SUICIDE PREVENTION ROADMAP

2021 - 2025

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

YOU ARE NOT ALONE

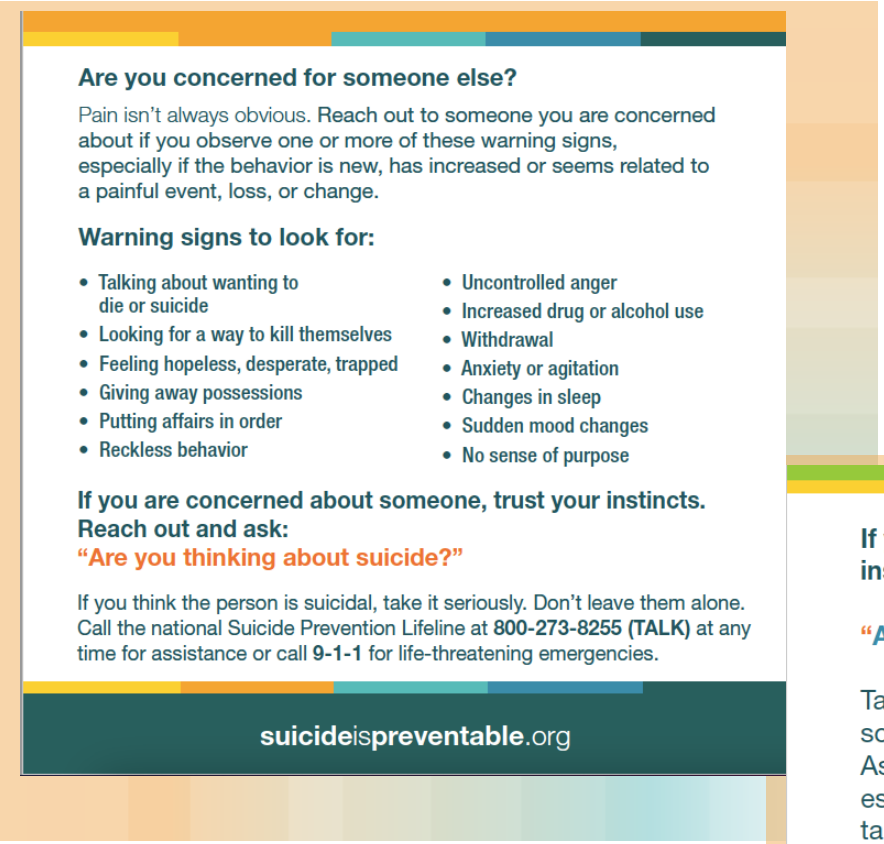
You are not alone in helping someone in crisis. There are many resources available to assess, treat, and intervene. Crisis lines, counselors, intervention programs and more are available to you, as well as to the person experiencing the emotional crisis.

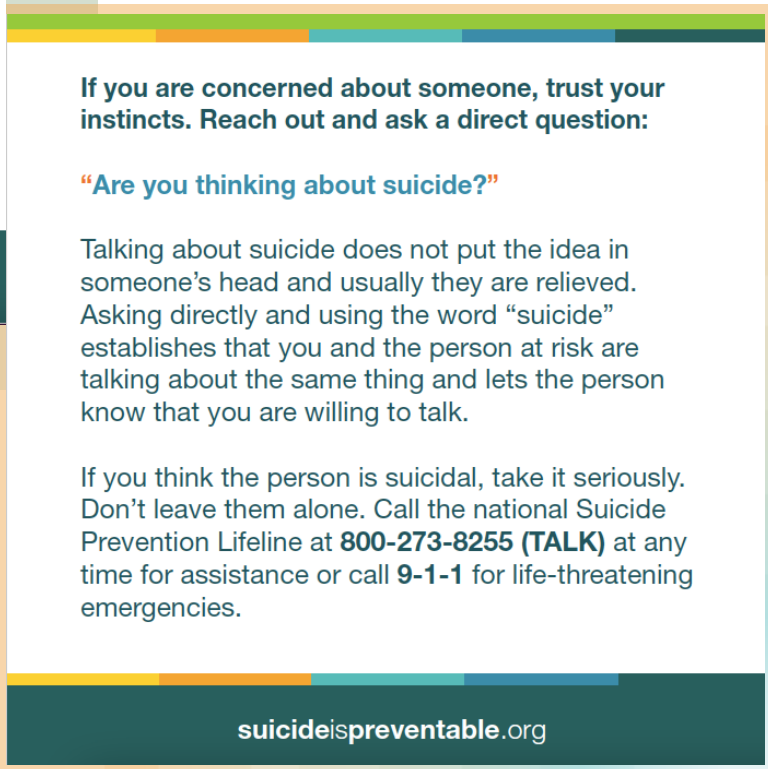
- Suicide Prevention Hotline: 877-663-5433
- CA Peer-Run Warm-Line: 855-845-7415
- Teen Line: Call 800-TLC-TEEN (852-8336) 6pm – 10 PST
  or Text 'TEEN' to 839863 from 6pm – 9pm PST
- The Trevor Project Lifeline (Help for LGBTQ+ youth 24/7):
  866- 488-7386 or Text START to 678-678
- Trans Lifeline (Lifeline run by and for trans people 24/7): 877-565-8860
- Veterans Crisis Line: 800-273-8255 (TALK), press "1" for Veterans

TABLE OF CONTENTS

ASKING DIRECTLY ABOUT SUICIDE

Asking about suicide directly is one of the most important things to do, yet it can be difficult for everyone, even professionals. Stigma and myths surrounding suicide and fear that introducing the topic will make the situation worse and even create liability often underlie this reluctance. Research shows that asking about suicide does not cause or increase suicidal thinking or lead to a greater likelihood of suicidal behavior. Rather, being asked directly promotes connection and can encourage a person to seek help and support. Talking more openly about suicide and educating people that asking about suicide can promote prevention are first steps everyone can take.





INTRODUCTION

Overview of Our Planning Process

In developing the Roadmap, Monterey County Behavioral Health (MCBH) received technical assistance and support through CalMHSA as part of a strategic planning for suicide prevention Learning Collaborative. This Learning Collaborative promotes sharing of knowledge and experience about strategic planning for suicide prevention efforts from around the state. Additional knowledge and research on suicide prevention is included from evidence-based national and international efforts. MCBH's Learning Collaborative members included the MCBH Prevention Manager and Epidemiologist, the Monterey County Health Department Public Information Officer and the Program Director for Suicide Prevention Services of the Central Coast.

- In fiscal year 2018-2019, Learning Collaborative members participated in five group webinars focusing on various aspects of the strategic planning process from strategic frameworks, to data collection and evaluation.
- In fiscal year 2019-2020, the Learning Collaborative built upon existing content to further explore in-depth components of comprehensive suicide prevention at the community and county levels.
- In fiscal year 2020-2021, MCBH's Learning Collaborative members hosted two meetings with key stakeholders and community members to present Monterey County data related to suicide and introduced the recommended framework for comprehensively addressing suicide on a county level.
- In addition, stakeholders were asked to assist in identifying resources that exist in Monterey County that are critical in creating a suicide safer community.

