



2013

Mental Health

University of Colorado Hospital

COMMUNITY HEALTH NEEDS ASSESSMENT

TABLE OF CONTENTS

Mental Health	3
Overview	3
Mental Health Not Good in Last 30 days.....	5
Short Term.....	5
Long Term	6
Demographic Description.....	7
Depression.....	10
Demographic Characteristics of Colorado Residents with Depression.....	11
Mental Health Status of Youth.....	12
Felt Sad or Helpless.....	12
Considered Suicide.....	12
Attempted Suicide.....	13
Suicide	14
Colorado Suicide Rate Compared to Other States	14
Suicide Rates for Adults in Colorado	15
Risk Factors for Suicide.....	16
Relationship between Substance Abuse and Mental Illness.....	18
Mental Health Professional Shortage Areas	18
Interventions	19
Resource Inventory	23

MENTAL HEALTH

OVERVIEW

Successful mental function leads to a productive life, meaningful relationships, positive contributions to society, and the ability to navigate changing circumstances. Mental disorders are frequently characterized by altered thinking and moods, and/or behaviors that lead to reduced functioning and/or emotional distress.¹

Mental disorders are the leading causes of disability in the United States. Twenty five percent of all years that are lost to disability or premature death are due to mental disorders.²

Suicide is the eleventh leading cause of death in the United States, and is responsible for approximately 30,000 deaths a year.³ ⁴ “Colorado consistently ranks in the top 10 states in terms of suicide rate. More Coloradans die by suicide than from illnesses such as diabetes, pneumonia or breast cancer. Suicide is the second-leading cause of death for youth (ages 10-14) in Colorado. In addition, nearly one out of every 13 Colorado youth report attempting suicide in the past year.”⁵

Most people in Colorado who died by suicide were suffering from depression at the time of death. Depression is a treatable mental health illness, and interventions to treat depression can in turn reduce suicide rates.⁶

In 2008, 7% of all adults in Colorado reported suffering from depression.⁶

Mental health and physical health are interrelated. If a person is feeling depressed, he/she is less likely to engage in physical activities that promote good health.

¹ Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28>

² The World Health Organization (WHO). The world health report 2004: Changing history. Annex Table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, Estimates for 2002; A126-A127. Geneva: WHO; 2004.

³ Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control (NCIP). Web-based injury statistics query and reporting system (WISQARS) [Internet]. Atlanta: CDC; 2010.

⁴ National Institutes of Health, National Institute of Mental Health (NIMH). NIMH strategic plan (revised 2008) [Internet]. Bethesda, MD: NIMH; 2008 [cited 2010 May 6].

⁵ Colorado's 10 Winnable Battles. Colorado Department of Health and Environment. <http://www.cdphe.state.co.us/hs/winnableBattles/mentalHealthSubstanceAbuse.html>

⁶ Ibid.

In turn, if a person's mobility is restricted due to illness or disease, he/she can be prone to feelings of hopelessness or despair, thus inhibiting their participation in recovery.⁷

The development of mental, emotional and behavioral (MEB) disorders can be quite complex and involve a variety of factors. Prevention and treatment usually requires approaches that are varied and involve addressing many contributing factors.

Mental health research has made great strides in 1) identifying risk factors that contribute to the development of mental illness, and 2) determining protective factors that protect people from developing mental disorders. A few of research's most significant findings focus on youth and include the following:

- Mental, emotional and behavioral (MEB) disorders are fairly common and usually begin early in life.
- Prevention is most effective in young people.
- School based interventions that focus on improving emotional and behavioral status can positively affect academic performance.⁸

Even though an estimated 60% of all people with a mental disorder do not receive treatment, the use of mental health services is higher now than in the previous decade due to more primary care physicians providing psychiatric services. In fact, people who seek treatment for mental health disorders were more likely to receive it from primary care physicians/nurses or other general medical doctors (23%) than mental health specialists, such as psychologists, social workers or counselors (16%) or psychiatrists (12%). Spiritual advisors and self-help groups treat another 10% each. People with the greatest unmet need for mental health treatment were those with low incomes or no insurance, the elderly and racial/ethnic minorities.⁹

⁷ Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28>

⁸ Ibid.

⁹ National Institute of Mental Health, <http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml>

MENTAL HEALTH NOT GOOD IN LAST 30 DAYS

BRFSS Survey Question: For how many days during the past thirty days was your mental health not good?

SHORT TERM

People reporting poor mental health for the short-term, or 1-7 days in the past 30 days, tended to be from counties reporting higher education and income levels, as well as higher housing costs Douglas County had the highest rates, while Denver County had the lowest rate.

On the other hand, these same counties do not report many long-term mental health issues, as shown in Figure 2 on the following page. Perhaps the ability to access helpful resources enables this group to successfully navigate short-term crises and prevent them from becoming long-term problems.

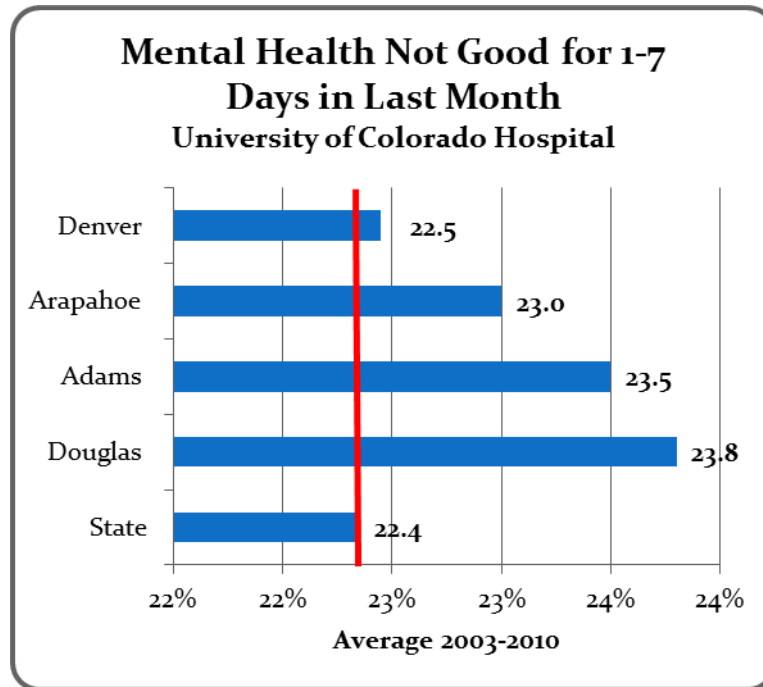


Figure 1 Mental Health Not Good for 1-7 Days in Last Month¹⁰

¹⁰ Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. National data not comparable. Average rate for 2003/2004, 2005/2006, 2007/2008, 2009/2010.

