



C A L I F O R N I A   D E P A R T M E N T   O F

# Mental Health

## **Suicide Prevention Plan Advisory Committee (SPPAC) Meeting Highlights**

Radisson Hotel, 500 Leisure Lane, Sacramento, CA 95815

**August 9, 2007**

### **Committee Action Items**

1. The deadline for additional comments on the proposed Prevention and Early Intervention (PEI) guidelines is Aug 9. All comments should be submitted to the Department of Mental Health (DMH) as soon as possible.
2. Committee members were encouraged to sign up to attend at least one of the Suicide Prevention Plan Public Workshops, scheduled for September 19 and 21.
3. SPPAC members interested in hosting community workshops are asked to contact Orlando Fuentes. Members interested in exploring the possibility of translated materials should contact Beverly Whitcomb to discuss. Laura Kaplan from the Center for Collaborative Policy (CCP) is available to provide facilitation coaching.
4. Ms. Whitcomb will coordinate the distribution of the September public workshop flier to SPPAC members on August 10th.
5. Committee members were asked to review the latest iteration of the *California Strategic Plan for Suicide Prevention* (CSPSP) and encouraged to discuss any concerns with Emily Nahat from DMH and Sharleen Dolan, the plan writer.
6. Dr. Roger Trent from the California Department of Health Services, Epidemiology & Prevention for Injury Control (EPIC) Branch, will develop and distribute a fact sheet of suicide statistics, including county information, to the committee.
7. SPPAC members will consider how to ensure accountability and measure progress of the CSPSP for the November committee meeting.
8. SPPAC staff will post SPPAC meeting notes and the revised plan on the DMH website prior to the public workshops.

### **Discussion Highlights**

Some committee members expressed interest in hosting public workshops in their own communities to reach populations that otherwise would not participate. There existed some concern that materials from DMH (including the CSPSP itself) are not translated into other languages. Given the high cost and tight timeline, DMH staff indicated that full translation into multiple languages may not be feasible. Members agreed to discuss the workshop process with DMH staff member Beverly Whitcomb (see action item #3).

The “data” discussion during the morning plenary session ranged from basic information about the data compiled thus far to the continued need for “breakout” statistics on specific racial, ethnic, and geographic groups in California.

## Meeting Notes

### **Item I: Welcome and Agenda Overview**

Facilitator Deb Marois from CCP opened the meeting with a review of the day's agenda and the SPPAC ground rules. All members and staff introduced themselves.

### **Item II: Suicide Prevention Planning/ Public Workshops: Recap and Update**

Emily Nahat, PEI Branch Chief, delivered opening remarks to the committee including a welcome and thank you for its continued work on suicide prevention, an update on the PEI stakeholder process, a review of the suicide prevention public workshop process, a description of the plan development and a review of the day's objectives.

Ms. Nahat provided an update on the proposed PEI guidelines, thanked the committee for their input on the PEI resource guide and noted that August 9<sup>th</sup> was the deadline for public comment (see action item #1). She then reviewed the suicide prevention public workshop process and asked members to attend at least one of the September workshops (see action item #2). She explained the planned outreach process and requested the committee's assistance with outreach, particularly to high risk groups including youth.

Next, Ms. Nahat discussed the iterative process used to revise the draft Plan and incorporate member's comments. She noted that many of the suggested actions contained sweeping recommendations that could be difficult to implement. In response to this, Sharleen Dolan, the plan writer, and Nahat tried to refocus directly on suicide prevention and create clear, specific and distinct recommendations. Nahat asked the group to review the revisions and comment back on any errors or omissions (see action item #3). Further details about the revision process are included in earlier documents.

Finally, Ms. Nahat delivered an overview of the objectives for the meeting, stressing that the day's discussion should focus on refining the strategic directions within the CSPSP. She asked the committee to keep in mind the transformational principles contained in the Mental Health Services Act (MHSA) and reviewed these concepts. Ms. Nahat also noted that members should avoid an abundance of recommendations that would require legislation and concentrate instead on balancing policy change with programmatic and administrative actions. Upon final adoption of the plan, this will increase the speed at which DMH and other state agencies are able to put the plan into action. In response to concerns committee members expressed about responsibility for implementing the plan, Ms. Nahat indicated that DMH is receptive to including suggestions about who can implement actions, but cautioned that the Plan can not issue mandates.

### Discussion:

- Some members expressed interest in hosting workshops in their own communities. Mr. Fuentes, Ms. Whitcomb and Ms. Kaplan will work with interested members to coordinate their efforts (see action item #4).
- With regards to accountability, one member encouraged the committee to closely examine and indicate which actions in the CSPSP that might be best implemented at the state, county, city and community levels.

