Missouri Suicide Prevention Plan

A Collaborative Effort

Bringing a National Dialogue to the State

(Revised 2012)

The Personal and Public Tragedy of Suicide

The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.

Kay Redfield Jamison

Suicide is the eleventh leading cause of death for adults and the third leading cause for kids.

There are many more suicides in Missouri than homicides

Every day two people die by suicide in Missouri

INTRODUCTION

Purpose of the Suicide Prevention Plan

"Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives."[1] "Compounding the tragedy of loss of life, suicide evokes complicated and uncomfortable reactions in most of us. Too often, we blame the victim and stigmatize the surviving family members and friends. These reactions add to the survivors' burden of hurt, intensify their isolation, and shroud suicide in secrecy."[2]

In response to national recognition of suicide as a worldwide public health problem, collaborative planning efforts began in Missouri that resulted in the passage of legislation in 2003 that mandates the development of this statewide suicide prevention plan. The Missouri Suicide Prevention Plan has been developed with broad input from public health experts, mental health providers, suicide survivors and twelve town hall meetings conducted in communities across Missouri (Appendix 1). The recommendations have been developed using reviews of research, experience of other states in suicide prevention and experience gained in suicide prevention efforts in Missouri. Broad community input was sought to tailor the scientific knowledge and national experience to address the specific needs of Missouri communities and organizations.

The planning process united various organizations and brought together partners who each play a role in identifying and solving the problem. This Plan was designed to assist stakeholders in providing services where most needed and where gaps in service exist, thus avoiding duplication and competition by suggesting ways to coordinate activities. This plan was developed to raise awareness of the suicide problem not only among the agencies and groups involved in the planning process, but also among the general population. This plan has been written in such a way as to be applicable to all groups and populations. And lastly, this plan encourages individual communities to develop customized strategies and implement them in a manner that fits their local needs and resources. All Missourians are urged to act on these recommendations to help reduce the preventable tragedy of suicide.

Suicide Prevention Principles for Missouri

This plan seeks to encourage the development of community-based plans and programs that:

- Enhance or strengthen protective factors and reduce the impact of risk factors;
- Promote and address help-seeking behaviors as the norm;
- Are targeted to the level and type of risk of the specific population in Missouri;

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[1] National Strategy for Suicide Prevention, p. 17
[2] Surgeon General's Call to Action

- Are developmentally appropriate and culturally sensitive;
- Are focused and adapted to the specific needs of a local area's population; and
- Are sustainable with repeated positive messages, prevention strategies and evaluation.

Definitions and clarifiers are included in the Appendix.

SUICIDE PREVENTION AND THE PUBLIC HEALTH APPROACH

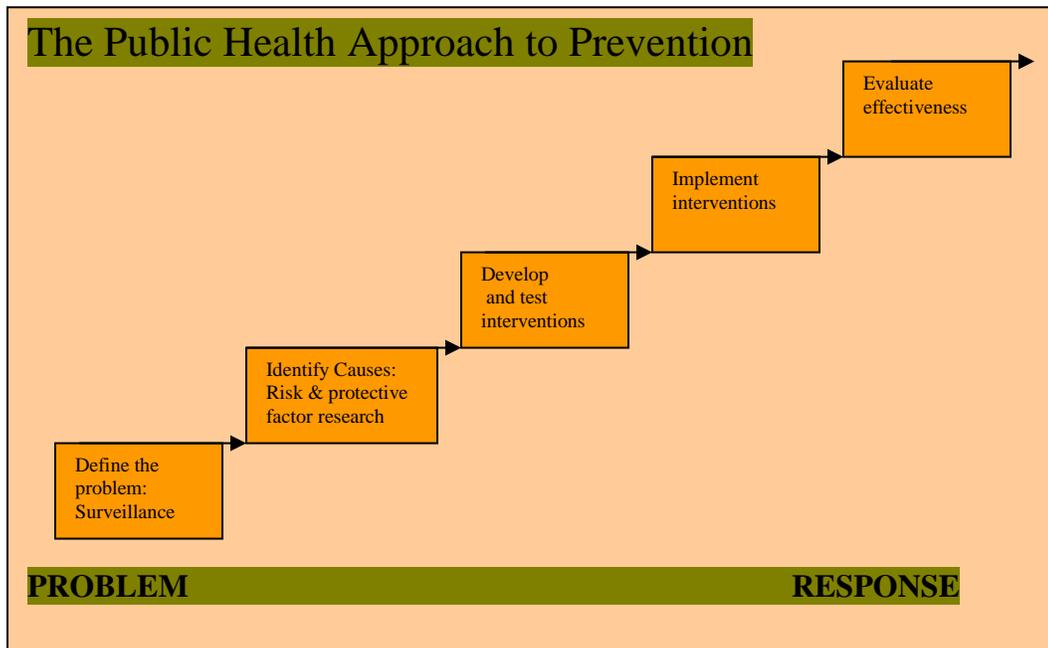**Suicide is a preventable public health problem.**

