Pennsylvania Adult Suicide Prevention Plan

Department of Public Welfare **Department of Health**

Department of Aging

To the Citizens of Pennsylvania:

We are pleased to present the Pennsylvania Adult and Older Adult Suicide Prevention Plan. Suicide claims the lives of over 1300 Pennsylvanians each year; that is an average of 3.5 lives each day. It is estimated that each suicide directly affects six people; therefore, over 7800 Pennsylvanians become survivors of suicide each year.

Former U.S. Surgeon General David Satcher presented the Call to Action to Prevent Suicide in 1999 in which he stated that the problems of suicide and suicide prevention are critical public health priorities for our nation. The National Strategy for Suicide Prevention debuted in 2001.

The Advisory committee of the Office of Mental Health and Substance Abuse Services (OMHSAS) prioritized a state suicide prevention plan as one of the major goals for OMHSAS. A workgroup was formed and began to meet in July 2005. This prevention plan is a collaborative effort between those dedicated individuals from both the public and private sectors of our state. The workgroup is striving to raise awareness about suicide and its prevention so that fewer Pennsylvanians experience the pain and grief resulting from the suicide death of a loved one.

On behalf of the Commonwealth of Pennsylvania we would like to thank the many who have put time and energy into this important initiative.

Estelle Richman	Nora Dowd Eisenhower	Calvin B. Johnson
Secretary of Public Welfare	Secretary of Aging	Secretary of Health

Lifekeeper Promise

Someone we love
Did not keep their life
In pain and anguish
They ended their strife

In this lifetime on Earth
We'll see them no more
Yet we carry them always
In our soul, in our core

Now we're left here
And we must stay
We have Life to live
To the fullest each day

For we are the Lifekeepers
A promise we make
To celebrate their Lives
Our own not to take

We are the Lifekeepers
Truth Bearers, Peace Seekers
We are the Wounded
We are the Healed
We are the Lifekeepers
Our commitment now sealed

written by Sandy Martin

About Adult Suicide: A Parent's Perspective

One of the realities of suicide prevention in the Commonwealth of Pennsylvania, and in all of its counties and municipalities, is that there will be no significant impact on the occurrence of suicide unless preventative efforts are pervasively and aggressively directed at adults, particularly adult males. One of the ironies of suicide prevention is that, with very few exceptions, little suicide prevention is directed at adults, and, outside of the military, the correctional system, and the Veterans Administration, there have been few meaningful attempts to reduce the incidence of suicide among men. This plan speaks to that need. It is a positive, long-awaited, and necessary step towards addressing the problem of adult suicide in every community in Pennsylvania.

I care a lot about adult suicide prevention. I even have some data on adult suicide on a bulletin board hanging next to my desk at my office. On this single sheet of paper are statistics downloaded many years ago from the Centers for Disease Control (CDC) web site. The data tables report US suicides for 1996 by age and gender. There's a small checkmark next to the total deaths for males ages 25-29. That year 2361 men in that age group completed suicide. I knew the guy on the end. His name was Paul, our oldest child, and he was 28 when we lost him in November 1996.

I look at those numbers every work day and I think about Paul. For a few moments the enormity of his loss and the severity of its after effects hit me, and the pain, the sadness, and the regrets sweep over me. Most of the time I quickly get back to the present and move on with my day. Yet I have not moved on or gotten over our loss, but somewhere in the intervening years I did recover from it. This is not the same thing as "healing," a term that, in my mind, equates a traumatic loss to a cut finger. I have rebuilt my life around my loss and I now live a "new normal," though one touched every day by the heavy shadow of suicide.

I often think of those grieving the other 2360 young men who completed suicide that sad year. Alone they may have left 14,000 to 19,000 people behind – parents, siblings, spouses, children, partners, and others who reflect the true scale and cost of adult suicide to society. I wonder if they too have achieved some measure of recovery. I wonder how many are dealing with depression, grief reactions, and other byproducts of suicide loss. I think of those still beset by guilt and those who continuously ask "why" or "what if" and those who forever replay things said or not said. I wonder how many are aware that their loss has increased their own risk of suicide. I wonder how many subsequent suicides, youth, adult, and elder, are linked to those yellowing CDC statistics.

As I turn away I am again reminded that there is nothing final about any suicide and I am reenergized to do something about it as the source of so much loss of life and so much enduring suffering. This plan aids that task. It defines the problem of adult suicide and outlines a broad strategy for government agencies at every level, community groups, educational institutions, the criminal justice system, businesses, health care and behavioral health providers, human service agencies, and individual citizens to play a role in reducing the incidence of suicide among the adult residents of our state. This

document can increase public awareness of the risk and preventability of suicide, drive greater knowledge of the warning signs of suicide, and, hopefully, spur development of more prevention, crisis intervention, and postvention resources to help those beset by suicidal thoughts and behavior and those coping with the aftermath of suicide. Let's do it!

Tony Salvatore
Springfield, PA
March 2006

Introduction

Both national and State suicide statistics reinforce the need for suicide prevention efforts. In 2003 PA had 1330 deaths by suicide; this is an average of over 3 deaths by suicide every day. About twice as many Pennsylvanians died by suicide than homicide. It is estimated that each suicide directly affects 6 people; in 2003 over 7800 Pennsylvanians became survivors of suicide. Suicide is one of the most preventable deaths, yet tragically most of these deaths still occur. In recognition of the problem, PA formed an Adult/Older Adult Suicide Prevention workgroup in July 2005 to develop a State Plan. The workgroup decided to use the "National Strategy for Suicide Prevention: Goals and Objectives for Action" as a template. PA has adopted the 11 National Goals and adaptations of the objectives.

Benefits of a State Plan

- Raise awareness and help make suicide prevention a statewide priority. This can help direct resources of all kinds to the issue
- Provide opportunities to use public-private partnerships and the energy of survivors to engage people who may not consider suicide prevention part of their mission. A state plan supports collaboration across a broad spectrum of agencies, institutions groups, and community leaders as implementation partners.
- Link information from many prevention programs to avoid unintentional duplication and share information about effective prevention activities.
- Direct attention to measures that benefit all people in PA and, by that means, reduce the likelihood of suicide, before vulnerable individuals reach the point of danger.

Putting the plan to work

The keystone of the plan is implementation; this is where you can make a difference. In addition to the work of state agencies, implementing the plan will require broad participation and collaboration from individuals and groups in local communities. Professionals and community volunteers must work side-by-side, and public agencies and private organizations will have to expand their partnerships to make a difference in suicide prevention.

