MHSOAC
Mental Health Services
Oversight & Accountability Commission

MHSOAC Suicide Prevention Subcommittee Meeting Brief

March 16, 2018 | Redding, California (Shasta County)

The first meeting of the MHSOAC Suicide Prevention Subcommittee is being held in Redding, California in Shasta County, a small county in rural Northern California - an area with the highest rates of suicide in the State. During 2014-16, the annualized suicide rate in Shasta County was 23.3 deaths per 100,000 residents.[1] This was more than double the state rate, with the majority of those deaths by firearm (56.7%).[2]

Meeting Overview

The overarching goals of the meeting are to share the project goals and objectives, and to explore with meeting attendees the potential causes of high suicide rates, barriers to reducing rates, and what could be done to reduce suicide, suicide attempts, and associated harm. Commissioners and meeting attendees will hear from a person with lived experience, in addition to a presentation on suicide prevention efforts in Shasta County.

The majority of the meeting will focus on a facilitated discussion with attendees on the challenges and potential solutions to preventing suicide and suicide attempts, and improving outcomes for survivors of suicide attempts and their families, including identification of models in California and elsewhere. Some topics for discussion could include:

- Integrated primary care, and primary care providers' role in suicide prevention efforts
- Populations at particular risk, and culturally competent outreach and service delivery strategies
- Means management, or whether someone at risk for suicide has access to the means to attempt or to die by suicide
- Challenges and opportunities for providing support for loss survivors in rural communities
- Community collaboration that is inclusive of the private sector

Meeting Materials

- *Developing a Strategic Statewide Suicide Prevention Plan: Project Framework* and *Project Brief* (developed by the MHSOAC)
- *Executive Summary: California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution* (developed by the former Department of Mental Health); the full document can be accessed via this link: https://www.sprc.org/sites/default/files/California_CalSPSP_V92008.pdf.
- *Overview of 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* and *Appendix A: National Strategy for Suicide Prevention Goals and Objectives for Action Summary List* (developed by the Office of the Surgeon General and the National Action Alliance for Suicide Prevention); the full document can be accessed via this link: https://www.ncbi.nlm.nih.gov/books/NBK109917/pdf/Bookshelf_NBK109917.pdf.
- *Guidance for State Suicide Prevention Leadership and Plans (*developed by SAMHSA)
- *Know the Facts: Local suicide rate doubles state rate* (developed by the Shasta County Health and Human Services Agency, updated December 2017)

For more information, including upcoming events, please visit http://mhsoac.ca.gov/suicide-prevention.

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[1] Three-year average annual, age-adjusted rate

[2] These statistics and more can be found in meeting material, *Know the Facts: Local suicide rate doubles state rate*, Shasta County Health and Human Services Agency, updated December 2017.

DEVELOPING A STRATEGIC STATEWIDE SUICIDE PREVENTION PLAN

Project Framework

Suicide is one of the leading causes of death in California, for both youth and adults. More than 4,000 Californians die by suicide every year, and thousands more attempt suicide.[1] Suicide and suicide attempts affect every person and location in California, from north to south, both in human costs and economic loss.

Assembly Bill 114 (Chapter 38, Statutes of 2017) directs the MHSOAC to develop a statewide strategic plan for suicide prevention. The MHSOAC will develop this plan with stakeholders and will leverage previous efforts, including the plan drafted in 2008 by the former Department of Mental Health.[2]

This strategic plan will outline an action agenda for the State of California, the counties, the mental health community and other partners to reduce suicide, suicide attempts, suicidal thoughts, and related harm to people, families, loved ones, and communities. This action agenda will recommend immediate, short-term, and long-term strategies to prevent suicides and improve outcomes for people at-risk, families and communities.

In order to develop the action agenda, the Commission will:

- Explore what is understood and not understood about suicide and suicide attempts, including information on incidence and rates across California's diverse population, risk factors, and protective factors;
- Identify best practices for reducing suicide and risks for suicide, and for fortifying protective factors;
- Identify public, private, community, and other resources, strategies, and opportunities to support suicide prevention; and
- Engage with communities, stakeholders, thought leaders and experts across the State to develop a shared understanding of and commitment to the findings and recommendations of the project.

Background

Suicide and suicide attempts affect every demographic group in California. More than twice as many Californians die annually by suicide as from homicide.[3] Rates vary in significant ways, however. Some three-quarters of Californians who die by suicide each year are male.[4] Adults aged 20-59 account for more than 70 percent of suicides in the state, while the highest suicide death rates are among middle aged and older adults.[5] The largest numbers of suicides occur in southern California, with Los Angeles County accounting for about 20 percent of statewide suicide deaths annually. In contrast, suicide death rates are highest in rural northern California, with rates in the Superior region close to twice the national average. Additional at-risk populations include people involved with the criminal justice system, people experiencing homelessness, immigrants and refugees, veterans and military personnel, and LGBTQ – particularly transition aged youth.[6] As is true nationally, Californians are most likely to die by suicide using firearms (42 percent) compared to other means, such as suffocation (27 percent) and poisoning (19 percent).[7]

In addition to the devastating human impacts on survivors of suicide loss, suicides and suicide attempts also significantly affect the economy. The American Foundation for Suicide Prevention reports that in 2010 suicides cost California over $4 billion in combined medical expenses and lost productivity.[8] Another report suggest that suicide and suicide attempts nationally cost anywhere between $58 billion and $94 billion in 2013.[9]

Project Goal

Develop a statewide suicide prevention plan to reduce suicide, suicide attempts, and suicidal self-harm, including thoughts of suicide, and associated harm to families, loved ones, and communities, and to improve outcomes for survivors of suicide attempts and their families. The plan should include prevention, early intervention, and response strategies.

In order to develop that plan, the Commission will work with survivors of suicide attempts, mental health consumers and family members, State agencies, the counties, providers, community leaders, and other partners.

Project Structure and Activities

The Chair has appointed Commissioner and former Chair Tina Wooton to Chair a Suicide Prevention Subcommittee to lead this work. The Commission should consider a Subcommittee of three to five Commissioners to guide this project. The Subcommittee would lead the project, supported by a staff lead, and draft a proposed Suicide Prevention Strategic Plan for consideration by the Commission.

Recognizing that the Commission is an independent state agency, and that most state resources for suicide prevention fall under the authority of the California Health and Human Services Agency, the Commission should work closely with the Agency in the information gathering, development, and drafting of the statewide suicide prevention plan.

The Commission will engage with a broad array of stakeholders to gather information and build a common understanding of the challenges and opportunities to reducing suicide, suicide attempts, and associated harms. Below are proposed activities to support the development of this shared understanding and to facilitate public involvement through the state.

- Commission Meetings. Public hearings, including presentations by people with lived experience, subject matter experts, policy leaders, and members of the public, are tentatively scheduled during the May and August 2018 Commission Meetings.

- Subcommittee Meetings. A series of meetings to engage stakeholders and subject matter experts to explore topics in greater detail will be organized throughout the state. At least one meeting may be held prior to May 2018 in Northern California and one meeting prior to August 2018 in Southern California.

- Community Forums. One or more community forums may be organized to highlight challenges and opportunities for groups at increased risk of dying by suicide, including older men, LGBTQ transition-aged youth, and veterans and military personnel, and to broadly promote suicide prevention awareness. One community forum may be organized in September 2018 during Suicide Prevention Week.

- Site Visits. Site visits will be organized to support the development of foundational knowledge regarding challenges and solutions to preventing suicide, suicide attempts, and self-harm, and promoting suicide prevention awareness.

- Small Group Discussions. Small group discussions may be organized in partnership with community leaders and organizations to provide a safe, welcoming, and culturally sensitive environment for people from these communities to share their experiences and participate in a discussion with their peers.

These activities would be supported by background materials prepared by staff and subject matter experts to review and summarize relevant, available data and published materials, as well as a strong communications effort to ensure public awareness of project events and emerging findings.

ENDNOTES

[1] American Foundation for Suicide Prevention. *Suicide: California 2017 Facts & Figures*. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf. See also Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Jan 12, 2018.

[2] California Department of Mental Health. *California strategic plan on suicide prevention: Every Californian is part of the solution*. 2008. Accessed on January 12, 2018 at https://www.sprc.org/sites/default/files/California_CalSPSP_V92008.pdf.

