THE SUICIDE PREVENTION PLAN *for* OHIO

2020 – 2022

OHIO'S VOICE FOR SUICIDE PREVENTION

OSPF
Ohio Suicide Prevention Foundation
OhioSPF.org

Letter from the OSPF Director

OSPF
Ohio Suicide Prevention Foundation
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Dear Friend,

The word "community" has two definitions. The first definition reads, "a group of people living in the same place or having a particular characteristic in common," and centers on the geography of people. The second definition of community is the one that tells a much better story. It defines community as, "a feeling of fellowship with others, as a result of sharing common attitudes, interests, and goals." This definition gives one a sense of the flavor of what makes a community such a special group to belong. This calls into play that there are shared goals which, in turn, invokes shared responsibility, inviting each person and organization to not only strive for the goal, but also to be entrusted with the individual responsibility so that the community can achieve the desired goal.

The Suicide Prevention Plan for Ohio yearns to work with that latter definition of community – creating the common community goal to prevent suicide and save lives by each person and organization sharing responsibility for the community's goal. The plan was created so that all communities can see their role in it and, at the same time, suggests specific goals to give definitive benchmarks to a community. The Suicide Prevention Plan for Ohio was created to promote local collaboration among groups, including healthcare, schools, workplaces, local ADAMH Boards, individuals with lived experience, families who have lost someone to suicide and others, focused on preventing suicide. Careful consideration was taken as the plan was created to ensure that it is inclusive and could be applied across multiple sectors of any community. As more community partners collaborate to prevent suicide, this also helps break down the wall of stigma that surrounds the subject of suicide.

The Ohio Suicide Prevention Foundation thanks all community partners in the valuable work that is being done to reduce suicides in Ohio and create communities that are caring and healthy for all people.

Sincerely,

Tony Coder
Executive Director

Letter from the Governor

Dear Fellow Ohioans,

Suicide is devastating for those left behind, including family members, loved ones, friends, and communities.

The suicide rate in Ohio has increased over the past decade, and on average, five Ohioans take their own lives each day, according to the Ohio Department of Health.

Moments after taking the oath of office, my first action as Governor was to create the RecoveryOhio initiative to ensure that we act aggressively to address the crises of substance use disorder and mental illness and to invest in the health and wellness of Ohio's citizens.

To enhance our understanding of the situation, I created and convened the RecoveryOhio Advisory Council, a group made up of leaders with diverse personal and professional backgrounds.

At the onset, I asked the council to provide suggestions on how to improve mental health and substance use prevention, treatment, and recovery support services in Ohio. The resulting "RecoveryOhio Advisory Council Initial Report," published in March, laid out the recommendations that provide the framework for the efforts we are now undertaking.

Today, we are pleased to announce the publication of an important resource to save lives: The Ohio Suicide Prevention Foundation's "Suicide Prevention Plan for Ohio." The document presents a strategy that will guide Ohio's efforts for suicide prevention.

The plan was created by a geographically and culturally diverse 33-member writing team of Ohioans from the public and private sector who have professional and personal experience with suicide. Under the direction of the Ohio Suicide Prevention Foundation, the team's dedication and hard work has resulted in a plan that considers the role each of us must play in preventing suicide until not one life is lost.

Very respectfully yours,

Mike DeWine

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Executive Summary

The *Suicide Prevention Plan for Ohio* is the result of a statewide effort to guide Ohio's suicide prevention efforts. Diverse stakeholders partnered, with the support of Ohio Governor Mike DeWine, with state and county agencies, private providers, philanthropic entities, local coalitions, and advocacy voices – most importantly those of families and suicide survivors – to craft a plan to mobilize and align efforts to prevent suicide.

The resulting plan sets out actions to be implemented over the next three years. While focused, the plan will remain dynamic going forward. As policies or other operating conditions change, and as results indicate where adjustments may be needed, planners will stand ready to adapt and edit goals, objectives, and action steps to prevent suicide.

The plan directs energy, focus, and resources to attaining its vision and outcomes by implementing specific goals and objectives. The objectives identified in the plan were informed by data, evidence-based approaches, and lessons learned from current practice. Any suicide prevention strategy not specifically called out in the plan or listed as part of a goal workplan also remains important to an overall initiative that blankets Ohio. As a collective impact effort, asking everyone involved in preventing suicide to focus on priority strategies will help to achieve the overall, shared vision of reducing the number of suicides every year until not one life is lost.

The following pages summarize the Ohio Suicide Prevention Strategic Plan. The final plan delineates its core assumptions, vision statement, target outcomes and five priority strategies with associated goals, objectives, and performance measures.

Ohio Suicide Prevention Strategic Plan Jan. 29, 2020–Dec. 31, 2022

Vision

Ohio will reduce the number of suicides every year until not one life is lost.

Intended Outcomes

Reduction in suicidality:

- Fewer number of suicides – decrease by 10% over three years.
- Fewer number of attempted suicides.
- Improved identification of those thinking of suicide.

Core Assumptions

1. Suicide is a public health issue. Ohio will:
   - Work together to prevent suicide.
   - Implement universal, selective, and indicated prevention as part of a comprehensive approach.
   - Focus on those with elevated suicide risk factors.
   - Identify and address barriers to competent suicide care.
   - Ensure suicide care is accessible and effective.
   - Promote postvention as a vital part of suicide prevention.

2. Interventions and approaches will be data and research-driven and culturally appropriate.

3. Ohio will increase public awareness about suicide and provide tools for responding effectively.

4. Stengthen the knowledge and skills of Ohio's workforce in identifying individuals at risk for suicide and intervening.

5. Substantial resources are necessary for a sustained effort to effectively decrease the suicide rate.

6. Stigma reduction through culture change will make a positive impact on suicide prevention.

7. Suicide prevention and postvention efforts must be evaluated for efficacy, impact, and continuous improvement through accurate data collection and analysis.

8. All efforts will be considered through a health-equity lens.

National Strategic Direction

1. Healthy and empowered individuals, families, and communities.
2. Clinical and community prevention strategies.
3. Treatment and support services.
4. Surveillance, research and evaluation.

Ohio Strategies

1. All Ohioans will recognize the warning signs and risk factors of suicide and respond appropriately.

2. Ohio will concentrate efforts on integrating suicide prevention practices and suicide care, including postvention, into high-impact systems, including health care, public safety, and education.

3. Ohio will build suicide prevention capacity and infrastructure at the organizational, local, and state levels.

4. Ohio will concentrate prevention efforts on groups identified by data as those with a higher rate of suicide, including:
   - Youth, ages 10-24
   - Males, ages 25-59
   - Veterans and military members
   - Residents of highest-risk Appalachian counties
   - Community population focus as identified by local data

5. Ohio will standardize, gather and utilize data to continuously inform and evaluate its approach.

Drivers for Strategy Goal Selection

To have maximum impact, Ohio's suicide prevention resources must be deployed to:

- Work hardest where the need is greatest.
- Capitalize on national and state trends and opportunities.
- Emphasize what works.

GOALS

Strategy 1

All Ohioans will recognize the warning signs and risk factors of suicide and respond appropriately.

Goals

1. Strengthen the public's knowledge and ability to promote wellness, recognize suicide risk, and take appropriate action for self and others.
2. Provide training to community groups, families, and other individuals in a person's support system on the prevention of suicide and related behaviors.
3. Encourage safe storage of firearms, medication, and other lethal means.

Strategy 2

Ohio will concentrate efforts on integrating suicide prevention practices and suicide care, including postvention, into high-impact systems including health care, public safety, and education.