Suicide is a major health problem because of the large number of people impacted and the enormous health care costs associated with it. However, there is a growing body of evidence that indicates that suicide is preventable. A large number of researchers have undertaken the task of understanding the roots of suicide and preventing its occurrence. Suicide can be prevented and its impact reduced in much the same way as public health efforts have prevented and reduced other health problems, such as infectious diseases, pregnancy complications, and injuries.

What can a Public Health Approach Contribute to Suicide Prevention?

The public health approach is a rational and systematic way to marshal prevention efforts and to assure that those efforts are effective. There are several characteristics of the public health approach that makes it the ideal way to address suicide prevention.

In concert with the clinical medical approach, which explores the history and health conditions that could lead to suicide in an individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior within a population group. The public health approach is based on the rigorous requirements of the scientific method, moving from problem to solution. It starts by defining the problem, and then identifies the risk factors, protective factors and causes of the problem. Utilizing that information, interventions are developed, implemented and evaluated for effectiveness.

The public health approach to any problem is interdisciplinary and draws upon the knowledge of many disciplines. This broad knowledge base allows the field of public health to be innovative and responsive to the many different underlying issues thought to be associated with suicide and suicidal behavior. The public health approach emphasizes collective action and cooperative efforts among diverse agencies such as health, mental heath, social services, education, law enforcement and corrections. The public health approach requires individuals, communities, organizations and leaders at all levels to collaborate in promoting suicide prevention.

The Public Health Approach to Prevention

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                                                          │ Evaluate     │──►
                                                          │ effectiveness│
                                          ┌──────────────┐└──────────────┘
                                          │ Implement    │
                                          │ interventions│
                            ┌────────────┐└──────────────┘
                            │ Develop    │
                            │ and test   │
                            │ interventions│
              ┌──────────────┐
              │ Identify Causes:│
              │ Risk & protective│
              │ factor research │
  ┌────────────┐
  │ Define the │
  │ problem:   │
  │ Surveillance│
  └────────────┘
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PROBLEM   **RESPONSE**

Although the diagram above suggests a linear progression from the first step to the last, in reality the steps often overlap and depend upon each other. In fact, the evaluation of effectiveness itself leads to a redefining of the problem and additional surveillance. The public health approach is a cycle. The next three sections of this report will address the specific steps of the public health model.

DEFINING THE PROBLEM OF SUICIDE

Suicide exacts an enormous toll from the American people.
- Suicide claims more than 38,364 American lives (2010).
- Suicide ranks as the 10th leading cause of death in the U.S.
- The rate of suicide is 12.4 per 100,000 equaling almost 1.5% of all deaths.
- An average of 1 person kills themselves every 13.7 minutes.
- For each completed suicide, as many as 25 people may make a non-lethal attempt.

Suicide affects everyone, but some populations have higher numbers.
- Suicide is the 3rd leading cause of death for youth age 15 – 24.
  - 15.8% of students have 'seriously considered' attempting suicide in the last 12 months.
  - 7.8% have made a suicide attempt in the last 12 months.
- Older adults (age 65 and over) account for 15.6% of completed suicides.
  - For those over the age of 65, there is 1 suicide for every 4 attempts.
  - About 60% of elderly patients who take their own lives have seen their primary care physician within a few months of their death.

