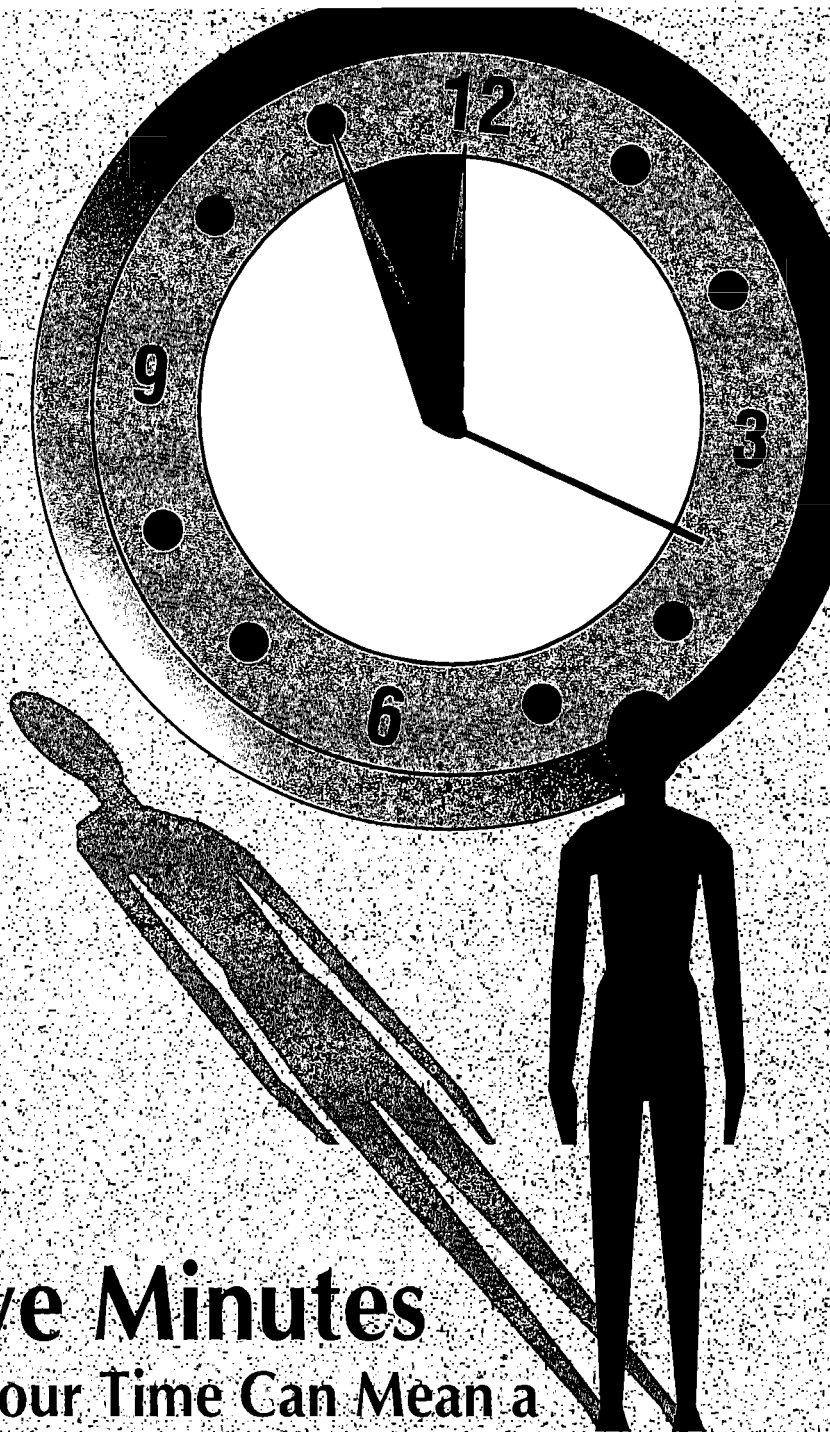

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Five Minutes of Your Time Can Mean a **Lifetime to a Suicidal Adolescent**

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American Association of Suicidology

To Understand and Prevent Suicide as a Means of Promoting Human Well-being

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TO: Youth Suicide by Firearms Conferee
FROM: Lanny Berman
DATE: March 5, 1997
RE: Consensus Statement

A wise philosophical type once said the "good things happen when you wait long enough." So here, at last, we have the final "Consensus Statement," drafted and redrafted by Mort Silverman with help from some of his friends and colleagues (Cheryl King, David Brent, and myself). Please note that this Statement is substantively in agreement with what we discussed on the last day of our meeting. It merely has better form and is better referenced than when last you saw it.

We agreed in Lake Bluff that the first step--once this document was completed--would be to disseminate it to every attendee to sign. As some conferees represented organizations, it was thought appropriate for these individuals to bring the document to their respective Board of Directors in order that the organization be a signatory. The Consensus Statement would also be published in various organization newsletters and journals, where appropriate.

Once that phase was accomplished, the second phase would be to seek add-on signatories representing a large array of institutions/organizations whom we would expect to further disseminate both this paper's information and objectives. We developed a long list of these in Lake Bluff, but I would appreciate your thoughts on any others you think appropriate for me to contact.

Please read and review the final document. If you have no substantive quarrel with the Statement, please sign your name where indicated and return the signed page (remember to xerox copy for yourself) to me in the enclosed envelope as soon as possible. If you must have Board approval to sign, please put this on the agenda for the next possible meeting and let me know a rough timeline as to when I might hear back from you/your Board.

If you have any major difficulty with the Statement and feel you cannot sign it as written, I also would very much appreciate your drafting your thoughts to me. Thanks!

Lanny

**Child and Adolescent Suicide Attempts: An Opportunity for Emergency
Departments to Provide Injury Prevention Education**

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Key words: Emergency Department, suicide, adolescent, child, injury prevention,
overdose, firearms, means restriction

In press, American Journal of Emergency Medicine

Abstract

The study objectives were to ascertain whether caretakers of suicidal children and adolescents received emergency department injury prevention education and to determine if injury prevention education and the medical outcome after a drug overdose are associated with caretakers restricting access to means of suicide. Participants were adult caretakers of children and adolescents who deliberately ingested a drug and received emergency department evaluation. Information was obtained by poison center chart review and phone interview. Fourteen percent of caretakers reported receiving injury prevention education concerning restricting access to potential means of suicide at home. Emergency department injury prevention education is significantly associated with caretakers restricting access to suicidal means even when controlling for medical outcome from the attempt. Because parents are less likely to restrict access to means of suicide without education, injury prevention education about restricting access to means of suicide should be given in the emergency department.

Child and Adolescent Suicide Attempts: An Opportunity for Emergency Departments to Provide Injury Prevention Education

Introduction: Traditionally, injury prevention education has focused on reducing pediatric morbidity and mortality. However, most caretakers of children and adolescents with preventable pediatric injuries who are treated and released by emergency department (ED) personnel do not receive documented injury prevention education (1).

Questions have been raised in the emergency medicine literature asking whether injury prevention education is indicated in the ED (2) or in cases of attempted suicide by poisoning (1).

Youth suicide attempts may represent an opportunity for injury prevention education in the ED. Suicide attempts by adolescents are a familiar presentation in most EDs. In Oregon, the only state with mandated reporting of adolescent suicide attempts, the 1988-92 annual rates of suicide attempts presenting to EDs ranged from a low of 118.1 per 100,000 for Asians to 307.6 per 100,000 for African Americans age 10-17 years (3). The overall attempt rate for 1988-93 was 196.6 per 100,000 age 10-17 years (4). It is known that an initial suicide attempt greatly increase the risk of a subsequent suicide attempt (3). Drug overdoses account for the majority of suicide attempts in both male and female adolescents, whereas firearms are involved in the majority of fatalities in both male and female adolescents (5).

"Means Restriction" is one strategy for injury prevention education as it applies to suicidal children and adolescents. Means restriction attempts to prevent suicide by limiting access to firearms, drugs, and other common means of committing suicide (6). The Centers for Disease Control's publication, *Youth Suicide Prevention Programs: A Resource Guide*, suggests that means restriction may be a potentially important strategy in reducing the rate of suicide among young people but notes that no evaluation of such efforts has occurred (6).

We were unable to find any data on injury prevention education as it relates to means restriction in the ED for adolescent suicide attempts. The objectives of our study were (a) to describe the extent to which adult caretakers of suicidal children and adolescents received ED injury prevention education and (b) to determine if caretakers' receiving injury prevention education in the ED and the adolescents' medical outcome after the suicide attempt are associated with the caretakers subsequently restricting access to means of suicide.

Materials and Methods: This study included review of charts from a regional poison control center, followed by a structured telephone follow-up interview. Adult caretakers of adolescents who made a suicide attempt by drug overdose were chosen for study for two reasons. First, it was the caretaker who called the poison control center after their child's suicide attempt and therefore were aware of the incident. Second, the caretakers would be able to confirm what injury prevention education took place in

the ED and what, if any, means restriction precautions the caretaker had subsequently implemented at home.

In the follow-up interview the caretakers of the adolescents were asked if at the time of the ingestion whether they had over the counter drugs, prescription drugs, alcohol, street drugs or firearms in the house. It was ascertained whether any member of the ED staff advised them to dispose of or lock up these substances and if this action was carried out at home. If means restriction was not addressed in the ED, caretakers were asked if they restricted access to lethal means on their own.

Patient charts from all contacts at a regional poison control center which received 51,485 calls from January 1 to December 31, 1993, were individually reviewed. A subject was eligible for study if (a) the patient took an intentional drug overdose or other toxic ingestion that was considered to be a suicide attempt by the poison control specialist, (b) he/she was 6-20 years old, (c) the initial contact with the poison control center was by an adult family member or caretaker, and (d) the patient was evaluated in an ED.

