MHSOAC Suicide Prevention Subcommittee Meeting Brief

June 13, 2018 | San Diego, California (San Diego County)

The third meeting of the MHSOAC Suicide Prevention Subcommittee is being held in San Diego, California in San Diego County, a large county in Southern California. During 2014-16, the average annual, age-adjusted suicide rate in San Diego County was 12.1 deaths per 100,000 residents, above the state average of 10.1.[1] The majority of people who died by suicide in 2016 were male (75%) and white (72%), and a plurality (68%) were age 25-64. The most prevalent means were by firearm (35%), hanging/suffocation (28%) and poisoning (21%).[2]

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. During the second meeting of the Suicide Prevention Subcommittee on May 23, 2018 in Sacramento, meeting attendees heard a presentation on a proactive approach developed by WellSpace Health Suicide Prevention and Crisis Services that provides better connections across systems. Meeting summaries are attached.

The goals of the third meeting of the Suicide Prevention Subcommittee are to explore local suicide prevention planning and implementation strategies and to identify priorities and brainstorm solutions in several strategic areas. Commissioners and meeting attendees will hear a presentation and musical performance about healing through arts, personal expression, and community building, followed by a presentation on San Diego County's recently released suicide prevention plan and a presentation on how the local Office of Education is supporting schools in implementing suicide prevention policies as directed by AB 2246 (O'Donnell, 2016).

The second half of the meeting will focus on a facilitated discussion with meeting attendees to identify priorities and brainstorm solutions, using the strategic directions outlined in the 2012 National Strategy for Suicide Prevention as a guide. The strategic directions are broad categories centered on healthy communities, training, crisis services and treatment, and data.

Meeting Materials

- Presenter biographies and PowerPoint Presentations
- Assembly Bill 2246 (O'Donnell, 2016)
- *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.
- *Developing a Strategic Statewide Suicide Prevention Plan: Project Brief* (developed by the MHSOAC)

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

[1] California Department of Public Health County Health Status Profiles 2018. Available online: https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP-County%20Profiles%202018.pdf

[2] Source: CDPH Vital Statistics Death Statistical Master Files. Prepared by: California Department of Public Health, Safe and Active Communities Branch Report generated from http://epicenter.cdph.ca.gov on: June 1, 2018.

Developing a Strategic Statewide Suicide Prevention Plan

May 23, 2018 | 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]

Agenda at a Glance

- Welcome and Introductions
- Survivor Story: Tatyana
- Presentation: WellSpace Health
- Open Public Discussion: Opportunities for Filling System Gaps and Building Connectedness

Meeting Overview. The second meeting of the Commission's Suicide Prevention Subcommittee was held in Sacramento, California. The aims of the meeting were to share the project objectives and to explore opportunities for filling system gaps and safely connecting people to services before, during, and after a crisis. These aims were addressed through presentations by a person with lived experience and WellSpace Health and its Suicide Prevention and Crisis Services program, as well as a facilitated discussion among meeting attendees. The contents of the presentations and group discussion are summarized below. The next Suicide Prevention Subcommittee meeting will be held on Wednesday, June 13, 2018 in San Diego.

Connecting People to Services and Providing Support.

One of the goals of the meeting was to identify ways in which people could be better connected to appropriate levels of care for preventing suicide and self-harm. Representatives from WellSpace Health in Sacramento were invited to present how they deliver proactive, comprehensive services as one way to enhance connectedness. Below is a brief overview of information presented.

Connecting Attempt Survivors to Services. The risk of a suicide attempt or death is highest within 30 days of discharge from an emergency department or inpatient psychiatric unit.[3] Furthermore, up to 70 percent of people who leave the emergency department after a suicide attempt never attend their first outpatient appointment.[4] WellSpace Health operates the *Emergency Department Follow-Up* program, which is designed to fill the gap between hospital discharge and follow-up services and treatment. The program

About WellSpace Health Suicide Prevention and Crisis Services

WellSpace Health operates the Suicide Prevention Crisis Line based out of Sacramento, California. The hotline, which is nationally accredited and a vital member of the National Lifeline network, serves Sacramento and Placer counties and many other counties in Northern California. The hotline answers calls 24 hours a day, 365 days a year. Additional services include support for survivors of suicide loss, emergency department follow-up, outreach, and training.

https://www.wellspacehealth.org/services/counseling-prevention/suicide-prevention

[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] Knesper, D. J. (2010). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Suicide Prevention Resource Center.

