

Recommendations for Suicide Prevention in Nebraska

A Report on the
Nebraska Suicide Prevention Symposium

August 11, 2006

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



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Nebraska Health and Human Services System Injury Prevention Program
Nebraska State Suicide Prevention Committee
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BryanLGH Medical Center provided meeting space and supplies for the Nebraska Suicide Prevention Symposium.

The following experts volunteered their time for the Expert Q&A session:

Don Belau, Ph.D., Director of Treatment Services, Youth Rehabilitation and Treatment Center-Geneva

Dave Miers, M.S., Manager of Mental Health Services, BryanLGH Medical Center Mental Health Services

Trish Schuster, suicide survivor, Suicide Prevention Committee

Robin Zagurski, MSW, Department of Psychiatry, University of Nebraska Medical Center

The following volunteers served as small-group facilitators or recorders:

Jeanne Bietz, Nebraska Health and Human Services System, Injury Community Planning Group (Recorder)

Cheryl Bullard, Nebraska Health and Human Services System (Recorder)

Heidi Gubanyi, Four Corners Health Department, Injury Community Planning Group (Facilitator)

Nancy Hall, Madonna Rehabilitation Hospital, Injury Community Planning Group (Facilitator)

Stephen Jackson, Nebraska Health and Human Services System (Facilitator)

Laurie Klosterboer, Nebraska Safety Council, Injury Community Planning Group (Recorder)

Barbara Pearson, Nebraska Health and Human Services System (Facilitator)

Arnold Remington, Targeted Adult Service Coordination, Suicide Prevention Committee (Recorder)

Table of Contents

Executive Summary	1
Introduction	2
The Symposium	3
Recommendations for Suicide Prevention in Nebraska	7
Briefing Materials	Appendix A
Evaluation of the Nebraska Suicide Prevention Symposium	Appendix B

Executive Summary

In Nebraska, suicide was the leading cause of injury death for adults ages 25-64, and the second leading cause of injury death for all age groups combined during the years 1999 through 2003. The suicide rate for Nebraska teens age 17 and under is higher than the national average.

To address the problem of suicide in Nebraska, the Nebraska Health and Human Services System Injury Prevention Program, the Injury Community Planning Group (ICPG), and the Nebraska State Suicide Prevention Committee sponsored the Nebraska Suicide Prevention Symposium. The Symposium, held June 23, 2006, in Lincoln, Nebraska, brought together a variety of interested stakeholders to develop these Recommendations for Suicide Prevention in Nebraska. The Prevention Committee had in 1999 developed a broad-based Suicide Prevention Plan (revised in 2004) it viewed as a vision for suicide prevention, but no action was taken on the plan because of a lack of funding. Committee members felt the need to engage a diverse group to translate that vision into an action plan. Knowing that granting agencies look for stakeholder buy in when making funding decisions, the committee decided that building widespread stakeholder consensus at the Symposium would position Nebraska well to obtain the funds necessary to reduce injuries and death from suicide in our state.

The Planning Committee wanted a highly efficient process that would gather input from a large group of stakeholders who all had many other activities competing for their time. Members selected a participatory process called a consensus conference to structure the Symposium. The process takes a diverse group of stakeholders with varying amounts of knowledge about a topic and puts them on a level playing field so they can reach consensus on a decision that needs to be made.

Symposium participants read carefully prepared briefing materials ahead of time, listened to presentations from a mental-health expert and a suicide survivor, then broke into small groups to discuss what they still needed to know to make informed choices among the options for suicide prevention initiatives. They drafted questions for an invited panel of experts, came back together in a large group to get them answered by the expert panel, then broke up again into small groups to draft action plan recommendations. Gathering once more in a large group, they voted on which four of 11 recommendations should be pursued. Finally, they deliberated over which of the several recommendations receiving similar amounts of support should be selected as the fourth action plan item, reached a mutual understanding of what the recommendations would involve, and decided to combine aspects of several recommendations into action plan items.

Participants selected these action plan priorities:

1. Explore collaboration between the Nebraska Department of Education, the Nebraska Health and Human Services System and the State Suicide Workgroup to develop a state-wide program of suicide assessment and prevention to integrate in school curricula.
2. Gather all suicide data available from state, county and local agencies, hospitals, and other organizations in order to obtain a better understanding of suicide in Nebraska, publish the data and prevention resources in print and on a state suicide education Web site, and target the resources especially to rural areas, health care providers, and schools.
3. Explore the implementation of the Emergency Department Means Restriction Education program, with inclusion of all emergency responders, not just emergency room staff. (See description in Appendix A.)
4. Implement a yearlong, statewide public awareness campaign that includes a focus on firearm safety in light of the new law allowing concealed weapons in Nebraska and employs communications tools developed by Project Relate. (See description in Appendix A.)

Introduction

In Nebraska, suicide was the leading cause of death due to injury for adults ages 25-64, and the second leading cause of injury death for all age groups combined during the years 1999 through 2003. The suicide rate for Nebraska teens age 17 and under is higher than the national average. (See Appendix A.)

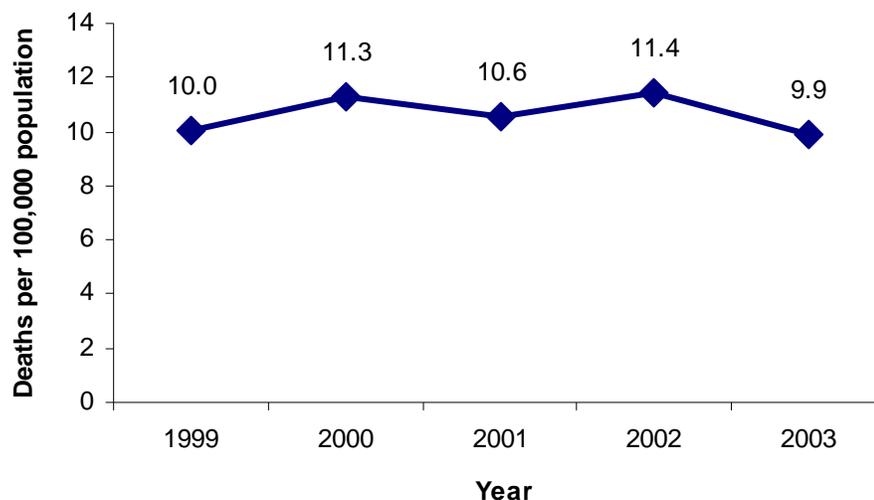
The Nebraska Health and Human Services System (HHSS) Injury Prevention Program, which is partially funded by a grant from the Centers for Disease Control and Prevention, is charged with conducting an injury prevention symposium each

budget year. Representatives of the Injury Community Planning Group (ICPG—the group that advises the Injury Prevention Program) formed a Planning Committee and recommended to the ICPG that the focus of this year’s symposium be suicide prevention. The Planning Committee worked closely with the Suicide Prevention Committee to plan the Nebraska Suicide Prevention Symposium.

The Symposium, held June 23, 2006, in Lincoln, Nebraska, brought together a variety of interested stakeholders to develop this Action Plan for Suicide Prevention in Nebraska. The Prevention Committee developed in 1999 and revised in 2004 a broad-based Suicide Prevention Plan it viewed as a vision for suicide prevention, but no action was taken on the plan because of a lack of funding. Committee members felt the need to engage a diverse group to translate that vision into an action plan. Knowing that granting agencies look for stakeholder buy-in when making funding decisions, the Prevention Committee decided that building widespread stakeholder consensus at the Symposium would position Nebraska well to obtain the funds necessary to reduce injuries and death from suicide in our state.

