Silent Suffering
Examining the effects of a public-health crisis spawned in part by a broken mental-health-care system.
Accessing coroners’ records difficult for reporting on suicide

Delving into the issue of suicide became a struggle for access to records.

The Dispatch collected 1,583 autopsy records, coroner reports and/or law-enforcement records from nine Ohio counties in to determine how many victims had been diagnosed with a mental illness, how many were being treated, and whether experts believed societal issues played a role in their deaths.

The counties were selected based on geography; their suicide rates, with some having above-average rates and some below; and demographics — rural, urban and suburban.

The counties were Adams, Ashtabula, Athens, Champaign, Licking, Franklin, Montgomery, Morgan and Sandusky.

Several counties at first refused to allow reporters to see investigative reports. While these documents are not public records, an exception in Ohio law allows journalists to review such documents but not copy them. The coroners then told the reporters they could not take notes because that in effect would be copying a record. For reporters, note-taking ensures accuracy.

The coroners were basing that edict on a written opinion by Ohio Attorney General Mike DeWine on a different point of law, one that allows journalists to look at the records of those who have concealed-carry gun permits. Reporters reviewing those records cannot take notes, take a picture or record the document in any way.

That opinion, however, does not mention coroners’ records. The law on coroners’ records is so murky that The Dispatch did not receive clear guidance from the attorney general’s office, either. The lack of clarity provided an additional hurdle for the newspaper to review records.

After much debate and negotiation, the coroners allowed the newspaper to review records.

Records show that unlike homicides, which typically generate thorough investigations, the amount of time spent piecing together the mental-health history of a victim and the events leading to a suicide varies greatly among coroners. Such information is very important to researchers and public-health officials who try to better understand and prevent suicide.

But the information is incomplete in Ohio.

The newspaper also analyzed 15 years’ worth of death records in all Ohio counties in which any person died by suicide. These records shed light on demographic information about victims and the method by which each died.
Silent suffering: Suicide is preventable, rarely discussed

By Jill Riepenhoff, Mike Wagner & Lori Kurtzman
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It’s the 10th-leading cause of death, but you’ll almost never see it mentioned in an obituary.

It kills as many people as breast cancer nationally, but it’s not recognizable by a ribbon or race.

In Ohio, it claims a life every seven hours.

Experts say this is 100 percent preventable. We can stop these deaths.

But we haven’t.

Like cancer in the 1960s and AIDS in the 1980s, suicide is a public-health crisis — one whose victims largely have been ignored by lawmakers, medical professionals and much of the public.

“These are the forgotten people,” said Jan Gorniak, the former Franklin County coroner who now is the deputy chief medical examiner in Washington, D.C. “It doesn’t make the newspaper, and it’s not on TV. We could save lives if we just talked about it. Mental-health problems are real, and we can’t ignore it any longer.”

When suicide is discussed, it’s often cloaked in judgment, in the misguided belief that people who take their lives are selfish and cowardly. Before there is understanding, there is shame, anger, blame.

But the vast majority of people who die by suicide suffer from a treatable mental illness, often depression.

For many reasons, they just don’t get the help they need.

“There is a huge, huge stigma,” said state Rep. Marlene Anielski, whose teenage son Joseph died by suicide in 2010. “It’s OK to have a broken arm, it’s OK to have cancer, but it’s not OK to have a mental-health issue.”

Those who have lived through suicide — a mother who lost her 16-year-old son, a wife left penniless after her husband took his life, a pastor who presided over his partner’s funeral, the nephew of a prominent local congressman who shot himself — say something clearly needs to change.

After Gov. John Kasich announced that Ohio was investing $2 million in suicide prevention, The Dispatch spent nine months examining the deaths that have claimed thousands of our children, mothers, fathers, grandparents and friends since 2000.

The newspaper studied 15 years’ worth of Ohio death records and scrutinized more than 1,500 coroners’ investigative reports on suicides in nine counties that represent a cross-section of the state.

The findings from those records are stark:
Since 2000, more than 20,000 people have died by suicide in Ohio — nearly triple the number of homicide victims.

More than 80 percent of those who took their own lives were male. Middle-age men, ages of 45 to 64, account for nearly a quarter of all suicides.

The youngest victims were just 8 years old — and there were three of them.

Even though the state’s suicide rate dropped last year to its lowest point in more than a decade, it still accounted for 10.8 deaths per 100,000 people. That means more than three Ohioans die by suicide every day.

But this isn’t an issue just for Ohio. It’s a national problem.

In 2013, the most recent national data available, more than 41,000 people died by suicide, putting the U.S. rate at nearly 13 deaths per 100,000. Ohio’s rate has mirrored the national average in the past decade and a half.

Yet even in states with the best rates, there are more than 8 deaths for every 100,000 people.

“I’m trained in psychiatry. I know the statistics. Yet it’s hard not to be shocked every year,” said Dr. John Campo, head of psychiatry at Ohio State University’s Wexner Medical Center.
Coroners’ records, which by law are to include detailed histories of suicide victims, paint a portrait of an overwhelmed mental-health system, a rigid insurance industry, unequal treatment of the mentally ill and a society unequipped to see the warning signs that someone is in danger.

Those records describe heartbreaking failures: A woman battling depression tried for weeks without success to schedule an appointment with a psychiatrist. A suicidal 19-year-old had to stop years of counseling after he lost his job and health insurance. A woman’s co-workers didn’t recognize what was happening when she gave them items from her purse and told them, “Remember, I will always love you.”

But not all records are so detailed. The Dispatch found that the fine points, which are needed to combat suicide, often are lacking. Some coroners in Ohio don’t conduct full investigations into the backgrounds of suicide victims, leaving many key questions unanswered.

“Finding what the stressors were and collecting all information is vital so we can do research and try to prevent more of these kinds of deaths from happening,” said Dr. Kent Harshbarger, the Montgomery County coroner since 2002.

Another gap in valuable information: No agency tracks suicide attempts. The Centers for Disease Control and Prevention estimates that, nationally, about 500,000 people a year try to take their own lives based on the number who check into an emergency department with self-inflicted injuries.

But those numbers don’t include, for example, the man who sat atop a bridge pier over I-670 at Neil Avenue this past summer, threatening to jump until Columbus police talked him down. Or the 5,000 people that Columbus medics take each year to Netcare Access, a mental-health-crisis facility on the West Side. The vast majority of them are suicidal.

Experts estimate that the true number of Americans attempting suicide each year exceeds 1 million.

**Call to action**

The issue of suicide as a public-health problem gained national attention in 1999, when then-U.S. Surgeon General David Satcher released the Call to Action to Prevent Suicide. “Americans in communities nationwide can make a significant difference in preventing suicide and suicidal behaviors,” read the report.

The goal was to develop a national strategy for prevention by raising public awareness, enhancing services and advancing research into suicide. But it lacked a concrete plan to achieve those goals, and suicide prevention largely faded from the spotlight.

Lately, though, tragedy has re-energized the issue. Reports of high suicide rates among U.S. servicemen and women coupled with the high-profile death of comedian Robin Williams last year got people talking again.

Research into suicide is on the rise, schools are teaching warning signs to teens, and this past summer, Franklin County created a task force specifically aimed at stopping suicide. State leaders are working to coordinate long-disjointed anti-suicide efforts, too. In Ohio, suicide prevention has found a champion in the state lawmaker who lost her teenage son five years ago.
“We think we’re getting close to a tipping point,” said Robert Gebbia, chief executive officer of the American Foundation for Suicide Prevention, a New York-based nonprofit group, which is the largest private funder of suicide research.

The foundation set a goal that has been widely accepted by mental-health professionals: Reduce the rate of suicides by 20 percent in the next 10 years.

To achieve that, lawmakers at all levels of government will need to act.

Right now, for example, the federal government spends $2.9 billion on HIV research, 78 times more than that spent on suicide prevention. A bill pending in Congress would increase the suicide-prevention research budget at the National Institute of Mental Health to $80 million. Gebbia’s group wants to see an additional $40 million in that pot.

“That’s still only a down payment,” he said. “We have to do more. We’re behind in the science.”

Researchers also want Congress to give $25 million to the CDC so that it can track suicides in all 50 states. Right now, 32 states are involved, including Ohio.

Experts say that states need to increase the number of mental-health-crisis centers and shore up Medicaid reimbursements that are woefully lower for mental-health providers than for those who treat physical ailments.

“Once the public attitude (about suicide) changes, the elected officials will follow,” Gebbia said.

And based on turnout at his group’s largest fundraiser, a series of “Out of the Darkness” walks held across the country each year, the stigma appears to be lifting.

More than 100,000 people walked in those fundraisers this year, 1,400 of them in central Ohio. They brought in $10 million nationally.

By comparison, Pelotonia, the local bike ride to support cancer research in Columbus, tallied more than $20 million this year.
Before March 20, 2014, Tricia Lawson-Cumer never imagined that her fun-loving son — the school-spirit leader at Westerville North, the kid who took Miss Teen North Central Ohio to the homecoming dance, the boy who was always smiling — would die so young.

“He was the happiest kid ever, and he always wanted other people to be happy,” Lawson-Cumer said.

Todd Cumber was 16 when he killed himself.

Among teens nationally, suicide is the second-leading cause of death behind accidents. Suicide claims more teens than cancer, influenza, diabetes, asthma and a host of other diseases combined. In Ohio, suicide has claimed more than 1,100 teens since 2000. Last year, the rate exceeded 11 suicides per 100,000 teens.

Their deaths can seem more sudden than adult suicides, more impulsive, said Dr. Jeff Bridge, an epidemiologist at Nationwide Children’s Hospital. That could be explained by the nature of teenagers, by their still-forming brains, or it could be a matter of perception: No one expects someone with so much life remaining to cut it short.

In hindsight, Lawson-Cumer now sees that her son couldn’t cope after finding himself in trouble at school.

It all began during his sophomore year, she said. He lost his spot on the varsity wrestling team and felt that his teammates and coach had turned against him. Then he found himself in the principal’s office for using Twitter to make fun of a classmate, a girl he considered a friend.

Lawson-Cumer was shocked. The son she knew detested bullying. Clearly, he regretted what he had done. She asked him how he was feeling.

“I’m fine,” he assured his mom. “Everything will blow over.”

But it didn’t. He asked his mother, who was in nursing school, when she would be done with her final exams.
Shortly after her final test, she found him dead on the floor of her bedroom, a gun in his hand.

