MASSACHUSETTS STRATEGIC PLAN FOR SUICIDE PREVENTION

"It is the hope that the plan will bring attention to the public health problem of suicide and the reality that there is a great deal that we can do to prevent it."

Timothy P. Murray,
Lieutenant Governor
September, 2009

"Suicide remains the sorrow that still struggles to speak its name."

Eileen McNamara
Boston Globe
December, 2007

MASSACHUSETTS COALITION FOR SUICIDE PREVENTION
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

INTRODUCTORY LETTERS

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I. INTRODUCTION

It is our goal that suicide and suicidal behavior be prevented and reduced in Massachusetts. With prevention strategies grounded in the best evidence available, the support and involvement of all stakeholders, and the guidance offered by this plan, we are confident we can make significant progress toward this goal over the next several years.

In Massachusetts:

- In 2007, there were 504 suicides in Massachusetts —more than deaths from homicide (183) and HIV/AIDS (143) combined[1].
- Most Massachusetts ' suicides occur in the middle age population; 43.8% of all suicides in 2007 were among those ages 35-54 years (N=221, 11.3 per 100,000)[2].
- Male suicides exceeded female suicides by more than 3 to 1 (in MA)[3].
- Both nationwide and in Massachusetts, youth suicide is the third leading cause of death for young people ages 15 – 24[4].
- Although the highest number of suicides among males occurred in mid-life ages 35-44 years (N=92, 19.2 per 100,000), the highest rate of suicide occurred among males 85 and older (N=16, 38.9 per 100,000)[5].
- The highest number and rate of suicides among females were among those ages 55-64 years (N=25, 6.6 per 100,000)[6].
- Nonfatal self-injury also burdens the Commonwealth's health care system— there were 4,305 hospital stays[7] (66.7 per 100,000) and 6,720 emergency department discharges[8] (104.2 per 100,000) for nonfatal self-inflicted injury in FY2007[9].

Experts agree that most suicides can be prevented. Suicide is less about death and more about the need to overcome unbearable psychological pain.

There is also general agreement that suicide and suicide attempts are under-reported at present, due to lack of data standards, pressure from some survivors, and stigma. Similar to other previously under-recognized problems (e.g. intimate partner violence, child abuse), as awareness of the scope of the problem rises and more people feel comfortable with reporting the event, rates may increase for a time. We anticipate that the same thing may happen with suicide; that is, as suicide and suicidal behavior become more recognized and is reported more frequently, rates will actually increase for a time.

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) is an initiative of the Massachusetts Coalition for Suicide Prevention, working in collaboration with the Department of

[1] Registry of Vital Records and Statistics, Massachusetts Department of Public Health
[2] *Op. cit*.
[3] *Op. cit*.
[4] WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System
[5] Registry of Vital Records and Statistics, Massachusetts Department of Public Health
[6] *Op. cit*.
[7] Massachusetts Inpatient Hospital Discharge Database, Division of Health Care Finance and Policy
[8] Massachusetts Outpatient Emergency Department Database, Division of Health Care Finance and Policy
[9] Massachusetts Observation Stay Database, Division of Health Care Finance and Policy

Public Health (DPH) and the Department of Mental Health (DMH). As the recipient of legislative funding for suicide prevention, the Department of Public Health also provided financial support and resources for the development of the plan.

The field of suicidology uses common words that have specific definitions relevant to the diagnosis, intervention and prevention of suicide; such words used in this document are defined in the Glossary in Appendix B.

The Massachusetts Coalition for Suicide Prevention

The Massachusetts Coalition for Suicide Prevention (MCSP) is a broad-based inclusive alliance of suicide prevention advocates, including public and private agency representatives, policy makers, suicide survivors, mental health and public health consumers and providers and concerned citizens committed to working together to reduce the incidence of self-harm and suicide in the Commonwealth. From its inception, the Coalition has been a public/private partnership, involving government agencies including the Department of Public Health and Department of Mental Health working in partnership with community-based agencies and interested individuals.

The MCSP's mission is to support and develop effective suicide prevention initiatives by providing leadership and advocacy, promoting collaborations among organizations, developing and recommending policy and promoting research and program development.

Massachusetts Department of Public Health Suicide Prevention Program

The Massachusetts Suicide Prevention Program, in the Division of Violence and Injury Prevention, provides support, education, and outreach to all Massachusetts residents, especially those who may be at increased risk, have attempted suicide, or have lost a loved one to suicide. Through education and outreach efforts, this program develops and disseminates materials designed to increase awareness and knowledge, provides community grants, and develops and evaluates training modules for populations at increased risk for suicide or suicidal behavior. This initiative educates professionals and the general public on the scope of suicide, self-inflicted injuries, and suicide prevention. Staff also can provide data, resources and support to communities and agencies which are either working to prevent suicide or coping in the aftermath of a suicide. The program has received state funding for implementation since FY2002.

The Suicide Prevention Program provides training to a broad array of individuals, including public health and mental health professionals, social workers, nurses, public safety officials, first responders, law enforcement officers, emergency medical technicians, corrections personnel, community leaders and advocates, survivors, counselors, clergy and faith community leaders, educators and school administrators, elder service staff, persons working with youth programs, advocates for the gay, lesbian, bisexual, and transgender communities and allies, and anyone interested in preventing self-harm and suicide in the Commonwealth of Massachusetts.

II. THE STRATEGIC PLANNING PROCESS

Massachusetts' first state plan for suicide prevention was completed and issued in 2002. Modeled on the National Strategy for Suicide Prevention, the State Plan offered a blueprint for the Commonwealth and collaborating partners for establishing priorities and implementing new, coordinated programming and services.

When the first State Plan was completed, there were no state funds for suicide prevention. However, the legislature appropriated $500,000 in funding for suicide prevention in FY 2002, and the line-item has grown, reaching a $4.75 million appropriation for FY09.

In 2007, recognizing that it was time to update and enhance the plan, the MCSP convened a seven-member Steering Committee to guide development of a new State Plan. Utilizing funding from legislatively appropriated resources for suicide prevention, the Department of Public Health provided financial support and resources to the development process.

Information Gathering

The Steering Committee committed to an extensive data-gathering process to assure inclusive information collection. Methods included a survey, an Electronic Town Meeting, stakeholder interviews, and focus groups. In addition, members of the MCSP were given the opportunity to offer feedback at several points in the plan's development. Over 500 individuals contributed their comments; this number accounts for the fact that any one person may have participated in multiple methods (for example, responded to the survey, participated in the electronic town meeting, and participated in a focus group).

Survey

As a key step in the planning process, a survey was developed to learn more about constituents' thoughts, suggestions, priorities, and vision on this public health issue.

The survey was conducted during May and June, 2007. Surveys were distributed at the DPH/DMH/MCSP Statewide Suicide Prevention Conference in May and the survey was publicized through the MCSP website and listserv. An online survey link was provided through the MCSP website.

There were a total of 189 responses to the survey: 102 paper surveys were completed at the conference and entered into the results database, 87 surveys were completed online.

Electronic Town Meeting

On June 6, 2007, the MCSP hosted an Electronic Town Meeting to solicit broad input on strategic planning priorities. The E-Town meeting attracted 280 participants, including 110 on-site at the meeting and 170 online.

Participants engaged in an interactive panel discussion and answered questions on key aspects of the previous State Plan, including:

- Reducing access to lethal means and methods of self-harm

- Improving access to and community linkages with mental health and substance abuse services
- Developing and implementing community-based suicide prevention programs
- Strategies to reduce the stigma associated with suicide and with being a consumer of mental health, substance abuse, and suicide prevention services

Interviews

Twenty individuals were interviewed in person or by telephone, including representatives from state agencies, MCSP leadership, members of the legislature, and survivors.

Focus Groups

Seventy-two individuals participated in eight focus groups:

- Consumers (individuals currently utilizing mental health services or who have received such services in the past)
- Survivors
- MCSP Members (Eastern Massachusetts)
- MCSP Members (Western Massachusetts)
- Elder Services Providers
- Veterans Services Providers
- Staff of the Massachusetts Department of Public Health
- Staff of the Garrett Lee Smith Project Grant (a federally-funded suicide prevention project focused on youth in state custody)

Both the interviews and focus groups asked for feedback on a number of questions, including:

1. What are the needs of you and or / your constituency around suicide prevention?
2. Do you have the data you need?
3. What are the challenges and barriers to suicide prevention?
4. What are the top three things that would need to happen for more forward movement on this issue?
5. In what areas are current efforts working well? Not working well?
6. Are you familiar with the current state plan? If so, how does it address your needs?
7. What has been the impact of the work coming out of the most recent state plan?
8. What are your suggestions for how the future strategic plan might best be circulated and used?

III. KEY FINDINGS FROM THE INFORMATION GATHERING

The comments, suggestions, and other information gathered during this outreach process were synthesized and integrated. They yielded a wealth of information and numerous suggestions about what might be included in the plan. Given the breadth of comments, it is not possible to highlight every single one. However, a number of **common themes** emerged that merited reflection and consideration for inclusion in the new state plan.

1. People don't think of suicide as a preventable public health problem.

2. There is a need for culturally competent, community-based training on suicide prevention that reaches broadly across the state to address the needs of survivors, consumers, caregivers, and targeted populations.

3. Stigma associated with suicide (either discussing feelings of suicide, loss to suicide, or experience with suicide) and/or with mental illness/substance abuse is a significant barrier to prevention and help-seeking.

4. Stigma may be associated with long and complex histories of oppression in some communities that take specific cultural forms, e.g. racial/ethnic communities, GLBT communities, etc.

5. Poor linkages exist at the state and community level between mental health, substance abuse, and community health services as well as with schools, faith-based organizations, and first responders.

6. There are barriers to accessing appropriate mental health care due to numerous obstacles including:
   - Lack of transportation, particularly in suburban and rural areas;
   - Interrupted or inconsistent care due to lack of standardized assessment protocols, problems with the Emergency Service Program (ESP) system, a shortage of trained mental health clinicians, HIPAA[10] rules restricting sharing of information, and complicated insurance and reimbursement regulations that often limit access to care, especially mental health treatment.
   - Inability or reluctance of many primary care physicians to address mental health issues with patients.
   - Cost.
   - Lack of culturally and linguistically appropriate mental health resources for racial, ethnic minority and GLBT consumers.