[4] Ibid.

serves people being released from the hospital, with goals of preventing future suicide attempts after an emergency department visit and connecting people to community-based services for ongoing treatment and support. First contact by the program occurs within 24 hours of discharge, and services include emotional support, debriefing, risk assessment and monitoring for suicidality, and individualized safe planning. The program is currently being implemented in four counties and is showing promising outcomes.

Connecting People with Known Risk. Using a proactive approach, Wellspace Health representatives presented how two programs are delivering screening, assessment, and service connection for people at risk.

- *Primary Care Follow Up Suicide Prevention program (PCFU)*: Established in 2016, the program integrates screening for suicide risk in Primary Care Health Centers and refers people to the 24-hour crisis lines through the electronic health record, and 30 days of follow-up, risk monitoring, emotional support, resource linkage, and safety planning.
- *Men and Providers Suicide (MAPS) Study*: The MAPS Study is a three-year randomized control trial funded by the Center for Disease Control and Prevention. The study screens middle-aged men seen by UC Davis Primary Care providers for depression and suicidality and provides intervention and follow-up.[5] WellSpace Health provides study participants follow-up care and support.

Support for First Responders. Finally, presenters shared how WellSpace Health is working to support first responders - people who may interact frequently with people in suicidal crisis – with suicide prevention training and support. Two programs were highlighted:

- *POST Academy Suicide Prevention Training for Peace Officers and 911 Dispatchers*: Provides multi-media training for dispatchers and peace officers throughout California to strengthen understanding of suicide and preparation for suicidal callers.
- *Suicide Prevention and Rural Counties Intervention (SPARC)*: Engages WellSpace Health Crisis Center with first responders on suicide-related calls or 5150s, as well as providing follow-up by phone to conduct risk assessment, monitoring, emotional support, and safety planning.

Identifying Priorities.

Meeting attendees identified several priorities and areas of emphasis for a statewide strategic plan to prevent suicide. These priorities include increasing access to appropriate services for at-risk groups, sustainability, creating a comprehensive approach to suicide prevention, and strengthening data collection and reporting on suicide and suicide attempt.

Increasing Access for At-Risk Groups. Meeting attendees reiterated the need for a statewide plan to be flexible to meet diverse community needs, but recognizing and responding to groups that may be more at risk for suicide. Some of these groups highlighted by meeting attendees included older adults, people experiencing homelessness, LGBTQ youth, school-aged children, first responders, and veterans.

Older adults: One meeting attendee specifically mentioned increased isolation and lack of access to suicide prevention resources for older adults. Meeting presenters responded to this comment by highlighting how primary care providers could identify and refer older adults to services, filling this access gap.

[5] Visit https://clinicaltrials.gov/ct2/show/NCT02986113 for more information.

People Experiencing Homelessness: People, particularly youth, experiencing homelessness were identified as an underserved at-risk group with unequal access to services, in part because they do not have contact information or a consistent, reliable address – making follow-up not possible or difficult. One meeting attendee identified a need to have more training for providers to understand the unique needs of transient populations, and better methods of outreach and engagement.

LGTBQ Youth: Several meeting attendees identified LGBTQ youth and gender diverse people as having specific needs that often go unaddressed. One approach may be to include gender and sexuality education for school-aged children. Another approach specifically identified by a meeting participant was to acknowledge cultural barriers in systems and services, such as "toxic masculinity," which may prevent children from expressing non-conforming gender identity and sexual orientation and parents, educators, and peers from accepting and supporting such expressions.[6]

First Responders and Caregivers: One meeting attendee highlighted the issue of "compassion fatigue" felt by first responders - with more exposure to suicidal people, first responders may become more indifferent and less empathetic. Meeting participants identified a need for first responders to have access to supportive services and policies that reduce compassion fatigue. Caregivers were identified as a group at increased risk of depression. Caregivers often put the needs of others before themselves and put off addressing their own needs.

