Suicide Prevention Plan Update

Minnesota Department of Health

2007

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Executive Summary

In May 2001, a comprehensive *National Strategy for Suicide Prevention* was released under the leadership of former U.S. Surgeon General David Satcher. The Institute of Medicine also addresses suicide as a significant public health problem in its 2002 publication, *Reducing Suicide: A National Imperative*. Most recently, the 2003 President's New Freedom Commission on Mental Health prioritizes suicide prevention in its national mental health agenda.

One million people worldwide die by suicide each year and 10 to 20 times more people attempt suicide. More people die from suicide than in all of the armed conflicts around the world. In Minnesota (2003):

- suicide is the second leading cause of death for 15- to 34-year-olds; the tenth leading cause of death for all ages combined;
- males comprise approximately 82 percent of all suicide deaths;
- the suicide rate for American Indians is approximately two times higher than for any other racial or ethnic group;
- of all age groups, persons 75-84 years have the highest suicide rate; persons aged 45-54 years have the second highest suicide rate;
- data on nonfatal, hospitalized self-inflicted injury indicate that, among females age 10 through 44, self-inflicted poisoning is the leading cause;
- an average of 469 persons have died each year from suicide, three times as many as have died from homicide; and
- more than half of all suicide deaths (52%) are attributed to firearms; other leading methods are poisoning and suffocation.

A 2003 study of suicide prevention in the United States Air Force demonstrates that a community-wide suicide prevention program aimed at decreasing stigma, enhancing social networks, facilitating help seeking and enhancing understanding of mental health was associated with a 33 percent risk reduction for completed suicide.

At the request of the 1999 Minnesota Legislature, the Minnesota Department of Health (MDH), in consultation with a large group of stakeholders from across the state, developed a statewide suicide prevention plan. It includes recommendations from the Commissioner of Health and 28 strategies from an ad hoc advisory group.

The 2001 Legislature appropriated to MDH $1.1 million annually to broaden implementation of the state plan. In accordance with the Minnesota Statute 145.56, a focus of this funding is grants for community-based programs. In 2002, the Legislature made a 13% grant funding reduction.

In 2002, 13 community grants and one evaluation capacity-building grant were awarded through a competitive process. In January 2004, a second round of 11 grants were awarded with an additional two smaller grants awarded later that year. The grants supported evidence-based education and outreach to:

- diverse populations at risk for suicide;
- students, parents, youth group leaders, community volunteers, faith leaders, and others with frequent student contact;
- the elderly and their caretakers;
- employers and employer groups; and
- education, health, corrections, social service and other professionals.

MDH continues to provide staff support for:

- coordinating and integrating state and community suicide prevention activities;
- working with local public health agencies and other partners to identify, develop, and implement culture- and age-specific best practices to prevent suicide;
- promoting greater public awareness and acceptance of mental health concerns; and
- collecting suicide and other data related to implementation activities identified in the state's suicide prevention plan.

- In November 2005, stakeholders gathered at a suicide prevention conference sponsored by the MDH, Yellow Ribbon of Minnesota

and SAVE, Suicide Awareness, Voices of Education and provided feedback about the progress and priorities of the state plan, which was continued in a series of regional meetings during January 2007.

Introduction and Background

Concern for suicide as a serious public health issue continues to grow and is promoted as such by the World Health Organization, the President and Surgeon General of the United States, members of Congress, federal agencies and the armed forces, state governors and legislatures, and national programs such as the Institute of Medicine.

In Minnesota, in 2005, 541 persons died by suicide. Minnesota's suicide rate has risen each year since 2000. In addition, over 3900 people were hospitalized due to self-inflicted injuries.

More than 90 percent of suicides are associated with diagnosable mental illness and/or alcohol and substance abuse. It is important to remember, though, that as many as 10 percent of people who suicide do not have any known psychiatric diagnosis. Also, more than 95% of those with mental disorders do not complete suicide. Suicide can be prevented.

In Minnesota (2005):

- suicide is the second leading cause of death for 15- to 34-year-olds; the tenth leading cause of death for all ages combined;
- males comprise approximately 82 percent of all suicide deaths;
- the suicide rate for American Indians is approximately two times higher than for any other racial or ethnic group;
- of all age groups, persons 75-84 years have the highest suicide rate; persons aged 45-49 years have the second highest suicide rate;
- data on nonfatal, hospitalized self-inflicted injury indicate that, among females age 10 through 44, self-inflicted poisoning is the leading cause;
- an average of 469 persons have died each year from suicide, three times as many as have died from homicide; and
- more than half of all suicide deaths (52%) are attributed to firearms; other leading methods are poisoning and suffocation.

