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# PREVENTING SUICIDE

The National Journal

volume two • number one



Donna Holland Barnes  
& Carl C. Bell  
Paradoxes of  
Black Suicide

•  
A Primer  
for Crisis Center  
Management

•  
"How I Stayed Alive  
When My Brain  
Was Trying to Kill Me"  
By Susan Rose Blauer

## One Nation—One Number



H. Reese Butler II, *Publisher*, with devoted companion *Budweiser Rio*.

## From the Desk of the Publisher

This is the last issue you will receive before the 36th Annual American Association of Suicidology conference in April in Santa Fe, NM. (See ads on page 12 and back cover.) CONTACT USA has partnered with the Kristin Brooks Hope Center (KBHC) and AAS to combine their annual CONTACT USA conference (the 34th) with KBHC's first-ever crisis center conference to make this an historic first.

This is an event you will not want to miss: five days for crisis center staffs to share, learn and be honored for the selfless service they provide, some for as long as 40 years. Tipper Gore has been invited to be the event's keynote speaker, and the band Firefall will perform at the Wednesday night banquet.

In keeping with the spirit of the conference, this, our first issue of 2003, offers you a primer on the new national phone number, 2-1-1. KBHC partners with AIRS/United Way of America to help build the infrastructure for this important safety "net"work. From its inception the slogan, One Nation—One Number, has been KBHC's call to action. The phone number 2-1-1 now achieves this in 19 states. In coming years 2-1-1, which uses the same technology we use with 1-800-SUICIDE, will cover the entire nation.

We urge all those who are considering 2-1-1 as an access point for their agencies to seek AIRS certification and become the local 2-1-1 provider. It is not a question of whether 2-1-1 will come to your community, it is a question of when.

In this same issue of *Preventing Suicide*, Donna Barnes, Ph.D. and Carl Bell, M.D. tackle the paradox of black suicide. Black women have the lowest rate of suicide in the United States. The authors examine suicide in the African-American community and issue a call for in-depth study. There is much we have to learn about the resiliency of black women, observations and/or lessons that may one day be applied to other races, cultures and religious beliefs.

Also in this issue is "Frontline," a new feature by our executive editor Lee Judy, who has a long history of running a successful crisis center (Life Crisis in St. Louis). In his piece on page 9, Lee shares the depth of his knowledge. At KBHC, we respect the work each agency does on the "frontline." This new regular feature is intended to give information to help you provide better service delivery.

In closing, I invite you, our readers, to write us about what you like and dislike in this issue, and what you would like to see in this journal in the future. This publication is intended to provide you with up-to-date information that, at times, may not be readily available. Its purpose is to help you in your important work

*'From its inception, the slogan, One Nation—One Number has been KBHC's call to action.'*

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**The Legacy of Paul Wellstone**

**“We should never separate the lives we live from the words we speak.”**

*The following letter is a message from Dr. Ellen Gerrity of the late Senator Paul Wellstone’s office. It was recently sent to the mental health community and is reprinted here with her permission.*

I am writing you on behalf of the family and staff of Sen. Paul Wellstone to thank you for your support and kindness in the aftermath of his tragic death on Oct. 25, when he, his wife Sheila, his daughter Marcia, and five others lost their lives in a plane crash in northern Minnesota.

Paul was always a strong voice for those who suffer from the injustice and pain that life can bring. Many of you knew him and share with me, his family and staff, and with the millions of people whose lives have been touched by him, a terrible sense of loss for ourselves and for our country.

As Paul’s mental health policy advisor for the past five years, I have been deeply honored to work with you on many issues, most particularly in our efforts to pass mental health parity legislation. If Paul were here today, he would want me to thank you for your work and tell you how amazing and generous you all are and how you must not stop working on behalf of mental illness. Those who have made a commitment to complete the work on the Mental Health Equitable Treatment Act need your help to see it through. He would tell you that your voice should be heard early and often. He would say we are not done yet and we all must work together to get it done.

Once years ago, Paul spoke at the Woodley House, a residential facility for people with mental illness in Washington, D.C. He spoke passionately about his brother, who was institutionalized in an appalling facility when Paul was only 10 years old. He spoke about how the discrimination in health care coverage that still exists today led to decades of debt for his parents and how he was fighting to do something about this injustice to ensure that those who are suffering receive decent care. He spoke the truth with passion, energy and commitment.

That day, when I looked back at the audience, at the hundreds of mental health providers and the people with mental illness who were listening to Paul, I saw the same look in their eyes—hope. Hope that the world could indeed become a better place, hope that this man could and would do something about the suffering they dealt with every day, hope and renewed belief that they as individuals could go on to help ease the suffering of those they cared for or survive the mental illness they personally endured.

Paul lived an authentic and examined life, and he believed in the tenets of his religion—to do the deeds of justice and kindness. He wrote in the introduction to his book, *The Conscience of A Liberal*: “We should never separate the lives we live from the words we speak.”

Paul never separated the life he lived from the words he spoke, even when to do so put him in harm’s way. It is this message that inspires all of us who shared his vision. Through this vision, we can know too that we are not alone in what we do. We are living proof of a network joined by a shared vision, a desire for a better world for those with mental illness, and no matter how separated we are as individuals by time or miles, or even death, we are all a family working for the same thing in the past, the present and the future.

More often now, I picture in my mind the 10-year-old Paul Wellstone, observing the abusive conditions of the public mental institution his brother was placed in years ago, and the fire that was lit in him that he carried forward, and lit in each of us. He fought for fairness and justice for all of us, and with all of us, every day. This is the legacy of Paul Wellstone, one that will carry us forward.

Thank you on behalf of Paul Wellstone, his family, his staff, and all who loved him, for your expressions of condolence and support, and for all that you do.

*Ellen Gerrity  
Senior Mental Health Policy Advisor to the late Senator Paul Wellstone  
Washington, D.C.*

**Kudos on the Creation of the Journal**

**To the Editor:** I just received my inaugural issue of *Preventing Suicide, The National Journal*. Congratulations on the issue and the excellent choice of Mort Silverman as editor in chief. H. Reese Butler II is proving that one individual with an idea can indeed make a difference. His late wife, Kristin, will live in his heart forever and in the hearts of thousands of others. If I didn’t already know how great Mr. Butler is through his suicide prevention efforts, I would know by his selection of a golden retriever for a pet.

