

Section 1: The Foundation

Recognizing the Need for Action

The Problem of Suicide in Georgia

Suicide is a tragedy that claims the lives of hundreds of Georgians each year –mothers and daughters, fathers and sons, brothers and sisters, friends, neighbors. Who completes suicide? People you meet at work, the grocery store, the gym, and places of worship; children in our schools, young adults in colleges and universities, and older people. Maybe someone you know. Maybe someone you love.

"I was shocked to learn that the suicide rate where I live is so high. What can I do?"

–A fellow Georgian

Did you know that in Georgia:

- 850 people a year die of suicide, making it the ninth leading cause of death among Georgians of all ages; it is the third leading cause of death among young Georgians ages 15-24.
- 44 percent of Georgia counties had suicide rates above the national rate.
- More Georgians die by suicide than homicide.
- An estimated 17,000 Georgians will seek emergency care this year for injuries related to suicide attempts.

These disturbing facts about suicide (*taken from Georgia Division of Public Health, 2000; CDC National Mortality Statistics; McCraig & Strussman, 1997*) show that it remains a serious public health problem in Georgia.

And there is more. These numbers are troubling, but they do not include many, many others who attempt suicide but never go to the hospital. They do not include unreported suicides. Suicide deaths are undercounted because death certificates may misclassify the cause of death as accident or by undetermined causes. Pressure to not report a death as suicide may come because many people wrongly see suicide as a mark of disgrace or shame—a stigma on themselves and their families. This stigma of suicide places a cruel burden on surviving family members and friends, who may, in hiding a suicide, be left to mourn in silence and secret.

Maybe someone you know. Maybe someone you love.

The Georgia Suicide Prevention Plan (Plan) will change how we think and act to prevent suicide. Working together through the Plan is intended to:

- Prevent deaths due to suicide across the life span.
- Reduce the occurrence of other suicidal behaviors.
- Reduce the suffering associated with suicidal behaviors and the traumatic impact of suicide on significant others.
- Provide opportunities and settings to enhance resilience, resourcefulness, respect, nonviolent conflict resolution, and inter-connectedness for individuals, families, and communities.

"Clearly we have major problems in the area of mental health that need our attention NOW."

—A fellow Georgian

Development of the Plan

Only recently, knowledge has become available to help us approach suicide as a preventable problem with realistic opportunities to save many lives.

The Georgia Suicide Prevention Plan (referred to throughout this document as Plan) is framed upon these advances in science and public health. The Plan is connected with national efforts to develop strategies for suicide prevention that can be carried out by public and private partners in communities across the country.

There has been international interest in suicide prevention for many years. In 1993, the United Nations (UN) and World Health Organization (WHO), in collaboration with the Canadian partnership led by Living Works Education and Alberta's Suicide Information and Education Centre (SIEC), hosted an international conference in Calgary, Canada. Representatives from twelve countries attended the conference. The results of that meeting were documented in a booklet called *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies (United Nations 1996)*. The UN *Guidelines* were developed as a way to facilitate the development of national strategies for the prevention of suicidal behaviors within the socio-economic and cultural context of any interested country (*Ramsey 2001*).

In 1987, Terri Ann Weyrauch, MD died by suicide. After her death, her parents began to volunteer with several local and national suicide prevention groups. Asked to review an early draft of the Guidelines, they sensed that the document provided the missing element needed for a suicide prevention effort in the U.S. The Weyrauchs conducted a year-long national survey to seek support for an activist grassroots organization that would promote the "political will" needed to move the federal government to "do something about the high rates of suicide nationally."

The Suicide Prevention Advocacy Network USA (SPAN USA), a national, non-profit advocacy organization, was founded in January 1996, "to create and implement a national suicide prevention strategy" based on the UN Guidelines. SPAN USA members include suicide survivors (persons close to someone who completed suicide), suicide attempters, and the people who support them. SPAN USA's efforts to

marshal political will for suicide prevention generated Congressional Resolutions recognizing suicide as a national problem and suicide prevention as a national priority.

