

Idaho's Suicide Prevention Plan





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Introduction

Idaho's suicide prevention plan was developed to help address the problem of suicide in Idaho.

Suicide is a significant problem in the United States and in Idaho. During the years 1990–2000, on average, more than 30,000 individuals died each year in the United States from suicide. Although it is generally agreed that not all suicides are classified as such⁽¹⁾, only unintentional injuries (“accidents”) surpassed suicide as the reported leading cause of death for 25–34 year olds in 2000. Suicide trailed unintentional injuries and homicides as the third leading cause of death for 15 to 24 year olds in 2000 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2003).⁽²⁾

Idaho consistently has had a higher suicide rate than the United States as a whole. From 1999–2001, 559 Idahoans died from suicide. It was second only to unintentional injury as the leading cause of death for Idahoans aged 15–34, and the ninth leading cause of death overall.⁽³⁾

Suicide is a complex problem, resulting from one or more biological, psychological, environmental, social and/or cultural factors. Idaho faces significant challenges in addressing this problem. Known risks include mental disorders, alcohol and substance use disorders, financial or relationship losses, lack of social support, barriers to care, and a sense of hopelessness (Appendix A).⁽¹⁾ Certain protective factors, such as problem-solving and conflict resolution skills, strong family and community connections, and access to effective clinical care for mental, physical and substance abuse disorders, can help counter these risks and challenges (Appendix A).⁽¹⁾



Numbers and rates are the public face of suicide. Personal pain and the sense of hopelessness leading to suicide, lost futures, and the heartache felt by loved ones left behind are the untold stories. In 1996, Jerry and Elsie Weyrauch of Marietta, Georgia lost their 34-year-old physician daughter to suicide. They channeled their grief into a positive force that ultimately led a national strategy to address suicide.

The 2001 U.S. Department of Health and Human Services Public Health Service blueprint to guide states working to prevent suicide, *National Strategy for Suicide Prevention: Goals and Objectives for Action*,⁽¹⁾ is a testament to the Weyrauchs. They exemplify Margaret Meade's statement: "Never doubt that a small group of thoughtful, committed people can change the world, indeed, it is the only thing that ever has." The Suicide Prevention Action Network (SPAN), a grassroots advocacy organization developed by the Weyrauchs in 1996, drove the public/private partnership that sponsored the National Suicide Prevention Conference in Reno, Nevada, in October, 1998. The Surgeon General's *Call to Action to Prevent Suicide* and the *National Strategy for Suicide Prevention*⁽¹⁾ resulted from this conference. Idaho's Suicide Prevention Plan is the result of an equally dedicated group of individuals who refuse to let the problem go unaddressed here.

Idaho Suicide Facts

Idaho's suicide data reveals four unique populations at higher risk for suicide completions.

- *Young Native American Males*
- *Elderly Males*
- *Working-aged Males*
- *Teenaged Males*

Idaho's suicide rate is higher than that of the United States as a whole. During the three-year period 1999–2001, there were 14.4 suicides in Idaho for every 100,000 citizens, as compared to 10.7 per 100,000 in the United States for the year 2000.⁽³⁾ Overall rates, though, do not point to the unique populations at risk.

A closer examination of Idaho suicide data reveals four unique populations at higher risk for suicide completions. These include young Native American males (15–24 years of age), elderly males (75 years of age and older), working-aged males (18–64 years of age), and teenaged males (15–17 years of age). Although the overall suicide rate in Idaho during 1999–2001 was 14.4 per 100,000 population, the rate for elderly males was 81.2 per 100,000; for working-aged males was 25.8 per 100,000; for 15–17 year old males was 22.5; and for Native Americans was 21.0 per 100,000. For the 10-year period 1992–2001, Native American males aged 15–17 had the highest suicide rate in Idaho at 115.8 per 100,000 population, with 18–24 year old Native Americans having a rate of 88.1 per 100,000 population.⁽³⁾ (Note: During the 10-year period 1992–2001, elderly white males had the second highest suicide rate in Idaho at 99.3 per 100,000 population.)⁽³⁾

Idaho males are approximately four times as likely to die from suicide as females.⁽³⁾ This also is true for the United States as a whole.⁽¹⁾ Firearms are the most common method for completed suicides in Idaho. Two out of every three suicides (67%) involved a firearm during the period 1999 – 2001.⁽³⁾ Nationally in 1998, 57% of all suicides were due to firearms.⁽¹⁾



Completed suicides are just one part of the problem. Nationally, it has been estimated that 20 individuals visit an emergency room for a suicide attempt for each reported suicide death.⁽³⁾ Although an emergency room database is not available in Idaho, an estimated 2,330 Idahoans aged 18 years and older attempted suicide within the previous 12 months, as determined by responses to the 2001 Idaho Behavioral Risk Factor Surveillance Survey (BRFSS). Sixty percent of reported attempts for ages 18 and older were made by females.⁽⁴⁾ Based on responses to the 2001 Youth Risk Behavior Survey (YRBS), almost 6,000 additional suicide attempts within the previous 12 months were estimated for 15–17 year olds. Almost two-thirds (63%) of reported attempts by 15–17 year olds were by females.⁽⁵⁾ Combined estimates from BRFSS and YRBS reveal almost 40 suicide attempts in Idaho, in 2001, for every completed suicide.

