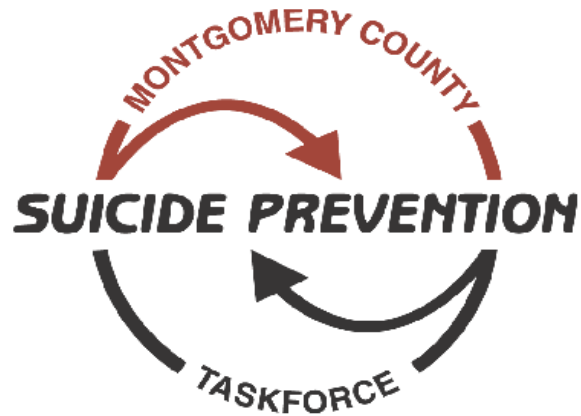


**Suicide as a
Community Health Problem
in Montgomery County:
An Agenda for Action**



**Montgomery County
Suicide Prevention Task Force**

November 2006

Prepared by Montgomery County Emergency Service, Inc

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This report was written in memory of all Montgomery County residents lost to suicide.

Executive Summary:

What do we want to do?

Since 2002 the Montgomery County Suicide Prevention Task Force, a coalition of county agencies, community groups, mental health providers, and other organizations, has worked to increase understanding of suicide prevention. The Task Force meets under the aegis of the Montgomery County Health Department. It has found that a comprehensive approach to suicide prevention is needed in the county. It proposes a suicide prevention strategy based on six goals:

1. Promote awareness that suicide is a preventable community health problem.
2. Develop broad-based community-wide support for suicide prevention.
3. Reduce the stigma linked to being a consumer of suicide prevention services.
4. Develop and implement community suicide prevention programs
5. Promote community efforts to reduce access to lethal means.
6. Implement training for recognition of and response to at-risk behavior.

Why do we want to do it?

Suicide claims 50-70 lives yearly in Montgomery County. Most victims are adult males in their most productive years. There are an estimated 1500 suicide attempts each year in the county, and 600 of these may require hospital treatment. Suicides and suicide attempts emotionally tax police, ambulance companies, hospitals, crisis centers, and mental health providers. Each suicide leaves behind family members and others who are severely traumatized by the loss and who may have serious problems as a consequence. These “suicide survivors” may experience symptoms of mental illness. All are left at risk of suicide, and some will attempt suicide.

What will it cost?

There is a solid foundation for suicide prevention in place in the county. It is the product of volunteer and agency resources, nominal funding, fund-raising, and in-kind contributions by Task Force members. These resources will continue to be applied to the task. Optimal use of existing systems remains essential to avoid duplication. However, some additional resources will be necessary to implement many of the proposed activities. The body tasked with implementing this plan will be best positioned to project the costs of the recommended activities. Where necessary, financial support may be drawn from foundations, and state and federal sources.

Introduction:

There were 52 reported suicides in Montgomery County in 2005 – *one every week*.

There were 337 suicides in the county from 2000-2004, *an average of 67 per year*.

There are more suicides in the county yearly than homicides and AIDS/HIV deaths combined.

There may be over 600 suicide attempts annually in the county serious enough to require hospitalization¹ – *almost two a day*. There are hundreds of other suicide attempts every year.

There are hundreds of youths, adults, and elders who thought about suicide and many who made a suicide plan that was fortunately not carried out. *All remain at risk of suicide*.

A suicide is a traumatic event for those close to the victim. 6-8 individuals are seriously affected by every suicide. There are 300-500 such “suicide survivors” in the county every year. They endure a painful bereavement and are left at increased risk of suicide because of their loss.

Suicide imposes an emotional burden on the county’s emergency responders. Suicidal behavior adds financial stress to the county’s medical and behavioral health care systems.

Suicide is a critical community health problem that warrants more concern and resources than it has received. This document makes the case for greater attention to suicide by:

- Defining suicide as a preventable problem in Montgomery County
- Assessing the status of suicide prevention efforts in Montgomery County
- Presenting a strategy to expand suicide prevention in Montgomery County

Suicide prevention is “a formal effort to reduce the effect of intrinsic risk factors (e.g., gender, race, age) and extrinsic risk factors (e.g., firearms availability, alcohol use), and to enhance the scope and strength of protective factors, to deter the onset of behaviors leading to suicide” (Montgomery County Emergency Service 2006).

Montgomery County needs a plan to build suicide prevention capacity and readiness -- now.

¹ Suicide Prevention Resource Center (www.sprc.org) “Pennsylvania Suicide Fact Sheet.” There are 80 medically serious suicide attempts per 100,000 residents in Pennsylvania.

Suicide Prevention Terminology and Data:

Basic Terms:

Lethal Means – The act, process, or instrument by which suicide is completed.

Means Restriction/Reduction – Limiting or removing access to lethal means.

Parasuicide – Self-harm with no intent to die that would not lead to death if untreated.

Suicidal Behavior – A spectrum inclusive of suicidal ideation, suicide planning, acquiring lethal means, an attempt, or a suicide completion.

Suicidal Ideation – Thoughts of self-harm or completing suicide.

Suicidality – Any level of suicidal behavior from ideation to making a plan to an attempt

Suicide Attempt – Self-harm intended to be fatal that does not result in death.

Suicide Completion² – A suicide attempt that results in death.

Suicide Intervention – Identification and evaluation of risk of self-harm and immediate appropriate safety and treatment measures.

Suicide Postvention – Aid following a suicide attempt or a suicide loss.

Suicide Risk – The foreseeable and fluctuating likelihood of a completed suicide.

Suicide Screening – A non-clinical determination of the presence of suicide risk factors.

Suicide Data:

County suicide data is derived from death certificates, which originate with the County Coroner and local physicians. This data is tabulated by the Pennsylvania Department of Health (PDOH) and is available to the public by year and age, gender, race, and means of death.

The Coroner reviews death certificates issued by physicians, and may reclassify a death as a suicide. This does not change the PDOH tabulations of reported suicides, and may lead to under-reporting of suicides. Suicide prevention planning should proceed with data on the actual incidence of suicide in the county.

Attempts are not centrally reported. Approximations of the occurrence of suicide attempts in the county must be made on the basis of statewide data and research studies.

² Herein suicide is “completed” rather than “committed.” The former has a less stigmatizing connotation than the latter and reflects the emerging perspective that suicide is the outcome of a multifactorial process. For these reasons, this is the accepted usage in the literature.

A Suicide Prevention Vision:

Planning starts with a vision of what should be to serve as an orientation to what can be. A vision is a brief description of a desired future that is envisioned and shared by the stakeholders.

In suicide prevention a vision must be optimistic, empowering, compelling, and energizing. It visualizes suicide prevention as a day-to-day reality.

Here is our vision for suicide prevention in Montgomery County:

- An active coalition of community groups, providers, schools, elected officials, clergy, criminal justice agencies, and others working to prevent suicide in Montgomery County.
- A suicide prevention capability integrated within existing systems to add capacity to structures in place to assure effectiveness and efficiency.
- A central source of technical support and expertise to coordinate and facilitate the ongoing implementation of suicide prevention resources in Montgomery County.
- A comprehensive, accessible, effective evidence-based system of suicide prevention, suicide intervention, and suicide postvention services.
- The elimination of misinformation and ignorance about suicide, fear and indifference towards those who are suicidal, and insensitivity towards those bereaved by a suicide.
- The reduction of the number of lives lost to suicide among all age groups, ethnic and racial groups, and communities in Montgomery County.
- A network of suicide loss support groups accessible to county residents bereaved by suicide to use as necessary.

“Society’s view of suicide and suicidal behavior is evolving from seeing such behavior as an individual act directly affecting a single person, to a societal event in which the suicide is one of many facets of a community – a community that must then accept a leading role in preventing its occurrence.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

Task Force Background:

The Montgomery County Suicide Prevention Task Force was formed in 2002 by the Montgomery County Health Department (MCHD).

We are the first countywide suicide prevention effort in Pennsylvania. We have a community-wide focus on suicide across the entire age spectrum: youths, adults, and elders.

Our mission is “to develop strategies to reduce the risk of suicide in Montgomery County through the collaborative efforts of community agencies and service providers.”

Our accomplishments to date include:

- A web site offering information about suicide and suicide prevention activities
- A Task Force brochure outlining our mission and aims
- A Task Force Listserv for member information-sharing
- The Annual Montgomery County Suicide Prevention Awareness Walk held every October in the Norristown Farm Park.
- Publication of the *Montgomery County Suicide Prevention Resource Guide*, the first publication of its kind in southeastern Pennsylvania
- A training on elder suicide for older adult service providers co-sponsored with the Office of Aging and Adult Services
- A regional workshop on federal level suicide prevention developments conducted by Jerry Reed, Executive Director of the Suicide Prevention Action Network (SPAN), a national suicide prevention advocacy organization based in Washington, DC
- Participation in health fairs and similar community information events
- Publication of articles on suicide prevention in the *Times-Herald* and in several weeklies
- Hosting QPR (Question, Persuade, Refer) suicide prevention trainings
- Hosting a suicide prevention education program for physicians and other providers
- Participation in a county-wide Students Against Destructive Decisions (SADD) conference for youth
- Suicide prevention education for college students in the county
- Financial support of reprinting of *Recovering from Suicide Loss: A Self-help Guide for those who have Lost Someone to Suicide* by Survivors of Suicide, Inc. (SOS).
- Participation in a Regional Task Force representing suicide prevention groups in the 5-county area.