[3] American Foundation for Suicide Prevention. Suicide: California 2017 Facts & Figures. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

[4] Ramchand, Rajeev and Amariah Becker. *Suicide Rates in California: Trends and Implications for Prevention and Early Intervention Programs*. Santa Monica, CA: RAND Corporation, 2014. Accessed on January 12, 2018 at https://www.rand.org/pubs/research_briefs/RB9737.html.

[5] Ibid.

[6] U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. 2012. Accessed on January 11, 2018 at https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf.

[7] National Center for Injury Prevention and Control, CDC. Data Source: NCHS Vital Statistics System for numbers of deaths. *WISQARS: Web-based Injury Statistics Query and Reporting System*. (1999-2014). Accessed January 12, 2018 at https://webappa.cdc.gov.

[8] American Foundation for Suicide Prevention. *Suicide: California 2017 Facts & Figures*. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

[9] Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A. and Silverman, M. M. (2016). *Suicide and Suicidal Attempts in the United States: Costs and Policy Implications. Suicide Life Threat Behav, 46*: 352–362. doi:10.1111/sltb.12225

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Developing a Strategic Statewide Suicide Prevention Plan: Project Brief

The Mental Health Services Oversight and Accountability Commission is charged with overseeing the **implementation of California's Mental Health Services Act** (also known as Prop 63) and the transformation of **California's mental health system**. The 16-member Commission is composed of one Senator, one Assemblymember, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor to represent different sectors of society, including people with mental health needs, their family members, law enforcement, education, labor, business, and the mental health profession.

In collaboration with stakeholders, the Commission provides vision and leadership to expand awareness and understanding of issues facing community mental health. The Commission conducts projects to examine critical issues and make informed decisions on how to improve services and provide better care to consumers.

Through the more than $2 billion generated every year by Prop 63, some $350 million is earmarked annually for prevention and early intervention services and another $100 million is designated for innovations. Most of those funds are distributed directly to counties to provide services with a range of goals, including reducing suicide. Assembly Bill 114 (Chapter 38, Statutes of 2017) authorized the MHSOAC to develop a new, statewide strategic plan for suicide prevention.

MHSOAC PROJECT ON SUICIDE PREVENTION

Suicide is one of the leading causes of death in California, for both youth and adults. More than 4,000 Californians die by suicide every year, and thousands more attempt suicide.

Suicide Prevention Subcommittee

Tina Wooton, Suicide Prevention Subcommittee Chair, MHSOAC Past Chair, and Consumer Empowerment Manager for Santa Barbara Department of Behavioral Wellness

Khatera Aslami-Tamplen, MHSOAC Vice-Chair, and Consumer Empowerment Manager for Alameda County Behavioral Health Care Services

Mara Madrigal-Weiss, MA, M.Ed Counseling, M.Ed Educational Leadership, MHSOAC Commissioner, and Lead Coordinator for the San Diego County Office of Education

The purpose of this project is to develop a suicide prevention plan informed by best practice and in collaboration with community members on the basis of shared understandings of the challenges and opportunities to reduce suicide, suicide attempts, and suicidal self-harm, and to improve outcomes for survivors of suicide attempts and survivors of suicide loss.

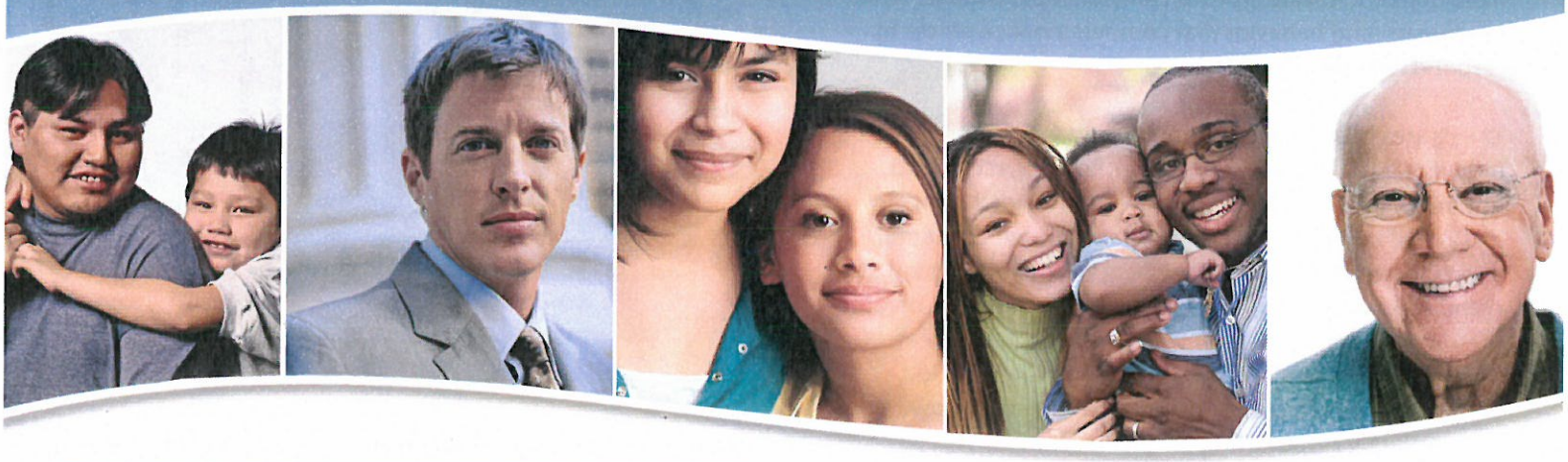
The project is led by the Suicide Prevention Subcommittee, a subcommittee of Commissioners appointed by MHSOAC Chair John Boyd, Psy.D.

Ashley Mills, MS, MHSOAC Senior Researcher, is the project staff lead.

For more information, please visit the Suicide Prevention Project Page at http://mhsoac.ca.gov/suicide-prevention.

California Strategic Plan on Suicide Prevention:
Every Californian Is Part of the Solution

Executive Summary



INTRODUCTION

The statistics about suicide are alarming. Suicide is the tenth leading cause of death in California. Every year approximately 3,300 Californians lose their lives to suicide; more suicide deaths are reported in our state than deaths caused by homicides. On average, nine Californians die by suicide every day. Suicide and suicidal behaviors occur among all age groups and across all socioeconomic, racial, and ethnic backgrounds.

The causes of suicide are complex. Too often there is lack of coordination between service systems and providers and a lack of knowledge about how to recognize the warning signs of suicide. And for far too long, suicide has been viewed as a taboo subject. Fear of stigma and discrimination surrounding suicide can be so pervasive that it often deters people from seeking help.

Suicide is a devastating tragedy in terms of the lives lost and the emotional heartbreak family members and other loved ones endure. This tragedy is even more distressing because suicide deaths are preventable.

Governor Arnold Schwarzenegger charged the California Department of Mental Health (DMH) with the development of the California Strategic Plan on Suicide Prevention. DMH embarked upon this work in partnership with the Suicide Prevention Plan Advisory Committee composed of mental health experts, advocates, providers, researchers, and representatives from nonprofit and government agencies. The Advisory Committee also included other important voices—survivors of suicide attempts and suicide loss. A copy of the Plan can be obtained online at *www.dmh.ca.gov.*

The *California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution (Plan)* is built upon the vision that a full range of strategies, starting from prevention and early intervention, should be targeted to Californians of all ages, from children and youth to adults and older adults. The *Plan* is a blueprint for local and state-level action.

This Executive Summary includes a fold-out chart that summarizes the core principles, strategic directions, recommendations, and next steps that are detailed in the *Plan*. The six core principles are embedded in all levels of planning, service delivery, and evaluation across the four strategic directions. These four strategic directions are broad levels of focus that the recommended actions and next steps address. The recommended actions are not an exhaustive list, but they reflect critical priorities to reduce suicide and its tragic consequences. Finally, the next steps outline activities that should be taken at the state and local levels to begin implementing the *Plan*.

Suicide prevention must be a priority in our state. While many challenges lie ahead in carrying out this work, tremendous opportunities also exist. With thousands of lives at stake each year, every Californian needs to be part of the solution.

California Department of Mental Health

Office of Suicide Prevention | 1600 9th Street, Room 150 | Sacramento, CA 95814 | 916-651-1178 | e-mail: suicideprevention@dmh.ca.gov | www.dmh.ca.gov

THE PROBLEM AND THE CHALLENGE

Suicide is defined as the intentional taking of one's own life. Suicidal behavior is a broader term that also includes self-inflicted, potentially injurious behaviors. Suicides may be "hidden" behind tragic events, such as lethal overdoses of prescription or illegal drugs, single car collisions with a fixed object, or incidents when an individual engages in a life-threatening behavior that compels a police officer to respond with deadly force.

