SEDGWICK COUNTY
SUICIDE PREVENTION TASK FORCE

Year Two Report

March 2002

Approved and Accepted by the Board of Sedgwick County Commissioners
March 5, 2003

"Sedgwick County - Strengthening Lifelines"

I. INTRODUCTION

In the year 2001, 48 people succumbed to suicide in Sedgwick County, leaving behind at least 384 survivors affected by these tragic losses. Surviving the death of a dear one is an experience of unrivaled pain, compounded by shame and guilt. Residual stigma associated with suicide, inadequate understanding about its risks and protective factors, and difficulties in catering to the unique needs of suicide survivors, leave communities continuously vulnerable to its detrimental effects. Most of these problems stem from insufficient funding for research and awareness campaigns.

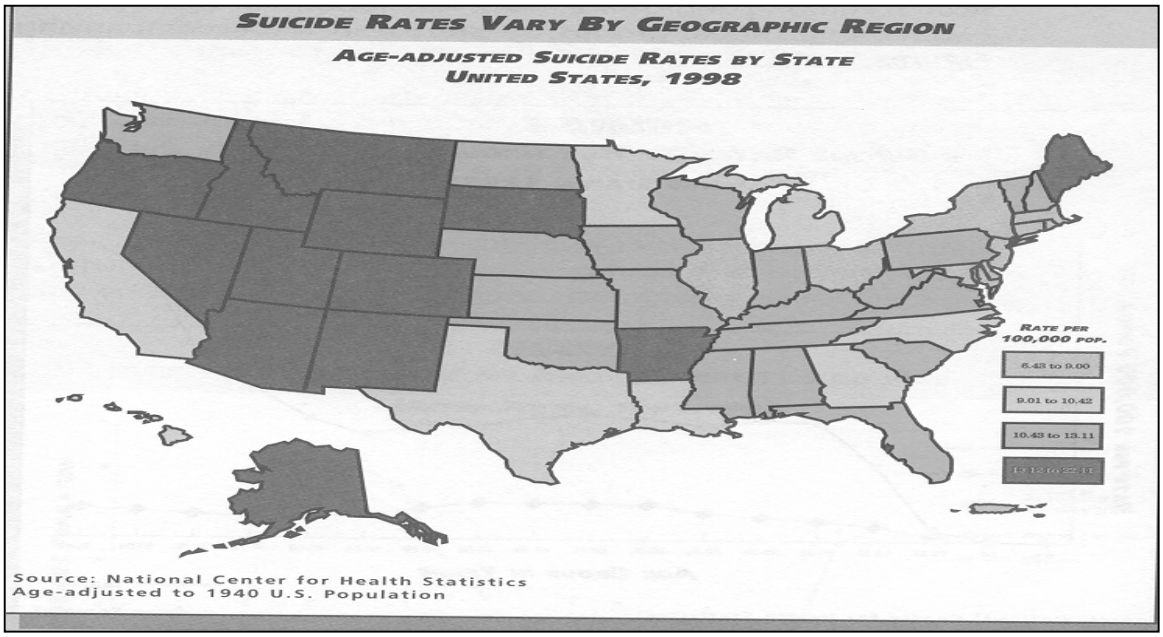
The latest reports on mental health like the Institute Of Medicine's *Reducing Suicide: a National Imperative 2002* and *The Interim Report of the President's New Freedom Committee On Mental Health* caution the nation about the impending mental health catastrophe if the attitude of denial and neglect by the federal, state and local authorities continues unchanged. The Sedgwick County Suicide Prevention Task Force (SPTF) intends to tackle the suicide problem by: (a) increasing awareness in the community; (b) reducing the stigma associated with suicide; (c) providing a timely safety-net that adequately responds to the needs of people contemplating suicide and to suicide survivors; and, (d) conducting on-going research on suicide prevention.

This report describes efforts of the SPTF over the last year. Due to the prevailing economic slowdown and heightened global stress situations, the SPTF anticipated an increase in the number of suicides locally in 2001. That the incidence stabilized instead, suggests that the SPTF is on the right track. Nonetheless, we are far from our goal of reducing the age-adjusted suicide rate to 6.0 per 100,000 people by 2010. The SPTF remains determined to establish long-term solutions that best fit local values and circumstances by drawing together a wide cross-section of local expertise in its strategic campaign to address this major public health problem.

II. SUICIDE IN THE UNITED STATES

AT THE NATIONAL LEVEL

Figure 1.



Did you know?

- In the year 2000, an American life was lost to suicide every 18 minutes.
- Suicide ranked as the 11th leading cause of death for all Americans in 2000 and has continuously ranked among the top 15 leading causes of death since 1975.
- About 29,350 Americans succumbed to suicide in 2000. There were 734,000 (documented) suicide attempts in the same year.
- Suicide outnumbered homicides (16,765) by 5 to 3. There are twice as many deaths due to suicide than due to HIV/AIDS (14,802).
- Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled. In 2000, suicide was the 3rd leading cause of death for the young.
- Firearms, by far the most common method of committing suicide (56.5%), are used in about 6 of every 10 self-inflicted deaths.
- Suicide rates remain highest among Americans aged 65 and older. In the month prior to their suicide, 75% of elderly persons had visited a physician.
- For every suicide death there are 5 hospitalizations and 22 Emergency Department (ED) visits for suicidal behaviors. Together the hospitalizations and ED visits total more than 670,000 annually (National Imperative, 2002).
- Over half of all suicides occur in adult men aged 25-65. Males are four times more likely to complete suicide than are females.

Adapted from National Strategy for Suicide Prevention, 2001 and USA 2000: Suicide statistics from www.aas.org.

THE NATIONAL RESPONSE

In early 2000, the Secretary of Health and Human Services officially established the National Strategy Federal Steering Group (FSG) for the purpose of formulating a national strategy for suicide prevention. FSG reviewed the recommendations from the Reno meeting (1998) and the Surgeon General's *Call to Action* (1999) to prevent suicide. They subsequently developed a comprehensive plan outlining 11 goals and 68 objectives. These, in turn, would stimulate the development of defined activities for local, state and federal partners. During 2000, public hearings on Goals and Objectives for Action were held in Atlanta, Boston, Kansas City and Portland. Following these hearings, the Department of Health and Human Services prepared *The National Strategy for Suicide Prevention: Goals and Objectives for Action, 2001(National Strategy* or NSSP).

THE NATIONAL STRATEGY

The *National Strategy* is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. Representing the combined work of advocates, clinicians, researchers and survivors, the *National Strategy* lays out a framework for action and guides development of an array of services and programs yet to be set in motion. It strives to promote and provide direction for modifying the social infrastructure in ways that will affect the most basic attitudes about suicide and its prevention. And, it envisages change in judicial, educational, and health care systems.

AIMS OF THE NATIONAL STRATEGY

- Prevent premature deaths due to suicide across the lifespan
- Reduce the rates of other suicidal behaviors
- Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends
- Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families and communities

Adapted from *The National Strategy For Suicide Prevention, 2001.*

The National Strategy's goals and objectives (Appendix E) are subdivided into categories of awareness, intervention and methodology (AIM). These are designed to encourage local, state and federal agencies to:

1. appropriately broaden the public's awareness of suicide and its risk factors;
2. enhance services and programs, both population-based and clinical care; and,
3. advance the science of suicide prevention.

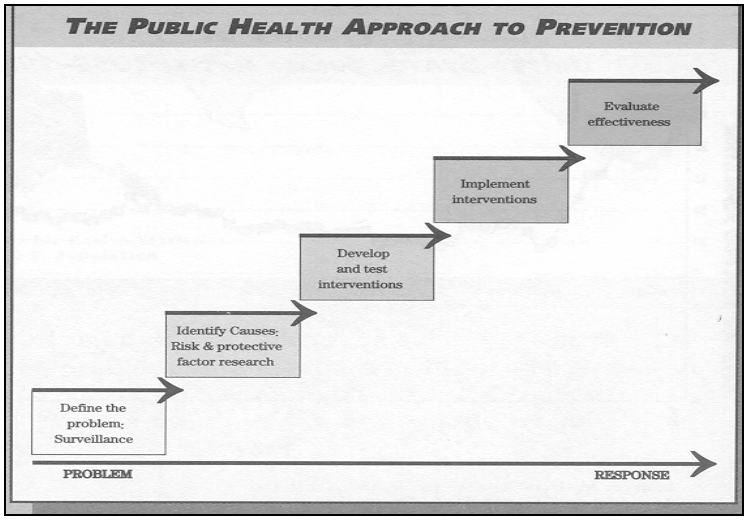
The National Strategy provides a framework that helps communities to devise their own broad-based empowering strategies for reducing suicides. It employs *the public health approach*, which has helped the nation effectively address problems as diverse as tuberculosis, heart disease, and unintentional injury.