We are a model for other counties, some of which have replicated our projects.

Task Force Member Organizations:

Representatives of the following agencies and organizations presently comprise the Task Force:

Access Services, Inc.
Brooke Glen Behavioral Hospital
Catholic Social Services
CeaseFire PA
Center for Literacy/Adult Diploma Program
Central Montgomery MH/MR Center
Child Death Review Team
Children's Aid Society
CONTACT Careline
Feeling Blue Suicide Prevention Council
Gateway Employment Services, Inc.
Lower Merion Counseling Center
Montgomery County Children & Youth Services
Montgomery County Department of Aging & Adult Services
Montgomery County Emergency Service, Inc. (MCES)
Montgomery County Health Department
Montgomery County Intermediate Unit (IU)
Montgomery County Mental Health/Mental Retardation – Drug & Alcohol Services
National Alliance for the Mentally Ill (NAMI)
Norristown Regional School District Pupil Services
Parents Involved Network (PIN)
Plymouth Community Ambulance Association
Survivors of Suicide, Inc. (SOS)
Tragedy Response Unit Support Team (T.R.U.S.T.)

We appreciate the support of these agencies and organizations as well as the contributions of past participants. The MCSPTF is grateful to the Montgomery County Health Department for the support and encouragement provided.

“Collaboration across a broad spectrum of agencies, institutions, and groups – from schools to faith-based organizations to health care associations – is a way to insure that prevention efforts are comprehensive.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

What We Know About Suicide:

This section summarizes what is known about suicide, the major risk and protective factors of suicide, the warning signs of suicide, and some of the prevailing misconceptions of suicide.

The most important thing that we know about suicide is that it is preventable. We also know suicide risk factors, warning signs of suicide, and suicide protective factors. Risk factors are demographic, psychological, social, cultural, interpersonal, and environmental variables that are associated with of suicide. Protective factors are demographic, psychological, social, cultural, interpersonal, and environmental variables that are associated with the nonoccurrence or reduced occurrence of suicide. Warning signs are behaviors that signal impending suicidal behavior.

Suicide Risk Factors

Risk factors for suicide fall into three groups:

- Fixed predisposing risk factors: These are long-term attributes acquired at birth or later that cannot be readily modified and create a lifelong risk situation.
- Dynamic modifiable risk factors: These are attributes produced by life experiences whose effects for most individuals can be changed and are not permanent.
- Near-term crisis sustaining risk factors: These are temporary attributes that may stabilize or be ameliorated but which tend to “drive” a suicidal crisis when they are present.

Suicide risk factors vary across the life span (see Figure 1) and for different populations such as racial and ethnic groups or those with serious mental illness. Risk factors alone do not cause suicide but interact with other variables to precipitate suicidal behavior (Beautrais et al. 2005). Risk factors can be used to screen individuals to determine potential vulnerability to suicide and in suicide prevention education.

Suicide Warning and Danger Signs

Warning signs are the earliest detectable indicators of heightened suicide risk before a suicide attempt. Three such signs were identified by an expert panel convened by the American Association of Suicidology (AAS) in 2003 (Rudd et al. 2006):

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide

“Suicide is an outcome of complex interactions among neurobiological, genetic, psychological, social, cultural, and environmental risk and protective factors.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

Observation of any or all of these signs should trigger immediate crisis intervention response.

The AAS panel cited the following as less imminent signs of suicidality (Rudd et al. 2006):

- Hopelessness
- Feeling trapped - No way out
- Withdrawal from family or friends
- Anxiety, agitation, sleep problems
- Dramatic mood changes
- No reason for living
- Reckless, risk-taking behavior

Observation of any of these signs should result in seeking help from a mental health provider.

General Suicide Risk Factors

Fixed predisposing risk factors include:

- Prior attempt(s) or other suicidal behavior
- Family history of suicidality (attempts, completions)
- Family history of depressive disorders
- Family history of abuse/violence
- Family history of alcohol or other substance misuse
- Poor problem-solving/coping skills
- Age, gender and race (e.g., elder white male, Native American)

Dynamic modifiable risk factors include:

- Divorced, separated, widowed
- Unemployment
- Few social supports/isolation
- Low self-esteem/self-worth
- A treatable psychiatric disorder
- Psychiatric hospitalization more than 1 month ago
- A manageable chronic illness/disability
- “Psychache” - severe psychological pain

Near-term crisis sustaining risk factors include:

- Hopelessness/severe depression
- Acute suicidal ideation
- Psychiatric hospital discharge less than one month ago
- Alcohol/substance use/intoxication
- Access to firearms/other lethal means

- Job/financial/social status loss
- Personal loss/separation/humiliation
- School/work/legal/criminal justice problems

General Protective Factors

Protective factors are attributes that mitigate risk factors and enhance resiliency. Like risk factors, some protective factors are accidents of birth. They also vary by age and population. Protective factors can also be acquired or lost. Protective factors are the building blocks of suicide prevention. Figure 2 summarizes the principal protective factors for suicide.

Figure 1. Risk Factors for Suicide by Age Group *(NY State Office of Mental Health 2005)*

Youth and Young Adults	Adults	Elders
<ul style="list-style-type: none"> • Co-morbid mental illness • Alcohol and/or substance abuse • Personal and family problems • Legal problems • Poor school/work performance • Prior attempts • Family history of suicidal behavior 	<ul style="list-style-type: none"> • Co-morbid depression and alcohol misuse • Employment problems • Interpersonal/marital problems • Criminal justice system problems • Financial/status loss • History of abuse • Prior attempts 	<ul style="list-style-type: none"> • Late onset depression • Social isolation • Loss of spouse • Alcohol and Rx/OTC drug misuse • Declining physical health • Chronic pain • Dependency • Personality/help-seeking inflexibility

General Protective Factors for Suicide

These are “baseline” protective factors that defend an individual from engaging in suicidal behavior. Protective factors may derive from an individual’s personality or mental and physical wellness or flow from her or his interpersonal, organizational, and social relationships.

Internal:

- Sense of purpose/meaning in life
- Good coping skills
- Resiliency/flexibility
- Life satisfaction
- Openness to experience
- History of positive adjustments
- Mental/physical wellness
- Spirituality

External:

- Marriage; parenthood
- Caring family and/or support system
- Concerned health provider
- Religious involvement
- Social participation
- Treatment for depression, other mental illness, substance abuse

Mental Illness and Suicide

While suicide and mental illness are not synonymous, individuals with serious mental illness such as major depression, bipolar disorder, and schizophrenia are at higher risk of suicide than those without these illnesses and constitute the largest at-risk group. The stigma attached to both suicide and mental illness, the impairment of help-seeking common to these illnesses, and disparities in service coverage demand that this group be given specific focus.

The incidence of suicide among those with serious mental illness (Bostwick and Pankratz 2000; Palmer et al. 2005; Roy 2001) is as follows:

- Overall about 5% of those with serious mental illness complete suicide
- About 6% of those with schizophrenia complete suicide
- About 2% of those treated as outpatients for a depressive disorder complete suicide.
- About 4% of those hospitalized for a depressive disorder complete suicide.
- About 9% of those hospitalized for a depressive disorder with suicidal ideation or an attempt complete suicide.

These are the major risk factors for suicide among individuals with serious mental illness (Bongar 1992; Fenton et al. 1997; Harris and Barraclough 1997; Haw et al. 2005; Nabors 2004; Roy 2001):

- Hopelessness/depressive episode
- Young age of onset of illness
- Early stage of illness (especially bipolar disorder, schizophrenia)
- Inadequate psychiatric treatment
- Frequent exacerbations/remissions
- Post-relapse improvement periods
- Psychiatric hospitalization(s)
- Poor treatment adherence/treatment reductions
- Loss of faith in treatment
- Frequent exacerbations/remissions/hospitalizations
- Co-occurring alcohol/substance misuse
- Fear of mental disintegration

Knowledge of these disorder-specific risk factors must be provided to mental health consumers and providers as well as to family members and others making up the support systems of individuals with serious mental illness in the county.

These are the key protective factors against suicide for those with serious mental illness (Montross, Zisook, and Kasckow 2005; Nabors 2004; 2005; Roy 2002):

- Available/accessible treatment adequate to individual needs
- Caring support systems
- Means restriction/removal (i.e., safeguards against access to guns, poisons, etc.)
- Ability to seek/accept professional help
- Insight into illness and suicidality
- Mutual self-help and positive coping skills
- Resiliency
- Life satisfaction

It has been said, “the single best way presently known to reduce suicide risk is to treat mental and addictive disorders” (Roy 2002). Appropriate, available, and accessible behavioral health treatment is the bedrock of a county suicide prevention effort. The importance of the community mental health system in reducing suicidality is enhanced by its emphasis on resilience, recovery, hope, and optimism as desired outcomes in serious mental illness.