Goals

1. Integrate suicide-specific care across health care, behavioral healthcare and addiction treatment organizations.
2. Provide training to clinical and social service providers on the prevention of suicide and other related behaviors.
3. Integrate suicide prevention best practices and suicide-specific care across educational systems, including Educational Service Centers.
4. Integrate suicide prevention best practices and suicide care across the public safety and emergency systems.

Strategy 3

Ohio will build suicide prevention capacity and infrastructure at the organizational, local, and state levels.

Goals

1. Increase the number of suicide prevention coalitions aligned with the Centers for Disease Control and Prevention's (CDC) seven strategies for preventing suicide.
2. Assess and strengthen postvention programs in local communities.
3. Increase understanding of the function and capacity of local Fatality Review Boards.
4. Explore opportunities to build capacity that addresses identified social determinants, barriers to care, and factors that contribute to the suicide rate.

Strategy 4

Ohio will concentrate prevention efforts on groups that current data has identified as being high risk for suicide, including:

- Youth, ages 10-24
- Males, ages 25-59
- Veterans and military members
- Residents of highest-risk Appalachian counties
- Community population focus as identified by local data

Goals

1. State government will prioritize its suicide prevention resource allocations and program actions toward target groups and encourage its partners to do the same.

Strategy 5

Ohio will standardize, gather, and utilize data to continuously inform and evaluate its approach.

Goals

1. Refine data systems, including collection and evaluation.
2. Improve data dissemination and public access to data.

The Approach to Developing the *Suicide Prevention Plan for Ohio*

In the summer of 2019, the Ohio Suicide Prevention Foundation (OSPF) initiated a statewide effort to develop a three-year strategic plan to guide Ohio's efforts for suicide prevention. A diverse group of stakeholders created a strong partnership for planning. Ohio Governor Mike DeWine has embraced this effort and committed staff, and resources to suicide prevention.

A 33-member planning team met several times to develop The Suicide Prevention Plan for Ohio. The team represented subject-matter experts, service sector, and regions. State and county agencies, private providers, philanthropic entities, local coalitions, and advocacy voices – most importantly those of families and suicide survivors – came together to craft a plan to mobilize and align efforts to prevent suicide.

The team was advised by formal and informal stakeholder feedback and expert consultation. The resulting plan sets out actions to be implemented over the next three years. While focused, the plan will remain dynamic going forward. As policies or other operating conditions change, and as results indicate where adjustments may be needed, planners will stand ready to update goals, objectives, and action steps to prevent suicide.

To launch the planning team, a set of guidelines was developed to lead discussion and look at strategies that have been utilized nationally and in Ohio to reduce suicide-related morbidity and mortality. The Ohio Suicide Prevention Foundation, in collaboration with a national expert in suicide prevention, Mike Hogan, Ph.D., helped guide planners to develop strategies driven by the need to:

- Work the hardest where the need is greatest.
- Capitalize on national and state trends and opportunities.
- Emphasize what works.

In Ohio and across the nation, as awareness increases within systems of physical and behavioral health care, providers are beginning to incorporate mental wellness and suicide prevention into standard care delivery. Planners examined programs and practices that are demonstrating efficacy and that generate momentum for broader commitment to emerging and best practices and the evaluations of outcomes. Ohio's history of stakeholder advocacy, grassroots coalitions, professional activism, philanthropic generosity, as well as state support in launching the first-of-its-kind, stand-alone, non-profit Ohio Suicide Prevention Foundation,

demonstrates that Ohioans believe in seizing any and all opportunities to raise public awareness and spur action.

On an issue as important as suicide prevention—especially when available funds are limited compared to fighting other leading causes of death—a strong focus on what works is essential. Suicide prevention was not a formal priority and obligation of health care organizations just a decade ago, but research over the past 15 years has now established the effectiveness of screening, targeted brief interventions, and treatments to prevent suicide.

Widely used suicide prevention initiatives require modification and updates to line up with new evidence and research. It must be noted that suicide prevention resources and programs nationally have been modestly funded.

Planning team meetings featured discussions informed by data analysis, evidence-based approaches, and lessons learned from current practices to create a plan with shared, collective support. The final plan delineates core assumptions, a vision, target outcomes, and five priority strategies with associated goals, objectives, and performance measures.

The strategies identified in the plan are important and strategic to bring necessary movement to this crucial public health issue. Nonetheless, the planning team recognizes that overall suicide prevention efforts radiate beyond listed priorities in any plan. Knowing this, the planning team strongly acknowledges that any suicide prevention strategy not specifically identified in the plan or listed as a part of a goal workplan also remains important to an overall initiative that blankets Ohio. As a collective impact effort, planners ask everyone involved in preventing suicide to align behind the identified priority strategies and to amplify other localized strategies to achieve the overall, shared vision of reducing the number of suicides every year until not one life is lost.

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Suicide in Ohio: An Overview of Suicide's Impact

In Ohio, approximately five people a day - family, neighbors, friends and loved ones - die by suicide. Ohioans may struggle with stress, mental illness, and/or thoughts of suicide, but often these struggles are not recognized in time for a life to be saved. Suicide is a public health issue that requires solutions that are based on effective strategies to increase protection of and care for those who are struggling with suicidal thoughts.

The suicide rate has increased over the past decade nationally and in Ohio. According to the Ohio Department of Health, the number of suicides has increased 44.8% between 2007 and 2018, 8 out of the 10 Ohio counties with the highest suicide rate are in Appalachia. Nearly 80% of suicide deaths are male. Suicide among veterans is also a concern, as Ohio has the sixth-largest veteran population in the nation, and veterans have a higher rate of suicide compared to the general population. Among youth, suicide is the leading cause of death for Ohioans 10-14 years of age and the second-leading cause of death for Ohioans who are 15-24 years old.

People who are struggling are often afraid to reach out because of fear of judgment. It is important that society addresses suicidality in the same way we talk about physical illness. The purpose of The Suicide Prevention Plan for Ohio is to reduce stigma, increase knowledge, enhance health care's role in prevention and mobilize community efforts to prevent suicide. Ohio must recognize that suicide is a health issue that can largely be prevented. The vision of this plan is that Ohio will reduce the number of suicides every year until not one life is lost.

RecoveryOhio and the Suicide Prevention Plan for Ohio

In 2019, Ohio Governor Mike DeWine introduced his RecoveryOhio initiative to aggressively address mental health, suicide, substance use disorders, and the stigma surrounding them. The RecoveryOhio Advisory Council developed initial recommendations that provide a summary of the current state of Ohio's public health crisis and offer advice on the next steps needed to address it. The RecoveryOhio Initial Report offers 75 recommendations including ways to address the following specific issues related to suicide:

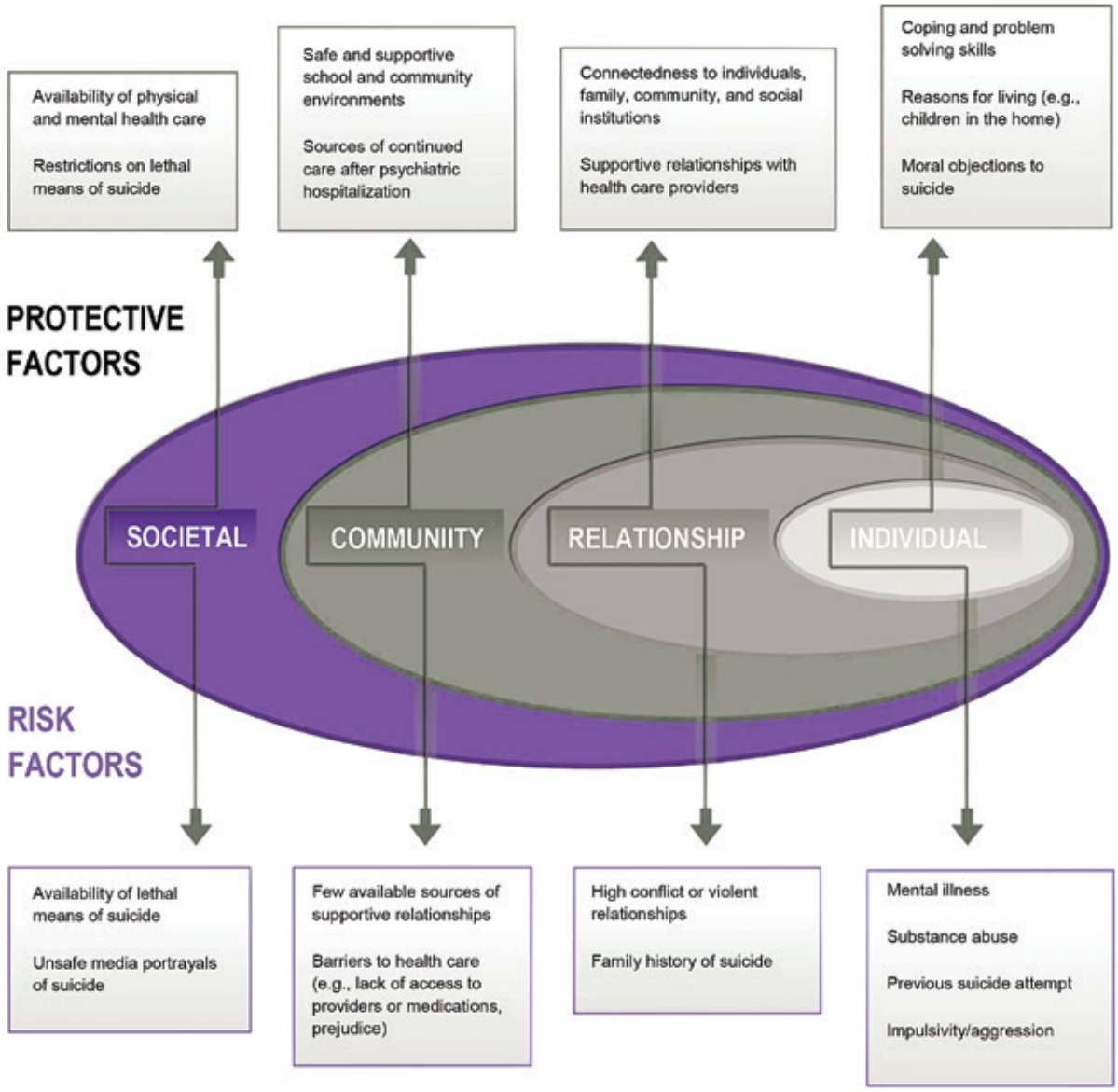
- How the state could best provide high-quality prevention and early intervention programming in communities and schools.
- How to improve access to treatment services in Ohio for mental health and substance use disorders.
- Recovery support strategies as foundations for wellness, including, but not limited to, peer support, employment, and housing.
- Improving the quality of care provided for mental health and substance use disorders in the community and in health care and criminal justice settings.
- How to create efficiencies across systems among, for example, state psychiatric hospitals, private hospitals, criminal justice settings, treatment facilities, recovery support programs, and in businesses so that Ohioans receive coordinated care and support that reduces duplication in service delivery and encourages quality care and outcomes.
- Providing service in a culturally competent way, and addressing underserved populations including, but not limited to, the need for:
  - Acute mental health care services for youth.
  - Care that addresses the distinct needs of families impacted by mental illness and addiction.
  - Care that focuses on the unique needs of older adults.
  - Care that focuses on the unique needs of veterans.
- What critical outcomes can be measured to improve Ohio's system of mental health and addiction services.
- How federal, state, and local resources can be better coordinated or redirected to meet the needs of Ohioans.
- Considerations for the state budget.

The Suicide Prevention Plan for Ohio looks to advance the RecoveryOhio mission to make a difference in the lives of Ohioans struggling with mental illness and suicide.

With nearly one in five adults in Ohio affected by a mental health disorder and five people dying by suicide every day, now is the time for action.[i] Ohio is dedicated to becoming a leader in suicide prevention. The Suicide Prevention Plan of Ohio planning team and dedicated stakeholders are ready to further the conversations Ohioans are having about suicide – to change the culture, improve help-seeking, and save lives.

