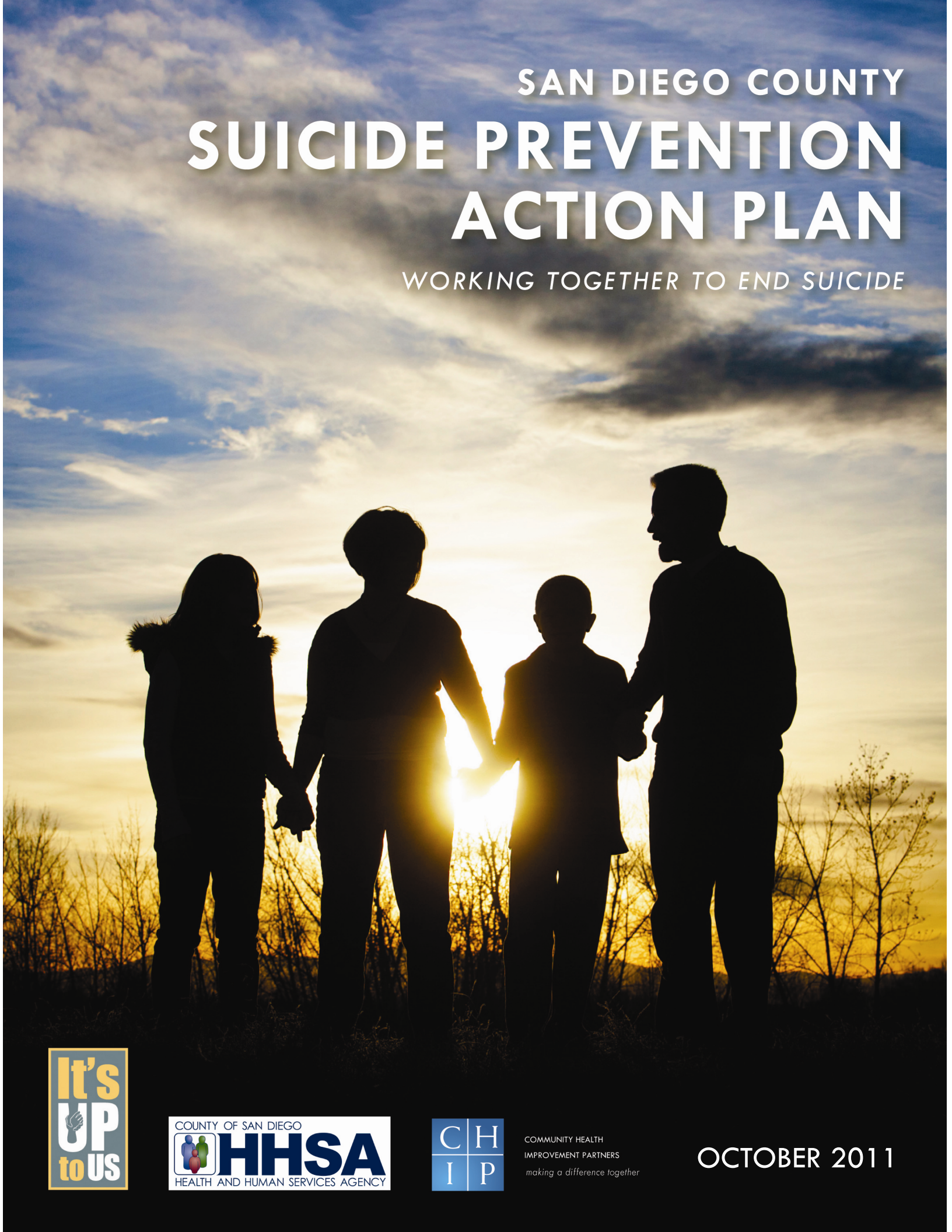

SAN DIEGO COUNTY
SUICIDE PREVENTION ACTION PLAN

WORKING TOGETHER TO END SUICIDE

It's UP to US

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

C H
I P
COMMUNITY HEALTH
IMPROVEMENT PARTNERS
making a difference together

OCTOBER 2011

The development of the Suicide Prevention Action Plan was funded by the County of San Diego Health and Human Services Agency (HHSA) Mental Health Services Act (MHSA).

SAN DIEGO COUNTY

SUICIDE PREVENTION ACTION PLAN

WORKING TOGETHER TO END SUICIDE

Foreword

LIVE WELL, SAN DIEGO!

In July 2010, the Board of Supervisors unanimously adopted a visionary 10-year plan, *LIVE WELL, SAN DIEGO!,* to improve the health and well being of our community. Supporting the County's vision, the plan strategically outlines goals and actions to provide innovative and integrated service delivery to the residents of San Diego so they can enjoy lives that are **Healthy, Safe** and **Thriving**. Each of these three strategic agendas has a distinct yet interwoven collection of measurable activities that are categorized within four major pillars:

- Building a Better System
- Supporting Positive Choices
- Pursuing Policy Changes for a Healthy Environment
- Changing the Culture From Within

The County of San Diego Suicide Prevention Action Plan supports the Health Strategy Agenda, known as "Building Better Health," which focuses on both tangible and perceived health issues. The Action Plan demonstrates the County's commitment to collaborating with community partners and businesses, aligning internal services to ensure safe communities for all residents, and puts *LIVE WELL, SAN DIEGO!: Building Better Health* into action. It will also be integrated into the Safety Strategy Agenda, known as "Fostering Safe Communities" in the future.

The Action Plan addresses the four major pillars in the following:

To **build a better service delivery system**:

- Improve identification of available suicide prevention services throughout the county to maximize resources and help minimize duplication of services and fragmentation in service delivery.
- Improve coordination of services for high-risk populations to more effectively inform the identification and prioritization of prevention strategies for those at risk of suicide.
- Expand data tracking requirements in San Diego County to include suicide and suicidal behaviors and actions.

To **support positive choices**:

- Build on existing resources such as the *It's Up to Us* campaign.
- Utilize public-private partnerships to extend resources throughout the County and ensure that messages are truly spread across the population as a whole.

To **pursue policy changes**:

- Expand basic prevention education and training to the population at large to so they can recognize the signs and symptoms of suicide risk as commonly as they can for other health risks like a heart attack or a stroke.
- Expand the definition of "providers" to include those outside of the behavioral health realm, and give them adequate training, education and support.
- Include the voice of those being served in the planning of training and interventions.

To **improve the culture from within**:

- Expand County employee knowledge about suicide prevention through education and training
- Strengthen existing policies and practices for employee health and wellness.

As we move forward with the implementation of *LIVE WELL, SAN DIEGO!*, this Action Plan will enable our community to measure its effects in reducing suicides in our county and promote our vision of a San Diego County that is healthy, safe and thriving.

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Acknowledgements

The County of San Diego Health and Human Services Agency (HHSA) would like to thank Community Health Improvement Partners (CHIP) and Harder+Company Community Research for their work on the development of the San Diego County Suicide Prevention Action plan. In addition, BHS would like to thank the many individuals and organizations that provided input to the design, implementation, and development of the strategies to inform the process. The success of the San Diego County Suicide Prevention Action Plan was dependent on the participation of service providers, County staff, and community members from throughout the County. We would like to gratefully acknowledge the following for their contributions to this effort:

- The members of the Suicide Prevention Action Plan Committee (SPAP-C), now called the San Diego County Suicide Prevention Council, who provided valuable input throughout this planning process, and who will continue to be instrumental in the successful implementation of the recommendations presented in this Action Plan.
- The co-chairs of the Suicide Prevention Council, Carol Skiljian and Beth Sise, for their overwhelming dedication through every step of this process.
- County staff, contractors, and community providers and stakeholders who provided invaluable feedback through the subcommittee and full committee meetings in the development of this Action Plan. Many dedicated individuals volunteered their time and expertise to fully inform the strategies presented here.
- All San Diegans who have participated and will continue to participate in suicide prevention efforts throughout the County.

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Executive Summary

Executive Summary

Suicide is a leading cause of non-natural death for all ages in San Diego County, second only to motor vehicle crashes.[1] In 2010, a total of 372 San Diegans died by suicide, for a rate of 11.5 suicides per 100,000 population.[2] This was higher than California overall (9.9 per 100,000) but slightly lower than the national rate (11.9 per 100,000).[3] On average, one suicide affects the lives of at least six other people, causing considerable grief, social stigma, and in some cases, elevated risk of additional suicides. Suicide also carries an economic toll, which is borne by social services, hospitals, primary care, and education sectors. The cost of suicide and suicide attempts in California is estimated to be as high as $4.2 billion per year.[4]

In 2009, the County of San Diego, Health and Human Services Agency (HHSA) launched a suicide prevention action planning process, which was informed by the National Strategy for Suicide Prevention and the California Strategic Plan on Suicide Prevention. Both advocate for a strong public health approach to suicide prevention, as well as the creation of local strategies based on the input of a diverse, representative group of stakeholders. The purpose of the Suicide Prevention Action Plan for San Diego County is to propose strategies that will enhance efforts to increase understanding and awareness of suicide, decrease stigma associated with suicide, and ultimately reduce the number of suicides in San Diego County.

Summary of Strategies

The Suicide Prevention Action Plan Committee conducted a comprehensive needs assessment and planning process to gather input from stakeholders and develop local prevention strategies. The strategies have been organized around three prevention elements proposed by the Institute for Medicine and highlighted in the California Strategic Plan:[5] universal, selective, and indicated strategies.

For a copy of the San Diego County Suicide Prevention Action Plan, go to www.up2sd.org and click on "Suicide Prevention Resources"

For more information on the Suicide Prevention Action Planning Process for San Diego County, go to: www.sdchip.org/spap.aspx

Universal Strategies

Designed to influence everyone, universal strategies are targeted to the general public, and reduce suicide risk by strengthening protective factors. Three universal strategies are recommended for use in reaching the general population:

- **Universal Training (UT).** A universally adopted curriculum should be developed and used to provide training throughout San Diego County. Through this training, the general public would receive basic education about the signs and symptoms of suicide, protective factors, as well as sources of help so that everyone knows when and how to access help for themselves, a friend, or family member. To ensure broad representation in universal suicide prevention efforts, public-private partnerships in suicide prevention should be strengthened.
- **Media Campaign (UM).** The current "It's Up to Us" media campaign should be continued and expanded. A universal message should be developed for use throughout the County and appropriately modified to reach different age and cultural groups. Media-related efforts should also include efforts to ensure responsible reporting of suicides.
- **System Level Impact (US).** The service delivery system and the capacity of specific service providers should be strengthened. A suicide prevention entity should be created to monitor the implementation of suicide prevention efforts and system-wide initiatives countywide. It is recommended that primary care physicians receive suicide prevention education so that they are better prepared to identify and address suicide risk factors among their patients. Changes to local laws or ordinances, or modifications to system practices at hospitals and other service locations, can address policy issues such as firearm safety and medication management.

Selective Strategies

Selective strategies focus on at-risk groups that have a greater probability of becoming suicidal, and aim to prevent the onset of suicidal behaviors. Four selective strategies are recommended for use in reaching high risk populations:

- **Education (SE).** Suicide prevention education efforts should be expanded to reach identified at-risk populations. These efforts should capitalize on community strengths and involve community stakeholders throughout the process—from development and implementation, to evaluation and refinement.
- **Training for Providers (STP).** Providers working directly with clients at risk for suicide need more training and support. For selective populations, the definition of provider should be broadened to include people outside of the behavioral services sector. For many selective populations, the initial point of contact is a community or faith based organization. In addition to standardized training and education, providers working with high risk populations need support to ensure they feel successful at their jobs and reduce burnout.
- **Skill Building and Training for Community Members/Clients (SSB).** Building on the strengths and resources already available in many communities, skill building programs should be expanded to provide tools for clients who may not access traditional mental health systems. Increased support is also needed throughout the community, since many individuals will seek assistance outside the traditional behavioral health system.

- **Utilization of Supportive Models (SSM).** Support models need to be expanded and legitimized in order to address mental health concerns. Not only are support models peer-to-peer based and more representative of the communities they serve, but they are often seen as less stigmatizing for consumers. These models can help reach populations who may not access traditional mental health services. Faith based communities, in particular, should be targeted for the delivery of informal crisis support.

Indicated Strategies

Indicated strategies target high-risk individuals that exhibit early signs of suicide potential. Four indicated strategies are recommended to reduce risk factors and increase protective factors among high-risk individuals:

- **Identification of High Risk Behaviors/Events (IRB).** Some events, including recent discharge from the hospital for a mental health crisis, or diagnosis of a chronic medical condition, greatly increase risk for suicide. But high risk behaviors and events may vary in character and prevalence across diverse cultures and populations; more research needs to be conducted to identify additional high risk behaviors and events. Data should be used to inform interventions for those at highest risk for suicide.
- **Integrate System of Care for High Risk Individuals (ISC).** The system of care for high-risk individuals needs further integration. Issues of client privacy, confidentiality, and access between multiple systems and providers often hamper current collaborative relationships. Local efforts should be expanded to address these and other barriers to an integrated system of care. Increased coordination between outpatient providers and hospital staff or discharge planners may save a life by ensuring the link to ongoing support following high-risk events.
- **Provision of Community Based Services (ICB).** Transportation and stigma are primary barriers to obtaining mental health services. Approaches to addressing these and related barriers include the provision of home-based mental health services, as well as mental health services located at community centers, primary care clinics, and other well-recognized sites in the community.
- **System Level Impact (ICS).** Formal collaboration between service providers would support increased data sharing and service coordination. In addition, efforts to encourage adherence to California's firearm legislation through media campaigns about responsible firearm ownership are recommended.

Overall Action Plan Concepts

Several overarching concepts are thread through the strategies and objectives presented in this action plan that frame a comprehensive, community based approach to suicide prevention efforts in San Diego County. As these recommendations are implemented, it is important that the following core concepts be considered.

- **Broaden the scope and reach of trainings** to include more community members and providers.
- **Adapt best practices** to ensure interventions are tailored to meet the specific needs of San Diego County as whole and/or specific target populations.
- **Coordinate suicide prevention services and priorities** to ensure needs are being met across systems.
- **Include the voice of those who are being served,** particularly those most at risk for suicide, in the planning of training and interventions to ensure strategies are successful.
- **Use data to evaluate prevention efforts and inform program planning.** Strengthening data collection, quality, sharing, and utilization efforts will ensure a robust system to evaluate the impact of suicide prevention efforts, to inform future decision-making, and to expand knowledge about suicide.

1 "Leading Causes of Death Among San Diego County Residents, 2007-2009" Web 22 June 2011. http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/EISB_Mort_Leading_Causes_of_Death_COSDres_2007-2009.pdf

2 San Diego County Department of the Medical Examiner, "2010 Annual Report" Accessed online http://sdcounty.ca.gov/me/docs/SDME_Annual_Report_2010.pdf 8/4/11. Population data: SANDAG, 2010 population estimates , accessed online www.sandag.org 8/4/11

3 National Vital Statistics Reports, Vol. 59, No. 4, March 16, 2011. Web 5 Aug. 2011. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf

4 California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010. http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/ SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf

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Introduction

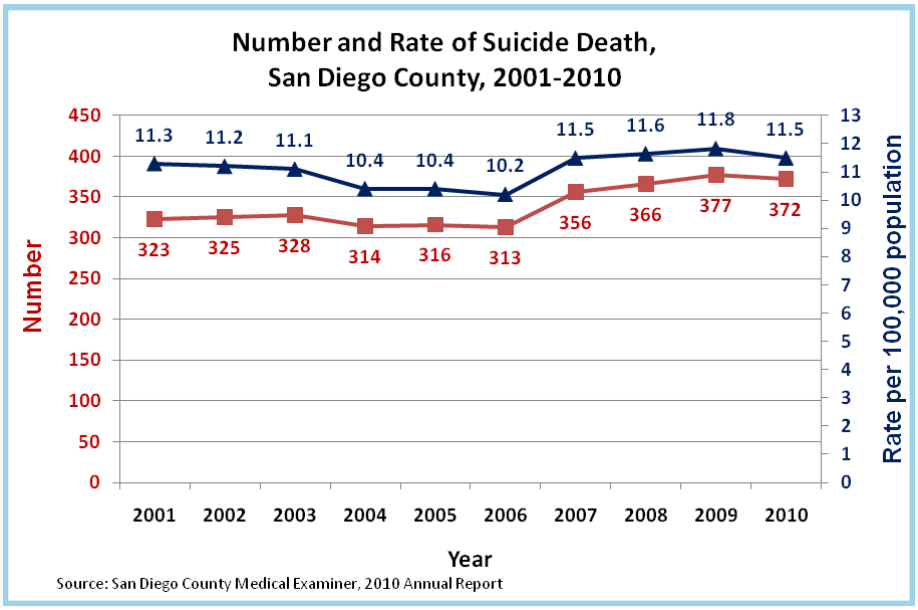
Introduction

In 2009, the County of San Diego, Health and Human Services Agency (HHSA) contracted with Community Health Improvement Partners (CHIP) to coordinate the local planning process to develop a Suicide Prevention Action Plan. Funded under the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI), CHIP was charged with the development and dissemination of a suicide prevention action plan to increase understanding and awareness of suicide, and reduce the stigma associated with suicide and suicidal behavior in San Diego County.