*Skip Simpson  
2828 Woodside Street  
Dallas, TX 75204*

**Editor’s note:** Mr. Simpson is an attorney specializing in psychiatric and psychological malpractice. He can be reached at <http://www.skipsimpson.com>. ■

**In Every Issue**

Letters 1

**Books**

- HarperCollins book editor Jennifer Brehl on *How I Stayed Alive When My Brain Was Trying to Kill Me* by Susan Rose Blauer 5

**Frontline**

- KBHC executive director G. Lee Judy offers a primer for crisis center management 9

Federal Investigator 10

The 1.800.SUICIDE Hotline 11

**Happenings**

- Upcoming Events Nationwide
- The Recent Past: The Wellstone Memorial Service in Washington, D.C. 15

**Features**

**Paradoxes of Black Suicide**

- Donna Holland Barnes, co-founder and president of the National Organization for People of Color Against Suicide, and Carl C. Bell, president and chief executive officer of the Community Mental Health Council and Foundation, Inc. in Chicago, IL, talk about suicide in the African-American community 2

**2-1-1**

- The hot new phone number to dial for social service information in local communities

What it can do for you 6

Certification for Crisis Line Workers: AIRS Versus AAS certification 7



**About this cover:**  
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Lisa Nelson Warner

Preventing Suicide, The National Journal, devotes space to letters from its readers. The journal requests that letters be addressed “To the Editor,” include a home address or telephone number and not exceed 250 words. Let us know what you think about our new publication. Letters may be sent by mail to 201 North Twenty-third Street, Suite 100, Purcellville, VA 20132, or by e-mail to [letterstotheeditor@hopeline.com](mailto:letterstotheeditor@hopeline.com). The journal reserves the right to edit letters to meet its style and length requirements.

By Donna Holland Barnes, Ph.D. and Carl C. Bell, M.D.

Since the mid-1990's, there has been a conscious effort on the part of many in this country to improve the science and practice of suicide prevention and intervention. Thanks to the Surgeon General's 1999 Call to Action, there is an emerging national awareness coupled with increased scientific inquiry. This was reinforced last fall with the publication of *Reducing Suicide: A National Imperative*, an important new report from the National Institute of Medicine. Nevertheless, much remains to be done.

We feel there needs to be more study of suicide in the African-American community, scientific inquiry that will seek to explain the many paradoxes and inconsistencies in the current literature. This article will present the reader with some of the often mystifying data on suicide in this segment of the American population and try to

# PARADOXES OF BLACK SUICIDE

highlight some of the contradictions we feel experts in suicidology and public health must study.

Before 1965, the suicide rate among blacks was one quarter that of whites. After 1970, suicide rates among blacks had escalated to half that of whites. In the 38 years since 1965, the suicide rate for black Americans has peaked twice, once in the late 1960's and again in the late 1980's. At the same time, suicide rates for African-American women have consistently hovered at a rate of two per 100,000 population (Griffith & Bell, 1989).

From 1980 to 1995, the suicide rate for black youths between the ages of 10 and 19 increased 114 percent, from 2.1 to 4.5 percent per 100,000 population. The suicide rate increased the most for black males between the ages of 10 and 14 years of age. It was 233 percent for blacks and 120 percent for whites. For blacks aged 15 to 19, the rate increased 128 percent. It went up only 19 percent for whites (MMWR, 1998).

By 1998, however, the number of suicides in the black male population, aged 15 to 24, had dropped and the number of black men who took their own lives returned to what it had been in the early 1980's. In 1994, the suicide level for black youths aged 15 to 24 was 21 per 100,000 population (IOM, 2002).

### The First Inconsistency

The first contradiction we wish to note has to do with the suicide rate of African-American women. Despite the fact that black women are often at a disadvantage in our society (e.g. discrimination, poverty and exposure to violence), they currently have the lowest suicide rates in the United States. Because of their disadvantaged status, African-American women's infrequent use of suicide as a solution to their problems puzzles many social scientists (Gibbs, 1997). (See table opposite.)

### The Second Inconsistency

The current literature shows that African-American women are just as likely to attempt suicide as European-American women but less likely to complete it.

We propose here that black women generally experience lower rates of hopelessness than their white counterparts and when they do attempt to end their lives, it is most often in response to hurt, anger, frustration or stress. We believe black women's "hopefulness" originates from having biologic (intellectual ability, personality traits and toughness) and psychological (intra-psychic) attributes—adaptive mechanisms such as ego resiliency, motivation, humor, hardiness and perceptions of self; emotional attributes—

‘Despite the fact that black women are often at a disadvantage in our society, they currently have the lowest suicide rates in the United States.’

emotional well-being, life satisfaction, optimism, happiness, trust, dispositional optimism, dispositional hope; cognitive attributes—cognitive styles, causal attribution such as an internal locus of control and blame, world view or philosophy of life, and wisdom; spiritual attributes, and attributes of posttraumatic growth, social (interpersonal skills, interpersonal relationships, connectedness and social support) and environmental (such as positive life events and socioeconomic status) systems in place that cultivate their resistance and also buffer them from a loss of hope.

We believe these systems consist of protective factors that work to safeguard them, such as an inner sense of music that is typified by gospel and blues, the natural toughening process African-American women are forced to endure, the development and maintenance of support networks and the belief that suicide is a “white thing.”

We attribute a great deal of black women's overall sense of “hopefulness” to the naturally occurring African-American strategies and coping mechanisms mentioned, and feel they need to be studied in light of the consistent and remarkably low rates of suicide in this part of the population (two women die by suicide per 100,000 population).

## Suicide Rates in 2000

White Males	<b>19.1</b> per 100,000 population
Black Males	<b>9.8</b> per 100,000 population
White Females	<b>4.5</b> per 100,000 population
Black Females	<b>1.8</b> per 100,000 population

### The Third Inconsistency

The third issue has to do with the increase in suicides between 1993 and 1994 in the black male population between the ages of 15 and 24. (See table on page 4.) The increase reflected there prompted the United States to declare suicide an epidemic among young black males. Remarkably, that table shows also that by 1998 the young black male suicide epidemic had vanished. The reason for the 25 percent decrease in the youthful African-American male suicide rate has never been explained.

### The Fourth Inconsistency

The fourth concern involves the low suicide rate of incarcerated black males. There are many more black men in correctional facilities than white. Nevertheless, white males are the most likely to end their lives in such places. Suicide rates for incarcerated men are approximately nine to fifteen times higher than for men on the outside—and prison suicide rates are approximately one and a half times higher than in the general population. Similarly, youths in detention and correctional facilities are four times more likely to commit suicide than youths in the general population.

