Fresno County Community-Based Suicide Prevention Strategic Plan

Written by

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For those who struggle, those who have been lost, those left behind, may you find hope…

Fresno Cares

2018

Introduction

In October 2011, a group of community leaders came together to look differently at our community's mental health system of care. Driven by the closure of the County's 24-hour mental health crisis unit, the group recognized that our ability to transform our mental health system was much greater working together than on our own as individuals, hospitals, government agencies, universities or community-based organizations.

Community Conversations around Mental Health has been working together ever since. . What started as a short-term effort has turned into a sustained and committed group of individuals across nearly every sector of our community.

So, in late 2016, when our community experienced a cluster of teen suicides, *Community Conversations* stepped up to facilitate an effort to form a Suicide Prevention Collaborative, to harness the passion around making a change in the suicide rate and to create a community-wide Suicide Prevention Plan. The Fresno County Department of Behavioral Health has served as the backbone organization to organize monthly meetings and has engaged three suicide prevention experts, DeQuincy Lezine, Ph.D., Noah Whitaker and Stan Collins to assist us in this endeavor.

This document is the culmination of over 18 months of dedicated effort by this group of individuals from across Fresno County who are devoted to preventing suicide in Fresno County. Now the real work begins--- to implement the plan. As you read through the document, keep in mind that this plan will change over time, as we learn more, try different things and listen to those who can inform us.

We welcome your feedback, ideas and suggestions. We know that it will take each and every one of us if we are going to make a difference. Please join us!

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Facilitator, Fresno County Suicide Prevention Collaborative
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Background and Rationale

How Suicide Impacts Fresno County

The headline in the *Fresno Bee* said: "After three Clovis West student suicides, parents demand more action." It was December 2016, and our community was reeling from a recent cluster of adolescent suicides. Those students were part of the disturbing death toll as 14 teenagers died by suicide in Fresno County in 2016. In most prior years, the number of teens who took their own lives ranged between 5 and 7. In 2017, with five adolescent deaths by suicide (ages 10-19), the trend may have returned to the historical pattern.

However, the sharp increase in teen suicides in 2016 is just a small part of the story. Based on data from prior years, for every teen suicide death, approximately 70 youth were treated in the emergency department following self-injury[1], and more than 5,000 adolescents thought seriously about ending their lives but likely did not attempt suicide[2]. Altogether, each year almost 1 out of every 5 teens in Fresno County experiences emotional pain so severe that the teen contemplates suicide. Each year, at least 1 in every 11 families in the county needs to cope with issues related to teen suicide.

Yet, even those numbers don't fully describe the Fresno County experience with suicide. In addition to the 14 teenagers who died by suicide in 2016, Fresno also lost 75 working-age men and women (ages 25 to 64) and 12 members of our older adult community (ages 65 or older). Based on data from prior years, approximately 870 adults (ages 20 years and older) received emergency treatment for self-inflicted injuries[3], while an estimated 28,000 adults seriously considered killing themselves[4]. Year after year, over 10% of households[5] in Fresno have directly faced issues related to suicide.

The emotional and social toll of suicidal thinking, self-injury, and suicide death are of paramount importance in discussing the impact the issue has on the community, but the economic impact also deserves attention. While some may see discussion of the financial side of suicide as callous, there are at

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[1] Epicenter Data, Non-fatal Emergency Department Visits, based on average of 350 visits per year for ages 10-19 years old from 2010 to 2014.
[2] YRBS Data, based on 2017 survey results of 17.2% of high school students reporting suicidal thoughts.
[3] Epicenter Data
[4] Based on NSDUH estimate of 3.96% of adults in CA.
[5] Census estimate of 296,305 households in Fresno County

least two reasons to do so. First, it is part of the real cost that individuals and families must bear when a suicidal crisis escalates into life-threatening action. Second, all prevention efforts have expenses, and knowing the costs that would occur without intervention helps us make the argument for investing in suicide prevention. According to the CDC, on average the medical expenses from emergency department treatment of self-injury are estimated at $3,400.[6] They estimate that an additional $1,088 cost to the family comes from lost wages during that time[7], raising the total financial impact to $4,488. The estimated cost of a suicide attempt is higher than the average monthly income for families in Fresno County.[8] Meanwhile, Fresno businesses are left with missing employees or severely reduced productivity. Furthermore, each suicide may also involve costs associated with emergency medical services, law enforcement response, funeral arrangements, legal services, and bereavement supports, among other expenses. Based on recent estimates, the total economic cost for suicide death and injury in Fresno County might be more than $140 million per year.[9]

To understand how the topic of suicide impacts Fresno County, we must also acknowledge how many people, beyond the immediate family, are affected by each suicidal crisis. Research studies consistently report that at least half of the population knows someone who has died by suicide, and one report found that one in three persons in the U.S. feels that suicide has profoundly impacted his or her life. A community survey conducted in Fresno County found that 79% of participants had personal or professional experience with suicide or suicide attempts. Many of us who are part of the Fresno Suicide Prevention Collaborative have been affected by suicide in our personal lives. Several have experienced the suicide death of a family member, and a few have survived their own suicidal crises. Chances are that you will have an experience with suicide loss or struggles during your lifetime as well. However, with planned efforts, we hope to avoid, or at least minimize, the impact of suicidal crises.

It is also useful to consider the picture of suicide in Fresno County within the broader context of suicide in the U.S. A 2018 report from the CDC found that "suicide rates increased in nearly every state from 1999 through 2016."[10] In 2016, almost 45,000 people in the US died by suicide, making it the 10th leading cause of death overall, and the second leading cause of death for individuals ages 10-34 years old. The national attention to suicide provides opportunities to learn from other communities and to adopt ideas that are being developed by suicide prevention experts around the world.

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[6] CDC WISQARS Cost of Suicide estimate is $3,400 for ED visit for self-injury.
[7] CDC WISQARS Cost of Suicide amount tied to work loss due to ED visit for self-injury is $1,088.
[8] Census Median Household Income is $3,830 per month.
[9] Shepard, et al (2016). Suicide and suicidal attempts in the United States: costs and policy implications. Suicide and Life-Threatening Behavior, 46(3).
[10] CDC VitalSigns, June 2018

The Fresno County Suicide Prevention Collaborative

The Fresno County Suicide Prevention Collaborative (the Collaborative) is a dynamic and diverse community stakeholder group that is working toward cohesive action to address suicidal behavior. The conceptual framework described in the section that follows is intended to help establish and underscore the value of such cross-systems collaboration. Thinking systematically about suicidal behavior and the context around it also helps to identify opportunities to bring missing voices to the table to strengthen the efforts of the Collaborative, reach diverse populations, and coordinate activities to maximize effectiveness.

The Collaborative's actions take place through a series of workgroups that are aligned by both function and sector. These workgroups are dynamic and can and should change over time. This approach highlights the fact that the role of each individual and organization contributes to the success of community-based suicide prevention efforts, that everyone has a role in suicide prevention and community health, and that no single organization or group will be successful without collaboration.

Figure 1. The Fresno County Suicide Prevention Collaborative Integrated Value Chain[11] and Suicide Prevention Resource Center's (SPRC) Strategic Planning model[12].

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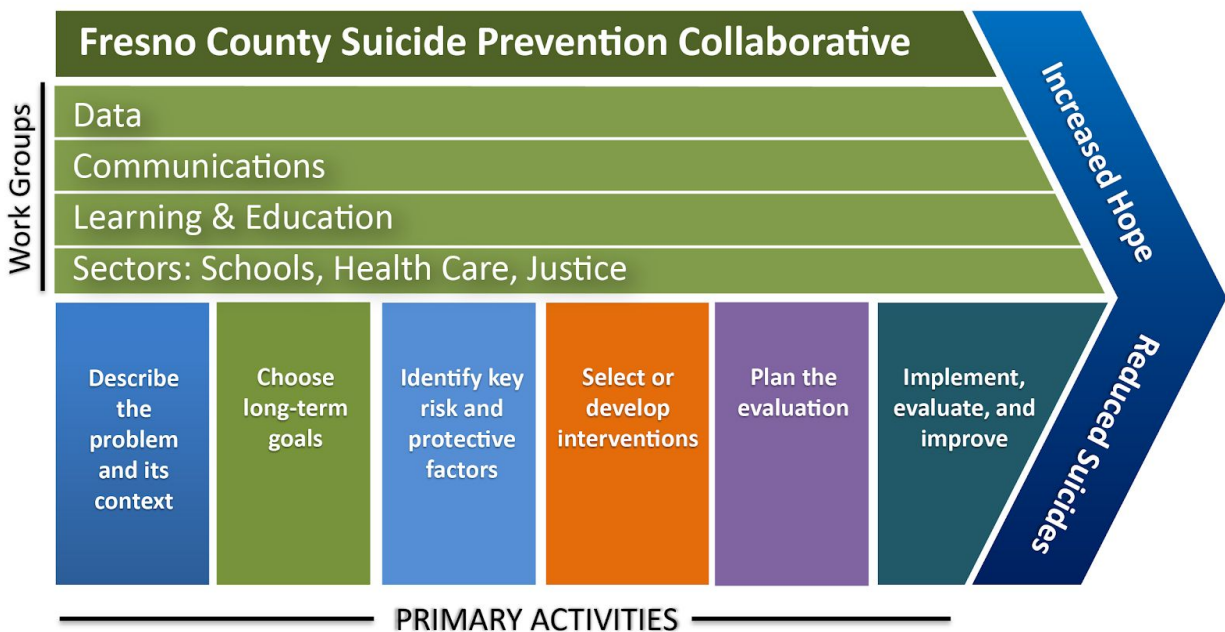
[11] Model developed by Noah J Whitaker
[12] http://www.sprc.org/effective-prevention/strategic-planning

The Fresno County Suicide Prevention Collaborative Integrated Value Chain and Suicide Prevention Resource Center's (SPRC) Strategic Planning model (Figure 1) demonstrates the ongoing processes that help advance action and the importance of the Collaborative and workgroups across the full intervention model. Through mutual efforts, the coordination of unified communication, surveillance and epidemiology, and data collection and analysis, multi-sector involvement and linkages will be established. This facilitates a better utilization of resources, funding, and in-kind contributions.

The Collaborative meetings, workgroups, key informant interviews, focus groups, and systems data were all collected and analyzed to form the training, programs, and associated activities that are proposed in this strategic plan. Once those strategies are selected and prioritized, training and programs can be implemented. The ongoing operations of those programs would continue to fall under the community engagement and input process of the Collaborative and its workgroups. These programs will need to engage in outreach activities that are combined with and amplified by the overall communications strategies developed by the Collaborative. The data collection workgroup, in conjunction with data from public surveillance systems and the sector-based workgroups, will review and evaluate the effectiveness of these programs. Through this value chain, the community of Fresno County will increase hope and reduce suicides in an effective and coordinated manner.

It is important to keep in mind that this is a continuous improvement process. Once evaluations are complete, they might indicate a need for new funding and resources, adjusting the current mix of resources, and modifying the strategic plan. Previous programs' interventions might prove to be ineffective or not suited to the Fresno County environment, and community needs may shift. However, it is also extremely important to bear in mind that suicide is complex and a long-term view must be taken when approaching this issue. Action can take decades to modify the generational impact of suicide.

History

Following the surge in teen suicides including a cluster of three suicides of students at one high school and increasing media attention, a special briefing was called at the Fresno County Sheriff's Office on December 21, 2016. School

> *"If any one sector could 'solve' the challenges of mental health, they would have. But they can't. We need to work together." - Lynne Ashbeck*

systems were also under pressure from California Assembly Bill 2246, signed into law September 26, 2016, which required all school districts to establish suicide prevention policies before the beginning of the 2017-2018 Academic Year. Several school districts were represented at the Sheriff's Briefing, along with representatives from behavioral health systems, law enforcement agencies, media outlets, and community organizations. That initial meeting laid the groundwork for the Teen Suicide Prevention Workgroup, which was set to convene on January 17, 2017. The Community Conversations group volunteered to take the lead in coordination and facilitation.

From the start, a promotion and prevention purpose for the community response that was coalescing was to bring major stakeholders together to work toward common goals. The initial goals were:

- *To improve the mental health of our community's teens as measured, in part, by increased resources/improved interventions, reduced numbers of teen suicide, and increased ability — as a community — to talk openly about this issue.*
- *To leverage and align our community's interests, resources, and initiatives around teen suicide into a single, cohesive effort.*

At the January meeting, it was determined to have at least a series of three face-to-face monthly meetings to plan how to move forward. Lessons learned from collective action from the Community Conversations effort to improve mental health care in Fresno were shared with the group. The meeting also included presentations designed to get everyone "on the same page" with fundamentals about suicide and suicide prevention, followed by discussion aimed at bringing local knowledge and expertise to the table to assess what we knew about teen suicide in Fresno and what different groups were doing that could help address the issue.

Capacity-Building

As noted, the community-based work to move suicide prevention efforts forward in Fresno County was foreseen by the group to have the most value if engaged in collaboratively. This led to a series of activities and the formation of workgroups, which have been active since the summer of 2017.

As part of the community response to the youth suicides, Valley Children's Hospital hosted "A Discussion on Teen Depression and Suicide Prevention" on February 11, 2017. Speakers from multiple agencies provided information in the public forum that was attended by over 200 participants. Event evaluations were positive and indicated community engagement in the topic.

In the process, the group identified assets currently in place but also found gaps that would need to be addressed before developing a comprehensive strategic plan. In response to available data about suicide and the eventual goal to focus on a lifespan approach to prevention, the group chose the name Fresno County Suicide Prevention Collaborative (the Collaborative).

Additionally, it was clear that the work ahead would encompass activity on multiple fronts at the same time:

- There was a need and desire to develop workgroups to help focus on specific sectors and activities to assist the group in describing the problem and more fully understanding its context.
- The group acknowledged that some likely elements of the plan could be identified immediately and initial work could begin with enhancing already existing programs and procedures, and building capacity for implementing the strategy once it was in place.

- School systems had the pressing need to respond to AB 2246[13] requirements, including training for staff and development of suicide prevention policies.
- Developing a comprehensive strategic plan required data and community input not immediately available, and thus systematic efforts were started to proceed with needs assessments first.

Suicide Prevention in Schools (AB 2246)

California Assembly Bill No. 2246 (Pupil suicide prevention policies) was signed into law on September 26, 2016, requiring all Local Education Agencies (LEAs – including school districts, charter schools, etc.) serving grades 7–12 to "adopt a policy on pupil suicide prevention, as specified, that specifically addresses the needs of high-risk groups… The policy shall be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts, and shall, at a minimum, address procedures relating to suicide prevention, intervention, and postvention."[14]

As directed by the new law, the California Department of Education released a "Model Youth Suicide Prevention Policy" (CDE Model Policy) in May 2017, along with resources related to youth suicide prevention. As stated in the model policy, "Additionally, the CDE encourages each LEA to work closely with their county behavioral health department to identify and access resources at the local level". In accordance with that recommendation, the Fresno County Department of Behavioral Health worked with the Fresno County Superintendent of Schools and Each Mind Matters to conduct a special training workshop for all LEAs to assist with developing suicide prevention policies and practices to meet the needs of the new law[15].

The training was held on June 19, 2017, and was attended by many of the LEAs in Fresno County. The workshop provided information about suicide and suicide prevention in general, as well as specific guidance around fulfilling the requirements outlined in the CDE Model Policy. Technical assistance was offered to groups representing the LEAs, along with worksheets, references, checklists, and resource guides. Many have also attended related webinars on school-based suicide prevention.

School districts in Fresno County have been supporting each other's efforts to develop and implement suicide prevention policies and procedures through the Collaborative's Schools Workgroup. While full implementation of comprehensive suicide prevention activities in the school is a long-term goal and will remain a fluid work-in-progress, districts participating in the Schools Workgroup have been successful in moving past compliance with the state mandate and expanding efforts on campus.

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[13] EDC. Title 1. Division 1. Part 1. Chapter 2. Article 2.5
[14] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB2246
[15] EDC. Title 1. Division 1. Part 1. Chapter 2. Article 2.5

Workgroups

To continue moving forward after the third meeting of the Community Conversations group focusing on suicide, the group identified common areas of interest among stakeholders supporting suicide prevention in Fresno County. To more efficiently make progress toward implementing overall objectives within specific community sectors, the group decided to form the following Workgroups:

- **Data Workgroup** is focused on working with local, state, and federal data collection methods for statistics, rates, and overall numbers regarding suicide in the Central Valley.
- **Communication Workgroup** is focused on conveying information to the public, the media, and other organizations in the Central Valley.
- **Learning and Education Workgroup** is focused on organizing the public education and training opportunities in the Central Valley.
- **Healthcare Workgroup** is focused on making connections between clinical providers, including hospitals, community health centers, emergency rooms, clinics, and other agencies, to promote suicide prevention.
- **Schools Workgroup** is focused on efforts in the school districts and addressing the need for youth suicide prevention, intervention, and postvention.
- **Justice & First Responders Workgroup** is focused on efforts in the justice system, including law enforcement, probation, and incarcerations.

Data

There currently is no central source of data about suicide and suicidal behavior in Fresno County. While the Pediatric Death Review Team for Fresno collects and analyzes data from multiple sources for youth (under 18 years old), there is no similar process for the majority of suicides or for non-fatal suicide attempts of any age. Thus, the Data Workgroup developed goals around collecting the data that is available in a variety of settings while also working to establish improved data-sharing systems. Due to the decentralized nature of data in Fresno, the needs for coordination and cooperation are significantly higher. The group slowly added members as the appropriate contact persons at each relevant agency were identified and engaged.

- Goal 1: Create a system allowing for data sharing to improve care. (2-3 years)
    - Objective A: Obtain legal interpretation of data-sharing capabilities in regard to HIPAA, FERPA, etc. (1-1.5 years)
    - Objective B: Improve data-collection capabilities. (ongoing, never-ending process)
- Goal 2: Create a Needs Assessment Report for Fresno County. (1 year)
    - Objective A: Pool de-identified data together. (6 mo.)
    - Objective B: Improve data-collection capabilities. (ongoing, never-ending process)

Communication

As noted in the guidance from the National Action Alliance for Suicide Prevention (the Action Alliance), clear communication between partners and out to the broader community is essential for a comprehensive prevention effort. As in other areas, there was no central or coordinated source of information related to suicide prevention before, and the Communication Workgroup seeks to bridge the gaps between related campaigns and public information activities across the county. In part, this included the development of a web presence for the Collaborative at http://www.fresnocares.org and an active Facebook Page[16]. Media outreach resulted in television interviews with Collaborative members and a televised Town Hall on teen suicide prevention.

- Goal 1: Connect with communication staff from different agencies to spread the work being done by the Collaborative.
  - Objective A: Create a shared database of communication staff.
  - Objective B: Update contact information as needed.
- Goal 2: Create partnerships with local media to assist in spreading safe reporting practices.
  - Objective A: Invite local media to Collaborative meetings, subcommittee meetings.
  - Objective B: Speak to News Managers and news staff on Collaborative efforts, including safe reporting.
- Goal 3: Create a website to house local, state, and national suicide prevention efforts.
  - Objective A: Begin by using the website to communicate with the Collaborative by sharing meetings, goals, and objectives of the subcommittees, and resources.
  - Objective B: Create a Facebook page that can be used to post information and link back to the website.
  - Objective C: Continue to update the website.
- Goal 4: Develop safe messaging guidelines

Learning and Education

Several groups have been providing community-based suicide prevention education and training for many years, but it was not coordinated or guided by a strategic plan. While continuing to provide training for the public using several models, the Learning and Education Work Group has provided opportunities for sharing information between training agencies with the potential for increased collaboration and planning. By using coordinated plans, the group hopes to achieve cost savings and expanded opportunities for increasing the skills of current trainers and recruiting additional trainers.

- Goal 1: Provide guidance and support regarding training resources to the community at large.
  - Objective A: Maintain website and a master list of training.
  - Objective B: Provide outreach to the community.
  - Objective C: Create a list of trainings and a description of the content and time of delivery (status: complete).
  - Gather a master list of trainers for Fresno County (complete).

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[16] https://www.facebook.com/Fresno-Cares-1261722283973345/

- Goal 2: Create a presentation for suicide prevention including mental health stigma, the statistics of suicide, the signs associated with suicide for children, teens, adults, and older adults, with an introduction on how to intervene and provide resources (status: complete).
    - Objective A: Recruit and train individuals to deliver the presentation across the county.
    - Objective B: Create a pre- and post-test to measure the outcome of KTS presentations.
    - Objective C: Deliver the presentation throughout Fresno County.
- Goal 3: Create informational content for outreach events (e.g., coping strategies and informative literature).
- Goal 4: Magnify our prevention and awareness efforts by recruiting new members to deliver presentations.
    - Objective A: Recruit presenters.
    - Objective B: Scheduling training for presenters.
    - Objective C: Schedule events throughout Fresno County.
    - Objective D: Deliver presentations.
- Goal 5: Bring the *S Word* documentary and director for screening events in August.

Health Care

Similar to the situation with schools, each health care system had its own programs and projects related to suicide prevention. The Health Care Workgroup has enabled the sharing of information about what is available in Fresno County from different sources and provided a forum for discussing shared needs around training and program development. Major hospitals and health systems, including health insurers, meet together to coordinate efforts going forward.

- Goal 1: Implement and sustain evidence-based training for suicide prevention screening and intervention for healthcare systems.
    - Objective A: Develop a strategy for implementing and sustaining a system of training in RRSR/CSSR for all healthcare providers
    - Objective B: Plan a series of targeted, ongoing trainings for a variety of professional programs across the healthcare disciplines.
    - Objective C: Study and evaluate training for healthcare professionals in providing services for loss survivors.
- Goal 2: Develop a unified understanding of the healthcare community that health care is inclusive of behavioral health.
    - Objective A: Increase the breadth of partners in the community and their commitment to addressing this need.
    - Objective B: Reduce stigma within the medical healthcare community.
    - Objective C: Mobilize health care providers in Fresno County to reduce stigma by increasing their knowledge and skills in advocacy and education.
- Goal 3: Establish a system of behavioral health integration in promotion and prevention care.

○ Objective A: Study, evaluate, and determine modes of support to increase integration that may include a psychiatric consultation line, a mobile team, and/or an intensive case management/linkage program.

○ Objective B: Any intervention in support of behavioral health integration will be supported by a robust system to evaluate outcomes, to include clinical practice and the experiences of those receiving services.

Schools

Schools Workgroup: At the start of this effort, to varying degrees, each school district and Local Education Agency (LEA) had its own programs and projects related to suicide prevention and mental health. The formation of the Schools Workgroup has enabled the sharing of ideas and resources, with collaborative relationships forming between LEAs and Fresno County Districts, in addition to support from the Fresno County Superintendent of Schools. In addition to work within the schools, the workgroup has also formed a strong working relationship with stakeholders in the Justice Workgroup and have held multiple joint meetings to coordinate prevention and intervention efforts.

● Goal 1: Support sharing of information, resources, materials, and processes among districts to support comprehensive school-based suicide prevention in all Fresno County Schools. (ongoing)

○ Objective A: Continue to host meetings as part of the Fresno County Suicide Prevention Council's Schools Workgroup to create a venue/mechanism for information-sharing among districts (ongoing)

■ Activity 1: Host bi-monthly meetings in partnership with the Fresno County Superintendent of Schools and the Fresno County Suicide Prevention Council to provide a venue for districts to meet, share information, and address relevant topics related to suicide prevention in the school setting. (ongoing)

○ Objective B: Gather materials and information about various best practices for school-based suicide prevention, including policies, forms, and protocols from districts participating in the Schools Workgroup, to create a system for sharing information and documents within the workgroup and beyond. (ongoing)

■ Activity 1: Share information, materials, and protocols to support best practices for re-entry processes, risk assessment and screenings, safety planning, and other components of school-based suicide prevention for students, including forms, notifications, referrals, and supports. (short-term)

○ Objective C: Support advanced trainings for school staff to provide suicide risk screenings and assessments.

