COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

# Office of Suicide Prevention Annual Report
# Suicide Prevention in Colorado
# 2013 – 2014

Submitted to the Colorado Joint Budget Committee,
the Health and Environment Committee of the House of Representatives,
and the Health and Human Services Committee of the Senate
by the Prevention Services Division
Colorado Department of Public Health and Environment
November 1, 2014

## Document Information

| | |
|---|---|
| Title: | Office of Suicide Prevention<br>Suicide Prevention in Colorado Annual Report 2013-2014 |
| Principal Authors: | Jarrod Hindman, M.S.<br>Violence and Suicide Prevention Section Manager<br><br>Shannon A. Breitzman, M.A., Director<br>Violence and Injury Prevention-Mental Health Promotion Branch<br>Prevention Services Division |
| Subject: | Report on suicide prevention programs and activities in Colorado in fiscal year 2013-2014 and the coordinating efforts of the Office of Suicide Prevention |
| Statute: | Section 25-1.5-101(1)(w)(III)(A), C.R.S. (House Bill 00-1432) |
| Date: | November 1, 2014 |
| Content: | Full Report Pages 1-10<br>Appendix A – House Bill 2012-1140 Assessment Results & Recommendations |

For additional information or copies of this report contact:

Jarrod Hindman, M.S.
Violence and Suicide Prevention Section Manager
Prevention Services Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530
303.692.2539
jarrod.hindman@state.co.us

# Office of Suicide Prevention Annual Report
# Suicide Prevention in Colorado 2013-2014

## Introduction

Pursuant to Colorado Revised Statute Section 25-1.5-101(1)(w)(III)(A), the Office of Suicide Prevention at the Colorado Department of Public Health and Environment is required to report annually on the status of program efforts to coordinate statewide suicide prevention services. This report details the office's suicide prevention initiatives throughout Colorado during the 2013-2014 fiscal year.

The mission of the Office of Suicide Prevention is to serve as the lead entity for suicide prevention and intervention efforts in Colorado, collaborating with communities statewide to reduce the number of suicide deaths and attempts in Colorado. In an effort to broaden the reach and impact of state-level suicide prevention activities, the office emphasizes using state funding to address strategic priority areas. These priority areas include funding local initiatives, focusing initiatives on high risk populations and highly impacted parts of the state, increasing knowledge about suicide risk and prevention resources, training individuals to recognize and respond to suicidal crisis, and forming and leading collaborative partnerships at the state and local level to implement innovative prevention and intervention strategies.

### The Impact of Suicide in Colorado

In 2013, there were 1,004 suicides among Colorado residents and the age-adjusted suicide rate was 18.5/100,000.[1] This is the second highest number of suicide deaths ever recorded in Colorado (1,053 in 2012), and the rate illustrates a continued upward trend in suicide deaths from 2009-2013. For purposes of comparison, the number of suicide deaths in 2013 exceeded the number of deaths from homicide (186), motor vehicle crash (507), breast cancer (537), influenza and pneumonia (608), and diabetes (786).[2] In 2013, suicide was the seventh leading cause of death for all Coloradans. Coloradans ages 45 to 54 demonstrated the highest suicide rate (30.9/100,000) and highest number of suicide deaths (225) compared to all other age groups. Among youth and young adults ages 10 to 34, suicide was the second leading cause of death. In 2012, the most recent year of data available nationally, Colorado had the fifth-highest suicide rate in the United States, [3] and is consistently among the ten states with the highest suicide rates nationally.

Regarding suicide attempts, there were 2,622 hospitalizations for suicide attempts in Colorado in 2013 and the age-adjusted suicide hospitalization rate was 48.3/100,000.[4] According to the 2013 Healthy Kids Colorado Survey, 24.3 percent of Colorado high school students indicated feeling sad or hopeless almost every day for two weeks or more in a row during the previous 12 months. Fourteen and one-half percent reported considering suicide, and 6.6 percent reported making one or more suicide attempts in the previous twelve months. For students who reported being gay, lesbian or bisexual, 59.4 percent indicated feeling sad or hopeless, 48.5 percent reported considering suicide, and 28.2 percent reported attempting suicide in the previous twelve months.[5]

---

[1] Retrieved October 6, 2014 from http://www.cdphe.state.co.us/cohid
[2] Ibid.
[3] Retrieved October 6, 2014 from http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2011OverallData.pdf
[4] Retrieved October 6, 2014 from http://www.cdphe.state.co.us/cohid
[5] Retrieved October 9, 2014 from http://www.hkcs.omni.org

### Colorado's 10 Winnable Battles

In 2013 the Colorado Department of Public Health and Environment (CDPHE) continued to focus on a number of priority areas, known as the "Winnable Battles," which represent key public health issues with the greatest potential to positively impact the health of Colorado citizens. Mental health and substance abuse have been identified as one of these priorities. Improved mental health and reductions in substance abuse are also part of the Governor's 2013 The State of Health plan. As suicide is linked to mental illness and substance abuse (depression is the most common factor associated with suicide death), a goal related to the suicide risk of working aged adults was included in the Mental Health and Substance Abuse Winnable Battle work plan. This goal is to "increase the percentage of adults who report experiencing depressive symptoms from 7 percent to 8.5 percent by 2016". Because men often do not self-identify as having depression, the aim of this goal is to raise awareness and help-seeking behavior among men, resulting initially in higher self-reports of depression. The Office of Suicide Prevention is addressing the goal related to the suicide risk of working aged adults through the Man Therapy project and website, described below, and through education and outreach efforts statewide. Men account for only one in ten *diagnosed* cases of depression, yet research suggests that between 50 and 65 percent of male depression goes undiagnosed. [6] It is imperative that Colorado focus mental health education and resources towards men. The website, www.mantherapy.org, is designed to empower men to take ownership of their mental health and to provide them with the tools to address depression, anger, anxiety, substance abuse and suicidal thoughts, and to find information on resources and referrals for professional support and services online and in their community.

## Key OSP Initiatives in Fiscal Year 2013-2014

The Colorado Office of Suicide Prevention is designated by the state legislature as the entity charged with leading statewide suicide prevention and intervention efforts in Colorado. The efforts of the office to coordinate data-driven, research-based suicide prevention initiatives statewide are crucial to address the burden of suicide in Colorado. Projects and initiatives are completed in partnership with organizations throughout Colorado working to prevent suicide at the state and community level.

### Senate Bill 2014-088 – Suicide Prevention Commission

In May 2014, Governor Hickenlooper signed Senate Bill 088 into law, which added Colorado Revised Statute 25-1.5-111, the Suicide Prevention Commission. The Suicide Prevention Commission was created, among other things, for the purpose of: a) providing public and private leadership for suicide prevention and intervention in Colorado; b) setting statewide suicide prevention priorities; c) serving as an advisor to the Office of Suicide Prevention; d) providing a forum for individuals and agencies to make recommendations to the Office of Suicide Prevention, The Governor's Office, and the General Assembly; and, e) ensuring that suicide prevention remains a state priority.

The 26-member Commission, which was appointed by CDPHE Executive Director Dr. Larry Wolk on September 30, 2014, began meeting in October 2014 and will meet on a quarterly basis. In its first year, the Commission will focus on identifying statewide suicide prevention priorities, as well as building and

[6] "Ranking America's Mental Health: An Analysis of Depression Across the States". Prepared for Mental Health America by Thomson Healthcare. November 29, 2007.

expanding public/private partnerships for suicide prevention and intervention in Colorado. A public co-chair and private co-chair will be identified to lead and be the public faces of the Commission. Members include state agency representatives, business leaders, mental health professionals, representatives from law enforcement, hospitals, medical providers, and veterans and active duty military, among others. Members will serve two-year terms and represent agencies and communities from throughout Colorado. Suicide Prevention Commission recommendations will be included in the annual Office of Suicide Prevention report to the Legislature beginning in November 2015. A new Office of Suicide Prevention staff member was hired in September 2014 to coordinate Suicide Prevention Commission activities.

## Man Therapy – www.mantherapy.org

In July, 2012, the Office of Suicide Prevention, Cactus Marketing Communications and the Carson J Spencer Foundation launched www.mantherapy.org. The website is designed specifically to reach working age men, who account for the highest number of suicide deaths in Colorado annually. Men are far less likely than women to access available mental health services.[7] Traditional suicide prevention messages that encourage suicidal individuals to ask for help and talk about their problems have not been universally effective with men. The Man Therapy campaign is designed to empower men to take ownership of their mental health and overall wellness. The campaign uses humor and straightforward communication, an approach designed to resonate with men. The approach is based on data regarding the circumstances surrounding male suicides (from the Colorado Violent Death Reporting System) and on market research conducted through focus groups and in-depth interviews. The Anschutz Foundation provided a grant to fund website development and collateral marketing materials, and significant in-kind resources were provided for campaign development by Cactus. The Office of Suicide Prevention funded the development of a comprehensive project evaluation plan in 2014, with a goal of implementing components of the plan in the upcoming fiscal year. The Office of Suicide Prevention is a key partner on the project, including funding three community grantees to disseminate and implement Man Therapy materials and gatekeeper training through June 2017.

The two primary goals of www.mantherapy.org are: 1) to change the way men think and talk about suicide and mental health; and 2) to provide men (and their loved ones) with tools to empower them to take control of their overall wellness. These tools include self-help tips, or "man therapies", that are every day suggestions to improve overall wellness; "gentlemental health", which provides information about suicide and men's mental health; "tales of triumph and victory", which are stories of Colorado men who are thriving after a suicidal crisis; and, an "18-point head inspection", which is a self-assessment to anonymously measure and identify individual needs related to emotional health. Additionally, the website suggests that it is "manly" to contact professional support when necessary. The Man Therapy campaign removes traditional mental health language and uses humor to help men feel welcome and at ease while visiting the site. The website provides information on depression and suicide, substance abuse, anger, and anxiety, and includes statewide resources specific to finding support and services related to each issue.

From July 1, 2013 through June 30, 2014, there were 11,851 visits to the website from Colorado, and 139,487 total visits (throughout the U.S. and internationally). More than 16,500 visitors completed the 18-Point Head Inspection, and more than 5,000 received information about crisis services. Visitors spent an average of just under six minutes on the site, which is high for industry standards. Preliminary evaluation findings report that 79 percent of visitors are men ages 25 to 64 and 11 percent are veterans or active duty

[7] "Ranking America's Mental Health: An Analysis of Depression Across the States." Prepared for Mental Health America by Thomson Healthcare. November 29, 2007.

military. Eighty percent would recommend the website to a friend, and 50 percent agreed or strongly agreed they were more likely to seek help after visiting the site. After completing the 18-Point Head Inspection, 79 percent of respondents suggested they may or will definitely use techniques recommended by the website to improve mental wellness.