Confinement in these institutions clearly promotes higher rates of suicide. The dynamic, however, does not appear to affect black males as much as it does white. Research is needed to explain why African-Americans seem better able to cope with hurt, anger, frustration and depression in such places.

After both the Epidemiologic Catchment Area Study and the National Comorbidity Study took age differences, gender, marital status and socioeconomic status into consideration, the initial higher rates of mental disorders (a risk factor for suicide) in African-Americans clearly dropped. African-Americans have just as many, if not more, risk factors that might promote suicide. Until research ceases to be focused primarily on the European-American population, we will never know why it is they fare better.

In conclusion, our current “ethnocentric monoculturalism”

## Suicide Rate per 100,000 for Black and White Males aged 15-24

Year	Black	White
1989	16.63	22.48
1990	15.13	23.19
1991	16.43	23.08
1992	19.72	22.68
1993	20.00	23.07
1994	20.53	23.94
1995	17.94	23.34
1996	16.72	20.99
1997	16.00	16.64
1998	14.98	19.28

This table reflects data in IOM, 2002.

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(Sue & Sue, 1999) prevents us from learning the strategies and resistance skills employed by the different segments of the African-American community, strategies that might help other populations with preventing suicide.

### Other Obscure Facts to be Explored

In addition to the four paradoxes of African-American suicide presented above, there are other issues to be examined.

A little-known, unreplicated study by Rothberg et al. (1987), which includes Department of Defense statistics from 1982 to 1984, reveals that the suicide rate for black military men between the ages of 45 and 55 was 18.7 per 100,000 population and that the suicide rate for whites in the same age group was 4.4. In this study, the suicide rates of middle-aged African-American men were four times higher than those of whites—an unusual finding that has never been studied or explained.

Herbert Hendin has observed that suicidal blacks come from homes where the father is abusive toward the mother. Why then, with African-American domestic violence homicide rates being higher than white rates, aren't African-American suicide rates higher?

David Clark (1993) also found a high rate of conduct disorders in adolescent suicide samples. This also poses a question: Given the frequency with which conduct disorder is diagnosed in black children, why are their suicide rates not higher?

Also worthy of notation here is the fact that suicide victims are more likely to come from non-intact families. Since the offspring of most Department of Children and Family Services are children of color, why aren't the suicide rates higher? ■

**Donna Holland Barnes is co-founder and president of the National Organization for People of Color Against Suicide. She is currently studying families who have lost a loved one to suicide, and working with the Department of Psychiatry at Howard University's School of Medicine in Washington, D.C. Dr Barnes has worked in the field of suicide for over a decade and is on the KBHC board of directors.**

**Carl C. Bell is president and chief executive officer of the Community Mental Health Council and Foundation, Inc., in Chicago, IL. He is director of public and community psychiatry and clinical professor of psychiatry and public health at the University of Illinois. He is currently principle investigator of Using CHAMP to Prevent Youth HIV Risk in South African Township-Community Mental Health Council, Inc. (NIMH 2R1 MH-01-004).**

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## Why This Book Matters to Me

By Jennifer Brehl

*The editor of How I Stayed Alive When My Brain Was Trying to Kill Me, talks about the significance of this new book by Susan Rose Blauner.*

Before the proposal for *How I Stayed Alive When My Brain Was Trying to Kill Me* (HarperCollins, \$24.50) landed on my desk, I received a phone call from Sue's agent. She said something like, "Hello, Jennifer, you don't know me, but I think I have a project that might be right for you." Now, I thought, how many times have I heard that?

She said somewhat tentatively, "I've heard that you lost a brother to, um, suicide." Well, yes, I had. My brother, Christopher, killed himself in June 1993.

My brother's suicide is no secret. Although it has had a profound effect on my daily existence and I think about it often, it does not define me, nor does it impede my living. That distinction is important, because many suicidal thinkers romanticize the aftereffects of their suicide, envisioning how their survivors will go on—in guilt or anguish or love. My family and I have gone on, and we are fine, and I wish to God my brother were here to share the joys and sorrows of everyday life as I experience it—as he could have experienced it.

A day later the proposal was sitting on my desk, eighteen neatly typed pages of what could be, I thought, one of the most powerful, hard-hitting and hopeful books that I'd ever read on the subject of suicide. Something spoke to me in Sue's short yet eloquent proposal: The declaration that "It's a feeling, and feelings pass, and if you talk to me, I'll help you get through it, just like I did." And today we have this book.

Sue and I have shared a lot of our feelings about suicide over the past year or so, albeit from different sides of the fence; we both agreed that my perspective is an important one to include. Through this book, Sue has helped me come to terms with many of the unresolved emotional conflicts I harbor about Chris's suicide. As I've said to her, I wish I'd had this book a decade ago.

In anticipation of writing this, I dug out my "Chris" file for the first time since his death. This is what I found: Numerous letters from our family that Chris had kept, including one that our brother, Ben, wrote to him in 1983, saying in part: "It may sound corny, but you're all a brother could ever want in an older brother." There were computer disks with Chris's poetry and various writings. There were the suicide notes, one to our parents and one to his siblings, and the order of service leaflet from his funeral.

The file also contained a letter from the funeral home thanking us for our "patronage." There was correspondence with insurance companies, doctors, the cemetery, the IRS (they don't forget you when you're gone), besides the deed to Chris's burial plot and the death certificate.



Susan Rose Blauner

And so what do I have? Paper, photos, mementos, words—artifacts, carefully preserved, of a wonderful life, beautifully, painfully lived. I'm thankful to have these artifacts, but they aren't enough. Chris is still dead. Twenty-nine years old with a bullet through his head.

On the morning of the funeral my siblings and I went to the funeral home. We asked if we could see our brother to say goodbye, and a soft-spoken woman said no, we couldn't—wouldn't want to—see his face. But wait, she said, and went into the room where his coffin lay waiting to be taken to the church. When she returned, she allowed us to approach the casket; she'd very kindly opened the bottom half. Each of us was able to touch his hands. I often try to recall the last time I saw my brother's face. I hate to admit it, but I can't. It was probably one of those innocuous occasions we all take for granted. Whenever it was, I didn't know it was the last time.