Denver, Adams, and Arapahoe Counties had more people reporting poor long term mental health than in Douglas County. People reporting negative mental health status on a longer term basis, or 8 or more days in the past month, typically come from counties that had high unemployment, higher poverty levels and lower median household incomes. Education levels were lower in these counties, too. Many of these counties also had a larger percentage of people claiming Hispanic or Latino heritage.

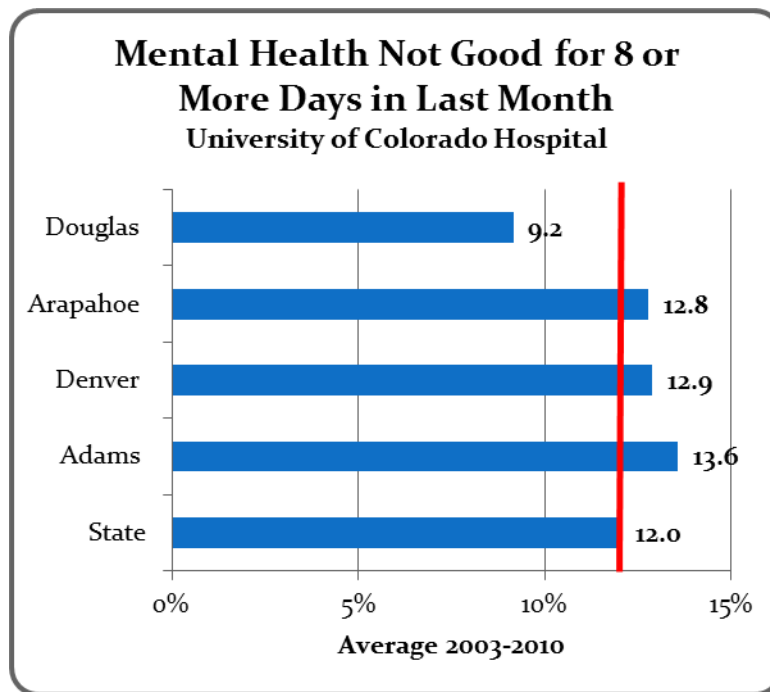


Figure 2 Mental Health Not Good for 8 or More Days in Last Month¹¹

¹¹ Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment, National data not comparable. Average rate for 2003, 2004, 2005/2006, 2007/2008, 2009/2010.

DEMOGRAPHIC DESCRIPTION

Females report poor mental health more frequently than males. People who have never married report negative mental health status in the short term more frequently than other groups, while being married or part of a couple seems to contribute to a more positive longer term mental health status. Differences among those of different races and ethnicity were not statistically significant.

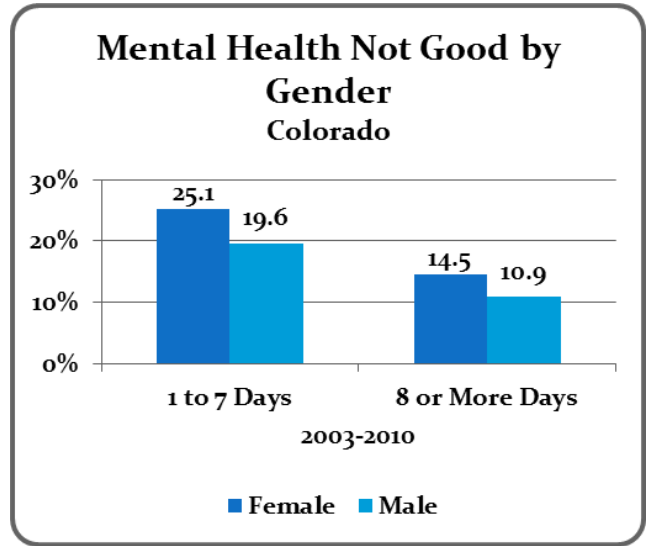


Figure 3 Mental Health Not Good by Gender¹²

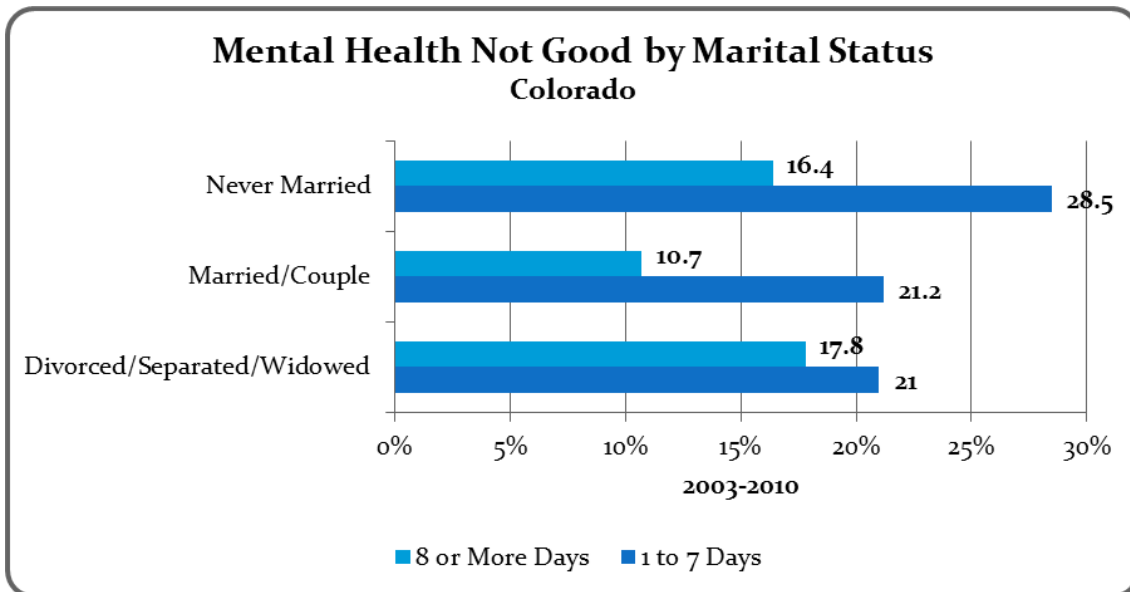


Figure 4 Mental Health Not Good by Marital Status¹³

¹² Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment.