- The public health approach to suicide prevention represents a rational and organized way to marshal prevention efforts and ensure that they are effective. In contrast with the clinical medical approach, which explores the history and health

conditions that could lead to suicide in a single individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior throughout a group or population. Its five basic steps are shown in Figure 2.

- The approach assumes that raising general public awareness about the extent to which suicide is a problem, and about the ways in which it can be prevented, can reduce suicide and suicidal behaviors.

Figure 2.



Adapted from *The National Strategy For Suicide Prevention, 2001.*

- The Strategy requires a variety of organizations and individuals to become involved in suicide prevention and emphasizes coordination of resources and culturally appropriate services at all levels of government. The NSSP represents the first attempt in the United States to prevent suicide through a coordinated approach by both the public and private sectors.

THE INSTITUTE OF MEDICINE (IOM) REPORT

Taking cues from the National Strategy, and from work being done in several federal agencies (National Institute of Mental Health, National Institute of Drug Abuse, Veterans Administration, Centers for Disease Control and Prevention, Substance Abuse, and Mental Health Services Administration, and National Institute on Alcohol Abuse and Alcoholism) the Institute of Medicine (IOM) convened the Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide to examine the existing science base, gaps in our knowledge, strategies for prevention, and research designs for the study of suicide. The IOM Committee in its publication, *Reducing Suicide: A National Imperative 2002* made the following observations.

- Suicidality, although clearly overlapping with the symptomology of the associated disorders (e.g., depression), doesn't appear to respond to treatment in exactly the same way. Depressive symptoms can be reduced by medicines without effective reduction in suicidality.

- Despite extensive research concerning suicide risk and protective factors, knowledge of how all these factors work in concert to evoke suicidal behavior or to prevent it, is yet incomplete.

- There are significant barriers to receiving effective mental health treatment. About two-thirds of people with diagnosable mental disorders do not receive treatment. The stigma associated with mental illness prevents needful people from coming out and seeking treatment. The fragmented organization of mental health services and the cost of care are amongst the most frequently cited barriers to mental health.

- Physicians are reticent to talk to their patients about suicide; they often do not ask about intent or ideation, and patients often do not spontaneously report it. Treatment of depression in primary care is associated with reduced rates of completed suicides. According to the American Medical Association, a diagnostic interview for depression is comparable in sensitivity and specificity to many radiological and laboratory tests commonly used in medicine. Yet, currently only about 30-50 percent of adults with diagnosable depression are accurately diagnosed by primary physicians.

- Patients are at much greater risk of suicide in the weeks immediately following discharge from the hospital after treatment for suicide-associated problems. Discharged patients who committed suicide were 3.7 times more likely to have had their outpatient care reduced in their last session. On the other hand, people who continued care had lower suicides rates.

- Programs such as the United States Air Force's suicide prevention program that integrate prevention at multiple levels are likely to be the most effective programs.

- Reducing availability or the lethality of a method of commission results in a decline in suicide by that method; method substitution does not invariably occur.

- Education of the media regarding appropriate reporting of suicides can limit imitation effects and thereby reduce suicide rates.

- While implementing comprehensive school-based programs is recommended and examples of programs that have shown some success in reducing suicidality are cited, the report is skeptical about effectiveness of simple awareness programs and warns that such programs could have negative effects.

- Suicide is responsible for 30,000 deaths each year. Mental illness, a primary risk factor, afflicts over 80 million people in the United States; almost 15 million people have serious mental illness. In comparison, breast cancer claims the lives of about 40,000 women per year and between 10-15 million people are living with the diagnosis of breast cancer. In 1998 over $400 million was allocated for

research into prevention, treatment and cure of breast cancer. The funding for suicide was less than $40 million in 2000. Given the enormous magnitude of the problem, the current allocation of fiscal resources is disproportionately low and substantial investment of funds is recommended to make suicide prevention, a meaningful process.

- Official statistics typically capture completed suicides only and are fraught with inaccuracies. The numbers are inaccurate because of under reporting and/or misclassification, (e.g., classifying suicides as death from undetermined causes). The quality of data on suicide attempts is even more tenuous than that of completed suicides.

- That suicide is, unfortunately, a medically expectable outcome of many mental illnesses should not be a justification for excluding such patients from clinical trials of psychoactive medicines.

- To effectively study suicide, better reporting of completed and attempted suicides is needed along with creation of common databases. This will help to carefully control and analyze the risk and protective factors related to suicide.

INTERIM REPORT OF THE PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH

Observations similar to those found in the IOM report are made in the *Interim Report of The President's New Freedom Commission on Mental Health (2002)*.

- Barriers to care within the mental health system and the fragmentation of services are two major reasons cited for the inadequate performance of the nation's mental health system.

- The nation's failure to prioritize mental health is a *national tragedy*. No loss is more devastating than suicide.

- While 90% of individuals who take their life have a mental disorder, many of them lack the care in months before their death that might have helped them to affirm life.

- Emphasizing the need for strong leaders, the Commission points to the US Air Force's success in reducing suicides," The Air Force program has many features, but none as inspiring as messages from its leader to change a military culture to reverse centuries of stoicism in the face of hardship- to encourage going for help".

SUMMARY

Findings from all three sources clearly indicate that the nation's mental health system is fragmented and in disarray, and therefore not in a position to efficiently deliver services to the people in need.

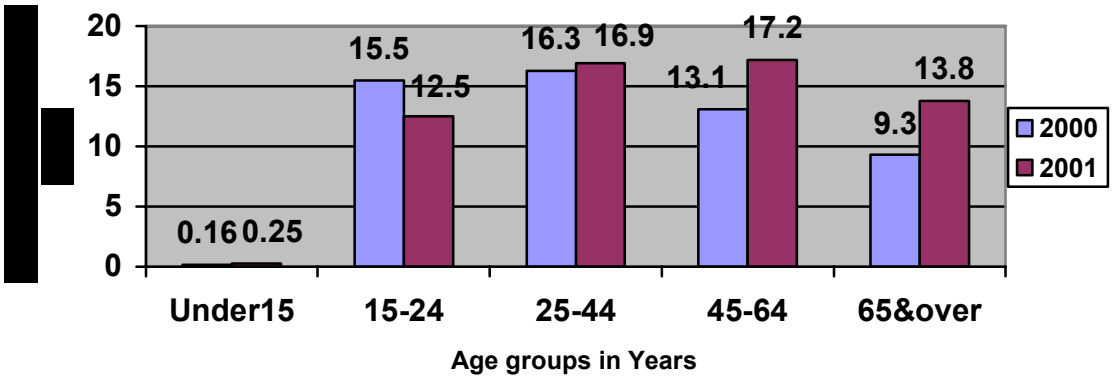
III. SUICIDE IN KANSAS

AT THE STATE LEVEL

- In the year 2001, suicide ranked as the14th leading cause of death in Kansas for all age groups accounting for 297 deaths (Table 1).
- Between 1995 and 2001, 2,222 Kansans committed suicide at an average of 317 suicides per year.
- In 2001, the age-adjusted rate of deaths due to suicide was 11.0 per 100,000 population.
- In 2001, as in the previous years, the number of suicides (297) in Kansas was more than double the number of homicides (144).
- In the year 2001, there was an increase in the age-adjusted death rates due to suicide in all age groups above the age of 25 years (Figure 3). In 2001, the number of suicide deaths (125) was highest in the age group 25 to 44.
- Males are at greater risk of completing suicide than females. Between 1995 and 2001, 1,841 males committed suicide at an age-adjusted rate of 20.3 compared to 381 females at an age-adjusted rate of 4.1 during the same period.
- When compared by marital status at the time of death, suicide rates were higher among divorced individuals of both sexes than in among those who are married.
- Firearms are the main method of choice for committing suicide in all age groups and in both sexes. Firearms accounted for 60% of all suicides in the state between 1995 and 1998. After firearms, the commonest methods were hanging (16%), carbon monoxide and motor vehicle exhaust (9.3%), and drugs (8.6%). In actual numbers, between 1995 and 1998, 781 Kansans shot themselves to death with a gun, which translates to one suicide with a firearm every 48 hours.