### **Item III: Data Workgroup: Report and Discussion**

Orlando Fuentes from DMH delivered a report on the activities of the SPPAC data workgroup. He introduced the workgroup members and summarized the data compiled thus far. Key statistics illustrated such topics as the disparity between male/ female suicides and suicide attempts, California statistics versus national statistics, and information on the methods often used in suicides and suicide attempts.

#### Discussion

- One member asked if all statistics are from the same year. Dr. Roger Trent from the California Department of Health Services, Epidemiology & Prevention for Injury Control (EPIC) Branch responded that the data provided was from the most recent year available. In most cases, this equated to 2004 or 2005.
- Several members requested information on the rate and number of suicides in California, broken down by county and city. Dr. Trent responded that he could provide this information.
- A number of members asked if it is possible to receive information on suicide by race/ethnicity and other subgroups such as LGBTQ in each county. Dr. Trent responded that this information is currently unavailable by county, though the California Violent Death Reporting System is beginning to compile it.
- Some members expressed concern that the CSPSP/ data does not pay enough attention to “high profile” suicides such as deaths from bridge jumping (most notably the Golden Gate Bridge). One member suggested that more information is needed related to where jumping occurs, i.e., specific locations. Failing to address these issues could, they argued, create a credibility gap in the plan as a whole. Dr. Trent responded that while this issue does receive a lot of public attention, it represents a tiny fraction of suicides in the state as a whole.
- One member asked for a fact sheet summarizing suicide information in California into talking points (see action item #6).
- One member expressed concern that no information is available for some types of suicides such as “death by police” and intentional single-car automobile collisions. Dr. Trent said that when reporting the cause of death, coroners are often unable to make these decisions without clear proof of suicide. An ongoing question is how to reach at-risk people who don’t appear in the data.
- Some members expressed concern that the data presented lacks the “human face of suicide” and suggests that it is not a problem in California, as our rates tend to be lower than elsewhere in the country. Data that portray the impact of suicide are needed, e.g., more suicides occur than homicides each year in CA.

- Other members suggested that the data should reflect the connection between suicide and co-occurring disorders such as substance abuse and mental illness. This data is currently unavailable.

#### **Item IV: Roundtable Discussion Instructions**

Facilitator Marois delivered the instructions for the remainder of the day's activities. Throughout the room, five roundtable "stations" were set up; one for each of the strategic directions in the CSPSP. Roundtable sessions were divided into two, one-hour sessions and two, half-hour sessions. Committee members were directed to attend the station for the strategic directions they most wished to comment on. In addition, members could choose to review full studies and other compiled data to inform their work throughout the day and during a scheduled study period. At the end of the day, members would participate in a "gallery walk" to examine the day's work, select their highest priorities using "dot voting" and identify any areas of significant concern. Notes from individual roundtable discussions are available upon request.

- One member questioned the need to "prioritize" suicide prevention activities, stating that ALL suicide prevention recommendations in the plan are priorities. Ms. Marois responded by saying that in order for the recommendations to be successful, it is possible that some need to happen before others. While further prioritization may take place in November, the process will give members an initial "snapshot" of possible places to begin implementation.

#### **Item V: Roundtable Discussion Round I**

See IV above. This was the first of two, one-hour sessions.

#### **Item VI: Public Comment**

The committee reconvened briefly after lunch to hear from any members of the public wished to comment on the process. One comment was submitted in writing:

- "Build upon natural alliances such as CAIRS (California Association of Information and Referral Services) and 211 provider networks (many 211 providers handle suicide risk calls)."

#### **Item VII: Roundtable Discussion Round II**

See item IV above. This was the second of two, one-hour sessions.

#### **Item VIII: Study Period**

Committee members examined the work accomplished by other groups and could also attend one of two "data stations" around the room.

### **Item IX: Roundtable Discussion Round III**

See item IV above. This was the first of two, half-hour sessions.

### **Item X: Roundtable Discussion Round IV**

See item IV above. This was the final roundtable session of the day.

### **Item XI: Gallery Walk**

Ms. Marois distributed eight green and five yellow “comment dots” to each member for the gallery walk. Members were instructed to place one green dot next to each CSPSP recommendation that they believe are the highest priority to accomplish because they have the potential for the biggest impact on suicide prevention in CA. Members were asked to place a yellow dot next to those items for which they had a significant concern.

### **Gallery Walk Summary**

Note: Approximately 20-25 SPPAC members participated in the prioritization activity. The total number of “dots” designated by SPPAC members as a high priority or significant concern is indicated in parenthesis following each item.

