COLORADO SUICIDE PREVENTION FOUNDATION

Another highly rural area in which suicide had become a problem was Colorado's Western Slope. Under the PCIS program, Zeik Saidman worked first with Karen Lavad, the Director of the Mesa County Suicide Prevention Coalition, and later with Sheila Linwood, the Executive Director of the Western Colorado Suicide Prevention Foundation in Grand Junction (the Mesa County Suicide Prevention Coalition became the Western Colorado Suicide Prevention Foundation during the PCIS initiative).

In 2003, the national suicide rate was 13 people per 100,000. For Mesa County, the rate was 21.7 people per 100,000—nearly double the national suicide rate. Although at the time, and today, no one knows the exact reason for the high suicide rates, Lavad speculated:

"We have many more sparse population areas on the Western Slope, which can lead to feelings of isolation. In Western rural communities, not only is there less access to mental health services, but there's probably a little less willingness to access them. For some people it can take several hours of driving to get to a counselor or psychiatrist. And in a small town, if you park your pickup in front of a therapist's office, everyone knows it's you inside,"[190] said Lavad.

This stigmatizing factor in mental health could be just one more reason that individuals avoid mental health care even though they are dealing with depression or another mental health issue that can put them at risk for suicide. For this reason, a small group of organizations came together to form a coalition to prevent suicide in Mesa County. The coalition began research and implemented a number of programs to help reduce the suicide rates in the area. "This concerned group of citizens included Herb Bacon, a retired banker who, through his family foundation, donated funds to match the Colorado Trust's PCIS grant and lay the foundation for the Mesa County Suicide Prevention Coalition to become a self-sustaining non-profit organization."[191]

Sheila Linwood, the former Executive Director of the Western Colorado Suicide Prevention Foundation, is a former police officer who started working with the Mesa County Suicide Prevention Coalition in 2003.

"I sort of fell into this position. I finished up my MBA degree after having worked in law enforcement. Through my law enforcement training, I also dealt with quite a bit of victims' advocacy training. Our training with regard to suicide was lacking. The attitude was that you didn't talk about suicide because that makes it happen. I was feeling frustrated on the street with the people that we did lose to suicide. I felt that it was very preventable if people would just reach out for help, if we could just get there and talk to them,"[192] says Linwood.

Several years later, Linwood was taking an ASIST training class in Grand Junction offered through Mesa State University.

"I was trying to decide what to do next professionally after finishing up my Masters degree. I ran into Karen Lavad at the ASIST training and offered to help out volunteering 20 hours a week with the Coalition. That 20 hours eventually turned into a full-time position. When you find someone who is interested in working in suicide prevention, you don't let them get away."[193]

Linwood went on to become the Executive Director of the Western Colorado Suicide Prevention Foundation in Grand Junction. "We first started to help reduce the suicide rate in one county [Mesa County Suicide Prevention Coalition], but out of necessity we have expanded to 21 counties in Western Colorado," says Linwood.

The first program created with PCIS/Colorado Trust funding was the Link for Life program. Link for Life stands for:

- Look and Listen
- Inquire about suicidal thoughts
- Note the level of risk
- Know your local resources.

This training program is offered in a variety of settings to help inform community gatekeepers about suicide risks and local resources to save lives. The program is similar in many regards to the QPR training, but differs because it was customized to provide comprehensive information about local resources. Once community gatekeepers know how to recognize the signs of someone at risk for suicide and intervene, they are trained to know which specific resources are available in their communities for referral.

The Western Colorado Suicide Prevention Program has developed other programs specific to Colorado's Western Slope population. Many members of the Western Slope workforce are employed in the oil and gas and construction industries, which have been found in recent years to be at high risk for suicide due to the dangerous working conditions, long hours worked far from home, and male-dominated "pull yourself up by the bootstraps" machismo.

Known as Hope for Hardhats, the outreach program provides training and awareness of suicide prevention in the construction fields through specific curriculum designed for "tough guys." The curriculum is brought to the jobsite using proven methods of tailgate safety meetings about the signs of suicide. Hope for Hardhats conducts Toolbox Talks, which encourage and receive referrals of workers whose circumstances place them at risk of mental health issues including suicidal ideation, and provide them with appropriate support services. The goals of the program are to:

- Increase at risk workers access to appropriate support and resources in order to reduce the risk of suicide or self-harm.
- Improve the building and construction industry's awareness and understanding of suicide issues and develop more supportive attitudes to those in the industry workforce at risk.
- Increase the level of well-being and social connectedness of all members of the industry community.
- Build strong resilience of new, mostly young workers in the industry (apprentices and trainees) to protect against suicide.[194]

PROJECT HOPE: SOUTHEAST MENTAL HEALTH SERVICES

In Baca, Bent, Crowley, Kiowa, Otero and Prowers counties, Lisa Chavez, an area native, worked through Southeast Mental Health Services to coordinate Project HOPE. Project HOPE focused on suicide education and awareness, gatekeeper trainings, screenings and appropriate referrals in this six-county area. Lisa made presentations at six county commission meetings and obtained financial support for the program from four of the six counties. According to an editorial written by Zeik Saidman, Project HOPE's initiative grew to include counseling services to southeastern Colorado's service men and women returning from Iraq and Afghanistan.[195]

TRI-COUNTY TRUST PROJECT: JEFFERSON CENTER FOR MENTAL HEALTH

In Jefferson, Gilpin and Clear Creek counties, Heather Trish, a trauma clinician and the Suicide Prevention Coordinator at the Jefferson Center for Mental health, coordinated the Colorado Trust-funded Tri-County Trust Project. This Suicide Prevention project serves middle school and high-school as well as providing gatekeeper training for hundreds of citizens in the three-county area. The Tri-County Project uses ASIST training and QPR gatekeeper trainings to make attendees become more aware of potential signs, risks and prevention strategies for suicide. Trish has also worked to create customized information sessions highlighting the unique risk factors facing the GLBTQ and the Latino/Hispanic communities.[196]

REACHING EVERYONE PREVENTING SUICIDE (REP)

In the Yampa Valley, specifically Routt and Moffat counties, the Suicide and Crisis Intervention Lifeline Coalition (SCILL), formed in response to an alarmingly high level of local suicides. Ronna Autrey, a realtor who lost her son Shaun to suicide in 2001, joined the group of concerned citizens meeting under the umbrella of Colorado West/Steamboat Mental Health. The group held meetings in Routt and Moffat counties to address suicide as a public health problem.

"We had two members trained as ASIST trainers; we conducted a media campaign—reaching out to local media to inform them of the ongoing and growing problem of suicide. We did public speaking where we could. Our efforts grew little by little. I compare it to the video game PacMan. We kept biting off little chunks and just kept going and going around the maze,"[197] say Autrey.

When the Colorado Trust released a request for grant proposals in 2002, the members of SCILL organized their efforts and were awarded funds to start Reaching Everyone Preventing Suicide (REPS), a volunteer coalition of community members invested in stopping suicide in the Yampa Valley and supporting those who lost a loved one to suicide through education and awareness. The group's mission statement was, "We believe that suicide is devastating to our community and that there are alternatives."[198]

REPS initial efforts were focused in Craig and Steamboat Springs; however, after several years, the groups merged and Tom Gangel, the Colorado West Regional administrator for nine rural, resort community mental health centers and an early advocate of the grassroots activities of REPS, asked Autrey to take over as REPS' coordinator. What began as a part-time volunteer position for Autrey has grown to a full-time paid position.

"After my son's death, my husband and I were working with a grief counselor. The counselor got to know my personality and encouraged me to attend some continuing education conferences that dealt with the issue of suicide. I started taking all these courses—ASIST, QPR—because I wanted to understand the hows and whys of suicide. If I was going to be leading support groups, I didn't want to be making mistakes,"[199] says Autrey.

Zeik Saidman, PCIS project facilitator for REPS, agreed with Autrey's desire to implement informed programming.

"The stability and passion of the survivors is a huge positive to the suicide prevention movement. Survivors often aren't given enough credit for the endless fight that they've undertaken. Working as a consultant, I earned a great respect for the survivors' passion and developed a sensitivity about the balance that needs to be sought for the survivor community. In the bleak times, during which the money has run out, the survivors are the force that keeps the movement going. However, we need to harness this passion and couple it with best practices and a studied approach to prevention to ensure that we're reaching audiences safely and effectively,"[200] says Saidman.

Autrey also became a member of SPCC, the statewide suicide prevention coalition, and took advantage of networking opportunities at state conferences. In May of 2002, the Suicide Prevention Coalition of Colorado hosted Wings of Hope, the first statewide suicide prevention conference since S.P.A.R.E.'s conferences began in 1986. Autrey attended the Wings of Hope Conference.

"I met so many mentors at these conferences, and now I mentor to them as well. These summits give us the opportunity to brainstorm together. Someone might ask, 'Have you tried this idea? It's working for us in our area,'"[201] says Autrey.

Autrey recalls meeting a woman from Montrose, Colo., who had recently applied for a grant from the local grange hall to fund ASIST trainings in her area. "We are such a rural area; I thought this might work for us, too." Autrey has become known as a fearless fundraiser, formulating creative ideas and non-traditional ways of raising funds for REPS' programs.[202]

The programs consist of a depression and bi-polar support group**,** which was founded in 2008. Autrey also tried establishing a support group for attempters of suicide, but unlike the success of the attempt survivors support group in Larimer County, Autrey found that in the Steamboat area, this group was unpopular.

"I really thought that maybe the attempters group would work, but it hasn't. I'm convinced that many attempt survivors are in denial—not ready to admit to themselves or others that they are suffering and need to seek help for depression or some other mood disorder."[203]

REPS has addressed the growing need for immediate support of the other group of "survivors"—family and friends who have lost loved ones to suicide. Autrey and six members of her 40-member, volunteer team have been trained in suicide loss prevention.

"We have established relationships with the local coroners and police departments. When there is a suicide they contact us, and we obtain permission to call the family—oftentimes, we are on site immediately following the event."[204]

The loss prevention team offers immediate support and has created a packet of information with local resources and tips to help. The packet contains *A Handbook for Survivors of Suicide*, created by the American Association of Suicidology, information about local HEARTBEAT survivor support chapters and a letter addressing the emotional rollercoaster in the days following a suicide.

"These survivors are going through hell immediately after the loss of a loved one. They don't have any idea how to go on. They may not look at the information packet for days or weeks after the event. And the police officer or mental health professionals could certainly have this information out. But as a survivor myself, I have a certain credibility that others might not in these initial moments. I can reach out to these people. I can put my arms around them and say, 'I've walked in your shoes. I'm here to help when you're ready,'"[205] says Autrey.

In the community, REPS focuses on suicide prevention as well as postvention. The group sponsors educational program in schools throughout the Yampa Valley. The presentations offer information about depression and suicide prevention for the students, the parents and community at-large. In 2010, REPS hosted Bryce Mackie, a college sophomore from the Chicago area. Mackie survived a suicide attempt while in high school when he was severely depressed and did not know what was wrong. Mackie went on to discover that he suffered from bi-polar disorder, and eventually made a documentary about his experience with depression and suicide in young adults. The 12-minute file, *Eternal High*, won 25 awards at the Sundance Film Festival and the SAMHSA Honorable Mention Voice Award for raising awareness of mental health issues.

"Bryce did presentations in the Craig and Haydn schools and did community presentations in the evenings, too. He speaks with his father, which really helps humanize the issues surrounding depression for many of the parents in our community. Bryce takes questions and makes himself available to speak with kids one-on-one after his presentation," says Autrey.

"We always have our school counselors and counselors from either Craig or Steamboat Mental Health on site to talk with students after the presentation. It's amazing that there were kids saying, 'Now I know what's wrong with my dad. I can't wait to go home and talk to my family about what I learned.' We also had students who finally felt it was the right venue to admit that they had been feeling this way themselves,"[206] says Autrey.

In a model similar to the Second Wind Fund, REPS works with the local mental health centers and a private donor to provide free counseling sessions for at-risk students. This donor, Sandy Dye, founded the Jeffrey Allen Dye Suicide Prevention Project at the Yampa Valley Community Foundation, after losing her son to suicide in 2007. Dye has worked closely with REPS and the Yampa Valley Medical Center on suicide awareness and prevention programming.

"Because [all three of our organizations] have a shared interest in this and because of the escalation of self-harm in the community, it became apparent we needed to do something,"[207] says Dye.

The three like-minded organizations joined forces and won an Arthur E. Anderson Community Impact Grant from the United Way to help fund the Yampa Valley Community Mental Health Conference: Building a Caring Community.

"We sat around the table and decided that we needed to pull the community together to deal with all of these issues that are tearing our children apart: drug and alcohol abuse, suicide, bullying,"[208] says Autrey.

The conference addresses cyber-bullying, depression in working-aged men and provide resources about mental health-related topics for community members, youths, educators, mental health and medical practitioners, and health and human services agencies.

In all of these collaborative efforts, Autrey realized that REPS could reach an even greater geographic expanse through additional collaboration. In May of 2011, REPS merged with the Western Colorado Suicide Prevention Foundation.

"We are all doing the same kind of work and rowing in the same direction. Through our collaboration, we can apply for even larger grants and reach people from Grand Junction to Rifle to Meeker to Craig, Hayden, Steamboat and beyond. When these rural areas are covered by a bigger coalition, we can get to places, find the gaps and make sure that people aren't falling through the cracks,"[209] says Autrey.

MONTELORES SUICIDE PREVENTION INITIATIVE: THE PINON PROJECT

While Zeik Saidman was busy consulting with the previously mentioned projects, his colleague, Lisa Carlson, Director of The Centers, advised the Montelores Suicide Prevention Initiative in Cortez, Colo.

This project is sponsored by The Piñon Project Family Resources Center and provides suicide prevention, postvention and intervention education and awareness programs in the southwest corner of Colorado.

The Piñon Project was created in 1994 thanks to the Colorado Trust's Healthy Communities Initiative. The community of Cortez and several surrounding areas held a series of community meetings and determined that there was a need for a family resource center—providing education, information and referrals to families on such topics as medical care, financial assistance, parenting strategies, and more. Today, The Piñon Project provides services to over 7,000 families each year and has grown into the largest family resource center in the state of Colorado.[210]

Diana Buza, Executive Director, recalls the impetus for the Montelores Suicide Prevention Project. "We had a family come in and ask us what we were doing about suicide prevention. At the time, we said, 'We think that's probably a mental health issue. We're really not doing anything about suicide prevention.' But that answer wasn't good enough for me. The next day, I contacted some people and we held a community meeting to see what was happening with suicide prevention,"[211] says Buza.

The findings were disturbing to Buza and the committee. "Nobody knew of anything being done about suicide awareness and prevention in our area. There was no SafeTALK, no ASIST programming, nothing in the schools."

The following month, the Colorado Trust put forth the PCIS Request for Proposals. The citizens of Montelores County organized and were successful in receiving funding for the suicide prevention project.

"It was thanks to a simple question from one person that it came to our attention that there was a serious lack of awareness about suicide in our community and a lack of organized programming to prevent the problem."[212]

Buza encountered similar problems as many of the rural communities partaking in the PCIS program. In Montelores County, suicide was an educational process. The Piñon Project developed a logic model similar to the public health continuum to address the problem. The first step was education. Few people were aware of the alarming suicide statistics in Southwestern Colorado. Many had a tendency to dismiss discussions of suicide awareness for fear of making waves in the small communities or stirring up an issue that was better left alone.

"We outlined three goals that we wanted to focus on for our community: education, prevention and early intervention. With education, we needed to increase the awareness the suicide is a public health problem that is preventable. We needed to increase the number of people who view suicide as a treatable disease,"[213] says Buza.

Buza and her team created a detailed list of populations that were at risk for suicide in the Cortez area. Their gatekeeper trainings included not just mental health professionals, but lay people in educational settings, in the senior communities and in the Native American communities in the area, the Navajo and Ute tribes.

The Project created suicide prevention manuals for doctors, clergy, educators, mental health professionals, police and fire departments, and distributed more than 200 of the manuals in its first year of operation. The team also created manuals and messages tailored specifically to the Native American tribes.

"It took over a year to get two different messages created for the tribes. We wanted the messages delivered in the Navajo and Ute languages. This was challenging because many Native American cultures view suicide differently. Traditionally there was a widespread denial of its existence. The Navajo language doesn't even have a word for 'suicide.' It's difficult to educate people about something that you can't even talk about,"[214]says Buza.

The team kept at it, though, working with representatives from the tribes to craft culturally sensitive messages. They hired local actors and created two public service announcements, which ran on the tribes' radio and television stations. Buza gauges the success of this initiative in two ways. In subsequent years, the Montelores Suicide Prevention Project had multiple requests from members of Native American tribes in New Mexico to use their materials and PSAs. After two years, The Project convinced tribe elders to hold an ASIST training at the reservation. Despite the taboo nature of suicide, the ASIST training had an attendance record of over 80% when held. The Ute Mountain tribe went on to host its own suicide prevention summit in 2009 and invited the Montelores Suicide Prevention Project to present at the event.

From its inception, the goal of the Montelores Suicide Prevention Initiative was to build sustainability in the community. After successfully shepherding SafeTALK and ASIST trainings into local schools, members of the Project forged a partnership with the School Community Youth Coalition in Cortez. The School Community Youth Coalition began in 2000, and its capstone project was the Teen Maze of Montezuma and Dolores counties, launched in 2001. The Teen Maze is a life-sized game board where teenagers are the pawns and life's choices are the dice. Teen Maze is designed to help teens better understand potential outcomes to life decisions concerning sex, substance abuse, and vocational/educational issues. Realistic scenarios help teens navigate their way through the Maze and find out about consequences of behaviors. The Maze is held yearly and open to youth in Southwest Colorado.

The Coalition first saw the Teen Maze program in Arizona, and proposed the program be moved to the Four Corners area. Missy Miller, one of the event coordinators says:

> "The Teen Maze is only for youth. It gives factual info. When kids are out of the maze, they can make good decisions."
>
> The School Community Youth Coalition invites schools and specific groups, such as 4H, to travel to the Teen Maze. There is no admission to the Teen Maze.
>
> "All participants are given a specific scenario, set up as a maze, and they must navigate through the Maze and see the real consequences of their actions," Miller explained.

> She added, "We focus on the effects of their choices including the array of consequences." The Teen Maze is used to encourage the youth to talk to their parents in a fun and factual way. The community is a large part of the Teen Maze as well.
>
> Miller stated, "The entire event is done by volunteers. It is an important enough event that the community puts many resources into it. "They can also talk to the community and their family members." "The great thing about the Teen Maze," Miller continued, "is those in the Maze can receive factual information on challenges in their real lives without being judged. They can actually see the consequences of their choices in relation to the real world."[215]

The Montelores Suicide Prevention Initiative is one of those community resources mentioned by Miller. They group hosts a Suicide Prevention room in the maze, where students learn about the signs of suicide and what they can do if they recognize those signs in themselves or someone else.