Mentioned at the Meeting: ThriveNYC

New York City's ThriveNYC initiative was mentioned as a comprehensive approach to improving mental health care and possibly effective suicide prevention. The initiative is built on six principles:

Change in Culture. Addressing stigma and demonstrating how everyone is a part of the solution.

Act Early. Focus on social emotional learning, youth and their relationships, and strong school and mental health collaboration.

Close Treatment Gaps. Identifying barriers to getting people the care they need and closing treatment gaps.

Partnering with Communities. Collaboration with communities and creating culturally competent solutions.

Use Data Better. Using best practices in data collection, surveys, and ongoing evaluations of initiatives.

Strengthen Government's Ability to Lead. Lead all government stakeholders towards shared objectives.

For more information:
https://thrivenyc.cityofnewyork.us/

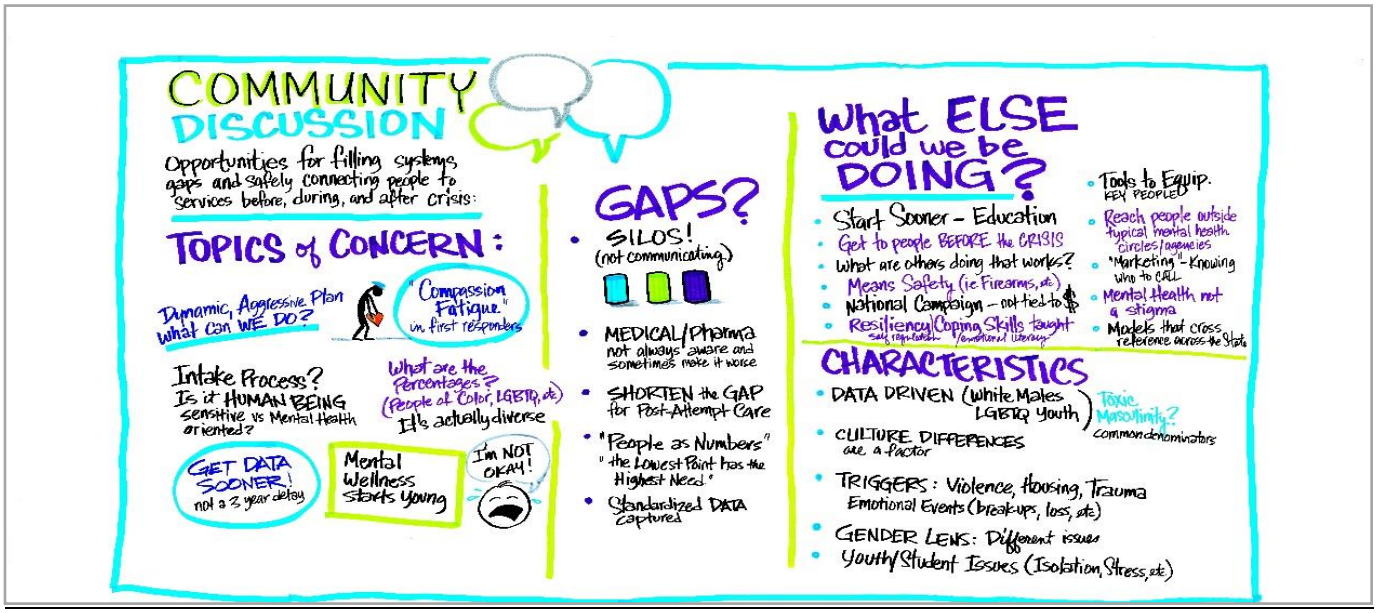
"Suicide is not just a mental health issue—it's a people issue."

Meeting attendee, on involving other systems and industries to prevent suicide

Creating a Sustainable Plan. One area of emphasis identified by meeting attendees was the need for a sustainable suicide prevention plan that does not rely on a single funding stream or department to be effective. Meeting attendees asserted throughout the meeting that suicide prevention strategies needed to be broader than mental health, and that suicide prevention should be built into research, policy, and practice across industries.

