Selective Suicide Prevention Strategies  
March 14, 2011  
Sub-Committee Notes

The second meeting of the Outreach and Direct Services Sub-Committee was held on March 14, 2011. Approximately twelve participants participated in brainstorming and the beginning of consolidated thinking regarding selective suicide prevention strategies. After participating in breakout sessions made up of 3-4 group members, participants were asked to present back their main strategies to the large group. From here, the large groups provided feedback on the strategies and identified those that were common across the small group. Due to time limitations, participants were able to provide feedback on the use of supportive models and technology (pros and cons).

This document includes:
1 – Large group findings and points for further discussion  
2 – Synthesis of the information from the breakout groups  
3 – Raw notes from the breakout groups

1 - Large Group Findings
These are the strategies identified by the large group. Further discussion time is needed to be able to determine which specific interventions and/or strategies should be moved forward. Additional questions for clarification have been added to further discussion.

What are the Selective interventions and/or strategies that should be presented to the CHIP Suicide Prevention Action Plan Committee?

• Education – How might education as a selective strategy be different from universal education?

• Training for Providers – Are there any specific trainings, trainers, or models of provider training that would be recommended? What would these cover that would make this a selective strategy?

• Skill Building and Training for Community Members/Clients – What additional skill areas might be considered in skill building and training?

• Utilization of Supportive Models - What are the organizational and system wide levels to implementing supportive models? Who has done it successfully?

• Research and data to inform practice - How can collaboration and cooperation really happen with data sharing?

• Effective Utilization of technology – Technology was described as both an opportunity and a barrier. How might this be addressed in the development of technology as a strategy for intervention?
2 - Breakout Groups – Synthesis

The following is a summary of the information generated in the 3 small groups during breakout. Themes are noted in responses and grouped together.

- **Creating a bridge to support**
  - See something – say something – do something

- **Research and Data**
  - Additional information needed about successful programs and duration, definition of success
  - Use data to identify at-risk populations
  - Use of local resources and expertise

- **Importance of cultural/linguistic match in staffing and content of programs/interventions**

- **Use of technology in all areas (training, education, media)**

- **Training and Support for Professionals and First Responders**
  - Training for physicians/PCP staff
  - Support for providers to address vicarious trauma
  - Yellow Ribbon/Red Folder as models

- **Crisis Support**
  - 24/7 Emergency response teams
  - Helplines and Warmlines

- **Neighborhood model of intervention**
  - In neighborhood
  - Reflects population
  - Sheriff storefront model/community policing model
  - Neighborhood watch model
  - Local training

- **Continuity of Care**
  - Direct outreach
  - Early detection – intervention
  - Screening – i.e. Mini Mental, PHQ 9
  - Flagging of high risk
  - Follow up

- **Education**
  - Including stigma reduction, myths vs. facts
  - Partner with or expand with schools, existing non-profits working with and advocating for mental health issues as well as with County sponsored trainings

- **Media campaigns**

<table>
<thead>
<tr>
<th>Going beyond PSA’s</th>
<th>Univision as a model</th>
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<tbody>
<tr>
<td>Social networking including app ads</td>
<td>Video games</td>
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<tr>
<td>Celebrity spokesperson (sports/reflect target populations)</td>
<td>Pet therapy – suicide prevention companion</td>
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<tr>
<td>Examples and testimonials</td>
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</tbody>
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Target population specific strategies include media campaigns through/with:
- Schools – GSA’s
- Faith organizations
- Clubhouses
- Support groups
- Native American social services on/off reservations
### Skills Building and Training – To help community and individuals

<table>
<thead>
<tr>
<th>Coping Skills Training including:</th>
<th>Provide skills/training for early intervention</th>
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<tbody>
<tr>
<td>DBT</td>
<td>Life skills training</td>
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<tr>
<td>Interpersonal relations</td>
<td>Train the trainer: people teach others</td>
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<tr>
<td>Emotional regulation</td>
<td>Community providers training to service providers</td>
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<tr>
<td>Problem solving</td>
<td>Training of faith community and lay persons</td>
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<tr>
<td>Distress tolerance</td>
<td>Self-esteem/self-worth → values</td>
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### Peer to peer and other forms of grassroots support

