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STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
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March 19, 2023

TO: The Honorable Senator Joy A. San Buenaventura, Chair
Senate Committee on Health & Human

FROM: Cathy Betts, Director

SUBJECT: [HB 622 HD2](#) - RELATING TO SUICIDE PREVENTION.

Hearing: March 20, 2023, 1:00 p.m.
Conference Room 225 & Via Videoconference, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) supports the bill and defers to the Department of Health on implementation and resource needs.

PURPOSE: This measure makes permanent the prevent suicide Hawai'i task force within the Department of Health. Requires the task force to focus on reducing the suicide rate among Native Hawaiians and Pacific Islanders in the State. Requires reports to the legislature. Effective 6/30/3000. (HD2)

The HD1 amended the measure by:

- (1) Deleting the substantive contents of this measure, which would have established a task force within the Department of Health to reduce the suicide rate among Native Hawaiians and Pacific Islanders in the State;
- (2) Inserting language codifying the existing Prevent Suicide Hawaii Task Force;
- (3) Amending the composition of Prevent Suicide Hawaii Task Force;
- (4) Amending the focus of the Prevent Suicide Hawaii Task Force to include the prevention of suicide among Native Hawaiians and Pacific Islanders;
- (5) Clarifying certain other operational requirements for the Prevent Suicide Hawaii Task Force;

- (6) Changing the effective date to June 30, 3000, to encourage further discussion; and
- (7) Making technical, nonsubstantive amendments for the purposes of clarity, consistency, and style.

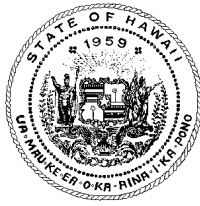
The HD2 further amended the measure by:

- (1) Clarifying the members to be appointed from the Department of Health;
- (2) Clarifying that a member be appointed by the Governor from a Native Hawaiian health and well-being organization;
- (3) Specifying that the members are to select the chairperson of the Task Force; and
- (4) Making technical, nonsubstantive amendments for the purposes of clarity, consistency, and style.

DHS appreciates the Legislature's attention to increasing access to mental and behavioral health services in Hawaii and supporting the necessary work with communities to reduce the risks of suicide. Accordingly, DHS will serve as a member of the task force.

Thank you for the opportunity to provide comments on this measure.

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA



STATE OF HAWAII | KA MOKU'ĀINA 'O HAWAII
DEPARTMENT OF PUBLIC SAFETY
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TOMMY JOHNSON
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Deputy Director
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No. _____

TESTIMONY ON HOUSE BILL 622, HOUSE DRAFT 2
RELATING TO SUICIDE PREVENTION.

By

Tommy Johnson, Director
Department of Public Safety

Senate Committee on Health and Human Services
Senator San Buenaventura, Chair,
Senator Henry J.C. Aquino, Vice Chair

Monday, March 20, 2023; 1:00 p.m.
State Capitol, Conference Room 225 and via Video Conference

Chair San Buenaventura, Vice Chair Aquino, and Members of the Committee:

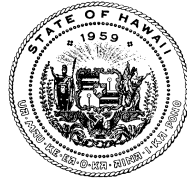
The Department of Public Safety (PSD) **supports** House Bill (HB) 622, House Draft (HD) 2, which seeks to make permanent the prevent suicide Hawai'i task force within the Department of Health, require the task force to focus on reducing the suicide rate among Native Hawaiians and Pacific Islanders in the State, and require annual reports to the legislature.

PSD previously supported the establishment of the prevent suicide Hawai'i task force to develop annual recommendations to the legislature to reduce deaths by suicide throughout the State of Hawai'i. In October 2021, the Bureau of Justice Statistics continued to identify suicide as a leading cause of death in local jails and state prisons. Correctional Mental Health Directors and Health Authorities at the National Commission on Correctional Health Care, the American Correctional Association, and the National Institute of Corrections continue to report increasing rates of suicide in correctional facilities nationwide.

In FY 2018, PSD began implementation of a plan of action to improve the its comprehensive Suicide Prevention Program. ACT 144, SLH 2007, Reports (FY 2018 to

current) document the improvements to the PSD's Suicide Prevention Program with data showing more than a 50% reduction in deaths by suicide at our jails and prisons during the 5-year period from 2018-2022 compared to the previous 5-year period from 2013-2017. As a regular participant in the Prevent Suicide Hawai'i Task Force meetings, PSD has benefited tremendously from the resources, expertise, partnerships, and demonstration of exceptional commitment to the prevention of suicide by task force members. In national comparisons, Hawai'i has outperformed other unified jail-prison systems in recent years. HB 622, HD 2 is aligned with PSD's ongoing work towards the goal of eliminating all preventable deaths by suicide. PSD embraces the opportunity to participate as a member of the prevent suicide Hawai'i task force while attempting to reduce the suicide rate for all Hawai'i residents.

Thank you for the opportunity to provide testimony in support of HB 622, HD 2.



STATE OF HAWAII
DEPARTMENT OF HEALTH
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**Testimony in OPPOSITION to HB622 HD2
RELATING TO RELATING TO SUICIDE PREVENTION.**

SENATOR JOY SAN BUENA VENTURA, CHAIR
SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

Hearing Date: March 20, 2023

Room Number: 225

1 **Fiscal Implications:** N/A.

2 **Department Testimony:** The Department of Health (DOH) opposes this measure as being
3 premature and insufficient to address suicide in Hawaii, and requests its deferral.

4 The existing Prevent Suicide Hawaii Task Force (PSHTF), created by House Concurrent
5 Reoslution (HCR) 66, Session Laws of Hawaii (SLH) 2016, has met bi-monthly to produce its
6 interim report in 2019 (attached) and work towards the strategic plan deliverable in 2025. DOH
7 recommends waiting for the final report before taking action, including naming participants on
8 the task force.

9 There is a single suicide prevention coordinator in DOH. Additional resources and strategies,
10 including establishing an appropriately staffed and funded formal suicide prevention program, is
11 likely necessary to address Hawai's rising suicide rate. Establishing this task force in statute
12 will not substantively add anything to prevention efforts in 2023. DOH strongly urges the
13 Legislature to act on the recommendations of the strategic plan due in 2025, in part because of
14 many other suicide prevention initiatives established in recent years:

- 15 • The Joint Military Suicide Prevention Task Force - represents all branches of the military,
16 including reserves, National Guard, and Coast Guard.
- 17 • The Hawaii Governor's Challenge to Reduce Suicide among Service Members, Veterans,
18 and their Families - a statewide initiative in partnership with the Substance Abuse and

1 Mental Health Services Administration (SAMHSA), the Department of Veterans Affairs,
2 all branches of the military, and state and community suicide prevention partners.

3 • Individual county suicide prevention task forces - Hawaii, Kauai, and Maui.

4 Hawaii averaged 196 suicide deaths per year, approximately 22% of all fatal injuries in the state.

5 Attempts outnumber deaths by 5-to-1. For the same time period, suicidal deaths in Native
6 Hawaiians averaged 35 per year and 13 per year in Pacific Islanders (Micronesians, Samoans,
7 and others). In the 15-24 age group, Native Hawaiian suicide deaths averaged 6 per year and
8 Pacific Islander deaths averaged 4 per year.

9 Enacting this measure adds no value to the ongoing work to prevent suicides, and in fact,
10 increases administrative burden due to chapter 92, HRS, given that it has 16 members.

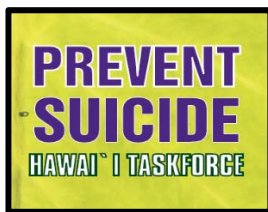
11 Thank you for the opportunity to testify.

12 **Offered Amendments:**

13

**REPORT TO THE
HAWAI'I STATE LEGISLATURE
TWENTY-NINTH LEGISLATURE, 2018
STATE OF HAWAI'I**

IN RESPONSE TO:
HOUSE CONCURRENT RESOLUTION (HCR) 66, H.D. 1, S.D. 1
of the Twenty-Eighth Legislature, 2016
*(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)*



Submitted By:
The Prevent Suicide Hawai'i 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

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John A. Burns School of Medicine
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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***

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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

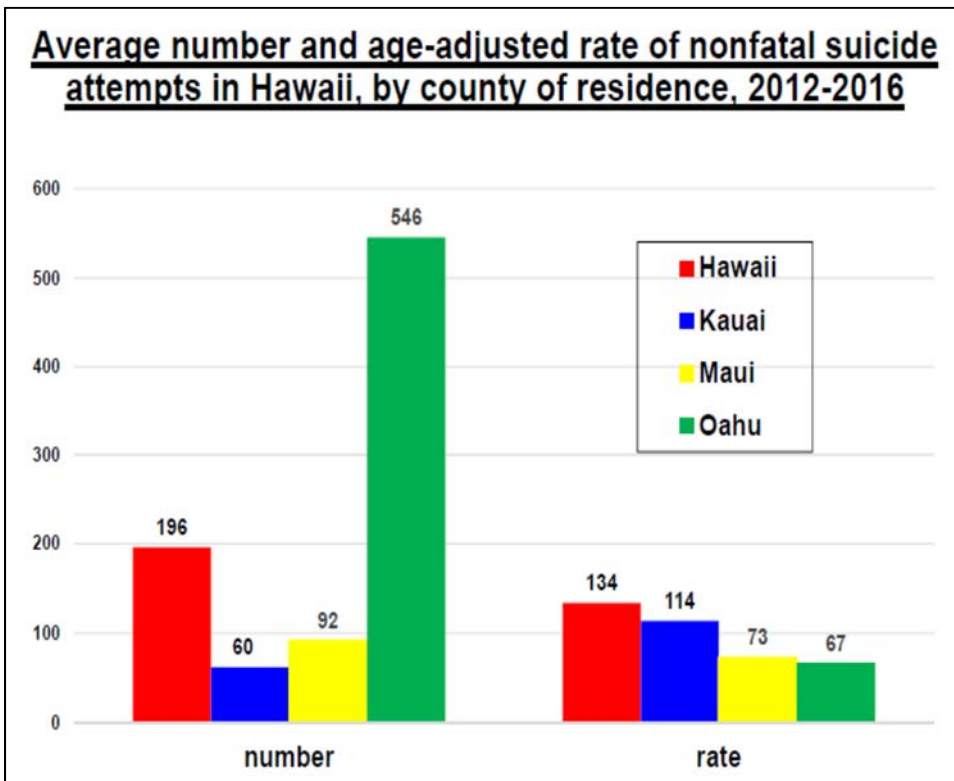
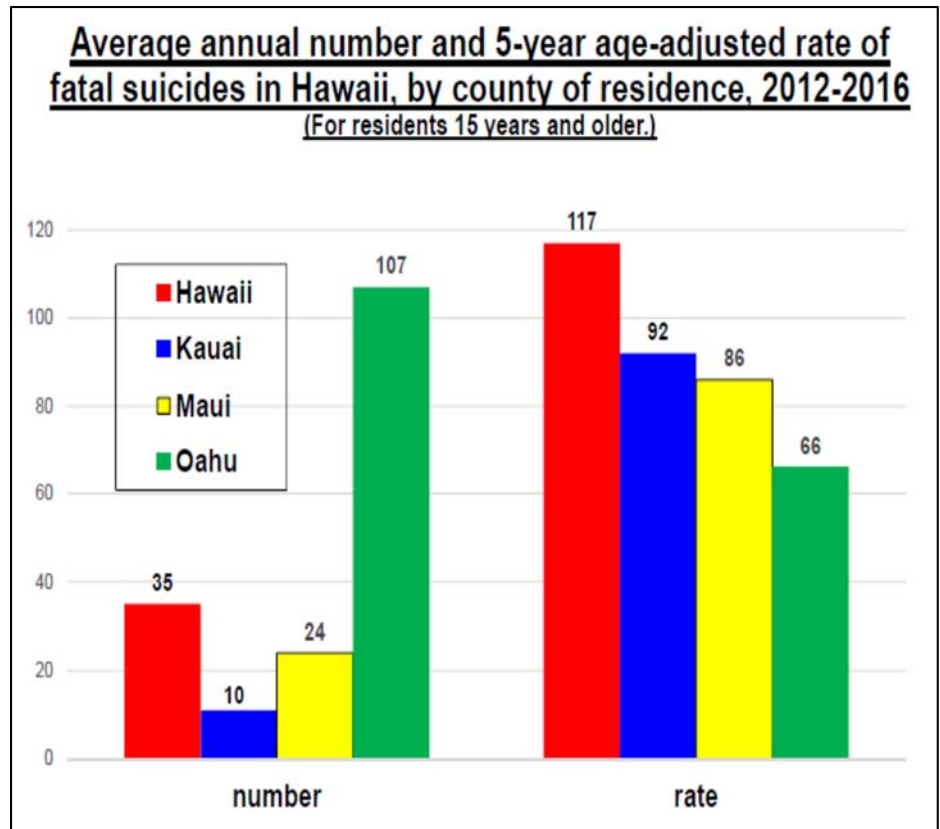
Suicide Deaths – Suicide was the most common cause of fatal injuries among Hawai'i residents over the five-year period from 2012 to 2016 (see figure), accounting for one-quarter (887, or 25%) of all fatal injuries, outpacing car crashes, homicide, unintentional poisoning, and drowning. One person dies 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	Poisoning 291	SUICIDE 162	Falls 459	SUICIDE 887
2	MVC*- pedestrian 14	MVC*- occupant 98	Poisoning 164	SUICIDE 222	Falls 109	Suffocation 65	Falls 673
3	Homicide 14	Poisoning 62	MVC*- occupant 53	UNDET. INTENT 57	Poisoning 93	SUICIDE 56	Poisoning 620
4	Suffocation 13	MVC*- motorcyclist 48	Homicide 47	Falls 53	Drowning 38	MVC*- pedestrian 42	MVC*- occupant 242
5	SUICIDE/ MVC*-occup 5 (each)	Drowning 31	MVC*- motorcyclist 38	Drowning 46	MVC*- pedestrian 29	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).