"The Teen Maze is just one of many programs that has helped us build sustainability. It's not just about financial sustainability. It's about reaching groups like the teenagers who will learn these lessons and pass them on to their families, their peer groups or the community,"[216] says Buza.

MIDWESTERN COLORADO SUICIDE PREVENTION/INTERVENTION COALITION: MIDWESTERN COLORADO MENTAL HEALTH

Jeanne Rohner, former CEO of Mental Health America of Colorado, provided guidance to two other PCIS/Trust-supported projects.

"MHAC was approached by the Colorado Trust when the PCIS initiative began. We had worked with the Trust on the Colorado LINK program, and we had forged a partnership that worked very well. The Trust always hired outside contractors to manage its initiatives. When the University of Colorado at Denver Centers applied to be the coordinating agency, the Trust requested that they partner with MHAC. The first three years of the initiative MHAC and the Centers worked very intensely together,"[217] says Rohner.

Rohner herself advised the Midwestern Colorado Suicide Prevention/Intervention Coalition sponsored by Midwestern Colorado Mental Health. This coalition provides suicide prevention outreach and training in Montrose, Delta, Ouray, San Miguel, Gunnison and Hinsdale counties. Midwestern Colorado Mental Health (now known as The Center for Mental Health) was founded in Montrose in 1964 to be a leader "in providing excellent behavioral health services for and with the communities of Western Colorado."[218]

Carol Jean Garner, director of non-clinical services at the Center has been working in suicide prevention for more than 30 years. Over the years, Garner became concerned that teens were growing up and becoming adults without the necessary skills to cope with their problems. It led her to push Diane Ryerson-Peake's SafeTEEN program into the local schools' curriculums.

"We took Diane's program and adapted it to our local needs. As long as you keep the basic parts of the program, you maintain its fidelity. We have been able to add a multitude of peer approved visuals including a PowerPoint activity. SafeTEEN has been one of the best school suicide awareness programs

we've used. We serve six counties and have had cooperation from all of our school systems. This has allowed us to reach over 1,600 students,"[219] says Judy Schmalz, the Suicide Prevention Coordinator for The Center for Mental Health.

The Midwestern Mental Health suicide prevention programming has expended significant energy in identifying and reaching traditional and non-traditional gatekeepers in the surrounding communities. "We're in a unique position, because many of the organizations doing gatekeeper training need to partner with other agencies to back up the training—to provide the needed treatment for those identified as being at-risk for suicide. Because we treat patients and clients, we are in a very good position to deliver a complete training and treatment program," says Schmalz.

The PCIS grant propelled this programming forward and allowed for the founding of the Suicide Prevention/Intervention Coalition. Today the coalition is a program of the mental health center and is an entirely grant-funded program with a paid staff person, Judy Schmalz, and 10 volunteers. The coalition supports programs to schools, senior centers, primary care physicians and others, and offers postvention support groups.

Just as the group customized the SafeTEEN program to meet the needs of the local communities, Schmalz and her team have worked to customize their gatekeeper training to target non-traditional gatekeepers specific to the six-county area that they serve.

"We conducted QPR trainings with the staff and rangers at Black Canyon of the Gunnison National Park [in Montrose]. This was an isolated area where people were driving their cars or jumping over the side and into the canyon. The Park Service people had no idea how to handle this, and we felt that a QPR training could help them immensely to recognize the signs or suicide and perhaps head off another tragedy,"[220] says Schmalz.

Schmalz's team has reached out to recreational districts in Crested Butte, Norwood and Gunnison to provide suicide awareness training to the recreational district staff that interacts with the public every day in community programs and at local community centers and swimming pools. Schmalz also pushed to deliver a SafeTEEN session to the cadre of teenage lifeguards employed at these pools.

The Midwestern Suicide Prevention/Intervention Coalition has reached out to area veterans to help troops returning from global conflicts to deal with domestic abuse and depression and to increase suicide awareness. ASIST trainings have been given to law enforcement dispatchers, the Colorado Workforce office employees who are dealing with individuals seeking work and navigating unemployment benefits, and the local Human Resources Council, comprised of H.R. professionals who are frequently involved in firings and employment disputes, which could serve as triggering incidents putting people at risk for suicide.

Gatekeeper training programs like those offered by the Midwestern Suicide Prevention/Intervention Coalition were a key component of the Colorado Trust's Preventing Suicide in Colorado initiative. The evaluative report published in 2007 at the conclusion of PCIS was called *Gatekeepers: Helping to Prevent*

Suicide in Colorado. The report addressed an often-asked question regarding gatekeeper training, "What do gatekeepers do with their training after it is completed?"

According to the report:

> The intent of this evaluation was to determine if people trained as gatekeepers use the skills they are taught to positively intervene so that potential suicide deaths are avoided and at-risk individuals are referred to professional services. Ten Colorado communities participated in this initiative, representing 32, or one-half of the state's counties. Over a three-year period, about 1,300 gatekeepers were trained across Colorado through this effort. Of these 1,300 gatekeepers, 570 participated in this evaluation. Most of these trainees used their gatekeeper skills to help individuals at-risk of suicide. Forty-four percent intervened at least once; 13% reported they had intervened more than once.
>
> The findings indicate that the strategy of gatekeeper training is a successful suicide prevention strategy. In other words, the findings provide hope that the longer-term effect will be to reduce the numbers and rates of suicide deaths and attempts.
>
> *Suicide in Colorado* found that at least half of the people at-risk for suicide in Colorado do not seek any type of professional help. The report recommended that communities "respond to this problem by building on existing resources to create a more focused network of formal and informal sources of support that can readily recognize those at risk, ensure that appropriate services are available and used, and link providers to ensure efficient and effective service delivery."
>
> Through the planning process, stakeholders in all 10 sites were interested in training community members to become gatekeepers. The logic of this community approach is based on the premise that suicide behavior has signs and symptoms that can be learned and recognized by non-mental health professionals. It follows that if more people know these signs and symptoms, and how to intervene, there would be an increase in identifying people who are at-risk of suicide.[221]

SUICIDE PREVENTION AND ADVOCACY COALITION: SUICIDE PREVENTION PARTNERSHIP OF THE PIKES PEAK REGION

Similar gatekeeper training efforts were part of the comprehensive suicide prevention programming offered by the Suicide Prevention Partnership of the Pikes Peak Region. Many of the SPPPPR programs were discussed in an earlier section titled "Suicide Prevention Partnership of the Pikes Peak Region: Targeting At-Risk Populations" on pages 29-31. According to a 2009 *Denver Post* editorial written by Zeik Saidman, "Jeanne [Rohner's] expertise has been invaluable to the Pikes Peak Partnership in Colorado Springs, which is working to expand its relationship with Fort Carson to provide suicide prevention training on the base."[222]

VOZ Y CORAZON: MENTAL HEALTH CENTER OF DENVER

Finally, the Colorado Trust provided funds to the Mental Health Center of Denver to launch the Voz y Corazon Suicide Prevention Program. Dr. Lydia Prado, the Director of Cultural Competency at the Mental Health Center of Denver and Voz y Corazon's program director, was concerned that according to the Centers for Disease Control, Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts than their White, non-Hispanic or Black, non-Hispanic peers.

"These girls often report not knowing 'how to be.' They do not feel quite accepted by the majority culture and yet they are different enough from their home culture that they don't feel that they quite belong there either. It's a challenge for these young women to develop a solid bicultural identity wherein all parts of themselves are valued and celebrated, where their heritage is honored as a strength and their joining with mainstream culture is supported,"[223] says Prado.

Voz y Corazon Suicide Prevention Program was founded to meet the need within this demographic of the Hispanic community in west Denver. Voz y Corazon's mission is to change how Latina youth think and feel about themselves. The program is a culturally responsive support, education and prevention program designed to teach Latina youth to recognize and respond to the signs of suicide in themselves and their peers.

Program directors have enlisted local artists and community members to mentor the teens and help them with self-expression through artwork. The groups host an annual teen art show and benefit at which participants' artwork is professionally displayed and available for purchase by attendees. Through fundraising programs like this and the original financial support from The Colorado Trust, Voz y Corazon has served over 1,000 Hispanic teens and young adults since its inception in 2004.[224]

At the end of the first grant cycle (2002-2006), the Colorado Trust realized there was still much work to be done. Many of the PCIS initiatives had undertaken an extensive planning process and were just getting their feet wet in the specifics of their individual programming in 2006. The Trust increased its level of commitment and extended the PCIS program until 2009. When the seven-year program drew to a close, the Colorado Trust had provided $4.9 million to increase the overall effectiveness of suicide prevention efforts throughout Colorado.

OFFICE OF SUICIDE PREVENTION IN FINANCIAL DANGER

Amidst all of the generous financial support from The Colorado Trust, the Office of Suicide Prevention, just two years into its existence, was facing its own funding dilemma. Members of the 2001-2002 Colorado Joint Budget Committee mistakenly thought the Colorado Trust was going to fund the Office of Suicide Prevention.

According to a paper written by Scott Moore, a Associate Professor of Political Science at Colorado State University, "In the midst of the 2002 legislative session, economic downturn and short revenues combined with recently constructed revenue and budgeting institutions (both Constitutional and statutory) to disorient budgeting from its relatively straightforward decision rules and roles."[225]

During 2001, the Joint Budget Committee had cautioned their colleagues that 2002 would be a very tight year and general fund revenues were predicted to expand only 4 percent, versus the typical 9-10 percent annual growth in the 1990s. Ironically, the predictions were even more optimistic than the financial realities. In 2002, the General Fund Revenues were down by -10.7% from the prior year.[226]

The 2001-2002 budget overages combined with the general fund revenue shortfalls spilled onto the 2002-2003 budget decisions

"Nobody had a stomach for making cuts as lobbyists and legislative advocates played a vigilant game of defense all session. Ultimately, it defaulted to the legislature's Joint Budget Committee to forge short term fixes for the state's financial problems."[227]

The Joint Budget Committee developed a list of $761 million in potential cuts[228] and drafted a set of bills to cut even more deeply with specifically targeted programs rather than across the board cuts. One of these programs, funded as a line item in Colorado General Fund, was the Office of Suicide Prevention.

Upon receiving word of the potential budget cuts, community advocates immediately organized. Some made phone calls to legislators across the state requesting that the dollars for the Office of Suicide Prevention be restored to the budget. Other advocates stormed the steps of the Capitol. Representatives from the Suicide Prevention Coalition of Colorado approached Brad Young, the Joint Budget Committee's Chairperson, and the other five members of the committee.

"Stephannie Finley volunteered to help me, Jim Earle and Dar and Dale Emme. She gave us a quick tutoring session on lobbying and led us around the Capitol. We were on our way to see John Witwer, a member of the JBC. Stephannie was getting ready to get Representative Witwer so that I could talk to him, and she asked me for my Coors business card. [Rice was the Manager of Prevention Partnerships and Programs for Coors Brewing Company.] I said, 'But I'm not here representing Coors.' Stephannie knew that the Coors name would get Witwer out of his meeting. It did and I was able to introduce myself as a member of SPCC and plead our case for the OSP,"[229] says Deanna Rice.

Following such a public outcry, the JBC called an emergency meeting. "The Committee reconvened and voted 5-to-1 to put the money back into the budget that very night. I was told it was the first time an emergency reinstatement had ever happened,"[230] says Rice.

WINGS OF HOPE: SPCC'S STATEWIDE SUICIDE PREVENTION CONFERENCE

With the regular funding restored to the Office of Suicide Prevention, Shannon Breitzman and representatives from the Suicide Prevention Coalition of Colorado began work on the first statewide suicide prevention conference in Colorado since the conferences of the late 1980s organized by S.P.A.R.E. SPCC volunteers such as Sharon Wink, Jo Mosby, Karen Johnson, Doris Walker and others, contacted grief support and prevention groups across the state with personal invitations to the conference.

Sharon Wink, who lost her oldest son to suicide in 1995, had a personal interest in increasing awareness and training within the educational and medical communities. Wink holds a Master's degree in counseling and served as the Director of Counseling at Arapahoe Community College for many years.

"I came at prevention efforts from a fairly unique position because I was a trained mental health worker, but I was also a survivor of my son's death by suicide. In my daily job responsibilities, I dealt with students who were suffering from depression and great anxiety. I saw in my professional life how pervasive this problem could become if not addressed,"[231] says Wink.

Wink became concerned that college and university faculty and staff were not being properly trained to deal with depressed or suicidal students. She held presentations for the faculty at Arapahoe Community College.

"There are many people who are frightened of the word 'suicide' and the idea of it. However, we did find some instructors who brushed this fear of the unknown aside and were willing to receive training and step into the emotional lives of students when it was necessary. Those people became great resources for referring students to the counseling center,"[232] says Wink.

Wink also brought in mental health professionals from the community who worked with depressed and suicidal people to train her staff at the counseling center. "We found a few of our staff at the counseling center who were comfortable working with at-risk students and mental health problems. We tended to funnel our most at-risk students through those individuals," says Wink.

At the same time, Wink's daughter was attending nursing school. Wink noticed that suicide prevention awareness and training was not a mandatory part of the curriculum for nurses and physicians.

"My daughter didn't receive any suicide prevention training in nursing school. With the loss of her brother, she was acutely sensitive to this gap in her education. It needs to become a part of the basic fabric of training for anybody who works with human beings on a daily basis—nurses, doctors, teachers."[233]

SPCC contacted doctors, nurses and educators, hoping to engage them in conversations about the issue of suicide prevention.

"We brought in suicide prevention and suicidology experts for a variety of breakout sessions. We also specifically geared sessions toward these medical and educational professionals. We asked pointed questions like, 'What are the problems you run into concerning the issue of suicide? When do you feel stymied or as though there are too many obstacles for you to be effective?' We tried to find out where the gaps in training and resources existed so that we could find pathways for these professionals to be effective gatekeepers."[234]

The first "Wings of Hope" conference was held in Denver in May of 2002 and had over 200 attendees. The conference re-invigorated the desire for statewide conversation and exchange of ideas that would continue for another five years.

Along with the annual Wings of Hope Conference, SPCC started its annual fundraiser Prisms of the Heart. In 2003, SPCC received a matching grant from The Colorado Trust in the amount of $20,000, which allowed the Coalition to hire its first part-time coordinator, Brenda Gierczak. The Coalition received this grant funding until 2005. SPCC's matching funds came primarily from its Prisms of the Heart fundraisers. As the Coalition's first staff person, Gierczak was instrumental in training the SPCC Speaker's Bureau, facilitating Town Hall meetings in Colorado's rural communities and assisting the Coalition with its annual conference and fundraising events.

Meanwhile, Shannon Breitzman worked to expand the reach of the OSP beyond the borders of Colorado. 2002 marked the first year that Breitzman was invited to present at the American Association of Suicidology national conference in Bethesda, Md.

"I was participating in as many national things as possible. It was important to constantly be around the people who were doing the work. This meant not only reaching out to preventionists in Colorado, but collaborating with suicidologists on a national level."[235]

Breitzman was invited to participate on a national think tank coalesced by the National Institute for Mental Health on the science of public awareness campaigns for suicide prevention.

"As a group, we determined that it is not helpful to just display the data regarding suicide. This strategy doesn't have a long-term effect as far as raising awareness or changing behaviors. We did a lot of studying about social marketing—how to present the problem of suicide on a national stage," says Breitzman.

While the National Institute for Mental Health studied the implications of a national public awareness campaign, the Education Development Center, Inc., received funding from SAMHSA to establish the Suicide Prevention Resource Center (SPRC). The Education Development Center serves as a clearinghouse for national resource centers in the areas of mental health promotion, injury and violence prevention, and substance abuse prevention. These centers include Children's Safety Network, the National Center for Mental Health Promotion and Youth Violence Prevention, and the Higher Education Center for Alcohol and Other Drug Prevention. Given the collaborative nature of the EDC, each finite center benefits from the knowledge and expertise of its counterparts.[236]

The SPRC was founded on the premise that science, skills and practice could be used to advance the National Strategy for Suicide Prevention. The SPRC was the first federally funded center of its kind. Staffed by experts in mental health, public health, communications, technology and education, the SPRC was its own think tank. It provided prevention support, training, and resource materials to strengthen suicide prevention networks and fulfill Objective 4.8 of the National Strategy for Suicide Prevention, which called for the development of "one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs."[237]

NATIONAL VIOLENT DEATH REPORTING SYSTEM

The Suicide Prevention Resource Center was founded in response to the National Strategy for Suicide Prevention. Also in response to the NSSP, several other federal agencies, (the National Institute of Mental Health, the National Institute of Drug Abuse, the Veterans Administration, the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and the National Institute on Alcohol Abuse and Alcoholism) joined together to fund an Institute of Medicine study in an effort to explore new directions for the field of suicidology. The study committee formed the Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide to examine the state of the science base, gaps in our knowledge, strategies for prevention, and research designs for the study of suicide. A committee was created with a broad range of expertise, including neuroscience, genetics,

epidemiology, sociology, anthropology, psychology, psychiatry and community interventions. While some members of the committee were experts in suicidology, the committee also included many who were not suicidologists but whose relevant expertise could contribute to a fresh view of the subject.

The committee was asked to address several tasks:

- An assessment of the scientific components of suicide including cognitive, affective, behavioral, sociological, epidemiological, genetic, epigenetic, and neurobiological components and an examination of the vulnerability of specific populations and age groups.
- An evaluation of the current status of primary and secondary prevention including risk, protective factors, and issues of contagion. Access to methods of suicide and the availability of emergency interventions will be considered.
- Strategies for studying suicide.
- Conclusions concerning gaps in knowledge, research opportunities and strategies for prevention of suicide.[238]

The resultant report of the committee's findings was published by the Institute of Medicine of the National Academies of Science is titled *Reducing Suicide: A National Imperative*. The report included four main recommendations by the committee. One recommendation was that the National Institute of Mental Health (in collaboration with other agencies) should develop and support a national network of suicide research 'Population Laboratories' devoted to interdisciplinary research on suicide and suicide prevention across the life cycle.[239]

> Surveillance is a cornerstone of public health, allowing realistic priority setting, the design of effective prevention initiatives, and the ability to evaluate such programs (Institute of Medicine report on Reducing the Burden of Injury, 1999). Non-uniformity in reporting suicide across jurisdictions introduces inaccuracies into data on prevalence and confounds the analysis of risk and protective factors. Ideally, coroners and medical examiners should receive uniform training to standardize diagnosis and information about suicide. However, given the limitations of funding, jurisdictional purview, and the influences of stigma and religion, the committee recognizes that this is unlikely to happen soon. The quality of data for suicide attempts is even less reliable than for completed suicides. The need for improved and expanded surveillance systems for suicide is highlighted as one of the central goals of the National Strategy for Suicide Prevention. National surveillance programs for HIV/AIDS and for motor vehicle deaths are currently in place and provide nationwide data that help form policies for prevention (see Chapter 10). Currently no such national program for suicide deaths or attempts exist. The National Violent Death Reporting System provides a promising framework that might be expanded into a national program that would provide the database for suicide deaths.[240]

In response to the *Reducing Suicide* report the National Violent Death Reporting System (NVDRS) was launched in six states in 2002. The Centers for Disease Control received funding from the federal government to launch the pilot program in Maryland, Massachusetts, New Jersey, Oregon, South Carolina and Virginia. Prior to the NVDRS, details about homicides and suicides resided in several different locations: the files of coroners, investigators, police officers and medical examiners. Unfortunately, the facts were not always collected in a uniform manner and were sometimes left out of files altogether.