Several broad public health themes are valuable considerations as groups and individuals move forward in designing and strengthening suicide prevention activities.

- Draw attention to a wide range of actions so that specific activities can be developed to fit the resources and areas of interest of people in everyday community life as well as professionals, groups, and public agencies. Suicide prevention is everyone's business.
- Seek to integrate suicide prevention into existing health, mental health, substance abuse, education, and human service activities. Settings that provide related services, such as schools, workplaces, clinics, medical offices, correctional and detention centers, eldercare facilities, faith communities, and community centers are all important venues for seamless suicide prevention activities.

- While population-based interventions are applicable without regard to risk status, it does not mean that one size fits all. The cultural and developmental appropriateness of suicide prevention activities derived from the plan are a vital design and implementation consideration.
- Seek to eliminate disparities that erode suicide prevention activities. Health care disparities are attributable to such differences as race or ethnicity, gender, education or income, disability, age, stigma, sexual orientation, or geographic location.
- Emphasize early interventions to promote protective factors and reduce risk factors for suicide. Progress depends on measures that address problems early so that fewer people become suicidal.

The five-step public health model is outlined here. It links defining the problem, identifying risk and protective factors, developing and testing interventions, implementing, and evaluating interventions. The steps can and often do occur at the same time and depend on one another.

Step 1: **Defining the problem**

Surveillance is the ongoing process of collecting information about the "who, what, when, where, how, and how many" of suicide. For example:

- In 2002 there were 1,326 deaths by suicide in PA
- In 2002 firearms accounted for 68.7% of deaths by suicide for those aged 65 and older
- In 2002 suicide was the second leading cause of death for ages 25-34 years in PA

Step 2: Identifying Causes through Risk and Protective Factors Research

Risk factors may be thought of as leading to or being associated with suicide. Protective factors reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. The following risk and protective factors are identified in the *National Strategy Prevention for Suicide: Goals and Objectives for Action.*

RISK FACTORS FOR SUICIDE

Biological, Psychological and Social Risk Factors

- Previous suicide attempt
- Mental disorders-particularly moods disorders such as depression and bipolar disorder, anxiety disorders, schizophrenia, and certain personality disorder diagnoses
- Alcohol and substance abuse disorders
- Family history of suicide
- History of trauma or abuse
- Hopelessness
- Impulsiveness and/or aggressive tendencies
- Some major physical illnesses

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs-for instance, the belief that suicide is a noble resolution of a personal dilemma
- Exposure to the influence of others who have died by suicide, including media exposure

PROTECTIVE FACTORS FOR SUICIDE

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Step 3: Develop and Test Interventions

Interventions are actions or programs which can reduce the impact of risk factors or support protective factors. Definitive pilot studies are frequently missing for many types of social and mental health interventions. Therefore, program planners may incorporate "promising" interventions into community plans before the evidence base is fully developed.

Step 4: **Implement Interventions**

Principles to keep in mind:

- Suicide prevention programs should coordinate with other prevention efforts, such as substance abuse.
- Programs must address the needs of people in each stage of life.
- Programs must be culturally sensitive.
- Prevention programs are more effective when they are long-term, with opportunities for reinforcement of attitudes, behaviors, and skills.
- Each community must develop a program that meets local needs and builds on local strengths

- Program planning should represent the community with respect to age, ethnicity, faith, occupation, sexual orientation, socioeconomic status, and cultural identity.

Step 5: **Evaluate Effectiveness**

A community should build in an evaluation to determine whether any intervention selected works under local conditions. Determining the costs associated with sustaining programs and comparing those costs to the benefits of the programs is another important aspect of evaluation.

- **Pennsylvania Strategy for Adult Suicide Prevention: Goals and Objectives**

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

In a democratic society, the stronger and broader the support for a public health initiative, the greater its chance for success. If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, the suicide rate can be reduced.

The objectives established for this goal are focused on increasing the degree of cooperation and collaboration between and among public and private entities that have made a commitment to public awareness of suicide and suicide prevention. They include:

- Developing public education campaigns
- Sponsoring national/statewide conferences on suicide and suicide prevention
- Organizing special-issue forums, and
- Disseminating information through the internet.

ACTION IDEAS:

- Develop information materials that can be distributed. Materials should describe suicide risk and protective factors, available community resources, and how to join in prevention efforts.
- Hold regional forums to present the Plan and provide information and encouragement.

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

Because there are many paths to suicide, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups-from schools to faith –based organizations to health care associations is a way to ensure that prevention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than these groups working alone. Public/private partnerships that evolve from collaboration are able to blend resources and build upon each group's strengths. Broad-based support for suicide prevention may also lead to additional funding, through governmental programs as well as private philanthropy, and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed it.

The objectives established for this goal are focused on developing collective leadership and on increasing the number of groups working to prevent suicide. They will help ensure that suicide prevention is better understood and that organizational support exists for implementing prevention activities. The objectives include:

- Organizing a State interagency committee to improve coordination and to ensure implementation of the Pennsylvania Strategy
- Establishing public/private partnerships dedicated to implementing the Pennsylvania Strategy

- Increasing the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities, and
- Increasing the number of faith based communities that adopt policies designed to prevent suicide.

ACTION IDEAS:

- Visit leaders of community groups, such as churches, United Way, senior centers, etc.. to engage their participation and support in integrating suicide prevention into ongoing programs. This should include other prevention programs, such as substance abuse, gambling addiction, child abuse, etc…
- Recruit and train at least one member of each community in PA to be a community organizer 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**

Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. However, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; they fear prejudice and discrimination. The stigma of suicide itself, the view that suicide is shameful and/or sinful, is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. Family members of suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved one suffer not only the grief of loss but often the added pain stemming from stigma.

Historically, the stigma associated with mental illness, substance abuse, and suicide has contributed to inadequate funding for preventive services and to low insurance reimbursements for treatments. It has also resulted in the establishment of separate systems for physical health and mental health care. One consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems. Moreover, this separation has led to bureaucratic and institutional barriers between the two systems that complicate the provision of services and further impede access to care. Destigmatizing mental illness and substance use disorders could increase access to treatment by reducing financial barriers, integrating care, and increasing the willingness of individuals to seek treatment.

The objectives established for this goal are designed to create the conditions that enable persons in need of mental health and substance abuse services to receive them. They include:

- Increasing the number of suicidal persons with underlying mental disorders who receive appropriate mental health treatment, and
- Transforming public attitudes to view mental and substance use disorders as real illnesses, equal to physical illness, that respond to specific treatments and to view persons who obtain treatment as pursuing basic health care.