¹³ Ibid.

One of the most consistent predictors of mental health status is age. The most significant data in the accompanying chart is that only a small percentage of people age 65 and older report negative mental health in the long term. Further, only a small percentage of people age 55 and older have negative mental health in the short term. In other words, most older people report good mental health for both short and long term.

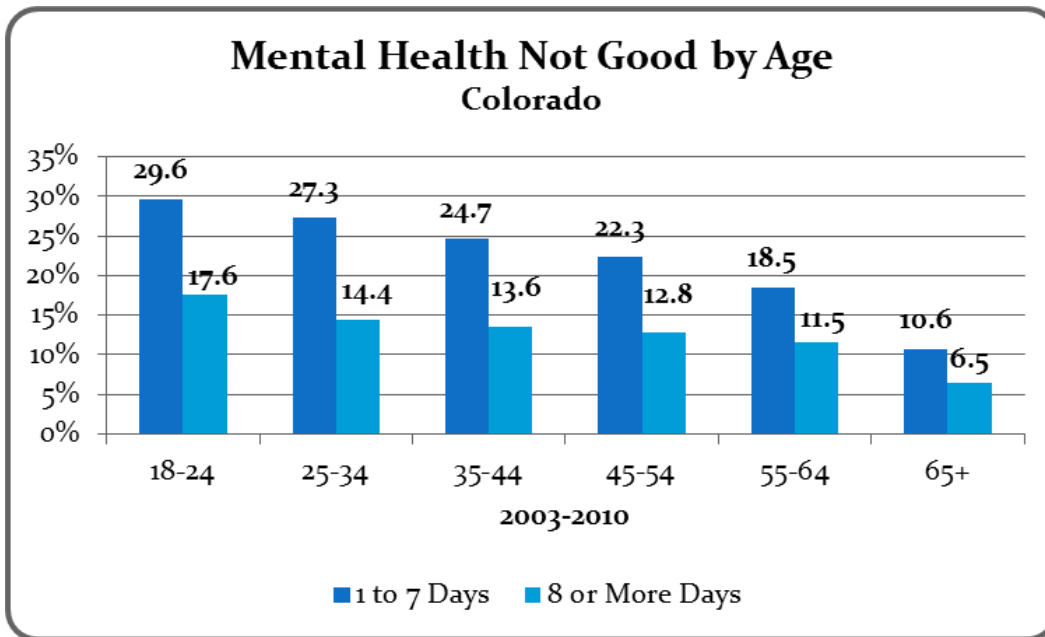


Figure 5 Mental Health Not Good by Age¹⁴

¹⁴ Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment.

Higher education levels lead to improvements in long term mental health status, but were not significant for the short term. Income levels under \$25,000 were significant for poor mental health in the short term, while no income differences were significant for long term mental health.