7. There is limited awareness about the effectiveness of reducing access to lethal means and methods of self-harm.

[10] P.L. 104-191, Health Insurance Portability and Accountability Act (HIPAA), 1996. The law includes protection of confidentiality and security of health data through setting and enforcing standards among other provisions.

At the same time, participants in the information gathering want the **infrastructure** to support undertaking these priorities to include:

1. Increased public awareness of suicide and suicide prevention
2. Stronger collaboration among state agencies
3. Consumer and survivor engagement at all levels of decision-making
4. Ongoing, coordinated advocacy for resources to support plan implementation, including alternative options to state funding
5. Commitment to addressing specific needs of higher risk populations and the creation of appropriate services and strategies
6. Continued investment in surveillance along with improved and expanded data collection
7. Regular evaluation of progress in plan implementation
8. Increased presence of additional regional and local suicide prevention coalitions and strengthening the state-wide coalition

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IV. USING THE STRATEGIC PLAN, AND MONITORING, EVALUATING, AND REPORTING PROGRESS

Using the Strategic Plan

The purpose of the Massachusetts Strategic Plan for Suicide Prevention is to provide a framework for identifying priorities, organizing efforts, and contributing to a state-wide focus on suicide prevention, over the next several years.

The State Plan is designed to be accessible to all stakeholders in the Commonwealth; stakeholders include individuals, groups, communities, organizations, institutions, and all levels of government. Understandably, this is a very broad and diverse group. And, by necessity, preventing suicide must be a very broad effort with diverse approaches. The MCSP hopes that all of those involved with suicide prevention will assume collective ownership of the Plan and use it to guide their efforts. With a variety of stakeholders acting together and using the state plan as a common point of reference, there is a vastly increased likelihood of achieving the Vision of Success (see Section V) for suicide prevention in Massachusetts.

Data-gathering and outreach during the strategic planning process helped identify a range of issues, and the Plan establishes a framework for specific goals related to suicide prevention. While the MCSP initiated efforts to begin development of the Plan, along with the Department of Public Health as the lead state agency and the Department of Mental Health, it does not assume that a specific agency or organization has the overall responsibility or capacity to address all, or even the majority, of these goals. Rather, this State Plan holds many opportunities for individuals, groups of people, communities, institutions, and organizations to make contributions toward achieving goals, individually and collectively. Collaborating and partnering with others can result in significantly greater impact. Likewise, this Plan does not assume that current state government funding will be the only resource for realizing these goals. Therefore, to ensure sustainability of all efforts, organizations must advocate for and pursue diversification of funding.

For those actively involved in suicide prevention, the Massachusetts Strategic Plan for Suicide Prevention can provide guidance and a framework as you proceed with your work. The State Plan can assist in identifying priorities as you develop an organizational strategic plan, an annual work plan, or specific action plans for your organization's efforts in suicide prevention. In this way, you can chart your organization's progress as well as measure your contributions against the overall goals of the statewide strategic plan. In addition, you are encouraged to coordinate with other organizations state-wide that may be working toward the same and/or complementary goals as presented in the State Plan.

Monitoring, Evaluating, and Reporting Progress

While the collective ownership and inclusive nature of the Massachusetts Strategic Plan for Suicide Prevention is a great strength, it also presents challenges because of the dispersed nature of the effort. For this reason the MCSP will take the lead in monitoring, evaluating, and reporting on the progress and implementation of the Plan.

MCSP will connect with stakeholders to track progress on implementation of the Plan, the status and success of specific goals and actions, and to solicit feedback on the strengths and weaknesses of the Plan itself. As with other organizations which must stay accountable to supporters and funders on an annual basis, MCSP will develop an annual progress report on the State Plan; this will be shared with the state legislature, appropriate state agencies and other stakeholders. The Plan and progress reports will serve as valuable resources to track and communicate progress and outcomes.

What This Plan Does Not Address and Next Steps

The scope of this plan is limited to statewide suicide prevention efforts across Massachusetts. We did not attempt to do an inventory of the significant suicide prevention activities already in place at various stages of implementation. Furthermore, because the Department of Public Health publishes 'Suicide and Self-Inflicted Injuries in Massachusetts' annually, we did not include a data report as part of the Plan.

This State Plan includes broad strategies appropriate to the statewide population. Examples of possible actions are general and not meant to be exhaustive. We recognize that some populations are at higher risk of suicide than others, including (but not limited to) consumers of mental health services, veterans, gay/lesbian/bisexual and transgender youth, survivors of trauma, and others.

Targeted population-based strategies are necessary and appropriate. While the Plan acknowledges that implementation will involve development of culturally specific and appropriate strategies and models for those at higher risk, the Plan does not identify targeted needs of populations known to be at increased risk of suicide, nor of specific geographic regions or communities. As part of implementing this Plan, it is our hope groups associated with both populations at increased risk of suicide, and coalitions addressing suicide prevention for regions, or cities and towns will use this Plan as a starting point to develop their own population-specific, more tailored plans.

Representatives of populations at increased risk have participated throughout the process of development the State Plan. As groups work to develop their own more targeted plans, the MCSP and the Department of Public Health will provide technical assistance to address suicide prevention for those groups at increased risk of suicide.

V. VISION OF SUCCESS AND GUIDING PRINCIPLES FOR SUICIDE PREVENTION PLANNING

A Vision Statement is a description of the desired future; it describes what success will look like at some future time. A Vision is an expression of possibility, based in reality yet far enough of a "stretch" that people are inspired to help make it happen despite the challenge and uncertain prospects for success.

The Vision gives a sense of direction. It presents a realistic, credible and attractive future.

Provided below are the components of the Vision of Success for Suicide Prevention.

Vision of Success

- Suicide is viewed as a preventable public health problem.
- Individuals experiencing mental illness, substance abuse, or feelings of suicide feel comfortable asking for help, and have access to culturally appropriate services in their communities.
- Suicide prevention services are provided in an integrated manner so that people receive the comprehensive coverage and support best suited for their individual needs.
- Suicide prevention activities incorporate elements of resiliency and protective factors as well as risk factors.
- Prevention strategies grounded in the best evidence available are used in cities and towns across the Commonwealth.
- There is a strong, diverse, state-wide suicide prevention coalition with regional coalitions in every part of the state, as well as local community coalitions.
- Institutions and organizations include mental health, suicide prevention, and risk and resiliency efforts as part of their health and wellness benefits, policies, curricula, and other initiatives.
- Suicide prevention is supported by public and private funding sources.
- There is a general public awareness of suicide prevention efforts in the Commonwealth and willingness to assist those who may be in need of help.

GUIDING PRINCIPLES

The guiding principles listed below reflect the beliefs of those who have contributed to the development of this State Plan. We hope these principles will continue to be reflected in the implementation of the plan.

We believe:

- Suicide affects people of all ages and must be addressed across the lifespan.
- Stigma and discrimination prevents open acknowledgment of mental illness and suicidal behavior, and this inhibits successful prevention, intervention, and recovery.
- Some populations are at higher risk of suicide than others; therefore, targeted population-based strategies and models are necessary and appropriate.
- Every person should have a safe, caring, and healthy relationship with at least one other person.
- Prevention should take into account both risk and resiliency of individuals and populations.
- All suicide prevention materials, resources, and services should be culturally and linguistically competent, and developmentally and age appropriate.
- Consumers and target groups should have input and participate in all levels of suicide prevention planning and decision-making.
- Information-sharing and collaboration must occur between all stakeholders in suicide prevention.
- The best evidence available should be used, to the extent possible, when planning, designing, and implementing suicide prevention efforts.
- More research and evaluation of suicide and suicide prevention programs, including innovative approaches and best evidence available, should be undertaken.
- To ensure sustainability of suicide prevention efforts, there should be advocacy for diverse funding and other resources.
- Comprehensive coverage, accessibility, and continuity of physical and mental health care services should be ensured.

VI. FRAMEWORK

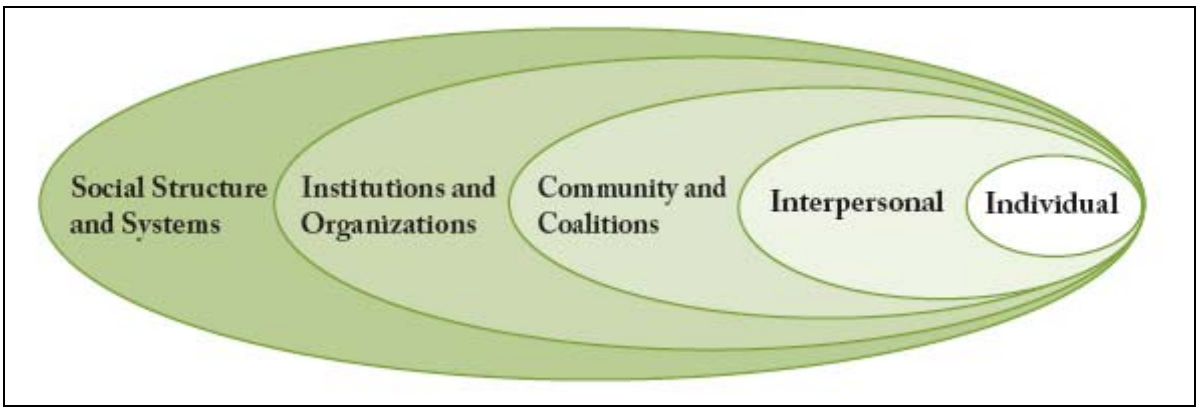
The Massachusetts Strategic Plan for Suicide Prevention recognizes the complex interplay between the various stakeholders (individuals, groups, communities, government, organizations, and institutions) in society that are involved with and, indeed, required for successful suicide prevention efforts. The Plan acknowledges this interdependency; it encourages and requires a connected and common effort among all stakeholders.

