2018

Community Conversations to Inform Youth Suicide Prevention

A STUDY OF YOUTH SUICIDE IN FOUR COLORADO COUNTIES

Presented to Attorney General Cynthia H. Coffman
Colorado Office of the Attorney General
By Health Management Associates

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

EXECUTIVE SUMMARY

BACKGROUND & PURPOSE

In December 2017, the Colorado Office of the Attorney General, Office of Community Engagement, hired Health Management Associates (HMA) to study four counties in the state (El Paso, Pueblo, Mesa, La Plata) which had experienced recent suicide clusters among middle and high school-aged youth and had historically high rates of suicide across every age group [1]. Key partners to this effort included the Office of Suicide Prevention at the Colorado Department of Public Health and Environment (CDPHE), local public health agencies, school districts and community mental health agencies in each of the four counties.

HMA designed a multipronged approach to the study with the goal of learning about opportunities and approaches to youth suicide prevention in each of the four counties, and across Colorado. Central to the study was the concept of community conversations. The project team conducted 42 key stakeholder interviews with representatives from public health, behavioral health, schools and youth serving organizations. The team also facilitated 34 focus groups with adults and youth from various communities and sectors. For comparison, focus groups were conducted with school staff and parents in Douglas and Larimer Counties, where the youth suicide rates were lower and/or there had not been recent suicide clusters.

HMA conducted secondary analyses on data for fatal and nonfatal suicidal behavior, including death certificate and hospitalization data, the Colorado Violent Death Reporting System, the Colorado Child Fatality Prevention System, and the Healthy Kids Colorado Survey. HMA also reviewed information on current suicide prevention activities and resources in the four counties and across Colorado, reviewed traditional and social media coverage related to suicide in the four counties and the state, and reviewed publicly available information on school policies and procedures related to suicide intervention, prevention and postvention in the aftermath of a student suicide or suicide attempt.

SCOPE OF THE PROBLEM

Since 2009, Colorado has seen an almost yearly increase in the number of suicide deaths. In 2009, there were 940 suicide deaths in total across Colorado, which was the highest number seen in the state at the time [2]. In 2016, the number of suicide deaths increased to a new high of 1,156 (giving an age-adjusted rate of 20.3 per 100,000 people) –although not statistically significantly higher than 2009 [3]. In 2016, Colorado ranked fifth in the nation in terms of suicide death rates and has consistently been in the top 10 since 2009 [4]. The increased number of suicide deaths in Colorado is commensurate with the numbers seen nationally over the same time. Between 2015 and 2017 in Colorado, there were 222 suicide deaths of young people between the ages of 10 and 18 [5]. Of those deaths, 67.6 percent were male (150 deaths) and 32.4 percent were female (72 deaths) [6].

When it comes to youth suicide attempts, females between the ages of 10 and 18 are disparately represented in the data. Between 2014 and 2015 (the most recent time-frame with public data available), the number of hospitalizations of Colorado residents ages 10-18, shows that 816 females were hospitalized due to a suicide attempt, while 249 males were hospitalized during this same period [7]. This suggests that more females are attempting suicide, but more males are dying by suicide.

In the 2017 Healthy Kids Colorado Survey (HKCS), a survey conducted every two years to better understand youth health, 17 percent of all participating middle and high school students reported considering suicide and 7 percent reported making one or more suicide attempts in the previous 12 months [8]. Again, this is similar to national data for this age group [9]. Looking at Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) youth, 44.8 percent reported considering suicide and 19.9 percent attempted suicide in the previous 12 months, highlighting the disparities experienced by this population [10].

EXECUTIVE SUMMARY
KEY FINDINGS

KEY FINDINGS

Key findings are presented by the study components: Key Informant Interviews, Community Focus Groups, and Additional Reviews.

Key Informant Interviews

The key informant interviews gathered information about youth suicide in each community, such as activities and efforts related to prevention, the current impact of suicide on the community, existing risk and protective factors, and barriers and facilitators for prevention efforts. Key informants also provided guidance for HMA on conducting focus groups in each county.

Every interviewee described the community impact of youth suicides as profound, with far-reaching social and emotional effects. Youth, parents and institutions all feel the force of the deaths, with a reaction of re-traumatization after each suicide. They stated that recent suicide deaths served as a galvanizing point and described an increase in activities dedicated to prevention efforts. However, they also recognized that access to resources and funding is thwarting some of these efforts.

RISK & PROTECTIVE FACTORS

The risk factors most often cited by interviewees in all four counties are poor employment and a struggling economy. Two critical impacts of an unstable economy identified by some interviewees are access to health insurance and access and availability of prosocial activities. In addition to the economic challenges of accessing prosocial activities, for rural areas within these counties, transportation and time also were identified as significant problems.

Specific to youth, the use of social media and technology was identified as a risk factor. Key informants called out issues such as cyberbullying, the loss of interpersonal social skills and an inability to take a break from constant interaction, especially negative interaction, on social media. Many expressed concern that adults do not know how to navigate the technological world of youth, and thus don't know how to help build youth resiliency around it. "Connected" youth are experiencing more social disconnectedness and isolation, and in some of the more rural communities, this is compounded by their geographic isolation.

Another commonly mentioned risk factor was a perceived lack of coping skills and resilience among youth. This was described as youth experiencing difficulties, such as the loss of a relationship or not achieving something in school or activities and being unable to cope with the setback.

The effect of being exposed to adult suicides and/or of having a family member die by suicide was mentioned as a risk factor by interviewees across the four counties. Some described their belief that adult suicides have had a significant, and perhaps underestimated, impact on youth. Additionally, some key stakeholders responded that they feel as though many parents do not believe or recognize the suicide risk for their children.

Protective factors described by key informants are consistent across the four counties, but there are differences in how they are applied. Interviewees described resources and youth suicide prevention efforts such as school-related assets, extracurricular activities, various suicide prevention and intervention efforts, increased collaborative efforts of the public health departments and increased cooperation across resources. The degree of

> "Out of tragedy, momentum has increased, brought in more resources for schools, acted as a focal point for the community at large, and started grassroots forums for people to help or get training." – Key Informant

access to these types of programs varies in each county, and even communities within these counties. Programs are not available to all youth because of cost, time to travel, and – in some cases – only competitive sports are available, and only to top performers.

Two additional sources of protection described by interviewees were churches/faith-based activities and Colorado's natural outdoor resources. Churches provide many youth-focused activities and can be a space for interpersonal interaction and positive activities. Yet there were also concerns that faith-based organizations might promote stigma toward suicide and may not be viewed as accessible by all youth – in particular, LGBTQ+ youth. Interviewees in each county described Colorado's natural resources as a protective factor that is being underutilized by families and institutions – again partly due to prohibitive costs, as well as geographic accessibility and transportation.

FACILITATORS & BARRIERS FOR SUICIDE PREVENTION

Each of the four counties has high levels of support for youth suicide prevention, occurring through efforts such as a summit to share best-practices (La Plata), continued and/or increased public health department coordination (El Paso and La Plata) and continued and increased community collaboration (Mesa). Most of the key informants described the importance and need to do primary prevention with individuals and families across the life-course to make real, long-lasting changes in suicide risk and rates.

The consensus across all four counties is that there are not enough resources to effectively implement youth suicide prevention, intervention and postvention activities [11].

EXECUTIVE SUMMARY
KEY FINDINGS

Each county faces a lack of funding for public health and social services programs. Additionally, there is a shortage of mental health providers overall and, in particular, a lack of mental health providers who accept Medicaid, who work specifically with adolescents and who have training and competence working with individuals experiencing a suicidal crisis.

Inter-organizational barriers were also described by interviewees. For example, they said that trainings often are planned, publicized and conducted by organizations without the knowledge or coordination of other agencies in the community. Another substantial barrier key informants discussed is a lack of equitable distribution of resources across agencies, and insufficient formal, robust referral protocols between agencies for at-risk youth.

Across the four counties several interviewees noted that stigma against or by specific populations thwarts prevention initiatives; for example, discrimination against LGBTQ+ individuals limits the places and resources from which those youth seek help. Additionally, they indicated that Native American and Hispanic populations often do not reach out to the formal resources that the interviewees provided.

Interviewees across all four counties identified the need for more people to be trained as gatekeepers [12], not just individuals in youth-serving agencies, but parents and family members, more school personnel including ancillary staff such as janitors, youth peers and the public in general. Interviewees also recommended implementing "booster sessions" – reaching back out to previously-trained individuals to reinforce key learning points and update them on referral resources. Finally, they also identified the need for training adults and parents about how to talk with children and youth about suicide.

Interviewees in all four counties described a perceived need to build resilience in young people. This included improving interpersonal interaction skills, teaching youth how to better navigate a social media environment and increasing prosocial, peer-to-peer activities for youth. Programs need to be accessible to all community members both by way of transportation and cost.

Community Focus Groups

> "People are becoming desensitized to the value of their life." – School Staff

Focus groups were an important component of this study and were designed to allow participants to interact in a discussion of their perceptions and opinions about youth suicide in their communities. Focus groups were conducted across the four counties, with groups of parents, youth (high-school age only), school administrators, other school staff, individuals from organizations that serve youth and community members interested in or engaged in youth suicide prevention activities. Focus groups with parents and school staffs in Douglas and Larimer Counties were included for comparison. These counties are demographically similar to the counties that were the focus of the project and did not experience recent youth suicide clusters and/or have comparatively lower youth suicide rates.

Participants in every focus group described the profound effect youth suicide has had on their communities. The words used include tension, worry, fear, devastation, shock, confusion, paralysis, exhaustion, urgency, desperate, surrender (people in care-giving roles leaving their jobs), and flight (parents unenrolling their kids from schools or outright moving to other communities). One especially troubling theme is the perception among participants that suicide is starting to seem normal in their communities, with some youth and adult participants expressing that suicide has become a conceivable option. Youth participants described feeling that if others (both adults and peers) could not get help for their problems, then they too may not be able to find help.

Focus group participants used phrases like "compassion fatigue," particularly for professionals in the middle and high schools. Parents, school administrators, teachers and school counselors often described a sense of fear. Compounding the problem, parents said they do not feel prepared to deal with such a significant issue; school staff described being in a constant state of crisis response. School staff in most of the focus groups indicated a need for greater support and training, particularly for staff who are not clinicians or counselors, in dealing with suicidal crisis in the schools.

Youth focus group participants said they felt that adults' response when there has been a suicide is confusing and inadequate. They expressed a strong desire to have authentic relationships with adults with whom they connect and feel comfortable. They sense that adults are fearful of saying the wrong thing and, unfortunately, this leads to no conversation about suicide at all, or an intense reaction where conversations feel like an inquisition of one's potential suicidality. Youth in several of the focus groups also indicated that they feel as though they are expected to act like adults and perform like adults, yet they are not always treated like adults or given the "credit" for being capable of handling frank discussions about difficult issues such as behavioral health problems, including suicide.

In virtually every focus group, participants discussed the stigma and taboo of suicide and mental health issues. In El Paso, Mesa and La Plata Counties, participants agreed there is pressure for parents and youth to appear perfect, and youth in those counties expressed that it feels like no one is allowed to show they have problems. In Pueblo County and rural El Paso County, participants discussed a strong culture of secrecy and not sharing problems outside of one's family unit, as opposed to the culture of appearing perfect and problem-free. There is a feeling that the stigma around mental health issues and suicide creates a sense of isolation in these communities, that those struggling with these issues feel as if they are struggling alone. Participants shared that families that experienced a suicide attempt or death often were seen as "tainted" and shunned by others in the community, instead of receiving resources and supports.

EXECUTIVE SUMMARY
KEY FINDINGS

By contrast, in the comparison communities of Douglas and Larimer Counties, focus group participants noted there is a willingness in the community to discuss suicide, and the stigma around mental health issues seemed to be abating – that although stigma is still an issue, more people were talking about mental health.

RISK & PROTECTIVE FACTORS

Pressure and anxiety about failing

The risk factor described the most consistently (more pronounced in El Paso, Mesa and La Plata counties) is pressure, mainly related to academic performance, but also in extracurricular activities. This included feeling that expectations placed on youth were unrealistic and youth were not given the tools to manage the pressure in a healthy way. Youth express that they are also managing information overload via the internet and social media, and other stressors such as school shootings, relationships and sex, divorce and substance use.

Youth and adults across the four counties, but particularly in El Paso, Mesa and La Plata, expressed a belief that the time and opportunity for youth to learn or practice self-care is lacking. Both youth and adults expressed that youth have no time to decompress and no break for their brains, especially with the current bell-to-bell instruction in most schools and the pace of extra-curricular activities.

> "There is a gap between who you are and what you are supposed to be." – School Administrator

Social media and cyberbullying

Another common theme around risk factors was the use of social media. Youth are described as always being connected to their phones, plugged into social media accounts or texting. Adults expressed concern that youth use of social media is limiting their face-to-face interactions with others, while also leading to exponentially more opportunities to be impacted by the emotional lives of their peers, making managing the spread of harmful information impossible. Youth expressed feelings of anxiety about the image that must be maintained on social media, and that mistakes they make feel magnified on social media.

Of additional concern with social media and technology overall is cyberbullying. Youth and adults note that youth who are experiencing bullying at school cannot escape the harassment, as it continues after school hours on social media or via text messages. Finally, several participants said that the internet and social media give youth easy access to information, both positive and negative, about the world around them. Participants expressed that this can be both empowering and beneficial, but also exposes youth to content that is adult in nature or violent/disturbing, and youth lack the skills and support to consume such information in a healthy way.

Lack of prosocial activities

Youth and adult focus groups across all four counties described a need to fund, increase and improve the social recreational activities provided to youth, and build awareness that prosocial activities can be protective against suicidal behavior in youth. Yet where these resources exist, there often are issues of access due to transportation or affordability. Again, by comparison a focus group participant in Larimer County stated that recreation centers were easy to access and made affordable to most youth.

> "There is a lot of space between kids and adults." – Youth

Lack of connection to a caring adult

Youth participants across the four counties described a deep desire to have authentic relationships with adults. When it comes to discussing difficult topics, youth across all communities shared that they do not often experience these interactions as authentic or helpful. Youth are concerned that adults will "freak out" or overreact and not listen. They expressed a wish that adults could just be with them in their pain without jumping to assessments or solutions, but rather just trying to understand. Along this same vein, youth groups across each county expressed frustration that adults, most often parents, tend to minimize their problems and pain. Youth feel disheartened when adults tell them to "raise their voice" or speak up about issues that concern them, but then shut them down when they do raise their voice.

When youth have established relationships with trusted adults, they reported they will go to those adults for support. However, building that trust requires time and a willingness and capacity to talk with youth about difficult subjects. The comparison community of Larimer County contrasted starkly with the focus counties related to this issue. Focus group participants described an established culture and set of practices around building strong youth-adult connections in the Poudre School District.

Judgment and lack of acceptance in the community

Many focus group participants expressed feelings that their community is not accepting of differences or is judgmental of those who do not fit with the dominant community norms. Youth explained that some people are afraid to be who they

> "You have to be a certain type of person to find comfort here." – Youth

EXECUTIVE SUMMARY

KEY FINDINGS

are, and that they are growing up in a culture of harsher judgment, belittling and a lack of acceptance, let alone tolerance. Of concern is the lack of community acceptance of youth who identify as LGBTQ+. Youth and adults described increased bullying of LGBTQ+ youth by both peers and adults within schools, a lack of response by schools and other youth-serving institutions, and routine, systemic isolation of these young people. Youth and adults also expressed finding hypocrisy where they feel values espoused by majority political and religious groups in some communities are not put into practice. In contrast, the focus groups in the comparison communities of Douglas and Larimer Counties did not express a sense of judgement or lack of acceptance as notable in their communities.

Substance use, mental disorders and trauma history and availability of behavioral health care

Across all counties and groups, youth and caregiver substance use and abuse, as well as depression and anxiety, were commonly discussed risk factors contributing to suicidal behavior in youth. These behavioral health issues were described as generational in scope, yet because of stigma and challenges in accessing behavioral health care, they often go underdiagnosed and undertreated. It is difficult to access behavioral health resources - both in and outside of the school setting - and many focus group participants expressed frustration that while resources are available when there is an immediate crisis, they are more limited when youth seek help to prevent a crisis or when they have an ongoing need after a crisis.

Participants described a shortage of providers, long wait times and high staff turnover in community mental health centers. Some participants said there is greater availability of services for children and youth covered by Medicaid, but fewer options for those with private or no insurance. Acute Treatment Units or inpatient facilities are located a significant distance away. There was also some frustration with community mental health centers, such as a lack of communication between schools and providers, a lack of understanding about how the system works and what families should expect, and a perceived or real lack of follow up or aftercare plans.

Adult suicide

Adult focus group participants in all four counties expressed that adult suicides are just as prevalent as youth suicides, but do not receive the same level of response or resources. Traditionally, youth suicide prevention and adult suicide prevention have been addressed somewhat separately. Focus group participants suggested that perhaps there hasn't been enough attention placed on how adult suicides in the community are impacting youth, especially the risk that adult suicides are normalizing and modeling suicidal behavior.

Factors that increase protection against youth suicide

Focus group participants described existing protective factors such as case management to help navigate support systems, trained school staff, community-based programs for youth to access and programs like Sources of Strength, an evidenced-based youth suicide prevention program. They also noted protective factors around access to prosocial activities such as sports, band and after-school activities in general. Participants in Pueblo, El Paso and La Plata counties reported that these activities are available, but there is a need for increasing access to them through things like registration fee assistance and/or transportation. They noted that groups not tied to academic achievement are also needed, as well as activities for youth who do not participate in sports or other school activities. Participants in Mesa County described limited availability to these types of activities which increase connectedness to more peers and caring, positive adults. Additionally, the natural environment surrounding the four focus counties was named as a protective factor, but with the caveat that access to things like hiking, camping, skiing and other outdoor activities can be expensive and hard to access.

SUICIDE INTERVENTION & PREVENTION ACTIVITIES

Training on how to help

The one theme that was the most consistent across all the focus groups in the four counties and comparison communities is whom youth turn to for help when they themselves are struggling – first and foremost, their peers. Yet in communities where the pressure to be successful is highest, youth participants said they go to no one for help. However, increasingly, when youth are worried about a suicidal friend, they do seek help from adults.

Youth are using Safe2Tell, which allows them to alert authorities when they believe someone may need help, but they said they are not likely to use a 1-800 help line and

would be hesitant to utilize a text line (although this was a preferred resource over calling a help line) for their own needs.

Youth stated in many ways that they want to talk about these issues with someone they know and trust, although they would rarely turn to parents for help because they are worried parents will overreact, underreact or be disappointed if their child is depressed or needs help. Many of the parents said they feel unprepared to help their children if they are feeling suicidal or come to them for help with a friend who is suicidal. Youth also communicated that they do not feel equipped to help their friends, yet they want to help.

EXECUTIVE SUMMARY

KEY FINDINGS

Both adult and youth participants feel that youth should be trained in suicide intervention. All group participants expressed concern with any suicide prevention classes or curriculum that are done only once, or over short segments with no sustained effort. Many youth noted frustration that some prevention activities seem to be mostly about adults looking like they are doing something to address the issue, but feel they are not really doing anything. They referred to this as putting a band aid on the problem and said they both want and need more than just band aids.

Youth want to learn how to ask about suicide, how to respond to someone in the moment and how to grieve and recover when there has been a loss. Additionally, youth and parents want to understand what will happen when they do seek help for suicidal thoughts - how to navigate the behavioral health system and what to expect.

By comparison, focus group participants in Larimer County noted that Poudre Valley School District trained every staff member in its schools and all incoming high school freshmen in suicide intervention using the Question, Persuade and Refer (QPR) curriculum. QPR is implemented as part of and in addition to a culture that supports ongoing relationship building and engagement between youth and adults.

Returning to school following a suicide attempt

Across the four counties, school staff and youth focus group participants shared concerns with how schools support students returning to school following a suicide attempt or mental health treatment for suicidal ideation. There are procedures and policies in place; however, participants expressed that these may lack the level of information and support to truly assist students, as well as support teachers in balancing academic expectations in the context of a student's return to day-to-day activities.

Resources

A common theme about community-based resources was that community members generally understand that there are resources, but they believe there is a lack of awareness about what they do and how to access them. Participants also noted a lack of coordination among organizations, citing duplicative and competing efforts. Among the four focus counties, there were differences in the level and coordination of community partnerships. Often, participants from community organizations perceived the level of accessibility and coordination to be higher than what youth and parents perceived. Part of this disconnect may be related to communication about resources, particularly a basic understanding on the part of families about how to access resources and what happens when you do. Another common theme about resources that was expressed by professionals in the schools and community-based organizations across all four counties, was that they are patchworked and non-sustainable because they generally are grant funded.

The grant funding is often short-term and tied to specific outcomes or deliverables, making it both difficult to sustain and hard to braid or blend funding streams. By comparison, focus group participants in Douglas County describe a strong mental health coalition with coordinated efforts. Focus group participants in Larimer County said there are strong relationships between their school-based mental health professionals and community resources.

FOCUS GROUP SUMMARIES PER COUNTY

It became clear at the outset that there are distinct communities with unique challenges and strengths even within each of the four focus counties, especially in El Paso and La Plata Counties. Findings from the focus groups should be considered in the context of these differences. For example, in El Paso County, most participants represented the northern part of the county, self-described as an affluent, religious community with a strong military presence of mainly officer-level personnel. Other parts of the county are described as less affluent and having a strong enlisted military presence or are rural communities with a very different set of risks for youth.

In La Plata County, the majority of participants were from Durango, which is viewed as a "big city" by residents from Bayfield and Ignacio. The cultures, socioeconomic status and diversity in these three towns are very different.

To a lesser degree, these community distinctions were also seen in Mesa, Douglas and Larimer Counties. Although Pueblo County shared themes with the other three counties that were the subject of the project, it was the most unique of the four. The full report includes a brief description of each of the four counties and the themes captured within and across their communities.

Additional Reviews

In addition to the key informant interviews and focus groups, HMA reviewed school policies and procedures related to suicide intervention, prevention and postvention in El Paso, La Plata, Mesa and Pueblo counties focused on the district/school board level for each school district in the county. HMA also examined media coverage of suicide looking at both traditional media (e.g., print newspapers, radio, and television) and internet-based media (e.g., online newspapers). Included in this review was how the topic of suicide and suicide prevention is addressed on social media separate from news stories covering a suicide or the topic of suicide. Finally, HMA assessed suicide prevention resources at the state and local level relevant to the four project communities. In depth discussion of these reviews can be found in the full report.

EXECUTIVE SUMMARY

RECOMMENDATIONS

LOOKING AHEAD

The following recommendations are the result of HMA's analysis of all data collected under this project, particularly the information gathered from community members through key informant interviews and focus groups. These recommendations are intended to be the start of a conversation about what state and local partners can do to address youth suicide in Colorado, and to increase alignment between and among programs at both levels.

1 **Prioritize relationship building between adults and youth.**

2 **Create a culture of support for youth in crisis/post-crisis.**
- *Train parents, youth, community youth leaders and school staff to identify and respond to suicidal youth.*
- *Prioritize support of teachers and counselors in the aftermath of a suicide death or attempt.*
- *Establish and communicate clear policies and/or procedures for supporting students returning to school after seeking care for suicidal ideation or other mental health concerns.*
    - *i. Proactively develop and refine school protocols and policies to align with best practices.*
- *Create cross-agency coordination protocols to support youth in crisis.*

3 **Implement programs or strategies that build resilience and coping skills.**
- *Provide self-care lessons or activities for youth.*
- *Teach youth interpersonal interaction skills and ways to better navigate a social media environment.*

4 **Increase access to prosocial activities and supportive environments.**

5 **Increase funding, length of funding periods, and flexibility of funds targeted to the primary prevention of youth suicide.**
- *Support youth led initiatives.*

6 **Leverage current public awareness campaigns to destigmatize getting help for mental health needs, including suicidal ideation.**
- *Implement a social norms campaign communicating that suicide is not a normal response to problems or feelings of depression/anxiety.*
- *Use social media to promote helping resources and messages of support and self-care.*
- *Model open dialogue about suicide and mental health.*

7 **Create coalitions of providers and foster relationships between providers and youth-serving organizations.**
- *Establish a practice to inform youth and parents/caregivers about next steps for youth referred for help about their suicidality.*

8 **Train media professionals on how to cover suicide safely.**

INTRODUCTION

BACKGROUND & APPROACH

In December 2017, the Colorado Office of the Attorney General, Office of Community Engagement, hired Health Management Associates (HMA) to study four counties in the state (El Paso, Pueblo, Mesa, La Plata) which had experienced recent suicide clusters among middle and high school-aged youth and had historically high rates of suicide across every age group [13]. Key partners to this effort included the Office of Suicide Prevention at the Colorado Department of Public Health and Environment (CDPHE), local public health agencies, school districts and community mental health agencies in each of the four counties (see Acknowledgements for a complete list of critical partners).

HMA designed a multi-pronged approach to the study with the goal of learning about opportunities and approaches to youth suicide prevention in each of the four counties, and across Colorado. Central to the study was the concept of community conversations. The project team conducted 42 key stakeholder interviews with representatives from public health, behavioral health, schools and youth serving organizations. The team also facilitated 34 focus groups with adults and youth from various communities and sectors. Many of the focus groups ignited conversations among community members that facilitators observed as oftentimes cathartic and empowering, as members of the community provided their thoughts about suicide risk in the community, as well as potential prevention strategies. Focus groups were conducted with school staff and parents in two comparison communities with similar demographics, where the youth suicide rate was lower and/or there had not been a recent suicide cluster [14].

In addition to the interviews and focus groups, HMA conducted secondary analyses on data for fatal and nonfatal suicidal behavior, including death certificate, hospitalization and emergency department data, the Colorado Violent Death Reporting System, the Colorado Child Fatality Prevention System and the Healthy Kids Colorado Survey. HMA also reviewed information on current suicide prevention activities and resources in the counties and within the state; reviewed traditional and social media coverage related to suicide in the four counties and state; and reviewed publicly available information on school policies and procedures related to suicide intervention, prevention and postvention in the aftermath of a student suicide or suicide attempt.

This report provides a summary of key findings from these various data sources within and across the counties studied. HMA analyzed the qualitative data collected to identify themes in the information shared. Following the key findings, HMA provides recommendations for the reader's consideration to inspire support for suicide prevention and to drive the targeting of resources.

OVERVIEW

HMA worked with CDPHE's Office of Suicide Prevention and Office of Vital Statistics to collect and review data related to suicide in the state and the four counties. State and local agencies have been working on data collection and analysis related to suicidal behavior and have published reports presenting this data (see Appendices A-D for data reports generated by CDPHE's Office of Vital Statistics specific to the four counties of focus for this project). HMA did not duplicate these efforts, but rather pulled from these sources to present a summary of suicidal behavior at the state level, and in the four counties and communities within them that were the focus of this project.

The data summarized in this report focuses mainly on suicidal behavior occurring among those between the ages of 10 and 18 between 2011 and 2015, supplemented by more recent data when possible.

SCOPE OF THE PROBLEM

It is important to note that suicide among individuals 18-24 years of age is also a growing problem and area of interest for suicide prevention activities in Colorado, but this age group was outside the scope of this project. Also, significant to note, each of these counties have higher rates of suicide across the age span. The impact of adult suicides on the community came up in almost all focus groups. Community members described feelings of emotional exhaustion with the topic of suicide; that suicide has become so common that people accept it as an inevitability and an option when one is overwhelmed by pressures.

SUICIDE IN COLORADO

Suicide deaths have increased almost every year since 2009 when there were 940 suicide deaths in total- the highest number seen in the state at that time [15]. In 2016, the number of suicide deaths increased to a new high of 1,156 (giving an age-adjusted rate of 20.3 per 100,000 people) –although not statistically significantly higher than 2009 [16]. In 2016, Colorado ranked fifth in the nation in terms of suicide rates and has consistently been in the top 10 since 2009 [17].

SCOPE OF THE PROBLEM

SUICIDE IN COLORADO

Between 2015 and 2017 in Colorado, there were 222 suicide deaths of young people between the ages of 10 and 18 [18]. Of those deaths, 67.6 percent were male (150 deaths) and 32.4 percent were female (72 deaths) [19]. The increased number of suicide deaths in Colorado is commensurate with the numbers seen nationally over the same period, and in part reflects the state's population growth. In addition to the loss of life, suicide deaths exact a financial toll on the community as it is estimated that each death costs approximately $3,500, in terms of direct costs (i.e. autopsy, law enforcement investigations), and $1.3 million in indirect costs from work loss [20]. The emotional cost to those surviving the suicide death of a loved one is immeasurable. A recent article in the official journal of the American Association of Suicidology estimates that for every suicide death, there are some 135 individuals directly affected [21].

When it comes to youth suicide attempts, females between the ages of 10 and 18 are disparately represented in the data. Between 2014 and 2015 (the most recent time-frame with public data available), the number of hospitalizations of Colorado residents ages 10-18, shows that 816 females were hospitalized due to a suicide attempt, while 249 males were hospitalized during this same period [22]. This suggests that more females are attempting suicide, but more males are dying by suicide.

In the 2017 Healthy Kids Colorado Survey (HKCS), a survey conducted every two years to better understand youth health, 17.0 percent of all participating middle and high school students reported considering suicide and 7.0 percent reported making one or more suicide attempts in the previous 12 months [23]. According to this survey, 15.9 percent of females reported that they made a suicide plan in the last year and 8.8 percent attempted suicide at least once in the last year (compared to 10.2% and 5.2% of males, respectively) [24]. Again, this is similar to national data for this age group [25]. Looking at Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) youth, 44.8 percent reported considering suicide and 19.9 percent attempted suicide in the previous 12 months, highlighting the disparities experienced by this population [26].

Across the state, the three most common methods of suicide among youth ages 10-17 are asphyxia, firearms, and overdoses [27, 28]. Females are much more likely to die by asphyxia (64.2% compared to 40.6% for males), while males are much more likely to die by firearms (52.3% compared to 17.9% for females) [29].

Within the State of Colorado, there are certain areas that have had higher suicide rates among youth and in more recent times, have seen spikes in the number of reported suicide deaths for the same population. While there are multiple counties and Health Statistic Regions (HSRs –

counties and aggregations of counties across Colorado) that have statistically higher age-adjusted suicide rates, the counties of El Paso (HSR 4), La Plata (HSR 9), Mesa (HSR 19) and Pueblo (HSR 7) were selected for participation in this project. Figures 1 and 2 below highlight the HSRs and counties within the State and give an overview of each region's suicide burden.

