DEPARTMENT OF HEALTH AND HOSPITALS

SUICIDE PREVENTION STRATEGIES

REPORT PREPARED IN RESPONSE TO HCR 15 OF THE 2013 REGULAR SESSION

FEBRUARY 1, 2014

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EXECUTIVE SUMMARY

The charge of House Concurrent Resolution 15 of the 2013 Regular Legislative Session is for the Department of Health and Hospitals (DHH) to study the most effective means to reduce suicide in Louisiana and to report its findings to the legislature. In conducting this study, the resolution stated that DHH may engage, collaborate with, and obtain information from stakeholder groups. DHH has thoroughly researched this issue and presents the following leading national strategies for suicide prevention. Also included in this report are the suicide prevention efforts currently in practice by DHH and other stakeholders in Louisiana.

This report is dedicated to the memory of Matthew Bison, whose tragic story of suicide inspires us all to strive harder and work more diligently to break down the barriers and taboos associated with suicide and reach out to persons suffering from suicide ideation and their families.

SUICIDE PREVENTION STRATEGIES

INTRODUCTION

Suicide is a prevailing, tragic health problem in the United States. Suicide is the 10th leading cause of death in the United States, claiming more than twice as many lives than homicide annually. In researching this public health issue, DHH studied several reports and initiatives both nationally and in the state of Louisiana. The leading guidance for national initiatives regarding suicide prevention, and the main source of material for this report, is derived from the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. This report is published by the U.S. Surgeon General's Office in conjunction with the National Action Alliance for Suicide Prevention. Statistics highlighted in this report bring clarity to the scope of this issue:

- On average, between 2001 and 2009, more than 33,000 Americans died each year as a result of suicide, which is more than 1 person every 15 minutes.
- More than 8 million adults report having serious thoughts of suicide in the past year, 2.5 million report making a suicide plan in the past year, and 1.1 million report a suicide attempt in the past year.
- Almost 16 percent of students in grades 9 to 12 report having seriously considered suicide, and 7.8 percent report having attempted suicide one or more times in the past 12 months

(U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012)

The American Association of Suicidology's 2010 report ranks Louisiana #34 in the country for rates of suicide at 12.3 per 100,000 people, placing it in the lower quartile with fewer suicides than other states (Drapeau & McIntosh , 2012).

The following populations have statistically higher rates of suicidal behaviors (not in ranking order):

- Persons with mental and/or substance use disorders
- Persons bereaved by suicide or have previously attempted suicide themselves
- Persons in justice and child welfare settings
- Persons who inflict non-suicidal self-injury
- Persons with medical conditions
- Persons who are lesbian, gay, bisexual, or transgender (LGBT)
- American Indians/Alaska Natives
- Members of the Armed Forces and veterans
- Middle-aged and older adults (age 65 and older)
  (U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

Although these groups have an increased risk for suicidal behaviors, the goals and objectives of the National Strategy do not focus on specific populations or settings. Rather, they are meant to be adapted to meet the distinctive needs of each group. Within the National Strategy for Suicide Prevention report, there are four main directives for suicide prevention:

1. Create supportive environments that promote healthy and empowered individuals, families, and communities;
2. Enhance clinical and community preventive services;
3. Promote the availability of timely treatment and support services; and
4. Improve suicide prevention surveillance collection, research, and evaluation.

A copy of the full National Strategy for Suicide Prevention report can be accessed at:
www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

This HCR 15 report includes a brief explanation of warning signs that the public should be cognizant of regarding suicidal behaviors and further details on the National Strategy, including recommendations to States about assisting those who are suffering or have suffered from suicide ideation in the past. Information regarding national and Louisiana initiatives undertaken in response to the National Strategy's directives is included in each section of this report.

WARNING SIGNS OF SUICIDAL BEHAVIORS

It is important to focus on fostering positive public dialogue and building public support concerning suicide prevention, including countering the traditional feelings of shame, prejudice, and silence that surround the issue. Part of accomplishing this is to ensure broad based understanding of the warning signs for suicidal behavior and the potential actions one can take to respond which are summarized in the table below.