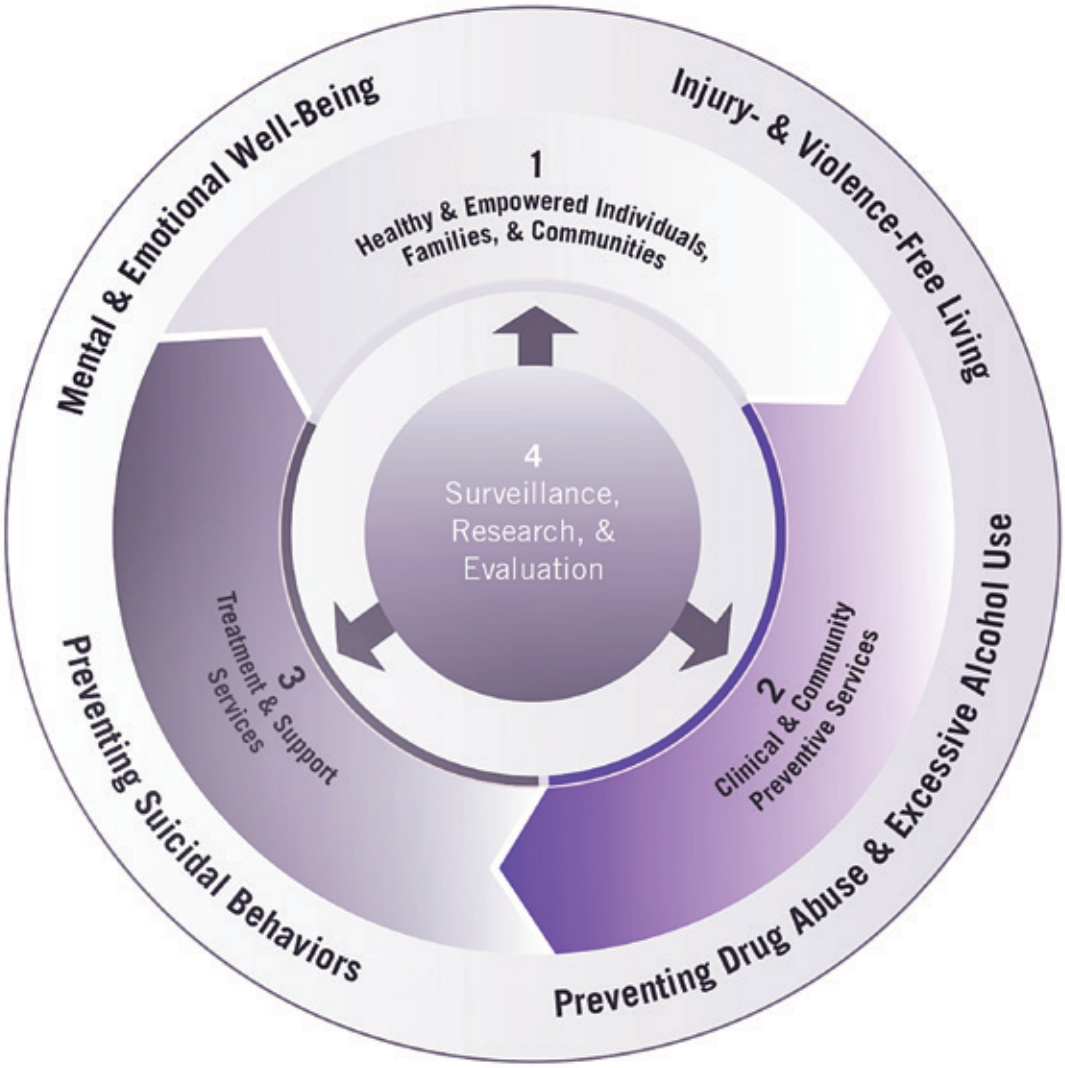
Risk and Protective Factors for Suicide

There are many things that can contribute to someone's risk for suicide. These factors are environmental, societal, biochemical, and situational. These can include Adverse Childhood Experiences (ACE), substance use, poverty, untreated mental illness, and financial difficulties. Risk factors can be balanced out to a certain degree by the presence of protective factors. Protective factors promote strength and resilience and ensure that vulnerable individuals are supported and connected with others, making suicide behaviors less likely.[ii]



Converting the National Strategy to Ohio's State and Local Efforts

In 2012, then U.S. Surgeon General Regina M. Benjamin and the National Action Alliance for Suicide Prevention developed the National Strategy for Suicide Prevention [iii] to address the emotional and financial impact that suicide has on the country. The plan is divided into four sections critical to preventing suicide, and Ohio planners reviewed and incorporated many of the national strategies and associated goals into *The Suicide Prevention Plan for Ohio*. Learn more about the National Strategy for Suicide Prevention.[iv]



The Plan

Vision

Ohio will reduce the number of suicides every year until not one life is lost.

Intended Outcomes

Reduction in suicidality:

- Fewer number of suicides – decrease by 10% over three years.
- Fewer number of attempted suicides.
- Improved identification of those thinking of suicide.

Core Assumptions

1. Suicide is a public health issue. Ohio will:
   - Work together to prevent suicide.
   - Implement universal, selective, and indicated prevention as part of a comprehensive approach.
   - Focus on those with elevated suicide risk factors.
   - Identify and address barriers to competent suicide care.
   - Ensure suicide care is accessible and effective.
   - Promote postvention as a vital part of suicide prevention.

2. Interventions and approaches will be data and research-driven and culturally appropriate.

3. Ohio will increase public awareness about suicide and provide tools for responding effectively.

4. Stengthen the knowledge and skills of Ohio's workforce in identifying individuals at risk for suicide and intervening.

5. Substantial resources are necessary for a sustained effort to effectively decrease the suicide rate.

6. Stigma reduction through culture change will make a positive impact on suicide prevention.

7. Suicide prevention and postvention efforts must be evaluated for efficacy, impact, and continuous improvement through accurate data collection and analysis.

8. All efforts will be considered through a health-equity lens.

Priority Strategies

1. All Ohioans will recognize the warning signs and risk factors of suicide and respond appropriately.

2. Ohio will concentrate efforts on integrating suicide prevention practices and suicide care, including postvention, into high-impact systems, including health care, public safety, and education.

3. Ohio will build suicide prevention capacity and infrastructure at the organizational, local, and state levels.

4. Ohio will concentrate prevention efforts on groups identified by data as those with a higher rate of suicide, including:
   - Youth, ages 10-24
   - Males, ages 25-59
   - Veterans and military members
   - Residents of highest-risk Appalachian counties
   - Community population focus as identified by local data

5. Ohio will standardize, gather, and utilize data to continuously inform and evaluate its approach.

Strategy 1

All Ohioans will recognize the warning signs and risk factors of suicide and respond appropriately.

Suicide is a public health crisis. All Ohioans must work together to prevent suicide. To that end, Strategy One seeks to mobilize the public to better identify individuals at risk for suicide, to know who to call for help, and to know what they can do to be supportive. This requires a coordinated, multi-platform public education and awareness campaign. A campaign like this could improve knowledge and self-efficacy in helping to reduce stigma and increase help-seeking among Ohio residents.

Additionally, targeted education and awareness training must be available to those with close access to a person at risk of suicide. These individuals, often referred to as "gatekeepers," can help ensure that individuals who may be at risk can be linked to care. For example, those who have contact with children in school, those who work with veterans, first responders, social workers, emergency department personnel, those who sell firearms, and peers.

Goal 1

Strengthen the public's knowledge and ability to promote wellness, recognize suicide risk and take appropriate action for self and others.

Objective

- Implement a suicide prevention awareness campaign that will resonate with target groups, their communities, and their support systems including youth, families, friends, and colleagues.
- Promote responsible media reporting of suicide that includes accurate portrayals of suicide and mental illness along with safe online content related to suicide.
- Ensure that public awareness campaigns include promotion of healthy lifestyles and community connections.
- Increase the number of family members who have access to education and information pertaining to:
  - Available resources.
  - How to access training.
  - How to reduce access to lethal means.

Goal 2

Provide training to community groups, families, and other individuals in a person's support system on the prevention of suicide and related behaviors.

Objective

- Increase availability of evidence-based suicide prevention gatekeeper trainings to those working with higher-risk groups.
- Increase access to and the number of people trained in evidence-based prevention for community members (i.e. youth, families, friends, peers, co-workers).

Goal 3

Encourage safe storage of firearms, medication, and other lethal means.

Objective

- Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means as part of an overall educational effort.
- Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership and to include safe storage as part of an overall educational effort.
- Embrace new safety technologies to reduce access to lethal means as part of an overall educational effort.

Strategy 2

Ohio will concentrate efforts on integrating suicide prevention practices and suicide care, including postvention, into high-impact systems, including health care, public safety, and education.

Across Ohio, three systems have the scope and reach to touch many of those most at risk for suicide. Targeting those professional systems and encouraging participants to understand and implement best practices can have an exponential result in preventing suicide. As a result, Strategy Two focuses on the health care, education, and first response and emergency systems.

New accreditation mandates for health and behavioral health providers are focusing on improved suicide care, and creating momentum to improve suicide prevention in health care settings. Specifically, the leading authority on health care accreditation, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), have added new standards in 2019 that require screening/assessment for and management of suicidality among all patients with behavioral health diagnoses. This mandate will be especially significant for hospital psychiatric units and emergency departments. Similarly, the Commission on Accreditation of Rehabilitation Facilities (CARF) International, the leading accreditor of behavioral health programs, has added new standards requiring improved care for those with suicidality through adherence to accreditation standards. These accreditation requirements create an opportunity to improve accreditation compliance while reducing suicide.

The plan also builds on the estimated 1,000 Ohio clinicians trained in an evidence-based treatment approach for people with suicidality called the Collaborative Assessment and Management of Suicidality (CAMS). Ohio can use its strong cadre of CAMS-trained clinicians to assess if a modest amount of additional support (e.g. a "booster shot" of Zero Suicide training) would enhance suicide care in Ohio.

Planners know that education plays a pivotal role in preparing professionals across all three targeted systems. Goals address how to improve the knowledge and skills of pre-service and practicing professionals. Educators are also constantly adjusting how to address the needs of students to ensure their healthy development.

Focusing on education also means elevating the engagement of school districts and institutions of higher education. The education system must continue its commitment to helping address the alarming rate of suicide among youth and young adults.