Figure 1. Map of age-adjusted suicide rates, per 100,000, by county across the lifespan, Colorado residents, 2011-2015 [34]

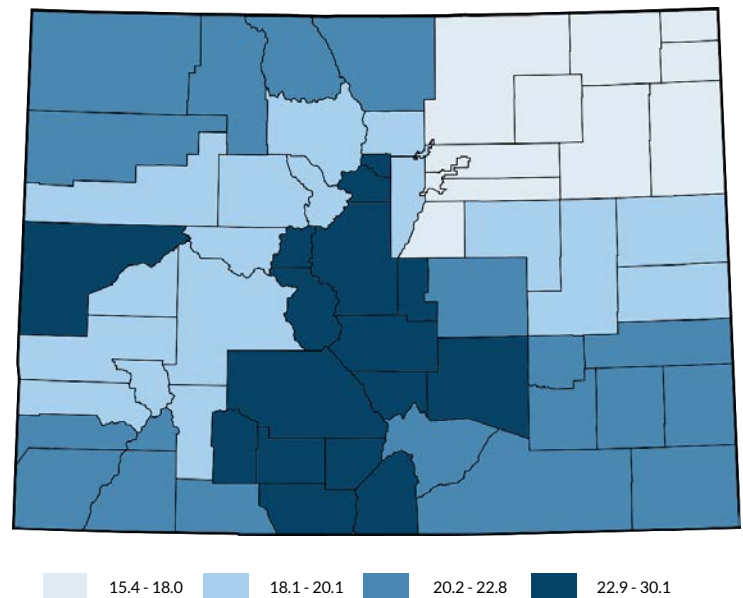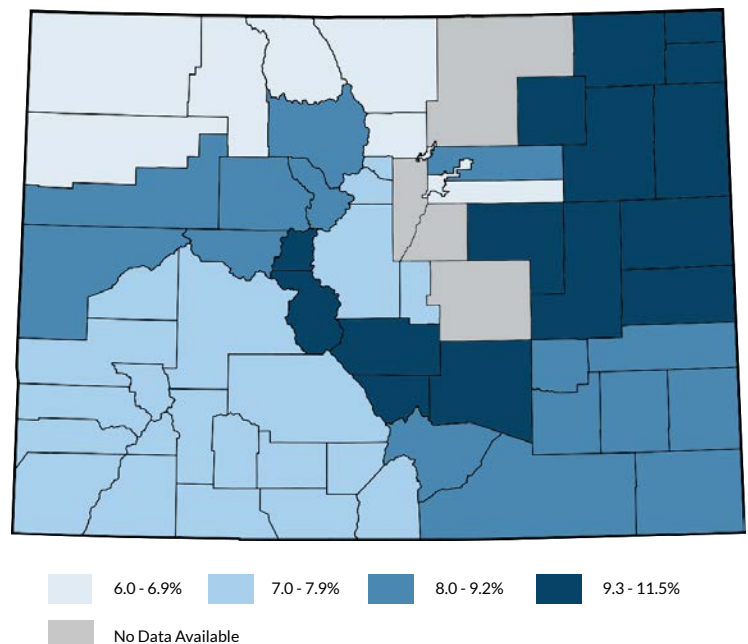
| 15.4 - 18.0 | 18.1 - 20.1 | 20.2 - 22.8 | 22.9 - 30.1 |

Figure 2. Regional Breakdown of youth who have attempted suicide at least once in the last year, 2015 [35]

| 6.0 - 6.9% | 7.0 - 7.9% | 8.0 - 9.2% | 9.3 - 11.5% |

No Data Available

SCOPE OF THE PROBLEM

SUICIDE IN COLORADO

According to the American Foundation for Suicide Prevention (AFSP), on average there are 123 suicides per day in the United States – nearly 45,000 Americans annually [30]. AFSP also notes that for every person who dies by suicide, there are approximately three attempts, nine ED visits for suicide attempts and 27 attempts that do not result in hospitalization or ED visits [31]. More specifically related to youth, a recent study in the journal *Pediatrics* found that from 2008 to 2015, the number of children and youth who were seen in the ED or admitted to the hospital for suicidal ideation or attempts dramatically increased [32]. The study showed that suicide-related diagnoses in that period tripled (from 0.66 % to 1.82%), and the rate increased the most for girls. In 2016 the Centers for Disease Control and Prevention (CDC) published data showing that middle school children now are as likely to die by suicide as from traffic accidents [33].

Suicide is an increasing problem across Colorado and in specific regions within the State. Various efforts are in place to address the issue, both at the state and local levels, but suicide deaths have still increased. A multitude of data has been collected and reported, but there remain interesting differences between HSRs and counties that may indicate some of the regional differences that exist in the State. If identified, understanding these differences could result in the implementation and evaluation of better targeted interventions and programs.

KEY STAKEHOLDER INTERVIEWS

BACKGROUND & APPROACH

The project began with interviews of more than 40 key stakeholders initially identified by CDPHE's Office of Suicide Prevention, then identified through the interview process. Stakeholders interviewed included, but were not limited to, representatives from public health, mental health, schools and community-based organizations. The purpose of the interviews was to gather information about youth suicide in each community, to learn about the activities and efforts related to youth suicide prevention and to gather information for HMA's approach to conducting focus groups in each county. Additionally, HMA asked a series of questions related to the impact of suicide on the community, risk and protective factors related to youth suicide, and barriers and facilitators for youth suicide prevention efforts. The key stakeholder interview guide can be found in Appendix E. HMA ensured key stakeholder anonymity to facilitate open dialogue in response to the interview questions.

FINDINGS FROM KEY STAKEHOLDER INTERVIEWS

The following includes a summary analysis of the information collected through the key informant interviews, including common themes that emerged within each county and across the four counties.

Impact on the Communities

Every interviewee described the impact of youth suicides on the community as profound, with the social and emotional effects reaching across the community. Youth, parents, and individuals from various community organizations and institutions all feel the impact of the deaths. All those interviewed described a reaction of being re-traumatized after each suicide that occurred. The interviewees noted that people in their communities feel on edge waiting for the next suicide to occur. For some stakeholders, there is a feeling of fear coming from a lack of understanding about what is causing the suicides and how to best prevent them. Interviewees from each community stated that recent suicide deaths served as a galvanizing point, but to varying degrees. Some interviewees felt that efforts started slowly, while others stated a fast reaction that is resulting in successful early collaborations. Consistent across all four counties is a push for an immediate response, while also planning for long-term primary and secondary prevention efforts. Interviewees from each of the counties described an increase in activities dedicated to prevention efforts, but also recognized that access to resources and funding is thwarting some of these efforts. All the interviewees listed pre-existing programs and resources present in the communities and described how these are enhanced or further supported by additional community interest or collaboration. There is a common perception that not enough is being done by agencies, but this was discussed within the context of the lack of resources for each agency.

> "Out of tragedy, momentum has increased, brought in more resources for schools, acted as a focal point for the community at large, and started grassroots forums for people to help or get training." – Key Informant

Mesa County and La Plata County interviewees cited large public meetings following several youth suicides that occurred in a short time period. These meetings served as the starting point for increased collaboration. La Plata interviewees described a

KEY STAKEHOLDER INTERVIEWS

FINDINGS

systematic and organized response. Mesa County interviewees described a further strengthening of collaboration that was already strong in the community. While El Paso and Pueblo interviewees didn't point to specific large public meetings occurring in response to the number of youth suicides, both counties have made strides towards more collaborative efforts. El Paso interviewees described a plethora of pre-existing resources and programs that have either improved communication within the community or improved collaboration among agencies. Pueblo interviewees also said they have seen increased communication among agencies.

Across all communities, interviewees discussed that youth suicides are seen as more tragic than adult suicides, and thus gain more attention. However, they also noted that adult suicides are more of a problem in terms of prevalence and the impact they have on the community. Some interviewees pointed to the high rate of adult suicides as a risk-factor for youth suicide.

Risk Factors

There was consistency across interviewees in the four counties regarding risk factors attributed to youth suicide. The three risk factors most often cited were poor employment and lack of economic opportunities for residents, the use of social media and technology among youth and a lack of coping skills or resilience among youth in the face of challenges.

The theme of "ups-and-downs" in the economy occurred across all counties. Two critical impacts of an unstable economy identified by some interviewees were access to health insurance and access and availability of prosocial activities for youth. In addition to the economic challenges of accessing prosocial activities, for rural areas transportation and time also were identified as issues.

The use of social media and technology was mentioned often as a risk factor for youth suicide. This was true across interviewees in all counties. Issues such as cyberbullying, loss of interpersonal social skills and an inability to take a break from constant interaction, especially negative interaction, on social media were called out as the primary reasons that this was a risk factor. Interviewees also discussed that adults and institutions do not know how to navigate the technological world youth are living in, and thus don't know how to help youth build the necessary resiliency. The result is youth are experiencing more social disconnectedness and isolation. In some of the more rural communities, interviewees said this is compounded by their geographic isolation.

Another commonly mentioned risk factor was a lack of coping skills and resilience among youth. This was described as youth experiencing difficulties, such as the loss of a relationship or not achieving something in school or activities, and being unable to cope with the setback.

Although less common than the three risk factors described above, some interviewees noted a "frontier," "bootstrap," or "Western" mentality as a risk factor for youth and adults - that individuals do not discuss their problems and do not reach out to traditional mental health services. Rather, people deal with their problems on their own. Associated with this bootstrap

mentality, interviewees described the easy access to lethal means, particularly firearms, as a risk factor, noting that this mentality has been passed down through generations of families within each of the counties.

The effect of being exposed to adult suicides and/or of having a family member die by suicide was also noted among interviewees in all counties. Some interviewees described their belief that the adult suicides in the community have had a significant impact on youth, and that perhaps this impact has been underestimated. Additionally, regarding both the question about risk factors and the question about barriers to suicide prevention, some interviewees responded that parents do not believe or recognize the suicide risk for their children.

Lastly, the experience of adverse childhood experiences (ACEs) [36] and high rates of substance abuse in the communities were described as risk factors by some interviewees across the four counties.

Protective Factors

The types of protective factors described by the key informants are consistent across the four counties, but there are differences in how these factors are applied. Interviewees often described resources or youth suicide prevention efforts in the community when discussing the protective factors for youth suicide. The resources include school-related assets such as school counselors and increased school-based mental health support services; extracurricular activities such as sports or agencies such as the Boys and Girls Club and 4-H; various suicide prevention and intervention efforts in the community; increased collaborative efforts of the public health departments; and increased cooperation across agencies.

The degree of access to these types of programs varies in each county, and even within these counties. For example, towns in La Plata County were described as more dispersed and less integrated. Where one town has a resource such as the Boys and Girls Club, another does not. There are similar issues in Mesa County. Interviewees in each of the four counties also shared that extracurricular programs are not available to all youth in the community because of cost and time to travel (i.e., parents work and cannot drive youth to activities or using the school bus to travel home prevents the youth from participating). In some cases, only competitive sports are available, to which generally only top performers have access.

Two additional sources of protection described by interviewees were churches/faith-based activities and Colorado's natural outdoor resources. Churches provide many youth-focused activities and can provide a space for interpersonal interaction. Interviewees described the positives of church-based activities; yet there were also concerns that faith-based organizations might promote a stigma toward suicide and may not be seen as accessible by all youth – LGBTQ+ youth in particular. Lastly, all the communities described Colorado's natural resources as a protective factor that is being underutilized by families and institutions, again partly due to prohibitive costs (i.e., buying camping equipment or ski lift tickets), as well as geographic accessibility and transportation.

KEY STAKEHOLDER INTERVIEWS
FINDINGS

Facilitators for Suicide Prevention

Facilitators for suicide prevention across the communities are similar, with varying levels of application across counties [37]. Interviewees from each of the four counties described that there are high levels of support for youth suicide prevention – whether it is coming from the intra-organizational level, cross-agency collaboration, or, in some counties, general community members. Communities have initiated collaborative efforts to maintain the momentum and interest to prevent youth suicide. This is occurring through efforts such as a summit to share best-practices (La Plata), continued and/or increased public health department coordination (El Paso and La Plata) and continued and increased community collaboration (Mesa).

A sentiment expressed by interviewees in all four counties was that stakeholders are interested in improving their postvention and primary prevention activities [38]. Most interviewees described the importance and need to do primary prevention with individuals and families across the life-span to make a real and long-lasting change in suicide risk and rates. This topic was explicitly described by many interviewees in addition to themes around ACEs, substance misuse, deficiencies in personal pro-social and resilience competencies, etc.

Youth participation in preventing suicides is described as an opportunity in some communities and as an activity that has already started in others. Many of the key informants interviewed are experienced suicide experts and recognize that the role of youth in suicide prevention needs to be better defined and understood. One interviewee stated that while youth need to understand that they are not the mental health professional, they are an important gatekeeper.

> "Kids are tired of grieving, they've been so impacted. If someone says something, the kids are not ignoring it."
> – Key Informant

Barriers to Suicide Prevention

The consensus across most key informants interviewed in all four counties is that there are not enough resources to effectively implement youth suicide prevention, intervention and postvention activities. Each county faces a lack of resources and funding for public health and social services programs. Additionally, there is a dearth of mental health providers in these communities and, in particular, a lack of mental health providers who accept Medicaid (or who do not significantly limit the number of Medicaid patients they will see), who work specifically with adolescents and who have training and experience working with suicidal individuals. In communities that have more mental health resources, very few providers are trained to work with youth or the providers only accept adults.

Inter-organizational barriers were also described by key informant interviewees in all four counties. Some interviewees noted that trainings often are planned, publicized and conducted by organizations without the knowledge of other agencies in the community. A lack of equitable distribution of resources across agencies also was noted. Some interviewees described insufficiency in formal, robust referral protocols or hand-offs between agencies for an identified at-risk person.

Further, some interviewees felt that the collaboration between agencies in a community is based on the relationships agencies already have, but this collaboration does not extend to all community-based organizations. For example, one pediatric office may have a strong referral process with a mental health resource center, yet another pediatric office in the same community may not have that same referral resource. A few key informants described limited collaboration due to territorial silos; however, they went on to say the challenges may be more about competing/conflicting agency policies and payment/funding structures. In La Plata County, some key informants felt there was a lack of collaboration between community agencies and the Southern Ute Tribe located in the area, as well as other Native Americans living in the area.

> "When it comes to youth suicides, it's the parents that are our biggest challenge. To get them to understand the landscape of the crisis that their kid is in."
> – Key Informant

Stigma associated with help-seeking – noted in the Risk Factors section as the "bootstrap mentality" – was described by most key informants interviewed as a barrier to effective suicide prevention. Across the four counties several interviewees noted that stigma against or by specific populations thwarts prevention initiatives, and that stigma against LGBTQ+ individuals limits the places and resources from which those individuals seek help. Additionally, interviewees indicated that Native American and Hispanic populations often do not reach out to the formal resources that the interviewees provided. Interviewees from all four counties stated that the Gun Shop Project, through which gun retailers promote messages of storing guns elsewhere if a family member is suicidal or has tried to kill him/herself, is active in their communities and has been relatively well received. Yet there still is resistance to the idea of locking up firearms among some community members in these counties. The taboo around the notion of "gun control" versus safe gun ownership was noted by some interviewees as a barrier to suicide prevention because safe gun ownership is perceived by many in the community as "gun control."

A barrier that was directly addressed in El Paso County, and referenced by key informant interviewees in the other counties, is the general public's misunderstanding of the public health approach to suicide prevention. A public health approach is focused on population level change and includes surveillance, the identification of risk and protective factors, and the development, implementation and evaluation of effective interventions. Due to the sense of urgency felt by these community members, there may be a lack of understanding or support for the need to examine the influence on suicide. There may be a lack of understanding that suicide is inherently complex and will not be eliminated by any one strategy or by one agency standing alone. Interviewees felt that there is a lot of pressure and blame placed on community-based agencies, especially schools, when youth suicides occur. Some interviewees expressed that the public demanded an "overly rapid response" to stop the suicides in the communities without a full understanding of safe and effective responses following a suicide (called postvention), as well as the appropriate timing of prevention activities.

KEY STAKEHOLDER INTERVIEWS

FINDINGS

Additional Resources Needed

Although the communities have different levels of collaboration and resources, the additional resources key informant interviewees expressed they want to see are very consistent. Interviewees across all four counties identified the need for more people to be trained as gatekeepers [39], not just individuals in youth-serving agencies, but parents/family members, more school personnel including ancillary staff such as janitors or youth peers, and the public. Interviewees also recommended implementing "booster sessions" - reaching back out to previously-trained individuals to reinforce key learning points and update them on referral resources. Finally, they also identified the need for training adults and parents about how to speak with youth about suicide.

Interviewees in all four counties described opportunities they see to build resilience in young people. This includes improving interpersonal interaction skills and teaching skills to better navigate a social media environment. Prosocial, peer-to-peer activities for youth need to be increased and better resourced. Interviewees expressed that programs need to be accessible both by way of transportation and cost. Interviewees also shared that access to affordable and varied levels of mental health support must be increased.

An additional need mentioned by some interviewees is for consistency in the policies and procedures for helping and referring identified at-risk youth, including support for youth in the aftermath of a suicide death or attempt. Along with consistency in policies and procedures, some interviewees expressed the need for a standard, shared screening tool so that identification and support could be standardized, and youth would not slip through the cracks. Finally, some interviewees expressed that postvention plans also need to be formalized between and among agencies.

Key Informant Interview Summaries by County

The key informants interviewed from each county described unique attributes and circumstances of their communities as reflected below.

> "We need to learn how to work together to take the next steps." – Key Informant

El Paso County
In El Paso County there is consensus about the great coordination that the public health department is providing. Interviewees feel that all the right agencies are present yet expressed that efforts have reached a point where a more significant level of collaboration between agencies is needed. A theme that continually emerged is the need to move from having meetings and discussing issues to taking concrete action and implementing initiatives. Key informants in each of the counties were asked to list agencies that provide prevention and support services. El Paso had the most consistency in terms of the list of agencies that the interviewees named that provide prevention and access to support services.

La Plata County
La Plata County key informants described two facets about the county: 1) a disconnection between the communities in the county – different communities have different resources and see themselves as unique; and, 2) for Durango, there is a struggle with identity - identifying as a small, close-knit, mountain town versus being a tourist or retiree destination with a transient population. This identity struggle may be compounded by economic disparities in the county. The services and resources listed by interviewees were done so with a designation of which community has and does not have them. The services are not equally dispersed or accessible. Many interviewees described a tension between providing limited resources to sustain the tourism economy and resourcing community prevention services and more prosocial activities for youth.

Mesa County
Mesa County key informants described the historical and strong collaboration that exists among agencies in their community. They also described the highly organized coordination between the groups. The recent cluster of youth suicides had increased collaboration and the drive to address the problem.

La Plata and Mesa Counties
Two similarities between La Plata and Mesa Counties arose in the key informant interviews. Interviewees described an interest in understanding if residents are amenable to raising municipal taxes to support prosocial and prevention programs. Interviewees in both counties described the lack of overall municipal funds in their communities and what funding is available is designated to other purposes (which they acknowledged are also important). The second similar theme is the barrier resulting from their locations in Colorado. Interviewees in both counties described that the closest services that could support youth are across state lines, yet interstate referrals generally are prohibited due to laws and payer restrictions. For example, there are resources that are closer and easier to reach in Utah or New Mexico, but an individual on a non-voluntary hold cannot be transferred from Colorado to an out-of-state facility.

Pueblo County
Pueblo County key informants described the long-standing, intergenerational ties in the community as a protective factor. There are large extended families who have lived in the county for generations, so there is an increased sense of identity within the community. This is also the only county that described the media as consistently reporting on suicides in an appropriate manner.

KEY STAKEHOLDER INTERVIEWS
FINDINGS

Recommendations from Key Informants for Conducting the Focus Group

1. Communities are still grieving and focus groups needed to be sensitive to that.

2. There has already been a lot of outreach asking about the causes and possible solutions to the problem, thus focus groups needed to build on what has already been asked and what has already been uncovered.

3. Inclusion of more and different groups and people would be important, as there is a sense that the usual agencies are the only ones participating.

4. Focus group questions should ask about what is working and how to expand on this, rather than only asking about what is not working.

5. Focus group participants should be asked what resources they believe are needed to move to the next level of suicide prevention work.

6. Focus group participants should be asked about their responses to the media reporting of suicides and prevention efforts.

Each of these four counties remain sensitive to discussing the specific suicides that occurred, and there is still great trauma and sadness. As the focus groups were scheduled, key informants noted that the facilitators needed to be aware of and sensitive to any family members of a person who died by suicide participating – even if that participant was serving as a representative of an agency and not as a family survivor. The response to these deaths has included many focus groups, meetings, and reports over the past two years. Knowing what was said and the results of these previous activities was critical for the facilitators. Interviewees noted that their communities would want to know that what they share is being used, and any recommended initiatives should build on what communities have already done in terms of prevention and postvention efforts.

Key informant interviewees in each of the four counties stated youth have provided input on the issue of suicide in the past to varying degrees, but they needed to be included as part of the solution and given a role in the focus groups. They expressed that too often youth feel things are happening to them, not with them. Some topics that the interviewees suggested to cover in the focus groups included how to get youth to utilize and refer to existing mental health and suicide prevention services and how can adults and institutions provide better or more support.

Interviewees in each of the four counties also expressed interest in parental participation. Some topics for parental focus groups suggested by interviewees included how parents discuss resilience, mental health and suicide with youth, and what will increase participation in parental gatekeeper trainings and other activities.

COMMUNITY FOCUS GROUPS

BACKGROUND & APPROACH

The focus groups were designed to allow participants to interact in a discussion of their perceptions and opinions about youth suicide in their communities. The objectives of the focus groups were to: (1) Gather participant input, opinions and concerns to better guide successful establishment of recommendations for effective suicide prevention; (2) Engage youth, parents, school staff, leaders from local youth-serving organizations and other key community members working on, or impacted by issues related to youth suicide, to better understand common and unique ideas, opinions and attitudes about youth suicide and youth suicide prevention resources and; (3) Understand the climate, attitudes and perceptions around existing risk and protective factors related to suicide and mental health within each county.

Focus group facilitation teams each consisted of three HMA staff, two for active listening to the feedback and facilitating the discussion, and one focused on taking notes and capturing the general sentiment of the discussion. For parent and youth focus groups, HMA ensured a locally-known and recommended behavioral health provider was on-site to attend to any participants that wanted or needed assistance. Recruitment was supported by engaging local stakeholders and existing groups, and there was a concerted effort made not to recruit focus group members who had been directly impacted by a recent suicide (within the past year). Additionally, HMA provided a comprehensive list of local behavioral health resources that was shared at each focus group to provide support to focus group participants.

COMMUNITY FOCUS GROUPS

BACKGROUND & APPROACH

Group facilitators combined the technique of open communication, asking open-ended questions and allowing for conversation between participants, with careful listening and observation. Although a dedicated team member was taking comprehensive notes for each group, participants were not identified specifically. Additionally, the analysis of the notes was summarized in aggregate to ensure no individual identifying information was included. Thirty-four focus groups were conducted across the four counties. Different groups were held for parents, youth (high-school age only), school administrators, other school staff (separate from administrators), individuals from organizations that serve youth and community members interested in or engaged in youth suicide prevention activities (e.g., faith leaders, law enforcement, medical and behavioral health professionals, etc.). Additionally, six parent and school staff focus groups were conducted in Douglas and Larimer Counties as comparison communities. These counties are demographically similar to the counties that were the focus of the project and did not experience recent youth suicide clusters and/or have comparatively lower youth suicide rates. The focus groups conducted in these counties identified differences between the counties of focus and the comparison counties. The Focus Group Guide used by facilitators can be found in Appendix F. HMA ensured confidentiality of focus group participants to facilitate open sharing of thoughts and feelings in response to the questions asked and the discussion of the group. The table to the right shows the number and type of focus groups held in each community.

Analysis of the focus group notes was conducted using the qualitative data analysis software, NVIVO (v.12). Initial codes were developed in tandem with the Focus Group Guide. Additional codes were developed as themes and topics emerged in the coding process. As new codes were developed, a review of previously coded transcripts was conducted to ensure the new codes were applied to them as well. Analysis of transcripts was completed by a qualitative researcher with extensive experience in implementing and evaluating youth suicide prevention initiatives in Colorado and other settings. Draft analysis of findings was reviewed by focus group facilitators and the qualitative researcher for clarification, refinement and additional context.

Analysis of the focus group information is organized similarly to how the Focus Group Guide questions were structured and capture themes across all or most of the four counties, as well as all or most of the types of focus groups held. Following this, themes are presented across focus groups within each county.

FINDINGS FROM FOCUS GROUPS

The findings below denote the perceptions, opinions and ideas of the individuals who participated in the focus groups in each of the four study counties, and in the two comparison counties.

Impact of Youth Suicide on Communities

"Our town is in pain." – School Staff

Participants in every focus group described the profound effect youth suicide has had on their communities. The words used include tension, worry, fear, devastation, shock, confusion, paralysis, exhaustion, urgency, desperate, surrender (people

Table 1. Focus Groups by County

County	Focus Group Participants	Number of Groups
El Paso	Parents	3
	Youth	4
	School Staff	3
	Community	3
	Youth Serving Organizations	1
	Total	**14**
La Plata	Parents	2
	Youth	2
	School Staff	1
	Community	1
	Youth Serving Organizations	0
	Total	**6**
Mesa	Parents	2
	Youth	3
	School Staff	2
	Community	2
	Youth Serving Organizations	1
	Total	**10**
Pueblo	Parents	0 *
	Youth	1
	School Staff	1
	Community	1
	Youth Serving Organizations	1
	Total	**4**

*Difficulty engaging Pueblo parents during the time of the study

in caregiving roles leaving their jobs) and flight (parents un-enrolling their children from schools or outright moving to other communities).

Perhaps most troubling as a theme is the perception among participants that suicide is starting to seem normal in their communities. Some youth and adult participants expressed that suicide has become a conceivable option. Youth participants conveyed there is a sense among some youth that if others (both adults and peers) could not get help for their problems, then they wonder how they would be able to get help.

Compassion fatigue

More than one focus group included the phrase "compassion fatigue," particularly for professionals in the middle and high schools. This included a sense of numbness and a sense of helplessness, with suicide attempts and deaths seeming like an inevitability. Youth and adults described some youth as being jaded and making light of suicidal behavior on social media by responding to peers with "JKY" (just kill yourself).

Fear

Parents, school administrators, teachers and school counselors described a sense of fear. For parents there is a fear that their own child(ren) might become suicidal. Compounding the problem, they also expressed that they don't feel prepared to deal with such a significant issue. School staff describe being in a constant state of crisis response and feeling that with social media it is difficult for schools and communities to be prepared

COMMUNITY FOCUS GROUPS

FINDINGS

with a response to a youth suicide. From the perspective of youth participants, the response from adults when there has been a suicide is confusing and inadequate. Youth focus groups across all four counties expressed a strong desire to have authentic relationships with adults with whom they connect and feel comfortable. When there has been a suicide death, or any kind of crisis, youth said they are not likely to talk about their feelings to an adult they don't know or with whom they don't have a connection. They sense that adults are fearful of saying the wrong thing, and unfortunately this leads to no conversation about suicide at all, or an intense reaction where conversations feel like an inquisition of one's potential suicidality. Some youth describe a change in the mood of classes and curriculum and a fear of discussing difficult topics out of a worry that the discussion may contribute to or trigger students who are suicidal. Youth said they feel that this fear may alienate students by sending a message that they cannot discuss things that are troubling them because these subjects are taboo to adults. Youth in several of the focus groups also indicated that they feel as though they are expected to act like adults and perform like adults (e.g., be successful in school, in extra-curricular activities, etc.) yet they are not always treated like adults or given the "credit" for being capable of handling more.

Secondary and ongoing trauma

Across every focus group with school staff and in some of the parent groups, participants expressed concern about the extreme levels of stress, dread and loss experienced by teachers and counselors. In one county, school staff voiced being so worried about there being a suicide death that each time an impromptu or short-notice meeting was called, leadership would state that it was not to announce a death to avoid re-traumatizing the staff. Participants noted that initially after the first several suicides, there was external blame and responsibility put on schools. Schools were often criticized as being non-responsive or not responding appropriately after suicides occurred. This compounded the fear and ongoing sense of dread experienced by school staff. School staff in most of the focus groups indicated a need for greater support and training, particularly for staff who are not clinicians or counselors, in dealing with suicidal crisis in the schools.

Community Perception and Response to Youth Suicide

Community response to fatal and non-fatal suicide behavior

In many focus groups, participants said there was increased community awareness and interest in preventing suicide because of the youth suicide clusters. More people were seeking information about the risk factors, warning signs and available resources. Many communities held summits, forums or invited speakers, and all events had high turnout. Across communities there seemed to be increased interest and involvement on the part of a variety of organizations. While this increased attention to the issue is positive, participants in each of the communities shared the concern that once the initial outcry for a response subsides, there is no lasting momentum. There was a sense that it is too easy to go back into the status quo until the next crisis occurs.

Stigma and taboo

"If we were openly talking about it we could change a generation." – Youth

Across the four counties that were the focus of the project, and in every focus group, participants discussed the stigma and taboo of suicide, and mental health issues in general. In El Paso, Mesa and La Plata Counties, participants agreed there is pressure for parents and youth to appear perfect, and youth in these counties expressed that it feels like no one can show they have problems. In Pueblo County and rural El Paso County, participants discussed a strong culture of secrecy and not sharing problems outside of one's family unit, as opposed to the culture of appearing perfect and problem-free.

Many focus group participants felt that the stigma around mental health issues and suicide is creating a sense of isolation in these communities. Youth and parents expressed there is a sense among their peers who may be struggling with mental health issues that they are the only ones who are struggling. Some youth participants described learning how to just "tolerate" distress and to "shove it underground" from adults who make these issues seem like something they should not talk about. Participants shared that families that experienced a suicide attempt or death often were seen as "tainted" and shunned by others in the community, instead of receiving resources and support. One youth described this as the "casserole" effect - when something bad happens the community rallies and brings casseroles, but with suicide deaths or attempts "it's crickets" - meaning no one is talking about it and no one is bringing casseroles.

The need to reduce and remove stigma from families who experience suicide was highlighted in each community. Participants said that for smaller communities within these counties (i.e., town or neighborhoods) the interconnectivity compounds the stigma, as community members are worried about everyone knowing their business.

By contrast, in the comparison communities (Douglas County and Larimer County), focus group participants expressed that there is a willingness in the community to discuss suicide and the stigma around mental health issues seemed to be abating – that although stigma is still an issue, more people were talking about mental health.

Factors that Increase Risk of Youth Suicide

Pressure and anxiety about failing

The risk factors related to youth suicide described by focus group participants were consistent across the four project counties, as well as in the comparison counties. The risk factor described the most consistently (more pronounced in El Paso, Mesa and La Plata counties) is pressure, mainly related to academic performance, but also performance in extracurricular activities. This pressure included feeling that the expectations placed on youth were unrealistic and youth were not given the

COMMUNITY FOCUS GROUPS
FINDINGS

tools to manage the pressure in a healthy way. The amount of homework and expectation to get good grades, coupled with expectations to succeed in sports or other activities is overwhelming; however, youth express that they are also managing information overload via the internet and social media, and other stressors inherent in our current culture. These stressors include school shootings, relationships and sex, divorce and substance use.

"Kids in this community are not allowed to appear to have any problems. They are not allowed to fail, and not taught that failure is okay or how to get through it. They are not allowed to appear weak. These kids think, 'I don't want to disappoint my parents anymore. Failure is not an option but suicide is." – Parent

Across adult and youth focus groups in El Paso, Mesa and La Plata counties, participants describe the pressure to succeed, to be in advanced placement classes, to excel in activities and to fit in as coming from both parents and peers. One focus group participant explained the term "bulldozer parent" as a parent who invests all their time and effort to making their children the "very, very best" at everything. A consequence of this is that their child(ren) cannot handle the pressure to never fail. The bulldozer parent does not allow space for their child to make mistakes and – more importantly – learn how to fix mistakes on their own. The idea that youth are not equipped to fail and are not resilient in the face of challenges came up across many focus groups in El Paso, Mesa and La Plata counties, as well as the comparison focus groups in Douglas County. Participants expressed concern that youth don't have the ability to handle failure or rejection because from the time they are very young, adults always step in to fix everything.

Along this same vein, youth and adults across the four counties, but particularly in El Paso, Mesa and La Plata, expressed that they believe there is a lack of time and opportunity for youth to learn or practice self-care. For example, they noted that typically emotional needs come after performance in order of importance. Youth have no time to decompress and no break for their brains, especially with the current bell-to-bell instruction in most schools and the pace of extra-curricular activities such as sports.

Social media and cyberbullying

Another common theme around risk factors, described across all focus groups in each of the project counties and comparison counties, was the use of social media. Both adults and youth described young people as always being connected to their phones, plugged into social media accounts or texting. Adults expressed concern that youth are sleep deprived due to their need to be connected at all hours. Youth expressed anxiety about missing out on something if they are not monitoring their social media presence.

"There is a gap between who you are and what you are supposed to be." – Youth

Youth and adult focus group participants felt that youth use of social media is limiting their face to face interactions with others, while at the same time making them feel connected to many more

people through sites like Instagram or Snapchat. This increased connection can lead to exponentially more opportunities to be impacted by the emotional lives of their peers and makes managing the spread of harmful information impossible. However, social media and online gaming are primary sources of social connections for youth, which poses a challenge for parents who want to limit youth use of technology but don't want to limit the youth's sense of connection to peers.

Youth expressed feelings of anxiety about the image that must be maintained on social media. Mistakes that youth make feel magnified when posted on social media and this can be made worse when parents get involved, weighing in on teen dramas via social media themselves. Youth feel pressure to put forward only their best self, which leads to feelings for inadequacy and loneliness. Adults, too, admitted to feeling and succumbing to the same pressures about putting one's best self on social media, even when it is not an accurate depiction; perhaps modeling that our authentic, albeit imperfect, selves are not good enough. There is a perception that everyone is happy and healthy which creates a false reality in which youth fail to learn that sometimes people are unhappy, and that unhappiness is not an uncommon or unacceptable feeling to have.