“I was pretty much in shock for three months,” she said.

Months later, she found an email Todd had written. As part of his punishment, the principal had Todd type a letter of apology to the girl. The principal did not share Todd’s email with the boy’s mother. In it, Todd called himself a dirt bag.

He wrote that he couldn’t do anything right, that he wasn’t worthy to live.

“If I had seen that letter, we’d have been at Children’s Hospital that day. This would have 100 percent not happened,” Lawson-Cumer said. “Those school people made him feel so bad about himself for making a mistake.”

She filed a wrongful-death lawsuit against Westerville schools last month. A spokesman for the district said he couldn’t comment on pending litigation.

A 2012 Ohio law requires teachers and other school officials to be trained every five years in suicide warning signs and prevention. The law honored the son of Rep. Anielski, a Republican from Cuyahoga County.

Joe was a tall, athletic kid who was hugged every day. He left behind a stunned family that since has pushed for programs to save suicidal kids.

“If that’s happening to us,” Anielski reasoned, “it’s happening all over.”

Still, most experts believe that Ohio law needs to do more. They say school training needs to happen annually.

Suicide experts often talk about a safety net that surrounds a vulnerable person, and teachers and fellow students are an integral part of a teenager’s protection. Doctors at Nationwide Children’s know that school intervention works. They’ve seen suicide attempts drop when schools make a concerted effort to talk to students about suicide prevention.

Said John P. Ackerman, the suicide-prevention coordinator for Children’s Center for Suicide Prevention and Research: “It’s like giving students an inoculation.”
On Super Bowl Sunday 2010, Missy Robb received her husband's alarming text: “I’m gonna kill myself.”

She raced to their Gahanna home and found Doug alive but dying. She dialed 911 and rushed to the hospital after medics took him away. For the next 12 hours, Robb sat bedside and watched her husband of 19 years slowly die from drinking a chemical solvent that burned through his body.

“I could feel his body getting colder,” she said. “I just sat there and watched the monitors.”

She had long feared that this day would come. Doug, 46, had suffered from depression for years and had twice attempted to end his life. To most people, he seemed happy. He had a great job at the Ohio attorney general’s office. He was studying to become a paralegal. He loved football, the Who, his wife and their three children: two teenagers and a young adult.

But Robb knew better. “I was afraid to go home some days. I knew he wanted to die.”

Even so, she was completely unprepared for his death. She didn’t even know where to bury him.

After the funeral, Robb struggled to find support from a community of suicide survivors. The group met only monthly; she needed more. She found herself increasingly depressed. She would stay in bed for a week. She lost her job as a nurse’s aide and was unable to hold a steady job.

Then it got worse: Doug’s life-insurance company refused to pay on the claim because he had taken his own life.

“I lost everything,” Robb said. “I lost my house. I lost my car. I lost my job. My credit is ruined.”
Most insurance policies contain a clause that says the company won’t pay on a claim if the holder
dies by suicide within the first two years. Doug had held the policy for 18 months. Had he died of a
physical disease or an accident, Robb would have received $250,000.

Instead, she received nothing.

Her story is familiar to coroners. Many survivors beg coroners to rule a self-inflicted death as
anything but suicide. In one case, a man rushed to the coroner’s office before the body of his brother
arrived and began pleading his case.

Some are embarrassed or ashamed. Others want to shield their children from the truth. Still others
want to protect life-insurance money.

Greg Rolfsen, the morgue supervisor and an investigator for the Franklin County coroner’s office,
said that as many as 30 families a year protest a ruling of suicide.

“Emotions can explode in suicide cases,” Rolfsen said. “We have had people just start yelling and
calling you names. We have had cases where people are sobbing and blaming themselves. Some just
refuse to believe it’s possible.”

Robb didn’t ask the coroner to change Doug’s cause of death, but she thinks it’s time for lawmakers
and insurance companies to rethink suicide. She wants the threshold for life-insurance policies in
cases of suicide lowered to a year. It’s a sticky issue, though: some studies have suggested that more
lenient policies can actually encourage suicide.

Nearly six years after her husband’s death, Robb still battles depression and anxiety. She finds solace
on her sectional couch surrounded by her three Great Danes and miniature pinscher. She adopted all
but one after Doug’s death.

“I didn’t think at this point in my life (I’d) be a single woman,” she said. “My life is such a mess.”

**Boldly telling the truth**
When Dan Ames ended his life nearly six years ago, the Rev. Philip College decided to tell the truth. He called every person listed in Ames’ address book and told them how his partner of 11 years had died and that Ames had loved them.

Then he wrote the obituary: “Daniel Mark Ames, 52, died unexpectedly Wednesday, Jan. 30, 2010, from suicide in Columbus, Ohio. He suffered most of his adult life from major depression and bipolar disorder.”

“As a pastor, I think it needs to be said. This privacy is part of the problem,” said College, the rector at St. John’s Episcopal Church in Worthington.

The coroner’s investigative report of Ames’ death explained none of this, though. It attributed his suicide simply to “relationship problems,” a gross understatement of what was going on his life.

Ohio law requires the state health department to collect information from coroners and law-enforcement agencies about suicides. Those details feed into the National Violent Death Reporting System, a tool used by researchers to help shape prevention programs and treatments.

The key questions about victims: Was there a history of mental illness or substance abuse? Were they facing a divorce or an upcoming court date? Did they have financial troubles or had they lost a job? Was there a history of suicide attempts? Had they told anyone they wanted to end their lives?

The Dispatch found that some Ohio counties aren’t providing that detailed information.

Morgan County, for example, doesn’t have coroner. He moved to Adams County, two hours away. Many of Ohio’s rural counties don’t have investigators in the coroner’s office.

Some coroners aren’t trained to do background investigations and don’t have financial resources to perform autopsies. Several coroners work part time and devote the majority of their time to their private practices.

When the economy was slumping, many Ohio coroners saw their budgets slashed.

“Nobody really cares that much about the coroner,” said Gorniak, Franklin County’s former coroner. “On a ballot, you have the presidential candidates and the other offices, and the dog catcher and then the coroner. But we have a public-health service role to perform as well as determining cause and manner of death. And it’s on us to help prevent more deaths.”

The data sometimes are sparse even in large counties. In Franklin County, for example, the coroner does not investigate a suicide if the victim dies in a hospital. More than a quarter of all victims are brought to a hospital and pronounced dead there, leaving a vacuum of information.

And medics transport virtually every child and teen to the hospital, leaving huge gaps in the circumstances of those deaths.

Unlike Montgomery County, which investigates every suicide, Franklin County relies on the police to investigate hospital deaths. But the records show that the police don’t do a thorough investigation of a victim’s background, either.
The investigation of Todd Cumer’s death said only that something might have happened at school. For Doug Robb, it mentioned only that he was depressed.

And then there were Ames’ “relationship problems.”

Ames and College, both deeply spiritual, met because of the Episcopalians Book of Common Prayer. College saw Ames carrying the prayer book and decided that he had to meet him.

A friendship began and blossomed into a committed relationship.

“We were definitely deeply connected,” College said.

College didn’t know until they moved in together that Ames, 52, had struggled with mental illness for decades.

He was diagnosed in his early 20s with bipolar disorder. He turned to alcohol to dull his pain, but that only added to his illness. He joined Alcoholics Anonymous to manage sobriety and turned to treatment to manage his mental health.

“He never accepted that,” College said. “He hated that part of himself.”

Few knew of Ames’ struggles. His was a successful salesman in the pharmaceutical industry, a sponsor in the AA program and an active member of Ohio State University’s alumni marching band.

But his illness took a turn after he lost his job in 2009. “It came as a complete shock to him. He had just received a raise and excellent marks,” College said. “I think that was a definite trigger.”

Ames had trouble finding firm footing again. He cashed in his retirement fund to buy a car. He quit going to AA.

“He’d go to the psychiatrist and come home with a new prescription, and I’d find the prescriptions lying around the house,” College said. “I was upset that he made irrational, illogical decisions. I was mad he wasn’t taking his medicine.”

Ames joined a gym and spent his days working out. It gave him purpose. But the joblessness weighed on him. In late January, College insisted that he do something about his irrational behavior.

It was the last time College saw Ames alive.

“The next morning, I went to work and didn’t say goodbye to him. That’s my biggest regret.”

Ames’ body was cremated and is interred in a niche at St. John’s, just below College’s office.

In the years since, suicide has touched the small congregation many times.

With College’s counseling and guidance, all but one family told the truth about how their loved one died.
Robert Shamansky was a Harvard law school graduate, successful lawyer, compassionate philanthropist and former congressman who dedicated much of his life to helping less fortunate people.

He had no history of mental-health issues and no major medical conditions.

But in August 2011, the Bexley resident told his nephew Sam Shamansky that was he was having suicidal thoughts. The 84-year-old checked himself into a hospital for five days.

Two days after his release, Robert bought a gun.

The next day, he shot himself.

To this day, no one knows why. Like nearly two-thirds of suicide victims, Robert didn’t leave behind a note explaining his actions.

Some survivors spend a lifetime searching for answers. Shamansky didn’t. Nor did he consider hiding the truth about his uncle’s death.

“This perception that people who end their lives this way are cowards and selfish is wrong,” said Shamansky, a well-known criminal-defense lawyer in Columbus. “I tell people all the time this act doesn’t have to define you, and this certainly didn’t define my uncle.”

Robert’s memorial service was packed with friends, politicians (including the governor), Columbus’ power-brokers and the guys he exercised with at the gym. At the service, some asked why Robert ended such a rich life. His nephew didn’t shy from the questions but also stressed that the “why” wasn’t important.
“These are very deeply personal issues, and people have the right to process them how they want,” he said.

Robert never asked his family for help, never wanted it. He rejected his nephew’s offer to live with him after he checked out of the hospital, perhaps because he was too proud.

But Shamansky understands the many suffering from depression or suicidal thoughts want, need and deserve help.

“The lack of mental-health resources is miserable,” he said. “In the work I do, I see people — rich or poor, black or white — who can’t get the mental-health help they need. It’s a national sin.”
Families struggle with Ohio’s mental-health-care system

By Jill Riepenhoff, Mike Wagner & Lori Kurtzman
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Debbie Sizemore begged emergency-department doctors to reconsider. But they said her delusional husband wasn’t a threat, not to her or anyone.

Go home, they said.

The next day, Sizemore found 56-year-old Randy crouched like a warrior, sword in hand, fighting the zombies on his TV. He glanced at his wife.

