INTRODUCTION TO
SUICIDOLOGY
Prevention, Intervention, Postvention

Suicide
Postvention
Response Team

Serving Cuyahoga County

Version 1.2, April 2015
Suicide Postvention Response Team

Serving Cuyahoga County

Introduction to SUICIDOLOGY
Prevention Intervention Postvention

Version 1.2, April 2015
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Prevention

A strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behavior.
Suicide Deaths
The Centers for Disease Control and Prevention (CDC) collects data about mortality in the U.S., including deaths by suicide. In 2013 (the most recent year for which full data are available), 41,149 suicides were reported, making suicide the 10th leading cause of death for Americans. In that year, someone in the country died by suicide every 12.8 minutes. After cancer and heart disease, suicide accounts for more years of life lost than any other cause of death.

To measure changes in the prevalence of suicide over time, the CDC calculates the country’s suicide rate each year. The suicide rate expresses the number of suicide deaths that occur for every 100,000 people in the population for which the rate is reported.

From 1986 to 2000, suicide rates in the U.S. dropped from 12.5 to 10.4 suicide deaths per 100,000 people in the population. Over the next 12 years, however, the rate generally increased and by 2013 stood at 12.6 deaths per 100,000.

Are Suicide Rates Still Rising?
CDC figures for death by suicide are currently lagging by more than a year. Information is not yet available for 2014.

Who is Most at Risk for Death by Suicide?
Suicide death rates vary considerably among different groups of people. The CDC reports suicide rates by four key demographic variables: age, sex, race/ethnicity, and geographic region/state.

Suicide Rates by Age
In 2013, the highest suicide rate (19.1) was among people 45 to 64 years old. The second highest rate (18.6) occurred in those 85 years and older. Younger groups have had consistently lower suicide rates than middle-aged and older adults. In 2013, adolescents and young adults aged 15 to 24 had a suicide rate of 10.9.

Suicide Rates by Sex
For many years, the suicide rate has been about 4 times higher among men than among women. In 2013, men had a suicide rate of 20.2, and women had a rate of 5.5. Of those who died by suicide in 2013, 77.9% were male and 22.1% were female.

Suicide Rates by Race/Ethnicity
White males accounted for 70% of all suicides in 2013. The highest U.S. suicide rate (14.2) was among Whites and the second highest rate (11.7) was among American Indians and Alaska Natives (Figure 5). Much lower and roughly similar rates were found among Asians and Pacific Islanders (5.8), Blacks (5.4) and Hispanics (5.7).

Note that the CDC records Hispanic origin separately from the primary racial or ethnic groups of White, Black, American Indian or Alaskan Native, and Asian or Pacific Islander, since individuals in all of these groups may also be Hispanic.

Suicide Rates by Geographic Region/State
In 2013, nine U.S. states, all in the West, had age-adjusted suicide rates in excess of 18: Montana (23.7), Alaska (23.1), Utah (21.4), Wyoming (21.4), New Mexico (20.3), Idaho (19.2), Nevada (18.2), Colorado (18.5), and South Dakota (18.2). Five locales had age-adjusted suicide rates lower than 9 per 100,000: District of Columbia (5.8), New Jersey (8.0), New York (8.1), Massachusetts (8.2), and Connecticut (8.7).
Suicide Methods
In 2013, firearms were the most common method of death by suicide, accounting for a little more than half (51.4%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 24.5% and poisoning at 16.1%.

Economic Impact of Completed Suicides
The economic cost of suicide death in the U.S. was estimated in 2010 to be more than $44 billion annually. With the burden of suicide falling most heavily on adults of working age, the cost to the economy results almost entirely from lost wages and work productivity.

Suicide Attempts
No complete count is kept of suicide attempts in the U.S.; however, the CDC gathers data each year from hospitals on non-fatal injuries resulting from self-harm behavior.

In 2013, the most recent year for which data is available, 494,169 people visited a hospital for injuries due to self-harm behavior, suggesting that approximately 12 people harm themselves (not necessarily intending to take their lives) for every reported death by suicide. Together, those harming themselves made an estimated total of more than 650,000 hospital visits related to injuries sustained in one or more separate incidents of self-harm behavior.

Because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors. But we know that many suicide attempts go unreported or untreated, and surveys suggest that at least one million people in the U.S. each year engage in intentionally inflicted self-harm.

As with suicide deaths, rates of attempted suicide vary considerably among demographic groups. While males are 4 times more likely than females to die by suicide, females attempt suicide three times as often as males. The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to a about 4:1 in the elderly.

Economic Impact of Suicide Attempts
Non-fatal injuries due to self-harm cost an estimated $2 billion annually for medical care. Another $4.3 billion is spent for indirect costs, such as lost wages and productivity.

