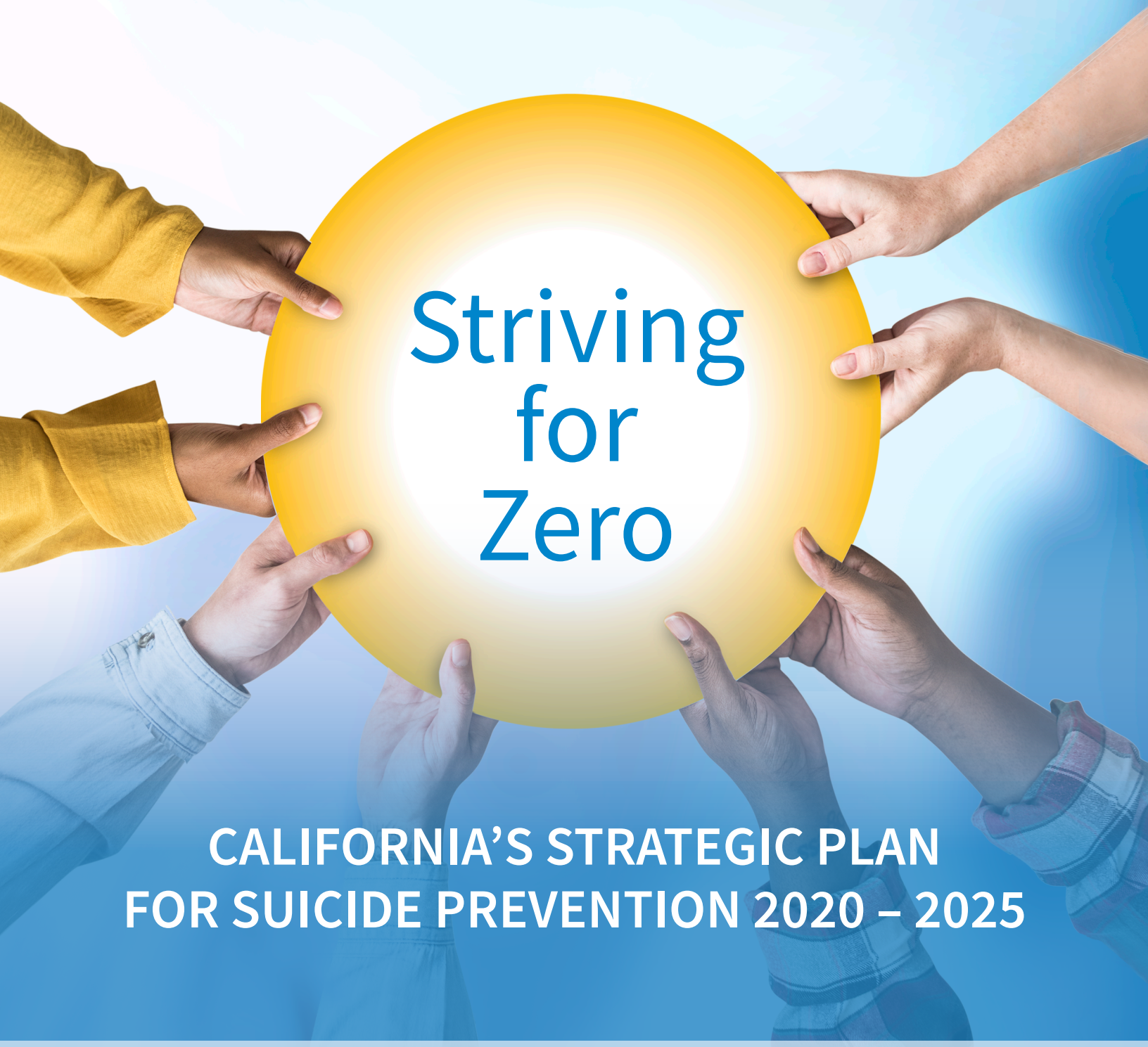
MHSOAC
Mental Health Services
Oversight & Accountability Commission



CALIFORNIA'S STRATEGIC PLAN FOR SUICIDE PREVENTION 2020 – 2025

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

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

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About the Commission

The Mental Health Services Oversight and Accountability Commission, an independent state agency, was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. Californians created the Commission to provide oversight, accountability, and leadership to guide the transformation of California's mental health system. The 16-member Commission is composed of one Senator, one Assembly member, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the Governor's appointees are people who represent different sectors of society, including individuals with mental health needs, family members of people with mental health needs, law enforcement, education, labor, business, and the mental health profession.

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Dedication

This plan is dedicated to people lost to suicide and people experiencing suicidal behavior, and their loved ones. The Commission would like to express its thanks to the many survivors, community members, family members, administrators, providers, researchers, and policymakers who contributed to the development of this plan. We greatly appreciate the time, commitment, and energy devoted to exploring the challenges and solutions surrounding efforts to prevent suicide.

We would like to extend a special thank you to the survivors of suicide attempt and loss who bravely and honestly shared their stories, experiences, and unique insights into opportunities to improve suicide prevention strategies. Many people are affected by suicide, including Commissioners and staff directly involved in the development of this plan. The Commission affirms the urgency of putting in place sound strategies to prevent further loss of life.

Lives can be saved. There is hope.

Get Help Now

If you or someone else needs support, a trained crisis counselor can be reached by calling the National Suicide Prevention Lifeline at **800-273-TALK (8255)** or by texting TALK to **741741**.

- Personas que hablan español, llamen a the Lifeline al **888-682-9454**.
- For teens, call the TEEN LINE at **310-855-4673** or text TEEN to **839863**.
- For veterans, call the Lifeline at **800-273-TALK (8255)** and **press 1**.
- For LGBTQ youth, call The Trevor Project at **866-488-7386** or text START to **678678**.
- For transgender people, call the Trans Lifeline at **877-565-8860**.
- For people who are deaf or hard of hearing, call the Lifeline at **800-799-4889**.
- For law enforcement personnel, call the COPLINE at **800-267-5463**.
- For other first responders, call the Fire/EMS Helpline at **888-731-FIRE (3473)**

All of the resources above provide confidential help and are available 24 hours a day, seven days a week. Suicide risk assessment is a collaborative and transparent process between the person at risk and the person conducting the assessment. Working together, support services and referral options are identified based on risk and need.

If Someone is Showing Warning Signs (see the back of this page for a listing) or Communicating a Desire to Die, Take the Following Steps:

1. **ASK** "Are you thinking about suicide or feeling that life may not be worth living?" and assess the person's safety by asking if the person has a specific plan and any intent to act on that plan. Ask if the person has already begun acting on these thoughts or made a suicide attempt. Risk of death by suicide increases significantly as people put more pieces of a plan in place.
2. **EXPRESS compassion**. The desire to die by suicide can be a frightening and isolating experience. Express compassionate care to emphasize that help is available, including confidential resources.
3. **REACH OUT** for support by calling the crisis lines (see above) to be connected to resources. All crisis lines are available for people in crisis AND individuals supporting people in crisis.
4. **FOLLOW-UP** by calling, texting, or visiting to ask how the person is doing and if additional support is needed.

Take a screen shot of this page if you're on your mobile device or make a copy if you're viewing the print version. This page can be saved for future use or sent to a loved one.
Originally from Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025.

Warning Signs

The Following Behaviors Could Indicate or Signal Suicide Risk:[1]

- Communicating a wish to die or plans to attempt suicide
- Expressing the experience of having thoughts of suicide that are intense, pervasive, or difficult to control
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Giving away possessions
- Drafting notes indicating intent or desire for suicide
- Communicating feeling hopeless or having no reason to live or persistent hopelessness
- Communicating feelings of guilt, shame, or self-blame
- Communicating feelings of being trapped or in unbearable pain
- Communicating being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly or engaging in risky activities
- Insomnia, nightmares, and irregular sleeping
- Withdrawing or feeling isolated
- Communicating or exhibiting anxiety, panic or agitation
- Appearing sad or depressed or exhibiting changes in mood
- Showing rage or uncontrolled anger or communicating seeking revenge

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MHSOAC
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Plan Contents

Executive Summary 9

Stigma and Myths 15

Introduction 17

Strategic Aims and Goals 19

- Strategic Aim 1: Establish suicide prevention infrastructure 22
- Strategic Aim 2: Minimize risk for suicidal behavior by promoting safe environments, resiliency, and connectedness 26
- Strategic Aim 3: Enhance early identification of suicide risk and increase access to services based on risk 31
- Strategic Aim 4: Improve suicide-related services and supports 34

Plan Development 39

Suicidal Behavior: Definitions, Theory, and Key Concepts for Prevention 45

- Definitions of Self-Directed Violence 45
- Means Matter 48
- Inherent Challenges and Emerging Innovations 49

Suicidal Behavior in California 53

- Suicide Data 53
- Data Limitations 56

Risk and Protective Factors 57

- Risk Factors 58
- Protective Factors 59
- Warning Signs 60

Best Practice in Suicide Prevention 65

- Universal Prevention Strategies 65
- Selective Prevention Strategies 71
- Indicated Prevention Strategies 73

State Workplan 77

References 95

Suicide is a significant public health challenge. According to the latest data, 4,323 Californians lost their lives to suicide in 2017. California's state suicide rate remains relatively stable, and rates are increasing in some communities.

Striving toward no lives lost to suicide will require a dedicated and sustained effort to integrate practices known to prevent suicide into our education, justice, healthcare, and other systems and our communities.

All Californians need to be vigilant – aware and responsive to the warning signs of suicide in their loved ones and even in themselves.

There is hope. The evidence for effective suicide prevention practices is growing every day. This comprehensive strategy incorporates the latest information and evidence to guide state and local actions for the benefit of all Californians and to save lives.

Executive Summary

More than 47,000 Americans lose their lives to suicide each year. While global suicide rates are decreasing, the national suicide rate has been on a steady rise since 1999. Some key facts about suicide in the United States and California:

- Suicide is the tenth leading cause of death in the U.S., and the second leading cause for people ages 10 to 34.
- Each year an estimated 25 suicide attempts occur for every death by suicide; among youth, up to 200 attempts occur for every suicide death.
- In 2017, the national suicide rate was 14 per 100,000 people. While California's rate – 10.7 per 100,000 residents – is lower relative to other states, certain counties and demographic groups have much higher rates.
- While women and youth of color attempt suicide at greater rates than other groups, middle-aged and older white men die by suicide at greater rates. In the U.S., nearly 7 out of 10 suicides are by white men.
- The most common method for suicide attempt is drug overdose, while firearms are the most common means for suicide death.

Suicide is a complex public health challenge involving many biological, psychological, social, and cultural determinants. The major risk factors for suicide are a prior suicide attempt; substance use disorder; mood disorders, such as depression; medical illness; and access to the methods to attempt suicide. The common factors that reduce risk for suicide are access to effective medical and mental health care; connectedness to others; problem-solving skills; and caring contacts, such as postcards or letters, from service providers and caregivers.

Challenges to Effective Suicide Prevention

Prevention efforts are challenged by misconceptions about suicidal behavior, despite advancements in the study of suicide and its prevention. These pervasive myths may prevent people at risk from seeking help and discourage people from asking loved ones about thoughts of suicide. The internal suffering that accompanies the desire to die may remain hidden unless a person is directly asked about the person's thoughts and needs. Risk factors may be missed in the absence of uniform suicide screening and assessment by mental health and substance use disorder providers, who often are delivering services in separate and uncoordinated systems. Misconceptions also undermine the effectiveness of strategies to reduce access to potentially lethal methods of injury. Such interventions are common in other prevention fields, yet they remain underutilized in suicide prevention. Physical barriers on bridges, locking doors on railways, and locking windows at lethal heights prevent accidental ***and*** intentional falling. Likewise, safely storing guns in the home prevents accidental ***and*** intentional injury and death among children and adults.

Effective prevention efforts must recognize that risk factors can be dynamic, changing over a person's lifetime. Researchers are exploring the variability in risk and protective factors among vulnerable groups, and much remains unknown. Deficiencies in data collection also limit understanding of the full extent

of suicidal behavior. For example, determining suicidal intent after a drug overdose can be difficult, resulting in underreporting and limited information to support prevention efforts. Suicide prevention also requires engagement of private and public partners across multidisciplinary fields, which requires a commitment to wide-scale collaborations that integrate planning and coordinate actions. Efforts are further complicated by inconsistent definitions of suicidal behavior, which affect data monitoring. Lastly, assessing for risk is not a uniform practice in California. This leads to inconsistency in suicide risk detection, which also is constrained by significant ethical, training, and legal considerations.

Suicidal Behavior in California, 2017

4,323: The number of Californians who died by suicide

18,153: The number of Californians who received service in an emergency department for intentional self-harm

108,075: The number of suicide attempts in California, based on the estimate of 25 suicide attempts for every one suicide death

Over 1.1 Million: The number of adult Californians who reported serious thoughts of suicide

Application of the Public Health Model to Prevent Suicide

Despite the challenges, research demonstrates that effective interventions can save lives, and that public health strategies can prevent loss of life on a broad scale. The Public Health Model involves four repeating steps: 1) defining the problem; 2) identifying the factors that increase or lower risk; 3) developing and evaluating prevention interventions; and 4) implementing interventions and disseminating results to increase the use of effective interventions.[2] (See Figure 1.) The Public Health Model is a key feature of the statewide strategic suicide prevention plan detailed in this document.

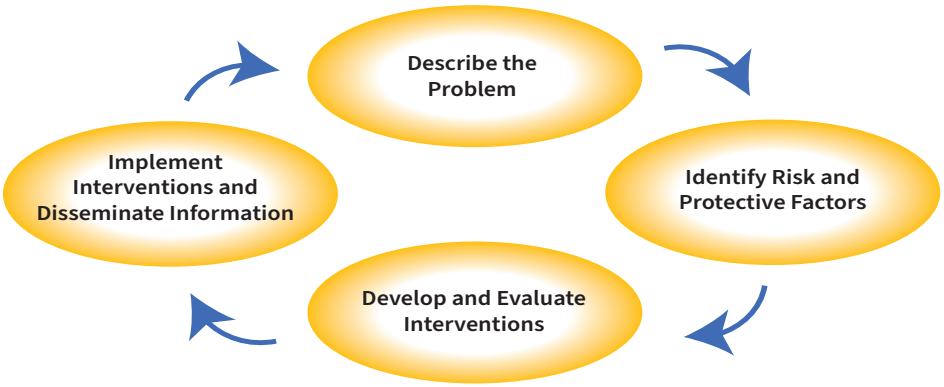


Figure 1. Public Health Model adapted from the World Health Organization's Preventing Suicide: A Global Imperative

Opportunities to Save Lives

California's Mental Health Services Oversight and Accountability Commission was directed by the Legislature to develop a new suicide prevention plan for the state. The Commission began its effort in early 2018 by reviewing California's previous strategic plan. Developed in 2008, the plan made numerous noteworthy recommendations, many of which were not fully implemented. Under the leadership of a subcommittee chaired by Commissioner Tina Wooton, the Commission engaged national and local experts; reviewed research; conducted site visits; and convened public hearings and forums across the state, where community members, policy leaders, and those with lived experience provided guidance and insight.

The Commission's goal was to produce an achievable policy agenda and a foundation for suicide prevention based on best practices. Its overarching objective is to equip and empower California communities with the information they need to minimize risk, improve access to care, and prevent suicidal behaviors. While the state can support local communities and assume a leadership role, the success of any strategic plan depends on the integrated efforts of private and public partners. This synergy is already taking place on many fronts. Private and public health care systems are integrating providers and systems serving mental health needs and substance use disorders. Unmet needs in health, mental health, and substance use disorders increase a person's risk for dying by suicide. Research has demonstrated how integrated and coordinated care can meet these needs and saves lives. Public health leaders are investigating risk factors for suicide and novel interventions for its prevention, within communities and service delivery systems. Schools are working with local leaders to increase access to mental health services and provide social emotional learning that will help students over their lifetimes. Businesses are recognizing the importance of workplace wellbeing and expanding pathways to support through modern employee assistance programs.

Comprehensive Approach Targeting a Continuum of Risk

California's Suicide Prevention Plan is Framed by Four Strategic Aims.

STRATEGIC AIM 1: Establish a Suicide Prevention Infrastructure

Similar to other public health challenges, preventing suicide statewide demands a strong infrastructure of information, expertise, evaluation, and communication. This infrastructure must support the systematic delivery of best practices, so success is not dependent on the valiant efforts of a single person, agency, or setting. Everyone can potentially play a role in suicide prevention. Information must be disseminated through trusted channels. Leaders must sustain suicide prevention as a public health priority and define the roles that partners play in planning, delivering, and monitoring efforts. Resources must be integrated and coordinated. Data must be standardized and routinely collected and monitored.

STRATEGIC AIM 2: Minimize Risk for Suicidal Behavior by Promoting Safe Environments, Resiliency, and Connectedness

Risk for suicide in all communities can be reduced by reducing environmental threats to safety, while building individual, family, and community resiliency. People at risk for suicide often experience extreme ambivalence about the desire to die or live, and experience a high degree of suffering. Eliminating or reducing access to a lethal method, such as a gun, creates time and opportunity for intervention during what are often transient crises. People can be taught skills to manage stressors, and to understand when they need to reach out for additional support. Increasing social connectedness can reduce stigma and isolation. Media, including the entertainment industry, can prevent suicide through responsible reporting of suicide death, by destigmatizing mental health needs, and by highlighting mental health resources.

STRATEGIC AIM 3: Increase Early Identification of Suicide Risk and Connection to Services Based on Risk

Risk may elevate for some despite efforts to create safe environments and build resiliency. Anyone can recognize the warning signs of suicide and can learn to communicate effectively with people at risk to determine the type of support needed. Screening tools can identify people at risk for suicide in many settings, while brief interventions – like those used for problem alcohol use – empower people at risk to recognize their personal warning signs, identify coping strategies and a supportive social network, reduce access to lethal means, and seek professional help to manage suicide crises. Crisis services and support also can assist with assessing for suicide risk and connection to services, and must be widely available, accessible, and varied to benefit the diverse range of people in need of help.

STRATEGIC AIM 4: Improve Suicide-Related Services and Supports

Timely services and supports must be available to people experiencing suicidal behavior, especially attempted suicides, and people experiencing the suicide death of a loved one. Mental health and substance use disorder providers must be equipped to help those at risk and trained to deliver care that reflects best practices. For example, low-cost, high-impact post-hospitalization postcards and referral services are effective strategies for preventing future suicidal behavior and must be a standard component of aftercare following hospital or emergency department discharge. Swift response to support families, loved ones, and, in some cases, entire communities, must follow every suicide.

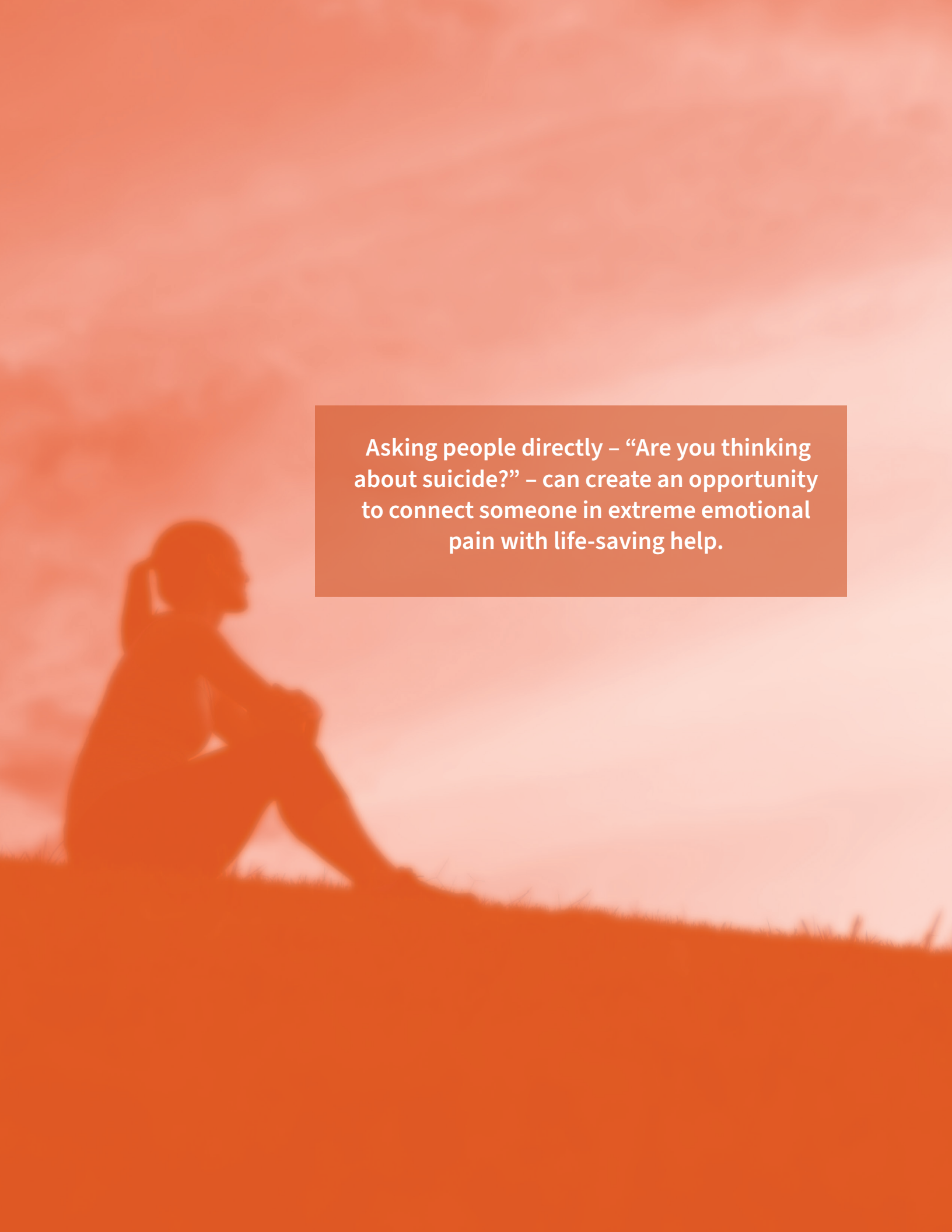
Next Steps

Lives can be saved from suicide if resources are dedicated to fortifying key components of a suicide prevention infrastructure. A five-year state workplan is detailed at the end of this plan. The state should take the following first steps now:

- Create the **Office of Suicide Prevention,** supported by the California Suicide Prevention Council. The Office should be charged with implementing the plan and evaluating progress. The Office should be within the California Department of Public Health.
- Expand the **California Violent Death Reporting System** within the Department of Public Health by allocating local assistance funding to supplement federal funding. This funding should support technical assistance to increase the standardized data entered into the system and increase the timely dissemination of information at the local and state levels to guide prevention efforts.
- Require **standardized suicide prevention training** for providers in all hospital settings and expand current requirements to **screen for suicide risk** in health, mental health, and substance use disorder care settings. Suicide screenings and assessments must be part of the immediate follow up when a person screens positive for mental health needs or substance use disorders. Training must include standardized suicide risk assessment and management of best practices. The state could accelerate the use of suicide risk assessment and management by advancing healthcare technology that supports triage-based assessments and timely connection to services.
- Require all hospitals to develop and implement **written uniform policies for discharge** after a person has received suicide-related services. Policies must include protocols for developing discharge plans, which must include a collaborative process to create a safety plan and to identify appropriate aftercare services; a plan for transitioning a person to another care setting or provider, home, school, and work; and a process for following-up with the person via written correspondence, email, text message, or other communication as directed by the person.