In 2014, the Man Therapy project received additional funding from the Anschutz Foundation to update campaign materials, purchase media and contribute to project evaluation. From October through December 2014, two new radio spots were created and will be rolled out in the Denver metro area, bus advertisements will be on RTD buses in metro Denver, and Altitude Sports and Entertainment will air a 30-second Man Therapy commercial during pre and post-game of Nuggets and Avalanche telecasts. There will also be a social media campaign, as well as new Man Therapy posters and other collateral which will be developed and disseminated statewide throughout the 2015 fiscal year.

## Community Grants

From July 1, 2013 through June 30, 2014, eighteen community agencies were funded one-time, $4,000 to $5,000 awards for projects designed to move suicide prevention efforts forward in their community. Funded activities included: suicide prevention and intervention training programs, agency website development and enhancement, and staff support. Funded agencies included:

- Adams State University (Alamosa County)
- Arapahoe / Douglas Mental Health Network (Arapahoe, Douglas counties)
- Aspen Hope Center (Pitkin County)
- Boulder County Public Health (Boulder County)
- Jefferson Center for Mental Health (Jefferson, Gilpin, Clear Creek counties)
- Metropolitan Denver Association (Denver County)
- Mental Health Center of Denver (Denver County)
- Midwestern Colorado Mental Health Center (Montrose, Delta, Gunnison, Ouray, Hinsdale, San Miguel counties)
- Pueblo Suicide Prevention Center (Pueblo County)
- Reaching Everyone Preventing Suicide (Routt, Moffat counties)
- Rural Solutions (Morgan, Logan, Sedgwick, Phillips, Yuma, Washington, Lincoln, Kit Carson, Cheyenne, Elbert counties)
- The Second Wind Fund (Statewide)
- Suicide Prevention Partnership Pikes Peak Region (El Paso County)
- Southern Ute Community Action Programs (La Plata County)
- Speak Up Reach Out (Eagle County)
- Western Colorado Suicide Prevention Foundation (Mesa County)
- Yellow Ribbon (Statewide)
- Youth Education and Safety in Schools, Douglas County Sheriff's Office (Douglas County)

On July 1, 2014, the Office of Suicide Prevention awarded eleven community suicide prevention grants to agencies that will focus on implementing the following four Office of Suicide Prevention priorities through June 30, 2017:

1. Evidence-based suicide prevention programs targeting high-risk populations, including older adults ages 65 and older, veterans and/or active duty military personnel, Hispanic female adolescents ages 10 to 24, or LGBTQ adolescents ages 10 to 24 in counties or regions of the state

with suicide death and/or attempt rates at or above the Colorado rate. Grantees implementing this priority include the Colorado Anti-Violence Program in Denver (working statewide), the Jefferson Center for Mental Health (Jefferson, Gilpin, Clear Creek counties), and the Carson J Spencer Foundation in Denver (grant activities will focus on El Paso and Pueblo counties).

2. Suicide prevention training for emergency department staff to assess and manage suicide risk and counsel parents and families on reducing access to lethal means in the home. Grantees implementing this priority include the Arapahoe/Douglas Mental Health Network and the Midwestern Colorado Mental Health Center (Montrose, Delta, Gunnison, Ouray, Hinsdale, San Miguel counties). Both grantees will be working with multiple hospitals in their service region during the three year funding period.

3. *Sources of Strength* youth suicide prevention program for high school aged youth. *Sources of Strength* is an evidence-based program designed to build emotional resiliency, increase school connectedness and prevent suicide. The program is based on a positive youth development model and is an approach to suicide prevention that builds protective factors among participating students in the school community. Grantees implementing this priority include Aurora Public Schools, Boulder County Public Health, and the Pinon Project Family Resource Center in Montezuma County.

4. Suicide prevention and wellness promotion among men ages 25 to 64 through the implementation of Man Therapy. Grantees will provide training to men and organizations that work with men, and will disseminate Man Therapy public information and awareness materials throughout their county / region. Grantees implementing this priority include North Range Behavioral Health in Weld County, the Pueblo Suicide Prevention Center, and the Western Colorado Suicide Prevention Foundation in Mesa County.

## House Bill 2012-1140 – Suicide Prevention and Follow-up in Colorado Hospitals

In May 2012, Governor Hickenlooper signed House Bill 1140 into law, which amended Colorado Revised Statute 25-1.5-101(1)(w)(III)(A) concerning the duties of the Colorado Department of Public Health and Environment as coordinator of suicide prevention programs throughout the state. The amendment requires the Office of Suicide Prevention to provide Colorado hospitals with information and materials about risk factors and warning signs for suicide, treatment and care after a suicide attempt, and available community resources for suicidal individuals. The information and materials are given to individuals and families who are in the emergency department or hospital for a suicide attempt or for making a suicidal gesture. A prior suicide attempt is the number one risk factor for suicide death, and appropriate after-care in the hours and days following hospital discharge is critical. These materials are designed to guide individuals and families through the after-care process.

The Office of Suicide Prevention partners with the Colorado Hospital Association, the Suicide Prevention Coalition of Colorado, and hospitals statewide to ensure that materials are delivered to the most appropriate personnel at each hospital in Colorado. In May 2014, an informational and resource packet was sent to each of Colorado's 88 short-term, critical access, licensed general, and Psychiatric hospitals. A cover letter and six sample materials / tools were included that provided information on staff training opportunities and resources that can be provided to individuals who have attempted suicide and their caretakers/family members prior to discharge by hospital staff.

During the 2012-2013 fiscal year, the Office of Suicide Prevention had a difficult time identifying appropriate points of contact at each Colorado hospital. As a result, the Office of Suicide Prevention partnered with the Suicide Prevention Coalition of Colorado in fiscal year 2013-2014 to build a more comprehensive contact database. That database was used to send the resource packet described above. The database was also used to disseminate an assessment of Colorado hospitals to determine current practices and needs for providing information and materials to individuals hospitalized for a suicide attempt. There are currently no statewide standards for what information and materials hospitals provide for a suicide attempt, and the assessment helps identify common practices and needs across the state. Findings from the assessment will help inform the implementation and priorities of HB 1140 moving forward.

Sixty-five percent of hospitals participated in the assessment including large urban and small rural hospitals from every region of the state. Seventy-seven percent of respondents reported that they were aware of their hospital receiving information and materials from the Office of Suicide Prevention (compared to 55 percent last year). Unfortunately, only 51 percent of respondents reported that their hospital is currently utilizing the materials. Reasons for not using the materials included being unable to access the materials (instructions were provided in the cover letter), not being aware of the materials, already providing suicide prevention information, lack of designated staff, and lack of knowledge and skills about how to present the information. Regarding training needs, 70 percent of respondents reported a desire for training on treatment compliance, 40 percent would like training on safety planning and screening, and 34 percent would like training on counseling on lethal means. Respondents reported that in-person, on-site training and online, self-administered training as the preferred training modalities. A comprehensive report of the year two HB 1140 assessment is provided in **Appendix A**.

## Training Emergency Department Staff in Counseling on Access to Lethal Means

The Office of Suicide Prevention partnered with the CDPHE Injury Prevention Program, Children's Hospital, the Colorado School of Public Health, and the Harvard Injury Control Research Center to develop and pilot a means restriction education training program at Children's Hospital in Denver. The training program is an emergency department adaptation of the Counseling on Access to Lethal Means Training, developed by the Harvard Injury Control Research Center. Means restriction efforts focus on the removal and/or safe storage of firearms and lethal medications in the home. The training is online and is completed by hospital staff in approximately one hour. The pilot began in January 2014 and all Children's Hospital emergency department social workers and mental health service providers completed the training, which teaches providers how to educate parents of suicidal youth about the techniques and importance of restricting access to lethal means in the home. Those who have attempted suicide are at an increased risk in the hours and days after discharge, and means restriction education is an evidence-based approach to reducing the risk of suicide death.

The evaluation of the pilot, led by the Colorado School of Public Health, assessed the Children's Hospital staff response to the training as well as to the delivery of the intervention, and examined parent recall and response to the delivery of the means restriction counseling / intervention. All social workers and mental health staff in the Children's Hospital Psychiatric Emergency Department reported the training to be useful and staff appreciated having a script and protocol to talk with parents. Staff also reported that the training and protocol were an improvement over prior practice. Telephone interviews were conducted with 122 parents/guardians who received the means restriction counseling. Interviews were conducted approximately two weeks after the hospital visit. Almost all recalled receiving an informational brochure and the counseling about safely storing medication and firearms. More than 90 percent reported the

counseling was respectful and clear, and that there was enough time to ask questions. While very few families reported unlocked firearms in the home, respondents showed improvement in locking medications after receiving the counseling from Children's Hospital staff.

Although a small sample size, the pilot results are promising. Results will be fully analyzed and submitted for publication in scientific journals during the 2015 fiscal year. Children's Hospital has adopted the Counseling on Access to Lethal Means training and will continue to implement the intervention with all families in the emergency department because of a suicide attempt. The Office of Suicide Prevention and the project team are exploring funding opportunities to conduct a larger scale implementation and evaluation of this intervention. The Office of Suicide Prevention will develop a strategy to make the training and program available to other Colorado hospitals during the 2015 fiscal year.

## Suicide Prevention in Colorado Schools

In September 2013, the Violence and Suicide Prevention Section Manager was elected Secretary of the Advisory Board of the Colorado School Safety Resource Center at the Colorado Department of Public Safety. The School Safety Resource Center works with schools and communities to create safe and positive school environments for Colorado students. Suicide prevention is a critical component of school safety, and the resource center has made it a priority in its work statewide.

The Office of Suicide Prevention partners with the Colorado School Safety Resource Center and the Colorado Department of Education to plan and host an annual symposium on suicide prevention, intervention and postvention in schools. More than 625 school personnel (counselors, school psychologists, safety teams and administrators) from across the state have attended symposia held in Lakewood, Highlands Ranch, Montrose, and Aurora. Seventy-five school personnel attended the October 22, 2013 symposium in Grand Junction and participant feedback was excellent. Those in attendance heard topics and panel presentations on suicide risk and data, risk assessment tools for schools, suicide prevention programs, and postvention guidelines for schools and communities. Attendees also received a packet of tools to help develop stronger school-wide suicide prevention protocols. On October 22 and 23, 2014, the Office of Suicide Prevention and several other suicide prevention partners will present at the School Safety Resource Center Safe Schools Summit in Loveland.

