California Strategic Plan on Suicide Prevention

Recommendations of the
Suicide Prevention Plan Advisory Committee to the
California Department of Mental Health

Draft for Stakeholder Input
September 2007

Contents

Part 1: A Societal Crisis

Purpose and Use of the Document

[Placeholder: This section will describe the intent and scope of the plan including a statement about the big picture goals or aims for suicide prevention in California. Additionally, this section will describe two important issues, assisted suicide and involuntary services, that fall outside the scope of this plan. These issues are and will be addressed as outlined below.

Within the context of this plan on suicide prevention it is important to acknowledge the dialogue that is occurring in various forums throughout the state and nation about assisted suicide for individuals who are terminally ill. Discussion about compassionate approaches for end of life care for individuals suffering from terminal illness is valuable. While the decisions in any direction that result from this dialogue will be momentous, policy recommendations about assisted suicide are outside the scope of this plan.

Also outside the scope of this plan are policy recommendations that aim to resolve issues related to involuntary services.]

The Problem and Challenge

[Placeholder: This section of the plan will summarize the most salient issues impacting the incidence of suicide including a description of risk factors, protective factors, and suicide indicators. This section will also outline key challenges to overcome for effective suicide prevention.]

Data and Statistics

[Placeholder: This section of the plan will provide a broad overview of data and statistics sufficient to describe the magnitude of the problem. A brief survey of data describing the incidence of suicide and self-inflicted injuries or suicide attempts among the general population and specific sub-populations (such as age group, historically underserved groups, and known high incidence populations) in California will be included. This section will also include data on means of suicide and self inflicted injuries, and a comparison of California's suicide rates to national suicide rates.]

Impact on individuals and communities.

[Placeholder: The intent of this section is to put a human face on those who have lost their lives and loved ones to suicide. It will describe the economic impact of suicide and suicide attempts on individuals and communities. This section will outline the individual and social impact of suicide and suicide attempts. The impact on individuals includes the impact on the individual who took their life, and family members, friends, and caregivers of the person who took their life.]

Culturally Competent Plan and Services

[Placeholder: The intent of this section is to outline considerations and principles of cultural competency for this plan and to provide working definitions of terms related to culture, race, ethnicity, other social groups, and historically underserved populations that will be used in this document.
Cultural competence, defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables work in cross-cultural situations" (National Standards for Culturally and Linguistically Appropriate Services in Health Care), is a core principle for statewide suicide prevention planning, education, service delivery, and research. It is a critical element for promoting awareness of suicide as a societal crisis, increasing hope for recovery and support, and improving access, assessment, intervention, and supportive services for all Californians.

This emphasis is consistent with statewide efforts to increase the quality of services for California's diverse racial, ethnic, spiritual/faith, social groups and underserved populations. It is also consistent with statewide and national efforts to reduce disparities in health care for historically underserved populations.

For the purpose of this document, culture is defined as "the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group" (National Strategy for Suicide Prevention, 2001; California Endowment, www.calendow.org; U.S. Department of Health and Human Services, Office of Minority Health).

Define race and ethnicity and describe some key issues of concern for access to and quality of care.

Describe key considerations and issues related to the following social groups and historically underserved populations:

- age or gender groups;
- individuals living with disabilities;
- Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)
- individuals with literacy issues;
- individuals living in rural populations; and
- homeless individuals. End placeholder.]

Working Definition and Scope of Suicide Prevention

[Placeholder: Suicide prevention encompasses a range of prevention, intervention and postvention strategies or approaches that are intended to reduce the incidence of suicide and suicidal behaviors. Suicide prevention includes efforts to foster resiliency, enhance protective factors for individuals and within the community, decrease risk factors, provide follow up care for suicide attempt survivors, and reduce the impact of suicidal behaviors on family, friends, and communities. Suicide prevention also includes research efforts toward further understanding racial, ethnic, cultural, social and biological factors that may contribute to the outcome of suicide and help seeking behaviors. Finally, suicide prevention encompasses efforts to evaluate and improve programs and interventions designed to reduce the incidence of suicidal behavior (National Strategy for Suicide Prevention, 2001; California Suicide Prevention Advocacy Network Plan, 2003; Maris et. Al., 2000; www.medicinenet.com; www.calendow.org)].