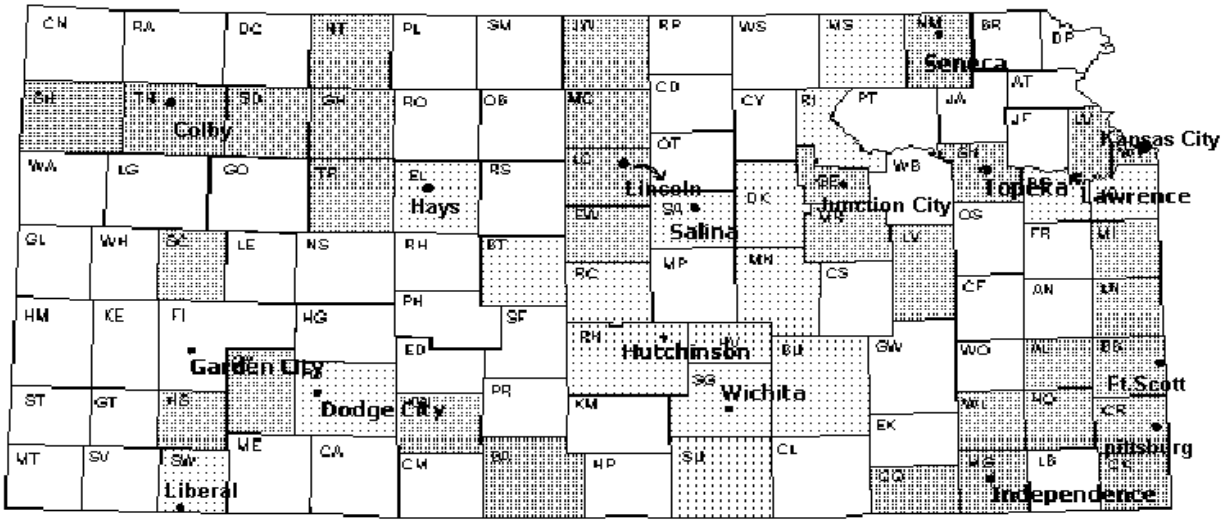
Adapted from *Research Summary, Suicides, Kansas, 1989-1998,KDHE & KDHE Year 2001 suicide statistics.*

Figure 3*. Suicide in Kansas by age-groups, 2000-2001.



** Age-adjusted death rate is for 100,000 population based on 2000 standard population.
Source*: Center for Health and Environmental Statistics, *KDHE.*

Figure 4. Suicide specific death rate for all counties in Kansas, 2001.



Counties with Suicide specific death rate for all age-groups less than or equal to 6.0 per 100,000 population (SPTF Goal for 2010).

Counties with Suicide specific death rate for all age-groups above 6.0 per 100,000 population but less than or equal to 11.0 per 100,000 population (Kansas State average).

Counties with Suicide specific death rate for all age-groups above 11.0 per 100,000 population.

Prepared by the SPTF Methodology Subcommittee using the 2000 standard population and the Suicides in Kansas, 2001 data obtained from Center for Health and Environment, KDHE.

Table 1*: Suicide Statistics for the state of Kansas, 1998 & 2001

County [1]	1998	2001	County [1]	1998	2001	County [1]	1998	2001
Allen (AL)	4	2	Greeley (GL)	1	0	Osborne (OB)	1	0
Anderson (AN)	1	0	Greenwood (GW)	1	0	Ottawa (OT)	2	0
Atchison (AT)	3	0	Hamilton (HM)	1	0	Pawnee (PN)	1	0
Barber (BA)	0	1	Harper (HP)	1	0	Phillips (PL)	2	0
Barton (BT)	0	3	Harvey (HV)	7	3	Pottawatomie(PT)	3	0
Bourbon (BB)	5	2	Haskell (HS)	0	2	Pratt (PR)	0	1
Brown (BR)	0	0	Hodgeman (HG)	0	0	Rawlins (RA)	0	0
Butler (BU)	8	4	Jackson (JA)	2	0	Reno (RN)	11	6
Chase (CS)	0	0	Jefferson (JF)	3	1	Republic (RP)	2	1
Chautauqua (CQ)	0	1	Jewell (JW)	0	1	Rice (RC)	3	1
Cherokee (CK)	4	3	Johnson (JO)	41	45	Riley (RL)	5	5
Cheyenne (CN)	0	0	Kearny(KE)	0	0	Rooks (RO)	0	0
Clarke (CA)	0	0	Kingman (KM)	0	0	Rush (RH)	0	1
Clay (CY)	0	0	Kiowa (KW)	0	1	Russell (RS)	0	0
Cloud (CD)	2	0	Labette (LB)	6	1	Saline (SA)	8	4
Coffey (CF)	1	0	Lane (LE)	0	0	Scott (SC)	0	1
Comanche (CM)	0	0	Leavenworth(LV)	8	9	**Sedgwick (SG)**	**64**	**48**
Cowley (CL)	2	3	Lincoln (LC)	2	1	Seward (SW)	2	2
Crawford (CR)	6	9	Linn (LN)	1	2	Shawnee (SN)	28	20
Decatur (DC)	0	0	Logan (LG)	1	0	Sheridan (SD)	0	1
Dickinson (DK)	3	2	Lyon (LY)	3	8	Sherman (SH)	3	1
Doniphan (DP)	1	0	McPherson (MP)	4	1	Smith (SM)	0	0
Douglas (DG)	9	11	Marion (MN)	1	1	Stafford (SF)	2	0
Edwards (ED)	0	0	Marshall (MS)	1	1	Stanton (ST)	0	0
Elk (EK)	1	0	Meade (ME)	0	0	Stevens (SV)	0	0
Ellis (EL)	1	3	Miami (MI)	4	8	Sumner (SU)	2	2
Ellsworth (EW)	1	1	Mitchell (MC)	0	2	Thomas (TH)	1	1
Finney (FI)	6	1	Montgomery MG)	5	5	Trego (TR)	0	1
Ford (FO)	3	2	Morris (MR)	1	3	Wabaunsee(WB)	3	0
Franklin (FR)	4	7	Morton (MT)	0	0	Wallace (WA)	0	1
Geary (GE)	6	8	Nemaha (NM)	0	2	Washington WS)	0	0
Gove (GO)	0	0	Neosho (NO)	0	3	Wichita (WH)	1	0
Graham(GH)	0	1	Ness (NS)	1	0	Wilson (WL)	1	2
Grant(GT)	2	0	Norton (NT)	0	1	Woodson (WO)	0	0
Gray(GY)	1	1	Osage (OS)	1	1	Wyandotte (WY)	13	31
Total suicide deaths in Kansas (1998)= 328			**Total suicide deaths in Kansas (2001) = 297**					

[1] Abbreviations for the county names obtained from US Census Bureau

*Source**: Center for Health and Environmental Statistics, KDHE

THE STATE RESPONSE

- The Kansas Suicide Prevention Steering Committee was formed in August 2000 following the national and regional conferences held by the U.S. Department of Health and Human Services in conjunction with the Surgeon General's office. Consequent to the Steering Committee's efforts, Kansas has a state suicide prevention plan. The draft of the state plan can be found in Appendix F.

- Raising public awareness about suicide prevention and reducing the stigma associated with suicide has been a major focus of the steering committee. A speaker's bureau has been formed to provide presentations on suicide prevention at events across the state.

- Continuing its efforts to raise awareness of the need for suicide prevention, the Steering Committee organized the third annual suicide prevention conference in 2002 in partnership with the Kansas Association of Mental Health Centers. The conference featured presentations by experts in the field of suicidology.

- A poster specifically targeting youth has been prepared by the Steering Committee, which is currently searching for a funding source to print these posters and distribute them in the schools throughout the state.

- Other efforts have been made to bring suicide prevention awareness to all parts of the state. Two 30-second Public Service Announcements targeted at increasing awareness and decreasing the stigma associated with suicide have been prepared and screened across the state of Kansas.

- ANSWER (Adolescents Never Suicide When Everyone Responds), a task force comprised of local law enforcement, a mental health association, schools, and various other groups of professionals continues to provide online resources and information about teen suicide.

- Kansas has a crisis center, Headquarters, Inc., whose staff responds to the national toll free number 1-800-SUICIDE for calls that originate from Kansas.

- In the year 2003, the Steering Committee hopes to have the Governor issue a proclamation on the importance of suicide prevention.

- The Steering Committee is planning to organize the fourth annual statewide suicide prevention conference in 2003, possibility in conjunction with a conference on aging. Renowned speakers with expertise in suicide prevention will be invited to make presentations. Workshops specifically targeted towards mental health providers, law enforcement members, teachers and other potential gatekeepers, will offer training in suicide prevention.

