

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.

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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	
9:20 a.m.	Background on Suicide Prevention Dave Miers, BryanLGH Mental Health	12:30 p.m. Small-Group Discussions Topic: Draft action plan priorities
9:35 a.m.	Profile of a Depressed Teenager Trish Schuster	1:45 p.m. Break
10:00 a.m.	Break Coffee and rolls	2:00 p.m. Large-Group Discussion Topic: Select action plan priorities Moderator: John Fulwider
10:15 a.m.	Small-Group Discussions Topic: Draft questions for expert panel	3:15 p.m. Concluding Comments Peg Prusa-Ogea, HHSS Diana Miles, CDC
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).

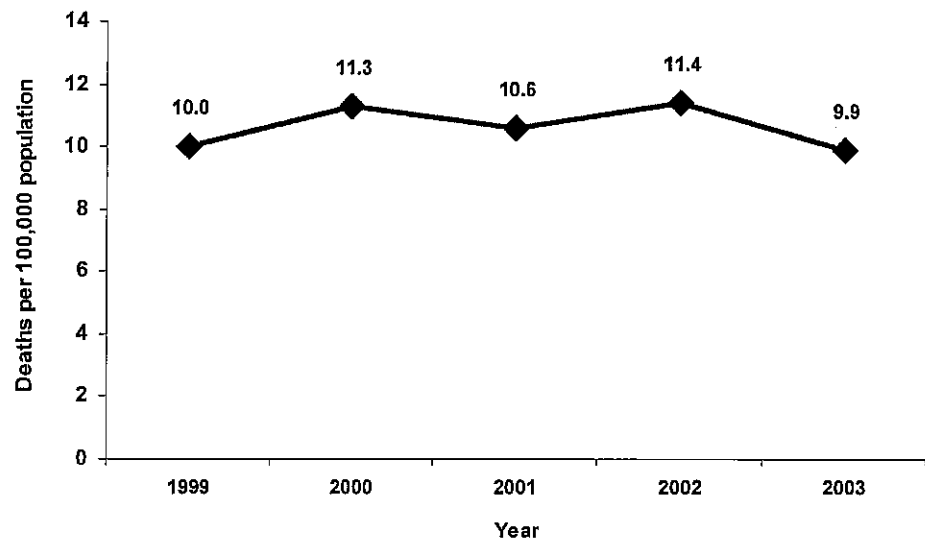
Suicide was the second leading cause of injury death for males and the third leading cause of injury death for females. Males were more likely to die from suicide than females for all age groups except for ages 5-14. Males age 75-85 and older were 15 times more likely to die from suicide than were females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

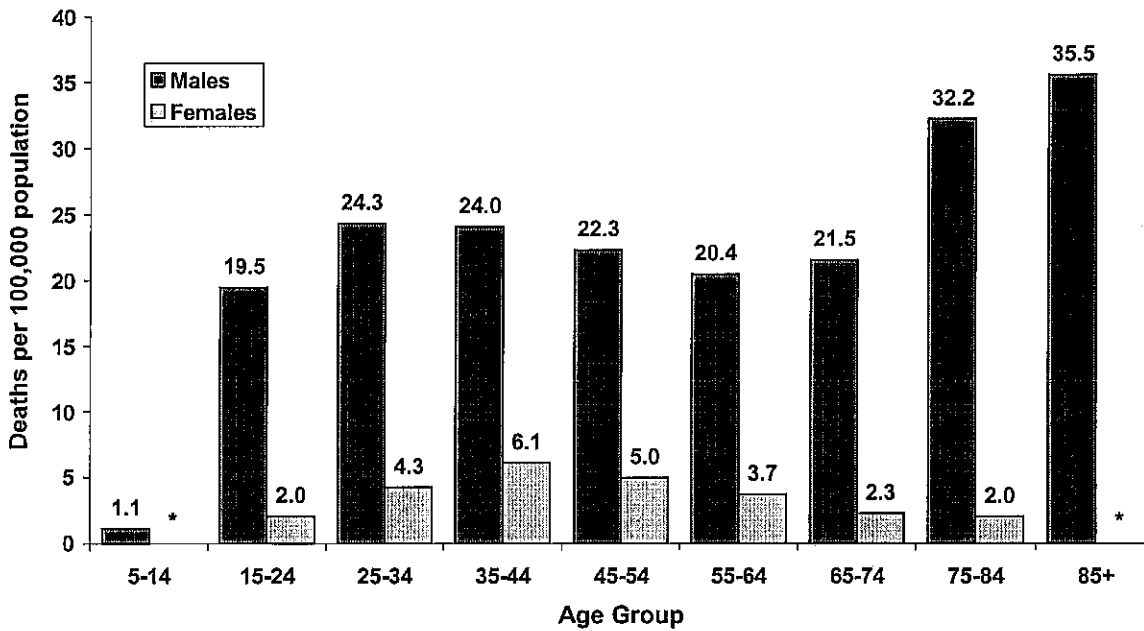
The rate of hospital discharges for suicide attempts differed significantly by age and gender. For the age groups from 5-64 years, hospital discharge rates for suicide attempts were higher for females than for males. This pattern differs from suicide deaths in which males predominate. Higher rates of 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%).

