DEPARTMENT OF HEALTH CARE SERVICES

SUICIDE PREVENTION PROGRAM eNEWS

Every Californian is Part of the Solution… How will you contribute?

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CALIFORNIA'S PIONEERS IN SUICIDE PREVENTION

In honor of National Suicide Prevention Week the Department of Health Care Services, (DHCS) Suicide Prevention Program interviewed five pioneers in the field of suicide prevention about the challenges they face, progress they've seen, recommendations of areas that need attention and where they see the suicide prevention movement going. We thank them for their time and for all of their important contributions to the prevention of suicide in California. We are hopeful that by sharing their stories we can all learn about the field of suicide prevention, gain perspective for our work and become inspired to continue our very important mission. We also thank them for their stated support and appreciation of the staff work conducted while with the former Department of Mental Health, and for its continued work now under DHCS. And of course, we appreciate all of our readers for all you do to reduce suicide and promote mental wellness for all Californians.

John Bateson is the author of The Final Leap: Suicide on the Golden Gate Bridge (2012, University of California Press) and Building Hope: Leadership in the Nonprofit World (2008, Praeger Press). Currently he is writing a book about military suicides. Formerly he was executive director of a crisis center in the San Francisco Bay Area.

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Challenges you faced when you started this work:
The biggest challenge when I started—which continues to this day—is the stigma associated with suicide. People don't want to talk about it, even people who have been directly affected, who have lost a loved one to suicide. This makes it difficult for individuals who are feeling suicidal to seek help. There are many misperceptions and erroneous beliefs about suicide, among them the belief that

people who are intent on killing themselves eventually will do it and there's little anyone can do to stop them. This is absolutely untrue. Research shows that 90 percent of people who survive an attempt don't go on to die by suicide. Many end up living happy, healthy, productive lives.

Progress you have seen over time:

- Suicide is receiving more media attention today—especially military suicides.
- The National Suicide Prevention Lifeline was launched and has grown substantially in recent years.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) is emphasizing suicide prevention in its national strategies.
- California has a suicide prevention plan and a state Office of Suicide Prevention (now the Suicide Prevention Program in the Department of Health Care Services).
- Suicide prevention is a priority area of funding for the state Mental Health Services Act (MHSA).
- Many crisis centers have expanded services and added online counseling components (chat and text).

Recommendations of areas that need further attention:

When I left the crisis center at the end of January 2012, partly to promote my book, The Final Leap: Suicide on the Golden Gate Bridge, published in February by the University of California Press, and partly to research a new book on military suicides, which UC Press has an option on, I received a proclamation from members of the California Legislature. In thanking them, I said that I'd like to see the State's Suicide Prevention Program take on a leadership role. Specifically, I'd like to see the Program work with professional organizations like the California Psychological Association and California Association of Marriage and Family Therapists, as well as state legislators, to require suicide prevention training for mental health professionals. I drafted a bill to this effect in 2008, but it didn't make it through the legislature. I'd also like the Program to be a champion behind the scenes for means restriction, as well as do more in collecting and disseminating data, increasing public awareness, educating people about warning signs, promoting effective resources like crisis lines, etc. I think the state strategy is sound (of course, I'm biased since I helped draft it), but without strong and visionary direction from somewhere, it's not going to get implemented. The Suicide Prevention Program should do a lot more, I think, including having more say in how MHSA funds for suicide prevention are used.

Where you see the suicide prevention movement going:

I think the suicide prevention movement today is where the movements for acquired immune deficiency syndrome (AIDS) and breast cancer were 20 years ago. It's starting to come out of the shadows, more information is available, people are beginning to talk about suicide without considering it taboo, and funding opportunities exist, at least in California with MHSA. The work being done in Detroit by Henry Ford Behavioral Health Services is cutting edge and may offer real opportunities for change.

