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COMPREHENSIVE SUICIDE PREVENTION PLAN

2005



Keeping Connecticut Healthy

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CONNECTICUT COMPREHENSIVE SUICIDE PREVENTION PLAN 2005

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THE INTERAGENCY SUICIDE PREVENTION NETWORK

The Interagency Suicide Prevention Network (ISPN) is an interagency, interdisciplinary collaboration facilitated by the State of Connecticut Department of Public Health (DPH). The DPH Injury Prevention Program assisted in the planning and implementation of the June 2000 Northeast Injury Prevention Network's Invitational Suicide Prevention Conference (Conference) that was held in Byfield, Massachusetts. State Injury Prevention Programs from the New England States, New York, New Jersey, Puerto Rico and the Virgin Islands invited up to ten people from the State or Territory to participate in the Conference. The Interagency Suicide Prevention Network is a result of the work begun at the Conference.

The Connecticut team included not only diverse agencies, but also diverse ages and both genders. In addition to the State of Connecticut Department of Public Health Injury Prevention Program (DPH), other agencies (one person) and individuals who the DPH invited to the Conference who were able to attend included the State Departments of Mental Health and Addiction Services, Education, Children and Families, Commission on Aging, Judicial Branch/Court Support Services Division; the Mental Health Association, a counselor from a private secondary school and United Way of CT/ Infoline. Since Connecticut's data indicated that there were increased rates of suicide among elders and young adults, as well as increasing rates among teens, the DPH focused Connecticut's efforts on suicide across the life span rather than the youth only focus adopted by several state plans.

The Connecticut team met in August of 2000 and decided to continue the planning process, naming the collaboration the Interagency Suicide Prevention Network (ISPN) in fall of that year. ISPN agreed that the DPH Injury Prevention Program would continue in the leadership/ facilitator role.

The mission of ISPN is to collaborate across agencies and disciplines to reduce suicide across the life span by:

- Developing a statewide comprehensive suicide prevention plan
- Facilitating communication and networking related to suicide, related health and mental health issues
- Identifying gaps in services and programs
- Identifying opportunities for eliminating duplication and improving services and programs
- Addressing training, research and data issues

ISPN has included and worked closely with the legislatively mandated CT Youth Suicide Advisory Board from the beginning of the initiative. In addition to the original agencies, agencies and constituencies that are or have been a part of ISPN are Corrections, Public Safety/Employee Assistance, Pediatrician/Adolescent Health, Department of Social Services, persons active in ethics/end of life and sexual minority youth issues and the Office of the Child Advocate. ISPN has an ongoing collaboration with a Geriatrician and has had the benefit of presentations from persons inside and outside of ISPN that have helped to inform the group as they developed the Plan.

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ISPN agencies, individuals and others have worked collaboratively within existing resources, for almost four years to gather information to develop the Recommendations in the Comprehensive Suicide Prevention Plan. ISPN and others involved in the process hope that the Plan will enhance existing and improve future efforts to reduce deaths and injuries due to suicide.

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INTRODUCTION

Suicide is a serious public health problem. Suicide is the eighth leading cause of death in the United States and a leading cause of death for Connecticut residents ages 10-64. Between 1999 and 2001 in Connecticut, 861 suicide deaths were reported.¹ In 1999, 4,021 people in Connecticut attempted suicide.²

Suicide prevention has garnered increased attention at national and state levels in recent years. In 2001 the United States Department of Health and Human Services produced the National Strategy for Suicide Prevention: Goals and Objectives for Action (National Strategy). The National Strategy "is designed to be a catalyst for social change, with the power to transform attitudes, policies and services. It reflects a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors in the United States."³

National Strategy for Suicide Prevention goals include:

1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention.
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
4. Develop and implement community-based suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Implement training for recognition of at-risk behaviors and delivery of effective treatment.
7. Develop and promote effective clinical and professional practices.
8. Increase access to and community linkages with mental health and substance abuse services.

¹ National Center for Injury Prevention and Control, WISQARS : <http://webapp.cdc.gov/cgi-bin/broker.exe>

² Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

³ National Strategy for Suicide Prevention: Goals and Objectives for Action :Summary/ Rockville , MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

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INTRODUCTION

National Strategy For Suicide Prevention goals (continued)

9. Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.
10. Promote and support research on suicide and suicide prevention.
11. Improve and expand surveillance systems. ⁴

The *Blue Ribbon Commission on Mental Health* was established by Connecticut's Governor, whose Executive Order "mandated the Commission to examine the mental health system and to recommend how it might be improved." ⁵The Report of the Governor's Blue Ribbon Commission, while not exclusively focused on suicide, provides important Connecticut-specific recommendations:

1. Address gridlock in care delivery for children and adults
2. Adjust rates to ensure adequate support for mental health services
3. Enhance community services for children and adults
4. Continue to develop locally based systems of care
5. Bring home children who have been placed in out-of-state residential facilities
6. Ensure coordinated care for young adults who are transitioning from DCF to DMHAS supported services
7. Enhance opportunities for recovery through consumer and family member involvement and empowerment
8. Implement an ongoing community education campaign
9. Integrate primary prevention into the state system
10. Improve the cultural competence of mental health service delivery
11. Address the programmatic and financial needs of the mental health system ⁶

⁴ National Strategy For Suicide Prevention: Goals and Objectives for Action. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

⁵ Report Of The Governor's Blue Ribbon Commission on Mental Health, July 2000

⁶ Report Of The Governor's Blue Ribbon Commission On Mental Health, July 2000

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COMPREHENSIVE SUICIDE PREVENTION PLAN

EXECUTIVE SUMMARY

The State of Connecticut Comprehensive Suicide Prevention Plan (Plan) builds upon the strengths of the National Strategy and the Blue Ribbon Commission. In addition, the Plan incorporates the public health approach which includes clearly defining the problem, identifying risk and protective factors, developing and testing interventions, implementing interventions and evaluating the effectiveness of those interventions.

The Plan addresses the following Goals⁷:

- Reduce the suicide rate
- Reduce suicide attempts
- Increase the number of persons seen in primary health care who receive mental health screening and assessment
- Increase the proportion of children with mental health problems who receive treatment
- Increase the proportion of juvenile justice facilities that screen clients for mental health problems.

The Plan also focuses on a life span approach to suicide prevention rather than primarily youth as some states have, because suicide and related issues impact people of all ages. While elderly males in Connecticut have the highest rate of suicide completions, rates have been increasing among Black and Hispanic males and teenagers. Children with behavioral health issues pose increasing challenges to Connecticut's educational system. In addition to decreasing suicide-related deaths and injuries among children, prevention efforts can lead to a decrease in future attempts and completions among Connecticut adults. The judicial system in Connecticut, recognizing the challenges and responsibilities to those within the system, has focused significant attention and resources on suicide prevention. Because many of the issues of persons within the judicial system are unique, the Plan has a separate criminal justice category.

⁷ From Healthy People 2010, www.healthypeople.gov

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EXECUTIVE SUMMARY

Plan Recommendations are grouped under five categories:

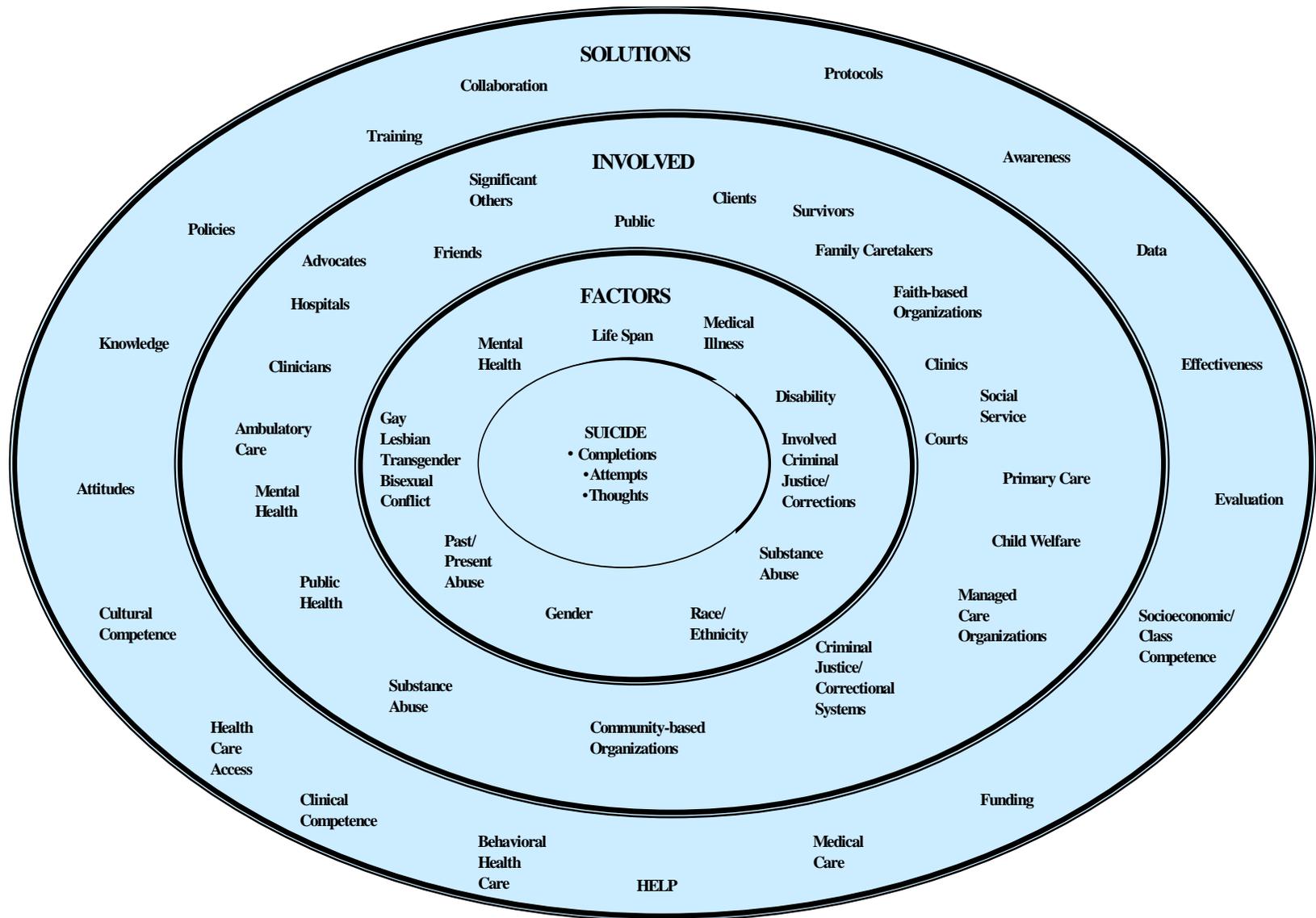
- Life Span or Overarching
- Children and Youth - Birth through 19
- Adults - 20 - 64
- Elders - 65+
- Criminal Justice System- all ages

Finally, Recommendations of Connecticut's Comprehensive Suicide Prevention Plan flow from a recognition that the continuum from individual change to system enhancement and change requires collaboration and cooperation.