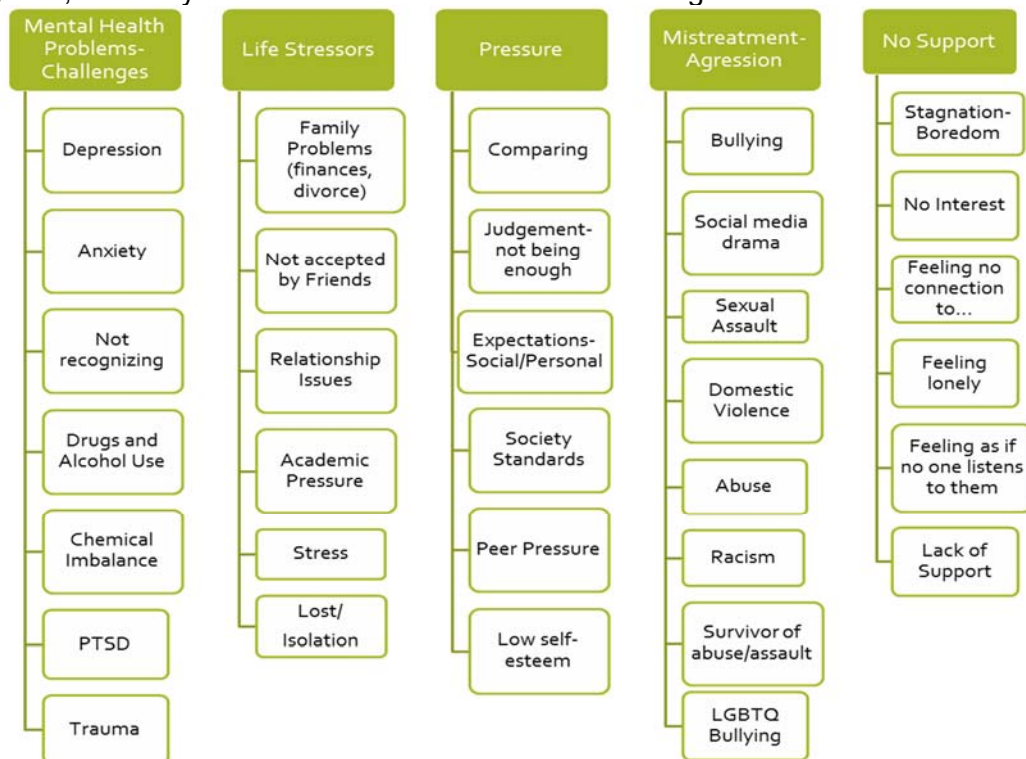
To complete the strategic plan, the PSHTF formed a temporary sub-committee which took on the responsibility of compiling the plan and associated recommendations. HCR 66 requested that the sub-committee include major agencies such as health, public safety, military and Veterans Affairs, the University 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 <i>Increase community awareness and communication around suicide prevention as a public health problem that is preventable.</i>	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 <i>Increase statewide capacity for training across multiple levels and disciplines, including a focus on cultural humility with diverse populations.</i>	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 <i>Promote suicide prevention as a core component of Hawai'i's overall system of care.</i>	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 <i>Increase Hope, Help, Healing, and Wellbeing among those personally touched by suicide and among those with lived experience.</i>	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 <i>Increase State and Community capacity to effectively and efficiently respond to individuals and communities affected by suicide and those with mental health challenges.</i>	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
<i>Conduct and support high-quality research and evaluation to inform suicide prevention programs, interventions, policies, and overall Statewide direction.</i>	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 <i>Ensure policies and protocols set the proper foundation for suicide prevention initiatives.</i>	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 be 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, it 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:

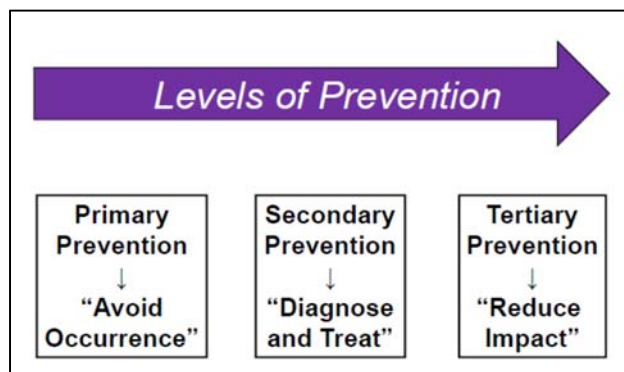
- Dissemination of strategic plan recommendations to PSHTF membership, partner agencies, and pertinent stakeholders.
- Meetings to plan and implement priority items, including with partner agencies.
 - This includes partnering with the Hawai'i State Legislature to explore recommended legislative items.
- 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).

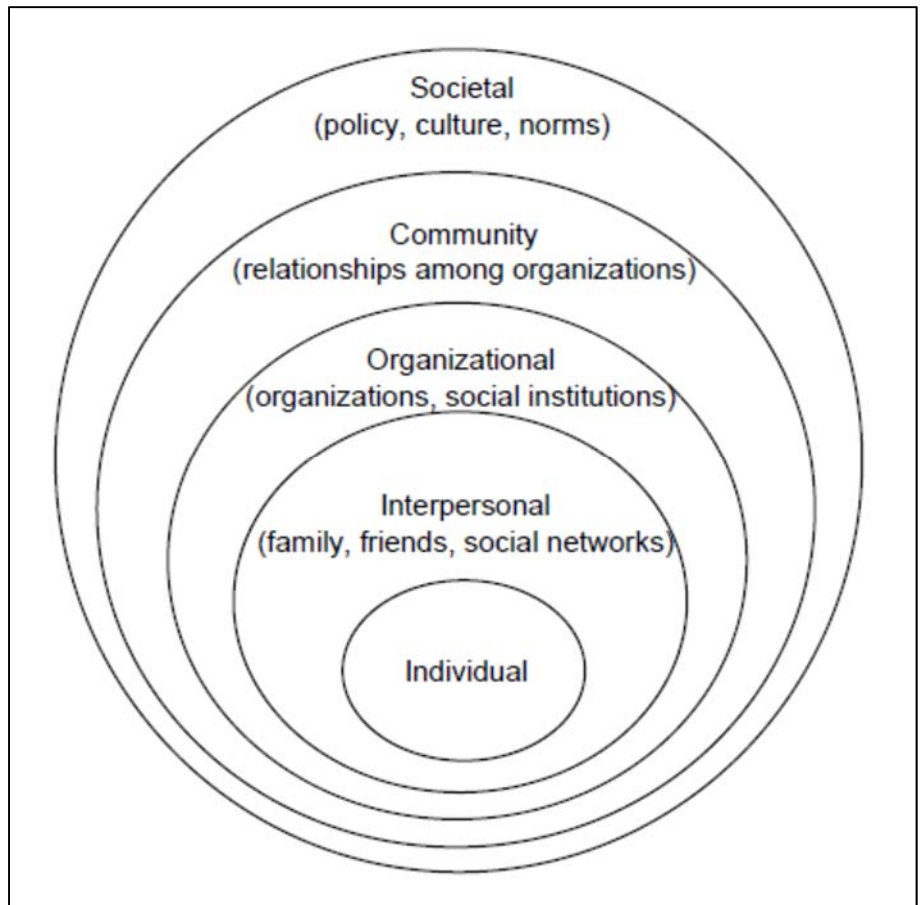
- Primary prevention refers to the most “upstream” type of prevention – that is, prevention of the occurrence of an illness or conditions before onset. Primary prevention activities promote health and protective factors, and protect against exposure to risk factors that lead to health problems (Owen, 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Advocacy for policies and resources. • Broad public campaigns to impact changes in culture and norms.

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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 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.

1 WHEREAS, the Legislature finds that suicide is a major
2 health concern that claims approximately one million lives
3 worldwide each year; and
4

5 WHEREAS, in Hawaii, suicide was the most common cause of
6 fatal injuries between 2010 and 2014, accounting for one out of
7 every four fatal injuries; and
8

9 WHEREAS, every two days, one person in Hawaii falls victim
10 to suicide; and
11

12 WHEREAS, the Prevent Suicide Hawaii Task Force is a
13 partnership of state, public, and private agencies and community
14 groups working in collaboration to provide leadership, develop
15 strategies, coordinate activities, and monitor progress of
16 suicide prevention efforts in the State; and
17

18 WHEREAS, the Prevent Suicide Hawaii Task Force includes the
19 Department of Health's Injury Prevention and Control Section in
20 planning and implementing these activities; and
21

22 WHEREAS, the Prevent Suicide Hawaii Task Force provides
23 leadership for suicide prevention activities statewide,
24 including National Suicide Prevention Week and suicide
25 prevention conferences; and
26

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



1 WHEREAS, the Prevent Suicide Hawaii Task Force is a
2 valuable ally in the effort to save lives from suicide; and
3

4 WHEREAS, the Legislature is concerned about the health,
5 safety, and welfare of all the people of Hawaii, including
6 military personnel, veterans, and visitors; now, therefore,
7

8 BE IT RESOLVED by the House of Representatives of the
9 Twenty-eighth Legislature of the State of Hawaii, Regular
10 Session of 2016, the Senate concurring, that the Prevent Suicide
11 Hawaii Task Force is requested to recommend a strategic plan to
12 reduce suicides in Hawaii by at least twenty-five per cent by
13 2025; and
14

15 BE IT FURTHER RESOLVED that the Prevent Suicide Hawaii Task
16 Force, in the course of developing its recommendations, is
17 requested to examine, evaluate, and determine methods to improve
18 education, awareness, support services, and outreach to best
19 prevent suicides in Hawaii; and
20

21 BE IT FURTHER RESOLVED that the Prevent Suicide Hawaii Task
22 Force is requested to form a temporary subcommittee to assist in
23 the development of its recommendations; and
24

25 BE IT FURTHER RESOLVED that the subcommittee is requested
26 to include individuals who have expertise or experience in
27 fields or disciplines related to suicide prevention and
28 education or awareness of suicide prevention; and
29

30 BE IT FURTHER RESOLVED that, at minimum, the following
31 individuals are requested to serve and be included on the
32 subcommittee:
33

34 (1) Four members to be appointed by the Governor, one from
35 each county, two of whom are requested to be a
36 survivors of attempted suicide or suicide loss
37 survivors;
38

39 (2) One member from the Adult Mental Health Division and
40 one member from the Child and Adolescent Mental Health
41 Division, to be appointed by the Director of Health;
42

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



- 1 (4) The Suicide Prevention Program Manager for the Army
2 Suicide Prevention Task Force or the Program Manager's
3 designee;
- 4
- 5 (5) One member from the Pacific Regional Behavioral Health
6 Alliance;
- 7
- 8 (6) One member from the Prevent Suicide Hawaii Task Force,
9 to be appointed by the Director of Health;
- 10
- 11 (7) One member to be appointed by the Dean of the John A.
12 Burns School of Medicine at the University of Hawaii
13 at Manoa, from its Department of Psychiatry;
- 14
- 15 (8) One member from the Hawaii Youth Leadership Council
16 for Suicide Prevention, to be appointed by the
17 President of the Senate;
- 18
- 19 (9) One member from the Hawaii Youth Leadership Council
20 for Suicide Prevention, to be appointed by the Speaker
21 of the House of Representatives;
- 22
- 23 (10) The Chair of the Board of the American Foundation for
24 Suicide Prevention Hawaii Chapter or the Chair's
25 designee;
- 26
- 27 (11) The President of the American Foundation for Suicide
28 Prevention Hawaii Chapter or the President's designee;
- 29
- 30 (12) The Community Liaison of the American Foundation for
31 Suicide Prevention Hawaii Chapter; and
- 32
- 33 (13) The President of the Board of Directors of Mental
34 Health America of Hawaii or the President's designee;
35 and
- 36

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

40

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



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

6
7 BE IT FURTHER RESOLVED that a certified copy of this
8 Concurrent Resolution be transmitted to the Director of Health,
9 who in turn is requested to transmit copies to the Governor; the
10 Administrator of the Hawaii Chapter of the Veterans
11 Administration; the Suicide Prevention Program Manager for the
12 Army Suicide Prevention Task Force; the Executive Director of
13 the Pacific Regional Behavioral Health Alliance; the Dean of the
14 John A. Burns School of Medicine at the University of Hawaii at
15 Manoa; the Chair of the Prevent Suicide Hawaii Task Force; the
16 Chair of the Hawaii Youth Leadership Council for Suicide
17 Prevention; the Chair of the Board, the President, and the
18 Community Liaison of the American Foundation for Suicide
19 Prevention Hawaii Chapter; and the President of the Board of
20 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 –

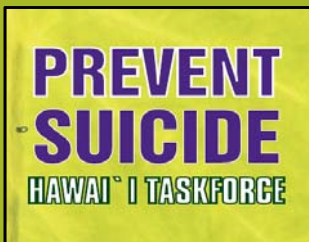
(updated 12/7/17)

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*



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



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***

ALOHA PASSING LIFE FORWARD



Kaniela Kaninau
March 31, 1995 -
April 5, 2013
Kalani High School
Senior

Not Just Statistics - Not Their Suicide



Charlie



Kaniela



Koa



Thomas



Michael



Diane



Kevin



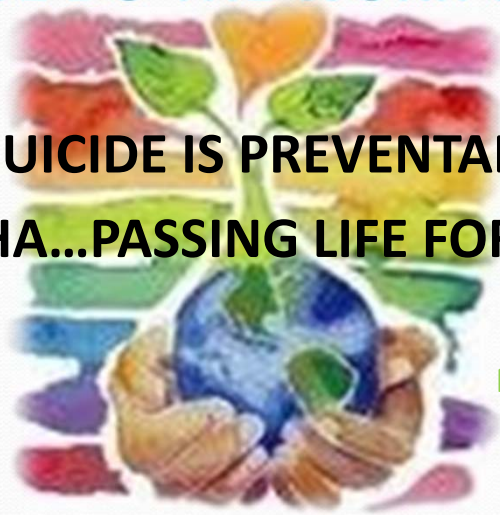
Thomas



Charles

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 10, 2015
1:30 to 3:00 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

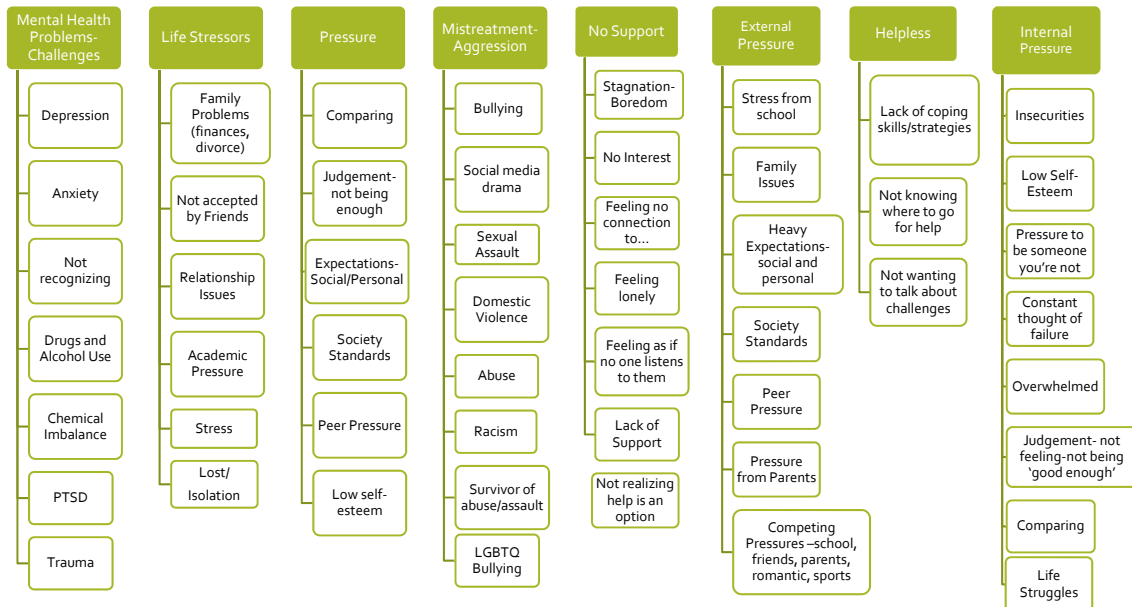
- Feedback from **larger PSHTF membership**
 - Discussions during meetings
 - Member survey circulated
- Intensive two-day session with **Dr. Jerry Reed**, co-convener of the National Strategy for Suicide Prevention
- Feedback from partner groups, including **Youth Leadership Council** for Suicide Prevention

