The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Book, Chair
Senator Mayfield, Vice Chair

MEETING DATE: Tuesday, September 17, 2019
TIME: 11:00 a.m.—12:30 p.m.
PLACE: 301 Senate Building

MEMBERS: Senator Book, Chair; Senator Mayfield, Vice Chair; Senators Bean, Harrell, Rader, Torres, and Wright

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Panel Discussion on Suicide Prevention and Mental Health: · Dr. Maggie Labarta, President/CEO, Meridian Behavioral Healthcare of Gainesville, Florida · Rene Garcia, Former Florida Senator, Hialeah, Florida · Kevin Hines, Suicide Survivor, Kevin & Margaret Hines Foundation . Danny Burgess, Executive Director, Florida Department of Veterans' Affairs · Rodney Moore, Assist. Sec. for Substance Abuse and Mental Health, Dept. of Children and Families . Jacob Oliva, Chancellor, Division of Public Schools, Florida Department of Education	Discussed

Other Related Meeting Documents

2017 National Suicide Deaths by Age

Age Group	Suicide Deaths	Crude Rate per 100,000 Population	Cause of Death Ranking
5-14	522	1.27	2
15-24	6,252	14.46	2
25-34	7,948	17.53	2
35-44	7,335	17.94	4
45-54	8,561	20.20	4
55-64	7,982	19.01	8
65+	8,568	16.85	-
Unknown	5	-	-

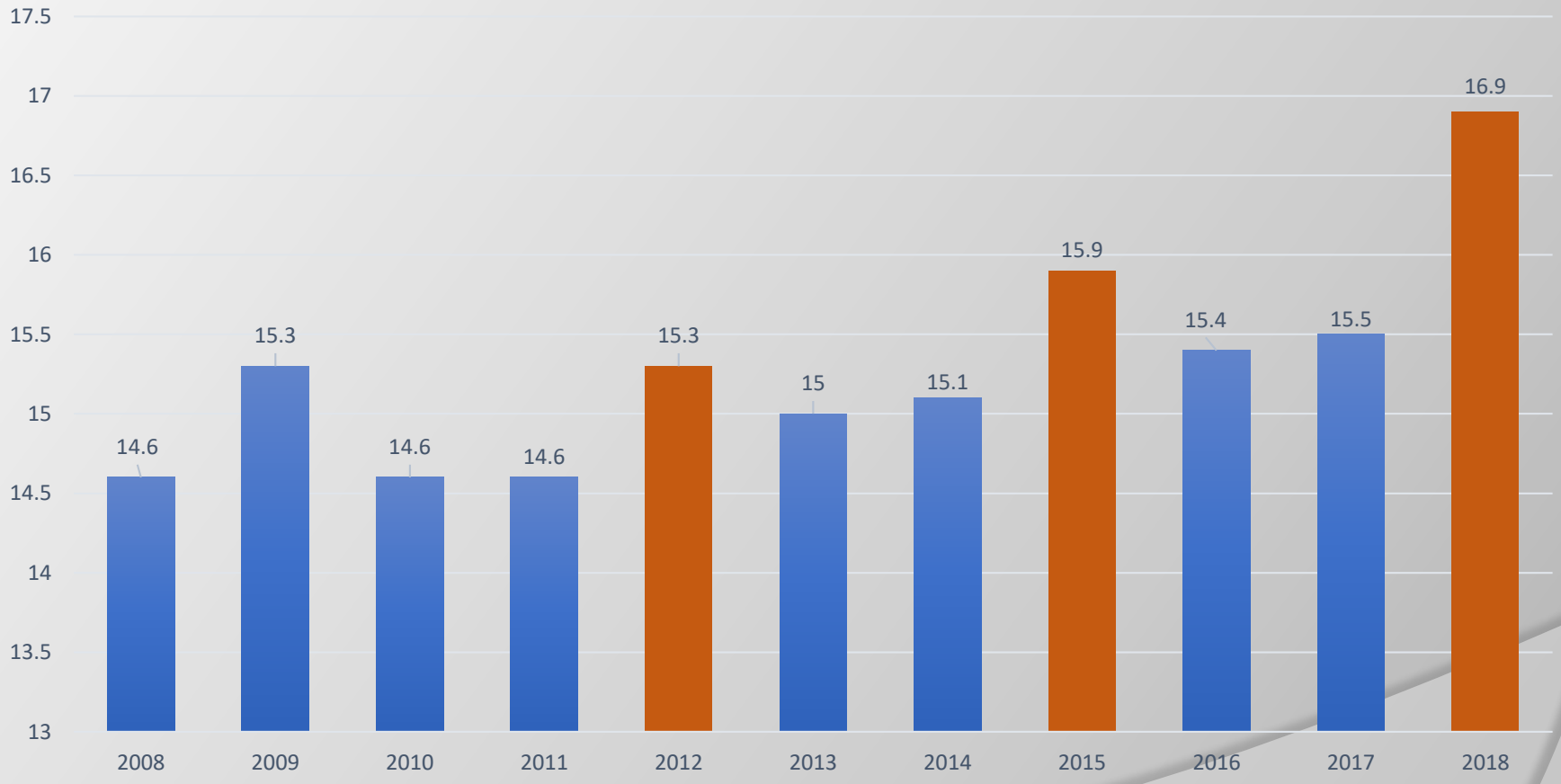
Source: NATIONAL CENTER FOR HEALTH STATISTICS (NCHS), NATIONAL VITAL STATISTICS SYSTEM

2018 Florida Suicide Deaths by Age

Age Group	Suicide Deaths	Rate per 100,000 Population	Cause of Death Ranking
5-14	21	0.9	4
15-24	296	12.0	3
25-34	427	15.6	2
35-44	504	20.0	4
45-54	603	21.8	4
55-64	737	26.4	8
65-74	473	20.3	12
75-84	338	25.8	15
85+	153	27.7	18
Total	3552	16.9	8

Data Source: TABLE D-11: RESIDENT DEATHS FOR SELECTED CAUSES, BY AGE GROUPS, BY COUNTY, FLORIDA, 2018: Florida Vital Statistics Annual Report (2018)

Florida Suicide Rate per 100,000 Population (2008-2018)



Data Sources: CHART D-13: RESIDENT SUICIDE DEATHS AND RATES PER 100,000 POPULATION, BY RACE AND GENDER, FLORIDA, CENSUS YEARS 1970-2000 AND 2007-2017: FLORIDA VITAL STATISTICS ANNUAL REPORT (2018)

OFFICE OF SUBSTANCE ABUSE AND MENTAL HEALTH

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SUICIDE PREVENTION COORDINATING COUNCIL
2018 ANNUAL REPORT

Department of Children and Families
Office of Substance Abuse and Mental Health

January 1, 2019

Rebecca Kapusta
Interim Secretary

Rick Scott
Governor

TABLE OF CONTENTS

I. Introduction

The Department of Children and Families (department) Office of Substance Abuse and Mental Health (SAMH) implements suicide prevention efforts through the Statewide Office for Suicide Prevention (SOSP). The SOSP collaborates with the Suicide Prevention Coordinating Council (SPCC) and other stakeholders to implement the 2016-2020 Florida Suicide Prevention Plan (Plan). One responsibility is to prepare this annual Report pursuant to section 14.20195(c), F.S. and present it to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The SPCC consists of 27 members whose mission is to develop effective strategies for suicide prevention. This year, the SOSP invited the SAMH regional offices and Managing Entity staff to join the SPCC as permanent guests and non-voting members.

The Report addresses suicide prevention efforts relative to the Plan and provides an overview of 2016 national suicide statistics and 2017 Florida suicide statistics. The Plan delineates the following goals:

1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.
2. Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.
3. Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors.
4. Provide training on the prevention of suicide and related behaviors to the community and clinical service providers.
5. Promote suicide prevention as a core component of health care services.
6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors.
7. Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts.

To obtain a statewide picture of suicide prevention activities, the SOSP asked stakeholders to complete the *2018 Suicide Prevention Activities* form that captures all suicide prevention related efforts. Section IV of this report summarizes suicide prevention activities implemented for 2018; Appendix 1 provides a full list the activities with future planned activities in Appendix 2.

Suicide prevention efforts specific to service members, veterans, and their families is a special focus of the SOSP. In 2017, with the assistance of the federal *Substance Abuse and Mental Health Services Administration's Service Members, Veterans, and their Families (SMVF) Technical Assistance Center*, SOSP created the Florida Implementation Plan. A subcommittee of the SOSP met to work towards implementation of the plan

throughout 2018. The efforts of the subcommittees are detailed in section VI of this Report.

II. An Overview of Suicide

Suicide is a major public health issue and a leading cause of death nationally, with complex causes such as mental health and substance use disorders, painful losses, exposure to violence, and social isolation.[1] Suicide is a tragic, but preventable event that has a devastating impact on families and communities. In 2017, **3,187 lives** were lost to suicide in Florida.

To better understand this complex public health problem and improve suicide prevention efforts, the SOSP and the SPCC continually review national and state-level suicide data. The information presented in this section provides the most recent suicide data available.

II.A. National Data

National suicide data for 2016, which is the most recent data available from the Centers for Disease Control and Prevention, is summarized below:

- The total number of deaths in the U.S due to suicide was 44,965.[2]
- Suicide was the tenth leading cause of death in the U.S.

Table 1 shows the 2016 national suicide deaths per age group. Notably, suicide was the second leading cause of death for individuals within the 5-14, 15-24, and 25-34 age groups, and the fourth leading cause of death for individuals within the 35-44 and 45-54 age groups.

Table 1: National Suicide Deaths in 2016

Age Group	Suicide Deaths	Rate per 100,000	Cause of Death Ranking
5-14	443	1.08	2
15-24	5,723	13.15	2
25-34	7,366	16.49	2
35-44	7,030	17.37	4
45-54	8,437	19.72	4
55-64	7,759	18.71	8
65+	8,204	16.66	16

[1] See, https://www.samhsa.gov/suicide-prevention, site accessed October 19, 2017.
[2] See, https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2016-508.pdf, site accessed September 17, 2018.
[3] See, https://www.cdc.gov/violenceprevention/suicide/statistics/index.html, site accessed September 17, 2018.

II.B. Florida Data

Data related to suicide in Florida for 2017, as reported in the *Florida Vital Statistics Annual Report (2017),*[4] is summarized below:

- The total number of deaths due to suicide was 3,187, which is a slight increase from 3,122 in 2016.
- Suicide was the eighth leading cause of death in Florida.
- The suicide rate per 100,000 population was 15.5. This is a slight increase from 2016 (15.4).

Table 2 shows the numbers of Florida suicide deaths per age group. Suicide was the second leading cause of death for individuals within the 25-34 age group in 2017, similar to the national ranking of 2016, and the third leading cause of death for individuals within 15-24 age group. Suicide was the fourth leading cause of death for individuals within the 5-14, 35-44, and 45-54 age groups.

Table 2: Florida Suicide Deaths in 2017

Age Group	Suicide Deaths	Rate per 100,000	Cause of Death Ranking
5-14	17	0.7	4
15-24	286	11.6	3
25-34	430	16.1	2
35-44	399	16.2	4
45-54	601	21.9	4
55-64	634	23.3	8
65-74	406	17.9	13
75-84	272	21.7	16
85+	141	25.5	18
Unknown	1	N/A	N/A
Total	3187	15.5	8

Data Source: TABLE D-11: RESIDENT DEATHS FOR SELECTED CAUSES, BY AGE GROUPS, BY COUNTY, FLORIDA, 2017: *Florida Vital Statistics Annual Report (2017)*[5]

Graph 1 shows that in 2017, Florida suicide rates for white and black males were higher than the rates for white and black females. The suicide rate for white males was the highest, while the suicide rate for black females was the lowest.

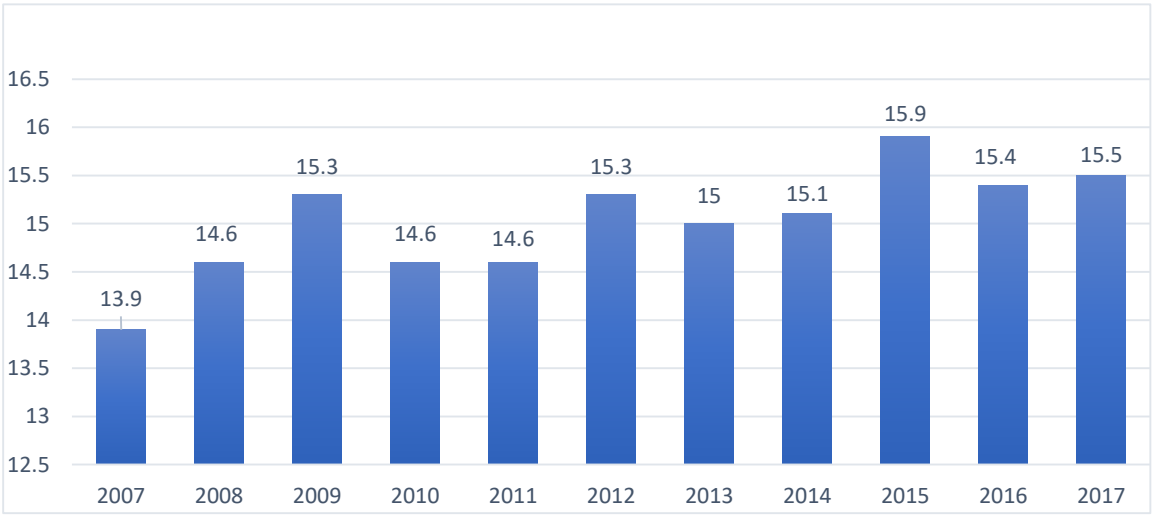
[4] See, http://www.flpublichealth.com/VSBOOK/pdf/2017/Deaths.pdf, site accessed October 3, 2018.
[5] See, http://www.flpublichealth.com/VSBOOK/pdf/2017/Deaths.pdf, site accessed October 3, 2018.

Graph 1: 2017 Florida Suicide Death Rates per 100,000 Population by Race and Gender

Data Source: CHART D-13: RESIDENT SUICIDE DEATHS AND RATES PER 100,000 POPULATION, BY RACE AND GENDER, FLORIDA, CENSUS YEARS 1970-2000 AND 2007-2017: *FLORIDA VITAL STATISTICS ANNUAL REPORT (2017)*[6]

Graph 2 shows a consistent upward trend in the suicide rate in Florida from 2007 to 2009. The trend fluctuates slightly from 2009 to 2017. The lowest suicide rate was 13.9 in 2007, while the highest was 15.9 in 2015. The suicide rate slightly increased from 2016 to 2017.

Graph 2: Suicide Rate per 100,000 Population, Florida (2007 - 2017)



Data Sources: CHART D-13: RESIDENT SUICIDE DEATHS AND RATES PER 100,000 POPULATION, BY RACE AND GENDER, FLORIDA, CENSUS YEARS 1970-2000 AND 2007-2017: *FLORIDA VITAL STATISTICS ANNUAL REPORT (2017)*[7]

[6] See, http://www.flpublichealth.com/VSBOOK/pdf/2017/Deaths.pdf, site accessed October 3, 2018.
[7] See, http://www.flpublichealth.com/VSBOOK/pdf/2017/Deaths.pdf, site accessed October 3, 2018.

III. Goals

In 2001, the U.S. Surgeon General issued the National Strategy for Suicide Prevention (National Strategy) to launch an organized effort to prevent suicide across the nation. Updated in 2012, the revised National Strategy represented a new approach to enlisting all states in the effort to prevent suicide. Florida's Plan is a collaboration of the SPCC and the SOSP. Section 14.20195(a), F.S., requires the SPCC to advise the SOSP "regarding the development of a statewide plan for suicide prevention, with the guiding principle being that suicide is a preventable problem."

The purpose of the Plan is to guide statewide efforts to decrease suicide-related deaths through a framework of goals and objectives that coordinate suicide prevention activities at the state and local community levels. The Plan can be viewed on the department's SOSP website.

Table 3 outlines the Plan's strategic directions, goals, and objectives. The four strategic directions align with the National Strategy, which are:

- Healthy and empowered individuals, families, and communities
- Clinical and community preventive services
- Treatment and support services
- Surveillance, research, and evaluation

Table 3: 2016-2020 State Plan for Suicide Prevention

Strategic Direction	Goal	Objective(s)
Healthy and Empowered Individuals, Families, and Communities	1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	1.1 Integrate suicide prevention into the values, culture, leadership, and workplace of a broad range of organizations, programs, and schools with a role to support suicide prevention activities. 1.2 Establish effective, sustainable, and collaborative suicide prevention programming at the state, tribal, and local levels.
	2. Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.	2.1 Reduce prejudice, stigma, and discrimination associated with suicidal behaviors and mental and substance use disorders.
Clinical and Community Preventive Services	3. Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors.	3.1 Encourage community-based settings to implement effective evidence-based programs and provide education to promote wellness. 3.2 Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

Strategic Direction	Goal	Objective(s)
	4. Provide training on the prevention of suicide and related behaviors to community and clinical service providers.	4.1 Update and modify suicide prevention trainings to meet the provider's specific needs and roles.
Treatment and Support Services	5. Promote suicide prevention as a core component of health care services.	5.1 Promote timely access to assessment, intervention, and effective care for individuals with heightened risks for suicide. 5.2 Establish linkages between providers of mental health and substance abuse services and primary care and community-based programs, including peer support programs.
	6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors.	6.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings. 6.2 Adopt, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risks.
Surveillance, Research, and Evaluation	7. Increase the usefulness of national and state-level surveillance data to inform suicide prevention efforts.	7.1 Identify available data to guide suicide prevention efforts.

This year, the SOSP and the SPCC analyzed the impact of goal two; increasing public knowledge of suicide prevention. To determine the type of suicide prevention related trainings conducted in the community and the number of individuals exposed to suicide prevention, the SOSP asked stakeholders to complete the *2018 Suicide Prevention Activities* form. The SOSP analyzed the 39 forms received. An analysis of the results is presented in the following section.

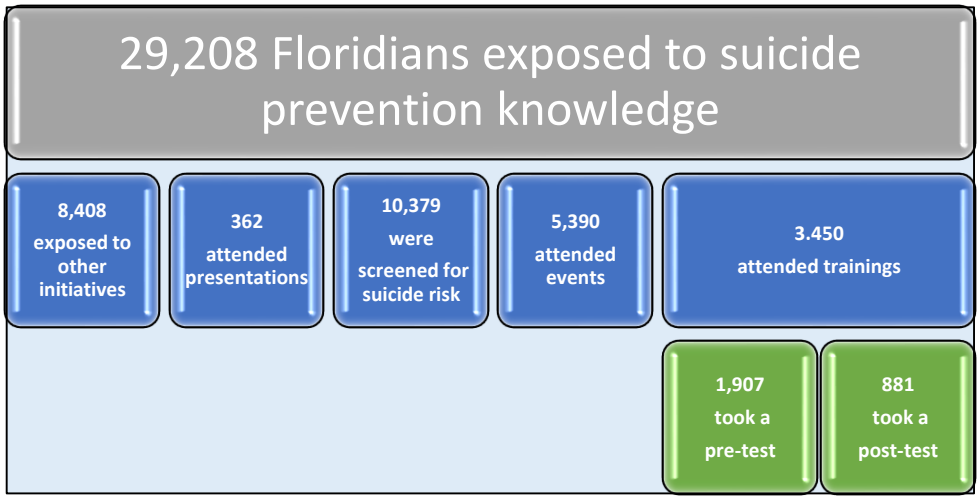
IV. Increase Public Knowledge of Suicide Prevention

Hosting informational tables at events, hosting events that focus on suicide prevention, or facilitating presentations on the topic are methods for increasing awareness. From January to July 2018, 14,160 individuals were exposed to general information about suicide prevention. This is an increase from 6,687 individuals who were exposed to a suicide prevention activity in 2017. In total, 29,208 individuals were exposed to suicide prevention in 2018.

Graph 3 shows that 63 suicide prevention trainings were provided to 3,450 individuals from January 1, 2018 to June 30, 2018, to increase knowledge of ways to help

someone who is suicidal, provide knowledge about the risk and protective factors, as well as ways to prevent deaths by suicide.

Graph 3: Exposure to Suicide Prevention Knowledge

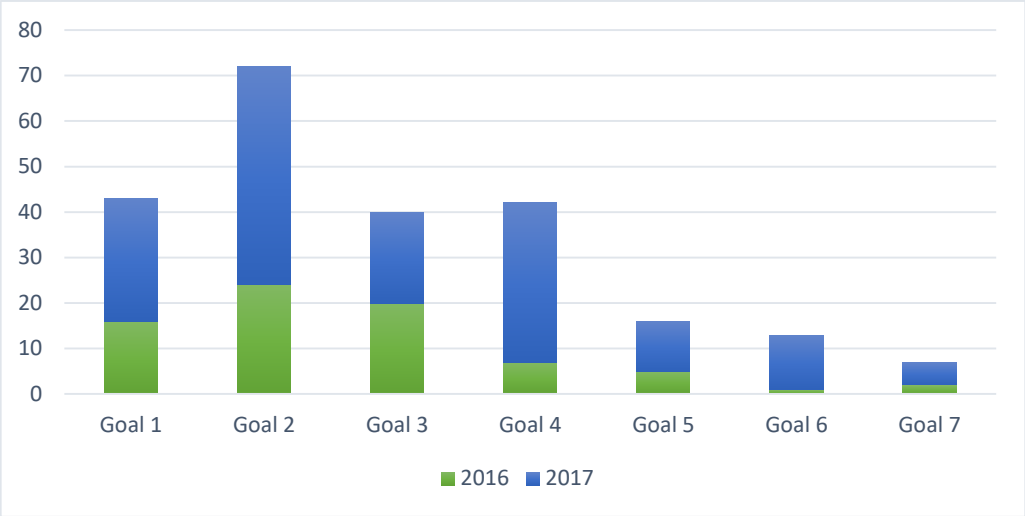


V. Two Year Implementation Assessment of the 2016-2020 Florida Suicide Prevention Plan

This year the SPCC completed a two-year implementation assessment of the Plan to assess awareness and use of the Plan; relevance of the Plan's goals; how each organization or agency's efforts map to the goals of the Plan; and identification of gaps in the Plan's goals based on each organization or agency's work. The SPCC formed a subcommittee composed of council members to complete the two-year assessment.

The Plan's ultimate goal is to decrease the number of deaths by suicide in Florida. The baseline was 2,961 deaths by suicide in 2014. A review of the number of deaths by suicide in 2015 and 2016 show that there was a 6.24% increase in deaths by suicide from 2014 to 2015 while there was a 0.95% decrease from 2015 to 2016. Graph 4 shows that there was an increase of the number of implemented activities for all goals from 2016 to 2017, except goal three, which remained the same.