A subject was considered lost to follow-up if he/she was unable to be contacted because (a) of a wrong or non-existent telephone number, (b) the subject moved without leaving a forwarding number, (c) the telephone had been permanently disconnected, (d) we failed to reach anyone at the given telephone number after 10 calls were made at various times of the day and week, (e) a pager number or pay phone was

reached with the responding party not knowing the caller or patient. (f) an answering machine was reached after 10 calls and then 3 messages were left with no response.

Information was obtained through a structured phone interview with the adult who contacted the poison control center or other responsible adult caretaker. The adolescent was not interviewed. The interviews took place an average of 15 months after the overdose, with a range of 2-19 months. Interviews were conducted by three physicians who had reviewed all documentation regarding each case. The interviewers described the study and obtained phone consent. This investigation was approved by the University of Illinois at Chicago's institutional review board.

The following information was obtained by poison center chart review:

- (a) Demographics including age, sex, race, location, relationship of caller, shared household between caller and patient, and site of exposure and
 - (b) Medical outcome defined as either no effect or adverse medical outcome. Adverse medical outcome included any notable medical effect ranging from minor through moderate, major and death using the American Association of Poison Control Center's criteria (7).
- All patients were followed until medically stable.

A structured interview was used to obtain the following categorical variables:

- (c) Presence or absence in the home of the following means of suicide at the time of the attempt: firearms, over-the-counter medications, prescription medications, or street drugs.
- (d) Occurrence of injury prevention education by any ED staff defined as an adult caretaker being advised to dispose of or lock up suicidal means listed above.
- (e) Caretaker manipulation of the home environment following the suicide attempt in an attempt to make it safer (either spontaneous action or due to recommendation). This was defined as having locked up or disposed of available means of suicide.
- (f) Presence of caretaker concern about repeat attempt.

Statistical analyses were performed on demographics of subjects lost to follow-up and those successfully interviewed to determine any sample bias. Descriptive statistics were calculated on information obtained. A multiple logistic regression model was used to determine the likelihood of caretaker restricting access to suicidal means associated with medical outcome and injury prevention education after controlling for age, gender and time from ingestion to follow-up. From the model, adjusted odds ratios (ORs) and 95% confidence intervals were computed (8). Alpha level for all statistical test was at 0.05. All statistical analysis were performed using SPSS for Windows Version 6.1 (SPSS, Inc. Chicago, Illinois, 1994).

Results: Seventy-one cases met the inclusion criteria. Fifty-four (76%) were successfully followed up. No significant differences existed between those contacted and those lost to follow-up regarding age, sex, race, location, relationship of caller to patient, or medical outcome.

Females accounted for 74% of the group, and race was 61% Caucasian, 28% African American, and 11% Hispanic. Forty-eight percent of the adolescents were from an urban area, 49% from suburbs, and 3% from rural areas. Age ranged from 10-20 years with 76% between 13-17 years. The family member who called the poison control center was the mother in 66% of the cases, followed by the adult sister in 10% of the cases, the father in 9% of the cases, and other relatives in 15% of the cases. The attempt took place at home in 96% of the cases with the remainder divided equally among other residence, school, and public areas. The caretaker and patient shared a common household in 97% of the cases.

Eighty-four percent took an acute ingestion whereas 16% were classified as an "acute-on-chronic" ingestion (an acute overdose of a medication that is being taken regularly). Seventy-one percent took over-the-counter medications, and in 75% of the cases the medication ingested belonged to a relative. A single medication was ingested in 64% of the cases. All overdoses were oral except for one adolescent who overdosed using her metered dose albuterol inhaler. Medical outcome of seventy-one subjects was no effect in 47% of the cases and adverse outcome in 53% of the cases. There were no fatalities.

During the follow-up phone interview, the caretakers of the adolescents who attempted suicide by ingestion reported the following potentially lethal means available in the home at the time of the attempt: 75% had prescription medication, 86% had over-the-counter medications, 2.2% had street drugs, and 24.5% had firearms. Overall, fifty-one of fifty-four (94.4%) households had at least one form of means of suicide available at the time of the attempt.

Suicide was addressed with 42% of the family members by a member of the ED staff, while 54% reported that suicide was not discussed and 4% could not recall. Injury prevention education about restricting access to over-the-counter medication, prescription medication, and street drugs was given at rates of 9.4%, 12.2% and 2.2% respectively. No caretaker reported being educated that firearms in the home increase the risk of suicide. At follow-up, 76% of the adults were not worried about the possibility of a repeat suicide attempt by the adolescent.

Of the fifty-one caretakers who had suicidal means accessible in the home at the time of ingestion, 61% (31/51) had not restricted access to means of suicide. Of those who received education about restricting access to medications, 86% reported they had locked up or disposed of those means at the time of the follow-up interview as compared with only 32% of the families who were not given injury prevention education (Fischer's exact test, $p = 0.011$). An adverse medical outcome in the adolescent caused by the poisoning was also significantly associated with the caretaker's limiting availability of means of suicide (Chi sq. test = 4.41, $p=0.036$). As seen in table 1,

injury prevention education in the ED following a suicide attempt significantly increases the odds of caretaker action to restrict access to potentially lethal means even when controlling for the medical outcome of the attempt.

Statistical tests were performed on the demographic variables of adolescent's age and sex, and a confounding variable, the amount of time from the ingestion and the follow-up. A chi-square test between adolescent males and females and caretakers who did and did not limit access to lethal means was not significant (Chi sq. =1.02, df =1, $p = 0.31$). Differences were also not found between the mean age of the adolescents whose caretakers restricted access to drugs and/or firearms and those who did not restrict access (paired t-test value = 0.91, df = 49, two-tailed p value = 0.4) and the number of days until follow-up of parents who disposed of drugs and/or firearms and those who did not restrict access (paired t-test value = 0.79, df = 48, two-tailed p value = 0.4).

Table 1 here

Discussion: Caretakers of suicidal adolescents educated in the ED about injury prevention take action to limit access to means of suicide, whereas caretakers not educated about restricting access are significantly less likely to do so. Unfortunately, in the ED, injury prevention education concerning suicide attempts occurs infrequently. Only

14% of caretakers of suicidal adolescents in this study received injury prevention education in the ED.

Our finding that injury prevention education occurs infrequently is similar to other studies. Of 1,449 injured pediatric patients presenting to an ED, only 3% received documented injury prevention education (1). Although firearms are the leading means of suicide (5), a study of pediatric nurse practitioners revealed that advice about firearm safety in the home was routinely given to only 7% of pediatric patients' families (9).

Failure to warn caretakers of suicidal adolescents about the risk of firearms is of particular concern. Firearms are the most common means of suicide in both sexes and account for the majority of completed adolescent suicide in the United States (5). Case control studies consistently find that firearm presence in the home significantly increases suicide risk (10,11). Suicide attempts by firearm are disproportionately likely to be fatal (12). Firearms are prevalent; the US Department of Justice estimates that 49% of households contain firearms (13). The 24.5% of households in this study reporting the presence of a firearm may represent an undercount.

Our study is limited by its small sample size and the potential for problems in recall or misreporting to give socially desirable results. The association between injury prevention education and means restriction could reflect a lack of recall by non-compliant caretakers. Another limitation is that not all toxic exposures are reported to a regional poison control center (16,17) therefore the generalizability of our findings are

unknown. Future studies need to prospectively document injury prevention education by ED staff, caretaker receipt and comprehension of the message, as well as compliance on follow-up.

We recommend injury prevention education be given to caretakers of suicidal adolescents. Caretakers are in the best position to modify their home environment. Our data confirm the importance of the home as a focus for injury prevention. Ninety-four percent of our study population homes had medications, the most common means of suicide attempts. Over twenty-four percent of the homes had firearms, the most common means of completed suicide. The presence of these agents in the home is of critical importance as we found that 96% of our patients made their suicide attempt at home. Moreover, adolescents who make one suicide attempt are at increased risk for another (5,14). The Oregon ED surveillance found that 27% of adolescent suicide attempts were by those who had made prior attempts during the previous five years (3). It is likely this is an underestimate because prior attempt status was unknown in 26% of cases. Adverse medical outcome from an attempt may represent an enhanced opportunity for caretaker action. In our data, caretakers were more likely to limit access if the adolescent had an adverse medical outcome associated with the attempt.

In response to the question of whether injury prevention education is indicated for adolescent suicide attempts, our results suggest the answer is yes. However, questions remain as to what impedes such education. Is knowledge among ED staff about adolescent suicide a factor? A recent study of law enforcement experience with voluntary

firearm disposal for suicide prevention found that at least for some individuals, inaccurate information about the role of firearms in adolescent suicide is a potential barrier to means restriction efforts (15). Have ED staff had training in psychiatric emergencies and relevant injury prevention education strategies? Is it the familiar situation of a busy ED usurping time that could be spent educating family members? Are safe methods for firearm disposal available? Future studies are needed to better characterize our findings and answer these questions.

Conclusion: Few families of suicidal adolescents receive injury prevention education in the ED about restricting access to potentially lethal means of suicide in the home. Injury prevention education is associated with caretaker action to restrict access to available means of suicide. Because caretakers are less likely to restrict access to means of suicide without being educated, we feel that injury prevention education about restricting access to means of suicide should be given in the ED.