■ Activity 1: Host a "train the trainer" event focused on the Columbia-Suicide Severity Rating Scale to support schools in adopting a uniform screening and assessment tool throughout districts (completed)

■ Activity 2: Continue to support districts in roll-out and expansion for utilization of the Columbia-Suicide Severity Rating Scale. (short-term)

○ Objective D: Work with districts to bring in organizations that support school climate change around mental health and suicide prevention. (ongoing)

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- **Activity 1:** Work with the California Department of Education and the National Alliance on Mental Illness California to bring "NAMI on Campus" clubs to Fresno County Schools.
- **Activity 2:** Work with districts to bring "Sources of Strength" to school campuses across the county. (short-term)
- **Goal 2:** Build collaboration with non-school agencies (law enforcement, health care, etc.) to increase communication and coordination around supporting youth. (ongoing)
  - **Objective A:** Increase coordination and collaboration between agencies working to support youth.
    - **Activity 1:** Host joint workgroup meetings with Justice and Health Care workgroups to identify gaps, barriers, resources, and successes in supporting youth. (ongoing)
      - **Status:** (Completed/ongoing) Hosted meetings in December 2017 and May 2018 with Justice Workgroup and local law enforcement agencies. Ongoing efforts will be more localized to match districts with local law enforcement agencies.
  - **Objective B:** Support facilitation of devising a mechanism to enable information-sharing among districts, health care, behavioral health, and law enforcement. (short-term)
    - **Activity 1:** Work with Justice and Health Care workgroups to develop a universal release of information, which would enable the sharing of information across systems to support safeguarding youth among various agencies. (short-term)
- **Goal 3:** Support districts in gathering data around referrals and assessment to identify needs and better deliver supports. (short-term)
  - **Objective A:** Provide a data-collection tool for schools and districts to utilize in tracking the number of assessments being conducted and the outcomes based on site-specific information by school and district.
    - **Activity 1:** Finalize a data tracking spreadsheet and share it with districts (short-term).
    - **Activity 2:** Compile and review data to identify areas and times of greatest risk and concern to support districts in providing supports on high-risk times (short-term).
- **Goal 4:** Provide information to non-school entities to identify school contacts to enable better communication across systems.
  - **Objective A:** Create and maintain a contact list that can be posted on the FresnoCares website for community and medical professionals to utilize when they need to communicate with the schools regarding a student currently or previously in their care. (completed/short-term/ongoing).

Justice and First Responders

As indicated by the initiation of this effort taking place at a meeting organized by the Fresno County Sheriff's Office, local justice agencies have demonstrated a strong commitment to participating in

suicide prevention that continues through their Workgroup. The initial focus has been on justice agencies working in the role of emergency response, often in interaction with other settings (e.g., Schools, Health Care). Training in the Crisis Intervention Team (CIT) model was initiated in 2017 and has been ongoing, with many Fresno Police Department officers now trained in the program that enhances response to behavioral health crises in the community.

- Goal 1: Develop and implement suicide prevention training specific to law enforcement, first responders, justice partners, and social services. (short-term)
    - Objective A: Create a web-based training to allow for accessibility and more efficient dissemination.
    - Objective B: Submit training for POST certification to assist with participation from law enforcement agencies.
- Goal 2: Continue better collaboration and communication between agencies represented by the Justice and First Responder Workgroup with school districts and other entities serving youth across the county. (ongoing)
    - Objective A: Work with districts and schools to reduce the number of law enforcement requests by collaborating to utilize a consistent suicide-risk screening tool to more effectively evaluate risk and provide appropriate levels of care for youth. (short-term)
        - Activity 1: Host a "train the trainer" event focused on the Columbia-Suicide Severity Rating Scale to support districts and law enforcement agencies in adopting a uniform screening and assessment tool. (completed)
        - Activity 2: Continue to support districts, law enforcement agencies, and justice partners in the roll-out and expansion of utilization of the Columbia-Suicide Severity Rating Scale. (short-term)
    - Objective B: Assist districts and community partners who serve youth in identifying available services and resources to better understand the roles of various agencies in the support continuum for youth. (ongoing)
        - Activity 1: Continue to host meetings to bring districts and local law enforcement entities, and other justice partners serving youth, together to continue collaboration towards stronger services and care for youth.
            - Status: (Completed/ongoing) Hosted meetings in December 2017 and May 2018 with Schools Workgroup and local law enforcement agencies. Ongoing efforts will be more localized to match districts with local law enforcement agencies.
        - Activity 2: Focus on rural areas to support communication between districts, law enforcement agencies, and justice partners. (short-term)
- Goal 3: Creation of flowchart of services. (Completed during system mapping process)
    - Objective A: Assist in identifying gaps in services.
    - Objective B: Assist in better understanding of services provided and roles of various agencies in the support continuum.

Understanding Suicide

Every suicidal crisis can be an excruciating ordeal for the individual who experiences it, and it is the result of a complex combination of biology, personality, thinking patterns, emotions, stress, social relationships, and environment. Suicidal behavior is not the simple result of a disorder or a single negative event. There are, however, ways to describe and understand what happens during a suicidal crisis, providing us with the opportunity to identify when a crisis is developing and respond in ways that can keep people alive and support their recovery.

Overview: the Suicidal crisis within life context

Figure 2. Crisis Coping Theory[17]
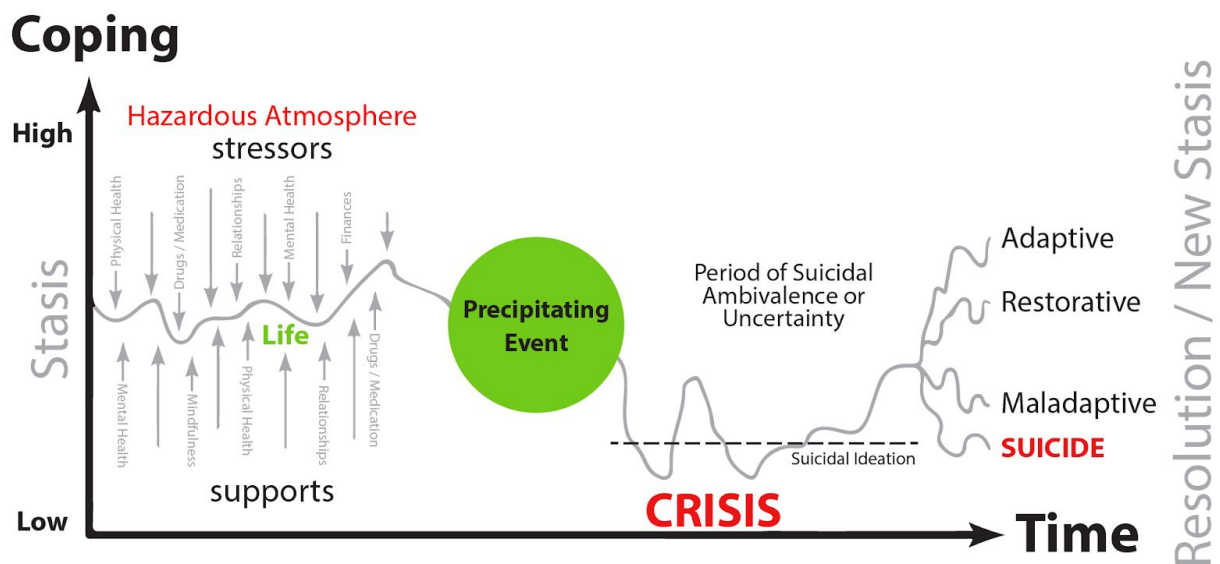
The intent of this Crisis Coping Theory model is to place suicide within the social and environmental context of an individual's ability to cope with the stress and emotional pain that affect both the decision-making process and how the crisis is resolved.

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[17] Illustration developed and adapted by Noah J. Whitaker, with permission from Frank R. Campbell Ph.D., Executive Director BRCIC. Grief & Crisis Theory model contained in the Baton Rouge Crisis Intervention Center Crisis Training Manual (1990-2005).

Crisis Coping Theory (Figure 2) was developed by Dr. Frank Campbell based on principles from community psychology[18,19,20]. Crisis Coping Theory proposes that crises, which are self-defined, often resolve within a 6- to 8-week time frame. This model has been further expanded to include suicidal ideation, specific stressors and supports, and concepts from dramaturgy[21] in sociology.

The expanded Crisis Coping Theory diagram (Figure 2) depicts the experience of a person moving from a normal level of coping (stasis) through a crisis, ending at a new state after the crisis (resolution). As contrasted to the more traditional 6- to 8-week time span, the duration in Figure 2 (shown on the horizontal axis) is not specified, because numerous variables influence how long a crisis will last and how complicated the resolution will be. For example, a crisis period might include multiple precipitating events, such as the death of a loved one followed by a job loss. Further details about the components involved in a suicidal crisis are outlined in the sections that follow this overview.

The vertical axis in Figure 2 represents an individual's coping ability. Whereas some individuals will have a stasis coping level that is high and resilient, others may begin lower and be more susceptible to being overwhelmed by stress. The gray line tracks the level of coping for a hypothetical person over time, indicating a high or low capacity for coping with stress, regardless of whether the mechanisms are healthy or constructive.

In Figure 3, the area labeled "Life" represents the day-to-day, or even moment-by-moment, fluctuations in an individual's supports (pictured pushing coping ability up) and stressors (shown pushing down on coping ability). The environment becomes more dangerous or hazardous when the fluctuations are rapid (frequency) or severe (amplitude). Note that the same variables that act as supports can also be stressors. For example, while a new job can be a positive development, it can also be stressful. The upward-pushing arrows include coping skills such as mindfulness that assist in counteracting stressors. Drugs or medications are included, as the coping line does not indicate positive or negative coping mechanisms; it simply represents the current level of coping. Coping mechanisms that offer temporary relief but have negative or unhealthy short- or long-term outcomes is referred to as maladaptive.

Figure 3

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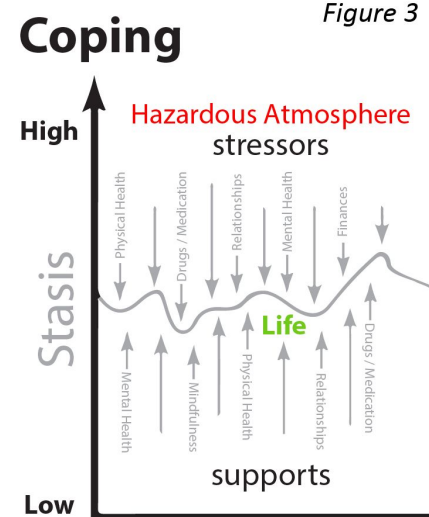
[18] Lindemann, E., 1944, Symptomatology and management of acute grief, American Journal of Psychiatry 101, pp. 141 -148.

[19] Caplan, G.,1974, Support Systems and Community Mental Health: Lectures on concept development, Behavioral Publications, New York.

[20] McGee, R.K., 1974, Crisis Intervention in the Community, University Press, Baltimore.

[21] Goffman, E. (1959) The Presentation of Self in Everyday Life. Broadway, NY: Doubleday.

Figure 4

Precipitating Event

When there are sudden or rapid changes in an individual's ability to cope, this can create a hazardous atmosphere where the individual's ability to cope declines. When a major life event or series of events occurs (Figure 4 labeled as precipitating event), the individual may enter a period of crisis. Examples of precipitating events include losing a job, social rejection, or developing clinical depression. Here, "crisis" means a state that the individual identifies as surpassing his or her ability to cope. During that time the person may become suicidal.

Often, when suicide deaths occur, people point to the precipitating event as the "cause" of the suicide, such as bullying, a relationship breakup, job loss, or some other easily identifiable life events. Doing so oversimplifies the complexity of suicide and fails to look at the contributing short- and long-term risk factors that influenced the individual's ability to cope. The sudden drop in coping skills attributed to the precipitating event in combination with a hazardous environment can lead the individual into crisis.

Suicidal ideation (Figure 5) is defined as thinking about, considering, or planning suicide. Thoughts can be active (e.g., I want to shoot myself) or passive (e.g., I wish I didn't have to wake up). Ideation can also predate the precipitating event as a result of prior maladaptive coping (coping strategies that are unhealthy, described in more detail later) with previous stressful life events. Ideation can also have periods of presence or absence throughout the crisis period and can fluctuate in severity (level of impairment), duration (length and frequency), and intrusiveness (individuals might not want to think about suicide but cannot prevent themselves from doing so). These periods can also contain one or more non-fatal suicide attempts, further increasing the risk of suicide. It is often when warning signs and communication of intent to die are most present.

Figure 5

Period of Suicidal Ambivalence or Uncertainty

Suicidal Ideation

CRISIS
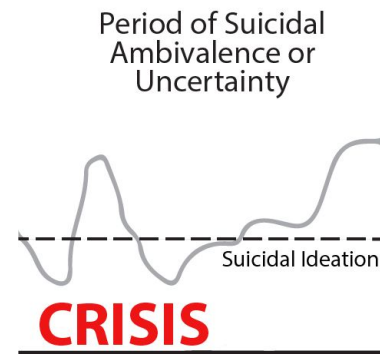
If an intervention, such as a LOSS Team response following a traumatic death (LOSS Team is described in the Programs section of this plan), is able to take place immediately following the precipitating event, it can assist the individual with infusing new adaptive coping skills. These time-sensitive adaptive coping skills can facilitate a more rapid end to the duration of the crisis and can better facilitate the path toward adaptive resolution or even assist the individual in resolving the precipitating event without entering into a crisis.

The period of time (Figure 5) during a crisis in which an individual is struggling with suicidal thoughts can also be referred to as suicidal ambivalence or uncertainty. The person is very literally struggling with the desire to live and the desire to end his or her pain and is making a life-or-death decision. This period of time can be protracted or resolved suddenly.

You might note the temporary spike within the coping timeline during this period. This depicts a temporary increase in coping that can be associated with additional but temporary supports, such as friends or family providing resources, or through engagement in maladaptive coping strategies like substance abuse. Friends or family might perceive the individual's crisis to be resolved as they observe the individual's increase in coping capacity, and thus reduce their support or withdraw as they perceive these additional supports are no longer necessary. Similarly, the maladaptive strategies, which are not sustainable, might take their toll during this period and further decline ability to cope.

Resolution and the establishment of a new stasis

When the suicidal ambivalence ends, the Crisis Coping Theory indicates four basic ways that the crisis could resolve (Figure 6). Once a crisis is resolved the individual proceeds to resolution, which can be thought of as a "new normal," and establishes a new stasis, which is a return to the beginning of the Crisis Coping Theory model with the initial level of coping adjusted to correspond to the resolution from the previous crisis.

Figure 6

The four types of resolution are:

- **Adaptive -** The individual's coping level increases as a result of the development or strengthening of supportive coping mechanisms that result in a higher and more stable coping level than before the precipitating event and subsequent crisis. This can also be referred to as post-traumatic growth.
- **Restorative** - The individual experiences recovery and returns to the approximate pre-crisis level of coping.
- **Maladaptive -** Reflects the adoption of strategies that might have been effective in increasing coping in the short term (e.g., substance use masking emotions) but that diminishes the individual's coping level over the long term and creates a hazardous atmosphere when entering the new stasis.
- **Suicide** - The individual dies by suicide at the end of the crisis period.
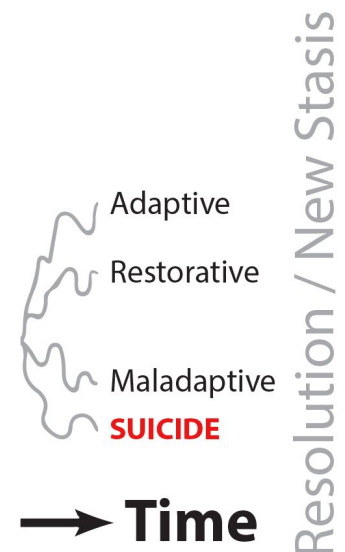
Integrating the Crisis Coping Theory into the strategic plan

This strategic plan provides recommended interventions along the Coping Crisis Theory model in conjunction with the Suicidal Crisis Path (Figures 7 and 8), to provide for strategies inclusive of prevention, early intervention, intervention, and treatment, as well as postvention services. As the model illustrates, the coping pathway is a continuous journey from stasis, through life, precipitating events, crises, resolution, and the return to stasis.

Figure 7. Crisis Coping Theory Intersection with Suicidal Crisis Path model[22]
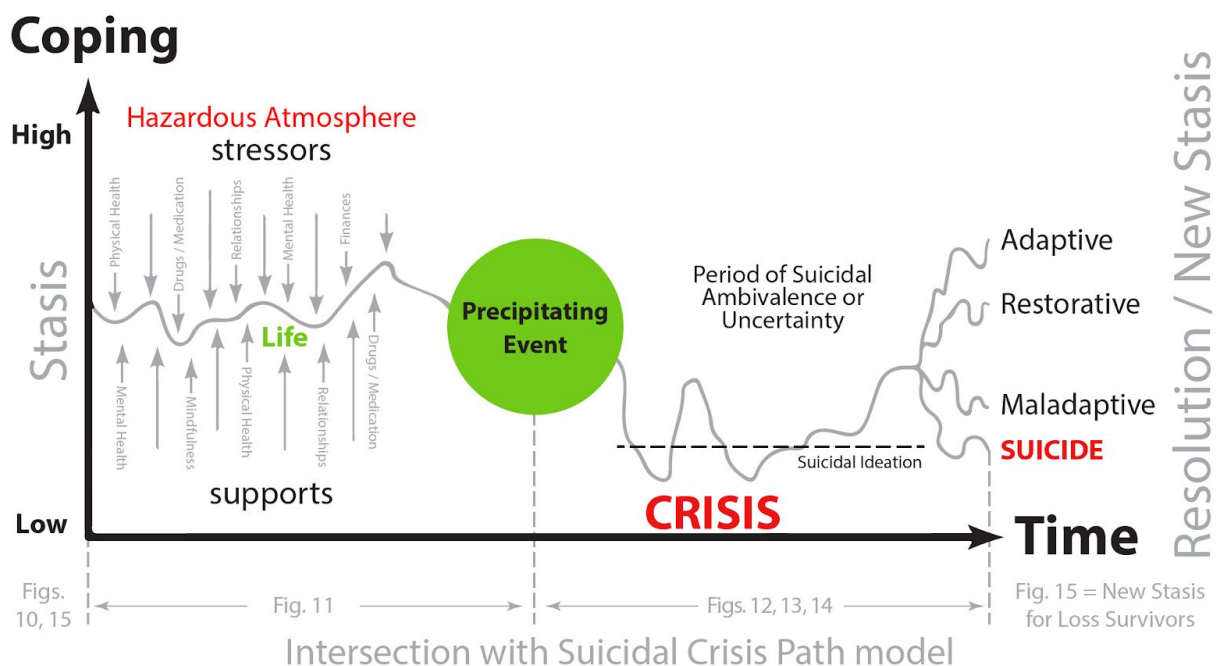
Activities along the entire span of the coping pathway can facilitate the infusion of adaptive strategies. These strategies can help provide additional support systems, identify decompensation, connect the individual to a community, alleviate burdensomeness, restrict access to lethal means, and protect the individual from self-harm, and can facilitate the prevention of suicide. This effect is carried forward into the future through the avoidance of maladaptive coping strategies and movement beyond restorative coping into post-traumatic growth. The acquisition of these skills, interventions, and supports can provide the individual with an enhanced ability to not only resolve or even avoid a current or future crisis; it can change the legacy of suicide in a community.

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[22] Model developed in collaboration by Dr. DeQuincy Lezine and Noah J. Whitaker

The Suicidal Crisis: Timeline of suicidal crisis and prevention

The Suicidal Crisis Path[23] is a model that intends to integrate multiple theoretical approaches and frameworks within the context of an individual's suicidal experience. In doing so, the purpose is to match intervention approaches with the timing, risk factors, and protective factors that would be the mechanism to prevent a suicide from happening. The Suicidal Crisis Path focuses on a specific instance of suicidal behavior with an identification of specific stages in the development and escalation of a crisis that might end in death (see Figure 8).

Figure 8. The Suicidal Crisis Path
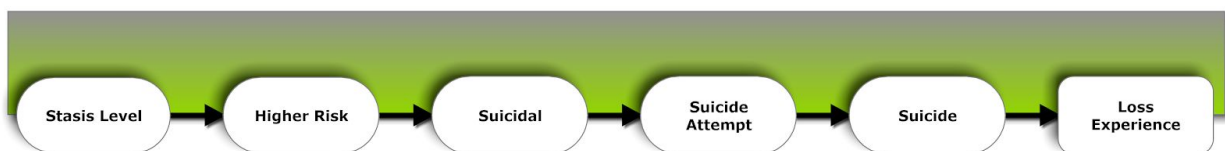
The elements within the model are applied in more detail in the sections that follow. However, one way to portray the use of the Suicidal Crisis Path in connecting theory and intervention is to place it within the context of Crisis Coping Theory as well as the framework for describing when interventions take place in relation to behavioral health problems (see Figure 9). The Continuum of Interventions includes (a) prevention and wellness promotion; (b) early intervention; and (c) clinical and crisis intervention.

Figure 9. The Suicidal Crisis Path with Crisis Coping Theory and Continuum of Interventions
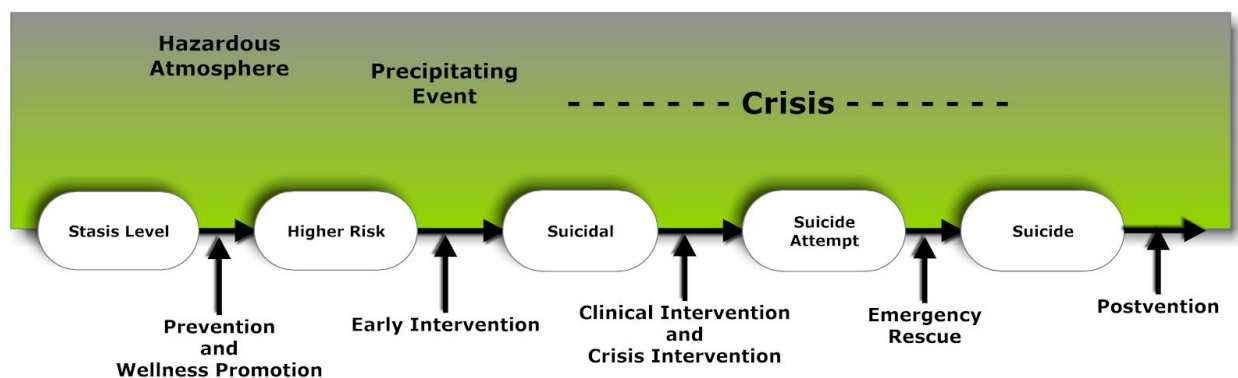
Like most public health issues, suicidal behavior has identifiable elements that connect one part of the path to the next. The following sections provide additional detail on the elements that push a person's experience along the Suicide Crisis Path.

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[23] The Suicidal Crisis Path model was developed by Dr. DeQuincy Lezine.

Levels of Influence: The Social-Ecological Model

As noted earlier, the risk of suicidal behavior develops because of a mix of biology, life events, and/or environment. A framework called the Social-Ecological Model helps in systematically considering the different levels of influence that contribute to an individual's health behaviors.

Within this model, there are interactions between individual, interpersonal, organizational, community, and public policy factors that influence the risk for suicidal behavior. The social ecology is pictured with overlapping rings to emphasize that factors at one level influence factors at other levels. This is a dynamic system where influence can flow in both directions. Thus, to be successful and sustained, prevention efforts must recognize and intervene with factors from multiple levels.

- **Individual** factors include biology, knowledge, attitudes, skills, and personal development.
- **Interpersonal** factors involve the interactions between a person and people in the person's formal as well as informal social networks, from family and friends through coworkers and acquaintances.
- **Organizational** factors include policies and practices of agencies, centers, companies, and other structured groups.
- **Community** factors involve characteristics of the relationships between organizations and relationships between social groups.
- **Public policy** includes laws, regulations, and policies from those at the local community level through global initiatives or international agreements.

The Social-Ecological Model helps with identifying the categories of environmental and personal characteristics to consider within the suicidal crisis path, particularly when describing how factors at multiple levels contribute to an increasing level of risk. The Social-Ecological Model is applied in the Suicidal Crisis Path as critical considerations in the initial transition from stasis to higher risk as pictured in Figure 10 (next page). This is a systematic way to identify and categorize the specific elements within the hazardous environment described in the Crisis Coping Theory.

Figure 10. The Social-Ecological Model within the Suicidal Crisis Path

Hazardous Environment

Identifying and Characterizing Risk

Research in epidemiology helps to identify the parts of an individual's environment, history, and health that are related to suicidal behavior. Some personal characteristics indicate who has a higher or lower likelihood of suicidal behavior (risk or protection markers, respectively). For example, gender can be a risk marker because, regardless of the cause, males have a higher risk for suicide. Then there are characteristics that have an identified role in making suicidal behavior more or less likely (risk or protective factors, respectively). For instance, depression can contribute directly to a suicidal crisis. Additionally, while some characteristics are present long before a suicidal crisis occurs (distal), the timing of others may be closer to when a suicidal crisis happens (proximal).

This strategic plan uses the following terminology:
- **Risk and protection markers** help us identify who might benefit from particular interventions, even if those markers are not directly involved in producing suicidal risk.
- **Risk and protective factors** (see Table 1) help us identify which interventions to use in order to decrease risk or enhance protection. Within the Crisis Coping Theory, risk factors act as stressors and protective factors function as supports.
- **Distal factors** become the focus of promotion and prevention.
- **Proximal factors** are addressed by early intervention prevention.