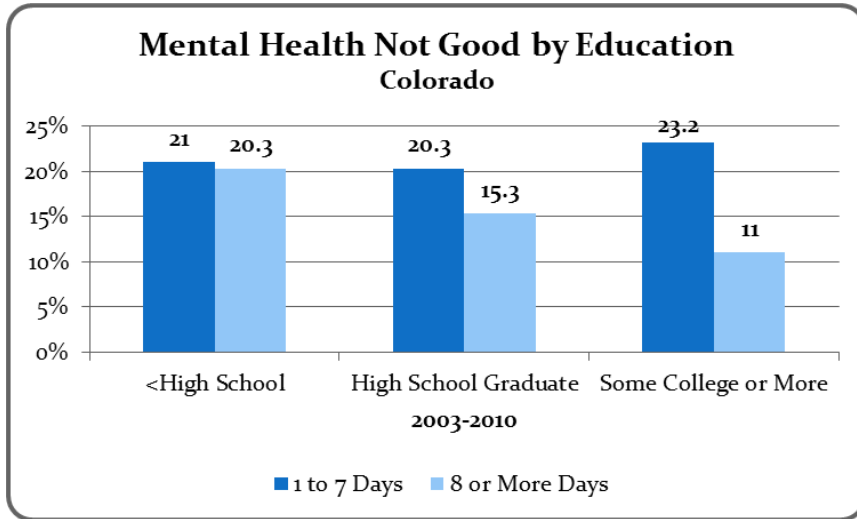


Figure 6 Mental Health Not Good by Education¹⁵

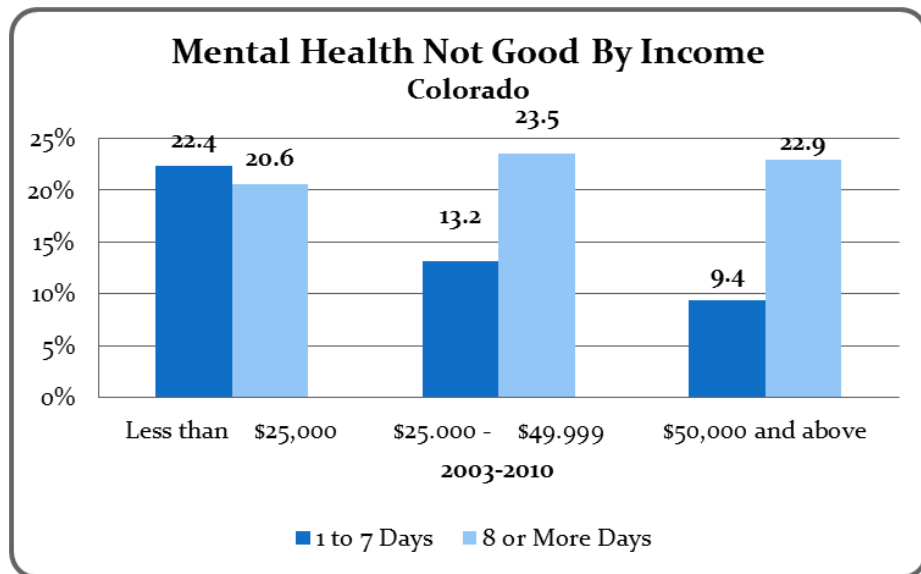


Figure 7 Mental Health Not Good by Income¹⁶

¹⁵ Chart Source: Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment.

¹⁶ Ibid.

DEPRESSION

“Depression is the most common mental disorder....Depression is more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide.... Depression is a real illness and carries with it a high cost in terms of relationship problems, family suffering, and lost work productivity.”¹⁷

Depression can also lead to suicide. In fact, half of those who die by suicide in the nation were experiencing major depression prior to their death. The suicide rate for people with major depression is eight times the rate of the general population.¹⁸

The 2008 depression rate in Colorado among adults was 7% of the population. The Colorado Winnable Battles goal for 2016 is 5% of the adult population.

Fortunately, depression can be treated successfully with psychotherapy, coping and cognitive-behavioral techniques, and medication.¹⁹ Exercise has also been proven to be a cost-effective and successful method for treating depression.²⁰ An interesting side note is that even though reducing social isolation helps treat depression, spending too much time talking about problems with friends can actually make depression worse.²¹

¹⁷ American Psychological Association, <http://www.apa.org/topics/depress/index.aspx>

¹⁸ Preventing Suicide in Colorado, Progress Achieved and Goals for the Future, <http://www.cdphe.state.co.us/pp/suicide/SuicideReportFinal2009.pdf>

¹⁹ American Psychological Association.

²⁰ Ibid.

²¹ Ibid.

DEMOGRAPHIC CHARACTERISTICS OF COLORADO RESIDENTS WITH DEPRESSION

Depression rates for those below 150% Federal Poverty Level are higher at 12.8% compared to the general population at 7%.

Depression Rates by Federal Poverty Level, 2008 Colorado

	Percentage	Lower Limit	Upper Limit
<150% FPL	12.8	9.1	16.6
>=150% FPL	5.4	4.5	6.3
All	7.0	6.0	8.1

Figure 8 Depression Rates by Federal Poverty Level, 2008²²

Whites have a significantly lower rate of depression compared to Hispanics. Seniors over 65 years of age also have a significantly lower rate of depression at 3.4% compared to the adult population at 7%. (Depression rates are not significantly different 1) between genders, 2) among different races and ethnic groups, or 3) across Colorado regions.)

Depression Rates by Race/Ethnicity 2008 Colorado

	Percentage	Lower Limit	Upper Limit
White, Non-Hispanic	5.9	4.9	6.9
Black, Non-Hispanic	9.9	3.2	16.6
Hispanic	10.7	7.1	14.4
Other	14.6	5.4	23.8
All	7.0	6.0	8.1

Figure 9 Depression Rates by Race/Ethnicity²³

²² Colorado Winnable Battles. Colorado Department of Health and Environment.

²³ Ibid.

MENTAL HEALTH STATUS OF YOUTH

The National Institute of Mental Health (NIMH) states that half of all lifetime cases of mental illness begin by age 14, and three quarters of all cases start by age 24. Anxiety disorders typically begin by late childhood, mood disorders by late adolescence, and substance abuse problems by the early twenties. Females are more likely to experience anxiety and mood disorders, while males experience more substance abuse problems.²⁴

Despite the availability of successful treatments, there are often long delays — sometimes decades — between the initial onset of symptoms and when people seek and receive treatment. Research indicates that untreated mental disorders in youth can lead to more severe, more difficult to treat illnesses in adulthood, and to the development of secondary mental illnesses.²⁵

FELT SAD OR HELPLESS

YRBS Survey Question: During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?

About 25% of all Colorado high school students felt so sad or hopeless every day for two or more weeks in a row during the past year (for 2005 and 2009) that they stopped doing some usual activities.²⁶ Differences among high school grades were not significant.

CONSIDERED SUICIDE

YRBS Survey Question: During the past 12 months, did you ever seriously consider attempting suicide?

Almost 14% of high school students in Colorado seriously considered suicide one or more times in the past twelve months for both 2005 and 2009.²⁷ Differences among high school grades were not significant.

²⁴ National Institute of Mental Health, <http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml>

²⁵ Ibid.

²⁶ Colorado Youth Risk Behavioral Survey, 2005 and 2009. Weighted data. Colorado Department of Health and Environment

²⁷ Ibid.

ATTEMPTED SUICIDE

YRBS Survey Question: During the past 12 months, how many times did you actually attempt suicide?

Almost 8% of all high school students attempted suicide in the past 12 months in 2009. The Colorado Winnable Battles Goal is 5% of high school students attempting suicide in the past 12 months. No significant differences were noted among the high school grades.