“Go smell the flowers,” he said, referring to a scene in The Walking Dead in which a woman shoots a young girl while telling her to keep her eyes on a patch of yellow flowers.

Sizemore called police. Officers handcuffed Randy and hauled the retired firefighter out of the house barefoot. He bellowed. His own dogs trembled with fear.

As the unimaginable scene unfolded, his wife thought: The hospital got it wrong.

Like Sizemore, plenty of families struggle with the state’s underfunded and overburdened mental-health-care system. They feel ignored, disrespected, forgotten. Coroner’s investigative files across Ohio outlined some of their tragic stories. Their families filled in the rest for The Dispatch.

In Sizemore’s case, police took Randy to a mental-health facility, where he stayed for 10 days.
Back at his Middletown home in southwestern Ohio, Randy began weekly sessions with a therapist and psychiatrist. He took seven different medications to help his depression, anxiety and aggression.

The drugs calmed him, but they seemed to take something from him, too.

“He lost the humanness in his eyes,” Sizemore said. “The spark wasn’t there anymore.”

At first, Sizemore, a registered nurse, dispensed Randy’s medication each day. He eventually asked to do it himself. His behavior again slipped into the bizarre.

On July 14, 2014, he woke early, kissed his wife and said, “I love you.”

He drove to his therapist’s office with a gun. His counselor found Randy slumped over in his car. He died later that day.

Later, as she sorted through her husband’s belongings, she found medical records from before they were married showing that he had been diagnosed with bipolar disorder. She also found an old note: “Sometimes I wonder if everyone were better off without me.”

Since her niece Shawna’s suicide, Ilona Hayes has been fighting to keep her son alive. The ordeal has left her in financial ruin.

Shawna, 16, died of a drug overdose in 2010. What followed was a nightmare. Hayes' then-13-year-old son, whom she requested not be named to protect him from ridicule, stopped playing sports. He started pulling into himself, withdrawing from everything. He blamed himself for his cousin’s death.

He came home from school one day with his name scratched into his arm. The cutting didn’t stop there.

Hayes, of the Far West Side, sought help.

“I was not going to lose my son like Shawna,” she said.

Her son was in and out of hospitals four times. He was prescribed anti-depressants, but they made him sluggish. Once he was out, he’d stop taking the pills, turning instead to marijuana. It didn’t make him a zombie the way the medicine did.

But he continued to cut. Last year, he sliced into his upper thigh, deeper than he had intended.

Scared and crying, he called his mom.

She drove him to Netcare, but he was transferred to Nationwide Children’s Hospital, which opened a mental-health crisis unit last year with funding from Franklin County’s ADAMH board.

Once at Children’s Hospital, doctors diagnosed Hayes’ son with post-traumatic stress disorder and major manic depression.

Now 18, he still refuses to take any medication and is afraid to see his doctors. He seems to be doing better, Hayes said, but she never can be sure.

“The system has failed him so much,” Hayes said.

The Linda Byers her family knew had changed. The joy was gone. She seemed anxious, afraid. Her body trembled like she’d been caught in the cold without a coat.
She was trying to get help, encourage by her family. But a depressed Linda bounced from hospital to hospital and only seemed to get worse. Some programs brushed her off because she didn’t seem ill enough. Counselors prescribed and tweaked her medication.

Her family doesn’t know whether she ever received a formal diagnosis. They don’t know if doctors knew about the brain injury she suffered at birth. All they saw were her fears, of the dark and of undressing to shower, deepening.

“I don’t know if anyone could have helped her, but no one did,” said Sue Shurig, Linda’s sister. “No one could really figure out what was wrong or how to treat her or how to make her better.”

Linda agonized for 18 months. She visited six hospitals and saw several counselors, only one of whom genuinely seemed to care. The 58-year-old Clintonville woman took her life in August 2014. She died with a fresh manicure and upcoming appointments on her calendar.

“I wish I knew what she really needed, what she really got from all of those people,” said Shurig, who lives in Worthington. “Was it the meds? I don’t know. Whatever it was, it wasn’t enough. And we are just left with the sickening question of: ‘What in the world happened?’”

Raquel Padro’s mental illness began with sleepless nights, insecurity and anxiety. She was 13. She just wanted to be like everyone else.

Her parents spent the next 12 years on a mission to help their youngest daughter. They researched, hired consultants, paid for treatment themselves and even sent her to Utah.

“As a mother, you always want to fix your child,” Eileen Padro said.

With no good options in Ohio, Raquel agreed to go to a residential treatment center in Utah. Doctors told her parents she would need to stay for six months to a year and that they would be responsible for the $25,000-a-month bill.

Homesick, Raquel came home after only three weeks.

She persuaded her parents to allow her to take a break from treatment so that she could get a job, fearing that an employer would frown upon her mental illness.

She landed a job selling designer handbags at Saks Fifth Avenue.

“One to two months later, she came to us and said, ‘I need help.’”

They found a program at OSU’s Harding Hospital, a daily eight-week outpatient program that took a cognitive-behavioral treatment approach that helps patients solve problems and change the way they act.

“Harding made such a big difference for her,” Padro said. “She was starting to make progress.”

And then the program ended. Raquel was left with weekly visits with a psychiatrist. It wasn’t enough.

She took her life last Thanksgiving weekend. The president of Saks sent a handwritten note of sympathy to her family.

Padro believes her daughter could have been saved if she had remained in the Harding program for a year.
She has been meeting with Dr. John Campo, head of psychiatry at Ohio State University’s Wexner Medical Center, to discuss ways to raise money for Harding Hospital so that it can become a long-term option for the chronically ill.

Padro wants to help, but she needed some time to pass after her daughter’s death.

“Raquel taught me true compassion, love and patience,” she said. “I miss her so much . . . It doesn’t seem right that she’s gone.”
Most people who commit suicide have mental illness, don’t receive care needed

By Mike Wagner, Jill Riepenhoff & Lori KurtzmanThe Columbus Dispatch • Wednesday November 18, 2015 9:00 AM

Amy Luxenburger rested her head on her mother’s shoulder in the back seat of the car, suspended somewhere between reality and the illness that imprisoned her mind. She stared at the birds outside.

“It’s so hard to pretend I’m normal,” she said. “It’s so hard trying to pretend I’m not crazy.”

It was the first time Jill Feather had heard her 27-year-old daughter say what they all knew: Amy needed help. For a moment, Feather was relieved.

But what followed would reveal much of what’s wrong with Ohio’s overburdened and underfunded mental-health system. Amy would struggle to find the proper therapy, medication and support from the very people who should have understood her illness. She would lose hope.

Like too many who enter the state’s system looking for help, she wouldn’t make it out alive.

“I can no longer fight against myself and these feelings that overtake me,” she would write. “I am not strong enough.”

The Dispatch’s nine-month look into suicide exposed how overwhelmed the state’s mental-health-care system is.

Ohio has an astonishing lack of therapists, hospital beds and crisis centers for suicidal patients, most of whom suffer from a mental illness. Those in despair often end up in emergency departments, where doctors well-versed in physical ailments struggle to treat illnesses of the brain. Patients can spend days waiting for a bed.

Insurance companies and Medicaid turn their backs on those patients, too, refusing to cover mental-health treatment or paying a fraction of the costs.

“We have a health-care system that is separate and is not equal,” said Dr. John Campo, head of psychiatry at Ohio State University’s Wexner Medical Center. “We need to level the playing field in how seriously we take mental-health problems.”

There are other flaws: Patients with mental illness may fear medications will harm them or won’t work. They might avoid their therapists. And families might not know that any of this is happening because of privacy laws for medical records.

In the past 15 years, more than 20,000 Ohioans died by suicide. Experts say nearly all such deaths could be prevented, but not unless the outdated system changes and state and federal governments increase their investment in mental health.

“You only have to see the pain in one mother’s eyes and know it’s the right thing to do,” said David Royer, executive director of the Franklin County Alcohol, Drug and Mental Health Board.
I just miss my baby girl. She was so really sick. She had mental issues for years; she knew it, I knew it. I knew the depression was hard, but I didn’t know it went to the depth of her soul. She was so talented. And had a voice like an angel and was such a free spirit. I thought we could get her mind regulated and she could have a decent life. — Jill Feather’s journal from 2013, after Amy’s suicide

Amy long hid the turmoil in her mind. She had been performing her whole life. The girl with the cute dimples sang on stage in the seventh grade and in musicals at Buckeye Valley High School. She wrote music and played in bands while earning a degree at Indiana’s Earlham College.

People were drawn to Amy, to her glowing hazel eyes and easy smile. She played piano just so friends could sing along.

In 2013, she was in Michigan caring for her grandpa when something broke. A visiting friend noticed her bizarre behavior. She could no longer dress herself. She hadn’t slept in two days. She was barely coherent when her parents and boyfriend arrived at the farm, and on the five-hour ride back to Columbus, she slipped in and out of lucidity.

She asked whether the birds outside her window were following them home.

Her parents drove her straight to OhioHealth Riverside Methodist Hospital, where doctors diagnosed her with Bipolar I Disorder. It was July 7, 2013. She would stay there for 13 days.

Forty years ago, mentally ill patients were sent to state hospitals for treatment. But in the mid-1970s, President Jimmy Carter created a commission aimed at patching deficiencies in the mental-health system. States began shifting services from hospitals to communities so that patients could be treated in less-restrictive environments.

The shift came without the infrastructure to support patients with chronic illnesses.

“Right now, they ping-pong from the emergency department to acute-care facilities to the community and back,” Campo said.

Today, only the most severely ill patients are sent to the state for care, such as those deemed incompetent to stand trial for a criminal act. The chronically ill struggle to find long-term intensive therapy in the community. In Franklin County, just a half-dozen facilities offer such inpatient services.

Across the state, treatment options are even more sparse.

Ohio has 97 places — counties, health centers, prisons or low-income neighborhoods — that lack mental-health-care professionals, according to the U.S. Health Resources and Services Administration. These determinations are based on criteria that include doctor-to-population ratio and driving distance to medical care.

Since 2011, nearly half of the state’s 88 counties have been added to the list of places with too few psychiatrists to meet the needs of the population.

The need is especially great in the Appalachian region of eastern and southern Ohio. Some of those 32 counties have suicide rates double and triple the state rate of 10.8 per 100,000 people. But their options for local mental-health care are sparse.

