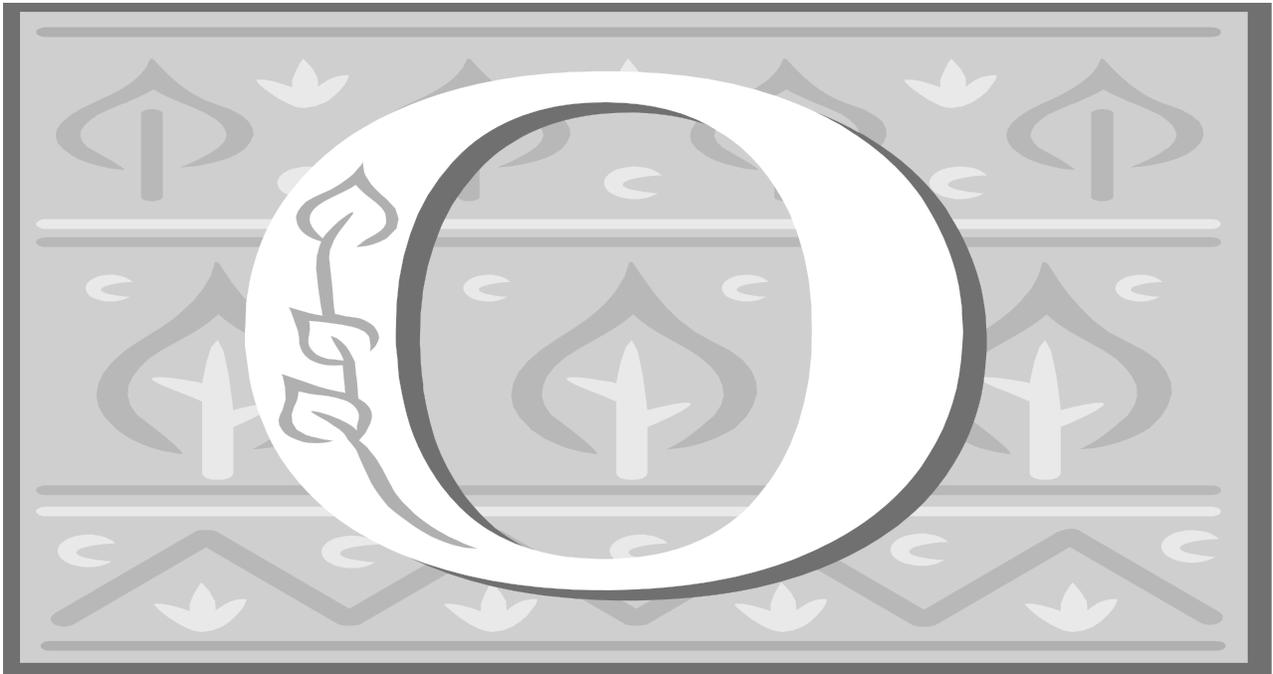


Pennsylvania Older Adult Suicide Prevention Plan



Zero Suicide- Not another life to lose

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INTRODUCTION

In the United States, one of the highest rates of suicide is found among older adults. Suicidal behavior later in life is intentional and lethal, especially among older white males. The risk of dying is greater in suicide attempts made by older adults. Risk factors can be identified; interventions and prevention can be successful. However, increasing awareness of the similarities and the differences of older adult suicide from adult and youth suicide is essential for an effective plan. As the older adult population increases over the next several decades, the numbers of late life suicides will dramatically skyrocket. "Baby Boomers" (those born from 1945-1964) already have substantially higher suicide rates than the World War II and other generations.

The five-step public health model of prevention is utilized here to identify the problem of suicide in older adults, identify risk and protective factors, develop and test interventions, and implement and evaluate interventions. It should be noted that detection of potential suicide in later life is complicated by the assumption that many of the symptoms, emotions, and circumstances in older persons that might be related to suicide risk, are often thought to be part of the normal aging process or confused with a physical problem.

Step 1: Defining the Problem

Older Adult Suicide Data

The older adult population is the fastest growing population in Pennsylvania and the United States. According to the Centers for Disease Control and Prevention (CDC), suicide rates increase with age and are among the highest for those 65 and older. According to the American Association of Suicidology, older adults represent 12.5% of the population; however account for 15.7% of all suicide deaths.

My mission in life... to promote the awareness and the prevention of suicide. It has been 2 ½ years since I lost my son Desmond. I still cry. I visit the cemetery every single day. I pray for him. I ask why...

Nothing has changed. The only thing that has changed is that I have learned to live better with the pain. The pain does not and will not ever go away.

You only learn to live with it.

Suicide has such a ripple effect.

Mother, father, brother, friends, aunts, uncles, grandparents, cousins,

employers, co-workers... I can go on

and on with the list. When someone

dies, not by suicide, people say, they

lived a good life or now they are not

suffering any longer. There is nothing

to say or nothing that can be said

when someone takes their own life.

We all need to work together to get in

the minds of those who are

contemplating suicide and help them

before it's too late.

Mark W. Schantzer

Gender

In the United States, more than 7,000 adults aged 60 years and older die of suicide annually. As the population ages, these numbers are expected to increase.¹ Approximately 83% of those suicide deaths between 2005-2007 were men, with a rate approximately six times that of women. While rates of suicide among women decline from middle age through older adulthood, the opposite pattern is seen with males whose rates increase with age.¹ Older adult male rates of suicide are nearly six times that of females (28.3 and 4.9 per 100,000 population). Male rates of suicide increase dramatically with age from 23.3 per 100,000 for those aged 60-69 years, 26.8 for those aged 70-79 and 35.6 for those aged 80 or older.²

Race/Ethnicity

During 2005-2009, the highest suicide rates for males age 65 and older were among non-Hispanic whites (32.37 suicides per 100,000) and the highest rate for females ages 65 and older were among the Asian/Pacific Islanders (6.01 suicides per 100,000).³

Means

Between 2005-2009 the greatest percentage of suicides occurred using firearms among all race/ethnic groups for persons 65 years and older except Asian/Pacific Islanders (non-Hispanic whites 74.1%, non-Hispanic blacks 74.8%, Hispanics 51.5%, American Indian/Alaska Natives 75%). For Asian/Pacific Islanders, suffocation accounted for the highest percentage of suicides among those 65 and older (52.4%). For three age groups (10-24, 25-64 and 65+) the greatest percentage of fatal self-harm injuries occurred by the use of firearms, with those 65 and older having the highest percentage of any age group (45.5%, 47%, and 72.1 %, respectively).³

Circumstances

Precipitating circumstances were identified for approximately 87% of older adult suicides. Current depressed mood (37.4%) current mental health problems (35.2%) and physical health problems (46.2%) were the most commonly identified circumstances. Older adults who die by suicide are more likely to have depression than individuals who die by suicide at a younger age. Many older adults who die by suicide recently visited a primary care physician: 20% on the same day, 40% within one week and 70% within one month of the suicide. Of those who died by suicide, 30.7 % left a suicide note and 23.4% disclosed their intent to die by suicide.² The results of toxicology testing following suicide in older adults indicates that females were more likely than males to be positive for antidepressants (45% and 19% respectively) and for opiates (37% and 18%, respectively). The percentage of positive tests for alcohol, amphetamines, cocaine and marijuana were nearly equal in both sexes.¹

Pennsylvania Data

Pennsylvania suicide trends for those aged 55-74, has varied from a low of 11.2 per 100,000 in 2001-2002 to a high of 14.7 in 2008-2009 (the most recent data year available). The five-year average suicide rate among Pennsylvanians ages 55 and older is lower than the rate in the 20-54 age group. Pennsylvania's rates are slightly lower than national rates and slightly higher than rates in regions 1-3, (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode island, U.S. Virgin Islands, Vermont, Virginia, and West Virginia).⁴

Step 2: Identifying Causes through Risk and Protective Factors Research

Risk Factors for Suicide in Older Adults:

Biological, Psychological and Social Risk Factors

- Depression (including late-onset depression)
- Co-occurring disorders, especially depression, diabetes, heart disease and stroke
- Somatic complaints
- Severe pain
- Frailty and perceived health decline
- Medications (amount and type)
- Burdened caregivers of older adults
- Inflexibility
- Low self-esteem, feelings of loss of dignity or control-sense of "being a burden"
- Anxiety, agitation, traumatic grief
- Isolation- "lack of belonging"
- Marital status (widowed, divorced)
- Race (White)
- Gender (male)
- Sexual orientation and gender identity

I first became aware of suicide at the age of 11, when I saw my father attempt suicide. I never imagined that I would ever be capable of getting to a place where I could try that, knowing how much that event affected me. Unfortunately, there was a time when I didn't have the will to be here any longer; but I found help, and over the years since then I was able to find knowledge and tools to help me to work through my challenges in a way that I wish my father had been able to do.

Joseph Alex Martin

Pennsylvania Older Adult Suicide Prevention Plan

- Increased age
- Substance use
- Loss of meaning, sense of hopelessness
- Family/personal history of suicide
- Ongoing stress, high degree of perceived stress
- Past history of mental illness
- Previous suicide attempts
- History of violence

Environmental Risk Factors

- Financial loss
- Residence in a care facility
- Desensitized to the violence of suicide
- Availability of a lethal agent

Social-Cultural Risk Factors

- Isolation
- Poor social support
- Living alone
- Abuse
- Family conflict
- Loss (relationship, role, functional capacity or support, health, work, mobility, finances), cumulative loss
- Barriers to accessing health care, especially mental health and substance use treatment

Protective Factors for Suicide:

- Effective clinical care for mental health, physical and substance use conditions
- Easy access to a variety of clinical interventions and supports in a variety of settings
- Restricted access to highly lethal means of suicide
- Support through ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and non-violent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

- Readily available social supports, including family of choice, close friends and confidants

Steps 3 & 4: Develop, institute and implement interventions that can reduce the impact of risk factors or support protective factors:

Principles for reducing risk:

- Suicide prevention program efforts such as addressing mental health and substance use conditions
- Programs must address the needs of people in each stage of life
- Programs must be culturally sensitive
- Prevention programs are most effective when they are long-term, with opportunities for reinforcement of attitudes, behaviors and skills
- Each community must develop a program that meets local needs and builds on local strengths
- Program planning should represent the community with respect to age, ethnicity, faith, occupation, sexual orientation, gender identity, social economic status and cultural identity.
- Older adult specific community groups and organizations should incorporate suicide prevention efforts into their work
- Treatment of depression in late life can decrease suicidal risk.

The differences found in a recent study between older adult males and females who die by suicide may be related to the gender roles and the unique experiences of aging. The National Strategy for Suicide Prevention, Goals and Objectives for Action suggests a number of strategies to reduce suicide including promoting awareness, reducing the stigma of seeking care for mental health and substance use, implementing community based programs, reducing access to lethal means, and providing training for practitioners who care for older adults. Older adult males in particular may benefit greatly from programs that seek to keep them active in later life, facilitate their access to mental health services, assist them in dealing with immediate crises, and evaluate their access to highly lethal weapons. Older adult females on the other hand, may benefit greatly from services to assist them in the earlier stages of the aging process, dealing with widowhood, and close monitoring of prescription medications, particularly opiates. Regardless of sex, an immediate and comprehensive response to suicidal ideation and previous suicide attempts is critical as nearly one in four older adults disclose their intent to take their lives before doing so.¹ The following plan is intended to target these recommended actions for implementation within Pennsylvania.

It should be noted that the issue of “assisted suicide” should be distinguished from suicide. The advocacy group, “Compassion and Choices”, shuns the term “assisted suicide” and supports what they call “aid in dying”. The group believes that giving a fading patient opportunity for a peaceful and dignified death is not suicide. A recent New York Times article indicates that helping the terminally ill end their lives, condemned for decades as immoral, is gaining traction and several states now have “death with dignity” bills in process. A Gallup poll indicates that terminology is a key factor in this issue. Seventy percent (70%) agreed that when patients and their families want aid in dying with dignity, it should be allowed. Yet in the same 2013 poll, only 51% supported helping a dying patient “commit suicide”.⁵

There are evidence-based practices for older adults that address depression, suicide and substance use that can guide the design of services for older adults. The three research studies listed below outline what has been effective for older adults in a variety of community-based settings.

- **PRISM-E (SAMHSA)** – Primary care research in Substance Use and Mental Health for the elderly
SAMHSA and several federal partners launched a 6 year study in 1998. The goal of the study was to determine if older adults do better when they receive mental health and substance use treatment that’s integrated into primary care or when they’re referred to specialists. The study screened thousands of older adults for depression, anxiety and at- risk drinking. The study concluded that older adults were more open to receiving mental health and substance use treatment that was integrated within primary care (71%), versus those who engaged in treatment through a referral to a specialist (41%).
- **PROSPECT (NIMH)** – Prevention of Suicide in Primary Care: Elderly Collaborative Trial
This study which was conducted in 2006 was designed to determine the effect of a primary care intervention on reducing suicidal ideation and depression in older adults. The study found that long-term assessments of depression, hopelessness, anxiety and physical and functional limitations in depressed older adults are critical. Older adults with these symptoms may be candidates for care management or mental health care, since they are at risk of remaining depressed.
- **IMPACT (Hartford Foundation)** – Improving Mood Promoting Access to Collaborative Treatment
In this study, 1800 older adults with depression received usual care versus collaborative/stepped care disease management of their depression in a

primary care setting. The intervention included an evidence-based algorithm and relapse prevention. Within the study, satisfaction with care increased, physical conditions improved, and the trial intervention had more than double the effectiveness of the usual care for depression.

Step 5: Concurrent Review-/Evaluate Effectiveness

A community should build in an evaluation to determine whether the selected intervention will work under local conditions. Determining the costs associated with the benefits of the program is another important aspect of evaluations.

PROCESS FOR DEVELOPING THE 2014 PENNSYLVANIA SUICIDE PREVENTION PLANS

In October of 2013, the Pennsylvania Adult and Older Adult Suicide Prevention Coalition received a grant from the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) as part of the “Mental Health Matters” initiative, to implement several suicide prevention initiatives including revising the 2005 Pennsylvania Adult and Older Adult Suicide Prevention Plans. In order to guide and direct this effort, a 31 member panel of experts was convened. Representatives were solicited from the Departments of Health, Aging, Corrections, and Military and Veterans Affairs, the Veterans Integrated Service Network, the County Commissioners Association, behavioral health managed care organizations, the OMHSAS Adult and Older Adult Advisory Committees, county suicide prevention taskforces, coroners offices, the National Alliance for the Mentally Ill of PA (NAMI PA), Area Agencies on Aging, the American Association of Retired Persons (AARP), the Rehabilitation and Community Providers Association (RCPA), the Pennsylvania Mental Health Consumers Association (PMHCA), the Keystone Pride Recovery Initiative (KPRI), and the PA Adult and Older Adult Suicide Prevention Coalition (PAOASPC). Although some organizations were unable to send representatives to the table, a diverse statewide committee was convened for its first in-person meeting in December of 2013. Members who participated in the committee are acknowledged for their work in developing the plans in Appendix G.

The current Pennsylvania Adult and Older Adult Suicide Prevention Plans were modeled after the original National Strategy for Suicide Prevention issued more than ten years ago by Surgeon General David Thatcher. Since the National Strategy was revised in 2012, it prompted a desire to update Pennsylvania’s plans to reflect current research, prevention strategies, and needs, and to guide suicide prevention efforts within the commonwealth over the coming years. Given the significant amount of work that went into the 2012 National Strategy, it seemed natural to use this document as a template in the development of the 2014 Pennsylvania plans.

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To begin the process, the goals and objectives within the 2005 state plans and 2012 national plans were reviewed and cross walked first by the full committee followed by a more intensive review and revision by workgroups assigned to each agreed upon goal. This resulted in the recommendation to use eleven goals within the Pennsylvania plans. The eleven Pennsylvania Adult and Older Adult Goals are parallel in their content. However, specifics related to adults and older adults are identified within the specific objectives and action steps of each respective plan. The 2012 National Strategy was also used to create Pennsylvania's objectives, action steps and some of the narrative. Like the National Strategy, *"the goals and objectives are broad in scope and encompass a wide range of activities. Many different groups at the local, regional and state levels, including counties, managed care organizations, provider organizations, social service agencies, educational institutions, workplaces, and health systems, etc., can play a role in advancing particular objectives. As a result, it is not possible to include specific target dates for the completion of each objective. All groups that have an interest in suicide prevention can use the goals and objectives to identify their own priority areas, thereby contributing to the full implementation of Pennsylvania's plans."*⁶

While the committee recognized the need for a comprehensive suicide prevention effort across the life span, the revised plans focus on adults and older adults due to funding requirements. Efforts are occurring concurrently to update and address suicide prevention efforts for children and youth.

In addition to the leadership provided by the PA Adult and Older Adult Suicide Prevention Plan Advisory Committee, input for the plans was gathered through four regional "Listening Sessions" which were held in early January of 2014 as well as through a questionnaire distributed through "Survey Monkey" during the January-February 2014 timeframe. A summary of comments and input gathered through these means is included in Appendix F.