IV. SUICIDE IN SEDGWICK COUNTY

AT THE COUNTY LEVEL

- According to the Kansas Department of Health and Environment, 48 people committed suicide in Sedgwick County during 2001.
- One out of every six Kansans who died from suicide is from Sedgwick County.
- From 1991-2001, 589 people committed suicide in Sedgwick County, at an average of 53 per year and at a rate of 12.64 per 100,000 population as compared to US average of 10.4 (Figure 6).
- In the last decade, 50% more residents of Sedgwick County died from suicide than homicide.
- Some confusion exists over the measurement of suicide deaths in the County. The Sedgwick County Regional Forensic Science Center (SCRFSC) assigns all deaths occurring within the Sedgwick County to the County toll. The Kansas Department Of Health and Environment (KDHE) assigns deaths according to the county of residence. To best understand suicides within the County, the Task Force supports statistics produced by the SCRFSC. However, when comparing statistics between Sedgwick County and other Kansas counties, it is more appropriate to use those issued by KDHE. See further explanation and an example of the discrepancy in Appendix D.

Figure 6* .Age-Adjusted Suicide rates ,1991-2001.

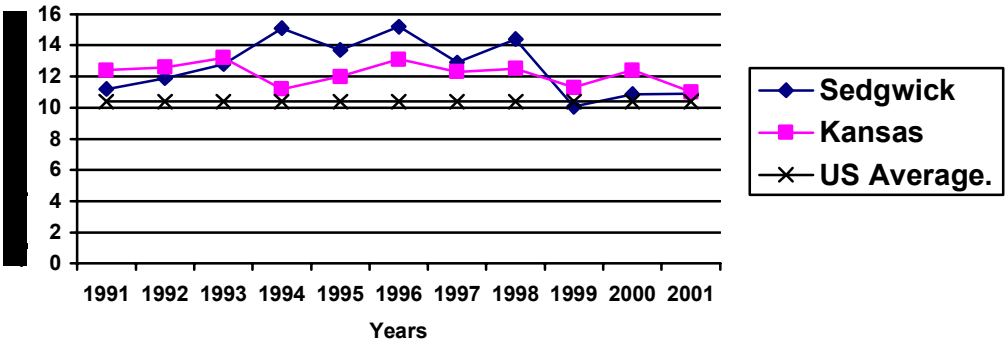
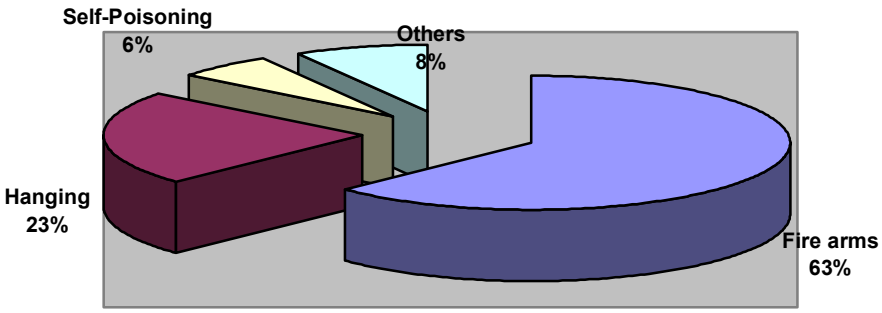


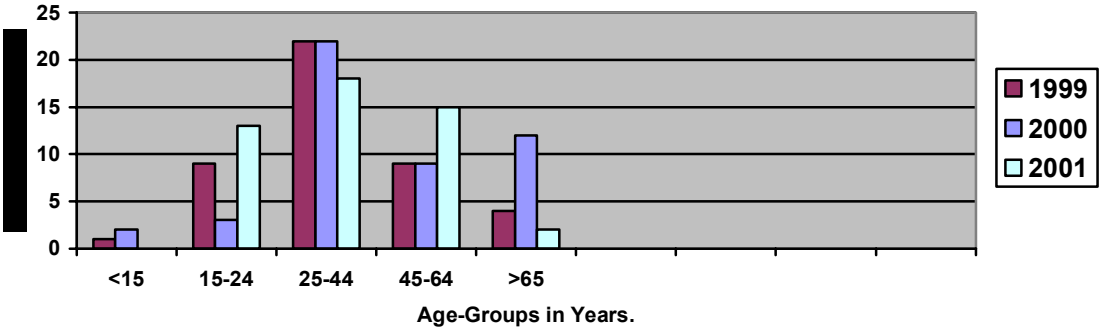
Figure 7*. Sedgwick county-Methods of Suicide Commision, 2000-01.



Source*: KDHE Center for Health and Environmental Statistics.

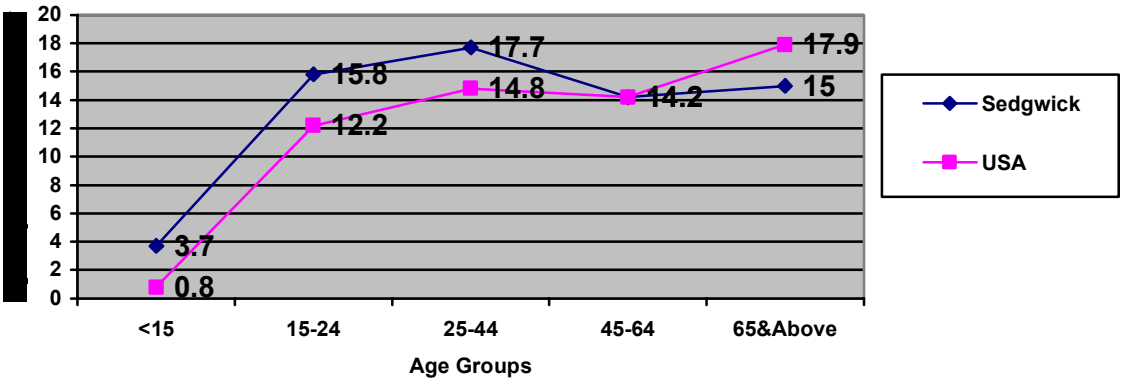
- The most common method of completing suicide in Sedgwick County is firearm discharge, followed by hanging/suffocation, and self-poisoning (Figure 7).
- Firearm usage has increased consistently for the past three years, accounting for 55.6% suicides in 1999, 60.4% in 2000 and 63 % in year 2001. This compares to 56.5% at the national level (USA Suicide: 2000 data).

Figure 8*. Number of Suicides by Age Group, Sedgwick County, 1999-2001.



- In 2001, there were 15 suicides in the age group of 45-64 when compared to 9 suicides in the same age group in 2000 (Figure 8).

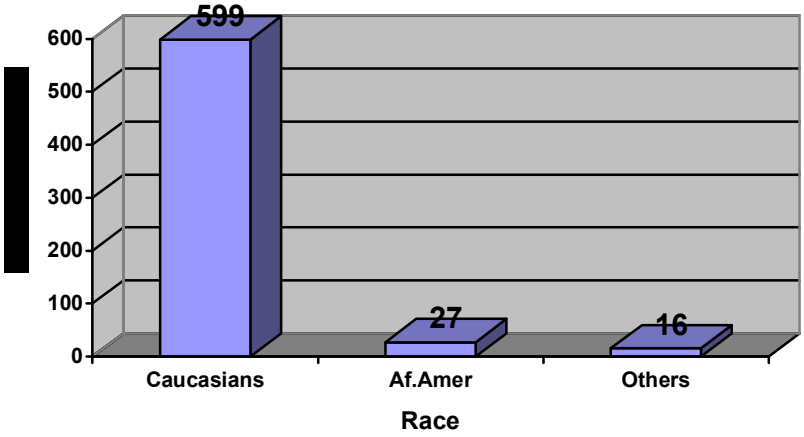
Fig 9*. Age-adjusted suicide rates by Age Group, Sedgwick County and USA, 1990-2000.



- From 1990-2000, age-adjusted suicide rates in Sedgwick County were highest among the 25-44 age group followed by the 15-24 age group (Figure 9). Between 1990-2000, 65.4% of suicide deaths were among persons younger than 45 years of age.

Source*: KDHE Center for Health and Environmental Statistics for County statistics and USA Suicide: 2000 for US stats.
**Age-adjusted suicide rates are for 100,000 population and based on 2000 standard population.