## Public Awareness and the Suicide Prevention Lifeline (1.800.273.TALK)

The *2012 National Strategy for Suicide Prevention* recommends research-informed communication efforts designed to change knowledge, attitudes, and behaviors while increasing awareness of warning signs for suicide, and connecting individuals in crisis with help.[8] The Office of Suicide Prevention dedicates funding to implementing this recommendation. The stigma of mental illness and substance abuse can prevent people from seeking assistance. The office's public awareness efforts focus on informing the public that suicide is preventable and on reducing the stigma of seeking help for mental or emotional distress. Educational materials were distributed to people and organizations in every region of the state in fiscal year 2013-2014. Man Therapy and House Bill 2012-1140 were emphasized, but the Office of Suicide Prevention continued to disseminate bookmarks, Start the Conversation youth posters

[8] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.* Washington, DC: HHS, September 2012.

and brochures, older adult brochures, fact sheets, and resource flyers via mail and at community events, conferences, and public presentations.

The Violence and Suicide Prevention Section Manager provided more than 30 suicide prevention and intervention presentations to community groups throughout Colorado and nationally in fiscal year 2013-2014. The office also responded to numerous media requests, appearing on television and radio broadcasts, as well as in newspapers and electronic media.

Educational resources disseminated by the Office of Suicide Prevention include information about the 24-hours a day, seven days a week, 1.800.273.TALK Lifeline number. There is evidence the office has had an impact on raising awareness about suicide prevention, while decreasing stigma for those seeking help by promoting the Lifeline on educational and promotional material disseminated throughout Colorado. Since the Office of Suicide Prevention opened its doors and began leading statewide suicide prevention efforts in 2000, calls to 1.800.273.TALK, which is operated by the Pueblo Suicide Prevention Center and Metro Crisis Services have increased every year (see table below), suggesting that awareness of this life-saving resource notably increased. In 2013, calls were made to the Lifeline from 63of the 64 counties in Colorado.

| Year | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| # Calls | 318 | 1,516 | 2,018 | 3,287 | 3,232 | 3,641 | 4,667 |

| Year | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|
| # Calls | 6,089 | 7,457 | 9,683 | 11,010 | 13,262 | 14,261 | 16,161 |

In 2014, Colorado began implementing the statewide behavioral health crisis response system. The system includes a statewide 24/7 hotline and warm line for those experiencing a behavioral health crisis, including suicidal crisis (844.493.8255). Because the new system is statewide, and because the organization answering the calls is a certified Lifeline call center, the Office of Suicide Prevention selected to not fund Lifeline call centers in Colorado beginning July 1, 2014. The Office of Behavioral Health and the Colorado Department of Human Services are funding and overseeing the crisis response system, which lead the Office of Suicide Prevention to shift funding in fiscal year 2015.

## Bridging the Divide: Suicide Awareness and Prevention Summit

The seventh annual Bridging the Divide: Suicide Awareness and Prevention Summit was held at Regis University in Denver on May 7, 2014. The Office of Suicide Prevention participated on the planning and was a co-host sponsor of this year's summit attended by 130 suicide prevention stakeholders from throughout Colorado. Keynote speakers at the event included Dr. Frank Campbell, suicide postvention specialist, Dr. David Covington, healthcare and suicide prevention specialist, Dr. Laura Porter, co-founder of ACE Interface, and, James Wright, Public Health Advisor with the Substance Abuse and Mental Health Services Administration. Senator Linda Newell won the Suicide Prevention Coalition of Colorado conference advocacy award for her leadership in sponsoring and helping pass Senate Bill 2014-088.

## The Suicide Prevention Coalition of Colorado

In fiscal year 2013-2014, the Suicide Prevention Coalition of Colorado, a multidisciplinary group of suicide prevention advocates and professionals from throughout Colorado, served as a key statewide partner. Major accomplishments included the development of a hospitals contact database in support of

the implementation of House Bill 2012-1140, community advocacy for suicide prevention, leadership and support for the development and passing of Senate Bill 2014-088, and leadership in planning and hosting the successful May 7, 2014 Bridging the Divide Summit.

The Suicide Prevention Coalition of Colorado enhances the Office of Suicide Prevention's capacity for statewide coordination and programming by leading advocacy efforts, assisting with engaging statewide partners, supporting individuals and families who have lost someone to suicide, and participating on the Suicide Prevention Commission and its related priority subgroups.

### Colorado Chapter of the American Foundation for Suicide Prevention

In June 2012, the Colorado Chapter of the American Foundation for Suicide Prevention signed its charter to promote and support suicide prevention, intervention and postvention efforts statewide. The chapter collaborates with the Office of Suicide Prevention and the Suicide Prevention Coalition of Colorado to raise awareness, promote community programs, and support survivors of suicide loss statewide. The Colorado Chapter organizes and hosts the annual Colorado Out of the Darkness Walk and disseminates American Foundation for Suicide Prevention-supported programs and educational materials statewide. More than 1,200 people attended the September 2014 Out of the Darkness Walk in Highlands Ranch, where the Office of Suicide Prevention hosted a resource table.

## Prioritizing Suicide Prevention in Colorado – Next Steps

Colorado has experienced increased suicide death rates and numbers since 2009, and unfortunately that trend continued in 2013 (1,004 deaths; rate of 18.5/100,000). The burden of suicide in Colorado is disproportionate to the available resources. While the Office of Suicide Prevention works diligently to maximize current resources and leverage strong partnerships and additional funding, more resources are needed to move statewide suicide prevention efforts forward.

Colorado needs more financial, human and political capitol dedicated to suicide prevention and intervention efforts. Prevention initiatives must focus on those Coloradans at highest risk for suicide, and on the parts of the state with the highest suicide rates. Data-driven and evidence based strategies must be utilized, and comprehensive evaluation of all initiatives must be conducted. This is why initiatives like Man Therapy, means restriction education, House Bill 2012-1140, and Senate Bill 2014-088 are priorities of the Office of Suicide Prevention. These initiatives are innovative and experiencing success, but more must be done.

Moving forward, the Office of Suicide Prevention will prioritize the following to address suicide in Colorado:

- successful convening and year one implementation of the Suicide Prevention Commission, including identifying statewide priorities and expanding public and private suicide prevention partnerships;
- continued implementation and evaluation of www.mantherapy.org in Colorado;
- implementation and evaluation of the Office of Suicide Prevention community grant program;
- implementation and evaluation of House Bill 2012-1140, directed at providing every hospital in Colorado with resources to give individuals and families at time of hospital discharge following admission for a suicide attempt;
- expanded implementation and evaluation of means restriction education at Colorado hospitals;

- partnership with the Colorado School Safety Resource Center and the Colorado Department of Education to host annual school symposium on suicide prevention;
- partnership with the Suicide Prevention Coalition of Colorado to plan and host the annual Bridging the Divide: Suicide Awareness and Prevention Summit;
- partnership with the Colorado Violent Death Reporting System staff to collect and analyze suicide death data;
- integration of suicide prevention with other public health programs to address the risks shared across health issues.

With additional resources, the Office of Suicide Prevention would prioritize the following to address suicide in Colorado:

- implement priorities to be identified by the Suicide Prevention Commission;
- expand the implementation and evaluation of www.mantherapy.org through increased marketing and a more comprehensive evaluation;
- expand the Office of Suicide Prevention statewide community grant program to more counties and at higher funding levels;
- expand the implementation and evaluation of means restriction education training to hospitals statewide;
- increase the impact of HB 1140 by providing hospitals with training for staff that work with suicidal patients and families;
- statewide implementation and evaluation of school-based suicide prevention programs that promote resilience and positive youth development as protective factors from suicide; and,
- increase and provide more coordinated training for gatekeepers on recognizing and responding to suicide risk among older adults, active duty military personnel and veterans, working age men, LGBTQ youth, Hispanic/Latina youth, and other high risk populations.

The Office of Suicide Prevention is poised to continue leading statewide suicide prevention efforts in Colorado, and is committed to expanding partnerships, implementing innovative and data-driven initiatives, and decreasing the burden of suicide. The burden of suicide in Colorado demands statewide leadership for prevention and intervention efforts, and the Office of Suicide Prevention is committed to providing that leadership through innovative prevention programs, strategic statewide partnerships, and advancement of prevention science.

COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

**Appendix A**

# House Bill 2012-1140 Assessment Results and Recommendations July 1, 2013 – June 30, 2014 – Year Two Report

Jarrod Hindman, MS
Office of Suicide Prevention, Colorado Department of Public Health and Environment

and

Aimée Trudeau, MPH, CHES
CDC Public Health Prevention Service Fellow

Correspondence concerning this report should be addressed to:
Jarrod Hindman, M.S.
Violence and Suicide Prevention Section Manager
Violence and Injury Prevention-Mental Health Promotion Branch
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530
303-692-2539
Jarrod.hindman@state.co,us

## INTRODUCTION

In 2013, 1,004 Coloradans died by suicide and 2,532 were hospitalized for a suicide attempt. In 2012, the most recent year of national data available, Colorado had the fifth highest suicide rate in the United States. Research shows that a previous suicide attempt is one of the most powerful predictors of subsequent fatal suicidal behavior, particularly in the first six months to a year after the attempt.[1] To address Colorado's high suicide rate, and to provide more comprehensive suicide prevention and intervention information and resources after a suicide attempt, the Colorado General Assembly passed House Bill 2012-1140. House Bill 2012-1140 amended Colorado Revised Statute 25-1.5-101, to include collaboration between the Colorado Department of Public Health and Environment (CDPHE) and licensed or certified hospitals for the provision of suicide prevention services. Those services may include providing educational materials to a suicidal person or to the parents or guardian of a suicidal minor prior to his/her release from the hospital following a suicide attempt or gesture (such as cutting oneself). The amendment also stipulates that CDPHE may work with hospitals to determine whether and where gaps exist in suicide prevention programs and services. Finally, beginning in November 2013 and each year thereafter, CDPHE will include findings from this gaps assessment, as well as recommendations to improve suicide prevention services through hospitals in Colorado, as part of the Office of Suicide Prevention's annual report to the Legislature.