It was estimated that there were almost 40 suicide attempts in Idaho in 2001 for every completed suicide.

Suicide Prevention

Suicide prevention requires the effort and coordination of a myriad of agencies, groups, and individuals.

Many suicides can be prevented. Prevention requires a comprehensive approach (Appendices B, C, D, E)⁽⁶⁾ that includes both developing protective factors (Appendix A) and concurrently reducing risk factors (Appendix A). No single agency or organization is uniquely qualified to fully address the problem. Suicide prevention requires the effort and coordination of a myriad of organizations, agencies, groups, and individuals. These include mental health providers, health care providers, tribes, schools and universities, law enforcement and judicial agencies, senior services agencies, community-based organizations, faith-based organizations, and survivors groups.

Strategies for suicide prevention fall into three categories:⁽¹⁾

- **Universal** — Address whole populations. For example, working to improve health insurance coverage.
- **Selective** — Address unique, at risk populations. For example, training gatekeepers (individuals who come into frequent contact with individuals in populations at risk for suicide) to recognize signs that an individual may be contemplating suicide and refer that person for help.
- **Indicated** — Target individuals at risk for suicide. Indicated strategies include crisis intervention and mental health treatment.

Purpose of the Plan

Idaho's suicide prevention plan was developed to address the problem of suicide in Idaho. It is intended to be a guide for agencies, organizations and individuals to follow at state, regional, and local levels when developing their own specific action plans. Because the statewide plan is based on current Idaho activities and needs, it will help to avoid a duplication of efforts at a time when resources are limited. When developing the plan, an attempt was made to link current science for preventing suicide with practical application in the field.

The plan looks beyond agencies and organizations, such as mental health providers, that traditionally have taken responsibility for preventing suicides. If prevention activities are to be accomplished when funding is scarce, prevention efforts must be undertaken by non-traditional providers such as faith-based organizations and organizations working with Idaho's unique populations at higher risk for suicide.

If suicide prevention activities are to be accomplished when funding is scarce, prevention efforts must be undertaken by non-traditional providers.

Development Process



In 1994, in response to a U.S. Public Health Service initiative, a small group of Idahoans met with their counterparts from 10 northwestern states to begin the process of addressing adolescent suicide using a public health approach. Idaho's Adolescent Suicide Prevention Task Force, which evolved into SPAN Idaho, was developed as a result of this meeting.

In November 2002, SPAN Idaho began developing a statewide suicide prevention plan at a meeting in Sun Valley that involved 63 participants from all regions of the state. In March 2003, State Representative Margaret Henbest secured funding to complete the plan development process.



A core planning group met in June 2003 to review work completed by SPAN Idaho and determine the processes to be used to gather additional regional input for the statewide plan. The core group represented SPAN Idaho, Adult and Children's Mental Health (Idaho Department of Health and Welfare), Safe and Drug-Free Schools (Department of Education), NAMI Idaho, Southeastern Public Health District, Red Flags (Idaho State University), Suicide Prevention Services (statewide suicide prevention hotline), Idaho Commission on Aging, the Legislature, First Lady Patricia Kempthorne, and Generation of the Child Initiative staff.

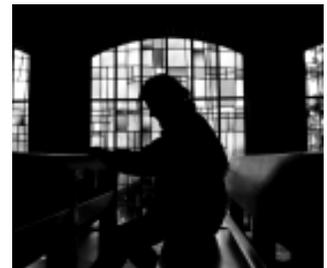


Idaho-specific data, comparative national data, and "best practices" gleaned from the Institute of Medicine's *Reducing Suicide: A National Imperative* (2002),⁽⁷⁾ provided background information to revise the SPAN Idaho draft plan. Each member of the core group was responsible for contacting one or more additional key organizations or agencies that represent or provide services to populations at risk for suicide. The expanded group was asked to review and comment on the second draft of the plan.

The expanded planning group included faith-based organizations, Tribes, Hispanic groups, State Mental Health Planning Council, Idaho Federation of Families, Idaho Council on Children’s Mental Health, Area Agencies on Aging, Department of Labor, Idaho State Police Post Academy, psychologist, psychiatrist, and physician’s organizations, and regional public health departments. Feedback was incorporated into the plan, which was reviewed and prioritized by the core group, creating a third draft.



Regional meetings were held in Coeur d’Alene, Lewiston, Boise, Twin Falls, Pocatello and Idaho Falls to allow public input into the plan. In addition to Idaho-specific suicide data and information on best practices, results of a region-specific resource inventory of suicide prevention activities and services was provided as background at the meetings. The draft plan also was available on the Internet for public comment. Input and feedback from regional meetings and Internet traffic was incorporated into the plan, which again was reviewed and prioritized by the core group to create the final draft.



Idaho’s Suicide Prevention Plan was unveiled at the November 2003 SPAN Idaho conference one year after the process was initiated.

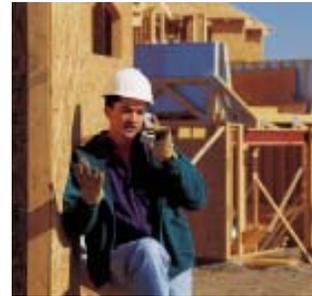


Priority Populations

Idaho's Suicide Prevention Plan is intended to reduce risks for both suicide attempts and suicide completions for all Idahoans. Although self-report data indicate that females in Idaho are almost twice as likely to attempt suicide as males^(4,5), the following groups are at highest risk for suicide completions.

