

SUICIDE DATA PROJECT

Final Report

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Marcia G. Toprac, Ph.D.**

Background

In 2001, U.S. Surgeon General David Satcher issued a report entitled “Call to Action” that identified suicide as a preventable public health problem. Since that time, several federal agencies (SAMHSA, CDC, NIH, HRSA, HIS) collaborated to develop and publish a National Strategy for Suicide Prevention, and states and local communities have used the National Strategy model to develop their own suicide prevention plans. Goal 11 of the National Strategy, “Improve and Expand Surveillance Systems”, stresses that data collection on suicides (and suicide attempts) should be an essential component of prevention efforts, not just at the federal and state levels, but in local communities, as well. Austin Travis County’s Suicide Prevention Plan includes two goals related to obtaining current data for research and prevention.

Austin/Travis County (Austin TC) has had the highest rate of suicide among the major metropolitan areas in Texas for the past several years for which data are available (2000-2004). These data, available through the Department of State Health Services (DSHS), are drawn from death certificates and made available to the public for analysis approximately three years after the end of the year in which they were collected. The data that DSHS makes available to the public is currently the only data readily available to track local rates and patterns of suicide and to plan prevention efforts. In other words, suicide data surveillance processes do not now exist in the Austin TC area. Concern about the continuing high local suicide rates and a desire to move forward with more detailed, data-based planning efforts prompted the Austin Travis County Suicide Prevention Coalition, Mayor’s Mental Health Task Force Monitoring Committee and the Austin Travis County Mental Health and Mental Retardation Center to initiate this project.

Purpose

The aim of this project was to determine how timely and accurate data on suicides occurring in the Austin TC area could be made available for ongoing local use to:

- (1) Plan community-wide and targeted suicide prevention interventions by identifying high risk groups and circumstances most likely to lead to suicide;
- (2) Identify emerging clusters of suicides so that postvention actions may be taken (postventions are actions taken after a suicide or group of suicides occur to help prevent more deaths by suicide); and
- (3) Assess the effectiveness of community-wide suicide prevention programs and community mental health initiatives.

While there are many issues and cautions regarding proper use of suicide data for assessing outcomes of interventions, accurate and timely data on suicides have potential

for use as one indicator of the impact of wide-scale prevention and service program initiatives.

This report includes specification of the data sources, pertinent data elements, processes for data monitoring, analysis and reporting, and roles of organizations and individuals involved. Rationale for the selected data source(s) and processes are provided.

The data sources and processes described in this report are intended to be just one component of a comprehensive and collaborative suicide prevention initiative that uses multiple sources of data and information for different purposes. As such, this report is focused on obtaining and using data from official sources of death data for targeted or community-wide prevention and some postvention efforts. The report does not address use of identified information to notify service providers or others about singular suicide events for the purpose of contacting identified survivors about available services and supports. It also does not address use of information or data on suspected deaths by suicide prior to official certification as such. Data for these purposes would need to come from sources other than those discussed in this report and would be subject to different confidentiality and ethical requirements.

Project Activities through the Preliminary Report (1/15/08)

In-person and/or telephone interviews were conducted with the following individuals:

- (1) John Hellsten, Ph.D., Epidemiologist, Environmental and Injury Epi, Texas Department of State Health Services (DSHS)
- (2) Susan Rodriguez, Child Fatality Review Team Coordinator, DSHS
- (3) Geraldine Harris, State Registrar, Vital Statistics, DSHS
- (4) David Lurie, Director, Austin Travis County Department of Health and Human Services (ATCHHSD)
- (5) Raquel Moreno, Registrar of Vital Records, Office of Vital Records (OVR), ATCHHSD
- (6) Janet Pichette, Manager, Public Health Response, Epidemiology and Surveillance Unit, ATCHHSD
- (7) Beth Devery, RN, JD, Chief Administrative Officer, Travis County Office of the Medical Examiner (TCME)
- (8) Dana Blazey, coordinator of the local Child Fatality Review Team, Travis County Attorney's Office.
- (9) Keri Lubell, Ph.D., Behavioral Scientist, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC)
- (10) Patty Williams, coordinator of the Suicide Prevention Coalition for the Beaumont, Texas area (undertook similar project for Beaumont area).

In addition, many relevant documents were collected and reviewed, including:

- (1) Handbook for Death Registration, DSHS
- (2) Item-by-Item Instructions for completion of Death Certificates (DSHS)\

- (3) Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Health Reporting (CDC)
- (4) Web-based Electronic Death Registration (EDR) Guides for Local Registrars and Medical Certifiers (DSHS)
- (5) Public Information Act, Chapter 552 (dealing with exceptions to the Act requirements regarding Birth and Death Records)
- (6) Administrative Code, Chapter 181 - Vital Statistics
- (7) Health and Safety Code, Chapter 193 – Death Records
- (8) Code of Criminal Procedure, Chapter 49 – Inquests on Dead Bodies (Duties Performed by Justices of the Peace and Medical Examiners)
- (9) Various agency and organization websites (particularly CDC and National Center for Suicide Prevention) and published and unpublished articles and documents related to suicide prevention and suicide data.

Findings

As mentioned previously, there are several local sources of information on suicides (e.g. the Austin Police Department, Emergency Medical Services, Travis County Sheriffs Department) other than the two focused upon in this report. Since these sources are not required by law to maintain records on all deaths in the community or all deaths by suicide, they will have data on a subset of all suicide deaths and their records are likely to include deaths presumed to be suicides along with those officially determined to be suicides. Therefore, they were not considered appropriate as a primary source of data for the purposes of this project and, thus, were not included in this investigation. However, data from these sources can be useful supplements to the data from the two sources discussed in this report.

There are two “official” sources of data on deaths by suicide in the local area:

(1) **Office of Vital Records (OVR), ATCHHSD** – coordinates collection of and is the repository of Death Certificates (DCs) for deaths that occur in Austin. Since the vast majority of deaths that occur in the Austin TC area occur within Austin (because it is the medical hub for the area), Raquel Moreno of OVR estimates that her office handles more than 99% of the DCs for Austin TC. There are four Justices of the Peace (JPs) who are responsible for the remainder of the DCs, i.e. for deaths that occur in their precincts within Travis County that are outside of Austin.