In December 2013, the Office of Suicide Prevention at CDPHE partnered with the Colorado Hospital Association and the Suicide Prevention Coalition of Colorado to craft a strategy for the year two implementation of House Bill 2012-1140. Additional partners from Mental Health America of Colorado, Metro Crisis Services (now Rocky Mountain Crisis Partners), the Pueblo Suicide Prevention Center, and a mental health crisis response coordinator from a non-metro hospital contributed to the development of the year two plan. Two strategic planning meetings were held, and the team determined that the second year of House Bill 2012-1140 implementation would focus on three primary components:

1) Build a comprehensive contact database for the 88 short-term, critical access, licensed general, and Psychiatric hospitals with the department, title and contact information of the individual responsible for overseeing suicide risk assessment and/or psychiatric emergency services in each facility.

[1] DeLeo D, Bertolote J., Lester, D. Self-directed violence. Chapter 7. In: Krug EG., Dahlberg LL., Merchy JA., Zwi A., Lozano R., eds. World report on violence and health. Geneva: World Health Organization; 2002.

a. To build the database, a telephone survey was conducted yielding contact information for 80 of the 88 hospitals. While this is not comprehensive, the database improved processes in year two and will provide a solid starting place for year three.

2) Provide every short-term, critical access, licensed general, and Psychiatric hospital[2] in Colorado with sample resource materials developed by the U.S. Department of Health and Human Services designed to provide individuals and families with critical information about suicide risk factors, warning signs and community resources to prevent future suicide attempts. Materials include information designed for individuals who have attempted suicide, family members or caretakers, and the hospital staff treating them.
   a. Because year one assessment results indicated that 45 percent of hospitals were not aware of receiving materials, and 47 percent reported not using them, a sample packet of materials was included instead of a box of bulk materials. The packet included a letter (attachment 2) with instructions for ordering materials based on hospital need. The packet also included a new resource from the Suicide Prevention Resource Center entitled "Continuity of Care for Suicide Prevention: The Role of Emergency Departments", and a brochure from eMed Colorado, Inc. detailing the "Emergency Medical Evaluation of Dangerousness" tool.
3) Conduct an assessment of every short-term, critical access, and licensed general hospital in Colorado to determine current practices and to identify any needs or gaps related to: 1) resources available to those who make a suicide attempt or gesture; 2) the process for referring those who make a suicide attempt or gesture to services, programs, and providers for follow-up care; and, 3) training needs among hospital and emergency department staff.
   a. The year one assessment was revised and vetted through several hospital and evaluation partners to expand and gain more detailed feedback in year two.

The following details the year two implementation and assessment of House Bill 2012-1140, and outlines recommendations and next steps to successfully moving the project forward.

[2] The project team selected to include Psychiatric hospitals in year two, but again to not include long-term and rehabilitative hospitals because most suicide attempters are not initially sent to these facilities, and to make the project more manageable.

## PROVISION OF EDUCATIONAL MATERIALS

The sample materials detailed in the letter found in Attachment 2 were mailed to 80 of Colorado's 88 short-term, critical access, licensed general, and Psychiatric hospitals in June 2014. Packets were mailed to the individuals identified in the hospital database described above. Letter recipients were asked to share the sample materials with their teams and to order the desired numbers of materials for their hospitals. Recipients were also notified that they would receive a follow-up email to confirm receipt of the materials and to encourage participation in the assessment (described on page 3 of this report).

## ASSESSMENT

The goals of the year two House Bill 2012-1140 assessment were to:

1) identify the staff position responsible for conducting suicide risk assessments and providing prevention and follow-up information to individuals and families,
2) gain a better understanding of hospital protocol and procedures at discharge for individuals hospitalized for a suicide attempt or gesture,
3) identify hospitals that partner with community mental health centers to conduct suicide risk assessments, and identify the responsible mental health center staff position,
3) identify barriers encountered by hospitals in providing suicidal individuals or their caregivers with information about after care and suicide prevention resources prior to release from the hospital following a suicide attempt or gesture,
4) learn more about suicide prevention training needs for hospital staff,
5) learn whether or not hospitals provide information related to means restriction and/or the safe storage of suicidal means, and
6) evaluate the use of materials recommended by the Office of Suicide Prevention.

The Office of Suicide Prevention worked with the project planning team to revise and update the electronic survey developed in year one. An electronic survey was again selected for ease and expense of distribution and analysis. This year, an evaluator from the Colorado School of Public Health and the Harvard Injury Control Research Center provided valuable feedback and input to the survey design. The survey was emailed to a total of 87 hospital representatives in July 2014. All of the hospitals are licensed or certified by CDPHE and most are members of the Colorado Hospital Association. The Office of Suicide Prevention and the Colorado Hospital

Association sent follow-up reminders and encouraged hospital contacts to complete the survey. The 21-question survey was estimated to take 10 to 15 minutes to complete, and the survey remained open until August 1, 2014. Respondents from 57 hospitals[3] completed the survey, yielding a 65 percent response rate. Although the response rate was acceptable, it did not meet the year two goal of 75 percent, and did not exceed the year one response rate (also 65 percent). Respondents included emergency department managers/directors, nursing managers, managers of assessment and referral teams, directors of behavioral health services or Psychiatric services, and managers of social work. A primary focus of the 2015 fiscal year implementation will be to identify cost effective ways to update and complete the contact database and increase the survey response rate to 75 percent or higher.

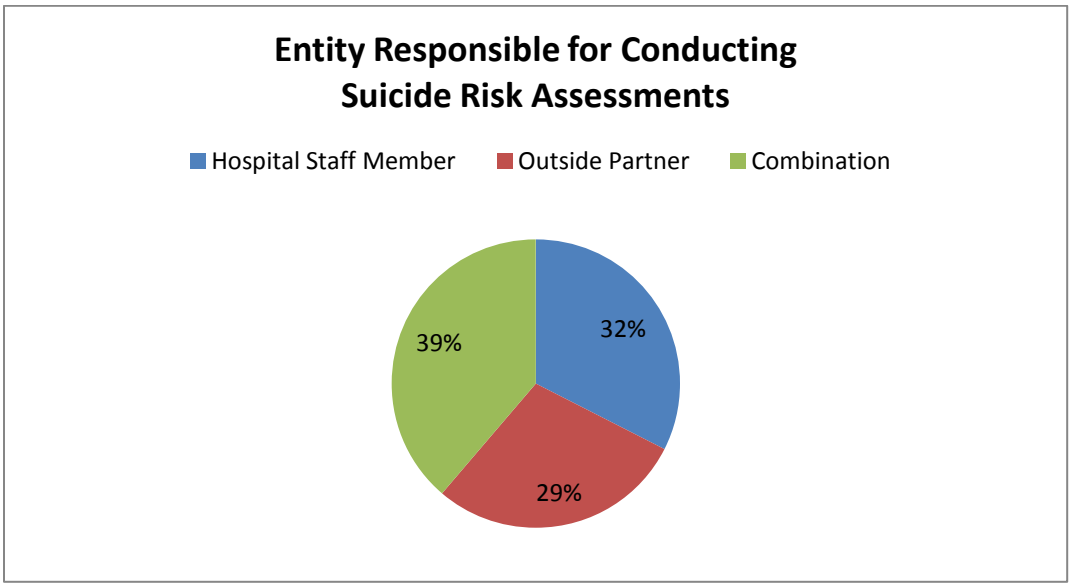
### *Assessment Results*

Procedures for Conducting a Suicide Risk Assessment

The majority of respondents (89 percent) reported that their hospital always assesses current level of risk when a patient presents with a suicide attempt. Eight percent reported usually assessing current level of risk, and three percent reported sometimes or rarely assessing current level of risk. As noted in Table 1, 29 percent of respondents reported that an outside partner agency is responsible for conducting suicide risk assessments, and 32 percent reported that hospital staff conducts suicide risk assessments. Thirty-nine percent reported that a combination of hospital staff and outside partner agencies are responsible for suicide risk assessments. Due to these findings, the Office of Suicide Prevention will identify those hospitals partnering with outside agencies to conduct suicide risk assessments, and add these partner agencies to the contact database so that they receive project materials too.

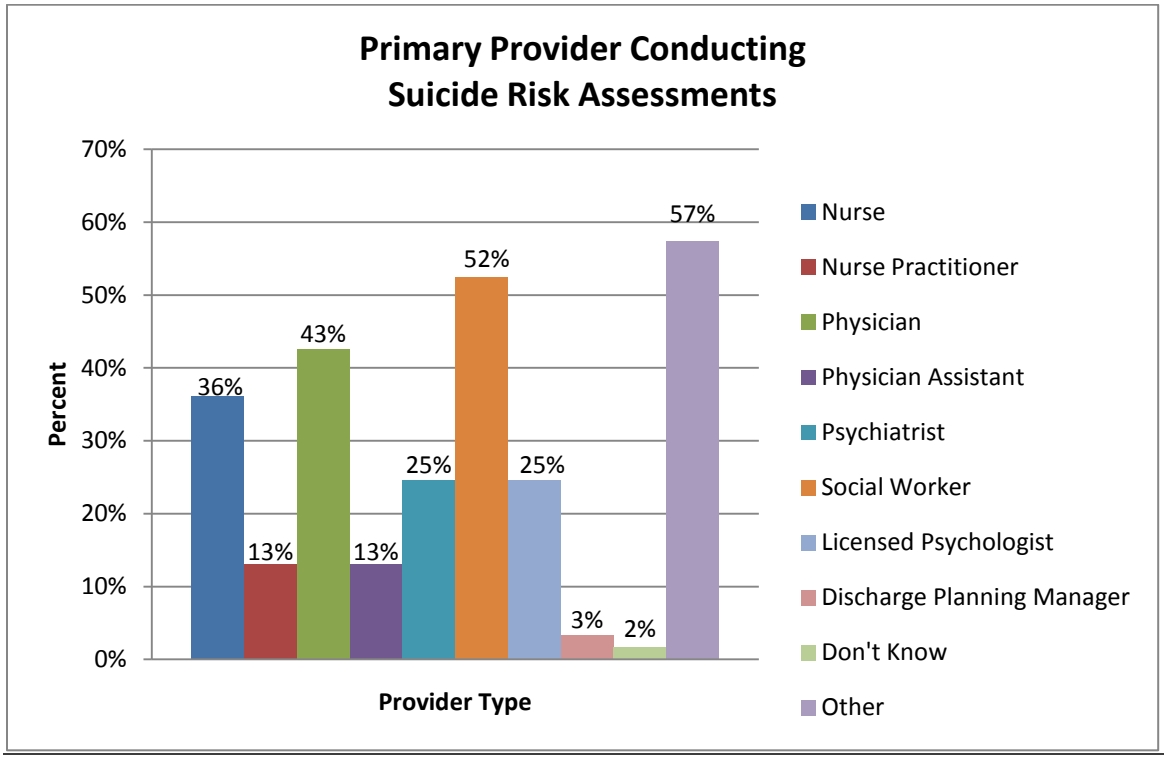
[3] Aspen Valley, Boulder Community, Avista Adventist, Littleton Adventist, Penrose, Porter Adventist, St. Francis, St. Mary Corwin, St. Thomas More, Children's Colorado, Colorado Plains Medical Center, Conejos County, Delta County Memorial, Denver Health, East Morgan County, Estes Park Medical Center, Good Samaritan, Lutheran, Saint Joseph, Family Health West, Grand River, Gunnison Valley, Heart of the Rockies, Keefe, Kit Carson, Lincoln Community, Longmont United, Mckee Medical Center, Medical Center of Aurora, Medical Center of the Rockies, Melissa Memorial, Memorial Health System, Mercy Regional Medical Center, Montrose Memorial, Mt. San Rafael, National Jewish, North Colorado Medical Center, North Suburban Medical Center, Ortho Colorado Springs, Parker Adventist, Parkview, Pikes Peak Regional, Pioneers Medical Center, Platte Valley, Poudre Valley, Presbyterian/St. Luke's, Prowers Medical Center, Rose, Sky Ridge, Southeast Colorado, Southwest Memorial , St. Anthony Summit, St. Mary's Regional Medical Center, Sterling Regional Medical Center, Swedish Medical Center, University of Colorado Hospital, Valley View, Weisbrod Memorial