I ask myself often, could I have done anything to prevent Chris's death? Maybe I couldn't have, but Chris could have—if he had had knowledge and straight-talking affirmation from someone like Sue who has endured the agony that he suffered. I could not understand what he meant when he told me, "It hurts me to live." I did not know what to say. But Sue does. That's why this book means so much to me: Sue gives me a voice, an understanding I wish I had had years ago, a voice I wish my brother Chris had heard eight years ago.

A wise man who knew and admired Chris said he thought my brother had suffered a "brain attack" at the moment he pulled the trigger—that Chris wouldn't have done it if he'd thought it through. At the time I thought this man (who later became my father-in-law) was being simplistic. But now I think he was right. If Chris had had a Crisis Plan, if he had really considered the realities of suicide and its aftermath—if he had waited five minutes—I don't think he would have pulled the trigger. Therein lies the tragedy.

And herein lies the hope. Whoever you are—a suicidal thinker, a family member, or a friend, or someone who is considering suicide—please read this book and take it to heart, and know that you can stay alive when your brain is trying to kill you.

Jennifer Brehl is Susan Rose Blauner's editor at HarperCollins publishers in New York, New York and the editor of the book, *How I Stayed Alive When My Brain Was Trying to Kill Me*. For more information, go to: <http://www.harpercollins.com>.

Author Susan Rose Blauner is donating 10 percent of the royalties on her new book to the Kristin Brooks Hope Center and the National Hopeline Network 1.800.SUICIDE (784-2433) hotline.

# 2-11

*By Diana Stuart Jones*

What  
is it?

Where  
is it?

Why  
do we  
need  
it?

As a newcomer to Hartford, CT, Samantha Gray (her name has been changed) was not sure where to turn for help. It was after 10 p.m. on a Monday. Gray, a single mother, had just arrived home from work. Her 16-year-old son was in the kitchen with his girlfriend. They had been waiting for several hours to tell her he had a drug problem and wanted to end his life.

Gray had no local doctor and had never heard of the National Hopeline Network's 1.800.SUICIDE hotline. Desperate, she called her next-door neighbor, who told her to call 2-1-1, the national telephone number that provides free access to health and human services information and offers referrals. The helpline operates 24 hours a day to connect individuals and families with community-based organizations and government agencies to help them with problems.

Within minutes, Gray was given the 1.800.SUICIDE hotline and found herself talking with a crisis worker in Rocky Hill. In addition to the National Hopeline Network hotline, the 2-1-1 information and referral (I&R) specialist also provided her with several names and telephone numbers to call about drug rehabilitation.

"The original idea was the creation of a single phone number that people all over the United States could call to find or give help in their area," explained Lori Warrens, executive director of the Alliance of Information and Referral Systems in Washington, D.C. AIRS is in partnership with the United Way of America to promote and implement 2-1-1 nationally.

At the end of December 2002, a total of 20 states had working 2-1-1 centers serving more than 51 million Americans, 18 percent of the population of the United States. According to Dan Williams, national 2-1-1 director, the goal is to serve 50 percent of the country by 2005.

'The idea is for 2-1-1 to become as commonly used for social service information in local communities as 4-1-1 is for telephone information and 9-1-1 is for fire and police assistance'

States that now have working 2-1-1 lines include Alabama, Connecticut, Florida, Georgia, Hawaii, Idaho, Louisiana, Michigan, Minnesota, Nebraska, New Mexico, New Jersey, North Carolina, Ohio, South Carolina, South Dakota, Tennessee, Texas, Utah and Wisconsin. There is also a 2-1-1 line in Toronto, Canada.

"The idea is for 2-1-1 to become as commonly used for social service information in local communities as 4-1-1 is for telephone information and 9-1-1 is for fire and police assistance," Warrens said.

In theory, the number 2-1-1 is intended to help people navigate the confusing maze of human service agencies and programs and put them in touch with key resources close to home. In states where the line is up and running, it often provides other services too.

Recent calls to 2-1-1 centers nationwide have resulted in people finding local jobs, child care, even free meals. In Honolulu, HI those who call the number 2-1-1 can find out what beaches are plagued that day with stinging jellyfish. And in Salt Lake City, Utah many people recently dialed 2-1-1 to find out how to help in the search for Elizabeth Smart, the 11-year-old who was kidnapped in June.

"The information available on 2-1-1 is largely dictated by the community," Warrens said.

As she and others point out, 2-1-1 lines can help callers find food, housing, even money to pay their electric bills. They can provide information on how to find health insurance, medical information, support groups and counseling, and they can direct callers to employment assistance. (With regard to the latter, 2-1-1 centers often

## Certification AIRS Versus AAS

Most 2-1-1 crisis line workers are accredited by the Alliance of Information and Referral Systems (AIRS) and/or the American Association of Sociology (AAS), organizations that have very different certification requirements, according to Joan Wright, chief certifying examiner for AAS in North America.

"The primary focus of AAS training is to teach a worker how to deal with a person in a life-threatening crisis," she explained. "AIRS training, on the other hand, is more focused on teaching a person how to use community resources.

"Most of the AIRS processes and procedures are very detailed," she continued. "They have more to do with technology, phones and on-line services than with how to answer a call from someone in crisis. More networking skills are required for AIRS certification than for AAS, which places its emphasis on how to answer the phone, assess risk and follow up on a call for help. The focus of AAS training is more crisis-oriented and more centered on the caller. AAS training explores how you are connected with the community—but only in the broadest sense."

The more detailed AIRS certification also takes twice as long to attain. AIRS certification takes a year while AAS certification takes only about six months. "Of course we do have more examiners at AAS," noted Wright. "Even so, the two certifications are very different and comparing them is like comparing apples and oranges."

According to Wright and Lori Warrens, executive director of AIRS, crisis line workers at many agencies and centers have or would like to have both certifications. Plans are currently in the works to create a new program that would simultaneously combine certifications. The latter is expected to debut "in the middle of 2003," according to Warrens. ■

—Diana Stuart Jones

provide names and numbers of organizations to help with financial and transportation assistance as well as job training.)

For older people and the disabled, phone numbers are offered for adult day care, meals, home health care, transportation and home services. Beleaguered parents can learn where to find child care, after-school programs, camps, mentoring and even recreation programs. Would-be volunteers may even find a list of organizations to contact.

To date, United Way and AIRS say callers seem pleased with what they find. "It's very helpful, especially for those of us with children," said graphic artist and mother of two, Henrietta Perry of New Jersey. She used 2-1-1 to find health insurance and sports for her teen-age boys.