In June, 2014, the final draft plans were circulated statewide for public comment by the Office of Mental Health and Substance Abuse. One comment on the plans was received from the Acquired Brain Injury Network of Pennsylvania, Inc. This organization indicates that the suicide rate for persons with traumatic brain injury is five times the rate in the general population and is still increasing. Since traumatic brain injury often resembles the symptoms of mental illness, they further recommend that it is important to screen for old and new injuries before proceeding with mental health treatment for suicidality since the injured brain does not benefit from the same medications or therapies as does mental illness.

LANGUAGE IN THE PLAN

Considerable discussion occurred among the Suicide Prevention Plan Advisory Committee in the development of the plans regarding the choice of language to refer to mental health and substance use. In keeping with the below guiding principle of “promoting the use of People First language and the reduction of medical and disease based labels”, the preferred language chosen for use throughout the plan is “mental health and substance use”. The term “behavioral health” is frequently used to refer to both mental health and substance use but is not used in the plan in order to avoid the misunderstanding that these are behaviors within a person’s control. Likewise, we have chosen to take the positive spin on the words, therefore using mental health instead of mental illness and substance use instead of substance abuse. Limited use of the terms “mental health condition and/or substance use condition” is used where necessary. The term, “family of choice” is used throughout the plan to reinforce the belief that individuals should be encouraged to include individuals they have identified as family in all important aspects of support and care.

BENEFITS OF A STATE PLAN:

- To guide the statewide agenda for suicide prevention and to target resources to the highest priority needs.
- To encourage public-private partnerships at the state, county, and local levels in order to support collaboration and avoid duplication across a broad spectrum of agencies, groups, and community leaders as well as suicide attempt survivors and suicide loss survivors.
- To link information about evidence-based and best practices for prevention, to share data that can be used to track trends, and to share information about training opportunities and resources across the state.
- To create a baseline of efforts within the state and to track success in reaching the goals outlined within the plan.

GUIDING PRINCIPLES FOR THE PLAN

- Design and implement suicide prevention activities in a culturally and developmentally appropriate fashion.
- Eliminate health care, race, ethnic, gender, education, income, disability, age, stigma, sexual orientation, gender identity, and geographic disparities that erode suicide prevention activities.

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- Emphasize early interventions to promote protective factors and reduce risk factors for suicide.
- Endorse suicide prevention as everyone's business.
- Promote the adoption of "Zero Suicides" as an aspirational goal, particularly within health care settings that provide services and support to defined populations.
- Promote People First language and wellness approaches through the reduction of medical and disease-based labels that promote stigma.
- Advocate for, invest in, and sustain all state suicide prevention efforts.

GOAL 1: INTEGRATE AND COORDINATE SUICIDE PREVENTION STRATEGIES ACROSS ALL SECTORS AND SETTINGS WITHIN THE COMMONWEALTH.

Goal 1 of the new Older Adult Pennsylvania Suicide Prevention Plan is a modified version of Goal 1 from the 2012 National Strategy for Suicide Prevention. The intent of this goal is to promote broad awareness of older adult suicide and suicide prevention and collaboration across a broad spectrum of agencies, institutions, and groups to include state agencies, counties, managed care organizations, mental health and substance use provider organizations, social service agencies, businesses, law enforcement, the criminal justice system, health care, and individuals that have frontline contact with individuals impacted by suicide including police, emergency management personnel, coroners, and funeral directors. In addition, the hope is to reach the general public who may not be aware of the signs of suicide in older adults or what to do if an older adult they know is at risk of suicide. Public/private partnerships that evolve from collaboration are able to blend resources and build upon each group's strengths while preventing duplication. Broad-based support for specific suicide prevention efforts may also lead to additional funding through governmental programs, as well as private philanthropy, and to the incorporation of older adult specific suicide prevention activities into the mission of organizations that have not previously addressed the issue. Integrating suicide prevention into the work of these community partners such as primary care, nursing homes, retirement communities, AAA's, Senior Centers, senior housing, home and community based service providers, veterans organizations, faith-based organizations, transportation services, etc., will promote greater understanding of older adult specific suicide and help counter the prejudice, silence and denial that can prevent individuals from seeking help.⁷

The following objectives and action steps address the need to first identify what is being done by who at all levels of the system related to suicide awareness and prevention. Once a baseline is established, the actions include: the creation of a statewide, inclusive, interagency advisory committee; identifying lead staff within each identified agency and to outline their responsibilities related to suicide prevention; and to use this committee to shepherd the work outlined in this plan. Concurrently, county-level suicide prevention taskforces need to expand in number and responsibility, since fewer than half of the counties have an identified taskforce with this focus. Action steps include providing technical assistance and support to these taskforces that play a key role in creating awareness and local responsibility for suicide prevention.

This goal also includes specific collaborative efforts with organizations, and projects that can enhance the older adult specific suicide prevention agenda within the state. Finally, health care efforts, including Medicare plans in Pennsylvania and Pennsylvania's managed care program, can be an opportunity to incorporate older adult specific suicide treatment, prevention and quality improvement into services.

OBJECTIVES:

Objective 1.1: Integrate suicide prevention into the values, culture, leadership and work of a broad range of organizations and programs with a role to support older adult specific suicide prevention activities.

Objective 1.2: Enhance and strengthen collaborations across federal, state, and local agencies to advance older adult specific suicide awareness and prevention efforts.

As co-chair to the Chester County Suicide Prevention Task Force and as a mother who lost her son to suicide, I would like to express my own observations about my experience. Losing my son at age 15 to suicide forever changed myself, my family and my world. My other children who were 2 years and 9 years younger than Jimmy experienced great difficulty navigating life, especially through their teen years. My husband eventually left the family and became involved in an addiction. The journey has been daunting, overwhelming and at times almost unbearable. I know that many people including extended family and friends were also profoundly impacted by Jimmy's death.

I am very proud to have become the person that I am today. I work for the cause of suicide prevention and mental health awareness. My work with older adults is very satisfying. Despite the outcome, I would do anything to reverse the events of May 15, 1992. After that day, life would never be the same.

Carol Harkins

Objective 1.3: Develop and sustain public-private partnerships to advance suicide awareness and prevention.

Objective 1.4: Integrate suicide prevention into health care efforts.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 1.1.1: Identify and evaluate older adult specific suicide awareness and prevention strategies currently in place within the commonwealth.

Action step 1.1.2: Engage community groups to integrate older adult specific suicide prevention within their respective organizations, including the development of local/agency suicide prevention plans.

Action step 1.1.3: Expand the number and capacity of County Suicide Prevention Taskforces across the commonwealth:

- Revise/re-issue the manual completed in 2009 to help county taskforces with start-up. Include in the manual recommendations for how to incorporate older adult issues in their efforts.
- Provide on-site technical assistance from a consultant or other counties (peer-to-peer) on the how to's of a county suicide prevention taskforce.
- Host monthly/quarterly webinars with county taskforces to educate, network, etc.
- Encourage County Suicide Prevention Taskforces to include older adult issues in their taskforces.

Action step 1.2.1: Organize an interagency committee, with representation from state and local agencies, to enhance coordination and advance implementation of suicide prevention strategies, including older adult specific suicide prevention strategies.

Action step 1.2.2: Identify a lead agency at the state and local levels to bring together agencies/groups that should be involved in suicide prevention and clarify each agency's area of focus/responsibility.

Action step 1.2.3: Ensure suicide prevention is integrated into state policies and program guidance under Medicare and Medicaid, including Pennsylvania's managed care program, HealthChoices. This would include sharing the final plan with the Centers for Medicare and Medicaid Services (CMS)/ the Department of Health and Human Services (DHS).

Action step 1.4: Identify methods to expand suicide prevention into health care by inviting primary care and Medicare representatives to participate in implementation efforts.

GOAL 2: IMPLEMENT COMMUNICATION AND EDUCATION EFFORTS TO CHANGE THE KNOWLEDGE, ATTITUDES AND BEHAVIORS OF THE PUBLIC IN ORDER TO PREVENT SUICIDE IN OLDER ADULTS

Goal 2 of the Pennsylvania plan borrows language from goal 2 in the 2012 National Strategy for Suicide Prevention. The intent of this goal is to enhance communication about older adult suicide, warning signs of suicide and suicide prevention resources through a variety of methods. National, state, and local suicide prevention organizations/advocacy organizations and the federal government have done considerable work in creating a wealth of resources that range from research documents, to posters and videos that have been used successfully to inform and educate the public. A list of resources/websites has been attached to this plan with most of these organizations offering low cost or free resources to assist in communication efforts. Specific resources for preventing suicide in older adults, however, are not readily available.

The following action steps recommend that state, county and local agencies/organizations add these resources to their websites/materials so that the range of resource material, including older adult specific resources, is shared widely across the state. It is also recommended that all

My name is Linda, my 38 year old son completed suicide on July 5, 2012. The emptiness in my life due to his effort to end his pain has made tremendous pain in our lives. He left behind two brothers, two sisters, a twelve year old daughter and a four year old son, and of course, me his mom. I tried to help him all during his teen years calling crisis and having him committed to hospitals. He hid his pain very well in the last few months before his death. No one had a clue that he was preparing to end his life. I can't cry around his siblings, so I cry silently at night in my bed. I can't understand how someone could choose death over life. I can't understand how a child I carried and raised, would choose to end his life. We need to be educated about the warning signs that we somehow missed. I don't want another family or mother to feel the pain and emptiness that is in my heart. I am hyper alert to my other family members, and much to their despair, I need reassurance that they are fine daily. I walk in the "Out of the Darkness" walks, to help raise money to educate everyone and to possibly prevent one other person from feeling that ending their life is the only answer.

Linda Kline

communication initiatives be guided by best practices to ensure successful outcomes. The actions also single out policy makers as key change agents for suicide prevention, and recommend providing such leaders with targeted information about state/local statistics about older adult suicides and trends, at risk populations along with recommended older adult specific interventions, and evidence-based practices.

It is paramount to provide individuals at risk, as well as the general population, with information about how and where to get connected to care and support for crises that could lead to suicide, including quick access to local and national crisis lines. Vital to this effort of getting individuals connected to care, are the stories of individuals who have received help and can motivate others to receive the help they need.

OBJECTIVES:

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach all populations, specifically older adults, within the commonwealth.

Objective 2.2: Reach federal, state, and local policymakers with dedicated communication efforts relating to older adult suicide and suicide prevention efforts.

Objective 2.3: Enhance online communication efforts that promote positive messages and support evidence-based and/or effective crisis intervention strategies.

Objective 2.4: Expand knowledge of the warning signs for older adult suicide.

Objective 2.5: Provide knowledge on how to connect older adults in crisis with assistance and care.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 2.1.1: Develop/distribute informational materials (resource materials, flyers, buttons, magnets, etc.) and conduct public education campaigns (speakers bureau, videos, billboards, etc.) on: older adult suicide risk and protective factors; national, state and community resources including crisis lines; anti-stigma messages, etc.

Action step 2.1.2: Inform counties, providers, stakeholders and others of the availability of free/low cost informational materials such as articles, research, posters, magnets, videos etc., from sites such as SAMHSA, and the American Foundation for Suicide (AFS), etc. (See resource section of plan for additional information)

Action step 2.1.3: Develop resources such as articles, research, videos, etc., specifically designed for older adult suicide prevention efforts.

Action step 2.1.4: Ensure that resources/materials are culturally and linguistically competent, including availability in other languages and braille.

Action step 2.1.5: Ensure that communication efforts incorporate the principles of effectiveness in the literature; and utilize materials (such as *“Making Health Communication Programs Work”* and *“Gateway to Health Communication and Social Marketing Practice”*) as referenced in the 2012 National Strategy for Suicide Prevention.

Action step 2.1.6: Evaluate the success of communication efforts. This may include tracking the number of calls/emails, when contact information is provided.

Action step 2.2: Create targeted resource documents specific to older adults, and related materials for federal, state and local policymakers, including material on evidence-based practices, evaluation data, etc., that can be used to impact policy decisions.

Action step 2.3.1: Recommend resources to add to state, county and local websites on suicide prevention (including how to access older adult specific mental health, substance use and crisis services, and information about risk and protective factors, etc.)

Action step 2.3.2: Provide positive messages through social media including mobile apps to help older adults with depression chart their moods and access crisis lines, use of the U.S. Department of Veterans Affairs crisis line call center chat line, etc.

Action step 2.4-2.5.1: Increase awareness of the role of crisis lines such as the National Suicide Prevention Lifeline/Veterans Crisis Line (800-273-TALK/8255) and other local crisis services and resources.

Action step 2.4-2.5.2: Incorporate stories of older adults who received and benefited from help into written and online materials, to motivate others to take actions.

GOAL 3: IDENTIFY AND INCREASE KNOWLEDGE OF THE FACTORS THAT PROMOTE OLDER ADULT RESILIENCY FROM SUICIDE AND THAT PROMOTE WELLNESS AND RECOVERY.

Goal 3 of the state plan is similar to Goal 3 in the 2012 National Strategy for Suicide Prevention, with some revisions made to the language. This revised goal changes the focus from reducing stigma to promoting older adult wellness and recovery from suicidal thoughts and actions. The concepts of wellness, recovery and resiliency are well known in the mental health and substance use fields, but are not well understood by the community at large, especially by older adults. These concepts need to be understood by significant people such as a person's family of choice, friends and staff who may be the first line of contact for older adults at-risk of suicide. Suicide is closely linked to mental health and substance use conditions, and while treatments exist for both, specific services for older adults are not widely available. In addition, the stigma of mental health and substance use conditions prevents many persons, especially older adults, from seeking assistance due to fear of prejudice and discrimination.

The following objectives and actions are designed to increase knowledge about mental health, substance use, and suicide in older adults such that people are not embarrassed to seek help and have a greater understanding that people can and do recover. Presentations by suicide attempt survivors and by individuals bereaved by suicide can be powerful ways to convey the message that, "I've been there, I received help and support and you can too." The actions also promote public education to increase general understanding of mental health, substance use, and suicide in order to dispel myths and eliminate stigma. Recent polls conducted by the Pennsylvania Mental Health Consumers Association found more stigma directed to people with mental health conditions than toward any other disability. For more information, see <http://www.pmhca.org/StigmaProject/media.html> and scroll down to information about surveys on stigma. Pre and post tests are recommended to evaluate the impact of any public education efforts so that future efforts can be modified and adapted accordingly.

It is important to recognize and take into account the impact that cultural and religious beliefs can have on protecting individuals from suicide, or how such beliefs might present a barrier to

Suicide prevention is not just a matter of getting the word out to those who struggle. A change is needed in how would-be supports treat those in emotional anguish. One of my personal goals is to teach appropriate response by sharing my story in print and in person. Family, friends, bosses, and any other acquaintances of potentially suicidal individuals are our front line in this battle. Although I take responsibility for my decision to attempt suicide, I am certain that if there had been a healthier response when I initially tried to express my feelings, it would not have happened.

Nancy Virden

people seeking help. For example, data show that African American women have the lowest suicide rate among females and older adult white males have the highest suicide rate of any other population group, demonstrating the need to understand how race, gender, age, and other factors impact suicide risk. Likewise, religious beliefs that oppose suicide may help protect older adults from suicide or present barriers to individuals admitting suicidal thoughts and seeking the help they need. Research has also demonstrated that social connections and problem solving skills can help insulate individuals from suicide. Best practices then can be implemented that draw upon what the research indicates will protect individuals from suicide.

OBJECTIVES:

Objective 3.1: Identify and promote effective programs and practices that increase older adults' protection from suicide risk.

Objective 3.2: Reduce the prejudice and discrimination associated with older adults' suicidal thoughts and actions, and mental health and substance use conditions.

Objective 3.3: Promote the understanding that mental health and substance use recovery is possible for all.

Objective 3.4: Educate the community about older adult protective factors from suicide risk and older adult risk factors of suicide.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 3.1.1: Develop measurable criteria including a survey to identify effective community based older adult suicide prevention programs and best practices.

Action step 3.1.2: Consolidate survey data and evaluate data for effectiveness, utilizing the above criteria, and communicate survey data through social media, public service announcements, and multiple media outlets.

Action step 3.1.3: Disseminate information on the importance of social connectedness and problem-solving skills as factors that can help prevent suicide in older adults.

Action step 3.1.4: Disseminate information on programs that have decreased older adults' suicidal thoughts and actions through connectedness.

Action step 3.2.1: Launch public service campaigns to educate communities on the facts related to older adult suicide, mental health, substance use, and how the community can help.

Action step 3.2.2: Expand health education efforts concerning older adult suicide, mental health, and substance use within local community organizations, including organizations that work with older adults.

Action step 3.2.3: Conduct initial community based surveys assessing stigma and discrimination surrounding older adult suicide and mental health and substance use conditions prior to targeted health education; conduct follow up surveys to assess the effectiveness of older adult specific targeted education.

Action step 3.2.4: Develop strategies for better understanding of cultural or religious beliefs that may help protect older adults or present barriers to seeking help.

Action step 3.2.5: Increase awareness of mental health and substance use in older adults in order to eliminate barriers to seeking help.

Action step 3.3.1: Launch public service campaigns in order to educate communities on the facts of older adult suicide, mental health, and substance use and how the community can help.

Action step 3.3.2: Expand health education efforts concerning older adult suicide, mental health and substance use within local community organizations.

Action step 3.3.3: Conduct initial community based surveys assessing community understanding of mental health and substance use recovery in older adults prior to targeted older adult specific health education; conduct follow up surveys to assess the effectiveness of targeted education.