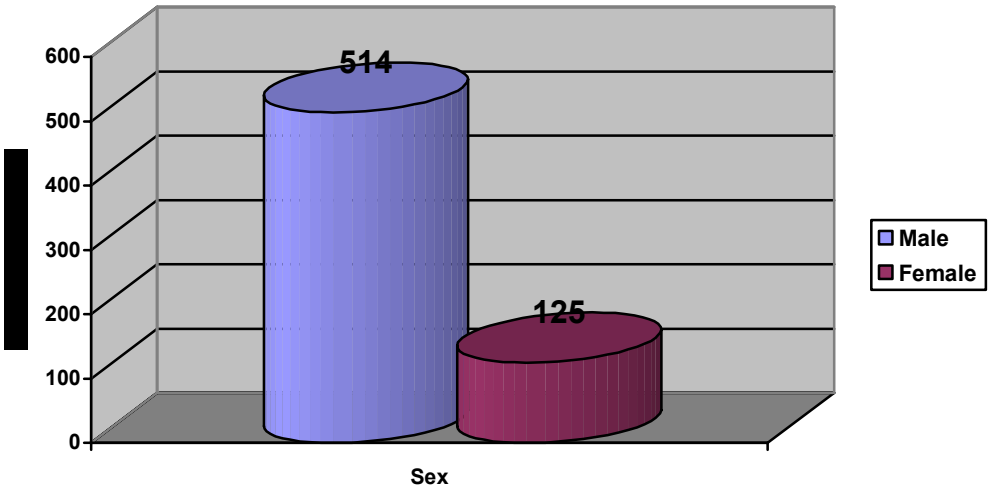
Figure10*. Number of Suicides by Race,Sedgwick County,1990-2001.



- Caucasians commit suicide at higher rates compared to other races. Out of 639 persons who committed suicide between 1990-2001, 599 (94.4%) persons were whites (Figure 10). In 2001, 41 out of 48 (85.41%) suicide deaths were of whites. Racial differences are thought to result from a complex set of factors, not yet fully understood. Currently no reliable counts on Hispanic/Latino suicides are available in Kansas or Sedgwick County (See appendix D).

- From 1990-2001, the age-adjusted suicide rates for males were four times higher than for females. In 2001, 42 out of 48 suicide deaths (87.5 %) were males. The differential death rates for men and women appear to be related to greater access by males to more lethal means such as firearms.

Figure 11*. Number of Suicides by Sex,Sedgwick County,1990-2001.



Source*: KDHE. Center for Health and Environmental Statistics.

THE COUNTY RESPONSE

- Following the Regional Meeting VII Conference on Suicide Prevention in Kansas City, MO, the Sedgwick County Community Suicide Prevention Steering Committee was formed on August 22, 2000 to address suicide and it's related issues in Sedgwick County.

- Acting upon the recommendations of the Steering Committee, the Board of County Commissioners (BOCC) established the Suicide Prevention Task Force (SPTF) on January 3, 2001. The original Task Force included appointees with expertise in Aging, Criminal Justice, Education, Mental Health, Ministerial, Public Health and Social Services and representatives of the general community. The overall goal set by the SPTF was to reduce the suicide rate in the county from 12.9 per 100,000 to 6.0 per 100,000 by 2010. The SPTF has completed its second year of operation.

- During its first two-years, the Task Force and its various subcommittees and working groups have involved more than 50 individuals (see appendices A&B) working together on behalf of the suicide prevention initiative.
  - The Awareness Subcommittee, composed largely of professionals from the fields of aging, crisis intervention, education, criminal justice, social service, mental health, ministry, and substance abuse has been working to reduce stigma associated with suicide and to increase public awareness about its prevention. The Subcommittee has developed and/or distributed various awareness materials like stigma brochures, community resource lists, and suicide prevention posters. They have made frequent use of media and Internet resources to encourage watchfulness and appropriate referrals of those in danger of self-harm.

  - The Intervention Subcommittee, composed largely of crisis intervention and mental health professionals, has developed an educational presentation to instruct viewers in means of identifying and assisting people exhibiting suicidal warning signs. The slide show, suitable for various audiences, recommends methods for improving access to appropriate mental health services and illustrates a postvention process for addressing the mental health needs of survivors of suicide.

  - The Methodology Subcommittee, composed largely of health services researchers, clinical investigators, and epidemiologists has designed a series of studies to better understand risk and protective factors associated with suicidal behavior. They are also, investigating the recovery path of survivors who are, themselves, at significantly increased risk of committing suicide.
- The following pages describe the activities undertaken during 2002 by the Sedgwick County Suicide Prevention Task Force, its three Subcommittees, and their various working groups.

V. THE SEDGWICK COUNTY SUICIDE PREVENTION TASK FORCE (SPTF)

Overall purpose: *To reduce the Sedgwick County suicide rate from 12.9 to 6 per* 100,000 by 2010, with special emphasis on the youth and the elderly.

- The SPTF initially adapted the 15 goals from the Surgeon General's *Call to Action*. With the publication of *The National Strategy for Suicide Prevention, 2001,* the SPTF revised its mission in line with the 11 newly refined goals. These goals were distributed among the three subcommittees, with some overlap where interests intersected.

YEAR TWO ACTIVITIES:

- In January 2002, the SPTF presented the Year One Report to the Board Of County Commissioners (BOCC). The Task Force Year One Report was made available to the public on the web site of the COMCARE of Sedgwick County at *www.sedgwickcounty.org/comcare.*
- At it's monthly meetings, the SPTF provides a forum for sharing the work being undertaken by the three subcommittees, and for coordinating that work with the efforts at the state and national level.
- In May 2002, the SPTF held a workshop for its members where Ms. Vera Bothner spoke on the use of Social Marketing for promoting suicide prevention.
- In recognition of suicide prevention week, the SPTF was instrumental in the issuance of a proclamation on the importance of suicide prevention by both the Wichita City Council and the Sedgwick County Board Of County Commissioners. These proclamations were issued during regularly scheduled public meetings.
- In September 2002, a suicide prevention conference and community meeting was held for the many individuals involved in the work of the SPTF, as well as for interested community members. The key feature of the day-long summit was a dynamic workshop on suicide assessment presented by Dr. Shawn C. Shea. Following the workshop, attendees worked together to develop a prioritized list of goals for the SPTF to consider in Year three.
- In an effort to increase effectiveness and marketing of suicide prevention materials, the SPTF reviewed three logo designs to be printed on all it's material, and decided to remain with the current logo.

ACTIVITIES PLANNED FOR YEAR THREE†:

- Coordinate and integrate the work of the subcommittees' with the community and state efforts to prevent suicide
- Provide necessary support to USD 259 in their efforts to prevent suicide in Wichita schools through the Yellow Ribbon Program
- Continue to explore funding possibilities
- Continue to distribute suicide prevention materials in the county

† See Budget narrative for year three proposal.

VI. AWARENESS SUBCOMMITTEE

The Awareness Subcommittee consists of the following workgroups a) the Public Awareness/Resources Workgroup; b) the Media Workgroup; and, c) the Stigma Workgroup (see appendix B for members' list).

Overall purpose: *Promote awareness that suicide is a public health problem that is preventable.*

The work of the Awareness Subcommittee has been guided by the following four goals adapted from the National Strategy For Suicide Prevention, 2001.

Goal 1: Promote awareness that suicide is a preventable public health problem
Goal 2: Develop broad-based support for suicide prevention
Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media

YEAR TWO GOAL AND OBJECTIVES:

GOAL:
Goal#1: Develop a public awareness campaign on suicide prevention and reduction of stigma associated with mental illness, substance abuse and suicidal behaviors

OBJECTIVES:

- Educate those in the field of social service, public health, criminal justice, primary care physicians, education, aging, ministry, mental health, substance abuse, as well as the general public on how to identify and respond to persons at risk for suicide through presentations and the distribution of 5,000 stigma brochures and 5,000 community resource list handouts
- Distribute suicide prevention information via the Internet through development of a website containing information on risk factors and warning signs
- Raise awareness of risk and prevention among youth and older adults through distribution of 200 posters to locations where these target groups congregate for activities

YEAR TWO ACTIVITIES:

- Made 18 media releases/ media coverages regarding suicide and suicide prevention
- Gave 10 formal and 10 collateral presentations

YEAR TWO ACTIVITIES (Cont'd):