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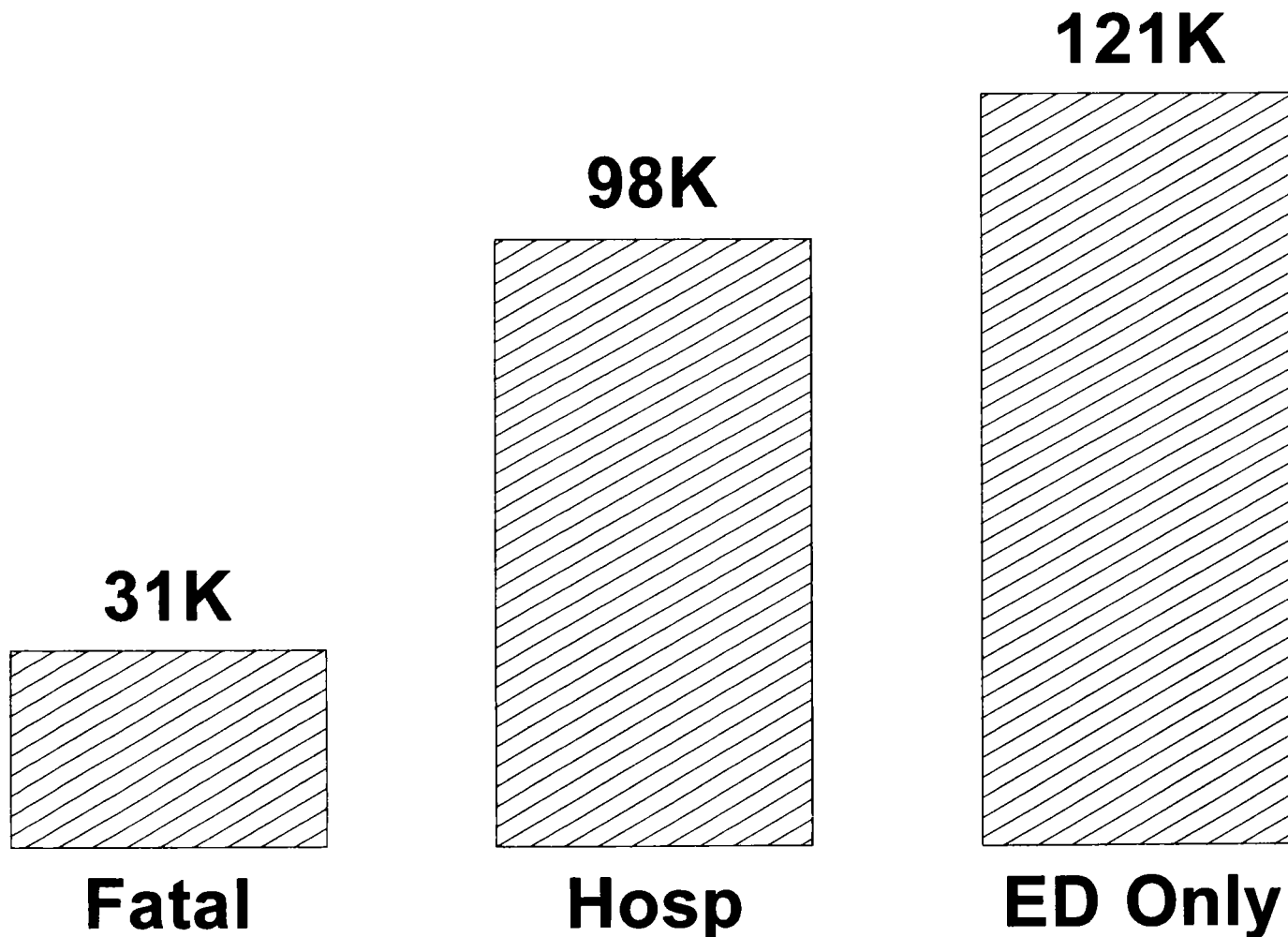
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Table 1
Adjusted Odds Ratios Associating Caretaker Restricting Access to
Suicidal Means with Injury Prevention Education and Medical Outcome

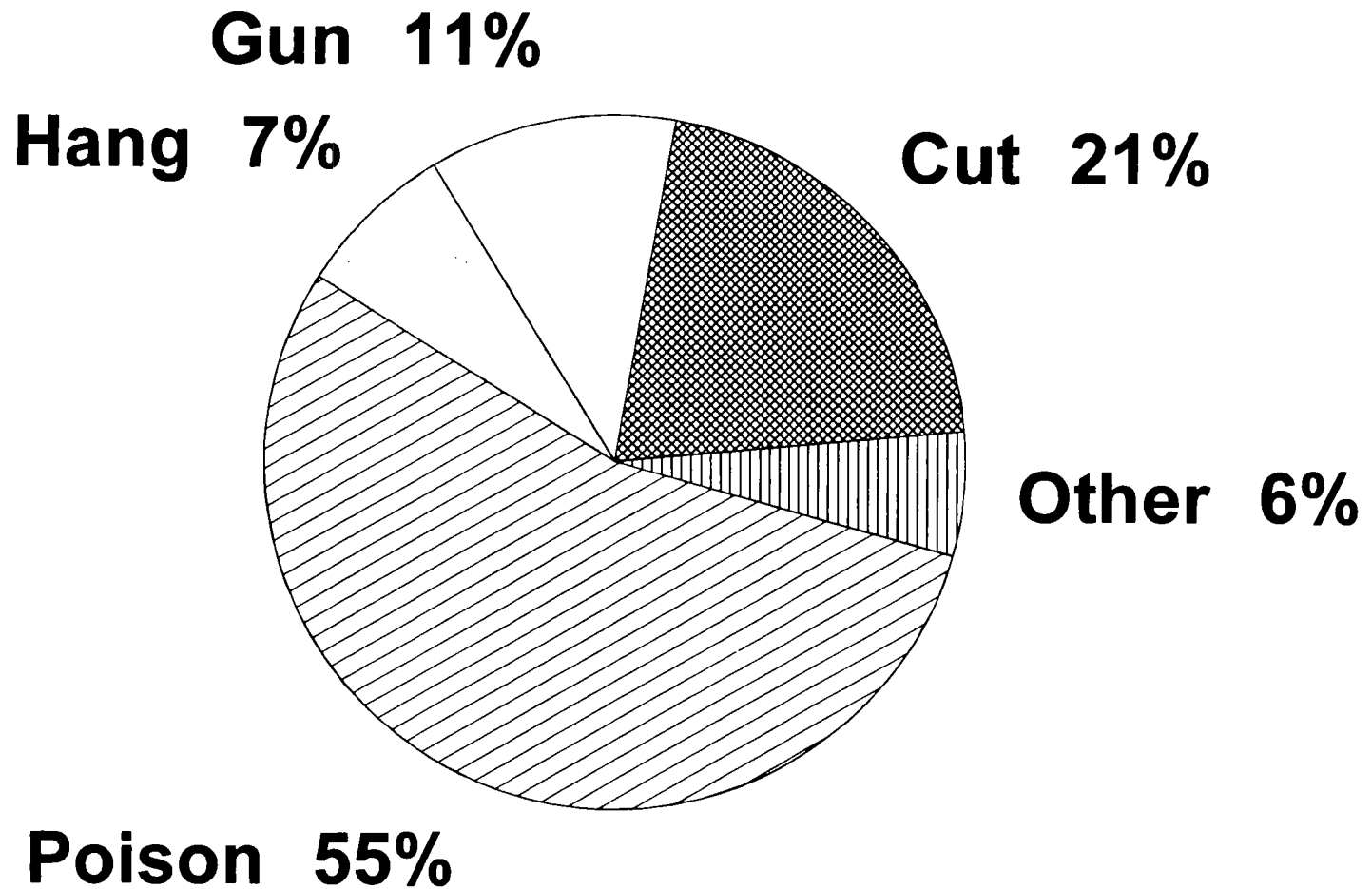
Injury Prevention Education	Crude Distribution Number		Adjusted Odds Ratio ¹	95% Confidence Interval ¹
	Means Not Restricted	Means Restricted		
Not Given	30	12	1.00	(----- -----)
Given	1	6	16.75	(1.41, 198.96)
Medical Outcome				
No Adverse Outcome	19	4	1.00	(----- -----)
Adverse Outcome	12	14	5.36	(1.18, 24.41)

¹Calculations were computed from a multiple logistic regression model. The model included not only two predictor variables, (1) injury prevention education and (2) medical outcome, but also three controlling variables, (1) gender of adolescent (male, female), (2) age of adolescent (in years), and (3) time from ingestion to follow-up (in months, which was determined by number of days divided by 30).