The NVDRS gathers and links information from all of these sources and from death certificates by following a standard protocol. By cross-referencing the reports of these professionals, information about a violent death is pooled in an anonymous database. This database allows preventionists in the injury and violence realms to place a violent death into context, hopefully giving some idea as to why it occurred. According to the Centers for Disease Control and Prevention, "For suicides, circumstances may include a history of depression or other mental health problems; recent problems with a job, finances, or relationships; or the recent death of a family member. Information about circumstances will describe trends for specific types of violence and will help to target prevention activities."[241]

By 2003, the CDC expanded the program to include 17 states. The second phase included participation from Alaska, California, Connecticut, Georgia, New Mexico, North Carolina, Oklahoma, Rhode Island, Utah, Wisconsin and Colorado.

"Prior to joining the NVDRS, we were working off of death certificate data in our epidemiological analysis of suicides in Colorado. Death certificates were the only information that we had available to us. They would tell us the age, gender, race and ethnicity of the deceased person and the method of death, but they didn't tell us the story behind the event. 'Why was this person choosing this particular option? What else was going on in this person's life before they died?' We were able to look at general demographics, but not examine risk factors that may have led to the suicide,"[242] says Dr. Holly Hedegaard, the Data Program Manager for the Emergency Medical and Trauma Services Section of the Colorado Department of Public Health and Environment and the Director of the Colorado Violent Death Reporting System (CVDRS).

With the inception of the Violent Death Reporting System, Hedegaard and her staff were able to compile more detailed analyses of suicide deaths. The Department could ask specific questions about suicide trends: the number of people who had a diagnosis of mental health problems, the number of people who were having intimate partner problems before their death, the number of people who had visited their physician the week immediately preceding their death. Examining this data allowed Hedegaard to work with the Office of Suicide Prevention and other state and local violence prevention practitioners to guide prevention programs, policies and practices.

A specific example of this targeted, data-driven research occurred when Hedegaard noted that a large number of suicides were occurring in working-aged men (ages 25-54). After sharing this information with the Office of Suicide Prevention and the Carson J Spencer Foundation, which was founded in 2005, the groups began a marketing and outreach campaign specifically targeting males in this age group. "We were able to think about what type of messages might work for men. We realized that we had to make the campaign not too touchy-feely and with a public awareness message that would encourage men to ask for help,"[243] says Hedegaard.

The CVDRS also began a data-linking collaboration with the Veterans Administration. The VA maintains its own in-depth database of suicidal occurrences in the armed forces. Hedegaard provided the VA with a list from the CVDRS of all the suicide deaths in individuals (ages 18 and over) from 2004-2008. Through a secure process, the VA ran the social security numbers of these deceased individuals through the

national VA database to determine veteran status. The VA cross-referenced those with veteran status to the CVDRS data set to determine a range of additional variables on each individual (employment status at the time of death, whether individuals had accessed medical care through the VA or another location, etc.

The data sharing allowed the team to pinpoint how many of the suicide victims had been seen at a VA facility for any type of care in the weeks of months prior to their death. Determining information such as this allows the VA to develop better screening tools for recognizing at-risk individuals and perhaps intervening before a suicide attempt.

In another study, the CVDRS was able to focus on suicide means within jail and prison settings. After several suicide deaths occurred in one year at a Colorado county jail, the Colorado Department of Corrections requested details about the methods of death. Hedegaard's was able to determine that all of the suicides were self-strangulations with socks. Thanks to the detailed accounts of the deaths accessible via the CVDRS database, the jail was able to conduct a strict limitation of means. By changing the type of footwear for inmates, the jail could make it impossible for suicide deaths to occur with the jail-issued socks.

In addition to these tangible recommendations and changes in suicide prevention resultant from the Colorado Violent Death Reporting System's data, Hedegaard believes that Colorado has seen intangible benefits as well.

"I believe that because of the CVDRS, the Health Department has strengthened its relationship with coroners and law enforcement. Before the CVDRS, we didn't have a reason to contact these groups after a death. The coroners would fill out a death certificate, and we would simply receive it in the mail. Now, we are collaborating with coroners and medical examiners to determine the details of each death. This has allowed for cross-platform knowledge sharing. Now, we have a retired county coroner on our Board, and I have learned so much information with regard to investigative practices from her,"[244] says Hedegaard.

"We have also been able to increase public awareness of suicide through our connections with law enforcement agencies. We give presentations to these groups about suicide and can provide them with hard evidence about trends in Colorado. It is thanks to the CVDRS that these partnerships have been strengthened in Colorado,"[245]says Hedegaard.

SUICIDE PREVENTION IN SCHOOLS

2003 was a banner year for mental health and suicide awareness and prevention in the schools. First, the Active Minds program established its first chapter in Colorado. Active Minds is a student-run, grassroots organization whose goal is to decrease the stigma surrounding mental health issues and increase mental health awareness among college students. The organization was founded in 2001 by Alison Malmon, then a junior at the University of Pennsylvania, following the suicide of her brother Brian. According to the Active Minds website, Malmon was "troubled that her brilliant and popular brother had struggled with depression in silence, even though he maintained a full schedule of extra

curricular activities and a superior grade point at Columbia University, Alison was convinced that stigma and lack of information kept Brian from seeking help. Determined to combat the stigma and address the lack of awareness about mental illnesses that most often strike young people at the pinnacle of their educational careers, Alison launched a program to promote mental health awareness on her campus."[246]

Today, Active Minds has more than 300 chapters on college campuses throughout the United States. The first Colorado chapter was founded at Front Range Community College in Westminster. In 2011, Colorado has six active chapters of Active Minds at: Front Range Community College, Pikes Peak Community College, Regis University, University of Colorado at Colorado Springs, University of Colorado Denver and the University of Northern Colorado.

The chapter at Colorado State University, now considered inactive, got off to an exciting start. The then president, Shannon, a student at CSU stated:

> It has been 11 short months since Active Minds at Colorado State University began, and I still can't believe the strides we've already made to reduce the stigma of mental illness on our campus. With almost every one of our officers having a diagnosable mental illness, Active Minds at CSU is very familiar with the struggles of students with mental health needs. We've strived to accommodate those students by not only advocating for their needs, but also by educating our peers. We've done this through a variety of fun, educational and supportive programs.
>
> Some of the programs we began in 2005 include our monthly Movie Madness, in which we show a mental health related movie, followed by a panel discussion with mental health professionals and individuals who have experienced the issue depicted in the film. Last year we won an award for Movie Madness from our university for Best Social Consciousness Program. We've also started a depression/anxiety peer support group for students, in coalition with the counseling center.
>
> Since we began in October of 2005, we have grown to over 30 active members, with more than 200 members on our email list serve. We've had appearances in three Colorado newspapers, including our school paper, *The Collegian*, the *Fort Collins Coloradoan* and the *Denver Post*. We've also been featured on our school's TV station and radio station.
>
> With a school of more than 24,000 students, we have found exposure to be our biggest hurdle. To solve this issue, we recently formed a publicity committee to advertise our events. This committee has since utilized numerous outlets to get the word out, including flyers, online newsletters, Facebook invitations, and announcing events in classes. Last week we recognized National Suicide Prevention Week, and for the first time we saw our media hype pay off. Students, faculty and staff showed up to all four of the events we had planned for the week, including a hugely successful Suicide Remembrance Candlelight Vigil. We handed out more than 300 Suicide Prevention Yellow Ribbons on our plaza and gave students information about our counseling center and the National Suicide Prevention Hotline. It was a great start to the 2006 school year, and we're looking forward to an extremely successful year.[247]

As with other student-directed programs, participation levels in the Colorado State University Active Minds chapter has fluctuated. Given the impermanent nature of student geography and the competition of other clubs and events, it is hard to maintain continuity with chapters. In spite of waning participation in recent years, during the peak of CSU's Active Minds chapter's participation, Kathleen McKinney examined Active Minds as part of her master's thesis research. According to an

article posted in the *Washington Post* online, McKinney found that "participating in the group's activities lessened the stigma that students associated with mental illness. 'In only an eight-week intervention time, [I was] able to show that there were some differences' in the students attitudes, said McKinney, now an instructor at Colorado State and faculty adviser for its Active Minds chapter."[248]

SAFE2TELL: AN INNOVATION IN VIOLENCE PREVENTION

2003 welcomed another school-based innovation, thanks to the perseverance of one woman and the financial generosity of the Colorado Trust. Since the early 1990s, Susan Payne, a law enforcement officer in Colorado had been working as a School Resource Officer, teaching children about ethics, drug abuse and school safety.

In spite of her good work, Payne was frustrated. Having developed a trusting relationship with the student population, Payne learned that many students had witnessed the signs of violent events before they occurred. Friends may know about self-destructive behavior or suicidal thoughts in a student when parents and educators do not. Other may have heard about planned car thefts or community mayhem before it occurred. However, Payne and others discovered that students were afraid to come forward with vital information because they did not want to be seen as snitches or want to suffer the repercussions if identified as the tipster.

Payne created a local hotline in Colorado Springs for students to report their tips anonymously. The program grew exponentially, and in 1999, Payne presented her program to Colorado Attorney General Ken Salazar with a recommendation for replicating it statewide. Salazar supported Payne's ideas and pushed for the establishment of a statewide hotline reporting concerns of community violence. In the following years, the shootings at Columbine occurred and the Governor's Columbine Review Commission corroborated Payne and Salazar's concerns about anonymity for callers.

According to the Colorado's Trust report *The Story of Safe2 Tell, "*in 2003, the Colorado Trust awarded a $375,000 grant to establish Safe2Tell; that year, a board had formed and Payne was appointed Program Director of Safe2Tell. In 2006, The Trust's second $375,000 grant helped expand the program; Payne was named Executive Director of Safe2Tell and became the first Special Agent with the Colorado Department of Public Safety-Homeland Security to focus on school safety. Safe2Tell's founders knew that a 24/7 hotline—with live, well-trained operators—was critical to the program's success. Colorado State Patrol Chief Mark Trostel immediately supported the program; he committed his dispatchers to answer all calls to the new hotline and arranged the Safe2Tell director's salary to be covered by the patrol's Homeland Security division."

"On September 14, 2004, the Safe2Tell hotline started taking calls. Since then, the number of calls and solid leads has grown. In each of the first two years, Safe2Tell received and followed up on about 100 tips. That number nearly tripled in the third year to 286, and in the fourth year grew to 531. Now, operators are receiving some 100 calls a month, nearly as many as they received in a single year when Safe2Tell was getting started." [249]

According to Jo McGuire, the Program Director at Safe2Tell, there are two distinct things that set Safe2Tell apart from other suicide prevention or school safety hotlines. 1) Safe2Tell follows up on every tip. According to McGuire, many hotlines send out reports about their received calls but do not close the loop on each case. Safe2Tell works in conjunction with schools, local law enforcement and the state police.

"We are functioning under the Attorney General's office, and all of our dispatchers are trained state patrolmen and women. We have the ability to say, 'We need the report. We need to know what type of intervention has occurred.' Under the information sharing laws that were developed after Columbine, we have been able to produce comprehensive reports about what action is taken after we receive a tip,"[250] says McGuire.

Safe2Tell's trained dispatcher accept calls about a variety of issues including domestic violence, child abuse, assaults and harassment, sexual assault and misconduct, alcohol and drugs use, weapons, stealing, arson, bullying, animal cruelty and suicide threats.

"When it comes to a suicide threat, a student can call on behalf of a friend. Many hotlines are trained to deal with the first party—the person whose life might be in danger. Our dispatchers are trained to deal with friends who might provide tips about self-mutilation or suicide threats. We have the manpower to get someone out to intervene in these situations, and we pull in third parties like the national suicide prevention hotline when needed. Our dispatchers are the first line of defense in diffusing situations, and then they pull in the professionals needed to ensure that students are getting help,"[251] says McGuire.

In 2010, Safe2Tell intervened in a suicide attempt thanks to a call-in tip. The Safe2Tell hotline received a call from a female student who was worried when her friend didn't show up at school that day. The caller said the friend had texted to ask, "What would you do if you never saw me again?" Safe2Tell contacted the school and local law enforcement and found that the girl had overdosed at her house. "We were able to save her because of a concerned friend. We've saved so many."[252]

By 2008, Safe2Tell had received more than 3,900 calls, which netted 1,194 solid tips leading to better schools and safer communities. The dispatchers deal with school counselors, law enforcement, teachers and families to focus on awareness and early intervention and to determine what action needs to be taken to help students, parents and school faculty facing a threat of violence.

Further helping Safe2Tell's efforts, in 2007, the Colorado General Assembly passed Senate Bill 07-197, ensuring the anonymity of persons reporting to the hotline and confidentiality of Safe2Tell records. Each year, schools put their own spin on the Safe2Tell program. Each school within a district receives Safe2Tell posters in English and Spanish along with access to training programs. Student chapters spread the word by wearing rubber bracelets engraved with the Safe2Tell hotline number, performing skits, creating local school Safe2Tell websites and holding awareness programs in their schools.

"Safe2Tell's prevention model is working. With chapters in schools across the state, Safe2Tell is a conversation jump starter. We encourage classroom discussion about depression and high-risk

behaviors," says McGuire. "Not only is it preventing violence in our communities, but we have saved lives—students who were contemplating suicide—because of anonymous tips. After Emily Keyes lost her life in the tragedy at Platte Canyon in Bailey, we had a student riding a bus who threatened to kill himself. Someone riding the bus overheard the student and called in a tip. We were able to intervene and connect the student with counseling. The school counselor believes that this student was serious about his suicidal statements. Without Safe2Tell, it's possible that no one would have noticed the warning signs. But because this anonymous bus rider felt safe to call-in a tip, the boy is still alive today."[253]

ADDITIONAL CHANGES KEEP SUICIDE PREVENTION EFFORTS GOING STRONG

2003 ushered in a staffing change at the Office of Suicide Prevention. After three years at the helm, Shannon Breitzman became the Director of Injury and Suicide Prevention Programs at the Colorado Department of Public Health and Environment, including sexual assault, violence, suicide, motor vehicle crashes and fall prevention. Cindy Hodge became the Program Manager for the Office of Suicide Prevention. Hodge worked in the field of mental health and child welfare for more than 13 years. Her professional experience focused primarily on crisis intervention, suicide/threat assessment, family and individual therapy and trauma response. During her year leading OSP, Hodge became a Master Trainer for the Applied Suicide Intervention Skill (ASIST) training curriculum and spoke extensively on crisis intervention and suicide awareness and prevention. After her tenure at the OSP, Hodge went on to become the Vice President of Training for LivingWorks, the parent company for the ASIST program.

In 2002, the President's New Freedom Commission on Mental Health was established by Executive Order 13263. The hope was that a nationwide mental healthcare system reform would result. It was recognized that extensive barriers caused inequality in access to care for the 54 million Americans with mental and physical disabilities. The result of the Commission's year-long study was the report, *Achieving the Promise: Transforming Mental Health Care in America.* The report was released in 2003, and describes a strategy for mental healthcare transformation that ensures services and supports that actively facilitate recovery and build resilience. It identifies six goals of transformation and highlights model programs to illustrate goals in practice which included. The main topics addressed were reduction of stigma surrounding mental illness, disparity in mental health accessibility, early mental health screening for all populations, the use of technology to improve access to care and service delivery and research driven by evidence-based practices.[254] It was clear from the report's goals that mental health care in our country was in dire need of reform.

Addressing the need for evidence-based practices discussed in *Achieving the Promise*, the newly formed Suicide Prevention Resource Center joined forces with the American Foundation for Suicide Prevention to launch the Evidence-Based Practices Project (EBPP). This program was launched to identify and disseminate information about evidence-based suicide prevention programs. By 2005, SAMHSA's National Registry of Evidence-Based Programs and Practices began reviewing and listing suicide prevention interventions. In 2007, the EBPP would evolve into the Best Practices Registry for Suicide Prevention to disseminate information about best practices. Today the Best Practices Registry is organized into three sections, each with different types of best practices:

- Evidence-Based Programs list interventions that have undergone evaluation and demonstrated positive outcomes.
- Expert and Consensus Statements list statements that summarize the current knowledge in the suicide prevention field and provide best practice recommendations to guide program and policy development.
- Adherence to Standards list suicide prevention programs and practices whose content has been reviewed for accuracy, likelihood of meeting objectives and adherence to program design standards.[255]

Colorado would eventually have three programs accepted in the Adherence to Standards list:

- Ask 4 Help Suicide Prevention for Youth—Yellow Ribbon
- Be a Link Suicide Prevention Gatekeeper Training—Yellow Ribbon
- Working Minds Suicide Prevention in the Workplace—Carson J Spencer Foundation

The Yellow Ribbon Programs were discussed at length in the Yellow Ribbon section on page 29. The Working Minds Suicide Prevention in the Workplace will be discussed in more detail in the Carson J Spencer Foundation section on page 86.

Globally, the fight for suicide prevention continued with the first World Suicide Prevention Day on September 10, 2003. World Suicide Prevention Day is an International Association of Suicide Prevention initiative in collaboration with the World Health Organization. The global day brought attention to the epidemic problem of suicide in the world and encouraged prevention groups across the globe to host activities that call attention to the global burden of suicidal behavior and to discuss local, regional and national strategies for suicide prevention, highlighting cultural initiatives and emphasizing how specific prevention initiatives are shaped to address local cultural conditions.[256]

NATIONAL SUICIDE PREVENTION LIFELINE: COLORADO IS CALLED UPON TO ADVISE

In 2004, Colorado was making its mark on the national suicide prevention scene again. Shannon Breitzman was embracing her new position as Director of Injury and Suicide Prevention Programs at the Colorado Department of Public Health and Environment. Having "founded" the Office of Suicide Prevention, Breitzman had extensive knowledge about successful suicide prevention and intervention programs in Colorado, including the statewide suicide prevention hotline in Pueblo. Breitzman was invited to participate on the steering committee for a National Suicide Prevention Lifeline to provide consultation from a state perspective on crisis lines.

