MHSOAC
Mental Health Services
Oversight & Accountability Commission

MHSOAC Suicide Prevention Subcommittee Meeting Brief

September 7, 2018 | Clovis, California (Fresno County)

The fourth meeting of the MHSOAC Suicide Prevention Subcommittee is being held in Clovis, California in Fresno County, a medium-sized county in Central California. During 2014-16, the average annual, age-adjusted suicide rate in Fresno County was 11.1 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 (71%) and white (51%), and a plurality (71%) were age 25-64. The most prevalent means were by hanging/suffocation (41%), firearm (25%), and poisoning (16%).[2]

Meeting Overview

The Commission's Suicide Prevention Subcommittee has held meetings in Redding, Sacramento, and San Diego, as of September 2018. All subcommittee meetings included presentations from suicide loss and attempt survivors, presentations from representatives of local suicide prevention efforts, and an open discussion with meeting attendees on the challenges, barriers, and solutions to preventing suicide. A summary for each subcommittee meeting is attached to this brief.

The goals of the fourth meeting of the Suicide Prevention Subcommittee are to explore local suicide prevention planning and implementation strategies. Commissioners and meeting attendees will hear a presentation by a survivor of suicide loss, followed by a presentation on Fresno County's recently released suicide prevention plan. Discussion following the presentation will explore challenges and opportunities for creating multidisciplinary collaboration among community members, including private sector partners and health care systems.

The second half of the meeting will focus on a facilitated discussion with meeting attendees on ways to create synergy between state and local suicide prevention efforts, priorities, and strategies. Key questions for discussion include: 1) what are the challenges with implementing a suicide prevention plan?; 2) how can suicide prevention be incentivized across a diverse array of partners?; and 3) how can a state suicide prevention plan support local suicide prevention plans?

Meeting Materials

- Summaries from past Suicide Prevention Subcommittee Meetings attached to this brief
- Presenter PowerPoint Presentation (available day of meeting)
- *Fresno County Community-based Suicide Prevention Strategic Plan* (available day of meeting)

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

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[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: August 30, 2018.

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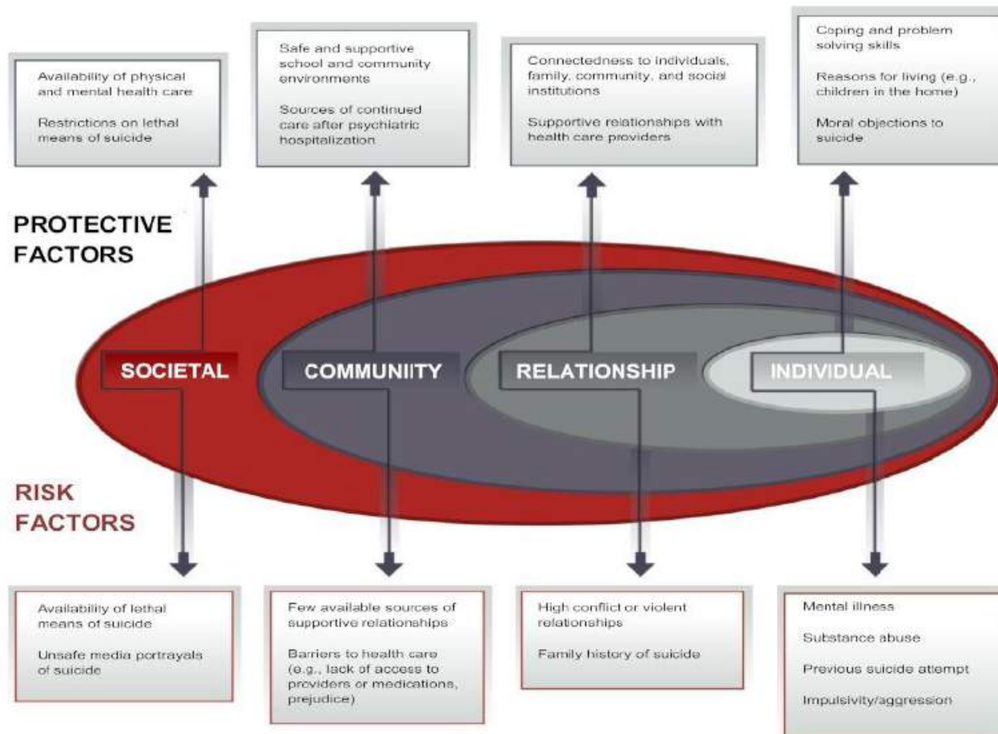
[1] American Foundation for Suicide Prevention. Suicide: California 2017 Facts & Figures. Accessed March 30, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

[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,

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[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.