(2) **Travis County Office of the Medical Examiner (TCME)** – is responsible for determining the cause of death (and doing the medical certification) for all deaths occurring in Travis County that require inquests, which by law includes all suicides or suspected suicides. The TCME is also responsible for keeping all records on the inquests they perform. The JPs for the parts of Austin that are outside of Travis County are responsible for conducting inquests and certifying deaths for suicides or suspected suicides that occur in those areas. The JPs for those areas have contracts with the TCME for conducting autopsies, however, it is still up to the JP to make the final determination

of cause of death and do the certification. The JP may do an inquest and certify the manner and cause of death for a suicide or suspected suicide without an autopsy.

Thus, while both the Austin OVR and the TCME maintain data on the vast majority of suicides that occur in Austin TC area, neither have all of the records. DSHS Vital Statistics is the only single source of records on all “officially” determined suicides occurring in the area.

Content, Timeliness, and Accessibility of Death Records of OVR and TCME

OVR Death Records: Death Certificates (DCs)

Death Certificates (DCs) are part of the standardized local, state, and national Vital Statistics registry system. Local registrars are responsible for collecting and retaining vital records, the information from which is then passed on to the state and national vital statistics registries.

In Texas, the funeral director, or person responsible for disposition of the body, has overall responsibility for timely and accurate completion of the DC, including obtaining the medical certification, and then filing the DC with the local registrar (OVR for Austin).

DC Content

DCs have two sections, a Demographic section completed by the funeral director and a Medical section completed by the individual responsible for certifying the time and cause of death, which in the case of suicides and other unnatural deaths, is the TCME (or JPs, in parts of Austin outside Travis County – see above).

Both sections of the DC have many items that could be relevant and useful for suicide prevention (and postvention) activities, including:

Demographic Section: Date of Death, Sex, Date of Birth, Age, Marital Status, Residence (address, city, state, county, zip code), Place of Death (type of place where the death occurred, e.g. hospital), County of Death (and city or town and zip code), and Facility Name (if death occurred in an institution). Additional relevant demographic information on the DC includes the Decedent’s Education, if the Decedent was of Hispanic Origin, the Decedent’s Race, whether the Decedent was ever in the Armed Forces, the Decedent’s Usual Occupation, and Type of Business/Industry. If the Decedent was a student at the time of death, this is entered in Usual Occupation and type of school (elementary, H.S.) is entered in Type of Business.

Medical Section: Time of Death, Cause of Death – Part 1 (Chain of Events – diseases, injuries or complications that directly caused the death), Cause of Death – Part 2 (Other significant conditions contributing to the death), Manner of Death (certifier indicates

whether the death was natural, an accident, suicide or homicide), and whether the Decedent was pregnant at the time of death.

In addition, there are several additional items collected for deaths due to injury (includes suicide): Date, Time, Place, Location (complete address, including zip code), and County of Injury, and Description of How Injury Took Place (e.g. fire arm, car/truck collision).

Timing and Manner of DC Completion and Submission

The funeral director is obligated by law to file the DC with the local registrar within 10 days of the death. This time period includes five days allowed for certification of the date, time, manner and cause of death by the appropriate certifier. In the case of unnatural deaths, such as suicide or suspected suicide, a lengthy investigation including an autopsy, is likely to be done. In such cases, the DC may be filed with the manner of death and/or cause(s) of death “Pending Investigation.” In such cases, an amendment is submitted when the manner and/or cause of death are determined. According to Beth Devery, Chief Administrator of the TCME, it often takes 6-8 weeks to complete certification of a death by suicide because final autopsy results must await toxicology screening results.

The local registrar is responsible for enforcing deadlines and ensuring that all information is submitted to DSHS in a timely and accurate manner. According to officials at DSHS, timeliness varies greatly by locality. The local registrar for Austin (Raquel Moreno, OVR) is considered to be very conscientious about timeliness and accuracy. According to the local registrar, most delayed DC filings to the Austin are those of out of town or out of state funeral homes. This may be less of a problem in the future because many funeral homes are moving towards using local area agents to expedite the filing process.

DSHS Vital Statistics has been working to automate the DC completion process for several years. There is a web-based death registration system and guidelines for using the system created for local registrars, medical certifiers, and funeral directors. However, the State Registrar (Geraldine Harris) reports that due to funding and other constraints, the DC completion process is still primarily manual. Local registrars send paper DCs to the state where the information is keyed, coded and entered into a central database. ICD-10 codes are assigned to every cause of death statement by a computer program supplied by the CDC. A certified ICD coder codes statements that are not automatically matched to codes. While the DC completion and submission process is still primarily manual in most of the state, the Austin OVR is further along in the automation process than other areas.

DC Accessibility/Confidentiality

The DC data is subject to a comprehensive quality assurance process to ensure the completeness and accuracy of data for each death occurring in Texas. DC data are not released for statistical analysis and research at the state (and national) level until all certificates for deaths occurring in that year are completed and certified (no longer pending investigation). Since there are a subset of deaths that take a very long time to resolve (e.g. for missing or unidentified bodies), an annual DC data set is generally

released two or three years after the end of the reporting year. As of the date of this final report, 2005 death data have not yet been released by DSHS.

The term “released” here refers to the use of unidentified data for aggregate reporting. As specified within the “exceptions” to release of public information in the Public Information Act, individual death certificates are not available to the public for 25 years after the death. The only information that the state or local registrar may release to the public from an individual certificate prior to that time is the “fact of death” – the name of the decedent, date and place of death.

However, local registrars and health department epidemiologists in Texas can and do use death data for their local areas prior to official release of the state data set. Within ATCHHSD, DC data are used to comply with federal (CDC) reporting requirements and are also part of the department’s comprehensive surveillance system. The OVR registrar regularly surveys the death certificates and notifies the Public Health Response, Epidemiology and Surveillance Unit of deaths due to particular diseases or causes that have been designated as “reportable conditions”. Depending on the condition, the OVR provides routine (weekly or monthly) summary mortality reports to the ATCHHSD Medical Director/PHR E&S Unit, who then reports to the CDC. Mortality data are reviewed to identify unusual clusters or trends, which may prompt more detailed epidemiological investigation to determine the source of exposure and risks associated with illness or death.