ACTION IDEAS:

- Develop a public awareness campaign including, educational presentations, around mental illness.

- Ensure that mental health services are culturally competent.

Goal 4: **Develop and Implement Suicide Prevention Programs**
Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources. The public health approach provides a framework for developing preventive interventions. Programs may be specific to one particular organization, such as a university or a community health center, or they may encompass an entire State. A special emphasis of this goal is that of ensuring a range of interventions that in concert represent a comprehensive and coordinated program.
The objectives established for this goal are designed to foster planning and program development work and to ensure the integration of suicide prevention into organizations and agencies that have access to groups of individuals for other purposes. The objectives also address the need for systematic planning at both the State and local levels, the need for technical assistance in the development of suicide prevention programs, and the need for ongoing evaluation. Objectives include:

- Increasing the proportion of local communities with comprehensive suicide prevention plans
- Increasing the number of evidence-based suicide prevention plans in schools, colleges, work sites, correctional institutions, aging programs, and family, youth and community service programs, and
- Developing technical support centers to build the capacity across the state to implement and evaluate suicide prevention programs.

ACTION IDEAS:
- Identify a lead organization to coordinate efforts.
- Assess existing plans to identify areas for improvement.

Goal 5: **Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm**
Evidence from many countries and cultures shows that limiting access to lethal means of self-harm may be an effective strategy to prevent self-destructive behaviors. Often referred to as "means restriction," this approach is based on the belief that a small but significant minority of suicidal acts are, in fact, impulsive and of the moment; they result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, a self-destructive act may be prevented by limiting the individual's access to the means to self-harm. Evidence suggests that there may be a limited time effect for decreasing self-destructive behaviors in susceptible and impulsive individuals when access to the means for self-harm is restricted.
Controversy exists about how to accomplish this goal because restricting means can take many forms and signifies different things to different people. For some, means restriction may connote redesigning or altering the existing lethal means of self-harm currently available, while to others it means eliminating or limiting their availability.

The objectives established for this goal are designed to separate in time and space the suicidal impulse from access to lethal means of self-harm. They include:

- Educating health care providers and health safety officials on the assessment of lethal means in the home and actions to reduce suicide risk
- Implementing a public information campaign designed to reduce accessibility of lethal means
- Improving firearm safety design, establishing safer methods for dispensing potentially lethal quantities of medications and seeking methods for reducing carbon monoxide poisoning for automobile exhaust systems, and
- Supporting the discovery of new technologies to prevent suicide.

ACTION IDEAS:

- Encourage medical personnel to routinely ask about the presence of lethal means of self-harm in the home.
- Educate family members on how to appropriately store and secure lethal means of self-harm.

Goal 6: **Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment**

Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients in need of these specialized assessment techniques and treatment approaches. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Key gatekeepers-people who regularly come into contact with individuals or families in distress- need training in order to be able to recognize factors that place individuals at risk for suicide, and to learn appropriate interventions. Key gatekeepers include teachers, clergy, police officers, primary health care providers, mental health care providers, correctional personnel, and emergency health care personnel.

The objectives established for this goal are designed to ensure that health professional and key community gatekeepers obtain the training that will help them prevent suicide. They include:

- Improving education for nurses, physician assistants, physicians, social workers, psychologists, and other counselors
- Providing training for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide, and
- Providing educational programs for family members of persons at elevated risk.

ACTION IDEAS:

- Include workshops on suicide prevention at annual meeting of professional associations.

- Encourage directors of education at professional schools in PA to include suicide prevention training in the curriculum.

Goal 7: **Develop and Promote Effective Clinical and Professional Practices**
One way to prevent suicide is to identify individuals at risk and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g., depressed mood, hopelessness, helplessness, alcohol and other drug abuse, among others). Another way to prevent suicide is to promote and support the presence of protective factors, such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes. By improving clinical practices in the assessment, management, and treatment for individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved. Moreover, promoting the presence of protective factors for these individuals can contribute importantly to reducing their risk.
The objectives established for this goal are designed to heighten awareness of the presence or absence of risk and protective conditions associated with suicide, leading to better triage systems and better allocation of resources for those in need of specialized treatment. They include:

- Changing procedures and/or policies in certain settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings, designed to assess suicide risk
- Incorporating suicide risk screening in primary care
- Ensuring that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)
- Increasing the numbers of persons with mood disorders who receive and maintain treatment
- Ensuring that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services
- Fostering the 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.

ACTION IDEAS:

- Work with hospital associations to develop tracking procedures for mental health follow-up.
- Distribute suicide risk posters for emergency rooms.
- Provide staff in – service training on suicide prevention.
- Sponsor depression screening days.
- Promote guidelines for aftercare treatment programs.
- Organize suicide survivors in the community to provide seminars.

Goal 8: **Improve Access to and Community Linkages with Mental Health and Substance Abuse Services**

The elimination of health disparities and the improvement of the quality of life for all Americans are central goals of Healthy People 2010. Some of these health disparities are attributable to differences of gender, race or ethnicity, education, income, disability, stigma, geographic location, or sexual orientation. Many of these factors place individuals at increased risk for suicidal behaviors.

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside a health plan or insurance program. Structural barriers include the lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers include cultural or spiritual differences, language, not knowing when or how to seek care, or concerns about confidentiality or discrimination. Reducing disparities is a necessary step in ensuring that all Americans receive appropriate physical health, mental health, and substance abuse services. One aspect of improving access is to better coordinate the services of a variety of community institutions. This will help ensure that at-risk populations receive the services they need, and that all community members receive regular preventive health services.

The objectives established for this goal are designed to enhance inter-organizational communication to facilitate the provision of health services to those in need of them. They include:

- Exploring the benefits for health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care
- Implementing utilization management guidelines for suicidal risk in managed care and insurance plans
- Integrating mental health and suicide prevention into health and social services outreach programs for at-risk populations
- Defining and implementing screening guidelines for schools and correctional institutions, along with guidelines on linkages with service providers, and
- Implementing support programs for persons who have survived the suicide of someone close.

ACTION IDEAS:

- Work with county health and social service agencies to address the need for all staff who make visits and/or provide case management services to the elderly to be trained to make appropriate referrals to mental health services.
- Provide training for group facilitators and community meeting spaces for suicide survivor support groups.

