New Jersey Department of Human Services

Division of Mental Health and Addiction Services

Adult Suicide Prevention Plan

2014 - 2017

Suicide is the 10th leading cause of death for all Americans, the 2nd leading cause of death for adults ages 25-34, and the 3rd leading cause of death for youth ages 15-24.[1] In New Jersey 60% of all violent deaths are suicides. Furthermore, suicides outnumber homicides in New Jersey by nearly two to one. [2]

New Jersey is committed to developing and implementing an Adult Suicide Prevention Plans/Initiatives/Strategies to address these statistics. In order to adequately and effectively respond to this national health problem, the Division of Mental Health and Addiction Services' (DMHAS) Suicide Prevention Committee began developing an Adult Suicide Prevention Plan for New Jersey in 2012 in accordance with, and guided by, the National Strategy for Suicide Prevention: Goals and Objectives for Action, published by the U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2008). In addition, the committee used as guidance and reference, the New Jersey Youth Suicide Prevention Plan.

This plan contains strategies and actions in addition to crisis responses for the specific concerns related to adult suicides; addressing current New Jersey needs and activities and linking up-to-date science for prevention with practical application in the field. The plan and subsequent action steps go beyond organizations and agencies to include broad based community activism in preventing suicides. Although New Jersey's rate of suicide is the second lowest in the nation, every suicide can potentially be prevented. This plan provides a guide to the process.

We are aware that preventing suicide can only be accomplished through collaborative efforts in partnership with our communities and agencies throughout the State as well as everyone's commitment to contribute to it.

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Commissioner
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[1] http://actionallianceforsuicideprevention.org/

[2] New Jersey Violent Death Reporting System v.05/09/2013, Center for Health Statistics, New Jersey Department of Health

New Jersey Division of Mental Health and Addiction Services

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Acknowledgements

Special thanks to Bretta Jacquemin, MPH, from the Centers for Health Statistics at the Department of Health for providing New Jersey data.

In addition, the Suicide Prevention Committee would like to acknowledge contributions of:

Deborah Klaszky, MSN, APN, previous Co-Chair. We are extremely grateful and indebted to Debi for her rich contributions and tireless efforts with regards to the formation and evolution of this committee in leading the cause to prevent suicides in New Jersey's adult population.

Table of Contents

	Page Number
Introduction	1
New Jersey Statistics	2
Risk Factors and Protective Factors	5
New Jersey Adult Suicide Prevention Activities	6
New Jersey Adult Suicide Prevention Plan Goals	9
New Jersey Suicide Prevention Action Steps	20
Suicide Prevention Plan Monitoring and Evaluation	21
Resources Used	22

Introduction

Following the release of the final New Jersey Youth Suicide Prevention Plan 2011 – 2014 by the Department of Children and Families (DCF), the Department of Human Services' Division of Mental Health and Addiction Services (DMHAS) began to review its own mental health and addiction assessment and treatment systems in relation to the recommendations included in the 'Youth Plan'.

Beginning in December 2011, a DMHAS internal workgroup (later formalized into the Suicide Prevention Committee of DMHAS), composed of staff with mental health and addictions training and experience, began an analysis of the current system and identified opportunities relevant to suicide prevention. The initial foci were as follows:

- Review DMHAS' goals and initiatives in relationship to the NJ Youth Suicide Prevention Plan 2011 – 2014;
- Enhance statewide strategies to prevent suicide;
- Promote greater public awareness about suicide prevention and resources statewide;
- Identify barriers to accessing mental health and substance use services, as well as opportunities to enhance this access;
- Promote evidenced-based and best practice programs, as listed on the Suicide Prevention Resource Center's Best Practices Registry, for the prevention and treatment of suicide and self-injury;
- Provide training to contracted agency staff on suicide prevention; and
- Explore expansion of the National Suicide Prevention Lifeline available in New Jersey.

Regular meetings were held, literature was reviewed and best practices across the nation were sought. Stigma related to mental illness and suicide, training, education and the development of a standardized suicide risk assessment tool were ideas explored that will be detailed in the section: New Jersey Adult Suicide Prevention Activities.