Seven counties don’t have a single psychiatrist.
“Access to mental-health care is poor here,” said Adams County Coroner Larry Best, who has been a doctor in extreme southern Ohio for more than 50 years. “There aren’t many professionals you can talk to.”

The high unemployment, significant substance-abuse issues and easy access to firearms make the region even more volatile.

But virtually every Ohio county has unmet needs.

For the people in greatest peril, half of the state’s counties have no hospital beds for mental-health patients.

The situation is even worse for children and teens. Only 12 of 88 counties have beds for them.

“We know there’s a shortage. We also know that the average age of practitioners is going up,” Campo said. “The real shortage is likely to get worse, not better.”

Dear Amy,

Weird call Friday from the “case manager.” She thought it was a joke when I told her you were dead. Pretty bad joke? She made it sound like you went to your follow-up appointment. I know that you took responsibility for your death, but of course, I wonder if the people you were first referred to would have been better — this might not have happened. But who knows? You were just so sick Amy; I am so sorry! — Jill Feather, about two weeks after Amy’s death

Amy completed five weeks of outpatient treatment at Riverside. She seemed better. Her boyfriend broke up with her, but even that seemed OK.

She finished her album. It was her first. She had been writing and recording for years, but she tackled the project with unexplained urgency, working through her songs as she visited her best friend in New Jersey.

A friend posted a video of them rehearsing in the kitchen, Amy, keyboard in her lap, her voice booming: “No fear at night, no fear at day / You’ll be all right, you’ll be OK.”

They wrapped up on Aug. 3, Feather’s birthday.

Amy returned to Columbus, where she visited a local medical center and told a psychiatrist that her medication was making her feel suicidal. She asked if she could try something else. She told her mom that the psychiatrist dismissed her concerns and doubled the dosage of her current medication.

“He just brushed Amy aside,” Feather said. “Riverside did a good job, but after this encounter, we started to lose faith in the mental-health system.”

The family paid for Amy to see a different therapist, but the damage had been done.

Hospitals and emergency departments aren’t the only options for a patient in central Ohio experiencing a suicidal crisis, but the alternatives are drowning in demand.

Netcare Access, the single-largest provider of mental-health care for adults in central Ohio, sees more than 10,000 patients a year. Law enforcement delivers about 2,000 of them. Another 5,000 come from emergency rooms.
The center has only 26 beds for patients in crisis.

“On any given day in Franklin County, people are waiting for a psych bed,” said Dr. Brian Stroh, Netcare’s assistant medical director. “There’s been so little expansion in our city.”

Netcare is largely supported by tax dollars from the ADAMH board. For every $5 the board spends on crisis care in the county, Netcare receives $1, making the center ADAMH’s largest beneficiary.

Medicaid doesn’t pay enough to cover patients’ costs, and nearly half of Netcare’s patients have the government insurance for the poor and disabled.

Medicaid pays only for the time the patient has face-to-face contact with a doctor.

“It costs a lot more than just that 15-minute intervention,” said ADAMH Executive Director Royer. “Their reimbursement for crisis services is outdated and needs to change.”

Patients generally stay at Netcare between 23 and 27 hours. They need time to stabilize, develop coping strategies and find ongoing care. That work typically is handled by nurses or social workers and not covered by Medicaid.

“What you see is that our community is disproportionately funding these services,” Royer said. “The state of Ohio has to modernize and recognize that we have inadequate reimbursement.”

Demand is overwhelming, too, at the Chalmers P. Wylie VA Ambulatory Care Center.

The center, on N. James Road at Stelzer Road, treats about 40,000 patients a year. At any given time, its two full-time suicide-prevention specialists juggle 80 to 120 veterans considered high risks for suicide.

“The top of my wish list would be to have more people working in my field,” said Bernard Williams, the center’s suicide-prevention coordinator. “We could do so much more.”

At Ohio State, where some mentally ill patients were waiting days in the emergency department for a bed, the hospital opened a new unit in 2013 for patients in mental-health crisis.

The Crisis Assistance Linkage and Management unit, known as the CALM unit, is quieter than an emergency department and smaller than a psychiatric hospital. About 150 patients a month receive intensive therapy there for one or two days before they are linked to therapists in the community. It’s an innovative approach for the region, one that experts say works.

It has eight beds.

My beloved Amy: She had a chemical brain issue with psychological symptoms, and it comes whenever. They (medical professionals) numbered her when she wasn’t meant to be numbered. She was anxious — afraid — dark. The (prescribed drugs) she was taking weren’t good for her brain. Funny — side effects of it all are suicidal thoughts/actions — that awful brain issue. — Jill Feather, a few weeks after Amy’s death

On the evening of Sept. 25, Amy attended a support group meeting for those living with bipolar disorder. The two women there offered little hope.

They spoke of their struggle with medications and the side effects. One talked about how often she had to be hospitalized after suicide attempts.
They told Amy not to expect life to get much better.

The timing couldn’t have been worse. In previous weeks, Amy had stopped taking her medication consistently and was feeling more anxious. She couldn’t find the energy to sing or write songs. She told one of her two brothers that she didn’t like music anymore, piercing the hope he had for his sister.

But Amy reassured her family that night. She told them she thought she would be able to live with the illness as long as she took her meds and continued with private counseling.

And so, on the morning of Sept. 26, Feather woke to a renewed faith. Amy would overcome her disorder. Amy would rediscover the joy she had lost.

Mother and daughter shared oatmeal and coffee as they drew up a grocery list. Amy seemed happy, at peace with the challenges that lay ahead. Feather left for work. It was the first time since that ride home from Michigan that she felt comfortable leaving Amy alone.

When she returned home later that day, the grocery list was still on the table.

She found her daughter lying on her bedroom floor.

Amy left a note that Feather sometimes carries in her pocket. Her tears have smudged its green ink.

“Again I find myself swallowed up,” it says. “I can no longer fight against myself and these feelings that overtake me. I am not strong enough. I’m sorry for how this will affect everyone. You have done everything you could. Please forgive me for my extreme selfishness. I just couldn’t handle things as they are. I am very sorry.”

Feather doesn’t blame the mental-health-care system for her daughter’s death. She doesn’t place fault with the psychiatrist who dismissed Amy’s plea to switch medications or the women who told her that life wouldn’t get better.

But she wonders whether everyone, including herself, could have done a little more to combat the mental illness that Amy, in one of her songs, called the “poison within me.”

*It is a physical illness with psychological symptoms. Amy was my much loved child. She had an illness. She had Bipolar. I can’t stand to think she will be called Amy is Bipolar. Nobody would say your child was cancer right? She was just Amy, and she had a disorder.*
Missed signs: Many factors contribute to thoughts of suicide

By Lori Kurtzman, Jill Riepenhoff & Mike Wagner The Columbus Dispatch • Thursday November 19, 2015 4:38 AM

Dale Earl left behind a hasty note, a length of chicken scratch his stunned family struggled to decipher.

Dale was in pain; that much was clear. He believed that he was doing poorly at work, that he was too heavy, too much in debt. The jovial 44-year-old who called everyone “buddy” had been planning to kill himself for six months, but something held him back.

“Waited until Goose’s legs were better,” Dale wrote before he shot himself in his Galloway home.

The human mind is infinitely complex. It is layer upon layer of thought and emotion and sensation, an intricate, bewildering web that allows one to simultaneously plan a suicide and that evening’s dinner.

It lets a woman finish out a day at work before she goes home to end her life. It lets a man on a business trip tell his family that he will call them the next day before he hangs up the phone and ensures that never will happen.

It lets Dale Earl, suffering through a deep despair he never talked about, surrender to hopelessness while still worrying about his beloved dog, Goose.

Suicide is just as complex. It goes against every natural flinch and brace, every instinct we have to stay alive. Even suicidal people don’t want to die, not totally.

In the mental-health community, everyone knows the true story of the survivor who leapt from the Golden Gate Bridge and realized, as the water rushed toward him, that he had made a huge mistake.

And so all of this — the conflicting thoughts, the ambivalence in the moment, the missed signs — makes it a challenge to fully understand and prevent suicide. It’s one problem that experts haven’t solved and that society hasn’t accepted, at least not yet.

“If you look at our society’s level of knowledge of mental health, it’s been very, very low — bordering on illiterate for many people,” said Christine Moutier, chief medical officer for the American Foundation for Suicide Prevention.

But that could be changing. Increased research and mental-health awareness over the past decade have forged new ways of identifying those who are or could be suicidal.

It isn’t complicated: What the experts know now can easily be digested and practiced by people who understand nothing more than their own humanity. This information could save lives.

While you can’t predict who is going to kill themselves, you can predict who might.

Dr. Natalie Lester prefers to write these things out, and so she heads to the dry-erase board, marker in hand. Before long, Lester, director of psychiatric emergency services at Ohio State University’s Wexner Medical Center, has sketched out a diagram of pain, the factors that are often in play in most suicides.
Mental illness.

It starts here. This is arguably the most important factor in suicides. Studies have shown that 9 out of 10 people who kill themselves had experienced some form of it at the time of their death. That includes anything from depression and anxiety disorders to schizophrenia and bipolar disorder.

The problem is that mental illness isn’t always readily apparent. Many times, it’s uncovered during psychological autopsies, after the person is already dead. Family members who swear this came out of nowhere look back and discover signs that they had missed.

That doesn’t mean they’re to blame. Moutier uses the word cloaking. Some people who are bogged down in depression, riddled with anxiety or addicted beyond their control don’t want others to know about it.

“It’s not our natural instinct as strong, smart, high-functioning people to say, ‘I need help — something’s changing and I need to look into this,’ ” Moutier said.

Take Dale Earl. He didn’t talk to a doctor. He didn’t even talk to his family about his problems. Dale was the kind of guy who plastered himself in duct tape for a Halloween party, who skied down snowy Vermont slopes wearing a giant orange-foam cowboy hat. If anyone was laughing through life, it was this guy, with his booming voice and endless one-liners.

“I don’t know who the hell that is,” he would mutter to his brother, before calling to the person who had recognized him: “Hi, buddy!”

And then he died, and it was clear something had been wrong. Thinking back, his nephew recognized in Dale the same isolating depression he had once suffered. He worried that he had failed his uncle. A lot of people did.

“I did not know who the hell that is,” said Dale’s brother, Dennis. “And I knew him well.”

Whitney Saleski didn’t know her father was suffering, either. Stan Saleski, a well-liked scout for the San Francisco Giants, killed himself while scouting in Baltimore last year. He was 59 and successful and beloved.