[6] The Good Men Project defines toxic masculinity as "a narrow and repressive description of manhood, designating manhood as defined by violence, sex, status and aggression. It's the cultural ideal of manliness, where strength is everything while emotions are a weakness; where sex and brutality are yardsticks by which men are measured, while supposedly "feminine" traits—which can range from emotional vulnerability to simply not being hypersexual—are the means by which your status as "man" can be taken away." For more information: https://goodmenproject.com/.

Need for a Comprehensive Strategy. Meeting attendees discussed the need to develop a comprehensive strategy to prevent suicide - beyond delivering mental health services. Priorities in this area identified by meeting attendees include having a trauma-informed plan with an explicit equity approach, broad inclusion of health care, education, and business partners, and supports at the community-level to promote social cohesion. One meeting attendee stated that people at risk for suicide may be triggered by life changes or loss, such as break-up of romantic relationship, loss of job, or death of a loved one. One presenter shared that it was changes in her physical health – during menopause – combined with not taking care of her own needs which eventually lead to several suicide attempts. It was not until she prioritized her well-being that she was able to heal.



Graphic design of the open public discussion

Data Collection and Reporting. Meeting attendees identified gaps in current data collection and reporting. The timeliness of data was highlighted as a barrier to understanding trends in suicide and impacts of programs. Meeting attendees identified challenges with the unavailability of timely data, specifically a three-year time lag between the calendar year and the year with the latest available data in data collection systems, such as those maintained by the Center for Disease Control and Prevention. Meeting attendees discussed how communities of color do not "show up in the data." Specifically, two scenarios were mentioned: (1) race/ethnicity is misidentified on death certificates, and (2) some communities are less likely to acknowledge mental health needs or circumstances that may support a determination of death as suicide by the coroner because of stigma, shame, or religious reasons. Meeting attendees asserted that enhanced data collection and reporting of suicides and suicide attempts was essential to more effective services and target limited funding.

Next Steps. The next Suicide Prevention Subcommittee meeting will be held on Wednesday, June 13, 2018. The meeting will be organized to explore planning for suicide prevention, implementation challenges and opportunities, and building in sustainability. The second public hearing will be held in fall 2018. The first draft of the strategic plan is scheduled to be released for public comment in spring 2019. For more information, including upcoming events, please visit http://mhsoac.ca.gov/suicide-prevention.

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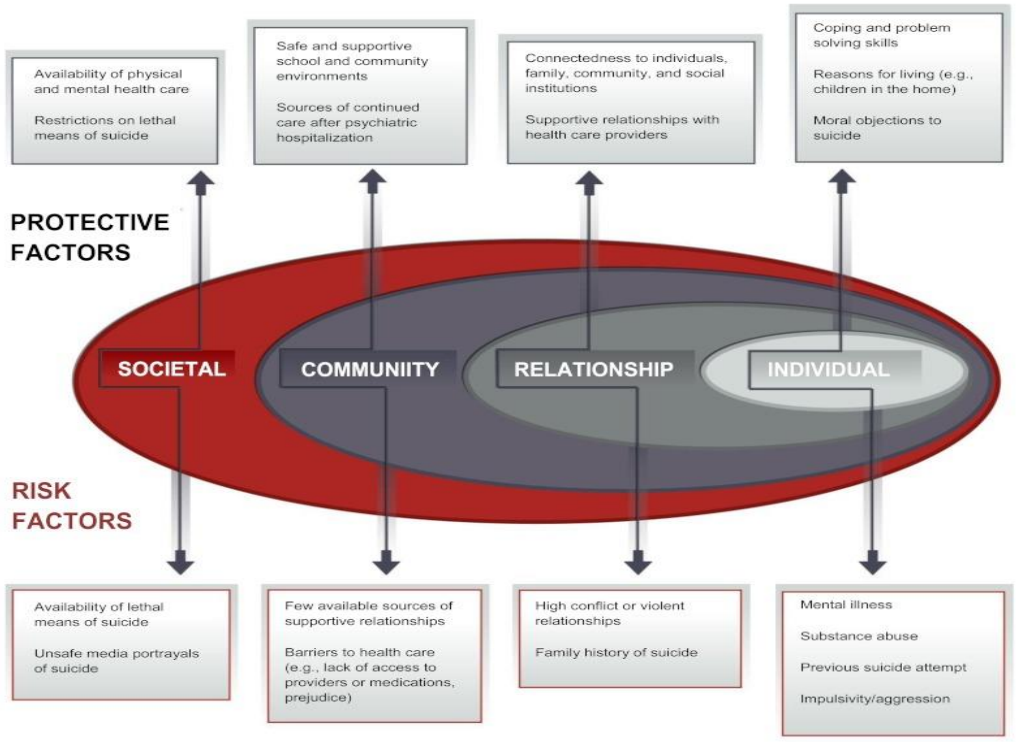
[1] American Foundation for Suicide Prevention. Suicide: California 2017 Facts & Figures. Accessed March 30, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