"On social media, we can say anything we want and get away with it. You can destroy someone in a text and there is no lash back {sic} to you. Destroys both the person doing it and the person you are doing it to." – Youth

Of additional concern with social media and technology overall is cyberbullying. Youth and adults from focus groups across the project counties described cyberbullying as a risk factor. Multiple participants expressed the fact that youth who are experiencing bullying cannot escape the harassment as it continues after school hours on social media or via text message.

Finally, several participants said that easy access to the internet and social media means that youth have easy access to information, both positive and negative, about the world around them. Access to information can be an empowering and beneficial thing. However, many adult focus group participants expressed concern that the information youth access is often adult in nature, with violent or disturbing content, and youth lack the skills and support to consume this information in a healthy way.

Sense of judgment or lack of acceptance in the community

"You have to be a certain type of person to find comfort here." – Youth

A sense that the community is not accepting of differences or is judgmental was also expressed across many focus groups in the four counties but was discussed much more in El Paso County and Mesa County. Youth explained that some people are afraid to be who they are, and that youth are growing up in a culture that expresses more harsh judgment, belittling and a lack of acceptance, let alone tolerance, of people who are unlike the norm in the community.

COMMUNITY FOCUS GROUPS

FINDINGS

Of concern is the lack of acceptance of youth who identify as LGBTQ+. Youth and adults described increased bullying of LGBTQ+ youth by both peers and adults within schools, a lack of response by schools and other youth-serving institutions, and routine, systemic isolation of these young people.

> "The intolerance mirrors polarization in the nation." – Community Organization

There was also discussion within several focus groups in El Paso and Mesa County that if one did not identify with the majority political affiliation or majority religion, there was a sense of intolerance and alienation. Youth and adults expressed finding hypocrisy in these communities where they feel the political/religious values espoused by the community are not put into practice. However, in Mesa County, a few of the participants noted that pastoral staff from a variety of churches in the county have come together specifically around finding ways to help prevent youth suicide and support families and their children. It was noted that this group included churches that espouse both more "conservative" values, as well as those considered more "liberal." In the comparison communities this sense of judgment or lack of acceptance was not expressed. In Douglas County, parents discussed the perception that youth have a high level of political awareness and awareness of the current animosity expressed between political affiliations, but that this does not result in the lack of acceptance or judgmental culture.

Lack of connection to a caring adult

"There is a lot of space between kids and adults."
– Youth

Youth participants across the four counties described a deep desire to have authentic relationships with adults, which they noted may seem counter to what adults, especially parents, often believe-which is that their teenagers want very little to do with them. Youth often just want to spend time with the adults in their life without feeling pressure to do or be anything, or adults trying to "fix" them.

When it comes to discussing difficult topics with adults, youth across all communities shared that they do not often experience these interactions as authentic or helpful. Youth are concerned that adults will "freak out" or overreact and not listen. Within schools, youth want to talk with someone they have a connection to, which is often not the counselor to whom they are sent. Also, youth said they often just need to talk something through but don't want to feel like they are the subject of an inquisition and don't want to jump right to a suicide risk assessment. Youth expressed a wish that adults could just be with them in their pain without jumping to assessments or solutions, but rather just trying to understand. Youth participants felt that adults do not understand what youth are dealing with and just need to listen.

> "Instead of talking at kids, talk with kids." – Youth

Along this same vein, youth in focus groups across each county expressed frustration that adults, most often parents, tend to minimize their problems and pain. Youth described feeling disheartened when adults tell them to "raise their voice" or speak up about issues that concern them, but then adults shut them down when they do. Some youth shared that they wish adults would be proactive and notice when youth need help or just a connection with an adult. They described times when they were feeling sad and no one noticed, or adults thought that they were "faking it" or trying to get attention - as though needing attention was a bad thing. Additionally, across both adult and youth focus groups there was discussion about not addressing problems until they become a crisis.

> "No one hears unless you scream." – Youth

This lack of authentic connection was especially felt in the aftermath of a suicide. Youth and school staff focus group participants expressed that school administrators may have unintentionally created a barrier between youth and the adults that youth would identify as someone with whom they could talk. For example, to provide safe postvention support, they may have focused too much on sending students to see a crisis counseling team member rather than allowing them to connect with a trusted teacher or support staff in the school, in addition to a professional mental health provider.

Youth focus group participants said when youth have established relationships with trusted adults, they will go to those adults for support when they need it. Building that trust requires time and a willingness and capacity to talk with youth about difficult subjects. In one comparison community, Larimer County, there was a stark contrast with the focus counties studied for this project. For example, in Larimer County, it was shared that there is an established culture and set of practices around building strong youth-adult connections in the Poudre School District, including a handout for staff on how to connect with students through conversation.

Lack of prosocial activities

Youth and adult focus groups across all four counties described a need to fund, increase and improve the social recreational activities provided to youth and build awareness that prosocial activities can be protective against suicidal behavior in youth. Where these resources exist, access often is an issue due to transportation or affordability. This affordability isn't restricted only to registration fees. Participants described situations where youth have not been able to participate in activities because of the cost of equipment or uniforms, or because they had no money for associated activities such as post-event meals. Again, by comparison in Larimer County, a focus group participant stated that recreation centers were easy to access and offer reduced fees to make activities more affordable. This could be related to many factors, including community views on tax policies related to the support of social programs and services [40].

COMMUNITY FOCUS GROUPS

FINDINGS

Substance use, mental disorders and availability of behavioral healthcare

"We don't have the capacity to respond until the crisis hits- it's like waiting until the tooth explodes before going to the dentist." – Community Member

Across all counties and groups, substance use and abuse, as well as depression and anxiety, by both youth and caregivers were also commonly discussed risk factors contributing to suicidal behavior in youth. Alcohol, marijuana, prescription pain pills and heroin were noted most frequently. Often substance abuse was described as generational in scope, yet because of the stigma related to these issues and challenges in accessing behavioral health care, it is underdiagnosed and undertreated.

Focus group participants across all four counties described challenges around accessing youth behavioral health resources- both in and outside of the school setting. Many focus group participants expressed that there are resources when there is an immediate crisis, but resources are more limited when people are seeking help to prevent a crisis or when there is an ongoing need in the aftermath of a crisis. Participants described a shortage of providers, high staff turnover at the community mental health centers and long wait times. Some participants said there is greater availability of services for children and youth covered by Medicaid, but fewer options for those with private or no insurance, as many non-Medicaid providers do not take insurance. In each county, access to inpatient behavioral health care for youth is a significant challenge - there are either no adolescent treatment units or beds available, or inpatient facilities are located a significant distance away.

Many school and parent focus group participants across the four counties expressed frustration with community mental health centers, describing a lack of communication between schools and providers, a lack of understanding about how the system works and what families should expect, and a perceived or real lack of follow up or aftercare plan. Most of the participants expressed a desire for more mental health professionals embedded in the schools to make access to care and follow-up easier.

Adult suicide

Adult focus groups in all four counties expressed that adult suicides are just as prevalent as youth suicides, but do not receive the same level of response or resources. Traditionally, youth suicide prevention and adult suicide prevention have been addressed somewhat separately. Focus group participants discussed that perhaps there hasn't been enough attention placed on how adult suicides in the community are impacting youth, especially the risk that adult suicides are normalizing and modeling suicidal behavior. Some participants described the root causes for adult suicides including the economic "boom and bust" experienced in some of these communities, male gender norms that endorse not talking about emotions and the Colorado culture or "Western Mentality" of solving your own problems rather than seeking help. There were no resources described by participants specifically for youth who experienced the suicide death of a family member. In one focus group specifically, there was an overt admittance that there is "uncertainty about how to best support the kids who are left as survivors of suicide loss."

Additional risk factors of note

Although not a theme expressed across multiple focus groups or across all four counties, two factors were mentioned more than once among adult participants in more than one county that warrant mentioning and further examination. Concussions resulting from injuries in youth were thought to be related to some of the suicide deaths in the counties studied for this project. Parents expressed a desire to know more about the relationship between concussions and suicide risk and a wish that health care providers were informing parents about the potential risk.

The other factor raised by some focus group participants was the risk of the transition between middle school and high school. This was described as a time when the academic and extracurricular performance pressures increase but the support decreases significantly.

Factors that Increase Protection Against Youth Suicide

Focus group participants described existing protective factors such as case management to help navigate support systems, trained school staff, community-based programs for youth to access and programs like Sources of Strength, an evidenced-based youth suicide prevention program.

Focus group participants also noted protective factors around access to prosocial activities such as sports, band and after-school activities in general. Participants in Pueblo, El Paso and La Plata counties reported that these activities are available, but there is a need for increasing access to them through things like registration fee assistance and/or transportation. Participants also noted that groups not tied to academic achievement are also needed – for example, if a student is not making good grades, they lose the opportunity to stay engaged in sports. Additionally, groups and activities for youth outside of school or school sports have been successful in engaging youth, such as a group for LGBTQ+ and allied youth. These types of groups increase connectedness to more peers and caring, positive adults.

The natural environment surrounding these four counties was named as a protective factor, but also with the caveat that access to things like hiking, camping, skiing, and other outdoor activities can be a challenge financially and in terms of transportation.

"We need to create bonds outside, in addition to school so that you can find where you belong." – Youth

COMMUNITY FOCUS GROUPS

FINDINGS

Suicide Intervention and Prevention Activities

"We are putting band aids on huge tears."
– School Staff

One theme that was consistent across all of the focus groups in the four counties and comparison communities, as well as all participants (youth and adults), is who youth turn to for help. Youth are turning to their peers first and primarily. However, in communities where the pressure to be successful is highest, youth participants said that they do not seek help from anyone. Yet they also described that, increasingly, when youth are worried about a friend they will seek help from adults. Concerns are being raised not only by direct interaction, but by social media posts. Peers can take screenshots of posts and use the screenshots to make a referral to a school counselor, Safe2Tell or other crisis support services.

Youth, by their own description and by what the adults are seeing, are using Safe2Tell. Participants across youth and adult focus groups see Safe2Tell as a trusted and respected resource; however, some concern was expressed about youth misusing Safe2Tell to either get out of school or to misreport another youth as a form of harassment. Youth in some of the focus groups stated that they do not admit to their peers that they would or have used Safe2Tell as there is some stigma among youth about using it. Even though Safe2Tell can be misused and might be somewhat stigmatized, it was clear from focus groups that it is being used as a resource.

Youth across all focus groups stated that they are not likely to use a 1-800 help line and would be hesitant to utilize a text line (although this was a preferred resource over calling a help line). Youth stated in many ways that they want to talk about these issues with someone they know and trust, although they expressed that they would rarely turn to parents for help and identified several reasons for this. They are worried that parents will overreact or under-react or be disappointed if their child is depressed or needs help. In many of the parent focus groups, participants expressed feeling unprepared for how to help their child who may be suicidal, or who come to them for help with a friend.

Youth participants across every county communicated that they do not feel equipped to help their friends, yet they have a desire to be trained in how to help. This was echoed in many of the parent and school staff focus groups, as well. Adult and youth participants feel that youth should be trained in suicide intervention, and that this should go beyond just finding an adult to help.

Adult and youth focus group participants across all four counties identified Signs of Suicide as the gatekeeper training being implemented in most schools. Although some adult participants felt the training was useful, often, the curriculum was described as outdated and irrelevant, and some youth and parent participants even found the training to be harmful, triggering past suicide-related trauma from the program's videos. Sources of Strength, an evidence-based program that uses peer leaders and a strength-based approach to prevent suicide and substance use, is currently being implemented in some high schools in the project counties with additional sites implementing in the future. Youth and adult focus group participants felt positively about this program and were especially grateful for the way in which the program engages youth from different groups to participate as leaders. Many youth group participants expressed a preference for programs that are youth led or youth driven. A good example of this type of program is Project Reasons in of El Paso County, a youth led initiative helping peers find reasons to live [41].

Across all groups, participants expressed concern with any classes or curriculum that are completed one time, or over short segments with no sustained effort. They also shared that the schools had held assemblies that were ineffective and voiced a strong preference for one-on-one or small group conversations about suicide. Finally, many participants shared a concern that while there is initial support for suicide prevention programs or education, that support loses momentum over time. Many youth focus group participants communicated frustration that these efforts seem to be mostly about adults looking like they are doing something to address the issue; it is "all about the words and not about the actions." Several youth and adult focus group participants referred to efforts to address youth suicide as putting a band aid on the problem, and they said they both want and need more than just a band aid.

Youth and school focus group participants expressed wanting to learn how to find joy in life but understand that it is okay to not be happy all the time. They want to learn how to cope with challenges and how to take care of oneself - strategies for self-care such as mindfulness. Regarding suicide intervention, youth want to learn how to ask about suicide, how to respond to someone in the moment and how to grieve and recover when there has been a loss. Youth and parents want to understand what will happen when they seek help for suicidal thoughts - how they navigate the behavioral health system and what they should expect.

"You are someone's favorite person, so build relationships and connect with kids." – School Staff

Focus group participants in the comparison county, Larimer County, noted that Poudre Valley School District trained every staff member in its schools in suicide intervention using the Question, Persuade and Refer (QPR) curriculum. This has been done at the high school, middle school and elementary school level for staff and all incoming freshmen to high school. QPR is implemented as part of and in addition to a culture that supports ongoing relationship building and engagement with youth.

COMMUNITY FOCUS GROUPS
FINDINGS

Returning to school following a suicide attempt

Across the four counties, school staff and youth focus group participants shared concerns with how schools support students returning to school following a suicide attempt or mental health treatment for suicidal ideation (a review of publicly available school policies related to suicide is provided in the School Policies and Procedures Section of this report, on page 27). From focus group discussion, there are procedures and policies in place for a returning student. However, participants expressed that these may lack the level of information and support to truly assist students, as well as support teachers in balancing academic expectations in the context of a student's return to day-to-day activities. Youth describe a mounting pressure while they are away from school to get help for their suicidality. This pressure makes it so that when they are back at school, they don't feel as though they got a break to take care of their mental health. Teachers expressed feeling like there were not realistic expectations for when students return regarding the work that they need to complete to catch back up with their peers. Further, teachers feel that it is unclear how flexible they can be in their efforts to best support a student and are equally unclear about what that student might need. In many of the schools, teachers are not allowed to talk with the students about mental health issues or suicide and are required to refer directly to school counselors, which puts up a barrier in their ability to support their students. Often this procedure/policy is in place to protect the confidentiality of the family and student, but it can present additional barriers to fully supporting a student's successful transition back to the school environment and re-engagement with trusted adults.

Resources

Focus group participants were asked about resources in the community related to suicide intervention and prevention. In all four counties and in the comparison communities, participants consistently named the behavioral health services but described the challenges with accessing these services as described earlier in this report.

A common theme expressed about community-based resources was that community members have a general understanding that there are resources, but there is a lack of awareness about what those resources do and how to access them. Participants also expressed that resources and community-based organizations lack coordination, citing duplicative and competing efforts. The main difference expressed between the counties was the level and coordination of community partnerships. Often, participants from community organizations perceived the level of accessibility and coordination to be higher than what youth and parents perceived. Part of this disconnect may be related to communication about resources, particularly a basic understanding on the part of families about how to access resources and what happens when you do.

Another common theme about resources expressed by professionals in the schools and community-based organizations across all four counties, was that community resources are patch worked and non-sustainable because they generally are grant funded.

The grant funding is often short-term and tied to specific outcomes or deliverables, making it both difficult to sustain and hard to braid or blend funding streams.

By comparison, parent and school staff focus group participants in Douglas County shared that Douglas County has a strong mental health coalition (Douglas County Mental Health Initiative) and perceive that there are coordinated efforts across sectors. Parent and school staff focus group participants in Larimer County also expressed the perception that there are strong relationships between their school-based (Poudre School District) mental health team and community resources, including warm handoffs for youth and families.

Focus Group Summaries Per County

This project focused on four study counties and two comparison counties. It became clear at the outset that within these counties there are distinct communities with unique challenges and strengths. This is especially true in El Paso County and La Plata County. It is important to point out that findings from the focus groups should be considered in the context of these differences within counties. For example, in El Paso County, many participants represented the northern part of the county, self-described as an affluent, religious community with a strong military officer presence. Other parts of the county are described as less affluent and having a strong enlisted military presence or are rural communities with a very different set of risks for youth. In La Plata County, most focus group participants were from Durango, which is viewed as a "big city" by citizens of Bayfield and Ignacio. The cultures, socioeconomic status and diversity in these three towns is very different. To a lesser degree these community distinctions were seen in Mesa, Douglas and Larimer Counties, and even less so in Pueblo. Below is a brief description of each of the four counties and the themes captured within and across their communities.

El Paso County

Focus group participants in El Paso County talked about several issues and characteristics they felt were unique to their communities. For example, the significant military presence was acknowledged by nearly everyone. Most, although not all, also noted the significant number of large Evangelical Christian organizations, particularly in the northern part of the county. Participants also said the size and diversity of the county – population demographics, geography, urban/rural, very affluent to very low-income, 17 school districts – made it more like a collection of communities, each very different from the others. For example, participants called out differences such as the more affluent, high-ranking military, evangelical influence in the North; lower-income, enlisted military and generational rural farming families in the South and East. Participants also suggested there are differences in family/school/community expectations of young people, again especially between northern and southern parts of the county. There was a strong sub-theme of many of the communities in the county not really being communities, a sense of, "there is no village – your hut is your hut," as stated by a school staff participant.

COMMUNITY FOCUS GROUPS

FINDINGS

Participants described a need for a county-wide, coordinated effort to address suicide that considers the differences across communities within El Paso County. This has already started, as participants described El Paso County Department of Public Health as providing a strong and helpful convening role, and the Board of Education and city council meet in joint sessions to address mental health. The types of partnerships that have started to form and need to be strengthened are between youth-serving entities – such as schools and non-profits – and mental health providing agencies. Youth-serving organizations are finding out about suicides from the youth or through the media instead of through the school districts or other partner agencies. This limits the ability of these organizations to respond quickly and appropriately. Educators also describe cases where a youth in crisis was released from a mental health hold with no notification to the school that the student was on a hold in the first place.

In Northern Colorado Springs, the pressure to perform and achieve that was discussed as a theme across the project counties was very pronounced. Youth and adults agree that youth are not learning how to take care of their mental health and that self-care is not a priority. Youth do not want to disappoint their parents and fear big consequences for their future if they make mistakes or fail.

Additionally, a theme heard in groups across all four counties that related to a lack of acceptance or tolerance for people's differences was also more strongly present in El Paso County, particularly so for LGBTQ+ youth. LGBTQ+ youth focus group participants described a range of experiences - from a lack of support, to alienation and harassment from adults in school settings. Fortunately, Colorado Springs has a strong community-based organization, Inside Out, which provides a safe place for LGBTQ+ youth to find support.

La Plata County

From the start in talking with focus group participants across La Plata County it was made clear that Durango, Bayfield and Ignacio are all very different and each has its own unique identity. For example, focus group participants in Durango described a community that is having an identity crisis and status is becoming more important. Some participants in the groups in Durango indicated that there is a more "permissive" attitude in Durango versus the other two communities.

> "Anything goes in Durango, but Ignacio and Bayfield are very different. People there view Durango as a kind of 'San Francisco' or 'Chicago' and they don't want to be like that."
> – School Staff

More pronounced in La Plata County compared to the other counties in the project, was the personal connection everybody feels when a suicide occurs because everyone knows each other. HMA attempted to recruit focus group participants who had not been directly impacted by a recent suicide in an effort to protect potential participants who were not ready to discuss suicide prevention. In La Plata County this was nearly impossible, as almost everyone has been directly impacted by suicide. This sense of everyone knowing everyone else also contributes to the stigma around seeking help for mental health-related problems. Focus group participants agreed that across the region, stigma around mental health and suicide is high, although it is improving with campaigns like "Let's Talk Colorado", the CODY Project and efforts of community-based organizations and San Juan Basin Public Health.

Participants also shared in a more significant way than other counties that access to behavioral health care is a significant challenge in this region. Individuals needing inpatient care must travel to Grand Junction or Denver. Access to a child psychiatrist is only available through tele-psychiatry. Waitlists are long for the community mental health center and follow-up care following a crisis is difficult to find.

Additionally, in La Plata County, several group participants reflected a more oppositional relationship with the media, with many expressing a perception that, despite efforts to work with and educate local reporters about how to appropriately cover suicides, there still was a feeling that coverage was sensationalized, hurtful and dangerous.

La Plata County participants discussed the number of resources and funding that are available in the county, but also discussed that these efforts tend to be insulated due to the geographic separation of the county's cities. However, there were significant bright spots regarding services and supports for youth, especially 4H, which was mentioned numerous times as being a valuable resource.

It is important to note that participation from Bayfield and Ignacio was low. In Ignacio, there were no participants for a parent or youth group. Community members explained that it is not easy to gain trust in these communities, especially in Ignacio where the Southern Ute tribe is located. As a result, the themes from this county are likely skewed toward Durango's culture and norms. An exploration of Bayfield and Ignacio, with time to build relationships there would be important to the identification of community specific risk and protective factors for suicide prevention.

Mesa County

In almost all focus groups in Mesa County, participants mentioned the area's "boom and bust" economy, and that it has been that way for many years. There was a perception that individuals and families can go from having nothing, to having everything, to having nothing again based on the market related to energy (coal, oil, gas). Related to this is a sense that there are two cultures here, the "haves" and the "have nots" and for youth without the financial means, accessing prosocial activities is very difficult. Many of the participants noted that there is a lack of access to affordable and available activities for youth in Grand Junction, and it is hard to get to places around town (e.g., on a bicycle or on the bus). For example, multiple participants expressed frustration that there is no recreation center in Grand Junction – whereas Fruita (also located in Mesa County, but 23 miles from Grand Junction) has a large center with a pool, gym and fitness equipment. A related sub-theme of many group participants was that there is a general resistance in the community to paying higher taxes to fund services and

COMMUNITY FOCUS GROUPS
FINDINGS

resources. Mesa County has the second-lowest funded school district in Colorado.

> "There's a perception that things are 'good enough.' So, saying there are not enough resources creates fear and hopelessness." – Community Member

Mesa County had the most consistency among community participants in their descriptions of the strength of partnerships in the community. This ranged across multiple sectors – faith-based, schools and community organizations. The two groups that were highlighted as not being involved but needing to be were parents and youth. Interestingly, parents and youth did not describe strong relationships across community resources and organizations. They believed there were plenty of helping resources, but that people don't know how to access them and that the resources were not coordinated.

Finally, there also was a strong sub-theme across the focus groups in Mesa County that suicide has just been something that has been a part of this community for a very long time. It has become part of the culture and history of many families, who also have experienced a lot of other generational trauma (e.g., domestic abuse, sexual abuse, alcohol/drug abuse, poverty, etc.). Coupled with a strong "pull yourself up by your bootstraps" mentality, this has led to many seeing suicide as just something that happens in Mesa County and people don't talk about it.

Pueblo County

Although Pueblo County shared themes with the other three counties that were the subject of the project, it was the most unique of the four. Known as "the littlest big city in Colorado," Pueblo is a blue-collar town where unlike other areas, families have spanned generations. Focus group participants here noted that the deep-rooted familial ties throughout Pueblo have created a unique interconnectedness which has resulted in a coinciding degree of secrecy. This culture of secrecy was a prevalent theme across the focus groups conducted in Pueblo and was evident in the youth focus groups and potentially in the lack of participation by parents in a parent focus group.

Unlike other communities included in this project, Pueblo youth focus group participants said there is not a push for high academic performance or higher education; and here more than 20 percent of the population lives below the federal poverty line. Focus group participants expressed concern that generational poverty has resulted in cyclical hopelessness. Participants discussed issues in the community with gang violence and high drug use that spans generations. Because of the instilled secrecy, youth are reluctant to talk about their experiences out of fear of repercussions such as police or child services involvement. This makes it difficult for adults to support youth for whom they have a concern. Focus group participants expressed frustration and concern that when referrals are made for youth to receive a suicide risk assessment

or behavioral healthcare there is very poor follow-up on the part of parents or caregivers. They indicated that sometimes this is due to transportation or financial barriers, other times this is thought to be due to a fear of family secrets being revealed, or fear and stigma of the behavioral healthcare system and what will happen next.

Also, unique to Pueblo is the large percentage of single parent and kinship care households, where family members are caring for children. Focus group participants described challenges with engaging parents and caregivers.

Although there are resources available in Pueblo, including behavioral health services, support services and pro-social activities, participants expressed that the lack of parental and caregiver engagement and follow-through, coupled with significant financial and transportation barriers, impedes children's success and involvement in treatment and healthy activities.

Many focus group participants expressed that there are presently several youth-focused initiatives that have provided an influx of resources and grant funding. Community organizations expressed frustration with the lack of participation from schools, and school administrators reported feeling overwhelmed with competing priorities. An additional frustration that was shared is that many of the grants given to Pueblo organizations are short term and limited in scope which creates barriers to sustainable solutions.

Due to these circumstances, focus group participants said many of Pueblo's youth experience varying degrees of trauma and few youth report having an adult with whom they can talk. Youth focus group participants describe the same concerns with fitting in and social media, but their experience of pressures and depression are quite different than youth in the other counties in the study. There is a level of resilience that has built up within the Pueblo community, but also a degree of desensitization to loss.

> "There is not an expectation of happiness." – Community Member

Despite these challenges, focus group participants consistently talked about a sense of community and cultural pride in Pueblo, as well as the fact that "Pueblo loves its children." This is evident in the number of youth-serving initiatives and groups meeting about different youth needs. With many working groups actively meeting monthly to address youth issues, the community could benefit from collectively working together across sectors, easing the demand for school and community representatives who are strapped for time and resources.

SCHOOL POLICIES & PROCEDURES

BACKGROUND & APPROACH

HMA reviewed school policies and procedures related to suicide intervention, prevention and postvention in El Paso, La Plata, Mesa and Pueblo counties [42]. For this review HMA focused on the district/school board level for each school district in the county, all in the context of Colorado state statutes and laws. In Colorado, there several statues that deal with suicide prevention within schools at the State level [43]. However, this review focused on three primary statutes (Figure 3).

In the context of the State statutes, each district's board policies were cataloged to gauge what were the most common policies, what policies most often seemed to be missing, and where there are opportunities for improvement. All the procedures and policies that were reviewed were from publicly available documents, typically through each school district's board website. However, it is important to note that according to the Colorado Association of School Boards all policies are public records, so the policies found in this review are considered accurate records of each district's policies [44]. There are school-level policies and procedures that can differ from school to school. These were not reviewed in this study, as there are too many schools to make a review of all their policies and procedures feasible.

Colorado school policies and procedures are broken down by area of focus (Figure 4):

Figure 4. Colorado School Policies and Procedures

A. Foundations/Basic Commitment Policies: these policies focus on the District's legal role in providing public education and the basic principles underlying School Board governance.

B. Board Governance/Operations: this section focuses on the school board – how it is appointed or elected; how it is organized; how it conducts meeting; and how the board operates.

C. General School Administration: this section contains policies focused on school management, administrative organization and school building and department administration.

D. Fiscal Management: all policies in this section are on school finances and the management of funds.

E. Support Services: these policies focus on non-instructional services and programs, particularly those such as safety, building and grounds management, office services, transportation and food services.

F. Facilities: this section contains information on facility planning, financing, construction and renovation.

G. Personnel: this contains policies that pertain to all school employees.

I. Instruction: the policies in this section are on the instructional program – basic curricular subjects, special programs, instructional resources and academic achievement.

J. Students: this section contains policies on students – admissions, attendance, rights and responsibilities, conduct, discipline, health and welfare and school-related activities.

K. School/Community Relations: this section has policies on parent and community involvement in schools.

L. Education/Agency Relations: this final section focuses on the school district's relationship with other educational genies.

Figure 3. Colorado Statutes Addressing Suicide Prevention in Schools

§22-1-123: Protection of student data- parental or legal guardian consent for surveys

This statute addresses what is often an area of concern when screening youth using a suicide assessment tool, as it requires parental permission for surveys given to students. However, in the statute, nothing limits the ability of a school district to administer a suicide assessment or threat assessment and so one can be given without parent or legal guardian consent.

§22-60.5-110: Renewal of license

Regarding the professional development of educators, the statute allows for suicide prevention training to count towards continuing education requirements, stating "such professional development may include, but need not be limited to, in-service education programs, including programs concerning juvenile mental health issues and the awareness and prevention of youth suicide." However, educators are not required to undergo youth suicide awareness and prevention training.

§24-33.5-1801. Legislative declaration

Now, therefore, the general assembly declares that: (a) Safe schools are a matter of statewide concern; (b) All schools have common needs and goals to ensure a safe environment; (c) Resources are needed to fully develop safety plans and practices in Colorado's schools, colleges, and universities; and (d) A school safety resource center dedicated to providing evidence-based practices and expertise to all schools is a cost-effective means to improve school safety.

Of these sections, the two of most interest are those governing students (Section J) and School/Community Relations (Section K). Section J contains all policies related to the screening of students for mental health issues, as well as suicide prevention, intervention in suicide attempts, and what to do when a suicide or other traumatic loss of life occurs. Section K houses the school district's crisis management policies, namely how the school communicates in a crisis to the public and who is involved in the crisis response team.

Within these sections, below is a list of all the policies that school boards could adopt within their own district in relation to suicide prevention and response to suicide:

Section J: Students
Screening/Testing of Students (and Treatment of Mental Disorders), Suicide Prevention [45], Intervention in Suicide Attempts, Suicide or Other Traumatic Loss of Life

Section K: School/Community Relations
Crisis Management (Safety, Readiness and Incident, Management Planning), Crisis Management Communications, Crisis Management Team

SCHOOL POLICIES & PROCEDURES

FINDINGS

Within each county included in the study (La Plata, Mesa, Pueblo and El Paso), each school district's school board website was searched for the most recent, publicly available school policies and procedures. These policies are district-wide policies and each school within each district could have its own distinct policies, but the focus for this review the overarching policies put in place that would inform each school within the district on how to proceed in reaction to issues related to suicide and suicide prevention. The summary results are listed in the table to the right.

FINDINGS

The table shows that the most common policies are those regarding student screening and crisis management planning. Unfortunately, most school districts across the four counties do not have a comprehensive set of policies when it comes to suicide and crisis management. According to school policies that are publicly available, and with the understanding that all school policies may not be public, the most common policies included are those dealing with the screening of students and crisis management planning, but there are districts where they either do not have such policies or do not share them publicly. All others, such as those dealing with suicide prevention and crisis management communication, are much rarer and "hit and miss" on which district has them and which district does not. This suggests there is certainly room for improvement as more school districts should consider having set policies in place that discuss suicide prevention, intervention and postvention, as well as how crises should be managed and communicated to students, families and the larger public.

Table 2: Current School Policies In Place by County and School District*

School District	Section J Policies: Students				Section K Policies: School/Community Relations		
	Screening, Testing & Treatment of Mental Disorders	Suicide Prevention	Intervention in Suicide Attempts	Suicide or Other Traumatic Loss of Life	Safety, Readiness and Incident Management Planning	Crisis Management Communications	Crisis Management Team
La Plata County							
District 9R	✓				✓		
Mesa County							
District 51	✓				✓		
Pueblo County							
District 60	✓				✓		
District 70	✓	✓			✓	✓	
El Paso County							
District 100J	✓				✓		
District 2	✓				✓		
District 3	✓				✓		
District 8	✓						
District 11	✓	✓			✓		
District 14	✓				✓	✓	
District 20**							
District 22	✓	✓	✓	✓	✓	✓	
District 23					✓	✓	✓
District 28**							
District 38	✓				✓		
District 49	✓				✓		
District 54	✓	✓			✓		
District 60	✓	✓		✓	✓	✓	
District RE2					✓		
District RJ1	✓				✓	✓	

* Does not indicate whether the policy adheres to best practices
** These districts had no publicly available policies regarding suicide/crisis management

It is important that schools have policies and procedures in place to prevent, intervene and respond to suicidal ideation and behavior of their students. Understanding how to identify, assess risk and intervene for a suicidal youth is critically important. Also, important, but sometimes given less emphasis, is the need for clear policies and procedures for supporting students returning to school following a suicide attempt or mental health crisis, as well as managing in the aftermath of a student suicide. When policies and procedures are in place, communicating these expectations to all school staff, even if they do not have a direct role in implementation is key to supporting students. Below are several resources that offer good information on what ideal school policies should look like both for suicide prevention and suicide postvention.