Alignment with California Strategic Plan for Suicide Prevention

Nationally and in California, suicide is a public health emergency in need of innovation and collaboration across multiple levels of prevention. The California's Mental Health Services Oversight and Accountability Commission was directed by the Legislature to develop a new suicide prevention plan for the state. While the state can support local communities and assume a leadership role, the success of any local strategic plan depends on the integrated efforts of private and public partners at the local level.

View the California Strategic Plan for Suicide Prevention "Striving for Zero" HERE.

Conceptual Framework and Suicidal Crisis Path

While strategic planning enables us to identify and prioritize goals, objectives and strategies that are most responsive and likely to be effective for Monterey County, we are fortunate to also rely on guidance about what is known to be effective. Our comprehensive approach to suicide prevention is a multi-layered, public health model based on several frameworks with demonstrated effectiveness in reducing suicide, as well as other negative health outcomes. It includes approaches from prevention to early intervention, effective crisis response, and support after a crisis as well as postvention (support after suicide).

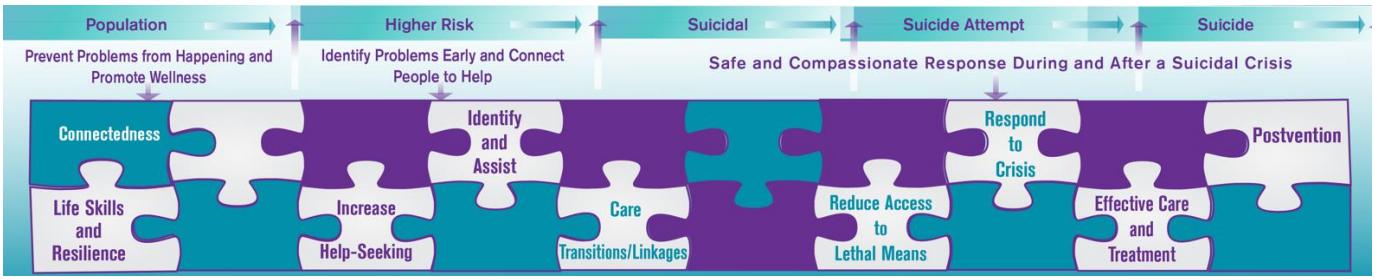
To develop a comprehensive and strategic plan for suicide prevention, it is important to understand the complexity of suicide. The Suicidal Crisis Path helps conceptualize an individual's suicidal experience. This model integrates multiple theoretical approaches and frameworks, including Crisis Coping Theory, and in doing so provides a framework for how to match intervention approaches with the timing, risk factors, and protective factors that would be the mechanisms to prevent a suicide from happening (1). This concept was outlined and applied in Fresno County's Strategic Plan for Suicide Prevention.

The Suicide Prevention Resource Center (SPRC) recommends nine strategies to ensure suicide prevention efforts are comprehensive and on broad goals that can be achieved through various activities customized to fit the needs of specific communities.

1. **Enhance Life Skills and Resilience:** Assist people in building life skills such as critical thinking, stress management, and coping to increase protective factors and reduce impacts from risk factors.
2. **Promote Social Connectedness and Support:** Supportive relationships and helping people to feel connected can limit impact of risk factors and protect individuals.
3. **Increase Help-Seeking:** Help individuals recognize when they need help. Increasing awareness of where to find support can reduce barriers to people reaching out for help in times of distress and prior to times of crisis.
4. **Identify and Assist Persons at Risk:** Raise awareness through education, training, and messaging campaigns to assist in identifying people in need and connecting them to the appropriate support.
5. **Ensure Access to Effective Mental Health and Suicide Care and Treatment:** Ensure individuals experiencing thoughts of suicide have access to timely and effective care.
6. **Respond Effectively to Individuals in Crisis:** Provide a continuum of care for individuals in distress to ensure people are receiving the appropriate level of care in the least restrictive setting.
7. **Support Safe Care Transitions and Create Organizational Linkages:** Ensure individuals who have been treated for suicide risk have uninterrupted care transitions.

8. **Provide for Immediate and Long-Term Postvention:** Develop postvention plans to provide effective and compassionate care for those impacted by suicide deaths.
9. **Reduce Access to Lethal Means:** Prevent individuals who are experiencing thoughts of suicide from accessing or obtaining lethal means to use in a suicide attempt.

When combining the SPRC's Comprehensive Approach to Suicide Prevention with the Suicidal Crisis Path, we can begin to identify what potential programs and interventions to implement and how they can be most effective.



In Monterey County's strategic plan for suicide prevention, we have grouped these approaches into the following strategic areas:

- Wellness & Prevention
- Intervention & Individual Supports
- Means Access / Safety
- Postvention: After a Suicide Death

NEXT STEPS FOR MONTEREY COUNTY | Creating a Suicide Safer Community
Develop suicide prevention leadership through an ongoing coalition that monitors and oversees implementation of the plan, coordinates activities, compiles/reviews/applies learns from data, builds and enhances partnerships and collaboration, leverages resources to build capacity, convenes stakeholders and gathers input from public and key partners.
Create a continuous quality improvement framework to monitor progress on goals and objectives that includes ongoing data collection to examine the problem of suicide in Monterey County and take a data informed approach. This includes developing Memorandums of Understanding and/or data sharing agreements across agencies and healthcare institutions for data sharing related to suicide.
Dedicate staffing to organize and lead the coalition and advance the goals outlined in the strategic plan. Identify funding opportunities, and dedicate funding when possible, to address goals and objectives prioritized by the coalition.

MESSAGING: THE POWER OF WORDS

When it comes to suicide prevention, the terms, phrases, and words we use can have a significant impact on the way messages are received. Messages can encourage someone to seek help and reach out, or they can push people further from the support they need. The suicide prevention community is trying to clarify the ways we all refer to actions related to suicide to better support help-seeking behavior among those that are at risk. Please assist us in changing the conversations about suicide and help us raise the bar for the conversations about suicide prevention. Each of us can play a part in promoting a more supportive environment, and it begins with the words we use.

Words to Consider ….

RECOMMENDED terminology

- Died by suicide
- Took their own life
- Ended their life
- Attempted to end their life

NOT RECOMMENDED terminology

- Committed suicide
  Note: Use of the word "commit" implies a negative act such as a crime or sin
- Completed suicide
  Note: This associates suicide with success
- Successful attempt or unsuccessful/failed attempt
  Note: There is no success, or lack of success, when dealing with suicide

Tips for Effective Messaging:

- Provide a suicide prevention resource
- Educate the audience on warning signs
- Avoid discussing details about the method of suicide
- Explain complexity of suicide and avoid oversimplifying. It's natural to want to answer the "why" involved in a suicide, but there is usually not one event that is the "cause" of a suicide attempt or death
- Focus on prevention and hope by using images and words that show people being supported, not suffering alone
- Avoid sensational language and statistics that make suicide seem common overall.
- Consider data that highlights help-seeking such as number of calls to the local crisis line.