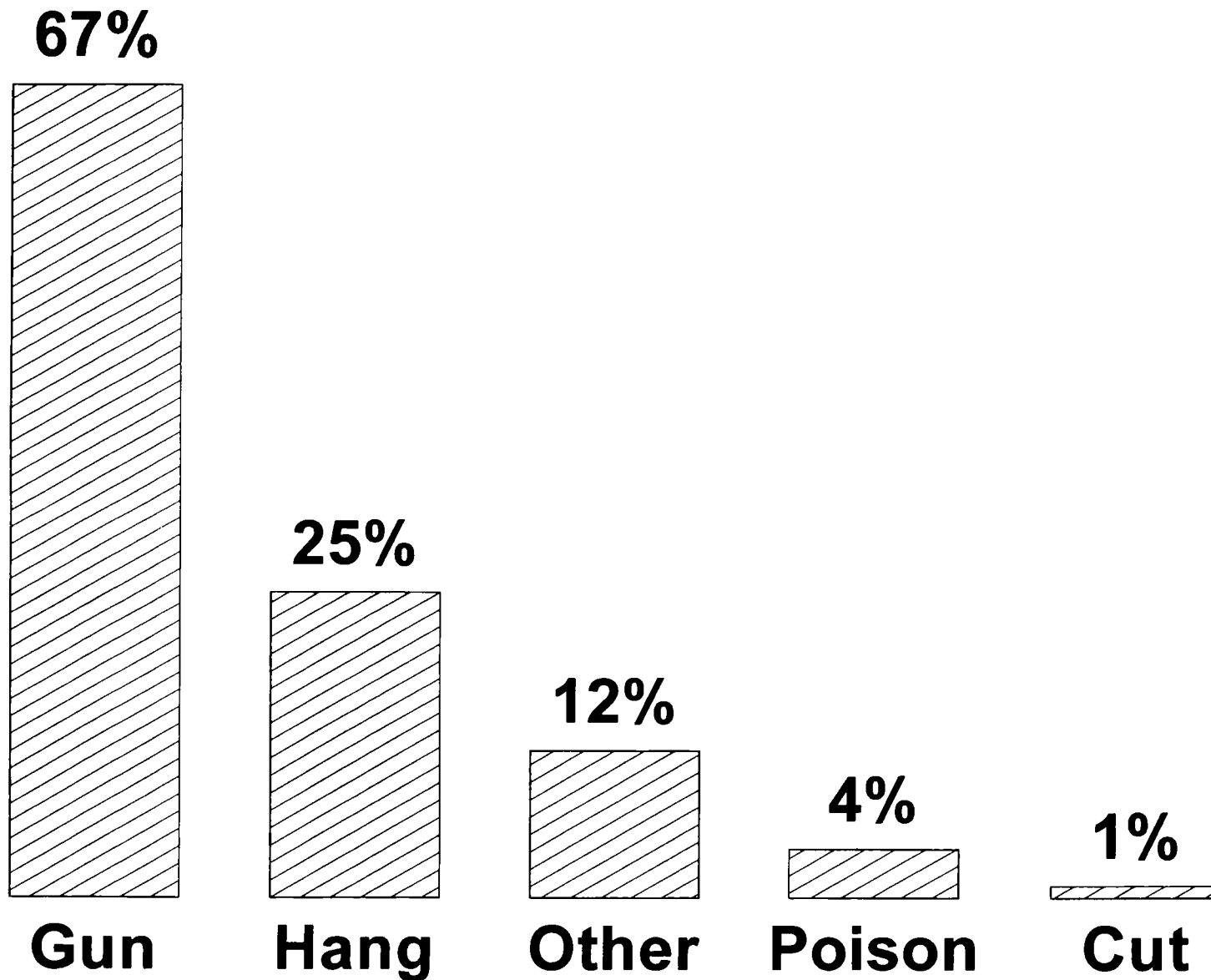
250K Suicides & Medically Identified Attempts/Yr (Excludes Intent Unknown)