Most states in the nation now have suicide prevention plans but Minnesota has emerged as a leader in implementing a plan that is evidence-based and population-based. Minnesota's plan is recognized as a model among states for its strong and effective public-private partnership.

Overview

At the request of the 1999 Minnesota Legislature, MDH has been convening a large group of statewide stakeholders to address the issue of suicide in Minnesota. In consultation with this ad hoc advisory group, the MDH developed a statewide suicide prevention plan (2000, MDH). It includes recommendations from the Commissioner of Health and 28 suggested strategies from the group.

The 2001 Minnesota Legislature provided MDH with $1.1 million annually to address the issue of suicide. In accordance with the Minnesota Statute 145.56, a focus of this funding is grants for community-based programs. In 2002, the Legislature made a 13% grant funding reduction.

As requested by the Minnesota Legislature, this biennial report summarizes funded activities from July 1, 2002 to June 30, 2004.

In 2002, 13 community grants and one evaluation capacity-building grant were awarded through a competitive process. In January 2004, a second round of 11 grants was awarded. Two smaller grants were awarded later that year. Grants support evidence-based education and outreach to:

- diverse populations at risk for suicide;
- students, parents, youth group leaders, community volunteers, faith leaders, and others with frequent student contact;
- the elderly and their caretakers;

- employers and employer groups; and
- education, health, corrections, social service and other professionals.

According to state statute, programs funded through community-based grants are to:

1) provide education, outreach and advocacy services to populations who may be at risk for suicide;
2) educate community helpers and gatekeepers - such as family members, spiritual leaders, coaches, business owners, employers, and co-workers - on how to prevent suicide by encouraging help-seeking behaviors;
3) educate populations at risk for suicide and community helpers and gatekeepers about information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and how to make or seek effective referrals to intervention and community resources;
4) provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12.

In addition, the legislature asked the Commissioner of Health to:

1) promote workplace and professional education on mental and substance abuse disorders and services;
2) provide training and technical assistance to local public health and other community-based professionals on best practices in suicide prevention;
3) collect and report on Minnesota-specific suicide data;
4) conduct and report on the impact and outcomes from implementation of the state's suicide prevention plan.

Community Grants 2002-2003

The thirteen community grants awarded in 2002 completed their grant agreements the end of 2003.

Those thirteen grantees, the amount of their award and their target populations were as follows:

Ain Dah Yung Center
$85,000 x 2 years
Target Population:
St. Paul American Indian middle school students

Chippewa Co. Family Services
$78,000 x 2 years
Target Population:
Chippewa County residents, farm family outreach

Hmong American Partnership
$90,000 x 2 years
Target Population:
Twin Cities Hmong families, youth and adults

MN Mental Health Association
$78,000 x 2 years
Target Population:
Adults in the workplace and the general public

Minneapolis Community Health
$42,000 x 2 years
Target Population:
Diverse youth populations and their "gatekeepers"

People Connection, Fosston
$94,000 x 2 years
Target Population:
Multi-generations in Polk and surrounding five counties

Range Mental Health Center
$53,000 x 2 years
Target Population:
Iron Range residents, especially youth, young adults, elderly

St. Paul Public Schools
$87,000 x 2 years
Target Population:
Cleveland and Washington Schools students in grades 6, 7, and 8

Suicide Awareness Voices of Education (SAVE)
$80,000 x 2 years
Target Population:
K-12 schools and education to older adult males

Urban Ventures, Minneapolis
$50,000 x 2 years
Target Population:
African-American young men and fathers, ages 15 to 26 years old

White Earth Reservation Tribal Mental Health
$90,000 x 2 years
Target Population:
White Earth Reservation youth, adults and elders

Winona Co. Community Health
$58,000 x 2 years
Target Population:
Winona County residents

Yellow Ribbon/Light for Life, Mankato
$65,000 x 2 years
Target Population:
Region Nine (south central Minnesota) residents, outreach to rural, Latino, and Somali communities

Each grantee was funded for two years to implement multiple strategies to prevent suicide in their community. Grantees implemented over 100 suicide prevention strategies. The two most common strategies were

- providing suicide prevention education to educational groups and media (61% of strategies), and
- producing resources, such adapting curricula and developing suicide response protocol (23% of funded strategies).