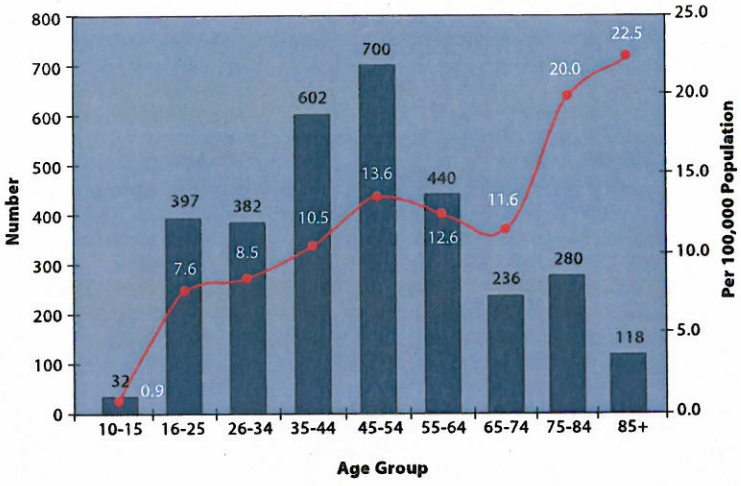
The causes of suicide are complex and vary among individuals and across age, gender, cultural, racial, and ethnic groups. The risk of suicide is influenced by an array of biological, psychological, social, environmental, and cultural risk factors. Many people who attempted or completed suicide had one or more warning signs before their death. Recognition of warning signs has a greater potential for immediate prevention and intervention when those who are in a position to help know how to appropriately respond.

Protective factors can reduce the likelihood of suicide by counterbalancing some of the risk factors. These protective factors include access to effective health and mental health care, strong connections to family and community support, and skills in problem solving, conflict resolution, and nonviolent handling of disputes.

Who Dies By Suicide?

- Adults over the age of 85 have the highest suicide *rate in California. The rate of suicide increases significantly* with advanced age. Depression and chronic illness are often significant risk factors for suicide among older adults.
- The largest *number* of suicide deaths occur in the age range of 45 to 54.
- Among youth and young adults between 16 to 25 years of age, suicide is the third leading cause of death. According to the U.S. Department of Health and Human Services, more teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, strokes, pneumonia, influenza, and chronic lung disease combined.
- Males are three times more likely to die by suicide than females. Women attempt suicide three times as frequently as men and are more likely to be hospitalized for self-inflicted injuries, primarily from poisoning or hanging. Sixty percent of hospitalizations for self-inflicted injuries are among females.
- Rates of suicide differ significantly among racial and ethnic groups. In California, whites have the highest suicide rate followed by Native Americans, Pacific Islanders, African Americans, Asians, people identifying as two or more races, and Latinos.

Suicide Death Rates (Line) and Number of Deaths (Bars) in California by Age, 2005. (California Department of Public Health)



Factors Associated with Increased Suicide Risk

- According to the National Institute of Mental Health, as many as 90 percent of individuals who died by suicide had a **diagnosable mental illness or substance abuse disorder**. Certain psychiatric diagnoses increase the risk of suicide substantially, such as major depression, bipolar disorder, and schizophrenia. Co-occurring mental illness and substance abuse exacerbate the risk of suicide.
- California Department of Corrections and Rehabilitation data indicate that suicide is the third leading cause of death in California's prisons. Nationally, more than half of all inmates in the **criminal justice system** have a mental illness; this rate is three times that of the general population.[1]
- The U.S. Department of Veterans Affairs (VA) estimates that there are 1,000 suicides per year among **veterans** receiving care through the VA health care system and as many as 5,000 per year among all veterans.
- Many individuals who are **homeless** meet many of the criteria for elevated suicide risk, such as untreated mental illness, social isolation, poverty, and substance abuse. Studies have found that individuals who are homeless for longer than six months may be at particularly high risk.[2]
- Specific **immigrant and refugee** populations face additional issues pertaining to acculturation, family and intergenerational conflict, and access to culturally and linguistically appropriate mental health services.[3]
- **Rural** states have the highest rates of suicide in the U.S., particularly among adult and older adult males and youth. Contributing factors may include availability and quality of mental health services, rates of gun ownership, and percentage of older adults in rural areas.[4]
- **Lesbian, gay, bisexual, transgender, and questioning** individuals, particularly adolescents and young adults, have significantly higher rates of suicidal ideation and suicide attempts than their heterosexual counterparts.[5]

- Suicide is the second leading cause of **postpartum** maternal deaths.[6] Up to 14 percent of women report suicidal ideation during pregnancy and in the postpartum period. Perinatal depression is believed to be one of the most common complications women experience during and after pregnancy.

Means of Suicide

Firearms are used in over 40 percent of suicides in California. Addressing access to firearms and controlled substances is one way to prevent many suicides.

Almost half of survivors of suicide attempts reported that less than one hour had passed between their decision to complete suicide and the actual attempt; another 24 percent indicated it was less than five minutes.[7] Restricting access to lethal means can put time between the impulse to complete suicide and the act itself, allowing opportunities for the impulse to subside or warning signs to be recognized.

The Cost of Suicide and Suicide Attempts

Suicide has both immediate and far-reaching effects on families and communities. Beyond the emotional toll, there are also financial costs. The economic burden of suicide is spread throughout various systems, including education, hospitals, primary care, mental health, and corrections. The estimated cost for the over 3000 suicides and 16,000 suicide attempts that occur every year in California is over $449 million per year, plus approximately $3.8 billion in lost lifetime productivity.

STRATEGIES FOR SUICIDE PREVENTION

Suicide prevention encompasses a wide range of prevention, intervention, and postvention strategies that offer education, foster resiliency, and enhance protective factors in individuals and communities.

Create a System of Suicide Prevention

A system of suicide prevention should include a range of services and programs designed to effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds. The system's success would be judged on how well the parts are coordinated and build upon one another. To ensure that this system is effective, it is critical to assess the assets and gaps, make a plan, implement it, and reassess it. In addition, coordination and partnerships must occur at multiple levels.

At the state level an Office of Suicide Prevention (OSP) has been established to provide a single point of contact and a central point of dissemination for information, resources, and data about suicide and suicide prevention programs. The OSP will serve as a liaison with national partners as well as other states, ensure that activities build on resources and materials where they already exist, and provide expert consultation on the development of local suicide prevention plans and activities.

At the local level, a broad range of partners need to collaborate to create a system of suicide prevention that crosses county, municipal, and district-wide jurisdictions. Local coordination efforts should include assessment, planning, implementation, and evaluation of the wide range of suicide prevention efforts needed at the community level.

Ultimately, a **multi-level public health approach** is needed to create a system that reduces risk factors and enhances protective factors for individuals and communities. This approach broadly promotes wellness and health as well as early intervention for individuals at risk, and it can reduce the likelihood of multiple negative outcomes, including suicide, mental illness, and violence.

Targeted Approaches

Several targeted approaches have been developed that provide services and supports that are tailored to the needs of a particular population at high risk, a type of setting, or a specific community need.

Suicide Prevention Hotlines

Hotlines are an effective way for people in crisis to reach out for help regardless of where they are or what time of day it is. Currently, California has eight accredited hotlines that are members of the National Lifeline (1-800-273-TALK).

Population-Specific Interventions

Due to the unique characteristics of different age groups and racial/ethnic populations, and the disparities in their access to services, effective suicide prevention approaches need to include outreach and intervention strategies specifically designed to target these groups.

Older Adults

Up to 75 percent of older adults visited their primary care physician within a month of their suicide, and the majority of them were not receiving mental health treatment. Many effective programs for older adults integrate mental health services with primary care and provide outreach, engagement, and education that are embedded within existing community structures and services that older adults commonly use.

Peer Support Models

A growing body of literature substantiates the effectiveness of services and supports delivered by individuals with direct experience of mental illness. Engaging individuals who have been impacted by suicide, including families, friends, and survivors, can be a powerful tool to prevent suicide and future attempts.

