DEPT. COMM. NO. 175

REPORT TO THE HAWAI'I STATE LEGISLATURE

IN RESPONSE TO:

HOUSE CONCURRENT RESOLUTION (HCR) 66, H.D. 1, S.D. 1
(requesting the Prevent Suicide Hawai'i Taskforce to recommend a strategic plan to reduce suicides in Hawai'i by at least twenty-five percent by 2025)
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAI'I

PREVENT SUICIDE HAWAI'I TASKFORCE

Submitted By:
The Prevent Suicide Hawai'i Taskforce
(PSHTF)
December 28, 2017

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

RECEIVED
SENATE
OFFICE OF THE PRESIDENT

'17 DEC 28 P3:30

RECEIVED
THE SENATE
CLERK'S OFFICE
STATE OF HAWAII

'17 DEC 29 A8:53

PREVENT SUICIDE HAWAI'I TASKFORCE

DEPT. COMM. NO. 175

December 28, 2017

Senator Ronald D. Kouchi
President, Hawai'i State Senate
Hawai'i State Legislature
415 South Beretania Street, Room 409
Honolulu, HI 96813

Dear Senate President Kouchi,

On behalf of the Prevent Suicide Hawai'i Taskforce (PSHTF), I am pleased to present you with the enclosed copy of our Report to the Hawai'i State Legislature. ***This report was requested by the 2016 Hawai'i State Legislature, through House Concurrent Resolution (HCR) 66, H.D. 1, S.D. 1, "Requesting the Prevent Suicide Hawai'i Taskforce to recommend a strategic plan to reduce suicides in Hawai'i by at least twenty-five percent by 2025."***

As you know, suicide is a serious and complex (yet preventable) public health problem that can have lasting harmful effects on our families and communities. Locally, suicide is the most common cause of fatal injuries among Hawai'i residents, accounting for 25% of all fatal injuries – outpacing car crashes, homicide, unintentional poisoning, and drowning. One person dies by suicide every two days in Hawai'i, making this an imperative public health issue for our State.

An overview of this report was provided during an informational briefing on December 8, 2017, which was sponsored by the House Committee on Health and Human Services, the Senate Committee on Commerce, Consumer Protection, and Health, and the Senate Committee on Human Services. A copy of that presentation is included in the appendix of this report.

This comprehensive report details our recommendations for statewide action, and also details the process through which the recommendations were created, and summarizes our call for action from the Legislature and State of Hawai'i. We look forward to engaging with you further in discussion and implementation of the strategic plan, how suicide/mental health issues impact your community, and how we can collaborate to improve safety and mental well-being for our local families.

Please do not hesitate to contact me at sugimotoj@dop.hawaii.edu if you have any questions, or if there are any other resources or information the we can provide.

Thank you again for your partnership and support.

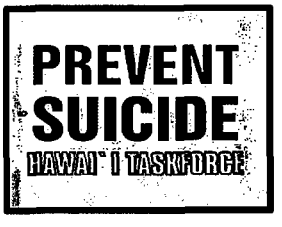
Most Sincerely,

Jeanelle J. Sugimoto-Matsuda, DrPH
Statewide Chair
Prevent Suicide Hawai'i Taskforce

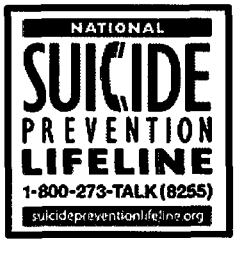
REPORT TO THE HAWAIʻI STATE LEGISLATURE

IN RESPONSE TO:

HOUSE CONCURRENT RESOLUTION (HCR) 66, H.D. 1, S.D. 1
(requesting the Prevent Suicide Hawaiʻi Taskforce to recommend a strategic plan to reduce suicides in Hawaiʻi by at least twenty-five percent by 2025)
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAIʻI



Submitted By:
The Prevent Suicide Hawaiʻi Taskforce
(PSHTF)
December 28, 2017



Prevent Suicide Hawai'i Taskforce (PSHTF)
Strategic Planning Sub-Committee
August 2016 to December 2017

Sub-Committee Chair:
Jeanelle Sugimoto-Matsuda, DrPH
Chair, Statewide Prevent Suicide Hawai'i Taskforce
Department of Psychiatry & Office of Public Health Studies
University of Hawai'i at Mānoa

JoAnne Balberde-Kamali'i
East Hawai'i Suicide Prevention Taskforce
& Hawai'i State Department of Education

Steven Balcom
Adult Mental Health Division
Hawai'i State Department of Health

Dr. David Brown
Regional Health Command – Pacific
US Pacific Command (PACOM)

Mona Cherry
Prevent Suicide Maui Taskforce

Merton Chinen
Office of Youth Services
Hawai'i State Department of Human Services

Nancy Deeley
Emergency Medical Services and Injury Prevention
System Branch
Hawai'i State Department of Health

Haylin Dennison
US Department of Veteran Affairs (former)

Kimberly Gallant
American Foundation for Suicide Prevention,
Hawai'i Chapter
& Honolulu Community College

Dr. Deborah Goebert
Department of Psychiatry
John A. Burns School of Medicine
University of Hawai'i at Mānoa

Trisha Kajimura
Mental Health America of Hawai'i

Ka'ohu'onapua (Pua) Kaninau-Santos
American Foundation for Suicide Prevention,
Hawai'i Chapter
& Lili'uokalani Trust

Regina (Gina) Kaulukukui
Prevent Suicide Kaua'i Taskforce,
Life's Bridges Kaua'i, & Kaua'i Police Department

Gordon Miyamoto
Project HI-AWARE
Hawai'i State Department of Education

Dr. Izumi Okado (support staff for sub-committee)
University of Hawai'i at Mānoa

Brent Oto
US Army

Tiara Peterkin
US Department of Veteran Affairs

Mara J. Pike
Mental Health America of Hawai'i

Cynthia (CJ) Rice
Project HI-AWARE
Hawai'i State Department of Education

Nancy Sallee
Orchid Isle Psychotherapy

Dr. Scott Shimabukuro
Child and Adolescent Mental Health Division
Hawai'i State Department of Health

Danielle Sodergren
US Marine Corps

Eric Tash
Hawai'i Chapter
American Foundation for Suicide Prevention

Monica Toguchi
O'ahu Prevent Suicide Hawai'i Taskforce
& Highway Inn

Dan Yahata
Hawai'i Chapter
American Foundation for Suicide Prevention

Dr. Victor Yee
Clinical Psychologist
(formerly with Hawai'i State Department of Public Safety)

Youth Members of the
Youth Leadership Council for Suicide Prevention

Statewide Prevent Suicide Hawai'i Taskforce (PSHTF)

The Prevent Suicide Hawai'i Task Force (PSHTF) is a state, public, and private partnership of individuals, organizations, and community groups working in the area of suicide prevention. PSHTF members collaborate to provide leadership, set goals and objectives, develop strategies, coordinate activities, and monitor the progress of suicide prevention efforts in Hawai'i.

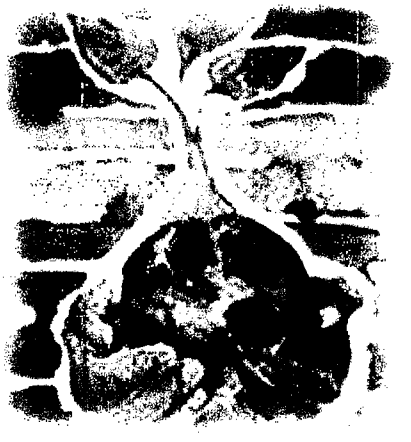
Taskforce Leadership:

- Statewide Chair – Jeanelle Sugimoto-Matsuda, DrPH, Department of Psychiatry & Office of Public Health Studies, University of Hawai'i at Mānoa
- Suicide Prevention Coordinator, Hawai'i State Department of Health – Nancy Deeley
- Island Taskforces
    - Kaua'i – Madeleine Hiraga-Nuccio
    - Hawai'i Island – Yolisa Duley, Pansy Lindomou, Nancy Sallee
    - Maui – Aris Banaag, Mona Cherry
    - O'ahu – Pua Kaninau-Santos, Joyce Parkhurst
- Additional representatives:
    - Military representative – Brent Oto, US Army, Chair of military ("cross-branch") taskforce
    - Youth Leadership Council (YLC) for Suicide Prevention – Mara Pike, Mental Health America of Hawai'i, Coordinator of YLC

We Acknowledge

With Love and Gratitude

- Those who we remember, those who are struggling, those who are caregivers, those who work to promote hope/help/healing.
- The Prevent Suicide Hawai'i Taskforce's (PSHTF) members, leadership, Steering Committee, and Island Taskforces.
- Partner organizations who contributed time and feedback to the Strategic Plan, including:
  - Hawai'i State Department of Health, Emergency Medical Services and Injury Prevention and Control System Branch
  - Agencies represented through the Strategic Planning Sub-Committee
  - Hawai'i State Legislature



Suicide Prevention in Hawai'i:
Passing Life Forward
through Hope, Help, and Healing

Table of Contents

Executive Summary

Suicide is a serious and complex preventable public health problem that can have lasting harmful effects on individuals, families, and communities. Locally, suicide is the most common cause of fatal injuries among Hawai'i residents accounting for 25% of all fatal injuries— outpacing car crashes, homicide, unintentional poisoning and drowning. One person dies by suicide in Hawai'i every two days. For every person who dies by suicide, more than 30 others attempt suicide. Every suicide attempt and death affects countless other individuals, having a profound impact on families and communities across the State of Hawai'i. And yet, suicide continues to be met with silence and shame. Stigma places formidable barriers to providing care and support to individuals in crisis, as well as to those who have lost a loved one to suicide.

This Hawai'i Suicide Prevention Strategic Plan is a systematic way of developing a response to suicide. Creation of this local strategy reflects both communities' and government's clear commitment to address the issue of suicide. With a bold and achievable goal of creating a healthy, safe, and empowered community by reducing suicide 25% by 2025, a key element in developing Hawaii's suicide prevention strategy was to move beyond a group of passionate, dedicated volunteers, and organizational representatives convened by the State – to establishing suicide prevention as a multi-sectoral priority that involves the health sector, education, judiciary, media, and others. The strategy encompasses cultural and social contexts, and is based on local best practices and interventions that have been evaluated in a comprehensive approach. Most importantly, these types of programs have demonstrated the capacity to save lives. The following report presents the findings and recommendations of the Prevent Suicide Hawai'i Taskforce.

'O ka hilina'i ka 'imi 'ana i kahi pohihihi a ka puka aku 'ana me ka 'ike.
(To possess an undaunting Hope: Believe that in the midst of confusion and bewilderment,
one is capable of seeking and holding onto the way toward a future possessing insight and vision.)
- Luana Kawa'a

This comprehensive plan seeks to increase the number of people in Hawai'i who are healthy and safe at every stage of life. Four core values guide our efforts related to suicide prevention—Aloha, Ola, Connectivity, and Culture. *Aloha,* unconditional love, is essential for all relationships and imperative to suicide prevention. *Ola* refers to life, health, hope, healing, contentment, and peace after a struggle, creating both a personal and spiritual sense of connectedness to others and place. The importance of connectivity in times of need is frequently expressed by those who have attempted suicide, as well as by those dedicated to preventing suicide in our communities. By building and maintaining relationships and connectivity, we enhance resilience. Culture refers to the values, traditions, and practices, of any group and is an important consideration in suicide prevention, particularly with our diverse communities. The Hawai'i Suicide Prevention Strategy recognizes that suicide prevention should be woven into all aspects of our lives.

The Hawai'i Suicide Prevention Strategy's goals and objectives fall within five strategic directions, which, when working together, may most effectively prevent suicides:

1. Hope: Increase awareness and communication around suicide prevention as a public health problem that is preventable; and increase statewide capacity for training across multiple levels and disciplines, including a focus on cultural humility in diverse populations.
2. Help: Promote suicide prevention as a core component of Hawaii's overall system of care.
3. Heal: Increase hope, help, healing, and wellbeing among those personally touched by suicide and among those with lived experience; and increase State and community capacity to effectively and efficiently respond to individuals and communities affected by suicide and those with mental health challenges.
4. Research and Evaluation: Conduct and support high-quality research and evaluation to inform suicide prevention programs, interventions, policies, and overall Statewide direction.
5. Policy and Advocacy: Ensure policies and protocols set the proper foundation for suicide prevention initiatives.

The goals and objectives for this strategy work together to inspire hope, promote wellness, increase protection, reduce risk, ensure effective treatment, and support healing. Suicide prevention is everyone's *kuleana.*

Introduction

Suicide is a serious, complex, preventable public health problem that can have lasting harmful effects on individuals, families, and communities. In the last few decades, suicide death rates in the U.S. have significantly increased for nearly every age group, with the greatest increases among indigenous groups (Curtin, Warner, & Hedegaard, 2016). In Hawai'i, it is a leading cause of death – one suicide occurs every other day – with more people dying from suicide than traffic-related injuries and drowning (Galanis, 2017). There has also been an increasing trend in the number of people treated in Hawai'i hospitals and emergency departments for non-fatal suicide attempts (Galanis, 2017). Response to such a complex issue requires a strategic and comprehensive approach, as well as sustained partnerships and resources.

The Issue of Suicide in Hawai'i

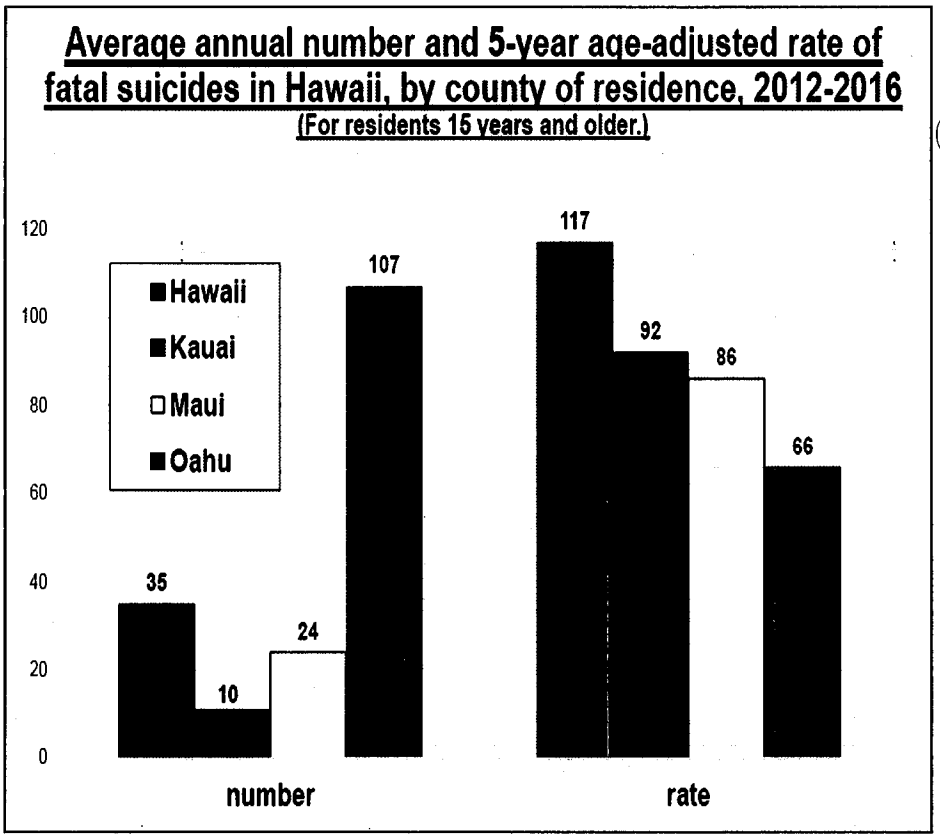
Suicide Deaths – Suicide was the most common cause of fatal injuries among Hawai'i residents over the five-year period from 2012 to 2016 (see figure), accounting for one-quarter (887, or 25%) of all fatal injuries, outpacing car crashes, homicide, unintentional poisoning, and drowning. One person dies by suicide in Hawai'i approximately every two days. Following the increasing trend of suicide deaths nationally, Hawai'i has also seen an rising rate of suicide death over the last ten years. (In Hawai'i, suicide death and attempt data are monitored and analyzed by the Hawai'i State Department of Health's Emergency Medical Services and Injury Prevention System Branch. Summary data are presented here, and a complete presentation can be found in the appendix of this report [Galanis, 2017]).

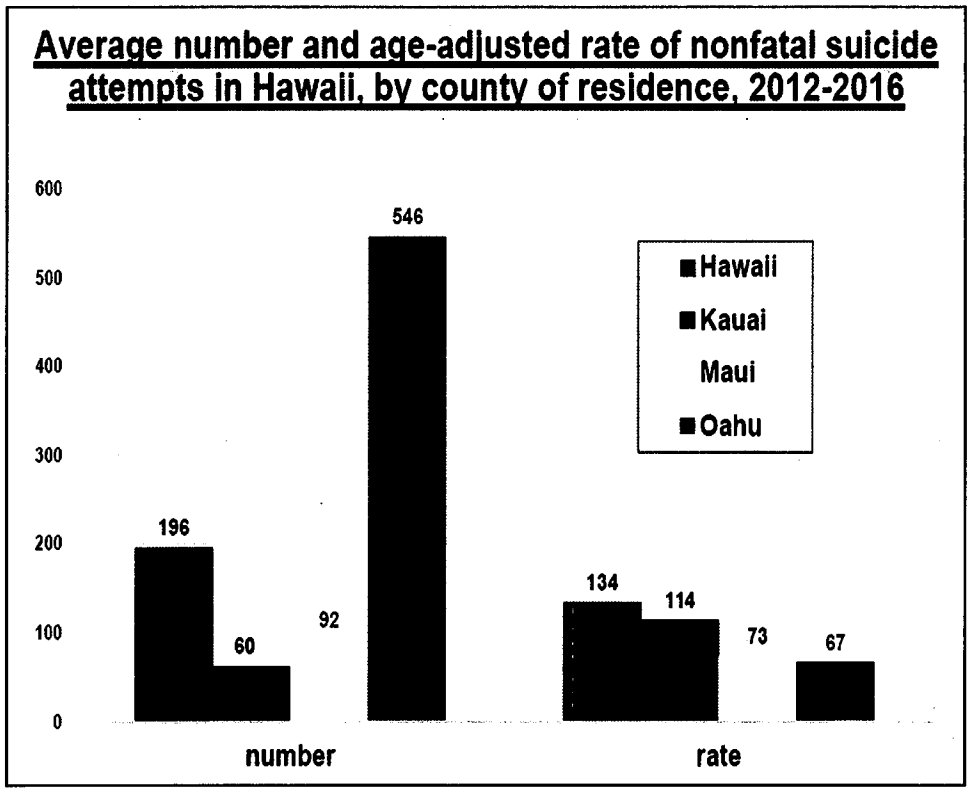
Causes of Fatal Injuries in Hawai'i, By Resident Age Group, 2012-2016

	0-14 y (84)	15-29y (575)	30-44 y (669)	45-59 y (889)	60-74 y (576)	75+y (759)	Total (3,552)
1	Drowning 19	SUICIDE 226	SUICIDE 216	[illegible]	SUICIDE 162	[illegible]	SUICIDE 887
2	[illegible]	MVC*-occupant 98	[illegible]	SUICIDE 222	[illegible]	[illegible]	[illegible]
3	[illegible]	[illegible]	MVC*-occupant 53	UNDET. INTENT 57	[illegible]	SUICIDE 56	[illegible]
4	[illegible]	[illegible]	[illegible]	[illegible]	Drowning 38	[illegible]	MVC*-occupant 242
5	SUICIDE/ MVC*-occup 5 (each)	Drowning 31	[illegible]	Drowning 46	[illegible]	MVC*-occupant 24	Drowning 181

*mvc = motor vehicle crash

Trends by County – For the time period of 2012-2016, 61% of all suicide deaths occurred among O'ahu residents (see figure). However, the overall age-adjusted rate for O'ahu (66 suicides per 100,000) was lower compared to residents of the Neighbor Islands (98 suicides per 100,000). This indicates that rates are significantly higher in our rural communities. Disparities in suicide risk in rural communities are well-documented (Hirsch, 2006). Rural communities also experience greater socioeconomic challenges, affecting their ability to pay for health services (US Department of Agriculture, 2007). Previous studies in Hawai'i have shown that rural residents are more likely than urban residents to use the emergency department for mental health care (Matsu et al., 2012; Onoye et al., 2013).





Suicide Attempts – Hawai'i has also seen an increasing trend in the annual number of non-fatal suicide attempts (see figure). Therefore, it is important to monitor not only suicide deaths, but also indicators such as hospitalizations and emergency department visits due to suicide attempts. For the period of 2012-2016, there were 186 suicide deaths per year, but also 350 hospitalizations (a 2:1 ratio to deaths) and 575 emergency department visits (a 3:1 ratio to deaths). As with suicide deaths, the majority of suicide attempts (61%) occurred on O'ahu, but the overall age-adjusted rate (67 suicide attempts per 100,000) was lower compared to residents of the Neighbor Islands (107 suicide attempts per 100,000).

Summary and Trends – the following table presents an at-a-glance summary of suicide death and attempt data for Hawai'i, for the period of 2012-2016:

	Suicide Deaths	Suicide Attempts (non-fatal)
Number per year	186 (215 if including deaths of undetermined intent)	925 (1,540 if including suicide records without principle diagnosis in injury field; 2,400 if also including injuries of undetermined intent)
Trends	Increasing (especially over past 10 years)	No statewide trend (O'ahu decreasing; Maui & Hawai'i Island increasing)
Gender	80% male	55% female
Age	Youth at lowest risk; 20-64 year-olds at highest risk	Youth (15-19 year-olds) at highest risk; Elderly at lowest risk
Mechanism	Hangings (50%); Firearms (19%)	Drugs/medicinal poisonings (63%)

The Prevent Suicide Hawai'i Taskforce

The Prevent Suicide Hawai'i Taskforce (PSHTF) is the major statewide, community-driven suicide prevention/mental health collaborative in the Hawai'i. Initially formed in 2001, following the release of the Surgeon General's report bringing suicide prevention into the public health realm (US Department of Health and Human Services [DHHS] 1999), it is the longest-standing and most sustained mental health collaborative in Hawai'i. The majority of the original PSHTF's members continue to play key leadership roles in suicide prevention. Today, the PSHTF is a network of over 100 different public and private organizations, and also includes island-specific taskforces that address island/community-driven activities. PSHTF members collaborate to provide leadership, develop strategies, implement awareness and training events, outreach to individuals and communities affected by suicide/mental health challenges, and monitor the progress of suicide prevention efforts in Hawai'i. All members work in suicide prevention/mental health and/or are concerned community members wishing to raise awareness around the issue, and many have also been personally impacted by suicide/mental health issues.

The Hawai'i State Department of Health now houses and directly supports the PSHTF, including the provision of a full-time Suicide Prevention Coordinator position. Hawai'i State Department of Health's Coordinator maintains an email list for the PSHTF. Examples of information that is shared through the email listserv are: agendas of upcoming meetings; minutes of past meetings; notices of future meetings and conferences; and local and national information. In addition, the Hawai'i State Legislature provides $100,000 annually, funneled through the Hawai'i State Department of Health, to support suicide prevention trainings and activities across the State (Act 213, under the General Appropriations Act of 2007).

House Concurrent Resolution (HCR) 66 of 2016 Hawai'i Legislative Session

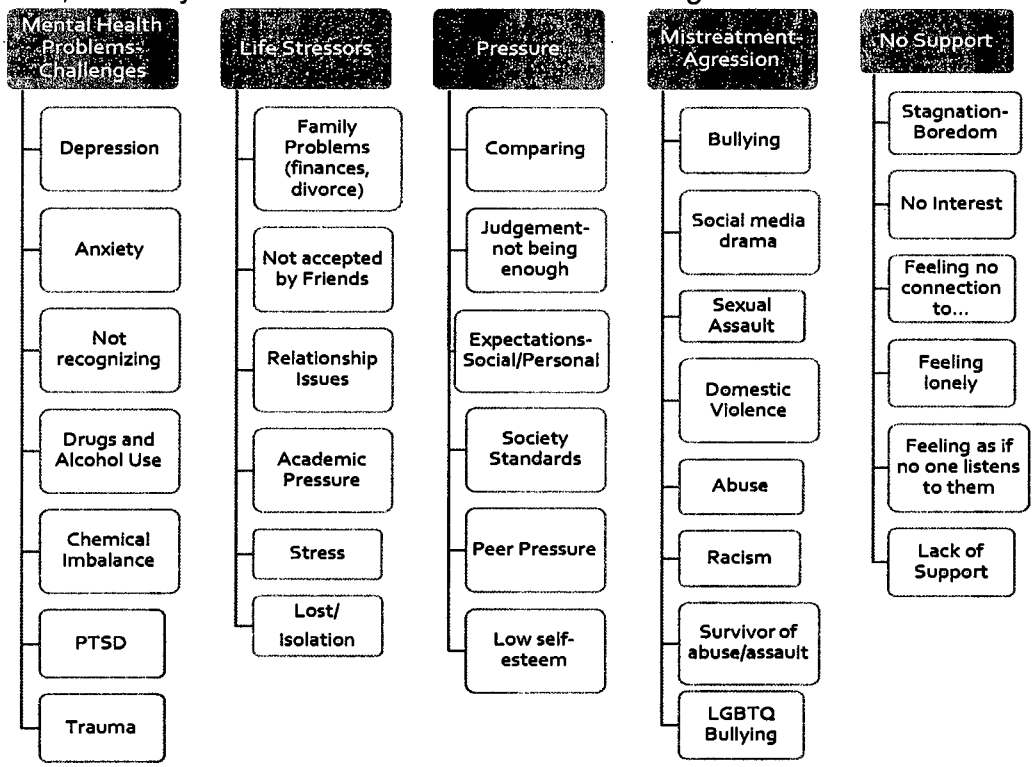
The PSHTF organized a legislative briefing in September 2015, as part of its suicide prevention week activities. As a result, a *House Concurrent Resolution (HCR 66 – see appendix)* was passed during the 2016 Hawai'i Legislative Session, requesting that the PSHTF recommend a strategic plan to reduce suicide in Hawai'i by at least 25% by the year 2025 (adapted from the national movement of "20% by 2025"). The national "Project 2025," launched by the American Foundation for Suicide Prevention (AFSP) in 2015, aims to develop and implement a comprehensive plan of action to approach the bold goal of reducing the annual suicide rate 20 percent by the year 2025 (AFSP, 2015b). In 2016, AFSP identified three critical areas, or "investment opportunities," that it will be focusing on at the national level: 1) firearms and suicide prevention; 2) large healthcare systems and application of the "Zero Suicide" approach; 3) emergency departments (AFSP, 2016).

To complete the strategic plan, the PSHTF formed a temporary sub-committee which took on the responsibility of compiling the plan and associated recommendations. HCR 66 requested that the sub-committee include major agencies such as health, public safety, military and Veterans Affairs, the University of Hawai'i, the

American Foundation for Suicide Prevention Hawai'i Chapter, and Mental Health America of Hawai'i. The HCR also allowed for the sub-committee to invite other agencies to participate, as appropriate. A comprehensive roster of participants, with roles and agency names, can be found in the appendix.

The sub-committee first convened in August 2016, and met approximately every two months through December 2017. The group designed a process which allowed members to study multiple sources of data and information ("share and absorb"), and subsequently discuss and integrate the information into the plan's recommendations ("reflect and synthesize"). The following data/information sources informed the sub-committee's discussions:

- Objective quantitative data, detailing the latest trends of suicide deaths and attempts in Hawai'i – provided by the Hawai'i State Department of Health (EMS and Injury Prevention System Branch).
- Direct feedback from PSHTF general membership – elicited through an online membership survey, as well as discussions during PSHTF meetings.
- Direct feedback from members of the Youth Leadership Council for Suicide Prevention – elicited through multiple discussion sessions and attendance at the 2017 Youth Summit at the Hawai'i State Capitol, facilitated by adult coordinators, and subsequently summarized and presented at sub-committee meetings.
    - Youth highlighted the importance of understanding the challenges and struggles experienced by youth, as a way to reach out to those who are suffering.



    - Youth also identified three core components to prevention – awareness campaigns; training for teachers, staff, and students, beginning in middle school; and wellness centers in each school complex.