Helpful Resources:

- Reporting suicide for the news media – www.ReportingOnSuicide.org
- Framework for successful messaging, national action alliance for suicide prevention – www.SuicidePreventionMessaging.org

MONTEREY COUNTY DATA OVERVIEW

Suicide is a devastating tragedy that can ripple out to impact whole communities. While suicide can impact anyone, certain populations are disproportionately impacted by suicide in Monterey County, meaning rates of suicidal behavior in these groups are higher compared with other groups.

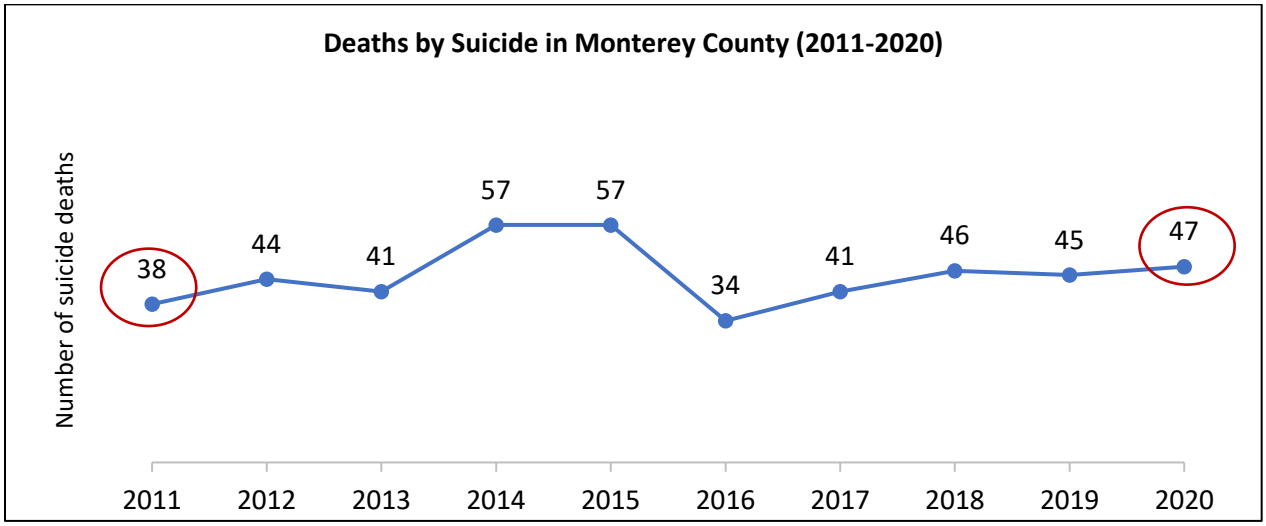
The need for complete data and proper assessment tools are important to understand the gravity of suicide attempts, ideations, and death within our county as well as to plan effective strategies and interventions. As the first step to data-driven strategy planning for Monterey County's suicide prevention roadmap, we created a data source map to gather suicide-related data during the initial planning process. Per the data source map, we explored information obtained from each source, assessed the feasibility of procuring it, and the ability to get near-real-time data. This led to coordination with other agencies to help establish contact persons within them and establish the data collection process.

We understand collecting and managing data is a work in progress. One of our goals is to establish direct HIPAA-compliant data sharing from emergency departments at all four hospitals in Monterey County to get real-time data input on suicide attempts. We identified the following data sources to report Monterey County data from 2004 to 2021:

- **Death by suicide**: Coroner's Office, Monterey County
- **Suicide ideation**: California Health Interview Survey
- **Suicide attempts**: Office of Statewide Health Planning Department

Suicide Deaths

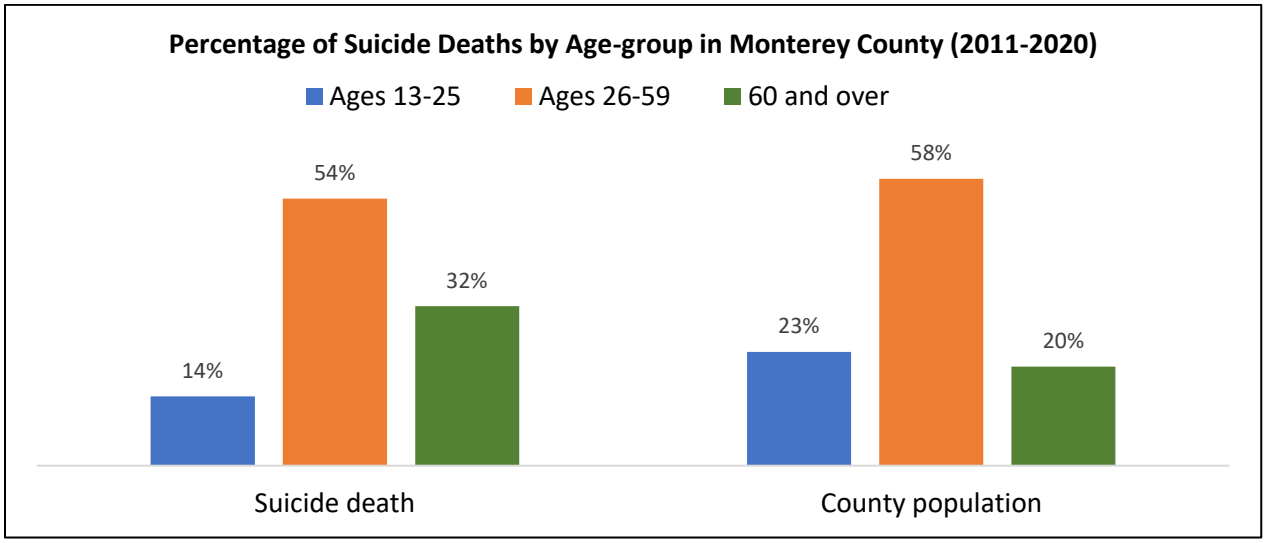
Suicide is the 11th leading cause of death in California (Centers for Disease Control and Prevention). In Monterey County from 2011 to 2020, on average, 45 people died by suicide every year. This accounts for a 24% increase in suicide deaths while the population growth was about 6% during the same period.