The funded grants sought to create change at multiple levels, including:

- *Individual people* to reduce their risk of suicide: the most common target audience (35%) who were most frequently educators and other adults working in schools or employers.
- *Key contacts of gatekeepers* who are in position of influence to reduce the risk of others (19%).
- *Agencies or systems* to improve access to services or change organizational climate (22%).
- *Communities* to create holistic change by addressing community attitudes and norms (24%).

Across the four levels, about one in five strategies (18%) targets special populations with high rates of suicide, such as American Indians.

An independent evaluation firm, Professional Data Analysts, Inc. (PDA) was contracted to build the capacity of grantees to complete their own local-level evaluation. PDA conducted three site visits and sponsored three conferences in which grantees learned and practiced their evaluation skills. The guided evaluation process helped many grantees become more accomplished prevention practitioners. By conducting their own evaluation from start to finish many grantees came to an enhanced understanding of how their grant activities reduce suicide, which afforded them a critical perspective from which to design stronger prevention initiatives.

2002-2003 Grantee Accomplishments

The following examples of grantee evaluations highlight the variety of lessons learned through evaluation.

The **Hmong American Partnership** (HAP) suicide prevention project was created in response to a series of multiple homicide/suicides in the Hmong community. Community experts identified several factors as important in preventing future deaths. Traditionally in the Hmong community mental health issues are not discussed, and there is a lack of direct dialogue in personal relationships. Because airing personal problems is seen as shameful, people may be reluctant to seek help outside the family or traditional channels.

HAP developed a unique strategy to address these issues with the harder-to-reach adult population. They broadcast a bi-weekly radio show in the Hmong language. The show encourages open communication and help-seeking. The evaluation demonstrated:

- The radio show has a broad reach: 7 out of 10 interview participants listened to the radio show, and most report listening to nearly every broadcast.
- Listeners are more likely to talk about topics that were formerly considered private compared to non-listeners.
- Those who listened to the show also believed it helped them to control their own emotions and communicate better with their spouse and children.

The **Ain Dah Yung Center** (ADY) provides intensive youth-development programming for American Indian youth in St. Paul. A community advisory board recommended that ADY prevent suicide among youth not only by teaching them facts about suicide and prevention, but also by working to reconnect them with Native culture and traditions, foster their pride in their cultural heritage, and help them develop a sense of purpose and value within their community. These protective factors guard against suicide and other harmful behaviors. In response, ADY augmented their existing youth development program with intergenerational activities at the Elder Lodge, an assisted-living facility.

Based on the evaluation results, ADY plans to expand the intergenerational component of their programming to encourage even more interaction between youth and elders.

Among other grantee accomplishments, one project lists its greatest accomplishment as: *"Providing a comprehensive suicide prevention program in the schools, involving all key gatekeepers - parents, staff and students."*

Some grants describe their greatest achievement as changes they saw in their target populations, the people and organizations they served: *"There is a great deal of stigma in relation to suicide and depression issues. The community is quite comfortable with not confronting these concerns or dealing with them. This project gave us the avenue to change this attitude in our community."*

Still other grants describe their accomplishments as "getting a foot in the door," or building connections and gaining access within the community that will allow them to continue suicide prevention work in the future. *"After encouraging and prodding, one hospital has now scheduled suicide Prevention training for 80 of their nurses. A start."*

One grantee summed it up by sharing: *"There is still a lot of work to do. Hope is the key."*

Community Grants 2004-2006

A second request for proposals outlining a competitive award process for the suicide prevention community grants program was developed and published in the State Register in the summer of 2003. Forty-eight proposals were received and scored by stakeholders and state agency staff. Eleven community grants were awarded in January 2004, and two additional grants in the fall of 2004, as follows:

Ain Dah Yung (Our Home) Center, St. Paul
$75,000 x 3 years
Target Population:
American Indian youth and families

Cass-Todd-Wadena-Morrison Community Health Services
$90,000 x 3 years
Target Population:
Young adults (12-24) and adults (25-44)

Hmong American Partnership, St. Paul
$75,000 x 3 years
Target Population:
Twin Cities Hmong families, youth and adults

Koochiching Family Collaborative
$75,000 x 3 years
Target Population:
Students, adults, and older adults

Leech Lake Band of Ojibwe
$75,000 x 3 years
Target Population:
American Indians 15-45