Sample of Messages

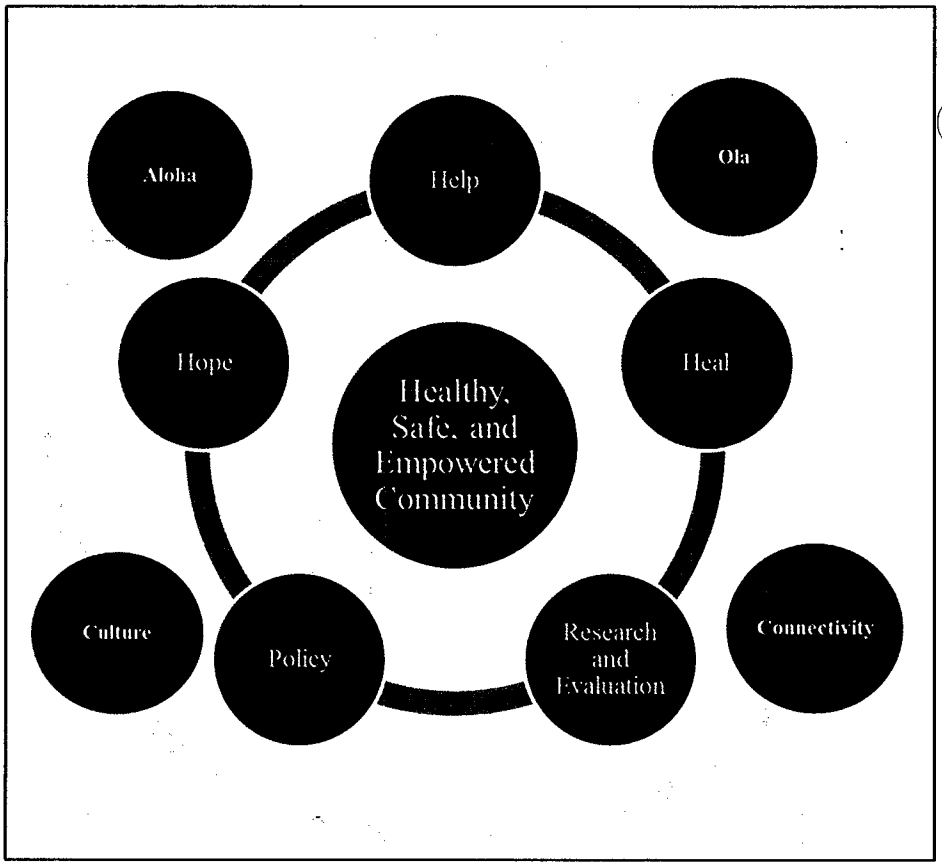
- Existing strategic plans and best practice documents.
  - 2012 National Strategy for Suicide Prevention: Goals and objectives for action – A report of the US Surgeon General and of the National Action Alliance for Suicide Prevention (http://store.samhsa.gov/product/SMA01-3517).
    - In November 2016, we were honored with a two-day intensive visit with Dr. Jerry Reed, Co-Lead of the National Strategy for Suicide Prevention Task Force. Dr. Reed educated the sub-committee about the National Strategy, as well as the process utilized by the National Task Force to complete the plan.
  - Hawai'i Injury Prevention Plan, 2012-2017 – assembled by the Injury Prevention Advisory Committee and the Hawai'i State Department of Health's Injury Prevention and Control Section (see http://health.hawaii.gov/injuryprevention/files/2013/09/Hawaii_Injury_Prevention_Plan_2012_to_2017_4mb.pdf, currently in revision).
  - Prevent Suicide Hawai'i Taskforce Strategic Plan for Suicide Prevention, 2015-2018 – the PSHTF's current internal strategic plan, assembled in 2014 (available on request).

Overview of Strategic Plan and Recommendations

Five over-arching strategies were identified to organize the strategic plan recommendations (see figure) – 1) Hope (primary prevention), 2) Help (secondary prevention and intervention), 3) Heal (tertiary prevention and postvention), 4) Research and Evaluation, and 5) Policy and Advocacy. The remainder of this report is organized according to these five strategies. Sub-committee members selected the area to focus on during the strategic planning process, though all sections were reviewed by the larger group.

In addition, four core values guide and provide context for the strategic plan as a whole – *Aloha, Ola* (life), Connectivity, and Culture (descriptions adapted from Goebert et al., in press):

- *Aloha* – a true core value of suicide prevention work, embedded in statements such as, "Passing life forward," and "No blame, no shame, just *Aloha*." *Aloha* means to love unconditionally, to give without the expectation of reciprocity, and to be empathic and compassionate. It represents the unselfish kindly concern for the good of another without expecting anything in return from them. Our state statute, *"Aloha Spirit"* (HRS 5-7.5) describes how we might exercise the power and life force of the *Aloha Spirit* on behalf of Hawaii's people (Office of Youth Services, 2012): "*Aloha* is the essence of relationships in which each person is important to every other person for collective existence. *Aloha* means to hear what is not said, to see what cannot be seen, and to know the unknowable."



- *Ola* – life, health, hope, healing, contentment, and peace after a struggle. In daily cultural practice, *ola* is the spiritual connectedness between a person's sense of being or identity with others and with the *mana* (life force) that flows through all animate and inanimate things. An '*Olelo Noe'au (No. 2017), by* Mary Kawena Pukui (1983), states, *"Loa 'a ke ola i Hālauaola"* – literally, "Life is obtained in the house-of-life: One is safe, well again."
- Connectivity – to be connected is to be filled with the renewing vibrancy of life (as compared to *ka'ele make,* an emptiness within that may make one vulnerable to defeat, resignation and death). By building and maintaining relationships and connectivity, we enhance resilience.
- Culture – an important consideration in suicide prevention, particularly with our diverse communities. It should be noted that culture refers not only to ethnic diversity, but more broadly to the values, traditions, practices, etc., of any group (e.g., geographic communities, age groups, professions, etc.).

The five strategies and four values make up the strategic plan's guiding framework, all of which center around the health, safety, and empowerment of our communities (see figure).

The following table provide an at-a-glance summary of the five strategies and corresponding objectives. In the following sections, each strategy is discussed in detail, and also proposed activities are provided for each objective.

GOAL	THEME	FORMAL OBJECTIVE
STRATEGY #1 – HOPE		
Goal #1A – Community Awareness *Increase community awareness and communication around suicide prevention as a public health problem that is preventable.*	Communication strategies	1.1 – Develop a sustained media and communication strategy, incorporating safe messaging guidelines, to raise awareness about suicide prevention.
	Messages	1.2 – Apply messaging and branding techniques to develop prevention messages that incorporate safe messaging, that resonate with Hawaii's communities.
	Media partners	1.3 – Foster ongoing partnerships with media professionals/outlets.
	Internet and social media	1.4 – Expand the use of internet and social media, with safe messaging, to promote suicide prevention.

GOAL	THEME	FORMAL OBJECTIVE
	Addressing stigma	1.5 – Increase knowledge of discrimination and stigma (in the context of mental health and suicide prevention), with marginalized/vulnerable communities, including LGBTQ, those with mental illness, and others.
Goal #1B – Training *Increase statewide capacity for training across multiple levels and disciplines, including a focus on cultural humility with diverse populations.*	Implementing trainings	1.6 – Increase the number of persons in organizations such as mental health, substance use, education, foster care, juvenile justice programs, health care providers, hospitals, law enforcement, faith-based, community, and workplaces trained to identify and refer people at risk for suicide.
	Resources for training	1.6 – Develop resources to increase the number of suicide prevention trainings available, and to expand the menu of evidence-based trainings.
	Dissemination of trainings	1.7 – Promote trainings for individuals and groups statewide.
STRATEGY #2 – HELP		
Goal #2 *Promote suicide prevention as a core component of Hawai'i's overall system of care.*	Awareness and training	2.1 – Promote help-seeking across multiple sectors and settings by partnering with State-/county-wide service providers, with emphasis on those that serve individuals at higher risk of suicide.
	Systems improvement	2.2 – Promote and support adoption and implementation of the Zero Suicide approach within Hawai'i's healthcare systems.
	Services during and immediately after crisis	2.3 – Promote the safety and wellbeing of all persons in suicidal crisis.
	Follow-up and continuity of care	2.4 – Implement systems and protocols to enable follow-up and continuity of care.
	Postvention response	2.5 – Increase capacity of communities and care/support systems to respond effectively to suicide clusters and prevent contagion, within their cultural context, and support implementation with education, training, and consultation.
	Policy and regulatory changes	2.6 – Ensure State and county laws facilitate all of the above objectives, and said laws are implemented appropriately.
STRATEGY #3 – HEAL		
Goal #3A – Survivor Supports *Increase Hope, Help, Healing, and Wellbeing among those personally touched by suicide and among those with lived experience.*	Support groups	3.1 – Ensure that every Suicide Loss and Lived Experience Survivor has access to a safe, nurturing, and sustainable community infrastructure to share/tell their stories, forgive, heal, survive, and thrive.
	Support group facilitators	3.2 – Ensure that every Suicide Loss and Lived Experience Survivor has access to a support group with skilled, trained, and culturally competent support group facilitators.
	Survivor stories	3.3 – Develop, support, maintain and publicize a statewide community-led Suicide Loss and Lived Experience Survivors' "story-telling bank."
	Venues	3.4 – Conduct, support and publicize activities and events that provide opportunities for assistance, validation, and comfort and for connecting and sharing stories.
GOAL #3B – Survivor Outreach *Increase State and Community capacity to effectively and efficiently respond to individuals and communities affected by suicide and those with mental health challenges.*	Outreach program	3.5 – Establish, support, maintain, and publicize a community-based statewide Suicide Outreach Program (SOP) on each island.
	Centralized information	3.6 – Develop, post, and publicize a real-time statewide catalogue of counseling, support groups, community events, and other support services and resources for those affected by suicide. Ensure catalog is available and accessible to service providers, health/medical professionals, and the community.
STRATEGY #4 – RESEARCH AND EVALUATION		
Goal #4	Data systems and sharing	4.1 – Facilitate the development and integration of suicide prevention data systems.

GOAL	THEME	FORMAL OBJECTIVE
Conduct and support high-quality research and evaluation to inform suicide prevention programs, interventions, policies, and overall Statewide direction.	Evaluation of local programs	4.2 – Evaluate existing Hawai'i-based suicide prevention programs, policies, and systems, instituting a "culture of evaluation" to ensure provision of high quality and evidence-based interventions.
	Quality improvement	4.3 – Support service organizations to incorporate organizational evaluation and quality improvement processes.
	Culture and diversity	4.4 – Support high-quality research and evaluation endeavors which will contribute to our understanding of the role of culture in suicide and suicide prevention.
	Pursue new opportunities	4.5 – Pursue funding and partnerships to expand research opportunities, both local and national.
STRATEGY #5 – POLICY AND ADVOCACY		
Goal #5 *Ensure policies and protocols set the proper foundation for suicide prevention initiatives.*	General funding	5.1 – Ensure adequate levels of funding and resources for all aspects of the strategic plan.
	Advocacy skills and capacity	5.2 – Encourage community members and professionals to engage in advocacy for suicide prevention.
	Organizational protocols and policies	5.3 – Encourage and support agencies and organizations to adopt protocols for suicide prevention, crisis response and management, and postvention.
	Codify the PSHTF	5.4 – Institutionalize suicide prevention networks and collaborations, including the Prevent Suicide Hawai'i Taskforce (PSHTF).

STRATEGY #1 – "HOPE"
(PRIMARY PREVENTION, AWARENESS, KNOWLEDGE)

This section of the strategic plan focuses on primary prevention efforts – that is, the most "upstream" actions that communities can take to address suicide prevention. On an individual level, primary prevention activities can increase a person's sense of belonging, connectedness, and purpose. On a community and societal level, awareness and training efforts can establish broad-based support for suicide prevention through outreach and collaboration with stakeholders, and also help to change the narrative regarding stigma associated with mental health and suicide. Regardless of place, position, or profession, suicide prevention is everyone's responsibility.

GOAL #1A – COMMUNITY AWARENESS
Increase community awareness and communication around suicide prevention as a public health problem that is preventable.

Community awareness campaigns are designed to improve recognition of suicide risk and help-seeking through increased understanding of the causes and risk factors for suicidal behavior (Mann et al., 2005). Public awareness campaigns have been used to provide education on mental illness and reduce discrimination and stigma. Such campaigns challenge the acceptance of suicide as inevitable, as a national character trait, or as an appropriate solution to life problems, including serious medical illness. Evaluation studies have demonstrated modest effects in improving attitudes regarding the causes and treatment of depression (e.g., Akroyd & Wyllie, 2002; Hegerl, Althaus, & Stefanek, 2003; Jorm, Christensen, & Griffiths, 2005; Paykel, Hart, & Priest, 1998). In a 2017 systematic review of media campaigns for suicide prevention, where suicide behaviors (mortality, attempts) and/or suicide literacy (knowledge, attitudes, help-seeking) was identified as a primary outcome, media campaigns appear to be most effective for reducing suicide deaths and attempts when delivered as part of a multi-component suicide prevention strategy, while "stand-alone campaigns" were modestly useful for increasing suicide prevention literacy (Torok, Calear, Shand, & Christensen, 2017). Level of exposure, repeat exposure, and community engagement were fundamental to the success of these campaigns.

Safe messaging is an extremely important concept when developing community awareness campaigns and events related to suicide prevention (Chung-Do et al., 2016b; Etzersdorfer & Sonneck, 1998). Studies indicate that when a suicide is highly publicized, glamorized, and/or described in detail, the potential for contagion or "copycat" suicides increases up to 14-fold, particularly among youth (Stack, 2003; Zenere, 2009). The magnitude of the increase in suicide deaths and attempts following an "unsafe" suicide story or publication is proportional to the amount, duration, and prominence of media (Gould, 2001). Safe messaging guidelines have been developed to safeguard public messages about suicide, and minimize suicide risk for vulnerable individuals who are receiving the messages (copies of guidelines are provided in report appendix). These guidelines can be applied to community awareness campaigns and educational/training efforts for suicide prevention for the general public, as well as provided to media outlets for reporting deaths (Suicide Prevention Resource Center, nd-b; Suicide Prevention Resource Center, nd-c).

Social media is increasingly being used for health-related issues, including communicating about suicide, particularly among youth (Dunlop, More, & Romer, 2011; Robinson et al., 2017). Due to concerns about causing distress or inducing suicidal thoughts or behaviors, however, only one recent study engaged youth in the development of social media-based suicide prevention interventions about safe ways to communicate about suicide online. Given the potential that social media holds to deliver messages to vast numbers of people across space and time, and the fact that young people often prefer to seek help from their friends and peers, safely educating and engaging young people to develop suicide prevention messages that can be delivered via social media is an obvious next step.

Community public awareness campaigns also offer survivors of suicide attempts, and those who have lost someone to suicide, the space to tell their stories (Chung-Do et al., 2016b). Story-telling serves as a way for them to share with the community, to heal, and to put a face to the issue of suicide. Safe messaging should always be applied in these story-telling activities. Safe messaging for survivor speakers includes ensuring the

speaker is at a place of healing where they are able to share their story without compromising their processing/recovery, where the focus is on what can be done to make things better in the future and a message of hope can be offered to the audience (Connect, nd).

Goal #1A – Detailed Objectives and Activities

OBJECTIVE 1.1 (communication strategies) – Develop a sustained media and communication strategy, incorporating safe messaging guidelines, to raise awareness about suicide prevention.

- 1.1.1 – Develop and maintain a statewide media campaign, utilizing safe messaging, to increase public awareness.
- 1.1.2 – Develop a budget and strategy to secure support, including public/private partnerships, for a sustainable media campaign.
- 1.1.3 – Pursue state, private, and federal grants for education, awareness, and marketing.
- 1.1.4 – Involve survivors of suicide (loss and attempts) and other experts, including researchers, medical professionals, clinicians, policymakers, and youth in the development of communication strategies.
- 1.1.5 – Use radio, websites, mobile devices, and social media as cost-effective methods for media coverage and dissemination.
- 1.1.6 – Convene a suicide prevention conference, including tracks such as those for youth, educators, survivors of suicide loss, suicide attempt survivors, researchers, and direct service providers.
- 1.1.7 – Codify September as suicide prevention month in Hawai'i.

OBJECTIVE 1.2 (messages) – Apply messaging and branding techniques to develop prevention messages that incorporate safe messaging, that resonate with Hawaii's diverse communities.

- 1.2.1 – Inventory and evaluate existing messages.
- 1.2.2 – Develop new, data-driven messages that take a multi-level approach to prevention and adhere to safe messaging guidelines.
- 1.2.3 – Conduct focus groups to develop and adapt messages for diverse communities (i.e., different cultural groups, age groups, etc.).
- 1.2.4 – Develop standard talking points and presentation slides for community presentations.
- 1.2.5 – Encourage help-seeking by including information about suicide prevention and intervention resources.
- 1.2.6 – Recruit local celebrities to participate in public awareness events and other forms of promotion.
- 1.2.7 – Use local resources to produce PSAs and other messages.

OBJECTIVE 1.3 (media partners) – Foster ongoing partnerships with media professionals/outlets.

- 1.3.1 – Assure that all media outlets, reporters, and journalists have, and understand, safe messaging guidelines.
- 1.3.2 – Educate all media on responsible reporting around suicide, as well as the safety of online content related to suicide and mental health.

OBJECTIVE 1.4 (internet and social media) – Expand the use of internet and social media, with safe messaging, to promote suicide prevention.

- 1.4.1 – Develop and maintain a Prevent Suicide Hawai'i Taskforce website and online resource directory.
- 1.4.2 – Provide targeted suicide prevention education and outreach via the internet and social media.
- 1.4.3 – Explore a virtual network/platform where the suicide prevention community can post on message boards, dialog in chat rooms, post videos and photos, and promote events (would include services, programs, access to crisis and text lines, etc., and be professionally monitored).

OBJECTIVE 1.5 (addressing stigma) – Increase knowledge of discrimination and stigma (in the context of mental health and suicide prevention), with marginalized/vulnerable communities, including LGBTQ, those with mental illness, and others.

- 1.5.1 – Educate the public on the effects of discrimination, stigma, mental illness, etc., to increase recognition that stigma pervades all communities.

- 1.5.2 – Promote activities/workshops, such as those focusing on wellness and healthy lifestyles, for groups at risk for suicidal thoughts, behaviors, and mental health conditions.
- 1.5.3 – Establish a speaker's bureau of trained individuals to respond to requests for education on suicide prevention, mental illness, discrimination, and stigma.
- 1.5.4 – Provide training and coordination for survivors (loss and attempt) and individuals in recovery to share their stories and coping strategies.

GOAL #1B – TRAINING
Increase statewide capacity for training across multiple levels and disciplines, including a focus on cultural humility with diverse populations.

Suicide prevention encompasses a range of interventions, many of which commonly focus on community or organizational "gatekeepers" whose contact with potentially vulnerable populations provides an opportunity to save lives (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Gatekeeper training generally refers to programs that seek to engage natural helpers in order to improve early identification of those at high risk for suicide and to facilitate timely mental health referrals (Isaac et al., 2009; Mann et al., 2005). "Universal" gatekeeper programs train organizational staff and community members to increase their knowledge of risk factors and warning signs of suicidal intentions. Historically, they have been divided into two main groups, defined as either designated or emergent (Ramsay, Cooke, & Lang, 1990). The designated group consists helping professionals (for example, those who work in the fields of medicine, social work, nursing, and psychology), and the emergent group consists of community members who may be recognized by those with suicidal intent (for example, clergy, recreation staff, police, coaches, and teachers). Local research has demonstrated that gatekeeper training can be culturally-tailored (Chung-Do et al., 2016a). Gatekeeper training has been shown to reduce suicide rates and suicide risks, though it has been primarily studied in the military (Melhum & Schwebs, 2001; Rozanov, Mokhovikov, & Stiliha, 2002). One randomized control trial of schools reported a significant increase in staff self-reported knowledge, appraisals of self-efficacy, and access to services up to one year after the training (Wyman et al., 2008). Another study in schools reported that reported that 63.6% of trainees had intervened with a suicidal youth within 6 months following the training (Chagnon et al., 2007).

There is unfortunately a dearth of empirical research on the long-term effects of training programs on youth, family, and community development (Knox et al., 2003). A recent analysis was conducted with grantees under the Garrett Lee Smith (GLS) Program for Youth Suicide Prevention, administered by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Youth suicide death rates in counties that implemented gatekeeper training were compared to a set of matched counties, finding lower suicide death rates among youth ages 10 to 24 years a year after the training in the intervention counties, in contrast to the comparison group (1.33 fewer deaths per 100,000) (Walrath, Garraza, Reid, Goldston, & McKeon, 2015). A second study with GLS grantees examined counties implementing integrative suicide prevention strategies, such as gatekeeper training with awareness campaigns, screening activities, improved community partnerships surrounding youth suicide prevention, linkages to services, programs for suicide survivors, and crisis hotlines. with matched counties. It found lower suicide attempt rates among youth in intervention counties, compared to matched counties (4.9 fewer attempts per 1,000 youth) in the year following implementation (Godoy-Garraza, Walrath, Goldston, Reid, & McKeon, 2015).

Goal #1B – Detailed Objectives and Activities

OBJECTIVE 1.6 (implementing trainings) – Increase the number of persons in organizations such as mental health, substance use, education, foster care, juvenile justice programs, health care providers, hospitals, law enforcement, faith-based, community, and workplaces trained to identify and refer people at risk for suicide.

- 1.6.1 – Provide suicide prevention trainings through PSHTF network – curricula may include ASIST (Applied Suicide Intervention Skills Training), SafeTALK, Connect, Mental Health First Aid, and other pertinent topics (e.g., crisis response, postvention, safe messaging, etc.).
- 1.6.2 – Provide trainings for students and families in elementary, intermediate, high school, and college settings – curricula would include suicide prevention, social/emotional learning, coping strategies, etc.

- 1.6.3 – Partner with educational systems/communities to provide teachers, counselors, behavioral health specialists, and other school personnel with annual suicide prevention trainings to increase awareness of risk factors for youth. *(Note – youth and supportive adults from our communities indicated that this needed to mandated for middle and high school.)*
- 1.6.4 – Explore and develop policies to require priority disciplines to complete a minimum of hours of training in suicide prevention, risk assessment, and intervention (e.g., during pre-service, upon hiring into the workforce, and ongoing and/or as part of recertification).

OBJECTIVE 1.7 (resources for training) – Develop resources to increase the number of suicide prevention trainings available, and to expand the menu of evidence-based trainings.

- 1.7.1 – Identify and recruit professionals and community members willing to be trained as trainers for evidence-based trainings.
- 1.7.2 – Leverage existing resources by maintaining and expanding partnerships.
- 1.7.3 – Develop mechanisms to increase financial support for trainings, including identification of entities that are able to share costs for staff trainings.

OBJECTIVE 1.8 (dissemination of trainings) – Promote trainings for individuals and groups statewide

- 1.8.1 – Develop annual training schedule for all islands.
- 1.8.2 – Promote trainings via listservs, agency websites, and other networks.
- 1.8.3 – Develop a social media mechanism/platform to disseminate training information.
- 1.8.4 – Identify and establish working partnerships with individuals and organizations to be liaisons for scheduling, promoting, and providing free facility use for community trainings.

STRATEGY #2 – "HELP" (SERVICES AND INTERVENTION)

This section of the strategic plan focuses on individuals, agencies, organizations, and systems which provide services for people and families that may be impacted by issues related to mental health and suicide. While our health systems (e.g., hospitals, emergency departments, clinics) provide many of these services, it is important to also give priority to connected/allied systems including education, housing, corrections, justice/courts, law enforcement and first responders, elder care, military/veteran services, etc.

GOAL #2
Promote suicide prevention as a core component of Hawaii's overall system of care.

Service providers have the access and opportunity to connect one-on-one with patients, and for a patient experiencing suicidal ideation or behavior, a meeting with a service provider can be the safe setting needed to help them open up and get life-saving help. It has been estimated that 83% of those who have died by suicide had health system contact in the year before suicide; however, few of them had a documented mental health diagnosis (LeFevre, 2014). Currently data estimate that 10% to 15% of patients who engage in medically serious suicide attempts will die by suicide within 10 years (Suominen et al., 2004). Approximately 14% of individuals who make medically serious suicide attempts will be re-admitted to the hospital for a suicide attempt within 1 year, and their cumulative risk of readmission for a suicide attempt after an index suicide attempt is 28.1% over 10 years (Gibb, Beautrais, & Fergusson, 2005). In addition, while an increasing number of hospitals provide routine screening for suicide risk, only 20% of hospitals in Hawai'i have access to on-site psychiatric consultation. Controlled studies have identified a number of successful approaches for reducing the risk of suicide attempts (e.g., Carter, Clover, Whyte, Dawson, & D'Este, 2005; Fleischman et al., 2008; Knesper et al., 2011; Motto & Bostrom, 2001; Spirito, Boergers, Donaldson, Bishop, & Lewander, 2002; Tarrier, Taylor, & Gooding, 2008; Zalsman et al., 2016), including four discussed in this section – Zero Suicide, continuity of care, safety planning, and lethal means counseling (see following paragraphs). In addition, a strong continuum of care across services within hospitals, as well as connections between hospitals and the community, can help institutionalize suicide prevention initiatives (Goebert & Sugimoto-Matsuda, 2017). The health care system has multiple opportunities and leverage points to build these linkages.

Zero Suicide is the call to action from the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention, inviting systems to aspire to and envision "zero suicide," starting with health care systems (National Action Alliance for Suicide Prevention, nd). Zero Suicide is not just a commitment to suicide prevention, but also a specific set of tools and strategies framed under seven categories – leadership commitment, workforce training, identification of risk, engagement in suicide care management, direct treatment, care transition, and quality improvement. Zero Suicide aims to improve care and outcomes for individuals at risk of suicide, within health care systems. It emphasizes: systematic use of an evidence-based suicide assessment protocol to identify suicidal ideation and risk in all patients; a focus on reducing the number of suicides occurring within 72 hours to the first few months after discharge through greater attention to discharge planning and facilitation of post-hospital care; and improved communication and collaborative care between inpatient and outpatient settings for people at risk for suicide.

Continuity of care and coordination of care require the support of a cohesive health services infrastructure, rather than numerous, disconnected facilities and care provision arrangements. A continuity-of-care infrastructure for achieving improved outcomes has been demonstrated as a best practice in health care systems and facilities (Center for Healthcare Research and Transformation, 2014; Knesper et al., 2011). Since mental health and physical health are intertwined, collaboration among mental health and general medical health providers is vital. For example, rather than the prohibitions against information-sharing which characterize disconnected systems, there must be effective sharing of pertinent health information in high-risk situations. In addition, system performance improvements require community capacity to track patients across community facilities. When a suicide or serious suicide attempt occurs, ideally all the care facilities involved should come together to do a root-cause analysis, and understand how to improve the entire system of care so as to prevent system failures from contributing to the next suicide death.

Safety planning and lethal means counseling – Safety planning is the comprehensive process completed in partnership with an at risk individual and his/her family/support network, that details how everyone will work to keep the individual safe. The process includes elements such as identifying the individual's stressors, preparing different coping strategies, names and contact information for support persons (including counselors, healthcare providers, and crisis lines), and instructions for medications and follow-up appointments. Another important component of the safety planning process is lethal means restriction and counseling. Lethal means restriction is a proven technique to keep at risk individuals safe, and is essentially working with the individual and his/her support network to keep the person away from means that could be used to take his/her life. This practice has recently expanded to include lethal means counseling to help clients at risk for suicide and their families reduce access to lethal means, particularly (but not exclusively) firearms. Training programs for health/service providers, such as CALM (counseling on access to lethal means), help to increase knowledge about the association between access to lethal means and suicide, provide education on the role of means restriction in preventing suicide, and increase skills and confidence to work with clients and their families to assess and reduce their access to lethal means (Runyan, Becker, Brandspigel, Barber, Trudeau, & Novins, 2016).

Goal #2 – Detailed Objectives and Activities

OBJECTIVE 2.1 (awareness and training) – Promote help-seeking across multiple sectors and settings by partnering with State-/county-wide service providers, with emphasis on those that serve individuals at higher risk of suicide.

- 2.1.1 – Identify and solidify partnerships with key state/county agencies and other priority organizations (e.g., first responders, law enforcement, justice/courts, corrections, military/veteran services, elder care homes/services). These should include organizations receiving state/county funds.
- 2.1.2 – Decrease stigma through awareness activities.
- 2.1.3 – Promote wellness initiatives for both service recipients and providers.
- 2.1.4 – Train social service and healthcare providers in suicide prevention and early intervention.
- 2.1.5 – Promote effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors, and support implementation of said practices.
- 2.1.6 Wellness Centers in each school complex (per youth)
- 2.1.7 – Through these service providers, convey information and resources to families, including available support groups. (Examples of resources available to families include Mental Health America of Hawai'i, Hawai'i Chapter of the National Alliance on Mental Illness, navigation projects, peer support, caregiver support, etc.).

OBJECTIVE 2.2 (systems improvement) – Promote and support adoption and implementation of the Zero Suicide approach within Hawai'i's healthcare systems.

- 2.2.1 – Identify and engage pertinent service systems (e.g., Hawai'i State Department of Health [Adult Mental Health Division, Child and Adolescent Mental Health Division], Trauma System and critical access hospitals, emergency departments, community health centers, Native Hawaiian healthcare system, insurers, allied health/medical providers [e.g., substance use, violence, etc.]).
- 2.2.2 (LEAD) – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
- 2.2.3 (TRAIN) – Develop a competent, confident, and caring workforce.
- 2.2.4 (IDENTIFY) – Systematically identify and assess suicide risk among people receiving care, utilizing best practice tools and protocols.
- 2.2.5 (ENGAGE) – Ensure every person identified has a suicide care management plan, or pathway to care, that is both timely and adequate to meet their needs.
- 2.2.6 (TREAT) – Use effective, evidence-based treatments that directly target suicidality.
- 2.2.7 (TRANSITION) – Provide continuous contact and support, especially after acute care.
- 2.2.8 (IMPROVE) – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

OBJECTIVE 2.3 (services during and immediately after crisis) – Promote the safety and wellbeing of all persons in suicidal crisis.