More Missourians die by suicide than by DWI, homicide, or AIDS.
- Missouri's rate of suicide is 14.3 / 100,000, which is the highest in Region VII (Kansas, Iowa, Nebraska and Missouri).
- Suicide is the 10th leading cause of death in Missouri.
- An average of 842 Missourians die by suicide annually (over the period 2007-2011).
- The leading methods of suicide in Missouri are: firearms (56%), suffocation (21%), and poisoning (18%)
- Men account for 79% of completed suicides; women 21%
- 93.6% of deaths by suicide are white non-Hispanics; while 5.1% are black/African-American

Note: National data are from the American Association of Suicidology, U.S.A. Suicide: 2010 Official Final Data, www.suicidology.org.

Missouri data are from the Missouri Department of Health and Senior Services, Death MICA Statistics, http://health.mo.gov/data/mica/mica/death.php.

RISK FACTORS AND PROTECTIVE FACTORS

The public health approach to suicide prevention often is based on decreasing risk factors associated with suicidal behavior and enhancing the protective factors. Understanding the interactive relationship between risk and protective factors in suicidal behavior continues to be studied and drives the development of interventions.

Risk Factors
Risk factors are a combination of stressful events, situations, and/or conditions that may increase the likelihood of suicide, especially when several coincide at any given time.
Risk factors for suicide include but are not limited to[3]:

Biopsychosocial Risk Factors:
- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders;
- Alcohol and other substance use disorders;
- Hopelessness;
- Impulsive and/or aggressive tendencies;
- History of trauma or abuse (bullying, violence and assault);
- Some major physical illnesses;
- Previous suicide attempt; and
- Family history of suicide.

Environmental Risk Factors:
- Job or financial loss;
- Relational or social loss (divorce, incarceration, legal problems);
- Easy access to lethal means; and
- Local clusters of suicide that have a contagious influence.

Sociocultural Risk Factors:
- Lack of social support and sense of isolation;
- Stigma associated with help-seeking behavior;
- Barriers to accessing health care, especially mental health and substance abuse treatment;
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma); and
- Exposure to suicidal behavior of others, including through media coverage and influence of others who have died by suicide

Protective Factors
Protective factors make it less likely that individuals will develop suicidal ideations; and may encompass biological, psychological or social factors in the individual, family and environment. Protective factors include: [4]

- Effective clinical care for mental, physical, and substance use disorders;

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[3] National Suicide Prevention Strategy
[4] National Suicide Prevention Strategy

o   Easy access to a variety of clinical interventions and support for help-seeking;
o   Restricted access to highly lethal means of suicide;
o   Strong connections to family and community support;
o   Support through ongoing medical and mental health care relationships;
o   Skills in problem solving, conflict resolution, and nonviolent handling of disputes; and
o   Cultural and religious beliefs that discourage suicide and support self-preservation.

INTERVENTIONS: DEVELOPMENT, IMPLEMENTATION AND EVALUATION

The first two steps of the public health model provide important information about populations impacted by suicide. Developing that knowledge into effective interventions is a central goal of public health.   Researchers in the field of suicide prevention are focusing efforts on specific groups. Interventions are grouped as follows:

Universal Interventions aimed at the general population without regard to individual risk.

Selected interventions aimed at those considered at heightened risk for suicide (having one or more risk factors).

Indicated Interventions aimed at specific individuals that have a risk factor or condition that puts them at extreme high risk.

Many suicide interventions have been developed and are being implemented; most continue to be evaluated to determine their effectiveness. Some of the more common interventions include clinical treatment, behavioral and relationship approaches, community-based efforts such as suicide and crisis prevention centers, school-based interventions, restricting access to means, gatekeeper training, improved access to care, awareness campaigns, media reporting and interventions with survivors.

The development, implementation and evaluation of effective interventions in Missouri is a major goal of this plan. The plan is intended to provide broad guidelines from which communities can base local planning and implementation efforts.

Recommendation

Communities should use this plan as a guide to the development and implementation of their own local plans. Through strong community action, the overall goal of this plan for suicide prevention is to reduce suicide and suicidal behaviors in all populations. Missouri has followed the AIM framework (Awareness, Intervention, Methodology) as stated in the Surgeon General's Call to Action with recommendations for initiatives in each of the three areas, awareness, interventions, and methodology.