Currently, mortality data for reportable conditions are reviewed manually and summarized by the OVR. However, an electronic DC system is currently under implementation, which will provide ATCHHSD the capability of accessing near real-time mortality data. While the electronic DC system is operational, capacity to access the mortality data for study is not expected until (approximately) Spring 2009. Until that time, the DC data continue to be reviewed manually for these conditions.

Since suicide has not been classified as a “reportable condition”, the OVR and PHR E&S Unit of ATCHHSD do not currently survey the DC data for cases of suicide, nor do they provide reports on suicide to any internal departments, external agencies, or the public.

TCME Death Records

As noted earlier, the TCME is required to retain records on all death inquests they perform. These records include demographic and cause of death data that overlap with that on DCs, as well as autopsy reports, toxicology reports, and other information collected to determine cause and manner of death.

It should be mentioned that medical examiners are known to be very conservative about certifying deaths as suicides. My contact at the CDC (Keri Lubell), noted that deaths certified as “undetermined”, single occupant vehicle accidents, accidental gun shot injuries or accidental hangings are often suspected to be, or later found to be, suicides.

Thus, data sources that include manner of death certifications by MEs will underestimate the true number of suicides.

Content of Case Records in TCME's Electronic Database (CME)

The TCME has recently completed installation of a new electronic data base (CME). Case data from the CME is available in the form of standard reports. The following delineates the information available in each of the standard reports.

- (1) **Medical Examiners (or Autopsy) Report** that includes the **Toxicology Report** and diagrams from the Autopsy. This report is primarily in narrative form and includes the following sections: External Examination, Evidence of Decomposition, Identifying Marks and Scars, Evidence of Treatment, Evidence of Injury, Internal Examination (including organ weights), Findings, Conclusions, and Manner. The Findings and Conclusions sections summarize the evidence and causes of death. The Manner section of the report is where the ME indicates that the death was a suicide (or natural, accident, homicide).

The Toxicology Report indicates whether or not certain substances were detected in the samples sent to the laboratory and, if detected, the amount of the substances. It includes tests for toxic substances (e.g. carbon dioxide), blood alcohol, and both legal and illegal drugs. Tests for alcohol and most illegal drugs are part of the standard screen. If the individual's history (in the Report of Investigation) indicates that he/she was taking particular medications, such as psychoactive drugs, screens for those medications will be requested.

- (2) **Report of Investigation (ROI)** has much of the same data as included in the DC along with additional information. Most of the information is collected directly by other sources (e.g. APD, Sheriff, DPS) and then reported to the TCME. The ROI includes the following sections and items:
 - A. Call Information:** Name of deceased, Case Number, name of TCME Investigator, Person who made the Report (e.g. police officer) and Reporting Agency, Date and Time of the Call, Arrival Date and Time, and Return Date and Time.
 - B. Decedent:** Date and Time of Death, Date of Birth, Age, Gender, Race, Address and County, Telephone Number, Social Security Number, Driver's License Number and State, Occupation, Marital Status, Height, Weight, Eye Color, and Hair Color.
 - C. Death:** Location of Death (description – e.g. home), Address and County of Death; Person who pronounced the death and their Agency (e.g. EMS), date and time of death; Person who found the body and Agency (can indicate friend or relative, etc.) and date and time found.
 - D. Notification:** Legal Next of Kin and their relationship to the deceased, address and telephone no.; Person who did the notification, method of notification, and date/time of notification; Person who did the identification, method of identification and date/time of identification.

- E. Disposition:** Who transported the body to the Morgue and Mortuary; the Funeral Home and the Exam Performed (e.g. Autopsy).
 - F. Incident:** Location of the incident (e.g. home, work), address and County; Date and Time of the Incident; Investigating Agency (e.g., APD) and Officers who did the investigation of the incident.
 - G. Medical History and Medications:** brief description.
 - H. Circumstances of Death:** Description of the circumstances of the death summarized by the TCME investigator (information may come from multiple sources). For suicides, in addition to a description of the death scene, such as whether a weapon or drugs were found, this section might include events that occurred in the person's life prior to the suicide, things the person said to family or others just prior, their apparent state of mind or wellbeing, whether or not a note was left, etc.
 - I. Investigative Addendum:** this is log of activities undertaken and communications made related to obtaining information (such as the suicide note or pill bottles) necessary for the inquest.
- (3) Case Narrative Report:** This is a lengthy description by the TCME Investigator summarizing information gathered from all sources, much of which duplicates information in the ROI. The Case Narrative Report presented in the following format:
- A. Circumstances:** repeats that in the ROI
 - B. Additional Medical History:** repeats that in the ROI
 - C. Observations at Scene:** more standardized format than in the ROI. Includes space to specify Scene Examination, Injuries, Clothing, and Weapon.

Timing and Confidentiality of TCME Data

As mentioned previously, cause and manner of death determination and certification for suicides often take as much 6-8 weeks to complete because toxicology screens are generally ordered and it takes time for the toxicology reports to be completed and returned from the laboratory. In the interim, the manner and/or cause of death in the TCME's internal records (as well as on DCs) may be indicated as "pending". The TCME does not release any information to the public until the case file is completed (nothing is pending).

By statute, data at the TCME is not subject to the same confidentiality constraints as the DC data maintained at the OVR. Data maintained at the TCME are not exceptions from the requirements of the Public Information Act, therefore, the public can request identified data. In some circumstances, the TCME may attempt to contact survivors to inform them that personal information has been released. The family does have the right to file an objection to release of the records with the Attorney General's Office. If the Attorney General's Office upholds the objection (occurs rarely), the records would not be released by the TCME.

External Reporting by TCME/Accessing TCME Data

Personnel at the TCME do not survey their data on an ongoing basis in order to notify external authorities of particular types of deaths, as do personnel at the ATCHHSD. They do supply identified inquest/autopsy reports and prepare summary data reports, when requested by members of the public or external governmental agencies. The TCME does prepare an annual report that includes statistical data in order to meet standards of the National Association of Medical Examiners.

The TCME follows guidelines and requirements of the Public Information Act when providing requested data (e.g. supplying the information within 10 days of the request, etc.). They charge \$10 for each case record request (full set of reports). They do not have formal agreements (i.e. memoranda of understanding) to facilitate sharing between agencies to which they regularly supply data. They follow the same Public Information Act guidelines in providing information to requestors such as Brackenridge Hospital as they do to individual members of the public.