Action step 3.3.4: Increase public awareness that older adults living with a mental health or substance use condition can recover and regain meaningful lives, including presentations by significant others including a person's family of choice, friends, peer mentors, and older adults who have attempted suicide or been bereaved by suicide.

Action step 3.4.1: Identify local community organizations that would benefit positively from older adult specific suicide prevention/intervention training.

Action step 3.4.2: Identify and implement evidence-based and promising practices for older adult specific suicide prevention/intervention training for community education efforts.

Action step 3.4.3: Conduct pre and post-tests of suicide education efforts to assess knowledge of older adult suicide protective factors and risk factors.

GOAL 4: PROMOTE RESPONSIBLE MEDIA REPORTING AND ACCURATE PORTRAYALS OF MENTAL HEALTH, SUBSTANCE USE, AND SUICIDE IN THE ENTERTAINMENT INDUSTRY, INCLUDING SAFE ONLINE CONTENT.

Goal 4 uses the language in goal 4 from the 2012 National Strategy for Suicide Prevention. This goal addresses the need to impact how older adult suicide, mental health, and substance use are addressed in the media and entertainment industry. This goal has been updated from the prior state and national plans to include the emergence of online content as a new medium for communication. Certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. Explicit and graphic media reporting sensationalizes and glamorizes death, and can lead to “copycat” suicides. Studies have also shown that fictional accounts of suicide in movies and television can lead to increases in suicide.⁸ Careful coverage, on the other hand, can encourage vulnerable people to seek help. Sharing stories of individuals who overcame a crisis and providing information on resources can provide a needed public service.

The following objectives and actions recommend providing guidance and resources to the media, journalism and communication schools on ways to report suicide and older adult suicide in particular, as well as mental health and substance use issues in an accurate fashion. In addition, the action steps recommend providing guidance to state government press offices who work with the media on an on-going basis. As new media tools or guidelines become available, these recommendations should be applied widely to include the safety of online content and emerging communication technologies and applications. In order to expand online crisis support, the Suicide Prevention Lifeline recently announced an innovative partnership with Facebook to offer crisis services via chat so that people in distress

NAME IT-CLAIM IT- TAME IT-FRAME IT!

It is important to define ourselves and not be labeled by others. An emerging movement of suicide attempt survivors has helped to be open, honest and true to the realities of our experiences. As suicide attempt survivors we are at great risk of re-attempts. Sharing our stories helps others realize they are not alone on our roads to recovery.

I am a proud gay man, an activist artist living with a mental illness (Bipolar II, The Sequel); in recovery from addictions; living with HIV since testing HIV positive September 27, 1988; a prostate cancer survivor; living with deafness, cataracts and hearing distortion; a suicide attempt survivor and suicide loss survivor after my dear sister Jennifer’s death by suicide in 1995.

When naming, claiming, taming and framing remember humor is the best medicine because there’s no copay. I am Mark Davis and approve this positively inspired and mutually shared message.

Mark Davis

can more easily access the support that they need.⁹ Award ceremonies, banquets, etc., is another strategy to recognize the media for accurate portrayals in their reporting.

OBJECTIVES:

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and older adult suicide in particular, and prominent individuals in the areas of entertainment and sports, who follow media guidelines in sharing their personal stories around mental health and substance use.

Objective 4.2: Disseminate guidance for Pennsylvania's journalism and mass communication schools regarding how to address consistent and safe messaging on suicide, mental health and substance use in their curricula.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 4.1.1: Disseminate recommendations to the media for reporting of suicide using, for example, www.reportingonsuicide.org, www.AFSP.org and training offered by the Carter Center for journalists.

Action step 4.1.2: Sponsor recognition events and incentives to honor the media for responsible reporting of suicide, mental health, and substance use.

Action step 4.1.3: Promote speakers bureaus and encourage consumers, peer leaders and others, especially older adults, to share their stories of recovery to increase public awareness.

Action step 4.1.4: Promote guidelines on the safety of online content and for new and emerging communication technologies and applications regarding mental health, substance use and suicide.

Action step 4.2.1: Address responsible depiction of mental health, substance use and suicide in educational curricula of Pennsylvania's schools of journalism, film and other disciplines in the communications field as well as through their ethics governing boards.

Action step 4.2.2: Provide informational material to Pennsylvania state government press offices regarding media reporting of mental health, substance use and suicide.

Action step 4.2.3: Offer training, webinars, etc., to journalism, film and other communications schools on promoting positive messages regarding mental health, substance use, and suicide.

GOAL 5: DEVELOP, IMPLEMENT AND MONITOR THE EFFECTIVENESS OF PROGRAMS AND SERVICES THAT PROMOTE WELLNESS AND PREVENT SUICIDE

New goal 5 addresses the development, implementation, and monitoring of programs and services that promote wellness and prevent suicide in older adults. This revised goal emphasizes the importance of wellness in preventing suicide in older adults and the concept that even simple and low cost interventions can make a big difference in preventing older adult suicide. For example, data has shown that individuals who have attempted suicide as well as individuals bereaved by suicide are at increased risk of suicide. However, research suggests that simple efforts to minimize isolation, increase social involvement, and provide follow-up support to people, including visiting individuals at home or providing online support groups, can have a powerful impact in reducing additional suicides.

The following objectives and action statements recognize the importance of engaging a wide range of community agencies and partners, including organizations that work specifically with older adults, to implement suicide prevention programs and services that take cultural, demographic and geographic issues into account. It is important in developing and implementing programs to use strategies that have been shown to be effective. Several online data bases are available to guide these partners in the development of evidence-based practices and services. The action steps also include providing suicide prevention toolkits, distributing information via websites, posters and resource guides on crisis hotlines, and providing technical assistance to build capacity to both implement

I am a survivor. These four words carry such a big meaning. For some, it means strength, determination and power to overcome a tough situation. However, for a survivor of suicide loss, it carries a very different meaning. To me, it symbolizes sorrow, loneliness and hope. Sorrow, for I will never have the chance to say good-bye to my sister. Loneliness, for few understand what it's like to experience sudden tragedy. Hope, for together, we can open the doors of communication, help those in need, and end the stigma. While nothing will bring Jana back, I hope the work I do in her memory through the Jan Marie Foundation can help prevent other siblings and parents from ever experiencing what it is like to be a survivor of suicide loss.

Marisa Brown

and evaluate older adult specific suicide programs and services. As noted previously, it is important for counties, managed care organizations, educational institutions, aging services organizations, and others to have their own suicide prevention plans in place to reduce the incidence of suicide within their jurisdiction.

OBJECTIVES:

Objective 5.1: Promote and encourage the coordination, implementation, and evaluation of comprehensive state, county, and local older adult specific suicide prevention programming.

Objective 5.2: Encourage county and local services to implement effective programs and provide education that promotes wellness and prevents older adult suicide.

Objective 5.3: Promote policies and practices that intervene to reduce suicidal thoughts and actions in older adults with suicide risk.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective older adult treatment and prevention programs for mental health and substance use.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 5.1.1: Engage multiple partners to coordinate culturally, demographically and geographically-appropriate older adult specific suicide prevention programming within each jurisdiction.

Action step 5.1.2: Evaluate older adult specific suicide prevention programming according to established standards using, for example, the Best Practice Registry for Suicide Prevention and the National Registry of Evidence-Based Programs and Practices.

Action step 5.2.2: Share information on research-based evidence-based older adult specific programs with state, county and local service partners.

Action step 5.2.3: Provide education through public awareness, on-going public service announcements, websites, and conferences.

Action step 5.2.4: Develop technical support to build the capacity across the state to implement and evaluate evidence-based older adult specific suicide prevention programs.

Action step 5.2.5: Increase the number of counties and local communities with comprehensive suicide prevention plans across the lifespan.

Action step 5.3.1: Identify and implement policies and practices that reduce suicidal thoughts and actions in older adults, including rapid follow-up after hospitalization (visits, calls, emails), outreach to isolated individuals, support groups, etc.

Action step 5.3.2: Encourage community providers, volunteer groups, stakeholders, aging services organizations and others to identify older adults who are isolated and in need of outreach and distribute information to older adults who are at risk of suicide including information on crisis lines, warm lines, warning signs, etc.

Action step 5.3.3: Develop, implement, disseminate and provide training on older adult specific suicide prevention tool-kits that include assessment and evaluation criteria, to state, county and community providers, to utilize in screening older adults potentially at-risk of suicide.

Action step 5.3.4: Provide information on specific at-risk populations and interventions and resources for each population as noted in Appendix A of this plan and in Appendix D of the 2012 National Strategy for Suicide Prevention.

Action step 5.4: Encourage the state, counties and local communities to provide referral information to older adult treatment and prevention programs in their jurisdictions through the use of the PA Link to Aging and Disability Resources, Network of Care website, social service resource guides, posters, etc.

GOAL 6: REDUCE ACCESS TO LETHAL MEANS OF SUICIDE AMONG INDIVIDUALS WITH IDENTIFIED SUICIDE RISK.

Goal 6 uses language similar to goal 6 in the 2012 National Suicide Prevention Strategy. The intent of this goal is to reduce access to various means of suicide particularly among older adults identified with high risks. Data indicates that firearms are the most common method of suicide in the United States which account for 56% of male suicides and 30% of female suicides. Among U.S. women, the most common suicide method is poisoning, primarily overdoses of medications, which account for 37% of female suicides, compared to 12% of male suicides. Adults 65 and older consume more prescribed and over-the-counter medications than any other age group. Although they comprise 13% of the population, older adults use 25-30% of the medications. Overuse of medications is one of the fastest growing health problems facing this country and one in five older adults suffers from problems with medications (or alcohol) and may not know it. Medication overuse, along with depression and alcohol overuse are risk factors for suicide among older adults.

Many of the following strategies are aimed at helping to minimize the highest risk means among the highest risk individuals. Studies have also indicated that many suicide attempts are not planned and may occur impulsively or before a person has the chance to receive help to get through a temporary crisis. By taking such precautions as having guns or medications locked away, many lives may be saved. Recent news coverage has indicated that in 2013, the Golden Gate Bridge has been the site of the highest number of suicides in its history. Signs with the National Suicide Prevention Lifeline number and telephones have been added to the Golden Gate Bridge and such preventative tools would create opportunities to save lives on bridges in Pennsylvania.

The following strategies include training aging service providers, mental health and substance use providers, significant people such as a person's family of choice, friends and others in regularly assessing access to lethal means for persons at-risk. Partnerships with firearm dealers and gun owners around suicide awareness and responsible gun ownership may also reduce risk. Likewise, physicians and pharmacists may be in a key position to monitor for risks of prescription overdoses. Valuable training resources, such as the Harvard University "Means Matters" project and the SPRC.org lethal means counseling, are two sources for training. Legislation or policy guidance should be promoted to ensure that firearm dealers as well as prescription managers receive at least brief training, such as "Mental Health First Aid", on recognizing the signs that an individual may be at-risk of suicide.

I was only nine years old when my mother abandoned me. I felt angry, sad and lost. What was wrong with me that made her kill herself, did she not know I loved her? Perhaps maybe if I could have stood up to my dad as he beat on her she would not have left me. Despite growing up in a world not knowing when trauma would strike, I wanted to be with my parents. To make things more complicated, I did not know how to deal with the feelings within me, no one to talk to, guide me or comfort me. That's when I build a closet inside to hide all of these dark feelings. Now, four decades later, I am getting the help I so needed as a child. I am a survivor of my own suicide attempts and am glad I learned to choose life. I have hope now, unlike my younger brother who killed himself and my older brother who turned to street drugs. Parents, brothers are gone from my life. Yet, why not me?

Dave Corbin

OBJECTIVES:

Objective 6.1: Encourage Pennsylvanians who interact with older adults at-risk for suicide to routinely assess access to lethal means.

Objective 6.2: Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Objective 6.3: Research and educate Pennsylvanians' on new safety technologies to reduce access to lethal means.

Objective 6.4: Partner with primary care, mental health, substance use and aging services providers and pharmacies to incorporate suicide awareness as a basic tenet of responsible prescription management.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 6.1.1: Disseminate materials aimed at educating families of choice, friends, physical health, mental health, substance use, aging services providers and others on evidence based practices on how to assess and limit access to lethal means among those at-risk of suicide.

Action step 6.1.2: Educate consumers, assessors, physical health, mental health, substance use, aging services providers and others, on *Means Reduction*, which is the process of separating a particularly lethal means of suicide, from those who attempt suicide.

Action step 6.1.3: Develop protocols to disseminate and distribute educational materials to Pennsylvanians who regularly interact with those at-risk of suicide.

Action step 6.1.4: Develop and enhance training initiatives using, for example, the Harvard University Means Matters project, the SPRC.org lethal means counseling, etc., to improve skills related to counseling on reducing access to lethal means through professional training programs, workshops, etc.

Action step 6.1.5: Distribute informational material on means restriction to significant people, including a person's family of choice, friends, and other natural supports, to increase the likelihood of positive outcomes.

Action step 6.2.1: Develop educational materials which promote suicide awareness for dissemination by firearm dealers upon the sale of every firearm. These materials will include referral and contact information for the National Suicide Hotline.

Action step 6.2.2: Recommend through legislation, regulations or policy statements (executive orders, etc.) that all firearm dealers complete a community-based training on the identification of suicide risk factors (e.g., Mental Health First Aid). This training may be offered to a firearm dealer specific cohort to improve efficacy.

Action step 6.3.1: Develop a means by which research on safety technologies can be encouraged in Pennsylvania.

Action step 6.3.2: Develop a means by which information and research on safety technologies can be disseminated, discussed, and/or implemented.

Action step 6.3.3: Provide an electronic forum (e.g., the Pennsylvania Adult and Older Adult Suicide Prevention Coalition's website with links to other websites such as the Department of Public Welfare's website) to allow for ease of access to research findings and educational materials on older adult specific suicide prevention, reduction of access to lethal means, and safety technologies.

Action step 6.4.1: Develop educational materials which promote suicide awareness, including referral and contact information for the National Suicide Hotline, which will be required for dissemination by the above providers upon the sale of identified medications or prescriptions.

Action step 6.4.2: Recommend through legislation, regulations or policy statements (executive orders, etc.) prescribers and pharmacists to complete a community based training on the identification of suicide risk factors (e.g., Mental Health First Aid). This training may be offered to a provider specific cohort to improve efficacy.

Action step 6.4.3: Encourage the use of electronic pill dispensing lockboxes for people who rely on medication but are at risk of overdosing.

GOAL 7: PROVIDE TRAINING ON THE PREVENTION OF SUICIDE

Goal 7 is similar to National Suicide Prevention goal 7 and focuses on providing training to the community, mental health and substance use providers, aging services providers and others that come into contact with older adults who may be at-risk of suicide. A wealth of training materials and training courses are available, which are targeted to professionals and non-professionals and range from a few hours to several days in length. Specific training materials targeted to professionals and non-professionals working with older adults and older adults themselves are not as readily available and need to be developed. The action steps recommend that such trainings can be used to help stakeholders recognize the warning signs of older adult suicide and know where to refer an older adult for services. In the case of mental health or substance use providers, more extensive training may be required including information on providing quality care and services based upon the latest research in older adult suicide. State

and local conferences and forums are also encouraged to reach large audiences with vital information.

Recommended mechanisms for ensuring that training is provided routinely across the state and across disciplines include making older adult specific suicide prevention training a requirement, issuing policies recommending training as part of regulatory requirements and including training through health care professional education (including graduate and continuing education and credentialing and licensing standards). The following action steps also recommend the tailoring of training to focus on age, ethnic, gender, racial, sexual orientation, gender identity, trauma and abuse issues. The inclusion of older adult suicide attempt survivors and suicide loss survivors in trainings is highly recommended to communicate stories that **individuals can and do recover, leading meaningful lives.**

OBJECTIVES:

Objective 7.1: Provide training on suicide prevention to community groups, especially those serving older adults.

Objective 7.2: Provide training to mental health, substance use, and aging services providers on the recognition, assessment and management of at-risk behaviors and delivery of effective clinical care for older adults with a high suicide risk.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of older adult suicide through health care professional education, including graduate, continuing education, and credentialing, accrediting and licensing bodies.

It is very difficult to put into a few sentences the devastation our son's suicide has had on our lives. I have compared it to being in a horrendous battle, with all of the terrible, debilitating wounds on the inside. We carry on for our other children, for the bit of hope we still have in our lives. To think my son fought this battle of depression alone devastates me. How I wish he had been able to seek and receive help. How I wish I was more informed about the subject of suicide before my son went off to college. How I wish I thought to say, when I knew Tyler was not acting right, "Are you thinking of killing yourself?" Most parents I speak with really can't hear my story- it is their worst nightmare. But I keep talking and hoping my words may help someone seek help instead of suicide.

Sheila Whitman

Objective 7.4: Develop and implement protocols and programs for clinicians, clinical supervisors, first responders, crisis staff, and other stakeholders on how to implement effective strategies for communicating and collaboratively managing older adult suicide risk.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 7.1.1: Identify community groups to present information and training.

Action step 7.1.2: Use available training curricula (available at the SPRC Center, QPR [Question, Persuade, Refer], MH First Aid Training, etc.,) to reach various groups.

Action step 7.1.3: Make educational programs available to significant people including a person's family of choice, friends, and others who are in close relationships with those at-risk or who have been affected by suicide.