Racial, Ethnic, and Cultural Communities

Employing culturally appropriate strategies make a substantial difference. To be effective in addressing suicide and mental illness, interventions need to incorporate knowledge, beliefs, and attitudes that reflect the families and communities they serve.

Children, Youth, and Young Adults
Nationally, many more children and youth need mental health services than receive them. Among those who do receive services, most receive them at school. School personnel are in a key position to identify early warning signs of suicide risk and assist students in finding help. School programs can enhance the capacity to build resiliency among students by adopting curricula that teach problem-solving skills, conflict resolution, and nonviolent handling of disputes.

Unfortunately, many young people who are at high risk of suicide may have already stopped attending school or may have contact with the juvenile justice system. It is critical to develop strategies to reach out to these individuals through community groups, places where young people congregate, and co-location of youth mental health specialists in primary care settings.

Criminal Justice and Law Enforcement
Several effective training models exist that educate officers about the signs of mental health problems and suicide risk and how to appropriately intervene while maintaining public safety. Programs such as jail diversion and re-entry offer models for collaboration between the prison system, community social services, and the community mental health system.

Employers
Integrating suicide prevention into work settings through resource directories, education, and training may reach a large number of adults who may be at risk, but who are not likely to seek out mental health services. Resources and information should be available to all employees and integrated into existing employee support networks.

Veterans and the Military
Strategies that take into account the specific experiences many veterans have had and the culture of the military are necessary to ensure that veterans receive the support they need. Given the magnitude of the problem, it is critical that the military, including the California National Guard and VA medical centers, are partners in suicide prevention.

Implementing Training and Workforce Enhancements

Effective suicide prevention strategies depend on a trained workforce. Providers in multiple service fields must be equipped to recognize and intervene when suicide risk is present. Service guidelines need to be developed that lead to trainings that specifically addresses the concerns and missed intervention opportunities in different settings, such as primary care, emergency response systems, crisis centers, older adult and long-term care programs, schools, and the venues served by law enforcement and probation officers.

Educating the Public to Take Action to Prevent Suicide

Effective suicide prevention strategies also depend on an educated public. Multiple strategies have been developed to provide appropriate information about suicide and how to find help in the community.

Gatekeepers
Gatekeepers are members of the community who may regularly come in contact with many individuals, some of whom may be contemplating suicide but are not likely to seek mental health services on their own. Gatekeeper training targets a broad range of individuals, such as school health personnel, employers, faith-based and spiritual leaders, community-based service staff, and natural community helpers. This model has been shown to be particularly effective for helping older adults and young people.

Reducing Access to Lethal Means
Reducing access to lethal means is an important component of suicide prevention when it is integrated with other local, regional, and state-level activities. Education about safe storage of potentially lethal means, such as firearms and medications, can save lives.

Public Awareness Campaigns
Public awareness campaigns can be an important education strategy to reach large numbers of people. Nearly two-thirds of those who have a diagnosable mental illness do not seek treatment because of fears of stigma and discrimination. Educating the media and entertainment industry about how to accurately report and portray information about suicide can counter the adverse effects of stigma and reduce the "contagion" effect.

Improving Program Effectiveness and System Accountability

While information is available about a number of effective and promising suicide prevention practices, much more needs to be learned about programs specifically designed to serve California's diverse population groups. With these substantial gaps in knowledge about how suicide impacts all Californians and how to better prevent it, a research agenda must be established to better develop responsive policies and design effective programs to reduce suicide's impact. Fortunately, California has the necessary partners and elements to take on this work.

NOTES:

[1] Lyon, D. 2007. Helping mentally ill criminals: Jailing offenders with mental illnesses serves no one, but new policies and funding are bringing about needed changes. State Legislatures. National Conference on State Legislatures, April, 2007.

[2] Eyman, R., Langley, J., Tolomiczenko, G., Rhodes, A. E., Links, P. Wasylenki, D., et al. 2002. The association between homeless and suicidal ideation and behaviors: Results of a cross-sectional survey. Suicide and Life Threatening Behavior, 32(4), 418-427.

[3] Fortuna, L. R., Perez, D. J., Canino, G., Sribney, W., & Alegria, M. 2007. Prevalence and correlates of lifetime suicidal ideation and suicide attempts among Latino subgroups in the United States. Journal of Clinical Psychiatry, 68(4), 572-581.

[4] Gamm, L.D., L. Hutchison, B.J. Dabney, and A. Dorsey, eds. 2003. Rural Healthy People 2010. Volume 2. College Station, TX: Texas A&M University System health Science Center.

[5a] Silenzio, V.M.B., J.B. Pena, P.R. Duberstein, J. Cerel, and K.L. Knox. 2007. Sexual Orientation and Risk Factors for Suicidal Ideation and Suicide Attempts Among Adolescents and Young Adults. American Journal of Public Health, Vol 97, No. 11, 2017-2019.

[5b] Russell, S.T. & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. American Journal of Public Health, 91(8), 1276-1281.

[6] Lindahl, V., J.L. Pearon, and L. Colpe. 2005. Prevalence of suicidality during pregnancy and the postpartum. Archives of Women's Mental Health. 8(2): 77-87. June, 2005.

[7] Simon, T.R., A.C. Swann, K.E. Powell, L.B. Potter, M. Kresnow, and P.W. O'Carroll. 2001. Characteristics of impulsive suicide attempts and attempters. Suicide and Life Threatening Behavior, 32 (supp.): 49-59.

California Department of Mental Health

California Strategic Plan on Suicide Prevention:
Every Californian Is Part of the Solution

CORE PRINCIPLES:

- Implement culturally competent strategies and programs that reduce disparities.
- Eliminate barriers and increase outreach and access to services.
- Meaningfully involve survivors of suicide attempts and the family members, friends, and caregivers of those who have completed or attempted suicide, and representatives of target populations.
- Use evidence-based models and promising practices to strengthen program effectiveness.
- Broaden the spectrum of partners involved in a comprehensive system of suicide prevention.
- Employ a life span approach to suicide prevention.

STRATEGIC DIRECTION 1:

Create a System of Suicide Prevention

Increase collaboration among state and local agencies, private organizations, and communities by coordinating and improving suicide prevention activities and services throughout the state, from health and mental health promotion through crisis intervention.

STATE - *Recommended Actions*

- Establish a statewide Office of Suicide Prevention (OSP).
- Engage a coalition of public partners to integrate, coordinate, enhance, and improve policies and practices.
- Develop a network of statewide public and private organizations.
- Convene and facilitate working groups that will address specific populations and issues.
- Expand the number and capacity of accredited suicide prevention hotlines based in California.
- Create a statewide consortium of suicide prevention hotlines.
- Identify and implement needed improvements in confidentiality laws and practices.

LOCAL - *Recommended Actions*

- Appoint a county liaison to the state Office of Suicide Prevention and convene a suicide prevention advisory council.
- Develop a local suicide prevention action plan.
- Enhance links between systems and programs to better address gaps in services and identify resources.
- Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging, social services, first responders, and hotlines.
- Integrate suicide prevention programs into education institutions, services for older adults, the workplace, and the criminal and juvenile justice systems.
- Develop and promote programs that reduce or eliminate gaps for historically underserved racial and ethnic groups and other high-risk populations.
- Ensure that the county has access to at least one accredited suicide prevention hotline call center.
- Explore opportunities for training and consultation between counties to develop suicide prevention hotline capacity.

STATE - *Next Steps*

- Staff the Office of Suicide Prevention established on February 6, 2008.
- Issue an action plan that assesses the current level of activities and major gaps, and identifies objectives toward implementing the initial activities described in "Next Steps."
- Establish a technical assistance infrastructure to support local suicide prevention efforts.
- Establish a coalition of state-level organizations to coordinate suicide prevention efforts. The coalition should include:
  - K-12 and higher education
  - Services for older adults
  - Criminal and juvenile justice systems
  - Veterans' services
  - Health and mental health services
- Assess the current status of suicide prevention hotlines in California and build a consortium of accredited suicide prevention hotlines statewide.
- Support expanded functions for the accredited suicide prevention hotline centers, such as training centers and after-care services.
- Enhance the database for monitoring, tracking, evaluating, and reporting suicide prevention hotline calls in California.
- Provide technical assistance to expand or link accredited hotlines to additional venues and formats to improve access to information on local services.
- Provide technical support to counties to conduct a comprehensive assessment of suicide prevention services.
- Link and provide technical support to county-level advisory councils.