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**Figure 1: Age-adjusted suicide death rates
Nebraska residents, 1999-2003 (n=894)**



Source: NHHSS Vital Statistics 1999-2003

structure the Symposium. The process takes a diverse group of stakeholders with varying amounts of knowledge about a topic and puts them on a level playing field so they can reach consensus on a decision that needs to be made. Symposium participants read carefully prepared briefing materials ahead of time, listened to presentations from a mental-health expert and a suicide survivor,¹ then broke into small groups to discuss what they still needed to know to make informed choices among the options for suicide prevention initiatives. They drafted questions for an invited panel of experts, came back together in a large group to get them answered by the expert panel, then broke up again into small groups to draft action plan recommendations. Gathering once more in a large group, they voted on which four of 11 recommendations should be pursued. Finally, they deliberated over which of the several recommendations receiving similar amounts of support should be selected as the fourth action plan item, reached a mutual understanding of what the recommendations would involve, and decided to combine aspects of several recommendations into action plan items.

This report details each step of the consensus conference to show how participants arrived at their action plan recommendations, then presents the recommendations themselves.

¹ A suicide survivor is a family member or friend of a person who commits suicide.

The Symposium

The Symposium's consensus conference process started with e-mail recruitment of a list of approximately 50 stakeholders selected by the Nebraska State Suicide Prevention Committee. Committee members compiled a diverse list of stakeholders including suicide survivors, school administrators and counselors, media, insurance industry, minority health, emergency medical services, behavioral health, state agency personnel, and others. Thirty-two people responded to one of several e-mail solicitations by registering online for the Symposium. Twenty-eight people attended the Symposium.

Briefing Materials

The Committee compiled information about suicide for inclusion in a packet of briefing materials. Well-organized background information is important in a consensus conference because it allows participants to start from a common base of information. This can help reduce the imbalances that occur in group decision-making when some group members have access to better information than the others. The Symposium briefing materials included statistics on suicide in Nebraska drawn from HHSS vital statistics data, hospital discharge data, and Child Death Review Team data; promising prevention practices taken from the Suicide Prevention Resource Center's list of evidence-based practices, other promising practices compiled by Nebraska agencies, a copy of the Prevention Committee's previous Nebraska State Suicide Prevention Plan; and an explanation of how consensus conferences work. The briefing materials are reprinted in Appendix A.

Background Presentations

Participants heard two presentations, one from a hospital mental health program manager and one from the mother of a teenager who died from suicide. The manager, Dave Miers of BryanLGH Medical Center West, discussed the Prevention Committee's creation of the Southeast Nebraska Suicide Prevention Project.² That project developed suicide prevention curricula for clergy, educators, law enforcement officials, and health care workers. It has enjoyed success. Law-enforcement agencies nationwide have asked about the law-enforcement cur-



Trish Schuster tells Symposium participants what she learned about suicide following her daughter's death.

riculum, and the Nebraska Law Enforcement Training Center in Grand Island has adopted it. The health care module is in use across Nebraska in Emergency Protective Custody training and presented regularly to Nebraska hospitals that are part of the Heartland Health Alliance. In developing the clergy module, the project pilot-tested eulogy recommendations written by Dr. David Litts of the Suicide Prevention Resource Center. Miers went on to discuss several suicide prevention programs in use in Nebraska, including Greenline Suicide Prevention Program, a system of staff supervision and counseling interventions designed to reduce the risk of suicidal and self-injurious behaviors among youth at the HHSS Youth Rehabilitation and Treatment Center in Geneva; and Project Relate,³ which aims to reduce the stigma of mental illness through television, print, billboard, and radio advertisements.

Trish Schuster told a moving personal story about the death by suicide of her teenage daughter, Dawn, and shared the many things she has learned about suicide. Beginning with a series of profiles of teenagers, she asked participants to try to guess which one might be expected to be at risk for suicide, then moved to a discussion of the stigma sur-

² More information is available at <http://www.nebhands.nebraska.edu/clinicalbehav.html#suicide>. Follow the links under the heading "Nebraska Suicide Prevention Training Curriculum."

³ <http://www.projectrelate.org>



Expert panelist Dave Miers answers a question from the audience.

rounding mental illness, the treatable nature of mental illness, and how to help depressed teenagers and train others to help as well. She described her and her family's experiences following Dawn's suicide in order to offer insights for suicide survivors. She recommended, and others mentioned later in the day, a book by Cait Irwin, "Conquering the Beast Within." She concluded by repeating a theme threaded through her presentation: "It takes a village to raise a child, and it takes a village to save a child."

First Small-Group Discussion

Organizers randomly assigned participants to one of four small groups when they arrived at the Symposium. Each small group had seven participants, a facilitator responsible for keeping the group on task, and a recorder who took notes about the group's deliberations. The Injury Prevention Program recruited the facilitators and recorders from the Injury Community Planning Group, the Suicide Prevention Committee, and HHSS Disease Prevention and Health Promotion. They received training from a consultant hired to facilitate the entire symposium. The Symposium facilitator, John Fulwider, based the training on materials from the Study Circles Resource Center, the National Issues Forum Institute, the By the People project of MacNeil/Lehrer Productions, and his own academic re-

search into participatory decision-making methods.

Small-group participants discussed the briefing materials and background presentations, then drafted two questions per group they still wanted answered in order to make fully informed decisions about what action plan items to recommend. The groups engaged in wide-ranging and very different discussions that reflected the diversity of their members. One group focused intently on suicide prevention in the schools, leading members to draft these two questions: "How do you bring awareness to parents and students regarding who is at risk and what to do about it?" and "How do we deal with the difficulties balancing confidentiality with disclosure and response?" Members in that group talked about the challenges involved in deciding how much to hold in confidence when a teenager decides to trust them with important information. One member said, "I worry about pressing too hard."

Another group's interests tended toward understanding existing research about suicide and wondering about the status of research and prevention program collaboration between Nebraska entities and national groups. The third group's discussion focused on two topics, suicide risk factors for children and the special cultural considerations when designing prevention programs for Nebraska's American Indian tribes. One of that group's questions was, "How do we target underrepresented populations with culturally specific interventions in geographically diverse areas?" The fourth group's discussion was notable for its emphasis on suicide among the elderly; members wondered whether Nebraska has an elder death review team that might better reveal the true incidence of suicide among the elderly, and talked about some of the reasons older people might choose to end their lives.

Expert Panel Q&A

Four volunteers comprised the expert panel: Don Belau, Ph.D., Director of Treatment Services, Youth Rehabilitation and Treatment Center-Geneva; Dave Miers, MS, Manager of Mental Health Services, BryanLGH Medical Center Mental Health Services; Trish Schuster, suicide survivor; and Robin Zagurski, MSW, Department of Psychiatry, University of Nebraska Medical Center.

Second Small-Group Discussion

The small groups met once more, this time tasked with drafting two to four recommendations each for what items should be included in the Action Plan for Suicide Prevention in Nebraska. The first group talked about focusing on prevention education in the schools, as well as expanding the currently hospital-based Emergency Department Means Restriction Education program – which instructs parents of youth at high risk of suicide about limiting access to firearms, medication, alcohol, and other lethal means of suicide. The second group's discussion included in-depth strategizing about a yearlong and statewide public awareness campaign that would especially reach residents of Nebraska's rural areas. The group noted that Project Relate already had developed some public service announcements, and thus there was no need to "reinvent the wheel." Members also talked about funding sources for such a campaign, which could be expensive to produce. The third group had an innovative idea that tied in well with the second group's proposal for an awareness campaign: members proposed that the campaign focus on properly securing firearms, given that Nebraska's law allowing people to carry concealed weapons will go into effect in January 2007. The fourth group was concerned with ensuring that information and training about suicide prevention be delivered in culturally and linguistically appropriate ways, and also shared several emphases with other groups – notably a desire to expand the Emergency Department program, and to work on prevention education in the schools.