Misinformation, Misconceptions, and Suicide

Misinformation about suicide is widespread. A lack of information about risk factors and warning signs leads to a lack of awareness about potential risk and the need to seek help. Information may need to be coupled with education to eliminate some of the pervasive myths about suicide (see Figure 3). Myths and misconceptions about suicide are not benign and may be more harmful than a simple lack of information. Some myths deter offering or seeking help; others are fatalistic or stigmatizing. All arise from and persist from ignorance. Misconceptions about suicide are often promulgated by the media and mass culture. Some health care professionals may subscribe to some groundless beliefs about suicide. Such misconceptions must be identified and exposed as fallacious and dangerous.

“Increased awareness coupled with the dispelling of myths about suicide and suicide prevention will result in a decrease in the stigma associated with suicide and life-threatening behaviors.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

Figure 3. Some Common Myths about Suicide

Misconception	Reality
<ul style="list-style-type: none"> Those who talk about suicide are “all talk” and won’t complete suicide. 	<p>Talking about suicide is a warning sign and many who talk about it do complete suicide.</p>
<ul style="list-style-type: none"> Those who have attempted suicide really wanted to die. 	<p>Suicidal people only want to be pain-free and would go on if their pain could be ended.</p>
<ul style="list-style-type: none"> Asking someone if they are thinking about suicide will only give them “ideas.” 	<p>Asking is often the only way to determine risk and to show that you care.</p>
<ul style="list-style-type: none"> Those who have attempted suicide are at very low risk of actually completing suicide. 	<p>Many suicide victims made one or more previous suicide attempts.</p>
<ul style="list-style-type: none"> If someone says that he is suicidal, telling him to “do it” will snap him out of it. 	<p>This may be the single worst thing that anyone can do. Never say “go ahead and do it.”</p>
<ul style="list-style-type: none"> Those who complete suicide are often psychotic. 	<p>Many may have had symptoms of mental illness, but most were in touch with reality.</p>
<ul style="list-style-type: none"> A suicide attempt that does not result in death shows that the individual wasn’t really serious about dying. 	<p>An attempt that doesn’t become a completion doesn’t mean that there was no serious intent to die.</p>
<ul style="list-style-type: none"> Most suicides occur with little or no warning. 	<p>Most people do mention what they are feeling and what’s driving them toward suicide.</p>
<ul style="list-style-type: none"> Improvement following a suicidal crisis means that the suicidal risk is over. 	<p>Many suicides occur following ‘improvement’. Suicidal feelings can return.</p>
<ul style="list-style-type: none"> Non-fatal acts are only attention-getting behaviors or only attempts to be manipulative. 	<p>For some people, suicidal behaviors are serious invitations to others to help them.</p>
<ul style="list-style-type: none"> Once a person is suicidal, he or she will be suicidal forever. 	<p>Most suicidal crises are temporary, and will pass if help is provided.</p>

Sources: Maris et al. (2000); Goldsmith (2002); US Public Health Service (2001)

Suicide Prevention Philosophy:

The Task Force has adopted the following tenets (SPAN USA 2001) to guide its efforts:

- Prevention programs should enhance protective factors.
- Family-focused prevention efforts may have a greater impact than strategies that focus only on individuals.
- Community programs need to strengthen norms that support help-seeking behavior in all settings, including family, work, school, and community.

We see suicide prevention as a multidimensional endeavor inclusive of prevention, intervention, and postvention (Shneidman 1971).

We believe that suicide prevention must use existing systems insofar as possible, establish a long-term community commitment, and provide for sustainability.

We regard a suicide prevention plan as a living document that will change over time in response to new needs, conditions, priorities, and resources.

We understand that a suicide prevention plan requires broad participation and collaboration and that this strategy is a beginning.

We acknowledge that achievement of the objectives comprising the strategy calls for building a strong knowledge base, community support for change, and a caring and concerned partnership.

We look upon suicide prevention as everybody's business and that the underlying purpose of our proposed strategy is to create community ownership in saving lives and reducing the suffering brought on by suicide.

“The integration of suicide prevention into existing service-based organizations provides opportunities to expand the numbers of individuals who may be reached by preventative interventions.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

Suicide Prevention Program Typology

This section outlines some of the methodologies of suicide prevention as identified in reviews of programs in use (Centers for Disease Control, 1992; Dekker 2004; Doan et al., 2003; Gardiner and Gaida 2002; Gould et al. 2003; Guo et al, 2003; Kalafat 2000; Mann et al. 2005; NY State Office of Mental Health 2005). The intent is to lay out the most commonly used tools of suicide prevention. This inventory is selective and not all-inclusive or exhaustive.

Community-based Programs

Community Suicide Prevention Education/Information: This approach involves imparting basic information on suicide, risk factors, protective factors, warning signs, sources of help, and how to handle an emergency through the media, group presentations, and other means. It may also include the use of health fairs, walks, etc.

Community Gatekeeper Training: This approach involves training individuals in the community who may have contact with individuals of any age who may be at risk of suicide. This includes police, postal workers, clergy, merchants, recreation and community organization staff, municipal personnel, and others. Training covers risk factors, warning signs, resources, and making referrals.

Means Restriction: This approach involves activities to reduce access to firearms, drugs, and other lethal means used through disposal or safe storage. It may include education about risk of firearms or other means in the home. It may involve individuals, local leaders, gun owners, hunters, physicians, mental health specialists, and others.

Media Education/Guidelines: This approach involves educating the media and providing guidelines about responsible suicide reporting to journalists, editors, and television and radio reporters. Areas addressed may cover deterring imitative behavior by minimizing details, not highlighting suicides, and conveying prevention information in features.

Post-suicide Postvention: This approach involves promoting peer volunteer and/or professionally led assistance and support to individuals and families who have experienced a suicide loss. Services may include intervention at the scene, follow-up in-home visits, telephone counseling, suicide loss support groups, and self-help information.

School System-based Programs

School Gatekeeper Training: This approach involves training administrators, teachers, nurses, aides, counselors, coaches, bus drivers, security officers, and others to recognize students at risk of suicide and refer them to sources of help. Gatekeepers should be vigilant to any changes in the behavior or routine of an at-risk student that may signal increased danger. Such training enhances school staff confidence that they can identify a potentially suicidal student.

Screening Programs: This approach involves the use of surveys, questionnaires, or other structured self-reports or data collection means to identify at-risk students for further assessment and help as indicated. Screening generally directly asks students about depressive symptoms, past or current suicidality, and risk factors.

Suicide Awareness Curriculum: This approach involves educating students on the incidence of suicide, suicide warning signs and risk factors, and community resources. It recognizes that adolescents are peer-oriented and are more likely to self-disclose about suicidality to a friend than an adult. Multiple sessions to semester-long programs appear to be the most beneficial.

Suicidal Crisis Postvention: This approach involves a planned pre-set policy-guided school-wide response to a suicide threat, attempt, or completion by a student, former student, staff, or other member of the school community. The rationale is to both avert subsequent suicidal behavior and the onset of other debilitating consequences. Elements include informing students and parents about the incident, staff debriefing, student counseling and support, media relations, and mobilization of community resources.

Post-crisis School Re-entry: This approach attempts to support and facilitate a student's return to school after a suicide attempt, hospitalization, or other crisis-related absence. The rationale involves both re-connecting the student to the school and its services as well as deterring any prospects for stigmatization or humiliation. Components include a school designated liaison working with the outside providers and parents.

Health System-based Programs

Primary Care Provider Education: This approach involves training general and family practice physicians, nurse practitioners, physician assistants, and other primary health care providers (as well as support staff with patient contact) in suicide risk factors, warning signs, and screening and assessment practices. Many suicide victims had a primary care contact within a month of their death (Luoma et al. 2002).

Emergency Department Staff Training: This approach involves training to assure that community hospital ER physicians and nurses recognize injuries related to a potential suicide attempt and make referrals to community resources for individuals treated on an outpatient basis. ERs constitute a key point of contact with high risk youths, adults, and elders and their families, and can be a portal to ongoing prevention and intervention.

In-home Provider Gatekeeper Training: This approach applies the gatekeeper concept to home health and other home care staff (nurses, therapists, aides, etc.) who provide in-home care to the homebound, disabled, or chronically ill children, adults, or elderly. It also includes volunteers who deliver in-home meals to the aged.

Mental Health System-based Programs

Crisis Centers/Hotlines: This approach involves the telephonic or walk-in crisis intervention and support to suicidal individuals on a 24/7 basis. The rationale is that suicidality is often brought on by a critical incident, which coupled with impulsivity and ambivalence creates a high risk situation. Crisis intervention deters self-harm during the crisis period. Mobile crisis teams may be a component of such services.

Warm Lines: This approach involves the provision of non-crisis telephone support to an individual experiencing suicidal ideation or other suicidal behavior below the intent to die threshold. It may also serve those troubled by chronic suicidality. These services are support-oriented and are not intended to deliver crisis intervention. They are “safe places” to initiate the help-seeking process.