- Implemented the timeline set for media events for the year 2001-2002
- Updated and distributed around 5000 of the community resource lists handouts
- Posted the Task Force Year One Report on the COMCARE of Sedgwick County *www.sedgwickcounty.org/comcare* website until the Sedgwick County Suicide Prevention site is complete
- Formed a website workgroup (with consulation by the Sedgwick County Public Health Department and the county web master) to create and develop the Sedgwick County Suicide Prevention web site
- Identified materials to be posted on the website
- Organized a community poster contest and developed a poster targeted towards the aged and the elderly, and distributed 200 of them to senior centers, assisted living campuses, senior dining centers, nursing homes and other gathering places
- Identified four probable sources to obtain youth suicide prevention posters: (1) a prevention billboard in the Topeka area; (2) poster developed by the Mental Health Association of the Heartland; (3) poster from Yellow Ribbon Program; and, (4) poster designed by Sedgwick County Communications
- Successfully prepared and revised a brochure addressing the stigma associated with suicide
- Successfully distributed a media release on stigma in March 2002
- Assisted with distribution of 5000 stigma brochures to presentation participants and to community organizations such as medical offices, police departments, funeral homes, and social services

ACTIVITIES PLANNED FOR YEAR THREE† :

- Distribute suicide prevention information via the Internet through development of a web site containing information on warning signs and risk factors
- In conjunction with the Kansas State Steering Committee, raise awareness of suicide and resources available through Public Service Announcements placed on radio and TV
- Raise awareness of risk and prevention among youth through the distribution of 200 posters to locations where this target group congregates at school and for other activities
- Raise awareness of suicide and resources available by placing a prevention message in the student's daily planners targeting secondary students in USD 259 and surrounding Sedgwick County schools
- Continue to work constantly with other members, encouraging due focus to stigma factor in educational presentations and other community initiatives
- Host media appreciation luncheon and provide 2002 update on suicide prevention efforts in Sedgwick County run Public Service Announcements on regular basis with alternating PSAs every three months

† See Budget narrative for year three proposal.

VII. INTERVENTION SUBCOMMITTEE

The Intervention Subcommittee consists of the two workgroups a) the Educational presentation Workgroup; and, b) the Postvention Workgroup (see appendix B for members list).

Over all purpose: *To develop and implement successful strategies for preventing self-inflicted deaths through education of individuals and groups at high risk of suicide and to transform public perceptions to view mental and substance use disorders as real illnesses, equal to physical illnesses, that respond to specific treatments.*

The work of the Intervention Subcommittee has been guided by the following goals adapted from the National Strategy for Suicide Prevention, 2001.

Goal 4: Develop and implement suicide prevention programs
Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm
Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment
Goal 7: Develop and promote effective clinical and professional practices
Goal 8: Improve access to and community linkages with mental health and substance abuse services

YEAR TWO GOALS AND OBJECTIVES:

GOALS:
Goal #1:Develop a suicide prevention educational program targeting those who work with youth and aging risk groups in the community
Goal#2: Increase access to appropriate mental health services among people at risk of suicide
Goal#3*: Reduce the number of self-inflicted deaths that occur among survivors of suicide

OBJECTIVES:
- Develop an educational slide presentation and train persons who will present information to community groups
- Coordinate with NEA in development of training for teachers concerning suicide risk, prevention, and referral to treatment for underlying mental disorders
- Consult with physician groups to identify interventions for patients who are considered to be at high-risk for suicide and, in coordination with the Behavioral Sciences Regulatory Board, use these to develop methods to enhance intervention skills for professionals
- Establish and present an official SPTF position regarding the need for appropriate lengths of stay in structured/protective environments among persons at immediate risk of suicide
- Establish and present an official SPTF position regarding the need for appropriate integrated array of services following structured/protective stay

*Deferred to the methodology Subcommittee by the Sedgwick County Suicide Prevention Task Force.

OBJECTIVES (Cont'd):

- Develop a postvention process for educating and serving the mental health needs of family members and other survivors of suicide in order to reduce risk among this vulnerable group

YEAR TWO ACTIVITIES:

- Completed the development of educational slide presentation on suicide prevention
- Trained interested members of the SPTF and subcommittees to make this educational presentation to the community
- Trained representatives from the Department of Aging to make presentations in the community
- In conjunction with the Awareness Subcommittee, gave a total of 10 formal and 10 collateral presentations
- Established a new work group in August to develop an official SPTF position statement regarding the need for: (1) appropriate lengths of stay in structured/protective environments among persons at immediate risk of suicide; and, (2) an appropriate integrated array of services following upon a structured/protective stay
- Representatives from USD 259 and COMCARE obtained training on the Yellow Ribbon Program in Colorado in November of 2002
- Met with the representatives of current support groups in the county and recommended the development of an additional support group for suicide survivors
- Developed a draft of a brochure to be distributed among suicide survivors

ACTIVITIES PLANNED FOR YEAR THREE† :

- Continue to update educational slide presentation and continue to train persons who will present information to community groups
- Continue to support the Department of Aging in giving presentations
- Continue to give collateral presentations to community groups
- Coordinate with NEA in development of a training track for teachers concerning suicide risk, prevention, and referral to treatment for underlying mental disorders with the implementation of the Yellow Ribbon Program
- Create a position statement and with support of the SPTF, distribute the position statement to providers, key legislators and advocacy groups regarding appropriate length of stay among persons at immediate risk of suicide
- Establish a "survivors of suicide" facilitated support group designed for immediate assistance following a suicide
- Distribute 2,500 postvention brochures to survivors and to community groups with whom they come in contact
- Provide necessary support to USD 259 in the implementation of Yellow Ribbon Program

† See Budget narrative for year three proposal.

VIII. METHODOLOGY SUBCOMMITTEE

Overall Purpose: *Seek ways to identify and address common data needs of providers of suicide-related services; provide technical support in program evaluation and testing of intervention strategies to other SPTF subcommittees; provide coordination for work of the Task Force; and, design and pilot a study to better understand risk and protective factors in individuals who commit suicide.*

The work of the Methodology Subcommittee has been guided by the following goals adapted from the National Strategy for Suicide Prevention, 2001.

Goal 10: Promote and support research on suicide and suicide prevention
Goal 11: Improve and expand surveillance systems

YEAR TWO GOALS AND OBJECTIVES:

GOALS:

Goal#1: Create design for study of risk and protective factors associated with suicidal behavior, including ways to reduce subsequent self-inflicted death by distraught survivors

Goal#2: Continue creation of literature archive for use by all members of the SPTF and interested public

Goal#3: By request, provide expertise in study design, sample selection and statistical analysis to other SPTF subcommittees in support of program evaluation, intervention design and grant preparation activities

Goal#4: Assist with creation of integrated activity set for selected risk groups

Goal#5: Begin work on study of needs of providers for data regarding suicide and suicidal behavior (admitted as too costly and time consuming)

Goal#6: Seek ways to prepare clinical research and intervention teams for partnership work with survivors and first responders

Goal#7: Seek external funding for science-based studies on reduction and prevention of suicide and suicidal behavior

Goal#8: Explore ways to extend to the larger provider community training and education regarding improved interventions and postvention activities

Goal#9: Manage project

OBJECTIVES:

- Search scientific works, professional journals and database collections. Obtain copies for use in designing studies and program interventions
- Serve as consultants at the request of the Awareness and Intervention Subcommittees
- In consultation with local health, public health and mental health professionals, design series of longitudinal studies focusing on understanding risk and protective factors
- Coordinate study partnerships

OBJECTIVES (Cont'd):

- Conduct pilot of psychological autopsy instruments among members of appropriate survivors' group
- Attend workshops led by recognized experts on rapid response intervention and data collection in preparation for psychological autopsy studies
- Work with SPTF Intervention Subcommittee to develop process for follow-up of postvention activities
- Prepare and submit at least one grant application
- Work with Behavioral Sciences Regulatory Board to develop policy regarding continuing education on suicide and suicidal behavior
- Provide oversight of personnel and products, including budgeting and preparation of periodic reports to SPTF and BOCC

YEAR TWO ACTIVITIES:

- Obtained new insight regarding the sensitivity of the subject and challenges that might be encountered in future, with materials brought by the subcommittee chair from the 2001 American Association of Suicidology conference held in Bethesda, Maryland
- Refined the initial research design to incorporate both an examination of the trajectory of survivor recovery as well as a rich portrait of suicide victims
- Developed and catalogued a growing archive of articles about various facets of risk and protective factors in suicide and suicidal behavior
- Identified several training workshops that would be suitable for training in postvention response situations
- Furnished resources for identifying potential partner groups of survivors
- Submitted a proposal for a pre-postvention study to the Sunflower Foundation (not funded)
- Obtained national suicide statistics for year 2000 and state and county suicide statistics for year 2001
- Evaluated various instruments from Sedgwick County Regional Forensic Science Center, conferences and other sources for use in our proposed studies

ACTIVITIES PLANNED FOR YEAR THREE† :

- Finalize and pilot instruments for series data collection
- Continue searching for external funding for crucial training of team that will conduct study of suicide survivors
- Continue to expand literature archive for use by researchers, clinicians and interested community members
- Identify members willing to be part of the first responder team data observation and formalize a training curriculum to prepare them for this task
- Provide issue-based content each month or as requested, for the SPTF web site
- Provide technical assistance for the other subcommittees

† See Budget narrative for year three proposal.