Large-Group Discussion

Participants took a break after their second small-group discussion. During the break a ballot was assembled containing each small group's recommendations. Several similar recommendations were combined, whittling a 16-item list down to these 11, listed in random order:

1. Develop a comprehensive tool kit of resources and information that is targeted to rural areas and special populations (medical providers, schools, etc.) related to suicide prevention and awareness. Written and electronic tool kit. / Integrate all behavioral health, public health and institutional data to



Symposium participants met in small groups to weigh the pros and cons of various suicide prevention strategies.

- get a better picture of what the problem is. Develop a website for dissemination of data and resources for suicide prevention.
2. Increase the level of awareness and action of the medical community in addressing mental illness.
3. Implement a yearlong statewide public awareness campaign.
4. Organize a statewide suicide prevention and recovery symposium bringing together stakeholders that offer resources, providing networking opportunities.
5. Develop a K-12 curriculum state wide on suicide prevention that can be integrated into current curriculum. / Develop a collaboration with the Nebraska Department of Education to develop a statewide plan to integrate suicide prevention into school system curricula. / Collaborate with the Dept. of Education and Health and Human Services System to develop a statewide program for assessment and intervention in Nebraska Schools.
6. Create a public educational campaign about locking up firearms in light of the concealed weapon law that will go into effect in January 2007.
7. Implement the Local Outreach to Suicide Survivors (L.O.S.S.) program throughout the

state but on a local basis including the components to support the program.

8. Implement teacher and clergy competencies in suicide prevention education.

9. Create regional implementation teams so that rural areas would have a more rural focus, cities would have a more urban focus, with diverse stakeholder representation.

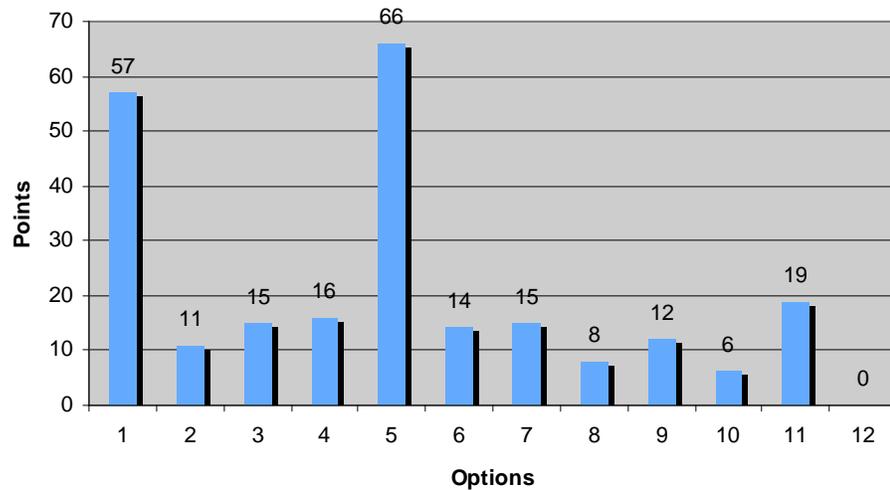
10. Behavioral health and public health officials will receive information/training on building resilience in a culturally competent and linguistically appropriate way.

11. The Emergency Department Means Restriction Education program targeting multi-generations will be implemented and expanded to include all emergency medical responders as well as emergency department staff.

After the break participants each selected their top four preferences. The results were tabulated and displayed as a bar chart showing which action items had the greatest support. In calculating support for the action items, four points were assigned each time an item was someone's Number One pick, three points when it was someone's second choice, two points for a third choice, and one point for a fourth choice. The results, shown in Figure 1, revealed clear group support for item 5, the statewide K-12 curriculum; item 1, the resource toolkit and suicide Web site; and item 11, the expansion of the Emergency Department program.

There was no clear fourth pick. A discussion took place regarding which of the several items receiving similar support should be selected. The deliberation focused initially on whether to adopt item 4, the statewide suicide prevention and recovery symposium, even though it had received just one point more than item 3, the yearlong statewide

Figure 2: Suicide Prevention Action Plan Options



public awareness campaign, and item 7, implementing the L.O.S.S. program statewide. Other possibilities discussed were further expanding the Emergency Department item to include developing a standard protocol for suicide response, combining the statewide symposium and the public awareness campaign, wrapping the concealed weapons education initiation and the statewide public awareness campaign together, and expanding the statewide awareness campaign to include Project Relate's teen improvisational theater group. After a short time the group seemed to settle on selecting the statewide awareness campaign as its fourth action item choice – with the concealed weapons education and improv group included.

Writing the First Draft

The first draft of this report was e-mailed to Symposium participants, who were given time to comment on it by e-mail or telephone. Comments were received from three participants, and are reflected in this report.

Recommendations for Suicide Prevention in Nebraska

Symposium participants selected four items for inclusion in the Recommendations for Suicide Prevention in Nebraska. They are:

- I. Explore collaboration between the Nebraska Department of Education, the Nebraska Health and Human Services System and the State Suicide Workgroup to develop a statewide program of suicide assessment and prevention to integrate in school curricula.
 - a. Implement the Columbia University TeenScreen Program in schools. Rated “promising” by the Suicide Prevention Resource Center, the program’s purpose is to “identify youth who are at-risk for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation.” The program has three stages: (1) Completion of a self-administered screening instrument. (2) Interviews with a clinician for students who screen “positive.” (3) Connection with a case manager for students found to need additional services. The program is flexible for schools that have different levels of resources and administrative structures, as the people who work with students who screen positive can be existing staff or external teams.
 - b. Partner with Nebraska Health and Human Services System to develop a plan to provide behavioral health professionals when schools need them to implement the TeenScreen program.
 - c. Include suicide education as a part of the teacher certification process.
 - d. Deemphasize handing out information to teenagers, and instead work to develop caring relationships with them.
2. Gather all suicide data available from state, county and local agencies, hospitals, and other organizations in order to obtain a better understanding of suicide in Nebraska, publish it and prevention resources in print and on a state suicide education Web site, and target the resources especially to rural areas, health care providers, and schools.
 - a. Consider advertising on the popular Web site MySpace.com or other Web sites popular with young people to draw attention to the suicide education Web site. The Web site must be multi-lingual.
 - b. Provide resources appropriate to a variety of groups, including health care providers, parents, and teachers.
 - c. Consult rural stakeholders to determine what resources they need.
 - d. Work to gather data from correctional facilities on inmate suicide attempts and completions.
 - e. Because only some hospitals report discharge data, information on suicide attempts and completions from hospitals is incomplete. Work to get more hospitals to report these data.
3. Explore the implementation of the Emergency Department Means Restriction Education program, with inclusion of all emergency responders, not just emergency room staff.
 - a. Include suicide training in, for example, emergency medical technician (EMT) training.
 - b. Develop a best-practice standard procedure for emergency personnel statewide to use in situations involving attempted suicide, to cover especially what measures are taken to assist people who survive suicide attempts.
 - c. Provide continuing education units (CEUs) to encourage medical personnel to take suicide training courses.
 - d. Provide critical incident stress management training for first responders who respond at the scene of a completed suicide.
 - e. Provide the Emergency Department Means Restriction Education program training to others in the community, for example religious leaders and counselors,

- so they can educate parents about means restriction as well.
 - f. Provide the training to law enforcement personnel at jails.
- 4. Implement a yearlong, statewide public awareness campaign that includes a focus on firearm safety in light of the new law allowing concealed weapons in Nebraska and employs communications tools developed by Project Relate.
 - a. Focus on properly securing firearms, given that Nebraska's law allowing people to carry concealed weapons will go into effect in January 2007.
 - b. Focus especially on reaching residents of Nebraska's rural areas.
 - c. Avoid "reinventing the wheel" by taking advantage of Project Relate's already-developed public service announcements.
 - d. Also employ Project Relate's teen improvisational theater group for outreach.
 - e. Depending on the availability of funds, consider all media outlets – newspapers, radio, television, and Web advertisements.
 - f. As one option for funding, ask broadcast stations to adopt suicide prevention as their public-service program for the year and give free air time.
 - g. Ensure that information about suicide prevention is delivered in culturally and linguistically appropriate ways.
 - h. Find celebrities touched by suicide and recruit them to speak at news conferences across the state.