- 2.3.1 – Identify and engage key crisis management and response systems (e.g., crisis lines, crisis response, law enforcement, fire departments, EMTs and paramedics, emergency departments).
- 2.3.2 – Support the maintenance and expansion of adequate crisis communication and response services, particularly in high-volume and rural areas, to appropriately meet crisis service needs.
- 2.3.3 – Expand psychiatric consultation at all emergency departments across the State, which may include employment of technology platforms (e.g., tele-mental health and tele-psychiatry).
- 2.3.4 – Ensure access to MH-1 consultation for all law enforcement officers in all counties.
- 2.3.5 – Promote training on, and implementation of, lethal means restriction and counseling on access to lethal means (CALM).
- 2.3.6 – Promote training on, and implementation of, safety planning protocols and practices.
- 2.3.7 – Adopt and implement guidelines to effectively engage families and support network, when appropriate, throughout entire crisis episode.
- 2.3.8 – Convey information and resources to families, including available support groups. (Examples of resources available to families include Mental Health America of Hawai'i, Hawai'i Chapter of the National Alliance on Mental Illness, navigation projects, peer support, caregiver support, etc.).

OBJECTIVE 2.4 (follow-up and continuity of care) – Implement systems and protocols to enable follow-up and continuity of care.

- 2.4.1 – Identify potential transitions between systems that require attention, such as discharge from emergency departments and inpatient hospitalization. However, these should not be limited to discharge from a healthcare entity (e.g., after calling a crisis line, discharge from military, release from correctional facility, homeless/house-less, school to workforce, workforce to retirement, etc.).
- 2.4.2 – Adopt and implement guidelines for follow-up contact after suicidal crisis (e.g., phone calls, sending post cards, case management, etc.).
- 2.4.3 – Adopt and implement protocols to ensure follow-up appointments are scheduled and services are received, employing strategies such as case management and care navigation.

OBJECTIVE 2.5 (postvention response) – Increase capacity of communities and care/support systems to respond effectively to suicide clusters and prevent contagion, within their cultural context, and support implementation with education, training, and consultation.

- 2.5.1 – Organize, train, and maintain a statewide postvention response team, which would include agencies such as the Hawai'i State Department of Health, grief/bereavement providers, etc.
- 2.5.2 – Identify and promote support groups and grief counseling (see also Goal #3), with understanding that these services will be varied given that individual find comfort in different ways.

OBJECTIVE 2.6 (policy and regulatory changes) – Ensure State and county laws facilitate all of the above objectives, and said laws are implemented appropriately.

- 2.6.1 – Continue to ensure parity for mental health services and providers, including access in rural communities.
- 2.6.2 – Ensure proper legislation and policies to support the implementation of, and access to, tele-mental health and tele-psychiatry.
- 2.6.3 – Ensure proper implementation of "Consent to Treatment" legislation, including adequacy of resources.
- 2.6.4 – Explore policy and regulatory changes (e.g., recruitment of trainees from rural areas, incentive programs, loan repayment, etc.) to bolster numbers of, and access to, mental health providers, particularly in rural areas.
- 2.6.5 – Explore creation of infrastructure to establish a youth wellness center in every school complex. *(Note – this was an added activity, based on prioritization from the 2017 Youth Summit.)*

STRATEGY #3 – "HEAL" (HEALING, SUPPORT, AND POSTVENTION)

This section of the strategic plan focuses on the essential supports, services, and systems for people and families after a mental health or suicide crisis and/or death. The term "survivor" is currently recommended to describe those who have lost a loved one to suicide ("loss survivor"), but also those who have survived their own suicide attempt ("attempt survivor") (and the terminology in this area continues to evolve). Individuals who are survivors of suicide loss, and those who have attempted suicide, are obviously vulnerable and have needs that are unique and compelling. Unfortunately, these groups are not adequately served. The following is an excerpt from the National Strategy for Suicide Prevention (National Action Alliance for Suicide Prevention, 2012):

> "The mental health and medical communities often fail to provide needed services to individuals who have attempted suicide and to those who have been affected by a suicide attempt or death. Individuals who have made a suicide attempt may receive insufficient care in the community. Those who have been bereaved by suicide may receive little or no guidance or support for the traumatic impact of this occurrence. While most individuals bereaved by suicide recover from the trauma, many people may suffer alone and experience harmful effects that can be devastating and sometimes long lasting. For these reasons, it is crucial to pay attention to the needs of these potentially vulnerable but underserved groups. In addition, deaths by suicide can affect whole organizations and communities, leading to concerns regarding suicide contagion particularly among youth."

GOAL #3A – SURVIVOR SUPPORTS
Increase Hope, Help, Healing, and Wellbeing among those personally touched by suicide and among those with lived experience.

The journey of a suicide survivor after the loss of a significant loved one, as well as those with lived experience (i.e., attempt survivors and those who struggle with mental health issues) can be excruciatingly painful, devastating, and traumatic. There is more stigma attached to suicide than any other form of death. Those bereaved by suicide often find it very difficult to admit that the death of their loved one was by suicide, and people often feel uncomfortable talking about the suicide with them (World Health Organization, 2008). Cultural, religious, and social stigmas and taboos surrounding suicide can make the journey all the more difficult. In addition, a suicide death or attempt impacts not just the individual and immediate family, but effects also expand to the larger social network and community.

In a general sense, support groups are made up of people who are directly and personally affected by a particular issue, condition, or concern. Support groups allow participants to connect with others who have been through the same experience, gain strength and understanding from the individuals within the group, and also provide the same to others (World Health Organization, 2008). In particular, support groups for suicide loss and attempt survivors can assist greatly, as a lack of communication can delay the healing process. The role of support groups in the healing, surviving, and thriving of suicide loss survivors is especially critical (Young et al., 2012). In addition to the feelings of loss, sadness, and loneliness experienced after any death of a loved one, feelings of guilt, confusion, rejection, shame, anger, and the effects of stigma and trauma are magnified in suicide loss survivors (Jordan, 2001; Jordan, 2008). In addition, survivors of suicide loss are at higher risk of developing major depression, post-traumatic stress disorder, and suicidal behaviors, as well as a prolonged form of grief. Added to all this burden is the substantial stigma, as discussed above and throughout this report, which can keep loss and attempt survivors away from much needed support and healing resources (Young et al., 2012). Thus, survivors may require unique supportive measures and targeted treatment to cope. In Hawai'i, it is imperative that support groups be set up in each county to maximize availability, accessibility, and likelihood of awareness and attendance. Fellow survivors can provide a message of hope that surviving is possible, while conveying that they understand all-too-well the associated challenges.

Goal #3A – Detailed Objectives and Activities

OBJECTIVE 3.1 (support groups) – Ensure that every Suicide Loss and Lived Experience Survivor has access to a safe, nurturing, and sustainable community infrastructure to share/tell their stories, forgive, heal, survive, and thrive.

- 3.1.1 – Support, maintain, and publicize current support groups and facilitators.
- 3.1.2 – Recruit and train new facilitators.
- 3.1.3 – Encourage, establish, support, maintain and publicize new support groups that meet regularly for Survivors of Suicide Loss and support groups for Lived Experience Survivors on each island.

OBJECTIVE 3.2 (support group facilitators) – Ensure that every Suicide Loss and Lived Experience Survivor has access to a support group with skilled, trained, and culturally competent support group facilitators.

- 3.2.1 – Recruit and train facilitators of Suicide Loss and Lived Experience Survivor support groups.
- 3.2.2 – Conduct ongoing refresher trainings.
- 3.2.3 – Recruit and hire coordinators to support facilitators.
- 3.2.4 – Develop mechanisms and activities to support facilitators as a network (e.g., setting up and hosting a real-time bulletin board for sharing information and experiences, developing facilitator group protocols, setting up short-term counseling support for facilitators who need it, etc.).

OBJECTIVE 3.3 (survivor stories) – Develop, support, maintain and publicize a statewide community-led Suicide Loss and Lived Experience Survivors' "story-telling bank."

- 3.3.1 – Integrate information from various community and governmental sources, to continually identify new survivors and those with lived experiences willing to share their story.
- 3.3.2 – Fund and set up a community partner/collaborative effort to coordinate, conduct, and archive interviews with Survivors of Suicide Loss and Lived Experience individuals.
- 3.3.3 – Develop and secure relevant agreements and protocols (e.g., for confidentiality, safety, data sharing, safe messaging, etc.).
- 3.3.4 – Identify and secure pertinent personnel (e.g., coordinator, trainer to work with survivors, video/documentation staff, etc.).
- 3.3.5 – Implement and monitor processes for recruitment, interviewing, editing, archiving, dissemination, etc.

OBJECTIVE 3.4 (venues) – Conduct, support and publicize activities and events that provide opportunities for assistance, validation, and comfort and for connecting and sharing stories.

- 3.4.1 – Support, conduct, and publicize survivor events (e.g., Out of the Darkness Community Walks, International Survivors of Suicide Loss Day Events, "Fight for Each Other" campaign, and others) on each island.
- 3.4.2 – Identify and enlist partners on each island to coordinate and conduct these events.
- 3.4.3 – Support and conduct annual LifeKEEPER Memory Quilt Workshops on each island.
- 3.4.4 – Identify and train survivors on each island to host and conduct a LifeKEEPER training on their respective islands.
- 3.4.5 – Develop, maintain, and publicize a bulletin board of community survivor events and workshops.

GOAL #3B – SURVIVOR OUTREACH

Increase State and Community capacity to effectively and efficiently respond to individuals and communities affected by suicide and those with mental health challenges.

People in crisis, those individuals who have been affected by suicide or a suicide attempt, or those who know someone in crisis, may need immediate guidance or support for the traumatic impact of this occurrence. Surviving a suicide loss or attempt can lead to many different emotions, being/feeling isolated, and confusion regarding the circumstances and what to do next (American Foundation for Suicide Prevention, 2015a). Therefore, outreach to survivors in a timely manner is imperative; that is, the sooner support can be provided, better outcomes can be expected (Moutier, 2015).

There is no "one size fits all" support and outreach. Activities may include outreach teams of professionals and trained individuals who have been bereaved by suicide, face-to-face and online support groups, memorial services, and other opportunities to interact with supportive individuals/organizations (National Action Alliance for Suicide Prevention, 2012). One of the most basic resources that can be offered to a survivor is information regarding phone, text, and web-based crisis resources that are available 24 hours a day, 7 days a week. In Hawai'i, we need to increase awareness and support of our Crisis Line, as well as the national text line (741-741). These entities are critical in providing emotional support and referral to services. In addition, new and emerging technologies, such as telehealth, chat and text services, and online support groups, also show promise in allowing people to connect virtually to sources of care (National Action Alliance for Suicide Prevention, 2012). Information about outreach services and activities also needs to be centralized, accessible, and continually updated. While there is a myriad of resources, support services, trainings, and community events available for those affected by suicide, information is constantly changing which can make it difficult for individuals to find the support and services they need at the time they are needed.

Goal #3B – Detailed Objectives and Activities

OBJECTIVE 3.5 (outreach program) – Establish, support, maintain, and publicize a community-based statewide Suicide Outreach Program (SOP) on each island.

- 3.5.1 – Identify, train, and support volunteers on each island to provide short-term one-on-one peer support and practical information to newly bereaved suicide loss survivors.
- 3.5.2 – Develop SOP volunteer standards and responsibilities.
- 3.5.3 – Develop confidentiality protocols and resource materials.
- 3.5.4 – Create a means of supporting the SOP volunteer network including group meetings and bulletin boards for sharing and problem solving.
- 3.5.5 – Maintain and expand the funding, publicity, and reach of the State's 24-hour Crisis Line.

OBJECTIVE 3.6 (centralized information) – Develop, post, and publicize a real-time statewide catalogue of counseling, support groups, community events, and other support services and resources for those affected by suicide. Ensure catalog is available and accessible to service providers, health/medical professionals, and the community.

- 3.6.1 – Research, identify, catalogue, and publicize suicide prevention organizations/activities and survivor support efforts in Hawai'i.
- 3.6.2 – Develop protocols for inclusion in the catalogue.
- 3.6.3 – Develop a mechanism to ensure catalog is updated in real-time.

STRATEGY #4 – RESEARCH AND EVALUATION

This section of the strategic plan outlines objectives and activities related to research, evaluation, data/data systems, and the "translation" of data/information to inform practice. While more is known about suicide and suicide prevention, in comparison to several decades ago, there is still much to investigate with regards to this complex public health issue. In addition, is important to ensure connection of high quality research and evaluation to real life practice, as well as ensure community and cultural context surround all aspects of data gathering, analysis, and dissemination.

Goal #4
Conduct and support high-quality research and evaluation to inform suicide prevention programs, interventions, policies, and overall Statewide direction.

It is time to strategically apply science and accountability to the public health problem of preventable suicide. While suicide rates have remained stable for decades, they have increased in the last several years locally and nationally. A public health approach, as outlined in this plan, to quickly and substantially reduce suicides and suicide attempts 25% by 2025 requires strategic deployment of existing evidence-based interventions, rapid development of new interventions, and measures to increase accountability for results. Researchers need to be galvanized and given the proper resources to further develop and consolidate knowledge needed to guide these actions. As researchers overcome data limitations and methodological challenges, they enable better prioritization of high-risk subgroups for targeted suicide prevention efforts, identification of effective interventions ready for deployment, estimation of the implementation impact of effective interventions in real-world settings, and assessment of time horizons for taking implementation to scale (Claassen, et al., 2014). This new knowledge will permit decision-makers to take strategic action to reduce suicide, and stakeholders to hold them accountable for results.

In 2009, a needs assessment was conducted to elicit local community concerns about youth issues (with focus on youth suicide, bullying and violence) that is still relevant today (Yahata & Kaninau, 2009). A key informant focus group provided insight on the relevancy and accuracy of existing documentation and reports for youth; made recommendations to enhance strength-based programs; determined assets, resources, and needs of communities; and identified preliminary strategies for moving forward on prevention efforts. The themes that emerged included the need to: develop, implement, and evaluate strategies in the context of their families and broader community; develop strengthening programs; empower and build capacity within these communities to identify and prioritize needs; develop, implement, evaluate, and sustain prevention; utilize natural leaders within communities; collaborate in support of these youth and their communities' health and well-being; support research, evaluation, reporting, and marketing of effective programs; and provide equitable distribution of resources in communities.

It is important for quality improvement, research, and evaluation activities to be done in a comprehensive manner, with respect to cultural values and perspectives. Sociocultural background influences individual and family perspectives, values, beliefs, and behaviors regarding health and well-being. These factors give rise to variation in recognition of symptoms, thresholds for seeking care, treatment engagement, and adherence to preventive measures and medications. This type of sensitivity in research can enhance relationships; promote a team-based approach; facilitate care coordination and program integration across health care systems; better engage the individuals, their family/social networks, and community-based services; facilitate communication, information-sharing, and evidence-based treatment; and enhance access to care.

With respect to priority research areas, identification of sub-groups with the greatest "risk density" (in terms of overlapping risk factors and numbers of individuals) can identify specific leverage points to reduce suicidality and maximize intervention efficiency. Subsequent alignment of sub-groups with intervention approaches/platforms confers two important benefits. First, it helps to overcome barriers to intervention which can hamper efforts to reduce suicide in the public at large. Equally important, it identifies entities (for example, communities, schools, health care systems, and military organizations) with accountability for a sub-group's

health. Thus leaders of these agencies/systems may be called upon to take action when given compelling evidence of the benefits of doing so.

Research and application of culturally competent approaches is another important key to success (Suicide Prevention Resource Center, nd-a). More research and evaluation are needed to dig deeper into the role of culture in suicide prevention, and how culture/community context can inform intervention design. "Tailoring" refers to the creation of interventions that utilize information about a given individual/group to determine what specific content they will receive, the contexts surrounding that information, by whom it will be presented, and the way it will be delivered. Overall, tailoring aims to enhance the relevance of the intervention and improve intervention response. A critical review found that interventions tailored to address limitations of existing practices have more impact (Cheater et al., 2005). However, only four studies focused on Native American populations, and not a single study included Pacific Islanders. A review of prevention programs among American Indian and Alaska Native communities concluded that programs work best if they are culturally relevant and developed with community input (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). Several studies have shown that tailoring is a promising approach for Native Hawaiians, including the PSHTF's local work in youth suicide prevention (Chung-Do et al., 2014; Chung-Do et al., 2015; Chung-Do et al., 2016a and 2016b; Goebert et al., in press; Suicide Prevention Resource Center, 2012). For tailoring to be successful, there must be a balance between fidelity to evidence-based approaches and culturally-informed aspects of the intervention. Ultimately, this will help inform ways to improve program delivery to underserved populations and reduce health disparities.

In addition to exploration of new research frontiers, it is equally as important to incorporate and institutionalize evaluation into day-to-day practice. This includes evaluation of ongoing programs, systems, and policies, and subsequently (ideally, in real-time) applying evaluation findings to improve these interventions. One challenge is that many evidence-based programs for suicide prevention have not been assessed in diverse populations, so their effectiveness with these populations is not known. When implementing a new program, including one that was done with a different population different, evaluation and pilot testing is recommended. To the extent possible, practice-based evidence programs should be included in evaluations, so that they can add to the evidence base for suicide prevention. Practice-based evidence is a term sometimes used to refer to practices that are embedded in local cultures and accepted as effective by the community. Practitioners of practice-based evidence models draw upon cultural knowledge to develop programs that are respectful of, and responsive to, local definitions of wellness. In some cases, practice-based evidence also refers to a participatory "ground-up" approach to designing programs, as opposed to a "top-down" process in which programs are developed by academic researchers and then disseminated to communities.

Evaluation also encompasses quality improvement (QI) processes within organizations. Quality improvement offers a way for systems and organizations to assess their programs and activities, identify shortfalls, and improve performance. A quality improvement approach should be a systematic, data-driven, outcomes-based, approach to organizational change. There are best practice "toolkits" available for suicide prevention activities (e.g., Zero Suicide, discussed in Strategy 2) that include strategies, tips, and resources, (e.g., simple frameworks that illustrate how successful performance of key functions ensures an effective response to suicide prevention; a brief tutorial on QI methods; strategies to systematically review an organization's suicide prevention activities, identify areas in which to focus improvement efforts, and measure and improve the capabilities; and local success stories and promising practices).

Goal #4 – Detailed Objectives and Activities

OBJECTIVE 4.1 (data systems and sharing) – Facilitate the development and integration of suicide prevention data systems.

- 4.1.1 – Conduct an inventory of all data and surveillance systems which track indicators relating to suicide risk, attempts, and/or deaths. Examples include, but are not limited to: hospitals, emergency departments, medical examiner/coroner records, crisis line/phone banks, law enforcement, crisis mobile outreach and case management, etc.
- 4.1.2 – Investigate access and sharing protocols for the above data systems, and establish agreements/permissions to allow for access.

- 4.1.3 – Conduct data analysis to compare and triangulate information from the various data systems.

OBJECTIVE 4.2 (evaluation of local programs) – Evaluate existing Hawai'i-based suicide prevention programs, policies, and systems, instituting a "culture of evaluation" to ensure provision of high quality and evidence-based interventions.

- 4.2.1 – Conduct an inventory of local suicide prevention, service/intervention, and postvention activities, and ascertain which activities have built-in evaluation and/or quality improvement processes.
- 4.2.2 – For those activities which do not already have built-in evaluation and/or quality improvement processes, identify those that should be prioritized for evaluation, and design and implement evaluation plans.

OBJECTIVE 4.3 (quality improvement) – Support service organizations to incorporate organizational evaluation and quality improvement processes.

- 4.3.1 – Develop evaluation and quality improvement "toolkit" to serve as a general guide for service organizations. Toolkit would include topics such as evaluation of related systems and protocols, training systems and requirements, and cultural competency.
- 4.3.2 – Disseminate toolkit to service organizations, and provide technical assistance in implementation.

OBJECTIVE 4.4 (culture and diversity) – Support high-quality research and evaluation endeavors which will contribute to our understanding of the role of culture in suicide and suicide prevention.

- 4.4.1 – Inventory existing literature on the relationship between culture and suicide/suicide prevention, and conduct systematic literature review (emphasis on native and indigenous populations, and also studies with local communities).
- 4.4.2 – Develop research plan and questions to begin to address gaps in knowledge.
- 4.4.3 – Identify and pursue potential funding sources for various portions of research plan.

OBJECTIVE 4.5 (pursue new opportunities) – Pursue funding and partnerships to expand research opportunities, both local and national.

- 4.5.1 – Partner with local research centers with expertise in mental health/suicide prevention investigation to identify and prioritize potential research funding streams (local and national, public and private).
- 4.5.2 – Identify and engage with potential private organizations and foundations to establish ongoing funding for local research in mental health and suicide prevention.

STRATEGY #5 – POLICY AND ADVOCACY

This section of the strategic plan outlines objectives and activities pertinent to policy and advocacy. In order for suicide prevention efforts to be effective, they must be supported by appropriate protocols and policies that facilitate implementation and success. It should be noted that "policy" is a broad term which refers not only to legislation, but also includes elements such as agency regulations and organizational protocols/policies.

Goal #5
Ensure policies and protocols set the proper foundation for suicide prevention initiatives.

Suicide is a leading cause of death and morbidity in Hawai'i. Yet, it has received relatively few resources and inadequate funding locally and nationally, in part because it has only recently been recognized as a major public health problem. Addressing suicide requires a multifactorial approach involving communities, workplaces, schools, the health sector, and justice systems (National Action Alliance for Suicide Prevention, 2012; Shepard, Gurewich, Lwin, Reed Jr., & Silverman, 2015). The American Foundation for Suicide Prevention (nd) conducts an annual review of federal and state policies related to suicide prevention to assist with legislative efforts. For example, there are examples of states' legislation related to training requirements for educators and health professionals. Policy and systems change are long-lasting and efficient ways to advance suicide prevention. Additionally, interventions must also be strategically implemented and evaluated, requiring funding.

While the Hawai'i State Department of Health has taken the lead in convening individuals and organizations from the public and private sectors, coordinating trainings, and sharing suicide prevention efforts, more needs to be done throughout the government. For example, clarifying each agency's areas of focus and responsibility is an important first step, making it easier for different agencies to work together and to obtain support for their respective suicide prevention efforts. Making suicide prevention a multi-sectoral priority, regardless of resources, will reduce suicides and suicide attempts in Hawai'i. In addition, organizational policies can guide and support staff in knowing when and how to refer someone for additional help, and in responding safely when a suicide or suicide attempt occurs in the community. This strategic has prioritized existing and potential programs with the greatest opportunity for success in attaining the goal of reducing suicide 25% by 2025 and creating a healthy, safe, and empowered community. In order for these changes to take root, advocacy efforts designed to educate policymakers and organizational leaders are important and can motivate stakeholders to take action by promoting suicide prevention initiatives, policies, and programs.

Goal #5 – Detailed Objectives and Activities

OBJECTIVE 5.1 (general funding) – Ensure adequate levels of funding and resources for all aspects of the strategic plan.

- 5.1.1 – Identify, inventory, and consolidate required funding across all sections of the strategic plan, and organize by funding source and recipient.
- 5.1.2 – Identify and pursue communication and advocacy strategies with funding sources, to ensure maintenance of adequate resource levels.
- 5.1.3 – Identify and pursue communication and advocacy strategies with funding recipients, to ensure resources are directed and managed appropriately for specified activities within the strategic plan.

OBJECTIVE 5.2 (advocacy skills and capacity) – Encourage community members and professionals to engage in advocacy for suicide prevention.

- 5.2.1 – Conduct periodic trainings on broad policy and advocacy topics/strategies for the general PSHTF membership and community.
- 5.2.2 – Identify core group of PSHTF members interested in taking leadership roles in suicide prevention advocacy, both locally and nationally.

- 5.2.3 – Provide period training for core policy/advocacy members.
- 5.2.4 – Engage in local and national advocacy activities relating to suicide prevention and mental health/wellness.

OBJECTIVE 5.3 (organizational protocols and policies) – Encourage and support agencies and organizations to adopt protocols for suicide prevention, crisis response and management, and postvention.

- 5.3.1 – Create and disseminate "toolkit" to assist organizations in various sectors to design and implement organizational protocols for suicide prevention, intervention, and postvention.
- 5.3.2 – Provide technical assistance to organizations in design and implementation of protocols.

OBJECTIVE 5.4 (codify the PSHTF) – Institutionalize suicide prevention networks and collaborations, including the Prevent Suicide Hawai'i Taskforce (PSHTF).

- 5.4.1 – Advocate for specific legislation to codify the Prevent Suicide Hawai'i Taskforce (PSHTF), and include language to specify that the PSHTF shall have oversight of the strategic plan's implementation, evaluation, and amendments.

Discussion and Next Steps

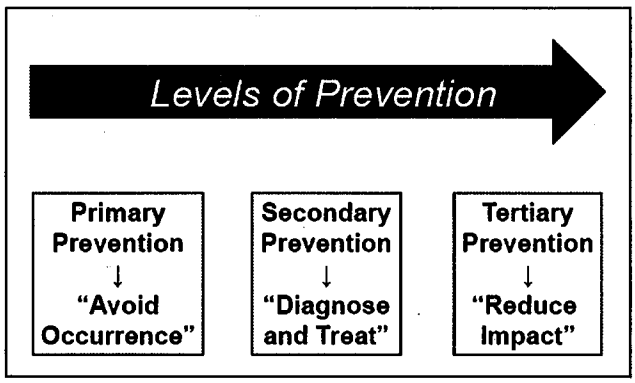
The Prevent Suicide Hawai'i Taskforce (PSHTF) is thankful for this opportunity to be a part of the shaping of suicide prevention strategies and activities for our State. However, we realize that planning is only a portion of what is needed to help our communities – the next step will be implementation and action. Therefore, we have begun to outline tasks that we will embark on, now that the formal plan and report have been completed:

- Dissemination of strategic plan recommendations to PSHTF membership, partner agencies, and pertinent stakeholders.
- Meetings to plan and implement priority items, including with partner agencies.
  - This includes partnering with the Hawai'i State Legislature to explore recommended legislative items.
- Ongoing monitoring and reporting of progress of different recommendations.
  - The strategic plan will be incorporated into our next statewide conference (tentatively in 2019).

Tools for Ongoing Planning and Monitoring

As previously discussed, suicide is a critical public health issue – that is, it is an issue that must be addressed from a community/population perspective. Thus, the PSHTF will continue to apply key public health concepts in its monitoring and implementation of the strategic plan.

Levels of Prevention – public health practitioners define three levels/stages within the general term of "prevention" (see figure).

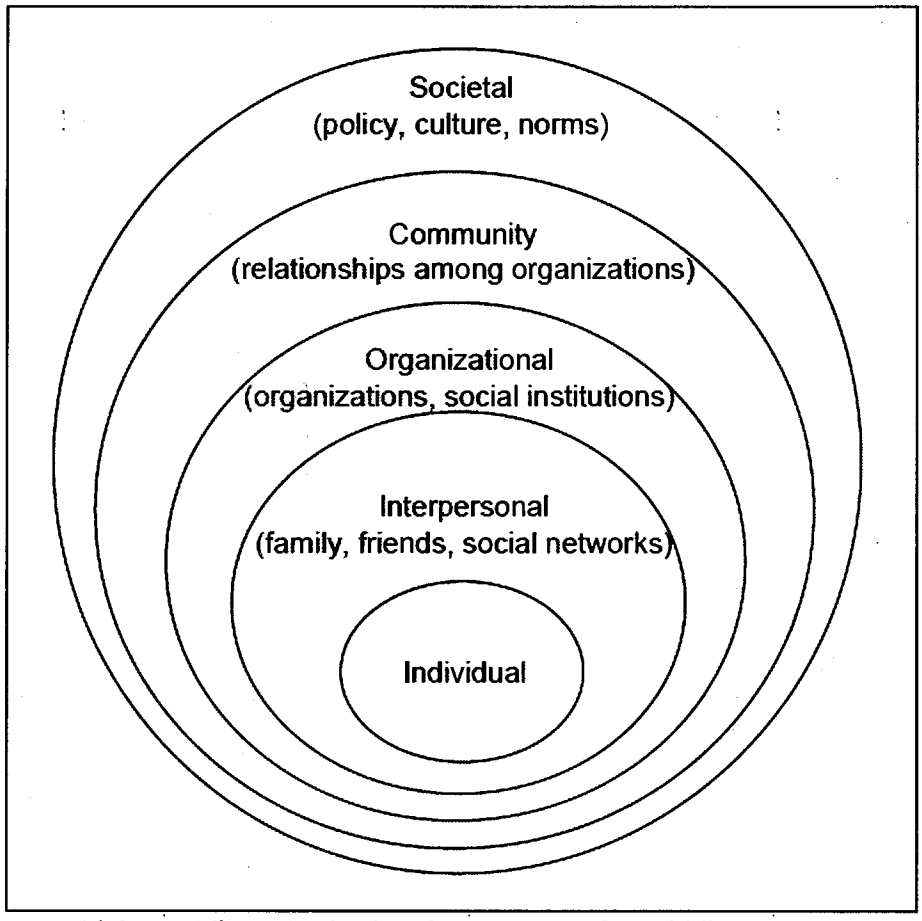


- Primary prevention refers to the most "upstream" type of prevention – that is, prevention of the occurrence of an illness or conditions before onset. Primary prevention activities promote health and protective factors, and protect against exposure to risk factors that lead to health problems (Owen, Splett, & Owen, 1999. This is done by addressing individual lifestyle behaviors, family/social networks, and the larger environment and community. In suicide prevention, for example, this would include efforts to prevent a young person from having thoughts of suicide. This might translate to programs such as teaching youth about positive coping skills, or efforts to ensure youth have connections to positive adult role models.
- Secondary prevention refers to early detection and/or intervention of an illness or condition, and also strategies to stop or slow the progression of disease. This often includes programs such as early screening (so that detection is achieved earlier than later), early treatment, and appropriate follow-up. Secondary prevention activities may target those who are more susceptible to health problems because of factors such as family history, age, lifestyle, health condition, or environmental factors (Owen, Splett, & Owen, 1999). In suicide prevention, for example, this would include efforts to institutionalize routine screening for risk factors such as depression, anxiety, and suicidal thoughts.
- Tertiary prevention refers to the management and rehabilitation of those who have been affected by an illness or condition. Interventions are aimed at those with diagnosed health conditions and reduce complications, improve their quality of life, and extend their years of productivity (Owen, Splett, & Owen, 1999). In suicide prevention, for example, this would include behavioral therapy, treatment with medications, and preventative measures such that future attempts are prevented (e.g., working with the youth to design and implement a safety/crisis plan).