Suicide claims the life of roughly one San Diegan a day.

Suicide is a leading cause of non-natural death for all ages in San Diego County, second only to motor vehicle crashes.[6] Suicide claims the lives of roughly one San Diegan per day, outnumbering homicides by nearly 3 to 1. In 2010, a total of 372 San Diegans died by suicide, for a rate of 11.5 suicides per 100,000 population,[7] higher than the California rate (9.9 per 100,000) but slightly lower than the national rate (11.9 per 100,000) for 2009.[8] An in-depth examination of county statistics reveals that suicide is more prevalent among certain populations and age groups. For example, in 2010, 257 of the 372 suicides that year were among adults aged 25 to 64 years, representing 69% of suicides overall, indicating they had the highest *number* of suicides. However, a look at these data in proportion to the total population reveals that men over the age of 65 had the highest *rate* of suicide (35.4 per 100,000) ,[9] meaning they were at greater risk.

Suicide takes an emotional toll on families and affects the wellbeing of the larger community. It is estimated that one suicide affects the lives of at least six other individuals, causing extreme loss and grief, social stigma, and, at times, elevated risk for additional suicides. Suicide also carries an economic toll, which is borne by social services, hospitals, primary care, and education sectors. The cost of suicides and suicide attempts in California is estimated to be as high as $4.2 billion per year.[10]



Summary of the Action Planning Process

The San Diego County suicide prevention action planning process was informed by the National Strategy for Suicide Prevention[11] and the California Strategic Plan on Suicide Prevention.[12] The National Strategy advocates a public health approach to suicide prevention, including key formative steps of collecting information about local suicide rates and causes.[13] The California Strategic Plan further recommends that each county "develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders".[14] The state plan also recommends that each local plan should design and implement a comprehensive assessment of existing county suicide prevention services to detect major gaps in services. Rather than a "one size fits all" approach to preventing suicide, services and programs should be designed to "effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds".[15]

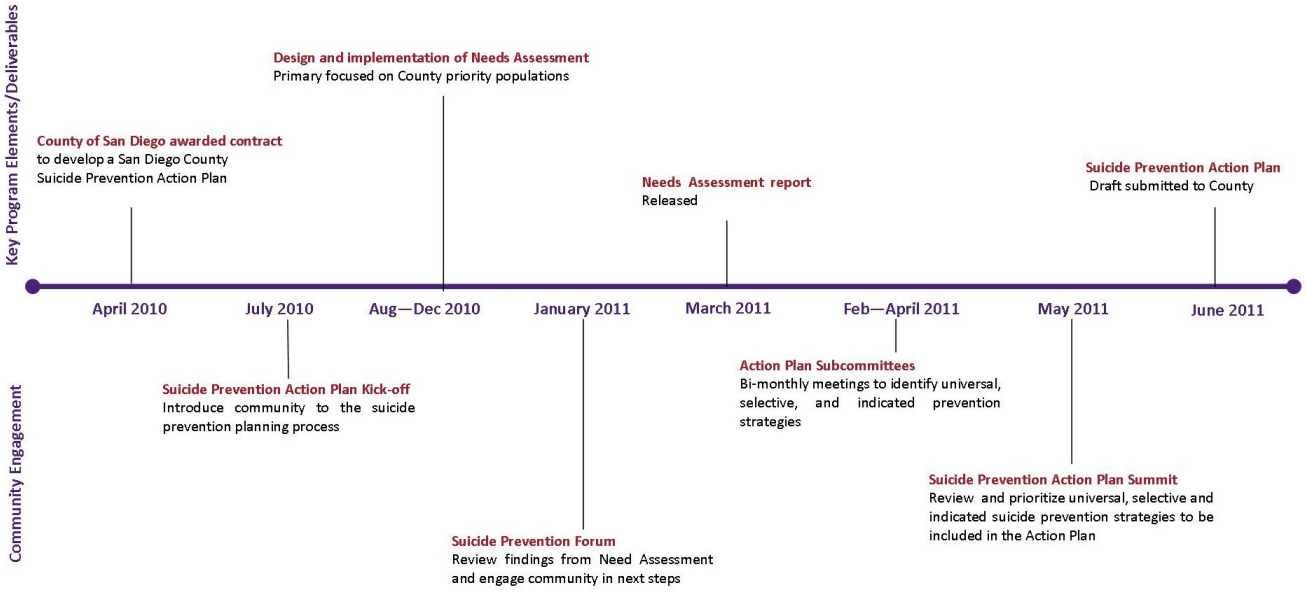
Since receiving the County contract, the Suicide Prevention Action Plan Committee (SPAPC) was formed with the initial purpose of creating and introducing a Suicide Prevention Action Plan for San Diego County. During the planning process, the SPAPC brought together a wide variety of mental health providers, additional Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) contractors, physicians, and other key stakeholders to assist in the development of the local action plan.

In the process of developing the Suicide Prevention Action Plan for San Diego County, CHIP contracted with Harder+Company Community Research to conduct the following activities:

- Design and conduct a Needs Assessment;
- Facilitate a Suicide Prevention forum to share the findings from the Needs Assessment;
- Conduct subcommittee meetings to focus on generating suicide prevention strategies;
- Facilitate a summit to review suicide prevention strategies and give recommendations for areas of prioritization; and
- Compile recommendations into a first draft of the Suicide Prevention Action Plan.

Exhibit 1 on page 3 provides a timeline for each component of the planning process. Additional detail for each component follows.

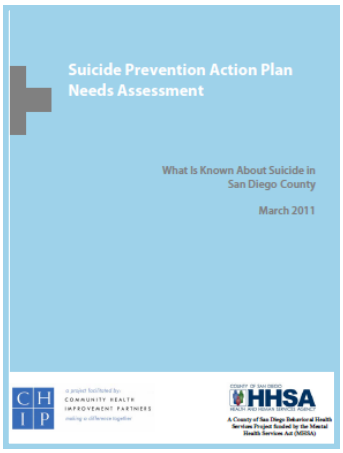
Exhibit 1: Suicide Prevention Action Plan Timeline



Needs Assessment

The overall purpose of the needs assessment was to provide local data and evidence to inform individuals, organizations, and agencies across San Diego County to take a strategic approach to suicide prevention at the local level. Specific objectives were to:

- Examine suicide rates among different population groups in San Diego County;
- Identify gaps in existing local suicide prevention services and supports;
- Assess County suicide prevention training for staff & contractors;
- Explore current best practice models;
- Identify opportunities for enhancing collaboration among local suicide prevention providers and initiatives; and
- Provide recommendations for a strategic, coordinated suicide prevention action plan.



The needs assessment report, *What is Known About Suicide in San Diego County,*[16] laid the foundation for the Suicide Prevention Action Planning Process for San Diego County. The report reviewed suicide and intentional injury data, and identified resources and gaps in existing suicide prevention efforts as well as provided recommendations for moving forward with the action plan. The findings were presented and discussed with over 200 participants at a suicide prevention forum held in January 2011.

Suicide Prevention Forum

On January 21, 2011, a suicide prevention forum was held at the Paradise Point Resort to:

- Identify key components of the Perfect[17] Depression Care program;
- Discuss and inform the results of the Suicide Prevention Action Plan Needs Assessment; and
- Participate in the development of strategies for the Suicide Prevention Action Plan.

There were 209 attendees from a variety of organizations, with keynote addresses from Dr. Wilma Wooten, Public Health Officer for the County of San Diego Health and Human Services Agency, and Dr. Edward Coffey, Vice President and CEO of Behavioral Health Services. During this forum, attendees were given the opportunity to choose a breakout group to discuss suicide prevention within targeted populations. Additional information on the forum can be found at www.sdchip.org/spap.aspx.

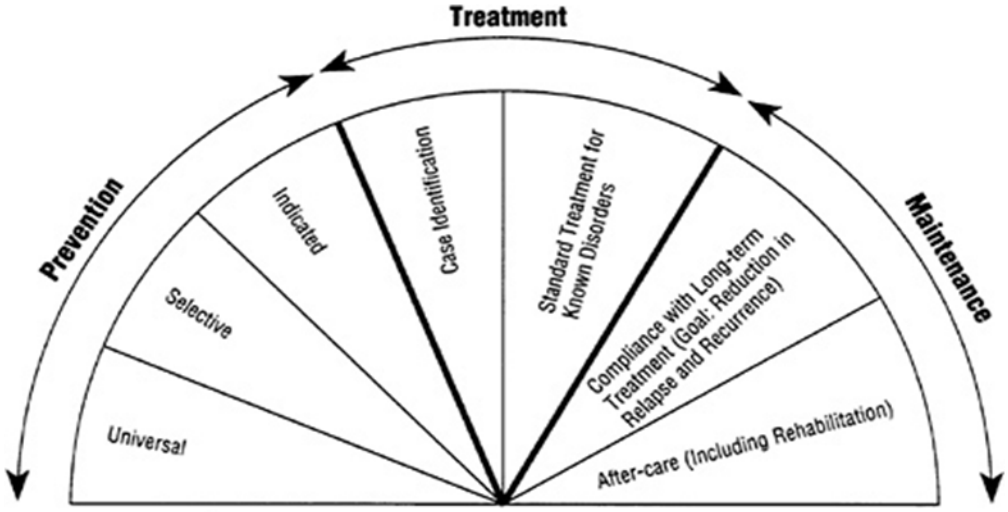
Action Plan Framework

The spectrum of interventions proposed by the Institute for Medicine and highlighted in the California Strategic Plan[18] formed the framework for organizing community and stakeholder input related to prevention strategies (Exhibit 2 on page 5). These interventions include all areas of intervention for mental health disorders. By design, the suicide prevention action planning process focused on the three elements of prevention: universal, selective, and indicated strategies.

The key aspects of the three components of prevention with relation to suicide prevention are defined below.[19] These components were used as focus areas to guide group discussions during SPAPC subcommittee meetings of the action planning process.

- **Universal strategies** are targeted to the general public or a whole population group. Designed to influence everyone, they reduce suicide risk by strengthening protective factors like community support and social skills, removing barriers to care, enhancing knowledge of what to do to help suicidal individuals, and increase access to help. Examples of interventions include public education campaigns, "suicide awareness" programs, education programs for the media on reporting practices related to suicide, and crisis response plans and teams.
- **Selective strategies** focus on at-risk groups that have a greater probability of becoming suicidal and aim to prevent the onset of suicidal behaviors among specific subpopulations. This level of prevention includes screening programs, gatekeeper training for "frontline" adult caregivers and peer "natural helpers," support and skill building groups for at-risk groups in the population, and enhanced accessible crisis services and referral sources.
- **Indicated strategies** target high-risk individuals that exhibit early signs of suicide potential. Programs are designed and delivered in groups or individually to reduce risk factors and increase protective factors. At this level, programs include skill-building support groups, case management for individual high-risk individuals, and referral sources for crisis intervention and treatment.

Exhibit 2: Mental Health Intervention Spectrum Diagram



Based on these prevention strategy definitions, a matrix for mapping out subcommittee meeting discussion topics was developed. In addition to eliciting input for strategies at each level of prevention, the SPAPC requested that subcommittee members also provide input related to how these prevention strategies would impact outreach activities, direct services, and systems or organizations. By organizing subcommittee meetings this way, community members and stakeholders were made aware of the content of the subcommittee meetings in advance, and could choose which meetings would most benefit from their input.

Action Planning Process

Meetings with community members and stakeholders to discuss each prevention focus area took place from January 2011 through June 2011. During these six months, five SPAPC meetings and six subcommittee meetings were convened to achieve the following:

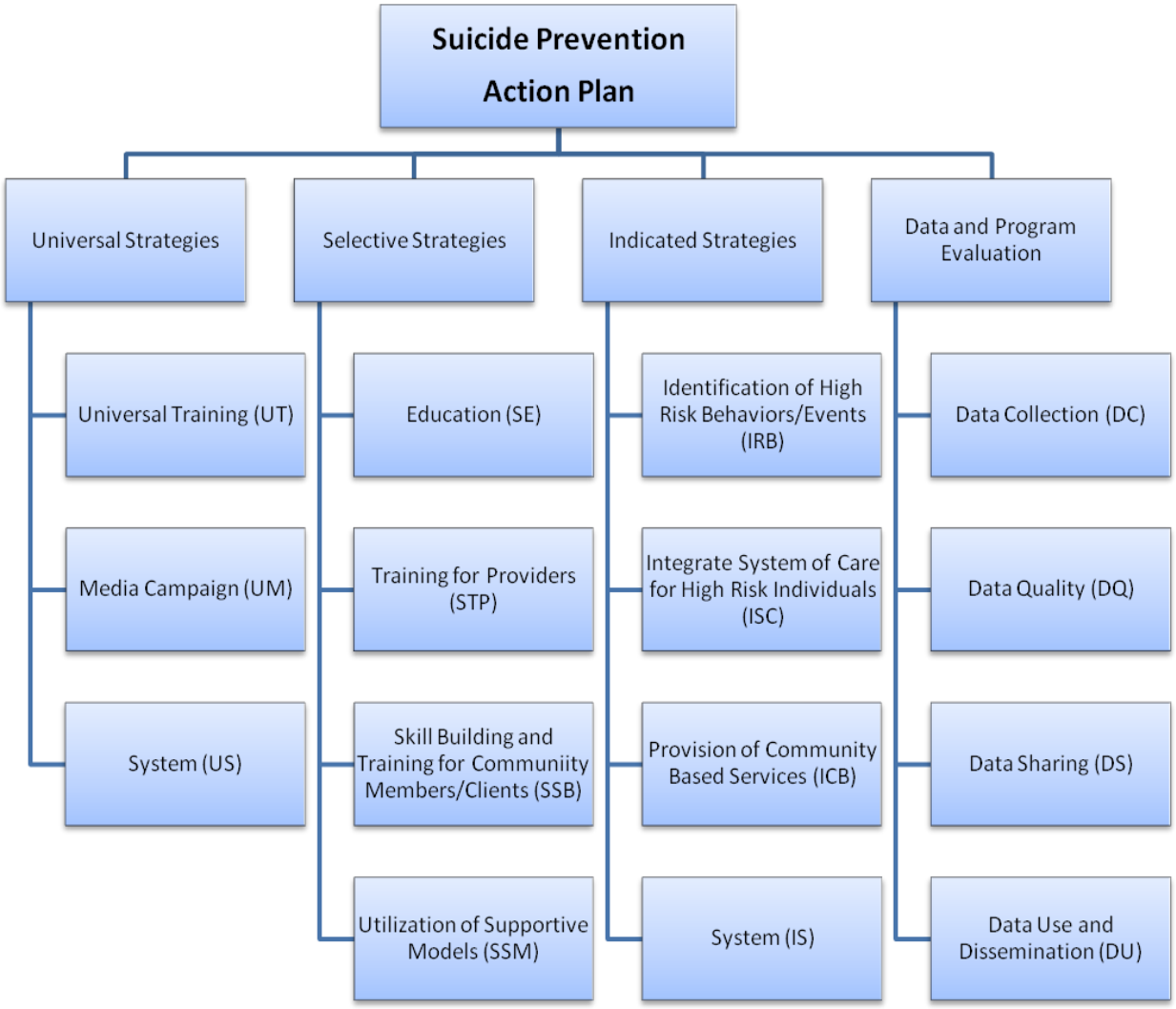
- Subcommittee Meetings: Identify universal, selective and indicated suicide prevention strategies
- SPAPC Meetings: Review and update progress on the planning process, discuss suicide prevention strategies identified in subcommittees, and address any emerging key areas of concern.

Subcommittee meetings addressed details related to the following four components: 1) suggested focus area actions; 2) cultural considerations, 3) service considerations, and 4) promising/best practices. The number of participants attending each subcommittee meeting ranged from 12 to 26. All subcommittee meetings were facilitated using a participatory process of decision making which allowed brainstorming to identify prevention strategies.[20] Work typically occurred in small breakout groups. Participants would then report back to the other participants on the strategies their group identified. Once all groups delivered their

report, participants were asked to prioritize the top three strategies. Time permitting; the top three strategies were discussed in further detail to inform the Action Plan. The SPAPC monthly meeting served as a platform to present the strategies identified during the sub-committee meetings.

The strategies identified in the Subcommittee and Committee meetings during the action planning process are presented in Exhibit 3, below.

Exhibit 3: Overview of Action Plan Strategies



Suicide Prevention Action Plan Summit

In May 2011, CHIP convened key stakeholders involved in the Suicide Prevention Action Plan development for a half day Summit. The goal of the Summit was to refine strategies and objectives identified through the subcommittee process. This was accomplished by additional input from participants, feedback about missing prevention strategies, and further assessment to inform recommendations for Action Plan implementation.

Through small group breakouts, stakeholders reviewed and discussed key universal, selective, and indicated strategies and objectives identified. Participants engaged in a prioritization activity in which they considered each of the proposed objectives, by keeping in mind their own knowledge and expertise in the field of mental health and/or suicide prevention and by using the following criteria:

- **Fit** – Can this intervention be successfully implemented with all or most of the identified high risk populations?
- **Funding priority** – Would you recommend this objective be identified as a funding priority for local agencies?
- **Resources (Human and Capital)** – Are organizational resources (staff, implementation materials, or other resources) available to implement the objective?