Table 1. Common Risk and Protective Factors for Suicidal Behavior

Risk Factors	Protective Factors
Symptoms of mental illness	Coping skills
Substance abuse	Problem-solving skills
Prior suicide attempt	Reasons for living / Reasons for not dying
Impulsivity	Moral objections to suicide
Aggression	Social connections
Relationship problems and conflicts	Quality healthcare
Family history of suicide	Safe and supportive school and community
Barriers to health care	
Available lethal means	
Unsafe media about suicide	

The hazardous environment described in the Crisis Coping Theory (Figure 7, page 18) relates to cumulative experience over the lifetime. Early childhood experiences interact with genetics to influence biology, and life experiences also provide (or deprive) a person of self-esteem, self-worth, coping strategies, personal beliefs, health knowledge, access to resources, and exposure to trauma, among other influences on memory and mental processing. Many fields of study (e.g., biology, psychology, sociology) have produced theory and research that help explain how specific experiences and contextual factors contribute to the type of hazardous environment that can generate a suicidal crisis.

However, in nearly all cases the core concept is that increasing negative outcomes lead up to a suicidal crisis. While the specific process varies based on the theoretical model being used, there is often some critical threshold where a person is at maximum risk for contemplating suicide and then some experience or occurrence (precipitating event) pushes the person past that threshold. Some of the main mechanisms that generate risk from the environment or experience are illustrated in Figure 11.

Figure 11. Suicidal Crisis Path with Risk Factors

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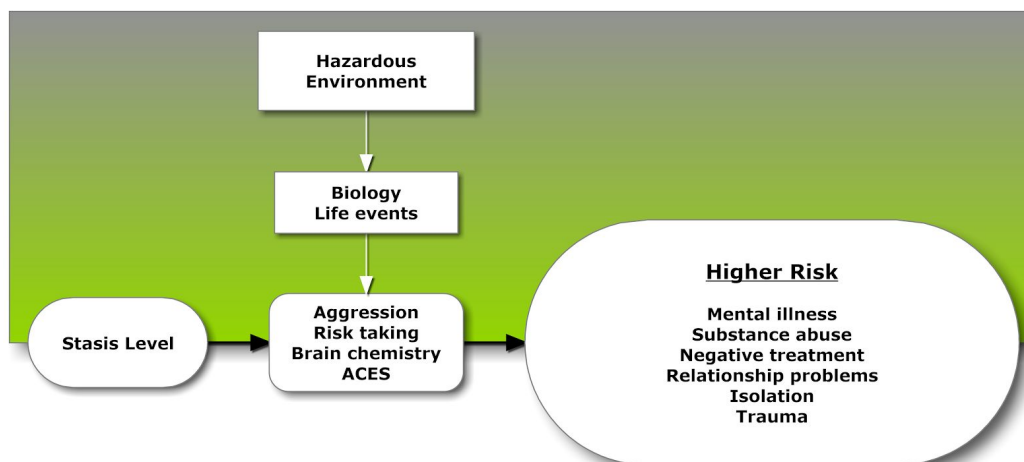
Understanding How Risk Escalates Into Suicidal Thinking

Contemporary theory and research about suicidal thinking have identified several key elements to focus on. Many of these are included in the Suicide Risk Assessment Standards used by the National Suicide Prevention Lifeline. While the specific details of each person's story may be unique, the risk factors generally end up contributing to emotional pain and stress. Experiences that result in feelings of defeat, humiliation, feeling like a burden to others or intense loneliness may be especially critical. As a person spends more time focused on the painful experience(s), he or she develops a desire to die to escape from that unbearable distress.[24] On the other side are potential "buffers" that are related to a person wanting to avoid dying (i.e., protective markers or factors). When the feeling of entrapment and subsequent desire to escape become intense enough, the person may become suicidal and actively seek ways to end life. This is one way to specify the internal process within the suicidal ambivalence period in the Crisis Coping Theory, describing the factors that determine when a person may be suicidal during a crisis.

As part of conducting suicide risk assessments when someone calls the National Suicide Prevention Lifeline (800-273-8255), the crisis counselors try to get information about the elements of a suicidal crisis to judge the level of risk and decide on appropriate actions to take. The specific aspects of risk that were identified based on a review of the available research and theory about suicide are provided in Table 2 below.[25] Note that the factors presented in Table 1 apply to overall risk (i.e., Stasis Level), whereas the factors in Table 2 are most relevant for assessing immediate risk during a crisis.

Table 2. National Lifeline Suicide Risk Assessment

Desire to Die	Intent to Die	Suicidal Capability	Buffers
Suicidal thoughts	Expressed intent	Prior suicide attempts	Immediate supports
Emotional pain	Suicidal planning	Prior suicide loss	Social supports
Hopelessness	Gathering materials	History of violence	Future plans
Helplessness	Making preparations	Available lethal means	Core beliefs
See self as a burden on others		Intoxication/substance abuse	Ambivalence about dying
Feeling trapped		Mental illness	Sense of purpose
Feeling incredibly alone		Extreme agitation	

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[24] O'Connor, Cleare, Eschle, Wetherall, & Kirtley (2016). The Integrated Motivational-Volitional Model of Suicidal Behavior: An Update. In: International Handbook of Suicide Prevention, 2nd. Edition. Hoboken: Wiley.

[25] Joiner T, Kalafat J, Draper J, Stokes H, Knudson M, Berman AL, & McKeon R (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. Suicide and Life-Threatening Behavior, 37(3), 353-365.

Warning Signs: Recognizing when someone may be suicidal

Figure 12. The transition from Higher Risk to Suicidal in the Suicidal Crisis Path
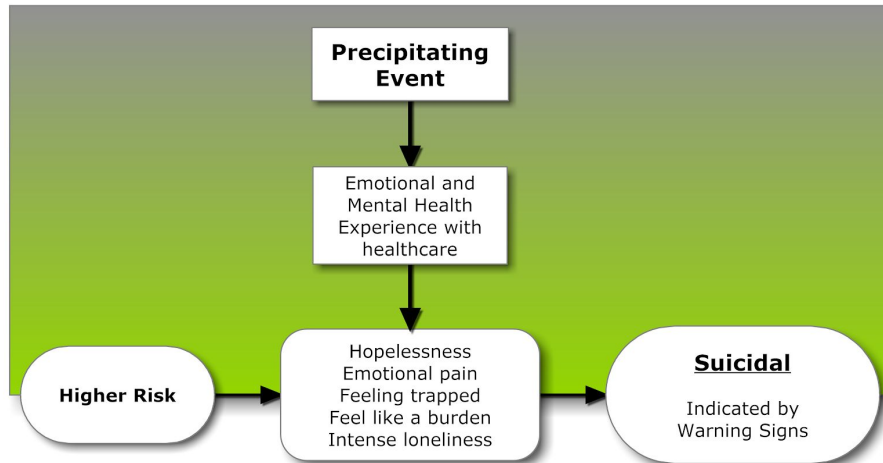
As noted in Figure 12, there is a special group of proximal risk markers that act as clues indicating that someone might currently be suicidal. Some reflect the ways that people try to deal with increasing distress before turning to suicide, and others indicate that a person might be at the stage of intending to die. These hints that might be displayed by individuals are called "Warning Signs." While someone considering suicide may exhibit any number of these signs (or none at all), knowing about the signs might help you identify when someone you know could be in a suicidal crisis.

The most common warning signs include:

- Talking or writing about suicide, wanting to hurt or kill him- or herself
- Looking for ways to die, like trying to get a gun or getting a lot of medication
- Increasing use of alcohol or drugs
- Seeing no purpose in life or having no reasons for living
- Feelings of anxiety or agitation, and trouble sleeping
- Feeling trapped or like there is no way out of a bad situation
- Expressing loss of hope in a positive future
- Withdrawing from family and friends
- Uncontrolled anger, rage, and desire for revenge
- Increasing risky or reckless activities
- Major changes in moods

Understanding How Suicidal Thinking Turns Into Behavior

The final factor in this model is the "capability" of attempting suicide, meaning the mental, emotional, and physical preparation to overcome our natural survival instincts and try to kill oneself. Then the person may carry out a suicide attempt, with a potentially deadly outcome (see Figure 13).

Figure 13. The move from thinking to behavior in the Suicidal Crisis Path

Research suggests that capability and access to means contribute to risk, and then the main factors that determine whether a person will make a suicide attempt concern the intent to act. Impulsivity (as a trait or state, such as with substance use) lowers the threshold for engaging in risky behavior, including suicidal action. Fear of death and anxiety about pain act as barriers to action. Detailed planning, visualization, and rehearsal can lower those barriers. Research has indicated that while some individuals engage in self-injury without an intent to die, the repetition can have the same impact as rehearsal and increase capability for future suicidal behavior. Thus, to accurately assess suicide risk and determine an appropriate response, it is imperative to ask about suicidal thoughts as well as behaviors and intent.

Understanding How a Suicide Attempt Becomes a Suicide

Figure 14. Critical elements of fatal suicide attempt in the Suicidal Crisis Path
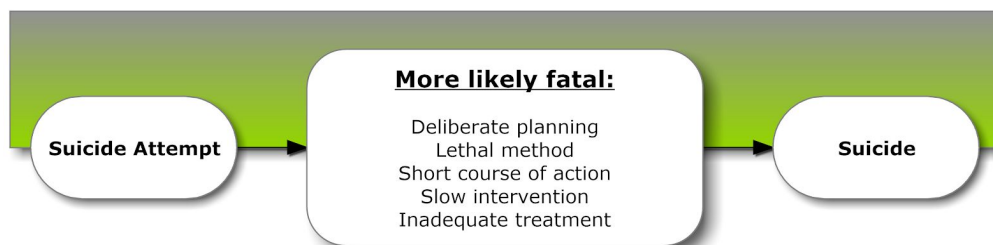
The Suicidal Crisis Path continues by specifying two key factors that determine if a suicide attempt will be fatal (see Figure 14). One aspect to consider is the lethality of the attempt, or how likely it is that death would occur if no intervention happens. It is important to note that while an impulsive suicide attempt might use any means of injury that is readily available when an individual deliberately plans an attempt he or she may be more likely to use a method with high lethality. A second component is how long it takes for death to occur, and thus how much time there is for rescue. For example, both the gunshot wound and an overdose with a highly toxic drug may have similar levels of lethality. However,

while death from a gunshot may happen quickly, death from overdose might take significantly longer (and thus present a greater likelihood of rescue).

Two of the main characteristics of the emergency interventions that influence outcome would be the effectiveness of medical procedures and the response time (i.e., how quickly the rescue effort is initiated). If the response time for a rescue is greater than the time it takes for an attempt to be fatal, then the quality of intervention will not help. However, even basic rescue methods might make a difference if provided quickly after an attempt.

Understanding How Suicide Affects Personal Connections

Finally, the Suicidal Crisis Path explicitly recognizes the impact that a suicidal act has on others, even extending beyond a suicidal death. For simplicity, the focus is on individuals affected by a suicide loss (suicide loss survivors), although the potential for similar consequences also applies to people affected by a nonfatal suicidal crisis. Recent estimates suggest that for each suicide in the U.S., approximately 115 people may be affected.[26] The effect of suicidal behavior on others can range from short-term shock to complicated grief that persists for years, primarily depending on the depth of personal connection. Thus, when one person dies by suicide it has the potential to be a precipitating event for the people connected to that person. Research has identified circumstances and experiences that influence the effect that suicide has on other people, including[19]:

- Type of relationship (e.g., parent, child, partner/spouse, cousin, roommate, coworker, etc.)
- Perceived emotional closeness and attachment style
- Direct exposure to the suicide death scene
- Perceived responsibility for causing (or not preventing) the suicide
- Perception of the degree of intentionality in the suicide
- Pre-existing mental health conditions
- Previous experience with suicidal behavior or loss
- Knowledge and understanding of suicidal behavior
- Quality of perceived social support
- Perceived stigma
- Social connections
- Coping skills and strategies

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[26] National Action Alliance for Suicide Prevention, Survivors of Suicide Loss Task Force (2015). Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/NationalGuidelines.pdf

The role that these factors play in determining whether or not a suicide loss will lead to increased risk among the suicide loss survivors is pictured in Figure 15.

Figure 15. The aftermath of suicide in the Suicidal Crisis Path
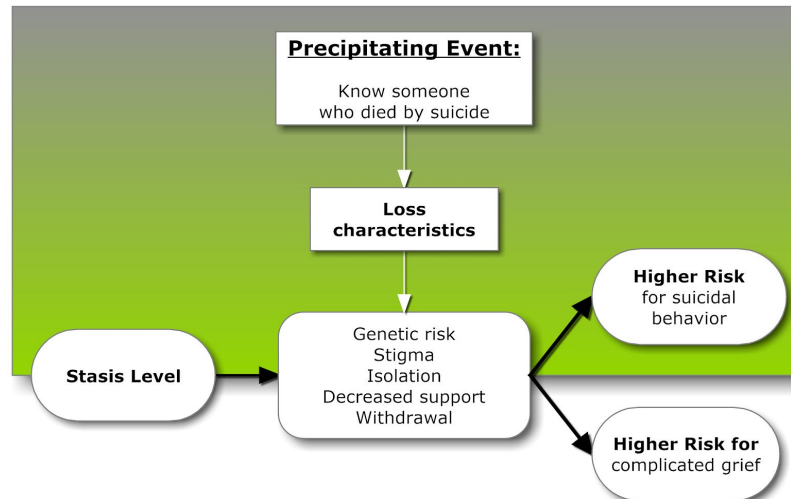
Stopping the crisis path

The programs and activities that are designed to stop someone's progression along the suicidal crisis path are called "interventions." There is a public health framework we use here that helps identify who interventions are intended for. Within this framework, programs can be described as "**universal**" when they are meant to change an entire community or population. For example, the healthcare industry uses universal blood pressure screening so that individuals routinely have their blood pressure checked when they seek care, regardless of their age, gender, or even the reason for seeking care. The second level of interventions, described as "**selective,**" are delivered to a select group or subgroup within the population, usually because they have an elevated risk for a health problem. For example, at a certain age, someone might be required to do routine blood tests in addition to checking blood pressure because of the increased risk of a heart attack. The third level of intervention is described as "**indicated**" and applies when the focus is on helping individuals who are currently experiencing the health issue. Continuing our example, this would include the treatment for a heart attack and the follow-up recommendations.

Comprehensive Suicide Prevention in Fresno County

As described in the previous section, the development of a suicidal crisis can be quite complex, and thus, to successfully address suicide we need a comprehensive approach. To be comprehensive it must address the range of components involved in suicide indicated in the models described earlier. The activities that make up such an approach must encompass wellness promotion and prevention, early intervention, treatment, crisis intervention, and postvention (or help after a suicide). Similarly, the chosen approaches would include those that are intended for the entire community (universal) as well as focused strategies to help groups with higher risk (selective) or currently in crisis (indicated), as well as broader wellness promotion (communications targeted to the general public or whole population).

To expand the reach and value of a comprehensive strategy, it can be helpful to combine concepts from different sectors: public health[27], business and government[28], and education[29]. The Combined Intervention Model for Suicide Prevention (Figure 16) was created to fuse the Pyramid of Intervention, Institutes of Medicine, and Total Quality Management 1-10-100 Rule. This also highlights the value of working across sectors to prevent suicide, because although jargon may differ, the core concepts are consistent.

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[27] Institute of Medicine. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. In: Mrazek PJ, Haggerty RJ, editors. Committee on Prevention of Mental Disorders, Division of Biobehavorial Sciences and Mental Disorders. Washington, DC: National Academy Press; 1994.

[28] Joel E. Ross. Total Quality Management: Text, Cases, and Reading. St. Lucie Press, 1993.

[29] Austin Buffum and Mike Mattos. Pyramid Response to Intervention: RTI, Professional Learning Communities, and How to Respond When Kids Don't Learn (Contemporary Perspectives on Literacy). Solution Tree Press; 1 edition (December 1, 2009).

Figure 16. Combined Intervention Model for Suicide Prevention

Pyramid of Interventions

Intensive

Indicated
Respond to crisis
Postvention

$100

Early Intervention

Selective
Identify and assist
Reduce access to lethal means
Care transitions

$10

Prevention

Universal

Foster connectedness
Teach life skills
Increase help-seeking

$1

Total Quality Management 1-10-100 Rule

Promotion - Whole Population
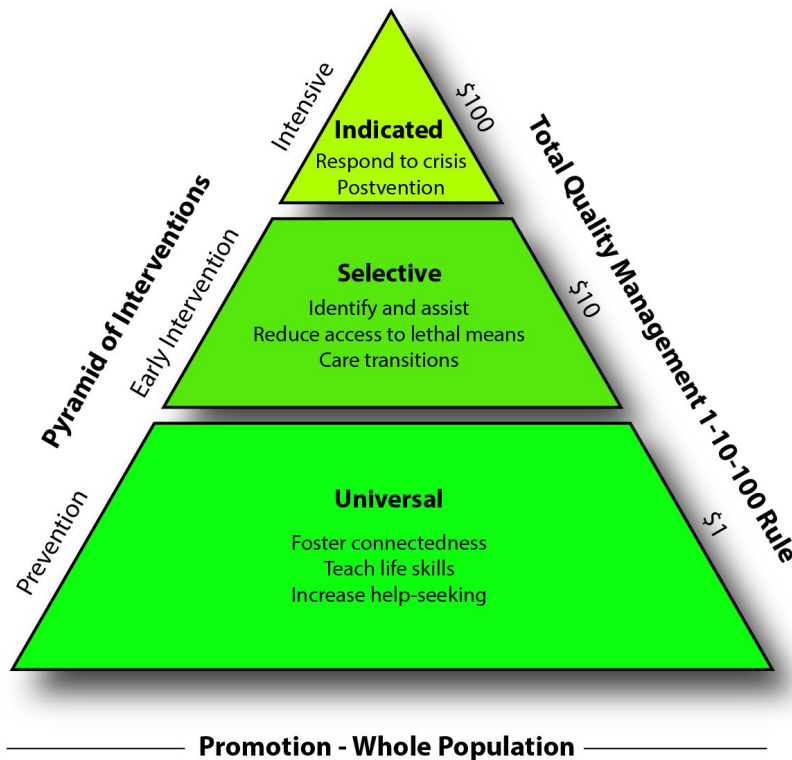
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The Pyramid of Interventions (Figure 16, left side) was developed in the context of the education sector through a concerted effort at Chicago's Adlai Stevenson High School as a concerted effort to shift responsibility for the success of students from a small group of professionals to become the responsibility of the entire school continuum.

The public health sector's Institute of Medicine (IOM) (Figure 16, middle) was developed to create better strategies to reduce both personal, systems, and social burdens associated with mental, emotional, and behavioral conditions. The IOM model emphasized a significantly broader scope of prevention that includes Universal, Selective, Indicated, and Whole Population communications, which are expanded upon later in this document.

Following World War II, the business and government sectors founded concepts that would lead to the development of Total Quality Management (TQM) inclusive of the 1-10-100 Rule (Figure 16, right side), which postulates that resource costs are exponential as failures in quality progress through a system. This concept postulates that a unit of resource (for example, money and staff time) can be most effectively expended on prevention costs; that it will cost a system ten units if a problem is detected

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[30] Figure and Combined Intervention Model for Suicide Prevention created by Noah J. Whitaker

while on the product line (early intervention); and that one hundred units would have to be expended if a problem progresses off the assembly line (intensive). This is, in essence, the old adage, "An ounce of prevention is worth a pound of cure."

By combining the common traits of these approaches, the strategic framework for suicide prevention becomes clearer. The use of broad and targeted communications campaigns can shift public perception from stigma to help-seeking behaviors. Programs to increase coping skills can prevent the progression and development of conditions that would otherwise contribute to suicide risk. Effective screening and assessment tools such as the Columbia-Suicide Severity Rating Scale can facilitate identification of risk factors and allow for early interventions that can prevent further progression. Evidence-based training on therapeutic tools can reduce the trauma and maladaptive coping that can follow adverse experiences.

Through this continuum of communication, training, screening, assessment, and treatment, resources can be more accurately targeted and utilized in an efficient manner so individuals are connected to the level of care and support that would be most beneficial. Specific activities cited below are organized according to the intended groups to be reached (i.e., Universal, Selective, Indicated) and are drawn from the recent CDC document *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*.

The Suicide Prevention Resource Center (SPRC) is a national resource that is funded to help organizations and communities address suicidal behavior. They have come up with a list of 9 types of activities that could work together as a comprehensive approach to counter suicide:
- Foster connectedness
- Teach life skills
- Increase help-seeking
- Identify and assist people at risk
- Reduce access to lethal means
- Effective care
- Care transitions
- Respond to crisis
- Postvention

These activities would take place in a coordinated fashion, with guidance provided by a public-private partnership that brings together a broad array of stakeholders to focus on making the comprehensive approach to suicide prevention in Fresno County a reality. As suggested by the SPRC, this group would use surveillance and evaluation data to ensure that the specific activities are effective and fit the local culture. They would help the Fresno County effort maintain momentum and focus on making enduring change for our area.

Health and Wellness Promotion

Efforts in the area of promotion are important in helping to shift perceptions, attitudes, and opinions as well as to promote help-seeking and stigma reduction. These efforts assist in supporting and increasing awareness of universal, selective, and indicated strategies[31]. Activities should include but not be limited to:

- Information about means restriction (such as the Gun Shop Project[32] and communication about railroad safety)
- Education (such as the development of packets for parents of school-age children and campaigns around the safe storage of medications, and adaptation of materials to be culturally and linguistically relevant)
- Events (such as KSEE24 Preventing Teen Suicide Forum, National Prescription Drug Take-Back Day, film screening, video competitions, awareness walks)
- Knowledge and awareness of good mental health practices as well as avoiding unhealthy activities. These campaigns should be carefully planned, rooted in local data relating to groups identified to be at an elevated risk, and based upon national communication recommendations to prevent inadvertently increasing risk rather than mitigating it.

Prevention (Universal strategies)

Foster connectedness. In a comprehensive approach, stakeholders in Fresno County would help individuals find and connect with community organizations. Helping build a sense of community in local neighborhoods and promoting civic participation lowers levels of stress and increases access to social capital. Those organizations would promote healthy family relationships, embrace cultural traditions, and provide opportunities for individuals to grow their social networks. Specific programs might teach parenting skills, support family financial planning, and help families find stable housing. Programs would also reach out to parents to get them to work with teachers and school personnel with the goal of engaging youth and creating a healthy school climate. Connectedness would also mean that agencies and organizations foster close relationships with each other, thus forming a tight-knit safety net where individuals no longer slip through the cracks.

Teach life skills. Community organizations need to sponsor a variety of programs and activities that teach or support the development of life skills that are appropriate for different ages and cultures. Fresno County would offer programs that help people enhance their resilience to life stress. Programs that have been developed to address alcohol and drug use might fit well within this category and would track outcomes related to suicidal behavior. Enhancing coping strategies helps individuals successfully handle life stress, which in turn reduces the risk of a suicidal crisis developing.

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[31] https://www.samhsa.gov/prevention
[32] https://www.hsph.harvard.edu/means-matter/gun-shop-project/

Increase help-seeking. Seeking help when needed would be considered a healthy norm, widely embraced by formal and informal leaders throughout Fresno in this comprehensive approach. Fresno County would systematically identify and address barriers to help-seeking. Programs would facilitate access to health care, behavioral health care, peer groups, and additional avenues for support and care. Strategies including incentives, transportation assistance, and technology would be used to address provider shortages in areas of need. In this system of care, the range of service options would also be expanded to provide multiple choices to those in need. It is also vastly important to emphasize the role that we all have in identifying those who are at risk and assisting them in getting the help they need. As a person gets deeper into a suicidal state, his or her ability to reach out for help declines, and thus it is paramount that others offer help when a crisis is identified.

Early Intervention (Selective strategies)

Identify and assist. In a comprehensive approach, the social support networks that are developed through the focus on connectedness will be knowledgeable about warning signs of suicide risk and how to aid recovery. Fresno County would offer various levels of training that would equip natural helpers like friends and family members with the information and skills that are needed to connect people in distress to the resources they need. Screening for emotional distress and suicide risk would be available in both clinical and non-clinical settings, with connections to effective supports available for those who are identified as needing help.

Clinical Intervention (Selective strategies)

Effective care. Health systems in Fresno County would have a consistent and integrated response in a comprehensive suicide prevention strategy. Screening, such as with the Columbia-Suicide Severity Rating Scale (C-SSRS), facilitate more accurate identification of at-risk individuals and more appropriate referrals. In receiving referrals when a person has been identified as having suicide risk, the health and behavioral health care teams will be competent and confident about addressing needs. Behavioral and physical health systems will be using an approach termed *Zero Suicide* that aims to prevent suicides through organizational policies and practices focused on providing the highest possible quality of care. Evidence-based practices would be employed by a trained clinical workforce that focuses specifically on addressing suicide risk when it is present. Follow-up aftercare would be a regular practice in a comprehensive approach.

Care transitions. Part of the follow-up care after a person has received services would involve timely access to the next service. Fresno County would have bridging programs in place to facilitate aftercare, especially in the high-risk period of discharge from emergency or inpatient services back into the community. There would also be full integration, including sharing of critical information, between health systems, behavioral health care, justice settings, schools, and community-based supports. This coordination would allow for smooth and nearly seamless transitions between care providers, avoiding risky gaps in services, as well as ensuring the presence of supportive systems for safety. In the

community, support systems would be in place to wrap around individuals recovering after a suicidal crisis. Promoting inclusion while countering negative stereotypes and prejudice associated with suicide and mental illness helps foster a safer community with successful care transitions.

