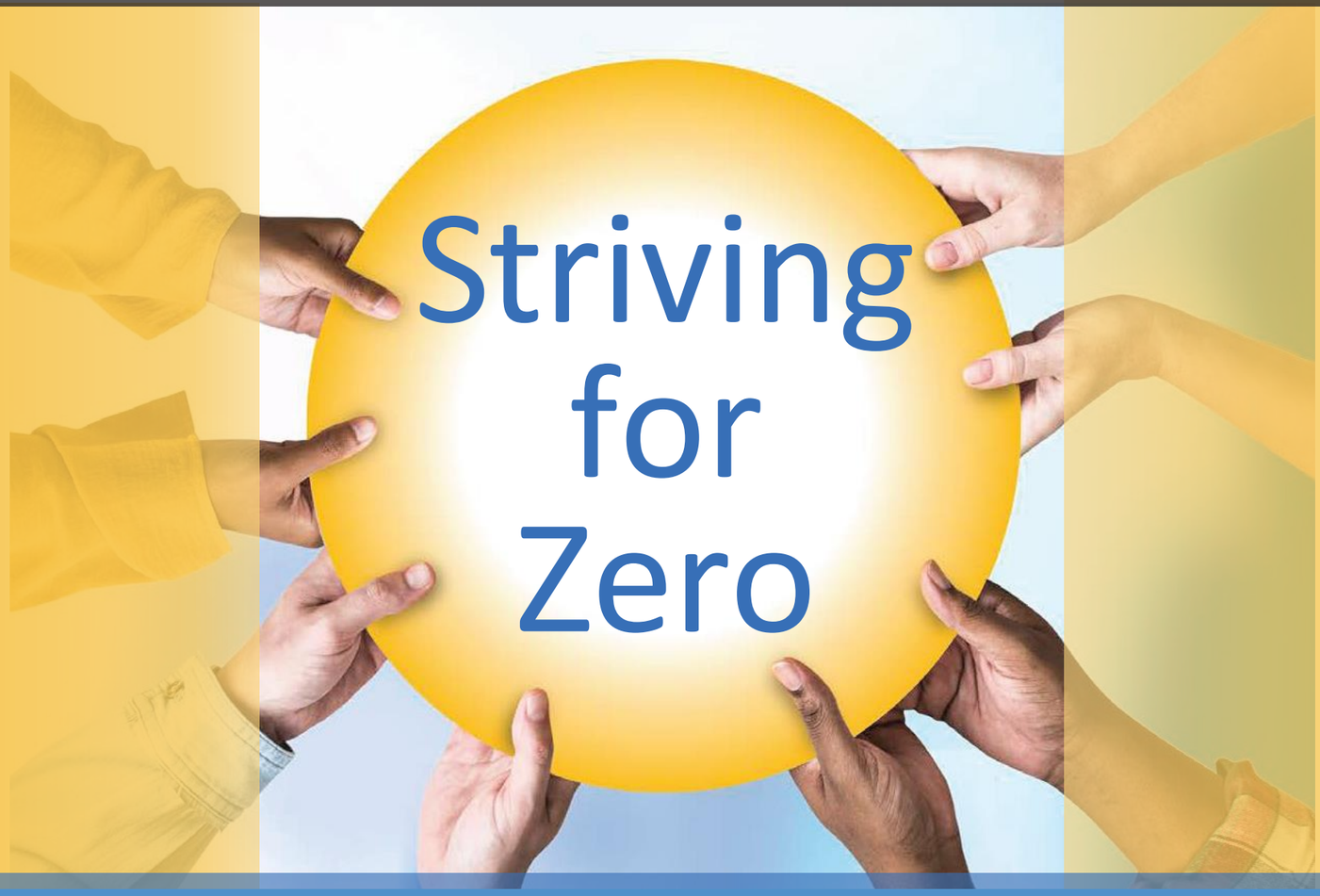


Striving for Zero Learning Collaborative

Describing the Problem of Suicide, June 30, 2021

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1**-888-682-9454

Welcome!

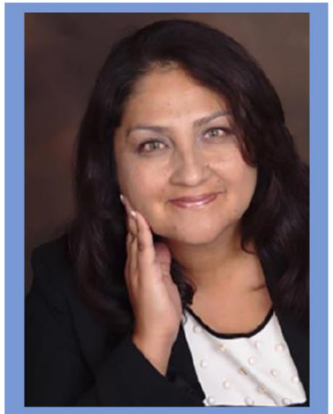
Please add your county name to your display name and introduce yourself in the chat.

We will share the slides and recording with you.

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)

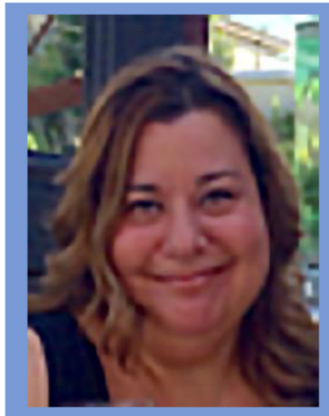
Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1-**888-682-9454

Rosio Pedroso, MPP



Rosio Pedroso, MPP, Principal of Pedroso Consulting has over 20 years of experience conducting research and evaluation for underrepresented and underserved communities. For the past four years she created content, programs and conducted outreach for California's Mental Health Movement, SanaMente, for Spanish-speaking populations. She has conducted evaluations, needs assessments, primary research, empathy studies, focus groups, and interviews on a variety of topics including K-5 literacy, secondary and postsecondary STEM initiatives for underrepresented groups and first-generation college students. Rosio has developed and conducted trainings on a variety of topics to increase awareness and prevention of suicide, child abuse, and cannabis use to Spanish-speaking communities. She also contributed to strategic planning efforts for suicide prevention and adult education consortiums in California. Rosio has provided technical assistance to county behavioral health agencies as a resource navigator since 2017.

Nicolle Perras, MPH, MA LMFT



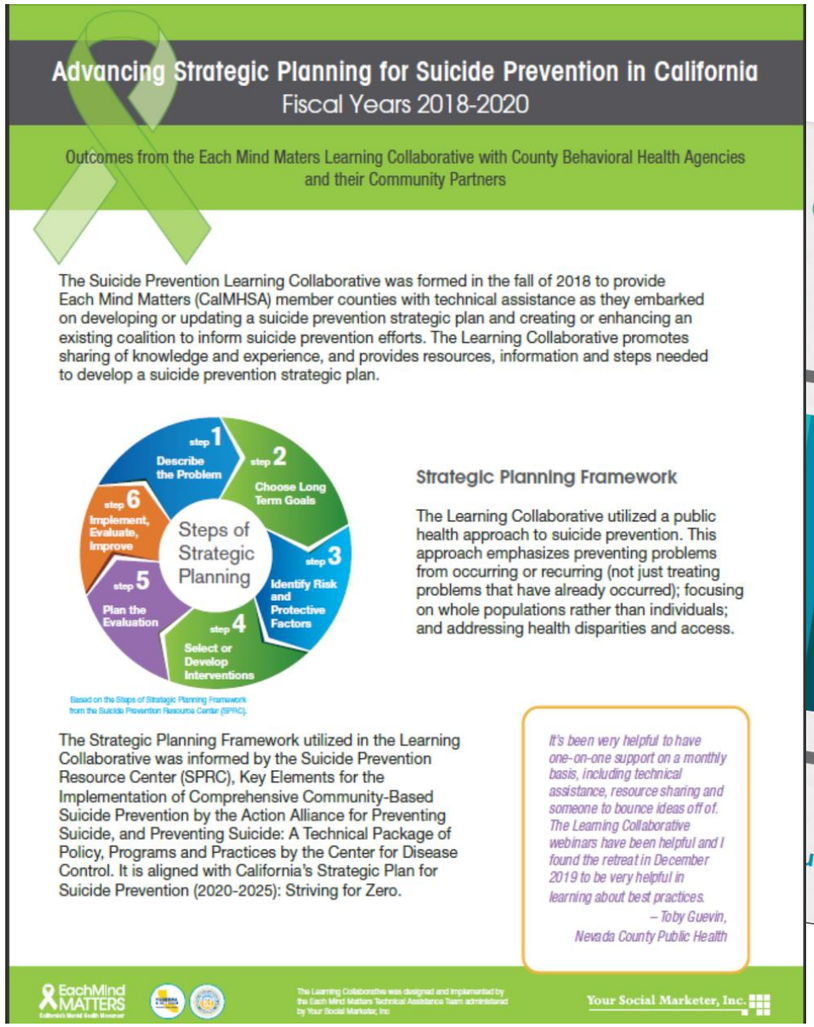
Nicolle Perras, MPH, MA, LMFT is a Health Program Analyst with the Los Angeles County Department of Public Health (DPH) and a Licensed Marriage and Family Therapist (LMFT). She has over 20 years of experience working in the field of public health research, program planning and evaluation. For the past 15 years at DPH she has worked on the connections between multiple forms of violence, health impacts of trauma, abuse and violence, and trauma informed care practices and systems change. Ms. Perras works to address mental health, suicide and violence as public health issues, examining them through the perspectives of social determinants of health, health equity and social justice. She has served as the suicide prevention lead for DPH and has been a member of the LA County Suicide Prevention Network since its inception.

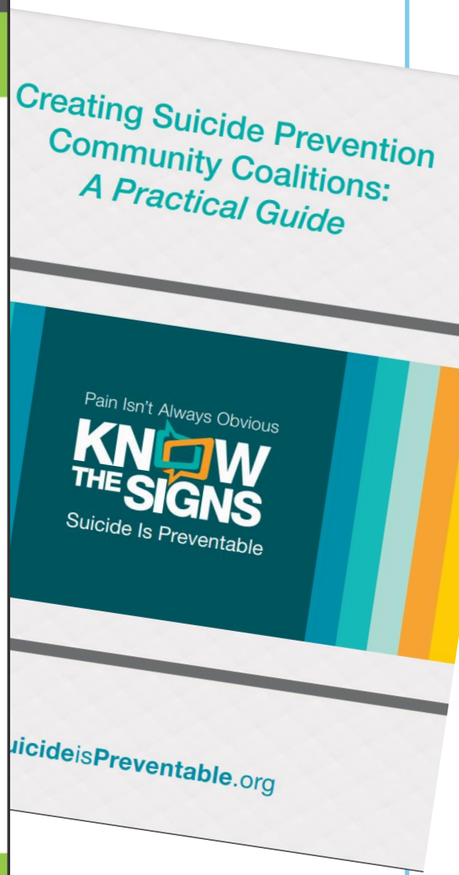
Striving for Zero Learning Collaborative

Advance local strategic planning and implementation and alignment with strategic aims, goals and objectives set forth in California's Strategic Plan for Suicide Prevention

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Builds on a previous Learning Collaborative offered by the California Mental Health Services Authority



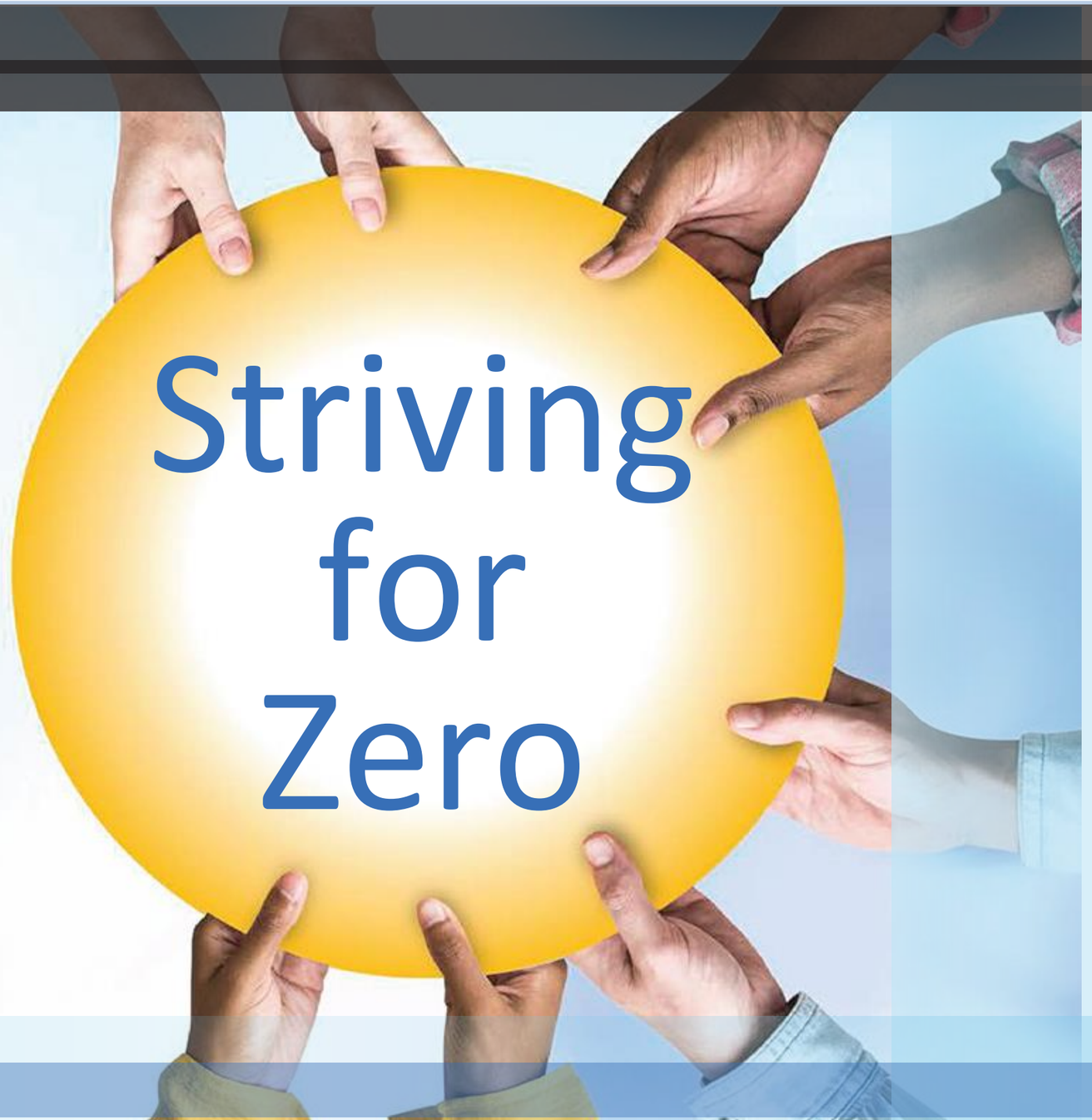


Pain Isn't Always Obvious
KNOW THE SIGNS
suicideispreventable.org

CalMHSA
California Mental Health Services Authority

Assembly Bill 114 (Chapter 38, Statutes of 2017) directed the Commission to develop a statewide strategic suicide prevention plan. In early 2018, the Commission formed a Suicide Prevention Subcommittee, which included Commissioners Tina Wooton (Chair), Khatera Tamplen, and Mara Madrigal-Weiss.

The Commission adopted Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025 in November 2019.



MHSOAC
Mental Health Services
Oversight & Accountability Commission

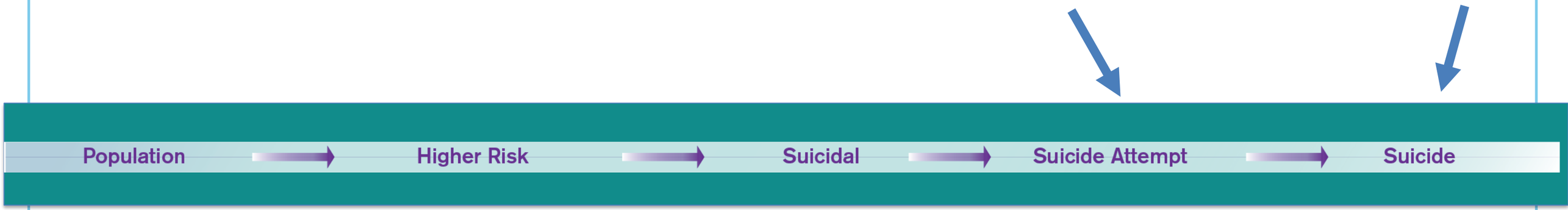
Find the Plan here: https://mhsoac.ca.gov/what-we-do/projects/suicide-prevention/final-report

Strategic Planning Framework

Based on the Steps of Strategic Planning Framework from the Suicide Prevention Resource Center (SPRC).