Sam Bloom's 23 year old son Sammy died by suicide in 1982. He had a serious mental illness. Sam has been a volunteer at Didi Hirsch Mental Health Service's Survivors after Suicide (SAS) Support Group since 1983. He has facilitated support groups for many years and serves on the SAS Advisory committee. Sam has participated in advocating for suicide prevention at the national, state and county levels since 1996. He is one of the founders of Suicide Prevention Action Network (SPAN)-California and served as its first President. He has also served on the Advisory Committee that developed the State Plan for Suicide Prevention.

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Challenges you faced when you started doing this work:
No money. When you get money, like the Garrett Lee Smith Suicide Prevention Grant or California's Mental Health Services Act (Proposition 63), things start to happen. SAMHSA has $40 million per year to run the Suicide Prevention Resource Center (SPRC) and give to colleges and universities. Establishing political will was and is a challenge. You get it through advocacy. Fifty to a hundred survivors got letters and delivered them to Congress members' offices in 1996.

The following is a chronology of some of the important developments in the suicide prevention movement:
1993: The World Health Organization (WHO) had some people at the University of Calgary and held a world meeting of suicidologists there. They published a booklet that described how nations could develop a national suicide prevention strategy.
1996: The Suicide Prevention Action Network USA (SPAN USA) was formed by Elsie and Gerald Weyrauch of Marietta, Georgia.
1997: The Weyrauchs went to an American Association of Suicidology (AAS) meeting and asked who would develop a national suicide prevention strategy. No one volunteered so they started advocating for it. The first year we got 6,000 letters to Congress. By the time several years passed we had delivered over a half million letters. The letters asked Congress provide resources for affordable and accessible mental health services and to develop a national suicide prevention strategy.
2001: The national strategy was developed and announced by the Surgeon General at an AAS conference.
2003: Senator Gordon and Sharon Smith's son, Garrett Lee, died by suicide while attending college.

2004: SAMHSA puts out $40 million per year through the Garrett Lee Smith Memorial Suicide Prevention Act. Also, Proposition 63 passed and money was allocated and the state is now actually spending the money.
2008: California developed the California Strategic Plan for Suicide Prevention.

Progress you have seen over time:
Los Angeles County's Partners in Suicide Prevention holds a quarterly conference to assist in formulating county plans to reduce suicide. I was amazed that 40 people were there and at least a dozen were talking about the suicide prevention programs in their agencies. When we started there was very little activity.

Getting enough manpower to do things is difficult. It costs $1,000 for a trip to Washington. Once the money showed up then we could get the government involved: SAMSHA, the Centers for Disease Control (CDC), the former California Department of Mental Health (DMH), Office of Suicide Prevention (OSP); and the Mental Health Services Oversight and Accountability Commission (OAC). We always partnered with the National Alliance on Mental Illness (NAMI).

Recommendations of areas that need further attention:
We're planning a conference in Los Angeles County and we're trying to train public information officers and reporters. There is always work needed with the media. Reporting guidelines need to be distributed to editors.

The medical profession, primarily family practice and primary care providers, need to be trained. And we need to include training in medical schools. The numbers say that almost half of prescriptions for antidepressants are written by general practitioners. They need to be trained about mental illness. The most recent issue of the American Association of Suicidology has a white paper on the fact that mental health professionals are not well trained about suicide assessment and treatment. The hospitals have an accreditation group that told the hospitals they had to do suicide prevention training. Work needs to be done in schools.

Where you see the suicide prevention movement going:
In a few years we ought to have programs established in states, counties and cities that can help people. It will be delayed by people being stigmatized and discrimination against mental illness. That needs to be knocked down. There needs to be public awareness about mental illness and suicide.

The rate is pretty good in California but we need to lower it. Rates are not going down. The rate has been going up the last three or four years. That's the wrong way. When we started, people were talking about eliminating suicide. We'll never do that. We need to get the rate to go downward. That will be our first success. We were doing really well. There was a warning on antidepressants and parents and doctors got concerned and the youth suicide rate went up 18 percent in one year. There is a lot more that could be done. In SPRC's Weekly SPARK we might find things we would want people to know about. For example, if someone was doing something good in New York we'd want to tell people about that. People ought to know about the National Action Alliance for Suicide Prevention (Action Alliance) and the SAMSHA Garrett Lee Smith grants.