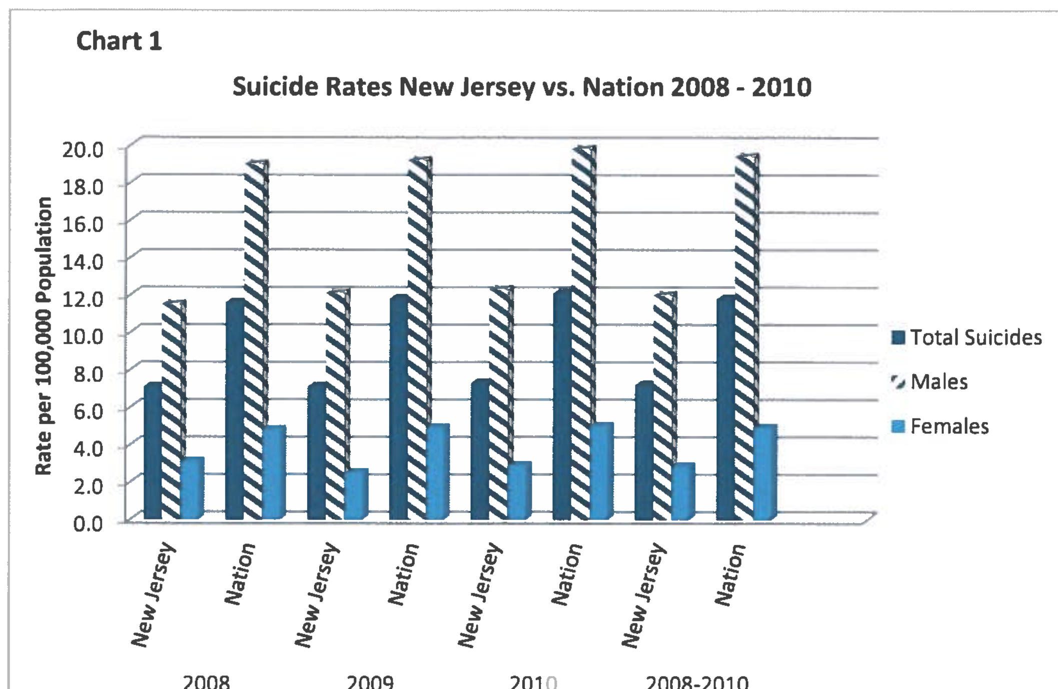
The Suicide Prevention Committee has overall responsibility for implementing, monitoring and evaluating this Plan.

Next Steps

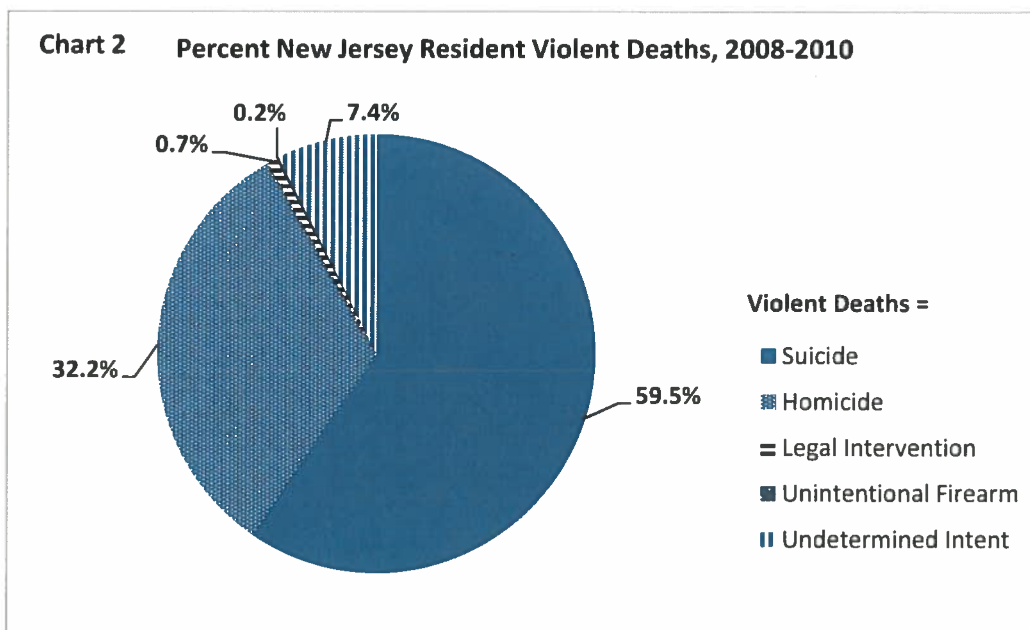
Action steps, monitoring and evaluation criteria will be developed with full involvement of representatives from our regional coalitions, Mental Health Planning Council and other key stakeholders. Each will be data-driven in order to allocate resources to prioritized regions, counties, and subgroups of the population, etc. The monitoring and evaluation components of this plan will include sections for accountability, regular reporting (at least annually) and revisions as necessary.