They spoke to him that night, Saleski and her mom, from their home in Oakwood, a Dayton suburb. Stan said he was headed to Kansas City the next day. It was Saturday, and they told him they loved him. They had done this for years.

When police called the next day, it seemed like a cruel joke. Saleski ran from her home and fell in front of a neighbor, screaming over the whine of his leaf blower. “HE’S DEAD!” she cried. “He’s dead.”

The idea that Stan had done this to himself was so foreign that Saleski and her mother first concocted elaborate theories about how he had been murdered. A lot of survivors do this. Police assured them that it was impossible.

Saleski dug through her father’s Internet-browser history, looking for any sign of his final thoughts. He had last searched for animals, for sports, for the weather.

“The core thing about him was his way of making you feel you knew everything about him,” Saleski said. “But you didn’t.”
Mental illness, though it may be the biggest underlying factor in suicide, isn’t the only one. The notes on Lester’s board continue.

**Chronic physical illness. Chronic pain.**

*The Dispatch* reviewed more than 1,500 cases from coroners’ offices around Ohio. Among the cases were those of an HIV-positive man, a man suffering from psoriasis and several people who were paralyzed or diagnosed with terminal cancer. A woman killed herself after she was hit by a bus and became addicted to pain pills. A man at the end stages of Parkinson’s disease scheduled his suicide around a family event and had his wife help him write his farewell note.

**Suicide in the family.**

Several cases involved siblings who had killed themselves. One man killed himself the day before the two-year anniversary of his father’s suicide. Another woman shot herself in the woods just as her father had done.

There are also certain demographics that place people in higher-risk groups: Male. Caucasian. Elderly. Single. Kids who are gay or transgender.

Though women attempt it three times as often, four times as many men actually die by suicide. Men tend to gravitate toward more lethal means.

Of course, most people fitting these categories never even consider suicide. And rarely are such predisposing factors the sole reason people kill themselves. Suicide isn’t that simple.

Lester moves on to another category: **Precipitating factors.** These change. These can be fixed or treated or end up not as bad as they seem.

They can also pile on a person who already is vulnerable. This is where mental-health professionals and friends and family can take note and try to intervene.

The factors include panic attacks and alcohol abuse, pain, insomnia, loss of a job, loss of a home, loss of a relationship. They include access to lethal means: Is there a gun in the home? A tall bridge nearby? Readily available pills?

Precipitating factors played into a lot of cases *The Dispatch* reviewed. In one, a Licking County man left behind a briefcase full of past-due notices and a note saying that he was tired of failing. “I guess I am ending it, ’cause I can’t look myself in the mirror anymore,” he wrote.

In another, a woman in Montgomery County hanged herself after a depression so lengthy that her son had come to accept that she would eventually die by suicide. In her note, she wrote that she was sorry that she had to die, but that no one would give her a job and she could not tolerate further sleepless nights.

Yet another case saw a teenager kill himself after he got an erection in school and a teacher called to notify his mother. Experts, though, caution not to pin a suicide on one cause, and this case shows why: The boy had attempted suicide the year before.

There is something else to note: The suicidal mind is a liar. It convinces its victims that the world is better off without them, no matter the evidence to the contrary.

It lied to Dale Earl, who believed that his debt was insurmountable — it wasn’t — and that he was
failing at work. In fact, his co-workers were the people who found him. They burst into his home after he didn’t show up, because Dale always came to work.

“The mind of the distressed suicidal person becomes more and more distorted in their logic and much more narrowed and tunnel vision,” Moutier said.

Those in the throes of suicidal thinking report feelings of worthlessness, of hopelessness. And while some, like Dale Earl and Stan Saleski, keep that pain to themselves, others seem to be screaming for someone to notice.

One case that The Dispatch reviewed detailed the heart-wrenching demise of a woman who gave away some of her belongings at work and told her co-workers to “remember, I will always love you.”

She didn’t show up for work the next day. Or the next day. The following day, a co-worker finally called police. An officer found the woman at her home, dying of a drug overdose. She told him that she hated herself and had swallowed all of the pills she had in her house. She spent several days vomiting.

In his report, the officer seemed relieved to have found her in time. He grabbed her cellphone and wallet so that she would have them at the hospital. She died within a week.

There are plenty of cases like that in local coroners’ records. Missed signs. Cries for help.

At least a quarter of those who killed themselves had said that they wanted to die. At least 12 percent had made previous attempts.

In the hours leading up to their deaths, at least 11 percent told someone of their plans. And at least 3 percent gave explicit warning signs — they gave away possessions, told loved ones where to find important papers or asked for a gun.

“Believe it or not, human behavior is incredibly predictable. The average person does actually notice these things,” Moutier said. “Most people, actually, their gut says, ‘Huh, something’s funny there.’ ”

Moutier said that people tend to ignore those gut feelings. They don’t want to interfere, or they’re afraid to offend. But she said people are remarkably willing to open up about their difficulties, if only they’re asked.

“I’ve had this conversation thousands of time with the most high-level professional people,” Moutier said. “One in probably a thousand didn’t want to talk about it. Every other person was like an open book.”

Of course, the conversation is only the start. Sometimes it’s enough to give someone pause, but sometimes they need more. Just as talk doesn’t shrink a tumor, it’s often not all that’s needed to treat a serious mental illness.

Erica Rogers knew what she was up against and still couldn’t save her 23-year-old boyfriend, whom she asked not be named. He suffered from schizoaffective disorder and could never find the right medications to stop the voices in his head. He couldn’t hold a job, couldn’t trust the world around him.

He was just a kid when he started trying to end his life. He would take pills and carve long grooves into his arms.

“She just felt like he didn’t belong,” Rogers said. “He felt like something wasn’t right.”
He called one day nearly five years ago to let her know that he had taken enough pills to blunt his fear of drowning. He was standing atop a Columbus bridge. If she got there in time, he said, she could say goodbye.

Rogers pedaled her bike furiously down Riverside Drive. She was too late.

“I don’t blame him,” said Rogers, now 27 and a social worker. “But ... where it ends like that and you see somebody try to get the help they need and can’t — it’s painful.”

It seemed that no one could save Shawn Keyes, either. He had attempted suicide 53 times in nine years, according to coroners’ records, before he killed himself in 2012. He was 48.

Marcus Keyes, 33, was never close to his father. His mother kept him and his brother shielded from Shawn and his problems. Keyes knew only that his dad had served in the military and picked up occasional odd jobs. He also knew that Shawn was a crack addict who seemed depressed most of the time.

“He tried to have, like, an all-right face on, but you could tell that something was always bothering him,” Keyes said. “I tried to get him to come to church with us, but he just didn’t want the help.”

After his father died, Keyes learned about the multiple attempts. He felt guilty, but also angry. His father didn’t leave a note, didn’t explain the desire to take his own life. It was a gesture Keyes has never understood.

“I’ve never even contemplated it. There’s too many people depending on me,” Keyes said. “Honestly, and the nicest way I can put it: He took the easy way out.”

Lester’s board has one last category: **Protective factors.**

These are the things that keep people alive. They’re missing in a lot of suicide cases.


Experts include lack of access to lethal means in this category as well — a suicidal person with a gun is at much greater risk than one without.

Moutier said these mitigating factors might be enough to keep afloat someone who is depressed and losing hope.

“But a person with the same mental-health condition who has not made contact with any health care, who copes with alcohol, (who is) in a firearm-owning family ... they begin to really focus on escaping their pain,” she said.

Research into these protective factors is lacking, but experts say they’re important all the same. They also make sense. A person who feels they have something to live for might choose to do so.

“Suicide is almost always ambivalent,” Lester says — that is, as much as someone wants to kill himself, there’s usually a part of him that desperately does not want to.
Second chances: Many who attempt suicide can be stopped

By Lori Kurtzman, Jill Riepenhoff & Mike Wagner The Columbus Dispatch • Friday November 20, 2015 5:36 AM

Richard Miller grabbed a loaded gun and headed to the river near his parents’ house. He was going to die. This time, there was no doubt.

“I knew I would pull the trigger,” he said. “I was done.”

It would be the end of a life of pain, of violence and molestation, of drugs and prostitution, of a troubled kid set loose on the streets at 14. Miller the boy wanted a hug. Instead, he got thrown through a wall.

Cory Dobbelaere’s world was about to collapse, and he saw no other way out. He swallowed every pill he could find.

He had grown up the golden child, wealthier than his classmates, success chasing him like a puppy. He was depressed by age 7, though he didn’t know it at the time. Bipolar disorder sent him soaring and crashing for years.

His business, a travel agency he had opened in his hometown, was about to implode. He owed a lot of people a lot of money.

Soon, everyone would know that he had failed.

Mary Brennen-Hofmann couldn’t sleep. She wandered the convent while the other sisters slumbered. She barely felt human anymore.

The young woman was sent to counseling, where she would cry through an entire session. When she admitted she was thinking of killing herself, the counselor called her selfish.

She made up her mind one November night.

“I decided this was it,” she said. “I can’t go on anymore.”

About suicide, people say:

We never saw it coming.

Nothing could stop him.

She was going to do it eventually.

Talking about it makes it worse.

With few exceptions, none of that is true.

Suicidal people don’t have to die. Most, in fact, don’t. And of those who attempt it and survive, 9 out of 10 ultimately won’t die by suicide.

They can be stopped, too. Sometimes, thwarting an attempt is as simple as hiding a gun or changing
the way potentially lethal medicine is packaged.

And talking about it actually can prevent it. Experts say suicide needs to be discussed more, especially between doctors and patients. Even if it’s uncomfortable. Even if no one sees it coming.

“If you’re afraid to ask,” said Dr. Natalie Lester, director of psychiatric emergency services at Ohio State University’s Wexner Medical Center, “then a patient who may really want somebody to help them is sort of a lost opportunity.”

The fact is, millions of Americans think about killing themselves each year.

While the numbers are far from exact, the Centers for Disease Control and Prevention estimates that nearly 4 percent of the adult population reported having suicidal thoughts in 2013, the most recent year for which such information is available. Seventeen percent of high-school students said they’d seriously considered it as well.

For many, it never went beyond thoughts.

But plenty did try — about 1.3 million adults, the CDC estimates. But again, that’s only a best guess. That would make about 32 attempts for every completed suicide in 2013. Nearly half a million adults ended up in an emergency department that year with self-inflicted injuries.