Part 2: Every Californian is Part of the Solution

Strategic Directions and Recommended Actions

This section outlines the priority focus areas and actions for suicide prevention in California. These priorities and actions are not intended to be an exhaustive list; assuredly there are many other actions that might be effective suicide prevention strategies or approaches. However, this plan reflects the priorities that emerged as the most urgent areas and actions for investment of resources to reduce suicide and its tragic consequences on individuals, families, and communities in California.

The priorities and actions in this plan are organized by three levels of focus for suicide prevention. *Strategic directions* describe the broadest level areas of focus and serve as the central aim to be addressed by more specific actions. In several cases, a description of core concerns and factors for the strategic directions is provided to expand upon the intention of the strategic direction(s).

Each strategic direction identifies several *recommended actions*. The recommended actions are priority activities that relate directly to fulfilling the imperative set forth by the strategic direction. Some of the recommended actions have sub-points that are intended to outline essential elements of the activity and provide further guidance for implementation of the action.

To ensure that cultural competency extends into every aspect of suicide prevention throughout California, recommendations that address and are sensitive to culture, race, ethnicity, language, gender, sexual orientation, and age factors or considerations were integrated into the recommended actions for each strategic direction.

Methods, tools, and resources are also suggested for many of the recommended actions. These methods are also not intended to be exhaustive but serve as examples of specific methods for achieving the recommended actions.

Strategic Direction 1: Raise awareness that suicide is preventable and create a supportive environment for suicide prevention.

Recommended Action 1.1: Launch ongoing public education campaigns on suicide indicators, risk and protective factors and how to get help.

1.1.1 Design campaigns informed by and for specific communities (target populations based on age, racial/ethnic, cultural, gender or other factors).
1.1.2 Inspire hope by publicizing that suicide is often preventable.
1.1.3 Address depression, discrimination, injury violence, abuse and trauma and their influencing factors.
1.1.4 Coordinate with existing efforts and use viable programs and providers that are already effectively serving the target populations.
1.1.5 Adapt campaigns and programs to match the needs of local communities.
1.1.6 Forge and evaluate promising new and creative approaches.

[Placeholder for information to be included in the rationale: Provide a brief definition of suicide indicators and risk and protective factors. Describe that the examples listed in reference to "specific communities" are not intended to be exhaustive and that local communities will determine needs. Also include available data, research, and outcomes of successful programs to support this action and inspire hope for making an impact on suicide prevention. Discuss the importance of using communication formats and methods appropriate to the target population.]

Example Methods, Tools, Resources

a. Deliver the message through state-of-the-art multi-media social marketing campaigns.
b. Collaborate with a leader in the film industry to create a suicide prevention film aimed at educating young people.
c. Promote National Suicide Prevention and Awareness Week.
d. Extend National Depression Screening Day statewide offering universal access to voluntary screening through providers in substance abuse treatment, mental health, and primary healthcare.
e. Employ ethnic media.
f. Utilize public relations approaches including speakers' bureaus and focused community forums.

Recommended Action 1.2: Collaborate with public and community based organizations to launch and sustain a multi-faceted campaign to reduce stigma and discrimination related to suicide prevention programs and services.

1.2.1 Design ethnic, racial, and culture specific campaigns informed by and for target communities.
1.2.2 Engage leaders and staff of key systems such as schools, colleges, universities, law enforcement, primary health care, and employers to assess and improve their organization's and system's policies and practices that influence stigma.
1.2.3 Promote the importance and role of natural support systems, consumer/peer-run services, and culturally specific ways of healing.

