MHSOAC Suicide Prevention Subcommittee Meeting Brief

May 23, 2018 | Sacramento, California (Sacramento County)

The second meeting of the MHSOAC Suicide Prevention Subcommittee is being held in Sacramento, California in Sacramento County, a county in California's Central Valley. During 2014-16, the average annual, age-adjusted suicide rate in Sacramento County was 13.1 deaths per 100,000 residents, above the state average of 10.1. The majority of people who died by suicide in 2016 were male (72%) and white (69%), and a plurality (38%) were age 45-64. The most prevalent means were by firearm (36%), hanging/suffocation (35%) and poisoning (20%).[1]

Below is an overview of the May 23 subcommittee meeting, followed by a brief report-out of several project activities since the March 16 subcommittee meeting.

Meeting Overview

The discussion during the first meeting of the Suicide Prevention Subcommittee, held on March 16, 2018, focused largely on disconnection—between people and community, but also disconnection or gaps in the system—as a barrier to suicide prevention. See attached site visits and meeting summary. The goal of the second meeting of the Suicide Prevention Subcommittee is to identify and explore possible solutions to fill system gaps and build connectedness.

Commissioners and meeting attendees will hear a story of healing from an attempt survivor, and the multiple modalities she uses to maintain recovery, followed by a presentation from WellSpace Health to explore opportunities for connecting people across health systems and crisis services. WellSpace Health is an integrated physical and behavioral health care provider in Sacramento, providing comprehensive services, including suicide prevention and crisis services.

The majority of the meeting will focus on a facilitated discussion with meeting attendees to identify opportunities for suicide prevention, specifically exploring the following questions:

- How can people be better connected to the appropriate level of care to prevent suicide and self-harm?
- What are the characteristics of a system that prevents suicide?
- What should a state plan for suicide prevention prioritize or emphasize?

Update on Project Activities

In addition to public meetings organized by the Commission, Commissioners and project staff talk with survivors of suicide attempt and loss and other experts, attend conferences, and participate in trainings in order to gather information for the development of California's suicide prevention plan. Below is a description of some of the project activities that have occurred since the first meeting of the Suicide Prevention Subcommittee on March 16, 2018.

National Council for Behavioral Health Conference

Project staff met with national suicide prevention experts and attended the National Council for Behavioral Health Conference in Washington, D.C. on April 22 through 25, including an all-day "preconference university" on the national *Zero Suicide Initiative.* See attached *Zero Suicide Initiative* factsheet. Approximately 45% of people who died by suicide saw their primary care physician within a

[1] California Department of Public Health Vital Statistics Death Statistical Master Files

month of death, and 83% saw a health care provider in the year prior to death.[2] These statistics, and significant reductions in suicide by programs that focus on safety, such as the *Henry Ford Health System* program, inspired the national *Zero Suicide Initiative.* This initiative seeks to create holistic, comprehensive health and behavioral health care systems, with a culture shift toward safety.[3]

Adolescent Mental Wellness Preconference and Conference

Project staff attended a symposium on *Media and Youth Suicide Reporting* hosted by Stanford Department of Psychiatry & Behavioral Sciences on April 26. The symposium targeted the media and included presentations on research, best practices, and youth perspectives on the challenges of responsible reporting and portrayals of suicide in the media. See attached factsheet. Staff also participated in the Adolescent Mental Wellness Conference on April 27 and 28. Conference workshops attended included youth and addiction in the developing brain, intersectionality and viewing mental health needs through a cultural and generational lens, and current best practices for suicide prevention among young people.

Student Mental Health Policy Workgroup

Subcommittee Member and Commissioner Mara Madrigal-Weiss and staff were invited to present and hear input on the development of the statewide suicide prevention plan during the California Department of Education's Student Mental Health Policy Workgroup meeting on May 11, 2018. Workgroup members and members of the public identified priorities and considerations for the statewide plan, including safe transport for kids from schools to services during crisis, early identification and screening for suicide risk in schools, local challenges to implementing state mandates, such as requirements under AB 2246, improved mechanisms for sharing confidential health information with schools, effective practices for inclusion of family in mental health treatment, and developing a robust referral system, including training for teachers and school staff.