The diagram on the following page illustrates some of the myriad factors, individuals and agencies that are important in Connecticut's efforts to reduce suicides and suicide attempts among its residents.

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SPHERES OF SUICIDE PREVENTION



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COMPREHENSIVE SUICIDE PREVENTION PLAN

OVERARCHING/LIFESPAN RECOMMENDATIONS

Promote Awareness That Suicide Is Preventable And That Mental Health Is Important To Overall Health⁸

- Promote and increase public and provider awareness of suicide protective factors, risk factors, contagion and related issues
- Promote awareness and dissemination of resources, including governmental, private, faith-based and others
- Encourage provision of behavioral health and suicide prevention information in places where people go
- Encourage enhancement of the existing resources, as well as development of new resources for behavioral health care and suicide prevention
- Address issue of contagion in development of resources and public awareness activities
- Increase awareness of the importance of means restriction because of the increased lethality of firearm suicide attempts
- Promote initiatives and media campaigns that minimize stigma related to behavioral health issues and suicide
- Promote awareness and recognition of the role of substance abuse in suicide
- Find “champions” to assist in improving public health and media campaigns
- Promote notification and utilization of Employee Assistance Programs and other mental health resources
- Increase sensitivity of neighborhoods to the negative effects of pervasive, unhealthy advertising
- Encourage enhancement of the existing resources, as well as development of new resources for suicide prevention.

⁸ Categories adapted in consultation with Dorian Long, State Department of Children and Families

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COMPREHENSIVE SUICIDE PREVENTION PLAN

OVERARCHING/LIFESPAN RECOMMENDATIONS

Promote, Develop and Implement Effective Prevention Strategies

- Promote awareness that suicide is a public health problem that is preventable
- Employ community-based interventions to enhance the social support of people living with serious mental illness in the community
- Promote awareness of the link between serious mental illness and suicide
- Employ community-based de-stigmatization practices that will assist people in seeking appropriate medical/psychiatric attention and receiving the effective treatments that are available for their condition
- Assess the environment to reduce means of self-harm
- Recognize the role of police, licensed clinical social workers, advance practice registered nurses, psychologists, physicians, psychiatrists, emergency mobile crisis teams and emergency rooms as resources for emergency assistance when a person is at eminent risk of self-harm⁹
- Increase resource allocation for prevention and treatment
- Promote responsible marketing of addictive substances and behaviors.
- Encourage employers, faith based organizations and community organizations to provide recurring training and counseling for helping people balance work and family life
- Address substance abuse and addictions in terms of life span development
- Recognize the role of substance abuse and mental health issues in suicide.

Promote Improved Access to Behavioral Health Care

- Support local and state efforts that increase access to treatment resources
- Promote confidential access to Employee Assistance Programs and other mental health resources
- Address continuity of care issues including access, treatment and follow-up

⁹ Connecticut General Statutes Section 17a-502 and 17a.-503

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COMPREHENSIVE SUICIDE PREVENTION PLAN

OVERARCHING/LIFESPAN RECOMMENDATIONS

Promote Improved Access to Behavioral Health Care (continued)

- Investigate treatment modalities, hours of operation, additional strategies that would increase access to treatment and prevention services
- Facilitate policies and practices that increase and ensure access to mental health care
- Promote mental health parity
- Facilitate appropriate policy change and reallocation of resources
- Facilitate information exchange and collaboration with professional organizations
- Expand public transportation support
- Identify systemic gaps
- Identify communities with higher instances of suicidal behaviors and increase services and access to services.

Promote the Provision of Quality Behavioral Health Care

- Identify particular needs of high-risk populations and high-risk situations
- Encourage development of critical incident response teams
- Assess existing and facilitate development of new standards for cultural competency plans that include communication styles, cultural issues, competence and subject matter, adherence to confidentiality issues, literacy and resource materials
- Promote policy changes that facilitate increased access and payment for treatment
- Encourage safe medical management of addictions
- Encourage clinically sound, evidence- based treatment that addresses the unique needs of the individual
- Partner with insurers to increase awareness of cost benefits of early, effective, clinically sound, evidence-based treatment
- Decrease, eliminate and treat signs and symptoms of suicide related behaviors.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

OVERARCHING / LIFESPAN RECOMMENDATIONS

Promote the Provision Of Quality Behavioral Health Care (continued)

- Promote early screening and assessment of depression and other mental health issues
- Make risk factors (“signs and symptoms”) known to human services workers
- Promote strategies to improve provider skills for communicating client needs to health plans and other payor services
- Provide age appropriate group interventions
- Encourage treatment providers (e.g. Alcoholics Anonymous, Gamblers’ Anonymous, Narcotics Anonymous) to hold age specific meetings
- Encourage medical, social service and mental health professionals to include assessment of suicide risk, substance use and addictions in routine exams and refer for appropriate treatment
- Cross train medical and mental health professionals in geriatric issues.

Enhance Suicide and Behavioral Health Data Collection, Surveillance, Research And Program/Service Evaluation

- Identify and/or develop a more comprehensive statewide data collection and surveillance system that includes suicide completion and attempt data from traditional and nontraditional sources
- Conduct statistically valid survey of known data sources and information related to suicide, suicidality and related issues
- Investigate and facilitate development of a central repository for acquisition and timely analysis of data related to suicide, suicide attempts, trends, patterns and related mental health and substance abuse issues
- Include ethnic and cultural factors in some facet of the suicide related data collection system

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COMPREHENSIVE SUICIDE PREVENTION PLAN

OVERARCHING/LIFESPAN RECOMMENDATIONS

- Develop, enhance and facilitate systems to evaluate suicide prevention strategies, training, policies, awareness, media and public education activities
- Facilitate interagency collaboration that improves data collection and analysis, surveillance, quality assurance and evaluation

Enhance Suicide and Behavioral Health Data Collection, Surveillance, Research And Program/Service Evaluation (continued)

- Encourage administrative review of suicide and suicide attempts by police, criminal justice, mental health and health care agencies
- Encourage appropriate interagency collaboration and sharing of summary data
- Use and disseminate results of data, surveillance and evaluation activities to increase awareness and improve programs, services and systems
- Evaluate efficacy of treatment
- Encourage academic and professional research
- Focus on appropriate and evidenced based treatment outcomes and evaluate programs for outcomes.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

CHILDREN AND YOUTH - BIRTH TO 19

Today, suicide in children and especially in youth is a leading health concern. Twenty percent of any high school population will think about suicide, 8% will try to commit suicide and 3% will require acute medical attention after a suicide attempt. Often, those youth who attempt suicide will have associated mental health or other behavioral concerns such as depression, substance abuse, a sense of hopelessness, increased stress and a lack of family support. Whereas suicide was a major concern mostly for White male youth, it is now also a significant problem for Latino, African American and Native American youth.

Many youth who attempt suicide follow routine health care protocols, are enrolled in school where they often do well, are active in the community and come from supportive homes. Usually, youth are not identified as being at risk for suicide until they actually make the attempt. Health providers rarely ask about suicidal ideation during the routine health examination unless they feel there is an indication to ask. Teachers may not be concerned unless the student's academic performance declines. Staff at community organizations and parents may not be aware of the warning signs for potential suicidal ideation.

It is essential to identify the early warning signs that lead to suicidal ideation in order to prevent suicide attempts. Health providers should ask about signs of depression, substance abuse, stress, lack of family support and possible suicidal ideation or attempts at every general examination. Teachers, parents, and staff of community organizations dealing with youth need to have the training to understand youth behaviors which may be outside of the expected norm, and how to approach youth exhibiting early warning signs of depression, substance abuse, stress, and lack of home support. Insuring the health of our children and youth requires the involvement of the entire community. Once such youth at risk are identified, they need strong links to the mental health system for support and treatment.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

CHILDREN AND YOUTH - BIRTH TO 19 (continued)

The recommendations noted below provide suggested directions to achieve the goal of reducing child and youth suicide. These recommendations identify the types of education needed for adults dealing with children and youth, the programs needed to support children and youth, and the types of access to mental health services needed by those children and youth at risk. Advocating for the needs of children and youth today will not only empower the children and youth to better deal with their own needs, but also help them become more supportive adults in the future.

Aric Schichor, M.D.

RECOMMENDATIONS CHILDREN AND YOUTH - BIRTH TO 19

Promote Awareness That Suicide Is Preventable And That Mental Health Is Important To Overall Health

- Promote a public awareness campaign that promotes the adult role in facilitating the mental health of children and youth
- Use non-traditional service providers and community partners to develop appropriate messages and strategies to reach diverse populations
- Enhance and facilitate training for children and youth, parents and caregivers, professionals on child development, substance abuse, coping skills, life skills, mental health issues, conflict resolution, competition and stress relieving strategies
- Promote awareness among adults of key male and female methods of suicide attempts and completions among children and youth
- Promote awareness of issues specific to children and youth who may be victimized by their peers because they are perceived to be not acceptable.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

CHILDREN AND YOUTH - BIRTH TO 19

Promote, Develop and Implement Effective Prevention Strategies

- Facilitate more early mental health prevention and intervention such as early childhood services and specialized nursery schools
- Encourage providers to discuss firearm safety with caregivers and include in client assessment
- Promote participation of schools and local agencies in local systems of care
- Expand after school and other positive youth activities
- Increase awareness of the significance of self-mutilating and cutting behaviors among children and youth.