The framework for planning provides a basic structure for defining, organizing, and supporting the Massachusetts Strategic Plan for Suicide Prevention. This framework was derived primarily from two well-known public health models: the Spectrum of Prevention and the Social-Ecological model.

The Massachusetts Strategic Plan for Suicide Prevention is organized around five dynamic and interactive Levels, designed to include and represent all stakeholders:

I. Individual
II. Interpersonal
III. Community and Coalitions
IV. Institutions and Organizations
V. Social Structure and Systems

These Levels represent a continuum from a specific individual (Level I) to the society in which that individual lives (Level V). The graphic below illustrates this continuum.



For the Plan to be successful, significant activity is required in each of the five Levels. The synergy of the Levels will result in increased awareness, momentum, and integration of suicide prevention efforts. The framework for the Plan is based on the assumption that action must occur within each of the five Levels. The Plan encourages information-sharing and collaboration between and among stakeholders. With a variety of stakeholders acting together in a concerted effort, there is an increased likelihood of success.

Each of the five Levels includes several components:

- **Theme:** A description of the overall purpose of the Level.

- **Audience:** The stakeholders at whom the Theme is aimed; those who will be affected by and those who will be involved with implementing the Goals. The Audience list for each Area is not intended to be exhaustive; it is presented to provide examples of possible stakeholders.

- **Goals:** Major long-term aims, and an articulation of the desired achievements for each Theme. The Goals for each Theme are not presented in any particular order. It is understood that many of the Goals, due to the structural and systemic complexity of the issues and the many stakeholders involved, will take more than five years to attain. In addition, some Goals may be on-going and never fully completed.

- **Examples of Possible Actions:** Actions are specific acts or activities that can be used to make progress toward a Goal. In this plan, the Actions presented are examples only; they are not meant to be prescriptive. Each stakeholder should make decisions about Actions to take and how to approach implementation based on their unique and specific situation. Creativity, innovation, and finding the best "fit" is encouraged.

Beyond presenting an overall Vision of Success for suicide prevention in Massachusetts (Section V), this Plan does not articulate specific outcomes desired and measures of success for each Goal and Possible Action. To identify specific measures of success for Goals and Actions was beyond the scope and time of this effort, and complicated by the multiplicity of stakeholders and decentralized nature of the work to be done. However, measuring progress and outcomes of specific Goals and Actions will be a key part of evaluating and reporting on the implementation of the Plan. As noted in Section IV, MCSP will take the lead in this effort and develop appropriate documentation.

The Goals, Strategies, and Actions in the Massachusetts Strategic Plan for Suicide Prevention have been developed based on suggestions from outreach and information gathering. To the extent possible, they were compared against the current growing knowledge base on suicide and suicide prevention and have met the criteria of being evidence-based; that is, they represent approaches to suicide prevention that have been developed and evaluated using scientific processes and have been found to be credible and sustainable.

Some of the Actions listed are already in various stages of implementation – some just beginning and others have been used for several years. Other Actions are examples that have not yet begun to be implemented. Still other Actions may be currently implemented by some stakeholders with others looking to replicate them.

The above components for each of the five Levels are presented in matrices on the following pages.

VII. MATRIX

LEVEL I: INDIVIDUAL

Theme

Promote the well-being, safety, and resiliency of individuals who may be at higher risk of suicide, and those whose lives have been touched by suicide

Audience (including, but not limited to): Suicide attempt survivors, survivors, people at higher risk, populations at higher risk

Goals	Examples Of Possible Actions
1A. Increase self-awareness of risk and protective factors and encourage help-seeking and support during a crisis and over the long-term	1. Promote public testimony from credible spokespeople, including those well-known, who have received help 2. Promote crisis plans for individuals who need them, their providers and support system 3. Develop plans/protocols for survivors: immediately following a suicide (e.g. a survivor contacts a survivor); in-person and on-line support groups, other specialized services 4. Disseminate appropriate materials and resources to individuals 5. Encourage evidence-based therapeutic treatment
1B. Educate providers and private and public funders on suicide risk and protective factors, warning signs, and available resources	1. Target education and training at professionals serving those at increased risk (primary care providers, mental health clinicians, caseworkers, nurses, and others) 2. Promote information on mental health and emergency resources available to assist individuals at risk of suicide and providers who serve them 3. Promote awareness of the differences between ongoing mental illness and situational stress, e.g. divorce, bereavement, academic problems, financial or professional loss, or other circumstantial stressors
1C. Support resiliency for those at risk through sustainable, skill-building efforts and resources	1. Conduct resiliency training across the life-span, including good decision-making, values clarification, coping mechanisms, impulse control, role models and mentors 2. Build individual help seeking and self-help skills 3. Increase awareness of how / where to get help

Goals	Examples Of Possible Actions
1D. Address ongoing needs of those at higher risk of suicide	1. Promote support groups, peer-to-peer training and outreach, and other avenues of peer education and support 2. Identify best venues for education to reach those most in need, e.g. home-based programs for elders, at the time of demobilization for members of the US military, safe schools programs for youth 3. Address environmental factors that contribute to suicidal behavior, such as discrimination, limited understanding of coping with those with mental illness, and lack of access to support and services 4. Educate individuals at higher risk on resources and help available including warm lines and hot lines

LEVEL II: INTERPERSONAL

Theme
Support and educate people to cultivate helping relationships and address suicide risks with awareness and sensitivity **Audience** (including, but not limited to): mental health consumers, survivors, suicide attempt survivors, families, including foster parents; friends; partners; peer groups; health care providers (nurses, doctors, therapists, counselors; emergency personnel (fire, police, EMTs); all personnel in health care, clinical, social and human service settings; HELP lines; clergy; school personnel; funeral directors; human resource staff

Goals	Examples Of Possible Actions
2A. Promote and develop systems of care that utilize the best evidence available to identify and help those at risk	1. Develop comprehensive protocols for service providers (health care, public safety, social service, educational institutions) in recognizing and treating suicidal behavior 2. Recognize those at risk through best available assessment tools; screening/checklist approaches (depression, behavioral health) 3. Incorporate "Lethal means counseling" into the existing suicide prevention protocols of gatekeepers and health/mental health providers
2B. Promote access to and continuity of care for individuals at risk through sustainable service linkages at the local, regional, and state level with all relevant providers	1. Support transitions and postvention services: re-entry plans for students and adults; step down from in-patient care; ensure a connection with a professional service provider is made 2. Identify needs and provide services to people in non-clinical environments, including caregivers 3. Increase face-to-face contact with those at risk through mentoring, visiting, volunteer advocates, and peer support groups 4. Identify and access approaches and avenues (that respect privacy and build trust) that increase the likelihood that those who are in need will ask for help
2C. Implement sustainable, replicable, and evidence-based training programs in recognizing and treating suicidal behavior	1. Encourage consistency of trainings where possible and appropriate 2. Conduct " gatekeeper" awareness and training programs for the lay and professional population

Goals	Examples Of Possible Actions
2D. Recognize and address the commonalities and the barriers (language, approaches, stigma, goals, training) that exist between professionals in different disciplines who are working with those at risk, so they can better connect and integrate prevention services	1. Increase opportunities for professionals serving higher risk populations to work more collaboratively 2. Provide training opportunities on collaborating and connecting suicide prevention to mental health, substance abuse prevention, and other related health issues 3. Create connections between community-based organizations and mental health professionals in providing a spectrum of appropriate and affordable services 4. Address the shortage of service providers who reflect characteristics of the populations served
2E. Design and implement multi-disciplinary protocols for all personnel and institutions who respond to individuals in crisis	1. Encourage appropriate and sensitive treatment of people with mental illness, in all settings 2. Ensure continuity of care for each individual in crisis and/or for people in treatment, by linking the individual with a service professional for a follow-up visit 3. Maintain, disseminate, and publicize resource directories (hard copy and web-based) for suicide prevention providers and others 4. Increase crisis intervention training; recognizing the fragility of people in crisis

LEVEL III: COMMUNITY AND COALITIONS

Theme
Create collaborations and foster networks to achieve broad impact through common goals in suicide prevention **Audience** (including, but not limited to): families, including foster parents; friends; partners; peer groups; survivors; consumers; neighborhoods; workplaces; faith communities and places of worship; sports teams; social and cultural clubs; professional networks, associations, and labor unions; local, regional, and statewide coalitions and networks; philanthropic organizations and funders; local government; local and county elected and appointed officials

Goals	Examples Of Possible Actions
3A. Advance and sustain local, community-based, and regional coalitions for suicide prevention, with connections to the state-wide coalition (MCSP)	1. Increase the number of community and regional suicide prevention coalitions while strengthening the statewide coalition; offer technical assistance and resources while affirming that each coalition is unique 2. Provide information about the availability of local grants for community-based efforts via community and regional coalitions 3. Build relationships and connections with existing networks to further efforts, e.g. Community Health Network Areas (CHNAs) and Regional Centers for Healthy Communities 4. Educate local government, elected and appointed officials and engage in community planning and prevention activities 5. Educate public and private funders and engage them in community planning and prevention activities
3B. Promote suicide prevention education and training for groups, communities and coalitions, and potential funders	1. Publicize trainings on the MCSP website and other websites 2. Create an MCSP listserv, and encourage regional and local coalitions to develop listserves or other communication systems 3. Develop, disseminate and share materials, technical assistance, and programs as needed, e.g., local resource guides, wellness campaigns, web-based tools 4. Facilitate networking and referrals through conferences and other convening approaches 5. Conduct education and outreach to local elected and appointed officials and potential funders