Inclusion of Youth Voice

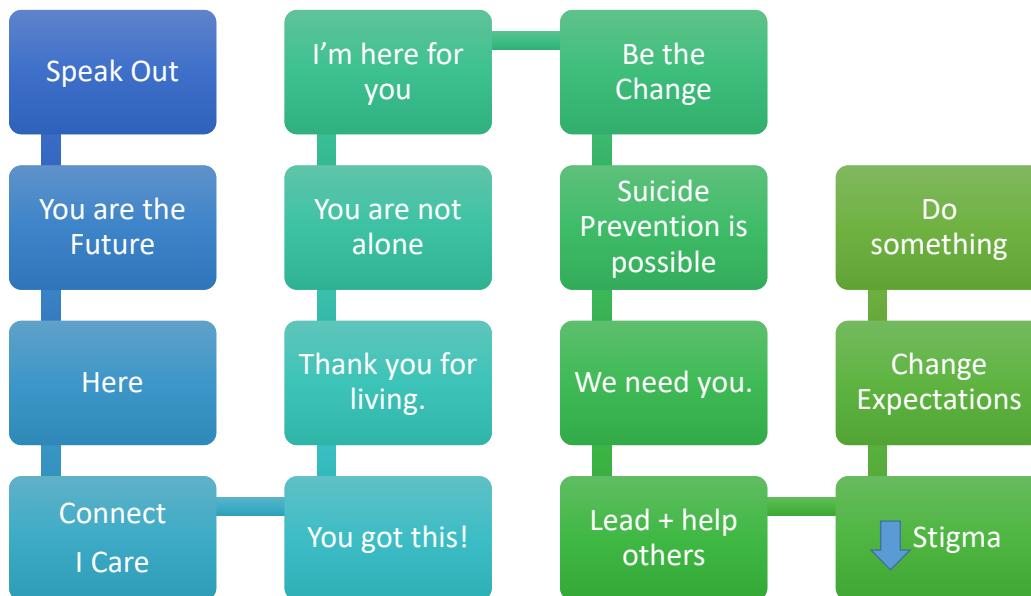
Through Youth Leadership Council (YLC) for Suicide Prevention



Challenges ~ Life Struggles



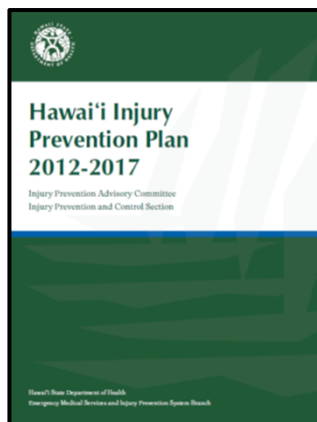
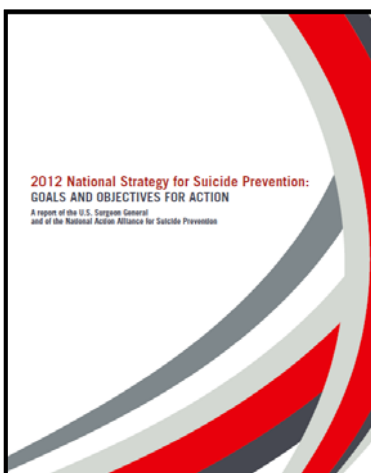
Messages



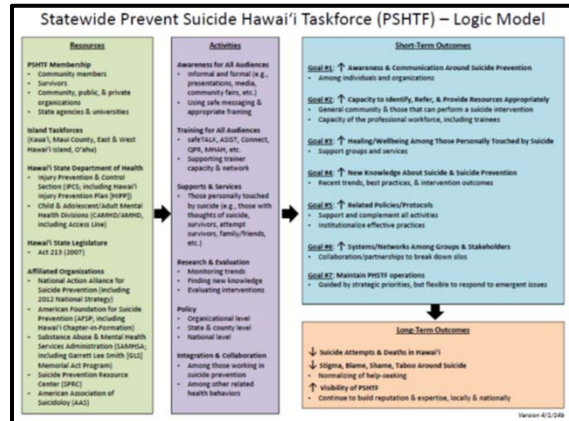
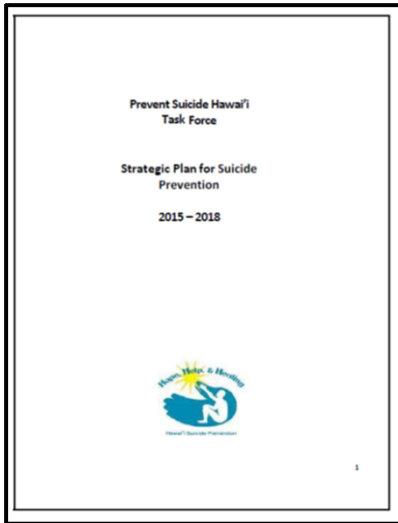
Messages

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

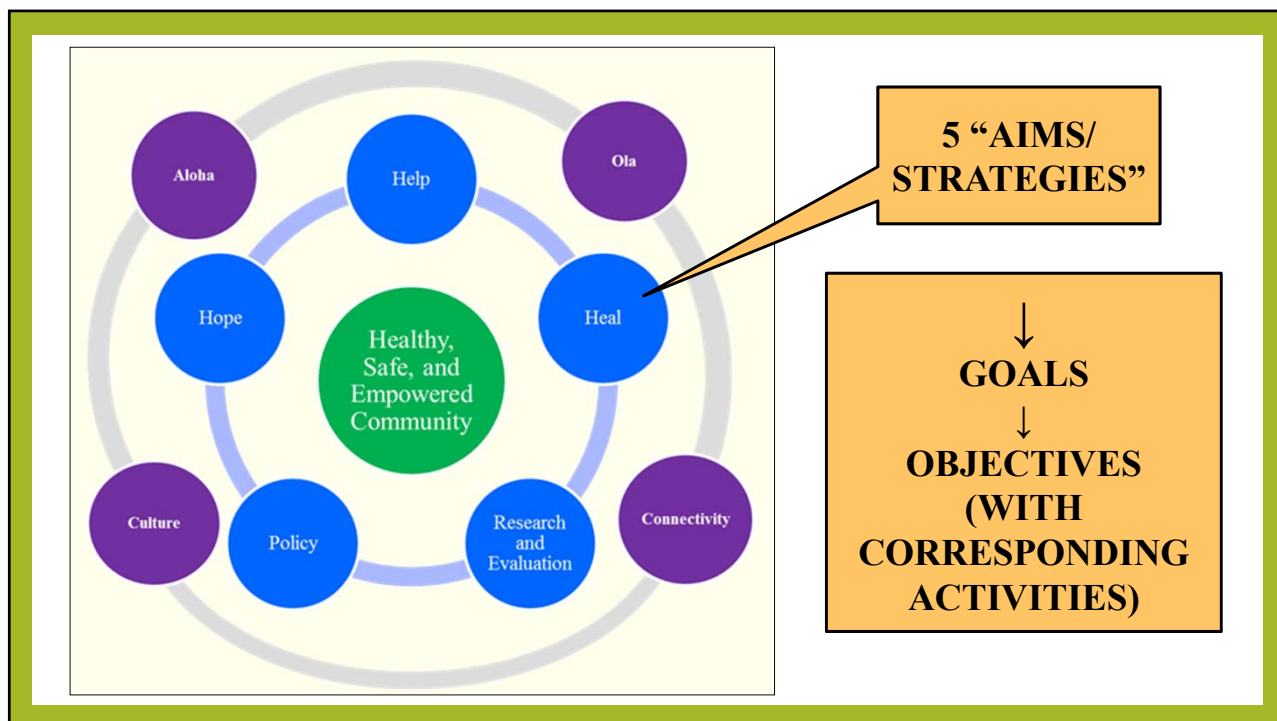


Additional Context



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.

THEME	FORMAL OBJECTIVE
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.

THEME	FORMAL OBJECTIVE
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” implementation

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.

THEME	FORMAL OBJECTIVE
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.

THEME	FORMAL OBJECTIVE
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.

THEME	FORMAL OBJECTIVE
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.

THEME	FORMAL 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

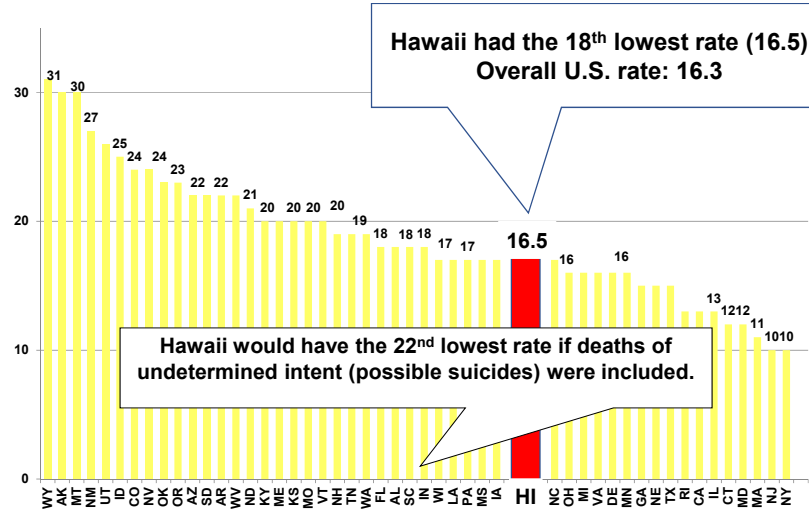
*Dan Galanis, Ph.D.
Epidemiologist
Injury Prevention and Control Section
EMS & Injury Prevention System Branch
Hawaii Department of Health*

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

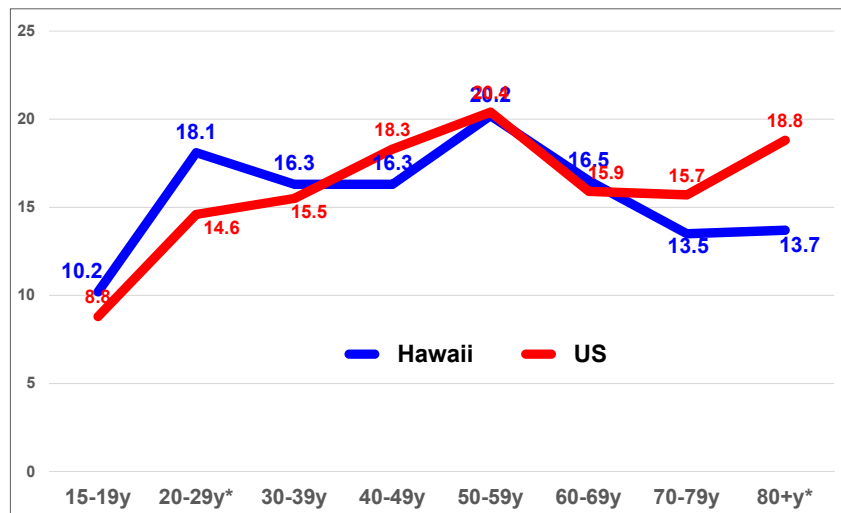
Overview of presentation

- **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

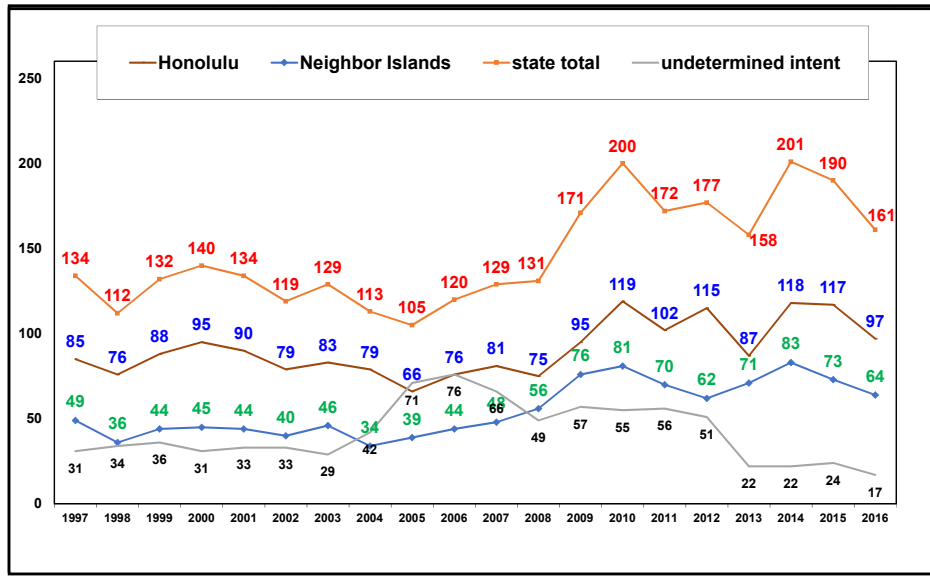
Causes of fatal injuries in Hawaii, by resident age group, 2012-2016

	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	falls 459	SUICIDE 887
2	mvc*- pedestrian 14	mvc*- occupant 98	poisoning 164	SUICIDE 222	falls 109	suffocation 65	falls 673
3	homicide 14	poisoning 62	mvc*- occupant	UNDET. INTENT	poisoning	SUICIDE 56	poisoning 620
4	suffocation 13	mvc*- motorcyclist 48	homicide 47	falls 53	falls 109	mvc*- pedestrian 42	mvc*- occupant 242
5	SUICIDE/ mvc*-occup 5 (each)	drowning 31	mvc*- motorcyclist 38	drowning 46	mvc*- pedestrian 29	mvc*- occupant 24	drowning 181

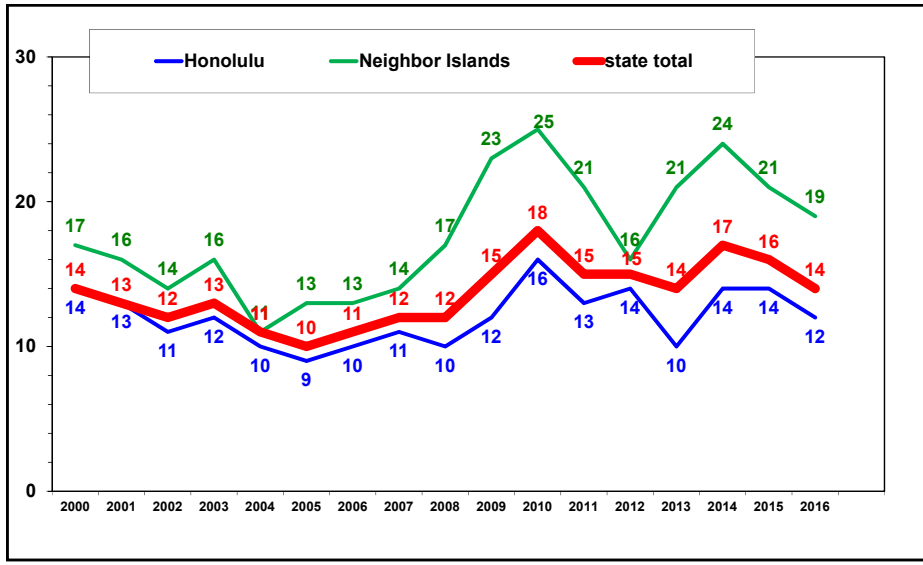
9th: undetermined intent (138)

*mvc = motor vehicle crash

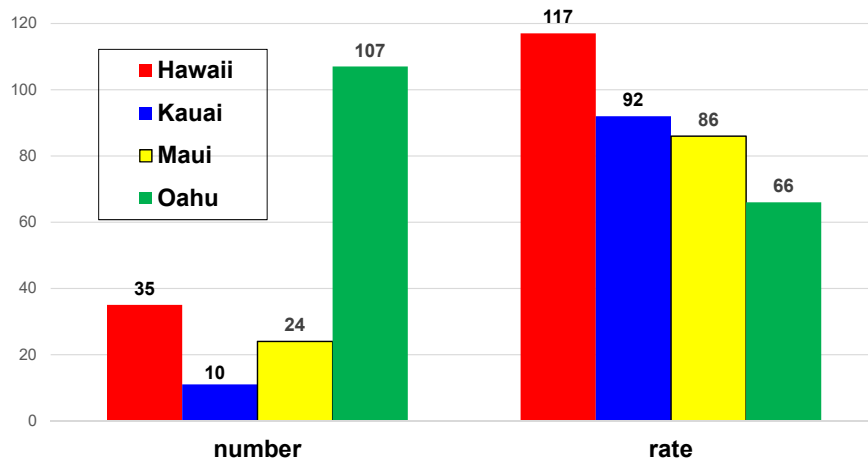
Annual number of suicides among Hawaii residents, by county of residence, 1997-2016