(American Foundation for Suicide Prevention)

Cuyahoga County
- Suicide rate of 11 per every 100,000 persons
- Lower than the national average of 11.5 per every 100,000 persons
- Ranks 47 out of 88 Ohio counties with 1 being the county with the highest suicide rate
- 77.9% of suicides are male
- 45-64 age group has the highest suicide rate

(Ohio Suicide Prevention Foundation)
Prevention Resources

ADAMHSCC Board
2012 W. 25th St.
6th Floor
Cleveland, OH 44113
216.241.3400
www.adamhsc.org

American Association of Suicidology
5221 Wisconsin Ave., NW
Washington, DC 20015
202. 237.2280
www.suicidology.org

American Foundation for Suicide Prevention
120 Wall St.
29th Floor
New York, NY 10005
212. 363.3500
www.afsp.org

LifeAct (Formerly SPEA)
29425 Chagrin Blvd.
Ste. 203
Cleveland OH 44122-4602
216.464.3471
www.lifeact.org

Ohio Suicide Prevention Foundation
2323 West Fifth Ave.
Columbus OH 43204
614-429-1528
www.ohiospf.org

Treatment Advocacy Center
200 N. Glebe Rd.
Ste. 801
Arlington, VA 22203
703.294.6001
www.treatmentadvocacycenter.org

NATIONAL AND LOCAL RESOURCES
The ADAMHS Board of Cuyahoga County is responsible for the planning, funding and monitoring of public mental health and alcohol and other drug addiction services delivered to the residents of Cuyahoga County. Under Ohio law, the ADAMHS Board is one of 50 Boards coordinating the public behavioral health system in Ohio.

The Board is a quasi-independent part of county government, governed by a volunteer Board of Directors. The Board has the legal responsibility and authority for the provision of mental health and addiction treatment services and contracts with provider agencies to deliver services that assist consumers and clients on the road to recovery.

**Question, Persuade, Refer (QPR) Suicide Prevention Training**

The ADAMHS Board of Cuyahoga County is offering FREE Question, Persuade, Refer (QPR) Training to physicians, healthcare workers, and other gatekeepers in Cuyahoga County to help prevent deaths by suicide and reduce the stigma associated with mental illness.

A gatekeeper is anyone in a position to recognize a crisis and warning signs that someone may be contemplating suicide.

QPR teaches three simple steps that anyone can learn to help save a life from suicide.

90% of people in a suicidal crisis will give some kind of warning of their intention to those around them.

**Suicide Prevention/Mental Health Crisis Services**

FrontLine Service, operator of the Cuyahoga County Suicide Prevention Hotline, is now offering Crisis Chat and Crisis Text, emotional supports for anyone who is depressed, despaired or thinking about suicide. Click the Chat Icon to learn more about Crisis Chat or access the confidential and anonymous service that is available daily from 3:00 p.m. - 9:00 p.m. You can also text “FLS” to 741741 to start Crisis Texting.

If you or someone you know is thinking about suicide call the 24-Hour Cuyahoga County Suicide Prevention Hotline operated by Frontline Service., Inc., at 216-623-6888.
American Association of Suicidology

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

The goal of the AAS is to understand and prevent suicide.

We accomplish this mission by directing efforts to:

- Advance Suicidology as a science; encouraging, developing and disseminating scholarly work in suicidology
- Encourage the development and application of strategies that reduce the incidence and prevalence of suicidal behaviors
- Compile, develop, evaluate and disseminate accurate information about suicidal behaviors to the public
- Foster the highest possible quality of suicide prevention, intervention and postvention to the public
- Publicize official AAS positions on issues of public policy relating to suicide.
- Promote research and training in suicidology

Founded in 1968 by Edwin S. Shneidman, PhD, AAS promotes research, public awareness programs, public education and training for professionals and volunteers. In addition, AAS serves as a national clearinghouse for information on suicide.

The membership of AAS includes mental health and public health professionals, researchers, suicide prevention and crisis intervention centers, school districts, crisis center volunteers, survivors of suicide loss, attempt survivors, and a variety of lay persons who have an interest in suicide prevention.

AAS, a not-for-profit organization, encourages and welcomes both individual and organizational members.
American Foundation for Suicide Prevention

The American Foundation for Suicide Prevention (AFSP) is the leader in the fight against suicide. We fund research, create educational programs, advocate for public policy, and support survivors of suicide loss. Led by CEO Robert Gebbia and headquartered in New York, AFSP has 67 local chapters with programs and events nationwide.

