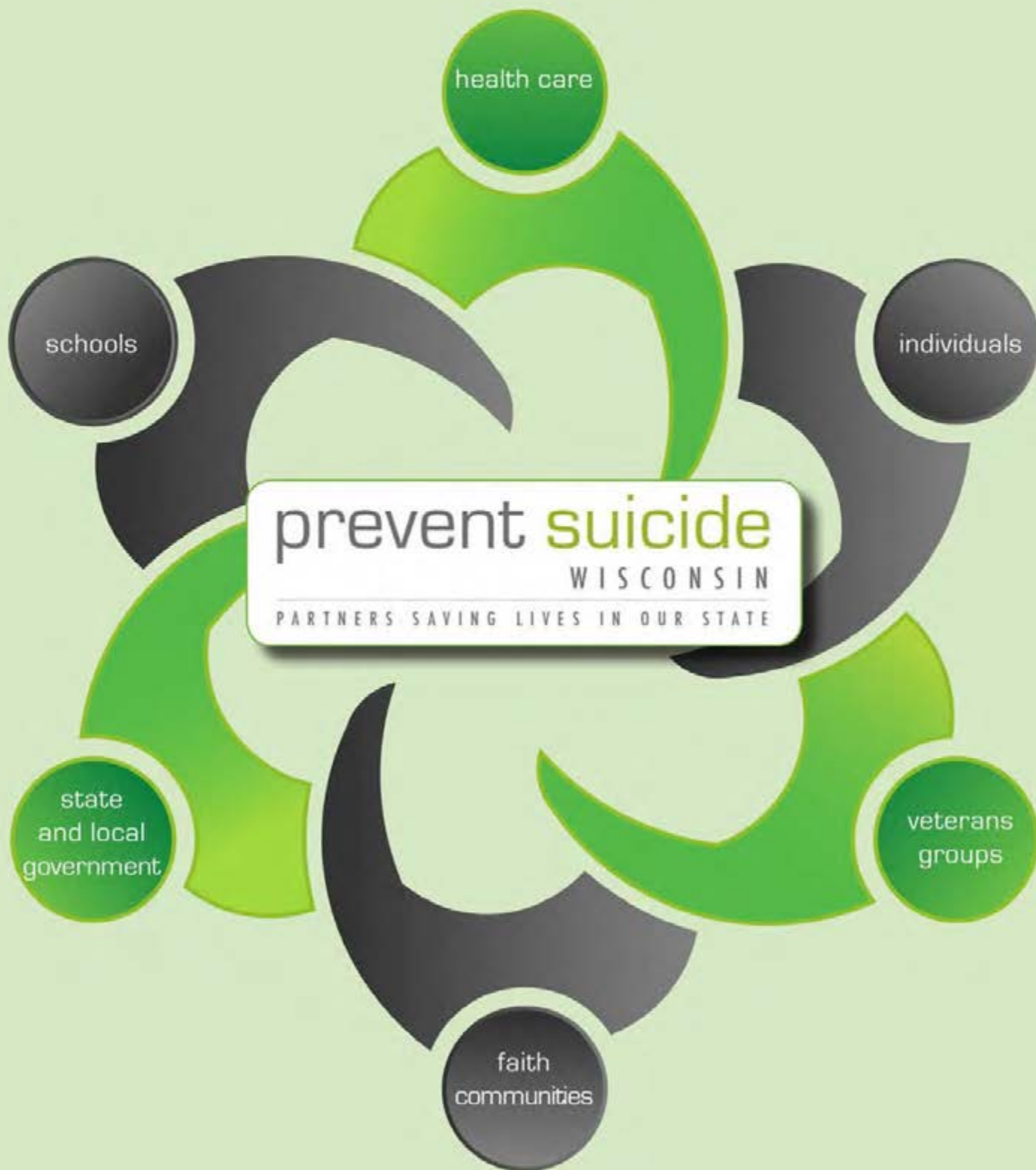


# WISCONSIN SUICIDE PREVENTION STRATEGY

Released 2015



## Everyone Plays a Role in Suicide Prevention

The Wisconsin Suicide Prevention Strategy is for you.

Whatever you do, wherever you live, work or play in Wisconsin, you can have a role in preventing suicide. And this plan can help. Find resources for yourself and for the groups listed below from Prevent Suicide Wisconsin at: [www.preventsuicidewi.org](http://www.preventsuicidewi.org)

**Individuals:** Anyone can learn about how to recognize the warning signs of suicide and how to respond to a loved one, friend, or neighbor who may be in pain.

**Local Suicide Prevention and Public Health Coalitions:** Work at your local level to establish plans and priorities for suicide prevention using the Wisconsin Suicide Prevention Strategy as a guide.

**State and County Policy Makers:** Make suicide prevention a priority and seek to align funding opportunities to be consistent with the goals and objectives of the Wisconsin Suicide Prevention Strategy.

**Health and Behavioral Health Care Organizations:** Learn about the Zero Suicide movement and how you can create systemic changes to impact suicide among the populations you serve. Screen patients, train clinicians in best practices for assessing and treating suicidal individuals, and promote reducing access to lethal means.

**Workplaces:** Train supervisors and managers to recognize signs of suicide and have protocols in place for supporting employees who may be at risk.

**Schools:** Educate your staffs on suicide. Have protocols in place for responding to students who may be suicidal. Educate students about how to recognize and respond to peers who may be suicidal. Support social-emotional development and problem-solving skill development to protect against suicide.

**Faith Organizations:** Have your leaders and members learn how to recognize and respond to those in your congregation who may be suicidal. Dedicate one service each year for educating your community about suicide.

Do you know or work with:

- People experiencing interpersonal problems or going through divorce?
- People facing challenges with their health, job, finances, or housing?
- Veterans or service members?
- People who are gay, lesbian, bisexual, or transgender?
- People with alcohol or other substance use issues?

All of these are among the groups at elevated risk of suicide (see Appendix 3). Learn more at: [www.preventsuicidewi.org](http://www.preventsuicidewi.org)

**If you or someone you know is in crisis, contact the National Suicide Prevention Lifeline**



**Introduction . . . . . 4**  
 Vision and Mission . . . . . 4  
 Background . . . . . 4  
 Plan Development . . . . . 5

**Overview. . . . . 6**  
 Table of Goals and Objectives . . . . . 7  
 Suicide Data. . . . . 7

**Goals and Objectives. . . . . 10**  
 Goal 1: Increase and enhance protective factors . . . . . 10  
 Goal 2: Increase access to care for at-risk populations . . . . . 16  
 Goal 3: Implement best practices for suicide prevention within the health care system . . . . . 20  
 Goal 4: Improve monitoring and evaluation of suicide and suicide prevention activities . . . . . 23

**References . . . . . 26**

**Appendices . . . . . 27**  
 Appendix 1: Key Wisconsin Accomplishments to Date . . . . . 27  
 Appendix 2: Prevent Suicide Wisconsin Steering Committee Members . . . . . 28  
 Appendix 3: Key Findings from *The Burden of Suicide in Wisconsin 2007-2011* . . . . . 29

## Introduction

### Vision and Mission

**Vision: Zero Suicide in Wisconsin. If zero isn't the right number, what is?**

The Zero Suicide vision of the Wisconsin Suicide Prevention Strategy is grounded in some of the most provocative and encouraging systematic efforts to prevent suicide. A systems approach focuses on quality improvement rather than blame when suicide attempts and deaths do occur. It also emphasizes the potential in improving systems as a whole instead of relying solely on the efforts of individuals. It is important to acknowledge that suicide-related events will occur, but it is critical to make a fundamental shift away from accepting suicide as an occasional consequence of mental health issues. While the goal of zero suicide was developed for health care entities serving defined populations, such as HMO members, the core principles of Zero Suicide — especially the belief that suicide is preventable — must permeate and inform all efforts in order to reduce suicide in Wisconsin. (See Goal 3 of this plan for further information on Zero Suicide.)