Goal 9: **Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media**

The media-movies, television, radio, newspapers, and magazines-have a powerful impact on perceptions of reality and on behavior. Research over many years has found that media representation of suicide may increase suicide rates, especially among youth. "Cluster suicides" and suicide contagion" have been documented, and studies have shown that both news reports and fictional accounts of suicide in movies and on

television can lead to increases in suicide. It appears that imitation plays a role in certain individuals engaging in suicidal behavior.

On the other hand, it is widely acknowledged that the media can play a positive role in suicide prevention, even as they report on suicide or depict it and related issues in movies and on television. The way suicide is presented is particularly important. Changing media representation of suicidal behaviors is one of several strategies needed to reduce the suicide rate.

Media portrayals of mental illness and substance abuse may also affect the suicide rate. Negative views of these problems may lead individuals to deny they have a problem or be reluctant to seek treatment- and untreated mental illness and substance abuse are strongly correlated with suicide.

The objectives established for this goal are designed to foster consideration among media leaders of the impact of different styles of describing or otherwise depicting suicide and suicidal behavior, mental illness, and substance abuse, and to encourage media representations of suicide that can help prevent rather than increase suicide. They include:

- Establishing a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness on television and in movies
- Increasing the number of television programs, movies and news reports that observe recommended guidelines in the depiction of suicide and mental illness, and
- Increasing the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula.

ACTION IDEAS:

- Identify survivors and community advocates who will be active participants in the monitoring group.
- Include survivors and advocates in curriculum development.

Goal 10: **Promote and Support Research on Suicide and Suicide Prevention**

All suicides are highly complex. The volume of research on suicide and its risk factors has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. The important contributions of underlying mental illness, substance use, and biological factors, as well as potential risk that come from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect an individual's risk for suicidal behavior is the next challenge. This understanding can contribute to the limited but growing information about modifying risk and protective factors change outcomes pertaining to suicidal behavior.

The objectives established for this goal are designed to support a wide range of research endeavors focused on the etiology, expression, and maintenance of suicidal behaviors across the lifespan. The enhanced understanding to be derived from this research will lead to better assessment tools, treatments, and preventive interventions. The objectives include:

- Increasing funds for suicide prevention research
- Evaluating preventive interventions, and

- Establishing a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.

ACTION IDEAS:

- Develop and distribute user-friendly toolkits on program evaluation.
- Increase the number of jurisdictions in PA that will collect and provide information on suicides.

Goal 11: **Improve and Expand Surveillance Systems**

Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. They are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions and to assess the impact of prevention efforts.

Data on suicide and suicidal behavior are needed at national, state and local levels. National data can be used to draw attention to the magnitude of the suicide problem and to examine differences in rates among groups (e.g., ethnic groups), locales (e.g., rural vs. urban) and whether suicidal individuals were cared for in certain settings (e.g., primary care, emergency departments). State and local data help establish local program priorities and are necessary for evaluating the impact of suicide prevention strategies.

The objectives established for this goal are designed to enhance the quality and quantity of data available on suicide and suicidal behaviors and ensure that the data are useful for prevention purposes. They include:

- Developing and implementing standardized protocols for death scene investigations
- Increasing the number of hospitals that code for external cause of injuries
- Supporting pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.

ACTION IDEAS:

- Implement a violent death reporting system that includes suicide and collects information not currently available from death certificates.
- Develop a set of community level indicators for progress in suicide prevention.

What is Suicide Postvention?

Postvention describes any form of post-trauma support. Postvention should occur after a suicide. It is the attempt to reduce the negative consequences that may affect those close to the victim after a suicide has occurred.

Postvention includes all interventions that attempt to reduce the negative consequences that may affect those close to the victim after a suicide has occurred. Postvention should begin as soon as possible after the suicide loss.

A suicide is a critical incident. Suicide loss is a crisis. It is an acute response on the part of those close to the victim. It disrupts psychological and physical well being, overrides coping mechanisms, and causes extreme stress and distress.

Postvention is basically a special form of crisis intervention. Its purpose is to deliver acute psychological support, lessen the distress, and help restore coping ability. Effective postvention requires some skill training and an orientation to the effects of a suicide loss.

Postvention is carried out to facilitate the recovery of individuals emotionally devastated by a suicide. Recovery involves eventually rebuilding a normal life around the loss. This may take help and that help is provided through postvention.

There are four objectives to any postvention effort:

- 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 involves (i) providing aid and support with the grieving process and (ii) assisting those who may be vulnerable to anxiety and depressive disorders, suicidal ideation, self-medicating, and other harmful outcomes of severe grief reactions.

Some communities have specialized postvention resources to deliver short-term on-site support and referrals to other community services. However, these resources remain an unmet need in most areas.

Suicide postvention can take two forms. In proactive postvention the program is advised of a suicide (usually by the Medical examiner or Coroner) and reaches out to the family. In reactive postvention referrals and self-referrals are made to the program.

Here are some strategies for meeting this need:

- Victim Services Model: This approach extends the mission of a victim services unit to include suicide postvention. Such entities serve those affected by very traumatic events. They could readily assist those traumatized by suicide.

- Medical Examiner's Office-based Model: Postvention is offered by some Medical Examiner's Offices (e.g., Philadelphia). The ME staff are involved with all suicides and are often in contact with the next-of-kin or others close to the victim.

- Crisis Center Model: The American Association of Suicidology, which accredits crisis centers, promotes their involvement in suicide postvention. These services offer a natural "fit" with their roles in crisis intervention, linkages to mobile crisis services, and working relationships with police and EMTs.

- Agency/Church Model: In some areas social service and mental health agencies and faith-based groups have developed postvention capabilities. These entities may offer support on a long- term basis.

- Trauma Response Model: Postvention may also be offered by community or faith-based groups that help after sudden deaths or disasters. The Tragedy Response Unit Support Team (T.R.U.S.T.) in Blue, Bell, PA is an example.

Each approach has advantages and disadvantages. However, any of these approaches could go far in meeting a critical unmet need in the community.

Populations at Risk

Although suicide reaches across all populations, certain groups experience an increased suicide risk. Tendencies, such as choice of lethal means, also vary among certain groups. Sections addressing some of the issues of these groups are included.

Looking Ahead

The Pennsylvania Strategy for Suicide Prevention creates a framework for suicide prevention for Pennsylvania. It is designed to encourage and empower groups and individuals to work together. The stronger and broader the support and collaboration on suicide prevention, the greater the chance for the success of this public health initiative. Suicide and suicidal behaviors can be reduced as the general public gains more understanding about the extent to which suicide is a problem, about the ways in which it can be prevented, and about the roles individuals and groups can play in prevention efforts.