[Placeholder for information to be included in the rationale: Provide a brief description of issues related to stigma and discrimination and the impact on individuals. Describe the reason for focusing on the essential elements outlined in this recommended action based on support in the literature. Include some examples of natural support systems and what is meant by acknowledging the importance of these systems. Explain the role of peer run services-address how these systems and approaches support stigma reduction.]

Example Methods, Tools, or Resources

a. Align with other state initiatives such as those sponsored by MHSA, NAMI, SPAN and California Department of Education.
b. Develop and use consumer empowerment and personal contact strategies, and peer to peer models.

Recommended Action 1.3: Educate and engage the news media and entertainment industry, including ethnic media, to promote balanced and informed portrayals of suicide, mental illness, and mental health care that support suicide prevention efforts.

1.3.1 Use and expand on existing guidelines to facilitate education efforts.
1.3.2 Adapt guidelines and educational approaches to the specific community and locale.
1.3.3 Create opportunities to promote greater understanding of the risks and protective factors, signs of risk, and how to get help.

[Placeholder for information to include in the rationale: Describe research, literature, and progress nationally and statewide on this action; include grassroots efforts and successes in this area.]

Example Methods, Tools, or Resources

a. Identify corporate sponsors for suicide prevention.
b. Provide opinion editorials (Op Eds) to newspapers.
c. Provide consultation to news media.

d. Collaborate with the National Suicide Prevention Lifeline to identify entertainment and sport celebrities or other influential spokespersons to champion suicide prevention.

Recommended Action 1.4: Identify and engage public and private partners to reduce access to lethal means.

[Placeholder: Address firearms, over the counter and prescription medications, and selected high structures.]

Strategic Direction 2: Increase leadership, collaboration and coordination among public agencies, private organizations and communities to improve services and build coalitions to prevent suicide.

[Placeholder for information to be included in the introduction to this section: emphasize coordination and collaboration to improve accessibility and promote comprehensive services; emphasize efficiency such as using/capitalizing on existing networks (e.g., for training and sharing resources to expand capacity and increase state and local interagency communication). Also, emphasize the need for public-private partnerships and list examples of who should be engaged for the planning and delivery of suicide prevention services such as private industry, HMOs, community-based organizations, local education agencies, small businesses and chambers of commerce.]

Recommended Action 2.1: Establish a State Suicide Prevention Office/Resource Center.

2.1.1 Engage state agencies including Department of Public Health, Department of Alcohol and Drug Programs, Department of Social Services, Department of Education, Department of Aging, California National Guard and Department of Corrections and Rehabilitation, to dedicate staff and resources for this center and collectively address suicide prevention.
2.1.2 Centralize coordination of key suicide prevention, intervention, postvention and research activities throughout the state.
2.1.3 Integrate and disseminate information to support community planning.
2.1.4 Develop and disseminate models and resources for suicide prevention activities such as culturally appropriate education and training programs, help lines and peer support programs.
2.1.5 Coordinate a periodic review and update of this plan by a committee of individuals with expertise and direct experience with suicide and suicide prevention.

[Placeholder for information to be included in the rationale: Describe the effectiveness of this approach for coordinating suicide prevention efforts based on literature and outcomes of other states with similar resource centers. Also briefly describe recent efforts to institute a coordination center in California including grassroots influence and

accomplishments. Describe the resources that might be provided through this coordination and resource center to improve suicide prevention efforts throughout the state. Include a description of potential roles for this center such as:

a. Develop State model curricula for different levels of training using evidence-based practices, promising practices and community-based evidence.
b. Track trends and suicide rate reduction over time.
c. Support learning communities with various consortia (e.g. college counseling centers, mobile crisis response, help lines, senior centers)
d. Furnish links to other resource centers such as California Department of Education's Healthy Kids Resource Center, Department of Social Services' Office of Child Abuse Prevention, Alcohol and Drug Programs, Aging, Veterans Affairs, and resource centers for persons with disabilities.
e. Operate as a liaison to the National Suicide Prevention Resource Center and expand its data collection and activities to meet California specific needs.
f. Seek federal funds to implement and conduct research on innovative programs for California's diverse populations and cultures.
g. Provide leadership conferences to disseminate information and strengthen suicide prevention efforts.]