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[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

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/

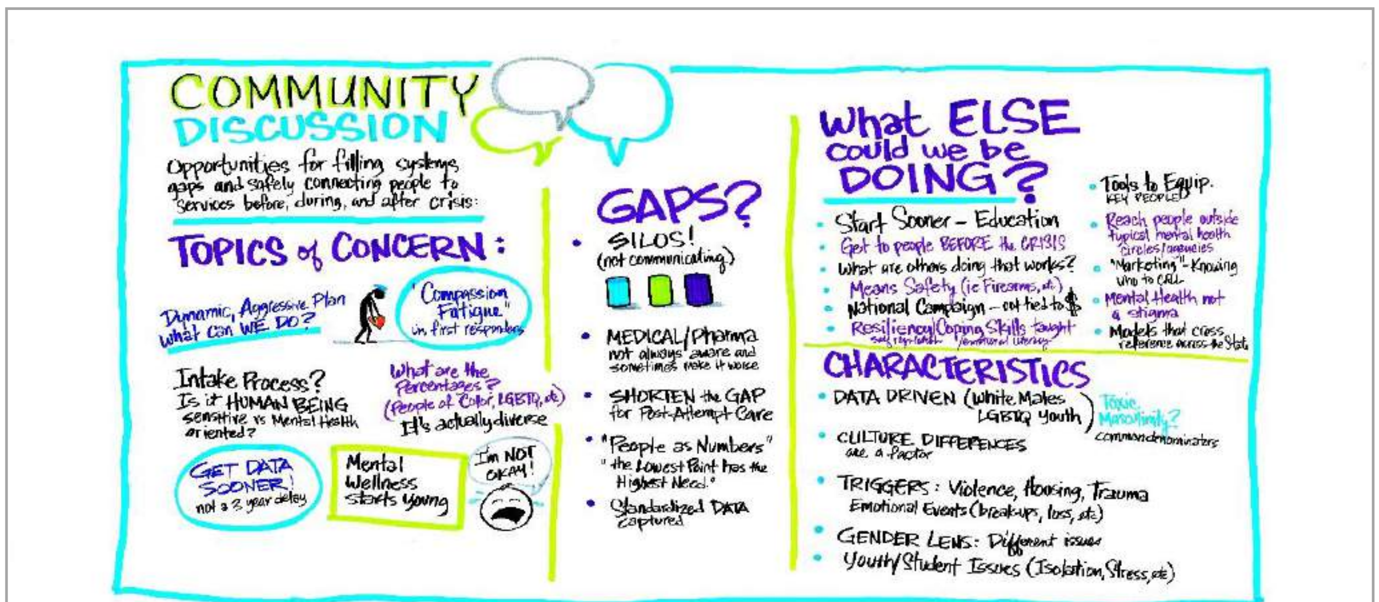
"Suicide is not just a mental health issue—it's a people issue."

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

June 13, 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]

Meeting Overview. The third meeting of the Commission's Suicide Prevention Subcommittee was held in San Diego, California. The goals of the meeting were to explore local suicide prevention planning and implementation strategies and to identify priorities and brainstorm solutions in several strategic areas. Commissioners and meeting attendees heard presentations 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. The contents of the presentations and group discussion are summarized below. The next Suicide Prevention Subcommittee meeting will be held in Clovis, California on September 7, 2018.

Agenda at a Glance

Welcome and Introductions

Musical Presentation by Dairrick Hodges, SOULcial Workers Collective

Presentation: Local Suicide Prevention Planning

Presentation: Implementing Suicide Prevention Plans in Schools

Open Public Discussion: State and Local Planning Strategies using the Four Strategic Directions Outlined in the 2012 National Strategy for Suicide Prevention

Healing Through Art

The meeting began with a presentation and musical performance from a survivor of suicide loss who discovered healing through art and creative expression. He used music during the meeting to communicate his lived experience as a child in the foster system and his experience after the loss of his family members to suicide. He stated that a clinical approach does not always work for some and that people who may identify themselves as "different" or "outcast" may benefit and heal through community building and artistic expression. He suggested providers think outside the box and relate to their clients. He stated that children do not connect well with adults that are perceived to have little to no experience with trauma.

"Authenticity and truth are what young people need and crave today. They need honest adults."

Dairrick Hodges on the importance of being relatable to youth seeking services

Local Suicide Prevention Planning

A representative of the Suicide Prevention Council presented on the recently revised local suicide prevention plan for San Diego County.[3] The Suicide Prevention Council is a county-wide collaborative

[1] American Foundation for Suicide Prevention. Suicide: California 2018 Facts & Figures. Accessed August 3, 2018 at https://afsp.org/about-suicide/state-fact-sheets/#California.
[2] Visit http://mhsoac.ca.gov/suicide-prevention for more information about the project and the Commission's Suicide Prevention Subcommittee.
[3] For more information, including access to the revised suicide prevention plan, please visit: http://www.sdchip.org/initiatives/suicide-prevention-council/.