Telephone Outreach: This approach is the opposite of hotlines and warm lines in that the provider initiates the contact with the at-risk individual. Similar to the Telephone Reassurance programs in use with the isolated elderly, this type of service would maintain daily socialization/risk monitoring contact between a trained staff/volunteer/peer caller and individuals who have manifested suicidal or other high risk behavior.

Peer Support Programs: This approach involves bringing together at-risk mental health consumers in a “safe” and caring group setting to receive the support of peers, and learn and practice critical coping and problem-solving skills. Peers who have been given group leadership and process training facilitate the groups. These groups may be hosted by providers or by peer-led services.

Post-attempt Postvention: This approach involves varying combinations of active therapy and support provided to individuals who have made a suicide attempt or engaged in other serious self-harm. The rationale is to avert a further attempt or other subsequent suicidal behavior by addressing modifiable risk and protective factors.

Treatment: This approach involves assessment, clinical intervention, and case management to at-risk individuals with depression, bipolar disorder, schizophrenia, and other mental illnesses. Treatment may include combinations of pharmacotherapy and psychotherapy (Tondo et al. 2001), and modalities such as Cognitive Behavioral Therapy and Dialectical Behavioral Therapy, which build self-help, self-esteem, treatment adherence, and other factors (Brown et al. 2005; Links et al. 2003;)

Family/Support System Training: This approach applies the gatekeeper concept to the immediate family or other support system members of mental health consumers felt to be at risk of suicide. Training covers risk factors, warning signs, resources, and basic techniques for helping a suicidal individual until crisis intervention or emergency response services engage.

Suicide & Suicide Attempts in the County

This section looks at the realities of suicide in Montgomery County and reviews the adequacy of current suicide prevention resources in the county.

Setting the Context

In the United States, there are approximately 30,000 suicides every year. In the Commonwealth of Pennsylvania, there are about 1400 suicides each year. In the tri-state metropolitan area (southeastern PA, southern NJ, and northern DE), there are more than 600 suicides yearly. In the five-county region of southeastern Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia counties), there are almost 400 suicides annually.

Table 1. Suicides in Southeastern Pennsylvania, 2002-2004³

County	Deaths	Average/Yr.	Rate/100,000
Bucks	186	62.0	10.1
Chester	111	37.0	7.9
Delaware	157	52.3	9.3
Montgomery	213	71.0	9.0
Philadelphia	475	158.3	10.8
Region	1142	380.6	10.1

Table 1 shows that Montgomery County accounts for almost 19% of the suicides in the five-county region. The county's suicide rate of 9.0 (the number of suicides per 100,000 residents) is below that of the region as a whole and lower than that of three neighboring counties.

Table 2 summarizes county suicides by the three major demographic variables for the three-year period ending December 31, 2004. This data is graphically laid out in Charts 1-3.

³ Source for Tables 1, 2, and 4: PA Department of Health, EpiQMS (Epidemiologic Query and Mapping System) (www.health.state.pa.us).

Table 2. Suicides in Montgomery County by age, gender, and race, 2002-2004

Gender/Race	Age 19/Under	Ages 20-64	Age 65/Over	Totals
White Males	3	128	23	154 (72.3%)
White Females	2	34	5	41 (19.2%)
Black Males	1	10	0	11 (5.2%)
Black Females	0	2	0	2 (0.9%)
Other Males	0	3	0	3 (1.4%)
Other Females	0	2	0	2 (0.9%)
Totals	6 (2.8%)	179 (84.0%)	28 (13.1%)	213

Chart 1. Suicides by Age, 2002-2004

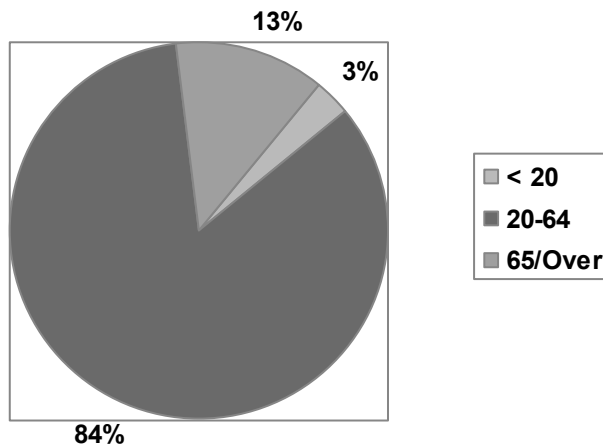


Chart 1 indicates that in Montgomery County, suicide claims the lives of more than three times as many adults as it does youths and elders combined. 84% of all county suicides involve individuals between the ages of 20 and 64.

60% of these deaths involve adult white males – a group that must be targeted for prevention if the incidence of suicide is to be reduced.

The county averages 9 elder suicides a year. Nationally, elders account for about 20% of all suicides with the highest rate of suicide of any age group among white males age 85 and over (Conwell 2001). US Census projections indicate that the county's age 85 and over population will increase 28% by 2015. The county should explore the source of the variance between local and national elder suicide rates and look into elder deaths by other than natural causes.

Chart 2. Suicides by Gender, 2002-2004

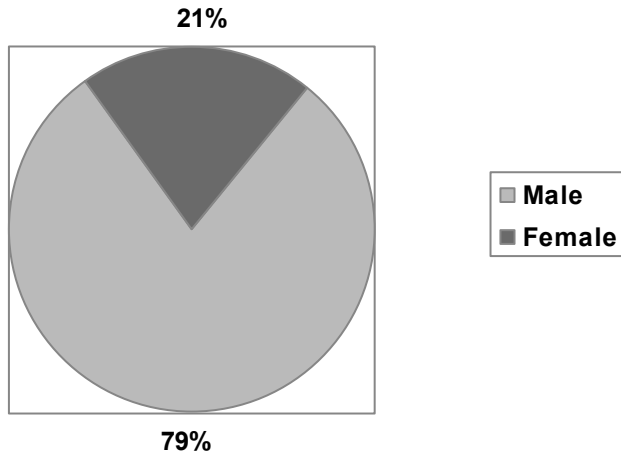


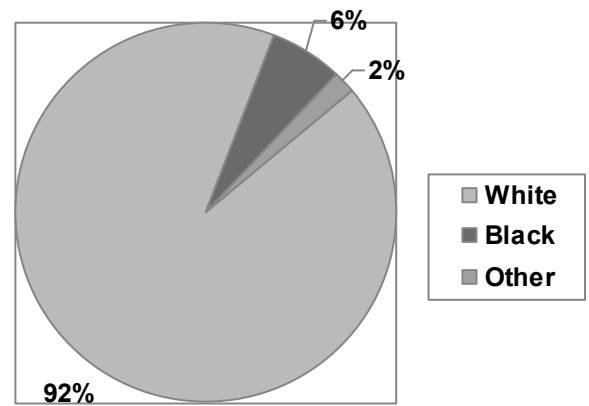
Chart 2 shows that suicide deaths in the county approximate an “80/20” distribution between males and females. This 4:1 gender pattern characterizes suicides at the state and national levels also.

This gender disparity has not yet been explained. It may reflect greater use of guns as lethal means by males, higher alcohol consumption by males, and less use of supports by males.

Studies have found that in regard to attempts this gender disparity is reversed: females make four times as many attempts as males (Maris et al 2000).

Chart 3 shows that most suicides in the county involve whites. In 2004, the US Census estimates that whites made up 86.2% of the county population. However, they accounted for 92% of the suicides. Afro-Americans, on the other hand, made up 10.5% of the population and 6% of the suicides. Native Americans and Asians made up 3.3% of the population and 2% of the suicides. This suggests that possible protective factors may prevail among minority communities (e.g., religiosity, cultural values, family supports, etc.).

Chart 3. Suicides by Race, 2002-2004



An area of concern in the county is that Afro-American suicides have increased from 5 in the years 1999-2001 to 13 from 2002-2004. These deaths predominantly involve adult males. This trend warrants close watching and intervention as possible.

Suicide in Montgomery County Municipalities

As shown in Figure 4⁴, suicides have occurred in every borough and township in the county. While most of the deaths happened in more urbanized and densely populated areas, even comparatively rural areas experienced losses.

Between January 1, 1999 and December 31, 2005, a total of 458 suicides took place in the county. Table 3 presents the municipalities that experienced the most suicides in this period. These 17 boroughs and townships accounted for 288 suicides collectively, almost 63% of all suicides in the county for the period.

Table 3. Municipalities with 10 or more Reported Suicides, 1999-2005

Municipality	Suicides
Lower Merion Township	32
Abington Township	29
Norristown Borough	28
Cheltenham Township	20
Springfield Township	19
Upper Merion Township	18
Pottstown Borough	17
Lansdale Borough	14
Horsham Borough	14
Upper Dublin Township	14
Upper Moreland Township	14
Limerick Township	12
Lower Providence Township	12
Montgomery Township	12
Whitpain Township	12
Whitemarsh Township	11
Hatfield Township	10

Source: Montgomery County Health Department

Table 3 and Figure 4 show that suicide is a county-wide tragedy.

“Suicide prevention must be integrated into programs and activities that already exist and be included in the agendas of communities...”