Promote Improved Access to Behavioral Health Care

- Conduct rapid assessment and planning of care for children, youth and their caregivers
- Ensure that clinical care is provided in the least restrictive environment
- Ensure timely access to behavioral health care
- Provide increased community-based services
- Reduce over-utilization of out of home care
- Promote system changes to expand the scope of services in schools
- Assess utilization of school-based mental health and substance abuse services
- Ensure that caregivers and gatekeepers are educated about Husky and Medicaid coverage for children and youth

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

CHILDREN AND YOUTH - BIRTH TO 19

Promote the Provision of Quality Behavioral Health Care (continued)

- Promote support of the appropriate use of clinical behavioral health interventions prior to the use of psychotropic medications
- Increase knowledge of the efficacy of the use of multiple psychotropic medications in children
- Increase collaboration between state agencies- education, public health, mental health and addiction services, judicial, children and families, mental retardation and social services
- Maintain and implement measures to ensure family/caregiver input is solicited, respected and heeded at the treatment, planning and evaluation level
- Develop and implement effective transition plans with participation of parents/caregivers and community service providers.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

ADULTS 19-64

Although suicide is particularly pronounced among youth (age 15-25) and the elderly (age 65 and above), suicide also is the second leading cause of death among young adults (age 25-34), and is highest among older men when compared with all age groups.¹⁰ Regardless of age, the vast majority of people who commit suicide have a major psychiatric disorder, whether or not this disorder has been diagnosed or treated. Unfortunately, many people do not receive appropriate or timely care for these conditions due to stigma, lack of information, and other issues. Among this population, the subset of adults who are at particular vulnerability are adults with schizophrenia spectrum disorders, bipolar disorders, major depression, and severe and persistent personality disorders. Because social isolation and segregation appear to be a causal risk factor for suicide, and because adults with these serious mental illnesses are often socially isolated due to stigma, poverty, and unemployment, there is an urgent need for strategies to include a community-based approach for adult suicide prevention.

Larry Davidson, Ph.D.

RECOMMENDATIONS

ADULTS AGES 19-64

Promote Awareness That Suicide Is Preventable And That Mental Health Is Important To Overall Health

- Promote awareness of potential detrimental effects of isolation due to excessive use of Internet and computer games
- Encourage wider and more creative dissemination of local social information
- Provide public education and information about resources in appropriate venues and times for young adults

COMPREHENSIVE SUICIDE PREVENTION PLAN

¹⁰ Data taken from *Achieving the Promise: Transforming Mental Health Care in America*. Final report of the President's New Freedom Commission on Mental Health. Washington, D.C.: Department of Health and Human Services, 2003.

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RECOMMENDATIONS

ADULTS AGES 19 - 64

Promote, Develop and Implement Effective Prevention Strategies

- Promote community policies and zoning regulations that discourage underage and excessive alcohol use
- Promote community interventions that discourage excessive alcohol and gambling advertising and promotions
- Increase and improve community opportunities for socialization
- Promote family/friend/significant other socialization as appropriate
- Include assessment of formal support systems in provider screening
- Seek assistance of faith community organizations
- Increase awareness of self help, mutual support groups, widow to widow, parents without partners, survivors of homicide, survivors of suicide, cancer survivor and other support groups
- Increase awareness of potential adverse impact of interpersonal violence, including domestic violence, sexual abuse and assault and resources including support groups
- Increase awareness and access to grief and bereavement counselors
- Increase transitional supports for retirement and/or loss of jobs
- Enhance and facilitate public awareness and educational activities for adult organizations, such as Parent Teacher Organizations, clubs, employers regarding firearm safety, storage and legislation
- Encourage human service professionals to ask about access to firearms when assessing safety issues
- Encourage mental health professionals to address means restriction with high -risk clients
- Encourage the administration of military departments and police academies to acknowledge the scope of the problem, facilitate increased training and awareness activities and address referral, treatment and stigma issues
- Investigate model program developed by the Air Force
- Increase survivor network of support

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

ADULTS AGES 19 - 64

Promote, Develop And Implement Effective Prevention Strategies (continued)

- Increase awareness among general public, lay personnel and home services workers, etc. of potential problem signs of/for suicide and resources for assistance.
- Encourage locally initiated and implemented strategies, resources and activities that encourage people to stay connected to the community.
- Identify and promote awareness of resources that address financial, parenting, educational issues and relationship breakups including divorce.

Promote Improved Access To Behavioral Health Care

- Encourage openness regarding suicide stigma in families.
- Educate families regarding family history of suicide as risk factor.
- Educate behavioral health professionals about communicating family history and encouraging help-seeking behaviors.
- Increase awareness of the potential impact of the challenge of transition, especially in early adulthood.
- Facilitate access to behavioral health services without adverse consequences.
- When relevant, encourage doctors to talk with patients and their families about biochemical issues related to suicide and mental health.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

ADULTS AGES 19 - 64

Promote The Provision Of Quality Behavioral Health Care

- Encourage colleges and universities to develop and implement clear action plans to support students with mental health issues
- Disseminate model policies and standards that provide legal protection and good care
- Work with hospitals, medical examiners and funeral directors to disseminate information regarding support groups, mental health, financial and other support services.
- Increase awareness of relationship between medical illness and emotional distress.

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COMPREHENSIVE SUICIDE PREVENTION PLAN ELDERS 65+

Depression remains an under diagnosed and under treated condition for some older adults. One tragic consequence of this condition may be suicide. In an attempt to heighten awareness about this risk in older adults, the Department of Public Health Interagency Suicide Prevention Network has formulated a comprehensive suicide prevention plan for older adults. In an attempt to raise awareness about this problem, specific prevention and screening guidelines have been drafted. By dealing with this issue in an up front, practical manner the best opportunity exists to impact on this problem as it relates to older adults.

As the number of older adults is dramatically increasing, now is the time to confront this matter directly. By widely disseminating these recommendations, it is hoped that routine screening and intervention will become more commonplace in the provision of care to older adults. Real opportunities exist to deal with the issue of suicide in older adults, and the guidelines that follow are an important first step in this ongoing process.

Gerard J. Kerins MD, FACP

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COMPREHENSIVE SUICIDE PREVENTION PLAN RECOMMENDATIONS ELDERS 65+

Promote Awareness That Suicide Is Preventable and That Mental Health Is Important To Overall Health

- Increase media awareness of elderly suicide
- Increase awareness in adult children of elders, extended family and friends
- Increase awareness of support services that will call an elder daily
- Provide information and enhance awareness among elder services such as meals on wheels, senior centers, clinics, Lifeline
- Increase local public awareness of community, faith-based and statewide support services
- Advertise, support and increase local public awareness of community, statewide and faith-based services and outreach efforts
- Develop, implement and disseminate awareness messages that dispel myth that “ it is to be expected at that age” .

Promote, Develop and Implement Effective Prevention Strategies

- Enhance public education to encourage appropriate precautions to improve safety and prevent injuries
- Facilitate elder programs and settings that maintain and promote social engagement e.g. peer to peer, intergenerational and cooperative housing
- Involve faith community
- Promote awareness of availability of the Elderly Ombudsman and protective services for the elderly
- Develop programs that promote increased social supports and utilize elder expertise
- Develop appropriate ways to market to elders

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

ELDERS 65+

Promote, Develop and Implement Effective Prevention Strategies (continued)

- Promote independence, quality of life by encouraging community attempts to provide greater mobility to elders
- Promote awareness of the potential impact of chronic illnesses and debilitating injuries on mental health
- Provide and encourage caretaker respite
- Encourage the medical and mental health communities to educate families
- Identify systems of local respite care
- Identify resources for skilled respite care
- Increase access to support services such as loss- support groups, creative outreach, Friendly Visitor, Friendship lines, etc.
- Increase non-traditional community supports such as gatekeepers
- Encourage and sustain community support groups for seniors
- Encourage agency support for policies and information that would assist lay personnel and home service workers to identify obvious signs of potential problems and to take appropriate action
- Provide training in medical and other health professions schools that addresses specific needs of elders related to suicide and related mental health issues
- Promote training for law enforcement that addresses elder suicide risk factors and potential behaviors that might indicate a mental health issue
- Improve and increase training for health, mental health and social service professionals in elder suicide risk factors and related mental health issues including use of scientifically validated screening instruments

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

ELDERS 65+

Promote, Develop And Implement Effective Prevention Strategies (continued)

- Create access to counseling and support sensitive to elder issues
- Facilitate, promote continuing professional education for health care professionals and paraprofessionals in elderly issues
- Facilitate strategies that encourage health care providers to include depression, suicide, and social issues in intake, assessment and treatment plans.

Promote Improved Access To Behavioral Health Care

- Facilitate closer collaboration between medical and mental health care staff; encourage appropriate cross-discipline referrals
- Create access to counseling and support sensitive to elder issues
- Offer mental health services in senior centers
- Encourage framing psychiatric problems as medical problems to facilitate access, diminish stigma
- Provide resources for accessible, affordable transportation that accommodates people with disabilities
- Encourage local governments and agencies to increase availability and utilization of transportation services.
- Increase faith-based network that would provide outreach to isolated individuals and others in need
- Involve faith community, clients and others in developing models/ strategies to increase access
- Facilitate strategies that view suicide as a family/caretaker/community support issue rather than only an individual issue
- Involve providers, geriatric physicians in providing professional education

CONNECTICUT

COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

ELDERS 65+

Promote Improved Access To Behavioral Health Care (continued)

- Understand difficulties in recognition and diagnosis among elderly, resolve referral issues
- Improve discharge planning, transition services including involving family/caretakers and primary medical practitioner as appropriate.