Mental Health Association of Minnesota, St. Paul
$75,000 x 3 years
Target Population:
Adults in the workplace and the community

People Connection, Fosston
$40,000 x 2.5 years
Target Population:
Multi-generations

Range Mental Health Center
$40,000 x 2.5 years
Target Population:
Youth, parents and other adults

Regents of the University of Minnesota, Minneapolis
$100,000 x 3 years
Target Population:
Somali refugees

Suicide Awareness Voices of Education (SAVE), Bloomington
$50,000 x 3 years
Target Population:
State grantees and communities

Volunteers of America, Golden Valley
$75,000 x 3 years
Target Population:
Older adults, their families and providers

White Earth Tribal Mental Health
$75,000 x 3 years
Target Population:
American Indian youth, adults and elders

Yellow Ribbon/Light for Life, Mankato
$100,000 x 3 years
Target Population:
State grantees and communities

2004 Grant Accomplishments

Suicide prevention grant activities continue to result in new and enhanced targeted and community-wide public health interventions. Community grantees are required to bring people, schools and organizations together to develop a public education plan. The Yellow Ribbon and SAVE organizations partner with the MDH to provide suicide prevention training and resources to grantees and other communities. This public–private partnership is a hallmark of Minnesota's unique approach and is one that enhances the roles of all partners.

The centerpiece of this initiative continues to be the **broad dissemination of suicide prevention information**. Mental health education is no different than any other health education. Minnesota communities are learning that the warning signs for suicide are as important as learning the warning signs for heart disease or diabetes or cancer. This information is distributed through newspapers, newsletters, town hall meetings, community presentations, workforce centers, radio, surveys, libraries, children's mental health and family service collaboratives, parent-teacher conferences, websites, colleges, service organizations, senior services, workshops, conferences and health and county fairs. It is reaching the elderly, students, parents, extension services and farmer-lender mediators, employers and employer groups, farmers, dentists, school administrators, funeral home directors, AARP, clergy and other spiritual leaders, parish nurses, newspaper editors and reporters, law enforcement, corrections, emergency medical service and other health providers and chiropractors, and bar and restaurant owners.

Stories from across the state illustrate the direct impact felt in communities as a result of this initiative. Service providers, students and other community members are learning how to identify mental health problems and suicide warning signs and how to encourage people to get professional help. High risk students are also learning other life skills such as problem-solving, coping and help-seeking for mental health problems and other suicide risk factors. Grateful and enthusiastic schoolteachers are requesting suicide prevention resources and assistance from their community grantee. Grantees from across the state tell of students coming forward for help following presentations on suicide prevention.

Employers in the public and private sectors are learning about suicide warning signs, how to intervene with and support employees with mental disorders and how untreated mental disorders may impact worker productivity.

Another key component of this initiative is to foster **community members working together to prevent suicide**. Grantees are bringing communities together to build hope and to identify age- and culture-specific suicide prevention strategies. In a number of cases, these community partnerships have resulted in securing matching funds or other grants to broaden their community's efforts. People are gathering to identify the unique meanings and needs their populations have regarding suicide. And community members are identifying strengths and gaps in their mental health services and improving the linkages and coordination among service providers and institutions.

Preventing Suicide In American Indian Communities

Suicide prevention among American Indians is a high priority of the Minnesota Department of Health. The rate of suicide among American Indians in Minnesota (19.96 per 100,000, US Census, 1997-2001) is over twice that of all other racial and ethnic groups. In comparison, the rate of suicide for non-Hispanic whites during this period is 7.55. In fact, suicide is the second leading cause of death among American Indians in Minnesota for two age groups: 15-24 and 25-34 (NCHS, 1997-2001). According to the Minnesota Student Survey, 34% of 6th grade American Indian girls report having thought about killing themselves, as compared to 20% of 6th grade girls statewide. One in five 9th grade American Indian boys (20%) report having attempted suicide, as compared to 7% of 9th grade boys statewide (Minnesota Student Survey, 2001).

The Minnesota Department of Health convened an American Indian Suicide Prevention Work Group. The purpose of the group is to support suicide prevention efforts in American Indian communities. The meeting agendas are largely determined by group interest and group activities decided by a rough consensus.

Progress of the American Indian Suicide Prevention Work Group

Over 30 work group participants represent tribal government agencies, not-for-profit organizations serving American Indians, and the Minnesota Department of Health. New group members are continually recruited and encouraged to contribute in order to ensure broad representation and continued conversation and learning.