The nation's first 2-1-1 line was created in 1997 in Atlanta, GA. Currently, 18 percent of the U.S. population is being served, 50 million people, according to Williams.

Before July 21, 2000—when the Federal Communications Commission moved to assign 2-1-1 as a national number for community information and referral services—Atlanta was among a number of communities that offered an often confusing list of telephone numbers to access local call-in lines, help lines and crisis hotlines.

Following the Sept. 11, 2001 terrorist attacks 2-1-1 took on real national significance. The attacks

highlighted the need for a new national number to reduce the burden on 9-1-1. In the wake of the tragedy, calls to 2-1-1 in Connecticut jumped by 20 percent. In New York State, where there was no 2-1-1 system in place, there were "approximately 400 numbers set up to handle the kinds of calls we do," Warrens said, pointing out that "in Atlanta, where thousands of passengers were stranded at Hartsfield International Airport, local residents called 2-1-1 to offer rooms for temporary shelter."

So far, the only major stumbling block to implementing the number nationally has been money.

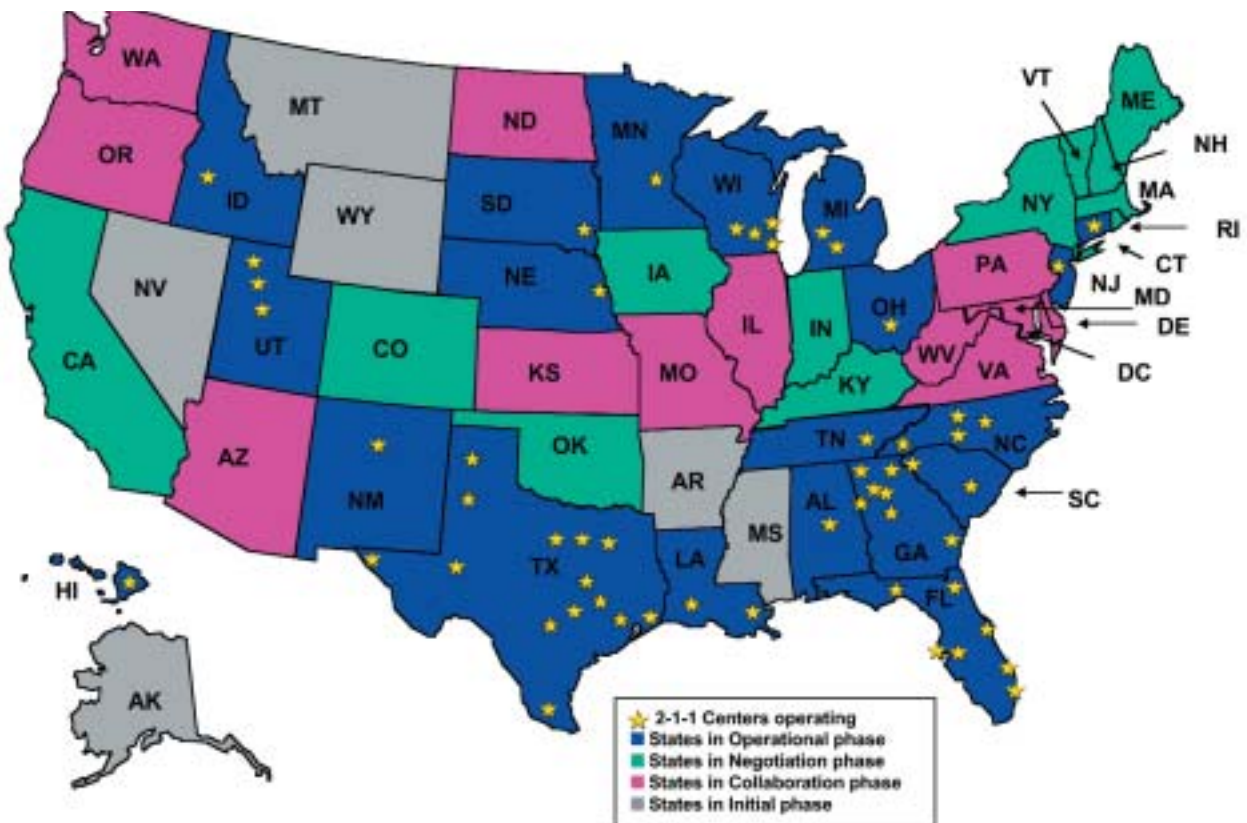
"That's been the major challenge," Warrens said. "When we received the original assignment, the economy was great and there were no budget cuts going on. Now, when we have budget cuts, is when we most need this kind of number." She favors a public-private partnership to help.

"The fact that we need this number so much now has been a selling point," she said. "The nation is concerned with security issues, and many see 2-1-1 as a community tool in a possible disaster."

Williams estimates annual operating costs for 2-1-1 at \$1 to \$1.50 per person.

*Diana Stuart Jones is managing editor of Preventing Suicide.*

### 2-1-1 serves more than 51 million Americans—18% of the U.S. population through 56 active 2-1-1 centers in 20 States





# Frontline

## A Primer for Crisis Center Management

By G. Lee Judy, Executive Director

Kristin Brooks Hope Center

Thirty-six years ago when Life Crisis Services of St. Louis, MO opened its doors, the term “suicide prevention” featured prominently in its title. The organization was originally known as “Suicide Prevention and Crisis Intervention.”

The way I see it, “suicide intervention” and “active [crisis] intervention” are synonymous. When someone in distress speaks to me of suicide, I automatically assume he or she is asking me for help and asking me to intervene, even though the words “save me” may not enter into our conversation.

This article is intended to help those on the front lines at crisis centers seeking American Association of Suicidology (AAS) certification. The recommendations that follow are based on my heartfelt personal belief that confusion over the terms “suicide intervention” and “active intervention” has left some at our nation’s crisis centers uncertain about how to actively intervene in a crisis.