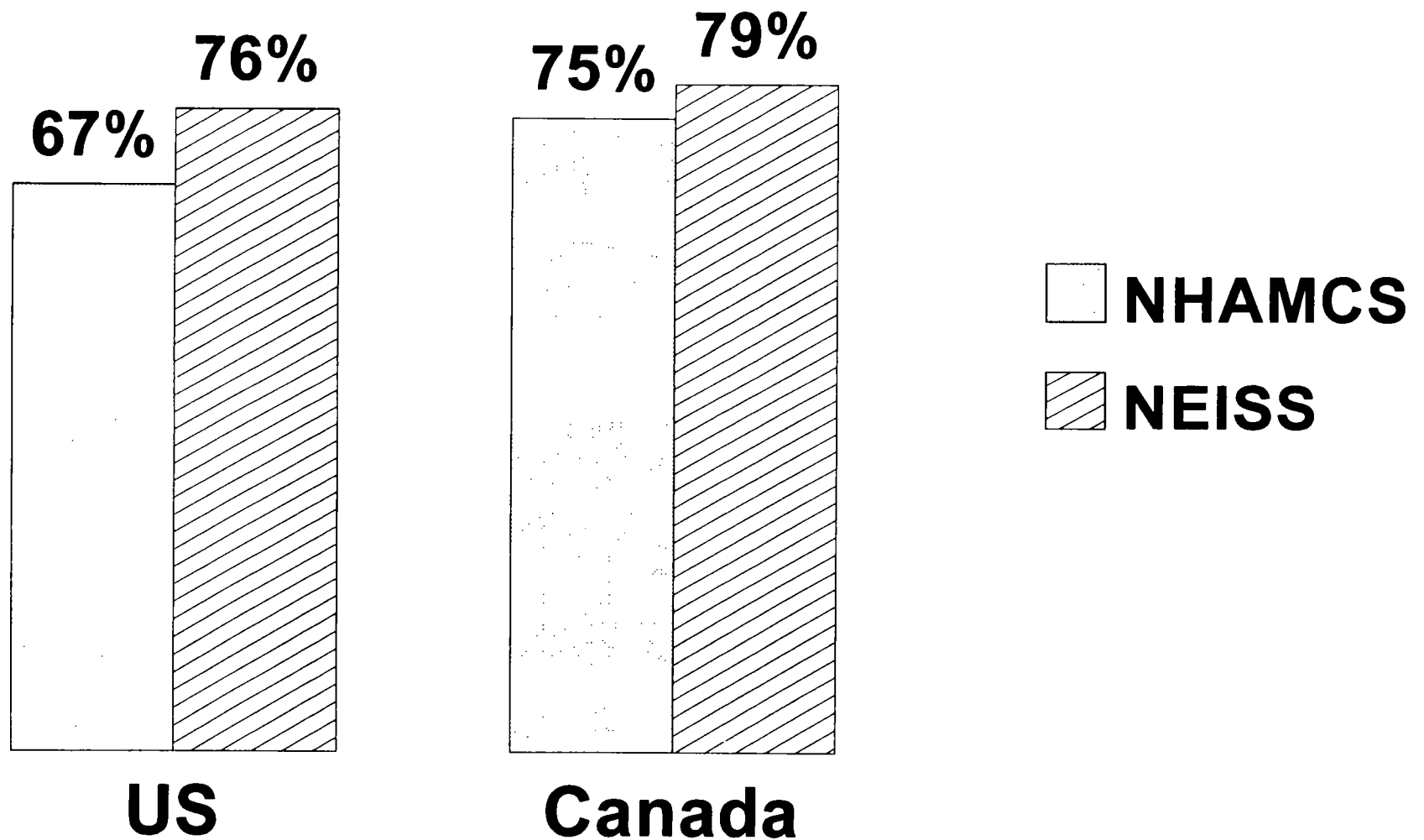
250,000 Suicides & Attempts/Year



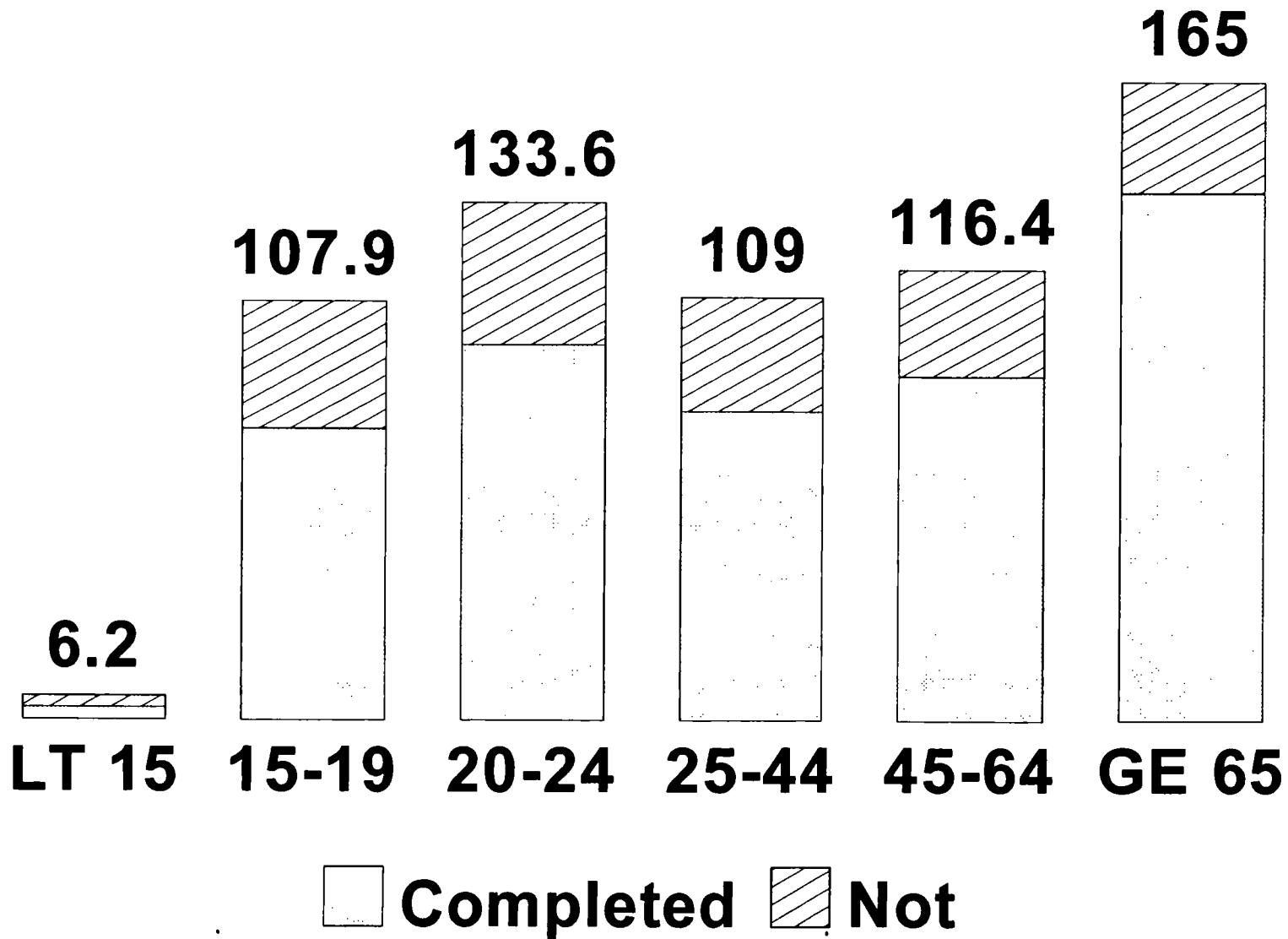
% of Attempts That Are Fatal



% of Gun Attempts That Are Fatal

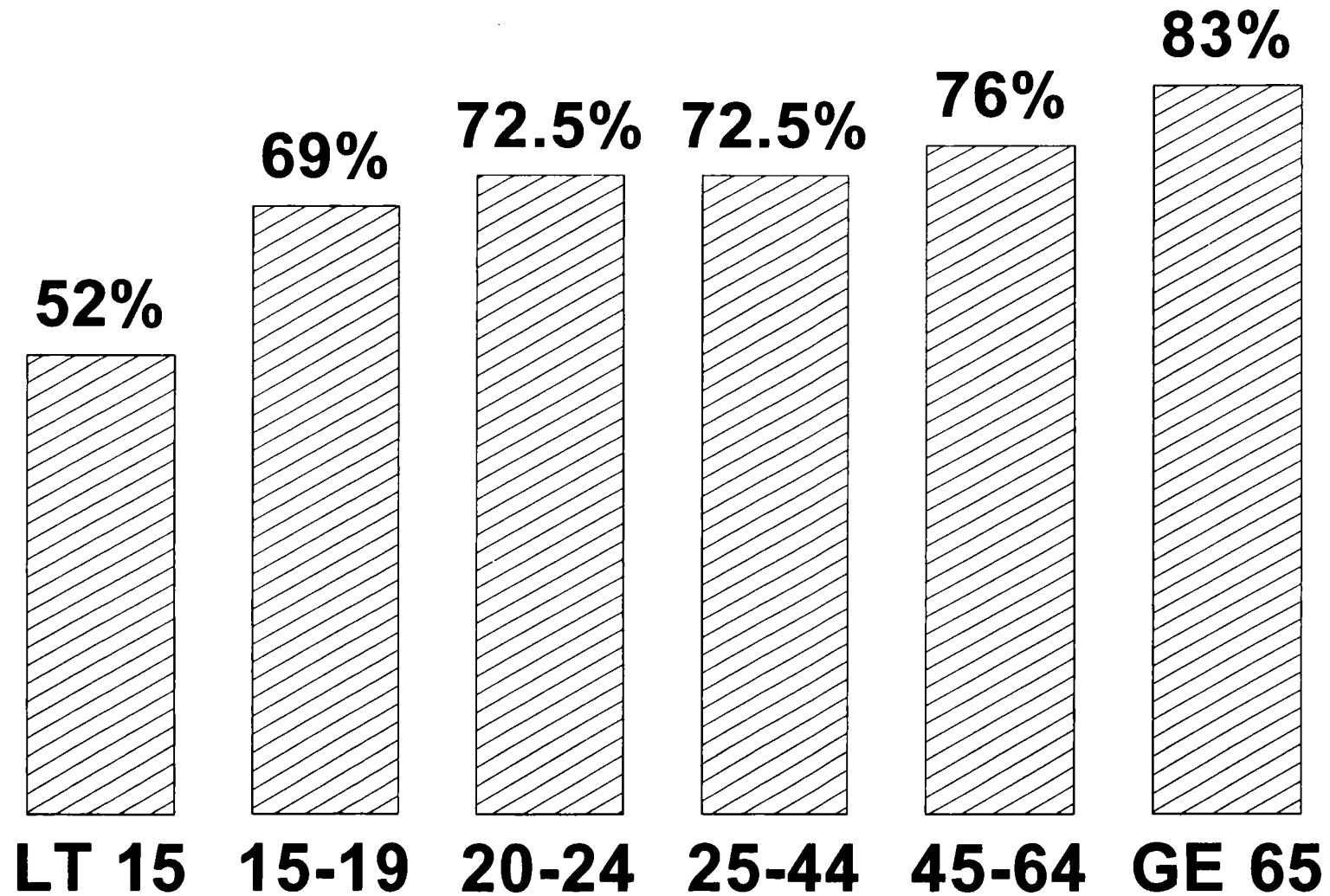


GSW Suicide Rate/100K Population

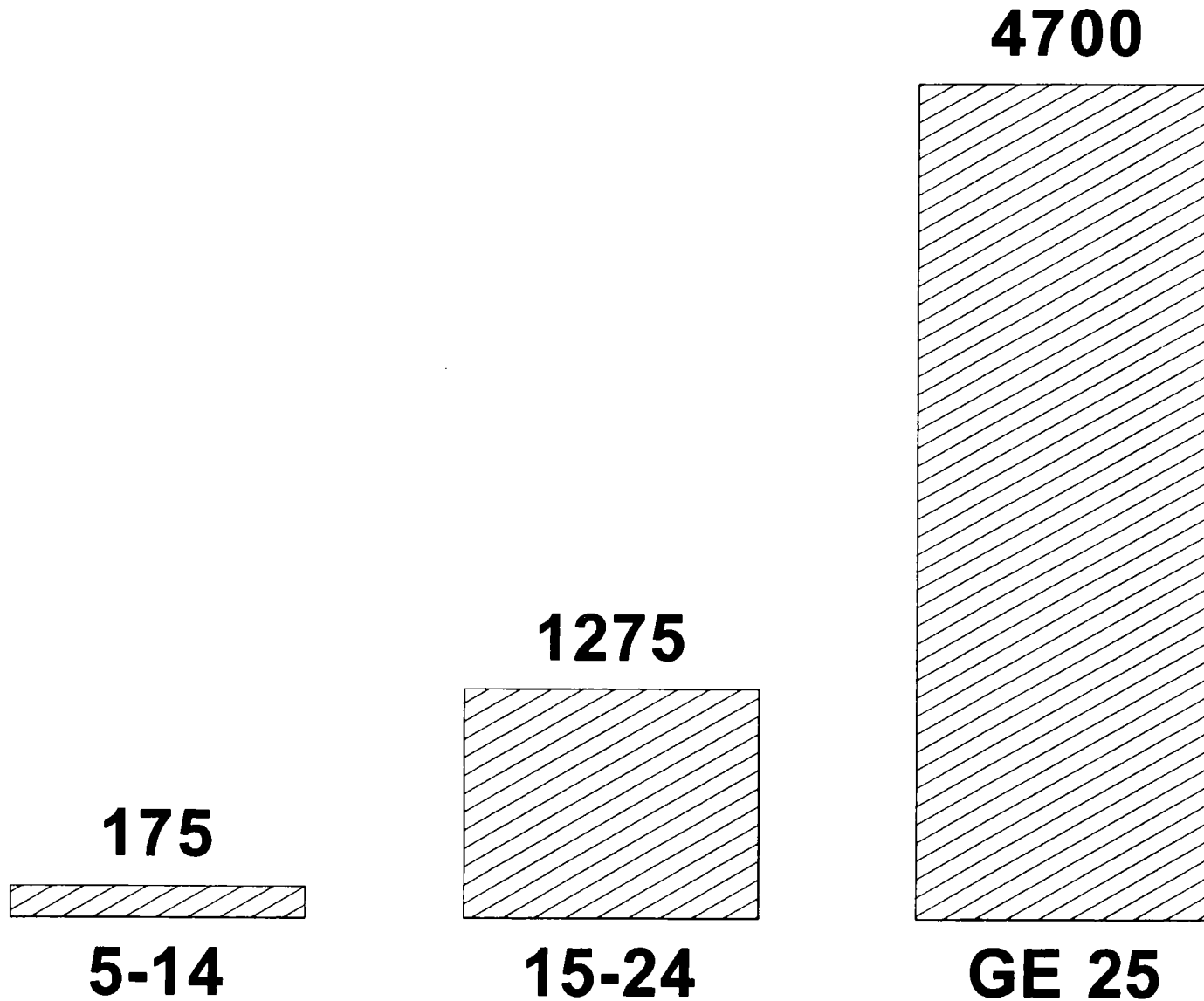


CDC

GSW Suicide Completion Rate



6150 Gun Suicide Survivors/Year



COST CATEGORIES

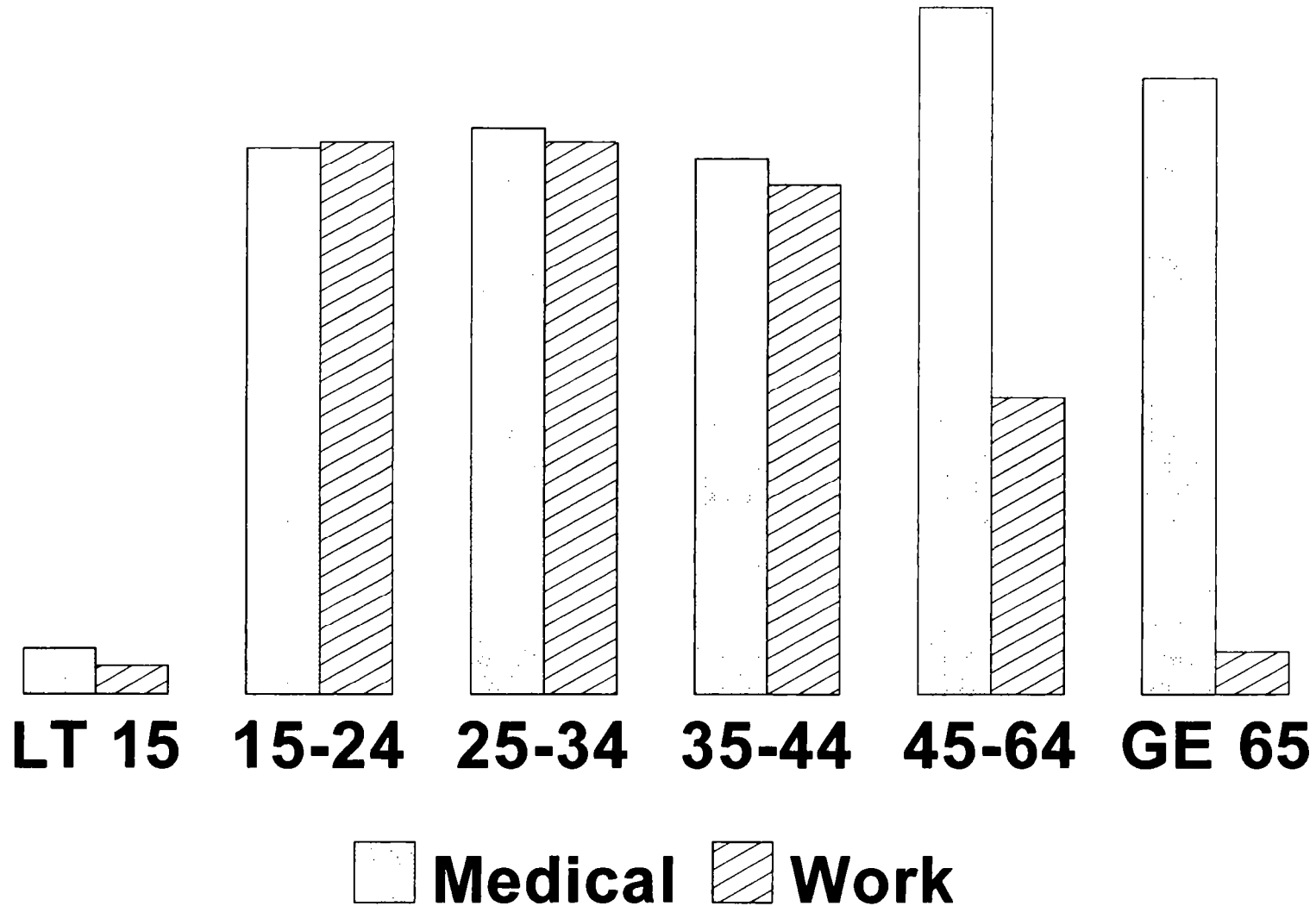
**Medical & Mental Health Care,
Including Claims Processing**