Recommended Action 2.2: In each county, appoint a responsible agency to convene an interagency council including public agencies and private corporations and organizations to identify and collectively address suicide prevention priorities and to liaison with the Statewide Suicide Prevention Office and Resource Center.

2.2.1 Develop local suicide prevention planning forums that include representatives from the Mental Health Department, Public Health Department, Native American Health Services, Alcohol and Drug Programs, Department of Social Services, Department of Education, Local Education Agencies, Department of Aging, Local Area Agency on Aging, Law Enforcement agencies, Department of Rehabilitation Regional Centers, local suicide prevention programs, individuals, family members and caregivers who are survivors of suicide loss, individuals who have attempted suicide, grassroots and community based organizations in target communities, community leaders and organizations representing diverse cultures and age groups and businesses, corporations and employers from key sectors.
2.2.2 Engage high risk communities in developing a needs/resources assessment, such as individuals who are homeless, veterans, have disabilities, represent a historically underserved ethnic group, are GLBTQ, are unemployed, live in rural areas or are otherwise isolated.
2.2.3 Coordinate state, federal and locally-funded programs and services in the county or region.
2.2.4 Establish clear protocols for communication, data sharing, linkages, care management, accessing services, and follow through when at risk or suicidal clients transfer to or utilize services from various public and private providers.

2.2.5 Identify any community sector, cultural group, or target population severely impacted by suicidal risk or with limited access to health, mental health, or other suicide prevention services and focus resources to that sector.
2.2.6 Expand intervention and treatment capacity in crisis services (including peer support, warmlines, and crisis residential services).
2.2.7 Identify service gaps and barriers to routine and urgent intervention and support services (e.g., accessibility of services including physical and language barriers), including how to best engage underserved communities or populations.
2.2.8 Support action planning and implementation within smaller "communities" such as schools, Native American Rancherias and tribal lands, cities, towns, rural areas, jails and prisons.

Example Methods, Tools, Resources

a. Emphasize one-stop multi-lingual, single point of contact for consumers.
b. Place conditions on local discretionary funds or provide incentives to expand suicide prevention efforts.
c. Identify and engage elected officials and other leaders to champion suicide prevention efforts.
d. Examine legislation that supports suicide prevention and identify effective models from other states.
e. Examine insurance limitations for individuals with a history of mental health problems and promote coverage that reduces stigma and discrimination (e.g., address health insurance discrimination based on mental health history and death benefits paid to survivors with a pre-existing clinical diagnosis).

Recommended Action 2.3: Create a statewide consortium of all accredited 24-hour suicide prevention help lines and websites in California to provide the highest quality services.

[Placeholder for information to be included in the introduction to this recommended action: describe key issues to be addressed through this consortium such as developing training to ensure help line staff speak in a way that the caller can understand and the need for translation of protocols for the threshold languages.]

2.3.1 Provide training and technical assistance to achieve consistent and effective practices.
2.3.2 Create standards for web search engines to list accredited 24-hour help lines and supervised websites prominently.
2.3.3 Address gaps in providing help line services with multiple language capacities.
2.3.4 Use standard measures to collect information for a better understand of who is using these services in California.

[Placeholder for information to be included in the rationale: Describe how a consortium might improve help line and web-based services in California. Also describe best

known information about number of calls to help lines in California and current challenges to obtaining consistency in service delivery.]

Recommended Action 2.4: Examine implementation of confidentiality laws and limits to confidentiality to identify and implement needed improvements for safety, health, wellness, and recovery.