To fully achieve its mission, AFSP engages in the following Five Core Strategies:

- Fund scientific research
- Offer educational programs for professionals
- Educate the public about mood disorders and suicide prevention
- Promote policies and legislation that impact suicide and prevention
- Provide programs and resources for survivors of suicide loss and people at risk, and involve them in the work of the Foundation

History

In 1987, a small group of caring individuals had a vision: establish a private source of support for suicide research and education, and essential suicide prevention efforts could be sustained into the future. These founding families—each of whom had lost a someone to suicide—joined with scientists to create what today is the American Foundation for Suicide Prevention, or AFSP.

Many of our original founders were concerned about an alarming rise in youth suicide over the previous four decades. During this period, the suicide of young men had tripled while for young women it had doubled. Suicide is currently the third leading cause of death among young people age 15 to 24. The highest overall rates of suicide are for adults age 40 to 59.

Before AFSP, there was no national-scope not-for-profit organization dedicated to understanding and preventing suicide through research, education and advocacy.

Since its founding in 1987, AFSP has:

- Mobilized and connected tens of thousands of people who have lost a family member, loved one, or friend to suicide;
- Reached thousands of individuals who are at risk for suicide, as well as those who love and care for them;
- Attracted the participation of members of the scientific and clinical communities, who conduct groundbreaking research on suicide and its prevention with support from AFSP;
- Established more than 50 local chapters in 35 states, with more in the process of forming;
- Educated hundreds of local communities about suicide and how to prevent it;
- Created a public policy and lobbying arm by merging successfully with an existing national policy organization, thus enabling AFSP to press for legislation and policies at the federal, state and local levels that advance the goal of preventing suicide;
- Substantially increased our funding from individual donors, including the thousands of highly motivated individuals who participate in our Out of the Darkness Walks;
- Educated reporters and the media about how to best cover suicide; and
- Communicated with hundreds of thousands of individuals through our website, social media, brochures, speakers and efforts to generate press coverage.

At the AFSP, our efforts to prevent suicide are firmly rooted in our understanding of why it occurs.

Because there are so many factors that contribute to suicide, our approach to prevention is broad, incorporating awareness and education programs and interventions designed for a variety of audiences.

Our prevention programs are designed to help:
• People who are thinking about suicide or engaging in suicidal behavior.
• Those who may be at risk for suicide because of a mental disorder or other vulnerability, or because they belong to a group with higher rates of suicide attempts or deaths.
• The general population: family members, caregivers, teachers, and others who can help to identify and refer people who may be at risk of suicide for help.
• Health and mental health care providers who come in contact with people at risk for suicide and their family members.

The research grants program is continually enhancing our knowledge of the causes of suicidal behavior and how it can be reduced. Our federal, state and grassroots advocacy efforts help to ensure the support and resources necessary to make suicide prevention a national priority.

Our Education and Prevention Programs
Our efforts to prevent suicide begin with increasing public and professional awareness of suicide as a mental health and public health problem.

Our innovative educational materials help teachers, parents, youth, and community leaders to understand suicide risk factors and warning signs, and support their efforts to assist those at risk for suicide to get the help they need.

We also collect and disseminate the latest research on suicide causation and prevention to physicians and mental health professionals so that they may more easily recognize and reduce suicide risk. And we work to reduce the stigma that deters so many people from seeking help.

AFSP seeks to reduce suicide and suicide attempts by developing and implementing our own innovative approaches to suicide prevention.

Programs for Teens and Young Adults
• More Than Sad: Teen Depression
• After a Suicide: A Toolkit for Schools
• Suicide Shouldn’t be a Secret PSAs
• The Truth about Suicide: Real Stories of Depression in College

Community Programs
• Involving Families in LGBT Youth Suicide Prevention
• Depression and Bipolar Awareness: From Diagnosis to Remission
• Living with Bipolar Disorder
• Billboard Program

Programs for Professionals
• More Than Sad: Suicide Prevention Education for Teachers and other School Personnel
• Physician and Medical Student Depression and Suicide
• LGBT Suicide and Suicide Risk: From Knowledge to Prevention
• Best Practices Registry for Suicide Prevention (BPR)
Our Mission
Prevent suicide by teaching young people to recognize the warning signs of suicide and to seek professional help for themselves and others.

What We Do
We save young lives. We teach teens to recognize the warning signs of suicide – and to encourage those at risk to seek help from a mental health professional.

In most cases, the depression that so often precedes suicide is both recognizable and treatable. Suicide is our most preventable form of death, according to former Surgeon General, David Satcher, MD, yet it is the second cause of death for Ohio teens.

Our innovative, evidence-based school programs are effective. At-risk youth seek treatment early – thereby preventing suicide and enabling recovery, allowing young people to live healthy, productive lives.

Our School Program: Recognizing Teen Depression and Preventing Suicide
LifeAct has delivered its signature program, Recognizing Teen Depression and Preventing Suicide, to more than 114,000 students and currently serves 132 Northeast Ohio schools. Our goal is to cause at-risk students to seek and receive treatment from a mental health professional, as treatment is life altering and often lifesaving. LifeAct saves families from the unfathomable loss of a child to suicide and helps teens to live healthy, productive lives.