Suicide is a huge, complex problem and Missouri's communities are too diverse in their members and needs for a single intervention to be adequate. Thus, a diverse array of interventions will be required to meet the particular local needs of the many unique communities in Missouri. Collaboration is essential if the activities outlined in this section are to be effective. The following are key to the success of this plan:

- Suicide prevention is everybody's responsibility. Every Missourian should effectively promote prevention efforts, whether at the individual, community or agency level.

- Additional federal, state and local funding should be pursued to increase access to mental health and substance abuse treatment and suicide prevention efforts.

Focus 1 - Awareness

In Missouri, the suicide prevention messages should be consistent among all those engaged with awareness efforts. That message should include information regarding:

- Risk and protective factors,

- Stigma reduction by increasing the acceptability of asking for help around mental health issues,

- The importance of screening and early interventions,

- The effectiveness of treatments currently available for mental illness and substance abuse disorders,

- Where to go for help. (See resource list.)

Action 1: Develop public awareness initiatives designed to change attitudes toward accessing care, the acceptability of seeking help and the availability of treatment.

- Develop public service announcements, brochures, resource guides; billboards, videos, Internet Web sites, and a speaker's bureau.

- Identify community partnerships and collaborations to distribute information.

- Identify funds and resources to assist in local implementation of awareness efforts.

- Promote the use of national and state suicide prevention hotline numbers.

- Develop strategies to target specific groups to receive information from the public awareness initiative. These groups will include but not be limited to the following:
    - Journalists, including print and broadcast media;
    - School boards, administrators, staff, and students;
    - Social services, health, mental health and criminal justice professionals;
    - Public officials, libraries, clergy;
    - Consumers, survivors and families; and
    - Employer associations, unions and safety councils.
- Promote inclusion of suicide prevention as part of conferences and training that pertain to high risk populations.

Action 2: Promote activities to further investigate and implement ways to influence positive attitudes and behaviors (to seek help and to access appropriate treatment).

Action 3: Develop training and education opportunities for providers of services to high-risk populations; including but not limited to:

- Education professionals:
- Case managers;
- Criminal justice professionals;
- Older adult service agencies, including Area Agencies on Aging (AAAs)
- Child and adolescent program providers;
- Social services, health, and mental health professionals;
- Employee assistance programs; and
- Suicide prevention training experience should be included in:
    - Basic professional development courses,
    - Continuing education courses and workshops,
    - Conferences and training sessions,
    - Existing community based forums attended by the above groups.

Action 4: Ensure that the suicide prevention message is consistent across agencies and that the prevention strategies and information about the risk and protective factors are integrated into suicide-related materials of all groups and agencies.

- Monitor the development of suicide prevention messages and assure that they are guided by the state plan.

Focus 2 - Interventions

Improve access and availability of services that encourage early detection, promote intervention and eliminate stigma associated with suicidal ideation/behavior.

Action 5: Endorse, recommend and/or develop appropriate screening tools.
- Assessment of coping and problem solving skills and help seeking behaviors;
- Promote informal mental health screenings (anxiety, depression, stress, etc);
- Encourage inclusion of formal mental health screenings to the medical community; and
- Assure use of age appropriate tools for early identification of suicidal ideation across the lifespan.

Action 6: Promote the development of prevention and intervention training within communities for all citizens.
- Develop community education opportunities;
- Recommend gatekeeper training curricula;
- Include suicide prevention and intervention training for those working in elementary and secondary education and institutions of higher learning;
- Identify key members of the community, both professional and lay persons;
- Target providers of services to high-risk populations; including but not limited to:
  o Education,
  o Case managers,
  o Criminal justice professionals,
  o Older adult service agencies, including Area Agencies on Aging,
  o Child & adolescent program providers,
  o Social services, health and mental health professionals,
  o Employee assistance programs, and
  o Churches, synagogues, mosques
- Suicide prevention training component(s) should be included in:
  o Professional curricula development,
  o Continuing education and refresher opportunities,
  o Conferences and related enrichment, and
  o Community based forums.