The Pennsylvania Strategy is comprehensive and sufficiently broad so that individuals and groups can select those objectives and activities that best correspond to their responsibilities and resources. The plan's objectives suggest a number of roles for different groups. Individuals from a variety of occupations need to be involved in implementing the plans, such as health care professionals, police, attorneys, educators, and clergy. Institutions such as community groups, faith-based organizations, and schools all have a necessary part to play. Sites for suicide prevention work include jails, emergency departments and the workplace. Survivors, consumers, and the media need to be partners as well, and governments at the Federal, State and local levels are key in providing funding for public health and safety issues.

Ideally, the Pennsylvania Strategy will motivate and illuminate. It can serve as a model and be adopted or modified by local communities as they develop their own suicide prevention plans. The Pennsylvania Strategy articulates the framework for statewide efforts and provides legitimacy for local groups to make suicide prevention a high priority for action.

The Pennsylvania Strategy encompasses the development, promotion and support of programs that will be implemented in communities across the state designed to achieve significant, measurable, and sustainable reductions in suicide and suicidal behaviors. This requires a major investment in public health action.

Now is the time for making great strides in suicide prevention. Implementing the Pennsylvania Strategy for Suicide Prevention provides the means to realize success in reducing the toll from this important public health problem. Sustaining action on behalf of all Pennsylvanians will depend on effective public and private collaboration because suicide prevention is truly everyone's business.

This is a working document. It is expected to change and further develop over time as new opportunities, participants, research, and conditions arise. Whether you have been involved in the initial development of the plan or are just now joining, you can make a difference by contributing to the plan's continued development.

AT RISK POPULATIONS

Military Suicide Prevention

The Department of Defense (DOD) and all branches of the service are addressing this silent killer by working with researchers, psychologists, psychiatrists, mental health professionals, doctors and others from a wide array of related disciplines.[i] Each service is represented on the DOD Suicide Prevention and Risk Reduction Committee and has developed individualized suicide prevention programs that are available on their websites.

Army
According to Army Deputy Chief of Staff's website the army suicide prevention mission is designed to improve readiness through the development and enhancement of the Army Suicide Prevention Program policies designed to minimize suicide behavior; thereby preserving mission effectiveness through individual readiness for Soldiers, Department of the Army civilians and their families.[ii]
http://www.armyg1.army.mil/hr/suicide.asp

Air Force
The Air Force Suicide Prevention Program (AFSPP) website states their prevention program mission and goals seeks to: Reduce the number and rate of active duty Air Force suicides, Advocate a community approach to suicide prevention, Provide assistance and guidance to organizations and individuals administering various components of the AFSPP and Identify factors contributing to the incidence of suicide and develop a response to reduce the impact of such factors.[iii]
https://www.afms.mil/afspp

Marine Corps
The US Marines Corps Community Services provides a wide range of services to help Marines do everything necessary to complete their mission. The Community Services suicide prevention program website offers downloadable information on warning signs and has details on how to get help.[iv]
http://www.usmc-mccs.org/suicideprevent/index.cfm

Navy
The Department of the Navy website includes their suicide prevention policy and states the Navy has a department wide prevention and training program. The Navy suicide prevention web site is designed to provide information on Navy Policy**,** Navy Training**,** and research in the area of suicide prevention training. In response to The U.S. Surgeon Call to Action Report**,** which pushed for the development of strategies to prevent suicide and the suffering that it causes, the Navy and Marine Corps joined forces to develop a plan to better address suicide prevention efforts.[v]
http://www.npc.navy.mil/CommandSupport/SuicidePrevention/

Coast Guard
The Coast Guard website states that their suicide prevention program is intended to provide training that focuses on awareness and prevention of suicide, with a team

approach. Each of the members of the Coast Guard is directed to make it their individual responsibility to become aware of signs and symptoms of suicide.[vi]
http://www.uscg.mil/hq/g-w/g-wk/wkw/EAP/suicide_prevention.htm

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[i] United States Department of Defense. DOD Suicide Prevention Awareness Campaign Held. Retrieved March 3, 2006, from http://www.defenselink.mil/releases/2002/b11252002_bt599-02.html.

[ii] Army G-1 Human Resources Policy. Suicide Prevention Mission . Retrieved March 3, 2006, from http://www.armyg1.army.mil/hr/suicide.asp.

[iii] U.S. Air Force. Air Force Suicide Prevention Program. Retrieved March 3, 2006, from https://www.afms.mil/afspp.

[iv] Marine Corps Community Services. Suicide Prevention Program. Retrieved March 3, 2006, from http://www.usmc-mccs.org/suicideprevent/ml/index.cfm.

[v] Navy Personnel Command. Navy Suicide Prevention Program. . Retrieved March 3, 2006, from http://www.npc.navy.mil/CommandSupport/SuicidePrevention.

[vi] U.S. Coast Guard Health & Safety Directorate. Suicide Prevention. Retrieved March 3, 2006, from http://www.uscg.mil/hq/g-w/g-wk/wkw/EAP/suicide_prevention.htm

Law Enforcement Suicide Prevention

Suicide is a silent epidemic that permeates all walks of life and all types of people; it does not discriminate. There are certain populations however that are at an elevated risk for suicide. One of these populations is law enforcement personnel. The rate of suicide for police officers is 3 – 4 times higher than the general population and more active law enforcement officers die by suicide than homicide. It is estimated that 300 police officers end their lives each year, although data is often hard to obtain. One Philadelphia police department was unwilling to share their data when requested and we can only assume many more follow suit. The stigma surrounding suicide continues to be an obstacle for preventing suicide therefore more attempts to raise awareness, particularly among law enforcement personnel, need to be made.

Police are at an elevated risk for

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

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

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

- Include (gatekeeper) suicide prevention training to the curriculum of cadets in the police academy
- Create peer support groups among the departments
- Encourage help seeking behavior

Dr. Joseph Violanti , a leading researcher and expert in police suicide, strongly advocates peers, supervisors and administrators learn how to detect, intervene and refer a suicidal officer (for help) as part of their training. He believes developing a program that includes psychological assessment, tracking high risk officers, access to firearms, family involvement and training would ultimately lead to a reduction of suicide among police officers.

References:

Violanti, J. M. (1996). *Police Suicide: Epidemic in Blue*. Springfield, IL: Charles C Thomas, Publisher

Hackett, Dell P. and Violanti, John M., Ph.D. ((2003). Police Suicide Tactics for Prevention. Springfield, IL; Charles C Thomas, Publisher

Turvey, B. (1997). *Police Officers: Control, Hopelessness And Suicide*. Los Angeles, California: Knowledge Solutions.
Diamond, D. (2003). Departmental barriers to mental health treatment: A precursor to police officer suicide.
Mohandie, K., & Hatcher, C. (1999). Suicide and violence risk in law enforcement: Practical guidelines for risk assessment, prevention, and intervention. *Behavioral Sciences and the Law, 17*(3), 357-376.