San Diego County Suicide Prevention Action Plan Strategies

Nine strategies identified in the plan aim to increase understanding and awareness of suicide, reduce stigma, and decrease the number of suicides in San Diego County.

The strategies include:

- Integrate and Coordinate Activities
- Media and Communication Campaigns
- Outreach for Coping and Connectedness
- Community Programming
- Means Reduction
- Frontline and Gatekeeper Training
- Healthcare Coordination and Capacity
- Clinical Assessment and Treatment
- Postvention Services

For more information, including access to the revised suicide prevention plan, please visit: http://www.sdchip.org/initiatives/suicide-prevention-council/.

formed in 2011 to provide oversight, guidance, and support to implement recommendations to eliminate suicide in San Diego County. The Council worked with partners – including the County Health and Human Services Agency– to gather input using focus groups, interviews, and online surveys from over 650 community members to develop the plan.

In addition to nine strategies listed in the box to the left, the plan identified and outlined strategies for specific populations at increased risk for suicide. These groups include Native American and African American communities, veterans, transition age youth, LGBTQ youth, formerly incarcerated men, seniors, survivors of suicide loss, people with mental health needs, gay, bisexual, and transgender men and refugees.

Implementing Suicide Prevention Plans in Schools

Representatives from the San Diego County Office of Education (SDCOE) presented how the county is providing support to school districts to implement a new law requiring school districts serving grades seven through twelve adopt a broad policy to address suicide intervention and postvention; train all staff on suicide prevention and deeper training for the school crisis staff; and recommends training for parents and education for students be included in the plan.[4] SDCOE provides support to school staff by offering AB 2246 policy development workshops, Youth Mental Health First Aid (YMHFA) training, Question, Persuade, and Refer (QPR) training, Applied Suicide Intervention Skills (ASSIST) training, NAMI on Campus, and a Suicide Prevention Resource Guide for Schools. They also provide education services to school-aged youth and consultation and partnership development services. SDCOE has served over 1,500 youth mental health educators and championed a comprehensive positive school climate approach through Positive Behavioral Interventions and Supports (PBIS) in schools, providing trauma-informed care, and restorative practices.

State Suicide Prevention Plan Priorities

The meeting included an open discussion with meeting attendees to discuss community priorities using the four strategic directions outlined in the 2012 National Strategy for Suicide Prevention: 1) Healthy and Empowered Individuals, Families and Communities; 2) Clinical and Community Preventative Services; 3) Treatment and Support Services; and 4) Surveillance, Research and Evaluation.[5] An overview meeting attendee input is provided below by each strategy. Meeting attendees recommended all strategies be

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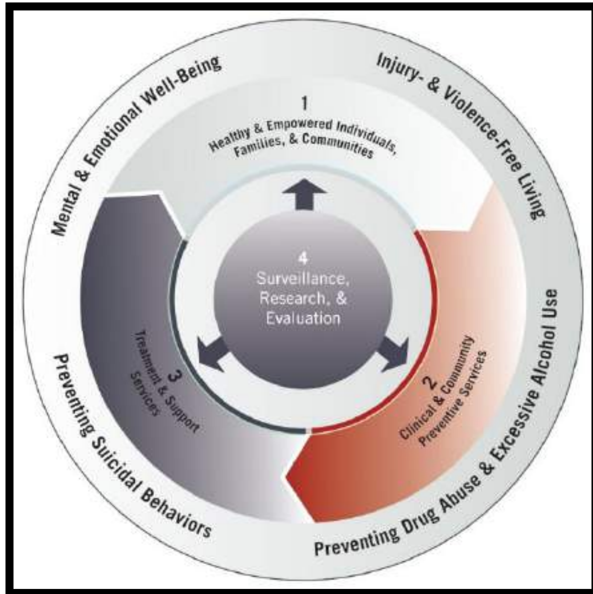
[4] AB 2246: Pupil suicide prevention policies (O'Donnell, 2016). Requires local educational agencies that serve pupils in grades 7-12 to adopt suicide prevention policies before the beginning of the 2017-18 school year.
For more information, including the California Department of Education's model suicide prevention policy, visit: https://www.cde.ca.gov/ls/cg/mh/suicideprevres.asp.

[5] Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): US Department of Health & Human Services (US).

inclusive of the concerns of people with disabilities, including deaf and hard of hearing and sight impairments, in addition to other diverse communities.