Goals	Examples Of Possible Actions
3C. Strengthen access to and collaboration among suicide prevention, mental health and health, substance abuse, crisis lines, and other prevention and advocacy services	1. Identify services available and service gaps in communities 2. Improve communication among service providers to support access and collaboration 3. Create and support avenues for open, multi-directional communication among Coalition members, including listservs and other venues 4. Integrate suicide prevention planning with planning for prevention and intervention of other health issues that share similar risk and protective factors, including mental health, substance abuse, and interpersonal violence, among others 5. Document successful community-wide approaches
3D. Support local data collection as part of suicide surveillance systems, and align with statewide efforts	1. Increase community awareness of available data 2. Train community members on how to locate and analyze available data, as needed
3E. Promote and support suicide prevention planning	1. Educate community and regional coalitions about the Massachusetts Strategic Plan for Suicide Prevention 2. Involve regional and local coalitions in implementing the Massachusetts Strategic Plan for Suicide Prevention 3. Increase engagement in suicide prevention activities through outreach to groups and constituencies at risk 4. Guide coalitions in developing suicide prevention plans tailored to their own specific needs 5. Encourage all communities to have a crisis plan and protocol, a review process/system for when a suicide occurs
3F. Develop additional primary prevention strategies	1. Increase awareness of the impact of violence and oppression on mental health 2. Collaborate with those developing trauma-informed care strategies within health and human service systems

LEVEL IV: INSTITUTIONS AND ORGANIZATIONS

Theme
Implement policies, procedures, initiatives, programs, and services in support of suicide prevention **Audience** (including, but not limited to): public, private, and non-profit organizations and institutions including educational institutions; health care providers; businesses, service-specific systems of providers (e.g., child care agencies, domestic violence shelters, elder care, homeless shelters); state and federal agencies and personnel (e.g. correctional facilities, veterans facilities), elected and appointed officials

Goals	Examples Of Possible Actions
4A. Address comprehensive continuity of physical and mental health care services	1. Promote case management and smooth referral systems to facilitate treatment access and treatment maintenance 2. Promote transportation services to providers, specifically for veterans, elders, homeless, people in rural areas 3. Address resource shortages (e.g., rural isolation and limited services, outpatient day programs, adolescent psychiatric beds, etc.) 4. Create incentives for treatment of patients with dual diagnosis issues (e.g. substance abuse and mental health) 5. Develop comprehensive protocols for service providers (health care, public safety, social service) in recognizing and treating suicidal behavior 6. Ensure statewide access to crisis support hot lines

Goals	Examples Of Possible Actions
4B. Support inclusion of mental health, suicide prevention, and resiliency efforts, and other initiatives into health and wellness benefits, policies, and curricula	1. Promote multiple mechanisms for delivering suicide prevention services; use schools and workplaces as access and referral points for services 2. Promote collaboration and integration among health issues in recognition of how experiences of violence and suicide can intersect. 3. Provide and improve prevention, intervention, and postvention services in the workplace and in workforce development and training programs 4. Promote state-wide K – 12 and college/university prevention, intervention, and postvention support and educational programs 5. Train employees in recognizing the warning signs and getting help for themselves and others
4C. Increase cultural competence among institutions and organizations and promote culturally diverse services	1. Connect with outreach efforts to community-based, racially, culturally and ethnically diverse groups and organizations 2. Equip organizations to provide culturally competent services 3. Increase the number of culturally competent mental health providers through workforce development, particularly those with expertise in adolescent and older adult mental health issues, and target geographically underserved areas 4. Provide suicide prevention training for medical interpreters
4D. Reduce access to and implement restrictions for methods of self-harm	1. Increase awareness of the effectiveness of means restriction as a suicide prevention strategy 2. Continue Massachusetts' successful gun safety regulations 3. Review train crossings where there have been suicides to assess safety features 4. Review major bridges and overpasses to assess safety features 5. Train health and mental health professionals to discuss risks of access to lethal means with their clients

Goals	Examples Of Possible Actions
4E. Support and focus the Massachusetts data-collection and suicide surveillance system at the state and local levels	1. Explore data on: passive suicide as an unrecognized cause of death; linkages between suicide and substance abuse overdoses 2. Improve documentation of race, ethnicity and language; secure data on certain populations (refugees); and distinguish rural, suburban, and urban data 3. Address under-reporting and nomenclature issues 4. Develop and share data on effectiveness and success of prevention programs and services; including costs of prevention vs. cost of crisis care 5. Explore approaches to make information sharing under HIPAA less difficult to ensure that services and resources are available for individuals in need 6. Include questions on suicidal behaviors, related risk factors and exposure to suicide on data collection instruments 7. Assess implementation of suicide prevention efforts in other states for possible application within the Commonwealth 8. Evaluate the impact and effectiveness of the Massachusetts Strategic Plan for Suicide Prevention in reducing suicide morbidity and mortality
4F. Promote the adoption of "zero suicide" as an aspirational goal by health care and community support systems that provide services and support the defined patient populations	1. Educate health care systems on the concept and dimensions of "zero suicide" 2. Establish a suicide prevention task force among state agencies to address the goal of reducing suicides and suicide attempts 3. Work with community support systems including state agencies that serve high risk populations to adopt a "zero suicide" policy

LEVEL V: SOCIAL STRUCTURE AND SYSTEMS

Theme

Reduce the stigma and discrimination associated with suicide, and promote healthy and help-seeking behaviors in society, with supportive policy, regulation, and law.

Audience (including, but not limited to): any individual of any age; society at-large; the media; philanthropic organizations and funders; state elected and appointed officials

Goals	Examples Of Possible Actions
5A. Maintain and promote political will and ongoing support for suicide prevention and resiliency building	1. Create a joint legislative, executive, and private sector commission to study and implement strategies to prevent suicide and self-harm 2. Implement mental health parity through federal and state legislation 3. Assess and address policies, programs, and procedures of public and private health insurance regarding suicide prevention and mental health services 4. Educate philanthropic organizations and funders about suicide and related prevention and engage them in policy and planning activities
5B. Reduce stigma associated with mental illness, substance abuse, violence and suicide	1. Promote help-seeking as a healthy behavior 2. Promote awareness that suicide is a preventable public health problem and that mental illness is treatable 3. Raise awareness and understanding of the mental health consequences of oppression and violence 4. Promote a multi-media public information campaign to dispel myths and increase awareness 5. Identify and develop credible advocates, prominent people, speakers bureau 6. Foster partnerships with and involve news media in public awareness efforts 7. Promote appropriate media reporting on and portrayals of suicide and mental illness and collaborate with the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) stigma reduction campaign 8. Develop, implement, monitor and update guidelines on the safety of online content for new and emerging communication technologies and applications

Goals	Examples Of Possible Actions
5C. Increase broad based support for suicide prevention	1. Conduct education and outreach on suicide and related prevention to elected and appointed officials at all levels of government 2. Increase outreach to cities and towns through the statewide coalition and the development of regional and local suicide prevention coalitions 3. Raise awareness of suicide as a public health problem among philanthropic organizations and funders and engage their support for suicide prevention activities 4. Disseminate the national suicide prevention research agenda 5. Foster sharing of research and data within the state
5D. Strengthen suicide prevention efforts at all state agencies, and ensure collaboration among and coordination within state agencies	1. Increase the numbers of people on state commissions and councils with suicide prevention expertise and include perspective representing youth, suicide loss survivors and suicide attempt survivors 2. Promote cross-agency dialogue within EOHHS 3. Implement recommendations of the January 2007 report to prevent suicide in Massachusetts prisons[11] 4. Align suicide prevention planning and implementation with Federal and State health and human services initiatives

[11] Hayes, Lindsay M. *Technical Assistance Report on Suicide Prevention Practices within the Massachusetts Department of Correction.* National Center on Institutions and Alternatives, January 31, 2007.

VIII. LOGIC MODEL

We are incorporating a logic model as part of the Massachusetts Strategic Plan for Suicide Prevention. A logic model communicates the logic or rationale behind a plan or program. It illustrates the relationship between inputs, processes, and outcomes—showing the chain of "logic", or what causes what toward the desired goal or outcome. Logic models are presented as a visual schematic, although there is no proscribed formula.

Included in this section of the State Plan are three sets of Logic Models, each based on the "Theory of Change Logic Model:"

A.) A model for the overall plan captures how implementing this planning framework of Levels/Themes will lead to the reduced incidence of suicide and self harm through short-term, then intermediate, and then finally, long-term outcomes.