<table>
<thead>
<tr>
<th>Parent to parent</th>
<th>“In their language”</th>
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<tbody>
<tr>
<td>Promotora model</td>
<td>Partnering in wellness</td>
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<tr>
<td>AA model</td>
<td>Recovery coach model</td>
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<tr>
<td>Mentor</td>
<td>Mobile units model</td>
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<td>Peer to peer</td>
<td>Animals</td>
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<td>art</td>
<td>Music</td>
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<tr>
<td>Telenovela → Self-help</td>
<td>In home visitors – ie. PHN, Meals on Wheels, RSVP</td>
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<tr>
<td>Online resources</td>
<td>Support group</td>
</tr>
<tr>
<td>Utilize paraprofessionals/people in recovery or on way to recovery and wellness</td>
<td>Confidentiality assured</td>
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Large Group Report Back – Raw Notes

What are the 3 interventions and/or strategies that should be presented to the CHIP Suicide Prevention Action Plan committee?

- Front line staff should receive education and training
  - People skills- training should emphasize this
- Utilize supportive models
  - Such as Yellow Ribbon, pet therapy, relationship based peer models
- See SMTG, Say SMTG, Do SMTG- strategy that is used in NYC for terrorism could be applied to suicide prevention
- Screening techniques to identify risk
- Maximize county resources- As a county there is a lot of opportunities to collaborate on available resources
  - Academic (universities), VA, Research Institutions
- Coordinate services
  - Bridge to care
- Media campaigns- extended information
  - Beyond PSA’s
  - Univision television as model for effective media messaging
- Utilize Technology
  - Social networking
  - Phone Apps
- 24 hour response team
- Good follow-up when someone contacts for help
  - Case management
- Provide targeted education with the aim of decreasing stigma
- Build infrastructure of resources – no closed doors philosophy for help seeking. Anyone who comes in contact with a high risk person should be a resource
  - Neighborhood – based
    - Normative setting (such as community centers)

What would it take to implement this intervention/strategy?

- Make intervention culturally specific
  - Address fears of engaging diverse communities
- Define prioritization- how is a priority population defined
- Technology – Bottom-up approach (collaborative conversation with patient/client regarding the fit of technology with the intervention)
  - Barriers- address these
  - Define policy of use
  - When to use – ask client if the technology fits the needs of the patient/client
    - Personalized approach to technology
- Need to determine what supports providers need to respond to increase in help-seeking?
- Good Samaritan Law- model the intervention to this law where the risk of being involved is addressed.
  - Liability- address liability in being involved
Breakout Group A – Raw Notes

+ What selective interventions and/or strategies have been implemented to prevent suicide and reduce suicide rates?

- Data: not sure about success, duration of success
- What are triggers to decrease success?
- MIL → education, stigma reduction, myths vs. facts
  - Older adult,
  - Children/adolescents
  - 18-24
  - Caregivers
  - Providers
  - LGBT
  - Conjoined therapy and support services
  - Engagement, trust
- Culturally specific
  - Japanese
- Matching client to provider
  - Peer to peer – MIL to MIL
    - Parent to parent
  - Cultural/linguistic match
- Grassroots – Promotora model
- In their language
- Examples and testimonials
- Flexibility, additional training for service providers
- Egoless approach
- Sponsors – AA model, partner to support wellness
- Instead of special unit, option for transition
- Mentor, recovery coach model
- Bigger scale of people
- Relationship based
- Mobile units model
- Confidentiality assured
- Support models vs. therapy

+ Which interventions and/or strategies would make the most impact in addressing suicide prevention in San Diego County?