California Mental Health Advocates for Children and Youth Conference

Project staff organized a youth-led workshop during the California Mental Health Advocates for Children and Youth Conference on May 17, 2018. The workshop included an interactive discussion on challenges and opportunities for reducing suicide and building wellness and resilience in at-risk youth. Youth led a discussion during the workshop that included descriptions of environments in which youth felt safe and supported, experiences of feeling dehumanized, and means restriction and replacement – taking away the means youth want to die by and replacing it with something to live for, such as creative arts, spirituality, people, and pets. Workshop participants recommended youth have opportunities to develop wellness plans before safety plans – which is often developed after a suicide attempt or self-harm.

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

[2] Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence, *Am J Psychiatry*, *159 (6)*, 909-16.
[3] Please visit https://zerosuicide.sprc.org/ for more information.

Developing a Strategic Statewide Suicide Prevention Plan

March 16, 2018 | Site Visits and Subcommittee Meeting Summary

Project Background. Suicide is a leading cause 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] Assembly Bill 114 (Chapter 38, Statutes of 2017) authorized the Mental Health Services Oversight and Accountability Commission to develop a new, statewide strategic plan for suicide prevention in California. To develop this plan, the Commission is organizing a series of public hearings and meetings, community forums, site visits, and small group discussions to understand challenges and opportunities for the prevention of suicide.[2]

Site Visits and Meeting Summary. The first meeting of the Commission's Suicide Prevention Subcommittee was held in Redding, California. Redding is the county seat in Shasta County, a small county in rural Northern California - an area with the highest rates of suicide in the State.[3] The overarching goals of the meeting were 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. The subcommittee organized a series of site visits prior to the meeting to support the understanding of several key concerns, including comprehensive suicide prevention planning, issues impacting Northern California Tribal communities, and care for people in or at-risk of suicidal crisis. The next Suicide Prevention Subcommittee meeting will be held on Wednesday, May 23, 2018 in Sacramento.

Agenda at a Glance

SITE VISITS

Shasta County Health and Human Services Agency

Redding Rancheria Tribal Health Center

The C.A.R.E. Center

MEETING

Welcome and Introductions

Survivor Story: Linda Heinrich

Presentation: Suicide Prevention in Shasta County

Open Public discussion: Suicide Prevention in Rural Communities

Suicide Prevention in Rural Communities. Meeting attendees identified challenges to preventing suicide in rural communities, including staff capacity, transportation to services, social and geographical isolation, access to lethal means, and stigma and discrimination. A representative of Shasta County presented information on how the County is addressing these challenges through a comprehensive suicide prevention strategy, led by the Shasta County Suicide Prevention Workgroup, which includes awareness programs and promotional events, resources on firearm safety, and community support.[4]

> ***"I didn't have to do my job alone."***
>
> *Amy Sturgeon, Community Education Specialist for Shasta County, on the benefits of working with a community-driven, multi-disciplinary workgroup on suicide prevention*

The County's presentation highlighted how the community agreed on a range of strategies but had to be empowered from within to put a plan into action. This action included organizing health fairs and awareness walks, forming a grief support group for loss survivors, developing specialized resources for schools and primary care providers, and deploying a campaign specifically designed to appeal to men – a group three to four times more likely to die by suicide compared to women and often resistant to accessing available services. The presentation also outlined a multi-tiered approach to training community members and groups at increased risk, including training for school-aged children and school staff on having a conversation about suicide, recognizing the signs of depression and other mental health needs, and demystifying the help available to address these needs.