**Table 1**




As indicated in Table 2, the primary staff member assigned to conduct suicide risk assessments varied considerably across facilities, with the largest response (57 percent) indicating 'other' (mostly trained mental health providers like licensed professional counselor, licensed clinical social worker, etc.). These data suggest that any training recommendations need to be delivered to multiple staff, but particularly to mental health provider staff.

**Table 2** (respondents could select more than one item, so total exceeds 100%)



Protocol and Procedures at Discharge from Inpatient Facilities or Emergency Departments

Questions designed to assess hospital protocol and procedures at discharge for individuals who made a suicide attempt or gesture were separated by 'adult' and 'minor' to measure differences in information and/or care based on the age of the patient. Table 3 illustrates protocols and procedures as they related to adults. All or most respondents indicated that adult patients are provided with information about safety planning, warning signs and risk factors, means restriction (reducing access to firearms and lethal medications in the home), and available suicide prevention resources. However, 21 percent of respondents reported that their hospital never provides information about resources, and 17 percent do not provide information about risk factors or reducing access to lethal means. Eighty-one percent of respondents indicated that all or most suicidal adults are provided assistance in scheduling a follow-up appointment with a mental health provider or primary care physician. Data are not available that indicate how many individuals attend follow-up appointments, which is a gap in the current available data.

**Table 3** (respondents could select more than one item, so total exceeds 100%)

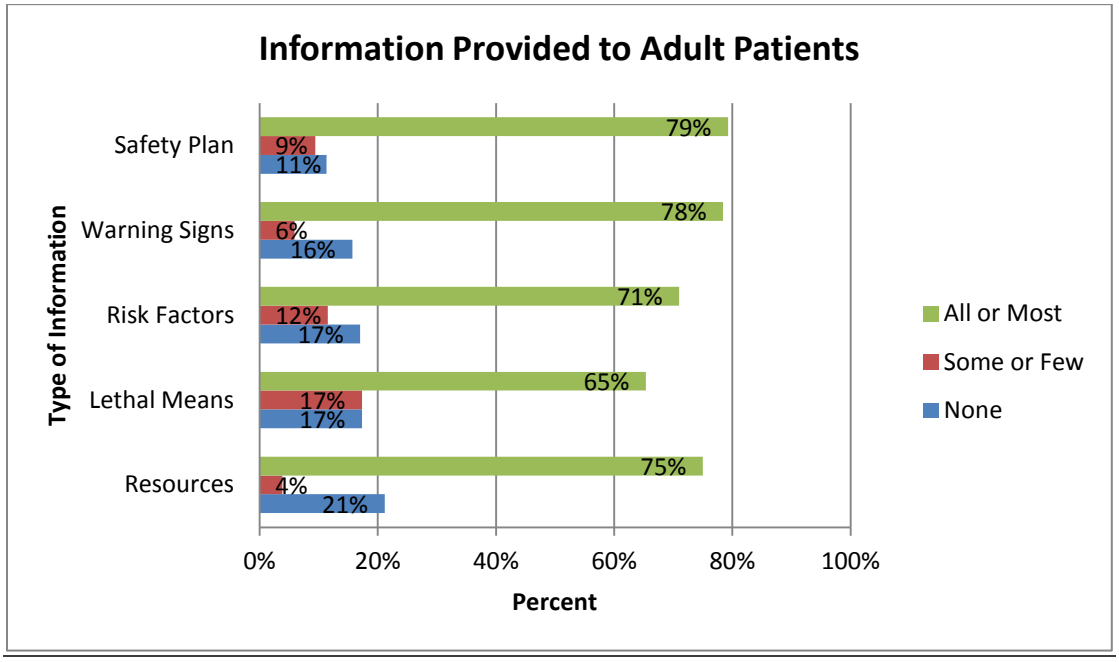
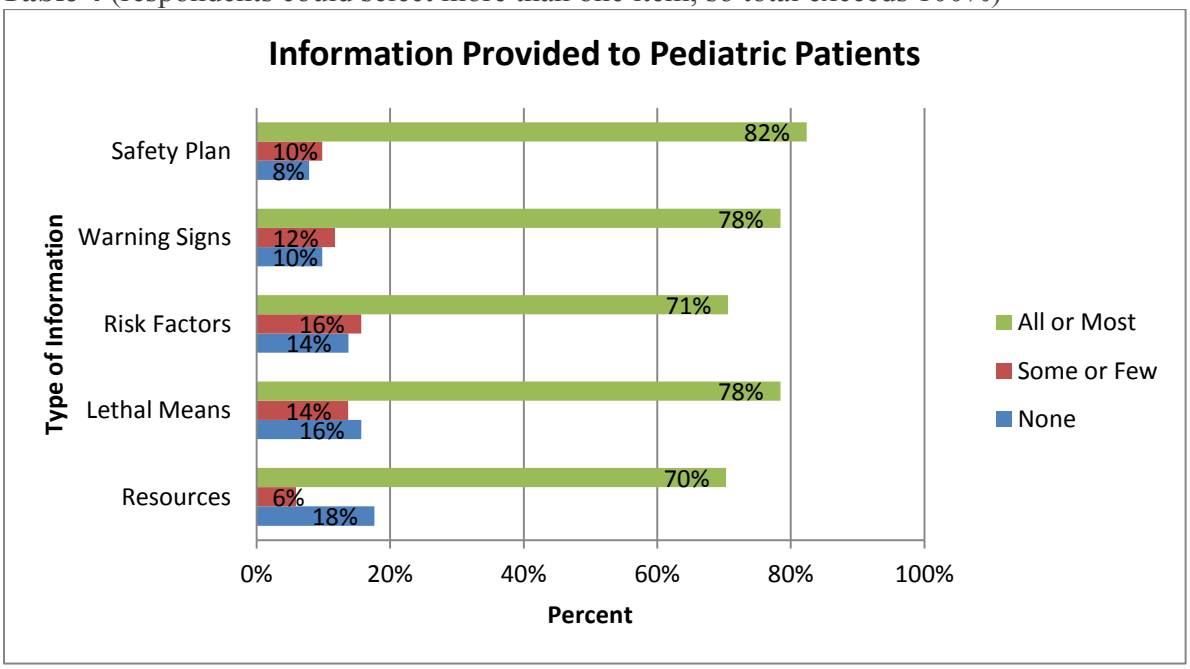



Table 4 depicts the information provided to the parents or caregivers of a minor patient who made a suicide attempt or gesture. Similar to adult patients, all or most parents or caregivers are provided with information about safety planning, warning signs and risk factors, means restriction, and available suicide prevention resources. Eighteen percent of respondents reported

that their hospital provides no information about resources, and 16 percent do not provide information about reducing access to lethal means. Eighty-four percent of respondents indicated that all or most parents or caregivers are provided assistance in scheduling a follow-up appointment with a community mental health provider or primary care physician. As stated above, data are not available that indicate how many individuals attend follow-up appointments, which is a gap in the available data that must be addressed.

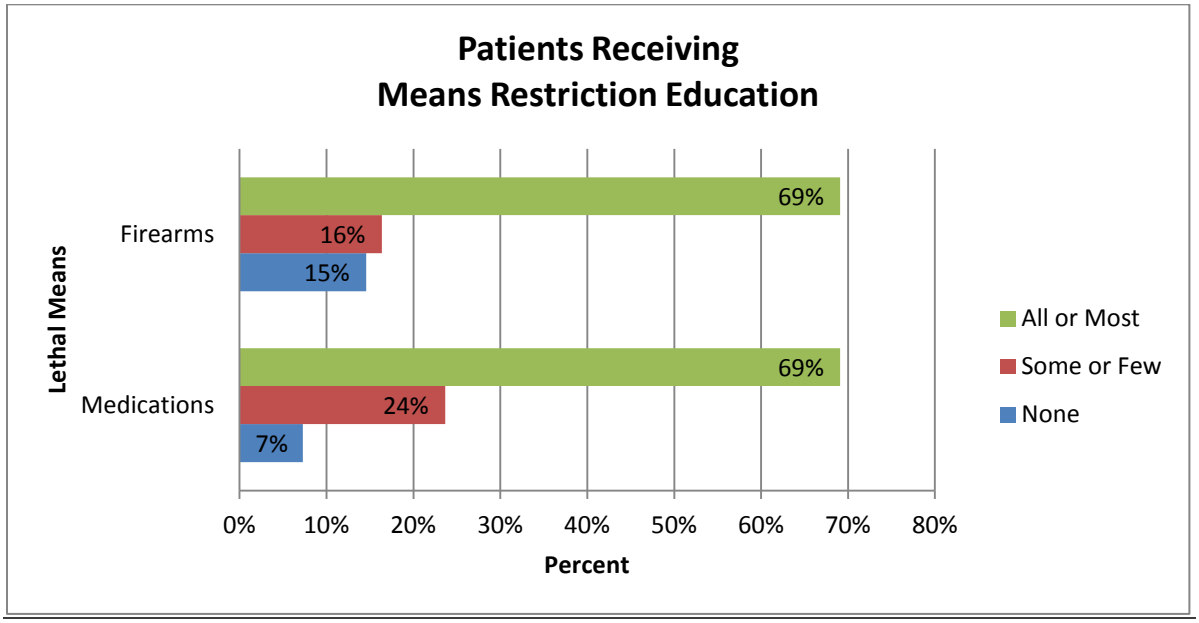
**Table 4** (respondents could select more than one item, so total exceeds 100%)




Means Restriction Education

A recent report by CDPHE shows that 76 percent of all firearm deaths in Colorado between 2005 and 2012 were suicides (49 percent of total suicide deaths involve a firearm). As a result, survey respondents were asked questions related to means restriction education and the safe storage of firearms and lethal medications. Table 5 illustrates that 31 percent of respondents reported that 'some', 'few' or 'none' of the suicidal patients received information about means restriction, suggesting inconsistency in providing this information to suicidal individuals and their caregivers across Colorado hospitals.