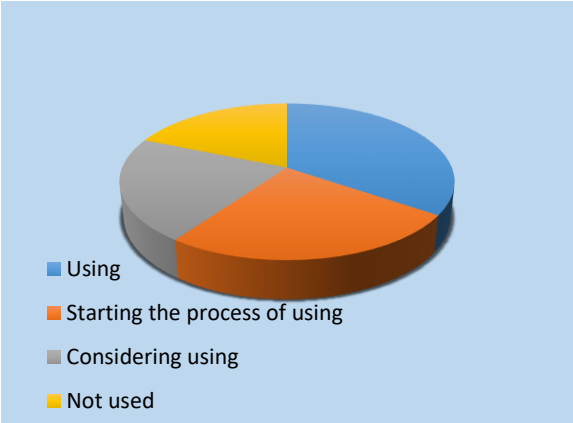
Graph 4: Goal Implementation



The subcommittee adapted and adjusted the instrument used by the *National Strategy for Suicide Prevention Implementation Assessment Advisory Group* to further assess the effectiveness of the Plan. The instrument was emailed to Floridian stakeholders on June 14, 2018, and the response period closed on July 19, 2018. Fifty-four responses were received and the findings are presented below.

Awareness and Use of the Plan:

Graph 5: Use of the Plan



Of the stakeholders who responded to the instrument, 65% were aware of the Plan while 35% were unaware. Stakeholders became aware of the Plan through training, online searches, the SPCC, upper management, seminars, community and Managing Entity meetings, Suicide Prevention Day at the Capitol, the SOSP, and workgroups.

Graph 5 shows that of the stakeholders who were aware of the Plan, 37% are already using the Plan to implement and organize suicide prevention efforts, 27% were starting the process of using the Plan, while 23% were considering using the Plan in the future, and 20% have not used the Plan.

Of the stakeholders who answered that they were using the Plan, 25% aligned their suicide prevention efforts with the Plan's goals, 71% cross-walked the Plan's goals against the organization's efforts to identify gaps and redundancies, and 4% were using the plan in other ways such as for training. Lastly, 86% of stakeholders have utilized or will utilize the Plan to identify gaps in the organization or program.

Relevance of the Plan's goals:

Stakeholders who were aware of and using the Plan indicated that Goal 6 received the highest priority and Goal 7 received the lowest priority. Answers to the instrument show that stakeholders prioritized the Plan's goals based on their resources, funds, and needs. One stakeholder stated that Goal 7 received the lowest priority because they use other data to guide their outcomes while another stakeholder stated that they would like to focus on Goal 7 to help plan a community strategic direction. A different stakeholder stated that Goal 3 is their lowest priority due to lack of resources and funds.

Stakeholders shared that some suicide prevention efforts are a direct result of the Plan as follows:

- Increased awareness and collaboration between providers, the Managing Entity, and law enforcement
- Implementation of a care coordination program and working closely with the Florida Linking Individuals Needing Care Coordination Program
- Implementation of policies to assess suicide risk and Baker Act
- Providing follow-up services for support
- Providing education and outreach
- Starting a local coalition
- Providing guidance to an action committee

Other efforts that were not a direct result of the Plan include:

- Providing Mental Health First Aid training to over 2,000 individuals
- Creation of a task force that incorporates child, family, and child welfare clinical departments to integrate best practices in prevention, assessment, and treatment

Identifying gaps in the Plan's goals based on each organization or agency's work:

The instrument asked if there were changes that can be made to the Plan. Stakeholders provided the following feedback:

- Create a marketing campaign for all Floridians and use public service announcements to start conversations about suicide prevention
- Add more available support and therapy services
- Focus on collaboration and the streamlining of processes
- Identify additional community resources especially in Spanish and Creole
- Provide Zero Suicide initiative resource materials

According to the survey, stakeholders would like support in the following:

- Information on updated evidence-based tools
- Assistance with building additional community supports
- Work groups that would help carry out the Plan
- A checklist of toolkits and guides to decrease time staff spend looking for information
- Assistance in finding a standardized evaluation form to identify at-risk individuals
- Assistance with risk assessments and suicide prevention data
- Basic education for individuals who have a serious mental illness and may be at risk for suicide
- Training for staff and presentations about suicide prevention
- The creation of a full time staff at the Managing Entity level to implement the Zero Suicide initiative
- The State of Florida's participation of the National Violent Death Reporting System

The SPCC will review this feedback and discuss ways to provide additional support in 2019.

VI. Efforts for Service Members, Veterans, and Their Families

In March 2017, the SOSP, along with interested stakeholders, participated in the federal Substance Abuse and Mental Health Services Administration's Service Members, Veterans, and their Families (SMVF) Technical Assistance Center's "Advancing Suicide Prevention Best Practices in SMVF Peer Support" Virtual Implementation Academy. Results from this collaboration include the creation of eight goals, the Peer Support Workgroup, and the Strategic Leadership Workgroup. In 2018, the Peer Support workgroup and other stakeholders worked on the following goals:

1. Develop an initiative for peer support for SMVF
2. Collaborate and standardize training across the state
3. Gather suicide prevention and peer resources in one, easy to access place
4. Increase interaction between voluntary, paid civilian, and SMVF peers
5. Promote outreach on a community level
6. Better understand the needs of SMVF
7. Increase use of suicide prevention and peer support best practices
8. Expand the level of peer support in communities for justice involved SMVF

The Peer Support Workgroup completed the following:

- The SOSP added resources for SMVF to the department's website and events to the online calendar
- The State Emergency Operation Center agreed to post events that focus on SMVF

- The Crisis Center of Tampa Bay provided a list of resources for SMVF in Florida that was shared via email and a link was added to the department's website
- A list of public service announcements that focus on SMVF was added to the department's website
- The workgroup reviewed the Department of Defense's national quarterly report on suicide deaths per service and component
- The workgroup discussed that the Crisis Center of Tampa Bay's phone call data can be used as a central method to collect data, such as caller information on veterans and the reasons they call

VII. Grants

Information on eight major federal grants operating in Florida to assist with suicide prevention efforts is below.

1. Florida Implementation of the National Strategy for Suicide Prevention (FINS) Project

The FINS Project is a partnership of the SOSP, the University of Central Florida (UCF), the University of South Florida (USF), and Florida Hospital. Using a mentorship model, FINS adopted and integrated the National Strategy for Suicide Prevention. The project ensures that health and behavioral health settings as well as adult-serving systems are prepared to identify, engage, and treat at-risk adults by using culturally competent evidence based/best-practice suicide prevention, treatment, safety planning, and care coordination services. Major grant activities completed to date are summarized below:

- Began a Zero Suicide initiative at the Florida Hospital Kissimmee (FHK) pilot site. Zero Suicide is a system wide-approach to improve outcomes and close gaps using the premise that death by suicide for an individual under a health or behavioral health system is preventable. Implementation activities include:
    - Establishing a Zero Suicide Committee
    - Collecting baseline data prior to the trainings
    - Conducting four trainings
    - Training 42 professionals in mental health, non-mental health, and medical work roles
- Developed a training plan for FHK's emergency department
- Began providing the Question Persuade Refer (QPR) training that teaches individuals how to recognize the warning signs of suicide and how to question, persuade, and refer someone to help. This is also known as a gatekeeper training. Four trainings have occurred and program staff will continue to offer the training every three weeks.

- Developed a screening tool to be embedded into FHK's electronic medical record system
- Developed care pathways for individuals admitted to FHK's emergency department for suicide risk screening
- Began developing partnerships within the community
- Debuted the pilot for *LINC to Life Safety Planning* training at the Florida Behavioral Health Conference to 36 participants
- Began *LINC Care Coordination* trainings in the community
- A UCF Masters of Social Work student began interning at FHK to assist with *LINC Care Coordination*

2. Central Florida Pathways to Awareness, Support, and Services (C PASS) Project

The C PASS Project, a Now is the Time Project Aware Community Grant, is a partnership between UCF, USF, and the Florida Council for Community Mental Health (FCCMH). The grant is in its third year of implementation. This project has coordinated, strengthened, and enhanced system-wide efforts to expand Youth Mental Health First Aid (YMHFA) training, behavioral health outreach, and engagement initiatives to high-risk regions in Central Florida including Citrus, Lake, Sumter, Orange, Seminole, and Volusia counties. YMHFA is an eight-hour educational program for youth-serving adults that introduces participants to the unique risk factors and warning signs of mental health problems in adolescents. The program teaches individuals how to help an adolescent who is in crisis or experiencing a mental health challenge, including suicide.

Training and outreach efforts for the past two years of the grant have targeted frontline professionals who work with high-risk youth experiencing mental health and substance use issues and who encounter significant life stressors and adversities such as exposure to violence, abuse, neglect, poverty, and other forms of victimization. The C PASS Project has supported the training of individuals who interact with youth through programs at the community level, including child protective investigators, community mental health providers, law enforcement, school personnel, faith-based leaders, and parents. Implementation of the C PASS Project has aimed to increase mental health literacy among youth-serving adults, policy-makers, and administrators of programs serving youth. Major grant activities completed to date are summarized below:

- Provided 84 YMHFA trainings to 1,584 individuals
- Certified 10 individuals as YMHFA instructors
- Participated in 105 community events and disseminated more than 4,000 materials to promote the C PASS project, mental health awareness, and help-seeking resources

- Identified and referred 1,818 youth to mental health services, crisis services, or other supportive services

3. Florida Linking Individuals Needing Care (FL LINC) Project

The FL LINC Project, a Garret Lee Smith State/Tribal Suicide Prevention Program, is a partnership between the SOSP, the FCCMH, UCF, USF, and three Managing Entities. Beginning in 2015, innovative strategies were developed to enhance services reaching at-risk priority populations. Grant activities have targeted the central, southeast, and northeast regions of the state. The goal of the grant is to increase the number of agencies, organizations, schools, and groups working together to implement suicide-prevention initiatives, in addition to improving care coordination services (follow-up care after a suicide or an attempt) to at-risk youth ages 10-24. Major grant activities completed to date are summarized below:

- Conducted 103 *Question Refer Persuade* (QPR) trainings to 1,658 individuals
- Conducted *Question Refer Persuade and Treat* (QPR-T) training to 67 professionals
- Conducted 16 *LINC Training and Care Coordination* trainings to 235 individuals
- Conducted two Step-Up trainings to 13 students
- Distributed 12,275 National Suicide Prevention Lifeline materials and 4,820 USF Family Guides at events, meetings, and trainings

4. Advancing Wellness and Resiliency in Education (AWARE)

The Department of Education's Project AWARE builds and expands the capacity of state and local educational agencies to address mental health issues among school-aged youth. The goals of the Project AWARE are to increase:

- Youth access to mental health services and supports
- Implementation of evidence-based, culturally responsive mental health practices
- Awareness of mental health issues within Florida's youth, families, schools, and communities

At the state level, partners from multiple youth-serving systems and organizations serve on a management team that provides oversight and leadership to systems that serve youth. At the local level, three Project AWARE districts are developing and implementing a multi-tiered system of mental health supports that will serve as a model statewide.

Project AWARE provides YMHFA training to school personnel and other adults who interact with school-aged youth. The YMHFA trainings focus on how to detect and respond to behavioral health issues in youth, and connect youth and families who may have behavioral health issues with appropriate services and supports. Project AWARE

has trained 68 certified YMHFA instructors, conducted 43 YMHFA trainings, and trained 519 YMHFA first aiders, at no cost to participants.

5. Noles CARE in Academics Project

Florida State University's (FSU) Noles CARE in Academics Project has enhanced existing campus suicide prevention interventions by providing more accessible resources to academic departments across the FSU campus. Noles CARE trained faculty, staff, and students within FSU's academic departments on local sources of support in the learning environment of students, and has encouraged early detection of student distress and referrals for professional help. Noles CARE incorporated specific components into the training that addresses high-risk groups, such as members of the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community, those identifying as racial or ethnic minority students, and student veterans. The goals of the project included:

- Assessing academic departments to determine the:
    - Needs of faculty, staff, and students in carrying out suicide prevention efforts
    - Desire to implement suicide prevention training
    - Preferences of faculty, staff, and students for receiving suicide prevention training
- Increasing the percentage of faculty and staff who feel competent in handling students' mental health concerns
- Increasing the percentage of student leaders who feel competent in intervening with distressed peers
- Increasing the perceived efficacy and comfort of students with talking to faculty and peers about getting help with their mental health concerns
- Utilizing a multidisciplinary leadership network to integrate suicide prevention training with other mental health initiatives on campus to increase student support for mental health within academic departments

The Noles CARE award ended September 29, 2018. Over the course of the grant, staff trained 1,933 individuals on suicide prevention and gave a program overview to 1,019 individuals.

6. Healthy Knights 2020 Project

The UCF Healthy Knights 2020 initiative promotes a campus-wide environment supportive of the development and maintenance of a healthy body, mind, and spirit to decrease the occurrence of mental health issues that lead to suicide. Currently, the UCF campus has several options for students to receive health, mental health, and behavioral health services.

The goals of the project include:

- Developing a crisis response plan that encompasses not only the UCF campus community, but the greater Orlando community, which includes linkage to the National Suicide Prevention Lifeline
- Increasing awareness of suicide risk factors such as depression and substance use, the warning signs, prevention strategies, and resources for high risk populations such as LGBTQ, students with co-occurring substance use and mental health issues, and student veterans through gatekeeper trainings
- Providing information on suicide prevention, identification, and reduction of risk factors, such as depression and substance abuse, promoting help seeking, and reducing the negative attitudes towards seeking care for mental health and substance use disorders
- Creating brochures and public service announcements specific to UCF and its community to help increase the awareness of suicide prevention
- Becoming a member of the Campus Program available through the Jed Foundation

7. College of Central Florida Suicide Prevention Initiative

The College of Central Florida (CF) Suicide Prevention Initiative project began in 2016 and focuses on systematic and cultural changes that will result in better identification of and help seeking for students at risk of suicide. Target populations include, but are not limited to, LGBTQ individuals, Native Americans and Native Alaskans, military family members, and veterans. CF's project will serve Marion, Citrus, and Levy counties in North Central Florida. The overarching goal of the project is to prevent suicide among students attending CF and their family members.

The objectives of this project are to:

- Develop a college advisory committee that will assist and advise in the creation of a campus-wide response protocol to manage the acutely distressed or suicidal student
- Increase the amount of training to CF students, faculty, and staff on suicide prevention and mental health awareness
- Increase collaboration among CF, Bay Care Behavioral Health Center, National Alliance on Mental Illness (NAMI), and other community partners to convey the message that suicide prevention is a community responsibility
- Increase the promotion of the National Suicide Prevention Lifeline

- Present educational seminars and informational materials to CF students, faculty, staff, and family members on suicide prevention, identification, and reduction of risk factors such as depression and substance use or abuse
- Increase help seeking among CF students and reduce the stigma attached for seeking help for mental and behavioral health issues among students

8. Project ECHO

The grant for Miami Dade College's Project ECHO (Engagement, Connection, Help-seeking, Outreach) began in September 2018. ECHO will create an infrastructure that assists Miami Dade College's eight campuses with suicide prevention and mental health awareness. ECHO will provide training, screening, and outreach to increase the help-seeking behavior of 165,000 students. ECHO will increase campus knowledge on suicide prevention and reduce stigma surrounding suicide and help seeking among a highly diverse student population.

The objectives for this project include:

- Developing a comprehensive help network using three memorandums of understanding with community providers
- Conducting QPR training for a minimum of 200 core college students, faculty, and staff
- Hosting a minimum of eight "I Screen, You Screen" screening events
- Hosting one or more real talk outreach events for a minimum of 15,000 students

VIII. Council Recommendations

The SPCC makes three recommendations to decrease deaths by suicide in Florida and to assist with the Plan's efforts. The three recommendations are presented below.

1. Expand the Capacity of the Statewide Office for Suicide Prevention

Expansion of the SOSP will enhance partnerships with local communities and key stakeholders and support the effective implementation of Florida's Suicide Prevention Plan. Expansion will improve strategic planning efforts with communities in order to reduce suicide at the local level. Accomplishing this requires additional resources, as well as additional staff. Expansion of the SOSP by at least one full-time Suicide Prevention Specialist, and program operations funding, would increase the office's ability to support and collaborate with the SPCC, local suicide prevention coalitions, and key stakeholders to better align suicide prevention efforts and reduce suicide in Florida.

2. Support and become involved with the National Violent Death Reporting System

The National Violent Death Reporting System (NVDRS) is the only state-based reporting system that collects and categorizes data on violent deaths from state and local medical examiner, coroner, law enforcement, toxicology, and vital statistics records into an anonymous database. The NVDRS covers all types of violent deaths, including homicides and suicides, in all settings, and for all age groups. The NVDRS may include data on mental health problems, recent problems with employment, finances, or relationships, physical health problems, and information about circumstances of death. Participation in the NVDRS will allow Florida the ability to design and implement suicide prevention and intervention efforts based on these data.

The Department of Health (DOH) submitted the grant application for Florida to access the NVDRS on August 7, 2018 and received the award notification in September. DOH will outsource the grant to a university via a competitive bid process. DOH's Division of Community Health Services will take the lead on working with the university and subsequent stakeholder workgroups. The SPCC recommends that SPCC members be actively involved with NVDRS' stakeholder workgroup and for the NVDRS to be statutorily mandated and funded beyond the life of the grant award. One example of a state that included NVDRS into its revised code language is Ohio (see Chapter 3701.01, Section 3701.93, Ohio Revised Code).

3. Fund School Suicide Prevention Training

The SPCC extends its recommendation that the Legislature appropriate funding for implementation of s. 1012.583, F.S., which directs the Department of Education to develop a list of approved youth suicide awareness and prevention training materials that may be used for training in youth suicide awareness and prevention for instructional personnel. This legislation was passed in 2016 through HB7029 without funding for training. The funding could be used to support implementation of s. 1012.583, F.S., by providing train-the-trainer trainings and materials for youth suicide awareness and prevention trainings approved by the Florida Department of Education. This request supports goal one of the Plan, which is to increase suicide prevention activities across multiple sectors and settings, and goal two, which is to increase public knowledge of the factors that offer protection from suicidal behaviors, and promote wellness and recovery.

APPENDIX 1: 2018 SUICIDE PREVENTION ACTIVITIES

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings

Date	Event	# Individuals
	Northwest Region	
2017-2018 school year	CDAC Behavioral Healthcare worked with schools to create a plan to address suicidal ideation in the classroom and presented the plan to teachers	-
2/21	Lakeview Center, Inc. provided *Crisis Intervention Training* (CIT) to law enforcement and community stakeholders	23
4th Thursday of the month	Lakeview Center, Inc. attended the monthly CIT stakeholders meeting	100
2/21	Florida Suicide Prevention Coalition, SOSP, SPCC, and the American Foundation for Suicide Prevention coordinated Suicide Prevention Day at the Capitol	42
5/2 & 6/6	CDAC Behavioral Healthcare attended the Suicide Prevention Coalition meeting	16
	Northeast Region	
Monthly	Stewart-Marchman-Act Behavioral Healthcare used a Suicide Risk Environmental Audit Tool	49
4/21	St. Augustine Youth Services held *Party for Prevention* event to promote awareness of mental health issues, child abuse, and suicide prevention	100
2/27	LifeStream Behavioral Center held *Empowering Protection and Connection* a speaker and resource fair where clinicians provided onsite support	100
As needed	Clay Behavioral Health Center, Inc. provided support to at risk individuals after critical incidents at school	-
1/20	Clay Behavioral Health Center, Inc. provided training on at-risk behaviors of youth to Clay County Law enforcement and emergency responders	20
Weekly and monthly	NAMI Gainesville held Connection Support Group and Family Support Group	-
Ongoing	Clay Behavioral Health Center, Inc. distributed *National Suicide Prevention Lifeline* information cards	-
	Central Region	
2/14	Magellan Complete Care attended the Suicide Prevention Task Force Meeting	14
4/11	Magellan Complete Care attended *Art of Happiness* event	600
4/14	Magellan Complete Care attended *To Write Love on Her Arms Run For It 5k Walk*	650
4/28	Magellan Complete Care attended the *NAMI Walk of Greater Orlando*	1000
1/22	BayCare Health Systems attended the Health Services Advisory Committee meeting	10
1/11, 2/8, 3/8, 4/12 & 6/14	BayCare Health Systems attended the Hernando County Alliance and Baker Act meeting	85
2/8 & 4/12	BayCare Health Systems attended the Hernando County Baker Act Subcommittee meeting	30
	Suncoast Region	
1/1	Personal Enrichment through Mental Health Services, Inc. attended the initial meeting for the *Zero Suicide* initiative and discussed the Memorandum of Understanding for collaboration	10

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings

Date	Event	# Individuals
1/31	Crisis Center of Tampa Bay attended the Suicide Prevention Task Force monthly event	20
2/7	University of South Florida presented *Campus Connect: Gatekeeper Training for Suicide Prevention*	25
1/1-5/30	David Lawrence Mental Health Center, Inc. initiated Mental Health Intervention Team in collaboration with Collier County Sheriff's Office to address the needs of high risk individuals in the community	52
	Southeast Region	
5/19	Magellan Complete Care attended the Florida Initiative for Suicide Prevention*'s Hugs for Hope 5K Walk*	300
5/22	Magellan Complete Care attended *My Life* event during mental health month	11
6/28-6/29	Crisis Center of Tampa Bay attended the *Commissioner Murman's Challenge* in Tampa to focus on SMVF and create a strategic plan for suicide prevention	35
	Southern Region	
6/12	NAMI Miami-Dade County, Inc. presented a *Suicide Prevention Project* presentation	50
1/29	Citrus Health Network, Inc. conducted Hazard Vulnerability Analyses at inpatient/residential behavioral health sites	-

Goal 2: Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery

Date	Event	# Individuals
	Northwest Region	
1/25	Capital Regional Medical Center hosted a suicide prevention discussion with guest speaker Clark Flatt, President of the Jason Foundation	430
1/1	SOSP wrote the *Suicide Prevention Day* proclamation and the *Suicide Prevention Week* proclamation	-
2/19-20	SOSP attended and presented at the *Taking Action for Suicide Prevention* mini-Conference	-
2/19, 2/20 & 2/21	SOSP and the Office of Adoption and Child Protection presented the Suicide Prevention Day Proclamation signed by the Governor	-
6/8	Cope staff was interviewed by News Channel 7 WJHG	-
2/22	Life Management Center attended Career Day at a high school and provided information on suicide prevention	200
2/28	Lakeview Center, Inc. presented *Population Management* and included suicide intervention at the Mental Health Corporations of America Annual Conference	100
3/7	Life Management Center attended *Community Awareness Day* at Gulf Coast State College	50
4/11	Life Management Center attended and spoke at the *Mental Health Awareness Day* at Chipola State College	100
5/25	Life Management Center spoke to a grief and loss group about mental health	10