Today's Agenda

- Describing the Problem of Suicide (Mortality and Morbidity Data)
- Describing the Problem of Suicide in California: A Brief Data Review by CDPH
- MHSOAC Data Dashboard
- County Spotlight Riverside County: Data Dashboard
- Using and Sharing Data
- Upcoming Modules and Collaborative Meetings

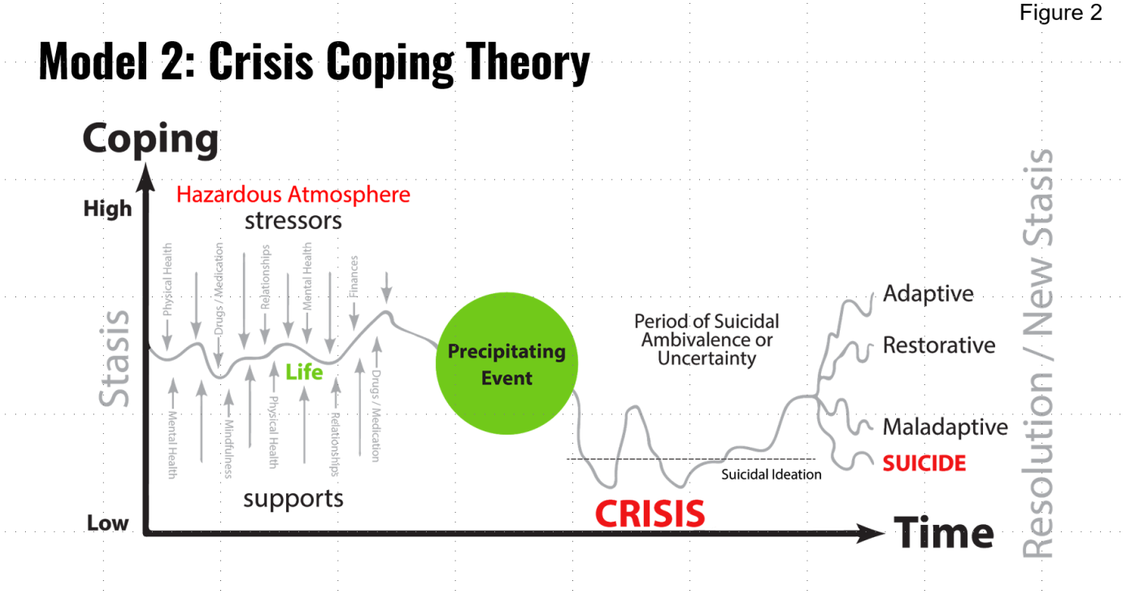


The Suicidal Crisis Path Model as a Framework for Understanding Suicide Prevention

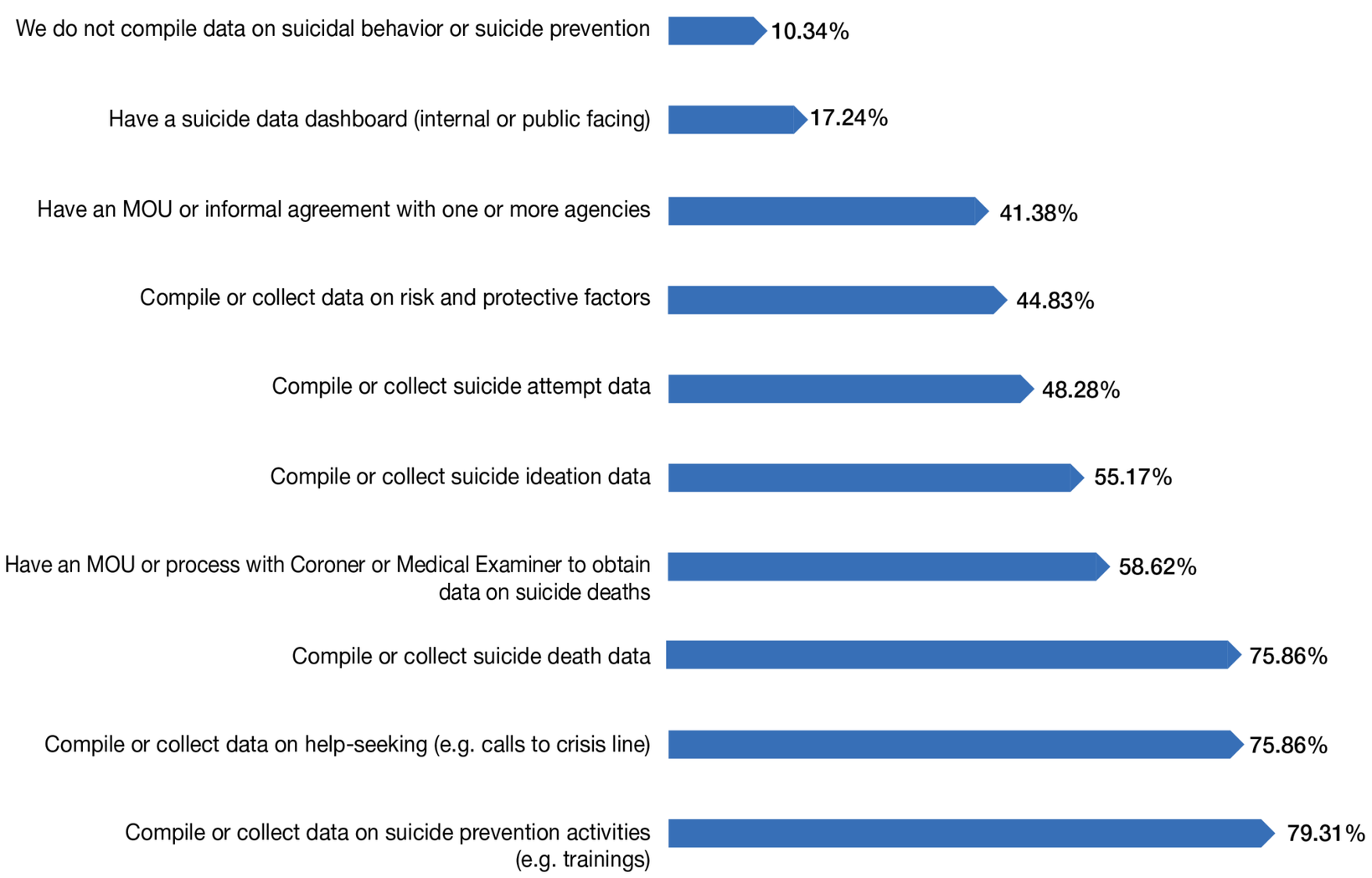
"The Suicidal Crisis Path is a model that intends to integrate multiple theoretical approaches and frameworks within the context of an individual's suicidal experience. In doing so, the purpose is to match intervention approaches with the timing, risk factors, and protective factors that would be the mechanisms to prevent a suicide from happening." (Lezine, D.A. & Whitaker, N.J., Fresno County Community-Based Suicide Prevention Strategic Plan, 2018)

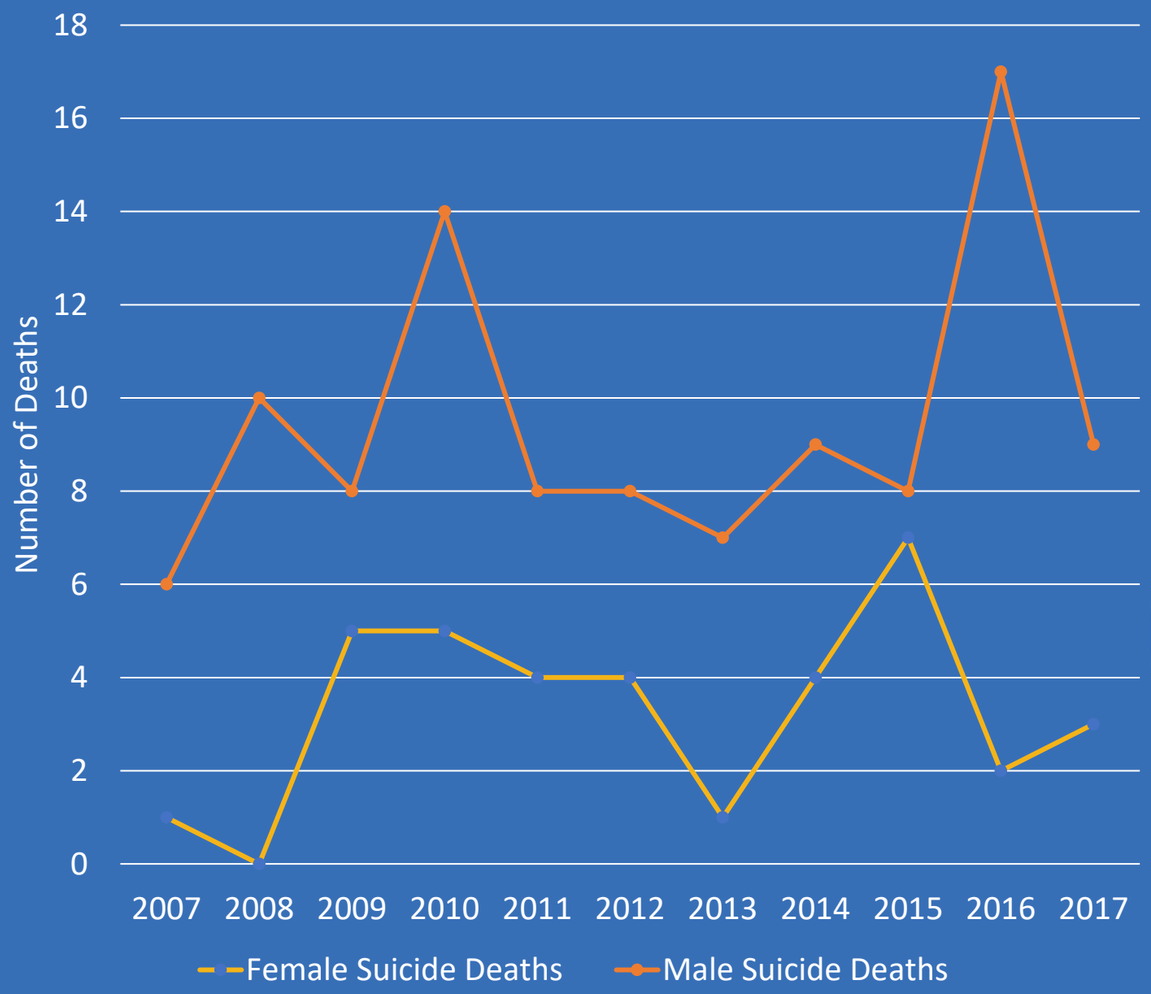
www.FresnoCares.org

Figure 2



Striving for Zero Learning Collaborative - Data Review Snapshot April 2021 (n 29)





What sources of data are available to help describe the problem of suicide?

What story does your data tell you? Whose story isn't being told?

How are you using and sharing the data?

Why Use Data?

- Provide context to local issue of suicide
- Dispel misconceptions
- Focus effort where the problem is most severe
- Identify risk and protective factors to select interventions
- Persuade funders, policy and decision makers
- Evaluate and measure change over time

A Comprehensive Approach to Suicide Prevention Requires Telling a Comprehensive Story about Suicide and Suicide Prevention in Your County

Who is seeking help by reaching out to a crisis or warm line or accessing services? Who isn't?

Who is thinking about suicide?

What community strengths can support suicide prevention efforts? What are the gaps?

Who is dying by suicide?
(Mortality Data)

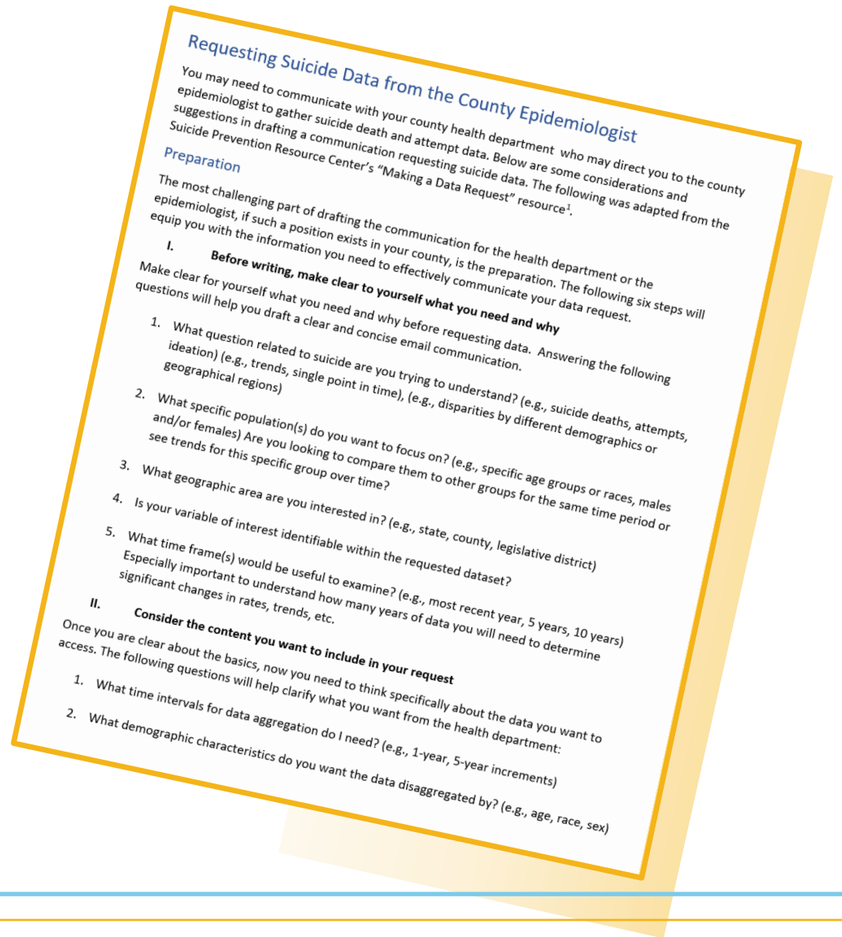
What risk and protective factors are present?

Who is attempting suicide?
(Morbidity Data)

What care transitions exist?

Sources	What it tells you
Coroner or Medical Examiner	Who dies by suicide Means of suicide, risk factors
EpiCenter (CDPH)	State and county Numbers, rates, means, ages and demographics Can create queries
Local hospitals **EpiCenter (CDPH)**	Non-fatal self injuries treated in hospitals and emergency rooms State and county Non-fatal & fatal injuries by method All ages & demographics Can create queries
CDC WISQARS	Non-fatal self injuries treated in hospitals and emergency rooms State and county Non-fatal self-inflicted injuries & method All ages and demographics Cost of injury reports Can create queries
The Mental Health Services Oversight and Accountability Commission (MHSOAC) Dashboard	COMING SOON!

Requesting Suicide Data from Your County Epidemiologist



Requesting Suicide Data from the County Epidemiologist

You may need to communicate with your county health department who may direct you to the county epidemiologist to gather suicide death and attempt data. Below are some considerations and suggestions in drafting a communication requesting suicide data. The following was adapted from the Suicide Prevention Resource Center's "Making a Data Request" resource[1].

Preparation

The most challenging part of drafting the communication for the health department or the epidemiologist, if such a position exists in your county, is the preparation. The following six steps will equip you with the information you need to effectively communicate your data request.

I. **Before writing, make clear to yourself what you need and why**

Make clear for yourself what you need and why before requesting data. Answering the following questions will help you draft a clear and concise email communication.

1. What question related to suicide are you trying to understand? (e.g., suicide deaths, attempts, ideation) (e.g., trends, single point in time), (e.g., disparities by different demographics or geographical regions)
2. What specific population(s) do you want to focus on? (e.g., specific age groups or races, males and/or females) Are you looking to compare them to other groups for the same time period or see trends for this specific group over time?
3. What geographic area are you interested in? (e.g., state, county, legislative district)
4. Is your variable of interest identifiable within the requested dataset?
5. What time frame(s) would be useful to examine? (e.g., most recent year, 5 years, 10 years) Especially important to understand how many years of data you will need to determine significant changes in rates, trends, etc.

II. **Consider the content you want to include in your request**

Once you are clear about the basics, now you need to think specifically about the data you want to access. The following questions will help clarify what you want from the health department:

1. What time intervals for data aggregation do I need? (e.g., 1-year, 5-year increments)
2. What demographic characteristics do you want the data disaggregated by? (e.g., age, race, sex)

Be prepared! Outline what you need and why

- ✓ Why you need their data
- ✓ Why they should care
- ✓ What data you would like them to share
- ✓ How you will use their data

Create a table shell of what you need

Be aware of data limitations

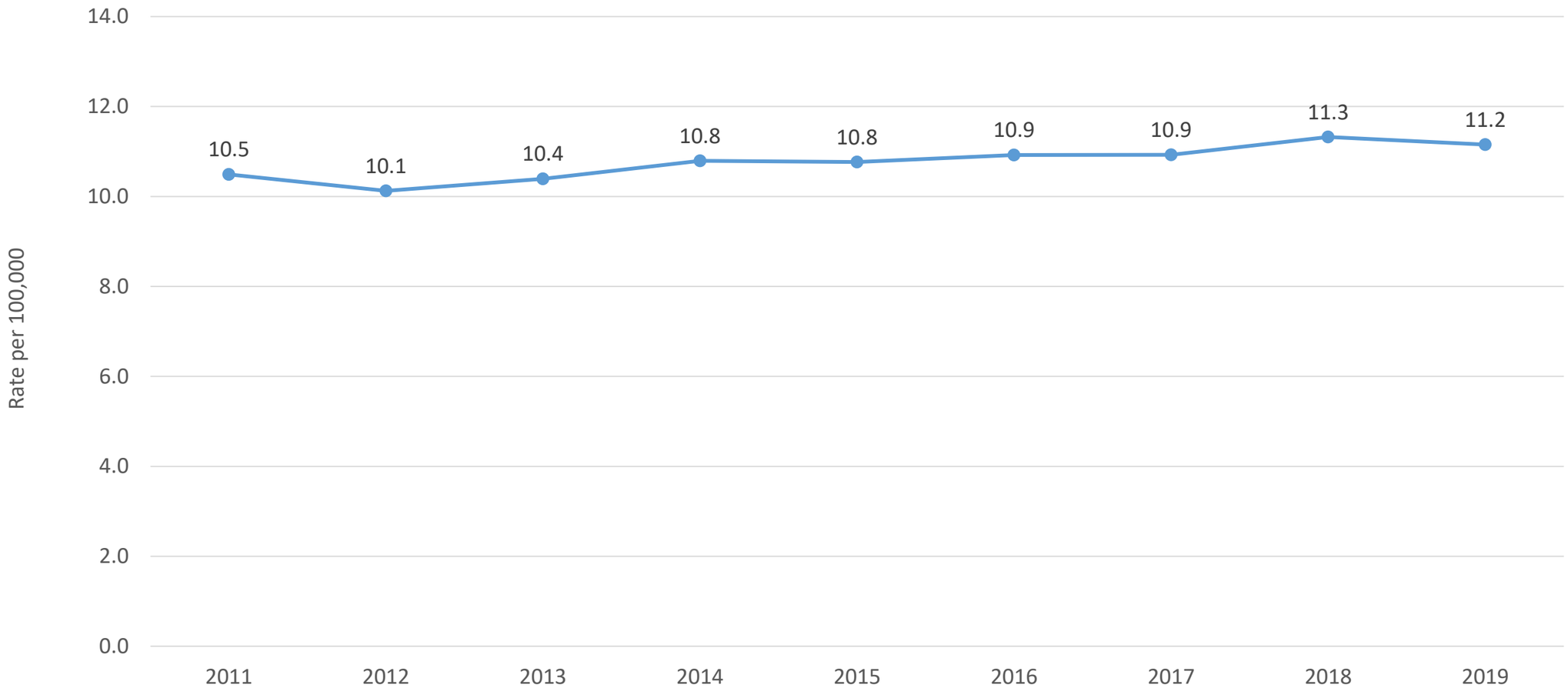
Describing the Problem of Suicide in California:

A Brief Data Review by CDPH

Trends in Suicide Mortality (Death Rates) and Morbidity (Self-Harm Rates) among Californians