For several years, Colorado's Office of Suicide Prevention had provided support to the 1-800-SUICIDE hotline number. In 2005, a second national crisis line was added with funding provided by SAMHSA. SAMHSA's goal with the National Suicide Prevention Lifeline (1-800-273-TALK) was to create a nationwide network with a mission to provide immediate assistance to individuals in suicide crisis. Both numbers (1-800-SUICDE and 1-800-273-TALK) were served by the Pueblo Suicide Prevention Center, an American Association of Suicidology certified center. From a state perspective, the Pueblo Suicide

Prevention Center staff was a fount of knowledge, maintaining and continually updating a database of resources in every county of the state in order to answer effectively all calls originating in Colorado.

Karen Mason took over the Office of Suicide Prevention and would serve as the Program Manager from October 2004 through April of 2006. Mason had worked in the mental health field for 15 years in a variety of settings in Colorado including the Mental Health Center of Denver as the Director of Quality Systems. While on board, Mason conducted town hall meetings throughout Colorado, a response to suggestions in the Suicide Prevention State Plan from 1998. The town hall meetings took place in Grand Junction for Mesa County, in Alamosa for the San Luis Valley, in Sterling for Northeastern Colorado, and in Steamboat Springs for Moffat and Routt counties. Each town hall meeting was jointly hosted with the local suicide prevention coalition and featured presentations by the Office of Suicide Prevention, the Suicide Prevention Coalition of Colorado and the local coalition. The discussion of local needs, as well as the identification of barriers and solutions, resulted in valuable connections among service providers and local and state entities. Important feedback included the need to strengthen statewide connections. Several state and local policy makers and representatives from the public and private sector attended the four meetings, for a total attendance of 135 people.[257]

Under Mason's leadership, the Office of Suicide Prevention provided support to the Suicide Prevention Coalition of Colorado. With OSP's help, SPCC developed a Speakers Bureau, comprised of professionals and trained volunteers who could mobilize and address topics a broad range of topics. These included short-term and long-term post-suicide grieving and coping by survivors; suicide warning signs; what to do if someone you know is considering suicide; treatment resources for people at-risk for suicide; neurological and physiological bases for suicidal behavior; suicide risk factors; developing comprehensive school prevention programs; stigma of mental disorders special demographics categories; suicidal trends in diverse demographic groups; murder-suicide; and general mental health.

In October of 2004, the Garrett Lee Smith Memorial Act (GLSMA) was signed into law. GLSMA was the first federal suicide prevention program aimed at youth. The law was named in memory of Senator Gordon H. Smith's (R-OR) son, Garrett, who died by suicide on September 8, 2003. The bi-partisan bill was aimed at curbing the rate of youth suicide in the United States. The Act, which amended the Public Health Act of 1944, created a three-tiered grant program at SAMHSA to help states, tribes, and colleges/universities to develop and implement youth, adolescent, college-age early intervention and prevention strategies to reduce suicide.

The initial authorization was for $82 million in federal funding over three years (2004-2007). This money was used for three suicide prevention programs. The first provides grants to states and tribal organizations to create and implement statewide/tribal suicide prevention plans. The states and tribal organizations are allowed to utilize the funding in a variety of ways, including providing access to adolescent mental health screening. The second part of the bill created matching-grants for colleges and universities to encourage the development of campus-based education campaigns and intervention and referral teams. The third component established the federal Suicide Prevention Resource Center discussed on page 73 to collect, analyze and disseminate best practices among grantees and outside entities working to end suicide.[258]

Since 2007, additional funding has been appropriated annually. Colorado received $1.2 million in 2006, which helped develop the Project Safety Net discussed on page 91 of this document. As of 2010, 34 states, 11 tribal organizations and 78 institutions of higher learning had received Garrett Lee Smith funding.

BOULDER COUNTY: COUNTYWIDE COMMUNITY INITIATIVES

In 2005, Boulder County mobilized its suicide prevention resources to ensure that the suicide prevention continuum was being covered in all areas. A group of concerned citizens founded the Boulder County Suicide Prevention, dedicated to supporting depression awareness and suicide prevention. Now known as the HOPE Coalition of Boulder County, the group works in conjunction with the local Mental Health Center and other non-profit organizations such as Colie's Closet. Colie's Closet, founded in 2004, is a youth-driven organization that works to further the understanding of depression and to prevent suicide. The grassroots organization was founded by Jenna Machado, a middle-school student in Boulder, after she lost her cousin Nicole (Colie) to suicide. Colie's Closet got its name because the group hosts an annual spring sale of gently used clothing to provide funds for Yellow Ribbon "It's Okay to Ask 4 Help!" suicide prevention trainings and provide financial support to the Second Wind Fund of Boulder County. The group of middle school and high school students works to diminish the stigma attached to depression and promote the knowledge that depression is treatable.[259]

CARSON J SPENCER FOUNDATION: REACTING TO EMERGING TRENDS

A large part of suicide prevention is recognizing and filling gaps where existing services and programs do not exist. The Carson J Spencer Foundation, founded in 2005, is one such organization working to find niche area in which suicide prevention can take on innovative approaches and react to emerging trends.

Dr. Sally Spencer-Thomas attended her first suicide prevention conference in 1991 as a graduate student at the University of Denver. "I was struck by how fascinating everything was and by the lack of information for the general public. At the time, I was working toward a doctoral degree in psychology, and we weren't talking about the issues of suicide prevention at all in graduate school,"[260] says Spencer-Thomas.

Spencer-Thomas, who had an interest in college counseling and law enforcement, took on a research project to examine law enforcement response to civilian suicide deaths. She interviewed more than 200 police officers inquiring about whether they had encountered on-the-job situations dealing with suicide. Spencer-Thomas and her team published the study in 1999, and were asked to present the results at the FBI Academy at Quantico, Va.

"We found that the more involved the officers were in the event, the more traumatic it was for them. For example, a suicide that occurred while an officer had a person in custody was much more traumatic than officers reporting to the call of a completed suicide. These officers were experiencing vicarious trauma response, and the number one response was anger."[261]

Five years later, in the summer of 2004, Spencer-Thomas' brother, Carson, experienced his first full-blown episode of mania, which led to his diagnosis of bi-polar disorder. Carson Spencer was a 35-year-old husband and father, with a dynamic personality, a successful career and an entrepreneurial spirit. Subsequently, he crashed into a depression and died by suicide in December of 2004. In response to the loss of Carson, Sally Spencer-Thomas and her family founded the Carson J Spencer Foundation in early 2005.

"In the beginning, our plan was to start a scholarship for emerging entrepreneurs. We also planned to give mental health agencies small grant money to help research bi-polar. We didn't have unlimited funds, and it was easy to get discouraged. We were a small fish in a big pond—a pond where organizations needed tens of thousands of dollars for research and programs. It felt like our small contributions really didn't matter."[262]

The foundation spent its first years focusing its mission and programs. It provided funds to the Second Wind Fund and developed relationships throughout the state. The Foundation wanted to support suicide prevention programming and wanted to support something that was entrepreneurial in spirit.

"Most importantly, we wanted to find something that was unique and going to make a difference. We held focus groups and distributed surveys and conducted interviews. We wanted to make sure we were partnering with existing organizations—filling in gaps and creating innovative programs rather than overlapping with what was already in the works in Colorado."[263]

Finally, the foundation focused its mission on three key elements.

- Coaching young leaders to develop social enterprises for mental health promotion and suicide prevention
- Delivering innovative and effective suicide prevention programs for working-aged people
- Supporting people bereaved by suicide.[264]

The first program began with high school students and evolved into a yearlong workshop called "The FIRE Within: Saving Lives through Business." "FIRE" stands for Future Innovative Resilient Entrepreneurs. Using Carson's entrepreneurial spirit as inspiration, the foundation aimed to ignite a passion for an entrepreneurial mindset and care for the common good in youth. The program goals were to build business skills and social networks among the next generations of leaders, while simultaneously providing opportunities for existing business leaders to participate in mentoring and service learning.

The yearlong curriculum, engages students through self-driven discovery, teaches them what it means to be successful entrepreneurs, leaders and workgroups, and applies these concepts to the public health issue of suicide. In a business plan competition, student groups develop sustainable businesses that raise revenue and awareness for suicide prevention and compete for varying levels of seed money to implement their plans. After being in this program for a year, youth are transformed into Future Innovative Resilient Entrepreneurs (FIRE).[265]

The first year of the program, the foundation partnered with Junior Achievement—Rocky Mountain, Inc., to create a pilot Social Enterprise Competition at Green Mountain High School in Lakewood, Colo., the same school whose suicides led to the formation of the Second Wind Fund. The goal of the competition was to create a business model (students learned to put together a needs assessment and business plan) for a socially derived "business" that would makes others aware of mental health issues.

Students at Green Mountain High School created a line of teeshirts meant to change the conversations people were having about mental health by inviting the question, "What does Vivacity mean?" The students' response to this question was, "Vivacity means loving life and living lively." The group of young entrepreneurs designed graphics for the teeshirts, which depicted a tree exploding into a wealth of life-affirming activities. They printed 400 shirts and debuted them at a fashion show at Dazzle Jazz Club in Denver. The show's message was, "finding your own inner superhero to overcome the inner villains that plague us." The young entrepreneurs created an accompanying brochure, which aimed to increase awareness of mental health struggles and provide students in needs with links to community resources. The team received seed money from UMB Bank to launch their line and by the end of the school year, the social enterprise had touched over 2,275 people.[266]

"We helped the students develop a survey that went out to students at Green Mountain High School. The survey gathered information about how many students had experienced depression, how many had actually used school or community resources. The survey asked about obstacles preventing students from seeking help for depression or other mental health issues. The majority stated that they were afraid if they used school or community mental health services—if people of authority knew that they were seeking help—bad things would happen to them. Their parents would be notified, the police would visit them. Most students didn't trust the confidentiality of schools counseling resources, and there seemed to be a mystery about depression—what it is and what it means. Although 39% of the 800 students surveyed had experienced mental health crises of their own of family members, few had sought help,"[267] says Spencer-Thomas.

The Vivacity project allowed students to reach out to one another, spreading a message of hope and help. The informational brochure helped to create a dialogue with the counseling services and administration and among students—passing along the message that school and community counseling services are safe and reducing the stigma surrounding mental health crises.

The FIRE students completed the experience with a greater knowledge of business acumen and the effect that social enterprises can have on the world around them. Students stated: "We opened others eyes as well as our own to depression," "When I was selling chocolates, I was just raising money for me. But now, we are selling for a good cause. It's a lot easier to sell something when it's a good cause. If I started a business of my own I would make a social enterprise," "Social enterprise will help me in the future; this experience helped me see business in a new way."[268]

While launching and perfecting its FIRE program, the Carson J Spencer Foundation teamed up with the Office of Suicide Prevention and Dr. Holly Hedegaard at the Colorado Violent Death Reporting System to determine what other areas of suicide prevention had been thus far overlooked.

"We found a gap in coverage—most people that were dying by suicide were middle-aged men. There were very few practices specifically targeting men and nothing specifically designed to raise awareness and prevention in the workplace,"[269]says Spencer-Thomas.

The Carson J Spencer team worked to create a program that would target workplace employees in a comprehensive way, regardless of their line of work. The Working Minds Program is the only one of its kinds in the nation that helps workplaces develop comprehensive suicide prevention program**s**.

The program began with the development of a website: www.workingminds.org. The site is filled with resources to help employers asking themselves: How are we promoting mental wellness in the workplace? How can we identify an employee at risk? What do we need to integrate prevention and postvention into the workspace? The site also includes professionally produced videos from Denver "celebrities" such as Colorado Governor John Hickenlooper and former NFL player Esera Tualo, who discuss mental health in the workplace.

Spencer-Thomas contacted the Mountain States Employers Council, an organization that partners with employers to maintain effective employer/employee relationships, and learned that most workplaces do not deal with the issue of suicide until one has occurred in or been connected to the workplace.

"They tend only to get interested when a tragedy has taken place. People will call their HR department or groups like the Mountain States Employers Council and ask, 'How can I support my workforce after this suicide has occurred?' They also frequently asked, 'What could we have done to help prevent this?'"[270]

The Carson J Spencer Foundation created postvention guidelines for the workplace and combined those with prevention tactics to create the Working Minds program. In the creation process, they learned that there is a critical link between helping people through the grieving process after the tragedy of suicide and making more people aware of what was happening through suicide prevention tactics. The response from corporate workplaces was positive, but highlighted several obstacles. In order to implement suicide prevention in the workplace, the program needs to be easy and affordable—employers need to be able to pull videos and worksheets off a shelf and implement the program in a short period of time. The Working Minds Toolkit, which was released in 2009 and became part of the National Best Practices Registry for suicide prevention, meets these needs with trainings that target supervisory staff and provide information regarding risk factors and warning signs.

"Many people don't realize that mental health issues can create huge costs for the employer. It doesn't always show up on their radar, but mental health issues can lead to increased absenteeism and increased health care costs. They often don't connect the dots with suicidal ideation because many of these things manifest themselves in the workplace as prescription drug abuse or something else. We're working to raise awareness to all of these behavioral warning signs. Suicidal ideation is far more common than most people realize, and we're giving people in the workplace the blueprint and tools to recognize this."[271]

The Carson J Spencer Foundation recently formed a partnership with the Colorado Coalition for the Homeless to bring the Working Minds training to homeless-serving populations, as increased numbers of recently homeless people are beginning to show up for services displaying multiple risks for suicide. Thus far, more than 1,100 people have been served through this program.

Meeting the third need of immediate postvention after a suicide, the Carson J Spencer Foundation created the iCare Packets. The iCare packages contain resources for families to let them know that there is a community who supports them after the loss of a loved one to suicide. The packages contain resources: books to assist the bereaved and lists of community support groups and other organizations that exist to help people through this very difficult crisis. Each package is customized with CDs of comforting music, a stuffed animal to offer comfort if there is a young child in the home, and a personalized note from the person who requested the package to let the recipient known that they are receiving this package because a greater community (including the sender) cares about them.[272]

Shortly after the establishment of the Carson J Spencer Foundation, the Office of Suicide Prevention solidified its partnership with the American Association of Suicidology by participating on the Program Committee of the national AAS conference, which was held in Broomfield, Colo. on April 13-16, 2005. The Office not only assisted with the planning of conference programs, but also jointly hosted a statewide networking session for all Colorado conference participants and national experts to coordinate national and state suicide prevention efforts.

VETERAN ADMINISTRATION: RESEARCH AND SUPPORT FOR SUICIDAL VETERANS

In early 2004, the Veterans Administration awarded a Mental Illness Research Education and Clinical Center (MIRECC) to Veterans Integrated Service Network (VISN) 19 in Colorado. MIRECC were established by Congress with the goal of researching the causes and treatments of mental disorders and using education to put new knowledge into routine clinical practice in the VA. In 1989, the first such center, the National Center for Post-Traumatic Stress Disorder (NCPTSD) opened in the United States. Utilizing government funding, these centers were established to serve as incubators for "new investigators, new clinicians and new methods of treatment"[273] within a contained sample group—the military. By combining all of research, education and clinical care into a single program, the Veterans Administration hoped to dramatically reducing the time from scientific discovery to implementation of mental health discoveries for veterans.

Following the creation of the NCPTSD, the VA created 10 MIRECCs across the country—each addressing a specific mental illness or illnesses across the spectrum of Veteran mental health. In early 2004, the VA Central Office requested applications for a new MIRECC. Dr. Robert Freedman, the chair of the Department of Psychiatry at the University of Colorado Health Sciences Center and Dr. Lawrence Adler, the Chief of Mental Health Services at the Denver Veterans Affairs Medical Center, teamed up to apply for the MIRECC grant. Both researchers had worked extensively together in the field of schizophrenia but saw a need for available funding in suicide prevention. They decided to focus their grant application on the treatment of serious mental illness as a means of suicide prevention. In 2005, the grant was

awarded and the VA Central Office announced the funding of a new MIRECC of the Veterans' Integration Service Network (VISN) 19, the Rocky Mountain Network.

The Rocky Mountain MIRECC was charged with conducting research, educational activities and clinical work focused on addressing suicidality in the Veteran population. According to the MIRECC announcement:

> The focus of the new VISN 19 MIRECC, directed by Lawrence E. Adler, MD, is suicidology. This MIRECC will lead efforts in the VA to develop effective educational and treatment strategies for suicide prevention. Suicide among veterans is influenced by a number of risk factors, some of which are related to military service and other traumatic life events. Other risks include mental illnesses such as depression and substance abuse.
>
> Current epidemiological models point to psychiatric illness as the single most significant, potentially modifiable factor associated with suicide. Although the VA has several ongoing programs to reduce the risk of suicide, the suicide rate among veterans remains significant. Because VA mental health care already makes good use of existing treatment modalities, lowering suicide rates further requires new approaches, including new pharmacotherapies, new psychotherapies, and new techniques to monitor the neurobiological mechanisms of treatment response.
>
> VA research in schizophrenia and other major mental disorders provides one model. Investigators in these areas have developed promising strategies for such incremental improvements. The VISN 19 MIRECC will lead efforts to adapt this model to suicidal behaviors. More effective assessment and treatment of suicidal behavior may ultimately lower the stigma of mental illness and increase veterans' willingness to access treatment.[274]

The new MIRECC was designed with a scientific, as well as, clinical infrastructure. Dr. Robert Freedman leads the scientific arm. The research team conducts ongoing research in areas such as the development of new drug strategies for schizophrenia, new psychotherapeutic strategies for bipolar disorder and improved therapeutic strategies for alcohol dependence, among others. Studies are being conducted on topics such as the effects of Traumatic Brain Injury (TBI) in self-harm behavior in veterans.

Some MIRECC research has practical applications such as the "Blister Packaging Medication to Increase Treatment Adherence and Clinical Response: Impact on Suicide" study. The VA determined that medication overdoses account for substantial numbers of suicide-related behaviors. When medication is enclosed in blister packaging (as opposed to large quantities available in one prescription bottle), patients adhere more strictly to the prescribed dosage and the chance of intentional medication overdose is significantly reduced.

According to MIRECC "the findings from this study will generalize to civilian and non-military health care settings. Any hospital or clinic dispensing medications can switch from the current means to blister packs and thereby realize similar increases in patient medication adherence. In turn, those patients can experience similar decreases in suicide-related behavior."[275]

Another partner in the Denver-based MIRECC is the University of Utah School of Medicine Brain Institute. The Director of the Brain Institute is Dr. Perry Renshaw, who serves on the MIRECC staff. Dr. Renshaw is an internationally recognized authority on the use of magnetic resonance spectroscopy methods to evaluate individuals with psychiatric and substance abuse disorders.

His work with MIRECC has focused on the role of altitude as a novel risk factor for suicide. Renshaw published an article in the September, 2010, online edition of the *American Journal of Psychiatry*, in which he reports that the risk for suicide increases by nearly one-third at an altitude of 2,000 meters, or approximately 6,500 feet above sea level.