There are articles from publications like the one by Sally Spencer-Thomas on Suicidology.org. It's the history of what has happened since those days. People have been trying to prevent suicide for a much longer time but this current movement started with the WHO. It takes a long time because you need to get many people's attention and it's hard to get people's attention until money comes along.

Several years ago I met a congressional staffer who said that people who go to psychiatrists are just a bunch of whiners. With people like that it's hard to make progress. Fortunately, there are enough caring people in both houses to allocate money. I don't know how long this will continue. The National Action Alliance task force is working on updating the national strategy. One thing we can do is get the state plan out and go through it and the things that have not been done we need to make them happen. That's important. The State's Suicide Prevention Program can be a force to advocate for specific actions by the counties.

Regarding the California Mental Health Directors Association (CMHDA), a couple of years ago there were people from some counties who were very excited and they were doing things and it was wonderful. When you give people money they really want to do it.

Leann Gouveia has served as Executive Director of Fresno Survivors of Suicide Loss (SOSL) since 2001. She holds a Bachelor's Degree in Political Science and a Master of Public Administration Degree both from California State University, Fresno. Leann is a survivor of suicide loss. Her mother, Sharon, died by suicide in 1994.

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Challenges you faced when you started doing this work:
I started in the mid 1990s and that was a very good time to become involved. But, though prevention was around for many years and work was done in the 1980s in our state, it was in the 1990s when survivors groups and SPAN USA was formed. We really broke through into a national effort. SPAN stared in 1996. In 1998 there was a Reno conference and that was where the Surgeon General put out the call to action to prevent suicide and that's when SPAN partnered with SAMSHA. In 1999 SPAN California started in our state.

We've been around in Fresno since 1985 and we've established key relationships and credibility. That takes a lot of time and you have to prove yourself in the community. People didn't know us. We were known as a survivor group. You must include survivors in the movement or it won't work. Survivors

have to prove themselves in terms of their knowledge base, getting their own funding, getting support, visibility and all the challenges nonprofits face.

There was no money so we did the best we could to make things happen at the local level like Senate Resolution 84 in 1985 and the House Resolution later that said suicide prevention was a national priority. Once we had those tools we could do more work locally. These national things were because of survivors in SPAN USA. SPAN USA a few years ago folded into AFSP.

A challenge was to get a good group on board. Finding dedicated individuals who were able to help through the resources they had to offer. You have community members who have a lot to give and they do give a lot. It was an effort finding those people and thinking about the things they could do to help. For example, we needed a Certified Public Accountant, an office, etc. We were setting up a professionally run business, though it was a nonprofit. We have standard operating procedures. I take that very seriously. I started with an empty incubator office and a lawn chair so there was a lot of work to do.

I'm very proud that we did it that way because no one else owned us. We are a self-sufficient, nonprofit agency not run by anyone else. We don't fall under anyone else's umbrella. I have seen other organizations over the years that have been started by a parent organization and a lot of times you lose your autonomy and your voice, and sometimes you go away after awhile when you are no longer a priority.

Progress you have seen over time:
There was SPAN USA, the Surgeon General conference in Reno to start the national strategy. SAMSHA flew a lot of us to be part of the input to help the Surgeon General put together the strategy.

You have Proposition 63 where we are just now seeing funding come down the pipe, and it was passed in 2004. I was part of the two-year program to develop the state plan. So there have been many things accumulating over time. I am still bringing things back to the local level to do things on a smaller scale.

Now people are calling me to ask me how to do these things. When you put your work out there other people become aware of it. It builds awareness, interest and a network and you start to help other people, as well. This includes everything from survivor groups to organizations that want to build a suicide prevention component in their programs. No one taught me how to do this work so it's important that I share what we learned here so we don't have to reinvent the wheel.