With this in mind, I offer the following for your consideration:

- Don’t hesitate to ask a caller whether he or she is having thoughts of suicide. Even though it is our business and we train crisis workers to ask this question, it is still a hard question to ask. That is why we at Life Crisis broach this subject with every caller at the beginning of the call and ask the following question: “Before we begin, are you having thoughts of suicide?” No one I have said this to has ever hung up or been offended.
- Always keep your ears tuned for clues that might suggest suicide might be an option for this individual. There are obvious clues such as: “I have had enough,” “I cannot go on,” “No one will miss me,” etc. There are less obvious clues such as: “I have had the worst day of my life,” “I can’t even keep a job,” “My electricity is going to be cut off today,” etc. There are also times when a caller denies any thoughts of suicide, yet our clinical judgment says: “I think this person may be suicidal because of his or her depression, alcohol or drug use, or other mental illness. I know these three factors account for 95 percent of the pre-existing conditions for suicide, and I had better pursue their suicidality.” Why aren’t we always tuned into these clues?
- Always be prepared to intervene—to send help. If we believe that the suicidal people who call us are ambivalent and are not sure they want to kill themselves, (why else would they have called?) then why should we not help them? Do you really think anyone who calls a hotline is not seeking help? Do you really think people who call our hotlines do not know we will intervene? If we do not intervene, we are no better than a next-door neighbor who tells this person to “get lost.” Intervention means we do everything in our power to find them and send someone to rescue them. This may involve using caller ID, tracing calls and getting neighbors and friends involved. It may even mean lying to them. It may mean telling them: “No, I am not sending the police” (when in fact the police are on the way). If our job is suicide prevention, then why not do all we can to intervene?
- Suicide prevention means not hiding behind excuses such as: “We are a friend line,” “We don’t trace,” “We have always been an anonymous line,” “No one would call us if we started tracking them down.” If you really believe the above, then you are not operating a suicide crisis line. That’s fine but don’t try to be something you are not. I would suggest in considering the above that you take a hard look at the facts. Do you really know that people would not call if you were to become more of an active interventionist? Do you know whether people who have called your line have killed themselves because you didn’t intervene? Why don’t you know?
- Make suicide intervention an important part of your training. Make certain your suicide lethality assessments are up to date. Make certain your role plays can guarantee you a crisis worker who is comfortable asking about suicide and actively intervening. None of us wants to miss a suicidal caller. Why not supervise and train our workers to make sure they are equipped?
- Aggressively follow up all your suicidal callers. This means setting standards that read something like: “All immediate high-risk callers will be called back every hour and all high-risk callers within at least 24 hours. Suicidal people can change their minds just like anyone else. Will they call us back even if they contract with us? The answer is, not necessarily. It is important to check up on them.
- When a third party calls, be aggressive about locating and contacting the person at risk. It certainly is easier not to call the person at risk. Why would they want to talk to a stranger who is meddling in their business? They would not. That’s why it is so critical for us to talk to them. These people are less ambivalent than those who actually call for help. They need our skills even more. The friend or family member who called also needs us even more, because it is difficult to help convince the individual in crisis that living is a better option. Why do we think that we can train a third person to be a suicide expert in a short, pressured phone call?
- Make certain that your crisis workers are in fact doing the assessments they are trained to do. Listening in while in the same room will tell you something. Will it tell you enough, however? What do they do when you are not listening? Why not listen covertly to them? Why not make test calls to the crisis line to make certain the crisis worker’s skills are the best? Why do we hide behind our desire to be nice instead?

In closing, let’s all get on the same page to ensure we are doing everything we can to prevent suicide. Let’s be active in our intervention. Let’s make it clear that when someone with suicidal thinking calls our hotlines we will identify them, without fail, and help keep them safe. ■

*G. Lee Judy recently resigned as chairman of the Board of Directors of the Kristin Brooks Hope Center, the National Hopeline Network and the 1.800.SUICIDE (784-2433) hotline to assume his new post. He is a former executive director of Life Crisis Services, Inc. in St. Louis, MO and a past executive director of the Washington University Child Guidance Clinic, a program of Washington University School of Medicine, also located in St. Louis.*

### First-ever NCSPT Internet Workshop on Youth Suicide

The National Center for Suicide Prevention Training (NCSPT) is embarking on its first internet-based workshop. Entitled “Locating, Understanding and Presenting Youth Suicide Data,” the free training, which starts Jan. 27 and ends March 7, allows participants to attend from just about anywhere.

NCSPT provides educational resources to help public officials, service providers and community-based coalitions develop effective suicide prevention programs and policies. NCSPT is federally funded through the Maternal and Child Health Bureau and is a collaborative effort between the Harvard Injury Control Research Center, <http://www.hsph.harvard.edu/hicrc/>, and the Education Development Center, [www.edc.org](http://www.edc.org). NCSPT recently received the support of the American Association of Suicidology (AAS), [www.suicidology.org](http://www.suicidology.org), which will co-sponsor the workshop series.

Anyone who has a computer and is interested in suicide prevention can take the training. The workshop is available in two versions: a facilitated version and a self-paced version.

The facilitated version is the equivalent of a class with 15 to 20 participants, instructed by Lloyd Potter, Ph.D., M.P.H., with lectures, activities and group discussions. Unlike a regular class, you choose when and where to participate. Within a day of the announcement of the training opportunity, the facilitated version of the course, which is limited to 20, filled up.

The self-paced version can accommodate as many as necessary, but it lacks interaction and networking opportunities and offers no expert feedback. There are no conference calls or real-time lectures as there are in the facilitated course.

“NCSPT is very excited to provide this learning opportunity,” said Deb Stone, M.P.H., M.S.W., the project director for NCSPT. “Based on the overwhelming number of registrations on the first day, it is clear there is both a real interest and need for suicide prevention training.”

The workshop has been approved by the National Association of Social Workers for 18 continuing education credits. NCSPT has also applied for CHES credits for health educators, CME credits for medical providers and CEUs for psychologists and counselors. You must be a member of a respective professional organization to receive credit. All participants who finish the course, however, will receive a certificate of completion.

Local and state health officials, mental health providers, counselors, teachers, members of community planning groups, policy makers and others are urged to take the workshop. For more information, go to: [www.ncspt.org/courses/orientation](http://www.ncspt.org/courses/orientation). Registration for the course is on a first-come basis. NCSPT will provide two additional online courses in the future. Visit the NCSPT website for more information ([www.ncspt.org](http://www.ncspt.org)).

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### SAMHSA Report on Co-occurring Mental Illness and Substance Abuse Disorders Sent to Congress

The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) has sent to Congress its long anticipated report on treatment services for those with co-occurring mental illness and substance abuse disorders. The document entitled Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders can be accessed online at [http://www.samhsa.gov/news/cl\\_congress2002.html](http://www.samhsa.gov/news/cl_congress2002.html).

Written input to SAMHSA from the National Association of Mental (NAMI) while the report was being created can also be accessed by logging onto <http://www.nami.org/update/20020405.htm>.