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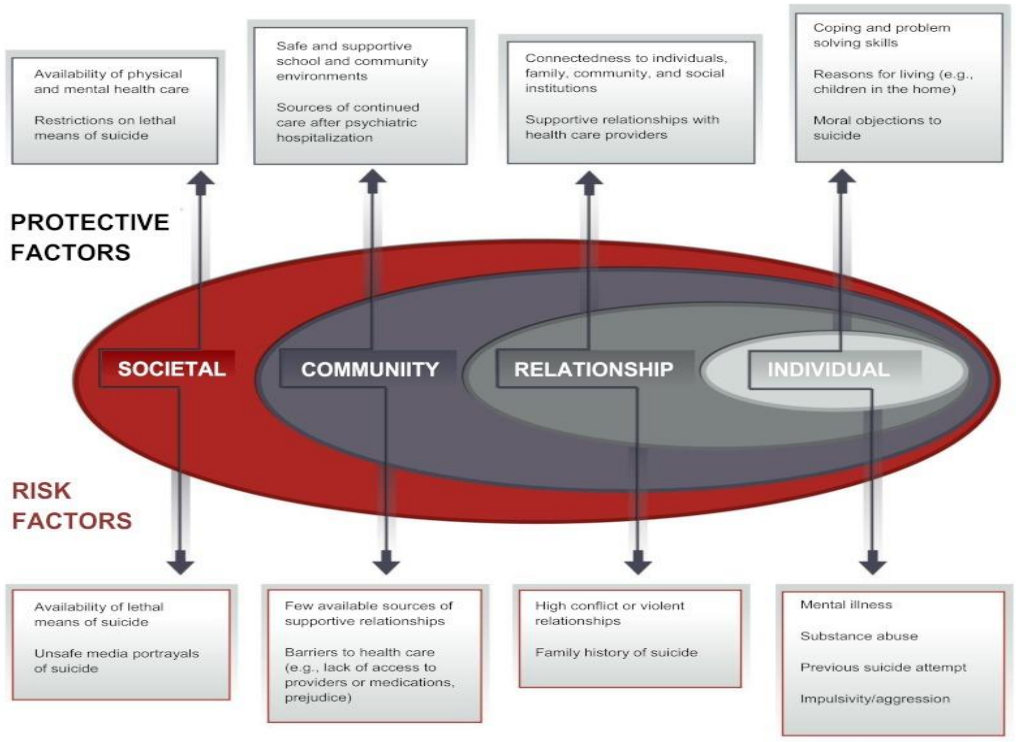
[1] American Foundation for Suicide Prevention. Suicide: California 2017 Facts & Figures. Accessed March 30, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

[2] Visit http://mhsoac.ca.gov/suicide-prevention for more information about the project and the Commission's Suicide Prevention Subcommittee

[3] Ramchand, R., & and Becker, A. (2014). *Suicide Rates in California: Trends and Implications for Prevention and Early Intervention Programs*. Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/research_briefs/RB9737.html.

[4] For more information: www.shastasuicideprevention.com

Public Health Approach to Suicide Prevention. Meeting attendees discussed suicide prevention within a public health framework, taking a broad view of the potential drivers behind suicide. Community conditions, life experiences especially around loss, trauma across the lifespan, and access to lethal means, such as firearms and legal and illegal drugs, were all identified as possible factors influencing suicide and suicide attempt. Meeting attendees discussed how, in a public health framework, everyone has a role in preventing suicide. Meeting attendees discussed protective factors and risk factors within a social ecological model, pictorially displayed in the 2012 National Strategy for Suicide Prevention:[5]



Site visit participants heard an overview of how the Shasta County Health and Human Services Agency is working to address community mental wellbeing, social and emotional resiliency, and adverse childhood experiences – in addition to direct mental health services – to prevent suicide and suicide attempt. The agency also is working to address firearm safety and access to firearms.[6] The means by which someone attempts suicide matter – 90 percent of people who attempt suicide and live do not go on to die by suicide in the future.[7] Several meeting attendees mentioned Harvard University's *Means Matter Campaign*, which promotes ways to reduce access to lethal means for suicidal people, including partnership with gun owner groups, as a resource for communities to start conversations about reducing access to lethal means.[8]