Data Source: Monterey County Coroner's office, US Census Bureau

Percentage of Suicide Deaths by Age

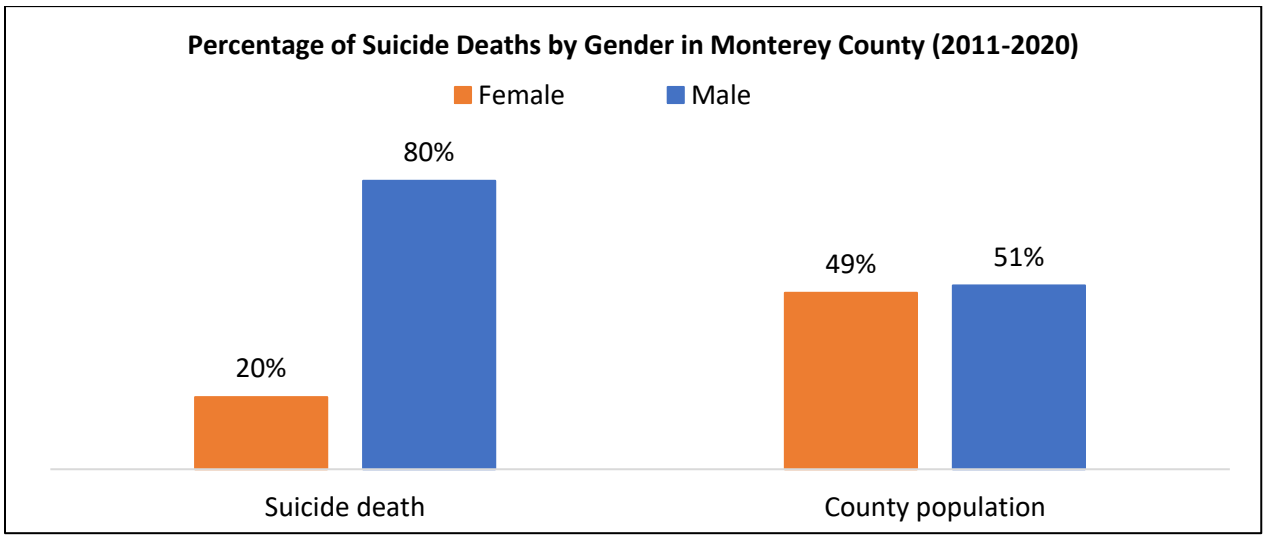
In the 10-year period (2011-2020), we observed that 54% of all the suicide deaths in Monterey County were among adults in the age group 26- to 59-year-olds. Also, 32% of the suicide deaths were among older adults (60 years and over) who formed 20% of the county population. The teens and transitional aged youth (13- to 25-year-olds) have consistently lower suicide death rates than adults even though they make up the 57% of all suicide attempts seen in emergency rooms of Monterey County.



Data Source: Monterey County Coroner's office, US Census Bureau.

Percentage of Suicide Deaths by Gender

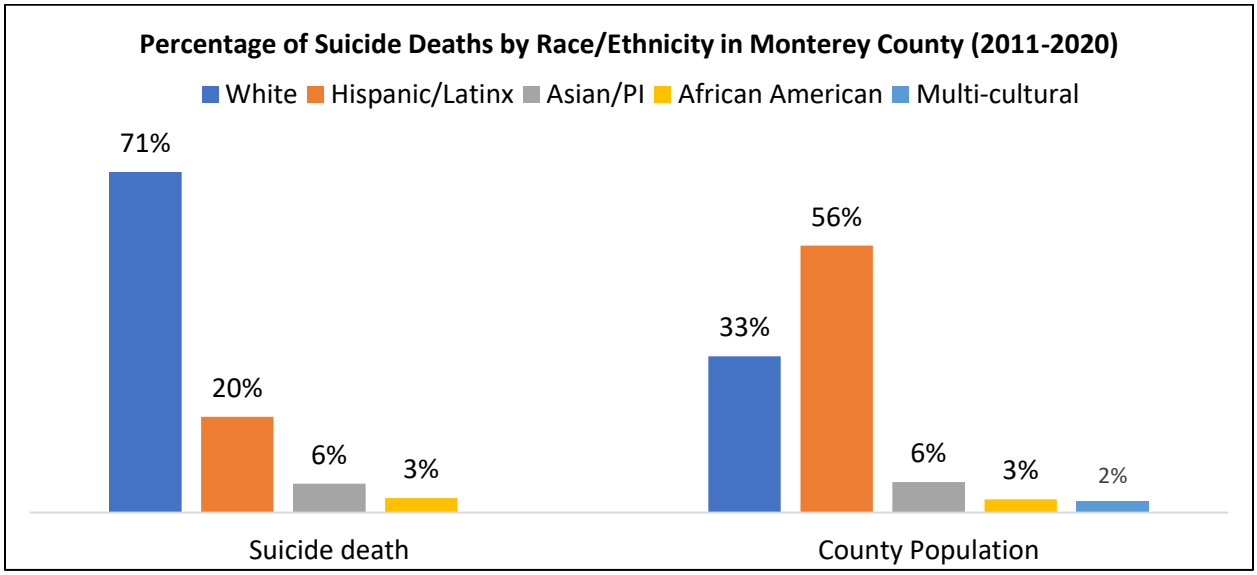
In Monterey County during 2011 and 2020, males accounted for 80% of suicide deaths whereas females accounted for 20% of suicide deaths. This is similar to what we observed nationwide. There were only two distinct categories in gender noted in the data we received from the coroner's office. We do not currently have a way to identify the actual gender identity of the individual which includes those who identify as transgender.



Data Source: Monterey County Coroner's office, US Census Bureau

Percentage of Suicide Deaths by Race/Ethnicity

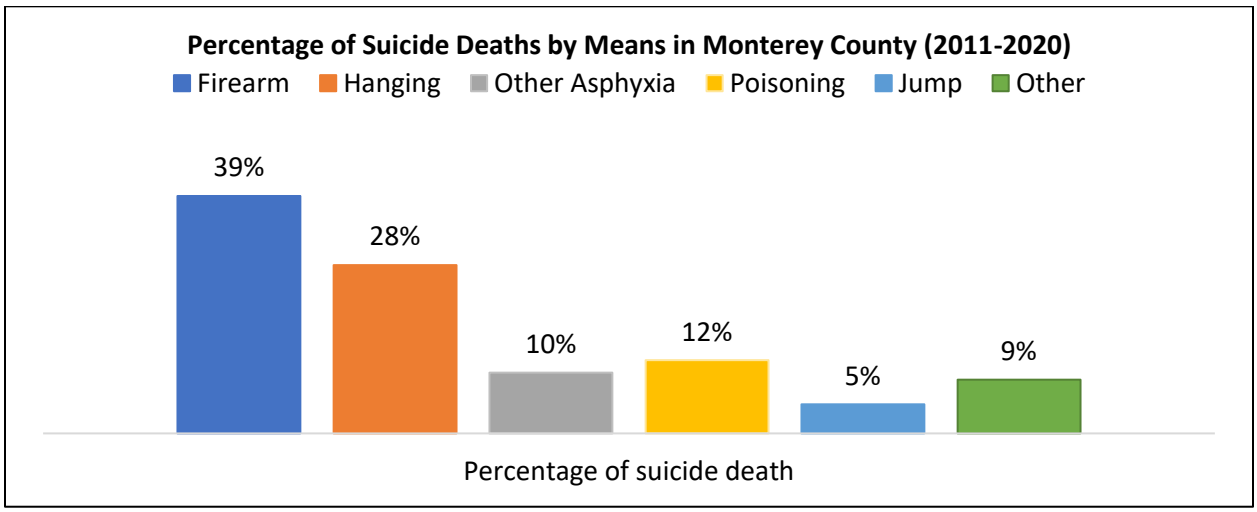
In Monterey County during 2011-2020, on average, 71% of suicide deaths were among White/ Caucasians, even though they make up 33% of the County's population. In order of decreasing prevalence, the percentage of suicide deaths among other races/ethnicity were Hispanic/Latinx (20%), Asian/Pacific Islander (6%), and African American (3%).