Action 7: Publicize community, state and national crisis telephone hotlines.
- Develop community rosters of available telephone services; and
- Assist providers of telephone services in marketing of services

Action 8: Develop community-based interventions/action plans that support participation of minority and non-traditional populations (caregivers, 1st responders, etc.).
- Support the development of community-based forums to address suicide;
- Involve local communities and support local efforts to prevent suicide by assessing and acting on local risk or protective factors;
- Provide or assist in obtaining funding for prevention initiatives sponsored by local efforts; and
- Facilitate formation of new suicide survivor support groups

Action 9: Promote and encourage the use of existing local prevention and intervention resources including but not limited to:
- Mental health service providers;
- Community service providers;
- Opportunities to facilitate community networking; and
- Development of a community resource guide; provided via access to a data base or website.

Action 10: Encourage collaboration among law enforcement, mental health and other service providers.
- Implement crisis intervention teams; and
- Cross train staff for greater understanding of situation management and to impact a positive end result

Action 11: Improve capacity for primary care providers to refer patients for appropriate care.
- Strive for mental health and substance abuse treatment insurance parity; and
- Identify and reduce barriers to adequate care (transportation, provider availability, facility location, financial, work-related, etc.).

Action 12: Promote the use of follow-up protocols and supports.
- Identify and provide protective services after suicide risk has been identified (support groups, skill building/educational programs, self-enhancement activities);
- Eliminate barriers in public and private insurance programs for provision of mental health treatments;
- Develop and implement effective training and support programs for family members of those at risk; and
- Identify protocols for aftercare for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.

Focus 3 - Methodology

Action 13: Develop methods to assess the occurrence of suicide attempts and suicide completions in Missouri.
- Improve reporting and the accurate surveillance of suicide and suicidal behaviors.

Action 14: Promote the development of scientific knowledge in suicide prevention activities within the state and the establishment of research partnerships.
- Review suicide prevention projects for their potential to add to evidence-based prevention knowledge and their effectiveness in diverse settings and among different age, gender and ethnic subgroups; and
- Foster partnerships to conduct scientific research and secure external funding.

Action 15: Assess the cultural, gender, and age attitudes toward getting help for depression and suicide, as well as the barriers (stigma) related to refusing help, and the attitudes of Missourians about clinical interventions for mood disorders (psychotropic medication and psychotherapy).

Bibliography

Children's Safety Network. (2000). *Fact sheets: Youth suicide prevention plans*. Newton, MA: Education Development Center.

Satcher, David. *Remarks of Surgeon General David Satcher at the release of The Surgeon General's Call to Action.* Delivered July 28, 1999. Retrieved June 19, 2004, from http://www.surgeongeneral.gov/library/calltoaction/remarks.htm

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General – Executive Summary*. Rockville, MD: US. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

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 Mental Health, 1999.

U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide*. Washington, DC: 1999.

APPENDIXES

1. TOWN HALL MEETING
2. HISTORY OF THE MISSOURI PLANNING PROCESS
3. EVIDENCE BASE FOR SUICIDE PREVENTION
4. RESOURCES
5. GLOSSARY

APPENDIX I

Report

on the

Town Hall Meetings

for the

Missouri Suicide Prevention Plan

A Collaborative Effort

Go to the people
Work with them
Learn from them
Respect them
Start with what they know
Build with what they have

And when the work is done
The task accomplished
The people will say,
"we have done this ourselves"
                    -Lao Tsu, China 700 BC

Introduction

Town Hall Meetings were held throughout the state during July, August and September of 2004 to receive public input on the draft suicide prevention plan in preparation for submission to the state legislature by December 31, 2004 as mandated by legislation passed in 2003. The plan is titled "Missouri Suicide Prevention Plan: A Collaborative Effort". This report is divided into two sections, one that describes the process used and the other describes the input received.

Process

A "Call to Host" was sent to mental health, health, corrections, education, and community-based organizations in April and May. Approximately twenty-three agencies and organizations responded to the call to host the town hall meetings. Many of who resided in the same cities or in close proximity to each other, thus some agencies agreed to share the responsibility of hosting town hall meetings. Host agency responsibilities included:

- Providing adequate space to hold a three to four hour meeting that is accessible to the community.
- Assisting in the general advertisement and promotion of the town hall meeting and to notify and involve key community leaders.
- Providing light refreshments (coffee or water) – optional.

The Town Hall Meetings were held in fourteen communities and generally lasted for approximately 2 hours. Approximately 535 individuals were in attendance. Participants included consumers, survivors and community representatives from health, mental health, alcohol and drug abuse, corrections, police, funeral directors, and educational agencies. The plan was made available prior to the meetings and attendees were encouraged to read the plan prior to the meeting.