Promote the Provision Of Quality Behavioral Health Care

- Review suicide prevention policies and procedures
- Develop behavioral health plans in concert with elder client
- As allowed, facilitate communication and sharing of information between providers and family/caretakers of elders
- Incorporate behavioral health assessment into annual physical screening
- Encourage physicians to address psychiatric as well as physical needs of patients
- Facilitate strategies that encourage health care providers to include depression, suicide, and social issues in intake, assessment and treatment plans
- Facilitate assessment models and treatment plans that address physical, mental and social areas of functioning

CONNECTICUT

COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

ELDERS 65+

Promote the Provision Of Quality Behavioral Health Care (continued)

- Promote policies and protocols that facilitate staff adoption of empathic behaviors when working with elders
- Encourage family involvement in treatment, planning and support
- Promote policies that recommend criminal background checks on staff in extended care facilities and other agencies that serve elders; sets standards for new employees regarding education and work history
- Assess availability of family, extended family, support network
- Promote policies that encourage facilities to set standards for accommodation of individual disabilities
- Encourage treatment plan goals that maximize independence while maintaining safety
- Encourage collaboration between medical and mental health care staff; encourage appropriate cross-discipline referrals.

CONNECTICUT

COMPREHENSIVE SUICIDE PREVENTION PLAN

CRIMINAL JUSTICE / LAW ENFORCEMENT/EMERGENCY RESPONSE

Suicide is a major issue for law enforcement and public safety agencies. Regardless of the setting, police, fire, emergency medicine, jails or correctional facilities, suicide prevention must remain a major consideration. Yet unlike mental health systems where suicide is a primary focus, suicide prevention is frequently perceived to be less important in public safety agencies due to their multiple responsibilities. This perception is frankly wrong. Police respond to calls for attempted, threatened, and completed suicides. Corrections staff deal with people who, by virtue of their incarceration show suicide rates nine times that of the general population and attention to in-custody suicide prevention has been virtually driven by civil litigation. For those helping professionals that are required to aid without the right of refusal, and to deal with people who may be unpleasant, violent, or unpredictable, public safety personnel must be prepared for anything. Aside from crisis intervention, referral to follow-up care may be the most important factor in ensuring long-term safety. With that in mind, it is only fair that police, Emergency Medical Services, and corrections officers be given the best training available and proper policy and procedures to be able to make the right referrals and facilitate access to care.

John Chapman, Psy. D., CCHP

CONNECTICUT

COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

LAW ENFORCEMENT/EMERGENCY RESPONSE

- Examine police training programs and provide recommendations specific to suicide and mental illness
- Encourage emergency service providers and other first responders to collaborate with local hospitals, training organizations and mental health providers to enhance knowledge of mental illness and suicide
- Encourage collaboration of police and mental health agencies
- Encourage development of specialized police units to deal with behavioral emergencies
- Review existing and encourage availability of critical incident services to police and emergency personnel impacted by suicide
- Review policies, practice and protocols in police lock-ups including screening and observation of persons in custody
- Encourage more police academy and police continuing education seminars and courses that facilitate an increase in police officer's knowledge of mental illness, suicidal thinking and related issues that could be relevant to their work

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

CRIMINAL JUSTICE - CROSS-CUTTING/OVERARCHING

- Increase knowledge of appropriate national standards related to:
 - Suicide prevention in the criminal justice system
 - Education of all staff
 - Screening of all inmates
 - Proper access to mental health care
 - Establishing and implementing concise and clear policies and procedures related to suicide prevention
 - Administrative review of serious suicide attempts and suicides
 - Critical incident support to corrections staff following serious suicide attempts or suicides
 - Reviewing each facility for environmental safety risks and taking corrective action where possible.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

CRIMINAL JUSTICE - CHILDREN/YOUTH

- Examine best practice models for treatment of youth in the Criminal Justice system, incorporate principles of developmental psychology into services for children and youth

Provide:

- Training in suicide prevention with annual refresher training for all youth corrections staff
- Clear and concise policy and procedures which allow for:
 - A recognition of risk factors
 - Steps to maintain safety of children at risk
 - Mechanisms or procedures for referring children to mental health services
- Proper screening and referral of all children coming into the criminal justice system including screening for risk factors including:
 - Depression
 - Physical and sexual abuse
 - Conduct problems
 - Agitated and aggressive behavior
- Correctional institutions and alternative settings that provide access to age appropriate care and specialists
- Institutions that facilitate access to victims services
- Institutions that facilitate access to post release health care through Medicaid enrollment, discharge planning.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

CRIMINAL JUSTICE - ADULTS

- Encourage and provide ready access to health and mental health care

Provide/ Promote:

- Training of all corrections staff in suicide prevention with annual refresher training
- Immediate screening of all inmates for suicide risk upon intake
- Avoidance of segregation and isolation, particularly within the first 24 hours
- Prompt evaluation of inmates by health and mental health staff
- Development of special needs treatment plans for seriously mentally ill offenders
- Development of continuity of care plans for inmates post release including enrollment in necessary treatment programs
- Training of correctional health staff in maintaining confidentiality of protected health information.

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COMPREHENSIVE SUICIDE PREVENTION PLAN

RECOMMENDATIONS

CRIMINAL JUSTICE - ELDERS

- Consider age-similar housing to decrease likelihood of victimization
- Assess for necessity of increased access to medical resources due to increased likelihood of elder having a medical condition
- Improve access to medical specialists, including mental health clinicians experienced in treating an older population
- Make accommodations for work and recreation to decrease isolation and to assure as active a lifestyle as possible
- Train all corrections staff in suicide prevention with annual refresher training
- Facilitate recognition by corrections staff that proper approach should include sensitivity to aging issue
- Assist elder inmates in coping with chronic diseases, infirmities and end-of-life issues.

CONNECTICUT

DATA

NATIONAL

Centers for Disease Control and Prevention
Ten Leading Causes of Death - United States

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Centers for Disease Control and Prevention
Ten Leading Causes of Death - Connecticut

Office of the Child Advocate

Suicide Mortality and Attempts - Data Summary Sheet

Suicide Mortality - 1999-2001

Suicide Attempts - 1999

10 Leading Causes of Death, United States 1999 - 2001, All Races, Both Sexes

Rank	Age Groups											All Ages
	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 16,729	Unintentional Injury 5,438	Unintentional Injury 4,133	Unintentional Injury 4,773	Unintentional Injury 20,089	Unintentional Injury 22,091	Unintentional Injury 35,498	Malignant Neoplasms 49,821	Malignant Neoplasms 144,277	Malignant Neoplasms 268,295	Heart Disease 1,783,702	Heart Disease 2,136,094
2	Short Gestation 13,199	Congenital Anomalies 1,601	Malignant Neoplasms 1,491	Malignant Neoplasms 1,543	Homicide 5,906	Homicide 9,328	Suicide 14,968	Unintentional Injury 46,589	Heart Disease 106,873	Heart Disease 190,052	Malignant Neoplasms 1,172,702	Malignant Neoplasms 1,656,697
3	SIDS 7,405	Malignant Neoplasms 1,258	Congenital Anomalies 587	Suicide 814	Suicide 4,847	Suicide 7,019	Homicide 13,599	Heart Disease 40,107	Unintentional Injury 37,261	Chronic Low. Respiratory Disease 33,202	Cerebro-vascular 441,130	Cerebro-vascular 498,565
4	Maternal Pregnancy Comp. 4,302	Homicide 1,147	Homicide 463	Homicide 666	Malignant Neoplasms 2,222	Malignant Neoplasms 2,919	Malignant Neoplasms 11,915	Suicide 19,663	Liver Disease 20,281	Cerebro-vascular 29,216	Chronic Low. Respiratory Disease 321,391	Chronic Low. Respiratory Disease 369,203
5	Respiratory Distress 3,120	Heart Disease 589	Heart Disease 320	Congenital Anomalies 616	Heart Disease 1,213	Heart Disease 1,886	Heart Disease 9,184	HIV 18,018	Cerebro-vascular 17,484	Diabetes Mellitus 27,853	Influenza & Pneumonia 171,357	Unintentional Injury 297,297
6	Placenta Cord Membranes 3,105	Influenza & Pneumonia 345	Benign Neoplasms 178	Heart Disease 500	Congenital Anomalies 702	Congenital Anomalies 678	HIV 7,267	Homicide 10,693	Suicide 16,460	Unintentional Injury 22,448	Diabetes Mellitus 157,964	Diabetes Mellitus 209,072
7	Unintentional Injury 2,702	Septicemia 294	Chronic Low. Respiratory Disease 139	Chronic Low. Respiratory Disease 243	Chronic Low. Respiratory Disease 267	HIV 494	Diabetes Mellitus 1,800	Liver Disease 10,009	Diabetes Mellitus 15,032	Liver Disease 17,161	Alzheimer's Disease 146,258	Influenza & Pneumonia 191,077
8	Bacterial Sepsis 2,155	Perinatal Period 243	Influenza & Pneumonia 139	Influenza & Pneumonia 133	Influenza & Pneumonia 204	Cerebro-vascular 375	Cerebro-vascular 1,783	Cerebro-vascular 7,664	HIV 12,169	Nephritis 9,248	Unintentional Injury 95,964	Alzheimer's Disease 147,946
9	Circulatory System Disease 1,952	Benign Neoplasms 174	Septicemia 114	Cerebro-vascular 132	Cerebro-vascular 202	Influenza & Pneumonia 345	Congenital Anomalies 1,400	Diabetes Mellitus 5,826	Chronic Low. Respiratory Disease 9,685	Suicide 9,158	Nephritis 94,284	Nephritis 112,256
10	Intrauterine Hypoxia 1,777	Chronic Low. Respiratory Disease 148	Cerebro-vascular 89	Benign Neoplasms 127	Diabetes Mellitus 147	Diabetes Mellitus 321	Liver Disease 1,209	Influenza & Pneumonia 3,114	Homicide 5,890	Septicemia 8,724	Septicemia 74,830	Septicemia 94,142