## **Strategic Direction A**

### **Recommended Action 1 (17)**

#### Areas of Priority:

- Launch and sustain a public/community education program on suicide indicators, risk and protective factors and how to get help (5).
- Design campaigns informed by and for specific communities (i.e., youth, older adults, and various ethnic and cultural groups) (6). Include foster parents, military and rural communities (1).
- Address depression in these public education campaigns (1). Specifically address depression brought on by discrimination, violence, abuse, mood disorders, and developmental and biological risk factors (2). Approach depression from a wellness and recovery perspective (1).
- Address the issue of privacy vs. transparency in the education campaigns (1)

#### Areas of Concern:

- Recommended Action 1(a) and (c) should be combined into a set of “guiding principals” instead of being stand alone actions. (1)

## **Recommended Action 2 (5)**

### Areas of Priority:

- Suicide stigma/ discrimination reduction campaign designed specifically for targeted ethnic and culture specific populations (1). “Culture” should not be restricted to ethnicity and race (1).
- Stigma reduction campaign started by targeting school principals, law enforcement personnel, employers and primary care providers (3)

## **Recommended Action 3 (0)**

### Areas of Concern:

- Use of “guidelines” to ensure that the media portrays a balanced view of suicide instead of creating a program to educate the media about suicide (1).

## **General areas of concern with Strategic Direct A**

- The public education campaign would not have enough funding to be implemented effectively (3).

## **Strategic Direction B**

### **Recommended Action 1 (13)**

#### Areas of Priority:

- Create a State Suicide Prevention Office/Resource Center to coordinate suicide prevention, intervention, and postvention activities throughout the state (7).
- Suicide Prevention Office should have dedicated staff with resources from each of the agencies outlined in SB 1356 (Lowenthal) to develop resources for suicide prevention activities, i.e., link to research base, technical assistance for cultural competency, state model curricula, etc. (1)
- Reconvene the SPPAC on an annual basis (5).

### **Recommended Action 2 (5)**

#### Areas of Priority:

- Create a responsible body and interagency forum at the count level to address priority suicide prevention needs (1)
- Create partnerships among community leaders to facilitate early identification, access and intervention (4)

### **Recommended Action 3 (3)**

#### Areas of Priority:

- Expand federal, state, local and private partnerships to develop procedures that support collaborative service delivery including data sharing to identify areas for and increase the effectiveness of suicide prevention efforts. (1)
- Establish clear protocols for communication, accessing services, and following through when at risk or suicidal clients transfer to or utilize services from various public and private providers (2).

#### Areas of Concern:

- Expanding intervention and treatment capacity in crisis services (1).

### **Recommended Action 4 (1)**

#### Areas of Priority:

- Create a consortium of statewide 24-hour suicide prevention lines and websites in California to develop service guidelines (1).

#### Areas of Concern:

- Create a consortium of statewide 24-hour suicide prevention lines and websites in California to develop service guidelines (1).

### **Recommended Action 5 (1)**

#### Areas of Priority:

- Evaluate conventional interpretations of confidentiality laws to ensure they are not merely mitigating risk, but are in the mental health client's self-determined best interest (1).

#### Areas of Concern:

- Distinguish between the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (3).

## **Recommended Action 6**

### Areas of Concern:

- The argument that reducing access to lethal means could be an infringement on the right to bear arms and discriminate against mental health clients and could dilute the importance of this recommended action.

## **Strategic Direction C**

### **Recommended Action 1 (3)**

#### Areas of Priority:

- Develop standards for elementary, secondary and post-secondary students to address suicide prevention and institutional safety plans using such sources as *Youth Suicide Prevention Guidelines for Schools, 2005* (1)
- Implement quality care/ utilization management guidelines in managed care and health insurance plans (1).
- Provide training guidelines for licensed professionals, non-licensed professionals, and caregivers (1).

#### Areas of Concern:

- Develop standards for elementary, secondary and post-secondary students to address suicide prevention and institutional safety plans using such sources as *Youth Suicide Prevention Guidelines for Schools, 2005* (1).

### **Recommended Action 2 (10)**

#### Areas of Priority:

- Require suicide prevention training for licensed health professionals and a periodic renewal process (8).
- Provide incentives for (or require) suicide prevention training for key groups such as college and university faculty, staff, resident advisors, and counselors for students with disabilities (1)
- Provide suicide prevention training for licensed care facilities (1).

#### Areas of Concern:

- Providing ongoing suicide sensitivity training for appropriate health care providers could be redundant and should be built into other training programs (1).