Crisis Intervention and Postvention (Indicated strategies)

Respond to crisis. A comprehensive approach would include crisis response plans with multiple options that allow for the most appropriate interventions to take place. This would include a response network with non-traditional partners that can assist at-risk individuals. A variety of alternatives to emergency services would be in place. Fresno County would promote the National Suicide Prevention Lifeline and the Crisis Text Line as resources that could be used by individuals in crisis as well as their social connections. First responders, including public safety officers, would be trained to work with mental health crisis situations with care and sensitivity. A team approach to responding to a crisis in the community would be employed, bringing trained mental health practitioners to the person in need of help. When additional services are needed, alternatives to emergency department and inpatient treatment would be available.

Reduce access to lethal means. In a comprehensive approach, issues related to lethal means would be handled with sensitivity and respect, working with everyone involved to plan for safety. Firearms dealers, gun ranges, and sporting clubs would work with public health and safety officials to develop protocols to help gun owners improve safe storage practices. Substance abuse prevention programs would also work with pharmacies, medical providers, and law enforcement concerning access to potentially lethal medications (e.g., expired prescription collection and disposal).

Postvention. In the event of a suicide death, Fresno County would have key supports in place to assist those who knew the person who died. A team would be available to respond to the scene and provide support. When additional grief support is needed, persons would be able to seek or refer individuals to peer help through suicide loss survivor support groups. In the comprehensive approach, community organizations would provide support as well, including programs addressing resiliency after trauma. The death would also be handled appropriately by the media, following expert guidelines and providing prevention support along with any reporting. Someone trained in psychological autopsy procedures would conduct a follow-up investigation after the suicide to acquire key information about what happened and what could be improved in the future.

# Where We are Now: Needs and Assets in Fresno County

Fresno County resides within the San Joaquin Valley, the southern half of the California Central Valley, a large flat region in the center of the state bordered by the Coast Range mountains to the west and the Sierra Nevada mountains to the east. The county is made up of 15 cities in addition to unincorporated areas. Nearly half of the land in Fresno County is farmland (1.9 million acres), where over 350 different crops are harvested each year.[33] The U.S. Census Bureau estimated that 989,255 people (299,456 households) resided in Fresno County as of July 1, 2017. Key demographic characteristics related to the suicide prevention strategy using Census Bureau estimates include:

- Age: 28.5% under 18 years old
- Gender: 50.1% female
- Race and Ethnicity: 53.2% Hispanic or Latino, 29.5% White non-Hispanic, 11.0% Asian, 5.8% Black, 3.0% Native American
- Military service: 3.9% were veterans

Fresno County has significant cultural diversity, with over 100 distinct cultures[34] and a language other than English spoken at home for 44.6% of individuals over five years old.[35] The threshold languages for Fresno County are English, Spanish, and Hmong.

To organize the available information about needs and assets in Fresno County, the information is described within the framework described in the section on Understanding Suicide, and the Suicidal Crisis Path in particular. Figure 17 provides an overview of risk, suicidal thinking, and suicidal behavior in Fresno County.

Figure 17. Suicidal behavior in Fresno County using the Suicidal Crisis Path
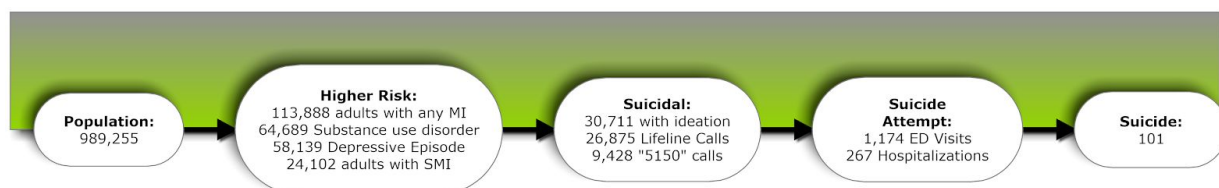
Suicidal Thoughts and Feelings

The National Survey on Drug Use and Health (NSDUH) is an annual survey used by the Substance Abuse and Mental Health Services Administration (SAMHSA) to collect information about mental health and

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[33] http://www.fcfb.org/Fresno-Ag/Fresno-Ag.php
[34] http://www.playfresno.org/about-fresno-county/overview
[35] https://www.census.gov/quickfacts/fact/table/fresnocountycalifornia/PST045217

substance use issues for individuals age 12 and older in the U.S. Approximately 70,000 participants complete the NSDUH and then population estimates are made based on the results from the national sample. The data tables for California are presented with three age groups (12–17 years, 18–25 years, and 26 and older). The 2016 NSDUH percents were then applied to Fresno County (matching age groups as closely as possible) to arrive at an age-adjusted estimate that takes into account the somewhat younger population in Fresno County.

Using the age-adjusted NSDUH estimates, approximately 30,711 individuals in Fresno County would say that they experienced "serious suicidal thoughts" in the past year.

The National Suicide Prevention Lifeline (the Lifeline) consists of a network of independent crisis centers and hotlines. Whenever possible, calls are routed to a center close to where the call originated. In Fresno County, those calls are answered by the Central Valley Suicide Prevention Hotline. However, some calls get routed to backup centers. Thus, the number of calls to the Lifeline originating from Fresno County (regardless of the center that answered) can be used as another indicator of suicidal thoughts and feelings. However, it should be noted that some callers may phone the Lifeline multiple times during the year and thus the number of calls is not equivalent to the number of unique callers.

As shown in Figure 18, there were 26,875 calls to the Lifeline originating from Fresno County in 2016 (15,360 to the general line, 8,886 to the veterans crisis line, and 2,629 to the Spanish hotline). While not all calls to the Lifeline involve a suicidal crisis, the number of calls can be used as an indicator of the level of emotional distress in Fresno County that sometimes reaches the point of suicidal crisis.

Figure 18. Lifeline calls originating from Fresno County
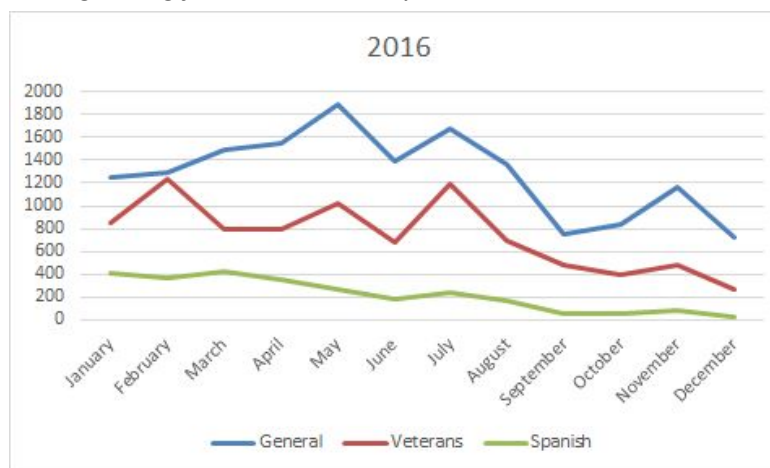
In California, the Lanterman-Petris-Short Act provides for the involuntary treatment including the "detention of mentally disordered persons for evaluation and treatment"[36], which is abbreviated to the code number 5150. The 5150 is a 72-hour hold used for instances when a person presents a danger to self, danger to others, or is gravely disabled because of a mental health condition. It should be noted that data on 5150 holds mixes together three situations, with one being related to suicide. At the time of this plan, the proportion of 5150 holds that involve danger to oneself has not been available. Nonetheless, data on the 5150 holds indicates trends in mental health emergencies, including suicidal crises. In Fresno County, American Ambulance provides secure transportation from the community to hospital for most, if not all, persons placed on a 5150 hold.

Using data from American Ambulance, two trends might be noted (see Figure 19): First, the number of 5150 calls has been increasing in recent years. Second, there are more calls for men than for women.

Figure 19. American Ambulance pre-hospital 5150 calls
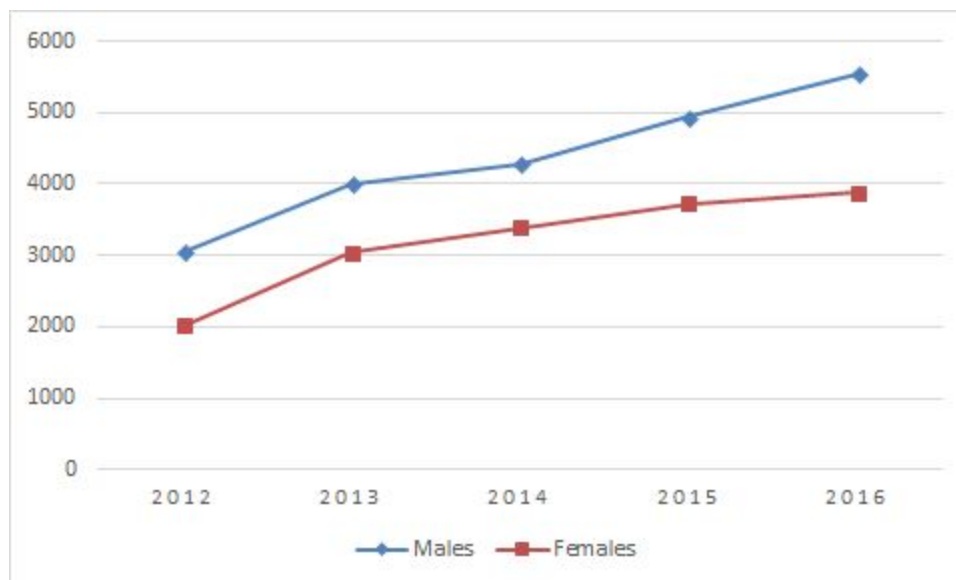
Most key informants had high levels of awareness about suicidal thinking and behavior from personal or professional experience (i.e., personal history of suicide attempt, losing someone to suicide, or having intervened to help support a client, friend, or family member). In general, individuals who were key informants rated their own ability to recognize suicidal risk higher than the community average. They also noted that some patients, especially those with Borderline Personality, may express suicidal thinking primarily for early intervention gains (e.g., attention, faster service, "manipulation").

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[36] https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150

Suicide Attempts

When key informants were asked whether the incidence of suicide was going up or down, there was almost universal perception that suicidal risk has increased in recent years. However, that judgment was primarily based on perception and anecdotal experiences. One key informant noted that it was possible for awareness of suicide to be increasing rather than increases in suicidal behavior.

The California Department of Public Health operates an injury surveillance system called EPICenter that provides county-level data on self-injury. It should be noted that the system currently records self-injury regardless of intent to die. Additionally, as with the Lifeline crisis call data, the system records the number of events and not the number of unique patients. Based on EPICenter data, in 2016 Fresno County had 1,174 emergency department visits and 267 hospital admissions related to self-injury.

At this time more detailed information in EPICenter is available through 2014. Using data for the 2010–2014 time period, on average there were 1,213 emergency department visits for self-injury each year. Examining the data by demographics, the sub-groups with the highest number and highest rate of self-injury are presented in Table 3.

Table 3. Sub-groups with high levels of ED visits for self-injury

	Largest number	Highest rate (per 100,000)
By Gender and Age	1. Females age 15-19 years old 2. Males age 15-19 years old 3. Males 20-24 years old 4. Females 20-24 years old 5. Males 25-29 years old	1. Females age 15-19 years old 2. Males age 15-19 years old 3. Males age 20-24 years old 4. Males age 25-29 years old 5. Females age 20-24 years old
By Race and Ethnicity	1. Hispanic or Latino 2. White 3. Black 4. Asian/Pacific Islander 5. Native American	1. White 2. Hispanic 3. Black 4. Asian/Pacific Islander *Native American rate unreliable

The most specific and informative data on suicidal thinking and behavior is likely to be obtained from health care, behavioral health care, and schools. In particular, information relevant to tracking suicidal thinking and behavior can come from the admission data from the hospital-based EpiCenter surveillance, treatment information from electronic health systems like Avatar, and community-based programs such as the Multi-Agency Access Point program. Unfortunately, that data was not available to be incorporated here. Additionally, information about youth was not available due to school districts opting out of the statewide California Healthy Kids Survey. When asked to rank suicide prevention

strategies in a community survey, the strategy with the most relevance for learning about suicidal behavior in Fresno County (surveillance) was ranked last. Similarly, data needs were not considered a priority for suicide prevention stakeholders involved in suicide prevention planning for Fresno County.

Suicide

In responding to an open-ended question on the survey conducted for the 2016 Fresno County MHSA Update, suicide was named as the 14th biggest problem facing the county. Information about the recorded suicides in Fresno County from 2012–2017 were provided by the Fresno County Department of Public Health.

As noted earlier, some characteristics serve as risk or protective markers – indicators of who might be more or less likely to engage in suicidal behavior. The groups with higher suicide risk based on comparing the percent of suicides and percent in the population are as follows:

- Matching national trends, Males account for 80% of suicides.
- While approximately 5% of Fresno County has served in the military, 15% of suicides involved someone with prior military service.
- In regard to marital status, there is an elevated risk for individuals who are single (43% of suicides, compared to 39% of Fresno County overall) and those who are divorced (18% of suicides, but 13% of adult population).
- For educational achievement, there is elevated risk for those with only high school-level education (37% of suicides, compared to 23% of adult population) and lower risk for each additional level of education: some college through associate's degree (24% of suicides vs 31% of population), bachelor's degree (9% of suicides vs 13% of population), and doctoral degree (1% of suicides vs 7% of population).
- As with non-fatal self-injury, the Race group with the highest risk is White, Non-Hispanic (56% of suicides, compared to 31% of the county population). However, in contrast to the pattern for self-injury, White, Non-Hispanic individuals also accounted for the largest number of suicides. In order of decreasing prevalence, the percent of suicides for other races was: (2) Hispanic (30%), (3) Asian/Pacific Islander (10%), (4) Black (4%), and (5) Native American (0.3%).
- Individuals from four industries accounted for approximately 33% of suicide deaths: (1) Education - youth and adults; (2) Agriculture and Farming; (3) Construction; (4) Trucking.

As depicted in Figure 20, suicides have occurred throughout the county with no particular geographic area immune to this issue. However, there are some areas in Fresno County that have a higher concentration of suicides, as shown in Figure 21.

Figure 20. Map of suicides in Fresno County by age and gender, 2012-2017.	Figure 21. Heatmap of suicides in Fresno County, 2012-2017.
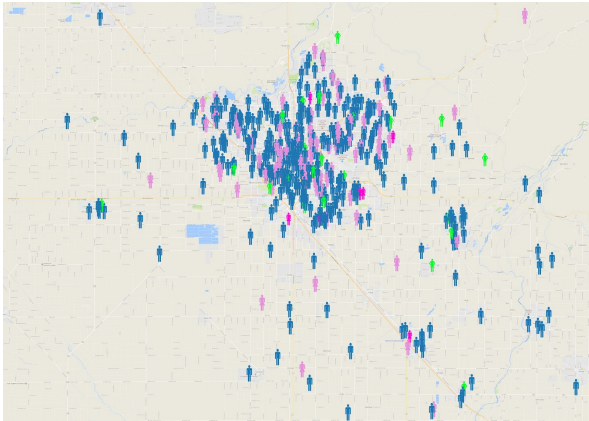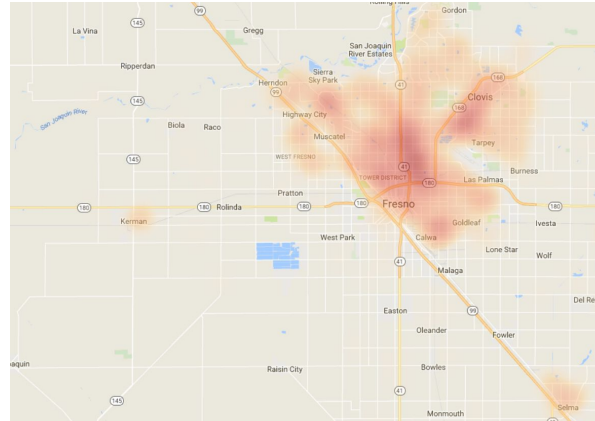
It can also be useful for planning purposes to know when suicides are more likely to occur. As shown in Figure 22, there are more suicides in Fresno County at breaks in the business or school day: Start of the day (8–9 a.m.), lunch hour (noon–1 p.m.), and getting back home (7–8 p.m.). Additionally, as depicted in Figure 23, while the myth about suicide is that deaths happen near the winter holidays, in Fresno County the peaks occur in the spring and fall, and fewer in the summer. This may be related to seasonal changes in employment, especially for the agricultural industry.

Figure 22. Frequency of Suicide by Hour, 2012-2017	Figure 23. Frequency of Suicide by Month, 2012-2017
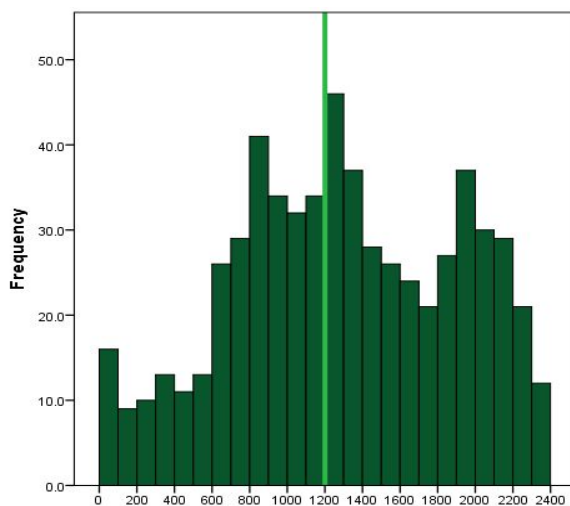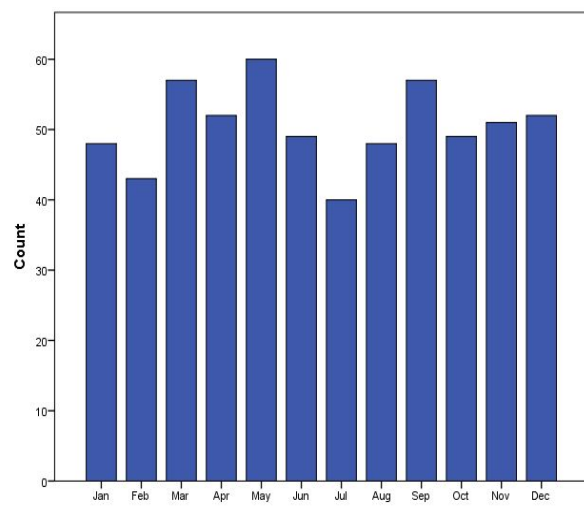
Understanding Suicidal Behavior in Fresno County

As part of the needs assessment process, data was gathered from secondary sources including the Census Bureau, California Department of Public Health, California Department of Justice, and the California Employment Development Department, among other sources indicated. Additionally, the Fresno Suicide Prevention Collaborative conducted an online survey called the Community Wellness Survey in the Fall of 2017 that gathered information related to suicide and suicide prevention from approximately 1,400 participants. The survey was followed by several focus groups and key informant interviews.

The ecological context for suicidal behavior in Fresno County

The categories included in the Social-Ecological Model were used in conjunction with research on suicide and suicidal behavior as well as the pattern of suicidal behavior in the county to apply the theoretical understanding of suicide to the specific needs and assets in Fresno County. Overall, key informants viewed suicidal behavior as a complex issue determined by an array of factors and not one or two critical events. That is consistent with the purpose of using this model for the context of suicidal behavior. As an overview of the environment that might contribute to the development of suicidal risk in Fresno County, the major categories from the Social-Ecological Model are depicted in Figure 24 with several highlights from the needs assessment that follows.

Figure 24. Applying the Social-Ecological Model to Fresno County
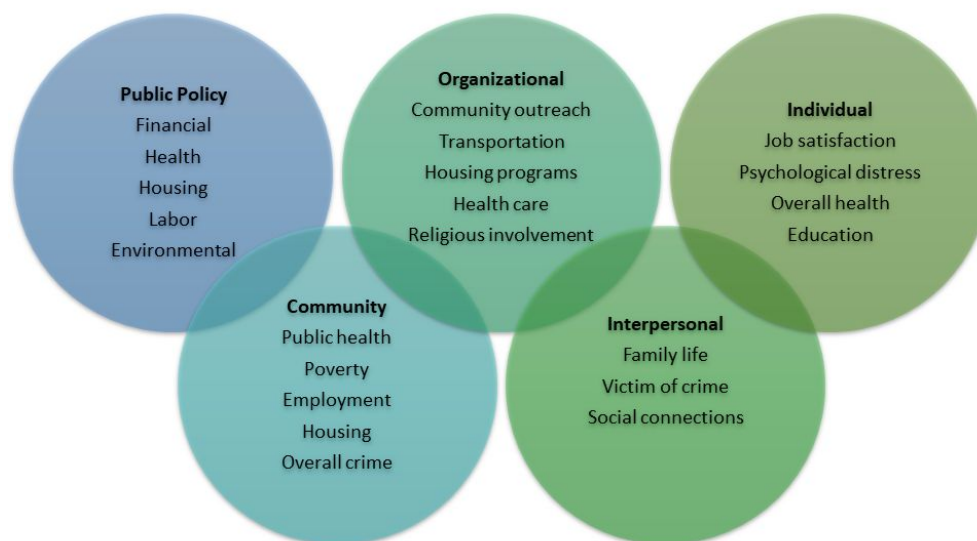
Needs

One key population-level risk factor for suicide is unemployment.[37] In 2017, 61% of adults in Fresno County were in the civilian labor force (compared to 63% for the state). **The unemployment rate for Fresno County was 10.3%, much higher than the state average of 4%**.

In terms of employment, agriculture is the third-largest industry in Fresno County, with approximately 37,400 workers, and three times as many men as women.[38] Compared to the California average, being employed in the agricultural industry is 377% more common in Fresno County (ninth highest county in the state). However, the county ranks 43rd for median income in the agricultural industry, with an average income of $24,000 per year for a full-time employee. The income range varies from $17,000 for a large number of employees in Mendota and Lenare, up to averages above $60,000 for a smaller number of employees in Clovis, Squaw Valley, and Sunnyside. Additionally, approximately 57% of the agricultural labor force works only part-time or seasonally.

Particularly with the extended drought in California, the agricultural industry (and thus a major part of Fresno County's economy) has been severely impacted. The 2012–2016 drought was one of the most severe in the recorded history for the state, and approximately 70% of the statewide losses in crop and dairy revenue have been within Fresno County and the San Joaquin Valley.[39] While the unemployment clearly takes a toll on those who have lost their jobs, it also disrupts social networks for the workers who remain employed. Further, agriculture and construction are listed as industries with high occupational risks for illness, injury, and death, and significant exposure to heat-related problems.[40]

> "The years of agricultural distress and misery and of financial crises constantly raise the proportions of mental diseases, and all that causes retrogression in a state, or in a class of men, is a cause of suicide." - Italian physician Morselli (1882)

The level of education in the population is also associated with suicide risk, with higher education being protective.[41] In Fresno County, 74% of the adult population has a high school diploma or equivalent and 20% have a bachelor's degree or higher (CA average is 82% with high school education, 32% with at least a bachelor's degree). Education is related to future economic opportunity, awareness, and access to resources, and information about getting help early in the course of illness. Thus, even when an

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[37] Gunnell & Chang (2016). Economic recession, unemployment, and suicide. In: *International Handbook for Suicide Prevention*, 2nd Ed. Hoboken: Wiley.

[38] https://statisticalatlas.com/county/California/Fresno-County/Industries

[39] Zelezny & Fu (2015). Impact of the drought in the San Joaquin Valley of California. California State University, Fresno. http://fresnostate.edu/academics/drought/

[40] CA Department of Public Health, Occupational Health Branch (2017). California Occupational Health Indicators: Annual measures of worker health and safety for years 2008-2013. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/AllIndicators08-13.pdf

[41] Platt (2016). Inequalities and suicidal behavior. In: International Handbook of Suicide Prevention, 2nd. Ed. Hoboken: Wiley.

adolescent is doing well in school, the education level of his or her parents can influence health outcomes. On the other hand, in the Fresno County Community Wellness Survey several parents cited school as a significant source of stress for youth. School pressures were noted from parents with children ranging from 3rd grade through 12th grade.

As with education, while income is not directly connected to suicide, in the U.S. it is a major factor in determining access and quality of healthcare and other resources. The level of deprivation or poverty in a population is sometimes associated with suicide rates.[42] **On average, 14% of the population in CA has income below the poverty line, but the rate is almost double that in Fresno County (26%)**. According to kidsdata.org, 31% of children in Fresno County are in low-income families (compared to 26% in CA), and 29% are in "food-insecure households" (compared to 23% for CA).