As a final point, while first responders and emergency personnel are often on the front lines of caring for those at-risk of suicide or who have attempted suicide, they also constitute a group at higher risk for suicide.[v] They need the tools to help those they serve. Across all three fields, professionals need to be supported for secondary trauma and its effects.

Goal 1

Integrate suicide-specific care across health care, behavioral health care and addiction treatment organizations.

Objective

- Provide learning opportunities to organizations on the core components of the Zero Suicide approach and in developing and implementing protocols for delivering services for individuals at differing levels of suicide risk in the most collaborative, responsive, and least-restrictive settings.
- Incentivize providers for incorporating elements of evidence-based suicide care through Medicaid reimbursement mechanisms.

Goal 2

Provide training to clinical and social service providers on the prevention of suicide and other related behaviors.

Objective

- Promote the adoption of core education and training guidelines regarding suicide prevention into the higher education curricula of health professions .
- Promote core education and training guidelines in suicide prevention best practices for professional licensing boards and related entities.

Goal 3
Integrate suicide prevention best practices and suicide-specific care across educational systems, including Educational Service Centers.

Objective
- Increase implementation and support for the PAX Good Behavior Game to improve self-regulation in children.
- Provide guidance and support to school districts and community partners to develop and implement evidence-based strategies to prevent suicide and promote mental wellness.
- Provide guidance and support for developing model school policies for suicide prevention and postvention services and protocols.
- Expand the use of OHYES! (Ohio Healthy Youth Environments Survey) for students grades 7–12 across school districts to provide the data to inform local strategies.

Goal 4
Integrate suicide prevention best practices and suicide care across the public safety and emergency systems.

Objective
- Expand statewide access to and implementation of Crisis Intervention Team (CIT) training for law enforcement jurisdictions, including education on suicide best-care practices and coping with secondary trauma.
- Increase training for public safety and emergency systems around evidence-based suicide care, including secondary trauma.

Strategy 3

Ohio will build suicide prevention capacity and infrastructure at the organizational, local, and state levels.

Across Ohio, state and local partnerships have been working to prevent suicide. Meeting today's challenge requires expanding the footprint of those already hard at work, building new capacity where gaps exist, and elevating the public's knowledge and skills. Specific goals recognize the crucial role of county coalitions and aim to bring best practice approaches to their work.

Preventing suicide must also include supporting those who have been affected by the suicide of a loved one, friend, neighbor or colleague. Building a postvention system that all Ohioans can access must be undertaken as part of this strategy's work.

Finally, Strategy Three looks at the longstanding need for Ohio to add suicide reviews and data collection to county death review boards. Because fatality review boards uncovered the opiate epidemic, lead, and infant mortality, among other issues, this lends credence to the formation of these entities.

Goal 1
Increase the number of suicide prevention coalitions aligned with the Centers for Disease Control and Prevention's (CDC) seven strategies for preventing suicide.

Objective
- Provide statewide training, technical assistance, and networking opportunities to suicide prevention coalitions to elevate coalition capacity and performance.
- Annually review coalition capacity using performance metrics.
- Establish a statewide partnership of suicide prevention coalitions.

Goal 2
Assess and strengthen postvention programs in local communities.

Objective
- Assess resource and service gaps related to existing care transition services.
- Develop a comprehensive postvention model for Ohio.
- Provide training and technical assistance on implementing comprehensive postvention services at the local level.

Goal 3
Increase understanding of the function and capacity of local fatality review boards.

Objective
- Engage current Fatality Review Boards that include suicide reviews to share their experiences and practices.
- Encourage suicide prevention coalition members to develop relationships with existing County Fatality Review Boards.

Goal 4
Explore opportunities to build capacity that address identified social determinants, barriers to care, and factors that contribute to the suicide rate.

Objective
- Promote the use of Ohio's Community Collective Impact approach to address community trauma and suicide with community planning entities.
- Provide technical assistance to coalitions on how to expand partnerships to better address community factors contributing to suicide and health disparities.

Strategy 4

Ohio will concentrate prevention efforts on groups that current data has identified as being high-risk for suicide, including:

- **Youth, ages 10-24**
- **Males, ages 25-59**
- **Veterans and military members**
- **Residents of highest-risk Appalachian counties**
- **Community population focus as identified by local data.**

In Ohio, many people are impacted by factors that increase the risk for suicide. Strategy Four concentrates efforts on groups of people that current data has identified as being high-risk. The following charts demonstrate the need to provide specific attention to veterans and active military service members, males ages 25-59, youth ages 10-24, and residents of highest-risk Appalachian counties. Additionally, the data for each county can and will guide local efforts to establish priorities.

Some of the goals and objectives articulated in Strategy Four align with goals and objectives articulated elsewhere in the plan. They are re-stated here to ensure that target populations are prioritized for service and support.

For additional information about demographics, refer to Appendix 2: *The Ohio Depratment of Health's Report on Suicide Demographics and Trends, Ohio, 2018.*

Goal 1
State government will prioritize its suicide prevention resource allocations and program actions toward target populations and encourage its partners to do the same.

Objective
- Ohio partners will prioritize targeted groups of people in funding, staffing, training, and other appropriate program policies.
- The Suicide Prevention Plan for Ohio will be widely disseminated to local government, non-profits, faith-based organizations, schools, civic clubs, philanthropic, and other stakeholder partners.

- The U.S. Department of Veterans Affairs and Ohio National Guard will identify military liaisons and a structure for integrating suicide prevention practices within military culture and coordinating strategies that will improve access to resources for military members, veterans and their families.
- Promote the Ohio Department of Health's Youth Suicide Prevention Coalition Plan and resources.
- Engage ADAMHS Boards as partners to improve the adequacy of suicide care in their provider networks for youth and other target populations as informed by local data.

Strategy 5

Ohio will standardize, gather, and utilize data to continuously inform and evaluate its approach.

Public policy and strategic decision-making should be grounded in data.

The use of data to refine suicide prevention priorities is important but can be challenging. Multiple data systems are at play and may compete at times. For example, schools may be asked to participate in several school-based youth surveys, but don't have the time or resources for participation. Timeliness of data can be challenging and data from the Ohio Violent Death Reporting System (OH-VDRS) can serve as a valuable resource, however, data collection specific to circumstances surrounding a suicide may lag more than a year. In addition to OH-VDRS, the Ohio Department of Health (ODH) conducts surveillance on emergency department and hospitalization discharge data to assess nonfatal self-harm visits. Most recently, ODH is working with the Centers for Disease Control and Prevention (CDC) to utilize syndromic surveillance, near real-time data collection of emergency department visits, to assess cases of nonfatal, suspected self-directed violence. However, several developments nationally and in Ohio create the possibility for a better integrated data strategy, particularly drawing on the strength of Ohio's health care and university systems. Developing a statewide data strategy takes a statewide effort. Advocating for and assisting in the development of a long-term data approach is essential as part of Ohio's comprehensive approach.

Goal 1

Refine data systems including collection and evaluation.

Objective

- Establish a surveillance system with near-real time data for nonfatal suspected suicide attempt emergency department visits.
- Collaborate with federal stakeholders and partners from other states to evaluate and refine nonfatal suspected suicide attempt definitions.
- Undertake research to determine how billing codes/claims data may inform future suicide care.
- Enhance and coordinate the collection of risk-factor surveys and associated data [i.e. Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), Ohio Healthy Youth Environments Survey (OHYES!)]
- Continue monitoring trends in suicide deaths utilizing ODH's Vital Statistics Mortality Data and the Ohio Violent Death Reporting System.

Goal 2

Improve data dissemination and public access to data.

