Minnesota State Suicide Prevention Plan

Goals and Objectives for Action

2015 - 2020

Prepared by the Minnesota Department of Health
and the MN State Suicide Prevention Task Force
Health Promotion and Chronic Disease
Center for Health Promotion
Injury and Violence Prevention Unit
Suicide Prevention Program
September 2015

Minnesota Statute 145.56

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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Preface from the Commissioner of Health

Suicide is a significant public health issue for Minnesota. It involves the tragic loss of human life as well as agonizing grief, fear and confusion in families and communities. The impact is not limited to an individual person or even the immediate family, but extends throughout communities and across generations.

The number of suicides in Minnesota has steadily increased for more than a decade. According to the Minnesota Center for Health Statistics suicide was the ninth leading cause of death in Minnesota in 2013 - 683 Minnesotans died of suicide with an age-adjusted suicide rate of 12.2 per 100,000 compared to 12.6 at the national level. Men 45-54 years of age had the greatest burden (120 suicides, at a rate of 31.1 per 100,000). American Indian youth aged 10-24 had the highest rate of suicide (28 per 100,000 during 2009-2013).

There is not one single path that leads to suicide. Many factors can increase the risk of suicidal thoughts and behaviors, such as childhood trauma, serious mental illness, physical illness, alcohol or other abuse, a painful loss, exposure to violence, social isolation, and easy access to lethal means. Factors such as meaningful relationships, coping skills and safe and supportive communities can decrease the risk of suicidal thoughts and behaviors.

The 2015-2020 Minnesota State Suicide Prevention Plan is based on the National Strategy for Suicide Prevention and on the evidence that suicides are preventable, mental illness is treatable and recovery is possible. The Minnesota Department of Health and Suicide Awareness Voices of Education (SAVE) co-chaired the creation of the plan. As directed by State Statute 145.56, the Minnesota Department of Health in collaboration with other state agencies and organizations and institutions in the community will refine, coordinate and implement this plan.

This plan calls for a comprehensive, public health approach of promoting health and wellness in our communities. We must better equip our public agencies, nonprofits, health care providers, and families to reduce suicides through timely, effective responses. At the same time, recent trends indicate a need to prioritize populations with increased risk such as middle-aged men and American Indians.

The preventable nature of suicide makes Minnesota's current suicide rates unacceptable. However, the preventable nature of suicide also means that through our plans and actions, we can provide the hope and help needed to turn these tragedies into recoveries and complete lives.

Sincerely,

Edward P. Ehlinger, MD, MSPH

Commissioner

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Dedication

This plan is dedicated to all residents in the State of Minnesota that have been touched by suicide. Whether by attempt, death, bereaved or those providing care to those impacted by suicide, we honor and recognize you as a valued member of our communities' history and our future. By working together, we know we can help those in need and prevent suicide in our state.

Goal

To reduce suicide in Minnesota by 10% in five years, 20% in ten years, ultimately working towards zero deaths.

When Minnesota fully implements this comprehensive suicide prevention plan across the lifespan (based on the social ecological model) while prioritizing subpopulations with known increased risk such as middle-aged males and American Indians, our State will see a significant reduction in suicides and suicidal behaviors because those living in Minnesota will feel connected, supported and have timely access to competent mental health services when needed.

Introduction

There is not one single path that will lead to suicide. Rather, throughout life, a combination of factors, such as a serious mental illness, physical illness, alcohol or other abuse, a painful loss, exposure to violence, social isolation, and easy access to lethal means may increase the risk of suicidal thoughts and behaviors.

To most effectively prevent suicidal behavior and deaths by suicide, and improve the health of all Minnesota residents, we need a comprehensive plan that:

- Collaborates across all sectors to address five broad themes
  - Injury- and violence-free living
  - Mental and emotional well-being
    - » Preventing drug abuse and excessive alcohol use
    - » Preventing suicidal behaviors
  - Supports a Health in All Policies approach
  - Decreases risk factors and promotes protective factors across four levels of influence (individual, relationship, community, societal)
  - Promotes health equity and the *Minnesota Healthy People 2020* vision to strengthen communities and improve conditions to promote health

Health in All Policies

Optimal health is more than just good medical care. It requires excellent schools, economic opportunities, environmental quality, secure housing, good transportation, safe neighborhoods and much more. Health in all policies emphasizes the need to collaborate across sectors to achieve common health goals. By including health in all policies we will impact the health of our communities and individuals and ideally decrease suicidal behaviors and deaths.

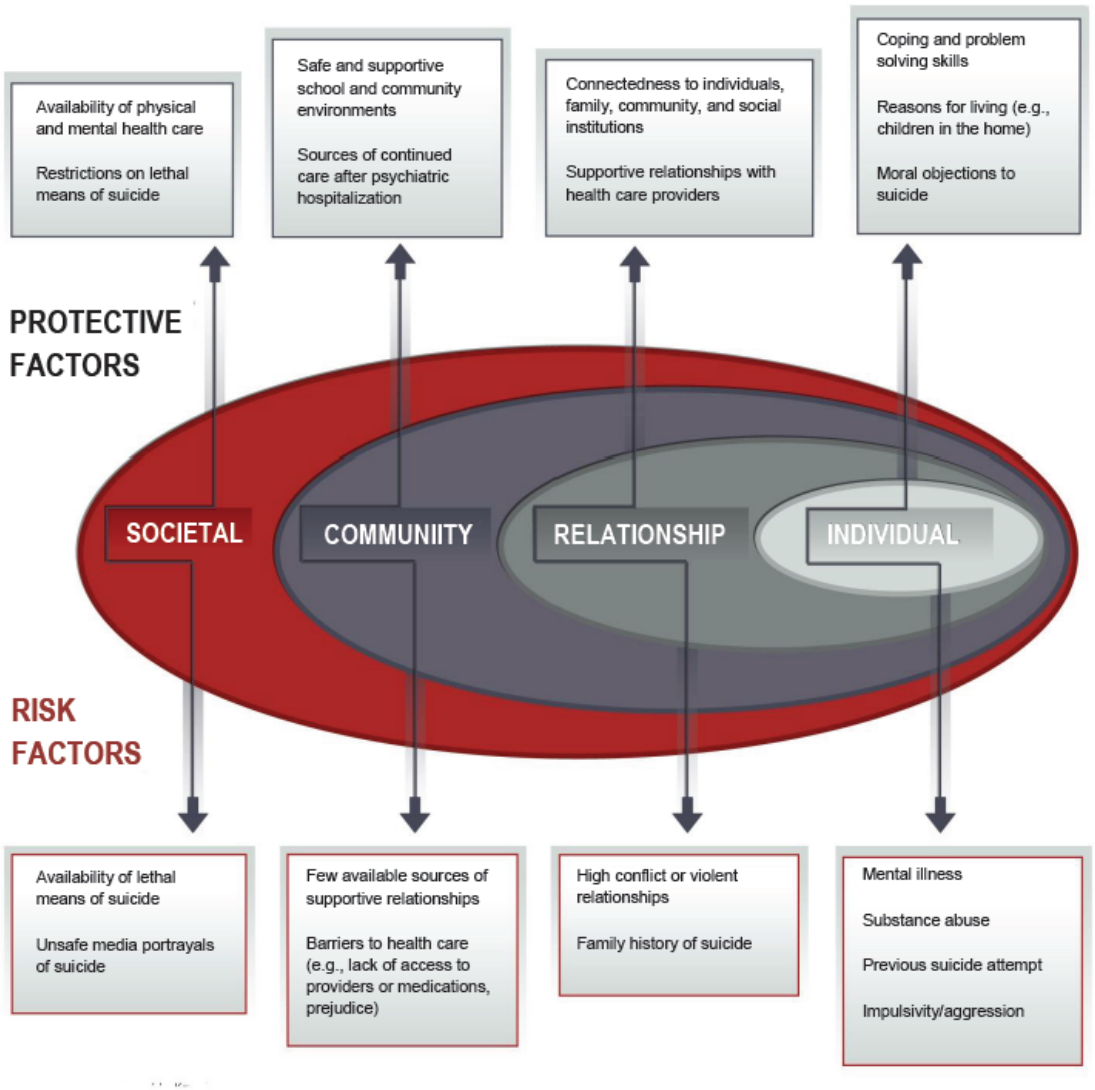
Social Ecological Model

Suicide is a complex outcome that is influenced by many factors. Individual characteristics may be important, but so are relationships with family, peers, and others, and influences from the broader social, cultural, economic, and physical environments.

Most suicide prevention efforts work to identify and reduce risk factors that make it more likely that a person will think about suicide or engage in suicidal behaviors. These include prior suicide attempts, diagnosable psychiatric illness, access to lethal means (such as a firearm or poisons), barriers to health care access, substance abuse, and social isolation.

In addition to reducing risk factors we need to also increase protective factors that promote strength and resilience and ensure that all persons are supported and connected. Risk and protective factors are found at many levels, from individual to community to society at large as explained in the social ecological model (Figure 1). This framework communicates the value of increasing protective and decreasing risk factors along four levels of influence: individual, relationship, community and societal.

Figure 1. Social Ecological Model



Adapted from: Dahlberg LL, Krug EG. Violence—a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002:1–56.

Health Equity

Following the National Strategy for Suicide Prevention's model (Appendix B), in Minnesota, we take a public health approach to suicide prevention. We believe this will prevent suicides and promote the general health and wellbeing for Minnesotans. As the Institute of Medicine said, "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy."

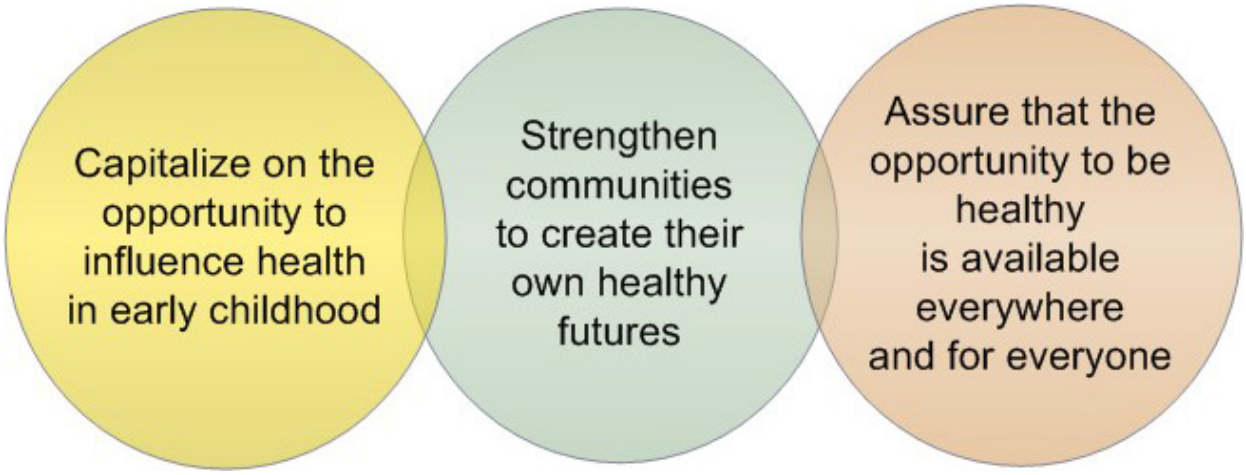
Health is a state of complete physical, social, spiritual and mental well-being and not merely the absence of disease or sickness. Health is created in the community through social, economic environmental conditions. Health disparities result when there are community- and system-based disadvantages such as structural inequities, racism, historical trauma, lack of economic and education opportunities.

Our Minnesota plan seeks to create supportive communities and environments that promote physical, mental, emotional and spiritual wellness of all persons and builds resilience and other protective factors to ensure that

individuals are connected and supported and have improved general health and reduced suicidal behaviors and deaths. In addition, focusing on health in early childhood, knowing that children thrive in the context of a thriving family and healthy community.

Our suicide prevention efforts fit within Minnesota's state health improvement framework – *Healthy People 2020* Vision: All people in Minnesota enjoy healthy lives and healthy communities (Figure 2).

Figure 2. Healthy People 2020 Vision



Suicide prevention in Minnesota

By using the above frameworks, Minnesota hopes to increase the capacity of our local communities to coordinate and implement culturally-appropriate suicide prevention activities to improve the health of its residents and decrease suicidal behavior and deaths.

By using this plan, we have collaboratively set out a path by which we can accomplish our main goal of reducing suicide in our state.

Implementation plan

A public-private advisory committee will be formed in 2015. This committee will work with content experts to identify needs and priorities and develop a two-year work plan with timelines, benchmarks and responsible agencies. The implementation advisory committee will monitor and document plan activities and recommend changes as needed. The implementation advisory committee will identify and communicate prevention activities and resources appropriate for the following sectors:

- State, Tribal and Local Governments
- Business and Employers
- Health care Systems, Insurers, and Clinicians
- Schools, Colleges, and Universities
- Nonprofit, Community, and Faith-Based Organizations
- Individuals and Families

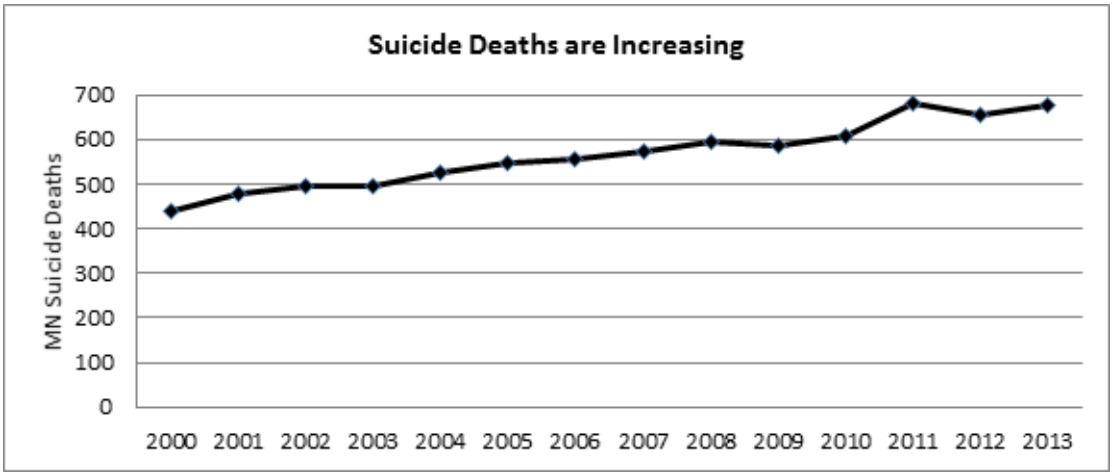
Sustaining suicide prevention

Most funds exist for a limited time; therefore all programming needs to be designed, funded and implemented with a sustainability mindset.

Given our limited resources it is critical that our prevention efforts build momentum by inspiring and catalyzing multiple stakeholders at the state and local level. Minnesota will need to deliberately select strong leaders to participate on the implementation advisory committee and build partnerships with a variety of stakeholders and diverse populations and sectors of the community. Working together, we should be able to secure necessary funding and support to prevent and significantly reduce suicides in Minnesota.

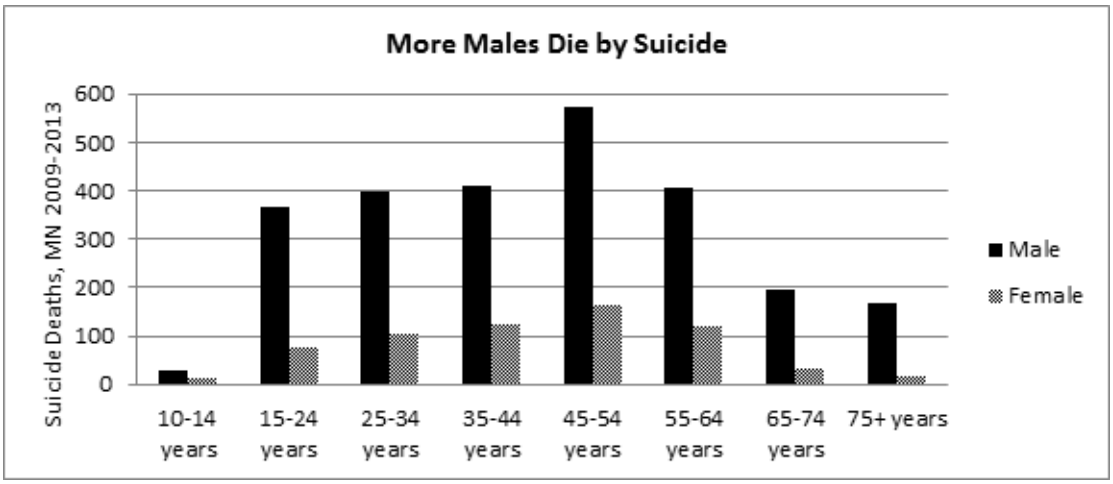
Minnesota Suicide Deaths

According to the Minnesota Center for Health Statistics in 2013 (the most recent complete data year), a total of 683 Minnesotans died of suicide – making it the ninth leading cause of death. The state's age-adjusted rate of suicide has gradually risen from a low of 8.9 per 100,000 in 2000 (n=440) to 12.2 per 100,000 in 2013 (n=683). In 2013 the U.S. rate was 12.6.



Source: CDC Wonder and Minnesota Center for Health Statistics

In 2013, nearly four males died by suicide for every female (males = 536, females = 147). The age-adjusted suicide rate for men in Minnesota was 19.3 per 100,000, compared to 5.2 per 100,000 for women. Males 45-54 years of age had the greatest burden and rate of suicides in Minnesota (120 suicides, rate of 31.1 per 100,000). Suicide was among the top five leading causes of death for all age groups between 10 and 64 years old.

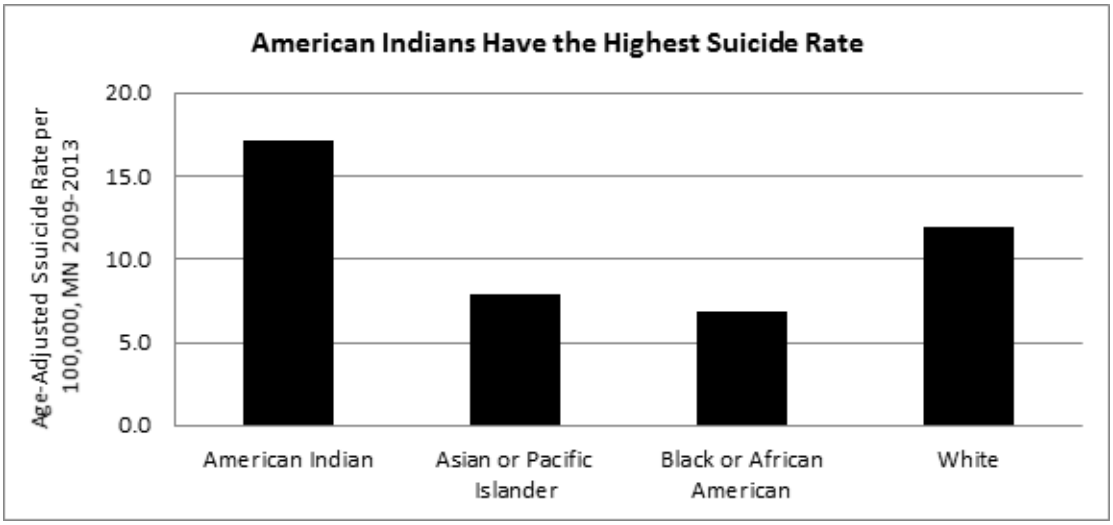


Source: CDC Wonder

Data - Suicide death and hospital-treated self-injuries in Minnesota

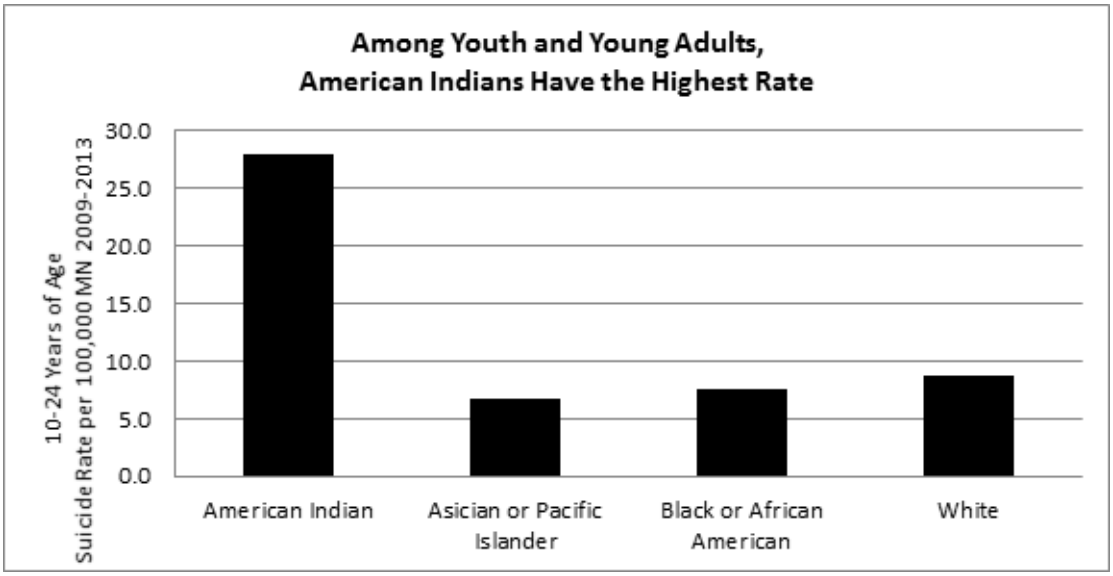
Suicide Rates Vary Across Races

In Minnesota in 2009-2013, the age-adjusted rate for American Indians was 17.2 per 100,000 (n=70) followed by Whites at 12.0 per 100,000 (n=2,941) and Asians/Pacific Islanders at 7.9 per 100,000 (n=92) and Blacks/African Americans at 6.9 per 100,000 (n=104).



Source: CDC Wonder

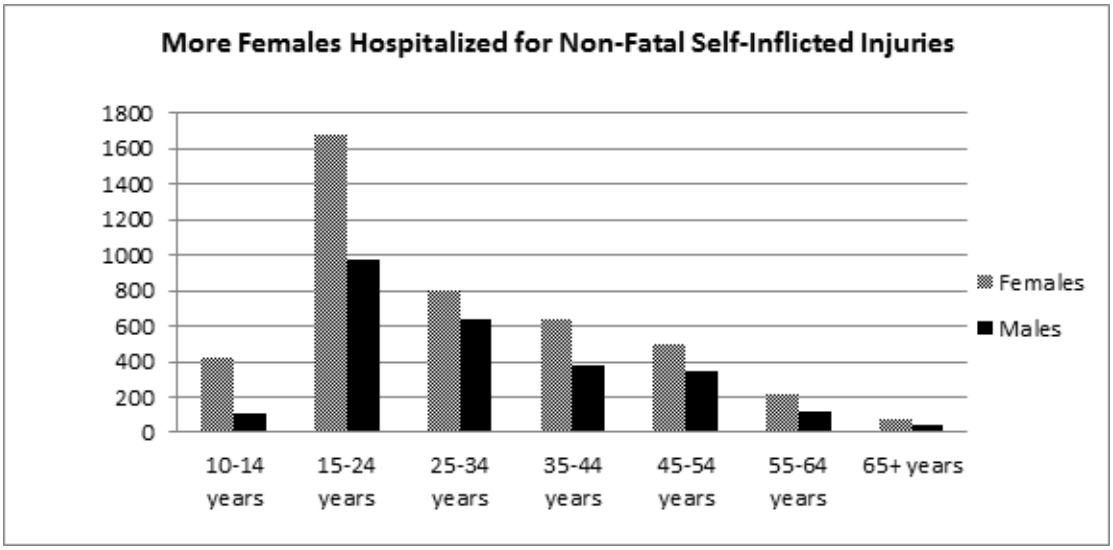
In Minnesota in 2009-2013, American Indian youth aged 10-24 had a suicide rate of 28.0 per 100,000 (n=30), followed by White youth at 8.8 per 100,000 (n=364), Black/African American youth at 7.6 per 100,000 (n=34) and Asian/Pacific Islander youth at 6.7 per 100,000 (n=22).



Source: CDC Wonder

Minnesota Hospital Treated Self-Inflicted Injuries

In 2013, females were more likely to attempt suicide and seek hospital treatment with a non-fatal self-inflicted injury than males. The female age-adjusted rate was 169.9 per 100,000 (n=4,295) and male rate was 99.6 per 100,000 (n=2,619). Females 15-19 years of age had the greatest burden and rate (n=1,033 at a rate of 587.7 per 100,000).



Source: Minnesota Injury Data Access System (MIDAS)

Goal 1: Support healthy and empowered individuals, families and communities to increase protection from suicide risk.

Minnesota seeks to create a supportive environment that promotes general health of Minnesota residents and reduces the risk for suicidal behaviors and related problems.

Objective 1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs to support suicide prevention activities.

Integrating suicide prevention into the values, culture, leadership and work of a broad range of organizations and programs will promote greater understanding of suicide and help counter the prejudice, silence and denial that can prevent persons from seeking help.

Tasks:

1. Encourage organizations to promote the psychological (cognitive, emotional and behavioral), spiritual and physical health of their employees and members.
2. Promote programs and policies that prevent abuse, bullying, violence and social exclusion.
3. Promote programs and policies that build social connectedness and promote positive mental and emotional health.
4. Train professionals and community/cultural leaders to increase awareness of suicide and prevention efforts and mental health and wellbeing.
5. Create and promote messages that “suicide is preventable” and “everyone has a role in preventing suicides.”

Objective 1.2 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

Increasing the knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and locally-available care helps everyone have a role in preventing suicide. Responsible media reporting that focuses on the warning signs of suicide and available help can reduce prejudice and prevent contagion.

Tasks:

1. Provide standard messaging around knowing the warning signs and how to connect to services ensures the information is accurate and consistent (to build synergy).
2. Compile, organize and make available (MinnesotaHelp.info) a master list of all crisis and support services available nationally, statewide and locally (24-crisis services and hotlines, support services such as peer specialists, prevention coalitions, trainings, awareness and fundraising events and grief supports).
3. Provide guidance to organizations on developing procedures or policies to identify and connect persons at high risk for suicide or in need of mental health support.
4. Promote safe messaging and media guidelines related to suicide events and prevention.
5. Promote and distribute existing safe messaging PSAs (such as makeitok.org) and media campaigns related to suicide and mental illness/health promotion.

Objective 1.3 Promote effective programs and practices that increase protection from suicide risk.

Promoting physical, mental, emotional and spiritual wellness and social connectedness can help prevent suicides and related behaviors. Communities and organizations that enhance connectedness can help promote overall health.

Tasks:

1. Support and educate the person at heightened risk for suicide and his or her family members and/or support network on how to maintain physical, mental, emotional and spiritual health and well-being.
2. Work with employers to include healthy living and mental health education and suicide prevention programming in their employee training programming.
3. Increase community programming that promotes social connectedness (such as volunteerism and multi-generational events).
4. Promote programs that decrease and address trauma in childhood such as physical, emotional, and sexual abuse (Adverse Childhood Experiences).

Objective 1.4 Reduce the stigma, prejudice and discrimination associated with suicidal behaviors and mental and substance abuse disorders.

Reducing stigma, prejudice and discrimination about mental disorders and suicide leads to greater acceptance by family members and friends and makes it more likely that the person will let others know about symptoms and seek help.

Tasks:

1. Communicate messages of resilience, hope and recovery to patients, clients, and their families with mental and substance abuse disorders.
2. Develop and distribute protocols and best practices to various types of organizations on how to support employees and members and provide for a safe, accepting environment.
3. Train professionals and community/spiritual/cultural leaders to better understand how to talk to and encourage those at risk to access help.

Objective 1.5 Provide care and support to individuals affected by suicide deaths and attempts in order to promote healing and implement community strategies to help prevent more suicides.

Providing care and support to individuals affected by suicide deaths and attempting to promote healing may prevent further suicides.

Tasks:

1. Compile, organize and make available a master list of suicide-specific grief support groups.
2. Promote grief counseling for individuals bereaved by suicide.
3. Provide emotional support to employees, educators, clinicians, first responders, emergency medical service providers, and other professionals after someone they work with or cared for dies by suicide.

Goal 2: Coordinate the implementation of effective programs by clinical and community preventive service providers to promote wellness, build resilience and prevent suicidal behaviors.

Minnesota seeks to create a wide array of support systems, services and resources that promote wellness and help individuals manage stressful challenges to prevent suicides and related behaviors.

Objective 2.1 Strengthen the coordination, implementation and evaluation of comprehensive state, tribal and local suicide prevention programming.

Strengthening the coordination, implementation and evaluation of comprehensive state, tribal and local suicide prevention will ensure an effective multi-layer approach is culturally appropriate and geographically available.

Tasks:

1. Develop a coordinated state, community and tribal level suicide prevention network.
2. Increase the suicide prevention capacity in Minnesota at the state, community and tribal level.
3. Increase coordination of suicide prevention efforts at the state, community and tribal level.

Objective 2.2 Expect providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Reducing access to lethal means (firearms, medicines/poisons, keys, sharp objects, materials used in hangings or suffocation, etc.) makes it less likely that the person with suicidal ideation will engage in suicidal behaviors, as well as decrease injuries, unintentional overdoses and substance abuse.

Tasks:

1. Develop policies and procedures for providers to routinely assess for access to lethal means and educate clients/patients on safe storage (inside and outside the home) recommendations.
2. Train providers on how to routinely assess for access to lethal means.
3. Partner with substance abuse prevention programs on medication take-back events and messaging around safe storage of medications (and chemicals) as an overdose prevention strategy.

Objective 2.3 Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible gun ownership.

Partnering with firearm dealers, firearm ranges, firearm safety instructors, and gun owners will help ensure that the messaging and strategies are supported and promoted by a trusted source and that they are technically accurate and culturally appropriate.

Tasks:

1. Educate and promote lethal means restriction in time of heightened risk.
2. Develop standard messages around risk for suicide and the importance of being alert to signs of suicidal behavior in a loved one and keeping firearms out of the person's reach.
3. Develop and distribute a local community action toolkit, similar to that developed by New Hampshire Gun Shop Project and used by other states.

Objective 2.4 Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Training of community service providers makes it easier to identify the person at risk and increases appropriate referrals.

Tasks:

1. Provide training on the signs and symptoms of suicidal behaviors and where to go for help (sources of support).
2. Compile, organize and make available a master list of suicide prevention trainings and trainers.

Objective 2.5 Increase communities capacity to promote resilience and wellness and other protective factors to reduce suicide and related behaviors.

Promoting resilience, wellness and other protective factors will ensure that individuals and communities are connected, supported and are able to solve problems in difficult times and thereby prevent or reduce suicidal behaviors, interpersonal violence, and other related problems.

Tasks:

1. Provide training on coping, problem-solving skills and help-seeking behaviors.
2. Increase community programming that promotes social connectedness (such as volunteerism and multi-generational events).
3. Promote policies and procedures for safe and supportive school and community environments.

Objective 2.6 Increase the capacity of communities to use evidence-informed programs and strategies to respond to suicide clusters and contagion within their cultural context, and support implementation with education, training and consultation.

Increasing communities' capacity to use evidence-informed programs and strategies to respond to a suicide and possible clusters and contagion in a culturally appropriate way can help to decrease suicides and related behaviors.

Tasks:

1. Provide postvention training to various professionals and communities.
2. Provide accurate technical assistance to communities and organizations responding to a recent suicide.
3. Train survivors on how to safely share their story to help heal themselves and others.

Goal 3: Promote suicide prevention as a core component of health care services.

Minnesota seeks to support health care systems to make suicide prevention a core goal to prevent suicides and related suicidal behaviors.

Objective 3.1 Promote timely access to assessment, intervention and effective care for individuals with a heightened risk for suicide.

Promoting timely access to high-quality culturally-appropriate services for persons at heightened risk for suicide is critical in reducing suicide risk.

Tasks:

1. Develop a comprehensive, easily accessible 24-hour crisis care plan (including phone, text, chat, face-to-face response and follow-up care statewide).
2. Develop transportation services plan for emergency psychiatric transport and nonemergency transport teams.
3. Develop protocols and improve collaboration among crisis lines, crisis centers, law enforcement, primary care, emergency medical service providers, mobile crisis teams, colleges, schools, hospitals, outpatient clinics, social services, mental health and/or chemical health professionals, and chaplains to ensure timely access to care for individuals with suicide risk.
4. Disseminate best practices for suicide assessment, intervention, care, means restriction and safe storage, transport, discharge and transfer and follow up for: hospitals, emergency departments, primary care, law enforcement, first responders, schools, poison center, mental health and/or chemical health providers, and chaplains.
5. Provide training on how to assess, intervene, and provide culturally competent care for: hospitals, emergency departments, primary care, law enforcement, first responders, schools, poison center, and mental health and/or chemical health providers, and chaplains.
6. Support the use of trauma-informed approach and trauma specific interventions.[1]

Objective 3.2 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in health care settings such as emergency department or hospital inpatient units.

Promoting continuity of care and the safety and well-being of all patients treated for suicide risk in emergency department or hospital inpatient units allows treatment to be better coordinated, aftercare to be improved, and results in better long-term outcomes.

Tasks:

1. Better understand the experiences of people who have received intervention for suicidal ideation or an attempt to identify gaps in continuity of care.
2. Develop and implement protocols, trainings and toolkit/resources to ensure immediate and continuous follow up after discharge from an emergency department to an inpatient unit.
3. Increase the workforce providing aftercare and follow-up services.
4. Encourage health care systems to implement the Zero Suicide Model.[2]

1 US Substance Abuse and Mental Health Services Administration. Trauma Informed Approach and Trauma Specific Interventions. Retrieved from: Trauma-Informed Approach and Trauma-Specific Interventionshttp://www.samhsa.gov/nctic/trauma-interventions

2 National Action Alliance for Suicide Prevention. Zero Suicide in Health and Behavioral Health Care. Retrieved from: http://www.samhsa.gov/nctic/

Objective 3.3 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.

Developing collaborations between emergency departments and other health care providers for individuals with heightened suicide risk will result in better care and outcomes.

Tasks:

1. Expand use of mobile crisis teams to assess, intervene, and provide stabilization services.
2. Increase availability of and reimbursement for behavioral health tele-health services.
3. Increase health care systems using integrative behavioral health.
4. Explore using phone/text/chat and face-to-face to assist with follow up and support individuals during heightened risk.

trauma-interventions

Goal 4: Increase the timeliness and usefulness of data systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.

Minnesota seeks to develop a data system to better understand suicide and suicidal related behaviors as well as develop targeted, effective strategies to prevent suicides and related behaviors.

Objective 4.1 Improve the usefulness and quality of suicide-related data.

Improving the usefulness and quality of suicide-relate data can help explain the scope of the problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs.

Tasks:

1. Implement the National Violent Death Reporting System.[3]
2. Establish a Suicide Statewide Epidemiological Outcomes Workgroup (S-SEOW).
3. Implement CDC's action plan for improving external cause of injury coding.
4. Promote the use of the self-directed violence uniform definitions and data elements developed by the CDC and Veteran's Affairs.

Objective 4.2 Improve and expand the state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

Improving and expanding the state/tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data will develop effective prevention efforts, especially at the local level.

Tasks:

1. Release updated data in a timely manner.
2. Establish a suicide death review.
3. Support the use of psychological autopsies.
4. Analyze the All Payers Claim Data.
5. Provide internship suicide epidemiology opportunities.

Objective 4.3 Increase the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, suicidal behaviors, related risk factors, and exposure to suicide.

Increasing the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, risk factors and exposures to suicide will help us to plan prevention and support services and to better understand community suicide prevention needs.

3 U.S. Centers for Disease Control and Prevention. National Violent Death Reporting System. Retrieved from: http://www.cdc.gov/violenceprevention/nvdrs/

Tasks:

1. Include the Adverse Childhood Experience module and suicide thoughts and attempts in the Behavioral Risk Factor Surveillance System survey at least every five years.
2. Increase the number of schools that participate in the Minnesota Student Survey.[4]
3. Measure attitudes, beliefs and knowledge around suicide and suicide prevention.
4. Encourage health care systems to monitor/measure suicide prevention activities and improve their system based on the findings.
5. Gather data on subgroups with increased risk (for example: LGBTQ populations, veterans, unintentional drug-related poisonings, American Indians, middle-aged males).

4 Minnesota Department of Health. Minnesota Student Survey. Retrieved from: http://www.health.state.mn.us/divs/chs/mss/

Goal 5: Sustain suicide prevention efforts.

Minnesota seeks to develop and implement a sustainable suicide prevention plan that reduces suicide and suicidal behaviors.

Objective 5.1 Monitor how the suicide prevention plan is being implemented in the state and local communities.

Monitoring how the suicide prevention plan is being implemented in the state and local communities will help to evaluate the quality and quantity of implementation and types of structures that may be more effective or efficient.

Tasks:

1. Establish an evaluation team to work with the Suicide Statewide Epidemiological Outcomes Workgroup (S-SEOW) to identify needs and monitor and evaluate the implementation of the state plan.
2. Make sure state grant-funded suicide prevention deliverables include state plan objectives and standard measurements to monitor implementation and effectiveness.
3. Seek funding to evaluate suicide prevention programs.

Objective 5.2 Inspire and catalyze momentum for suicide prevention efforts at the state, tribal and community level.

Inspiring and catalyzing momentum beyond initial planning and after grant funds are depleted is critical to sustaining suicide prevention efforts over time.

Tasks:

1. Recruit and cultivate strong leaders and advocates for suicide prevention.
2. Identify and establish strong relationships with a diverse group of partners to help with the launch and implementation of the suicide plan.
3. Formalize any partnerships between agencies using Memorandum of Understanding (MOUs) as appropriate to make sure the plan is sustained.

Objective 5.3 Secure additional funding and/or resources to expand and sustain suicide prevention efforts.

Tasks:

1. Prioritize and seek additional funds to support and implement the suicide prevention plan.
2. Seek a diverse source of funds to expand and sustain suicide prevention efforts.

Appendix A: Goals and Objectives Summary

Goal 1: Support healthy and empowered individuals, families and communities to increase protection from suicide risk.

Objective 1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs to support suicide prevention activities.

Objective 1.2 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

Objective 1.3 Promote effective programs and practices that increase protection from suicide risk.

Objective 1.4 Reduce stigma, prejudice and discrimination associated with suicidal behaviors and mental and substance abuse disorders.

Objective 1.5 Provide care and support to individuals affected by suicide deaths and attempts in order to promote healing and implement community strategies to help prevent more suicides.

Goal 2: Coordinate the implementation of effective programs by clinical and community preventive service providers to promote wellness, build resilience and prevent suicidal behaviors.

Objective 2.1 Strengthen the coordination, implementation and evaluation of comprehensive state, tribal and local suicide prevention programming.

Objective 2.2 Expect providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Objective 2.3 Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible gun ownership.

Objective 2.4 Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Objective 2.5 Increase communities' capacity to promote resilience and wellness and other protective factors to reduce suicide and related behaviors.

Objective 2.6 Increase communities' capacity to use evidence-informed programs and strategies to effectively respond to suicide clusters and contagion within their cultural context, and support implementation with education, training and consultation.

Goal 3: Promote suicide prevention as a core component of health care services.

Objective 3.1 Promote timely access to assessment, intervention and effective care for individuals with a heightened risk for suicide.

Objective 3.2 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in health care settings such as emergency department or hospital inpatient units.

Objective 3.3 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.

Goal 4: Increase the timeliness and usefulness of data systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.

Objective 4.1 Improve the usefulness and quality of suicide-related data.

Objective 4.2 Improve and expand the state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

Objective 4.3 Increase the number of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, suicidal behaviors, related risk factors, and exposure to suicide.

Goal 5: Sustain suicide prevention efforts.

Objective 5.1 Monitor how the suicide prevention plan is being implemented in the state and local communities.

Objective 5.2 Inspire and catalyze momentum for suicide prevention efforts at the state, tribal and community level.

Objective 5.3 Secure additional funding and/or resources to expand and sustain suicide prevention efforts.

Appendix B: Crosswalk of MN Suicide Prevention Plan Goals and Objectives with National Strategy for Suicide Prevention

Minnesota State Suicide Prevention Plan	2012 National Strategy for Suicide Prevention
Goal 1. Support healthy and empowered individuals, families and communities to increase protection from suicide risk.	**Strategic Direction 1.** Healthy and empowered individuals, families and communities
Objective 1.1. Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs to support suicide prevention activities.	**Objective 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.
Objective 1.2. Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	**Objective 2.4.** Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.
Objective 1.3. Promote effective programs and practices that increase protection from suicide risk.	**Objective 3.1.** Promote effective programs and practices that increase protection from suicide risk.
Objective 1.4. Reduce stigma, prejudice and discrimination associated with suicidal behaviors and mental and substance abuse disorders.	**Objective 3.2.** Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
Objective 1.5. Provide care and support to individuals affected by suicide deaths and attempts in order to promote healing and implement community strategies to help prevent more suicides.	**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.
Goal 2. Coordinate the implementation of effective programs by clinical and community preventive service providers to promote wellness, build resilience and prevent suicidal behaviors.	**Goal 5.** Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.
Objective 2.1. Strengthen the coordination, implementation and evaluation of comprehensive state, tribal and local suicide prevention programming.	**Objective 5.1.** Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.
Objective 2.2. Expect providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	**Objective 6.1.** Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
Objective 2.3. Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible gun ownership.	**Objective 6.2.** Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
Objective 2.4. Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.	**Objective 7.1.** Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.
Objective 2.5. Increase communities' capacity to promote resilience and wellness and other protective factors to reduce suicide and related behaviors.	**Objective 5.2.** Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

Minnesota State Suicide Prevention Plan	2012 National Strategy for Suicide Prevention
Objective 2.6. Increase communities' capacity to use evidence-informed programs and strategies to effectively respond to suicide clusters and contagion within their cultural context, and support implementation with education, training and consultation.	**Objective 10.4.** Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
Goal 3. Promote suicide prevention as a core component of health care services.	**Goal 8.** Promote suicide prevention as a core component of health care services.
Objective 3.1. Promote timely access to assessment, intervention and effective care for individuals with a heightened risk for suicide.	**Objective 8.3.** Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
Objective 3.2. Promote continuity of care and the safety and well-being of all patients treated for suicide risk in health care settings such as emergency department or hospital inpatient units.	**Objective 8.4.** Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.
Objective 3.3. 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.	**Objective 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 followup after discharge.
Goal 4. Increase the timeliness and usefulness of data systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.	**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.
Objective 4.1. Improve the usefulness and quality of suicide-related data.	**Objective 11.1.** Improve the timeliness of reporting vital records data. **Objective 11.2.** Improve the usefulness and quality of suicide-related data.
Objective 4.2. Improve and expand the state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.	**Objective 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.
Objective 4.3. Increase the number of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, suicidal behaviors, related risk factors, and exposure to suicide.	**Objective 11.4.** Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.
Goal 5. Sustain suicide prevention efforts.	Suicide Prevention Resource Center. (2013). **Leaving a Legacy: Recommendations for Sustaining Suicide Prevention Programs.** Waltham, MA: Education Development Center, Inc.
Objective 5.1. Monitor how the suicide prevention plan is being implemented in the state and local communities.	**Objective 13.3.** Examine how suicide prevention efforts are implemented in different states/territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.
Objective 5.2. Inspire and catalyze momentum for suicide prevention efforts at the state, tribal and community level.	Suicide Prevention Resource Center. (2013). **Leaving a Legacy: Recommendations for Sustaining Suicide Prevention Programs.** Waltham, MA: Education Development Center, Inc.
Objective 5.3. Secure additional funding and/or resources to expand and sustain suicide prevention efforts.	Suicide Prevention Resource Center. (2013). **Leaving a Legacy: Recommendations for Sustaining Suicide Prevention Programs.** Waltham, MA: Education Development Center, Inc.

Appendix C: MN Statute 145.56 Suicide Prevention

Subdivision 1. Suicide prevention plan

The commissioner of health shall refine, coordinate, and implement the state's suicide prevention plan using an evidence-based, public health approach for a life span plan focused on awareness and prevention, in collaboration with the commissioner of human services; the commissioner of public safety; the commissioner of education; the chancellor of Minnesota State Colleges and Universities; the president of the University of Minnesota; and appropriate agencies, organizations, and institutions in the community.

Subdivision 2. Community-based programs

To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund:

a. community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

b. community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

c. community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources;

d. community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12, and for students attending Minnesota colleges and universities;

e. community-based programs to provide evidence-based suicide prevention and intervention to public school nurses, teachers, administrators, coaches, school social workers, peace officers, firefighters, emergency medical technicians, advanced emergency medical technicians, paramedics, primary care providers and others; and

f. community-based, evidence-based postvention training to mental health professionals and practitioners in order to provide technical assistance to communities after a suicide and to prevent suicide clusters and contagion.

Subdivision 3. Workplace and professional education

a. The commissioner shall promote the use of employee assistance and workplace programs to support employees with depression and other psychiatric illnesses and substance abuse disorders, and refer them to services. In promoting these programs, the commissioner shall collaborate with employer and professional associations, unions, and safety councils.

b. The commissioner shall provide training and technical assistance to local public health and other community-based professionals to provide for integrated implementation of best practices for preventing suicides.

Subdivision 4. Collection and reporting suicide data

a. The commissioner shall coordinate with federal, regional, local, and other state agencies to collect, analyze, and annually issue a public report on Minnesota-specific data on suicide and suicidal behaviors.

b. The commissioner, in consultation with stakeholders, shall submit a detailed plan identifying proposed methods to improve the timeliness, usefulness, and quality of suicide-related data so that the data can help identify the scope of the suicide problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs. The report shall include how to improved external cause of injury coding, progress on implementing the Minnesota Violent Death Reporting System, how to obtain and release data in a timely manner, and how to support the use of psychological autopsies.

c. The written report must be provided to the chairs and ranking minority members of the house of representatives and senate finance and policy divisions and committees with jurisdiction over health and human services by February 1, 2016.

Subdivision 5. Periodic evaluations; biennial reports

To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. By July 1, 2002, and July 1 of each even-numbered year thereafter, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house of representatives and senate with jurisdiction over health and human services issues.

Source: Statute Accessed on August, 8 2015 at https://www.revisor.mn.gov/statutes/?id=145.56

Appendix D: State Plan Development - Tasks and Timeline

Tasks and Timeline	
September 2012	The U.S. Surgeon General and the National Action Alliance for Suicide Prevention released the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. The National Strategy was a call to action intended to guide suicide prevention across the United States of the next decade. It includes 13 goals and 60 objectives to reflect most current suicide prevention knowledge, research and practice within in the current society and health care delivery model.
June 2013	MN State Suicide Prevention Planning Task Force Co-Chairs reviewed and identified 40 of the 60 National Objectives that are appropriate for a state-level plan. This Minnesota Department of Health is the legislatively designated (Statute 145.56) agency to lead and coordinate suicide prevention in Minnesota. In June 2013, the MDH suicide prevention coordinator, Melissa Heinen, teamed with Dan Reidenberg, the executive director of SAVE (Suicide Awareness Voices of Education), to co-chair the MN State Suicide Prevention Planning Task Force.
September 2013	Over 80 stakeholders and community members helped prioritize objectives and identify stakeholders to participate on subcommittees. An email with a link to an online survey was sent to suicide prevention stakeholders and related email lists throughout Minnesota. Recipients we asked to forward the survey link to persons who may be interested in suicide prevention. The survey asked participants to prioritize the 40 objectives, identify objectives they were interested in helping develop and provide feedback on suicide prevention in MN.
March 2014	MN State Suicide Prevention Planning Task Force held its first quarterly meeting and formed four subcommittees. The four Subcommittees were formed to help develop recommendations for the four national strategy strategic directions: • Healthy and empowered individuals, families and communities • Clinical and community preventive services • Treatment and support services • Data, research and evaluation. The public and private subcommittee co-chairs were also members of the Task Force. The subcommittee co-chairs were responsible for recruiting subcommittee members from the community with input from Task Force members and the September 2013 survey volunteers.
May 2014	The subcommittees meet and identified three to five priority objectives based on September 2013 stakeholder survey findings and subcommittee members' input. Subcommittees continued to meet as needed through October 2014 to develop recommendations for prioritized objectives.
June 2014	The MN State Suicide Prevention Planning Task Force met. The Task Force reviewed subcommittee priority objectives.

Tasks and Timeline	
September 2014	The MN State Suicide Prevention Planning Task Force met. The Task Force reviewed subcommittee recommendations.
November 2014	A MN State Suicide Prevention Plan draft was released to Task Force and Subcommittee members for review and comment.
December 2014	A MN State Suicide Prevention Plan draft was revised based on Task Force and Subcommittees members' review and feedback.
January 2015	A revised MN State Suicide Prevention Plan draft was released online for public comment. Over 50 stakeholders and community members completed the online survey to help identify priorities, identify partners to assist with implementing the state plan and provide general feedback. The MN State Suicide Prevention Planning Task Force met. The Task Force recommended how to disseminate the final MN State Suicide Prevention Plan.
April 2015	Minnesota Department of Health reviewed MN State Suicide Prevention Plan and revised based on public feedback.
September 2015	MN State Suicide Prevention Plan released.

Appendix E: Glossary

Adverse childhood experiences (early childhood trauma)

A traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.

Affected by suicide

All those who may feel the effect of suicidal behaviors, including those bereaved by suicide, community members, and others.

Behavioral health

A state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health problems include mental and substance use disorders and suicide.

Contagion

A process by which exposure to the suicide or suicidal behavior of one or more persons influences others to attempt to die by suicide

Health disparity

A population-based difference in health outcomes (e.g., women have more breast cancer than men).

Health equity

When every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Health inequity

A health disparity based in inequitable, socially-determined circumstances (for example, American Indians have higher rates of diabetes due to the disruption of their way of life and replacement of traditional foods with unhealthy commodity foods). Because health inequities are socially-determined, change is possible.

Means

The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

Methods

Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Postvention

An intervention conducted after a suicide to promote healing and reduce the risk after a suicide for those affected by the suicide of a loved one.

Structural inequities

Structures or systems of society — such as finance, housing, transportation, education, social opportunities, etc. — that are structured in such a way that they benefit one population unfairly (whether intended or not).

Structural racism

The normalization of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians.

Suicide
Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide attempt
A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide attempt survivor
An individual who has survived a prior suicide attempt.

Suicidal behaviors
Behaviors related to suicide, including preparatory acts, suicide attempts, and deaths.

Suicidal ideation
Thoughts of engaging in suicide-related behavior.

Survivor of suicide loss
Family members, friends, and others affected by the suicide of a loved one.

Appendix F: Subcommittee Participant List

Subcommittee 1. Healthy and Empowered Individuals, Families, and Communities

Chairs

Donna Fox, National Alliance on Mental Illness MN
CPT Ronald Jarvi Jr., MN National Guard

Members

Janet Benz, St. Catherine University, Christopher Benz Foundation
Connie Berg, Red Lake Indian Reservation Vocational Rehabilitation Services
Glen Bloomstrom, Living Works Education
Lindy Fortin, Veterans Affairs Medical Center
Dave Garmon, Minneapolis Police Department
Dan Hanson, Army National Guard
Melissa Hensley, Augsburg College
Karen Levad, Formerly with Western Colorado Suicide Prevention Foundation
Meghann Levitt, Carlton County Public Health and Human Services, TXT4Life
Brenda Mack, Northwestern Mental Health Center
Sara Maaske, Minnesota Department of Health
Dr. Brittany Miskowiec, Minnesota Army National Guard
Brent Munce, Anoka-Hennepin School District
Barry Scanlan, Anoka Hennepin School District
Jeff Seidl, Metro Critical Incident Stress Management Team, Minneapolis Police Department
Julie Smith, Inner Wisdom Counseling and Medication, LLC and White Earth Band of Ojibwe Reservation Member
Patty Wetterling, Minnesota Department of Health

Subcommittee 2. Clinical and Community Preventive Services

Chairs

Sue Benolken, Minnesota Department of Education
Stephanie Downey, Evergreen Youth & Family Services

Members

Kelley Adelsman, American Foundation for Suicide Prevention SEMN Chapter
Karen Anoka, Leech Lake Health Division
Janet Benz, St. Katherine University, Christopher Benz Foundation
Chris Caulkins, Century College
Melinda Domzaliski-Hansen, Minnesota Department of Commerce
Dana Farley, Minnesota Department of Health
Lisa Hoogheem, MN School District 622
Cheryl Kreager, Juvenile Justice Coalition of Minnesota
Donna LeKander, Carlton County Children's Mental Health and Family Services Collaborative
Mary Marana, Crisis Line and Referral Service

Nancy Riestenberg, Minnesota Department of Education
Nelly Torori, Minnesota Department of Human Services
Tehout Selameab, Arcadia Research and Evaluation
Anne Turnbull, Century College
Alyssa VonRuden, Minnesota Department of Commerce

Subcommittee 3. Treatment and Support Services

Chairs

Mary Jo Verschay, Minnesota Department of Human Services
Chris Walker, CentraCare Health and Minnesota Hospital Association (Representative)

Members

Deborah Anderson, Minnesota Poison Control System
Mark Bublitz, Northern Pines Mental Health Center
Tanya Carter, White Earth Tribal Mental Health
Nancy Houlton, UCare
Rachel Jokela, Minnesota Department of Health
Mark Kragenbring, Department of Human Services
Brenda Liestman, CentraCare
Paul Nistler, Upper Mississippi Mental Health Center
Larraine Pierce, Department of Human Services
Joan Stauffer, Volunteers of American on MN
Laura Weber, Canvas Health
Steve Wickelgren, LE-AST Services

Subcommittee 4. Data, Research and Evaluation

Chairs

Lynette Renner, University of Minnesota School of Social Work
Jon Roesler, Minnesota Department of Health

Members

Melissa Adolfson, EpiMachine LLC
Andrew Baker, Hennepin County Medical Examiner's Office
Iris Borowsky, University of Minnesota Department of Pediatrics
Bonnie Klimes-Dougan, University of Minnesota Department of Psychology
Amy Leite-Bennett, Hennepin County
Anna Lynn, Minnesota Department of Human Services
Jennifer McNertney, Minnesota Hospital Association
Jacob Melson, Great Lakes Inter-Tribal Epidemiology Center
Danielle Montoya-Barthelemy, Minnesota Department of Human Services
Pete Rode, Minnesota Department of Health
Joe Schindler, Minnesota Hospital Association
Darcie Thomsen, Amherst H. Wilder Foundation

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