Working-Aged Males — 18–64 years of age:

More than half (55%) of all suicides in Idaho during 1999–2001 were among working-aged males, although they comprised less than one-third (31%) of the population. During 1999–2001, the suicide rate among 18–64 year old males living in Idaho was 25.8 per 100,000.⁽³⁾



Although information on employment status of working-aged Idaho males who complete suicide is not collected, national studies associate suicide with unemployment and economic distress.^{(7),(8),(9)} A two-fold increase in the risk of suicide has been noted among the unemployed in the United States.⁽⁷⁾ The suicide rate for working aged males in Idaho is almost twice (1.8 times) that of the state overall.⁽³⁾

Elderly Males:

Idaho's suicide rate for those aged 75 years and older is second only to that of 15–17 year old Native American males. For the three-year period 1999–2001, elderly men had a suicide rate almost six times higher than for the population as a whole. While the average annual rate in Idaho for the three-year period was 14.4 per 100,000 population, the rate among males aged 75 years and older was 81.2 per 100,000.⁽³⁾



Although Idaho-specific information is not available, studies associate suicide among the elderly with risks that include death of a spouse, isolation, depression, and serious medical conditions. Additionally, there is a greater likelihood that death will result from suicide attempts among the elderly because they are more likely to be medically fragile, less likely to be discovered after an attempt because they are more likely to live alone, and they are more likely to use highly fatal methods.⁽⁷⁾

Teenaged Males (15–17 years of age):

Nationally, suicide is the third leading cause of death for teenagers, following unintentional injury and homicide. In Idaho, suicide is the second leading cause of death for teenagers following unintentional injury.⁽³⁾



During 1999–2001 in Idaho, 15–17 year old boys completed suicide at about five times the rate of girls the same age (22.5 versus 4.2 per 100,000).⁽¹⁾ The 2001 Idaho Youth Behavior Risk Factor Survey of 9th through 12th graders found that almost twice as many teenaged girls attempted suicide as teenaged boys (63% versus 37%).⁽⁵⁾



Many factors that increase teenagers' risk for suicide are understood: mental disorders, substance abuse, prior suicide attempt, sexual abuse, impulsive and aggressive behavior, and access to firearms.⁽³⁾ These

risks can be addressed using strategies that include building social and problem solving skills, providing self-referral information, training gatekeepers to identify and refer individuals exhibiting signs of potential self-harm, and screening and referring individuals to treatment. Evaluations of the effectiveness of the various approaches have not been completed.⁽⁷⁾

Native Americans:

Young Native American males (15–17 years) have the highest suicide rate in Idaho. At 115.8 per 100, 000 during 1992–2001, the rate was higher than that of elderly white males (99.3 per 100,000). At 88.1 suicides per 100,000 population, Native American males aged 18–24 had the third highest rate in Idaho during the same 10-year period.⁽³⁾



The pattern of suicides across the life-span among Native Americans is quite different than other groups.⁽⁷⁾ The rate among Native Americans is highest among younger age groups, peaking at age 25–34 nationally and 15–17 in Idaho, then tapering off with increasing age. It is lowest for older males. For other races, there is a dramatic rise among 15–24 year olds, that flattens and holds across the working years, followed by a dramatic increase among older males.

Important Risk & Protective Factors

Several important factors that might increase risk for suicide have been identified. Especially challenging are abuse and a history of suicide in a family or among friends. In addition, several protective factors can help deter suicidal thoughts and actions.

Mental disorders — particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders — can make an individual more at risk for suicide. Also, abuse of alcohol and other substances can be tied to suicide.⁽³⁾ More than 90% of suicides in the United States are associated with mental illness and/or substance abuse.⁽⁷⁾

Other risk factors for suicide include impulsive and/or aggressive tendencies, a sense of hopelessness, and a history of trauma or abuse. Some major physical illnesses, along with barriers to health care, increase the risk. A previous suicide attempt or family history of suicide also increase risk.⁽³⁾

Losses such as a job, financial, relational or social loss increase the risk for suicide, as well as having easy access to lethal means. Local clusters of suicide may have a contagious influence.⁽³⁾

Important risks also include social and cultural factors. Lack of social support and a sense of isolation increase a person's risk for suicide. In addition, barriers to timely and appropriate mental health and substance abuse treatment, and the stigma that prevents people from seeking such help, increase risk. Some cultural and religious beliefs, as well as exposure to other who have completed suicide — even exposure through the media — increase risk.⁽³⁾

The good news is that there are important protective factors that can help counter suicide risks. Included among these are cultural and religious



beliefs that discourage suicide, problem-solving and conflict resolution skills, skills in handling disputes in a non-violent manner, and strong family and community support.⁽³⁾

Effective clinical care for mental, physical, and substance abuse disorders, as well as easy access to care also can help protect against suicide. Support during ongoing medical and mental health care relationships is important, as is support to encourage people to seek care for mental illness and substance abuse disorders.⁽³⁾