When asked if the TCME would prepare regular reports on suicide deaths for use by the local health or mental health agencies, the Chief Administrator replied that they would do so by specified request for each report. In other words, they will not prepare and send reports on a regular schedule without a request being made each time. To facilitate such a process, the TCME's Information Technologist (IT person) could program a specialized report for this purpose that could then be run and delivered each time the TCME's Office is prompted to do so by the requestor.

Case reports in the CME are not easily retrievable by Manner of Death (e.g. Suicide). If a requestor wanted the case reports for all suicides that occurred in January 2008, the IT person would have to write a program to retrieve them. For example, I made a request for four sample case reports of people who'd committed suicide in the past year (2 adults and 2 youth). The TCME could not fulfill my request without either names or date of death plus age of specific individuals. If the requestor does not have identifying information such as this, the IT person must write a program to identify cases that meet the requestor's criteria.

It is also difficult to retrieve statistical data (e.g., frequencies of particular types of deaths) from the TCME's electronic CME database. The information maintained in the system is primarily in text form and is generally retrieved through the standard report formats for individual cases described previously. The IT person must write special programs to create statistical reports from the CME. Due to the difficulty of retrieving statistical reports from the CME, the TCME keeps manual counts for some of their reporting requirements.

Individuals or agencies that request reports requiring programming will be charged for the IT person's time. It is not clear whether or not there are additional charges for re-running specialized reports once they've been programmed.

The TCME Chief Administrator offered the following advice to facilitate public information requests for case reports on suicides (i.e. to obtain the reports more quickly): Have identifying information (names best, or date of death and age) and specify which reports you want (see Standard Reports above) for each. All three of the basic reports (Medical Examiners Report, Report of Investigation, and Case Narrative) have relevant and unique information. The Report of Investigation and the Case Narrative have the most detail and relevance, but they do not include the final determination of cause and manner of death (that is only within the Medical Examiner's Report). They also do not include the Toxicology Report, if that is of interest.

Recommendations and Rationale

In light of the information gathered and described above and other factors noted below, the following recommendations are offered:

Recommendation 1: The primary source of data for regular review and analysis of suicide deaths that occur in the Austin TC area should be the death certificates collected and retained by the OVR. This recommendation is made with recognition that the OVR data does not include DCs for the small number of deaths that occur in Travis County outside of Austin (efforts can be made to include these DCs in the future).

Recommendation 2: The project should be one part of a collaborative suicide prevention and response endeavor ("the Collaborative") involving ATCHHSD, the Austin/Travis County Mental Health and Mental Retardation Center (ATCMHMR), the Mayor's Mental Health Task Force Monitoring Committee (MMHTFMC), Austin/Travis County Suicide Prevention Coalition, and other agencies and stakeholders including (but not limited to) the Austin Police Department, the Austin Independent School District, TCME, mental health advocacy groups, private mental health professionals, and funeral directors and representatives of the faith community. Determination of the lead or host agency of the Collaborative, its specific membership, purposes, policies, and procedures are beyond the scope of this project.

Recommendation 3: ATCHHSD should take the lead in implementing the work of the suicide data project described in this report, with continued planning input and assistance provided by representatives of ATCMHMR, MMHTFMC, and the Austin/Travis County Suicide Prevention Coalition.

Recommendation 4: Data available at TCME should be accessed as a secondary source when more detailed information is necessary for in-depth analyses or for specific surveillance investigations or postventions that require the release of identified data.

Recommendation 5: Other sources of timely information about suicides from other members of the Collaborative should contribute, along with unidentified information drawn from the DCs, to a notification process to quickly identify suicide clusters and contagions. Determination of the entity that would collect the notifications and decide

whether, when, who and how to respond is beyond the scope of this project (see note in Recommendation 2 above).

Rationale:

- The DC data are already collected, stored, regularly reviewed and used for reporting and analysis by offices within ATCHHSD (OVR and PHR E&S).
- Creating a system that calls upon already existing data and processes decreases costs and increases the likelihood of success of implementation of the project.
- The data available on deaths by suicide from the DC are sufficiently detailed, accurate, and timely to serve as the primary source of information for the stated purposes of this project.
- The public health prevention focus of the project falls within the mission of the ATCHHSD (as contrasted with the mission of the TCME). This factor supports the role recommended for ATCHHSD in this report, as well as the expenditure of agency resources to accomplish the project. [This should not be construed to mean that ATCHHSD be the sole source of resources contributed to the implementation of this project.]
- With the exception of specific knowledge pertaining to suicide and its prevention, considerable technical knowledge and expertise necessary to oversee and carryout the work of the project (e.g. in-depth knowledge of the death certificate data elements, expertise in epidemiological data analysis and disease surveillance) already exists at ATCHHSD.
- The Director of ATCHHSD (David Lurie) expressed interest in and enthusiasm for involving his agency in carrying out the project. He noted that the project fits the agency's prevention orientation, offered some initial suggestions on how the project might fit into agency processes, and viewed the project as an opportunity to bring mental health expertise into general health investigations and preparedness response planning. The OVR Registrar and the Manager of the PHR E&S Unit have also demonstrated interest in the project. Support and interest by top level and implementation level personnel of ATCHHSD also increase the likelihood of successful implementation.
- Designating ATCHHSD as the lead agency for this phase of the Suicide Data Project could logically extend to ATCHHSD's involvement in the next (tentatively planned) phase that will involve collection and use of data on suicide attempts. In contrast, the investigation of suicide attempts (not resulting in deaths) would not be consistent with the TCME's mission.
- It may be possible to integrate other aspects of the broader collaborative suicide response and prevention initiative into ATCHHSD's Public Health Response, Epidemiology and Surveillance and Public Health Emergency Preparedness and

Response programs and processes. Again, calling upon existing processes can decrease costs and increase the success of implementing planned programs.

Activities and Additional Findings and Results Since Preliminary Report

1. Obtained feedback on Preliminary Report Recommendations from stakeholders:
 - A. Obtained feedback from David Lurie, Director of ATCHHSD, and key staff Janet Pichette and Raquel Moreno prior to submitting preliminary report and incorporated their comments into report
 - B. Met with and obtained feedback from Susan Stone, M.D., Executive Director of the MMHTFMC and Merily Keller, Co-Facilitator of the ATC Suicide Prevention Coalition.
 - C. Met with and obtained feedback from David Evans, Executive Director of ATCMHMR and Iliana Gilman, Director of Communications.
 - D. Gave presentation on report and recommendations to MMHTFMC and requested their comments/feedback.