When conceptualizing the three levels of prevention, the term "working upstream" is often coined. When one works upstream, it is common to discover that not all contributors to a health issue are related to an individual's biology. Providers must also consider broader factors that determine whether people in a community are healthy, as well as factors that account for differences in health status/outcomes of different groups. Social determinants of health refer to the conditions of daily life that impact health, as well as factors such as access to power, money, and resources (Solar & Irwin, 2010). The health of a community depends not only on the

individual genetics and behaviors of its residents, but also the social, political, economic, and environmental conditions that exist. Health disparities occur when there are different conditions/environments across different groups.

The Social Ecological Model – Ecological approaches, including the widely applied social ecological model, are one of the cornerstones of public health planning and practice. Such approaches conceptualize health broadly, including physical, mental, and social well-being (WHO, 1947). Ecological approaches also consider the multiple factors that contribute to the health of an individual and population, and how those different levels of influence interact with one another (Israel, Schulz, Parker, Becker, Allen, & Guzman, 2003; National Institutes of Health [NIH], 2011; Sallis, Owen, & Fisher, 2008; Wallerstein & Duran, 2003). In addition to individual-level attitudes and behaviors, there are many relational, structural, environmental, and policy factors which influence a person's health outcomes, including social determinants of health (e.g., economics, social networks, housing, culture, etc.). A multi-level, public health approach is recommended to effectively address complex community-wide topics such those which contribute to the leading causes of morbidity and mortality among youth.



The social ecological model (see figure) is also a valuable a tool that helps to frame and organize the multitude of factors that influence a particular health topic/behavior, so that multi-level interventions can subsequently be planned and implemented strategically (Bronfenbrenner, 1979; NIH, 2011; WHO, 2002). While many health programs and interventions are implemented at the individual level (e.g., provider to patient, on a one-to-one basis), the social ecological model acknowledges that a person does not exist in isolation. People are influenced by their relationships, the organizations and communities they belong to, the places where they live/work/play, and the societal forces that surround all of us (e.g., policies, social norms, cultural values, media, etc.). Of note for clinicians and providers who work with youth, research supports social ecological models in youth development, with growing applications in risk behaviors such as youth violence and suicide prevention research and practice (Bowen, Rose, Powers, & Glennie, 2008; Umemoto Baker, Helm, Miao, Goebert, & Hishinuma, 2009; Williams, Riveras, Neighbours, & Reznik, 2007). It is only with a strategically planned effort to better guide our collective movement that a coordinated, integrated, and comprehensive approach to health and wellness is possible.

There are five levels of influence described in the social ecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988; NIH, 2011):

LEVEL	DESCRIPTION	EXAMPLES OF INTERVENTIONS
Individual	Characteristics of the individual, including knowledge, attitudes, behaviors, self-concept, skills, etc. Includes the developmental/biological history of the individual.	• Education programs that help people prevent, control, and manage health conditions. • Individual clinical encounters, interventions, and treatment.
Interpersonal	Formal and informal social networks and support systems, including the family, co-workers, and friends.	• Enhancing opportunities for interpersonal contact and connection (e.g., clubs, teams, groups). • Group-based activities or interventions (e.g., family strengthening, peer groups).
Organizational/ Institutional	Social organizations/institutions with organizational characteristics, as well as formal and informal rules and regulations for operation.	• Working with organizations to increase availability/access to health-promoting goods and services. • Ensuring appropriate training for those working for and/or being served by the organization.
Community	Relationships among organizations, institutions, and informal networks.	• Strengthening communication and connection among organizations. • Interventions aiming to increase cohesion or individuals and groups within a particular community.
Societal	Includes local, state, and national laws and policies. Also considers broader determinants such as culture, norms, and media.	• Advocacy for policies and resources. • Broad public campaigns to impact changes in culture and norms.

Reference List

Akroyd, S, & Wyllie, J. (2002). *Impacts of national media campaign to counter stigma and discrimination associated with mental illness: Survey 4.* Wellington, New Zealand: New Zealand Ministry of Health. Publication 9-20-0004.

American Foundation for Suicide Prevention (AFSP). (2015a). *Survivor outreach program: Handbook. New York, NY: American Foundation for Suicide Prevention.* Accessed from: http://chapterland.org/wp-content/uploads/sites/10/2015/06/SOP-Handbook.pdf

American Foundation for Suicide Prevention (AFSP). (2015b, October 27). *The American Foundation for Suicide Prevention launches Project 2025.* New York, NY: American Foundation for Suicide Prevention. Accessed from: https://afsp.org/american-foundation-suicide-prevention-launches-project-2025/

American Foundation for Suicide Prevention (AFSP). (2016, August 29). *Nation's largest suicide prevention organization releases three investment opportunities that will reduce suicide rate 20 percent.* New York, NY: American Foundation for Suicide Prevention. Accessed from: https://afsp.org/nations-largest-suicide-prevention-organization-releases-three-investment-opportunities-will-reduce-suicide-rate-20-percent/

American Foundation for Suicide Prevention (AFSP). (nd). *Public policy priorities.* New York, NY: American Foundation for Suicide Prevention. Accessed from: https://afsp.org/our-work/advocacy/public-policy-priorities/

Bowen, G. L., Rose, R. A., Powers, J. D., & Glennie, E. J. (2008). The joint effects of neighborhoods, schools, peers, and families on changes in the school success of middle school students. *Family Relations, 57,* 504-516.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: The Harvard University Press.

Carter, G. L., Clover, K., Whyte, I. M., Dawson, A. H., & D'Este, C. (2005). Postcards from the EDge project: Randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *British Medical Journal, 331,* 805.

Center for Healthcare Research and Transformation. (2014). Care transitions: Best practices and evidence-based programs. Retrieved from http://www.chrt.org/assets/policy-papers/CHRT-Care-Transitions-Best-Practices-and-Evidencebased-Programs.pdf

Chagnon, F., Houle, J., Marcoux, I., et al. (2007). Control group study of an intervention training program for youth suicide prevention. *Suicide and Life Threatening Behaviors, 37,* 135-144.

Cheater, F., Baker, R., Gillies, C., Hearnshaw, H., Flottorp, S., Robertson, N., Shaw, E. J., & Oxman, A. D. (2005). Tailored interventions to overcome identified barriers to change: Effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews, 3*(art no: CD005470). doi 10.1002/14651858.CD005470

Chung-Do J. J, Bifulco, K,. Antonio, M., Tydingco, T., Helm, S., & Goebert, D. (2016a). A cultural analysis of the NAMI-NH Connect Suicide Prevention Program by rural community leaders in Hawai'i. *Journal of Rural Mental Health, 40*(2), 87-102.

Chung-Do, J. J., Goebert, D. A., Bifulco, K., Sugimoto-Matsuda, J., Balberde-Kamali'i, J., Ka'ae, D., ... & Walter, L. (2016b). Safe messaging for youth-led suicide prevention awareness: Examples from Hawai'i. *Hawai'i Journal of Medicine and Public Health*, *75*(5), 144.

Chung-Do, J., Goebert, D., Bifulco, K., Tydingco, T., Wilcox, S., Aea, D., Arume, B., & Alvarez, A. (2015). Mobilizing communities at-risk to prevent youth suicides. *Journal of Health Disparities Research and Practice, 8*(4), 108-123.

Chung-Do, J. J., Napoli, S. B., Hooper, K., Tydingco, T., Bifulco, K., & Goebert, D. (2014). Youth-led suicide prevention in an indigenous rural community. *Psychiatric Times.* Retrieved from http://www.psychiatrictimes.com/cultural-psychiatry/youth-led-suicide-prevention-indigenous-rural-community

Claassen, C. A., Pearson, J. L., Khodyakov, D., Satow, P. M., Gebbia, R., Berman, A. L., ... & Lento, R. M. (2014). Reducing the burden of suicide in the US: the aspirational research goals of the National Action Alliance for Suicide Prevention Research Prioritization Task Force. *American journal of preventive medicine*, *47*(3), 309-314.

Connect. (nd). *Telling your own story: Best practices for presentations by suicide loss and suicide attempt survivors.* Retrieved from http://theconnectprogram.org/survivors/telling-your-own-story-best-practices-presentations-suicide-loss-and-suicide-attempt

Curtin, S. C., Warner, M., & Hedegaard, H. (2016). Increase in suicide in the United States, 1999-2014. *NCHS Data Brief, 241,* 1-8.

Dunlop, S. M., More, E., & Romer, D. (2011). Where do youth learn about suicides on the internet, and what influence does this have on suicidal ideation? *Journal of Child Psychology and Psychiatry, 52*(10), 1073-1080. doi 10.1111/j.1469-7610.2011.02416.x

Etzersdorfer. E., & Sonneck, G. (1998). Preventing suicide by influencing mass-media reporting: The Viennese experience, 1980-1996. *Archives of Suicide Research, 4*(1), 67-74.

Fleischman, A., Bertolote, J., Wasserman, D., DeLeo, D., Bolhari, J., Botega, N., et al. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. *Bulletin of the World Health Organization, 86,* 703-709.

Galanis, D. (2017, December). *Suicides and suicide attempts in Hawai'i.* Presentation at Hawai'i State Legislature Informational Briefing. Honolulu, HI: EMS and Injury Prevention System Branch, Hawai'i State Department of Health.

Gibb, S. J., Beautrais, A. L., & Fergusson, D. M. (2005). Mortality and further suicidal behavior after an index suicide attempt: A 10-year study. *Australian and New Zealand Journal of Psychiatry, 39,* 95-100.

Godoy-Garraza, L., Walrath, C., Goldston, D. B., Reid, H., & McKeon, R. (2015). Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on suicide attempts among youths. *JAMA Psychiatry*, *72*(11), 1143-1149. doi: 10.1001/jamapsychiatry.2015.1933

Goebert, D., Alvarez, A., Andrade, N. N., Balberde-Kamalii, J., Carlton, B. S., Chock, S., Chung-Do, J. J., Eckert, M. D., Hooper, K., Kaninau-Santos, K., Kaulukukui, G., Kelly, C., Pike, M. J., Rehuher, D., & Sugimoto-Matsuda, J. (in press). Hope, Help, and Healing: Culturally-embedded approaches to suicide prevention, intervention, and postvention services with Native Hawaiian youth. *Psychological Services.*

Goebert, D., & Sugimoto-Matsuda, J. (2017). Medical School Hotline: Advancing suicide prevention in Hawai'i. *Hawai'i Journal of Medicine and Public Health*, *76*(11), 310.

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). *Reducing suicide: A national imperative.* Washington, DC: National Academies Press.

Gould, M. S. (2001). Suicide and the media. *Annals of the New York Academy of Sciences, 932,* 200-221.

Hegerl, U., Althaus, D., & Stefanek, J. (2003). Public attitudes towards treatment of depression: Effects of an information campaign. *Pharmacopsychiatry, 36*, 288-291.

Hirsch, J. K. (2006). A review of the literature on rural suicide: Risk and protective factors, incidence, and prevention. *Crisis, 27*(4), 189-199.

Isaac, M., Elias, B., Katz, L. Y., Belik, S. L., Deane, F. P., Enns, M. W., ... & Swampy Cree Suicide Prevention Team (12 members) (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. *The Canadian Journal of Psychiatry, 54*(4), 260-268.

Israel, B. A., Schulz, A. J., Parker, E. A., Becker, A. B., Allen, A. J., Guzman, J. R. (2003). Critical issues in developing and following community based participatory research principles. In M. Minkler & N. Wallerstein (Eds.), *Community-Based Participatory Research for Health* (pp 53-76). San Francisco, CA: Jossey-Bass.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life Threatening Behaviors, 31,* 91–102.

Jordan, J. R. (2008). Bereavement after suicide. *Psychiatric Annals, 38,* 679–685.

Jorm, A. F., Christensen, H., & Griffiths, K. M. (2005). The impact of Beyond Blue: The national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australia and New Zealand Journal of Psychiatry, 39,* 248-254.

Kawa'a, L. (2009). *Morning Mana'o.* Retrieved from http://morningmanao.blogspot.com/2009/04/hilinai-believe.htm

Knesper, D. J., American Association of Suicidology, and Suicide Prevention Resource Center. (2011). *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the Emergency Department of Psychiatry Inpatient Unit.* Newton, MA: Education Development Center, Incorporated.

Knox, K. L., Litts, D. A., Talcott, G. W., et al (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *British Medical Journal, 327,* 1376.

LeFevre, M. L. (2014). Screening for suicide risk in adolescents, adults, and older adults in primary care: US Preventive Services Taskforce recommendation statement. *Annals of Internal Medicine, 160*(10), 719-726.

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., ... & Mehlum, L. (2005). Suicide prevention strategies: A systematic review. *JAMA, 294*(16), 2064-2074.

Matsu, C. R., Goebert, D., Chung-Do, J. J., Carlton, B., Sugimoto-Matsuda, J., & Nishimura, S. (2012). Disparities in psychiatric emergency department visits among youth in Hawai'i, 2000-2010. *Journal of Pediatrics, 162*(3), 618-23.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly, 15*(4), 351-377.

Melhum, L., & Schwebs, R. (2001). Suicide prevention in the military: Recent experiences from the Norwegian armed forces. *International Review of the Armed Forces Medical Services, 74,* 71-74.

Middlebrook, D. L., LeMaster, P. L., Beals, J., Novins, D. K., & Manson, S. (2001). Suicide prevention in American Indian and Alaska Native communities: A critical review of programs. *Suicide and Life-Threatening Behavior, 31(suppl.),* S132-S149. PMID: 11326757

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of post-crisis suicide prevention. *Psychiatric Services, 52,* 828-833.

Moutier, C. (2015, August.) *Suicide Loss Outreach Program launched nationwide by the American Foundation for Suicide Prevention.* New York, NY: American Foundation for Suicide Prevention.

National Action Alliance for Suicide Prevention. (n.d.) *Zero suicide in health and behavioral health care.* Retrieved from http://zerosuicide.actionallianceforsuicideprevention.org/

National Action Alliance for Suicide Prevention and the Office of the Surgeon General. (2012). *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.* Washington, DC: HHS.

National Institutes of Health (NIH). (2011, June). *Principles of community engagement (2nd ed).* Bethesda, MD: National Institutes of Health, Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. Accessed from: https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Office of Youth Services (2012, August). *RFP service specifications.* Honolulu, HI: Office of Youth Services, Hawai'i State Department of Human Services.

Onoye, J., Helm, S., Koyanagi, C., Fukuda, M., Hishinuma, E., Takeshita, J., & Ona, C. (2013). Proportional differences in emergency room adult patients with PTSD, mood disorders, and anxiety for a large ethnically diverse geographic sample. *Journal of health care for the poor and underserved, 24*(2), 928-942.

Owen, A. L., Splett, P. L., & Owen, G. M. (1999). *Nutrition in the Community: The Art and Science of Delivering Services (4th ed).* New York, NY: McGraw-Hill.

Paykel, E. S., Hart, D., & Priest, R. G. (1998). Changes in public attitudes to depression during the Defeat Depression Campaign. *British Journal of Psychiatry, 173,* 519-522.

Pukui, M. K. (1983). *Ōlelo No'eau: Hawaiian proverbs and poetical sayings.* Honolulu, HI: Bishop Museum Press.

Ramsay, R. F., Cooke, M. A., & Lang, W. A. (1990). Alberta's suicide prevention training programs: A retrospective comparison with Rothman's developmental research model. *Suicide and Life Threatening Behaviors, 20,* 7-22.

Robinson, J., Bailey, E., Hetrick, S., Paix, S., O'Donnell, M., Cox, G., ... & Skehan, J. (2017). Developing social media-based suicide prevention messages in partnership with young people: Exploratory study. *Journal of Medical Internet Research – Mental Health, 4*(4).

Rozanov, V. A., Mokhovikov, A. N., & Stiliha, R. (2002). Successful model of suicide prevention in the Ukraine military environment. *Crisis, 23,* 171-177.

Runyan, C. W., Becker, A., Brandspigel, S., Barber, C., Trudeau, A., & Novins, D. (2016). Lethal means counseling for Parents of youth seeking emergency care for suicidality. *Western Journal of Emergency Medicine, 17*(1), 8-14. http://doi.org/10.5811/westjem.2015.11.28590

Sallis, J. F., Owen, N., & Fisher, E. B. (2008). Ecological models of health behavior. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health Behavior and Health Education (4th ed)* (pp 465-485). San Francisco, CA: John Wiley & Sons.

Shepard, D. S., Gurewich, D., Lwin, A. K., Reed Jr., G. A., & Silverman, M. M. (2015). Suicide and suicidal attempts in the United States: Costs and policy implications. *Suicide and Life Threatening Behavior, 46*(3), 352-362.

Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health*. Geneva, Switzerland: World Health Organization.

Spirito, A., Boergers, J., Donaldson, D., Bishop, D., & Lewander, W. (2002). An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(4), 435-442.

Stack, S. (2003). Media coverage as a risk factor in suicide: Public health policy and practice. *Journal of Epidemiology and Community Health, 57,* 238-240. doi:10.1136/jech.57.4.238

Suicide Prevention Resource Center. (2012). *State, tribal, and territory youth suicide prevention and early intervention grant program descriptions: Hawai'i – University of Hawai'i program description.* Waltham, MA: Suicide Prevention Resource Center, Education Development Center, incorporated. Retrieved from http://www.sprc.org/grantees/statetribe/desc/showStateTribe.asp?st_trID=91

Suicide Prevention Resource Center. (nd-a). *Evidence-based prevention.* Waltham, MA: Suicide Prevention Resource Center, Education Development Center, Incorporated. Retrieved from https://www.sprc.org/keys-success/evidence-based-prevention

Suicide Prevention Resource Center. (nd-b). *Recommendations for reporting on suicide.* Waltham, MA: Suicide Prevention Resource Center, Education Development Center, Incorporated. Retrieved from http://reportingonsuicide.org/wp-content/themes/ros2015/assets/images/Recommendations-eng.pdf

Suicide Prevention Resource Center. (nd-c). *Safe and effective messaging for suicide prevention.* Waltham, MA: Suicide Prevention Resource Center, Education Development Center, Incorporated. Retrieved from http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/safemessaging.pdf

Suominen, K., Isometsa, E., Suokas, J., Haukka, J., Achte, K., & Lonnqvist, J. (2004). Completed suicide after a suicide attempt: A 37-year follow-up study. *American Journal of Psychiatry*, 161, 562–563.

Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioral interventions to reduce suicide behavior: A systematic review and meta-analysis. *Behavior Modification, 32*(1), 77-108.

Torok, M., Calear, A., Shand, F., & Christensen, H. (2017). A systematic review of mass media campaigns for suicide prevention: Understanding their efficacy and the mechanisms needed for successful behavioral and literacy change. *Suicide and Life Threatening Behaviors, 47,* 672-687. doi 10.1111/sltb.12324

Umemoto, K., Baker, C. K., Helm, S., Miao, T., Goebert, D. A., & Hishinuma, E. S. (2009). Moving toward comprehensiveness and sustainability in a social ecological approach to youth violence prevention: Lessons from the Asian/Pacific islander Youth Violence Prevention Center. *American Journal of Community Psychology, 44*(3-4), 221-232.

US Department of Agriculture. (2007). *Rural definitions: Data documentation and methods.* Retrieved from http:/www.ers.usda.gov/Data/Ruraldefinitions/documentation.htm.

US Department of Health and Human Services (DHHS) (1999). *The Surgeon General's call to action to prevent suicide.* Washington, DC: Department of Health and Human Services, US Public Health Service. Retrieved from https://profiles.nlm.nih.gov/ps/access/nnbbbh.pdf

Wallerstein, N., & Duran, B. (2003). The conceptual, historical and practice roots of community-based participatory research and related participatory traditions. In M. Minkler & N. Wallerstein (Eds), *Community-Based Participatory Research for Health (1st ed)* (pp 27-52). San Francisco, CA: Jossey-Bass.

Walrath, C., Garraza, L. G., Reid, H., Goldston, D. B., & McKeon, R. (2015). Impact of the Garrett Lee Smith youth suicide prevention program on suicide mortality. *American Journal of Public Health, 105*(5), 986-993. doi: 10.2105/AJPH.2014.302496

Williams, K., Riveras, L., Neighbours, R., & Reznik, V. (2007). Youth violence prevention comes of age: Research, training and future directions. *Annual Review of Public Health, 28,* 195-211.

World Health Organization [WHO]. (1947). *Constitution.* New York, NY: World Health Organization.

World Health Organization [WHO]. (2002). *World report on violence and health.* Geneva, Switzerland: World Health Organization.

World Health Organization and The International Association for Suicide Prevention. (2008). *Preventing suicide: How to start a survivors' group.* Geneva, Switzerland: Department of Mental Health and Substance Abuse, World Health Organization.

Wyman, P. A., Brown, C. H., Inman, J., et al. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76,* 104-115.

Yahata D., & Kaninau P. (2009). *2009 Native Hawaiian youth violence, bullying, and suicide needs assessment report.* Honolulu, HI: Papa Ola Lokahi.

Young, I. T., Iglewicz, A., Glorioso, D., Lanouette, M., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience, 14*(2), 177-186. PMCID PMC3384446

Zalsman, G., Hawton, K., Wasserman, D., et al. (2016). Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry, 3*(7), 646-659.

Zenere, F. J. (2009). Suicide clusters and contagion. *Principal Leadership, 10*(2), 12-16.

Appendices

The following appendices are included with this report:

1. Copy of House Concurrent Resolution (HCR) 66 (HD1, SD1) of the 2016 Hawai'i State Legislature
2. Roster of Strategic Planning Sub-Committee Members
3. Slide deck from Informational Briefing on December 8, 2017, where strategic plan recommendations were presented to legislators
4. Stories shared by loss survivors Pua Kaninau-Santos and Monica Toguchi
5. General resources for mental health promotion and suicide prevention
6. Brochure – "Suicide prevention in Hawai'i: Passing life forward"
7. Safe messaging guidelines – "Safe and effective messaging for suicide prevention," and "Recommendations for reporting on suicide"

HOUSE OF REPRESENTATIVES
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

H.C.R. NO. 66 H.D. 1 S.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE PREVENT SUICIDE HAWAII TASK FORCE TO RECOMMEND A STRATEGIC PLAN TO REDUCE SUICIDES IN HAWAII BY AT LEAST TWENTY-FIVE PER CENT BY 2025.

WHEREAS, the Legislature finds that suicide is a major health concern that claims approximately one million lives worldwide each year; and

WHEREAS, in Hawaii, suicide was the most common cause of fatal injuries between 2010 and 2014, accounting for one out of every four fatal injuries; and

WHEREAS, every two days, one person in Hawaii falls victim to suicide; and

WHEREAS, the Prevent Suicide Hawaii Task Force is a partnership of state, public, and private agencies and community groups working in collaboration to provide leadership, develop strategies, coordinate activities, and monitor progress of suicide prevention efforts in the State; and

WHEREAS, the Prevent Suicide Hawaii Task Force includes the Department of Health's Injury Prevention and Control Section in planning and implementing these activities; and

WHEREAS, the Prevent Suicide Hawaii Task Force provides leadership for suicide prevention activities statewide, including National Suicide Prevention Week and suicide prevention conferences; and

WHEREAS, the Prevent Suicide Hawaii Task Force meets bi-monthly to address suicide prevention issues statewide; and

WHEREAS, the Prevent Suicide Hawaii Task Force is a valuable ally in the effort to save lives from suicide; and

WHEREAS, the Legislature is concerned about the health, safety, and welfare of all the people of Hawaii, including military personnel, veterans, and visitors; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-eighth Legislature of the State of Hawaii, Regular Session of 2016, the Senate concurring, that the Prevent Suicide Hawaii Task Force is requested to recommend a strategic plan to reduce suicides in Hawaii by at least twenty-five per cent by 2025; and

BE IT FURTHER RESOLVED that the Prevent Suicide Hawaii Task Force, in the course of developing its recommendations, is requested to examine, evaluate, and determine methods to improve education, awareness, support services, and outreach to best prevent suicides in Hawaii; and

BE IT FURTHER RESOLVED that the Prevent Suicide Hawaii Task Force is requested to form a temporary subcommittee to assist in the development of its recommendations; and

BE IT FURTHER RESOLVED that the subcommittee is requested to include individuals who have expertise or experience in fields or disciplines related to suicide prevention and education or awareness of suicide prevention; and

BE IT FURTHER RESOLVED that, at minimum, the following individuals are requested to serve and be included on the subcommittee:

(1) Four members to be appointed by the Governor, one from each county, two of whom are requested to be a survivors of attempted suicide or suicide loss survivors;

(2) One member from the Adult Mental Health Division and one member from the Child and Adolescent Mental Health Division, to be appointed by the Director of Health;

(3) One member from the Hawaii Chapter of the Veterans Administration;

(4) The Suicide Prevention Program Manager for the Army Suicide Prevention Task Force or the Program Manager's designee;

(5) One member from the Pacific Regional Behavioral Health Alliance;

(6) One member from the Prevent Suicide Hawaii Task Force, to be appointed by the Director of Health;

(7) One member to be appointed by the Dean of the John A. Burns School of Medicine at the University of Hawaii at Manoa, from its Department of Psychiatry;

(8) One member from the Hawaii Youth Leadership Council for Suicide Prevention, to be appointed by the President of the Senate;

(9) One member from the Hawaii Youth Leadership Council for Suicide Prevention, to be appointed by the Speaker of the House of Representatives;

(10) The Chair of the Board of the American Foundation for Suicide Prevention Hawaii Chapter or the Chair's designee;

(11) The President of the American Foundation for Suicide Prevention Hawaii Chapter or the President's designee;

(12) The Community Liaison of the American Foundation for Suicide Prevention Hawaii Chapter; and

(13) The President of the Board of Directors of Mental Health America of Hawaii or the President's designee; and

BE IT FURTHER RESOLVED that the members of the subcommittee are requested to elect a chair, a vice chair, and any other necessary officers from among its members; and

BE IT FURTHER RESOLVED that the subcommittee is requested to meet as often as necessary during 2016 through 2017 to assist the Prevent Suicide Hawaii Task Force develop its recommendations; and

BE IT FURTHER RESOLVED that the Prevent Suicide Hawaii Task Force is requested to submit a report of its findings and recommendations to the Legislature, including any proposed legislation, no later than twenty days prior to the convening of the Regular Session of 2018; and

BE IT FURTHER RESOLVED that a certified copy of this Concurrent Resolution be transmitted to the Director of Health, who in turn is requested to transmit copies to the Governor; the Administrator of the Hawaii Chapter of the Veterans Administration; the Suicide Prevention Program Manager for the Army Suicide Prevention Task Force; the Executive Director of the Pacific Regional Behavioral Health Alliance; the Dean of the John A. Burns School of Medicine at the University of Hawaii at Manoa; the Chair of the Prevent Suicide Hawaii Task Force; the Chair of the Hawaii Youth Leadership Council for Suicide Prevention; the Chair of the Board, the President, and the Community Liaison of the American Foundation for Suicide Prevention Hawaii Chapter; and the President of the Board of Directors of Mental Health America of Hawaii.