Income is a determinant of housing, and home-ownership is associated with lower suicide rates.[43] In Fresno County, the number of housing units occupied by owners (52%) is only slightly lower than the state average (54%). However, in the 2016 Fresno County MHSA Update, housing and homelessness were ranked 3rd among mental health-related problems facing the county. In an April 2018 report, the California Housing Partnership declared that Fresno County has a "housing emergency." In addition to higher levels of homelessness, the renters with the lowest income levels spend 73% of their income on rent.[44] As noted earlier, Fresno County has high levels of poverty, and major industries in the county, like agriculture, produce a low median income. Thus, **for a large proportion of the population, for every $4 the family earns, after paying for housing they have $1.08 to use for everything else, from food and clothes through health care**. There was a perception among a few key informants that poverty was a major contributor due to a lack of access to resources and other poverty-associated stressors and behaviors, a type of "culture of poverty" stigma.

As noted in the section on risk factors that elevate suicide risk, extensive research has demonstrated that adverse childhood experiences (ACEs) are associated with a large number of negative health outcomes, including suicide. Work on adverse community experiences also points to the social environment that generates individual ACEs. One of the major contributors is crime, which creates an unsafe environment, and even incarceration has the potential to disrupt families. In the Fresno County Community Wellness Survey, crime was one of the top three community wellness issues. Each year in Fresno County there are approximately 6,000 violent crimes, 3,200 property crimes, and 7,000 domestic violence calls.[45] The crime rate leads to incarceration rates of 439 per 100,000 in jail and 65 per 100,000 in prison.[46]

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[42] Gunnell & Chang (2016). Economic recession, unemployment, and suicide. In: *International Handbook for Suicide Prevention*, 2nd Ed. Hoboken: Wiley.

[43] Platt (2016). Inequalities and suicidal behavior. In: International Handbook of Suicide Prevention, 2nd. Ed. Hoboken: Wiley.

[44] https://1p08d91kd0c03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2018/04/Fresno-HNR-2018.pdf

[45] www.doj.ca.gov

[46] CA Sentencing Institute

In addition to their direct impact on wellness and quality of life, severe or chronic illnesses have also been linked with suicide risk.[47] Out of 57 counties in California, Fresno County ranks 49th on health outcomes and 54th on health factors.[48] According to data from the California Department of Public Health, Fresno County is worse than the state average on 23 of 26 health indicators, including overall death rate (724 per 100,000 vs 609), diabetes deaths (26 vs 21), stroke deaths (45 vs 35), accidental deaths (43 vs 30), homicide (7 vs 5), and suicide (11 vs 10). In the UCLA California Health Interview Survey (CHIS), 26% of participants aged 18–64 rated themselves in fair or poor health (CA average was 19%). Beyond direct risk associated with health issues, the health issues of an individual can generate significant stress for the entire family in multiple ways.

As one example indirect effect, some health factors like obesity and respiratory conditions can decrease the likelihood that parents would engage in healthy behaviors with their children, such as outdoor exercise. Fresno County was also in the top three counties for obesity on the CHIS (37% compared to CA average of 26%), and obesity can transfer from one generation to the next. Then, with Fresno County having the highest pollution burden in the state based on CHIS results, it should come as no surprise that 19% of youth in the county have asthma[49], or that the rates of chronic lower respiratory disorder (34 vs 32) and lung cancer (30 vs 29) are higher in Fresno County compared to the state averages.[50] These health conditions can act as stressors in the family or interfere with plans for healthy outdoor activity.

In the survey for the 2016 Fresno County MHSA Update, community participants cited stigma as the top mental health-related problem in the county. Key informants interviewed in Fresno County as part of developing the suicide prevention plan also noted stigma and a culture of "no weakness," especially in professional communities. However, in the same 2016 Fresno County MHSA Update survey, 82% held a positive view of mental health, and 75% had positive views of individuals with mental illness. Similar results were found in the Fresno County Community Wellness Survey, where 91% had sympathy for individuals with mental illness, most participants agreed that suicide was linked to depression,

> Stigma is an overarching term that includes multiple factors ranging from negative stereotypes to prejudice and discrimination.

and most disagreed with negative stereotypes about suicide. On the other hand, key informants also said the parents tended not to take their children seriously when they do communicate about suicidal thoughts and feelings. Key informants perceived social intolerance toward mental illness, help-seeking behaviors, and perceptions of weakness were all major barriers toward help-seeking. In general, the feeling was that there is a lot of silence and lack of discussion around suicide. Conversations about

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[47] Berman, AL., Pompili, M. (2011). Medical Conditions Associated with Suicide Risk. Washington, D.C.: The American Association of Suicidology.
Maris RW, Berman AL, Silverman MM. Comprehensive Textbook of Suicidology 1st Edition. The Guilford Press; 1 edition (August 10, 2000), pg 342-56
[48] County Health Rankings
[49] www.kidsdata.org
[50] California Department of Public Health (CDPH)

mental illness and suicide often take place in private. Many respondents had a shared theme around secret-keeping. This contributes to a lack of awareness of the larger issue and need for systems approaches. It remains possible that the perception of high stigma prevents people from discussing the issue and therefore perpetuates the silence.

Among key informants, there was a mixed agreement with the statement that suicide is preventable. Most respondents felt that in the current environment, it was not possible to prevent all suicides because of systems gaps and limited mental health resources. Objectively, the number of licensed mental health professionals in the San Joaquin Valley is lower than the average for California: psychologists (16 per 100,000 vs 43), psychiatrists (7 per 100,000 vs 15), LMFT (35 per 100,000 vs 80), and LCSW (25 per 100,000 vs 48).[51]

Key informants indicated that the issue of suicide may receive less attention because there are complex issues in society that make addressing a single issue more challenging. It is thus imperative for policymakers to see the connections between issues. In that way, it will be clear how providing community supports for those who have high needs is connected to public health concerns. However, based on information in the Community Wellness Survey, participants see the public policy area as one of the major challenges for Fresno County. Both the political environment and the ability of community members to make changes were rated among the lowest in three areas of community wellness. That might be the cause for the lower-than-average voter engagement in the county (e.g., 43% of eligible voters participated in the 2016 election compared to 60% participation at the national level and 58% participation in California). This indicates that perhaps additional information and capacity-building will be necessary to improve the level of political efficacy to the point where the community can persuade policymakers to invest in suicide prevention.

Potential assets

Belonging to a religious organization has been shown to be a protective factor against suicide. This may be an asset in Fresno County, given that compared to the California average, there is a higher level of religious involvement in Fresno County.[52] However, key informants indicated that youth spiritual leaders and ministers lack training in suicide prevention and thus are not comfortable discussing or approaching the issue.

In the 2016 MHSA survey, lack of information in the community was cited as one of the biggest challenges to improving mental health in Fresno County. Yet, participants in the Community Wellness Survey rated knowledge among the highest dimensions of wellness. This may indicate that the community has the capacity to understand and use knowledge about mental health and suicide prevention if they can be reached with that information. Indeed, the objective level of knowledge about suicide in the community survey was a score equivalent to only a passing grade (75% correct). One of

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[51] https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf
[52] https://www.bestplaces.net/religion/city/california/fresno

the areas of knowledge to improve may be changing the perception of high stigma in the community using a social norms approach. Yet, in the Community Wellness Survey, the national strategies that would help increase what we know in this area were ranked fairly low: Research ranked 8th of 11 and Evaluation ranked 9th.

However, there are also positive experiences, and in some ways the community is healthy. An interesting note: many key informant interviewees felt that systems were failing but that individuals were succeeding in preventing suicide. Most key informants felt that most suicides are preventable and that additional deaths could be prevented through increased training, supportive programs, development of a common nomenclature, marketing and communications around stigma reduction, and a high receptivity to involvement in efforts. There was a very high level of interest in both in-person and community-held training and a very high disfavor for online training opportunities (almost derision). They valued the engagement of in-person training as well as the networking opportunities for community-held training sessions.

Possible Factors Determining Risk in Fresno County

Needs

In general, on the Community Wellness Survey, the individual dimensions of wellness with the lowest ratings included physical health, financial situation, and occupational opportunity. This subjective data is consistent with the objective data described above.

One approach to understanding risk is to examine differences between the general population and groups known to have a higher risk for suicidal behavior. For some groups with a large enough sample size in the Community Wellness Survey, differences emerged comparing those with higher risk to the rest of the participants.

Individuals with a history of mental health treatment tended to have lower stigma about suicide and to be more sympathetic to individuals who may have experienced suicidal crises. They also tended to have a higher level of knowledge about suicide (81% on the objective test). They were also **less likely to seek help outside of the mental health system** (especially from parents, family, phone services, and faith leaders).

Community Wellness Survey **participants with a history of mental health treatment had lower-than-average ratings across all dimensions of individual and community wellness**. However, the survey results indicate that ratings across all dimensions of individual and community wellness may improve with age. Given that some youth groups have a high risk for suicidal behavior, it may be important to emphasize that perceptions of wellness may improve over time.

Individuals with a history of military service who participated in the Community Wellness Survey were less likely to seek help by phone or text. Similarly, **men, in general, were less likely to seek help by phone or text** and also less likely to seek help from mental health providers. However, **men were more likely than women to seek help from a partner**.

Knowledge about mental health services and trends in help-seeking vary by race and ethnicity. Compared to other race groups, survey participants who were **White were more likely to seek help for mental health providers**, had a higher knowledge about suicide, but were less likely to seek help by text or from faith leaders. Participants who were **Hispanic or Latino were more likely to seek help from a parent, text service, or faith leader**. Participants who were **Asian had lower spiritual wellness, were less likely to know where to go for help, and less likely to seek help from mental health professionals, text services, primary care doctors, or faith leaders**.

The most consistent barrier is a lack of available funding and challenges around funding prevention programs, which are perceived to have a lower value as the impact of interventions can be more difficult to study, track, and prove with data outcomes. Although most interviewees agreed that suicide is preventable, they felt that a lack of awareness, knowledge of resources, and access to those resources were the main barriers to being able to prevent all suicides. Another significant barrier was lack of time and perception of relative importance. They felt other issues were more dominant due to immediate need. There was a particular lack of resources for rural areas. More generally, key informants again noted a lack of education and awareness of mental/behavioral health conditions overall.

Potential assets

The highest-ranked strategy on the Community Wellness Survey (increasing knowledge) would apply here, as does the strategy of promoting effective programs (ranked 5th out of 11).

Community-recommended solutions from the 2016 MHSA Update included:
- Outreach and engagement, cultural appropriateness, media, client-centered approach, and Mental Health First Aid to counter perceived stigma.
- Outreach and engagement, info about access, info about wellness and recovery, speakers bureau, share lived experience, social media, and "develop a resource specialist who can work directly with families through a crisis event" for countering low information.
- More housing options, supportive services, info about eligibility, and rural access to M.A.P. for housing problems. (MHSA 2016)

Survey participants noted that students feel connected to school through (1) activities, after-school opportunities, or student groups; (2) having a personal connection with caring adults; and (3) ability to participate in decision-making. When asked what helps kids cope in Fresno County, parents reported exercise and outdoor activities, having safe indoor locations to meet up, music programs, and social media, along with the importance of having positive support at home.

Key informants felt that there was an opportunity to save lives via proactive messaging campaigns, increasing the availability of support groups, hospital follow-up programs, and increasing education and training among promotion and prevention care and other medical professionals. There was a general feeling that increasing education and resource knowledge across professional groups would increase identification and intervention. There was a high willingness to engage in systems approaches, building a shared language, and improving skills.

There was an overall perception that the youth systems are far stronger at identifying and responding to risk, but that this can create opportunities for adult systems to learn and embrace similar models. Key informants believed that this would be one critical way to disrupt the suicidal process. There was a perception shared by nearly all key informants that the community is trying to make improvements, but systems could coordinate better. However, it is beneficial to note that there wasn't a feeling of complacency, but that increased coordination would make efforts more effective.

Groups in Fresno County with Higher Risk for Suicidal Behavior

Needs

Key informants believed that high-risk groups often have more than one high-risk characteristic, which makes identification and support difficult as well as focusing on suicide as opposed to other presenting problems. There may also be difficulties distinguishing between behavior and mental illness. Key informants believed that individuals with lived experience and attempt survivors lack adequate supports and program access. Stressful factors included: money, environment, isolation, postpartum, anxiety, depression, contagion based upon work experiences, and environment, including exposure to traumatic events.

Significant behavioral health issues exist in Fresno County. In general, individuals in Fresno County reported levels of family life impairment, psychological distress, and work impairment higher than the state average.[53] Using the age-adjusted estimates from the SAMHSA NSDUH state reports, approximately 64,690 county residents (7.9%) have a substance use issue; 113,890 residents (16.9%) have some mental illness; 58,140 residents (7.1%) experience clinical depression in the past year; and 24,100 adults in the county (3.6%) have a severe mental illness diagnosis. Based on the 2016 MHSA Update, 81% of residents might know someone with a mental illness. Also in the MHSA Update, the community ranked substance abuse as the 4th most important mental health issue facing Fresno County. For substance use, participants noted that "younger admissions have been on the increase" and among youth, marijuana is the promotion and prevention drug, followed by alcohol. For "admissions aged 20+, meth is the most common substance," while "among admissions over 55, heroin is the promotion and prevention."

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[53] UCLA California Health Interview Survey

Potential assets

Key informants believed that in general suicidal risk can be detected by individuals and successful intervention can take place. Fresno County could better support someone at risk for suicide through institutional linkages, increased community supports, and information. There is a high receptivity toward working together but a perception that system barriers and lack of funding prevent such collaboration. Even with the barriers, there was a high level of anticipation that individual risk could be identified and mitigated with additional supports.

Factors that Might Escalate Suicidal Risk in Fresno County

Needs

In the 2016 MHSA Update, community stakeholders noted that access and cultural barriers were among the biggest mental health-related problems facing Fresno County. Key informants for the suicide prevention strategic planning also noted issues with a lack of knowledge and access to resources. Stigma was again cited as a perceived factor in limiting help-seeking activities and willingness to talk. Cultural and religious beliefs may be particularly important in understanding the stigma issues. Other issues included difficulty getting transportation to services and problems with the 5150 process.

In the Community Wellness Survey, individuals were asked if they had ever experienced a suicidal crisis themselves, which is referred to in the field as lived experience with suicide (lived experience). Those who had lived experience had stronger disagreement with negative stereotypes about suicide, stronger agreement with suicide being tied to depression, and higher knowledge about suicide. However, they also tended to have more positive views of suicide. Participants with lived experience had lower ratings across all dimensions of individual and community wellness and were less likely than others to seek help from parents, family, friends, phone lines, promotion and preventive care providers, or faith leaders. However, they were as likely as others to seek help from mental health providers or text services.

Potential assets

In the 2016 MHSA Update the majority of respondents who had received services (73%) found them to be helpful, while 13.5% said "not helpful." The report also noted that while 79% of respondents said they knew where to get help, on analysis there were "significant gaps in information about system delivery". Community-recommended solutions included:
- Expanding services for adults, children, and rural communities, integrating services, providing more information to the public, offering transportation options, and expanding the M.A.P. program for access barriers.
- Conducting more outreach and engagement, workforce development, expanding cultural services, expanding interpreter services, and training on "cultural humility" for cultural barriers.

On the Community Wellness Survey, 56% of participants agreed that they knew the warning signs of suicide risk, and 79% agreed that they knew where to get help. Overall, the top 5 places where individuals would seek help are: (1) mental health, (2) partner, (3) friend, (4) promotion and prevention care provider, (5) phone hotline. Relevant strategies were highly ranked by participants, especially training (#2) and promoting effective practices (#3), with media training at #6.

Mental health and school professionals were asked what approach they currently use for suicide prevention, and the most common responses were: active listening, assessment, referral, therapy (CBT, DBT), intervention models like ASIST and QPR, attention to safety, and 5150.

In focus groups and interviews, respondents believed that parents and close family would notice their risk quickly. Multiple informants expressed a desire for increased suicide sensitivity training akin to customer service, a desire for more knowledge and skills around recognition and intervention, and a desire for more preventive services. Respondents reported high confidence in their own ability to notice risk and in the performance of their own organizations but often believed that other systems did not detect risk well. There was still a desire to increase both individual and organizational awareness of recognition risk. Perceptions tended to be that risk factors were higher now than historically, possibly due to economic stressors.

All key informants felt that there is an ability to impact the issue and decrease deaths. The main mechanisms to prevent suicide according to key informants were: community engagement, safe messaging, more integrated systems and cross-systems collaboration, support groups, crisis services, peer supports, and overall increased communication. Key informants also noted some pocketed population-specific programs, and individual characteristics most likely to help prevent or reduce suicide in Fresno County were resiliency, personal connectedness, and supports.

Factors Related to Increased Suicidal Behavior in Fresno County

Potential assets

Key informants suggested that to prevent individuals from engaging in suicidal behavior, Fresno County needs more wraparound services to provide for a variety of interventions and supports to disrupt the complicated mix of comorbidity present with suicide risk. Also suggested was an increase in population-specific supports: for mothers, Native American youth, and people who don't meet 5150 criteria or the threshold for traditional mental health services. Overall, there is increasing recognition of the need for suicide prevention and developing a shared language around suicide interventions.

Factors Related to Fatality of Suicide Attempts

Needs

Currently, the data available related to fatality concern the predominant suicide methods. In Fresno County 37% of suicides involve firearms, 33% involve hanging, 15% involve poisoning, and 5% involve railroad incidents.

Key informants believed that the determining factors for fatality included the lethality of the means used as well as the degree of intent. It was perceived that the more individuals intended to die, the greater the chance that they would die and the less preventable the death would be.

Factors Related to the Aftermath of Suicide

Needs

Key informants noted that suicide causes significant trauma in those who knew the person. Elements such as isolation, substance abuse, and adverse childhood experiences intensify the effect. They also noted that the population is living longer but not healthier (increased pain, decreased mobility and overall health).

Potential assets

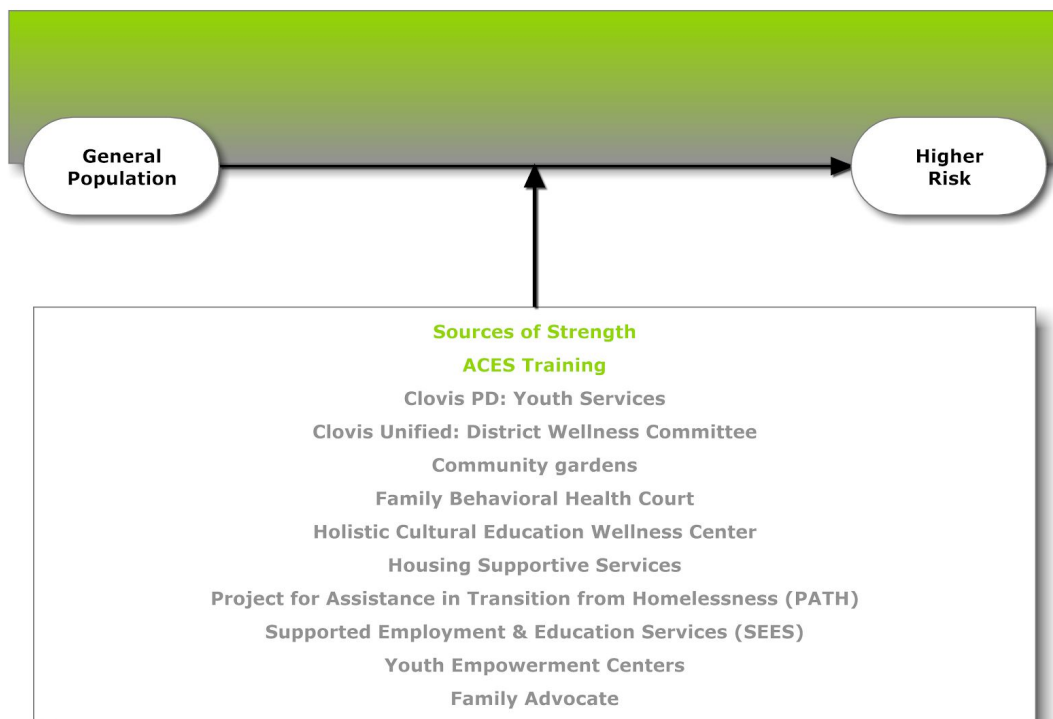In a focus group with individuals who were close to someone who died by suicide (suicide loss survivors), there was significant interest in the LOSS Team model (more details in the programs section). There was also an ongoing need for loss survivor support groups, as well as faith-based supports, individual-level peer supports, and community group supports based upon shared relationships, such as mothers.

Recommendations for Suicide Prevention Activities

Prevention and Wellness Promotion: Lower risk in the community

As noted earlier, the primary goal of prevention activities (and one goal of wellness promotion) is to stop suicidal risk from developing. In considering potential programs or initiatives in the category of promotion and suicide prevention, it is useful to note that activities described as early intervention or tertiary for other health problems can be incorporated here.[54] As shown in Figure 25, two programs (noted in green) are recommended to be added to existing efforts (noted in gray) for promotion and prevention. In addition to communication and social marketing campaigns, these programs will complement the existing programs listed in Appendix A that help foster connectedness, teach life skills, and increase help-seeking.

Figure 25. Prevention and wellness promotion activities recommended for Fresno County

General Population → Higher Risk

Sources of Strength
ACES Training
Clovis PD: Youth Services
Clovis Unified: District Wellness Committee
Community gardens
Family Behavioral Health Court
Holistic Cultural Education Wellness Center
Housing Supportive Services
Project for Assistance in Transition from Homelessness (PATH)
Supported Employment & Education Services (SEES)
Youth Empowerment Centers
Family Advocate

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[54] Because suicide is the reference point for activities in this plan, programs that might be described as tertiary for other problems may function as primary prevention here. For example, once adverse experiences have occurred, the ACEs Training simultaneously functions as a tertiary intervention for trauma, early intervention for behavioral health, and prevention for suicide.
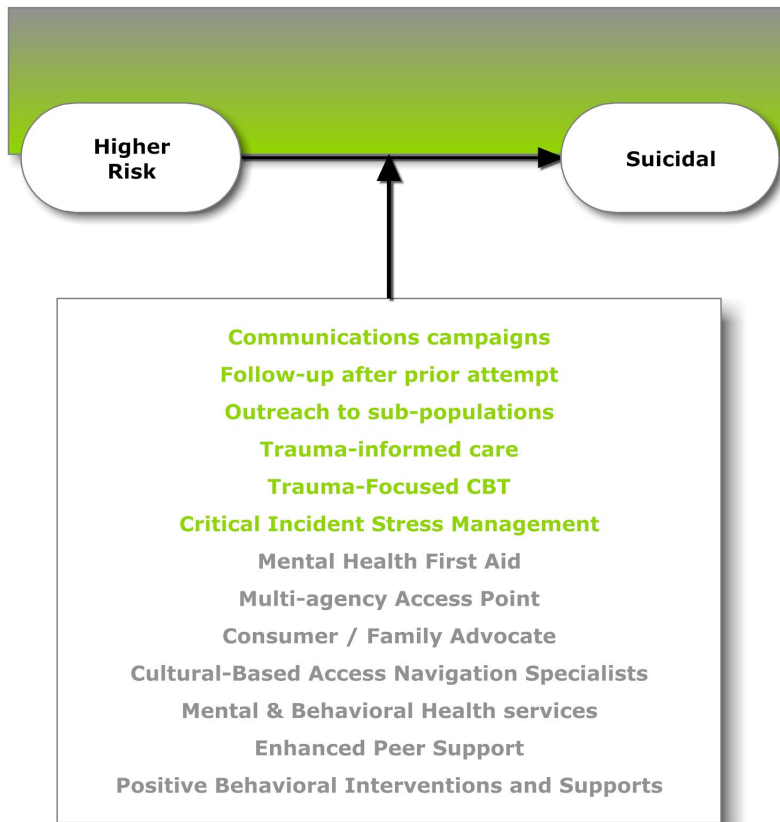
Implementation questions:

- How can the Collaborative connect with urban planning and development?
- What cultural or community efforts are already taking place that could help improve health and wellbeing?
- How can the Health Care Workgroup engage stakeholders in Occupational and Environmental Health?
- What are the possibilities for coordinating behavioral health outreach with efforts aimed at improving the overall community health in Fresno County?
- How can the Learning and Education Workgroup engage stakeholders in services related to divorce, unemployment, and housing?
- How can the community address the real or perceived high student stress and socio-economic disparities in school services?
- How can the Collaborative refine the approach to addressing stigma to focus on specific elements that are problematic in Fresno County?

Early Intervention: Helping someone through a crisis before it becomes suicidal

The goal of early intervention is to help someone with an elevated risk of suicide to avoid having a suicidal crisis. The early intervention prevention programs, sometimes referred to as "early intervention," focus on helping a person through a crisis in a way that prevents it from turning into a life-threatening situation. In general, early intervention prevention programs are offered to individuals or groups with identified risk (Selective). However, there are some cases where a message or program might be distributed throughout a population (Universal), though the content is meant to stop risky situations from turning into suicidal crises. To bolster existing programs and activities indicated in Appendix A (noted in gray), the approaches recommended for early intervention are noted in green in Figure 26.