> The Western states have some of the highest average elevations in the nation and, according to data derived from the National Geospatial Intelligence Agency and the National Aeronautics and Space Administration (NASA), also the highest suicide rates. In 2006, the latest year for which national data was available, Montana, Idaho, Wyoming, Utah, Colorado, Nevada, New Mexico, Arizona, and Oregon accounted for nine of the 10 highest suicide rates in the country. Alaska also was in the top 10 in suicide rates.
>
> The high suicide rates in the West prompted Renshaw, the study's senior author and also an investigator with the Veterans Affairs Rocky Mountain (VISN 19) Mental Illness Research, Education, and Clinical Center (MIRECC), to undertake the research. “We thought it was reasonable to ask if some aspect of high altitude is related to suicide,” he said. “Altitude was the strongest factor we could find in our study. But we believe there’s also some other factor we can’t account for yet.”
>
> After analyzing data from a U.S. Centers for Disease Control and Prevention (CDC) database with information on 3,108 counties in the lower 48 states and District of Columbia, Renshaw and his colleagues from the University of Utah Brain Institute, Veteran Affairs Salt Lake City Health System, and Case Western Reserve University concluded that altitude is an independent risk factor for suicide, and that “this association may have arisen from the effects of metabolic stress associated with mild hypoxia (inadequate oxygen intake)” in people with mood disorders. In other words, people with problems such as depression might be at greater risk for suicide if they live at higher altitudes.
>
> The researchers also concluded that the West's higher rates of gun ownership, a well-recognized factor in suicide, and lower population density -- suicide is more prevalent in rural areas—may be connected with altitude in influencing suicide rates. The study concludes, however, that gun ownership and low population density cannot sufficiently explain the prevalence of suicides at higher altitudes.
>
> William M. McMahon, M.D., professor and chairman of psychiatry at the University of Utah, believes the study represents an important step in understanding the higher suicide rates in the Mountain Region. “Dissecting the many environmental and genetic factors leading to high rates of suicide in Utah and the surrounding mountain states has been a daunting task,” he said. “This study is a real milestone.”
>
> To verify the study conclusions, Namkug Kim, Ph.D., the study’s first author and a former post-doctoral fellow under Renshaw, conducted a similar data study in South Korea and found that the suicide rate in areas at 2,000 meters increased by 125 percent in that country.
>
> Other research has shown that lack of oxygen at higher altitudes is associated with worsening mood that can last for up to 90 days. Understanding the full relationship between altitude and suicide will require much more study, according to Renshaw, who’d like to see epidemiologists look at the issue. “If altitude is related to suicide, then perhaps we could look with greater urgency at why this is true and what we can do to prevent it,” he said.

According to journalist Katie Drummond, in her article "Mean Altitude, Your suicide risk rises with your elevation, startling studies find" published in *The Daily* online, "Renshaw's study controlled for dozens of variables, including unemployment, income and gun ownership. Altitude remained the most potent factor."

> In a 1973 study in the medical journal Chest, researchers concluded that oxygen therapy improved the dispositions of hypoxic patients suffering from obstructive pulmonary disease. More recently, several studies concluded that treatments for Acute Mountain Sickness such as nifedipine, a drug that dilates the vascular system, have an antidepressant effect for those suffering from bipolar disorder. Several studies have also linked chronic hypoxia with mood disturbances, especially among those with prior emotional instability." Renshaw and his colleagues are trying to determine whether oxygen deprivation can trigger latent mental disorders, or just worsen existing ones. They're also trying to establish precise differences in brain metabolism at areas of different altitude by comparing brain scans from residents of Boston and Salt Lake City.

Peter Gutierrez, a prominent suicidology researcher and Research Clinical Psychologist at MIRECC, is excited about the prospect of applying Renshaw's research to the military population. "Perry has this national geological database with the altitude of every county and country. It will be interesting to investigate this with our soldiers who are in Afghanistan. The average altitude of Afghanistan is about 1,500 feet higher than the average altitude in the United States in the Intermountain West. It's not the only explanation for soldiers' suicide, but it could be a significant piece."

The clinical arm of the MIRECC was designed with an outreach over the nine-state Rocky Mountain region including Colorado, Nevada, Wyoming, Utah and Nevada. The clinical goal in the establishment of the MIRECC was to attempt to lower barriers by making the referral process simple and direct and by de-stigmatizing the reasons for veterans to seek treatment. The clinical outreach is directed:

- Population-wide through the media and veterans' service organization to all recent veterans in the region and their families
- Service-wide to all military installations charged with discharge of veterans
- profession-wide to all psychiatrists, psychologists, nurses, social workers and physicians through their professional societies to let them know of the VA's special interest in suicidal veterans, and
- VISN 19 system-wide to let all VA healthcare providers know the referral procedure for suicidal veterans.[276]

Peter Gutierrez, a pre-eminent suicidology researcher, joined the MIRECC staff in August of 2006. At the time, Gutierrez was a Professor of Psychology at Northern Illinois University, a licensed clinical psychologist and the President of the Board of Directors of the American Association of Suicidology. While teaching at Northern Illinois, Gutierrez's research focused on risk factors as well as protective factors surrounding adolescent suicide.

"When I started teaching at Northern in 1996, we were still working on assessment of risk—developing and testing self-reporting measures and analyzing risk factors for suicide,"[277] says Gutierrez.

Gutierrez co-authored a book on his research called *Adolescent Suicide: An Integrated Approach to the Assessment of Risk and Protective Factors*. According to a review by Susan M. DeLuca, MSW, LSW, for the American Association for Suicidology, "One of the many strengths of the book is the authors' choice to address risk and protective factors concurrently thus emphasizing their shared effect. The overview of these determinants aids the professional in the development and validation of measurement tools exclusively created for teens. Given the prevalence of adolescent suicide, this succinct yet extensive work should be on every clinician's, school administrator's and researcher's desk."[278]

After the publication and subsequent review of the book, Gutierrez's work in suicidology and prevention became known nationwide. Gutierrez began a rigorous lecture and presentation schedule, including a presentation at his first AAS national conference in 1998. Within two years, he was asked to run for Director of the AAS Research Division. Soon, Gutierrez was in line for the Board Presidency. In 2005, he was awarded the AAS Shneidman Award for outstanding contributions in research in suicidology.

"Things were moving along pretty well in my career. People would ask me if I ever thought about leaving Northern. I used to say that the only reason I would leave is if someone was staring a suicide research center,"[279] says Gutierrez.

No sooner were the words out of Gutierrez's mouth than a suicidology colleague, Dr. Jan Kemp, approached him. At the time, Kemp was the Education Director at the fledging MIRECC in the Rocky Mountain region, and she went on to become the VA's National Suicide Prevention Coordinator. Kemp and Gutierrez arranged to meet at the AAS conference, and by August of 2006, Gutierrez was working as a consultant and subsequently a Research Clinical Psychologist at MIRECC.

In subsequent years, the Veterans Administration became more focused on its suicide prevention efforts, and Gutierrez continued to expand the relevance of MIRECC programs in Colorado and beyond the Rocky Mountain region.

NEW OSP LEADERSHIP AND A "SAFETY NET" FOR COLORADO

In April of 2006, Jarrod Hindman took over as director of Colorado's Office of Suicide Prevention. Prior to taking the reins at OSP, Hindman was the Youth Violence Prevention Coordinator for the Colorado Department of Public Health and Environment and worked at the Center for the Study and Prevention of Violence at the University of Colorado at Boulder. Hindman's primary prevention background was a benefit to Colorado's suicide prevention efforts, providing a broader perspective on addressing suicide as a piece of a larger public health puzzle. Hindman's first order of business was to change the format of the community grants provided by the OSP from a one-year to a three-year grant cycle.

"The goal in making this change was to allow grantees to build capacity, improve evaluation of their prevention activities, and develop a plan for sustainability. By focusing these dollars on specific high-risk groups which were identified with the help of the Colorado Violent Death Reporting System, we could really focus on data-driven, concrete outcomes for each of the programs,"[280] says Hindman.

The high-risk groups identified through Hindman's OSP/CVDRS research were returning and active veterans of the current conflicts, the Lesbian Gay Bisexual Transgender population, college-aged students, working-aged men, older adults and Native American Youth.

The first round of three-year grants was awarded in 2006. In October, the Office of Suicide Prevention received $1.2 million from SAMHSA, through the Garrett Lee Smith Memorial Act. This three-year grant came at just the right time, providing Hindman with additional funds to support youth suicide prevention, while allowing him to redirect dollars within the OSP community grants to other target populations.

The funds awarded through the Garrett Lee Smith grant were designated to implement a program called "Project Safety Net." "This program was designed to build a safety net for adolescents in the juvenile justice and child welfare systems, Hispanic/Latino(a) youth, and lesbian, gay, bisexual, transgender, questioning youth. Adolescents in these categories are at high risk for suicidal behavior, so Project Safety Net implemented strategies and trainings designed to ensure that youth at risk for suicide were identified, assessed and referred to appropriate services. The seven communities selected for implementation of Project Safety Net had high suicide death and hospitalization rates among youth, the existence of an established suicide prevention agency and the presence of an active suicide prevention coalition. Having an existing agency and an active coalition in a community increased the likelihood that suicide prevention efforts would be sustained beyond the three-year grant period."[281] The safety net will be made up of adults trained to recognize and respond to signs of suicide among youth in these populations.

Agencies from Douglas, El Paso, Jefferson (including Gilpin and Clear Creek counties), Pueblo and Weld counties; and the northeast region of Colorado (nine counties), and west-central Colorado (six counties) were selected to receive Project Safety Net funding. Participating communities worked with their local coalition and with a subcommittee advisory council of the Suicide Prevention Coalition of Colorado. The communities created and disseminated cross-system referral and follow-up protocols for treatment and care of suicidal youth. A "safety net" of parents, educators and responsible adults was trained as gatekeepers in the Applied Suicide intervention Skills Training (ASIST) and the Question, Persuade, Refer (QPR) training. Finally, grantees worked with a marketing specialist to create public awareness campaigns targeting potential suicide interveners.

OSP conducted rigorous process, outcome and performance evaluations throughout the Project Safety Net initiative and contracted with an evaluation team from Colorado State University to design and implement outcome evaluation tools in each participating community. At the end of three years, in 2009, 1,760 individuals in the participating counties had been trained as gatekeepers. 35 percent of those trained identified someone who was suicidal within six months of receiving the training and referred them to appropriate services. A three-month follow-up survey of trainees showed that of the youth identified as suicidal by trainees, 81 percent were referred for services. Training participants suggested that they would benefit from additional training to refine their skills. Project Safety Net was also implemented at the University of Colorado at Boulder. Two hundred twenty-nine faculty, student

leaders, athletic department staff, residence hall monitors and representatives from the Greek system were trained to recognize suicide risk factors among students.[282]

In working with the marketing specialists, Project Safety Net grantees developed a bilingual public awareness campaign targeting all adults in the five-county area. The "Start the Conversation—Suicide Prevention is Your Business" campaign reinforces the role that all community members play in suicide prevention. Included in the campaign were radio spots, posters, bumper stickers, buttons and information brochures. All materials were available in Spanish and English, including specific contact information for each county. Additionally, the OSP has distributed the materials statewide to promote youth suicide prevention.[283]

In October of 2009, the Office of Suicide Prevention extended Project Safety Net to enhance and expand the safety net in Colorado described above.

DOUGLAS COUNTY: A PROJECT SAFETY NET GRANTEE

One successful community-integration model, which acquired much of its seed money from Project Safety Net, is the Douglas County Suicide Prevention Alliance.

"In 2006, there were a handful of us working in our own little worlds that saw a need to be more cohesive and community minded around suicide prevention," says Leslie Clemensen, the Student Wellness Coordinator in Douglas County School**s**. "What really stood out to me was that our suicide attempts in Douglas County were much higher than the state average."[284]

Clemensen spoke with a contact at Arapahoe/Douglas Mental Health, Lynn Pender, the director of the Douglas County Second Wind Fund, and Carla Turner, who is part of the Douglas County Youth Initiative.

"We all had our separate ventures going on in suicide prevention, and one afternoon, we decided that suicide prevention and intervention is bigger than any one of our entities or agencies. We needed a community approach to a community problem."[285]

The group invited some Douglas County victims advocates, representatives from both Arapahoe/Douglas and Highland Behavioral Health, members of the faith community, first responders from the fire department, representatives from Skyridge Medical Center and survivors who had lost loved ones to suicide, the coroners office, the sheriff's office, the hospitals and the Kiwanis Club of Castle Pines.

Soon this disparate group became the Douglas County Suicide Prevention Alliance. In the early months, the Alliance focused on sharing of information: available resources and inter-agency communication and support mechanisms. With the Project Safety Net grant money, the Alliance was able to hire a facilitator

to organize the coalition meetings, provide administrative assistance and keep all of the separate entities on track.

"Since we hired our facilitator, much more strategic work is being done. We're all busy working full-time in our areas of expertise, so now when we come together, we have someone who holds us accountable, allowing us to focus on ways in which we can collaborate and what we want to accomplish,"[286] says Clemensen.

The Alliance began with identification of resources for at-risk individuals and made those resources known to the community with the use of a one-page handout. The handout walks people through the steps to helping a suicidal individual in Douglas County including what to do, whom to call and what resources are available to help during a suicidal crisis and afterwards.

The Alliance is developing a website and has experimented with social media such as Facebook to develop a presence and increase outreach to help people know the warning signs of suicide. Piggybacking on the use of social messaging, the Alliance has developed a strong partnership with local law enforcement. Not only has Douglas County implemented the Safe2Tell program, but they have *also* created a Text-a-Tip program.

"Text-a-Tip is a partnership between the Alliance and the Douglas County Sheriff's Department. The program is funded through drug seizure money. Our school dispatch staff is available 24/7 to receive anonymous encrypted texts. They can carry on real-time conversations about risky behavior in the community and pass the information along immediately to trained representatives at the sheriff's department."

"We have high school students who text tips about friends planning a fight, a party with illegal drug and alcohol use or friends who have threatened suicide. We have documented five suicide interventions on active suicidal kids since the program began two years ago. In another situation, the sheriff's department was able to intervene on a drug overdose because of a texted tip,"[287] says Clemensen.

Partnerships with local law enforcement do not stop at texting. The Alliance has worked with law enforcement to identify problems with transporting and transfer of suicidal students.

"When we have a suicidal student at school, we needed to devise a system to get them safely transported to a local emergency room. If parents or friends are picking up the student, that at-risk person doesn't always make it to the emergency room. When the student does arrive at the hospital, hours can be spent asking the same questions that school officials and law enforcement have already asked,"[288] says Clemensen.

The Alliance met with law enforcement and emergency room staff to create a comprehensive protocol ensuring that each agency in the assessment and treatment process received consistent background on the student. Armed with information about prior attempts, mental health background and behavior at school, school officials, law enforcement and medical professionals can work together to devise a safety plan for the at-risk student.

The Douglas County Alliance and the Douglas County Schools also adopted the ASIST program to faculty and staff on suicide awareness and intervention.

"I've been in the district for 25 years. We've been doing a decent job of intervention with our students. Once we knew a kid was in trouble, we had the paperwork…we had the systems in place to track kids. What we didn't have was a common training around identifying at-risk students. That is where the ASIST program fit into place."[289]

The Alliance and Douglas County Schools utilized Project Safety Net funds to ensure that more than 200 school personnel and community members were trained in ASIST. The District focused on establishing a well-trained adult infrastructure, so that at-risk students were referred to staff that were trained to help them find the proper resources. The District also standardized their assessment and safety plan forms to follow the ASIST model.

"We are the only school district in the nation that uses paperwork and a student interventions model that is designed to meld with the ASIST model. We wanted the language and forms to match so that our teachers, our mental health professionals, our counselors and our parents were receiving the same information. When an at-risk student returns to school, they have a safety plan determined by their level of risk. This plan identifies safe people and places at school, the medications that a student is taking and other factors that might help with re-entering kids to the school system after a mental health crisis. It also helps the parents become part of the team because they know, 'Here are some of the things that we are going to do at school to help you child,'"[290] says Clemensen.

After ensuring that a strong adult safety net was in place, Douglas County Schools began utilizing the Signs of Suicide (SOS) awareness of prevention program at the middle school and high school level.

SOS is a two-day secondary-based intervention that was launched by Screening for Mental Health, Inc., in September of 2006. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends, and encourages help seeking using the ACT technique (Acknowledge, Care, Tell). The SOS High School program is the only school-based suicide prevention program listed on SAMHSA's National Registry of Evidence-based Programs and Practices that addresses suicide risk and depression, while reducing suicide attempts. The intervention attempts to prevent suicide attempts, increase knowledge about suicide and depression, develop desirable attitudes toward suicide and depression, and increase help-seeking behavior.[291]

"The formation of the Douglas County Alliance has allowed all of our programming—school-based and otherwise—to transform into high-level community efforts. We can set priorities as a community which allows us to tailor all of our suicide prevention efforts to ensure a common goal,"[292] says Clemensen.

METRO CRISIS SERVICES: ADDRESSING THE NEED FOR BETTER ACCESS TO CARE

In late 2006, Jeanne Rohner, then CEO of Mental Health America of Colorado, convened a series of inter-agency and interdisciplinary discussions surrounding the accessibility of mental health services in the Denver metro area. During its planning phase, the project became known as "The Triage Project." The

word "triage" means to assess a person's need, then find the most appropriate available service to help with that need.

"We had individuals with mental health crisis spending hours in emergency rooms or ending up in jail. We knew that there must be a better way to handle the mental health crisis in the Denver-metro area. MHAC brought together a huge coalition of people and started a capital campaign to fund 'The Triage Project,'"[292] says Rohner.

Three facts drove the original planning sessions:

- Hospital emergency rooms were overloaded with increasing numbers of people — about 40,000 annually—with mental illness and substance abuse disorders who could not find help elsewhere.
- Increasing numbers of mentally ill people were being held in jails on relatively minor infractions because law enforcement officials were not able to find help for them.
- The metro area didn't have a coordinated system of 24-hour emergency mental-health care.[293]

The planners consisted of more than 200 professionals from law enforcement, mental health agencies, substance abuse programs, universities and government, including the first lady, Jeannie Ritter. The group strategized and planned for over three years. Modeling the project on similar programs in Arizona, Texas and Maryland, the original vision of The Triage Project was to create a crisis triage system in the seven-county Denver metro area at which crisis intervention services would be available 24 hours a day, seven days a week.

The project's initial funding consisted of money provided by Centura, Exempla and Health One, with an additional funds provided by the Colorado Health Foundation, the Caring for Colorado Foundation and the Rose Medical Foundation. In July of 2008, MHAC was awarded $478,504 from the Robert Wood Johnson Foundation Local Funding Partnerships program for the "The Crisis Triage Project" to "develop a coordinated system of care for people in the metropolitan Denver area who experience mental health crisis."[294]

The vision of the Triage Project was to phase the delivery of direct services to the community.