National Strategy for Suicide Prevention: Goals and Objectives for Action

⁴ This graphic was prepared by the Montgomery County Health Department.

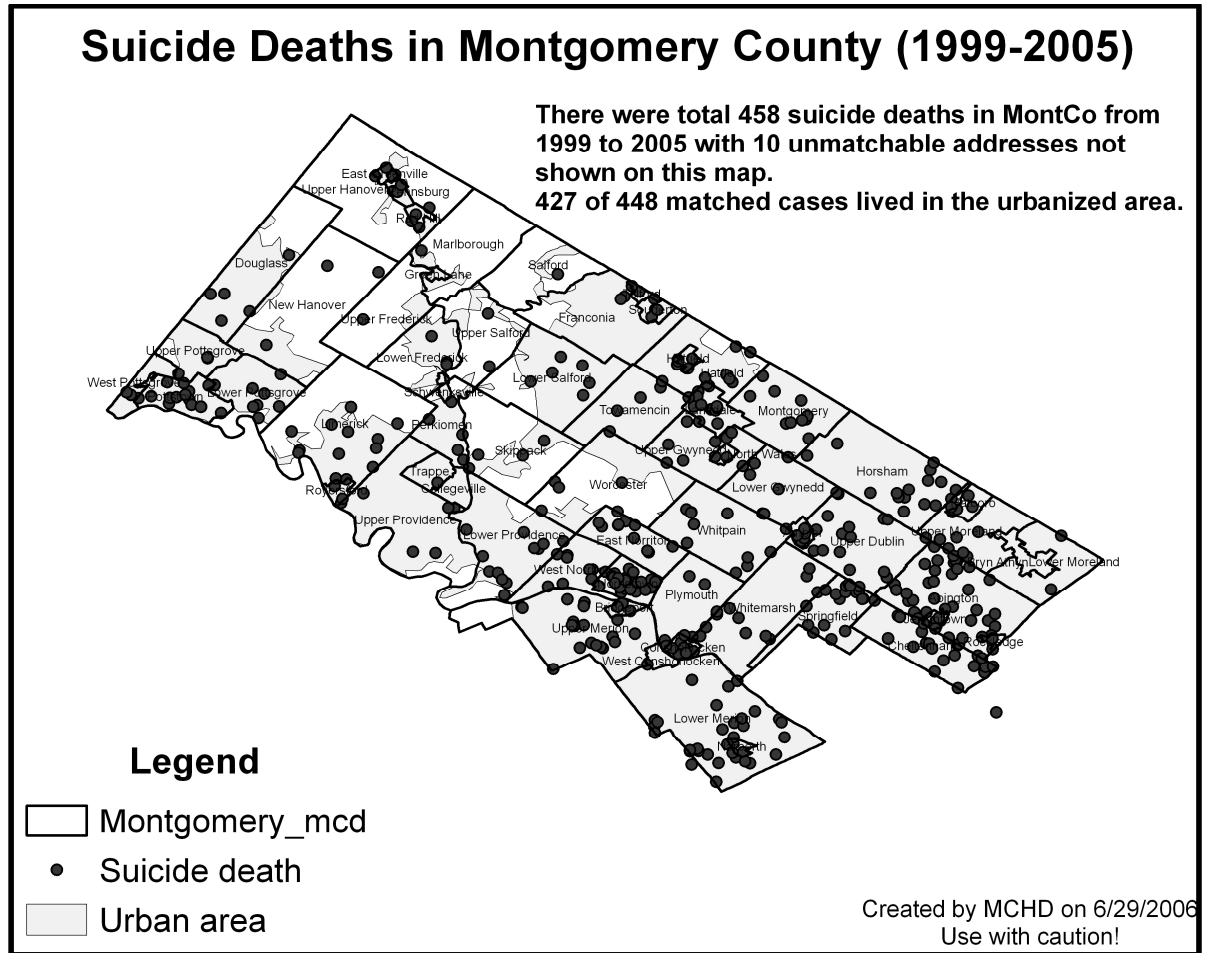


Figure 4. Distribution of Suicides in Montgomery County Municipalities, 1999-2005

Firearms and Suicide in Montgomery County

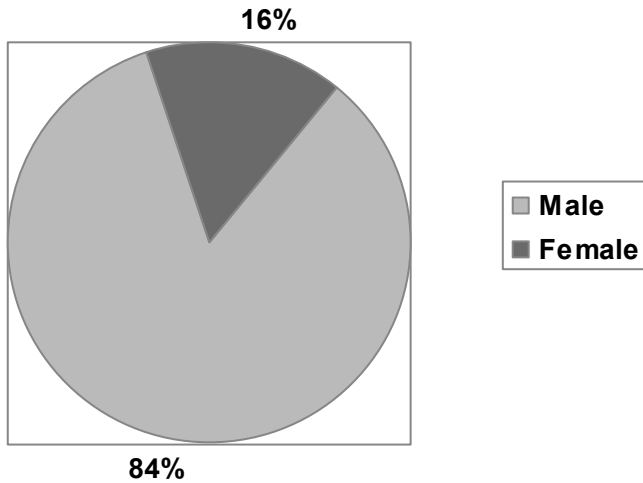
Handguns and other types of firearms are the most frequently used lethal means associated with suicide in Montgomery County. Of the 213 suicides in the county in 2002-2004, 94 or 44.1% involved firearms.

Table 4 breaks down firearms-related suicide by age. Adults accounted for almost 82% of suicides involving guns and elders made up just less than 16% of firearm suicides.

Table 4. Suicides Involving Firearms in Montgomery County by Age, 2002-2004

Age	Number	%
Under 20	2	2.1
21-64	77	81.9
65 and Over	15	15.9
Total	94	

Chart 4. Firearm Suicides by Gender, 2002-2004



As shown in Chart 4, males were the victims in 84% of the firearms-related suicide in the county. This level of gun utilization as lethal means helps explain the pronounced gender differential among male and female suicide victims (Miller and Hemenway 1999). Men make greater use of guns. Also impulsivity, often aided by alcohol consumption, plays a part in many male suicides. Firearms are readily available in many households and become the means of choice when impulsivity turns a temporary crisis into a permanent tragedy.

Suicide Attempts in Montgomery County⁵

Females make three times as many attempts as males; youths make more attempts than adults do; and elders make fewest attempts (Maris et al., 2000). It is estimated that there are from 8 to 25 attempts for each suicide (Mosciki 2001). Applying this ratio indicates that ***there may be 500 to 1700 suicide attempts in the county***. State data cited earlier implies that there may be about 600 suicide attempts in the county every year involving hospitalization. Assuming that there is at least one non-medically serious suicide attempt for each one necessitating hospitalization gives us a conservative working estimate of 1200 suicide attempts each year in the county. Many of these most likely occur in the municipalities with the highest incidence of suicide (see Table 3).

Suicide attempts are both psychologically and physically injurious. A history of one or more attempts is a permanent lifelong risk factor for suicide for an individual. A family history of attempts is a risk factor for others in the family.

⁵ Data on the incidence of suicide attempts in the county is not available

Those who have attempted suicide have a 0.5% risk of suicide in the first year after the attempt and over 5.0% risk after nine years (Owens et al. 2002). There should be outreach to suicide attempters to offer them support and aftercare to reduce their subsequent risk of suicidality.

Suicide Loss: The Aftermath of Suicide

A suicide afflicts family members and others with a severe and prolonged bereavement. At best a suicide loss is a difficult and troubling experience while at worst it may bring elevated risk for psychiatric and somatic problems (Jordan and McMenemy, 2004). The nature of suicide loss has been described as follows:

The grief after a suicide is significantly different than the grief felt after other kinds of losses. Losing someone to suicide has a much more intense and long lasting impact. It involves a struggle with complex social, emotional and cultural issues that can make grief overwhelming and isolating. The experience changes and challenges personal relationships, spiritual beliefs, concentration, and memory. Emotions and general health may become unsettled and fragile. All realms of life are affected (Survivors of Suicide, Inc., 2006).

Three forces are at work in cases of suicide loss (Jordan, 2001). First, those affected struggle more than other grievers in trying to “make sense” of the loss. Second, they feel greater guilt, blame, and responsibility. Third, they are beset by conflicting feelings of abandonment and anger and towards the victim.

Those bereaved by suicide must often deal with the stigma surrounding suicide and the many myths of suicide. These negative encounters impair the grieving process, cause withdrawal from seeking help, and increase vulnerability to depression, grief reactions, and other problems.

Postvention must be part of a suicide prevention strategy. It has four objectives:

- Ease the trauma and related effects of the suicide loss
- Prevent the onset of adverse grief reactions and complications
- Minimize the risk of suicidal behavior
- Encourage resilience and coping

Postvention must especially be available, for those with psychiatric or substance abuse disorders who may have a recurrence of their symptoms and go into crisis due to the stress of their loss.

“Ideas for Action: Develop and offer peer leadership training for facilitators of suicide survivors support groups.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

Suicide Prevention Resource Availability

This section looks at resource availability and accessibility in relation to some critical suicide risk factors. Practical alternatives for improving availability and accessibility are outlined.