Goal 2: Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery

Date	Event	# Individuals
2017-2018 school year	CDAC Behavioral Healthcare provided suicide prevention information to schools and ways to refer students to the Education and Counseling for High School Opportunities program. Also participated in school crisis teams and provided education about the warning signs to faculty	-
6/21	SOSP presented *Suicide Prevention in Florida*	19
5/11	Life Management of Northwest Florida held the *Walk for Mental Health Awareness Month* event	50
6/13	Lakeview Center, Inc. discussed suicide on local T.V. (WEAR-3)	-
6/13	Lakeview Center, Inc. discussed suicide and violence on local radio (WCOA1370 am)	-
6/18	Lakeview Center, Inc. wrote about suicide awareness and prevention on the agency newsletter titled *Focus Briefs*	-
Ongoing	Lakeview Center, Inc. added the *Crisis Text Line* on the organization's website (just text 741741)	-
	Northeast Region	
As needed	Clay Behavioral Health Center, Inc. provided training on suicide prevention to church youth groups	15
1/24	Stewart-Marchman-Act Behavioral Healthcare participated in *Behavioral Health Day* at the Capitol	60
January 2018	Lutheran Services Florida Health Systems promoted the *Question, Persuade and Refer* (QPR) training	-
Weekly	Lutheran Services Florida Health Systems distributed via email suicide prevention news links and newsletters and videos available on the Suicide Prevention Resource Center website	-
	Central Region	
4/24	Central Florida Cares Health System met with a local hospital, law enforcement, and local court to discuss community prevention efforts	16
4/28	Central Florida Cares Health System provided mental health, substance abuse, & suicide prevention resources at the *2018 NAMI Walk*	100
5/16	St. Petersburg College Regional Community Policing Institute held an *In Harm's Way* law enforcement suicide prevention training	60
6/12, 6/13, 6/19 & 6/20	BayCare Health Systems attended *Roll Call* with local law enforcement	80
5/4 & 6/1	BayCare Health Systems attended a meeting with local law enforcement	16
Weekly	BayCare Health Systems attended the Baker Act Resource Team calls	72
	Suncoast Region	
2/20 & 4/23	St. Petersburg College Regional Community Policing Institute held an *In Harm's Way* law enforcement suicide prevention training	83
6/1	Crisis Center of Tampa Bay presented at the AIRS National Conference – *On Time, On Target: Working with Veteran Peers - Addressing the needs of veterans peers working with transitioning veterans and their families*	70
6/1	SPCC co-authored an article that focuses on suicide prevention and law enforcement and will be published by the Florida Sheriffs Association	-
6/18 & 7/23	David Lawrence Mental Health Center, Inc. discussed teen suicide on a morning radio talk on B103.9	-

Goal 2: Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery

Date	Event	# Individuals
	Southeast Region	
3/1	Magellan Complete Care held an informational table at the *St. Lucie County Fair*	10
5/10	Magellan Complete Care held a table at a mental health awareness event in St. Lucie	10
6/7 & 6/21	Magellan Complete Care distributed mental health resources at the Florida Community Health Center in Fort Pierce	65
	Southern Region	
3/16, 4/18, 6/8, 6/10, 6/15, 6/20 & 6/23	Monroe County Coalition, Inc. posted messages that focused on suicide prevention and crisis line numbers on Facebook	4,660
3/3	Monroe County Coalition, Inc. attended Mariner's Hospital *Community Family Wellness Fair*	170
3/4	Monroe County Coalition, Inc. attended *Key Colony Beach Day*	430
6/9	Monroe County Coalition, Inc. attended *Pride Fest Community Level* event	200

Goal 3: Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors

Date	Event	# Individuals
	Northwest Region	
Ongoing	Lakeview Center, Inc. implemented the *Suicide Assessment Five-step Evaluation and Triage* (SAFE-T) protocol	300
Ongoing	Lakeview Center, Inc. integrated the high risk suicide/homicide alert system into electronic medical record system to alert and facilitate coordination of high risk individuals	-
	Northeast Region	
Biweekly	Stewart-Marchman-Act Behavioral Healthcare facilitated *QPR*	101
As needed	Stewart-Marchman-Act Behavioral Healthcare facilitated *Question, Persuade, Refer, Treat* (QPR-T) suicide risk assessment	8
1st Monday of every month	LifeStream Behavioral Center facilitated *QPR* and *Zero Suicide* as part of new hire orientation training	25
Yearly	Lutheran Services Florida Health Systems monitored, introduced and strengthened evidence-based programs across provider network through on-site technical assistance	48
5/8 & 5/23	NAMI Gainesville implemented *Family to Family* program and *Ending the Silence* curriculum	-
1/1	Lutheran Services Florida Health Systems collaborated with FL LINC's Care Coordination pilot program and provided the training to two providers	40
	Central Region	
	None reported	
	Suncoast Region	
2/8 (several days)	Crisis Center of Tampa Bay facilitated small group trainings on suicide prevention	125
	Southeast Region	
	None reported	

Goal 3: Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors

Date	Event	# Individuals
	Southern Region	
1/1	Care Resource Community Health Center trained behavioral health clinicians and implemented evidenced based interventions such as Dialectical Behavior Therapy, Eye Movement Desensitization and Reprocessing, Motivational Interviewing, and Cognitive Behavioral Therapy to individuals who are high risk for suicide	15

Goal 4: Provide training on the prevention of suicide and related behaviors to community and clinical service providers

Date	Event	# Individuals
	Northwest Region	
Ongoing	CDAC Behavioral Healthcare completed *Assessing Suicide Risk*, a web-based training	10
2/20 & 2/21	Florida Suicide Prevention Coalition coordinated the *Florida Taking Action for Suicide Prevention* mini-conference	42
4/12	CDAC Behavioral Healthcare provided *Mental Health First Aid* training for adults	26
1/13, 2/1, 2/24, 3/8	Bridgeway Center, Inc. provided *Mental Health First Aid* training for adults	60
1/23, & 2/3	Bridgeway Center, Inc. Provided *Mental Health First Aid* training for youth	10
1/16, 1/25, 2/8, & 2/9,	CDAC Behavioral Healthcare presented and held an activity on bullying prevention	837
5/18	Apalachee Center Inc. provided *Mental Health First Aid* training	8
5/26	CDAC Behavioral Healthcare provided *Mental Health First Aid* training for adults	6
1/11, 2/16, 4/19, 5/8, 5/23 & 6/14	Life Management of Northwest Florida provided *Mental Health First Aid* training for adults	90
3/30 & 6/7	Life Management of Northwest Florida provided *Mental Health First Aid* training for youth	33
	Northeast Region	
5/18	Stewart-Marchman-Act Behavioral Healthcare held *Who is Jay? Mental Health Symposium*	200
Monthly	Stewart-Marchman-Act Behavioral Healthcare provided the *Crisis Intervention Training* (CIT)	180
5/17	St. Augustine Youth Services participated in *Fighting Mental Health Stigma* forum with Revive Ministries	8
4/18	St. Augustine Youth Services trained Transitional Life COACHES staff in Baker Act procedures and suicide warning signs	4
1/2	Lutheran Services Florida Health Systems provided *QPR* training	73
6/18	Lutheran Services Florida Health Systems conducted two week trainings for recovery peers seeking Florida certification	50
Yearly	Lutheran Services Florida Health Systems conducted trainings for *Crisis Intervention*, *SBIRT*, and *Mental Health First Aid* trainings for youth and adults	800
	Central Region	
1/15	Central Florida Cares Health System provided *CIT*	21
2/13, 2/20, & 3/30	Central Florida Cares Health System facilitated *QPR*	64

Goal 4: Provide training on the prevention of suicide and related behaviors to community and clinical service providers

Date	Event	# Individuals
1/18, 3/9, 4/17, 5/4, 6/14, 6/27	Hispanic Family Counseling, Inc. provided *Mental Health First Aid* training for youth in English and Spanish	87
5/11 & 6/29	Hispanic Family Counseling, Inc. provided *SafeTALK* training	36
2/15, 4/26, 5/17 & 6/7	BayCare Health Systems provided *Mental Health First Aid* training	43
	Suncoast Region	
4/9	Crisis Center of Tampa Bay provided suicide prevention training at Grace Family Church	11
4/12-4/13	Crisis Center of Tampa Bay provided *ASIST* training	24
4/17	Crisis Center of Tampa Bay attended the American Association of Suicidology Conference	2
5/16	University of South Florida presented *Adolescent Suicide Prevention* at Speak Up for Kids	35
6/13	Crisis Center of Tampa Bay presented at the Florida Council Against Sexual Violence Biennial Training Conference	15
Ongoing/Multiple dates	David Lawrence Mental Health Center, Inc. facilitated *Crisis Intervention Training* for law enforcement, corrections officers and certain civilian positions	85
January-June	David Lawrence Mental Health Center, Inc. provided *Mental Health First Aid* training	31
January-June	David Lawrence Mental Health Center, Inc.'s staff took online training including: *Suicide Risk Factors, Screening and Assessment*; *Adolescent Suicide*; *Community-Based Suicide Prevention*; *Suicide Screening for Direct Care Providers*	29
	Southeast Region	
	None reported	
	Southern Region	
3/1	Hope for Miami provided *Mental Health First Aid* training for youth	3
3/24	Better Way of Miami, Inc. provided suicide awareness and prevention training	48
Ongoing	NAMI Miami-Dade County, Inc. presented trainings to *Ending the Silence* presenters	-
6/20	NAMI Miami-Dade County, Inc. presented *Signs and Symptoms of Mental Health Challenges*	20
Multiple dates	Citrus Health Network, Inc. had individuals certified to use the *Columbia Suicide Severity Rating Scale*	139

Goal 5: Promote suicide prevention as a core component of health care services

Date	Event	# Individuals
	Northwest Region	
	None reported	
	Northeast Region	
Monthly or every visit	Stewart-Marchman-Act Behavioral Healthcare utilized the *Columbia Suicide Severity Rating Scale*	10,000
Weekly	Clay Behavioral Health Center, Inc. partnered with Clay County Department of Health for suicide prevention outreach at the Teen Clinic	30

Goal 5: Promote suicide prevention as a core component of health care services

Date	Event	# Individuals
Ongoing	Clay Behavioral Health Center, Inc. provided suicide prevention education and information to integrated health individuals	-
1/1	Lutheran Services Florida Health Systems shared best practices of *Suicide Risk Triage* and wellness safety plans with providers	2
1/1	Lutheran Services Florida Health Systems provided remote and on-site technical assistance to providers after identifying best practice needs and review of suicide deaths charts	-
1/1	Lutheran Services Florida Health Systems distributed survivor loss resources to provider staff after critical incidents	1
2/1	Lutheran Services Florida Health Systems attended prevention coalition meetings, Department of Juvenile Justice, behavioral health advisory councils and assisted Hernando and Lake County communities in developing a Facebook page for Family Support titled *It Takes a Village*	695
	Central Region	
2/9	Magellan Complete Care hosted the *13th Annual Florida Initiative for Suicide Prevention Awards Gala*	300
2/7	Central Florida Cares Health System held a lunch and learn on evidence based trainings for trauma & suicide	46
5/2	Central Florida Cares Health System held a lunch & learn on Cognitive Behavior Therapy for depression, anxiety, and suicide	53
	Suncoast Region	
2/22	Personal Enrichment through Mental Health Services, Inc. reviewed the *Zero Suicide* initiative surveys	15
Monthly	Florida Suicide Prevention Coalition distributed the monthly newsletter	250
	Southeast Region	
	None reported	
	Southern Region	
January to June 2018	Hope for Miami completed level 2 case management and assessment of youth	30
6/29	Concept Health Systems provided suicide prevention training	12
3/1	Citrus Health Network, Inc. utilized the *Outpatient Behavioral Health Safety Plan* for individuals identified as medium or high risk for suicide	-

Goal 6: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors

Date	Event	# Individuals
	Northwest Region	
Ongoing	CDAC Behavioral Healthcare implemented *SAFE-T*	-
1/2	Apalachee Center Inc. reviewed the suicide risk assessment and protocol processes	10
	Northeast Region	
Ongoing	St. Augustine Youth Services provided out-patient resources to youth and families and made referrals for additional assessments	16
4/23	St. Augustine Youth Services participated in the 3-day state wide *Hi Fidelity Wraparound* training for the COACHES program and the Targeted Case Management program	7
Continuous	LifeStream Behavioral Center implemented FL LINC and Care Coordination Services	-
	Central Region	

Goal 6: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors

Date	Event	# Individuals
Continuous	Hispanic Family Counseling, Inc. utilized the PHQ-9	300
2/27	Central Florida Cares Health System earned the *QPR-T* certification	6
	Suncoast Region	
3/27	University of South Florida presented *Suicide Prevention – From Awareness to Action: What to Look for, What to Do, and How to Help*	35
	Southeast Region	
	None reported	
	Southern Region	
1/1	Care Resource Community Health Center utilized the *PHQ-9* and the *Patient Health Questionnaire 2* (PHQ-2)	-
3/21	Volunteers of America of Florida, Inc. implemented the *SafeTALK* training	35
4/23	Monroe County Coalition, Inc. attended the *SafeTALK* training	1
3/1	Citrus Health Network, Inc. utilized the *Columbia Suicide Severity Rating Scale*	-
Ongoing	Citrus Health Network, Inc. utilized the *PHQ-9* and *PHQ-2*	-
1/29	Citrus Health Network, Inc. held a policy meeting to discuss risk assessment procedures	-
3/8	Citrus Health Network, Inc. held an adult case management suicide risk assessment policy meeting	-
4/4	Agape Network held an outpatient staff meeting	51

Goal 7: Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts

Date	Event	# Individuals
	Northwest Region	
2/19	The Florida Department of Health's Health Violence and Injury Prevention Program participated and presented at the Florida Suicide Prevention Conference	3
5/1	The Florida Department of Health's Health Violence and Injury Prevention Program participated in a national project for collection of youth suicide data, and lay foundational groundwork for improving partnerships to address risk factors for suicide through the Child Safety Collaboration, Innovation and Improvement Network	10
5/7	The Florida Department of Health attended the National Violent Death Reporting System reverse site visit	3
	Northeast Region	
Various dates	St. Augustine Youth Services participated in the development of development of the *2017 Community Health Assessment* and *2018-2020 Community Health Improvement Plan for St. Johns County*	-
6/1	Lutheran Services Florida Health Systems wrote a grant proposal utilizing Florida Department of Health suicide death data for Clay County. Surveillance data demonstrated need for mental health and suicide prevention for veterans, transition-aged youth and young adults.	-
	Central Region	
	None Reported	
	Suncoast Region	

Goal 7: Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts

Date	Event	# Individuals
1/1	Crisis Center of Tampa Bay handled 3,142 calls routed from the *National Suicide Prevention Lifeline*	3,142
	Southeast Region	
	None Reported	
	Southern Region	
	None reported	

APPENDIX 2: PLANNED ACTIVITIES FOR JULY 2018-FEBRUARY 2019

Organization	Activity	Date
SOSP and SPCC	Write the Suicide Prevention Day proclamation	2019
	Chair SPCC quarterly meetings	2018 & 2019
	Update the website calendar of events	2018 & 2019
Centerstone of Florida, Inc.	Host *Centerstone's Life: Story Dinner*	9/21/2018
	Host Centerstone's Life: Story 5K/10K Run and Walk	9/22/2018
The American Foundation for Suicide Prevention	Coordinate *Out of the Darkness Walk* in Martin County, Charlotte County, Pensacola, Palm Beach, Highlands County, Miami-Dade County, Palatka, St. Petersburg, Panama City Beach, Pasco County, Sarasota County, Ocala, Treasure Coast, Brevard County, Emerald Coast, Broward County, St. Augustine, Jacksonville, Monroe County, Tampa Bay, Naples, and Orlando	September 15, 22, 29 October 6, 7, 20, 27, 28 November 11, 17 December 1, 2, 8, 9, 2
NAMI Palm Beach	Coordinate the *NAMI Walk* in Palm Beach County	10/27/2018
Hispanic Family Counseling, Inc.	Provide *Youth Mental Health First Aid* training	7/26/2018 & 8/24/2018
	Have a table at the *Out of the Darkness Walk* in Melbourne	11/3/2018
	Present *Talk Saves Lives* at the Mexican Consulate	Continuous
	Provide a suicide prevention presentation	9/10/2018
Personal Enrichment through Mental Health Services, Inc.	Have the *Suicide Awareness/Prevention Training* at the St. Thomas Episcopal Church	7/6/2018
	Provide *Applied Suicide Intervention Skills Training* (ASIST)	8/16-8/17
Crisis Center of Tapa Bay	Provide *ASIST* Training	7/2, 7/23, 8/30, and 9/4
David Lawrence Mental Health Center, Inc.	Provide suicide screen & risk assessment training using the Columbia Suicide Severity Rating Scale (C-SSRS)	7/16/2018
	Official transition to using the C-SSRS tool agency-wide	9/3/2018
	Provide *Mental Health First Aid* training	9/21/208
	Provide *Crisis Intervention Training* for law enforcement	9/28/2018
	Partner with Collier County Public Schools and Collier County Sheriff's Office to develop suicide prevention training for all educational providers	2018-2019 School year
	Await for response to become a suicide prevention hotline site	Pending review
Central Florida Cares Health System	Attend the *Florida Linking Individuals Needing Care Annual Zero Suicide Meeting* at the *Florida Behavioral Health Conference*	8/16/2018
	Host a lunch & learn that will focus on crisis counseling	10/3/2018
	Provide *QPR* trainings	2018-2019
CDAC Behavioral Healthcare, Inc.	Implement *Signs of Suicide Prevention Program* in high schools	2018-2019
	Implement the *Self-Injury Prevention Program* to students	2018-2019
	Implement the *Second Acknowledge, Care, Treatment (ACT) Program* to reinforce learning about the signs of depression and suicide to high school students	2018-2019
	Complete *Assessing Suicide Risk*, a web-based training	Ongoing

	Provide *Mental Health First Aid* for Adults to faith-based community and staff as needed	8/4/2018 & 9/7/2018
	Provide bullying prevention educational presentations to schools in Escambia and Santa Rosa counties	2018-2019 school year
	Attend the *Suicide Prevention Coalition* meetings	7/11/2018 and as scheduled
Life Management Center of Northwest Florida	Provide *Mental Health First Aid* training	7/28/2018, 8/14/2018 & 11/16/2018
	Attend the *Annual Suicide Survivors Candlelight Vigil*	11/17/2018
	Host the *Annual Suicide Prevention Conference*	To be determined
	Attend the *Bridge of Hope Suicide Prevention Walk*	9/8/2018
	Co-host the *Suicide the Ripple Effect Movie Screening*	To be determined
Lakeview Center, Inc.	Sponsor the *Recovery and Trauma informed Conference* that will include a focus on suicide prevention and community coordination	10/8/2018
	Be available to local news media outlets for presentations and discussions as requested	Ongoing
Bridgeway Center, Inc.	Provide *Mental Health First Aid* trainings	Ongoing
Apalachee Center Inc.	Provide *Mental Health First Aid* training	8/1/2018
	Become a certified instructor to provide *Mental Health First Aid* training for youth	9/10/2018
Florida Department of Health	Submit the National Violent Death Reporting System (NVDRS) application and partner with a university	8/8/2018
	Offer the Capital Circle Office Complex's Betty Easley Center as a potential host site for the *2019 Florida Suicide Prevention Conference*.	To be determined
	Promote suicide prevention and intervention related webinars on the *Florida Department of Health Employee Portal* (TRAIN)	Ongoing
Florida sheriffs Association	Publish an article that focuses on suicide prevention in law enforcement	9/1/2018
Florida Suicide Prevention Coalition	Sponsor *Centerstone's 16th Annual Live:Story 5K/10K Walk and Run*	9/22/2018
	Have a table at *MindFest*. MindFest celebrates everything about mental health and wellness	10/6/2018
	Coordinate the *2019 Suicide Prevention Day at the Capitol*	2/21/2019
	Coordinate *Florida Taking Action for Suicide Prevention* mini-conference	2/19/2019 & 2/20/2019
Better Way of Miami, Inc.	Provide suicide awareness and prevention training	9/1/2018 & 3/1/2019
Volunteers of America of Florida, Inc.	Implement *SafeTALK*	9/7/2018
	Implement *Suicide Prevention by Cenpatico* (Sunshine Health)	10/26/2018
	Attend the *Post Traumatic Stress Disorder and Suicide Prevention Veterans* event	11/19/2018
Hope for Miami	Deliver the *Signs of Suicide* workshop to middle and high school students through a signed agreement with Sandy Hook Promise	Fall 2018
	Provide *Mental Health First Aid* training for youth to new staff	Fall 2018
	Provide level II case management and assessment to youth	Fall 2018

NAMI Miami-Dade County, Inc.	Speak at the *Suicide Prevention and Mental Health* event	9/25/2018
	Implement *Ending the Silence*	9/12/2018 & as needed
Monroe County Coalition, Inc.	Present county suicide rates and the University of Miami suicide report for Monroe County during the Coalition Meeting	7/17/2018
	Include the *Suicide Prevention Lifeline* number in newsletter	12/31/2018
	Post suicide prevention Facebook messages	12/31/2018
	Train staff on *SafeTALK Train the Trainer*	12/31/2018
	Provide community level event education and awareness	Ongoing
Care Resource Community Health Center	Train staff on prevention of suicide, ways to speak with individuals who call, and appropriate referral processes	7/1/2018
	Create an infomercial about suicide prevention to be displayed on the agency television system, agency website, social media, and YouTube page. This video will be played hourly by individuals within the agency	7/11/2018
	Host a community event to discuss suicide prevention	7/16/2018
	Include suicide in the treatment of substance use disorder/trauma	10/31/2018
Stewart-Marchman-Act Behavioral Healthcare	Utilize the C-SSRS tool	Monthly or every visit
	Host *Who is Jay? Mental Health Symposium*	5/1/2019
	Implement SAMSHA's Zero Suicide Grant	9/1/2018
	Facilitated *Question, Persuade, Refer, Treat* (QPR-T) suicide risk assessment	As needed
	Facilitate *QPR* trainings	Biweekly
	Use a suicide risk environmental audit tool	Monthly
Gateway Community Services, Inc.	Complete a suicide prevention education for staff and consumers	8/3/2018
St. Augustine Youth Services	Use psychological evaluations and refer high risk youth	7/1/2018
	Participate in *Walk for Suicide Prevention/Awareness*	Fall 2018
	Initiate the *Community Action Team* for St. Johns County	7/1/2018
	Have suicide prevention and Baker Act training for all staff	Fall 2018
	Provide quarterly training to the Crisis Intervention Program at St. Johns County Sheriff's Office.	September and December 2018
	Implement suicide prevention and intervention trainings	7/1/2018
Clay Behavioral Health Center, Inc.	Attend *Community Outreach* at Orange Park Town Hall	8/10/2018
	Staff will attend *QPR* training	8/8/2018
	Staff will attend the *Orange Park Fall Festival*	10/1/2018
	Provide suicide prevention information at the Clay County Health Department Teen Clinic	Weekly
Citrus Health Network, Inc.	Create an internal *Zero Suicide* task force	To be determined
	Host a suicide prevention public health fair	To be determined
	Follow-up with the Hazard Vulnerability Analysis for Crisis Units	To be determined
BayCare Health Systems	Participate in *Hernando County Alliance and Baker Act* meeting	Monthly in 2018
Agape Network	Hold a clinical team meeting and training	10/17/2018
NAMI Gainesville	Attend the Symposium on Adolescent Suicide Prevention	7/18/2018
Lutheran Services Florida Health Systems	Organize and conduct two 2-day *Wellness Recovery Action Plan* (WRAP) trainings and train two staff to facilitate WRAP	7/16/2018
	Attend *Helping Others Health Training* in Ocala *how peer specialists can help instill hope in their at-risk individuals*	8/20/2018