These phases are:

- Establish a round-the-clock, free crisis line staffed by trained professionals.
- Create and maintain a large online public database with details about all available treatment resources in the metro area.
- Open the first of three 24-hour Crisis Centers. Each Center will include an urgent care walk-in clinic and 16 residential beds for short term rapid stabilization.[295]

This phasing began with the hiring of a Chief Executive Officer in September of 2009. Daniel Ward, the new Chief Executive Officer, previously started and ran several community mental health treatment

programs. “In the 1980s and early 1990s, [Ward] was instrumental in building and managing a state-of-the-art crisis system in Grand Rapids, Mich. That system included a 24-hour call center, a 24-hour emergency walk-in clinic, a short-term medication-only clinic and 14 six-to-twelve-bed specialized residential facilities for non-hospital rapid stabilization and post-hospital step-down.”

“This well-developed crisis system enabled the sprawling urban community to drastically reduce its use of psychiatric hospital beds and to virtually eliminate the use of medical hospital emergency departments for behavioral health crises.”

According to Metro Crisis Services, “[Ward] was also, for several years, the first Ombudsman (conflict resolver) in a mental health system in the United States, working to address inter-agency issues that impeded appropriate patient "flow" through available treatment programming.”[296]

By May of 2010, the Triage Project hired administrative staff and clinicians to man the crisis hotline. In June, the call center opened with limited service to law enforcement agencies. Triage staff conducted trainings with all 37 law enforcement agencies in Colorado about the hotline services. In the first six months of operation, the Project received 400 callers referred by police officers.

Like many of MHAC’s initiatives, it was not long before The Triage Project spun off to become its own 501(c)3 known as Metro Crisis Services. A grant from the Colorado State Division of Behavioral Health enabled the Metro Crisis Research team to create the largest and most comprehensive online service directory of mental health resources, substance abuse treatment and supportive human services in the state comprised of more than 1,500 organizations and 3,500 privately-funded, faith-based, peer and self-help programs.[297]

The next steps for MCS are the exploration of potential sites for three walk-in clinics with at least 48 beds. “The plan is that MCS would grow into several crisis centers at which people would be able to walk in, get around the clock help and perhaps stay for observation for up to 24 hours,”[298] says Dr. Michael Allen, director of the University of Colorado Depression Center.

The Crisis Centers are intended as an alternative to the use of hospital emergency departments for mental health crisis situations. They will be designed as places where law enforcement personnel can simply refer or drop off individuals in need instead of taking them into medical hospitals. In addition to 24/7 walk-in crisis assessment and intervention, the Crisis Centers will also operate rapid stabilization units, in which individuals will be offered a safe, medically-supervised, home-like setting where they can de-escalate, re-stabilize and begin recovery.[299]

In 2011, Metro Crisis Services also began the process to become an American Association of Suicidology accredited Suicide Crisis Center. Upon receiving certification, Metro Crisis Services will be the second accredited crisis center in Colorado, along with Pueblo Suicide Prevention Center.

While busy convening stakeholders for the formation of Metro Crisis Services, Mental Health American of Colorado also received a joint grant with the Heartland Network to review the 1998 Colorado state suicide prevention plan and to update the 2002 Colorado Trust report *Suicide in Colorado.* Funding in

the amount of $75,000 was provided by the Colorado Trust to "enhance the *Colorado Suicide Prevention and Intervention Plan*, to-date the state's most comprehensive approach to suicide prevention, education and awareness."[300]

MHAC and the Heartland Network worked with the Office of Suicide Prevention and the Suicide Prevention Coalition of Colorado to host stakeholder meetings throughout Colorado to contribute to the development of the plan update. The new plan, which was to be published in 2009, would also utilize new data, such as the Colorado Violent Death Reporting System, to inform and prioritize recommended strategies.

The final report, *Preventing Suicide in Colorado: Progress Achieved & Goals for the Future*, was released in September of 2009. "The report focused 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."[301]

SUICIDE PREVENTION: THE MILITARY STEPS UP

In May of 2006, the military realized a growing need for suicide prevention within its ranks. The United States Air Force led the charge with programs designed to decrease suicide using a community approach in which prevention and assistance were a focus long before someone became suicidal. The Vice Chief of Staff of the Air Force Commissioned a Suicide Prevention Integrated Product Team composed of all functional areas of the Air Force. This team developed and launched the Air Force Suicide Prevention Program.

The program consisted of the following priorities: community awareness and education; Command's responsibility as gatekeepers and agents of cultural change to make seeking assistance acceptable; leadership involvement; suicide education as part of officer and enlisted professional military education; developing an Air Force version of the Violent Death Reporting System for tracking fatal and non-fatal self-injuries; required annual suicide training of all active duty, reserve, guard and appropriated-funded civilian employees. Trauma stress teams (formerly known as critical incident stress management teams), were formed throughout the Air Force. These multi-disciplinary teams were comprised of representatives from mental health and medical staff, chaplains, family support center and peers.

The premise of the program was that "effective suicide prevention means we create a community that provides assistance long before someone becomes suicidal."[302]

The Army followed suit with the establishment of an Army Suicide Prevention Task Force. The Army declared a month-long "stand-down" to address suicides among soldiers. As part of this "stand-down," the Army established a Task Force including representatives from the Army's offices of personnel and human resources, the medical department, the chief of chaplains, and more. Lt. Colonel Leo Ruth, said

that the task force was commissioned to examine "all of the Army's recent suicides" in an attempt to find commonalities. The army began any exploration of demographics such as age and deployment history to see if any trends existed.[303]

The ultimate product of the Task Force's work was a multi-faceted suicide prevention campaign plan for the Army. It consisted of a video written and produced to reduce the stigma associated with soldiers seeking mental health care; suicide prevention trainings not only for soldiers and enlisted men but for families and civilians connected with the military; a Commander's Toolkit for each base with resources and training for base leaders concerning suicide. The Army began a training program for post-traumatic stress disorder, brain injuries and stress. Additional mental health professionals were hired, and all of the Army's medical personnel in recognizing post-traumatic stress disorder, brain injuries and suicide risk.[304]

In Colorado, soldiers saw the benefit of the Army's suicide prevention programs implemented by a passionate prevention advocate, Maj. General Mark Graham. Maj. Gen. Graham and his wife Carol lost their oldest son Jeff, an Army Lieutenant when a roadside bomb exploded in Iraq. The following year, their younger son Kevin, a top ROTC cadet at the University of Kentucky, took his own life. Graham became a powerful promoter of reducing the stigma around depression and mental illness in the military and turned his base, Fort Carson in Colorado Springs, into a suicide prevention laboratory.

The mission of the Fort Carson Suicide Prevention Program is to:

- Reduce the number and rate of suicides
- Advocate a multidisciplinary approach to suicide prevention
- Provide assistance and guidance to organizations and individuals administering various components of the Suicide Prevention Program
- Identify factors contributing to the incidence of suicide and develop a response to reduce the impact of such factors[305]

Graham is a strong proponent of the ACE (Ask Care Escort) program, which functions in a similar manner to the QPR program used in many schools and communities. He speaks all over the country about his belief that depression is insufficiently recognized, a factor that many believe contributed to his son's death. In a speech he delivered at "Paving the Road Home," SAMHSA's Second National Behavioral Health Conference on Returning Veterans and Their Families, in 2008, Graham warned that "the same lack of recognition could endanger many of the 800,000 veterans who have returned home from Iraq and Afghanistan, as well as service members on active duty. Why? Because depression and other behavioral health issues—including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance abuse, and suicide—are risks to all who serve in combat zones."[306]

Graham's belief is that the "Army's new guidance is to make it a sign of strength, not weakness, to come forward to seek mental health care."[307] Graham and his wife have become closely involved in working with the Suicide Partnership of the Pikes Peak Region. El Paso County and SPPPPR dedicated the Pikes Peak region's crisis hotline to the memory of Kevin and Jeff Graham.

In 2007 the military continued its fight against suicide when the Joshua Omvig Veteran Suicide Prevention Act was signed into law. The Act was enacted to "direct the Secretary of Veterans Affairs to develop and implement a comprehensive program designed to reduce the incidence of suicide among veterans."[308]

Joshua Omvig was a 22-year-old veteran Army specialist who served an 11-month tour of duty in northern Iraq with the 339th Military Police Company. Omvig returned from Iraq in 2005, and began showing signs of depression and was suffering from flashbacks and nightmares. Omvig ultimately confided to his family that he believed he had post-traumatic stress disorder (PTSD). His family encouraged him to seek counseling, but Omvig worried that doing so would damage his career. In December 2005, he took his life. Omvig became the human face behind a legislative attempt to address the growing problem of suicide among veterans.[309]

The Omvig Act was driven by veterans' advocates who complained that the Veterans Administration, which "provides healthcare for 7.8 million enrollees nationwide—was not adequately serving veterans' mental health needs." They noted that veterans face long waits to see mental healthcare providers, and Frances M. Murphy, the VA's Deputy Under Secretary for Health Policy Coordination, has stated that "waiting lists render [mental health] care virtually inaccessible." [310] By some accounts, demand for care was simply outstripping the resources of an unprepared and under-funded VA.

The Act addressed these deficiencies in the VA system. It ordered the Secretary of Veterans Affairs, "in developing and implementing the comprehensive program outlined in this Act, [to] take into consideration the special needs of veterans and of elderly veterans who are at high risk for depression and experience high rates of suicide."

> It directed the Secretary to develop and carry out a comprehensive program designed to reduce the incidence of suicide among veterans. Requires the program to include: (1) mandatory training for appropriate staff and contractors of the Department of Veterans Affairs (VA) who interact with veterans; (2) mental health assessments of veterans; (3) designation of a suicide prevention counselor at each Department medical facility; (4) research on best practices for suicide prevention; (5) mental health care for veterans who have experienced sexual trauma while in military service; (6) 24-hour veterans' mental health care availability; (7) a toll-free hotline; and (8) outreach and education for veterans and their families. Authorizes the Secretary to develop and carry a peer support counseling program as part of such program. Requires the Secretary to report to Congress on the program.[311]

Shortly after the passage of the Omvig Act, the VA's Suicide Prevention Hotline became operational. Like the national suicide prevention hotlines, the Veterans Crisis Line is toll-free and confidential. It connects veterans in crisis with qualified VA responders. Veterans and their loved ones can receive hotline support even if they are not registered with VA or enrolled in VA healthcare.

"The professionals at the Veterans Crisis Line are specially trained and experienced in helping Veterans of all ages and circumstances—from Veterans coping with mental health issues that were never addressed to recent Veterans struggling with relationships or the transition back to civilian life. Since its

launch in 2007, the Veterans Crisis Line has answered more than 400,000 calls and made more than 14,000 life-saving rescues."[312]

In 2009, the Veterans Crisis Line added an online chat services for Veterans in crisis. "Veterans Chat" allows Veterans to anonymously chat online with a trained VA counselor. "If the 'chatter' is determined to be in a crisis, the counselor can take immediate steps to transfer the person to the VA Suicide Prevention Hotline, where further counseling and referral services are provided and crisis intervention steps can be taken."[313]

According to Dr. Jan Kemp, the original Education Director at the MIRECC in the Rocky Mountain Region, and now the VA's National Suicide Prevention Coordinator, "The chat line is not intended to be a crisis response line. Chat responders are trained in an intervention method specifically developed for the chat line to assist people with emotional distress and concerns. We have procedures they can use to transfer chatters in crisis to the hotline for more immediate assistance."[314]

"MANSPEAK": SUICIDE PREVENTION GETS INSIDE THE HEADS OF MEN

Much of the problem in getting soldiers, particularly male soldiers, to call or utilize the Veterans Crisis Hotline or chat services is as a result of the male "pull yourself up by the bootstraps" and "fix your problems yourself" mentality. In 2007, the Office of Suicide Prevention and the Carson J Spencer Foundation teamed up to begin work on a groundbreaking campaign. After receiving word from Dr. Holly Hedegaard, of Colorado's Violent Death Reporting System, that the largest percentage of suicides in Colorado were working-aged men (ages 35-54), the OSP/CJSF collaboration garnered national attention from researchers and scholars in suicide at the American Foundation for Suicide Prevention (AFSP). AFSP agreed to fund the creation of a statewide public awareness campaign to enhance help-seeking behavior in this demographic.

The campaign began with critical market research to better focus resources. The goal of the campaign is to reduce the stigma associated with seeking help to improve mental and emotional health. In 2008, the Office of Suicide Prevention began work with Cactus Marketing in Denver to develop a comprehensive marketing plan. A review of existing public awareness campaigns revealed a lack of effort specifically targeting men with suicide prevention messages. To increase the breadth of the project, the OSP convened an advisory board comprised of both Colorado and national suicide prevention experts to guide the development of campaign materials.

No other state has adequately addressed the challenges of reaching working-age men, as these men tend to avoid seeking help and are less responsive to emotionally driven communication.

According to Sally Spencer-Thomas, the Executive Director of the Carson J Spencer Foundation, "It is really, really deeply hard-wired in men that it is not masculine to ask for help. [They] tend not to see their personal crisis through a mental-health frame. 'It's not depression.' Things happened *to* them. Their wife left them. They lost their job."[315]

The campaign, designed around the concept of "manspeak," will be released in the fall of 2011 and will offer edgy, intriguing and even darkly humorous messages to men's attention. The goal of the project team is to eliminate some of the stigma men attach to mental healthcare.

COLLEGES AND UNIVERISITIES ENACT NEW PROGRAMS TO PROTECT THEIR STUDENTS

In December of 2004, Patrick McKee took his life while home from college on holiday break. Patrick had become depressed during his fall semester, and college officials were made aware of his depression. However, given the murky interpretation of the Family Educational Rights and Privacy Act (FERPA), college officials could not inform McKee's parents of his depression. According to the Suicide Prevention Resource Center of Newton, Mass., "The FERPA rules surrounding privacy for an at-risk college student are ambiguous. There are no uniform standards for when parents can be contacted about a student's behavior. The only clear rule is that information can be shared when the student is a clear and imminent danger to their self or others. Often, whether to contact a parent is a judgment call by the college."[316] Although Patrick McKee was clearly depressed, the judgment about whether he was a danger to himself was subjective. McKee's parents were not alerted to their son's depressed state and found out after he took his life.

In 2006, the McKees led a charge to get Colorado Senate Bill 06-67 passed. The bill would allow colleges to alert a parent or designated person of the possibility that the student is at risk of committing suicide. According to the legislation, "This bill would clear all hurdles to information sharing if the student signs a consent form. College staff would not need to worry about violating federal privacy rules in informing a contact person designated by a student when the student has displayed warning signs for suicide."[317]

The bill did not pass in the Colorado Senate; however, the face of information sharing and student privacy at secondary institutions changed the following year after the massacre at the Virginia Polytechnic Institute and State University in 2007. Following the massacre at which Seung-Hui Cho, killed 32 people and wounded many others before taking his life, a review commission, similar to the Columbine Review Commission, was convened. In a report to the President of the United States on the Virginia Tech incident, the committee reported "repeatedly hear[ing] reports of 'information silos' within educational institutions and among educational staff, mental health providers, and public safety officials that impede appropriate information sharing."[318]

These "information silos" are management systems incapable of reciprocal operation with other. They are oftentimes related systems such as the staff, mental health providers, students and public safety at a secondary institution. Seung-Hui Cho had documented behavioral health issues, and although several campus entities knew tidbits of information related to Cho's mental state immediately preceding the shootings, the lack of information sharing, driven in part by antiquated FERPA laws, prevented these groups (or systems) from working together to get Cho help and perhaps prevent the tragedy.

FERPA was passed in 1974 and "prohibits disclosing without consent the educational records of students who attend or have attended an educational program that receives federal funding from the Department of Education. The right to consent belongs to the student's parents until the student reaches age 18 or attends a school beyond high school, at which time it transfers to the student."[319]

Information such as social security numbers, grades and other indicators of student performance, cannot be shared about an adult or postsecondary student without the student's permission.

However, distinct determinants were never established when it came to mental health reports. The unclear FERPA regulations combined with the Privacy Rule of Health Insurance Portability and Accountability Act (HIPAA) made universities wary of sharing any student information—even with parents who might be funding the student's education.

As a result of the Virginia Tech report, significant changes to the FERPA regulations went into effect in 2009. The changes that received the greatest level of attention were the "changes related to health and safety emergencies, which now allow greater flexibility in sharing information from a student's education record." According to section 34 CFR 99.36 of FERPA, "educational agencies and institutions are now permitted to disclose personally identifiable information, without consent, from education records to appropriate parties, including parents, whose knowledge of the information is necessary to protect the health and safety of the student or others."[320]

The broad-sweeping changes to Federal legislation did not render the McKee bill moot. The McKee bill pushed for a student to voluntarily sign a consent form for sharing of information if the student was deemed a risk to himself or others. The changes to FERPA regulation did make the red tape of information sharing (voluntary or not) much easier to navigate for universities across the country.

Colleges and universities could not stop there, however. According to the 2002 Colorado Trust report *Suicide in Colorado*, "Some risk factors associated with suicide are heightened during the transition to college. Young people disconnected from their traditional support structure and experience increased stress from the rigors of college. Research shows the most effective way to prevent suicide is to intervene early and determine the best form of treatment."[321]

Although changes were in the works at the national level, armed with this information from the Trust's report, Colorado was making changes of its own concerning suicide prevention in the university setting. During the 2006 legislative session, the Governor signed into law the, "Colorado Higher Education Student Suicide Prevention Act" and Senate Joint Resolution 13, "Concerning the Promotion of Suicide Education Programs in Higher Education." This legislation was "intended to promote awareness and educational programs to prevent suicide at institutions of higher education."[322]

"The Act called for the Colorado Commission on Higher Education to select one or more willing institutions of higher education to participate in a two-year pilot program, which would create a campus wide program to allow all students the option to fill out a consent form containing the contact information of a person who can be notified in case a student exhibits suicidal behavior"[323]–the wishes of the McKee family.

The Commission selected Adams State College, Colorado State University and Northeastern Junior College to implement the program. Although each of the institutions actively engaged in the creation or revamping of suicide prevention programming, Adams State College created a comprehensive Mental

Health and Suicide Prevention Policy, which was at the forefront of efforts by Colorado colleges and universities. The program was recognized at the "2009 Colorado Campus Forum on Mental Health held in Breckenridge as being 'fully 2 years ahead of other institutions in the development of policy to undergird efforts such as those described in this report.'"[324] Further indications of Adams State College's innovative program was that one of ASC's Students of Concern (SOC) Committee presented at the National Behavioral Intervention Team Association meeting held in San Antonio, Tex., in 2009.