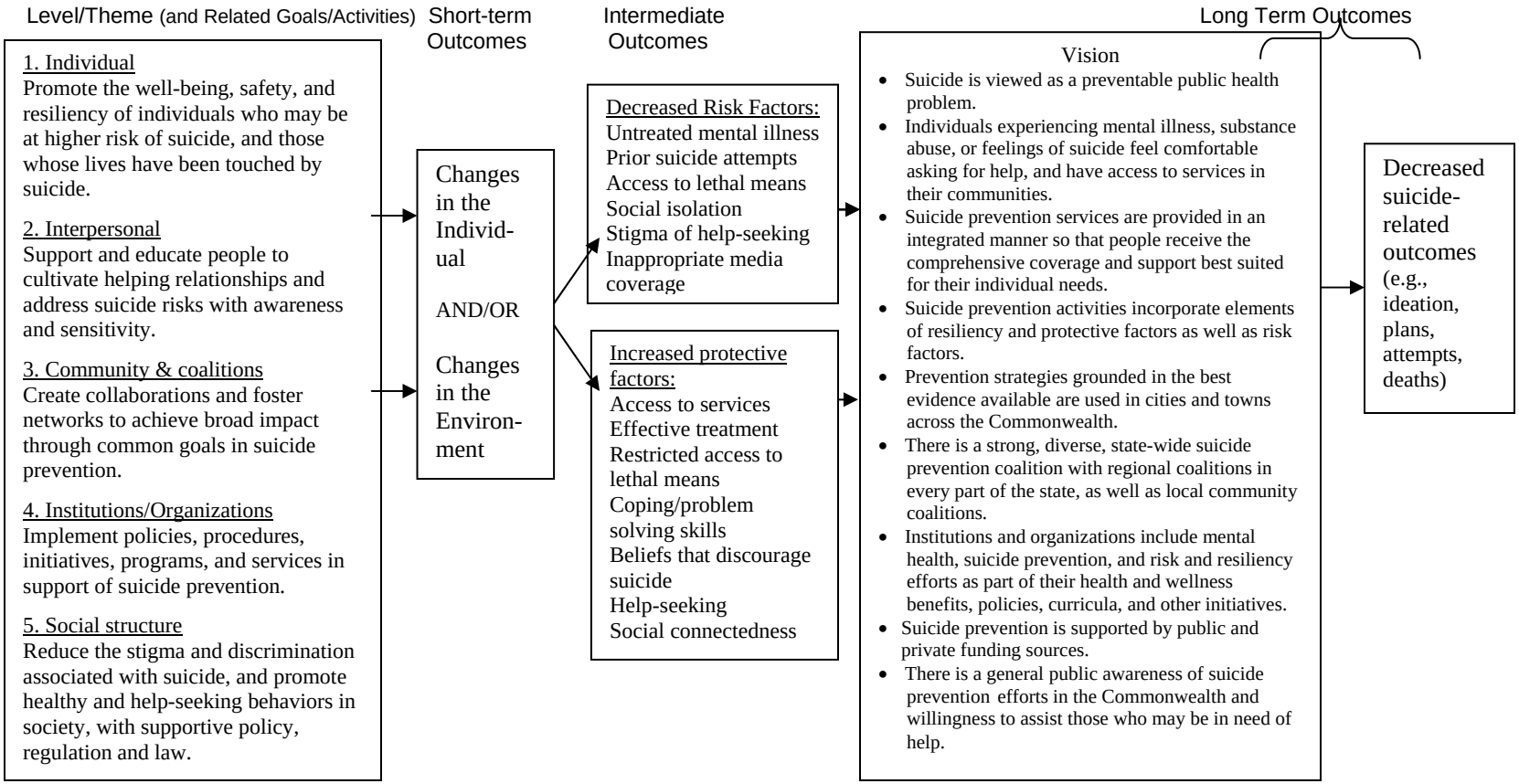
B.) There are logic models for each of the five Levels of the framework—individual, interpersonal, community and coalitions, institutions and organizations, and social structures and systems. These illustrate how implementation of Possible Actions will result in the realization of each Level/Theme.

C.) A final set of logic models will be developed in the future to address Possible Actions. A sample Action logic model is included here, for Level III, Goal 3A, Action 1. Other models will be developed in collaboration with MCSP members as we begin to implement the plan.

For more information on logic models, see 'Everything You Wanted To Know About Logic Models But Were Afraid to Ask' (Schmitz and Parsons,) at http://www.insites.org/documents/logmod.pdf

If you'd like more detailed information about logic models and other ways to evaluate suicide prevention programs, visit the website of the National Center for Suicide Prevention Training at http://training.sprc.org/. The workshop entitled 'Planning & Evaluation for Youth Suicide Prevention' includes a section on 'Using Logic Models for Plan Implementation'. Their online courses are free and self-guided, though electronic registration is required.

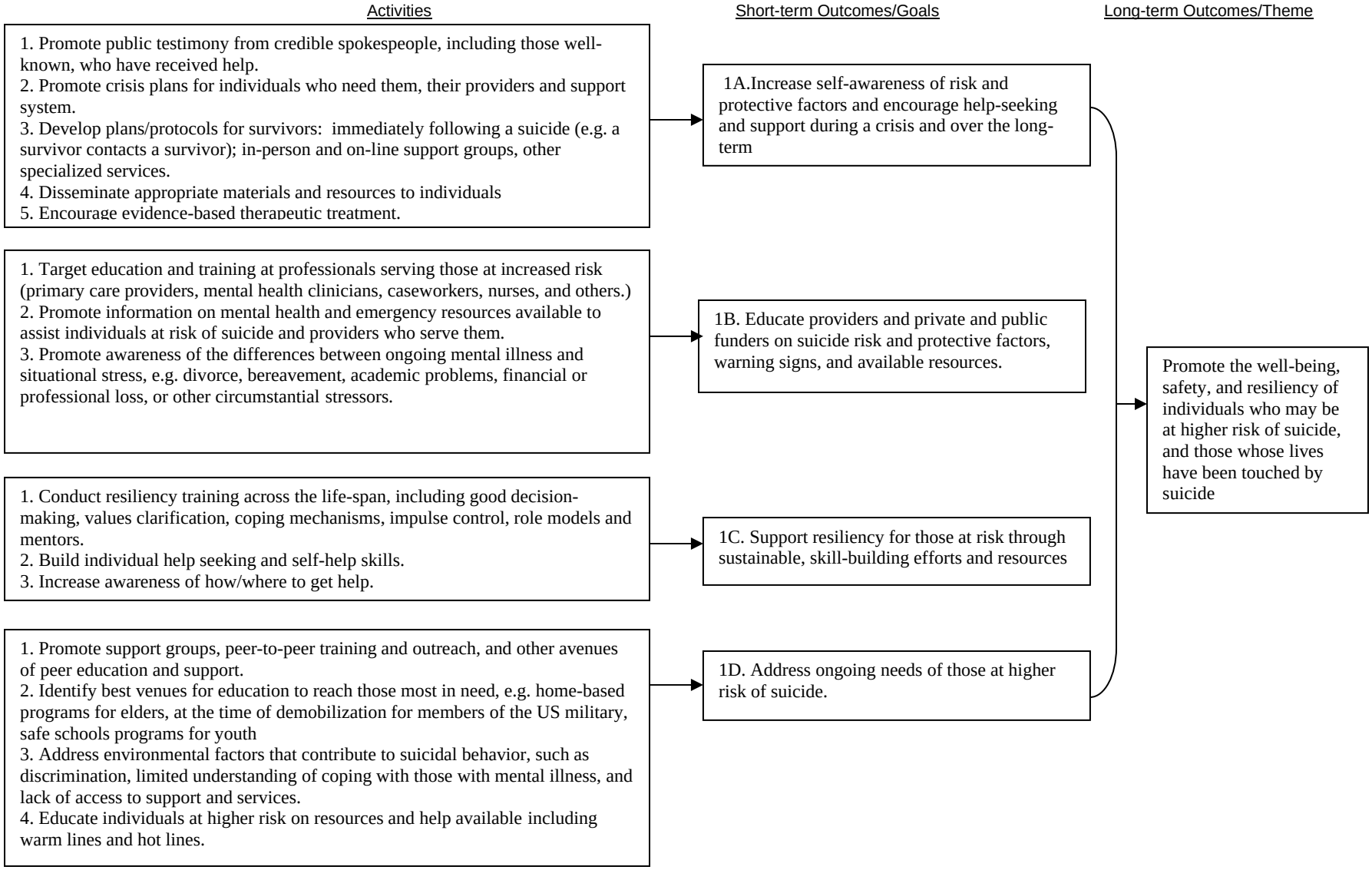
A. Logic Model for Overall Plan



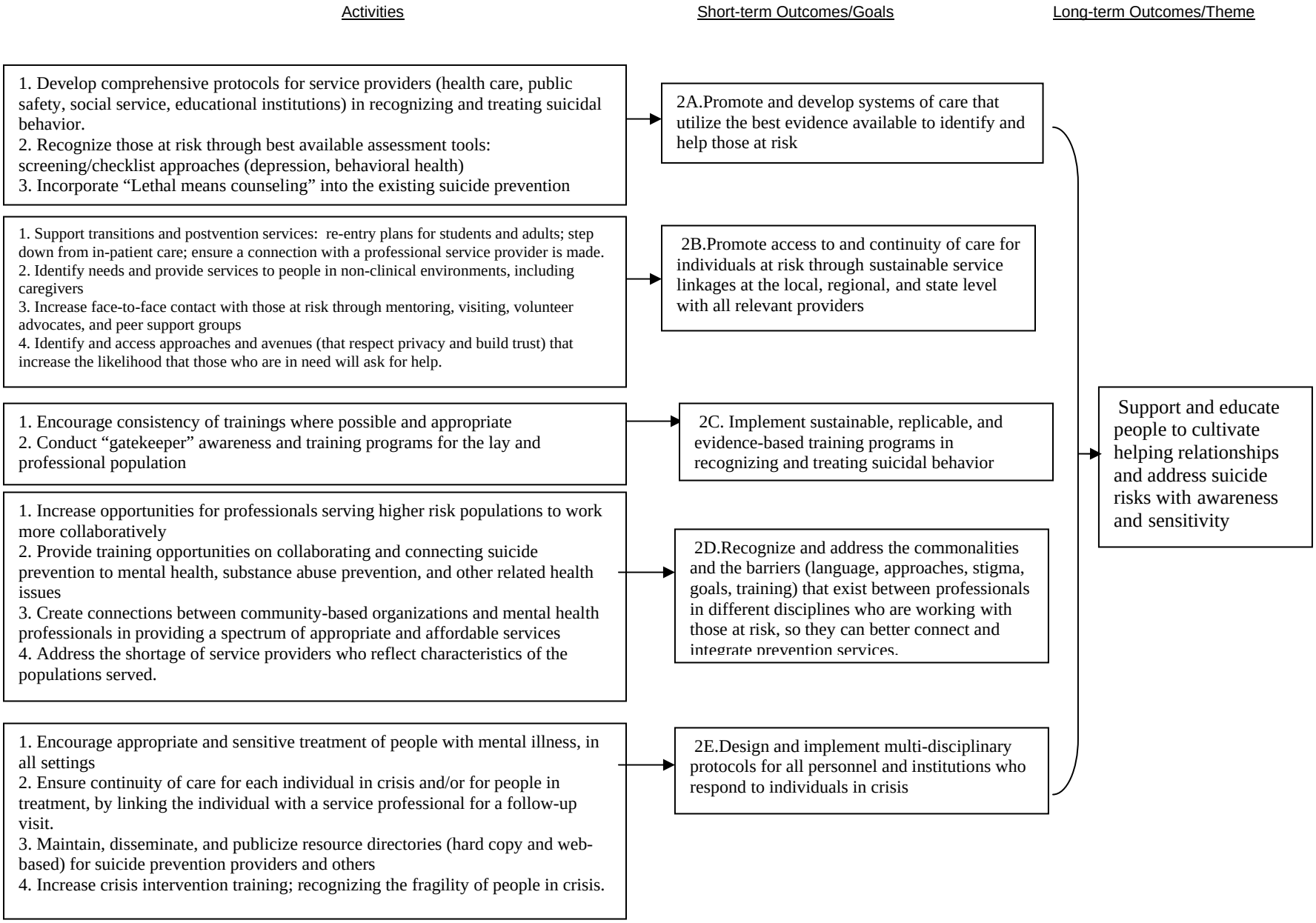
Guiding Principles:

- Suicide affects all ages and must be addressed across the lifespan
- Stigma and discrimination prevents open acknowledgment of mental illness and suicidal behavior, and this inhibits successful intervention, prevention, and recovery
- Some populations are at higher risk of suicide than others; therefore, targeted population-based strategies and models are necessary and appropriate
- Every person should have a safe, caring, and healthy relationship with at least one other person
- Prevention should take into account risk and resiliency of individuals and populations
- All suicide prevention materials, resources, and services must be culturally and linguistically competent, and developmentally and age appropriate
- Consumers and target groups must have input and participate in all levels of suicide prevention planning and decision-making
- Information sharing and collaboration must occur between all stakeholders in suicide prevention
- The best evidence available must be used, to the extent possible, when planning, designing, and implementing suicide prevention efforts
- More research and evaluation of suicide and suicide prevention programs , including innovative approaches and best evidence available, must be undertaken
- To ensure sustainability of suicide prevention efforts, there must be advocacy for diverse funding and other resources
- Comprehensive coverage, accessibility, and continuity of physical and mental health care services should be ensured

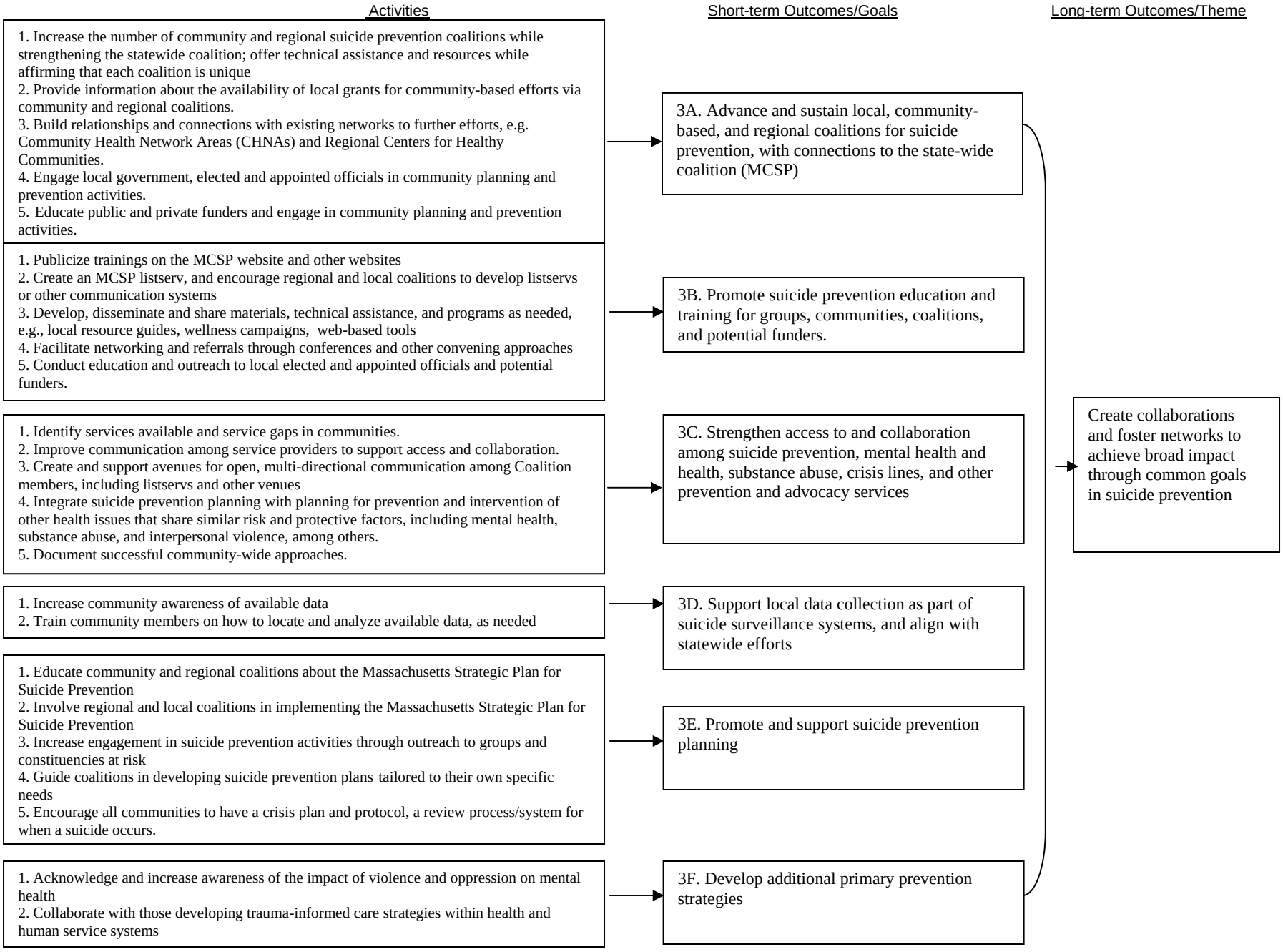
B. Level I-Individual



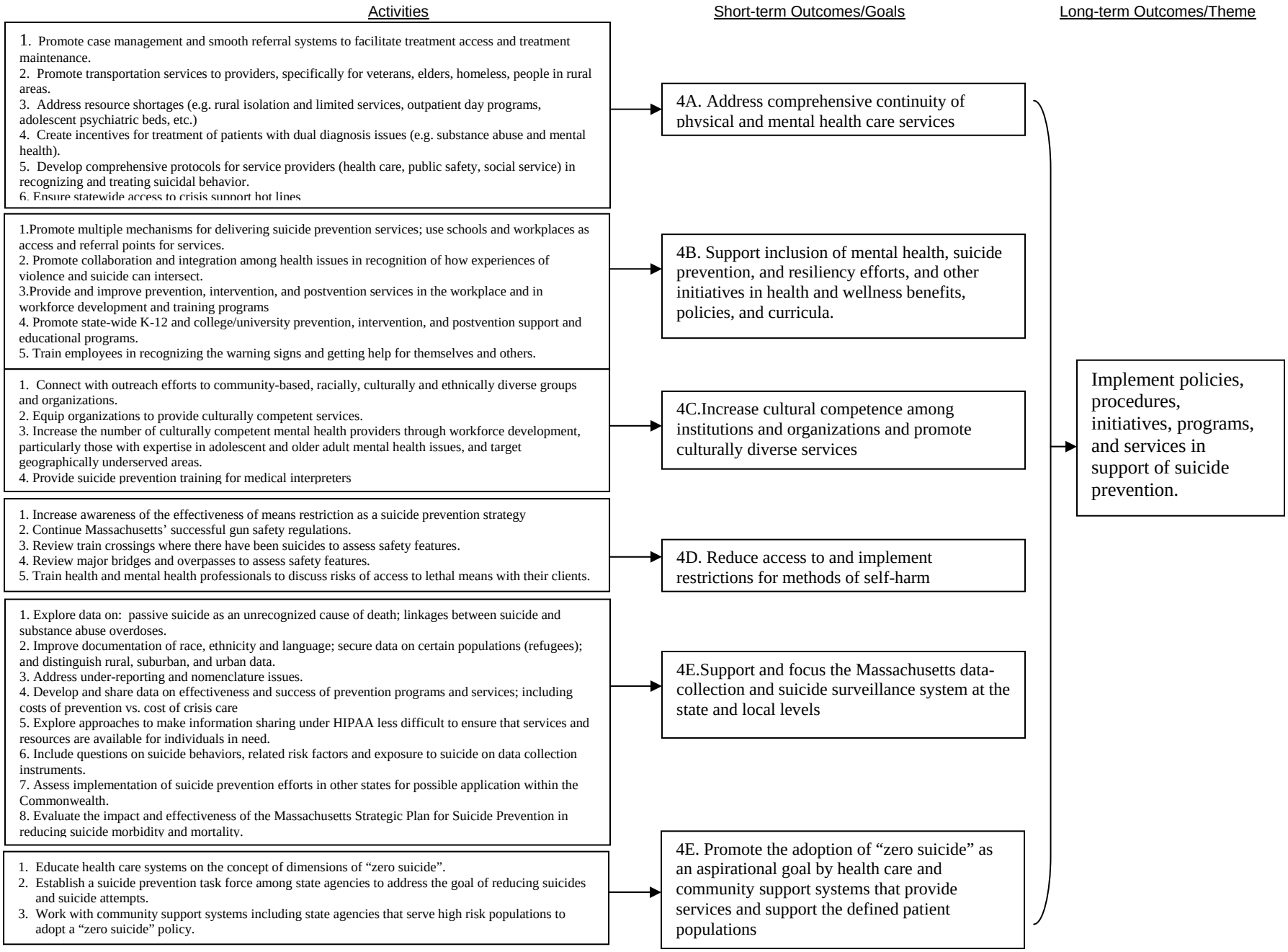
B. Level II-Interpersonal



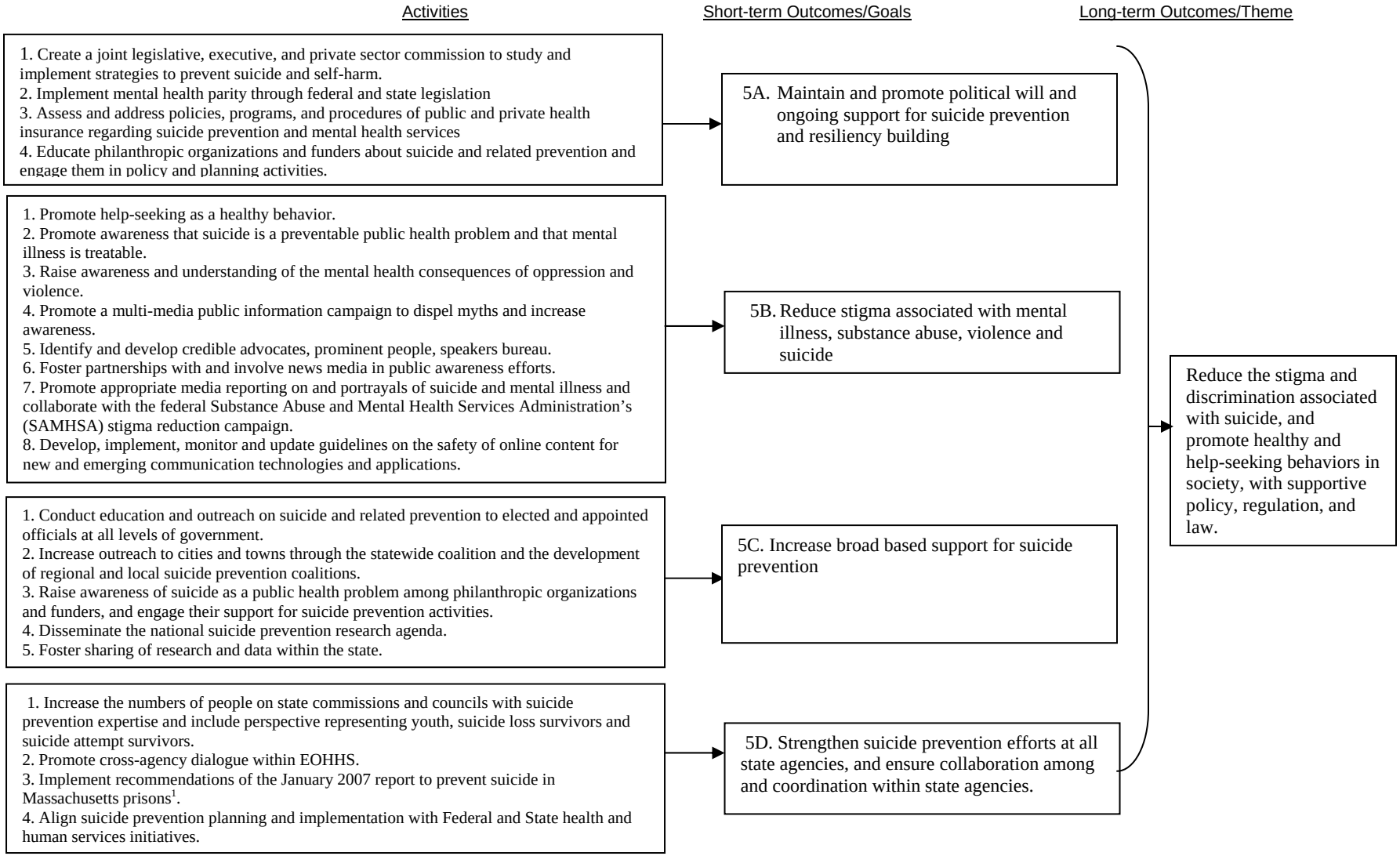
B. Level III-Community and Coalitions



B. Level IV-Institutions and Organizations



B. Level V-Social Structure and Systems

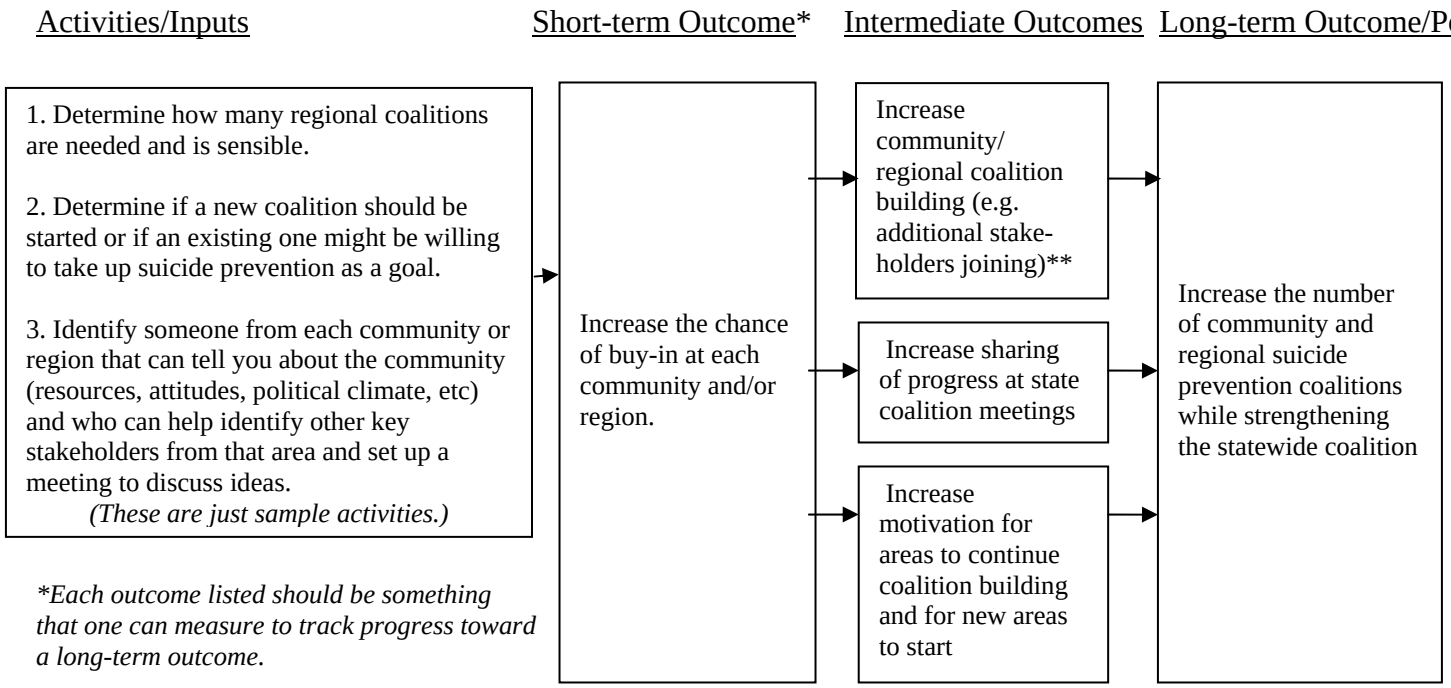


C. Example of a Logic Model for a Possible Action found in Level III, Goal A.

The first step is to ask, "What are your goals and what do you hope to accomplish?" For the purposes of Level III, Goal A, Possible Action 1, we hope to accomplish the following:

"Increase the number of community and regional suicide prevention coalitions while strengthening the statewide coalition"

Ideally, the activities (sometimes called *inputs and resources*) selected will be based on best practices in the field (e.g. practices that other communities have used and found to be effective) and the long-term outcome (sometimes called *outputs*) that one strives towards will be based on a need that was identified in the community or via a collaborative process.



**Each outcome listed should be something that one can measure to track progress toward a long-term outcome.*

*** One may wish to have a subsequent logic model for coalition building and how that will be achieved.*

IX. TWO EXAMPLES OF HOW THE PLAN COULD WORK

A. Introduction

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) does not address the specific targeted needs of specific geographic regions or communities, or of populations known to be at increased risk of suicide (e.g., consumers of mental health services, veterans, gay/lesbian/bisexual, transgender youth, and others). As part of implementing this State Plan, it is our hope that planning groups associated with both populations at increased risk of suicide, and coalitions addressing suicide prevention for regions, or cities and towns will use this Plan as a starting point to develop their own population-specific, more tailored plans.