Data Source: Monterey County Coroner's office, US Census Bureau

Percentage of Suicide Deaths by Means of Death

For effective suicide prevention strategies, it is important to know the means of death. Monterey County suicide data for 2011-2020 shows that usage of firearms and hanging are the two most common means of death in Monterey County, followed by other forms of asphyxia and poisoning. This is similar to what has been observed in the state of California. Means of death differed between age groups, gender, and race/ethnicity (this information is provided in the "means access and safety chapter" of this document).



Data Source: Monterey County Coroner's office, US Census Bureau. Other causes of suicide deaths in the chart refer to self-inflicted injury by drowning, impact Injury, physical injury-cut/knife, using accelerant/burns/fire.

WELLNESS AND PREVENTION

Wellness and prevention efforts are important to help stop problems from happening while promoting overall well-being, which includes both behavioral health and physical health. This is done by having a range of programs and natural supports throughout the community that help a person build life skills, foster resilience, and connectedness throughout their lifetime (3-6).

Rationale and Overview

Suicidal behavior develops because of complex interactions between a person's biology, life events, and/or their environment. The Socio-Ecological Model, a well-known prevention framework, demonstrates how interactions between individual, interpersonal, organizational, community, and public policy factors influence risk for suicidal behavior.

Our approach to prevention aims to address broad social, emotional, and physical factors that can ultimately influence suicide risk. Strategies at the population level seek to enhance protective factors such as connectedness, contacts with caregivers, problem-solving skills, and coping skills. Protective factors are characteristics that make it less likely that an individual will consider, attempt, or die by suicide. For example, the skills and strategies that children and teens gain through Social Emotional Learning (SEL) have been shown to increase protective factors and reduce risk factors associated with suicide (7).

Similarly, social media and online technology platforms are opportunities to foster connection and resilience but can also contribute to risk. Social Media Guidelines for Mental Health Promotion and Suicide Prevention include strategies for promoting prevention and building in safety measures to ensure those who express warning signs and distress on social media platforms are identified and connected with appropriate supports (8).

In addition to communication and social marketing campaigns, programs intending to promote health and wellness or prevent suicidal risk from developing act by fostering connections, teaching life skills, and increasing help-seeking behavior.

Potential Strategies:

- Offering programs that enhance protective factors to build resilience and mitigate risk factors for suicide, e.g. programs that foster resilience and connection
- School-based Social and Emotional Learning (SEL) and Mindfulness programs
- Community-wide awareness and recognition of warning signs and how to support an individual in crisis across the lifespan (e.g. gatekeeper trainings, awareness campaigns, outreach, Town Hall presentations)

- Community wide education and stigma reduction campaigns to promote mental health and help-seeking including personal stories of hope and recovery
- Promoting safe and effective messaging principles with the news media and spokes people in the community
- Working with local employers to promote wellness and suicide prevention at the workplace
- Universal screenings by healthcare providers for depression and suicidal ideation
- Awareness of and availability of suicide prevention hotlines and accessible crisis supports
- Awareness of means safety strategies and programs
- Linkages to care and services
- Promoting safe use of social media and technology (9)

INTERVENTION AND INDIVIDUAL SUPPORTS

Intervention to prevent suicide involves identifying and helping people who are at risk as soon as possible, treatment for mental health and substance use disorders, and providing comprehensive supports after a suicide attempt. Systems delivering the right care at the appropriate time and in the least restrictive setting will be most effective in supporting individuals who are considering suicide. It is important to have an individualized and developmentally appropriate approach for each person taking into account their cultural background, family system, social supports and experiences with behavioral health and healthcare institutions.

Rational and Overview

Providing the appropriate level of supports based on risk is a large undertaking and is an essential component of a comprehensive system of suicide prevention. As noted above, this includes identifying and assisting individuals who are experiencing thoughts of suicide and ensuring they have access to appropriate services in the least restrictive setting. Interventions should be designed to help a person through a crisis in a way that prevents it from turning into a life-threatening situation and facilitates their development of coping skills and resiliency.

When considering interventions for suicide prevention, it is important to start with best practice for screening and risk assessment. This includes knowledge of risk and protective factors and warning signs; using evidence-based assessments; and procedures for categorizing risk, clinical decisions, and safety planning. It is also important to document risk level, actions taken and effective referral procedures. Standardization makes the process of identifying risk and connecting people to services transparent and collaborative for the provider and person at risk. While evidence-based assessments and standardization is recommended, it is also important to remember that individuals will express their emotional distress through their cultural perspective and life experiences. Understanding cultural differences in suicide prevention is an emerging area of best practice and will be incorporated into strategies adopted in Monterey County.

Much of the research and theory around suicide risk agrees there are four key components to determining suicide risk: ideation, intent, capability, and buffers (also known as protective factors). Although suicide ideation alone presents a low risk for a suicide attempt, too often individuals who are experiencing only thoughts of suicide are routed through the same crisis response as someone who is at high risk due to experiencing a combination of ideation, intent, and capability with low levels of buffers. This can be very traumatizing to the individual who is at low risk and lead to them avoiding reaching out for help in future instances. Linking standardized risk assessment protocols with a continuum of crisis services helps ensure individuals receive the appropriate level of intervention based on the results of the assessment. A continuum of crisis services includes assessment, crisis stabilization, and linkage to an appropriate level of ongoing care. Specific components may include crisis lines and other mechanisms for providing immediate support, mobile crisis teams or other mental health

supports that provide risk assessments, acute mental health crisis stabilization and robust peer crisis services using evidence-based models as an alternative to inpatient hospitalization.

The weeks and months following a suicide attempt are frequently ones with elevated risk. We know today that a 48-hour and or a 72-hour hold may keep an attempt survivor safe for a short while, but in fact does not necessarily mitigate the desire to die. Research demonstrates that risk is elevated particularly in the first few weeks and months following an attempt, therefore a follow-up plan should be implemented no later than the first week and continuing during the first year. This compelling data highlights the need for proactive and robust follow-up care during these critical time periods (10).

Bridging the transition from inpatient to outpatient care can help mitigate risk by providing continuity of care and support for individuals who have made a suicide attempt or have been assessed for suicidality in the emergency department, or after discharge from psychiatric facilities. Follow-up care can be provided through phone calls, texts, postcards, letters, telehealth or in-person visits intended to offer support and encouragement to follow-up with outpatient care. Potential benefits to follow-up care include reduced suicidality and/or attempts, reduced hospital readmissions and return visits to the emergency department, and cost savings.

Potential Strategies:

Potential strategies for intervention involve early identification of issues and an individualized approach that is appropriate for each of the persons impacted.