Adams State College's program created:

- A voluntary student emergency contact provision gives students the opportunity to designate the person(s) the student would like Adams State College to contact in the event that concerns arise about the student's general state of mental health and potential suicidality specifically.
- The Students of Concern Committee (SOC) for proactively identifying students who may be becoming a threat to themselves or others.
- Clearer protocols with the San Luis Valley Comprehensive Community Mental Health Center and area law enforcement including the ASC Police Department in responding to students who are suicidal.
- Greater information sharing between on-campus entities such as the ASC Police Department, the Incident Management Team and academic departments with the SOC.
- Increased the training available to students, faculty and staff regarding identification and intervention with students who may be suicidal. This training has included improvements to Resident Assistant training including the "Behind Closed Doors" experiential training component, outside speakers such as Brett Sokolow from the National Center for Higher Education Risk Management, and sending students and employees through the two-day Living Works Applied Suicide Intervention Skills Training (ASIST).[325]

Independent of the Colorado Higher Education Student Suicide Prevention Act, Trinidad State Junior College was the recipient of a federal grant from the Garrett Lee Smith Memorial Campus Suicide Prevention Program to develop the Suicide Prevention Outreach and Education (SPOE) Project to address the need for suicide prevention, education and unified referral among a rural eight-county region of Southern Colorado. The SPOE Project goals were:

- to develop a coordinated and knowledgeable suicide prevention network coalition infrastructure among mental health, high school, college and community gatekeepers in the region;
- to develop social marketing campaigns to destigmatize mental disorders and increase help-seeking behavior among students by offering activities and materials to at least 800 students; and
- to provide training for at least 50 faculty, staff and administrators to increase the number of trained gatekeepers in the community.[326]

The Trinidad State Junior College SPOE Project was created in conjunction with Spanish Peaks Mental Health Services and in partnership with regional high schools in Huerfano, Las Animas, and six San Luis Valley counties that identified the need for a suicide prevention, education and outreach program to build unified, effective and sustainable suicide prevention and mental health awareness infrastructure through campus-based education and outreach.

BRIDGING THE DIVIDE: A STATEWIDE SUICIDE PREVENTION SUMMIT

Known for her campus-based suicide prevention efforts at Regis University, Dr. Sally Spencer-Thomas collaborated with the Office of Suicide Prevention, the Suicide Prevention Coalition of Colorado and Regis University to host the inaugural Bridging the Divide: Suicide Awareness and Prevention Summit. After five years in existence, the last Wings of Hope Conference took place in 2007. In 2008, Spencer-Thomas, who was serving as the Director of Leadership Development at Regis University in Denver, Colo., picked up the conference planning gauntlet and organized the Bridging the Divide Conference. "Conference tracks were included for first responders, educators, work place wellness coordinators, health professionals and those who lost a loved one to suicide. A banquet was held during the conference, where Speaker of the Colorado House of Representatives Andrew Romanoff presented, and First Lady of Colorado Jeanne Ritter and 9 News received awards of recognition for excellence in suicide prevention. A new documentary on men and depression, *Men Get Depression*, was screened and copies of the DVD were provided to all attendees." The Conference was attended by more than 300 people and continues annually today.[327]

That same year, the Office of Suicide Prevention and the Injury Community Planning Group at the Colorado Department of Public Health and Environment begin development of a training module for first responders (emergency medical service providers and law enforcement). According to the QPR Institute first responders have a high degree of line-of-duty exposure to suicidal behaviors "both in the pre-attempt phase (when suicidal persons are communicating intent and desire to attempt suicide via suicide warning signs), and after a suicide attempt or completion."[328] For this reason, first responders need to be trained to discern warning signs as well as diffuse potentially fatal situations. Simultaneously, first responders often have a higher-than expected suicide rate compared to other professions. With support from Colorado's State Emergency Medical and Trauma Services Advisory Council, trainings were delivered throughout Colorado. First responders were given information on "properly caring for individuals and their families when called to the scene of a suicide attempt or fatality, recognizing suicidal behavior among their fellow first responders, and the need for colleague-to-colleague interventions to prevent suicide."[329]

UNIVERSITY OF COLORADO AT DENVER DEPRESSION CENTER: A NATIONAL NETWORK

Although many first responders may not take their own lives in response to repeated interaction with suicidal situations, many could suffer from some form of depression. In 2008, the Depression Center at the University of Colorado Denver School of Medicine opened. The establishment of the Colorado Depression Center was the first step in a national effort to link centers focused on depression and bipolar disorder. The first Depression Center in the United States was founded in 2001 at the University

of Michigan as a comprehensive center devoted to patient care, research, education and public policy in depression and related disorders. The goal was to bring depression into the mainstream of medical research, care, education and public policy.

The University of Michigan, in conjunction with the National Institute of Health (NIH), launched the National Network of Depression Centers (NNDC) initiative in conjunction with colleague institutions across the nation. The primary goal of NNDC was to transform and accelerate the understanding and treatment of depressive and bipolar disorders by developing an integrated network of leading Depression Centers. The leaders of the initiative hoped that a nationwide network of research and clinically based institutions would allow for psychiatrists, psychologists, social workers and other mental health professionals to share information and best practices, and to team up for major projects. The multidisciplinary outreach programs of NNDC would help to better diagnose and treat depression and bipolar illness, as well as eradicate stigma associated with these diseases. With the founding of the new Depression Center at the University of Colorado Denver School of Medicine, the national initiative to link centers shifted into full gear.

> "The Colorado Depression Center was started in 2008 with the generous support of George Wiegers of Vail, Colorado. Inspired by the NNDC vision, Wiegers saw an opportunity to bring a state-of-the-art multidisciplinary disciplinary depression facility to Colorado. Wiegers approached Dr. Robert Freedman, Chair of the Department of Psychiatry at the University of Colorado with his vision for establishing the center, and through their partnership, the Depression Center was opened at the Anschutz Medical Campus in Aurora, Colorado.
>
> The Depression Center offers a specialized practice where senior faculty from the Department of Psychiatry provides expert consultations for patients with depression and mood disorders. Patients receive a comprehensive assessment, recommendations and a treatment plan based on the most current knowledge in the field.
>
> Our psychiatrists and psychologists collaborate with the patient and family to select state-of-the-art treatments. Options may include education, medication, and/or short-term evidence-based individual, group or family therapy. Most patients eventually transition to a provider in their community for long-term follow-up care.[330]

The Depression Center has a research arm focused on treatment of depression and bipolar disorder. The department conducts research on transcranial magnetic stimulation, a non-invasive treatment for depression. They also conduct studies on new pharmaceuticals for the treatment of depression and bi-polar, which are not FDA approved or available to the-public.

The research arm also focuses on the treatment of depression and other mood disorders outside the realm of traditional mental health. Research members work directly with obstetricians, emergency room physicians and family practitioners on the study of depression. For example, the Depression Center staff has helped create a suicide screening test model for recognizing and treating depression in a primary care setting.

In addition to the research division, the Depression Center also has a clinical arm dedicated to fostering the development of better psychotherapies. "We got started as a group of psychiatrists. All of us are

experts in our fields. We know the research and got frustrated with what drugs *weren't* able to do for our patients. For this reason, we're exploring other psychotherapies which might complement pharmaceutical treatments. We're working on things like exercise programs, sleep studies—a more holistic approach to the treatment of depression,"[331] says Dr. Michael Allen, Research Director of the Depression Center.

The Depression Center has a community programs arm that conducts education and outreach concerning depression. "We are very interested in promoting an adolescent depression awareness program, partly as suicide prevention. We are also doing community outreach—trying to get outside of our four walls to work with interested parties to increase knowledge and expertise about depression."[332]

A community outreach focus led staff from the Colorado Depression Center to a collaboration with the Aspen Valley Medical Foundation. In 2009, an Aspen resident approached the Aspen Valley Medical Foundation about his experiences with the mental health system in the mountain community. As the man sought help for his teenage daughter in crisis, he was dismayed to discover how difficult it was to get her the help she needed. He found the system nearly impossible to navigate. There was no centralized access point to help him identify and screen providers in the area, and when he did find providers, he found them difficult to access. He was frequently told that to get her the help she needed, they would have to go elsewhere, to Grand Junction, Denver or even outside of the state. The man approached the Aspen Valley Medical Foundation with a request that they lead the charge to fix the system.

The Foundation contracted with the University of Colorado Denver Depression Center to conduct a thorough assessment of the Aspen community's mental health system and develop a series of recommendations for transforming it into a model for other communities. Over the course of 10 months, a Depression Center team of experts in clinical delivery, program development and evaluation, mental health systems management, emergency mental health and suicide prevention engaged the Aspen community to discover strengths that could be built upon and develop a strategic plan for areas where there is an opportunity for change and improvement.[333]

The Depression Center has also joined forces with the Office of Suicide Prevention and the Suicide Prevention Coalition of Colorado to offer public relations and messaging support. "I look around the room at SPCC meetings and there are a lot of people with deep knowledge and emotion about suicide who may have limited resources. What we would like to do is bring some of the Depression Center resources—our experience with media relations, our teleconferencing capabilities, our technology—to the table to help SPCC to move a little faster on some of the things that they want to do," [334] says Michael Allen.

FAITH-BASED COMMUNITIES FOCUS ON SUICIDE AND MENTAL HEALTH

Another member of the Suicide Prevention Coalition of Colorado involved in innovative suicide prevention programming is Susan Marine of Boulder. In October of 2007, Marine attended a conference called "Mental Health and Faith Communities: Sharing the Promise of Hope and Healing." Representatives from 20 faith communities in Boulder and Broomfield counties met with

representatives from the National Alliance for Mental Health (NAMI) Boulder County, Mental Health Partners and the Boulder County Aging Services to discuss the idea of "Mental Health Ministry." The mission of mental health ministry is to develop the capacity of faith-based congregations to support recovery and wellness with individuals and families facing serious mental health issues.

From this daylong conference the idea for the Interfaith Network on Mental Illness (INMI) was born. Susan Marine, who lost her son to suicide in 2003 and her daughter to suicide in 2007, was a co-founder of this organization.

"One of the interesting things about mental health is that it isn't a 'casserole' dish. There is so much stigma around it, and people who have mental health problems in their family are not treated as others who have 'legitimate' medical illnesses in their family."[335]

Marine was a member of church where the minister's husband suffered from mental illness, and thus she-was surrounded by a caring community who realized the importance of fostering personal and community mental health.

"It's a somewhat unusual faith leader who is going to put much emphasis on mental health or suicide because the excuse seems to be that they have many other things to do. But we developed a mental health ministry at our church. This spurred the idea for the Interfaith Network on Mental Illness. The group aimed to reach out across the community to people of all faiths."[336]

INMI operated as an outreach program of NAMI Boulder County until December of 2010, when it became a standalone non-profit. Since its inception, INMI "has offered a series of conferences, workshops and other events for clergy (pastors, ministers, priests, rabbis, imams, etc.), staff and lay leaders of faith communities in Boulder and Broomfield counties."[337]

Marine and the co-founders spearheaded the development of a mental health resource guide for faith communities in the Boulder/Broomfield area. The group compiled material from the National institute of Health and NAMI for all major mental illnesses. They also created a directory of local resources that are available to people with different kinds of mental health issues. The final section offer tips on making a faith community more responsive to persons with mental illnesses. INMI sells the directories to faith-based congregations.

"It's our hope that the guide will be in a location where it can be easily accessed and somebody can find resources for specific needs or perhaps just browse it and get some general information about mental illness."[338]

In addition to its local programs, in April 2011 INMI launched a separate website, The Caring Clergy Project, for faith community leaders anywhere. The Caring Clergy Project serves the same purpose as INMI, "to increase awareness and understanding of mental illness among clergy, staff, lay leaders and members of faith communities and help them more effectively develop and nurture supportive environments for persons dealing with mental illnesses and their families and friends"[339] on a national

level. The project aims to provide useful information about mental illness, to allow clergy people to recognize if a congregant needs to be evaluated and treated by a mental health professional.

COLORADO'S SCHOOL SAFETY RESOURCE CENTER

Following the Virginia Tech shootings, President George W. Bush requested that Colorado Governor Bill Owens convene a group of Colorado's top school safety experts, including many of those involved in the Columbine Review Commission, to study broad mental health issues as they relate to Columbine and other acts of school violence. Due to the unfortunate circumstances surrounding the Columbine tragedy, Colorado had developed a cadre of school safety experts who could be called upon to advise on a national-scale after the Virginia Tech shooting. The following year, new-Governor Bill Ritter made school safety a top legislative priority for his 2008 agenda.

That year, Colorado School Safety Resource Center Bill (SB 08-001) was signed into law, mandating the establishment of the School Safety Resource Center in the Department of Public Safety to "assist schools in preventing, preparing for, responding to and recovering from emergencies and crisis situations and to foster positive learning environments. It includes the identification of pilot sites to receive enhanced school safety services. This legislation created the Center's advisory council, composed of representatives from five other state agencies, higher education and school districts."[340]

Linda Kanan was a Colorado school psychologist for 25 years before being hired as the director of the new Colorado School Safety Resource Center (CSSRC). From 2003 to 2008, Kanan was the Intervention Coordinator for Cherry Creek Schools, serving as the main district consultant on suicide threats. She was interviewed for her position at Cherry Creek Schools by Dr. Bill Porter. She credits the mentorship of Porter and school psychologist Tom Barrett with her early career interest in suicide prevention.

Kanan positioned the Center to collaboratively assist local schools and communities to create safe, positive and successful school environments for Colorado students in all pre-K—12 and higher education schools. CSSRC provides consultation, resources, training and technical assistance to foster safe and secure learning environments, positive school climates and early intervention to prevent crisis situations.

"We have equal numbers of requests for trainings on threat assessment, suicide prevention and intervention and bullying. We provide resources to schools to assist districts and individual schools with their safety planning," [341] says Kanan.

One such resource created by the School Safety Resource Center is "Suicide Prevention and Intervention—A Guide for Schools." The guide provides in-depth information to assist schools with planning a suicide prevention program. There are sections dedicated to suicide prevention programs available to schools (ASIST, QPR, SafeTEEN, Yellow Ribbon, etc.) with information about how to obtain and implement each program, the cost and target audience. The guide does not endorse any specific program or service, but instead provides resources for further investigation by a district and/or school before implementation in the community.

As part of the Resource Center's community trainings, they developed a series of Youth Suicide Symposiums. In a partnership with the Office of Suicide Prevention and the Colorado Department of Education, CSSRC offered the first symposia in May of 2010 in Lakewood, Colo. CSSRC convened a panel of experts who presented on the topic of suicide prevention, intervention and postvention. Presenters such as Leslie Clemensen, the Student Wellness Coordinator for Douglas County Schools, presented on successful suicide prevention work within her school district. Event attendees were school counselors and psychologists, school administrators and directors. The first symposia was so well received, the CSSRC has hosted two in more Highlands Ranch and Montrose. In total, the CSSRC symposiums have trained more than 525 people in youth suicide prevention across the state.

"Not only do we have expert panels, but we've put together resource guides and information. Attendees can sit at tables with their school teams and leave with actual resources that other school districts have created and implemented to be used as models. These include suicide assessment forms, mental health and counseling intake forms, and more. These allow districts who may not have organized suicide prevention efforts yet to use, take and adapt what other districts are doing," says Kanan.[342]

The CSSRC operate with a staff of four and utilizes an appointed Advisory Board comprised of community experts like Jarrod Hindman, the Director of the Colorado Office of Suicide Prevention. "The original funding was supposed to be for six staff people in our office. But due to tough economic times, we've already taken a 30 percent reduction to our budget, and we've only been operating for three years. We're doing the best that we can though, by fostering collaborations with other professional organizations," [343] says Kanan.

The CSSRC also provides technical assistance to many of these organization—coalitions and community advocacy groups throughout the state. The Center provides much needed facts and figures to legislative Bill sponsors. In 2010-11 the Center's staff worked closely with Senator Pat Steadman and Representative Sue Schafer on Colorado's anti-bullying legislation.

House Bill 11-1254, for which the CSSRC provided technical assistance was signed into law on May 13, 2011. The increasing number of suicides attributed to bullying across the country finally gained the attention of the legislature. HB 1254 establishes "a number of initiatives designed to deter student behavior known as bullying, defined as expressions – physical, verbal or electronic – intended to coerce, intimidate or harm other students."[344]

The provisions of HB 1254 will not be implemented by the Department of Education until "sufficient moneys have been transferred or appropriated to the Cash Fund, and then, the Department of Education will decide which public schools, facility schools or collaborative groups of public schools will be awarded grants for the school bullying prevention and education program."[345]

Kanan is quick to warn that bullying is not the root cause of suicide. "We need to work on how we message the link between the two topics. There has definitely been a connection in recent years between bullying/cyber-bullying and suicides. Bullying isn't the only cause of suicide, although it may have been the trigger."[346]

SUPPORTING SUICIDE ATTEMPT SURVIVORS

In 2006, Juliet Carr's father made two unsuccessful suicide attempts. After her father was taken to an emergency room, admitted for emergency observation, charged with a felony suicide attempt in the state of Florida and subsequently released, Carr's family was left reeling from what had transpired. Carr "searched in vain for some tool, book, website, support group, e-book or pamphlet to help [her] feel validated, supported, not alone and less confused."[347] When her search left her feeling empty and more confused, Carr and sister realized that other family members of attempt survivors must share similar feelings.

"We were looking for resources to support each other within our family. We wanted answers to questions like: Is what we are doing to support each other normal? Are we being healthy? How do we support my Dad? What do I tell my children?"[348]

With few answers available to her, Carr decided to create some of her own. She sent out a series of surveys and began receiving phone calls from loved ones, friends, and suicide attempters. The information that Carr gathered was compiled into a book, *Attempted Suicide: The Essential Guidebook for Loved Ones*. The book combines more than 30 interviews from attempt survivors with resources and advice for families and friends in the aftermath of a suicide attempt. Carr hopes to have the book published in 2011. After completing the book, she hoped to donate future proceeds to an organization that provided help to those affected by suicide attempts. When Carr did not find such an organization, she and her sister founded one themselves.

"Before we did this, I really wanted to make sure something didn't already exist like our foundation and our website. I connected with the Suicide Prevention Coalition of Colorado and the American Association of Suicidology and discovered that no organization like ours existed. It's mind boggling to me. Attempted suicide is so much more common than completion, but we hear so little about support after an attempt."[349]

The Kirwan-Carr Foundation was established in 2008 as "the first international organization dedicated to supporting individuals affected by a suicide attempt. A suicide attempt is an act focused on taking one's life that is unsuccessful in causing death. The foundation's goals will be accomplished by:

- Creating a website (www.AttemptedSuicideHelp.com) that will provide immediate access to support and resources.
- Researching and interviewing people who have attempted suicide and people who have had a loved one attempt suicide.
- Providing age-specific books written for adults, teens, and children. The first one is entitled *Attempted Suicide: The Essential Guidebook for Loved Ones*
- Creating a documentary that will give a voice and face to the millions of people while addressing the stigma surrounding suicide and suicide attempts.
- Raising awareness about the effects on loved ones when someone attempts suicide.