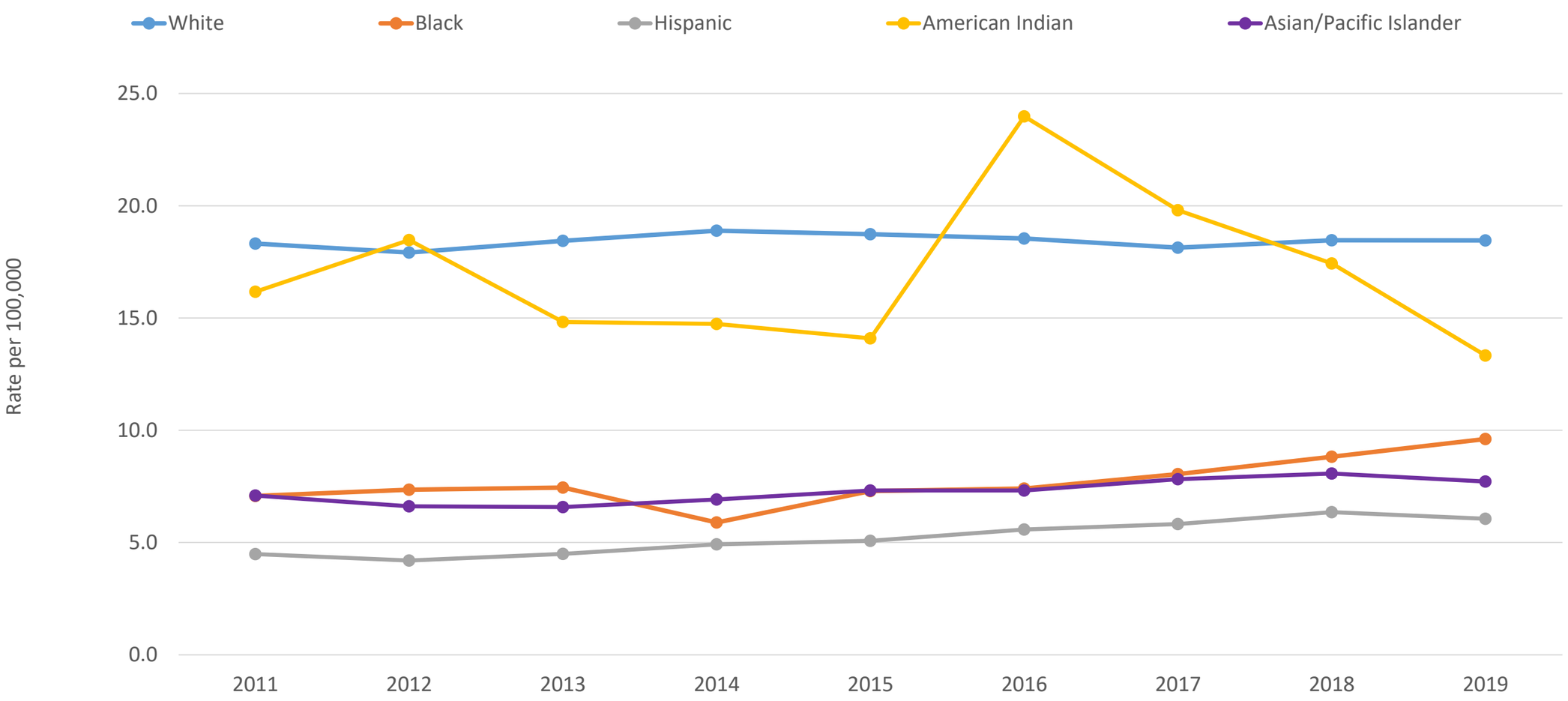
Renay Bradley and Nichole Watmore
CA Department of Public Health
Injury and Violence Prevention Branch

Suicide Rates in California, 2011-2019



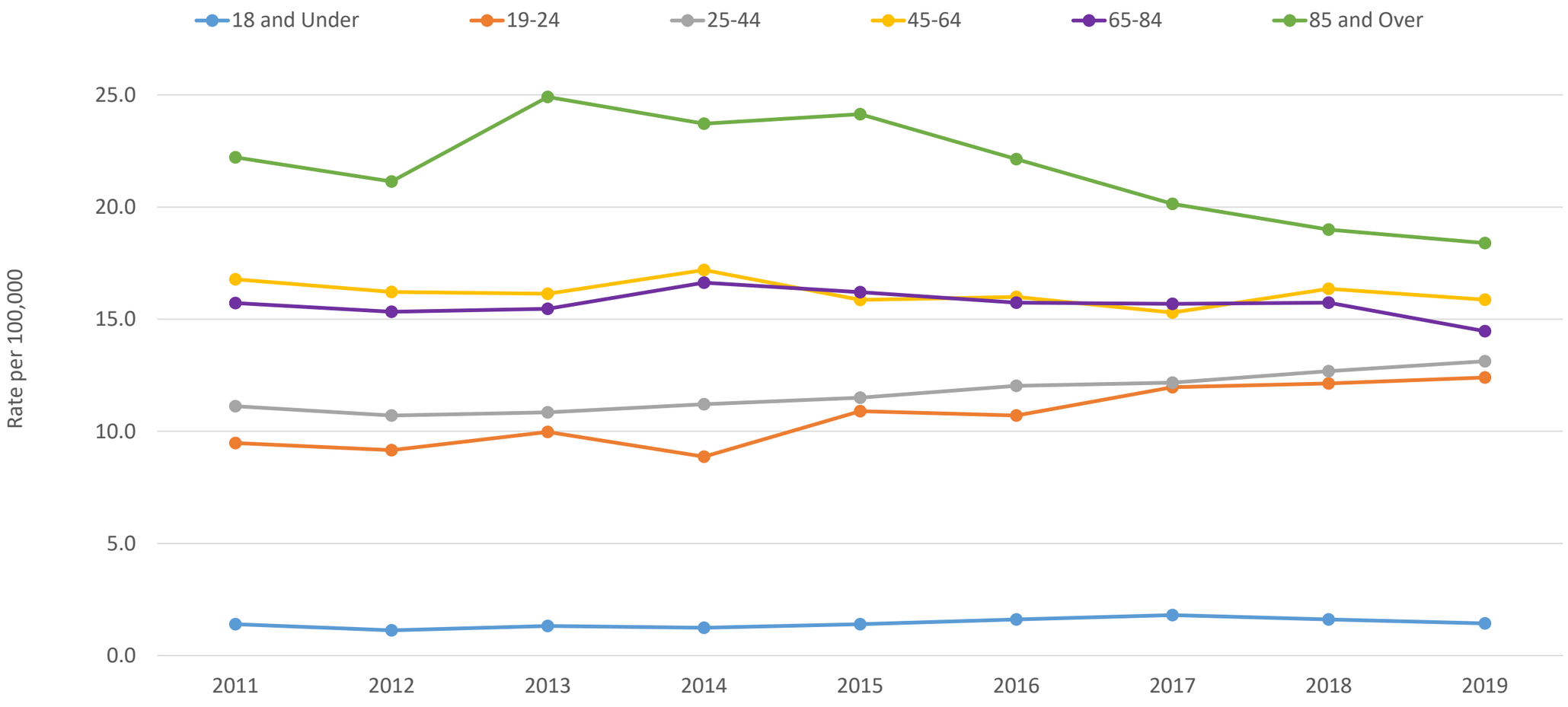
Source: 2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF); CA Dept. of Finance P-3 Population Projection File (2010-2060)

Suicide Rate by Race/Ethnicity in California, 2011-2019



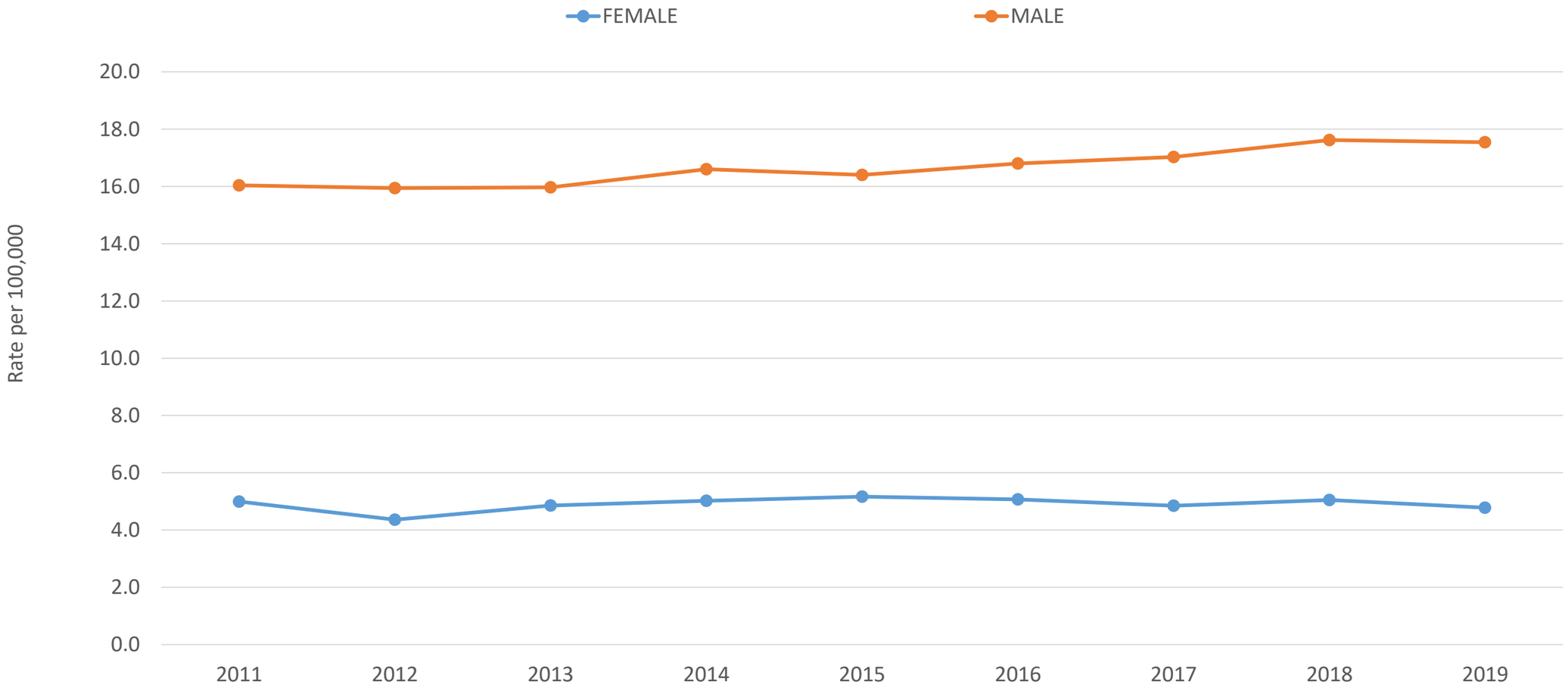
Note: Rates for American Indians are unstable due to small sample size.
Source: 2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF); CA Dept. of Finance P-3 Population Projection File (2010-2060)

Suicide Rate by Age Group in California, 2011-2019



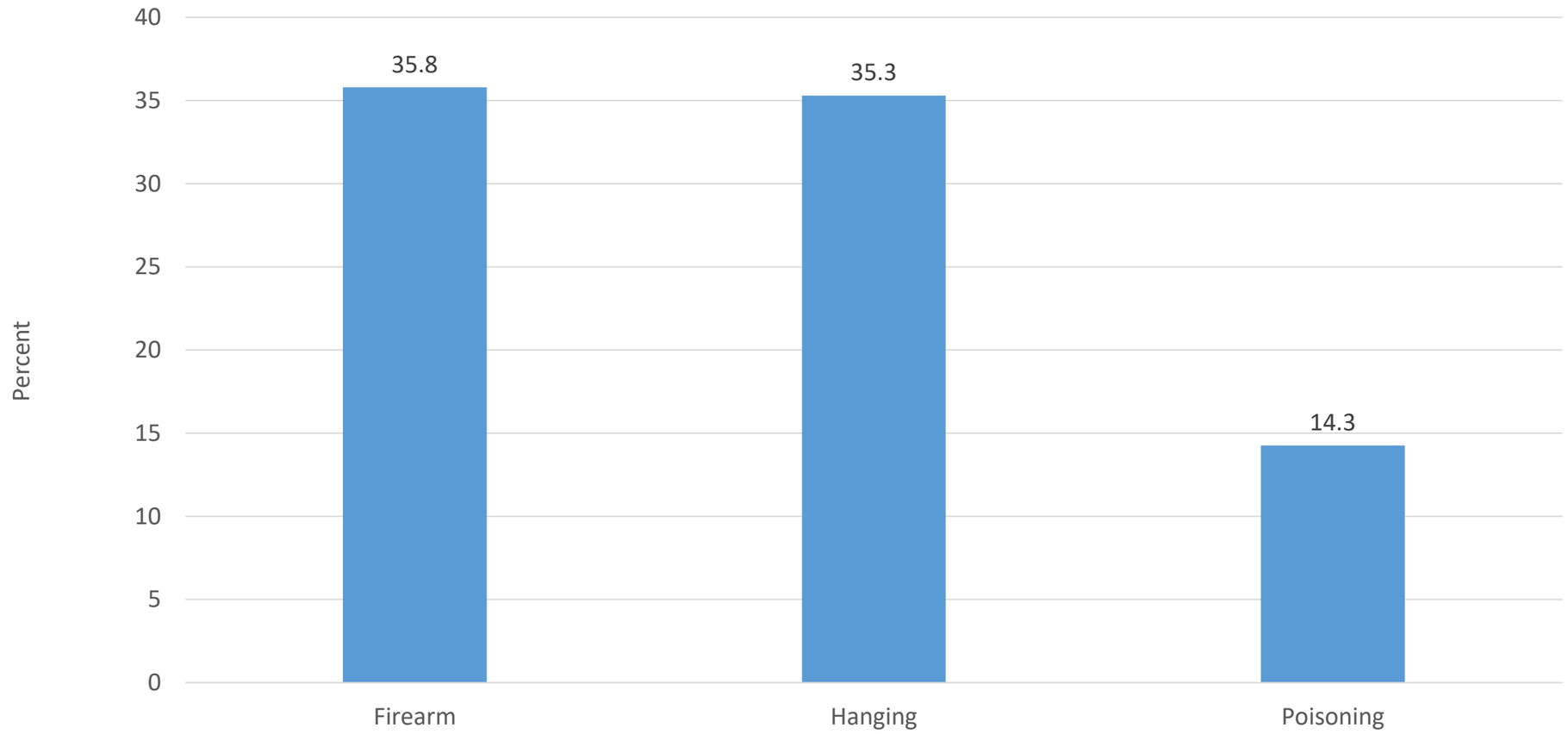
Source: 2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF); CA Dept. of Finance P-3 Population Projection File (2010-2060)

Suicide Rate by Sex in California, 2011-2019



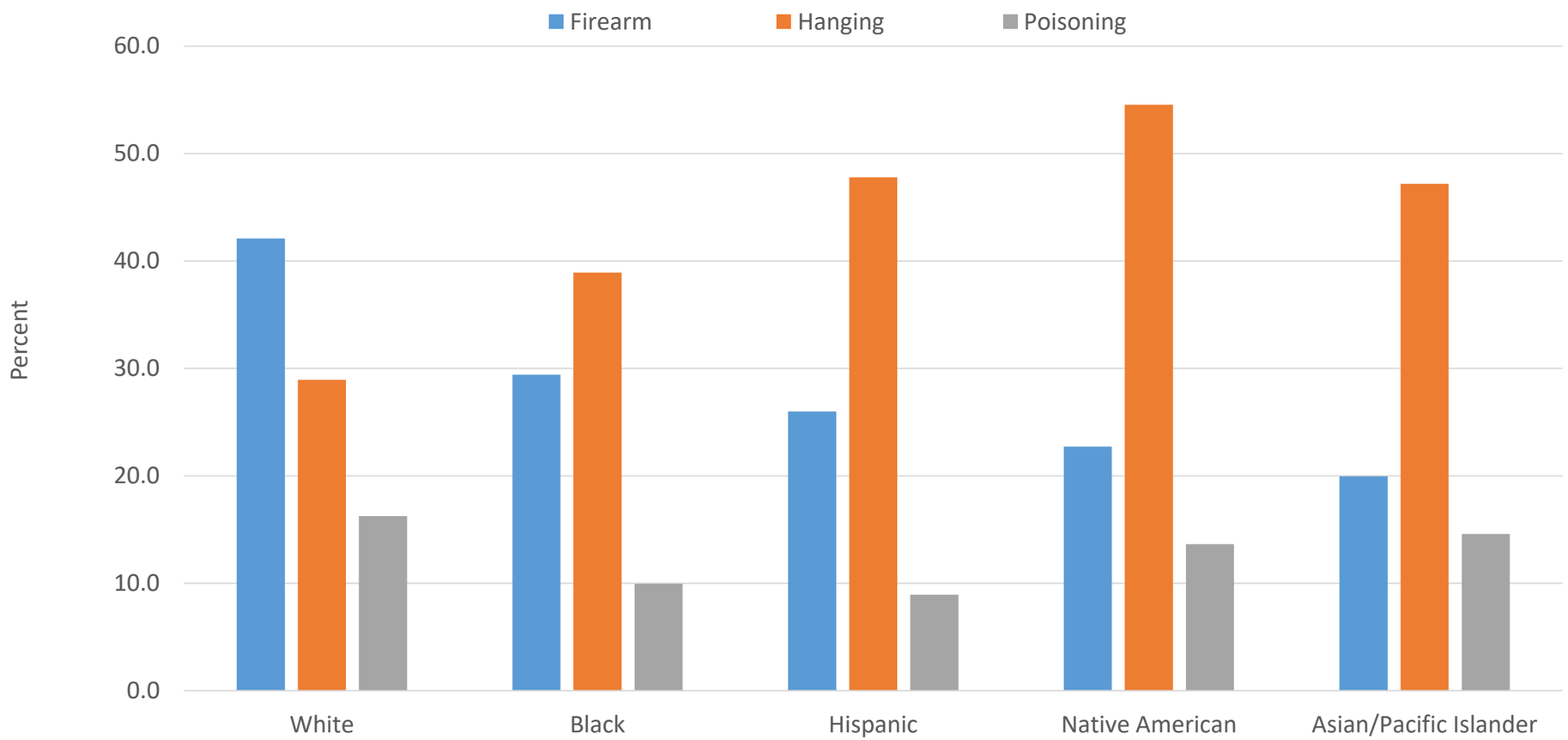
Source: 2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF); CA Dept. of Finance P-3 Population Projection File (2010-2060)