Appendix A: Briefing Materials

Briefing Materials

Nebraska Suicide Prevention Symposium

Inside You'll Find:

- Statistics on suicide in Nebraska, broken down by demographic characteristics and method used
- Promising practices used elsewhere to reduce suicide rates among various groups
- An earlier draft of a suicide prevention plan created by the Nebraska's State Suicide Prevention Committee
- A detailed explanation of the "consensus conference" decision-making process

Why This Symposium?

In Nebraska, suicide was the leading cause of injury death for adults ages 25-64, and the second leading cause of injury death for all age groups combined during the years 1999 through 2003. **The suicide rate for Nebraska teens age 17 and under is higher than the national average.** (See pages 2-4 for more statistics.)

The Nebraska Health and Human Services System Injury Prevention Program and the Nebraska State Suicide Prevention Committee are sponsoring the Nebraska Suicide Prevention Symposium. The Symposium will bring together a variety of interested stakeholders with the goal of developing an "Action Plan for Suicide

Prevention in Nebraska."

This symposium is being held with funding from a Centers for Disease Control and Prevention Injury Grant. There have been suicide prevention activities conducted in the past, but there has not been a coordinated effort. There is a volunteer workgroup, but their efforts are limited by the lack of funds and competing demands on its members.

The Suicide Prevention Workgroup, the volunteer workgroup, has developed a broad-based Suicide Prevention Plan (see page 7). This plan is a vision for suicide prevention; with the Symposium, we hope to **translate that vision into action.** The Action

Plan that is developed will be one that will be owned by a variety of stakeholders. Granting agencies look for stakeholder buy-in when making funding decisions; with the widespread stakeholder consensus we will develop at the Symposium, Nebraska will be well-positioned to **obtain the funds necessary** to reduce injuries and death from suicide in our state.

The day's agenda includes small-group discussion and the opportunity to question a panel of experts. The Symposium will employ an efficient, stimulating decision-making process called a "consensus conference" (see page 8) that gives everyone a full and fair chance to have a say in drafting the Action Plan.

Contents

Suicide in Nebraska **2**

Promising Practices **5**

State Suicide Prevention Plan **7**

How a Consensus Conference Works **8**

Agenda

9 a.m.	Welcome Joann Schaefer, Chief Medical Officer Nebraska Health and Human Services System	Sandwich Buffet Moderator: John Fulwider Panelists: Robin Zagurski, LCSW, UNMC Don Belau, Ph.D., YRTC-Geneva Dave Miers, MS, BryanLGH Trish Schuster
9:10 a.m.	The Consensus Conference: An Introduction John Fulwider, Consultant	12:30 p.m. Small-Group Discussions Topic: Draft action plan priorities
9:20 a.m.	Background on Suicide Prevention Dave Miers, BryanLGH Mental Health	1:45 p.m. Break
9:35 a.m.	Profile of a Depressed Teenager Trish Schuster	2:00 p.m. Large-Group Discussion Topic: Select action plan priorities Moderator: John Fulwider
10:00 a.m.	Break Coffee and rolls	3:15 p.m. Concluding Comments Peg Prusa-Ogea, HHSS Diana Miles, CDC
10:15 a.m.	Small-Group Discussions Topic: Draft questions for expert panel	
11:30 a.m.	Working Lunch / Expert Q&A	

Suicide in Nebraska

Overview

In Nebraska, suicide was the leading cause of injury death for individuals age 25-64, and the second leading cause of injury death for all age groups combined between 1999 and 2003. On average, 179 Nebraskans (10.6 per 100,000) died and 1,276 (75 per 100,000) were treated at a hospital for suicide/self-inflicted injuries in Nebraska each year.

Deaths

The age-adjusted death rate for suicide remained relatively stable from 1999 to 2003 in Nebraska. The range of the age-adjusted rate was from 9.9 to 11.4 per 100,000 population.

Suicide rates varied by age, gender and race. Among Nebraska residents, the suicide death rate was the lowest for persons under age 15 (0.8 per 100,000), and was the highest for persons age 35-44 (15.1 per 100,000). For males, the highest rate of death from suicide occurred among Nebraskans age 85 and older (35.5 per 100,000). For females, the highest rate was seen in the 35-44 age group (6.1 per 100,000).

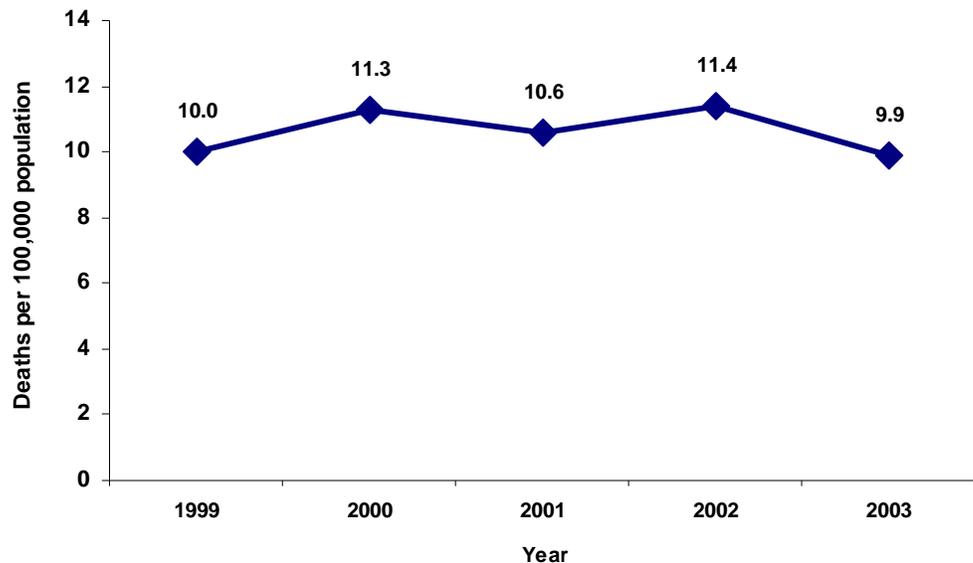
Suicide was the second leading cause of injury death for males and the third leading cause of injury death for females. Males were more likely to die from suicide than females for all age groups except for ages 5-14. Males age 75-85 and older were 15 times more likely to die from suicide than were females of the

same age group. The age-adjusted suicide death rate was more than 5.7 times higher for males than for females (18.3 vs. 3.2 per 100,000 respectively).

Whites had the highest suicide rate (10.9 per 100,000); the rate was 1.8 times higher than the rate for African Americans. The age-adjusted suicide death rates for Asians and African Americans are significantly lower than the state rate (8.5 and 6.2, vs. 10.6 per 100,000 respectively).

The methods used in suicide also differed by age. Firearms were the leading cause of suicide death among Nebraskans of all ages. Suffocation and poisoning were also methods that resulted in suicide deaths and were seen more frequently in younger age groups (age 15 – 54) than in older age groups.