Based on participants' individual rankings, facilitators engaged participants in discussion about their ranking, and selected the three highest priority objectives as a group. These three objectives were discussed in further detail by breakout participants.

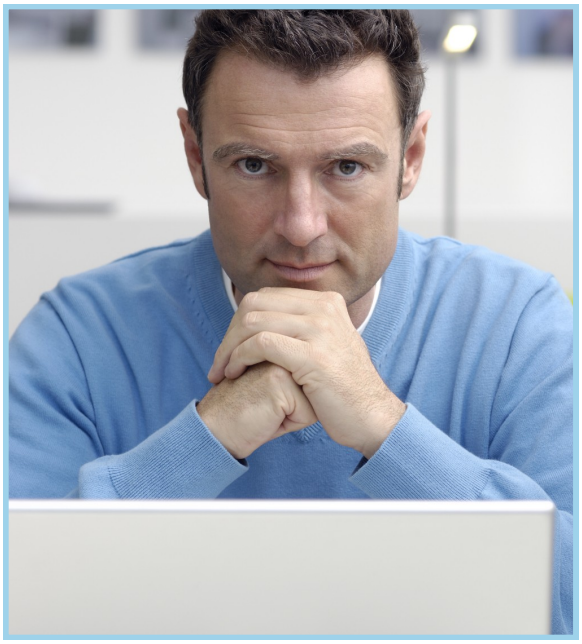
Additional Opportunities for Feedback

In order to create a forum for ongoing feedback during the planning process, and to accommodate stakeholders who could not attend meetings, two components were added: a web portal and a survey.

Web Portal. The CHIP website was an important, ongoing communication link between SPAPC members, staff and the public. On the website's Suicide Prevention Action Plan page, meetings were publicized; all data and information that was shared at the SPAPC meetings were available on an ongoing basis; and summaries of steps taken and preliminary decisions were presented to facilitate transparency in planning and invite additional community response. Comments from the public via the portal were documented and considered in the crafting of the plan.[21]

Survey. A survey was developed via Survey Monkey and posted on the CHIP website to gather additional feedback, thoughts, suggestions, and priorities from community members on the action plan. A total of eight respondents completed the survey.

How to Read the Action Plan



The following sections lay out the recommended strategies and their corresponding objectives. This section provides some guiding principles of the action plan as well as things to keep in mind when reading each section.

Guiding Principles

As described above in the planning process section, the action plan was developed with input from multiple and diverse stakeholders. It reflects the feedback obtained during this process and builds off existing suicide prevention efforts. It further provides recommendations for additional services and supports. In reviewing the objectives outlined in each section, the following should be kept in mind:

- **No one person/entity is responsible.** The action plan was written as a vision for comprehensive suicide prevention services throughout San Diego County. To make this vision a reality, the community as a whole needs to be involved in the implementation of each objective. This includes County Behavioral Health Services, other mental health and behavioral health providers, public health, other social service providers, healthcare or primary care providers, private business, consumers of services, faith-based communities, and other non-government agencies and organizations. Buy-in across sectors will ensure that each objective can be fully implemented to best reach the intended target populations.
- **All objectives should be met to reduce suicide in San Diego County.** Several objectives presented were identified during the action plan summit as priorities. Priority objectives were those determined by stakeholders to be most important; however, all objectives presented in this action plan should be utilized.
- **Many objectives require additional planning.** Most of the objectives provide basic recommendations for moving forward and key components or examples to follow. Additional planning will be required to integrate these recommendations into existing services, as well as to identify additional resources needed to expand services.
- **Recommendations are based on best practices.** Throughout this document, best practices at the national and local level are identified as recommendations for moving forward. Where possible, examples of best practices are highlighted and links for additional information are provided. These are by no means an exhaustive list but rather a reflection of the general knowledge of existing resources gathered during the needs assessment and planning process.

- **Focus on interventions, not programs.** In citing best practices and providing examples, several interventions are highlighted. Many of these interventions are already in place in existing programs in San Diego. In general, the intervention or model on which it is based is highlighted rather than the specific program. In some cases, individual programs are presented; however, they are not necessarily the only existing local model or program. References to programs and resources can be found in each action plan section as well as Appendix A for specific strategies.
- **Evaluation and monitoring of progress are key.** In order to measure success of each objective as well as the plan as a whole, a comprehensive evaluation plan is needed. For a more complete discussion of specific recommendations for strengthening the ways in which suicide prevention efforts are tracked and measured, see the Research and Data section.

Definitions

Key target populations: Groups identified at the beginning of the action planning process as key groups to focus on during the needs assessment and development of the action plan.

- Lesbian, Gay, Bisexual, Transgender (LGBT);
- Native American;
- Latino;
- Older Adults - ages 65 years and older;
- Asian/Pacific Islander (API);
- Transitional Age Youth (TAY) – ages 18-24 years.

More information about the specific suicide rates as well as risk and protective factors associated with each population can be found in the Suicide Prevention Action Plan Needs Assessment, *What is Known About Suicide in San Diego County*.[22]

High risk populations: Groups of people who are statistically more likely to complete suicide.

- Veterans;
- Recently divorced or separated individuals;
- Middle aged men;
- Older adults – ages 65 years and older;
- Individuals with a history of substance abuse;
- Individuals with a history of foster care;
- Individuals with a history of sexual abuse;
- Individuals with a previous suicide attempt, or suicide in the family;
- Individuals with a chronic mental health disorder, especially those also dealing with physical health issues or substance abuse.

High-risk behaviors and events: These include, for example, emergency department discharge, psychiatric hospital discharge, divorce or separation, and job loss, among others.

Overview of Strategies

Exhibit 3 on page 6 provides an overview of the organization of strategies as presented in the action plan. These are Universal Strategies, Selective Strategies, and Indicated Strategies. A fourth section of strategies, called Data and Program Evaluation, cut across the previous three, and are presented as their own section. Each strategy contains corresponding objectives that serve as recommendations to follow to achieve each strategy. Additional detail is described for each objective in the sections to follow.

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6 "Leading Causes of Death Among San Diego County Residents, 2007-2009" Web 22 June 2011. http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/EISB_Mort_Leading_Causes_of_Death_COSDres_2007-2009.pdf.

7 San Diego County Department of the Medical Examiner, "2010 Annual Report" Accessed online http://sdcounty.ca.gov/me/docs/SDME_Annual_Report_2010.pdf 8/4/11. Population data: SANDAG, 2010 population estimates , accessed online www.sandag.org 8/4/11.

8 National Vital Statistics Reports, Vol. 59, No. 4, March 16, 2011. Web 5 Aug. 2011. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf.

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11 Substance Abuse and Mental Health Administration (SAMHA). *National Strategy for Suicide Prevention: Goals and Objectives*. Web. 8 June 2011. <http://store.samhsa.gov/product/SMA01-3517>.

12 California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 8 June 2011. <http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf>.

13 Suicide Prevention Resource Center. *Suicide Prevention: A Public Health Approach*. Substance Abuse and Mental Health Services Administration (SAMHSA). Web. 1 Sept. 2010. <http://www.sprc.org/library/phasp.pdf>.

14 California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010. <http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf>.

15 Ibid.

16 Community Health Improvement Partners. *What is Known About Suicide in San Diego County.* Web. 8 June 2011. <http://sdchip.org/media/4131/Suicide%20Prevention%20Needs%20Assessment_Final%203.25.11.pdf >.

17 The Depression Care Program was developed in 2001 by Dr. Edward Coffey at Henry Ford Health System. More information can be found at http://www.henryfordmacomb.com/body.cfm?id=48947.

18 California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010. <http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf>.

19 Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health. *Reducing Suicide: A National Imperative*. Ed. SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney. Washington, D.C.: The National Academies Press: 2002.

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21 The web portal can be accessed at: http://groups.google.com/group/spapcforum?pli=1

22 Community Health Improvement Partners. *What is Known About Suicide in San Diego County.* Web. 8 June 2011. <http://sdchip.org/media/4131/Suicide%20Prevention%20Needs%20Assessment_Final%203.25.11.pdf http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>.

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Universal Strategies

Universal Strategies

Universal strategies target the general public or a whole population group. Designed to influence everyone, they reduce suicide risk by strengthening protective factors like community support and social skills, removing barriers to care, enhancing knowledge of what to do to help suicidal individuals, and increase access to help. Interventions might include public education campaigns, "suicide awareness" programs, education programs for the media on responsible reporting practices related to suicide, and crisis response plans and teams.[23]

Overall Concepts for Universal Populations

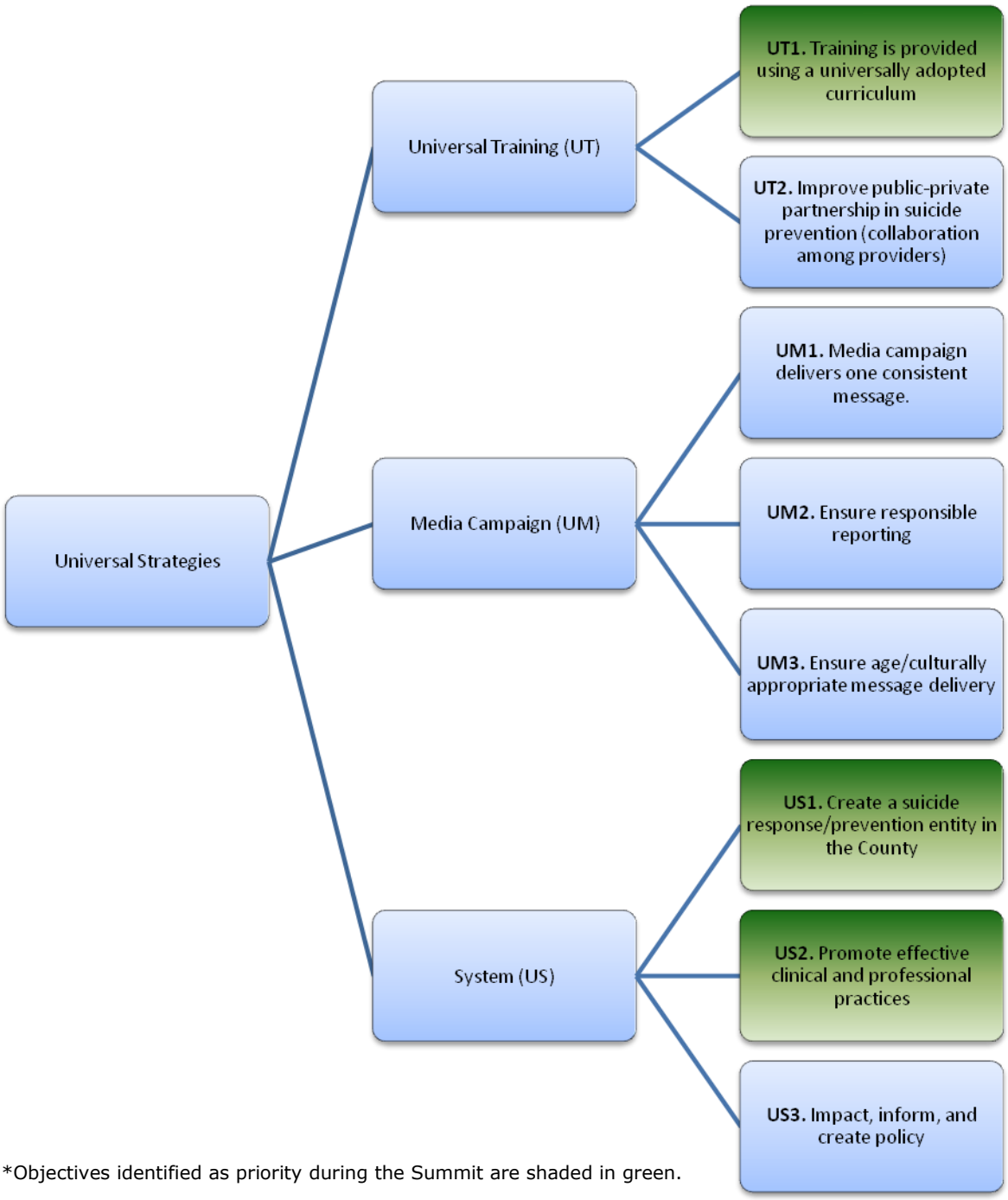
Several key concepts frame universal suicide prevention strategies. These include:

- **Build upon existing resources**. Across the three recommended universal strategies, there are existing programs and interventions that should be supported and expanded to further their scope. For example, *It's Up to Us,* a mental health stigma reduction/suicide prevention media campaign, began the stigma reduction component in September 2010 and implemented the suicide prevention component in July 2011.
- **Broaden the reach of education and training**. The aim of many universal strategies is to communicate basic prevention information to the general population. For suicide prevention, this might include a widespread media campaign that addresses the signs and symptoms of suicide, as well as training for social service and healthcare providers about what to do if they see or suspect suicide risk among their clients. Ultimately, the goal is for everyone to learn how to recognize the warning signs for suicide, just as they can for other health risks like a heart attack or a stroke. Useful analogies include public health education for cold and flu precautions such as 'Cover your cough' or fire safety such as 'Stop, drop and roll'.
- **Core components with customizable context.** There are nationally recognized best practices for training, media and other universal interventions. These models should be applied and tailored to the specific needs of San Diego County as whole and/or specific target populations.
- **Public-private partnerships are vital.** Across all universal strategies, stakeholders from public and private sectors are needed to extend resources throughout the County as well as ensure that messages are truly spread across the population as a whole.

Universal Strategies

Eight objectives have been identified as key components in a comprehensive system of suicide prevention among universal populations. Organized into three strategy areas, these objectives are presented in Exhibit 4 and described in further detail below.

Exhibit 4: Overview of Universal Strategies



*Objectives identified as priority during the Summit are shaded in green.

Strategy Definitions

The following are descriptions of each of the three universal strategies:

- **Universal Training (UT).** A universally adopted curriculum should be developed and implemented to provide training to both the general public and service providers throughout San Diego County. Specific recommendations are made detailing what needs to be included in the training, as well as how and with whom it should be implemented. This strategy approaches suicide prevention from the perspective that all need to be involved.
- **Media Campaign (UM).** The current media efforts of the *It's Up to Us* campaign should be continued and expanded. It is recommended that a universal suicide prevention message that can be transmitted throughout the county, and that can be appropriately formatted and modified to reach different age and cultural groups be developed.
- **System Level Impact (US).** Several recommendations were made for strengthening the service delivery system as well as building the capacity of providers. This strategy includes a recommendation for the creation of an entity to monitor the implementation of suicide prevention efforts, as well as system wide initiatives that can impact the entire county.

Priority Objectives

The three objectives identified as priority within universal strategies are:

UT1. Training is provided using a universally adopted curriculum

Throughout the planning process, there was a particular emphasis on the need to change the way members of the community at large perceive their role in suicide prevention. Rather than relying only on the behavioral health system, the general public should receive basic education and training about the signs and symptoms of suicide, protective factors, and key sources of help so that everyone can respond effectively during a suicidal crisis.

There are already several organizations successfully providing training in San Diego County. It is recommended that these trainings be reviewed and assessed so that a universal curriculum can be adopted and implemented to provide training throughout the county.

Common elements identified from existing trainings

- Models for universal education already exist. It is important to review these and build off of them to address the needs of the identified target populations;
- Universal training efforts take a public safety approach to suicide prevention and identify core ideas and information that everyone should know, similar to past public health education campaigns for issues such as fire safety (*Stop, Drop and Roll)* and cold/flu prevention (*Cover your Cough)*. These past efforts identified common, basic, and easy to remember messages that were delivered broadly. It is important that any curriculum adopted include this approach to ensure suicide prevention messages are widely distributed;
- Selected curricula should allow for individualization by population. While there are recognized core training components, there should be some flexibility in both training implementation as well as content to address the needs of target populations.

Evidence based, promising, or local models that can support this objective

Suicide Prevention Resource Center (SPRC): Overview of Available Training Resources

The SPRC has developed several training fact sheets for service providers and community members working in suicide prevention. These fact sheets include identification of risk and protective factors as well as identifying how to intervene. Training information is available for many populations including:

- Alcohol and Other Drug (AOD) Counselors
- Clergy
- Co-workers
- Employers
- College students
- Foster Parents
- Nurses
- Primary Care Providers
- Teachers
- Teens

Additionally, the SPRC offers opportunities for both online and community based training. By offering both, the SPRC is able to reach more people. Multiple methods should also be considered when implementing local trainings.

More information about these resources can be found at: www.sprc.org/featured_resources/customized/index.asp

Suggested best practices and local models for training include:

- Suicide Prevention Resource Center[24] evidence based models and education materials (see sidebar);
- Mental Health First Aid[25] curriculum;
- Universal public safety training models in other areas such as CPR and fire prevention;
- Air Force Suicide Prevention Program;[26]
- Be A Link!® Suicide Prevention Gatekeeper Training[27] and Ask 4 Help!® Suicide Prevention for Youth;[28]
- Partnering with faith communities using existing models.[29]

Culturally competent implementation

When creating a universal training for all groups, cultural competency must be considered. One method of ensuring cultural competency is to adopt common themes while simultaneously encouraging the personalization and individualization for each community.