Recommendations of areas that need further attention:
I want to see the Suicide Prevention Program pulling us together once a year, including survivors. I would like to see every county have a suicide review team. A few counties have a formal one, others are more loosely organized. These are like the child and adolescent death review teams. Things are not going to happen unless they are mandated. School, county mental health, etc. programs won't be truly effective unless they are mandated. If a county has a death review team they get extra

funding from the State. I would like to see the same thing for suicide review teams. After we have a year of data we plan to write a report to the county. We might be able to learn things about patterns of suicide in the county that we don't yet know. I'm hoping that this could lead to better use of resources.

Where you see the suicide prevention movement going:
I see it as something that waxes and wanes. It was big in the 1980s when you had people coming from the State to train trainers then that faded away. They did presentations in their communities but there was no mandate. From the 1990s on there were national efforts going on. Now the trend is local to move program at the local level. We also see the Veterans Administration involved.

The survivor movement has escalated and is becoming more educated about suicide and they want to go out and do something. They are merging with county, state and national organizations. It's at its peak and I hope it doesn't go away. There will be another crisis that comes along and they will focus on that. There needs to be nonprofits that just do suicide prevention all the time rather than an organization that does 50 things.

I'd like to see strengthening of the Suicide Prevention Program and county efforts for suicide prevention, bringing in survivor groups and mandates. In Washington State they required everyone to take CPR to get a drivers license and the rate of heart attack deaths went down. What would happen to the suicide rate if people were required to get suicide prevention training to get a drivers license?

Marilyn Koenig is the co-founder and executive director of Friends for Survival, a suicide bereavement support program providing services since 1983. Her son, Steven, age 18 died by suicide in 1977.

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Challenges you faced when you started doing this work:
It wasn't a great struggle. We had people very dedicated to the purpose of helping one another. That was and is our strength. But the problem was lack of visibility. Support groups were just starting in 1983 when we started our group. The community awareness wasn't there. The families who contacted us were very open to the services of a support program. We're not a support group, we're a support program. Meetings are not enough. A sustainable program needs to offer a variety of

services. Presently, we are writing a doctrine on how to start, maintain and sustain a non-profit, peer support bereavement program for families after a suicide.

Progress you have seen over time:
The proliferation of support groups and the acceptance of the value of support groups is certainly progress. Over the years the health care community, including suicidologists, the American Association for Suicidology (AAS) and the American Foundation for Suicide Prevention (AFSP) have come to recognize the credibility and value of peer support programs for these grieving families.

Recommendations of areas that need further attention:
The quality of support programs and the expansion of services is a critical need across the country. We need to improve the terminology to more accurately reflect what it is we're talking about. People think "survivors" means people who attempted suicide and didn't die (attempters). There was a meeting of national leadership that determined the survivor groups, formerly called Survivors of Suicide, will now be referred to as suicide bereavement support groups (SBSG). That is one example of the language that needed to change. This has clarified who we are and what we do.
There is a need for support groups for attempters and also for their family members. The community is calling and asking for these services.

Where you see the suicide prevention movement going:
Families and friends who have been affected by the suicide death of another have fueled the suicide prevention movement. Their willingness to be public and expose their experience has made a huge difference in all of our communities. This willingness has created a new public awareness regarding the tragedy of suicide and the need for more research and services.

My involvement in suicide prevention is personal, not professional. I lost a son to suicide in December 2004. Since then, my wife and I have worked to reduce death by suicide across the lifespan, particularly with Transition Aged Youth (TAY) by promoting mental health and suicide prevention awareness and resources.

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Challenges you faced when you started doing this work:
Overcoming cultural adversity has been a challenge. As a culture and a society we are not trained in suicide prevention. We are taught that if we cut ourselves we put on a band aid or get stitched up. But nobody taught me about suicide prevention.