Prevention and Intervention. Meeting attendees discussed how suicide prevention approaches should be data-driven, but how often data are not adequate or available. Despite data challenges, site visit presentations and meeting attendees identified several groups of people at risk for suicide, including the LGBTQ community,

[5] Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012). *National Strategy for Suicide Prevention: Goals and objectives for action*. Washington, DC: US Department of Health & Human Services.
[6] Shasta County's gun safety program was adapted with permission from materials developed by the New Hampshire Firearms Safety Coalition. More information can be found here: https://www.co.shasta.ca.us/docs/libraries/hhsa-docs/Suicide-Prevention-II/2016-firearm-brochure-final-2-0.pdf?sfvrsn=c309e589_0.
[7] For a summary of the research: https://www.hsph.harvard.edu/means-matter/means-matter/survival/
[8] For more information on the Means Matter Campaign: https://www.hsph.harvard.edu/means-matter/

older adults, members of Tribal communities, and veterans. Meeting attendees also highlighted professions that also may be at increased risk, including peace officers and farm workers.

LGBTQ. At an early age, LGBTQ and gender diverse people can develop a sense of not feeling safe and experience trauma, particularly when they experience rejection, shame, and isolation and bullying by their peers. When seeking services, meeting attendees discussed how LGBTQ and gender diverse people can face significant stigma and discrimination based on their gender and sexual orientation, especially in more rural communities. Meeting attendees asserted that more needs to be done to reach out to LGBTQ people, especially kids and in school settings, to let them know that there is support and a community available to help them. One method for doing this is through a school-based LGBTQ peer group or outreach and engagement by community-based LGBTQ centers.[9]

Older Adults. One meeting attendee voiced concern over the lack of assessment and services for older adults, particularly in under-resourced rural communities. Older adults experience high suicide rates driven primarily by unmet mental health needs, personality traits and coping mechanisms, physical health conditions, life stressors – such as loss of loved ones - and social disconnection, and impairments in functioning and disability.[10] A representative of Mendocino County shared with meeting attendees a program in her county that uses senior peer volunteers to engage isolated seniors, increasing protective factors, and connecting seniors to services if there are signs of suicide risk.[11]

Tribal Communities. Some of the challenges to preventing suicide in Tribal communities include lack of access to services, transportation, and substance use. Discussions during the site visit to the Redding Rancheria Tribal Health Center highlighted how access to services was difficult because of geography and availability. Services are often spread out and distributed unevenly or are not available or accessible to certain Tribal communities. Transportation is another barrier to accessing not only services but cultural events that could keep people connected to their Tribal community and culture. Finally, use of drugs and alcohol – personal use but also use by family members in the home – was identified as an additional potential cause of increased suicide rates, particularly among Native youth.

Veterans. Meeting attendees also discussed veterans as a group at increased risk of suicide, and the potential causes of that increase. Meeting attendees representing veterans spoke about "warrior mentality," and how members of the military have to be warriors in combat to protect themselves and others. This mentality can be hard to shift, once a veteran returns home. As a result, veterans struggle to access the care and support needed to respond to the trauma experienced in the military. A representative of the veterans' community commented on his own experience saying that he intentionally isolated himself, and did not want help. He went on to say that sometimes we need to create our own community, a safe place for veterans to go so they do not have to "deal with the chaos and confusion alone" – but can find safety among peers.

Mentioned at the Meeting

AB 89 (Levin, 2017) Effective January 1, 2020, requires all licensees and applicants for licensure as a psychologist to have completed a minimum of six hours of coursework, and/or applied experience under supervision in suicide risk assessment and intervention.

AB 2246 (O'Donnell, 2016) Requires local educational agencies that serve pupils in grades 7-12 to adopt suicide prevention policies before the beginning of the 2017-18 school year.