Objective

- Complete data mapping focused on suicide care that includes specific county-level data.
- Create and publicize a data dashboard for suicide and suicide-related outcomes.
- Create fact sheets on established high-risk populations.
- Continuously monitor data to identify new/emerging high-risk groups.

Next Steps

All involved in the development of this plan are committed to its implementation. The Ohio Suicide Prevention Foundation (OSPF) will work with its partners to oversee next steps. The OSPF will convene stakeholders to develop objective-level work plans with assigned responsibilities and due dates. Ongoing monitoring of performance metrics and conditions throughout Ohio will ensure plan activities remain calibrated toward success.

For more information on the Suicide Prevention Plan for Ohio or more information on suicide prevention, please visit: https://www.ohiospf.org.

Appendix 1

Suicide Prevention Plan for Ohio Alignment with the National Strategy for Suicide Prevention

The planning team for the *Suicide Prevention Plan for Ohio* thought carefully about how the Ohio plan would align with the 2012 National Strategy for Suicide Prevention while making it specific to our state and its residents. What follows are the five priorities of the *Suicide Prevention Plan for Ohio* and how each priority aligns with the National Strategy for Suicide Prevention.

Ohio Strategy One: All Ohioans will recognize the warning signs and risk factors of suicide and respond appropriately.	
National Strategic Direction Alignment	**National Goal Alignment**
Strategic Direction 1. Healthy and Empowered Individuals, Families, and Communities	**Goal 1.** Integrate and coordinate suicide prevention activities across multiple sectors and settings. **Goal 2.** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors. **Goal 3.** Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.
Strategic Direction 2. Clinical and Community Preventative Services	**Goal 6.** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. **Goal 7.** Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
Strategic Direction 3. Treatment and Support Services	**Goal 8.** Promote suicide prevention as a core component of health care services.
Ohio Strategy Two: Ohio will concentrate efforts on integrating suicide prevention practices and suicide care, including postvention, into high-impact systems, including health care, first responders, and education.	
Strategic Direction 1. Healthy and Empowered Individuals, Families, and Communities	**Goal 1.** Integrate and coordinate suicide prevention activities across multiple sectors and settings. **Goal 2.** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors. **Goal 3.** Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.
Strategic Direction 2. Clinical and Community Preventative Services	**Goal 5.** Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors. **Goal 6.** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. **Goal 7.** Provide training to community and clinical services providers on the prevention of suicide and related behaviors.
Strategic Direction 3. Treatment and Support Services	**Goal 8.** Promote suicide prevention as a core component of health care services. **Goal 9.** Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors.

Ohio Strategy Three: Ohio will build suicide prevention capacity and infrastructure at the organizational, local, and state levels.	
Strategic Direction 3. Treatment and Support Services	**Goal 10.** Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.
Strategic Direction 4. Surveillance, Research, and Evaluation	**Goal 11.** Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action. **Goal 12.** Promote and support research on suicide prevention. **Goal 13.** Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.
Ohio Strategy Four: Ohio will concentrate prevention efforts on groups identified by data as those with a higher rate of suicide, including: • Veterans and military members • Males ages 25 to 59 • Youth ages 10 to 24 • Residents of highest-risk Appalachian counties • Community population focus as identified by local data	
Strategic Direction 1. Healthy and Empowered Individuals, Families, and Communities	**Goal 1.** Integrate and coordinate suicide prevention activities across multiple sectors and settings. **Goal 2.** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors. **Goal 3.** Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.
Strategic Direction 2. Clinical and Community Preventative Services	**Goal 5.** Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors. **Goal 6.** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. **Goal 7.** Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
Strategic Direction 3. Treatment and Support Services	**Goal 8.** Promote suicide prevention as a core component of health care services. **Goal 9.** Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors. **Goal 10.** Provide care and support to individuals affected by suicide deaths and attempts to promote healing, and implement community strategies to help prevent further suicides.
Ohio Strategy Five: Refine data systems including collection and evaluation.	
Strategic Direction 4. Surveillance, Research, and Evaluation	**Goal 11.** Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action. **Goal 12.** Promote and support research on suicide prevention. **Goal 13.** Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Appendix 2

The Ohio Department of Health's Report on Suicide Demographics and Trends, Ohio. 2018

Ohio Department of Health

Suicide Demographics and Trends, Ohio, 2018

Suicide in Ohio

Suicide and intentional self-harm are major public health problems. In 2018, suicide was the 11th leading cause of all death in Ohio among all ages, the leading cause of all death among Ohioans 10-14 years of age and the second leading cause of all death among Ohioans 15-34 years. Suicide accounted for 17.5% of all injury-related deaths in 2018 and was the second leading injury-related cause of death among Ohioans 15 years and older.

From 2007 to 2018:

- suicide deaths increased 44.8%, from 1,268 to 1,836.
- the age-adjusted suicide rate increased 40.7%, from 10.8 to 15.2 deaths per 100,000 people.

FAST FACTS

- From 2007 to 2018, the number and rate of suicides increased.
- In 2018, there were 1,836 suicides.
- Since 2014, the rate among black, non-Hispanic and white, non-Hispanic males increased 53.8% and 24.0%, respectively.
- In 2018, adults 45-64 years of age had the highest rate of suicide, followed by adults 25-44 years.
- From 2007 to 2018, the rate of youth suicide (10-24 years) increased 64.4%, from 7.3 to 12.0 deaths per 100,000.
- Males are disproportionately burdened by suicide across the lifespan. Overall, the suicide rate among males is nearly 4 times the rate among females.

RESOURCES

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

- Crisis Text Line
  Text "4HOPE" to 741741

Figure 1. Number and Age-Adjusted Rate of Suicide, Ohio, 2007–2018

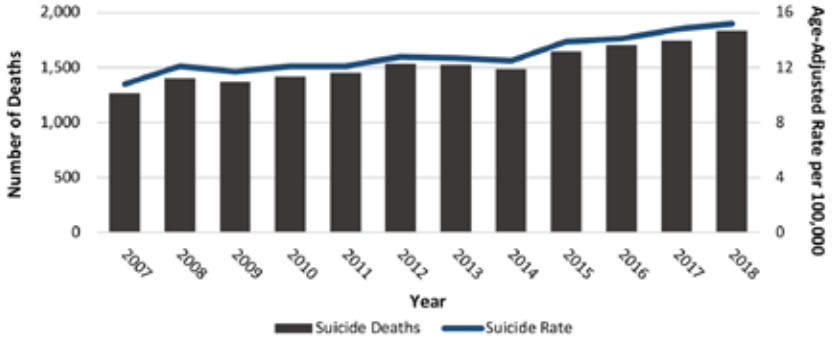
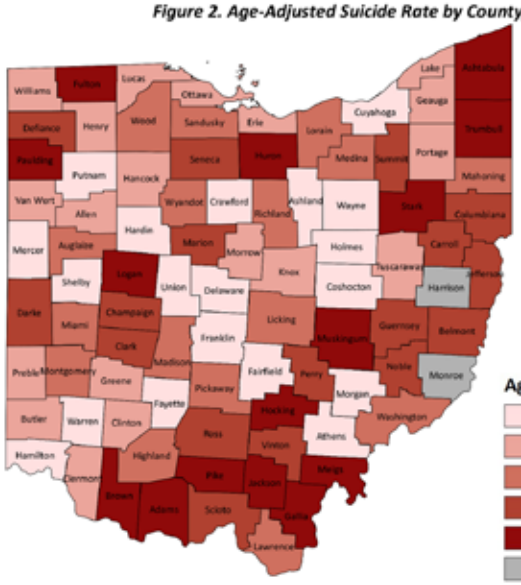


Figure 2. Age-Adjusted Suicide Rate by County, Ohio, 2014–2018



- For the time period of 2014–2018, Meigs County had the highest age-adjusted suicide rate. For every 100,000 residents, nearly 24 died by suicide.
- Holmes County had the lowest age-adjusted suicide rate (7.5 per 100,000).