Police

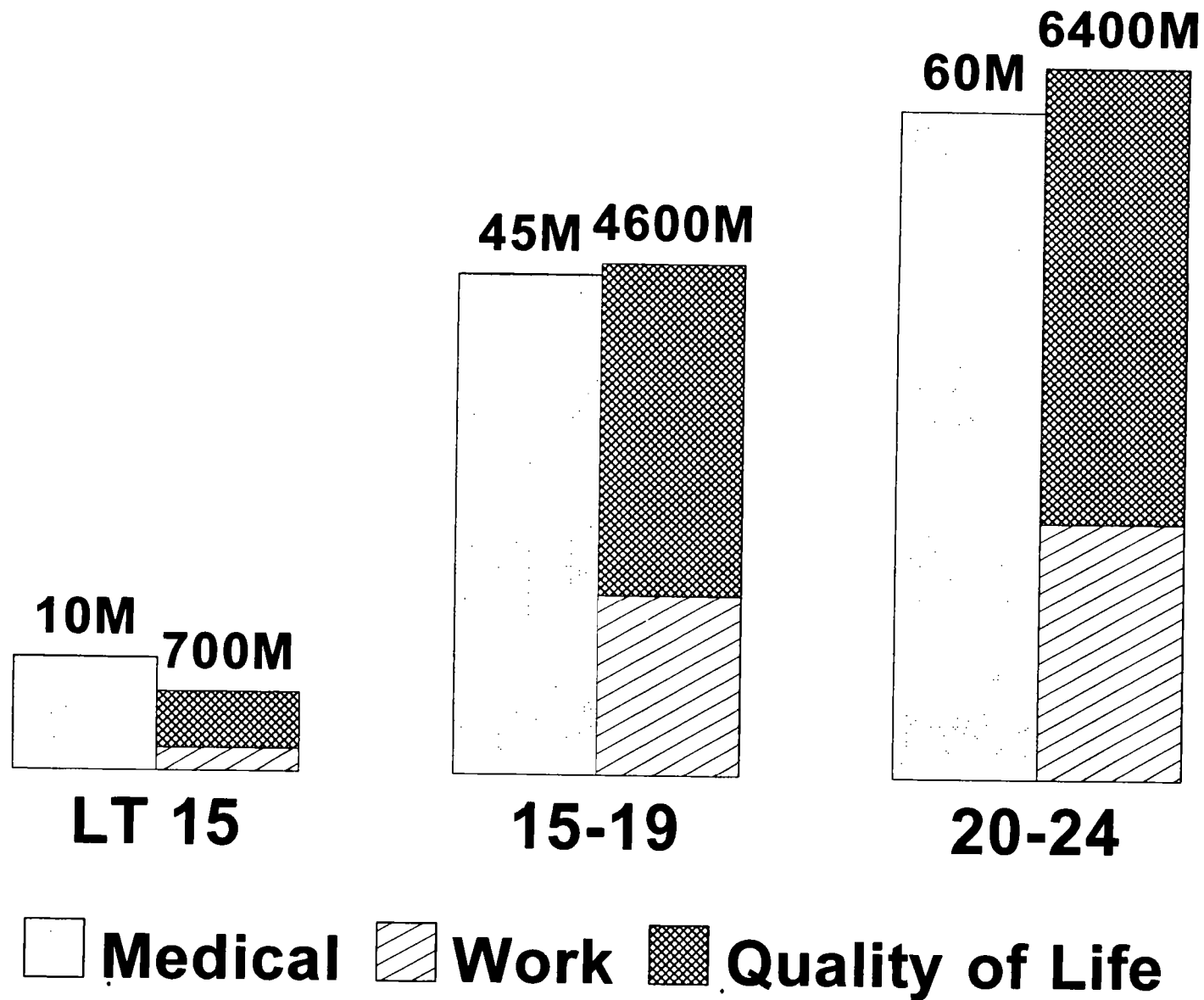
Lost Wage and Household Work

Pain, Suffering & Lost Quality of Life

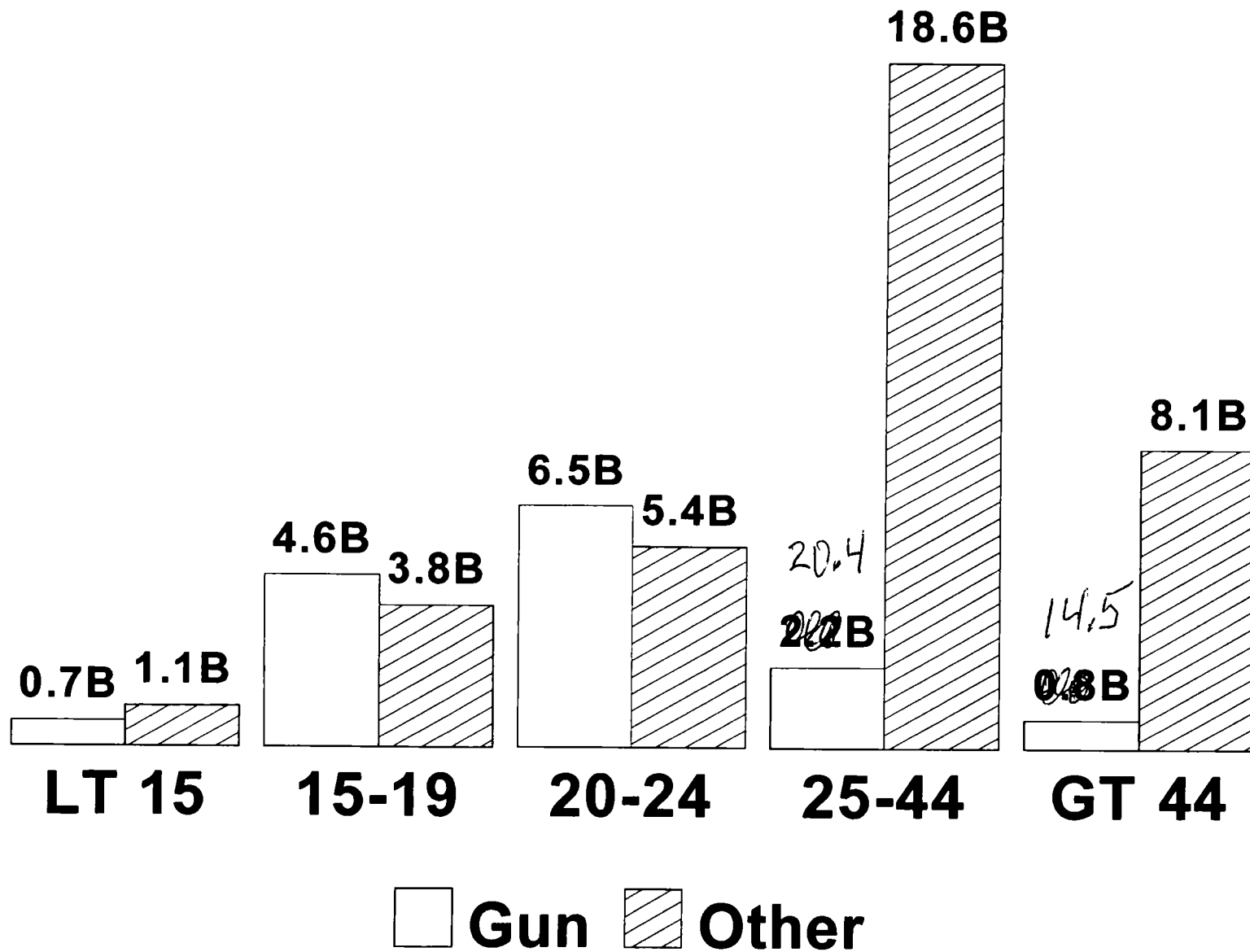
Gun Suicide Medical \$580M, Work \$13.9B