Plan Format

Idaho's suicide prevention plan is based on Idaho-specific needs and resources. The format mirrors that of the national plan, separating goals (what we want to accomplish), outcomes (the change we expect to see), and strategies (generally, how the changes might be accomplished) into **Awareness, Implementation, Methodology (AIM)** categories.⁽¹⁾ Additionally, Idaho's plan includes development of the infrastructure needed to oversee plan implementation. The four categories are defined as follows:

- **Infrastructure** — Goals, outcomes and strategies addressing the tangible framework needed to secure resources to coordinate and provide information and technical assistance to organizations, agencies, and individuals working to implement goals and strategies within the plan, and to update the plan over time.
- **Awareness** — Goals, outcomes and strategies addressing increasing knowledge on a wide-scale basis.
- **Implementation** — Goals, outcomes and strategies addressing the programs and activities conducted to prevent suicides.
- **Methodology** — Goals, outcomes and strategies addressing program evaluation, surveillance, reporting, and research.

Key elements of a plan include engaging a broad and diverse group of partners, developing a sustainable and functional infrastructure, engaging in appropriate activities and tracking progress.



Goals – Outcomes – Strategies

Infrastructure

The tangible framework needed to coordinate plan implementation, to provide information and technical assistance to organizations, agencies, and individuals working to implement components of the plan, and to update the plan over time.

What we want to accomplish:

#1: Develop a central coordinating body for leadership in implementing suicide prevention efforts in Idaho.

The change we expect to see:

#1: A central coordinating body for leadership and implementing suicide prevention efforts in Idaho will be in place and will have accomplished the following:

- a. Resources have been acquired to support state and local infrastructure.
- b. Statewide and local planning groups are functioning.
- c. Statewide and local action plans are coordinated.
- d. Plan implementation oversight is functioning.
- e. Resource directories have been developed and are being maintained.
- f. Technical assistance is available.
- g. Formal and informal information sharing is being accomplished between and among organizations.
- h. A mechanism is in place for coordinating with tribal and minority populations on implementation issues so they are consistent with cultural traditions and concerns.
- i. Data needs for suicide prevention have been identified.
- j. A method is in place for plan updates.



Generally, how the change might be accomplished:

At the state level:

- a. Public and private resources are identified for infrastructure development (eg., grants, contracts, volunteers, staff, physical location, equipment etc.).
- b. Avoid duplication by utilizing existing group(s), expanding their role(s) and function(s) for statewide coordination.
- c. Explore the mechanisms other states have used to implement their suicide prevention plans.
- d. Coordinate communication between state and local levels.
- e. Hold an annual conference for information sharing.

At the local level (as self defined):

- a. Public and private resources are identified for infrastructure development (eg., grants, contracts, volunteers, staff, physical location, equipment etc.).
- b. Avoid duplication by utilizing existing group(s), expanding their role(s) and function(s) for local coordination.
- c. Coordinate communication between local and state levels.

Awareness

Increased public knowledge of suicide related issues in Idaho, of risks and protective factors for suicide, and of available suicide prevention and intervention resources.

What we want to accomplish:

#2: Increase awareness of suicide as a mental health issue in Idaho.

The changes we expect to see:

#2: Idahoans have increased awareness of the following:

- a. Statewide and regional suicide statistics.
- b. Risk and protective factors for suicide.
- c. Symptoms of depression and mental illness.
- d. The connection between depression, substance abuse, mental illness and suicide.
- e. Warning signs for suicide.
- f. Stigma surrounding mental health, mental illness, and help seeking.
- g. Available resources and services.
- h. Best methods for suicide prevention.
- i. Access to care issues.

Generally, how the changes might be accomplished:

At the state level:

- a. Distribute media guidelines to local groups and organizations.
- b. Conduct an annual public event to raise awareness of suicide related issues.
- c. Provide information to physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community service groups, gun shop owners, pawn



shop owners, bartenders, Alcoholics Anonymous groups, meals on wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others.

- d. Develop a mechanism for coordinating with tribal and minority populations on awareness issues so they are consistent with cultural traditions and concerns.
- e. Develop a coordinated / collaborative state-level awareness action plan and disseminate to local groups and organizations.
- f. Gather and disseminate information on available resources and services using the most appropriate means (eg. website, teleconference etc.).

At the local level (as self defined):

- a. Distribute media guidelines to local media outlets.
- b. Conduct local public events to raise awareness of suicide related issues.
- c. Provide information to physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community service groups, gun shop owners, pawn shop owners, bartenders, Alcoholics Anonymous, meals on wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others.
- d. Link to information on national and state events / campaigns related to suicide issues.
- e. Develop a coordinated / collaborative local awareness action plan.
- f. Gather and disseminate information on available resources and services.

Implementation

Enhance and promote programs, services, and activities, to prevent suicides by promoting protective factors and reducing risks.

What we want to accomplish:

#3: Identify, compile and disseminate best known practices and materials for the following:

- a. Promoting protective factors against suicide-related behaviors.
- b. Reducing risks for suicide-related behaviors.
- c. Crisis response.
- d. Working with populations having higher risk for suicide.
- e. Working with suicide survivors.
- f. Training gatekeepers.
- g. Mental health providers.
- h. Primary care providers.