Utilizing a fun, interactive curriculum which includes video, role playing, small group work, lecture and Q&A, LifeAct instructors teach students how to identify individuals who may be suffering from major depression and/or may be at risk of suicide; how to respond; and where to refer. This primary prevention program complements the mental health unit in high school health classes. The program can be integrated into other classes, as well.

Students are taught that they are the “first line of defense” in preventing suicide, since many teens who make a plan to end their lives inform a friend.

An evidence-based evaluation validates that the program causes at-risk teens to seek and receive help from a mental health professional in the weeks following their participation in our program.

To schedule the Recognizing Teen Depression and Preventing Suicide program in your school, call us at 216.464.3471.
Durkheim and Sociological Theory

In 1897, Emile Durkheim - the founder of sociology - presented the first notable theory of suicide, focusing on suicide at a societal level. The key variables he identified were social integration and social regulation and he examined how these variables played out in relation to the four types of suicide that he identified:

- **Egoistic** – seen in individuals who lack social integration and are detached from traditional social bonds or society
- **Altruistic** – occur when individuals are too fully socially integrated, and, thus, feel that their death would benefit society
- **Anomic** – most often happen in societies where there is minimal social regulation (lacking regulation results in a failure to instill a sense of meaning, or a failure to provide a moral framework in the lives of its citizens)
- **Fatalistic** – occur in societies where social regulation is extreme and authority is oppressive and controlling (suicidal persons in these situations would rather die than continue living in such stifling conditions)

Baumeister and the Escape Theory of Suicide

In 1990, Roy Baumeister proposed the “escape theory.” It has been widely influential, particularly in explaining adult male suicides. Baumeister explained suicide as a sequential process, involving the following six steps:

1. Falling short of standards occurs when a person fails to meet unrealistically high life expectations or experiences negative life experiences or setbacks
2. Internalization of self-blame as failures are viewed as being solely the individual’s fault and fuels low self-esteem
3. Aversive sense of self occurs when a harshly negative view of self, versus a positive view of others, is firmly established
4. Negative affect and/or negative consequences as a result of the previous step manifest as depression, anxiety or anger
5. Cognitive constriction by either intentional or unintentional avoidance and rejection of “meaningful thought” (individual focuses on day-to-day needs at the expense of forward thinking, and, thus, experiences narrowed thinking or tunnel vision)
6. Reckless behaviors, absence of emotion, and irrational thought often surface as substance abuse, self-harm, risky behaviors, and/or social withdrawal (notion of suicide becomes less fearsome and sometimes this need to escape escalates to suicidality)

Edwin Shneidman and Psychache

Pioneering suicidologist Edwin Shneidman believed that the central factor in all suicides is the presence of “psychache,” and the influence of psychache on theoretical thinking of suicidality has been enormous. Psychache is defined as the “hurt, anguish, soreness, and aching psychological pain in the mind.” It is “the pain of shame or guilt, or humiliation, or loneliness, or fear, or angst, or dread of growing old.”

Psychache results when an individual’s vital needs are not met or are frustrated. Shneidman believed that the majority of suicides were due to frustrated needs experienced in the following four ways:

1. Thwarted love, acceptance or belonging
2. Excessive helplessness or the feeling that one has no control
3. Damaged self-image invokes feelings of avoidance, shame, defeat, and humiliation
4. Damaged relationships, accompanied by subsequent feelings of grief

It is important to note that each person has a different threshold for enduring psychache. When that threshold is reached, or when the individual deems the psychache to be unbearable and overwhelming, the most drastic effort to reduce it – suicide – emerges as the answer.

Shneidman’s theory stresses that suicide is not necessarily the wish to die but is rather a means to ending the psychological pain.
Leenaars and the Multidimensional Model of Suicide

Leenaars, along with Shneidman before him, is a leading researcher of “psychological autopsies” – a term that Shneidman first coined. He is also a leading authority on the analysis of suicide notes. These investigations are extremely effective in understanding, retrospectively why someone has taken his or her life.

When Leenaars undertakes a suicidal analysis, he employs idiographic (specific) and nomothetic (general) elements. This is essential to capture a more complete illustration of the lost life. He draws on resources such as personal documents, interviews with survivors, official government reports, suicide notes, and any other available sources.