**Mission: Increase the effectiveness and sustainability of suicide prevention programming at the state and local levels in Wisconsin.**

The Wisconsin Suicide Prevention Strategy is designed to increase the effectiveness of suicide prevention efforts by focusing on a reasonable set of goals that will promote widespread use of evidence-based and best practices for suicide prevention in Wisconsin. The aim is to reach “saturation” levels of these practices, whereas they are currently “sprinkled” across the state reducing their impact. For example, training clinicians in assessing and treating their clients who are suicidal should not be encouraged in one community but not another. It should be happening all across Wisconsin. By working with state agencies, local suicide prevention coalitions, as well as other partners and interested individuals, this plan is intended to mobilize coordinated, effective efforts to address suicide. The plan’s progress toward these aims will be monitored by the Department of Health Services’ contractor for suicide prevention services, currently Mental Health America of Wisconsin, which will also facilitate contributions from the Prevent Suicide Wisconsin Steering Committee.

The Wisconsin Suicide Prevention Strategy assumes continued direction through the Prevent Suicide Wisconsin Steering Committee and continued support to local suicide prevention coalitions, through which many of the components of this plan will be implemented. This support may include, but is not limited to:

- The annual Communities in Action to Prevent Suicide Conference.
- Regular teleconference calls to provide education to local coalitions and support networking.
- Maintenance of the Prevent Suicide Wisconsin Listserv and website.
- Opportunities for funding through grants, mini-grants, or special projects.
- Support to expand implementation of Zero Suicide initiatives in health care organizations throughout Wisconsin.
- Other types of technical assistance and training.

### Background

The *Wisconsin Suicide Prevention Strategy* was first released in 2002, following the initial *National Strategy for Suicide Prevention*. The following statement from Richard McKeon, Chief of the Suicide Prevention Branch at the federal Substance Abuse and Mental Health Services Administration, captures the state of suicide prevention at the time:

“Over the decades, individual [mental health] clinicians have made heroic efforts to save lives... but systems of care have done very little.”

At that time, there were 30,000 deaths by suicide per year in the United States, about 650 per year in Wisconsin. There was no infrastructure in place to address suicide prevention, with a limited selection of evidence-based programs and few other tools. The systemic approaches that existed, such as the efforts by the Wisconsin Department of Public Instruction in support of state laws that require youth be educated about suicide prevention, as well as the training and technical assistance provided to local organizations by a relatively new group of survivors of suicide, HOPES (Helping Others Prevent and Educate about Suicide), were in their early stages of development. It was true at the time that if someone called a state agency or non-profit organization asking what their community should do in the aftermath of a suicide, no one had a clear answer.

Thirteen years later a great deal has changed in the knowledge about suicide prevention, resources, tools, programs, and infrastructure. Wisconsin's accomplishments are summarized in Appendix 1. A considerable statewide infrastructure has been developed to support suicide prevention. There are now agencies and organizations that can respond clearly and knowledgeably to that call for help in the aftermath of a suicide. In addition, training exists for mental health and substance use professionals on screening, assessing, and managing suicidal clients. Recognition and response competencies are being built into many systems, including public instruction, child welfare, criminal justice, public health, and health care. Reducing access to lethal means is being accepted as an important evidence-based practice. That is the good news. The bad news is that suicides have increased to over 700 per year in Wisconsin, a trend that mirrors what has been happening nationally.

This Wisconsin Suicide Prevention Strategy calls for a smarter, more intentional investment of state and community resources to save lives. Experience, research, and science in the past 13 years have led to strategies to make this happen.

- The work of hundreds of people in Wisconsin at the state and local level to strengthen suicide prevention efforts.
- A 2014 report, *The Burden of Suicide in Wisconsin 2007-2011*, which represents the most up-to-date picture of who is dying by suicide, how they are dying by suicide, and the circumstances that may be associated with those deaths.
- The updated *National Strategy for Suicide Prevention* released in 2012.
- The work of the National Action Alliance for Suicide Prevention.
- The ever-growing list of evidence-based and best practices.

The goal of the Wisconsin Suicide Prevention Strategy is not to try to do everything, but to focus on a manageable list of objectives that respond to the realities of suicide in Wisconsin and the interventions that have the best chance of achieving success here.

## Plan Development

The Wisconsin Suicide Prevention Strategy is a product of the Prevent Suicide Wisconsin (PSW) Steering Committee. PSW arose in 2009 when suicide prevention stakeholders from around the state identified the need to brand Wisconsin's suicide prevention efforts in order to give them more visibility. The PSW Steering Committee includes survivors of suicide loss and suicide attempts, representatives of local suicide prevention coalitions, representatives from the Department of Health Services and the Department of Public Instruction, as well as other stakeholders in suicide prevention efforts. (See list of members in Appendix 2). This group meets quarterly and provides oversight to Wisconsin's suicide prevention efforts, including programs supported by state and federal grants. At a meeting in August 2013, this group identified initial ideas for this Wisconsin Suicide Prevention Strategy. The basic outline of the plan was accepted in August 2014, and the final version was approved in February 2015.

## Overview

An overview of the Wisconsin Suicide Prevention Strategy's goals and objectives can be found in the table on the following page.

The four goals align with the four strategic directions from the *National Strategy for Suicide Prevention*:

1. Healthy and Empowered Individuals, Families, and Communities
2. Clinical and Community Preventive Services
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation

Another way to think about the goals in more everyday language would be:

1. Reduce the likelihood that individuals will become suicidal.
2. Increase the likelihood that those who do become suicidal will be identified and have timely access to treatment and services.
3. Make sure that those services meet the highest standards of care.
4. Evaluate whether these efforts are making a difference.

The first three goals are also consistent with the prevention framework outlined by the Institute of Medicine. According to this framework, prevention activities can take place at three levels of specificity:

- ***Universal preventive interventions*** that target the general population without consideration of risk. These focus on preventing the development of risk for suicide by eliminating the underlying causes of risk for everyone.
- ***Selective preventive interventions*** utilize data to understand the characteristics associated with suicide to identify individuals at higher risk.
- ***Indicated preventive interventions*** focus on those showing signs of mental illness, or with suicidal thoughts or behavior, to address immediate risk and protective factors surrounding the individual.

## Wisconsin Suicide Prevention Strategy — Goals and Objectives

<b>GOAL 1: INCREASE AND ENHANCE PROTECTIVE FACTORS.</b>
A. Implement strategies that reduce the impact of adverse childhood experiences (ACEs) and promote social-emotional development in children.
B. Increase social connections.
C. Assist communities, families, and individuals in creating suicide-safe environments for people at risk of suicide.
<b>GOAL 2: INCREASE ACCESS TO CARE FOR AT-RISK POPULATIONS.</b>
A. Expand access to services for mental health and substance use disorders, as well as suicidal thoughts and behavior.
B. Decrease stigma associated with help-seeking, mental health and substance use disorders, and suicide through evidence-based and best practices, including contact with people in recovery.
C. Increase the public’s knowledge of risk factors for suicide, recognition of suicide warning signs, and preparedness to respond to suicidal individuals.
<b>GOAL 3: IMPLEMENT BEST PRACTICES FOR SUICIDE PREVENTION WITHIN THE HEALTH CARE SYSTEM.</b>
A. Increase resources for mental health and health care providers in screening, assessment, and treatment of mental health and substance use disorders, as well as suicidal thoughts and behavior.
B. Improve continuity of care for high-risk suicidal patients after emergency department visits and discharge from inpatient settings to community providers.
<b>GOAL 4: IMPROVE MONITORING AND EVALUATION OF SUICIDE AND SUICIDE PREVENTION ACTIVITIES.</b>
A. Use Wisconsin death certificate and violent death data to describe the burden of suicide in Wisconsin, improve data collection, and expand data linkages to further the understanding of suicide.
B. Use data to identify subpopulations at elevated risk of suicide in order to guide program efforts.
C. Evaluate interventions used to reduce suicide attempts and deaths in Wisconsin.

Table 1. Goals and Objectives.