	Provide a WRAP training for peer participants in Ocala	9/18/2018
	Attend the circuit break out session at *Florida Behavioral Health Conference 2018*	8/16/2018
	Attend the *Mental Health Northeast Florida Summit* and be part of the suicide prevention panel support and attendance/marketing	10/3/2018
	Participate in the *Out of Darkness Walk*	12/1/2018
	Market the *International Peer Assistance Conference* in Orlando where workshops on peers and suicide prevention are planned	12/3/2018
	Provide *Mental Health First Aid* training for adults	9/5/2018
Revive Ministries and Magellan Complete Care	Host *You Are Not Alone, Speak Out* 2nd Annual Suicide Awareness Concert	9/30/2018
St. Petersburg College Regional Community Policing Institute	Provide the *Effective Leadership Response to the Challenges of Law Enforcement Suicide* training	Ongoing
	Provide *Innovative Interventions and Practices for Suicide Prevention* training	Ongoing
	Provide the *Positives of Being a Law Enforcement Family: Best Practices for Law Enforcement Family Programs*	Ongoing
	Provide *Model Policies on Critical Incident Peer Support* training	Ongoing
	Continue to update the http://policesuicide.spcollege.edu/	Ongoing
	Search and apply for grants that will fund *In Harm's Way*	Ongoing

APPENDIX 3: COUNCIL MEMBERS AND DESIGNEES

Organization	Designee/Member Name
1. Statewide Office for Suicide Prevention	Dr. Sofia Castro (Chair)
2. Florida Association of School Psychologists	Dr. Gene Cash
3. Florida Sheriffs Association	Matt Dunagan
4. Suicide Prevention Action Network USA*	No designee
5. Florida Initiative of Suicide Prevention	Jackie Rosen
6. Florida Suicide Prevention Coalition	Judy Broward
7. American Foundation of Suicide Prevention	Tara Sullivan
8. Florida School Board Association	Karen Brill, Designee
9. National Council for Suicide Prevention	Dr. Dan Reidenberg
10. State Chapter of AARP	Larry Dixon
11. Florida Alcohol and Drug Abuse Association	Dr. Louise Ritchie
12. Florida Council for Community Mental Health	Dr. Kim Gryglewicz, Designee
13. Florida Counseling Association	Dr. Carly Paro
14. NAMI Florida	Cindy Foster
15. Secretary of Elder Affairs	Gretta Jones, Designee
16. State Surgeon General (DOH)	Shay Chapman, Designee
17. Commissioner of Education	Dr. David Wheeler, Designee
18. Secretary of Health Care Administration	Jack Plagge, Designee
19. Secretary of Juvenile Justice	Dr. Gayla Sumner, Designee
20. Secretary of Corrections	Dr. Dean Aufderheide, Designee
21. Executive Director of the Department of Law Enforcement	Seth Montgomery, Designee
22. Executive Director of the Department of Veterans Affairs	Alfred D. Carter, Designee
23. Secretary of the Department of Children and Families	Dr. Sofia Castro, Designee
24. Executive Director of the Department of Economic Opportunity	Traci Jones, Designee
25. Governor's appointee	Stephen Roggenbaum
26. Governor's appointee	Donna M. Schulz
27. Governor's appointee	Open Seat
28. Governor's appointee	Open seat

* This organization no longer exists.

FLORIDA SUICIDE PREVENTION PLAN

2016-2020

Department of Children and Families
Office of Substance Abuse and Mental Health

April 15, 2016

Mike Carroll
Secretary

Rick Scott
Governor

Table of Contents

Appendices

I. Executive Summary

In 2001, the U.S. Surgeon General issued the National Strategy for Suicide Prevention (National Strategy) to launch an organized effort to prevent suicide across the nation. Updated in 2012, the National Strategy represented a new approach to enlisting all Americans in the effort to prevent suicide. In Florida, suicide prevention strategies are developed and implemented in partnership with the Statewide Office for Suicide Prevention (SOSP), the statutorily created Suicide Prevention Coordinating Council (Council), and local communities. The SOSP is administratively housed in the Department of Children and Families' (Department) Office of Substance Abuse and Mental Health. The Florida Suicide Prevention Plan (Plan) is a joint effort of the Council and SOSP. Section 14.20195(a), F.S., requires the Council to advise the SOSP "regarding the development of a statewide plan for suicide prevention, with the guiding principle being that suicide is a preventable problem".

In 2014, suicide was the second leading cause of death for individuals ages 25-34 and the third leading cause of death for ages 5-24 in Florida. The purpose of this Plan is to guide statewide efforts to decrease suicide related deaths through a framework of goals and objectives that coordinate suicide prevention efforts at the state and local community levels.

The Department's mission is to:

- Work in Partnership with Local Communities to Protect the Vulnerable;
- Promote Strong and Economically Self-sufficient Families; and
- Advance Personal and Family Recovery and Resiliency.

To meet the Department's mission, the SOSP has organized the Plan's goals into four strategic directions similar to the National Strategy:

- Healthy and Empowered Individuals, Families, and Communities;
- Clinical and Community Preventive Services;
- Treatment and Support Services; and
- Surveillance, Research, and Evaluation.

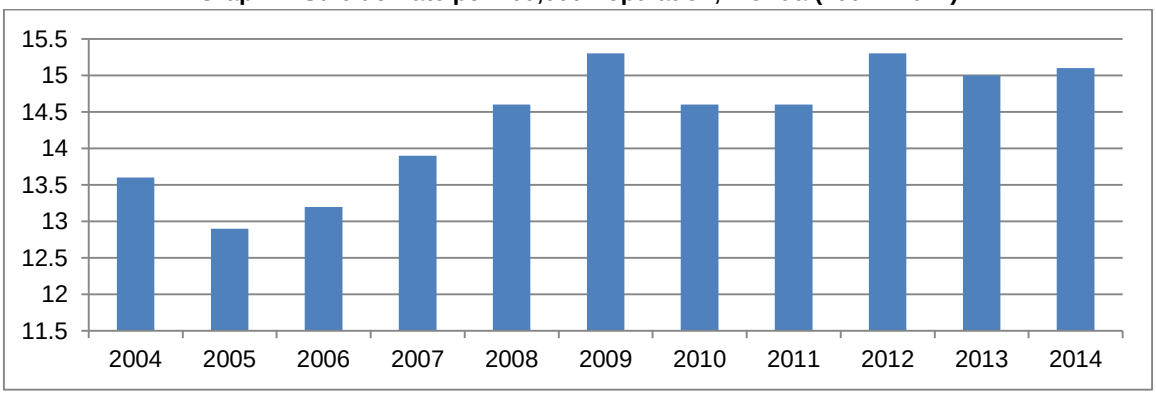
The Plan describes suicide prevention initiatives at the state and local community levels that aim to decrease suicide related deaths. Suicide prevention initiatives implemented by local communities and a variety of stakeholders provide the foundation that moves Florida's Plan forward. Section V of this document provides a list of suicide prevention activities and associated resources under each of the Plan's goals to support statewide implementation by multiple stakeholders. Section V is also available in a brochure format in the Department's website, at:

http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention.

II. Current Status

Suicide was Florida's 10th leading cause of death in 2014, with 2,961 individuals taking their own lives. On average, one Floridian dies by suicide every three hours, and over twice as many die by suicide as by homicide according to the American Foundation for Suicide Prevention. Graph 1 shows an upward trend in the suicide rate from 2005 to 2009. The trend fluctuates from 2009 to 2014. However, it has continually remained above the 2007 rate through 2014.

Graph 1. Suicide Rate per 100,000 Population, Florida (2004 - 2014)



Data Sources: CHART D-4: RESIDENT DEATHS FOR LEADING CAUSES AND RATES PER 100,000 POPULATION, BY AGE GROUP, FLORIDA, 2013: *Florida Vital Statistics Annual Report (2013)*[1] and TABLE D-3: RESIDENT DEATHS AND RATES PER 100,000 POPULATION FOR 25 LEADING CAUSES, BY RACE, FLORIDA, 2004 AND 2014: *Florida Vital Statistics Annual Report (2014)*[2]

Although suicide data is unavailable for certain populations in Florida, it's essential to look at the 11 national high risk populations.

Individuals with mental and/or substance use disorders

Individuals with major depressive disorder, bipolar disorder, anxiety disorder, and schizophrenia are at higher risk for suicide. A 2009 to 2013 combined annual average shows that 120,000 adolescents had at least one major depressive disorder per year and 69% did not receive treatment in Florida. It also shows that approximately 525,000 adults had serious mental illnesses per year and 63.7% did not receive treatment.[3]

Alcohol and substance abuse is a risk factor for suicide; therefore, individuals with substance use disorders are also at high risk for suicide. A 2009 to 2013 combined annual average shows that approximately 124,000 adolescents in Florida reported that they used illicit drugs in the month prior to being surveyed. [4] Although Florida does not currently report to the National

[1] See, http://www.flpublichealth.com/VSBOOK/pdf/2013/Deaths.pdf, site accessed, September 24, 2015.
[2] See, http://www.flpublichealth.com/VSBOOK/pdf/2014/Deaths.pdf, site accessed, September 24, 2015.
[3] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Florida, 2014. HHS Publication No. SMA–15–4895FL. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
[4] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Florida, 2014. HHS Publication No. SMA–15–4895FL. Rockville, MD: Substance Abuse and Mental Health Services

Violent Death Reporting System, the CDC found that in 2010, 33.4% of individuals who died by suicide tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, including heroin and prescription pain killers.[5]

Men in midlife and older men

Florida 2013 data shows that the two highest suicide rates were among men at midlife and older men.[6] The risk-related behaviors for men in midlife are underreporting of mental health problems, interpersonal violence, economic hardships, not seeking help, dissolution of intimate relationships, and risk factors similar to other age groups such as mental illness, substance abuse, and access to lethal means. The risks for older men are social disconnection, physical illness, functional decline, and mental disorders.

Members of the Armed Forces and veterans

As of September 2014, there were a total of 1,584,000 veterans living in Florida, and of that total 794,000 were over 65 years old.[7] Although specific suicide data for Florida is unavailable, the Department of Defense reported in 2014, nationally there were 273 suicides for the active component and 170 suicides for the reserve component.[8] The active component includes the Air Force, Army, Marine Corps, and Navy while the Reserve component includes Air Force Reserve, Army Reserve, Marine Corps Reserve, Air National Guard, and the Army National Guard. Additionally, the National Strategy states that veterans are approximately 20% of the U.S. suicide deaths as estimated by the Centers for Disease Control and Prevention (CDC).

Lesbian, gay, bisexual, and transgender (LGBT) populations

It's imperative that Florida begins to collect data on LGBT populations due, in part to the fact that gay and bisexual men are at higher risk for suicide attempts before they turn 25 years old. According to a study reported by the CDC, seventh to 12th grade LGB students were more than twice as likely to attempt suicide compared to heterosexual students.[9] Additionally, family-rejected LGB youth are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection.[10]

American Indians/Alaska Natives

Florida suicide data for American Indians/Alaska Natives is available for age-adjusted death rates per 100,000 populations from 2004 to 2010. This data shows that the suicide death rate for American Indians ages 18 to 85 years and older was 6.65. This rate was higher than the 5.30 death rate for all American Indian ages.[11] Some risk factors for American Indians/Alaska

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Administration, 2015.

[5] See, http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf, site accessed March 29, 2016.

[6] See, http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html, site accessed September 30, 2015.

[7] See, http://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Florida.pdf, site accessed March 28, 2016.

[8] See, http://www.dspo.mil/Portals/113/Documents/DoD-Quarterly-Suicide-Report-CY2015-Q3.pdf, site accessed March 28, 2016.

[9] See, http://www.cdc.gov/msmhealth/suicide-violence-prevention.htm, site accessed March 29, 2016.

[10] See, http://www.thetrevorproject.org/pages/facts-about-suicide, site accessed March 29, 2016.

[11] NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates. Available at http://www.cdc.gov/injury/wisqars/fatal.html, site accessed March 30, 2016.

Natives are alcohol and other substance use, discrimination, historical trauma, and limited access and use of mental health services. [12]

Individuals who have attempted suicide

There is no complete count of suicide attempts in Florida; however, the data shows that the total number of hospital discharges involving suicide and self-inflicted injury has continued to increase from 28,983 in 2007 to 52,391 in 2013.[13] Nationally, females attempt suicide three times more often than males. 25:1 is the estimated ratio of youth suicide attempts to youth suicide deaths.[14] According to research, future attempt reduction is possible if efforts to challenge isolation and provide follow-up support are available after a suicide attempt. [15]

Individuals bereaved by suicide

Future research is needed on individuals bereaved by suicide in Florida. Someone bereaved by suicide is similar to a survivor of suicide. The CDC defines a survivor as a family member or friend of a person who died by suicide. These individuals experience guilt, anger, abandonment, denial, helplessness, and shock. It is estimated that there are between six and 32 survivors per suicide.[16]

Individuals with medical conditions

Due to various symptoms such as depression, suicide ideation, and level of pain, individuals with medical conditions such as cancers, degenerative diseases of the central nervous system, traumatic injuries and other disorders of the central nervous system, HIV/AIDS, chronic kidney disease, arthritis, migraine, and asthma are at high risk for suicide. [17] Currently, Florida does not capture this type of data.

Individuals in justice and child welfare settings

The Florida juvenile suicide rate for adolescents ages seven to 17, captured from 1990 to 2014, is 20.5 per one million juveniles.[18] A national survey identified 110 juvenile suicides between 1995 and 1999. The study revealed that the majority of suicides occurred in training schools/secure facilities and detention centers; however 15.2% of the suicides occurred in residential treatment centers.[19] A national cohort study found that former child welfare involved

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[12] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

[13] HCUPnet. Healthcare Cost and Utilization Project (HCUP). State statistics from HCUP State Inpatient Databases 2007-2013, Agency for Healthcare Research and Quality (AHRQ), based on data collected by the Florida Agency for Health Care Administration and provided to AHRQ. http://hcupnet.ahrq.gov/. Accessed October 14, 2015.

[14] See, http://afsp.org/about-suicide/suicide-statistics/, site accessed March 29, 2016.

[15] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

[16] Berman, AL. Estimating the population of survivors of suicide: Seeking an evidence base. Suicide and Life-Threatening Behavior 2011. 41(1), 110–116.

[17] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

[18] See http://www.ojjdp.gov/ojstatbb/special_topics/stateprofile.asp, site accessed March 31, 2016.

[19] See https://www.ncjrs.gov/pdffiles1/ojjdp/grants/206354.pdf, site accessed March 31, 2016.

individuals were four to five times more likely to be hospitalized for suicide attempts than the general population. [20]

Individuals who engage in nonsuicidal self-injury (NSSI)

Nonsuicidal-self injury data is unavailable in Florida. National research shows that self-injury youth who attempt suicide experienced suicidal ideation and depression symptoms compared to youth who self-injure only. Research also indicates that NSSI individuals are at risk of dying by suicide within 10 years.[21]

III. Plan Development

In 2015 the SOSP and the Council met quarterly to discuss the Plan's development. At its March meeting, the Council created a committee to identify the Plan's goals and objectives. This Committee consisted of Council members and community stakeholders, and met every two weeks through June. The Committee's efforts to develop the Plan are summarized below:

1. The SOSP distributed a survey to stakeholders asking them to identify local planned programs, opportunities, and resources regarding suicide prevention for 2016-2020. Stakeholders included health care systems, insurers, clinicians, nonprofit agencies, community and faith-based organizations, state and local governments, schools, colleges, universities, and businesses. The SOSP and the Committee used the survey responses to help establish the Plan's goals and objectives. Appendix 1 summarizes the survey respondents by agency type and the top five initiatives identified statewide; Appendix 2 provides a map of the Department's six regions.
2. The Committee used information from the National Strategy to further develop goals and objectives and to identify Florida's strategic directions.
3. The Council created an annual assessment to look at the Plan's impact on deaths by suicide in Florida, review updated data and resources, and update and revise the plan, as needed. The annual assessment approach will begin in December 2017, and will include:
    - Stakeholder feedback;
    - Data review related to suicide deaths in previous years;
    - Review of Florida Youth Risk Behavior and Florida Substance Abuse surveys; and
    - National data review related to health-seeking behavior, prevalence rates, and treatment utilization to provide context for Florida data.

[20] Vinnerljung, B., Hjern, A. and Lindblad, F. (2006), Suicide attempts and severe psychiatric morbidity among former child welfare clients – a national cohort study. Journal of Child Psychology and Psychiatry, 47: 723–733. doi: 10.1111/j.1469-7610.2005.01530.x

[21] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

IV. Goals

The Plan is organized into four strategic directions, seven goals, and 11 objectives that guide suicide prevention efforts and activities. Additionally, due to the fact that suicide is a public health issue that affects family members, friends, coworkers, and communities, Section V of the Plan details action steps that stakeholders can use to implement suicide prevention efforts and activities in their communities.

Strategic Direction	Goal	Objective(s)
Healthy and Empowered Individuals, Families, and Communities	1. Integrate and coordinate suicide prevention activities across multiple sectors and settings	1.1 Integrate suicide prevention into the values, culture, leadership, and workplace of a broad range of organizations, programs, and schools with a role to support suicide prevention activities 1.2 Establish effective, sustainable, and collaborative suicide prevention programming at the state, tribal, and local levels
	2. Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery	2.1 Reduce prejudice, stigma, and discrimination associated with suicidal behaviors and mental and substance use disorders
Clinical and Community Preventive Services	3. Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors	3.1 Encourage community-based settings to implement effective evidence-based programs and provide education to promote wellness 3.2 Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk
	4. Provide training on the prevention of suicide and related behaviors to community and clinical service providers	4.1 Update and modify suicide prevention trainings to meet the provider's specific needs and roles.
Treatment and Support Services	5. Promote suicide prevention as a core component of health care services	5.1 Promote timely access to assessment, intervention, and effective care for individuals with heightened risks for suicide 5.2 Establish linkages between providers of mental health and substance abuse services and primary care and community-based programs, including peer support programs
	6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors	6.1 Adopt, disseminate and implement guidelines for the assessment of suicide risk among persons receiving care in all settings. 6.2 Adopt, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.
Surveillance, Research, and Evaluation	7. Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts	7.1 Identify available data to guide suicide prevention efforts

V. Action Steps

The Action Steps provide resources to support the Plan's statewide implementation at the community level. To download these steps in a brochure format, visit http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention.

Goal	Action Steps
1. Integrate and coordinate suicide prevention activities across multiple sectors and settings	**State, Tribal, and Local Governments:** • Promote and implement comprehensive suicide prevention efforts at the state level. Visit http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention/meetings to read the 2015 Annual Report of the Suicide Prevention Coordinating Council. • Coordinate efforts through the Office of Substance Abuse and Mental Health. Contact it at 850-487-2920 or email samh@myflfamilies.com • The Suicide Prevention Resource Center lists suicide prevention efforts by settings that include juvenile justice, primary care, schools, and the workplace. To learn more visit http://www.sprc.org/library_resources/sprc **Businesses and Employers:** • Implement organizational changes to promote the mental and emotional health of employees, as well as individuals with behavioral health conditions, across multiple sectors and settings. Examples of organizational change include *Zero Suicide,* a specific set of strategies and tools to promote suicide prevention. To learn more visit http://zerosuicide.sprc.org/ • First responders/law enforcement/fire fighter agencies are urged to contact the *In Harm's Way* initiative. Training-of-Trainers, Critical Incident Peer Support, and use of the Tool Kit and other resource materials are available at http://policesuicide.spcollege.edu/ **Nonprofit, Community-, and Faith-based Organizations:** • Implement programs and policies to build social connectedness and promote positive mental and emotional health of individuals, families, and communities. Visit http://www.sprc.org/bpr/section-i-evidence-based-programs for a list of evidence-based programs. **Health System, Insurers, and Clinicians:** • Adopt a No Suicide Tolerance program to improve care and outcomes for individuals at risk of suicide in health care systems by implementing the Zero Suicide Toolkit, available at http://zerosuicide.sprc.org/toolkit **Individuals and Families:** • Attend a training/webinar to learn suicide warning signs and how to help/support family and friends who might be at risk for suicide. Visit http://training.sprc.org/ for a list of online trainings.

Goal	Action Steps
Goal 1 continued: Integrate and coordinate suicide prevention activities across multiple sectors and settings	• Contact and join a local community suicide prevention task force for opportunities to become involved with suicide prevention efforts. Visit the Florida Suicide Prevention Coalition at http://www.floridasuicideprevention.org/
2. Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery	**State, Tribal, and Local Governments:** • Identify and promote strategies which promote wellness and resiliency. Visit http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention/suicide-attempt-survivors for information about suicide attempt survivors. • Encourage law enforcement, firefighters, and other first responders to attend a tuition-free 8-hour training titled *Law Enforcement Suicide Prevention Training of Trainers,* which has been designated as a best practice by the National Action Alliance for Suicide Prevention, to learn facts, statistics, truths and myths about suicide, organizational leadership, signs and signals, intervention strategies, and more. For more information email heisler.laura@spcollege.edu or call 727-341-4437. • Encourage law enforcement, firefighters, and other first responders to visit http://policesuicide.spcollege.edu/ to learn more about trainings and the Law Enforcement Suicide Prevention Tool Kit designed to help them present suicide prevention training within their departments and reduce the stigma associated with seeking help. • Become familiar with and implement the *Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*, a resource from the National Action Alliance for Suicide Prevention's efforts: http://actionallianceforsuicideprevention.org/task-force/juvenilejustice **Businesses and Employers:** • Have managers and coworkers visit http://www.sprc.org/for-professionals for information on the roles of the workplace in suicide prevention. **Health System, Insurers, and Clinicians:** • Provide ongoing training, coaching, and supervision in evidence-based practices/programs for clinical staff. Visit http://store.samhsa.gov/product/Quick-Guide-for-Clinicians-Based-on-TIP-50/SMA13-4793 for a free copy of SAMHSA's *Quick Guide for Clinicians Based on TIP 50*. • Visit http://www.suicidology.org/training-accreditation/rrsr-pc for a training on *Recognizing & Responding to Suicide Risk: Essential Skills in Primary Care*.