10 Leading Causes of Death, Connecticut 1999 - 2001, All Races, Both Sexes

Rank	Age Groups											All Ages
	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	
1	Short Gestation 143	Unintentional Injury 28	Unintentional Injury 24	Unintentional Injury 32	Unintentional Injury 146	Unintentional Injury 220	Unintentional Injury 398	Unintentional Injury 571	Malignant Neoplasms 1,619	Malignant Neoplasms 3,118	Heart Disease 23,021	Heart Disease 26,702
2	Congenital Anomalies 138	Malignant Neoplasms 12	Malignant Neoplasms 15	Malignant Neoplasms 13	Suicide 50	Homicide 52	Suicide 127	Malignant Neoplasms 553	Heart Disease 1,093	Heart Disease 1,993	Malignant Neoplasms 15,723	Malignant Neoplasms 21,212
3	SIDS 64	Congenital Anomalies 11	Congenital Anomalies 6	Heart Disease 10	Homicide 35	Suicide 51	Malignant Neoplasms 112	Heart Disease 422	Unintentional Injury 367	Chronic Low. Respiratory Disease 270	Cerebrovascular 5,470	Cerebrovascular 5,947
4	Maternal Pregnancy Comp. 61	Heart Disease 7	Chronic Low. Respiratory Disease 4	Congenital Anomalies 8	Malignant Neoplasms 23	Malignant Neoplasms 24	Homicide 110	HIV 257	Liver Disease 216	Diabetes Mellitus 248	Chronic Low. Respiratory Disease 4,054	Chronic Low. Respiratory Disease 4,454
5	Placenta Cord Membranes 52	Homicide 6	Heart Disease 4	Chronic Low. Respiratory Disease 3	Heart Disease 16	Heart Disease 18	Heart Disease 107	Suicide 191	Suicide 183	Cerebrovascular 229	Influenza & Pneumonia 2,436	Unintentional Injury 3,265
6	Intrauterine Hypoxia 27	Influenza & Pneumonia 4	Homicide 4	Septicemia 3	Congenital Anomalies 4	Congenital Anomalies 8	HIV 70	Liver Disease 121	HIV 180	Unintentional Injury 205	Diabetes Mellitus 1,677	Influenza & Pneumonia 2,629
7	Respiratory Distress 26	Septicemia 3	Benign Neoplasms 2	Suicide 3	Cerebrovascular 3	Chronic Low. Respiratory Disease 4	Diabetes Mellitus 15	Homicide 85	Cerebrovascular 163	Liver Disease 179	Alzheimer's Disease 1,528	Diabetes Mellitus 2,133
8	Necrotizing Enterocolitis 20	Chronic Low. Respiratory Disease 2	Cerebrovascular 2	Four Tied 2	HIV 3	Influenza & Pneumonia 4	Liver Disease 14	Cerebrovascular 62	Diabetes Mellitus 134	Nephritis 118	Nephritis 1,337	Septicemia 1,579
9	Bacterial Sepsis 16	Meningitis 2	Influenza & Pneumonia 2	Four Tied 2	Five Tied 1	Four Tied 2	Septicemia 13	Diabetes Mellitus 56	Septicemia 77	Septicemia 115	Septicemia 1,321	Nephritis 1,566
10	Circulatory System Disease 16	Three Tied 1	Four Tied 1	Four Tied 2	Five Tied 1	Four Tied 2	Two Tied 11	Septicemia 35	Chronic Low. Respiratory Disease 74	Suicide 108	Unintentional Injury 1,263	Alzheimer's Disease 1,548

CONNECTICUT

OFFICE OF THE CHILD ADVOCATE REPORTS ¹¹

During the 1998 to 2002 period the Office of the Child Advocate produced comprehensive reports on three child fatalities in which adolescents completed suicide. In addition, an investigation has begun on a recent teen suicide. All of the children who completed suicide were between 12 and 18 years of age. Four were teenage females, and one was an adolescent male. All completed suicide by hanging. One female teen was listed as bi-racial, one male was African-American and the others were Caucasian. They came from diverse family configurations and socioeconomic circumstances. All of the children were known to the Department of Children and Families. Two of the girls had a history of out of home placements, and all of the children exhibited behavioral health and other issues.

¹¹ Connecticut General Statutes sections 46a-131(b) and (c) mandate that the Connecticut Child Fatality Review Panel “review the circumstances of the death of any child who has received services from a state department or agency addressing child welfare, social or human services or juvenile justice.”

The Office of the Child Advocate is charged by CGS 46a-13L with the “responsibility to advocate for necessary changes in public policy and practice to ensure the safety and well-being of Connecticut’s children.”

Not all child deaths are reported to the Office of the Child Advocate. All deaths that are reported to the OCA are reviewed but “thorough investigations are conducted into those situations where there are indications of possible public systems failures. The purpose of these investigations is to determine whether public agencies and professionals who are responsible for protecting children can do a better job and to identify opportunities to improve practice.”

CONNECTICUT

Suicide Mortality and Attempts in Connecticut Data Summary Sheet¹

Mortality (1999-2001)

- **Total number of deaths:** 861
- **Top 3 methods:**
 1. Firearm (39%, n=339)
 2. Hanging, Strangulation, and Suffocation (27%, n=229)
 3. Poisoning (25%, n=217)
- **Gender:** Male: 80% Female: 20%
- **Race/Ethnicity:** White (non-Hispanic): 89%, Black: 5%, White Hispanic: 5%, Asian: 1%, American Indian: <1%
- **Greatest proportion of deaths** was among adults aged 40-49 years (22%, n=188), followed by adults aged 30-39 years (20%, n=175), and adults aged 50-59 years (16%, n=140).
- **Among teenagers**, <1% (n=3) were among 10-14 year-olds and 6% (n=50) were among 15-19 year-olds.

Attempts (Hospitalizations, 1999)

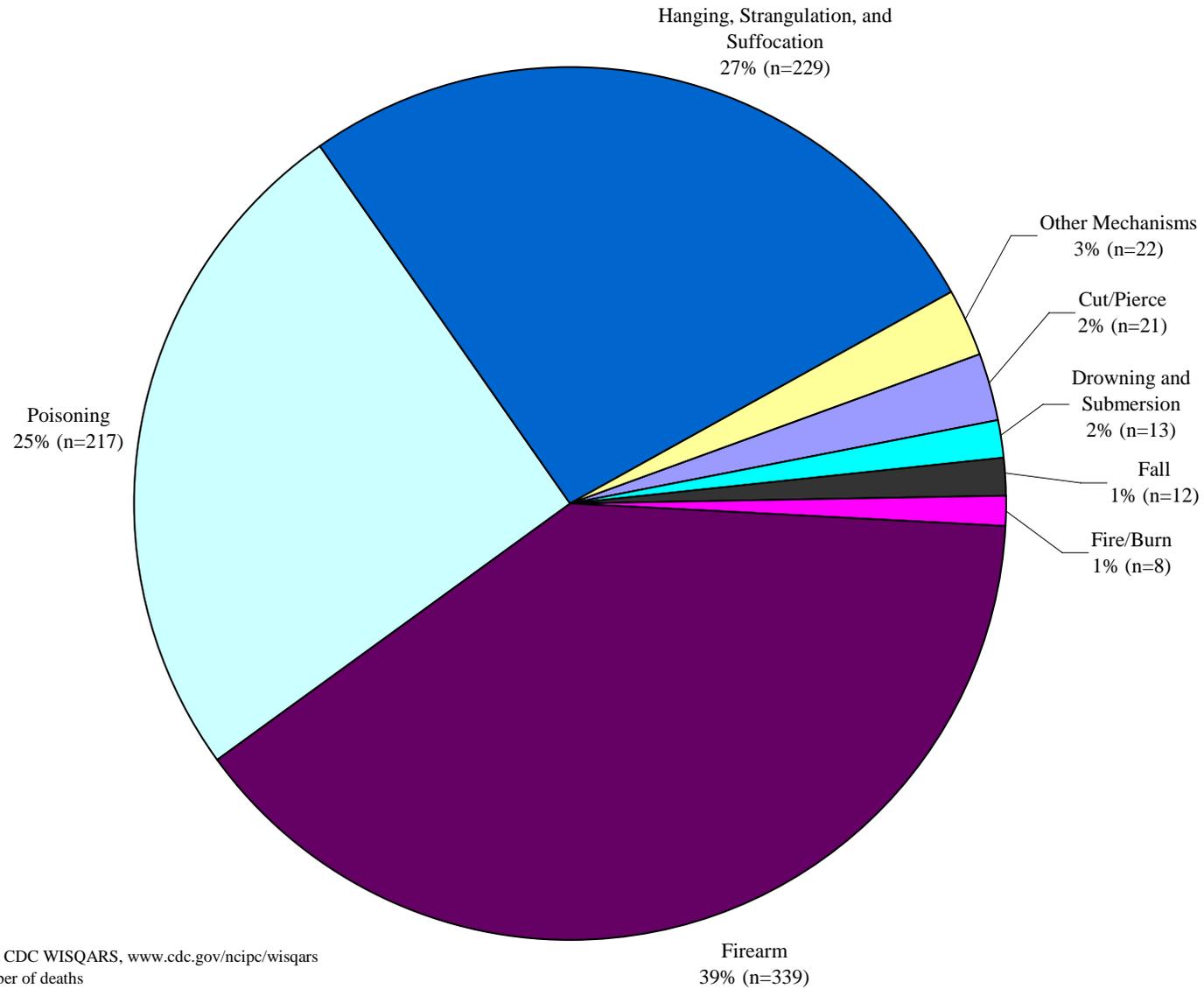
- **Total number of attempts:** 4,021
- **Top 3 methods:**
 1. Poisoning by solid or liquid substances (64%, n=2,577)
 2. Cut/Pierce (25%, n=997)
 3. Other methods/late effects (6%, n=260)
- **Gender:** Female: 60% Male: 40%
- **Race/Ethnicity:** White: 69%, Black: 7%, Hispanic: 9%, Asian: <1%, American Indian: <1%, Other: 14%
- 18 (0.4%) attempts were among children *less than 10 years old*.
- **Greatest proportion of attempts** was undertaken by adults aged 35-44 years (26%, n=1,039), followed by adults aged 25-34 years (23%, n=935), and teenagers aged 15-19 years (16%, n=649).