Suicide Prevention and Adults with Serious Mental Illness

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

Mental illness does not cause suicide. Rather those with mental illness are exposed to more risk factors that raise their vulnerability to suicidal behavior. Ironically, the public largely believes that suicide happens mainly to those who are mentally ill. This is one of the many myths of suicide.

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

Here is a summary of the incidence of suicide among those with serious mental illness (SMI) such as Major Depressive Disorder, Bipolar Disorder, and Schizophrenia:

- 5% of overall SMI population completes suicide (vs. 1.5% in general population)
- Schizophrenia is involved in up to 15% of all suicides (as many as 4000 deaths yearly)
- Individuals with Schizophrenia are at more than 30 times higher risk of suicide than the general population
- 9% - 15% of Major Depressive Disorder sufferers eventually die by suicide
- Major Depressive Disorder sufferers have 21 times more suicide deaths than the general population
- 10%-15% of those with Bipolar Disorder will complete suicide
- 50% of those with Bipolar Disorder will attempt suicide at least once in their lifetime

These are some of the suicide risk factors for those with serious mental illness:

- Episodes of hopelessness, anxiety, and depression
- Young age of onset and early stage of illness
- Inadequate treatment and treatment reductions
- Frequent exacerbations/remissions
- Post-relapse improvement periods
- Psychiatric hospitalization(s) (especially the first 30 days after discharge)
- Co-occurring alcohol and other substance use and abuse

Of course, those with mental illness also have risk factors related to race and ethnicity, gender, age, a history of abuse or suicidal behavior, access to firearms, work, school, or

legal problems, and others. This accumulation of risk is what accounts for the prevalence of suicide among consumers and which necessitates preventative measures on their behalf.

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

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

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

All behavioral health providers, both public and private, should:

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

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

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

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

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

experience the suicide of a loved one or close friend have access to grief support resources.

Recommendations for a VA Strategy for Suicide Prevention

The VA's strategy for suicide prevention should include **universal** components designed to activate the system as a whole for the prevention of suicide and to ensure that mental health and substance use disorders in primary and medical specialty patients are identified and treated effectively; **targeted** components designed to prevent suicide and identify periods of increased risk in veterans known to have mental health or substance use disorders; and **indicated** components designed to address the needs of veterans acutely or chronically at increased risk for suicide. The program addresses five basic principles:

Universal Components:

1. The system as a whole must act to ensure that all providers, consumers, and families understand the personal suffering and public health impact of mental health and substance use disorders, and that they recognize that suicide is usually a potentially preventable complication of psychiatric illness. The system must also ensure that access to behavioral health care is readily available to all Veterans who need it in a manner that is destigmatized. In the universal component emphasis will be placed in promoting awareness of demographic factors to suicide risk. These include:
   - Presence of psychiatric illness
   - Presence of and communication of a plan
   - Comorbid substance use disorders
   - Age 65 and older or younger for chronic substance use, bipolar or schizophrenia
   - Lack of social supports (marital status)
   - Family history
   - History of abuse
   - Presence of hopelessness

2. For Veterans in primary care, medical specialty services, and long term care, there must be systematic screening to identify those with mental health and substance use disorders, followed by strategies to ensure that diagnostic evaluations are completed, and that effective treatment is made available that address the patient's safety. Adequate assessment for suicide risk must be performed and clinician actions must be documented.

Targeted Components:

3. For Veterans with diagnosed mental disorders, treatment strategies must include evidence-based elements designed to prevent suicide. These should include specific pharmacologic strategies, reduction of access to means for self-harm, decrease patient isolation, involve family and other supports when clinically

indicated, provide ongoing monitoring for periods of increased suicide risk, and adjustment of treatment when they are present.

Indicated Components:

4. During periods when Veterans are at increased acute or subacute risk for suicide, systems must have the capacity to ensure that care of increased frequency, intensity, and comprehensiveness can be provided, including inpatient services when appropriate.

5. For veterans at high chronic or persistent risk for suicide including those with previous suicide attempts, treatment should directly target suicidal risk as well as the underlying disorders.

More specifically, the VA Strategy for Suicide Prevention should include:

1. Educating all providers about suicide prevention from the perspective of their roles within the Veterans Health Administration, specifically addressing the associations of suicide with mental health and substance use disorders, aging, pain, chronic medical illness, social isolation, and other risk factors, and the possibilities for prevention.

2. Activating and engaging the entire community, including families, Veterans Support Organizations, Veterans Benefits Administration staff, and Veterans themselves as well as the public in destigmatizing mental health and substance use disorders, in recognizing these conditions and other risk factors, and in facilitating behavioral health treatment for those who need it.

3. Screening of Veterans in primary care and medical specialty settings, and long term care for mental health and substance use disorders, followed by diagnostic evaluations and implementation of treatment, either through collaborative/integrated care models or by referral to behavioral health services. This strategy is likely to be of specific value for those who have recently entered the VHA system, for older Veterans, those with serious medical illnesses or disability, and those with chronic pain.

4. Implementing and evaluating strategies for the evaluation of Veterans with mental health and substance use disorders to identify those predisposing factors that increase the risk of suicide (e.g, social isolation, impulsivity) as well as ongoing monitoring to identify periods when they are acutely (or subacutely) at increased risk for suicide.
5. Ensuring access to care that is more frequent, intensive, or comprehensive, including inpatient services when necessary, for Veterans during periods of increased risk for suicide.

6. Promoting of evidence-based strategies for suicide prevention into the care of all Veterans with mental health and substance use disorders including use of pharmacological treatment strategies shown to reduce the risk of suicide such as opiate maintenance treatment (e.g., buprenorphine or methadone), lithium for bipolar disorder, and clozapine for treatment of schizophrenia especially in veterans within the first 5-10 years after diagnosis.

7. Developing and implementing strategies for reducing access to lethal means and methods of self-harm for Veterans with mental health or substance use disorders, especially for those at increased risk for suicide. These should focus on issues including firearm hygiene and attention to the manner in which medications are packaged.