New Jersey Suicide Statistics

While the adult suicide rate (per 100,000 population) in New Jersey is lower than most other states, suicide remains a public health issue in NJ (Chart 1). From 2008-2010, 3,325 New Jersey residents died a violent death. Of those, 60% (the majority) were related to suicide (Chart 2).



Rates are age-adjusted using the 2000 US Standard Population Data
Source: New Jersey Violent Death Reporting System, v.5/9/2013



Source: New Jersey Violent Death Reporting System v.05/09/2013, Center for Health Statistics, Office of Policy and Strategic Planning, Office of the Commissioner, New Jersey Department of Health, May 10, 2013

According to the New Jersey Department of Health (DOH), male suicide victims outnumber females by nearly four to one in our State (Table 1). In addition, as seen nationally, there has been a marked increase in suicides among 45 – 64 year olds.

Table 1
Suicide by Gender and Age, New Jersey, 2008-2010

		2008		2009		2010		2008-2010	
		N	*Rate*	*N*	*Rate*	*N*	*Rate*	*N*	*Rate*
Males									
	Under 19	18	**	27	2.3	25	2.1	70	2.0
	20-24	34	12.6	45	16.4	40	14.3	119	14.4
	25-44	162	13.7	173	14.8	142	12.2	477	13.6
	45-64	202	17.9	227	19.7	237	20.2	666	19.3
	65+	83	17.3	60	12.3	99	20.0	242	16.6
Male Total		499	11.5	532	12.1	543	12.3	1,574	12.0
Females									
	Under 19	8	**	3	**	8	**	19	**
	20-24	4	**	6	**	8	**	18	**
	25-44	49	4.1	38	3.2	45	3.8	132	3.7
	45-64	57	4.7	55	4.5	66	5.3	178	4.8
	65+	28	4.1	16	**	13	**	57	2.8
Female Total		146	3.1	118	2.5	140	2.9	404	2.9
All Suicides									
	Under 19	26	1.1	30	1.3	33	1.4	89	1.3
	20-24	38	7.3	51	9.6	48	8.9	137	8.6
	25-44	211	8.8	211	8.9	187	8.0	609	8.6
	45-64	259	11.1	282	11.8	303	12.5	844	11.8
	65+	111	9.6	76	6.5	112	9.4	299	8.5
All Total		645	7.1	650	7.1	683	7.3	1,979	7.2

** Rates not calculated for <20 observations.
Rates are per 100,000 population and are age-specific or age-adjusted using the 2000 US Standard Population.

New Jersey's Center for Health Statistics, Office of Policy and Strategic Planning within DOH has provided the suicide data by county, as well, in Table 2. There are four counties with large increases in suicide rates (close to 50% or more) when comparing 2008-2010 data to data from 2003-2005: Cape May; Hunterdon; Sussex; and Warren. This data will assist the State in prioritizing resource allocation for suicide prevention activity efforts.

Table 2
Suicide Rates by County of Residence, 2003-2005 and 2008-2010

	2003 - 2005		2008 - 2010		% Rate Change
	N	*Rate*	*N*	*Rate*	
Atlantic	72	8.9	90	10.2	15%
Bergen	160	5.7	185	6.4	12%
Burlington	98	7.3	92	6.4	-12%
Camden	176	11.4	142	9.1	-20%
Cape May	31	10.2	47	14.9	47%
Cumberland	45	9.8	41	8.8	-11%
Essex	124	5.3	122	5.1	-3%
Gloucester	64	7.7	72	8.1	5%
Hudson	89	4.8	115	5.8	21%
Hunterdon	28	7.1	46	11.5	62%
Mercer	70	6.3	87	7.4	18%
Middlesex	136	5.6	181	7.1	26%
Monmouth	138	7.3	151	7.9	9%
Morris	80	5.5	91	5.7	3%
Ocean	144	8.6	167	9.4	10%
Passaic	90	6.1	104	6.8	10%
Salem	16	8.4	12	**	
Somerset	54	5.9	56	5.5	-6%
Sussex	33	7.4	48	11.2	52%
Union	86	5.2	86	5.3	1%
Warren	21	6.5	37	10.7	66%
Total*	1,759	6.6	1,978	7.2	9%

* Total 2003-2005 includes 4 suicides with unknown residence county. Total 2008- 2010 includes 6 suicides with unknown residence county.