SPAN USA propelled the creation of an innovative public/private partnership that worked jointly to sponsor a National Suicide Prevention Conference in Reno, Nevada, in October 1998 (SPAN USA Reno Conference). SPAN USA and the Centers for Disease Control and Prevention (CDC) commissioned briefing papers to summarize the evidence base for suicide prevention among at-risk populations and to make recommendations for public health action to be considered during the Conference (Silverman, Davidson, and Potter, 2001).

SPAN USA Reno Conference participants included researchers, health, mental health and substance abuse clinicians, policy makers, suicide survivors, consumers of mental health services, and community activists and leaders. They discussed presentations of the briefing papers and engaged in careful analysis of what was known and what needed to be learned about suicide and its potential responsiveness to a public health model for suicide prevention. Working in regional, multidisciplinary groups, participants at the SPAN USA Reno Conference offered many additional recommendations. An expert panel successively refined the recommendations into a list of 81.

AIM

Awareness Intervention Methodology

Moving forward with the work of the SPAN USA Reno Conference, the Surgeon General issued his *Call to Action to Prevent Suicide* in July 1999, emphasizing suicide as a serious public health problem (USPHS, 1999). The Surgeon General's Call introduced a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM). AIM describes 15 broad recommendations containing goal statements, general objectives, and recommendations for implementation that are consistent with a public health approach to suicide prevention. AIM represents a consolidation of the highest-ranked of the 81 SPAN USA Reno Conference recommendations according to their scientific evidence, feasibility, and degree of community support.

The recommendations of both the SPAN USA Reno meeting and *The Call to Action* have been refined with a view to developing a comprehensive plan outlining national goals and objectives that would stimulate the subsequent development of defined activities for local, State and Federal partners. SPAN USA has worked to build the Georgia Suicide Prevention Plan in concert with this national strategy while incorporating specific state needs and interests.

National goals and objectives were refined as part of a broadly inclusive process which has invited critical examination by scientific, clinical, and government leaders; other professionals; and the general public. Revised draft goals and objectives were also posted on the World Wide Web, inviting comment. During 2000, public hearings were held in Atlanta, Boston, Kansas City, and Portland to provide a face-to-face forum for additional input and clarification. Key experts across the country provided additional review. These experts included scientists, survivors, researchers, consumers, public health leaders, advocates, clinicians, and business leaders.

SPAN USA has mobilized support in community meetings across the state. Following this series of focus group meetings and community meetings, SPAN USA adapted state-appropriate goals and objectives from the National Strategy for the Plan.

Governor Roy Barnes and the Georgia Legislature appropriated funds in fiscal year 2001 for SPAN USA to develop the Plan. SPAN USA partnered with the Georgia Department of Human Resources, Division of Public Health and the National Mental Health Association of Georgia to write the Plan. The result of that work is the document you are now reading.

The Georgia Suicide Prevention Plan Concept

This Plan to prevent suicide is a comprehensive and integrated approach to reduce the loss and suffering from suicide and suicidal behaviors across the life span. It encompasses the promotion, coordination, and support of activities that will be implemented across Georgia as culturally appropriate, integrated programs for suicide prevention among Georgians at the state, regional, county, and community levels.

A broad public/private partnership is essential for developing and implementing a state suicide prevention plan. Interwoven within the Plan are three key ingredients for action to improve suicide prevention: **1) a knowledge base, 2) the political will to support change and generate resources, and 3) a social strategy to accomplish change.**

Developing a suicide prevention plan provides an opportunity to convene public and private partners across many sectors of society—state government, public health, education, human services, faith communities, volunteer organizations, advocacy, and business—to sustain a true, Georgia-wide effort.

Benefits of a State Plan

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

Suicide is an outcome of complex interactions among neuro-biological, genetic, psychological, social, cultural, and environmental factors. Multiple risk and protective factors interact in suicide prevention. Development of a State Plan can bring together multiple disciplines and perspectives to create an integrated system of interventions across multiple levels, such as the family, the individual, schools, the community, and the health care system.

Collaborating in a State Plan can help develop priorities. Resources are always finite and priorities direct resources to projects that are likely to address the greatest needs and achieve the greatest benefits. Some kinds of expertise are not available across all communities. A State Plan can provide assistance with valuable kinds of expertise to strengthen community programs.