Striving for Zero

The elimination of suicide in California will require leadership, commitment, and honest conversations about suicide risk, resiliency, and barriers that disrupt suicide prevention efforts. This plan outlines public health aims aligned with nationally directed strategies and calls for crucial advancements in innovation and health care access using practices capable of helping millions of people. California has the ingenuity, capacity, and leadership to take a decisive stand against suicide. One life lost to suicide is one too many, so let's begin now.



Asking people directly – “Are you thinking about suicide?” – can create an opportunity to connect someone in extreme emotional pain with life-saving help.

Stigma and Myths

Stigma is a Major Obstacle to Preventing Suicide.

Stigma refers to negative attitudes and beliefs about people with behavioral health needs. Such needs include problem substance use and problem eating, serious psychological distress, and mental health needs, and their severity can range from distress to diagnosable illnesses and disorders. Stigma not only discourages people from seeking help, but also can prevent people, families, and communities from becoming connected with meaningful support. Stigma also affects the reporting and recording of suicides and the circumstances leading up to a suicide, such as a previous attempt or death in the family. Consequently, prevention efforts are stymied by the underreporting of suicidal behavior. To demonstrate one tactic that can combat stigma, the Commission uses non-stigmatizing language throughout this plan. Stigmatizing language includes the phrases *committed suicide*, *completed* or *successfully completed suicide*, *suicidal person*, *unsuccessful* or *failed suicide attempt*, and *mentally ill*.

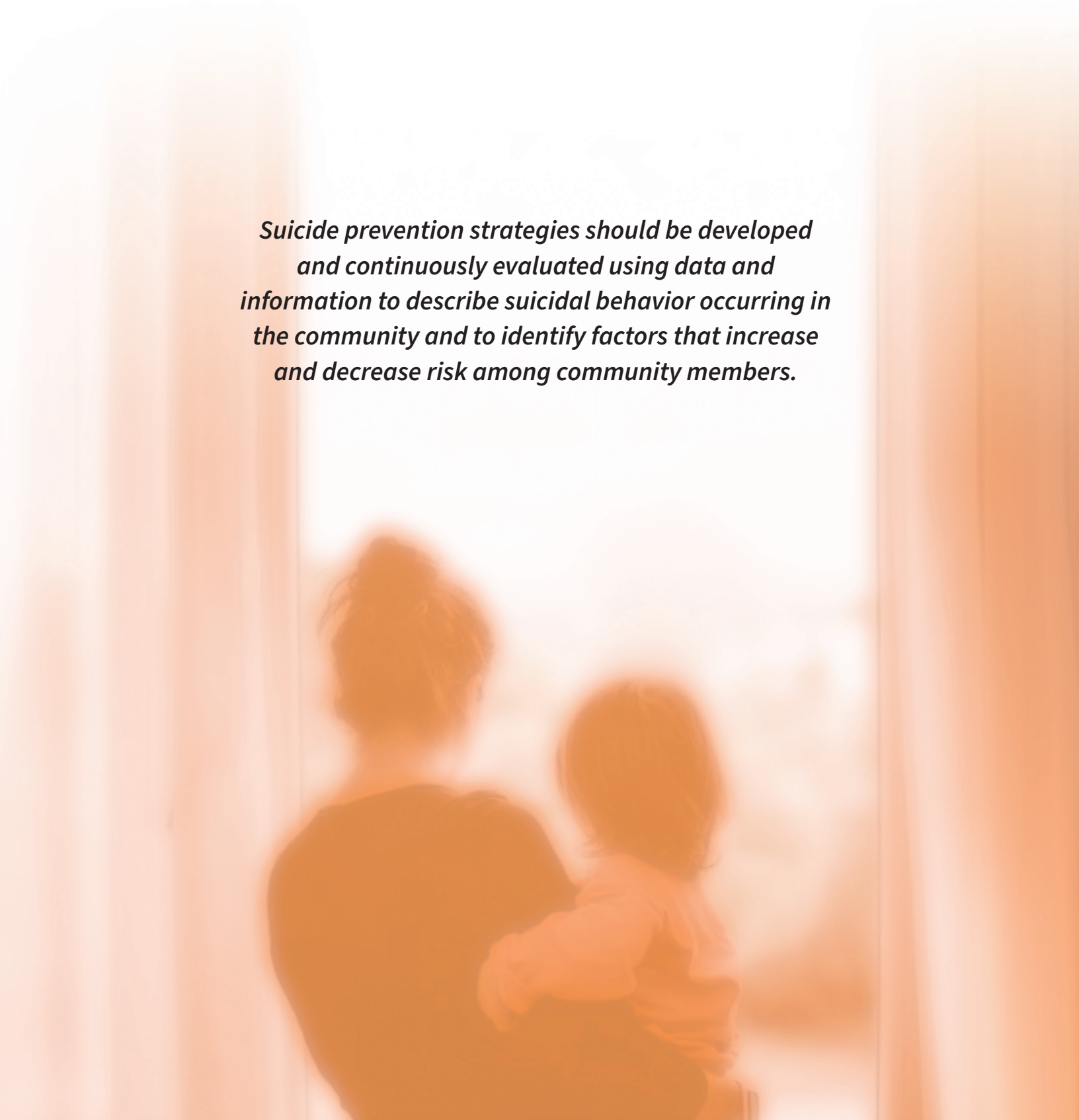
STIGMATIZING:	NON-STIGMATIZING:
Committed Suicide	Died by Suicide
Suicidal Person	Person at Risk of Suicide
Mentally Ill Person	Person Living with Mental Health Needs

Myths and Misconceptions About the Prevention of Suicide also Hinder Prevention Efforts.[3]

Below are common examples of these myths and the facts associated with each.

MYTH	FACT
Most suicides are impulsive and happen without warning.	Over 70 percent of people who die by suicide communicated to someone their plans for the attempt prior to death.[4] Planning, including obtaining the means by which to attempt suicide and identifying a location, often happens well before the attempt – sometimes years in advance.[5] Most suicides are preceded by warning signs, such as communicating the desire to die, of having no reason to live, or the feeling of being a burden.
People who want to die are determined and there is no changing their minds.	Over 90 percent of people who were interrupted in a suicide attempt will not go on to die by suicide at another location or by other methods.[7] Research suggests that those at risk for suicide often show extreme ambivalence about the desire to die or live, and express a high degree of suffering. The accounts of attempt survivors suggest that many people are relieved to have lived through an attempt and regain their desire to live.[8] This fact highlights the opportunity to intervene and separate the person at risk from lethal means for a suicide attempt.
Communicating about suicide will plant the seed for thoughts of suicide, increasing risk.	Communicating openly about suicide and asking about risk has been shown to be lifesaving. It encourages people to seek help, promotes a sense of belonging, and connects people to care.

Suicide prevention strategies should be developed and continuously evaluated using data and information to describe suicidal behavior occurring in the community and to identify factors that increase and decrease risk among community members.



Introduction

Suicide is a serious public health challenge, accounting for nearly 800,000 deaths each year worldwide.[9] In the United States, suicide remains among the top 10 causes of death, claiming twice as many lives each year as homicide. Suicide rates have remained relatively intractable nationally over the past 50 years, and rose 33 percent between 1999 and 2017 – from 10.5 to 14 per 100,000 Americans.[10] It is estimated that for every suicide, there are approximately 25 suicide attempts.[11] For youth aged 15 to 24, as many as 200 attempts may occur for every death.[12]

Thoughts of suicide are more common. In 2017, for example, an estimated 9.8 million adults nationally reported experiencing thoughts of suicide. Far fewer – 2.8 million adults – made suicide plans, while 1.3 million adults attempted suicide.[13]

Beyond its profound impact on the person, family, community, and society, suicide poses an estimated economic cost of $93.5 billion in lost productivity and medical expenses in the U.S.[14] In California, suicide resulted in an average of $1,085,227 per death in lost productivity and medical expenses in 2010.[15] This does not include the cost of other suicidal behavior, such as suicide attempts that did not result in death.

Nationally and in California, suicide has emerged as a public health emergency in need of innovation across multiple levels of prevention, in part because of historically intractable rates.[16] A public health approach offers considerable promise to meet the challenge.[17] This approach seeks to increase the health of the community in order to reduce the risk experienced by each person and, likewise, to increase the health of each person to reduce risk in the community.[18] Under this model, individual health is shaped by the physical, psychological, cultural, and social environments in which people live, work, and go to school.[19]

Application of the Public Health Model to Prevent Suicide

The Public Health Model involves four repeating steps: 1) defining the problem; 2) identifying the factors that increase or lower risk; 3) developing and evaluating prevention interventions; and 4) implementing interventions and disseminating results to increase the use of effective interventions. (See Figure 1.) The Public Health Model is a key feature of the statewide strategic suicide prevention plan detailed in this document.

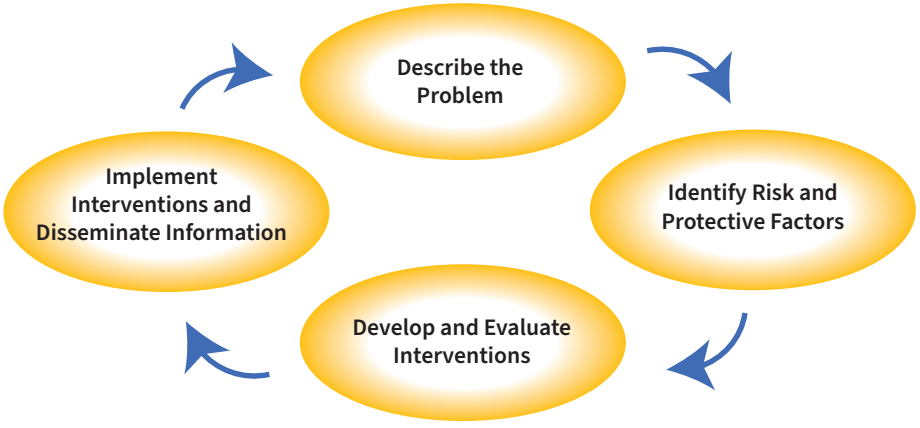


Figure 1. Public Health Model adapted from the World Health Organization's Preventing Suicide: A Global Imperative

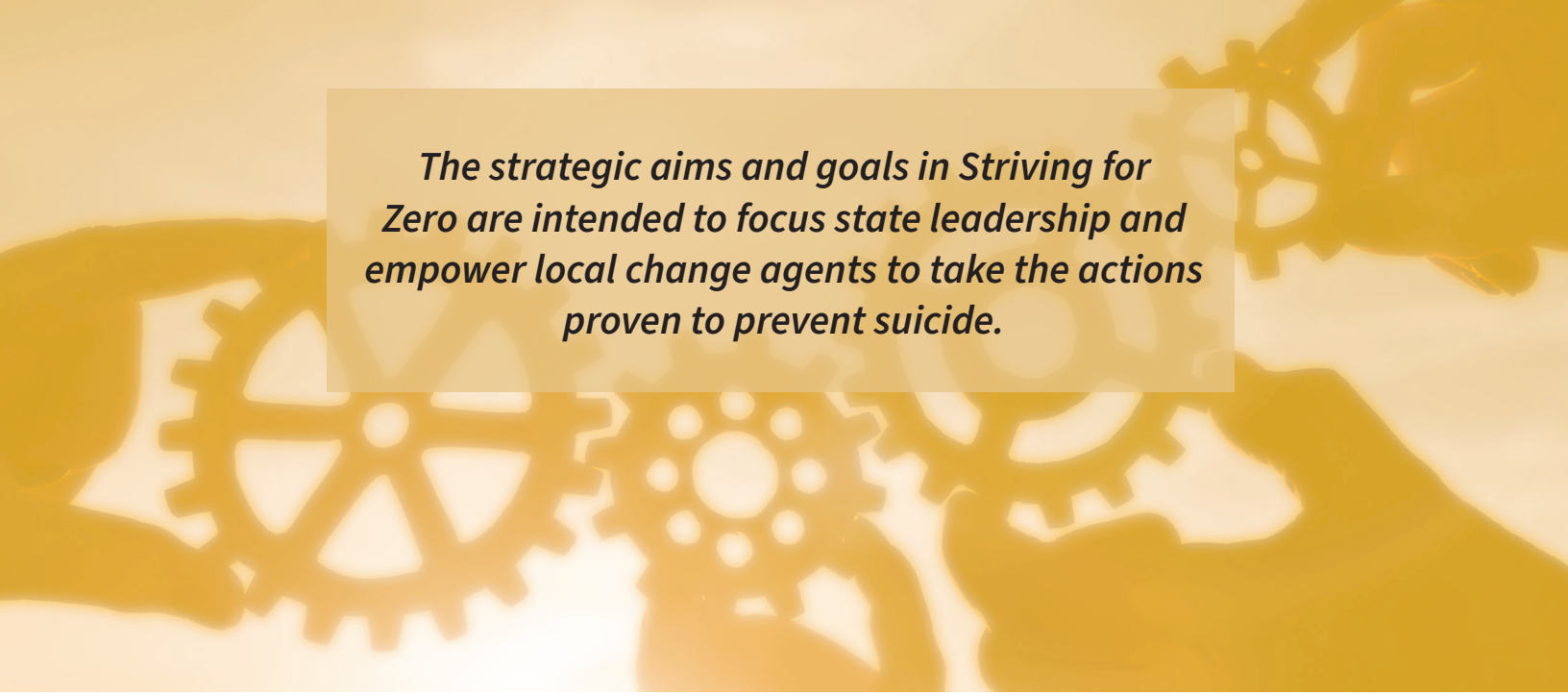
California's Strategic Plan for Suicide Prevention

The first half of California's Strategic Plan for Suicide Prevention outlines the strategic aims, goals, and actions needed to prioritize suicide prevention efforts across the state over the next five years, with the ultimate goal of no lives lost to suicide. These pages detail the tactics, or "how to" steps, that can help California communities effectively prevent suicide using contemporary best practices. The second half of the plan describes terms, theory, challenges, and evidence related to the coordinated delivery of suicide prevention efforts. Finally, the document concludes with a five-year workplan to implement state objectives that support local and regional efforts.

This document builds upon multiple ongoing state and local suicide prevention efforts. As part of those efforts, many resources have been developed to support implementation of best practices in suicide prevention. Over 100 suicide prevention reports, webinars, ads, posters, and public campaign resources can be found at Each Mind Matters Resource Center at http://emmresourcecenter.org.

For More Information or Resources, Visit These Sites:

- **Suicide Prevention Resource Center** | http://www.sprc.org/
- **Each Mind Matters** | http://emmresourcecenter.org
- **Know the Signs** | https://www.suicideispreventable.org/
- **National Suicide Prevention Lifeline** | www.suicidepreventionlifeline.org
- **National Action Alliance for Suicide Prevention** | https://theactionalliance.org/
- **American Association of Suicidology** | https://suicidology.org/
- **American Foundation for Suicide Prevention** | https://afsp.org/



The strategic aims and goals in Striving for Zero are intended to focus state leadership and empower local change agents to take the actions proven to prevent suicide.

Strategic Aims and Goals

California's Strategic Plan for Suicide Prevention establishes a foundation of suicide prevention directed by best practices for the benefit of state and local partners. Increasing the use of best practices in suicide prevention statewide is an achievable goal. But responsibility for success must be shared among private and public partners, and efforts must be driven by private and public data and resources, including human and fiscal assets. State funding should support key areas outlined in the report's action steps, which include establishing state leadership, delivering technical assistance, developing guidance, and fortifying and expanding data collection and reporting systems. To ensure sustainability, however, other public and private assets must be leveraged and continuously pursued.

The following pages present a roadmap to align local and regional efforts with state priorities in delivering best practices in suicide prevention. Local communities can start now to identify local leaders in health, mental health, and substance use disorders; build coalitions; and identify data and information to understand and communicate the problem of suicidal behavior in their communities. Communities can then take the subsequent steps in the Public Health Model by identifying risk and protective factors; developing interventions and conducting evaluation; and disseminating effective practices.

Key Action Partners

To effectively reduce suicide, a broad range of partners must commit to integrate suicide prevention into their organizations' leadership, values, and work. Many are already fully engaged and are making a difference; many others will need to take on new responsibilities to help reduce the loss, pain, and suffering associated with suicide. Key action partners should be included in the planning and, when appropriate, implementation of suicide prevention objectives.

Below is a list of key action partners essential to *Striving for Zero*.

- People with lived experience with suicidal behavior (survivors of loss and attempt)
- Advocates, researchers, and providers working with vulnerable groups (youth, older adults, veterans, LGBTQ, firearm/violence prevention)
- Business sector (gun vendors, funeral directors, entertainment leaders, media representatives, other businesses identified via data collection)
- Coroners/Medical Examiners
- Criminal and juvenile justice (professionals, researchers, leaders)
- Education (school, college, and university administrators, teachers, counselors, staff)
- Faith-based communities (members and leaders)
- Families (parents, caregivers, others viewed as family)
- First responders
- Health, public health, mental health, and substance use disorders (researchers, leaders, providers, administrators)
- Tribal communities (leaders, traditional healers, advocates)

Plan Components

This plan serves as strategic guidance to equip local communities with information on best practices and areas of focus with the greatest potential for preventing suicide. The plan is organized using the following components:

- **Strategic aims** are broad areas of focus to reduce suicidal behavior.
- **Goals** accompany each strategic aim to help governments, community organizations, providers, and other partners to focus suicide prevention efforts using best practice approaches or interventions. These efforts are detailed in the Best Practice in Suicide Prevention section of this plan.
- **Desired outcomes and short-term targets** are identified under each goal. Measuring incremental steps and progress toward reaching each goal, while monitoring suicide data, will be critical.[20] Desired outcomes, such as reduction in suicide or suicidal behavior, may or may not directly result from specific strategies and may take more than five years to achieve. Short-term targets are measurable direct results from the implementation of state and local objectives, and are anticipated to be achievable in less than five years – or the term of this plan.
- **Objectives** at the state, regional, and local levels are included under each goal and are listed to support planning. A five-year workplan for each state objective can be found beginning on page 77.

Plan Quick View

California's Strategic Plan for Suicide Prevention is framed by four strategic aims and 12 goals. Each goal statement embeds suicide prevention strategies and approaches with the greatest potential to prevent suicide in communities across the state. See the Best Practices in Suicide Prevention on page 65 section of this plan for more detail about the evidence of effectiveness.

STRATEGIC AIM 1: ESTABLISH A SUICIDE PREVENTION INFRASTRUCTURE

- Goal 1: Enhance visible leadership and networked partnerships
- Goal 2: Increase development and coordination of suicide prevention resources
- Goal 3: Advance data monitoring and evaluation

STRATEGIC AIM 2: MINIMIZE RISK FOR SUICIDAL BEHAVIOR BY PROMOTING SAFE ENVIRONMENTS, RESILIENCY, AND CONNECTEDNESS

- Goal 4: Create safe environments by reducing access to lethal means
- Goal 5: Empower people, families, and communities to reach out for help when mental health and substance use disorder needs emerge
- Goal 6: Increase connectedness between people, family members, and community
- Goal 7: Increase the use of best practices for reporting of suicide and promote healthy use of social media and technology

STRATEGIC AIM 3: INCREASE EARLY IDENTIFICATION OF SUICIDE RISK AND CONNECTION TO SERVICES BASED ON RISK

- Goal 8: Increase detection and screening to connect people to services
- Goal 9: Deliver a continuum of crisis services within and across counties

STRATEGIC AIM 4: IMPROVE SUICIDE-RELATED SERVICES AND SUPPORTS

- Goal 10: Deliver best practices in care targeting suicide risk
- Goal 11: Ensure continuity of care and follow-up after suicide-related services
- Goal 12: Expand support services following a suicide loss

STRATEGIC AIM 1:
ESTABLISH A SUICIDE PREVENTION INFRASTRUCTURE

1 STRATEGIC AIM

GOAL 1: ENHANCE VISIBLE LEADERSHIP AND NETWORKED PARTNERSHIPS

Desired Outcome Increased awareness and sustainability of suicide as a preventable public health priority.

Short-term Target By 2025, state leadership is advancing suicide prevention as a public health priority, and all counties have leaders and coalitions engaged in suicide prevention efforts.

State Objectives

Objective 1a Establish centralized, visible state-level leadership by creating the Office of Suicide Prevention within the California Department of Public Health to provide strategic guidance, deliver technical assistance, develop and coordinate trainings, monitor data, conduct state-level evaluation, and disseminate information to advance statewide progress.

Objective 1b Engage private and public partners by creating the California Suicide Prevention Council to advance suicide prevention efforts with strategic planning and dissemination of best practices in their respective sectors.

Local and Regional Objectives

Objective 1c Establish leadership to provide clear direction for suicide prevention efforts and prioritize goals with maximal impact. Suicide prevention leadership may come from a coalition, a task force, or from health, mental health, and substance use disorder agencies or organizations.

Objective 1d Identify leaders who can champion suicide prevention as a public health priority. Leaders drive progress, develop and sustain relationships with partners, and help focus attention on suicide prevention as a core mission when faced with competing priorities.

Objective 1e Hold regularly scheduled meetings to convene stakeholders, prioritize suicide prevention activities based on data and community input, leverage resources to build capacity across systems and communities/regionally, and expand services based on effectiveness.

Objective 1f Formalize a coalition of private and public partners to advance suicide prevention efforts by being an "action arm" to local and regional leaders.[21] Private and public leaders should be brought together to leverage their influence to champion efforts prioritized in their own sectors.[22] Within coalitions, sector-specific or strategy-specific subgroups should be created to focus expertise and keep members energized and engaged.[23] Consistent logistical support, strategic guidance, technical assistance and other infrastructure should be provided to the coalition by local leadership.[24]

1 STRATEGIC AIM

GOAL 2: INCREASE DEVELOPMENT AND COORDINATION OF SUICIDE PREVENTION RESOURCES

Desired Outcome Increase in coordination and integration of suicide prevention resources through planning and collaboration across diverse partners and systems.

Short-term Target By 2025, all counties are working to prioritize suicide prevention and are implementing suicide prevention initiatives, which could include activities such as establishing a dedicated website listing local suicide prevention resources, forming coalitions, and creating strategic plans.

State Objectives

Objective 2a Accelerate the development and management of suicide prevention resources in communities across California, and support capacity building to use best practices in suicide prevention by disseminating guidance and resources.

Objective 2b Identify opportunities to integrate suicide prevention strategies across systems and programs. The state should promote communication and information sharing among private and public partners and provide guidance on incorporating suicide prevention messaging into diverse settings, strategies, and public health campaigns.

Objective 2c Align efforts and investments to address multiple forms of violence that may share risk and protective factors with suicide, including strategies for reducing trauma in early childhood.

Local and Regional Objectives

Objective 2d Develop a local suicide prevention plan and implementation strategy to prevent suicidal behavior across the lifespan and to address the goals outlined in the state's strategy, in addition to addressing local needs. Funding allocated to local behavioral health departments under the Mental Health Services Act can be used for suicide prevention planning, as well as developing and implementing strategies.

Objective 2e Map local and regional assets across sectors to coordinate resources and align funding priorities. Develop data that demonstrates how investments in specific suicide prevention strategies could lead to improved outcomes and cost savings in other areas, such as emergency services and healthcare. Assets may include programs or features of the community, such as safe and welcoming community spaces, parks, or centers. Assets can be mobilized through planning processes that identify underutilized community strengths, such as Asset-Based Community Development strategies.[25]

Objective 2f Document the roles and responsibilities of each partner, and any data or funding streams associated with partners and their affiliation. Each partner has a role to play, and all partners bring potential for innovating common practices.

Objective 2g Integrate suicide prevention strategies into existing services being delivered through local settings, systems, and programs. Community health workers and in-home service providers, for example, should be trained to recognize warning signs of suicide and able to connect people at risk to care or crisis services.