Preventing Suicide: A Toolkit for High Schools (applicable to middle school settings as well): https://store.samhsa.gov/shin/content//SMA12-4669/SMA12-4669.pdf

The Trevor Project's Model School Policy: https://www.thetrevorproject.org/wp-content/uploads/2017/09/District-Policy.pdf

Suicide Prevention Resource Center's After a Suicide - A Toolkit for Schools: http://www.sprc.org/resources-programs/after-suicide-toolkit-schools

Colorado Department of Public Safety, School Safety Resource Center: https://www.colorado.gov/cssrc

TRADITIONAL MEDIA & SUICIDE

BACKGROUND & APPROACH

HMA reviewed media coverage of suicide (among all age groups) looking at both traditional media (e.g., print newspapers, radio, television) and internet-based media (e.g., online newspapers). Included in this review was how the topic of suicide is addressed on social media separate from news stories covering a suicide or the topic of suicide.

Media reporting can have an impact on suicide. When news sources report inappropriately about suicide it can increase risk within a community or demographic; conversely, when reporting is appropriate it can raise awareness about the issue and provide critical information about helping resources. More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable populations, contributing to suicide diffusion. Oftentimes this increase is related to the amount, duration and prominence of coverage. The risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic or graphic headlines or sensationalizes/glamorizes a death. However, covering suicide in a more careful manner, even briefly, can help to change public misconceptions and correct myths, while also encouraging those who may be vulnerable to seek help. Additionally, coverage highlighting stories of recovery and help-seeking have been shown to decrease risk and support help-seeking behaviors within a community or demographic. Therefore, media and online coverage should be informed by using best practices to avoid spreading misinformation and instead offer hope. The goal of this media review was to better understand current reporting practices around suicide in the four counties that are the subject of this project by reviewing the types of articles put out by traditional (i.e. newspapers, news stations) media sources. This review did not examine media coverage on hope and recovery that may have had a positive impact.

For the traditional media review in the four counties, newspapers and news channel websites were searched for any articles related to suicide that were posted between January 1, 2013 and December 31, 2017, looking back over the previous five years to allow for assessments of patterns in reporting. Each site was searched virtually using the key term "suicide" and results were focused on local events, excluding any national or international stories that touched upon suicide (such as suicide bombings, suicides in other counties/states or articles from non-local newspapers). News stories were then further narrowed down to exclude those that discussed physician-aid-in-dying, murder-suicides or suicide by police. The articles that were included were ones about specific individual incident(s), as well as events in the community related to suicide prevention (e.g., fundraisers, informational articles). It is also important to note that only printed articles were included in this review, the scope of the project did not allow for the review of news segments or video clips so these were not included in this search.

All articles were then compared to the Recommendations for Reporting on Suicide from the American Association of Suicidology and the American Foundation for Suicide Prevention [46]. Some of the characteristics were combined into one larger category for ease of the review. A tracking document was created to mark where articles noted positive characteristics and negative characteristics (see Table 3 below) as each article was read through fully. The results were accumulated to give an overall summary of the traditional media landscape in each county.

Table 3. Summary of Characteristics Included in Media Scan

Positive Characteristics:	Negative Characteristics:
Resources • Inclusion of local or national hotline numbers and/or logo • Inclusion of treatment options	**Photos** • Photos of location or method of suicide/suicide attempt • Photos of memorials and/or grieving • Photos of bodies/investigation scene
Warning Signs • Inclusion of warning signs	**Sensational** • Big, prominent sensational headline
Proper Terminology • Use of proper terminology - "died by suicide"	**Improper Terminology** • Use of strong, dramatic language • Description of suicide as inexplicable • Use of improper terminology – "commit," "successful," "unsuccessful," or "failed attempt" • Reporting similar to a crime • Oversimplification of suicide
Experts Cited • Information from suicide prevention experts	**Allowing Open Unmonitored Comments on Online Platform**
Public Health Frame • Discussion of suicide as a public health issue • Description of suicide as preventable and complex • Inclusion of causes of suicide	**Details of Suicide** • Inclusion of information about or contents of suicide note • Inclusion of name and/or school • Description of location or method of suicide

FINDINGS

In the tables below, the findings are presented cumulatively by news source with the numbers signifying the percentage of articles put out by that news source during the period that had that characteristic. For example, if a news source put out 20 articles that were related to suicide and five of those included helpful resources and 8 included the details of a suicide, the resulting percentages would be 25 percent and 40 percent respectively. This helps to show where each news source is making good progress regarding having positive characteristics and where news sources could be better regarding having negative characteristics.

In terms of limitations of this review, there were a select number of news sources where their full news archive was not able to be searched and so the full date range (1/1/2013 to 12/31/2017) was not included. As well, there was a wide range on the number of articles put out by each news source over this time span, so it is difficult to compare across news sources. Finally, articles could have been missed during the review period as articles could have been removed, updated (and therefore the article could have been sorted by updated date vs. published date) or overlooked.

TRADITIONAL MEDIA & SUICIDE

FINDINGS

El Paso County

El Paso County, due to the size of the county, had the most news sources to pull from including one newspaper (The Gazette) and news articles found on four major news stations (CBS, ABC, NBC and FOX affiliated stations). While all sources had searchable databases, three of the news stations (FOX, ABC and NBC) limited their searches so the full-time period (1/1/2013-12/31/2017) could not be reviewed. The Gazette did a good job of using proper terminology (i.e. rise of suicides, died by suicide, etc.) and of citing experts, often of a woman from a local suicide prevention organization. However, in the same articles, the Gazette often mentioned details of the youth suicide (i.e. name of individual, school, location and method) and used improper terminology (i.e. strong or sensationalistic language, without cause or inexplicable).

For the news stations, the CBS affiliate (hereby referred to as KKTV11) usually did a good job of posting articles with resources and citing resources. They also had good articles where local experts were interviewed about multiple facets related to suicide and suicide prevention. For the other three news stations, they followed a similar line of often quoting experts and posting resources, but too often fell into the trap of listing too many details about a suicide and, at times, using improper terminology to describe a suicide and suicide trends in El Paso. Knowing that the local public health agency did a lot of work with media, there did seem to be marked growth in the number of stories with proper suicide reporting with KKTV11 and the ABC news affiliate, although these changes were not as prevalent with the other two news stations (FOX, NBC) or the newspaper.

Table 4. Summary of El Paso County Traditional Media

News Source (# articles reviewed)	Positive Characteristics					Negative Characteristics				
	Resources	Warning Signs	Proper Terminology	Public Health Frame	Experts Cited	Sensational	Photos	Improper Terminology	Details of Suicide	Open Comments
The Gazette (23)	34.8%	0.0%	56.5%	4.3%	43.5%	4.3%	21.7%	30.4%	56.5%	0.0%
KKTV 11 News (18)	55.6%	22.2%	22.2%	0.0%	38.9%	0.0%	22.2%	33.3%	22.2%	0.0%
KRDO News Channel 13* (9)	55.6%	11.1%	0.0%	0.0%	55.6%	11.1%	11.1%	22.2%	33.3%	33.3%
KOAA News 5* (3)	0.0%	0.0%	33.3%	0.0%	66.7%	0.0%	0.0%	33.3%	0.0%	0.0%
Fox21 News* (3)	66.7%	33.3%	66.7%	0.0%	33.3%	0.0%	33.3%	0.0%	66.7%	0.0%

Searches were not available for the full date range from these media sources.

La Plata County

In La Plata County, the main news source is the Durango Herald, the local newspaper. The community has been critical of the newspaper about how suicide is reported. HMA's analysis of reporting, over the five-year period revealed problematic reporting but also found some positives. The positives are that the Herald does provide a listing of resources in nearly every article and, more recently, has begun using proper terminology to describe both individual suicide events and trends of suicide within the county. However, there are some serious concerns with the Herald's reporting. The most pressing of which is the inclusion of details about specific suicide events. Nearly every article mentions the name of the individual, their age, their school, and the location and method of suicide. Many of the more recent articles also include maps with GPS pinpoints of where exactly the event took place, many times accompanied by inappropriate photos of the location and of memorials or people grieving. Many of the articles use sensational headlines (i.e. mentioning the method in the article headline) or material that does not follow the reporting guidelines.

While in some ways the Herald seems to be responding to the complaints from the community, they have not taken substantive steps to follow the Recommendations for Reporting on Suicide from the leading experts and seem unwilling to back away from posting details of suicides, claiming that not posting details does more harm than good (see "We write about suicide because it is a public health issue" from 8/5/2017). Out of all the news affiliates surveyed across the four counties, the Herald is the one that has seemed to spark the most outcry from the community, often for good reason

TRADITIONAL MEDIA & SUICIDE

FINDINGS

Table 5. Summary of La Plata County Traditional Media Sources

News Source (# articles reviewed)	Positive Characteristics					Negative Characteristics				
	Resources	Warning Signs	Proper Terminology	Public Health Frame	Experts Cited	Sensational	Photos	Improper Terminology	Details of Suicide	Open Comments
The Durango Herald (46)	80.4%	13.0%	23.9%	10.9%	19.6%	26.1%	13.0%	6.5%	73.9%	0.0%

Mesa County

In Mesa County, the two major sources are the local newspaper (The Daily Sentinel) and local news station (KKCO 11/KJCT 8). Overall, the two news sources do a good job of reporting on suicide as they both often list resources and cite experts from the local community. However, there are still issues around posting details of a suicide (in one case the contents of a suicide note, including a picture of the note were included) and including inappropriate photos. As well, many of the articles reporting on suicide deaths came across like crime reports. For the news stations (which share the same articles on two different sites), their biggest misstep is including open comments on all their articles related to suicide and failing to report suicide as a complex preventable public health issue.

Pueblo County

Pueblo is limited in the number of news sources, as all news channels are based in Colorado Springs (El Paso County). The main newspaper, the Pueblo Chieftain, had a small number of articles related to suicide and none regarding the more recent youth suicide deaths. For the articles in the newspaper that did relate to suicide, many of them did a good job of citing experts in the article but would often use strong terms to describe recent trends. Overall, Pueblo had one of the smaller traditional media pools from which to review articles and postings, but for the most part, the articles had many positive characteristics with a few minor issues over the five-year period.

Table 6. Summary of Mesa County Traditional Media Sources

News Source (# articles reviewed)	Positive Characteristics					Negative Characteristics				
	Resources	Warning Signs	Proper Terminology	Public Health Frame	Experts Cited	Sensational	Photos	Improper Terminology	Details of Suicide	Open Comments
The Daily Sentinel (41)	31.7%	7.3%	24.4%	7.3%	46.3%	4.9%	9.8%	19.5%	29.3%	0.0%
KKCO 11 News/ KJCT 8 News (8)	62.5%	12.5%	37.5%	0.0%	25.0%	25.0%	25.0%	25.0%	25.0%	100.0%

Table 7. Summary of Pueblo County Traditional Media Sources

News Source (# articles reviewed)	Positive Characteristics					Negative Characteristics				
	Resources	Warning Signs	Proper Terminology	Public Health Frame	Experts Cited	Sensational	Photos	Improper Terminology	Details of Suicide	Open Comments
KRDO News Channel 13* (3)	66.7%	33.3%	33.3%	0.0%	0.0%	33.3%	0.0%	66.7%	0.0%	33.3%
KOAA News 5* (4)	25.0%	0.0%	50.0%	0.0%	50.0%	25.0%	25.0%	25.0%	50.0%	0.0%
Fox21 News* (1)	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
The Pueblo Chieftain (10)	30.0%	10.0%	30.0%	0.0%	60.0%	10.0%	0.0%	20.0%	10.0%	10.0%

Searches were not available for the full date range from these media sources.

SOCIAL MEDIA & SUICIDE

OPPORTUNITIES & CHALLENGES

The size and lack of boundaries make social media hard to grasp and fully understand.

Youth indicate they are using Snapchat at the highest rates.

On Snapchat youth can share violence, self-harm, bullying, and suicidal behavioral with minimal fear of intervention from adults.

Many platforms meet the needs of their users by creating opportunities to intervene and support.

Social media allows for youth to connect with supports or others going through similar issues.

Allows for social media platforms and organizations providing services and supports to meet users where they are.

BACKGROUND & APPROACH

According to a Pew Research Center survey conducted in 2018, 95 percent of teens report they own or have access to a smartphone, a 22-point increase from 2015; and today, 45 percent of teens ages 13-17, report being online on a near-constant basis, twice as many as reported in the 2014-2015 survey [47].

In the 2018 Pew survey, youth were asked what types of social media they use:

- **YouTube (85%)**
- **Instagram (72%)**
- **Snapchat (69%)**
- **Facebook (51%)**
- **Twitter (32%)**

Youth were asked which social media platforms they use *the most*:

- **Snapchat (35%)**
- **YouTube (32%)**

HMA conducted a review of social media to (1) further explore the positive and negative effects of social media on youth suicide; (2) identify and report on changes to social media platforms and; (3) recommend strategies to maximize the good influences and minimize the bad influences of social media on youth. The top four most popular media platforms, (YouTube, Instagram, Snapchat, and Facebook) were reviewed and are summarized below.

You Tube   FINDINGS

In 2018, 85 percent of teens ages 13-17 reported being YouTube users. YouTube currently has active resources and protections in place.

Positives: If a user enters, "how to kill yourself," in the YouTube search engine, the National Suicide Prevention Lifeline information appears at the very top.

Negatives: Although it appears that YouTube filters out many of the violent and graphic videos, there are still some triggering videos and images left for youth to see.

Concerns: YouTube does filter the video and audio content on its platform, but with over 1.3 billion users worldwide and an estimated 18,000 videos uploaded hourly, it's an overwhelming amount of content to review. YouTube connects to all other social media sites directly, so a user can share YouTube videos on all other platforms. Because of this, a violent YouTube video can be viewed and shared thousands of times across all platforms before YouTube has a chance to review and take down the content.

SOCIAL MEDIA & SUICIDE

FINDINGS

Instagram

In 2018, 72 percent of teens ages 13-17 reported being Instagram users.

Positives: When a user searches, "#suicide", they are asked if they need help and are given an option to get support, see the posts or cancel. If the user selects, "get support," they are taken to the Instagram Help page and prompted with the following options [48]:

Figure 5. Instagram Help Messages [48]

Talk to a Friend: Message or call someone you trust.

Reach out to a friend with a call or text. If you're not sure what to say, consider starting with something like this: 'I'm going through something difficult and was hoping to talk with you about it. If that's OK with you, please let me know.'

Talk with a helpline volunteer: Call or text a trained helper who can listen and support you.

Call a trained helper at National Suicide Prevention Lifeline

Text a trained Crisis Counselor at Crisis Text Line

Call a trained counselor at The Trevor Project (for LGBTQ+ youth, friends and family members)

Call a trained counselor at the Veteran/Military Crisis Line

Get tips and support: See suggestions for ways to support yourself.

Get outside

Be creative

Soothe your senses

Just relax

Negatives: Unfortunately, if the user selects to continue to, "see the posts," there are a mixture of triggering photos of self-harm and dark quotes, along with a few quotes of hope and healing.

Concerns: Instagram has now adopted similar features to Snapchat, where video and chat messages can be private and time-limited. It can be assumed that many of the conversations that potentially put youth at risk are happening in private conversations that adults are not able to review.

Snapchat

In 2018, 69 percent of teens ages 13-17 reported being a Snapchat user. Teens also reported using Snapchat (35%) the most out of all other social media platforms.

Positives: A source of revenue for social media platforms is advertising. Snapchat allows for advertisements, including public awareness campaigns, allowing for messaging directly to youth on a platform they use the most. An example of Snapchat public awareness messaging used in Colorado is Protect What's Next, a youth marijuana education campaign.

Negatives: Snapchat allows for users to send private, time-limited messages (called snaps), to one another creating an environment where youth can share videos of violence, self-harm, bullying and suicidal behavior, with minimal fear of intervention. Unless a screen shot is taken, it is almost impossible for another youth to show evidence to adults or the authorities. In addition, Snapchat alerts the user when a screenshot is taken, also citing the individual who took the screenshot, making anonymous reporting difficult and possibly preventing youth from seeking help. In addition, Snapchat does not have any messaging or support when users cite violence, self-harm or suicide.

Concerns: Reported "E-suicide notes" have increased in other countries [49]. Youth communicate instantaneously online and in return expects instant results both on and offline. Gone might be the days of handwritten letters and phone calls, and now possibly even text messages [50]. As companies race to keep up with the risks associated with their platforms, youth must also be better equipped to immediately act in situations where peers might be in danger.

Facebook

Until 2017, Facebook was the most popular social media site. In a 2014-2015 survey, 71 percent of teens ages 13-17 reported using. In 2018, only 51 percent of teens reported being Facebook users. Facebook is easier to access conversations. Therefore, a search of Facebook was conducted and the first sixty pages of both Facebook-Pages and Facebook-Groups were reviewed after searching the term "suicide". Below includes information collected from this review.

Positives: When a user searches "suicide" on Facebook-Pages, 50 percent of the pages are resources, while 5 percent would be considered harmful. The remaining pages are personal pages, unrelated to suicide. If a user searches "suicide" on Facebook-Groups, 91 percent of the groups were resources or support groups, and no groups were found harmful, the remaining 9 percent of groups were unrelated to suicide.

SOCIAL MEDIA & SUICIDE

FINDINGS

When searching "suicide" on the main search engine, Facebook will prompt the user if they would like support for themselves (right) or a friend (below). In addition, a user can "give feedback" on an individual post if they are worried about a friend, which includes self-harm/suicide reporting (Figures 5-6). Once reported, Facebook will also provide prompts to support a friend.

Negatives: Although most of the pages and groups on Facebook are resources and supports, very few (3%) of the pages mention youth or teens in the title. Although Facebook still must continually monitor and filter content, they seem to do a better job than other social media platforms, possibly due to the length of their popularity.

Concerns: Youth are still not protected from the triggering comments or hateful speech that can be written on posts. Because Facebook connects with all other social media, content and conversations can span across social media sites making them difficult to control.

Figure 6. Facebook Help Messages for a Friend

If a friend needs support –

Get ideas for how to support _____

Empathize and listen

Validate your friend's emotions

Ask open ended questions

Make sure they're safe

Connect them with counselor, health professional, or helpline

Reach out to _____ (chat function)

Hi _____, it sounds like you're going through a hard time. I'm here to listen. Please tell me what's going on.

Ask us to look at the post (report)

What should I do if someone posts something about suicide or self-injury? (takes the user to www.facebook.com/help/216817991675637)

Send a caring card

Facebook allows for you to pick and send an E-card

Connect with another friend

Hey, this post makes me feel worried about _____. Do you have any idea why she would have written this? Do you think there's something we can do to help?

Figure 5. Facebook Help Messages for Yourself [51]

If the user needs support –

Talk with a friend – message or call someone you trust.

Talk privately with a friend you trust.
Pre-written message directly to selected friend: "Hi, I'm going through something difficult and was hoping to talk with you about it. If that's OK with you, please message me back"

Contact a helpline – they can listen and help you work through this.

Call a trained helper at National Suicide Prevention Lifeline

Start a chat with a trained helper at the National Suicide Prevention Lifeline

Text a trained Crisis Counselor at Crisis Text Line

Call a trained counselor at The Trevor Project (for LGBTQ+ youth, friends, and family members)

Call a trained counselor at the Veteran/Military Crisis Line

Get tips and support – see suggestions for ways to support yourself.

Get outside
Go for a walk, jog or bike ride
Visit a library or museum
Go to your favorite spot or park

Be creative
Draw something simple
Make your favorite snack or dessert
Write down how you're feeling

Soothe your senses
Take a bath or shower
Smell a scent you like
Listen to peaceful music

Just relax
Look up at the sky and clouds
Read a new book or magazine
Take a nap

CONCLUSION

MEDIA & SUICIDE CONCLUSION

Media sources have a great responsibility in educating the public and to do so in a way that is helpful rather than harmful. This remains true when reporting on the issue of suicide, which is a complex subject to cover. Traditional media sites, while perhaps not as prevalent as they once were, are still great sources of information for individuals living in El Paso, La Plata, Mesa and Pueblo counties. As such, the sites have the ability to inform readers about the issue of suicide in such a way as to dispel myths, provide resources and encourage help-seeking behaviors.

Looking more closely into the main traditional news sources in each affected community, it is clear that each source could do a better job of following the Recommendations for Reporting on Suicide from the American Association of Suicidology and the American Foundation for Suicide Prevention [52]. The in-depth scan showed missteps across all counties, such as reporting the details of a suicide or including inappropriate language that sensationalizes a suicide death. However, many sources did a good job of including resources and getting quotes from experts, helping to provide accurate information to readers. Overall, there are improvements to be made in traditional media reporting in all four counties to help prevent the increase in suicide risk that can accompany any suicide death and help the community better understand and deal with suicide.

Social media sites allow people to connect including family, friends and others going through similar issues and situations. In addition, it allows for organizations, services and supports to meet users where they are, and can be used for mass public awareness messaging. Social media has also created an opportunity for platforms to intervene, support and connect at-risk users to services. After reviewing the top four social media platforms, no pro-suicide sites were found, possibly due to administrative filtering or the pages are not publicly searchable under the term "suicide."

The size of social media and the lack of boundaries make it hard to grasp and fully understand. Youth indicate they are using Snapchat at the highest rates, causing concern due to the instantaneous and short-lived nature of an environment where youth are able to share violence, self-harm, bullying and suicidal behavioral with minimal fear of intervention from adults.

To protect against the bad and maximize the good, youth-serving organizations need to continue to promote mass-media messaging through platforms such as Snapchat, Instagram and YouTube. In addition, since youth are most likely reaching out to other youth privately and directly, this means that educating youth to respond to friends in crisis is critical, as they may be the only one to see a message and provide immediate help. Adults and authorities are reliant on social media platforms to filter content and provide avenues for users to seek help. In addition, parental or guardian oversight which begins with education for parents/caregivers on types of social media, how it can be used and questions and conversations to have with youth, is needed. As an example, Mind Springs Health in Mesa County has developed informational resources for protecting youth in the digital age [53]. Unfortunately, the internet cannot be controlled; therefore, we must build resiliency and protective factors in our youth and teach youth to critically and safely consume media to mitigate the risks associated with social media.

RECOMMENDATIONS FOR PREVENTION

LOOKING AHEAD

The following recommendations are the result of HMA's analysis of all data collected under this project, particularly the information gathered from community members through key informant interviews and focus groups. These recommendations are intended to be the start of a conversation about what state and local partners can do to address youth suicide in Colorado. These are not detailed or comprehensive, as readers of the report may see issues they would prioritize that are not necessarily captured in the recommendations provided below. These recommendations are based on data gathered from the four counties that were the focus of the project, and from two comparison counties. However, as many counties across Colorado are experiencing high youth suicide rates, it is our hope that the recommendations are relevant for all of Colorado's youth.

Prioritize Relationship-Building Between Adults and Youth

Youth stated in many ways that they want authentic relationships with adults and are more likely to talk about difficult topics with adults they trust and to whom they feel connected. In schools, teachers and other school staff should be encouraged to make a point of engaging with youth in a way that sends a message that adults in the school care about them beyond just their school work. In the community, adults working with youth in community-based organizations and settings, like coaches, faith leaders, youth development specialists, etc. as well as parents, also offer natural supports and connections for youth. To build and maintain trust, adults interacting with youth need to be prepared to talk *with* them about "the hard stuff" and *not at them* with lectures and advice, and not dismissing their feelings as them "just being teenagers."

LOOKING AHEAD

RECOMMENDATIONS

Efforts should be made to create environments where any door is the right door for youth to outreach to adults and those adults are equipped to know what to do when a young person is expressing suicidality or other complex issues. That said, many youth in the focus groups shared that they do not expect adults to know exactly what to say or do and that is okay – what they often need and want is an adult who can just be supportive and listen.

Create a Culture of Support for Youth in Crisis/Post-Crisis

Train All School Staff, Parents, Adults Working with Youth in the Community, and Youth to Identify and Respond to Suicidal Youth

Youth seek help from their peers and beyond that, youth will reach out to adults that they know and trust. When young people reach out to adults it is because they believe that adult will not overreact or underreact to the situation. Because any adult in the school, or outside the school setting, can be the adult with whom a youth connects, all adults interacting with young people should be trained to respond. Additionally, youth expressed a need and desire to have the skills to know how to respond in the moment to a peer expressing suicidality and how to help them. Both youth and adult focus group participants believe that youth are able and ready to be trained in this way. Along these lines, suicide prevention programs, especially those with a gatekeeper training component, should be carefully considered for the relevancy and safety of the content, and should be implemented with sensitivity to timing in relation to any recent suicides in the community.

Prioritize Support of Teachers and Counselors in the Aftermath of a Suicide Death or Attempt

Teachers and school counselors are on the front-lines when it comes to interacting with youth when one of their peers has died by suicide. Across each of the four study counties, many of those who were interviewed as key informants or who participated in a focus group said there needs to be more done to help teachers and school counselors cope with their feelings of grief, loss, guilt and helplessness after a student suicide or attempt. This should be in addition to providing them with the necessary skills and tools to engage effectively with their students. On top of wanting to be there to help their students and support them through such difficult circumstances, teachers and counselors often feel the brunt of expectations from school administrators, parents and students for how schools should respond when there is a youth suicide. They need to know who has "got their backs" and what supports are available to them as they navigate these issues both in their professional roles and personal feelings.

Establish and Communicate Clear Policies and/or Procedures for Supporting Students Returning to School After Seeking Care for Suicidal Ideation or Other Mental Health Concerns

Teachers, parents and students often struggle to re-integrate into school after having been absent to seek treatment for suicidal ideation or other mental health needs. Establishing specific and clear policies and procedures for how to help returning students succeed when they come back to school is critical – for teachers, for parents and for the students. Inconsistencies in approaches and expectations from staff can create unnecessary stress for students and their parents, making it harder for them to navigate an already difficult situation. When possible, schools should work with parents to set up a re-entry plan as soon as a student has left; when that is not an option, then schools should work with parents, students and teachers to develop such a plan prior to the student's return. In this way, it will be clear to everyone what will happen when the student returns and the specific prerequisites the student must meet to ensure they are on track with academic requirements. This also allows the student the ability participate as fully as possible in school programs and activities, while still receiving the support they need to focus on getting well. In addition to clear policies and procedures, schools must proactively develop and refine of protocols and policies in alignment with known best-practices.

Implement Programs or Strategies that Build Resilience and Coping Skills

Teaching coping skills and building resilience in youth should start early and opportunities to exercise these skills should be provided often and in multiple contexts. Schools and community-based programs should begin with elementary aged children, implementing activities that teach empathy, emotion regulation, problem-solving and conflict resolution. Across many adult focus groups, we heard about excellent elementary school-based programs focused on these types of skills; however, they noted that the emphasis on these skills started disappearing in middle school and were completely absent by high school. When academic requirements increase, youth, school professionals and parents have prioritized grades and bell-to-bell instruction over social emotional learning. Exploring ways to incorporate social emotional learning into the classroom from preschool through high school is important addressing the issue of youth suicide, including improving interpersonal interaction skills and teaching skills to better navigate a social media environment. Sources of Strength, a school-based suicide prevention program, focuses on building resilience and connection for young people in middle and high schools. Sources of Strength is currently being implemented in many schools across the state with support from the Office of Suicide Prevention.

Additionally, increasing opportunities for this type of learning to occur in community settings can ensure multiple contexts for youth to build resilience and coping skills. Along with programs that can be implemented in schools or communities, simply modeling for youth how to cope with failure and challenges can be helpful. Setting expectations that acknowledge imperfections rather than absolute perfection can set the stage for coping in healthy ways when faced with obstacles or losses.

Provide Self Care Lessons or Activities for Youth

Particularly through schools and other youth-serving organizations, communities should adopt programs that can help teach youth self-care. There are evidence-based programs that show youth how to intentionally take care of their mental, emotional, spiritual and physical health; and to self-regulate to

LOOKING AHEAD

RECOMMENDATIONS

reduce the stressors in their lives, even when they cannot change their immediate circumstances. Similarly, making these kinds of programs available for more parents can help both adults and youth develop resiliency and coping mechanisms that make suicide a less appealing or available option.

Increase Access to Prosocial Activities and Supportive Environments

Youth need prosocial activities like those offered through recreation centers, Boys and Girls Clubs, libraries, 4-H, camps, etc. These were either absent in the counties we studied, or access was hindered by cost and transportation challenges. Identifying funding mechanisms to establish these kinds of offerings, as well as to offset costs and provide transportation should be a consideration at the local level, as well as through the funding provided by state and foundation programs and resources.

Ensuring access to organizations that provide support and resources particularly to LGBTQ+ youth is a way to provide a supportive place for these young people when they are experiencing a lack of acceptance and tolerance in other environments. Additionally, adults should understand and ensure the enforcement of anti-discrimination and anti-harassment policies within school and community settings.

Increase Funding, Length of Funding Periods, and Flexibility of Funds Targeted to the Primary Prevention of Youth Suicide

Currently there are small grants, often given through competitive community grant programs and targeting specific types of interventions or activities. The Office of Suicide Prevention at CDPHE provides grant funding to Colorado communities and has made a relatively small state general fund budget go a long way. However, suicide is a significant burden in Colorado and the current state investment is not on par with this burden. It is important to increase resources available to address suicide across all ages, and in particular, ensuring that there are resources targeted to the unique needs of youth. Public/private partnerships and investments by philanthropic organizations would be important to explore to augment existing state resources for suicide prevention. It is also important to examine ways in which funding periods can extend beyond one-to-three years and instead allow for long-term investments with time to create sustainable change, such as with the community grant program administered by the Office of Suicide Prevention, and the Substance Abuse Mental Health Services Administration's Garret Lee Smith Grant program [54], both of which have five-year funding cycles. Lastly, grant funding should be available with the flexibility for communities to utilize the monies to build protective factors against youth suicide. These types of strategies are more difficult to measure than a "program in a box" in terms of outcomes, yet more investment in protective factors and primary, front-end prevention is needed. Efforts are underway with the support of Sources of Strength and the Garrett Lee Smith funding priorities but should be enhanced and expanded where possible.

Support Youth Led Initiatives

As part of an increase in funding to support additional resources and services, there should be an effort to include initiatives that are designed and implemented by youth for youth. One example of this is a youth founded, youth led organization based in El Paso County called Project Reasons [55]. Many of the schools in the four counties participating in the project have already organized student groups dedicated specifically to suicide prevention or supporting students with mental health needs. Much of what we heard from both youth and adults in the focus groups and interviews was that young people are ready and willing to take on more in terms of helping their friends and peers who are struggling with suicide or other mental health issues; but they also want support and tools for doing so. CDPHE's Youth Partnership for Health and the Colorado Youth Advisory Council, could be valuable resources in helping to identify and evaluate youth-led initiatives across the state for potential funding opportunities.

Leverage Current Public Awareness Campaigns to Reduce Stigma and Implement Social Norms Campaigns to Address Unhealthy Beliefs and Perceptions

Model Open Dialogue About Suicide and Mental Health

There currently are several statewide and regional media and public awareness campaigns being conducted by CDPHE, local public health agencies and other organizations working to destigmatize mental health issues and encourage individuals and families to seek help. One example of this is the Let's Talk Colorado campaign funded by the State Innovation Model grant from the Center for Medicare and Medicaid Innovation [56]. The goal of the campaign is to initiate an inclusive conversation about mental health.

Using principles and messages from public awareness campaigns, develop community and organizational cultures where there can be open, honest and appropriate dialogue about suicide and mental health issues for all ages. This includes understanding the various resources and programs that are available to support individuals and families in need and knowing how to connect people to them.

