Indicated Suicide Prevention Strategies  
April 25, 2011  
Sub-Committee Notes

The final Suicide Prevention Action Plan Sub-Committee was held on April 25, 2011 during which indicated strategies were discussed. Over 20 participants, many new to the subcommittee meetings, attended the meeting on indicated suicide prevention strategies. The initial part of the meeting was dedicated to reviewing the planning process and providing a summary of the universal and selective strategies identified in previous subcommittee meetings. Following this review, participants were grouped into four breakout sessions made up of 4-5 group members to have a focused discussion on indicated strategies. The breakout sessions were selected based on progress that was made in prior subcommittee meetings and areas that were requested by committee staff.

The topics selected for the focused small group breakouts were:
1. What indicated interventions and/or strategies would make the most impact for middle aged men (45-64)?
2. What indicated interventions and/or strategies would make the most impact for direct for direct services (focused on anyone needing services)?
3. What indicated interventions and/or strategies would make the most impact for system/organization?
4. How can research and data support indicated strategies?

This document includes:
1 – Priority populations for indicated strategies  
2- Raw notes related to indicated strategies from the four breakout groups  
3- Raw notes from the large group report back.

1. Priority Populations (selected by County, local data trends, and participant input)
   - Older Adults
     o homebound/ recent medical or mental health diagnosis
   - Asian Pacific Islander
   - TAY Youth (16-24)
     o Expand to all adolescents
   - Native American
   - Latino
   - LGBTQ
   - Survivors of Suicide Loss
   - Military
   - Middle Aged Men (45-64)
   - Divorce
   - Forensics
   - Dual Diagnosis (Substance use and mood disorders)
   - Recent hospital discharge status
   - Homeless
2- Raw notes related to indicated strategies from the four breakout groups

Breakout Group 1. *What indicated interventions and/or strategies would make the most impact for middle aged men (45-64)?*

- **Risk Factors for middle age men as identified by the group**
  - Stigma
  - Health Diagnosis
  - Self Perception of weakness when seeking for help: “weak”
  - Substance abuse-
    - increases suicide risk for intended and not intended
  - Divorce
  - Job loss
  - Homelessness
  - Loss of self-esteem
  - Mental health diagnosis
  - Veteran Status
- **Strategies**
  - Normalizing it in the media
  - Using appealing personalities
  - Targeted massages
  - Utilizing primary care doctors who are trained to assess mental health Symptoms
  - Follow up calls after discharge from hospital, clinic, doctor visits
  - Continuity of care-post hospital discharge, correlate hosp with risk
  - Better advertising for suicide hotlines
  - Advertising at stadiums, college, sports, health clubs, magazines

Breakout Group 2. *What indicated interventions and/or strategies would make the most impact for direct for direct services (focused on anyone needing services)?*

- **Strategies**
  - Dev a relationship
  - Target towards pop.
  - Collaborative w/ consumer
  - Issues of rapport/trust (client centered)
  - Treat w/respect
  - Meet where client is
  - Listen
- **Assessment of Risk Factors/Protective Factors**
  - Every pop should be assessed (i.e., specific for pop. Ex. Internet, face to face)
  - Training/guideline specific for your population
  - Note “red flags” and game plan of what to do
  - *Key is how to address for each population
  - Re-asses as needed
• Collaboration Across Agencies
  o “No wrong door”→ refer
  o Reduce duplication of services
  o “Warm handoff”
  o “One stop shop”-holistic care model
  o Address barriers

Treatment plan
  o Individualized
  o Consider relationship

• Risk factors/protective factors + collaboration (pop. Specific)
  o Consider barriers/try to eliminate
  o Skill building
  o Strength based
  o Safety plan
  o Be mindful of stigma

• Resource Available
  o Gate Keeper (access + crisis)
  o Updated regularly

• Home based/site based treatment
  o Mandated/required home visits
  o Telehealth (VA currently using)
  o Follow up by medical
  o Ongoing case management
  o Addressing therapist education

Breakout Group 3. What indicated interventions and/or strategies would make the most impact for system/organization?

• Mental Health first aid-certificate program
• Formalize collaboration between agencies
• Adopting PEI strategies within each agency- wellness w/in PEI agencies
• Train on trauma informed services
  o Also address secondary trauma
• Utilize family members as resources
• Increased integration, awareness, and continuity of care
• Flexible benefits to encourage work/life balance for employees→wellness classes
• Yoga classes, etc
• Incorporate best practices already identified in other counties/agencies
Breakout Group 4. How can research and data support indicated strategies?