Goal	Action Steps
Goal 2 continued: Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery	**Schools, Colleges, and Universities:** • Attend and support the Annual Suicide Prevention Day at the Capitol. Contact Judy Broward gatorjudy2@gmail.com for information. • Download *The Role of High School Teachers in Prevention Suicide* by visiting http://www.sprc.org/basics/roles-suicide-prevention • Educators, parents, and students can take the *More than Sad* training by visiting www.morethansad.org • High schools can download *Preventing Suicide: A Toolkit for High Schools* by visiting http://store.samhsa.gov/product/SMA12-4669 • Download *Youth Suicide Prevention School-based Guide* at http://theguide.fmhi.usf.edu/ **Nonprofit, Community-, and Faith-based Organizations:** • Plan, promote, and attend the Suicide Prevention Day at the Capitol. Contact Judy Broward gatorjudy2@gmail.com for information. • Plan and promote *Out of the Darkness* walks. For more information visit http://afsp.donordrive.com/ • Become familiar with and implement the *Faith.Hope.Life.* campaign, a resource from the National Action Alliance for Suicide Prevention: http://actionallianceforsuicideprevention.org/task-force/faith-communities/YLM-home • Facilitate understanding of risk and resiliency factors in specific cultural groups (e.g., race, ethnicity, faith, sexual orientation, socio-economic status, profession or trade) and utilize data to target suicide prevention and intervention efforts in specific populations. Visit http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention/meetings for current data on suicide. The data is included in the Annual Report of the Suicide Prevention Coordinating Council. • Develop and implement communication strategies that convey culturally competent messages of help, hope, and resiliency. Visit http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf to download *The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience* prepared by the Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention. **Individuals and Families:** • Learn the warning signs for suicide risk. Visit http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention/about-suicide • Learn the steps necessary to prevent/stop bullying. Visit http://www.stopbullying.gov/what-you-can-do/teens/index.html • Learn the youth suicide warning signs. Visit http://www.youthsuicidewarningsigns.org/

Goal	Action Steps
3. Develop, implement, and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors	**Health System, Insurers, and Clinicians:** • Implement evidence-based practices/programs for customers. To find a list of evidence-based programs visit http://www.sprc.org/bpr/section-i-evidence-based-programs • Screen for mental health needs, including suicidal thoughts and behaviors, and make referrals to treatment and community resources, as needed. Visit http://www.sprc.org/library_resources/items/suicide-screening-and-assessment for suicide screening and assessment. **Schools, Colleges, and Universities:** • Develop a postvention action plan. Visit http://www.sprc.org/library_resources/items/suicide-postvention-strategies-school-personnel for postvention strategies for school personnel. • Increase school-based and community-based access to mental health and counseling services for individuals at risk of suicide, and encourage the use of those services. Download *The Role of High School Mental Health Providers in Prevention Suicide* by going to http://www.sprc.org/basics/roles-suicide-prevention **Nonprofit, Community-, and Faith-based Organizations:** • Increase awareness of community resources for suicide prevention by providing resources on organization websites. • Order free materials from http://store.samhsa.gov/
4. Provide training on the prevention of suicide and related behaviors to community and clinical service providers	**Nonprofit, Community-, and Faith-based Organizations:** • Provide suicide prevention trainings to organizations in the health system, insurers, clinicians, police departments, first responders, and schools. For information on webinars and trainings, visit http://www.sprc.org/training-institute **Schools, Colleges, and Universities:** • Educate staff on appropriate available services. Encourage staff to refer those at risk for suicide to these services. To learn about college and university suicide prevention, visit http://www.sprc.org/collegesanduniversities • Train relevant school and organization staff to recognize students and employees at potential risk of suicide. For more information visit http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/
5. Promote suicide prevention as a core component of health care services	**Businesses and Employers:** • Promote the availability of online and phone support services. Visit http://www.suicidepreventionlifeline.org/ or share the National Suicide Prevention Lifeline number: 1-800-273-TALK (8255). • Order free materials by visiting http://www.suicidepreventionlifeline.org/getinvolved/materials.aspx

Goal	Action Steps
Goal 5 continued: Promote suicide prevention as a core component of health care services	**Nonprofit, Community-, and Faith-based Organizations:** • Coordinate the services of community-based programs by requesting support from local mental health and substance abuse providers. **Individuals and Families:** • Find information to help individuals who are struggling at the following website http://www.thencsp.org/#!SUPPORT%20A%20FRIEND/c8xp
6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors	**Health System, Insurers, and Clinicians:** • Educate family members and significant others about appropriate steps to support individuals at suicide risk during treatment and/or after discharge from an Emergency Department or inpatient unit. Visit http://www.sprc.org/library_resources/items/suicide-risk-guide-evaluation-and-triage to download *Suicide risk: A guide for evaluation and triage*.
7. Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts	**State, Tribal, and Local Governments:** • Find the Suicide Prevention Coordinating Council's state level surveillance data at http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention/meetings

VI. Suicide Prevention Resources

In an effort to raise awareness of suicide prevention, information about the risk and protective factors and the warning signs for suicidal behavior are summarized below.

Risk Factors

The Centers for Disease Control and Prevention defines risks as characteristics associated with suicidal behaviors. With risk factor awareness, stakeholders and other interested individuals can assist with recognizing and preventing suicide. Examples of risk factors include[22]:

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness

[22] See, http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html, site accessed, September 24, 2015

- Impulsive or aggressive tendencies
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

Warning Signs

The American Association of Suicidology defines warning signs as indicators that a person may be more at risk for suicidal behaviors. Suicide is preventable and increasing awareness of the warning signs is critical to ensuring that individuals in crisis are recognized and receive the help they need. Additionally, awareness of the risk factors and warning signs can reduce the stigma attached to suicide and to individuals exhibiting potential suicidal thoughts or behaviors. The following is a partial list of warning signs from the American Association of Suicidology[23]:

- Increased substance (alcohol or drug) use
- No reason for living; no sense of purpose in life
- Anxiety, agitation, unable to sleep or sleeping all of the time
- Feeling trapped – like there's no way out
- Hopelessness
- Withdrawal from friends, family, and society
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Dramatic mood changes

Individuals experiencing higher risk of possible suicide may exhibit some or all of the following behaviors:

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or,
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

[23] See, http://www.suicidology.org/resources/warning-signs, site accessed, September 24, 2015

Protective Factors

According to the Centers for Disease Control and Prevention,[24] the following list of protective factors may reduce the risks for suicidal thoughts and behaviors:

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes

Resources

To get help for yourself or a loved one, contact the following:

1. National Suicide Prevention Lifeline. Provides crisis support 24 hours a day, 7 days a week by phone and live chat. 1 (800) 273-8255. Website: www.suicidepreventionlifeline.org
2. The Veterans Crisis Line. Connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call **1-800-273-8255** and **Press 1**, chat online, or send a text message to **838255** to receive confidential support 24 hours a day, 7 days a week.

To learn more about the risk and protective factors, visit:

1. The American Association of Suicidology. The AAS is a charitable, nonprofit membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. http://www.suicidology.org/resources/warning-signs
2. The Centers for Disease Control and Prevention Injury, Prevention and Control: Division of Violence Prevention. The Division's mission is to prevent injuries and deaths caused by violence. http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html
3. The Florida Suicide Prevention Coalition. The Coalition's mission is to collaborate with stakeholders to develop and implement suicide prevention, intervention, and postvention strategies and programs. http://www.floridasuicideprevention.org/learn_the_signs.htm
4. The Florida Department of Children and Families' Statewide Office for Suicide Prevention. SOSP and the Council guide suicide prevention efforts in Florida. http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention/about-suicide

[24]See, http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html, site accessed, September 24, 2015

5. The Suicide Prevention Resource Center. The SPRC is the nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. It provides technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide. It also promotes collaboration among a variety of organizations in the field of suicide prevention. http://www.sprc.org/basics/risk-and-protective-factors

To learn more about suicide prevention, ways to help, and become involved, visit:

1. The Suicide Prevention Resource Center. http://www.sprc.org/
2. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. Its mission is to reduce the effect of substance abuse and mental illness on America's communities. http://www.samhsa.gov/
3. The Florida Department of Children and Families' Statewide Office for Suicide Prevention guides suicide prevention efforts in Florida. This Office is also responsible for updating the Statewide Plan and writing an annual report to the Governor's Office. http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention
4. The Florida Suicide Prevention Coalition collaborates to develop and implement suicide prevention, intervention, postvention strategies, and programs. Additionally, the Coalition, along with other organizations, coordinates the annual Suicide Prevention Day at the Capitol. http://www.floridasuicideprevention.org/

VII. Contact

For more information about the Statewide Plan or suicide prevention efforts, contact the Statewide Office for Suicide Prevention at 850-487-2920 or email samh@myFLfamilies.com. *Florida's 2016-2020 Statewide Plan for Suicide Prevention* can be accessed at http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention

Appendix 1

CATEGORIES OF ORGANIZATIONS THAT RESPONDED TO THE 2015 FLORIDA SUICIDE PREVENTION SURVEY

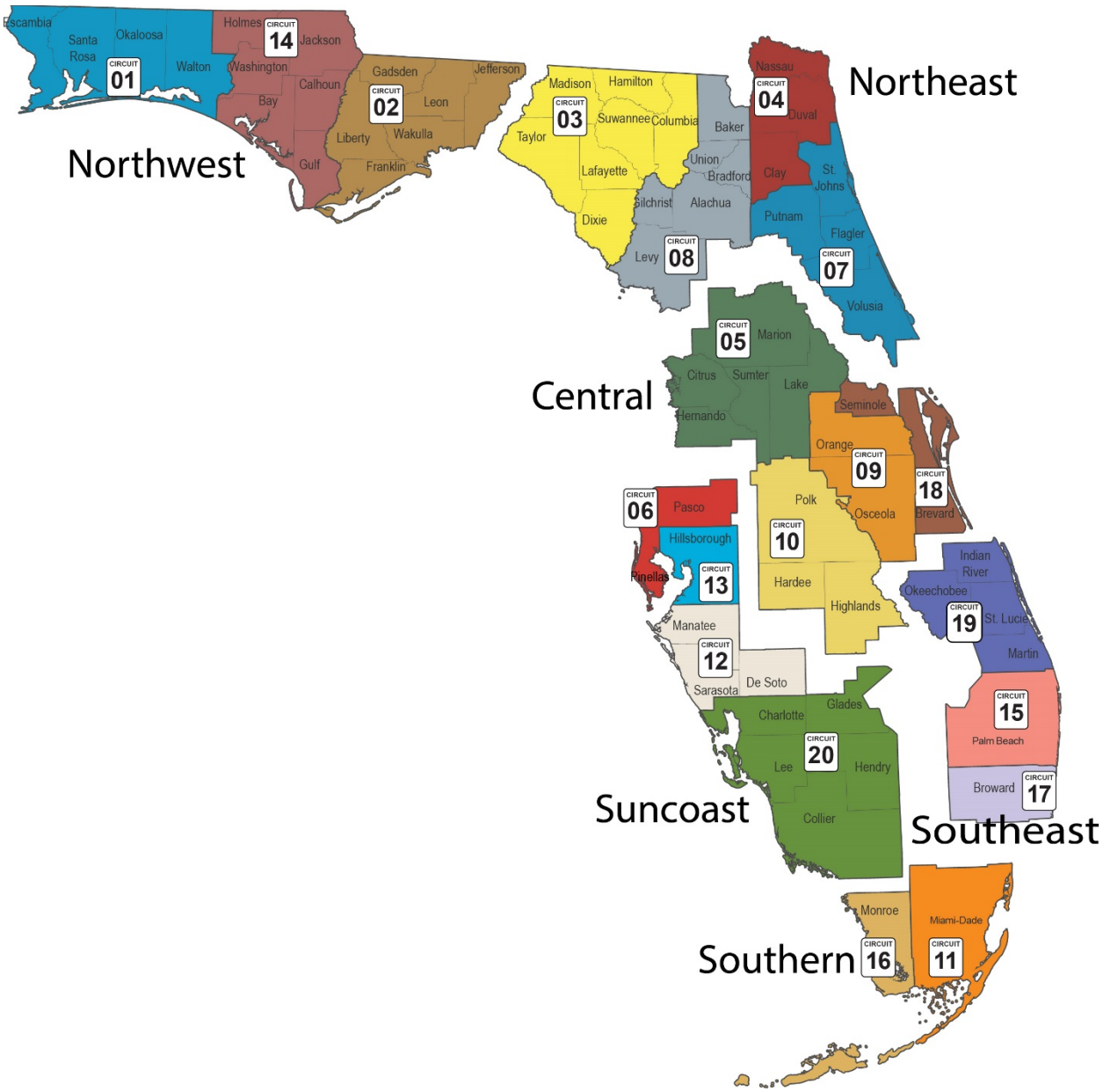
Percentages of Types of Organizations					
Region	**Type of Organization**				
	Health Care Systems, Insurers, and Clinicians	Nonprofit, Community-, and Faith-Based Organizations	State and Local Government	Schools, Colleges, and Universities	Businesses and Employers
Northwest Region	9%	56%	2%	33%	0%
Northeast Region	9%	57%	2%	32%	0%
Central Region	0%	86%	14%	0%	0%
Southeast Region	30%	50%	0%	20%	0%
Southern Region	15%	67%	13%	0%	5%
SunCoast Region	9%	78%	0%	13%	0%

Top Five Suicide Prevention Initiatives Identified by Organization

- Health Care Systems, Insurers, and Clinicians
    - Screen for mental health needs/make referrals
- Nonprofit, Community-, and Faith-Based Organizations
    - Develop/implement communication strategies that convey messages of help, hope, & resiliency
- State and Local Government
    - Assess needs/resources
- Schools, Colleges, and Universities
    - Implement programs and policies to build social connectedness and promote positive mental and emotional health
- Businesses and Employers
    - Implement organizational changes to promote the mental and emotional health of employees

Appendix 2

MAP OF DEPARTMENT'S GEOGRAPHIC REGIONS



MEMORANDUM

TO: School District Superintendents
School District School Principals
School District Student Services Directors

FROM: Jacob Oliva

DATE: August 30, 2019

Contact Information:
Dr. David Wheeler
850-245-7847
David.Wheeler@fldoe.org
DPS: 2019-117

SUBJECT: **Suicide Risk Assessment and "Suicide Prevention Certified Schools" – Senate Bill 1418**

The 2019 Florida Legislature passed Senate Bill 1418 and Governor Ron DeSantis signed the bill into law on June 25, 2019 (Chapter 2019-134, Laws of Florida). SB 1418 amends section (s.) 1012.583, Florida Statutes (F.S.), by requiring the Florida Department of Education (FDOE) to develop a list of approved suicide screening instruments and establish additional criteria and posting requirements for "Suicide Prevention Certified Schools."

The FDOE, in collaboration with the Statewide Office for Suicide Prevention and suicide prevention experts, identified two suicide risk screening instruments appropriate for assessing suicide risk in school-age youth:

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

These instruments and additional resources on suicide awareness and prevention are posted on the web pages of the Student Support Services Project and the Office of Safe Schools.

The FDOE recommends that youth suspected of suicide risk be referred to a school-based mental health services provider (i.e., FDOE-certified school psychologist, school social worker, school counselor or licensed mental health provider) for a suicide risk assessment using one of the approved instruments. The FDOE also recommends that each district adopt a policy requiring a suicide risk assessment by a school-based mental health services provider prior to the initiation of an involuntary examination (Baker Act).

SB 1418 establishes additional criteria for the "Suicide Prevention Certified School" designation. In order to be considered a "Suicide Prevention Certified School," the school must take the following actions:

1) Incorporate two hours of suicide awareness and prevention training for all instructional personnel (see http://sss.usf.edu/resources/topic/suicide/index.html for a list of FDOE-approved trainings);
2) Adopt a policy mandating the use of an approved suicide risk assessment instrument prior to an involuntary examination; and
3) Identify at least two school-based staff members certified to administer the C-SSRS and SAFE-T risk assessment instruments.

Schools that meet the criteria for a "Suicide Prevention Certified School" must report compliance to the FDOE by completing the attached form – *SPCS Certification* – and submitting the completed form to SuicidePreventionSchools@fldoe.org. The FDOE will post the list of "Suicide Prevention Certified Schools" on the Office of Safe Schools web page at http://www.fldoe.org/safe-schools/.

SB 1418 also requires districts to post a list of "Suicide Prevention Certified Schools" on the district website and each school to post their "Suicide Prevention Certified School" status on the school website. The FDOE will provide additional guidance on school and district reporting and posting requirements, and will be providing technical assistance and developing rules to support the implementation of s. 1012.583, F.S., for approval by the State Board of Education.

If you have questions regarding suicide risk assessment or "Suicide Prevention Certified Schools," please contact Dr. David Wheeler at David.Wheeler@fldoe.org or 850-245-7847.

JO/dw

Attachment

cc: School District Staff Development Coordinators
School District School Safety Specialists





Preventing Suicide:

A Technical Package of Policy, Programs, and Practices

National Center for Injury Prevention and Control
Division of Violence Prevention

Preventing Suicide:

A Technical Package of Policy, Programs, and Practices

Developed by:

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2017

Division of Violence Prevention
National Center for Injury Prevention and Control
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Atlanta, Georgia

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Contents

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Overview

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. These strategies include: strengthening economic supports; strengthening access and delivery of suicide care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk. The strategies represented in this package include those with a focus on preventing the risk of suicide in the first place as well as approaches to lessen the immediate and long-term harms of suicidal behavior for individuals, families, communities, and society. The strategies in the technical package support the goals and objectives of the *National Strategy for Suicide Prevention*[1] and the National Action Alliance for Suicide Prevention's priority to strengthen community-based prevention.[2] Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business, labor, and government can bring about the successful implementation of this package.

What is a Technical Package?

A technical package is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome.[3] Technical packages help communities and states prioritize prevention activities based on the best available evidence. This technical package has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing suicide. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The ***evidence*** for each of the approaches in preventing suicide or its associated risk factors is included as the third component. This package is intended as a resource to guide and inform prevention decision-making in communities and states.

Preventing Suicide is a Priority

Suicide, as defined by the Centers for Disease Control and Prevention (CDC), is part of a broader class of behavior called *self-directed violence*. Self-directed violence refers to behavior directed at oneself that deliberately results in injury or the *potential* for injury.[4] Self-directed violence may be *suicidal* or *non-suicidal* in nature. For the purposes of this document, we refer only to behavior where suicide is intended:

- **Suicide** is a death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- **Suicide attempt** is defined as a *non-fatal* self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide is highly prevalent. Suicide presents a major challenge to public health in the United States and worldwide. It contributes to premature death, morbidity, lost productivity, and health care costs.[1,5] In 2015 (the most recent year of available death data), suicide was responsible for 44,193 deaths in the U.S., which is approximately one suicide every 12 minutes.[6] In 2015, suicide ranked as the 10th leading cause of death and has been among the top 12 leading causes of death since 1975 in the U.S.[7] Overall suicide rates increased 28% from 2000 to 2015.[6] Suicide is a problem throughout the life span; it is the third leading cause of death for youth 10–14 years of age, the second leading cause of death among people 15–24 and 25–34 years of age; the fourth leading cause among people 35 to 44 years of age, the fifth leading cause among people ages 45–54 and eighth leading cause among people 55–64 years of age.[6]

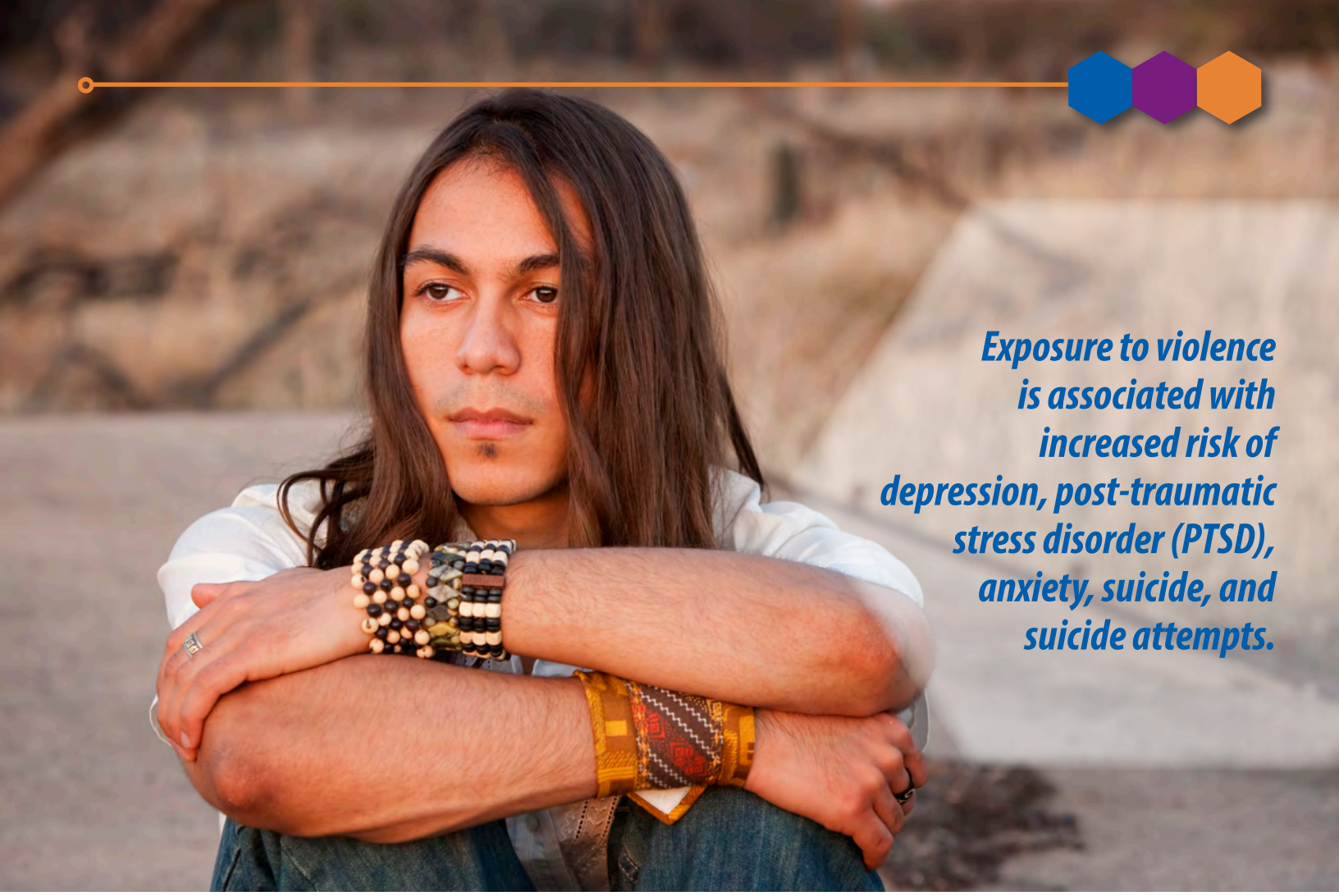
Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the life span occurring among non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic White population groups. In 2015, the rates for these groups were 19.9 and 16.9 per 100,000 population, respectively.[6] Other population groups disproportionately impacted by suicide include middle-aged adults (whose rates increased 35% from 2000 to 2015, with steep increases seen among both males (29%) and females (53%) aged 35–64 years[6]; Veterans and other military personnel (whose suicide rate nearly doubled from 2003 to 2008, surpassing the rate of suicide among civilians for the first time in decades)[8,9]; workers in certain occupational groups,[10,11] and sexual minority youth, who experience increased suicidal ideation and behavior compared to their non-sexual minority peers.[12-14]

Suicides reflect only a portion of the problem.[15] Substantially more people are hospitalized as a result of nonfatal suicidal behavior (i.e., suicide attempts) than are fatally injured, and an even greater number are either treated in ambulatory settings (e.g., emergency departments) or not treated at all.[15] For example, during 2014, among adults aged 18 years and older, for every one suicide there were 9 adults treated in hospital emergency departments for self-harm injuries, 27 who reported making a suicide attempt, and over 227 who reported seriously considering suicide.[6,16]

Suicide is associated with several risk and protective factors. Suicide, like other human behaviors, has no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental and societal influences that interact with one another, often over time.[1,5] The social ecological model—encompassing multiple levels of focus from the individual, relationship, community, and societal—is a useful framework for viewing and understanding suicide risk and protective factors identified in the literature.[17] Risk and protective factors for suicide exist at each level. For example, risk factors include:[1,5]

- **Individual level**: history of depression and other mental illnesses, hopelessness, substance abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants
- **Relationship level**: high conflict or violent relationships, sense of isolation and lack of social support, family/loved one's history of suicide, financial and work stress
- **Community level**: inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications)
- **Societal level**: availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness.