Action step 7.1.4: Utilize suicide loss survivors and suicide attempt survivors in trainings/presentations.

Action step 7.1.5: Address cultural competency/diversity in training and educational programs geared to the population being addressed.

Action step 7.1.6: Sponsor conferences including an annual state suicide prevention conference.

Action step 7.2.1: Provide training to physical health, mental health, substance use and aging services providers on the recognition, assessment and management of at-risk behaviors and delivery of, or referral to, effective clinical care for older adults with suicide risk.

Action step 7.2.2: Use available training curricula to increase confidence and empowerment in working with people with suicide risk and effective support services for those bereaved by suicide including trainings such as Assessing and Managing Suicide Risk (AMSR), Applied Suicide Intervention Skills Training (ASIST), etc.

Action step 7.2.3: Promote/sponsor suicide prevention training for physical health, mental health, substance use, and aging service providers.

Action step 7.2.4: Develop a policy strongly recommending the inclusion of older adult specific suicide prevention training as part of continuing education requirements within existing provider regulations.

Action step 7.2.5: Provide resource material, journal articles and training to address emotional and legal issues associated with adverse patient outcomes, including death by suicide.

Action step 7.2.6: Educate practitioners on how to exchange confidential patient information appropriately to promote collaborative care, while safeguarding patient rights.

Action step 7.2.7: Address the need for and value of a team based approach to management of suicide risk through the dissemination of best practice information on the benefits of this approach.

Action step 7.2.8: Include cultural competency components specifically focused on age, ethnicity/gender/racial identity formation, minority status, LGBTQI identity development and disenfranchised groups such as the homeless.

Action step 7.3.1: Develop and promote the adoption of core education and training guidelines on the prevention of older adult suicides through health care professional education including graduate, continuing education, credentialing, accreditation and licensing bodies.

Action step 7.3.2: Collaborate with academic partners and providers in Pennsylvania to develop and adopt core education and training guidelines addressing the prevention of older adult suicide.

Action step 7.3.3: Collaborate with accrediting and credentialing entities to promote evidence based and best practice older adult suicide prevention training for the organizations they accredit/re-accredit, credential/re-credential and license/re-license.

Action step 7.3.4: Sponsor professional development opportunities including webinars, lunch and learn, etc., for health care professionals and aging service professionals.

Action step 7.3.5: Link older adult specific suicide related curricula with training on trauma, substance use, and interpersonal violence.

Action step 7.3.6: Promote and support the inclusion of protective factors such as learning skills, problem solving, conflict resolution and non-violent handling of disputes in any curricula.

Action step 7.3.7: Distribute *Practical Suicide-Risk Management for the Busy Primary Care Physician* to primary care providers.

Action step 7.4.1: Develop and implement protocols /programs for clinicians and clinical supervisors, first responders, crisis staff, aging services providers and other stakeholder groups on how to implement effective strategies for communicating and collaboratively managing older adult suicide risk.

Action step 7.4.2: Recommend that all persons, regardless of age, treated for trauma, sexual assault, or physical abuse, in emergency departments, receive mental health services.

Action step 7.4.3: Ensure communication and collaboration across multiple levels of care, by developing clinical preventative and communication protocols for clinicians, clinical supervisors, first responders, crisis staff and professionals who provide older adult protective services as well as others who provide support to older adults with suicide risk.

Action step 7.4.4: Distribute “Lifeline Best Practices for Helping Callers” to all crisis hotlines/warm lines within Pennsylvania to improve competence in handling crisis calls.

GOAL 8: PROMOTE THE EFFECTIVE ASSESSMENT, PREVENTION AND TREATMENT OF SUICIDE AS A CORE COMPONENT OF ALL HEALTH CARE SERVICES.

Pennsylvania’s 8th Goal is a combination of goal 8 and goal 9 in the National Strategy for Suicide Prevention. The Pennsylvania Suicide Prevention Plan Advisory Committee recommended the collapsing of these two national goals since the focus of the two goals was perceived as similar in nature. The intent of Goal 8 is to ensure that all health care services, especially aging service providers, effectively assess, prevent and treat suicide. An overarching goal, as reflected in one of the guiding principles of this plan and promoted by the Action Alliance for Suicide Prevention, is “ending suicide in healthcare settings”. A recent presentation by Dr. Michael Hogan of Hogan Health Solutions on this issue described this shift in perspective as follows: “rather than accepting suicide as inevitable, ask how many deaths of people in our care are acceptable; rather than having specialty referrals to niche staff, suicide prevention should be part of everyone’s job; rather than individual clinical judgment and actions, use standardized screening, assessment, and interventions; rather than hospitalization when people admit they are in crisis, promote collaborative, recovery oriented community care; rather than saying “if we can save one life..”, we should say “**Not Another Life to Lose.**”¹⁰

The Action Alliance also identified programs that have garnered attention for their novel approaches and positive outcomes including the U.S. Air Force, Henry Ford Health Systems, Magellan Maricopa Collaborative, Veteran’s Health Administration, and the Central Arizona Programmatic Suicide Deterrent System Project. Core components to the success of these systems are reflected in the following objectives and action steps and throughout this plan. Key elements of organizational culture change within these programs include: creating a leadership-

driven culture which includes suicide attempt and suicide loss survivors in leadership and planning; same day access to care; email visits; emphasis on means restriction; stratifying levels of risk and establishing associated interventions; safety planning instead of “contracts”; establishing and maintaining a competent and caring workforce; follow-up after acute care by phone, postcards, and visits; treating mental health conditions and suicidality together; and applying a data driven quality management approach.^{11 12}

The following objectives and action steps emphasize establishing guidelines for assessing and documenting risk factors. It is recommended that primary care practitioners routinely conduct at least brief suicide risk assessments and screen for mental health and substance use, including problem gambling, since research indicates that a large percentage of individuals visited their primary care physician prior to their suicide.¹³ A recent study by the Center for Health Policy and Health Services Research at Henry Ford Health System in Detroit, found that 83% of individuals received health care treatment (medical and primary care more frequently) in the year prior to dying, and 20 % had seen a health care worker the week before they died.¹⁴ Studies indicate that the majority of people who die by suicide- 90% or more- had a mental health condition at the time of their death.¹³ However, in the Henry Ford Health System study, a mental health diagnosis was made in less than half of the cases. While it isn't clear if a mental health condition was present prior to death, it is likely that at least a percentage of these individuals had a mental health condition that went undetected.¹⁴ In addition to primary care, mental health and substance use systems should be required to assess risk at all intakes and regularly monitor individuals at the highest risk. Risk assessments should be documented according to standards that can lead to tailored interventions based on the level and type of risk.

Hello, my name is Jennifer and I am 32 years old. For 18 years I was suicidal and dependent on the mental health system, medicine, hospitals, and ECT. I used to stand on bridges for comfort, overdose constantly, and wander around high crime neighborhoods wanting to get shot. I felt hopeless, frustrated, alone, scared, and speechless when 2 years ago the next best option suggested to me was experimental brain surgery. Today, 2 years later, I work as a Peer Specialist in a psychiatric emergency room that I used to frequent. Every time I go to work I fight the stigma of mental illness head on. I relate to the people there to provide comfort, resources, and help them find hope in their lives or be an example of hope when they have nothing in this world to live for. I not only represent recovery there to my peers but the staff that used to treat me. I am truly happy I created a life worth living and thankful I have a future to look forward to.

Jennifer Chera

Timely access to services (specifically designed for older adults) - and rapid follow-up are two additional key components to quality services that can interrupt the cycle of suicide. Hotlines, warm lines, counseling by phone, texting, etc., and having procedures in place to guarantee 24 hour/7 day a week access to services tailored to older adults are ways to ensure rapid access. Research has demonstrated that discharge from an inpatient psychiatric facility, emergency department, urgent care facility, or a residential addiction program can be a high risk timeframe for suicide. Therefore, the following actions recommend policies that would require providers to follow-up, by phone or in person, within 24 hours following discharge from these facilities. Case management programs, peer specialist programs and crisis intervention programs have already assumed this responsibility in some parts of the state. Each county/managed care organization, and senior service organizations, should consider assigning lead responsibility for such follow-up within their jurisdiction.

Central to continuity of care, is the sharing of information among caregivers. Mental health and primary care providers should cross-monitor for medication side-effects. Videoconferencing and telemedicine are methods to help assess for risk and share information across systems without the need for travel.

As already noted in many of the goals, it is always good policy to include people who are significant to the individual in the entire process of care. Likewise, suicide attempt survivors and suicide loss survivors can be instrumental in helping others to access/engage in treatment. Providing services in the least restrictive fashion, which balances autonomy with safety, is always the best choice. Many individuals in the system have already experienced past trauma or abuse and alternatives to coercion should be used to minimize re-traumatization. When adding issues of aging, the balance of autonomy with safety can be particularly difficult to achieve. Significant time should be devoted to ensuring that older adults' wishes are honored, including advance directives, while still considering personal/public safety.

OBJECTIVES:

Objective 8.1: Promote adoption of zero suicide, across the lifespan, as an aspirational goal of health care and community support systems.

Objective 8.2: Develop and implement protocols, guidelines and training for assessing and documenting older adult risk and delivering timely and effective older adult specific services in the most collaborative and least restrictive settings.

Objective 8.3: Promote continuity of care and rapid follow-up among: suicide prevention/intervention programs, health care systems, crisis programs, emergency departments, inpatient units, older adult services, and community based programs (including peer support).

Objective 8.4: Encourage health care delivery systems and aging service systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.5: Promote safe disclosure of suicidal thoughts and actions by all individuals receiving services.

Objective 8.6: Adopt and implement guidelines to effectively engage significant people, including a person's family of choice and friends, when appropriate, throughout the entire episodes of care for older adults with suicide risk.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 8.1: Encourage adoption of the goal of "zero suicides", across the lifespan, by health and behavioral health systems.

- Encourage managed care organizations, counties, and providers, etc. to conduct root cause analysis of older adult suicide attempts and deaths and use findings to improve service quality.
- Distribute Henry Ford Health Systems Perfect Depression Care program as a promising approach.

Action step 8.2.1: Develop and implement protocols for delivering services (including aging service providers) to older adults with high suicide risk that:

- Value shared responsibility, collaborative care and effective communication with individuals, families and significant others.
- Identify alternatives to coercion, restraint, and involuntary treatment while ensuring the safety of individuals in crisis.
- Address issues related to past trauma or abuse that may make individuals reluctant to seek help for fear of being re-traumatized.

Action step 8.2.2: Encourage timely availability of older adult specific services through the use of crisis hotlines, warm lines, chat services, self-help tools, crisis outreach, and counseling by phone, texting or Internet to allow persons in crisis to access help 24 hours a day, 7 days a week.

Action step 8.2.3: Disseminate and implement guidelines for assessment of older adult suicide risk in primary care, hospitals, and mental health and substance use care, and ensuring that aging service treatment plans include information on suicide plans, intent, access to lethal means, previous attempts and presence of acute risk factors.

Action step 8.2.4: Develop and implement strategies for frequent monitoring of older adults known to have high risk factors.

Action step 8.2.5: Disseminate and implement clinical practice guidelines for mental health, substance use, and other providers who serve older adults at-risk for suicide.

Action step 8.2.6: Develop protocols for differentiated responses based on clinical needs (e.g., intoxicated and suicidal, chronically suicidal, suicidal with active psychosis, suicidal with dementia).

Action step 8.2.7: Disseminate guidelines and provide training on documentation and treatment of suicide risk including determining the proper level of treatment based on risk, needs and preferences.

Action step 8.2.8: Recommend that state agencies, managed care organizations and others in an administrative capacity issue a policy to mental health, substance use, health and aging service providers highly encouraging suicide risk assessments with all intakes.

Action step 8.2.9: Encourage routine and consistent use of brief suicide risk assessments within primary care and aging services.

Action step 8.3.1: Establish policies that recommend follow-up outpatient treatment occur within 24 hours of inpatient and emergency department discharge. Such follow-up can include use of peer specialist programs, case management programs, and/or crisis programs.

Action step 8.3.2: Disseminate information about prototypes for integrating crisis and clinical services such as the VA crisis line relationship with the National Suicide Prevention Lifeline, whereby call responders interact with providers nearest to the individual to arrange and facilitate follow up.

Action step 8.3.3: Encourage primary care, mental health, substance use, and aging service programs to establish mechanisms to facilitate rapid access to services when individuals are in crisis.

Action step 8.3.4: State agencies, managed care organizations, counties and others in an administrative capacity should develop policies/protocols for follow-up/continuity of care after periods of high risk for suicide including emergency department visits or hospitalizations.

Action step 8.3.5: Encourage the use of Peer Specialist programs, case management and/or crisis programs to provide mandatory follow-up within 24 hours following hospital discharge.

Action step 8.3.6: Collaborate with hospital associations to develop tracking procedures for mental health follow-up for older adults.

Action step 8.3.7: Promote the role of primary care in collaborating with mental health and substance use and aging service providers regarding medication side effects.

Action step 8.3.8: Promote use and development of computerized records systems that would facilitate interdisciplinary team approaches across all treatment providers that the older adult wants included in his/her treatment.

Action step 8.3.9: Promote collaboration of all treatment providers (substance use, mental health, alternative medicines, pain clinic, aging service providers, etc.) and social supports through phone contact or video teleconferencing when developing discharge plans.

Action step 8.3.10: Encourage interactions from treatment providers/consumers at the next level of care, including nursing home care and community based services, while the member is working on discharge planning from an inpatient facility.

Action step 8.3.11: Reinforce the role of intensive case managers, resource coordinators, certified older adult peer specialists, and others to assist with navigation through mental health, physical health and aging programs.

Action steps 8.3.12: Distribute older adult suicide risk posters throughout the community such as housing complexes, faith based entities, senior centers, physician offices, emergency rooms, etc.

Action step 8.3.13: Organize older adult suicide survivors in the community to provide seminars on accessing and engaging in treatment.

Action step 8.4.: Develop policies for public and private managed care companies to conduct root cause analyses of older adult suicide attempts and deaths, supervisory reviews, reviews of aggregate data for trends, and focused quality assurance studies on issues related to older adult suicide risk as part of their continuous quality improvement efforts.

Action step 8.5: Educate and train providers on ways to address the disclosure of suicide risk in order to eliminate provider apprehension and liability.

Action step 8.6.1: Train significant people, including a person’s family of choice and friends, to understand, monitor, and intervene with loved ones who are at- risk for suicide.

Action step 8.6.2: Develop guidelines to help providers balance respecting autonomy, versus safety, in their work with individuals with high suicide risk and people that are significant to them, including family and friends.

GOAL 9: PROVIDE CARE AND SUPPORT TO INDIVIDUALS AFFECTED BY SUICIDE DEATHS AND ATTEMPTS TO PROMOTE HEALING AND IMPLEMENT COMMUNITY STRATEGIES TO HELP PREVENT FURTHER SUICIDES.

Goal 9 of the Pennsylvania plan is identical to goal 10 in the National Strategy for Suicide Prevention. The focus of the goal is on providing effective services and support to those individuals (across the lifespan) affected by suicide, including individuals who have made a suicide attempt, individuals bereaved by a suicide and community members who are affected by a suicide. These services are referred to as “postvention” services. All too often, individuals are left to themselves to deal with the aftermath of a suicide. Suicide attempt survivors and individuals bereaved by a suicide are both high risk populations for future suicide. Postvention strategies should also include communities where older adults live, such as nursing facilities, retirement communities, and senior hi-rises as well as places of worship.

The following objectives and actions include identifying strategies and services available statewide to individuals in the aftermath of a suicide attempt or death and expanding appropriate care to affected individuals in every county. It is recommended that a list of resources be advertised through websites, posters, directories, etc. Information on national best practice interventions and toolkits for providing effective supports should be distributed to counties, providers, and others to guide the development of evolving postvention services in the state. Support groups, memorial services, on-line support and other approaches have been used widely and successfully.

Counties and local organizations also need resources to deal effectively with what is known as suicide contagion or clusters, or “copycat” suicides. Proper intervention early in the aftermath of a single or multiple suicides can reduce the trauma and sensationalism that might lead to further deaths. Support is also needed for individuals on the frontlines that have to deal professionally with a suicide, but may need support themselves for what they have experienced. Emergency medical technicians, firefighters, police, funeral directors and other providers can benefit from training and support to better understand and respond to these situations while ensuring that they receive necessary support for their own needs.

OBJECTIVES:

Objective 9.1: Identify all suicide strategies and services that respond to and care for individuals affected in the aftermath of a suicide attempt or suicide death (postvention) and promote awareness of these resources.

Objective 9.2: Provide appropriate clinical care and support to individuals across the lifespan affected by a suicide attempt or death, including trauma treatment and care for complicated grief as well as peer-to-peer supports.

Objective 9.3: Engage suicide attempt survivors, including older adults, in suicide prevention planning including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 9.4: Disseminate, implement, and evaluate guidelines/resources for communities to respond effectively to suicide clusters within their cultural context, and support implementation with education, training and consultation.

I am a survivor of my mother’s suicide in 1966, when I was nine years old. Some things have changed since then, there are support groups, prevention campaigns, but people still avoid the survivors. They still feel isolated. At the time of my loss, no one talked about her, pictures were put away; she was erased from my life. There were no attempts to help me grieve. Many times later in life, I felt “stuck”, sometimes depressed. I built great walls around me, I suppose for self-protection. As the years passed, I came to grieve and remember in my own way as an adult. For this reason, I started a support group in my area to give the survivors what I had wished for myself.