Key Elements of a State Plan

A State Plan has many interrelated elements contributing to success in reducing the toll from suicide. They include:

- A means of engaging a broad and diverse group of partners to develop and implement the Plan with the support of public and private policies
- A sustainable and functional operating structure for partners with authority, funding, responsibility, and accountability for the state plan development and implementation
- Agreements among state agencies and institutions outlining and coordinating their appropriate segments of the State Plan
- A summary of the scope of the problem and consensus on prevention priorities
- Specified goals, and objectives integrated into a conceptual framework for suicide prevention
- Appropriate activities that can be evaluated for practitioners, policy makers, service providers, communities, families, agencies, and other partners
- A data collection and evaluation system to track information on suicide prevention and benchmarks for Plan progress

"The costs of suicide in terms of the effects it has on families and friends and on the community are much greater than the costs of prevention."

—A Georgia counselor

Using the Public Health Approach to Prevent Suicide

The Plan represents a highly blended synthesis of perspectives from researchers and scientists, practitioners, leaders of private non-governmental organizations and groups, federal agencies, survivors, and community leaders. Because the Plan is meant to be useful for applications outside the tightly controlled research environment, it builds onto the limited realm of scientific evidence in suicide prevention. While goals and objectives must be consistent with available scientific evidence and support the expansion of the scientific knowledge base, they are intended for use in other environments of public policy and community action.

The goals and objectives in the Plan are among many elements needed, but not the entire Plan. The blend of evidence represented in the goals and objectives helps guide an informed selection of activities for suicide prevention across the broad spectrum of communities in Georgia. The state dialogue to determine specific activities to accomplish each objective will be an extension of the consensus reached on these higher order goals and objectives. In that subsequent step, responsibility and accountability for carrying out activities will be accorded in the details of how each activity should be accomplished, by whom, and with what resources.

Several broad public health themes for the Georgia Plan are interwoven throughout this document. These themes are valuable considerations as groups and individuals across Georgia move forward in designing and strengthening suicide prevention activities.

The six themes are as follows:

- 1 Draw attention to a wide range of actions so that specific activities can be developed to fit the resources and areas of interest of people in everyday community life as well as professionals, groups, and public agencies. As the ninth leading cause of death among Georgians, suicide affects families and communities everywhere across the state. Suicide prevention is everyone's business.
- 2 Seek to integrate suicide prevention into existing health, mental health, substance abuse, education, and human services activities. Settings that provide related services, such as schools, workplaces, clinics, medical offices, correctional and detention centers, eldercare facilities, faith communities, and community centers are all important venues for seamless suicide prevention activities.
- 3 Guide the development of activities that will be tailored to the cultural contexts in which they are offered. While population-based interventions are applicable without regard to risk status, it does not mean that one size fits all. The cultural and developmental appropriateness of suicide prevention activities derived from the Plan are a vital design and implementation consideration.
- 4 Seek to eliminate disparities that erode suicide prevention activities. This is an important commitment in the Georgia Suicide Prevention Plan. Health care disparities are attributable to such differences as race or ethnicity, gender, education or income, disability, age, stigma, sexual orientation, or geographic location.

- 5 Emphasize early interventions to promote protective factors and reduce risk factors for suicide. As important as it is to recognize and help suicidal individuals, progress depends on measures that address problems early and promote strengths so that fewer people become suicidal.
- 6 Seek to build statewide capacity to conduct integrated activities to reduce suicidal behaviors and prevent suicide. Capacity building will ensure the availability of the resources, experience, skills, training, collaboration, evaluation, and monitoring necessary for success.

Moving forward with the Plan can bring suicide prevention into the forefront of Georgia's public commitment to health and well-being. Working together in a coordinated and systematic way towards implementing appropriate activities for each objective will lead to measurable progress.

The foundation for developing and implementing the Georgia Suicide Prevention Plan is the five-step public health model presented in *National Strategy for Suicide Prevention: Goals and Objectives for Action*. The public health approach is designed to organize prevention efforts and resources in such a way that they reach large groups or populations of people systematically and effectively.