It is important to recognize that the vast majority of individuals who are depressed, attempt suicide, or have other risk factors, do *not* die by suicide.[18,19] Furthermore, the relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status.[1,5]



Exposure to violence is associated with increased risk of depression, post-traumatic stress disorder (PTSD), anxiety, suicide, and suicide attempts.

Protective factors, or those influences that buffer against the risk for suicide, can also be found across the different levels of the social ecological model. Protective factors identified in the literature include: effective coping and problem-solving skills, moral objections to suicide, strong and supportive relationships with partners, friends, and family; connectedness to school, community, and other social institutions; availability of quality and ongoing physical and mental health care, and reduced access to lethal means.[1,5] These protective factors can either counter a specific risk factor or buffer against a number of risks associated with suicide.

Suicide is connected to other forms of violence. Exposure to violence (e.g., child abuse and neglect, bullying, peer violence, dating violence, sexual violence, and intimate partner violence) is associated with increased risk of depression, post-traumatic stress disorder (PTSD), anxiety, suicide, and suicide attempts.[20-26] Women exposed to partner violence are nearly 5 times more likely to attempt suicide as women not exposed to partner violence.[26] Exposure to adverse experiences in childhood, such as physical, sexual, emotional abuse and neglect, and living in homes with violence, mental health, substance abuse problems and other instability, is also associated with increased risk for suicide and suicide attempts.[22,27] The psychosocial effects of violence in childhood and adolescence can be observed decades later, including severe problems with finances, family, jobs, and stress—factors that can increase the risk for suicide. Suicide and other forms of violence often share the same individual, relationship, community, and societal risk factors suggesting that efforts to prevent interpersonal violence may also prove beneficial in preventing suicide.[28-30] CDC has developed technical packages for the different forms of interpersonal violence to help communities identify additional strategies and approaches (https://www.cdc.gov/violenceprevention/pub/technical-packages.html). Further, just as risk factors may be shared across suicide and interpersonal violence, so too may protective factors overlap. For example, connectedness to one's community,[31] school,[32] family,[33] caring adults,[34,35] and pro-social peers[36] can enhance resilience and help reduce risk for suicide and other forms of violence.

The health and economic consequences of suicide are substantial. Suicide and suicide attempts have far reaching consequences for individuals, families, and communities.[37-40] In an early study, Crosby and Sacks[41] estimated that 7% of the U.S. adult population, or 13.2 million adults, knew someone in the prior 12 months who had died by suicide. They also estimated that for each suicide, 425 adults were exposed, or knew about the death.[41] In a more recent study, in one state, Cerel et al[42] found that 48% of the population knew at least one person who died by suicide in their lifetime. Research indicates that the impact of knowing someone who died by suicide and/or having lived experience (i.e., personally have attempted suicide, have had suicidal thoughts, or have been impacted by suicidal loss) is much more extensive than injury and death. People with lived experience may suffer long-term health and mental health consequences ranging from anger, guilt, and physical impairment, depending on the means and severity of the attempt.[43] Similarly, survivors of a loved one's suicide may experience ongoing pain and suffering including complicated grief,[44] stigma, depression, anxiety, post-traumatic stress disorder, and increased risk of suicidal ideation and suicide.[45,46] Less discussed but no less important, are the financial and occupational effects on those left behind.[47]

The economic toll of suicide on society is immense as well. According to conservative estimates, in 2013, suicide cost $50.8 billion in estimated lifetime medical and work-loss costs alone.[47] Adjusting for potential under-reporting of suicide and drawing upon health expenditures per capita, gross domestic product per capita, and variability among states in per capita health care expenditures and income, another study estimated the total lifetime costs associated with nonfatal injuries and deaths caused by self-directed violence to be approximately $93.5 billion in 2013.[48] The overwhelming burden of these costs were from lost productivity over the life course, with the average cost per suicide being over $1.3 million.[48] The true economic costs are likely higher, as neither study included monetary figures related to other societal costs such as those associated with the pain and suffering of family members or other impacts.

Suicide can be prevented. Like most public health problems, suicide is preventable.[1,5] While progress will continue to be made into the future, evidence for numerous programs, practices, and policies currently exists, and many programs are ready to be implemented now. Just as suicide is not caused by a single factor, research suggests that reductions in suicide will not be prevented by any single strategy or approach.[1,49] Rather, suicide prevention is best achieved by a focus across the individual, relationship, family, community, and societal-levels and across all sectors, private and public.[1,5]

Assessing the Evidence

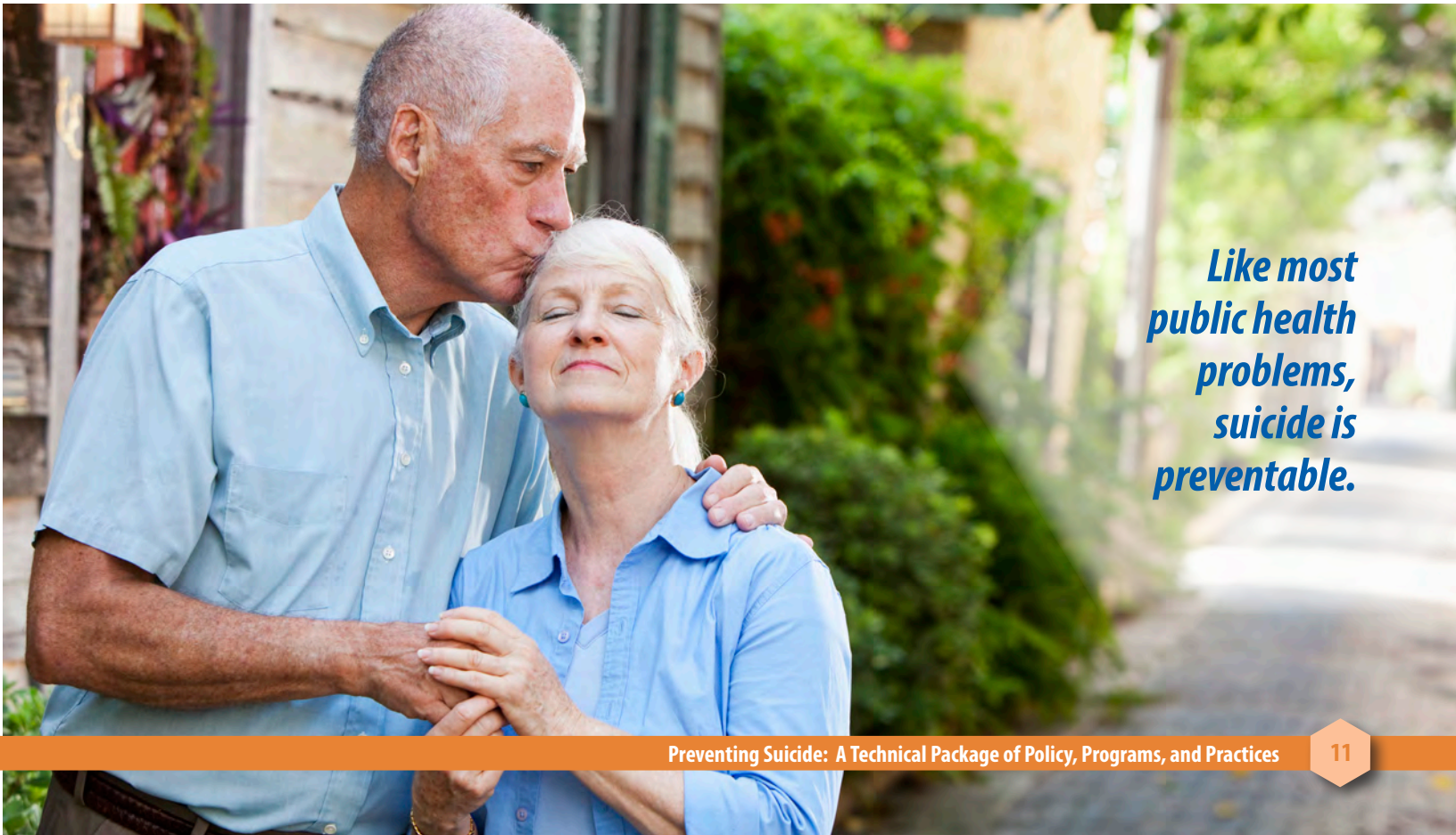
This technical package includes programs, practices, and policies with evidence of impact on suicide or risk or protective factors for suicide. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria: a) meta-analyses or systematic reviews showing impact on suicide; b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on suicide; c) meta-analyses or systematic reviews showing impact on risk or protective factors for suicide, or d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk or protective factors for suicide. Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of suicide but instead are supported by evidence indicating impacts on risk or protective factors for suicide (e.g., help-seeking, stigma reduction, depression, connectedness). In terms of the strength of the evidence, programs that have demonstrated effects on suicidal behavior (e.g., reductions in deaths, attempts) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community engagement and family programs on suicidal behavior. Thus, approaches in this package that have effects on risk or protective factors reflect the developing nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy in terms of the nature and quality of the available evidence. Not all programs, policies, or practices that utilize the same approach are equally effective, and even those that are effective may not work across all populations. Tailoring programs and conducting more evaluations may be necessary to address different population groups. The evidence-based programs, practices, or policies included in the package are not intended to be a comprehensive list for each approach, but rather to serve as examples that have been shown to impact suicide or have beneficial effects on risk or protective factors for suicide.

Contextual and Cross-Cutting Themes

One important feature of the package is the complementary and potentially synergistic impact of the strategies and approaches. The strategies and approaches included in this technical package represent different levels of the social ecology, with efforts intended to impact community and societal levels, as well individual and relationship levels. The strategies and approaches are intended to work in combination and reinforce each other to prevent suicide (see box on page 12). The strategies are arranged in order such that those strategies hypothesized to have the greatest potential for broad public health impact on suicide are included first, followed by those that might impact subsets of the population (e.g., persons who have already made a suicide attempt).



Preventing Suicide

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

It is important to note that these strategies are not mutually exclusive but each has an immediate focus. For instance, social-emotional learning programs, an approach under the *Teach Coping and Problem-Solving Skills* strategy, sometimes include components to change peer norms and the broader environment. The primary focus of these programs, however, is to provide children and youth with skills to resolve problems in relationships, school, and with peers, and to help youth address other negative influences (e.g., substance use) associated with suicide.

The goal of this package is to stress the importance of comprehensive prevention efforts and to provide examples of effective programs addressing each level of the social ecology, with the knowledge that some programs, practices, and policies may impact multiple levels. Further, those that involve multiple sectors and that impact multiple levels of the social ecology are more likely to have a greater impact on the overall burden of suicide.

Suicide ideation, thoughts, attempts, and deaths vary by gender, race/ethnicity, age, occupation, and other important population characteristics.[6,50] Further, certain transition periods are also associated with higher rates of suicide (e.g., transition from working into retirement, transition from active duty military status to civilian status).[48,51] In fact, suicide risk can change along with dynamic risk factors. For example, individuals' coping skills may change during periods of crisis and heightened stress, limiting their normal ability to effectively solve problems and cope. Research indicates that suicide risk changes as a result of the number and intensity of key risk and protective factors experienced.[52] Ideally, the availability of multiple strategies and approaches tailored to the social, economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience.[1]

Identifying programs, practices, and policies with evidence of impact on suicide, suicide attempts, or beneficial effects on risk or protective factors for suicide is only the first step. In practice, the effectiveness of the programs, policies and practices identified in this package will be strongly dependent on how well they are implemented, as well as the partners and communities in which they are implemented. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

Data-driven strategic planning processes can help communities with this work.[53-55] These planning processes engage and guide community stakeholders through a prevention planning process designed to address a community's profile of risk and protective factors with evidence-based programs, practices, and policies. These processes can also be used to monitor implementation, track outcomes, and make adjustments as indicated by the data. The readiness of the program for broad dissemination and implementation (e.g., availability of program materials, training and technical assistance) can also influence program effects. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

This package includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business, labor or health care is critical to implement a particular policy or program (e.g., workplace policies; treatment to prevent re-attempts). The role of various sectors in the implementation of a strategy or approach in preventing suicide is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing suicide are described.

Strengthen Economic Supports

Rationale

Studies from the U.S. examining historical trends indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old.[56,57] Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress may increase an individual's risk for suicide or may indirectly increase risk by exacerbating related physical and mental health problems.[58] Buffering these risks can, therefore, potentially protect against suicide. For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing while also paying for necessities such as food and medical care, job training, child care, among other expenses required for daily living. In providing this support, stress and anxiety and the potential for a crisis situation may be reduced, thereby preventing suicide. Although more research is needed to understand how economic factors interact with other factors to increase suicide risk, the available evidence suggests that strengthening economic supports may be one opportunity to buffer suicide risk.

Approaches

Economic supports for individuals and families can be strengthened by targeting household financial security and ensuring stability in housing during periods of economic stress.

Strengthening household financial security can potentially buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability, are examples of ways to strengthen household financial security.

Housing stabilization policies aim to keep people in their homes and provide housing options for those in need during times of financial insecurity. This may occur through programs that provide affordable housing such as through government subsidies or through other options available to potential homebuyers such as loan modification programs, move-out planning, or financial counseling services that help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

- Reductions in foreclosure rates
- Reductions in eviction rates
- Reductions in emotional distress
- Reductions in rates of suicide

Evidence

There is evidence suggesting that strengthening household financial security and stabilizing housing can reduce suicide risk.

Strengthen household financial security. The *Federal-State Unemployment Insurance Program* allows states to define the maximum amount and duration of unemployment benefits that workers are entitled to receive after a job loss.[59] An examination of variations in *unemployment benefit programs* across states demonstrated that the impact of unemployment on rates of suicide was offset in those states that provided greater than average unemployment benefits (mean level: $7,990 per person in U.S. constant dollars). The effects of *unemployment benefit programs* were also consistent by sex and age group.[59] Another U.S. study examining the link between unemployment and suicide rates using monthly suicide data, length of unemployment (less than 5 weeks, 5-14 weeks, 15-26 weeks, and greater than 26 weeks), and job losses found that the duration of unemployment, as opposed to just the loss of a job, predicted suicide risk.[60] Together, these results suggest that not only should state unemployment benefit programs be generous in their financial allocations, but also in their duration.

Other measures to strengthen household financial security (e.g., transfer payments related to retirement and disability insurance, unemployment insurance compensation, medical benefits, and other forms of family assistance) have also shown an impact on rates of suicide. A study by Flavin and Radcliff[61] examined the impact of states' per capita spending on transfer payments, medical benefits, and family assistance (Temporary Assistance to Needy Families—TANF) and total state spending on suicide rates between 1990-2000, controlling for a number of suicide risk factors (e.g., residential mobility, divorce rate, unemployment rate) at the state level. As per capita spending on total transfer payments, medical benefits, and family assistance increased there was an associated decrease in state suicide rates. In terms of lives saved, Flavin and Radcliff calculated the cost of reducing a state's suicide rate by a full point for the years studied.[61] At the national level, they estimated 3,000 fewer suicides would occur per year nationwide if every state increased its per capita spending on these types of

assistance by $45 per year.[61] Although this was a correlational study, the results demonstrate the potential benefits of policies that reach particularly vulnerable individuals during periods of great need. More evaluation studies are needed to further understand the outcomes impacted by programs such as these.

Housing stabilization policies. The *Neighborhood Stabilization Program*[62] was designed to help neighborhoods suffering from high rates of foreclosure and abandonment by slowing the deterioration of the neighborhoods and providing affordable housing options for low, moderate, and middle-income homebuyers. This program also offers financial assistance to eligible individuals for the purchase of a new home. Although this program has not been rigorously evaluated for its impact on suicide outcomes, it addresses foreclosure and eviction, which are risk factors for suicide. A longitudinal analysis of annual data on suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased in U.S. states, so did the state suicide rate, particularly among working-aged adults.[63] Another study of data from 16 U.S. states participating in the *National Violent Death Reporting System* found that suicides precipitated by home foreclosures and evictions increased more than 100% from 2005 (before the housing crisis began) to 2010 (after it had peaked).[57] Most of these suicides occurred prior to the actual loss of the decedent's home. These findings suggest that integrating suicide prevention resources, messaging, and referrals into financial, foreclosure, and move-out planning and counseling services may help to prevent suicide.

Strengthen Access and Delivery of Suicide Care

Rationale

While most people with mental health problems do not attempt or die by suicide[18,19] and the level of risk conferred by different types of mental illness varies,[64-66] previous research indicates that mental illness is an important risk factor for suicide.[5,67] State-level suicide rates have also been found to be correlated with general mental health measures such as depression.[68,69] Findings from the *National Comorbidity Survey* indicate that relatively few people in the U.S. with mental health disorders receive treatment for those conditions.[70] Lack of access to mental health care is one of the contributing factors related to the underuse of mental health services.[71] Identifying ways to improve access to timely, affordable, and quality mental health and suicide care for people in need is a critical component to prevention.[5] Additionally, research suggests that services provided are maximized when health and behavioral health care systems are set up to effectively and efficiently deliver such care.[72] Apart from treatment benefits, these approaches can also normalize help-seeking behavior and increase the use of such services.

Approaches

There are a number of approaches that can be used to strengthen access and delivery of suicide care, including:

Coverage of mental health conditions in health insurance policies. Federal and state laws include provisions for equal coverage of mental health services in health insurance plans that is on par with coverage for other health concerns (i.e., mental health parity).[73] Benefits and services covered include such things as the number of visits, co-pays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. If a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law. Equal coverage does not necessarily imply good coverage as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions. Rather it helps to ensure that mental health services are covered on par with other health concerns.

Reduce provider shortages in underserved areas. Access to effective and state-of-the-art mental health care is largely dependent upon the training and the size of the mental health care workforce. Over 85 million Americans live in areas with an insufficient number of mental health providers; this shortage is particularly severe among low-income urban and rural communities.[74] There are various ways to increase the number and distribution of practicing mental health providers in underserved areas including offering financial incentives through existing state and federal programs (e.g., loan repayment programs) and expanding the reach of health services through telephone, video and web-based technologies. Such approaches can increase the likelihood that those in need will be able to access affordable, quality care for mental health problems, which can reduce risk for suicide.

Safer suicide care through systems change. Access to health and behavioral health care services is critical for people at risk of suicide; however this is just one piece of the puzzle. Care should also be delivered efficiently and effectively. More specifically, care should take place within a system that supports suicide prevention and patient safety through strong leadership, workforce training, systematic identification and assessment of suicide risk, implementation of evidence-based treatments (see *Identify and Support People at Risk*), continuity of care, and continuous quality improvement. Care that is patient-centered and promotes equity for all patients is also of critical importance.[75]

Potential Outcomes

- Increased use of mental health services
- Lower rates of treatment attrition
- Reductions in depressive symptoms
- Reductions in rates of suicide attempts
- Reductions in rates of suicide

Evidence

There is evidence suggesting that coverage of mental health conditions in health insurance policies and improving access and the delivery of care can reduce risk factors associated with suicide and may directly impact suicide rates.

Coverage of mental health conditions in health insurance policies. The *National Survey on Drug Use and Health (NSDUH)* is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and service utilization.[50] Using data from this survey, Harris, Carpenter, and Bao[76] found that 12 months after states enacted *mental health parity laws*, self-reported use of mental healthcare services significantly increased. Moreover, subsequent research by Lang[69] examined state mental health laws and suicide rates between 1990 and 2004 and found that mental health parity laws, specifically, were associated with an approximate 5% reduction in suicide rates. This reduction, in the 29 states with parity laws, equated to the prevention of 592 suicides per year.[69]

Reduce provider shortages in underserved areas. One example of a program to improve access to mental health care providers is the *National Health Service Corps (NHSC)*, which offers financial incentives to attract mental/behavioral health clinicians to underserved areas.[77] Programs such as *NHSC* encourage individuals to work in the mental health profession in locations designated as Health Professional Shortage Areas (HPSAs) in exchange for student loan debt repayment. A 2012 retention survey conducted by the Health Resources and Services Administration (HRSA), found that 61% of mental and behavioral health care providers continued to practice in designated mental health shortage areas after their four year commitment to the *NHSC*.[78] Although this program has not been evaluated for impact on suicide, it addresses access to care, which is a critical component to suicide prevention.

Telemental Health (TMH) services refer to the use of telephone, video and web-based technologies for providing psychiatric or psychological care at a distance.[79] *TMH* can be used in a variety of settings (e.g., outpatient clinics, hospitals, military treatment facilities) to treat a wide range of mental health conditions. It can also improve access to care for patients in isolated areas, as well as reduce travel time and expenses, reduce delays in receiving care, and improve satisfaction interacting with the mental health care system. A systematic review of *TMH* services found that services rated as high or good quality were effective in treating mental health conditions such as depression, schizophrenia, substance

abuse, and suicidal ideation and suicide.[79] Further, Mohr and colleagues[80] conducted a meta-analysis examining the effect of psychotherapy delivered specifically via telephone and found that it significantly reduced depressive symptoms in comparison to face-to-face psychotherapy. They also found that treatment attrition rates were significantly lower among patients receiving telephone-administered psychotherapy compared to patients receiving face-to-face therapy.[80] Thus, *TMH* may not only offer improved access to mental health care, but it may also ensure continuity of care, and thereby further reduce the risk for suicide.