Figure 26. Early Intervention activities recommended for Fresno County

Implementation questions:

- How can the Health Care Workgroup support expansion of the Multi-agency Access Point program, especially in rural areas?
- How can the Communications Workgroup specifically reach men, individuals in the military, veterans, and industries with higher-than-average suicide risk (agriculture, construction, trucking)?
- What connections can the Collaborative make to reach people at critical times of day when suicides are more likely to occur?

Clinical and Crisis Intervention: Helping someone through a suicidal crisis

As part of the ongoing process of improving county response to suicidal crises, the Collaborative engaged in a crisis system mapping process based on the concepts in Sequential Intercept Mapping. In addition to providing valuable information about current service practices and opportunities for improvement, the process resulted in flow charts of the crisis system for adults and children (see Appendix B). The essential elements of those charts are portrayed in relation to the Suicidal Crisis Path and some suicide prevention plan components in Figure 27.

Figure 27. Simplified flowchart of Fresno County crisis system within the Suicide Crisis Path
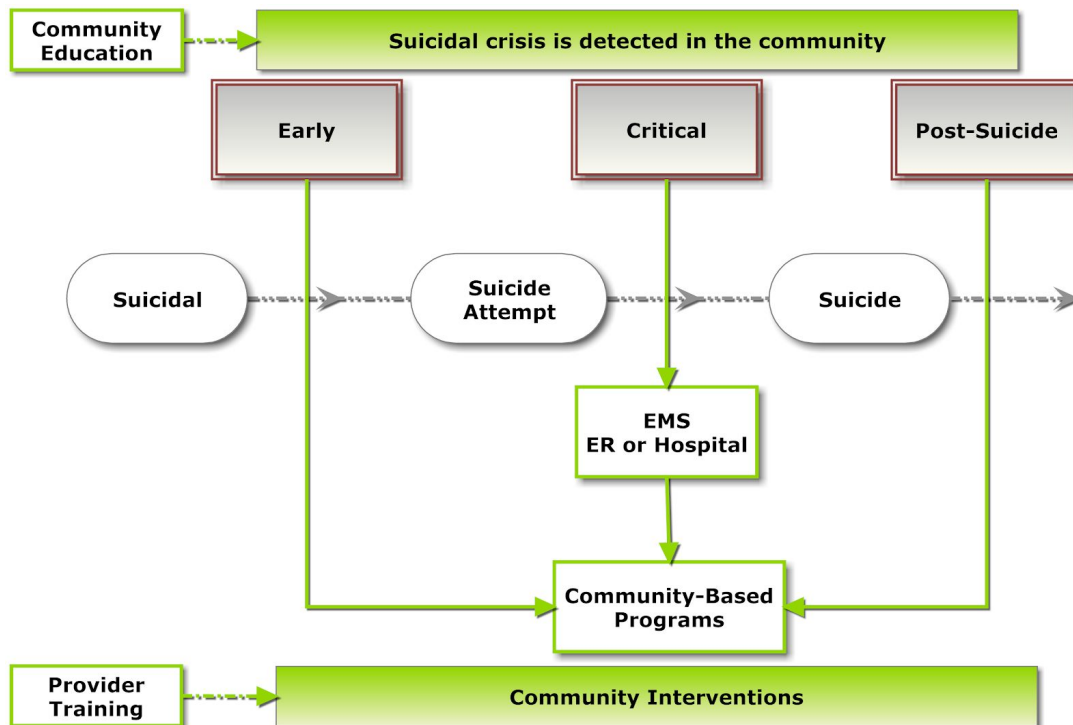
The Fresno County Crisis System Mapping provided the opportunity to systematically identify the procedures and practices that regularly occur when someone is identified as having current suicidal thoughts or feelings. Thus, the crisis system pertains to the parts of the Suicidal Crisis Path from when someone enters a suicidal crisis through postvention that takes place after a suicide death, and additional programs (noted in green) are recommended to bolster existing efforts (noted in gray) to further improve the process (see Figure 28).

Figure 28. Clinical and Crisis Intervention activities recommended for Fresno County
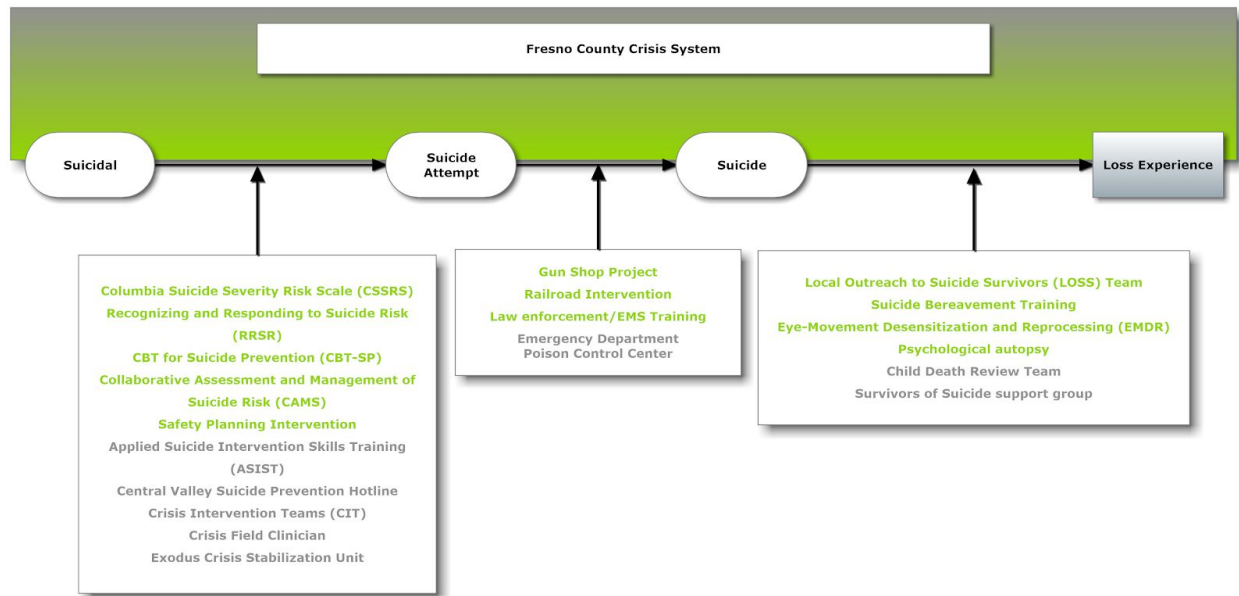
Implementation questions:

- How will the Collaborative follow through on recommendations that came out of the crisis system mapping?
- How can the Justice and Health Care Workgroups coordinate efforts to establish a LOSS Team for Fresno County?
- How can the Data Workgroup develop the information infrastructure that is needed for meaningful and ongoing evaluation of Collaborative efforts?

Goals & Objectives for Action

The future of suicide prevention efforts in Fresno County is dependent upon a comprehensive approach that is inclusive of promotion, universal, selective, and indicated activities as described earlier in this document. These activities necessitate training for the whole population, for "gatekeepers" (people who hold a role or position of authority and facilitate entry into a system), screening, assessment, treatment, and support.

There are numerous training and treatment models that are available in addition to or in place of the ones recommended below. The training and programs selected for recommendation were chosen with the following criteria in mind:
- Accessibility to the community
- Cross-systems collaboration
- Continuity in language and strategy
- Evidence-based, promising practice, or adheres to standards in the field of suicidology
- Ability to integrate or adapt to fit the local environment

Training

Training efforts are essential to a comprehensive strategy for suicide prevention. Everybody has a role in preventing suicide, but due to stigma, lack of formal education on the topic, and a lack of awareness of the prominence of the issue, as well as prevalent misconceptions, individuals might not see or understand their valuable role in helping to save lives.

Comprehensive training programs should provide a variety of educational opportunities that connect with points along the Suicide Risk Path. This approach to training allows for a broad range of intervention strategies, including prevention, early intervention, intervention and treatment, and postvention services, and facilitates the inclusion of a broad range of community members in the process of instilling hope and saving lives. This is also a valuable approach as it helps educate more members of the community that suicide is the result of more complex phenomena than just psychopathology.

Training should span from general education about mental health, such as Mental Health First Aid (MHFA), through screening (C-SSRS), into assessment (RRSR), to highly focused and specialized training such as the Eye-Movement Desensitization and Reprocessing (EMDR – successful in treatment for loss survivors, especially those with visual imprint) psychotherapeutic treatment for people who are distressed due to traumatic life experiences. This conforms training to the public health pyramid by providing training across the entire population (promotion and prevention or universal), specific groups that data demonstrates has an increased risk (early intervention or selective), and individual-level intervention (tertiary or indicated) service providers.

It is recommended that Fresno County adopt a training portfolio that builds consistency across multiple sectors by utilizing a training catalog that offers consistent training and that is also capable of being or has already been tailored to different sectors, time allowances, and population groups. In this context, for example, the Recognizing and Responding to Suicide Risk (RRSR) series is preferred over the similar training Collaborative Assessment and Management of Suicidality (CAMS), as RRSR has adapted training to groups such as primary care, pediatricians, colleges and universities, correctional facility clinicians, emergency departments, and mental health clinicians. This enables more collaboration between these groups by developing a consistency in language, treatment approach, and support. It also has the benefit of building greater consistency of experience for the service recipients, as the treatment will be more consistent across the various systems with which they interact.

The Collaborative should also develop an inventory of universal skill-based training, such as anger management, financial management, communication, conflict management, stress management, and parenting classes that are currently available through numerous community partners. This inventory can highlight readily available resources as well as identify needs and gaps. This can also facilitate easier awareness and access for community members and new potential partners.

It is not intended for these recommendations to be implemented simultaneously. The Collaborative needs to prioritize training based upon the level of available resources, including funding, interest, and time availability.

Recommended Training

National Council for Behavioral Health Trainings[55]

Mental Health First Aid (MHFA) is an 8-hour training that provides a broad education about assisting individuals in crisis who are expressing signs of a possible mental health condition. It facilitates the use of the 5-step action model ALGEE (Ask, Listen, Give reassurance and information, Encourage professional help, Encourage self-help). MHFA can help reduce stigma, increase comfort in assisting individuals, and help to provide an overview of local resources.

Youth Mental Health First Aid (YMHFA) is an 8-hour training with information tailored to recognizing a mental health-related crisis among adolescents ages 12–18. This training is primarily designed for adults who have contact with adolescents. This training focuses on the use of the 5-step ALGEE action model.

MHFA supplemental modules are sector-tailored modules that can be utilized during the 8-hour MHFA course with content designed to educate specific groups.
- Public Safety (first responders, corrections officers, and other public safety professionals)

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[55] https://www.mentalhealthfirstaid.org

- Fire and EMS
- Higher Education
- Older Adults

Table 4. National Council for Behavioral Health training

Title	Audience	Duration	Strategy
Mental Health First Aid	Ages 18+	8 hours	Selective
- Instructor certification is a 5-day training of trainers for either 15 or 30 participants and can include a higher education module. 5-day MHFA Instructor training for up to 30 people is $36,200 or $32,600 for members of the National Council. 3-day MHFA Instructor training for up to 15 people is $21,500 . - Expedited MHFA Instructor training for up to 16 currently accredited instructors seeking the second certificate is $18,750 or $16,875 for members of the National Council. - Instructors are required to conduct a minimum of 3 trainings per year to maintain certification. If dually certified in both MHFA and YMHFA, instructors still must complete a total of three sessions within 1 year, with at least one session in MHFA and one in YMHFA. - Actual MHFA & YMHFA training delivery has a material fee of $15-25 per participant.			
Youth Mental Health First Aid	Ages 18+	8 hours	Selective
See Mental Health First Aid content above, as pricing and requirements are the same.			

LivingWorks Education, LLC pyramid of trainings[56]

suicideTALK is a customizable training that can range from 90 minutes to four hours, which is focused on developing a basic understanding of the issue of suicide and how it can be prevented. This training does not impart in-depth skills but instead focuses on awareness. This training aids participants in understanding that suicide is a public health problem, how individuals and community contribute to safety or stigma, and how participants can make a difference.

esuicideTALK is an online program organized around the question, "Should we talk about suicide?" This program provides a structure in which session members can safely explore some of the most challenging attitudinal issues about suicide and encourages members to find a part that they can play in preventing suicide. This is an electronic alternative to suicideTALK, facilitating easier access to training.

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[56] https://www.livingworks.net

safeTalk is an expanded training ranging from 3–4 hours and explores the topic of suicide and prevention in greater depth. The training is based on the TALK model: Tell Ask Listen KeepSafe. This training focuses on assisting participants in recognizing invitations for help that are commonly displayed by at-risk individuals.

Applied Suicide Intervention Skills Training (ASIST) is a 15-hour in-depth training with an emphasis on suicide first aid interventions. This training assists participants in exploring their attitudes about this topic and increasing their ability to recognize risk and explores the Pathways for Assisting Life (PAL) model for suicide prevention.

Suicide to Hope is a 1-day training for clinicians and other professional helpers who are, or would like to be, involved in ongoing suicide care for people, once they are safe. This workshop advances the Pathway to Hope (PaTH) model for setting and working toward recovery and growth goals. This hope-oriented approach helps attendees become more confident, caring, and engaged in their provision of services.

Table 5. LivingWorks Education, LLC training

Title	Audience	Duration	Strategy
suicideTALK	Ages 15+	90 min to 4 hours	Selective
● suicideTALK T4T costs are included in the ASIST T4T. No additional costs for training or materials. ● Training is flexible and can be customized by each trainer. ● No participant maximum.			
esuicideTALK	Ages 15+	1–2 hours	Selective
● Can be accessed by most computers. ● Ability to bookmark progress and return to it later. ● Easy to distribute wide access. ● Pricing: Individual - $25, 25 licenses - $450, 100 licenses - $1,500, 500 licenses - $6,000, unlimited - $10,000 annually (includes a custom homepage displayed before training).			
safeTALK	Ages 15+	3–4 hours	Indicated
● T4T for 10 candidates: $8,870.00 + taxes. ● $9.95/kit per person plus taxes and shipping. ● Each trainer is required to complete 3 workshops in year 1, and 2 sessions per year thereafter. ● One trainer and one community resource person can conduct a workshop for 15–30 participants.			
ASIST	Ages 16+	15 hours	Indicated
● T4T for 15 candidates: $39,735.00 + taxes. ● T4T for 24 candidate: $60,888.00 + taxes. ● Each ASIST training has a per person cost of $39.95 plus taxes and shipping for participant kits.			

● Each trainer is required to complete 3 workshops in year 1, and 1 session per year thereafter.			
suicide to Hope	Clinicians	8 hours	Indicated
● Training for Facilitators per candidate cost: $2,500 + travel, accommodations, per diem, etc. ● Very large provider facilitator training offerings are limited two a few opportunities per year. ● Each candidate must have attended an ASIST session prior to attending the facilitator training. ● One facilitator can provide training sessions for up to 24 participants comprised of clinicians and other professionals helping people understand and work through their suicide experiences toward a better quality of life.			

American Association of Suicidology trainings[57]

Recognizing & Responding to Suicide Risk (RRSR)[58] is a series of sector-tailored trainings that focus on conveying state-of-the-art treatment guidelines developed by a panel of internationally recognized experts in the field of suicidology, driven by evidence-based research. The RRSR series focuses on eight topical areas that expand to cover 24 core competencies.

The eight topical areas of RRSR:
- Attitudes and Approaches for Working with Suicidal Clients
- Understanding Suicide
- Collecting Assessment Information
- Formulating Risk
- Developing a Treatment and Services Plan
- Managing Care
- Documenting
- Understanding Legal Issues Related to Suicidality

RRSR in PC Providers of Youth & Young Adults is a seventy-five-minute workshop which assists primary care practitioners in learning the unique characteristics of adolescents who are distressed and might be suicidal. The training focuses on the importance of routine screening and strategies for effective care management. This training can be expanded upon with the use of the Suicide Prevention Resource Center's publication *Suicide Prevention Toolkit for Rural Primary Care*.

RRSR: Essential Skills in Primary Care is a ninety-minute workshop that helps increase the effectiveness in eliciting suicide risk and formulating effective treatment approaches. This training can be expanded

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[57] http://www.suicidology.org
[58] Jacobson JM, Osteen P, Andrea Jones A, and Berman A (2012). Evaluation of the Recognizing and Responding to Suicide Risk Training. Suicide and Life Threatening Behavior. 42(5), 471-85.

upon with the use of the Suicide Prevention Resource Center's publication *Suicide Prevention Toolkit for Rural Primary Care.*

RRSR: Essential Skills for Clinicians is a two-day training that assists therapists, social workers, psychiatric nurses, physicians, and similar treatment providers in understanding suicide and learning 24 core competencies in the treatment of individuals with suicidal intent.

RRSR for Correctional Facility Clinicians is a two-day training targeted to clinicians in the jail and prison settings that provide care to inmates, a population that can have an increase in the number of manipulative individuals and malingered symptoms.

RRSR In College & University is a two-day training that facilitates an understanding of creating systems for safety while considering the unique characteristics of the college setting.

RRSR In the Emergency Department is a one-day training for physicians, registered nurses, physician assistants, and nurse practitioners in the emergency department setting. Emergency departments are critical locations for the triage of individuals who are suicidal, especially as individuals may present with non-psychiatric complaints or deny ideation. This program assists treatment professionals in effectively detecting and managing these cases.

AAS/AFSP Suicide Bereavement Clinician Training Program is a one-day workshop that assists mental health practitioners as well as clergy, pastoral counselors, school personnel, and others in learning vital skills to support the post-traumatic growth of those impacted by suicide, which frequently involves the need to resolve complicated grief. The affected population has unique treatment needs for which many clinicians have not been adequately prepared. Effective treatment is essential, as those impacted by suicide loss have an elevated risk for death by suicide.

Psychological Autopsy Certification Training Program is a two-day training program that facilitates skills to conduct a postmortem investigative process, which explores how and why a specific individual died by suicide. This information can further inform local suicide prevention efforts by detecting the individual contributors to a death by suicide as well as revealing local-level contributions to suicide risk.

Table 6. American Association of Suicidology training

Title	Audience	Duration	Strategy
RRSR in PC Providers of Youth & Young Adults	MDs, RNs, PAs, and NP	90 minutes	Indicated
- Hosted training for up to 100 attendees: $7,626 without CMEs or $9,626 with CMEs. *Or* Webinar for up to 100 attendees: $5,597 without CMEs or $7,597 with CMEs. - Additional: Hosted training or webinar but not both. Scheduled on the same day as Primary Care training for a reduced cost of trainer travel. - Training for Trainer: 90 min. training for up to 100 clinicians, plus 2-day training for 10 trainers (3 day total). - T4T costs: $13,070 without CMEs or $11,070 with CMEs, includes both RRSR Youth & Primary Care.			
RRSR: Essential Skills in Primary Care	MDs, RNs, PAs, and NP	90 minutes	Indicated
- Hosted training for up to 100 attendees: $6,396 without CMEs or $8,396 with CMEs - *Or* - Webinar for up to 100 attendees: $5,597 without CMEs or $7,597 with CMEs. - Additional: Hosted training or webinar but not both. Scheduled on the same day as Youth training for a reduced cost of trainer travel. - Training for Trainer: 90 min. training for up to 100 clinicians, plus 2-day training for 10 trainers (3 day total). - T4T costs: $13,070 without CMEs or $11,070 with CMEs, includes both RRSR Youth & Primary Care.			
RRSR: Essential Skills for Clinicians	Clinicians: LMFT, LCSW, etc.	2 days	Indicated
- Hosted training for up to 50 attendees: $11,378 without CMEs or $13,378 with CMEs. - Training for Trainer: training for up to 50 attendees & 10 trainers $20,295 without CMEs or $22,295 with CMEs. - Additional: Hosted training or webinar but not both. Scheduled on the same day as Corrections training for a reduced cost of trainer travel. 5 days total, 2 for training and 3 for T4T.			
RRSR for Correctional Facility Clinicians	Clinicians: LMFT, LCSW, etc.	2 days	Indicated
- Hosted training for up to 50 attendees: $13,715 without CMEs or $15,715 with CMEs. - Training for Trainer: training for up to 50 attendees & 10 trainers $20,295 without CMEs or $22,295 with CMEs. - Additional: Hosted training or webinar but not both. Scheduled on the same day as Clinicians training for a reduced cost of trainer travel. 5 days total, 2 for training and 3 for T4T.			

RRSR In College & University	Clinicians: LMFT, LCSW, etc.	2 days	Indicated
- Hosted training for up to 50 attendees: $13,038 without CMEs or $15,038 with CMEs. - Training for Trainer: training for up to 50 attendees & 10 trainers $20,295 without CMEs or $22,295 with CMEs. 5 days total, 2 for training and 3 for T4T.			
RRSR In the Emergency Department	MDs, RNs, PAs, and NP	1 day	Indicated
- Hosted training for up to 40 attendees: $11,439 without CMEs or $13,439 with CMEs. - Training for Trainer: training for up to 40 attendees and 10 trainers: $14,822 with CMEs or $16,822 with CMEs. 2 days total, 1 for training and 1 for T4T.			
AAS/AFSP Suicide Bereavement Clinician Training Program	Clinicians, pastors, counselors, school personnel, etc.	1 day	Indicated
Hosted training for up to 200 attendees: $8,180 without CMEs.			
Psychological Autopsy Certification Training Program	Special	2 days	Indicated - postmortem
- Hosted training for up to 50 attendees: $36,622 with CMEs or $38,622 with CMEs. - Training attendees must apply to the American Association of Suicidology and meet criteria, including submission of CV or resume, and substantiate qualification and ability to perform psychological autopsies.			

Recommended Training Specific to Traumatic Experiences

Trauma is one of the common foundational elements that drive risk for suicide. Unresolved or ineffectively treated trauma can lead to a host of negative outcomes. The value of recognizing, addressing, and responding to traumatized individuals, as well as providing effective care and treatment, is essential to the long-term reduction of suicide attempts and completions in a community. This can be achieved through both the philosophy behind care, such as Trauma-Informed Care and sensitivity of Adverse Childhood Experiences, as well as specific skills such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, the Care and Collaborative Assessment and Management of Suicidality, and Eye Movement Desensitization and Reprocessing.

Trauma-Informed Care[59] is a treatment approach that focuses on the strengths of a traumatized individual and recognizes the significant effects that trauma enacts upon them. This is a systems

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[59] https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf

approach that is woven throughout multiple training offerings and is a philosophy of care. Specific training offerings are possible[60], though this is really an approach to treatment. Trauma is often an underlying and unaddressed condition that can further hinder recovery by complicating treatment, leads to accidental retraumatization, and elevates lifetime risk for suicide. This model can assist treatment providers in detecting and adjusting treatment to incorporate the prevalence and pervasiveness of suicide in the lives of individuals served while enhancing system linkages and supports to assist in resolving underlying trauma.

Adverse Childhood Experiences[61] (ACEs) are negative experiences such as abuse (physical abuse, sexual, emotional), household challenges (mother treated violently, household substance abuse, mental illness in the household, parental separation or divorce, criminal household member), and neglect (emotional, physical). These experiences can impact lifelong morbidity and mortality. A modern understanding of this issue was pioneered through a joint study between the CDC and Kaiser[62]. Strategies such as those put forth in the Center for Disease Control and Prevention's Essentials for Childhood[63] can be embraced to help create programs and supports to increase long-term favorable outcomes, including the decrease of:

- Risky health behaviors
- Chronic health conditions
- Low life potential
- Early death

Table 7. Adverse Childhood Experiences training[64]

Title	Audience	Duration	Strategy
Adverse Childhood Experiences	Licensed clinicians	See below	Selective

Training relating ACEs can be engaged in informally and can be approached through a variety of programs that assist in addressing the root causes of these experiences. Some programs and efforts are already underway in the community. Below is a brief listing of a few options.
- Example training, resources, and programs:
    ○ Agreement between the Department of Behavioral Health and the Fresno Superintendent of Schools for school-based supportive services.[65]
    ○ Perinatal Wellness Center: program has established competency with DBT, CBT, and EMDR.			

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[60] https://www.nasmhpd.org/online-training

[61] https://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract

[62] https://www.cdc.gov/violenceprevention/acestudy/about.html

[63] https://www.cdc.gov/violenceprevention/pdf/essentials_for_childhood_framework.pdf

[64] www.emdrhap.org

[65] http://www.co.fresno.ca.us/Home/Components/News/News/372/1557

> ○ Trauma Training for Educators (free):
>   http://ciscentraltexas.org/resources/traumatraining/
> ○ Communities in Schools: https://www.communitiesinschools.org
> ○ Parent-Child Interaction Therapy (PCIT): http://www.pcit.org

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT)[66] is a psychotherapy that blends a wide range of both cognitive and behavioral techniques to aid individuals in recognizing their response to a situation rather than upon a situation itself. It seeks to utilize a structured, time-limited approach to identify and modify dysfunctional behaviors, beliefs, and similar decision processes. By identifying and modifying these systems, problems can be mitigated by changing from maladaptive to adaptive problem-solving skills and coping. One of the greatest strengths of this approach is the collaborative relationship between patient and clinician in recognizing and modifying thoughts and behaviors.