For more information, including the California Department of Education's model suicide prevention policy, visit: https://www.cde.ca.gov/ls/cg/mh/suicideprevres.asp

[9] The Gay Straight Alliance is an example of LGBTQ and ally alliances in schools: https://gsanetwork.org/
[10] Conwell Y. (2014). Suicide later in life: challenges and priorities for prevention. *Am. J. Prev. Med. 47(3Suppl. 2), S244–S250*.
[11] For more information: https://www.mendocinocounty.org/home/showdocument?id=17691

Several professions also were highlighted at the subcommittee meeting when attendees were identifying groups at risk, including peace officers, firefighters, and emergency medical technicians. Meeting attendees identified chaplains as a potential resource to support members of these groups, along with peer support. One member of law enforcement spoke during the meeting about an uptick in peace officers on stress disability and possible influence of social and political climates and impacts on mental health. Meeting attendees also mentioned farm and construction workers as two groups with high rates of suicide.[12]

Meeting attendees mentioned several efforts underway to train various community groups in suicide prevention. One effort specifically mentioned has the potential to train faith-based communities in suicide prevention.[13] However, one meeting attendee commented on how educators were under pressure to be in a position to identify and respond to a suicidal student even if unprepared and under-resourced, saying "they're [educators] collectively holding their breath." Regardless of the role of the person being trained, meeting attendees acknowledged that resources must be available in the community to connect people identified as at-risk.

Postvention. Site visit presentations and meeting attendees highlighted the need for more programs and services to support people caring for a suicidal person or survivors of suicide loss. Programs and services designed to support people who have lost someone to suicide – and who could be at increased risk for suicide themselves - is referred to as *postvention*. Postvention is critical to suicide prevention as knowing someone who has died by suicide is a significant risk factor for suicide and other negative mental health outcomes.[14] One meeting attendee from NAMI New Hampshire spoke about the *Connect Program* with meeting attendees. The postvention component of the program helps communities and service providers respond in a coordinated and comprehensive way after a suicide.[15]

> ***"We're great at giving help but terrible at asking for it."***
> *Meeting attendee during the discussion on support for caregivers and professionals working or interacting with people in or at risk for suicidal crisis*

Meeting attendees spoke about processing grief, and how people experience grief in different ways at different times. A loss survivor described how she not only lost her stepson to suicide but how she had to grieve the loss of her relationship as she knew it with her husband. One meeting attendee commented that families in Native and Latino communities do not talk about suicide or suicide attempts. He agreed with other meeting attendees that the sooner you start talking, the sooner the healing process begins. There was a discussion about the importance of providing loss survivors safe space to talk about grief and the understanding that there will be set backs in the healing process, and for offering supportive services and respite to caregivers of suicidal people.

Next Steps. The next Suicide Prevention Subcommittee meeting will be held on Wednesday, May 23, 2018 in Sacramento. The theme of the meeting will be "connections," and the agenda will be organized around presentations and discussion on strengthening connections within the community – between primary care, hospitals, schools, law enforcement, crisis support, and more. The first public hearing on suicide prevention will be held during the Thursday, May 24, 2018 Commission meeting in Sacramento. For more information, including upcoming events, please visit http://mhsoac.ca.gov/suicide-prevention.

[12] *Mates in Construction* was mentioned as a resource for construction worker suicide prevention: http://matesinconstruction.org.au/
[13] *Soul Shop* was mentioned as a suicide prevention training for faith-based communities. For more information: http://www.soulshopmovement.org/
[14] Pittman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Lancet Psychiatry, 1, 86–94*.
[15] For more information: http://www.theconnectprogram.org/training/reduce-suicide-risk-and-promote-healing-suicide-postvention-training

ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

- » LEAD
- » TRAIN
- » IDENTIFY
- » ENGAGE
- » TREAT
- » TRANSITION
- » IMPROVE

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

SPRC

National Action Alliance

2.10.15

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential elements of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs). These elements include:

1. **LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
2. **TRAIN** » Develop a competent, confident, and caring workforce.
3. **IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
4. **ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. **TREAT** » Use effective, evidence-based treatments that directly target suicidality.
6. **TRANSITION** » Provide continuous contact and support, especially after acute care.
7. **IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

If we do not set big goals, we will never achieve them. In the words of Thomas Priselac, president and CEO of Cedars-Sinai Medical Center:

"It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It's about purposefully aiming for a higher level of performance."