Address Inaccurate and Unhealthy Social Norms

Within the four counties suicide seems prevalent and almost common place. Focus group participants described emotional fatigue and a sense of inevitability regarding suicide. Many expressed that suicide has become normalized as an option for dealing with difficult and/or overwhelming situations and mental health issues. Although suicide seems like the norm in these counties, it is an inaccurate perception, as most community members, including young people, are not engaging in suicidal behavior. Likewise, young people in these counties feel pressure to be high achieving and not make mistakes. Perfection has become the perceived norm which is creating a fear of failure and an inability to cope when things are not perfect. These

RECOMMENDATIONS

norms are not only inaccurate, but they are especially dangerous to young people. Social norm campaigns should be implemented to deliver positive messages about the healthy behaviors and attitudes of most community members. These messages can focus on the ways that people who are struggling find care and support, including self-care practices. Such a campaign can also include messages that show how all people are imperfect and offer examples of how people show resilience in the face of mistakes and challenges. In addition to campaigns, the media can be a partner in promoting healthy norms by not promoting the inaccurate perceptions and beliefs, and instead upholding the positive norms in the community. In this way healthy perceptions, behaviors and choices become the norm.

Use Social Media to Promote Helping Resources and Messages of Support and Self Care

Use social media platforms owned by organizational partners to promote messages from public awareness and social norms campaigns, as well as provide links to resources and providers where people can go for help. Offer information about what types of resources are available, how to access them, whether there are costs or other eligibility requirements, and how to navigate systems to find the right services and supports. Social media can be a powerful tool for sharing self-care tips, materials and models, especially if they are created in ways that make them easy to re-post, copy or forward without degrading the quality of the information. There are also opportunities to create support groups through social media, especially for individuals who often feel marginalized and/or disenfranchised - to show that they are not alone, not the only one feeling down, lonely, overwhelmed or depressed; and to give hope and offer help.

Create Coalitions of Providers and Foster Relationships Between Providers, Schools and Youth Serving Organizations

As noted in the report, a core theme among interviewees and focus group participants across all four counties in the study was the issue of availability of accessible, affordable and suitable (e.g., child psychiatrists) mental health providers and services. Exacerbating this lack of providers is the complexity of systems whose structures, policies and protocols often create barriers to youth and families who need help. For example, school policies can conflict with health system or provider policies regarding who can access what information about a child's mental health diagnosis and treatment. This can leave parents in the position of having to figure out what information to communicate with various school and health care teams supporting their child. Similarly, a family's access to needed mental health care often depends on whether they have health insurance that covers those services, if there are any providers in their area who will accept their insurance, and if they have any cost-sharing requirements. This is true both for private insurance as well as for publicly-funded programs such as

Medicaid. As this project did not include an assessment of the current mental health system in Colorado or in the counties studied, HMA is not making recommendations specific to improvement in those systems. A review of assessments recently completed (such as one by the Colorado Health Institute entitled, *The Unmet Challenge, Colorado Struggles to Address Mental Health and Substance Use: A Colorado Health Access Survey Issue Brief* [57]) regarding the current behavioral health system in Colorado or completion of an updated assessment of the system specific to children and youth would be important to the creation of recommendations that address where Coloradans are experiencing challenges with getting behavioral health care. Creating coalitions among youth-serving organizations including schools, external providers, and to the extent possible, payers could help to reduce at least some of these types of barriers. Providing parents with help identifying what is available to their child and assistance in navigating the various provider programs and systems would eliminate many barriers to care.

Another option for addressing the barrier to care is the Second Wind Fund [58]. This program matches youth aged 19 and younger who are at risk of suicide with a licensed therapist in their community. Referrals are made to the program by school staff or other professionals on behalf of youth who are uninsured or under-insured and otherwise could not access the mental health care they need.

Establish the Practice of Informing Youth and Parents/Caregivers About What Happens When a Youth is Referred to a Health Care Provider for Suicidality

As a component of building the relationships and coalitions described above, one specific recommendation is to establish clear, standardized protocols and practices for communicating with parents about what to expect when their child is referred to a mental health provider for suicidality. Given the need to get youth who express suicidal ideation into care as quickly as possible, staff within schools and youth serving organizations need to provide parents/caregivers and students more information about what happens next. This information should include what the family's options are, what providers will and will not do, what the school's expectations are, etc. Particularly in instances where issues with a student crop up unexpectedly for parents and/or school staff, it is critical to have a structured protocol in place to support parents/caregivers and students so, to the extent possible, they know what they need to do.

These recommendations align with many of the recommendations of the Suicide Prevention Commission of Colorado and the Office of Suicide Prevention at CDPHE identified in the Office of Suicide Prevention Annual Report 2016-2017 [59]. HMA conducted a brief review of available activities, programs and resources related to youth suicide prevention, intervention and postvention available in the state and in the four counties which can be found in Appendix G.

LOOKING AHEAD

RECOMMENDATIONS

Train Media Professionals on How to Cover Suicide Safely

Media coverage of suicide should be informed by best practices as outlined in the Recommendations for Reporting on Suicide from the American Association of Suicide Prevention [60]. Research has shown that the risk of additional suicides increases when news coverage of suicide includes explicit description of the suicide method, uses dramatic or graphic headlines or pictures, or when a suicide is repeatedly covered which can sensationalize or glamorize the death [61]. The way in which media outlets cover suicide can negatively affect a community by contributing to the risk of suicide contagion, but it also can be positive by encouraging help-seeking and providing information about resources.

Suicide is a complex issue and it is important to engage media professionals as partners in responsible reporting and suicide prevention. This requires educating them, so they know how to be a valuable partner in suicide prevention. In addition to the Recommendations for Reporting on Suicide noted above, media professionals can and should consult with suicide prevention experts at the Office of Suicide Prevention when preparing a news story about suicide [62].

Tools and trainings have been created and made available for use in community efforts to train media professionals. El Paso County Public Health created a brief training video that provides recommended best practice approaches for covering suicide. The video, which can be accessed here: https://www.youtube.com/watch?v=zkl_5UMHln4&feature=youtu.be was created in collaboration with CBS affiliate, KKTV 11 News, suicide prevention experts and a renowned media ethics expert. The training in the video is provided by a media professional with a 30-year career. Utilizing a media professional to provide training on safe reporting of suicides can be an effective way of engaging other media professionals. In El Paso County, the health department has spearheaded an initiative around the training video called the *Five for 5 Challenge to Save Lives*. The challenge asks journalists to take at least five minutes to watch the video, share with five colleagues and use responsible reporting techniques to save lives.

Another training provided by media professionals is offered through the Poynter Institute in partnership with the American Foundation for Suicide Prevention, Suicide Awareness Voices of Education, among others, can be accessed at: https://www.newsu.org/reporting-mental-health-suicide. This training increases understanding about safe and helpful reporting on suicide and mental health conditions.

LIMITATIONS
& CONCLUSION

LIMITATIONS

As with almost all qualitative research, there are limitations in the key informant interview and focus group research. For example, key stakeholders for one on one interviews were identified by the Office of Suicide Prevention at CDPHE first, and then additional stakeholders were identified through the first round of interviews. There are likely other key stakeholders who were not identified through this process that could have contributed additional or different information than what was captured here.

Limitations with the focus group research includes the varying levels of participation in focus groups and the amount of time between focus groups in some communities. Across all communities there were some focus groups that did not have many participants and so the experiences and opinions of a broader group were not captured. Focus groups were held over a significant time period (between February 2018 and June 2018), which can expose participants to events that may influence their perceptions and opinions. These limitations were unavoidable, however, given the goal of reaching a large and broad set of target populations, which required more time for coordination and implementation. Additionally, in the comparison communities – Douglas and Larimer Counties – focus groups were conducted only with parents and school staff; there were no focus groups with youth, staff from youth-serving organizations, general community members, or separate groups for school staff and school administrators. The Media review was limited by necessity of time and budget. Our review of traditional media was limited to sources in Colorado and did not extend to postings on social media.

There were several strengths of this study, including the multidisciplinary make-up of the research team, the separation of analysis staff from focus group facilitators, and the total number of focus groups conducted. The research team included staff and researchers with strong backgrounds in suicide prevention, intervention, and postvention at multiple socio-ecological levels and with varying populations. The qualitative analysis was conducted by a researcher with extensive experience in analyzing suicide-related data and information. Using a researcher who was not involved in the focus group data collection strengthened the raw data analysis in that other extraneous variable related to the focus group experiences did not influence the coding and analysis. The review and refinement of the analysis by the focus group facilitators allowed for the context – such as the effect of the focus groups to be layered into the reporting where it was significant to the findings. The relatively large number of focus groups held across the State of Colorado allowed for a broad catchment of experiences, perspectives, populations, and inclusion.

CONCLUSION

For many years Colorado has experienced high suicide rates, yet despite the historical and growing prevalence of suicide, as this report has shown, talking about it is still considered a taboo by many people in the state. The stigma and shame associated with suicide specifically and with mental health issues generally, appear to some extent to be rooted in what many of the individuals who participated in this study called, "The Western mentality;" a stubborn independence and self-reliance that considers needing or asking for help a weakness, and that doesn't believe in sharing personal or family issues. It is also, for many, rooted in a need to appear as though everything is perfect and the inaccurate perception that individual struggles are isolated and rare. This project supports other more rigorous research that shows the complexities and nuances of addressing suicide. There are no easy answers or formula responses. However, information gathered through this project and reported here does shed light on ways that Colorado can and should continue to work to prevent suicide, especially among youth.

Importantly, there are many individuals and organizations in Colorado committed to addressing youth suicide by building protective factors and reducing barriers and risk factors. Key to all of these efforts is the continuing and open dialogue about mental health and about suicide. As we heard from nearly all the youth focus group participants in this study, youth want to have real, meaningful conversations with adults about these issues. They want to connect with adults and other youth who can help them answer their questions, acknowledge and understand their feelings, and support them in learning how to care for themselves even through difficult circumstances.

Through this study, the Attorney General's Office of Community Engagement, CDPHE's Office of Suicide Prevention, and the counties who participated have helped to show that Coloradans care about this issue and about their youth. There are many positive attributes in Colorado's communities upon which to enhance the partnerships and good work that state and local partners are engaged in to address youth suicide. The recommendations laid out in this report align with recommendations from the Office of Suicide Prevention and provide additional information to guide and enhance work already happening in Colorado and in El Paso, La Plata, Mesa and Pueblo Counties. Looking ahead, Colorado youth and adults must bolster protective factors and mitigate the risks identified in this project.

APPENDIX A
EL PASO COUNTY DATA PROFILE

County Data Profiles were provided by the Colorado Department of Public Health and Environment. References within these profiles are not included in the report Endnotes (Appendix H) and are footnoted within each profile.

COLORADO
Department of Public
Health & Environment

El Paso County Suicide Data Profile

The data within this profile represents suicide deaths and attempts of residents of El Paso County, who died or were injured in Colorado.[1] The data are organized by data source, in the following categories; Vital Statistics data, Colorado Violent Death Reporting System data, and Colorado Hospitalization Association data. Data are presented as counts, percentages, and rates per 100,000 population with 95 percent confidence intervals, and broken out by age.[2],[3] The 95 percent confidence interval is a statistical range calculated around the age-specific suicide rate. **When comparing two rates, when the confidence intervals do not cross or intersect each other then, this represents a statistically significant difference.**

It should be noted that, while these data indicate a significant public health issue within the county, recovery from suicidal thoughts and behaviors remains the most frequent outcome. These data are intended to shed a light on the very real experience of suicide loss within the community to inform prevention efforts. However, the conclusion that suicide is inevitable or rampant would be an inappropriate use of these data. The experience of suicide exists on a continuum; millions of Americans experience suicidal ideation every year, but only a small percentage of those make an attempt, and even fewer die[4]. Those who make an attempt and survive have a higher risk of later suicide, but over 90 percent of those who survive an attempt will not go on to die by suicide.

---

[1] Excluded are deaths and injuries of non-residents, or events that occurred outside of the state.
[2] Age specific population estimates come from the Colorado State Demography Office, except for 2017 data which represents Colorado State Demography Office forecast data for the 2017 population. The rates presented which include 2017 are subject to minor changes once the official population estimates are released.
[3] Data are suppressed if they represent counts of less than 3. Rates are presented in 3 year groups to adjust for small numbers.
[4] Source: https://www.cdc.gov/violenceprevention/pdf/suicide-factsheet.pdf Source: http://www.sprc.org/scope/attempts

El Paso County Suicide Data Profile
Colorado Department of Public Health & Environment

Colorado Vital Statistics Data (2003-2017)

This section highlights data from the Colorado Vital Statistics program housed at CDPHE. These data are derived from the death certificate, which is the official decree that contains information on the manner and cause of death.[5] These data represent all El Paso County decedents who had a manner noted as suicide between 2003 and 2017.[6]

As shown in Table 1, youth suicide rates in El Paso County remain significantly lower than those experienced by older populations. However, as shown within Figure 1 and Table 2, below, a trend has emerged in recent years that shows an increase in incidence of suicide within younger populations. That trend is mirrored by increasing adult suicide rates in the county as well, indicating an overall concern for residents of all ages. The experience of El Paso County in terms of an increase in youth suicide rates has also been seen across the state and nationwide. Due to the variable confidence intervals, it cannot be said with statistical certainty that the youth rate in El Paso County is higher than that of the state. However, adult rates in El Paso County for those ages 25+ are statistically higher than state rates.

Table 1. Age specific suicide rates, 2003-2017*								
	El Paso County Residents				State Totals			
Age Group (years)	N	Pop.	Age-specific rate	95% Confidence Interval	N	Pop.	Age-specific rate	95% Confidence Interval
10-18	117	1,242,015	9.4	7.7-11.1	696	9,191,607	7.6	7.0-8.1
19-24	196	917,284	21.4	18.4-24.4	1,290	6,395,379	20.2	19.1-21.3
25+	1,500	5,868,730	25.6	24.3-26.9	11,654	50,176,955	23.2	22.8-23.7

*2017 data represent population forecasts, and are subject to minor changes

---

[5] Death certificates are completed by funeral home directors, and the coroner or physician who certified the death.
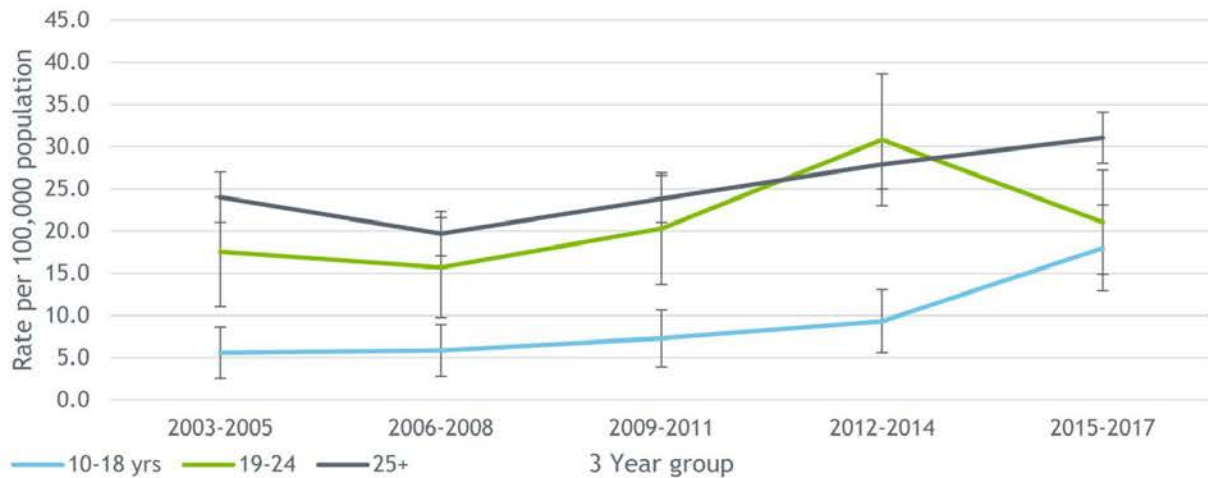[6] For more information, visit: www.colorado.gov/pacific/cdphe/vital-statistics-program

El Paso County Suicide Data Profile
Colorado Department of Public Health & Environment

Figure 1. Age specific suicide rates by 3 year period, El Paso county residents, 2003-2017*

*2017 data represent population forecasts, and are subject to minor changes

Table 2. Age specific suicide rates by 3 year period, El Paso county residents, 2003-2017*									
	10-18 years			19-24 years			25+ years		
	N	Age-specific rate	95% Confidence Interval	N	Age-specific rate	95% Confidence Interval	N	Age-specific rate	95% Confidence Interval
Time period	El Paso County Residents								
'03-'05	13	5.6	2.6 - 8.6	28	17.6	11.1-24.1	250	24.0	21.1-27.0
'06-'08	14	5.9	2.8 - 8.9	27	15.7	9.8-21.6	217	19.7	17.1-22.3
'09-'11	18	7.3	3.9 - 10.7	36	20.3	13.7-26.9	281	23.8	21.0-26.6
'12-'14	24	9.3	5.6 - 13.1	60	30.8	23.0-38.6	346	27.9	25.0-30.9
'15-'17	48	18.0	12.9 - 23.1	45	21.1	14.9-27.2	406	31.1	28.0-34.1
Time period	State Totals								
'03-'05	113	6.4	5.2-7.6	227	19.6	17.0-22.1	1,942	21.6	20.6-22.5
'06-'08	102	5.7	4.6-6.8	219	17.7	15.3-20.0	1,986	21.0	20.1-21.9
'09-'11	125	6.9	5.7-8.1	248	19.7	17.2-22.1	2,271	22.7	21.8-23.7
'12-'14	139	7.4	6.2-8.7	280	21.1	18.6-23.6	2,644	25.1	24.1-26.0
'15-'17	217	11.1	9.6-13.0	316	22.5	20.0-25.0	2,811	25.1	24.2-26.1

*2017 data represent population forecasts, and are subject to minor changes

In Colorado, the issue of firearm fatalities centers on suicide. The method a person uses in a suicide attempt plays a large role in determining if that individual will have the opportunity to recover and get past the point of crisis. Many suicide attempts occur with little planning during a short-term crisis. Exploring options to ensure that those at risk for suicide, especially
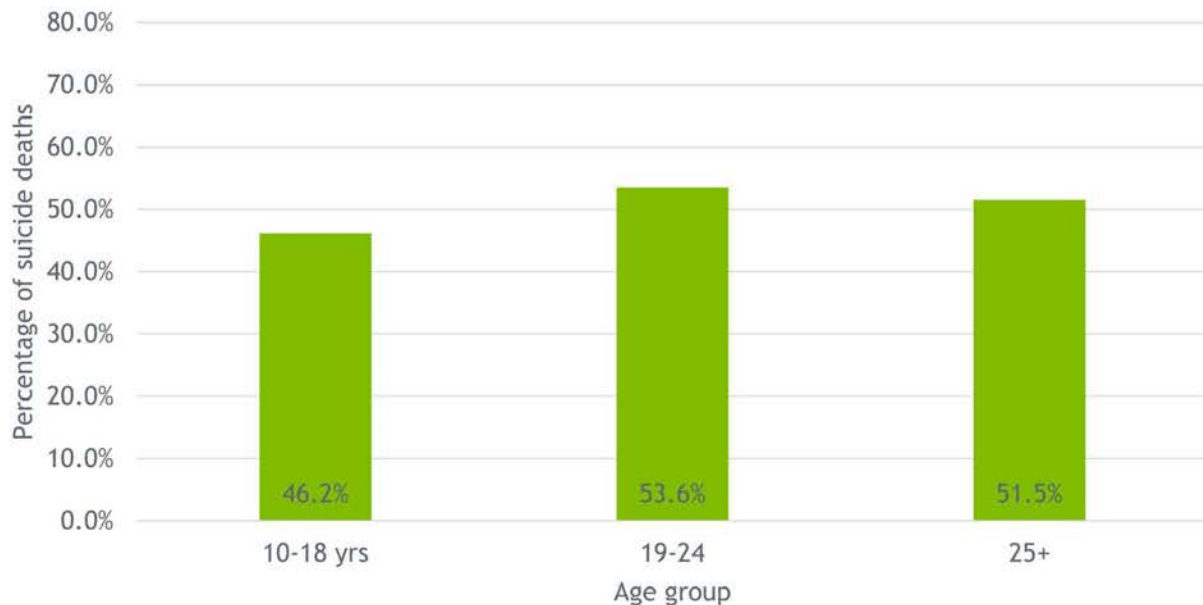
El Paso County Suicide Data Profile
Colorado Department of Public Health & Environment

youth, do not have access to a firearm or other lethal method during a period of crisis can be life-saving.

Figure 2. Percentage of suicide deaths where the method of injury was a firearm, El Paso county residents, 2012-2017

Colorado Violent Death Reporting System Data (2004-2016)

The following data come from the Colorado Violent Death Reporting System (CoVDRS) housed at CDPHE.[7] The CoVDRS is a public health surveillance system designed to obtain a complete census of all violent deaths occurring in Colorado, to collect demographic information and associated risk factor data, and to track the circumstantial information surrounding each death.[8] The CoVDRS collects and inputs data from multiple sources, including death certificates, coroner/medical examiner reports, and law enforcement investigations. As Table 3 indicates, the most frequently cited circumstances for younger suicide decedents ages 10-18 included current depressed mood, recent crisis, and family relationship conflicts.[9] For older populations, while current depressed mood was also the number one reported circumstance,

---

[7] Colorado is one of 42 states and territories currently participating in the broader National Violent Death Reporting System (NVDRS), which is maintained and funded by the Centers for Disease Control and Prevention (CDC). For more information visit: www.colorado.gov/pacific/cdphe/colorado-violent-death-reporting-system
[8] A violent death includes any death by suicide, homicide, unintentional firearm discharge, legal intervention, or acts of terrorism, as well as selected deaths of undetermined intent when the death may have been the result of violence.
[9] It should be noted that these circumstances are not mutually exclusive and many decedents have several of these circumstances noted.

El Paso County Suicide Data Profile
Colorado Department of Public Health & Environment

other life situations are more prevalent including identified mental health concerns and intimate partner problems. Among all age groups, the percentage of decedents receiving current mental health treatment is quite low, around 30 percent. This indicates that access to or acceptability of mental health supports within the community may be a prevention priority. However, suicide prevention is not the relegated responsibility of the mental health provider community. Because mental health concerns may not be central to every suicide decedent, community level strategies are also necessary.

Table 3. Suicides in El Paso county by age and circumstances, 2004-2016						
Circumstances	10-18 yrs		19-24		25+	
	N	%*	N	%*	N	%*
Suicides with 1+ known circumstance	98	97.0	176	95.7	1,302	97.0
Current depressed mood	63	64.3	127	72.2	936	71.9
Crisis in last two weeks	45	45.9	58	33.0	391	30.0
Family relationship problem	43	43.9	30	17.1	198	15.2
Current mental health problem	37	37.8	60	34.1	477	36.6
Disclosed suicidal intent	34	34.7	63	35.8	415	31.9
School Problem	34	34.7	7	4.0	**	**
Ever treated for mental health problem	34	34.7	55	31.3	436	33.5
Current mental health treatment	29	29.6	41	23.3	360	27.7
Left a suicide note	28	28.6	44	25.0	504	38.7
Intimate partner problem	28	28.6	78	44.3	516	39.6
Death preceded by argument	28	28.6	45	25.6	233	17.9
History of suicidal thoughts or plans	24	24.5	38	21.6	219	16.8
History of previous suicide attempts	22	22.5	55	31.3	366	28.1
Contributing criminal legal problem	18	18.4	30	17.1	190	14.6
Problem with other substance	11	11.2	39	22.2	199	15.3
Recent suicide of friend or family	10	10.2	5	2.8	57	4.4

* Percentage calculated out of cases where at least one circumstance was known
** counts of less than three are suppressed

There is a clear, yet complicated, relationship between mental health and substance use. Toxicology results collect data at one point in time, which limits the ability to infer the direction of the relationship between mental health and other risk behaviors. Prior research suggest that poor mental health can exacerbate substance use, and vice versa, and that both poor mental health and substance use behaviors may share a common manner of causation. Contrary to portrayals in the media, suicide deaths do not have a single cause and are often the product of a complex number of stressors operating at the individual level. As such,

El Paso County Suicide Data Profile
Colorado Department of Public Health & Environment

limited causal connections should be drawn from toxicology reports included in Table 4. By way of comparison, statewide the presence of marijuana within younger suicide decedents is around 20%[10], while the presence of alcohol within adult populations is generally closer to 40% [11].

Table 4. Suicides in El Paso county by age and toxicology, 2004-2016						
Toxicology	10-18 yrs		19-24		25+	
	N	% *	N	% *	N	% *
Toxicology available	93	92.1	175	95.1	1,280	95.3
Marijuana present	14	15.1	34	19.4	155	12.1
Alcohol present	6	6.5	67	38.3	477	37.3
Amphetamine present	6	6.5	14	8.0	95	7.4
Antidepressant present	6	6.5	14	8.0	237	18.5
Benzodiazepine present	4	4.3	14	8.0	135	10.6
Cocaine present	**	**	6	3.4	34	2.7
Opioid present	**	**	20	11.4	226	17.7

* Calculated out of cases where toxicology information was reported
** counts of less than three are suppressed

Colorado Hospital Association Data (2011-2015)

The figures in this section come from data collected from the Colorado Hospital Association. The data represent both hospitalizations and emergency department visits in El Paso County related to suicide attempts.[12] As mentioned above, the vast majority of those who attempt suicide will not go on to die by suicide. However, a prior suicide attempt does increase the risk for suicide death, and the month following discharge from a hospital or emergency department after an attempt does present a high risk time frame for reattempt or suicide death. Whereas males are disproportionately represented within suicide deaths, females are disproportionately represented in attempt data, with a peak rate in later adolescence.

[10] Colorado Violent Death Reporting System, Toxicology of suicide decedents ages 10-19, 2011-2015.
[11] Colorado Violent Death Reporting System, Toxicology of suicide decedents ages 20+, 2011-2015.
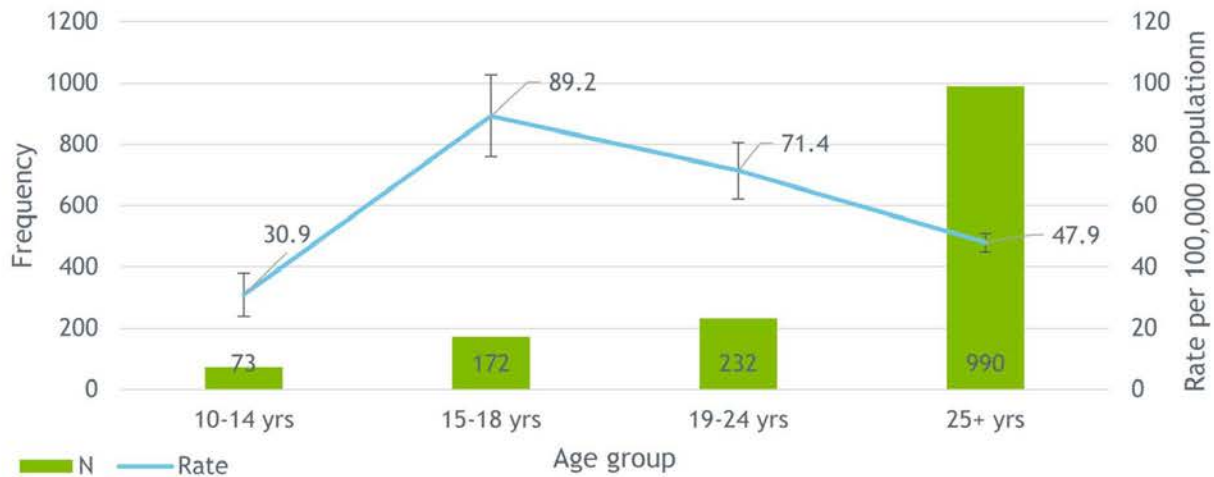[12] Suicide attempt data are coded using ICD 9 CM diagnostic codes (https://www.cdc.gov/nchs/icd/icd9cm.htm). Based on a transition to ICD 10 CM, 2015 data are an approximation comprised of events between 10/1/2014-9/30/2015.

El Paso County Suicide Data Profile
Colorado Department of Public Health & Environment

Figure 3. Non-fatal suicide-related hospitalizations and crude rates by age: El Paso county residents, 2011-2015*

* "2015" data comprised of events between 10/1/2014-9/30/2015
Data Source: Emergency Department Visit Data, Colorado Hospital Association.
Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment.

Figure 4. Non-fatal suicide-related emergency department visits and crude rates by age: El Paso county residents, 2011-2015*

* "2015" data comprised of events between 10/1/2014-9/30/2015
Data Source: Emergency Department Visit Data, Colorado Hospital Association.
Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment.

The data in this addendum are provided to put the information contained within the body of the report into context. Suicide continues to present a complex public health issue that Colorado is committed to preventing. Understanding and analyzing available data is the first step in identifying opportunities for prevention, intervention as well as indicate potential gaps in programming.

APPENDIX B
LA PLATA COUNTY DATA PROFILE

County Data Profiles were provided by the Colorado Department of Public Health and Environment. References within these profiles are not included in the report Endnotes (Appendix H) and are footnoted within each profile.

La Plata County Suicide Data Profile

The data within this profile represents suicide deaths and attempts of residents of La Plata County, who died or were injured in Colorado.[1] The data are organized by data source, in the following categories; Vital Statistics data, Colorado Violent Death Reporting System data, and Colorado Hospitalization Association data. Data are presented as counts, percentages, and rates per 100,000 population with 95% confidence intervals, and broken out by age.[2],[3] The 95% confidence interval is a statistical range calculated around the age-specific suicide rate. **When comparing two rates, when the confidence intervals do not cross or intersect each other, then this represents a statistically significant difference.**

It should be noted, that while these data indicate a significant public health issue within the county, the more frequent occurrence remains recovery. These data are intended to shed a light on the very real experience of suicide loss within the community to inform prevention efforts. However, the conclusion that suicide is inevitable or rampant would be an inappropriate use of these data. The experience of suicide exists on a continuum, millions of Americans experience suicidal ideation every year, but only a small percentage of those make an attempt, and even fewer die[4]. Those who do make an attempt and survive have a higher risk of later suicide, but over 90% of those who survive an attempt will not go on to die by suicide.

---

[1] Excluded are deaths and injuries of non-residents, or events that occurred outside of the state.

[2] Age specific population estimates come from the Colorado State Demography Office, except for 2017 data which represents Colorado State Demography Office forecast data for the 2017 population. The rates presented which include 2017 are subject to minor changes once the official population estimates are released.

[3] Data are suppressed if they represent counts of less than 3. Rates are presented in 3 year groups to adjust for small numbers.

[4] Source: https://www.cdc.gov/violenceprevention/pdf/suicide-factsheet.pdf; Source: http://www.sprc.org/scope/attempts

La Plata County Suicide Data Profile
Colorado Department of Public Health & Environment

Colorado Vital Statistics Data (2003-2017)

This section highlights data from the Colorado Vital Statistics program housed at CDPHE.[5] These data represent all La Plata County decedents who had a manner noted as suicide between 2003 and 2017.[6]

Table 1. Age specific suicide rates, 2003-2017*								
	La Plata County Residents				State Totals			
Age Group (years)	N	Pop.	Age-specific rate	95% Confidence Interval	N	Pop.	Age-specific rate	95% Confidence Interval
10-18	6	86,309	7.0	2.5-13.6	696	9,191,607	7.6	7.0-8.1
19-24	9	75,571	11.9	5.4-21.0	1,290	6,395,379	20.2	19.1-21.3
25+	117	524,858	22.3	18.3-26.3	11,654	50,176,955	23.2	22.8-23.7

*2017 data represent population forecasts, and are subject to minor changes

As shown in Table 1, youth suicide rates in La Plata County remain lower than those experienced by older populations. However, a trend has emerged in recent years showing an increase in incidence of suicide within younger populations in the county, which is in line with national data as well. For instance, during the five years of 2013-2017 the number of youth ages 10-18 who died by suicide was equal to the number lost during ten year span of 2003-2012 and the rate nearly doubled. The same is true for older youth ages 19-24 but not true for the adult suicides, ages 25+ in the county, which have remained relatively stable. Given the small size of the population and the variability of the data, it is difficult to make any sweeping generalizations with statistical certainty.