[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

Presenter Bios

Dairrick Hodges is the Founder and Executive Artistic Director of the SOULcial Workers. The SOULcial Workers envision a world where every youth is provided the safety and support to explore and develop identity. The SOULcial Workers envision a world where all youth have equal access to the arts and are empowered by connected, compassionate and culturally competent communities.

About Dairrick from http://www.thesoulcialworkers.com/: At my core I am child of survival, and it is ultimately my lived experiences that have guided my pursuits as both an artist and in social work. I spent the larger part of my upbringing in the child welfare system. I know first-hand what it is like to grow up in world where dysfunction is your norm. Lived most of my youth never having the language to identify nor regulate my emotions. I was additionally unable to identify the impact my traumatic experiences had on my ability to function in school, build relationships and establish safety in any environment.

It wasn't until I discovered the arts that I learned the importance of self-expression and developed the tools necessary to process some of the things I had survived throughout my journey. I was able to explore and gain exposure to various forms of artistry; foster my talents and establish a sense of identity that has carried through my life, which I have dedicated to creating similar avenues for youth like myself.

The number one challenge youth have expressed to me are feelings of loneliness and disconnection. They have been surviving through extreme levels of trauma and adverse circumstances, and are being silenced by shame. This creates symptoms from our youth that can present across a spectrum of behaviors ranging from substance abuse to suicide, which is the second-leading cause of death among youth in the United States.

Youth who are provided access to creative outlets, the opportunity to process their emotions, and a chance to understanding how to separate who they are, from what has happened to them, will score exponentially higher on the resiliency scale and demonstrate an improved capacity for wellness throughout adulthood.

It is important for young people to understand the dynamics of relationships, to know how to identify healthy and unhealthy relational patterns and gain the skills to build them in their own lives. Youth need a community of compassionate and invested people to walk with them through lives obstacles. I have founded this organization as a vow to play my part in creating awareness to preventing senseless loss; to ensure that no one is neglected or feels alone, limited by their differences or experiences and robbed of the opportunity to reach their full potential.

So much about the way we connect needs real change, and I believe that this kind of change requires artist to get involved and create it. As artists we are gifted with abilities to inspire and influence. We naturally possess a necessary vulnerability that gives us the power to create community connection, and connected communities create change. Personally I can't think of a better place to invest our aspirations for a better world than in our youth. After all, this world belongs to them.

Stan Collins has worked in the suicide prevention field for over 17 years. He has presented or provided training to over 750,000 adults and youth on the subject of suicide prevention including medical professionals, military, law enforcement, school staff and community members. In 2001, he testified before a United States Senate Subcommittee on the topic of youth suicide. Currently he is working as a consultant in the field, focusing on technical assistance in creation and implementation of suicide prevention curriculums and strategies. Stan is part of the California Department of Education's workgroup that developed the "Model Policy for Youth Suicide Prevention" in response to AB2246. Part of his work currently includes providing trainings to school districts across the state to assist in implementing AB2246 policies and procedures. He is the co-founder of the Directing Change Program and Film Contest. In addition, he is co-author of the Know the *Signs Training Resource Guide for Suicide Prevention in Primary Care* toolkit, and author of the San Diego County *Suicide Prevention Gatekeeper Training for First Responders*.