- Definitions of suicide
  - Definite vs probable vs possible
- Data linkages
  - Expanded history of suicide
  - Hospitalization
  - Religious communities
  - Challenge i.e. taboos re: Talking about dead people in some cultures/communities
- Immigration status
  - Details of race
- Ethnic /immigrant communities cultural standards
  - Trust
  - Communication
- Family Involvement-data/information
  - Id data gaps
  - Groups
  - Means-availability
  - Spectrum of suicidality
  - Mental/Medical Hx (?)
    - Economic hardship
    - Divorce
    - Family Hx
- SHAC
- Detailed investigation
- Shared data
- Hosp/MD/School/church
- Policy
- Data sharing by individual
- Firearm status/policy re: access
- Hospital data
- Hospital Association
- Consider how to work/add on to existing policy changes
- Re: discharge info/rate of readmission

3- Raw notes from the report back from each breakout group to the large group

Breakout Group 1.

<table>
<thead>
<tr>
<th>Risk Factors:</th>
<th>Strategies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma-barrier</td>
<td>Normalize</td>
</tr>
<tr>
<td>Health Diagnosis</td>
<td>Targeted messages</td>
</tr>
<tr>
<td>Self perception “weak”</td>
<td>Involve PCP</td>
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<tr>
<td>Substance abuse (co-occurring)</td>
<td>Have a spokesperson</td>
</tr>
<tr>
<td>Divorce</td>
<td>F/U calls post discharge</td>
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<tr>
<td>Job loss</td>
<td>Increase advertising for hotlines</td>
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<tr>
<td>Veteran status-“having served”</td>
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<tr>
<td>Home bound</td>
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### Mental health Diagnosis

#### Breakout Group 2.

<table>
<thead>
<tr>
<th>Strategies:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>▪ Develop relationship with client that promotes an individualized approach</td>
<td>▪ Utilize home Tele-health as a way to increase access to care.</td>
</tr>
<tr>
<td>o Consider having mandatory home visits as part of the treatment plan</td>
<td>o VA currently uses this model</td>
</tr>
<tr>
<td>o Make treatment accessible for those homebound</td>
<td></td>
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<tr>
<td>▪ Collaborative approach with client</td>
<td>▪ Use a holistic model</td>
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<tr>
<td>▪ Relational model</td>
<td>▪ One stop model of care</td>
</tr>
<tr>
<td>▪ Assess risk factors and have knowledge of risk factors</td>
<td>▪ Promote individualized treatment versus manualized treatment</td>
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<tr>
<td>▪ PCP need to own the health issues/status of patient, including red flag patient with issues for further services</td>
<td>▪ Strengthen collaboration with agencies</td>
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#### Breakout Group 3.

<table>
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<tbody>
<tr>
<td>▪ Increase Training</td>
</tr>
<tr>
<td>▪ M H Certificate</td>
</tr>
<tr>
<td>▪ Formalize collaboration with agencies</td>
</tr>
<tr>
<td>▪ Employee programs that promote health</td>
</tr>
<tr>
<td>▪ Train on trauma-informed services</td>
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| ▪ Increase utilization of family members in treatment as they are the information holders |
| ▪ Increase integration of services/comprehensive                                   |
| ▪ Identify what’s working with other counties                                       |
| ▪ Adopt PEI w/in agency to develop awareness of existing programs via policies/procedures |

#### Breakout Group 4.

<table>
<thead>
<tr>
<th>Strategies:</th>
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</thead>
<tbody>
<tr>
<td>▪ Currently underestimate suicide rates</td>
</tr>
<tr>
<td>▪ Categorize data by defining what is definite vs. probable</td>
</tr>
<tr>
<td>▪ Create data linkages</td>
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<tr>
<td>▪ Consider the return of an Audit Committee</td>
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| ▪ San Diego has concentration of African immigrant community with challenges regarding |
|   o Access to info                                                         |
|   o Language/trust                                                        |
|   o Lack of local awareness of cultural history from country of origin-taboo’s and politics, family background |
|   o Barriers w/ immigration status                                         |
| ▪ Data camps for:                                                         |
|   o What we know and don’t know                                           |
|   o High risk behaviors like cutting                                      |
|   o Medical risk factor                                                   |
|   o Family risk factor                                                   |
| ▪ Fire arm policy                                                        |
Items to Follow Up from Group Discussion

- Data and data collection:
  - Identify/expand data sources
  - How are data collected?
- Existing strategies for LGBT Youth:
  - Policies to reduce stigma
  - Protection against bullying
  - Non discrimination statements that specify LGBT
- Access to services vs. utilization of services