To ensure universal trainings are implemented in a culturally competent manner, the following elements should be considered:

- Identify core components that cross all demographics;
- Customize content whenever possible to include and address specific barriers faced by a population group;
- When possible have a "relatable person" deliver the training.
- Incorporate components and elements into the training that can be customized by population group;
- When a member of the target population is not available to deliver the training, use an ambassador or community representative to vouch for trainer or do a warm handoff when necessary;
- Work with local organizations that already address the needs of diverse members of the San Diego community.

While a cultural match between trainer and target population is ideal for implementing culturally competent suicide prevention trainings, this may not be possible for all local communities. However, there are several organizations achieving success in San Diego County by working to implement cultural compassion. These organizations and staff should be included in the ongoing discussion about the culturally compassionate implementation of training to ensure it is delivered in a sensitive manner to all target populations.

Ensuring success

In order to ensure the success of universal training, the following groups need to be involved:

- Public and private organizations;
- Political, cultural, and community leaders;
- Organizations already providing trainings;
- Subject matter experts to be involved in the identification and/or development of training;
- Media in order to widely distribute the message.

Training Targets

Widespread suicide prevention training should be made available to several sectors of the population. The following community groups, individuals, and organizations were identified as targets for universal training:

- Medical community (primary care, emergency department, and others)
- Universities, schools (elementary, middle, and high school), and other educators
- Clergy
- Media
- Athletes
- Pharmacists
- Grant makers and foundations
- Private corporations
- Financial institutions
- Political, community, and cultural leaders (local, state, and national)
- Champions (spokespersons)
- Mail carriers
- Survivors
- Theme parks
- Insurance companies
- Family members
- Police departments

Risk Factors for Suicide

The impact of some risk factors can clearly be reduced by certain interventions. Risk factors that cannot be changed (such as previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder or following a significant stressful life event.

Biopsychosocial Risk Factors

- Mental disorders
- Alcohol and other substance abuse
- Hopelessness
- Impulsive or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socialcultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing care
- Certain cultural and religious beliefs
- Exposure to, including through media, and influence of others who have died by suicide

**Courtesy of www.sprc.org*

US1. Create a suicide response/prevention entity in the county

It was highly recommended that a suicide response or prevention entity be convened for San Diego County. This entity should exist outside of the County system; a collaborative group of existing organizations that work together to implement suicide prevention efforts, and ensure compliance with mandates. To be successful, this entity must be inclusive of local organizations; particularly those with a history of suicide prevention work in the community. The creation of a suicide response/prevention entity will guarantee ongoing conversation and monitoring of efforts to improve suicide prevention countywide.

Evidence based, promising, or local models that can support this objective

Common elements of successful local collaboratives include:

- Involving representatives from multiple fields/stakeholder groups;
- Representing different perspectives;
- Developing and reviewing multiple solutions;
- Identifying common goal(s);
- Defining the purpose of the collaborative;
- Convening purposeful, ongoing meetings to continually assess the extent to which collective efforts are "moving the needle" (i.e., reducing suicide);
- Adapting as needed to keep moving toward the goal(s);
- Having a sense of shared responsibility among those involved.

There are several successful local collaboratives that address other public health issues that can serve as examples or models. These include:

- HIV Education: San Diego County HIV Prevention Community Planning Group;[30]
- Harm Reduction Coalition;[31]
- County of San Diego Suicide Homicide Audit Committee;[32]
- Regional Task Force on the Homeless.[33]

Culturally competent implementation

Recommendations to ensure the culturally competent implementation of a suicide prevention entity include:

- Include representatives from culturally diverse ethnic groups, LGBT, veterans, teenagers, seniors, and religious groups;
- Involve community members, key target populations, and consumers of services in the creation, implementation, and evaluation of entity effectiveness.

Ensuring success

To ensure the success of a suicide response/prevention entity, a broad representation of suicide prevention stakeholders need to be engaged in working towards this goal. These would include local suicide prevention organizations, as well as continued and/or additional representation from:

- Local government agencies;
- Community mental health services organizations;
- Other local community based organizations;
- Local help, crisis, and resource call lines;
- Hospitals and related associations;
- Mental health advocacy organizations;
- Business associations;
- Military and veteran service providers;
- San Diego area public school systems;
- San Diego area universities and community colleges;
- Local medical and psychological Societies;
- Local medical examiner/coroner.

US2. Promote effective clinical and professional practices

The need for effective clinical and professional suicide prevention practices was discussed throughout the action planning process. With regards to a focus on universal populations, education for primary care physicians and staff was identified as a top priority, given the high number of patients they encounter day to day. When considering a public health approach, primary care practices were identified as one of the best "points of first contact" to effectively screen and identify people at risk of suicide. It is recommended that training be developed and implemented to better prepare primary care practices to identify suicide risk factors and warning signs in their patients.

Training models for primary care practices are currently available (see previous SPRC sidebar, page 14); however, the model that best meets the needs of the San Diego community needs to be identified.

Evidence based, promising, or local models that can support this objective

Several best practice and promising models were identified for further consideration. These include:

- Screening, Brief Intervention and Referral to Treatment (SBIRT)[34] – a successful model currently used to screen, identify, and refer to treatment people at risk for alcohol problems that might be adapted and used to screen for depression and suicidal intent;
- Telemedicine and phone access support to ensure that remote populations can access screening and referral services;
- "Every contact" efforts – programs that require that all medical and social service providers to inquire about patient or client mood and suicidal ideation at each visit;
- Same day access programs – Building into programs the ability for people who are shown to be at-risk during screening to be seen the same day rather than wait for an appointment later;

Protective Factors for Suicide

Protective factors are quite varied and include an individual's attitudinal and behavioral characteristics, as well as attributes of the environment and culture. Some of the most important protective factors are outlined below:

- Strong connections to family and community support;
- Support through ongoing medical and mental health care relationships;
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes;
- Cultural and religious beliefs that discourage suicide and support self preservation;
- Effective clinical care for mental, physical, and substance use disorders;
- Easy access to a variety of clinical interventions and support for helpseeking.

**Courtesy of www.sprc.org*

- Physician Office Protocol Development Guide for Suicidal Patients[35] and Customized Information Primary Care Providers[36] - best practice programs for primary care providers, offered by the Suicide Prevention Resource Center (SPRC).

Additional recommendations include:

- Involve primary care practice staff and their professional associations in initial planning efforts to gain buy-in and shared responsibility;
- Expand the local Depression Screening Day[37] efforts to include periodic opportunities for broad screening and referral efforts throughout the year.

Culturally competent implementation

Recommendations to ensure the promotion of effective clinical and professional practices is inclusive and reflects the cultural diversity of the community include:

- Conduct outreach to minority and immigrant groups;
- Expand or replicate County prevention program strategies (e.g., Positive Solutions[38] and Elder Multicultural Access and Support Services (EMASS)[39] utilizes the promotora model).

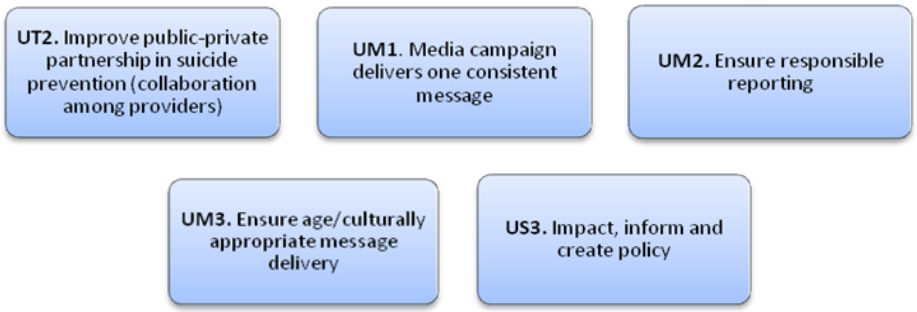
Ensuring success

In order to improve the suicide prevention efforts targeting clinical and professional practices, it is important to include:

- Physician and other primary care practice leadership;
- County leadership;
- Mental health organizations;
- Academia;
- Cultural/minority group leadership;
- School and college leadership;
- Faith-based leadership;
- Other organizations, including SPRC, organizations for retired people, and Older Women's League.

Additional Universal Objectives

Five additional objectives, not identified as priority, but nonetheless important to serve the needs of universal populations, are described below.



UT2. Improve public-private partnership in suicide prevention (collaboration among providers)

Strengthening public/private partnerships in suicide prevention efforts is critical to ensuring comprehensive representation. In order to successfully implement the strategies and objectives detailed in this action plan, both private and public sector entities must work together collaboratively. To strengthen public-private partnerships, it is recommended that:

- Efforts be dedicated to employer engagement, such as including universal suicide prevention messages in new employee orientation packets;
- A convening authority be identified that will continue to bring people together;
- Implementation of the universally adopted curriculum be made a practice standard that is included in employee orientation packets;
- A collaborative curriculum be developed to address private/public needs;
- Organizations share information about their own crisis intervention needs;
- Schools are included in the collaboration for possible implementation in high school.

UM1. Media campaign delivers one consistent message.

Building on the current efforts of the *It's Up To Us* campaign, the following recommendations are made to expand upon existing public education efforts. These include:

- Develop a Care for Others message;
- Use media to change the norms by identifying the root causes of suicide;
- Shift community norms so that mental health needs are addressed and discussed openly;
- Talk about suicide in a manner that is relevant to the population;
- Do not glorify suicide or portray it as romantic, normal, or heroic;

- Address relevant topics such as bullying, isolation, and self-esteem;
- Create value-based messages and speak to who is responsible;
- Include signs and symptoms as well as resources;
- Utilize Ambassadors and Champions and provide them with training;
- Involve multiple systems in messaging – public, private, faith-based;
- Use new media such as social networking websites, instant messaging, internet, cell phones, chat rooms;
- Use traditional media methods (i.e., newsroom, local television, print and social media outlets);
- Purchase media time.

UM2. Ensure responsible reporting

In addition to implementing a media campaign, several recommendations were made to encourage responsible reporting on suicide by the media. These include:

- Hold ongoing conferences for the media, as well as individual briefings for media outlets (i.e., Union Tribune newsroom, local television affiliates);
- Show these conferences on all major networks;
- Increase media awareness in handling suicide related stories;
- Recognize reporters and media outlets that provide appropriate coverage and related stories;
- Include personal stories;
- Change Public Service Announcement (PSA) timing to increase viewership;
- Utilize a wide variety of media such as television, radio, bus, newspaper, and mail;
- Establish an ongoing committee to address responsible reporting.

Community Health Improvement Partners (CHIP) and Suicide Prevention Action Plan Committee (SPAPC) Media Briefing

On Friday June 10, 2011, CHIP and SPAPC held a media briefing to provide recommendations for responsible reporting on suicide. Recently in San Diego County, several tragic events sparked increases in media coverage related to suicide; the media briefing was planned in response to this coverage. Media outlets were provided with *At-a-Glance: Safe Reporting on Suicide*, published by the Suicide Prevention Resource Center, as well as local resources to provide to the public during media coverage on suicide for individuals who might be experiencing crisis situations. A media subcommittee has been established through the SPAPC to continue these efforts.

The *At-a-Glance: Safe Reporting on Suicide* factsheet is available at:
www.sprc.org/library/at_a_glance.pdf

Local resources recommended to media outlets:
The Access & Crisis Line: 1-800-479-3339
www.up2sd.org

UM3. Ensure age/culturally appropriate message delivery

In order to increase the effectiveness of the media messages, the messages should be developed in an age and culturally appropriate manner designed to reach a wide audience.

To develop and deliver messages that are effective in reaching the community at large, it is recommended that:

- Messages are representative of appropriate age and cultural groups in the County;
- Existing models be considered in broadcast networks such as Spanish language television network;
- Language and themes that resonate with the community are used in messaging;
- A tool box be developed that media outlets can refer to when covering a suicide related story.

US3. Impact, inform and create policy

Suicide prevention efforts must also be addressed at a policy level. This might include changes to local laws or ordinances, or modification to existing system practices at hospitals or other service providers. Recommended policy issues to be addressed include:

- Changes to medication management to reduce the ability to overdose:
  - Reduce the number of over the counter pills sold in one bottle;
  - Reduce the number of prescription pills sold at one time;
  - Use health literacy friendly language on prescription labels;
  - Provide education about secure medication storage during discharge follow-up after a suicide attempt.[40]
- Review and consider ways to leverage existing or pending healthcare policy changes at the hospital level. For example, under changes in advance of the provisions of the Patient Protection and Affordable Care Act, healthcare providers will be penalized for unnecessary or repeat hospital admissions which drive up the national healthcare costs.[41] Those who treat and stabilize suicidal patients might be motivated to implement effective discharge education and planning to reduce preventable visits that are costly to them and place patients at risk.
- Build onto new policies to implement the collection of information to inform and address suicide prevention efforts. The Data and Program Evaluation Strategies section on page 51 provides recommendations for strengthening service and system evaluation efforts to ensure that data is used to drive improvements in suicide prevention.

23 Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health. *Reducing Suicide: A National Imperative.* Ed. SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney. Washington, D.C.: The national Academies Press: 2002.

24 Suicide Prevention Resource Center. www2.sprc.org/bpr/section-i-evidence-based-programs. Accessed June 2011.

25 Mental Health First Aid. www.mentalhealthfirstaid.org/cs/program_overview/. Accessed June 2011.

26 The Air Force Experience – Suicide Prevention. www.sprc.org/grantees/pdf/2006/dlitts_AirForce.pdf. Accessed June 2011. Also see: Air Force Suicide Prevention Program. Available at: afspp.afms.mil. Accessed June 27, 2011.

27 Be a Link Suicide Prevention Gatekeeper Training. (San Diego Chapter of Yellow Ribbon: www.yellowribbonsd.org) www2.sprc.org/sites/sprc.org/files/BeALinkSuicidePrevGatekeepeeTraining.pdf. Accessed June 2011.

28 Ask 4 Help Suicide Prevention for Youth.(San Diego Chapter of Yellow Ribbon-www.yellowribbonsd.org www2.sprc.org/sites/sprc.org/files/Ask4HelpSuicidePreventionYouth.pdf. Accessed June 2011.

29 Mental Health Ministries. www.mentalhealthministries.net/. Accessed June 2011.

30 HIV Education: San Diego County HIV Prevention Community Planning Group. www.sdhivprevention.org/. Accessed June 2011.

31 Harm Reduction Coalition. www.harmreduction.org/index.php. Accessed June 2011.

32 The Suicide Homicide Audit Committee (SHAC) was formed in 1994 by the County Health and Human Services Agency and comprised of members from community based organizations, education, juvenile justice, health, medical examiner's office, law enforcement, faith-based organizations, and the military. The goal of the committee was to identify the causes of, and develop solutions for prevention of youth suicide and homicide. From 1995 – 1999, the SHAC met monthly and reviewed more than 148 violent deaths of youth in the County ages 8-19 years reviewed and made recommendations to the County Board of Supervisors to improve prevention efforts.

33 Regional Task Force on the Homeless. www.rtfhsd.org/. Accessed June 2011.

34 Screening, Brief Intervention, Referral and Treatment. www.samhsa.gov/samhsanewsletter/Volume_17_Number_6/SBIRT.aspx

35 Physician Office Protocol Development Guide for Suicidal Patients. www.sprc.org/library/OfficeProtocolDevelopmentGuide.pdf. Accessed June 2011.

36 Customized Information: Primary Care Providers http://www.sprc.org/featured_resources/customized/pdf/primarycareprovider.pdf. Accessed June 2011.

37 National Depression Screening Day. http://www.mentalhealthscreening.org/events/national-depression-screening-day.aspx

38 Positive Solutions provides outreach, and mental health prevention and early intervention to homebound, isolated seniors 60 years and older from all cultural backgrounds who reside in North County and Downtown San Diego. Depression, PEI, Prevention and Early Intervention, Seniors, homebound seniors, problem solving therapy, PEARLS (Program to Encourage Active Rewarding Lives)

39 Provides culturally appropriate, peer based, outreach and engagement services to 800 seniors in San Diego County's Filipino, Latino, African American and African refugee communities. Services are designed to address mental health issues, prevention activities, and increase access to mental health care

40 Studies show that warning parents who have taken their child to the emergency room for a suicide attempt about suicide risks and providing education about reducing access to firearms, drugs and other means can reduce the likelihood of another suicide attempt. Kruesi, M. J. *Intervention Summary: Emergency Department Means Restriction Education (*2010*).* National Registry of Evidence-Based Programs and Practices. Web. 13 Dec. 2010. <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=15>.

41 Kaiser Health News. Julie Appleby. *Unnecessary Hospital Admissions Targeted By New Payment Plan.* 2010 Dec 07. http://www.kaiserhealthnews.org/Stories/2010/December/07/hospital-admissions.aspx.

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Selective Strategies

Selective Strategies

Selective strategies target high-risk groups that have a greater probability of becoming suicidal, and aim to prevent the onset of suicidal behaviors. This level of prevention includes screening programs, gatekeeper training for "frontline" adult caregivers and peer "natural helpers," support and skill building groups for at-risk groups in the population, and enhanced accessible crisis services and referral sources.