- Relationship based support
  - Peer to peer
  - AA sponsor model
  - Supports daily social contact
o Partnering in wellness
o Recovery coach model

- Neighborhood model of intervention
  o In neighborhood
  o Reflects population
  o Sheriff storefront model/community policing model
  o Neighborhood watch model
  o Local training

- Paraprofessionals/people in recovery or on way to recovery and wellness

- Physician training re: somatization

- Train the trainer: people teach others
  o Community providers training to service providers

- Training of faith community
  o Lay persons

- Bridge support

- Support for providers
  o Vicarious trauma
  o Therapists, doctors, police officers

- Coping skills training – within education

- Challenges due to social media
  o Text vs. communication

- Impact of economy/budget cuts

- Rejoining large group/society
  o Expanding real social network

+ What regions or populations should be targeted? How should these regions or populations be prioritized?

- First Responders
- Identification of potential peers/mentors/sponsors
- Training of front line providers
- Identified populations
  o Military
  o Children
  o Adolescents
  o Older adult
  o 18-24
  o LGBT
  o Caregivers
  o Providers
  o Culturally specific
Breakout Group B – Raw Notes

+ What selective interventions and/or strategies have been implemented to prevent suicide and reduce suicide rates?

- Helpline, warm line
  - Specific target populations (Vets, LGBT, teen, age, NAMI, etc.)
- Education
  - SD school district prevention program
  - PERT trainings
  - NAMI consumer programs and family programs
  - Yellow Ribbon
- Research and statistics
  - Identified at-risk populations

+ Which selective interventions and/or strategies would make the most impact in addressing suicide prevention in San Diego County?

- Follow up
- 24/7 Emergency response teams
  - Peer to peer, culturally sensitive, regionally located
- Media campaigns
  - Going beyond PSA’s
  - Social networking → video games
    - Application ads
  - Univision as a model
  - Celebrity spokesperson
    - Sports
    - Target population
  - Pet therapy – suicide prevention companion
- Target population strategies
  - Schools – GSA’s
  - Faith organizations
  - Clubhouses
  - Support groups
  - Native American social services on/off reservations
  - Culturally specific training
- Suicide prevention training
- Self-esteem/self-worth → values
What regions or populations should be targeted? How should these regions or populations be prioritized?

- LGBTQI → Latino LGBTQI
- Veterans and active duty military
- Native American
- Vietnamese
- Caucasian males
- Hispanic and Latina women
- Seniors (men)
- East County middle aged and North Coastal seniors
- Youth (targeting younger → elementary)
- Should we prioritize by rate or number?
  - Prioritization for funding?
Breakout Group C – Raw Notes

+ What selective interventions and/or strategies have been implemented to prevent suicide and reduce suicide rates?

- Coping skills – specify
  - DBT
  - Interpersonal relations
  - Emotional regulation
  - Problem solving
  - Distress tolerance
- Education/training of PCP, HH Persons
- Screening – i.e. Mini Mental, PHQ.9
- Culturally Normed – peer to peer
- Yellow Ribbon/Red Folder
- Flagging – identifying in different ways
- Prioritize cultural match when available
- Peer operated warm lines
- Support through music, art, animals
- Online resources for training and education – support groups
- In home visitors – ie. PHN, Meals on Wheels, RSVP
- Provide skills/training for early intervention
- Telenovela → Self-help
  - Support group
- Use of current/cutting edge research to provide data

+ Which interventions and/or strategies would make the most impact in addressing suicide prevention in San Diego County?

- Life skills training
- Easy and timely access to services
- Service coordination
- Direct outreach
- Early detection – intervention
- See something – say something – do something
- Maximize use of resources
  - Education – VA – Research/technology
  - Translational research
    - Research trial → community practice
+ What regions or populations should be targeted? How should these regions or populations be prioritized?

- Youth – i.e. LGBT, College, Bullying
- Elderly – with chronic/hypochondriacal
- Severally and persistently mental illness → substance abusers
- Special groups – i.e. elderly males, Native Americans