Training is available directly through the Beck Institute for in-person training and supplemented with online training opportunities for clinicians that are unable to join in-person sessions. It is strongly recommended that training is followed by at least one series of 10 one-hour phone/video conferencing support sessions. These sessions can take place weekly, bi-weekly for twenty weeks, or monthly for ten months. This support can take the form of *Supervision* which includes participants recording actual therapeutic sessions for review utilizing privacy compliant technology, or through *Consultation,* which does not include a review of recorded sessions. A blended approach to include both *Supervision* and *Consultation* is recommended to help overcome barriers around privacy concerns and technological limitations, and will also allow for comparisons between the two models during evaluation to find the model that is most effective within the community of Fresno County.

Supervision and *Consultation* take place within the context of a four-person cohort of clinicians. To support the objectives and environment of the Collaborative, it is recommended that these cohorts contain individuals from across systems rather than within systems. For example, a cohort could be comprised of one clinician from education, one from community behavioral health, one from justice, and one from a medical provider. This will maximize cross-systems collaboration, networking, and a greater understanding of the overall challenges and successes in the community.

In addition to training for clinicians, Beck Institute provides skills-based trainings for people of all walks of life to use within the context of their work setting to help others. Examples of human service workers for whom we provide training include: community agency workers, medical professionals, teachers, and corrections. Workshops for human service workers are skills-based and experiential to teach how to use fundamental CBT skills to help those they encounter in the course of their work. Skills that are taught to

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[66] https://beckinstitute.org

human service workers include: relaxation techniques, changing your thinking, setting goals, motivational techniques, decision making, and setting action plans. Workshops on these skills may be offered to homogeneous or mixed, small or large groups of any combination.

Each training in *Table 8 Cognitive Behavioral Therapy training* is available through a single provider, the Beck Cognitive Behavioral Therapy, and is hosted on Psychwire[67].

Table 8. Cognitive Behavioral Therapy training

Title	Audience	Duration	Strategy
Essentials of CBT	Licensed clinicians*	See below	Selective
In-person training is available and recommended as it can be both more cost effective as well as increase networking across systems, which in support of the strategic recommendations contained within this strategic plan. Training can entail from 1 to 5 days of training, inclusive of Essentials of CBT as well as selected focuses such as Depression, CBT for Anxiety, and CBT for Personality Disorders, Trauma-Focused CBT, CBT for Suicide Prevention, and others. - In-person training costs are $4,500 per day plus trainer travel and accommodation. - No cap on attendance, though it is recommended that training have a soft cap around 80 and in multiples of 4 to ensure both engagement in role-play activities as well as grouping into cohorts. 10 sessions of group Supervision is $4,000 per four-person cohort. 10 sessions of group Consultation is $3,000 per four-person cohort. - It is recommended that cohorts be composed of individuals from different sectors to maximize cross-system collaboration, networking, and experiential learning. Alternatively or as a supplement to in-person training, online training is also available. The online version will help participants learn the fundamentals of the Beck Approach to CBT. Led by Dr. Judith Beck, this interactive course provides the foundation you need to provide effective treatment and hone your therapeutic skills. View clinical roundtable discussions, video recordings of therapy sessions, and learn how our Beck Institute faculty conceptualize cases, structure client sessions, and teach clients the cognitive and behavioral skills they need to make changes and accomplish goals. Become a part of our interactive online community by sharing your experiences on our Forum and get your questions answered by our experienced faculty. - Online training - Training takes place on set dates, but participants do not have to be available at a specific time. - The online course is 8 hours over four weeks. - Pricing for the online course is $350 per person with price breaks for additional courses and large groups. If Essentials of CBT is purchased at the same time as CBT for Depression, CBT for Anxiety, and CBT for Personality Disorders, the total pricing becomes $1,490 per person.			

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[67] https://psychwire.com/beck

Beck can also customize training for non-licensed therapists, allied health workers, medical professionals, teachers, corrections, etc.			
Integrating CBT and Mindfulness	Licensed clinicians	See below	Selective

- Online training
- Previous CBT knowledge necessary, ideally through completion of Essentials of CBT.
- Training takes place on set dates, but participants do not have to be available at a specific time.
- The online course is 1-2 hours per lesson over four lessons.
- Pricing for the online course is $150 per person (price breaks for additional courses and large groups).

CBT for Depression	Licensed clinicians	See below	Selective

Deepen your understanding of depression and learn how CBT experts successfully treat mild to severe depression.

- Online training
- Previous CBT knowledge necessary, ideally through completion of Essentials of CBT.
- Training takes place on set dates, but participants do not have to be available at a specific time.
- The online course is 16 hours over eight weeks.
- Pricing for the online course is $590 per person (price breaks for additional courses and large groups).

CBT for Anxiety	Licensed clinicians	See below	Selective

Master the skills needed to effectively treat common anxiety disorders including generalized anxiety disorder, panic disorder, social anxiety disorder, and obsessive-compulsive disorder. Build your CBT skill set by learning evidence-based interventions for anxiety.

- Online training
- Previous CBT knowledge necessary, ideally through completion of Essentials of CBT.
- Training takes place on set dates, but participants do not have to be available at a specific time.
- The online course is 16 hours over eight weeks.
- Pricing for the online course is $590 per person (price breaks for additional courses and large groups).

CBT for Personality Disorders	Licensed clinicians*	See below	Selective

Learn a variety of strategies to diagnose, conceptualize, and treat clients with personality disorders. Discover how to use the therapeutic alliance to achieve therapeutic goals and help clients improve their relationships outside of therapy.

● Online training ● Previous CBT knowledge necessary, ideally through completion of Essentials of CBT. ● Training takes place on set dates, but participants do not have to be available at a specific time. ● The online course is 15 hours over six weeks. ● Pricing for the online course is $590 per person (price breaks for additional courses and large groups).			
CBT for Suicide Prevention	Licensed clinicians*	See below	Indicated
Cognitive Behavioral Therapy for Suicide Prevention[68] is a therapeutic approach aimed at preventing re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of risk factors and stressors (e.g., relationship problems, school- or work-related difficulties) leading up to and following the suicide attempt; safety plan development; skill building; and psycho-education.[69] ● At the time of the writing of this Draft, pricing information was not available outside of the in-person pricing provided under Essentials of CBT.			
Trauma-Focused CBT	Licensed clinicians*	See below	Selective
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)[70] is a cognitive behavioral therapy[71] that was adapted to fit the specific and unique needs of children, adolescents, adult survivors of abuse, and families who experienced trauma. This treatment approach can follow DBT and enhance the treatment by providing trauma-specific clinical interventions and skills. ● At the time of the writing of this Draft, pricing information was not available outside of the in-person pricing provided under Essentials of CBT. Direct communication with the Beck Institute is pending future meetings and discussion once their full team is available.			

*The Beck Institute can also customize this training for non-licensed therapists, allied health workers, medical professionals, teachers, corrections, etc.

Dialectical Behavioral Therapy

Dialectical Behavioral Therapy (DBT)[72] is a treatment approach developed by Marsha Linehan with the specific application of treating the chronically suicidal patient. DBT has been implemented in a variety of settings including in combating suicidal ideation, non-suicidal self-injury, substance abuse, eating disorders, and other conditions that can contribute to suicide risk. This treatment modality has been effectively adapted for a variety of ethnic populations and age groups, making it an ideal tool for use in

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[68] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2888910/

[69] Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[70] https://tfcbt.org

[71] https://beckinstitute.org/get-training/training-for-organizations/

[72] https://dbt-lbc.org

Fresno County. The full model created by Marsha Linehan requires a concerted multi-year effort with a dedicated and focused treatment team. DBT Skills training is still possible for engagement in a less rigid structure and can be utilized in individual, group, and systems settings. Due to the nature of the Collaborative, it is recommended that the broader skills training be engaged.

The course selected below is described as follows[73]: "Learn the Dialectical Behavior Therapy (DBT) skills that are the foundation of DBT treatment. Dr. Marsha Linehan has designed this interactive and engaging course to help you master the clinical application of DBT Skills. You will gain in-depth knowledge of the four DBT Skills modules of Mindfulness, Emotion Regulation, Interpersonal Skills, and Distress Tolerance to treat suicidal and difficult-to-treat clients in your clinical practice."

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[73] https://psychwire.com/linehan/dbt-skills

Table 9. Dialectical Behavioral Therapy training[74]

Title	Audience	Duration	Strategy
DBT Skills	Licensed clinicians	See below	Indicated

- Online training – available through Psychwire
- Training takes place on set dates, but participants do not have to be available at a specific time.
- The online course is 12 hours over six weeks.
- Pricing for the online course is $590 per person
- In-person training may be possible, but pricing and information subject to the selected source when utilizing DBT skills trainings as opposed to the strict Linehan model.

The Collaborative Assessment and Management of Suicidality

The Collaborative Assessment and Management of Suicidality (CAMS)[75] is a problem-focused clinical intervention designed to enhance coping (refer to Crisis Coping Theory) and treat the drivers of suicide risk (refer to Suicidal Crisis Path model) to reduce and eliminate suicidality. This clinical intervention focuses on a collaborative approach between the patient and the clinician in conjunction with the utilization of the Suicide Status Form (SSF) suicide-specific assessment, suicide-specific treatment planning, tracking of on-going risk, and clinical outcomes and dispositions.

Table 10. Collaborative Assessment and Management of Suicidality training[76]

Title	Audience	Duration	Strategy
CAMS	Licensed clinicians	See below	Indicated

- Book: Managing Suicidal Risk: A Collaborative Approach, Second Edition; approx. $34 each
- Training can be completed through a three-hour online course in conjunction with self-study.
- Group Course: CAMS-care Training, $99 per person.
- Group Course: CEU Credits, $36 per person.
- Can be enhanced with both in-person role-play training as well as 1-hour long consultation calls.

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[74] www.emdrhap.org
[75] David A. Jobes. The Collaborative Assessment and Management of Suicidality (CAMS): An Evolving Evidence-Based Clinical Approach to Suicidal Risk. Suicide & Life Threatening Behavior 42(6) December 2012. pp. 640-53.
[76] https://cams-care.com/

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR)[77] is an eight-phase psychotherapeutic approach to assisting individuals in processing and resolving distressing thoughts stemming from traumatic life experiences. Confronting and overcoming the impact of trauma is highly effective at alleviating distressing memories that can drive maladaptive coping skills and contribute to risk for suicide. Conditions EMDR has been found effective at treating include depression, anxiety, phobias, excessive grief, somatic conditions, and addictions, lending this approach to being appropriate for mitigating a wide range of contributing factors to risk for suicide.

Table 11. Eye Movement Desensitization and Reprocessing training[78]

Title	Audience	Duration	Strategy
EMDR	Licensed clinicians, others*	See below	Indicated

- Training cost is $890 per person ($445 per session, and there are two sessions).
- There are two sessions + consultations within 24 months of starting the process.
  - Session 1 (3 days): 10 hours didactic + 10 hours of supervised practice
  - Session 2 (3 days): 10 hours didactic + 10 hours of supervised practice
  - Consultations: 10 hours
- Participants must complete 10 hours of consultation on their own, 4–6 of which is recommended be completed before the second training.
- The consultant directory must be utilized for trainer fees, in addition to the $790 per person.
- Only licensed mental health professionals working at least 30 hours per week for non-profit or the public sector are eligible.
  - Must be in good standing in the jurisdiction in which they practice; you will be asked to supply your license number and the issuing authority.
  - Must be licensed in a clinical mental health field.
- Session is eligible for 20 CEUs per participant, which must be paid individually. Alternatively, organizing entities capable of issuing CEUs may do so.
- Minimum of 24 attendees.
- Maximum size is limited by facilities, as attendees are split into small working groups of 9.
- The training sessions must fall on a Friday, Saturday, Sunday.

*Others: Individuals not yet licensed
- Not yet licensed

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[77] http://www.emdr.com
[78] https://www.emdrhap.org

- ○ Must be working towards licensing.
  - ○ Must be working under the supervision of a licensed clinician who can complete and sign the Supervisor's Approval Form.
- ● Master's Degree Student
  - ○ Degree must be in a mental health field that will lead to licensing after graduation.
  - ○ Must be in the clinical portion of your training (first-year students are not eligible).
  - ○ Must be working under the supervision of a licensed clinician who can complete and sign the Supervisor's Approval Form.

Programs

The programs in this section have been recommended because each program and strategy promotes connectedness between individuals, between individuals and their families and community organizations, and among community organizations and social institutions, which are all pillars of the recommendations put forth by the Centers for Disease Control and Prevention[79], Joiner's Interpersonal Theory of Suicide[80], in the origins of the modern understanding of suicide[81], and underpinnings of both the Crisis Coping Theory and the Suicidal Crisis Path. The more an individual has connectedness, the more accessible and forthcoming additional supports can be in times of stress to help counteract and intervene in periods of decompensation.

Programs promoting connectedness should not be supported simply for the sake of promoting community connectedness. These programs and approaches should be replicated or modeled from evidence-based approaches, target varied populations who have low or deteriorating connectedness (such as homebound older adults), are difficult to reach with standard outreach (overcome with initiatives such as Promotores de Salud) and local at-risk populations (such as suicide attempt survivors, survivors of loss, and middle-aged white males).

The individuals and organizations involved in these strategies should be engaged in education and training to recognize and interrupt the development of suicidal behavior (such as through MHFA and ASIST training), integrate with systems to reduce and respond to interpersonal violence, and include a mix of targeted approaches to reach vulnerable populations (such as the geographically isolated, LGBTQ+, and middle-aged and older white males).

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[79] https://stacks.cdc.gov/view/cdc/5275/cdc_5275_DS1.pdf
[80] Thomas Joiner. Why People Die by Suicide. (2007) Harvard University Press; 1 edition.
[81] Émile Durkheim. Suicide: a Study in Sociology. Free Press, New York. (Original work published 1897)

Recommended Programs

LOSS Team

LOSS Team or *Local Outreach to Suicide Survivors*[82] embraces the Active Postvention Model (APM)[83] in which a team of trained suicide loss survivors responds to the scene of suspected or probable suicide deaths. The team provides information, support, warm linkage, and resources to the newly bereaved. This team serves as a nexus between the newly bereaved and community-based services for support and recovery. LOSS Teams typically engage in two different models.

The most common response in a community is a passive response. This is not one of the two LOSS Team models. Passive responses involve survivors of loss eventually finding their way to services, often as a result of maladaptive coping becoming untenable. These maladaptive coping skills can include behaviors such as substance abuse and uncontrollable anger as a result of their unresolved grief. Most commonly, communities offer no additional supports and any sought-out services tend to be through traditional mental health services providers such as private clinicians. Suicide loss can be stigmatizing and survivors of loss can be dissuaded from engagement in supportive services for fear of further stigmatization. Some areas might offer a peer support group such as Survivors of Suicide Loss (sometimes referred to simply as Survivors of Suicide). These services tend to be rare, and individuals might have to travel vast distances to engage in them or the frequency in which they are offered can make participation challenging and sporadic.

A Delayed Response Postvention Model involves one individual or a small response team that offers support days, weeks, months, or even years after a loss. The activation of the team can come from a variety of sources inclusive of local law enforcement, referrals from mental health providers, faith-based organizations, or from individuals who conduct an internet search or learn about the team in some other way. Contact can be limited to phone or Internet-based communication, or might involve in-person meetings at a formal site, in the community, or in a loss survivor's home. The team then connects the survivor with whatever services exist in the community.

The Active Postvention Model includes direct engagement with the coroner or medical examiner, emergency dispatch, or communication with first responders such as patrol officers, fire personnel, emergency medical technicians, hospitals, chaplains, or others that are actively called to or informed of a possible or probably suicide death. The protocol and activation of a team under the APM should be developed in close partnership with local law enforcement, as the team responds to active incident scenes and scene etiquette must be closely observed. Teams are often comprised of loss survivors, clinicians, or other volunteers who are trained to respond. This team is a primary support and referral

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[82] http://www.lossteam.com
[83] Frank R. Campbell, Louis Cataldie, John McIntosh, and Kari Millet, An Active Postvention Program. Crisis (2004), 25, pp. 30-32.

mechanism for the newly bereaved. This model helps to immediately interrupt the transitional period after a precipitating event to provide adaptive coping strategies and reduce the incidents of crisis. This can help facilitate the newly bereaved in more rapidly and successfully moving to adaptive resolution and a new stasis.

The Mixed Postvention Model includes elements from Active Postvention, Delayed Response Postvention, and Passive Postvention. The team could aim to build core competencies through beginning with a delayed response model while building trust, relationships, and experience to graduate into an increasing volume of active responses. Active responses also might not always be possible due to delays in notification, a lack of adequate resources, or other mitigating factors. The mixed model allows for flexibility and adaptability to these fluctuations as well as creating a team culture in which it is acceptable to go from active to delayed as the situation calls for. Through marketing, communication, and longevity, community members affected by suicide could gain knowledge of the team and reach out for support.

LOSS Team services can be most effective when combined and supported with additional services. These services include peer support groups, access to grief and bereavement counseling services (ideally with clinicians who have completed the *AAS/AFSP Suicide Bereavement Clinician Training Program*), including therapeutic services for complicated grief, and even visualized trauma. Additional supports include the availability of books, journals, financial advice, and respite activities.

Table 12. LOSS Team proposed budget allotment

Title	Audience	Duration	Strategy
LOSS Team & supportive services	Varied	Ongoing	Indicated
- LOSS Teams vary widely in available funding. Most teams serve with a volunteer base. Funding is needed for resources, training, uniforms, supportive services such as grief counseling, financial counseling, volunteer management, team member respite and counseling, participation in national conferences, etc. - It is recommended, for the greatest success, that this program receive robust funding support. - Long-term sustainability can be partially supported via fundraising efforts, though due to the fluctuations in these activities as well as funding competition, this should be considered additive rather than core, to ensure the stability of services.			

Electronic Communication Supportive Services

The modern environment presents unique challenges and opportunities for supporting community members with pre-crisis, crisis, and post-crisis phone, text, or internet communication-based services. Ideally, emotional and behavioral challenges could be mitigated through preventive services, but that

simply isn't practical, as people will have a variety of stressors and challenges present that can overwhelm this coping mechanism (as demonstrated in Crisis Coping Theory and the Suicidal Crisis Path model).

Utilizing the Combined Intervention Model for Suicide Prevention, it becomes obvious that an array of services is necessary and cost-effective in providing a continuum of services to facilitate appropriate and cost-effective supports. It is recommended that the array of services include a Warmline, Crisis Line, and Call Center Follow-up. In addition to these programs, services such as a text line, virtual chat rooms, smartphone/tablet applications (such as 7 Cups of Tea), and other forms of supportive electronic communications may be utilized.

It is also recommended that these programs take place with system integration required across the array of services to ensure a seamless transition between support systems. These systems should additionally serve as a hub or gateway for referrals to other supportive services, as well as supportive follow-up, to help ensure service engagement and success.

Warm Line

Warm lines are peer-run and paraprofessional supportive pre-crisis services available at no charge to callers[84]. These early intervention services facilitate community outreach for individuals, family members, and others who are suffering from emotional and/or mental health challenges inclusive of contributing factors such as loneliness and isolation. The intent is to provide supportive services to prevent the escalation to crisis services. These services can also function as a referral system to additional support services such as behavioral health care or peer support groups, or can escalate services to crisis services as interaction may indicate. These services help to facilitate better community health, are in alignment with the Crisis Coping Theory, and help to disrupt the Suicidal Pathway. They can also result in a more efficient and effective utilization of crisis services and disrupt the trajectory toward crisis and possible hospitalization. These services can also help reduce stigma and reach community members that are isolated or avoid traditional service engagement.

Crisis Line

Crisis telephone services are among the oldest approaches designed specifically for suicide prevention, beginning in the 1950s with the Samaritans service in England. The Los Angeles Suicide Prevention Center was founded in 1958, providing the first 24-hour crisis line using community volunteers, with San Francisco following in 1962. Since then, crisis centers have been the primary providers of crisis hotline services. Many crisis centers offer services including multiple hotlines (and warmlines), outpatient therapy, or community outreach. In addition to telephone services, some crisis hotlines also offer support using internet-based chat or SMS texts.

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[84] https://power2u.org/wp-content/uploads/2018/03/Warmline-Guide.pdf

The National Suicide Prevention Lifeline (the Lifeline; 800-273-8255) comprises a national network of approximately 150 crisis centers connected through a central telephone number that individuals can use anywhere in the US. The Lifeline project at the national level has been federally funded since 2005 and is specifically called for in legislation. However, each participating center operates primarily with local or state funding. All crisis centers that participate in the Lifeline network are required to be independently certified or accredited and have written policies about referral, training, and risk assessment. The Lifeline has established evidence-based guidelines and standards. National evaluation research with Lifeline centers indicates that suicidal callers experience decreases in psychological pain, hopelessness, and intent to die.[85]

Whenever possible, calls are routed to the network crisis center closest to the person making the call so that they will be speaking with someone familiar with the area and local resources. In Fresno County, the Lifeline network center is the Central Valley Crisis and Suicide Prevention Hotline (CVSPH), established in 2013, which was accredited by AAS in 2014 and joined the Lifeline soon after. The CVSPH employs both paid staff and supervised volunteer crisis counselors.

Crisis centers can provide the following services:

- Provide free, 24-hour access to staff trained in suicide assessment and intervention
- Thoroughly assess for risk of suicide, provide support, offer referrals, develop a safety plan, and dispatch emergency intervention, if necessary
- Connect directly with local mobile crisis teams
- Avert unnecessary ED visits and better ensure needed ED visits
- Intervene when a caller is not willing or able to ensure his or her own safety

Table 13. Call Center Follow Up proposed budget allotment

Title	Audience	Duration	Strategy
Warm Line[86]	Trained staff	Ongoing	Selective
Funding is dependent upon staffing, scope, and scale, as well as a variety of other factors. A Request for Proposal (RFP), Request for Application (RFA), or similar process should be considered.			
Crisis Line*	Trained staff	Ongoing	Indicated
*Currently funded through MHSA 3-Year Expenditure Plan			
Call Center Follow Up	Trained staff	Ongoing	Selective
Funding is dependent upon staffing, scope, and scale, as well as a variety of other factors. A Request for Proposal (RFP), Request for Application (RFA , or similar process should be considered.			

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[85] CDC. Preventing Suicide: A Technical Package
[86] https://power2u.org/peer-run-warmlines-resources/

Call Center Follow Up[87] is a program that expands the role of a local crisis hotline (Central Valley Suicide Prevention Hotline) to include not only valuable telephonic crisis intervention services but also enhances their role in the prevention framework by enhancing service engagement after a crisis call and/or contact with law enforcement or mental health professionals through the 5150 processes. It fosters connectedness and provides valuable encouragement to callers to attend appointments, navigate complex systems, and engage with additional treatment to help alleviate their distress.

Sources of Strength

Sources of Strength[88] is a comprehensive wellness program often implemented in school settings including middle school, high school, and college/university. The program is an evidence-based suicide prevention program that uses positive peer social norming strategies to enhance protective factors associated with reducing suicide risk at the school population level. Sources of Strength takes a shared risk and shared protective factor approach, ultimately impacting other associated risk issues, such as substance abuse, non-suicidal self-injurious behaviors, and other forms of violence (i.e., dating violence, sexual violence, and bully/harassment behaviors)[89]. A benefit of Sources of Strength is that it can also be implemented in a broader community context, including staff trainings, workplace wellness, parent support, and faith-based and cultural groups.

Sources of Strength is designed to be a multi-year change initiative rather than a one-time assembly or class. Sources of Strength uses Social Network Theory to select diverse peer leaders to increase the spread of impact across cliques and social groups long term. As part of the initial training, peer leader teams and their adult advisors are taught how to create and carry out numerous public health campaigns using active learning methods and interactive messaging techniques for maximum engagement and impact across the wider population. Positive social norming and positive psychology methods focused on hope, help, and strength messaging are strategically built into each campaign. Within campaigns, a step-by-step, layered approach is used to draw out internalized strength stories from students and staff. Teams employ at minimum four to six campaigns throughout a year, each of which is designed to increase connectedness and support, early help-seeking behaviors, youth and adult connectedness, positive self-efficacy, and healthy coping skills, while reducing social isolation and codes of silence.

A distinct advantage of the Sources of Strength model is that rather than just concentrating on individual-level risk and warning signs, it focuses on socio-ecological factors at the population level (Figure 4. The Ecological Model within the Suicidal Crisis Path). This approach helps to build connectedness between students and the school and targets whole population wellness (Universal). This helps to lower risk within the entire population, prevent the trajectory of youth who have entered the

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[87] https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/2015-Follow-up-OnePage.pdf
[88] https://sourcesofstrength.org
[89] Wyman PA, Brown CH, LoMurray M, Schmeelk-Cone K, Petrova M, Yu Q, Walsh E, Tu X, and Wang W. An Outcome Evaluation of the Sources of Strength Suicide Prevention Program Delivered by Adolescent Peer Leaders in High Schools. Am J Public Health. 2010 September; 100(9): 1653–1661.

suicidal pathway, and more accurately identify suicidal youth so system resources can be more efficiently deployed (1-10-100 Rule, Figure 16).