** Rates not calculated for <20 observations.

Rates are per 100,000 population and are age-adjusted using the 2000 US Standard Population

Source: New Jersey Violent Death Reporting System v.05/09/2013, Center for Health Statistics, Office of Policy and Strategic Planning, Office of the Commissioner, New Jersey Department of Health, May 10, 2013

Risk Factor and Protective Factors for Suicidal Behavior

Identifying risk and protective factors is critical in suicide prevention. Many lists are available in the literature that summarize what makes it more likely (risk factors), or less likely (protective factors), that individuals will consider, attempt, or die by suicide. These factors can be fixed (historical/static factors) or modifiable (clinical/dynamic). Risk depends on the interaction and dynamics between historical, clinical and risk management factors not just the number of factors present.

The following are examples of each category and **are not exhaustive**:

RISK FACTORS

Historical/Static factors

- History, including family history of suicide attempt, suicidal gestures or ideation
- Mental illness (diagnosed or undiagnosed), especially mood and substance use disorders
- Gender, age
- LGBTQI (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex)
- History of trauma (PTSD) and traumatic events, including bullying
- Lack of Social Support, living alone, without a significant other
- Unemployment and/or decrease in social or economic status
- Significant disappointment by lover or spouse, family members
- Loss of a loved one, anniversary of important losses
- Struggle with cultural adjustment

Current Clinical/Dynamic risk factors

- Current suicidal ideation and/or intention to commit suicide with or without plan
- Availability of highly lethal methods
- Impulsivity
- Feelings of worthlessness, hopelessness or helplessness
- Serious medical problems/disabilities
- Severe psychic pain, anxious ruminations
- Insomnia
- Command hallucinations to hurt self or other delusions

PROTECTIVE FACTORS

- Reasons for living (meaning and future plans)
- Children/family/social supports and supportive community environment
- Moral/religious belief system
- Availability of physical and mental health care and substance use treatment
- Restrictions on lethal means of suicide
- Coping/Problem solving skills

New Jersey Adult Suicide Prevention Activities

Throughout 2011 and 2012, the NJ Youth Suicide Prevention Advisory Council advised the DHS-DMHAS and the Department of Children and Families (DCF) that the majority of calls originating in New Jersey to the National Suicide Prevention Lifeline were not being answered in NJ, but instead by Lifeline Crisis Centers located out-of-state.

In reaction to these concerns and P.L. 2011, C. 166, which required DCF and DHS to complete a study of the status of NJ-based suicide prevention hotlines, the DMHAS and DCF collaborated on a report to the NJ Legislature titled: "The Effectiveness and Sufficiency of Services Provided by NJ-based Suicide Prevention Hotlines". One of the chief findings in this report was that none of the five agencies (CONTACT of Burlington County, CONTACT of Mercer County, CONTACT We Care, Mental Health Association of New Jersey, University of Medicine & Dentistry of New Jersey---now Rutgers University, and University Behavioral Healthcare), which were certified by the National Suicide Prevention Lifeline program as Lifeline Crisis Centers, had the resources to provide 24/7 Lifeline services. Therefore, no Lifeline calls could be answered in State after 11p.m.

In December 2012, DMHAS issued a Request for Proposals (RFP) to "Implement a Statewide Suicide Prevention Hotline and Coordinate Call Response with the National Suicide Prevention Lifeline to Increase Suicide Prevention Efforts for Youth and Adults in NJ." The RFP made available $674,000 on an annual basis to one provider agency to develop a 24/7 hotline available for callers of any age (youth and adults). Following an intensive comparative review of all applicant proposals, a contract for this service was awarded to Rutgers University Behavioral Health Care. This service, now known as the NJ Hopeline, began operations on May 1, 2013 with promising outcomes. The calls are answered by a combination of trained volunteers, paid and volunteer peer positions with a minimum of one clinician supervisor per work shift. The Hopeline staff provide follow up calls and are able to "warm transfer" emergency calls to emergency service providers. The service also includes the capability to handle text messaging and live chat.