Mechanism of Suicide in California, 2019



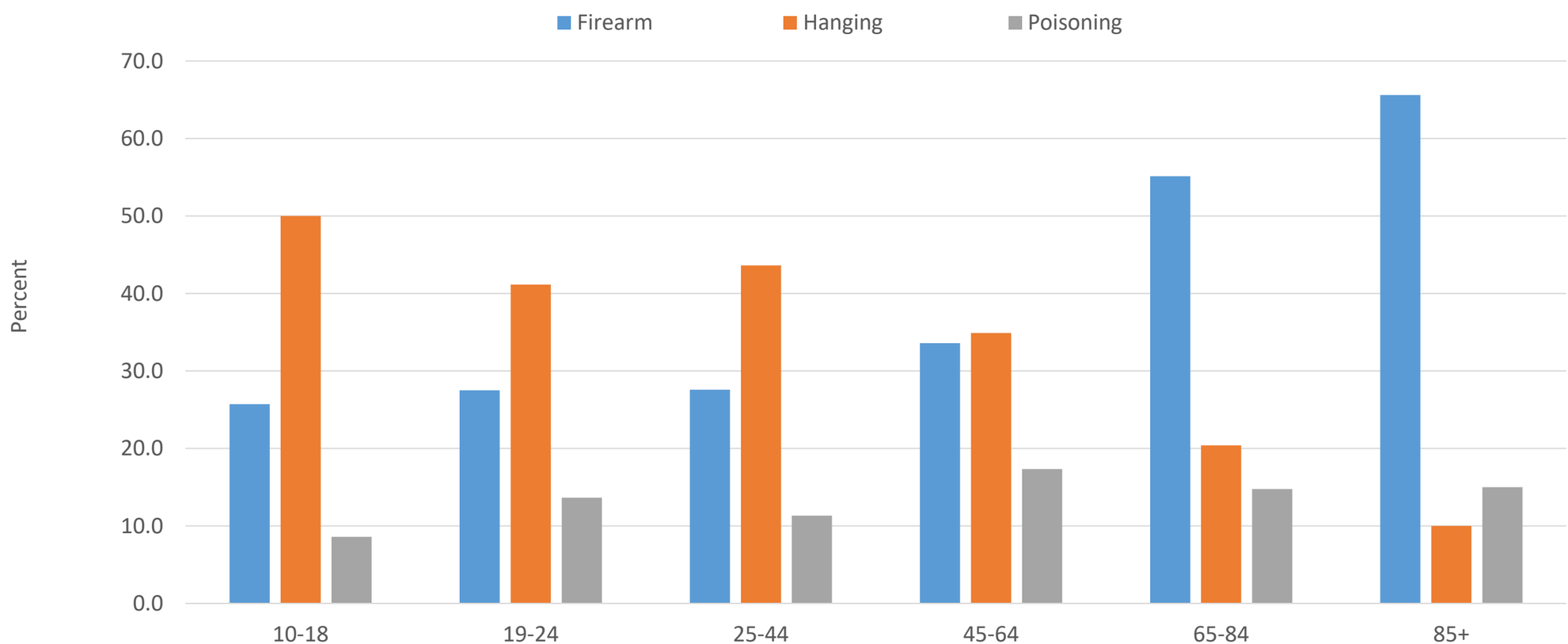
Source: 2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF)

Mechanism of Suicide by Race/Ethnicity in California, 2019



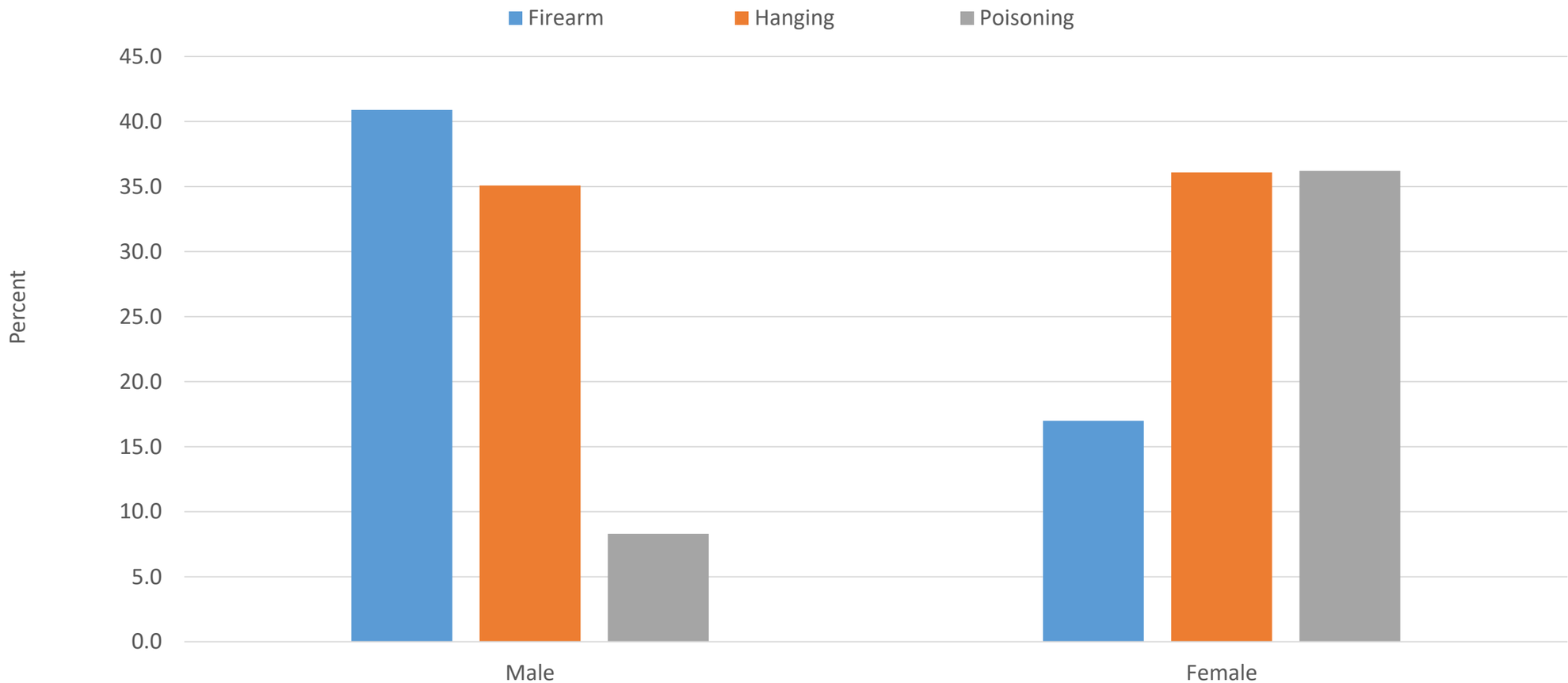
Source: 2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF)

Mechanism of Suicide by Age Group in California, 2019



Source: 2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF)

Mechanism of Suicide by Sex in California, 2019

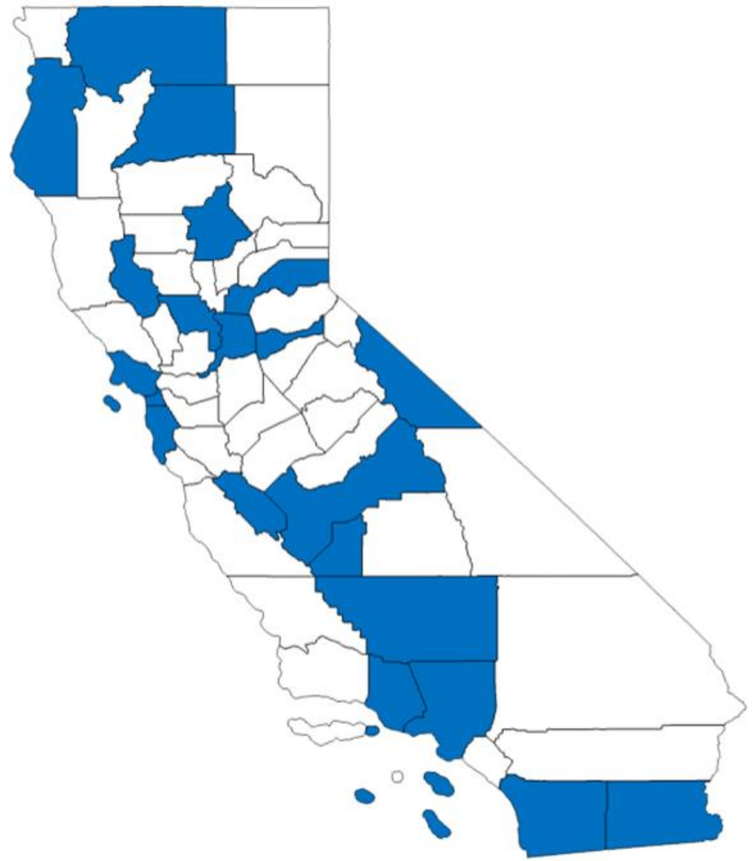


Source: 2019 deaths: CDPH, CA Comprehensive Master Death File (CCMDF)

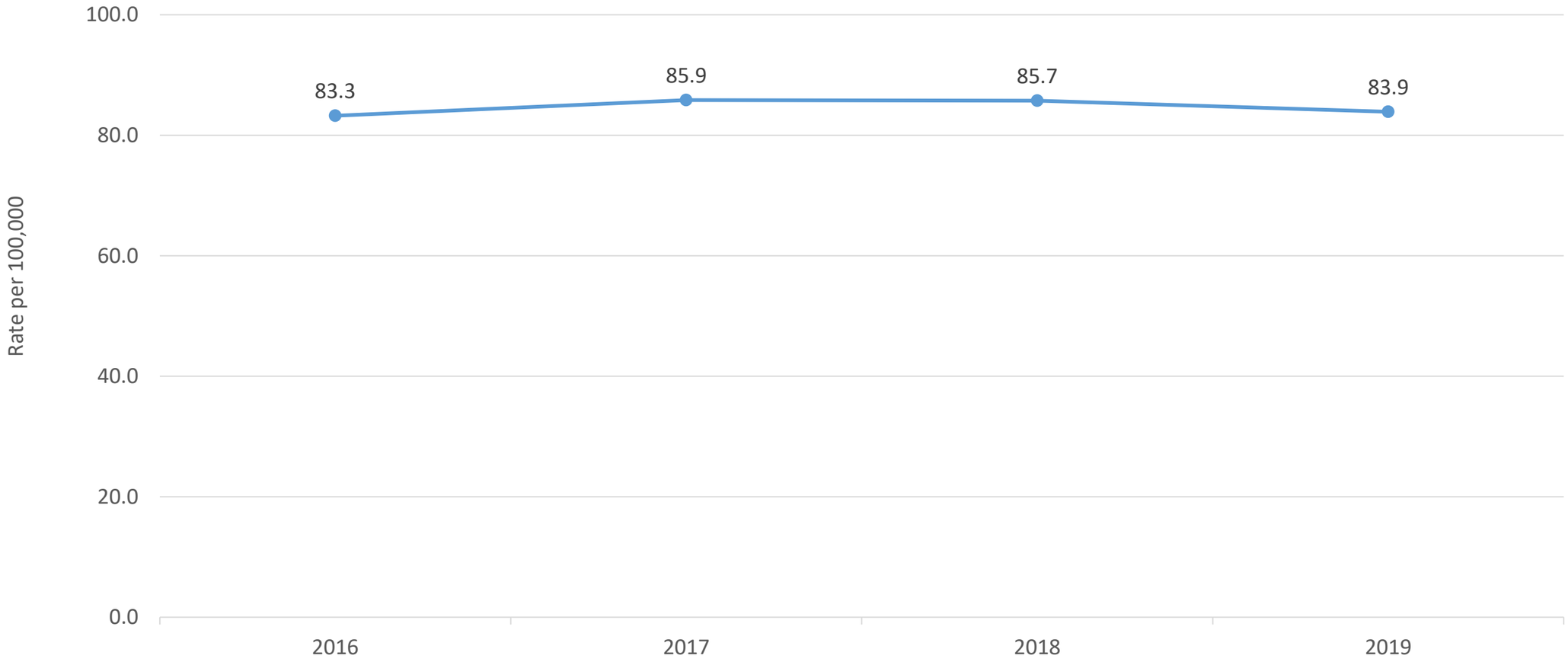
California Violent Death Reporting System (CalVDRS)

- CalVDRS is a part of the CDC's National Violent Death Reporting System (NVDRS)
- CalVDRS links vital statistics data with reports from coroners, medical examiners, and law enforcement officials to provide information on circumstances surrounding violent deaths in California
- Data available for 21 counties for 2018
- About 50% of violent deaths in California

- Please contact Renay.Bradley@cdph.ca.gov if you would like to learn more about CalVDRS

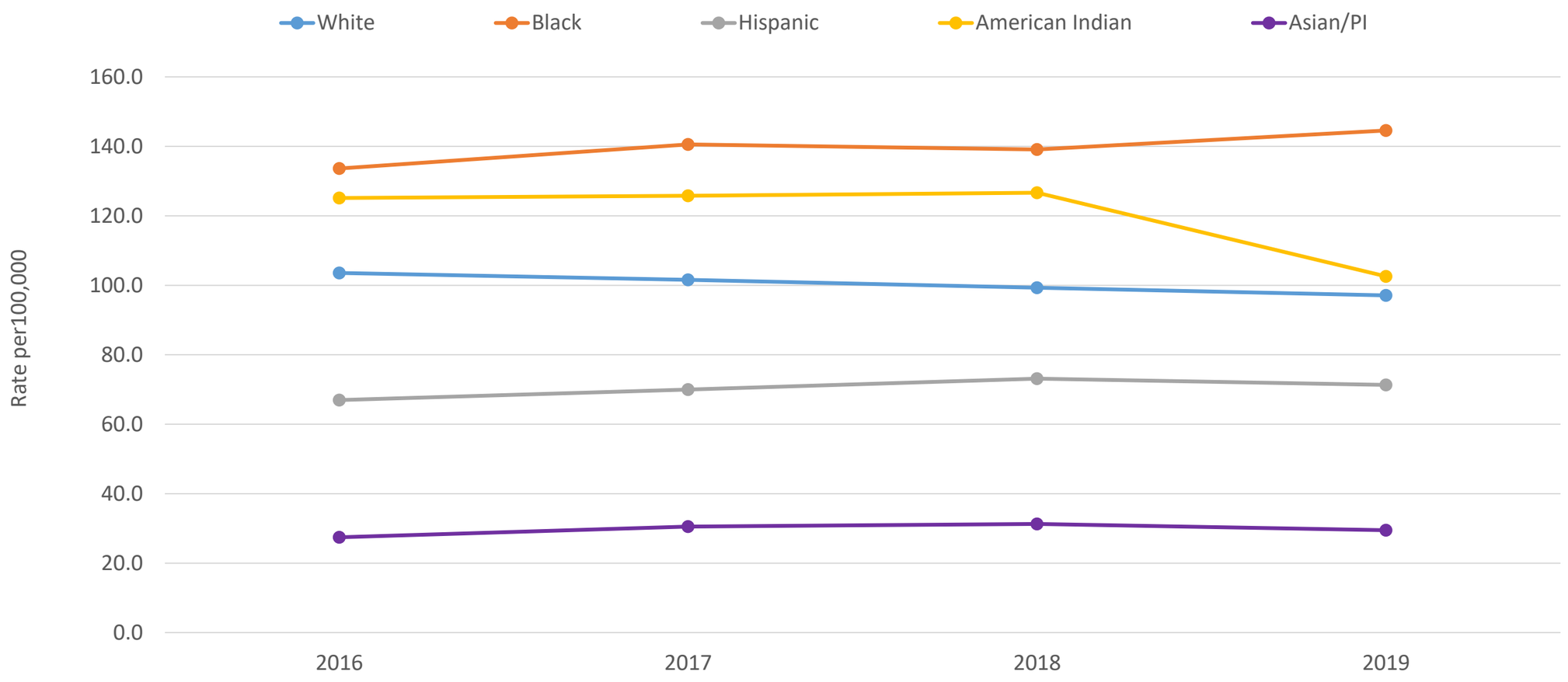


Rates of Self-Harm Emergency Department (ED) Visits in California, 2016-2019



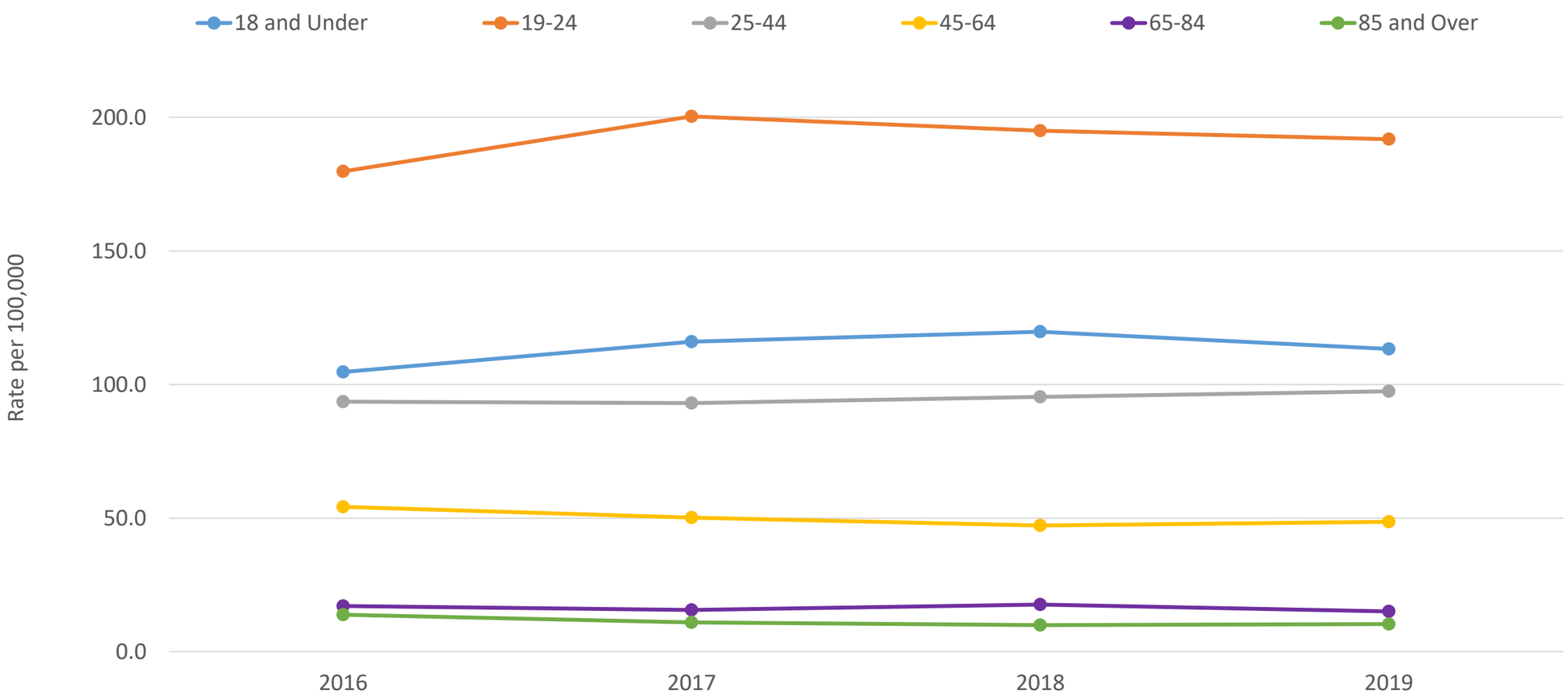
Source: 2016-2019 ED Visits: Office of Statewide Health Planning and Development (OSHPD), Emergency Department Data; CA Dept. of Finance P-3 Population Projection File (2010-2060)