The change we expect to see:

#3: Best known practices and materials are available and accessible for designing and developing programs, services, and activities for preventing suicides.

Generally, how the change might be accomplished:

At the state level:

- a. Acquire resources to support state activities.
- b. Support existing effective programs.
- c. Implement state initiative(s) that address suicide prevention by promoting protective factors and resiliency.
- d. Educate gatekeepers including: physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community service groups, gun shop owners, pawn shop owners, bartenders, Alcoholics Anonymous, meals on

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- wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others.
- e. Develop toolboxes of best practices for use by service providers, schools, organizations, and others.
 - f. Develop a mechanism for coordinating with tribal and minority populations so cultural traditions and concerns are addressed in practices and materials available for use by these populations.
 - g. Provide prevention interventions for high risk populations.

At the local level (as self defined):

- a. Acquire resources to support local activities.
- b. Support existing effective programs.
- c. Implement local initiative(s) that address suicide prevention by promoting protective factors and resiliency.
- d. Develop local programs, services, and activities based on best practice toolboxes.
- e. Educate local gatekeepers including: physicians and other health care professionals, mental health professionals, senior centers, business owners, human resources department staff, tribal leaders, educators and school personnel, parent-teacher organizations, clergy, law enforcement, suicide survivor groups, community services groups, gun shop owners, pawn shop owners, bartenders, Alcoholics Anonymous, meals on wheels, mobile health clinics, book mobiles, loan officers working with agricultural people, legislators and others..
- f. Provide prevention interventions for high risk populations.

Methodology

Gather data to evaluate the effectiveness of programs, activities, and clinical treatments, and conduct suicide-specific surveillance and research.

What we want to accomplish:

#4: *Develop and disseminate guidelines for outcome and performance measurement for suicide prevention efforts:*

The change we expect to see:

#4: *Guidelines and performance measures have been developed and distributed.*

Generally, how the changes might be accomplished:

At the state level:

- a. Conduct a search for guidelines used by other states and organizations.
- b. Conduct a search for performance measures used by other states and organizations.
- c. Obtain funding to conduct measurement-related research.

What we want to accomplish:

#5: *Identify statewide and local suicide-related needs and resources. Identify gaps in service and barriers to accessing care.*

The change we expect to see:

#5: *A needs and resource assessment is completed. Gaps in services and barriers to accessing care have been identified.*



Generally, how the change might be accomplished:

At the state level:

- a. Retain a contractor to conduct a statewide survey.
- b. Convene a statewide meeting of service providers and consumers and identify needs and gaps.
- c. Serve as a resource for tribes and Hispanic groups as they address their needs.

At the local level (as self defined):

- a. Gather local resource information.

What we want to accomplish:

#6: Develop a systematic and repeated method of monitoring suicide-related attitudes, intentions and behaviors.

The change we expect to see:

#6: Regularly collected data are available to guide suicide prevention-related decision making.

Generally, how might the change be accomplished:

At the state level:

- a. Utilize Youth Risk Behaviors Survey data.
- b. Fund and utilize data from the Mental Health Module of the Behavioral Risk Factor Surveillance System.
- c. Request Emergency Room discharge data from hospitals.
- d. Make suicidal behavior a “reportable disease.”
- e. Develop a depository for all suicide and suicide-related data.
- f. Conduct a population-based survey of adult Idahoans.
- g. Disseminate data statewide.

At the local level (as self defined):

- a. Request Emergency Room discharge data from local hospitals.
- b. Disseminate data locally.



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Appendix A

Important Protective Factors for Suicide (Include individual's attitudinal and behavioral characteristics as well as attributes of the environment and culture.)

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

Important Risk Factors for Suicide (Some cannot be changed but can alert others to heightened risk during periods of recurrence of mental or substance abuse disorders or following significant stressful life events.)

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance use disorders
- Impulsive and/or aggressive tendencies
- Hopelessness
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