Universal Suicide Prevention Resources – Risk aversion/reduction at community level

Universal prevention includes activities aimed at the general community to minimize the emergence of suicidality.

<i>Selected Risk Factors</i>	<i>Resources</i>	<i>Constraints</i>	<i>Options</i>
Firearms accessible in household	Gun safety education. Gun locks. Gun disposal programs.	Gun manufacturers, dealers, and gun safety courses do not address suicide risk related to gun ownership.	Develop “Guns in the Home and Suicide Risk” pamphlet. Partner with EMS units to provide gun locks in service areas. Promote turning in of unused firearms.
Alcohol misuse <i>Alcohol increases impulsivity, risk-taking, and myopic either/or thinking, and limits consideration of options and future consequences of acts.</i>	Limited “drink wisely” information available	No community health materials available on link between alcohol misuse and suicide, and very little on the prudent consumption of alcohol.	Prepare information on the role of alcohol use, misuse, and abuse in suicide. Post information about alcohol and suicide risk in PA Liquor Stores

“By eliminating the easy availability of one particular means of suicide, impulsive individuals do not substitute another method in the immediate time frame.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

Suicide as a Community Health Problem in Montgomery County: An Agenda for Action

<i>Selected Risk Factors</i>	<i>Resources</i>	<i>Constraints</i>	<i>Options</i>
<p>Serious mental illness including major depression, bipolar disorder, and schizophrenia.</p>	<p>A county mental health program committed to system transformation and adoption of the recovery model.</p> <p>A comprehensive and centralized crisis intervention service able to respond to suicidality and other life-threatening psychiatric emergencies</p> <p>A community mental health system offering a wide variety of services in diverse settings with good geographic coverage.</p> <p>WRAPs (Wellness Recovery Action Plans) used by mental health consumers to self-manage their illness can include a suicide prevention component called a “Plan for Life.”⁶</p>	<p>High-risk individuals with dual mental illness/alcohol-drug diagnoses would benefit from closer integration of the MH and D&A systems.</p> <p>Commercial payer guidelines limit psychiatric inpatient care for suicidal individuals with primary D&A problems</p> <p>Prevention has not characterized community mental health. While most disorders cannot be prevented their role in suicide risk can. MH staff must be aware of the permanent nature of suicide risk in agency clientele.</p> <p>Treatment non-adherence reduces value of the best care and raises suicide risk.</p>	<ul style="list-style-type: none"> • D&A system and provider as stakeholders in the county suicide prevention effort. • Suicide risk awareness training for D&A staff. <p>Persuade carriers that acute suicidality is a fluid situation due to impulsivity among alcohol/substance users and that authorization of inpatient care should be made on a case-to-case basis.</p> <p>Establish annual continuing education requirements for MH provider staff at all levels in suicide risk factors in those with depression, bipolar disorder, schizophrenia, and other illnesses.</p> <p>Educate consumers, families, advocates on role of treatment in lowering suicide risk</p>

⁶ See www.dbsalliance.org/info/planforlife.html for an example of a Plan for Life.

Selected Suicide Prevention Resources – Risk reduction in targeted high-risk groups

Selective prevention (also known as secondary prevention) comprises activities targeting individuals with one or more suicide risk factors who are potentially at greater than average risk of suicidal behavior or showing emerging signs of suicidality.

<i>Selected Risk Factors</i>	<i>Resources</i>	<i>Constraints</i>	<i>Options</i>
<p>Youths experiencing school and/or family problems or behavioral health problems.</p> <p><i>Despite the low number (see Table 2) of youth suicides in Montgomery County prevention must be directed at this group to reduce attempts and parasuicidal acts such as cutting. Non-fatal suicidal behavior creates long-term risk and increases exposure to psychiatric problems.</i></p>	<p>Student Assistance Program (SAP) operates in all school districts.</p> <p>Intermediate Unit (IU) offers psychological services to students in non-public schools</p> <p>ACCESS Services, Inc. offers crisis counseling services for youth/families.</p> <p>The Jason Foundation is a local branch of a national youth suicide prevention program based in TN. Brooke Glen Behavioral Hospital is the local sponsor.</p>	<p>Effective resources that are only limited by school year availability and loss of contact with students who leave district/school or drop out.</p> <p>ACCESS recently expanded its services through working with Montgomery County Office of Mental Health and its availability is not yet widely known to the general public.</p> <p>New program in process of publicizing its availability.</p>	<p>Explore use of “Signs of Suicide” (S.O.S.)⁷ (a SAMHSA Model Program) that teaches youths the signs of depression and suicide in their friends and selves and how to get help.</p> <p>Promote awareness of ACCESS to schools, youth agencies, clergy, pediatricians, and other referrers.</p> <p>Youth suicide prevention focus and capabilities may enable it to serve as the key local resource for the <20 population.</p>

“The nature of being in a suicidal crisis can sometimes impede an individual’s ability to obtain appropriate medical care for themselves.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

⁷ See www.mentalhealthscreening.org/schools/index.aspx. and Aseltine and DeMartino, 2004.

Indicated Suicide Prevention Resources – Risk reduction in high-risk individuals

Indicated prevention covers activities targeting high-risk individuals showing possible early signs of suicidality. This is also known as tertiary prevention, which describes activities targeting individuals who have experienced a suicide attempt or suicide loss to reduce adverse consequences and ongoing risk.

<i>Selected Risk Factors</i>	<i>Resources</i>	<i>Constraints</i>	<i>Options</i>
<p>Recent/prior suicide attempt</p> <p><i>Attempts are fixed risk factors for suicide. An attempt is a critical incident that may be followed by post-traumatic stress disorder, another risk factor.</i></p> <p><i>Attempts may be stigmatized, which may cause those who have made a suicide attempt to avoid reaching out for help and support.</i></p>	<p>“Suicide Anonymous” (SA) self-help support group for individuals troubled by suicidal behavior</p> <p>There are several organizations offering mutual self-help support resources for those with mental illness.</p> <p><i>After an Attempt</i> - set of 3 guides for ERs, attempters, and family members (English/Spanish) by National Alliance on Mental Illness (NAMI)</p> <p>CONTACT CareLine for Greater Philadelphia – A crisis intervention telephone service.</p> <p>Acute partial hospitalization programs and day treatment services may serve as follow-up resources after an attempt.</p>	<p>The only SA group in the county/region meets in Norristown</p> <p>These resources are oriented to the primary disorder and do not directly address any accompanying suicidality.</p> <p>Cost of hard copy version (free PDF download from www.nami.org)</p> <p>Operates 365 days/year, but not 24 hours/day. Underutilized as a post-attempt support resource</p> <p>Partial hospitalizations programs are available in Abington, Norristown, and Pottstown.</p>	<p>Assist SA sponsor, Feeling Blue Suicide Prevention Council, to form a group in the Pottstown area</p> <p>Assist support resource to start groups and other supports for those coping with suicidal feelings.</p> <p>Work with NAMI-Montco to assure that ERs provide guides to patients and families.</p> <p>Put link to guides on Task Force web site</p> <p>This service can be included in information provided by ERs, crisis centers, and first responders.</p> <p>These programs and other day programs will be offered any necessary help to enhance their value to post-attempters.</p>

Suicide as a Community Health Problem in Montgomery County: An Agenda for Action

<i>Selected Risk Factors</i>	<i>Resources</i>	<i>Constraints</i>	<i>Options</i>
Family history of suicide loss	<p>Survivors of Suicide, Inc. (SOS) offers monthly mutual self-help support groups for adults bereaved by suicide.</p> <p>The Compassionate Friends (TFC) offers grief support groups to parents, siblings, and grandparents for the loss of a child of any age to any cause including suicide.</p> <p>The Safe Harbor Program at Abington Memorial Hospital provides support to children and families bereaved by suicide.</p> <p>The Center for Loss & Bereavement offers groups on suicide loss.</p> <p>Tragedy Response Unit Support Team (TRUST) assists in cases of sudden death.</p>	<p>The only SOS group in the county meets in Bryn Mawr.</p> <p>TFC groups meet at several locations around the county but they do not deal with loss involving parents, spouses, etc.</p> <p>Many individuals will not travel across the county to attend a group.</p> <p>TRUST cannot cover the entire county.</p> <p>Except for the aid provided by TRUST, the county lacks a source of postvention available immediately after a suicide.</p> <p>There are no supports serving those with mental illness who have lost a member of their family or support system to suicide.</p>	<p>Work with SOS to organize groups in other county sites (e.g., Pottstown, Norristown areas).</p> <p>Help publicize the availability of suicide loss support through the Safe Harbor Program and the Center for Loss & Bereavement.</p> <p>Explore creating community trauma response teams in other areas using the TRUST model.</p> <p>Establish 24/7 suicide postvention offering telephone support and in-home help in the aftermath of a suicide⁸.</p> <p>Work with NAMI and the Montgomery Co. Office of Mental Health to establish peer led suicide loss groups.</p>

“No one is immune to suicide...”

National Strategy for Suicide Prevention: Goals and Objectives for Action

⁸ The American Association of Suicidology advocates that all crisis centers offer postvention, which is a requirement for their voluntary crisis center accreditation (see www.suicidology.org).