2.4.1 Consider special issues or challenges with respect to minors and confidentiality.
2.4.2 Engage representatives that offer multiple perspectives (including but not limited to specific racial/ethnic groups, consumers, family members, caregivers, community service providers and public agencies) to collaboratively identify issues and best solutions.
2.4.3 Focus on solutions that address both safety and privacy in consideration of social stigma related to mental illness, alcohol and drug problems, and use of suicide prevention services.

Strategic Direction 3: Develop and implement service guidelines and provide training for consistent and effective early identification, referral, access, intervention, and follow up care.

Recommended Action 3.1: Develop, disseminate and promote service and training guidelines targeted to key gatekeepers for culturally competent assessment, intervention, and follow up care.

3.1.1 Include individuals, organizations, or communities who have been impacted by attempted and completed suicide such as the person who made the attempt, family members, caregivers, co-workers, classmates, friends, first responders and corrections staff in designing guidelines or procedures for follow up care.
3.1.2 Engage public and private organizations or businesses in the development of guidelines and training of staff.
3.1.3 Develop standards for elementary, secondary and post-secondary education to address suicide prevention in institutional safety plans. Include standards for immediate response and in-service training, using sources such as *Youth Suicide Prevention Guidelines for Schools*, 2005, California Department of Education.
3.1.4 Implement quality care and utilization management guidelines in health insurance plans for approval of services and effective response to suicide risk or suicidal behavior.
3.1.5 Provide training guidelines for:
- licensed health and mental health professionals;
- non-licensed professionals and caregivers;
- law enforcement, legal professionals and correctional staff;
- College and university staff; resident advisors; accommodation specialists/counselors; and student health services staff for college and university students.

Example Methods, Tools, Resources

a. Build upon or adapt existing successful models of multifaceted risk assessment.

Recommended Action 3.2: Require training for selected occupations to increase understanding of protective and risk factors; improve suicide risk assessment and recognition, treatment, management and aftercare interventions; and to reduce stigma and discrimination.

3.2.1 Integrate training on culturally competent programs and interventions in the curricula.
3.2.2 Include the perspective of individuals who have attempted suicide and family members, friends or caregivers of those who have attempted suicide to heighten sensitivity.
3.2.3 Integrate training requirements in existing infrastructures such as credentialing, licensing, and continuing education programs for professionals and care facilities including group homes, day treatment centers, adult day health centers and hospitals.
3.2.4 Require crisis and suicide prevention training for licensed health professionals and a periodic renewal process. Include:
- primary health care providers;
- emergency response personnel;
- licensed mental health and substance abuse professionals and staff;
- law enforcement, juvenile justice, and correctional personnel, including probation and parole officers;
- credentialed staff in middle schools and high schools.

3.2.5 Promote training requirements for college and university faculty, staff, resident advisors, and counselors for students with disabilities.

[Placeholder for information to be included in the rationale: Describe outcomes, lessons, successes and challenges from systems that have already implemented suicide prevention training into job training, credentialing, or licensing.]

Recommended Action 3.3: Educate family members, caregivers and friends of those who have attempted suicide, individuals who have attempted suicide and natural community helpers to recognize, appropriately respond to, and refer people showing signs of suicide risk.

3.3.1 Provide education that is specific to target populations (e.g., age group, ethnicity, gender and culture).
3.3.2 Collaborate with public and private community-based and grassroots organizations to develop and implement peer-based training and suicide prevention programs.

3.3.3 Cultivate family and consumer teaching teams and panels to provide education and convey their experience-based perspective on suicide and suicide prevention.
3.3.4 Extend peer- and community-based education to businesses and natural community helpers in communities who have experienced suicide and suicide attempts.
3.3.5 Develop a self-awareness check, including on-line formats, for the general community and those at risk.

[Placeholder for information to be included in the rationale: Brief description of natural community helpers as coaches, hairstylists, faith leaders, promotoras, community health workers, indigenous healers, etc. Describe rationale for peer based education, progress in this area thus far, successes and challenges. Include a statement about the need for training standards, monitoring and reflective supervision.]

Recommended Action 3.4: Develop directories or roadmaps to local suicide prevention and intervention services that include information about how and where to access services and techniques on how to deal with roadblocks.