Overall Concepts for Selective Populations

Several key concepts frame selective suicide prevention strategies. These include:

- **Identification of available services and programs.** There is a need to better identify available suicide prevention services throughout the county. This information should be disseminated to both providers and the community at-large to help minimize duplication of services and fragmentation in service delivery, and to maximize resources.
- **Coordination of services and priorities.** Better coordination of services is important in serving high-risk populations. Current challenges to coordination include insufficient knowledge of available services and providers among community members, lack of inclusion in the planning process of non-behavioral health providers who come into contact with selective populations, and limited data to identify the protective and risk factors faced by these populations. It is expected that better coordination of services will inform the identification and prioritization of prevention strategies for those at-risk of suicide.
- **Expand the definition of "providers" to include those outside of behavioral health, and provide them with training, education, and support.** Within many at-risk populations, individuals seek support and crisis intervention services from trusted persons and entities outside of behavioral health. These include providers in faith-based, primary care, and education settings. It is important to expand the definition of provider so that these non-behavioral health providers are included in the conversation about the needs of the community and the resources available. To support the "no wrong door" approach to services, training and support should be offered to these providers. Additionally, recognizing the importance of non-behavioral health support in the community is vital step towards decreasing the stigma around mental health.
- **Include the voice of those who are being served.** For selective strategies to be successful, the voices of members of at-risk populations need to be included in the planning of training and interventions. Input is often not sought from at-risk groups such as youth, veterans, and identified cultural groups during these crucial planning steps.

Selective Strategies

Six objectives have been identified as key components in a comprehensive system of suicide prevention among selective populations. Organized into four strategy areas, these objectives are presented in Exhibit 5 and described in further detail below.

Exhibit 5: Overview of Selective Strategies

*Objectives identified as priority during the Summit are shaded in green.

Strategy Definitions

The following are descriptions of each of the four selective strategies.

- **Education (SE).** Building on the universal strategy of Universal Training (UT), recommendations to improve education to priority and identified at-risk populations are offered. This strategy capitalizes on community strengths, and should thus involve community stakeholders throughout the process; from development, to implementation, refinement, and evaluation.
- **Training for Providers (STP).** Additional training and support resources are needed for providers encountering clients and at risk for suicide. The definition of a provider needs to be expanded to include individuals and entities outside of the behavioral services sector, since for at-risk populations, the initial point of contact is often a community based provider or faith-based organization.
- **Skill Building and Training for Community Members/Clients (SSB).** Several recommendations are made for providing outreach and training to at-risk populations within their own communities. By utilizing the strengths and resources already available, it is recommended that skill-building programs be developed and/or expanded at the community level to provide tools for clients who may not access traditional mental health systems.
- **Utilization of Supportive Models (SSM).** Building off the previous strategy (SSB), it is recommended that supportive models be expanded based on existing community-based support systems to include peer support as a means of reaching at -risk populations. Special emphasis should be placed on the strong history that faith based communities have in the delivery of informal supportive and crisis support.

Priority Objectives

The three objectives identified as priority within selective strategies are:

SE1. Education is provided to priority communities and populations

The goal of providing information and education to the community at large is described throughout the action plan in efforts to increase the ways in which education is delivered to community members, consumers, and providers. Throughout the planning process, one focus of discussion was how to reach more people and provide the *correct* information. In order to successfully implement effective education, increased linkage is needed between providers working in the areas of suicide prevention and behavioral health to non-profits working with targeted at-risk or priority communities. In addition, significant effort needs to be made to increase the working relationships with schools, since they are a point of access to at-risk youth. There is also a need for increased collaboration with community organizations working to provide mental health advocacy due to their strong relationships in local communities.

The type of information that should be included in education to priority communities and populations include:

- Stigma reduction;
- Myths and facts about suicide;
- Resources and information.

To successfully implement suicide prevention education in high-risk populations, appropriate partners, staff educators, and methods for outreach and education must be included. Educators should represent the population to be served, and match as closely as possible on factors such as age and cultural background.

In an effort to create a system that educates and informs itself, it is also recommended that training provided by and to community members be used to inform County sponsored trainings.

Evidence based, promising, or local models that can support this objective

Best practice models and promising local programs share the following key elements:

- Messages and education are targeted to a specific population;
- Partnerships are developed to foster increased access to target populations;
- Members of the target population are included in the development and dissemination of information and education.

Recommendations from best practice models and promising local education programs include:

- Clearly define at-risk and priority populations so that education can be tailored to meet their needs;
- Use technology for greater reach, especially among youth;
- Use age and/or culturally matched educators and outreach and education staff when appropriate and available;
- Ensure that education is culturally and linguistically appropriate.

Culturally competent implementation

Recommendations to ensure the culturally competent implementation of education to priority communities and populations include:

- Culturally match education to the target groups or populations;
- Require providers to participate in cultural competency training;
- Gather input from the community and their various cultural groups throughout the process (i.e. input is needed during development phase for the education, and consumer evaluations should be completed on the quality of the materials);
- Prioritize the involvement of youth to accurately capture the youth voice and have them assist in the development of youth targeted material;
- Involve cultural brokers and allies to support community priorities and to appropriately "translate" the content to the target population;
- Consider the role of culture in the discussion of suicide myths and facts and appropriately address the real myths for each community;
- Consider broad definitions of culture and vulnerable populations when determining specific interventions for selective populations.

Ensuring success

In order to ensure the success of providing education to priority populations, the following groups need to be involved:

- A County presence from Health and Human Services Agency;
- Representatives from each of the identified priority or high risk populations;
- Youth;
- Faith-based organizations;
- Social service providers;
- Primary care providers;
- Educational institutions at all K-12 levels in addition to colleges and universities.

Groups with increased rates of suicide include whites, older men, and divorced or widowed individuals

Additionally, individuals already viewed as leaders in mental and behavioral health should be included due to their significant experience and expertise.

STP1. Training is developed and implemented for front line professionals and first responders

In the context of suicide prevention, the definition of front line provider needs to be broadened to include those people providing support outside of the behavioral health system. This may include individuals in faith communities, support staff at community agencies, and other staff within community organizations who have strong connections to underserved populations.

Standardized training for front line providers needs to be identified and made available, and an ongoing conversation needs to ensue about expectations of these providers. In some cases, front line providers are in a position to link and refer clients to suicide prevention resources, and thus need accurate information about the resources that are available in the community. However, in other settings and underrepresented communities, front line providers are often called upon to provide an intervention. These providers, in particular, also need the support to provide appropriate interventions when necessary. Current suicide prevention programs with staff who are not mental health licensed professionals should be examined and their training curricula adapted, modified, or strengthened to create a standard training model for San Diego County.

Evidence based, promising, or local models that can support this objective

Recommendations from evidence based and local models for training for front line professionals and first responders include:

- Develop material for each specific high risk population;
- Provide acute intervention;
- Engage "cultural brokers" (an ambassador or representative from the community);
- Use mental health professionals to provide crisis services;
- Use existing evidence-based and best practice guidelines identified by the Suicide Prevention Resource Center;[42]
- Broaden the definition of first responder to make current trainings available to more people;
- Deliver trainings to volunteers and staff that provide them with support resources and consistent messaging.

Culturally competent implementation

Recommendations to ensure the culturally competent implementation of training for front line professionals and first responders include:

- Require culturally competency training that is provided in different languages;
- Use technology to increase ways in which training is provided (such as via the internet);
- Provide education about the common reactions to work related stress and burnout and help support staff impacted by suicide in all settings.

Ensuring success

Partners that should involved to ensure success with the implementation of training for front line professionals and first responders include:

- County Board of Supervisors;
- County Sheriff and Police Chiefs;
- Fire Chiefs;
- Key decision makers involved in establishing funding;
- Advocates including Champions from within County leadership at Health and Human Services Agency;
- School Board Members and District Superintendents.

SSM1. Utilize supportive models for early intervention among identified populations

Peer-to-peer support models need to be expanded and legitimized to address mental health concerns. Not only are peer-to-peer support models more representative of the communities they serve, but they are often seen as less stigmatizing for consumers. Support group models with established roots are already held in community settings, and can be built upon to provide early intervention for high risk populations. Additionally, there should be special consideration placed on the strong history of support through faith based organizations. Faith-based support models have been in place informally and continue to serve the needs of many people who are reluctant to seek services through the traditional behavioral health system.

Conversations about how to help at-risk community members through informal systems are already taking place; however, there is little communication between the informal systems of support available at the community level, and the behavioral health system. To better facilitate this communication, support models need to be granted legitimacy so they are viewed as equal players in suicide prevention efforts.

Collaboration and partnership is crucial to serving the needs of populations at high-risk for suicide. As people are seeking services from informal systems, there may come a time when the informal structure is not able to meet the needs of the person. Establishing partnerships between informal and formal support systems will aid in the provision of appropriate referrals to the behavioral health delivery system. San Diego County should be prepared to assist community level first responders when the provision of support, encouragement, and coping skills are not enough, and a more intense level of intervention is required.

Evidence based, promising, or local models that can support this objective

Several local supportive models were identified throughout the planning process as possible models for replication. Some of these supportive models are already serving people with mental health challenges, but others are provided as best practice opportunities.

Key elements of successful supportive models include:

- Peer-to-peer support;
- Relationship-based;
- Less formal structure;
- Familiarity;
- Cost effective;
- Capacity built within a community, so level of education and/or income is not prohibitive.

Supportive models already in place include:

- Alcoholics Anonymous (AA) model;
- Faith-based support programs;
- Spiritual models of support;
- Promotora model;
- Medical support models;
- Peer-to-peer models;
- Gatekeeper models;
- Parent to parent;
- Partner in Wellness;
- Recovery Coach model;
- Mobile health unit model.

In San Diego County, more than three out of every four suicides were among males, and nearly half of all suicides were among persons ages 45-64 years.

Culturally competent implementation

Key recommendations to ensure that supportive models are implemented in a culturally competent manner include:

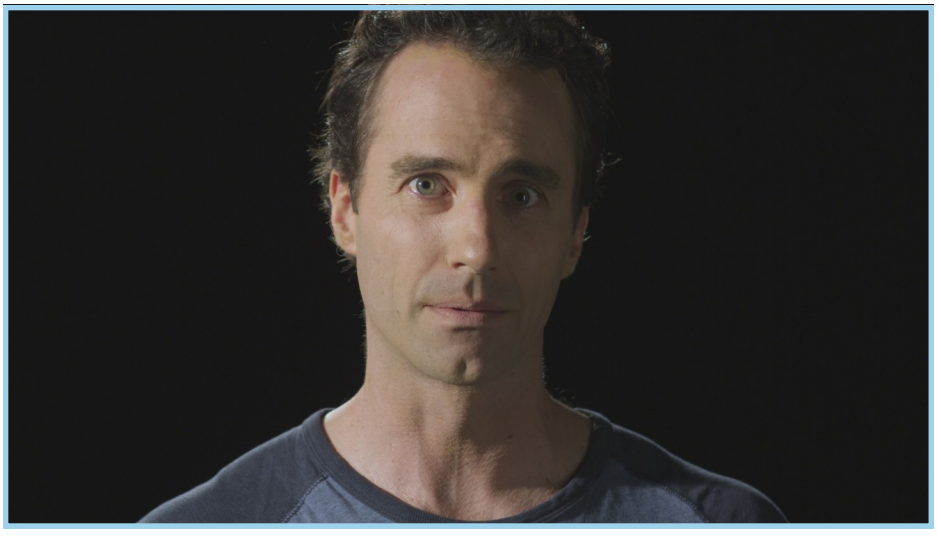
- Provide the supportive model programs in a safe and non-judgmental environment;
- Address the differing cultural views and/or perceptions of suicide;
- Provide community based implementation to gain community buy in;
- Use peers when developing supportive models to reduce stigma;
- Deliver in neutral community settings.

Ensuring success

In order to ensure the successful implementation of supportive models the following people need to be involved:

- Alcoholics Anonymous (AA) leaders;
- Respected community leaders;
- Promotoras from the community;
- Faith-based leaders;
- Champions of the mental health field, including local celebrities;
- General society defined "heroes and heroines" to create buy in and to give legitimacy;
- Healthcare providers.

Additionally, it was recommended that a conversation occur about how services provided by supportive models can be legitimized into the County system, and how they might be included more formally into the billing structure.



Additional Selective Objectives

The following provides descriptions of additional objectives recommended to best serve selective populations.

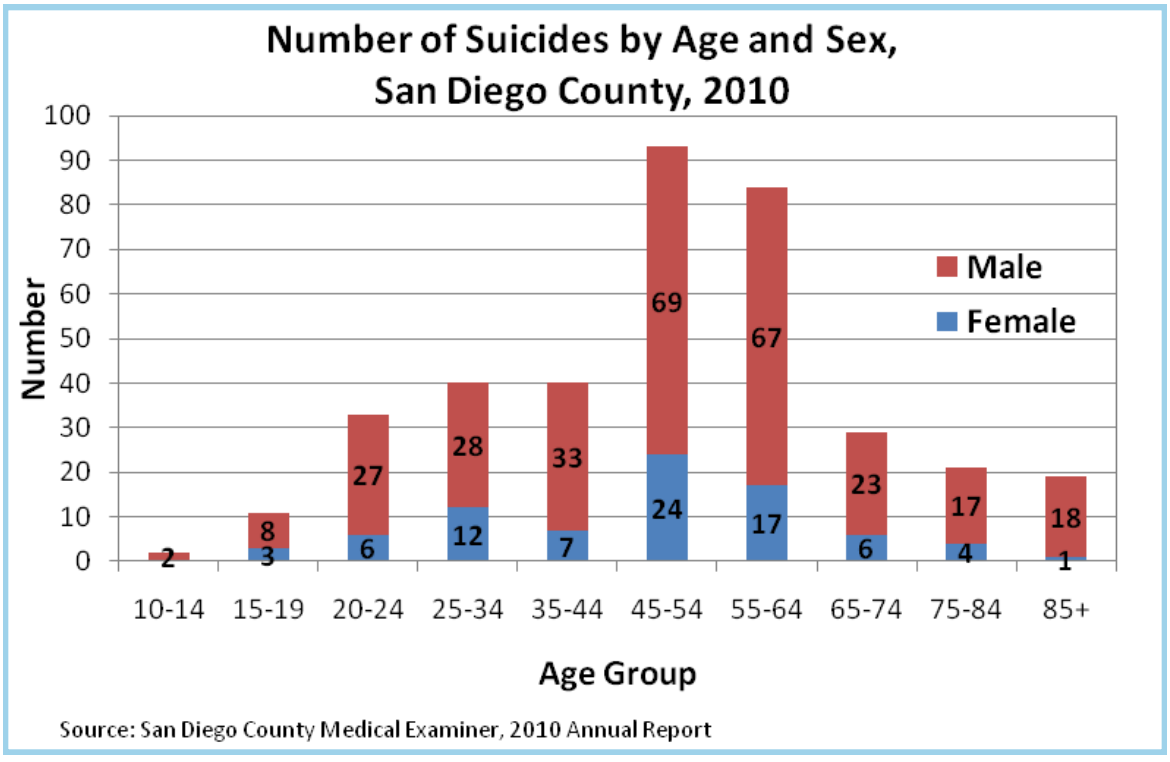
STP2. Address secondary trauma among providers

SSB1. Implement skill building workshops or services for community members

SSM2. Increase use of alternative interventions and therapies

STP2. Address secondary trauma among providers

Practicing mental health and community health providers who work with high risk populations need to be provided support, training, and other resources to ensure they feel successful and supported in their jobs. Providers working with high risk populations frequently experience "burnout" as a result of working with so many clients in crisis. Additional support should be identified and made available to providers throughout the county. This is especially true for front line workers who deal with clients in crisis on a regular basis. This objective builds on the previously identified objective of training (STP1) that should be made to better equip providers to deal with patients in crisis.



SSB1. Implement skill building workshops or services for community members

The implementation of skill building workshops is intended to provide education for the development and strengthening of coping and relationships skills. By providing instruction in these skills, community and service providers can offer educational interventions to at-risk communities that are unable to access mental health services. Often, the qualifying criteria to obtain mental health services include only those with significant symptomology. This excludes a significant proportion of the population who may be functioning below their desired level and could benefit from skill building.

Another key idea related to skill building workshops is the ability to teach concrete and effective skills to community members, in a manner that will help community members better identify symptoms and risk factors for suicide. This also reflects the need to expand the definition of front line providers to include community members. Many of the people who would receive training are also those that may lead skill building workshops, since they are already viewed as leaders in their communities. It is important to work with these community leaders, as they may act as cultural brokers, giving legitimacy to the services and interventions being offered. There are several existing models using cultural brokers, community leaders, and promotoras to provide education and build capacity in the community for other public health issues. These existing models should be reviewed to determine how they might be expanded to include mental health and specifically suicide prevention.

SSM2. Increase use of alternative interventions and therapies

The use of alternative interventions and therapies should be considered as a way to provide intervention and to engage communities and individuals who might be reluctant to seek traditional mental health services. While these might not be adopted as therapies, it is important to consider their use in outreach, engagement, and retention of clients.