Rates of Self-Harm ED Visits by Race/Ethnicity in California, 2016-2019



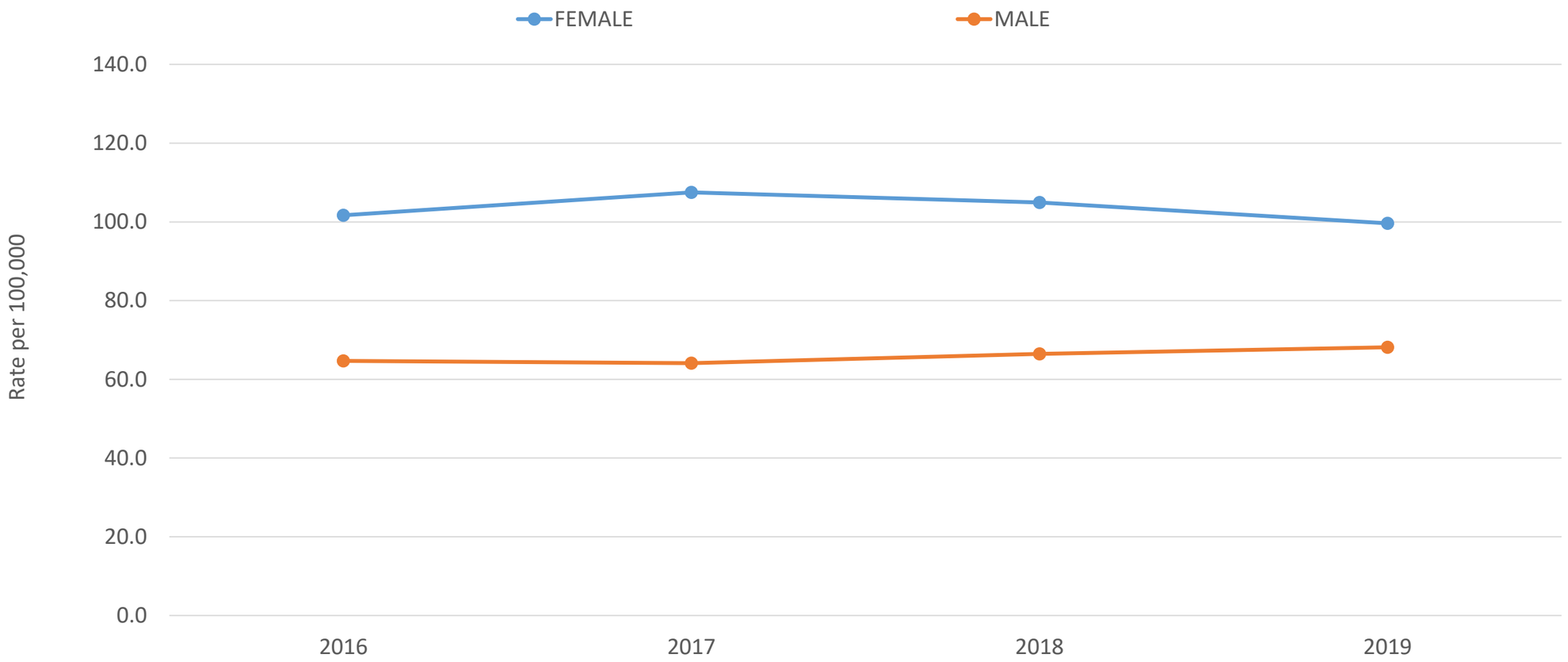
Source: 2016-2019 ED Visits: Office of Statewide Health Planning and Development (OSHPD), Emergency Department Data; CA Dept. of Finance P-3 Population Projection File (2010-2060)

Rates of Self-Harm ED Visits by Age Group in California, 2016-2019



Source: 2016-2019 ED Visits: Office of Statewide Health Planning and Development (OSHPD), Emergency Department Data; CA Dept. of Finance P-3 Population Projection File (2010-2060)

Rates of Self-Harm ED Visits by Sex in California, 2016-2019



Source: 2016-2019 ED Visits: Office of Statewide Health Planning and Development (OSHPD), Emergency Department Data; CA Dept. of Finance P-3 Population Projection File (2010-2060)

Summary of Recent Trends

- Suicide death rates in California vary by race/ethnicity, age, and sex
  - Individuals at elevated risk for suicide include:
    - Whites, American Indians
    - Older adults (85+)
    - Males
- Most common mechanism of suicide is firearms, and this varies by race/ethnicity, age, and sex
  - Individuals at elevated risk for using firearms as a mechanism of suicide:
    - Whites
    - Older adults (85+)
    - Males
- Self-harm ED visit rates in California also vary by race/ethnicity, age, and sex
  - Individuals at elevated risk for self-harm ED visits include:
    - Blacks, American Indians
    - Youth age 19-24
    - Females

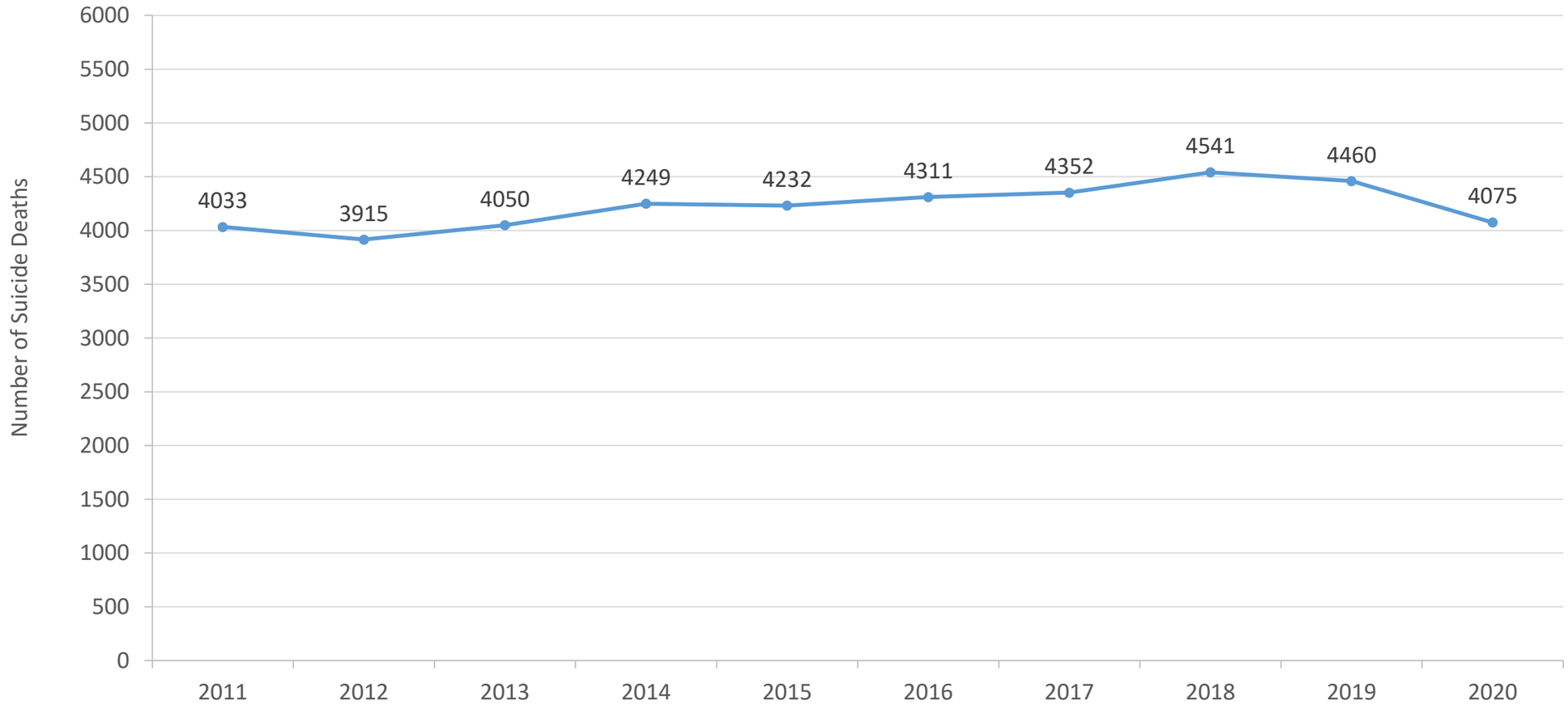
Have these trends continued into 2020?

Save the date! July 28, 2021 - The CDPH Suicide Prevention Program and Violence Prevention Initiative are hosting a webinar to kick off establishment of the new statewide Office of Suicide Prevention:

Suicide Prevention in CA - Suicide Rates, the Impact of COVID-19 Pandemic, and CDPH's Office of Suicide Prevention

The next slide is a preview of one of the slides that will be presented at the July 28th webinar…

Number of Suicide Deaths that occurred in California, 2011-2020



Source: 2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2020 deaths: CDPH, CA Comprehensive Master Death File (CCMDF)

Questions?

Renay Bradley, Renay.Bradley@cdph.ca.gov

Nichole Watmore, Nichole.Watmore@cdph.ca.gov

Sara Mann, Sara.Mann@cdph.ca.gov

MHSOAC Data Dashboard

Please provide feedback on the dashboard to Rachel Heffley at Rachel.Heffley@mhsoac.ca.gov before July 16, 2021.

Suicide Incidence & Rate Dashboard: https://mhsoac.ca.gov/resources/transparency-suite/suicide-incidence-and-rate-dashboard

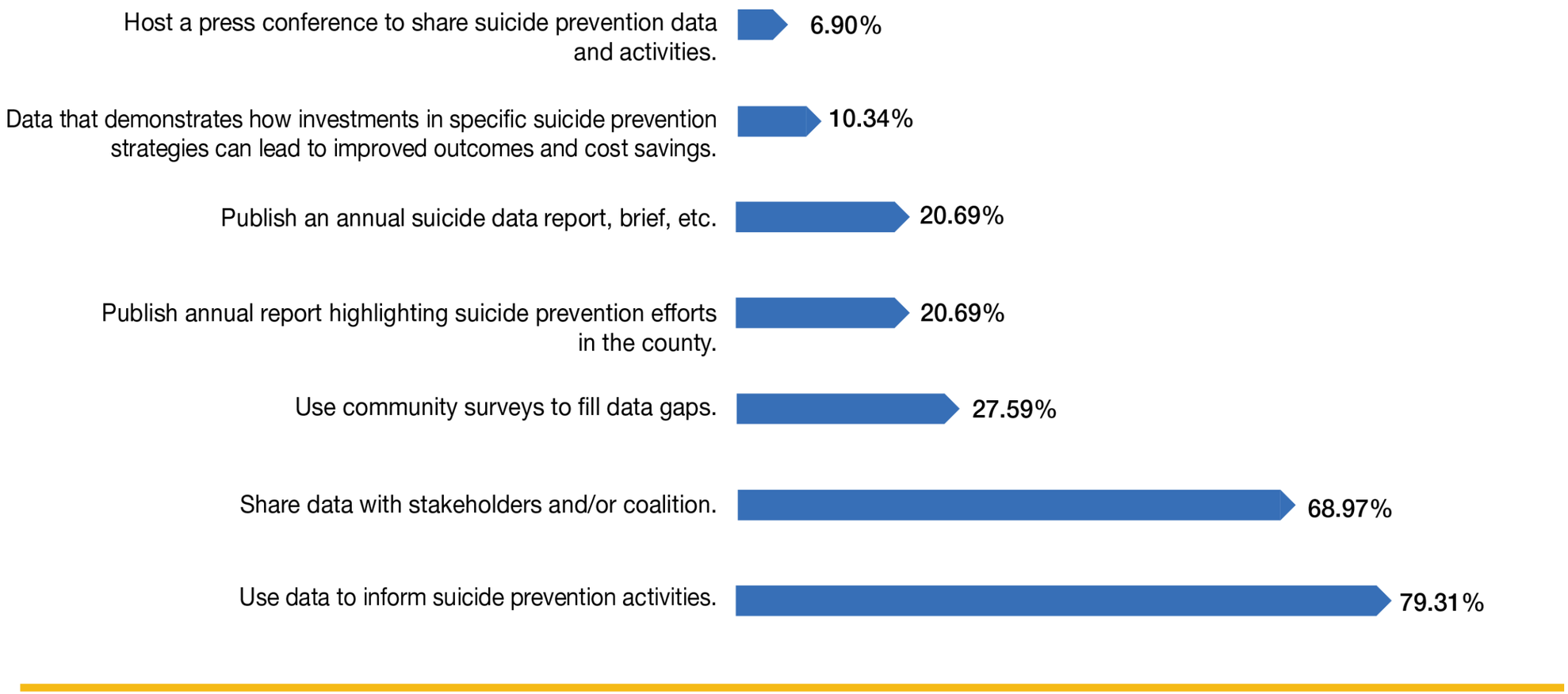
Password: Rainbow13

County Spotlight:

Riverside County

Sharing and Using Data

Striving for Zero Learning Collaborative - Sharing of Data Snapshot April 2021 (n 29)



Tips for Effective Messaging on Suicide Prevention

- ✓ 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

Data Sharing Tips

Words to Consider...