Graphic display of the four strategic directions outlined in the 2012 National Strategy for Suicide Prevention

Strategic Direction 1: Healthy and Empowered Individuals, Families and Communities. The goals of this strategic direction are integration of suicide prevention across settings and sectors, implementation of communication efforts to change knowledge, attitudes, and behaviors, increase protective factors and promotion of responsible media reporting. Meeting attendees discussed the importance of empowering communities to talk openly about suicide and mental health, specifically community members with lived experience. Community ambassadors knowledgeable about available resources were mentioned as a potential method of connecting people with services.

Currently available programs, as well as access points like schools and clubs, should be leveraged to increase utilization of resources. Meeting attendees discussed how youth often use their peers to find resources. Meeting attendees discussed how early signs of a mental health crisis may come across as behavioral problems. Rather than punishment, there should be a focus on determining the root cause of the behavior - early intervention could deter and prevent further behavioral problems. There is a lack of consumer engagement and training on how to participate in the behavioral health process. Loneliness and lack of social emotional leaning, particularly among older adults, could be an at-risk indicator. Parents of children in crisis are sometimes left to cope on their own. One meeting attendee stated that there is no definition of what a healthy family is and most people do not know what constitutes one until they have been exposed to an unhealthy one.

Strategic Direction 2: Clinical and Community Preventative Services. The goals of this strategic direction are implementation of effective programs that prevent suicide and promote wellness, reduction of access to lethal means among people at risk and deliver training on how to address suicidal thoughts and behaviors. Meeting attendees reiterated the need to have a spectrum of resources available to people in crisis and training and support for people helping people in crisis. One meeting attendee noted that the indication of a plan does not necessarily mean that a person goes on to die by suicide. Meeting attendees identified Emotional CPR as one tool for community members to help people in crisis. Emotional CPR is a program designed to train people to support people in emotional crisis by listening, empowering and reconnecting with support systems.[6] Meeting attendees also discussed the importance of language in creating an environment in which people experiencing suicidal thoughts or feelings can feel safe.

[6] For more information, please see: https://www.emotional-cpr.org/.

People would feel more confident and comfortable helping someone in a crisis if they knew what resources were available. Communities receive funding from many sources, and often community members are not aware of available trainings, programs and services. Meeting attendees stated that a directory of available services – regardless of funding source – would be beneficial for consumers and families.

Strategic Direction 3: Treatment and Support Services. The goals of this strategic direction are promotion of suicide prevention as core to health care services, implementation of assessment and treatment of suicidal behaviors and delivery of care and support for suicide loss survivors. Meeting attendees reiterated the impact that stigma can have on preventing people from seeking help, and how stigma can prevent people from showing compassion for others who are suffering. One meeting attendee stated that physical and visible ailments often garner sympathetic responses while invisible or intangible ailments garner apathy or disdain. Meeting attendees suggested that Medi-Cal pay for alternative treatments, such as yoga and biofeedback to measure stress levels. Mid-level services, such as urgent care centers, should be expanded to give people in crisis alternatives to hospitalization. A representative of Kern County shared that the county is implementing the Zero Suicide Initiative.

Mentioned at the Meeting:

Wellness Recovery Action Plan (WRAP)

"WRAP is a manualized group intervention for symptom and illness management for people with mental health disorders. WRAP guides participants through the process of identifying and understanding their personal wellness resources and then helps them develop an individualized plan to use these resources daily."

WRAP is listed in the National Registry of Evidence-based Programs and Practices.

For more information, visit: https://nrepp.samhsa.gov/ProgramProfile.aspx?id=1231

Strategic Direction 4: Surveillance, Research and Evaluation. The goals of this strategic direction are to increase the timeliness and usefulness of suicide-related data, promotion of research on suicide prevention and evaluation of effectiveness of suicide prevention efforts and dissemination of findings. One meeting attendee suggested more long-term studies on the effects of prolonged use of psychotropic drugs should be conducted to assess any change in the frequency or severity of negative side effects. Studies should be conducted on people who have died by suicide and people who have attempted suicide to discern the differences between them. Strengthening data collection efforts will require strengthening relationships with coroners and other people responsible for determining cause of death. It is also critical to include in these studies the children and family members of attempt survivors and people who die by suicide. Evaluation efforts should be able to demonstrate what success looks like and should have clearly defined outcome measures. A type of universal release form may benefit people who frequently access services through varied entry points.

Next Steps.
The next Suicide Prevention Subcommittee meeting will be held in Clovis, California (Fresno County) on September 7, 2018. The Commission will host a community forum in San Leandro, California on October 24, 2018 to brainstorm diverse approaches to preventing suicide. The next public hearing will be held on October 25, 2018 in the Oakland, California area. 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.