Objective 2h Leverage partnerships through a coalition (see Goal 1) to identify shared prevention goals across diverse settings and communities, such as education, child welfare, social services, health care, and justice settings. These partners may share goals with suicide prevention for reducing risk and increasing protective factors, such as creating safe and active communities to reduce social isolation. All can be leveraged to reduce suicidal behavior and meet other goals for health and wellness promotion.

1 STRATEGIC AIM

GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

Desired Outcome Increase in the use of standardized data to guide suicide prevention state and local policy and planning, resource management, and investment.

Short-term Target By 2025, 80 percent of all suicide deaths are electronically entered into the California Violent Death Reporting System and communities are using publicly available, timely aggregated data to strengthen suicide prevention strategies.

State Objectives

Objective 3a Establish centralized electronic reporting systems to capture data related to suicide deaths and suicidal behavior. The systems should include data by demographics—such as race/ethnicity, age, sex, gender identity, and sexual orientation—as well as vulnerable group membership, such as military service and women in the perinatal and postpartum period. Uniform coding procedures should be used.

Objective 3b Develop a data monitoring and evaluation agenda on suicide deaths and suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions ("save data") that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance to support state and local data and information sharing, including methods for sharing confidential information among diverse partners while adhering to state and federal privacy and security laws.

Objective 3c Standardize policies and procedures for investigating and reporting suicide as a cause of death. These should include uniform definitions of suicide, as well as protocols for working with suicide loss survivors and informing health officials in the context of a suicide cluster. Such protocols should include clear requirements for how cause of death is determined, how investigations are conducted, and how information is reported, and by whom, within a certain time following death. The procedures also should include training on methods for minimizing misclassification and accelerating timely reporting.

Local and Regional Objectives

Objective 3d Use local data and information to define the problem of suicidal behavior, identify factors that increase or lessen risk for suicide, develop interventions, conduct evaluations, and disseminate effective preventive practices.

Objective 3e Use suicide death and attempt data to evaluate the proportion of suicidal behavior that results in death. The results should be used to identify high-risk groups, target them with selective prevention strategies, and focus resources on specific lethal means restriction strategies.

Objective 3f Consider the use of death review teams for clinical and forensic review of suicide deaths. Team members should include representatives of coroners and medical examiners, law enforcement, subject matter experts, and others with legal access to confidential information. Data compiled by the team should be used to support prevention goals using the Public Health Model.

Objective 3g Partner with coroners, medical examiners, and local health department representatives to identify and eliminate barriers to the electronic reporting of suicide death data into the California Violent Death Reporting System. The effort should enable access to data to strengthen suicide prevention, while establishing policies and procedures to protect privacy.

Objective 3h Use anonymous community surveys to fill data gaps. For example, people with non-fatal, self-directed violence may not seek medical attention following the injury, thereby reducing the number of such reports.[26] Communicate that help is available by listing or displaying suicide prevention resources directly on the survey.

Objective 3i Build relationships with local colleges and universities and identify capacity for research to support local and state suicide prevention goals.

STRATEGIC AIM 2: MINIMIZE RISK FOR SUICIDAL BEHAVIOR BY PROMOTING SAFE ENVIRONMENTS, RESILIENCY, AND CONNECTEDNESS

2 STRATEGIC AIM

GOAL 4: CREATE SAFE ENVIRONMENTS BY REDUCING ACCESS TO LETHAL MEANS

Desired Outcome Decrease in suicides and initial and subsequent intentional self-harm hospital visits.

Short-term Target By 2025, all counties are using data and information to develop and implement targeted lethal means restriction strategies to prevent suicidal behavior and are measuring effectiveness.

State Objectives

Objective 4a Create a research and policy agenda to advance the goal of creating safe environments by reducing access to lethal means.

Objective 4b Monitor state-level trends in lethal means used for suicidal behavior and develop a statewide strategy for technical assistance to expand efforts to reduce access to the lethal means identified.

Objective 4c Disseminate information regarding federal funding available to support suicide barriers in the design or redesign of bridges and other sites where deaths by suicide may occur.

Local and Regional Objectives

Objective 4d Use the Public Health Model to evaluate risk and identify the methods of suicidal behavior used by community members and by specific demographic (such as race/ethnicity, age, sexual orientation, and gender identity) and cultural groups to guide development of focused prevention efforts. Once identified, develop tailored means restriction strategies and evaluate impact.

Objective 4e Promote safe medication disposal methods in the community or through pharmacies and other health care providers, including activities such as "take back" campaigns led by local public health departments that help people dispose of unused or expired medications. Partner with local pharmacies to increase the availability of methods to dispose of unused medication and highlight suicide and overdose prevention resources for people filling prescriptions.

Objective 4f Disseminate information to local gun shop and range owners to increase awareness of suicide prevention efforts, suicide warning signs, and available resources. Partner with local firearm safety trainers to incorporate suicide prevention awareness into trainings. Invite local gun shop and range owners to join local coalitions. Partner with law enforcement to guide dissemination of lawful options for temporarily transferring firearms for storage in times of suicide crisis or when Gun Violence Restraining Orders apply.[27] Resources to support this strategy can be found here: https://emmresourcecenter.org/resources/suicide-prevention-gun-shop-activity.

Objective 4g Disseminate information through local health departments to community partners about available overdose prevention resources, methods, and medications to counteract overdose, such as naloxone for opioid overdose.

Objective 4h Form regional and local workgroups composed of community members, first responders, transportation representatives, coroners and medical examiners, and crisis service providers to identify specific sites in the community frequently used for suicide, or those that provide the opportunity for suicide.

- These sites can be in the built environment or natural sites. Common types of sites include buildings, bridges, and train railways. Characteristics communities should consider in identifying sites are places that provide the opportunity for a person at risk to fall from a height and sites from which falling would place a person in front of a moving vehicle, such as a train. More than one suicide at a site should raise safety concerns.
- Once sites are identified, develop and implement plans to construct barriers to deter or prevent falling. Consider the benefits and risks of installing signs that list crisis services resources, such as suicide prevention hotline information, and provide positive, life-affirming messages. One risk, for example, could be drawing attention of people at risk to a particular site.

Objective 4i Create agreements among local bridge and rail authorities, first responders, and crisis services providers to collect data documenting events in which people were prevented from falling, any services they received and the outcomes. Include reporting requirements, such as biannual or quarterly reports.

2 STRATEGIC AIM

GOAL 5: EMPOWER PEOPLE, FAMILIES, AND COMMUNITIES TO REACH OUT FOR HELP WHEN MENTAL HEALTH AND SUBSTANCE USE DISORDER NEEDS EMERGE

Desired Outcome Increase mental health and substance use disorder service utilization and reduce unmet behavioral health need as assessed by the California Health Interview Survey.

Short-term Target By 2025, all counties have peer support providers trained in suicide prevention integrated into local outreach and engagement services and programs.

State Objectives

Objective 5a Create a research and policy agenda to advance the goal of empowering people, families, and communities to reach out for help when mental health and substance use disorder needs emerge.

Objective 5b Integrate social-emotional learning programs into private and public education curricula to strengthen communication and problem-solving skills, emotional regulation, and conflict resolution skills among children and youth.

Local and Regional Objectives

Objective 5c Identify community needs and expand community-based services for managing stressors and building resiliency, which may include coping skills, critical thinking, stress management, conflict resolution, and problem-solving skills. Expand community-based services to include activities that increase life skills, including mindfulness practices, critical thinking, stress management, conflict resolution, problem-solving, and coping skills; tailor activities based on age group and setting, and according to how different groups experience and mitigate stress. Cultural models of suicide can clarify how culture affects the experiences of stressors, the cultural meaning of stressors, and how different cultures express suicidal behavior.[28]

Objective 5d Expand outreach and engagement strategies to promote behavioral health and community services and resources. To do this, identify barriers that community members face in seeking services for behavioral health needs, and develop strategies to make services more accessible, convenient, and culturally respectful to increase the likelihood people will pursue and stay connected to such services.

Objective 5e Partner with community organizations and businesses to expand awareness of suicide warning signs and prevention resources. Coordinate suicide prevention awareness campaigns with other social marketing campaigns designed to reduce mental health stigma and discrimination and reduce relevant public safety threats, such as misuse of medication or unsafe gun storage practices.

Objective 5f Expand services to increase mental health literacy across the lifespan, encourage people to seek help for health, mental health, and substance use disorder needs, and promote messages of hope that lives can be saved from suicide.

Objective 5g Develop a network of peer support providers to help people navigate health, mental health, and substance use disorder care systems. Peer support providers are people with lived experience with suicidal behavior or behavioral health needs. Assess the importance of ensuring cultural congruency between people with lived experience and a target audience, such as youth helping youth or veterans helping veterans. Ensure youth peers have clear and easy pathways to caring adults who can help them navigate their options. Create a transparent feedback loop to encourage peer support providers to identify ways health, mental health, and substance use disorder systems can be more responsive to people at risk for suicide.

2 STRATEGIC AIM

GOAL 6: INCREASE CONNECTEDNESS BETWEEN PEOPLE, FAMILY MEMBERS, AND COMMUNITY

Desired Outcome Increase in reported school connectedness among public school students in grades 7, 9, and 11 as assessed by the California Healthy Kids Survey.

Short-term Target By 2025, all counties have suicide prevention strategies that include community-based services intended to reduce social isolation and strengthen relationships between people and their families, friends, and caregivers and are measuring effectiveness of services.

State Objectives

Objective 6a Create a research and policy agenda to advance the goal of increasing connectedness between people, family members, and community.

Objective 6b Identify and promote opportunities to foster positive and supportive relationships.

Local and Regional Objectives

Objective 6c Increase services intended to build positive attachments between children, youth, their families, other adults, and social supports in their community to increase a sense of belonging, strengthen a sense of identity and personal worth, and provide access to larger sources of support. Social support can be found in schools, faith-based communities, cultural centers, and other community-based organizations.

- Tailor strategies to be responsive to needs based on age and culture. For example, create social support groups, led by veterans or active-duty members of the military, which allow military service members to safely share their experiences; disseminate talk-based warmline phone numbers targeting older adults to reduce feelings of isolation and loneliness; and use communication methods relevant to an older population, such as advertising in health care settings or through traditional media.

Objective 6e Promote a culture free of stigma and discrimination by allowing for an open dialogue about mental health and mental health resources, and by delivering supportive messages of hope and recovery for people with mental health needs and substance use disorders. Establish policies and methods for enforcement to create cultures that support healthy lifestyles and environments that are affirmative and that prevent violence, including bullying and discrimination.

Objective 6f Identify opportunities to integrate suicide prevention strategies into services intended to reduce other forms of violence, such as child and elder maltreatment. These forms of violence may share risk and protective factors with suicidal behavior. For example, reducing interpersonal stress and teaching conflict resolution skills among at-risk families has the potential to increase a sense of connectedness and protect against suicide.

Objective 6g Partner with community-based organizations to build and promote opportunities for volunteerism to increase connectedness and a sense of purpose.

2 STRATEGIC AIM

GOAL 7: INCREASE USE OF BEST PRACTICES FOR REPORTING OF SUICIDE AND PROMOTE HEALTHY USE OF SOCIAL MEDIA AND TECHNOLOGY

Desired Outcome Reduce events referred to as "suicide clusters," when multiple suicides occur within a particular time period or location, especially among youth.

Short-term Target By 2025, all counties are conducting activities to increase awareness of best practices for reporting suicide to local media partners. Activities could include offering informational sessions, posting information online, and holding informational sessions.

State Objectives

Objective 7a Create a research and policy agenda to advance the goal of increasing use of best practices in reporting of suicide and to promote healthy use of social media and technology.

Objective 7b Increase awareness of best practices for reporting on suicides by collaborating with journalism associations and organizations to disseminate information and resources to journalism and media partners.

Objective 7c Integrate into college and university journalism curricula best practices for communicating about suicide through various forms of media and entertainment.

Objective 7d Identify and disseminate best practices for using and consuming social media and technology to improve wellbeing, destigmatize mental health needs, and increase help-seeking for mental health and substance use disorder services.

Local and Regional Objectives

Objective 7e Identify media and entertainment industry partners and deliver training on best practice guidelines for reporting about suicide. Identify local public information officers and spokespeople, including first responders and law enforcement officials, and deliver training in best practices for messaging following a suicide.

Objective 7f Disseminate information found online at http://reportingonsuicide.org/ and http://suicidepreventionmessaging.org/ to members of the media – reporters, editors, and producers – regarding how risk is conferred and to improve understanding of guidelines supporting suicide prevention on a broad scale. Resources to support this strategy can be found here: https://emmresourcecenter.org/resources/making-headlines-guide-engaging-media-suicide-prevention-california.

Objective 7g Partner with members of media to disseminate information about resources, encourage people to seek help for mental health needs and substance use disorders, and reduce stigma and discrimination that may prevent people from accessing services and supports. Entertainment media include film, television, podcasts, music, and theater.

Objective 7h Disseminate information about how suicide risk can effectively be expressed by people on various social media sites and highlight social media resources for identifying and reporting concerns about content. Most social media sites now have a method for reporting content that raises alarms.

Objective 7i Integrate into public campaigns and health and mental health curriculum in schools best practices for developing healthy social media habits and using social media in a way that promotes connectedness to reduce isolation.

Objective 7j Minimize the circulation of misinformation by creating communication strategies for use in the event of a suicide – including pre-existing agreements with media partners. Include a formal strategy for managing information on the most used social media sites and monitor social media posts by others related to the suicide death.

STRATEGIC AIM 3: ENHANCE EARLY IDENTIFICATION OF SUICIDE RISK AND INCREASE ACCESS TO SERVICES BASED ON RISK

3 STRATEGIC AIM

GOAL 8: INCREASE DETECTION AND SCREENING TO CONNECT PEOPLE TO SERVICES BASED ON SUICIDE RISK

Desired Outcome Decrease in suicidal behavior and increase in connection to services based on risk.

Short-term Target By 2025, all people screened for suicide in health care settings are connected to services necessary to reduce risk and increase factors that protect against suicide, and receive brief interventions (if applicable).

State Objectives

Objective 8a Create a research and policy agenda to advance the goal of increasing detection and screening to connect people to services based on suicide risk.

Objective 8b Adopt the Zero Suicide Initiative within health, mental health, substance use disorder care systems.

Objective 8c Expand resources to support health care providers increase access and linkage to mental health and substance use disorder services and culturally appropriate support services for people identified as needing such services. This strategy includes providers in correctional settings.

Objective 8d Increase standardized training offered to health, mental health, and substance use disorders providers in suicide risk assessment and management best practices. Enhance uniform suicide risk assessment and management in health care settings to align with Joint Commission guidelines and the Zero Suicide Initiative. Such settings include state and local correctional facilities.

Objective 8e Invest in technology in systems serving health, mental health, and substance use disorder to improve uniform suicide risk assessment and management. Goals include identifying people at risk and triaging those at risk into appropriate services and culturally appropriate support.

Local and Regional Objectives

Objective 8f Deliver suicide prevention training to people who are in positions to identify warning signs of suicide and refer those at risk to mental health and substance use disorder services and culturally appropriate supports. Support youth gatekeepers by identifying trusted adults who can help them with next steps once a young person is identified as at risk. Provide people the opportunity to reinforce knowledge and skills acquired during training through periodic booster sessions. Build capacity and sustainability for suicide prevention training across systems using train-the-trainer models or evidence-based online trainings.

- Consider the intensity of training needed and offer a variety of sessions to expand capacity and meet varied demand. For example, in a school setting, teachers, administrators, and other school personnel might receive brief trainings on suicide prevention awareness. Selected teachers, especially those who lead youth groups, and counselors might receive intensive trainings focused on how to deliver brief interventions.

Objective 8g Screen people seen in health, mental health, and substance use disorder care settings for suicide risk and deliver best practices in suicide risk assessment and management to those who screen positive for risk. Such settings include state and local correctional facilities.

- Suicide screenings can follow positive results on other screening tools. For example, screening specific to suicide risk should follow positive screens for depression, anxiety, trauma, physical pain, and problem alcohol, drug use, and eating. Comprehensive suicide risk assessments follow screening.

- The Joint Commission recommended the use of screening and assessment tools that include the following: Ask Suicide Screening Toolkit (ASQ) by the National Institute of Mental Health; the Columbia—Suicide Severity Rating Scale (C-SSRS) Triage Version; Patient Health Questionnaire 9 (PHQ-9) Depression Scale; Suicide Behavioral Questionnaire Revised; Scale for Suicidal Ideation-Worst; and the Beck Scale for Suicide Ideation.[29]

Objective 8h Integrate best practices in suicide risk assessment and management in health, mental health, and substance use disorder care settings and workflows. Create uniform policies and procedures to make screening, assessments, and decision-making routine. Clarify billing methods for services.

Objective 8i Deliver training to key action partners for conducting suicide screening in community-based settings when a person is identified as exhibiting warnings signs or communicating a desire to die. The Columbia-Suicide Severity Rating Scale has been adapted to meet the needs of diverse settings and populations and can be accessed for free here: http://cssrs.columbia.edu/.

Objective 8j Train first responders and other personnel patrolling or monitoring community sites used for suicidal behavior, such as bridges and railways. The training should include how to identify warning signs, use de-escalation techniques, and disseminate information on local suicide prevention resources, including crisis hotline numbers. Consider pairing first responders with trained behavioral health or crisis service providers to deliver interventions, if needed.

3 STRATEGIC AIM

GOAL 9: PROMOTE A CONTINUUM OF CRISIS SERVICES WITHIN AND ACROSS COUNTIES

Desired Outcome Increase in linkage to community-based services for people experiencing suicidal behavior and their families and caregivers.

Short-term Target By 2025, 80 percent of all crisis services providers are trained in suicide prevention and are referring people in distress to community-based services based on risk assessments.

State Objectives

Objective 9a Develop and implement a strategy to coordinate the delivery of crisis services, including an assessment of current crisis services infrastructure and private and public funding for services.

Objective 9b Create a research and policy agenda to advance the goal of promoting a continuum of crisis services within and across counties.

Objective 9c Create uniform standards for suicide and crisis hotlines in the state, including standards for training and core competencies for call responders; protocols for performance and quality assurance monitoring; and procedures for making referrals to services, including emergency services.

Local and Regional Objectives

Objective 9d Evaluate the continuum of crisis services available through private and public resources and identify gaps in the continuum, such as warm lines to reduce loneliness and isolation and access lines to connect people to local resources. Identify potential funding sources within each region of the state.

Objective 9e Promote the use of crisis services as alternatives to hospitalization and as a resource to support people in distress, by advertising crisis hotline and warmline numbers and other methods. Deliver suicide prevention training to all providers of such services.

Objective 9f Disseminate information on available crisis service resources to health, mental health, and substance use disorder care partners. Encourage these partners to include crisis services in safety plans developed through an alliance between partners and people at risk.

Objective 9g Create memorandums of understanding between systems of care and community-based crisis services to provide follow-up for people transitioning out of care systems, including protocols for protecting the confidentiality of people at risk. Health, mental health, and substance use disorder care systems should have protocols in place for obtaining consent for follow-up care from people at risk. To coordinate efforts, document clear methods of communication between crisis service providers and other systems, such as community corrections, child welfare, and veterans' services.

STRATEGIC AIM 4:
IMPROVE SUICIDE-RELATED SERVICES AND SUPPORTS

4 STRATEGIC AIM

GOAL 10: DELIVER BEST PRACTICES IN CARE TARGETING SUICIDE RISK

Desired Outcome Decrease in suicidal behavior as measured by intentional self-harm data reported by hospitals.

Short-term Target By 2025, 50 percent of licensed mental health and substance use disorder providers have received standardized training in best practices in suicide risk assessment and management and in interventions specific to preventing suicide.

State Objectives

Objective 10a Create a research and policy agenda to advance the goal of delivering best practices in care targeting suicide risk.

Objective 10b Create a process to certify providers trained in delivering best practices in suicide risk assessment and management and in interventions specific to preventing suicide. Certification could include minimum education, training, and continuing education requirements, and should include a review and approval process. This strategy includes providers in correctional settings.

Objective 10c Create a strategy to increase health, mental health, and substance use disorder provider workforce capacity to deliver suicide-related services.

Local and Regional Objectives

Objective 10d Expand the use of telehealth and telemedicine providers with training in best practices for suicide-related treatment - especially in rural communities - to enhance timely access to care targeting suicide risk.

Objective 10e Promote safety planning by prompting health, mental health, and substance use disorder providers to record safety plans in electronic medical record systems and by making plans accessible to people via commonly used portals.[30]

Objective 10f Create a local online, public directory that lists providers delivering suicide-related treatment and includes information about insurance eligibility and criteria for new clients.

Objective 10g Partner with health, mental health, and substance use disorder care systems and providers to improve delivery of services and supports to caregivers and family members of people transitioning from care settings following services for suicidal behavior. The efforts should prioritize safety and address service gaps. People at risk should be key decision-makers in defining support networks and the role each member of the network plays in creating safety and recovery.

Objective 10h Disseminate information to caregivers and family members on how to support a person at risk by serving as a resource identified by the person in safety planning; how to reduce environmental safety risks by promoting means safety, especially at home; and how to help manage harmful behaviors stemming from underlying health, mental health, and substance use disorder needs, such as escalating alcohol or drug use.

4 STRATEGIC AIM

GOAL 11: ENSURE CONTINUITY OF CARE AND FOLLOW-UP AFTER SUICIDE-RELATED SERVICES

Desired Outcome Reduce subsequent suicidal behavior among people discharged from emergency departments and hospital settings after suicide-related services.

Short-term Target By 2025, all people prior to being discharged from emergency departments and hospital settings after receiving suicide-related services create a plan for follow-up care and contact over a 12-month period or more, as needed.

State Objectives

Objective 11a Create a research and policy agenda to advance the goal of ensuring continuity of care and follow-up after suicide-related services.

Objective 11b Establish a program to deliver training on lethal means restriction counseling to health care providers, and distribute gun and medication lock boxes and locks to hospitals, with prioritized distribution to families and caregivers of people being discharged following a suicide attempt.

Objective 11c Ensure delivery of best practices for continuity of care following discharge after suicide-related services in emergency departments and hospital settings, including the routine, standardized use of follow-up cards, texts, and emails.

Local and Regional Objectives

Objective 11d Increase the use of electronic health records to document a person's safe transition to another provider, and ensure life-saving information is transmitted, while protecting the person's privacy.

Objective 11e Facilitate safe and timely care transitions by providing linkages to culturally and linguistically appropriate outpatient mental health and substance use disorder providers, crisis services, safety planning or crisis response planning, and by reducing access to lethal means.

Objective 11f Disseminate to emergency department administrators the ***Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments*** found at http://www.sprc.org/sites/default/files/EDGuide_full.pdf, along with the ***Quick Guide for Clinicians*** found at http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf, to increase awareness of safe discharge practices for people seen for suicide-related services.

Objective 11g Train health care providers to deliver lethal means counseling to family members and caregivers supporting people who are discharged from a health care setting after suicidal behavior.

Objective 11h Disseminate information on lethal means counseling to health care providers across hospital settings. Prioritize providers who predominantly serve at risk-groups or work in high-risk settings, such as emergency departments. Promote free online training, such as Counseling on Access to Lethal Means available at https://training.sprc.org/, and the use of online toolkits, such as https://health.ucdavis.edu/what-you-can-do/.

Objective 11i Create uniform policies and procedures for safely transitioning people or students back into the workforce and home or school following a suicide attempt, suicide, or hospitalization for a mental health crisis.

Objective 11j Create uniform policies and procedures to connect people released from correctional settings who have been identified as at risk for suicide, or who were receiving suicide-related services in custody, to appropriate services in the community. Include a standardized process for transferring confidential data and information.