3.4.1 Tailor materials to key gatekeepers, individuals who have attempted suicide, family members, and caregivers of those who have attempted or completed suicide.
3.4.2 Address confidentiality issues and how individuals can connect with advocacy representatives.
3.4.3 Include strategies for approaching communication barriers.

[Placeholder for information to be included in the rationale: Committee concerns and other literature-research or experience-based such as from focus groups-in support of this action.]

Strategic Direction 4: Expand suicide prevention programs in communities and front line systems to increase points of access for effective suicide prevention, risk assessment, treatment and aftercare.

[Placeholder for information to be included in this introduction: Implement strategies and programs that emphasize protective factors to build resilience, promote mental health, and reduce stigma and discrimination. Also, in this section, describe that recommendations are for programs to increase capacity for suicide risk assessment, recognition, treatment, management and aftercare interventions in front line systems for selected populations or conditions such as: major risk factors attributed to older adults; Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); those experiencing serious psychiatric illness, particularly those experiencing first onset of psychiatric illness; those with substance use problems, those with immigration/ refugee/acculturation issues; intergenerational trauma; sexual and physical violence;

grief/loss; achievement pressure; isolation; bullying; and other major risk factors considered a priority for California. Additional content for this introduction section will encourage counties and local communities to support, expand and sustain community-based programs that are successful. Finally, emphasize that involvement of community members in the delivery of services and education such as *natural connectors* (e.g., people who are active in their church, schools, or youth peer leaders) and leaders in communities is crucial.]

Recommended Action 4.1: Integrate suicide prevention and early intervention programs into the K-12 and higher education systems and campuses to promote resilience, increase identification of suicide risk, and facilitate timely linkage to appropriate services, including community-based organizations.

4.1.1 Build resilience and skills to problem solve, resolve conflict and handle disputes in a nonviolent way.
4.1.2 Focus on promising youth development approaches for all youth, including transition age youth, foster children/youth, and elementary school age children.
4.1.3 Provide safe and effective voluntary programs for youth that address rites of passage, adolescent distress, academic achievement pressure, substance abuse issues, depression and emotions, crisis intervention, stigma and discrimination; and teach sensitive ways for parents/caregivers and children/youth to talk about mental health issues (i.e., mental health literacy).
4.1.4 Address continuity of care between campuses and treatment providers through effective protocols for information sharing and care management.
4.1.5 Include youth leadership and peer support to educate and support young people, identify risk signs and respond appropriately.
4.1.6 Link to existing school programs such as school-based health centers, bullying and violence prevention programs, and school safety plans.
4.1.7 Increase awareness of campus services including on-line self help and peer support programs.

[Placeholder for information to be included in the rationale: Describe efforts, progress and successes in this area. Also include information from the literature on suicide prevention programs in school systems. Describe challenges for implementation.]

Example Methods, Tools, and Resources

a. Provide support to teachers by increasing school counselors.
b. Ensure every school district has at least one counselor to provide leadership in suicide prevention that will act as a point person.
c. Implement the *Health Framework for California Public Schools, Kindergarten Through Grade Twelve* and Health Education Standards.
d. Adopt established and effective programs for youth outreach.

Recommended Action 4.2: Deliver culturally appropriate integrated suicide prevention, early identification and intervention programs and follow up care services through health care systems.

4.2.1 Include the following systems: mental health, drug and alcohol programs, health, and emergency response systems.
4.2.2 Utilize key *points of contact* professionals such as primary care providers and staff, and mental health professionals to reach out to those at risk for suicide.
4.2.3 Provide outreach and appropriate services for those who are homebound or without transportation, including older adults.
4.2.4 Provide support and services to individuals traumatized by suicide or suicidal behaviors.
4.2.5 Expand and develop community-based ethnically and culturally focused peer support services linked to the health care system, including survivor support groups or systems.
4.2.6 Implement routine voluntary screening as standard protocol in primary care, especially for older adults.
4.2.7 Provide integrated care for patients with co-existing mental health and substance abuse problems.