Age-adjusted suicide death rates
Nebraska residents, 1999-2003 (n=894)



Source: NHHSS Vital Statistics 1999-2003

Hospital Discharges

The overall estimated age-adjusted rate of hospital discharge for suicide injuries resulting from suicide attempts was 75 per 100,000 residents in Nebraska.

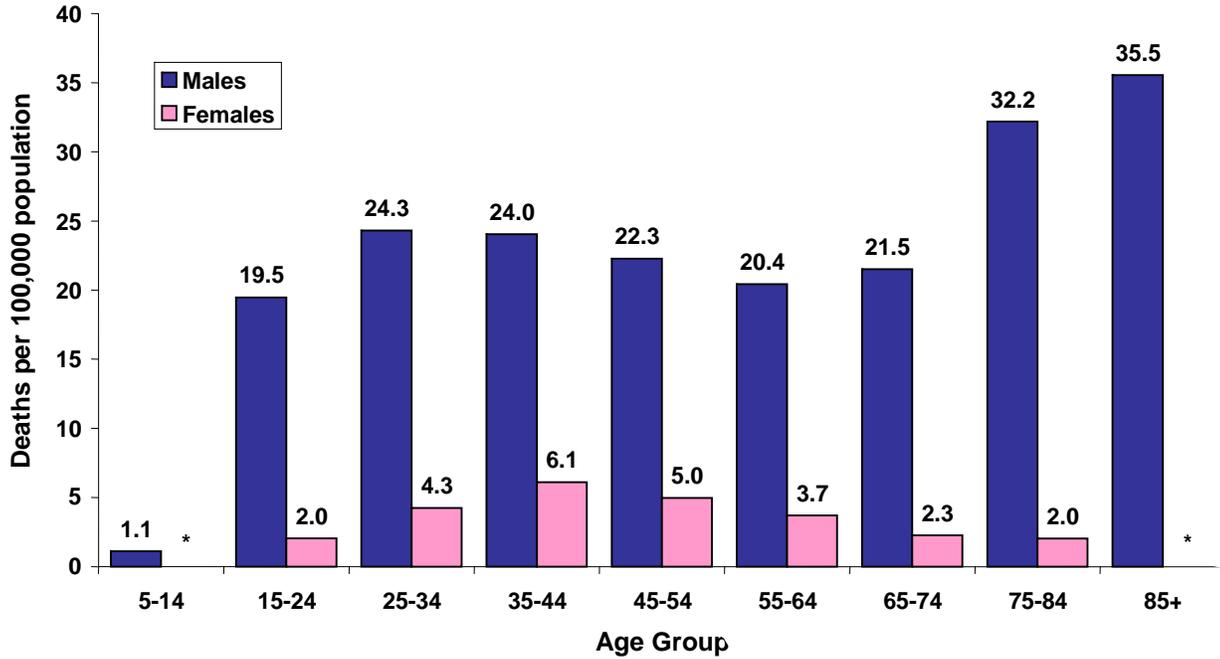
The rate of hospital discharges for suicide attempts differed significantly by age and gender. For the age groups from 5-64 years, hospital discharge rates for suicide attempts were higher for females than for males. This pattern differs from suicide deaths in which males predominate. Higher rates of hospital discharges for suicide attempts were seen among Nebraskans age 15-44. The highest rate was seen in the 15-24 age group for both males and females (117 and 244 per 100,000 respectively).

For both gender groups and

all age groups, hospital discharges for suicide attempts were most frequently the result of poisoning (78.8%). The rate for suicide attempts by poisoning was more than twice as high for females as for males (82.5 for female vs. 35.4 for male). However, the age-adjusted rate of hospital discharge for suicide attempts by firearms was five times higher for males (2.1) than for females (0.4).

The methods used in suicide attempts resulting in hospital treatment were different from those resulting in death. Approximately 79 percent of hospital visits for suicide attempts were the result of poisoning, 14 percent were due to cutting/piercing, and 2 percent due to firearms. In contrast, the majority of suicide deaths were the result of firearms (57%), suffocation (21.7%), or poisoning (16.4%).

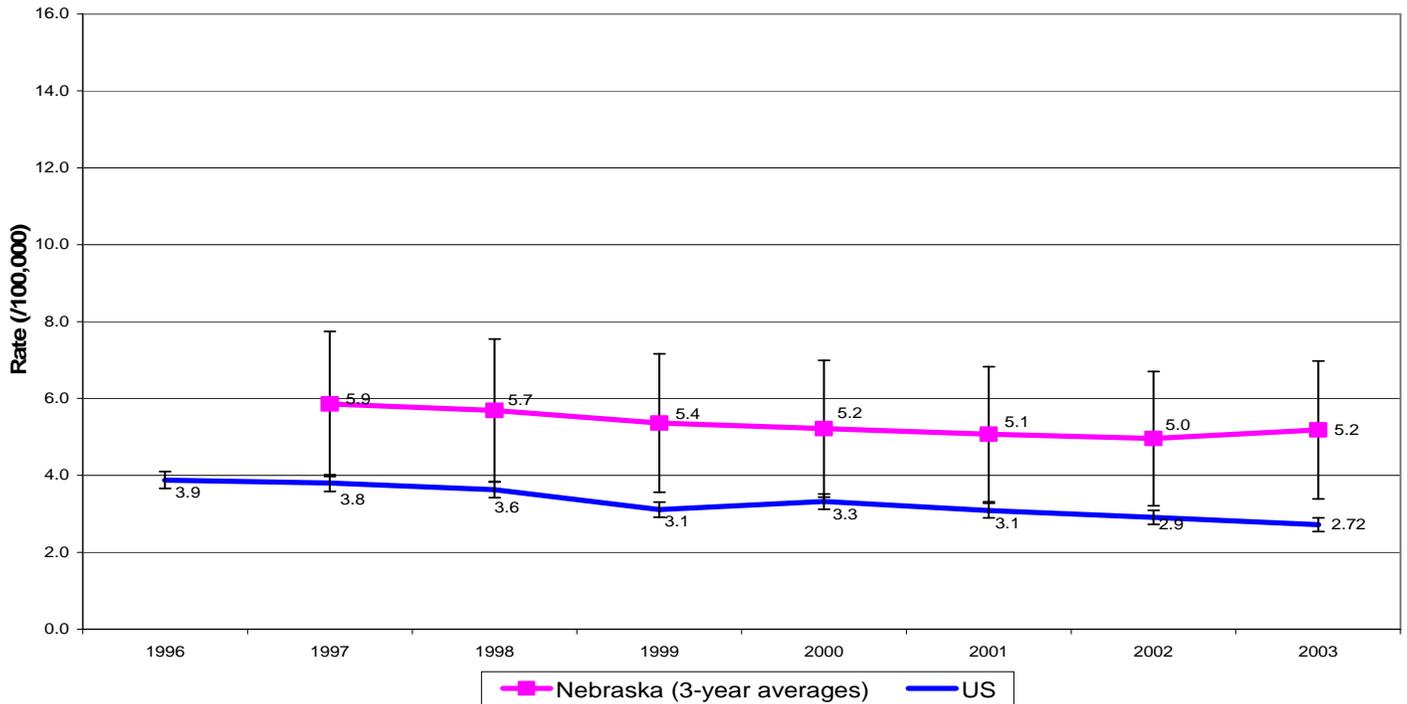
**Suicide death rates by age and gender
Nebraska residents, 1999-2003 (n=894)**