RECOMMENDED terminology

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

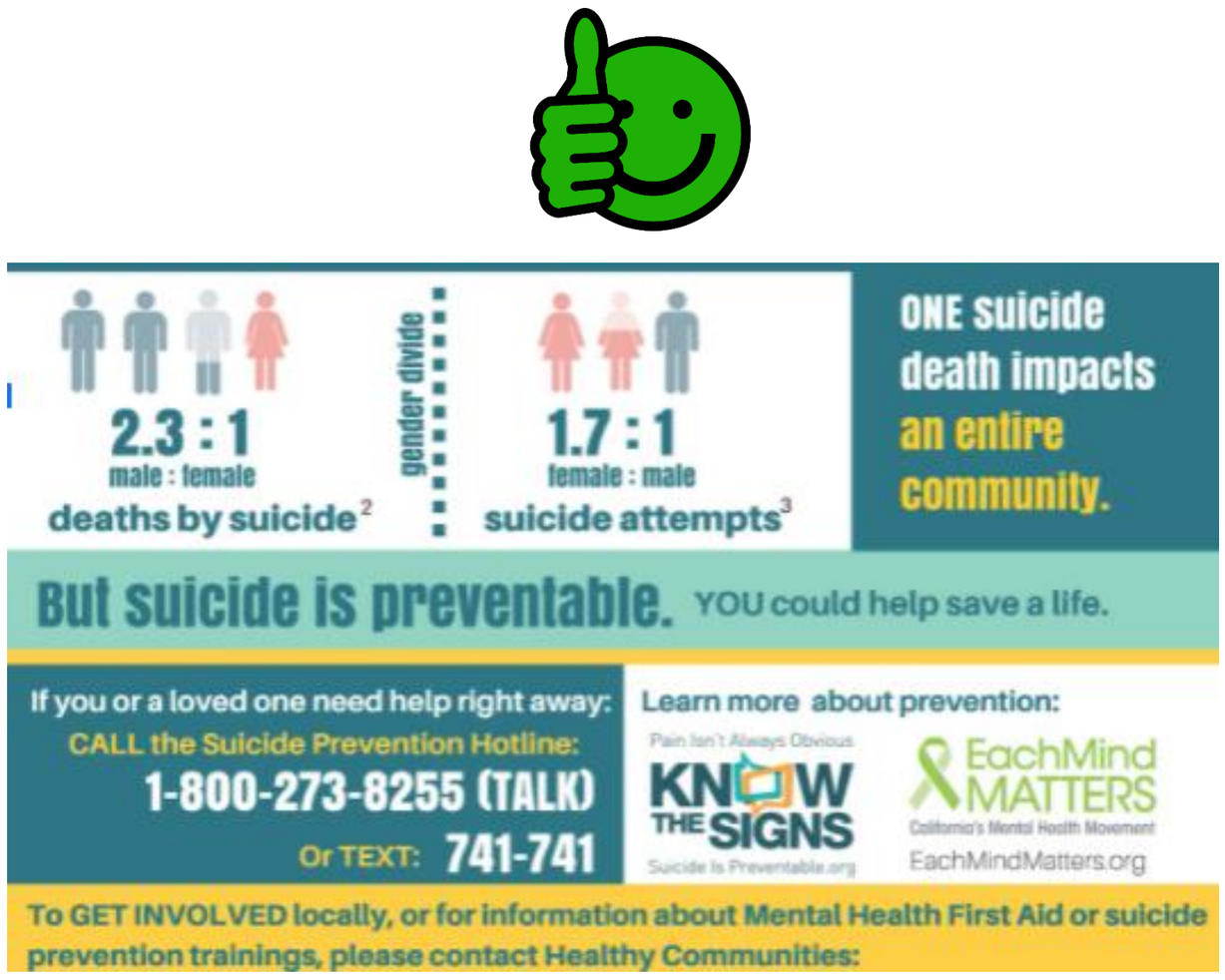
NOT RECOMMENDED terminology

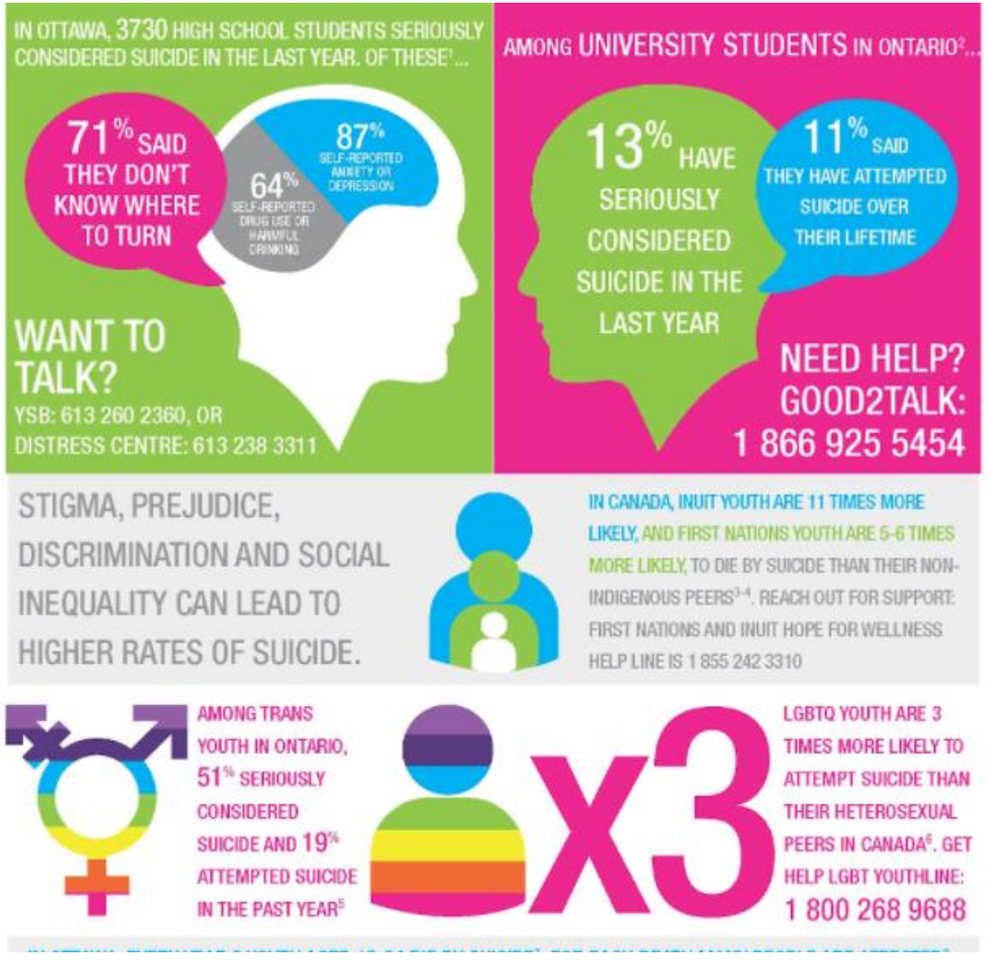
Committed suicide
Note: Use of the word "commit" implies a negative act such as a crime or sin.

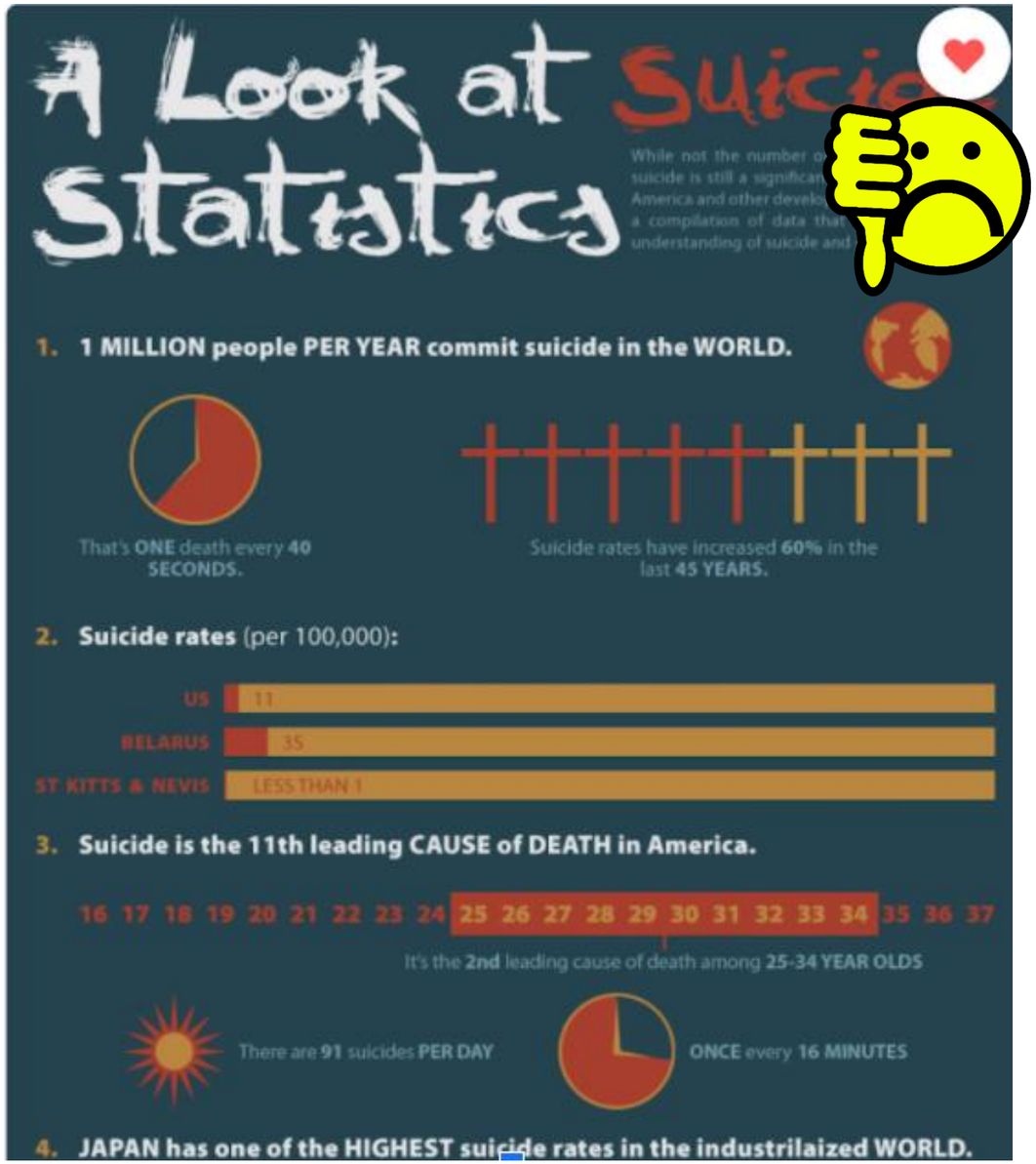
Completed suicide
Note: This associates suicide with success.

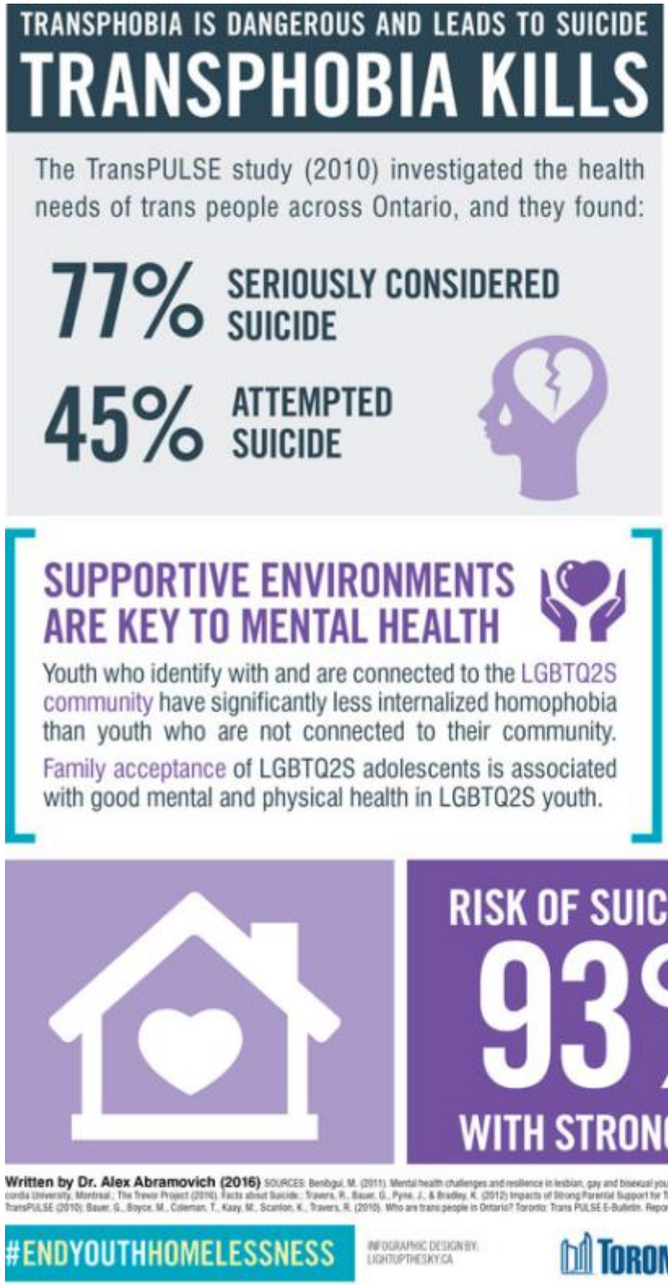
Successful attempt or unsuccessful/failed attempt
Note: There is no success, or lack of success, when dealing with suicide.

- Rates vs. Percentages
- Words matter: Avoid statements such as "more likely to die by suicide" and instead use language such as "are at disproportionate risk for suicide".
- Provide context when possible (e.g. compare with population)
- Consider your audience to assess what data to share (and not to share)
- Use data visuals that are easy for the reader to interpret or preferably has the summary point(s) narrated for them
- Be explicit about the data you are presenting, clearly label all data, note time period and identify if talking about rates, numbers or percentages
- Provide a balanced narrative
- Bookend data with messages of prevention and hope; what people can do to prevent suicide

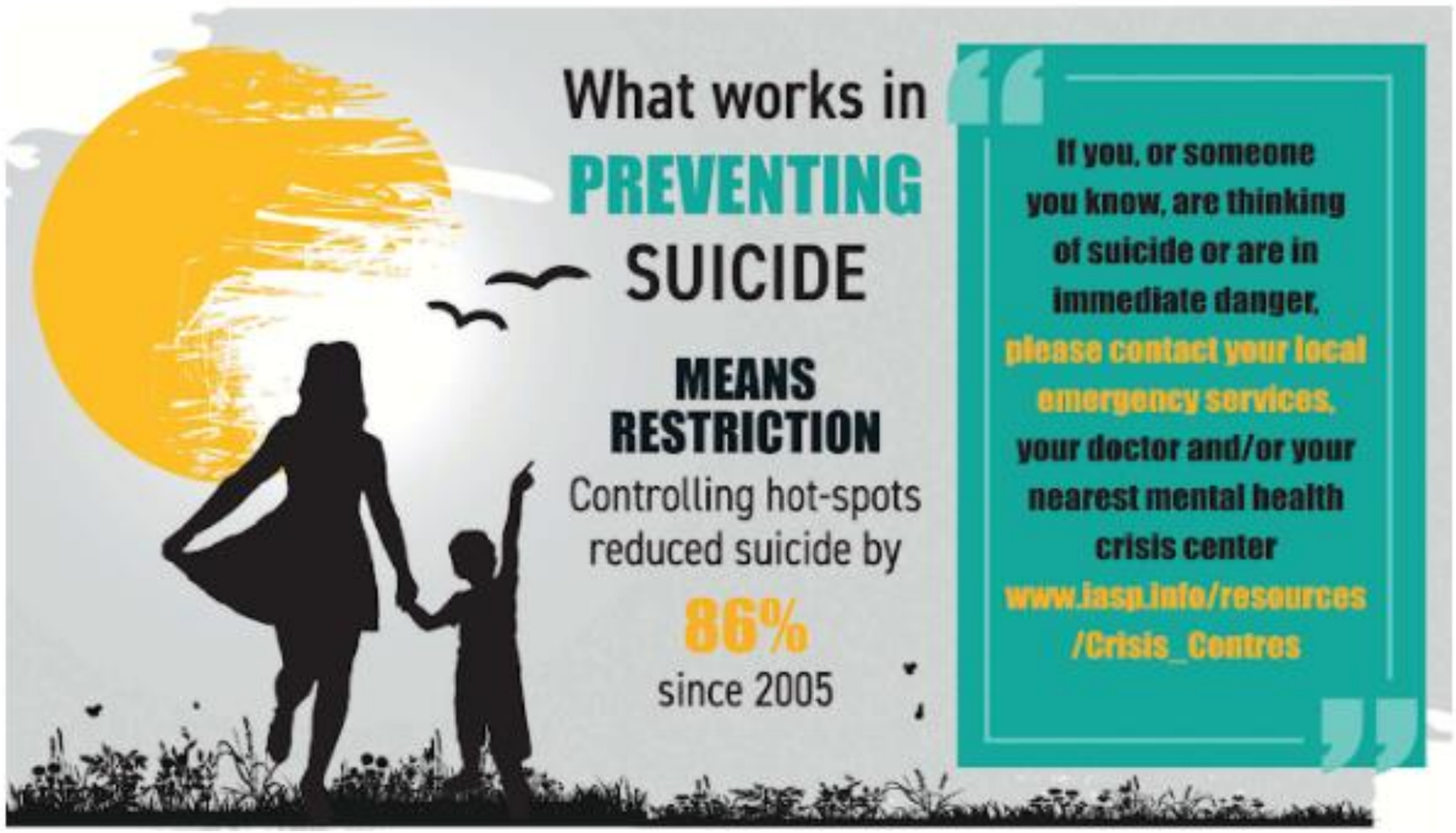

2.3 : 1
male : female
deaths by suicide[2]
gender divide
1.7 : 1
female : male
suicide attempts[3]
ONE suicide death impacts an entire community.
But suicide is preventable. YOU could help save a life.
If you or a loved one need help right away:
CALL the Suicide Prevention Hotline:
1-800-273-8255 (TALK)
Or TEXT: 741-741
Learn more about prevention:
Pain Isn't Always Obvious
KNOW THE SIGNS
Suicide Is Preventable.org
EachMind MATTERS
California's Mental Health Movement
EachMindMatters.org
To GET INVOLVED locally, or for information about Mental Health First Aid or suicide prevention trainings, please contact Healthy Communities:


IN OTTAWA, 3730 HIGH SCHOOL STUDENTS SERIOUSLY CONSIDERED SUICIDE IN THE LAST YEAR. OF THESE[1]...
71% SAID THEY DON'T KNOW WHERE TO TURN
64% SELF-REPORTED DRUG USE OR HARMFUL DRINKING
87% SELF-REPORTED ANXIETY OR DEPRESSION
WANT TO TALK?
YSB: 613 260 2360, OR
DISTRESS CENTRE: 613 238 3311
AMONG UNIVERSITY STUDENTS IN ONTARIO[2]...
13% HAVE SERIOUSLY CONSIDERED SUICIDE IN THE LAST YEAR
11% SAID THEY HAVE ATTEMPTED SUICIDE OVER THEIR LIFETIME
NEED HELP? GOOD2TALK: 1 866 925 5454
STIGMA, PREJUDICE, DISCRIMINATION AND SOCIAL INEQUALITY CAN LEAD TO HIGHER RATES OF SUICIDE.
IN CANADA, INUIT YOUTH ARE 11 TIMES MORE LIKELY, AND FIRST NATIONS YOUTH ARE 5-6 TIMES MORE LIKELY, TO DIE BY SUICIDE THAN THEIR NON-INDIGENOUS PEERS[3-4]. REACH OUT FOR SUPPORT: FIRST NATIONS AND INUIT HOPE FOR WELLNESS HELP LINE IS 1 855 242 3310
AMONG TRANS YOUTH IN ONTARIO, 51% SERIOUSLY CONSIDERED SUICIDE AND 19% ATTEMPTED SUICIDE IN THE PAST YEAR[5]
x3
LGBTQ YOUTH ARE 3 TIMES MORE LIKELY TO ATTEMPT SUICIDE THAN THEIR HETEROSEXUAL PEERS IN CANADA[6]. GET HELP LGBT YOUTHLINE: 1 800 268 9688


A Look at Statistics
Suicide
While not the number
suicide is still a significan
America and other develo
a compilation of data that
understanding of suicide and
1. 1 MILLION people PER YEAR commit suicide in the WORLD.
That's ONE death every 40 SECONDS.
Suicide rates have increased 60% in the last 45 YEARS.
2. Suicide rates (per 100,000):
US
11
BELARUS
35
ST KITTS & NEVIS
LESS THAN 1
3. Suicide is the 11th leading CAUSE of DEATH in America.
16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
It's the 2nd leading cause of death among 25-34 YEAR OLDS
There are 91 suicides PER DAY
ONCE every 16 MINUTES
4. JAPAN has one of the HIGHEST suicide rates in the industrilaized WORLD.