According to the 1999 United States Surgeon General's Report on Mental Health, 51 percent of those with one or more mental disorders in the United States have a lifetime history of at least one substance abuse disorder. Sufferers, the U.S. Surgeon General pointed out, often find it difficult to receive diagnostic and treatment services even though these disorders are very treatable. (Research shows that if one disorder goes untreated, both usually worsen and over

time additional complications arise that often result in poor responses to traditional treatment, increased risk of other serious medical programs, suicide, criminalization, homelessness and separation from family and community.)

Significant progress has been made in the development of successful evidence-based interventions and programs, but states and communities have been slow to adopt evidence-based practices—the result (according to the recently published SAMHSA report) of a lack of coordination among services systems, complicated funding streams, stigma and barriers related to clinical staff licensure and training.

In all, the recently published report—mandated by Congressional legislation passed in 2000—contains five major sections. In addition to a comprehensive review of scientific research on treatment and prevention of co-occurring disorders, it includes a description of how states currently serve those with co-occurring disorders, efforts by SAMHSA and various states to develop innovative programs and a five-year action for SAMHSA.

Unfortunately, the document—which was intended to provide states with guidance on how to use existing programs to invest in such practices—fails to recommend changes to Federal mental health and substance abuse block grants that might create additional incentives for recipients of such funds. Instead, the document recommends a new SAMHSA-funded incentive grant program on co-occurring disorders to help enhance state infrastructure and treatment systems. The latter would require new and additional funds from Congress (unlikely in the current budget environment) and not block grant funding.

Failure to recommend changes to Federal mental health and substance abuse block grants is the result of pressure brought to bear in Congress by abuse agencies and providers opposed to the idea of granting states flexibility to blend funds from individual block grants here, and in the process do away with some of the cumbersome reporting and accounting requirements required. The longstanding debate between mental illness and substance abuse advocates over the merits and role of separate Federal substance abuse and mental health block grants, which was raging in 2000 when this report was mandated, continues.

In a recent press release, the National Alliance for the Mentally Ill (NAMI) expressed disappointment that the report failed to address barriers in existing block grants, and indicated it will continue to advocate for more flexibility in the block grants to pay for integrated treatment for the afflicted.

On the plus side, this new report looks at barriers that have prevented the nation's substance abuse and mental health systems from coming together to deal with this urgent problem and takes note of inflexible funding streams and lack of capacity, pointing out that evidence-based service models do exist and that currently there are some recovery-oriented, integrated treatment programs for mental illness and substance abuse within coordinated and organized systems and treatment settings.

It also contains much useful information. Included is a comprehensive review of existing clinical and services research. The latter demonstrates that integrated treatment is effective in achieving better outcomes than models that rely on uncoordinated parallel and sequential services.

In regards to block grants, the report points out that “nothing in the reporting or accounting requirements precludes programs from using block grant funds to provide integrated treatment for co-occurring substance abuse and mental disorders.” And, it also provides descriptions of how certain states are currently financing integrated treatment.

The report states unequivocally that SAMHSA intends to elevate treatment and prevention of co-occurring disorders as a major priority. This includes a new five-year plan for the agency to assist states in improving outcomes for individuals with co-occurring disorders by improving access to evaluation and treatment in both systems to ensure that “any door is the right door.” SAMHSA also intends to move toward helping states develop seamless systems designed to foster early intervention, treatment and follow-up care based upon evidence-based practice.

As part of this effort, the report recommends establishment of a national co-occurring disorders prevention and treatment technical assistance and cross-training center at SAMHSA and increased Federal collaboration (particularly with the National Institutes of Health and the Centers for Medicare and Medicaid Services) to enhance research attention and funding on co-occurring disorders.

—Diana Stuart Jones ■

*In coming months, Preventing Suicide will take a hard look at different pieces of pending legislature and possible grant opportunities offered to states to improve their overall effectiveness in helping those in crisis.*

*In addition, this journal will present information about existing state initiatives to prevent suicide, at times comparing the plans of one state with another, all with an eye to improving effectiveness.*

Help is just a phone call away, that's the beauty of the National Hopeline Network's easy-to-remember 1-800-SUICIDE (784-2433) number. The way we see it, the more certified crisis centers in our network, the more effective our services will be. That's why we're issuing a blanket invitation to crisis centers across the nation to join us, free of charge.

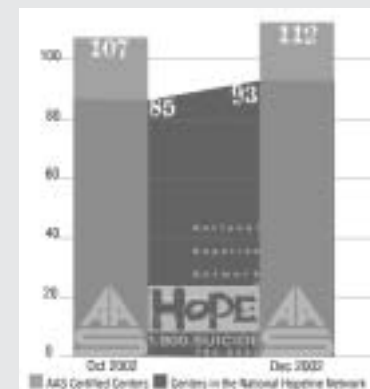
The National Hopeline Network is the nation's only suicide prevention crisis hotline network linking American Association of Suicidology (AAS) and CONTACT USA certified crisis centers under one toll-free number. A simple call to our toll-free number puts a person in crisis (or someone close to that person) in immediate touch with help at the nearest AAS- or CONTACT USA-certified crisis center. The line is staffed 24 hours a day.

The fact that your crisis center may not be certified is not a problem. Free of charge, we will help you obtain national certification, thanks to a three-year Substance Abuse Mental Health Services Administration (SAMHSA) grant, awarded jointly to the American Association of Suicidology (AAS) and the Kristin Brooks Hope Center.

The grant is for the expansion and support of national crisis-center services and subsequent research to evaluate their effectiveness. Even charges for telephone calls received via 1-800-SUICIDE are paid for by the SAMHSA grant.

For information about joining, contact April Jackson, AAS certification coordinator, or Shannon May, director of the National Hopeline Network. Ms. Jackson can be reached at (202) 237-2280 or e-mailed at [ajackson@suicidology.org](mailto:ajackson@suicidology.org). To reach Ms. May call (540) 338-5756 or e-mail her at [Shannon@hopeline.com](mailto:Shannon@hopeline.com).

The AAS website is [www.suicidology.org](http://www.suicidology.org). The website for the Kristin Brooks Hope Center is [www.hopeline.com](http://www.hopeline.com). ■



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# First Collaborative Crisis Centers Conference

April 21-26, 2003  
Santa Fe, NM



Co-sponsored by:

**CONTACT USA**

**American Association of Suicidology**

**Kristin Brooks Hope Center, program manager for the  
National Hopeline Network 1.800.SUICIDE (784-2433)**

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In recognition of the immense importance of crisis center services to communities across the nation, these three national organizations have come together in a collaborative spirit to develop this overarching and specially focused program for crisis intervention centers and telephone helplines.