In Colorado, the issue of firearm fatalities centers on suicide. The method used in a suicide attempt plays a large role in determining if that individual will have the opportunity to recover and get past the point of crisis. Many suicide attempts occur with little planning during a short-term crisis. Exploring options to ensure that those at risk for suicide, especially youth, do not have access to a firearm during a period of crisis can be life-saving. The

[5] These data are derived from the death certificate, which is the official decree that contains information on the manner and cause of death. Death's certificates are completed by Funeral home directors, and the Coroner or Physician who certified the death
[6] For more information visit: www.colorado.gov/pacific/cdphe/vital-statistics-program

La Plata County Suicide Data Profile
Colorado Department of Public Health & Environment

proportion of firearm suicides across the age groups in La Plata county is higher than those seen across the state, indicating a potential opportunity to partner with the firearm community to develop community-wide strategies designed to enhance firearm safety to include suicide prevention strategies.

Figure 1. Age specific suicide rates, La Plata county residents, 2003-2017*
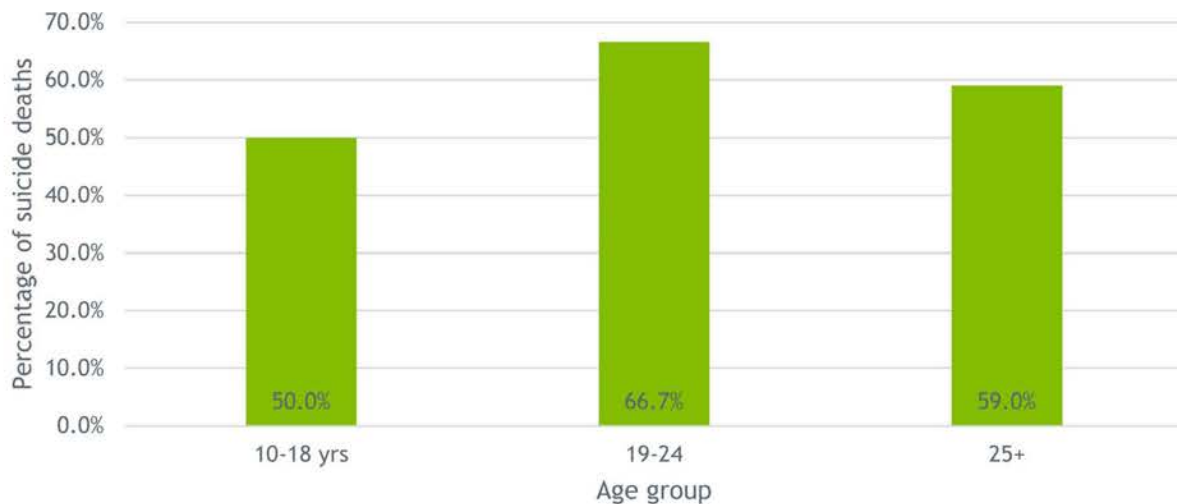
Colorado Violent Death Reporting System Data (2004-2016)

The following data come from the Colorado Violent Death Reporting System (CoVDRS) housed at CDPHE.[7] The CoVDRS is a public health surveillance system designed to obtain a complete census of all violent deaths occurring in Colorado, to collect demographic information and associated risk factor data, and to track the circumstantial information surrounding each death.[8] The CoVDRS collects and inputs data from multiple sources including death certificates, coroner/medical examiner reports, and law enforcement investigations. The most frequently cited circumstances for younger suicide decedents ages 10-18 included current depressed mood and a school problem. For those ages 19-24, a problem with alcohol was more frequently cited. For older populations, while current depressed mood was also the number one reported circumstance, other life situations are more prevalent including identified mental health concerns and intimate partner problems. Among all age groups, the

---

[7] Colorado is one of 42 states and territories currently participating in the broader National Violent Death Reporting System (NVDRS), which is maintained and funded by the Centers for Disease Control and Prevention (CDC).For more information visit: https://www.colorado.gov/pacific/cdphe/colorado-violent-death-reporting-system

[8] A violent death includes any death by suicide, homicide, unintentional firearm discharge, legal intervention, or acts of terrorism, as well as selected deaths of undetermined intent when the death may have been the result of violence.

La Plata County Suicide Data Profile
Colorado Department of Public Health & Environment

percentage of decedents receiving current mental health treatment is quite low, around 30%. This indicates that access to or acceptability of mental health supports within the community may be a prevention priority. However, suicide prevention is not the relegated responsibility of the mental health provider community; because mental health concerns may not be central to every suicide decedent, community level strategies are also necessary.

Table 3. Suicide in La Plata County, Preceding Circumstances for those ages 25+, 2004-2016		
Circumstances	25+	
	N	%*
Suicides with 1+ known circumstance	86	87.8
School Problem	**	**
Current depressed mood	41	47.7
Recent non-suicide death of friend or family	13	15.1
History of suicidal thoughts or plans	12	14.0
Current mental health problem	37	43.0
Ever treated for mental health problem	32	37.2
Current mental health treatment	28	32.6
Family relationship problem	8	9.3
Crisis in last two weeks	27	31.4
Disclosed suicidal intent	28	32.6
Intimate partner problem	25	29.1
History of previous suicide attempts	15	17.4
Problem with other substance	10	11.6
Death preceded by argument	10	11.6
Problem with alcohol	19	22.1

** counts of less than three are suppressed; youth data ages 10-24 suppressed

There is a clear, yet complicated, relationship between mental health and substance use. Toxicology results collect data at one point in time, which limits the ability to infer the direction of the relationship between mental health and other risk behaviors. Prior research suggest that poor mental health can exacerbate substance use, and vice versa, and that both poor mental health and substance use behaviors may share a common manner of causation. Contrary to portrayals in the media, suicide deaths do not have a single cause and are often

La Plata County Suicide Data Profile
Colorado Department of Public Health & Environment

the product of a complex number of stressors operating at the individual level. As such, limited causal connections should be drawn from toxicology reports included in Table 3. However, in line with the circumstances for those ages 19-24, alcohol does appear to be a contributing factor in a majority of those suicide deaths.

Table 3. Suicides in La Plata County by age and toxicology, 2004-2016						
Toxicology	10-18 yrs		19-24		25+	
	N	%*	N	%*	N	%*
Toxicology available	5	100.0	7	100.0	80	81.6
Marijuana present	**all data suppressed due to low numbers**		**	**	15	18.8
Alcohol present			6	85.7	35	43.8
Amphetamine present			**	**	**	**
Antidepressant present			**	**	11	13.8
Benzodiazepine present			**	**	7	8.8
Cocaine present			**	**	**	**
Opioid present			**	**	16	20.0

Colorado Hospital Association Data (2011-2015)

The figures in this section come from data collected from the Colorado Hospital Association. The data represent both hospitalizations and emergency department visits in La Plata County, for suicide attempts.[9] As mentioned above, the vast majority of those experiencing a suicide attempt will not go on to die by suicide. However, a prior suicide attempt does increase the risk for suicide death, and the month following discharge from a hospital or emergency department after an attempt does present a high risk time frame for reattempt or suicide death. Converse to the disparity seen within suicide deaths, females are disproportionately represented in attempt data with peak rates in later adolescence.
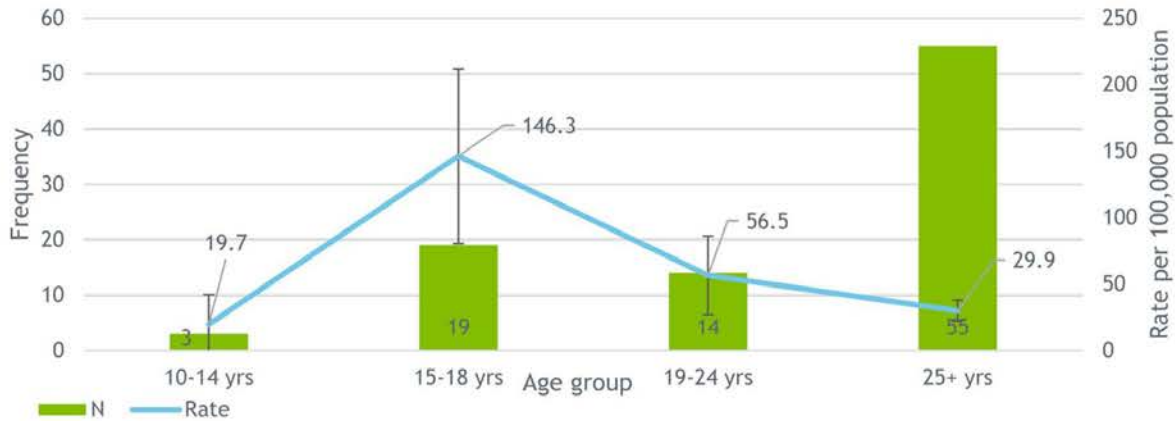
---

[9] Suicide attempt data are coded using ICD 9 CM diagnostic codes (https://www.cdc.gov/nchs/icd/icd9cm.htm). Based on a transition to ICD 10 CM, 2015 data are an approximation comprised of events between 10/1/2014-9/30/2015.

La Plata County Suicide Data Profile
Colorado Department of Public Health & Environment

Figure 3. Non-fatal suicide-related hospitalizations and crude rates by age: La Plata county residents, 2011-2015*

* "2015" data comprised of events between 10/1/2014-9/30/2015
Data Source: Hospital Discharge Data, Colorado Hospital Association. Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment

Figure 4. Non-fatal suicide-related emergency department visits and crude rates by age: La Plata county residents, 2011-2015.

* "2015" data comprised of events between 10/1/2014-9/30/2015
Data Source: Emergency Department Visit Data, Colorado Hospital Association. Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment.

The data in this addendum are provided to put the information contained within the body of the report into context. Suicide continues to present a complex public health issue that Colorado is committed to preventing. Understanding and analyzing available data is the first step in identifying opportunities for prevention, intervention as well as indicate potential gaps in programming.

APPENDIX C
MESA COUNTY DATA PROFILE

County Data Profiles were provided by the Colorado Department of Public Health and Environment. References within these profiles are not included in the report Endnotes (Appendix H) and are footnoted within each profile.

Mesa County Suicide Data Profile

The data within this profile represents suicide deaths and attempts of residents of Mesa County, who died or were injured in Colorado.[1] The data are organized by data source, in the following categories; Vital Statistics data, Colorado Violent Death Reporting System data, and Colorado Hospitalization Association data. Data are presented as counts, percentages, and rates per 100,000 population with 95 percent confidence intervals, and broken out by age.[2,3] The 95 percent confidence interval is a statistical range calculated around the age-specific suicide rate. **When comparing two rates, when the confidence intervals do not cross or intersect each other then, this represents a statistically significant difference.** Data collected and reported by coroners, law enforcement, and other death investigators is crucial in crafting prevention priorities, directing funding, and shaping future efforts. The data directly informs opportunities for prevention, intervention, as well as helps to identify gaps in programming.

It should be noted that, while these data indicate a significant public health issue within the county, recovery from suicidal thoughts and behaviors remains the most frequent outcome. These data shed a light on the very real experience of suicide loss within the community in order to inform prevention efforts. However, the conclusion that suicide is inevitable or rampant would be an inappropriate use of these data. The experience of suicide exists on a continuum; millions of Americans experience suicidal ideation every year, but only a small

---

[1] Excluded are deaths and injuries of non-residents, or events that occurred outside of the state.
[2] Age specific population estimates come from the Colorado State Demography Office, except for 2017 data which represents Colorado State Demography Office forecast data for the 2017 population. The rates presented are subject to minor changes once the official population estimates are released.
[3] Data are suppressed if they represent counts of less than 3. Rates are presented in multiple year groups to adjust for small numbers.

Mesa County Suicide Data Profile
Colorado Department of Public Health & Environment

percentage of those make an attempt, and even fewer die[4]. Although those who attempt and survive have a higher risk of later suicide, over 90 percent of those who survive an attempt will not go on to die by suicide.

Colorado Vital Statistics Data (2003-2017)

These data are derived from the death certificate, which is the official decree that contains information on the manner and cause of death.[5] These data represent all Mesa County decedents who had a manner noted as suicide between 2003 and 2017.[6]

As shown in Table 1, youth suicide rates for those ages 10-24 in Mesa County remain significantly lower than those experienced by older populations. However, within Figure 1 and Table 2, a trend has emerged in recent years that shows an increase in incidence of suicide within younger populations, which is seen both statewide and nationally. That trend is mirrored by the adult suicide rates in the county, indicating an overall concern for residents of all ages. However, due to the smaller numbers and highly variable confidence intervals, it cannot be said with statistical certainty that the youth rate in Mesa County is higher than that of the state. Adult rates in Mesa for those ages 25+ are statistically higher than state rates.

Table 1. Age specific suicide rates, 2003-2017*								
	Mesa County Residents				State Totals			
Age Group (years)	N	Pop.	Age-specific rate	95% Confidence Interval	N	Pop.	Age-specific rate	95% Confidence Interval
10-18	25	255,485	9.8	6.0-13.6	696	9,191,607	7.6	7.0-8.1
19-24	43	183,085	23.5	16.5-31.5	1,290	6,395,379	20.2	19.1-21.3
25+	440	1,415,801	31.1	28.2-34.0	11,654	50,176,955	23.2	22.8-23.7

---

[4] Source: https://www.cdc.gov/violenceprevention/pdf/suicide-factsheet.pdf Source: http://www.sprc.org/scope/attempts
[5] Death certificates are completed by funeral home directors, and the coroner or physician who certified the death.
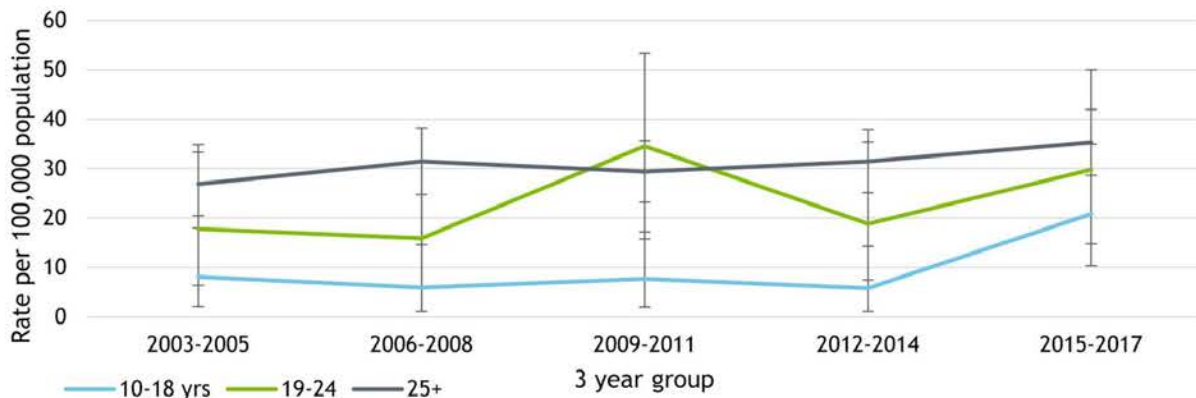[6] For more information, visit: www.colorado.gov/pacific/cdphe/vital-statistics-program

Mesa County Suicide Data Profile
Colorado Department of Public Health & Environment

Figure 1. Age specific suicide rates by 3 year period, Mesa county residents, 2003-2017

*2017 data represent population forecasts, and are subject to minor changes

Table 2. Age specific suicide rates by 3 year period, 2003-2017*									
	10-18 years			19-24 years			25+ years		
	N	Age-specific rate	95% Confidence Interval	N	Age-specific rate	95% Confidence Interval	N	Age-specific rate	95% Confidence Interval
Time period	Mesa County Residents								
'03-'05	4	8.1	2.1-18.0	6	17.8	6.4-34.9	67	26.9	20.4-33.3
'06-'08	3	6.0	1.1-14.6	6	15.9	5.7-31.2	85	31.5	24.8-38.1
'09-'11	4	7.7	2.0-17.2	13	34.6	15.8-53.3	86	29.4	23.2-35.7
'12-'14	3	5.8	1.1-14.3	7	18.9	7.5-35.4	94	31.5	25.1-37.9
'15-'17	11	20.8	10.3-35.0	11	29.8	14.8-50.0	108	35.3	28.7-42.0
Time period	State Totals								
'03-'05	113	6.4	5.2-7.6	227	19.6	17.0-22.1	1,942	21.6	20.6-22.5
'06-'08	102	5.7	4.6-6.8	219	17.7	15.3-20.0	1,986	21.0	20.1-21.9
'09-'11	125	6.9	5.7-8.1	248	19.7	17.2-22.1	2,271	22.7	21.8-23.7
'12-'14	139	7.4	6.2-8.7	280	21.1	18.6-23.6	2,644	25.1	24.1-26.0
'15-'17	217	11.1	9.6-13.0	316	22.5	20.0-25.0	2,811	25.1	24.2-26.1

*2017 data represent population forecasts, and are subject to minor changes

In Colorado, the issue of firearm fatalities centers on suicide. In Mesa County, 40 percent of the suicide deaths of youth ages 10-18 are due to firearm. The proportion rises to 65 percent for those ages 19-24 and 60 percent for those over the age of 25.[7] The method a person uses in a suicide attempt plays a large role in determining if that individual will have the

---

[7] Vital Statistics 2003-2017

Mesa County Suicide Data Profile
Colorado Department of Public Health & Environment

opportunity to recover and get past the point of crisis. Many suicide attempts occur with little planning during a short-term crisis. Exploring options to ensure that those at risk for suicide, especially youth, do not have access to a firearm or other lethal method during a period of crisis can be life-saving.

Colorado Violent Death Reporting System Data (2004-2016)

The following data come from the Colorado Violent Death Reporting System (CoVDRS) housed at CDPHE.[8] The CoVDRS is a public health surveillance system designed to obtain a complete census of all violent deaths occurring in Colorado, to collect demographic information and associated risk factor data, and to track the circumstantial information surrounding each death.[9] The CoVDRS collects and inputs data from multiple sources, including death certificates, coroner/medical examiner reports, and law enforcement investigations.

As Table 3 indicates, the most frequently cited circumstances for younger suicide decedents included mental health concerns and a recent crisis.[10] For older populations, while current depressed mood and mental health concerns were also leading reported circumstances, other life situations are more prevalent, including physical health concerns and intimate partner problems. Among the 10-18 age group, the proportion of decedents receiving mental health services around the time of death is higher than seen across the state. However, that proportion drops significantly in early adulthood, indicating that access to or acceptability of mental health supports within the community may be a prevention priority. For adult populations, partnerships with primary care and physical health settings seems warranted given the proportion of adult suicides with a physical health concern at the time of death.

---

[8] Colorado is one of 42 states and territories currently participating in the broader National Violent Death Reporting System (NVDRS), which is maintained and funded by the Centers for Disease Control and Prevention (CDC). For more information visit: www.colorado.gov/pacific/cdphe/colorado-violent-death-reporting-system.
[9] A violent death includes any death by suicide, homicide, unintentional firearm discharge, legal intervention, or acts of terrorism, as well as selected deaths of undetermined intent when the death may have been the result of violence.
[10] It should be noted that the circumstances in Table 3 are not mutually exclusive and many decedents have several of these circumstances noted.

Mesa County Suicide Data Profile
Colorado Department of Public Health & Environment

Table 3. Suicides in Mesa county by age and circumstances, 2004-2016	10-18 yrs		19-24		25+	
Circumstances	N	%*	N	%*	N	%*
Suicides with 1+ known circumstance	21	100.0	37	94.9	385	96.5
Current mental health problem	10	47.6	10	27.0	178	46.2
Ever treated for mental health problem	10	47.6	9	24.3	152	39.5
Disclosed suicidal intent	9	42.9	16	43.2	144	37.4
Crisis in the last two weeks	8	38.1	13	35.1	137	35.6
Current depressed mood	8	38.1	15	40.5	211	54.8
Current mental health treatment	8	38.1	5	13.5	125	32.5
History of suicidal thoughts or plans	7	33.3	7	18.9	80	20.8
Family relationship problem	7	33.3	7	18.9	64	16.6
Death preceded by argument	7	33.3	11	29.7	68	17.7
Left a suicide note	6	28.6	8	21.6	139	36.1
Intimate partner problem	6	28.6	19	51.4	124	32.2
History of previous suicide attempts	5	23.8	8	21.6	102	26.5
School Problem	5	23.8	3	8.1	3	0.8
Contributing criminal legal problem	4	19.1	7	18.9	55	14.3
Problem with other substance	4	19.1	4	10.8	47	12.2
Physical health problem	3	14.3	**	**	157	40.8
Recent suicide of friend or family	3	14.3	**	**	13	3.4

* calculated out of cases where at least one circumstance was known
** counts of less than three are suppressed

There is a clear, yet complicated, relationship between mental health and substance use. Toxicology results collect data at one point in time, which limits the ability to infer the direction of the relationship between mental health and other risk behaviors. Prior research suggests that poor mental health can exacerbate substance use, and vice versa, and that both poor mental health and substance use behaviors may share a common manner of causation. Contrary to portrayals in the media, suicide deaths do not have a single cause and are often the product of a complex number of stressors operating at the individual level. Given that, and the low numbers included below, limited causal connections should be drawn from toxicology reports included in Table 4.

However, further exploration into the substance use behaviors within the county is warranted, given the figures below. By way of comparison, statewide the presence of marijuana within

Mesa County Suicide Data Profile
Colorado Department of Public Health & Environment

younger suicide decedents is around 20%[11], while the presence of alcohol within adult populations is generally closer to 40%[12].

Table 4. Suicides in Mesa county by age and toxicology, 2004-2016						
Toxicology	10-18 yrs		19-24		25+	
	N	%*	N	%*	N	%*
Toxicology available	18	85.7	32	82.1	335	84.0
Marijuana present	8	44.4	5	15.6	28	8.4
Alcohol present	3	16.7	19	59.4	135	40.3
Antidepressant present	**	**	**	**	32	9.6
Benzodiazepine present	**	**	**	**	23	6.9
Amphetamine present	**	**	**	**	17	5.1
Cocaine present	**	**	**	**	7	2.1
Opioid present	**	**	**	**	48	14.3

* calculated out of cases where toxicology information was received
** counts of less than three are suppressed

Colorado Hospital Association Data (2011-2015)

The figures in this section come from data collected from the Colorado Hospital Association. The data represent both hospitalizations and emergency department visits in Mesa County related to suicide attempts.[13]

As mentioned above, the vast majority of those experiencing a suicide attempt will not go on to die by suicide. However, a prior suicide attempt does increase the risk for suicide death, and the month following discharge from a hospital or emergency department after an attempt does present a high risk time frame for reattempt or suicide death. Whereas males are disproportionately represented in suicide fatalities, females are disproportionately represented in attempt data and there is a peak in later adolescence for the rate.

---

[11] Colorado Violent Death Reporting System, Toxicology of suicide decedents ages 10-19, 2011-2015.
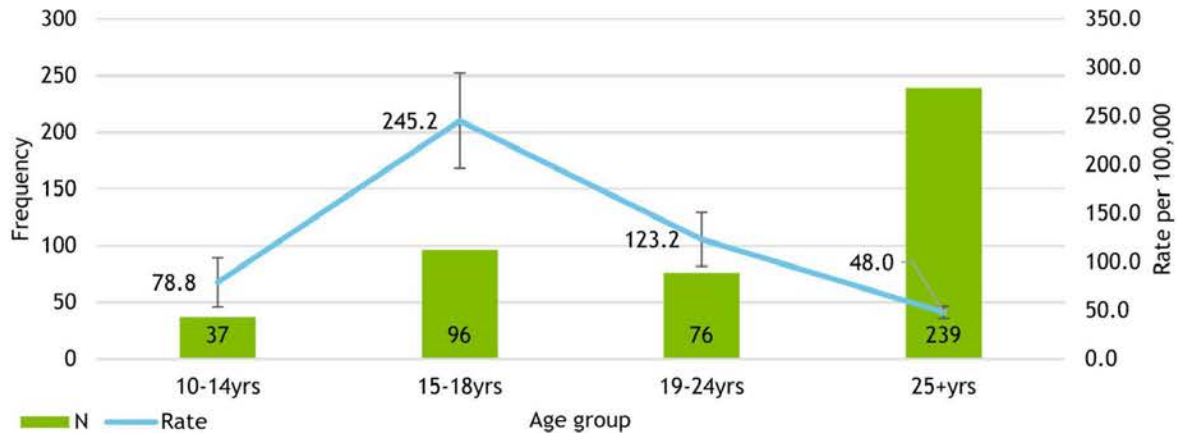[12] Colorado Violent Death Reporting System, Toxicology of suicide decedents ages 20+, 2011-2015.
[13] Suicide attempt data are coded using ICD 9 CM diagnostic codes (www.cdc.gov/nchs/icd/icd9cm.htm). Based on a transition to ICD 10 CM, 2015 data are an approximation comprised of events between 10/1/2014-9/30/2015.

Mesa County Suicide Data Profile
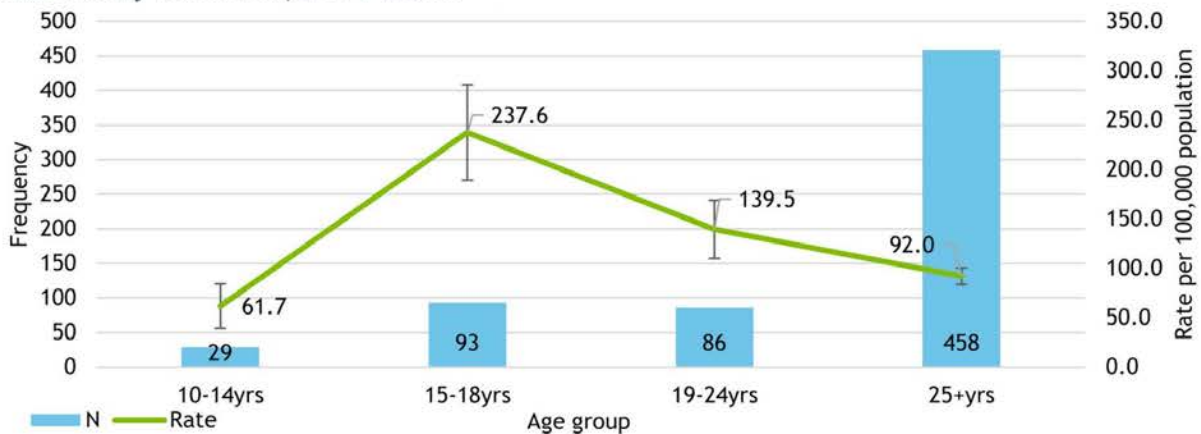## Colorado Department of Public Health & Environment

Figure 2. Non-fatal suicide-related emergency department visits and crude rates by age: Mesa county residents, 2011-2015*

* "2015" data comprised of events between 10/1/2014-9/30/2015
Data Source: Emergency Department Visit Data, Colorado Hospital Association. Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment

Figure 3. Non-fatal suicide-related hospitalizations and crude rates by age: Mesa county residents, 2011-2015.*

* "2015" data comprised of events between 10/1/2014-9/30/2015
Data Source: Hospital Discharge Data, Colorado Hospital Association. Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment.

The data in this addendum are provided to put the information contained within the body of the report into context. Suicide continues to present a complex public health issue that Colorado is committed to preventing. Understanding and analyzing available data is the first step in identifying opportunities for prevention, intervention as well as indicate potential gaps in programming.

APPENDIX D
PUEBLO COUNTY DATA PROFILE

County Data Profiles were provided by the Colorado Department of Public Health and Environment. References within these profiles are not included in the report Endnotes (Appendix H) and are footnoted within each profile.

Pueblo County Suicide Data Profile

The data within this profile represents suicide deaths and attempts of residents of Pueblo County, who died or were injured in Colorado.[1] The data are organized by data source, in the following categories; Vital Statistics data, Colorado Violent Death Reporting System data, and Colorado Hospitalization Association data. Data are presented as counts, percentages, and rates per 100,000 population with 95% confidence intervals, and broken out by age.[2],[3] The 95% confidence interval is a statistical range calculated around the age-specific suicide rate. **When comparing two rates, when the confidence intervals do not cross or intersect each other then, this represents a statistically significant difference.** Data collected and reported by coroners, law enforcement, and other death investigators is crucial in crafting prevention priorities, directing funding, and shaping future efforts.

It should be noted that, while these data indicate a significant public health issue within the county, recovery from suicidal thoughts and behaviors remains the most frequent outcome. These data are intended to shed a light on the very real experience of suicide loss within the community to inform prevention efforts. However, the conclusion that suicide is inevitable or rampant would be an inappropriate use of these data. The experience of suicide exists on a continuum; millions of Americans experience suicidal ideation every year, but only a small percentage of those make an attempt, and even fewer die[4]. Those who make an attempt and

---

[1] Excluded are deaths and injuries of non-residents, or events that occurred outside of the state.
[2] Age specific population estimates come from the Colorado State Demography Office, except for 2017 data which represents Colorado State Demography Office forecast data for the 2017 population. The rates presented which include 2017 are subject to minor changes once the official population estimates are released.
[3] Data are suppressed if they represent counts of less than 3. Rates are presented in 3 year groups to adjust for small numbers.
[4] Source: https://www.cdc.gov/violenceprevention/pdf/suicide-factsheet.pdf Source: http://www.sprc.org/scope/attempts

Pueblo County Suicide Data Profile
Colorado Department of Public Health & Environment

survive have a higher risk of later suicide, but over 90% of those who survive an attempt will not go on to die by suicide.

Colorado Vital Statistics Data (2003-2017)

This section highlights data from the Colorado Vital Statistics program housed at CDPHE.[5],[6] As shown in Table 1, youth suicide rates for those ages 10-24 in Pueblo County remain lower than those experienced by older populations. However, as shown within Figure 1 and Table 2, below, a trend has emerged in recent years that shows an increase in incidence of suicide within younger populations, which has also been seen nationally and across the state. That trend is mirrored by the adult suicide rates in the county as well, indicating an overall concern for residents of all ages. However, due to the smaller numbers and highly variable confidence intervals, it cannot be said with statistical certainty that the youth rate in Pueblo County is higher than that of the state.

Table 1. Age specific suicide rates, 2003-2017*								
	Pueblo County Residents				State Totals			
Age Group (years)	N	Pop.	Age-specific rate	95% Confidence Interval	N	Pop.	Age-specific rate	95% Confidence Interval
10-18	39	298,531	13.1	9.0-17.2	696	9,191,607	7.6	7.0-8.1
19-24	43	204,061	21.1	14.8-27.4	1,290	6,395,379	20.2	19.1-21.3
25+	406	1,556,640	26.1	23.6-28.6	11,654	50,176,955	23.2	22.8-23.7

*2017 data represent population forecasts, and are subject to minor changes

In Colorado, the issue of firearm fatalities centers on suicide. In Pueblo County, 41 percent of the suicide deaths of youth ages 10-18 are due to firearm. The proportion drops to 37.2 percent within 19-24 years and rises again to 54.4% for those aged 25 and over.[7] The method an individual uses in a suicide attempt plays a large role in determining if that individual will have the opportunity to recover and get past the point of crisis. Many suicide attempts occur with little planning during a short-term crisis. Exploring options to ensure that those at risk

---

[5] These data are derived from the death certificate, which is the official decree that contains information on the manner and cause of death. Death certificates are completed by funeral home directors, and the coroner or physician who certified the death.
[6] For more information, visit: https://www.colorado.gov/pacific/cdphe/vital-statistics-program
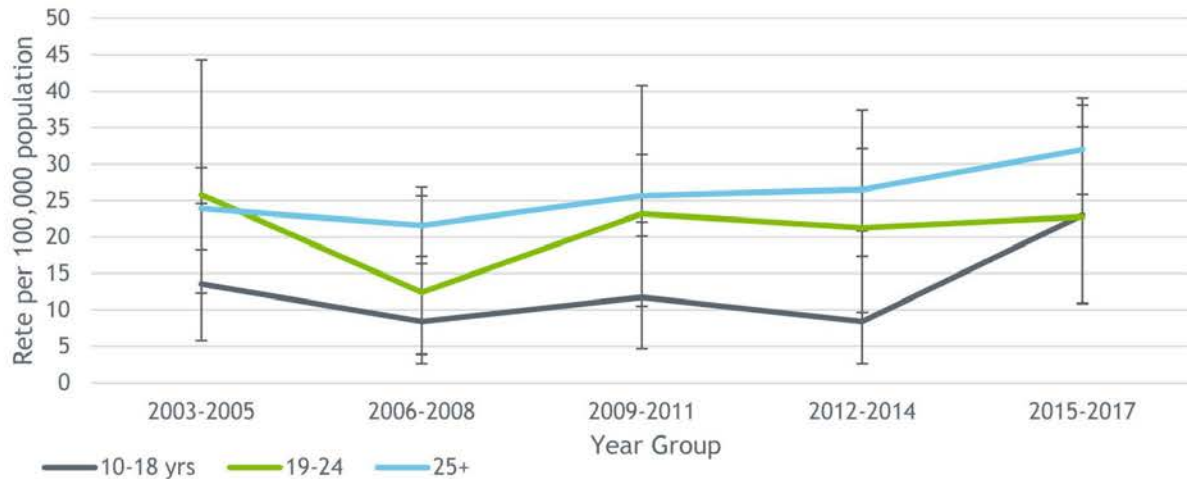[7] Colorado Vital statistics, 2003-2017

Pueblo County Suicide Data Profile
Colorado Department of Public Health & Environment

for suicide, especially youth, do not have access to a firearm or other lethal method during a period of crisis can be life-saving.