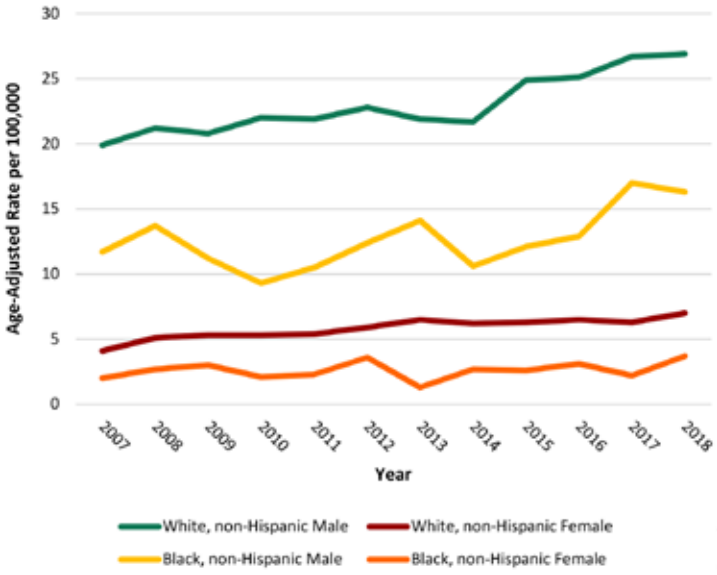
Age-Adjusted Rate per 100,000

- 7.5 - 12.8
- 12.9 - 14.2
- 14.3 - 15.6
- 15.7 - 18.0
- 18.1 - 24.1
- Rate suppressed

1

Trends by Demographic

Figure 3. Age-Adjusted Suicide Rate by Race/Ethnicity and Sex, Ohio, 2007–2018



From 2007 to 2018, the overall age-adjusted suicide rate among all race/ethnicity and sex categories represented in Figure 3 have increased.

Rates are highest among white, non-Hispanic males.

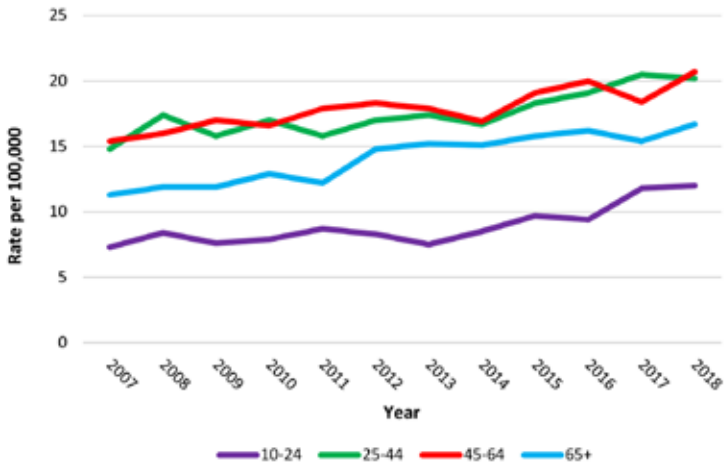
Since 2014, the age-adjusted rate of suicide among white, non-Hispanic and black, non-Hispanic males increased dramatically.

- The rate among black, non-Hispanic males increased 53.8%, from 10.6 in 2014 to 16.3 deaths per 100,000 in 2018.
- The rate among white, non-Hispanic males increased 24.0%, from 21.7 in 2014 to 26.9 deaths per 100,000 in 2018.

*Race/ethnicity categories are mutually exclusive. Specified race (white, black, other) excludes Hispanic ethnicity. Other race/ethnicity groups not shown due to small numbers.

**In Ohio, five people die by suicide every day.
One youth dies by suicide every 33 hours.**

Figure 4. Crude Suicide Rate by Age Group, Ohio, 2007–2018



In 2018, adults 45-64 years of age had the highest rate of suicide, followed by adults 25-44 years.

From 2007 to 2018, the rate of:

- youth suicide (10-24 years) increased 64.4%, from 7.3 to 12.0 deaths per 100,000.
- adult suicide among 25-44 year olds increased 36.5% (14.8 to 20.2) and among 45-64 year olds increased 34.4% (15.4 to 20.7).
- older adult suicide (65+ years) increased 47.8%, from 11.3 to 16.7 deaths per 100,000.

2

Age and Sex

- In 2018, there were 387 suicides among females (21.1%) and 1,449 suicides among males (78.9%).
- Males are disproportionately burdened by suicide across the lifespan.
- Males 55-64 years of age had the highest number of suicide deaths, while the rate is highest among males 75 years and older.

Figure 5. Number of Suicides by Age and Sex, Ohio, 2018

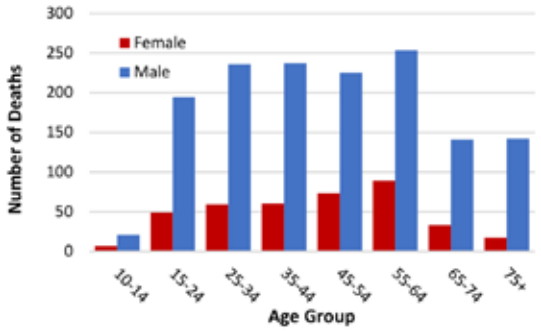
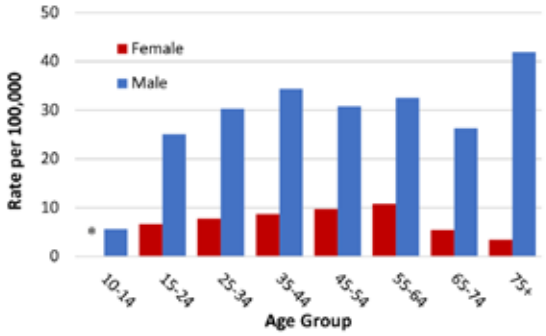


Figure 6. Suicide Rate by Age and Sex, Ohio, 2018



*rate suppressed when count <10

Mechanism

- From 2007 to 2018, the number of suicides by suffocation (e.g. hanging) increased 75.0% (from 300 to 525), suicides by firearm increased 48.5% (from 647 to 961), and suicides by drug overdose remained relatively steady (from 154 to 156).
- In 2018, firearm was leading mechanism of suicide among both females and males, accounting for one-third of female suicides and more than half of male suicides.
- Among females, suicide by drug overdose accounted for 24.8% of deaths compared to only 4.1% among males.