Common warning signs of suicidal behaviors:

- Talking about wanting to die, feelings of hopelessness, being trapped, or in pain, or feelings of being a burden to others
- Looking for a way to kill oneself, including increased use of alcohol or drugs
- Acting anxious, agitated, or reckless
- Sleeping too little or too much, withdrawing or feeling isolated

Actions to take if you believe someone is at risk of suicide:

- Ask them if they are thinking about killing themselves. Contrary to popular belief this will not put the idea into their heads, or make it more likely that they will attempt suicide
- 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 behavioral health professional
- Remove any objects that could be used in a suicide attempt

(U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

In addition, activities that address the needs of vulnerable groups, to eliminate disparities, and to tailor treatment to the cultural and situational circumstances of the individual are critical to suicide prevention efforts. The most recent knowledge base for suicide prevention methods should be utilized in conjunction with existing efforts that address the public, physical and behavioral health needs of the person through continuity of care. Additionally, families and friends, stakeholders, clinicians, and others should find methods to reduce access to lethal means among individuals with identified suicide risks as a way to avoid potentially hazardous situations.

NATIONAL STRATEGY DIRECTIVE 1
CREATE SUPPORTIVE ENVIRONMENTS THAT PROMOTE HEALTHY AND EMPOWERED INDIVIDUALS, FAMILIES, AND COMMUNITIES

Suicide shares risks and protective factors with mental and substance use disorders, trauma, and other types of violence, such as bullying and domestic violence. Eliminating the biases and prejudices associated with suicidal behaviors, mental and substance use disorders, and exposure to violence is a key area of focus within this directive. Emphasizing that recovery is possible is essential. Communication efforts, such as campaigns and social marketing interventions, can play an important role in changing knowledge, attitudes, and behaviors to promote suicide prevention. Safe and positive messages addressing mental illness, substance use, and suicide can help reduce prejudice and promote help seeking.

NATIONAL FOCUS:

Below are some current national initiatives, programs and trends that respond to this directive:

- The military has made many changes to contribute to creating an environment that fosters help seeking behavior among service personnel who are thinking of suicide. This has included activities such as:
    - Creating the veteran's option on the National Suicide Prevention Lifeline so that veterans will be able to speak directly with other veterans. The Veteran's Administration (VA) protocol is for the Lifeline veteran to contact law enforcement to intervene in active suicide attempts with follow up support from the local VA.
    - Establishing a VA suicide prevention coordinator for each state who facilitates interventions and training for service personnel and other gatekeepers of the military population. The VA prevention coordinator for Louisiana is April Foreman, Ph.D.

- Training service personnel as suicide prevention/intervention trainers. This train the trainer model allows for expansion of service personnel who are alert to signs of suicide and can act at gatekeepers that are able to link the person at-risk to helpful resources that can intervene.
- Creating a VA suicide prevention manual and developing training materials for civilian clinicians on issues impacting service personnel and military culture in preparation for the return home of individuals who are currently deployed.
  - The number of male veterans under the age of 30 who commit suicide jumped by 44 percent between 2009 and 2011, which is the most recent year data has been made available. Suicide rates for female veterans also increased by 11 percent between 2009 and 2011 (Kemp & Bossarte, 2012).
  - The suicide rate among veterans remains well above that for the general population, with roughly 22 former servicemen and women committing suicide every day. However, VA officials have seen decreases in the suicide rates of veterans who seek care within the VA health system. Of the 22 deaths a day, only about five are patients in the health system (Kemp & Bossarte, 2012).