Prevent Suicide Hawai'i Taskforce (PSHTF) – Strategic Planning Sub-Committee

From House Concurrent Resolution [HCR] 66, 2016 Legislative Session

http://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=HCR&billnumber=66&year=2016

– Roster of Sub-Committee Members –

(updated 12/7/17)

COMMITTEE POSITION		NAME	ROLE AND ORGANIZATION
1	HCR 1a – Governor appointed, Kaua'i	Regina (Gina) Kaulukukui	Executive Director, Life's Bridges Kaua'i (also with Kaua'i Police Department)
2	HCR 1b – Governor appointed, Maui	Mona Cherry	Co-Chair, Prevent Suicide Maui Taskforce
3	HCR 1c – Governor appointed, Hawai'i Island (East Side)	JoAnne Balberde-Kamali'i	School-Based Behavioral Health Specialist, Hilo High School, Hawai'i State Department of Education
4	HCR 1d – Governor appointed, Hawai'i Island (West Side)	Nancy Sallee	Marriage and Family Therapist, Orchid Isle Psychotherapy
5	HCR 1e – Governor appointed, O'ahu	Monica Toguchi	President and Owner, Highway Inn
6	HCR 2a – Adult Mental Health Division	Steven Balcom	Crisis Services Coordinator, Adult Mental Health Division, Hawai'i State Department of Health
7	HCR 2b – Child and Adolescent Mental Health Division	Dr. Scott Shimabukuro	Assistant Administrator of Operations, Child and Adolescent Mental Health Division, Hawai'i State Department of Health
8	HCR 3 – Veterans Administration Hawai'i	Tiara Peterkin (current) Haylin Dennison (former)	Suicide Prevention Program Coordinator & Reach Vet Coordinator, US Department of Veteran Affairs, Pacific Islands Healthcare System
9	HCR 4 – Army Hawai'i/DOD Taskforce	Brent Oto	Suicide Prevention Program Manager, US Army (Schofield Barracks)
10	HCR 5 – Pacific Regional Behavioral Health	Dr. David Brown (current) Danielle Sodergren (former)	Regional Director, Psychological Health Regional Health Command – Pacific (RHC-P); Behavioral Health Consultant, US Pacific Command (PACOM)
11	HCR 6 – Prevent Suicide Hawai'i Taskforce	Dr. Jeanelle Sugimoto-Matsuda	Statewide Chair, Prevent Suicide Hawai'i Taskforce; (also Assistant Professor, Department of Psychiatry & Office of Public Health Studies University of Hawai'i at Mānoa)

COMMITTEE POSITION		NAME	ROLE AND ORGANIZATION
12	HCR 7 – John A. Burns School of Medicine	Dr. Deborah Goebert	Professor, Department of Psychiatry, University of Hawai'i at Mānoa
13	HCR 8 – Youth Council – youth	Members of Statewide Youth Leadership Council for Suicide Prevention	
14	HCR 9 – Youth Council – adult	Mara J. Pike	Community Outreach Manager, Mental Health America of Hawai'i
15	HCR 10 – American Foundation for Suicide Prevention, Hawai'i Chapter – Board Chair	Eric Tash	Board Chair, American Foundation for Suicide Prevention (Hawai'i Chapter)
16	HCR 11 – American Foundation for Suicide Prevention, Hawai'i Chapter – President	Kimberly Gallant (current) Dan Yahata (former)	Chapter President, American Foundation for Suicide Prevention (Hawai'i Chapter) (also Licensed Clinical Social Worker, Wellness Center, Honolulu Community College)
17	HCR 12 – American Foundation for Suicide Prevention, Hawai'i Chapter – Community Liaison	Ka'ohu'onapua (Pua) Kaninau-Santos	Community Liaison, American Foundation for Suicide Prevention (Hawai'i Chapter) (also 'Ohana Team Lead, Queen Lili'uokalani Trust – Wai'anae Kīpuka)
18	HCR 13 – Mental Health America of Hawai'i	Trisha Kajimura	Executive Director, Mental Health America of Hawai'i
19	Added – Corrections/Public Safety	Dr. Victor Yee	Clinical Psychologist (formerly with O'ahu Community Correctional Center, Hawai'i State Department of Public Safety)
20	Added – K-12 Education	Gordon Miyamoto and Cynthia (CJ) Rice	Acting Director & Project Coordinator, Project HI-AWARE, Comprehensive Student Support Services Section, Hawai'i State Department of Education
21	Added – Human Services	Merton Chinen	Director, Office of Youth Services, Hawai'i State Department of Human Services
22	Support Role	Nancy Deeley and Therese Argoud	Suicide Prevention Coordinator and Section Manager, Emergency Medical Services and Injury Prevention System Branch, Hawai'i State Department of Health
23	Support Role	Dr. Izumi Okado	University of Hawai'i at Mānoa (serving as support staff for strategic planning sub-committee)

Suicide Prevention in Hawai'i

Passing Life Forward
through Hope, Help, and Healing

PREVENT SUICIDE HAWAI'I TASKFORCE

Informational Briefing
Hawai'i State Legislature
Friday, December 8, 2017
Hawai'i State Capitol

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

WELCOME...
AND
THANK YOU!!!

We Acknowledge
with love and gratitude

- Those we have lost, those who struggle, those who provide love and support for our families and communities
- Supporting agencies, including:
  - Hawai'i State Legislature
  - Hawai'i State Department of Health
- Prevent Suicide Hawai'i Taskforce members and partners

Agenda

- Grounding and framing
  - Our purpose
  - The issue
- Introduction to strategic plan
  - Process
  - Guiding framework
- Summary of recommendations, by section
- Questions/discussion

Introductions

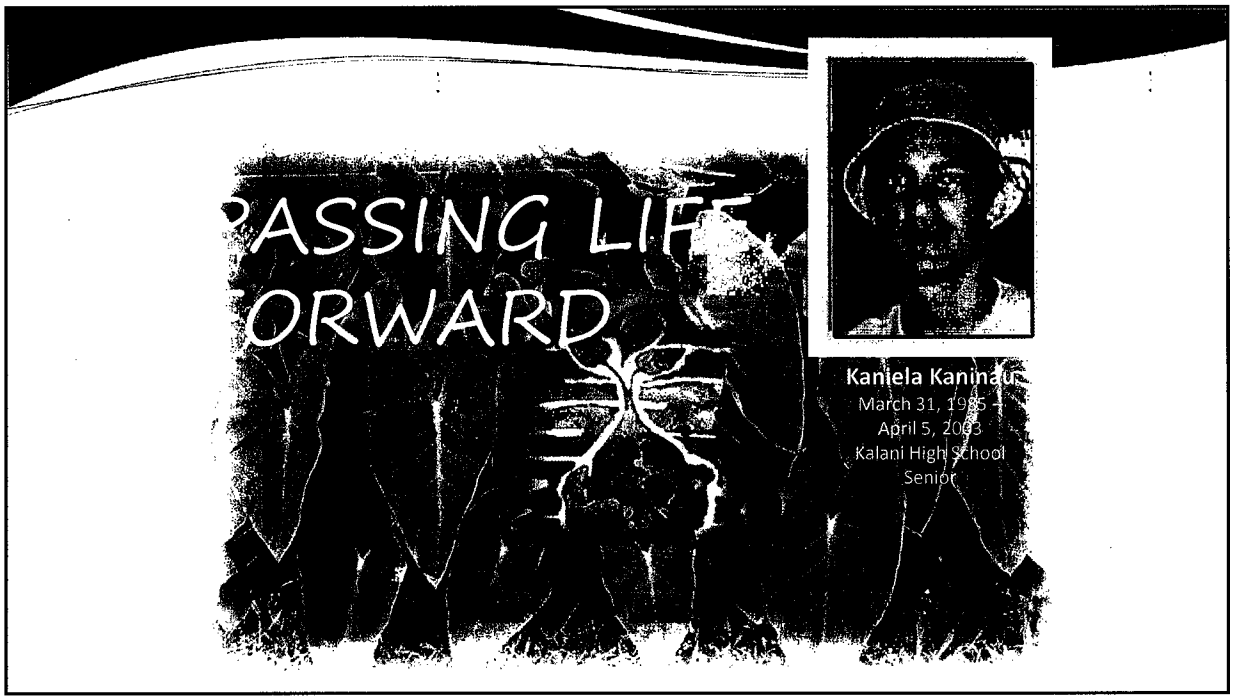
Our Strategic Planning Committee
(please see handout for details)

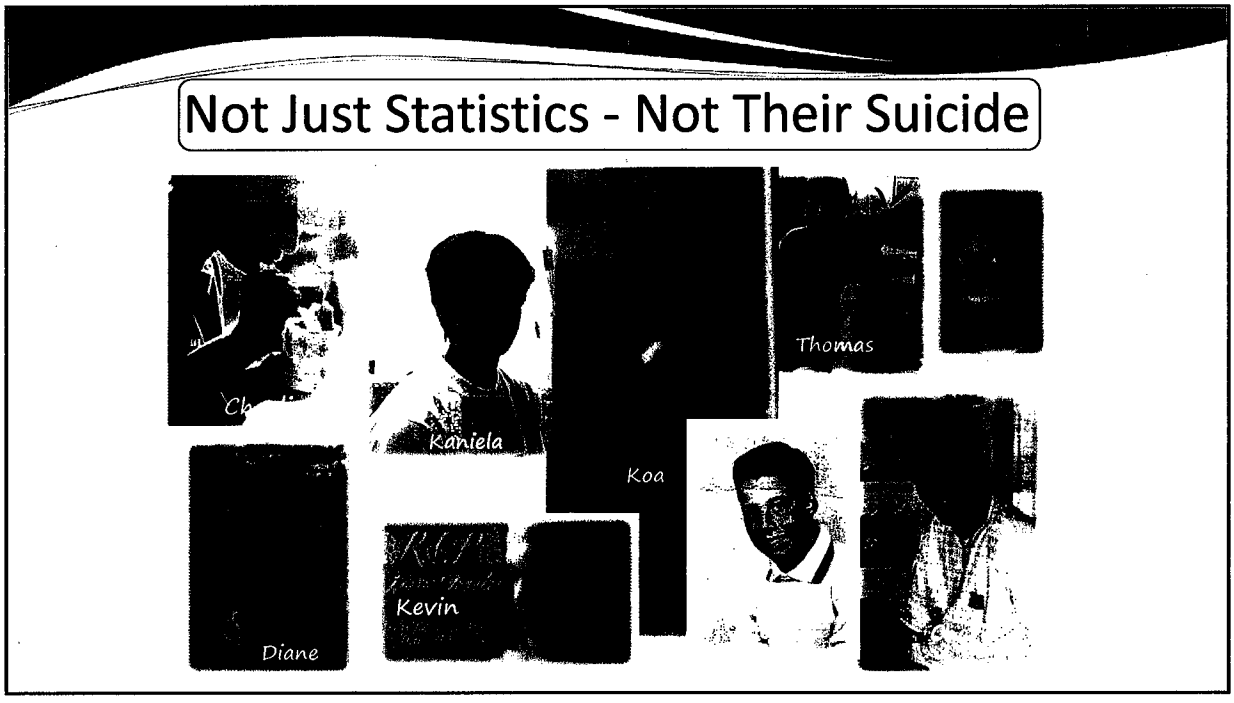
Thank you to everyone present!

- JoAnne Balberde-Kamalii
- Steven Balcom
- David Brown
- Mona Cherry
- Merton Chinen
- Nancy Deeley
- Haylin Dennison
- Kimberly Gallant
- Deborah Goebert
- Trisha Kajimura
- Pua Kaninau-Santos
- Gina Kaulukukui
- Gordon Miyamoto
- Izumi Okado
- Brent Oto
- Tiara Peterkin
- Mara Pike (and youth members)
- CJ Rice
- Nancy Sallee
- Scott Shimabukuro
- Danielle Sodergren
- Jeanelle Sugimoto-Matsuda
- Eric Tash
- Monica Toguchi
- Dan Yahata
- Victor Yee

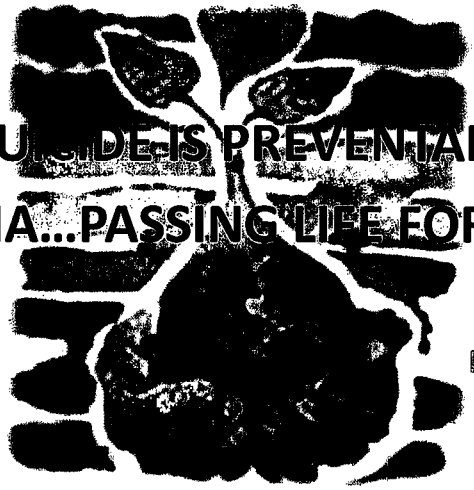
From the Hearts of Survivors

Ms. Pua Kaninau-Santos
& Ms. Monica Toguchi


ASSING LIF
ORWARD
Kaniela Kaninau
March 31, 1985 -
April 5, 2003
Kalani High School
Senior


Not Just Statistics - Not Their Suicide
Kaniela
Thomas
Koa
Kevin
Diane

WHY WE DO THE WORK WE DO!



- SUICIDE IS PREVENTABLE
- ALOHA...PASSING LIFE FORWARD

MAHALO!

The Prevent Suicide Hawai'i Taskforce (PSHTF)

- Community-based network of individuals and organizations
  - Public, private, community, non-profit, military, schools, healthcare, etc.
  - Awareness events, trainings, survivor supports, etc.
- Initially formed in 2001, with many original members still participating
  - Today a statewide network, with activity on all islands
  - Island specific taskforces on Kaua'i, Maui, Hawai'i Island, O'ahu

Brief Review of Statewide Data

Dr. Daniel Galanis
Epidemiologist
Hawai'i State Department of Health
Emergency Medical Services &
Injury Prevention System Branch

So, how did we get here?

(and where exactly is "here"?)

Suicide Prevention in Hawai'i: *Passing Life Forward*

Informational Briefing
Thursday, April 5, 2012

The Twenty-Sixth Legislature
State of Hawai'i
Regular Session of 2012

Suicide Prevention in Hawai'i: *Passing Life Forward*

Informational Briefing

Hawai'i State Legislature

Thursday,
September 20, 2012
1:30 to 2:00 p.m.

Hawai'i State Capitol
Room 329

HOUSE OF REPRESENTATIVES
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

H.C.R. NO. 66 H.D. 1 S.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE PREVENT SUICIDE HAWAII TASK FORCE TO RECOMMEND A STRATEGIC PLAN TO REDUCE SUICIDES IN HAWAII BY AT LEAST TWENTY-FIVE PER CENT BY 2025.

HCR 66 – Highlights

- Deliverable – strategic plan report
  - Statewide strategic plan, including (but not limited to) policy recommendations
  - 20 days prior to convening of 2018 regular session
- Sub-committee of PSHTF
  - Certain roles specified, and others added

Our Process

- Sub-committee formed in August 2016
  - Members focused on area(s) in their expertise/interest areas
- Met every other month, with work in between
  - "Learning" + "synthesis"

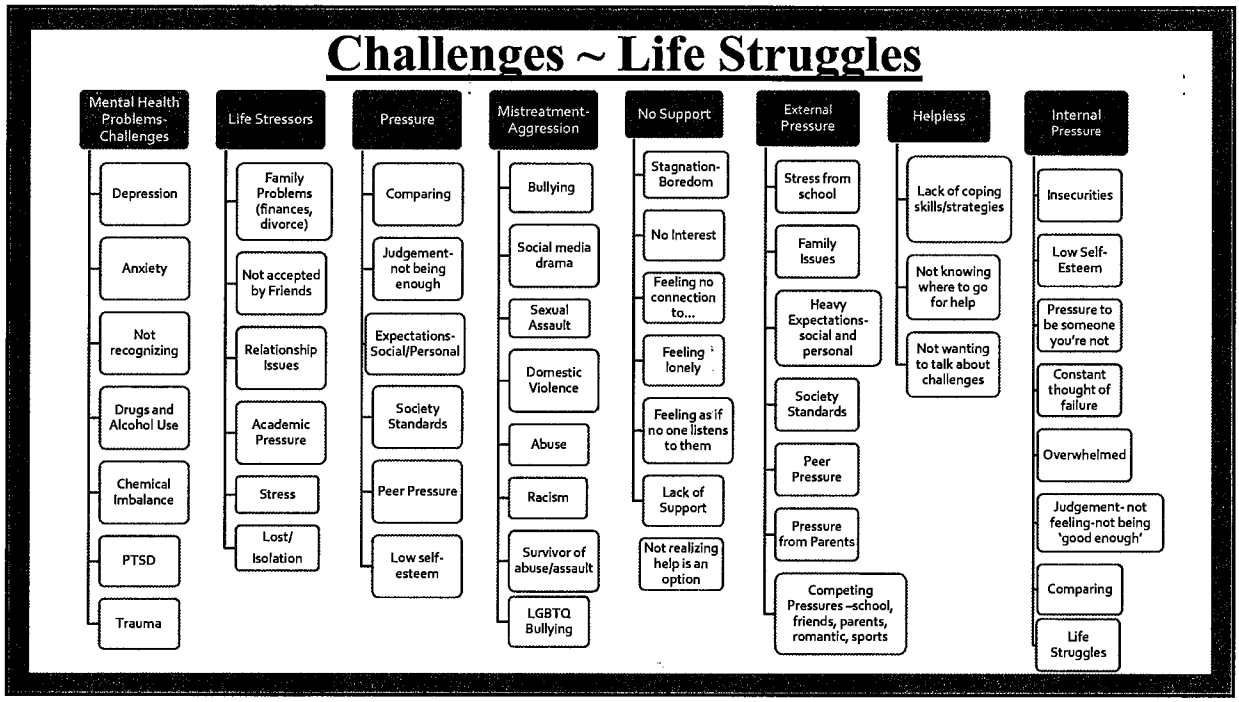
Our Process

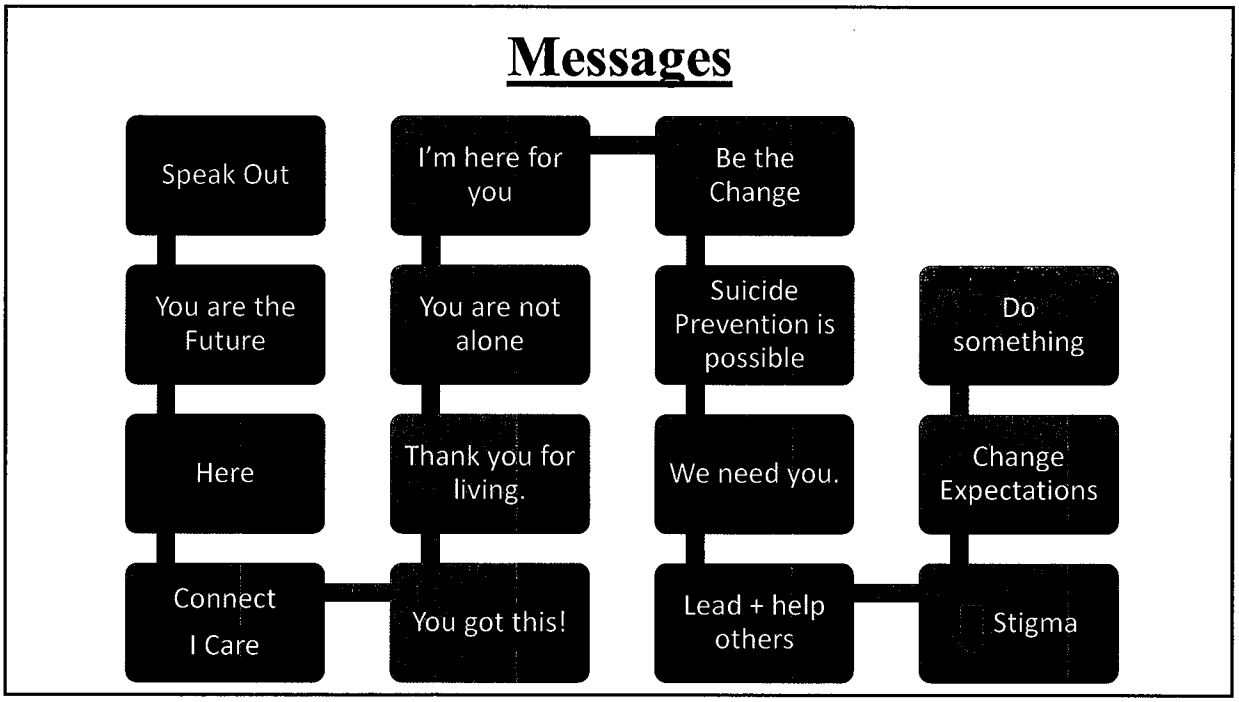
Expertise from Outside the Sub-Committee

- Feedback from larger PSHTF membership
  - Discussions during meetings
  - Member survey circulated
- Intensive two-day session with Dr. Jerry Reed, co-convener of the National Strategy for Suicide Prevention
- Feedback from partner groups, including Youth Leadership Council for Suicide Prevention

Inclusion of Youth Voice

Through Youth Leadership Council (YLC) for Suicide Prevention

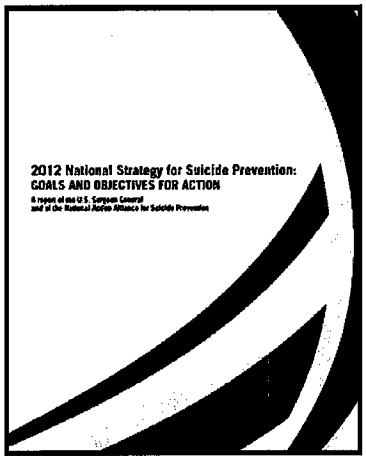

Challenges ~ Life Struggles
Mental Health Problems-Challenges
Depression
Anxiety
Not recognizing
Drugs and Alcohol Use
Chemical Imbalance
PTSD
Trauma
Life Stressors
Family Problems (finances, divorce)
Not accepted by Friends
Relationship Issues
Academic Pressure
Stress
Lost/ Isolation
Pressure
Comparing
Judgement-not being enough
Expectations-Social/Personal
Society Standards
Peer Pressure
Low self-esteem
Mistreatment-Aggression
Bullying
Social media drama
Sexual Assault
Domestic Violence
Abuse
Racism
Survivor of abuse/assault
LGBTQ Bullying
No Support
Stagnation-Boredom
No Interest
Feeling no connection to...
Feeling lonely
Feeling as if no one listens to them
Lack of Support
Not realizing help is an option
External Pressure
Stress from school
Family Issues
Heavy Expectations-social and personal
Society Standards
Peer Pressure
Pressure from Parents
Competing Pressures –school, friends, parents, romantic, sports
Helpless
Lack of coping skills/strategies
Not knowing where to go for help
Not wanting to talk about challenges
Internal Pressure
Insecurities
Low Self-Esteem
Pressure to be someone you're not
Constant thought of failure
Overwhelmed
Judgement- not feeling-not being 'good enough'
Comparing
Life Struggles

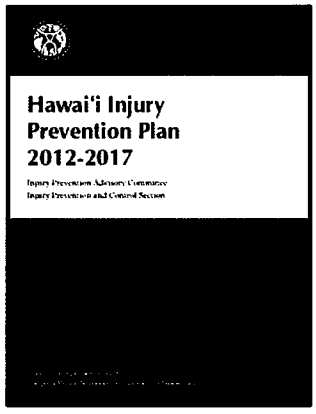

Messages
Speak Out
I'm here for you
Be the Change
You are the Future
You are not alone
Suicide Prevention is possible
Do something
Here
Thank you for living.
We need you.
Change Expectations
Connect
I Care
You got this!
Lead + help others
Stigma

Messages

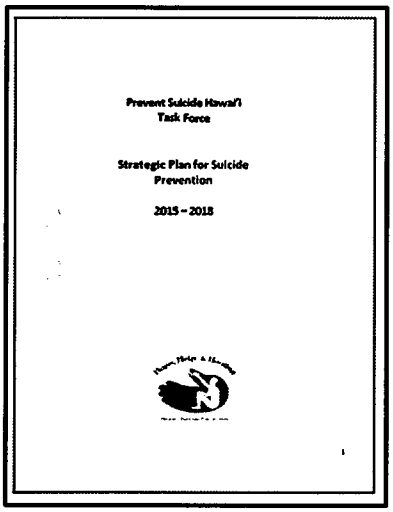
Everything is OK Right Now!!	The struggle is real...we need you.	Believe	LOVE.
Let's take a walk and exhale all the BS!	I got you #igotu #gotufam	HOPE	Be kind to yourself
Acceptance/ Respect	Love yourself + Love others	I'll stand by you always	Strength thru networking

Additional Context



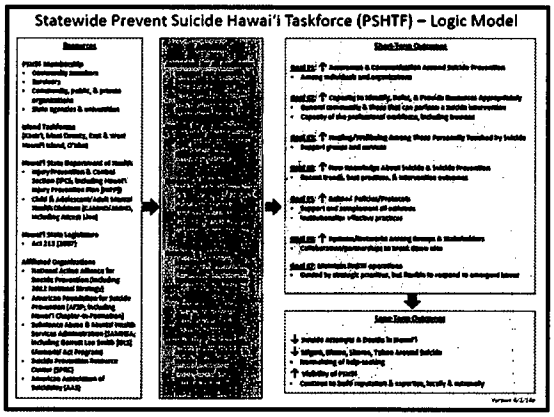


Additional Context

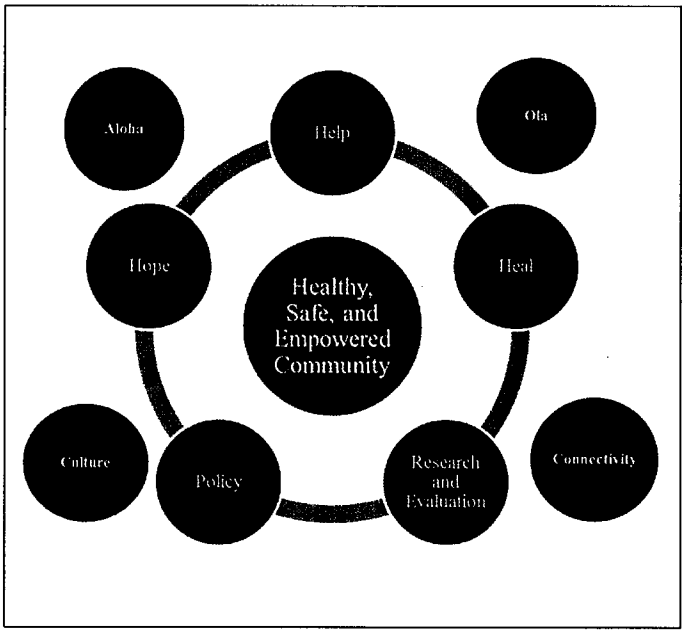

Prevent Suicide Hawai'i
Task Force

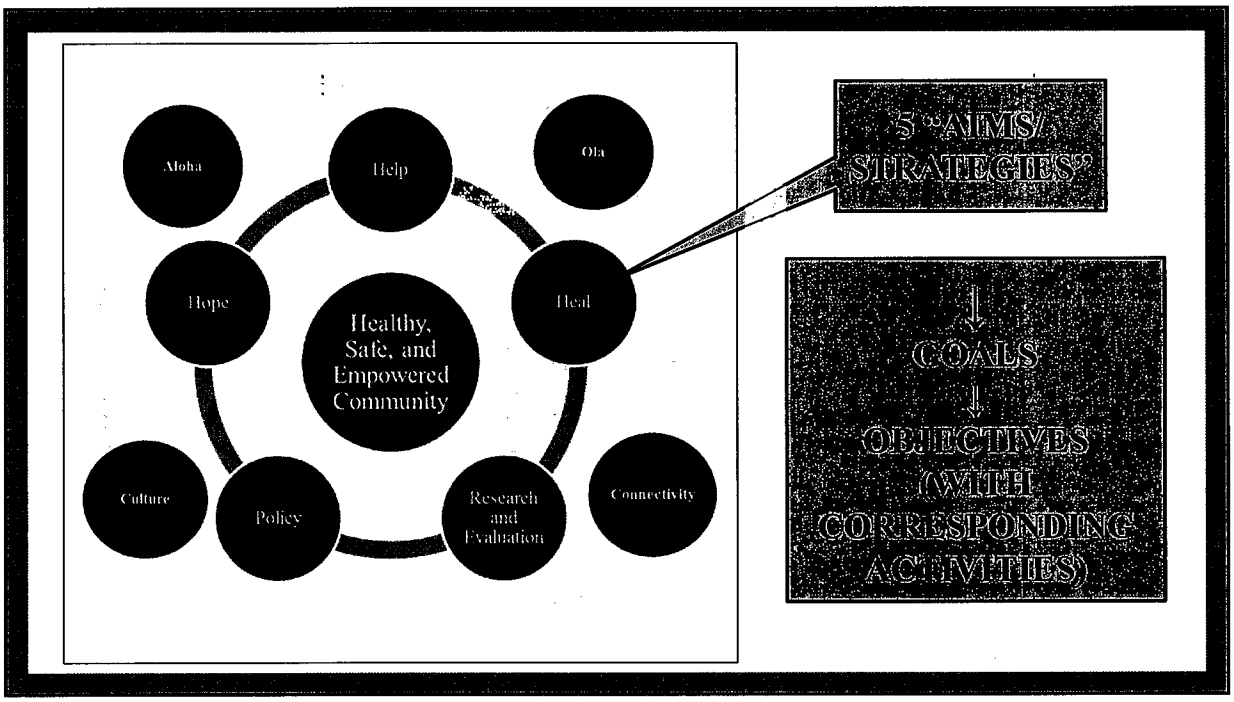
Strategic Plan for Suicide
Prevention

2015 – 2018



Results: Our Guiding Framework





Strategy #1 – "Hope"

Goal #1A – Public Awareness

Increase awareness and communication around suicide prevention as a public health problem that is preventable.

THEME	FORMAL OBJECTIVE
Awareness Strategy	1.1 – Develop a sustained media and communication strategy to raise awareness about suicide prevention and safe messaging.
Media, messaging, and branding	1.2 – Develop tools for messaging and branding, and foster ongoing partnerships with media professionals/outlets.