The budget for this activity is presented in Table 14. This budget was created utilizing quotes received from Sources of Strength over a three-year period. Year One assumes implementation across twenty school sites. Year Two assumes ongoing participation from twenty school sites and adding ten new sites. Year Three and beyond assume maintaining current school sites and proceeding with ten additional sites per year. Considering there are approximately 348 public schools in Fresno County, implementation and funding would be vital considerations, but this program tends to be relatively cost-effective, especially when considering the effects of the Combined Intervention Model for Suicide Prevention (Fig 16), diminished student risk, and increased school connectedness.

Table 14. Sources of Strength sample budget

Title	Audience	Duration	Strategy
Sources of Strength	Adult Advisors, Peer Leaders	See below	Universal
- Four-day Train the Trainer session. - Three- to six-hour Adult Advisor training. - Four- to six-hour Peer Leader training. - Costs = $175,000 over three years for 20 schools $35,000 Train the Trainer Skills Session Training $100,000 Training/Co-Training Phase Year One (i.e. 20 schools at $5,000 per school) $17,500 Training/Co-Training Phase Year Two (i.e. 20 Schools at $500 each, plus expansion to include 10 new schools at $750 per school) $22,500 Local Trainer Training Phase Year Three and Ongoing (i.e 30 Schools at $500 each, 10 schools at $750) - Support Phase Year One, Two, and Three already included in program costs.			

Community-based Peer Supports

Community-based peer supports[90] are services in which people who identify with a specific life experience can find support and guidance from others with the same or a similar experience. The core of the service is the connectedness created between equals as well as the value of the shared experience itself. These services often evolve organically from grassroots volunteerism and advocacy. These peer services are distinct from social supports such as families, faith-based groups, friends or coworkers, etc. The main distinction is that the peer relationship exists solely due to the shared experience whereas social supports are preexisting relationships and can exist for a multitude of reasons. Peer services often lack funding, broader training, and integration with larger systems.

The life experiences that can lead to peer support services include Adverse Childhood Experiences (ACEs) (such as sexual abuse, physical violence, and psychological abuse), adult and professionally experienced trauma (such as through personal loss, during combat, first-responder experiences, and medical communities), sexual orientation (LGBTQ+), medical conditions (such as diabetes, mental illness, cancer, and traumatic brain injuries), and similar experiences in which trauma or marginalization occurs.

Community-based peer supports are founded on community connectedness through individuals who have experience with one or more of the characteristics above, who are then trained and receive organizational support to provide supportive services to others who have similar characteristics. These services can take different forms, such as peer-run organizations, peers as providers, peer-led recovery groups and mutual support, and supervision and service coordination, among other forms of peer support. One specific example of the value of peers support is found in the Critical Incident Stress Management Program (CISM)[91]. Organizations that are not traditionally linked to behavioral health should also be included, such as the Employment Development Department, Housing Authority, libraries, athletic clubs, gun shops, hobby shops, and others.

Services should be implemented beyond in-person support groups to include a variety of strategies[92]. Strategies can include but are not limited to self-help, supportive self-help, peer supports, peer

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[90] Travis J, Roeder K, Walters H, Piette J, Heisler M, Ganoczy D, Valenstein M, Pfeiffer P. Telephone-based mutual peer support for depression: a pilot study. Chronic Illn. 2010 Sep;6(3):183-91

Chien WT, Thompson DR, Norman I. Evaluation of a peer-led mutual support group for Chinese families of people with schizophrenia. Am J Community Psychol. 2008 Sep;42(1-2):122-34.

Rachel Miller and Susan E. Mason. Open-ended and Open-door Treatment Groups for Young People with Mental Illness. Soc Work Groups. 2012 Winter; 35(1): 50-67

[91] Everly Jr. G, Raymond Jr. FB, Mitchell JT. Critical incident stress management (CISM): A review of the literature. Aggression and Violent Behavior. 2000 Jan-Feb; 5(1):23-40

[92] https://www.sprc.org/resources-programs/way-forward-pathways-hope-recovery-and-wellness-insights-lived-experience

specialists, hiring and supporting peer providers in the workplace, and include both suicide attempt survivors, suicide loss survivors, and others with lived experience. Additional services include crisis hotlines, hotline follow-up services (as mentioned earlier), inclusion of peers in mobile response teams (such as the LOSS Team), inclusion of peers in training to improve traditional response efforts (such as CIT and Trauma Informed Care), educational efforts (such as NAMI's In Our Own Voice, and Ending the Silence) and respite care. Services should include easier pathways to access through existing and emerging technologies such as online support groups, texting services, video conferencing, and warmlines. Services should be agile and flexible to respond to changes in the Fresno County environment, capacity, and available communications technology.

These services can be networked together for mutual benefit, targeted outreach, referral, support, and communication. Peer supports should be diverse so that a wide array of community members can be reached and connected to in non-traditional ways. This will assist in the prevention, early identification, referral, and support of community members across the coping journey.

The focus of efforts should first be placed upon building, supporting, and growing peer supports for suicide attempt survivors, suicide loss survivors, and the friends, families, and other supports for these individuals.

Table 15. Community-based peer supports proposed budget allotment

Title	Audience	Duration	Strategy
Community-based peer supports	Various	Ongoing	Universal /Selective
- Total funding allocation is currently deferred. - Funding could be provided on a grant basis in which core requirements must be met, including training, data collection, and systems integration. - This approach could lend itself toward a vast array of services in a cost-effective manner that reaches specific populations and difficult-to-reach groups through utilizing providers with a respectable reputation and proven community record.			

Community-based Supportive Services

Community-based supportive services[93] are primarily provided by trained professionals and paraprofessionals such as behavioral health providers, educators, law enforcement, medical providers, community-based organizations, jails and prisons (including juvenile justice), inpatient services, and others. The primary distinguishing characteristic between these services and peer-based services is that the service providers might not have lived experience and are providing these services in an organizational capacity.

Services in this area can include individual and group counseling, medication, Assertive Community Treatment (ACT)[94], Crisis Intervention Teams[95], school-based mental health early intervention and treatment[96], substance abuse support and recovery services, and similar support systems and models. Peer supports should be included in these services whenever possible to strengthen engagement, inclusion, and provide a unique perspective to care providers.

Table 16. Community-based supportive services proposed budget allotment

| Title	Audience	Duration	Strategy
Community-based supportive services	Various	Ongoing	Selective
- Total funding allocation is currently deferred. - Funding could be provided on a grant basis in which core requirements must be met, including training, data collection, and systems integration.			

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[93] https://www.samhsa.gov/treatment
[94] https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
[95] http://www.co.fresno.ca.us/Home/Components/News/News/326/1557
[96] http://www.co.fresno.ca.us/Home/Components/News/News/372/1557?backlist=%2F

Next steps

Figure 29. The Fresno County Suicide Prevention Collaborative Integrated Value Chain and Suicide Prevention Resource Center's (SPRC) Strategic Planning model.
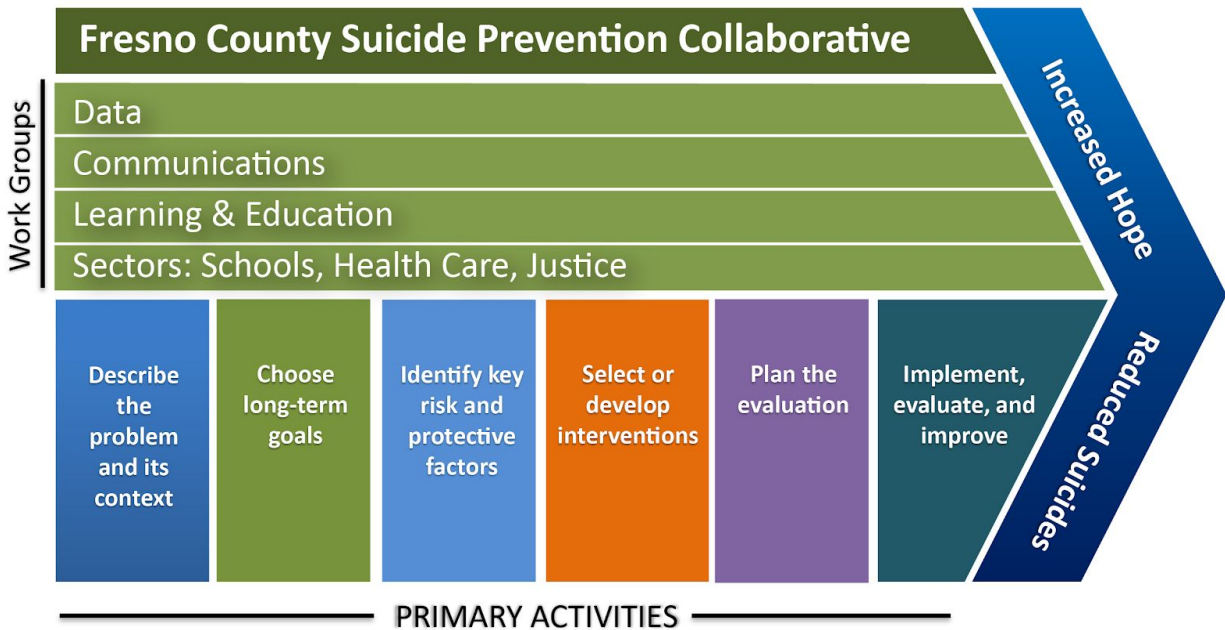
The Fresno County Suicide Prevention Collaborative Strategic Plan is the result of a vast partnership working through cohesive action to change the legacy of suicide. The strategies and recommendations in this document stem from eighteen months of concerted effort to gain an understanding of the problem of suicide and its context within Fresno County. The Collaborative grew from the deep roots of Community Conversations and sprouted into an effort focused upon the topic of suicide. Workgroups branched into specific focal areas to develop an understanding of the risk and protective factors across the community and within the specific sectors of schools, justice, and healthcare. The Collaborative also formed functional workgroups around data, communications, learning, and education. With this strategic plan, the efforts will begin to bud as interventions are selected, prioritized, implemented, and evaluated. Ultimately, the fruits of the Collaborative will be increased hope and reduced suicides in our community.

Looking into the future, the next stage of development is for the Collaborative as a whole and the workgroups within their areas to review this document, select and prioritize the training and programmatic recommendations, and commit to the funding structure to support this work. A strong focus on program evaluation is vital to the success of this strategic plan and to ensure programs are effective. While this process is underway, there are ongoing goals and objectives the workgroups have

established and should continue to advance. Below are some of the major needs and suggestions to continue the success and momentum of a suicide-safer Fresno County.

The process of implementing these recommendations and the activities presented throughout this document should be viewed through the lens of continuous improvement. This document is intended to be refined and expanded upon as more groups and voices are included, each of which will bring unique perspectives, strengths, challenges, needs, and value. These efforts are dependent upon community-based efforts, not just those of a single or handful of groups and organizations. To be successful these efforts must be inclusive and adapt to emerging community needs and data. The recommendations provided below are with that intent in mind and should be interpreted as flexible rather than exhaustive or limited listings.

Recommendation 1: Zero Suicide

Responsible entity: Health Care Workgroup

Description: Zero Suicide is first and foremost an approach that involves the commitment of a health or behavioral health system to the idea that suicide is a preventable outcome for individuals in their care. This is a commitment to patient safety as well as the support of clinical staff. Zero Suicide is also a model with seven essential elements for a care system to most effectively prevent suicide among patients:

1. Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
2. Train – Develop a competent, confident, and caring workforce.
3. Identify – Systematically identify and assess suicide risk among people receiving care.
4. Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
6. Transition – Provide continuous contact and support, especially after acute care.
7. Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

This approach has been adopted by individual hospitals, large health care systems, and even state health care systems. There is an established pathway to implementing a zero suicide framework.[97]

Recommendation 2: Expand Partnerships

Responsible entity: The Collaborative

Description: For efforts to thrive, the Collaborative must maintain a focus on continually expanding partnerships and ongoing community capacity, development, and outreach. This should take place through the social and professional networks of Collaborative participants and partnering agencies to

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[97] https://zerosuicide.sprc.org/how-do-i-get-started

include adjacent groups, organizations, and coalitions, and identification and outreach to partners missing from the table. The groups listed below are meant as examples of a few current missing voices in the Collaborative. Partnership expansion should include but also develop beyond these groups.

- Business sector: large employers, privately held businesses, small businesses, industries (such as agriculture/farming), unions, and employee assistance programs (often referred to as EAP).
- Cultural/ethnic groups: African American, Hmong, LGTBQ, refugees, first nations.
- Education: colleges and universities, apprenticeship programs (welders, plumbers, electricians, etc.), certificate or licensure programs (beauty schools, dental assistants, massage therapy, etc.).
- Age-related groups: Area Agency on Aging and other older adult groups, student clubs and leadership, and young business professionals.
- Faith-based organizations: spiritual leaders (formal and informal), peer support groups, chaplains, pastoral counselors, etc.

Recommendation 3: Development of a Communications Plan

Responsible entity: Communication Workgroup

Description: Utilize the Communication Resource Center's *Strategic Communication Planning: A Workbook for Garrett Lee Smith Memorial Act State, Tribal, and Campus Grantees*[98] to finalize initial development of a communications plan to reach a the broader community with a message of hope, provide resources and supportive information to the community as a whole as well as targeted messages to groups with heightened risk as identified within this strategic plan and through the continued efforts of the Data Workgroup.

- Continue to build upon the media relationship with KSEE 24 NBC and KMPH Fox.
- Develop relationships with additional news and communications outlets.

Recommendation 4: Training Implementation & Outreach

Responsible entity: Learning and Education Workgroup and Communications Workgroup

Description: Training opportunities will be developed on a continuous basis. The priority and sequencing of these events will need to be organized and notifications, as well as training registration, requires the coordination of the Learning and Education workgroup functioning in conjunction with the Communications workgroup.

Recommendation 5: Continue Needs Assessment and Evaluation Planning

Responsible entity: Data Workgroup

Description: There are multiple areas where complete information about suicidal thinking, behavior, or risk was not yet available. In many instances data that could improve the understanding and tracking of

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[98] https://www.sprc.org/sites/default/files/migrate/library/GLSWorkbook.pdf

needs and assets in Fresno County may already exist but need to be gathered and integrated. For example, data is collected as part of the Multi-agency Access Point program that was not available to include in the plan at this time. Several health care centers also use electronic health records, sometimes with the same software (e.g., Avatar), but data from those systems were also not available to include here. In other instances, procedures for systematically recording the data need to be established. For instance, school districts in Fresno County stopped participating in the California Healthy Kids Survey and no alternative source of health information for students has been identified. It is also expected that parts of the crisis system mapping process will be repeated to assess changes over time (e.g., closing service gaps and addressing new needs).

Recommendation 6: Population-Specific Outreach

Responsible entity: Various workgroups as indicated below.
Description: Focused efforts within specific work groups and partnering organizations needs to take place on a continuous basis. This outreach and engagement needs to deploy a consistent voice and message as developed in partnership with the **Communications** workgroup. In addition, programs such as the Multi-Agency Access Program should be expanded to reach more of the community, particularly in rural areas and communities where knowledge of services is lacking.

- **Justice**: Negotiators, chaplains, dispatch, patrol, lawyers, correctional officers, and those identified within the justice system.
- **Health Care**: Emergency Department workers as well as service recipients, hospital personnel, private practitioners (especially pain management and physical therapy), as well as cultural healers (e.g. shamans, medicine man/woman).
- **Education**: Students, parents, teachers, faculty, staff, and supportive services (IT, crossing guards, transportation, etc.).
- Cultural/Ethnic Groups: Caucasian, Hispanic or Latino, African American, Hmong, LGBTQ, and other minority communities.
- Faith-based organizations: spiritual leaders (formal and informal), peer support groups, chaplains, pastoral counselors, etc.
- Farming Industry[99,]: The farming industry presents unique challenges due to subcultural norms that restrict access and often acceptance of behavioral health needs and priorities that transcend ethnic social groups. Recent data from the Centers for Disease Control (CDC)[100] demonstrate that further research is needed to gain a more accurate understanding of the impact of suicide in this community, but those in the farming industry tend to work long hours in isolative conditions and face growing economic and resource challenges. Agriculture is the heart of the valley and it is essential that this community is highlighted in local efforts to meet the unique needs and overcome the challenges to accessing care.

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[99] http://www.kmjnow.com/2018/05/16/farmers-union-urges-usda-to-address-farm-suicide-crisis/
[100] https://www.cdc.gov/mmwr/volumes/67/wr/mm6725a7.htm

Appendix A

Inventory of Existing Interventions & Programs

I.   Universal Strategies

    A. Foster connectedness

- Child Welfare Mental Team/Katie A Team[101]
- Children & Youth Juvenile Justice Services – ACT[1]
- Clovis Police Department: Youth Services Division[102]
- Clovis Unified: district wellness committee to develop and monitor coordinated prevention efforts[2]
- Collaboration with Adult Education, community college, ROP and SEES[1]
- Collaborative Treatment Courts[1]
- Community Gardens[1]
- Community Response/Law Enforcement (Crisis Field Clinicians)[1]
- Consultation Services for Utilization of Consumers and Volunteers[1]
- Cultural Specific Services (Living Well Program)[1]
- Family Behavioral Health Court available for kids who may benefit from the services[2]
- Holistic Cultural Education Wellness Center[1]
- Integrated Mental Health Services at Primary Care Clinics[1]
- Integrated Wellness Activities[1]
- Probation Department - deputy POs on HS campuses; Probation Officers on elementary campuses[2]
- Training Law Enforcement and first responders, on mental health[1]
- Transitional Age Youth (TAY) Services & Supports Full Service Partnership[1]
- UCSF Fresno / CRMC: behavioral health screening integrated into primary care clinics—screening, assessment, short-term treatments, case management, referrals[2]
- Wellness Integration and Navigation Supports for Expecting Families[1]

    B. Teach life skills

- Blue Sky Wellness Center[1]

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[101] From 2017-2020 MHSA Update
[102] Reported during Fresno County Suicide Prevention Collaborative Meeting 2/10/2017

- Clovis Unified: school-wide assemblies with speakers about depression, suicide prevention, substance abuse; parent trainings[2]
- Cultural Awareness Training/Linguistic Access for Staff, Consumers, and Family Members[1]
- Educate Consumers and Family Members on Mental Health Disorders, Meds, and Side Effects[1]
- Flex Account for Housing[1]
- Housing - Master Leasing[1]
- Housing Supportive Services[1]
- Older Adult Team[1]
- Project for Assistance Transition from Homelessness (PATH)[1]
- Supported Employment & Education Services (SEES)[1]
- Youth Empowerment Centers[1]

C. Increase help-seeking

- Consumer/Family Advocate Services[1]
- Courts—adjust hearings around kids' needs and make sure they have access to appropriate mental and physical health care[2]
- Cultural-Based Access Navigation Specialists (CBANS)[1]
- Family Advocate Position[1]
- Fresno County DBH/Exodus Recovery Access Line[2]
- Multi-Agency Access Point (MAP)[1]
- Outreach to High Schools / Career Academy[1]
- Therapeutic Child Care Services[1]
- Transportation Access[1]

II. Selective Strategies

A. Identify and assist people at risk

- ASSIST and SafeTALK training in community
- Clovis Unified: ASSIST and SafeTALK training for staff[2]
- Clovis Unified: Clovis Support Intervention Programs
- Clovis Unified: suicide awareness required in 9th grade health[2]
- Columbia-Suicide Severity Rating Scale[3]
- Fowler Unified: ASSIST Training; PREPARE training; threat assessments[2]
- Fresno County Office of Education: school psychologists perform suicide risk assessments and counseling to kids identified as needing help
- Juvenile Court—attorneys and judges always on the lookout for kids in the courtroom who may need mental health services[2]
- Kelly Orender: QPR Training[2]

- Kings View—rural triage[2]
- Mental Health Training for PCP, Teachers, Faith-Based and Other Community Partners[1]
- Probation Department: referrals for identified youth to mental health services[2]
- Raphael Health Ministry/*Be Not Afraid* (for Catholic youth)[2]
- Recognizing & Responding to Suicide Risk – for Primary Care (planned)[103]

B. Reduce access to lethal means

C. Effective care

- AB 109 - Outpatient Mental Health & Substance Services[1]
- AB 109 Full Service Partnership (FSP)[1]
- Assertive Community Treatment[1]
- Blue Sky Wellness Center[1]
- Children/Youth/Family Prevention and Early Intervention[1]
- Children Full Service Partnership (FSP) SP 0-10 Years[1]
- Children's Expansion of Outpatient Services[1]
- Clovis Unified: peer support and counseling
- Clovis Unified: school counselors and psychologists at every school[2]; teacher referrals to counselors and psychologists; intervention programs at all grade levels for students with significant social-emotional difficulties[2]
- Co-Occurring Disorders Full Service Partnership (FSP)[1]
- Enhanced Peer Support[1]
- Fresno County DBH/Exodus Recovery Psychiatric H/C Facility (adult)[2]
- Fresno County Office of Education: Positive Behavioral Interventions and Supports (PBIS)[2]; follow-up mental health services; support in ED programs; students can be referred to the services as needed[2]
- First-Onset Team[1]
- Fowler Unified: school psychologists[2]
- Fowler Unified: United Health Clinic provides behavioral health services; Fresno County DBH counseling services provided on-site in the district[2]
- Functional Family Therapy[1]
- Medications Expansion[1]
- Older Adult Team[1]
- Perinatal[1]
- RISE[1]
- Rural Services-Full Services Partnership (FSP)[1]
- Rural Services-Outpatient/Intense Case Management[1]
- School-Based Services[1]

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[103] Planned activity by the Fresno County Suicide Prevention Collaborative

- St. Paul Newman Center—offers support groups[2]
- Transitional Age Youth (TAY) - Department of Behavioral Health[1]
- Valley Children's: 24/7 telepsychiatry for medication consultation/management; M-F psychology services for pediatrics patients followed by outpatient clinic services; 24/7 social work services in the ED[2]
- UCSF Fresno/CRMC—inpatient services and urgent care; acute interventions/consultations for medical complications of suicide attempts, mental health issues, etc.[2]
- Vista (comprehensive mental health services) [1]
- Youth Empowerment Centers[1]
- Youth Wellness Center[1] - DBH—Youth Wellness—connect/link 17 and under with ongoing services after crisis visit to PHF/hospital; Outpatient services—all ages; Transitional-age youth[2]

D. Care transitions

- Intensive Transitions Team[1]
- Suicide Attempt follow-up by Central Valley Suicide Prevention Hotline[3]
- Supervised Overnight Stay[1]

III. Indicated Strategies

A. Respond to crisis

- Community Response/Law Enforcement (Crisis Field Clinicians) [1]
- Central Valley Suicide Prevention Hotline
- Crisis Intervention Team (CIT)[2]
- Crisis Residential Treatment Construction[1]
- Crisis Stabilization Voluntary Services[1] – Fresno County DBH/Exodus Crisis Stabilization and Urgent Medication Clinic (for youth and adult)[2]
- Kings View: crisis responders (assessing and interventions for 5150s; setting up safety plans and linking to services)[2]
- Police Department 5150[2]
- The Lodge[1]
- Urgent Care Wellness Center (UCWC) [1]

B. Postvention

- FCCAAP—monitoring pediatric suicides; effective prevention actions per CDR protocol[2]
- Fowler Unified—school psychologist follow-up and referral[2]
- FCOE—school psychologists deployed to school sites following a suicide or any other type of crisis[2]

- Hinds Hospice: Fresno Survivors of Suicide Loss[2]
- LOSS Team[3]
- Psychological Autopsy[3]

Appendix B: Crisis System Map Flow Charts

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CARES

Adult Flowchart

Law Enforcement

Community/Home
Faith
MD's/PCP
Employment
Hospitals/VA

Contact Hotline

Risk Identified
Active Suicide Attempt?

Contact Hotline/Poison Control Center
Is there still a risk?

Law Enforcement

5150 Hold
Will a hold be placed? Y/N

De-escalate

Yes

No

Yes

No

No

EMS

Hospital/ED

Evaluated by LCSW, PhDs/PsyDs
Is the 5150 lifted? Y/N

Yes

Medical Attention Needed? Y/N

Hospitalized/Treatment

Crisis Center
Assessed by MD/NP

Discharge –
Care Coordination/ Planning

Yes

No

No

Postvention
Who does what?

– Death by Suicide –

Coroner

Law Enforcement / Coroner

Survivors of Suicide Loss

Other – LOSS Team

Refer to Services

- Counseling Services
- Navigators – MAP Point
- Support Groups – NAMI
- Services for MH in Primary Care
- VA - Wraparound Services
- Turning Point Rural Mental Health Services