**Table 5**

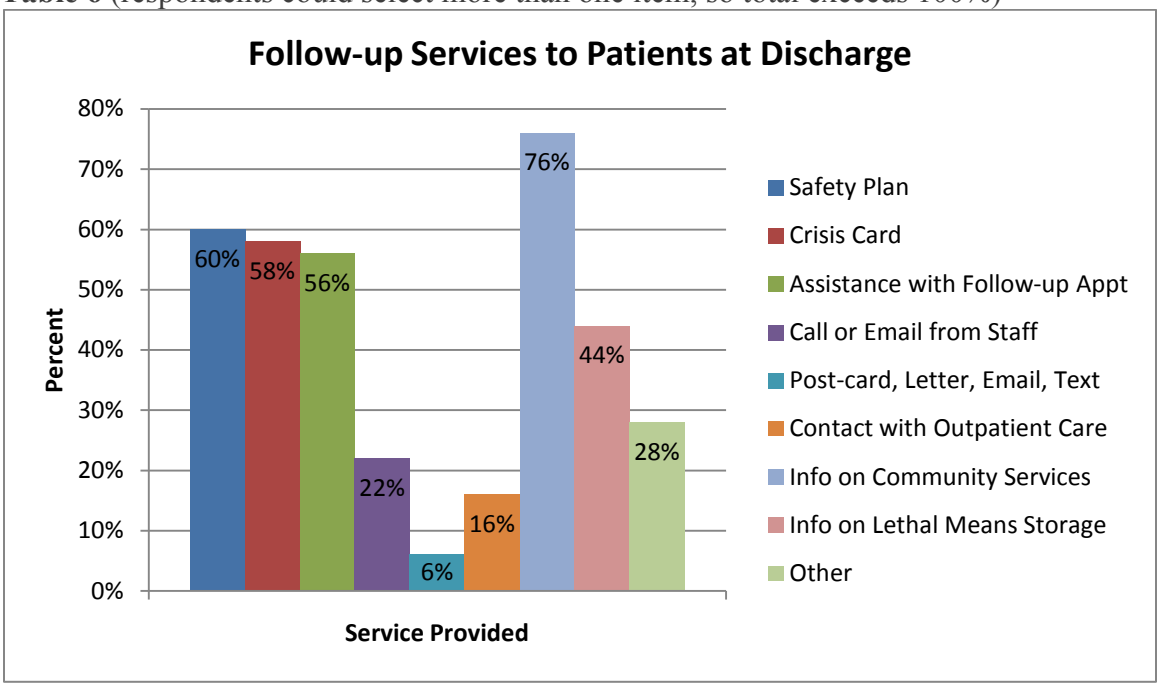



Assessment and Follow-Up

Sixty-six percent of survey respondents reported that their hospital does not have a protocol for following-up with suicidal patients after they are discharged from the hospital (8 percent responded 'do not know'), suggesting that most hospitals do not engage with suicidal patients after they have been discharged. Because most hospitals do not follow-up with suicidal patients once they are discharged, state and community suicide prevention partners may want to explore opportunities to enhance and/or provide follow-up services.

Regarding follow-up information and resources provided to suicidal patients and families at discharge, Table 6 illustrates the type of services that respondents indicated their hospital provides. While 76 percent of respondents indicated providing information on community services, only 60 percent reported providing a safety plan and 22 percent call or email patients after discharge to follow-up.

**Table 6** (respondents could select more than one item, so total exceeds 100%)



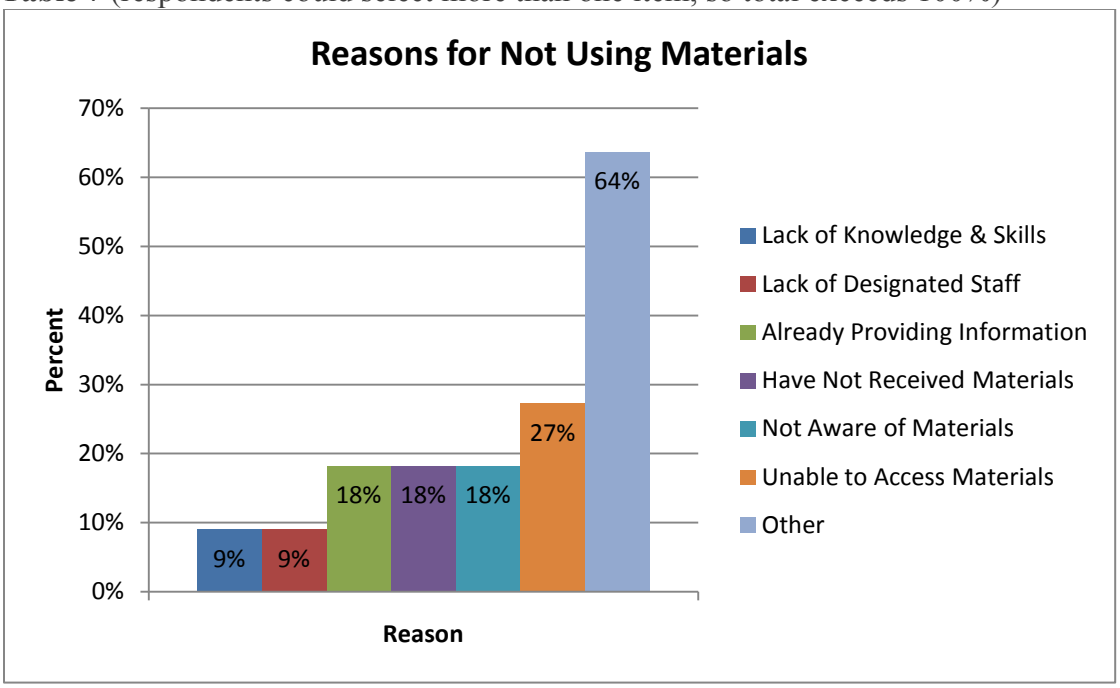

Utilization of Suicide Prevention Materials Provided by the Office of Suicide Prevention

The majority of respondents (77 percent) reported that they were aware of their hospital receiving the sample packet of informational resources and tools from the Office of Suicide Prevention in June 2014, which is a significant increase from the 55 percent who were aware of receiving materials in year one. Unfortunately, only 51 percent of respondents reported currently using the materials, which is not an increase over the year one response. Twenty-eight percent of respondents were not sure if their hospital is using the materials, suggesting that more work needs to be done to ensure that the most highly informed staff at each hospital receive materials and complete the survey.

When asked why they were not using the materials provided by the Office of Suicide Prevention (see Table 7), 27 percent reported being unable to access the materials, 18 percent reported already providing other information and materials, and nine percent identified the lack of a designated staff member whose responsibility it is to provide the information. Sixty-four percent indicated 'other' reasons for not using the materials, which included not having enough materials, running out of materials, currently reviewing materials, and in the process of ordering additional materials. These results suggest that the Office of Suicide Prevention must develop

new and more effective strategies for ensuring that hospitals and key staff have access to all pertinent project information and materials.

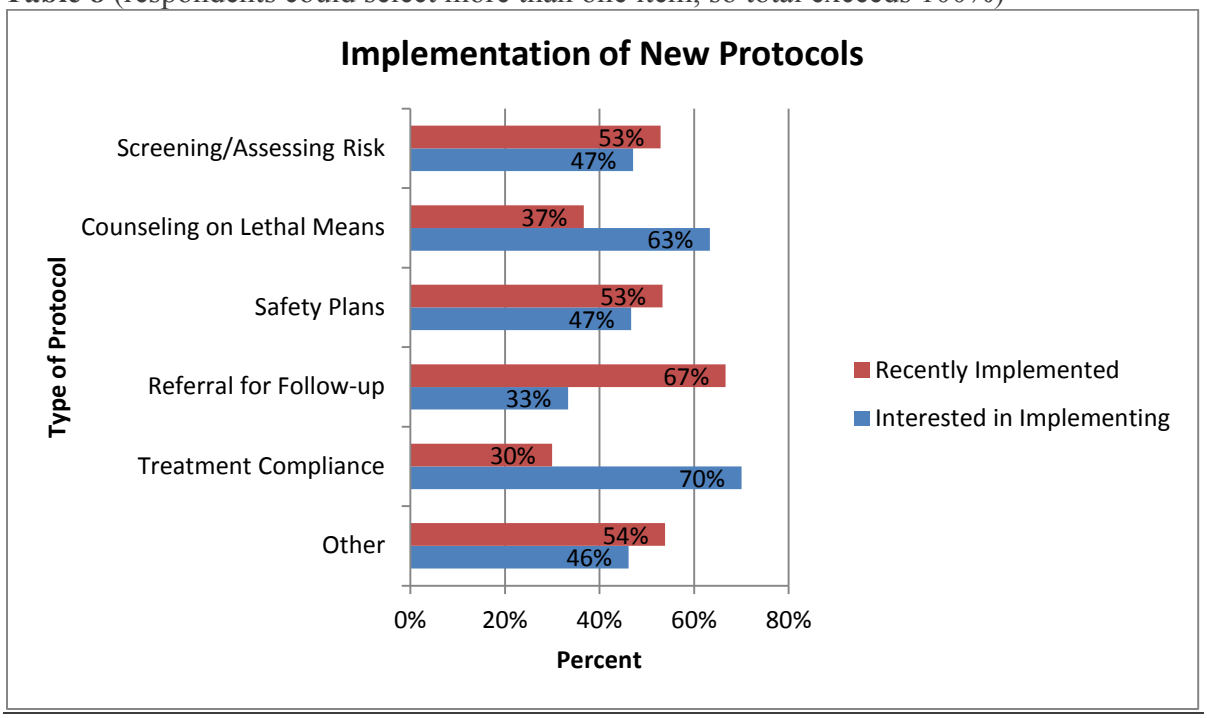
**Table 7** (respondents could select more than one item, so total exceeds 100%)




New Protocols Hospitals Have Implemented or Would Like to Implement

Respondents were asked to indicate which areas of their hospital a) implemented new protocols in the past three years or, b) is interested in implementing new protocols. As indicated in Table 8, 67 percent of respondents indicated their hospital recently implemented referral to follow-up protocol, and 53 percent implemented safety plans and screening or risk assessments. Only 37 percent reported implementing lethal means counseling protocol. Seventy percent of respondents are interested in implementing protocol related to treatment compliance, and 63 percent are interested in protocol related to lethal means counseling.