Figure 1. Age specific suicide rates by 3 year period, Pueblo County Residents, 2003-2017*

*2017 data represent population forecasts, and are subject to minor changes

Table 2. Age specific suicide rates by 3 year period, Pueblo county residents, 2003-2017*									
	10-18 years			**19-24 years**			**25+ years**		
	N	Age-specific rate	95% Confidence Interval	N	Age-specific rate	95% Confidence Interval	N	Age-specific rate	95% Confidence Interval
Time period	**Pueblo County Residents**								
'03-'05	8	13.6	5.8-24.6	10	25.8	12.3-44.3	69	23.9	18.3-29.6
'06-'08	5	8.4	2.7-17.4	5	12.4	3.9-25.7	65	21.6	16.4-26.8
'09-'11	7	11.8	4.7-22.1	9	23.2	10.5-40.8	81	25.7	20.1-31.3
'12-'14	5	8.4	2.7-17.4	9	21.3	9.7-37.5	85	26.5	20.9-32.1
'15-'17	14	23.0	11.0-35.1	10	22.8	10.8-39.1	106	32.0	25.9-38.1
Time period	**State Totals**								
'03-'05	113	6.4	5.2-7.6	227	19.6	17.0-22.1	1,942	21.6	20.6-22.5
'06-'08	102	5.7	4.6-6.8	219	17.7	15.3-20.0	1,986	21.0	20.1-21.9
'09-'11	125	6.9	5.7-8.1	248	19.7	17.2-22.1	2,271	22.7	21.8-23.7
'12-'14	139	7.4	6.2-8.7	280	21.1	18.6-23.6	2,644	25.1	24.1-26.0
'15-'17	217	11.1	9.6-13.0	316	22.5	20.0-25.0	2,811	25.1	24.2-26.1

*2017 data represent population forecasts, and are subject to minor changes

Pueblo County Suicide Data Profile
Colorado Department of Public Health & Environment

Colorado Violent Death Reporting System Data (2004-2016)

The following data come from the Colorado Violent Death Reporting System (CoVDRS) housed at CDPHE.[8] The CoVDRS is a public health surveillance system designed to obtain a complete census of all violent deaths occurring in Colorado, to collect demographic information and associated risk factor data, and to track the circumstantial information surrounding each death.[9] The CoVDRS collects and inputs data from multiple sources, including death certificates, coroner/medical examiner reports, and law enforcement investigations.

As Table 3 indicates, the most frequently cited circumstances for younger suicide decedents ages 10-18 centered around a recent crisis or argument, including intimate partner problem.[10] Intimate partner problems also played a significant role for young adult suicide decedents. These indicate a need to support the community with potential conflict resolution and relationship-building skills early on. For older populations, identified mental health concerns figured more prominently. Among all age groups, the percentage of decedents receiving current mental health treatment is quite low, around 30%. This indicates that access to or acceptability of mental health supports within the community may be a prevention priority. However, suicide prevention is not the relegated responsibility of the mental health provider community because mental health concerns may not be central to every suicide decedent. Community level strategies are also necessary.

Table 3. Suicides in Pueblo county by age and circumstances, 2004-2016						
Circumstances	10-18 yrs		19-24		25+	
	N	%*	N	%*	N	%*
Suicides with 1+ known circumstance	30	96.8	30	88.2	341	94.7
Crisis in the last two weeks	13	43.3	12	40.0	119	34.9
Death preceded by argument	13	43.3	10	33.3	54	15.8
Intimate partner problem	12	40.0	19	63.3	129	37.8
Current depressed mood	12	40.0	15	50.0	180	52.8
Left a suicide note	10	33.3	7	23.3	131	38.4
Disclosed suicidal intent	10	33.3	16	53.3	117	34.3
Ever treated for mental health problem	10	33.3	13	43.3	108	31.7

[8] Colorado is one of 42 states and territories currently participating in the broader National Violent Death Reporting System (NVDRS), which is maintained and funded by the Centers for Disease Control and Prevention (CDC). For more information, visit: https://www.colorado.gov/pacific/cdphe/colorado-violent-death-reporting-system
[9] A violent death includes any death by suicide, homicide, unintentional firearm discharge, legal intervention, or acts of terrorism, as well as selected deaths of undetermined intent when the death may have been the result of violence.
[10] It should be noted that the circumstances presented in Table 3 are not mutually exclusive and many decedents have several of these circumstances noted.

Pueblo County Suicide Data Profile
Colorado Department of Public Health & Environment

Contributing criminal legal problem	8	26.7	8	26.7	50	14.7
Current mental health problem	8	26.7	14	46.7	124	36.4
Current mental health treatment	8	26.7	11	36.7	90	26.4
Family relationship problem	8	26.7	4	13.3	57	16.7
History of previous suicide attempts	7	23.3	8	26.7	68	19.9
School Problem	7	23.3	**	**	**	**
History of suicidal thoughts or plans	3	10.0	6	20.0	49	14.4
Problem with alcohol	3	10.0	3	10.0	90	26.4

* calculated out of cases where at least one circumstance was known
** counts of less than three are suppressed

There is a clear, yet complicated, relationship between mental health and substance use. Toxicology results collect data at one point in time, which limits the ability to infer the direction of the relationship between mental health and other risk behaviors. Suicide presents a significant and complicated public health issue. Prior research suggest that poor mental health can exacerbate substance use, and vice versa, and that both poor mental health and substance use behaviors may share a common manner of causation. Contrary to portrayals in the media, suicide deaths do not have a single cause and are often the product of a complex number of stressors operating at the individual level. Given that and the low number of youth decedents represented, limited causal connections should be drawn from toxicology reports included in Table 4.[11]

Table 4. Suicides in Pueblo county by age and toxicology, 2004-2016						
Toxicology	**10-18 yrs**		**19-24**		**25+**	
	N	%*	N	%*	N	%*
Toxicology available	28	90.32	29	85.29	308	85.56
Marijuana present	4	14.29	7	24.14	21	6.82
Alcohol present	**	**	10	34.48	110	35.71
Amphetamine present	**	**	**	**	18	5.84
Cocaine present	**	**	**	**	16	5.19
Antidepressant present	**	**	**	**	29	9.42
Benzodiazepine present	**	**	**	**	16	5.19
Opioid present	**	**	**	**	43	13.96

* calculated out of cases where toxicology information was received
** counts of less than three are suppressed

[11] By way of comparison, statewide the presence of marijuana within younger suicide decedents is around 20%, while the presence of alcohol within adult populations is generally closer to 40%- Colorado Violent Death Reporting System 2011-2015
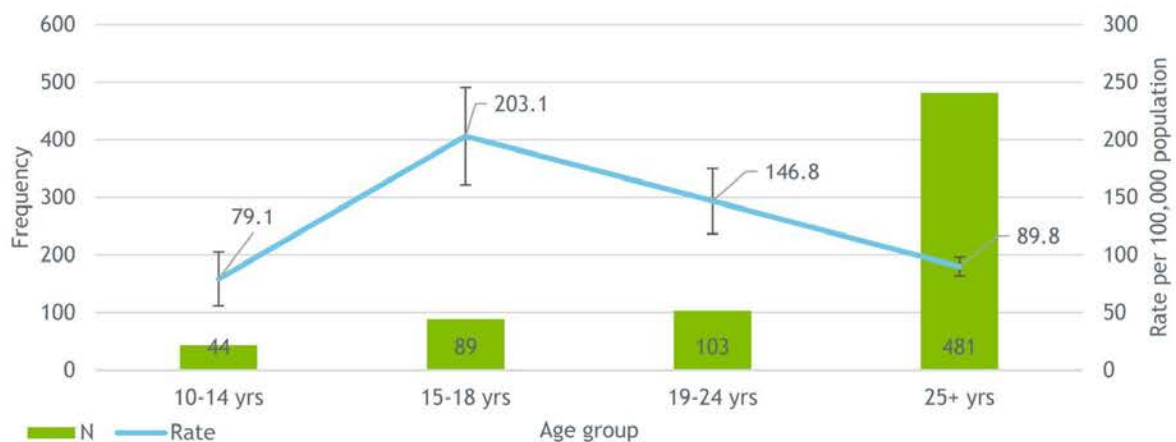
Pueblo County Suicide Data Profile
Colorado Department of Public Health & Environment

Colorado Hospital Association Data (2011-2015)

The figures in this section come from data collected from the Colorado Hospital Association. The data represent both hospitalizations and emergency department visits in Pueblo County related to suicide attempts.[12] As mentioned above, the vast majority of those experiencing a suicide attempt will not go on to die by suicide. However, a prior suicide attempt does increase the risk for suicide death, and the month following discharge from a hospital or emergency department after an attempt does present a high risk time frame for reattempt or suicide death. Whereas males are disproportionately represented within suicide deaths, females are disproportionately represented in attempt data with a peak rate in later adolescence.

Figure 2. Non-fatal suicide-related hospitalizations and crude rates by age: Pueblo county residents, 2011-2015.

* "2015" data comprised of events between 10/1/2014-9/30/2015

Data Source: Hospital Discharge Data, Colorado Hospital Association. Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment.

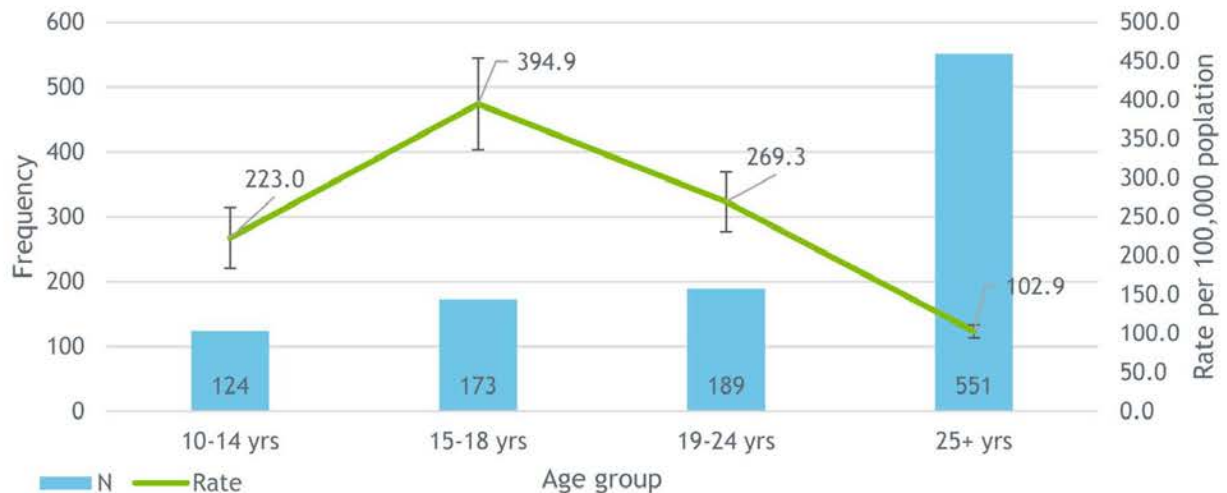* "2015" data comprised of events between 10/1/2014-9/30/2015

---

[12] Suicide attempt data are coded using ICD 9 CM diagnostic codes (https://www.cdc.gov/nchs/icd/icd9cm.htm). Based on a transition to ICD 10 CM, 2015 data are an approximation comprised of events between 10/1/2014-9/30/2015.

Pueblo County Suicide Data Profile
Colorado Department of Public Health & Environment

Figure 3. Non-fatal suicide-related emergency department visits and crude rates by age: Pueblo county residents, 2011-2015*

Data Source: Emergency Department Visit Data, Colorado Hospital Association. Prepared By: Vital Statistics Program, Colorado Department of Public Health and Environment.

The data in this addendum are provided to put the information contained within the body of the report into context. Suicide continues to present a complex public health issue that Colorado is committed to preventing. Understanding and analyzing available data is the first step in identifying opportunities for prevention, intervention as well as indicate potential gaps in programming.

APPENDIX E

KEY STAKEHOLDER INTERVIEW GUIDE

INTRODUCTION

As you know, over the past several years, El Paso, Mesa, La Plata and Pueblo counties have been greatly impacted by the issue of youth suicide. As one of several responses, the Colorado Office of the Attorney General/Office of Community Engagement has contracted with Health Management Associates, Inc. (HMA), a national research and consulting firm with an office based in Colorado, to lead work in these four counties in an effort to better understand the youth suicide trend and help to inform strategies for prevention. Additional key partners include the Office of Suicide Prevention at the Colorado Department of Public Health and numerous other stakeholders.

The primary goal of the project is to support communities in developing local solutions to prevent youth suicide. A secondary goal is to foster the relationship between local communities and state government efforts. To start this project HMA is conducting interviews with key stakeholders identified by the Office of Suicide Prevention at the state health department-including representatives from public health, mental health, schools, community-based organizations and others. The purpose of these interviews is to gather information about youth suicide in your community, to learn about the activities and efforts in your community related to suicide prevention, to identify additional key stakeholders that you feel HMA should talk with, to hear what you would like to learn from the focus groups HMA will be conducting in your community and to inform our approach to conducting the focus groups.

We value your input and the critical role you play in suicide prevention for your community. We very much appreciate your time to talk with us today, as well as your insights and ideas.

GENERAL INFORMATION

This is the beginning of a partnership in which we would like to stay in contact with you so that we may keep you updated as the project progresses, as well as to get ongoing feedback on components of the project. Can we make sure that we have the correct information for you? Please verify your name, organization, title and general job responsibilities.

- Please describe what role your organization plays in suicide prevention and/or intervention in your community.
- Please tell us what role you play in suicide prevention and/or intervention in your organization and/or community.
- Would you please share your perspective about how youth suicide has impacted your community?
- Please describe the suicide prevention activities/initiatives available in your community?

    - How are these resourced?

- When you think of your community, what do you think are the risk factors related to youth suicide?

    - Are these unique to youth suicide?
    - Do you believe these may be unique to your community?
    - Are there risk factors that are unique to particular groups in your community? For example, boys versus girls? Straight youth versus gay, lesbian or bisexual youth, others
    - Do you feel that there has been any change in your community that has increased the risk for youth suicide?

- When you think of your community, what do you think are protective factors related to youth suicide?

    - Are these unique to youth suicide?
    - Do you believe these may be unique to your community?
    - Are there risk factors that are unique to particular groups in your community? For example, boys versus girls? Straight youth versus gay, lesbian or bisexual youth, others

- What are some of the barriers and facilitators to preventing youth suicide in your community?
- What resources are available in your community to help youth who are or might be depressed, anxious, or thinking about suicide?

    - Prompt – If participant does not mention suicide intervention resources, ask specifically about it. If they list some, but uncertain which is related to suicide intervention/prevention, list what they described and ask which of them is most appropriate for suicide intervention.

- What suicide prevention activities/efforts do you believe are needed?

    - What suicide prevention activities would be the most effective in your community and why?

- Relative to other communities in Colorado, what do you think about suicide prevention efforts in your community?

APPENDIX E

KEY STAKEHOLDER INTERVIEW GUIDE

FOCUS GROUPS

HMA will be conducting a series of focus groups in each of the four identified counties. These focus groups will help us to identify needs, gaps, strengths, key partners, and community-specific efforts and concerns to inform prevention priorities and strategies for each unique community. Focus Group participants will include the following stakeholders: Parents, youth, school staff, local youth-serving non-profit leaders, and other key community members, based on each individual community's needs (faith leaders, health professionals, law enforcement, social services providers.

- What are the questions you would like HMA to ask in the focus groups? What information would help in the suicide prevention efforts of your community?
- Are there issues or concerns that may come up in these focus groups to which we should be particularly sensitive? [examples: words, language, concepts, etc.?]
- What recommendations do you have regarding recruiting focus group participants?
- May we reach out to you in the near future to discuss particular organizations and/or individuals in your community that you recommend we outreach to find participants for focus groups?

KEY STAKEHOLDERS

- Are there other key stakeholders you would recommend HMA interview?
    - May we follow up with you to get contact information for these key stakeholders?
- How would you like to be involved in the project moving forward?

APPENDIX F

FOCUS GROUP GUIDE

INTRODUCTIONS

The Colorado Office of the Attorney General's Office of Community Engagement is partnering with the Office of Suicide Prevention at the Colorado Department of Public Health and Environment and stakeholders in four Colorado counties that have been impacted by youth suicides, especially in recent years (El Paso, La Plata, Mesa and Pueblo). The partnership is focused on a project to better understand the youth suicide trend in Colorado and inform strategies for prevention.

Health Management Associates, Inc. (HMA), a national research and consulting firm with an office based in Colorado, is leading the work on this project. Central to the project is focus groups with community members in each of the four counties to understand the climate, attitudes, knowledge, and existing risk and protective factors related to suicide and mental health within each county. Focus groups will be conducted with the following:

- Parents in the participating community (planned for three focus groups in El Paso County, two each in Pueblo and Mesa counties, and one in La Plata County).
- Youth in the participating community (planned for three focus groups in El Paso County, two each in Pueblo and Mesa Counties, and one in La Plata County).
- School District staff (planned for teachers counseling and other support staff) (three focus groups in El Paso County, two each in Pueblo and Mesa Counties, and one in La Plata County).
- School staff from a comparison school district (planned for two focus groups in El Paso County and one each in Pueblo, Mesa, and La Plata Counties).
- Community members in the participating community (planned for three focus groups in El Paso County, two each in Pueblo and Mesa Counties, and one in La Plata County).
- Parents in a comparison community (planned for one focus group in each county).
- Representatives from youth serving organizations in the affected community (planned for one focus group in each county).

OBJECTIVES

The focus groups will allow participants to interact in a discussion of their opinions about the topics and issues raised by the facilitator's questions. Facilitation will combine the technique of open communication (both giving and receiving information) with careful listening, observation, and skillful direction. The discussion will provide insight to deepen HMA's understanding of the issue of youth suicide in each county. The information collected will be analyzed and summarized in aggregate. No individual identifying information will be collected or shared. The following type of analysis and summarized information will be provided in a report to the Office of Community Engagement, the Office of Suicide Prevention and key stakeholders in the four Colorado counties:

- Summaries by type of group within each county;
- Summary of identified themes across groups within each county;
- Summaries across counties by group type;
- Summary of identified themes across all groups in all four counties.

The objectives of the focus groups are to:

- Gather participant input, opinion and concerns to better guide successful establishment of recommendations for effective suicide prevention.
- Engage youth, parents, school staff, leaders from local youth-serving organizations, and other key community members working on, or impacted by issues related to youth suicide to better understand common and unique ideas, opinions and attitudes about youth suicide and youth suicide prevention resources.
- Understand the climate, attitudes, and existing risk and protective factors related to suicide and mental health within each county.

COMPARISONS

The focus group facilitation team consists of three HMA team members, two focused on active listening to the feedback and facilitating the discussion, and one focused on taking notes and capturing the general sentiment of the discussion.

For parent and youth focus groups HMA will ensure one locally-known and recommended behavioral health provider on-site to attend to any participant who finds the discussion upsetting. HMA is making a concerted effort not to recruit focus group members who have been directly impacted by a recent suicide (within the past year) by engaging local stakeholders and existing groups in our recruitment efforts. Additionally, HMA will ensure that a comprehensive list of local behavioral health resources is shared at each focus group to provide support to focus group participants if/as they need.

HMA will aim for the focus groups to consist of a minimum of six and a maximum of 12 participants. HMA will work with stakeholders in each county to try and recruit a diverse set of participants with a spectrum of ideas and opinions – language, race, age, gender, sexual orientation, gender identity, education level and mobility.

APPENDIX F

FOCUS GROUP GUIDE

GUIDING PRINCIPLES

HMA will conduct focus groups according to the following guiding principles:

- Ensure an accessible location and room set up; create a friendly, comfortable climate.
- Conduct meeting in a welcoming tone, assuring participants that there are no wrong answers and that responses in the discussion will not be attributed to specific individuals.
- Establish ground rules for the discussion, including that information about specific suicide deaths or nonfatal suicidal behavior will not be discussed.
- Ensure neutrality in words and expressions and sensitivity to the topic and participants' emotions.
- Seek balance among participants.
- Encourage those who are less talkative to participate.
- Ensure all participants feel their voices are heard and valued.
- Ensure participants are respectful of each other and different opinions.
- Provide refreshments for focus group participants.
- Ensure a there is a plan in place to follow up with any participants who may need support immediately after the meeting.

AGENDA & SCRIPT

Welcoming Remarks

- Hello and welcome. Thank you for coming.
- Facilitators introduce themselves and a bit about their qualifications.

Background & Introductions

- We are talking to a number of groups of community members: young people and adults from four counties in Colorado that have been significantly impacted by youth suicide. The Colorado Office of the Attorney General's Office of Community Engagement contracted with HMA to work with stakeholders in these four counties on an effort to better understand youth suicide and help to inform strategies for prevention. Additional key partners include the Office of Suicide Prevention at the Colorado Department of Public Health, the local public health agency, and other local partners. The primary goal of the project is to support communities as they are developing local solutions to prevent youth suicide. A secondary goal is to enhance the collaboration between youth suicide prevention efforts in each local community and statewide efforts.
- We have invited you to talk to us so that we can better understand some of the concerns and thoughts about youth suicide in your community, including the risk and protective factors in your community, as well as what your community is doing/can do about youth suicide prevention.
- We are not here to collect names, personal stories, or specifics about suicides that have occurred in the community. Rather, we want to know what you think about these issues, what solutions are in the community, and what solutions need to be developed.
- We have a few ground rules and would like to have you offer some as well. Notes will be taken so we can capture important ideas and information, but no names will be used in reporting the results of the session.

    - Gather participant input, opinion and concerns to better guide successful establishment of recommendations for effective suicide prevention.
    - Engage youth, parents, school staff, leaders from local youth-serving organizations, and other key community members working on, or impacted by issues related to youth suicide to better understand common and unique ideas, opinions and attitudes about youth suicide and youth suicide prevention resources.
    - Understand the climate, attitudes, and existing risk and protective factors related to suicide and mental health within each county.

- There are no wrong answers to the questions we ask. Suicide is a complicated and difficult issue. We really want to know what you think, so we hope that you feel free to talk openly. What you share is totally up to you. You don't have to answer any questions that you don't want to and you are free to stop taking part at any time and you may leave at any time.
- Talking about difficult topics can make some people feel bad; talking about suicide might bring up feelings that some of you will want to talk about further. At the end of the group discussion, we will also provide information about available resources in your community.
- For parent and youth groups-A trained counselor will be available during and after the focus group to talk in private for those who might find this helpful.
- Before we begin, I want to reassure you that what is said here is strictly confidential, and your names will not be used in any report about the discussion. We want to stress that everything that is said within this group should stay within this group. We will be taking notes and these notes are only to make sure that we remember what the group said and so we can include everyone's point of view in our report. Your name or any identifying information will not be reported with findings from this discussion.
- Does anybody have any questions about what I've just said or anything else? Please help yourself to the refreshments at any time.

APPENDIX F
FOCUS GROUP GUIDE

PARTICIPANTS INTRODUCTION

- Let's start by going around the room and saying our first names and tell something about what you like to do for fun.
- Please tell us your name and your preference for how we all refer to you. Remember, we will not use names in the reports and findings we produce.

QUESTIONS

PERCEPTION OF THE PROBLEM IN THE CONTEXT OF THE COMMUNITY

- Would you please share your perspective about how youth suicide has impacted your community?
- What sorts of things do you hear from your peers about this issue in your community?
- Do you think there is something about your community that affects the way people think about or respond to suicide?
- What has been done to reduce or address the issue of youth suicide in your community?
- Have these efforts been successful? Why/Why not?

RISK & PROTECTIVE FACTORS

- What are the most important health and social issues facing youth in your community today?
- For youth focus group: What do you think adults need to know, that they perhaps don't know, about young people and the problems that they might be having?
- What are the issues in your community that increase the risk for youth suicide?
- What are the things in your community that decrease the risk for youth suicide?
- For parents: How do you talk with your kids about coping with challenges? What are ways that adults can build resilience in kids?

SUICIDE INTERVENTION

- Describe resources that are available to help individuals who might be depressed, anxious, or thinking about suicide?
    - Are these accessible?
- What would improve them?
- What do you think young people do if they are someone they know if feeling suicidal? Who do you think they go to for help?
- For young people: If you or someone you knew was feeling suicidal, what would you do?
    - If you asked for help-who would you ask?
    - Would you use any of the following resources? Why or why not? Safe2Tell, Crisis Text Line (aka Below the Surface campaign in El Paso county), National Lifeline, Others?
    - What do you think keeps some people from getting help in your community?
- For school groups: What school policies/procedures or practices are in place for handling students who require assessments and/or are having a crisis event?
    - What policies/procedures or practices are in place for students returning to school following a suicidal crisis?
    - What policies/procedures or practices are in place for the student body following a suicide death in the community?

SUICIDE PREVENTION

- What do you think might help to prevent youth suicide?
- What are some of the barriers to youth suicide prevention in your community?
- What types of services do you think are most important for your community to provide to prevent suicide?
- What suicide prevention activities would be the most effective for youth in your community and why?
- What are you willing to support or participate in regarding suicide prevention programs or activities? Training? Identifying ways to fund activities?

APPENDIX F

FOCUS GROUP GUIDE

CLOSING & WRAP UP

- These are all of the questions we have for you today. Does anyone have anything they think we should know but did not ask about?
- Suicide can be a hard topic to talk about and it may bring up feelings that some of you may want to talk about further. We have some helpful information about available resources in your community and we encourage you to take this information with you. [For parent and youth focus groups: A trained counselor is available to talk in private for those who might find this helpful.]
- Please remember that whatever has been said in this room stays in this room.
- Thank you very much for participating.
- Before we close, is there anything we did not ask you that you would like to make sure we include, or that you think is very important for us to capture?
- Again, we appreciate you taking the time to talk with us today about this important topic. The information, ideas and insights you provided to us are very valuable and will be incorporated into the project work to inform both the process and the outcome.

APPENDIX G

ACTIVITIES & RESOURCES

INTRODUCTION

The Colorado Office of the Attorney General's Office of Community Engagement is partnering with the Office of Suicide Prevention (OSP) at the Colorado Department of Public Health and Environment and stakeholders in four Colorado counties impacted by youth suicides, including recent youth suicide clusters (El Paso, La Plata, Mesa and Pueblo). The partnership is focused on a project to better understand the youth suicide trend in Colorado and inform strategies for prevention.

Health Management Associates, Inc. (HMA), a national research and consulting firm with an office based in Colorado, was contracted to lead the work on this project. The project includes interviews with key stakeholders, focus groups youth and adult community members, secondary analysis of suicide and suicide risk data, a review of media coverage of suicide, a review of available resources and activities, and a review of prevention programs and resources. This report provides a summary of the resources and activities available in each community related to youth suicide prevention, postvention and intervention.

SUICIDE PREVENTION ACTIVITIES THROUGHOUT COLORADO

COLORADO OFFICE OF SUICIDE PREVENTION

The Colorado Office of Suicide Prevention (OSP) [63], located in the Department of Public Health and Environment, was created in statute in 2000 to serve as the lead entity for suicide prevention and intervention efforts in Colorado. In 2014, the state legislature created in statute the Suicide Prevention Commission to provide public and private leadership to suicide prevention efforts and to advise the Office of Suicide Prevention.

The Office of Suicide Prevention is a resource for suicide related data, strategic guidance on suicide intervention and prevention efforts, and a funder of community grants for suicide prevention. The Office is currently coordinating implementation of the following programs and initiatives.

ZERO SUICIDE INITIATIVE

Zero Suicide is a framework prioritized in the National Strategy for Suicide Prevention and endorsed by multiple national organizations and the Colorado Suicide Prevention Commission. Core to the Zero Suicide initiative is the belief that suicide deaths of people receiving care in health systems are preventable. Key elements of the initiative include leadership, training, screening and risk assessment, patient engagement, treatment, transition care and quality improvement.

During the 2016 Legislative Session, the Colorado General Assembly passed Senate Bill 147, which tasked the OSP with the implementation of Zero Suicide within health systems and the expansion of the framework to serve a variety of Colorado settings including the justice system, faith communities, school-based health centers and higher education. The bill requires partnership with the Office of Behavioral Health to ensure consistent training and awareness of current mental health hold criteria and procedures.

In partnership with the Office of Behavioral Health and the Anschutz Foundation, the Office of Suicide Prevention has hosted two Zero Suicide Academies. The Academy prepares health care or other sector teams to implement Zero Suicide within their agency. As of April 2017, all 17 community mental health centers in Colorado are trained in the framework, as are 11 other health-serving organizations such as large health systems, behavioral health organizations, managed service organizations, a school district and one hospital. Beginning in October 2018, the OSP will also be receiving five-year funding to support the expansion of Zero Suicide within five counties of focus, including Mesa, El Paso and Pueblo counties.

THE COLORADO FOLLOW UP PROJECT

The Follow Up Project utilizes Rocky Mountain Crisis Partners (RMCP) to provide telephonic follow-up support to patients following discharge from an emergency department. RMCP provides hotline services for the statewide crisis system and responds to calls to the National Suicide Prevention Lifeline for Coloradans. RMCP, as part of the Colorado Crisis System, is connected to the 24/7 walk-in clinics, community resources and can dispatch mobile crisis services.

The Follow-Up Project involves connecting patients who have been evaluated for suicidal thoughts or behaviors within an emergency department with the hotline prior to discharge. RMCP then provides continuing follow-up contact via telephone for at least 30 days or until the patient is connected with mental health services.

SUICIDE PREVENTION TOOLKIT FOR COLORADO PRIMARY CARE PROVIDER

The Office of Suicide Prevention updated a toolkit created by the Suicide Prevention Resource Center to be specific to primary care practices in Colorado [64]. Through federal grants, the OSP is currently funding the implementation of the toolkit within several sites throughout the state. The toolkit provides actionable steps and resources for practices to address suicide prevention, including identification of suicidal individuals, risk assessment, safety planning, lethal means counseling and follow-up care.

APPENDIX G
ACTIVITIES & RESOURCES

GARRETT LEE SMITH YOUTH SUICIDE PREVENTION GRANT FROM THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

In 2017, the Office of Suicide Prevention was awarded a five-year grant from SAMHSA in the amount of $736,000 per year to support evidence-based youth suicide prevention efforts for those ages 10-24. The grant funds regional youth suicide prevention coordinators in each Colorado Crisis System region, including in regions where the four counties that are the subject of this project are located. The funding also supports the saturation of evidence-based strategies in select counties of focus, including Mesa, El Paso and Pueblo counties. The evidence-based strategies include: Sources of Strength in middle and high schools; Collaborative Assessment and Management of Suicidality clinical trainings for behavioral health providers; the Follow-Up Project in emergency and inpatient hospitals; gatekeeper trainings for those working in youth-serving organizations; and support coordination of Zero Suicide implementation within health systems.

COLORADO GUN SHOP PROJECT

The Gun Shop Project is an education and awareness initiative focused on partnering with firearm advocates, gun shops, firing ranges and firearm safety course instructors to adopt and promote messages about firearm safety and suicide prevention. In 2017, the Gun Shop Project was in 21 counties, including Mesa, El Paso, La Plata and Pueblo counties.