IX. SUMMARY

- Suicide is a troubling, but potentially preventable and extremely important public health issue for the residents of Sedgwick County irrespective of race, sex, or age.
- In Sedgwick County alone, on average, 50 lives are lost annually to suicide. One out of every six suicides that occur in Kansas is attributed to Sedgwick County.
- It is the goal of the Sedgwick County Suicide Prevention Task Force (SPTF) to reduce the rate of suicides from the current level of 12.9 per 100,000 to 6.0 per 100,000 by the year 2010.
- The SPTF endorses the findings of The Interim Report of the President's New Freedom Committee On Mental Health which identify *the failure to set "mental health and suicide prevention as national priorities"* as a key barrier to care within the mental health system. The Interim Report further labels the nation's failure to prioritize mental health and suicide prevention as a national tragedy.
- The Task Force has identified similar roadblocks in its efforts to reduce the number of self-inflicted deaths in Sedgwick County. The SPTF plans to continue increasing awareness in the communities by: (1) identifying and refining ways to reach target populations and community at large, and (2) to assist people to reach out and seek help.
- The SPTF intends to work towards an improved, specific and sufficient access to the mental health services required by the family members and survivors of suicide.
- The SPTF intends to continue long-term research on suicide to reduce the number of self-inflicted deaths and to better understand the healing process of suicide survivors.

X. RECOMMENDATIONS

Taking a cue from the Interim Report of the President's New Freedom Commission on Mental Health 2002, suicide rates in Sedgwick County can be reduced by

- Continuing to provide strong leadership at the top level with a comprehensive broad-based community approach. Such an approach has the potential to save lives in many settings: in colleges, and universities, faith communities, businesses, health and social service agencies and schools by sending messages across communities that reaching out for help is not a weakness.

- Overcoming the barriers to appropriate mental health and suicide prevention services. Sedgwick County is well on its way to becoming an exemplar in the development and testing -of prevention programs that blend the wisdom of modern science with the compassion of skilled professionals.

REFERENCES

- The Surgeon General's *Call to Action* to Prevent Suicide, 1999
  U.S Public Health Service, Washington, DC.
- National Strategy for Suicide Prevention: Goals and Objectives for Action, 2001
  U.S Department of Health and Human Services, Public Health Service
  Rockville, MD.
- The source for national suicide data is USA Suicide: 2000 published by the American Association Of Suicidology.
- The source for Kansas and Sedgwick County data is the Center for Health and Environmental Statistics, Kansas Department of Health and Environment.
- Interim Report of the President's New Freedom Commission on Mental Health, 2002.
- Reducing Suicide: A National Imperative 2002.

APPENDIX A

SEDGWICK COUNTY SUICIDE PREVENTION TASK FORCE MEMBERS

MEMBERS	ORGANIZATION
Baalman, Beverly	COMCARE of Sedgwick County
Bomhoff, Kevin (CHAIR)	Wichita State University
Burghart, Jon	COMCARE of Sedgwick County
Burns, Robert	Sedgwick County Sheriff department
Casey, Harold	SAACK
Class, Randy (VICE- CHAIR)	Family Consultation Services
Collins-Thoman, Christine	Via-Christi, Behavioral Health Good Shepherd Campus
Donaldson, Deborah	Div. of Human Services, Sedgwick County
Frantz, Gerald	Sedgwick County Public Health Department
Kellerman, Rick	University of Kansas School of Medicine
McGinniss, Liz	Wichita Public Schools
Mohr, Rose Mary	Mental Health Association
Moses, Terri	Wichita Police Department
Navarro, Mary	Wichita Public Schools
Preskorn, Sheldon	Psychiatric Research Institute
Pickard, Toni	Wichita State University
Reed, Carla	SRS Kansas
Rush, Bill	COMCARE Mental Health Advisory Board
Steelberg, Elsie	Prairie View
Sullivan, John	SRS Kansas

APPENDIX B

AWARENESS SUBCOMMITTEE MEMBERS

MEMBERS	ORGANIZATION
Alexander,Kelly	SRS Kansas
Baalman, Beverly	COMCARE of Sedgwick County
Batt, Vivian	COMCARE of Sedgwick County
Benoit,Jennifer	Regional Prevention Center
Cissell, Monica	Sedgwick County Aging Department
Collins-Thoman, Christine	Via-Christi, Behavioral Health Good Shepherd Campus
Flax, Jim	Wichita Public Schools
Frey, Kendra	Clientifica, Inc
Friesen, Sara	Psychiatric Research Institute
Gregory, Tara	Regional Prevention Center
Harris, Marla	McConnell Air Force Base
Hixson, Janice	NAMI
Huebert, Cornelia	The Mental Health Association of South Central Kansas
Jabara, Mary	Goddard Public Schools
Kleinsorge, Kim	Sedgwick County Sheriff
Moses, Terri	Wichita Police Department
Murray, Terry	Kansas National Guards
Payton, Stephanie	Sedgwick County Division of Human Services
Pote, Edwina	Sedgwick County Fire Department
Sullivan, John	SRS Kansas
Sullivan, Linda	Wichita Public Schools
Willsie, Debbie	SRS Kansas

STIGMA WORKGROUP

MEMBERS	ORGANIZATION
Baalman, Beverly	COMCARE of Sedgwick County
Moses, Terri	Wichita Police Department
Pote, Edwina	Sedgwick County Fire Department
Sullivan, John	SRS Kansas
Sullivan, Linda	Wichita Public Schools

PUBLIC AWARENESS/RESOURCES WORKGROUP MEMBERS

MEMBERS	ORGANIZATION
Baalman, Beverly	COMCARE of Sedgwick County
Batt, Vivian	COMCARE of Sedgwick County
Cissell, Monica	Sedgwick County Aging Department
Flax, Jim	Wichita Public Schools
Frey, Kendra	Clientifica, Inc.
Gregory, Tara	Regional Prevention Center
Harris, Marla	McConnell Air Force Base
Murray, Terry	Kansas National Guards
Willsie, Debbie	SRS Kansas

MEDIA WORKGROUP

MEMBERS	ORGANIZATION
Baalman, Beverly	COMCARE of Sedgwick County
Gregory, Tara	Regional Prevention Center
Jabara, Mary	Goddard Public Schools
Moses, Terri	Wichita Police Department

INTERVENTION SUBCOMMITTEE MEMBERS

MEMBERS	ORGANIZATION
Alter, Kristin	COMCARE of Sedgwick County
Burghart, Jon	COMCARE of Sedgwick County
Capps, George	Park City Police Department
Casey Harold	SAACK
Steelberg, Elsie	Prairie View, Inc

EDUCATIONAL PRESENTATION WORK GROUP

MEMBERS	ORGANIZATION
Casey Harold	SAACK
Burghart, Jon	COMCARE of Sedgwick County

POSTVENTION WORK GROUP

MEMBERS	ORGANIZATION
Alter, Kristin	COMCARE of Sedgwick County
Burghart, Jon	COMCARE of Sedgwick County
Capps, George	Park City Police Department
Casey Harold	SAACK
Steelberg, Elsie	Prairie View, Inc

METHODOLOGY SUBCOMMITTEE MEMBERS

MEMBERS	ORGANIZATION
Beck, Shari	Sedgwick County Regional Forensic Science Center
Benson, Christine H	Mc Connell Air Force Base
Davis, Steve	Prairie View, Inc
Grinage, Bradley	University of Kansas School of Medicine, Wichita
Hawley, Gary	COMCARE of Sedgwick County
Moyer, Carol	KDHE
Pickard, Toni	Wichita State University
Swan, James H.	Wichita State University
Swan, Sandy	Via-Christi
Ticer-Voth, Colleen	Via-Christi
Sankara, Ishwara Raghu Prashanth	Wichita State University
Agrawal, Neetika	Wichita State University
Guduguntla, Chakradhar	Wichita State University