The content of group discussions includes:

- An historical perspective of American Indian history relevant to issues of mental health and suicide;
- The incidence of suicide in American Indian communities;
- Community assets that may be marshaled to address the problem;
- Strategies for decreasing the rate of suicide among American Indians; and
- The role of the State of Minnesota in supporting prevention efforts in American Indian communities.

In June 2004, staff from the Ain Dah Yung Center and their Ain Dah Yung Juniors drummers and dancers presented at the American Indian Mental Health Conference, as well as other members of the AI Suicide Prevention Work Group. Staff from Leech Lake Tribal Health prepared a brochure with assistance from other members of the Work Group and distributed them at the conference sessions to invite other communities to join the work group.

Members have discussed holding community-wide discussions about suicide prevention in their respective communities. Additionally, the members have presented findings from the Work Group to the Tribal Health Directors and to the state Suicide Prevention Advisory Group. These presentations foster a shared, developing vision of suicide prevention. The work group continues to grow in mutual respect, understanding and trust between group members and agencies. The group will continue to address suicide based on each member's commitment and the meeting discussions.

Group discussions reveal important themes about suicide prevention in American Indian communities. Each American Indian community is unique. Research-based, public health prevention approaches may best serve American Indian communities if they are reconceptualized to address several key factors.

- Leadership by members of the community regarding program design and implementation must be fostered.
- Many individuals are working in American Indian communities to prevent suicide. Their wisdom should be more widely shared.
- Traditional beliefs and practices can be a powerful tool in addressing the complex web

of factors associated with suicide. Elders are a key resource.
- Talking about suicide and mental health requires special consideration due to historical abuses. Mental illness was used as a rationale for taking land from American Indians, forcing the sterilization of women, sending individuals to institutions, and breaking up families.
- An assets-based approach to suicide prevention efforts would be most successful.
- Some individuals and communities hold a traditional belief that talking about a problem brings it forth, which must be considered when developing prevention efforts.
- Partnerships with other agencies and organizations, including the State of Minnesota, can be a powerful tool in addressing suicide statewide. Building trust in partnerships is a key to success.

The American Indian Suicide Prevention Work Group brings together a variety of interested parties to prevent suicide in American Indian communities. The group is poised to more effectively assist American Indian communities prevent suicide in the coming years. Valuable information has been gained on how to shape state and tribal partnerships regarding suicide prevention and how to initiate community-wide discussions and activities about suicide prevention.

Suicide Prevention Plan Implementation

In addition to managing the community grants program and facilitating stakeholders' progress toward implementation of the state suicide prevention plan, MDH promotes and supports the state plan through the following activities:

- Convening the Minnesota Council on Suicide Prevention Council and Technical Assistance Team;
- Convening and supporting the activities of the American Indian Suicide Prevention Work Group;
- School crisis planning;
- Providing technical assistance, training, and resources to local public health, grantees, other stakeholders and their partners;
- Collecting and reporting of suicide and mental health data;
- Participating as a member of the State Mental Health Advisory Council and Children's Subcommittee;
- Regional hospital and stakeholder planning for emergency preparedness and mental health;
- Planning and sponsoring suicide prevention conference for diverse communities;
- Planning, supporting and providing statewide professional development in the area of infant, child and caregiver mental health;
- Convening MDH mental health work groups;
- Promoting maternal and child mental health through the Family Home Visiting Program, the Follow Along Program, N-CAST training, Part C activities for children with developmental disabilities and families, and the Minnesota Children with Special Health Needs clinics;
- Preventing risk behaviors though Chemical Health, Methamphetamine and Sexual Violence Prevention Programs;
- Developing cross-department and interagency funding and capacity-building proposals;
- Providing staff support and technical assistance to the state Child Mortality Review Panel; and
- Presenting to county, state and national conferences and events.

Next Steps

MDH staff will continue to work with state and community agencies, organizations, institutions, local public health, and other stakeholders as described above to refine, coordinate, and implement the state suicide prevention plan using an evidence-based, public health approach focused on prevention. As a national leader in

implementing a state suicide prevention plan, the state of Minnesota is breaking ground in providing for a systematic capacity-building model for diverse communities in suicide prevention.