There are centuries of adversity about dealing with someone who takes their life. When someone takes or considers taking their life people around them experience denial and fear. We have to overcome our fear to deal with people who are thinking about taking their life. We have to overcome the comment that they are going to do it anyway. I disagree that it is inevitable that a person will take their life. No life is a lost life. We all have the ability to overcome whatever adversity that might be going on.

Talking about culture and society, we need more and better research and understanding about how our brains function and how we use medication. Looking at this as a higher level health matter, if I was to say to you that there was a disease epidemic we would as a society be demanding a cure that doesn't have side effects. There is some literature about lithium reducing suicidal ideation but there are issues with it. Clozapine is another one. It's been shown in a couple of studies that it reduces suicidal ideation but there are issues around it, too. There is no good medicine cure for suicidal ideation without side effects.

Progress you have seen over time:
In California, we've seen a series of things enacted such as the MHSA, suicide prevention work going on, the California Strategic Plan for Suicide Prevention that's passed, the Suicide Prevention Program has been started, and the Jason Flatt Act for school age suicide prevention. In our own work we've gone to the public colleges in California and addressed issues in individual colleges then went to the governing bodies of the three public institutions in California. The progress we've seen is that each of the three enacted work about student mental health and suicide prevention. All have advisory bodies on student mental health, and they have received several million dollars in grant funds from MHSA. One of the other things we've seen is there is a push to have local and regional governments adopt suicide prevention plans and programs. A number of cities and counties have adopted suicide prevention plans.

Recommendations of areas that need further attention:
Everything. The work in suicide prevention is in its infant stage. The good news is that for a few decades now, and in California since 2005, there's been a lot of work done. But, there is only one measurement standard that's critical that tells us where we're at and that is the number of people in California who are losing their lives from suicide, and we need to reduce that number. We need suicide awareness training.

Everyone should read the document that came out through California Mental Health Services Authority (CalMHSA) work which was a survey of Californians in 2011 entitled Suicide Prevention Situational Overview. It's on yourvoicecounts.org. It gives us an idea of which social groups are more aware of suicide prevention and why, and those who are less aware. It gives you an idea about how to shape an awareness program.

There are three standards of measurement typically used for suicide -- rate, cause of death and the actual number of deaths. The highest rate is among the elderly. The highest cause of death by suicide is among young people. But the actual number of deaths is highest among our adult population from

about the ages of 30-64. I bring this up because one of the groups that is difficult to get involved is the business community. We need programs and approaches to help our adult population. We need to shape information and do a far better job of outreach to people in the business community to try to address our adult deaths. We have programs for young people. When a young person dies it's a tragedy that someone didn't have the opportunity to live out their life. When an older person dies we are concerned because they are vulnerable. We haven't shaped the message about adults and we have to do a better job of that.

Where you see the suicide prevention movement going:
We need more legislation. People need to be more systematic in working with their lawmakers to get things passed. The State of Washington just passed a bill that requires suicide awareness training for mental health professionals. There is a movement afoot in California to pass similar legislation.

Another area that needs attention is better ways of communicating such as using social networking. There are early stages of talk about developing a mobile application; people in crisis could get immediate assistance through use of their smart phone or iPad.

Another area where we need to do a better job is using prior attempters or those who have had ideation. They have gone through the experience. The experience is far more telling and valuable than looking at it analytically. We need to hear what they went through and that can help in the development of new approaches.

Suicide prevention is in its infant stages. We have some programs and some best practices but we need to focus on ways to reduce the number of deaths. We're grateful for a lot of things that have been developed but it's not good enough. It wouldn't be good enough tomorrow if there was a disease epidemic and there was a cure but it only helped 50 percent of the people. We would be outraged and wouldn't accept that. There needs to be more effective therapies or other forms of treatment. We can't rest on our laurels. The only thing we can rest on is if we see lives being saved. It's encouraging that communities are addressing this. The more of them that do it other people will step forward and recognize that we should all be involved in suicide prevention.

As human beings we live in a community. Treating an individual with a personal method is important, but we should not overlook that we interact through institutions. If we use a community/urban village approach the individual will be far safer.