LOCAL - *Next Steps*

- Appoint a liaison in each county to the state Office of Suicide Prevention.
- Convene or build upon an existing entity to establish a local suicide prevention advisory council to develop a suicide prevention system.
- Design and implement a comprehensive assessment of the existing county suicide prevention services and supports and the major gaps.
- Develop a local suicide prevention action plan, through an inclusive community process based on the comprehensive assessment.
- Assess the capacity of local or regional accredited suicide prevention hotline(s) and take steps to achieve accreditation of call centers or build the capacity of already accredited call centers.

STRATEGIC DIRECTION 2:

Implement Training and Workforce Enhancements to Prevent Suicide

Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow-up care across all service providers.

STATE - *Recommended Actions*

- Convene expert workgroups to establish suicide prevention service and training guidelines and model curricula for targeted service providers.
- Expand opportunities for training for selected occupations and facilities.
- Determine which occupations are to be targeted for required training and to implement the requirements.

LOCAL - *Recommended Actions*

- Establish annual targets for suicide prevention training and develop and implement a plan to meet these targets.
- Increase the priority of suicide prevention training and tailor state guidelines to meet local needs.

STATE - *Next Steps*

- Assess the current criteria and standards for service and training guidelines that address suicide prevention, early intervention, treatment, and suicide attempt follow-up care for California's diverse population.
- Recommend, develop, and broadly promote standard service and training guidelines and curricula for targeted service providers. Review licensing and credentialing processes to assess viability of new training requirements.
- Coordinate and review surveys on local training needs and provide support to counties.
- Deliver "train the trainer" sessions for targeted service providers.

LOCAL - *Next Steps*

- Review local Mental Health Services Act Workforce Education and Training assessments to expand suicide prevention training. If needed, conduct a supplemental survey for suicide prevention training and technical assistance needs. Set local training targets for selected occupations and develop a plan to meet those targets and measure progress.
- Tailor, disseminate, and promote service and training guidelines. Design and implement an inclusive community process to adapt guidelines as necessary.

STRATEGIC DIRECTION 3:

Educate Communities to Take Action to Prevent Suicide

Raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.

STATE - *Recommended Actions*

- Launch and sustain a suicide prevention education campaign.
- Coordinate the suicide prevention campaign with any existing social marketing campaigns designed to eliminate mental health stigma and discrimination.
- Engage and educate the news media and the entertainment industry.
- Promote information and resources to reduce access to lethal means.
- Disseminate and promote models for suicide prevention education for community gatekeepers.

LOCAL - *Recommended Actions*

- Build grassroots outreach and engagement efforts to tailor the suicide prevention campaign to meet community needs.
- Engage and educate local media to promote greater understanding of the risks and protective factors related to suicide and how to get help.
- Educate individuals to recognize, respond to, and refer people demonstrating acute risk factors warning signs.
- Promote and provide suicide prevention education for community gatekeepers.
- Develop and disseminate directory information on local suicide prevention and intervention services.
- Incorporate peer support and peer-operated services models.

STATE - *Next Steps*

- In conjunction with any existing social marketing efforts, develop and implement an age-appropriate, multi-language education campaign to positively influence help-seeking behaviors and reduce suicidal behaviors.

- Obtain the necessary social marketing consultation to design, test, and promote the suicide prevention messages for target populations at risk for suicide.
- Support local efforts to engage and educate the media by disseminating resources from national suicide prevention organizations.
- Identify a strategy for reducing access to lethal means in California.
- Identify and disseminate models that counties can use to implement suicide prevention gatekeeper education.
- Conduct regional training to build local capacity of peer support programs.
- Design and maintain a web page for the Office of Suicide Prevention that provides links to information; identify and develop new information as needed.

LOCAL - Next Steps

- Coordinate local outreach, awareness, and education with other social marketing efforts to expand suicide prevention messages and information in multiple languages.
- Design and implement a strategy to better engage and educate the local media on the importance of appropriate and responsible reporting about suicide.
- Design a community education plan that may include a community calendar of activities promoting suicide prevention; integration of suicide prevention information into ongoing services; and localizing national and state suicide prevention events.
- Reach out to community gatekeepers to increase their awareness and participation in suicide prevention efforts.
- Develop and widely disseminate a directory of local suicide prevention services and update as necessary.
- Foster the development of peer support programs.

STRATEGIC DIRECTION 4:

Improve Suicide Prevention Program Effectiveness and System Accountability

Improve data collection, surveillance, and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

STATE - *Recommended Actions*

- Develop a California surveillance and research agenda.
- Test and adapt evidence-based practices and promote the evaluation of promising community models.
- Identify or develop methodologies for evaluating suicide prevention interventions.
- Make suicide and suicide attempt data easily accessible to the public and policy makers.

LOCAL - *Recommended Actions*

- Increase local capacity for data collection, reporting, surveillance, and dissemination.
- Build local capacity to evaluate suicide prevention programs to improve those programs.
- Establish or enhance capacity for suicide death reviews and provide regular reports to the Office of Suicide Prevention and the local suicide prevention advisory council.
- Enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.

STATE - *Next Steps*

- Working collaboratively with local, state, and national entities, develop a California-specific research agenda. Design a process to identify priority activities from a comprehensive review of multiple data sources and an inclusive decision-making process.

- Improve data collection and reporting as well as surveillance systems to better understand suicide trends and the impact of protective and risk factors in diverse populations. Target research in key areas, such as policies and programs appropriate for specific ethnic, cultural, and age groups.
- Develop an evaluation component to track and monitor the statewide effort.
- Develop and disseminate data reports on special topics and specific target populations to enhance programs and service delivery.

LOCAL - *Next Steps*

- Assess local data sources and reporting processes pertinent for suicide prevention and develop and implement a strategy to enhance data collection.
- Coordinate with the state Office of Suicide Prevention to build local capacity for program evaluation.
- Establish a suicide death review process and provide regular reports to the suicide prevention advisory council

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Overview

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action

What is the 2012 National Strategy for Suicide Prevention?

The 2012 National Strategy for Suicide Prevention (the National Strategy) is the result of a joint effort by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention (Action Alliance).

The National Strategy is a call to action that is intended to guide suicide prevention actions in the United States over the next decade. It outlines four strategic directions with 13 goals and 60 objectives that are meant to work together in a synergistic way to prevent suicide in the nation.

Why a National Strategy for Suicide Prevention?

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. Many people may be surprised to learn that suicide was one of the top 10 causes of death in the United States in 2009. And death is only the tip of the iceberg. For every person who dies by suicide, more than 30 others attempt suicide. Every suicide attempt and death affects countless other individuals. Family members, friends, coworkers, and others in the community all suffer the long-lasting consequences of suicidal behaviors.

Key facts

- Suicide is the 10th leading cause of death, claiming more than twice as many lives each year as does homicide.
- On average, between 2001 and 2009, more than 33,000 Americans died each year as a result of suicide, which is more than 1 person every 15 minutes.
- More than 8 million adults report having serious thoughts of suicide in the past year, 2.5 million report making a suicide plan in the past year, and 1.1 million report a suicide attempt in the past year.
- Almost 16 percent of students in grades 9 to 12 report having seriously considered suicide, and 7.8 percent report having attempted suicide one or more times in the past 12 months.

Suicide places a heavy burden on the nation in terms of the emotional suffering that families and communities experience as well as the economic costs associated with medical care and lost productivity. And yet suicidal behaviors often continue to be met with silence and shame. These attitudes can be formidable barriers to providing care and support to individuals in crisis and to those who have lost a loved one to suicide.

Recognizing the importance of suicide prevention to the nation, in 2001 Surgeon General David Satcher released the first National Strategy for Suicide Prevention. This landmark document launched an organized effort to prevent suicide in the United States.

Activity in the field of suicide prevention has grown dramatically since the National Strategy was issued in 2001. Government agencies at all levels, schools, nonprofit organizations, and businesses have started programs to address suicide prevention. Important achievements include the enactment of the Garrett Lee Smith Memorial Act, the creation of the National Suicide Prevention Lifeline (800–273–TALK/8255) and its partnership with the Veterans Crisis Line, and the establishment of the Suicide Prevention Resource Center (SPRC). Other areas of progress include the increased training of clinicians and community members in the detection of suicide risk and appropriate response, and enhanced communication and collaboration between the public and private sectors on suicide prevention.