- There is a growing trend toward utilizing "Postvention as Prevention." Individuals who have survived the loss of someone close to them from suicide are at higher risk of dying by suicide themselves. Postvention refers to assisting the people surrounding suicide victims through their own grief recovery process and working to minimize their personal risk of dying by suicide him/herself. Postvention includes activities such as providing support for families at the scene of a suicide, letting them know what to expect and what resources are available to them when they are ready, and support groups.
- There are increased efforts to use social media and online resources. The National Suicide Prevention Lifeline has been piloting "Crisis Chat" services. This allows an individual to chat online about their crisis with a trained responder. Youth and young adults tend to be high users of this service; they are comfortable sharing personal information online. Additionally, suicide response content is appearing on Facebook, Twitter, etc. Facebook has a mechanism to alert the National Suicide Prevention Lifeline when someone posts suicidal content on line, and there has been some professional networking about suicide on Twitter.
- Resources from reputable sources about suicide are readily available online. The Suicide Prevention Resource Center (SPRC) is a Substance Abuse & Mental Health Services Administration (SAMHSA) sponsored entity that has several fact sheets and guides for different gatekeeper groups, including online trainings. There are also many other sources of information including the American Association of Suicidology (AAS), the Suicide Prevention Action Network (SPAN), and the American Foundation for Suicide Prevention (AFSP). Several of these groups also make policy recommendations about suicide.
- There is a national trend where suicide is now being addressed as a public health issue. Public health strategies toward suicide prevention include national initiatives to reduce access to means to kill oneself, as well as, education and information dissemination on suicide causality, issues, and prevention. The Harvard School of Public Health advocates for this strategy and created the free online Counseling on Access to Lethal Means (CALM) course that is posted on the Suicide Prevention Resource Center's (SPRC) website (http://www.sprc.org).
- In efforts to curb the rates of youth suicide, many states have adopted legislation relating to suicide in the school system. Some states mandate training school personnel so that all staff is more alert to when a student might be thinking of suicide and how to connect them to resources; some have also enacted legislation on anti-bullying.

The National Strategy report recommends that State and Local Governments undertake the following actions in order to help meet this first directive:
Identify a lead agency to coordinate and convene public and private stakeholders, assess needs and resources, and develop and implement a comprehensive strategic suicide prevention plan.
Develop and implement an effective communications strategy for promoting mental health and emotional well-being that incorporates traditional and new media.
Disseminate *Recommendations for Reporting on Suicide* to news organizations.
Schools, Colleges, and Universities can: • Implement programs and policies to prevent abuse, bullying, violence, and social exclusion. • Implement programs and policies to build social connectedness and promote positive mental and emotional health. • Integrate information about the responsible depiction of suicide and suicide-related behaviors into the curricula of schools of journalism, film, and other communications disciplines.

(U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

LOUISIANA FOCUS:

Some Louisiana initiatives that respond to this directive include:

- Louisiana has implemented legislation on anti-bullying (R.S. 17:416 & 416.13) and legislation requiring training for school personnel on suicide prevention and how to connect students to resources (R.S. 17:282.4).
- OBH implemented the Louisiana Partnership for Youth Suicide Prevention (LPYSP) from 2006-2013 through funds awarded by SAMHSA under the Garret Lee Smith Memorial Act. The goal of LPYSP was to reduce youth suicides and suicidal behavior in Louisiana. This statewide project targeted approximately 15,000 youth and young adults ages 10-24 and the professionals that work with them; youth of that age group are at increased risk for suicidal ideation. The objectives of LPYSP were:
    1) promoting awareness that youth suicide is a public health problem;
    2) creating local leadership and sustainability through the development of local coalitions;
    3) increasing high quality peer support programs;
    4) expanding gatekeeper trainings;
    5) expanding Applied Suicide Intervention Skills Training (ASIST); and
    6) expanding and improving data collection systems.
- The LPYSP's media campaign included bus boards, billboards, print ads, and movie theater public service announcements statewide for the duration of the grant (31 billboards, PSA's in 19 theaters, 15 bus boards in New Orleans, and advertisements in 80 daily/weekly papers across state).
    - Each advertising message included the Lifeline hotline number.
    - DHH sponsored a Yellow Ribbon Youth Suicide Awareness and Prevention Week, which included a Walk for Youth Suicide Prevention, a state capitol rally, a poster/essay contest, health fairs, and a Suicide Prevention Conference with 10,907 participants.