The following two summaries are provided as examples of how planning can advance suicide prevention for communities. These summaries are not intended as models to be followed, but as samples of how planning can advance suicide prevention for different kinds of communities. The first addresses a community of interest statewide—suicide among older adults, for which a working group developed a plan for services and needed resources. The second example features a geographic community—a suburban town that formed a local coalition and planned activities as a strategy for coping with a series of youth suicides.

The State Plan can assist in identifying priorities as you develop a strategic plan, an annual work plan, or specific action plans for your community or area of interest in suicide prevention. It can help you can chart progress as well as measure your contributions against the overall goals of the overall State Plan.

We look forward to hearing how planning is helping your community or interest group as we begin implementing the Massachusetts Strategic Plan for Suicide Prevention.

B. Older Adult Summary

According to vital records, obtained from death certificates, Massachusetts adults 65 and older account for 15.8% of suicides yet comprise only 13.5% of the population. Historically there has been significant interest in preventing suicide among older adults, and legislative language in the FY 08 budget called for a study to address suicide among elders / older adults.

To develop this report, the Department of Public Health (DPH) pulled together a team representing their healthy aging and suicide prevention staff, the Executive Office of Elder Affairs (EOEA), the Department of Mental Health (DMH), and providers serving older adults throughout the Commonwealth. They are currently working on a plan to address suicide among those older residents of Massachusetts. As part of informing the State Plan, a focus group targeted elder service agencies and older adults.

Current service areas are divided into community services, gatekeeper training and clinical training, and collaboration with EOEA.

Community Services—Older adults were identified as a priority population in a Request for Proposals, and this generated lots of interest from community providers. DPH funds are supporting grants to several community-based agencies serving elders. Services in different communities include: awareness and intervention training for senior service staff; depression screening; care management; elder

diagnostic assessments for homebound seniors; survivor support and outreach for bereaved elders; and specialized survivor support for bereaved gay / lesbian/ bisexual / transgender elders.

General Training—Training has been targeted directly at elder serving agencies through conferences and outreach to elder service programs. Current training in place includes: comprehensive suicide prevention and education; training for gatekeepers and elder service support staff; and training in suicide assessment and screening. The Question, Persuade and Refer curriculum (QPR) trained 40 new trainers serving older adults throughout Massachusetts. In addition, the annual suicide prevention conference featured a track on elder suicide, and suicide prevention workshops were integrated into Massachusetts Council on Aging conferences and the Aging with Dignity conference.