- Suicide prevention crisis lifelines and crisis supports are available, understood by the community and used when needed
- Provide gatekeeper training for professionals and peers who are in direct contact with individuals at disproportionate risk for suicide
- Consistent use of standardized risk assessment tools across settings such as: schools, behavioral health, healthcare, law enforcement and first responders
- Implement wraparound models in school and community settings to ensure children and youth who are identified at risk of suicide are served in a trauma informed manner in a least restrictive setting
- Map out how individuals in crisis are connected with care and establish/promote alternatives to hospitalizations with culturally and linguistically competent continuity of care
- Availability of follow-up interventions (for individuals or families) and effective re-entry protocols for students returning to school after a suicide attempt
- Availability of clinicians trained in assessing and ongoing care for suicide risk to support their recovery
- Evidence-based training on safety planning and reducing access to lethal means, such as the CALM model for clinicians and healthcare providers (11)
- Offer and promote Suicide Attempt Survivor Support Groups

MEANS ACCESS AND SAFETY

Means safety refers to actions to reduce or eliminate access to lethal means for individuals that are experiencing thoughts of suicide. It includes efforts to reduce access to specific objects (e.g., medications, firearms, sharp objects) as well as locations (e.g. bridges, parking structures) that could be used in suicide attempts.

Reducing access to lethal means is the most evidence-based suicide prevention strategy.

Rational and Overview

Most efforts to prevent suicide focus on why people take their lives. As we understand more about who attempts suicide, including when and where and why, it becomes increasingly clear that how a person attempts – the means they use – plays a key role in whether they live or die.

Numerous studies show when lethal means are made less available or less deadly, suicide rates by that method decline, and frequently suicide rates overall decline. The most effective strategies for lethal means restriction are physical deterrents (12-21).

Most crises are short-term: putting time and space between someone and lethal means can reduce risk of suicide. Since 70% of suicide attempt survivors will not attempt suicide again in their lifetime, and 90% of people who attempt suicide will not go on to die by suicide, if access to the most highly lethal means is restricted during a first attempt, that individual is unlikely to die by suicide (16-18).

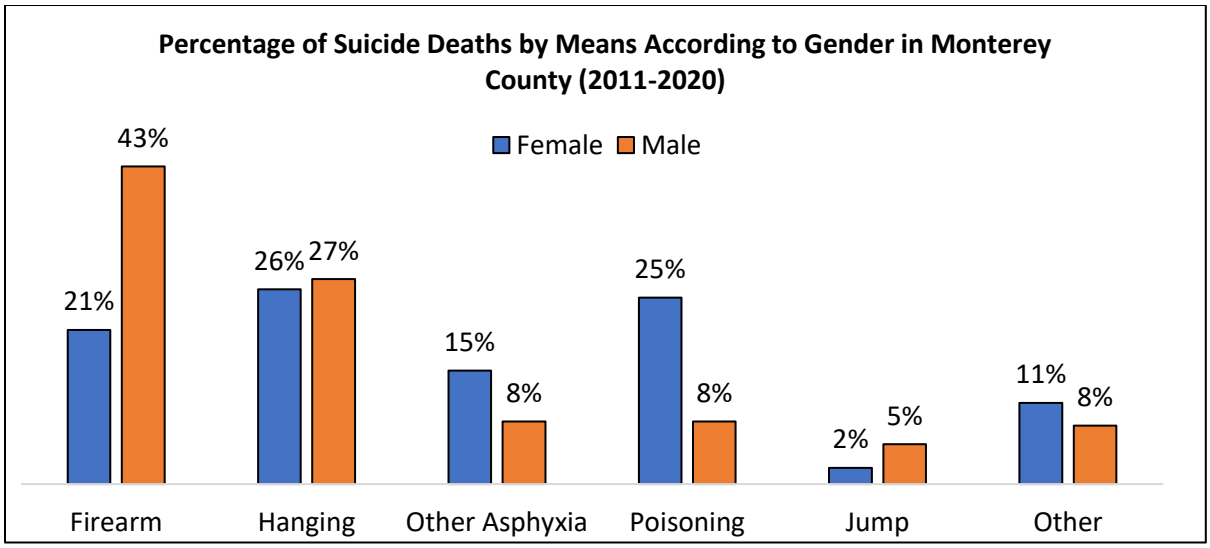
Additionally, the means someone chooses for a suicide attempt is not necessarily related to their level of intent to die. Interviews with suicide attempt survivors showed no distinction in intent to die based upon the potential lethality of the means used. People often assume if one means is taken away, the person will simply use another method. However, research suggests most individuals have a preference for a particular means and are unlikely to substitute if one is removed. If substitution of means does occur, the substituted method is likely to be less lethal.

There are four basic ways to restrict or reduce access to lethal means by persons at imminent risk of suicide:

1. Place the person in a safer environment
2. Put a barrier between the person and the means
3. Create time between the person and the means
4. Make the means (and an attempt) less lethal

There are some common elements among any means safety efforts: a public awareness component, where information and resources are available to help people understand the importance of means safety and how they can use the information; training for key gatekeepers that offer specific information about their role in promoting and supporting means safety; and lethal means counseling from providers and others that are in an important position to intervene with those at highest risk. Some of the details of means safety approaches vary depending on the means in question, its availability in the environment, legal issues, and individual factors.

For effective suicide prevention strategies, it is important to know the means of death by suicide and how it varies between different socio-demographic groups. Usage of firearms and hanging is the most common means of death in Monterey County followed by other forms of asphyxia, and poisoning. Caucasian adult males accounted for more than half of the suicide deaths. While hanging was the most common means of suicide death among those 25 years and younger, firearm usage accounted for death among adults (26+) and older adults. Poisoning is the most common means of death among women followed by hanging/asphyxia, whereas in men, usage of firearms and hanging was the most common means of death by suicide. Firearm usage is the most common means of death among Caucasians whereas death by hanging accounted for 42% of suicide among the Hispanic/Latinx population followed by firearm usage (27%). Poisoning by an overdose of prescription drugs accounted for more than half of the suicide attempts in Monterey County. We can utilize this data to create targeted means of safety approaches for preventable strategies such as firearms and poisonings.



Data Source: Monterey County Coroner's office, US Census Bureau

Potential Strategies:

- Address access to means for specific demographic populations based upon Monterey County data with tailored outreach strategies
- Partner with the community and key stakeholders to expand existing efforts and strategies to reduce access to lethal means
- Train behavioral health, substance use and health care professionals in counseling on means safety
- Implement county-wide firearm suicide prevention means safety campaign
- Increase barriers and signage at sites and locations vulnerable to suicide attempts
- Identity and collaborate with existing prescription drug and opioid coalitions and programs to integrate suicide prevention and means safety

Examples of Successful Interventions to Reduce Access to Lethal Means

United Kingdom: Fewer suicide deaths following replacement of coal gas with natural gas. Limiting prescription size and altering packaging resulted in fewer suicides.

Israel: 40% reduction in suicides of soldiers when policies changed to require weapons be stored on base.

Sri Lanka: Ban on certain chemicals used in pesticides associated with reduction in suicides.

New Zealand: Suicide deaths reduced to zero after barriers were reinstalled on bridges.