Heather Nemour is a Project Specialist for the San Diego County Office of Education, Student Support Services; Student Mental Health & Well-Being. She works with school districts and schools to increase mental health literacy, reduce the stigma around mental health and promote positive school climate models. Ms. Nemour is a certified trainer in Youth and Adult Mental Health First Aid, Restorative Practices, Developmental Assets, Standards of Quality Family Strengthening & Support and is a SWIS Facilitator supporting several schools throughout the county in implementing data based decision making around student behavior. Ms. Nemour has eighteen years of leadership experience coordinating school-based support services in Chula Vista, California. She was instrumental in the development and sustainability of five school-based Family Resource Centers that support over 70 schools in the South Bay. Ms. Nemour received her BS in Sociology and MA in Sociological Practice both at California State University, San Marcos.

Violeta Mora is a Project Specialist with Student Mental Health & Well-Being (SMHWB) program at the San Diego County Office of Education. The goal of SMHWB is to support the mental health and well-being of students. Ms. Mora has been committed to supporting schools, students and families with resources to remove barriers that impact student success since 1994.

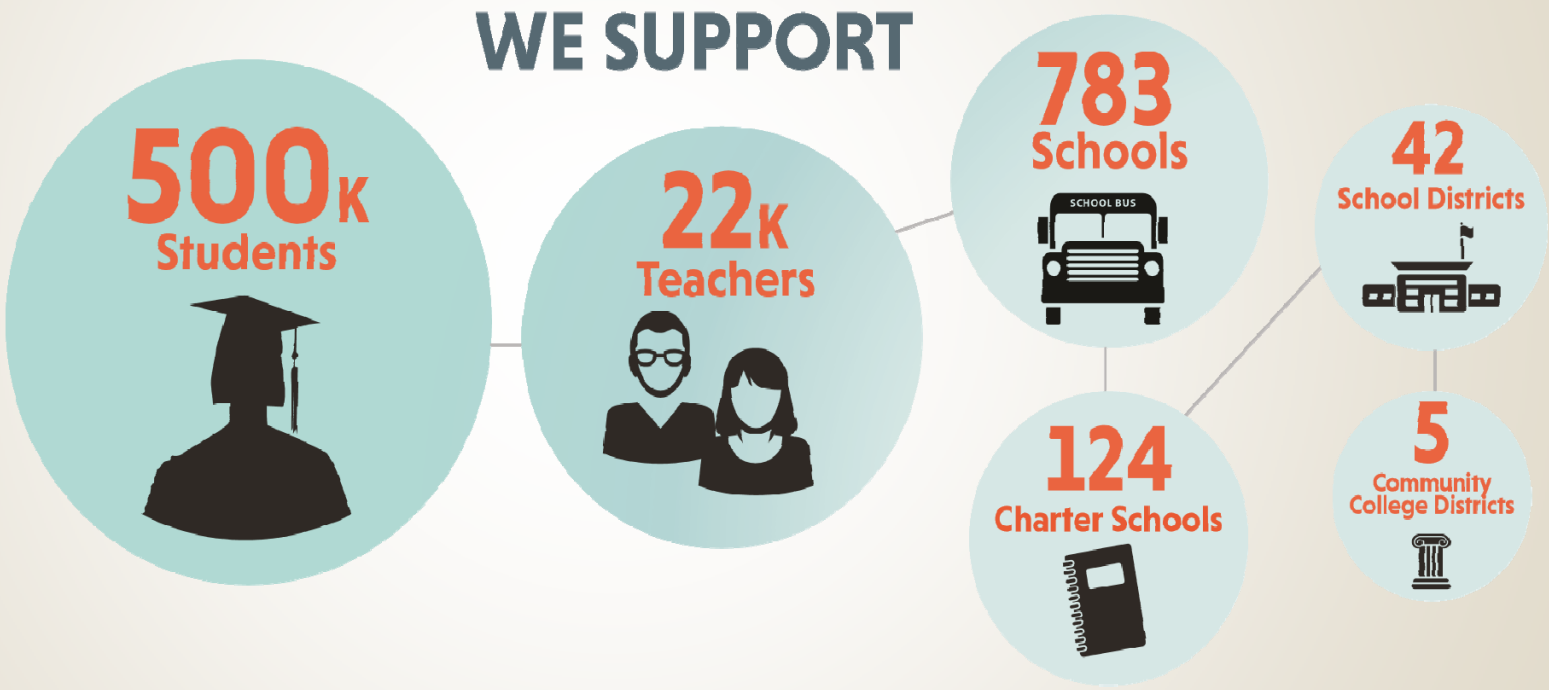
AB2246: Suicide Prevention in Schools

Heather Nemour & Violeta Mora

Project Specialists for Student Mental Health & Well-Being

June 13, 2018

About Us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Teachers