Safer suicide care through systems change. *Henry Ford Health System*, which is a large health maintenance organization (HMO) in the state of Michigan, pioneered *Perfect Depression Care,*[81] the pre-cursor to what is now called *Zero Suicide*. The overall goal of *Perfect Depression Care* was to eliminate suicide among HMO members. More broadly, the goal of the program was to redesign delivery of depression care to achieve "breakthrough improvement" in quality and safety by focusing on effectiveness, safety, patient centeredness, timeliness, efficiency, and equity among patients. The program screened and assessed each patient for suicide risk and implemented coordinated continuous follow-up care system wide.[81] An examination of the impact of the program found that there was a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, and the intervention years, 2002-2009. During this time period, the suicide rate fell by 82%.[81,82] Further, among HMO members who received mental health specialty services, the suicide rate significantly decreased over time from 1999 to 2010 (110.3 to 47.6 per 100,000 population; $p<.04$) with a mean of 36.2 per 100,000 over the period.[83] Additionally, for those HMO members who accessed only general medical services as opposed to specialty mental health services, the suicide rate increased from 2.7 to 5.6 per 100,000 ($p<.01$).[83] Similarly, in the state of Michigan, rates of suicide in the general population increased over the period from 9.8 to 12.5 per 100,000 ($p<.001$).[83]

Create Protective Environments

Rationale

Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment interventions) but on changes to the environment can increase the likelihood of positive behavioral and health outcomes.[84] Creating environments that address risk and protective factors where individuals live, work, and play can help prevent suicide.[1,17] For example, rates of suicide are high among middle-aged adults who comprise 42.6% of the workforce[85]; among certain occupational groups[10,11]; and among people in detention facilities (e.g., jail, prison),[86] to name a few. Thus, settings where these populations work and reside are ideal for implementing programs, practices and policies to buffer against suicide. Changes to organizational culture through the implementation of supportive policies, for instance, can change social norms, encourage help-seeking, and demonstrate that good health and mental health are valued and that stigma and other risk factors for suicide are not.[87,88] Similarly, modifying the characteristics of the physical environment to prevent harmful behavior such as access to lethal means can reduce suicide rates, particularly in times of crisis or transition.[89-94]

Approaches

The current evidence suggests three potential approaches for creating environments that protect against suicide.

Reduce access to lethal means among persons at risk of suicide. Means of suicide such as firearms, hanging/suffocation, or jumping from heights provide little opportunity for rescue and, as such, have high case fatality rates (e.g., about 85% of people who use a firearm in a suicide attempt die from their injury).[95] Research also indicates that: 1) the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes,[96,97] and 2) people tend *not* to substitute a different method when a highly lethal method is unavailable or difficult to access.[98,99] Therefore, increasing the time interval between deciding to act and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving. The following are examples of approaches reducing access to lethal means for persons at risk of suicide:

- *Intervening at Suicide Hotspots.* Suicide hotspots, or places where suicides may take place relatively easily, include tall structures (e.g., bridges, cliffs, balconies, and rooftops), railway tracks, and isolated locations such as parks. Efforts to prevent suicide at these locations include erecting barriers or limiting access to prevent jumping, and installing signs and telephones to encourage individuals who are considering suicide, to seek help.[100]

- *Safe Storage Practices.* Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating vulnerable individuals from easy access to lethal means. Such practices may include education and counseling around storing firearms locked in a secure place (e.g., in a gun safe or lock box), unloaded and separate from the ammunition; and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts.[89,101]

Organizational policies and culture that promote protective environments may be implemented in places of employment, detention facilities, and other secured environments (e.g., residential settings). Such policies and cultural values encourage leadership from the top down and may promote prosocial behavior (e.g., asking for help), skill building, positive social norms, assessment, referral and access to helping services (e.g., mental health, substance abuse treatment, financial counseling), and development of crisis response plans, postvention and other measures to foster a safe physical environment. Such policies and cultural shifts can positively impact organizational climate and morale and help prevent suicide and its related risk factors (e.g., depression, social isolation).[88,102]

Community-based policies to reduce excessive alcohol use. Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides.[103-105] Policies to reduce excessive alcohol use broadly include zoning to limit the location and density of alcohol outlets, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age.[105] These policies are important because acute alcohol use has been found to be associated with more than one-third of suicides and approximately 40% of suicide attempts.[106]

Potential Outcomes

- Increases in safe storage of lethal means
- Reductions in rates of suicide
- Reductions in suicide attempts
- Increases in help-seeking
- Reductions in alcohol-related suicide deaths

Evidence

The evidence suggests that creating protective environments can reduce suicide and suicide attempts and increase protective behaviors.

Reduce access to lethal means among persons at risk of suicide. A meta-analysis examining the impact of *suicide hotspot interventions* implemented in combination or in isolation, both in the U.S. and abroad, found associated reduced rates of suicide.[100,107] For example, after erecting a barrier on the Jacques-Cartier bridge in Canada, the suicide rate from jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year.[108] Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites.[108] Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the *removal* of safety barriers from the Grafton Bridge in Auckland, New Zealand. After removal of the barrier, both the number and rate of suicide increased five-fold.[93,109]

Another form of means reduction involves implementation of *safe storage practices*. In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from 5 trauma centers, researchers found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents.[110] Further, a recent systematic review of clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own.[101]

Another program, the *Emergency Department Counseling on Access to Lethal Means (ED CALM)*, trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan et al[89] found that at post-test 76% (of the 55% of parents followed up, n=114) reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (i.e., 67%), all (100%) reported guns were currently locked up at post-test.[89]

Organizational policies and culture. *Together for Life* is a workplace program of the Montreal Police Force implemented to address suicide among officers. Policy and program components were designed to foster an organizational culture that promoted mutual support and solidarity among all members of the Force. The program included training of supervisors, managers and all units to improve competencies in identifying suicidal risk and to improve use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking.[111] Police suicides were tracked over 12 years and compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 78.9% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29.0 per 100,000).[111]

Another example of this approach is the *United States Air Force Suicide Prevention Program*. The program included 11 policy and education initiatives and was designed to change the culture of the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge (i.e., education and training), and investigates every suicide (i.e., outcomes measurement). The program represents a fundamental shift from viewing suicide and mental illness solely as medical problems and instead sees them as larger service-wide problems impacting the whole community.[112] Using a time-series design to examine the impact of the program on various violence-related outcomes, researchers found that the program was associated with a 33% relative risk reduction in suicide.[112] The program was also associated with relative risk reductions in related outcomes including moderate and severe family violence (30% and 54%, respectively), homicide (51%), and accidental death (18%).[112] A longitudinal assessment of the program over the period 1981 to 2008 (16 years before the 1997 launch of the program and 11 years post-launch) found significantly lower rates of suicide after the program was launched than before.[87] These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation of program components in that year than in the other years.[87]

Finally, while the evidence is still being built for suicide prevention in correctional facilities, preliminary evidence suggests organizational policies and practices that include routine suicide prevention training for all staff; standardized intake screening and risk assessment; provision of shared information between staff members (especially in transitioning or transferring of inmates); varying levels of observation; safe physical environment; emergency response protocols; notification of suicidal behavior/suicide through the chain of command; and critical incident stress debriefing and death review can potentially reduce suicide.[102] When these policies and practices were implemented across 11 state prisons in Louisiana, suicide rates dropped 46%, from a rate of 23.1 per 100,000 before the intervention to 12.4 per 100,000 the following year.[113] Similar programs have seen declines in suicide both in the United States and in other countries.[114]

Community-based policies to reduce excessive alcohol use. While multiple policies to limit excessive use of alcohol exist, several studies on alcohol outlet density and risk factors for suicide, such as interpersonal violence and social connectedness,[115-118] suggest that measures to reduce alcohol outlet density can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over 6 years in 581 California zip codes, indicated that greater density of bars, specifically, was related to greater suicide and suicide attempts, particularly in rural areas.[119]

Promote Connectedness

Rationale

Sociologist, Emile Durkheim theorized in 1897 that weak social bonds, i.e., lack of connectedness, were among the chief causes of suicidality.[120] Connectedness is the degree to which an individual or group of individuals are socially close, interrelated, or share resources with others.[121] Social connections can be formed within and between multiple levels of the social ecology,[17] for instance between individuals (e.g., peers, neighbors, co-workers), families, schools, neighborhoods, workplaces, faith communities, cultural groups, and society as a whole. Related to connectedness, social capital refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations.[122,123] Many ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. While the evidence is limited, existing studies suggest a positive association between social capital (as measured by social trust and community/neighborhood engagement), and improved mental health.[124,125] Connectedness and social capital together may protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, and by increasing belongingness, personal value, and worth, to help build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its members and provide collective primary prevention activities to the community as a whole.[121]

Approaches

Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement may protect against suicide.

Peer norm programs seek to normalize protective factors for suicide such as help-seeking, reaching out and talking to trusted adults, and promote peer connectedness. 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. These approaches typically target youth and are delivered in school settings but can also be implemented in community settings.[126]

Community engagement activities. Community engagement is an aspect of social capital.[127] Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and group physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide.

Potential Outcomes

- Increases in healthy coping attitudes and behaviors
- Increases in referrals for youth in distress
- Increases in help-seeking behaviors
- Increases in positive perceptions of adult support

Evidence

Current evidence suggests a number of positive benefits of peer norm and community engagement activities, although more evaluation research is needed to examine whether these improvements in factors that protect against suicidal behavior translate into reduced suicide attempts and deaths.

Peer norm programs. Evaluations show that programs such as *Sources of Strength* can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a randomized controlled trial of *Sources of Strength* conducted with 18 high-schools (6 metropolitan, 12 rural), researchers found that the program improved adaptive norms regarding suicide, connectedness to adults, and school engagement.[36] Peer leaders were also more likely than controls to refer a suicidal friend to an adult. For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Finally, trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders.[36]

Community engagement activities. A vacant lot greening initiative was undertaken in Philadelphia between 1999 and 2008. Local residents and community members worked together to green 4,436 lots (or 7.8 million square feet) in four areas of the city. Researchers found significant reductions in community residents' self-reported level of stress, a risk factor for suicide, and engagement in more physical exercise, a protective factor for suicide, than residents in control vacant lot areas. There is some evidence for other cross-cutting benefits, including reductions in firearm assaults and vandalism.[128,129]

Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Life skills encompasses many concepts, but most often include coping and problem-solving skills, emotional regulation, conflict resolution, and critical thinking. Life skills are important in protecting individuals from suicidal behaviors.[126] Suicide prevention programs that focus on life and social skills training are drawn from social cognitive theories,[130] surmising that suicidal behavior is attributed to either direct learning and modeling or environmental and individual (e.g., hopelessness) characteristics. The inability to employ adequate strategies to cope with immediate stressors or identify and find solutions for problems has been characterized among suicide attempters.[131] Teaching and providing youth with the skills to tackle every day challenges and stressors is, therefore, an important developmental component to suicide prevention.

Approaches

Social-emotional learning programs and parenting skill and family relationship programs are two approaches for teaching coping and problem-solving skills.

Social-emotional learning programs focus on developing and strengthening communication and problem-solving skills, emotional regulation, conflict resolution, help seeking and coping skills. These approaches address a range of risk and protective factors for suicidal behavior. They provide children and youth with skills to resolve problems in relationships, school, and with peers, and help youth address other negative influences (e.g., substance use) associated with suicide.[126] These approaches are typically delivered to all students in a particular grade or school, although some programs also focus on groups of students considered to be at high risk for suicide. Opportunities to practice and reinforce skills are an important part of programs that work.[132]

Parenting skill and family relationship programs provide caregivers with support and are designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities.[132] Programs are typically designed for parents or caregivers with children in a specific age range and can be self-directed or delivered to individual families or groups of families. Some programs have sessions primarily with parents or caregivers while others include sessions for parents or caregivers, youth, and the family. Specific program content typically varies by the age of the child but often has consistent themes of child development, parent-child communication and relationships, and youth's interpersonal and problem-solving skills.

Potential Outcomes

- Reductions in suicide ideation
- Reductions in suicide attempts
- Reductions in suicide risk behaviors (i.e., depression, anxiety, conduct problems, substance abuse)
- Improvements in help-seeking behavior
- Improvements in social competence and emotional regulation skills
- Improvements in problem-solving and conflict management skills

Evidence

Several social-emotional learning and parenting and family relationship programs have been shown in rigorous evaluations to improve resilience and reduce problem behavior and risk factors for various behaviors, including ones closely related to suicide, such as depression, internalizing behaviors, and substance abuse.[133]

Social-emotional learning programs. The *Youth Aware of Mental Health Program (YAM)* is a program developed for teenagers aged 14–16 that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school and other problems.[134] In a cluster-randomized controlled trial conducted across 10 European Union countries and 168 schools, students in schools randomized to *YAM* were significantly less likely to attempt suicide and have severe suicidal ideation at the 12-month follow-up compared to students in control schools which received educational materials and care as usual. Overall, the relative risk of youth suicide attempts among the *YAM* group was reduced by over 50% demonstrating that out of 1000 students, five attempted suicide in the *YAM* group compared to 11 in the control group. Additionally, related to severe suicide ideation, in the *YAM* group, relative risk fell by 49.6%.[134]

Another example is the *Good Behavior Game (GBG),* which is a classroom-based program for elementary school children aged 6–10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior. The goal of the *GBG* program is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior.[135] Two cohorts of youths participated in the program in 1985-86 and 1986-87 school years when they were in the first and second grades. A number of proximal and distal outcomes were assessed among the two cohorts over time. With respect to distal suicide-related outcomes, an outcome evaluation of the *GBG* indicated that individuals in the first cohort, who were assigned to participate in *GBG* when they were in the first grade, reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, between the ages of 19 to 21, compared to peers who had been in a standard classroom setting. The beneficial effect of the program was consistent for suicidal ideation regardless of whether baseline covariates were included.[135] The *GBG* effect on attempts was less robust in some adjusted models including caregiver mental health. In the second cohort of *GBG* students, neither suicidal ideation nor suicide attempts were significantly different between *GBG* and the control interventions.[135] The researchers believed this may have been due to a lack of implementation fidelity, including less mentoring and monitoring of teachers. *GBG* was also found to be associated with reduced risk of later substance abuse and other suicide risk factors among the first cohort of students. Results for the second cohort were generally smaller but in the desired direction.[136]

Parenting skill and family relationship programs. Parenting and family skills training approaches have shown promising impacts in preventing key risk factors associated with suicide. For example, the *Incredible Years (IY)* is a comprehensive group training program for parents, teachers and children designed to reduce conduct and substance abuse problems (two important suicide risk factors in youth) by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotional self-regulation and social competence (all protective factors for suicide).[132] The program includes 9-20 sessions offered in community-based settings (e.g., religious, recreation centers, mental health treatment centers, and hospitals). Several studies have demonstrated the effect of the *IY* program on reducing internalizing symptoms, such as anxiety and depression, and child conduct problems.[137,138] The program is also associated with improved problem-solving and conflict management; these skills were maintained at 1-year follow-up.[139-141] Additionally, the program demonstrated greater benefits in mother-rated child internalizing symptoms, compared to the waitlisted control group, when parent, child, and teacher components were included.[132]

Additionally, *Strengthening Families 10–14* is a program that involves sessions for parents, youth, and families with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions. The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance abuse, two important risk factors for suicide.[142] *Strengthening Families* has been shown to significantly decrease externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants, as well as reduce depression, alcohol use, and drug use among participating families.[142]

Identify and Support People at Risk

Rationale

In order to decrease suicide, care of, and attention to, vulnerable populations is necessary, as these groups tend to experience suicidal behavior at higher than average rates. Such vulnerable populations include, but are not limited to, individuals with lower socio-economic status or who are living with a mental health problem; people who have previously attempted suicide; Veterans and active duty military personnel; individuals who are institutionalized, have been victims of violence, or are homeless; individuals of sexual minority status; and members of certain racial and ethnic minority groups.[8,9,12,13,143] Supporting people at risk requires proactive case finding and effective response, crisis intervention, and evidence-based treatment. Finding optimal ways of identifying at risk individuals, customizing services to make them more accessible (e.g., Internet-based services when appropriate) and engaging people in evidence-based care (e.g., through such measures as collaborative treatment), remain key challenges.[81,144,145] Simply improving or expanding services does not guarantee that those services will be used by people most in need, nor will it necessarily increase the number of people who follow recommended referrals or treatment. For example, some people living in disadvantaged communities may face social and economic issues that can adversely affect their ability to access supportive services.[70]

Approaches

The following approaches focus on identifying and supporting people at increased risk of suicide.

Gatekeeper training is designed to train teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services. Gatekeeper training may be implemented in a variety of settings to identify and support people at risk.[146]

Crisis intervention. These approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at risk) to trained volunteers or professional staff via telephone hotline, online chat, text messaging, or in-person. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of depression, hopelessness, and subsequent mental health care utilization.[147] Similar to means reduction, crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Treatment for people at risk of suicide can include various forms of psychotherapy delivered by licensed providers to help individuals with mental health problems and other suicide risk factors with problem-solving and emotional regulation. Treatment usually takes place in a one-on-one or group format between patients and clinicians and can vary in duration from several weeks to ongoing therapy, as needed. Treatment that employs collaborative (i.e., between patient and therapist or care manager) and/or integrated care (e.g., linkage between primary care and behavioral health care) can help engage and motivate patients, thereby increasing retention in therapy and decreasing suicide risk.[148-150]

Treatment to prevent re-attempts. These approaches typically include follow-up contact and use diverse modalities (e.g., home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts.[151] Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and one-on-one interpersonal therapy and/or group therapy. Approaches that engage and connect people who have attempted to peers and providers are especially important because many attempters do not present to aftercare; 12%-25% re-attempt within a year, and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt.[151]

Potential Outcomes

- Reductions in suicidal ideation
- Reductions in suicide attempts
- Reductions in suicide rates
- Reductions in depression and feelings of hopelessness
- Reductions in re-attempts
- Improvements in coping skills
- Increases in treatment engagement and compliance with medications

Evidence

The current evidence suggests that identifying people at risk of suicide and the continued provision of treatment and support for these individuals can positively impact suicide and its associated risk factors.

Gatekeeper training. *Applied Suicide Intervention Skills Training (ASIST)* is a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers to identify and connect with suicidal individuals, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources. In a study employing a randomized controlled trial, Gould, Cross, Pisani, Munfakh, & Kleinman[152] evaluated the training across the *National Suicide Prevention Lifeline* network of hotlines over the period 2008-2009. Using data from 1,410 suicidal individuals who called 17 Lifeline centers, the researchers found that callers who spoke with *ASIST*-trained

counselors were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of their call, compared to callers who spoke to non-*ASIST* trained counselors. Counselors trained in *ASIST* were also more skilled at keeping callers on the phone longer and establishing a connection with them. However, training in *ASIST* did not result in more comprehensive suicide risk assessments than usual care training.[152]

Gatekeeper training has also been a primary component of the *Garret Lee Smith (GLS) Suicide Prevention Program*, which has been implemented in 50 states and 50 tribes. A multi-site evaluation assessed the impact of community gatekeeper training on suicide attempts and deaths by comparing the change in suicide rates and nonfatal suicidal behavior among young people aged 10–24 in counties implementing *GLS* trainings, with the trajectory observed in similar counties that did not implement these trainings. Counties that implemented *GLS* trainings had significantly lower youth suicide rates one year following the training implementation.[153] This finding equates to a decrease of 1 suicide death per 100,000 youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010. Counties implementing *GLS* program activities also had significantly lower suicide attempt rates among youth ages 16 to 23 in the year following implementation of the *GLS* program than did similar counties that did not implement *GLS* activities (4.9 fewer attempts per 1000 youths).[154] More than 79,000 suicide attempts may have been prevented during the period examined.

Crisis intervention. Suicide prevention hotlines are one way to provide crisis intervention. In an evaluation of the effectiveness of the *National Suicide Prevention Lifeline* to prevent suicide, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a follow-up assessment between 1 and 52 days (mean=13.5 days) after the initial assessment. Researchers found that over half of the initial sample were seriously considering suicide when they called, and they had a plan for their suicide. Researchers also found that among follow-up participants, there was a significant decrease in psychological pain, hopelessness, and intent to die between initiation of the call (time 1) to follow-up (time 3).[155] Between time 2 (end of the call) to time 3, the effect remained for psychological pain and hopelessness, but was not significant for intent to die, suggesting that greater effort at outreach during and following the call is needed for callers with high levels of suicide intent.[155]

Treatment for people at risk of suicide. The *Improving Mood—Promoting Access to Collaborative Treatment (IMPACT)* program aims to prevent suicide among older primary care patients by reducing suicide ideation and depression. *IMPACT* facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager.[156] The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24-months of follow-up[156,157] relative to patients who received care as usual.

Collaborative Assessment and Management of Suicidality (CAMS), is a therapeutic approach for suicide-specific assessment and treatment. The program's flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. Sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the therapeutic alliance and increasing treatment motivation in the suicidal patient. *CAMS* has been tested and supported in 6 correlational studies,[144] in a variety of inpatient and outpatient settings, and in one RCT with several additional RCTs under way. A feasibility trial with a community-based sample of suicidal outpatients randomly assigned to *CAMS* or enhanced care as usual (intake with a psychiatrist or psychiatric nurse practitioner followed by 1-11 visits with a case manager and medication as needed) found better treatment retention among the *CAMS* group and significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at the 12 month follow-up.[158]

Other examples include *Dialectical Behavioral Therapy (DBT)* and *Attachment-Based Family Therapy (ABFT)*. *DBT* is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation issues. The components of *DBT* include individual therapy, group skills training, between-session telephone coaching and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving *DBT* were half as likely to make a suicide attempt at the two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined.[159]

ABFT is a program for adolescents aged 12–18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety.[160] A randomized controlled trial of *ABFT* found that suicidal adolescents assigned to *ABFT* experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of *ABFT* participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%).[160]

The Veterans Affairs *Translating Initiatives for Depression into Effective Solutions* project (*TIDES*) uses a depression care liaison to link primary care and mental health services. The depression care liaison assesses and educates patients and follows-up with both patients and providers between primary care visits to optimize treatment. This collaborative care increases the efficiency of providing mental health services by bringing mental health care to the primary care setting, where most patients are first detected and subsequently treated for many mental health conditions. An evaluation of *TIDES* found significant decreases in depression severity scores among 70% of primary care patients.[161] *TIDES* patients also demonstrated 85% and 95% compliance with medication and follow-up visits, respectively.[161]

Treatment to prevent re-attempts. Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicide deaths. For example, *Emergency Department Brief Intervention with Follow-up Visits* is a program that involves a one-hour discharge information session that addresses suicidal ideation and attempts, distress, risk and protective factors, alternatives to self-harm, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific timeline for up to 18 months. A randomized controlled trial that enrolled suicide attempters from eight hospital emergency departments in five countries (Brazil, India, Sri Lanka, Iran, and China) found that a brief intervention combined with nine follow-up visits over 18 months was associated with significantly fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively).[162]

Another example of treatment to prevent re-attempts involves *active follow-up contact approaches* such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers and decrease isolation.[151] These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al[151] interventions to prevent repeat suicide attempts in patients admitted to an emergency department for suicide attempt were found to reduce re-attempts by approximately 17% for up to 12 months post-discharge; however, the effects of these approaches beyond 12 months on re-attempts has not yet been demonstrated.[151] Also, because the number of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on suicide.