Education on the recognition of at-risk behavior and the delivery of effective clinical treatment to reduce suicide attempts and suicide was assessed as a critical need. Actions already taken involved training for mental health and addiction treatment staff in the use of the Columbia-Suicide Severity Rating Scale (C-SSRS) by Dr. Kelly Posner, PhD. Dr. Posner provided four, half-day training sessions in May 2012 with a total of 319 people from all areas of the State. The audience included psychiatric emergency service screeners, mental health (both adult and child) clinicians, school-based personnel and state officials.

In addition, in September and October 2012, in coordination with the US Substance Abuse and Mental Health Services Administration's (SAMHSA) administrative staff, DMHAS was able to schedule and provide 48 individuals with Mental Health First Aid Training utilizing our State hospitals as training locations.

Two New Jersey schools were awarded Garrett Lee Smith Grants to reduce youth suicide. DMHAS has begun coordinating suicide prevention efforts with UMDNJ-TLC (Traumatic Loss Coalitions) and Monmouth University. The TLC will be concentrating their activities in six counties (2 each year): Camden and Monmouth the first year; Bergen and Passaic the second year; and Hudson and Middlesex the last year; targeting youths from age 10-24 years of age. Monmouth University's focus is on promoting wellness and resiliency on their campus. DMHAS will assist in coordinating with service providers in our systems of care and linking them to specific training opportunities provided through Garrett Lee Smith Grant Awards. We plan to continue such efforts with any new Garrett Lee Smith award recipients in New Jersey.

On May 3, 2013, DMHAS staff met with DOH staff and the Assistant State Medical Examiner (in charge) to review and discuss ways to improve our collaboration regarding suicide data and suicide prevention efforts. By state law, the DOH is responsible for collecting data on suicide attempts and completions throughout the state. The DOH is also a member of the National Violent Death Reporting System coordinated by the CDC. All participants agreed this was a positive step and will continue to meet on a quarterly basis to ensure ongoing collaborative efforts among the Departments.

A recent CDC-funded initiative: the Injury Control Research Center for Suicide Prevention (ICRC-S) focuses on a public health approach to suicide research and suicide prevention. The University of Rochester was awarded a five-year grant to establish an ICRC-S. Rochester's center is one of only 11 in the country funded by the CDC. It also is the only one focused primarily on suicide prevention. The University of Rochester has partnered with the Education Development Center, Inc. (EDC) for this ICRC-S. The ICRC-S is designed to serve as a catalytic role in the northeastern regions, and nationally, promoting public health approaches that will reduce the mortality and morbidity associated with suicide and attempted suicide. In May of 2013 DMHAS appointed an "injury control officer" to represent New Jersey in this collaborative community and to participate in their first initiative of a Research Training Institute (RTI). The purpose of this was to learn about the shared body of knowledge and skills in suicidology, public health and prevention, as well as relevant research methodologies. This collaboration is a work in progress with promising outcomes.

DMHAS has recently funded and contracted for the development of three Peer Respite Centers, one in each of the 3 regions of the state. Half of the staff members at these Peer Operated Respite Centers must be peer providers. There are five respite beds at each site and the individual respites will function as a treatment alternative for consumers who may be experiencing a psychiatric crisis and not wanting/needing inpatient hospitalization or other traditional mental health services. The average length of stay will be 7-14 days, with the expectation that the consumers will be able maintain safety during their brief stay at the Peer Respite Center. The sites will link consumers to community Self-help Centers and other supportive care resources in their community.

On June 27, 2013, the Commissioners of the DHS and the Department of Transportation and the Executive Director of NJ Transit met at the Trenton Rail Transportation Center to publicly announce a collaborative effort to prevent suicides by train throughout the state. NJ

Transit also unveiled a new poster that listed the call number 855-NJ HOPEL (654-6735) for the NJ Hopeline 24/7 statewide suicide prevention hotline. NJ Transit has placed a NJ Hopeline poster at every NJ Transit station in New Jersey.

The Mental Health Association of New Jersey's (MHA-NJ) Peer Recovery WarmLine is a statewide, toll-free line operated 365 days per year to assist individuals during times of need or concern, as well as at any point to further their mental health wellness and recovery. All calls are answered by trained, supportive mental health consumers with the goal of getting to know the caller – how they view themselves, understand their situation, and see the world around them. The WarmLine received national recognition in 2012 as a recipient of the Innovative Program of the Year from Mental Health America. The Peer Recovery WarmLine answered 12,265 calls in 2012.