It is impossible to generalize suicide attempts. No two are alike. Some are carefully planned, while some are rash. Some are desperate cries for help, while some leave no room for survival.

Where they intersect is a chasm of hopelessness and pain, a low that drove their victim to the unthinkable. Experts are only beginning to understand the nuances of suicide attempts, but they say much of what the public thinks it knows about the subject is wrong.

Richard Miller is a whip of a man, thin and buzzing with energy. He sits down in a busy New Philadelphia coffee shop, eager to tell his story. Like many who have crawled their way back from near death, he has become an evangelist for survival.

He just turned 47.

“It’s nice to have birthdays,” he says.

He was born in Michigan to alcoholic parents. Home was chaotic, violent. He learned to take a beating before he learned how to read.

“You’re talking a 3-, 4-, 5-year-old that gets thrown through a wall because I wasn’t going to my room fast enough,” he says. “That’s the kind of affection that I got.”

He was 5 when his mom remarried, when his family blended into another, with seven kids in all. Nothing got better. Two of his stepbrothers began molesting him almost immediately, he said.

Miller got into trouble, a lot of it. He skipped school, dabbled in drugs, stole a car. He was 14 when his parents told him to get out.

“All this time, all I was looking for was love,” he said, “and what I got was rejection.”

Miller ended up on the streets, a young prostitute finding solace in a bottle. Drugs and alcohol dulled
the pain. They made life bearable, for a while.

At 18, he was living in Virginia Beach with an older man who paid for his drugs and his clothes. One night, he loaded a .22-caliber rifle and put it to his chin. He felt sorry for himself. He pulled the trigger.

The bullet careened to the left and shattered his jaw. Doctors saved him. He awoke tethered by tubes to a hospital bed. His eyes filled with tears.

He was alive and hated it.

Here’s another thing people get wrong about suicide: It tends to be an impulsive act.

It might not always seem like it, not after someone has spent days or even years thinking about it, after they have arranged wills and written lengthy notes and designated who gets what jewelry. But the decision to end it all — to really go for it — is relatively quick.

A 2007 study found that 1 in 4 attempters took less than five minutes to think about it. Nearly half took less than 20 minutes.

That means the suicidal moment can pass. The crisis can subside and the person can live.

Especially if someone has made it hard to die.

Really want to protect someone who might be suicidal?

Take away their guns.

Guns are responsible for more suicides than any other method. They’re involved in more than half of such deaths. That’s because guns are really effective at killing people.

*The Dispatch*’s review of coroners’ records found that plenty of people suffering from severe mental illness had easy access to guns: a man with schizophrenia who felt demons were after him; an Air Force veteran suffering from PTSD and a host of personal problems; a woman who heard voices telling her to shoot herself and her young son until she ultimately did.

A study by the Harvard School of Public Health found that suicide rates were higher in states with higher gun ownership. The reverse was true as well — fewer guns, fewer completed suicides.

Taking away guns isn’t the only thing that works. Bridge barriers successfully block jumpers. Newer cars discourage carbon monoxide deaths. And a change in medicine packaging slows suicidal overdoses.

A British study found that overdose deaths of paracetamol, the active ingredient in Tylenol, dropped by 43 percent after legislation there shrunk over-the-counter packs to 16 pills.

When the government made it harder to overdose, people simply didn’t.

Cory Dobelaere grew up in rural northwestern Ohio, in a home nothing like Richard Miller’s. His parents, an educator and a farmer, loved him, encouraged him. They had no idea what was going on inside his mind.
Dobbelaere has striking blue eyes and a quick smile. He is 44. It hasn’t been easy regaining that smile.

He tells of a charmed, ambitious life that skidded out of control in 1999, when he bankrupted his travel business in Paulding County by sending clients on far more extravagant vacations than they had purchased. He was borrowing the money from future trips and could no longer keep up.

“I was so depleted and wanted to die,” he says, and so he tried to do just that. “I was truly livid that I woke up.”

He was hospitalized for months after his first suicide attempt. He underwent intensive testing, and doctors diagnosed him with bipolar disorder. The implication that he was mentally ill enraged him. It also was a relief.

It explained so much — how he could feel so high, and then so low.

“It’s certainly not the life that I chose,” he says.

Dobbelaere ended up going to prison for theft from his travel-agency clients. It was a nightmare for him. He says he was raped repeatedly by other inmates, and that a psychologist scoffed at his pain: Poor little rich kid doesn’t like prison.

Five years after his release, the charmed kid was homeless, walking aimlessly until his shins screamed. He spent three years on the streets in Cleveland and Detroit and ended up in jail again, where his estranged parents picked him up.

He weighed 118 pounds, his flesh clinging to his bones. His mental illness finally looked like a physical one. His father and mother, who had gone into debt to repay his victims, finally seemed to understand.

“It shocked my parents,” he says. “Something snapped in them.”

A suicide attempt tends to draw immediate concern, a flood of attention. But considering that most people who die by suicide do so on their first try, focusing only on attempters ignores a huge group that needs help.

Experts say that a key to thwarting suicide is to catch the early signs, long before an attempt. And so efforts are underway to screen patients for suicidal thoughts even if they visit a doctor for, say, a sore elbow.

A few years ago, Ohio State was part of an eight-hospital national study in which emergency departments screened patients for suicide risk. Nearly every patient — no matter their reason for showing up to the emergency room — was asked whether they felt depressed, whether they’d had recent thoughts about suicide, and whether they had attempted it in the past.

The results surprised even the researchers.

The emergency departments were able to detect a suicide risk in nearly 6 percent of their patients, double what they detected without asking the extra questions.

At Ohio State, nurses were identifying several depressed or suicidal people each day, said Dr. Jeffrey Caterino, vice chairman of research for the Ohio State Department of Emergency Medicine. Those patients weren’t otherwise telling doctors that they were in trouble.
In one case, a man showed up at Ohio State’s University Hospital East with a cough and a sore throat. When asked the screening questions, he acknowledged that he was having suicidal thoughts. He had been for a while.

Doctors referred him to a specialized unit inside Harding Hospital that offers quick, intensive treatment for patients in crisis. The man said those questions might have saved his life.

While Ohio State’s portion of the study ended nearly two years ago, it changed the approach in the emergency department, Caterino said. Nurses there continue to screen patients.

“A lot of times, we’re the only contact people have with the health-care system,” Caterino said. “We may be the only people who ask that question.”

The Ohio Department of Mental Health & Addiction Services is trying to expand that web of so-called gatekeepers, too. Over the next year and a half, it plans to hold six training events for health-care professionals to teach them how to screen, assess and seek treatment for at-risk patients.

It’s the first time the agency has been able to do that. State money earmarked for suicide prevention made it possible.

“When you are depressed and you walk down a hallway at work, you are wanting the patches of fluorescent light shining off the floor to just swallow you up, so you sink into unreality and no one will even know you are gone because you are nothing.”

This is how Mary Brennen-Hofmann’s mind sometimes works. She has lived with major depressive disorder for years. And this is how she was feeling 30 years ago at the convent. Like something was crushing her. Like her limbs were encased in cement.

Brennen-Hofmann grew up a good Catholic girl in Clintonville. The family was big and the church was across the street. She had no plans to become a nun, but then she became one, and she found herself living very uncomfortably at a St. Louis convent.

“I felt like I couldn’t do anything right,” she says.

She’s sitting in her office at North Central Mental Health Services in the Short North, where she is the coordinator of suicide prevention services. Another survival evangelist.

Back at the convent, Brennen-Hofmann struggled to get out of bed. Even her toothbrush was too heavy. She had been moody in high school, but this was a low she had never experienced.

It lasted nearly a year.

Nov. 13, 1985, was the day she decided to die. She swallowed a bottle of pills. Her immediate relief turned to worry. What if it wasn’t enough? She stole the convent car, drove it onto the freeway and steered straight into a guardrail.

Like the others, she awoke in a hospital. Unlike the others, she felt instant regret.

“I realized this probably was not a good idea after all,” she says. “I didn’t really want to die.”

She moved forward, quit the convent. She married and had two beautiful daughters and backpacked
across the country. She got involved in helping to save people just like her.

She lived because she didn’t die. She survives because she found reason to keep going.

There’s no single way to manage suicidal feelings, to stay alive no matter that nagging sadness. Medication helps a lot of people. So does therapy. But those who suffer typically need a wider system of support.

Mental-health professionals are trying. They’ve developed smart-phone apps that help patients identify their feelings and seek help, and have expanded some phone crisis lines to accept text messaging. Some universities have erected kiosks that allow students to screen themselves for mental-health issues.

Brennen-Hofmann keeps a piece of paper in her purse, a single sheet folded so often that it’s as soft as a tissue. It’s the safety plan she has developed, a form that outlines her warning signs, her coping strategies, the phone numbers she can call for help. She looks at it when she’s feeling down. At the bottom of the paper are some reasons to live: her daughters, her husband, her puppy named Fish.

“It kind of centers me — it’s like, OK, wait a minute, it’s not as bad as it feels,” she said. “It’s kind of some rational thinking that you can hold in your hand when you’re not feeling rational.”

Dobbelaere, who wrote a book on mental illness and has spoken to groups across the country, has a wide network of friends who text and call and make a meaningful fuss at the first sign of danger. They have reason to worry: Not long ago, he got off a plane during a layover in Chicago and disappeared into the city, looking for a tall building.

“But because he seems fine,” said his mom, Kris Dobbelaere, “doesn’t mean he is.”

As for Miller, he has learned to accept his pain. It’s a part of him, like his eyes and his laugh. It’s been there even as he has returned to school and reunited with his family and launched a recovery program for others who are suffering.

It doesn’t go away just because he wants it to.

Over the years, he has made more than a dozen serious attempts on his life. When he wasn’t actively trying to harm himself, he was doing it passively through reckless behavior, on a mission to die despite everything life had given him: a wife, two kids, so many chances.

He and his wife separated in 2009. He fled to his parents’ house in Michigan and one low night, he headed to the riverbank to end things for good. The .38 was loaded. All he had to do was pull the trigger.

Except that he didn’t. He has no idea what stopped him. He walked back inside and picked up the phone.

Richard Miller called for help.

*If you are having thoughts of suicide, call the Franklin County suicide-prevention hotline at 614-221-5445, or the national hotline at 1-800-273-8255.*
Suicide survivors share their letters to the departed

By Mike Wagner, Lori Kurtzman & Jill Riepenhoff The Columbus Dispatch • Saturday November 21, 2015 5:34 AM

Suicide destroys more than its victim.