The state suicide prevention plan currently includes 28 strategies. MDH continues to work with multiple statewide stakeholders to assess community resources and facilitate state and community efforts, both public and private, to promote a comprehensive and effective approach to suicide prevention in the state. Key priority areas that continue to emerge as needs in the implementation of the state plan include:

- Stigma as a barrier to addressing suicide and mental health as a health problem;
- Mental health education to all populations;
- Mental health early interventions;
- Supply and access to mental health services, both population-based and clinical care;
- Professional education and use of evidence-based mental health interventions; and
- Capacity to collect and analyze suicide and mental health data.

As this initiative grows, more communities come forward to request assistance in suicide prevention. More schools are opening their doors to suicide prevention and just as many are waiting for such resources in their districts. Elder care programs and employers across the state are similarly in need of targeted programs to address the issue of suicide. Through this initiative and efforts to strengthen it, Minnesota can reach even more of its citizens to prevent the further tragic loss of life by suicide.

As Minnesota communities learn about suicide and how to prevent it, the gaps in the mental health system loom large. These issues are not unique to Minnesota but are confirmed as national public health priorities by both the President's Commission on Mental Health and the United States Surgeon General's Office. States are encouraged to address these public health concerns in order to save lives and improve the productivity of its citizens. Minnesota has a solid start in mobilizing communities to prevent suicide through diverse partnerships and multiple levels of interventions initiated and sustained through the state suicide prevention plan and the landmark sponsoring legislation that supports it

In November 2005, stakeholders gathered at a suicide prevention conference sponsored by the Minnesota Department of Health, Yellow Ribbon of Minnesota and SAVE, Suicide Awareness, Voices of Education.

The conference attendees affirmed progress, developed priorities and suggested new avenues for action. The next step is to bring this information to groups throughout the state for greater input and feedback.

Progress has been made on the State Suicide Prevention Plan. Some strategies have been accomplished, including eliminating the reporting of suicide as a crime statistic. Some strategies are no longer relevant, such as the study of access through the senior drug program of psychotropic medications. Finally, some strategies are addressed by other initiatives. For example, the work of the Minnesota Mental Health Action Group and the Governor's Initiative on Mental Health focuses on the issues of universal access to mental health care and crisis services.

A common language and understanding of symptoms of warning signs has been developed. Education for community helpers and "gatekeepers" (who are in a position to identify warning signs and make referrals) has reached thousands of Minnesotans. In addition, the Minnesota Council for Suicide Prevention convenes stakeholders and offers resources sharing and training for communities.

The group affirmed the current state plans, indicating that while progress has been made, the strategies are still relevant and should be prioritized. They emphasized the need for increasing awareness through education and interventions for high-risk groups.

Alignment of the state plan with the National Strategy for Suicide Prevention is an additional consideration.

National Strategy for Suicide Prevention and the Minnesota State Plan

Section 1: Awareness

1. Promote Awareness that Suicide is a Public Health Problem that is Preventable	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 1.1: By 2005, increase the number of States in which public information campaigns designed to increase public knowledge of suicide prevention reach at least 50 percent of the State's population. Objective 1.2: By 2005, establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public. Objective 1.3: By 2005, convene national forums to focus on issues likely to strongly influence the effectiveness of suicide prevention messages. Objective 1.4: By 2005, increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the World Wide Web.	Implement an ongoing, coordinated multi-strategy, multi-media, and multi-partner public awareness and anti-stigma campaign. Establish partnerships with Minnesota media vendors to promote increased public service for suicide prevention. Develop and promote the use of common language, uniform terminology, and consistent messages regarding suicide and mental health terminology.

2. Develop Broad-Based Support for Suicide Prevention	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 2.1: By 2001, expand the Federal Steering Group to appropriate Federal agencies to improve Federal coordination on suicide prevention, to help implement the ***National Strategy for Suicide Prevention***, and to coordinate future revisions of the ***National Strategy*** Objective 2.2: By 2002, establish a public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy. Objective 2.3: By 2005, increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities. Objective 2.4: By 2005, increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.	Identify community-based agencies that can promote suicide prevention. **Facilitate networking and referrals** between these and other public, private, and community-based mental illness and substance abuse prevention and treatment agencies. Build community capacity to provide outreach, advocacy, and education through home- and community-based programs to high risk populations.

3. Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse and Suicide Prevention Services.	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 3.1: By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health. Objective 3.2: By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments. Objective 3.3: By 2005, increase the proportion of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health. Objective 3.4: By 2005, increase the proportion of those suicidal persons with underlying mental disorders who receive appropriate mental health treatment.	Develop and promote the use of common language, uniform terminology, and consistent messages regarding suicide and mental health terminology. Educate and promote the role of natural community "helpers" (clergy, spiritual leaders and advisors, coaches, community business people, community education, private organizations, etc.) to support self-preservation instincts and encourage culture- and age-specific help-seeking behaviors.

Section 2: Intervention

4. Develop and Implement Community-Based Suicide Prevention Programs	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 4.1: By 2005, increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector, and c) support plan development, implementation, and evaluation in its communities. Objective 4.2: By 2005, increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.	Study and develop a statewide K-12 prevention and intervention program. Promote employee assistance and workplace programs. Build community capacity to provide outreach, advocacy, and education through home- and community-based programs to high risk populations.

Objective 4.3: By 2005, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide. Objective 4.4: By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide. Objective 4.5: By 2005, increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention programs. Objective 4.6: By 2005, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior. Objective 4.7: By 2005, increase the proportion of family, youth and community service providers and organizations with evidence-based suicide prevention programs. Objective 4.8: By 2005, develop one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs.	

5. Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 5.1: By 2005, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks. Objective 5.2: By 2005, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.	Promote and enforce means restriction.

Objective 5.3: By 2005, develop and implement improved firearm safety design using technology where appropriate. Objective 5.4: By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide. Objective 5.5: By 2005, improve automobile design to impede carbon monoxide-mediated suicide. Objective 5.6: By 2005, institute incentives for the discovery of new technologies to prevent suicide.	

6. Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 6.1: By 2005, define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels. Objective 6.2: By 2005, increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk and identification and promotion of protective factors. Objective 6.3: By 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors. Objective 6.4: By 2005, increase the proportion of clergy who have received training in identification of and response to suicide risk and behaviors and the differentiation of mental disorders and faith crises. Objective 6.5: By 2005, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide.	Work with post-secondary educational institutions to include course work and curricula on suicide prevention and intervention in education. Require and provide start-up funds for Continuing Education-eligible training, both basic and advanced, on suicide prevention and intervention. Work with professional licensing, certifying and re-certifying, and accrediting bodies to include education requirements on suicide prevention and intervention.

Objective 6.6: By 2005, increase the proportion of correctional workers who have received training on identifying and respond-ing to persons at risk for suicide. Objective 6.7: By 2005, increase the proportion of divorce and family law and criminal defense attorneys who have received training in identifying and responding to persons at risk for suicide. Objective 6.8: By 2005, increase the proportion of counties (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide. Objective 6.9: By 2005, increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.	

7. Develop and Promote Effective Clinical and Professional Practices	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 7.1: By 2005, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan. Objective 7.2: By 2005, develop guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings. Objective 7.3: By 2005, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients. Objective 7.4: By 2005, develop guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.	Develop and promote the implementation of culturally-specific and age-appropriate patient education. Study impact of patients' rights laws on access to crisis mental health care Strengthen emergency services requirements in the Comprehensive Mental Health Act. Study policies of public and private licensed institutional care regarding suicide prevention and intervention practices and access to methods to commit suicide. Educate and promote the role of natural community “helpers” (clergy, spiritual leaders and advisors, coaches, community business people, community education, private organizations, etc.) to support self-preservation instincts and encourage culture- and age-specific help-seeking behaviors. Study universal access to, coverage of, and related costs of adequate mental health care.

Objective 7.5: By 2005, increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors. Objective 7.6: By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended. Objective 7.7: By 2005, increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse. Objective 7.8: By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers). Objective 7.9: By 2005, incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all Federally-supported healthcare programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare). Objective 7.10: By 2005, include screening for depression, substance abuse and suicide risk as measurable performance items in the Health Plan Employer Data and Information Set (HEDIS).	

8. Increase Access to and Community Linkages with Mental Health and Substance Abuse Services	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 8.1: By 2005, increase the number of States that require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.	Study universal access to, coverage of, and related costs of adequate mental health care.