¹ Suicide Mortality and Morbidity Charts and Graphs, Jennifer Morin, MPH, State Department of Public Health

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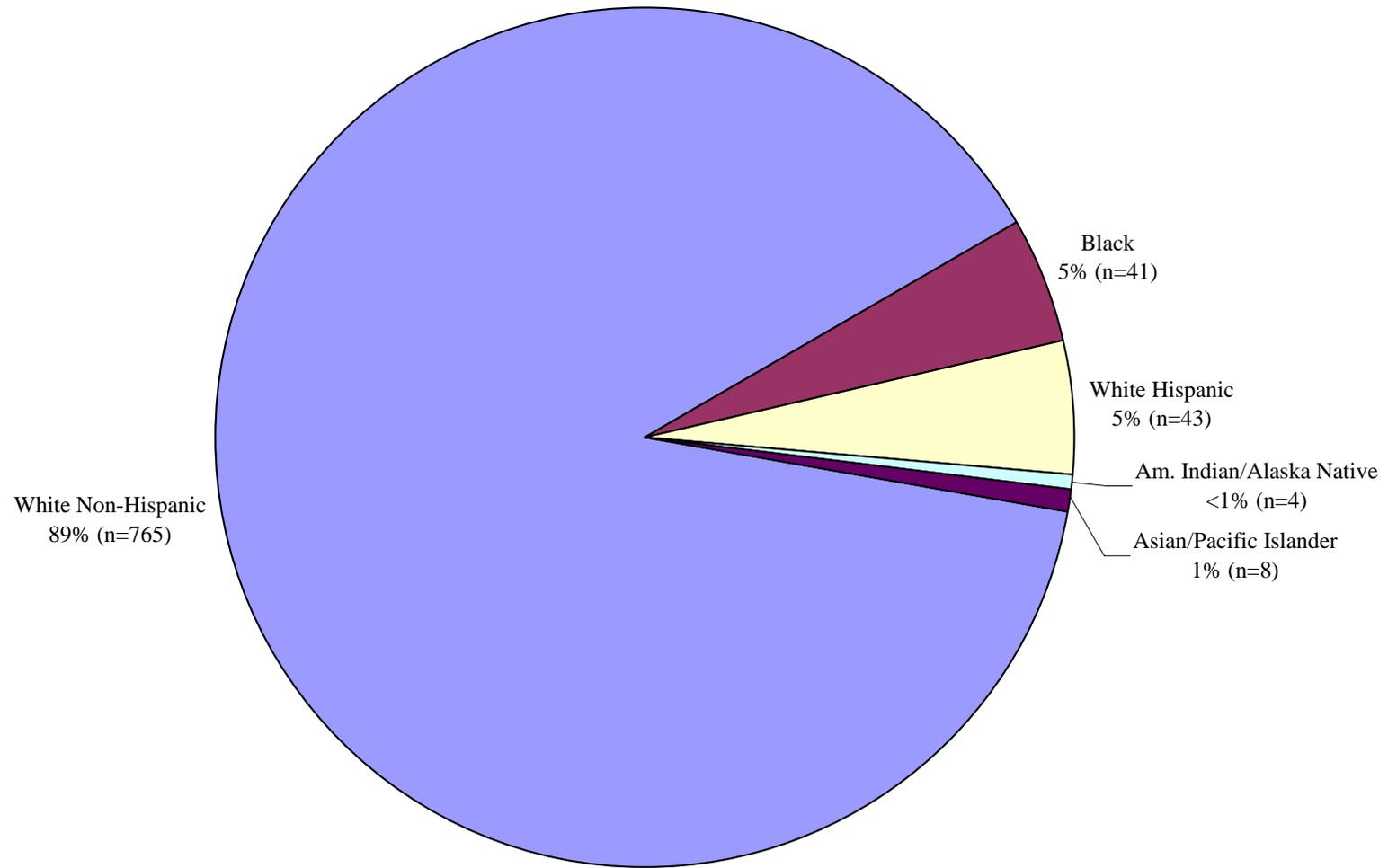
Frequency of Suicide Mortality by Method - Connecticut, 1999-2001



Source: CDC WISQARS, www.cdc.gov/ncipc/wisqars
n=number of deaths

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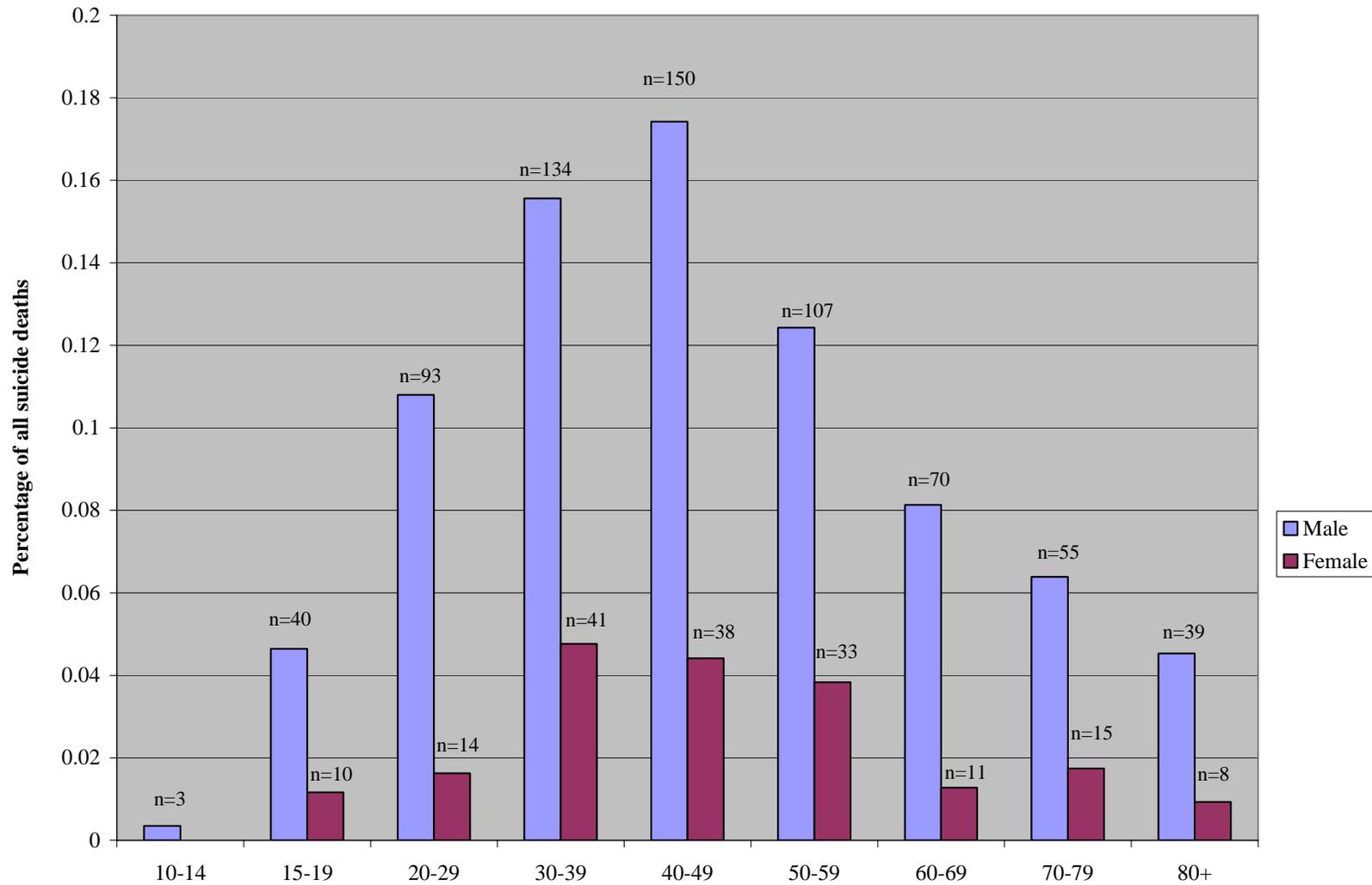
Frequency of Suicide Mortality by Race and Hispanic Ethnicity - Connecticut, 1999-2001



Source: CDC WISQARS, www.cdc.gov/wisqars

CONNECTICUT

Frequency of Suicide Mortality by Age Group and Gender - Connecticut, 1999-2001



Source: CDC WISQARS, www.cdc.gov/ncipc/wisqars

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MORTALITY

**Number of Suicide Deaths and Percentage of Suicide Deaths,
by mechanism - Connecticut, 1999-2001**

Cause	Number	Percent
Cut/Pierce	21	2%
Drowning and submersion	13	2%
Fall	12	1%
Fire/Burn	8	1%
Firearm	339	39%
Poisoning	217	25%
Hanging, Strangulation, and Suffocation	229	27%
Other Mechanisms	22	3%

Source: Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2003). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available from: URL: www.cdc.gov/ncipc/wisqars. [2004 March 24].

MORTALITY (continued)

**Number of Suicide Deaths and Percentage of Suicide Deaths,
by age group and gender - Connecticut, 1999-2001**

Age Group	TOTAL		MALE		FEMALE	
	Number	Percent	Number	Percent	Number	Percent
10-14	3	<1%	3	<1%	0	0%
15-19	50	6%	40	5%	10	1%
20-29	107	12%	93	11%	14	2%
30-39	175	20%	134	16%	41	5%
40-49	188	22%	150	17%	38	4%
50-59	140	16%	107	12%	33	4%
60-69	81	9%	70	8%	11	1%
70-79	70	8%	55	6%	15	2%
80+	47	5%	39	5%	8	1%
TOTAL	861	100%	691	80%	170	20%

Source: Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2003). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available from: URL: www.cdc.gov/ncipc/wisqars. [2004 March 24].