783
Schools
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42
School Districts
124
Charter Schools
5
Community College Districts

Mental Health & Well-Being

SDCOE Unit dedicated to this work

- Professional Development
- Technical assistance and consultation
- Service & resource identification
- Partnership development

MENTAL HEALTH & WELLNESS

What is AB2246?

- AB 2246 requires that school districts serving grades 7-12 students to adopt a board policy to address suicide prevention, intervention, and postvention
- Must train all staff on suicide prevention and deeper training for the school crisis staff
- Recommends training for parents and education for students be included in plan

Proactive Response to AB2246

- AB2246 Policy Development Workshops
- Youth Mental Health First Aid Certification training (YMHFA)
- Question, Persuade & Refer (QPR)
- **Applied Suicide Intervention Skills Training (ASIST)**
- *NAMI on Campus*
- *Suicide Prevention Resource Guide for Schools*

Enhancing AB2246

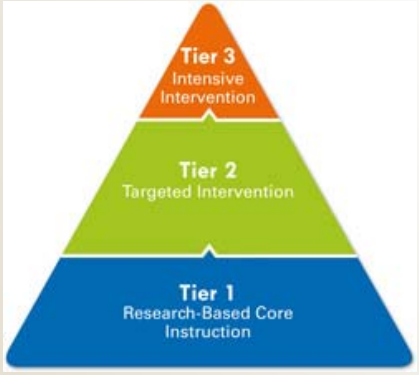
- Requests from school staff to go deeper
- Dr. Lisa Boesky: Suicide Prevention Expert
- Assessing Suicidal Students : ***Key Issues and Strategies Administrators, School Counselors, School Psychologists, School Social Workers, and School Nurses Need to Know***

Lessons Learned

Suicide prevention is best addressed through schoolwide positive climate programming

School Climate Interventions

- **Structure:** Positive Behavior Interventions in Schools (PBIS)
- **Lens:** Trauma-Informed Care
- **Approach:** Restorative Practices