Cozette Stoltzfus

Objective 9.5: Provide health care providers, first responders and other stakeholders with care and support when an individual under their care dies by suicide.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 9.1.1: Develop and conduct a county/local survey to identify all suicide prevention strategies currently in place.

Action step 9.1.2: Distribute a directory of resources available to those bereaved by suicide or affected by a suicide attempt.

Action step 9.2.1: Distribute information on best practice interventions through the Best Practices Registry for Suicide Prevention- <http://www.sprc.org/bpr>.

Action step 9.2.2: Publicize information on clinical and support services available to individuals in Pennsylvania affected by suicide through websites, posters, brochures, directories, etc.

Action step 9.4.1: Disseminate the Center for Disease Control recommendations on managing suicide contagion- <http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm>

Action step 9.4.2: Identify experts and funding sources to provide education/training and consultation on suicide clusters.

Action step 9.5.1: Identify ways to provide information/training to emergency medical technicians, firefighters, police, funeral directors, etc., who provide services to suicide attempt survivors and suicide loss survivors, so they can better understand and respond to needs.

GOAL 10: INCREASE TIMELINESS AND USEFULNESS OF DATA REPORTING SYSTEMS RELEVANT TO OLDER ADULT SUICIDE, AND IMPROVE THE ABILITY TO COLLECT, ANALYZE AND USE THE INFORMATION FOR ACTION.

Goal 10 is similar in focus to goal 11 of the National Strategy for Suicide Prevention. The intent of this goal is to ensure that data regarding suicide, across the lifespan, is collected and reported in a standardized reporting system for national data collection purposes and that data is utilized to impact suicide prevention policy decisions at the national, state and local levels. A primary source of statewide data on suicide is collected through the submission of death certificates sent from county coroners' offices to the state Department of Health. This data is

then transmitted to the Centers for Disease Control. Currently, coroners' offices report their data on violent deaths, which include suicide, through independent reporting systems. Complicating this data reporting, is the fact that suicides may be misclassified as homicides, accidents or death from natural causes. The absence of detailed data, such as data related to sexual orientation and gender identity, provide an incomplete picture of the risk factors for specific population groups.¹⁵ In addition, there is a two year gap between the end of the state reporting period and the year when the data becomes available to the public. The implementation of a standardized reporting system, such as the National Violent Death Reporting System, would greatly enhance the timeliness and consistency of suicide death reporting within the commonwealth. However, the transition would require new state regulations and/or legislation. It is recommended that a report be prepared outlining the barriers and steps necessary for Pennsylvania to participate in the National Violent Death Reporting System.

It is further recommended that similar independent data reporting systems, including the Army National Guard "Critical Incident Management System (CIMS) and the state system be reviewed for data interchange. Governing policies and best practices should guide the reporting system linkage. Data from additional sources such as law enforcement, emergency medical services and inpatient units should be linked to enhance quality care. It should be determined if these independent data systems can be linked and the data utilized at the state level. The following strategies include the implementation of a data collection system within Pennsylvania's HealthChoices managed care program, as well as in Medicare, in order to track trends and actions that should be taken to eliminate suicide.

OBJECTIVES:

Objective 10.1: Identify, evaluate, and disseminate information on current reporting systems, programs, procedures and policies for suicides and suicide related incidents.

Objective 10.2: Improve and expand public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

Objective 10.3: Promote and improve the timeliness and accuracy of reporting and disseminating vital data.

ACTION STEPS TO ACHIEVE THE OBJECTIVES:

Action step 10.1.1: Develop a report identifying the barriers to Pennsylvania participating in the National Violent Death Reporting System.

Action step 10.1.2: Collect current reporting systems, programs, procedures and policies in Pennsylvania. Two examples include the Army National Guard “Critical Incident Management System (CIMS)” and the York County Suicide Prevention Coalition.

Action step 10.2.1: Develop state representative surveys and data collection instruments that include questions on suicide, related risk factors, and exposure to suicide.

Action step 10.2.2: Enhance Pennsylvania’s death certificate reporting system to include suicide-related information while ensuring data is reported in a timely and consistent reporting system.

Action step 10.2.3: Implement a data collection system within Pennsylvania’s HealthChoices managed care program on suicide trends and actions taken to eliminate suicide.

Action step 10.2.4: Encourage the Implementation of a data collection system within Medicare managed care programs in the commonwealth on suicide trends and actions taken to eliminate suicide, and explore ways to facilitate data sharing from within Medicare to the state data collection system.

Action step 10.2.5: Identify and disseminate effective data collection efforts at the national, state and community levels.

Action step 10.2.6: Develop community level risk factors to assist communities, in particular, older adult communities, in implementing suicide prevention efforts.

GOAL 11: PROMOTE AND SUPPORT RESEARCH ON OLDER ADULT SUICIDE AND SUICIDE PREVENTION

Goal 11 of the Pennsylvania Suicide Prevention Plan is similar to goal 12 in the 2012 National Strategy for Suicide Prevention. This goal promotes the dissemination of older adult suicide and suicide prevention research, including the establishment of a state registry that individuals can use to access information on effective interventions. According to the 2012 National Strategy, research on suicide prevention and treatment of mental health and substance use conditions has increased considerably during the past 20 years. Findings have contributed to

the development of assessment tools, resiliency-building interventions, and treatment and symptom-monitoring techniques.¹⁶

Movement is underway, to develop a research agenda on suicide and suicide prevention that will be available in the future at the state and local level. This movement can be strengthened by incorporating older adult specific research as well. The following actions support building collaborative efforts with potential Pennsylvania researchers on topics that would promote the goals identified in the state suicide prevention plan. Actions include establishing contacts at major universities and research centers to discuss potential funding sources and ideas that would lead to research grant submissions. Information on grant opportunities, older adult specific research-based practice standards and evidence-based interventions should be made available through conferences, websites and written materials. Major leaders will be encouraged to attend national and regional conferences to gather information on the current suicide prevention research to share with Pennsylvania constituents at conferences, on websites and in written communication.

The impact of my husband's suicide on my life, my children and grandchildren.... I don't think there is one word or even a sentence to describe the profound loss, the emptiness, heartache, loss of my security. In fact, while mourning my husband's death, I also was mourning the death of my life, life as I knew it for 30 years. My husband was a normal everyday middle class man, your neighbor, your friend, a local fireman and the last person on earth you would think to commit suicide, but he did... February 8, 2013.

Cassy Kwaczala

OBJECTIVES:

Objective 11.1: Help connect researchers with funding sources

Objective 11.2: Promote timely dissemination of older adult suicide and suicide prevention research

Objective 11.3: Establish a registry of interventions with demonstrated effectiveness for prevention of older adult suicide.

ACTION STEPS TO SUPPORT THE OBJECTIVES:

Action step 11.1.1: Identify funding sources for older adult suicide prevention research.

Action step 11.1.2: Develop a list of potential research funding opportunities and post information on various web sites such as OMHSAS and the Adult and Older Adult Suicide Prevention Coalition.

Action step 11.1.3: Establish university contacts interested in partnering on suicide research in PA and collaborate on grant opportunities.

Action step 11.2.1: Identify key PA research on older adult suicide and suicide prevention and disseminate information via PA websites.

Action step 11.2.2: Communicate knowledge of state/local suicide and suicide prevention research, particularly older adult suicide, to the Research Prioritization Task Force and national suicide prevention organizations.

Action step 11.2.3: Attend national/ regional conferences to gather information on suicide and suicide prevention and make latest research information available at state/local conferences, via websites, and through written materials.

Action step 11.3.1: List research-based best practice standards and evidence-based interventions in distributed materials, at conferences, etc., and on web sites.

Appendix A: At Risk Populations

Suicide Prevention and Individuals with Serious Mental Health and or Substance Use Conditions

Mental health and substance use conditions are widely recognized as important risk factors for suicide in all age groups. Substance use along with any mood disorder may be particularly likely to increase suicide risk.

In *Achieving the Promise: Transforming Mental Health Care in America*, the President's New Freedom Commission on Mental Health (2003) noted: "Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves." This is of concern because suicide gravely impacts those with mental health and/or substance use conditions.

Mental health conditions do not cause suicide. Rather those individuals with mental health conditions are exposed to more risk factors (including substance use) that raise their vulnerability to suicide. Ironically, the public largely believes that suicide happens mainly to those with mental health conditions, not understanding the potentially lethal combination of substance use co-occurring with mental health conditions. This is one of the many myths of suicide.

Much of what is known about suicide comes from studies of those diagnosed with mental health and substance use conditions. In *Night Falls Fast: Understanding Suicide* (2000), Kay Redfield Jamison tells us that the gap between what we know about suicide and its use in prevention is "lethal." Dr. Jamison is sadly right.

A brief summary of information on suicide risk among those individuals with serious mental health conditions such as Major Depressive Disorder, Bipolar Disorder, Anxiety Disorder, and Schizophrenia, and Substance Use is provided here, along with appropriate resources. For more detailed and extensive information on specific mental health and substance use conditions with highest risk factors for suicide; please see the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention: www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html, or www.actionallianceforsuicideprevention.org/NSSP or

www.samhsa.gov/nssp. Hard copies may be ordered through SAMHSA Store at www.samhsa.gov/nssp or by calling toll free at 1-877-SAMHSA-7 (1-877-726-4727).

MENTAL HEALTH CONDITIONS:

MOOD DISORDERS

Mood disorders are among the most common and may be the most life-threatening psychiatric illnesses (Goodwin and Jamison, 2007)

Major depressive disorder, also called *major depression* or *unipolar disorder*, is characterized by a combination of symptoms, such as sadness and loss of interest or pleasure in once-pleasurable activities, which interfere with everyday life. It has been estimated that 12 to 17 percent of individuals will experience a major depressive episode within their lifetime (Rihmer and Angst, 2005). Individuals with major depressive disorder have 21 times more suicide deaths than the general population and 9% - 15% of individuals with major depressive disorder eventually die by suicide.

Bipolar disorder, also called **manic-depressive illness**, is characterized by dramatic mood swings, going from an overly energetic “high” (mania) to sadness and hopelessness (depression). The estimated lifetime prevalence of bipolar disorders is 1.3 to 5 percent (Rihmer and Angst, 2005). Suicide risk is particularly high among individuals with bipolar disorders, which is strongly associated with suicidal thoughts and actions. Over their lifetime, the vast majority (80 percent) of [people] with bipolar disorders have either suicidal ideation or ideation plus suicide attempts (Valtonen, Suominen, Mantere, Leppamak, Arvilommi, Isometsa, 2005). Approximately 15 to 19 percent of [people] with bipolar disorders die by suicide. The suicide rate among [people] with bipolar disorder is estimated to be more than 25 times higher than the rate in the general population (Tondo, Isacsson, Baldessarini (2003).

ANXIETY DISORDERS

Anxiety disorders affect about 40 million American adults aged 18 and older (about 18 percent) in a given year (Kessler, Chiu, Demler, Merikangas, Walters, 2005). Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance use conditions, which may mask anxiety symptoms or make them worse. The presence of any anxiety disorder in combination with a mood disorder (co-occurring) is associated with a higher likelihood of suicide attempts in comparison with a mood disorder alone (Sareen, Cox, Afifi TO, et al, 2005). Among adults in the general population (i.e. not in the Armed Forces or veterans),

panic disorder and PTSD have been found to be more strongly associated with suicide attempts when there is a co-occurring personality disorder (Napon, Belik, Bolton, Sareen, 2010)

SCHIZOPHRENIA

Schizophrenia is a severe disorder characterized by disturbances in perception, thought, language, and social function. Schizophrenia is involved in up to 15% of all suicides (as many as 4,000 deaths yearly). Individuals with Schizophrenia are at more than 30 times higher risk of suicide than the general population. The greatest indicator of suicide risk among people with schizophrenia is active psychotic illness (e.g. delusions) combined with symptoms of depression. Alcohol use conditions have been reported in studies examining suicide attempts and schizophrenia.

SUBSTANCE USE CONDITIONS

Suicide is the leading cause of death among people with substance use conditions. Substance use may increase the risk of suicide by intensifying depressive thoughts or feelings of hopelessness while at the same time reducing inhibitions to hurt oneself (Skog, 1991). Alcohol and other drugs can cause a “transient depression,” heighten impulsivity, and cloud judgment about long-term consequences of one’s actions.

Alcohol and drug use conditions are second only to depression and other mood disorders as the most frequent risk factors for suicide (Centers for Disease Control, 2011). According to the data from the National Violent Death Reporting System (NVDRS), in 2008 alcohol was a factor in approximately one-third of suicides reported in 16 states (Karch, Logan, Patel, 2011). Opiates, including heroin and prescription painkillers, were present in 25.5 percent of suicide deaths, antidepressants in 20.2 percent, cocaine in 10.5 percent, marijuana in 11.3 percent, and amphetamines in 3.4 percent. This is especially significant when one considers that individuals with co-occurring mental health and substance use conditions are at higher risk for attempting suicide.

The following suicide risk factors for individuals with serious mental health and/or substance use conditions include:

- Episodes of hopelessness, anxiety, and depression
- Young age of onset and early stage of illness
- Inadequate treatment and treatment reductions
- Frequent exacerbations/remissions

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- Post-relapse improvement periods
- Psychiatric hospitalization(s) (especially the first 30 days after discharge)
- Co-occurring alcohol and other substance use

Individuals with mental health conditions also have risk factors related to race and ethnicity, gender, age, a history of abuse, past suicide attempts, access to firearms, work, school, or legal problems, and others. This accumulation of risk is what accounts for the prevalence of suicide among consumers and which necessitates preventative measures on their behalf.

These are key protective factors that counter the onset and progression of suicidality:

- Treatment adequate to need
- A caring personal support system
- Means restriction/removal (i.e., no guns, controlling medications)
- Ability to seek/accept professional help
- Availability/accessibility of help
- Mutual support for those at-risk

Given what we know about suicide and mental health, what can we do?

All mental health and substance use providers, both public and private, should:

- Know the risk factors, warning signs, and myths of suicide
- Be able to talk about suicide with clients and patients
- As applicable, identify hazards in facilities that may be used for a suicide attempt
- Be trained in crisis intervention
- Educate families about suicide risk

Here are some specific suggestions for county mental health systems: Assure that all providers recognize suicide as a preventable community mental health problem.

1. Assure that county suicide prevention plans (i) exist, (ii) speak to the risk of adults living with serious mental health conditions, and (iii) are being implemented.
2. Assure that county mental health plans recognize the need for aftercare and supports for suicide attempters to deter future suicidal behavior.
3. Assure that all mental health providers screen for suicidality at admission, after serious life events or losses, and after changes affecting treatment.
4. Assure that modalities such as cognitive behavioral therapy, which have been found to reduce suicide, are available.
5. Assure the availability of groups that offer mutual support and “safe places” for individuals who make multiple suicide attempts (e.g., “Suicide Anonymous”).

There is much that needs to be done, but these steps would make a real difference.

In closing, bear in mind that nothing is more detrimental to recovery from mental health conditions than suicidality and nothing shatters mental health wellness like losing someone to suicide. Mental health consumers are far more likely to have experienced the loss of someone they know to suicide because of the high incidence of suicide among those with serious mental health conditions. For this reason, providers should see that consumers who experience the suicide of a loved one or close friend have access to grief support resources.

Pennsylvania Department of Corrections Suicide Prevention Efforts

The latest statistics published by the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Justice confirm that suicide mortality rates per 100,000 state inmates consistently exceed suicide mortality rates in the community (BJS, 2012; Kochanek, Jianquan, Murphy, Miniño, & Kung, 2011; Murphy, Jianquan, & Kochanek, 2012). Indeed, a recent longitudinal study of all 50 state prison systems revealed that suicide was routinely among the five leading causes of death among inmates (BJS, 2012). However, leading experts in the field of suicidology believe that correctional systems can reduce suicide mortality rates by augmenting identification protocols, developing system-wide procedures to enhance suicide prevention policies, and improving continuity of care practices (Hayes, 2013). In response, the Pennsylvania Department of Corrections instituted numerous evidence-based practices for suicide prevention which have resulted in mortality rates *less* than national prison averages 10 of the past 14 years, suicide mortality rates periodically *less* than community mortality rates, and the 18th lowest mortality rate for suicide in the United States (BJS, 2012; Kochanek et al., 2011; Murphy et al., 2012). Pennsylvania's Department of Corrections realized these systemic reductions despite maintaining the sixth largest state corrections population in the United States (i.e., 50,918 inmates).

RISK FACTORS AMONG INMATES

Suicide and self-injurious acts are serious dangers in any correctional setting. Therefore, early identification, appropriate housing and monitoring, and proper treatment of a potentially self-

destructive inmate is critically important, both for the individual in need of service and for the facility charged with his/her care. Suicide potential can be evaluated by using the following criteria.

Suicidal Plan

The potential for suicide is greater when there is a well-organized and detailed plan developed by the inmate. The potential also increases when the means of the suicide identified in the plan is readily available to the inmate and can be lethal.

Prior Suicidal Behavior

The potential for suicide is greater if the individual has experienced one or more prior attempts of a lethal nature or has a history of repeated threats and depression. In addition, individuals involved in many episodes of self-injurious behavior (SIB) are at increased risk to complete suicide.