COLORADO-NATIONAL COLLABORATIVE (CNC) FOR SUICIDE PREVENTION

The Office of Suicide Prevention is partnering with state and national partners to develop, implement, and evaluate comprehensive community-based suicide prevention in Colorado. Key players in the initiative include the Injury Control Research Centers (ICRC), American Foundation for Suicide Prevention (AFSP), Centers for Disease Control and Prevention (CDC), Suicide Prevention Resource Center (SPRC), National Action Alliance for Suicide Prevention, Substance Abuse and Mental Health Administration (SAMHSA), Colorado Department of Public Health and Environment (CDPHE), Colorado's Suicide Prevention Commission, Rocky Mountain Mental Illness Research, Education and Clinical Center at the Denver Veterans Administration Medical Center, Governor's Office, Colorado Behavioral Healthcare Council, Colorado School of Public Health, and the University of Colorado Depression Center. The goal of the CNC is to reduce the overall suicide rate in Colorado by 20 percent by 2024. In 2017, the Collaborative prioritized counties on which to focus, and began developing a funding strategy. The six counties of focus include El Paso, Pueblo, Mesa and La Plata counties.

COMMUNITY GRANT MAKING

The Office of Suicide Prevention is funding community grants focused on four key Office priorities: Community based efforts, Zero Suicide, Sources of Strength [65], and the dissemination of Man Therapy [66]. Thirteen community organizations received five years of funding (FY 2018-2022). Mesa, El Paso and La Plata county are among the funded communities.

SUICIDE PREVENTION COALITION OF COLORADO

The Suicide Prevention Coalition of Colorado is made up of concerned agencies, organizations and individuals who are working in the areas of suicide prevention, intervention and postvention across the state. The purpose of the group is to reduce suicide and its impact for all Coloradoans through advocacy, collaboration and education. The group helps to promote upcoming events related to suicide, such as support groups and trainings, offers resources such as information for becoming community advocates and resource maps, and puts on a conference regarding suicide prevention. Current members include the Colorado Chapter of the American Foundation for Suicide Prevention, the Arapahoe/Douglas Mental Health Network, CDPHE, the Centennial Mental Health Center, the Douglas County Sheriff's Department, the Hope Coalition, the Jefferson Center for Mental Health, the Second Wind Fund, Sources of Strength, the Suicide Prevention Coalition of Eagle Valley, and the Yellow Ribbon Suicide Prevention Program.

COLORADO SCHOOL SAFETY RESOURCE CENTER

The Colorado School Safety Resource Center (CSSRC) provides free resources, training and technical assistance to schools and local agencies to help create safe and secure learning environments and positive school climates. The CSSRC also helps to support schools, school officials, and community efforts in their work to prevent, prepare for, respond to and recover from all types of emergencies and crisis situations. All resources, including trainings and consultations, are available to schools throughout the state at no-cost.

SOURCES OF STRENGTH

Sources of Strength is a best practice program designed to enhance protective factors through peer social networks to change unhealthy norms, with the goal of preventing suicide, bullying and substance abuse. The program uses peer leaders, from a wide range of cliques within each school, that are trained to have one-on-one conversations, develop a PSA program in their school, present peer-to-peer presentations, and develop media messages for the school [67]. Sources of Strength has been shown to increase youth-adult connectedness, increase peer referrals of suicidal friends to adults, increase school engagement and increase positive perceptions of adult support for suicidal youth and the availability of seeking help [68]. Currently, the Office of Suicide Prevention is funding the implementation of Sources of Strength in four communities while the Colorado Attorney General's Office is also providing funding to implement the program in 40 additional schools across the State [69].

APPENDIX G

ACTIVITIES & RESOURCES

COLORADO CRISIS SERVICES

Colorado Crisis Services is a statewide resource for mental health substance use or emotional crisis help, information and referrals [70]. Formed under Governor Hickenlooper, in collaboration with the Colorado Department of Human Services, the goal is to increase access to mental health services for all Coloradoans and to strengthen the State's mental health system. The services provided include the statewide crisis line (1-844-493-TALK [8255]) that connects callers to a mental health professional who can provide immediate support, as well as walk-in crisis services at twelve locations across the State. The crisis services/stabilization unites offer in-person crisis support, information, and referrals and, in certain locations, can provide a crisis bed for up to 5 days for voluntary or involuntary treatment.

SAFE2TELL COLORADO

Safe2Tell is an anonymous way for students, parents, school staff and community members to report concerns regarding both their safety and the safety of others, either through the Safe2Tell mobile app, calling the Safe2Tell line (1-877-542-7233) or via an online form through the Safe2Tell website (safe2tell.org). Reports can be made to share concerns regarding bullying, threats, fights, drugs, weapons, sexual misconduct, stalking, dating violence, suicidal behaviors and any other dangerous situation.

When a concerning report is submitted, the tip is forwarded immediately to school officials, mental health professionals and/or law enforcement agencies as appropriate. Safe2Tell also works to follow-up with the school to make sure the tip was followed up on. During the 2017-2018 school year, there were 16,000 reports received (an increase of 74% since the 2016-2017 school year) with a majority regarding suicide threats [71].

MENTAL HEALTH FIRST AID COLORADO

Mental Health First Aid teaches individuals how to identify, understand and respond to signs of mental illness and substance use disorders. Participants in the course learn risk factors and warning signs for mental health and addiction concerns, how to help someone both in a crisis and non-crisis situation, and where to turn for help. The module can be implemented in schools, with first responders, with providers and a variety of other settings to help all individuals learn how to assesses and manage a mental health crisis.

AFSP COLORADO

The American Foundation for Suicide Prevention (AFSP) is a national organization that raises awareness, funds scientific research and provides resources and aid to those affected by suicide. The Colorado chapter focuses on delivering innovative prevention programs, educating the public about risk factors and warning signs, raises funds for suicide research and programs and reaches out to individuals who have lost to someone to suicide [72].

NAMI COLORADO

The National Alliance on Mental Illness (NAMI) is a nationwide advocacy group that provides education and advocacy to support those suffering the effects of mental illness and their families. NAMI Colorado has fourteen affiliates through the state and offers continual training, volunteering opportunities and support group classes throughout the year. Trainings include programs that aim to develop skills to help people cope with the challenges of mental illnesses, including friends and family members.

MENTAL HEALTH COLORADO

Mental Health Colorado is a leading advocate in the State for the prevention and treatment of mental health and substance use disorders, and is an affiliate of the national organization, Mental Health America. Mental Health Colorado focuses on engaging policymakers and providers, from the local level to the state level, to promote early intervention, expand access to affordable services and eradicate stigma and discrimination.

SECOND WIND FUND

The Second Wind Fund is an organization that works to decrease the incidence of suicide of children and youth by removing the financial and social barriers to treatment. The Fund connects youth, those ages 19 and younger, who are at risk for suicide and either lack insurance or are under-insured, to a licensed therapist in their local community and the Second Wind Fund covers the cost of therapy. A referral to the Second Wind Fund must come from a school mental health staff or other qualified mental health professional. Currently the Fund services the following counties: Adams, Arapahoe, Archuleta, Broomfield, Chaffee, Clear Creek, Delta, Denver, Douglas, El Paso, Elbert, Grand, Gunnison, Jefferson, La Plata, Logan, Mesa, Montezuma, Morgan, Ouray, Park, Pueblo, Routt, Saguache, San Miguel, and Teller.

TREVOR PROJECT

The Trevor Project is a national 24-hour, toll free confidential suicide hotline for LGBTQ youth (1-866-488-7386). In addition to the Lifeline (and corresponding text (START to 678678) and online chat programs), the Trevor Project also offers suicide prevention trainings and resources to support schools, communities and individuals in creating safe, accepting and inclusive environments for LGBTQ youth. The Trevor Project also supports research around vulnerable populations, suicidal risk factors and social factors influencing suicidal ideation and attempts.

APPENDIX G

ACTIVITIES & RESOURCES

SUICIDE PREVENTION ACTIVITIES WITHIN THE FOUR COUNTIES

From the key informant interviews and focus groups, there were also a variety of activities occurring related to suicide intervention, prevention and postvention, some of which have already been mentioned and some of which are unique to each county.

EL PASO COUNTY

In El Paso county, a couple of the unique activities come from Colorado Springs-based organizations, including the Colorado Springs branch of NAMI and Inside Out. The NAMI branch was mentioned quite a few times as being an active, involved branch in the area that offered a wide variety of resources including support groups, Mental Health First Aid, education and classes, and outreach programs. Inside Out offers a safe space for local LGBTQ+ youth to go to spend time together and express themselves, learn more about sexual health and suicide prevention, be provided food and clothing, and participate in leadership development opportunities. Finally, in response to the recent cluster, El Paso County Public Health began convening a workgroup focused on youth suicide prevention that brings key informants from a variety of fields, such as school representatives, law enforcement, providers and community members.

Pikes Peak Suicide Prevention is another resource in the community which provides education on suicide prevention and includes the following programs: Children Left Behind by Suicide, free counseling and the Jeffrey & Kevin Graham Support Services for persons with thoughts or actions towards suicide and their family members. Other activities and resources commonly cited included a local crisis response team that responds to 911 suicide related calls, Mental Health First Aid, Sources of Strength and Zero Suicide.

LA PLATA COUNTY

In La Plata county some of the most commonly cited local activities included programming coming out of the local library, which is considered a big part of the community and an extremely well-run local fixture. As well, in La Plata, the 4H club for students plays a big role of support for many kids given the rural nature of large parts of the county. In connection to the 4H, one organization was recently started in the memory of a young man who died by suicide called the CODY (Community Overcoming Depressed Youth) Project that helps to raise money for the 4H and uses their meetings to talk about issues facing kids. Another group, the Rainbow Youth Center, is focused on providing a safe space for LGBTQ+ youth, families and allies in the county that provides peer-led educational and recreational activities to high school-aged kids. The Southern Ute Community Action Programs (SUCAP) group also does a lot of work around youth suicide to help kids develop self-confidence, self-awareness and leadership skills. Finally, the county has worked to bring in resources such as QPR trainings, Sources of Strength and Kevin Hines, the creator of the recent documentary film "Suicide the Ripple Effect" that focuses on the devastating effects of suicide and the positive ripple effects of advocacy, inspiration and hope. San Juan Basin Public Health is currently serving as the backbone organization, coordinating efforts to develop a suicide prevention action plan and convening community partners to address suicide in the region.

MESA COUNTY

In Mesa County, there was a widespread response in the community after the recent increase in youth suicides, spearheaded by the Mesa County Public Health Department, that brought together a wide range of community members to begin discussions about how everyone could work together to address the issue of youth suicide. As well, the local college, Colorado Mesa University, has also offered activities to the community, such as suicide awareness walks, to help engage the community. There are also a wide variety of organizations that touch upon youth suicide prevention such as Don't Sink, Camp Hope, Project Hope, Together Colorado, and NAMI Western Slope. Another interesting group that has arisen in Mesa County is a group of local ministers who have monthly meetings and host an event called "Who's Listening" in response to the youth suicide issue, which was something more unique to this county.

There are also many activities seen in counties across the state such as Sources of Strength, QPR trainings, ASIST trainings, trauma informed parenting classes and the Gun Shop project which are all addressing various aspects of youth suicide prevention in the county.

PUEBLO COUNTY

In Pueblo County, a lot of recent initiatives have been created to work with youth to address the variety of issues they face today, including suicide. These new initiatives include the Pueblo Youth Advisory Council and the One Community group. The Advisory Council offers opportunities for youth to be able to meet with community leaders to share their perspectives and insights on current issues they face and to have a voice in thinking of ways to address various local problems. The One Community group is another coalition that has risen with partners across many organizations in Pueblo whom are working with youth to try and work more collaboratively within Pueblo. In addition, Health Solutions, the local mental health center, has recently gotten funding to hire a suicide prevention coordinator whose job is to try and connect all the different groups, initiatives and programs working to address suicide together to better align activities and funding.

The Pueblo Department of Public Health & Environment (PDPHE) State Innovation Model (SIM) grantees have created a presentation on mental health stigma reduction, an overview of common mental illnesses, and suicide prevention measures to present to high school students in the Pueblo region. This presentation is shown twice a year to make sure all freshmen students are getting the information in their health courses and know where and how to get help when dealing with a mental health crisis, mental illness and/or are feeling suicidal.

In July of 2017, the SIM grantees at PDPHE began partnering with Mental Health First Aid trainers at Health Solutions to set up monthly trainings for community members. PDPHE staff are required to be certified before January 1, 2019. Nearly 200 people in both the community and at PDPHE have been certified since last July. With this training being in such high demand, a SIM grantee at PDPHE was certified as a MHFA instructor in July of 2018.

Other unique Pueblo activities include the wide variety of programming put on by the local library system specifically geared towards youth, the Pueblo Mentoring Collaborative trying to connect youth and young adults with adult community members to provide positive role models, and the El Pueblo oral history project, which is trying to gather the histories of local citizens in order to build a sense of pride in Pueblo. Kaiser Permanente has also launched a new initiative in Pueblo to encourage people to speak up about depression and mental health, putting up a large mural by the local Riverwalk with "we are in this together" posted. Additionally, both the Gun Shop Project and the Sources of Strength youth leadership program are in Pueblo.

APPENDIX G

ACTIVITIES & RESOURCES

MENTAL HEALTH RESOURCES

In each community, resources were surveyed to gauge what would be available to someone seeking mental health and/or suicide prevention resources. The goal was to focus on what resources could be reached immediately if someone needed more immediate help and then also places individuals could contact to learn more about accessing long-term supports. This search did not focus on organizations that generally serve youth, although those organizations could also serve as resources for young people.

We started at the nationwide level with a selection of the largest helplines available to young people, including the national lifeline and crisis text line. The next level of resources reviewed were statewide programs and helplines that could be used by young people to seek both suicide prevention help, as well as mental health counseling. Then each county was reviewed to determine what resources were available in terms of general mental health resources, such as local mental health centers or counseling centers. In addition, resources were found that related more specifically to suicide prevention such as local suicide prevention organizations, support groups and other local resources.

The resources listed below are not exhaustive and others may exist that were not found in this search. As well, the resources listed below are based on what is available online, which may not be an accurate reflection of what currently exists in communities as outdated resources can be posted. There may be other groups whose work touches upon suicide prevention and/or mental health but were not included as the focus was on places and organizations with a more immediate focus on mental health and/or suicide.

NATIONAL RESOURCES

National Lifeline (24/7)
1-800-273-8255
Spanish: 1-888-628-9454
Deaf & Hard of Hearing: 1-800-799-4889

TrevorLifeline (24/7)
1-866-488-7386

LoveIsRespect Hotline (24/7)
1-866-331-9474

Crisis Text Line
Text Hello or Start to 741741

Veteran's Crisis Line
1-800-273-8255 and Press 1
Chat: https://www.veteranscrisisline.net/get-help/chat
Text 838255

STATEWIDE RESOURCES

Colorado Crisis Services
coloradocrisisservices.org
1-844-493-TALK (8255)
Text TALK to 38255
Business Office: 791 N. Chambers Rd., Suite 400, Aurora CO 80011

Safe2tell
1-877-542-7233

Colorado Office Of Suicide Prevention
http://www.coosp.org/
4300 Cherry Creek Drive South, Denver, CO 80246-1530

Suicide Prevention Coalition of Colorado
www.suicidepreventioncolorado.org
720-934-2387

Mental Health First Aid Colorado
c/o Colorado Behavioral Healthcare Council
303-832-7594
1580 Logan Street, Suite 400, Denver, CO 80203

Office of Behavioral Health, Department of Human Services
https://www.colorado.gov/pacific/cdhs/behavioral-health
303-866-7524
3824 W. Princeton Circle, Denver, CO 80236

Mental Health Colorado
https://www.mentalhealthcolorado.org/
720-208-2220
1120 Lincoln Street, Suite 1606, Denver, CO 80203

Helen and Arthur E. Johnson Depression Center, University of Colorado
https://www.coloradodepressioncenter.org/
303-724-3300
13199 East Montview Blvd., Suite 330, MS F550, Aurora, CO 80045

Sources of Strength
www.sourcesofstrength.org
Email: info@sourcesofstrength.org
701-471-7186
10020 Carmody Ln., Lakewood, CO 80227

Yellow Ribbon Suicide Prevention
www.yellowribbon.org
303-429-3530
Po Box 644, Westminster, CO 80036-0644

American Foundation for Suicide Prevention (AFSP), Colorado Chapter
www.afsp.org/colorado
E-mail: colorado@afsp.org
8200 S. Quebect St., A207, Centennial, CO 80112

Brain Injury Alliance of Colorado
http://biacolorado.org
303-355-9969
1325 S. Colorado Boulevard, Suite B300, Denver, CO 80222

Let's Talk Colorado
https://letstalkco.org/
E-mail: LetsTalkCO@tchd.org

Man Therapy
http://www.mantherapy.org/

APPENDIX G

ACTIVITIES & RESOURCES

EL PASO COUNTY

AspenPointe
http://www.aspenpointe.org/
719-572-6100
Toll Free: 1-855-277-3678
115 S. Parkside Dr., Colorado Springs, CO 80910

> Walk-in Crisis Center (24/7)
> 115 South Parkside Drive
> Colorado Springs
> Open 24 hours a day, 7 days a week

> Walk-in Crisis Center
> 6071 East Woodmen Rd, Suite 135
> St. Francis Medical Center, North Care Bldg., Colorado Springs
> Open 7 a.m. to 11 p.m., 7 days a week

El Paso County Public Health
https://www.elpasocountyhealth.org/
719-578-3199
1675 W. Garden of the Gods, Suite 2044, Colorado Springs, CO 80907

Mayfield Counseling Centers
https://mayfieldcounseling.com/
719-452-4803

Inside Out Youth Services
https://www.insideoutys.org/
719-328-1056
223 N. Wahsatch Ave., Suite 101, Colorado Springs, CO 80903

Suicide Prevention Partnership Pikes Peak Region
http://www.pikespeaksuicideprevention.org/home.html
719-573-7447
704 N. Tejon St., Colorado Springs, CO 80903

Children Left Behind by Suicide
http://www.pikespeaksuicideprevention.org/childrenleftbehind.html
719-573-7447
704 N. Tejon St., Colorado Springs, CO 80903

NAMI Colorado Springs
Crisis Line: 1-844-493-8255
https://namicoloradosprings.org/
510 East Willamette, Colorado Springs, CO 80903

Heartbeat Colorado Springs
http://heartbeatsurvivorsaftersuicide.org/
https://www.facebook.com/COSHeartbeat/?ref=br_rs
719-229-9657

Second Wind Fund
http://www.swfmd.org
303-988-2645

Colorado Veterans Administration
Eastern Colorado Health Care System
http://www.denver.va.gov
303-399-8020

LA PLATA COUNTY

Axis Health System (Formerly Southwest Colorado Mental Health Center)
http://www.axishealthsystem.org/
Hotline: 970-247-5245

Columbine Center (Axis)
a970-259-2162
281 Sawyer Drive, Suite 100, Durango, CO 81302

Cortez Counseling Center (Axis)
970-565-7946
215 West Arbecam, Cortez, CO 81321

Pagosa Springs Counseling Center(Axis)
970-264-2104
475 Lewis St., Suite 104, Pagosa Springs, CO 81147

Crossroads at Grandview (Axis)
 970-403-0180
1125 Three Springs Blvd, Durango, CO 81301

La Plata Integrated Healthcare (Axis)
970-335-2288
1970 E. 3rd Avenue - Unit #1 - Lower Level, Durango, CO 81301

Southern Ute Community Action Programs, Inc.
http://sococaa.org/
970-563-4517
QPR Gatekeeper Training:
http://sococaa.org/spotlight/suicide-prevention/

Heartbeat Durango
https://www.heartbeatofdurango.com/
970-749-1673

Second Wind Fund
http://www.swfmd.org
303-988-2645

San Juan Basin Public Health
281 Sawyer Drive
Durango, CO 81303
970-247-702

MESA COUNTY

West Springs Hospital
http://www.mindspringshealth.org/treatment/locations/grand-junction/
970-263-4918
515 28 ¾ Road, Grand Junction, CO 815013

Mesa County Public Health
http://health.mesacounty.us/
970-248-6900
510 29 ½ Road, Grand Junction, CO 81504

St. Mary's Medical Center
970-298-2273
2635 N. 7th St., Grand Junction, CO 81501

Heartbeat Grand Junction
 https://afsp.org/support_group/heartbeat-of-grand-junction/
970-778-9274

Colorado Veterans Administration
Grand Junction VA Medical Center
http://www.grandjunction.va.gov
970-263-2800
2121 North Avenue, Grand Junction, CO 81501

Second Wind Fund
http://www.swfmd.org
303-988-2645

Mind Springs Health
http://www.mindspringshealth.org/
Crisis Line: 888-207-4004

Grand Junction Walk-In Crisis Services (24/7)
515 28 ¾ Road, Grand Junction, CO 81501
24/7 Admissions: 970-201-4299

Outpatient Center
515 28 ¾ Road, Grand Junction, CO 81501
Psychiatric Scheduling Line: 970-683-7222

APPENDIX G

ACTIVITIES & RESOURCES

PUEBLO COUNTY

Second Wind Fund
http://www.swfmd.org
303-988-2645

NAMI Southeast Colorado
https://namisoutheastco.org/
719-315-4975
P.O. Box 4, Canon City, CO 81212

Joseph H. Edwards Active Adult Center
(Senior Resource Development Agency)
719-583-6611
230 N. Union Ave, Pueblo, CO 81003

Pueblo Walk-In Crisis Services (24/7)
1302 Chinook Lane
Pueblo, CO 81001
1-844-493-TALK (8255)

Heartbeat Pueblo
http://www.pueblospc.org/heartbeat.html

Colorado Veterans Administration
Eastern Colorado Health Care System
http://www.denver.va.gov
719-553-1093
303-399-8020 X3093

Health Solutions (Formerly Spanish Peaks
Behavioral Health Centers)
http://www.health.solutions
719-545-2746
41 Montebello Road, Pueblo, CO 81001

Parkview Medical Center, Behavioral Health
Division
719-595-7891
400 W. 16th Street, Pueblo, CO 81003

RESOURCES CONCLUSION

Overall there are a wide variety of resources available nationwide, across the state of Colorado and within the four local communities around suicide prevention, intervention and postvention. These activities often include different types of training, such as QPR, ASIST and Mental Health First Aid; local resources and programming for youth, such as through local non-profit organizations, youth clubs and community groups; and workgroups or coalitions that are working on combining efforts across different actors to create bigger impacts. However, one commonly cited issue is that there are often too many groups trying to work with youth and youth suicide prevention and they don't always communicate well so resources are spread too thin and services are duplicated. This issue was echoed across all four communities and while there are efforts to address that issue, because of the sheer number of groups and individuals interested there is still work to be done. As well, since many organizations and groups rely on grant funding, resources can come and go as the funding dries up which can make it harder for individuals to find long-term supports. Nevertheless,youth suicide prevention is a high priority for these communities and there are many people and organizations throughout each county, and the State, that are dedicated to helping youth overcome challenges and prevent youth suicide.

APPENDIX H

ENDNOTES

1. In this case we are using the definition of a suicide cluster provided by the Suicide Prevention Resource Center. This definition is multiple suicidal behaviors or suicides that fall within an accelerated time frame, and sometimes within a defined geographical area. HMA did not investigate the specific suicides or circumstances in the four counties studied. HMA is also not using the term cluster synonymously with contagion.

2. Jarrod Hindman and Shannon A. Breitzman, Suicide Prevention in Colorado Annual Report 2011-2012, Office of Suicide Prevention, Colorado Department of Public Health and Environment (Denver, CO, 2012).

3. Sarah Brummett, Emily Fine, Jarrod Hindman and Lindsey Myers, Suicide Prevention in Colorado Annual Report FY 2016-2017, Office of Suicide Prevention, Colorado Department of Public Health and Environment (Denver, CO, 2017).

4. Ibid

5. Colorado Health Information Dataset (COHID), Center for Health and Environment Data, Colorado Department of Public Health and Environment, 2018, http://www.cohid.dphe.state.co.us/

6. Ibid

7. Ibid

8. Healthy Kids Colorado Survey 2017, Colorado Department of Public Health and Environment (Denver, CO, 2018).

9. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf

10. Important to note that questions that ask about gender orientation and/or sexual orientation are not asked consistently across the state, as any region and/or school district can opt out of asking those questions.

11. Postvention is an organized response in the aftermath of a suicide to accomplish one or more of the following: Facilitate the healing of individuals from the grief and distress of suicide loss; mitigate other negative effects of exposure to suicide; prevent suicide among people who are at high risk after exposure to suicide. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/NationalGuidelines.pdf

12. From the Question, Persuade, and Refer (QPR) Gatekeeper Training for Suicide Prevention, an educational training program designed to teach lay and professional "gatekeepers" the warning signs of suicide and how to respond. Gatekeepers can include anyone who is strategically positioned to recognize and refer someone at risk of suicide. https://www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention

13. In this case we are using the definition of a suicide cluster provided by the Suicide Prevention Resource Center. This definition is multiple suicidal behaviors or suicides that fall within an accelerated time frame, and sometimes within a defined geographical area. HMA did not investigate the specific suicides or circumstances in the four counties studied. HMA is also not using the term cluster synonymously with contagion.

14. The budget and time frame did not allow for additional focus groups with youth in the comparison communities.

15. Jarrod Hindman and Shannon A. Breitzman, Suicide Prevention in Colorado Annual Report 2011-2012, Office of Suicide Prevention, Colorado Department of Public Health and Environment (Denver, CO, 2012).

16. Sarah Brummett, Emily Fine, Jarrod Hindman and Lindsey Myers, Suicide Prevention in Colorado Annual Report FY 2016-2017, Office of Suicide Prevention, Colorado Department of Public Health and Environment (Denver, CO, 2017).

17. https://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2016/2016datapgsv1b.pdf?ver=2018-01-15-211057-387

18. Colorado Health Information Dataset (COHID), Center for Health and Environment Data, Colorado Department of Public Health and Environment, 2018, http://www.cohid.dphe.state.co.us/

19. Ibid

20. Ethan Jamison, Sasha Mintz, Karl Herndon and Kirk Bol, Suicide in Colorado, 2011-2015: A Summary from the Colorado Violent Death Reporting System, Colorado Violent Death Reporting System, Colorado Department of Public Health and Environment (Denver, CO, 2017).

21. How Many People Are Exposed to Suicide? Not Six. Julie Cerel PhD, Margaret M. Brown DrPH, Myfanwy Maple PhD, Michael Singleton PhD, Judy van de Venne PhD, Melinda Moore PhD, Chris Flaherty PhD. First published: 07 March 2018 https://doi.org/10.1111/sltb.12450

22. Colorado Health Information Dataset (COHID), Center for Health and Environment Data, Colorado Department of Public Health and Environment, 2018, http://www.cohid.dphe.state.co.us/

23. Healthy Kids Colorado Survey 2017, Colorado Department of Public Health and Environment (Denver, CO, 2018)

24. Ibid

25. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf

26. Important to note that questions that ask about gender orientation and/or sexual orientation are not asked consistently across the state, as any region and/or school district can opt out of asking those questions.

27. The Colorado Child Fatality Prevention System only reports on youth suicide data for of youth ages 10-17.

28. 2018 Legislative Report, Youth Suicide Data 2012-2016, Colorado Child Fatality Prevention System, 2018

APPENDIX H

ENDNOTES

29. Ibid

30. https://afsp.org/about-suicide/suicide-statistics/

31. http://www.sprc.org/scope/attempts

32. Gregory Plemmons, Matthew Hall, Stephanie Doupnik, James Gay, Charlotte Brown, Whitney Browning, Robert Casey, Katherine Freundlich, David P. Johnson, Carrie Lind, Kris Rehm, Susan Thomas, Derek Williams Hospitalization for Suicide Ideation or Attempt: 2008–2015, Pediatrics, May 2018

33. https://www.cdc.gov/mmwr/volumes/65/wr/mm6543a8.htm?s_cid=mm6543a8_w

34. Jamison, Mintz, Herndon and Bol, Suicide in Colorado, 2011-2015

35. Healthy Kids Colorado Survey 2015

36. Adverse Childhood Experiences (ACEs) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life. Such experiences include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence. http://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/

37. A thing that makes an action or process easier

38. Primary prevention aims to reduce the incidence of disease and injury; it involves interventions that are applied before there is any evidence of disease or injury.

39. From the Question, Persuade, and Refer (QPR) Gatekeeper Training for Suicide Prevention, an educational training program designed to teach lay and professional "gatekeepers" the warning signs of suicide and how to respond. Gatekeepers can include anyone who is strategically positioned to recognize and refer someone at risk of suicide. https://www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention

40. HMA's study did not include an analysis of the factors related to funding of prosocial activities.

41. https://www.projectreasons.org/

42. HMA did not review additional policies related to school climate or non-discrimination.

43. https://afsp.org/wp-content/uploads/2016/04/Suicide-Prevention-Statutes-Schools-1.pdf

44. https://www.casb.org/Page/211

45. The Board directs that the programs developed include information that shall help the school staff, parents/guardians and students to: 1) Understand the developmental stages of adolescence; 2) Understand how feelings of depression and despair can lead to suicide; 3) Recognize the early warning signs of suicide; 4) Learn how to help in a suicidal crisis: 5) Identify community resources where teenagers can get help; 6) Address the impact of such a tragedy.

46. "Recommendations for Reporting on Suicide", American Foundation for Suicide Prevention (2016), https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf

47. Pew Research Center's survey of U.S. teens, ages 13-17, conducted March 7-April 10, 2018. http://www.pewinternet.org/2018/05/31/teens-social-media-technology-2018

48. https://help.instagram.com/553490068054878/?helpref=hc_fnav&bc[0]=Instagram%20Help&bc[1]=Privacy%20and%20Safety%20Center&bc[2]=Report%20Something

49. A newer trend and its medico-legal implications in India, C Behera, Krishna Karthik, TD Dogra, S Lalwani, T Millo, and SR Singh, Medico-Legal Journal, Vol 82, Issue 2, pp. 80 – 82, First Published May 22, 2014 https://doi.org/10.1177/0025817213514155

50. Chhabra, N., MD, & Bryant, S. M., MD. (2016). Snapchat toxicology: Social media and suicide. Annals of Emergency Medicine, 68(4), 527-527. doi:10.1016/j.annemergmed.2016.05.031

51. https://www.facebook.com/help/594991777257121/

52. "Recommendations for Reporting on Suicide", American Foundation for Suicide Prevention (2016)

53. https://mindspringshealth.org/protecting-kids-digital-age/

54. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107991/

55. https://www.projectreasons.org

56. https://letstalkco.org/

57. Accessed at: https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20BH%20report%20May%202018_0.pdf

58. http://thesecondwindfund.org

59. https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2016-2017-Legislative-Report.pdf

APPENDIX H

ENDNOTES

60. https://www.suicidology.org/Resources/Recommendations-for-Reporting-on-Suicide

61. http://reportingonsuicide.org/

62. https://www.colorado.gov/pacific/cdphe/suicide-prevention-contacts

63. https://www.colorado.gov/pacific/cdphe/suicide-prevention-commission

64. https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_CO-Suicide-Prevention-Toolkit-For-Providers.pdf

65. 'Office of Suicide Prevention community grantees', Colorado Department of Public Health & Environment, https://www.colorado.gov/pacific/cdphe/office-suicide-prevention-community-grantees

66. Ibid

67. FAQ, Sources of Strength, https://sourcesofstrength.org/discover/faq/

68. Wyman, P. et al. (2010). An outcome evaluation of the Sources of Strength suicide prevention program delivered by adolescent peer leaders in high schools. American Journal of Public Health, Vol. 100: 1653-1661.

69. Skinner, A. (2017) "AG Coffman Joins Pueblo Community Leaders to Announce Youth Suicide Prevention Initiatives Across Colorado", https://coag.gov/press-room/press-releases/12-12-17

70. 'About', Colorado Crisis Services, http://coloradocrisisservices.org/about/

71. Data 2 Report SY 2017-2018. Safe2Tell Colorado, https://safe2tell.org/sites/default/files/u18/Data2Report%20PDF%20SY%202017-2018.pdf

72. AFSP Colorado, AFSP, https://afsp.org/chapter/afsp-colorado/