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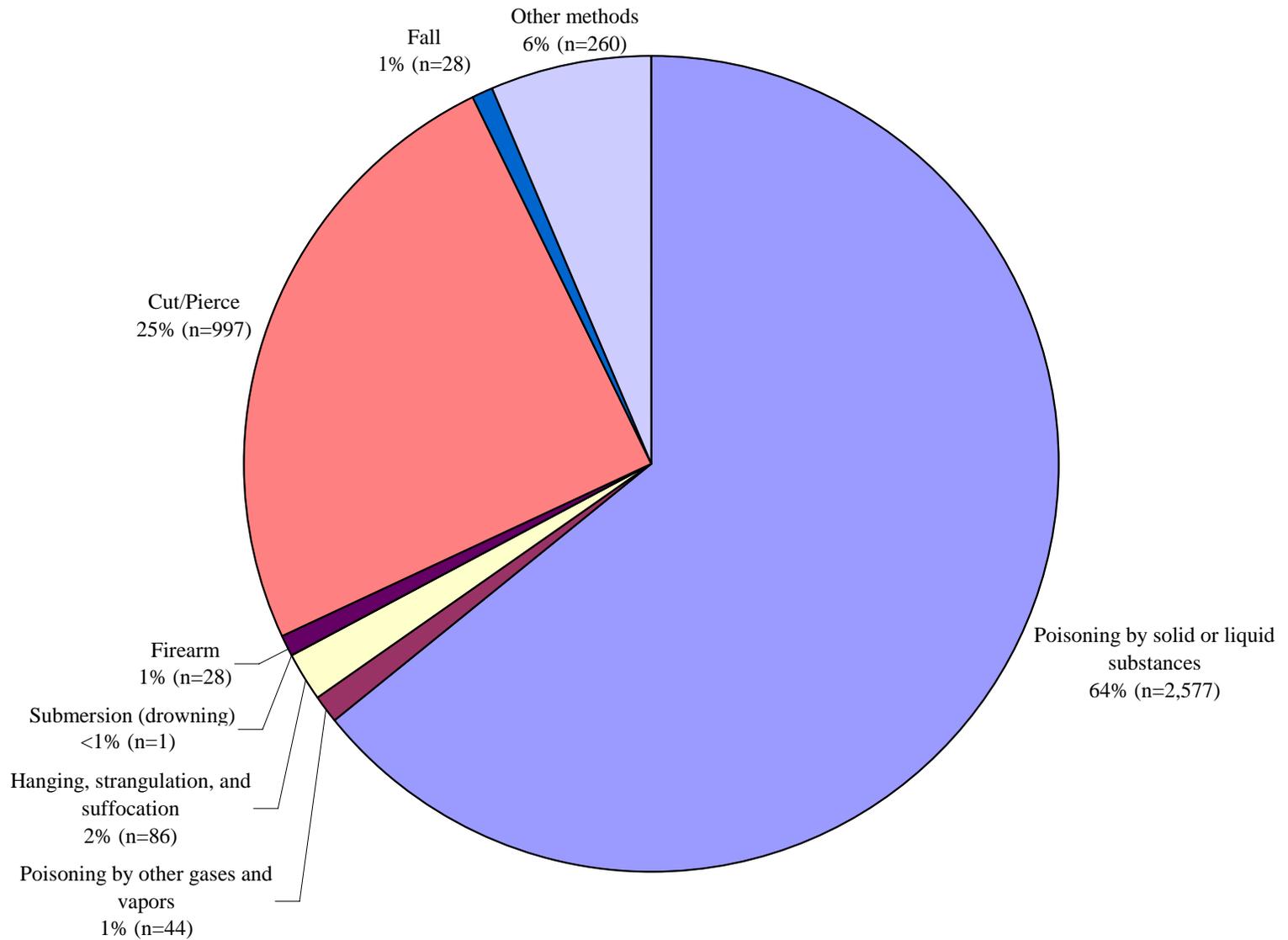
Number of Suicide Deaths and Percentage of Suicide Deaths, by race and Hispanic ethnicity - Connecticut, 1999-2001

Race/Ethnicity	Number	Percent
White Non-Hispanic	765	89%
Black	41	5%
White Hispanic	43	5%
American Indian/Alaska Native	4	<1%
Asian/Pacific Islander	8	1%

Source: Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]*. (2003). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available from: URL: www.cdc.gov/ncipc/wisqars. [2004 March 24].

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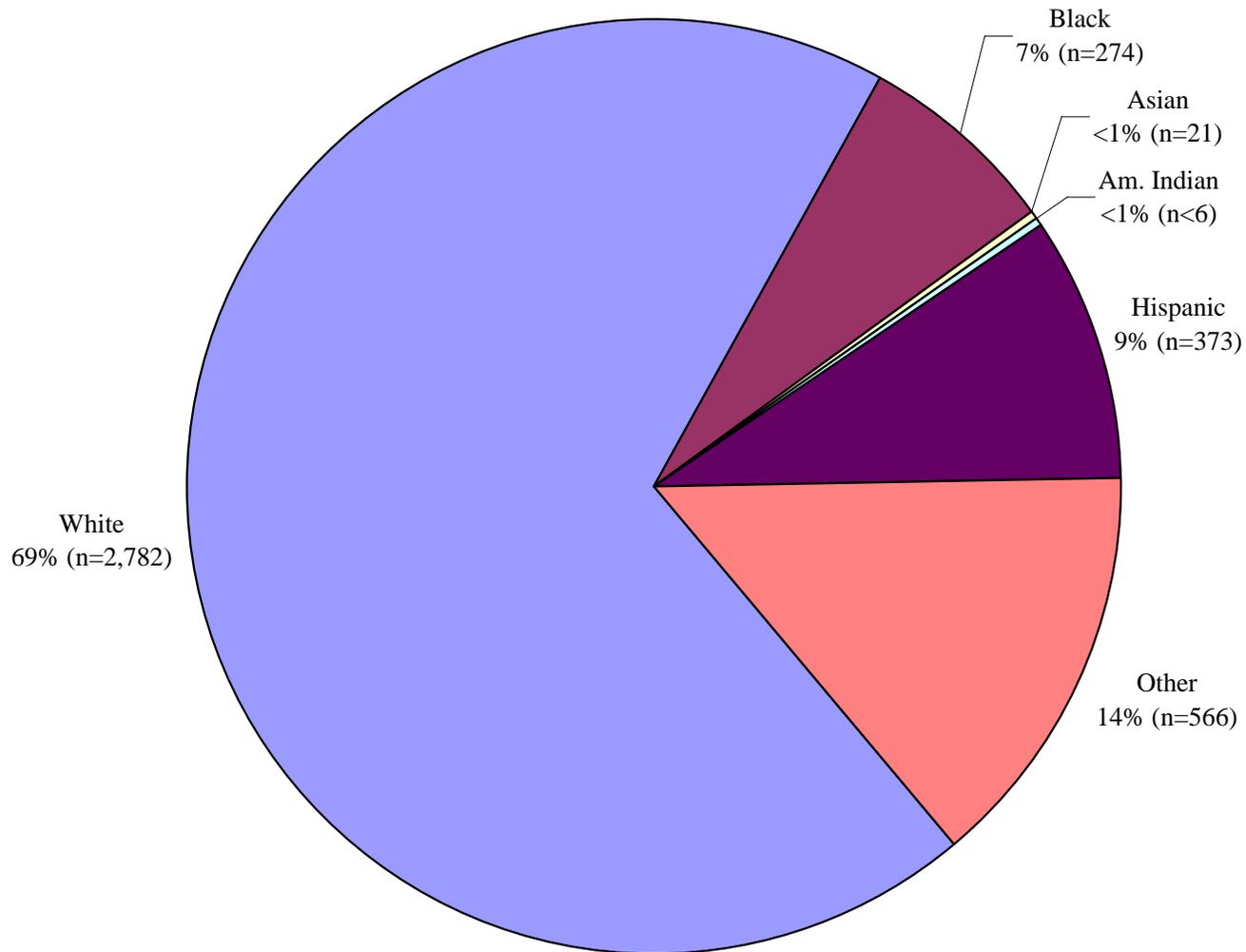
Frequency of Suicide Attempts by Method - Connecticut, 1999



Source: Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

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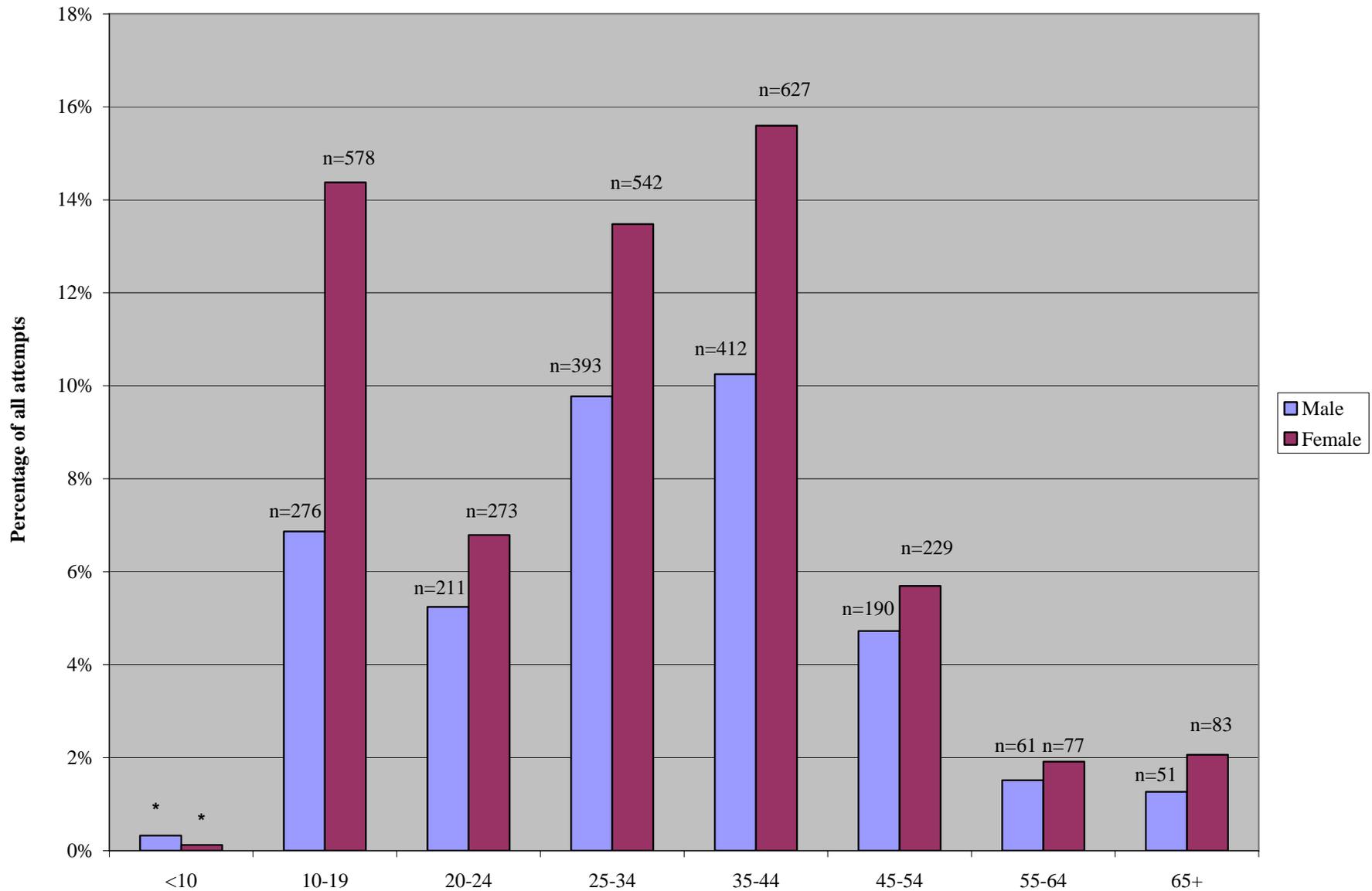
Frequency of Suicide Attempts by Race and Hispanic Ethnicity - Connecticut, 1999