He interprets both intrapsychic and interpersonal features to decipher what drives an individual to suicide:

- Intrapsychic
  - Unbearable psychological pain
  - Cognitive construction rigid thinking, tunnel vision
  - Indirect expressions ambivalent thoughts toward living, contradictory feelings
  - Inadequate adjustment cannot cope with problems, losses and weakened ego

- Interpersonal
  - Interpersonal relations frustrated relationships
  - Rejection/aggression loss or abandonment, aggression turned inward
  - Identification/egression strong attachment to another that is not met, need to escape

For Leenaars, suicide is a “multidimensional malaise,” or a combination of “biological, psychological, intrapsychic, interpersonal, social, cultural and philosophical” elements, as opposed to the simple escape from pain. In his view, a penetrating investigation into the person’s lived experiences gives us much more of the “why” someone died by suicide.

Joiner’s Interpersonal Theory of Suicide

A popular contemporary theory of suicidal behavior is Thomas Joiner’s Interpersonal Theory of Suicide (2005). It has been especially useful in explaining the prevalence of suicide in older adults, in particular, older adult males. There are three factors which need to be present for a suicide:

1. Thwarted Belongingness – an absence of meaningful connections to others or a strain of a loss of previously strong relationships
2. Perceived Burdensomeness – a perception that someone feels that he or she is a burden on others (they believe that they fail to make meaningful contributions to society and that they are a liability)
3. Acquired Capability for Suicide – the degree to which an individual is able to initiate a suicide attempt

Beck and Hopelessness Theory

Aaron Beck presented the Hopelessness Theory of suicide in the 1970s. He asked what possible force could drive a person to violate and override the “survival” instinct to kill him or herself. That force turned out to be hopelessness – the “catalytic agent” that drives the suicidal desire. He found that hopelessness is a stronger indicator of suicidal intent than depression.

The individual has a stored reservoir of negative models which determine how he/she will perceive and interpret new information. In the case of suicidal ideation, these models exacerbate feelings of hopelessness at the expense of positive, productive information.
Beck and Hopelessness Theory cont.
Beck has been pivotal in devising measurements to aid clinicians in assessing mental illness and suicidality. Some of these include:

- Beck Depression Inventory (BDI)
- Suicide Intent Scale (SIS)
- Beck Hopelessness Scale (BHS)

Beck believes that cognitive change, in addition to behavioral change, is crucial to effective treatment. This is evident in the practice of Cognitive Behavioral Therapy (CBT), which he helped develop. He also feels that clinicians should target a patient's feelings of hopelessness for more positive treatment outcomes.

Linehan and Emotion Dysregulation Theory
Marsha Linehan’s theory of Emotion Dysregulation is often referred to as a “bio-social” theory, as biological and physiological elements figure prominently in an individual's responses to stress and emotion regulation. An afflicted person is characterized as experiencing intense emotions and an increase in sensitivity – even hypersensitivity – in upsetting situations.

These extreme emotional states are intense and aversive. Sufferers desperately attempt to manage their symptoms. Sometimes these efforts to cope, or regulate the pain, manifest as self-injury, and in extreme cases, suicide can result.

Linehan developed Dialectical Behavior Therapy (DBT) to help patients treat their emotional dysregulation. In this treatment, behavioral skill deficits are taught within a problem-solving and skills-training framework, and there is an emphasis on skill building and behavioral change

(Olson)
Definition of Suicide

Currently, in the western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution. (Shneidman)

The Ten Commonalities

1. The common purpose of suicide is to seek a solution
2. The common goal of suicide is the cessation of consciousness
3. The common stimulus in suicide is intolerable psychological pain
4. The common stressor in suicide is frustrated psychological needs
5. The common emotion in suicide is hopelessness-helplessness
6. The common cognitive state in suicide is ambivalence
7. The common perceptual state in suicide is constriction
8. The common action in suicide is egression
9. The common interpersonal act in suicide is communication of intention
10. The common consistency in suicide is with lifelong coping patterns

(Shneidman)
“Suicide is an outcome the requires several things to go wrong all at once”

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(Knesper)
Suicide Risk Factors

Risk factors are characteristics or conditions that increase the chance that a person may try to take their life. The more risk factors – the higher the risk.

**Health Factors**
- Mental health conditions
- Depression
- Bipolar (manic-depressive) disorder
- Schizophrenia
- Borderline or antisocial personality disorder
- Conduct disorder
- Psychotic disorders, or psychotic symptoms in the context of any disorder
- Anxiety disorders
- Substance abuse disorders
- Serious or chronic health condition and/or pain

**Environmental Factors**
- Contagion would include exposure to another person’s suicide, or to graphic or sensationalized accounts of suicide
- Access to lethal means including firearms and drugs
- Prolonged stress factors which may include harassment, bullying, relationship problems, and unemployment
- Stressful life events which may include a death, divorce, or job loss

**Historical Factors**
- Previous suicide attempts
- Family history of suicide attempts

(American Foundation for Suicide Prevention)
An active volunteer coalition formed in 2003
- Mental health care providers
- Social service providers
- Educators
- Clergy
- Law enforcement
- Survivors of suicide loss
- Other concerned citizens

Our mission is to reduce the loss and suffering caused by suicide and suicidal behavior.