Stress

The potential for suicide is greater if the individual is subject to stress from increased pressures such as, but not limited to:

- difficulties in coping with legal problems;
- the loss of a loved one through death or divorce;
- the loss of valued employment (high paying position in Correctional Industries);
- anniversary of incarceration date or offense;
- serious illnesses or diagnosis of terminal illness;
- threats or perceived threats from peers;
- sexual victimization, particularly after the first submission;
- placement in segregation;
- unexpected punishment (misconducts or additional sentence or parole denial);
- cell restriction;
- recent transfer from another state or county facility;
- recently returned to prison due to a parole violation;
- any movement to and from segregation (watch closely for several hours);
- long sentence coupled with poor external supports (family or volunteers) and/or minimal involvement in facility supports (education, treatment, activities, and employment);
- somatic complaints of a vague nature that do not respond to treatment;
- history of violence toward others;
- intellectual/developmental disability;
- requesting protective custody;

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- deemed to be a “high profile” case;
- long sentence, including life; and/or
- history of alcohol and/or drug use conditions.
- Traumatic event, significant wound/injury, physical disability

Prior Suicidal Behavior of Someone Significant To the Individual

The potential for suicide is greater if a parent, spouse, close relative or a person significant to the individual has attempted or died by suicide.

Symptoms

The potential for suicide is greater if the individual manifests symptoms such as:

- auditory and/or visual hallucinations, particularly command hallucinations ordering the person to harm himself/herself;
- delusions;
- any change from the individual’s sleep pattern (this may be manifested by either a decrease or increase in sleep);
- any change from the individual’s ordinary eating pattern. (This may be manifested by either a decrease or an increase in the individual’s appetite with an accompanied decrease or increase in weight);
- social withdrawal;
- apathy;
- despondency;
- severe feelings of hopelessness and helplessness;
- general attitude of physical and emotional exhaustion;
- agitation through such symptoms as tension, guilt, shame, poor impulse control or feelings of rage, anger, hostility or revenge;
- giving away personal property;
- removal of every visitor from the visiting list;
- changing next of kin notifications;
- sudden elevated mood (“everything’s OK attitude”); and/or
- psychic or somatic anxiety.

Personal Resources

The potential for suicide is greater if the person has no family or friends, or his/her family and friends are unwilling to help. Potential is greater if a significant other evidences a defensive, rejecting, punishing attitude, or denies that the individual needs help.

Acute vs. Chronic Aspects

The potential for suicide is greater when there is a sudden onset of specific symptoms. An individual who has recently learned that he/she has a serious disorder is at greater risk than a person who has been coping with the problem for years. The acute risk is higher if the person appears anxious.

Medical Status

The potential for suicide is greater when there is a chronic, debilitating illness, especially when it involves an alteration of body image or life style.

A person considering suicide does not demonstrate all of these signals. Generally, the more characteristics the individual has, the greater the potential for self-harm. Every suicide attempt, including gestures, is taken seriously.

STATISTICS RELATED TO SUICIDE RISK FACTORS IN THE PENNSYLVANIA DEPARTMENT OF CORRECTIONS

- Mental health conditions: although inmates on the mental health/intellectual disability roster comprise approximately 22% of the PA state prison population, these individuals comprise approximately 60% of the suicides.
- Substance use conditions: approximately 70% of inmates who died by/attempted suicide had histories of substance use conditions.
- Males: males account for approximately 95% of the PA state prison population and account for approximately 98% of suicides.
- Caucasians: although Caucasians comprise only 34% of the PA state prison population, these individuals comprise over 50% of all suicides.
- Older Adults: due to mandatory sentencing and a reduction in parole, the PA state prison population has been getting older. Depression is underdiagnosed among older adults and we are carefully monitoring this population.
- Sex Offenders: this population is a growing risk, possibly related to the increased difficulty of obtaining parole.
- Lifers/Long Term Offenders: although inmates with life sentences comprise 17% of the PA state prison population, they comprise more than 40% of the suicides.
- Parole Violators: these are offenders who are returned to prisons after failing to adjust in the community. In some cases, they may still be under the influence of alcohol or other drugs. Our speculation is that these individuals panic when they realize that their likelihood of being re-paroled might be remote.

- Administrative Segregation: although this population had a high rate in the past it has decreased since new policies have been implemented.

STRATEGIES TO REDUCE DOC SUICIDES

- All Pennsylvania Department of Corrections employees receive at least two hours of suicide prevention training during their basic training regimens, followed by one hour of refresher training annually.
- The Pennsylvania Department of Corrections recently recognized the need for enhanced system-wide suicide prevention training initiatives. Subsequently, the department commenced the delivery of the *Crisis Intervention Team (CIT)* training and *Mental Health First Aid* training for all corrections employees. By the end of 2013, the Department of Corrections trained more than 300 employees in the CIT model. The Department is scheduled to have all DOC staff trained in *Mental Health First Aid* by the end of FY 2014. Additionally, one of the initial CIT trainings was geared toward county employees from around the state. Plans to begin offering CIT regionally (i.e., within SCIs) are also underway. Overviews of the CIT implementation have been provided at various conferences to include NAMI, PPWA, and Forensic Rights and Treatment Conference. All Superintendents were trained in CIT at a two-day meeting in January of 2014. Currently, the DOC has five statewide MHFA trainers who will continue to train staff. However, the Department of Corrections intends to have 30 trainers trained by June of 2014 with the intent of training ALL staff by the end of FY 2014.
- The departmental disciplinary process and suicide prevention has been greatly augmented during this past year regarding inmates with mental health and serious mental health conditions. Our Hearing Examiners received a specialized training on the recent policy amendments and new provisions to the disciplinary process by the Licensed Psychologist Director, the department's Office of Chief Counsel, and the Supervising Hearing Examiner at Central Office. Specific changes included the elimination of disciplinary sanctions for suicide attempts and other intentional self-injurious behaviors, the implements associated with these behaviors, other non-assaultive behaviors associated with these behaviors, and threatening statements made while engaging in a suicide attempt or self-injurious behavior. The suicide risk associated with segregating inmates (diagnosed with mental health and serious mental health conditions) for extended periods of time was also considered as the following paragraph indicates. Restrictions permitted for this population were increased significantly on the amount and type of disciplinary sanctions for any institutional violation.

Pennsylvania Older Adult Suicide Prevention Plan

- The Pennsylvania Department of Corrections has many suicide prevention protocols in place for all inmates. For example, every inmate who is received by or enters the Department of Corrections, at any time, is assessed for suicide risk by a psychologist and given a pamphlet that describes the stressors associated with incarceration, the risk factors for suicide associated with incarceration, tips on identifying and recognizing a crisis during incarceration, the procedures of how to access mental health services while incarcerated, and what to do if a fellow inmate exhibits emotional distress or is contemplating suicide. Every State Correctional Institution must have a local system in place for the regular distribution of these educational pamphlets for their inmate populations.
- At every State Correctional Institution in Pennsylvania, a locally developed video is aired on the inmate dedicated channel for the purposes of introducing the mental health staff, services offered by this staff, and additional educational material on suicide prevention and suicide risk identification.
- Every State Correctional Institution in Pennsylvania conducts random suicide response drills. Suicide response drills are aimed at improving response times from medical, custody, and other appropriate staff. Summary reports of these drills are submitted to the Institutional Critical Incident Manager to ensure that the Critical Incident Stress Management Team is activated afterward.
- The Pennsylvania Department of Corrections maintains robust pre-placement suicide risk screenings for certain housing placements. For example, before an inmate is placed in segregation for a violent institutional misconduct, pre-placement suicide risk screenings are conducted by a security staff member, a nursing staff member, and a psychologist. Inmates who are identified as being at heightened or imminent suicide risk are immediately diverted to inpatient settings and not placed in segregation.
- The Pennsylvania Department of Corrections has concentrated significant efforts on improving, developing, and implementing additional clinical operations associated with suicide prevention. For example, in 2013, **Suicide Prevention Committees**, consisting of multidisciplinary professionals, were established at every State Correctional Institution. The committees meet monthly, review critical incidents, recommend policy changes, and evaluate facility processes and procedures as they relate to suicide prevention. Each committee must send monthly reports of updates to Central Office for additional oversight and quality assurance purposes.

- The Pennsylvania Department of Corrections has drastically enhanced the requirements and procedures for clinical reviews of self-injurious behaviors, suicide attempts, and suicides, while acknowledging the increased importance on postvention efforts. Highlights of these changes include requirements for the clinical review team to be chaired by the Licensed Psychologist Manager, the requirement of a clinical review for all serious suicide attempts, and additional Central Office oversight of every clinical review for quality improvement/quality assurance purposes.
- The Pennsylvania Department of Corrections maintains tracking systems of all suicides, attempted suicides, and self-injurious behaviors that occur in all State Correctional Institutions for the specific intent of identifying trending or clustering.

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LAW ENFORCEMENT SUICIDE PREVENTION

Suicide is a silent epidemic that permeates all walks of life and all types of people; it does not discriminate. There are certain populations, however, that are at an elevated risk for suicide. One of these populations is law enforcement personnel. The rate of suicide for police officers is 3 – 4 times higher than the general population and more active law enforcement officers die by

suicide than homicide. It is estimated that 300 police officers die by suicide each year, although data is often hard to obtain. One Philadelphia police department was unwilling to share their data when requested and we can only assume many more follow suit. The stigma surrounding suicide continues to be an obstacle for preventing suicide. Therefore more attempts to raise awareness, particularly among law enforcement personnel, need to be made.

Police are at an elevated risk for:

- Divorce
- Post-Traumatic Stress Disorder (PTSD)
- Alcoholism

These factors greatly enhance their risk of suicide. Stress factors, symptoms of PTSD and alcoholism, depression and suicidality, all require recognition and early detection. Effective methods in helping officers with these issues need to be incorporated into any law enforcement suicide prevention program.

Not surprisingly the leading cause of suicide for police is by firearms, with most suicides occurring at home. Although law enforcement officers have daily access to firearms, restriction to access of them can still be included as part of a suicide prevention training. There are other components of suicide prevention which are gaining more popularity across the country. These methods include:

- Gatekeeper suicide prevention training in the curriculum of cadets in the police academy

My name is Marie Bartos and I am a survivor of suicide loss. My husband, Stephen Milkovits, was a police officer and a United States Marine Corp veteran. Ten years ago, he made the unfortunate decision to take his life, in our home, as I helplessly watched in horror. Since his death, I wondered why am I here, what is my purpose in life? I found my answer through advocacy and survivor outreach with our local chapter of the American Foundation for Suicide Prevention (AFSP). Sharing my story and helping those who are living the hell that I have lived through, has become my passion, my calling, my reason for living. Survivors of suicide loss need to know they're not alone, it's not their fault and there is a light at the end of the darkness. Each of us has to find our own way, on our own terms, in our own time, but knowing that someone knows how we feel is in its own way comforting. I've taken this tragedy and made it my triumph. I've become more compassionate, caring, loving, but most of all, understanding and accepting of life. As painful as it is sometimes, it's given me hope-hope that I've never had before. Hope that anything is possible. It also made me realize the strength that I have within. If I can save one life, it makes it all worth it.

Marie Bartos

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- Creating peer support groups among the departments, and
- Encouraging help seeking behavior

Dr. Joseph Violanti, a leading researcher and expert in police suicide, strongly advocates peers, supervisors, and administrators learn how to detect, intervene and refer a suicidal officer (for help) as part of their training. He believes developing a program that includes psychological assessment, tracking high risk officers, access to firearms, family involvement, and training would ultimately lead to a reduction of suicide among police officers. Dr. Violanti has authored an informational website including a suicide prevention toolkit for use by law enforcement departments that can be found at: <http://policesuicide.spcollege.edu/indexIHW.htm>

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Members of the Armed Forces and Veterans

DEPARTMENT OF DEFENSE (DOD)

Suicide prevention is a top priority for the Department of Defense (DoD). Reflecting this, the Secretary of Defense established the Defense Suicide Prevention Office (DSPO) in November 2011 to serve as the focal point for all DoD suicide prevention programs, policies, and surveillance activities.

DSPO oversees all strategic development, implementation, centralization, standardization, communication, and evaluation of DoD suicide risk reduction programs, policies and surveillance activities. To reduce the impact of suicide on Service members and their families, DSPO uses a range of approaches related to policy, research, communications, law, and mental health. DSPO works with the Army, Navy, Air Force, Marine Corps, Coast Guard and National Guard Bureau to support our Service members and strengthen a resilient and ready force. DSPO strives to help foster a climate that encourages Service members to seek help for their mental health conditions.

DSPO is working with its partners to enhance suicide prevention efforts in the military by responding to a range of critical recommendations, including those offered by the DoD's Task Force on the Prevention of Suicide by Members of the Armed Forces. These efforts include establishing, monitoring, and analyzing the results of suicide prevention research and surveillance activities to identify suicide risk factors and translate findings into policy and strategies. DSPO is working with the Department of Veterans Affairs, the Centers for Disease Control and Prevention, and the

Hello, my name is Russell Crupe; I lost my son Russell Jr. to suicide in July 2012. Russell was a decorated combat veteran having served in Iraq.

I will never know why this happened but it has surely changed our lives forever. Parents should never have to bury their children. We are very proud of Russell in that he was never selfish and is missed by a lot of friends and family. My life is changed in that we worked together and will never be the same. When I travel, I no longer have him to call to let him know where we are at. Memories are often a curse because no matter what I do he was always part of it. I hope and pray that the government will look harder at Post Traumatic Stress Disorder (PTSD) and find ways to help our military so other families will not suffer what we are doomed to endure.

Russell Crupe

Pennsylvania Older Adult Suicide Prevention Plan

National Center for Telehealth & Technology (T2), among others, on these surveillance efforts.

The Department of Defense Suicide Event Report (DoDSER) program was launched in 2008 to refine suicide surveillance within DoD. This was one of the surveillance efforts used at DoD to help characterize the suicidal behavior of military personnel. The DoDSER assesses several areas of interest to suicide prevention efforts, including demographics, mental health history, circumstances at the time of the event (e.g., stressors and significant life events), and deployment history.

The DoDSER program is a collaborative effort of the National Center for Telehealth & Technology (T2) and the Services' suicide prevention program offices. Since January 1, 2008, the DoDSER program has standardized suicide surveillance across the Services with the ultimate goal of facilitating the DoD's suicide prevention mission. When a death is ruled a suicide by the Armed Forces Medical Examiner System (AFMES), a designated professional from the respective Service reviews records, conducts interviews when appropriate, and responds to the DoDSER items via the secure web-based DoDSER application (<https://dodser.t2.health.mil>). As of January 1, 2010, all Services have been collecting data on both suicides and suicide attempts, with some Services collecting data on additional nonfatal suicide events. The DoDSER items collect comprehensive information about the Service Member and the suicide event.

The AFMES indicates that 301 Service Members died by suicide in 2011 (Air Force = 50, Army = 167, Marine Corps = 32, Navy = 52). This number includes deaths strongly suspected to be suicides that are pending final determination. DoDSER Points of Contact (POCs) submitted reports for 100% of AFMES confirmed 2011 suicides (Air Force = 46, Army = 159, Marine Corps = 31, Navy = 51) as of the data extraction date (26 April 2012). A total of 915 Service Members attempted suicide in 2011 (Air Force = 241, Army = 432, Marine Corps = 156, Navy = 86). DoDSERs were submitted for 935 suicide attempts (Air Force = 251, Army = 440, Marine Corps = 157, Navy = 87). Of the 915 Service Members who attempted suicide, 896 had one attempt, 18 had two attempts, and 1 had three attempts.

Department of Defense Resources

Department of Defense's Office of the Under Secretary of Defense for Personnel and Readiness's Defense Suicide Prevention Office (DSPO) <http://www.suicideoutreach.org/>

Department of Defense Suicide Event Report (DoDSER)
<http://www.t2.health.mil/programs/dodser>

DoDSER 2011 Annual Report
http://www.t2.health.mil/sites/default/files/dodser/DoDSER_2011_Annual_Report.pdf

PENNSYLVANIA NATIONAL GUARD SUICIDE PREVENTION PROGRAM

In calendar year 2012 within the Pennsylvania Army National Guard (PAARNG), there were 52 suicide ideations, 22 suicide attempts and 5 suicides and 1 suicide attempt in the Pennsylvania Air National Guard (PAANG). In calendar year 2013 there were 53 suicide ideations, 15 suicide attempts and 4 suicides in the PAARNG and 2 suicide ideations, and 1 suicide attempt in the PAANG.

The Pennsylvania National Guard (PNG), an organization that is made up of approximately 20,000 Soldiers, Airman and their Families. The sheer size of this organization creates a rather large foot print in the state of Pennsylvania that is directly affected by the implications of suicidal behavior. Unlike active duty military Families, National Guard Families are their communities. National Guardsmen are integrated into society so their neighbors along with their fellow Soldiers and Families feel their struggles. The leadership of the Pennsylvania National Guard, the community, state and federal government agencies, private veteran's organizations, and non-profit agencies all have a vested interest in preventing military suicides.