- Providing support and referrals in the form of a chat room or message board and volunteers willing to help and share their stories through the website.
- Receiving feedback and input from survey and feedback forms on the website—the foundation will be consumer driven.
- Advocating for change in the mental health industry and the way attempters and their loved ones are treated by hospitals, counselors and doctors.[350]

In the coming months, the Foundation will launch their comprehensive website www.AttemptedSuicideHelp.com, which will provide 24/7 access to resources and downloads to guide families through the immediate days, weeks and months following a suicide attempt.

"We'll offer practical tips for the first 72 hours after an attempt. Things people can do on a daily and weekly basis to help themselves and their loved one. Big things like creating a safety plan and scheduling a counseling session before you even leave the hospital. Little, but very important things, like always carrying a water bottle and a notebook with you. People don't realize that in their shock and grief, they are dehydrated because they haven't had anything to drink in three days. They also discover that they think they will remember names of doctors, nurses, therapists, but in the haze after a loved one's attempt, it helps to write things down."[351]

The future of the Kirwin-Carr Foundation holds plans for a documentary to give a face to attempters, and perhaps the creation of a smart phone application.

"I'd like to see something that would create an email or a pop up on your phone every day. It would provide daily reminders encouraging family members to focus on their own wellness as well as that of their family member. One day it might say, 'Go for a walk around the block today.' Another will say, 'Give someone a hug today.' It's easy to hole up in your house after a family member's suicide attempt. Out of shame, out of fear, out of unsurety. It's so important for people to maintain contact with others, both emotional and physical."[352]

THE ROCKY MOUNTAIN WEST: A HUB FOR MILITARY RESEARCH ON SUICIDE PREVENTION

In 2009, the United States Army convened a Suicide Prevention Task Force. Two committees on the Task Force were a community prevention committee and a screening and assessment committee. Longtime suicidology colleagues, Peter Guterriez, a Research Clinical Psychologist at the VISN 19 MIRECC in Denver, and Thomas Joiner, a leading expert on suicide from Florida State, served on the Army screening task force committee.

"Our goal was to provide expert consensus on how the Army should be screening and assessing for suicide risk. A related task was to provide recommendations to the Department of Defense about changes to the post-deployment, mandatory comprehensive health screening when soldiers first return from deployment," says Gutierrez.[353]

After six months of study, the task force was convened by the Military Operational Medical Research Program (MOMRP) to share findings. At the time, Joan Hall, the Senior Program Manager of

Psychological Health Research Program, U.S. Army Medical Research and Material Command, MOMRP, was advising on the research portion of a grant proposal for the MOMRP.

"Dr. Hall approached me with lots of questions. She had been working closely with the suicide research portfolio and had been thinking about ways that the Department of Defense could better coordinate all of this suicide research they wanted to do. I told her about several clinical trials which Thomas [Joiner] and I had discussed. She asked us if we had considered putting together a consortium," says Gutierrez.[354]

Gutierrez and Joiner created a proposal for a Military Suicide Research Consortium. In 2009, the Department of Defense Assistant Secretary of Defense (Health Affairs) from the Defense Health Program Enhancement (DHPe) awarded a $17 million federal grant to Florida State University and the Denver Veterans Affairs Medical Center to establish the Department of Defense Military Suicide Research Consortium (MSRC). "The consortium was the first of its kind to integrate Department of Defense and civilian efforts in implementing a multidisciplinary research approach to suicide prevention."[355]

"The VA and the Department of Defense recognized that even with all of the smart people they have, they don't have a lot of background in suicidology unless they collaborate with university-based researchers. It was a smart leveraging of dollars on the part of the military to take the best advantage of intellectual resources available in this field."[356]

The Denver Veterans Affairs Medical Center and Florida State University were each awarded $8.5 million to address suicide as a public health issue across the military and the general population. "Through a multidisciplinary approach and the use of state-of-the-art research methodology, the MSRC will yield new scientific data regarding suicidal behavior. Novel findings will assist in the development of more effective prevention interventions, risk assessment methods and treatments to decrease suicide. Findings also will serve to provide recommendations for improving policy and clinical practice guidelines."[357]

"Assessing risk for suicide has been the focus of extensive research in the civilian sector," says Gutierrez. "However, very little is currently known about how relevant existing tools are when applied to the military. The consortium will allow us to determine how best to screen and assess personnel, develop effective interventions and ultimately reduce suicides."[358]

Colonel Carl Castro, MOMRP director, underscored the need for scientifically proven prevention and screening methods. He noted that currently none of the suicide prevention training used by the military is evidence-based. "[They are] good ideas, experts thinking that is what we need to do, but we do not have any evidence that that training actually, in fact, prevents suicides."[359]

A database of suicide research that is relevant to the military will be created as part of the consortium's work. The system will be searchable and will be used to provide suicide research data to policymakers and others. "We are working out agreements with other research teams around the world who are conducting relevant research, and hopefully, gathering preliminary data from them as well so it is all

available in one centralized data warehouse that will be fully searchable and fully queryable,"[360] said Gutierrez.

The efforts of the consortium are different from previous research in that a coordinated set of studies will be developed, rather than one single project conducted over time. External advisory boards will help identify gaps in the current literature on military suicide, and the consortium will work with a pool of researchers from around the world to develop research proposals and conduct the research.

"The Consortium has allowed us to capitalize on the relative 'smallness' of the suicidology field. There aren't that many suicidologists. We all know each other and collaborate with each other all the time. When we put in the final proposal for the MSRC, we incluced a list of suicidologists who had agreed to be members of the research program. This is an international group of the 'who's who' in the field. Thomas [Joiner] and I set a research agenda for the consortium based on what we believe are the priorities – screening/assessment and intervention. We then went to our research program members and said, here's where we're focusing research."[361]

The research program members returned with six project proposals, which are under review for funding. Five are intervention studies and one is a screening/assessment study. The intervention projects are focused mostly on active military personnel as participants and the assessment study is being run at the Veterans Administration. The projects will test things like cognitive intervention for sleep problems.

"Sleep disturbances are a significant probe into PTSD and depression. They are also significant drivers of suicide in the general population. Sleep disturbances are relatively easy to treat with cognitive therapy, and there is much less stigma to treating those problems than calling them 'mental health issues'. We see this one as brief and easy to deliver in a very effective way,"[362]says Gutierrez.

Other projects are designed to be tested in the field—in the everyday lives of soldiers or Veterans. One example is the iCaring Text Message. "In the 1960s Jerome Motto, a University of California at San Francisco psychiatrist, came up with the idea of sending periodic caring letters to suicidal folks—expressions of concern about their well-being. In 1969, he convinced the government to fund an 843-patient trial in which half the people got letters and half didn't for five years. For the first two years, when letters were most frequent, there were half the number of suicides in patients who received them."[363]The iCaring Text Message is a twenty-first century version based upon this premise. Soldiers will receive a series of supporting messages during their aftercare period. One set of messages would be identical and the other set would be tailored to each individual's unique risk and protective factors.

Capitalizing on Smart Phone technology, the Department of Defense has been developing mobile applications such as a smart phone PTSD coach. MSRC is currently evaluating a proposal for a Mobile Hope Kit. One component of cognitive therapy for those at-risk for suicide is to create a box or place filled with concrete reminders of their reasons for living like letters from families, photos, mementos, etc. Suicidal individuals can review this "hope kit" during a time of crisis. The Smart Phone app, Mobile Hope Kit, will be built upon the same idea. "The project would build a library of items that could be

accessed from a soldier's phone: audio files, videos, photos, texts—anything that reminds an at-risk soldier of his or her reasons for living."[364]

HEALTH AGENDA AND ASSESSMENT IN THE DENVER PUBLIC SCHOOLS

The same year as the founding of MSRC, Denver Public Schools published its *DPS Health Agenda 2015*. The Health Agenda was created by a task force because:

> Denver Public Schools (DPS) recognizes the significant impact that health has on the academic achievement of students. Healthy kids make better students, and better students make healthier communities. Plus, a healthy workforce contributes to more effective instruction, operations and positive role modeling in school settings. Schools contribute to health in many ways, including nutrition services, physical education and the work of school nurses, social workers and psychologists. Schools also strive to provide a safe and enriching environment for learning.
>
> DPS hopes to make a notable difference by focusing energies and resources on a targeted set of health goals that can be accomplished within five years. This set of goals is called the DPS Health Agenda 2015.
>
> The DPS Health Agenda 2015 was developed by the Denver School Health Advisory Council through the work of committees and with input from more than 1,200 stakeholders who completed a survey.[365]

Ellen Kelty, a team leader for the Denver Public Schools Department of Social Work and Psychological Services, was integral in writing the social and emotional goals in the document. One of the two social and emotional goals in the document was to provide Signs of Suicide (SOS) curriculum to every sixth and ninth grader in the Denver Public Schools by 2015. Recognizing that most suicidal youths are not likely to seek help, DPS made it a priority to educate students at the most influential times, sixth and ninth grades, proven to be transitional years (to middle school and high school) and consequently, challenging to youth.

"We chose the 'Signs of Suicide' program because it has been shown to reduce suicide attempts by 40 percent among the student population. We also want to train almost 180 social workers and school psychologists who serve our schools,"[366]says Kelty.

Kelty's staff not only trains students, but extends offers for parents to take part in staff and parent trainings as well. The DPS team has discovered several obstacles in the SOS trainings due to the cultural diversity of Denver Public Schools. "We've translated everything into Spanish, and a lot of my staff speaks Spanish and can deliver the trainings. However, we have over 100 different languages spoken by our DPS families. I had a student ask me if we could translate the curriculum into Burmese," says Kelty.

Kelty, the main point of contact for suicide prevention in the district, has created a comprehensive suicide risk assessment form and an electronic database that promotes cross-platform information sharing about a student's mental and physical health.

"We've had people from other states call and ask if they can use our Risk Assessment form. It's very comprehensive, and the biggest thing is that each section has multiple check boxes to ensure that nothing falls through the cracks."[367]

If a student is identified as at-risk for suicide, two DPS staff people must immediately conduct a risk assessment using the form. During the assessment, staff people ask about not only the incident or statement which prompted the student to be flagged as at-risk, but ask about a student's plan for suicidal behavior and whether they have access to means. DPS personnel are required to contact the principal and students' parents before the assessment is considered complete.

"We work with all of the team members to ensure that this student will have a safety plan in place when they walk out of the school. The parents need resources to get professional help for their child. The student needs a plan with designated 'safe' people to talk with when those hopeless feelings surface. We also ask our students to sign a pledge committing to not hurting themselves. Some people will tell you that these pledges aren't effective, but we've had a positive response to them."[368]

Kelty also requires staff members to write pledges documenting steps that they plan to take toward building resiliency characteristics in their students. She has made SOS training a part of teachers' professional development recommendations and offers professional development credits for the classes.

DPS has also committed to working with specific high-risk population such as kids in special education and the LGBTQ community. Kelty is part of an LGBTQ Task Force that "exists to ensure that district policy is enforced and to offer advice to the Board about issues that affect Gay and Lesbian students, staff, parents, and the community."[369] The Lesbian, Gay, Bisexual and Transgender Education Advisory Council is comprised of DPS staff, representatives from Rainbow Alley, local PFLAG chapters and the Gill Foundation.

The task force addresses specific issues such as:

- Training of school personnel to be more understanding of the issues affecting GLBTQ youth
- Direct support to students including those students attempting to create GSAs
- Making materials available to students, teachers and schools in an effort to meet the needs of GLBTQ students
- Advising on policy changes and inclusion
- Offering advice and help in dealing with specific issues that arise at each school.[370]

"We're focused on early intervention at Rainbow Alley, and we're working with service agencies all over the city to ensure that our LGBT and questioning youth are connected with the support they need. Our work with the DPS LGBTQ Education Advisory Council has been a great collaboration. It's allowed all of the parties to not only work on fostering a better school environment for our youth, but to specifically address issues surrounding bullying with the HB 1254 legislation,"[371] says Corey Barrett, Director of Rainbow Alley.

NATIONAL ACTION ALLIANCE: TEN YEARS IN THE MAKING

In 2010, the National Action Alliance for Suicide Prevention was established. 2010 was a particularly significant year because it was the 10-year anniversary of the National Strategy for Suicide Prevention

(NSSP). "The National Action Alliance for Suicide Prevention provides an operating structure to catalyze planning, implementation and accountability for updating and advancing the National Strategy for Suicide Prevention. Out of this alliance will grow advancements for practitioners, policymakers, service providers, communities, families, agencies and other partners that play a vital role in reducing the burden of suicide in America."[372]

Sally Spencer-Thomas, Executive Director of the Carson J Spencer Foundation, was named Executive Secretary of the Action Alliance, and was particularly instrumental in the selection of the private sector and public sector candidates to lead the Alliance. The private sector co-chair is former U.S. Senator Gordon H. Smith, who is currently President and CEO of the National Association of Broadcasters in Washington, DC. The Garrett Lee Smith Memorial Suicide Prevention Act was named for Gordon Smith's son who took his life days before his 22nd birthday.

Representing the public sector as the co-chair is Secretary of the Army John McHugh. Combined with the initiatives already underway (MIRECC under the Veterans Administration and the MSRC under the Department of Defense), adding McHugh to the National Action Alliance was a bold statement for the military's serious focus on the suicide.

"The global problem of suicide deserves a unified approach to prevention," said Secretary of the Army John McHugh. "We may never completely eradicate suicide, but we will not be deterred from focusing our best efforts each and every day on preventing this tragedy."[373]

CONCLUSION

Tracking the history of suicide prevention, postvention and intervention in Colorado does not provide all of the answers to the devastating and ongoing problem of suicide. Some may say that these 60 years of documented history have been all for naught. In spite of the tireless work of the individuals and organizations in this document, the rate of suicide in Colorado continues to increase yet we will never know what our rate would have been without these measures.

Some of this increase may be due to broad-sweeping national challenges in the last 10 years. Our country has been faced with an ongoing recession; high unemployment rates; the stresses of multiple international conflicts and wars, which result in recurring deployment of our military; bleak job prospects when our soldiers reenter the civilian workforce; and less access to mental health services, as state and local budgets are sliced.

We are also faced with more Colorado-specific challenges:

- High gun ownership which provides more access to lethal means, resulting in more suicide completions. ("There are at least a dozen U.S. case–control studies in the peer-reviewed literature, all of which have found that a gun in the home is associated with an increased risk of suicide. The increase in risk is large, typically 2 to 10 times that in homes without guns, depending on the sample population [e.g., adolescents vs. older adults] and on the way in which the firearms were stored."[374])

- Overcoming the stigma of depression and mental health issues in the midst of an antiquated Western "Pull-yourself-up-by-the-bootstraps" mentality.

- And in recent months, the speculation that high-altitude may exacerbate the effects of existing mood disorders in at-risk individuals.

When faced with all of these seemingly insurmountable challenges, it would be the easy choice to throw our hands up and say, "We'll never make a difference in preventing suicide. Why continue to try?" But, Colorado has done just the opposite. Our suicide prevention efforts are built around a cadre of "compassionate risk takers—compassionate to people's plight, while at the same time, strong enough to say, 'Something needs to be done about this.'"[375] With limited funds and sparse staffing, these dedicated people have managed to create new data-driven programs that have been accepted onto the SPRC's Best Practices Registry and have continued to contribute to the ongoing national conversation about suicide prevention.

"Colorado has a huge network of people in the suicide prevention, intervention and postvention world. In spite of few dollars and disparate agendas, these often fragmented 'mom and pop' shops have managed to make a real difference,"[376] says Jarrod Hindman, Director of Colorado's Office of Suicide Prevention.

But one might counter with the argument that the numbers of completed suicides have continued to grow. The evaluation of suicide intervention and prevention programs is different than other

developmental programs. In prevention, the major goal is immeasurable. One cannot simply cite a decrease in suicide attempts as proof of success. In prevention, the success lies with all of the people that we don't know about. The individuals who are still alive because a trained gatekeeper recognized the signs of depression or suicidal tendencies; the teenager who decided not to take her life after participating in a suicide awareness training at school; the son who recognized the signs of his father's bipolar disorder after a community presentation and got help for his father. These are the statistics that are not recorded and published in the reports.

What makes Colorado unique in its suicide prevention efforts? The citizens of Colorado were organizing and pushing for state-level support for suicide prevention before it even became part of the national agenda. Colorado has a virtual directory of leaders who have been trend-setters in the world of suicide prevention – creating school-based education programs, conducting scientific research in the field of suicidology, serving on national committees and federal work groups to advise others about what has and has not worked in suicide prevention. Colorado is a heavy-hitting state thanks to professionals and community advocates who have the manpower and the voice to evoke change at a national level.

But it is time to evoke change at the state level once again. In 1998, our group of compassionate risk-takers had a cause around which to rally—creating a plan and advocating for funding to open an Office of Suicide Prevention. The passion of these individuals and organizations gave birth to the Suicide Prevention Coalition of Colorado. Throughout the years, SPCC has served as a guiding body—an umbrella under which all of Colorado's leaders can gather to exchange ideas and organize to evoke change. Although many of Colorado's beacons of suicide prevention are still members of the statewide coalition, many have stepped back into their own communities or back into the national fight. Our state-level fight, in spite of a coalition, is mere embers in comparison to the work that needs to be done.

Here we are 13 years later, the Coalition and our individual leaders of prevention need to rally around another state-level fight. The Office of Suicide Prevention was founded in 2000 with a budget of $157,846. Colorado Senate Bill 149, which was signed into law in March of 2011, includes $283,843 for suicide prevention. Although this marks in increase in funding, in the year 1992, the State of Washington allocated $2 million for a suicide prevention program.[377] In the "Analysis of Colorado's Suicide Prevention and Intervention Plan," written by students at the University of Colorado at Denver Health Science Center Graduate School of Public Affairs, the authors stated:

> We have found the Office of Suicide Prevention's means of implementing the 1998 plan to be highly efficient. For every dollar appropriated to the OSP by the State, $3.75 were leveraged in Federal grants, substantial partnerships, and fundraising efforts, maximizing the total fiscal resources available to the OSP (Colorado Department of Public Health and Environment, 2002-2007).[378]

The Office of Suicide Prevention has managed to leverage its available funds to the hilt, but Colorado has multiple other primary prevention programs funded in the millions of dollars. An increase in the Office of Suicide Prevention's funding would allow suicide prevention programming in Colorado to grow. "I could write at least three or four job descriptions that would be beneficial to our office,"[379] says Hindman.

The Coalition is still comprised of a strong group of passionate risk-takers—albeit a much smaller group than 13 years ago. Better equipped, this group could re-engaging leaders who are based in Colorado and reach out to those who may be fighting the national fight in Colorado but could be helping with our state efforts, as well. We need to demand more funding for suicide prevention programming and the Office of Suicide Prevention, more direct suicide-prevention legislation and a standardization of resources. It is the hope of the author, that this historical document will be the catalyst that will reignite the state-level flame.

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SPCC
Suicide Prevention Coalition of Colorado

Colorado Department of Public Health & Environment
Office of Suicide Prevention

STATE OF COLORADO
1876

Colorado Department
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and Environment