### **Recommended Action 3 (7)**

#### Areas of Priority:

- Educate family and natural community helpers to recognize, respond to and refer people showing signs of suicide risk (4).
- Develop a non-professional grassroots training program (1).
- Encourage counties to collaborate with non-profit/ grassroots organizations to utilize non-governmental resources for the development of a non-governmental suicide prevention program (1).
- Train non-professionals to teach businesses and the mental health community how to recognize signs and refer people to appropriate services (1).

### **Recommended Action 4 (1)**

#### Areas of Priority:

- Develop tools to navigate the mental health system for counties specific to the professional populations that mental health services interact with such as physicians, coroners and law enforcement (1).

### **Strategic Direction D**

#### General Areas of Concern:

- Use of the word “culture” in the text could be problematic in that it might marginalize the majority in suicide prevention efforts (1).

### **Recommended Action 1 (9)**

#### Areas of Priority:

- Integrate suicide prevention and early intervention programs into the entire education system (K through post-secondary institutions) (1).
- Suicide prevention programs in schools should focus on youth development for transition age, foster, and elementary age youth (1).
- Include youth leadership peer strategies and peer support in school suicide prevention programs (5).
- Link school suicide prevention programs to existing school programs on topics such as bullying, violence prevention, and school safety plans (2).

#### Areas of Concern:

- The sub points of Recommended Action 1 do not adequately address problems at the post-secondary/ college level (1).

## **Recommended Action 2 (6)**

### Areas of Priority:

- Include the homeless population in integrated suicide prevention programs for “front line” systems such as emergency response systems (1).
- Include primary care providers in suicide prevention programs for “front line systems” (2).
- Suicide prevention outreach for homebound or those without transportation, (including older adults) (2).
- Provide support services to individuals traumatized by suicide and suicidal behaviors (1).

### Areas of Concern:

- Implementing routine voluntary screening as standard protocol in primary care, especially for older adults (1).
- Veterans and those with post-traumatic stress disorder are not included in Recommended Action 2(f) (1).

## **Recommended Action 3 (3)**

### Areas of Priority:

- Develop suicide prevention programs that address the needs of those living in rural areas, those who are homebound, or those who are otherwise isolated (1).
- Establish insurance reimbursement for home care and assisted living (1).
- Educate policy makers and clinicians regarding the risk of suicide for those over 60 (1).

## **Recommended Action 4 (2)**

### Areas of Priority:

- Maintain a list of local suicide intervention, treatment, or support services for employers (1).
- Increase mental health literacy in workplaces (1).

## **Recommended Action 5 (6)**

### Areas of Priority:

- Implement suicide prevention programs and improve the capacity for early identification and intervention within law enforcement (1).
- Provide prevention, early intervention and treatment services for mental health problems in the law enforcement system (3).

- Deliver discharge transition support for inmates in recovery and rehabilitation (1).
- Suicide prevention programs for probation, law enforcement and corrections officers (1).

### **Recommended Action 6 (7)**

#### Areas of Priority:

- Provide incentives for innovation to expand culturally and linguistically appropriate approaches with community defined evidence and move towards evidence-based prevention and intervention strategies (2).
- Incentives should emphasize high risk groups such as Native American males, Latina adolescent girls, Asian Pacific Islander adolescents, females, older adults and the LGBTQ community (5).

### **General Comments for Strategic Direction D**

- The introductory text for Strategic Direction D should include the importance of family (1).
- The introductory text for Strategic Direction D should include language about tailoring programs to specific populations (1).
- Include a “roadmap” for the success of Strategic Direction D, i.e., a set of steps for achieving the goals of D (1).
- Include language in the direction to develop AND sustain the programs in Strategic Direction D (1).

### **Strategic Direction E**

#### **Recommended Action 1 (6)**

#### Areas of Priority:

- Expand the California Violent Death Reporting System to gather detailed suicide data throughout California to increase knowledge of risk factors and predictive behaviors for suicide (2).
- Collaborate with the national research community to conduct research to close the gap between risk factors and predictive behaviors for suicide (3).
- More research on risk factors and warning signs in order to translate the data to the public better (1).

#### Areas of Concern:

- Working with coroners to determine how to improve investigations to increase understanding of suicide and enhance prevention efforts Coroners are politically pressured not to disclose suicide data publicly. This needs to change. Also

Coast Guard personnel aren't allowed to discuss suicide even though they retrieve bodies from bridges (1).