- During the grant period from 2006-2013, educational information was disseminated to over 40,000 individuals at presentations, health fairs, trainings, prevention walks, etc.
- The LPYSP Grant ended on September 29, 2013. OBH did apply for a SAMSHA Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention Grant in June 2013, but did not receive funding. When the grant was ending, OBH used unspent funds to purchase materials to continue the gatekeeper trainings: safeTALK and ASIST. There is no specific OBH funding dedicated to Suicide Prevention. However, during the LPYSP Grant, OBH worked to build a sustainable trainer network. OBH developed a cadre of OBH staff (state-office and field) who can be mobilized to conduct safeTALK and ASIST trainings at no additional cost.

NATIONAL STRATEGY DIRECTIVE 2
ENHANCE CLINICAL AND COMMUNITY PREVENTIVE SERVICES

Clinical and community-based programs play a key role in promoting wellness, resiliency, and preventing suicidal behaviors among various groups. Clinical preventive services, including suicide assessment and screening by health care providers, are crucial to assessing suicide risk and connecting individuals to available clinical services and other treatment options. A wide range of community partners, including schools, workplaces, and faith-based organizations, also have an important role in delivering prevention services at the local level. Greater coordination among community and clinical prevention providers can have positive effects in preventing suicide and related behaviors.

NATIONAL FOCUS:

Some current national initiatives and/or programs to address this objective include:

- The Trevor Project is a national initiative targeted to address the Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) population, ages 13-24, through multiple mechanisms and via multiple media sources, including a presence on Facebook and Twitter and free, online interactive trainings. Youth can reach out with their concerns via the 24/7 hotline, TrevorText, or TrevorChat to a trained responder. This group has also developed training modules for suicide prevention specifically aimed at this population, including modules for university campuses, younger youth, and to educate adults about issues LGBTQ youth face.
- There are multiple reputable organizations creating and disseminating information about suicide via websites, fact sheets, and guides for specific gatekeeper groups. Educational information includes regular electronic bulletins or newsletters and trainings (Lifeline, AAS, SPAN, AFSP, etc.). The Suicide Prevention Resource Center (SPRC) is actively soliciting different groups for what information/education they need and adapting new materials for these groups.

The National Strategy report recommends that State and Local Governments undertake the following actions in order to help meet this second directive:
Identify groups at risk and work with various stakeholders to implement suicide prevention policies and programs that address the needs of these groups.
Sponsor trainings and disseminate information on means restriction to mental health providers, professional associations, and patients and their families.
Sponsor medication take-back days and ongoing methods for the disposal of unwanted medications (e.g., secure collection kiosks at police departments or pharmacies).
Schools, Colleges, and Universities can: • Ensure that students at-risk of suicide have access to mental health and counseling services and are encouraged to use those services. • Train relevant school staff to recognize students at potential risk of suicide and refer to appropriate services. • Integrate appropriate core suicide prevention competencies into relevant curricula (e.g., nursing, medicine, allied health, pharmacy, social work, education)
Individuals and families can: • Learn the signs and symptoms of suicide and suicidal behaviors and how to reach out to those who may be at risk. • Store household firearms locked and unloaded with ammunition locked separately and take additional measures if a household member is at high risk for suicide. • Dispose of unwanted medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g., a medication lock box) if a member of the household is at high risk for suicide.

(U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

LOUISIANA FOCUS:

Some Louisiana initiatives that respond to this directive include:

- With the implementation of the Louisiana Partnership for Youth Suicide Prevention (LPYSP), trainings in suicide prevention, awareness, and intervention were conducted for gatekeepers, who are those most likely to come in contact with youth who are suicidal. This included four thousand-five hundred-sixty-six (4,566) students, professionals and other community members that were trained as gatekeepers.
- Additionally, since First Responders are more at-risk due to the traumatic events they witness, there were three hundred-eighty (380) Baton Rouge firemen trained in safeTALK. SafeTALK teaches members of the community to recognize people with thoughts of suicide and to connect them to suicide first aid resources. This half-day workshop was developed by Living Works Education (a Canadian public service company dedicated to suicide). SafeTALK typically precedes the 2-day ASIST workshop (Applied Suicide Intervention Skills Training) and offers a carefully crafted set of steps that makes it possible for attendees to leave the training willing and able to be suicide alert helpers.
- Peer helper programs were established and implemented in 26 schools. In these programs, students were trained to recognize signs and symptoms of suicide and given information about where they could get help. Additionally, as peers, they were trained not to keep promises of "don't tell anyone" when friends who are thinking of suicide confide in them.

- Under the grant, 32 individuals were trained as ASIST trainers and 14 individuals were trained as safeTALK trainers. Individuals were trained all over the state so that each area of the state had its own cadre of trainers who could train others going forward. These trainings can still be offered on an ongoing basis using the existing cadre of trainers.

NATIONAL STRATEGY DIRECTIVE 3
PROMOTE THE AVAILABILITY OF TIMELY TREATMENT AND SUPPORT SERVICES

Individuals at high risk for suicide require clinical evaluation and care to identify and treat behavioral health, medical conditions, and to specifically address suicide risk. Evidence-based approaches include safety planning (i.e., working collaboratively with each patient to develop an action plan for times of crises) and specific forms of psychotherapy that can be used to support treatment for underlying behavioral health conditions. Addressing suicide risk is particularly important when treating individuals who have survived a suicide attempt. According to the National Strategy, care for individuals with high suicide risk should include the following tenets:

- Involve the individual in the development of their own safety plan, and provide care that is matched to the person's level of risk, needs, and preferences according to an evidence-based treatment model;
- Address the cultural issues of the client in the plan of care including linguistic, racial/ethnic, sexual, and gender;
- Provide multiple points of access to appropriate treatment in the least restrictive environment;
- Integrate care across various systems and share client outcomes data amongst providers/caregivers;
- Focus on continuity of care and follow-up after discharge from treatment; and
- Empower and involve families in treatment, peer support, and post-discharge follow-up.

NATIONAL FOCUS:

Some current national initiatives and/or programs to address this objective include:

- Widely disseminate information on the National Suicide Prevention Lifeline. This single number routes calls to certified crisis call centers in the Lifeline network that are nearest the caller based on the area code and exchange numbers. Local call centers are more knowledgeable about local suicide prevention/intervention resources and can provide referrals to them. There is also a three tier back up system for call centers so that if the first call center is busy, it will roll over to a 2nd and 3rd call center without dropping the call. This increases the likelihood of callers being able to reach a trained crisis counselor without having to be put on hold or wait to be called back.
- There are some communities developing protocols to collaborate with other community partners in responding to a suicide death. One model involves a team being called out by law enforcement and/or coroner's offices to the site where someone has killed themselves. This team can let families know what they may experience and what resources are available to them when they are ready. The teams tend to be survivors who have lost a loved one to suicide and/or trained counselors.

- Due to continuing stigmatization of suicide, the loved ones left behind can find it difficult to share their experiences with people who have not been likewise impacted. That is why increasing utilization of support groups for family and friends of individuals who have committed suicide is essential. There is a healing comfort that happens when survivors can share with others that empathize. Individuals who are further along in their own grieving process can convey the message of "it will get better" to new survivors, and this instills hope for the new survivor. Survivors of others' suicides have been instrumental in creating materials for the general public about beneficial vs. detrimental practices when responding to survivors, and they are strong advocates for suicide prevention policies, practices and programs.
- Increasing the number of gatekeepers who are alert to signs that someone might be suicidal and knowing who in their communities can help is a common strategy. One way to increase these numbers is to develop a cadre of trainers who can train others in how to recognize and respond to someone at-risk for suicide.

The National Strategy report recommends that State and Local Governments undertake the following actions in order to help meet this third directive:
Disseminate information about the National Suicide Prevention Lifeline and other local or regional crisis lines.
Promote the availability of online support services and crisis outreach teams.
Develop protocols and improve collaboration among crisis centers, law enforcement, mobile crisis teams, and social services to ensure timely access to care for individuals with suicide risk.
Schools, Colleges, and Universities can educate students who are in training to become mental health, social service, or health care providers on the identification and treatment of individuals at high risk for suicide.

(U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

LOUISIANA FOCUS:

Some Louisiana initiatives that respond to this directive include:

- The Baton Rouge Crisis Intervention Center, under the directorship of national expert, Dr. Frank Campbell, developed a LOSS (Local Outreach to Suicide Survivors) team (http://lossteam.com) that has become a model for others relative to immediate, initial contact after a suicide. The LOSS team increases the probability of families and friends of the individual who committed suicide reaching out for help during the grieving process and starts necessary postvention activities.
- In efforts to expand support services for the friends and family of individuals who have committed suicide, the Louisiana Partnership for Youth Suicide Prevention (LPYSP) sponsored a training on Postvention and Survivors of Others' Suicide support groups. The goal was to train others to be able to provide postvention services in response to completed suicides in their areas and on how to develop Survivor Support Groups. Individuals from each area of the state were trained so that each area would have the capacity to increase support to this at-risk population.

- Infrastructure development and coalition building was also a focus of the LPYSP. As a result, eight (8) coalitions were established in East Baton Rouge, Calcasieu, Lafayette, Caddo, Ouachita, Morehouse, Orleans and Jefferson Parishes. Individuals interested in preventing and intervening with suicide came together to contribute to safer communities. These coalitions reached over 20,000 individuals with general awareness educational presentations. Some of these coalitions still exist and work together in their areas. OBH State Prevention Program Managers work closely with the Prevention Coordinators in each Local Governing Entity (LGE) and monitor coalition activities and needed suicide prevention trainings during quarterly site visits. Technical assistance and resources are available to the LGEs through these OBH Program Managers who continue to work with the LGEs through scheduling and conducting ongoing ASIST and safeTALK trainings.
- Through the LPYSP, two thousand-two hundred-eighty (2,280) youth were screened for depression and past or current suicidal ideation during the grant period of 2006-2012. Those that scored positive were referred for counseling. Screenings were provided in areas of the state identified with higher suicide risk or areas where there were recent suicides (i.e. Ouachita, Morehouse and East Baton Rouge parishes).

NATIONAL STRATEGY DIRECTIVE 4
IMPROVE SUICIDE PREVENTION SURVEILLANCE COLLECTION, RESEARCH, AND EVALUATION

There has been substantial improvement in recent years relative to suicide-related surveillance, research, and evaluation. However, additional efforts are needed to inform and guide suicide prevention efforts nationwide. As such, the collection and integration of surveillance data should be expanded and improved. Additionally, although some evidence is available regarding the effectiveness of particular interventions and approaches, there is a need to assess the effectiveness of new and promising practices.

NATIONAL FOCUS:

In addition to the National Strategy, there are several other national research and evaluation initiatives regarding suicide prevention. Some of these include:

- Attempts to evaluate suicide prevention programs by SAMHSA: The Suicide Prevention Resource Center evaluates suicide prevention programs and maintains information on these different programs on their website. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) maintains information on evidence-based prevention programs specifically targeted at suicide prevention.
- The Centers for Disease Control and Prevention (CDC) maintains national suicide data. The final data for a year is released three years after the calendar year ends. The data is then utilized by others in their prevention and research efforts.

The National Strategy report recommends that State and Local Governments undertake the following actions in order to help meet this fourth directive:
Analyze and identify strategies to increase the efficiency of state-based processes for certifying, amending, and reporting vital records related to suicide deaths.
Implement the Center for Disease Control's action plan for improving external cause of injury coding.
Adopt recommended self-directed violence uniform definitions and data elements developed by the CDC and Veteran's Affairs.
Improve data linkage across agencies and organizations, including hospitals, psychiatric and other medical institutions, and police departments, to better capture information on suicide attempts.
Schools, Colleges, and Universities can conduct research to identify new, effective policy and program interventions to reduce suicide and suicidal behavior, and share suicide-related research findings with state and local suicide prevention coalitions, health care providers, and other relevant practitioners.

(U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

LOUISIANA FOCUS:

Specifically in Louisiana, the Department of Health and Hospitals' Office of Public Health, Center for Vital Records & Statistics collects state data regarding suicide-related deaths and provides this information when requested.

Additionally, since 1998, DHH's Office of Behavioral Health (OBH) has co-sponsored the Louisiana Caring Communities Youth Survey (CCYS) with the Louisiana Department of Education. The CCYS surveys students in grades 6, 8, 10, and 12 statewide. The survey was developed to measure students' involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors. The survey is conducted every two years. In 2010, additional questions were added to collect data specific to depressive symptoms. In 2012, the survey was further expanded by the addition of questions related to previous suicide attempts and the impact of suicide to respondent's life. Collecting such data will allow for school and community planning activities regarding suicide prevention and intervention. Specific survey data from the CCYS 2012 statewide report can be found as an addendum with this report. The CCYS will be conducted again in 2014 with no additional questions to be added at this time.

Magellan of Louisiana is the access point for the state's behavioral health services. Magellan's access line is manned 24/7.

FIREARM SAFETY

In response to the resolution author's specific request for correlations between mental health, suicide, and gun control, DHH has included the following source material for review:

Federal law under 18 U.S.C. 922(g) prohibits any person from purchasing a firearm who is an unlawful user of or addicted to any controlled substance or who the court has adjudicated as a mental defective or who has been committed to a mental institution. The current law in Louisiana regarding this issue went into effect on January 1, 2014, under R.S. 13:753, which states "Each district clerk of court shall report to the Louisiana Supreme Court for reporting to the National Instant Criminal Background Check System [NICBCS] database the name and other identifying information of any adult who is prohibited from possessing a firearm pursuant to the laws of this state or 18 U.S.C. 922…[for] adjudication in a court of that district for any of the following:"

- An acquittal of a felony crime by reason of insanity;
- A court determination that a person is mentally incompetent to stand criminal trial; or
- A court order requiring that a person be involuntarily committed to an inpatient mental health treatment facility as per R.S. 28:54 (civil commitment).

The statute further requires that the report be submitted within ten business days of the date of conviction, adjudication, or order of involuntary commitment. In return, the Supreme Court must submit the information to the NICBCS database within fifteen business days after receiving the report.

The National Strategy recommends partnering with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership. The Harvard School of Public Health has implemented a project titled Means Matter (http://www.hsph.harvard.edu/means-matter/), which researches the impact of reducing access to lethal means on suicide attempts. For example, New Hampshire successfully piloted a project with Means Matter to involve gun owners and gun sellers in suicide prevention efforts. Guidelines on how to avoid selling or renting a firearm to a suicidal customer were shared with gun sellers, and gun stores and firing ranges were encouraged to display and distribute suicide prevention materials tailored to their customers. The program provided gun owners and sellers with training on how to recognize when someone was suicidal and utilized them as a resource to help distribute information about accessing the National Suicide Prevention Lifeline.

Below are national statistics regarding suicide and firearms gathered by the CDC in its 2010 National Hospital Ambulatory Medical Care Survey:

All suicides	
Number of deaths:	38,364
Deaths per 100,000 population:	12.4
Cause of death rank:	10
Firearm suicides	
Number of deaths:	19,392
Deaths per 100,000 population:	6.3
Percentage of overall suicides:	50.5%

(National Hospital Ambulatory Medical Care Survey: 2010 Emergency Department Summary Tables, 2010)

CONCLUSION

The Department of Health and Hospitals remains committed to the prevention of suicide and suicide ideation throughout Louisiana. There have been several key initiatives undertaken in Louisiana that are aimed at reducing rates of suicide and working toward increasing suicide prevention awareness and training. These programs have laid vital infrastructure for the state's overall positive impact on suicide rates as shown by the Louisiana Caring Communities Youth Survey (CCYS) with declining depressive symptoms in middle and high school students. This is primarily attributable to the prevention efforts implemented through the aforementioned activities and the dedicated work of suicide prevention specialists to create a solid foundation for future activities and programs in this field. DHH strives to reach out to those in need and continues to break down barriers to receiving necessary assistance and services. Through continual study of new and innovative national and state prevention strategies and initiatives, DHH hopes to assist others like Matthew Bison and prevent further suicide tragedies.

ACKNOWLEDGMENTS

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ADDENDUM

Table 11. Percent of Students Responding to Mental Health and Suicide Indicators

		Grade 6	Grade 8	Grade 10	Grade 12
		State 2012	State 2012	State 2012	State 2012
Needs Mental Health Treatment (Scored 13 or more points on the K6 screening scale for psychological distress. See text for further explanation.)		16.8	19.4	19.8	17.7
Have you ever been impacted by someone's suicide? (Percentage of students who answered "Yes.")		15.4	22.9	26.7	26.4
If you marked "Yes" on the question above, please rate on a scale of 1-5 how it impacted you.	1 (It had no effect on me.)	6.5	3.5	3.2	2.6
	2 (It had little effect on me.)	15.0	12.6	11.9	11.2
	3 (It had some effect on me.)	22.2	29.0	29.7	31.9
	4 (It had considerable effect on me.)	18.6	22.3	24.8	24.8
	5 (It had great effect on me.)	37.7	32.6	30.4	29.4
Has there ever been a time in your life when you experienced a loss by suicide? (Answered "Yes")		14.3	18.5	20.4	20.6
If you marked "yes" on the question above, how long ago did the suicide happen?*	Within the last year.	70.1	78.6	80.5	82.5
	Within the past two or three months (60-90 days)	20.3	15.2	13.6	12.6
	In the past month (30 days).	9.6	6.1	5.9	5.0
If you marked "yes" on the question above, was the loss a blood relative or friend? (Mark all that apply)*	Friend/peer	3.6	6.3	8.8	10.2
	Blood relative	4.4	5.1	4.7	4.3
	Friend/family	4.6	5.5	5.6	5.0
	Best friend	1.2	2.1	1.9	1.3
If you marked "yes" to the question above, have you spoken to anyone about your loss?*	No	49.7	52.8	53.0	46.5
	Yes	50.3	47.2	47.0	53.5
Have you ever considered attempting suicide? (Answered "Yes")		11.6	22.3	26.4	24.4
Have you ever attempted suicide? (Answered "Yes")		3.8	7.1	8.9	8.0
Are you currently taking any medication that was prescribed for you because you had problems with your behavior or emotions? (Answered "Yes")		16.3	14.5	11.8	10.5

		Grade 6			Grade 8			Grade 10			Grade 12		
		State 2008	State 2010	State 2012	State 2008	State 2010	State 2012	State 2008	State 2010	State 2012	State 2008	State 2010	State 2012
Depressive Symptoms Calculation**	High Depressive Symptoms	2.7	2.4	2.1	4.3	4.4	3.5	3.7	4.3	3.1	2.5	2.4	1.9
	Moderate Depressive Symptoms	79.2	76.7	70.1	75.5	73.1	68.5	75.4	74.8	69.9	72.1	70.9	67.2
	No Depressive Symptoms	18.1	20.9	27.8	20.1	22.5	27.9	20.9	21.0	27.0	25.4	26.7	30.8

*Not all students that answered "Yes" to the question "Has there ever been a time in your life when you experienced a loss by suicide?" answered this question. Responses to this question are based upon the students that answered "Yes" to the question above AND this question.

**Calculated from student responses to four depressive symptoms questions. See text for further explanation.

Source: 2012 Caring Communities Youth Survey (CCYS) Report
http://www.picardcenter.org/ResearchAreas/QualityOfLife/CCYS/Documents/2012%20State%20of%20Louisiana%20Profile%20Report.pdf