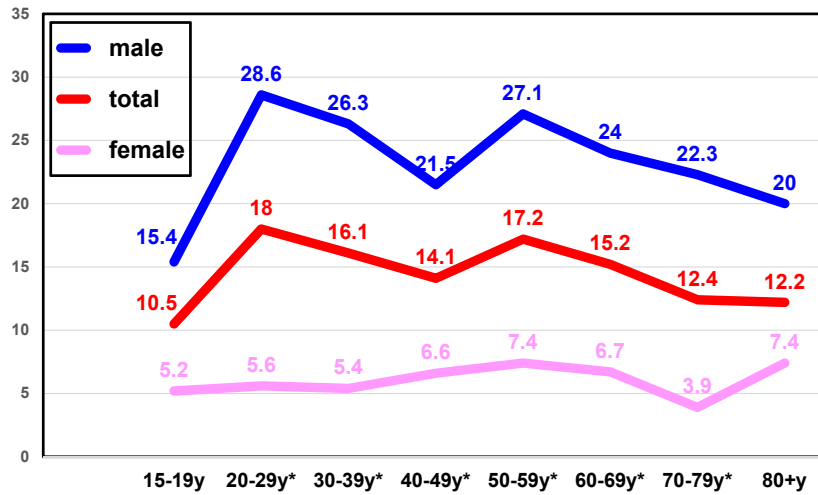
Age-adjusted rates (/100,000) of suicides among Hawaii residents, 15 years and older, 2000-2016



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

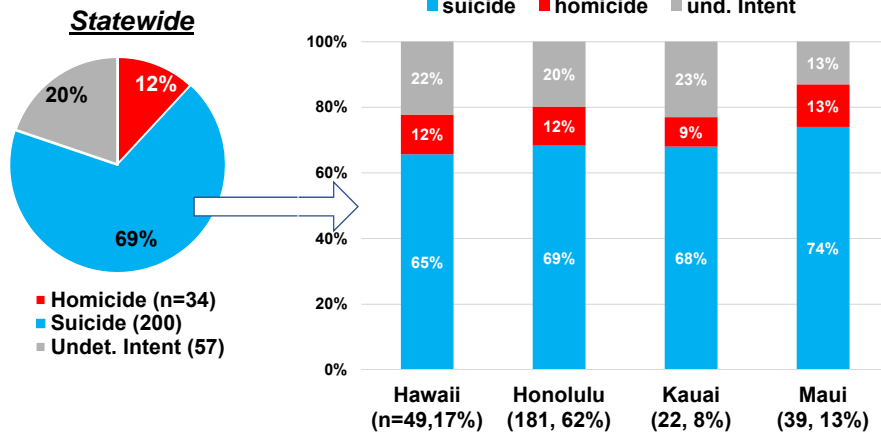


**indicates statistically significant difference in rate between genders*

**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*

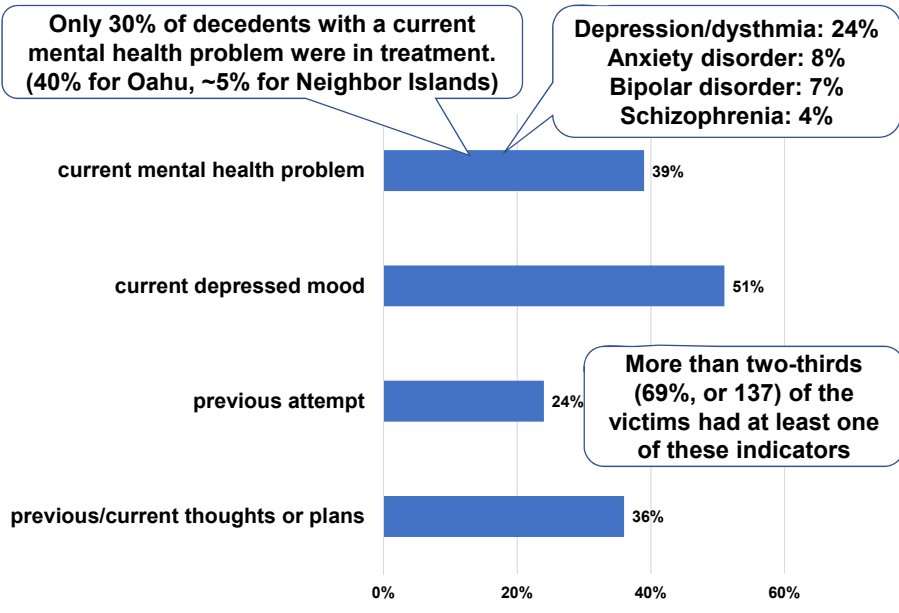
Hawaii NVDRS, 2015: Type of violent death (n=291)



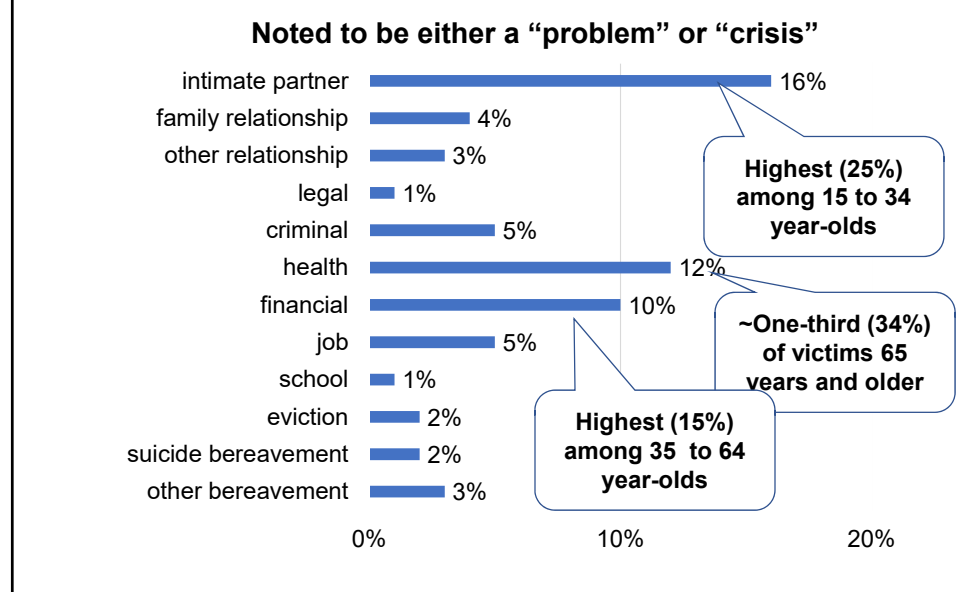
Suicides (n=200)

- **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

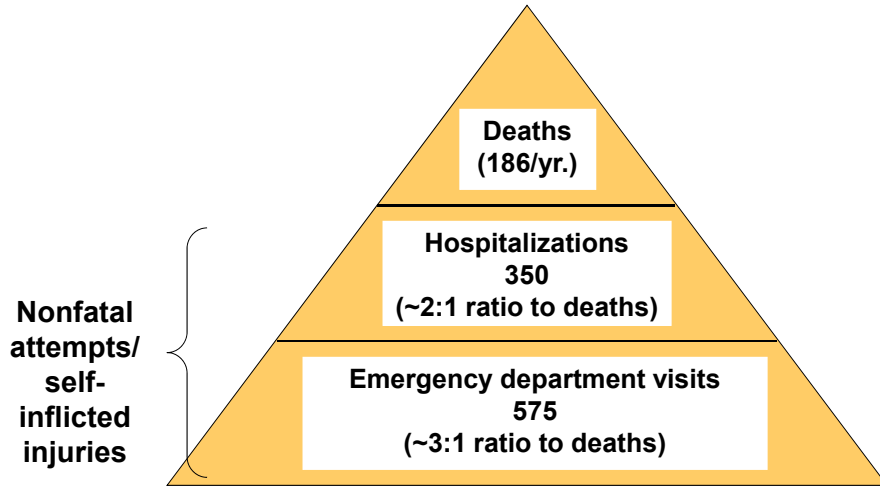
NVDRS, 2015:
Indications of mental illness among suicide victims (n=200)



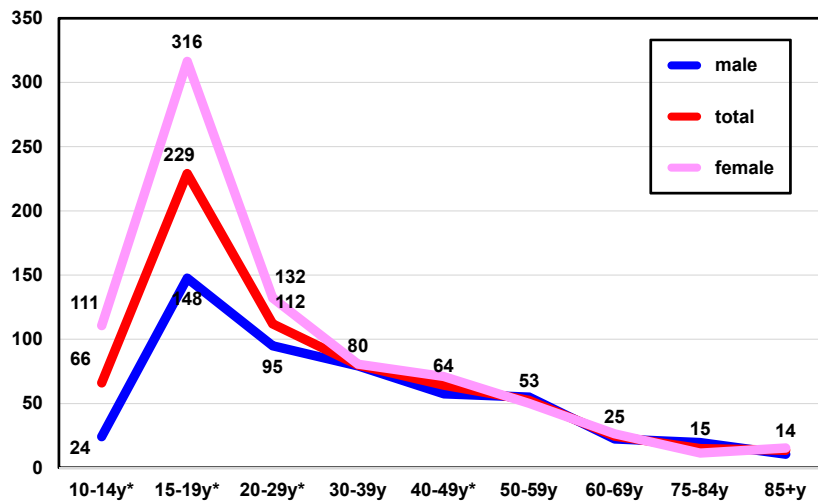
Hawaii NVDRS, 2015:
“Relationship and life stressors” among suicide victims (n=200)



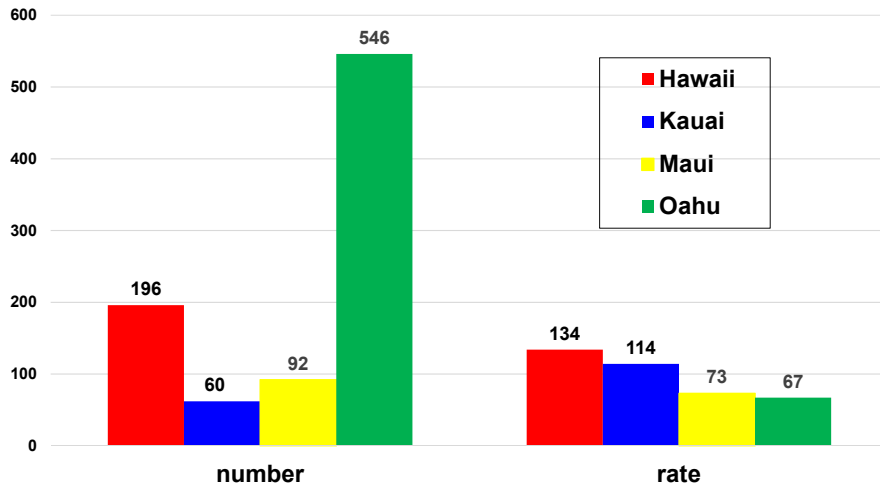
“Injury Pyramid” for suicides and attempts in Hawaii, 2012-2016



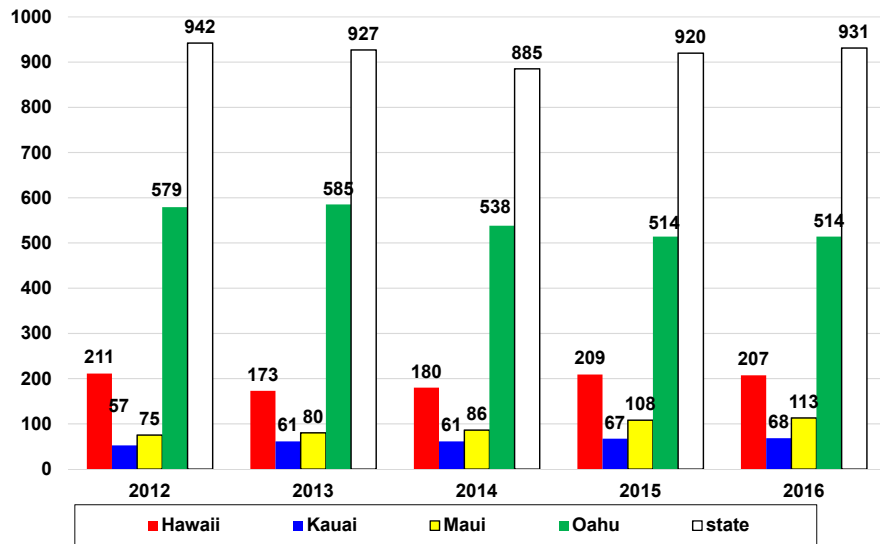
Annual rate (/100,000) of nonfatal suicide attempts among Hawaii residents, by gender and age group, 2012-2016



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



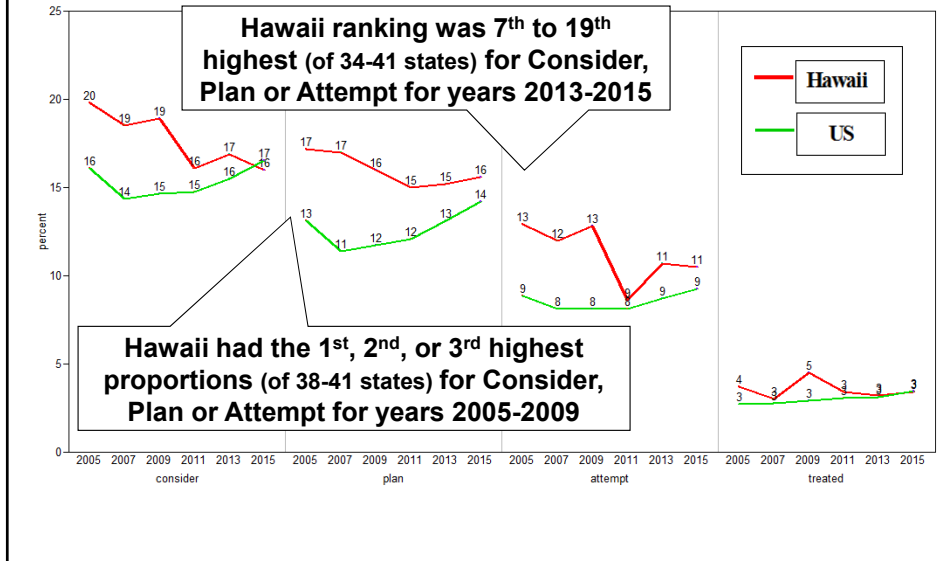
Summary – suicides & attempts in Hawaii, 2012-2016

	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**

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.