Why was the National Strategy updated and revised?

The National Strategy was revised to reflect major developments in suicide prevention, research, and practice during the past decade. Examples include the following.

An increased understanding of the link between suicide and other health issues. Research confirms that health conditions such as mental illness and substance abuse, as well as traumatic or violent events can influence a person's risk of suicide attempts later in life. Research also suggests that connectedness to family members, teachers, coworkers, community organizations, and social institutions can help protect individuals from a wide range of health problems, including suicide risk.

New knowledge on groups at increased risk. Research continues to suggest important differences among various demographics in regards to suicidal thoughts and behaviors. This research emphasizes that communities and organizations must specifically address the needs of these communities when developing prevention strategies.

Evidence of the effectiveness of suicide prevention interventions. New evidence suggests that a number of interventions, such as behavior therapy and crisis lines, are particularly useful for helping individuals at risk for suicide. Social media and mobile apps provide new opportunities for intervention.

Increased recognition of the value of comprehensive and coordinated prevention efforts. Combining new methods of treating suicidal patients with a prompt patient follow-up after they have been discharged from the hospitals is an effective suicide prevention method.

How is the National Strategy organized?

The 2012 National Strategy for Suicide Prevention is closely aligned with the National Prevention Strategy, released in June 2011, which outlines the nation's plan for promoting better health and wellness among the population. This comprehensive plan seeks to increase the number of Americans who are healthy at every stage of life. Three of its seven priority areas—mental and emotional well-being, preventing drug abuse and excessive alcohol use, and injury- and violence-free living—are directly related to suicide prevention. Like the National Prevention Strategy, the 2012 National Strategy for Suicide Prevention recognizes that prevention should be woven into all aspects of our lives. Everyone—businesses, educators, health care institutions, government, communities, and every single American—has a role in preventing suicide and creating a healthier nation.

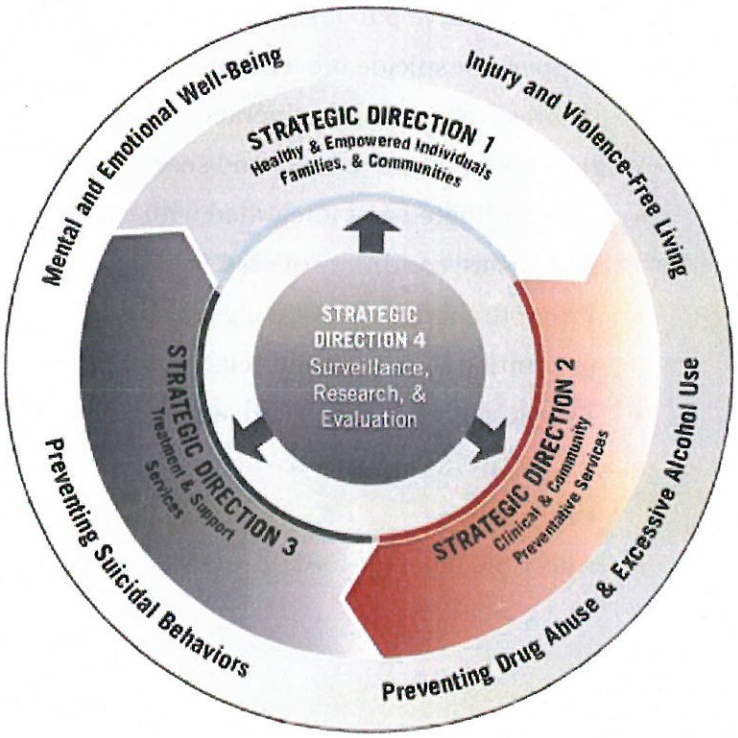
Contents

The 2012 National Strategy for Suicide Prevention contains five sections and seven appendices. Major contents include:

- An introduction to suicide prevention and overview of the 2012 National Strategy.
- A section on each of the four strategic directions and their respective goals and objectives. Each section includes suggestions on what different groups can do to support the goals and objectives.
- A crosswalk from the 2001 goals and objectives to the 2012 goals and objectives.
- Information and resources on groups identified as having increased suicide risk.
- Other general suicide prevention resources.

The National Strategy's goals and objectives fall within four strategic directions, which, when working together, may most effectively prevent suicides:

1. Create supportive environments that promote healthy and empowered individuals, families, and communities (4 goals, 16 objectives);
2. Enhance clinical and community preventive services (3 goals, 12 objectives);
3. Promote the availability of timely treatment and support services (3 goals, 20 objectives); and
4. Improve suicide prevention surveillance collection, research, and evaluation (3 goals, 12 objectives).



This organization represents a slight change from the AIM (Awareness, Intervention, Methodology) framework adopted in the 2001 National Strategy. The Awareness area has been included under Healthy and Empowered Individuals, Families, and Communities. The goals and objectives formerly included in the Intervention area have been spread across the first three strategic directions. Methodology has been expanded to include not only surveillance and research but also program evaluation. The 2001 goals and objectives have been updated, revised, and in some cases, replaced to reflect advances in knowledge and areas where the proposed actions have been completed.

Although some groups have higher rates of suicidal behaviors than others, the goals and objectives do not focus on specific populations or settings. Rather, they are meant to be adapted to meet the distinctive needs of each group, including new groups that may be identified in the future as being at an increased risk for suicidal behaviors. Information on groups currently identified as having suicide risk is presented in the Appendix.

What are some of the major themes in the National Strategy?

Everyone has a role in preventing suicides. The goals and objectives in the National Strategy work together to promote wellness, increase protection, reduce risk, and promote effective treatment and recovery.

From encouraging dialogue about suicidal behavior to promoting policies that support suicide prevention, the National Strategy states that suicide prevention efforts should:

- Foster positive public dialogue, counter shame, prejudice, and silence; and build public support for suicide prevention;
- Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities;
- Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
- Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems;
- Bring together public health and behavioral health;
- Promote efforts to reduce access to lethal means among individuals with identified suicide risks; and
- Apply the most up-to-date knowledge base for suicide prevention.

How was the National Strategy revised and updated?

Revisions to the National Strategy were initiated and overseen by the Action Alliance, a public-private partnership of more than 200 national leaders, in collaboration with Office of the U.S. Surgeon General. Launched in September 2010, the Action Alliance is dedicated to advancing the National Strategy by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives, and cultivating the resources needed to sustain progress. Chaired by the Honorable John McHugh, Secretary of the Army, and the Honorable Gordon H. Smith, President and CEO of the National Association of Broadcasters, the Action Alliance brings together highly respected national leaders representing more than 200 organizations. At its core is an executive committee supported by several task forces.

In 2010, the Action Alliance created the National Strategy for Suicide Prevention Task Force, which coordinated the revision of the National Strategy. Chaired by Surgeon General Regina M. Benjamin and SPRC Director Jerry Reed, the task force, a public-private partnership, led efforts to weave suicide prevention into all aspects of Americans' lives. Other federal entities that contributed to the National Strategy include the U.S. Department of Veterans Affairs, the U.S. Department of Defense, and the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services.

In addition to SPRC, the private sector was equally represented in the development of the National Strategy. Among many private entities, guidance was given by Facebook, the Entertainment Industries Council, Mental Health Association of San Francisco, University of Illinois of Chicago, University of Rochester Medical Center, and University of Calgary, Canada. Members of the National Council for Suicide Prevention (NCSP) also contributed to the development of and supported the launch of the National Strategy, among them the American Association of Suicidology, American Foundation for Suicide Prevention, Jason Foundation, Jed Foundation, National Organization for People Against Suicide, Samaritans USA, Suicide Awareness Voices of Education, and Yellow Ribbon Suicide Prevention Program.

The strategy also reflects the input of family members who have lost loved ones to suicide, those who have attempted suicide, national organizations dedicated to reducing suicide, and many others.

Resources

For additional information about the National Strategy for Suicide Prevention, visit:

- http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html
- http://www.samhsa.gov/nssp
- http://www.actionallianceforsuicideprevention.org/NSSP

Appendix A: National Strategy for Suicide Prevention Goals and Objectives for Action Summary List

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state/territorial, tribal, and local levels.

Objective 1.3: Sustain and strengthen collaborations across federal agencies to advance suicide prevention.

Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.

Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.

GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

Objective 2.2: Reach policymakers with dedicated communication efforts.

Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.

Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is possible for all.

GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of suicide and other related behaviors.