Among Colorado teenagers who died by suicide, almost half of them experienced a personal crisis within two weeks prior to death. The crises typically involved conflicts in intimate relationships, disciplinary problems, and other life stressors. These teens were more likely to abuse substances, be aggressive in relationships, demonstrate antisocial behavior, and be depressed.²⁸

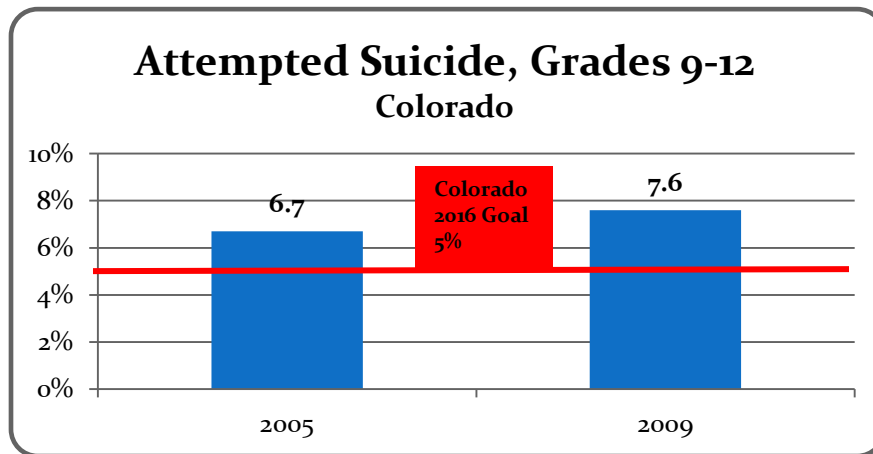


Figure 10 Attempted Suicide, Grades 9-12^{29,30}

²⁸ Preventing Suicide in Colorado, Progress Achieved and Goals for the Future, <http://www.cdphe.state.co.us/pp/suicide/SuicideReportFinal2009.pdf>

²⁹ Colorado Youth Risk Behavioral Survey, 2005 and 2009. Weighted data. Colorado Department of Health and Environment.

³⁰ Colorado's 10 Winnable Battles. Colorado Department of Health and Environment. <http://www.cdphe.state.co.us/hs/winnableBattles/mentalHealthSubstanceAbuse.html>

COLORADO SUICIDE RATE COMPARED TO OTHER STATES

Colorado’s suicide rate is significantly higher at 16.5 per 100,000 persons than the national average of 11 deaths per 100,000 persons. In the chart below, Colorado ranked sixth in the nation for suicide deaths when examining the average rates for 2001-2005. The highest rates for suicide are concentrated in the western states and are not unique to Colorado.³¹

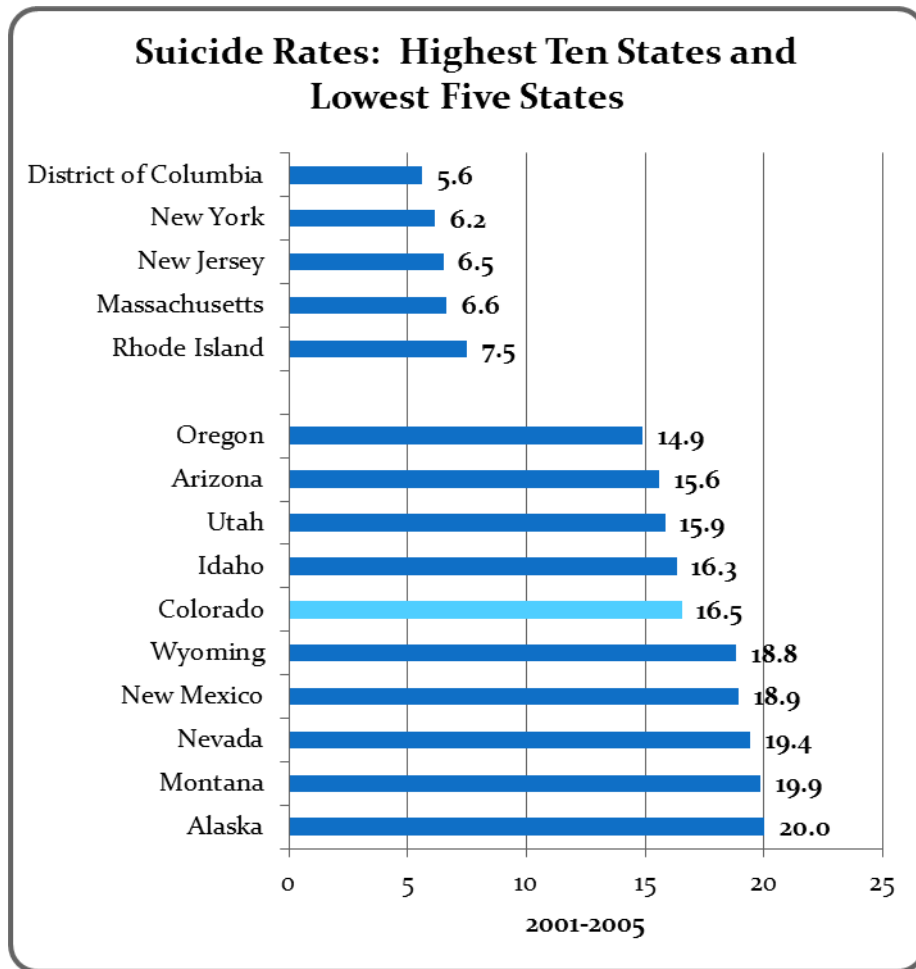


Figure 11 Suicide Rates: Highest Ten States and Lowest Five States³²

³¹ Preventing Suicide in Colorado, Progress Achieved and Goals for the Future, Rates per 100,000. <http://www.cdphe.state.co.us/pp/suicide/SuicideReportFinal2009.pdf>

³² Colorado Office of Suicide Prevention, Colorado Department of Health and Environment.

SUICIDE RATES FOR ADULTS IN COLORADO

Suicide mortality rates are higher in Colorado than in the nation for people 18 years and older. All counties have rates higher than the HP 2020 goals. Most counties have suicide rates that are lower than the state rate, while Douglas County has the highest rate of suicides.