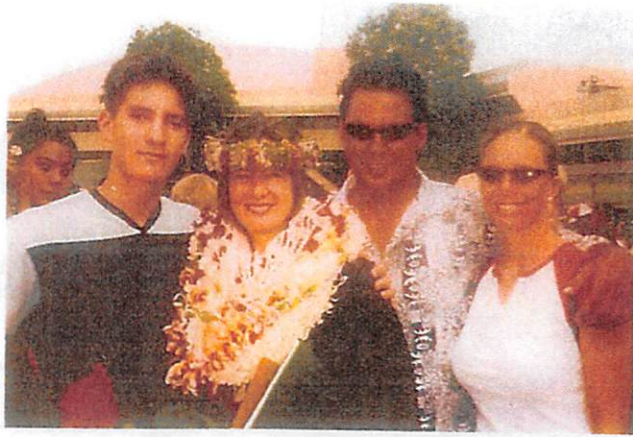
His mood also changed as he became more irritable, and rebellious at times, and I also noticed he was engaging in



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.



General Resources for Mental Health Promotion & Suicide Prevention




You are not alone!



[This is a working list of resources, and is by no means exhaustive, but provides a snapshot of those working to "pass life forward" in our State. For questions about this resource list, contact the Hawai'i's Caring Communities Initiative (HCCI) for Youth Suicide Prevention at HCCI-Contact@dop.hawaii.edu.]

FOR MENTAL HEALTH EMERGENCIES/CRISIS

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

	<p>For ANYONE in Crisis: National Suicide Prevention Lifeline (NSPL) <i>National 24/7 crisis line</i> 1-800-273-TALK (8255) TTY: 1-800-799-4TTY (4889) http://www.suicidepreventionlifeline.org/</p>	
<p>For Youth & Young Adults: 1-800-273-TALK (8255)</p>  <p>http://www.youmatter.suicidepreventionlifeline.org/</p>	<p>For Veterans: 1-800-273-TALK (8255) Press "1" to reach the Veterans Crisis Line or Text to 838255</p>  <p>Also, confidential chat at http://www.veteranscrisisline.net/</p>	

CRISIS TEXT LINE |

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/>

If you need support, please call the Trevor Lifeline: 866 488 7386

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-MSD/>
- 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](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)
<p>“Suicide Prevention 101”</p>	<p>A very basic presentation to introduce audiences to foundational information around suicide prevention – i.e., core principles, local data, warning signs, and resources.</p>	<p>All audiences</p>	<p>1 hour</p>	<p>Jeanelle Sugimoto-Matsuda, sugimotoj@dop.hawaii.edu</p> <p>Nancy Deeley, nancy.deeley@doh.hawaii.gov</p>
<p>“Connect” Training Program (parent organization = National Alliance on Mental Illness, New Hampshire)</p> 	<p>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.</p>	<p>All audiences – foundational training (adaptable to specific groups, including youth)</p>	<p>3-4 hours</p>	<p>Jeanelle Sugimoto-Matsuda, DrPH, UH Department of Psychiatry, sugimotoj@dop.hawaii.edu</p> <p>Deborah Goebert, DrPH, UH Department of Psychiatry, goebertd@dop.hawaii.edu</p> <p>http://www.theconnectprogram.org/</p>
<p>SafeTALK (parent organization = Living Works)</p> 	<p>“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.</p>	<p>All audiences – step-by-step process of connecting with someone who may be thinking about suicide</p>	<p>3-4 hours</p>	<p>Jeanelle Sugimoto-Matsuda, DrPH, UH Department of Psychiatry, sugimotoj@dop.hawaii.edu</p> <p>Nancy Deeley, MPH, Hawai‘i State Department of Health, nancy.deeley@doh.hawaii.gov</p> <p>https://www.livingworks.net/programs/safetalk/</p>
<p>ASIST (Applied Suicide Intervention Skills Training; parent organization = Living Works)</p> 	<p>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.</p>	<p>Individuals (community members and professionals) willing to and/or tasked with conducting full suicide interventions (including risk assessments and safety planning)</p> <p><i>It is recommended that trainees attend Connect and/or SafeTALK prior to ASIST</i></p>	<p>2 full days</p>	<p>Jeanelle Sugimoto-Matsuda, DrPH, UH Department of Psychiatry, sugimotoj@dop.hawaii.edu</p> <p>Nancy Deeley, MPH, Hawai‘i State Department of Health, nancy.deeley@doh.hawaii.gov</p> <p>https://www.livingworks.net/programs/asist/</p>

– TRAININGS OFFERED BY PSHTF PARTNERS –

Curriculum	Description	Appropriate For	Approximate Length	Main Contact(s)
<p>“Youth Suicide and Bullying Prevention” (YSBP) Training</p> 	<p>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.</p>	<p>All audiences – foundational training, versions for youth and adults available</p>	<p>2-3 hours</p>	<p>Mental Health America of Hawai‘i amanda.martinez@mentalhealthhawaii.org (808) 521-1846 http://mentalhealthhawaii.org/</p>
<p>“Grow a Rainbow” Training</p> 	<p>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).</p>	<p>Adult audiences</p>	<p>2-3 hours</p>	<p>Mental Health America of Hawai‘i amanda.martinez@mentalhealthhawaii.org (808) 521-1846 http://mentalhealthhawaii.org/</p>
<p>Youth Mental Health First Aid</p> 	<p>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.</p>	<p>Adult audiences – those who regularly interact with youth</p>	<p>1 full day</p>	<p>Cynthia “CJ” Rice cynthia_rice@notes.k12.hi.us (808) 305-9798 www.mentalhealthfirstaid.org</p>
<p>“More than Sad”</p> 	<p>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.</p>	<p>All audiences</p>	<p>1-2 hours</p>	<p>Pua Kaninau-Santos pkshawaii@gmail.com https://afsp.org/our-work/education/more-than-sad/</p>

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 as 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.oahupshawaii.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 Admin-
istration (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 |



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

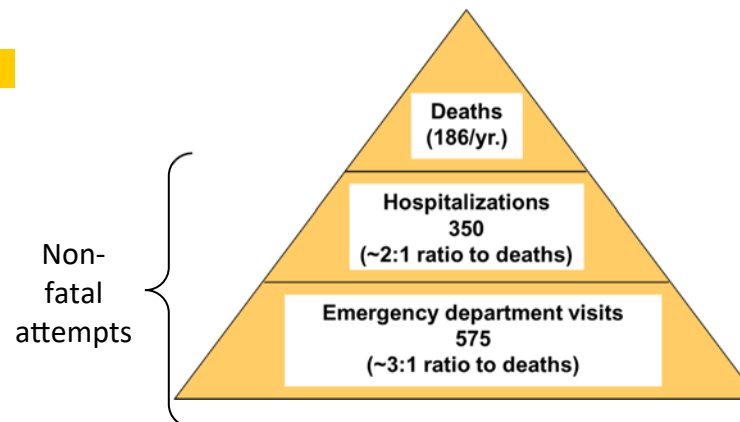
According to the Hawai'i State Department of Health, someone in Hawai'i dies by suicide every two days.

- 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 >>

Safe and Effective Messaging for Suicide Prevention

- 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, ConnectSafely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National 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 Sciences.



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:



- Big or sensationalistic headlines, or prominent placement (e.g., “Kurt Cobain Used Shotgun to Commit Suicide”).
- Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.
- Describing recent suicides as an “epidemic,” “skyrocketing,” or other strong terms.
- Describing a suicide as inexplicable or “without warning.”
- “John Doe left a suicide note saying...”.
- Investigating and reporting on suicide similar to reporting on crimes.
- Quoting/interviewing police or first responders about the causes of suicide.
- Referring to suicide as “successful,” “unsuccessful” or a “failed attempt.”

DO THIS:



- Inform the audience without sensationalizing the suicide and minimize prominence (e.g., “Kurt Cobain Dead at 27”).
- Use school/work or family photo; include hotline logo or local crisis phone numbers.
- Carefully investigate the most recent CDC data and use non-sensational words like “rise” or “higher.”
- 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.
- “A note from the deceased was found and is being reviewed by the medical examiner.”
- Report on suicide as a public health issue.
- Seek advice from suicide prevention experts.
- 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



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

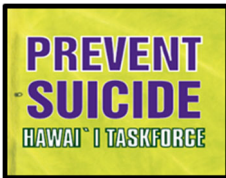
If someone you know exhibits warning signs of suicide:

- 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.





Prevent Suicide Hawai'i Taskforce
*Hawaii's Statewide Public-Private Network
promoting hope, help, and healing
and passing life forward in our local communities*



March 19, 2023

Chair Joy A. San Buenaventura
Vice Chair Henry J.C. Aquino
Senate Committee on Health and Human Services
Hawai'i State Legislature
415 South Beretania Street
Honolulu, HI 96813

RE: full support for HB622 HD2 – relating to suicide prevention

Makes permanent the prevent suicide Hawai'i task force within the Department of Health. Requires the task force to focus on reducing the suicide rate among Native Hawaiians and Pacific Islanders in the State. Requires reports to the legislature. Effective 6/30/3000. (HD2)

For Senate Committee on Health and Human Services – hearing on March 20, 2023 at 1:00 p.m. in conference room 225 and via videoconference

Chair San Buenaventura, Vice Chair Aquino, and distinguished members of
The Senate Committee on Health and Human Services:

The Steering (Leadership) Committee of the Prevent Suicide Hawai'i Taskforce wishes to affirm our **full support of HB 622 (House Draft 2)**. In this testimony we offer key points as to why this bill deserves your favorable vote, especially at this critical time.

The issue of suicide

In Hawai'i, one of our community members dies by suicide every other day. This dire public health issue unfortunately affects all communities and disciplines, though disproportionately impacts our vulnerable communities such as our Native and Indigenous peoples, our rural residents, and our youth and young adults. What's more, the immense stigma around mental health and suicidality increases the challenge that faces us when encouraging people to seek help when needed.

The Prevent Suicide Hawai'i Taskforce (see attachment for more information):

First convened in 1999, the Taskforce has continued to grow and evolve ever since, an incredible demonstration of staying power and partnership. Many inaugural members continue to play key roles.

- Today, we are Hawaii's largest and longest-standing grassroots (volunteer-based) collaborative focused on suicide prevention. Our membership is diverse and includes all counties, professionals from various disciplines, and most importantly, those who have been personally impacted by suicide (e.g., those who have lost a loved one to suicide, those with personal struggles, etc.).
- Over time, the Taskforce has become the State's leader in raising awareness around suicide, providing trainings to various audiences, supporting those impacted by suicide, and conducting research and evaluation activities. The Taskforce is also author of Hawaii's Suicide Prevention Strategic Plan, which was requested by and reported to the Legislature: <https://go.hawaii.edu/k8k>.

Why your support of HB 622 HD2 matters, especially in this Legislative Session:

1) It formalizes the Taskforce, and recognizes members' commitment

Your support of HB 622 HD2 not only ensures the long-term sustainability of the Taskforce, but also conveys proper acknowledgement and gratitude to those who have already paved the way. **It firmly documents the Legislature's earnest and serious commitment to preventing suicide**, and is particularly symbolic to those of us who have survived the loss of our loved ones to suicide, or live with our own struggles.

2) It ensures sustained momentum of, and accountability to, Hawaii's Strategic Plan

HB 622 HD2 will formally designate the Taskforce as the lead entity to monitor and evaluate the Strategic Plan, adding an element of accountability for all stakeholders involved in the Plan's implementation. Since presentation of the

plan in 2017, the Taskforce has already been monitoring its progress, and we have also begun the process of revisiting and updating the Plan. **As the Plan's original authors, we are intimately familiar with its intended design and use, and so are in a unique position to facilitate implementation and evaluation.**

3) *It ensures sustained partnerships among key agencies*

While all agencies named in the bill are already active participants in the Taskforce, HB 622 HD2 ensures sustained commitment from all parties. We are aware that some may be concerned about workload; our core members validate these concerns and also empathize, given that we all voluntarily serve in our roles beyond our required professional and personal responsibilities. In response, we ask the Committee to reflect on such a statement (i.e., "prioritizing suicide prevention is too much work"), and what type of message that sends to the community. In addition, please be assured the Taskforce is already self-driven and organized. This includes elements such as internal bylaws, regularly scheduled public meetings, communication mechanisms, and a core leadership (Steering Committee). **We are ready. This is the next step not for only the network, but also for the suicide prevention movement in Hawai'i.**

Should you have questions or require additional information about this bill, or any resources related to suicide prevention, please do not hesitate to reach out to us. Dr. Jeanelle Sugimoto-Matsuda is the Taskforce's advocacy liaison, and can be reached at junesugi88@gmail.com or (808) 291-9930.

Thank you, once again, for prioritizing suicide prevention in our local communities; promoting hope, help and healing; and most importantly, *PASSING LIFE FORWARD.*

With Deepest Aloha,



Deborah Goebert, DrPH – Current Co-Chair, State PSHTF
(*expertise in mental health research, youth/adolescent health, community and cultural interventions, community engagement; Inaugural Taskforce member*)



Gina Kaulukukui – Current Co-Chair, State PSHTF
(*expertise in postvention, grief/bereavement, domestic violence; Inaugural Taskforce member*)



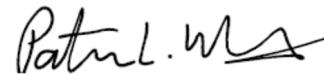
Jeanelle Sugimoto-Matsuda, DrPH – Immediate Past Co-Chair, State PSHTF;
Taskforce Advocacy Liaison
(*expertise in mental health research, policy/advocacy, health systems*)



Brent Oto, MA, CPS – Immediate Past Co-Chair, State PSHTF; Taskforce
military representative (*expertise in awareness and training, military/veterans affairs, substance abuse counseling*)



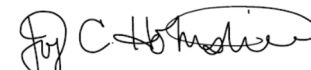
Madeleine Hiraga-Nuccio – Co-Chair, Prevent Suicide Kaua'i Taskforce
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Patricia Wistinghausen – Co-Chair, Prevent Suicide Kaua'i Taskforce
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H. Yolisa Duley, PhD – Co-Chair, Hawai'i Island Prevent Suicide Taskforce
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Joy Hohnstine, MA, MEd – Co-Chair, Hawai'i Island Prevent Suicide
Taskforce (*expertise in behavioral health, awareness and training, K-12 education*)



Danielle Bergan – Co-Chair, E Ola Hou Prevent Suicide Maui County
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Pua Kaninau-Santos, MSW – Liaison, O'ahu Prevent Suicide Hawai'i
Taskforce (*expertise in postvention, bereavement training and services for families, Native Hawaiian health, community engagement; Inaugural Taskforce member*)



Kathleen Merriam, LCSW, CSAC – Board Co-Chair, Hawai'i Chapter of the
American Foundation for Suicide Prevention (*expertise in mental health systems, engagement with consumers, crisis services, postvention*)



Mestisa Gass, PsyD – Board Co-Chair, Hawai'i Chapter of the American
Foundation for Suicide Prevention (*expertise in clinical psychology and therapies, awareness and training*)



Bryan L. Talisayan
Executive Director, Mental Health America of Hawai'i



Aloha from the Prevent Suicide Hawai'i Taskforce (PSHTF)!



Suicide in Hawai'i

- Suicide is the 2nd-leading cause of fatal injury in Hawai'i (the leading cause for 16-44 year olds). For every death, another two people are hospitalized for suicide attempts, and another three are treated in emergency departments. [data source: Hawai'i State Department of Health]
- About 1 in 7 Hawai'i high school youth consider suicide, 1 in 6 make a suicide plan, and 1 in 9 attempt suicide. [data source: 2019 Hawai'i Youth Risk Behavior Survey]

The Taskforce

- We are a community-based, grassroots **network of agencies and individuals** who work in and/or care about suicide prevention. The Taskforce aims to be the “hub” that coordinates suicide prevention activities and communication.
- Convened in 1999, community passion has kept the Taskforce going ever since. Today, partners include state agencies (e.g., Health, Education, Public Safety, University of Hawai'i), healthcare entities, non-profits, and community organizations. Many also come to the table as loss survivors (lost a loved one to suicide) or those who struggle personally.
- The Taskforce is the **author of Hawaii's Suicide Prevention Strategic Plan** (<https://go.hawaii.edu/k8k>), requested by and reported to the Hawai'i State Legislature. We lead and support various suicide prevention activities – awareness, trainings, research, advocacy, supports for those personally impacted by suicide – all of which align with the Strategic Plan.