APPENDIX C

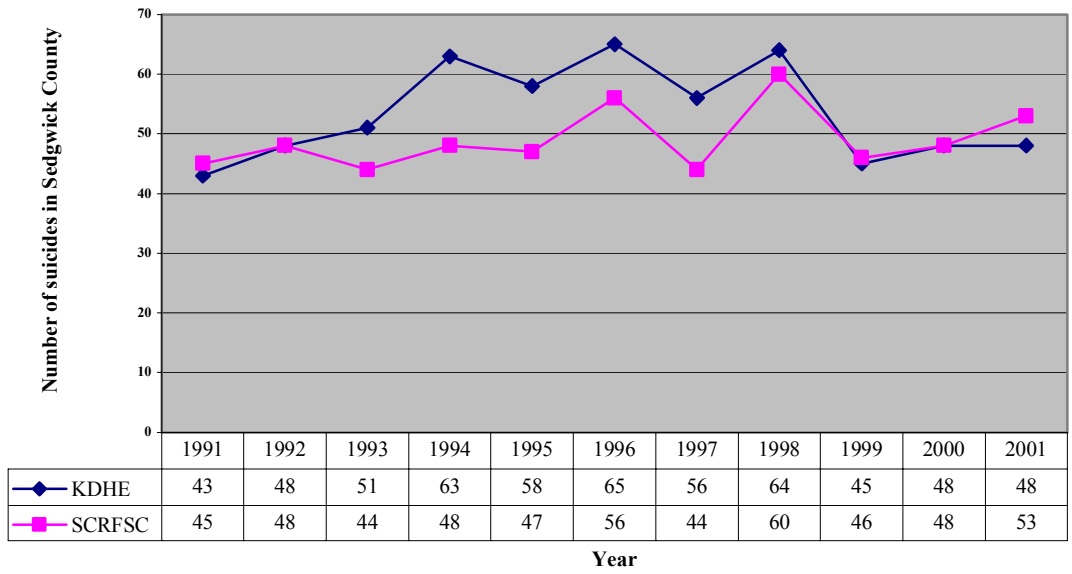
GLOSSARY

BSRB	Behavioral Sciences Regulatory Board
CEU	Continuing Education
CMHC	Community Mental Health Center
CPAAA	Central Plains Area Agency on Aging
COMCARE	Comprehensive Community Care of Sedgwick County
DCCCA	Douglas County Citizen Committee on Alcoholism
ED	Emergency Department
EAP	Employee Assistance Program
EMS	Emergency Medical Services
IOM	Institute Of Medicine
KDHE	Kansas Department of Health and Environment
KDOA	Kansas Department on Aging
KPTS	Kansas Public Telecommunications Service
NAMI	National Alliance for the Mentally Ill
NEA	National Education Association
NSSP	National Strategy For Suicide Prevention
PCP	Primary Care Physician
PSA	Public Service Announcement
PTA	Parent Teachers Association
RFP	Request for proposal
SAACK	Substance Abuse Assessment Center of Kansas
SAMHSA	The Substance Abuse and Mental Health Services Administration
SCRFSC	Sedgwick County Regional Forensic Science Center
SRS	Kansas Department of Social and Rehabilitation Services
USD	Unified School District
VCRMC	Via-Christi Regional Medical Center
WSU	Wichita State University

APPENDIX D
SEDGWICK COUNTY SUICIDE DATA

- There are two sources to obtain the Sedgwick County suicide data. The first source is the Sedgwick County Regional Forensic Science Center (SCRFSC), and the second one is the Center for Health and Environmental Statistics, Kansas Department of Health and Environment (KDHE).

- Both the KDHE and SCRFSC data originate from death certificates obtained in Sedgwick County. However, there exist significant disparities manner in which each source classifies suicide events.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
KDHE	43	48	51	63	58	65	56	64	45	48	48
SCRFSC	45	48	44	48	47	56	44	60	46	48	53

- KDHE assigns a suicide death to a particular county based on the victim's place of residence.

- Conversely, SCRFSC records suicides according to the county in which the self-inflicted death occurred.

- KDHE does not currently breakout suicides by people of Hispanic/Latino heritage. SCRFSC reports that 1 of 53 suicides recorded by them as occurring in Sedgwick County during 2001 was attributed to a Hispanic/Latino individual.

APPENDIX E

NATIONAL STRATEGY FOR SUICIDE PREVENTION (NSSP) GOALS FOR ACTION 2001

The National Strategy for Suicide Prevention's 11 goals and 68 objectives are subdivided into categories of awareness, intervention and methodology (AIM). The NSSP urges the local, state and federal levels to follow this approach.

AWARENESS: Appropriately broaden the public's awareness of suicide and its risk factors

Goal 1: Promote awareness that suicide is a preventable public health problem

Goal 2: Develop broad-based support for suicide prevention

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

INTERVENTION: Enhance services and programs, both population-based and clinical care

Goal 4: Develop and implement suicide prevention programs

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

Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment

Goal 7: Develop and promote effective clinical and professional practices

Goal 8: Improve access to and community linkages with mental health and substance abuse services

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

METHODOLOGY: Advance the science of suicide prevention

Goal 10: Promote and support research on suicide and suicide prevention

Goal 11: Improve and expand surveillance systems

Adapted from *The National Strategy For Suicide Prevention, 2001*

APPENDIX F

KANSAS STATE SUICIDE PREVENTION PLAN (DRAFT)

AWARENESS: Appropriately broaden the public's awareness of suicide and its risk factors:

1. **Promote public awareness that suicide is a public health problem and as such, many suicides are preventable. Use information technology appropriately to make facts about suicide and its risk factors and prevention approaches available to the public and to health care providers**

Strategies:

- Kansas State "Suicide Awareness Month"
- Publicize through the school system; notes home to parents about the signs and symptoms of depression in children, PTA speakers from the state speaker's bureau about suicide and stress in children
- Billboards
- Video about suicide that could be shown to groups
- Shorter videos about suicide for TV public announcements-have a TV station adopt this as an issue
- Radio public announcements

2. **Expand awareness of and enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment**

Strategies:

- Work with community and professional groups
- Ask Kansas Mental Health Centers to offer "suicide prevention "or "depression prevention" workshops in schools and /or to community groups such as the Chamber of Commerce, the Young Matrons, etc
- Provide professional training in a variety of cities across the state about suicide, its prevention, and state resources (Speaker's Bureau)
- Develop a brochure that can be given to not-for-profit organizations and CMHCs about what to do/where to go if suicidal

3. **Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeing help for such problems**

Strategies:

- Develop a slogan for the state about mental illness; use a contest for middle school children or tie in with National Mental Health Month or National Depression Awareness Month

Adapted from *Kansas Suicide Prevention Steering Committee Website: http//www.kasp.org/suicide/*

INTERVENTION: Enhance services and program, both population-based and clinical care

1. **Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk**
2. **Increase the referral to specialty care when appropriate**

Strategies:

- Convene state's insurance companies to help develop strategies to focus on this issue
- Clearly identify further steps for PCPs when faced with the suspicion of a behavioral health or substance abuse disorder
- Clearly identify further steps for PCPs when identifying a suicidal individual

3. **Institute training for all health, mental health substance abuse and human services professionals about suicide risk assessment and recognition, treatment, managements and aftercare interventions**

Strategies:

- Develop statewide conference
- Work with BSRB to make suicide prevention CEUs a requirement for mental health professionals
- Work with the NEA state chapter or associated organization to develop a training track for teachers about suicide

METHODOLOGY: Advance the science of suicide prevention

1. **Enhance research to understand risk and protective factors related to suicide, interactions and effects on suicidal behaviors. Increase research on effective suicide prevention programs, clinical treatments for suicidal individuals and culture specific interventions**

Strategies:

- Identify a funding source to aid in the development of statewide programs
- Create and distribute an RFP for program development and innovate clinical approaches

2. **Develop additional scientific strategies for evaluating suicide prevention interventions and ensure that evaluation components are included in all suicide prevention programs**

Strategies:

- As in 1 above
- Also, work with the departments of psychology, social work, or counseling at state universities to encourage research in the area of program evaluation

3. **Encourage the development and evaluation of new prevention technologies, including firearm safety measures, to reduce easy access to lethal means of suicide**

Strategies:

- Identify state experts in the area of Suicidology
- Identify a state legislator interested in behavioral health issues
- Working with these individuals, facilitate the creation of regulations related to pharmacy procedures and firearm safety

Adapted from *Kansas Suicide Prevention Steering Committee Website: http//www.kasp.org/suicide/*

APPENDIX G
Budget Request for Year Three