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

Sociocultural Risk Factors

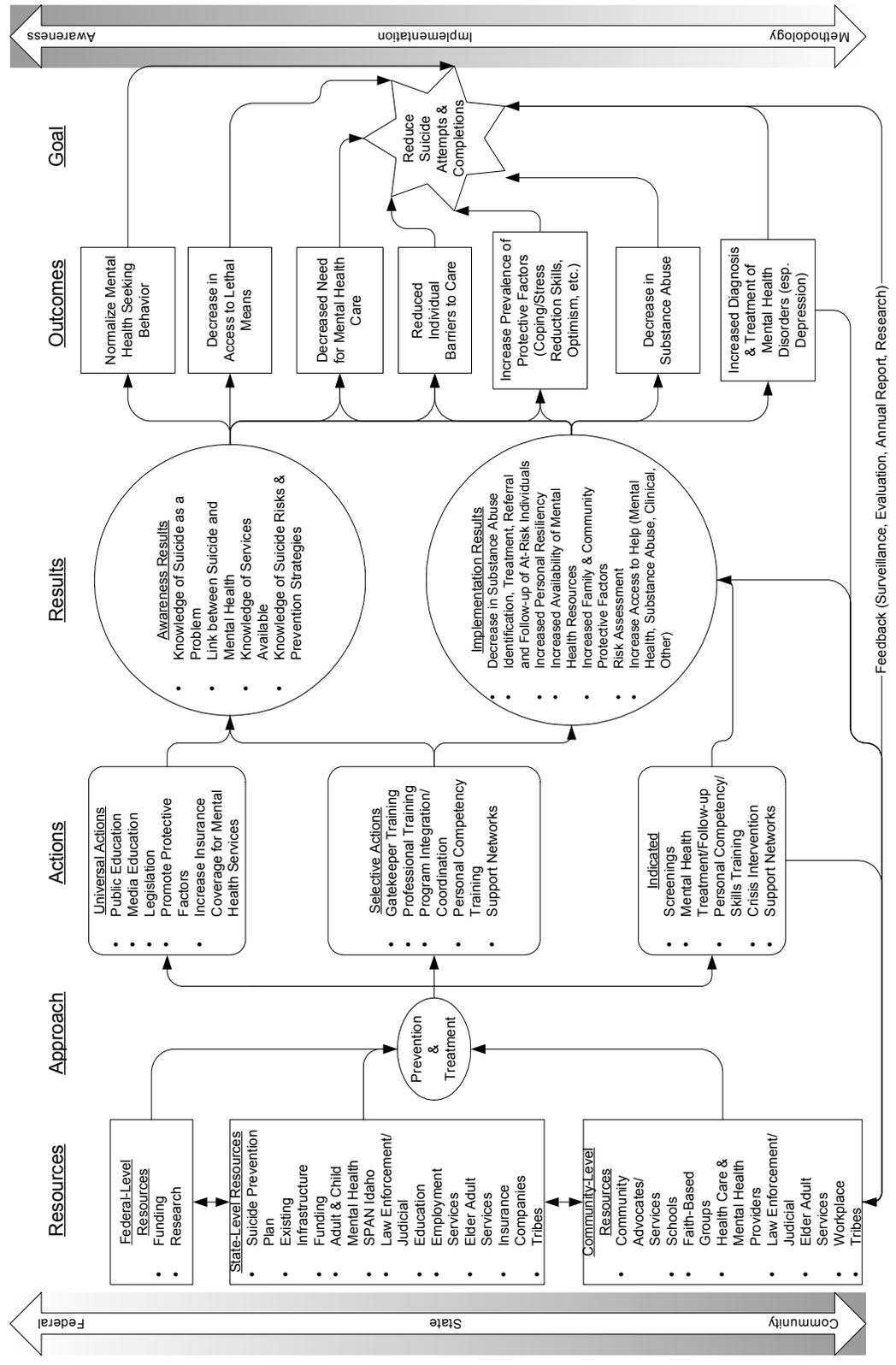
- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of personal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

Source: National Strategy for Suicide Prevention: Goals and Objectives for Action (2001). U.S. Department of Health and Human Services, Public Health Service. Rockville, MD.

Appendix B

Suicide Prevention Plan: Best Practices Overview

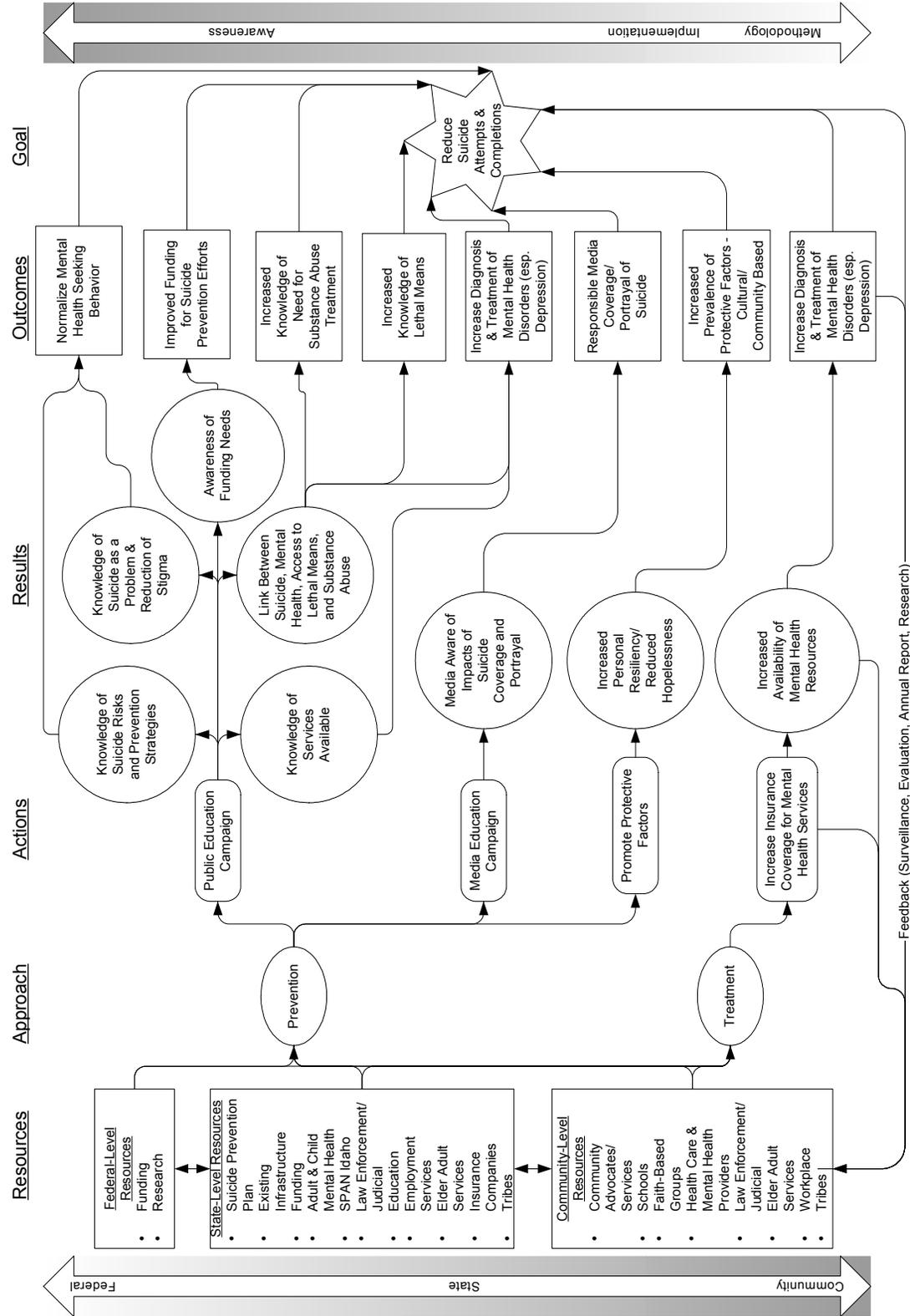
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Appendix C