Other things to know

- We are here as a resource/hub for the community. Though suicide is complex and there is still much to be done, there is also a lot of great work and partnerships to be proud of.
- When speaking or writing about suicide, keep safe messaging in mind. For example, don't glamorize or sensationalize suicide. We also discourage publicizing details on how and where a suicide took place. We recommend terms like “died by suicide” instead of “completed/committed suicide.” See <https://reportingonsuicide.org/> for more details.
- **Download a copy of our comprehensive resource directory at this link** (<https://go.hawaii.edu/k8X>), or via the QR code. →



THANK YOU FOR ALL THAT YOU DO FOR HAWAII'S COMMUNITIES!!!

Direct questions about this handout to the Taskforce, via Jeanelle Sugimoto-Matsuda at preventsuicidehi@gmail.com.

Version 1/18/2023



UNIVERSITY OF HAWAII SYSTEM

‘ŌNAEHANA KULANUI O HAWAII

Legislative Testimony

Hō'ike Mana'o I Mua O Ka 'Aha'ōlelo

Testimony Presented Before the
Senate Committee on Health and Human Services
Monday, March 20, 2023 at 1:00 p.m.

By

Lee Buenconsejo-Lum, Interim Dean

and

Deborah Goebert, DrPH, Professor, Department of Psychiatry and Principal
Investigator, The Hawaii's Caring Communities Initiative for Youth Suicide Prevention

John A. Burns School of Medicine

And

Michael Bruno

Provost

University of Hawai'i at Mānoa

HB 622 HD2 – RELATING TO SUICIDE PREVENTION

Chair San Buenaventura, Vice Chair Aquino, and Members of the Committee:

Thank you for the opportunity to provide testimony in SUPPORT OF HB 622 HD2 which makes permanent the prevent suicide Hawai'i task force within the Department of Health (DOH). The bill also requires the task force to focus on reducing the suicide rate among Native Hawaiians and Pacific Islanders in the state.

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. It was established in 2006 and in 2017 to reduce suicide by 25% by 2025. JABSOM has participated in task force activities since its inception and currently has a faculty member serving as co-chair.

Members of the PSHTF published an article looking at hope (primary prevention), help (crisis intervention and treatment, and healing (support after a suicide death) from a cultural perspective to capture local efforts in suicide prevention. (Attached.) We agree more needs to be done.

Native Hawaiian and Pacific Islander groups in Hawai'i are at increased risk of suicide deaths, behaviors and thoughts, especially among youth. According to data from the Department of Health, EMS & Injury Prevention Branch, 10-year suicide death rates by primary ethnicity are 516.8 per 100,000 for Native Hawaiians and 374.4 for

Micronesians compared to 241.0 for Caucasians, 139.6 for Japanese, and 101.8 for Filipinos between 2010-2019.

The 2019 Youth Risk Behavior Survey for Hawai'i showed that 15.9% of Native Hawaiian high school students and 15.2% of other Pacific Islander students made a plan for suicide in the past 12 months, compared to 14.5% of Filipino students, 11.9% of Caucasian students, and 8.5% of Japanese students. Suicide has lasting and profound impacts on families and communities.

This measure would be beneficial in make progress into hope, help, and healing steps that could be taken in order to reduce the number of suicide deaths, as well as seeking solutions to prevent suicide by studying models, practices and policies. We support continued development and evaluation of culturally adapted programs and policies with the necessary funds to conduct the work.

Thank you for the opportunity to provide testimony on this bill.

Hope, Help, and Healing: Culturally Embedded Approaches to Suicide Prevention, Intervention and Postvention Services With Native Hawaiian Youth

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Hawai'i; Davis Rehuher and Jeanelle Sugimoto-Matsuda, Hawaii's Caring Communities Initiative for Youth Suicide Prevention, Honolulu, Hawai'i, and Department of Psychiatry, John A. Burns School of Medicine, University of Hawai'i at Mānoa.

Mahalo to the youth, families and communities that have been touched by suicide and shared their struggles, insights, time, energy and ideas about suicide prevention. Mahalo to the youth leaders, community partners, and staff of the Hawaii's Caring Communities Initiative for their dedication to suicide prevention and mental wellness and inspiring work. This article was developed, in part, under grant U79SM060394 from the Substance Abuse and Mental Health Services Administration (SAMHSA), Mental Health America of Hawai'i, The Queen's Medical Center, and the University of Hawai'i at Mānoa, SEED Inclusion, Diversity, Equity, Access and Success Initiative. The views, opinions and content of this publication are those of the authors and contributors, and do not necessarily reflect the views, opinions, or policies of our funders, and should not be construed as such.

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Suicide rates have reached their highest documented levels in the United States with the greatest increases among indigenous youth, including Native Hawaiians. Culturally informed, effective prevention and treatment services are needed now more than ever for Native communities to heal and flourish. Multicomponent prevention and service strategies rooted in indigenous values and approaches show the most promise. Native Hawaiian communities are united around a common goal of suicide prevention, intervention and postvention, linking cultural meanings to improve understanding and guide local efforts. This paper highlights important cultural values to consider when developing and implementing suicide prevention, intervention and postvention. Strategies build upon the strengths of Native Hawaiian youth and their respective communities. Native Hawaiian sayings anchor each level and serve to organize a set of culturally informed and culturally embedded programs and approaches along the continuum of prevention, intervention and postvention. Application of indigenization to suicide prevention enhances connections to people and place, inspiring hope among Native Hawaiian youth, their families and their communities.

Keywords: youth suicide, Native Hawaiian, culture, prevention, postvention

Suicide is a serious and preventable public health problem worldwide with indigenous youth having significantly higher rates than nonindigenous youth (Harlow, Bohanna, & Clough, 2014). In the United States, suicide rates have reached their highest documented levels with the greatest increases among indigenous groups (Curtin, Warner, & Hedegaard, 2016). Recent reviews emphasize the need for studies to comprehensively examine the impact of culture (Colucci & Martin, 2007; Harlow et al., 2014). Cultural norms, used in purposeful ways, facilitate a positive sense of belonging to a valued community (Kana'iaupuni, 2005). A review of prevention programs for Native communities concluded that the best programs are culturally relevant and developed with community input (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). Community involvement makes a significant difference in well-being because it reinforces the contemporary discourse in Native communities that *our culture is our treatment* (Kral et al., 2009). Multicomponent prevention strategies that incorporate indigenous involvement in the development, cultural tailoring, and delivery, show the most promise.

Native Hawaiian Suicide

Locally, suicide is the most common cause of fatal injuries among Hawai'i residents, accounting for 26% of all fatal injuries—outpacing car crashes and drowning (Galanis, 2016). Youth suicide death and attempt rates are highest among Native Hawaiians, having a profound impact on their communities (Else, Andrade, & Nahulu, 2007; Galanis, 2016). Native Hawaiian youth and emerging adults (15–24 years of age) were 2.3 times more likely to die by suicide compared to Caucasian youth in Hawai'i (14.0 per 100,000 vs. 6.2, respectively; Galanis, 2016). Furthermore, Native Hawaiian youth were 2 times more likely to have made a suicide attempt in the last year compared to their Caucasian peers (14.1% vs. 7.1% respectively; Hawai'i Health Data Warehouse, 2017).

Recent theories of health behaviors have moved away from reinforcing victim-blaming and stigmatizing attitudes to examining historical trauma response and colonization as a determinant of health for indigenous peoples (Brave Heart, Chase, Elkins, & Altschul, 2011). Policies rooted in colonization severed indigenous groups from their language, families and communities as well as their cultural knowledge, protocols and norms that maintain wellness. For example, U.S. missionaries confiscated Native Hawaiian lands in 1848, followed by U.S. land seizures from 1893 to 1898.

During the same period, restrictions on language, hula and traditional medicine were enacted, stripping Native Hawaiians of natural resources relied upon for subsistence as well as their cultural practices. Therefore, it is not surprising that in pre-European contact Hawai'i, suicide was rare (Pukui, Haertig, Lee, & McDermott, 1972). However, since Hawai'i began collecting suicide statistics in 1908, rates for Native Hawaiians have been increasing and are among the highest in the world for youth (Else et al., 2007; Wong, Sugimoto-Matsuda, Chang, & Hishinuma, 2012).

While efforts are being made to revitalize indigenous cultural practices, youth often find themselves having to navigate their native culture at home and the dominant Western culture at school and work. Native Hawaiian youth with high levels of Hawaiian cultural affiliation and low levels of assimilation to the dominant Western culture were more likely to attempt suicide (Yuen, Nahulu, Hishinuma, & Miyamoto, 2000). Sexual activity, having sex with both males and females, experiencing family conflict, witnessing family violence and poor family support were also risk factors for youth suicide attempts (Else et al., 2007). Local longitudinal research indicated that suicidal ideation, anxiety and parent expectation were the best predictors of suicide attempts for Native Hawaiians and non-Hawaiians with no interaction by ethnic identity (Hishinuma et al., 2017). However, significant differences were found between groups in hope and help-seeking, with Native Hawaiian youth increasing help-seeking and decreasing hope to a greater degree (Goebert, Hamagami, Hishinuma, Chung-Do, & Sugimoto-Matsuda, in press).

Despite exposure to adversity, most Native Hawaiian youth do not develop suicidality (Carlton et al., 2006; Goebert et al., 2000). Protective factors for preventing suicidality include talking with parents, higher levels of family cohesion, family organization and parental bonding (Else et al., 2007). Community members provide a tremendous amount of support, enhancing youth well-being and identification with their community (Chung-Do et al., 2014). A strong sense of community identity can increase feelings of self-efficacy, connectedness and purpose (CDC, n.d.; McCabe, 2007; Whitbeck, Chen, Hoyt, & Adams, 2004). From a Native Hawaiian perspective, strengths-based approaches enhance existing assets and relationships in these families and communities (Yahata & Kaninau, 2009). Communities unite around a common goal of suicide prevention, linking cultural meanings that maintain and strengthen their group, social morals and ethics (Yuen et al., 2000; Yuen, Yahata, & Nahulu, 2006).

Nearly a decade ago, a needs assessment of community concerns was conducted about youth suicide, bullying and violence (Yahata & Kaninau, 2009). Key informants serving Native Hawaiian youth ages 15 to 24 provided insight on the relevancy and accuracy of existing reports for these youth; made recommendations to enhance strengths-based programs; determined assets, resources and needs of Native Hawaiian communities; and identified strategies for moving prevention efforts forward. Overall, their findings contributed to the growing body of evidence supporting the importance of developing and sustaining culturally informed Native Hawaiian youth programs. The themes that emerged indicated the need to: develop, implement, and evaluate culturally appropriate strategies in the context of their families and broader community; utilizing natural leaders within communities; and supporting both youth and community wellbeing. Comprehensive and integrated approaches are more successful in addressing youth suicide prevention (Garraza, Walrath, Goldston, Reid, & McKeon, 2015). Furthermore, a study of local community members engaged in youth suicide prevention demonstrated that youth-led programs enhance youth participation and lead to improved self-concept, connectedness and improved mental health and wellness (Chung-Do et al., 2015). Programs must include processes that allow space for sharing thoughts, beliefs, values and relationships to be expressed in actions, words and the intricacies of the way we live. Effective suicide prevention programs require sufficient time to form meaningful relationships to access, exchange and transform understanding and action among program participants. Native Hawaiian communities enthusiastically support strengths-based approaches. This paper highlights cultural aspects of suicide prevention strategies that build upon the strengths of Native Hawaiian youth and their respective communities.

Overarching Principles

Native Hawaiians and those with whom they work, such as many of the authors, strive for excellence in community-level systems for families—past, present and future. Members of this research and clinical team, henceforth referred to as we, share common goals and have developed robust understandings of approaches to healing and wellness rooted in our sense of place. Our community and clinical work, academic research and policy advocacy are informed by Native Hawaiian practices, beliefs and traditions. We provide training to community and clinical service providers on the prevention of suicide. We develop, implement and monitor effective programs that promote wellness, balance, resilience and hope. We encourage suicide prevention as a core component of health, endorsing and implementing effective clinical practices for assessing and treating those identified as being at risk for suicidal behavior.

Native Hawaiian values are at the forefront of our suicide prevention work, providing a deeper meaning and process. Four Native Hawaiian values repeatedly came up in our respective work and now serve to guide our collective efforts—*aloha*, *ola*, *mālama* and *pilina*. The first value, *aloha*, means to love unconditionally, to give without the expectation of reciprocity, to be empathic and compassionate. It represents the unselfish kindly concern for the good of another without expecting anything in return from them. Hawaiian wisdom indicates “*Ua ola loko i ke aloha*,” meaning “love is imperative to one’s mental and physical welfare.” Our second value, *ola*, translates to “life.” 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. 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). The third value, *mālama*, is commonly translated as to take care of, tend, attend, care for and show reverence. *Mālama* has many contexts relevant to suicide prevention (e.g., *e mālama ola*—care for all life, without being told or asked; *e mālama kekahi i kekahi*—care for each other). However, the concept of *mālama* begins with each of us (Kawa’ā, 2009a). To care for life, care for others and take care of our *kuleana* (responsibility), we must first *mālama* ourselves (take good care of ourselves). When we are off balance, it is challenging, if not impossible to care for others.

Our fourth value, *pilina*, refers to connectivity and relationships. 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. The metaphor of the intertwining of the ‘ie’ie (*vine*) and *koa* (prized, native hardwood tree) as shared by Native Hawaiian cultural specialist Luana Kawa’ā (2010) captures this value.

The ‘ie’ie is a crawling vine that would cling to the *koa* tree. Let’s consider the *pilina* or relationship between the *koa* and the ‘ie’ie. *The koa* stands mighty and tall while the ‘ie’ie is much more delicate and fragile, yet one compliments the other. So it is our *pilina* with each other. Good relationships have this kind of [empathic, complementary] balance. When one person is weak, the other is strong. When one needs protection, the other provides a safe place. When one person is growing and learning the other provides the stable foundation allowing the growth to take place. At times we may need to be the *koa*, strong, tall, steadfast and immovable. In our vulnerable times, we may be like the ‘ie’ie, creeping and crawling along, clinging to those around us as we make our way. *This is what makes pilina*, relationships in our lives so important, so essential, as we find our way through this journey called life.

By building and maintaining of these relationships, we enhance resilience. To put this metaphor into practice, one of our youth groups learned to weave the ‘ie’ie, that they harvested, cleaned, and dried. *The ‘ie’ie*, while fragile at time, can be a source of strength when woven together into a basket and transformed to serve as a vessel for life.

These four values are integrated into our collective efforts to promote hope, help and healing for youth suicide prevention. We believe that hope, help and healing are interconnected in suicide prevention as help-seeking cannot occur without hope and healing, and healing cannot truly happen without hope and help from others. We share ‘*ōlelo no’eau*, which are Native Hawaiian sayings that reflect our values, convey wisdom to guide thinking and action and serve to frame our strategies.

Hope: Primary Prevention and Early Intervention

‘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.