It rips into the lives of those left behind. Families, friends and witnesses agonize over questions that have no answers.

Some blame themselves. Some wrestle with what more they could have done. Most struggle to move on.

This year, an estimated 250,000 people will become survivors of suicide because a loved one died.

Today marks a worldwide event in which suicide survivors gather to share their stories of healing. International Survivor of Suicide Loss Day was inspired by U.S. Sen. Harry Reid, whose father, Harry, died in 1972.

While examining suicide’s devastating toll in Ohio, The Dispatch reviewed more than 1,500 coroners’ cases and interviewed dozens of survivors and bystanders.

Some shared their stories of loss and what they wished the victims had known before they took their lives. Working with the survivors, The Dispatch turned their thoughts into letters to those who died.

Timothy Mayle was diagnosed with cancer in September of 2013. With his wife, Debbie, by his side, he fought the disease with chemotherapy and other treatments. But the cancer spread from his spleen to other organs, and he was told he had two months to live. In March of 2014, upon returning from the Cleveland Clinic to his house in Geneva, in Ashtabula County, the 48-year-old attorney shot himself in front of two of his four children — Shay 25, and Zach, 11. His other two children, Lindsey, 17, and Alexis, 13, were not home at the time.

Dear Tim,

The cancer is what took you. It ate away your insides and turned you into someone we didn’t recognize. And it was so cruel for all of us, because for months, the doctors kept saying, “This is treatable. You are going to be okay.”

Then after months of chemo and all that pain, they tell us you’d have two months to live.

I’ve replayed that last night in the hospital over and over. When you called me to come get you, I knew you were in such pain. I could hear it in your voice. I can’t believe they listened to you and took you off your pain medication and steroids. Why would they do that? What were they thinking?

I can’t believe how much pain you were in when I got there. The pain had taken over your mind, and you weren’t you.

On the way home from the hospital, I could hear you moaning in the back seat.

I left for the pharmacy thinking that you would just stay in bed until I got back with your
prescription. And then I got the call from Shay. She was screaming and crying, saying that you shot yourself in the backyard. That she and Zach begged and pleaded for you not to do it.

The kids watched you, Tim. They watched from the kitchen window.

You were the best father any child ever could have had. No parent has ever devoted more to his kids. Basketball wasn’t your life all those years; it was just how you shared your love with the kids. You never missed a game as a coach or dad.

And I know that wasn’t you with the gun. But our kids witnessed that, Tim. They had prepared for you to die because you were so sick, but not like that. Both of them would be diagnosed with PTSD.

I was so angry at you for the longest time.

You were still alive when I got there. I still have visions of giving you CPR, putting my fingers over the hole in your chest and you taking your last breath.

For the first couple of weeks afterward, the kids and I slept together as a family in the living room, because no one wanted to be alone.

The counseling helped some, but the kids really struggled. I would hold Zach at night until he fell asleep. He blames himself. He thinks he should have been able to stop you.

He just wants to go play ball with his daddy or have you in the stands for his games.

Shay was so angry. She is playing professional basketball in Germany now, and you would be so proud of her. She knows she wouldn’t have played at Duke without you. She wouldn’t have made it to where she is without you.

All four of the kids just miss you so much.

You gave up your career to stay home and take care of our kids. You cleaned the house, did the laundry, fixed the cars and took care of our lives.

Everything changed here when you died.

Now, I have long days teaching at school and taking care of the kids. They have learned how much you did, because they have to do a lot more now.

I miss you, too, and I’m thankful for all the good you brought to my life.

I feel like I have to do more to help stop suicide. Just recently, a boy I had in class, a 16-year-old football player, killed himself. It just devastated our community. Last year, a girl approached me at school and told me she thought of killing herself. I got her some help, and I want to help others so they don’t go through anything like this. I’m sure the Tim I knew, the real one, not the one the cancer took, would want the same.

Love,

Debbie

Donna Jackson, 55, of Middletown, in southwestern Ohio, suffered from high blood pressure and
heart problems in the summer of 2011 and went into a coma for weeks. Doctors weren’t sure she would survive. Her twin sons, Meshach and Shadrach, were devastated. When Jackson awoke, she learned that Meshach, 19, had taken his life.

Dear Meshach,

I can’t believe it will be almost five years since I lost you. Since we all lost you.

I knew something was wrong the moment I woke up from the coma. I still don’t know how long I was out. Two or three weeks; I just don’t remember.

I went walking down the hallway asking where my family was and asking the nurses if anyone had called.

And then I found your brother, and he read me a passage from the Bible. He led me into that room where our family and friends were waiting with the pastor, and they told me you were gone.

I couldn’t believe it. I still can’t believe it.

They told me you prayed over me in that hospital room over and over, night after night. I think a lot of people thought I was going to die. Did you think that? Is that why you did this? It’s the only reason any of us could think you would want to leave us.

I don’t know. Only God knows.

I try hard to think about the good and not the bad.

I remember when you and Shadrach, my little toddler twins, got into the cupboards and poured salt and pepper, honey, flour, sugar and all that stuff on top of one another. And you guys were just laughing and laughing when I was giving you a bath. Or when you guys were playing high-school ball together and you threw him the alley-oop and he did a one-hand dunk, and the whole gym went crazy. Or the time you made the half-court shot just before the buzzer.

You and your brother were so good at basketball. I loved watching you play all those years.

And you were doing so good at college, and I was so proud of you boys always getting good grades. I was nervous about you going to the Air Force, but I was proud of that, too.

You were so happy the last day I saw you, and you were getting ready to go to Texas for your training. You were so handsome, and I know you would have looked so nice in that blue uniform.

I try to visit the cemetery, but that’s so hard. I was still in the hospital the day of your funeral. The doctors let me go to the church and the memorial, but they wouldn’t let me get out of the car at the cemetery.

People were being nosy and asking all kinds of questions back then. They still do sometimes. I try to answer them, but I don’t know what to say. Their hearts were in the right place. They had a candlelight vigil for you at the high school, and people still tell me what a nice boy you were.

I’m doing OK, but I have to go see doctors all the time for my heart and my blood pressure.

Your brother misses you so much. He lives in Arizona, and we both just take it one day at a time.

Sometimes I wish I had never come out of the coma.
I go to the support groups, because talking about you helps. They call me a survivor. I'm not sure what that really means. There are plenty of days I don't feel like one. I'm just your mama. And you will always be my baby boy.

It’s so hard, but God doesn't make mistakes. All we can do is hold on to each other.

Love,

Your Mama

Hilliard resident Jeff Russell, 60, was at Griggs Reservoir Park near Upper Arlington in August 2014 when a 60-year-old Columbus woman drove her car off Riverside Drive and into the Scioto River. Russell tried to save her. Authorities ruled her death a suicide. (Her family was comfortable with Russell sharing his story but asked that their loved one not be named.)

To the woman I tried to save,

When I saw the car come off Riverside Drive onto the grass and head toward the river, I thought it was kids messing around. I thought for sure the car was going to veer off. But it just kept going.

And somehow, the car made it through the one narrow opening among all the trees and went airborne into the river. It never slowed down, and I never saw brake lights.

I'm a caregiver for elderly people, and that day, I was there to take a 100-year-old woman for a drive. I told her to stay in the car. Then I ran more than 100 yards down to the river and yelled to a man bicycling on the trail to call 911.

I was going to dive, but I saw the rocks and had to wade in before I jumped into the deeper water.

The car had started to sink, but I pounded on the window and managed to get your attention. You cracked the window but said nothing. We made eye contact for a couple seconds, but then you turned and looked straight ahead. You didn’t show emotion. You never spoke a word to me.

I didn’t understand what was happening. You were just holding on to something with a tapestry on it, and you stayed focused on that. I thought maybe I could break the back window and pull you out, but I didn’t have a rock or anything. I never got the feeling that you wanted to be saved.

Then the car went underneath the water. I just kept diving down. Over and over.

I was hoping that you had gotten out, or that there was an air pocket. I saw a policeman in the water with me, and later I learned a third person jumped in, too. I treader water with the policeman until the emergency vehicles arrived, and then I climbed back onto the rocks to wonder what had just happened.

I was upset with myself for not being able to do more. I thought I should have been able to get you out. I didn’t want to talk to the reporters there, and the police officer tried his best to comfort me and make me feel better.

The police and firefighters gave me a bravery award, but I was far more concerned about your family. I couldn’t imagine what they were going through.
When I heard it was ruled a suicide, I didn’t know what to think. I thought maybe it wasn’t that. Maybe you were just in shock or something. But you didn’t look like you wanted help.

I didn’t know what was wrong or why you drove into the river that day, but I’ve thought about that day so much. I went back to that spot by the river the next day and saw the tire tracks. They stayed there for about three weeks. I went down there maybe a dozen more times after it happened. I’m not sure why. Maybe I wanted some kind of closure.

I recently met with your family after they reached out to me. It was a good meeting. I think it helped them, and I know it helped me.

I don’t dwell on it, but I was depressed for a while.

Every time I drive by the river, I think about what happened. I think about you.

I’m a Christian, and I can only hope that you found peace.

Sincerely,

Jeff

In March 2010, Ohio State University custodian Nathaniel Brown, 50, of Columbus, walked into the OSU mechanical building, shooting and injuring one boss and then killing supervisor Larry Wallington before taking his own life. The murder-suicide left many people reeling, including Brown’s common-law wife, Donna Dunson, and Wallington’s mother, Shirley, both of Columbus.

Dear Nate,

I couldn’t take it anymore, Nate. That’s why I left you a few days before you did what you did.

You weren’t a monster or a bad man like the news made you out to be, but you had a dark side. I felt that dark side too many times over our 30 years together. And that last time, when you left the scar on my face — well, it was too much for me.

You had two personalities. One was very sweet and kind. You were the kind of man who would do anything to help people out. You made the best barbecue I ever tasted, and we had so many good times.

But the other Nate was just so angry.

I know it was that side of you that came out that day at Ohio State.

I know you felt you weren’t treated right, but you shouldn’t have gotten guns and did what you did. I think you just snapped. I think you needed help, Nate, and if you had gotten it, a lot of things would have been different.

I know it was hard for you as a kid. Those other boys who were supposed to be like your brothers beat you all the time. And that man who was supposed to be like a father to you was just mean. I think that’s where you got all that anger.