- Data collection is challenged by a fear of “fault finding;” in that confidentiality rules keep us from learning the findings from psychological autopsies and completed suicides (1).
- The proposed "consistent method of tracking and reporting suicide prevalence/incidents among clients..." is not worded clearly enough. Clarify that such tracking and reporting not include names or other identifying data that "flag" individuals but are limited to collective data for statistical purposes (1)

### **Recommended Action 2 (5)**

#### Areas of Priority:

- Create a policy action team to translate case review team findings in suicide prevention policies and programs (4)
- Promulgate laws to create suicide review teams in each county (1)

### **Recommended Action 3 (3)**

- Conduct a program of research on suicide and suicide prevention specific to California to support better policies and programs (1).
- Encourage the use of community-based participatory research and action research methods including longitudinal studies and qualitative methods such as focus groups, ethnography, and oral histories. Potential partners include universities, community organizations, policy institutes, and foundations (2).

### **Recommended Action 4 (1)**

- Evaluate suicide prevention programs and strategies to ascertain their effectiveness (1).

**Adjournment: 5:00 pm**

## ATTENDEES

### Committee members

Last	First	Affiliation	Pre sent
Aguirre	Alfredo	California Mental Health Director's Association	X
Areán, Ph.D.	Patricia	University of California, San Francisco	
Arroyo	Bill	Los Angeles County Department of Mental Health	
Bateson	John	Contra Costa Crisis Center	X
Bell, Ph.D.	Susan	University of California, Berkeley	X
Bloom	Sam	SPAN-California	X
Boomer	Lisle	Protection and Advocacy, Inc.	X
Bragg	Martin	CA Polytechnic State University, San Luis Obispo	X
Brody	Delphine	California Network of Mental Health Clients	X
Buck	John	Turning Point Community Programs	X
Cawthorn, MFT, MAC	Rick	Hoop Valley Tribal Council	X
Chaffee	Mark	SPAN-California	X
Clayton, MA	Diana	NAMI of Shasta County	X
Colwell	Barbara	LAUSD	X
Cory	Carole	California Department of Aging	X
Craig	Rebecca	Dept. of Corrections & Rehabilitation	X
Curren	Joe	Redwood Coast Senior, Inc.	X
Curry, Ph.D.	Kita	CCCMHA & Didi Hirsch Community Mental Health Center	X
Fetrow	Steven	California National Guard, Headquarters	
Garcia	Leticia	Senator Alan Lowenthal, 27th Senate District	
Garcia	Luis	California Mental Health Planning Council	X
Gaw, MD, DLFAPA	Albert	SF DPH CMHS (Community Mental Health Services)	X
Gorewitz, Ph.D.	Janet	Martinez Detention Facility	
Gouveia	Leann	Fresno Survivors of Suicide Loss	X
Hayashi	Mary	Mental Health Services Oversight and Accountability Commission	
Kiehl	Steven	California National Guard, Headquarters	X
Lawson III	Morris		
Lee	Tom	Department of Social Services	X
Locario	Seprieono	Native American Health Center	X
Mays, Ph.D., MSPH	Vickie	University of California, Los Angeles	
Morales	Ed	Dept. of Corrections & Rehabilitation -Division of Juvenile Justice	
Pena	Maria	Mira Costa College Disabled Student Programs and Services	X
Pines, Ph.D.	Michael	Los Angeles County Office of Education, School of Mental Health	X
Ranahan	Dede	National Alliance of Mental Illness, California	X
Robbins, CFRE	Charles	The Trevor Project, Administrative Offices	X
Russell	Mindy	Law Enforcement Chaplaincy Sacramento	
Selix	Rusty	California Council of Community Mental Health Agencies	
Sheldon	Betsy	California Department of Education	X

Steele	Clyde	Office of Co-Occurring Disorders	X
Trent, Ph.D.	Roger	CA Department of Health Services, Epidemiology & Prevention for Injury Control (EPIC) Branch	X
Willson	Billee	Sacramento County Department of Health and Human Services	X
Yee, Ph.D.	Tina Tong	SF Community Behavioral Services	X

### **Project Staff**

Department of Mental Health: Emily Nahat, Orlando Fuentes, Bev Whitcomb, Sonia Mays, Bertha MacDonald

CSUS Center for Collaborative Policy: Deb Marois, Laura Kaplan, Sue Woods, Sarah Rubin, Sam Magill

Consultant/Writer: Sharleen Dolan

### **DOCUMENTS AVAILABLE**

- Agenda
- Goals for 8/8 SPPAC meeting
- CSPSP Public Workshop flier
- CSPSP- DRAFT for Discussion 8-9-07
- Writer's Notes for Revisions made post 7/12/07 SPPAC Meeting
- Research Abstracts and Reports- SPPAC Data Workgroup August 3, 2007
- Data Workgroup presentation
- Opportunities and Challenges for Suicide Prevention Planning in CA
- CSPSP- Common Terms for Roundtable Discussion
- SPPAC Roundtable Discussion Guidelines