Example Methods, Tools, and Resources

a. Co-locate mental health programs and services in natural community settings appropriate to age groups and cultural groups such as public health, community clinics and health centers, recreational facilities, schools and school-based health centers, Native American centers, and senior centers to reduce stigma, cultivate use of natural support systems, integrate and facilitate access, services, and follow up.
b. Use volunteers to extend services, for example in emergency response programs.
c. Hire mental health clients/survivors to train first responders of suicide crisis calls on their perspective and to assist with de-escalation in pre-crisis situations.
d. Implement client/survivor-run respite centers to accommodate people who are experiencing emotional distress so they can receive help earlier and circumvent the need for hospitalization.

Recommended Action 4.3: Integrate suicide prevention and early intervention programs into community-based programs for older adults, such as Area Agencies on Aging, Social Services programs or other organizations that provide services to older adults to promote resilience, early identification and linkage to appropriate care services.

4.3.1 Develop programs that address the needs of those living in rural areas, who are homebound or otherwise isolated.

4.3.2 Facilitate cross-coordination among all agencies and organizations that serve seniors.
4.3.3 Establish insurance reimbursement for home care and assisted living.
4.3.4 Develop resources for peer educators and promote social support programs that highlight and harness the contributions of seniors in their communities and society to improve sense of worth and hopefulness.
4.3.5 Educate policy makers and clinicians about the risk of suicide for those over 60.

Example Methods, Tools, and Resources

a. Provide wrap around services for seniors.
b. Develop a train the trainers model to help caregivers of seniors.

Recommended Action 4.4: Incorporate and sustain suicide prevention activities in employee assistance programs and other support services offered by employers, including military, to build resilience, facilitate early identification and link employees to appropriate treatment or follow up care services.

a. Develop resources for employers to assist employees exhibiting suicide indicators or suicidal behaviors, those who are family members or friends of individuals presenting with suicidal behaviors or those who are suicide survivors.
b. Maintain a current list of local suicide prevention, intervention, treatment, or support services and make this available to all employees.
c. Target veterans, police officers and mental health professionals/staff as high risk groups.
d. Increase mental health literacy in workplaces (e.g., include education on wellness, suicide prevention and all aspects of mental health).

Recommended Action 4.5: Implement suicide prevention programs, improve capacity for early identification of suicide indicators and expand use of effective interventions for suicidal behaviors within law enforcement, juvenile justice and correctional systems, including jails and prisons.

4.5.1 Assess and address mental health needs of individuals entering the system.
4.5.2 Provide prevention, early intervention and treatment services for mental health problems.
4.5.3 Provide integrated care for clients with co-existing mental and substance abuse disorders.
4.5.4 Deliver discharge transition support for recovery and rehabilitation.
4.5.5 Develop peer education and support programs.

Recommended Action 4.6: Sponsor innovative programs and sustain effective current approaches that fill service gaps for historically underserved and target populations at highest risk for suicide.

4.6.1 Focus on programs that address priority service gaps identified by needs assessments conducted by local interagency planning forums.

4.6.2 Include and coordinate with natural community settings, such as Native American Health Centers, that are already effectively serving the target populations.
4.6.3 Include program components that involve family, care-giver and peer support.

Strategic Direction 5: Improve data collection, research and information-sharing with the public to advance suicide prevention efforts and measure progress.

Recommended Action 5.1: Make suicide surveillance data easily accessible to the public at large and regularly provide the data to public and private policy makers at all levels to improve understanding of suicide and enhance prevention efforts.