The PNG is already noticing a decrease in suicides. The number of successful interventions has also substantially increased and evidence supports the reasons because of 1) suicide prevention and intervention education and training initiatives, and 2) the implementation of the Suicide Related Incidents Reporting Regulation. According to the PAARNG DPH, "The Suicide Related Incidents Reporting Regulation and R3SP training program have been pivotal, by requiring units to report suicide ideations, suicide attempts and deaths by suicide when they occur. Leaders are held accountable to ensure these Soldiers receive the care they need. We are teaching leaders how to respond and identify suicidal behaviors before they result in a crisis. This regulation has helped mental health to be taken more seriously in the Pennsylvania National Guard."

Pennsylvania National Guard Resources

Family Programs (717) 861-2650, Child and Youth Program (717) 861-6289, Yellow Ribbon Program (717) 861-2597, Employment Outreach (717) 861-2640, Employer Support of the Guard and Reserve (717) 861-8782, Resilience, Risk Reduction and Suicide Prevention Programs (717) 861-8976, Psychological Health Program (717) 673-4785, Sexual Assault prevention and Response Program (717) 861-6427, Survivor Outreach Services (814) 533-2481, Transition Assistance (717) 861-2813.

U.S. ARMY SUICIDE PREVENTION PROGRAM

This program uses Applied Suicide Intervention Skills Training (ASIST) to prepare designated gatekeepers to recognize suicide risk and intervene. All Army personnel, including civilians, are required to participate in Ask, Care, and Escort (ACE) suicide prevention and awareness training. The website also includes awareness materials, data, and tools for commanders to develop suicide prevention programs.

The Army Suicide Prevention Program (ASPP), a proponent of Deputy Chief of Staff, G-1 (DCS, G-1), has an Army-wide commitment to provide resources for suicide intervention skills, prevention, and follow-up in an effort to reduce the occurrence of suicidal behavior across the Army enterprise. The ASPP develops initiatives to tailor and target policies, programs, and training in order to mitigate risk and behavior associated with suicide. A function of the ASPP is to track demographic data on suicidal behaviors to assist Army leaders in the identification of trends. The goal is to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army DA civilians, and Army Family members. The ASPP establishes a community approach to reduce Army suicides through the function of the Community Health Promotion Councils (CHPC). The CHPC integrates multidisciplinary capabilities to assist commanders in implementing local suicide-prevention programs, and establishes the importance of early identification of, and intervention with problems that detract from personal and unit readiness. The ASPP has 3 principle phases or categories of activities to mitigate the risk and impact of suicidal behaviors, prevention, intervention, and postvention.

U.S. Army Resources

www.armyg1.army.mil/hr/suicide/default.asp

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action

http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

DA PAM 600_24 Health Promotion, Risk Reduction, and Suicide Prevention RAR 7 September 2010 http://www.apd.army.mil/pdffiles/p600_24.pdf

U.S. AIR FORCE

The AF Suicide Prevention Program is built on the 11 overlapping core elements listed below stressing leadership and community involvement in the prevention of suicides.

1. Leadership Involvement 2. Addressing Suicide Prevention through Professional Military Education 3. Guidelines for Commanders 4. Unit-based Preventive Services 5. Wingman Culture 6. Investigative Interview Policy 7. Post Suicide Response (Postvention) 8. Integrated Delivery System (IDS) and Community Action Information Board (CAIB) 9. Limited Privilege Suicide Prevention Program 10. Commanders Consultation Assessment Tool 11. Suicide Event Tracking and Analysis

U.S. Air Force Resources

Air Force Suicide Prevention website <http://www.afms.af.mil/suicideprevention/index.asp>

Air Force Instruction 90-505, 10 August 2012, Special Management Suicide Prevention Program <http://www.afms.af.mil/shared/media/document/AFD-130423-030.pdf>

U.S. MARINE CORPS

The Marine Corps Suicide Prevention program (MCSPP) establishes policy and provides resources, guidance, and training for suicide prevention programs.

The desired outcome of the MCSPP is a proactive, efficient, and effective strategy to maintain the readiness of both individual marines and their units. This strategy is aligned with the Marine Corps larger, holistic prevention approach to mental health that seeks to develop coping skills, increase resilience, and increase access to and engagement of mental health, healthcare services.

The Marine Corps Manpower and Reserve Affairs website has multiple links to information in reference to the MCSPP.

U.S. Marine Corps Resources

Marine Corps Order 1720.2 Marine Corps Suicide Prevention Program <http://www.marines.mil/Portals/59/Publications/MCO%201720.2.pdf>

Marine Corps Manpower and Reserve Affairs website https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MF/G_Behavioral%20Health/BH_Community%20Counseling%20and%20Prevention

U.S. NAVY

The Navy's Suicide prevention website provides links to policies, training, and resources. The Navy Suicide Program focuses at the Commander's level.

Commanders play a crucial role in facilitating the local actions that build lives worth living, enhancing resilience, enabling access to support services, and diverting people from a path to suicide. They also help those left behind to pick up and start to heal if the tragedy of suicide does strike.

The first step is for Commanders to designate a Suicide Prevention Coordinator (SPC) and make sure that person gets training to assist in implementing the following steps. 1. Strengthen Your Foundation 2. Enhance Awareness 3. Build Skills 4. Be Prepared 5. Intervene 6. Reintegrate 7. Respond 8. Report

U.S. Navy Resources

Navy Suicide Prevention Website http://www.public.navy.mil/BUPERS-NPC/support/21st_century_sailor/suicide_prevention/Pages/default.aspx

Commanding Officer's Suicide Prevention and Response Toolbox
http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/Documents/Suicide%20Prevention%20Commander%20Toolbox%2015%20Nov.pdf

U.S. COAST GUARD

United States Coast Guard website, Office of Work-Life Programs- Suicide Prevention Program, has multiple links that will connect the Coast Guard personnel to available services and resources.

The goals of the Coast Guard's Suicide Prevention Program are to:

- a. Minimize suicidal behavior among all Coast Guard employees and their family members by empowering all Coast Guard personnel to recognize persons in distress and to take supportive action to help them,
- b. Encourage help-seeking behavior by reducing the stigma historically associated with receiving mental health care, and
- c. Protect those who responsibly seek mental health treatment from unfair actions resulting from seeking help.

Pennsylvania Older Adult Suicide Prevention Plan

Measures of success for the Coast Guard Suicide Prevention Program include:

a. Reduced suicidal behaviors. b. Increased awareness of warning signs and circumstances associated with suicidal behavior. c. Increased number of personnel of all ranks who know what to do to assist distressed individuals, and d. An increase in the number of personnel who understand that mental health care can be obtained without risk to one's career.

The Coast Guard Suicide Prevention Program consists of seven components including Command Climate, Crisis Response, Limit on Command Access to Mental Healthcare Information, Notification and Hand-off in Criminal Investigations, Postvention, Reporting, and Training.

U.S. Coast Guard Resources

Commandant Instruction 1734.1A Suicide Prevention Program

http://www.uscg.mil/HEALTH/cg1122/docs/pdf/CI_1734_1A.pdf

United States Coast Guard website Office of Work-Life Programs- Suicide Prevention Program

http://www.uscg.mil/worklife/suicide_prevention.asp

VETERANS

The suicide rate for active duty military personnel has historically been significantly lower than the rate for a comparable population of civilians. However, the number of suicides and suicide attempts has been steadily growing over the past several years.

There are similar concerns within the veteran population. The Center for Disease Control and Prevention estimates that veteran's account for approximately 20% of the deaths from suicide in America. Some 8,000 veterans are thought to die by suicide each year, a toll of about 22 per day, according to a 2012 VA study. These numbers may be a gross underestimation as this number includes only data from 21 states, not including Texas or California. The number of suicides has grown over 11% in the most recent 4 years. In the most recent date the suicide rates for male Veterans Health Administration patients were approximately 1.4 times greater than for other American men. For female veterans involved in VHA services, rates were approximately twice as high as among American women. Approximately half of all suicides in VHA occurred among patients known to have mental health conditions.

VA suicide prevention began earnestly in 2004 with the inception of the Mental Health Strategic Plan. This plan has assisted in increasing core mental health staff on a national level by 50 percent. In addition, the VA suicide prevention program is based on the principle that prevention requires ready access to high quality mental health services within the health care

system, supplemented by public education and awareness, and availability of specific services which address the needs of those at highest risk. Activities which have been sponsored by the suicide prevention network have included creating a national office for suicide prevention, partnering with SAMSHA and its Lifeline program to add a veteran's call center to its national crisis line, funding suicide prevention coordinators with support staff in each VA medical center and initiating public information forums focused on promoting the use of the of the VA mental health services for those in need.

The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, [chat online](#), or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for [deaf and hard of hearing](#) individuals is available.

VA is working to make sure that all Veterans and their loved ones are aware of the Veterans Crisis Line. To reach as many Veterans as possible, VA is coordinating with communities and partner groups nationwide, including community-based organizations, Veteran Service Organizations, and local health care providers, to let Veterans and their loved ones know that support is available whenever, if ever, they need it.

Veterans Resources

Veterans Crisis Line <http://www.veteranscrisisline.net/>

U.S. Department of Defense/U.S. Department of Veterans Affairs Suicide Outreach
<http://www.suicideoutreach.org/>

Murder-Suicide

Murder-suicide is a “dramatic, violent event” in which a person, almost always a man, commits one murder or multiple murders, and then shortly after dies by suicide.¹ According to the most recent edition (fourth edition published in 2012) of the Violence Policy Center's (VPC), “American Roulette: Murder-suicide in the United States,” there was no comprehensive national database to accurately track incidents, fatalities, and survivors of murder-suicide events. However the data gathered by the VPC is worth noting as those who have committed homicide, followed by suicide within 72 hours, seems to show specific trends.²

Pennsylvania Older Adult Suicide Prevention Plan

The most recent data, gathered by VPC from news reports during the first six months of 2011 shows:

- There were 313 murder-suicide events resulting in 691 total deaths (378 were homicides)
- 280 (89.5%) of these events involved firearms
- 283 (90%) of the 313 perpetrators were male
- 288 (76%) of the 378 homicide victims were female
- 225 (72%) of the events involved an intimate partner; of those, 94% of homicide victims were females
- 55 (14.5%) of the homicide victims were under 18
- 66 children were survivors who witnesses some aspect of one of these events
- 80% of the total events occurred in the home, while 84% of intimate partner events occurred in the home
- 25% of these events involved a perpetrator 55 or over
- There is a subcategory of intimate partner murder-suicide events, in which a man (called a “family annihilator”) kills his intimate partner and children, as well as other family members, before dying by suicide

The following are conclusions drawn in the VPC report:

- There are significant fatalities of murder-suicide events that go well beyond the suicide itself, including the deaths of family, friends, co-workers and/or strangers.
- There are significant emotional repercussions, including guardianship changes, for the children of those involved in murder-suicide events.
- Domestic violence is associated with a significant number of murder-suicides. Therefore, intervention and legislation related to domestic violence may be a way to address this issue.
- Depression and failing health have been cited as contributing factors to murder-suicide among older persons.
- The overwhelming use of firearms as the weapon in these events points to the need for efforts that will restrict access to those with some of the risk factors listed above.
- A comprehensive national database of murder-suicide events should be established.

References:

1. Peter M. Murzak et al., “The Epidemiology of Murder-Suicide,” *Journal of the American Medical Association* 267, no. 23 (June 1992): 3179-3183.

2. American Roulette: Murder-Suicide in the United States, Fourth Edition by the Violence Policy Center, 2012, as well as related publications can be found at <http://www.vpc.org/studyndx.htm>.

Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Populations (LGBTQI)

According to the Kaiser Family Foundation Issue Brief of January 2014 entitled Health and Access to Care and Coverage for LGBT Individuals in the U.S. Who Are LGBT, people who are LGBT (and by extension Q and I), have an elevated risk for some mental health, substance use, and physical health conditions.

Attention to elevated risk for suicide in this population is limited because death certificates do not identify decedent's sexual orientation, gender identity or expression. The Kaiser Foundation report finds that individuals who identify as LGBT are 2.5 times more likely to experience depression, anxiety, and substance misuse. The report reveals that 26% of bisexual females, 11% of bisexual males, 6% of gay males and a 3% rate among all other subgroups have recently considered suicide. In addition, anti-gay bias and homophobia put people who are LGBTQI, and those simply perceived to be, at greater risk for physical violence, with people of color who are transgender at particular risk. People who are transgender have faced some type of discrimination when seeking routine medical care. Persons who are LGBTQI report histories of discrimination and stigma at an unacceptable rate of 66%. People who are LGBTQI are present across all religious, cultural, political, ethnic, socio-economic, gender and racial populations. Some may experience double minority stress, stigma and discrimination, a type of "double jeopardy". LGBTQI persons who are older may be excluded from nursing homes and may need to go "back in the closet" although they were previously "out", and there are adverse financial consequences for LGBTQI couples, even if legally married in another state, leaving them vulnerable to poverty. Closing the knowledge gap, addressing homophobia and ensuring equality among all minorities to reduce stigma and discrimination are necessary factors for the prevention of suicide.

Pennsylvania Older Adult Suicide Prevention Plan

Factors that foster and promote resilience in people who are LGBTQ or I include family acceptance, connection with caring others and a sense of safety, positive sexual/gender identity and availability of quality, culturally appropriate mental health treatment. Strategies for preventing suicide and thoughts and actions in people who are LGBTQI include: reducing sexual orientation and gender related prejudice and associated stressors, improving identification of depression, anxiety, substance use and other mental health conditions, increasing availability and access to LGBTQI affirming treatments and mental health services/supports. An additional goal is to reduce bullying and other forms of victimizations and micro-aggressions that contribute to vulnerability within families, schools, workplaces, and congregate care facilities such as nursing homes and hospitals. It is necessary to enhance factors that promote resilience, including family acceptance and public safety, such as changing discriminatory laws and public policies and reducing suicide contagions. These goals will require collaboration between suicide prevention and LGBTQI organizations to ensure the development of culturally appropriate suicide prevention programs, services and materials, and to facilitate access to care for at-risk individuals.

In 2008 The Office of Mental Health and Substance Abuse Services (OMHSAS) convened a group of stakeholders at the request of the Deputy Secretary to address the needs of people who identify as LGBTQI who seek mental health and substance use treatment within the Pennsylvania managed care system. This group sent 3 major recommendations to the Deputy. First is to protect LGBTQI individuals from discrimination and mistreatment. Next, is to ensure that OMHSAS and contracted providers ensure culturally affirmative environments of care for individuals who identify as LGBTQI. Lastly, to ensure clinically competent behavioral health care for individuals who identify as LGBTQ or I. From this effort two bulletins and a white paper were published and can be found on www.parecovery.org. The bulletins address non-discrimination and guidelines to ensure affirmative environments and clinically appropriate services. It was noted that some clinicians were non-discriminatory and would like to be affirmative and competent; however, had a knowledge gap that needed to be addressed. A white paper addressing so-called conversion therapy was also published to highlight the harm that can be done with this method and noted that all major professional therapeutic groups such as the two APA's and NASW rejected this as competent therapy.

The Keystone Pride Recovery Initiative, KPRI, emerged out of this effort and has engaged in developing and implementing a web based and one day training in creating welcoming environments and a two day training for clinicians who wish to provide competent care. The curriculum was developed in partnership with the Pennsylvania Mental Health Consumers Association, (PMHCA), and Drexel University Behavioral Health Education with a grant from SAMHSA. KPRI is also working on public policy to promote equality and changing discriminatory

laws. Data collection that includes sexual orientation gender identity/expression, for more accurate reporting, is also a goal of the group.

Founded in 1972, the Persad Center headquartered in Pittsburgh is the nation's second oldest licensed counseling center whose mission is to strengthen LGBTQ communities. Outreach, training, advocacy and prevention programs are provided. In Philadelphia, the Pink and Blues support group is a valuable resource in the southeast part of the state. The Lesbian, Gay, Bisexual, Transgender Elder Initiative (LGBTEI) serves the Delaware Valley and beyond to protect and expand the rights of LGBTQI older adults as well as advocate for services and resources that are competent, culturally sensitive, inclusive and responsive to the needs of elders who identify as LGBT. There are large areas in Pennsylvania that do not have resources close by, however, resources may be available by contacting the above organizations and there are national organizations listed in the resource section.

Allies have been effective in promoting positive change in the dominant culture on issues of equality. An ally is a person who is a member of the dominant, majority heterosexual group who works to end oppression in his or her professional life through support and advocacy of the minority LGBTQI group. They speak out about discrimination and the denial of legal powers and privileges for people who are LGBTQI. They are a tremendous support and force for justice in the LGBTQI community.

Appendix B: Definitions*

Bereaved by suicide - Family members, friends, and others affected by the suicide of a loved one (also referred to as suicide loss survivors).

Best practices - Activities or programs that are in keeping with the best available evidence regarding what is effective.

Contagion - A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

Culturally competent - A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures, including the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Means - The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs)

Means restriction - Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods - Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Older Adults - Persons aged 60 or more years.

Postvention - Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Risk factors - Factors that make it more likely that individuals will consider suicide. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Substance use "condition" - A pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances (such as alcohol); prescription drugs (such as analgesics, sedatives, tranquilizers, and stimulants); and illicit drugs (such as marijuana, cocaine, inhalants, hallucinogens, and heroin).