### Suicide Data

The development of this plan was guided, in part, by *The Burden of Suicide in Wisconsin 2007-2011* report. The report, released in 2014, includes the most recent data available at the time. Data from this report is used here to provide background information on suicide and self-injury in Wisconsin. Data from this report is also used to illustrate the importance of the goals and objectives outlined in this plan. A full copy of *The Burden of Suicide in Wisconsin 2007-2011* report can be found at: [www.dhs.wisconsin.gov/publications/P0/p00648-2014.pdf](http://www.dhs.wisconsin.gov/publications/P0/p00648-2014.pdf)

The key findings from the report can be found in Appendix 3.

### Suicide Deaths

Suicide is a significant health problem in Wisconsin. It is the 11th leading cause of death in the state and the 2nd leading cause of deaths due to injury (Wisconsin Interactive Statistics for Health, “WISH”). From 2007 to 2011 there was an average of 724 suicide deaths annually. This is up from 649 average annual deaths from 2001-2006.

Men are at a greater risk of dying from suicide at all ages. The greatest risk of suicide for both sexes is age 45-54 and for men age 85+.

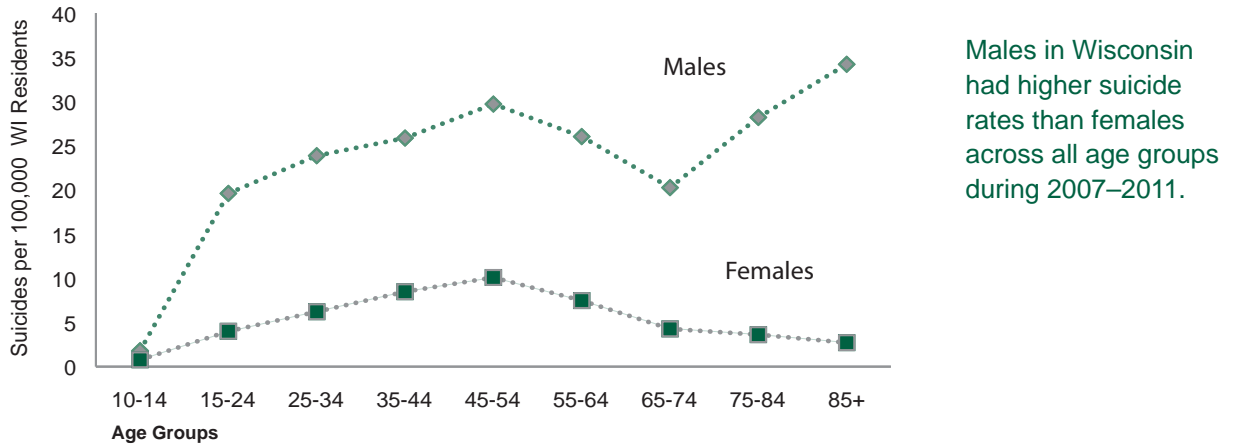


Figure 1. Suicide rates (per 100,000 Wisconsin residents) by age and sex, 2007-2011.

Demographic data from death certificates of suicide victims show other populations at risk. These include non-Hispanic Whites, American Indians, people with low educational attainment, veterans, divorced individuals, and those living in the northern and western regions of Wisconsin.

**Suicide Attempts and other Self-Inflicted Injuries**

Deaths by suicide represent only one element of the burden of suicide. For every suicide death there are more than 10 emergency department visits and hospitalizations related to self-inflicted injury.

Age and sex patterns differ between suicides and self-inflicted injuries as measured by emergency department visits and hospitalizations. Women are seen for suicide attempts and other self-injuries more often than men. Teens and young adults are seen for suicide attempts and other self-injuries at higher rates than any other age group. Survey data indicates that females and racial and sexual minority youth are disproportionately burdened by suicidal thoughts and suicide attempts.

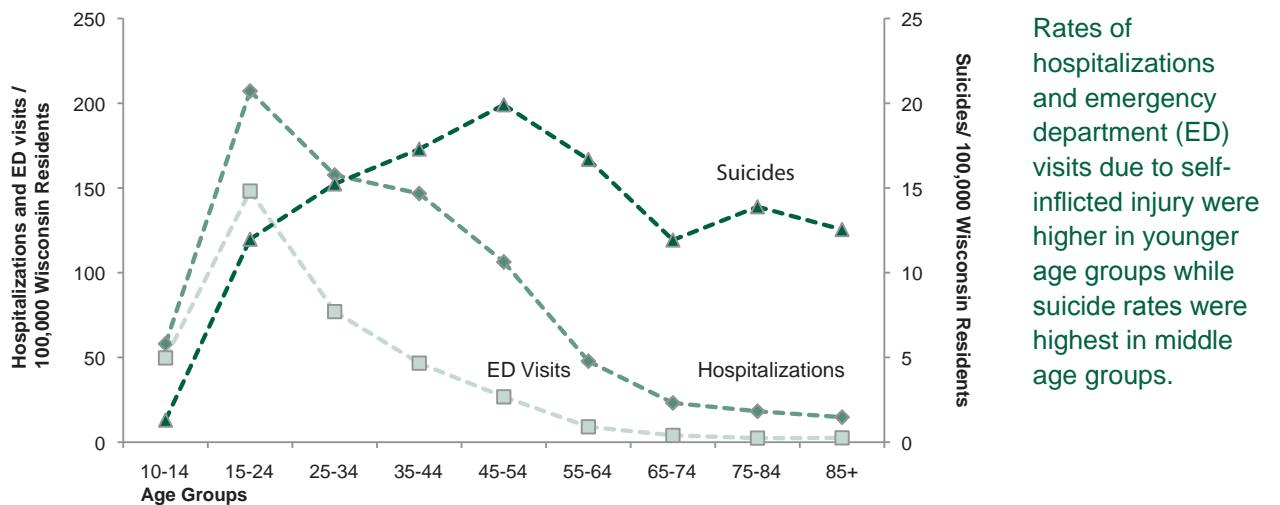


Figure 2. Rates of suicide, inpatient hospitalization, and emergency department visits due to self-inflicted injury (per 100,000 Wisconsin residents) by age, 2007-2011.



### *Suicide Disparities*

In addition to the gender and age disparities illustrated in the previous sections, *The Burden of Suicide in Wisconsin 2007-2011* report identified other subpopulations whose risk for suicide or self-inflicted injuries may be elevated.

- Whites experienced the highest suicide rates followed by American Indians / Alaskan Natives, Asian/Pacific Islanders, Blacks, and Hispanics\*.
- High school students of racial and ethnic minority backgrounds were more likely to report suicidal thoughts and behaviors than their White peers.
- People with less than a high school degree appeared at heightened risk for suicide while people with a graduate or professional level degree appeared at reduced risk.
- Divorced people appeared at heightened risk for suicide while married people appeared at reduced risk.
- Lesbian, gay, and bisexual teens were more likely to report poor mental health, suicidal thoughts, and suicidal behaviors than their heterosexual peers.
- Veterans accounted for nearly 20% of suicides in Wisconsin, while less than 10% of the state's residents over age 18 were veterans.

\*"Hispanics" may be of any race.

It is important to emphasize that being White, less educated, divorced, gay, or a veteran is not actually *predictive* of suicide. Nor does being a member of one of these groups necessarily increase inherent suicide risk. Rather, circumstances and behaviors that these groups experience more frequently than other groups may explain why they also experience higher rates of suicide. For instance, individuals who are divorced may experience increased social isolation, which along with other factors may increase their risk of suicide. Or there may be underlying conditions, such as mental health or substance use disorders, which increase the risk of divorce and suicide.

Using local data may help local coalitions identify how best to target their efforts towards groups that have demonstrated elevated risk in their area. See Goal 4 of this plan for additional information about using data and evaluation to support suicide prevention.

## Goals and Objectives

This section discusses the goals and objectives in more detail, the data behind them, and related prevention opportunities that can be pursued by diverse stakeholders in Wisconsin.

The strategic opportunities described here are by no means exhaustive. Rather, these suggestions serve as examples to help everyone think about how they can get involved in suicide prevention through their roles as individuals, community members, and leaders. In addition, each objective includes several “Evaluation Considerations” to emphasize the importance of monitoring the implementation of prevention activities and evaluating their impacts. These are offered as a starting point. Stakeholders need to consider what information must be collected in order to assess the effectiveness of their activities in preventing suicide in Wisconsin. Resources to assist in addressing the strategies outlined in this section have increased significantly in recent years. A few key resources are identified in this document, but individuals interested in learning about additional and more current resources should visit the Prevent Suicide Wisconsin website: [www.preventsuicidewi.org](http://www.preventsuicidewi.org).