42 Suicide Prevention Resource Center. www.sprc.org/ Accessed June 16, 2011.

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Indicated Strategies

Indicated Strategies

Indicated strategies target high-risk individuals that exhibit early signs of suicide potential. Programs are designed and delivered in groups or individually to reduce risk factors and increase protective factors. At this level, programs include skill-building support groups, case management for individual high-risk individuals, and referral sources for crisis intervention and treatment.[43]

Overall Concepts for Indicated Populations

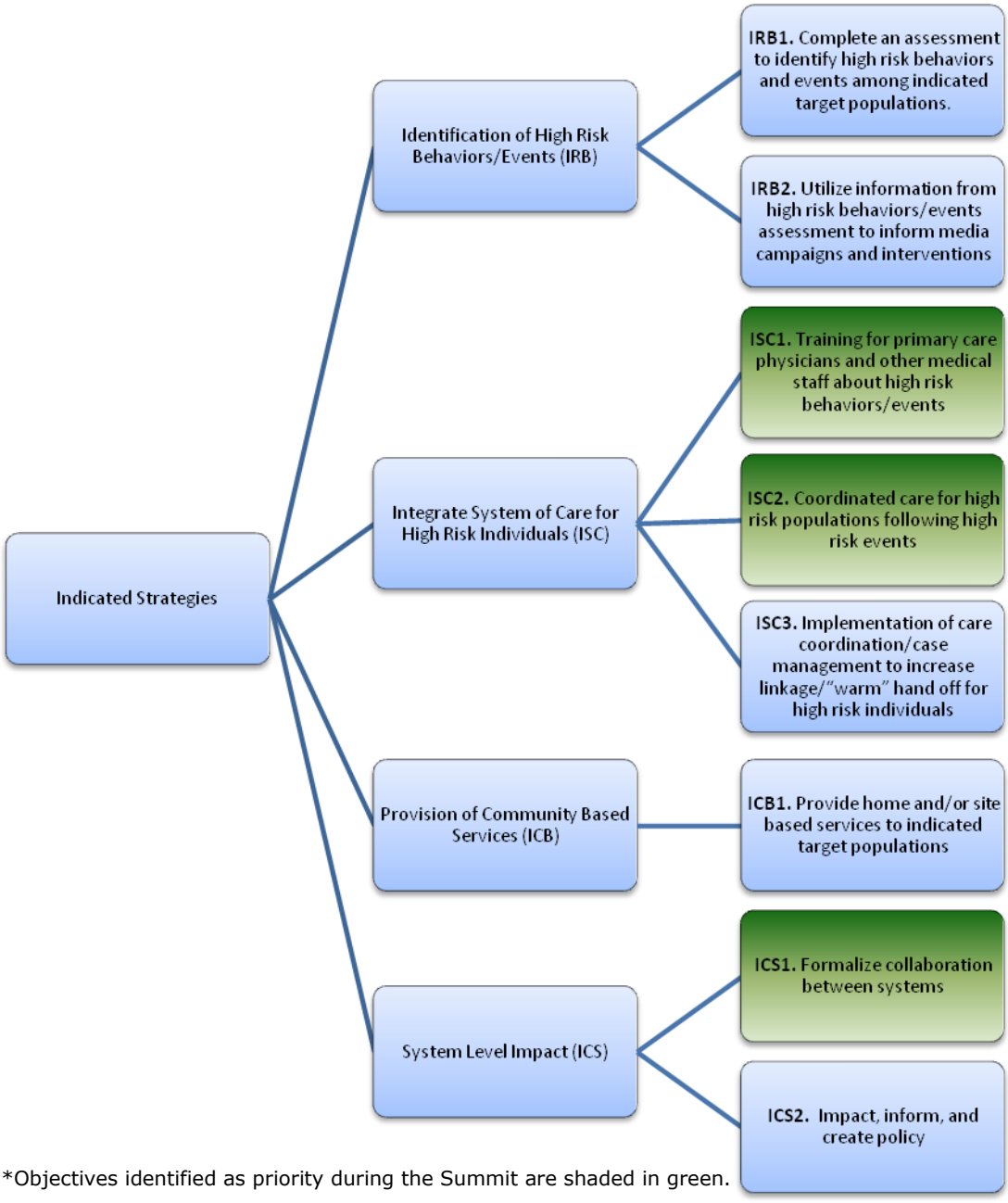
Several key concepts frame indicated suicide prevention strategies. These include:

- **Coordination of services.** Improved coordination of services is critical to a successful system of intervention when serving high-risk individuals. Current challenges to coordination include capacity of the current technology infrastructure, limits of confidentiality, and the service seeking patterns of high utilization clients.
- **Incentives to Collaborate.** To achieve effective coordination of services, formal collaboration is needed; incentivizing this collaboration among providers is vital to ensuring full participation from diverse stakeholders. Providers should be informed and provided information that describes the "pay-off" of collaboration. It is important to target the incentive to the appropriate audience. For example, organizations that need to see a financial benefit to collaboration will need cost benefit data or details of other economic benefits.
- **Utilization of best practices for data collection and data quality assurance.** Currently, there are several data reporting requirements in existence in San Diego County for public health issues. It is recommended that these be expanded upon to include suicide and suicidal behaviors and actions.
- **Review the success of current model programs to identify and develop accurate guidelines for data collection and data quality.** Increases in the amount of data and improvements in the accuracy of data available locally can help better target services to identified clients. Several examples exist locally and nationally (Self Directed Violence Surveillance[44] and Veteran's Affairs[45]) of guidelines for how to use data to inform programs; however, the data available may not be complete enough to fully inform suicide prevention efforts. It is recommended that there be further assessment on the need for additional data.

Indicated Strategies

Eight objectives have been identified as key components in a comprehensive system of suicide prevention among indicated populations. Organized into four strategy areas, these objectives are presented in Exhibit 6 below, and described in further detail beginning on page 39.

Exhibit 6: Overview of Indicated Strategies



*Objectives identified as priority during the Summit are shaded in green.

Strategy Definitions

The following are detailed definitions of each of the four indicated strategies.

- **Identification of High-Risk Behaviors/Events (IRB).** To effectively target intervention services to high-risk individuals, high-risk behaviors/events must be appropriately identified. Current available data identifies some high-risk events for individuals, including discharge from a hospital after a suicide attempt, and diagnosis of a chronic medical condition. However, more needs to be known about the high-risk behaviors and events in all target populations, since they may not be the same across various cultural groups and sub-populations.

- **Integrate the System of Care for High-risk Individuals (ISC).** Integration of the system of care for high-risk individuals should be continued. Current collaborative relationships are often negatively affected by issues of privacy, confidentiality, and difficulty accessing multiple systems and providers. Additional work needs to occur at the local level to address barriers to an integrated system.

- **Provision of Community Based Services (ICB).** For high-risk individuals, there are numerous barriers to accessing traditional mental health services. For example, transportation and stigma were identified as two priority barriers to be addressed. Recommendations for overcoming these barriers include providing mental health services in the client's home, at community centers, primary care clinics, and other sites that are central to a community.

- **System Level Impact (ICS).** For indicated populations, collaboration on suicide prevention efforts will be most effective if approached from the system level. Relationships and interactions between community members, consumers, providers, and community leaders need to be fostered and strengthened. In this strategy, recommendations are made for ways to strengthen these collaborative relationships so that high-risk individuals can be better served by system level collaboration.

Priority Objectives

The three objectives identified as priority within indicated strategies are:

ISC1. Training for primary care physicians and other medical staff about high-risk behaviors/events

Primary care physicians were identified as the service providers who have the greatest potential for interaction with high-risk individuals, particularly those not already identified by the mental health system. The importance of providing training to primary care providers and other medical staff was highlighted throughout the planning process, as was the importance of ongoing opportunities to deliver training. Education is needed for these front-line providers so they are able to identify high-risk events, and provide appropriate intervention to patients exhibiting high-risk behaviors[46]. High-risk events include recent medical diagnosis, and discharge from emergency departments and medical or psychiatric inpatient hospital settings. These trainings should include screening and assessment education so that physicians are prepared to assess clients for suicidality following a high-risk event.

Evidence based, promising, or local models that can support this objective

Best practice models and promising local programs share the following key elements:

- High-risk individuals are clearly defined;
- Training reaches medical professionals and support staff in addition to the primary care physician (PCP);
- Training is provided frequently with opportunities for ongoing training.

Recommendations from best practices and local models for training for primary care physicians and other medical staff about high-risk behaviors and events include:

- Use technology to increase access to information about high-risk individuals, and define the high-risk patient population by using this in-house data;
- Provide resources and educational information;
- Establish concrete guidelines for providing interventions to high-risk individuals;
- Provide specific suicide prevention training rather than including suicide prevention in other trainings;
- Implement a comprehensive suicide prevention training program that also involves monitoring;
- Provide training specifically on suicide risk assessment;
- Embed the mental health model in physical health settings to help reduce stigma;
- Implement strategies, including incentives for collaboration, to increase and support the collaboration between mental health and physical health providers.

Strengths of current models or programs:

- Comprehensive data systems that allow for increased data and information sharing;
- Data and information sharing, allowing for clients to be monitored more closely;
- Use of technology to increase access to information and resources;
- Audits and internal monitoring to increase the accountability of primary care physicians and other medical staff.

Culturally competent implementation

To ensure training for primary care physicians and other medical staff about high-risk behaviors/events is implemented in a culturally competent manner, the following should be considered when developing the training:

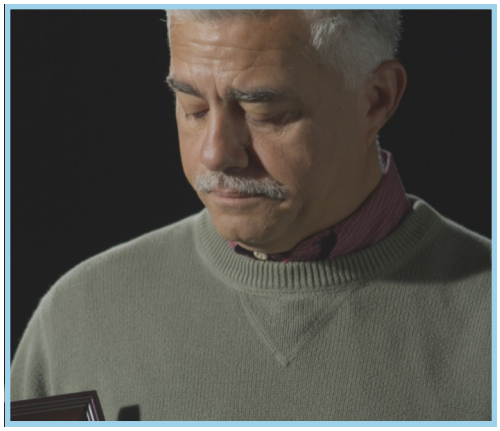
- Materials and other information needs to be developed in a culturally competent manner;
- Information delivered in the trainings must be relevant to the high-risk groups identified at the primary care practice;
- Address language barriers and how to overcome with patients (i.e. use of interpreters);
- Training should include how to engage with various cultural groups identified as high-risk;
- It should be suggested that appointments are longer in order to accommodate the additional mental health assessment by physicians;
- Differing cultural beliefs related to suicide and suicide risk factors should be included in the training;
- Include a component about communication styles of various identified high-risk groups including cultural differences;
- Consider implementing screeners that target specific high-risk individuals, and ensure that these screeners are reliable and available in multiple languages;
- Include how to talk about suicide in a manner appropriate to the identified high-risk groups.

Ensuring success

One of the key concepts described previously in this section is the importance of incentivizing collaboration. This is a key recommendation for all indicated strategy objectives. For this objective in particular, the following persons need to be involved:

- Primary care physicians and medical employees (both public and private);
- Information technology (IT) support – Data systems must be capable of capturing and reporting needed data;
- Competency Evaluator – someone within the system to ensure that the training is being provided and that assessment are being completed by primary care physicians and identified staff;
- Public and private partner leadership.

ISC2. Coordinated care for high-risk populations following high-risk events



There is a great need for improved coordination of care for high-risk individuals following high-risk events. Currently, following a patient through the mental health system is challenging due to many factors, including patients switching providers, seeking services from multiple providers, receiving services within both the public and private service delivery systems, and confusion about the legality and propriety of sharing of confidential information. Formalized coordination between outpatient providers and hospital staff or discharge planners may save a life by ensuring ongoing support.

Coordinated care includes those services that provide continuity of care for high-risk individuals following high-risk events. Coordinated care following an inpatient psychiatric hospital discharge is particularly important. This has been identified not only as a high-risk time for suicide attempt, but also because these recommendations have already been in place at the local level. However, there has not been enough time to support their successful implementation.

This local strategy reflects the goals of the National Strategies for Suicide Prevention. As stated in *Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead,* "One of the most common, and perhaps detrimental, examples is suicidal patients who are treated in emergency departments. In this setting, patients generally don't receive adequate treatment to address underlying mental illnesses or substance use problems, nor do they leave connected with the kind of follow-up outpatient care that could expedite their recovery."[47] San Diego County service providers believe that coordinated care should be a local priority for improving care for high-risk individuals.

Evidence based, promising, or local models that can support this objective

Evidence based models and practices to support this priority objective include:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)[48] model;
- Perfect Depression Program[49] – Henry Ford Health System;
- Discharge planning and coordination;
- Coordinated follow-up care using appropriate methods of communication with the patient;
- Assertive Community Treatment[50];
- Use of peer specialists;
- Improved data collection to track patient connections to ongoing mental health services following a psychiatric hospital discharge, or hospital discharge following a suicide attempt.

Additional recommendations from evidence based and local models for coordinated care for high-risk populations following high-risk events include:

- Implement the SBIRT model more widely to reach more clients and provide appropriate intervention;
- Support the integration of physical and mental health services to increase coordination of services for clients;
- Provide follow-up contact using the approach that best fits the client. This may include phone, internet, mail, in-person contact, or use of other providers as liaisons;
- Establish and maintain relationships between mental health and primary health providers;
- Expand and support the role of the discharge planner in hospital settings to allow for time dedicated to linkage;
- Expand and support the use of outpatient provider time to work more closely with discharge planners;
- Consider the use of peer specialists to support the transition from inpatient to outpatient care (See text box below);
- Expand the use of Assertive Community Treatment, which works with high-risk, high utilization populations.

The New York Association of Psychiatric Rehabilitation Services, Inc.
Peer Bridger Program

In 1994, the New York Association of Psychiatric Rehabilitation Services, Inc. (NYAPRS) received funding from the New York State Office of Mental Health to implement a demonstration project *aimed at helping individuals with long or repeat state hospital stays to make successful transitions back into their home communities.*

NYAPRS Peer Bridger Project provides four primary service interventions:

- *engagement in a uniquely personal, positive supportive relationship with a peer;*
- *involvement in an array of Peer Support Meetings located both in the hospital, and following discharge, in the community;*
- *linkage to a broad range of community-based service and natural supports;*
- *teaching community adjustment and wellness self-management skills.*

The NYAPRS Peer Bridger Program was identified as a promising model for San Diego County. Service providers who work with high-risk population identified the need for more peer to peer involvement and recommend that this model be considered locally. Additionally, this program was expanded into private healthcare with a Mental Health Administrative Service Organization partnering to implement the program with identified clients.

This information and additional details are available at www.nyaprs.org/peer-services/peer-bridger/.

Strengths of current models or programs include:

- Behavioral health outpatient providers are already reaching out to hospitals. The recommendations for this objective promote strengthening these relationships and formalizing the collaboration;
- County guidelines already require a client discharged from an inpatient hospital be seen again within 72 hours. These recommendations support this mandate and provide additional resources to strengthen the linkage;
- As with the previous objective, which recommends training for primary care physicians and other medical staff about high-risk behaviors/events (ISC1), systems with integrated mental health and physical health services already in place are able to share more information, allowing for greater coordination;
- Consider a way to use the Single Accountable Individual (SAI), a designation in the current behavioral health data system to improve communication and linkage.

Culturally competent implementation

To ensure the culturally competent implementation of coordinated care for high-risk populations following high-risk events, the following considerations should be made:

- Providers need education and training on effective ways to support the coordination of care;
- Coordinated care training could be built into existing cultural competency training requirements, and provided via the current system;
- Outreach and follow-up care should be provided by other staff members, not only clinicians;
- Follow-up and linkage services should be provided by a person who is a cultural match to the client;
- Expand staffing to ensure a cultural match for each client identified as high risk for suicide.

Ensuring success

One of the key concepts identified previously in this section was the importance of incentivizing collaboration. This is especially important when working to coordinate care for high-risk individuals following high risk events. Additionally, the person or position responsible for coordination of care should be well defined within the organization providing care. Currently, there is confusion about whether this is the role of the discharge planner or the outpatient provider. A consistent definition across the system would help to alleviate this confusion. Others who need to be involved are:

- Peers;
- Family members;
- Hospital representatives;
- Mental health administrative service organizations;
- Outpatient providers;
- County leadership;
- Governing body to oversee efforts;
- Leaders of local agencies that provide services to high-risk individuals;
- All agencies working with high-risk individuals, in order to coordinate both services and systems.

ICS1. Formalize collaboration between systems

One key success of the process for the development of the Suicide Prevention Action Plan was the networking and collaboration between service providers on the topic of suicide prevention. This opportunity for informal collaboration led to in-depth discussions about the need for formal collaborations in order to strengthen the system for high-risk individuals.

> **"Alone we can do so little; together we can do so much."**
> *-Helen Keller*

Formalizing collaboration would support improved data sharing and service coordination by providing for:

- Sharing of individual level treatment data;
- Sharing of hospital or system level data on high-risk behaviors/events;
- Sharing of patient discharge information from hospitals.

Evidence based, promising, or local models that can support this objective

Several local models of collaboration have been successful in working with confidential information and high-risk or vulnerable populations.

Key elements common to successful collaborations include:

- A small group of partners begins work on the collaborative; once a mission and vision are developed, additional partners can be recruited;
- Partners must share a common vision, and define the goals, objectives, and purpose of their collaboration;
- Partners should formalize an agreement or memorandum of understanding with data security safeguards well-defined.