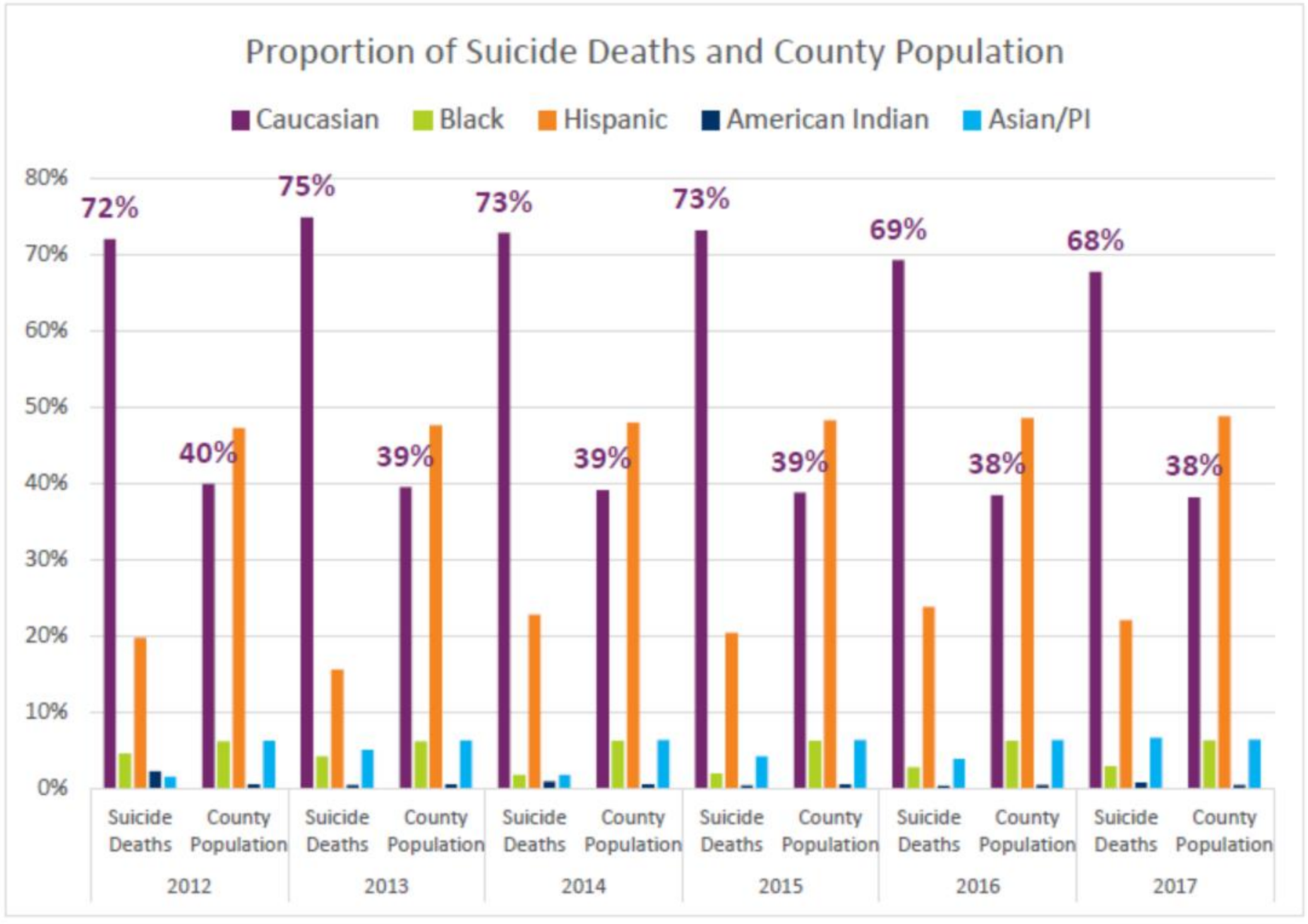

TRANSPHOBIA IS DANGEROUS AND LEADS TO SUICIDE
TRANSPHOBIA KILLS
The TransPULSE study (2010) investigated the health needs of trans people across Ontario, and they found:
77% SERIOUSLY CONSIDERED SUICIDE
45% ATTEMPTED SUICIDE
SUPPORTIVE ENVIRONMENTS ARE KEY TO MENTAL HEALTH
Youth who identify with and are connected to the LGBTQ2S community have significantly less internalized homophobia than youth who are not connected to their community.
Family acceptance of LGBTQ2S adolescents is associated with good mental and physical health in LGBTQ2S youth.
LGBTQ2S YOUTH = 14X THE RISK OF SUICIDE THAN STRAIGHT CISGENDER YOUTH
WHY ARE LGBTQ2S PEOPLE AT HIGHER RISK?
STIGMA
DISCRIMINATION
REJECTION
VIOLENCE
TRAUMA
PREJUDICE
RISK OF SUICIDE DECREASES BY 93% WITH STRONG FAMILY SUPPORT
Written by Dr. Alex Abramovich (2016) SOURCES: Benbgui, M. (2011). Mental health challenges and resilience in lesbian, gay and bisexual young adults: Biological and psychological internalization of minority stress and victimization. Concordia University, Montreal.; The Trevor Project (2016). Facts about Suicide.; Travers, R., Bauer, G., Pyne, J., & Bradley, K. (2012) Impacts of Strong Parental Support for Trans Youth. A report prepared for Children's Aid Society of Toronto and Delisle Youth Services.; TransPULSE (2010). Bauer, G., Boyce, M., Coleman, T., Kaay, M., Scanlon, K., Travers, R. (2010). Who are trans people in Ontario? Toronto: Trans PULSE E-Bulletin. Report No: 1(1).
#ENDYOUTHHOMELESSNESS
INFOGRAPHIC DESIGN BY: LIGHTUPTHESKY.CA
TORONTO
TD
A WAY HOME
519
SPACE FOR CHANGE

It is the leading cause of DEATH in people under 30.
Jumping in front of TRAINS has become such a popular method of SUICIDE in Japan, train companies charge the FAMILIES for DAMAGES.


What works in
PREVENTING
SUICIDE
MEANS
RESTRICTION
Controlling hot-spots reduced suicide by
86%
since 2005
If you, or someone you know, are thinking of suicide or are in immediate danger, please contact your local emergency services, your doctor and/or your nearest mental health crisis center
www.iasp.info/resources/Crisis_Centres

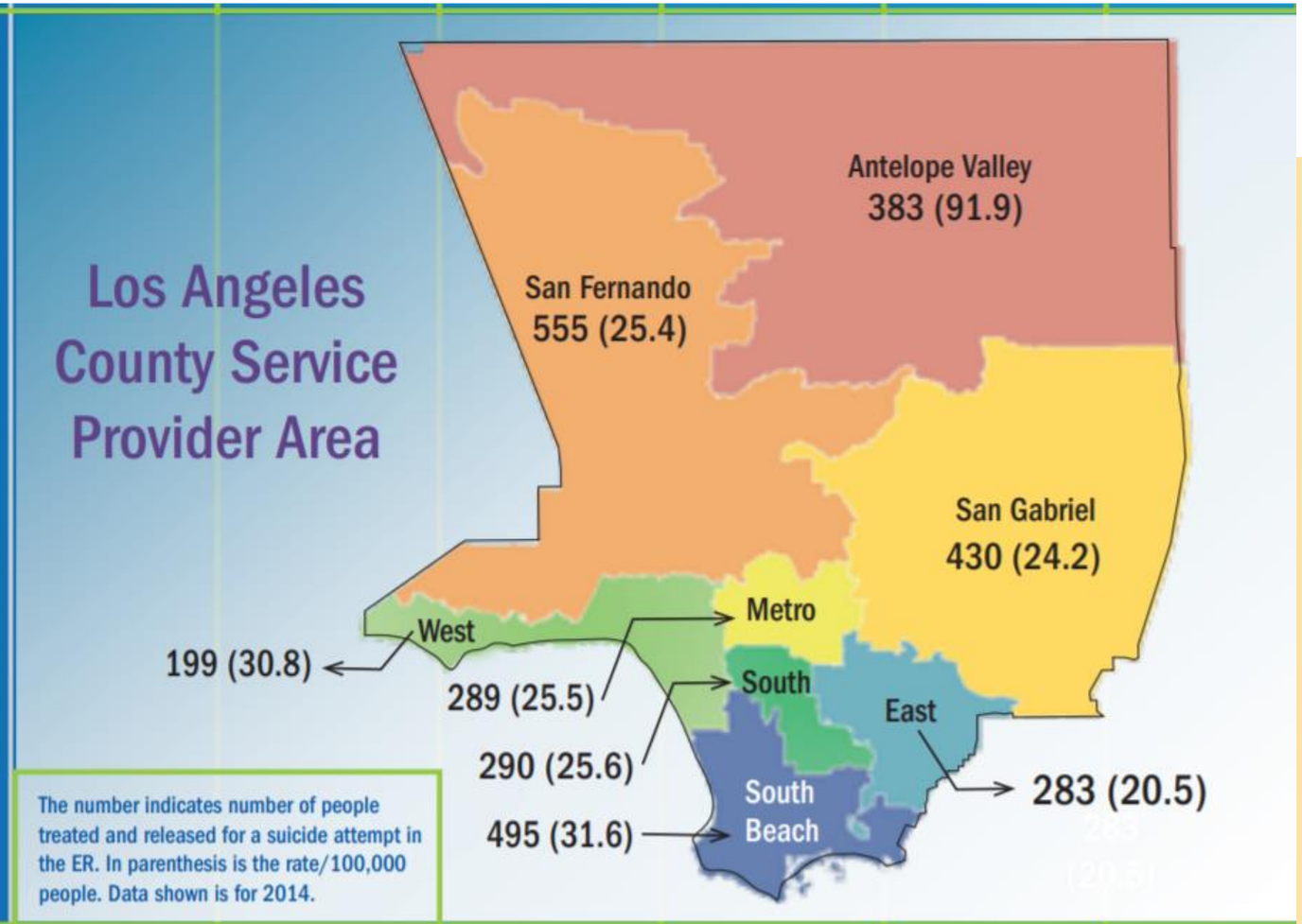
Offer Context

Figure 7. Source: CDPH Vital Statistics Death Statistical Master Files



Geographic Information

In 2014, the latest year for which suicide attempt data is available, 2,924 Angelenos were treated in the ER for a suicide attempt. Of these, 1,642 (32.7/100,000) were female. The rate was highest for African Americans (47.9/100,000), followed by white (39.6/100,000). Youth were at highest risk for being seen for a suicide attempt: 1,482 were under the age of 25, with the highest rate (90.4/100,000) for young people aged 15 to 19.

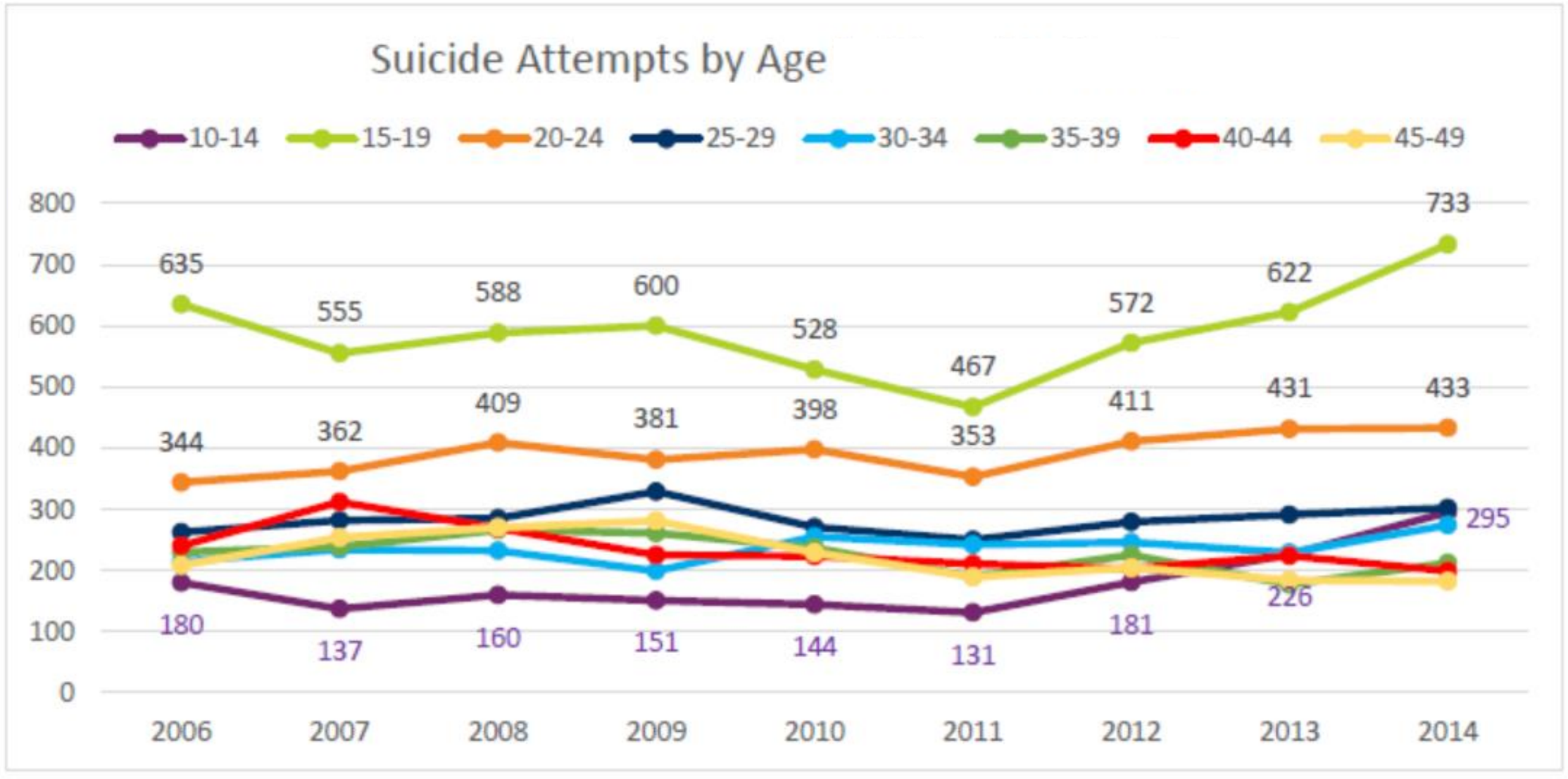


The number indicates number of people treated and released for a suicide attempt in the ER. In parenthesis is the rate/100,000 people. Data shown is for 2014.

Admitted to Hospital for Suicide Attempt[3]						
Number	4,192	4,114	4,051			
Rate per 100,000 population	41.0	40.0	39.4			

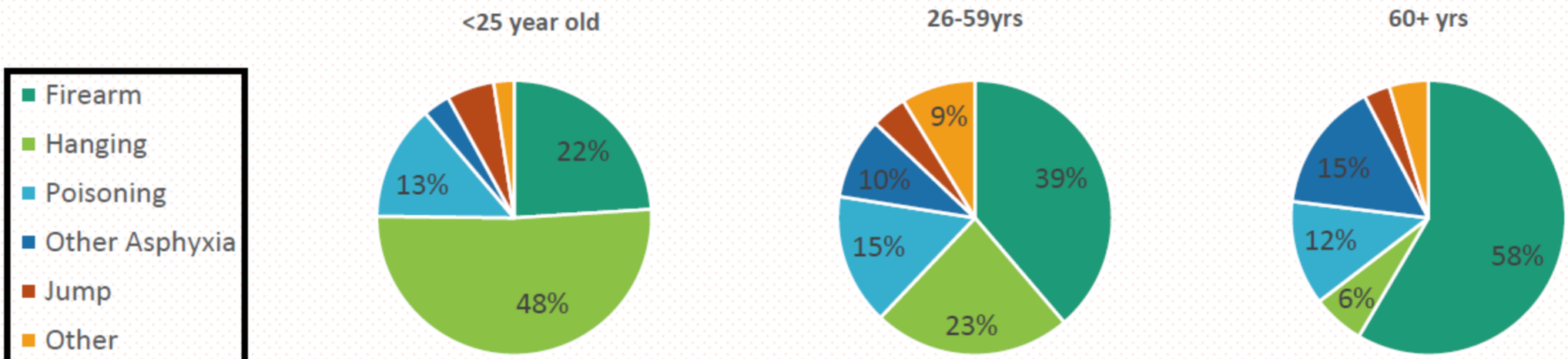
Telling a story visually-what do you take away from this?

Figure 13. Source: California Office of Statewide Health Planning and Development, Emergency Department Data



Considering Your Audience

Means of death by Age-group (2009-2019)



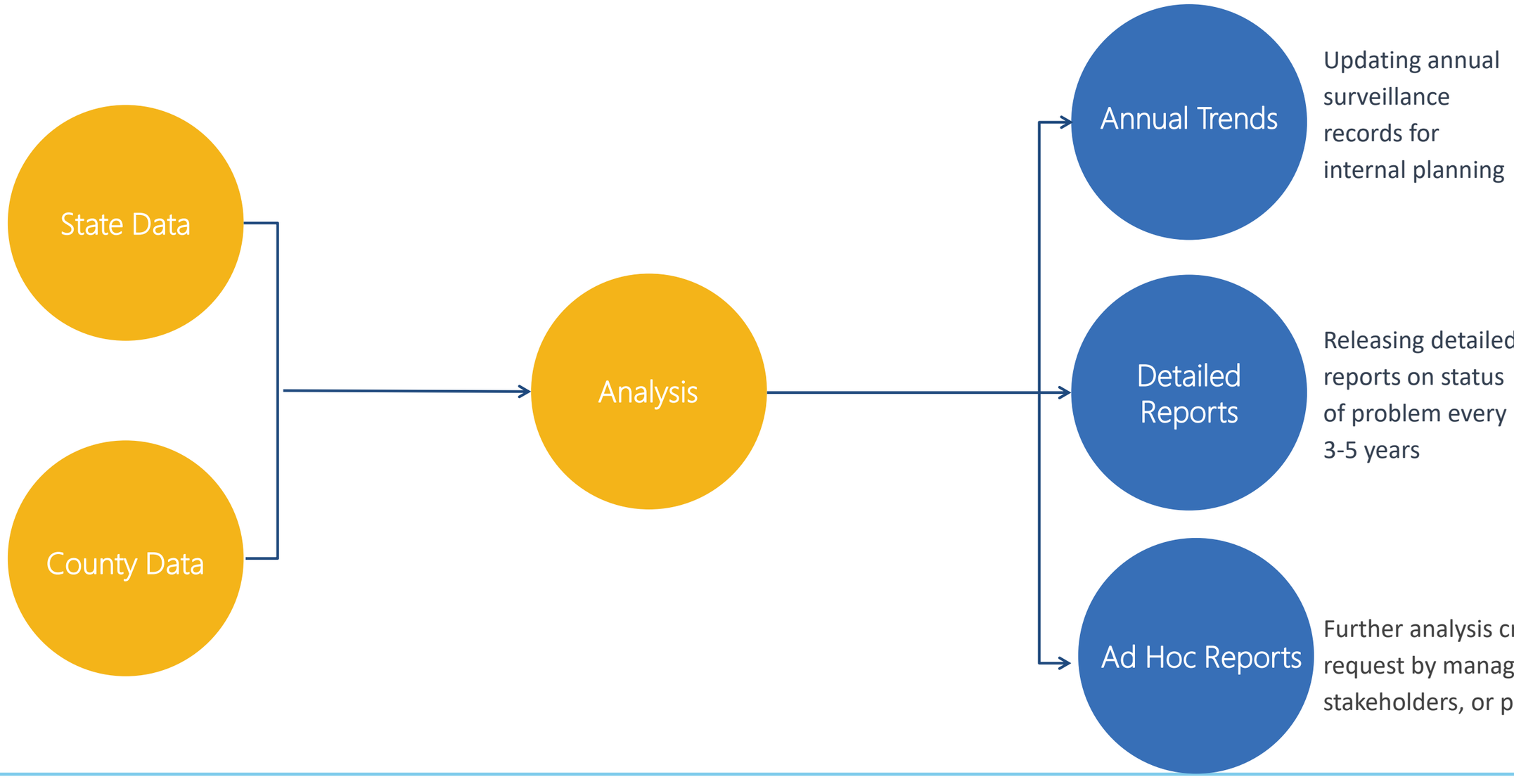
Children and Young adult (<25 yrs):
Hanging is the most common means of death followed by Firearm usage and Poisoning