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems. While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

To assist health and behavioral health plans and organizations, the Suicide Prevention Resource Center (SPRC) offers an evolving online toolkit that includes modules and resources to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at www.zerosuicide.com
and at www.zerosuicideinstitute.com

FOR MORE INFORMATION, PLEASE CONTACT:
Zero Suicide
Suicide Prevention Resource Center
Email: zerosuicide@edc.org

RECOMMENDATIONS FOR REPORTING ON SUICIDE

Developed in collaboration with: American Association of Suicidology, American Foundation for Suicide Prevention, Annenberg Public Policy Center, Associated Press Managing Editors, Canterbury Suicide Project - University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, ConnectSafely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National Alliance on Mental Illness, National Institute of Mental Health, National Press Photographers Association, New York State Psychiatric Institute, Substance Abuse and Mental Health Services Administration, Suicide Awareness Voices of Education, Suicide Prevention Resource Center, The Centers for Disease Control and Prevention (CDC) and UCLA School of Public Health, Community Health Sciences.

IMPORTANT POINTS FOR COVERING SUICIDE

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.

Suicide Contagion or "Copycat Suicide" occurs when one or more suicides are reported in a way that contributes to another suicide.

References and additional information can be found at: www.ReportingOnSuicide.org.

INSTEAD OF THIS:	DO THIS:
• Big or sensationalistic headlines, or prominent placement (e.g., "Kurt Cobain Used Shotgun to Commit Suicide").	• Inform the audience without sensationalizing the suicide and minimize prominence (e.g., "Kurt Cobain Dead at 27").
• Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.	• Use school/work or family photo; include hotline logo or local crisis phone numbers.
• Describing recent suicides as an "epidemic, " "skyrocketing," or other strong terms.	• Carefully investigate the most recent CDC data and use non-sensational words like "rise" or "higher."
• Describing a suicide as inexplicable or "without warning."	• Most, but not all, people who die by suicide exhibit warning signs. Include the "Warning Signs" and "What to Do" sidebar (from p. 2) in your article if possible.
• "John Doe left a suicide note saying…".	• "A note from the deceased was found and is being reviewed by the medical examiner."
• Investigating and reporting on suicide similar to reporting on crimes.	• Report on suicide as a public health issue.
• Quoting/interviewing police or first responders about the causes of suicide.	• Seek advice from suicide prevention experts.
• Referring to suicide as "successful," "unsuccessful" or a "failed attempt."	• Describe as "died by suicide" or "completed" or "killed him/herself."

AVOID MISINFORMATION AND OFFER HOPE

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses, that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90% of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information and advice that promotes help-seeking.

SUGGESTIONS FOR ONLINE MEDIA, MESSAGE BOARDS, BLOGGERS & CITIZEN JOURNALISTS

- Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies and procedures could support removal of inappropriate and/or insensitive posts.

MORE INFORMATION AND RESOURCES AT:

www.ReportingOnSuicide.org

HELPFUL SIDE-BAR FOR STORIES

WARNING SIGNS OF SUICIDE

- **Talking about wanting to die**
- **Looking for a way to kill oneself**
- **Talking about feeling hopeless or having no purpose**
- **Talking about feeling trapped or in unbearable pain**
- **Talking about being a burden to others**
- **Increasing the use of alcohol or drugs**
- **Acting anxious, agitated or recklessly**
- **Sleeping too little or too much**
- **Withdrawing or feeling isolated**
- **Showing rage or talking about seeking revenge**
- **Displaying extreme mood swings**

The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide but may not be what causes a suicide.

WHAT TO DO

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone
- Remove any firearms, alcohol, drugs or sharp objects that could be used in a suicide attempt
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK (8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

THE NATIONAL SUICIDE PREVENTION LIFELINE

800-273-TALK (8255)

A free, 24/7 service that can provide suicidal persons or those around them with support, information and local resources.

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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.