8. Developing and validating comprehensive strategies for identifying veterans with histories of suicidal behaviors that place them at high chronic risk. These should include strategies for linking with community agencies and providers to allow for identifying episodes that do not directly lead to care within the VHA, as well as for integrating information from diverse sources within the VA system. Activities should include evaluating the clinical and preventive benefits versus the privacy risks of flagging charts to facilitate the identification and close monitoring of those at chronically elevated risk of suicide.

9. Evaluating the feasibility of establishing registries of suicide attempts to guide care planning, resource allocation, and quality management activities.

10. Providing treatment that addresses suicidality as well as treatment of the underlying disorder for those who have attempted suicide. For those who receive acute care within VA facilities for suicide attempts or accidental overdoses, the risk of suicide should be evaluated and interventions to decrease risk should be initiated before discharge. For those who have attempted suicide in the past, as well as for others at high risk, psychotherapy that specifically addresses suicidality should be provided as well as comprehensive treatment related to the underlying disorder.

11. Ensuing that the VA accesses comprehensive data on suicide in the population it serves obtaining the causes of death for all veterans from the states or the National Death Index on an ongoing basis, and that it utilizes these data together with that from within the VHA in quality improvement initiatives and the evaluation of the outcomes of specific programs.

12. Prioritizing the develop of research infrastructures as well as MERIT , HSR&D, and Cooperative Studies projects devoted to expanding the evidence-base on strategies for suicide prevention.

Suicide and Alcohol Use, Misuse, and Abuse

When it comes to suicide, alcohol brings about many of things that heighten the danger. It increases impulsivity and decreases inhibition. It increases negative self-image and decreases self-esteem. It also deepens depression and social isolation.

Suicide risk increases with the intake and length of time alcohol is consumed. However, suicide risk can rise even without chronic drinking or dependence. It is probably not an overstatement to say that suicide risk increases with the first drink.

Nationally, an average of 25% of all suicides (about 7500 deaths yearly) are alcohol-related. Studies have found that 20%-35% of suicide victims used alcohol just prior to death. One study in Erie, NY determined that 33% of victims used alcohol.

Alcohol use is common among suicide attempters. Research shows that 65% used alcohol; 50% used alcohol just prior to the attempt. Many attempts occur during binge drinking episodes. Alcohol-induced impulsivity may be a factor in this behavior.

Among those who are alcohol dependent, 18% complete suicide. Suicide is 120 times more prevalent among adult alcoholics than in the general population. Alcohol also plays a major role in suicides among youths and elders.

The gender differential applies to suicides associated with alcohol misuse: men make up 80% of the victims, women 20%. According to the Centers for Disease Control (CDC), in 2001 alone, alcohol-related suicides accounted for 236,873 years of potential life lost.

The principal risk factors for suicide linked to alcohol use include:

- Interpersonal loss
- Employment/financial loss
- Family history of suicide
- Family history of alcoholism in primary relatives
- Current/past treatment for alcoholism
- Early onset of drinking
- Relapse
- High alcohol intake
- Alcohol dependence

Alcohol misusing victims typically have four or more of following factors: major depressive disorder, prior thoughts of suicide, continued drinking, poor social supports, unemployment, and living alone.

Co-occurring alcohol abuse and mental illness significantly increases risk

Those who misuse alcohol and prescription drugs misusers have a 40 times greater risk of suicide. Such co-morbidities lessen the likelihood of help and intervention.

Department of Corrections Suicide Prevention

Suicide is the third leading cause of death in prisons throughout the country, following natural causes and AIDS (Metzner, et. al., 1998). Since 1995, when there was a sharp increase in the rate of suicides among inmates in Pennsylvania, the Department of Corrections has enhanced its suicide preventions efforts. There are videotapes and brochures provided for inmates and staff trainings. Department officials also have developed a risk indicators checklist that is administered to all offenders upon entering the system. Since these initiatives were implemented, the suicide rate has declined even though the inmate population has increased. The Department compared the suicide rate with a U.S. population of similar size, adjusted for age, gender and race distribution in the community, and found that that inmates fare relatively well by this measure compared to a comparable unincarcerated U.S. population. In fact, the suicide rate in the PA DOC is actually lower.

Risk Factors Among Inmates

- Mental illness: although inmates on the mental health/mental retardation roster comprises approximately 17% of the PA prison population, they comprise approximately 60% of the suicides
- Substance abusers: approximately 70% of inmates who completed/attempted suicide had histories of substance abuse
- Male: males account for approximately 95% of the PA prison population, and they comprised approximately 98% of the suicides.
- Caucasian: although Caucasians comprise only 34% of the PA prison population, they comprise over 50% of the suicides
- Elderly: due to mandatory sentencing and a reduction in parole, the PA prison population has been getting older. Depression is underdiagnosed among the elderly, and we are carefully monitoring our older offenders.
- Sex offenders: this population is a growing risk, probably related to the increased difficulty in obtaining parole
- Lifers/long term offenders: although lifers comprise 17% of the PA prison population, they comprise 40% of the suicides
- Parole violators: these are offenders who are returned to prisons after failing to adjust in the community. In some case, they may still be under the influence of alcohol or other drugs. Our speculation is that these individuals panic when they realize that their likelihood of being re-paroled might be remote
- Administrative segregation: although this population had a high rate in the past, it has decreased since new policies have been implemented

Strategies to Reduce DOC Suicides

- Training: required that all staff receive at least 2 hours of initial training followed by 1 hour of annual refresher training
- Updating policies and procedures
- Expand mental health treatment for inmates

- When possible, divert inmates with mental illnesses from placement in administrative segregation
- Disseminate suicide prevention and mental health information to the inmate population
- Increase the comprehensiveness of clinical reviews conducted following all suicides and frequency of reviews following serious gestures
- Enhance services for non-mentally ill inmates: programs on substance abuse (AA, NA, etc…) sex offender treatment, children's visitation centers, etc.

Information for this section is taken from articles written by Lance Couturier, Ph.D., Pennsylvania Department of Corrections.