Adults (26-59 yrs):
Firearm usage is the most common means of death followed by Hanging/asphyxia

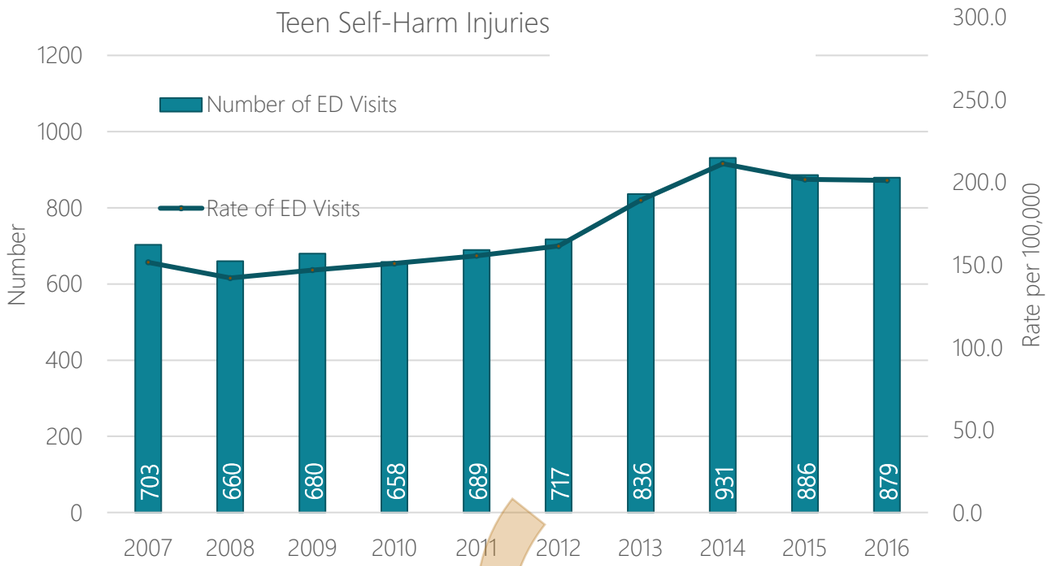
Older Adults (<60 +yrs):
Firearm usage is the most common means of death followed by other forms of Asphyxia/Hanging

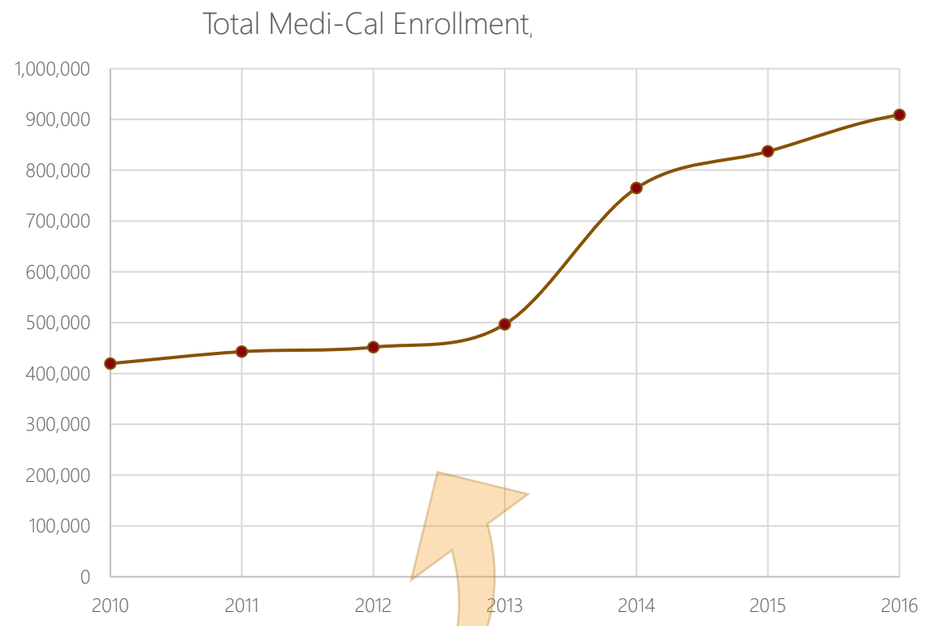
Defined as continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice, surveillance can:

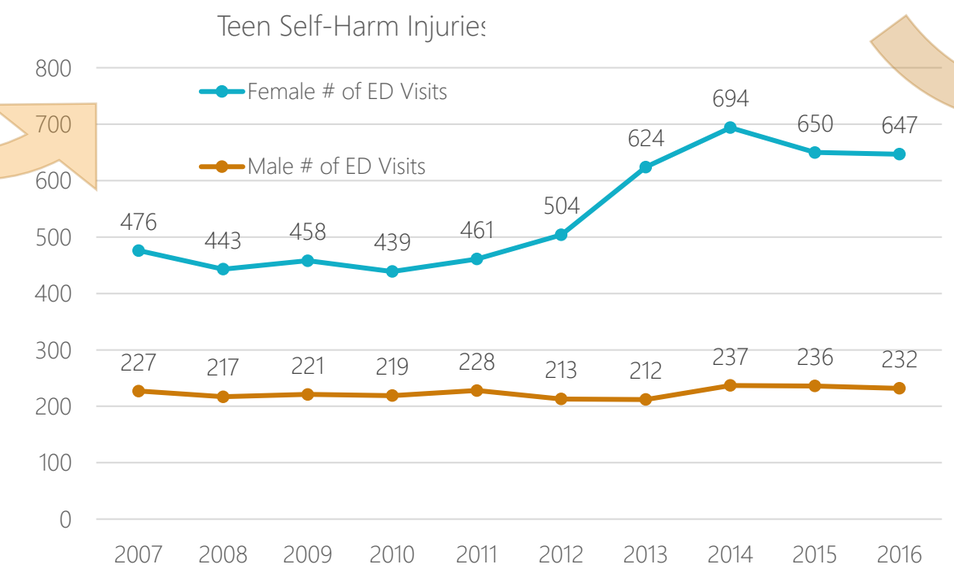
- Serve as an **early warning system** for impending public health emergencies;
- **Document the impact** of an intervention, or **track progress** towards specified goals
- **Monitor and clarify** the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies.



Example



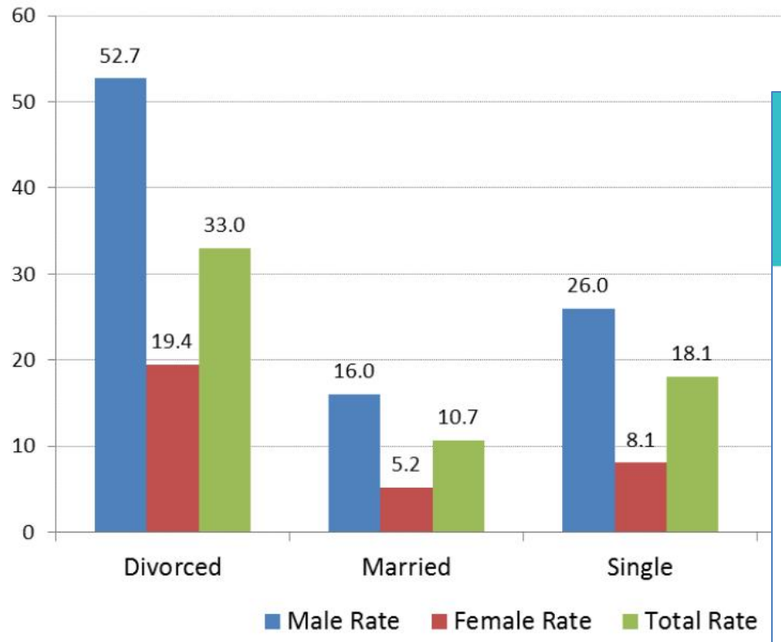




When you identify interesting trends, you can investigate further, identifying key demographics or other covariates of interest

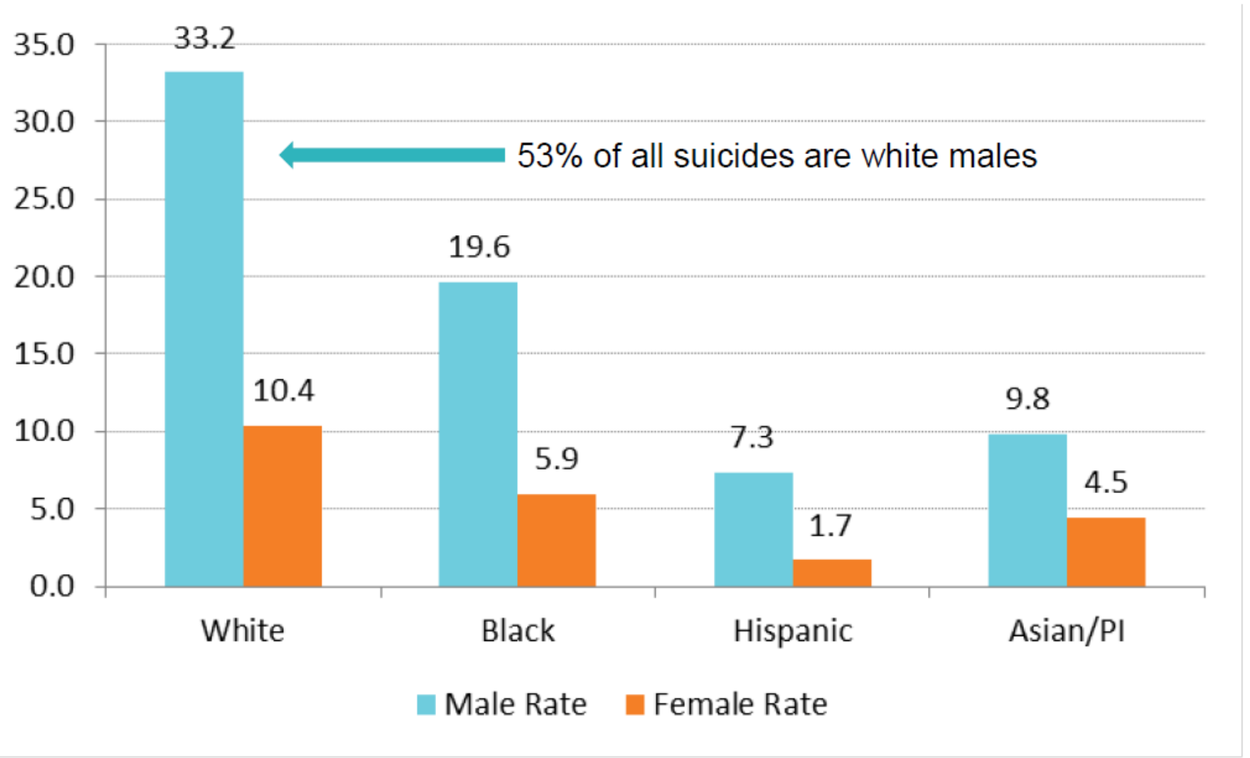
Sharing findings helps to generate ideas about what other factors may be involved behind trends

SUICIDE RATES BY MARITAL STATUS, 2016



Sources: County of San Diego, Health and Human Services Agency, Emergency Medical Services, Medical Examiner Database, 2000 – 2016. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2016. CDC WONDER On-line Database. U.S. Census Bureau, 2007-2016 American Community Survey.

SUICIDE RATES BY RACE AND GENDER, 2016



Sources: County of San Diego, Health and Human Services Agency, Emergency Medical Services, Medical Examiner Database, 2000 – 2016. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2016. CDC WONDER On-line Database. U.S. Census Bureau, 2007-2016 American Community Survey.

Rates per 100,000 people

What’s Next?

Module 2:

Describing the Problem of Suicide

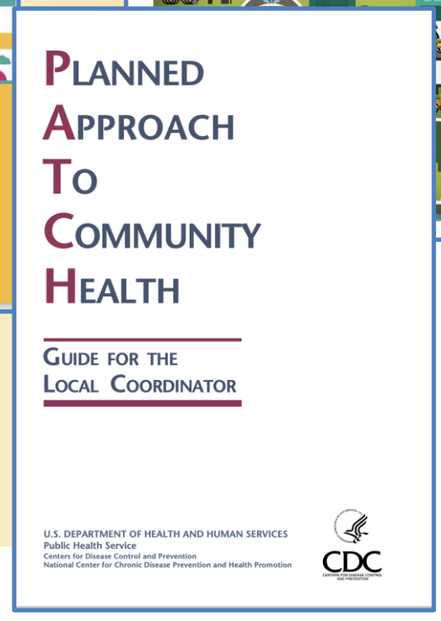
Part II: Suicide Ideation, Help-Seeking, Risk and Protective Factors, Resource Mapping)

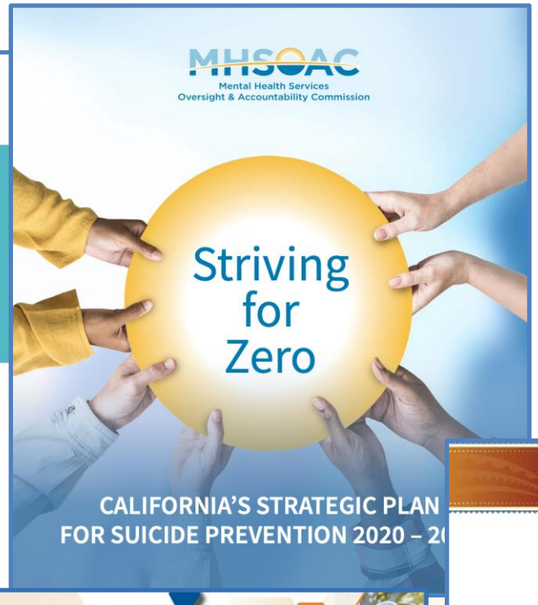
Online Module: July 21, 2021
10 a.m. to 12 p. m.

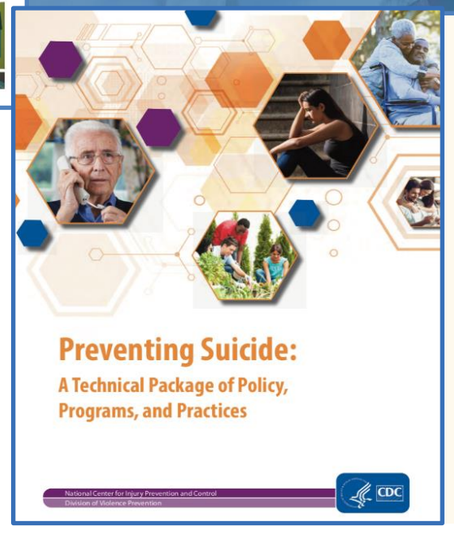
Learning Objectives:
By the end of this module, participants will be able to:

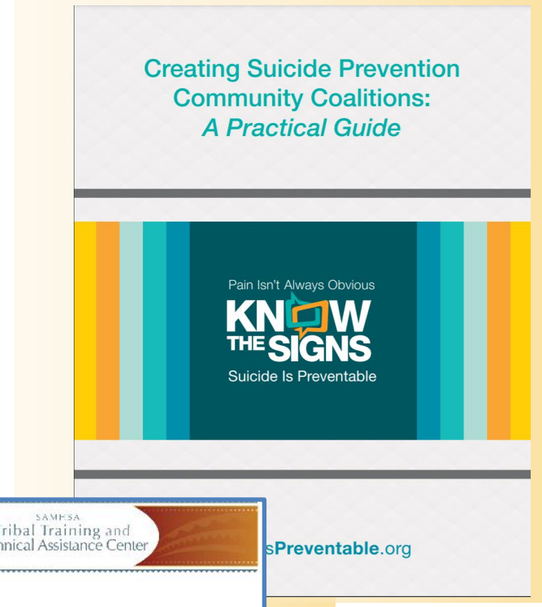
- List and understand the different methods of gathering suicide ideation, help-seeking, risk and protective factor data to define the problem and inform suicide prevention efforts in their county.
- List key questions that guide a resource mapping process
- Explain the purpose of a Suicide Fatality Review Team

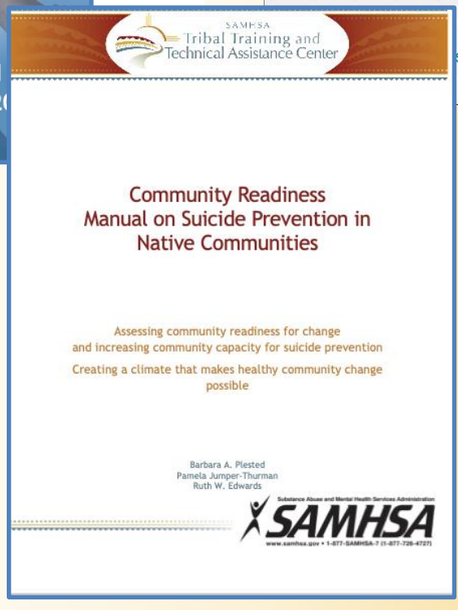
Guiding Resources











Thank you for your time

For more information please contact: jana@yoursocialmarketer.com

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1**-888-682-9454

Programs that have taken the public health approach to suicide prevention have demonstrated outcomes of reductions in suicidal behaviors, as well as other negative outcomes.