DMHAS is moving towards a 'trauma informed system of care', in which all mental health and addiction services (assessing, treating or support services) will consider whether individuals have experienced trauma and will intervene to ameliorate its effects.

At present, task force and work groups are forming to develop policies and action steps for this goal. As part of these initiatives, DMHAS is providing Mental Health First Aid training throughout the State which will raise awareness that trauma is one of the risk factors for suicidal behaviors and provide response interventions.

NJ Adult Suicide Prevention Plan Goals

1. Promote **awareness** that suicide is a public health problem that is preventable.

2. Develop **broad-based support** for suicide prevention.

3. Improve and expand **surveillance systems.**

4. Develop and implement strategies to **reduce the stigma** associated with being a consumer of mental health, substance use and suicide prevention services.

5. Strengthen and expand **community-based suicide prevention** and postvention programs.

6. Implement **education** for **recognition** of at-risk behavior and delivery of effective treatment.

7. Develop and promote effective **clinical practices** to reduce suicide attempts and suicide.

8. Improve **access to community services** for persons with mental health and substance use disorders.

9. **Improve media reporting and the depiction** of suicide, suicidal behavior, mental illness and substance use in the electronic and print formats.

10. Promote and support **research** on adult suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Goal #1:

Promote awareness that suicide is a public health problem that is preventable.

Rationale

There are many ways to address the common social, emotional, environmental and health factors related to suicide and suicide risk. By educating the community at large about suicide, the risk and protective factors, we would be more effective in preventing suicide.

Objectives:

1.1 Advocate for significantly reduced rates of adult suicidality among health care and community support systems that provide services and support to individuals at risk for suicide in the State.

1.2 Continue to develop and implement a public information strategy that explains that suicide is preventable and is related to mental health, substance use and other at-risk factors.

1.3 Implement a public information campaign designed to reduce accessibility of lethal means used to commit suicide.

1.4 Establish effective and sustainable programs for suicide prevention by fostering collaboration among providers of the Division of Mental Health and Addiction Services (DMHAS) and other state departments and divisions, social and other media, community-based organizations, stakeholders and the general public.

1.5 Increase the number and quality of public and private agencies that are involved in collaborative and complementary dissemination of current suicide prevention information.

Goal #2:

Develop broad-based support for suicide prevention.

Rationale

Since the cause of suicide is complex, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups –from schools to faith-based organizations to health care associations –is necessary to ensure that prevention efforts are comprehensive and effective.

Objectives:

2.1 Organize a State interagency committee involved with the coordination and implementation of the New Jersey Adult Suicide Prevention Plan.

2.2 Establish public and private partnerships dedicated to implementing the New Jersey Adult Suicide Prevention Plan.

2.3 Increase the number of state and local agencies, professional (including primary care), volunteer, faith-based communities and other groups that integrate suicide prevention activities into their ongoing activities.

2.4 Promote access to materials such as monographs, periodicals, videos, outreach posters, information pamphlets, electronic communication and related materials on suicide prevention for New Jersey residents.

2.5 Educate and seek out the support of policymakers with dedicated communication efforts.

Goal #3:

Improve and expand surveillance systems.

Rationale

Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. These systems are used to track trends, identify new problems, provide evidence to support activities and initiatives, and identify risk and protective factors. Data provides information about the factors associated with of suicide and who —by gender, age, race, and location - is statistically most at risk. Such data enables us to target high risk populations for program interventions more precisely and increase the likelihood of their effectiveness.

Objectives:

3.1. Work collaboratively with the Department of Health (DOH)—Center for Health Statistics, Office of Policy and Strategic Planning and the Office of the State Medical Examiner regarding suicide and suicide attempt data.

3.2 Improve coordination of data collection regarding suicide investigations with state, local agencies, and their partners.

3.3 Establish a mechanism for systematic collection and analysis of suicide attempt data.

3.4 Publish an annual report on suicides in New Jersey integrating data from multiple state data management systems.

Goal #4:

Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance use and suicide prevention services.

Rationale

Destigmatizing mental illness and substance use disorders can improve access to treatment by reducing barriers, integrating care and increasing the willingness of individuals to seek treatment. "Normalizing" mental health and substance use can change public perception, convey the benefits of prevention among both stakeholders and the general public. Identifying and engaging all target audiences in the effort to reduce stigma also helps to establish a level of community connectedness where every person in the community can become an "anti-stigma ambassador".