Result: There were no substantive changes to the recommendations resulting from these meetings. A suggestion was made by a member of the MMHTFMC to add representatives of the faith community into the “Collaborative” mentioned in the Recommendations. This modification to the Recommendations was made.

Finding: A work group, the Suicide Postvention Advisory Group, has been formed by the ATC Suicide Prevention Coalition to draft a set of protocols to guide community response in the event of one or more youth suicides in order to prevent additional suicides from occurring. The group is composed of representatives from ATCMHMR, Seton Hospital System, ATC Suicide Prevention Coalition, AISD, private mental health practitioners, and others. This group might be considered the beginnings of the “Collaborative” mentioned in the Recommendations. In addition to developing protocols, the group will address informal information flow between organizations about the occurrence of youth suicides or near death attempts.

2. Met with David Lurie and several staff of ATCHHSD to discuss next steps in the project, i.e. how to make progress toward implementation of the Recommendations.

Findings: ATCHHSD staff had a number of questions and concerns about how data might be used, about data confidentiality and about adding suicide to their surveillance responsibilities though it is not designated as a “reportable condition”.

Result: Mr. Lurie and staff agreed to begin addressing the report Recommendations by performing epidemiological analyses of suicides that had occurred in 2007. They decided to delay specification of an implementation plan

until those analyses were completed. Staff set a deadline of June 30th for completion of the analyses and report.

3. Met with Janet Pichette, Director of Public Health Response, Epidemiology and Surveillance, and staff member Jessie Patton-Levine, to review initial results of analyses on 2007 suicide deaths and to provide suggestions for further analyses.
4. Met with John Hellsten, Epidemiologist at DSHS, who has performed many analyses on statewide suicide death data, and Merily Keller of the ATC Suicide Prevention Coalition, to review initial draft of analyses and to get their suggestions for further analysis.

Result: Compiled John Hellsten's and Merily Keller's suggestions for additional analyses along with my own and communicated them in writing to Janet Pichette and Jessie Patton-Levine.

5. Reviewed final draft of Report on 2007 Deaths by Suicide with Janet Pichette and Jessie Patton-Levine and discussed feasible options for ongoing surveillance and reporting on suicide deaths by ATCHHSD. Also discussed within-department confidentiality issues.

Findings: I learned that the PHR E&S Unit of ATCHHSD does quarterly data reports on many reportable conditions. Therefore, the Director of PHR E&S noted that quarterly frequency reports on deaths by suicide might be feasible without the addition of staff. I also learned that there are no formal restrictions on using identified death data within ATCHHSD, but staff generally transmit data to one another without including identifiers unless it is necessary to have them for the work being performed.

Result: A Summary Report on Suicide Deaths: January 2007 – March 2008 has been completed by Jessie Patton-Levine of the PHR E&S Unit of ATCHHSD (a copy of the report is included in the Appendix).

6. Met with Suicide Postvention Advisory Group. Presented on project, along with Janet Pichette and Jessie Patton-Levine from ATCHHSD. Gathered information about how this group's activities might intersect with the Suicide Data Project in the future.

Results: The Postvention Advisory Group members were very enthusiastic about the short and long term possibilities for ATCHHSD's involvement in suicide prevention through data surveillance, analysis, investigation and reporting. There was some discussion about the possibility of expanding the project to include not just mortality data, but morbidity data, i.e. suicide attempts. The group also discussed a need for an operational definition of suicide attempts and how such data might be collected by local hospitals. Representatives from Seton Hospital

System discussed possibilities for capturing data on suicide attempts within their system.

The group was also very interested in the suicide death data and analyses presented by Jessie Patton-Levine and Janet Pichette. They offered examples of how the data might be used for prevention and postvention efforts. I asked Merily Keller, the group leader, for her reflections on the report data and for examples of how the data might be used to include with this report (her responses are included in the Appendix).

7. Made a formal request to the TCME for a complete data download (all information available) on four sample cases on deaths by suicide from their electronic database (CME) - - two adult cases and two youth cases. I made this request so that I could more accurately describe the information available on deaths by suicide at the TCME's Office.

Findings: The TCME's office was not able to select sample cases without having some identifying information to locate the cases. More specifically, they were not able to select cases in which the manner of death was designated as suicide without having their Information Technologist (IT) write a special program to retrieve the cases.

Result: I had to find names of individuals who had committed suicide in order to make the request.

8. Received and reviewed four case examples requested from TCME (after finding names of individuals who'd died as a result of suicide from a few sources). Met with Beth Devery, Chief Administrator of the TCME, to ask questions about the case records I'd received in order to better understand the content of their electronic data system and how to access information from it. Specifically, the aim was to learn how ATCHHSD or others could obtain the data expeditiously if more detailed information were required for investigations.

Findings: Information from the TCME's electronic database (CME) is accessed by requesting a few standardized reports. Most reports contain filled-in responses or lengthier narratives for each data element rather than coded response categories. This makes it difficult to retrieve statistical reports from the system. In fact, the IT person must write special programs to retrieve summary information across cases because the standard reports are all case specific.

Results: More specificity regarding data available at the TCME has been added to earlier sections of this report, along with information about how to request data on deaths by suicide in an expeditious manner.

9. Called a meeting of key decision makers of ATCHHSD and ATCHMHR in order to come to agreement on short term roles and responsibilities regarding suicide

data surveillance, analysis and reporting and related prevention initiatives, as well as to consider a longer term vision for collaboration. Invitees From ACTHHSD included David Lurie, Shannon Jones (Acting Director while Mr. Lurie is Acting Ass't City Manager), Dr. Huang (Medical Director) and Janet Pichette (Director of PHS, S&E). Invitees from ATCMHMR were David Evans (Executive Director) and Iliana Gillman (Director of Communications), and Dr Susan Stone represented the MMHTFMC.

Results: All invitees were able to attend except David Lurie. Though there wasn't much time for discussion of the long-term vision, there appeared to be general agreement about its contents among the participants, as well as interest in moving towards the vision. Two optional short-term agreements were discussed. David Evans expressed agreement with the roles and responsibilities outlined for ATCMHMR in both options. Since the key decision maker for ATCHHSD was not present, Shannon Jones asked that Janet Pichette meet with David Lurie to obtain his feedback on the draft agreement (Option 1). Janet Pichette was not able to meet with Mr. Lurie prior to submission of this report.