Objective 11k Create uniform policies and protocols to support health, mental health, and substance use disorder providers in the creation or revision of safety plans for persons at risk. Examples include uniform procedures for establishing a connection between the person and a new provider; policies ensuring timely delivery of information to the new provider; and policies addressing the importance of follow-up within 24 to 48 hours of the transition. Create memorandums of understanding among local crisis service providers to establish relationships with people prior to discharge and ensure follow-up after discharge.

Objective 11l Create uniform protocols for counseling people discharged from emergency departments and hospitals after receiving suicide-related services on restricting access to lethal means. Families and caregivers should be included in such counseling.

4 STRATEGIC AIM — GOAL 12: EXPAND SUPPORT SERVICES FOLLOWING A SUICIDE LOSS

Desired Outcome Reduce the amount of time between a suicide loss and access to bereavement services specifically designed to meet the needs of suicide loss survivors.

Short-term Target By 2025, all counties have written policies and procedures for coordinated, timely, and respectful responses by service providers following a suicide loss, including formal agreements with local coroners and medical examiners to support the initiation of services.

State Objectives

Objective 12a Create a research and policy agenda to advance the goal of expanding support services following a suicide loss.

Objective 12b Assess and expand effective resources available to suicide loss survivors and develop capacity statewide to deliver appropriate and respectful services following a suicide loss. The resources should include information and training for bereavement service providers on topics specific to suicide and to grief that is unique to suicide loss.

Objective 12c Ensure written postvention – a planned response for the delivery of services after a suicide - policies and procedures are developed, adopted, and disseminated to staff in all settings where people are receiving mental health and substance use disorder services and supports.

Local and Regional Objectives

Objective 12d Develop an integrated postvention services plan to guide delivery of best practices following a suicide loss. The plan should tailor strategies to settings and cultures, including schools, workplaces, faith communities, hospitals and health care settings, tribal communities, and correctional facilities. The plan should identify a lead agency or organization responsible for ensuring adequate capacity, training, and effectiveness in the delivery of activities that support survivors, service providers, and community members after a suicide loss. Enter into agreements that contain clearly defined roles and procedures to increase the effectiveness of coordinated responses, such as procedures for sharing private information and data based on the role of each provider. Resources to guide creation of a community postvention response can be found here: https://www.cibhs.org/pod/after-rural-suicide.

Objective 12e Develop an online bereavement toolkit consisting of community- specific resources. Partner with hospitals, first responders, funeral directors, faith-based communities, and coroners and medical examiners to distribute the toolkit in print or via web links. Resources to support funeral directors' participation in this strategy can be found here: https://www.sprc.org/resourcesprograms/ help-hand-supporting-survivors-suicide-loss-guide-funeral-directors.

Objective 12f Provide training to first responders, crisis service providers, and access line responders on best practices in supporting suicide loss survivors, from understanding their unique needs to helping them access resources.

Objective 12g Create local suicide bereavement support programs or expand capacity and sustainability of existing programs using ***Pathways to Purpose and Hope,*** found at https://emmresourcecenter.org/resources/pathways-purpose-and-hope- guide-creating-sustainable-suicide-bereavement-support-program.

Objective 12h Expand support services designed and facilitated by survivors of suicide loss. Train survivors of suicide loss to speak safely and effectively about their loss and create a local speakers bureau to give a forum for survivors to deliver suicide prevention messaging to the public. Provide training for suicide loss survivor service facilitators and create opportunities for service facilitators to support each other, including group debrief sessions.

Objective 12i Enter into memorandums of understanding with coroners and medical examiners to establish coordinated, timely, and respectful responses following a suicide loss, and establish policies and protocols to govern activities in the event of a suicide. Components should include how information is shared, and with whom, and how the privacy of families is respected, including a process for determining how and when to reach out to family members with resources and support. This strategy includes people who die by suicide in correctional or hospital settings.

Striving for Zero incorporates the latest science regarding suicide and its prevention and the experiences and insights of California's communities.

Plan Development

With Assembly Bill 114 (Chapter 38, Statutes of 2017), the California Legislature directed the Mental Health Services Oversight and Accountability Commission to develop a statewide strategic suicide prevention plan. The Commission began the work in early 2018 by forming a Suicide Prevention Subcommittee, which included Commissioners Tina Wooton (Chair), Khatera Tamplen, and Mara Madrigal-Weiss.

Community Engagement and Site Visits

The Commission organized a series of meetings and events to help members better understand challenges in suicide prevention and identify opportunities for improvement. The gatherings were designed to engage Californians in a discussion about suicide and its prevention and to ensure that statewide planning reflected the state's unique cultural, ethnic, linguistic, and economic diversity. Open to the public, the meetings sought to incorporate a broad range of perspectives to support the development of shared knowledge to advance strategic planning. Please visit www.mhsoac.ca.gov for a full list of community engagement activities and summaries from events.

The Subcommittee held meetings in Fresno, Sacramento, San Diego, and Shasta counties to hear presentations on local suicide prevention initiatives and explore with community members the challenges and opportunities surrounding suicide prevention. Several priority areas emerged from these meetings: the urgency of early identification of suicide risk; the need for better methods to reduce isolation; the lack of access to appropriate services; and the importance of leveraging partnerships to build capacity. At two public hearings, the Commission explored these and other issues with suicide loss and attempt survivors, providers, researchers, and other subject matter experts, and heard recommendations for closing gaps in data collection, service delivery, and training and education.

The Commission also convened workshops and forums designed to gather perspectives from communities affected by suicide in ways that are not well documented by data, groups such as youth, first responders, and people from diverse cultural backgrounds. A common finding from these events was that suicide prevention efforts are most effective when they are culture-specific and include planning and delivery by people from the at-risk group. In addition, project staff participated in the City of Los Angeles Mayor's Challenge to Prevent Suicide,[31] and heard input from members of the California Department of Education's Student Mental Health Policy Workgroup, Indian Health Services, California Rural Indian Health Board, and many other organizations.

The Commission also visited several sites to explore opportunities for suicide prevention. These included the Rancheria Health Center and Counseling and Recovery Engagement Center in Shasta County, UCSF Benioff Children's Hospital in Alameda County, and the Golden Gate Bridge.

Research and Subject Matter Expert Consultation

As part of its research for this report, project staff met with local and national leaders in suicide prevention. Staff worked with representatives of departments under the California Health and Human Services Agency as well as other government and private partners. These included mental health, substance use disorder, public health, law enforcement, and education officials as well as representatives of foundations, nonprofit organizations, the healthcare industry, and other businesses. Staff also engaged with national leaders from the American Foundation for Suicide Prevention, National Zero Suicide Initiative, National Action Alliance for Suicide Prevention, Suicide Prevention Resource Center, Centers for Disease Control and Prevention, U. S. Substance Abuse and Mental Health Services Administration, and Suicide Awareness Voices of Education. Staff participated in a national convening of behavioral health and suicide prevention experts and attended a training on the Zero Suicide Initiative.

Finally, the Commission conducted a critical review of the latest research on suicide prevention best practices and consulted national and global frameworks for preventing suicide, including:

- The 2012 National Strategy for Suicide Prevention, developed by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention
- Public Health Action for the Prevention of Suicide: A Framework (2012) and Preventing Suicide: A Global Initiative (2014) by the World Health Organization
- Preventing Suicide: A Technical Package of Policy, Programs, and Practices by the Centers for Disease Control and Prevention

The Commission contracted with content experts at Stanford University to provide technical guidance on research and best practices in suicidology and public health strategy. Suicidologist Dr. Rebecca Bernert led the team of technical advisors, which included Drs. Keith Humphreys and Shashank V. Joshi.

Previous Suicide Prevention Plan

Development of this suicide prevention blueprint included a review of the state's previous plan. In September 2006, Governor Arnold Schwarzenegger directed the former Department of Mental Health to develop a statewide strategic suicide prevention plan. It was approved by the Governor's Office on June 30, 2008, but many of the recommendations were not fully implemented. The new plan retains much of what was proposed, with updated best practices in means restriction, health care, and data monitoring and evaluation. Key advancements directed by the previous plan – some of which were partially implemented – are briefly highlighted below.

Leadership

The 2008 plan called for a dedicated state office to provide coordination and collaboration across the state. The Office of Suicide Prevention was established by the Department of Mental Health, but was transferred and reorganized into the Suicide Prevention Program after the department was closed in 2012.[32] The program is currently housed within the Department of Health Care Services.[33] Core functions of the office, such as convening regional meetings, disseminating resources to county suicide prevention liaisons, and coordinating suicide prevention activities to advance the goals under the plan, have since ended.

Guidance for Policy and Practice

Local suicide prevention activities have expanded since 2008, largely through funding with Mental Health Services Act (MHSA) dollars. A portion of the funding is directed toward the prevention of the consequences of unmet mental health needs, including suicide. County behavioral health departments use this funding to reduce risk factors for mental health needs through "prevention programs" and "early intervention programs," and by initiating suicide prevention efforts that prevent suicide as a consequence of mental health needs.[34] Local behavioral health departments spent over $13 million during fiscal year 2016-2017 on suicide prevention activities, including suicide prevention hotlines, gatekeeper training, depression screening for older adults, and services supporting suicide loss survivors.[35]

Several counties have suicide prevention plans and local task forces or collaboratives with multi-disciplinary partners that are working together to prevent suicide. Counties with local plans include Contra Costa, Fresno, Kings, San Diego, San Mateo, Santa Clara, Solano, Tulare, and Tuolumne. Counties that have local collaboratives include Contra Costa, Fresno, Kings, Los Angeles, Napa, Nevada, San Diego, San Mateo, Shasta, Solano, Tulare, Tuolumne, and Ventura. Other counties, such as Marin, Santa Cruz, and Stanislaus, are in the planning phase. For example, Stanislaus County was approved to use MHSA Innovation funding to use collective impact principles to develop a local suicide prevention plan but does not have a plan in place at this time.[36]

California public schools with students in grades seven through 12 are required to develop a "Pupil Suicide Prevention Policy." The policy must be created in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts, and must include procedures related to suicide prevention, intervention, and postvention. All policies were to be in place by the 2017-2018 school year. A review conducted in 2018 by the Trevor Project found that 86 percent of schools that are required to have plans have them in place, leaving approximately 69 schools without plans.[37]

Local and state correctional officials have made significant changes to suicide prevention efforts in custodial settings. Each local correctional facility is required to have a comprehensive suicide prevention program to identify, monitor, and deliver services to people at risk of suicide.[38] The program must include suicide prevention training, screening at intake, processes for facilitating coordination between staff and health care providers, housing considerations to reduce access to lethal means, supervision, reporting requirements, and an administrative review process for suicide and suicidal behavior.[39] Changes to regulations effective July 1, 2020 require two to four hours of suicide prevention training for all correctional and probation officers.[40]

In 2017, the California State Auditor issued a report calling for more transparency of suicide and suicide attempt in state correctional facilities.[41] The following year, legislation was passed to require the California Department of Corrections and Rehabilitation to submit to the Legislature an annual report on the department's efforts to prevent suicide and suicide attempt among inmates.[42] The department must include progress toward the goals of conducting risk assessments, delivering suicide prevention training to staff, and reducing risk factors associated with suicide, among other objectives.[43] There is no statewide effort in place to evaluate these changes.

Training and Workforce Enhancements

Another goal of the 2008 plan was to develop and implement training and workforce enhancements to prevent suicide. Legislation passed in 2017 required licensed psychologists to receive no less than six hours of training in suicide risk assessment and intervention by 2020.[44] Additional legislation was passed in 2018 to extend this requirement to mental health professionals licensed by the Board of Behavioral Sciences.[45] In addition to increased training for clinicians, the Legislature allocated $1.7 million for one-time general funding for online suicide prevention training for all public middle and high school students and staff in California.[46] Despite these critical advancements, there still remains a need for standardized training guided by best practices. Finally, legislation passed in 2018 requires licensed health care practitioners who provide prenatal or postpartum care to screen clients for mental health needs and requires health plans to create maternal mental health programs.[47] There is no requirement, however, to assess for or manage suicide risk if mental health needs are identified.

Technical Assistance

The 2008 plan outlined the need for technical assistance, such as establishing regional learning collaboratives, training guidance, an online clearinghouse, and ongoing support for local suicide prevention efforts. The Commission approved one-time MHSA funding of $40 million over four years for statewide infrastructure, such as a clearinghouse of best practices to assist in training and technical assistance efforts, as well as a suicide hotline system, which would benefit all counties.[48] That investment resulted in several initiatives administered by the California Mental Health Services Authority – some of which are still operational.[49] These initiatives created regional networks focused on collaboration and development of best practices and delivered suicide prevention training. They also produced social media marketing campaigns, and partnered with crisis centers to expand cultural and linguistic competent outreach, technology capacity to chat and text functions, and improved crisis line data collection.[50] Among the work made possible by this investment are the Know the Signs Campaign, the Directing Change program and film contest, and the California Suicide Prevention Network.

The Know the Signs Campaign is a social marketing initiative to educate Californians on how to recognize the warning signs of suicide, how to talk to someone in crisis, and how to access services.[51] The campaign also works with members of the media to promote consistency with national recommendations for reporting suicides in the news. Directing Change is a program and film contest in California designed to engage students in creating films to promote positive conversations about mental health and suicide prevention.[52] Lastly, the California Suicide Prevention Network was established to centralize statewide suicide prevention activities, reduce stigma associated with suicide, and increase access to care for people at risk of suicide.[53] The network also produced common metrics for evaluating suicide prevention hotlines: the demographic data of callers, the reason for the call, call volume, and the suicide risk of caller.[54]

Suicide Hotline Assessment

One next step identified in the 2008 plan was to assess the status of coverage and accreditation for suicide prevention hotlines.[55] The Department of Health Care Services was directed in 2016 to conduct a comprehensive assessment of suicide hotlines and to recommend funding strategies to ensure hotlines have adequate resources to meet demand.[56] The department produced a report that documented the structure, capacity, and funding of suicide hotlines accredited by the American Association of Suicidology across the state.[57] The report highlighted the demand for a statewide suicide hotline system but also stated that a lack of data prevented the department from determining the funding needed to meet demand.[58] As of 2019, $4.3 million per year of MHSA funding, along with local and private funds, support California's 11 National Suicide Prevention Lifeline Centers.[59]

Public Review

The draft statewide strategic suicide prevention plan was first released for public comment on July 3, 2019. The Subcommittee received written and verbal comments before the plan was submitted to the Commission for consideration.

Plan Note

This plan does not include physician-assisted dying, which is sometimes referred to as assisted suicide. In California, the End of Life Option Act allows qualified adults with a terminal illness to request aid-in-dying drugs from their physician.[60]


Suicide is a complex public health challenge that demands a comprehensive approach that intervenes along a continuum of risk, leaving "no wrong door" for a person in need.

Suicidal Behavior: Definitions, Theory, and Key Concepts for Prevention

Suicidal behaviors exist on a broad continuum of risk, and include desire to die; suicidal ideation; suicide attempt planning; suicide attempts; and death by suicide. The Centers for Disease Control and Prevention uses the term ***self-directed violence*** to describe a range of violent behaviors that can be fatal or non-fatal, suicidal or non-suicidal; suicide itself is defined as "death caused by self-directed injurious behavior with any intent to die as a result of the behavior."[61] For the purposes of this document, non-fatal, suicidal self-directed violence is referred to as "suicidal behavior."

Definitions of Self-Directed Violence

Self-directed violence is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. [62] Behavior can be non-suicidal or suicidal.

Non-suicidal self-directed violence is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself, with no evidence - implicit or explicit - of suicidal intent.

Suicidal self-directed violence is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself, with evidence – implicit or explicit - of suicidal intent. Suicidal self-directed violence includes:

- ***Suicidal attempt,*** a non-fatal, self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
- ***Interrupted or aborted suicide attempt,*** an effort to injure oneself that is stopped by the person attempting self-harm, or by another individual prior to fatal injury. This can occur at any point during the act, such as after the initial thought or after the onset of behavior.
- ***Preparatory acts*** or preparation toward making a suicide attempt, taken before potential for harm has begun. This can include any action beyond a verbalization or thought, such as purchasing a gun or preparing for one's death by suicide by giving away belongings.

Suicidal behavior also can include suicidal ideation, which is defined as having the desire to die, or thinking about engaging in behaviors to die.[63] Suicidal ideation can be passive or active.[64] If it is active, suicidal ideation can be nonspecific, can include a method but no intent or plan, can include a method and intent but no plan, and can include method, intent, and plan.[65] For the purposes of this document suicidal ideation is referred to as suicidal behavior, unless specified.

Suicidal Ideation Definitions and Screening

Five levels of suicidal ideation – increasing in severity - are outlined within the Columbia-Suicide Severity Rating Scale:[66]

Suicidal Desire – Person has a wish to be dead or not alive, or a wish to fall asleep and not wake up.

Suicidal Ideation (Thoughts) – without thoughts of method
Nonspecific thoughts about suicide or wanting to end one's life, without thoughts of a method for an attempt. Example: Life is not worth living.

Suicidal Ideation: Includes method - no intent or plan
No specific plan with time, place, or method details worked out. Example: I've thought about driving off the road or overdosing, but never of acting on the thought.

Suicidal Ideation: Includes method and some intent - but no plan
Thoughts of an attempt method, with some intent to act. Example: I've thought about driving off the road and have thought about acting on it when feeling at my worst.

Suicidal Ideation: Includes method, intent, and plan
Thoughts of attempting suicide with details of a plan and some intent to carry it out. Example: I've started to work out plans for how to overdose and intend to carry it out.

The Columbia-Suicide Severity Rating Scale uses the following questions to screen for severity of suicidal ideation and is used to support decisions for services and referral based on risk:

1. Have you wished you were dead or wished you could go to sleep and not wake up?
2. Have you had any thoughts of suicide?
3. Have you been thinking about how you might do this? For example, "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it … and I would never go through with it."
4. When you had these thoughts, did you have some intention of acting on them? As opposed to "I have the thoughts but I definitely will not do anything about them."
5. Have you started to work out or have you worked out the details of how to attempt suicide? Do you intend to carry out this plan?

See www.csssrs.columbia.edu for downloadable measures designed for select settings and groups.

Assessing for Suicide Risk

The risk posed by suicidal ideation varies according to the intensity, duration, and pervasiveness of ideation; the controllability of symptoms; reasons for living; and history of past suicide attempts or non-suicidal self-injury.[67] As a result, the Columbia-Suicide Severity Rating Scale and other assessment measures prioritize evaluation of the intensity of suicidal ideation (e.g., asking about duration, controllability, deterrents, reasons for the thoughts) as well as evaluation of suicidal behavior (e.g., history of suicide attempt, interrupted or aborted attempt, preparatory behaviors, and intentional self-harm without desire or intent to die).[68] Suicide risk assessment is discussed in greater detail in subsequent sections that review best practices in collaborative assessment and management of suicide risk. Best practices in suicide risk assessment and management use a collaborative and transparent approach to assessing for suicide risk and to support delivery of additional services, referral, or safety planning.[69]

Suicide Theory

Suicide is a complex public health challenge involving many biological, psychological, social, and cultural determinants.[70] Several theories about why people die by suicide seek to explain how multiple factors may increase risk in the context of profound emotional suffering. According to one predominant theory, known as the Interpersonal Theory for Suicide, three components must align to predict risk for suicide or a serious suicide attempt: thwarted belongingness, perceived burdensomeness, and acquired capability for lethal self-injury.[71]

Thwarted Belongingness and Perceived Burdensomeness

The Interpersonal Theory for Suicide includes two components of the desire to die by suicide and depression: "thwarted belongingness" and "perceived burdensomeness."[72] Thwarted belongingness is described as a state of "unmet need to belong."[73] Both the theory and extensive research indicate that people have a fundamental need to belong and that, when that need is thwarted, it increases risk.[74] A sense of belonging can increase during times of national celebration and in times of national crisis, such as during wartime. One illustration of this involved the change in the national daily suicide rate following the attacks on September 11, 2001.[75] In the year following the attacks, suicide rates in entire U.S. communities showed an unprecedented decrease – but only on that day, not in the period before or after.[76] Similar findings are observed in times of national celebration.[77] Perceived burdensomeness is the false belief that "my death is worth more than my life."[78] Unemployment, health problems, and incarceration are examples of situations in which a person may feel like they are a burden to others. This finding aligns with empirical research indicating that these situations increase risk for suicide.[79]

Acquired Capability

The components described above are modifiable components of depression and reflect the desire to die. But the theory proposes that these factors are not on their own predictive of risk. Indeed, most people with depression do not go on to die by suicide. The theory instead suggests that people are most at risk when these components are present in combination with an acquired capability for self-injury, or "the ability to engage in suicidal behaviors acquired through life experiences that habituate pain tolerance and fearlessness about death."[80] Such experiences may include exposure to physical pain, violence, and provocative life experiences, such as childhood trauma, witnessing a traumatic event, suffering from a chronic medical illness, or engaging in self-directed violence.[81] Indirect exposure to others' pain and injury also may increase acquired capability, increasing risk among groups such as veterans, physicians, nurses, and first responders.[82]

Means Matter

While reducing access to lethal means is a central element in global and national suicide prevention plans, it remains poorly understood – and underutilized for reducing suicide in California.[83] Suicidal behavior is often method-specific, and a person's choice of means is driven by multiple factors. These include the lethality, accessibility, and acceptability of the method.[84] Eliminating or reducing access to a particular method during a crisis creates lifesaving time and opportunity for intervention.[85] These dynamics are critical because crises involving suicidal behavior tend to be transient, and characterized by extreme ambivalence about the wish to die or stay alive.[86] Research shows that when a person's attempt is thwarted, he or she does not go on to die by suicide at other locations, times, or by other methods.[87] As such, the placement of time between thoughts of suicide and a person's ability to obtain lethal means for an attempt represents a practical, lifesaving approach to prevent suicide.[88]

Gun access – especially access to guns in the home – is a significant consideration in suicide prevention because the majority of people who die by suicide use a firearm.[89] While drug overdose is the most common method of suicide attempt, firearms are the most lethal.[90] Only about 15 percent of people who attempt suicide with a firearm will survive.[91] Using a highly lethal method of dying by suicide does not necessarily indicate a stronger desire to die.[92] Death by suicide is the result of many contributing factors, including choice of means, preexisting health, mental health needs, substance use disorders, and the amount of time lapsed before rescue or medical intervention, among others. Lethality of means increases with age and escalates with the number of suicide attempts.[93]

Key resource: www.meansmatter.org

Inherent Challenges and Emerging Innovations

Due to the nature of suicide, there are several inherent barriers to preventing it, making the implementation of comprehensive suicide prevention efforts challenging.[94] These challenges are not immutable, but overcoming them will require a concerted effort.

Mental Health and Suicide Stigma

Harmful myths and stigma may discourage people from seeking help, prevent people from disclosing suicide risk, and hinder intervention and access to services. If left unaddressed, stigma can prevent multidisciplinary coordination across public and private industry partners, settings, and philosophies, and reduce the likelihood that suicide prevention will be included in public health strategies.[95] For example, though the majority of deaths by firearm occurs by suicide, suicide prevention and lethal means restriction are rarely discussed in gun safety campaigns and initiatives that promote safe gun storage.[96] Stigma also may affect public awareness of available services or effective practices to prevent suicide. Stigma likewise prevents people from seeking help for mental health needs and is tied to disparities in seeking services for mental health needs and health access.[97] Men, for example, are more likely to receive mental health services in emergency departments because of perceived stigma associated with receiving mental health care. Understanding these disparities may help to identify targeted strategies for prevention and education training.