Objective:

4.1 Increase coordination among state agencies and entities such as DHS, DCF, DOH, Department of Education, DMHAS, the Division of Aging Services, the Governor's Council on Mental Health Stigma, the Governor's Council on Alcoholism and Drug Abuse, professional groups, associations and individuals to address the issue of stigma associated with using mental health and substance use services.

4.2 Change public attitudes to understand mental health and substance use disorders as real illnesses equal to physical illness, that respond to specific treatments and to view persons who obtain treatment, as pursuing basic health care.

Goal # 5:

Strengthen and expand community-based suicide prevention and postvention programs.

Rationale

Effective suicide prevention, intervention and postvention strategies are based on a public health approach and require a broad-based community commitment. Although there is not one "suicide type," there are adults who are at a higher risk based on particular risk factors. To help adults in need, community professionals and organizations must mobilize resources, identify risk and protective factors, and bring focused attention to the issue of suicide.

Rigorous evaluations for measuring effectiveness are needed as evidence-based programs are developed and implemented. The science of suicide prevention is still developing. Therefore, emerging strategies, promising practices, and other approaches, with a foundation based in best practices may be used in addition to existing evidence-based strategies.

Objectives:

5.1 Increase the number of behavioral health providers and local communities with comprehensive suicide prevention plans.

5.2 Expand and improve training in suicide prevention to increase knowledge regarding evidence based practices and best practices for suicide prevention, intervention and postvention for schools, colleges and universities, work sites, correctional institutions, aging programs, family and community-based organizations.

5.3 Improve coordination with cultural and faith-based entities to share resources and information on suicide prevention and postvention.

5.4 Gear specific suicide prevention and postvention efforts towards higher risk populations such as individuals with mental illness, severe medical conditions, individuals involved in non-suicidal self-injuries, college students, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex populations, men in mid-life, older adults, immigrants, non-English speaking adults, individuals who are deaf and hard of hearing, persons addicted to and/or abusing substances, individuals with gambling addictions, adults affected by trauma (including veterans), and adults in the correctional system and other out-of-home settings.

5.5 In coordination with the DMHAS' Disaster and Terrorism Branch, mobilize available resources to communities and/or individuals negatively affected by natural and/or man-made disasters and terroristic attacks (e.g., 9/11, hurricanes, flooding, fire).

Goal # 6:

Implement education for recognition of at-risk behavior and delivery of effective treatment.

Rationale

Suicide risk often can go undetected. Thus, clinicians who treat individuals at risk for suicide require ongoing professional development and training in the growing body of suicide evaluation and treatment. Health professionals could benefit from additional training on the proper assessment, treatment and management of suicidal patients. Education on the proper screening and recognition of risk factors, such as depression and substance use, could facilitate a decrease in the number of suicides by expediting individuals' referrals for treatment. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Objectives:

6.1 Provide training to mental health and substance use providers on the recognition, assessment, and management of at-risk behavior, identification of persons at risk and delivery of effective clinical care for people with suicide risk; including referral to community-based services.

6.2 Improve and provide education for physicians, primary care physicians, physician assistants, nurse practitioners, nurses, social workers, psychologists, counselors and other primary care providers on the identification of depression and substance use and their relationship to suicide risk.

6.3 Provide education for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide.

6.4 Provide educational programs for family members of persons at evaluated to be at risk.

Goal # 7:

Develop and promote effective clinical practices in the least restrictive setting to reduce suicide attempts and suicide.

Rationale

Clinical judgment and practice methods improve when structured and anchored by research findings. Gathering, disseminating and promoting the latest research-based knowledge to professionals will ensure that they are equipped to properly treat individuals who present as a risk to self. Research that identifies risk factors for suicide and related treatment approaches should be promptly implemented and utilized. Such research must address group and individual characteristics, as well as environmental and situational factors. Clinical and professional practices, informed by evidenced-based practices, will improve clinical decision making, thereby lead to a reduction of suicide attempts and completions.

Objectives:

7.1 Implement and promote evidence-based, best practice guidelines and uniform procedures and/or policies across all settings that provide services to consumers with mental health and substance use disorders on suicide prevention, assessment and treatment of suicidality.

7.2 Encourage all New Jersey suicide prevention programs to review and implement evidence-based or best-practices; including an evaluation component that demonstrates outcome effectiveness.

7.3 Incorporate depression and suicide-risk screening in primary care with appropriate mental health and substance use referrals as needed.