Objective 4.3: Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.

Objective 4.4: Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

Strategic Direction 2: Clinical and Community Preventive Services

GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Objective 6.2: Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Objective 6.3: Develop and implement new safety technologies to reduce access to lethal means.

GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

Objective 7.5: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Strategic Direction 3: Treatment and Support Services

GOAL 8. Promote suicide prevention as a core component of health care services.

Objective 8.1: Promote the adoption of "zero suicides" as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

Objective 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Objective 8.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.

Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

Objective 8.8: Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid followup after discharge.

GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.

Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.

Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.

Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objective 10.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.

Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

Objective 10.5: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Strategic Direction 4: Surveillance, Research, and Evaluation

GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objective 11.1: Improve the timeliness of reporting vital records data.

Objective 11.2: Improve the usefulness and quality of suicide-related data.

Objective 11.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

Objective 11.4: Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.

GOAL 12. Promote and support research on suicide prevention.

Objective 12.1: Develop a national suicide prevention research agenda with comprehensive input from multiple stakeholders.

Objective 12.2: Disseminate the national suicide prevention research agenda.

Objective 12.3: Promote the timely dissemination of suicide prevention research findings.

Objective 12.4: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objective 13.1: Evaluate the effectiveness of suicide prevention interventions.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.

Objective 13.3: Examine how suicide prevention efforts are implemented in different states/territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.

Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Guidance for State Suicide Prevention Leadership and Plans

The history, content, scope, breadth and ownership of state suicide prevention efforts vary widely. Suicide prevention leadership may come from a statewide coalition, governor's office, task force, or health agency (including public health, mental health, injury prevention and others). SAMHSA recommends that behavioral health (BH) agencies play a leadership role on suicide prevention efforts. SAMHSA also recommends that BH agencies play a part in shaping, implementing, monitoring and regularly updating their state suicide prevention plan. Block grant resources may be used for suicide prevention activities.

This guidance recognizes that states and their suicide prevention activities vary widely. SAMHSA suggests that state BH agencies lead in two ways. **The first is by raising the bar on suicide prevention and care as a central public health and behavioral health problem**. Given 37,000 deaths annually from suicide, mental illness and substance abuse a possible factor in 90 percent of suicides and the highest risk of suicide occurring among people with serious mental illness and alcohol a factor in approximately one-third of all suicides, BH agencies should play a leadership role. Since the Nation's first National Strategy on Suicide Prevention was published just over a decade ago, our plans and strategies are still evolving. Therefore, SAMHSA urges BH agencies lead in ways that are suitable to a growing area of concern and help raise the bar: convening stakeholders, building capacity (e.g., supporting coalitions, developing training resources) and "growing" suicide prevention efforts. In times of limited resources, leadership is most valuable.

The second area of guidance is to emphasize the value of having a written strategic plan that addresses suicide across the lifespan, in order to maximize existing resources, promotes broad collaboration, and monitor progress. SAMHSA suggests the following key areas for inclusion in state suicide prevention plans—and efforts to implement the plans.

Key Plan Elements and Characteristics

State suicide prevention plans should contain core elements such as identifying evidenced based practices and programs that address prevention and treatment, training the existing behavioral health workforce on identifying, screening, assessing and treating individuals with suicidal thoughts and behaviors, and providing continuity of care so that those at high risk are able to safely transition from acute care settings to outpatient care. In addition, the following are key characteristics that contribute to an effective suicide prevention plan.

- **Plans should be data-driven, while strategies may be flexible.** In order to effectively allocate resources, states should identify and prioritize high-risk populations and settings by using available data that:
  - Identifies populations with both high numbers and high rates of suicide attempts and deaths (nationally, for example people with mental illness and elderly males are at elevated risk).
  - Points to geographic areas and settings in which risks of suicide are high (e.g., rural areas, behavioral health care settings, correctional settings, etc.)
  - Characterizes patterns of suicide deaths and attempts, including which risk factors are associated with different populations (such as mental illness, substance abuse disorders, people just discharged from inpatient/emergency departments, people with prior attempts, etc.)
  - Allows States to respond to suicide clusters with support and postvention.

  EXAMPLE: Delaware plan: http://www.sprc.org/sites/sprc.org/files/state_plans/plan_de.pdf (pp. 13-17)

- **Plans should be comprehensive, but set priorities.** They should integrate and coordinate suicide prevention activities across multiple sectors and settings. They should address both risk and protective factors. The plan should account for differences within the state and incorporate monitoring over time for effectiveness. The plan should include goals, objectives, types of activities and special populations.

  EXAMPLE: Massachusetts plan: http://www.sprc.org/sites/sprc.org/files/state_plans/plan_ma.pdf (pp. 19-30)

- **Plans should incorporate a collaborative effort by multiple public and private organizations, while focusing on what can first be done.** Suicide prevention cannot be a one-person or single-agency effort. Ultimately, health, mental health, substance abuse, education, justice, veterans and other agencies and private sector groups need to be involved and play a role in developing and implementing the plan. Coalitions, task forces, or multi-agency work groups can build commitment and ownership. Key players can include: schools/educational systems, healthcare systems, community prevention coalitions, criminal justice and aging systems. Behavioral health agencies should not only participate but offer key leadership based on their knowledge of and access to behavioral health resources and information. Given the elevated risk for people with mental health/ substance use disorders, a special focus within behavioral health systems of care is appropriate. Behavioral health systems should strive to eliminate suicides among those receiving care by providing training to the BH workforce on screening, assessing, and treating individuals with suicidal thoughts and behaviors,, promoting continuity of care among high risk groups such people discharged from inpatient units and Emergency Departments, linking to the National Suicide Prevention Lifeline, and promoting and implementing evidence based interventions. See:
  http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf
  Suicide attempt survivors and family members who have lost loved ones to suicide who become engaged in the cause of suicide prevention and care are essential participants in any planning effort.

- **Plans should be clinically informed, but based on the public health approach.** BH agencies and professionals often focus on individual characteristics of suicidality and how those can be treated. However, to be effective, suicide prevention plans should also take a public health approach, looking not only at individual characteristics, but identifying risk and protective factors in populations, partnering across sectors, and working across the spectrum of prevention, intervention, and postvention. This will often need to involve non-BH settings such as primary care and Emergency Departments.

  EXAMPLES: North Carolina plan:
  http://www.injuryfreenc.ncdhhs.gov/About/YouthSuicidePreventionPlan.pdf (p. 9)
  Colorado plan: http://www.cdphe.state.co.us/pp/suicide/SuicideReportFinal2009.pdf (pp. 15-18)

- **Plans should focus on a lifespan approach.** Many state plans have focused exclusively on youth. While prioritizing youth suicide is urgent because of the special tragedy of losing young lives, suicide in midlife is more common and has been increasing in frequency. Effective state plans should focus on identifying risk and protective factors of populations across the lifespan and be flexible in addressing unique challenges related to various factors (geographic location, race, ethnicity, etc.).Planning should also take into account groups with elevated or increasing rates or numbers of suicide attempts or deaths, such as American Indian/Alaska Natives, Hispanic and LGBT youth, veterans and the military, and men in midlife.

  EXAMPLE: Wisconsin plan:
  http://www.dhs.wisconsin.gov/health/InjuryPrevention/pdffiles/WISuicidePrevStrategy.pdf (pp.6-10)

- **Plans should utilize research and safety informed communications.** These efforts should promote hope and resilience, and awareness of the warning signs for suicide and how to connect individuals in crisis with assistance and care.

  Example: Oregon plan:
  (http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/2000plan/Pages/sectn2-5.aspx)

- **Plans should promote accountability, and be regularly monitored, updated and revised.** The field is still learning how to prevent suicide; a commitment to learning that seeks improvement but does not blame is important. Data on suicide and suicide attempts should be monitored and analyzed on an annual basis, including suicidal behavior among those receiving care in behavioral healthcare systems. State suicide prevention plans should be living documents. Annual action plans should identify who is responsible for carrying out the different elements of the plan, and suicide prevention leaders should assess progress at least annually. Periodically (every 3 years at most), those involved in statewide suicide prevention work should gather to look at the impact the plan has had, review updated data and resources, and update and/or revise the plan.

  EXAMPLE: Nebraska plan: http://www.sprc.org/sites/sprc.org/files/state_plans/plan_ne.pdf (pp. 3-4)

SHASTA COUNTY HEALTH AND HUMAN SERVICES AGENCY

People's Health

Outcomes • Planning • Evaluation

Know the facts: Local suicide rate doubles state rate

DID YOU KNOW?