Objective 8.2: By 2005, increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention. Objective 8.3: By 2005, define guidelines for mental health (including substance abuse) screening and referral of students in schools and colleges. Implement those guidelines in a proportion of school districts and colleges. Objective 8.4: By 2005, develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts. Objective 8.5: By 2005, increase the proportion of school districts in which school-based clinics incorporate mental health and substance abuse assessment and management into their scope of activities. Objective 8.6: By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers. Objective 8.7: By 2005, define national guidelines for effective comprehensive support programs for suicide survivors. Increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented. Objective 8.8: By 2005, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans.	Build community capacity to provide outreach, advocacy, and education through home- and community-based programs to high risk populations. Educate communities and schools staff on the co-occurrence of substance abuse with depression, mental illness, and brain disease. Explain the relationship between impulsive behaviors in children and youth and access to lethal methods. Identify gaps, barriers to, and costs for basic suicide crisis, "safety net," and follow-up services, especially in schools. Strengthen emergency services requirements in the Comprehensive Mental Health Act. Study policies of public and private licensed institutional care regarding suicide prevention and intervention practices and access to methods to commit suicide.

9. Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 9.1: By 2005, establish an association of public and private organizations for the purpose of promoting the accurate and responsible representation of suicidal behaviors, mental illness and related issues on television and in movies.	Establish partnerships with Minnesota media vendors to promote increased public service for suicide prevention. Develop and promote the use of common

Objective 9.2: By 2005, increase the proportion of television programs and movies that observe promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues. Objective 9.3: By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations. Objective 9.4: By 2005, increase the number of journalism schools that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.	language, uniform terminology, and consistent messages regarding suicide and mental health terminology.

Section 3: Methodology

10. Promote and Support Research on Suicide and Suicide Prevention	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 10.1: By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates. Objective 10.2: By 2005, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice, and for training of researchers in suicidology. Objective 10.3: By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors. Objective 10.4: By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.	Identify Minnesota's research agenda.

11. Improve and Expand Surveillance Systems	
National Strategy for Suicide Prevention	**Minnesota State Plan**
Objective 11.1: By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions). Objective 11.2: By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides. Objective 11.3: By 2005, increase the proportion of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by coding external cause of injuries, utilizing the categories included in the International Classification of Diseases. Objective 11.4: By 2005, implement a national violent death reporting system that includes suicides and collects information not currently available from death certificates. Objective 11.5: By 2005, increase the number of States that produce annual reports on suicide and suicide attempts, integrating data from multiple State data management systems. Objective 11.6: By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior. Objective 11.7: By 2005, implement pilot projects in several States that link and analyze information related to self-destructive behavior derived from separate data systems, including for example law enforcement, emergency medical services, and hospitals.	As not all suicides are reported as such, study suicide-reporting practices. Collect, analyze, and report Minnesota-specific data on suicide and suicidal behaviors.

Suggested Priorities 2007-2010

High-risk populations include:

- Suicide attempt survivors,
- older adults,
- American Indians, and
- youth.

Awareness

- Focus on building protective factors
- Work on reducing the public's exposure to violence through the media
- Create new avenues for awareness building: Spirit Run, Bracelets, stress balls, pens and pins "info on what can do, who to call" & info cards that go along
- Develop branding strategies
- Increase understanding of co-morbidity and dual diagnosis

Intervention

- Invest in targeted case management
- Increase access to specialized mental health services, particularly those what address co-morbidity and dual diagnosis
- Better crisis planning and education
- Postvention
- In-home family based therapy
- Eliminate barriers to treatment

Methodology

- Use data better, especially to health plans around costs
- Identify areas for future research including: identify effective programs and strategies and use to drive funding; adequate resources to collect culturally-specific data; pay attention to peripheral areas, such as substance abuse or car accidents.
- Research should include environmental and community levels
- Expand child mortality reviews to different populations, such as middle-aged group or elderly.
- Expand child mortality review for suicides under age of 15 to look at attempts
- Translate Cognitive Behavioral Therapy into universal strategies.
- Educate public on means restriction; promote resources on patient and parent education
- Investigate life insurance practices as a barrier to reporting suicides
- Develop more effective ways to utilize technology in suicide prevention programs and practices

Some new priorities emerged:

Process

- Develop a menu of prevention strategies based on nationally established and promising practices for prevention, early identification and early intervention that ranges from low or no cost to programs that require additional resources

New Initiatives

- Investigate new ways to use technology; for example, create a BLOG for success strategies, indexed by category
- Encourage volunteerism by building partnerships with existing volunteer groups and existing initiatives
- Address workforce shortages
- Shift to a broader approach including mental health, chemical health, violence prevention
- Support the work to ensure universal health coverage
- Create a youth agenda; youth involvement in a leadership way
- Address truancy and relationship to depression