The meetings consisted of a Power Point presentation describing the development and contents of the plan, an open mike session, and breakout groups. Participants were asked to respond to the plan by answering the following questions:

1. What did you like about the plan and why?
2. What did you like least about the plan and why?
3. What has not been included, but should be?
4. What can be done to make it more likely that people will act on recommendations and become involved in suicide prevention activities?

Participants were given three methods to provide general feedback and to respond to these four questions:

1. Attendees were given an opportunity to provide verbal feedback during the meeting during the open mike session and during the group breakout sessions.
2. Feedback cards that listed the four questions were distributed to each attendee. They were asked to provide written feedback and to submit the cards at the end of the meeting.
3. Attendees were given a dedicated e-mail to send additional comments after the meeting.

Input

Surveys of the attendees during the meetings revealed that 80 to 90% of the attendees had not read the plan prior to the meeting. A summary of responses from the fourteen meetings to each of the four questions are listed below.

1. What did you like about the plan and why?

All attendees recognized the importance of suicide prevention and expressed the need for collaborative action. Attendees favorably responded to the use of the National Suicide Prevention Strategies, the Surgeon General's Call to Action and the Public Health Approach as models for the state plan.

Other components of the plan that received recurring positive comments included: use of local community resources, awareness and prevention education, early identification of risk factors, evidence based practices, stigma reducing strategies, and attention to survivors' issues. Comments reflected the plan was comprehensive, broad based, well organized and easy to read.

2. What did you like least about the plan and why?

In summarizing the written comments received for this question, it became more evident that many of the attendees were not familiar with the plan and that the questions were misinterpreted. For example many comments listed were more accurately in response to question number 3.

Many of the comments under this question reflect a desire for more information and education on specific risk factors and at risk groups (for example violence and abuse and specific age categories). The items participants liked least about the plan is that it did not include how the plan was to be funded.

3. What has not been included but should be?

Funding was the major point identified as missing from the plan; how to access money, sustain programming and fund efforts seemed to be the primary roadblock. Interventions for specific populations (G/L/B/T, Hispanic, rural, youth/elderly, etc.) identification of and access to resources (telephone hotline numbers, crisis services, and counseling services), improved skill building programs (coping, awareness, teacher education, etc.) identification of reference materials, websites, and training curricula were frequently cited. The lack of psychiatric

inpatient beds and after hours crisis options were frequently mentioned.

4. What can be done to make it more likely that people will act on recommendations and become involved in suicide prevention activities?

Creating media advertising and community based awareness campaigns were identified as the leading way to get people involved. Enhancing public education, creating greater awareness and making training opportunities more readily available were recommended. Identifying 'systems of care' within communities, options and availability for help, and how to become a 'helper' were recommendations as well. Collaborative efforts that advance advocacy, reduce stigma and encourage greater community involvement were also suggested.

Conclusion

The Town Hall meeting process allowed for considerable input from consumers, survivors and providers at the local level. The plan was generally well received and community input was productive. Town Hall audiences were supportive of the plan and expressed hope that it would be implemented. Many criticisms of the plan resulted from not having read the draft prior to the meeting: other critiques were useful to the writing team and they worked to finalize the draft plan.

APPENDIX II

ACTING ON SUICIDE PREVENTION
MISSOURI'S ROLE IN A NATIONAL MOVEMENT

A.   Call to Action

In 1998 the U.S. Surgeon General, David Satcher, identified suicide as a major public health problem. He convened more than 450 leading public health officials, mental health professionals and consumer advocates from all over the country to begin the process of addressing suicide as a significant health problem. This resulted in *The Surgeon General's Call to Action to Prevent Suicide (1999)* where Dr. Satcher established the promise that

> "We must promote public awareness that suicides are preventable. We must enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment. And we must reduce the stigma associated with mental illness that keeps many people from seeking help that could save their lives."

The Surgeon General's Call to Action to Prevent Suicide presented the nation with an initial blueprint for addressing suicide AIM
- Awareness,
- Intervention
- Methodology

AIM provided both the framework for immediate implementation of suicide prevention initiatives and also served as the foundation for development of the more comprehensive *National Strategy for Suicide Prevention*.