Strategy #1 – "Hope"

Goal #1A – Public Awareness

Increase awareness and communication around suicide prevention as a public health problem that is preventable.

THEME	FORMAL OBJECTIVE
Social Media	1.3 – Expand the use of social media to promote suicide prevention.
Addressing Stigma	1.4 – Increase knowledge of discrimination and stigma (in the context of mental health and suicide prevention), with marginalized/vulnerable communities, including LGBTQ, those with mental illness, and others.

Strategy #1 – "Hope"

Goal #1B – Training

Increased statewide capacity for training across multiple levels and disciplines, including a focus on cultural competency in diverse populations.

THEME	FORMAL OBJECTIVE
Conducting Trainings	1.5 – Increase the number of persons in organizations such as mental health, substance use, education, foster care, juvenile justice programs, health care providers, hospitals, law enforcement, faith-based, community, and workplaces trained to identify and refer people at risk for suicide.

Possible Legislative Action: Establishment of training requirements for priority disciplines, such as educators.

Strategy #1 – "Hope"

Goal #1B – Training

Increased statewide capacity for training across multiple levels and disciplines, including a focus on cultural competency in diverse populations.

THEME	FORMAL OBJECTIVE
Resources & Capacity for Training	1.6 – Develop resources to increase the number of suicide prevention trainings and to expand the menu of evidence based trainings.
Dissemination of Trainings	1.7 – Promote trainings for individuals & groups statewide.

Strategy #2 – "Help"

GOAL #2

Promote suicide prevention as a core component of Hawai'i's overall system of care.

Awareness & Training	2.1 – Promote help-seeking across multiple sectors and settings by partnering with State-/county-wide service providers, with emphasis on those that serve individuals at higher risk of suicide.
Systems Improvement	2.2 – Promote and support adoption and implementation of the Zero Suicide approach within Hawai'i's healthcare systems.
Services During & Immediately After Crisis	2.3 – Promote the safety and wellbeing of all persons in suicidal crisis.

Strategy #2 – "Help"

GOAL #2 – Promote suicide prevention as a core component of Hawai'i's overall system of care.

Follow-Up & Continuity of Care	2.4 – Implement systems and protocols to enable follow-up and continuity of care.
Postvention Response	2.5 – Increase capacity of communities and care/support systems to respond effectively to suicide clusters and prevent contagion, within their cultural context, and support implementation with education, training, and consultation.
Pertinent Policy & Regulatory Changes	2.6 – Ensure State and county laws facilitate all of the above objectives, and said laws are implemented appropriately.

Examples Include:

- **Parity for providers**
- **Supporting Tele-psychiatry**
- **"Consent to treatment" implement-ation**

Strategy #3 – "Healing"

Goal #3A – Survivor Supports

Increase Hope, Help, Healing & Well-being among those personally touched by suicide and among those with lived experience.

THEME	FORMAL OBJECTIVE
Support Groups	3.1 – Ensure that every Suicide Loss and Lived Experience Survivor has access to a safe, nurturing, and sustainable community infrastructure to share/tell their stories, forgive, heal, survive, and thrive.
Support Group Facilitators	3.2 – Ensure that every Suicide Loss and Lived Experience Survivor will have access to a support group with skilled, trained, and culturally competent support group facilitators.

Strategy #3 – "Healing"

Goal #3A – Survivor Supports

Increase Hope, Help, Healing & Well-being among those personally touched by suicide and among those with lived experience.

THEME	FORMAL OBJECTIVE
Survivor Stories	3.3 – Develop, support, maintain, and publicize a statewide community-led Suicide Loss and Lived Experience Survivors' "story-telling bank" that is available and accessible to the public.
Venues	3.4 – Conduct, support, and publicize activities and events that provide opportunities for assistance, validation, and comfort, and for connecting and sharing stories.
Campaigns	3.5 – Support and conduct campaigns geared towards survivors (e.g., Fight for Each Other, which reaches all service branches).

Strategy #3 – "Healing"

Goal #3B – Survivor Outreach

Increase State and Community capacity to effectively and efficiently respond to individuals and communities affected by suicide and those with mental health challenges.

THEME	FORMAL OBJECTIVE
Crisis Lines	3.6 – Maintain and expand the funding, publicity, and reach of the State's 24-hour Crisis Hotline other crisis lines (e.g., Text line).
Outreach Program	3.7 – Establish, support, maintain, and publicize a community-based statewide "Suicide Outreach Program (SOP)" on each island.

Possible Legislative Action: Establishment of, and resources towards, statewide outreach and response team (see also "Help" section)

Strategy #3 – "Healing"

Goal #3B – Survivor Outreach

Increase State and Community capacity to effectively and efficiently respond to individuals and communities affected by suicide and those with mental health challenges.

THEME	FORMAL OBJECTIVE
Centralized Information	3.8 – Develop, post, and publicize a real-time dynamic statewide catalogue of counseling, support groups, community events, and other support services and resources for those affected by suicide, that is available and accessible to providers, health/medical professionals, community and the public.

Strategy #4 – Research & Evaluation

Goal #4 – Conduct and support high-quality research and evaluation to inform suicide prevention programs, interventions, policies, and overall Statewide direction.

Data Systems & Sharing	4.1 – Facilitate the development and integration of suicide prevention data systems.
Evaluation of Local Programs	4.2 – Evaluate existing Hawai'i-based suicide prevention programs, policies, and systems, instituting a "culture of evaluation" to ensure provision of high quality and evidence-based interventions.

Possible Legislative Action: Resources towards evaluation efforts, and include evaluation requirements for state-funded programs.

Strategy #4 – Research & Evaluation

Goal #4 – Conduct and support high-quality research and evaluation to inform suicide prevention programs, interventions, policies, and overall Statewide direction.

Quality Improvement	4.3 – Support service organizations to incorporate organizational evaluation and quality improvement processes.
Culture and Diversity	4.4 – Support high-quality research and evaluation endeavors which will contribute to our understanding of the role of culture in suicide and suicide prevention.
Pursue New Opportunities	4.5 – Pursue funding and partnerships to expand research opportunities, both local and national.

Strategy #5 – Policy

Goal #5 – Ensure policies and protocols set the proper foundation for suicide prevention initiatives.

Funding (general)	OBJECTIVE 5.1 – Ensure adequate levels of funding and resources for all aspects of the strategic plan.
Advocacy skills and capacity	OBJECTIVE 5.2 – Encourage community members and professionals to engage in advocacy for suicide prevention.

Strategy #5 – Policy

Goal #5 – Ensure policies and protocols set the proper foundation for suicide prevention initiatives.

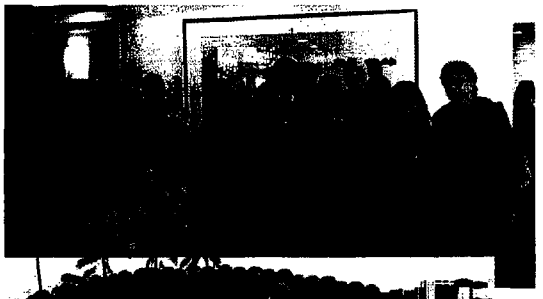
	OBJECTIVE
Organizational Protocols & Policies	5.3 – Encourage and support agencies and organizations to adopt protocols for suicide prevention, crisis response and management, and postvention.
Codify the PSHTF	5.4 – Institutionalize suicide prevention networks and collaborations, including the Prevent Suicide Hawai'i Taskforce (PSHTF).

Possible Legislative Action: Formally, codify the PSHTF, and delegate responsibility for monitoring of strategic plan implementation.

Next Steps

- Completion and dissemination of formal strategic plan document
- Report back to pertinent stakeholders
- Begin to establish plans for implementation
  - Priority meetings/connections
  - Preparation of specific items for 2018 Legislative Session

Questions and Discussion



And…THANK YOU!!!

Suicides and suicide attempts in Hawaii

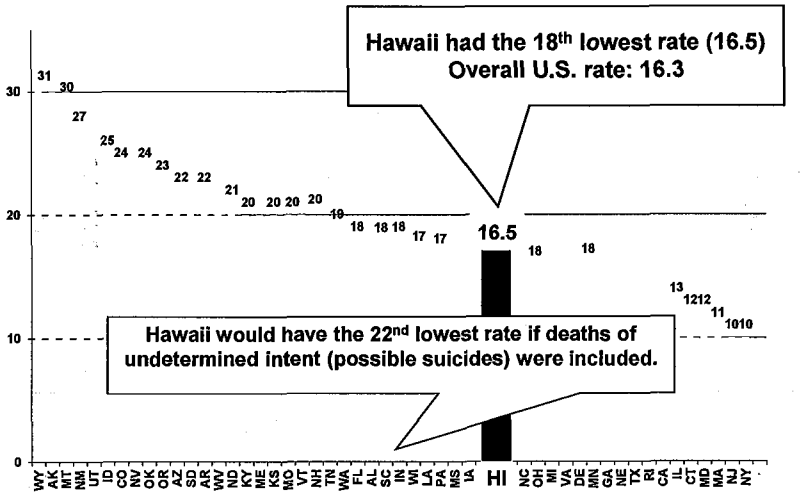
Dan Galanis, Ph.D.
Epidemiologist
Injury Prevention and Control Section
EMS & Injury Prevention System Branch
Hawaii Department of Health

Ph: 733-9236
E-mail: daniel.galanis@doh.hawaii.gov

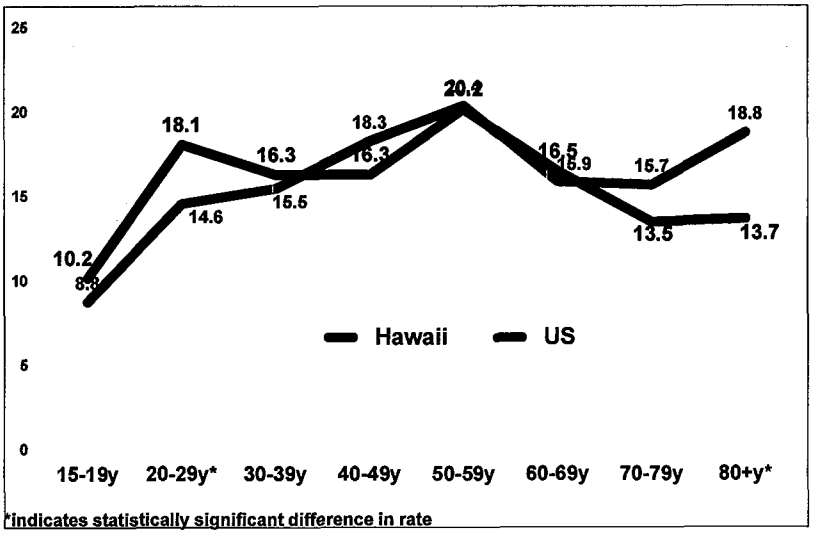
Overview of presentation

- Suicides (fatal injuries)
  - *Comparisons w/ rest of U.S. (through 2015)*
  - *Local description*
    - *Trends, geography, demographics of victims*
    - *More detailed data from Hawaii's NVDRS (autopsy records)*
- Suicide attempts (nonfatal injuries)
  - *Emergency department (ED) visits and hospitalizations*
    - *Data from the Hawaii Health Information Corp.*
- Survey data
  - *YRBSS data* (Youth Risk Behavioral Surveillance System)

Average annual suicide fatality rate (/100,000), by state, 2012-2015 (Ages 15 years and older)



Annual suicide fatality rate (/100,000), Hawaii vs. US, by age group, 2012-2015



*indicates statistically significant difference in rate

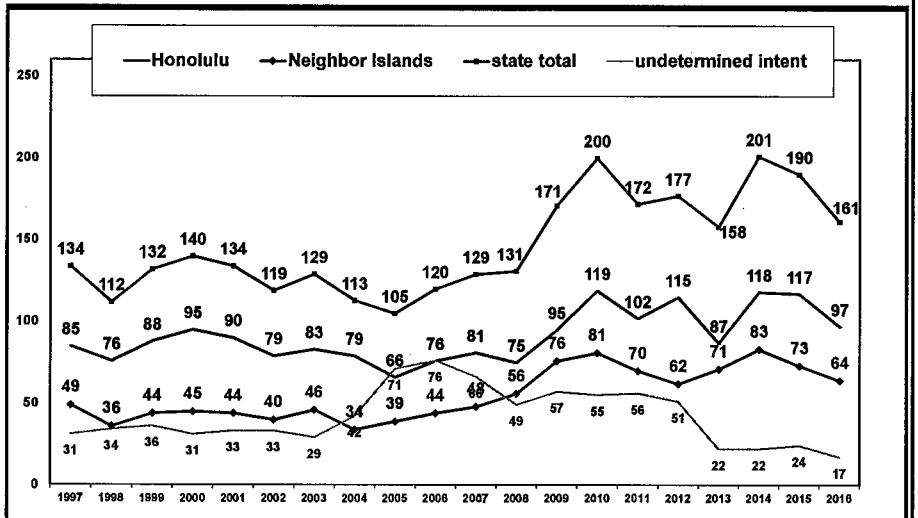
Causes of fatal injuries in Hawaii, by resident age group, 2012-2016

	0-14 y (84)	15-29y (575)	30-44 y (669)	45-59 y (889)	60-74 y (576)	75+y (759)	total (3,552)
1	drowning 19	SUICIDE 226	SUICIDE 216	poisoning 291	SUICIDE 162	fall 59	SUICIDE 887
2	mvc*-pedestrian 12	mvc*-occupant 98	poisoning 164	SUICIDE 222	fall 109	suffocation 66	fall 674
3	homicide 14	poisoning 62	mvc*-occupant	UNDET. INTENT	poisoning	SUICIDE 56	poisoning 620
4	suffocation 13	mvc*-motorcyclist 48	homicide 47	fall 59	g	mvc*-pedestrian 29	mvc*-occupant 242
5	SUICIDE/ mvc*-occup 5 (each)	drowning 31	mvc*-motorcyclist 39	drowning 46	mvc*-pedestrian 29	mvc*-occupant 24	drowning 181

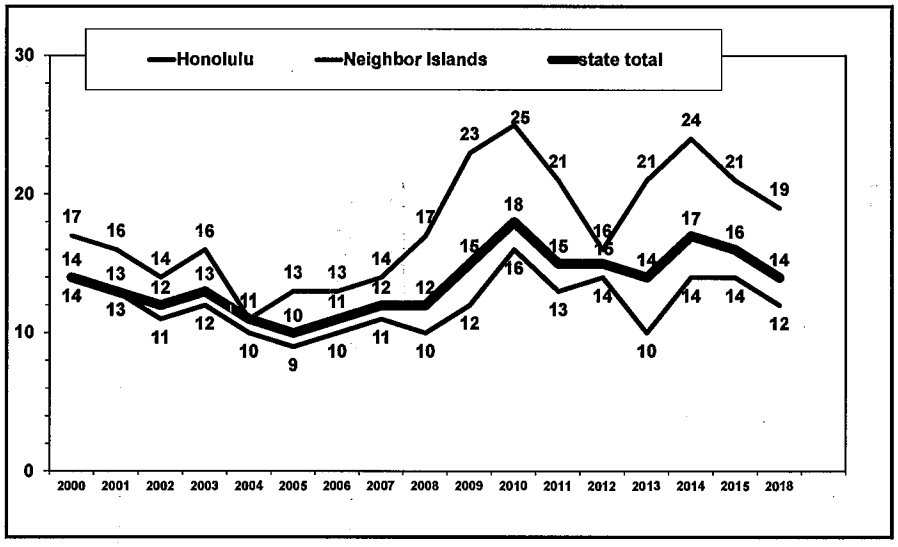
9th: undetermined intent (138)

*mvc = motor vehicle crash

Annual number of suicides among Hawaii residents, by county of residence, 1997-2016

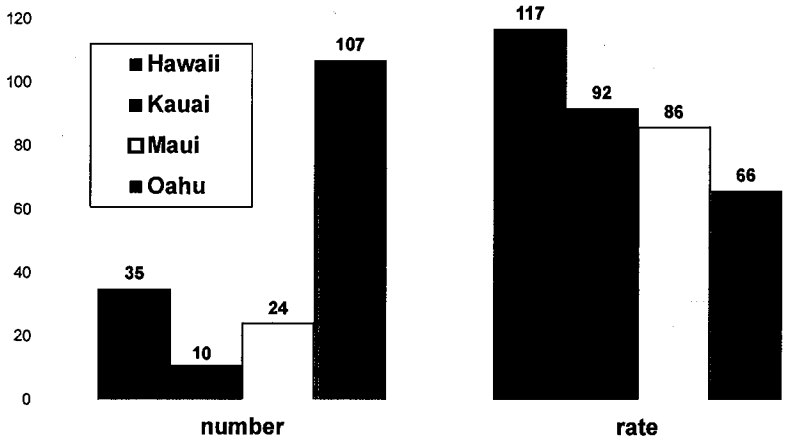


Age-adjusted rates (/100,000) of suicides among Hawaii residents, 15 years and older, 2000-2016

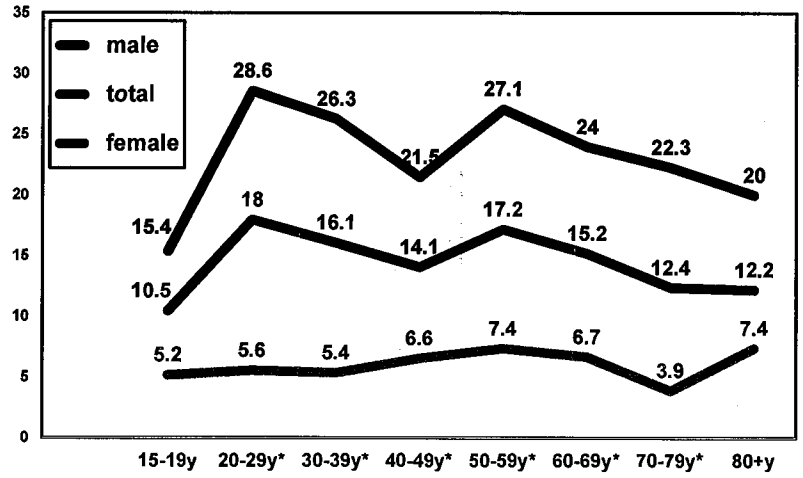


Average annual number and 5-year age-adjusted rate of fatal suicides in Hawaii, by county of residence, 2012-2016

(For residents 15 years and older.)



Annual suicide fatality rate (/100,000) among Hawaii residents, by gender and age group, 2012-2016

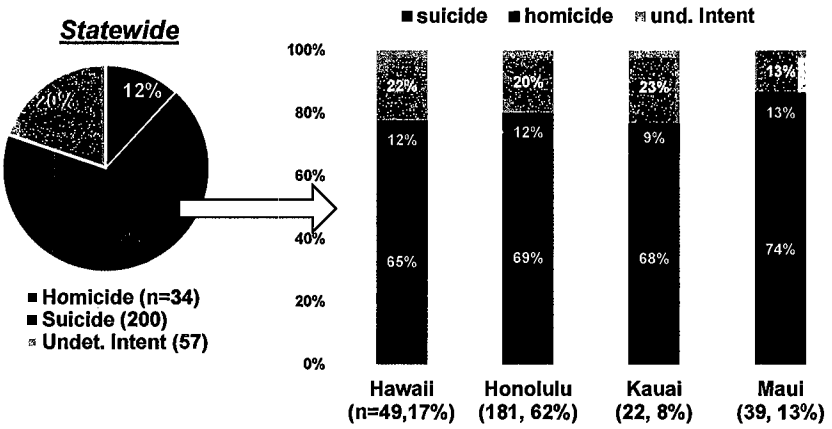


**indicates statistically significant difference in rate between genders*

Suicide data from Hawaii's National Violent Death Reporting System, 2015

Dr. Alvin Onaka
and
Brian Pang,
Office of Health Status Monitoring
Hawaii Department of Health

Hawaii NVDRS, 2015: Type of violent death (n=291)



Suicides (n=200)

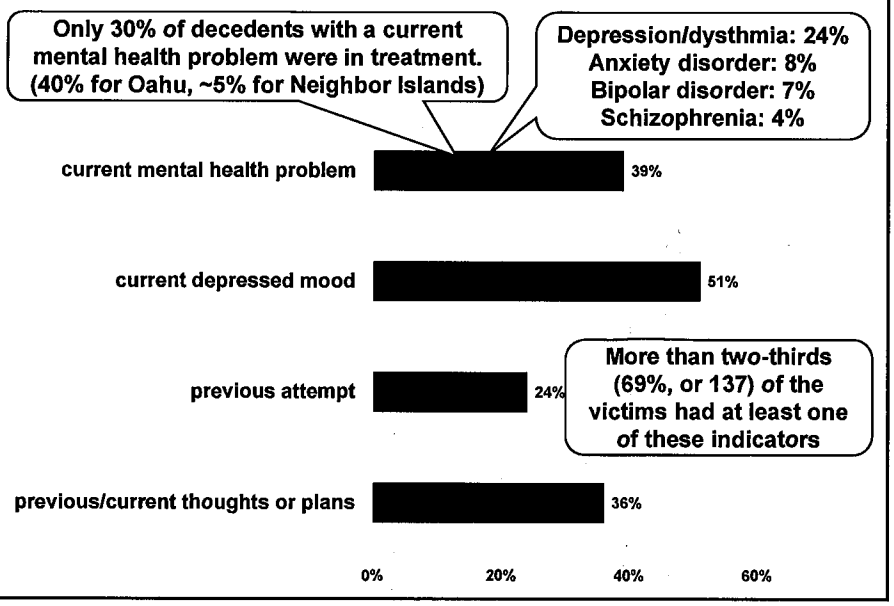
- Victim age widely distributed
  - *Almost all (97%, or 194) were 18 years or older, however*
- Mostly (78%, or 156) male
- Almost all (98%, or 195) Hawaii residents

- Mechanism: ~half (52%) by hanging/suffocation
  - *22% from firearms, 10% drug overdose, 10% jumping*

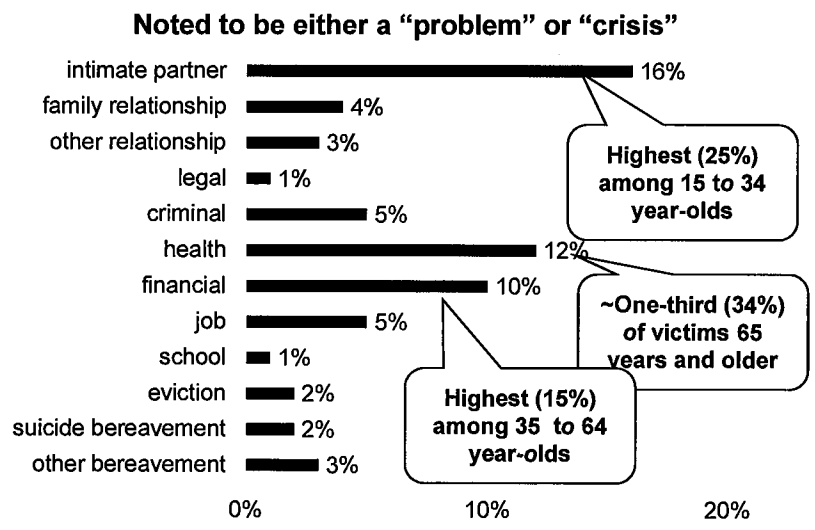
- ~5% (9 victims) were homeless
- Sexuality: 49% blank/unknown, 48% heterosexual
  - *Seven victims (4%?) gay/lesbian/bisexual*

- Alcohol (87% tested): 33% positive, 21% BAC≥.08
- Drugs (~87% tested): 18% pos. marijuana, 17% opiates, 15% amphetamines, 2% cocaine (42% pos. for any) 12

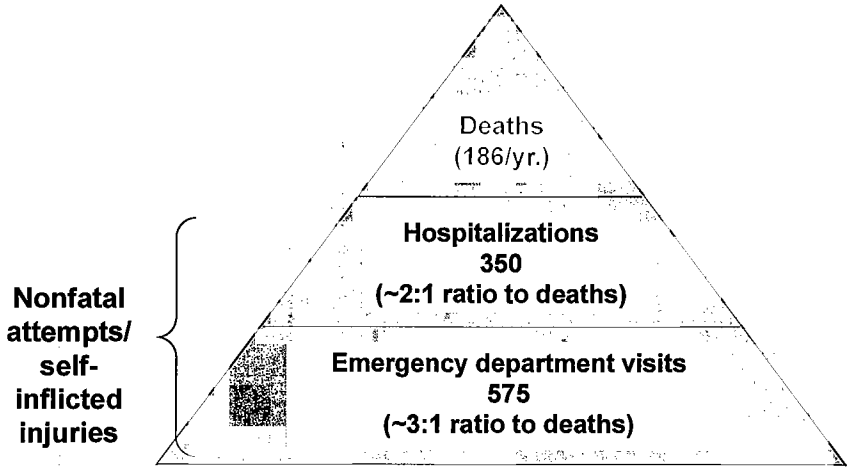
NVDRS, 2015:
Indications of mental illness among suicide victims (n=200)



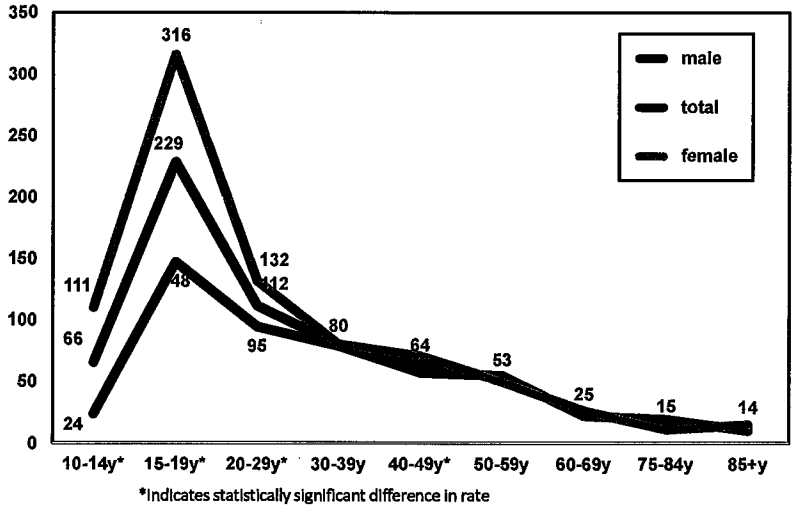
Hawaii NVDRS, 2015:
"Relationship and life stressors" among suicide victims (n=200)



"Injury Pyramid" for suicides and attempts in Hawaii, 2012-2016

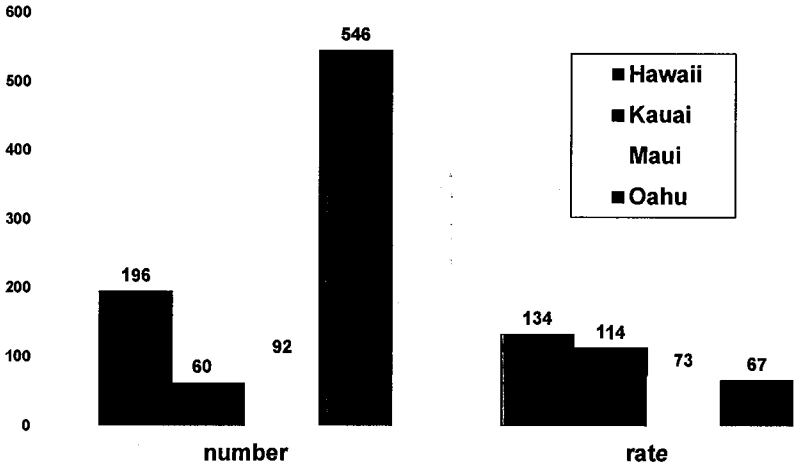


Annual rate (/100,000) of nonfatal suicide attempts among Hawaii residents, by gender and age group, 2012-2016

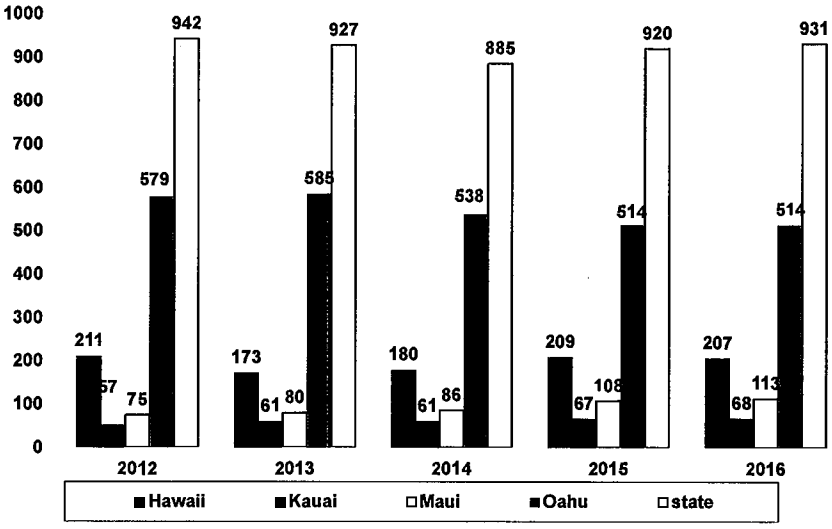


*Indicates statistically significant difference in rate

Average number and age-adjusted rate of nonfatal suicide attempts in Hawaii, by county of residence, 2012-2016



Annual number of nonfatal suicide attempts in Hawaii, by county of residence, 2012-2016



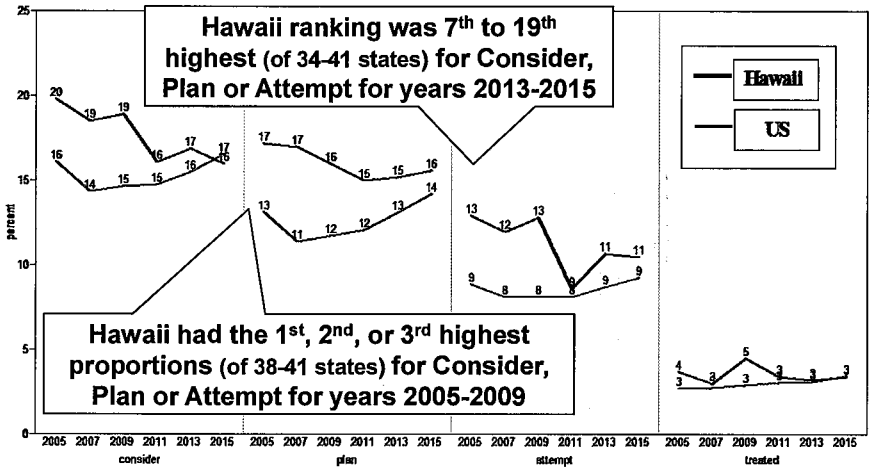
Summary – suicides & attempts in Hawaii, 2012-2016

	Suicides	Attempts (nonfatal)
Number/year	186 (215?)	925 (1,540? 2,400?)
Trends	increasing (esp. over 10 years)	no statewide trend (Oahu decreasing, Maui & Hawaii increasing)
Gender	80% male	55% female
Age	Youth lowest risk, 20-64 yrs. highest	Youth (15-19y) highest risk, elderly lowest
Mechanism	Hangings (50%), firearms (19%)	Drugs/medicinal poisonings (63%)

Risk factor survey data from Hawaii high school students (YRBSS)

- During the past 12 months, did you ever seriously consider attempting suicide? ("consider")
- During the past 12 months, did you make a plan about how you would attempt suicide? ("plan")
- During the past 12 months, how many times did you actually attempt suicide? ("attempt")
- If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse? ("treated")

Trends in self-reported suicide risk factor prevalence among high school students, Hawaii vs. US, 2005-2015



Summary

- **Important cause of injury mortality in Hawaii**
  - *Generally increasing numbers and rates, esp. over last 10 years*
  - *Rates comparable to US, across most age groups*
- **Deaths vs. nonfatal attempts: Different epidemiology**
  - *Gender, age, mechanism*
  - *Geography: high rates for Hawaii County, low for Oahu*
- **YRBSS: Hawaii students trending towards US average in suicidality**

22

Suicide:

A Mom Speaks Out

By: Pua Kaninau and Dan Yahata, co-chairs of the State Suicide Prevention Steering Committee

On April 5, 2003, my life forever changed!