Disparities in Health Care Access

The success of suicide prevention services traditionally has been dependent upon people at risk seeking the services they need. This reality poses a heavy burden on people who may be in crisis, and has persisted despite the effectiveness of screening protocols to guide triage and referral.[98] Services that specifically address suicide risk often are limited to select settings, such as a single community hospital, which limits the delivery of integrated health care services across settings.[99] Variability in clinical practices can stymie the delivery of effective programs, and rural communities commonly experience shortages in services, especially for people with complex needs.[100]

While psychosocial treatments for suicidal behaviors are effective, a lack of access to specialized care providers trained in such methods may limit their widespread use.[101] Insurance coverage also can create barriers for people seeking to see specialists, while language and cultural factors pose additional challenges for people seeking providers able to understand them and provide care that can effectively reduce risk. Non-medical settings, such as the workplace or community centers, may be underutilized as opportunities to connect people with systems of care. These limitations may prevent services and effective approaches from being scaled statewide, or even within the same community.[102] Uniform guidelines for establishing visible and easily accessible pathways to access services has the potential to bridge this gap. Such guidelines could include centralized online resource hubs, provider referral networks with clearly described eligibility criteria, and standard protocols for best practices in transferring mental health emergency calls answered by 911 dispatchers to mobile crisis units or teams.

Missed Detection

Despite detection efforts, people at risk for suicide may not be identified and receive the services they need when they need them.[103] This challenge can be addressed by suicide prevention efforts that are integrated into entire systems to ensure people at risk do not fall through gaps. Nationally, as of July 1, 2019, all people seen in medical settings for a primary diagnosis or primary complaint of a behavioral health need, including those seen in emergency departments as well as outpatient and inpatient settings, are required to be screened for suicide risk.[104]

Other major suicide prevention initiatives in healthcare are underway. The Zero Suicide Initiative is an international movement toward systems transformation dedicated to preventing suicide within healthcare systems, with free toolkits and training programs.[105] Studies show that the majority of those who die by suicide interact with their doctor and health care system in the weeks and months prior to death.[106] The Zero Suicide Initiative promotes a system of continuous quality improvement in which health and behavioral health care providers develop policies and implement practices known to prevent suicide.[107] The potential to eliminate suicide when best practices are used and those at risk are uniformly connected to evidence-based services has been demonstrated through the Henry Ford Health System's Perfect Depression Care program, upon which the initiative is based.[108] Essential elements of the initiative are:

1. **Lead** systemwide culture change committed to reducing suicides
2. **Train** a competent, confident, and caring workforce
3. **Identify** people in care settings with suicide risk via comprehensive screenings
4. **Engage** all people at risk of suicide using a suicide care management plan
5. **Treat** thoughts of suicide and behaviors using evidence-based treatments
6. **Transition** people through care with warm hand-offs and supportive contacts
7. **Improve** policies and procedures through continuous quality improvement

Recent innovations in technology also offer hope for improving the detection of suicide risk, presenting opportunities for greater precision as well as increased screening sensitivity and better triage of people into services.[109] Machine learning is a form of Artificial Intelligence that enables a computer to learn patterns without prior programming and to devise complex algorithms to improve the accuracy of prediction.[110] Data routinely collected through electronic health records may be helpful in predicting future suicidal behavior.[111] An algorithm in one study of hospital admission data – age, gender identity, zip code, medication, and diagnostic history, for example – was 84 percent accurate in predicting whether someone who was seen at the hospital for either non-suicidal self-injury or suicide attempt would attempt suicide in the following week.[112] The algorithm was 80 percent accurate in its prediction for a two-year period.[113] Such suicide prediction modeling is being developed for use in large healthcare systems, such as the U.S. Department of Veterans Affairs and Kaiser Permanente.[114]

Machine learning also is being utilized by social media companies.[115] For years, Facebook users have had the ability to report posts by friends and family who they believed to be at risk for suicide. In response to the posts, Facebook's Community Operations team connects the flagged Facebook user with resources. Facebook has expanded its suicide prevention efforts by using machine learning to identify "suicidal expression" in posts by people at risk by monitoring phrases they use or comments from family and friends. Whether content is flagged by friends and family or by machine learning, the response is the same – a Community Operations team member reaches out to the person at risk, and, in emergencies, works with first responders.

Challenges in Terminology and Uniformity

Definitions for suicidal behavior are not uniform, and, likewise, there are no standards for suicide risk assessments, which affect risk detection, disclosure of risk, and reporting.[116] Despite calls for uniformity and national and state standards for screening, reporting, and data monitoring, there remain significant differences in how data are captured and how people are screened and referred to services.[117] Clinical practice guidelines for suicide prevention also reflect a lack of consensus, which may affect uniform procedures in risk assessment, triage, and training.[118] Differences in screening may hinder the ability to distinguish people at risk, preventing the delivery of effective programs and research of risk factors.[119] In response to these challenges, the Centers for Disease Control and Prevention created uniform guidelines to aid precision and comparability in the prevention and monitoring of suicidal behaviors.[120] Mandated screening and means restriction policies offer opportunities to aid detection given their universal use.[121]

Barriers to Innovation

Despite advancements in suicide prevention, much is still unknown, and research exploring risk factors and treatments for suicidal behaviors remains a national and global priority. Specialists trained to conduct this research, however, are few relative to the need and priority. There is still much to understand about fundamental factors that contribute to risk for suicide and how risk changes over the lifespan, especially for specific groups.[122] Risk factors change over time, and often are internal to each person. Identifying these internal factors is key to the detection of risk and intervention, as is the dissemination of information about how risk factors contribute to suicidal behavior and how those factors can be managed.[123] Finally, monitoring dynamic risk factors requires substantial and expensive infrastructure critical to building and sustaining effective suicide prevention initiatives.[124]

Research may be further hindered by funding and infrastructural barriers, and by methodological, ethical, and safety challenges inherent to conducting epidemiological studies or research among those at high risk for suicide. Research on the effectiveness of interventions specifically targeting suicide risk is scarce. Until recently, people at risk for suicide were excluded from clinical drug trials due to safety concerns. This limited the study of new treatments. The U.S. Food and Drug Administration now mandates assessment of suicide risk across all Central Nervous System drug trials.[125]

Some communities experience higher rates of suicide than others; this may be in part attributable to high gun ownership and disparities in the access and use of health, mental health, and substance use disorder care.

Suicidal Behavior in California

The following section describes suicidal behavior specific to California. It presents the state's suicide prevalence and rates based on the most recent data available. California's trends in suicide rates and suicidal behavior are aligned with national statistics, though some deviations are noted below. Trends in population and vulnerable group suicide rates are significantly affected by the method used for suicidal behavior; more lethal means, such as firearms, are involved in more suicide deaths.[126]

Suicide Data

In 2017, 4,323 Californians who lost their lives to suicide.[127] California's age- adjusted[1] suicide rate is 10.7 per 100,000 people – one of the lowest rates among states – compared to the national rate of 14.0 per 100,000 people.[128] California's relatively low suicide rate may be attributable to its policies regulating access to guns.[129] In general, states with high rates of gun ownership tend to have higher rates of suicide and accidental death by firearm, whereas states with lower rates of gun ownership have lower suicide rates.[130] While California's suicide rate is low compared to most other states, variability exists across counties. For example, Humboldt County has one of the highest suicide rates in California at 24.3 per 100,000 residents.[131] Santa Clara County has the lowest suicide rate in California at 7.5 per 100,000 residents.[132] Variability in rates may be attributable to certain characteristics that increase risk for suicide, such as high gun ownership and less access to health care in rural communities.[133]

While rates are generally higher in rural Northern California counties, 2017 data show that a greater ***number*** of suicides claim the lives of residents in Southern California, specifically Los Angeles (21 percent of total suicides), Orange (10 percent of total suicides), Riverside (8 percent of total suicides), San Bernardino (6 percent of total suicides), and San Diego (5 percent of total suicides) counties, consistent with their population density.[134] Half of all suicides in California in 2017 were reported in these five counties.[135] This concentration highlights the need for – and promise of – targeted, community-driven approaches and use of data to understand local and regional opportunities. (Note: suicide data that includes sexual orientation and gender identity are not currently collected and reported across the state.)[136]

Suicide by Means

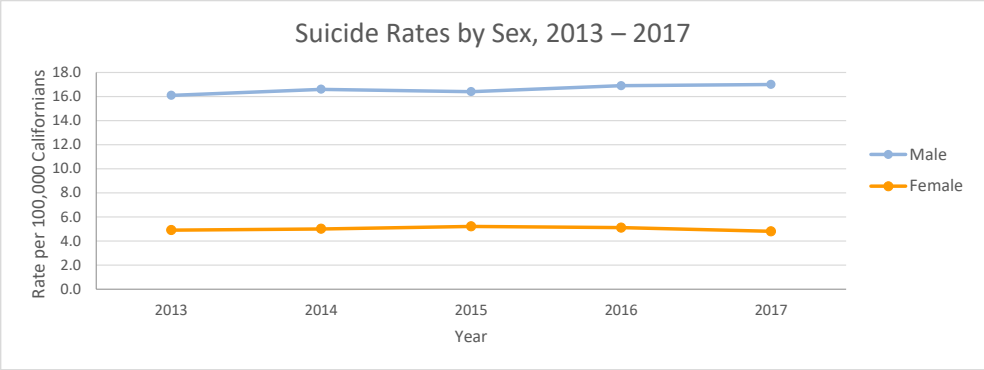
Firearm (37 percent of total suicides), hanging and suffocation (32 percent of total suicides), and poisoning, which includes overdose (16 percent of total suicides), are the three most common ways people died by suicide in 2017 in California.[137] These trends are consistent with national trends.[138] Californians aged 30 and younger were more likely to die by hanging or suffocation, while people older than 50 were more likely to die by firearm.[139] The trend of younger people dying by suffocation is consistent with national trends.[140] These differences in use of means highlights the opportunity to focus suicide prevention resources to target strategies that reduce access to certain means for certain at-risk groups.[141]

[1] Rates are adjusted using the 2000 US Standard Population weights and using 5 year age groupings for county and 10 year age groupings for the other variables. The age of the youngest suicide death is 10.

Suicide Rates by Sex

In 2017, males died by suicide at a rate more than three times higher than the rate of females in California.[142] This statistic is consistent with national data showing that males are nearly four times more likely to die by suicide than females.[143] This difference is largely explained by the use of more violent means among males.[144] In other words, while attempt rates are higher for females, males are more likely to die as a result of an attempt because they use a firearm. Research consistently demonstrates that regardless of age group or culture, males are more likely to die by suicide and females are more likely to attempt suicide.[145] Males dying by suicide at higher rates is consistent internationally, except for China, where females – particularly young, rural residents – die by suicide at greater rates than males.[146]

Suicide rates are higher among males. Between 2013 and 2017, suicide rates increased slightly for males and remained relatively stable for females. Data on sexual orientation or gender identity is not currently collected. (See Graph 1.)

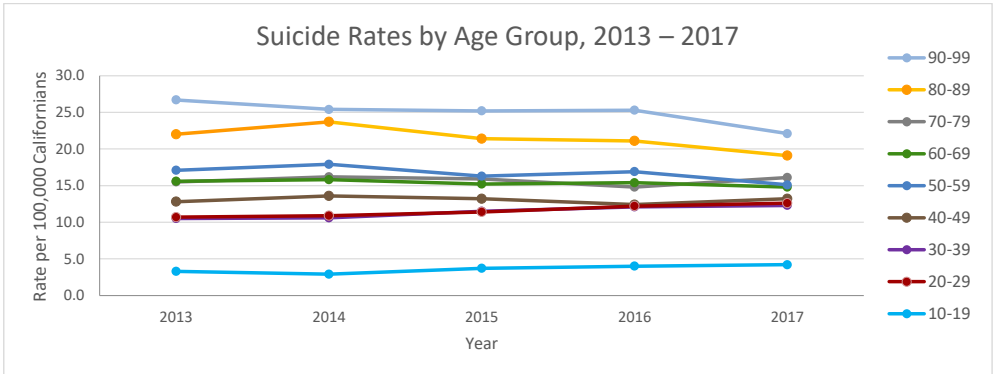


Graph 1. Data extracted from the California Department of Public Health's EpiCenter at http://epicenter.cdph.ca.gov.

Suicide Rates by Age Groups

Risk of dying by suicide increases with age. In 2017, the suicide rate peaked at 14.5 per 100,000 for people between the ages 25 and 29, increased through middle-age, and was highest among Californians aged 85 and older (20.7 per 100,000 people).[147] This pattern is consistent with national trends. Californian men aged 85 and older had the highest suicide rate of any age group, at 45.1 per 100,000 people.[148] People in younger age groups attempt suicide at higher rates compared to older age groups but survive their attempt in part because of the selection of less lethal means for suicide.[149]

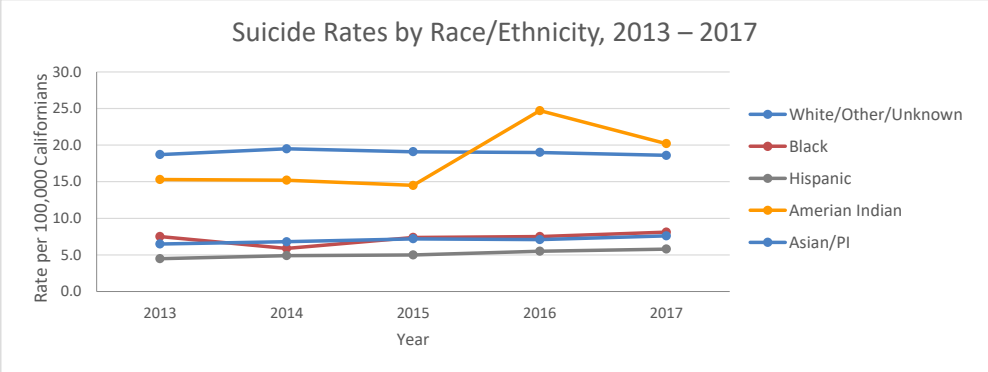
Suicide rates increase as Californians age. Between 2013 and 2017, suicide rates remained relatively stable for most groups, with slight increases for Californians in the middle years. (See Graph 2.)



Graph 2. Data extracted from the California Department of Public Health's EpiCenter at http://epicenter.cdph.ca.gov.

Suicide Rates by Race/Ethnicity Suicide rates in California are highest among whites (17.1 per 100,000 people) and Native Americans (15.6 per 100,000 people).[150] Native Hawaiian/Pacific Islander Californians had the next highest rate in 2017, at 14.1 per 100,000 people.[151] All other racial/ethnic group suicide rates were under 10 per 100,000 people.[152] This pattern is consistent with national trends, with white males accounting for nearly 70 percent of all suicide deaths in the U.S. in 2017.[153]

Suicide rates are highest for white and Native American Californians. Between 2013 and 2017, suicide rates remained relatively stable for most groups. Suicide rates among Native Americans have increased. (See Graph 3.)



Graph 3. Data extracted from the California Department of Public Health's EpiCenter at http://epicenter.cdph.ca.gov.

Suicide by Military Service Status

In 2017, there were 640 suicides by Californians aged 18 years and older who had served in the U.S. Armed Forces, accounting for 15.3 percent of all suicides in California that year.[154] The majority of current and former service members who died by suicide were male (96.7 percent) and white (79 percent); and 43 percent were between the ages of 25 and 64 at the time of death.[155] Additionally, 40 percent were between the ages of 65 and 84 at death.[156]

The majority – 65.6 percent – of Californians who served in the Armed Forces and died by suicide in 2017 used a firearm.[157] Data showing that service members are more likely than other at-risk groups to die by suicide using firearms highlights the need for prevention strategies to consider the means by which different vulnerable groups die by suicide.[158] Data collection does not distinguish between current and former service members, or veteran or active duty status.[159]

Suicide in Law Enforcement Custody

State and local law enforcement agencies are mandated to report the number of deaths in custody along with arrest data, including death by suicide, to the California Department of Justice.[160] Custody settings include correctional housing, booking areas, holding cells, treatment units, and common areas, in addition to crime or arrest settings. Between 2005 and 2017, 922 people died by suicide in law enforcement custody.[161] The number of suicides in custody settings has decreased from an annual high of 83 in 2013 to 60 in 2017.[162] Most people who died by suicide in custody were male (93 percent) and were classified as white (49 percent), Hispanic (31 percent), or African American (11 percent).[163]

Other Suicidal Behavior Data

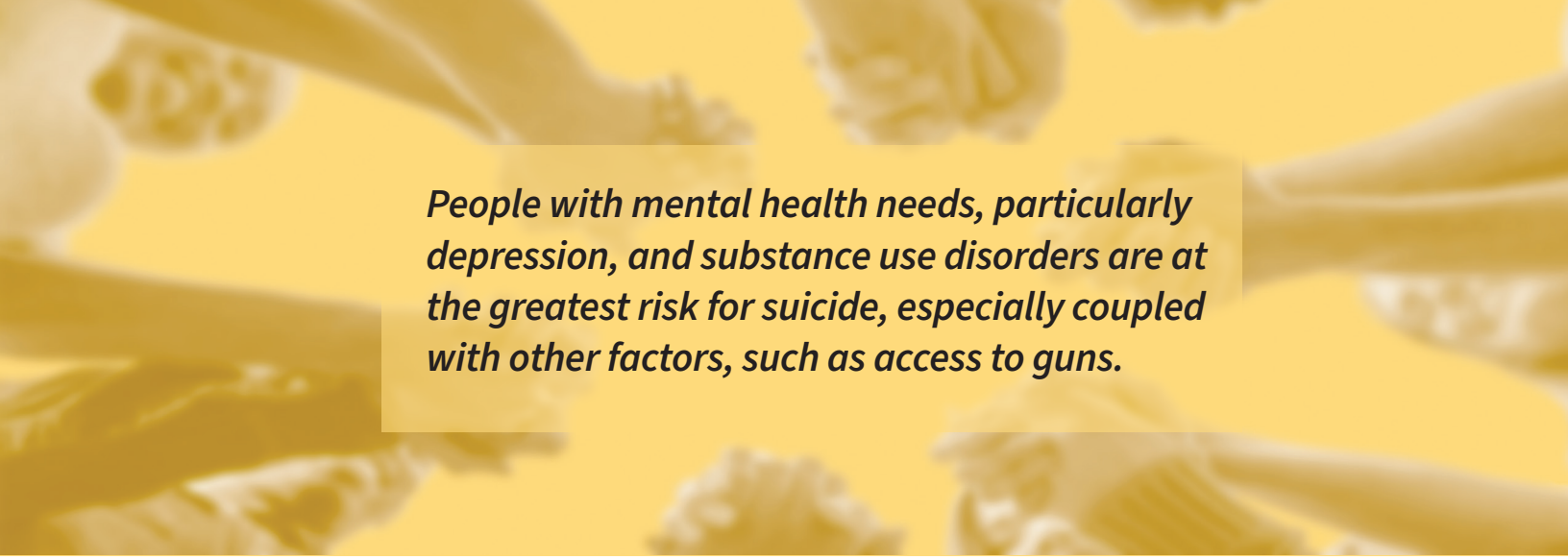
In 2017, 18,153 Californians visited or were admitted to an emergency department for intentional self-harm.[164] Less is known about the prevalence of thoughts of suicide, because data may be limited to national or local self-report surveys. According to one survey, an average of 1,115,000 Californians over the age of 18 – about 3.8 percent of all adults – reported having serious thoughts of suicide in the past year.[165] Another survey estimated that 19 percent of California 9th graders and 18 percent of California 11th graders seriously considered attempting suicide in the past year.[166]

Data Limitations

There are many limitations to using current data to support suicide prevention efforts. The widely acknowledged underreporting of suicide as a manner of death on death certificates is one challenge.[167] Manner of death includes natural and unnatural death, which includes suicide, homicide, accidental, or undetermined; cause of death refers to the circumstances of death, such as a gunshot wound. Coroners inquire into and determine the manner and cause of death when suicide is known or suspected.[168] After a death, a coroner or medical examiner follows procedures and protocols to investigate by documenting and evaluating the setting in which someone died; evaluating the body of the decedent; and evaluating medical, mental health, and social history.[169] Underreporting of suicide can occur because of inconsistent death classification.[170] While one coroner might label a death a suicide, another coroner confronted with the same circumstances might rule it "undetermined" or "accidental." Cultural and religious beliefs, as well as stigma, also may influence the accuracy of reporting and death records.[171]

Several other barriers limit the use of suicide data for prevention efforts.[172] One is the inconsistent use by local jurisdictions of electronic reporting in centralized state databases, such as those maintained by the California Department of Public Health and the Office of Statewide Health Planning and Development.[173] Many death records remain in print form, which substantially delays reporting and real-time monitoring of suicide within and across counties.[174] Further, bridge and railway suicide deaths are not reported in a unified manner by individual sites to a centralized reporting system. Instead, information is housed across multiple agencies, such as the California Department of Transportation (CalTrans), local transit districts, federal rail authorities, the California Highway Patrol, local sheriff-coroners, and other private entities.[175] Compiling such data is crucial to evaluating public health risk and policy need, but a centralized reporting system is not in place.[176]

Untimely data reporting and monitoring also may limit the ability of professionals to intervene when several suicides occur in proximity in place or time, known as a suicide cluster.[177] Inconsistent coding methods may compound the difficulty of drawing comparisons between years, settings, or at-risk groups. In addition, data tends to be restricted to suicide deaths, despite critical opportunities for prevention in data associated with both suicide attempts and "save data," which describes a thwarted suicide attempt and subsequent connection to crisis services. For example, public data does not include how many people had repeat visits to the emergency department for suicidal behavior, discharge or follow-up care outcomes, or first- time suicidal behavior not requiring triage services. These challenges highlight the need to disseminate data collection, standardization, and monitoring best practices statewide.



People with mental health needs, particularly depression, and substance use disorders are at the greatest risk for suicide, especially coupled with other factors, such as access to guns.

Risk and Protective Factors

Risk factors are characteristics that may make suicidal behavior more likely to occur, while protective factors are characteristics that make suicidal behavior less likely.[178] Importantly, such factors often occur in the context of health and mental health needs and substance use disorders, interacting with other complex social, demographic, and situational dynamics. Factors that increase suicide risk, for example, are dangerous for people living with depression, but are manageable for other people.

Some risk factors are modifiable, while others – such as history of suicidal behavior or demographic characteristics –are not. Suicide prevention efforts are effective when they target high-risk settings or risk and protective factors that can be modified, such as increasing screening and access to services for depression and other needs. Warning signs, by comparison, are behaviors that may indicate or signal acute risk for suicide, which may be similar to or distinct from risk factors.[179] See the next page for a list of risk and protective factors and warning signs.

Typically, risk can be elevated during times of acute or lasting transition, though the higher exposure is not limited to such periods. These transitions can include job loss, marital status changes, hospitalization, housing changes, and military service discharge or post-deployment. Risk appears to be additive – the more factors, the higher the risk – and it cuts across demographic, economic, social, and cultural boundaries. **Major risk factors for suicide are prior suicide attempt; substance use disorder; mood disorder, such as depression; access to lethal means; and physical health needs**.[180]

Protective factors include the absence of risk factors and increased connectedness to community, culture, spiritual faith, and other factors that reduce risk, such as access to health care and social support and safe storage of guns and medications. **Major protective factors for suicide are effective mental health care; connectedness to people, family, community, and social institutions; problem-solving skills; and contacts, such as postcards or letters, from service providers and caregivers**.[181] Some factors both increase and reduce risk. For example, prior suicide attempt increases risk in some and lessons risk in others, as many people who attempt suicide once never attempt again.[182] This fact highlights the need to continuously evaluate and monitor the variability of risk and protective factors.