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

Step 1: Clearly Defining the Problem

Surveillance is the ongoing process of collecting information about the "who, what, when, where, how, and how many" of suicide in Georgia. Needs assessment is another valuable contribution to the first step of the Public Health model because it helps us clearly define the existing conditions that affect the problem.

Surveillance information can tell us how much of a burden suicide is to the state and the community. Surveillance reports can show trends in risk and protective factors for suicide. State surveillance data for the Plan came from the publication called *Suicide in Georgia: 2000*. Some of the highlights of that report may surprise you. For example, did you know that:

- suicide rates are five times higher for males than for females in Georgia?
- the suicide rate among Georgia African-Americans aged 15-24 was 40 percent higher in 1996-1998 than it was in 1984-1986?
- suicide rates are two times higher for whites than African-Americans in Georgia?
- the suicide rate for Georgia's rural counties is more than 17 percent higher than the urban county rate?

Step 2: Identifying Causes through Risk and Protective Factors Research

The base for suicide prevention comes from observing suicide risk factors, suicide protective factors, and their interactions.

Suicide risk factors are things that increase the potential for a person's suicide or suicidal behavior. A person's age, gender, or ethnicity can increase the impact of certain risk factors or combinations of risk factors for them. Understanding risk factors can help counteract the myth that suicide is a random act or results from stress alone.

Suicide protective factors are things that reduce the potential for a person's suicide or suicidal behavior. Protective factors include attitudes and behaviors.

Both risk and protective factors include a wide variety of characteristics of individuals and groups. These characteristics include things like a person's family history, biology, psychology, and socio-cultural situation. They also include environmental conditions, such as easy access to the highly lethal means of suicide or easy access to help and treatment services.

The following Risk and Protective Factors for Suicide are identified in the *National Strategy for Suicide Prevention: Goals and Objectives for Action*.

Risk Factors for Suicide

Biological, Psychological and Social Risk Factors

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

Environmental Risk Factors

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

Socio-cultural Risk Factors

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

Protective Factors for Suicide

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

Information about risk and protective factors contributes to selecting useful interventions for suicide prevention. But much remains to be learned; especially about how these risk and protective factors interact across the life course and how community suicide prevention programs can best integrate this information.

Reducing Risk Factors

Interventions are actions or programs that can reduce the effect of risk factors and/or increase protective factors. An example of an intervention would be providing effective treatment for depressive illness.

Some risk factors cannot be changed, such as a previous suicide attempt, but even these may have a signal purpose. They can serve as reminders of the heightened risk of suicide when the individual is ill or suffering adversity.

Enhancing Protective Factors

If we want to prevent suicide, enhancing resilience and protective factors is as important as reducing risk. Unfortunately, positive resistance to suicide is not permanent. This means that activities to support and maintain protection against suicide need to be repeated and ongoing

Step 3: Develop and Test Interventions

This step has several parts. First, it involves developing interventions, which are prevention actions or programs that can reduce the impact of risk factors or support protective factors. Rigorous scientific testing of interventions before they are put in place widely is important to ensure that the interventions are safe, ethical, and practical. There are several stages to this testing, beginning with efficacy studies that look at whether an intervention works under ideal conditions.

If the answer is “yes, they work under ideal conditions,” then effectiveness studies may be carried out under real world settings. This further testing with larger groups can lead to refinements and improvements in the intervention and understanding critical factors in implementing the intervention that may affect the people for whom it works.

Step 4: Implement Interventions

Prevention science in other areas such as substance abuse prevention and violence prevention shows some principles for effective action that apply to suicide prevention initiatives too. When we begin to implement the goals and objectives of Plan, we should base our efforts on these prevention principles. Here are the prevention principles to keep in mind:

- 1) Piecemeal, “here and there” prevention efforts may be weak; comprehensive programs are much more effective. For example, some community suicide prevention programs might include media campaigns and policy changes. These kinds of campaigns are much more effective when they are accompanied by programs that touch people personally in settings like schools, sports events, faith communities, and the workplace.
- 2) Suicide is related to many other problems facing Georgia’s communities and cannot be addressed alone. As a result, suicide prevention programs should coordinate with other prevention efforts such as those designed to help reduce substance abuse.
- 3) We need suicide prevention programs that can address the unique needs of people in each stage of life. This means suicide prevention programs must be developmentally appropriate and must address protective and risk factors across all age groups.
- 4) Suicide prevention programs must be culturally sensitive.
- 5) Prevention programs are stronger when they are long-term, with repeated opportunities to reinforce targeted attitudes, behaviors, and skills.
- 6) Family-focused prevention efforts have a greater effect than goals that focus on parents only or children only.
- 7) Prevention efforts tend to be stronger when they address multiple risk and protective factors. The higher the level of risk, the stronger the suicide prevention effort must be and the earlier it should begin.
- 8) To prevent suicide, we need to develop healthy communities across Georgia. We can do this through coordinated prevention programming with a local focus. Each community needs to develop its own suicide prevention plan that is tailored to meet local needs and build on local strengths.
- 9) Suicide prevention program planning and implementation must involve people, agencies, and organizations that represent the community broadly with respect to age, ethnicity, faith, occupation, sexual orientation, socioeconomic status, and cultural identity.
- 10) Training programs must seek to develop skills and not just work to increase knowledge. Effective training for skills requires multiple opportunities to *practice* the skills themselves, not just learn about them.
- 11) Public information campaigns about suicide prevention need to be ongoing efforts in order to maintain awareness. They should be developed with the assistance of persons knowledgeable about social marketing.

Step 5: Evaluate Effectiveness

"The lack of evaluation research is the single greatest obstacle to improving current efforts to prevent suicide among adolescents and young adults."

Morbidity and Mortality Weekly Report (MMWR)
April 22, 1994, Vol. 43/No. RR-6

Evaluations need to occur following the development and testing of interventions (Step 3) and following implementing interventions in the community (Step 4). Ideally, program planners will choose programs that have been fully evaluated and shown to be effective. Sometimes interventions are chosen which have not been fully evaluated, but are thought to be “promising” based on initial or partial evidence. Other available interventions follow known prevention principles or expert recommendations and might be considered “best practices” but lack evidence of effectiveness. A community should build in an evaluation to determine whether any intervention selected works under local conditions. ***Community suicide prevention programs must budget the time and money to build in evaluation right from the start!***

Determining the costs associated with sustaining programs and comparing those costs to the benefits of the programs is another important aspect of evaluation. This cost evaluation may help you receive continuing funding to sustain your program.

Web resources listed at the end of the Plan provide useful sources of information about designing and carrying out evaluations.

Working Together to Save Lives

"We as a society cannot let this go on any longer. We can't keep sweeping it under the carpet and hoping nobody notices."

— A Georgia Survivor

Mobilizing Communities for Action

The heart of the Plan is a call to *you*—caring people in local communities all over the state—asking you to take action to prevent suicide.

The Plan itself started with one family who lost a daughter to suicide. The family brought together a small group of people they had met who also wanted to address suicide prevention. The group started meeting together once a month to explore how they could mobilize the state to take action. Others joined them, and the Plan you are now reading is the result. You can use a similar process in your community.