*Fewer than five deaths

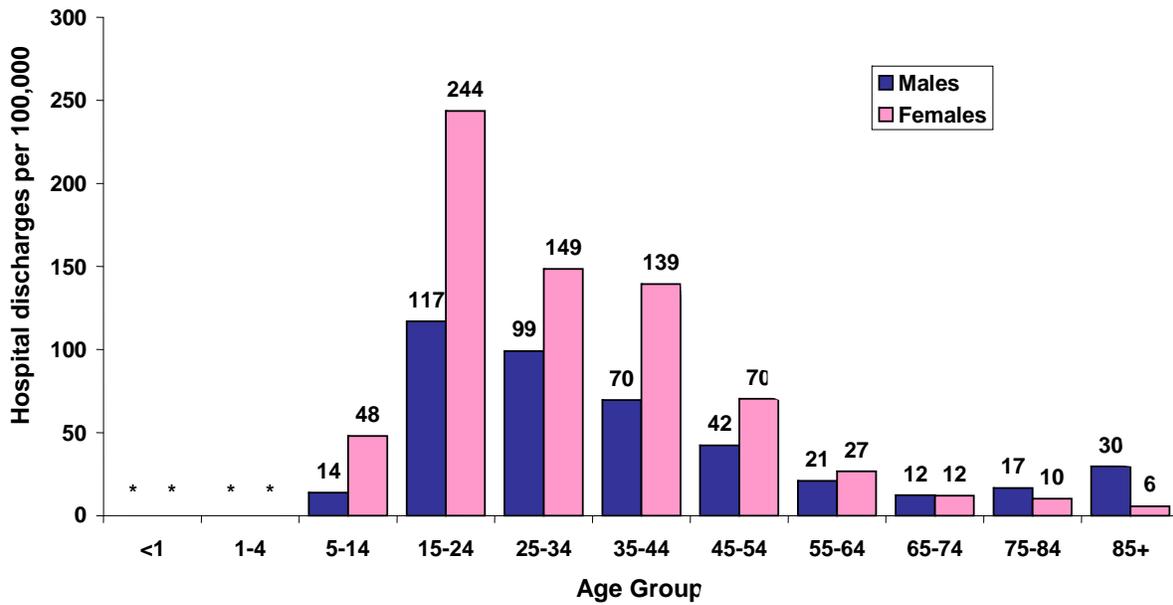
Source: NHHSS Vital Statistics 1999-2003

**Suicide Rates, Children Ages 10-17
US and Nebraska, 1996-2003**



Nebraska rates are three year averages. The 95% confidence intervals around each point are also shown. Nebraska rates are significantly higher than US rates for 1999 and 2002 (confidence intervals do not overlap).

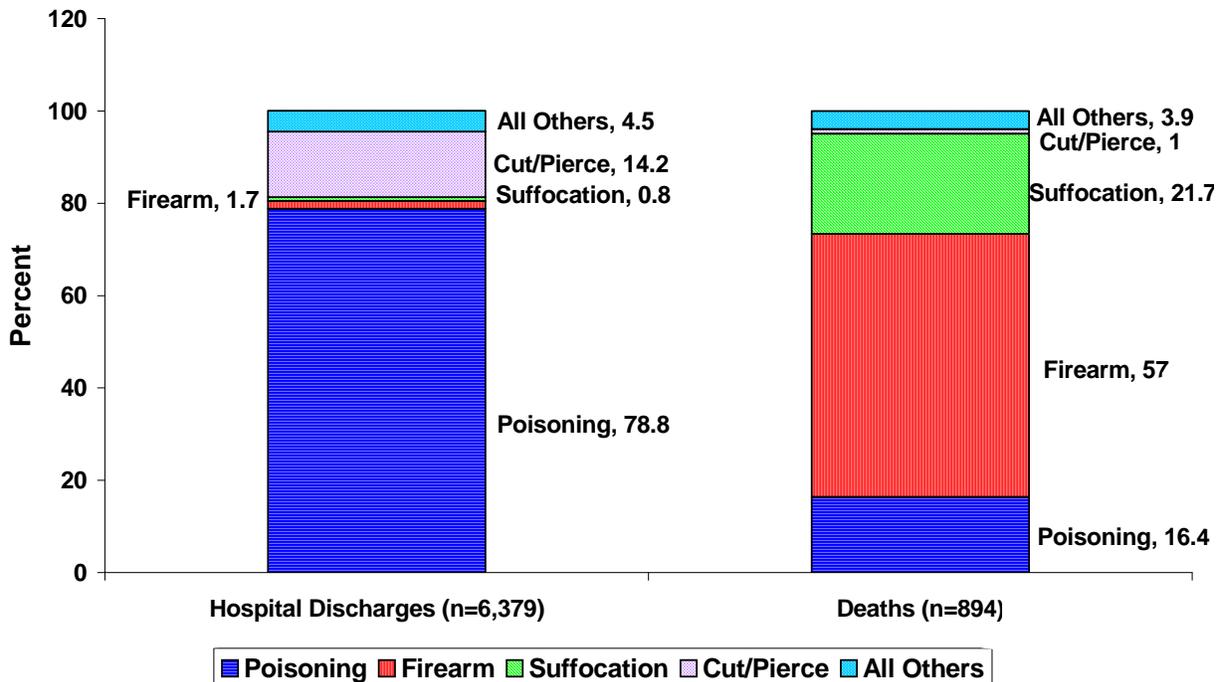
**Suicide attempt hospital discharge rates by age and gender
Nebraska residents, 1999-2003 (n=6,379)**



*Fewer than five discharges

Source: NE Hospital Discharge Data 1999-2003

**Comparison of methods used, suicide hospital discharges vs. deaths.
Nebraska residents, 1999-2003**



Source: NE Hospital Discharge Data & NHHSS Vital Statistics 1999-2003

Promising Practices

Emergency Department Means Restriction Education

The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted by department staff (an unevaluated model has been developed for use in schools).

Emergency department staff are trained to provide the education to parents of child who are as-

essed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised.

The content of parent instruction includes:

1. Informing parent(s), apart from the child, that the child was at increased suicide risk and why the staff believed so;
2. Informing parents that they can reduce risk by limiting access to lethal means, especially firearms; and,
3. Educating parents and problem solving with them about how to limit access to lethal means.

Intervention Type

Treatment

Target Age

6-19

Gender

Male & Female

Ethnicity

Multiple

Columbia University TeenScreen Program

The purpose of the Columbia TeenScreen Program (CTSP) is to identify youth who are at-risk for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation. While screening can take place in any number of venues, including juvenile justice facilities, shelters, and doctor's offices, the program has been primarily conducted in school settings. The program involves the following stages:

1. All students who have appropriate parent permission and who themselves assent to participation

complete one of three self-administered screening instruments: (1) the Columbia Health Screen (CHS), (2) the Columbia Depression Scale (CDS), or (3) the Diagnostic

Predictive Scales (DPS). The CHS is a 14-item self-report measure of suicide risk; the CDS is a 22-item depression screen; and the DPS is a computerized screen for depression, anxiety, and substance abuse.

2. Students who screen "positive" on the selected screening tool are interviewed by a clinician to determine if further evaluation is neces-

sary.

3. Students who are found to require additional services are connected with a case manager to arrange for appropriate intervention.

Recognizing that schools differ in regards to administrative structure and resources, TeenScreen provides examples of several intervention models for students who screen positive and are deemed "at-risk." These include existing staff, external team and one-person models.