Cultural Considerations

Some risk and protective factors vary depending on the group targeted for suicide prevention efforts. For example, spirituality and religion are tied to reduced risk for suicidal behavior.[183] Spirituality and religion are deeply rooted in the culture, values, and norms of most ethnic groups.[184] Both can reinforce and strengthen cultural identity, protecting against risk.[185] Both may provide congregational opportunities to connect with community members, especially in times of stress, loss, and despair, reducing isolation and increasing resiliency and belonging. This can further mitigate risk by fostering hope and connection, promoting a sense of personal purpose or meaning, and teaching coping skills through spiritual practice.[186]

While religion is a protective factor for many communities, there are important differences among vulnerable groups. For example, religion may increase suicide risk among lesbian, gay, bisexual, and transgender people.[187] Adherence to religious doctrine that conflicts with sexual orientation and gender identity can create confusion, distress, and isolation. This may be further compounded when people cannot seek support for their conflict and distress among members of their faith-based community.

Risk Factors

Suicide risk factors at the individual level include:[188]

- Prior suicide attempt(s)
- Thoughts of suicide with intent and planning (especially intense, pervasive, difficult to control)
- Perceiving few reasons for living
- Demographic factors (male sex, indigenous or white ethnicity, middle to older age)
- Unmet acute or persistent physical health and behavioral health needs, including chronic pain, disability, substance use, and mood disorders
- Access to lethal means and gun ownership, especially having guns in the home
- Social isolation and low sense of belongingness
- Feeling hopeless about the future
- Unstable mood or sleeping patterns, including insomnia and nightmares
- Hospitalization or incarceration
- New or ongoing financial or employment problems

Suicide risk factors at the relationship level include:

- End of a relationship or marriage, including by death or divorce
- Relational dissatisfaction and problems, including abuse
- Unstable or conflictual relationships

Suicide risk factors at the community level include:

- Lack of access to appropriate and affirmative health, mental health, and substance use disorder care
- Disconnection from culture and cultural practices

Suicide risk factors at the societal level include:

- Cultural beliefs or institutions that promote social isolation
- Sensationalistic media coverage, especially for youth
- Mental health stigma and discrimination

Protective Factors

Factors that reduce or protect against risk at the personal level include:[189]

- Life skills for coping, especially during stressful events and life changes (including problem-solving skills, coping skills, ability to adapt to change)
- Coping skills and resource acquired after previous suicidal behavior
- Personal or religious beliefs that prohibit or discourage suicide
- High self-esteem and sense of worth
- Strong quality of life with a purpose for living
- High sense of belongingness

Factors that lessen or protect against risk at the relationship level include:

- Connectedness to family or family of choice
- Genuine support from family or family of choice
- Relationships that affirm sexual orientation and gender identity

Factors that lessen or protect against risk at the community level include:

- Access to appropriate and affirmative health, mental health, and substance use disorder care
- Connectedness to neighborhood, community, or social group
- Community members who check in with one another
- Social institutions that promote healthy and active lifestyles

Factors that lessen or protect against risk at the societal level include:

- Cultural or religious beliefs that prohibit or discourage suicide and value purposeful living
- Religious affiliation or spiritual community membership

Warning Signs

The following behaviors could indicate or signal suicide risk:[190]

- Communicating a wish to die or plans to attempt suicide
- Expressing the experience of having thoughts of suicide that are intense, pervasive, or difficult to control
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Giving away possessions
- Drafting notes indicating intent or desire for suicide
- Communicating feeling hopeless or having no reason to live or persistent hopelessness
- Communicating feelings of guilt, shame, or self-blame
- Communicating feelings of being trapped or in unbearable pain
- Communicating being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly or engaging in risky activities
- Insomnia, nightmares, and irregular sleeping
- Withdrawing or feeling isolated
- Communicating or exhibiting anxiety, panic or agitation
- Appearing sad or depressed or exhibiting changes in mood
- Showing rage or uncontrolled anger or communicating seeking revenge

Vulnerable Groups

Members of some groups and occupations may be more vulnerable to suicide than others. Despite this increased vulnerability, most people in the groups described below will not die by suicide or engage in suicidal behavior. And, regardless of group membership, suicide most often occurs among people with mental health needs and is a symptom of depression.[191] The following list is not exhaustive; it is intended to demonstrate differences and trends among groups and to highlight suicide prevention resources. Communities must utilize the Public Health Model to document the problem of suicidal behavior and identify vulnerable community members, risk and protective factors, and effective interventions.

People in Middle and Older Age

Suicide rates among people in middle age – 35 to 64 years of age – are increasing.[192] Between 1999 and 2010, suicide rates among people in middle age have increased nearly 30 percent, especially among people aged 50 to 59.[193] In 2017, people of middle age represented 25.9 percent of the U.S. population but 35.1 percent of people who died by suicide.[194] Historically, older adults – or people over the age of 65 - have had the highest rates of suicide.[195] In 2017, this group represented 15.6 percent of the U.S. population but accounted for 18.2 percent of all suicides.[196] The high suicide rates among older adults may be driven by factors such as use of highly lethal means; unmet health, mental health, and substance use disorder needs, especially late-life onset of depression; personality traits and coping mechanisms; life stressors, such as the loss of loved ones; social disconnection; and impairments in functioning and disability.[197]

KEY RESOURCE: Preventing Suicide among Men in the Middle Years: Recommendations for Suicide Prevention Programs| Developed by the Suicide Prevention Resource Center: http://www.sprc.org/sites/default/files/resource-program/SPRC_MiMYReportFinal_0.pdf.

People Discharged from Hospital Settings

People seen in emergency departments for self-injury, regardless of their intent to die, are 30 times more likely to die by suicide than people who do not self-injure.[198] People discharged from psychiatric hospitalization are at especially high risk for future suicide and suicidal behavioral. Suicide risk increases during the first week of admission to a psychiatric hospital and during the first week after discharge.[199] For veterans, one study showed that suicide risk may be elevated during the first three months following discharge from a psychiatric hospital.[200] Common challenges that increase risk following discharge include missed follow-up appointments for outpatient care; a lack of resources or connection to such resources; unsupportive relationships or social networks, resulting in isolation and shame; and referrals that do not match individual needs.

KEY RESOURCE: Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit| Developed by Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center: http://www.sprc.org/sites/default/files/migrate/library/continuityofcare.pdf.

Veterans

Veterans account for approximately 14 percent of all suicides in the U.S.[201] More than half of the veterans who die by suicide are 55 years of age or older, but the suicide rate among veterans between the ages of 18 and 34 has increased by 11 percent, rising from a rate of 40.4 deaths per 100,000 people in 2015 to 45 deaths per 100,000 people in 2016.[202] Data show that nearly 70 percent of veteran suicides are by firearm, compared to less than 50 percent of all non-veteran suicides.[203] This fact underscores the importance of considering the means by which vulnerable group members die by suicide in any suicide prevention strategy.[204] Veterans have unique risk and protective factors related to military service, in addition to factors previously mentioned.[205] Protective factors include a strong sense of belongingness to a unit and resilience to withstand adversity.[206] On the other hand, transitioning out of military service may increase suicide risk.[207] Stressful experiences during this transitional period include a loss of purpose and sense of identity, difficulties securing employment, conflicted relationships with family and friends, and other challenges related to adapting to post-military life.[208]

KEY RESOURCE: National Strategy for Preventing Veteran Suicide (2018-2028) | Developed by the U.S. Department of Veterans Affairs: https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

Sexual Orientation and Gender Identity

Lesbian, gay, bisexual, transgender, queer, and questioning people may be at increased risk for suicide.[209] Currently, it is difficult to evaluate risk for suicide among LGBTQ people because sexual orientation and gender identity are not reported in death records. Healthcare settings, such as hospitals and emergency departments, also do not report sexual orientation and gender identity of people seen for suicide-related services, making it even more difficult to evaluate suicidal behavior among this vulnerable group. Self-report surveys of suicidal behavior are the primary source of data. One survey of youth in primary care estimated that 20 percent of lesbian, gay, and bisexual youth have attempted suicide.[210] Suicide risk also is elevated among transgender people.[211] One study showed that 40 percent of transgender people attempted suicide at least once in their lifetime, with 92 percent of those making the attempt before the age of 25.[212] Studies indicate that as many as 50 percent of transgender and gender non-conforming youth have attempted suicide.[213] Rejection of sexual orientation and gender identity by family and caregivers may significantly increase risk for suicide among LGBT youth, highlighting the need to include family-based interventions in suicide prevention efforts.[214]

KEY RESOURCE: Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth | Suicide Prevention Resource Center: http://www.sprc.org/library/SPRC_LGBT_Youth.pdf.

Youth of Color

American Indian and Alaska Native youth and young adults have the highest rate of suicide of any cultural or ethnic group in the United States.[215] Suicide is the second leading cause of death for American Indian and Alaska Native children and adults ages 10 to 34.[216] A recent study found that African American children ages five to 12 – both boys and girls - are dying by suicide at twice the rate compared to white children.[217] This finding highlights the need for continuous evaluation using the Public Health Model, as new at-risk groups emerge. Youth attempt suicide at greater rates than people of other ages.[218] Racial and ethnic differences also are found among suicidal behavior.[219] Latina adolescents, in particular, report the highest rates of suicidal behavior of any youth group.[220] As many as one in seven Latina youth attempt suicide, a rate greater than any other youth group of the same age.[221]

KEY RESOURCE: To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults| Developed by the U.S. Department of Health and Human Services: https://store.samhsa.gov/system/files/sma10-4480.pdf.

Rural Community Residents

People living in rural communities are at greater risk for suicide than those in more urban or densely populated communities.[222] Many rural communities feature characteristics with risk factors for suicide, such as gun ownership, social isolation, and difficulty accessing health, mental health, and substance use disorder care, and social services.[223] Even if services are available in rural communities, additional challenges can affect the quality and timeliness of access.[224] These include:

- A shortage of health care providers to conduct preventative assessments and offer referrals and warm handoff to needed services, especially services focused on suicide risk
- Limited numbers of qualified, culturally competent providers and staff
- Transportation, particularly in areas where people must travel long distances to seek services
- Insurance coverage that is accepted by the practitioner or provider
- Language barriers that prevent people from communicating with service providers
- Privacy concerns, especially for residents seeking mental health services in small communities[225]

KEY RESOURCE: Understanding the Impact of Suicide in Rural America |National Advisory Committee on Rural Health and Human Services, Department of Health and Human Services: https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-impact-of-suicide.pdf.

People Working in Certain Occupations

People in certain occupations are at increased risk for suicide.[226] Characteristics of occupations where risk might be elevated include jobs that are socially isolating; involve a high level of stress; are low paying or cause an increasing student loan debt-to-income ratio; expose employees to violence or traumatic events; are fast-paced and require long hours; or are inconsistent, such as seasonal work.[227] Construction and mining occupations carry particularly high risk, with the largest percentage – 20 percent in 2015 — of men who die by suicide working in those trades.[228] Arts, design, entertainment, sports, and media occupations have the highest rates of suicide among both women and men. People in other occupations with increased risk include first responders, such as police, firefighters, and paramedics; physicians; nurses; and veterinarians.[229]

KEY RESOURCE: Comprehensive Blueprint for Workplace Suicide Prevention |National Action Alliance for Suicide Prevention: https://theactionalliance.org/communities/workplace/blueprintforworkplacesuicideprevention.

People in Correctional Settings

People in correctional settings have higher rates of suicide compared to their counterparts in the community.[230] Correctional settings in California include prisons, jails, and juvenile detention facilities. Suicidal behavior may increase upon incarceration, but there is some evidence that people in custody may have experienced a history of suicidal behavior and other risk factors, such as unmet mental health needs and substance use disorders, prior to becoming incarcerated.[231] Risk may remain elevated after a person is released from prison or jail.[232] Elevated suicide risk also is found among people who work in correctional settings. One study found that correctional officers have a 39 percent higher chance of suicide compared to the average for other occupations.[233] This elevated risk for suicide may be due to work stress and its impact on family life, leading to separation and divorce.[234]

KEY RESOURCE: Suicide Prevention Resources for Adult Corrections| Developed by the Suicide Prevention Resource Center: https://www.sprc.org/sites/default/files/resource-program/AdultCorrectionsResourceSheet.pdf.

Women During the Perinatal and Postpartum Period

Suicide is a leading cause of death during pregnancy and one year postpartum, also known as maternal suicide, and suicidal ideation has been detected in the range of 13.1 percent to 33 percent of pregnant women.[235] Risk factors for maternal suicide include sleep disturbances, depression, anxiety, a postpartum psychosis diagnosis, and a bipolar disorder diagnosis. Maternal suicide risk is not just limited to the immediate postpartum period.[236] The highest risk for maternal suicide occurs at nine to 12 months postpartum.[237]

KEY RESOURCE: California's Maternal Mental Health Strategic Plan (MMH Task Force) (2017) https://static1.squarespace.com/static/56d5ca187da24ffed7378b40/t/5b40f84503ce641f98dbd329/1530984521889/Report-CATaskForce-7.18.pdf.

Research has demonstrated that lives can be saved from suicide and that public health approaches have the potential to prevent loss of life on a broad scale.

Best Practice in Suicide Prevention

The Institute of Medicine organizes suicide prevention activities along a continuum, ranging from universal to selective to indicated.[238] Universal prevention efforts focus on the entire population and seek to deter suicidal behaviors by creating safe environments, increasing connectedness, building skills, and promoting mental health.[239] Selective prevention efforts target people within vulnerable groups who have been identified as at greater risk for suicidal behaviors.[240] Indicated prevention efforts focus on serving people engaged in suicidal behavior and providing timely intervention to prevent future suicidal behavior.[241] Best practices reach across the social ecology, intersecting at person, relationship, neighborhood, and societal levels.[242] Certain suicide prevention activities with strong evidence of effectiveness have demonstrated significant return on investment. These include training for health professionals; early identification of substance use disorders and mental health needs, particularly depression; and creating barriers to prevent people from accessing methods to die by suicide.[243]

Best practices can lead to successful outcomes only if strong infrastructure is in place. For the purposes of this plan, infrastructure refers to visible, multilevel leadership and networked partnerships; effective management of resources; and use of data for monitoring and improvement.[244] Suicide prevention, as a public health challenge, is not unique in requiring infrastructure to support the delivery of best practices. An analysis of California's anti-tobacco initiative, for example, found that creating anti-smoking infrastructure was identified as the biggest challenge to the success of the effort.[245] Many of the best practices described below already are in use in select settings or communities throughout California.

Universal Prevention Strategies

Universal suicide prevention strategies are broad and are intended to reduce risk in the general population. Best practices in this category focus on protecting the safety and health of the community through reducing access to lethal means, connecting people to social networks, building resiliency, safe reporting by the media following a suicide death, and increasing access to care. Research demonstrating the effectiveness of universal prevention strategies is scarce, limiting both knowledge about such strategies and investment in their development. The section below highlights best practices in universal suicide prevention.

Lethal Means Restriction

Lethal means restriction – or reducing someone's access to the lethal methods by which to die by suicide – is one of the best empirically supported methods of reducing suicide.[246] The effectiveness of reducing access to lethal means has been demonstrated in multiple countries and across a wide range of interventions.[247] The United Kingdom saw a reduction in suicides following replacement of coal gas – which contains carbon monoxide – with natural gas.[248] After Israel adopted a policy requiring soldiers to lock their weapons in storage when on leave, suicide deaths were reduced by 40 percent.[249] A ban on certain chemicals in Sri Lanka was associated with a reduction in suicides involving pesticides in that country.[250] Suicide deaths by carbon monoxide dramatically decreased following the implementation of strict controls on motor vehicle exhaust gas emissions in the U.S.[251] And policies that limited the number of prescriptions written for certain medications, along with their pack size, resulted in fewer suicides involving those medications in several countries.[252]

Conversely, the potential consequences of removing safety measures also has been documented. The removal of safety barriers from a central city bridge in Australia, for example, led to an immediate increase in the numbers and rate of suicide at the bridge.[253] Suicide deaths were reduced to zero at sites where barriers were removed and then reinstalled, as was the case in New Zealand.[254] The effects of barrier installations are significant and immediate, and there is no evidence showing that their addition increases suicides at other locations or by other methods.[255] In California, Caltrans is required to consider suicide risk in the design or redesign of bridges, and there are federal funds accessible for construction of suicide deterrent systems. However, there are no standards to guide prevention and policy at other sites.[256]

The most effective methods of lethal means restriction are physical deterrents, which include carbon monoxide emission controls in vehicles; locking screen doors, windows, and drawers; suicide deterrent systems on railways and bridges; firearm safety mechanisms, such as gun locks and safes; and overdose prevention, such as the use of naloxone or blister packaging of medications.[257] Other effective methods include signage and connection to crisis services and means restriction counseling. Studies show that these methods can and should be combined with physical deterrents, where applicable.[258]

Focus on Common Lethal Means—As demonstrated above, policies restricting the availability and accessibility of the means by which people die by suicide has the potential to significantly reduce suicide rates by those means. In California (and nationally), where suicide most commonly occurs when firearms are used, access to and the availability of firearms increases risk for unnatural death, including suicide.[259] Firearms that are loaded or unlocked are tied to increased risk for intentional and unintentional death.[260] Policies that reinforce gun safety and safe storage practices have been found to reduce risk for injury and death. For example, state bans on the sale of handguns that do not adhere to safety standards – sometimes referred to as "junk guns" – have demonstrated population-level effects on reducing suicide rates.[261] Some states have expanded temporary transfer laws to include a temporary transfer of a firearm from a person at risk to another person if such transfer is necessary to prevent imminent death or great bodily harm.[262] Finally, research has shown an association between risk-based gun removal laws and a reduction in suicides by firearm.[263] The Gun Violence Restraining Order is an example of a risk-based gun removal law in California.[264] Granted by a court, such orders allow for the removal of all firearms and ammunition from certain people – those experiencing suicidal or homicidal thoughts or behaviors, for example – and prohibit purchase and ownership of firearms and ammunition during the duration of the order.[265]

In addition to policy changes to support means safety, programs to collaborate with gun shop and shooting range owners to prevent suicide among gun owners and their family members show promise. The Gun Shop Program, for example, was developed in New Hampshire after three people died by suicide by a firearm purchased at the same gun shop. Materials designed for and by gun shop owners were distributed to local shops and included information for identifying and interacting with a customer who may be at risk for suicide. Modeled after effective strategies in New Hampshire, the former Superior California Suicide Prevention Network developed best practice guidance on how to engage with community members on firearm suicide prevention messaging and approaches, such as increasing awareness of warning signs and increasing help-seeking by people at risk.[266] Recognizing shared goals, the American Foundation for Suicide Prevention and the National Shooting Sports Foundation are collaborating to expand awareness of firearm safety measures to prevent suicide.[267] In Washington state, the National Rifle Association and the Second Amendment Foundation supported legislation to increase suicide prevention training and messaging for firearm professionals.[268]

California Community Highlight: The Golden Gate Bridge's Suicide Deterrent System

California is home to several bridge and rail sites where people die by suicide in large numbers every year. The most well-known among these is the Golden Gate Bridge in San Francisco.

An average of 30 people die by suicide each year at the bridge. Since the bridge opened in 1937, more than 1,700 people have lost their lives. Most people who die by suicide at the bridge are male, white, under 40 years of age, and live in the Bay Area. Fewer than 35 people have survived their attempt.

In addition to the roughly 30 known suicides in 2017, 235 people were saved from falling by a variety of public and private agencies and citizens, including the Golden Gate Bridge Patrol, California Highway Patrol, iron workers on the bridge, tow truck operators, Bridgewatch Angels volunteers, and many others.

Nets made of marine-grade woven steel, supported by scaffolding, are being installed to prevent death and deter people from considering the bridge a means of dying by suicide. The barrier will cost an estimated $211 million in federal, state, and local funding.

Gaining approval to install the bridge barrier was not easy and took years, even requiring a change to federal transportation laws to allow for funding of suicide prevention projects. Many opponents of the bridge barrier cited aesthetic concerns. The barrier is expected to be fully installed by early 2021.

For more information, please visit http://www.bridgerail.net/.

While firearms cause the most deaths by suicide, overdose is the most common method of suicide attempt.[269] In addition to policies that restrict prescriptions and allowable volumes of medications, other policies that increase the use of harm-reduction interventions can prevent overdose by certain drugs. For example, medication-assisted treatment **–** specifically, the use of naloxone – may reduce suicide by opioid overdose. Naloxone is a medication that works almost immediately to reverse opiate overdose. It has few known adverse effects, no potential for abuse, and can be rapidly administered through intramuscular injection or nasal spray. While most professional first responders and emergency departments are equipped with naloxone, emergency service providers may not arrive in time to revive overdose victims. In recent years, California has made naloxone more accessible through a statewide standing order allowing the administration of naloxone by family members and friends in a position to intervene during an opioid-related overdose.[270]

Assessing Access to Lethal Means—Assessing access to lethal means and providing counseling to restrict such access are two best practices shown by evidence to reduce suicidal behavior.[271] One study found that families of high-risk youth were significantly more likely to remove or secure lethal means in the home when counseled in the emergency department following suicidal behavior by a child.[272] Despite such evidence, people identified as having suicidal ideation, or those who have been discharged from healthcare settings after attempting suicide, are not counseled routinely on means safety.[273] Counseling on Access to Lethal Means (CALM) is a free resource available to identify people who could benefit from lethal means counseling, ask about their access to lethal methods, and work with them—and their families—to reduce access.[274] Health care providers are well-positioned to assess for access to lethal means when such a step is relevant to health care, but many feel uncomfortable doing so. In one study, community-based mental health providers were more likely to assess for and reduce access to lethal means collaboratively with people at risk and their families after they received training in CALM.[275]

Connectedness

Connectedness is the degree to which a person or group is socially close, interrelated, or shares resources with others.[276] Connectedness can protect a person who is facing adversity. Peer programs in the military, for example, have been shown to effectively reduce risk for suicide when social networks are created between military members and their peers.[277] Although communities are not necessarily bound by neighborhoods, schools, or other institutions, these structured environments can be catalysts for reducing suicide risk among a broad population. School connectedness has consistently been shown to play a critical role in protecting adolescents against many negative outcomes, including suicidal behaviors.[278] Groups that promote connectedness, such as the school-based Genders and Sexualities Alliance, show promise in reducing suicidal ideation and attempt among youth.[279] Family connectedness can buffer against suicide risk. Family acceptance of sexual orientation and gender identity among youth has been demonstrated to protect against suicide risk, and can be modified using evidence-based approaches, such as the Family Acceptance Project's Family Intervention Approach.[280]

Risk for suicide is reduced when people have trust in social networks and are engaged in community.[281] Research shows that there is a relationship between connectedness and safety, namely that people are more likely to socially engage in environments that are safe, affirmative, supportive, and free of violence and discrimination.[282] Suicidal behavior may share risk and protective factors with other forms of violence,

such as domestic violence and the maltreatment of children and the elderly.[283] Shared risk factors include lack of social support, economic stress, and substance use.[284] Shared protective factors include the coordination of community resources and services, connectedness, and family support.[285] Prevention resources to create training, programs, and partnerships can be used collectively to respond to multiple forms of violence, including suicide.[286] Addressing multiple forms of violence is a prudent approach, especially because different forms of violence overlap and intersect.[287]

Resilience and Skills Training

Resilience is the ability to withstand, adapt to, and recover from adversity, threats, and stress. Resilience is associated with coping, or people's individualized ability to manage both everyday stressors as well as more extreme stressors in their lives. Communities – including neighborhoods, schools, and organizations – can build resilience by strengthening cultural values and cultural identity; by reinstituting collective history, language, spirituality, and healing practices; and through collective action.[288] Culture in this context can refer to racial/ethnic; vocational, such as first responder and culinary; and special population, such as military culture.