I feel bad for the families of those other men. I’m sorry for the pain you caused them, and I wish we could have found a way to make you better before it came to this.
I was devastated. I still am. I can’t believe it all ended like this. I will always love you.

Love,

Donna

**To the man who shot my son,**

I used to call you the devil. I used to say the devil killed my son. You did kill him.

I was in shock and disbelief when my oldest grandson called to tell me what had happened. You hear about these murder-suicides on the news all the time, but you don’t understand it until something like this happens to you.

At first, I thought it was a straight murder, but when I heard it was a suicide, too, it changed my attitude.

I hear all these stories about people having tough upbringings, and that’s why they do bad things. I don’t buy that. We all have to take responsibility for our actions. But I’ll admit some of the anger went away and my feelings turned into sadness for everyone.

I didn’t have much of a relationship with my son anymore, but we had recently had a breakthrough. We made plans for him to come over that weekend and straighten things out between us. I thought it was going to be a new start for us.

Instead, I had to bury my son. I never got a chance to tell him I was sorry. Or that I loved him no matter what.

I feel bad for your family and your wife. And I would tell them that I forgive you.

Life is too short to be walking around with all that anger.

Rest in Peace,

Shirley
Some survivors cope with loss by helping others affected by suicide

By Mike Wagner, Lori Kurtzman & Jill Riepenhoff The Columbus Dispatch • Sunday November 22, 2015 7:44 AM

Before they began healing others, they had to escape their own despair.

Jeff Cooper sat alone on Christmas Eve, glancing between the gun on the table and a photo of all he had lost. Divorce was taking his wife and five-bedroom home, and suicide had claimed his son about two years earlier.

Joe Ward stood next to the railroad tracks in the middle of the night on the second anniversary of his son’s suicide. He video recorded the train as it raced by, wanting to feel what his son did.

Marilyn Phelps pulled down her Halloween decorations hours after her son shot himself. There was nothing to celebrate.

Rick Baumann looked around at the smiling faces during a family birthday party and sobbed, thinking only of the one who wasn’t there.

Every one of them could have given up. They could have sunk deeper into their anguish. They could have allowed their hopelessness to consume them. But they didn’t.

As time healed their pain, despair turned to determination. Over the years, they have helped hundreds of people who suffered as they did.

“All we can do is accept this loss without ever understanding it, and lean on one another to move forward,” said Mary Ann Ward, a suicide-prevention advocate who leads support groups. “I can give hope to those who are newer than I. From the pain, we can grow in knowledge and wisdom, and experience joy again.”

If not for the devotion of such advocates, countless others could have died, too. Here are the stories of a few they helped save.

Lifelong pact

The burly guy from the sheriff’s department was in the audience at the town theater listening to a woman talk about suicide. Suddenly she stopped talking and pointed in his direction.

“That is the man that saved me,” Amanda Stidam told the crowd. “He made me feel like my life mattered.”

A few months earlier in 2013, Jeff Cooper had waited nearly two hours to meet Stidam. He had lost his son Luke to suicide and wanted to thank her for what she was doing for the cause. He had heard about the thousands of dollars she was raising for suicide prevention by running marathons. And how she would write the names of the people lost on her arms, legs and T-shirt.

But Stidam had everyone fooled. She had planned her own death, even written suicide notes. She had never recovered from losing her mom three years earlier.

If not for the brief encounter with Cooper, she likely would have joined those she ran to save.
“I had no idea that I mattered that much to her,” said Cooper, a retired sergeant and detective with the Logan County Sheriff’s Office. “It showed me how powerful it can be when you show someone you care, even if it’s just for a few minutes.”

Cooper, too, knows what it feels like to be saved. In September 2011, after he learned that his son had taken his life, Cooper returned to his home to find three strangers in the house waiting with other family members.

The three women were from the Local Outreach to Suicide Survivors (LOSS) Team that serves Champaign and Logan counties. LOSS team members are volunteers, some suicide survivors, who are contacted by local coroners or authorities to respond to a scene and offer the family support.

At first, Cooper was cold to the women. Reluctantly, he started sharing stories about Luke, about how much his son loved baseball and how he wished he would have done more to help him. A few days later, Cooper noticed one of the women at his son’s funeral, and they embraced.

About two months later, so inspired by the support he received, Cooper became a LOSS Team member. Since 2008, when the Champaign and Logan LOSS Team was founded, to the end of 2014, their members have helped 87 families cope with suicide.

“I learned from my experience in law enforcement you can’t just tell people sorry for your loss and turn around and leave,” Cooper said. “In that moment and in the days, weeks or years following, they need to know someone cares. When I tell them I lost my son, their faces change and the guard comes down. By the time I leave their homes, they are usually hugging me and I’m hugging them.”

Cooper and Stidam continue to save each other. In the past two years, there were moments when each slid back into agony. But they have a lifelong pact to be there when they need each other.

“It’s amazing what can happen when you let someone know how much you matter to them,” said Stidam, of Dublin. “That’s what Jeff did for me. And it saved me.”

**Roaring back**

The teenage girl handed him a note, but Rick Baumann was too busy to open it. He had to finish shaking hands with a long line of students who were thanking him for educating them on suicide prevention. Baumann had been asked to speak after a suicide, because school officials feared other students might do the same.

When the class cleared, Baumann opened the note.

The girl was planning to hang herself.

Baumann was weary from speaking to seven classes throughout the day and had trouble remembering what the girl looked like. He rushed to the teacher, and together they eventually found her sitting in her next class.

Over the next hour, Baumann gained the 16-year-old’s trust. He persuaded her to talk to the school counselor and to have her parents come to the school. Together, they forged a plan to get her help. She is still following that plan today.

“It just helps me to know I am helping someone else,” said Baumann, assistant coordinator of suicide prevention for North Central Mental Health Services. “I know the hopelessness that they are feeling.”
Baumann lost his 33-year-old son, Gabe, to suicide in March 2007. But he had begun dedicating much of his life to suicide prevention after his son’s first attempt, in 1992. He had served 5,000 hours as a volunteer before Gabe’s death.

“After his son died, I didn’t know if we would ever see Rick again,” said Susan Jennings, Rick’s colleague. “But he came roaring back, and he has helped save more people than even he will ever know.”

Baumann, 77, started working full time for North Central Mental Health in the Short North following his son’s death, running suicide-prevention hotlines and support groups. He continues to talk to groups in schools, veteran’s hospitals and other places in need of his wisdom.

For most of his presentations, he spreads out large quilts with the faces of about 30 people who took their lives. Gabe is pictured in the middle of one of them.

“When people look at that quilt, I can tell right away whether they lost someone,” he said. “I can see it in their eyes.”

Baumann still thinks of the teenage girl who handed him that note and the many others like her.

More recently, he was speaking to fourth graders when a boy stood up in front of his classmates and said he was thinking of killing himself.

The boy sent Baumann a note thanking him for saving his life.

**Honoring Jeffrey**

She was a tall, thin, attractive woman wearing stylish glasses, and the moment she first walked into the support group meeting, Marilyn Phelps was drawn to her.

It took only a few minutes for Phelps to sense the woman was more troubled than most. She had lost her son a few months earlier and hated the world. She was angry and bitter, challenging everyone and everything. She told Phelps and the others that she didn’t know how they ever could feel better and blamed God for letting this happen.

Phelps engaged the woman in private conversations for about a year and let her vent. Eventually, the woman admitted she was considering taking her own life.

Phelps persuaded her to see a therapist. Those sessions might have saved the woman.

“I didn’t want the world to lose such an extraordinary woman,” Phelps said. “I know I made a difference in her life. I think my son would have been really proud of me. I try to honor him with all that I do.”

Phelps’ son Jeffrey was 22 when he took his life in October 1994. She believes he suffered from a mental illness but always refused her attempts to seek help. One night, Phelps tricked Jeffrey and drove him to a local mental-health facility. When he saw the sign, Jeffrey jumped from the car and sprinted away.

He died months later. In the aftermath of his suicide, Phelps realized she would never be a grandmother. She considered taking her own life.
And it took Phelps, 66, more than five years to seek help, because she wasn’t getting any better. That’s when she started attending support groups and met people who had learned to live with the pain. Two years later, she became an advocate, and ever since she has been leading support groups or speaking to students about suicide prevention.

But Phelps still has her own struggles. She still partly blames herself for not doing enough for Jeffrey.

She buys Christmas presents for other little boys to help her get through the holidays.

“There isn’t going to be any closure — ever,” she said. “But I’ve found peace inside by trying to give other survivors hope.”

Phelps remains good friends with the stylish woman who lost her son.

The two women forged a bond through death, and now are trying to save others from the despair that nearly swallowed each of them.

**Always there**

Gwen Longbotham was on the roof fixing her chimney when she learned that Mary Ann Ward had lost her son to suicide. She was among the first people Ward called, and Longbotham lay on the roof for an hour trying to comfort her friend.

Almost exactly a year later, Longbotham made her own agonizing call to Ward, telling her that she, too, had lost a son to suicide.

“All I remember is Mary Ann saying, ‘I’ll be right there,’” said Longbotham. “She was always there.”

Ward was there immediately that day, making sure her friend had everything she needed, even stocking the fridge with ice cream and rice pudding for comfort.

She was there three weeks later with her husband, Joe, when they picked up Longbotham and took her to the first of many suicide survivor meetings.

She and Joe were there on John’s birthday, releasing balloons and heartfelt messages into the sky.

And Mary Ann was there when Longbotham thought about taking her own life.

“The bottom line is Mary Ann quite literally has saved my life,” said Longbotham, 66, of Worthington. “And on many occasions.”

Mary Ann and Joe Ward, both 66, of Columbus, have been helping heal others shortly after their son Murray, who was diagnosed with bipolar disorder, stood in front of a train in May of 2009.

They started attending support groups about three weeks after their son’s death, and for many years have served as advocates in Survivors of Suicide meetings and consoled people who have lost children in Compassionate Friends meetings.

But it took months, and even years, for each of them to process their pain and guilt and to understand that they had to change their lives to survive. They have watched people run away from them in grocery store aisles because they were afraid to talk to them about their son. They don’t watch television or read anything that is connected to tragedy or evil. They do whatever they can to eliminate tension or controversy from their lives.
“We had to shrink our world,” Mrs. Ward said. “From the moment I got that phone call, my life changed in every way. And I know this is hard to understand for people, but I’m a better person now. I have learned to be compassionate, appreciate the beauty in life, live in the present moment and treasure the gift of being a human being.”