- Suicide is now the 10th leading cause of death for Americans and the second leading cause of death among teenagers.
- Factors that can put a person at risk for suicide include history of previous attempts, family history, alcohol or drug abuse, depression or other mental illness, stressful life event or loss, and easy access to lethal methods.
- Suicide is often related to depression, which can be treated with medicine and psychotherapy/ counseling.
- Alcohol increases impulsivity, which is a significant risk factor for suicide. Intoxicated people are more likely to attempt suicide using more lethal methods.
- During 2014-2016, more than 81% of gun deaths in Shasta County were suicides and more than half of all suicides were completed with firearms.

Contributing Staff:
Jeff Van Ausdall and Stephanie Taylor. Last updated: December 2017.

WHERE WE WERE (BASELINE):

20.4 suicides per 100,000 population during 1999-2001 (3-year average annual age-adjusted rate) in Shasta County.

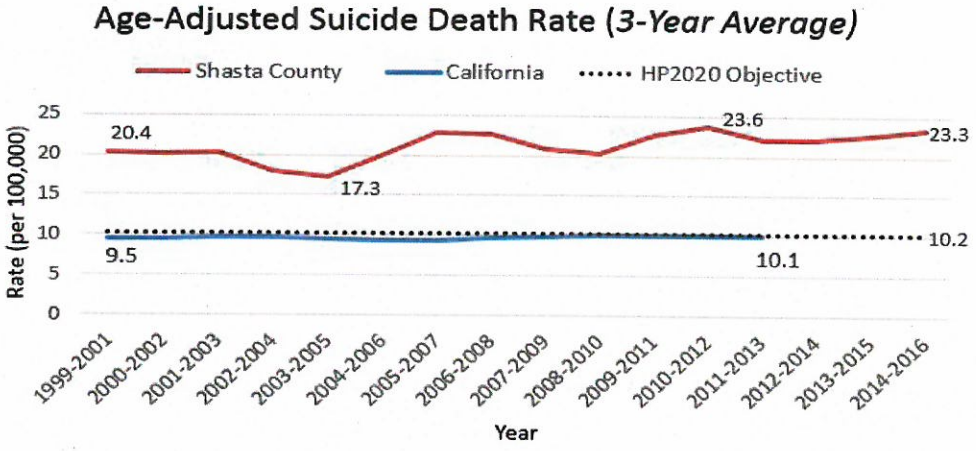
WHERE WE ARE:

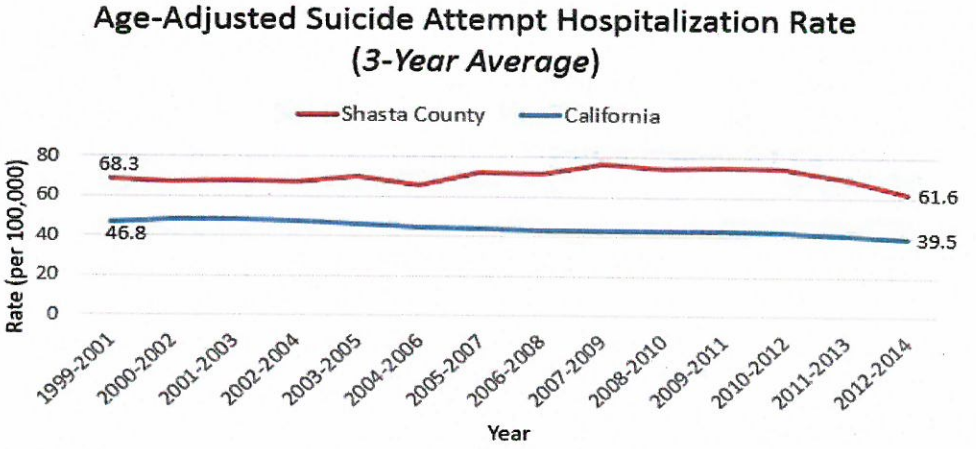
23.3 suicides per 100,000 population during 2014-2016 (3-year average annual age-adjusted rate) in Shasta County.

WHERE WE WANT TO BE:

The Healthy People 2020 goal is to reduce suicides to no more than 10.2 per 100,000 population (age-adjusted rate).

DEFINITION: Number of suicides and suicide rate (age-adjusted deaths per 100,000 population, ICD-10 codes U03.0, U03.9, X60-X84, and Y87.0, and suicide listed as the manner of death on the death certificate), and number of suicide attempts resulting in hospitalization and hospitalization rate for Shasta County residents (ICD-9 codes 950.0-958.9), 1999-present.





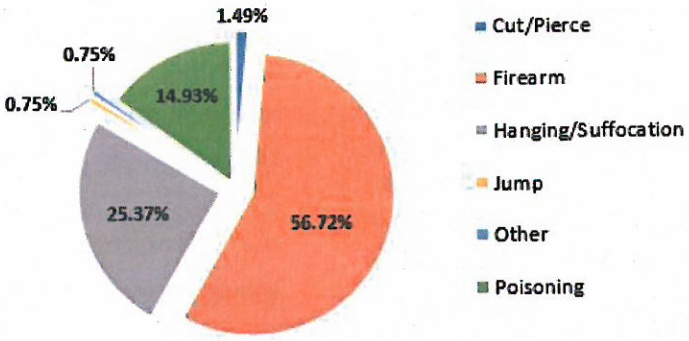
KEY POINTS:

- In 2014, there were 468,000 emergency department visits for self-inflicted injuries and 42,826 deaths due to suicide in the U.S., 50% of them by firearms.

- In California from 1999-2013, suicide death rates were stable and at or below the national target of 10.2 per 100,000 population. Hospitalization rates decreased from 46.8 to 39.5 per 100,000 population from 1999 to 2014.

- In Shasta County, suicide deaths increased between 1999 and 2016 from 20.4 to 23.3 per 100,000. Hospitalization rates decreased, however, from 68.3 to 61.6 per 100,000.

Method of Suicide in Shasta County, 2014-2016



PRIMARY PREVENTION ACTIVITIES:

- Promote healthy relationships with family and friends, and help people who are at risk of suicide connect with community activities and organizations to prevent social isolation.

- Work to eliminate stigma of mental illness and increase the percentage of clinically depressed people who receive treatment.

- Reduce access to firearms by depressed people through safe firearm storage, including use of trigger locks, gun cabinets, separation of ammunition from an unloaded firearm, and/or temporarily storing firearms at a responsible relative's or friend's home.

- Train health care providers to more effectively identify and address depression that may lead to suicide attempts, particularly in the elderly, among whom depression may not be as obvious.

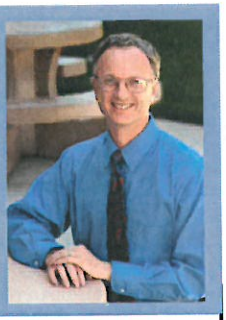
- Reduce substance abuse (particularly alcohol) and incidence of chronic disease among seniors.

- Advocate for crisis intervention services.

- Learn the warning signs of suicide and appropriate interventions, such as those taught in Question, Persuade, Refer (QPR) classes.

- Get involved with local suicide prevention efforts—visit www.shastasuicideprevention.com.

From the Desk of
Andrew Deckert, MD, MPH
Shasta County Public Health Officer



Suicide is an important public health problem that does not get enough attention, in part because of the social stigmatization and blaming of victims and their families and friends. This might lead to underreporting of suicide attempts and inadequate health care for people who attempt suicide. We can all learn to recognize the warning signs, including hopelessness, substance abuse, anger, anxiety, withdrawal and mood changes. Some factors that can help protect a person from suicidal thoughts and behavior include skills in problem solving, easy access to mental health facilities, family and community support, and cultural beliefs that discourage risky behaviors and suicide.

Suicide prevention is everybody's business. To your health!

Data source: Shasta County Public Health; California Department of Public Health, Office of Vital Statistics and Office of Statewide Health Planning and Development (OSHPD); CDPH Vital Statistics Death Statistical Master Files; Vital Records Business Intellegence System (VRBIS); http://epicenter.cdph.ca.gov; https://wonder.cdc.gov; California Department of Finance Demographic Research Unit; Centers for Disease Control and Prevention; Healthy People 2020; American Association of Suicidology.