Additional recommendations from evidence based and local models for formalizing collaboration include:

- Review and consider the collaborative model developed by the County of San Diego, Aging and Independence Services for fall prevention;
- Partners in the collaborative should receive education about privacy rights and limitations in order to work within the guidelines of the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA);
- Review local models for working with vulnerable populations, such as foster children, that have been recognized nationally;
- Formalize the collaboration with the use of Memorandums of Understanding or Interagency Agreements.

Culturally competent implementation

Key recommendations to ensure that formal collaborations are inclusive, reflect the cultural diversity of the community, and are implemented in a culturally competent manner include:

- Agencies, service providers, and community members must all buy into the importance of the collaboration, including the vision, mission, objectives, and purpose;
- Use common tools to assess and identify high-risk individuals, so that collaborative partners are able to better identify their targets;
- Develop a sub-committee of the collaborative from the beginning stages to ensure cultural competency.

Ensuring success

To ensure the success of a formal collaborative, all partners need to have a passion for collaboration, and the community must be willing to work together to solve the problem. Continued success of collaboratives is often based on the perception of successful "rallying" of the community to achieve their goals.

Partners needed to achieve this success include:

- Key decision makers in the community;
- Behavioral health providers;
- Primary care providers;
- Community based organizations;
- Patients and community members;
- Data experts;
- County leadership;
- Leadership of local agencies providing services to high-risk individuals.

"A community is like a ship; everyone must be prepared to take the helm"
-Author unknown

Additional Indicated Objectives

Five additional indicated objectives were recommended to best serve high-risk individuals.

IRB1. Complete an assessment to identify high-risk behaviors and events among indicated target populations

Further identification of suicidal risk factors among high-risk populations is needed. Although risk factors for the general population and some target populations such as middle-aged men and older adults have already been identified, risk factors of all high-risk populations need to be better identified in order to develop appropriate interventions. Risk factors for the general population and more specific risks for target populations can be found in the Needs Assessment Report, *What is Known About Suicide in San Diego County*.[51]

High risk events include psychiatric hospital discharge, divorce, job loss, and loss of a loved one, among others.

Additional recommendations include:

- Assess methods of communication and the use of technology for all target populations, and develop interventions based on this assessment;
- Identify the appropriate means of assessment for each population. In other words, how do we reach them in a culturally competent manner;
- Identify a funding source or lead organization for this effort;
- Consider using clinicians already working with high-risk individuals to complete these assessments;
- Billing requirements would have to be modified due to the additional role for clinicians.

IRB2. Utilize information from high-risk behaviors/events assessment to inform media campaigns and interventions

Information collected through suicide risk assessments should be compiled and used to inform media campaigns and the development and implementation of targeted interventions for high-risk individuals. This information could also assist in the development of trainings, treatment guidelines, and skill-building interventions, as well as for safety planning.

ISC3. Implementation of care coordination/case management to increase linkages/warm hand-off for high-risk individuals

The implementation of care coordination, or case management, is recommended for high-risk clients who might not be able to seek appropriate care even if the system itself was more formally coordinated and improvements were made in communication. Priority should be given to persons discharged from a hospital or emergency department after a suicide attempt. The purpose of this is to ensure that high-risk clients make it to the next level of appropriate care.

With high-risk clients not already receiving mental health services, there should be a focus on building a relationship with the client, and ensuring the case manager or case coordinator can relate to the cultural background of the client. There could be numerous barriers of access for high-risk clients. Programs and providers should address barriers with their clients so they are better able to navigate the system. Due to the long-term needs of high-risk clients, case managers should provide ongoing follow-up and referral to long-term care resources as the client ages in the system.

ICB1. Provide home and/or site based services to indicated target populations

Two primary barriers to care for high-risk individuals were identified by this objective:

- Transportation. Older adults and residents of rural San Diego County communities, in particular, have difficulty accessing services due to transportation issues;
- Stigma. There is a stigma attached to going to a dedicated mental health location for services.

Mandating home visits for high-risk individuals, especially older adults, and co-locating medical and mental health or psychiatric services were two recommendations made to overcome the barriers described above. Co-locating services would likely increase the frequency of completed follow-up appointments by patients, and improve communication between behavioral and physical health providers.

With the expansion of home-based and co-located services, it would be necessary to improve provider education on home-based modalities of service. The provision of home-based services is population specific, and should not be applied as broadly as other objectives. Recommendations for implementation include the prioritization of target populations:

- Rural communities;
- Older adults;
- Psychiatric home health population. Clients with chronic mental health disorders who are also receiving treatment for chronic physical illness such as renal failure, diabetes, etc.

ICS2. Impact, inform, and create policy

It was recommended that efforts continue to encourage firearm safety and medication management. Specifically:

- Increase safety campaigns around firearm safety;
- Reduce the number of over-the-counter pills sold in one bottle;
- Reduce the number of prescription pills sold at one time;
- Provide education about means restriction for those being discharged from a hospital or emergency department after a suicide attempt.

43 Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health. *Reducing Suicide: A National Imperative*. Ed. SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney. Washington, D.C.: The National Academies Press: 2002.

44 Self Directed Violence Surveillance. www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf. Accessed June 2011.

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Data and Program Evaluation Strategies

Data and Program Evaluation Strategies

To address suicide as a public health problem, a sustained and systematic collection, analysis, and dissemination of accurate information on the incidence, prevalence, and characteristics of fatal and non-fatal suicidal behavior is needed. Effective and coordinated suicide surveillance allows for realistic priority-setting, facilitation of the design of prevention programs, and the ability to evaluate these programs.

When developing universal, selective, and indicated strategies to inform the Action Plan, the importance of accurate and up-to-date research and data collection emerged across all three strategies. Rather than imbed data and program evaluation related strategies into each prevention level, they are presented independently in this section to guide future discussions of how to build upon current local research and data collection efforts to construct meaningful indicators that can be monitored over time.

Thus, this section provides an overview of the recommended strategies and objectives to improve our local research and data collection system, in order to strengthen the identification of suicidal risk factors, protective factors, and high risk groups, and the evaluation of local suicide prevention efforts.

Overall Concepts for Data and Program Evaluation Strategies

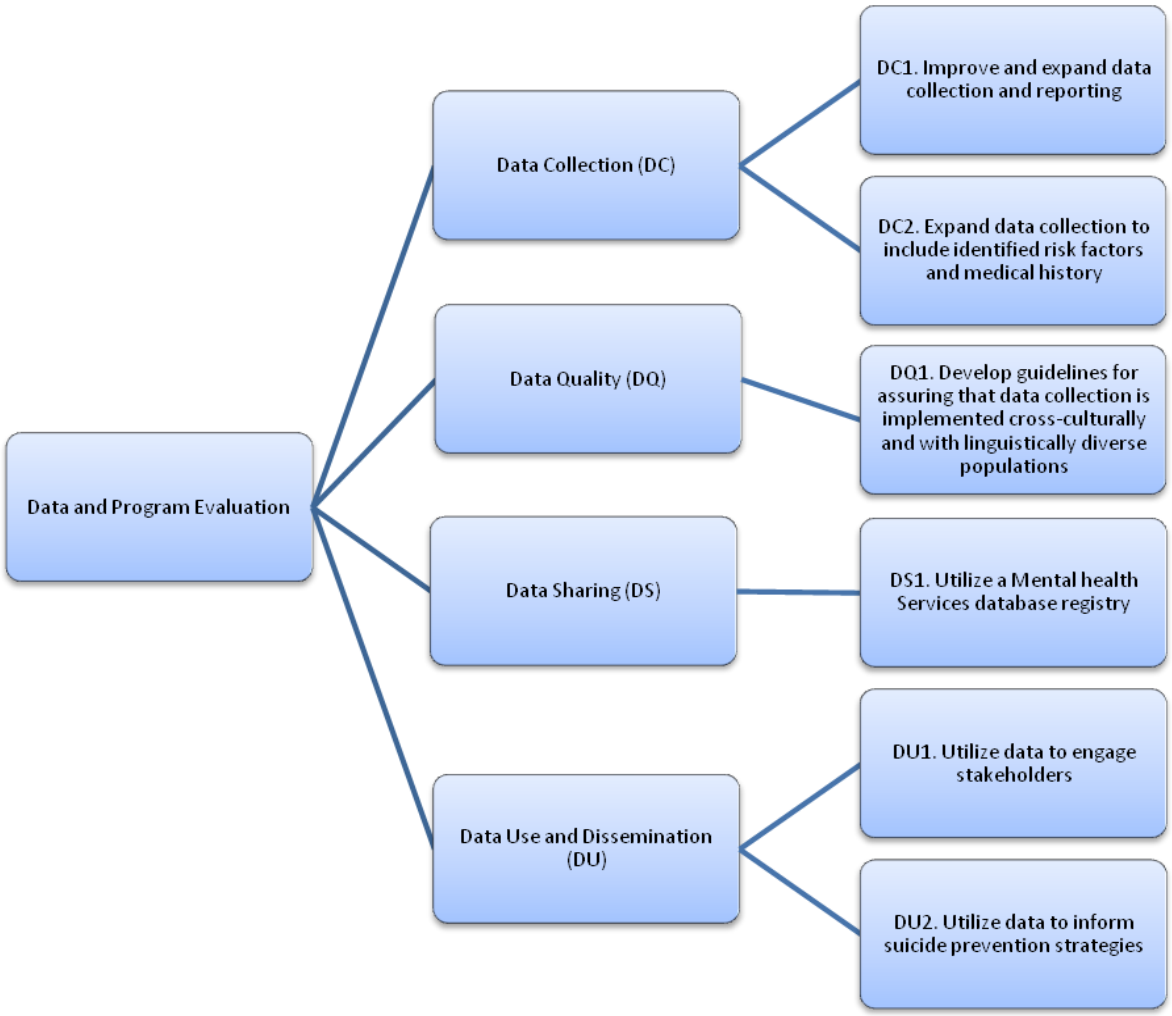
Several key concepts frame data and program evaluation strategies. These are:

- **Strategies are interdependent.** The data and program evaluation strategies presented here must all occur to build a successful suicide and suicide prevention data system. In other words, each step is dependent on the preceding ones. For example, data quality cannot be fully assessed until all necessary data elements are collected. Additionally, data cannot be fully utilized to inform program design if vital data elements are missing.
- **Cross-sector involvement is vital.** While the importance of accurate data and program evaluation was evident throughout the planning process, discussions were somewhat limited in that there were few participants who were well-versed in data collection, quality, or utilization. In order to effectively implement data and program evaluation strategies, it will be critical to include cross-sector partners who have expertise in research and data, as well as suicide and suicide prevention best practices. This includes representatives from sectors that provide suicide surveillance data such as County Emergency Medical Services (EMS), hospitals, mental health service providers, and others.
- **Additional refinements are needed to move forward.** The strategies presented here are offered as a framework for a robust data collection and utilization system. In order to build effective strategies for research and data, additional planning will be needed. Conversations need to occur with key stakeholders to develop action steps for moving each objective forward.

Summary of Data and Program Evaluation Strategies

Four strategies were identified to create a comprehensive local process for monitoring relevant data pertaining to suicide and suicide prevention, inform efforts in an ongoing way to improve programs, and ensure that services are maximized. In order to achieve this, a multi-step process is recommended; including enhancing data collection and analysis, properly disseminating data to all relevant stakeholders, and utilizing these data appropriately to inform suicide prevention efforts. Each strategy is supported by one or more objectives, as presented in Exhibit 7 and described in further detail in the following sections.

Exhibit 7: Overview of Data and Program Evaluation Strategies



Data Collection (DC)

Currently, when a death by suicide occurs, the case is investigated by the County Medical Examiner. Information about the decedent and the circumstances of the death are collected and compiled into a report during this investigation. Self-inflicted injury hospitalization and emergency department discharge data are collected at the population-level via standard protocol. In addition, each County funded program tracks their suicide prevention efforts to monitor service provision.

Current Local Sources of Suicide-Related Data

- Suicides: Medical Examiner
- Self-Inflicted Injuries: Hospital and Emergency Department Discharges
- Behaviors, Access, and Other County-level Survey Data: Regional or national surveys, such as the Youth Risk Behavior Survey (YRBS) and the California Health Interview Survey (CHIS)
- Suicide Prevention: Individual program and service level data

While some suicide and self-inflicted injury data collection efforts do exist, they are based on standard protocol not specific to suicide, and missing important data elements that could help inform suicide prevention efforts. Similarly, there are some important program-level data elements that are not currently captured in a standard way to inform evaluation efforts across programs. Thus, the utility and reproducibility of the resulting information is questionable.

Three key objectives are recommended to strengthen data collection efforts across the County. These include expanding the amount of information collected following a suicide, standardizing data collection efforts across programs to better document suicide prevention efforts, and using the data to inform the community about strategies that have the greatest potential to achieve a reduction in suicide.

DC1. Improve and expand data collection and reporting

Prior to data being used to identify risk factors, protective factors, and circumstances of suicide to inform suicide prevention efforts, accurate information must be collected. The National Center for Injury and Prevention Control recently released recommendations regarding data elements that should be collected for all self-directed violence, including suicide.[52] As highlighted in the text box above, suicides are reported by the County Medical Examiner and tracked by the County of San Diego, Emergency Medical Services (EMS). When a suicide occurs, demographic data (such as the gender, age, ethnicity, marital status) of the victim are captured, as well as information about the suicide (method, location, toxicology). However, there are data limitations.

For example, data specific to the nature and status of the most current employment of victims of suicide is not collected; rather, a general description of the victim's work history is gathered. More specific, standardized data on job–related information would assist in

estimating the impact of specific types of jobs or job loss, and the development and tracking of employment-based prevention efforts. There are also limitations to how medical examiner data is reported. For example, the location of the suicide is collected but not included in the public data reports, making it difficult to examine suicide rates at a neighborhood level.

The Self-Directed Violence (SDV) Surveillance guidelines recommend expanding the data elements that are typically collected when a suicide occurs to include education and employment history, previous medical history, and other associated factors, such as recent history of a personal crisis.[53] It is recommended that for San Diego County, expanding suicide surveillance to include these elements be considered. This may include collecting supplemental information to include more information about risk factors.

In addition to tracking suicide at the individual level, standardized community and service-level data need to be tracked to effectively monitor suicide prevention efforts across programs. These include:

- Process measures, including the number and type of services provided, people served, number of people screened, assessed and/or referred for services;
- Tracking of process and outcome measures for provider and consumer trainings;
- Community level measures to ensure changes are leading to a healthier community, such as how suicide prevention efforts impact community health outcomes;
- Community level findings, such as awareness of suicide. For example, build off of and compare to the "It's Up to Us" campaign baseline data.

Additional recommendations for data collection and reporting include:

- Make data a priority;
- Centralize data in one location to examine information from multiple sources at once, or ensure data collection systems have compatible exporting features;
- Standardize data collection across systems;
- Conduct and support local research efforts;
- Collect and examine treatment effectiveness data;
- Ensure individual confidentiality.

From 2001 through 2010, 3,390 people died by suicide in San Diego County. There were nearly three times as many suicides as homicides.

DC2. Expand data collection to include identified risk factors and medical history

The Self-Directed Violence (SDV) Surveillance recommendations discussed in the previous objective (DC1) include expanding the categories of self-directed violence to include fatal and non-fatal suicidal behavior. Non-fatal suicidal self-directed violence includes both suicide attempts that are interrupted by self and suicide attempts interrupted by another.[54,55] Some suicides and suicide attempts are categorized as accidents rather than suicidal self-directed violence due to lack of evidence to conclusively determine whether the event was a suicide. When expanding data collection, it will be important to gather information about substance use, suicidal ideation at the time of injury, history of personal crisis, and other individual level variables to inform how injuries and deaths are categorized. Doing so has the potential to cause an increase in the number of deaths and injuries that are categorized as suicide or suicide attempt.

It is also recommended that risk and protective factor information be collected to assess the characteristics associated with those seeking and utilizing services, and the individual-level outcomes associated with factors. Recommendations for the collection of risk and protective factors include:

- Collect prevalence data for suicide and self-inflicted injury at various levels of the system;
- Collect prevalence data for individuals experiencing with poor mental health and suicidality at various levels of the system, with or without an attempt;
- Consider the use of non-traditional data sources;
- Involve multiple systems, including the County Medical Examiner, County Emergency Medical Services, emergency departments, hospitals, and military services;
- Use stakeholder input to inform a strong suicide prevention system;
- Collect and examine treatment effectiveness data.

Data Quality (DQ)

Ensuring data quality is critical to the success of an enhanced data collection system. General recommendations to do so include:

- Clearly define data elements so that information is collected consistently across providers and systems;
- Data collection efforts should be sensitive to the stigma attached to conversing about suicide because some individuals will not be comfortable providing accurate personal data. Thus, a process for ensuring confidentiality is needed;
- Develop guidelines for tracking, entering, and assuring data quality, and implement a formal training for how to do so; and
- Make it a requirement to establish quality control of data across systems.

DQ1. Develop guidelines for assuring that data collection is implemented cross-culturally and with linguistically diverse populations

Race and ethnicity are not always collected in a standardized way across systems. For example, Native American/Alaska Native is a race/ethnicity category tracked statewide, but due to small sample sizes, Native American populations are often grouped under a category labeled "Asian/Other" in local suicide surveillance reports. This makes it difficult to track suicide rates in smaller populations. It is recommended that specific race/ethnicity data be shared to examine suicide rates within the diverse communities of San Diego County.