10. Asked for clarification from ATCHHSD lawyer (Kay Boccella) about sharing identified death certificate data with ATCMHMR.

Result: Ms. Boccella stated that ATCHHSD cannot share identified death data with ATCMHMR because the exceptions to the Public Information Act pertaining to Death Certificates restricts such sharing. I still have questions pertaining to this issue that I believe merit further pursuit. However, the contents of the draft Memorandum of Understanding included in this report are in alignment with the answer provided by Ms. Boccella.

11. Reviewed many more documents and websites. In doing so, I became much more familiar with the National Strategy for Suicide Prevention, the National Violent Death Data Survey, as well as the research literature on suicide prevention.

Draft Memorandum of Agreement (MoU) between ATCHHSD and ATCMHMR

The following draft of an MoU between ATCHHSD and ATCMHMR derives from the Recommendations included in this report, as well as the "Short Term Agreement - Option1" presented at the 8/18/08 meeting of ATCHHSD and ATCMHMR (in the Appendix) that was influenced by activities undertaken and information gathered after the Recommendations were written. The elements of the MoU were selected as initial steps towards a more comprehensive local suicide prevention initiative (such as that set forth in broad terms in the Long Term Vision presented in the next section).

**Memorandum of Understanding
Regarding Data on Deaths by Suicide
And Associated Postvention and Prevention Activities
Draft 8/28/08**

Purpose and Background

The following represents an agreement (“The Agreement”) between Austin Travis County Health and Human Services Department (ATCHHSD) and Austin Travis County Mental Health and Mental Retardation (ATCMHMR) regarding roles and responsibilities pertaining to surveillance, analysis, and reporting on deaths by suicide using death certificate data. It also covers, in general terms, suicide postvention and prevention activities associated with these data based functions.

ATCHHSD and ATCMHMR acknowledge that suicide has been proclaimed by the Center for Disease Control (CDC) to be a significant public health problem and that suicide rates can be reduced by prevention efforts. Rates of suicide in Travis County have exceeded state and national averages for the last five years for which public information has been available (2000-2004). ATCHHSD, ATCMHMR, and many other local agencies, organizations and stakeholder groups share a common desire to reduce the rate of suicide in this community. Since responsibility for addressing the public health issue of suicide does not fall clearly under either ATCHHSD’s nor ATCMHMR’s mission, both agencies recognize the need for a collaborative effort involving their own agencies and other local agencies and organizations to address the public health issue of suicide.

The National Strategy for Suicide Prevention (U.S. Surgeon General, 2001) adopts CDC’s four-step approach to addressing public health problems. The first step in prevention involves defining the problem – how big of a problem is suicide, where does the problem exist, and whom does it affect. Data on these topics are critical to help determine where prevention resources are most needed. The National Strategy for Suicide Prevention’s 11th goal – “Improve and expand surveillance systems” stresses the importance of **local** surveillance systems to prevention initiatives. Thus, this Agreement focuses upon initiating the use of existing local data (the Death Certificates collected and stored by the Office of Vital Records of ATCHHSD) as a first step in creating a disease surveillance system for suicide and suicide attempts.

Both agencies recognize the limitations of the death certificate data in informing prevention and postvention efforts, the desirability of more comprehensive (and more timely) data to better target interventions, as well as the need for broader and better defined roles and responsibilities in the area of suicide surveillance and prevention. However, current resource constraints (and legal constraints pertaining to data confidentiality) limit this Agreement to the roles and responsibilities the agencies voluntarily agree to undertake that are specified below. The Agreement does not preclude other local organizations and agencies from undertaking suicide data surveillance or prevention activities.

Definitions

Deaths by Suicide (or suicide deaths): refers to deaths for which the “manner of death” specified on the Death Certificate is suicide.

Surveillance: refers to the systematic and ongoing collection and review of data on suicide deaths.

Postvention: refers to actions taken after a suicide or group of suicides occurs to help prevent more deaths by suicide.

The Community: refers to the city of Austin. Death Certificates referred to in this Agreement are collected and maintained by the Office of Vital Records (OVR) of ATCHHSD, which, at this point in time, is only responsible for vital records for the city of Austin. If the scope of responsibility of OVR were to change during the performance period of this Agreement to include all of Travis County in addition to Austin, or if ATCHHSD is otherwise able to access death certificates from areas in Travis County outside of the city of Austin, then “The Community” shall refer to the both the city of Austin and Travis County.

Community Partners: refers to local agencies, organizations, and stakeholders, other than ATCHHSD and ATCMHMR, who are regular participants in community collaborations related to suicide prevention. Community partners include, but are not limited to, the Austin Travis County Suicide Prevention Coalition, the Mayors Mental Health Task Force Monitoring Committee, the Austin Independent School District, Seton Hospital System and others.

Suicide Cluster: a group of suicides that occur closer together in time and space than would normally be expected in a given community. The CDC definition of a suicide cluster is the same, but includes suicide attempts (“is a group of suicides or suicide attempts...”). However, since the activities specified in this Agreement do not include suicide attempts, this phrase was omitted from the definition. ATCHHSD will use local data from the past and professional judgment to determine how to apply the definition given above. However, it should be noted that experts in the area of suicide research and prevention have suggested that a group of suicides do not have to be verified by statistical analysis to be regarded and acted upon as a cluster. Thus, the term “suspected” cluster is used in the agreements that follow.

Suicide Contagion: the process in which suicidal behavior is initiated by one or more individuals following the awareness of a recent suicide threat, attempt or completion, or a fictional depiction of such behavior.

Elements of Agreement

It is agreed that ATCHHSD will:

- produce quarterly reports on suicide deaths in the community from Death Certificate data. Reports will include simple counts of suicide deaths by age group (25 years old and under, over 25) and, if possible, by gender. Reports will be sent to ATCMHMR by the 15th of the month following the end of the quarter (e.g. April 15, July 15, October 15, January 15).
- produce an annual report on deaths by suicide in the community by June 30th of the following year. The report will be composed of epidemiological analyses of all relevant data available in the death certificates and will include, when possible, comparisons to local data from previous years and state and national data.
- will develop internal procedures for ongoing monitoring of suicide deaths and will alert ATCMHMR's Executive Director and designated staff contact if formation of a suicide cluster is suspected between quarterly reports.