7.4 Promote the use of evidence-based tools for screening, assessment, diagnosis and treatment of persons with mental health and substance use disorders; including the assessment of lethal means in the home.

7.5 Ensure that people who are treated in emergency departments for suicide attempts, trauma, sexual assault, or physical abuse also receive mental health services.

7.6 Foster suicide-risk education for family members and significant others of people receiving care for the treatment of mental health and substance use disorders.

7.7 Ensure that individuals (e.g., emergency medical technicians, firefighters, police and funeral directors) who typically interface with suicide survivors (significant others, family, friends, etc.) are educated to understand and respond appropriately to their unique needs.

7.8 Educate health care providers and health and safety officials on the assessment of lethal means in the home and the appropriate actions to reduce suicide risk.

Goal # 8:

Improve access to community services for persons with mental health and substance use disorders.

Rationale

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having adequate health insurance or not having the financial capacity to pay for services outside of a health plan or insurance plan. Structural barriers refer to a lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers may be caused by cultural or spiritual differences, language difficulties, not knowing when or how to seek care, as well as concerns about confidentiality or discrimination. The transition of Medicaid expansion and new Marketplace opportunities may reduce such barriers. The easier and more acceptable it is to seek and receive treatment for mental health and substance use, the more likely it is that people will do so. With timely and appropriate treatment and social services, most people can recover and rebuild healthy productive lives.

Objectives:

8.1 Identify, address and overcome barriers to access mental health and substance use services.

8.2 Work with all appropriate state departments and health and social services outreach programs for at-risk populations to increase access to an integrated network of effective, efficient, culturally competent and linguistically accessible mental health and substance use services; including suicide prevention and treatment services.

8.3 Increase community awareness of culturally competent and linguistically relevant mental health and substance use services.

8.4 Define and implement screening guidelines, along with guidelines on linkages with service providers, for schools, colleges, correctional institutions, and primary care sites.

8.5 Implement support programs for persons who have survived the suicide of someone close.

8.6 Continue to promote and enhance the NJ Suicide Prevention HOPELINE.

8.7 Encourage all DMHAS contracted agencies to promote NJ Mental Health Cares and 211 as resources for families seeking mental health and addiction services.

8.8 Improve access to mental health and substance use treatment via linkage and referral.

Goal # 9:

Improve media reporting and the depiction of suicide, suicidal behavior, mental illness and substance use in the electronic and print formats.

Rationale

Changing media representation of suicide, suicidal behavior, mental illness and substance use is one of several strategies needed to reduce the suicide rate. The way that suicide is depicted in the media is particularly important. The media can play a positive role in suicide prevention by creating the kind of long-lasting culture change that makes suicide prevention universally relevant, relatable and attainable.

Objectives:

9.1 Disseminate information on nationally recognized guidelines for media reporting about suicide with an effort to reduce the stigma and prevent future suicides.

9.2 Utilize the nationally recognized guidelines outlined in the "Reporting on Suicide: Recommendations for the Media" (Annenberg Public Policy Center, 2001) and Suicide Prevention Resource Centers' "At a Glance: Safe Reporting on Suicide" for reporting on suicide.

9.3 Utilize local experts on suicide and suicide prevention for consultation and training with the media and academic programs in journalism.

9.4 Work with New Jersey academic journalism and film programs to include guidance on the appropriate depiction and reporting of mental illness, suicide and self-injury in their curricula.

Goal # 10:

Promote and support research on adult suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Rationale

Suicide is a widely recognized public health problem. As a result, it has been researched extensively. In recent decades, this research has yielded findings that have informed public education efforts, affected clinical practice and, ultimately, permitted individuals to access pertinent services in times of urgent need. Continued research into the complexities of suicide is needed to promote effective clinical practice, public health efforts and prevention strategies.

Objectives:

10.1 Encourage mental health and substance use providers to apply for grant funding and actively participate in research on suicide prevention.

10.2 Encourage all mental health and substance use agencies to stay abreast of the newest research findings related to assessment and treatment of suicidality and implementation of suicide prevention strategies.

10.3 Promote ongoing statewide dissemination of evidence-based suicide prevention models and strategies for suicide prevention.

This section to be developed at a later date after input from key stakeholders and will be included as an addendum to this plan

Suicide Prevention Plan Monitoring and Evaluation

This section to be developed at a later date after input from key stakeholders and will be included as an addendum to this plan

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