B.   National Strategy for Suicide Prevention

In 2001 the U.S. Department of Health and Human Services, through the Surgeon General's Office issued the *National Strategy for Suicide Prevention*. The strategy identifies suicides high cost to the American nation noting that as the eighth leading cause of death in Americans, suicide kills 50% more people than homicide and twice as many people as HIV/Aids. The goal of the strategy is to provide national guidance to prevent suicide and reduce the rates of suicidal behaviors, reduce the traumatic after effects that suicide has on family and friends and to enhance the resiliency and interconnectedness of individuals and their communities. The national goals are:
1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
4. Develop and implement suicide prevention programs

5. Promote efforts to reduce access to lethal means and methods of self-harm
6. Implement training for recognition of at-risk behavior and delivery of effective treatment
7. Develop and promote effective clinical and professional practices
8. Improve access to and community linkages with mental health and substance abuse services.
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media
10. Promote and support research on suicide and suicide prevention
11. Improve and expand surveillance systems

C.   The *Missouri Suicide Prevention Plan 2001-2003*.

The initial *Missouri Suicide Prevention Plan 2001-2003* was developed in a collaborative process headed by then Missouri Department of Health and Missouri Department of Mental Health using a series of regional and statewide planning meetings that also included Department of Elementary and Secondary Education, Department of Corrections, community self-help groups and survivors. This plan using the AIM format led to actions including:

1. Public awareness campaigns using radio, TV and billboards.
2. Suicide prevention training for professional caregivers including public health nurses, school counselors, gambling counselors, substance abuse counselors, probation and parole officers and others
3. Training of hundreds of Suicide Prevention Gatekeepers (gatekeepers are anyone who by virtue of their daily activity come into contact with individuals who may be at risk for suicide and can recognize and refer for help).
4. Community based efforts.

D.   The Missouri Legislature takes Action

In Fall of 2003 the 92nd General Assembly passed the bipartisan House Bill #'s 59 and 269 directing the Director of the Department of Mental Health in partnership with the Department of Health and Senior Services in collaboration with other agencies and community organizations to develop a new state suicide prevention plan including but not limited to workplaces, schools and public and community health settings. The plan was submitted to the general assembly in 2004.

Appendix III
Evidence Base for Suicide Prevention

Strategy	Rationale	Limitations	Effect
School-based Suicide Awareness Curriculum	Some research available on teenager's attitudes on help seeking behavior	▪ Some shifts in desirable attitudes ▪ some evidence of increase in maladaptive coping ▪ Possibility of contagion.	Minor increase in knowledge and attitude shifts.
Screening	Extensive research on risk factors available from psychological autopsy studies and studies of attempters	▪ Many false positives identified ▪.Assistance in referrals to adequate treatment necessary.	If targets of screening depression, substance abuse and suicide attempts are treated the potential impact on reducing suicides is considerable.
Gatekeeper Training	Similar to CPR Trains members of general public to identify persons at risk, briefly intervene then refer person to professional	Repetition of training program appears necessary	Evidence of knowledge gain and reduction of gender specific suicidal rates
Crisis Centers and Hotlines	Psychological autopsy studies indicate that suicide is often associated with a stress event	Widely available but less apt to be used by boys	Decrease of over 1/3 in suicide rate for young white females
Restriction of lethal means	Several studies indicate availability of firearms in homes significantly increases risk of completed suicide	Second Amendment rights limit acceptability within segments of public	23% reduction in firearm suicides reported. Method substitution appears to be minimal.
Media Education	Numerous studies indicate existence of suicide contagion	Media might be reluctant to participate. Turn over of editorial staff and journalists would require repetition of education programs.	7% reduction in suicides reported in first year and 20% over 4 years post guidelines.
Postvention/crisis intervention	Several studies have examined	High risk persons are not necessarily identified without systematic screening	Not yet known.