It is agreed that ATCMHMR will:

- designate a key staff contact, in addition to the Executive Director, to receive and review the data reports produced by ATCHHSD. The staff contact may share data with other groups that are working collaboratively on suicide prevention and postvention.
- designate a qualified staff member or representative to assist ATCHHSD with development of the annual report. This individual may or may not be the designated key staff contact.
- use data from the quarterly and annual reports, along with information from other sources (TCME data and "unofficial"/informally collected information), to plan and implement postvention and prevention initiatives in collaboration with other community partners (and ATCHHSD, if ATCHHSD so chooses).
- will be responsible for determining, in collaboration with community partners, whether or not to act upon cluster alerts by ATCHHSD. Due to limitations of the data provided by ATCHHSD (e.g. timeliness), other sources of information will be used along with data provided by ATCHHSD to monitor the possible emergence of suicide clusters and suicide contagion processes that contribute to the development of clusters. ATCMHMR will not hold ATCHHSD accountable if a cluster of suicides emerges that was not identified by ATCHHSD.

It is agreed that ATCHHSD, ATCMHMR, and collaborating partners will seek funding to support and expand this initiative.

Period of Performance

This Agreement shall commence upon certification by both ATCHHSD and ATCMHMR and shall terminate upon request of either agency or when superseded by another agreement covering the area of concern.

Certification

By signing this agreement, both parties agree that the provisions contained herein are subject to all applicable Federal, State, and local laws, regulations and/or guidelines, particularly those related to privacy rights and maintenance of and access to records and other confidential information.

By signatures affixed below, the parties specify their agreement:

David Lurie

Director

Austin Travis County Health and Human Services Department

Date

David Evans

Executive Director

Austin Travis County Mental Health Mental Retardation Center

Date

A Long Term Vision for Collaboration Between Local Agencies and Organizations Re: Public Health Response to Suicides/Suicide Attempts

The following long-term vision is included here to provide a picture of what a more comprehensive initiative might entail if additional resources were available. This is just one possible vision for future collaboration around suicide data use and prevention activities. It represents my own views (though informed by many discussions with others) and not the views of any organization or agency involved in this project. It is a modification and elaboration of the Long Term Vision document presented at the 8/18/08 meeting of agencies (included in the Appendix).

- ATCHHSD, ATCMHMR and other local agencies and organizations have created and implemented a nationally recognized model for collaborative community response to the public health problem of suicide and serious suicide attempts.

- Suicide deaths/serious attempts have been designated as, or are treated in the same manner as, “reportable” conditions. Incidents of suicide and serious attempts are reported to the ATCHHSD Public Health Response, Epidemiology and Surveillance Unit (PHR E&S) by local hospitals, EMS, APD, TC Medical Examiners Office and others. Reported data are monitored and analyzed (along with official death certificate data) and investigations are undertaken, as appropriate, to determine whether clusters/contagions are occurring.
- Information collected and documented on suicide deaths by the TCME have been standardized and enhanced, incorporating many of the data elements of the National Violent Death Reporting System and in line with recommendations in Goal 11 of the National Strategy for Suicide Prevention. More complete and accurate data are entered on death certificates for suicides by the TCME (e.g. specific causes of death and contributing causes). Thus, both sources of data, TCME records and the Death Certificate, contain more information useful for targeting prevention efforts.
- A Behavioral Health Epidemiologist in the PHR E&S Unit of ATCHHSD is responsible for data monitoring, analysis and reporting of suicides/serious attempts and for coordinating investigations of suspected clusters. ATCMHMR staff members are designated to assist with investigations, as needed. Monthly reports on suicide deaths and serious attempts are provided to ATCMHMR and ATCMHMR is notified about any investigations undertaken that may suggest the need for postvention activities.
- ATCMHMR has responsibility for initiating/coordinating postvention responses to potential suicide/suicide attempt clusters, in collaboration with other agencies and in accordance with accepted protocols (e.g. protocols currently being developed by Suicide Postvention Advisory Group).
- The ATCHHSD Behavioral Health Epidemiologist performs epidemiological analyses on the suicide death and attempt data annually and shares the report on the analyses with ATCMHMR, MMHTFMC, Austin/Travis County Suicide Prevention Coalition and other collaborating organizations. The Behavioral Health Epidemiologist also performs special analyses on specific suicide-related issues, drawing upon the more in-depth data available at the TCME to supplement the ATCHHSD data, when needed. ATCMHMR and collaborating organizations use the data reports to plan targeted community suicide prevention initiatives.
- The ATCHHSD Behavior Health Epidemiologist participates in the local collaborative suicide prevention planning meetings coordinated by ATCMHMR. In addition to functions pertaining to suicide, the Behavioral Health Epidemiologist provides behavioral health expertise to epidemiological analyses and investigations of occurrences of other diseases and conditions.

- A variety of evidence-based and promising primary, secondary and tertiary suicide prevention strategies and programs are implemented in the Austin/Travis county area by ATCMHMR and collaborating organizations.
- The effectiveness of prevention efforts is evaluated by those involved or by university partners. Success of the broad-based, collaborative community prevention initiative is demonstrated by dropping rates of suicide and suicide attempts in the Austin/Travis County area.

Comparison of 2007 Suicide Death Data With Historical Death Data: Timely Data Could Inform Local Prevention and Postvention Efforts

by Merily H. Keller, August 2007

The recent rough draft of suicide death data from an analysis by the Travis County Health Department is quite helpful for prevention and postvention efforts. The Austin-Travis County Suicide Prevention Coalition would like to thank the Health Department for their work on this project with Dr. Marcia Toprac and urge them to consider if this might be done on a regular basis.

The timely local data points to some possible trends which could help target local prevention efforts by the Austin Suicide Prevention Coalition working with other coalition member such as ATCMHMR, AISD, Seton Hospital, NAMI etc.