5.1.1 Expand the California Violent Death Reporting System to gather detailed suicide data throughout California to increase knowledge of diverse individuals' and populations' risk factors and predictive behaviors for suicide.
5.1.2 Work with coroners to determine how to improve investigations and reports to increase understanding of suicide and enhance prevention efforts.
5.1.3 Implement consistent methods of tracking and reporting suicide prevalence and incidents among clients of mental health, alcohol and drug programs, corrections and school districts.
5.1.4 Increase capacity for data collection, reporting and dissemination to inform program development and training.
5.1.5 Collaborate with the national research community to identify research priorities and conduct research to close the gap between risk factors and predictive behaviors for suicide.

[Placeholder for information to be included in the rationale: Describe data and committee discussion points that outline issues that this action aims to improve. The Suicide Prevention Plan Advisory Committee identified some initial barriers to implementation such as: fear of fault finding related to improving data collection; confidentiality rules limit access to data related to findings from psychological autopsies and completed suicides; and pressures families, caregivers, or others experience due to stigma or discriminations results in skewed data.]

Recommended Action 5.2: Encourage counties to establish suicide review teams with both a case review team, made up of select representatives that have legal access to confidential information, and a policy action team to translate aggregated and de-identified data from the case review team into policies and programs.

5.2.1 Include on the case review teams representatives from the office of the coroner or medical examiner, police, mental health agencies, and other appropriate agencies legally charged to protect confidentiality.
5.2.2 Include on the policy action teams government and non-government groups concerned with suicide and mental health, advocates, and clients of the mental health systems.

5.2.3 Report findings and data to the communities and help disseminate de-identified stories to put a “human face” on suicide statistics.
5.2.4 Use child death review teams as a model.

[Placeholder for information to include in the rationale: Provide examples of similar successful programs. Implementation concern is that lack of funding and voluntary nature of suicide death review teams may result in low action.]

Recommended Action 5.3: Conduct a program of epidemiological research on suicide and suicide prevention, specific to California, to support better policies and programs.

5.3.1 Increase knowledge about Californians who have attempted suicide including traumatic experiences (such as adverse childhood events), lived experiences in using mental health services, and specific risks based on race and ethnicity, gender, age, disability and other factors to identify high-risk individuals in California.
5.3.2 Encourage the use of community-based participatory research and action research methods including longitudinal studies and qualitative methods such as focus groups, ethnography, and oral histories.
5.3.3 Develop methods to investigate various stages of suicidal behaviors (e.g., ideation, planning, and aftermath) to expand knowledge for improved services.

Example Methods, Tools, or Resources

a. Seek research partners such as federal agencies, universities, community organizations, policy institutes and foundations.

Recommended Action 5.4: Develop and disseminate additional scientific strategies for evaluating suicide prevention interventions.

5.4.1 Outline outcome measures for similar suicide prevention activities to improve consistency and include outcomes of importance to program participants (e.g., measures for prevention programs serving youth or older adults).
5.4.2 Provide scientific assistance to programs for selecting best practices and for evaluating results.
5.4.3 Use the Substance Abuse and Mental Health Services Administration (SAMHSA) repository of evidence-based practices and encourage people to follow its research criteria (i.e., proven, promising, emerging).
5.4.4 Research efficacy of intervention programs in California to learn more about how social norms change and stigma is reduced.
5.4.5 Improve knowledge of effective culturally and linguistically appropriate approaches and intervention strategies.

Example Methods, Tools, and Resources

a. Provide funds to encourage development of strategies to meet the needs of ethnic-focused suicide prevention programs by bringing together culturally-competent providers, community groups, and organizations for summit conferences.

Part 3: Start Now and Keep Building

Summary

First steps: Begin laying a foundation now

a. Expand on current exemplary activities (provide some examples of these and include multi-cultural approaches)
b. Describe coordination and collaboration activities and methods that could make a big difference.

Moving Forward: Next steps

Disseminate the Plan

Periodic Assessment of Progress and Plan Update Process

Appendix A: Key California Data and Statistics Report
Appendix B: Suicide Prevention Glossary
Appendix C: Development Process for this Plan
Appendix D: Highlights of Suicide Prevention Efforts
Appendix E: Resources

Appendix: F: References

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