Trainings to Support Positive School Climate

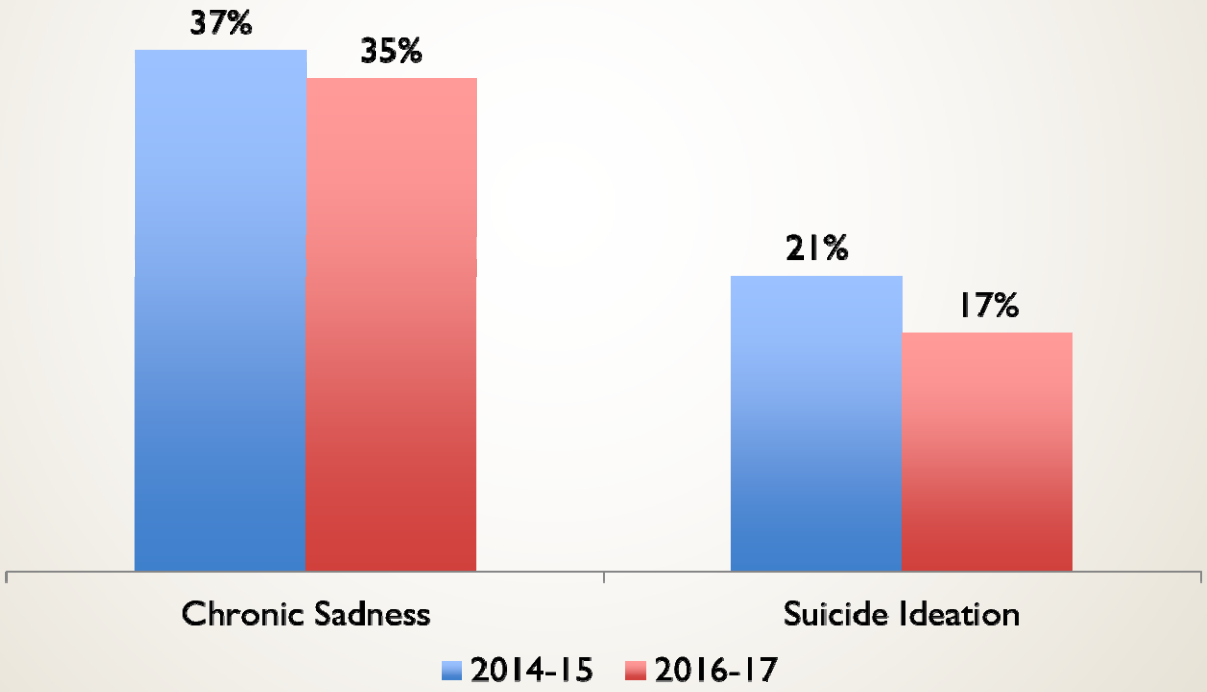
- Science of Gratitude
- Mindfulness
- Self-Care and Trauma
- Youth Anxiety
- Gay Lesbian Straight Education Network (GLSN)
- CSEC and Bullying Prevention and Intervention
- Social Emotional Intelligence
- Building Asset Based Relationship with Youth
- Standards of Quality for Family Strengthening & Support

San Diego Countywide Improvements

California Healthy Kids Survey 7th, 9th and 11th Grade Students Who Scored Their School Environment High			
	2014-15	**2016-17**	**Cal-Well Outcome**
Total School Supports	29%	32%	**+3%**
Caring Adults in School	33%	35%	**+2%**
High Expectations-Adults in Schools	41%	43%	**+2%**
Meaningful Participation at School	11%	14%	**+3%**
School Connectedness	42%	49%	**+7%**
Academic Motivation	22%	24%	**+2%**

San Diego CHKS Survey Data

Trends for High School Students



Questions

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.

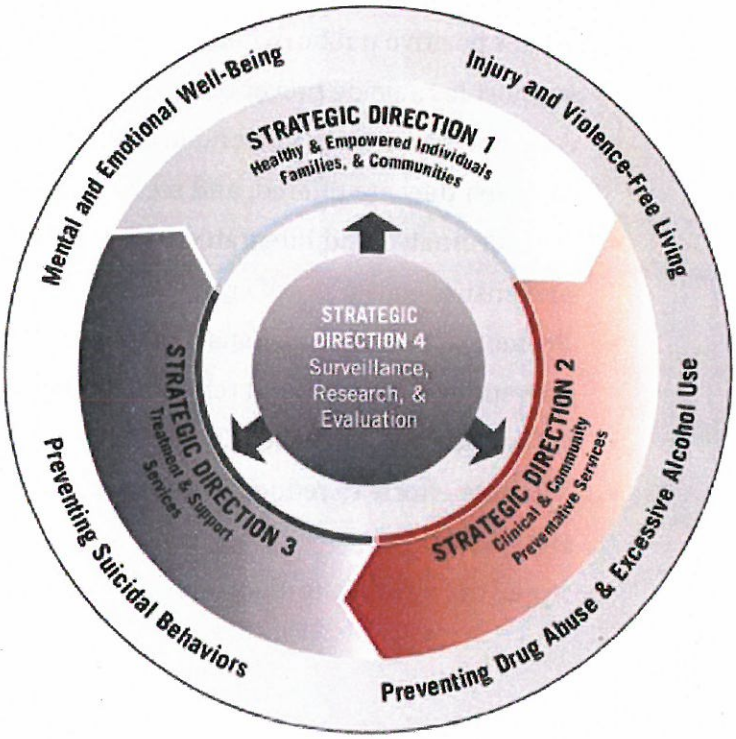
Contents

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.

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.