Working Locally, One Suicide Prevention Champion by One

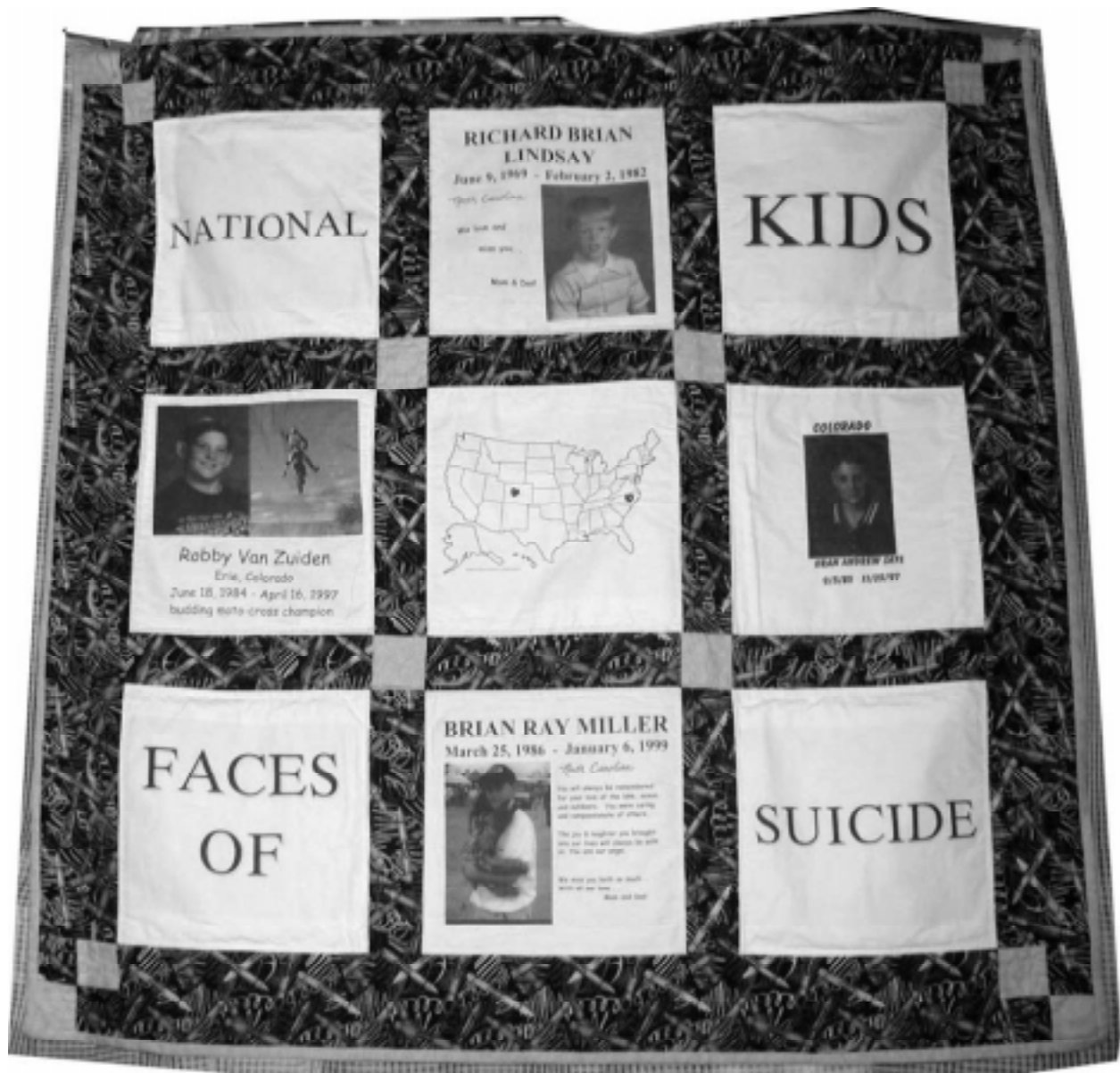
Effective suicide prevention efforts have to take place at the local level. The state and regional levels provide necessary support, but it's really up to the local communities to bring the action home. All it takes to start mobilizing a local community for suicide prevention is one person—any person from any walk of life. The group that person talks to about suicide prevention might be a woman's club, a ministerial alliance, or maybe a family resource center. The truth is, the starting point doesn't matter; *getting started* does. It matters that the person or group is determined to address the problem of suicide where they live and that they build a coalition of interested community and professional partners for action.

The first step in mobilizing your community is to recognize that the problem of suicide touches many people in every area, including yours. A lot of people may not know that fact, but would want to help if they knew. Many may know someone at risk for suicide, or may have been deeply touched by suicide already, but they may not know how to get involved. You can be a motivator in all these cases. As you start to take action, you will meet more and more people that will want to work with you.

***Remember, suicide prevention
in your area starts with you.
Whoever you are and wherever you are,
you can mobilize your community to
develop and launch a
suicide prevention initiative.
You can help save lives.***

The National Kid's Quilt

This quilt shows some of the faces of children age 12 and under who died by suicide. The CDC reports that for 1996 through 1998 the 3rd leading cause of death in youth 10-20 is suicide.



*"I am of the opinion
that it is society's
discrimination of the
illnesses that
lead to suicide, that so
often make these illnesses
too painful to bear!"*

–Georgia Suicide
newsletter contributor