In a randomized controlled trial of the post-crisis suicide prevention long-term follow-up contact approach, Motto and Bostrom[163] found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than did patients in the control group who received no further contact. Other studies have also shown post-crisis letters and coping cards to be protective against suicide ideation and attempts.[164,165]

Finally, *Cognitive Behavior Therapy for Suicide Prevention (CBT-SP)* is an example of a therapeutic approach to prevent re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of proximal risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicide attempt; safety plan development; skill building; and psychoeducation. *CBT-SP* also has family skill modules focused on family support and communication patterns as well as improving the family's problem-solving skills. A randomized controlled trial of *CBT-SP* found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide re-attempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual.[166]

Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicide deaths.


DAILY NEWS
BREAKING NEWS
ECONOMY
BUSINESS
POLITICS

Lessen Harms and Prevent Future Risk

Rationale

Millions of people are bereaved by suicide every year in the United States and throughout the world.[5] Risk of suicide and suicide risk factors has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contact to suicide.[167] Care and attention to the bereaved is therefore of high importance. Despite often good intentions, media and others responding to suicide may add to this risk. For example, research suggests that exposure to sensationalized or otherwise uninformed reporting on suicide may heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to what is known as suicide contagion.[168,169]

Approaches

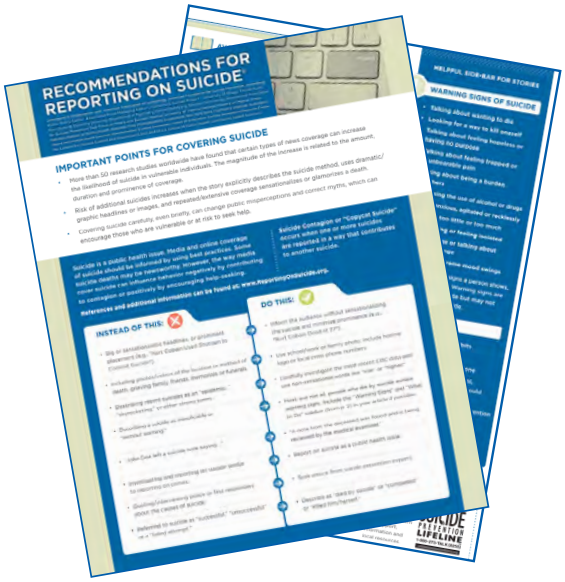
Some approaches that can be used to lessen harms and reduce future risk of suicide include postvention and safe reporting and messaging following a suicide.

Postvention approaches are implemented *after* a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, or other close contacts. These programs have not typically been evaluated for their impact on suicide, attempts, or ideation, but they may reduce survivors' guilt, feelings of depression, and complicated grief.[170]

Safe reporting and messaging about suicide. The manner in which information on a recent suicide is communicated to the public (e.g., school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Reports that are inclusive of suicide prevention messages, stories of hope and resilience, risk and protective factors, and links to helping resources (e.g., hotline), and that avoid sensationalizing events or reducing suicide to one cause, can help reduce the likelihood of suicide contagion.[171]

Potential Outcomes

- Reductions in suicidal ideation
- Reductions in suicide attempts
- Reductions in rates of suicide
- Reductions in psychological distress
- Improvements in reporting following suicide
- Reductions in contagion effects related to suicide



Evidence

Current evidence suggests that postvention and safe reporting and messaging can impact risk and protective factors for suicide.

Postvention. One example of a postvention program with evidence of impact on risk and protective factors for suicide is the *StandBy Response Service* (*StandBy*). *StandBy* provides clients with face-to-face outreach and telephone support through a professional crisis response team. Site coordinators develop customized case management plans, referring clients to other existing community services matched to their needs.[172] In a study by Visser, Comans, and Scuffham,[172] *StandBy* clients were significantly less likely to be at high risk for suicidality (suicide ideation and attempts) and had less psychological distress than a suicide bereaved comparison group who had not had contact with the *StandBy* program (48% and 64% respectively). Additionally, research suggests that active postvention approaches in which outreach to suicide survivors occurs at the scene of a suicide is associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings compared to passive postvention (i.e., approaches where survivors self-refer for services).[173]

Safe reporting and messaging about suicide. One way to ensure safe reporting and messaging about suicide is to encourage news media to adhere to *Recommendations for Reporting on Suicide* (http://www.reportingonsuicide.org). The most compelling evidence supporting these recommendations for reporting comes from Austria. After a sharp increase in suicides on the Viennese subway, media guidelines were introduced and an interrupted time-series design was used to evaluate the national impact of the guidelines on subsequent suicides. Changes in the quality and quantity of media reporting resulted in a nationwide significant reduction of 81 suicides annually.[169] Finally, research suggests that not only does reporting on suicide in a negative way (e.g., reporting on suicide myths and repetition) have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can also demonstrate protective effects against suicide.[174] Reports of individual suicidal ideation (not accompanied by reports of suicide or suicide attempts) along with reports describing a "mastery" of a crisis situation where adversities were overcome was associated with significant decreases in suicide rates in the time period immediately following such reports.[174]

Sector Involvement

Public health can play an important and unique role in addressing suicide. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate suicide prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing suicide, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone. As noted in the *National Strategy for Suicide Prevention,*[1] the integration and coordination of prevention activities across sectors and settings is critical for expanding the reach and impact of suicide prevention efforts.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

The strategies and approaches described in this technical package are summarized in the Appendix along with the relevant sectors that are well positioned to lead implementation efforts. For example, business and labor, the health sector (including insurers, providers, and health systems), and government entities are in the best position to implement programs and policies that *Strengthen Economic Supports* and *Strengthen Access and Delivery of Suicide Care*. These types of supports go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that increase the risk for suicide. Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Moreover, partnerships with non-governmental and community organizations can be instrumental in increasing awareness of and garnering support for policies affecting individuals and families.

The public health sector has been at the forefront of many community-based prevention efforts, working collaboratively with schools and community-based organizations, to change social norms and positively impact health behavior. Public health is well suited to take on a similar leadership role in *Promoting Connectedness* through peer norm and community engagement activities and supporting the development, evaluation, and adoption of effective programs that *Teach Coping and Problem-Solving Skills* to prevent the risk of suicide in the first place. These programs are often delivered in school and community settings, making education and non-governmental organizations vital partners in prevention.

Businesses, workplaces, and local and state government entities, on the other hand, are in the best position to establish policies and support practices that *Create Protective Environments* where people live, work, and play. Public health entities can serve in an important role by gathering and synthesizing information, working with other governmental agencies (e.g., criminal justice, defense) and agencies within the executive branch of their state or local government in support of policy and other approaches, and evaluating the effectiveness of measures taken. In a similar fashion, public health entities can partner with schools, workplaces, and community organizations to implement and evaluate prevention programs, policies and practices geared toward creating safe, healthy, and supportive environments.

Finally, this technical package includes a number of interventions delivered in hospital, primary care, behavioral health care, and community settings designed to *Identify and Support People at Risk*. The intensity and activities for many of these interventions require the expertise of professionals who are licensed and trained to deliver critical intervention support. The health, social services, and justice sectors can work collaboratively to support individuals at high-risk for suicide and their families. These activities also require coordination of supports across various service providers and community organizations.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in preventing the risk of suicide in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are also necessary for prevention planning and implementation.

Gathering ongoing and systematic data is important for prevention efforts. However, it is also important to gather data that are uniform and consistent across systems. Consistent data allow public health and other entities to better gauge the scope of the problem, identify high-risk groups, and monitor the effects of prevention programs and policies. Currently, it is common for different sectors, agencies, and organizations to employ varying definitions of suicidal ideation, behavior, and death that can make it difficult to consistently monitor specific outcomes across sectors and over time. For example, the manner in which deaths are classified can change from one jurisdiction to another, and can change based on local medical and/or medico-legal standards.[4] CDC's uniform definitions and recommended data elements for self-directed violence provide a useful framework to help ensure that data are collected in a consistent manner across surveillance systems.[4]

Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's *National Vital Statistics System (NVSS)*[7] and the *National Violent Death Reporting System (NVDRS)*[175] are examples of surveillance systems that provide data on deaths from suicide. *NVSS* is a nationwide surveillance system that collects demographic, geographic, and cause-of-death data from death certificates.[7] *NVDRS* is a state-based surveillance system (currently in 40 states, the District of Columbia, and Puerto Rico) that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention approaches.[175] Data from state and local Child Death Review teams[176] and Suicide Death Review Teams (which are in a few states) offer another source to identify deaths and obtain insight into the gaps in services, systems, and modifiable risk factors for suicide.

The *National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP)* provides nationally representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments, and can be used to assess national rates of, and trends in, self-harm injuries by cause (e.g., falls, poisoning, etc.), age, race/ethnicity, sex, disposition (where the injured person goes when released from the emergency department).[6]

In addition to information on deaths and nonfatal injuries, there are also surveillance systems that provide national, state, and some local estimates of suicidal behavior. The *Youth Risk Behavior Surveillance System (YRBSS)* collects information from a nationally representative sample of 9–12 grade students and is a key resource in monitoring health-risk behaviors among youth, including whether youth have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose.[177] The *YRBSS* data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies.[177] The *National Survey on Drug Use and Health (NSDUH)*[50] is an annual survey of the civilian, non-institutionalized population aged 12 years and older. *NSDUH* provides both national and state-level estimates of substance use (alcohol, tobacco, illicit drugs, and non-medical use of prescription drugs); mental health (past year mental illness, co-occurring illnesses); and service utilization, along with suicide ideation, suicide plans, and suicide attempts. *NSDUH* is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.[50]

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of suicide and its associated risk and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for suicide prevention has advanced greatly over the last few decades. However, additional research is needed to understand the impact of programs, policies, and practices on suicide (and suicide attempts, at a minimum), as opposed to merely examining their effectiveness on risk factors. More research is also needed to examine the effectiveness of primary prevention strategies (before risk occurs) and community-level strategies to prevent suicide at the population level. It will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach. Lastly, there are also many potential opportunities to build and strengthen partnerships across program areas (e.g., violence prevention, substance abuse prevention) to evaluate the impact of different approaches on multiple outcomes.

Conclusion

Suicide is a serious public health problem. Rates of suicide have been on the rise for more than a decade and the costs stretch well into the billions of dollars each year. While suicide is a rare outcome statistically, its human impact has a ripple effect that is far-reaching. Each of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide on a daily basis—at home, at work, and in our communities. Suicide and suicide attempts are public health issues of societal concern. There are a number of barriers that have impeded progress, including, for example, stigma related to help-seeking, mental illness, being a survivor and fear related to asking someone about suicidal thoughts. Fortunately, like many public health problems, suicide is preventable,[1,5] and more is being done to prevent suicide than ever before, as evidenced by the work of the National Action Alliance for Suicide Prevention,[39,40,75,88] the release of the first world report on suicide,[5] and more timely surveillance data, to name just a few examples.

In an effort to continue pushing the field and society further towards prevention, this technical package includes strategies and approaches that ideally would be used in a comprehensive, multi-level and multi-sectoral way. It includes strategies and approaches to prevent the risk of suicide in the first place, as well as strategies focused on lessening the immediate and long-term harms of suicidal behavior. It includes strategies that range from a focus on the whole population regardless of risk to strategies designed to support people at highest risk. Importantly, this technical package extends the bounds of the typical prevention strategies to consider approaches that go beyond individual behavior change to better address risk factors impacting communities and populations more broadly (e.g., economic policies to strengthen housing and financial security).

While the evidence base continues to emerge, the collection of programs, policies, and practices laid out here are available for implementation now. In keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in that implementation. Moreover, as new evidence becomes available, this technical package can be refined to reflect the current state of the science.

In closing, and in keeping with a message of resilience as spoken by those with lived experience, "hope, help, and healing is possible."

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Appendix: Summary of Strategies and Approaches to Prevent Suicide

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/ Protective Factors for Suicide	
Strengthen economic supports	**Strengthening household financial security**				Government (local, state, Federal) Business/Labor
	Unemployment benefit programs	✓		✓	
	Other income supports	✓			
	Housing stabilization policies				Government (local, state, Federal)
	Neighborhood Stabilization Program			✓	
Strengthen access and delivery of suicide care	**Coverage of mental health conditions in health insurance policies**				Government (local, state, Federal) Healthcare Social Services
	Mental Health Parity Laws	✓		✓	
	Reduce provider shortages in underserved areas				
	National Health Service Corps (NHSC)			✓	
	Telemental Health (TMH)			✓	
	Safer suicide care through systems change				
	Henry Ford Perfect Depression Care (Pre-cursor to Zero Suicide)	✓		✓	
Create protective environments	**Reduce access to lethal means among persons at risk**				Government (local, state) Public Health Healthcare
	Intervening at suicide hot spots	✓			
	Safe storage practices		✓	✓	
	Emergency Department Counseling on Access to Lethal Means (ED CALM)			✓	
	Organizational policies and culture				Business/labor Justice Government (local, state, Federal)
	Together for Life	✓			
	US Air Force Suicide Prevention Program	✓		✓	
	Correctional suicide prevention	✓			
	Community-based policies to reduce excessive alcohol use				Government (local, state) Business/labor
	Alcohol outlet density	✓		✓	
Promote connectedness	**Peer norm programs**				Public Health Education
	Sources of Strength			✓	
	Community engagement activities				Public Health Government (local)
	Greening vacant urban spaces			✓	

*This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing specific activities.

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/ Protective Factors for Suicide	
Teach coping and problem-solving skills	**Social-emotional learning programs**				Public Health Education
	Youth Aware of Mental Health Program		✓	✓	
	Good Behavior Game		✓	✓	
	Parenting skill and family relationship approaches				Public Health Education
	The Incredible Years			✓	
	Strengthening Families 10–14			✓	
Identify and support people at risk	**Gatekeeper training**				Public Health Health Care
	Applied Suicide Intervention Skills Training			✓	
	Garret Lee Smith Suicide Prevention Program	✓	✓		
	Crisis intervention				Public Health Social Services
	National Suicide Prevention Lifeline		✓	✓	
	Treatment for people at risk of suicide				Healthcare Social Services Justice
	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)		✓	✓	
	Collaborative Assessment and Management of Suicidality (CAMS)		✓	✓	
	Dialectical Behavioral Therapy (DBT)		✓	✓	
	Attachment-Based Family Therapy (ABFT)		✓		
	Translating Initiatives for Depression into Effective Solutions project (TIDES)			✓	
	Treatment to prevent re-attempts				Healthcare Social Services
	ED Brief Intervention with Follow-up Visits	✓			
	Active follow-up contact approaches	✓	✓		
	CBT for Suicide Prevention		✓		
Lessen harms and prevent future risk	**Postvention**				Healthcare
	StandBy Response Service		✓	✓	
	Safe reporting and message about suicide				Public Health Media
	Media Guidelines	✓			

*This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing specific activities.

For more information

To learn more about preventing suicide, call 1-800-CDC-INFO or visit CDC's violence prevention pages at www.cdc.gov/violenceprevention.

National Center for Injury Prevention and Control
Division of Violence Prevention

AK2017

CourtSmart Tag Report

Room: SB 301 **Case No.:** **Type:**
Caption: Senate Children, Families, and Elder Affairs Committee **Judge:**

Started: 9/17/2019 11:02:37 AM
Ends: 9/17/2019 1:19:27 PM Length: 02:16:51

11:03:16 AM Opening remarks by Chair Book
11:03:58 AM Introductions by Speakers
11:04:25 AM Maggie Lambarta introduces herself
11:04:49 AM Former Rene Garcia
11:05:12 AM Kevin Hines, Suicide Survivor introduces himself
11:06:25 AM Secretary Burgess, Dept. Veterans'' Affairs introduces himself
11:08:03 AM Dr. Sofia Castro Suicide Prevention Specialist introduces herself
11:09:03 AM Jacob Oliva, Chancellor Dept. of Education
11:09:51 AM Sofia Castro explains her charts
11:12:55 AM Chair Book speaks
11:13:55 AM Sofia Castrol answers Chair Books question regarding increase in deaths during certain times of the year
11:14:47 AM Chair Book asks what role does social media play
11:15:10 AM Dr. Maggie Labarta speaks to answer Chair's question
11:15:37 AM Dr Labarta explains how social media teaches kids how to commit suicide
11:16:32 AM Dr. Labarta also speaks on how bullying can increase suicide rates
11:16:51 AM Jacob Oliva speaks on social medias role
11:17:11 AM Jacob Oliva also says that silica media can have a positive effective if used properly
11:17:53 AM Jacob Oliva speaks about additional funding to teach kids how to act responsible
11:19:07 AM Chair Book speaks on how anyone can fall victim and what are groups most vulnerable
11:20:12 AM Sofia Castro speaks on age if children vulnerable and mental health issues
11:21:20 AM Sofia Castrol speaks on white males having the highest suicide rate
11:22:19 AM Sophia says that in 2016 female teenagers had a higher rate of suicide
11:22:57 AM Senator Garcia speaks on unique risks and national averages
11:24:09 AM Senator Garcia continues to speak
11:25:35 AM Senator Garcia speaks on accountability for suicide prevention provider
11:27:20 AM Dr. Maggie Labarta speaks about accessing risk
11:28:20 AM Dr., Labarta speaks about economic and social issues that can contribute
11:30:31 AM ACES Adverse Childhood Experiences further explains by Dr. Labarta
11:31:31 AM Dr. Labarta speaks on how to lower ACE scores
11:32:06 AM Secretary Danny Burgess speaks on the impacts of suicide on Veterans'
11:32:53 AM Mr., Burgess speaks about transitioning into civilian life
11:33:45 AM Mr. Burgess speaks about PTSD and the recovery process
11:34:45 AM Mr. Burgess speaks about Traumatic Brain Injury being a trigger point
11:35:24 AM Mr. Burgess speaks about alternative therapy process that Senator Wright sponsored
11:36:13 AM 211 crisis hotline by Senator HARRELL
11:36:41 AM Chair Book introduces Kevin Hines
11:37:42 AM Kevin Hines speaks on how it is to be a survivor
11:38:11 AM Kevin was born into poverty and living in hotels
11:38:50 AM Kevin and his brother were placed in foster care
11:39:18 AM Kevin’s brother dies from a lung infection due to neglect
11:39:44 AM Kevin said he did get adopted into a nice home he had abandonment issues

11:40:19 AM Kevin says our brain would break and come crumbling down from all the pressure of dealing with life and issues
11:41:03 AM He was being treated for bipolar and epileptic seizers
11:42:08 AM in Sept 2001 Kevin jumped off the Golden Gate Bridge
11:43:08 AM Kevin said all he wanted that day was for someone to reach out to him and ask if he's ok
11:44:16 AM Kevin speaks on the many surgeries and rehab it took to survivor
11:45:15 AM Kevin said he also had an instant regret for what he's done
11:45:39 AM Our thoughts don't have to own or rule our reactions
11:46:16 AM Kevin has a built in prevention plan for himself when he feels down and a way to go forward
11:47:16 AM Kevin say media should create more positive platforms
11:48:20 AM Kevin says we need to be more creative in being positive
11:49:21 AM Chair Books gives info on suicide hotline
11:49:48 AM Chair Book would also like panel to explain some of the services available
11:50:12 AM Mr. Oliva speaks how to help kids in school
11:50:31 AM Mr. Oliva speaks of steps and evaluation process for kids
11:51:32 AM Mr. Oliva and explains how a system of care can be positive
11:52:16 AM Mr. Oliva explains how certain school districts explains who is responsible for students
11:52:50 AM Mr. Oliva said funding has been increased for employees and training
11:53:15 AM Mr. Oliva speaks of screening implementation and evaluation process
11:54:11 AM Making sure kids have positive activities
11:54:55 AM Chair Books asks question regarding parents intervention and asking questions
11:55:54 AM Dr. Labarta says if child is Baker acted then they can speak w/o parents' permission
11:56:29 AM Dr. Labarta speaks about the Baker act and it's need to be updated
11:57:18 AM dr. Labarta speaks about needing 72 hours to speak with students and make a plan
11:58:16 AM Dr. Labarta says it is important to let kids speak without parents around
11:59:16 AM Dr. Labarta speaks about 3 tier first level in schools being trained in mental health
12:00:02 PM See Us YouTube from Leon County Schools
12:00:39 PM Hope squads are peer lead and how effective they are
12:01:02 PM PALS by the University of Florida kids helping kids
12:02:07 PM Dr. Labarta speaks out early education and prevention
12:03:07 PM Chair asks about the LGBT youth and how this effects them
12:03:31 PM Dr. Labarta speaks LGBT kids are so vulnerable and internal stress
12:04:21 PM Dr. Labarta speaks about community and schools finding acceptance
12:05:26 PM Chair Books asks are there services available and are they efficient
12:06:09 PM Mr. Burgess speaks that there is more we can do to work with our local communities
12:06:45 PM looking to expand the 211 process
12:06:58 PM Senator Simpson helped expand the crises hotline
12:07:15 PM Veteran's hotline for suicide prevention for peer to peer
12:07:51 PM Mr. Burgess said we need to take this statewide with the 211 program
12:08:50 PM Chair Book asks Garcia to explain things we need to be doing
12:09:40 PM Senator Garcia said peer specialist is of the utmost importance
12:10:02 PM Senator Garcia says peer specialist says money and lives
12:10:37 PM Senator Garcia need special health care for veterans'
12:11:03 PM Senator Garcia says veterans' need to have choices with healthcare choices
12:11:51 PM Senator Garcia says doctors and PCP need to have open communication
12:12:31 PM Senator Garcia suggests a portal to open communication so people have choices
12:13:03 PM Senator Garcia says let's eliminate the stigma of mental health
12:13:54 PM Partner with Feds to develop a system to get assistance veterans
12:14:22 PM Senator Garcia says teaming up with the Feds is key to success for vets and their family
12:15:25 PM Senator Harrell addressed federal legislation and needs for enablement

12:16:26 PM Senator Garcia says VA are very interested in working with state
12:17:05 PM Garcia says they want to are very happy for what Florida wants to do with their funding
12:17:37 PM Garcia speaks about our robust managed care
12:18:18 PM Senator Harrell wants to address families of veterans' and PTSD and how it effects them
12:19:34 PM Mr. Burgess says families are absolutely effected
12:20:34 PM Mr. burgess says the 211 plan is available for families
12:20:50 PM Mr. burgess speaks of paring so families can stay together
12:21:23 PM GI Law for pro bono services to vets and their families
12:22:30 PM chair Book speaks about our next meeting
12:23:29 PM Senator Torres speaks as a veteran and about funding for veteran and counselors for kids
12:24:08 PM Senator Torres speaks about the need to get word out on services available
12:24:53 PM Torres says bottom line is communication for providers
12:25:47 PM Torres speaks about the rap around program in schools and how effective they are
12:26:07 PM Chair Books thanks the entire panel and next meeting will consider a committee bill
12:26:38 PM Chair book speaks about draft of reporting bill
12:26:53 PM Recording Paused
12:31:50 PM Monitor has changed View