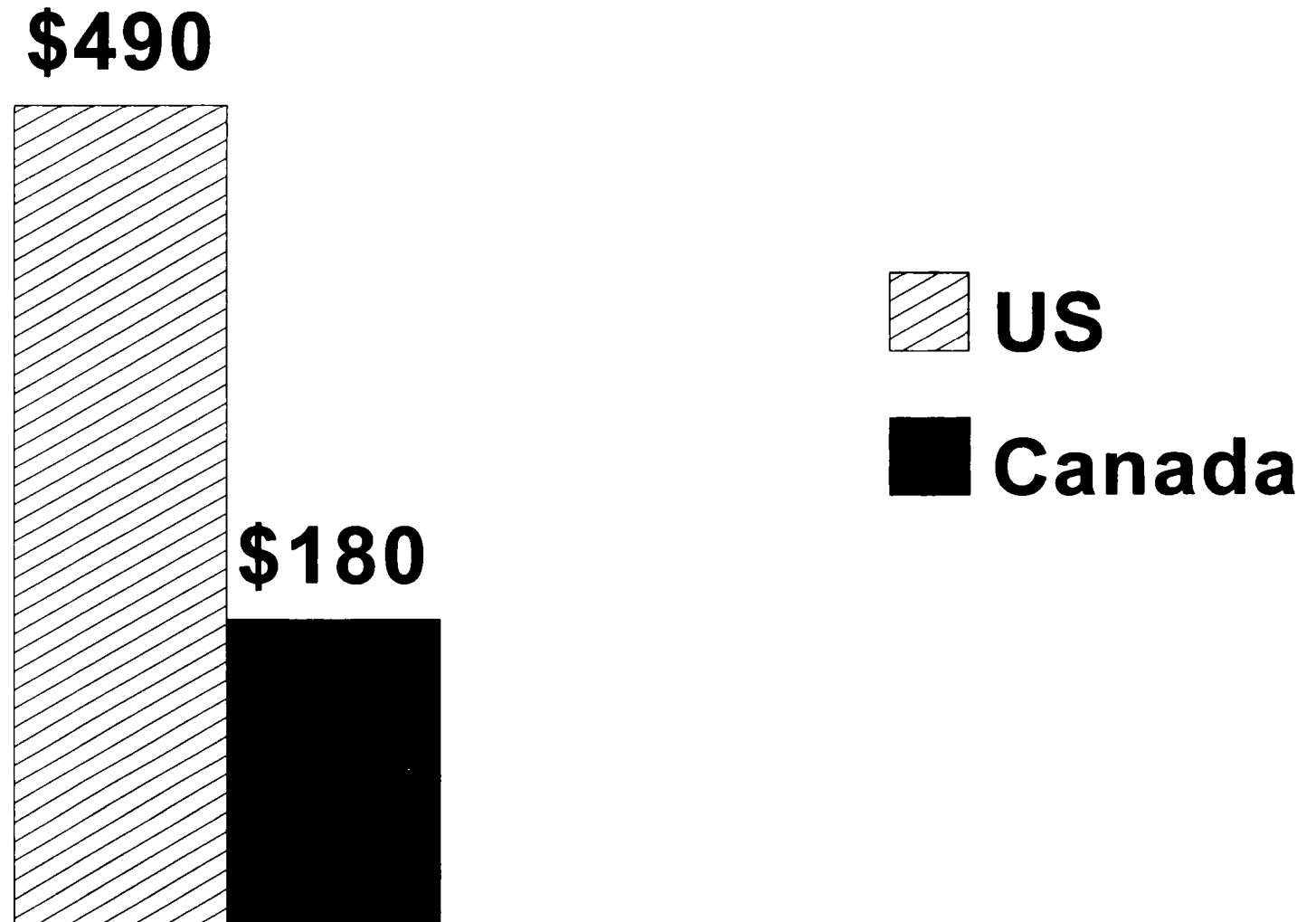
Youth Gun Suicide \$11.9B /Yr



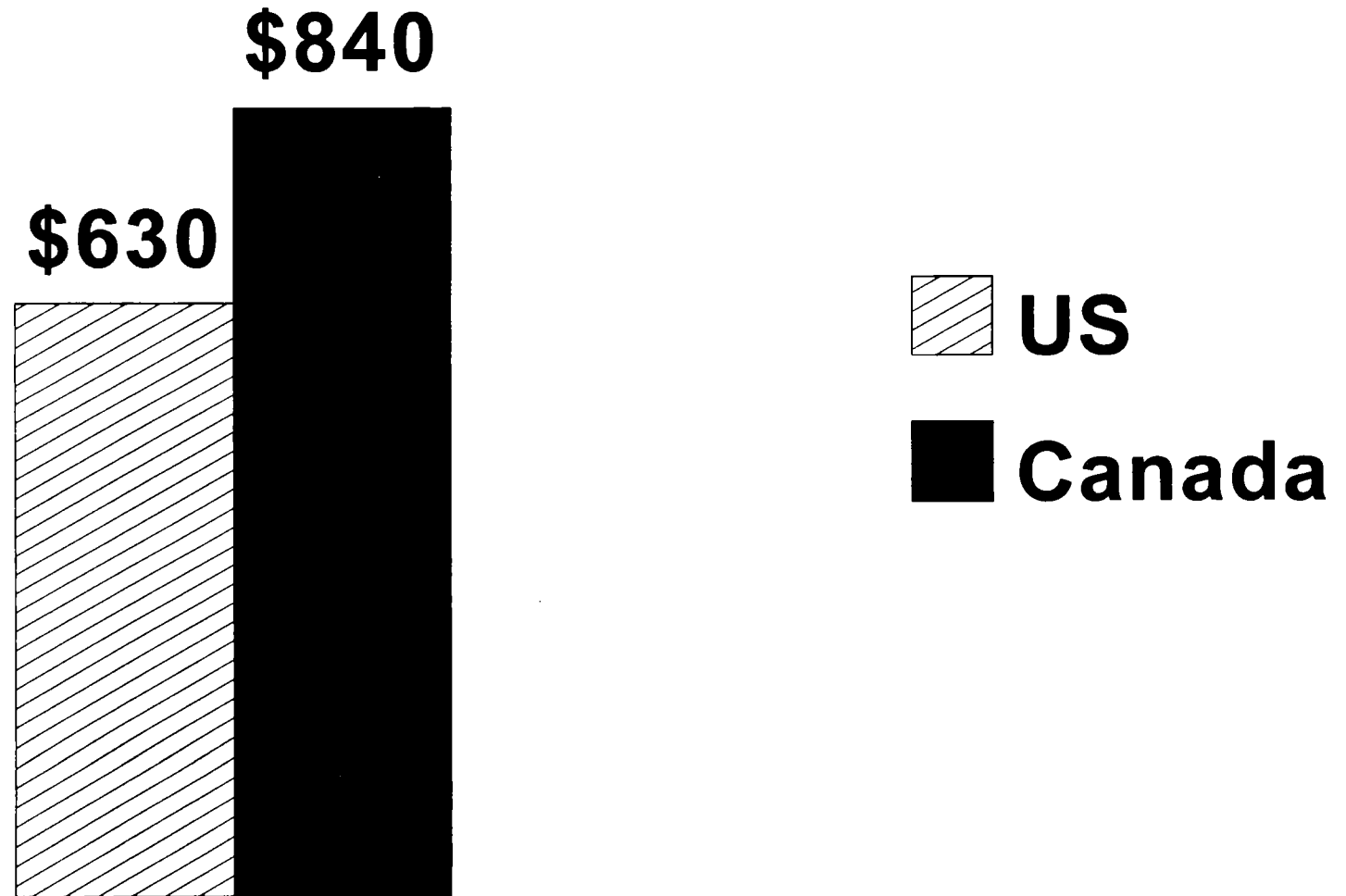
Youth Suicide ~~\$52B/Yr~~ ⁸⁴



Gunshot Costs Per Resident



Gunshot Costs Per Gun (in 1993 US \$)