Appendix IV

RESOURCES

I   Federal Policy and Plans

National Action Alliance for Suicide Prevention
http://ActionAllianceForSuicidePrevention.org/

National Strategy for Suicide Prevention 2012: Goals and Objectives for Action
www.samhsa.gov/NSSP

Surgeon General's Call to Action to Prevent Suicide (1999)
http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBBH

II   State and National Resources

Active Minds Chapters
www.activeminds.org/our-programming/chapters/find-a-chapter

American Association of Suicidology
www.suicidology.org

American Foundation for Suicide Prevention
www.afsp.org

Best Practices Registry
www.sprc.org/bpr

Center for Violence and Injury Prevention at Washington University's Brown School
http://cvip.wustl.edu

Means Matter Campaign (Harvard Injury Control Research Center)
www.MeansMatter.org

MentalHealth.gov
www.mentalhealth.gov

Mental Health First Aid in Missouri
http://mhfamissouri.org

Missouri Ask Listen Refer (online suicide prevention training program)
www.moasklistenrefer.org

Missouri Campuses Care
   http://suicide.missouri.edu

Missouri Department of Health and Senior Services
   http://health.mo.gov/

Missouri Department of Mental Health
   http://dmh.mo.gov/crisis.htm

National Institute of Mental Health
   www.nimh.nih.gov/health/topics/suicide-prevention/

National Suicide Prevention Lifeline: 1-800-273-8255
   www.suicidepreventionlifeline.org

Pharmacists Preventing Suicides
   www.pharmacistspreventingsuicides.com

Show Me You Care About Suicide Prevention annual state conference
   www.mimhtraining.com/show-me-you-care/

Suicide Lifeguard mobile phone app
   www.mimhtraining.com/suicide-lifeguard/

Suicide Prevention Resource Center
   www.sprc.org

The Trevor Project
   www.thetrevorproject.org

Veterans Crisis Line
   www.VeteransCrisisLine.net

Zero Suicide in Health and Behavioral Health Care
   www.ZeroSuicide.com

III   Missouri Data on Deaths, Hospitalization and ER Visits

Missouri Information for Community Assessment (MICA)
   http://health.mo.gov/data/mica/MICA/

Missouri Suicide Prevention Project data page
   http://dmh.mo.gov/mentalillness/suicide/data.htm

Appendix V

Glossary
for Missouri State Suicide Prevention Plan

attempter: *an individual who makes a nonfatal suicide attempt. An attempter carries out a suicide plan but does not die as a result of their action(s)*

awareness: *broaden the public's recognition, knowledge and understanding*

best practice: *an activity or program based on the best available evidence regarding what is effective*

biopsychosocial: *biological, psychological and social elements that may influence behavior(s) (mental disorder, substance use/abuse, history, etc.)*

cause: *contributing factor or condition*

completer: *a person who intentionally caused their own death*

comprehensive suicide prevention plans: *plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting , biological, psychological and social factors*

connectedness: *closeness to an individual, group or people within a specific orgnaization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others*

contagion: *a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.*

culturally appropriate: *a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles,*

depression: *a collection of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack or pleasure*

environmental: *physical or social elements that influence behaviors (financial, home, relationships, etc.)*

gatekeeper: *those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as needed*

goal: *a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work*

intervention: *a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition*

lethality: *the potential for death*

means: *the insturment or object whereby a self-destructive act is carried out*

means restriction: *techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm*

methodology: *advance the scientific research, evaluation, and monitoring systems for the prevention of suicide and suicidal behaviors*

method: *action or technique which results in an individual inflicting self-harm*

non-lethal: *non-fatal, injury may occur*

objective: *a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often*

outcome: *a measurable change in the health of an individual or group of people that is attributable to an intervention*

postvention: *a strategy or approach that is implemented after a crisis or traumatic event has occurred (this can also be a form of prevention for future attempts).*

prevention: *a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors*

protective factors: *factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment*

risk factors: *those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment*

screening tools: *those instruments and techniques used to evaluate individuals for increased risk of certain health problems; examples, questionnaires, check lists, self-assessment forms, etc.*

sociocultural: *consideration of the influences of societal &/or cultural norms, beliefs and attitudes*

stakeholders: *entities, including organizations, groups and individuals, that are affected by and contribute to decisions, consultations, and policies*

stigma: *an object, idea, or label associated with shame, disgrace, dishonor or reproach*

suicidal behavior: *a variety of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide*

suicide: *death where there is evidence that a self-inflicted act led to the person's death*

surveillance: *the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings*

survivor: *family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide*