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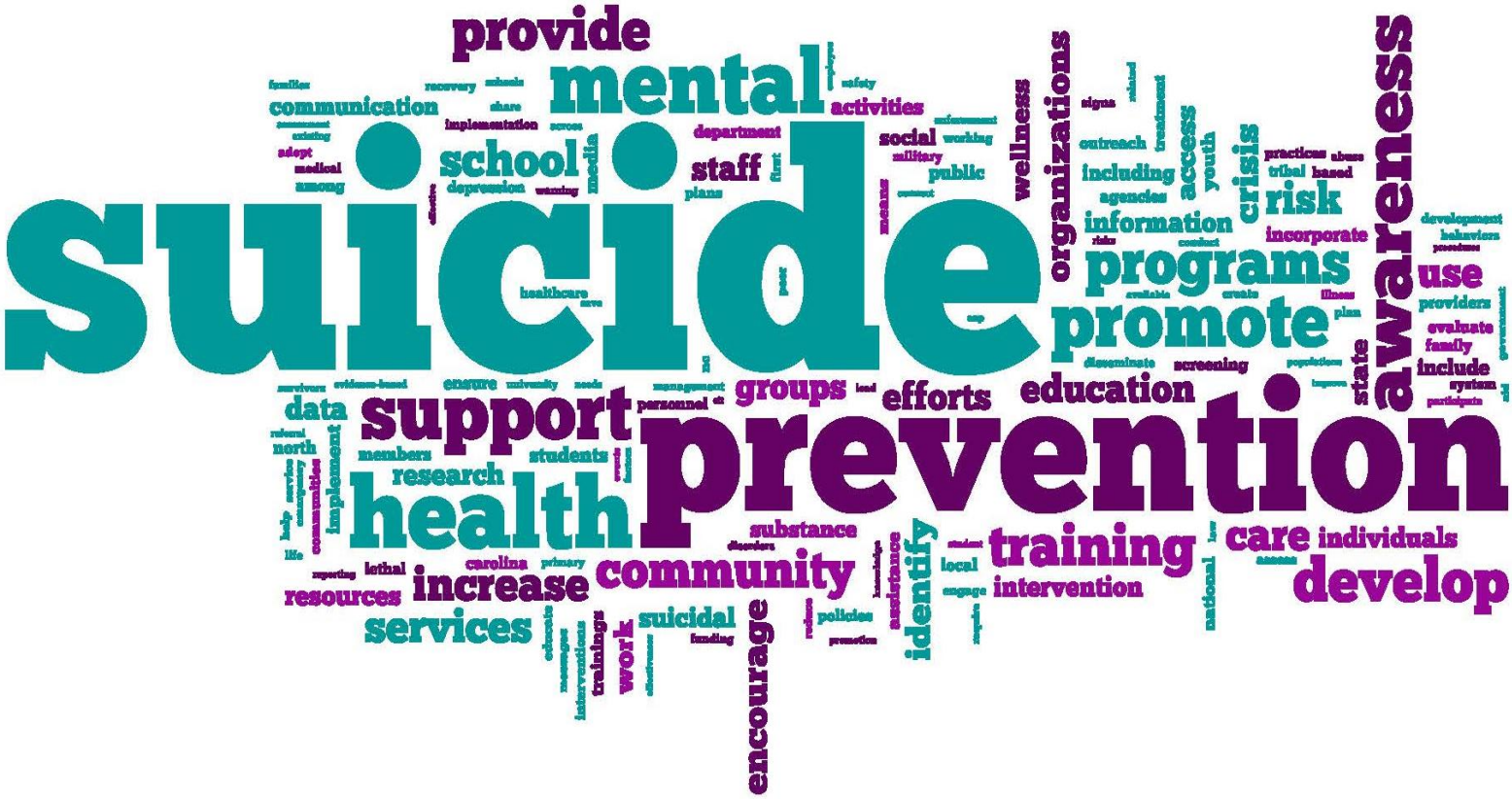
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Injury and Violence Prevention (IVP) Branch
N.C. Chronic Disease and Injury Section
N.C. Division of Public Health

Policy Development/Prevention and Early Intervention Team
N.C. Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services
N.C. Department of Health and Human Services

The University of North Carolina Gillings School of Global Public Health
Department of Health Behavior

EXECUTIVE SUMMARY

A. Section 1 - Introduction

The North Carolina Injury and Violence Prevention (IVP) Branch is located in the Chronic Disease and Injury (CDI) Section, within the N.C. Division of Public Health (DPH), which has been designated by the N.C. General Assembly as the lead agency for injury prevention in North Carolina. The IVP Branch's programs provide funding, training, and technical assistance to public health professionals working across North Carolina. The Branch works to promote the use of research and data to ensure local communities are implementing initiatives that are effective. In 2004, the IVP Branch led stakeholders through a process to develop *Saving Tomorrow's Today, North Carolina's Plan to Prevent Youth Suicide* to align with six goals from the *2001 National Strategy for Suicide Prevention (NSSP).*

In late 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its second *National Strategy for Suicide Prevention*, outlining 13 goals and 60 objectives, organized by four strategic directions: 1) *Healthy and Empowered Individuals, Families, and Communities*; 2) *Clinical and Community Preventive Services*; 3) *Treatment and Support Services*; and 4) *Surveillance, Research, and Evaluation*. To coincide with its release, SAMHSA encouraged states to develop suicide prevention plans across the lifespan. Concurrent with the *2012 NSSP*, the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) worked with the North Carolina Institute of Medicine (NCIOM) to develop a mental health treatment-focused *Suicide Prevention and Intervention Plan*, which concentrates on the role of multiple medical care facilities to reduce suicide contemplations, attempts, and deaths in the state of North Carolina.

In late 2013, the IVP Branch initiated a 16-month process to develop a statewide *2015 N.C. Suicide Prevention Plan***.** The development of a new plan, seen as a complement to the DMH/DD/SAS plan, provided an opportunity to bring together a group of approximately 180 diverse suicide prevention stakeholders to contribute to its creation.

The primary purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and to highlight examples of the actions they can take to reduce suicide. Funds and resources available to support coordinated suicide prevention efforts are limited. As such, the plan development process focused on developing a road map for stakeholder groups in North Carolina to address the burden of suicide. The road map approach aligns with current efforts across the state that leverage partnerships and resources to prevent suicide. Using this plan, practitioners from a variety of disciplines at the state, regional, and local level can align their efforts to plan, implement, and evaluate suicide prevention efforts.

Those interested in preventing suicide in North Carolina are encouraged to review the *2015 N.C. Suicide Prevention Plan* in its entirety. However, hyperlinks are provided to allow readers to quickly advance to various sections of the plan, including lists of examples of how each of the following 10 stakeholder groups can contribute to suicide prevention in North Carolina: 1) Governmental Agencies/Departments (Federal, State, Local); 2) Tribal Governments; 3) Health Care Systems, Insurers, and Clinicians; 4) Businesses, Employers, and Professional Associations; 5) Primary and Secondary Schools; 6) Colleges and Universities; 7) Nonprofit, Community, and Faith-based Organizations; 8) Research Organizations (including universities); 9) Individuals, Families, and Concerned Citizens; and 10) Military Entities.

B. Section 2 - How the 2015 N.C. Suicide Prevention Plan Was Developed

From September 2013 through December 2014, a planning team comprised of staff from the IVP Branch, the DMH/DD/SAS, Community Policy Management Section, and the University of North Carolina at Chapel Hill Gillings School of Global Public Health, Department of Health Behavior, led the plan development process. They engaged the assistance of more than 180 suicide prevention stakeholders, representing 10 stakeholder groups, from across the state. Stakeholders worked in either a Working Group or a Consulting Group. Members of both groups: a) completed an online survey to assess alignment of North Carolina activities and needs with the *2012 NSSP*; b) identified examples of what stakeholders in North Carolina are doing to address suicide; c) provided feedback on drafts of individual plan sections; and d) submitted endorsements of the plan.

Working Group members also attended two in-person meetings (April 30 and June 24, 2014). At the first in-person working group meeting participants worked in small groups to: a) determine how *2012 NSSP* objectives should remain for consideration in the North Carolina plan; and b) identify examples describing what stakeholder groups could be or are already doing to prevent suicide in North Carolina. Following the meeting, Working and Consulting Group members completed an online exercise to collect over 500 additional examples of what stakeholders are doing or could be doing to address suicide in North Carolina. At the second in-person meeting, Working Group members participated in small group activities to prioritize goals and objectives by importance (e.g., reduces the burden of suicide in North Carolina, uses a comprehensive approach that targets multiple levels, uses interventions that are cost-effective) and feasibility (high, medium, low) for emphasis in the plan.

Following a formal review by the N.C. Department of Health and Human Services Office of Communications, the final version of the *2015 N.C. Suicide Prevention Plan* was completed and uploaded to the N.C. Injury and Violence Prevention Branch's website. Additional marketing materials were developed by IVP Branch staff as part of a separate communication and dissemination plan for the *2015 N.C. Suicide Prevention Plan*.

C. Section 3 - How Can You Use the 2015 N.C. Suicide Prevention Plan?

The plan was developed to provide stakeholders with a greater understanding of how everyone can contribute to the prevention of suicide and suicidal behaviors in our state, including the following examples:

Identify examples of what you can do. This plan was specifically created to allow anyone to pick it up and identify different ways that they can work to address suicide prevention in North Carolina.

> ***Example:*** *A business owner, distressed over the recent suicide of one of her staff members, refers to the plan to gather ideas on how to better promote mental health wellness and offer support for her employees.*

Identify resources. Increase your knowledge about the local and national resources available to people who are in crisis, so that you are able to provide information about those resources to those who might benefit.

> ***Example:*** *A university staff member familiarizes himself with the resources listed in Section 7 of the plan; subsequently, he posts and distributes information to students about the National Suicide Prevention Lifeline, the Trevor Project, and other resources.*

Advocate for suicide prevention. Contact local and state policymakers to express concern about the burden of suicide and suicidal behaviors within North Carolina, and to promote the development of strong suicide prevention practices and supportive resources for suicide loss and suicide attempt survivors statewide.

> ***Example:*** *An individual writes her legislator to advocate for easier accessibility to low- or no-cost mental health treatment resources within her community, utilizing the data about suicide in North Carolina within the plan to illustrate the burden of the problem within the state.*

Get involved/get trained. Promote accessibility of suicide intervention skills training for all, and utilize the resources described in this plan to complete training yourself, if you have not already done so.

> ***Example:*** *Upon reading about it in the plan, a health care provider enrolls in a Question, Persuade, Refer (QPR) training so that she can better understand and respond to patients who demonstrate warning signs of suicidal ideation and behavior.*

Leverage this information for funding opportunities. Use the data and information within this plan as supporting evidence to apply for funding for suicide prevention or mental health promotion programs, or research.

> ***Example:*** *The development director of a nonprofit organization applies for grant funding to support his organization's suicide prevention activities. He references the plan in the application to showcase the significant amount of interest in and concern about the problem of suicide in N.C. and to demonstrate the need for increased funding by highlighting data about its impact.*

Readers are encouraged to consider these ideas as a springboard to action and the overall plan as a guide for their efforts, as well as to share this plan with others in their communities. Suicide prevention efforts in North Carolina will be stronger,

more sustainable, and have greater impacts if each of us develops a comprehensive understanding of the problem and is prepared to act, together.

D. Section 4 - What Does the Problem of Suicide Look Like in North Carolina?

Six data sources (five statewide and one national) were used to provide a broad, population-based overview of suicide and self-inflicted injury in North Carolina. Understanding the burden of suicide and self-inflicted injury in North Carolina is essential to developing and implementing effective prevention and intervention strategies:

- In 2012, suicide became the leading cause of injury death in North Carolina and remained so in 2013.
- Non-fatal self-inflicted injuries resulting in hospitalization or an Emergency Department (ED) visit are more common than suicide deaths.
- Firearms are the most common method of suicide in North Carolina.
- Males are more likely to die as a result of suicide than females. Females are more likely to be hospitalized or visit an ED for a self-inflicted injury than males.
- Youth and young adults have the highest rates of self-inflicted injury hospitalizations and ED visits of all age groups in North Carolina.
- In addition to sex and age, suicide related disparities in North Carolina have been identified by race, sexual orientation, and veteran status.

The *Burden of Suicide in North Carolina 2013*[1] and the *State of North Carolina Coordinated Chronic Disease, Injury, and Health Promotion State Plan 2013*[2] have additional information on the burden of suicide in North Carolina.

E. Section 5 - In What Direction Should N.C. Be Heading?

The *2015 N.C. Suicide Prevention Plan* aligns closely with the *2012 National Strategy for Suicide Prevention (NSSP)*[3]. As a result, the goals and objectives in the *2015 N.C. Suicide Prevention Plan* are organized according to the four strategic directions (SD) included in the *2012 NSSP.* These strategic directions outline a comprehensive strategy for suicide prevention through the continued support of effective approaches and the identification of areas in need of greater development or resources. The *2012 NSSP* included 13 Goals that describe more information about the strategic directions. Developers of the *2015 N.C. Suicide Prevention Plan* adopted all 13 Goals (Table ES-1). Color-shading is used throughout the plan to indicate the four strategic directions.

Table ES-1. N.C. Goals (n=13) by Strategic Direction.
#1 - Healthy and Empowered Individuals, Families, and Communities
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings. ***GOAL 2.*** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors. ***GOAL 3.*** Increase knowledge of the factors that offer protection from suicidal behaviors or promote wellness and recovery. ***GOAL 4.*** Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.
#2 - Clinical and Community Preventive Services
GOAL 5. Develop, implement, monitor effective programs that promote wellness and prevent suicide and related behaviors. ***GOAL 6.*** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. ***GOAL 7.*** Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
#3 - Treatment and Support Services
GOAL 8. Promote suicide prevention as a core component of health care services. ***GOAL 9.*** Promote and implement effective clinical and professional practices for assessing and treating those identified as

[1] North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (N.C. DPH), 2013a
[2] N.C. DPH, 2013b
[3] U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (DHHS), 2012

Table ES-1. N.C. Goals (n=13) by Strategic Direction.
being at risk for suicidal behaviors. ***GOAL 10.*** Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.
#4 - Surveillance, Research, and Evaluation
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action. ***GOAL 12.*** Promote and support research on suicide prevention. ***GOAL 13.*** Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

For the 61 objectives developed for the *2015 N.C. Suicide Prevention Plan*, stakeholders in North Carolina identified **32 prioritized objectives** (ordered by importance and feasibility) for emphasis in the *2015 N.C. Suicide Prevention Plan.* Table ES-2 lists the 32 prioritized objectives in rank order, based on weighted scoring of importance and feasibility. For each objective, the level of feasibility (high or medium) is noted following the wording of the objective.

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).

Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
1	5.2	Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors. *High*
2	7.1	Develop training on suicide prevention to community groups. *High*
3	11.3	Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. *Medium*
4	9.1	Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings. *High*
5	8.3	Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide. *Medium*
6	1.1	Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities. *High*
7	8.2	Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. *High*
8	6.1	Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means. *High*
9	11.2	Improve the usefulness and quality of suicide-related data. *High*
10	13.3	Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective. *High/Medium*
11	4.1	Accurate data and resources readily available and accessible for pick up use by media and other. *Medium*
12	7.3	Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education. *Medium*
13	3.1	Promote effective programs/practices that increase protection from suicide risk. *High*
14	9.2	Disseminate and implement guidelines for clinical practice and continuity of care for providers working with people with suicide risk. *Medium*
15	10.3	Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups. *Medium*
16	13.6	Establish resources/guides to gain access to impact/effectiveness data (e.g. toolkit, resource centers). *High*
17	5.1	Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial/tribal/local suicide prevention programming. *Medium*
18	5.3	Strengthen efforts to increase access to/delivery of effective programs and services for mental health/substance use disorders. *High*

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).		
Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
19	10.1	Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels. *Medium*
20	2.4	Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care. *High*
21	1.5	Integrate suicide prevention into all relevant health care reform efforts. *Medium*
22	10.5	Provide health care providers, first responders, others with care/support when a patient under their care dies by suicide. *High*
23	8.8	Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge. *Medium*
24	2.1	Develop, implement, and evaluate communication efforts designed to reach defined segments of the population. *High*
25	2.2	Reach policymakers with dedicated communication efforts. *Medium*
26	7.5	Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk. *High*
27	9.5	Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental health/substance use disorders. *Medium*
28	7.2	Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. *High*
29	9.3	Promote the safe disclosure of suicidal thoughts and behaviors by all. *Medium*
30	3.2	Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders. *Medium*
31	3.3	Promote the understanding that recovery from mental and substance use disorders are real and possible for all. *Medium*
32	9.4	Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk. *Medium*

F. Section 6 - What Can We (Stakeholders) Do to Address Suicide in N.C.?

Planning process participants identified over 500 examples of what various stakeholder groups, collectively and individually, can do to address suicide in North Carolina.

Section 6 includes lists of stakeholder suicide prevention examples organized by strategic direction, with bolded objectives and examples representing prioritized objectives (i.e., high importance and high/medium feasibility). Examples are presented by stakeholder group in ascending order with three numerical references (i.e., #.#.#): the first number represents the goal number; the second represents the objective number; and the third represents the example number (i.e., 5.2.6 label refers to goal 5, objective 2, and example 6). Detailed information about examples identified is included in Appendix D of the plan. Some of the examples identified may be the same or similar for multiple objectives. In addition, some examples were identified as being relevant for more than one stakeholder group, and when so, are cross-listed. It is possible that some examples may also be relevant for additional stakeholder groups, but were not identified as such. The complete list of examples, presented by the stakeholder group(s) for which the example was identified, is included in Appendix E.

The examples identified through the planning process may or may not be inclusive of: a) all known evidence-based strategies; b) all types of interventions occurring in North Carolina c) examples relevant for all target audiences; or d) opportunities to address high risk-populations that available data indicate are disproportionally affected by suicide. Some examples may be more or less effective, as the plan development process did not require that all examples listed have

evidence of effectiveness. For some examples, it may be important to tailor the activity for specific target populations at increased risk of suicide (e.g., people with disabilities, LGBTQ citizens, and military or veterans).

G. Section 7 - Where Can I Go to Learn More about Suicide Prevention?

The *2015 N.C. Suicide Prevention Plan* provides information and hyperlinks for additional resources about suicide prevention, at the state and national level, for the following categories: a) Suicide Prevention; b) Mental Health; c) Suicide Disparities ; d) Evidence Based-Practices; e) Advocacy and Awareness; and f) Data and Surveillance.

H. Section 8 - Endorsements

A total of 46 entities and organizations have provided a formal endorsement of the *2015 N.C. Suicide Prevention Plan.*