A Suicide Prevention Strategy for Montgomery County:

This section presents the overarching goals for suicide prevention in the county.

County Goals for Suicide Prevention

The Task Force proposes the following six goals as the framework for a county all-ages suicide prevention strategy. These goals were adopted from similar goals guiding suicide prevention efforts at the national (US Public Health Service, 2001) and state (PA Department of Public Welfare, 2002, 2006a, 2006b) levels. This will facilitate consistency and conformity of county efforts with those at other levels.⁹

Goal 1: Promote Awareness that Suicide is a Preventable Community Health Problem

This goal addresses the need for greater community understanding of the nature of suicide, the key risk and protective factors, warning signs, and interventions. It aims to raise the community's recognition of suicide as a debilitating problem and motivate open discussion of its dangers and how to avert them.

Goal 2: Develop Broad-based Countywide Support for Suicide Prevention

This goal calls for the creation of a county-level suicide prevention network to advocate for greater prevention, intervention, and postvention. It aims to generate widespread public backing for acting to reduce a wholly avoidable loss of life and source of ongoing suffering. This goal in particular, and the strategy in general, would be facilitated by staff support to coordinate activity and lend expertise in suicide prevention.

Goal 3: Reduce the Stigma Linked to Being a Consumer of Suicide Prevention Services

This goal supports appropriate mental health care for suicidal persons and an environment facilitating help seeking by those who experience suicidal behavior. It aims to unburden at-risk individuals from a sense of shame or feelings of personal blame or weakness that interferes with seeking help..

Goal 4: Develop and Implement Community Suicide Prevention Programs

This goal relates to developing a formal structure of suicide prevention programs across the county focusing all age, racial, and ethnic groups. It aims to build the capacity and capability to mobilize, direct, and evaluate the outcome of community action against a persistent community health problem.

⁹ The Task Force selected goals deemed appropriate for a county-level suicide prevention effort.

Goal 5: Promote Community Efforts to Reduce Access to Lethal Means

This goal specifically addresses the role of firearms in the majority of suicides in the county. It aims to assure that implements intended for sport or the protection of one's self or family do not become the instrument of a devastating personal or family tragedy.

Goal 6: Implement Training for Recognition of and Response to At-Risk Behavior

This goal calls for a broad-based effort to educate health care, criminal justice, social service personnel and others to identify, initially aid, and arrange or provide ongoing care to those showing signs of risk or suicidal behavior. The aim is to assure that those in positions to recognize the potential for suicide in those they serve or encounter and direct them to sources of risk assessment and help.

These six goals will serve as the matrix linking existing and forthcoming suicide prevention programs in various systems and sectors in a common effort to facilitate accountability, avoid duplication and fragmentation, and optimize the effectiveness and continuity of preventative measures.

“A strategy to prevent suicide is a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course.”

National Strategy for Suicide Prevention: Goals and Objectives for Action

Montgomery County Suicide Prevention Assessment:

This section identifies the key activities that the Task Force feels are necessary to achieve the objectives relating to the goals for suicide prevention in the county.

Goal 1: Promote Awareness that Suicide is a Preventable Community Health Problem

Objectives	Activities	Status
<p>a) Developing suicide awareness campaigns to disseminate information to increase understanding of suicide risk, warning signs, and basic aid measures</p> <p><i>Two possible themes are:</i></p> <ul style="list-style-type: none"> • “Suicide is a Preventable Problem that we can do Something About” • “Suicide is Everybody’s Business – Know the Warning Signs” 	<p>Presenting suicide prevention/awareness programs at community gatherings.</p> <p>Have display/materials table at various conferences, community health fairs, etc.</p> <p>Contribute articles on suicide and suicide loss to the daily and weekly newspapers in the county.</p> <p>Display literature on suicide risk, warning signs, and sources of help at every county government facility serving the public.</p>	<ul style="list-style-type: none"> • The Task Force holds the Annual Montgomery County Suicide Prevention Awareness Walk in the Norristown Farm Park • Montgomery County Emergency Service (MCES) prepares articles on suicide to be submitted to the print media by the Montgomery County Health Department (MCHD) • QPR (Question/Persuade/Refer) suicide prevention training is available from Feeling Blue Suicide Prevention Council
<p>b) Sponsoring a Montgomery County Suicide Prevention Day conferences/forums on suicide and suicide prevention with sessions on youth, adult, and elder topics.</p>	<p>An annual conference for representatives from health care, human services, education, criminal justice, business, and government to learn of programs applicable to their settings to be held on a day annually recognized by the County Commissioners.</p>	
<p>c) Disseminating information through the internet</p>	<ul style="list-style-type: none"> • Post Suicide Prevention Plan on the Web. • Expand information on Task Force web site 	<p>MCHD maintains a Task Force web site offering basic information on risk factors, myths, resources, etc.</p>

Goal 2: Develop Broad-based County-wide Support for Suicide Prevention

Objectives	Activities	Status
<p>a) Organize a county-level suicide prevention program</p> <p>See “Next Steps” on p.39</p>	<ul style="list-style-type: none"> • Diversify membership of oversight body • Create a county-wide e-mail list/listserv to disseminate suicide prevention information • Establish “Montgomery County Suicide Prevention Week” with county wide educational programs in communities, schools, and organizations. • Work with the County Collaborative to reach key stakeholders in all areas. 	<p>The Task Force is the first broad-based suicide prevention effort in the county. It has raised the profile of suicide prevention but has not undertaken any activities to directly reduce the incidence of suicide. This is the “next step” and the purpose of this document.</p> <p>As a small ad hoc effort the Task Force was unable to penetrate all appropriate targets.</p>
<p>b) Increase the number of community and school districts groups that integrate suicide prevention activities into their ongoing activities</p>	<ul style="list-style-type: none"> • Reach out to administrators, counselors, Student Assistance Program (SAP) staff, and other school personnel to become stakeholders in the county’s suicide prevention planning and programming. • Survey school districts to determine types and status of suicide prevention activities in place. 	<p>School system participation in the Task Force has been limited to the IU and the Norristown Regional School District (with past involvement of the Regional SAP representative). The Task Force or its successor must structure itself to attract and maintain school district involvement.</p>
<p>c) Increasing the number of faith based communities with policies to prevent suicide</p>	<ul style="list-style-type: none"> • Use this document in outreach to this community segment. • Conduct suicide prevention panel discussions in churches in the county. 	<p>Churches are a potent route for sharing the message of suicide prevention, building support, and becoming part of the solution through training of clergy, pastoral counselors, and lay leaders.</p>

Goal 3: Reduce the Stigma Linked to Being a Consumer of Suicide Prevention Services

Objectives	Activities	Status
<p>a) Facilitate appropriate mental health treatment for suicidal persons.</p> <p><i>The President’s New Freedom Commission on Mental Health included destigmatization of suicide prevention services as part of the necessary transformation of the US mental health system (Goal 1.1)¹⁰.</i></p>	<p>Support the Montgomery County MH/MR-D&A Service’s effort to transform the community mental health system to better ‘fit’ the “recovery model” and be more oriented to the needs of consumers of mental health services.</p> <p>Establish a 24/7 county-wide “warm line” run by peer support specialist trained to provide telephonic support and referrals in cases not involving a crisis or acute suicidality.</p>	<p>The county has a strong community mental health system that offers a broad range services accessible to most county residents. This service network is a viable suicide prevention asset. Its value can be enhanced by:</p> <ul style="list-style-type: none"> • Assuring that all providers have policies for initially screening new clients for suicide risk and assessing those found to be at risk on an ongoing basis • Assuring that all agency staff know the main risk factors and warning signs of suicide. <p>Montgomery County is the state leader in mental health consumer peer support specialists programs. A “warm line” fits the peer support model.</p>
<p>b) Address attitudes that foster stigmatization of those who experience suicidal behavior.</p>	<p>Increase public understanding that mental illness is a major risk factor for suicidal behavior</p>	<ul style="list-style-type: none"> • Provide county media with information dispelling suicide myths. • Encourage individuals who have experienced suicidal behavior and loss to share their stories.

¹⁰ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Goal 4: Develop and Implement Community Suicide Prevention Programs

Objectives	Activities	Status
a) Increase the number of providers with suicide prevention policies that define staff handling of crisis situations involving staff or clients.	Adopt/develop/distribute model organizational suicide prevention policy defining responsibilities, steps to be taken, emergency contacts, and staff training requirements..	Such policy statements have been prepared in many schools but are not commonly found in other settings.
b) Increase suicide prevention plans in schools, work sites, correctional institutions, aging programs, and family, youth and community services.	Adopt/develop/distribute model organizational/institutional suicide prevention plans. Intent is to bring prevention “inside” school, work, and service settings.	Feeling Blue Suicide Prevention Council offers workplace suicide prevention training.
c) Develop a technical support center to build capacity in the county and implement suicide prevention programs	<ul style="list-style-type: none"> • Develop criteria to evaluate plans; ask universities to evaluate plans • Look at the prospects to create a position to coordinate the workgroups projects 	Presently the Task Force relies on ad hoc leadership and assistance from within its membership. Broader suicide prevention will need ongoing staff leadership and support to be effective.
d) Defining and implementing screening guidelines for youth and adults in schools and correctional institutions, along with guidelines on linkages with service providers	Assist schools in selecting evidence-based screening instruments for use with individuals felt to be at risk. Assist adult/juvenile facilities to develop screening protocols	The Teen Screen Program ¹¹ identifies at-risk youth through a 2-stage screening.
e) Implementing support programs for persons who have survived the suicide of someone close and self injurers or those who have made a suicide attempt or are troubled by chronic suicidal ideation.	Support groups offer “safe” settings for peer support to facilitate recovery from loss or build protective factors to avert suicidal behavior. Such groups build knowledge and coping/ problem-solving skills and give opportunities for self-help.	See pages 24-24 for assessment of county support groups. There are no support resources for those with mental illness problems who may go into crisis or recurrence because of loss or suicidal behavior.