Figure 7. Number of Suicides by Mechanism, Ohio, 2007–2018

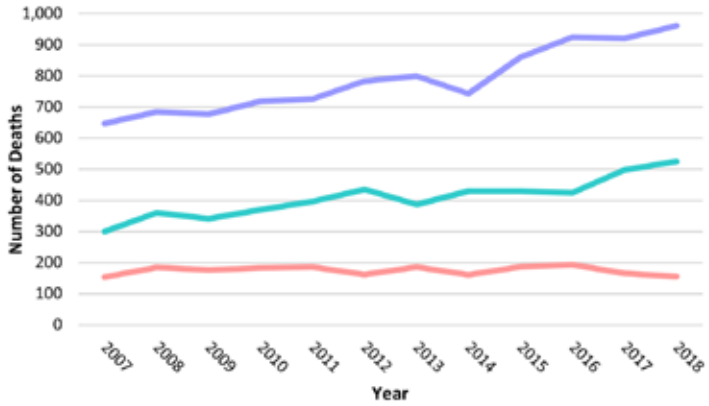
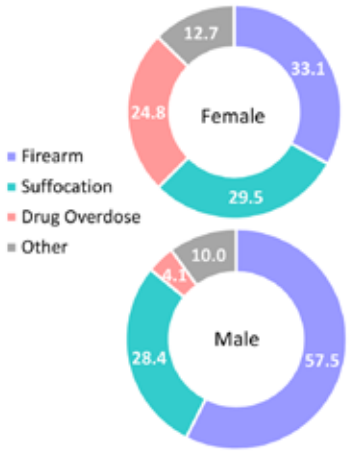


Figure 8. Percent of Suicides by Mechanism and Sex, Ohio, 2018



Source: Ohio Department of Health (ODH) Bureau of Vital Statistics; analysis conducted by ODH Violence and Injury Prevention Section.
Analysis includes Ohio residents with any of the following ICD-10 codes as the underlying cause of death: X60-X84, Y87.0, U03. Rates calculated per 100,000 population.
Age-adjusted rates are based on the 2000 U.S. standard population.

3

2007–2018 Demographic Summary

Table 1. Number of Suicides by Year and Demographic Characteristic, Ohio, 2007–2018

Demographics	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	
	#	#	#	#	#	#	#	#	#	#	#	#	Rate*
Age													
5-9	0	0	1	0	0	0	1	0	0	0	2	0	--
10-14	8	15	14	6	9	18	14	25	14	17	25	28	3.8
15-24	166	186	167	180	197	177	161	172	210	198	244	243	16.0
25-34	193	223	198	246	228	233	244	221	258	302	296	295	19.1
35-44	252	293	262	245	225	254	256	258	269	251	301	297	21.3
45-54	283	308	330	317	334	324	316	295	335	305	308	298	20.1
55-64	190	188	206	216	243	263	253	242	271	327	268	342	21.2
65-74	80	103	100	108	101	122	137	148	146	160	146	174	15.1
75+	96	86	92	102	100	131	129	124	145	146	154	159	18.8
Sex													
Female	228	285	288	291	291	318	336	325	339	365	328	387	6.3
Male	1,040	1,117	1,082	1,129	1,146	1,204	1,175	1,160	1,309	1,341	1,416	1,449	24.8
Race/Ethnicity													
White, non-Hispanic	1,159	1,256	1,252	1,309	1,320	1,381	1,364	1,338	1,494	1,533	1,546	1,632	16.7
Black, non-Hispanic	92	111	92	79	87	109	107	95	103	118	138	150	9.8
Other, non-Hispanic	7	14	9	11	15	10	17	27	20	29	27	18	5.0
Hispanic	10	21	17	21	13	19	18	22	22	23	27	31	7.1
Race/Ethnicity and Sex													
White, non-Hispanic Female	211	255	261	265	269	287	321	292	305	329	297	346	7.0
White, non-Hispanic Male	948	1,001	991	1,044	1,051	1,094	1,043	1,046	1,189	1,204	1,249	1,286	26.9
Black, non-Hispanic Female	15	20	22	16	17	26	11	21	20	24	17	31	3.7
Black, non-Hispanic Male	77	91	70	63	70	83	96	74	83	94	121	119	16.3
Hispanic Female	1	5	2	5	2	4	3	3	8	2	5	6	--
Hispanic Male	9	16	15	16	11	15	15	19	14	21	22	25	10.7
Total	1,268	1,402	1,370	1,420	1,451	1,534	1,524	1,488	1,648	1,706	1,744	1,836	15.2

Source: Ohio Department of Health (ODH) Bureau of Vital Statistics; analysis conducted by ODH Violence and Injury Prevention Section. Analysis includes Ohio residents with any of the following ICD-10 codes as the underlying cause of death: X60-X84, Y87.0, U03. Due to missing demographic information, demographic categories may not sum to total.
Race/ethnicity categories are mutually exclusive. Hispanic includes any race. Specified race (white, black, other) excludes Hispanic ethnicity. Other race includes American Indian and Asian/Pacific Islander.
*Rates presented for age groups are age-specific. Rates presented for sex and race/ethnicity are age-adjusted to the 2000 U.S. standard population.
Rates calculated per 100,000 population and suppressed when counts <10.

4

Appendix 3

Relevant Legislation Related to Suicide Prevention in Ohio

The Jason Flatt Act, Ohio, in honor of Joseph Anielski (HB 543, 129th General Assemblyand 132nd General Assembly)-- Enact free training every five years for all employees designated by the school board for recognizing students who may be at risk of harming themselves. The 132nd General Assembly increased the frequency of the mandatory free training from every five years to every two years.

Ohio Suicide Prevention Day, September 10th (HB 149, 130th General Assembly)-- Designates September 10 every year as "Ohio Suicide Prevention Day."

Suicide Prevention Programs at Public Institutions of Higher Education (HB 28, 131st General Assembly) -- Public Institutions of Higher Learning are required to have information concerning the following on their webpage: Crisis intervention access, mental health program access, multimedia application access, student communication plan, and postvention plan.

State of Ohio License Plates (SB 159, 131st General Assembly)-- Allows schools or school districts to have a State of Ohio license plate where $30 of the $40 upcharge goes directly to the school for the purpose of the emotional and mental well-being of their student body.

Main Operating Budget (HB 64, 131st General Assembly)-- $2,000,000 appropriation for suicide prevention.

Ohio Survivors of Suicide Loss Day (HB 440, 131st General Assembly)-- Designates the Saturday before Thanksgiving as "Ohio Survivors of Suicide Loss Day."

Appendix 4

Report Citations

[i] *The National Survey on Drug Use and Health (NSDUH) by the Substance Abuse and Mental Health Services Administration (SAMHSA),2016-17. https://www.samhsa.gov/data/report/2016-2017-nsduh-state-estimates-substance-use-and-mental-disorders*

[ii] *Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): US Department of Health & Human Services (US); 2012 Sep. Available from: https://www.ncbi.nlm.nih.gov/books/NBK109906/figure/introduction.f1/*

[iii] *https://www.ncbi.nlm.nih.gov/books/NBK109917/pdf/Bookshelf_NBK109917.pdf ; 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.; National Action Alliance for Suicide Prevention;*

[iv] *Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): US Department of Health & Human Services (US); 2012 Sep. [Figure], ORGANIZATION OF GOALS AND OBJECTIVES. Available from: https://www.ncbi.nlm.nih.gov/books/NBK109906/figure/introduction.f3/*

[v] *Suicide and Life-Threatening Behavior, The American Association of Suicidology, 2018*

THE SUICIDE PREVENTION PLAN *for* OHIO

Jan. 29, 2020 – Dec. 31, 2022

Are you struggling with suicidal thoughts? Are you worried about a friend or loved one and need support?

You are not alone.
Your life is worth fighting for.

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Get Support by Phone

The National Suicide Prevention Lifeline is available 24/7. Skilled crisis workers answer the phone and will listen, provide support, and any resources that may be helpful.

Get Support by Text

Text the keyword 4HOPE to 741 741 to chat with a skilled crisis worker at the Crisis Text Line.

MY3

Be Prepared with a Safety Plan

If you struggle with suicidal thoughts and would like to create a safety plan for yourself that you can share with those you trust, download the My3 App by the National Suicide Prevention Lifeline.