This historic five-day event offers an unprecedented opportunity for crisis center administrators, staff and volunteers to gather, network and learn. Days one and two (April 22 and 23) focus exclusively on crisis centers and helplines. More than 18 workshops are scheduled on such diverse topics as fund-raising, caring for staff, grant writing, software and technology, and certification, as well as clinical programs on sexual callers, lethality assessment, etc. On days three through five (April 24-26), dozens of additional crisis center offerings are scheduled, interspersed among more than 175 papers, workshops, posters, and panels on suicidology and suicide prevention topics. For one minimal registration fee, you benefit from the depth of intensive focus on topics of interest to crisis centers and the breadth of the Annual AAS Conference.

## **Program Highlights:**

- Plenary sessions on hot topics, such as what is happening on the national level relevant to crisis center work
- Registration fee includes:
  - Two receptions*
  - Three luncheons*
  - Three banquets*
  - Continental breakfast*
  - Registration materials*
- Center and worker recognition
- A performance by "Firefall"
- Unlimited networking and sharing opportunities

This conference is subsidized specifically for crisis centers. The special registration fee of \$250 is strictly for crisis center managers, staff and volunteers.

**Registration Fee: Only \$250!**

**For registration materials or more information:**

**American Association of Suicidology**

[www.suicidology.org](http://www.suicidology.org)

[info@suicidology.org](mailto:info@suicidology.org)

**202-237-2280**



### Wellstone Memorial Service in D.C.

By H. Reese Butler II

**WASHINGTON, D.C.**—On Nov. 13, I went alone to the memorial service of United States Senator Paul Wellstone at the Washington Hebrew Congregation. There were thousands in the audience, more than a few familiar faces. I was there to pay quiet homage to my friend and hero.

I met Paul Wellstone only three years before he died. From the start, he believed in me and my vision to improve suicide prevention services in this country. The proudest moments of my life were in 2000. The first occurred when he presented on the floor of the United States Senate the legislation that created the SAMHSA grant under which the Kristin Brooks Hope Center operates. The second came several weeks later, when he spoke for more than a half hour about the nation's escalating suicide problem. It was then I began believing my wife Kristin might not have not died in vain and that she would live on through me. These memories flooded my mind the night of the service when Paul's colleagues and friends, United States senators Pete Domenici and Tom Daschle, spoke.

The first time I ever met Senator Domenici was at a press rally, May 5, 2000, for the Kennedy-Domenici Early Intervention and Mental Health Treatment Act. I was living then in California, where after Kristin's death I had established a suicide prevention hotline. I had decided to attend the rally at the last minute after a pleasant phone conversation with a man who wanted me to connect his public service announcements to our hotline. I did not know him well.

Because a lot of people were expected at that rally, I got there early and took a seat in the front row, unaware the front-row seats were reserved for speakers. When one of the latter failed to appear, it was assumed I was his substitute. I seized the opportunity and spoke about Kristin and suicide, about the need for certified crisis lines. I ended my short talk with a question: Why, I asked, if daycare centers in this country are required to be certified, aren't hotlines that deal with people in psychiatric crisis also certified?

The crowd rose to its feet, clapping, and United States Senator Edward Kennedy walked over and shook my hand. He told me he had a friend who had recently died by suicide, and I handed him the legislation that I had developed. He sat down

We invite readers to contribute suicide prevention events for inclusion in our calendar. Send your submissions to: [calendar@hopeline.com](mailto:calendar@hopeline.com). Please include the official title of the event, its date and a brief description, along with the name of a contact, and a way to reach that person.

**February 4 at 6 p.m. (on the second Tuesday of each month)**—NAMI-New York City Metro Monthly "Housing for People with Mental Illness," 40 East Thirty-fifth Street, Lower Level (between Madison and Park avenues).

**February 6-9**—"American Academy of Hospice and Palliative Medicine: 15th Annual Assembly" featuring session: "Self-Determined Death Among Older Women: A Comparison of Suicide and Euthanasia." Royal Pacific Resort, Orlando, FL. [www.aahpm.org/events.htm](http://www.aahpm.org/events.htm).

**February 7**—"Trauma and Suicide: Effects in the Minority Community," a conference by the National Organization for People of Color Against Suicide, Adams Mark Hotel, Auraria, Denver, CO. Contact Dora Smith at (404) 349-9854 or e-mail her at [www.nopcas.com](http://www.nopcas.com).

**February 12-16**—"7th Annual World Congress on Stress, Trauma and Coping: Crisis Intervention in a Changing World," Baltimore Marriott Waterfront, Baltimore, MD. Contact Shelley Cohen at (410) 750-9600 or e-mail her at [scohen@icisf.org](mailto:scohen@icisf.org).

February

and read it. He told me it was good and agreed to co-sponsor it with Senator(s) Reid and Wellstone.

Six weeks later, Senators Kennedy, Wellstone and Reed introduced the legislation in the Senate, and Paul Wellstone delivered an impassioned speech calling for the creation of the National Hopeline Network and 1-800-SUICIDE. His Senate colleagues listened. He accomplished in six weeks what no one had been able to do in 37 years—he created hope for suicidal Americans and also secured funding.

I cried as I stood in the crowd at Paul's service, remembering all this.

So many things came together for me that night, all of them intertwined in some way or other. Coincidence? I think not.

**H. Reese Butler II is publisher of this journal and president of the Kristin Brooks Hope Center.**

You are invited to become a subscriber to *Preventing Suicide: The National Journal*. Through September 2004, subscription costs are covered by a grant as part of the educational awareness component of the SAMHSA suicide prevention initiative. Please complete and return the enclosed card with your name and mailing address to the KBHC Journal Subscription Department, 201 North 23rd Street, Purcellville, VA 20132. If you prefer, you may enter your subscription electronically at [subscriptions@hopeline.com](mailto:subscriptions@hopeline.com). Please feel free to duplicate this subscription form for colleagues and other people interested in preventing suicide.

Special Invitation:

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Telephone Number (with area code)		E-mail address
To help us better serve <i>Preventing Suicide: The National Journal</i> readership and its interests, please complete the following information about yourself:		
Place of employment		job title
Are you currently involved in the prevention of suicide? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please give a brief explanation of your work and how long you have been involved in suicide prevention:		
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