Clinical Training— It has been recognized that there is a shortage of mental health clinicians with expertise in suicide prevention. Clinicians representing elder services in different parts of the state participated in "Assessment and Management of Suicide Risk" training developed by the American Association of Suicidology and the Suicide Prevention Resource Center. Additional training has targeted primary care physicians and nurses, visiting nurses, and other clinicians serving older adults.

Collaboration with EOEA—To support mental health services for older adults DPH provides funding to the EOEA. Services include medication management; home-based mental health counseling; and training towards certification in geriatric mental health.

C. Example of a Massachusetts Community Suicide Prevention Coalition

In response to several youth suicides over several years, a suburban Boston community mobilized a suicide prevention coalition. Members represented local elected and appointed officials, school faculty and administrators, health and mental health services, public safety, clergy, students, parents, the District Attorney's office, and the local preschool consortium. They reached out to the Massachusetts Coalition for Suicide Prevention, and were linked with many suicide prevention resources. They also established cooperative relationships with the town police, fire department, clergy, school, and mental health agencies and individuals to plan for a more coordinated and effective response to individuals in need. This community coalition focused on both school and community based efforts. Their efforts have been featured in several local newspapers and television programs.

In schools, a psychologist worked with high school students at risk for depression or suicide. Faculty and staff were trained in the 'Question, Persuade, and Refer' (QPR) curriculum on identifying warning signs of suicide and options for intervention, and school counselors and nurses received training in self-injury. The coalition also worked with a local drug and alcohol prevention program to provide education and support related to alcohol and drug use among youth.

Several suicide prevention curricula were implemented with students. The Signs of Suicide curricula (SOS) taught 8-11th graders how to respond to a suicide attempt. And a pilot program taught students to resist risky behavior through coping skills such as impulse control, social problem solving, anger management, media resistance, and enhanced communication skills. The coalition also looked at school policy and adopted a crisis management model for contingency planning if a school or community crisis occurs, including when school is not in session.

Outside of the schools, the Coalition conducted a series of focus groups on suicide-related concerns. They implemented a town-wide action campaign to raise awareness on suicide and depression, including: town-wide posting of an informational poster; designating a weekend when all churches and synagogues discussed depression and suicide; and a "One-Town/One-Book" reading and discussion of William Styron's *Darkness Visible* on his struggles with depression. Community and school protocols for emergencies to prevent rumors and provide accurate information were updated.

A variety of community members were QPR-trained, including representatives of the District Court, community and civic organizations, town department employees, clergy, parents, and other interested residents. The coalition also launched a website. They adopted guidelines for appropriate memorials following a suicide or other traumatic death, and met with local journalists to promote responsible media reporting on suicide.

This community coalition continues to focus on preventing youth suicide, but has expanded its focus to include depression and suicide among elders, middle-aged men, and veterans.

APPENDIX A: RESOURCES FOR COMMUNITY AND GROUP SUICIDE PREVENTION

The list below represents a sample of resource materials useful to communities and groups starting to plan for suicide prevention. A comprehensive library of suicide prevention materials is available from the website of the Suicide Prevention Resource Center at www.sprc.org.

Data

Data-Driven prevention planning model
URL: http://www.sprc.org/library/datadriven.pdf
A suicide prevention planning model by Richard Catalano and David Hawkins is outlined in five steps. The model assumes that a broad-based coalition has been formed and is sufficiently organized to support the infrastructure necessary for this plan.

Finding data on suicidal behavior
URL: http://www.sprc.org/library/datasources.pdf
Sources for collecting suicide and suicidal behavior data at both the local and national level are listed.

Means Matter
http://www.hsph.harvard.edu/means-matter/
A website devoted to restricting access to lethal means as an evidence-based suicide prevention strategy. Includes a section on Recommendations for Communities and Suicide Prevention Groups under 'Taking Action'.

National Violent Death Reporting System (NVDRS)
http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm
The National Violent Death Reporting System (NVDRS) seeks to provide communities with a clearer understanding of violent deaths so they can be prevented. NVDRS accomplishes this goal by informing decision makers and program planners about the magnitude, trends, and characteristics of violent deaths so appropriate prevention efforts can be put into place; and evaluating state-based prevention programs and strategies. Suicide is included in violent deaths, and Massachusetts is one of the participating states.

Program Planning and Implementation

Community coalition suicide prevention checklist
URL: http://www.sprc.org/library/ccspchecklist.pdf
This document is a result of a Scientific Consensus Meeting, sponsored by several of the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and Centers for Disease Control and Prevention through grants to the University of Rochester Center for the Study and Prevention of Suicide. The checklist contains ideas for whom to include in coalitions for suicide prevention in different settings.

Feasibility tool for the implementation of prevention programs
URL: http://www.sprc.org/library/feasibility_tool.pdf

Each page contains a chart to fill in to determine the feasibility of different elements of a prevention program, including: Resources, Target Populations, Organizational Climate, Community Climate, Evaluability, and Future Sustainability

Funding your program, determining your needs and developing a plan
URL: http://www.sprc.org/library/fundingtips.pdf
Contains tips, as well as websites for government grants, foundations, and statement research.

Leaving a legacy: Sustaining change in your community
URL: http://www.sprc.org/grantees/pdf/2006/legacywheel2.pdf
State/Tribal/Adolescents at Risk Suicide Prevention Grantee Technical Assistance Meeting, December 12–14, 2006, North Bethesda, MD. Explains the "Legacy Wheel" model of program planning, implementation, and evaluation.

Suicide prevention community assessment tool
URL: http://www.sprc.org/library/catool.pdf
Adapted from: Community Assessment Tool developed by the Suicide Prevention Program at the Massachusetts Department of Public Health. This assessment tool is targeted for "prevention networks," coalitions of change-oriented organizations and individuals working together to promote suicide prevention. It is comprised of four sections intended to gather information on: a) each community addressed; b) all agencies and individuals within the prevention network; c) target populations; and d) community suicide risk factors and prevention resources.

Awareness and Education

National Center for Suicide Prevention Training (NCSPT) workshops.

http://training.sprc.org/

NCSPT provides educational resources to help public officials, service providers, and community-based coalitions develop effective suicide prevention programs and policies. Workshops are free of charge, online, and self-paced. Topics include: Locating, understanding, and presenting youth suicide data; Planning and evaluation for youth suicide prevention; an introduction to gatekeeping; the research evidence for suicide as a preventable public health problem.

Suicide prevention: The public health approach
URL: http://www.sprc.org/library/phasp.pdf
Defines the five main steps of the public health approach and applies it toward suicide prevention.

Warning Signs for Suicide Prevention from The American Association for Suicidology
http://www.sprc.org/featured_resources/bpr/PDF/AASWarningSigns_factsheet.pdf
The warning signs were developed by an expert working group convened by the American Association of Suicidology. Citing the importance of distinguishing warning signs from risk factors, the group defined warning signs as the earliest detectable signs that indicate heightened risk for suicide in the near-term (i.e., within minutes, hours, or days), as opposed to risk factors which suggest longer-term risk (i.e., a year to lifetime.)

APPENDIX B:
DEFINITIONS AND GLOSSARY

Provided on the following pages is a glossary of terms used in the plan.

Some of the terms in this glossary are adapted from one published in the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

Best practices/best evidence available – activities or programs that are in keeping with the best available evidence regarding what is effective

Consumer – A person who currently receives mental health services or who received such services in the past

Culturally appropriate – the ability of an organization or program to be effective across cultures, including the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services

Depression – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure; a medical condition requiring diagnosis and treatment

Education – the teaching, learning, and understanding of specific facts, concepts and abstract principles, related to suicide prevention that can be applied in a variety of settings.

Effective – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in the target group more than in a comparison group

Evaluation – the systematic investigation of the value and impact of an intervention or program

Evidence-based – programs that have undergone scientific evaluation and have proven to be effective

Gatekeepers (suicide gatekeepers) – individuals trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate; gatekeepers can be non-professionals who work with at-risk populations including administrators, coaches, home health aides, and others

HIPAA – The Health Insurance Portability and Accountability Act of 1996 enacted by the US Congress to ensure security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as strengthening social support in a community)

Means – the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication)

Means restriction – activities designed to reduce access or availability to means and methods of deliberate self-harm

Methods – actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping)

Mood disorders – mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states. Included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders

Outcome – a measurable change in the health of an individual or group of people that is attributable to an intervention

Postvention – a strategy or approach that is implemented after a crisis or traumatic event has occurred

Prevention – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors

Protective factors – factors that make it less likely those individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment

Public information campaigns – efforts designed to dispel myths and provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards

Public health approach – the systematic approach using five basic evidence-based steps that are applicable to any health problem that threatens substantial portions of a group or population. The five steps include defining the problem, identifying causes, developing and testing interventions, implementing interventions and evaluating interventions

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes

Risk factors – factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment

Screening – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment

Social support – assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services, and include support from family, friends, religious communities and other affiliation groups

Stakeholders – entities including organizations, groups, and individuals that are affected by and contribute to actions and decisions

Stigma – an object, idea, or label associated with disgrace and reproach

Suicidal act (also referred to as suicide attempt) – potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death or injuries.

Suicidal behavior – a spectrum of activities related to suicide and self-harm, including self injury, attempted suicide, or suicide

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior

Suicidality – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in physical injuries

Suicide attempt survivors – individuals who did not die from an attempt to take their own life

Surveillance – the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings

Survivors/Suicide survivors – family members, significant others, or acquaintances who have experienced the loss by suicide of someone in their life

Training – teaching people to use specific skills, for the specialized tasks of suicide intervention and prevention, which are not generally used in other situations, and can not be used by unqualified individuals.

Warning signs – signals that can be verbal, non-verbal or behaviors that a person uses to indicate that they are at risk of suicide