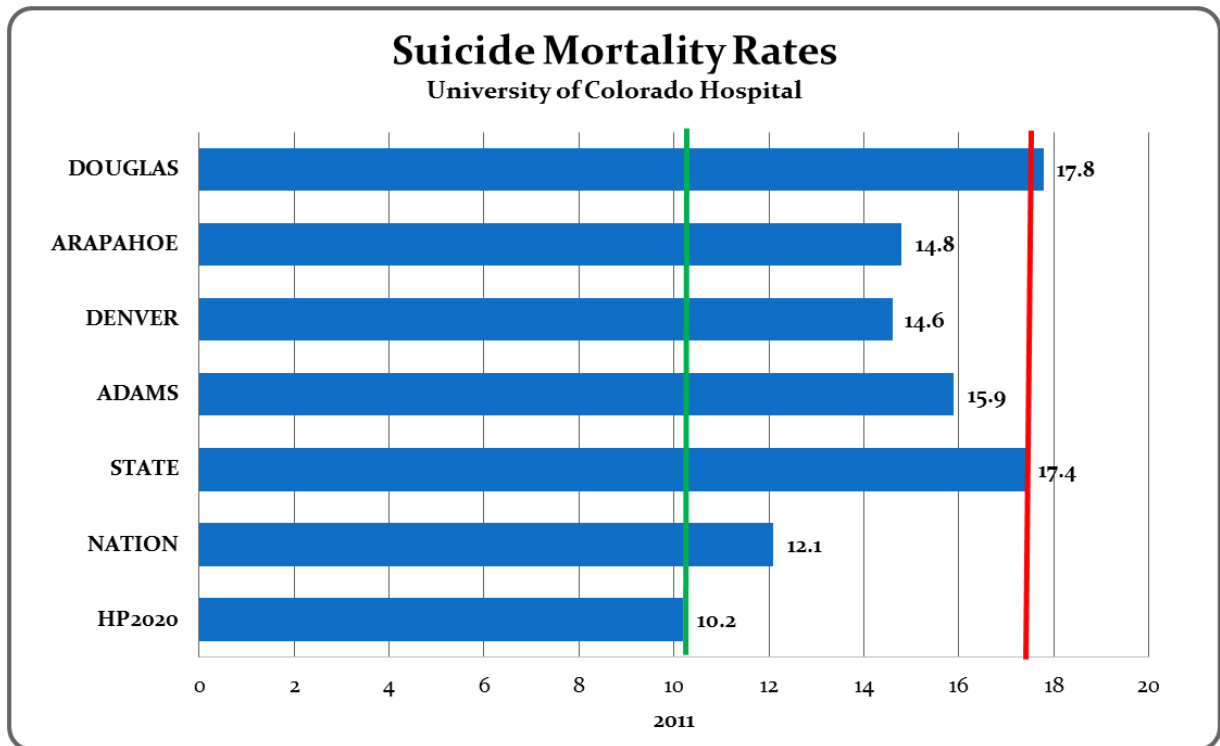


Figure 12 Suicide Mortality Rates³³

³³ Chart Source: Colorado Department of Public Health and Environment. National Vital Statistics System. Data per 100,000 population. National rate 2010.

RISK FACTORS FOR SUICIDE

Within Colorado, three factors are strongly associated with higher suicide rates:

- higher levels of unemployment,
- higher proportions of people living in social isolation, and
- a lower percentage of Hispanic populations, whose cultural norms are more apt to discourage suicide.³⁴

In Colorado, suicide risk is strongly correlated with depression, other mental disorders and substance abuse. Other facts are as follows.

- Among 20-24 year olds, 45% of suicides showed evidence of a problem with an intimate partner prior to death.
- Approximately 70% of young and middle-aged people were depressed prior to committing suicide.
- Most men ages 25-54 had a problem with alcohol and had not sought professional help prior to suicide.³⁵

SOCIODEMOGRAPHIC VARIABLES FOR SUICIDE

Suicide is frequently associated with a mix of sociodemographic variables, which include cultural, situational, and social factors. The table below lists these factors, as well as at risk subpopulations.³⁶

Sociodemographic Variables for Suicide

Gender	Male
Age	Elderly
Social status	Low
Educational status	Low
Marital status	Unmarried, separated, divorced, widowed
Residential status	Living alone
Employment status	Unemployed, retired, insecure employment
Economic status	Weak (males)
Profession	Farmer, female doctor, student, sailor
Special subpopulations	Students, prisoners, immigrants, refugees, religious

³⁴ Preventing Suicide in Colorado, Progress Achieved and Goals for the Future, <http://www.cdphe.state.co.us/pp/suicide/SuicideReportFinal2009.pdf>

³⁵ Ibid.

³⁶ Lonqvist, J.K. (2000) Epidemiology and causes of suicide. In: New Oxford Textbook of Psychiatry, Vol, 1, (Eds.) Gelder, M.G., Lopez-Ibor Jr, J.J. & Andreasen, N.C., pp 1033 - 1039, New York : Oxford University Press.

	sects
Special institutions	Hospitals, prisons, army

Other demographic variables listed by the Colorado Department of Health and Environment include White/non-Hispanic race, military veterans, and individuals who are lesbian, gay, bisexual or transgendered. Contributing factors for suicide among older people are physical problems, isolation, and friends and family members dying. Veterans struggling with post-traumatic stress disorder, traumatic brain injuries and/or substance abuse are at risk for suicide. Sexual minority youth and adults are at a higher risk of suicide than heterosexuals. In one youth survey, 44% of sexual minority respondents reported attempting suicide compared to 13.5% among their heterosexual peers.³⁷

PSYCHOLOGICAL AND BIOLOGICAL INFLUENCES ON SUICIDE RATES

Psychological and biological influences on suicide rates are listed below.³⁸

Psychological and Biological Influences on Suicide Rates

Family history	Suicidal behavior, mental disorders
Mental disorders	Any disorder, depression, substance use disorders, personality disorders, schizophrenia
Contact with psychiatric services	Any contacts, recent contacts, post-discharge period, psychotropic drugs
Psychiatric symptoms	Hopeless, helpless, depressive, psychotic, delirious, anxious, aggressive, introversive
Suicidal behavior	Previous suicide attempts, suicidal ideations, death wishes, indirect gestures
Physical health	Severe physical illness such as cancer, AIDS, stroke, and epilepsy; permanent sickness
Availability of suicide methods	Easy access to lethal methods

Suicide can be prevented with appropriate interventions that include: recognizing signs of depression, treating depression with medications, and fostering supportive social relationships.³⁹

³⁷ Colorado's 10 Winnable Battles. Colorado Department of Health and Environment. <http://www.cdphe.state.co.us/hs/winnableBattles/mentalHealthSubstanceAbuse.html>

³⁸ Longvist.