We offer information, education and support to lessen the incidence of suicide and the stigma associated with suicide and suicide loss.

**Task Force Goals**
- Reflect the national strategy for suicide prevention as outlined by the United States Department of Health and Human Services
- Increase awareness that suicide is a public health and mental health problem in order to reduce stigma and increase individual's ability to seek help
- Reduce factors that increase suicide risk
- Gather more data about suicide attempts and evaluate the effectiveness of programs designed to prevent suicide
- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
Intervention

a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition
FrontLine Service is a contract agency of the Alcohol, Drug Addiction & Mental Health Services Board of Cuyahoga County and a partner agency of United Way Services of Greater Cleveland.

FrontLine Service, formerly MHS, manages the 24/7 Suicide Prevention Hotline for children and adults whose safety and health are threatened by mental health challenges or overwhelming stressors. We provide Crisis Assessment and Intervention services throughout Cuyahoga County, Ohio, and have done so without interruption since 1995. In 2011, our Mobile Crisis Team received more than 20,000 requests for services.

We reach out to children and families whose lives have been shattered by violence, working closely with those who have experienced or witnessed sexual and/or physical abuse, kidnapping, suicide, homicide or rape. We provide the intensive clinical services needed to help overcome the trauma and to break the cycle of violence in homes and communities across Cuyahoga County.
Know The Warning Signs

An easy-to-remember mnemonic

IS PATH WARM?

I  Ideation
S  Substance Abuse
P  Purposelessness
A  Anxiety
T  Trapped
H  Hopelessness
W  Withdrawal
A  Anger
R  Recklessness
M  Mood Changes

A person in acute risk for suicidal behavior most often will:
• Threaten to hurt or kill self, or talk of wanting to hurt or kill self
• Look for ways to kill self by seeking access to firearms, available pills, or other means
• Talk or write about death, dying or suicide, when these actions are out of the ordinary

Additional warning signs include:
• Increased substance (alcohol or drug) use
• No reason for living; no sense of purpose in life
• Anxiety, agitation, unable to sleep or sleeping all of the time
• Feeling trapped - like there's no way out
• Hopelessness
• Withdrawal from friends, family and society
• Rage, uncontrolled anger, seeking revenge
• Acting reckless or engaging in risky activities, seemingly without thinking
• Dramatic mood changes

(American Association of Suicidology)
Postvention

a strategy or approach that is implemented after a crisis or traumatic event has occurred
Cuyahoga County Medical Examiner’s Office

PROTOCOLS

The Medical Examiner investigates the circumstances of all deaths reported to the office and certifies the cause and manner of death of those cases in which jurisdiction is assumed. Ohio Revised Code chapter 313 requires the Medical Examiner to be notified of all deaths that are:

- Sudden, when a person is in apparent good health
- Not under the care of a physician
- Suspicious, unusual or unexplained
- The result of violence
- Unlawful or due to criminal neglect

A body also may be brought to the CCMEO if the deceased is unidentified or if the next of kin is unknown.

The Medical Examiner’s Office is not designed to handle bereaved relatives. Arrangements for viewing of the body should be made with a funeral director.

Autopsies are not performed on all cases

- Autopsy reports are generally available in about three months (or possibly more) from the date of death
- Toxicology results and other studies can take longer
Psychological Autopsy Certification Training

Developed in 1960 by AAS’s founding president, Dr. Edwin Shneidman, as well as Robert Littman, MD, and Norman Farberow, PhD, and refined over the years since, the psychological autopsy has become a best practice postmortem procedure to reconstruct the proximate and distal causes of an individual’s death by suicide or to ascertain the most likely manner of death where that manner of death is equivocal and left undetermined by a medical examiner or coroner. The psychological autopsy, furthermore, helps promote understandings to the often-asked “why?” question raised by survivors regarding the suicide of their loved one, is used in case-control research studies to better ascertain risk factors for suicide, and helps to answer questions of causation in both individual cases (e.g. where negligence may be alleged) or suicide and interconnections between cases (as in clusters of suicides), hence lessons learned to inform prevention efforts.

Certification Training Course is a two-day, face-to-face training program leading to certification as a Certified Psychological Autopsy Investigator. Fees vary.

Upon completion of this training, participants will be able to:
• Discuss the history and purposes of the psychological autopsy as a postmortem investigatory tool
• Identify the procedures used in the conduct of a psychological autopsy investigation
• Effectively implement a psychological autopsy protocol and associated procedures to conduct, analyze, and understand how and why an individual died in the manner they did

Registrants certified through the AAS Psychological Autopsy Certification Program may, thereafter, list their certification from AAS as a credential that offers assurance to potential contractors and employers that one has demonstrated training and expertise in the use of this procedure. Certified individuals will be offered inclusion in an AAS roster of certified psychological autopsy investigators, hence may be offered opportunity to conduct psychological autopsy investigations at registrant-designated fees on AAS psychological autopsy projects.