Intervention Type

Treatment

Target Age

11-18

Gender

Male & Female

Ethnicity

Multiple

PROSPECT

The Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) intervention combines treatment guidelines for community-dwelling elderly populations with care management for patients diagnosed as depressed. Guidelines consist of a clinical algorithm for treating geriatric depression in a primary care setting, with citalopram being the first-line recommendation for pharmacotherapy. Care management is conducted by a "depression care manager" who works with the primary care phy-

sician (PCP) and a supervising psychiatrist. As described in the PROSPECT protocols:

"In PROSPECT, a specially trained master-level clinician works in close collaboration with a depressed patient's PCP to implement a comprehensive disease management program. When a patient had been diagnosed with a depressive syndrome that requires treatment, PROSPECT health specialists implement the various clinical tasks necessary for a successful treatment outcome, includ-

ing educating older depressed patients and their family about depression, identifying and addressing comorbid physical and psychiatric conditions interfering with antidepressant treatment, monitoring adherence, managing treatment-emergent adverse effects and regularly assessing change in depressive symptoms to evaluate whether the current treatment is effective or whether it needs to be modified."

Intervention Type

Treatment

Target Age

60+

Gender

Male & Female

Ethnicity

Multiple

C-Care/CAST

C-Care/CAST is a school-based intervention for students at risk for suicide. It combines one-on-one counseling with a series of small-group training sessions. C-Care (Counselors-Care) provides an interactive, personalized assessment and a brief motivational counseling intervention. It is delivered in 2 sessions: a 2-hour, one-to-one computer-assisted suicide assessment called the Measure of Adolescent Potential for Suicide and a 2-hour motivational counseling intervention designed to:

1. Deliver empathy and support;
2. Provide personal information;
3. Reinforce coping skills and help-seeking behaviors;
4. Increase access to help; and,
5. Enhance access to social support.

CAST (Coping and Support Training) is a small group skills training intervention. Twelve one-hour sessions incorporate key concepts, objectives, and skills

that are outlined in a standardized implementation guide. Sessions target mood management (depression and anger management), drug use control, and school performance by helping youth apply newly acquired skills and gain support from family and other trusted adult leaders. The implementation guide also specifies the motivational preparation and coaching activities required of the CAST leader (generally a master's level high-school teacher, counselor, or nurse).

Intervention Type	School-Based
Target Age	14-18
Gender	Male & Female
Ethnicity	Multiple

SOS: Signs of Suicide

SOS incorporates two prominent suicide prevention strategies into a single program, combining a curriculum that aims to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors associated with suicidal behavior. In the didactic component of the program, SOS promotes the concept that suicide is directly related to mental illness,

typically depression, and that it is not a normal reaction to stress or emotional upset. The basic goal of the program is to teach high school students to respond to the signs of suicide as an emergency, much as one would react to signs of a heart attack. Students are taught to recognize the signs and symptoms of suicide and depression in themselves and others and to follow the specific action steps

needed to respond to those signs.

Program activities include a 50-minute classroom presentation that features a 25-minute video, a teacher-led discussion, and the administration and scoring of the SOS Student Screening Form. Support materials such as posters, handouts, and cards are provided.

Intervention Type	School-Based
Target Age	14-18
Gender	Male & Female
Ethnicity	Multiple

Other Promising Practices

Brief Psychological Intervention after Deliberate Self-Poisoning: This intervention provides four sessions of psychotherapy for adults who deliberately poisoned themselves.

dropout, and other at-risk behaviors including suicide-risk behaviors.

Lifelines: Lifelines is a school-based suicide prevention curriculum comprised of four 45-minute sessions.

Specialized Emergency Room Intervention for Suicidal Adolescent Females: This intervention provides specialized emergency room care for female adolescent suicide attempters and their mothers.

Reconnecting Youth Class: Reconnecting Youth is a school-based selective/indicated prevention program that targets young people in grades 9 – 12 who show signs of poor school achievement, potential for school

Project Relate: Project Relate is a public service campaign that strives to break down the stigma and stereotypes associated with mental illness and help the public relate to those who cope with these issues.

The project is a joint effort between mental health service providers, advocacy groups, and non-profit organizations across Nebraska.

Zuni Life Skills Development: The Zuni Life Skills Development curriculum is a culturally tailored intervention that targets high school students.

the Coroner's office, LOSS acts as a first response team when a suicide occurs. The team, which consists of survivor volunteers and mental health staff, meet the coroner and other first response officials (law enforcement, etc.) at the scene of the suicide. LOSS team members are there to offer resources, support, and sources of hope to the newly bereaved.

L.O.S.S. (Local Outreach to Survivors): The LOSS (Local Outreach to Suicide Survivors) program is a pioneering effort to bring immediate support to survivors as close to the time of death as possible. Working with

Greenline Suicide Prevention Program: Greenline is a system of staff supervision and counseling interventions designed to reduce the risk of suicidal and self-injurious behaviors to youth residing in a correctional facility.

Nebraska State Suicide Prevention Plan

Nebraska's State Suicide Prevention Committee (NSSPC) embraces the aim and model proposed by the former United States Surgeon General, David Satcher, M.D., in the 2001 publication *National Strategy for Suicide Prevention: Goals and Objectives for Action*. The NSSPC enforces an open membership policy with a goal of promoting local, grassroots initiatives through the 2005-2006 Nebraska State Suicide Prevention Plan.

The Nebraska State Suicide Prevention Committee (NSSPC) has three subcommittees, Awareness, Intervention, and Methodology. The following is the 2005-2006 state plan as developed by these committees and approved by the overall NSSPC.

Awareness

- Promote awareness that suicide is a preventable public health problem.
- Disseminate information about resources and web sites available through faith based organization, service clubs, non profits, corporations and occupational health through private, public, and non-profit partners in the NSSPC and broader community
- Continue to reach out to public/private schools and colleges with special emphasis to the age group of 10-24 by including them in NSSPC activities
- Reach out to the elderly through Aging Services by

the dissemination of educational materials on depression and suicide prevention

- Provide State and Regional prevention programs with information about suicide prevention
- Work with public health and Cooperative Extension to more fully involve youth organizations in suicide prevention activities
- Build on "Project Relate" activities to reduce stigma associated with seeking help for mental health problems. Engage local foundations to promote activities associated with mental illness awareness week, suicide prevention month, and mental health month
- Increase access to community linkages with MH/SA services:
- Provide a link on the HHSS Suicide Prevention website for free depression screening provided by BryanLGH Medical Center
- Interchurch Ministries of Nebraska will publicize notice of screening availability to churches and encourage parish health nurses to include depression screening as wellness activities

Intervention

- Develop and implement suicide prevention programs
- Empower organizations to seek American Association

of Suicidology (AAS) national certification for crisis centers by encouraging Region 5 to educate the other Regions on the AAS Accreditation process

- Encourage organizations to become networked under a single, toll-free telephone number, 1.800.SUICIDE (784-2433) through the Kristin Brooks National Hopeline Network
- Put links to AAS and Hopeline Network on the HHSS Suicide Prevention website
- Expand Suicide Prevention Curriculum (SPC) training to law enforcement officers and fire personnel to include mandated training of new officers and renewed information for veteran officers
- Partner with the School Community Intervention Program (SCIP) at the Lincoln Medical Education Partnership to implement the Signs of Suicide (SOS) program to provide classroom suicide prevention education and depression screening
- Implement the Emergency Department Means Restriction Education program to educate parents and problem solve with them about how to limit access to lethal means following an episode in which a child presents with increased risk of suicide.
- Provide community-wide

crisis management support (postvention education) for dealing with a loss as a result of suicide by implementing training through the LOSS program (Local Outreach to Suicide Survivors)

- Develop and promote effective practices
- Continue to promote the use of the Teen Screen program by medical facilities that serve youth
- Continue use of Nebraska's Green Line program for juvenile residential settings
- Continue to update and distribute SPC via NEBHANDS website

Methodology

- Promote and support research on suicide and suicide prevention
- Promote evaluation on the Green Line Program to support its inclusion as evidence based practice
- Promote University of Nebraska research on suicide prevention, and Selective Serotonin Reuptake Inhibitors (SSRIs) role in suicide prevention
- Improve and expand surveillance systems
- Encourage Public Health integration of Mental Health data on suicide attempts, Regional Center admissions and Crisis Center admissions

How a Consensus Conference Works

Introduction

The decision-making process we will use at the Nebraska Suicide Prevention Symposium is called a consensus conference. This process takes a diverse group of stakeholders with varying amounts of knowledge about and interest in a topic and puts them on a level playing field so they can, it is hoped, reach consensus on some decision that needs to be made. Ideally, the process allows each participant a full and fair opportunity to influence the outcome, even when a large number of people need to be consulted. Consensus conferences are designed to minimize or eliminate some negative things that can happen when diverse groups interact, such as domination of the discussion by one or two influential or high-ranking people. They can also be more efficient, stimulating and rewarding for participants than alternative processes such as brainstorming sessions and formal committee meetings.