³⁹ Ibid.

RELATIONSHIP BETWEEN SUBSTANCE ABUSE AND MENTAL ILLNESS

Many people with serious substance abuse issues also struggle with underlying mental illness. The most common serious mental disorders associated with chronic substance abuse include “schizophrenia, bipolar disorder, manic depression, attention deficit hyperactivity disorder (ADHD), generalized anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, panic disorder and antisocial personality disorder.”⁴⁰ Some people take drugs to alleviate symptoms of mental disorders (self-medicating), while others develop mental illness as a result of drugs (ecstasy leads to depression and anxiety). Further, chronic drug abuse during adolescence can interfere with learning normal socialization behaviors and cognitive development, and ultimately lead to serious mental disorders.⁴¹

MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS

Mental Health Professional Shortage Areas (HPSA) in Centura Health’s primary service areas include the counties of Summit, Rio Grande, Pueblo, Alamosa, and Fremont - the same county that had one of the highest suicide rates. Mental Health Professional Shortage Areas that serve low-income groups are located in La Plata and Archuleta Counties. All other counties in Centura’s primary market area are not designated as Mental HPSAs. However, even in these areas, people without health insurance, with low incomes, or language barriers can have difficulty accessing mental health care.⁴²

⁴⁰ National Drug Intelligence Center, U.S. Department of Justice.
<http://www.justice.gov/ndic/pubs7/7343/index.htm#What>

⁴¹ Ibid.

⁴² Colorado Department of Health and Environment,
<http://www.cdphe.state.co.us/pp/primarycare/shortage/mhhpsa.pdf>

INTERVENTIONS

“Statewide organizations, networks and advocacy groups have actively promoted suicide prevention in Colorado. Mental Health America of Colorado has provided technical assistance to communities that are developing suicide prevention programs and initially sponsored the Suicide Prevention Coalition of Colorado. The Pueblo Suicide Prevention Center provides statewide suicide prevention, intervention and postvention services in response to calls to the 1-800-273-TALK and 1-800-SUICIDE national hotlines. Foundations and federal agencies also have provided vital funding and technical assistance for suicide prevention efforts in Colorado. For example:

- The Western Colorado Suicide Prevention Foundation, based in Grand Junction, has funded a range of suicide prevention programs and activities in six Western Slope counties.
- Colorado is one of 17 states that has been awarded funding from the Centers for Disease Control and Prevention to develop the National Violent Death Reporting System, which provides a clearer picture of suicide death characteristics and trends (e.g., methods used, locale and precipitating events or circumstances).
- With the support of three-year grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Denver’s Regis University and Trinidad State Junior College in southern Colorado are working to enhance services for students with mental health or substance abuse problems that place them at risk of suicide.
- Colorado is one of more than 30 states receiving funding from SAMHSA to implement suicide prevention programs to youth statewide.
- The Colorado Trust’s \$4.1 million Preventing Suicide in Colorado initiative has supported a variety of activities in 31 of the state’s 64 counties over the past six years – from community suicide prevention training; to partnership and capacity building; to outreach, counseling and therapy programs.

Colorado enters its second decade of suicide prevention efforts with a major asset: a growing infrastructure of collaborative, community-based suicide prevention programs and services. A sampling of the numerous suicide prevention efforts within Colorado are listed below. Though not a full listing, the following programs provide examples of the types of strategies recommended by stakeholders in the process of developing this plan as important to suicide prevention efforts in the next decade.

A focus on subpopulations at high risk for suicide: Civilians for Veterans

Campaign Colorado former First Lady Jeannie Ritter headed a campaign aimed at expanding access to mental health services for military veterans living in rural areas of the state. The Civilians for Veterans campaign, launched in July 2008 with a \$50,000 grant from the Firefly Fund, is a collaborative effort of several mental health groups, the Colorado Behavioral Healthcare Council and the U.S. Department of Veterans Affairs. The campaign will raise money to support the extension of existing VA services into rural areas, focusing initially on the San Luis Valley, Montrose County, La Junta and Lamar.

A focus on culturally-competent suicide prevention: Voz y Corazón Latina teens are at higher risk of suicide attempt than other teens. Important efforts have been made to address this suicide behavior using a culturally-competent approach. This program, established under the auspices of the Mental Health Center of Denver, was designed by Latina leaders and teens to help Latina teens develop healthy identities through suicide prevention trainings. A key component of the program is regularly scheduled mentoring and art groups that result in an annual Art Gallery of works illustrating creative expression of the lives, emotions and hopes of the Latina teenagers.

A focus on integration of primary health and mental health care: Northern Colorado Health Alliance (NCHA) NCHA, which serves low-income residents in Weld County, is an example of integrated physical and mental health care. This partnership of a behavioral health center, primary care clinics and a hospital system is structured so that an individual who enters the project from any “door” can easily access the services of other partner providers. Fundamental to integrated care is co-location of physical and mental services as well as staff trained to work collaboratively across health sectors. A medical chart system that includes information and treatment for both physical and mental health care practitioners is under development.

A focus on cross-system suicide prevention: Project Safety Net. Project Safety Net, coordinated by the Office of Suicide Prevention at the Colorado Department of Public Health and Environment, is a three-year initiative launched in October 2006 that involves five counties, the University of Colorado at Boulder and the Suicide Prevention Coalition of Colorado (SPCC). The goal is to build a safety net for adolescents and young adults who are at a heightened risk for suicidal behavior.

In the five counties (El Paso, Larimer, Mesa, Pueblo and Weld), adults working with adolescents ages 15-18 in the juvenile justice and child welfare systems, and the adolescents’ parents or caregivers, are receiving suicide intervention and referral skills training. At the University of Colorado, similar training is offered to faculty, athletic department staff, resident advisors, Greek system representatives and others who work with students.