Certified Counselors: American Association of Suicidology is an NBCC-Approved Continuing Education Provider (ACEP™) and may offer NBCC-approved clock hours for events that meet NBCC requirements. The ACEP solely is responsible for all aspects of the program.

Psychologists: This program is sponsored by the American Association of Suicidology. The American Association of Suicidology is an organization approved by the American Psychological Association to offer 12 Continuing Education Units for psychologists. The American Association of Suicidology maintains responsibility for this program.

(American Association of Suicidology)
Postvention Resources

Cornerstone of Hope
5905 Brecksville Rd.
Independence, Ohio 44131
216.524.4673
www.cornerstoneofhope.org

ADAMHSCC Board
2012 W. 25th St.
6th Floor
Cleveland, OH 44113
216.241.3400
www.adamhscc.org

Beachwood, St. Mark’s SOS Support Group
22111 Chagrin Blvd.
Beachwood, OH 44122
216.752.5698

FrontLine Service
1744 Payne Ave.
Cleveland, OH 44114
216.623.6555
www.frontlineservice.org

Elisabeth Severance Prentiss Bereavement Center
17876 St. Clair Ave.
Cleveland, OH 44110-2602
800.707.8922
www.hospicewr.org

Middleburg Heights SOS Support Group
Middleburg Heights Community Church
7165 Big Creek Parkway
Middleburg Heights, OH 44130
440.237.1359

Westshore Critical Incident Response Service
P.O. Box 26222
Fairview Park, Ohio 44126
440.333.1237
www.westshorecirs.com
MISSION STATEMENT: Cornerstone of Hope is dedicated to providing support, education, and hope for the grieving.

SUPPORT GROUPS
Each quarter we offer several support groups based upon age or type of loss, including: Accidental Overdose, Adult Loss, Perinatal and Infant Loss, Loss of Child, Loss of Spouse, Loss to Murder, Loss to Suicide, and Young Adults who have had a loss. Cornerstone of Hope also offers F.L.I.G.H.T. (Families Living in Grief and Healing Together) for children, teens and families.

COUNSELING
Each grief experience is unique and can be very complicated and overwhelming. Receiving individual attention to discuss your feelings in a safe environment with a professional provides you with support during the most difficult time in your life. Individual, couple and family counseling, and art therapy for teens and children is available on a sliding fee scale based upon income.

MEMORIAL CEREMONIES AND SPECIALTY PROGRAMS
We honor and remember loved ones who have gone before us at our annual Springtime Butterfly Release and Christmas Candle Lighting and Remembrance Ceremony.

PROGRAMS FOR FAMILIES AND YOUTH
Summer bereavement camps help youth who are grieving and often feel alone, meet others who have also had a loss. Cornerstone combines traditional camp activities and field trips with personalized memorial projects. Through these experiences, meaningful friendships are formed.

We understand that it can be extremely difficult for children to receive support after school with all the academic and extracurricular demands. We make special arrangements to provide individual or group support at your child’s school to ensure that grief support is available at a convenient time and location for the parent or guardian.

The death of a student, teacher, coach or member of the community can impact an entire school district, neighborhood or group. When this occurs, Cornerstone can mobilize an experienced team to help manage the crisis and provide community outreach.

CONTINUING EDUCATION
Cornerstone is accredited by the State of Ohio to provide CEU programs for a variety of disciplines for professionals to maintain their licensure. Educational Units are offered at an affordable cost, and discounted corporate rates are available. We also offer ongoing specialized self-care workshops for caregivers and professionals. While our primary focus is bereavement topics to educate local professionals on how to better serve the grieving, we also offer programs on universal subjects that can be utilized in other clinical setting as well.

MORE INFORMATION
Please visit our website cornerstoneofhope.org or call our Cleveland office at 216.524.4673 or Columbus office at 614.824.4285.
Northern Ohio LOSSteams

Based on a national program, LOSSteams provide immediate assistance, support and guidance to family and friends at the time of a suicide. Statistics have shown that before the introduction of LOSSteams, an average of 4.5 years passed before survivors sought professional support. That time has been reduced to an average of less than 60 days in communities with LOSSteams.

Ashtabula County LOSSteam
Ashtabula County Mental Health and Recovery Services Board
4817 State Rd.
Ste. 203
Ashtabula, Ohio 44004
440.992.3121

Lorain County LOSSteam
The Nord Center
6140 South Broadway Ave.
Lorain, OH 44053
440.204.4240
In the tragic event of a suicide, we are available for support and assistance.