POSTVENTION

Postvention is defined as an organized response after a suicide death. It includes a range of strategies, from immediate response after a suicide death, to ongoing support for suicide loss survivors. Postvention strategies seek to foster individual, group and community healing and support, as well as mitigate potential negative effects of exposure to a suicide.

Rational and Overview

It is estimated that 50% of the population will be exposed to the suicide of someone they know at some point in their life. The impact of a suicide death can bring about immense trauma and complicated grief for those close to the person who died. The grief process following a suicide is often different from the grief process after other causes of death. This complicated grief can include painful and confusing emotions such as guilt, shame, anger and blame, which can become debilitating and may not improve over time. These impacts may have far reaching consequences, at times, affecting whole communities. Research finds individuals exposed to suicide are at a higher risk of developing depression, post-traumatic stress disorder, social isolation and suicidal behaviors, which can continue 5 to 10 years after the death (2221-2332).

Postvention efforts seek to directly assist suicide loss survivors in this process by providing support and strategies for coping and healing. Many suicide loss survivors benefit from connecting with others who understand complicated grief, or perhaps are suicide loss survivors themselves. Loss survivors may also benefit from working with a professional therapist, which can help to alleviate the severity of trauma exposure, as well as reduce the length of time toward healing. Education on suicide prevention and the complex causes of suicide can help individuals work through some of the guilt, shame and stigma that may be felt.

Since the grief experienced after a suicide is experienced differently by each individual, postvention uses a multitude of strategies in order to assist the individual, family or community when and where they need it.

Postvention resources and supports typically fall into three categories: active, delayed and passive. Active postvention is the immediate response taken after a suicide death. For example, specially trained individuals can offer resources and help to family members, witnesses or others that are directly impacted by the death and may accompany first responders at the scene of a suicide death. Delayed postvention happens as soon as possible after a suicide death, but not at the scene of death. It involves organized outreach to suicide loss survivors, providing information on available postvention resources and support. Passive postvention refers to resources and supports accessible to loss survivors when they reach out for help.

Community & School Postvention Plans

The impact of a suicide death can affect whole communities, particularly if the person who died was well-known or the death happened in a public place. Having a postvention plan in place before a crisis occurs is the best way to ensure an effective, coordinated postvention response. Postvention plans can be constructed at the community level, city or county level, and within schools and workplaces.

Potential Strategies:

Postvention resources and supports typically fall into three categories: active, delayed and passive. These potential strategies will happen in stages, as appropriate.

- Support groups specializing in suicide loss and bereavement offered in languages that meet communities' needs
- Increase awareness of and access to existing survivors of suicide loss support groups and resources
- Clinicians who have special training in suicide related bereavement and are known in the community
- Develop integrated postvention plans that guide response after a suicide death in communities and key settings, such as schools and workplaces. Postvention plans should include response teams that aid in reducing time between suicide related death and resources given to survivors (243)
- Increase the number of clinicians, counselors, and providers that are skilled and trained in offering suicide bereavement services and create a directory to facilitate the ability of loss survivors to connect with skilled providers

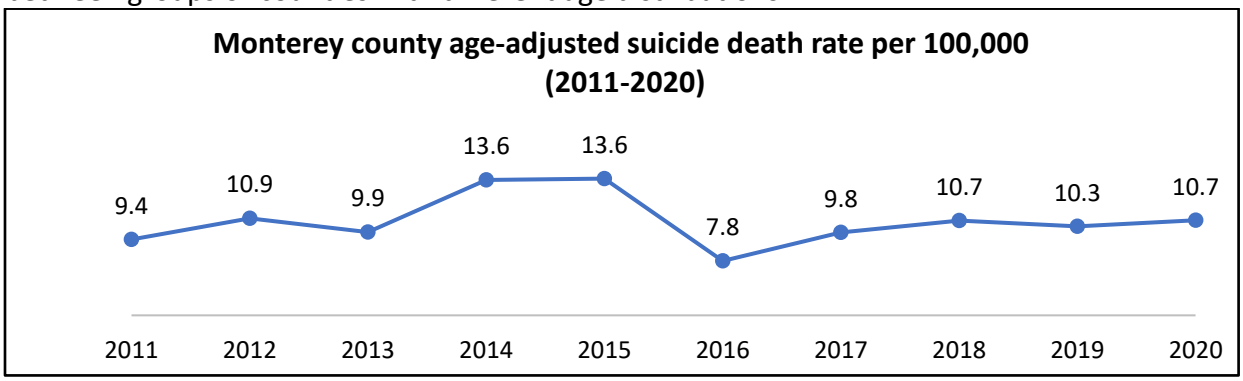
REFERENCES

1. Lezine, D.A & Whitaker, N.J., Fresno County Community-Based Suicide Prevention Strategic Plan, 2018.
2. Monterey County Coroner's Office, U.S. Census Bureau
3. Dazzi, T., Gribble, R., Wessely, S., & Fear, N. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? Psychological Medicine, 44(16), 3361-3363.
4. Caroline A. Blades, Werner G.K. Stritzke, Andrew C. Page, Julia D. Brown. The benefits and risks of asking research participants about suicide: A meta-analysis of the impact of exposure to suicide-related content. Clinical Psychology Review, Volume 64, 2018, Pages 1-12, ISSN 0272-7358.
5. Gould MS, Marrocco FA, Kleinman M, Thomas JG, Mostkoff K, Cote J, & Davies M. Evaluating Iatrogenic Risk of Youth Suicide Screening Problems. JAMA, April 6, 2005 – Vol 293, No 13.
6. Eynan et al (2014). The Effects of Suicide Ideation Assessments on Urges to Self-Harm and Suicide. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 35 (2), 123-131.
7. American Association of Suicidology (AAS) & Society for the Prevention of Teen Suicide (SPTS) (2012) Upstream Youth Suicide Prevention Expert Panel Meeting Summary. pp 1-12.
8. TEAM Up, 2014. Social Media Guidelines for Mental Health Promotion and Suicide Prevention. Entertainment Industries Council
9. https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_final.pdf
10. National Action Alliance for Suicide Prevention. (2019). Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care. Washington, DC: Education Development Center, Inc.
11. Counseling on Access to Lethal Means, Suicide Prevention Resource Center
12. Kreitman, N. The coal gas story: United Kingdom suicide rates, 1960-71. Br J Prev Soc Med. 1976 Jun; 30(2):86-93. https://www.ncbi.nlm.nih.gov/pubmed/953381
13. Lubin, G., N. Werbelogg, D. Halperin, M. Shmushkevitch, M. Weiser, and HY Knobler. Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. Suicide Life Threat Behav. 2010 Oct;40(5):421-4. doi: 10.1521/suli.2010.40.5.421. https://www.ncbi.nlm.nih.gov/pubmed/21034205
14. Pelletier AR. Preventing suicide by jumping: the effect of a bridge safety fence. Inj Prev. 2007;13(1):57–59. doi:10.1136/ip.2006.013748. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2610560/#__ffn_sectitle
15. Reisch, T. and K. Michel. Securing a Suicide Hot Spot: Effects of a Safety Net at the Bern Muenster Terrace. Suicide Life Threat Behav. 2005 Aug;35(4):460-7. https://www.ncbi.nlm.nih.gov/pubmed/16178698
16. Owens D, Horrocks J and House A. Fatal and non-fatal repetition of self-harm: systematic review. British Journal of Psychiatry. 2002;181:193-199.
17. O'Donnel I, Arthur A, Farmer R. A follow-up study of attempted railway suicides. Social