Suicide Prevention Plan: Universal Actions

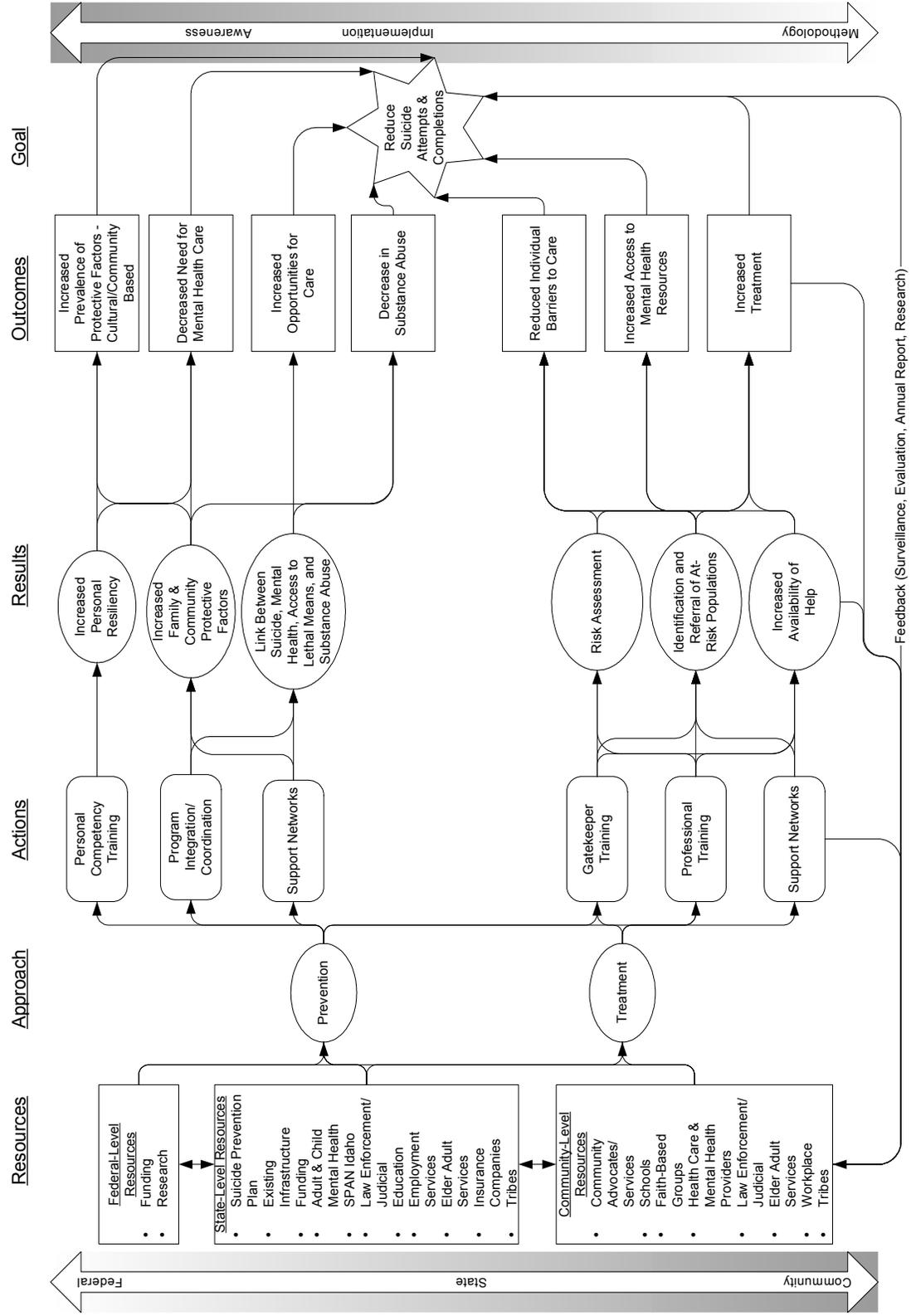
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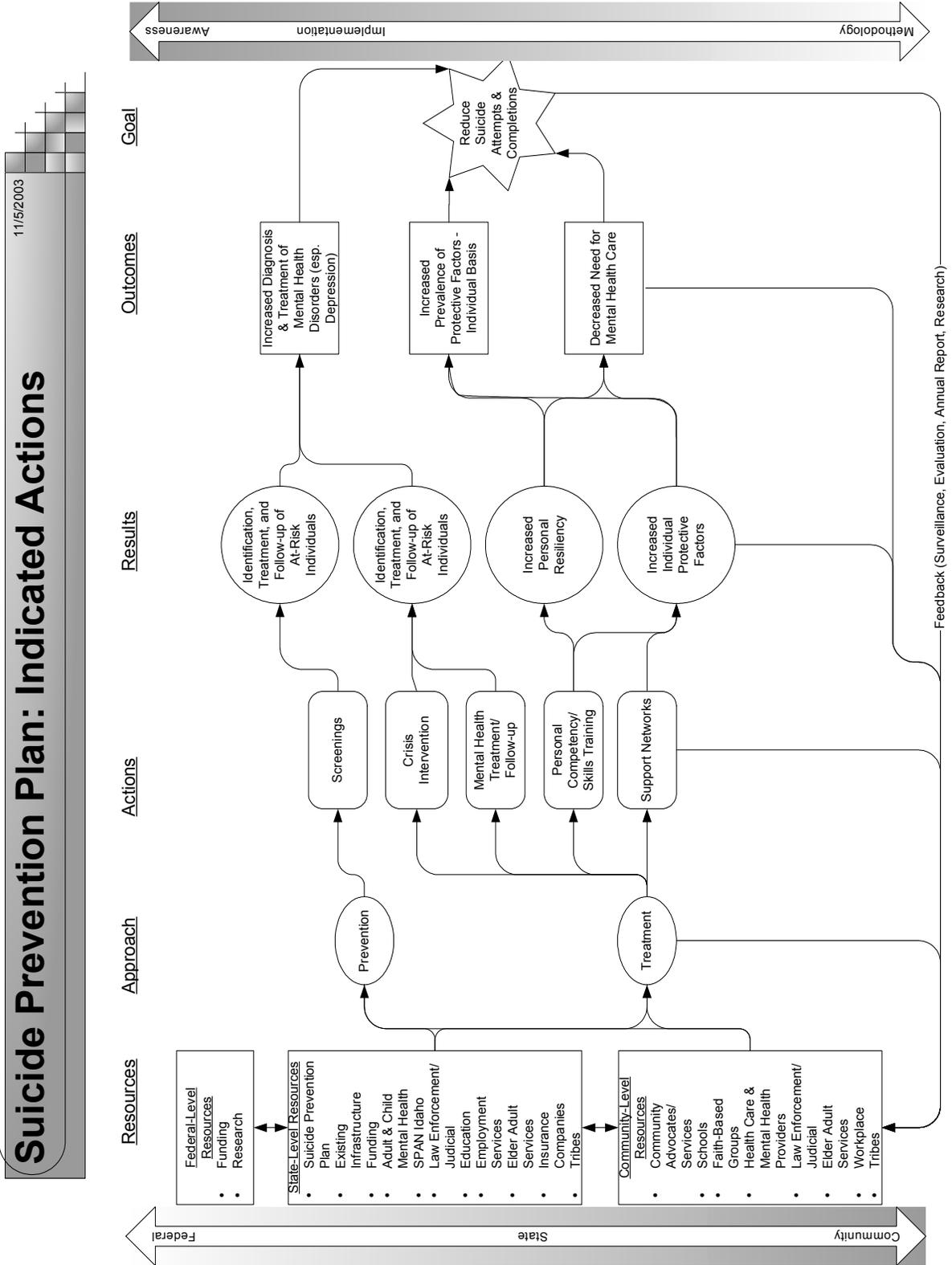
Appendix D

Suicide Prevention Plan: Selective Actions

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Appendix E



Glossary

Best Practices — activities or programs that are in keeping with the best available evidence regarding what is effective.

Effective — prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Evaluation — the systematic investigation of the value and impact of an intervention or program.

Gatekeepers — those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal — a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Means — the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Outcome — a measurable change in the health of an individual or group of people that is attributable to an intervention.

Protective factors — factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Resource — a source of supply or support (e.g., technical assistance, training, funding, etc.).

Risk Factors — those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Social Support — assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Stigma — an object, idea, or label associated with disgrace or reproach.

Strategy — a method or approach for achieving an end.

Suicidal Ideation — self-reported thoughts of engaging in suicide-related behavior.

Suicide Attempt — a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide — death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.



Suicide Attempt Survivors — individuals who have survived a prior suicide attempt.

Suicide Survivors — family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance — the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Technical Assistance — consultation to provide special knowledge, training, data products, etc.

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