~‘Ike Pono ‘Oe, 2016

Hilina'i translates to believe in hope or to believe that things will get better. It also means to trust and lean on. These words express a *mana'o* (thought, belief or theory) toward life and health (Kawa'a, 2009b). In trying times, we need to lean on others and believe in hope. While hope is integral to all aspects of suicide prevention, intervention and postvention, it is the focus of primary prevention. The following are other essential values for primary prevention:

- *Ho'olohe pono*: listen well or "be there" (active and attentive listening) and *ho'olono*: listen deeply and go beyond what is being said.
- *Ma ka hana ka 'ike* (from doing one learns) and *hana lima* (work with the hands) (Pukui & Elbert, 1986). These approaches offer youth an experiential learning format that integrates their thoughts and feelings. Youth are able to find something they are good at and cultivate that skill (Duponte, Martin, Mokuau, & Paglinawan, 2010).

Hawaii's Caring Communities Youth Leadership Program for Suicide Prevention

Increasing evidence shows community-based injury prevention programs for youth are successful as well as youth leadership programs that involve youth as key stakeholders (Dalton, Elias, & Wandersman, 2007). Embedded within a community-based approach is the recognition that health is disproportionately impacted among marginalized groups, such as rural and minority populations (Freire, 1998). Local youth leadership programs in Hawai'i have been developed with these fundamental values as the foundation. One of these programs is the Hawaii's Caring Communities Initiative (HCCI) for Youth Suicide Prevention. It used an innovative youth and community-mobilization model to collaborate with six youth-serving and community health organizations in rural communities across Hawai'i (Chung-Do et al., 2014, 2015, 2016a, 2016b). Youth and community members were trained as trainers to develop awareness projects and activities that incorporated evidence-based practices, ensuring these projects were culturally relevant and met the unique needs of the community. Having indigenous youth included in the planning, development, implementation and evaluation of local youth suicide prevention efforts increases the likelihood of positive impacts (Reitz & Banerjee, 2014). Indigenous youth provide valuable cultural insight and creativity, informing youth suicide prevention initiatives so that they become strong models of prevention in the community (CDC, n.d.). HCCI used a youth leadership model that focused on developing youth leaders in suicide prevention through training, youth empowerment and team-building activities. This increased their sense of belonging and attachment to place. In alignment with community-based participatory principles, this model provided a framework for organizations to develop their unique plan to not only address the community's needs but also to utilize the strengths of the organization and the community.

Our approach requires youth-adult partnerships (Camino, 2005). We have found that not only do youth frequently indicate that they turn to their grandparents in a crisis, that their interactions with *kūpuna* (elders) and other supportive adults, role models and mentors are critical to program success. We have also learned that it is important to *ho'opono* (set and understand expectations) for youth-adult partnerships. This helps to identify what is happening in everyone's lives beyond their concerns for suicide and facilitates a greater understanding of youth and supportive adult needs,

defines youth voice, and enables the fusion of Native culture in a way that supports one's social and generational cultural values. Interventions based on a strengths-based model of positive youth development can promote healing and facilitate a sense of belonging to a valued community (Kral et al., 2009; Trinidad, 2009). Our partnerships seek to promote protective factors among youth by providing opportunities to take leadership roles and to connect them to culturally grounded activities, increasing their knowledge and comfort as leaders, encouraging health promotion, validating the youth's role in the community, while fostering social and community connectedness. The aim is to instill hope for self, peers, families and community. Pathways are generated for other youth to have hope, connect to help, survive and begin the healing to thrive. As one HCCI youth leader described "When you want to do something with your life, you'll figure out that you want to do something for your community, people in your community, outside, this and that. I realized that."

Hawai'i Youth Leadership Council for Suicide Prevention

The Hawai'i Youth Leadership Council for Suicide Prevention provides a youth voice for statewide suicide prevention work, leadership development and training on suicide prevention, civic engagement and community service opportunities. It also connects members with supportive adults who help them champion suicide prevention in their home communities. These socially engaged young leaders will have the knowledge that their actions can effect positive change (Martin, Pittman, Ferber, & McMahan, 2007). They already possess an awareness and motivation to make positive change in their world. They have the skills and capacity to make a contribution; are resourceful, connected and experienced; they can access and navigate their way through different settings and institutions, creating opportunities to be engaged in purposeful action that can lead to positive social change and improvements in conditions for themselves and their communities. Youth councils are an effective means to engage youth voices in community decision-making (Checkoway & Gutierrez, 2006). Successful youth councils lay a foundation by addressing: (1) membership diversity (e.g., community representation, gender, ethnocultural identity, socioeconomic status, sexual orientation, and suicide attempt survivors), which helps ensure a variety of viewpoints and encourages creativity in discussions; (2) infrastructure; and (3) work environment. Youth council mentors deliberately support meaningful youth action by building youth capacity, deepening youth motivation and negotiating opportunities for access to policymakers and other constituents. It is powerful to see how their voices emerge when they take ownership. The Hawai'i Youth Leadership Council for Suicide Prevention is the heart of our efforts. Youth serve as ambassadors for their communities across the state and act as the authentic voice in our activities.

Help: Intervention

'Ike aku, 'ike mai, kokua aku kokua mai; pela iho la ka nohana 'ohana.

Recognize others (watch), be recognized (observe), help others, be helped; such is the family/community way.

~'Ōlelo Noe'au Pukui (1983), No. 1200

The words expressed in this *'olelo no'eau* reflect a fundamental philosophy necessary for creating and sustaining a system for

suicide prevention. Many Native Hawaiians and others living in Hawai'i consider everyone in their community a part of their extended family. In the *'ohana* (family), you know others and they know you; you help others and know you will be helped.

Connect Suicide Prevention Program (Gatekeeper Training)

Suicide prevention programs employ gatekeeper training strategies to educate natural helpers to recognize warning signs for suicide and know how to respond appropriately. Four broad themes of cultural needs were identified by community leaders in suicide prevention during focus groups held in 2012 as a first step to developing youth suicide prevention programs in the community, emphasizing the importance of honoring community knowledge and prioritizing relationship (Chung-Do et al., 2016). The themes included: (1) training curriculum must provide an intentional space for relationship-building; (2) program trainers from outside of the community must get to know the community, cultural protocols and level of community readiness before initiating a program; (3) training programs must incorporate local examples; and (4) an interactive environment must encourage trainees to be active participants in the learning process. Adherence with these themes will facilitate acceptance of culturally tailored, evidence-informed programs. Furthermore, it is important for the person who self-identifies as being connected to the community also to be recognized and accepted by the community. This is also an opportunity for the community trainers to show appreciation for their connection(s) to the community with humbleness and cleanse any "reconnect" that may be needed. This strengthens the connection with the community and respectfully acknowledges the responsibility the trainer has in regards to the community. Uncle Ish Stagner, *kupuna* and psychologist, referred to our need to connect to and be connected with the whole being through PINK: *pu'uwai* (heart), *ike* (mind), *na'auao* (gut intuition), *kino* (body).

Our youth with lived experience who strive for understanding and a better tomorrow selected the following *'ōlelo no'eau* (saying) to express the wisdom of their ancestors in overcoming adversity.

Loa'a ke ola I Hālau-a-ola.

Life is obtained in the House-of-life: One is safe, well again. A play on *ola* (life, health, hope, healing, contentment, and peace after a struggle).

~'Ōlelo Noe'au Pukui (1983), No. 2017

Additionally, the importance of change in reframing an event, resolving a conflict or restoring a developmental deficit is critical. Two essential values pertain to this:

- *Ho'ohuli*: To turn, reverse, curl over like a breaking wave, change an opinion; to shift your thinking; to physically and emotionally turn from or to something; to look for, search, explore, investigate; to seek the truth.
- *Ho'ololi*: To amend, alter, transform; to take a new form or to change or modify one's thoughts, feelings, or behaviors.

Emergency Department Training

Emergency departments play a fundamental role in suicide prevention and may be a primary or sole source of health care, especially among rural and indigenous populations (Matsu et al., 2013; Sugimoto-Matsuda & Rehuher, 2014). We found that youth in rural, primarily Native Hawaiian communities were nearly four times more likely to use an emergency for mental health care at a higher level of acuity. While all emergency department providers are in a position to communicate with family and friends, facilitate engagement in outpatient care and prevent future suicide attempts, those serving our Native Hawaiian communities place greater emphasis on the importance of relationships, demonstrating cultural humility. Rather than restricting the *Connect* training to their discipline, our rural providers encourage integration with the community, thereby increasing their outreach, enhancing trust and willingness to seek care. The value expressed by *kekahi i kekahi* (everything/everyone is connected) signifies their approach. We are community/family members first.

Family Treatment Center's Cultural Integration Program

The Queen's Medical Center's Family Treatment Center promotes the health and well-being of Hawai'i's adolescents and their families, providing inpatient mental health services for youth of whom the vast majority suffer suicidality. Core treatment strategies include cognitive-behavioral approaches (e.g., educational competence, constructive thinking, age-appropriate behavior and appropriate judgment in social situations); developing emotional competence (e.g., developing coping skills, building a capacity for empathy, developing positive regard for self and others); family strengthening; promoting well-being; developing a sense of community (e.g., enriched and balanced life experiences; cultural, spiritual and social awareness; Hawaiian concepts of community and relationships to people and the environment). The cultural integration program considers values as a central component of well-being (Carlton et al., 2011). Adolescents with prosocial values have a foundational guide for beliefs, social behavior and attitudes that can lead to honest, respectful and responsible decision making. The goals of the cultural integration program are to have the values reinforced in class, in therapy (individual, group and family), and throughout the treatment milieu. For example, values are introduced in class and their definitions discussed briefly. Youth then journal with writing and/or drawings, reflecting on what it means to them. Later that day, the value is revisited in group and individual therapy during which youth share their interpretations. In the early stages of treatment, many youth discuss their life experiences and how these values have been violated by family members, severing their identity with their Native Hawaiian culture. Using values in therapy allows the therapist to have awareness and understanding of the youth's thoughts, views, and perspectives; emotional and cognitive capacities; interpersonal relatedness and morality that they may not have otherwise. It is believed that by living the values, the youth will become more resilient and cope better with future adversity. This program includes concepts of values, relationships, actions and the intricacies of the way youth live, creating a more effective program.

Therapeutic progress can be gauged during individual therapy as illustrated by the composite case of Kaimana, Power of the Ocean Boy, and two values he explored during individual therapy

(Chock, Carlton, Andrade, & Goebert, 2014). Kaimana was admitted to the Family Treatment Center with suicidality. His mother had died from an alcohol related illness when he was younger, and he was living in his fourth foster care home. Kaimana was an avid body surfer, smart and maintained a sustained relationship with an adult mentor. Initially, he selected the value *olu'olu* (pleasing state of calm, pleasure, comfort). His therapy session focused on the role the ocean played in relieving stress. The ocean proved a place to surf and spearfish. He was able to appreciate its practical uses for play and work. As he focused on his emotions, Kaimana shared that, when he would jump into the ocean, he would feel that all of his problems would disappear and his anger and frustration with life would subside. It became his focus for mentalization, as he moved from needing to physically be in the ocean to relax to being there symbolically. Kaimana also revisited the Hawaiian value *hō'ihī* (something sacred, to be respected, dignified, spoken of). He claimed that when it came to relationships, only the ocean was always there for him. As he delved into his connection to the culture, he discussed his mother and his feelings toward her. He believed that the ocean is most sacred place on earth. His mother's ashes were scattered in the ocean, and his mother's *'aumakua* (ancestral spirit) was the turtle. He had a special connection with turtles because they hold his mother's spiritual energy. Kaimana began to identify with his culture through past generations, strengthening his sense of self and reaching out to reconnect with relatives.

Most recently, the unit began a collaborative project on healing through art, in which murals along its walls reflect Native Hawaiian cultural values (Consillio, 2016). The project started with the treatment team and mural artists from the community discussing goals and implementation. The vision of the mural concentrated on the medical center's royal Founders, Queen Emma and King Kamehameha IV and their son, Crown Prince Albert Kamehameha. The mural attempted to capture the *'ano* (nature, meaning, quality) conveyed in the story of how the young Queen dealt with the death of her 4-year-old son, followed by her 29-year-old husband 15 months later. Following her devastating losses, she embarked on a transformative journey up to the summit of Mauna Kea, to become one of Hawai'i's great monarchs. Youth on the unit went to the *kalo* (taro) field, where they helped to care for the *kalo* and discussed values. They continued the cultural component of the treatment with *mo'olelo* (story) and *'ōlelo no'eau* (sayings) to reinforce the values previously taught. Relationships and actions were then seen in the interactions with each other and on the wall of the unit. Overall, youth and staff worked together to continue to develop prosocial behaviors. This combined treatment of experiential cultural immersion and artistic expression vicariously teaches these adolescents to sublimate powerful emotions of devastating loss and sorrow that can be transformed into hope and positive action. It is a powerful heuristic healing approach that incorporates indigenous Hawaiian culture and mythic ancestral narratives. Notably, this indigenous culture treatment approach is based on the epistemology of our four overarching principles (i.e., *aloha*, *ola*, *mālama* and *pilina*) that are refined into specific values (e.g., *ho'ohuli* and *ho'ololi*) that meet the needs of the treatment context clinicians must creatively work within. As with primary prevention, this has also allowed youth to utilize their strengths and connected to others around shared values.

Heal: Postvention

Mālama ola no na lei.

A rainbow is waiting: In moments when darkness is all around, and it's hard to see beyond it, a rainbow or preserver of life for youth is waiting.

~ *Kapuna* Uncle Val Kepilino and Aunty Malia Craver

Mālama ola no na lei is an excerpt taken from the song *Pu'uhonua Nani*, (Beautiful Refuge) (Queen Lili'uokalani Children's Center, 2013). Aunty Malia Craver helped to guide Hawaiian children and families toward cultural pride as source of nourishment, healing and strength. There are moments in life filled with darkness, confusion, doubt and uncertainty, especially after a significant loss. They can also include feelings of shame, guilt and blame. Such tragic moments can contribute to contagion and further increase suffering and feelings of hopelessness among youth, their families and the community. We assist youth in understanding what resilience is and how they identify it in their life. We also use a resilience framework to support the community and help them through the grieving and healing process. Influenced by community support and a sense of belonging and cultural respect, our indigenous Hawaiian youth and families have demonstrated resilience. Our experience has repeatedly shown that Native Hawaiian communities desire coming together to grieve and heal. Therefore, there is a need for family/extended family grief groups to be available after a death. Additionally, community postvention work needs to use small community meetings, prevention training with emphasis on process to be led by locals and have local community members who are willing to serve as resource people to the greatest degree possible. This demonstrates honor and respect for cultural tradition and recognition of leaders. Native Hawaiian community members share a willingness to speak openly and graphically within family/extended family about suicide because they see value in not hiding the death. However, when this is combined with not understanding safe messaging, others who may be at risk can contribute to contagion. When we have shared prevention and postvention information after a suicide death, it has been welcomed due to the need to encourage healing, hope and help-seeking as a natural progression. Passing life forward is essential for restoring hope. It reinforces the need for early involvement in primary prevention, as contagion levels are high in our island communities. We must create change as well as reaffirm connections with family and community. Trained facilitators foster a safe, nurturing place for youth and families to express their emotions and share their stories, honestly, passionately and without judgment. To be able to focus on the strengths and gifts within the youth, families and communities, the partnerships of youth and adults, *kapuna* wisdom and community leaders in collaboration with skilled community people with aloha and cultural understanding. Additionally, community members want gate-keeper information shared with natural helpers, traditional healers, schools and medical providers. The following values are integral to postvention efforts:

- *Ho'okala*: The act of releasing or forgiving. Used as a stage of the *ho'oponopono*, (conflict resolution that forgives and frees one from the negative energy that perpetuates the trauma or wrong that was done by you or to you by someone else).