Suicide - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior

Note: The term “committed” suicide is discouraged because it connotes the equivalent of a crime or sin. The Center for Disease Control has also deemed “completed suicide” and “successful suicide” as unacceptable. Preferred terms are “death by suicide” or “died by suicide”

Suicidal thoughts and actions - Includes thoughts related to suicide, including preparatory acts, as well as suicide attempts and deaths. The term suicidal behavior is commonly used in the field but has been replaced by thoughts and actions throughout the document.

Suicide attempt survivors - Individuals who have survived a prior suicide attempt.

Suicide loss survivors - See bereaved by suicide.

*Definitions taken from the National Strategy for Suicide Prevention and the Suicide Prevention Resource Center.

Appendix C: Risk and Protective Factors

RISK FACTORS FOR SUICIDE

- Previous suicide attempt
- Diagnosis of depression
- Family history of suicide
- Recent loss including one or more of the following: independence, health status, job, home, money
- Death or terminal illness of a loved one
- Divorce or loss of major, significant relationship
- Loss of health, either real or imagined
- Someone close to the person has died by suicide
- Recent disappointment or rejection
- Being expelled from school/fired from job
- Sudden loss of freedom/fear of punishment
- Victim of assault or bullying

PROTECTIVE FACTORS

- Strong bonds with friends and family
- Restricted access to lethal means
- Effective and appropriate clinical care for mental, physical and substance use conditions
- Easy access to a variety of clinical interventions and support for seeking help
- Community support
- Support from ongoing medical and mental health relationships
- Life skills such as decision making, conflict resolution, anger management, non-violent ways of handling disputes and problem solving
- Strong beliefs in the meaning and value of life
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts
- HOPE for the future

Appendix D: Warning Signs of Suicide and What to do:

WARNING SIGNS OF SUICIDE*

- Talking about wanting to die;
- Looking for a way to kill oneself by seeking access to firearms, available pills, or other means;
- Talking or writing about death, dying or suicide;
- Talking about feeling hopeless or having no purpose;
- Suddenly happier and calmer, especially after a period of depression or sadness;
- Giving away prized possessions;
- Getting affairs in order, making arrangements;
- Talking about feeling trapped or being in unbearable pain;
- Talking about being a burden to others;
- Increasing the use of alcohol or drugs;
- Acting anxious, agitated, or reckless;
- Sleeping too little or too much;
- Withdrawing from friends, family and society or feeling isolated;
- Showing rage or talking about seeking revenge; and
- Displaying extreme mood swings.

The more of these signs a person show, the greater the risk of suicide.

WHAT TO DO

If someone you know exhibits signs of suicide:

- Do not leave the person alone;
- Remove any objects that could be used in a suicide attempt;
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK/8255; and
- Take the person to an emergency room or seek help from a medical or mental health professional.

*Adapted from Recommendations for Reporting on Suicide website (www.reportingonsuicide.org); the National Council for Suicide Prevention (www.ncsponline.org/suicide-prevention/warningsigns) and the Pa Adult and Older Adult Suicide Prevention Coalition <http://preventsuicidepa.org/>

HERE IS AN EASY-TO-REMEMBER MNEMONIC ON THE WARNING SIGNS OF SUICIDE**

IS PATH WARM?

- I** Ideation
- S** Substance Abuse

- P** Purposelessness
- A** Anxiety
- T** Trapped
- H** Hopelessness

- W** Withdrawal
- A** Anger
- R** Recklessness
- M** Mood changes

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral

** Taken from the American Association of Suicidology (www.suicidology.org)

Appendix E: Resources/Websites

FOR IMMEDIATE HELP OR SUPPORT CALL THE NATIONAL SUICIDE PREVENTION LIFELINE AT 1-800-TALK (8255) or ONLINE at www.suicidepreventionlifeline.org

For direct access to websites below, place your cursor over the website and hit the control button and left mouse button together.

American Association of Suicidology (AAS)

www.suicidology.org

American Foundation for Suicide Prevention (AFSP)

www.afsp.org

Crisis Link: Prevention, Intervention, Support and Training

www.crisislink.org

LGBT Youth Suicide

www.eriegaynews.com

The Link's National Resource Center

www.thelink.org

National Alliance on Mental Illness (NAMI)

www.nami.org

LivingWorks Education Inc.

www.livingworks.net

Means Matter, Harvard School of Public Health

www.hsph.harvard.edu/means-matter

Metanoia

www.metanoia.org/suicide

National Council for Suicide Prevention (NCSP)

www.ncsponline.org

National P.O.L.I.C.E. Suicide Foundation

www.psf.org

Pennsylvania Older Adult Suicide Prevention Plan

Law Enforcement Suicide Prevention

<http://policiesuicide.spcollege.edu>

National Suicide Prevention Lifeline

www.suicidepreventionlifeline.org

National Organization of People of Color
Against Suicide (NOPCAS)

www.nopcas.com

Norman Institute - gender orientation

1-816-960-7200

QPR Institute

www.qprinstitute.com

Samaritans USA

www.samaritiansnyc.org

Suicide Awareness Voices of Education (SAVE)

www.save.org

Centre for Suicide Prevention

www.suicideinfo.ca

Suicide Anonymous

www.suicideanonymous.net

Action Alliance for Suicide Prevention

www.actionallianceforsuicideprevention.org

Suicide Prevention Resource Center (SPRC)

www.sprc.org

Tears of a Cop

www.tearsofacop.com

Trevor Helpline (LGBTQ Youth)

www.thetrevorproject.org

Veterans

www.veteranscrisisline.net

FEDERAL GOVERNMENT SOURCES:

Centers for Disease Control (CDC)

<http://www.cdc.gov/ViolencePrevention/pdf/Suicide-DataSheet-a.pdf>

CDC-US Mortality Statistics

www.cdc.gov/ncipc/wisqars/

National Council for Suicide Prevention (NCSP)

www.ncsp.org

National Institute of Mental Health (NIMH)

<http://nimh.nih.gov/health/topics/suicide-prevention/index.shtml>

Action Alliance for Suicide Prevention (AASP)

www.actionallianceforsuicideprevention.org

The Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov

NATIONAL STRATEGY DOCUMENTS:

National Strategy for Suicide Prevention-National Action Alliance for Suicide Prevention

www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

www.actionallianceforsuicideprevention.org/NSSP

www.samhsa.gov/nssp

Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead, 2010

Educational Development Center, Inc.

www.sprc.org/library/ChartingTheFuture_Fullbook.pdf

Reducing Suicide: A National Imperative, 2002

Institute of Medicine

<http://www.nap.edu/openbook.php?isbn=0309083214>

Pennsylvania Older Adult Suicide Prevention Plan

STATE SOURCES:

Pennsylvania Adult and Older Adult Suicide Prevention Coalition

www.PreventSuicidePA.org

Pennsylvania Youth Suicide Prevention

www.payspi.org

PA Recovery

www.parecovery.org

Center for the Prevention of Suicide

www.med.upenn.edu/suicide/

Philly Health Info

<http://phillyhealthinfo.org/>

Mental Health and Aging

www.mhaging.org

Pink and Blues (LGBTQI resource)

<http://www.pinkandblues.info>

Pennsylvania Mental Health Consumers Association

Keystone Pride Recovery Initiative- LGBTQI

<http://pmhca.org/projects/kpri.html>

YOUTH SUICIDE PREVENTION SOURCES:

Active Minds

www.activeminds.org

Jason Foundation

www.jasonfoundation.com

The Jed Foundation

www.jedfoundation.org

School Based Youth Suicide Prevention Guide

<http://theguide.fmhi.usf.edu/>

Pennsylvania Older Adult Suicide Prevention Plan

Signs of Suicide-Suicide Prevention Program for Secondary Schools (SOS)

www.mentalhealthscreening.org/highschool/index.aspx

Services for Teens at Risk Center (STAR)

www.wpic.pitt.edu/research/star/default.htm

TeenScreen: Adolescent Suicide and Mental Health Screening Programs

www.teenscreen.org

Youth Suicide Prevention Program

www.yspp.org

Yellow Ribbon Youth Suicide Prevention Program

www.yellowribbon.org

MEDIA REPORTING ON SUICIDE:

Picture This: Depression and Suicide Prevention, 2009

www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf

Recommendations for Reporting on Suicide, 2011

www.reportingonsuicide.org

EVIDENCE-BASED AND BEST PRACTICES FOR SUICIDE PREVENTION:

Best Practices Registry for Suicide Prevention

Suicide Prevention Resource Center (SPRC) and American Foundation for Suicide Prevention (AFSP)

www.sprc.org/bpr

National Registry of Evidence-Based Programs and Practices

SAMSHA, HHS

www.nrepp.samhsa.gov

SUICIDE DATA:

National Violent Death Reporting System (NVDRS)
Centers for Disease Control and Prevention (CDC), HHS
www.cdc.gov/injury/wisqars/nvdrs.html

Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements,
Version 1.0, 2011. National Center for Injury Prevention and Control, CDC, HHS
www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html

Appendix F: Summary of Four Regional “Listening Sessions” on the Plan and Summary of Survey

The Pennsylvania Adult and Older Adult Suicide Prevention Plan Advisory Committee hosted four regional listening forums, via webinar, during January, 2014. The purpose of the forums was to solicit broad stakeholder input into the revised adult and older adult suicide prevention plans. During these forums, the participants on the line were asked to respond to seven questions. The questions were developed to capture ideas related to the objectives in the 2005 Pennsylvania Adult and Older Adult Suicide Prevention Plans. The same seven questions were asked during each forum and the feedback that was given was incorporated into the revised objectives and action steps within the 2014 Pennsylvania Adult and Older Adult Suicide Prevention Plans. More than 50 individuals attended the listening sessions including state employees, providers, counties, managed care organizations and consumers of service. Listed below are the seven questions used in the forums followed by the major recommendations related to each question.

QUESTION 1: WHAT ARE THE WAYS IN WHICH PENNSYLVANIA CAN PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT CAN BE PREVENTED?

- ❖ The use of the internet (Facebook, twitter, etc.)
- ❖ Billboard campaigns, advertising through the media- radio, television, on buses etc.
- ❖ Promote phone numbers for crisis centers, advertise hotlines and chat rooms for crisis intervention, distribute pamphlets/brochures to include statistics and information on prevention and help.
- ❖ Encourage health providers and others to talk about suicide prevention and provide more information on the topic.
- ❖ Provide continuing education such as Question, Persuade, Refer (QPR) and Mental Health First Aid.
- ❖ Celebrity endorsements.

QUESTION 2: HOW CAN PENNSYLVANIA PROMOTE COLLABORATION AMONG A BROAD SPECTRUM OF AGENCIES AND INSTITUTIONS FROM COLLEGES TO FAITH-BASED ORGANIZATIONS TO PREVENT SUICIDE?

- ❖ Host the state suicide prevention conference annually
- ❖ Provide technical assistance and support to county suicide prevention taskforces including a how-to manual and quarterly networking calls
- ❖ Network with the Garrett Lee Smith grant around risk screening
- ❖ Consider Applied Suicide Intervention Skills Training (ASIST)

- ❖ Identify churches to take responsibility
- ❖ Have managed care conduct performance standards

QUESTION 3: WHAT ACTIONS CAN PENNSYLVANIA TAKE TO REDUCE THE STIGMA ASSOCIATED WITH MENTAL “ILLNESS” AND SUBSTANCE “ABUSE”, INCLUDING NEGATIVE PORTRAYALS IN THE MEDIA, IN ORDER TO CONNECT PEOPLE WITH SERVICES AND PREVENT SUICIDE?

- ❖ Educate through presentations on radio, Lions, Kiwanis, schools, etc.
- ❖ Educate staff in emergency rooms, police, corrections officers, etc.
- ❖ Use information on AFSP.org on how to work with the media
- ❖ Host media awards.
- ❖ Have survivors of suicide attempts, suicide loss tell their stories.

QUESTION 4: HOW CAN PENNSYLVANIA INSTILL PREVENTIVE INTERVENTIONS INTO LOCAL COMMUNITIES SUCH AS HEALTH CENTERS, UNIVERSITIES, SENIOR CENTERS, CORRECTIONAL FACILITIES, ETC.?

- ❖ Implement risk assessments in physicians’ offices.
- ❖ Network with Active Minds-that works with college students with mental health issues.
- ❖ Have a speakers bureau for presentations
- ❖ Provide funding for state lead on suicide
- ❖ Engage health providers through the Dept of Health

QUESTION 5: IN WHAT WAYS CAN PENNSYLVANIA REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM?

- ❖ Firearms issue is a balancing act between protecting lives and protecting rights.
- ❖ Need to look at Harvard University Means Matters project
- ❖ Promote voluntary turning in of medications, weapons.
- ❖ Need to look at “accidental” medication overdoses among the elderly.
- ❖ Gun safes and gun locks are important
- ❖ Free resource on lethal means counseling on SPRC.org

QUESTION 6: HOW SHOULD PENNSYLVANIA TARGET TRAINING AND BEST PRACTICE INTERVENTIONS FOR PROFESSIONALS AS WELL AS COMMUNITY GATEKEEPERS SUCH AS POLICE, CLERGY, TEACHERS, ETC., SO THEY HAVE THE SKILLS TO IDENTIFY RISK AND MAKE REFERRALS TO PREVENT SUICIDE?

- ❖ Post discharge follow-up is important after a crisis. Is there a way to reinforce through regulations? Could use crisis programs and peer specialists to do.
- ❖ Training across the board is needed. Bill in process would require teachers to be trained
- ❖ Can we require training such as MH First Aid or QPR for mental health and drug and alcohol providers and others?
- ❖ Encourage a variety of training: Mental Health First Aid, Question, Persuade and Refer, ASIST, Means Matters, AFSP training for survivor support groups, etc.
- ❖ Lobby credentialing agencies to require training in their standards.

QUESTION 7: WHAT DOES PENNSYLVANIA NEED TO DO TO PROMOTE RESEARCH AND DATA COLLECTION IN ORDER TO BETTER UNDERSTAND SUCH THINGS AS WHY INDIVIDUALS BECOME SUICIDAL, WHERE AND WHY SUICIDES ARE HAPPENING AND WHAT INTERVENTIONS REDUCE SUICIDE?

- ❖ Should require consistent reporting by coroners and others
- ❖ Suicide rating scale, or something similar, should be required screening with all intakes.
- ❖ What is the role of managed care in setting standards?

The above seven questions, plus an additional question listed below, were used to gather statewide input into the Adult and Older Adult Suicide Prevention Plans through “Survey Monkey”. The survey was made available during the months of January and February, 2014. A summary of the survey results is listed below. The full survey results will be posted on www.parecovery.org following the publication of this plan.

A total of 154 individuals responded to the survey. Of that total, 69% (100) were females and 28% (44) were males. One person self-identified their gender and two persons choose not to disclose their gender. The largest numbers of respondents (50%) were ages 41-59, while 32% were age 22-40 and 18% were age 60 or older. The vast majority (87%) of individuals completing the survey identified as white (135) and 59% identified as mental health professionals. However, community members, social service employees, state and county employees, suicide loss survivors, suicide attempt survivors, persons in drug and alcohol recovery, emergency workers, veterans and military personnel also participated in the survey.

Participants were asked to choose their top recommendations from the forced choice answers to each question provided in the survey.

QUESTION 1:

Providing public education was the number one recommendation to promote public awareness that suicide is preventable with 114 people identifying this as one of their top three choices. In addition, 86 people recommend targeting policy makers to promote prevention policies and programs while 83 individuals suggest promoting the national and local suicide crisis lines.

QUESTION 2:

In order to promote broad collaboration on suicide prevention, 110 individuals recommend identifying a lead state and local agency to bring together partners to work on suicide prevention. Including suicide prevention as a quality management goal in HealthChoices was prioritized by 88 individuals.

QUESTION 3:

Actions to counter negative portrayals of mental illness and substance use in the media include public awareness campaigns that promote recovery from mental health and substance use disorders as real and possible (121 responses) and the inclusion of survivors and advocates in curriculum development (108 responses).

QUESTION 4:

In order to instill suicide prevention into local organizations, 108 persons recommend promoting suicide risk assessments in community and social service agencies. Increasing the number of suicide prevention plans within these organizations was suggested by 97 individuals.

QUESTION 5:

Education was the overwhelming recommendation to reduce access of lethal means of self-harm. Educating family members (91responses), educating the public (89 responses) and educating health care and safety officials (85 responses) are highly recommended.

QUESTION 6:

Health professionals (102 responses) and the community (110 responses) were the primary audiences targeted to receive training to increase skills to prevent suicide. Regarding best practices, 104 people recommend the implementation of programs for high risk individuals and 102 persons suggest rapid follow-up following crisis inpatient stays.

QUESTION 7:

Regarding data collection, 99 individuals recommend the development of indicators for evaluating the effectiveness of suicide prevention interventions. Increasing the number of jurisdictions that collect information on suicide was recommended by 77 persons.

QUESTION 8: WHAT CAN PENNSYLVANIA DO TO HELP PEOPLE WHO HAVE SURVIVED SUICIDE LOSS?

Question 8 was added to the survey at the request of the Adult and Older Adult Suicide Prevention Advisory Committee. The majority of respondents (100) recommended providing information to first responders on how to deal with the aftermath of suicide including responding to caregivers need for support.

Appendix G: Pennsylvania Adult and Older Adult Suicide Prevention Plan Advisory Committee

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PA Behavioral Health and Aging Coalition

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