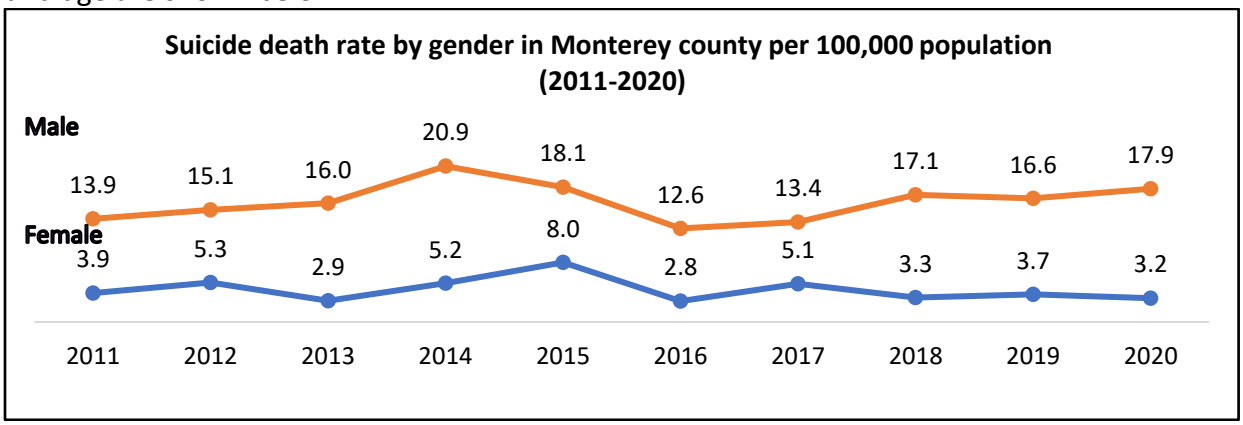
Science and Medicine, 1994; 38:437-42.
18. Suominen K, Isometsa E, Suokas J, et al. Completed suicide after a suicide attempt: a 37 year follow-up study. AMJ Psychiatry 2004; 161:563-564.
19. Gunnell D, Fernando R, Hewagama M, Privangika WD, Konradsen F, Eddleston M. The impact of pesticide regulations on suicide in Sri Lanka. Int Epidemiol. 2007; 36(6):1235-1242.
20. Beautrais, A.L., Effectiveness of barriers at suicide jumping sites: a case study. Aust NZ J Psychiatry. 2001 Oct;35(5):557-5562.
21. Hawton K. United Kingdom legislation on pack sizes of analgesics: background, rationale, and effects on suicide and deliberate self-harm. Suicide Life Threat Behav. 2002 Fall;32(3):223-9. doi: 10.1521/suli.32.3.223.22169. PMID: 12374469.
22. Responding to Grief, Trauma and Distress After a Suicide: U.S National Guidelines, 2015, National Action Alliance for Suicide Preventon.
23. Postvention is Prevention – The Case for Suicide Postvention, John R Jordan, May 2017, Death Studies, 41(3).
24. Https://www.cibhs.org/pod/after-rural-suicide

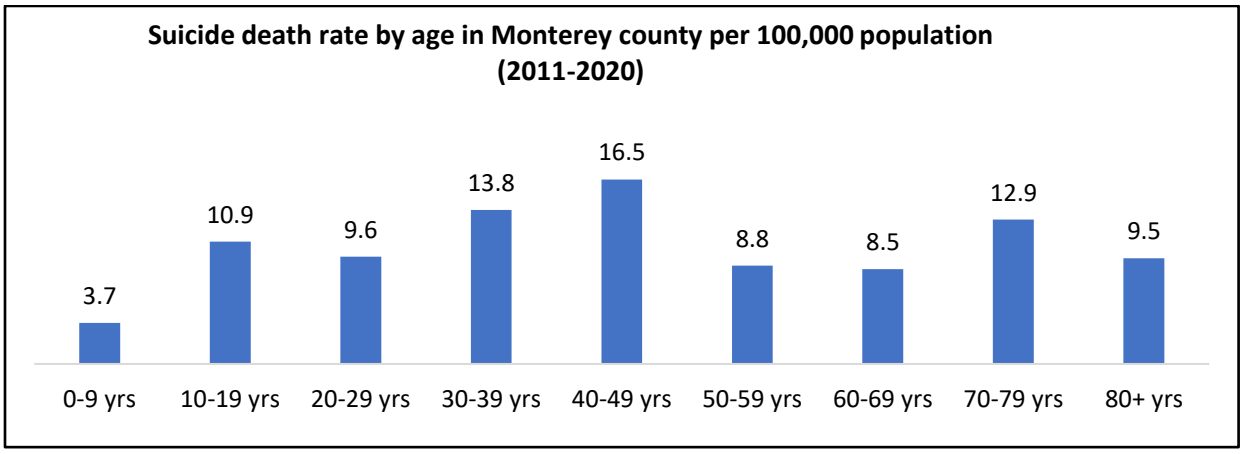
APPENDIX A: Suicide Rates per 100,000

The age-adjusted suicide rate for Monterey County for the year 2020 is similar to that of CA state (10.7 per 100,000 residents) while the national suicide rate is 13.4. The age-adjusted rates are rates that would have existed if the population under study had the same age distribution as the "standard" population and is a way to make fairer comparisons between groups or counties with different age distributions.



Crude rates are expressed as the number of deaths by suicide divided by the population, then multiplied by 100,000. The aggregate suicide death rate in Monterey County based on gender and age are shown below.





APPENDIX B: High-risk Population

A **high-risk population** is a group disproportionately affected by suicide. While suicidal thoughts and behaviors are more common in certain populations, suicide risk and protective factors are not inherently tied to identifying as part of that population. Just because an individual is part of a high-risk population, does not mean the individual is automatically at higher risk for suicide and messaging around risk should be done with caution to avoid potentially unintended harmful messaging.

The National Action Alliance for Suicide Prevention explains high risk in several ways:

- Large numbers of suicide deaths or attempts
- Higher rates of deaths or attempts rates are calculated as a proportion of a particular group
- Higher rates indicate a disproportionate impact from what might be expected if suicide were evenly distributed in a population group
- Those with high percentages of suicidality as a percentage of the population
- Upward trends in numbers or rates within a population group

A comprehensive approach to suicide prevention includes a broad range of prevention, early intervention, treatment and postvention strategies. Targeting these strategies for populations disproportionately affected by suicide applies this framework to a subset of the general population that is more likely to experience risk factors for suicide.