Canada by Province, USA

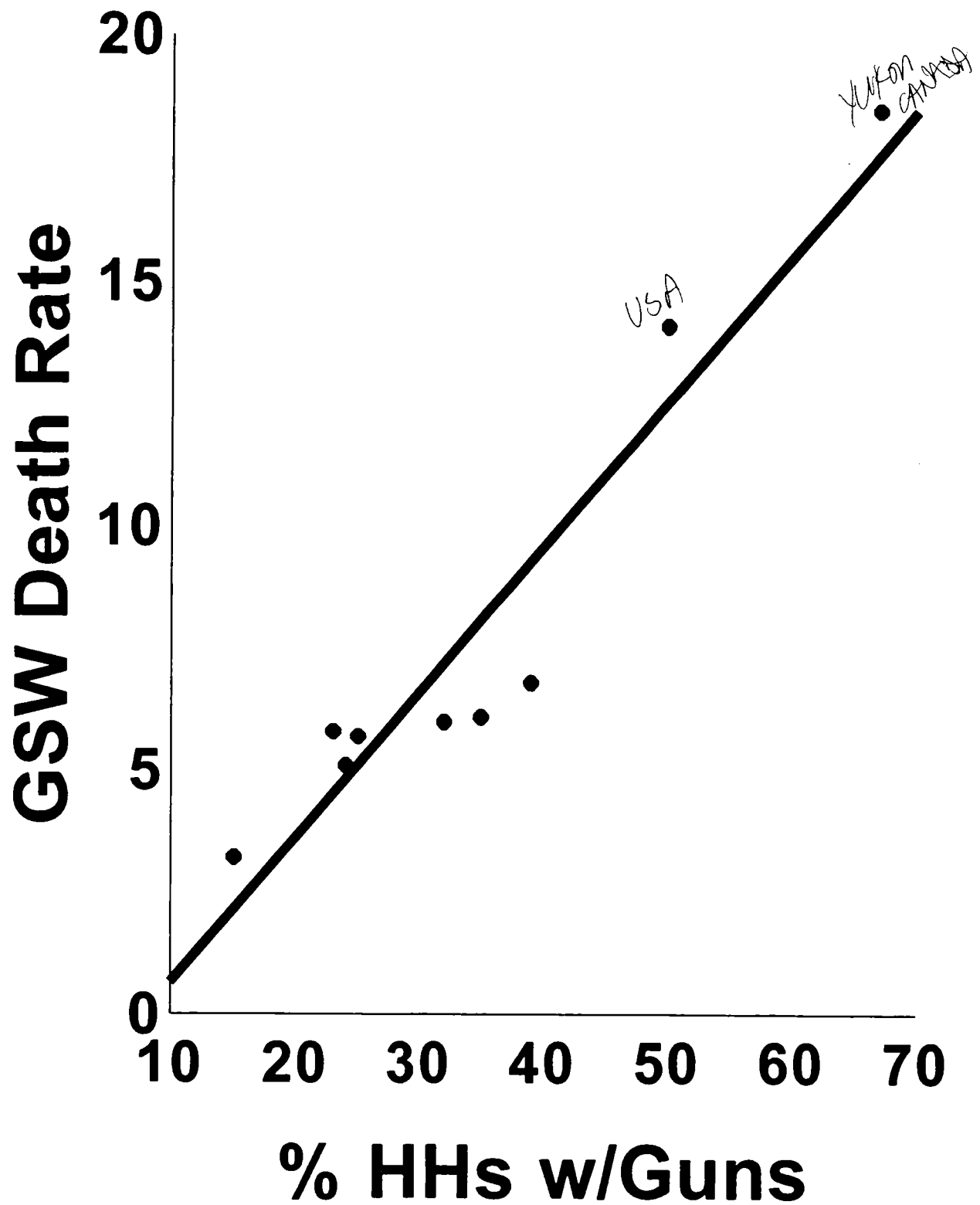


Table 18

Haddon's Injury Control Strategies
Applications to Suicide Prevention

Primary Prevention (Pre-Injury Phase)

1. Prevent the initial creation of the hazard

Do not manufacture handguns for nonmilitary or nonsecurity uses

Reduce the toxic content of domestic gas

Reduce psychological stress

Improve social support networks

2. Reduce the amount of hazard that is created

Provide opportunities for all members of society to contribute
(employment)

Allow only plastic bullets to be sold as ammunition for nonsecurity
uses

Limit the number of pills per bottle sold of over-the-counter and
prescription medications commonly involved in overdoses

Control the distribution (sales) and registration of firearms

3. Prevent the release of a hazard that already exists

Set standards for the purchasing of firearms

Limit access to alcohol (amount, frequency, timing)

Prevent access to illicit drugs

Promote responsible alcohol consumption

Require training in conflict resolution/anger management

Limit sales of toxic chemicals

Secondary Prevention (Injury Phase)

4. Modify the rate of release or spatial distribution of the hazard from its source

Enforce judicious prescribing techniques (no automatic refills) of potentially dangerous medications

Individual tablet packaging of medications to prevent rapid consumption of large quantities

Implement a national firearms tracking system

Enforce seat belt use in all vehicles

Provide automatic ventilation systems or automatic engine cut off valves in automobiles when toxic gases are detected

Provide psychological interventions (therapies) for the psychiatrically ill

5. Separate, in time or space, the hazard from persons to be protected

Place trees, utility poles, and other rigid objects away from roadsides

Develop laws to prevent the severely psychiatrically ill from gaining access to weapons

Separate ammunition from firearms

Confiscate firearms and all medications after suicide attempts

Establish a uniform national waiting period between the application to purchase a firearm and its sale.

6. Interpose a barrier between the hazard and person to be protected

Initiate "911" or emergency hotline numbers everywhere

Provide air bags that inflate automatically in automobile crashes

Keep hunting weapons and firearms in locked cabinets outside of the home

Develop additives for alcohol and other poisonous drugs that reduce or block absorption in the body at increased concentrations

Place high barriers and increased lighting on bridges and high buildings

7. Modify contact surfaces and structures to reduce injury

Prevent access to rooftops of high buildings

Alter medications to reduce harmful side effects of drug ingestion (cardiovascular, CNS)

Redesign bullets to reduce injury severity

Need more demand instead of vegetation - NFA

8. Strengthen the resistance of persons who might be injured by the hazard

Stress reduction and mutual support programs in the community

Health promotion and wellness programs in schools and the workplace

Early detection of distress, dysfunction and disorder in institutional settings

Initiate psychoeducational programs throughout the community

Tertiary Prevention (Post-Injury Phase)

9. Move rapidly to detect and limit damage that has occurred

Improve medical knowledge and training in the assessment, diagnosis, and treatment of suicidal individuals

Provide emergency medical response teams and improved communication systems (telephones on bridges)

Provide postvention teams to work with survivors of suicide

Promote first-aid training for laymen

10. Initiate immediate and long-term reparative actions

Provide hospitalization and psychotherapy for suicide attempters

Support research on suicide prevention

Provide community mental health services (followup) for all behavioral problems seen in emergency rooms

Adapted and expanded from:

Haddon and Baker (1981)

Gerberich et al (1985)

Robertson (1986)

Kellermann et al (1991)

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East Boston Neighborhood Health Center (East Boston)
Family Health Services (Trenton, NJ)
Harlem Hospital's Injury Prevention Program (New York City)
Health Education Center (Pittsburgh)
National Association of Pediatric Nurse Associates and Practitioners (Cherry Hill, NJ)
New Haven Regional Prevention Program (New Haven, CT)
New York Academy of Medicine (New York City)
New York City Department of Health (New York City)
New York State Nurses Association (Latham, NY)
New Yorkers Against Gun Violence (Brooklyn)
Operation Peace in Philadelphia (Philadelphia)
The Organization for African American Wellness (Montclair, NJ)
Pediatric Associates of Norwood and Franklin, P.C. (Norwood, MA)
Physicians for Social Responsibility, Pioneer Valley Chapter (Northampton, MA)

South

Action America Murder Must End Now – AAMMEN (Marietta, GA)
Advocacy for Victims of Gun Violence Clinic, Catholic University (Washington, DC)
Ambulatory Pediatric Association (McLean, VA)
American Academy of Child and Adolescent Psychiatry (Washington, DC)
American Prosecutors Research Institute (Alexandria, VA)
Build the Missing Peace (Baltimore)
Center to Prevent Handgun Violence (Washington, DC)
Child Welfare League of America, Inc. (Washington, DC)
The Children's Defense Fund (Washington, DC)
Children's National Medical Center (Washington, DC)
Children's Safety Network (Arlington, VA)
Cook-Ft. Worth Children's Medical Center (Ft. Worth)
Coastal Rehabilitation Hospital (Wilmington, NC)
George Washington University - Department of Pediatrics (Washington, DC)
Handgun Control, Inc. (Washington, DC)
Interfaith Health Program of the Carter Center (Atlanta)
Johns Hopkins Center for Gun Policy and Research (Baltimore)
Kentucky Injury Prevention and Research Center (Lexington, KY)
Marylanders Against Handgun Abuse Education Fund, Inc. (Baltimore)
Miami Children's Hospital, Child Advocacy Program (Miami)
National Association of Children's Hospitals and Related Institutions (Alexandria, VA)
National Safe Kids Campaign (Washington, DC)
North Carolinians for Gun Control, Durham Chapter (Durham, NC)
Physicians for Social Responsibility -- National (Washington, DC)
Texans Against Violence (Dallas)
Think First Miami (Miami)

Midwest

Allendale Association (Lake Villa, IL)
American Academy of Pediatrics (Elk Grove Village, IL)
American Medical Association (Chicago)
Canneto Studios, Inc. (Columbus, OH)
Chicago Alliance for Collaborative Effort (Chicago)
Children & Family Justice Center of Northwestern University School of Law (Chicago)
Children's Home & Aid Society of Illinois (Chicago)
Children's Home Society (St. Paul, MN)
The Children's Medical Center (Dayton, OH)
Children's Memorial Medical Center (Chicago)
Children's Mercy Hospital, Department of Emergency Medicine (Kansas City, MO)
Community Action For Youth Survival (Chicago)
Community Mental Health Council, Inc. (Chicago)
First United Methodist Church -- Evanston (Evanston, IL)
Illinois Council Against Handgun Violence (Chicago)
Illinois Council on Training (Springfield)
Illinois Department of Children & Family Services (Chicago)
Illinois Masonic Medical Center (Chicago)
Illinois Nurses' Association (Chicago)
Jane Addams Hull House Association (Chicago)
LaRabida Children's Hospital & Research Center (Chicago)
League of Women of Voters of Illinois (Chicago)
Lutheran Social Services of Illinois (Des Plaines, IL)
Mercy Home for Boys & Girls (Chicago)
Near North Health Service Corporation (Chicago)
Northwestern University Medical School, Department of Pediatrics (Chicago)
Physicians for Social Responsibility, Chicago Chapter (Chicago)
Rehabilitation Institute of Chicago (Chicago)
Riley Hospital for Children, Community Education Department (Indianapolis)
Rush Medical College, Department of Pediatrics (Chicago)
Schwab Rehabilitation Hospital & Care Network (Chicago)
T.A.S.C., Inc. (Chicago)
THINK FIRST Foundation (Park Ridge, IL)
Uhlich Children's Home (Chicago)
University of Iowa, Injury Prevention Research Center (Iowa City)
The Youth Campus (Park Ridge, IL)

West

American Academy of Pediatrics -- California Chapter Two (Inglewood, CA)
Ceasefire Foundation of Washington (Seattle)
Hawaii Department of Health (Honolulu)
Harborview Injury Prevention and Research Center (Seattle)
Kapiolani Medical Center for Women & Children (Honolulu)
Monterey Institute of International Studies (Monterey, CA)
National Center for Violence Prevention (Ashland, OR)
Oregon Pediatric Nurse Practitioners Association (West Linn)
Physicians for Social Responsibility, Los Angeles Chapter (Santa Monica)
Trauma Foundation and Pacific Center for Violence Prevention (San Francisco)
Violence Prevention Coalition of Greater Los Angeles (Los Angeles)

91 organizations (current as of October 16, 1996)