My teen son Kaniela Kaninau, 5 days after his 18th birthday and 2 months before his graduation from high school, died by suicide.

Looking back now, I see the many signs that I just passed off as typical teen rebellious behavior. Anyone of these signs alone might not be enough to act upon, however the accumulation of all of these signs together were clearly enough to tell us something was very wrong.

My son started to have changes in his regular life patterns, like staying up late, often till 2 and 3 am in the morning on a school night *(insomnia)* and sleeping longer than usual after school and on weekends *(part of depression).*

Some of his written assignments were full of suicidal ideation, and was very clear pleas for help, but of course I only read the papers and knew this after the fact.

Alcohol and substance abuse is a clear warning sign. I had my suspicions regarding substance abuse, but my son always denied this.

My husband, who recently passed away due to liver cancer, had a big argument with Kani on the morning before he went to school on the day he died. He had also been worried about strained relationships he had with his friends.

Kani was doing fine in school, then began to have difficulty staying on top of his school assignments, turning them in late or not at all. I worked with him to stay on top of his assignments, but never connected this to depression. How can one focus and do the work if he or she is suffering from major depression? This all became clear to me after the fact.

His mood also changed as he became more irritable, and rebellious at times, and I also noticed he was engaging in

more high risk behaviors like he was taking more chances with his skateboarding.

His moods shifted from a normal disposition--happy-go lucky, talkative and pleasant--to withdrawn, somber and quiet.

I think my son was in acute suicidal crisis for several days preceding his death based on conversations I had with his friends, who noticed his change in mood at school.

Kani and family at mom's graduation May 2002 .

At home he was quiet (not usual), sat next to his dad and watched TV with him till late.

The Vice Principal and the School Counselor spent time with Kani right before his passing, as they noticed he was more and more despondent.

Kani was released to a counselor, and my daughter picked him up at school. She knew something was not right and talked to her brother for a couple of hours. My daughter then immediately called us and both his father and I came to him right away.

We talked about the situation, and I skirted the issue of suicide, as an after thought mother's gut reaction. I did not ask the suicide question directly.

I remember saying something like, "You wouldn't do anything to harm yourself, right Kani" or something to that affect.

Of course my son said, "No," and I never stayed on the topic. He said he was okay, and asked if we could go home. Then after the fact, and against my gut feeling, I let him go out with his friends. The rest of the family thought it was a good idea because he was concerned about his friends and what they thought about a specific issue that concerned him.

What I know now is when an individual is assessed to be at high risk and in an acute suicidal crisis, you should NEVER LEAVE THEM ALONE and LINK THEM IMMEDIATELY TO A DOCTOR/PSYCHOLOGIST / PSYCHIATRIST CARE.

He took his life that evening. Of course I never saw any of the signs because I labeled that behavior as teen rebellion. I had zero education on mental health/depression. I did not have a clue even though the signs were so loud.

My advocacy work started with my son Kani's death and now having learned so much from this experience, I am his voice bringing hope to the sons and daughters who are crying out silently for help! This is the passion that is lit within.

I share my story today with as many parents and students as I can in the hopes of preventing anyone else from losing a loved one this way.

So *why does suicide happen?* No one knows for sure, but the # 1 risk factor of suicide is depression. Depression is treatable and suicide is preventable. There are many warning signs and care steps in managing a potential suicidal crisis.

If you know someone who is depressed or in crisis, talk to them, instill in them a sense of HOPE for the future and let an adult know right away! Show your aloha by getting them the help they need. Go with your gut if something does not feel right and refer them to help!

HELP is out there!!! If you are feeling sad or depressed, talk to a family member, friend, teacher, school counselor, coach or pastor. If no one is near, pick up the phone and call the state access Suicide Crisis Line at 1-800-753-6879. Talking about suicidal thoughts and feelings is the first step towards HEALING.

Don't keep these thoughts and feelings to yourself, go get help!

Top 10 Warning Signs

1. Depression (mood swings, insomnia)
2. Alcohol and substance abuse
3. Strained relationships (parents/boyfriend or girlfriend)
4. Ideation (thoughts of dying, taking life, expressing this in writing, school papers)
5. Attempts (self mutilation/cutting, medication/ poisoning)
6. School irregularities (poor grades/not turning in work or turning in work late, lateness to school)
7. Threats of taking one's life or verbalizing life not worth living
8. Giving away prized possessions
9. Stock piling pills, access to firearms
10. Feelings of hopelessness/helplessness

MONICA & CHARLIE'S STORY

Monica Toguchi is Owner of Highway Inn,
Member of the Prevent Suicide Hawai'i Taskforce and
the Hawai'i Chapter of the American Foundation for Suicide Prevention,
and survivor of her son Charlie's suicide.

This is a summary of her story that she allowed us to share.

Hi Pua,
Please share this on behalf of me and Charlie.

Kaka'ako [Highway Inn] was named *Ho'ōla Mau* (life moves forward), in honor of my personal loss and the work that must be accomplished. I have a special bench out front for Charlie – *"He hali'a aloha no Charlie,"* or "In Memory of Charlie."

For me, it's the frustration with the [education and health systems]. In Charlie's case, he had both [education and health] interventions. It was an uphill battle, and there seemed to be a lack of understanding about suicide prevention and mental health in general.

[The health system] knew he was cutting, and I reported to them that he tried to [take his life] once. They refused to renew his intensive family treatment, even though his grades were not improving and he had an IQ of 140. [The health and education systems'] response to his depression was to call the police every time he didn't go to school. I asked if he could start school later. I asked if he could get tutors. They denied all my requests, and only in retrospect should I have hired an attorney to get involved.

I am well-educated and thought I was being smart, proactive, and assertive. But clearly, the system is broken. In the end, not even the school principal called me to express his condolences when Charlie died. That's how bad it was in the real world back in 2011.

FOR MENTAL HEALTH EMERGENCIES/CRISIS

If you or someone you know is suicidal, don't hesitate!

For ANYONE in Crisis:
National Suicide Prevention Lifeline (NSPL)
National 24/7 crisis line
1-800-273-TALK (8255)
TTY: 1-800-799-4TTY (4889)
http://www.suicidepreventionlifeline.org/

For Youth & Young Adults:
1-800-273-TALK (8255)

http://www.youmatter.suicidepreventionlifeline.org/

For Veterans:
1-800-273-TALK (8255)
Press "1" to reach the Veterans Crisis Line
or Text to 838255

Also, confidential chat at
http://www.veteranscrisisline.net/

Crisis Text Line
A free, 24/7 support for those in crisis (the organization also trains volunteers to support people in crisis)

- Text ALOHA to 741-741
- http://www.crisistextline.org/

Trevor Helpline
National 24/7 hotline for LGBTQ youth

- 1-866-4U-TREVOR (488-7386)
- Text the word "Trevor" to 1-202-304-1200
- Chat at http://www.thetrevorproject.org/

Military One Source
24/7 counseling/coaching hotline, provided by the Department of Defense, at no cost to service members and their families

- Stateside: 1-800-342-9647
- TTY/TDD: 866-607-6794
- http://www.militaryonesource.mil/ for confidential chat, and also to view international calling instructions

Crisis Line of Hawai'i
Hawai'i's 24/7 crisis line

- O'ahu: 832-3100
- Neighbor Islands Toll Free: 1-800-753-6879

Hawai'i Poison Hotline
Resource for management of poison exposure, assistance with identification of unknown medications, and severe overdoses.

LOCAL ORGANIZATIONS AND COLLABORATIONS

Statewide Prevent Suicide Hawai'i Taskforce (PSHTF)
Main contacts:

- Nancy Deeley, MPH, Suicide Prevention Coordinator, Department of Health, nancy.deeley@doh.hawaii.gov
- Jeanelle Sugimoto-Matsuda, DrPH, Current Chair (2017-2018), sugimotoj@dop.hawaii.edu

The Prevent Suicide Hawai'i Task Force (PSHTF) is a state, public, and private partnership of individuals, organizations, and community groups working in the area of suicide prevention. PSHTF members collaborate to provide leadership, set goals and objectives, develop strategies, coordinate activities, and monitor the progress of suicide prevention efforts in Hawai'i. In addition, an email list is maintained for the PSHTF. Examples of information that is shared through the email listserv are: agendas of upcoming meetings; minutes of past meetings; notices of future meetings and conferences; and local and national information shared by PSHTF members and the Department of Health Suicide Prevention Coordinator.

Prevent Suicide Hawai'i Taskforce (PSHTF) – Island Taskforces
In addition to the statewide PSHTF, there are five island taskforces that address island/community-specific issues. Island taskforces are located on the Big Island, Maui, Kaua'i, and O'ahu.

- Kaua'i – Chair Madeleine Hiraga-Nuccio (madeleine.hiraga-nuccio@doh.hawaii.gov), www.preventsuicidekauai.org
- Hawai'i Island, East Side – Chair Yolisa Duley (hduley@hawaii.edu), Co-Chair Pansy Lindomou (lindomou@gmail.com)
- Hawai'i Island, West Side – Chair Nancy Sallee (orchid_isle_psychotherapy@yahoo.com)
- Maui – Chair Aris Banaag (arisb@hawaii.edu), Co-Chair Mona Cherry (nanacherry1954@hotmail.com)
- O'ahu – Chair Pua Kaninau-Santos (pkshawaii@gmail.com), Co-Chairs – Joyce Parkhurst (joyceparkhurstlsw@gmail.com) and Brent Oto (brent.oto@us.army.mil), http://www.oahupshawaiitaskforce.org/

DOD/Military Partnerships
Collaboration with our military partners has grown exponentially over the past few years. There is also active collaboration/workgroups which facilitate cross-branch communication and collaboration. Below are points of contact for suicide prevention activities/services in the various branches:

- Army – Brent Oto, Suicide Prevention Program Manager (brent.k.oto.civ@mail.mil)
- Army National Guard – Melody Bell, Suicide Prevention Program Manager (melody.r.bell.ctr@mail.mil); https://hawaiiguardohana.org/suicide-prevention-program.php
- Army Reserves – http://www.usar.army.mil/Commands/Support/9th-MSC/
- Marines – Mary Stephens, LPC, LMFT (mary.stephens@usmc.mil)
- Navy – Robert Torrison, LCSW-C, Suicide Prevention Program Manager (robert.l.torrison@navy.mil)
- Air National Guard – LTC Leah Boling, Wing Chaplain (leah.boling@us.af.mil); LTC Daniel Leatherman, Deputy Wing Chaplain (daniel.leatherman@us.af.mil)
- Department of Veteran Affairs, Pacific Islands Healthcare System – Tiara Peterkin, LCSW, Suicide Prevention Program Coordinator & Reach Vet Coordinator (tiara.peterkin@va.gov); http://www.hawaii.va.gov/services/mentalhealth.asp

American Foundation for Suicide Prevention (AFSP) – Hawai'i Chapter
Main contacts:

- https://afsp.org/chapter/afsp-hawaii/
- Eric Tash, MPH, Board Chair, macnut@hawaii.rr.com
- Kimberly Gallant, LCSW, Chapter President, gallantk@hawaii.edu
- Pua Kaninau-Santos, MSW, Community Liaison, pkshawaii@gmail.com

AFSP is the nation's leading organization bringing together people across communities and backgrounds to understand and prevent suicide, and to help heal the pain it causes. A small group of board members and volunteers have established a formal Chapter in Hawai'i. AFSP's major activities include the Out of the Darkness Community Walks, International Survivors of Suicide Loss events, "Party for Prevention," and other trainings and awareness activities to increase community knowledge and capacity around suicide prevention.

"A Place in the Middle" – a strength-based approach to gender diversity and inclusion
Directed and produced by Emmy Award-winners Dean Hamer and Joe Wilson, "A Place in the Middle" brings an enlightened Hawaiian perspective to efforts to create welcoming and inclusive schools and communities for children of all ages. This 25-minute film, adapted from the PBS Independent Lens feature documentary "Kumu Hina," approaches diversity and cultural preservation in a youth-friendly way by telling the story through the youth's own point of view. Organizations and educators are welcome to incorporate the film into trainings/curricula, and/or contact Dean and Joe directly for technical assistance.

- http://aplaceinthemiddle.org/

Hawai'i State Department of Health (DOH)
DOH is the state-designated "lead agency" for suicide prevention activities. The following sections of DOH relate to mental health and/or suicide prevention:

- Emergency Medical Services and Injury Prevention System Branch – main resource for suicide prevention trainings & information, including poison prevention
  http://health.hawaii.gov/injuryprevention/
- Adult Mental Health Division – http://health.hawaii.gov/amhd/
- Child & Adolescent Mental Health Division – http://health.hawaii.gov/camhd/

Hawai'i State Department of Education (DOE)

- http://www.hawaiipublicschools.org/Pages/Home.aspx
  - Comprehensive Student Support Services Section: http://www.hawaiipublicschools.org/TeachingAndLearning/StudentLearning/PersonalizedLearning/Pages/home.aspx
  - The DOE was also recently awarded two federal grants to address mental health (now known as Project HI-AWARE – advancing wellness and resilience in education) and school climate (http://www.hawaiipublicschools.org/ConnectWithUs/MediaRoom/PressReleases/Pages/DOE-awarded-$12.7-million-to-enhance-safety,-mental-health-initiatives.aspx).
- Specific information on bullying and safe schools can be found at: http://www.hawaiipublicschools.org/BeyondTheClassroom/SafeSchools/Pages/home.aspx

Hawai'i Youth Services Directory
A service of the Office of Youth Services (OYS; under the State Department of Human Services), this searchable directory includes a variety of social service organizations and activities for youth and young adults. Organizations can create a free log-in to add their organization's information to the directory.

- http://808youth.com/

Lili'uokalani Trust (formerly Queen Lili'uokalani Children's Center)
Lili'uokalani Trust is a social service agency committed to the orphaned and destitute children in the State of Hawai'i, with preference given to those of Hawaiian ancestry. Pua Kaninau-Santos oversees a number of suicide prevention efforts including training and support for suicide survivors.

- http://onipaa.org/, Pua Kaninau-Santos – pkshawaii@gmail.com or kkaninausantos@onipaa.org
- ***Lili'uokalani Trust also hosts support/grief groups specific for survivors of suicide loss.***

Mental Health America of Hawai'i (MHAH)
MHAH provides trainings, presentations, and resources for adults and youth. The organization also supports individuals and families around mental health issues, and participates in advocacy activities.

- http://mentalhealthhawaii.org/, (808) 521-1846
  - ***MHAH offers one of the most comprehensive and updated social service directories:*** http://mentalhealthhawaii.org/img/findingHelpPhoneList.pdf
  - Also available on MHAH's website is a ***"Finding Help Consumer Guide,"*** which describes different types of mental illnesses, treatments, medications, providers, and programs. http://mentalhealthhawaii.org/img/findingHelpConsumerGuide.pdf
- MHAH coordinates a Bullying Prevention Taskforce, and houses an online toolkit for bullying prevention (http://bullypreventiontoolkit.weebly.com/). They also coordinate the "Rainbow Youth Coalition," a collaboration of organizations with expertise in LGBTQ issues/supports.

National Alliance on Mental Illness (NAMI) Hawai'i
Offers education, advocacy, and support for persons with mental illness and their families.

- www.namihawaii.org, (808) 591-1297

University of Hawai'i at Mānoa, Department of Psychiatry
In addition to conducting research on mental/behavioral health in Hawai'i, the Department houses the "Hawai'i's Caring Communities Initiative (HCCI) for Youth Suicide Prevention."

- Department of Psychiatry – http://blog.hawaii.edu/dop
- HCCI – http://blog.hawaii.edu/hcci or HCCI-contact@dop.hawaii.edu

Youth Leadership Council for Suicide Prevention
Main contacts:

- Mara Pike, Program Coordinator at Mental Health America of Hawai'i (mpike@mentalhealth-hi.org)

Mental Health America of Hawai'i and the University of Hawai'i's Department of Psychiatry facilitate the Youth Leadership Council. Approximately 50 youth from across the state are now part of the Council, serving as advocates for suicide prevention in their respective communities. Interested youth/organizations can contact MHAH for information on the process for becoming involved in the Council (includes an application/interview process to ensure youth's readiness for serving as a youth leader).

Other Organizations and Agencies
There are many groups, formal and informal, that are currently working in suicide prevention. The following list provides just a snapshot of these groups – and thankfully, the list continues to grow!

- Action With Aloha
- Alu Like
- American Foundation for Suicide Prevention, Hawai'i Chapter
- BRAVEHEART
- CARE Hawai'i
- Castle Medical Center
- Catholic Charities of Hawai'i
- Chaminade University
- Department of Defense (Army, Army National Guard, Marines, Navy, Veteran's Administration)
- Enterprise Honolulu
- Family Court
- Gebco Hawai'i
- GLSEN Hawai'i
- Hale Ho'ola Hamakua
- Hale Kipa
- Hawai'i Pacific University
- Hawai'i Primary Care Association
- Hawai'i S.P.E.A.R. Foundation of America
- Hawai'i State Department of Education
- Hawai'i State Department of Health (Adult Mental Health Division, Child & Adolescent Mental Health Division, Alcohol & Substance Abuse Division, Emergency Medical Services & Injury Prevention System Branch, Maternal & Child Health Branch, Tobacco Settlement Fund Management)
- Hawai'i State Department of Human Services (Office of Youth Services)
- Hawai'i State Legislature
- Helping Hands Hawai'i
- Hilo Medical Center
- Honolulu Community College
- Hope Services Hawai'i
- Judiciary – First Circuit
- Kahuku Medical Center
- Kahuku United Methodist Church
- Kapi'olani Community College
- Kapi'olani Medical Center for Women and Children
- Ka'u Hospital
- Kaua'i Veteran's Memorial Hospital
- Kids Hurt Too
- Ko'olauloa Community Health and Wellness Center
- Lana'i Community Hospital
- Life's Bridges Kaua'i
- Maui Community College
- Maui Economic Opportunity
- Maui Memorial Medical Center
- Mental Health America of Hawai'i
- Moloka'i Community Health Center
- Moloka'i General Hospital
- Office for Social Ministry, Catholic Diocese
- Police Departments (all counties)
- Queen Lili'uokalani Children's Center
- Queen's Medical Center
- Tripler Medical Center
- University of Hawai'i Hilo
- University of Hawai'i at Mānoa (John A. Burns School of Medicine, Office of Public Health Studies, School of Social Work, Counseling and Student Development Center)
- University of Hawai'i at West O'ahu
- Wahiawa General Hospital
- Wai'anae Coast Comprehensive Health Center
- Wilcox Memorial Hospital

TRAININGS ON SUICIDE PREVENTION, MENTAL HEALTH, AND ASSOCIATED TOPICS

– PRIMARY SUICIDE PREVENTION TRAININGS –

Curriculum	Description	Appropriate For	Approximate Length	Main Contact(s)
"Suicide Prevention 101"	A very basic presentation to introduce audiences to foundational information around suicide prevention – i.e., core principles, local data, warning signs, and resources.	All audiences	1 hour	Jeanelle Sugimoto-Matsuda, sugimotoj@dop.hawaii.edu Nancy Deeley, nancy.deeley@doh.hawaii.gov
"Connect" Training Program (parent organization = National Alliance on Mental Illness, New Hampshire) Connect Training Professionals & Communities in Suicide Prevention & Response	The "Connect" training was brought to Hawai'i via the Hawai'i's Caring Communities Initiative (HCCI) on Youth Suicide Prevention (see "Grant Activities"). Developed by the National Alliance on Mental Illness (NAMI) of New Hampshire, "Connect" is a comprehensive, ecological, community-based approach to train professionals and communities in suicide prevention and response. Training topics include suicide as a public health issue, risk and protective factors, warning signs, how to connect with someone who may be at-risk for suicide, safe messaging around the issue of suicide, and protocol/systems development within and among agencies.	All audiences – foundational training (adaptable to specific groups, including youth)	3-4 hours	Jeanelle Sugimoto-Matsuda, DrPH, UH Department of Psychiatry, sugimotoj@dop.hawaii.edu Deborah Goebert, DrPH, UH Department of Psychiatry, goebertd@dop.hawaii.edu http://www.theconnectprogram.org/
SafeTALK (parent organization = Living Works) SafeTALK	"SafeTALK" (TALK = tell, ask, listen, keep safe) was brought to Hawai'i via the "Hawai'i Gatekeeper Training Initiative" (see "Grant Activities"). It is a three-hour gatekeeper training intended for everyone in the community. It is an evidence-based training program which teaches individuals to be "alert helpers." Participants learn to recognize warning signs for suicide, approach someone at-risk and ask if they are thinking about suicide, and then connect them to a caregiver or professional that can then work with the individual to keep safe.	All audiences – step-by-step process of connecting with someone who may be thinking about suicide	3-4 hours	Jeanelle Sugimoto-Matsuda, DrPH, UH Department of Psychiatry, sugimotoj@dop.hawaii.edu Nancy Deeley, MPH, Hawai'i State Department of Health, nancy.deeley@doh.hawaii.gov https://www.livingworks.net/programs/safetalk/
ASIST (Applied Suicide Intervention Skills Training; parent organization = Living Works) ASIST	ASIST was the first gatekeeper training brought to Hawai'i. The Prevent Suicide Hawai'i Taskforce (PSHTF; see section on "Collaborations and Partnerships"), founded in 2001, prioritized training as its primary priority and selected ASIST since there were already certified trainers in the State. ASIST is a two-day training intended for those in the community who are willing and able to be a caregiver that can provide "suicide first aid" for someone who is having thoughts of suicide. ASIST-trained individuals are able to assess an individual's level of risk, discuss risk and protective factors, and develop a safety plan. Anyone in the community, not only mental health professionals, can become ASIST-trained. SafeTALK participants are taught to seek out those trained in ASIST when they are looking to keep someone safe.	Individuals (community members and professionals) willing to and/or tasked with conducting full suicide interventions (including risk assessments and safety planning) *It is recommended that trainees attend Connect and/or SafeTALK prior to ASIST*	2 full days	Jeanelle Sugimoto-Matsuda, DrPH, UH Department of Psychiatry, sugimotoj@dop.hawaii.edu Nancy Deeley, MPH, Hawai'i State Department of Health, nancy.deeley@doh.hawaii.gov https://www.livingworks.net/programs/asist/

– *TRAININGS OFFERED BY PSHTF PARTNERS* –

Curriculum	Description	Appropriate For	Approximate Length	Main Contact(s)
"Youth Suicide and Bullying Prevention" (YSBP) Training 	Mental Health America of Hawai'i's YSBP training offers strategies to recognize and intervene in suicide and bullying. In the workshops, participants learn to: 1) define bullying and understand the roles we play in bullying; 2) identify symptoms of depression and recognize signs of suicide; and 3) listen, ask, support, and empower the youth to get help.	All audiences – foundational training, versions for youth and adults available	2-3 hours	Mental Health America of Hawai'i amanda.martinez@mentalhealthhawaii.org (808) 521-1846 http://mentalhealthhawaii.org/
"Grow a Rainbow" Training 	Mental Health America of Hawai'i's "Grow a Rainbow" training offers resources and strategies for supporting Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth and families. The training helps organizations create "safe spaces" for LGBTQ youth (e.g., programs that are welcoming and empowering to these youth).	Adult audiences	2-3 hours	Mental Health America of Hawai'i amanda.martinez@mentalhealthhawaii.org (808) 521-1846 http://mentalhealthhawaii.org/
Youth Mental Health First Aid 	Youth Mental Health First Aid is a full-day education program which introduces participants to unique risk factors and warnings signs of mental health issues in adolescents, builds understanding of the importance of early intervention, and teaches individuals how to help an adolescent who may be in crisis or experiencing a mental health challenge. These trainings are currently coordinated and sponsored through a federal grant awarded to the Hawai'i State Department of Education.	Adult audiences – those who regularly interact with youth	1 full day	Cynthia "CJ" Rice cynthia_rice@notes.k12.hi.us (808) 305-9798 www.mentalhealthfirstaid.org
"More than Sad" 	Developed by the American Foundation for Suicide Prevention, "More Than Sad" helps participants to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. It can be conducted in the school setting, for high school youth and educators, and also in the community for adults/parents/families.	All audiences	1-2 hours	Pua Kaninau-Santos pkshawaii@gmail.com https://afsp.org/our-work/education/more-than-sad/

MAJOR AWARENESS ACTIVITIES

Prevent Suicide Hawai'i "Healing After" Conference
Main contacts:

- Nancy Deeley, MPH, Suicide Prevention Coordinator, Department of Health, nancy.deeley@doh.hawaii.gov

The "Healing After" conference was originally conceived of by Pua Kaninau-Santos, who lost her son to suicide in 2003 and ever since has been one of Hawai'i's champions of suicide prevention. The aim of the conference is to bring together a community of survivors, advocates, educators, policymakers, and health professionals around the issue of suicide. The conferences aim to increase awareness of suicide, skills to respond to those at risk, and abilities help those who have survived the loss of a loved one. The most recent conferences were held on 11/20/13 (O'ahu) and 4/20/15 (Hawai'i Island). The next conference is tentatively expected in the 2018-2019 fiscal year.

"Out of the Darkness" Community and Campus Walks
Main contact:

- American Foundation for Suicide Prevention, www.afsp.org/hawaii for information and registration (all events)

One of the major activities of the American Foundation for Suicide Prevention's (AFSP's) Hawai'i Chapter (see "Collaborations and Partnerships") is the organization of "Out of the Darkness" Community and Campus Walks. The purpose of the Walks is to promote awareness around suicide prevention, as well was to raise funds that will benefit local activities and research. 2017-2018 walks include:

- 3/15/17 – O'ahu, Honolulu Community College
- 9/9/17 – O'ahu, Ala Moana Beach Park
- 10/7/17 – Hawai'i Island, Waimea Elementary School
- 10/14/17 – Kaua'i, Waimea Athletic Field Complex

International Survivors of Suicide Mini-Conferences
Main contact:

- American Foundation for Suicide Prevention, www.afsp.org/hawaii for information and registration (all events)

Another major activity of AFSP is the organization of gatherings/mini-conferences which coincide with International Survivors of Suicide Loss Day. The event welcomes survivors of suicide loss, and provides a safe and healing space where everyone can comfortably participate in a way that is meaningful to them. 2017-2018 events include:

- 11/18/17 – O'ahu, Pacific Beach Hotel
- 11/18/17 – Wailuku, Maui

GRANT ACTIVITIES

On October 21, 2004, the Garrett Lee Smith (GLS) Memorial Act was signed into law by President Bush at a White House ceremony. The Garrett Lee Smith Memorial Act was introduced by Senator Gordon Smith (R-OR) in memory of his son who had recently died by suicide. This legislation provides a funding mechanism for state agencies, college campuses, and tribal nations to implement suicide prevention, intervention, and awareness programs.