A quick review of the local data which might inform prevention efforts includes: (note: a more thorough comparison will be done with the 07 data compared with historical data in the future with epidemiologists)

Age Group Comparison

1. The local data for 2007 indicates the largest number of deaths in two age groups: 25-34 (27 deaths) and 45-54 (34 deaths)

This is a somewhat younger group than that indicated in the analysis below for Texas overall for 1999-2004 and for Travis County which shows the groups 35-44 and 45-54 as having the largest numbers of deaths. We may need to look at specific prevention efforts aimed at young to middle age adults.

2. Local data also indicates that there were 7 deaths for those 18 years of age or younger which is a higher than average number of deaths for this age for Travis County. This adds weight to the anecdotal death data received by the local coalition of deaths and serious attempts which indicated a cluster of youth suicides for teens in 2007-2008.

The Medical Alert Re Teen Suicides attached which was sent to primary care physicians and mental health professionals by the local coalition working through Seton Hospital in 2007 is an example of a prevention effort aimed at those who interact with teens. Timely local data could help inform the need to send alerts such as this in the future.

Gender Comparison

3. 9 deaths for women aged 45-54 is a larger number of deaths for women in this age group that Travis County has seen historically and does not follow national trends. Women typically do not have as high rates of death by suicide as men. This trend is something to watch closely regarding prevention efforts and outreach to women. Note that Dr. John Hellsten, DSHS, has stated that he has recently seen an increasing rate of deaths by suicide for women in Texas. It would be worthwhile to check with him to see if that is for Texas overall or for certain

Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
5 to 14	23	0.7	33	1.0	28	0.8	24	0.7	23	0.7	20	0.6	151	0.8
15 to 24	287	9.2	346	10.9	321	9.8	322	9.6	348	10.2	335	9.7	1,959	9.9
25 to 34	363	12.4	371	11.7	380	11.8	401	12.2	370	11.1	395	11.7	2,280	11.8
35 to 44	457	14.4	456	13.7	483	14.4	530	15.7	504	15.0	451	13.4	2,881	14.4
45 to 54	349	14.4	397	15.2	428	15.6	435	15.4	526	18.1	449	15.1	2,584	15.7
55 to 64	179	11.8	188	11.8	225	13.6	242	13.7	253	13.5	275	14.0	1,362	13.1
65 to 74	171	15.7	135	11.8	157	13.6	164	14.0	158	13.3	164	13.7	949	13.7
75 and over	173	18.9	167	18.0	191	20.1	183	18.9	172	17.4	200	19.9	1,086	18.9
All Ages	2,002	10.5	2,093	10.4	2,214	10.8	2,304	11.0	2,355	11.0	2,290	10.6	13,258	10.7
Footnote	Rates Per 100,000													
	<i>Rates for "All Ages" are Age Adjusted. Others are age group specific @.@ indicates numerator too small for rate calculation Age Adjustment Uses 2000 Standard Population</i>													

Travis County Deaths for Intentional Self-Harm (Suicide) (X60-X84, Y87.0) 1999-2004														
	1999		2000		2001		2002		2003		2004		1999-2004	
Age	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
5 to 14	1	@.@	1	@.@	1	@.@	0	@.@	1	@.@	0	@.@	4	@.@
15 to 24	14	10.9	16	10.7	18	12.0	13	8.8	12	8.3	12	8.5	85	9.9
25 to 34	14	10.6	25	15.5	16	9.6	26	15.4	14	8.0	13	7.3	108	11.0
35 to 44	20	17.6	14	10.3	28	20.3	23	16.7	14	10.0	18	12.7	117	14.5
45 to 54	16	18.8	17	17.0	23	21.8	23	21.4	23	20.6	17	14.8	119	19.1
55 to 64	2	@.@	6	12.4	3	@.@	14	25.7	10	16.6	17	26.4	52	16.1
65 to 74	2	@.@	5	16.7	7	23.0	8	26.2	11	35.4	4	@.@	37	20.1
75 and over	2	@.@	5	20.0	6	23.5	3	@.@	7	27.0	9	34.3	32	21.1
All Ages	71	9.8	89	11.1	102	12.8	110	13.6	92	12.2	91	11.4	555	11.9

AUSTIN AREA YOUTH SUICIDE PREVENTION COMMUNITY ALERT **To Primary Care Practitioners & Mental Health Clinicians**

Austin has had more youth (age 15-19) die by suicide in a 6 month period than teens of this same age died by suicide in all of 2005.* According to definitions from the Centers for Disease Control, this would qualify as a youth suicide cluster.

In order to contain this cluster and help prevent a contagion effect, the Austin Suicide Prevention Coalition, the Seton Health Care Network, and the Austin Council of PTAs is asking all primary care practitioners and mental health clinicians in our area to do four things:

- **Be ALERT** to possible warning signs youth may give about their emotional state and know the risk factors and warning signs for suicide
- **Increase your staff's AWARENESS** that Austin youth of middle school and high school age may be of increased risk of death by suicide because of the current cluster and possible contagion effect
- **Increase ACCESS to care** by giving priority access in your medical and mental health practice to middle and high school youth and their parents who may have had contact with the youth who died or who have been distraught by accounts of their deaths
- **Always ASK** about any thoughts of suicide youth may have so that immediate and appropriate referrals may be made

Research indicates that a majority of adults who die by suicide have recently seen their primary care physician. Although we cannot confirm this for youth, we suspect that the same finding may hold true. With this in mind, primary care physicians and their staff have a unique opportunity to intervene with youth. Please note that the majority of recent youth deaths by suicide have been in the Central and West Austin areas where families tend to see private physicians.

Ninety percent of those who die by suicide have an underlying mental health condition or substance abuse condition (although that condition may not be diagnosed or adequately treated). Mental health clinicians in our area are advised to make sure that **ALL of the youth they treat** have safety plans that include how to access help in an emergency from their treatment team and available and concerned adults in their life.

We also urge you to have all youth in your practice and their parents (**Save A Number to Save A Life**) program their cell phones with the local hotline to help number for **ATCMHMR Psychiatric Emergency Services and Mobile Crisis Outreach 512-454-3521 as well as the National Suicide Prevention Lifeline 1-800-273-TALK (8255)**

For more information on youth suicide prevention & postvention, (what you do AFTER a suicide to help prevent more suicide deaths), please go to the following web sites:

- Seton HealthCare Network and <http://www.TexasSuicidePrevention.org>

****= anecdotal information only since official death data for 2007-2008 has not been released or confirmed and 2005 is the last year for which we have official death information.***