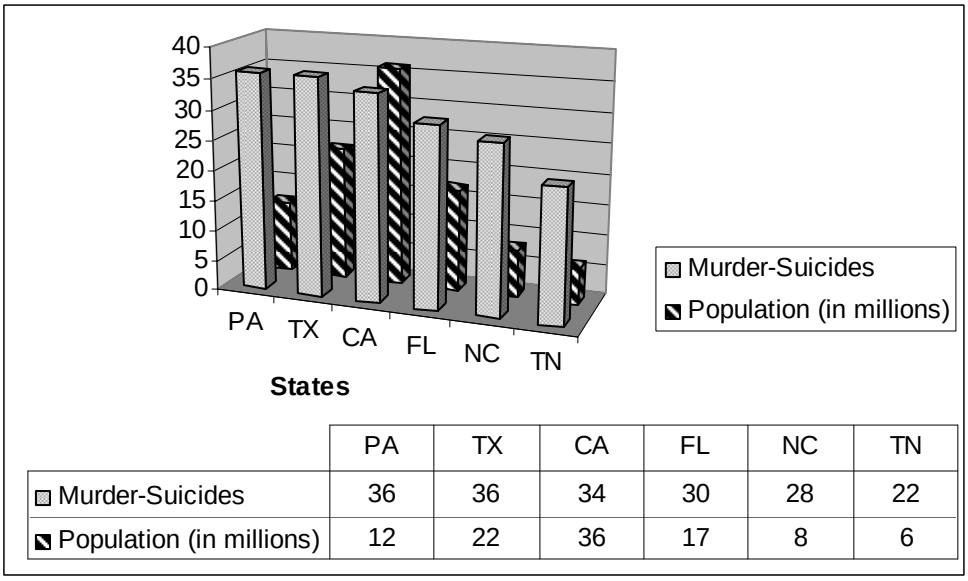
Metzner, JJ., Cohen, F., Grossman, L.S., and Wettstein, R.M.(1998)Treatment in jails and prisons. In R.M. Wettstein (Ed.) Treatment of offenders with mental disorders. NY, NY: The Guilford Press.

Murder-Suicide

An often overlooked yet disturbing trend is the prevalence of murder-suicides, not only in the United States, but particularly in Pennsylvania. A new study by the Violence Prevention Center has determined there are at least 10 murder-suicides each week in the U.S. and approximately 1,000 to 1,500 deaths per year. The study was conducted from January 1, 2005 to July 1, 2005 and the results are disturbing.[1] Pennsylvania is one of six states with more than 10 murder-suicides in the six-month period of the study:

Pennsylvania	18	Florida	15
Texas	18	North Carolina	14
California	17	Tennessee	11

If you plot the number of murder-suicides vs. the population of these states, one can see Pennsylvania has a disproportionate amount of murder-suicides.



	PA	TX	CA	FL	NC	TN
Murder-Suicides	36	36	34	30	28	22
Population (in millions)	12	22	36	17	8	6

Also, in the previous report for the first six months of 2004 Pennsylvania had 17 murder-suicides per month. Whether this increase will continue has yet to be determined, but clearly this is becoming a major health problem for Pennsylvania.

There is no database and tracking system to fully report this information therefore it is likely these numbers are underestimated and there is no way to determine the number of people affected by murder-suicide. This traumatic event has the potential to severely impact not only family members, friends, and acquaintances but even the entire community, especially if a mass murder occurred.

Several trends have been identified with murder-suicide in this report. The most common method of death was by firearms, approximately 92%, and the majority of the offenders (over 90%) are male. The most common form of murder-suicide (74%) involved an intimate partner, such as a spouse, girlfriend/boyfriend, common-law spouse or ex-spouse. Because the offender is often male, approximately 94% of the deaths were females killed by their intimate partner. On average, the offenders are several years older than their partners; the average difference in age is 6 years. Most murder-suicides occur in the home (77%) with the majority taking place in the bedroom.

These murder-suicides can be characterized by the following traits and circumstances: the offender is typically male between the ages of 18 and 60, usually depressed, in a long-term relationship marked with discord and often domestic violence, with feelings of jealousy and the belief their sexual partner has been unfaithful sexually (real or imagined). When a triggering event such as a separation or threatened separation occurs, he becomes enraged, murders the partner then kills himself.

There is also a sub-category of intimate partner murder-suicides involving a male "family annihilator," where the perpetrators not only kill their partner, but also their children and other family members before killing themselves. These offenders are also often depressed, have financial or other problems and feel the family is better off dead than to remain living and having to deal with his problems. Another theory is that these individuals view the family as an extension of themselves; they are depressed, paranoid, and suicidal, and the only way to kill themselves is to kill their families as well.[2]

While the majority of the murder-suicides are perpetrated by males, there are female offenders. These women usually kill their children, then themselves, and rarely, if ever, kill their intimate partner as well. The most common choice of a weapon is a firearm used approximately 63% of the time.

Unfortunately, there are no studies specific to law enforcement officers involved in murder-suicides. However, because the rate of suicide is higher in law enforcement officers than the general public, and there were several incidences involving police during the duration of the report, the conclusion was drawn that police officers also have a higher rate of murder-suicide. Access to firearms and the nature of the officers (control over and responsibility for others) contribute to this belief.

Finally, there may be a correlation between the death penalty and the murder-suicide rate. States with the death penalty tend to have more homicides and murder-suicides than states without the death penalty. Looking at the number of people on death row, and the number of murder-suicides per month, there may be a trend:

State	Murder-suicides per month	# of Inmates on Death Row
PA	18	231
TX	18	409
CA	17	649
FL	15	388
NC	14	190
TN	11	108

Interviews with inmates and details of the crimes seem to indicate that many of the homicides were meant to be murder-suicides but the offender "chickened out." Also, in a paper presented at the World Conference on Violence and the Future of Society, Katherine van Wormer and Chuk Odiah from the University of Northern Iowa have proposed there be another category of suicide, or suicide by execution where the offenders purposely and knowingly commit their crimes in states that have the death penalty, or commit another homicide while in prison to bring about the death penalty.[3] Again, there is insufficient data to confirm these beliefs.

In conclusion, the number of murder-suicides occurring in Pennsylvania is disproportionately high per our population and merits further attention. The number of people and communities affected by this traumatic event is also significant. Support for these individuals is necessary. One can only speculate at the traumatic impact on children or loved ones by witnessing, being in the proximity of, or finding the bodies after a murder-suicide. A database or method of tracking murder-suicides would help us to better understand these deaths and lead to prevention strategies. Finally, restricted access to firearms, especially when a history of depression, suicidal gestures and/or domestic violence has been reported, has the potential to greatly reduce the number of murder-suicides in Pennsylvania.

[1] American Roulette: Murder-Suicide in the United States by the Violence Policy Center, 2005

[2] Palermo, G. B. (1994) Murder-suicide – An extended suicide. *International Journal of Offender Therapy and Comparative Criminology 8*, (3), 205-216.

[3] van Wormer, Katherine, MSSW, PhD, and Odiah, Chuk, M.Sc, PhD: Paper presented at the World Conference on Violence and the Future of Society, Dublin, Ireland, August 20-23, 1997.

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