GLS State Grantee – University of Hawai'i at Mānoa, John A. Burns School of Medicine, Department of Psychiatry (funding period 2011-2014)
"Hawai'i's Caring Communities Initiative (HCCI) for Youth Suicide Prevention"
Main contacts:

- Deborah Goebert, DrPH, UH Department of Psychiatry, goebertd@dop.hawaii.edu
- Jeanelle Sugimoto-Matsuda, DrPH, UH Department of Psychiatry, sugimotoj@dop.hawaii.edu

The overall goal of the Hawai'i's Caring Communities Initiative (HCCI) is to prevent youth suicide and increase early intervention. This was accomplished by increasing public awareness, increasing community-based support for youth suicide prevention, and expanding gatekeeper training in at-risk communities. Furthermore, HCCI promotes clinical practices and parent education to reach youth who have attempted suicide. With the goal of preventing youth suicide and increasing early intervention, these projects have positively impacted at-risk communities and the statewide suicide crisis infrastructure in Hawai'i. This Initiative aligns with the State's strategic goals for suicide prevention, and builds upon previous efforts of the Hawai'i Gatekeeper Training Initiative. HCCI implemented two strategic projects entitled

Mobilizing Communities At-Risk (MCAR) and Enhancing the Statewide Trauma Network (ESTN), using the rubric of the Communities that Care (CTC) system.

GLS Campus Grantee – Chaminade University of Hawai'i (funding period 2012-2015)
"E Ho'opili No Na Haumana"
Main contacts:

- Dale Fryxell, PhD, Chaminade Department of Psychology, dfryxell@chaminade.edu

The E Ho'opili No Na Haumana Project at Chaminade University of Honolulu has been thoughtfully and collaboratively developed to prevent suicide attempts and completions, and to enhance services for students with mental and behavioral health problems such as depression and substance use/abuse that put them at-risk for suicide and suicide attempts. In collaboration with a Native Hawaiian clinical psychologist who lost his son to suicide, the project adapted the QPR (question, persuade, refer) Gatekeeper Training to be more relevant to Asian American and Pacific Islander (AAPI) individuals. The project also created a campus resource center that houses a wide array of resources, available to students and staff, that are specific to the cultures of the diverse peoples of Hawai'i.

GLS Campus Grantee – University of Hawai'i at Hilo (funding period 2012-2015)
Main contacts:

- Yolisa Duley, PhD and Sulma Gandhi, PhD, Student Health & Wellness Programs, hduley@hawaii.edu

The goal of the project is to prevent suicide and improve the mental health of UH Hilo students through a peer-to-peer health education and support network, and through improved communication networks and knowledge among key staff and gatekeepers who come in contact with students needing mental health interventions. The project's objectives are as follows: (1) develop high-quality, culturally relevant training materials for student peers and seminar materials for gatekeepers; (2) develop seminar materials for family members of high-risk students to be presented at semester Orientation Programs; (3) recruit students from targeted at-risk populations to attend the semester-long workshops as part of their student employment; (4) recruit volunteer students for introductory two-hour training workshops from other student populations; (5) reduce the stigma of seeking mental health assistance; (6) increase early intervention in student mental health issues by referrals from peers; (7) increase overall utilization of campus mental health services and the National Suicide Prevention Lifeline; and (8) increase utilization of campus mental health services in the targeted high risk student populations.

GLS State Grantee – Hawai'i State Department of Health (funding period 2008-2011)
Main contacts:

- Therese Argoud, MPH, Program Manager, Department of Health, therese.argoud@doh.hawaii.gov
- Nancy Deeley, MPH, Suicide Prevention Coordinator, Department of Health, nancy.deeley@doh.hawaii.gov

The Hawai'i Gatekeeper Training Initiative (HGTI) was implemented by the Emergency Medical Services and Injury Prevention System Branch (EMSIPSB) of the Hawai'i State Department of Health (DOH). The aim was to reduce suicide deaths and attempts among youth ages 10-24 in our State. HGTI used three evidence-based training curricula: Applied Suicide Intervention Skills Training (ASIST), safeTALK, and Signs of Suicide (SOS). EMSIPSB leveraged grant resources by incorporating gatekeeper training into three systems that already impact significant numbers of youth in both the school and community settings. These agencies included: Department of Education (Peer Education Program, and School-Based Behavioral Health), the Department of Health Alcohol and Drug Abuse Division (agencies contracted to provide treatment services in their Adolescent Substance Abuse Outpatient School-Based Treatment Program, and prevention services in their Youth Substance Abuse Prevention Partnerships Initiative), and the Honolulu Police Department (Emergency Psychological Services/Jail Diversion Program).

GLS Campus Grantee – University of Hawai'i at Mānoa, Counseling and Student Development Center (funding period 2009-2012)
Main contacts:

- Kathrine Fast, PhD, UH Mānoa Counseling and Student Development Center, kathrine@hawaii.edu

The project addressed seven goals focusing on infrastructure development needs: 1) assess system-wide and campus specific needs; 2) develop policies and procedures for responding to critical mental health events; 3) identify system-wide and community-based resources; 4) establish campus-specific resource networks; *5)* increase awareness and knowledge of risk and protective factors for suicide attempts among gatekeepers; 6) increase awareness and knowledge of risk and protective factors for suicide attempts among students; and 7) develop informational, educational, and training materials regarding risk and protective factors for suicide attempts and mental health adjustment.

POLICY/ADVOCACY, STRATEGIC PLANNING, AND SYSTEMS-BUILDING

House Concurrent Resolution (HCR) 66 of 2016
http://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=HCR&billnumber=66&year=2016
During the 2016 Hawai'i Legislative Session, HCR 66 was passed, which calls upon the Prevent Suicide Hawai'i Taskforce (PSHTF) to form a temporary sub-committee to craft a statewide strategic plan to reduce suicide deaths and attempts in Hawai'i at least 25% by the year 2025. The PSHTF is in the process of convening this sub-committee, and determining what steps need to be taken to complete the strategic plan. The plan will be completed and presented back to the Legislature in December 2017.

General Appropriations Act of 2007 (Act 213)
Act 213 requires the Department of Health to establish and implement a suicide early intervention and prevention program and prepare and submit a detailed report to include expenditures and all activities performed. As a result, $100,000 is appropriated to the Department of Health annually, which funds a permanent "Suicide Prevention Coordinator" position within the Injury Prevention and Control Section, as well as ongoing trainings (e.g., safeTALK, ASIST, Connect), speaking engagements, project support, and conferences.

Hawai'i Injury Prevention Plan (HIPP)
Available for download at:
http://health.hawaii.gov/injuryprevention/files/2013/09/Hawaii_Injury_Prevention_Plan_2012_to_2017_4mb.pdf
The Hawai'i Injury Prevention Plan (HIPP) is a collaborative effort of the Injury Prevention Advisory Committee (IPAC) and the Emergency Medical Services and Injury Prevention System Branch (EMSIPSB) of the Department of Health. The HIPP's goals are to: 1) provide an overall plan for reducing injuries statewide; 2) provide direction and focus to IPCP's efforts in the next five years; 3) provide guidance to other organizations and agencies involved in injury prevention; and 4) serve as a catalyst for organizations and agencies to collaborate on reducing/preventing injuries. The latest iteration of the HIPP (2012-2017) includes a section focused on suicide prevention, with goals including: 1) develop and implement prevention training for "gatekeepers"; 2) launch a public awareness campaign; and 3) develop and promote effective clinical & professional practices & policies.

MAJOR NATIONAL AGENCIES AND RESOURCES

National Suicide Prevention Lifeline (NSPL)
The NSPL is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. The NSPL website offers additional resources.

- www.suicidepreventionlifeline.org
- 1-800-273-TALK (8255)
- ***The NSPL is now connected with several social media sites, including Facebook, Twitter, YouTube, and Tumblr.*** Instructions can be found here – http://suicidepreventionlifeline.org/help-someone-else/ – on how to report suicidal content. Reports will generate referrals to a counselor with the NSPL, who will attempt to make contact with the user.

Crisis Text Line
A free, 24/7 support for those in crisis. Text 741741 from anywhere in the US to text with a trained counselor. The Text Line also trains volunteers to support people in crisis.

- http://www.crisistextline.org/
- Text ALOHA to 741-741

Suicide Prevention Resource Center (SPRC)
The nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. SPRC offers an extensive online library of free resources, reports, data briefs, etc.

- www.sprc.org

Substance Abuse & Mental Health Services Administration
SAMHSA's core competencies include releasing and managing block grants and special programmatic funding and providing states, providers, communities and the public with the best and most up-to-date information about behavioral health issues and prevention/treatment approaches.

- www.samhsa.gov
- ***The majority of materials are available for free download and order (including shipping) via SAMHSA's website:***
  http://store.samhsa.gov/facet/Issues-Conditions-Disorders/term/Suicide. Popular items include:
  - Magnet – "National Suicide Prevention Lifeline, 1-800-273-TALK"
  - Wallet card – "Suicide warning signs: Get the facts and take action"
  - Wallet card – "Having trouble coping? With help comes hope. Suicide warning signs"
  - Wallet card – "Having trouble coping after a disaster? Talk with us."
  - Wallet card – "Assessing suicide risk: Initial tips for counselors"
  - Wallet card – "Suicide assessment five-step evaluation and triage (SAFE-T): Pocket card for clinicians"
  - Brochure – "A guide for taking care of yourself after your treatment in the emergency department"
  - Brochure – "A guide for taking care of your family member after treatment in the emergency department"
  - Brochure – "A guide for medical providers in the emergency department taking care of suicide attempt survivors"
  - Fact sheet – "Recommendations for reporting on suicide"
  - Report – "Preventing suicide: A toolkit for schools"
  - Report – "National strategy for suicide prevention 2012: Goals and objectives for action"
  - Report/toolkit – "SAMHSA's disaster kit"

Action Alliance for Suicide Prevention
The public-private partnership advancing the National Strategy for Suicide Prevention, which was authored by the US Department of Health & Human Services (DHHS). This report presents a national strategic prevention framework for action. It lists goals and objectives that serve as a roadmap for direction.

- www.actionallianceforsuicideprevention.org
- Report can be downloaded at http://store.samhsa.gov/product/SMA01-3517

American Association of Suicidology (AAS)
Advancing scientific/programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

- www.suicidology.org

American Foundation for Suicide Prevention (AFSP)
Initiatives include research, new educational campaigns, innovative demonstration projects, and policy work.

- www.afsp.org
- ***AFSP offers one of the most comprehensive set of resources to support individuals, families, and communities after a suicide loss*** – visit the "I've Lost Someone" section of their website at: https://afsp.org/find-support/ive-lost-someone/.

Friendship Line for Elders – crisis intervention hotline AND warmline for non-urgent calls
The Friendship Line provides round-the-clock crisis and wellness services, including active suicide intervention, providing emotional support, elder abuse prevention and counseling, giving wellbeing checks, grief support through assistance and reassurance, and information and referrals for isolated older adults and adults living with disabilities. The service is run by the Institute on Aging, a San Francisco, California-based non-profit dedicated to preserving the dignity, independence, and well-being of aging adults and people living with disabilities.

- (415) 750-4111 or (650) 424-1411
- https://www.ioaging.org/services/all-inclusive-health-care/friendship-line

"Means Matter"
Harvard University's "Means Matter" campaign is working to increase the proportion of suicide prevention groups who promote activities that reduce a suicidal person's access to lethal means of suicide, and who develop active partnerships with gun owner groups to prevent suicide.

- https://www.hsph.harvard.edu/means-matter/

Mental Health America
Founded in 1909, Mental Health America is the nation's leading community-based non-profit dedicated to addressing the needs of those living with illness, and promoting the overall mental health of all Americans.

- http://www.mentalhealthamerica.net/

National Alliance on Mental Illness (NAMI)
NAMI is the nation's largest grassroots mental health organization. NAMI advocates for access to services, treatment, supports, and research and is steadfast in its commitment to raising awareness and building a community of hope.

- www.nami.org

National Institute of Mental Health (NIMH; under the National Institutes of Health)
NIMH is the lead federal agency for research on mental disorders. NIMH is one of 27 institutes and centers that make up the National Institutes of Health (NIH), the nation's medical research agency.

- https://www.nimh.nih.gov/about/index.shtml

SAVE (Suicide Awareness Voices of Education)
SAVE's work is based on the foundation and belief that suicide should no longer be considered a hidden or taboo topic, and that through raising awareness and educating the public, we can SAVE lives.

- www.save.org

The Connect Suicide Prevention Project
A project of NAMI New Hampshire, Connect is an evidence-based program offering training and resources in prevention/intervention and postvention.

- www.theconnectproject.org

The JED Foundation
JED is a national non-profit, aiming to protect emotional health and prevent suicide for the nation's teens and young adults. The organization's three major focus areas are: 1) work with schools to strengthen and evaluate their mental health, substance abuse, and suicide prevention programs; 2) develop resources and create partnerships; and 3) educate and equip students, families, and communities to know when and how to support others who are in distress or struggling with a mental health issue.

- https://www.jedfoundation.org/

How Can I Be a Gatekeeper?

Signs to be aware of...

Warning signs for *immediate* action:

- Threatening to, or talking about, hurting or killing oneself
- Looking for ways to kill oneself
- Talking/writing about death, dying, or suicide

Other signs to be aware of:

- Difficulty at work/school
- Neglect of appearance/hygiene
- Withdrawing from activities, family, friends
- Sudden improvement in mood after being down/withdrawn
- Feeling uncontrollable anger, hopeless, trapped
- Giving away favorite possessions
- Increasing alcohol or drug use
- Being unable to sleep, or sleeping all the time

What do I say?

- Validate feelings (you sound upset, it seems that you're frustrated)
- Validate the circumstances (I'm worried, how long has this been going on)
- Ask the tough questions - "Are you thinking about killing yourself?" "Have you ever felt so down that you thought of ending your life?"

REMEMBER, IF YOU OR SOMEONE YOU KNOW NEEDS HELP, DON'T HESITATE:

- Do not leave the person alone.
- Connect to a resource.

Department of Health's Crisis Line of Hawai'i: 832-3100 (O'ahu) & 1-800-753-6879 (Neighbor Islands) OR the National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Resources and More Information

Local resources

- Hawai'i State Department of Health (www.hawaii.gov)
- O'ahu Prevent Suicide Hawai'i Taskforce (www.oahupshawaiitaskforce.org)
- Mental Health America of Hawai'i (www.mentalhealthhawaii.org)
- American Foundation for Suicide Prevention (AFSP), Hawai'i Chapter (www.afsp.org/hawaii)
- Hawai'i's Caring Communities Initiative (blog.hawaii.edu/hcci)
- National Alliance on Mental Illness (NAMI) of Hawai'i (www.namihawaii.org)

National resources

- Suicide Prevention Resource Center (www.sprc.org)
- American Foundation for Suicide Prevention (www.afsp.org)
- American Association of Suicidology (www.suicidology.org)
- Substance Abuse & Mental Health Services Administration (www.samhsa.gov)
- Crisis Text Line (www.crisistextline.org)
- The Trevor Project for LGBT youth (www.thetrevorproject.org; 24/7 helpline at 1-866-4U-TREVOR [488-7386])

Crisis Text Line
Text ALOHA to 741-741

CRISIS TEXT LINE

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

For more information about this brochure, contact the Hawai'i's Caring Communities Initiative at HCCI-contact@dop.hawaii.edu.

Suicide Prevention in Hawai'i: Passing life forward

"The work of suicide prevention must occur at the community level, where human relationships breathe life into public policy."
-David Satcher, MD, PhD
Sixteenth Surgeon General of the US

Suicide: A Public Health Issue

Suicide prevention

There is a great deal of stigma around the issue of suicide. As a community we can send the message that it's ok to talk about suicide, and support those who need to seek help.

Remember...

- Suicide is generally preventable.
- Suicide prevention encompasses the entire lifespan.
- Cultural issues are important in suicide prevention.

Facts about suicide prevention

- Talking about suicide does NOT cause someone to be suicidal.
- Most people who die by suicide DO communicate their plans in advance (though they may do so indirectly).
- Most people who contemplate suicide ARE ambivalent right until the end.

What is a "gatekeeper"?

Suicide is an issue that affects everyone in the community. Therefore, we ALL have a responsibility in suicide prevention.

- As gatekeepers, we all have the power to intervene when someone needs help, regardless of our role in the community.

What Does Research Tell Us About Suicide Prevention?

Suicide in Hawai'i

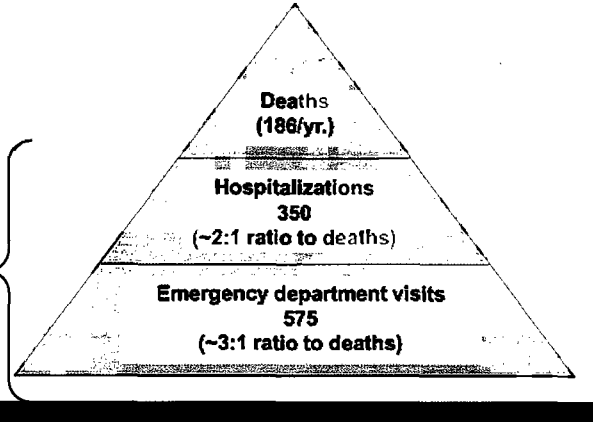
According to the Hawai'i State Department of Health, someone in Hawai'i dies by suicide every two days.

- For the time period of 2012-2016, suicide was the overall leading cause of fatal injury death (residents and non-residents).
- Hawai'i's youth (15-19 year olds) are at highest risk for attempting suicide, while adults (20-64 year olds) are at highest risk for dying by suicide.

According to the 2015 Youth Risk Behavior Survey, Hawai'i's high school students reported higher rates of making a suicide plan (15.6%) and attempting suicide (10.5%), compared to the national average.

What is the good news?

The Injury Pyramid below tells us that suicide deaths represent only a *portion* of all self-inflicted injuries that occur.



What Prevention Activities Are Going on in Hawai'i?

Some examples include:

- The Hawai'i State Department of Health's (DOH) EMS and Injury Prevention and Control System Branch supports various suicide prevention activities and trainings.
- The Prevent Suicide Hawai'i Task Force (PSHTF) is a partnership of individuals, organizations, and community groups collaborating to provide leadership for suicide prevention efforts in Hawai'i. There are also island-specific taskforces on O'ahu, Kaua'i, Maui, and the Big Island.
- The University of Hawai'i, Department of Psychiatry, conducts research on mental health issues. The Department also oversees the "Hawai'i's Caring Communities Initiative (HCCI) for Youth Suicide Prevention."
- Mental Health America of Hawai'i administers a variety of programs related to suicide, bullying, and mental health, including the Youth Leadership Council for Suicide Prevention.
- Hawai'i has a local chapter of the American Foundation for Suicide Prevention (AFSP), the nation's leading non-profit for suicide prevention which was founded by survivors (those who have lost a loved one to suicide).

Safe and Effective Messaging for Suicide Prevention

This document offers evidence-based recommendations for creating safe and effective messages to raise public awareness that suicide is a serious and preventable public health problem. The following list of "Do's" and "Don'ts" should be used to assess the appropriateness and safety of message content in suicide awareness campaigns. Recommendations are based upon the best available knowledge about messaging.[1,2,3] They apply not only to awareness campaigns, such as those conducted through Public Service Announcements (PSAs), but to most types of educational and training efforts intended for the general public.

These recommendations address message content, but not the equally important aspects of planning, developing, testing, and disseminating messages. While engaged in these processes, one should seek to tailor messages to address the specific needs and help-seeking patterns of the target audience. For example, since youth are likely to seek help for emotional problems from the Internet, a public awareness campaign for youth might include Internet-based resources.[4] References for resources that address planning and disseminating messages can be found in SPRC's Online Library (http://library.sprc.org/) under "Awareness and Social Marketing".

The Do's—Practices that may be helpful in public awareness campaigns:

- **Do emphasize help-seeking and provide information on finding help.** When recommending mental health treatment, provide concrete steps for finding help. Inform people that help is available through the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) and through established local service providers and crisis centers.

- **Do emphasize prevention.** Reinforce the fact that there are preventative actions individuals can take if they are having thoughts of suicide or know others who are or might be. Emphasize that suicides are preventable and should be prevented to the extent possible.[5]

- **Do list the warning signs, as well as risk and protective factors of suicide.** Teach people how to tell if they or someone they know may be thinking of harming themselves. Include lists of warning signs, such as those developed through a consensus process led by the American Association of Suicidology (AAS).[6] Messages should also identify protective factors that reduce the likelihood of suicide and risk factors that heighten risk of suicide. Risk and protective factors are listed on pages 35-36 of the *National Strategy for Suicide Prevention*.

- **Do highlight effective treatments for underlying mental health problems.** Over 90 percent of those who die by suicide suffer from a significant psychiatric illness, substance abuse disorder or both at the time of their death.[7-8] The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support in an understanding community.[9]

The Don'ts—Practices that may be problematic in public awareness campaigns:

- **Don't glorify or romanticize suicide or people who have died by suicide.** Vulnerable people, especially young people, may identify with the attention and sympathy garnered by someone who has died by suicide.[10] They should not be held up as role models.

- **Don't normalize suicide by presenting it as a common event.** Although significant numbers of people attempt suicide, it is important not to present the data in a way that makes suicide seem common, normal or acceptable. Most people do not seriously consider suicide an option; therefore, suicidal ideation is not normal. Most individuals, and most youth, who seriously

Continued > >

- consider suicide do not overtly act on those thoughts, but find more constructive ways to resolve hem. Presenting suicide as common may unintentionally remove a protective bias against suicide in a community.[11]

- **Don't present suicide as an inexplicable act or explain it as a result of stress only.** Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.[12] Additionally, it misses the opportunity to inform audiences of both the complexity and preventability of suicide. The same applies to any explanation of suicide as the understandable response to an individual's stressful situation or to an individual's membership in a group encountering discrimination. Oversimplification of suicide in any of these ways can mislead people to believe that it is a normal response to fairly common life circumstances.[13]

- **Don't focus on personal details of people who have died by suicide.** Vulnerable individuals may identify with the personal details of someone who died by suicide, leading them to consider ending their lives in the same way.[14]

- **Don't present overly detailed descriptions of suicide victims or methods of suicide.** Research shows that pictures or detailed descriptions of how or where a person died by suicide can be a factor in vulnerable individuals imitating the act. Clinicians believe the danger is even greater if there is a detailed description of the method.[15]

Acknowledgment

SPRC thanks Madelyn Gould, PhD, MPH [Professor at Columbia University in the Division of Child and Adolescent Psychiatry (College of Physicians & Surgeons) and Department of Epidemiology (School of Public Health), and a Research Scientist at the New York State Psychiatric Institute] for her extensive contributions and guidance in drafting and editing this document.

---

[1] Gould, M. S., Jamieson, P. & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist, 46*(9), 1269-1284.

[2] Gould, M.S. (1990). Suicide clusters and media exposure. In S. J. Blumenthal & D. J. Kupfer (Eds.), *Suicide over the life cycle* (pp.517-532). Washington, DC: American Psychiatric Press.

[3] Chambers, D. A., Pearson, J. L., Lubell, K., Brandon, S., O'Brien, K., & Zinn, J. (2005). The science of public messages for suicide prevention: A workshop summary. *Suicide and Life-Threatening Behavior, 35*(2), 134-145.

[4] Gould, M. S., Velting, D., Kleinman, M., Lucas, C., Thomas, J. G., & Chung, M. (2004). Teenagers' attitudes about coping strategies and help seeking behavior for suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(9), 1124-1133.

[5] U.S. Department of Health and Human Services. (2001). *National strategy for suicide prevention: Goals and objectives for action.* Rockville, MD: Author.

[6] Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., and Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36*(3), 255-262.

[7] Shaffer, D., Gould, M. S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry, 53* (4), 339-348.

[8] Conwell Y., Duberstein P. R., Cox C., Herrmann J.H., Forbes N. T., & Caine E. D. (1996). Relationships of age and axis I diagnoses in victims of completed suicide: a psychological autopsy study. *American Journal of Psychiatry, 153*, 1001-1008.

[9] Baldessarini, R., Tondo, L, & Hennen, J. (1999). Effects of lithium treatment and its discontinuation on suicidal behavior in bipolar manic-depressive disorders. *Journal of Clinical Psychiatry, 60* (Suppl. 2), 77-84.

[10] Fekete, S., & A. Schmidtke. (1995) The impact of mass media reports on suicide and attitudes toward self-destruction: Previous studies and some new data from Hungary and Germany. In B. L. Mishara (Ed.), *The impact of suicide.* (pp. 142-155). New York: Springer.

[11] Cialdini, R. B. (2003). Crafting normative messages to protect the environment. *Current Directions in Psychological Science, 12*(4), 105-109.

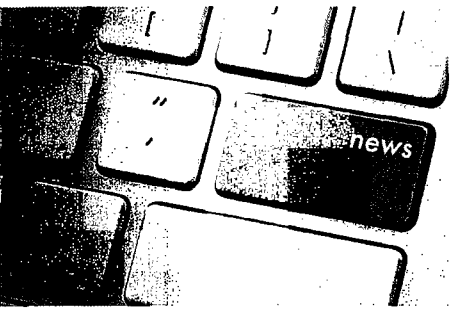
[12] Fekete, S., & A. Schmidtke. op. cit.

[13] Moscicki, E.K. (1999). Epidemiology of suicide. In D. G. Jacobs (Ed.), *The Harvard Medical School Guide to suicide assessment and intervention* (pp. 40-51). San Francisco: Jossey-Bass.

[14] Fekete, S., & E. Macsai, (1990). Hungarian suicide models, past and present. In G. Ferrari (Ed.), *Suicidal behavior and risk factors* (pp.149-156). Bologna: Monduzzi Editore.

[15] Sonneck, G., Etzersdorfer, E., & Nagel-Kuess, S. (1994). Imitative suicide on the Viennese subway. *Social Science and Medicine, 38*(3), 453-457.

RECOMMENDATIONS FOR REPORTING ON SUICIDE



Developed in collaboration with American Association of Suicidology, American Foundation for Suicide Prevention, Annenberg Public Policy Center, Associated Press Managing Editors, Canterbury Suicide Project - University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, Connect, Safely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National Action Alliance on Mental Illness, National Institute of Mental Health, National Press Photographers Association, New York State Psychiatric Institute, Substance Abuse and Mental Health Services Administration, Suicide Awareness Voices of Education, Suicide Prevention Resource Center, The Centers for Disease Control and Prevention (CDC) and UCLA School of Public Health, Community Health Solutions.

IMPORTANT POINTS FOR COVERING SUICIDE

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.

Suicide Contagion or "Copycat Suicide" occurs when one or more suicides are reported in a way that contributes to another suicide.

References and additional information can be found at: www.ReportingOnSuicide.org.

INSTEAD OF THIS:	DO THIS:
• Big or sensationalistic headlines, or prominent placement (e.g., "Kurt Cobain Used Shotgun to Commit Suicide").	• Inform the audience without sensationalizing the suicide and minimize prominence (e.g., "Kurt Cobain Dead at 27").
• Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.	• Use school/work or family photo; include hotline logo or local crisis phone numbers.
• Describing recent suicides as an "epidemic," "skyrocketing," or other strong terms.	• Carefully investigate the most recent CDC data and use non-sensational words like "rise" or "higher."
• Describing a suicide as inexplicable or "without warning."	• Most, but not all, people who die by suicide exhibit warning signs. Include the "Warning Signs" and "What to Do" sidebar (from p. 2) in your article if possible.
• "John Doe left a suicide note saying...".	• "A note from the deceased was found and is being reviewed by the medical examiner."
• Investigating and reporting on suicide similar to reporting on crimes.	• Report on suicide as a public health issue.
• Quoting/interviewing police or first responders about the causes of suicide.	• Seek advice from suicide prevention experts.
• Referring to suicide as "successful," "unsuccessful" or a "failed attempt."	• Describe as "died by suicide" or "completed" or "killed him/herself."

AVOID MISINFORMATION AND OFFER HOPE

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses, that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90% of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information and advice that promotes help-seeking.

SUGGESTIONS FOR ONLINE MEDIA, MESSAGE BOARDS, BLOGGERS & CITIZEN JOURNALISTS

- Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies and procedures could support removal of inappropriate and/or insensitive posts.

MORE INFORMATION AND RESOURCES AT:

www.ReportingOnSuicide.org

HELPFUL SIDE-BAR FOR STORIES

WARNING SIGNS OF SUICIDE

- Talking about wanting to die
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious, agitated or recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide but may not be what causes a suicide.

WHAT TO DO

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone
- Remove any firearms, alcohol, drugs or sharp objects that could be used in a suicide attempt
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK (8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

THE NATIONAL SUICIDE PREVENTION LIFELINE

800-273-TALK (8255)

A free, 24/7 service that can provide suicidal persons or those around them with support, information and local resources.

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