Another challenge is that for some cultural communities, discussing suicide, suicidal ideation, and mental health issues is considered taboo. Additionally, some cultures will not discuss death, so capturing accurate information about the circumstances of a suicide. Recommendations for addressing these cultural norms in a sensitive manner to improve data collection efforts include:

- Engage community leaders to build trust across ethnic and immigrant communities;
- Involve families in data collection efforts; and
- Engage faith communities to assist in establishing trust.

Data Sharing (DS)

Currently, individual entities collect data to measure their own suicide prevention efforts and the effectiveness of their programs, but these data are rarely shared across the system. For example, a program might do a suicide risk assessment on a client and follow up with that client to provide services, but the information collected about the individual in the risk assessment is not shared outside of that program. Doing so would expand opportunities for learning to take place across systems.

DU1. Utilize a Mental Health Services database registry

It is recommended that a suicide data registry be developed, to collect and analyze data collected across multiple sources and systems. In order to achieve this, data sharing guidelines must be developed and implemented that are in line with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state confidentiality of information requirements. Recommendations for a suicide data registry include:

- Recruit experts in data sharing to inform this process. Include key suicide data collection stakeholders, as well as others that have been involved in data sharing with other entities. Some organizations have already identified ways to share information across providers while still adhering to HIPAA and other privacy protections. For example, the San Diego County Office of Education has been able to work with juvenile justice, child welfare services, and other departments to share information on individual high-risk students. There are experts in this field who can advise organizations on how to develop a plan for data sharing while maintaining client confidentiality;
- Include effective confidentially and privacy safeguards and consider how data can be de-identified;
- Identify an entity to be responsible for the central location and management of a database or registry.

Data Use and Dissemination (DU)

Once quality data is collected, it can be effectively used to inform policy change, suicide prevention efforts, and program improvements. This feedback loop will ensure that data is not only tracked, but used to examine changes in key outcomes over time. Program and service-level indicators, as well as population-based indicators describing deaths by suicide and suicide attempts, should be included to ensure a comprehensive suicide prevention evaluation approach. There are two inter-related objectives recommended to achieve data utilization and dissemination: Utilize data to engage stakeholders, and utilize data to inform suicide prevention strategies.

DU1. Utilize data to engage stakeholders

Suicide and suicide prevention data can be used to engage consumers in suicide prevention efforts, thus increasing the potential for stakeholder involvement. Recommendations to achieve this include:

- Publish data and make the information widely available, especially for successful suicide prevention efforts;
- Demystify and de”myth”ify suicide to prepare consumers to hear messages about suicide prevention;
- Provide accurate and appropriate information to providers and consumers. This includes suicide data as well as information about available services;
- Rebrand mental health and suicide prevention terminology to make messages more accessible.

DU2. Utilize data to inform suicide prevention strategies

Data are critical to the continual expansion and improvement of suicide prevention efforts, and should be used to inform practice and strategies. Recommendations to achieve this include:

- Ensure data is collected and disseminated about successful suicide prevention programs so that future efforts can be modeled after best practices;
- Define success measures for mental health and suicide prevention so that providers are working toward a common goal;
- Identify the duration of successful interventions;
- Use data to identify at-risk populations and emerging areas of need;
- Continue to use local resources and expertise.

Additional recommendations for effective data use and dissemination include:

- Utilize data that are currently collected, such as compliance data for County funded prevention programs;
- Report current data based on the most up-to-date information to best inform practice;
- Share case information when a suicide occurs to review the circumstances and identify ways interventions can be improved;
- Report program satisfaction data to ensure consumers are benefiting from the services they receive;
- Include a wide variety of stakeholders in data utilization, including:
  - Access & Crisis Line;
  - Psychological Emergency Response Team (PERT);
  - Adult Protective Services;
  - Private practice offices/providers;
  - Private provider health care systems;
  - County of San Diego;
  - Schools;
  - Law enforcement;
  - Veteran's Affairs.

"It is the long history of human kind (and animal kind, too) those who learn to collaborate and improvise most effectively have prevailed"

-Charles Darwin

52 Crosby, AE, Ortega L, Melanson C. Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, national Center for Injury Prevention and Control; 2011. http://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf

53 Ibid

54 Ibid

55 It is important to note that the Self-Directed Violence Surveillance covers many different forms of self-directed violence, including non-suicidal self-directed violence, which is behavior that is self-directed and deliberately results in injury but with no evidence of suicidal intent. This type of behavior is not addressed in this action plan.

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Overall Concepts

Overall Concepts

The strategies and objectives presented in the Action Plan identify several overarching concepts that frame a comprehensive approach to suicide prevention efforts in San Diego County. As recommendations for each component within the spectrum of prevention are implemented, it is important that the following core concepts are addressed.

- **Broaden the scope and reach of trainings to include more community members and providers.** The goal of universal prevention is that everyone will have a basic level of knowledge and understanding of the importance of mental health care, core risk and protective factors of suicide, and where to go for help. In order for this information and education to be disseminated to the entire community, it is important that access to training be widespread.

  It is also important to expand the definition of "providers" to include those outside of behavioral health. Many at-risk individuals continue to seek support and crisis intervention from lay providers outside of behavioral health. These services providers, as well as recognized community leaders, should be trained to identify suicide risk factors, protective factors and the resources available.

- **Adapt best practices to the meet the needs of key target populations locally.** Nationally recognized best practices for training, media, and other interventions and objectives are available. The central tenets of these models should be utilized and tailored to the specific needs of San Diego County as whole, and/or specific target populations.

- **Improve coordination of services and priorities across the prevention spectrum.** There is a need to better identify available suicide prevention services throughout the county. This information needs to be disseminated to providers and to the community at-large in order to minimize duplication of services and fragmentation in service delivery, as well as to conserve resources.

- **Include the voice of those who are being served.** In order for the Action Plan strategies to be successful, the voices of individuals receiving services, particularly those at highest risk for suicide, need to be included in the planning of trainings and interventions. Input is frequently not sought from the target populations, including youth, veterans, and various cultural groups during these crucial planning steps.

- **Use data to evaluate prevention efforts and inform program planning.** To address suicide as a public health problem, a sustained and systematic collection, analysis, and dissemination of accurate information on the incidence, prevalence, and characteristics of fatal and non-fatal suicidal behavior is needed. Effective and coordinated suicide surveillance allows for realistic priority-setting, facilitation of the design of prevention programs, and the ability to evaluate these programs.

- **Involve the entire community in the implementation of suicide prevention strategies and recommendations.** Achieving zero suicides is not a feat that can be taken on by any one organization or individual. The entire community must rally together to prevent suicide and its devastating consequences in San Diego County.

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Appendices

Appendix A: Resources

The following are resources identified throughout the action planning process. Resources have been organized by objective.

UNIVERSAL STRATEGIES	
Universal Training (UT)	
UT1. Training is provided using a universally adopted curriculum	Suicide Prevention Resource Center evidence based models and education materials - www2.sprc.org/bpr/section-i-evidence-based-programs Mental Health America Mental Health First Aid curriculum - www.mentalhealthfirstaid.org/cs/program_overview/ Air Force Experience with Suicide Prevention - www.sprc.org/grantees/pdf/2006/dlitts_AirForce.pdf Yellow Ribbon *Be A Link!*® Suicide Prevention Gatekeeper Training - www2.sprc.org/sites/sprc.org/files/BeALinkSuicidePrevGatekeepeeTraining.pdf. *Ask 4 Help!*® Suicide Prevention for Youth - www2.sprc.org/sites/sprc.org/files/Ask4HelpSuicidePreventionYouth.pdf Partnering with faith communities using models such as Mental Health Ministries - www.mentalhealthministries.net/ Building bridges: Mental health consumers and members of faith-based and community organizations in dialog - http://store.samhsa.gov/shin/content/SMA04-3868/SMA04-3868.pdf Consensus statement on suicide and suicide prevention from an inter-faith dialogue - www.sprc.org/library/Consensus_Statement.pdf National Suicide Prevention Lifeline Suicide Warning Signs - www.suicidepreventionlifeline.org/GetHelp/SuicideWarningSigns.aspx
UT2. Improve public-private partnership in suicide prevention (collaboration among providers)	*No specific resources identified*.

Media Campaign (UM)	
UM1. Media campaign delivers one consistent message	It's Up to Us Media Campaign http://www.up2sd.org/
UM2. Ensure responsible reporting	*At-a-Glance: Safe Reporting on Suicide* - http://www.sprc.org/library/at_a_glance.pdf. *Guidelines for media when developing stories:* www.ReportingOnSuicide.org.
UM3. Age/Culturally appropriate message delivery	Suicide Prevention Resource Center materials on how to work effectively with different populations – http://library.sprc.org/browse.php?catid=13
System (US)	
US1. Create a suicide response/prevention entity in the County	HIV Education: San Diego County HIV Prevention Community Planning Group - www.sdhivprevention.org/ Harm Reduction Coalition - www.harmreduction.org/index.php. Regional Task Force on the Homeless - www.rtfhsd.org/
US2. Promote effective clinical and professional practices	Screening, Brief Intervention and Referral to Treatment (SBIRT) – www.samhsa.gov/samhsanewsletter/Volume_17_Number_6/SBIRT.aspx Suicide Prevention Resource Center Physician Office Protocol Development Guide for Suicidal Patients - www.sprc.org/library/OfficeProtocolDevelopmentGuide.pdf. Suicide Prevention Resource Center Customized Information Primary Care Providers - www.sprc.org/featured_resources/customized/pdf/primarycareprovider.pdf. Positive Solutions provides outreach, and mental health prevention and early intervention to homebound, isolated seniors 60 years and older from all cultural backgrounds who reside in North County and Downtown San Diego. Depression, PEI, Prevention and Early Intervention, Seniors, homebound seniors, problem solving therapy, PEARLS (Program to Encourage Active Rewarding Lives) Elder Multicultural Access and Support Services -E Mass provides culturally appropriate, peer based, outreach and engagement services to 800 seniors in San Diego County's Filipino, Latino, African American and African refugee communities. Services are designed to address mental health issues, prevention activities, and increase access to mental health care. Utilize a promotora model.
US3. Impact, inform, and create policy.	Means Restriction - The National Strategy for Suicide Prevention (NSSP) placed an emphasis on promoting efforts to reduce access to lethal means and methods of self-harm. - www.sprc.org

SELECTIVE STRATEGIES	
Education (SE)	
SE1. Education is provided to priority communities and populations	National Suicide Prevention Lifeline – Assessing Suicide Risk: Initial Tips for Counselors - www.suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard_AssessingRisk_GREEN.pdf Mental Health America Mental Health First Aid curriculum -
Training for Providers (STP)	
STP1. Training developed and implemented for front line professionals and first responders	Yellow Ribbon - Yellow Ribbon Suicide Prevention Program - www.yellowribbonsd.org/ University of California San Diego (UCSD) Counseling and Psychological Services Red Folder – http://caps.ucsd.edu/resources_fac_staff_web/resources_fac_staff_red_folder.html and http://caps.ucsd.edu/downloads/handbooks/redfolder_0809.pdf Well Aware – Education and information for school staff and school administrators - www.wellawaresp.org/ Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities - http://store.samhsa.gov/product/SMA10-4515?WT.ac=EB_20110505_SMA10-4515 Department of Defense Suicide Prevention and Risk Reduction Committee (SPARRC) - http://www.dcoe.health.mil/Content/navigation/documents/dcoe%20fact%20sheet%20sparrc.pdf
STP2. Address secondary trauma among	People prevent Suicide - http://peoplepreventsuicide.org/contamination-ptsd/
Skill Building and Training for Community Members/Clients (SSB)	
SSB1. Implement skill building workshops or services for community members	Action Planning for Prevention and Recovery - http://store.samhsa.gov/shin/content//SMA-3720/SMA-3720.pdf
Utilization of Supportive Models (SSM)	
SSM1. Utilize supportive models for early intervention among identified populations.	Promotora model Partner in wellness AA model Recovery coach model Mobile units model Self-help models
SSM2. Increase use of alternative interventions and therapies.	*No specific resources identified*

INDICATED STRATEGIES	
Identification of High Risk Behaviors/Events (IRB)	
IRB1. Complete an assessment to identify high risk behaviors and events among indicated target populations	*No specific resources identified*
IRB2. Utilize information from high risk behaviors/events assessment to inform media campaigns and interventions	*No specific resources identified*
Integrate System of Care for High Risk Individuals (ISC)	
ISC1. Training for primary care physicians and other medical staff about high risk behaviors/events	*No specific resources identified*
ISC2. Coordinated care for high risk populations following high risk events	UCSD Bridge to Recovery Program - http://health.ucsd.edu/specialties/psych/bridge-to-recovery/ Screening, Brief Intervention, and Referral to Treatment (SBIRT) model http://www.nattc.org/find/news/attcnews/epubs/addmsg/july2010article.asp. Perfect Depression Program, Henry Ford Health System, Detroit, *Pursuing Perfect Depression Care*. Psychiatr Serv 2006 57: 1524-1526 and www.henryford.com/body.cfm?id=48947 Assertive Community Treatment; NYAPRS Peer Bridger program - www.nyaprs.org/peer-services/peer-bridger/ Optum Health Peer Bridger - www.nyaprs.org/peer-services/optum-peer-bridger/
ISC3. Implementation of care coordination/ case management to increase linkage/"warm" hand off for high risk individuals	The Suicide Prevention Resource Center (SPRC) and the American Association of Suicidology (AAS) recently released the Continuity of Care for Suicide Prevention and Research, a comprehensive report offering recommendations for the ongoing care of patients at risk for suicide who have been treated in emergency departments and hospitals.
Provision of Community Based Services (ICB)	
ICB1. Provide home and/or site based services to indicated target populations	*No specific resources identified*

Appendix B: Training Guide

Training was identified throughout the Action Plan as key strategy in local suicide prevention efforts. Appendix B.1 provides an overview of all recommendations related to training throughout the Action Plan.

Exhibit B1: Summary of Action Plan Training Strategies

Focus Area	Strategy	Objective	Key Recommendations
Universal	**Universal Training (UT)** ***(See Exhibit B.2 for a list of identified targets for Universal Training)***		
	UT	UT1. Training is provided using a universally adopted curriculum	♦ Build off of existing models for universal education to address the needs of identified target populations; ♦ Take a public safety approach to suicide prevention and identify core ideas and information that everyone should know; ♦ Selected curricula should allow for individualization to address the needs of specific target populations.
	UT	UT2. Improve public-private partnership in suicide prevention (collaboration among providers)	♦ Efforts should be dedicated to employer engagement, such as including universal suicide prevention messages in new employee orientation packets; ♦ A convening authority should be identified that will continue to bring people together; ♦ Implementation of the universally adopted curriculum should be made a practice standard; ♦ A collaborative curriculum should be developed to address private/public needs; ♦ Organizations should communicate their crisis intervention needs; ♦ Schools should be a part of collaboration for possible implementation in high school.

Exhibit B1: Summary of Action Plan Training Strategies (continued)			
Focus Area	**Strategy**	**Objective**	**Key Recommendations**
Selective	**Training for Providers (STP).**		
	STP	STP1. Training is developed and implemented for front line professionals and first responders	♦ Training needs to be made more widely available and accessible; ♦ The definition of front line provider needs to be broadened to include people providing support outside of the behavioral health system; ♦ Standardized training needs to be identified and made available. Build off of current programs; ♦ There needs to be an ongoing conversation about what is expected from front line providers.
	STP	STP2. Address secondary trauma among providers.	♦ Provide practicing mental health and community health providers working with high-risk populations support, training and other resources to ensure that they as providers feel successful and supported in their jobs and avoid burnout; ♦ Additional support should be identified and provided to providers throughout the County. This is especially true for front line workers who work with crisis on a frequent basis; ♦ Build off of other provider training efforts to help them feel better equipped to deal with patients in crisis.
Indicated	**Integrate System of Care for High Risk Individuals (ISC)**		
	ISC	ISC1. Training for primary care physicians and other medical staff about high risk behaviors/events	♦ Primary care physicians were identified as the service providers who have the most interaction with high risk individuals, particularly those individuals not already identified by the mental health system. ♦ Information and education for primary care providers is needed so they are able to identify high risk events and provide appropriate intervention when clients initially exhibit high risk behaviors. ♦ Training should include screening and assessment education so that physicians are prepared to assess clients for suicidality following a high-risk event.

Multiple training targets, including community groups, individuals, and organizations, were identified as targets for Universal Training. These are presented in exhibit B2.

Exhibit B2: Community groups, individuals and organizations identified as targets for Universal Training.

- Medical community
- Universities
- Clergy
- Schools
- Educators
- Media
- Pop culture
- Police Department
- Financial institutions
- Political, community, and cultural leaders (locally, state, and national)
- Champions (spokespersons)
- Mail delivery people
- Survivors
- Theme parks
- Athletes
- Pharmacists
- Grant makers
- Foundations
- Family members
- Cox Communications
- Insurance companies

The Suicide Prevention Action Plan was funded by the County of San Diego Mental Health Services Act (MHSA).