### Goal 1: Increase and enhance protective factors.

*Objective A: Implement strategies that reduce the impact of adverse childhood experiences (ACEs) and promote social-emotional development in children.*

In Wisconsin, personal and relationship challenges including recent crises, physical health problems, job problems, and intimate partner problems are circumstances that frequently contribute to suicide (Figure 3). **Greater emotional intelligence — the ability to regulate emotions and solve interpersonal problems — may help people experiencing such difficulties cope more effectively, thereby reducing their likelihood of turning to suicide or high-risk behaviors, such as drug and alcohol use.** Research suggests that the provision of stimulating, nurturing environments during childhood may support the development of emotional intelligence, while neglectful or harmful environments impede the acquisition of emotional skills.<sup>1</sup>

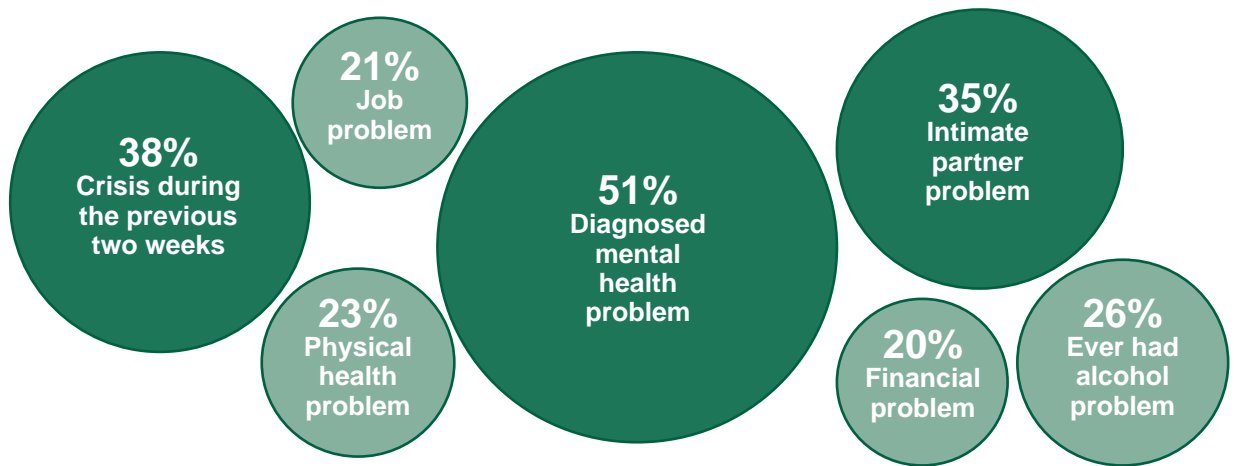


Figure 3. Percentage of suicides for which key circumstances were indicated (among those for which circumstances were known), Wisconsin Violent Death Reporting System, 2007-2011.

<sup>1</sup>Zeidner, M., Matthews, G., Roberts, R. D., & MacCann, C. (2003). Development of emotional intelligence: Towards a multi-level investment model. *Human Development*, 46(2-3), 69-96. Accessed at: [search.proquest.com/docview/224024932?accountid=26724](http://search.proquest.com/docview/224024932?accountid=26724).

Research on ACEs shows that certain types of family dysfunction, including mental illness, substance abuse, neglect, physical and sexual abuse, as well as other adversities experienced during childhood, are directly related to negative health outcomes later in life. People who have experienced significant ACEs are more likely to later face mental illness, substance abuse, and suicide themselves than those who have not. Additional research indicates that exposure to trauma and adversity can change brain function, particularly affecting areas of the brain related to emotion regulation, problem solving strategies, and relationship building skills.

**People who experience four or more ACEs are more likely to report mental health problems and history of suicide attempt(s) than those who report fewer ACEs.**

- In 2010, approximately 58% of Wisconsin residents reported having experienced at least one ACE.
- Of Wisconsin residents who reported at least one ACE, 25% reported having experienced four or more.
- Wisconsin residents who reported four or more ACEs were four times more likely to have been diagnosed with depression than those with no ACEs.
- According to the original ACE study conducted in California from 1995-1997, 18% of people with four or more ACEs had attempted suicide compared to only 1% of people with no ACEs.<sup>2</sup>

Figure 4. Key findings related to adverse childhood experiences, Wisconsin Behavior Risk Factor Survey 2011-2012.

Currently, a number of initiatives in Wisconsin are working to incorporate understanding of ACEs into health and human service activities. Such programs also seek to improve the delivery of trauma-informed care, where there's a shift from asking patients "What is wrong with you?" to "What has happened to you?" By supporting efforts to provide nurturing environments for childhood development and assistance for vulnerable families, stakeholders in suicide prevention can promote factors that protect against suicide while greatly expanding their network of partners. State level partners in this area include the Office of Children's Mental Health, the Department of Health Services' Trauma-Informed Care initiative, and the Department of Public Instruction's Trauma-Sensitive Schools approach.

**Strategic Opportunities**

- Support programs and policies that promote the development of social skills and emotion regulation as key components of children's health and education. (*Universal preventive intervention*)
- Work with partners to facilitate the provision of supportive services for children who experience adversity and their families. (*Selective preventive intervention*)
- Promote the delivery of trauma-informed care. (*Selective preventive intervention*)

**Evaluation Considerations**

- Number of people trained in trauma-informed care.
- Implementation of social-emotional development curriculum in schools.
- Percentage of children experiencing abuse, neglect, and other forms of trauma.
- Number of organizations offering services to help facilitate healthy parent-child interactions.

<sup>2</sup>Dube SR, Anda RE, Felitti VJ, Chapman D, Williamson DF, Giles WH. (2001). Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: Findings from Adverse Childhood Experiences Study. *JAMA*;286:3089-309. Accessed at: [www.ncbi.nlm.nih.gov/pubmed/11754674?dopt=Abstract](http://www.ncbi.nlm.nih.gov/pubmed/11754674?dopt=Abstract).

### Protecting Against Suicide

In 2010, the Fond du Lac School District received a five-year grant from the federal Substance Abuse and Mental Health Services Administration to use the PAX Good Behavior Game (GBG) in 1st and 2nd grades at three schools. The benefits to playing the GBG include fewer behavior problems and reduction of student problems with tobacco, alcohol, and other drug use. Long-term studies have found that youth playing the GBG in 1st grade have fewer thoughts of suicide as young adults than peers not exposed to the GBG.

**A story:** A teacher had to step out of the classroom for a few minutes to assist a student. She was worried that her students would be out of control when she returned because they had no adult supervision. But instead of the noise she expected to hear as she neared her classroom, she heard only silence. After praising her students for being so quiet in her absence, one student shared that they had started a GBG — all on their own. The students had learned what to do to keep themselves in control.

#### Resources

- ✓ Wisconsin Children’s Trust Fund, Adverse Childhood Experiences in Wisconsin: [wischildrenstrustfund.org/index.php?section=adverse-childhood](http://wischildrenstrustfund.org/index.php?section=adverse-childhood)
- ✓ Wisconsin Department of Public Instruction, school-friendly resources addressing positive mindsets and behavior:
  - Safe Schools Initiative: [sspwi.wi.gov/sspwi\\_safeschool](http://sspwi.wi.gov/sspwi_safeschool)
  - Student Services/Prevention and Wellness Team: [sspwi.wi.gov](http://sspwi.wi.gov)
  - Trauma-Sensitive Schools: [sspwi.wi.gov/sspwi\\_mhtrauma](http://sspwi.wi.gov/sspwi_mhtrauma)

#### *Objective B: Increase social connections.*

Many people in Wisconsin experience low levels of social connectedness. According to data from the Behavioral Risk Factor Surveillance System included in the 2014 County Health Rankings, 17% of Wisconsin adults report inadequate social support (County Health Rankings, 2014). As Figure 5 shows, levels of social support vary throughout Wisconsin.

Healthy communities provide infrastructure for social interaction at multiple levels. Strategies for increasing social connections function to bring individuals and families together and promote concepts of shared responsibility within communities. Research demonstrates relationships between loneliness and risk factors for suicide. A report in the *Annals of Internal Medicine* found that men who have more social connections, such as through marriage and religious participation, tend to have a lower risk of suicide. Study participants who had the most connections had less than half the risk of suicide over 24 years as those with the fewest social ties (Reuters, July 16, 2014). Connectedness to others, including family members, teachers, and coworkers, as well as community, faith-based, and social organizations, plays an important role in protecting individuals from suicide.

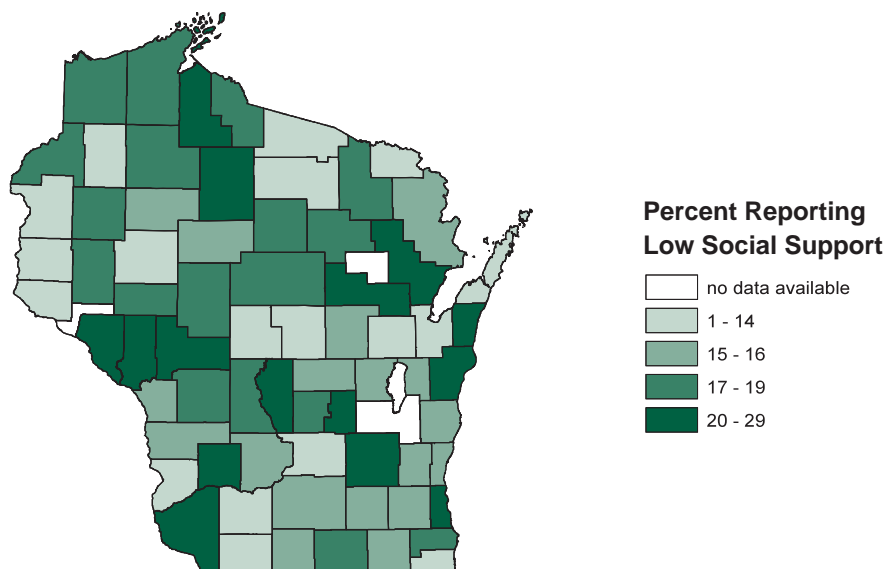


Figure 5. Map of county-level percentages of adults reporting low social support, *County Health Rankings, 2005-2010*.

### Strategic Opportunities

- Support active efforts to bring community members together through local organizations, social clubs, and community events. (*Universal preventive intervention*)
- Encourage outreach to individuals at risk of isolation, such as the elderly, the disabled, and those living in rural areas. (*Selective preventive intervention*)
- Assess attitudes of local clergy regarding suicide and provide training as appropriate. (*Universal preventive intervention*)
- Utilize peer or other support groups to facilitate meaningful social connections among those who are experiencing suicidal thoughts, who have attempted suicide, or who have lost loved ones to suicide. (*Indicated preventive intervention*)

### Evaluation Considerations

- Number of people provided outreach activities to reduce isolation.
- Support groups established for individuals at risk of isolation; number of people participating.
- Percentage of Wisconsin residents reporting low social support at the local and state level.
- Number of organizations in the community whose stated goals include fostering connections among community members.

### Resources

- ✓ Area Agencies on Aging, Resources for the Elderly:  
[www.dhs.wisconsin.gov/aging/contacts/REGAAAS.HTM](http://www.dhs.wisconsin.gov/aging/contacts/REGAAAS.HTM)
- ✓ Recovery Peer Run Organizations in Wisconsin:  
[www.recoveryprosupport.net/](http://www.recoveryprosupport.net/)
- ✓ NAMI Peer-to-Peer Program:  
[www.nami.org/Find-Support/NAMI-Programs/NAMI-Peer-to-Peer](http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Peer-to-Peer)

*Objective C: Assist communities, families, and individuals in creating suicide-safe environments for people at risk of suicide.*

Though a person may experience repeated occurrences of suicidal thoughts, the acute intention to end his or her life — a suicidal crisis — is temporary. Therefore, a key strategy for suicide prevention is creating suicide-safe environments, which lessen an at-risk person’s ability to attempt suicide. Increasing the time or effort required to act upon suicidal intent can create a window of opportunity for the suicidal crisis to pass or for a friend, family member, or other person to intervene. Suicide-safe environments also reduce the likelihood that a person who does attempt suicide will die. Most people who survive a suicide attempt do not go on to die by suicide. Ensuring that suicide attempt survivors receive appropriate professional care and other support services is critical to promoting recovery.

### Means Matter

#### A SUICIDE . . .

A 20-year-old with a drug problem moved back in with his parents after his girlfriend broke up with him. When he stopped going to work, his parents contacted a mental health center and urged him to see a counselor. He refused. He called his girlfriend hoping to get back together, but she wouldn’t speak to him. He felt desperate. He went to his father’s gun cabinet, removed a loaded gun, and shot himself in the head. He died within seconds.

#### A LIFE SAVED . . .

A 20-year-old with a drug problem moved back in with his parents after his girlfriend broke up with him. When he stopped going to work, his parents contacted a mental health center and urged him to see a counselor. He refused. He called his girlfriend hoping to get back together, but she wouldn’t speak to him. He felt desperate. He went to his father’s gun cabinet, but the guns had been removed. He found a razor and cut his wrists. His parents found him an hour later and brought him to the hospital where he was treated and agreed to get help.

Means Matter (Suicide, Gun Safety, and Public Health)

[www.meansmatter.org](http://www.meansmatter.org)

Creating suicide-safe environments for particular groups or individuals requires understanding patterns in the selection of various means of suicide and assessing their availability. In Wisconsin, firearms are the most common means of suicide, accounting for over 45% of deaths. Firearms are also the means of suicide attempt most likely to result in death. As such, people working to create suicide-safe environments for themselves or others should seriously consider how the presence of accessible firearms can mean the difference between life and death. Other common means or methods of suicide that must be addressed include hanging, strangulation, and suffocation, which together account for approximately 25% of suicides, and poisoning, primarily via medication overdose and secondarily via carbon monoxide, which accounts for nearly 20%. (Healthiest Wisconsin 2020 Baseline and Health Disparities Report, [www.dhs.wisconsin.gov/hw2020/baseline.htm](http://www.dhs.wisconsin.gov/hw2020/baseline.htm).)

Factors such as age and sex influence the means used by suicide decedents. Suicides among older people involve firearms more often than suicides among younger people. Additionally, firearms are the most common means of suicide among males, while poisoning is the most common means of suicide

among females (Figure 6). In terms of reducing access to lethal means, such information suggests that addressing firearm safety is particularly important to maintaining suicide-safe environments for males and older adults. For females and young adults, addressing the availability of medications is a key area of focus.

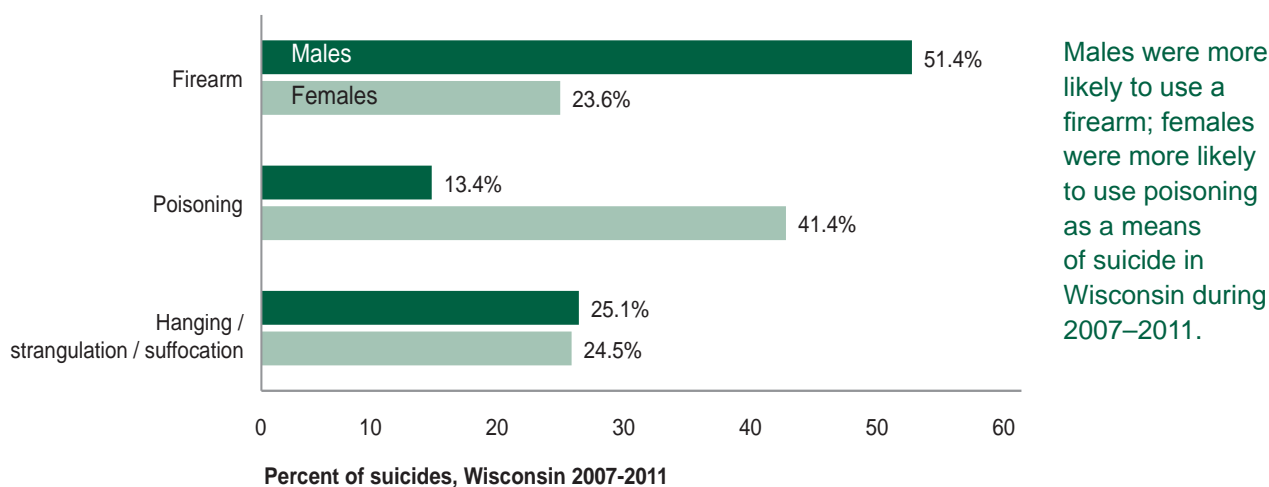


Figure 6. Distribution of means of suicide by sex, Wisconsin 2007-2011.