**Table 8** (respondents could select more than one item, so total exceeds 100%)

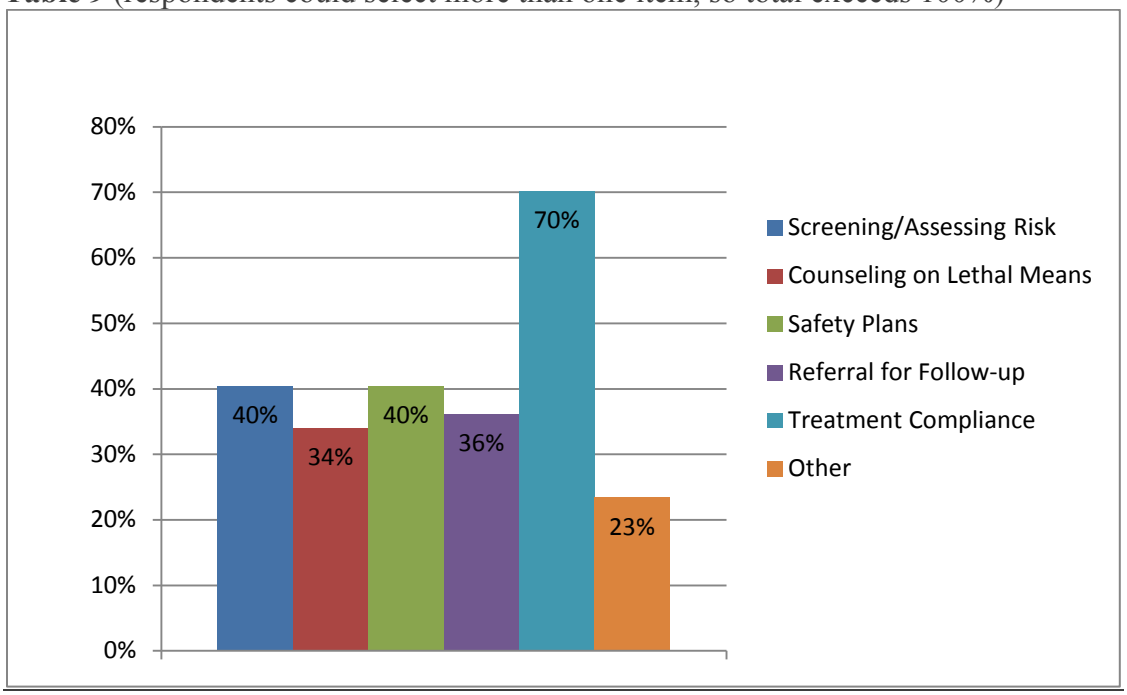



Suicide Prevention Training Needs

The final two questions of the survey assessed current training needs. As highlighted in Table 9, 70 percent of respondents indicated a desire for additional training specific to ensuring patient compliance with treatment recommendations, protocol and follow-up. Forty percent indicated a desire for additional training related to safety planning, 40 percent would like more training related to screening and conducting suicide risk assessments, and 36 percent would like training about counseling on lethal means. 'Other' trainings needs identified included training regarding the DSM-5 and training about screening for and measuring suicidal lethality.

When asked to identify the most useful training modality, 66 percent of respondents identified self administered on-line training, and 60 percent identified on-site in-person training, suggesting that both modalities are useful. Forty-seven percent of respondents reported online webinar training as useful, while only 19 percent reported off-site in-person training as useful.

**Table 9** (respondents could select more than one item, so total exceeds 100%)




## LIMITATIONS TO IMPLEMENTATION

When House Bill 2012-1140 was drafted, hospitals were not required to utilize information and materials provided by the Office of Suicide Prevention, and there was no fiscal note attached to the bill. As a result, the Office of Suicide Prevention was charged with implementing and assessing House Bill 2012-1140 using limited existing resources. The Suicide Prevention Coalition of Colorado partnered with the Office of Suicide Prevention this year to provide temporary staff support to develop and help build a hospital contact database, but ongoing support and follow-up was not possible given the limited resources.

Because 60 percent of year one respondents reported not receiving the bulk materials sent by the Office of Suicide Prevention, the project team this year selected to send sample materials rather than bulk materials, with instructions for ordering larger quantities of desired items. Given that only 51 percent of respondents this year reported current use of the materials, the project team again is challenged to identify a more effective process for providing project materials to hospitals and better encouraging hospitals to use the materials.

## RECOMMENDATIONS

While this year's 65 percent response rate did not meet the original project goal of 75 percent, responses are again strong enough to provide insight into the needs of hospitals in Colorado and next steps for the project. Moving forward, the Office of Suicide prevention will reconvene the implementation planning team and expand the project partners to develop strategies for implementing the following recommendations:

1. Expand the hospital contact database to include updating all existing contacts, completing missing contact information, ensuring the database has a primary contact for each of the 88 hospitals, and adding contact information for community mental health centers who partner with hospitals to conduct suicide risk assessments.
2. Include additional evidence-based practice recommendations for following-up with suicidal patients after discharge when sending informational materials.
3. Include additional information about evidence-based training programs for hospital staff on treatment compliance for suicidal patients, safety planning, conducting screening and risk assessments, follow-up referral protocol, and lethal means counseling.
4. Increase participation in the House Bill 2012-1140 assessment from 65 to 75 percent in order to better identify current practices, protocol and training needs. The survey will be reviewed and revised to ensure that it is up to date, easy to complete, and relevant.

## NEXT STEPS

During the 2014-2015 fiscal year, the Office of Suicide Prevention will continue to make every effort to develop a comprehensive hospital contact database, ensure that project materials are put in the hands of the correct individuals at each hospital, and increase assessment response rates. The project team will again explore the use of a phone survey, and will attempt to utilize volunteers and additional staff time to identify key hospital staff. The Office of Suicide Prevention will continue to partner with the Colorado Hospital Association and the Suicide Prevention Coalition of Colorado to provide resources and materials to Colorado hospitals. The Office of Suicide Prevention will ensure that House Bill 2012-1140 efforts are aligned with relevant priorities identified by the Suicide Prevention Commission, and will share any emerging strategies, protocol and training programs available to hospitals and emergency department.

**Attachment 1 - Assessment**

House Bill 2012-1140
Year Two, Phase TWO Survey (Electronic)

Thank you for agreeing to take this survey for the Colorado Office of Suicide Prevention. It is designed to take approximately 10 to 15 minutes to complete. If you are not familiar with your hospital or emergency department protocols for treating suicidal patients, please pass this survey to the individual most familiar with the protocol.

Every year, approximately 900 Coloradans die by suicide and 2,750 are hospitalized for suicide attempts. To address this major health issue, the Colorado Legislature passed House Bill 2012-1140, which requires the Office of Suicide Prevention, the state lead for suicide prevention, to provide hospitals with educational materials to be distributed at discharge to patients who have attempted suicide.

The purpose of this survey is to (a) better understand the discharge protocols at Colorado hospitals and emergency departments for individuals who have made a suicide attempt or gesture, (b) identify barriers encountered by hospitals in connecting suicidal patients to local suicide prevention resources, and (c) assess your facility's current suicide prevention training efforts and needs.

Throughout this survey, “suicide attempt” is used to refer to both attempts and gestures.

1) What is the name of the hospital where you are currently employed?

_____

2) What is your official title?

_____

3) If a patient presents with a suicide attempt, does your hospital assess their current level of suicide risk?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

4) Does a staff member of your hospital conduct suicide risk assessments, or does your hospital partner with a community mental health center or other organization for suicide risk assessments?

- ☐ Staff Member
- ☐ Outside Partner (Please specify the agency name:_____)
- ☐ Combination
- ☐ Other (please specify)

5) What is the name of the hospital department that conducts suicide risk assessments?

_____

6) What is the title of the individual that oversees this department?

_____

7) Who is generally the primary provider that conducts suicide risk assessments on patients who have attempted suicide (mark all that apply)?

- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychiatrist
- ☐ Social Worker
- ☐ Licensed Psychologist
- ☐ Discharge Planning Manager
- ☐ Don't know
- ☐ Other (Please specify):

8) When an <u>adult patient</u> who has made a suicide attempt is discharged from inpatient or emergency department care, what proportion receives the following information:

| All | Most | Some | Few | None | |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | A Safety Plan* (developed in partnership between patient and a clinician) |
| ☐ | ☐ | ☐ | ☐ | ☐ | Warning signs of suicide and Depression |
| ☐ | ☐ | ☐ | ☐ | ☐ | Risk factors for suicide |
| ☐ | ☐ | ☐ | ☐ | ☐ | Education on reducing access to lethal means |
| ☐ | ☐ | ☐ | ☐ | ☐ | Follow-up appointment with outpatient mental health provider |
| ☐ | ☐ | ☐ | ☐ | ☐ | Coordination with care providers (primary care, behavioral health, workplace or employee assistance, community programs, etc.) |
| ☐ | ☐ | ☐ | ☐ | ☐ | Community crisis and suicide prevention resources (e.g., hotline number) |
| ☐ | ☐ | ☐ | ☐ | ☐ | Other information (please specify) |

9) When a pediatric patient (under the age of 18) who has made a suicide attempt is released from the Emergency Department or discharged from the hospital to a parent or guardian, does this responsible party receive information for the youth regarding:

| All | Most | Some | Few | None | |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | A Safety Plan* (developed in partnership between patient and a clinician) |
| ☐ | ☐ | ☐ | ☐ | ☐ | Warning signs of suicide and Depression |
| ☐ | ☐ | ☐ | ☐ | ☐ | Risk factors for suicide |
| ☐ | ☐ | ☐ | ☐ | ☐ | Education on reducing access to lethal means |
| ☐ | ☐ | ☐ | ☐ | ☐ | Follow-up appointment with outpatient mental health provider |
| ☐ | ☐ | ☐ | ☐ | ☐ | Coordination with care providers (primary care, behavioral health, workplace or employee assistance, community programs, etc.) |
| ☐ | ☐ | ☐ | ☐ | ☐ | Community crisis and suicide prevention resources (e.g., hotline number) |
| ☐ | ☐ | ☐ | ☐ | ☐ | Other information (please specify) |

** A Safety Plan (also called Crisis Plan) is usually a six-step document that includes the patient's individual warning signs that a mental health crisis is developing, individual strategies for distracting himself/herself, friends/family to contact for social distraction, friends/family to ask for help, formal providers/hotlines to ask for help, and methods to reduce access to lethal means of suicide at home.*

10) What proportion of patients (or parents/guardians of underage patients) who have been treated for a suicide attempt receive counseling from hospital staff about temporarily storing any household firearms away from the home or locking them in such a way that the patient has no access?

- ☐ All
- ☐ Most
- ☐ Some
- ☐ Few
- ☐ None

11) What proportion of patients (or parents/guardians of underage patients) who have been treated for a suicide attempt receive counseling from hospital staff about temporarily storing any lethal medications at home in such a way that the patient has no access?

- ☐ All
- ☐ Most
- ☐ Some
- ☐ Few
- ☐ None

12) In compliance with House Bill 2012-1140 described above, the Office of Suicide Prevention sent Informational Brochures to all Colorado hospitals in November 2012, and samples again in

June 2014, which outline the warning signs of depression, risk factors for suicide, and suicide prevention resources and tools. The names of the brochures are below:

1. After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors
2. After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department
3. After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department
4. National Suicide Prevention Lifeline wallet card

Were you aware that your hospital received these materials?

- ☐ Yes
- ☐ No

13) Is your hospital utilizing the materials provided by the Office of Suicide Prevention?

- ☐ Yes
- ☐ No
- ☐ Don't know

14) If you are not using the materials provided by the Office of Suicide Prevention, please tell us why (check all that apply):

- ☐ Limited staff resources
- ☐ Lack of knowledge and skills about how to provide patients with the information
- ☐ Lack of designated staff member whose responsibility it is to provide the information
- ☐ We already provide referral and safety planning information to patients and families
- ☐ We have not received the materials from the Office of Suicide Prevention
- ☐ Was not aware the materials are available
- ☐ Not sure how to access these items within the hospital
- ☐ Other (please explain)

15) In 2013, the Suicide Prevention Resource Center released *Continuity of care for suicide prevention: The role of emergency departments* (http://www.sprc.org/sites/sprc.org/files/library/ContinuityCare_Suicide_Prevention_ED.pdf ). The Office of Suicide Prevention emailed and sent copies of this document to your hospital in June 2014. Please check all of the following that apply to your use of the document:

- ☐ I am aware of this document
- ☐ The department responsible for conducting suicide risk assessments is aware of the document
- ☐ My hospital is using this document as a blueprint in suicide prevention planning and protocol development
- ☐ My hospital is using this document to prioritize staff training
- ☐ My hospital is not using this document
- ☐ Other (please explain)

16) In your hospital, who is responsible for providing prevention and follow-up information/resources to patients or families prior to discharge?

- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Physician
- ☐ Physician Assistant
- ☐ Psychiatrist
- ☐ Social Worker
- ☐ Licensed Psychologist
- ☐ Discharge Planning Manager
- ☐ Don't know
- ☐ Other (Please specify):

17) Do you have a protocol for following-up with suicidal patients after they are discharged from your hospital?

- ☐ Yes
- ☐ No
- ☐ Don't know

18) What follow-up services do you provide to patients discharged after a suicide attempt (check all that apply):

- ☐ A personalized safety plan, discussed and provided at time of discharge.
- ☐ Crisis card or other information with contact information to help after discharge (local crisis center or National Suicide Prevention Lifeline).
- ☐ Assistance in scheduling the first follow-up appointment before discharge, preferably within 24 to 72 hours and at least within seven days after discharge.
- ☐ Call or email from facility staff or another organization to check-in and encourage compliance with follow-up primary care or mental health appointments.
- ☐ Post-card, letter, email or text message to check-in and encourage compliance with follow-up primary care or mental health appointments.
- ☐ Outpatient mental health services contact the hospital if the patient does not appear for the follow-up appointment that the hospital arranged.
- ☐ Information about mental health services in the community.
- ☐ Information about how/where to temporarily store firearms outside the home.
- ☐ Information about safely storing/disposing lethal medications and drugs.
- ☐ Other: please specify

19) Please indicate in which areas your hospital has either a) implemented new protocols in the past three years or b) is interested in implementing new protocols?

| *Recently Implemented* | *Interested in Implementing* | |
|---|---|---|
| ☐ | ☐ | Screening, assessing and managing suicide risk |
| ☐ | ☐ | Counseling on reducing access to lethal means |
| ☐ | ☐ | Safety plans |

| | | |
|---|---|---|
| ☐ | ☐ | Referring patients to appropriate follow-up services |
| ☐ | ☐ | Increasing treatment compliance and other follow-up support post discharge |
| ☐ | ☐ | Other (please specify) |

20) In what areas would your hospital be interested in receiving staff training (check all that apply)?

- ☐ Screening, assessing and managing suicide risk
- ☐ Counseling on reducing access to lethal means
- ☐ Safety plans
- ☐ Referring patients to appropriate follow-up services
- ☐ Increasing treatment compliance and other follow-up support post discharge
- ☐ Other (please specify)

21) What training modality is most useful and effective for staff in your hospital?

- ☐ In-person training at the hospital
- ☐ In-person training off site but within 50 miles
- ☐ Online training via live webinar
- ☐ Online training, self-administered
- ☐ Other or combination of the above (please specify)

Thank you for your time and cooperation! Please contact Jarrod Hindman at the Office of Suicide Prevention at the Colorado Department of Public Health and Environment with any follow-up questions or concerns at jarrod.hindman@state.co.us or 303.692.2539.

STATE OF COLORADO

John W. Hickenlooper, Governor
Larry Wolk, MD, MSPH
Executive Director and Chief Medical Officer

Dedicated to protecting and improving the health and environment of the people of Colorado

4300 Cherry Creek Dr. S.
Denver, Colorado 80246-1530
Phone (303) 692-2000
Located in Glendale, Colorado

www.colorado.gov/cdphe

Colorado Department
of Public Health
and Environment

**Attachment 2 – Hospital Letter**

June 20, 2014

Dear *,

During the 2012 Session, the Colorado Legislature passed a bill designed to decrease the number of suicides in Colorado by working with hospitals to get information into the hands of those who attempt suicide and their families. The Office of Suicide Prevention at the Colorado Department of Public Health and Environment (CDPHE), in partnership with the Colorado Hospital Association (CHA), is pleased to provide your hospital with the enclosed suicide prevention and intervention sample materials. CDPHE and CHA continue to work with suicide prevention and mental health organizations statewide to prevent suicide. Colorado has the eighth highest suicide rate in the US, and a prior suicide attempt is the leading risk factor for suicide death. The enclosed materials are intended to provide helping resources for individuals and their families who have experienced a suicide attempt.

Samples of the following materials are enclosed for individuals, families, and hospital staff, and are intended to equip attempt survivors and their families with the tools necessary to prevent future suicide attempts.

1. After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors
2. After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department
3. After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department
4. National Suicide Prevention Lifeline Wallet Card
5. Continuity of Care for Suicide Prevention: The Role of Emergency Departments
6. Emergency Medical Evaluation of Dangerousness, eMed Colorado, Inc.

Please share the enclosed materials with your emergency department and in-patient doctors, nurses, and psychiatric teams. If your staff agrees that these materials are helpful, they can be ordered from the following sources: Items 1-4 can be ordered and shipped for free from the

Substance Abuse and Mental Health Services Administration (SAMHSA) store at http://store.samhsa.gov/term/Emergency-Department-Treatment. The brown brochure provides useful information about suicide and suicide prevention and can be given to doctors, nurses and psychiatric teams at your hospital. The green brochure can be given to the family or caretaker of someone who has attempted suicide, and the blue brochure can be given to patients who have attempted suicide or had suicidal ideation. Item 5 can be downloaded from the Suicide Prevention Resource Center (SPRC) at http://www.sprc.org/sites/sprc.org/files/library/ContinuityCare_Suicide_Prevention_ED.pdf, and includes detailed information about available emergency department protocol and training opportunities.

Appropriate after-care and follow-up are critical components of recovery, and the enclosed materials are designed to provide the information and resources families need to effectively navigate a successful recovery.

In the next two weeks, you will receive an email requesting your participation in an assessment via Survey Monkey. The survey should take no more than 10 to 15 minutes to complete and is designed to help the Office of Suicide Prevention better understand discharge protocol at Colorado hospitals and emergency departments for individuals who have made a suicide attempt or gesture. The survey is also being used to identify barriers encountered by hospitals in connecting suicidal patients to local suicide prevention resources, and to assess current suicide prevention training efforts and needs. Please complete the survey at your earliest convenience.

Thank you for your key partnership in disseminating this important information to hospital staff, and to every individual and family that comes through your doors as a result of a suicide attempt. For questions or to learn more about the project, or to request that the Office of Suicide Prevention provide support to order and ship any of the above materials to your facility, please contact Jarrod Hindman at the Office of Suicide Prevention at jarrod.hindman@state.co.us or 303.692.2539.

Thank you.

Jarrod Hindman, MS
Director, Office of Suicide Prevention
Prevention Services Division