Effective life skill interventions include techniques that promote critical thinking, conflict resolution, stress management, and coping, and that help people safely manage challenges such as economic stress, divorce, physical illness, and aging. Best practice approaches to building universal life skills have been developed for school-aged children and youth. The Good Behavior Game, for example, is an early education classroom management technique that shows promise in reducing suicidal behavior for decades following program delivery.[289] Life skills programs tailored to specific cultural norms and values also are supported by evidence of their effectiveness. One, the American Indian Life Skills Development curriculum, shows promise in reducing depression and suicidal behavior among Native youth.[290]

Responsible Media Reporting

Exposure to suicidal behavior by one person may facilitate the occurrence of subsequent, similar behaviors by others, especially among adolescents.[291] Due to exposure, multiple suicides may occur within a particular time period or location, a pattern known as a suicide cluster.[292] Suicide clusters are rare and happen almost exclusively among youth.[293] The media may inadvertently increase suicide risk when reporting the details of a suicide.[294] For example, extensive media coverage of suicide – in amount, duration, and prominence – is associated with increases in suicide rates.[295] Harmful media practices, such as reporting details about the method used, also may increase risk for suicidal behavior in others, especially young people.[296] Further, suicidal behavior using a particular method – even an uncommon method – may increase if that method is identified and described in media reports.[297]

Best practice for responsible reporting of suicide include communicating messages demonstrating that suicide is preventable, printing or airing stories of hope and resilience, providing links to helping resources, and refraining from airing or publishing reports that sensationalize suicide. Local media can partner in effective suicide prevention by disseminating the message that suicide is preventable through fictional story lines, real-life reporting, billboards, and public service announcements.[298] Positive storylines about mental health and suicide can prompt media consumers to take direct action to seek or provide help.[299] Such storylines also empower people to have open conversations with friends and family.[300]

CALIFORNIA COMMUNITY HIGHLIGHT: RESPONSE FOLLOWING SUICIDE CLUSTER

Between May 2009 and March 2015, nine people who were either incoming or current high school students or alumni of a single Santa Clara County school district died by suicide. The California Department of Public Health requested assistance from the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration to investigate the deaths and explore how youth suicide in Santa Clara County, its school districts, and its cities could be prevented in the future.

Recommendations included:

1. Using multiple prevention approaches to address multiple risk factors
2. Ensuring access to evidence-based mental health care
3. Strengthening family relationships and family-based programs
4. Increasing students' connection to school and school-based programs
5. Identifying and supporting people at risk
6. Strengthening crisis Intervention
7. Delivering services to loss survivors in the event of a student suicide
8. Launching prevention efforts involving other forms of violence
9. Reducing access to lethal means for youth at risk
10. Using safe messaging and reporting about suicide
11. Engaging in strategic planning for suicide prevention
12. Selecting and implementing evidence-based programs
13. Mandating continuous program evaluation

For more information, please visit
https://www.sccgov.org/sites/phd/hi/hd/epi-aid/Documents/epi-aid-report.pdf.

Access to Health, Mental Health, and Substance Use Disorder Care

Services that deliver appropriate, timely, and accessible health, mental health, and substance use disorder care have the potential to prevent suicide. Best practices include administrative policies, such as full coverage of mental health needs and substance use disorders in insurance policies and managed care, as well as policies that address provider shortages, especially in rural and underserved communities.[301] Policies to address provider shortages include the use of financial incentives and the expansion of telehealth approaches that connect providers and clients through phone, video, and internet-based technologies.[302] Mobile and telehealth approaches may increase access to health care, especially in physically isolated communities.[303] Research on telehealth approaches to suicide care is limited but promising.[304]

Clear messaging to create easy pathways to available services also shows promise for suicide prevention. Messaging that encourages people to seek help includes teaching early recognition of mental health needs and reducing the stigma associated with seeking help by normalizing the behavior among peers. Peer norm programs seek to normalize protective factors – including reaching out and talking to trusted people – and also promote peer connectedness.[305] By leveraging the leadership qualities and social influence of peers, these approaches can be used to shift group-level beliefs and promote positive social and behavioral change.[306] This approach has been especially successful in school settings but has also shown promise in the workplace and other settings.[307]

Selective Prevention Strategies

Selective prevention strategies are those focused on detection of risk and the screening of select subgroups that may develop risk for suicidal behaviors. Best practices in this category are effective strategies used to identify risk and intervene early, and to connect people to services. Best practices in selective suicide prevention are highlighted below.

Collaborative Care

Collaborative care is an integrated care model that has been tested in over 80 randomized control trials. While it has not specifically been shown to reduce suicide, studies have confirmed the benefits of collaborative care for people with risk factors for suicide, namely depression and anxiety.[308] Under this model, traditional primary care is integrated with a team comprised of a care coordinator and a specialty behavioral health provider.[309] This team creates a holistic plan for the person based on best practices, client-directed goals, and the monitoring of those goals, making adjustments as needed when progress is stalled. Two landmark studies demonstrate reduced suicidal ideation using collaborative interventions for older adults experiencing depression. The Prevention of Suicide in Primary Care Elderly: Collaborative Trial reduced suicidal ideation and depression among older adults through a collaborative approach between a person, a primary care physician, and a health specialist, such as a nurse, social worker, or mental health provider.[310] Second, the Improving Mood—Promoting Access to Collaborative Treatment approach involves developing a care plan – with input from the person, primary care provider, care manager, and consulting psychiatrist – to reduce depression and suicidal ideation in older adults. Evaluation of this model demonstrated significant decreases in depression and suicidal ideation, in addition to improved functional and quality of life outcomes.[311]

Depression Screening and Management by Physicians

The majority of people who die by suicide had contact with their primary care physician in the year prior to death, while almost half had contact in the month preceding death.[312] Despite such contact, suicide risk is under-recognized and underserved in these critical primary care settings.[313] Nearly 70 percent of people experiencing depression who see a primary care physician will report physical complaints, such as physical pain or sleep disturbances.[314] Training for primary care physicians on identification of suicide risk and treatment of depression and other risks, such as substance use, shows promise in preventing suicide, especially when delivered in collaborative care models.[315]

Gatekeeper Training

Gatekeeper training is designed to train teachers, families, coaches, military commanders, supervisors, clergy, emergency responders, urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating connection to services.[316] Gatekeeper training focuses on increasing a person's ability to recognize warning signs of suicide and provide referral.[317] Some trainings include information on delivering brief interventions to support people at risk for suicide, such as reducing a person's access to lethal means.[318] Gatekeeper training may be implemented in a variety of settings to identify and support people at risk.[319] Such trainings have been shown to increase knowledge of risk factors and warning signs and increase confidence among people responding to someone expressing a desire to die.[320]

CALIFORNIA COMMUNITY HIGHLIGHT: AVAILABLE GATEKEEPER TRAININGS

Below are several options for suicide prevention awareness and support trainings for gatekeepers. While not exhaustive, this list is intended to give the reader a starting point to explore available trainings.

Question, Persuade, Refer (QPR) | https://qprinstitute.com/.

Trainings by ***Living Works*** | https://www.livingworks.net/.

Trainings specific to school settings available through the ***American Foundation for Suicide Prevention*** | https://afsp.org/our-work/education/more-than-sad/ and https://afsp.org/our-work/education/signs-matter-early-detection/.

Crisis Response

Crisis response can include a variety of crisis services, ranging from warm lines and crisis lines to crisis stabilization support and short-term crisis residential care.[321] Best practice approaches for systematic crisis response include centralized call centers that use real-time coordination across systems, coordinated mobile crisis outreach and support, and crisis residential and stabilization services.[322] The delivery of coordinated crisis services also has been shown to reduce redundancies and costs associated with connecting people with an appropriate level of care to prevent suicidal behavior.[323]

Under effective models, suicide prevention hotline, text, and chat services provide 24-hour support to conduct suicide assessment and intervention, provide referrals to appropriate services, help people develop safety plans, and connect people with mobile crisis or emergency resources.[324] The hotlines generally prevent suicide in two ways: They ensure the immediate safety of at-risk callers, and they link those who may be at risk of suicide with appropriate and available resources.[325] Effective training and standards for practice are critical. A study of crisis line staff who received Applied Suicide Intervention Skills Training showed improved outcomes for callers, including reduced depression, a reduced sense of being overwhelmed, lower suicide risk, and increased hopefulness.[326]

CALIFORNIA COMMUNITY HIGHLIGHT:
CALTRANS DISTRICT 7 AND DIDI HIRSCH COLLABORATION

Local transportation leaders are partnering with suicide prevention centers to create safe environments with physical deterrents and crisis services messaging and response. Caltrans District 7, which covers Los Angeles and Ventura counties, in partnership with Didi Hirsch Mental Health Services and regional first responders, are working to prevent suicide by identifying community sites used for suicidal behavior, constructing barriers, when feasible, and installing suicide hotline signage and cameras, where appropriate. The effort is supported by a committed network of partners, including first responders, facility and equipment owners, suicide prevention and crisis services, and local authorities. Coordination continues once a site is identified and fortified. For example, trained camera monitors identify a person at risk and alert first responders and crisis services.

For more information, please visit http://didihirsch.org/.

Indicated Prevention Strategies

Indicated prevention strategies focus on people engaged in suicidal behavior and people bereaved by the loss of a loved one to suicide. Best practices in this category focus on providing care that specifically targets suicidal behavior and following-up with people who have been discharged from healthcare settings after being served for suicidal behavior. Indicated prevention best practices also deliver coordinated, timely, and respectful services to suicide loss survivors.

Suicide Risk Assessment and Management

Best practice for screening and risk assessment in health, mental health, and substance use disorder care settings includes provider knowledge of risk and protective factors and warning signs, procedures for categorizing risk and making clinical decisions based on risk, evidence-based assessments and safety planning, documentation of risk level and action taken, and caring referral procedures.[327] Standardization makes the entire process of identifying risk and connecting people to services transparent and collaborative for the provider and person at risk.[328] Two steps are particularly critical to this collaborative process – obtaining informed consent and the use of a standardized decision-making process to routinize risk designations based on suicide attempt history, the severity of current symptoms of suicide risk, and the integration of risk factors.[329] Standardizing risk assessment and management has the potential to reduce clinical or legal concerns about errors in judgment that might overestimate or underestimate risk.[330] Suicide risk assessments help identify acute, modifiable, and treatable risk factors and help providers recognize when people need more structured methods for managing daily living.[331]

The Columbia-Suicide Severity Rating Scale is a common screening tool that uses a series of questions in plain language to help users identify whether a person is at risk for suicide, assess the severity and immediacy of the risk, and identify possible support.[332] The tool is suitable for all ages and special populations and is available in over 100 country-specific languages.[333] In healthcare settings, the Patient

Health Questionnaire (PHQ9) is an assessment that asks nine questions about depressive symptoms experienced in the prior two weeks, with one question devoted to thoughts of dying or being "better off dead." The PHQ9A is the PHQ9 modified for adolescents ages 11 to 17.[334] Finally, the Ask Suicide-Screening Questions is a tool used to identify a youth at risk in medical settings and takes less than one minute to complete.[335] Positive screens obtained through the use of this tool prompt providers to conduct additional, in-depth assessments.[336]

Safety planning is a brief intervention that incorporates best practices in means restriction, problem-solving, social support, and emergency resources.[337] Safety planning is not a "no-harm contract" or "contract for safety" that requires people at risk to promise a provider the person will not engage in suicidal behavior; research shows such "contracts" are not effective and actually can increase risk.[338] The Safety Plan, developed by Barbara Stanley, Ph.D. and Gregory Brown, Ph.D., and Crisis Response Planning tools are evidence-based and commonly used in many settings. The Safety Plan includes methods for keeping homes safe; recognizing warning signs of suicide; identifying ways to cope with thoughts of suicide; and identifying friends, family, and mental health and emergency resources, such as the location of the nearest emergency department.[339] Crisis Response Planning is a strategy used to develop written steps for a person at risk for suicide to take during times of crisis or when under stress. Using an index card, people list steps for identifying personal warning signs, along with coping strategies and social and professional support. Results of a randomized clinical trial show that Crisis Response Planning reduced suicide attempts by 75 percent compared to using safety contracts, or contracts in which a person vows not to self-injure.[340]

Treatment Interventions

Effective care that targets suicide risk specifically is effective when it is structured and integrates problem-solving skills; collaborative assessment; service planning; and caring, consistent follow-up.[341] Below are behavioral and pharmacological interventions shown to be efficacious in the treatment of suicidal behaviors:

- **Dialectical Behavioral Therapy** is a cognitive behavioral treatment that combines therapy, skills training, and coaching and has been shown to be effective for treating suicidal behavior and non-suicidal self-injury at any age.[342] Dialectical Behavioral Therapy has been adapted for adolescents in a shorter format – from 16 weeks to 12 months – and includes skill modules to improve parent-child communication, among other skills.[343] In addition, nonclinical applications have been adapted for school settings and teach students in grades six through 12 mindfulness, emotional regulation, and interpersonal skills.[344]
- **Cognitive Behavioral Therapy for Suicide Prevention** is a cognitive behavioral treatment for people who have attempted suicide within the last 90 days.[345] The primary goals of this intervention are to reduce suicide risk factors, enhance coping skills, and prevent future suicidal behavior.[346] The therapy is designed to help people use more effective means of coping with stressors and problems that trigger suicide crises.[347]

- **Collaborative Assessment and Management of Suicidality** is a suicide-specific therapeutic framework that can be delivered with other treatments and across different settings, including community and inpatient settings.[348] A psychotherapeutic framework that "amplifies active collaboration" between a service provider and a person at risk, it assesses for and addresses factors that are increasing risk.[349] The alliance between provider and client is intended to support the person at risk's motivation to live.[350]
- **The Attempted Suicide Short Intervention Program (ASSIP)** is a brief intervention specifically for attempt survivors.[351] It emphasizes the therapeutic alliance between provider and survivor developed in an initial interview. Findings are promising. When combined with clinical treatment, ASSIP was able to reduce suicidal behavior over a two-year period for people who recently attempted suicide.[352] ASSIP also has been demonstrated to reduce health care costs.[353]
- **Pharmacological interventions** can reduce suicide risk by addressing mental health needs.[354] Antidepressants, such as selective serotonin reuptake inhibitors, can alleviate depression and associated suicide risk.[355] Lithium for the treatment of mood disorders and clozapine for the treatment of schizophrenia have been shown to reduce suicide among people with these needs.[356]

Innovations in this area continue, and largely target highly treatable risk factors – such as insomnia – with low-risk interventions to prevent suicide.[357] Non-mental health interventions show promise for targeting risk. One example are services that address sleep disturbances, which may reduce risk and can be delivered through brief, targeted interventions.[358] Repetitive transcranial magnetic stimulation (rTMS) also shows promise in addressing suicidal ideation. This approach uses a magnet to target and stimulate specific areas of the brain and is typically used to treat depression and anxiety. In one study, 40 percent of people served with bilateral rTMS therapy reported no longer experiencing thoughts of suicide.[359] In addition, ketamine is a pharmaceutical drug recently approved for therapeutic use to rapidly reduce depressive symptoms and suicidal ideation.[360] Studies show acute suicide risk is almost immediately reduced with administration of ketamine, and beneficial effects can extend up to 10 days.[361]

Emergency Department Interventions

Emergency departments play a key role in suicide prevention efforts.[362] Statistics show that 20 percent of people who die by suicide visited an emergency department within a month of death, and 60 percent of survivors of suicide attempt sought medical care for their injuries in emergency departments. National data suggest that interventions in the emergency department may decrease suicide deaths by 20 percent.[363] The Emergency Department Safety Assessment and Follow-Up Evaluation study evaluated an emergency department intervention that combined universal screening for suicide risk; secondary assessment by a physician; resources at discharge, including a safety plan; and follow-up telephone calls over a year-long period. The study found significant decreases in suicidal behavior among people who received the intervention.[364]

The effectiveness of delivering follow-up care – also referred to as caring contacts – to people discharged from hospital settings after suicidal behavior is backed by strong evidence.[365] One of the most empirically successful approaches to suicide prevention was the "caring letters study," in which contact after

discharge significantly reduced suicide among people who were hospitalized for depression or suicide risk.[366] People who participated in the study were contacted using low-cost methods, such as postcards and short, caring notes, at least four times a year for five years.[367] Suicide rates were compared with people who received no contact following discharge during the same period.[368] People in the contact group had a lower suicide rate in all five years of the study.[369] Another study demonstrated significant return-on-investment for commercial insurance and managed care plans when people released from hospital or emergency departments for suicidal behavior received follow-up phone calls.[370] Likewise, follow-up calls from crisis line providers are not only cost-effective, but have been shown to reduce future suicidal behavior for people discharged from health care settings.[371]

CALIFORNIA COMMUNITY HIGHLIGHT: WELLSPACE HEALTH

California communities are linking suicide prevention centers with healthcare systems to deliver best practices. One example is WellSpace Health in Sacramento. WellSpace Health delivers integrated health and behavioral health care and operates the Suicide Prevention Crisis Line serving Northern California counties. One program, the Primary Care Follow Up Suicide Prevention program, integrates screening for suicide risk in primary care and refers people to 24-hour crisis lines through the electronic health record. The program also provides 30 days of follow-up, risk monitoring, emotional support, resource linkage, and safety planning. Another initiative, the Emergency Department Follow-Up program, reaches out to people at risk who are nearing discharge from hospital settings within 24 hours of discharge, delivering follow-up services that include emotional support, risk assessment, safety planning, and monitoring.

For more information, please visit https://www.wellspacehealth.org/services/behavioral-health-prevention/suicide-prevention.

Postvention

Postvention efforts are organized prevention activities directed toward suicide loss survivors, or people who have lost a loved one to suicide. These survivors may include family, friends, clinicians, physicians, coworkers, and crisis line volunteers. Loss survivors sometimes encounter stigma associated with suicide, a reaction that may not accompany other manners of death and can act as a profound barrier to overcoming grief.[372] Activities that may carry benefits for loss survivors include services to address grief and distress associated with suicide loss, services that specifically mitigate negative effects of exposure to suicide, and services that prevent suicide by people at risk following exposure to suicide.[373] Face-to face bereavement support groups are the most studied intervention for loss survivors, while bereavement services that take a family-oriented approach show promise.[374] With this model, family members can explore together their individual responses following a suicide and assess the family's collective response.[375] Family members may become more engaged in the healing process because the family support system is also being served and potential miscommunication or dysfunction is reduced.[376]

Five Year State Workplan

The workplan below outlines the next steps to implement state objectives identified in the Strategic Aims and Goals section of this plan. Next steps identified below are designed to support local and regional implementation and statewide advancement of objectives.

GOAL 1: ENHANCE VISIBLE LEADERSHIP AND NETWORKED PARTNERSHIPS

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 1A Establish centralized, visible state- level leadership by creating the Office of Suicide Prevention within the California Department of Public Health to provide strategic guidance, deliver technical assistance, develop and coordinate trainings, monitor data, conduct state-level evaluation, and disseminate information to advance statewide progress.	By July 1, 2021, the State should create the Office of Suicide Prevention under the California Department of Public Health. By December 31, 2021, the Office of Suicide Prevention should develop a plan to facilitate regional quarterly meetings across the state to share resources, best practices, and lessons learned in developing strategies to deliver a continuum of crisis services to prevent suicidal behavior. By July 1, 2022, the Office of Suicide Prevention should develop a strategy for leveraging federal grant and block grant funding and private investment in suicide prevention strategies. By July 1, 2022, the Office of Suicide Prevention should develop a strategy for evaluating the State's suicide prevention plan and report annually on incremental progress toward each goal, including progress toward short-term targets and long-term outcomes. By July 1, 2023, the Office of Suicide Prevention should host and maintain an online clearinghouse to support implementation of best practices and technical assistance.
OBJECTIVE 1B Engage private and public partners by creating the California Suicide Prevention Council to advance suicide prevention efforts with strategic planning and dissemination of best practices in their respective sectors.	By July 1, 2021, the State should create the California Suicide Prevention Council and appoint councilmembers. The Office of Suicide Prevention should provide administrative support to the council. By December 31, 2021, the California Suicide Prevention Council should hold its first meeting and develop a strategic work plan. The work plan should include how the council will support the state strategies outlined in this plan. By July 1, 2022, the California Suicide Prevention Council should form sector-specific or strategy-specific subgroups to focus expertise within the council and develop guidance to support suicide prevention efforts in specific sectors.

GOAL 2: INCREASE DEVELOPMENT AND COORDINATION OF SUICIDE PREVENTION RESOURCES

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 2A Accelerate the development and management of suicide prevention resources in communities across California, and support capacity building to use best practices in suicide prevention by disseminating guidance and resources.	By July 1, 2021, the State should create incentives for local and regional suicide prevention planning and implementation, including offering grants to support capacity building to deliver best practices prioritized in the state's plan. By July 1, 2021, the State should amend existing legislation requiring public schools with students in grades K through 12 to develop a suicide prevention policy by including a provision of oversight by the Department of Education. The amendment should require schools to submit policies to the department for review and dissemination, and the department should deliver technical assistance and support to schools without policies. The department also should examine barriers to suicide prevention identified by schools – including liability issues, privacy laws, security measures, and legal requirements for parental consent – and develop recommendations to address them. The department should be required to collect aggregated data on suicide risk assessments conducted by schools, including student demographics (grade, sex, race/ethnicity, sexual orientation, and gender identity) and suicide risk level data. The Department of Education should evaluate the effectiveness of current school policies and revise its model policy based on best practices. In addition, the department should develop a strategy for evaluating policies on an ongoing basis, through metrics such as reductions in suicidal behavior, increases in connection to services, and increases in students and school personnel seeking help. By July 1, 2021, the State should amend existing legislation requiring public schools with students in grades K through 12 to develop a suicide prevention policy by expanding this mandate to colleges and universities. By July 1, 2022, the Office of Suicide Prevention should disseminate information to support local suicide prevention planning and implementation, which may include methods such as holding regional learning collaboratives and communities of practice to share resources and data, best practices, and lessons learned.

GOAL 2: INCREASE DEVELOPMENT AND COORDINATION OF SUICIDE PREVENTION RESOURCES

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 2B Identify opportunities to implement the integration of suicide prevention strategies across systems and programs. The state should seek opportunities to promote communication and information sharing among private and public partners and provide guidance on incorporating suicide prevention messaging into diverse settings, strategies, and public health campaigns.	By July 1, 2022, the Office of Suicide Prevention and the California Suicide Prevention Council should develop and disseminate guidance to increase effective collaboration among public and private partners to integrate suicide prevention strategies across statewide programs and initiatives. This guidance must include disseminating information for increasing collaboration with people with lived experience with suicidal behavior and behavior health needs.[377] This effort must include a description of legal and ethical challenges and barriers that may arise as services are integrated, such as challenges and barriers associated with sharing confidential information.
OBJECTIVE 2C Align efforts and investments to address multiple forms of violence that may share risk and protective factors with suicide, including strategies for reducing trauma in early childhood.	By July 1, 2022, the State, with leadership from the Department of Public Health and private and public partners, should conduct an environmental scan of population-based universal violence prevention strategies and programs across the state. This survey should include suicide prevention programs as well as those that address shared risk and protective factors for multiple forms of violence. By December 31, 2022, the State, with leadership from the Department of Public Health and private and public partners, should develop recommendations to help communities increase community cohesion and safety, especially for vulnerable groups, and highlight areas of California where programs are making an impact. The effort should focus on ways to increase key protective factors, including connectedness, resiliency, and economic opportunity, as well as other social determinants of health. By July 1, 2023, the State, with leadership from the Department of Public Health and private and public partners, should identify a common set of measures and indicators that could be used by programs addressing violence prevention to enhance alignment, track progress, and improve understanding of needs and gaps statewide.

GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 3A Establish centralized electronic reporting systems to capture data related to suicide deaths and suicidal behavior. The systems should include data by demographics – such as race/ethnicity, age, sex, gender identity, and sexual orientation – as well as vulnerable group membership, such as military service and women in the perinatal and postpartum period. Uniform coding procedures should be used.	By July 1, 2021, the State should authorize counties to utilize interagency death review team models to identify, review, and evaluate suicide death trends, circumstances, and outcomes to inform and strengthen local prevention strategies, including the sharing of confidential information while protecting privacy. By July 1, 2021, the State should create incentives for schools to regularly participate in the California Healthy Kids Survey to monitor trends in suicidal behavior among students. These should include allocating additional resources to create reports on student suicidal behavior that are specific to each school and additional incentives for collecting key demographic data, such as sexual orientation and gender identity. By December 31, 2021, the State, with leadership from the Department of Public Health, should expand the existing California Violent Death Reporting System (CalVDRS) to more counties to collect and analyze local and state suicide data by delivering technical assistance to local coroners and medical examiners. The assistance should enhance the timely and electronic reporting of suicide deaths and their circumstances – including contributing factors and the specific location of death if outside the home – to help identify and fortify the safety of sites used by people to die by suicide. The State should invest additional resources in technical assistance to increase participation by coroners, medical examiners and law enforcement agencies in the CalVDRS to provide more detailed information on circumstances surrounding violent deaths, including suicide. This detail should include standardized data on demographic characteristics, membership in a vulnerable group, utilization of mental health services prior to death, and social determinants, such as housing and employment status. By January 1, 2022, the State, with leadership from the Department of Public Health and the Department of Health Care Services, should identify additional data elements to be collected via the California Health Interview Survey. The additional data should focus on suicide risk and protective factors to improve monitoring of suicidal behavior across the state.

GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 3A *continues*	By July 1, 2023, the State, including private and public partners, should develop and implement a strategy to improve the standardization of coding and reporting of suicidal behavior, including the development of guidelines for determining intent to die by suicide. The state also should develop a plan to deliver training and technical assistance to hospital representatives to improve the identification, coding, and reporting of suicidal behavior for people seen in emergency departments and admitted to hospitals. By December 31, 2023, the State, including private and public partners, should create a mechanism for centralized and electronic reporting of the number of people screened for suicide risk in hospitals and emergency departments, and data documenting how those who were positively identified at various levels of risk were triaged into services. For example, data in electronic health records could be extracted and aggregated prior to submission to a centralized database. This effort also should explore opportunities to expand the State's participation in the Centers for Disease Control and Prevention's National Syndromic Surveillance Program BioSense Platform, a database that collects and analyzes near real-time data and trends on people receiving services in emergency departments.[378]
OBJECTIVE 3B Develop a data monitoring and evaluation agenda on suicide deaths and suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions ("save data") that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance to support state and local data and information sharing, including methods for sharing confidential information among diverse partners while adhering to state and federal privacy and security laws.	By December 31, 2021, the Office of Suicide Prevention should create a task force, including people with lived experience and other subject matter experts, to develop a data monitoring and evaluation agenda on suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance on local program evaluation and should identify measures to monitor state-level outcomes. The agenda should create and implement methodology for using suicide death and suicidal behavior data to evaluate the proportion of suicidal behavior that results in death, and should describe how trends in high-risk groups and lethal means used will be monitored. The task force should identify opportunities for expanding research exploring community-defined practices that reduce suicide risk in diverse cultural groups and should disseminate findings directly to affected communities and the public.

GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 3B *continues*	By July 1, 2023, the task force should develop for the Governor and Legislature a proposal to create a centralized, electronic database and reporting standards to capture data on interrupted or aborted suicide attempts and crisis service interventions that resulted in the de-escalation of desire and intent to die by suicide. The data must include the type of intervention used and should include the type of services referred and the duration between incident and entry into services. Data sources include, but are not limited to, first responders, emergency and health care providers, crisis service providers, and bridge and transportation representatives. The proposal must include an estimate for costs associated with the centralized database, as well as reporting standards.
OBJECTIVE 3C Standardize policies and procedures for investigating and reporting suicide as a cause of death. These should include uniform definitions of suicide, as well as protocols for working with suicide loss survivors and informing health officials in the context of a suicide cluster. Protocols should include clear requirements for how cause of death is determined, how investigations are conducted, and how information is reported, and by whom, within a certain time following death. Training on methods for minimizing misclassification and accelerating timely reporting also should be provided.	By July 1, 2023, the Office of Suicide Prevention should form a task force to develop and disseminate best practices in suicide death investigation procedures, including guidance for coroners and medical examiners for documenting behavioral issues, hospitalizations, medications, histories of suicidal behavior, and family mental health and substance use disorder. Guidance should include methods for sharing data with local or state death review teams with the goal of identifying opportunities for improvement in prevention strategies. The input also should include guidelines for coroners and medical examiners for identifying and reporting sexual orientation and gender identity of people who die by suicide and should include recommendations for any necessary modifications to existing reporting systems to enable reporting on sexual orientation and gender identity of people who die by suicide.

GOAL 4: CREATE SAFE ENVIRONMENTS BY REDUCING ACCESS TO LETHAL MEANS

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 4A Create a research and policy agenda to advance the goal of creating safe environments by reducing access to lethal means.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2. Exploring opportunities to 1) clarify criteria for when a firearm should be returned to the gunowner after it was transferred specifically to prevent a suicide attempt under current law; and 2) for strengthening gun violence prevention measures, such as expanding eligibility for obtaining Gun Violence Restraining Orders and expanding requirements for background checks at the point of firearm sale, were identified as priorities in the drafting of this plan.
OBJECTIVE 4B Monitor state-level trends in lethal means used for suicidal behavior and develop a statewide strategy for technical assistance to expand efforts to reduce access to the lethal means identified.	By December 31, 2021, the Office of Suicide Prevention should enter into data use agreements to receive suicide-related data from state departments to monitor the use of lethal means in suicidal behavior and evaluate trends. The office should use the data to tailor technical assistance resources. Information on reducing deaths by suicide and suicidal behavior using ligatures outside of correctional and hospital settings was identified as a need in the preparation of the state suicide prevention plan. By July 1, 2022, the State, with leadership from the Department of Public Health, should develop and implement a technical assistance strategy to expand information on practices for reducing access to lethal means and availability of methods that can prevent injury due to suicidal behavior and death by suicide, including policies to restrict access to guns and policies to increase use of gun locks, gun and medication safes, devices to dispose of unused medication, and medications to counteract overdose, such as naloxone for opioid overdose.

GOAL 4: CREATE SAFE ENVIRONMENTS BY REDUCING ACCESS TO LETHAL MEANS

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 4C Disseminate information regarding federal funding available to support suicide barriers in the design or redesign of bridges and other sites where deaths by suicide may occur.	By December 31, 2022, the Office of Suicide Prevention should create an online clearinghouse of strategies and resources for reducing access to lethal means, including information on available private and public funding. The online clearinghouse should include methods to accelerate dissemination and implementation of best practices, such as quick factsheets and "how to" guides. The online clearinghouse should include information on new approaches to reducing access to lethal mean as they emerge. By December 31, 2023, the Office of Suicide Prevention should form a task force to review and make recommendations for modifying buildings, bridges, and other structures if such modifications are needed to prevent suicide at identified locations. The office should partner with the California Coastal Commission, the Office of Historic Preservation, transportation leaders, and others to address "line of sight" and other aesthetic concerns that may impede modifications that improve safety.

GOAL 5: EMPOWER PEOPLE, FAMILIES, AND COMMUNITIES TO REACH OUT FOR HELP WHEN MENTAL HEALTH AND SUBSTANCE USE DISORDER NEEDS EMERGE

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 5A Create a research and policy agenda to advance the goal of empowering people, families, and communities to reach out for help when mental health and substance use disorder needs emerge.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2.

GOAL 5: EMPOWER PEOPLE, FAMILIES, AND COMMUNITIES TO REACH OUT FOR HELP WHEN MENTAL HEALTH AND SUBSTANCE USE DISORDER NEEDS EMERGE

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 5B Integrate social-emotional learning programs into private and public education curricula to strengthen communication and problem-solving skills, emotional regulation, and conflict resolution skills among children and youth.	By July 1, 2024, the State, with leadership from the Department of Education, the State Board of Education, and the Instructional Quality Commission, should develop standards for social emotional learning and require implementation of such standards in schools.

GOAL 6: INCREASE CONNECTEDNESS BETWEEN PEOPLE, FAMILY MEMBERS, AND COMMUNITY

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 6A Create a research and policy agenda to advance the goal of increasing connectedness between people, family members, and community.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2.
OBJECTIVE 6B Identify and promote opportunities to foster positive and supportive relationships.	By July 1, 2023, the Office of Suicide Prevention should develop and disseminate guidance on creating or expanding social support as a means of normalizing protective factors, such as reaching out for help for mental health needs and substance use disorders and proactive problem-solving. Guidance should include how social support can be developed in diverse settings, including schools, workplace, and community settings. Guidance should include specific strategies to reduce risk for vulnerable group members. Guidance should include opportunities to leverage self-help groups, especially those supporting vulnerable group members, such as Alcoholics Anonymous, and support groups, such as the National Alliance on Mental Illness' Connection Recovery Support Group. Guidance should include measures of effectiveness specific to reducing suicide and suicidal behavior and methods for evaluation.

GOAL 7: INCREASE THE USE OF BEST PRACTICES FOR REPORTING OF SUICIDE AND PROMOTE HEALTHY USE OF SOCIAL MEDIA AND TECHNOLOGY

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 7A Create a research and policy agenda to advance the goal of increasing use of best practices in reporting of suicide and to promote healthy use of social media and technology.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2.
OBJECTIVE 7B Increase awareness of best practices for reporting on suicides by collaborating with journalism associations and organizations to disseminate information and resources to journalism and media partners.	By July 1, 2022, the Office of Suicide Prevention should create a task force with media and journalism outlets and organizations that publish journalism ethics codes to develop a process for promoting and incentivizing the use of best practices for reporting of suicide. This effort should produce guidance on increasing awareness of best practices for reporting and messaging about suicide in the media and for partnering with media and entertainment industry representatives. It also should include a strategy for dissemination of resources.
OBJECTIVE 7C Integrate into college and university journalism curricula best practices for communicating about suicide through various forms of media and entertainment.	By July 1, 2024, the Office of Suicide Prevention should form a task force to develop recommendations for integrating best practices for communicating about suicide in the media in college and university journalism programs.
OBJECTIVE 7D Identify and disseminate best practices for using and consuming social media and technology to improve wellbeing, destigmatize mental health needs, and increase help-seeking for mental health and substance use disorder services.	By July 1, 2024, the State, including private and public partners, should develop a process for disseminating information and resources on the healthy use of social media, tailored to age-group and setting, as well as information and resources for parents and caregivers.

GOAL 8: INCREASE DETECTION AND SCREENING TO CONNECT PEOPLE TO SERVICES BASED ON SUICIDE RISK

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 8A Create a research and policy agenda to advance the goal of increasing detection and screening to connect people to services based on suicide risk.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 3. Improving compliance with state and federal parity laws and timely access to health and mental health care, and ensuring insurance coverage of preventative services were identified as key policy areas identified during the drafting of this plan.
OBJECTIVE 8B Adopt the Zero Suicide Initiative within health, mental health, and substance use disorder care systems.	By January 1, 2023, the State, in consultation with private and public partners, should form a task force to make recommendations for implementing the Zero Suicide Initiative framework into public and private health, mental health, and substance use disorder care systems across California. This effort should include the identification of state funds that may be needed to build capacity for technical assistance and training. As part of this initiative, the department should partner with California health systems currently implementing the Zero Suicide Initiative, such as Kaiser Permanente.
OBJECTIVE 8C Expand resources to support health care providers increase access and linkage to mental health and substance use disorder services and culturally appropriate support services for people identified as needing such services. This strategy includes providers in correctional settings.	By July 1, 2022, the State, in consultation with private and public partners, should create incentives to expand the use of Collaborative Care in health care systems. Options may include expanding the scopes of practice for physician assistants and nurse providers specifically trained in suicide prevention risk assessment, management, and referral; creating guidance and reducing barriers for billing health plans for services; and reducing documentation burdens.

GOAL 8: INCREASE DETECTION AND SCREENING TO CONNECT PEOPLE TO SERVICES BASED ON SUICIDE RISK

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 8D Increase standardized training offered to health, mental health, and substance use disorder providers in suicide risk assessment and management best practices. Enhance uniform suicide risk assessment and management in health care settings to align with Joint Commission guidelines and the Zero Suicide Initiative. Such settings include state and local correctional facilities.	By December 31, 2022, the Office of Suicide Prevention should disseminate guidance on screening for suicide risk for at-risk groups, including people exposed to physical and sexual abuse, victims of domestic or other interpersonal violence, families and youth in the child welfare system, LGBTQ-identified and questioning youth, and people in detention settings or on probation or parole supervision. By July 1, 2023, the State, in consultation with private and public partners, should develop a strategy for delivering training in best practices for suicide risk assessment and management to all health care providers. Because health care providers are at increased risk for suicide themselves, trainings should include a component on best practices for provider wellness, including methods of reducing burn-out, compassion fatigue, and vicarious trauma.
OBJECTIVE 8E Invest in technology in systems serving health, mental health, and substance use disorders to improve uniform suicide risk assessment and management. Goals include identifying people at risk and triaging those at risk into appropriate services and culturally appropriate support.	By July 1, 2023, the Office of Suicide Prevention should form a task force to develop and disseminate guidance on the use of technology to support suicide risk assessment and management, and to improve the triaging of people in high-risk settings, including health care systems. This effort also should assess the use of administrative data to detect and monitor suicide risk when screening is not feasible. For example, school administrative data indicating risk might include absences, excessive tardiness, and significant changes in academic performance and behavior in school.

GOAL 9: DELIVER A CONTINUUM OF CRISIS SERVICES WITHIN AND ACROSS COUNTIES

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 9A Develop and implement a strategy to coordinate the delivery of crisis services, including an assessment of current crisis services infrastructure and private and public funding for services.	By July 1, 2022, the State, with leadership from the Department of Health Care Services and private and public partners, should form a task force to develop a strategy for evaluating crisis services and to determine the extent to which crisis services prevent suicidal behavior. Based on its findings, the task force should make recommendations for standardizing crisis service delivery systems across the state. The recommendations should address training and capacity barriers, and the evaluation plan should be implemented by July 1, 2023. As part of this effort, the State should assess the current capacity for training and technical assistance and determine what additional assistance is needed to systematically improve crisis services statewide, including opportunities to expand bilingual and bicultural crisis providers. The department should explore the possibility of implementing the Crisis Now Model across California.[379] The department also should develop a process to monitor quality assurance and quality control of crisis services, including how the state will regularly track data, targets, and measures and report to the public. After assessing need and identifying private and public funding sources, the department should make recommendations to the Governor and Legislature about any additional resources required to ensure the crisis services network is sufficiently funded. The department should consider the use of a tool, such as the Crisis Resource Need Calculator, for its assessment. By December 31, 2022, the Office of Suicide Prevention should develop and disseminate guidance on planning and coordinating crisis services for schools, colleges, and universities to prevent suicidal behavior among students. The guidance should include information about how schools could formally connect to crisis services and supports in the community. By December 31, 2022, the Office of Suicide Prevention should develop and disseminate guidance on integrating best practices in suicide prevention in crisis intervention training as well as co-responder models, in which law enforcement and mental health providers respond jointly to behavioral health crises. The best practices should include assessment and referral to services based on suicide risk and on increasing safety by reducing access to lethal means.

GOAL 9: DELIVER A CONTINUUM OF CRISIS SERVICES WITHIN AND ACROSS COUNTIES

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 9B Create a research and policy agenda to advance the goal of promoting a continuum of crisis services within and across counties.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 3.
OBJECTIVE 9C Create uniform standards for suicide and crisis hotlines in the state, including standards for training and core competencies for call responders; protocols for performance and quality assurance monitoring; and procedures for making referrals to services, including emergency services.	By December 31, 2021, the Office of Suicide Prevention should develop a strategy for collecting crisis services data and monitoring the quality, timeliness, and effectiveness of services to reduce suicidal behavior. As part of this effort, the office should develop uniform standards for suicide prevention hotlines and centers, including standards on training for hotline staff and performance targets. One option is the adoption of minimum standards set by an accrediting organization, such as the American Association of Suicidology or the National Suicide Prevention Lifeline. The office should identify incentives for adhering to uniform standards, such as making adherence a condition for state funding.

GOAL 10: DELIVER BEST PRACTICES IN CARE TARGETING SUICIDE RISK

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 10A Create a research and policy agenda to advance the goal of delivering best practices in care targeting suicide risk.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 4. Implementing the Federal Parity Law and ensuring health insurance coverage for services to address suicide risk – specifically, mental health and substance use disorder services – were identified as key policy goals during the drafting of this plan.
OBJECTIVE 10B Create a process to certify providers trained in delivering best practices in suicide risk assessment and management and in interventions specific to preventing suicide. Certification could include minimum education, training, and continuing education requirements, and should include a review and approval process. This strategy includes providers in correctional settings.	By July 1, 2023, the State, in consultation with private and public partners, should create incentives for behavioral health licensing entities to develop a certification for providers who deliver best practices suicide risk assessment, management, and treatment and to develop a database of all certified providers that is accessible to the public. California's mental health licensing entities include the Medical Board, the Board of Psychology, and the Board of Behavioral Sciences.
OBJECTIVE 10C Create a strategy to increase health, mental health, and substance use disorder provider workforce capacity to deliver suicide-related services.	By December 31, 2022, the Office of Suicide Prevention should develop an online resource center to support continuing education for health, mental health, and substance use disorder care providers in best practices in suicide prevention interventions and therapies. By December 31, 2024, the State, in consultation with private and public partners, should require education and training in best practice therapies targeting suicide risk in all medical and clinical education training curricula.

GOAL 11: ENSURE CONTINUITY OF CARE AND FOLLOW-UP AFTER SUICIDE-RELATED SERVICES

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 11A Create a research and policy agenda to advance the goal of ensuring continuity of care and follow-up after suicide-related services.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 4.
OBJECTIVE 11B Establish a program to deliver training on lethal means restriction counseling to health care providers, and distribute gun and medication lock boxes and locks to hospitals, with prioritized distribution to families and caregivers of people discharged following a suicide attempt.	By July 1, 2023, the State, in consultation with private and public partners, should create a program to support training for health care providers and hospitals on distributing means safety products, such as lock boxes for guns or medications, and education to families and caregivers of people discharged after receiving services for a suicide attempt. This effort should consider challenges and opportunities for integrating information on lawful options for transfer and removal of firearms and ammunition in the home to keep a person at risk safe from future injury and death.
OBJECTIVE 11C Ensure delivery of best practices for continuity of care following discharge after suicide-related services in emergency departments and hospital settings, including the routine, standardized use of follow-up cards, texts, and emails.	By July 1, 2023, the State, in consultation with private and public partners, should require all hospitals and emergency departments to develop policies and protocols for delivering counseling on lethal means restriction; distributing means safety products, such as lock boxes for guns or medications; and sending follow-up messages to people discharged after receiving services for a suicide attempt. This effort should include an assessment of the readiness of health care professionals to discuss lethal means restriction and disseminate resources to support restriction, and should make recommendations for training and other support. This effort should explore the effectiveness of different types of messaging, such as handwritten and electronic forms.

GOAL 11: ENSURE CONTINUITY OF CARE AND FOLLOW-UP AFTER SUICIDE-RELATED SERVICES

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 11C *Continues*	Protocols and practices must include provisions detailing how informed consent will be obtained and how follow-up care will reflect a collaborative, transparent approach with the person at risk to prioritize outpatient care. Protocols and procedures must include brief interventions involving best practices in safety planning and lethal means counseling. Follow-up care must be linguistically and culturally respectful. Protocols and practices should include methods for tracking linkages to referrals to services, when possible. By July 1, 2023, the Office of Suicide Prevention should form a task force to develop and disseminate best practice guidance and make recommendations for comprehensive aftercare for people discharged from hospital settings. This effort should standardize a process for delivering follow-up, establishing care linkages prior to discharge, and ensuring ongoing monitoring and support. Guidance should highlight California's suicide prevention hotlines and centers by establishing a connection between such resources and suicide attempt survivors prior to discharge, and requiring routine follow-up to ensure connections to services. Guidance should include opportunities to increase "rapid referrals" and identify incentives for health care providers. These referrals involve people who either are being treated in an emergency department or are approaching hospital discharge; the goal is to connect them from inpatient care to outpatient services within 24 to 48 hours after discharge. By July 1, 2023, the State, in consultation with private and public partners, should create incentives for outpatient mental health and substance use disorder care providers to enter into agreements with hospitals to accept referrals and develop a process for confirming timely outpatient appointments prior to discharge. By July 1, 2024, the Office of Suicide Prevention should partner with schools, universities, and colleges to identify challenges and opportunities for safely transitioning students back into schools after hospitalization for suicidal behavior and develop and disseminate best practice guidance.

GOAL 12: EXPAND SUPPORT SERVICES FOLLOWING A SUICIDE LOSS

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 12A Create a research and policy agenda to advance the goal of expanding support services following a suicide loss.	By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 4.
OBJECTIVE 12B Assess and expand effective resources available to suicide loss survivors and develop capacity statewide to deliver appropriate and respectful services following a suicide loss. The resources should include information and training for bereavement service providers on topics specific to suicide and to grief that is unique to suicide loss.	By July 1, 2022, the Office of Suicide Prevention should develop a statewide directory of survivor support service providers across settings, including in schools, workplaces, health care offices, faith communities, tribal communities, and correctional facilities. By January 1, 2023, the Office of Suicide Prevention should form a task force to evaluate services delivered to people bereaved by suicide loss, identify gaps in services, and disseminate findings. By July 1, 2024, the task force should make recommendations for implementing best practices in local team-based responses following a suicide loss in a community or specific setting, including how to manage privacy and information and data sharing among members of the team. By July 1, 2024, the task force should develop guidance for coroners, medical examiners, and law enforcement for supporting people bereaved by suicide. The guidance should include methods for reducing stigma and shame; for responding to cultural differences following a suicide loss; and for supporting people delivering services to loss survivors.
OBJECTIVE 12C Ensure written postvention – a planned response for the delivery of services after a suicide - policies and procedures are developed, adopted, and disseminated to staff in all settings where people are receiving mental health and substance use disorder services and supports.	By July 1, 2022, the Office of Suicide Prevention should develop and disseminate guidelines for postvention policies and procedures in the event of suicide by a person receiving services in mental health and substance use disorder care settings. Guidelines should consider materials developed by the American Association of Suicidology's Clinician Survivor Task Force and others, and should identify and address legal and ethical concerns, such as maintaining confidentiality of the client who died by suicide while the clinician receives suicide bereavement services.

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Get Help Now

If you or someone else needs support, a trained crisis counselor can be reached by calling the National Suicide Prevention Lifeline at **800-273-TALK (8255)** or by texting TALK to **741741**.

- Personas que hablan español, llamen a the Lifeline al **888-682-9454**.
- For teens, call the TEEN LINE at **310-855-4673** or text TEEN to **839863**.
- For veterans, call the Lifeline at **800-273-TALK (8255)** and **press 1**.
- For LGBTQ youth, call The Trevor Project at **866-488-7386** or text **START** to **678678**.
- For transgender people, call the Trans Lifeline at **877-565-8860**.
- For people who are deaf or hard of hearing, call the Lifeline at **800-799-4889**.
- For law enforcement personnel, call the COPLINE at **800-267-5463**.
- For other first responders, call the Fire/EMS Helpline at **888-731-FIRE (3473)**.

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