### Strategic Opportunities

- Disseminate gun locks and encourage safe storage of firearms. (*Universal preventive intervention*)
- Promote incorporating suicide barriers or nets into the design of bridges. (*Universal preventive intervention*)
- Support installation of pill collection boxes where community members can safely dispose of unused medications. (*Universal preventive intervention*)
- Institutions and residential facilities can utilize well-documented best practices in order to restrict access to ligatures and prevent hangings. (*Indicated preventive intervention*)
- Train clinicians, including those in emergency departments as well as mental health settings, and other professionals to ask about the availability of means for attempting suicide and provide strategies for creating suicide-safe environments. Counseling on Access to Lethal Means (CALM) is one such training. (*Indicated preventive intervention*)

### Evaluation Considerations

- Number of gun locks disseminated.
- Amount of medications collected in drop boxes or on collection days.
- Number of providers trained in best practices for addressing availability of means.
- Number of health care organizations in the community with stated policies on addressing the availability of lethal means.
- Rates of suicide by various means at the state and local level.

**Resources**

- ✓ “Means Matter,” Harvard School of Public Health: [www.meansmatter.org](http://www.meansmatter.org)
- ✓ “CALM: Counseling on Access to Lethal Means,” Suicide Prevention Resource Center: [www.sprc.org/bpr/section-III/calm-counseling-access-lethal-means](http://www.sprc.org/bpr/section-III/calm-counseling-access-lethal-means)
- ✓ Emergency Department Means Restriction Education, Evidence-Based Program: [www.nrepp.samhsa.gov/ViewIntervention.aspx?id=15](http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=15)
- ✓ National Suicide Prevention Lifeline: [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

**Goal 2: Increase access to care for at-risk populations.**

*Objective A: Expand access to services for mental health and substance use disorders, as well as suicidal thoughts and behavior.*

According to *The Burden of Suicide in Wisconsin 2007-2011* report, 59% of suicide decedents in Wisconsin were observed in a depressed mood around the time of death. Over 50% of suicide decedents suffered from diagnosed mental health problems and 26% suffered from alcohol problems. Approximately 43% were currently receiving mental health treatment and 52% had received treatment at some point in their lives. The large percentage of suicide decedents who had engaged with mental health services suggests that Wisconsin’s mental health system is not sufficiently prepared to assist individuals experiencing suicidal thoughts or crises. On the other hand, nearly half of Wisconsin residents who died by suicide had never received mental health services. It is likely, however, that such services could have benefited these individuals. Multiple factors may contribute to a person’s decision not to seek help, including stigmatization of mental health and substance use disorders, lack of insurance, or other financial obstacles and geographical barriers to accessing care. As Figure 7 shows, many counties in Wisconsin suffer from severe shortages of mental health service providers.

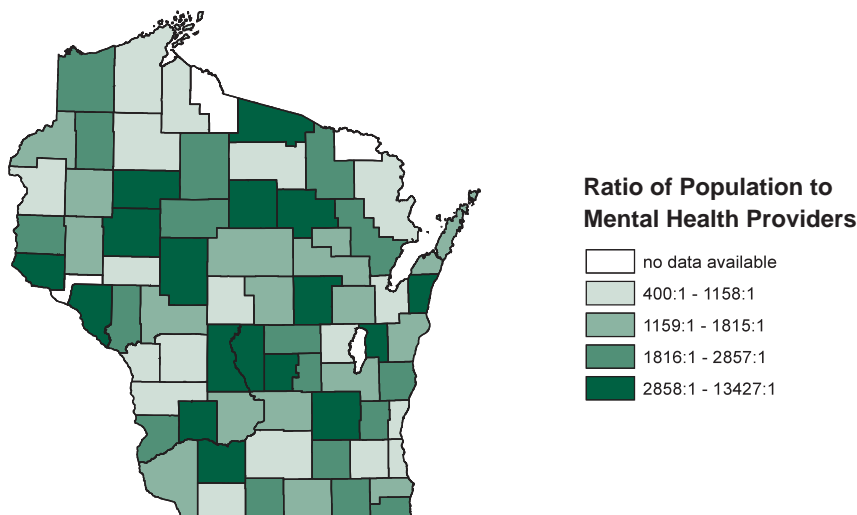


Figure 7. Map of county-level ratios of county population to number of mental health providers, National Plan and Provider Enumeration System – NPI Files 2013.



The data demonstrate that improving access to and quality of treatment for mental health issues is critical to suicide prevention in Wisconsin. Fortunately recent changes in health care policy have sought to address this issue both nationally and in Wisconsin. Since 2008, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) has required that the financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to insurance benefits for mental health or substance use disorders are no more restrictive than the predominant requirements or limitations applied to other medical benefits. In addition, the 2010 Patient Protection and Affordable Care Act (ACA) expanded access to care by helping people obtain affordable private insurance plans. The ACA also strengthened MHPAEA's mandates by requiring insurers who participate in the Marketplace to provide coverage for mental health and substance use disorders on par with coverage for physical health services.

### Are You Insured?

- In 2012 it was estimated that 11% of Wisconsin residents were uninsured for all of or at some point in the year.
- Adults ages 18-44 were the least likely to have health insurance coverage.
- Men ages 18-64 were more likely to be uninsured than women.

Figure 8. Wisconsin Family Health Survey, 2012: Key Findings. Wisconsin Department of Health Services. (2014).

It is critical that the intended beneficiaries of these policy changes can access the services to which they are entitled. As Figure 8 shows, men and young adults in Wisconsin are more likely to be uninsured than women and older adults. Suicide prevention efforts targeted toward these populations should address insurance coverage in order to improve access to services for mental health and substance use disorders.

In Wisconsin, the 2013-2014 legislative session provided funding for critical community-based services and supports for children and adults with mental disorders. This funding will be used to address inequities in access to services. Health provider shortage areas have been identified in both rural communities and inner city neighborhoods throughout the state. Increasing the sheer number of providers in a region will not necessarily solve this problem. Access to care is affected by the types of providers and specialists in a region, their geographical distribution within communities, the structure and funding sources of local health care delivery settings, and the availability of transportation. To eliminate barriers to accessing care, health care providers at all levels must consider expanding their scope of practice and utilizing telemedicine or virtual visits to increase their reach.<sup>3</sup>

### Strategic Opportunities

- Assist with outreach strategies to ensure that all eligible people are enrolled in Medicaid or a private insurance plan through the Marketplace. (*Universal preventive intervention*)
- Support efforts to ensure that private plans meet the parity requirements established by federal and state law. (*Universal preventive intervention*)
- Join efforts to ensure that service expansions approved by the Legislature in 2013-2014 are successfully implemented and monitored. (*Selective preventive intervention*)
- Build on efforts to integrate mental health and substance use disorder treatment with primary care to reduce stigma around accessing services and improve integrated care. (*Universal preventive intervention*)

<sup>3</sup>How Many Doctors Will Wisconsin Need? UW Population Health Institute Issue Brief. Vol 11(1). Nov. 2012.

**Evaluation Considerations**

- Percentage of residents enrolled in health insurance, including Marketplace plans.
- Implementation of new or expanded mental health and substance use treatment options.
- Ratio of mental health service providers to population at the state and local level.
- Percentage of people who report sufficient access to mental health services.