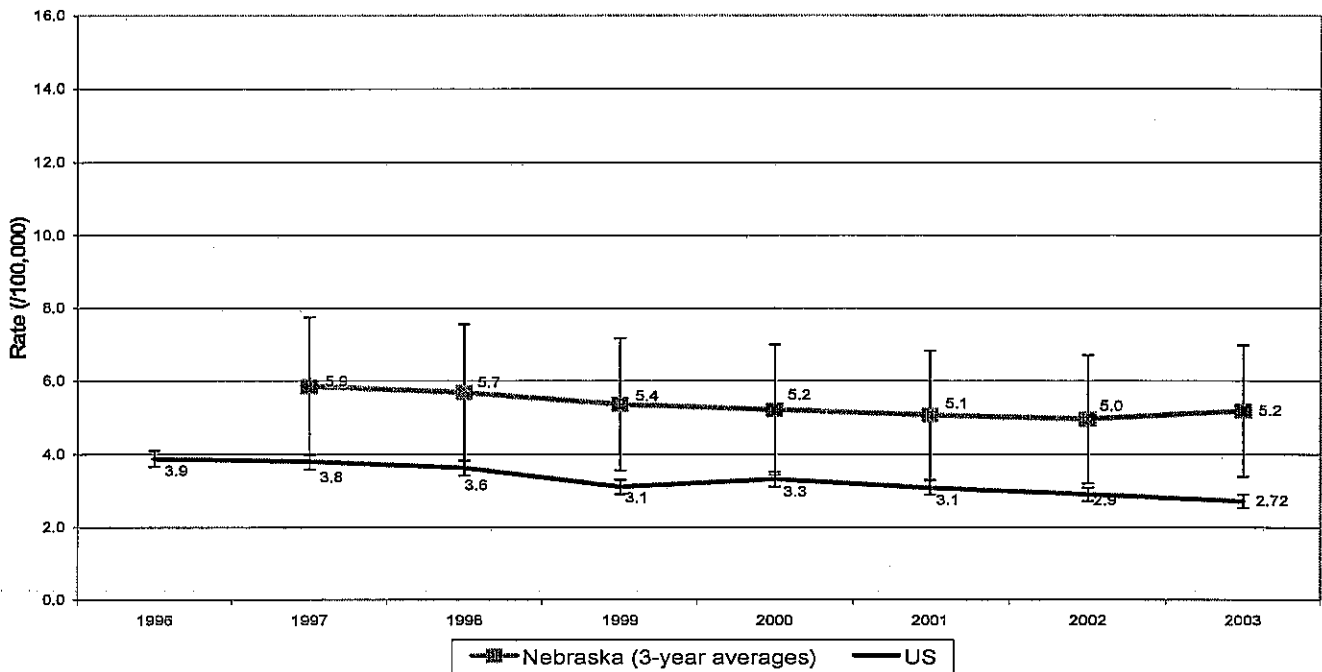
**Suicide death rates by age and gender
Nebraska residents, 1999-2003 (n=894)**