- *Manawa*: The proper or right time or opportunity for a change. Readiness depends on community—for most, immediate needs are one day to two weeks after a death while others need a much longer period of adjustment.
- *Hō‘ihi*: To treat everyone with dignity and respect. It is essential to partner with those who have shown care and continuity in the community. It emphasizes relationship building and connectivity.
- *Hāloa*: To care for and honor our *kūpuna*, as we look to our ancestors, moving forward for divine guidance and spiritual connection. *Hāloa* (long breath or eternal life), is the first Native Hawaiian and is the younger brother of *Kalo* (taro). The story of *Hāloa* reminds Native Hawaiians of the life cycle, and that we are part of nature and all connected, rooted in traditions and spirituality. It is symbolic, and to our people and culture, it is real.

The process we have developed, employ and describe began with the traditional knowledge and approaches of our *kūpuna* and ancestral narratives, which we have furthered by the contemporary needs and disciplined innovation of our youth, parents and elders.

Conclusion

Effective suicide prevention for indigenous youth requires a broad-based community commitment with many layers, occurring simultaneously. Innovative strategies rooted in community problem-solving use the transformative power of indigenization and community involvement. Comprehension of local, traditional indigenous perspectives of suicide and well-being enhances the knowledge of existing evidence (Else et al., 2007; Yuen et al., 2000). Native American studies show a relationship between attenuated suicide rates and community ties to traditional values and community involvement in health, education and cultural services (Chandler & Lalonde, 1998). Prevention programs in indigenous communities work best if they are culturally relevant and developed with local input (Middlebrook et al., 2001). Such programs create supportive community, strengthen families and give individuals tools to be healthy and resilient. Indigenous epistemology centers on youth programs, encouraging production and teaching of knowledge and social voice (Trinidad, 2009). It engenders indigenization, and thereby empowers communities to tell their stories, traditions and practices of past and present; communities, cultures and social practices, once seen as marginalized, become sources of hope (Trinidad, 2009). Indigenization represents a paradigm shift in developing Native programs; it links intervention to a sense of community (Meyer, 2001; Trinidad, 2009). Our prevention and clinical work are examples of applying indigenization to suicide prevention; contemporary approaches underpinned by ancestral traditions that resonate and thereby strengthen the resolve of youth to wait out with hope, ultimately defying thoughts of giving up on one's self, family, community and life. Relationships are built through connections to people and place. Through indigenization, involved communities can evoke their history and traditions, then develop culturally relevant, locally directed healing interventions that integrate scientific principles that determine effectiveness and efficacy with technical consultation from academic researchers and community advisors. Suicide prevention and intervention efforts for Native Hawaiian communities must be culturally guided.

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HB-622-HD-2

Submitted on: 3/19/2023 9:53:27 AM

Testimony for HHS on 3/20/2023 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Michael Golojuch Jr	Testifying for Stonewall Caucus of the Democratic Party of Hawaii	Support	Remotely Via Zoom

Comments:

Aloha Senators,

The Stonewall Caucus of the Democratic Party of Hawai‘i; Hawai‘i’s oldest and largest policy and political LGBTQIA+ focused organization fully supports HB 622 HD 2.

We do request that the LGBTQIA+ community to represented on the task force. The needs for the LGBTQIA+ community are different than the straight and/or cisgender community.

We hope you all will support this important piece of legislation.

Mahalo nui loa,

Michael Golojuch, Jr.
Chair and SCC Representative
Stonewall Caucus for the DPH



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Senate Committee on Health and Human Services

Senator Joy A. San Buenaventura, Chair

Senator Henry J.C. Aquino, Vice Chair

Monday, March 20, 2023, 1:00 PM, Conference Room 225 & Videoconference

RE: HB 622 HD 2 – RELATING TO SUICIDE PREVENTION

Position: IN SUPPORT

Dear Chair San Buenaventura, Vice-Chair Aquino, and Members of the Committee on Health and Human Services,

Papa Ola Lokahi testifies **IN SUPPORT** of HB 622 HD 2, which amends the duties of the Prevent Suicide Hawaii Task Force to focus on Native Hawaiian and Pacific Islander suicide prevention efforts. Papa Ola Lokahi supports efforts that aim to be culturally responsive to address health disparities that impact Native Hawaiians. We appreciate that this bill intends to focus on suicide reduction among the NHPI community and seeks to incorporate culturally appropriate prevention models, which attend to the holistic way Native Hawaiians view health. Further, we appreciate the State Legislature's thoughtfulness in this task force's membership.

Papa Ola Lokahi has an established track record in Native Hawaiian health education, which helped to address the disparities Native Hawaiian communities faced during the height of the COVID-19 pandemic, and as it continues to evolve. Additionally, Papa Ola Lokahi supports and facilitates the dissemination of traditional ways of healing in our communities that encompasses the mind, body, and spirit connection, which is the basis of Native Hawaiian health. Our work aims to address the social and cultural determinants of health that contribute to the dire health statistics, such as those described in this bill. We work closely with the five Native Hawaiian Health Care Systems, which provide direct and enabling services, and other providers across the state that serve Native Hawaiian communities.

Papa Ola Lokahi supports this measure and affirms that attention to suicide prevention is critical to our people and Native Hawaiian health.

Thank you for the opportunity to testify in **SUPPORT** of **HB 622 HD 2**.

Papa Ola Lōkahi, the Native Hawaiian Health Board, authorized by the federal Native Hawaiian Health Care Improvement Act, is charged with raising the health status of Native Hawaiians to the highest possible level, which we achieve through strategic partnerships, programs, and public policy.



**Testimony to the Senate Committee on Health and Human Services
Monday, March 20, 2023; 1:00 p.m.
State Capitol; Conference Room 225
Via Videoconference**

RE: HOUSE BILL NO. 0622, HOUSE DRAFT 2, RELATING TO SUICIDE PREVENTION.

Chair San Buenaventura, Vice Chair Aquino, and Members of the Committee:

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS** House Bill No. 0622, House Draft 2, RELATING TO SUICIDE PREVENTION.

By way of background, the HPCA represents Hawaii's Federally Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines to over 150,000 patients each year who live in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

This measure, as received by your Committee, would:

- (1) Codify the existing Prevent Suicide Hawaii Task Force (Task Force) into the Department of Health's statutes, Chapter 321, Hawaii Revised Statutes;
- (2) Amend the duties of the Task Force to focus on Native Hawaiian and Pacific Islander suicide prevention efforts; and
- (3) Clarify the Task Force's membership.

This bill will take effect on June 30, 3000.

Testimony on House Bill No. 0622, House Draft 2
Monday, March 20, 2023; 1:00 p.m.
Page 2

The HPCA recognizes that the mental health needs of the State continue to outweigh present capacity. These needs were greatly exacerbated due to the profound level of stress placed on individuals, families, and entire communities as economic hardships, disruptions in normalcy, and the stark isolation of quarantine have greatly complicated daily life. This has led to an increase in suicides in Hawaii and across our Nation.

Because the HPCA is embedded in Hawaii's most underprivileged and isolated communities throughout the State, we believe we can greatly help in this cause. We can offer our expertise, daily interaction with key demographic cohorts, and trust with communities from decades of providing primary care to Medicaid recipients.

The HPCA stands ready and willing to assist in this effort.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiiipca.net.



Submitted Online: March 17, 2023

HEARING: Monday, March 20, 2023

TO: Senate Committee on Health & Human Services
Sen. Joy SanBuenaventura, Chair
Sen. Henry Aquino, Vice Chair

FROM: Eva Andrade, President

RE: Strong Support for HB 622 HD2 Relating to Suicide Prevention

Hawai'i Family Forum is a non-profit, pro-family education organization committed to preserving and promoting life, family and religious freedom in Hawai'i. We are very concerned about suicide, because it affects the vulnerable people in our community, especially our youth, elderly and those who are incarcerated.

A report to the 2018 Hawai'i Legislature indicated that between 2012-2016, suicide was the most common cause of fatal injuries among Hawai'i residents, accounting for one-quarter of all fatal injuries. According to the U.S. Department of Health and Human Services, in 2019, suicide was the leading cause of death for Native Hawaiians/Pacific Islanders ages 15-24. They are also three times less likely to receive mental health services or to receive prescription medications for mental health treatment as compared to non-Hispanic whites.¹

Experts in Hawai'i rightly point out that suicidal behaviors, for people of any age, are usually rooted in many different factors, with mental health issues playing an important role in the overall mix. It is a "perfect storm" of emotional issues and the only way to begin making a difference, is by identifying and treating each person. And the good news, is that it is fixable by awareness and treatment.

Making permanent the prevent suicide Hawaii Task Force will ensure that a strategic plan is developed and maintained to reduce suicides within the Native Hawai'ian community and to provide accurate information to the wider community is an effort we applaud. Establishing this Task Force itself, we believe, will bring a range of personal and professional perspectives to these efforts. Through our work with churches over the past twenty-five years, we have come to believe that collaboration and understanding are critical to improving the lives of Hawai'i's people. Like all the partners, colleagues, and supporters that work together to reduce suicides in Hawai'i, we feel deeply that suicide is preventable. It will be the spirit of collaboration – from policymakers and advocates to clinicians and clients – that will make suicide prevention possible in our communities.

Mahalo for the opportunity to submit testimony in support of this measure.

¹ <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=172> (accessed January 30, 2023)



Hawaii Medical Association

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COMMITTEE ON HEALTH AND HUMAN SERVICES

Senator Joy A. San Buenaventura, Chair

Senator Henry J.C. Aquino, Vice Chair

Date: March 20th, 2023

From: Hawaii Medical Association

Bernard Robinson, MD, Public Policy Committee

Re: HB 622 HD2 RELATING TO SUICIDE PREVENTION.

Position: Support

The Hawaii Medical Association is deeply concerned about the impact of mental illness across the state. According to the National Alliance for the Mentally Ill (NAMI), Hawai'i lost 176 lives to suicide in a single year¹. Despite the high rate of suffering and death associated with mental health disorders, an astounding 67% of affected adults in Hawai'i do not receive proper treatment². This is the highest rate of any state in the country. During the pandemic, widespread isolation and social distancing has strained an already overburdened system. Calls to the Hawai'i Crisis Text Line increased by 54% in April 2020, indicating that an even higher proportion of patients are not receiving the mental health care that they need³. This crisis is particularly pronounced for minority populations, including Native Hawaiian and Pacific Islanders.

In the absence of a comprehensive crisis stabilization system, patients experiencing a mental health crisis face limited options. Law enforcement and emergency medical services (EMS) offer immediate response 24 hours a day, but often lead to excessive costs, delays in care, and/or inadequate treatment⁴. Emergency departments (ED) are appropriate for severely mentally ill patients (i.e. acutely psychotic or actively threatening themselves or others), but are not designed for prolonged treatment over 8-12 hours.

Properly researching and supporting a comprehensive behavioral health crisis stabilization system for Hawaii will save lives. The HMA appreciates the addition of reports to the legislature and the focus on Native Hawaiian and Pacific Islander populations. Thank you for allowing the Hawaii Medical Association to testify in support of this measure.

2023 Hawaii Medical Association Officers

Angela M. Pratt, MD, President • Elizabeth Ann Ignacio, MD, President Elect • Michael Champion, MD, Immediate Past President
Nadine Tenn-Salle, MD, Treasurer • Thomas Kosasa, MD, Secretary • Marc Alexander, Executive Director

2023 Hawaii Medical Association Public Policy Coordination Team

Elizabeth Ann Ignacio, MD, Chair • Beth England, MD, Co-Chair
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REFERENCES

1. Resources – National Alliance for Mental Illness Hawaii. (n.d.). Retrieved February 20, 2022, from <https://namihawaii.org/resources/>
2. Adult Data 2021. (n.d.). Mental Health America. <https://www.mhanational.org/issues/2021/mental-healthamerica-adult-data>
3. Child & Adolescent Mental Health Division. (n.d.). State of Hawaii Department of Health. <https://health.hawaii.gov/camhd/>
4. The Substance Abuse and Mental Health Services Administration. (n.d.). Crisis Services: Meeting Needs, Saving Lives | SAMHSA Publications and Digital Products. US Department of Health and Human Services. <https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001>

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Senator Joy A. San Buenaventura, Chair

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REFERENCES

1. Resources – National Alliance for Mental Illness Hawaii. (n.d.). Retrieved February 20, 2022, from <https://namihawaii.org/resources/>
2. Adult Data 2021. (n.d.). Mental Health America. <https://www.mhanational.org/issues/2021/mental-healthamerica-adult-data>
3. Child & Adolescent Mental Health Division. (n.d.). State of Hawaii Department of Health. <https://health.hawaii.gov/camhd/>
4. The Substance Abuse and Mental Health Services Administration. (n.d.). Crisis Services: Meeting Needs, Saving Lives | SAMHSA Publications and Digital Products. US Department of Health and Human Services. <https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001>

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March 17th, 2023

COMMITTEE ON HEALTH AND HUMAN SERVICES

Senator Joy A. San Buenaventura, Chair

Senator Henry J.C. Aquino, Vice Chair

Group Testimony in Support of HB 622 HD2 RELATING TO SUICIDE PREVENTION

'Ahahui o nā Kauka is an organization of Native Hawaiian physicians dedicated to the health of the people of Hawai'i and Native Hawaiians in particular. Acknowledging the alarming suicide statistics related to Native Hawaiians and Pacific Islanders mentioned in this bill, we voice our support for this measure in general but must advocate for better inclusion of organizations and physicians with experience working with the Native

Hawaiian and Pacific Islander communities. Specially we suggest the inclusion of at least one Native Hawaiian physician in this task force, and we offer to recommend a physician to fill this role.

HB-622-HD-2

Submitted on: 3/16/2023 7:25:10 PM

Testimony for HHS on 3/20/2023 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Dara Carlin, M.A.	Individual	Support	Written Testimony Only

Comments:

Stand in Support

HB-622-HD-2

Submitted on: 3/17/2023 8:32:43 AM

Testimony for HHS on 3/20/2023 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Caroline Azelski	Individual	Support	Written Testimony Only

Comments:

In support of HD2.

Thank you.

HB-622-HD-2

Submitted on: 3/18/2023 6:24:49 PM

Testimony for HHS on 3/20/2023 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Will Caron	Individual	Support	Written Testimony Only

Comments:

In 2019, suicide was the leading cause of death for Native Hawaiians and Pacific Islanders between the ages of 15–24. That same year, Native Hawaiians and Pacific Islanders were three times less likely to receive mental health services or prescription medications for mental health treatment, compared to white youth.

This is a public health emergency and its tied directly to systemic racism and a history of colonial violence that is still impacting Native peoples of the Pacific in Hawai‘i today. Making the Prevent Suicide Hawai‘i Task Force within the Department of Health permanent and directing it to focus its efforts to address this problem makes sense. Please pass HB622 HD2.

HB-622-HD-2

Submitted on: 3/18/2023 9:28:03 PM

Testimony for HHS on 3/20/2023 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
John Bickel	Individual	Support	Written Testimony Only

Comments:

Suicide is so horrible. We must do all we can to prevent it. This is one step.

HB-622-HD-2

Submitted on: 3/17/2023 10:45:56 AM

Testimony for HHS on 3/20/2023 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Cards Pintor	Individual	Support	Written Testimony Only

Comments:

Aloha,

I support this bill.

Mahalo nui,

Cards Pintor