The Process

To understand a consensus conference, it helps to examine the thinking behind each of its parts:

Briefing Materials: Participants are sent briefing materials well in advance of the consensus conference. The materials are carefully prepared to present an objective summary of the matter to be discussed, including such things as the history of the problem, current statistics, and pro-and-con accounts of solutions tried in other times and places. Lack of knowledge is a key obstacle to people's full and fair participation in a discussion; the briefing materials help eliminate that obstacle.

Small-Group Discussion to Draft Questions: Participants are randomly assigned to small groups of 6-12 people, with whom they will meet twice during the conference. At the first meeting, small-group members have a broad discussion of the issue at hand, drawing heavily on the briefing materials. They ask each other questions about the briefing materials. Drawing on their own experiences and expertise, they offer additional information to the group that was not covered in the briefing materials. They determine what they still need to know in order to make a good decision, and work together to draft questions to ask a panel of experts. They submit their questions to a moderator, who combines duplicates in preparation for the upcoming Q&A with Experts segment.

Q&A with Experts: Each small group sits together in a large room with the other small groups. The moderator calls on groups in turn to ask their questions. (Each group selects a spokesperson or two.) An invited panel of subject experts chosen for their knowledge and their commitment to speak objectively answers the questions. The moderator works to ensure questions are answered to everyone's satisfaction, prompting the experts for more details as necessary.

Small-Group Discussion to Draft Priorities: Small-group members return to their meeting rooms for an in-depth discussion of the consensus conference objective. In the case of the Suicide Prevention Symposium, the objective is to craft an action plan for suicide prevention in Nebraska. Each small group will work together to draft five priorities for the action

plan (e.g. this action should be taken; money should be spent this way; etc.). They submit their priorities to a moderator, who compiles every group's submissions and uses them to create a ballot in preparation for the upcoming Large Group Discussion segment.

Large-Group Discussion: Participants again return to the large room for the final segment of the conference. Small groups sit together again at the same tables. Each participant ranks the priorities on the ballot, which includes his or her own group's ideas and those of other groups. The moderator tabulates the ballots quickly and displays a bar graph of the results. The assumption is that this first ballot will show high levels of agreement between participants. If it does not, the moderator leads a discussion aimed at reaching consensus, or a high level of agreement if consensus can't be reached in the time allowed. Additional ballots are taken if necessary.

History of Consensus Conferences: The National Institutes of Health developed a "consensus development conference" in 1977 to "produce evidence-based consensus statements addressing controversial issues in medicine important to health care providers, patients, and the general public." To avoid possible conflicts of interest in making recommendations, organizers select unbiased panelists who are highly regarded in their own fields of expertise but not closely tied to the subject. Recent NIH conferences have dealt with producing "state of the science" reports on Cesarean delivery, chronic insomnia, menopause, and improving end-of-life care.

While the NIH is still using the process several times a year, consensus conferences have seen the greatest development in Europe. In the late 1980s the Danish Board of Technology adapted the process to involve lay citizens, aiming to help lawmakers understand the social context of emerging technologies and create an informed public debate about technology. The Danes have applied the model recently to teleworking, electronic surveillance, and road pricing. Elsewhere, the most popular consensus conference topic has been genetic modification of food.

How the Nebraska Suicide Prevention Symposium

Differs from Other

Consensus Conferences:

The Danish consensus conference procedure employs eight days of discussion over a period of three months. The NIH's conferences typically take 2½ days. In compressing the Suicide Symposium consensus conference into one day, we have had to eliminate one key aspect: the writing of a report during the conference by the participants themselves. Instead, the moderator of the large-group discussion will write a report based on the priorities selected in the large-group discussion, information gleaned from a debriefing session with the small-group facilitators, and a review of notes taken by the small-group assistants. The moderator will e-mail the draft report to every participant and accept comments by e-mail for a two-week period before preparing a final report and submitting it to the Nebraska Health and Human Services System's Injury Prevention Program.

Appendix B: Evaluation of the Nebraska Suicide Prevention Symposium

Participants completed evaluation forms at the end of the Symposium. Results from the 23 completed surveys show participants were satisfied with the experience. They gave the overall Symposium an average rating of 4.39 on a 5-point scale, and gave an average response of “better” to the question, “How would you rate the Suicide Symposium’s consensus conference approach, compared with other approaches to generating recommendations from a large working group?” Asked to select the approach they would use if they were responsible for generating recommendations from a large working group, 14 participants, or 61%, selected consensus conference. Five others selected combinations of approaches that included the consensus conference, making the total number of participants who would use the approach by itself or in combination with another approach 19 out of 23, or 83%.

Figures A1 and A2 show responses to other evaluation questions.

Figure A1: Participant Satisfaction with Symposium

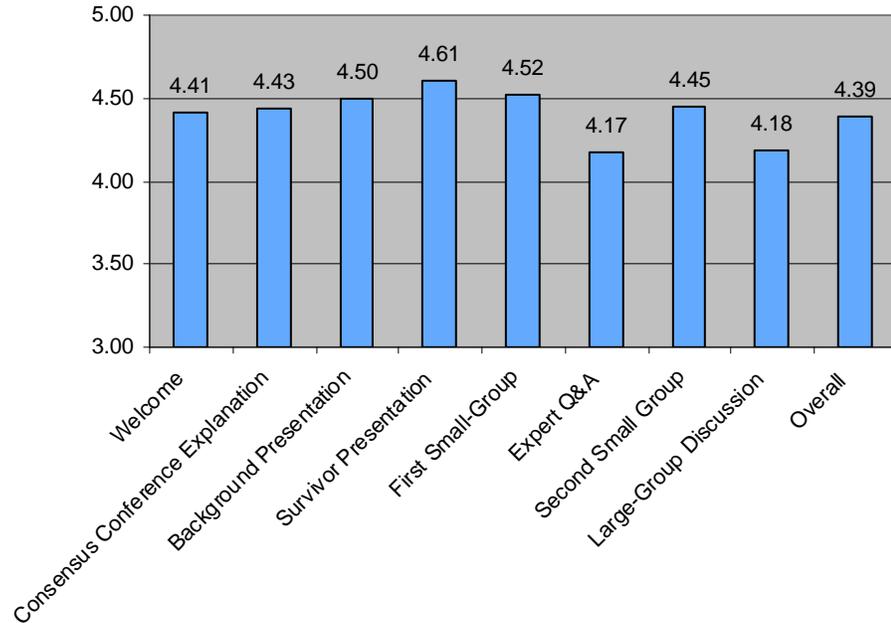


Figure A2: Consensus Conference Compared with Other Processes