Source: Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

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Frequency of Suicide Attempts by Age Group and Gender - Connecticut, 1999

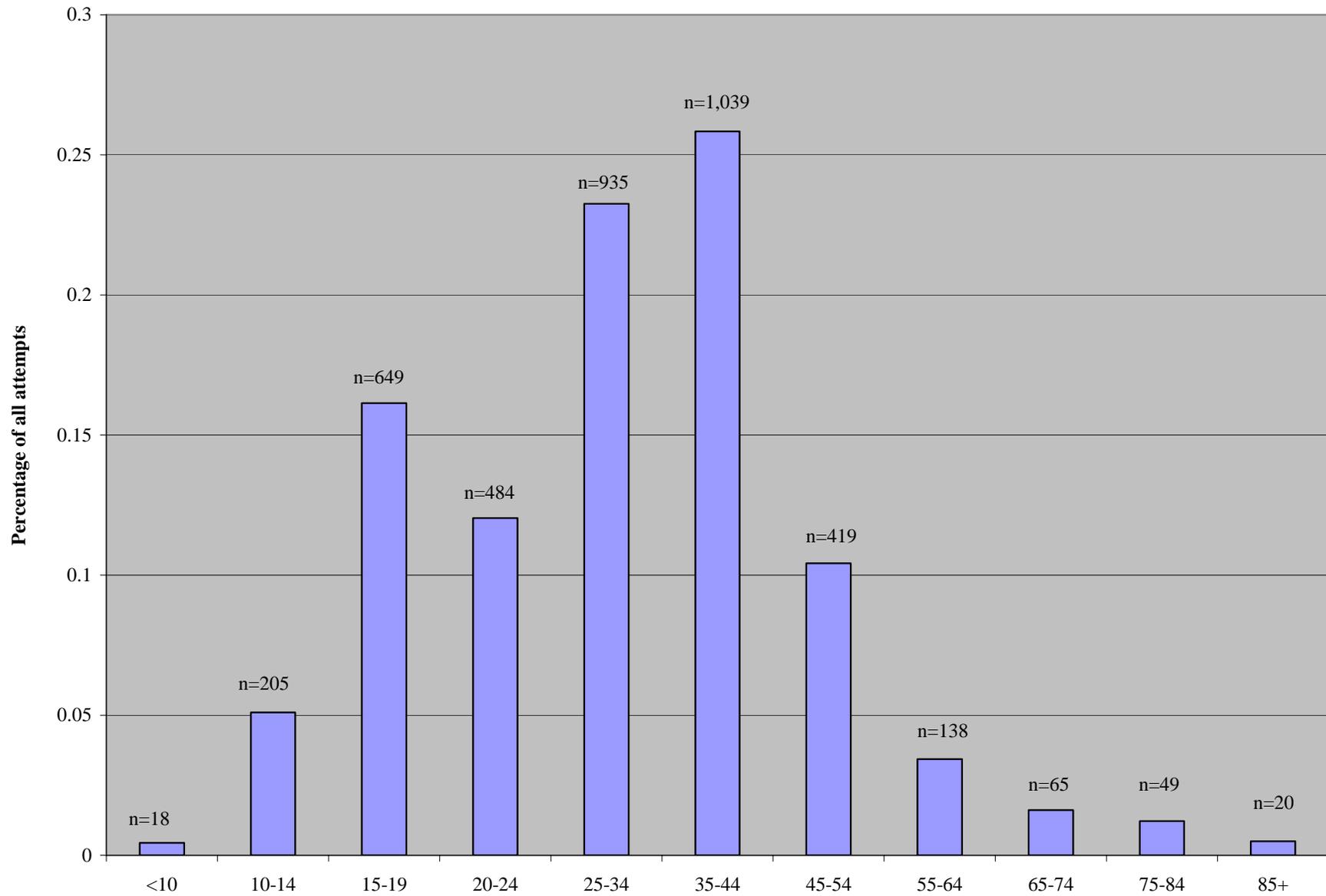


Source: Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

* Numbers too small to disclose.

CONNECTICUT

Frequency of Suicide Attempts by Age Group - Connecticut, 1999



Source: Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

CONNECTICUT

Number of Suicide Attempts and Percent of all Attempts, by mechanism - Connecticut, 1999

Mechanism	Number	Percent
<i>All methods</i>	4,021	100%
Poisoning by solid or liquid substances	2,577	64%
Poisoning by other gases and vapors	44	1%
Hanging, strangulation, and suffocation	86	2%
Submersion (drowning)	1	<1%
Firearm	28	1%
Cut/Pierce	997	25%
Fall	28	1%
Other methods/late effects	260	6%

Source: Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

Number of Suicide Attempts and Percent of All Attempts, by age group and gender - Connecticut, 1999

Age Group	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
<10	*		a		a	
10-14	205	5%	49	1%	156	4%
15-19	649	16%	227	6%	422	10%
20-24	484	12%	211	5%	273	7%
25-34	935	23%	393	10%	542	13%
35-44	1,039	26%	412	10%	627	16%
45-54	419	10%	190	5%	229	6%
55-64	138	3%	61	2%	77	2%
65-74	65	2%	22	1%	43	1%
75-84	49	1%	20	<1%	29	1%
85+	20	<1%	9	<1%	11	<1%
Total	4,003	100%	1,594	40%	2,409	60%

Source: Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

*** There were a total of 18 attempts among this age group. Due to small numbers in the gender categories, they are not included in the column totals.**

a Due to confidentiality regulations, figures are not disclosed for less than six events.

CONNECTICUT

Number of Suicide Attempts and Percentage of All Attempts, by race and Hispanic ethnicity - Connecticut, 1999

Race/Ethnicity	Number	Percent
<i>All races</i>	4016	100%
White	2782	69%
Black	274	7%
Hispanic	373	9%
American Indian/Alaska Native	a	
Asian/Pacific Islander	21	1%
Other	566	14%

Source: Connecticut Hospital and Emergency Department Discharge Database, provided by Connecticut Hospital Association for Annual Year 1999.

a Due to confidentiality regulations, figures are not disclosed for less than six events.

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APPENDIX

CONNECTICUT

RESOURCES

CONNECTICUT

State Department of Children and Families

State Department of Education

State Department of Mental Health and Addiction Services
State Department of Public Health

United Way of Connecticut/2-1-1-Infoline

Youth Suicide Advisory Board/Packet

<http://www.state.ct.us/dcf/YSAB/index.asp>

Guidelines for Suicide Prevention: Policies and Procedures - 2nd
Edition

<http://www.state.ct.us/sde/deps/Student/PsychSocial/index.htm#Publications>

<http://www.dmhas.state.ct.us/>

<http://www.dph.state.ct.us/>

Injury Prevention Program - 860-509-7805

In Connecticut dial 2-1-1 for 24 -hour crisis line, information, referral

<http://www.infoline.org/>

INTERNET WEB SITES

<http://www.suicidology.org/index.cfm>

<http://www.mentalhealth.org/suicideprevention/default.asp>

<http://www.cdc.gov/ncipc/>

<http://www.ncspt.org>

<http://www.ncianet.org/cjisl.cfm>

<http://www.ncchc.org/resources/statements/mentalhealth.html>

<http://www.sprc.org>

<http://www.surgeongeneral.gov/library/calltoaction/default.htm>

NATIONAL

- American Association of Suicidology
- National Strategy for Suicide Prevention
- National Center for Injury Prevention and Control
- National Center for Suicide Prevention Training
- National Center on Institutions and Alternatives
- National Commission on Correctional Health Care
- National Suicide Prevention Resource Center
- Surgeon General's Call to Action to Prevent Suicide

CONNECTICUT

ELDERS

- American Society on Aging
833 Market Street Suite 511
San Francisco, CA 94103-1824
- Elderly Suicide Prevention Advocacy
1-888-649-1366
- Yates Conwell M.D.
University of Rochester
Rochester, N.Y.
- Center for Elderly Suicide Prevention
and Grief Related Services
3330 Geary Blvd. 3rd floor
San Francisco, CA 94118-3347
- Institute on Aging
Patrick Arbor, Director
Grief Bereavement

CONNECTICUT



Keeping Connecticut Healthy