**Resources**

- ✓ Federal Health Insurance Marketplace: [www.healthcare.gov](http://www.healthcare.gov)
- ✓ Wisconsin Department of Health Services, Community Mental Health Services: [www.dhs.wisconsin.gov/dmhsas/dcindex.htm](http://www.dhs.wisconsin.gov/dmhsas/dcindex.htm)
- ✓ Wisconsin Office of the Commissioner of Insurance, Consumer Health Information: [oci.wi.gov/consumer/health.htm](http://oci.wi.gov/consumer/health.htm)

**Objective B: Decrease stigma associated with help-seeking, mental health and substance use disorders, and suicide through evidence-based and best practices, including contact with people in recovery.**

Stigma and discrimination against people with mental health and substance use disorders remain significant barriers to care. On one hand, individuals experiencing problems may not want to view themselves as suffering from a mental health or substance use disorder because of the negative connotations associated with such diagnoses. As a result, they may fail to seek care. Ultimately, their condition may deteriorate to the point at which they become suicidal. On the other hand, those who do seek care may experience distancing from individuals in their lives and other forms of discrimination because their mental health or substance use issues have been identified.

Evidence has shown that the most effective method for reducing stigma is targeted, local, consistent, credible contact with people who have identified themselves as having a mental illness and are willing to discuss it. When individuals have contact with other people that they view as “like themselves,” they are less likely to retain stigmatizing attitudes. This requires empowering individuals to disclose their own issues with mental health and substance use. Targeted media strategies and initiatives within specific sectors, such as workplaces, health systems and schools, can also work to eliminate stigma.

**Ending Stigma One Story at a Time**

Wisconsin Initiative for Stigma Elimination (WISE) offers training to assist people in making the decision to tell their stories in an effective way. Disclosure by individuals perceived as peers is the most effective means of reducing stigma. WISE also has a video library of people sharing their stories of recovery:

[rogersinhealth.org/resources/](http://rogersinhealth.org/resources/)

**Strategic Opportunities**

- Support events, programs, and activities at all levels that address stigmatization of mental health and substance use issues. (*Universal preventive intervention*)
- Encourage partners in the health and social services sectors to include stigma reduction in their culture, values, and programming. (*Universal preventive intervention*)

- Identify and promote targeted media strategies that effectively counter stigma against mental health and substance use disorders, as well as seeking help for these issues. (*Universal preventive intervention*)
- Work with health care providers to promote the delivery of appropriate, compassionate, and non-judgmental care for people with mental health and substance use disorders (*Selective preventive intervention*), as well as suicidal thoughts and behavior. (*Indicated preventive intervention*)

#### Evaluation Considerations

- Number of trainings done to support reduction of stigma and discrimination.
- Number of individuals exposed to stigma reduction messages.

#### Resources

- ✓ Wisconsin United for Mental Health, a public-private partnership working to reduce stigma: [www.wimentalhealth.org](http://www.wimentalhealth.org)
- ✓ Man Therapy, an example of a targeted media campaign designed to appeal to working-age men: [mantherapy.org](http://mantherapy.org)

#### *Objective C: Increase the public's knowledge of risk factors for suicide, recognition of suicide warning signs, and preparedness to respond to suicidal individuals.*

Research has identified many risk factors that can contribute to suicide. In Wisconsin, these include mental health problems, substance use disorders, physical health problems, intimate partner and other relationship problems, job and financial problems, and personal crises. In addition, people who have been divorced, served in the armed forces, or attained less than a high school degree tend to be overrepresented among Wisconsin residents who die by suicide. Ensuring that policymakers, community leaders, employers, providers of health and social services, and members of the faith community understand the impact of these risk factors can help engage them in suicide prevention.

In addition to understanding risk factors, individuals must be able to recognize the warning signs of suicide and to intervene appropriately. Unfortunately, many people do not know how to respond to someone experiencing suicidal thoughts. In Wisconsin, one-third of suicide decedents disclosed their intent to die by suicide to another person. If that person had been trained to respond appropriately, many of these deaths may have been prevented. Across Wisconsin, individuals who have lost loved ones to suicide are leading efforts to educate their communities on how to talk about suicide with someone in crisis.

There are many tools available for training people to become “gatekeepers,” people who recognize the warning signs of suicide and are prepared to intervene. For example, QPR (Question, Persuade, Refer) is a short educational program that provides simple instructions for assisting suicidal individuals in the same way that CPR provides instructions for assisting people who have been physically injured. Though QPR was developed for a general community audience, it can be adapted for use by specific groups of professionals or volunteers who interact with people at risk of suicide. Such groups may include providers of physical, mental, and behavioral health services, people who support those experiencing unemployment or financial problems, divorce attorneys and others who witness relationship conflict, law enforcement agents, and many others. In Wisconsin, hundreds of individuals have already been trained to teach QPR, but continuing to train trainers and gatekeepers is of critical importance. Research suggests that this approach to suicide prevention is most effective when communities are sufficiently saturated with “gatekeepers,” meaning that a substantial proportion of community members have been trained.

### We Are All Gatekeepers

A teacher participated in QPR training at her school. However, she recognized the warning signs of suicide not in a student but in her teen daughter. That same day she was empowered to ask her daughter directly if she was thinking about killing herself. The daughter readily acknowledged that she had acquired the means for suicide and had made a farewell video. The mom took her daughter for counseling. A year later when the accidental death of another student caused the girl's school counselor to ask her how she was doing, the girl reported that she was fine and knew that suicide was not the way to deal with her problems.

#### Strategic Opportunities

- Disseminate knowledge of risk factors for suicide to leaders at various levels within the public, private, and nonprofit sectors. (*Universal preventive intervention*)
- Support the training of additional trainers in QPR or other "gatekeeper" programs, including Mental Health First Aid and Youth Mental Health First Aid. (*Universal preventive intervention*)
- Ensure that employees and volunteers at agencies who interact with individuals at risk of suicide are trained as gatekeepers. (*Selective preventive intervention*)

#### Evaluation Considerations

- Number of individuals trained as trainers for QPR or other gatekeeper education programs.
- Number of individual gatekeepers trained in suicide prevention.
- Number of trained individuals who have utilized training, identified individuals at risk, and made referrals.

#### Resources

- ✓ QPR Institute: [www.qprinstitute.com](http://www.qprinstitute.com)
- ✓ Mental Health First Aid: [www.mentalhealthfirstaid.org/cs/](http://www.mentalhealthfirstaid.org/cs/)
- ✓ ASIST: [www.livingworks.net/programs/assist/](http://www.livingworks.net/programs/assist/)

### Goal 3: Implement best practices for suicide prevention within the health care system.

*Objective A: Increase resources for mental health and health care providers in screening, assessment, and treatment of mental health and substance use disorders, as well as suicidal thoughts and behavior.*

The majority of individuals who died by suicide were involved with mental health treatment at the time of their death or had been involved in mental health treatment previously. And many of the objectives in this plan are designed to ensure that those in need of treatment have access to it. Therefore, it is critical to ensure that mental health, substance use, and health care providers are equipped with the best practices in identifying and responding to individuals who may be suicidal. Fortunately, there are an increasing number of tools available. These include screening tools, such as the Columbia Suicide Severity Rating Scale (C-SSRS), professional training on treating individuals who are suicidal, such as Assessing and Managing Suicide Risk (AMSR) and Collaborative Assessment and Management of Suicide (CAMS), and protocols for various settings in responding to individuals who are suicidal. The Zero Suicide movement is directed primarily at these providers and has created an evolving website to support these efforts.

### Strategic Opportunities

- Use existing conferences and training events to support education of health care providers in best practices in screening, treatment, and management of individuals who are suicidal. *(Indicated preventive intervention)*
- Promote Zero Suicide principles and practices and work with partner organizations to increase awareness and implementation of these practices. Health care systems, including behavioral health settings, should complete a Zero Suicide organizational assessment as a first step in implementing better practices to reduce suicide. *(Selective preventive intervention)*
- Mental health, substance use, and health care providers should become familiar with evidence-based training and practices around suicide prevention and seek opportunities to take part in trainings. *(Selective preventive intervention)*

### Evaluation Considerations

- Number of organizations participating in Zero Suicide workshops; number completing and updating organizational assessments.
- Number of clinicians participating in trainings to enhance their competencies in assessing and managing suicide risk.
- Number of local coalitions with health care organization representation.
- Length of time between sentinel events (suicides and attempts) among HMO/managed care members in organizations with Zero Suicide initiatives.
- Rates of reported suspected suicides in reportable deaths (as required in Chapter 51) in Department of Health Services programs.