Project partners are working together to create and disseminate cross-system referral protocols for care and treatment of suicidal individuals and reach out to potential suicide interveners through campus and community awareness campaigns.

A focus on community-based comprehensive efforts: Reaching Everyone Preventing Suicide (REPS) Suicide prevention stakeholders in Moffat and Routt counties joined forces in April 2004 to create Reaching Everyone Preventing Suicide. As one project among a number of community based comprehensive projects that received

support from The Colorado Trust's Preventing Suicide in Colorado initiative, this comprehensive program includes education and training of residents in the Yampa Valley and screening, risk assessment, referral to mental health services, emergency and on-going treatment for individuals at-risk of suicide and their families. Postvention services to families and friends of individuals who have completed suicide are also provided as a component of the comprehensive effort toward suicide prevention.

A focus on increased mental health treatment: Second Wind Fund The Second Wind Fund was established by Green Mountain Presbyterian Church following the suicide deaths of four Jefferson County high school students during the 2001-02 school year. Its goal is to decrease the incidence of teen suicide by removing financial and social barriers to treatment for at-risk youth. Over the past several years, the Second Wind Fund has raised more than \$600,000 through its annual Walk/Run/Ride event, which drew nearly 3,000 participants in 2008. The money is used to subsidize professional therapy (up to 20 sessions) for economically disadvantaged high school students who are identified as at least moderately at risk for suicide. Referrals are initiated by school counselors or administrators, with the involvement and consent of a student's parents. Since 2003, the program has served more than 1,200 students in Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson and Park counties. Students can choose from a list of 60 state-licensed therapists who have experience with teens at risk for suicide, and who have agreed to see Second Wind clients at a reduced hourly rate.

A focus on education of Colorado's media: Suicide Prevention Coalition of Colorado's Annual Media Award In 2008, the Suicide Prevention Coalition of Colorado honored Denver television station KUSA-Channel 9 for its commitment to promoting mental health and preventing suicide. Over the past two years, KUSA has broadcast dozens of pieces focusing on salient issues in the field, ranging from the suicide risk among combat veterans, the elderly and other vulnerable populations, to the connection between incarceration and mental health. The Suicide Prevention Coalition of Colorado also cited KUSA for promoting National Depression Screening Day, sponsoring a suicide prevention helpline, and offering free mental health screenings as part of its 9Health Fair program, which reaches more than 87,000 Coloradans in 165 communities each year. In spring 2008, KUSA co-sponsored and provided coverage of Mirrors and Metaphors: Reflections on Suicide, Mental Health and Healing, a month-long art exhibit at Access Gallery in west Denver.

Promising and evidence-based strategies

Colorado suicide prevention stakeholders now have the benefit of a national registry of strategies with evidence or promise of effectiveness. These programs are classified as evidence-based (either effective or promising) by the Suicide Prevention Resource Center and the American Foundation of Suicide Prevention, and include: community-based, emergency-room, primary care, school-based health clinics and service delivery programs.

Information about these programs may be accessed at www.sprc.org/bpr/ebpp.asp#list.⁴³

The American Foundation for Suicide Prevention is working in partnerships with other entities to find new and improved methods to prevent suicide. One of its key goals is to disseminate information about best practices to interested community groups throughout the country. The most current projects listed on its web-site are the following.

- “The Interactive Screening Program, which has developed and pilot-tested an interactive, web-based method of reaching out to students at risk of suicide, and encouraging them to get help.
- The Physician Depression and Suicide Prevention Project, which works with a range of other groups and professional organizations to address the disproportionately high rates of suicide among physicians and physicians in training.
- The International Project on National Suicide Prevention Strategies, which is bringing together experts from around the world to examine and evaluate individual countries' strategies for suicide prevention, and to encourage replication of evidence-based projects and approaches.
- The Media Project, which encourages responsible reporting of suicide by news media.
- The Hungarian Suicide Prevention Project, which has provided training about identifying and treating patient depression to physicians and other clinicians in a region of Hungary with an extremely high suicide rate.
- The Suicide Data Bank, which has collaborated with therapists who lost a patient to suicide, to improve recognition of suicide risk and treatment of seriously suicidal individuals.
- The LGBT Depression and Suicide Prevention Project, an initiative aimed at reducing suicide among lesbian, gay, bisexual and transgender populations.
- The Billboard Campaign looks to educate Americans about the serious nature of depression, and to urge those clinically depressed to see their doctor.”⁴⁴

A Systematic Review (of) Suicide Prevention Strategies in the Journal of the American Medical Association noted two of the most effective methods in reducing suicide rates: 1) physician education in depression recognition and treatment, and 2) restricting access to lethal means and devices.⁴⁵ These conclusions reinforce the need to support primary care providers in their efforts to screen and treat those at risk for suicide.

⁴³ Preventing Suicide in Colorado, Progress Achieved and Goals for the Future, <http://www.cdphe.state.co.us/pp/suicide/SuicideReportFinal2009.pdf>

⁴⁴ American Foundation for Suicide Prevention, http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=7429AB1E-EF88-4847-6DC010CBA738604C

⁴⁵ http://www.afsp.org/files/Misc_//JAMA.National_Strategies.pdf

Other resources include the following programs and organizations:

- National Registry of Effective Programs and Practices - a searchable online registry of more than 160 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment.
<http://nrepp.samhsa.gov/>
- Substance Abuse and Mental Health Services:
<http://www.samhsa.gov/prevention/>
- National Institute of Mental Health:
<http://www.nimh.nih.gov/health/index.shtml>
- National Institute of Health, The Science of Mental Illness, <http://science-education.nih.gov/customers.nsf/MSMental>
- Medline Plus. Mental Health and Behavior,
<http://www.nlm.nih.gov/medlineplus/mentalhealthandbehavior.html>
- Office of Suicide Prevention, <http://www.cdphe.state.co.us/pp/suicide/>

RESOURCE INVENTORY

See Resource Inventory at the end of Substance Abuse for a combined Substance Abuse/Mental Health Resource Inventory.