¹¹ The Columbia University TeenScreen Program is a national youth mental health and suicide risk screening program (see www.teenscreen.org and Shaffer et al., 2004).

Goal 5: Promote Community Efforts to Reduce Access to Lethal Means

Objectives	Activities	Status
<p>a) Educating health providers and health safety officials on the assessment of lethal means in the home and actions to reduce suicide risk.</p>	<ul style="list-style-type: none"> • Outreach to healthcare providers, including EMTs, and police • Partner with the Montgomery County Medical Society and the Montgomery County Health Department to see that every primary care provider in the county receives a copy the <i>Physician Firearm Safety Guide</i> (American Medical Association, 1998). 	
<p>b) Implementing a public information campaign designed to reduce accessibility of lethal means. Firearms are the main lethal means involved in suicides in the county. Gun ownership is a major risk factor for male youths and elders.</p>	<ul style="list-style-type: none"> • Encourage the inclusion of suicide info into gun safety classes • Provide gun safety education to elders, family members, and providers • Encourage safe disposal of old or unused firearms and ammunition. 	
<p>c) Improving firearm safety and promoting safer methods for storing and dispensing potentially lethal medications,</p>	<p>Develop information in “suicide proofing” the household environment by eliminating/securing firearms, minimizing quantities of medications on hand, and so on.</p>	<p>See page 22 of this report for the status of activities for reducing access to guns by high-risk individuals.</p>

Goal 6: Implement Training for Recognition of and Response to At-Risk Behavior

Objectives	Activities	Status
a) Educate nurses, physician assistants, physicians, social workers, psychologists, and other counselors in youth, adult, and elder suicide.	Offer accredited continuing education (CE) credit courses on suicide risk identification for licensed health, mental health, and long-term care professionals.	Colleges, hospitals, and providers offer CE for licensed professionals. Eagleville Hospital, the Horsham Clinic, and MCES offer suicide education.
b) Train clergy, teachers and other educational staff, correctional workers, on how to identify and respond to persons at risk for suicide	Adopt/develop suicide screening training modules for clergy, educators, correctional officers, probation officers	MCES gives suicide prevention training to county correctional officers and prison counselors.
c) Provide education for family members of persons at elevated risk (i.e., those with mental illness, elder males, youths with attempt history).	Partner with NAMI and SE PA Mental Health Assn. to offer suicide prevention education programs to family members of individuals with serious mental illness.	Review/adapt available programs on alcohol misuse, depression, and schizophrenia developed by MCES.
d) Promote policies in hospital emergency departments, substance abuse treatment centers, mental health treatment centers, designed to assess suicide risk	Arrange appropriate in-service education for physicians, nurses, and other clinical staff who may encounter at-risk individuals,	Community hospitals and behavioral health providers in the county have not been adequately drawn into suicide prevention to date.
e) Incorporate suicide risk screening in primary care.	Partner with the Montgomery County Medical Society to explore suicide risk screening in family care/general practice settings.	

“Educating family members and significant others about how to watch for changes in mood and behavior, and how to access help when needed are important to ensure that a person at risk does not become self-destructive.”

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Objectives	Activities	Status
f) Ensure that individuals who provide services to suicide survivors understand and respond appropriately to their needs (e.g., EMTs, firefighters, police, clergy, funeral directors)	<ul style="list-style-type: none"> • Provide postvention training to police and EMTs • Provide postvention training to clergy • Provide postvention training to MCES crisis staff and other hotlines to give 24/7 access to support and resource information. 	<ul style="list-style-type: none"> • MCES booklet <i>What Emergency Responders Need to Know About Suicide Loss</i> • SOS booklet <i>What Clergy Need to Know About Suicide Loss: How to Help</i> • MCES currently offers postvention to former patients and other MH consumers.
g) Increase the number of persons with mood disorders at-risk of suicide who receive and maintain treatment to reduce risk.	Promote training of mental health clinicians in Cognitive Behavioral Therapy and Dialectical Behavioral Therapy	Montgomery County Office of Mental Health has sponsored educational programs in these modalities for clinicians.
h) Foster education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide	<ul style="list-style-type: none"> • Promote offering of adult education courses on family/household suicide prevention by school districts and Montgomery County Community College 	MCES booklet <i>What Everyone Should Know About Suicide</i> may serve as a basic informational resource.
i) Mobilize home health agencies, hospices, assisted living facilities, skilled nursing facilities, adult day care centers, and senior center staffs as gatekeepers for elders.	Develop/adopt gatekeeper training modules for: <ul style="list-style-type: none"> • In-home providers • Long-term care facilities • Community-based senior citizen programs 	“QPR” (Question, Persuade, Refer) ¹² is a widely used gate-keeper training program. It is offered by the Feeling Blue Suicide Prevention Council.

“First responders have the opportunity to set the tone for being respectful and sensitive to the needs of survivors...”

National Strategy for Suicide Prevention: Goals and Objectives for Action

¹² See www.qprinstitute.com.

Next Steps:

This report has defined suicide and suicide loss as serious community problems deserving of concerted community action.

We have proposed meaningful goals to serve as the framework for a comprehensive suicide prevention strategy for the county. Concrete achievable objectives have been set for each goal.

We have put forth a multi-layered strategy calling for a reasonable set of initiatives on a manageable number of fronts. The next steps are:

1. Distribute this report to stakeholders in county and municipal government, and the health and human services, criminal justice, education, religion, and business sectors for review and feedback.
2. Revise the report as necessary.
3. Designate a lead agency to support small oversight body charged with setting priorities and establishing a timeline and work plan for the achievement of the objectives.
4. Delineate tangible outcomes for each activity to be undertaken as part of the strategy to permit timely evaluation of the results.
5. Mobilize key groups and organizations to implement specific objectives on behalf of the communities or constituencies that they serve.

We further recommend the formation of two interdisciplinary postmortem review processes based on the model of the Child Death Review Team as follows:

- *A Suicide Review Team* to examine every death in Montgomery County classified by the Coroner as a suicide to (i) assure accurate data on the incidence of suicide, and (ii) to identify pertinent targets for prevention and intervention.
- *An Elder Death Review Team* to examine every death in Montgomery County of an individual age 65 or over by non-natural causes to identify the occurrence of possible suicides as a result of self-starvation, non-adherence to medical treatment, and accidents.

These measures will extend current suicide surveillance system and improve knowledge of the epidemiology of suicide in Montgomery County.

This document was prepared by Montgomery County Emergency Service, Inc. (MCES).

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REVIEWER FEEDBACK

1. Do you agree with the Task Force’s “Suicide Prevention Vision”?

YES

NO

If not, please explain: _____

2. Is the “What We Know About Suicide” section informative, helpful and clear?

YES

NO

If not, please explain: _____

3. Is the proposed “Suicide Prevention Philosophy” meaningful?

YES

NO

If not, please explain: _____

4. Does the “Suicide Prevention Program Typology” clearly present possible approaches?

YES

NO

If not, please explain: _____

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5. Does “Suicide and Suicide Attempts in the County” sufficiently define the problem?

YES

NO

If not, please explain: _____

6. Does the “Suicide Prevention Resource Availability” section reasonably outline existing prevention, intervention, and postvention services in the county?

YES

NO

If not, please explain: _____

7. Do you agree with “A Suicide Prevention Strategy for Montgomery County”?

YES

NO

If not, please explain: _____

8. Are there any goals and/or objectives that should be added to the proposed strategy?

YES

NO

If yes, please provide: _____

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9. Is the “Strategic Assessment: What Needs to be Done” in-depth and accurate?

YES

NO

If no, please explain: _____

10. Do the proposed “Next Steps” lay out a direct course for the next phase of suicide prevention?

YES

NO

If no, please explain: _____

May we?

Send you more information about suicide prevention

Contact you about suicide prevention training

Contact you about getting involved with suicide prevention

Other: _____

Name: _____ Title: _____

Organization: _____

Street Address: _____

Town: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____

THANK YOU!

***Please return to: Tony Salvatore
Montgomery County Emergency Service, Inc.
50 Beech Drive
Norristown, PA 19403-5421
610-279-6100 or tsalvatore@mces.org
Fax: 610-279-0978***