*Fewer than five deaths

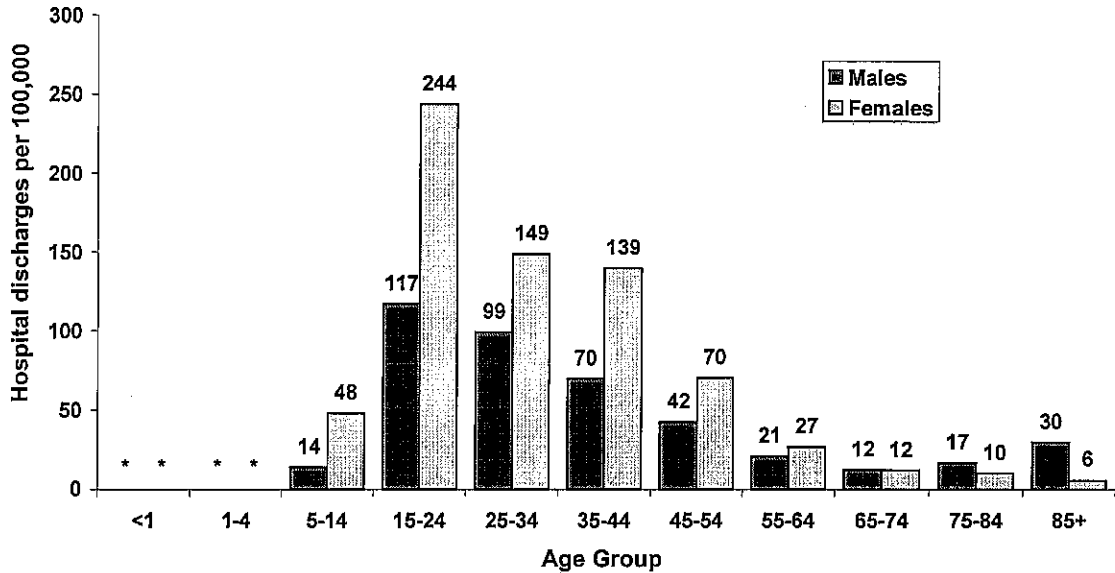
Source: NHHSS Vital Statistics 1999-2003

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



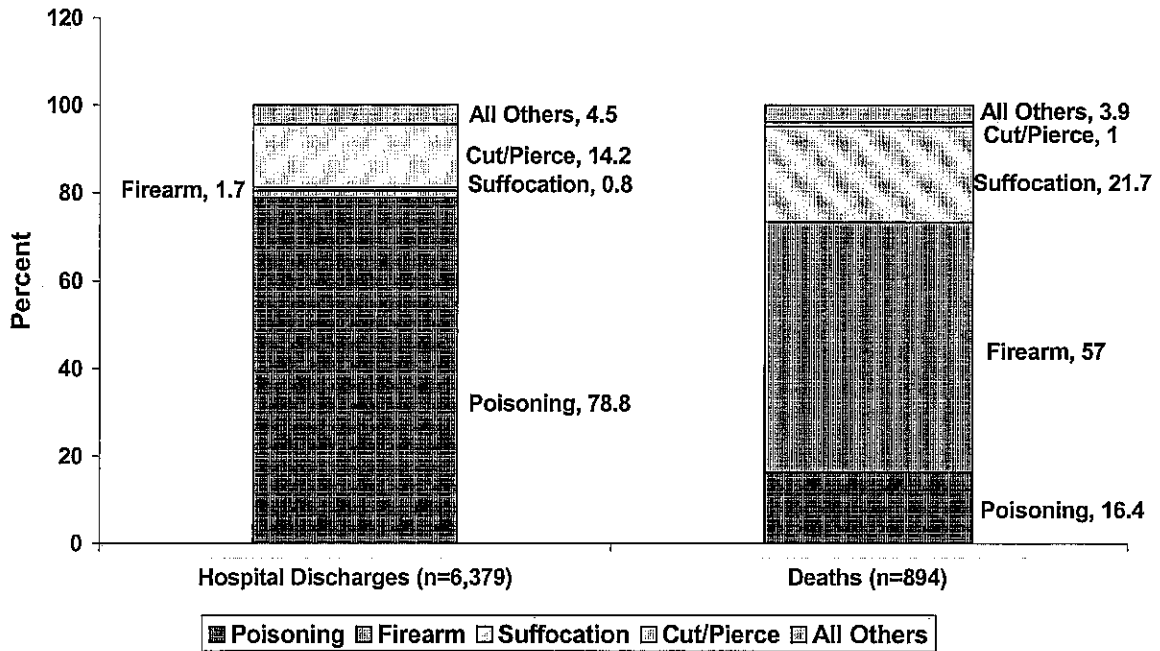
Nebraska rates are three year averages. The 95% confidence intervals around each point are also shown. Nebraska rates are significantly higher than US rates for 1999 and 2002 (confidence intervals do not overlap).

**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 staffs are trained to provide the education to parents of child who are as-

sessed 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.

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

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

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

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

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.

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

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.

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 rank-orders 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.