Our primary goal is to let families know that they are not alone during this difficult time.

Together, we provide:
- Timely response to survivors
- A listening ear
- Information about local resources available to survivors

**An Active Postvention Model (APM)**

Research reveals differences between those who receive an active model of postvention compared to those who receive a traditional passive postvention.

APM survivors:
- Present sooner for treatment
- More likely to attend survivor support group meetings
- Attend more support group meetings
Current SPRT Affiliates

SUICIDE POSTVENTION RESPONSE TEAM

ADAMHS Board of Cuyahoga County
American Association of Suicidology
American Foundation for Suicide Prevention, Northern Ohio Chapter
Cornerstone of Hope
Bedford Police
Berea Police
Brook Park Police
Busch Funeral & Cremation Services
Care Alliance
Cleveland Metroparks
Cleveland State University Facilities and Safety Team
Cuyahoga County Medical Examiner’s Office
Cuyahoga County Metropolitan Housing Authority Police
Cuyahoga County Police Chiefs Association
Cuyahoga County Suicide Prevention Task Force
ES Prentiss Bereavement Center
Fairview Park Police
FrontLine Service
Independence Police
Lakewood Police
LifeAct
North Olmsted Police
Olmsted Township Police
Parma Police
South Euclid Police
Southwest Enforcement Bureau Crisis Negotiator Team
The City Mission
Westshore Critical Incident Response Services
Westshore Enforcement Bureau Hostage/Crisis Negotiator Team
Coping With Suicide Loss

HOW CAN I HELP SOMEONE WHO IS GRIEVING?

Reach out. Be there. Your very presence will be comforting and reassuring.

Follow the lead of the person who is grieving. Some survivors of suicide loss find it helpful to talk about the details of the death, share pictures of their loved one, cry, or express their intense emotions. Others prefer not to.

Listen with your full attention.

Don’t be afraid to ask about their loved one or to say their loved one’s name. It hurts so much more when no one talks about the person they lost.

Offer to help with specific tasks. Instead of saying, “I’m here if you need me” or “Tell me what I can do to help,” ask, “Can I help by…”

...picking your kids up from school?
...walking the dog?
...helping with the grocery shopping?
...helping with funeral arrangements?
...picking someone up at the airport?
...making phone calls?
...organizing your mail?

Remember that everyone deals with loss differently. Learn more about what survivors of suicide loss go through in the Personal Stories section at www.afsp.org

(American Foundation for Suicide Prevention)

Avoid Saying “Committed” Suicide

• It is an antiquated term
• Suicide is not a crime, but instead a national health issue
• “Died by suicide” or “suicided” are suggested
Recommended Reading

Assessing and Managing Suicide Risk: Guidelines for Clinically Based Risk Management
The incidence of suicide is elevated in all mental health diagnoses and patient suicide is the number one reason for malpractice lawsuits against psychiatrists. The author focuses on crucial need for clinicians to perform a thorough, systematic suicide risk assessment on all patients who might be at some risk for suicide.

Autopsy of a Suicidal Mind
Shneidman, E.S., 2004, Oxford University Press
Autopsy of a Suicidal Mind is a uniquely intensive psychological analysis of a suicidal mind. In this poignant scientific study, the author assembles an extraordinary cast of eight renowned experts to analyze the suicidal materials, including a ten-page suicide note, given to him by a distraught mother looking for insights into her son’s tragic death. Each of the eight experts offers a unique perspective and the sum of their conclusions constitutes an extraordinary psychological autopsy. This book is the first of its kind and a remarkable contribution to the study of suicide. Mental health professionals, students of human nature, and persons whose lives have been touched by this merciless topic will be mesmerized and enlightened by this unique volume.

Child and Adolescent Suicidal Behavior: School-Based Prevention, Assessment, and Intervention
Miller, D.N., 2011, The Guilford Press
Meeting a crucial need, this book distills the best current knowledge on child and adolescent suicide prevention into comprehensive guidelines for school-based practitioners. The author draws on extensive research and clinical experience to provide best-practice recommendations for developing school-wide prevention programs, conducting risk assessments, and intervening at different levels of intensity with students at risk. Also presented are postvention procedures for responding effectively if a suicide does occur. Legal and ethical issues are addressed in detail. Reproducible handouts include sample assessment questions for students, teachers, and parents; the book’s large-size format and lay-flat binding facilitate photocopying.

After Suicide Loss: Coping with Your Grief
This book is written specifically to help survivors during the first year after a suicide. It is organized around the first few days, few weeks, few month, etc. It is short, concise and very practical in its orientation to providing concrete suggestions and help for survivors.

For additional resources for all ages, please consider visiting Lindsay’s Lending Library at Cornerstone of Hope. For hours, please call 216.524.4673.