### Resources

- ✓ Zero Suicide: [zerosuicide.actionallianceforsuicideprevention.org](https://zerosuicide.actionallianceforsuicideprevention.org)
- ✓ Columbia Suicide Severity Rating Scale (C-SSRS): [www.cssrs.columbia.edu](http://www.cssrs.columbia.edu)
- ✓ Collaborative Assessment and Management of Suicide (CAMS): [sites.google.com/site/cuajsplab/home](https://sites.google.com/site/cuajsplab/home)
- ✓ Assessing and Managing Suicide Risk (AMSR): [www.sprc.org/training-institute/amr](http://www.sprc.org/training-institute/amr)

### Getting to Zero

North Central Health Care (NCHC), a behavioral health provider serving Lincoln, Langlade, and Marathon counties, participated in a workshop on Perfect Depression Care, a Zero Suicide initiative. They identified that the 18 different programs they operated all used different tools to screen clients for suicide risk. As a result there was not clear communication across services. With the implementation of a new electronic medical record system, NCHC implemented uniform suicide screening and followed that up by developing common protocols for follow-up care based on the level of risk.

**Objective B: Improve continuity of care for high-risk suicidal patients after emergency department visits and discharge from inpatient settings to community providers.**

According to the Suicide Prevention Resource Center:

The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an emergency department (ED) or inpatient psychiatric unit, yet as many as 70 percent of suicide attempt patients of all ages never attend their first outpatient appointment. Therefore, access to clinical interventions and continuity of care after discharge is critical for preventing suicide.

While there are various evidence-based practices that can be implemented, these are only beginning to be recognized by these entities. And because “continuity” assumes someone on the other end, EDs and hospitals cannot achieve this without partnerships with community behavioral health and health providers, consumers, family members, and other community stakeholders.

Wisconsin’s initial efforts to work with EDs have offered promise. However, it is clear that there are many systemic hurdles to overcome. And, as the data suggests, this is also one of the most critical links in the chain of care that can be targeted for action.

### **It Takes a Community to Create Better Care in the Emergency Department**

In April 2013, Wisconsin United for Mental Health held a summit on Improving Care to People with Mental Illnesses in Emergency Departments. The summit brought together ED staffs, mental health professionals, county human service staffs, persons living with mental illnesses, and advocates to explore how to better serve people with mental illness in this setting. The need to bring together these stakeholders at the local level was identified as an important goal to ensure optimal care.

#### **Strategic Opportunities**

- Use existing relationships with key health care organizations to promote efforts to enhance continuity of care. (*Indicated preventive intervention*)
- Bring together hospital and ED providers with community health and behavioral health providers and other stakeholders begin the dialogue around how to enhance continuity of care for individuals at risk of suicide. (*Selective preventive intervention*)
- Provide ED staff with “After An Attempt” brochures for individuals treated for suicide attempts and their family members or friends. (*Indicated preventive intervention*)

#### **Evaluation Considerations**

- Number of EDs/hospitals provided training on continuity of care.
- Number of EDs/hospitals implementing practices to improve response to individuals who are suicidal and continuity of care.
- Number of ED patients/family members seen as a result of a suicide attempt who receive brochures or other informational materials.
- Rates of suicide and self-injury following a previous self-injury hospitalization/ED visit at the hospital, local, and state level.

## Resources

- ✓ *Continuity of Care for Suicide Prevention: The Role of Emergency Departments:* [www.sprc.org/sites/sprc.org/files/library/ContinuityCare\\_Suicide\\_Prevention\\_ED.pdf](http://www.sprc.org/sites/sprc.org/files/library/ContinuityCare_Suicide_Prevention_ED.pdf)
- ✓ *Continuity of Care for Suicide Prevention and Research.* (2011): [www.sprc.org/sites/sprc.org/files/library/continuityofcare.pdf](http://www.sprc.org/sites/sprc.org/files/library/continuityofcare.pdf)
- ✓ Wisconsin United for Mental Health, Information for Emergency Departments: [www.wimentalhealth.org/emergency-dept](http://www.wimentalhealth.org/emergency-dept)

## Goal 4: Improve monitoring and evaluation of suicide and suicide prevention activities.

*Objective A: Use Wisconsin death certificate and violent death data to describe the burden of suicide in Wisconsin, improve data collection, and expand data linkages to further the understanding of suicide.*

Epidemiology, the use of data to identify risk factors and track the occurrence and trends in areas such as suicide and suicide attempts, is vital in identifying the burden of suicide. Data and evaluation are not just important in research, but are important components for any change effort. *The Burden of Suicide in Wisconsin 2007-2011* report is an example of the use of data for programmatic direction and measurement of intervention. Wisconsin will work to utilize the collection and analysis of data to assure that resources used in the state to prevent suicide are used effectively to decrease suicide attempts and suicide.

The Wisconsin Violent Death Reporting System, which is part of the National Violent Death Reporting System, is a key data source to guide suicide prevention activities. Furthermore, publicly available data contained on the Wisconsin Interactive Statistics on Health (WISH) website can be useful for local stakeholders to help guide local prevention activities. This activity will focus on increasing the use of and access to these data sources for state and local level suicide prevention efforts. It will also encourage the use of or linkages with additional data sources as they become available.

### Strategic Opportunities

- Work with local coroners, medical examiners, and law enforcement to improve data collection to get better data on high-risk groups such as LGBT persons and veterans.
- Publish a Burden of Suicide report on a regular basis (e.g. every 3-5 years).
- Utilize the WISH system to obtain data on suicide and self-injury to guide suicide prevention efforts in local communities.
- Create or collaborate with child death review teams or suicide and violent death review teams at the local level to identify circumstances associated with these deaths and potential prevention strategies.

### Evaluation Considerations

- Number of coalitions that include their coroner/medical examiner.
- Number of coalitions that collaborate with child death review teams or violent death review teams.
- Number of coalitions that utilize data to drive their local suicide prevention efforts.

**Resources**

- ✓ Wisconsin Department of Health Services, Wisconsin Interactive Statistics on Health, information from the Wisconsin Violent Death Reporting System: [www.dhs.wisconsin.gov/wish/](http://www.dhs.wisconsin.gov/wish/)
- ✓ Wisconsin Department of Health Services, Wisconsin Injury Prevention Program: [www.dhs.wisconsin.gov/health/injuryprevention/index.htm](http://www.dhs.wisconsin.gov/health/injuryprevention/index.htm)

**Objective B: Use data to identify subpopulations at elevated risk of suicide in order to guide program efforts.**

As noted above, *The Burden of Suicide in Wisconsin 2007-2011* report identified populations at elevated risk of suicide (see Appendix 3). By targeting efforts to work with these populations, there may be a better chance of having an impact on suicide in Wisconsin. Over time, the relative risk of suicide among various groups may change. As such, continuous surveillance and investigation are necessary to ensure that prevention efforts remain focused on the populations and communities with the greatest needs.

Wisconsin has implemented a variety of such targeted interventions to date:

- Wisconsin has held six “Warrior Summits” designed to bring together veterans, their families, veterans service organizations with civilian human and social services providers so that everyone can better understand the needs of veterans, the resources available, and especially how to help those veterans reintegrating from foreign conflicts.
- Wisconsin has promoted Man Therapy, a social marketing campaign directed at men. Through use of a humorous website and promotional materials the campaign hopes to encourage men to seek help for possible mental health concerns.
- While the LGBT population is understood to be at higher risk of suicide, much of this is a function of absence of social support. For instance, LGBT youth are at 8 times greater risk of suicide if they do not have support from their family.<sup>4</sup> Gay-straight alliances in schools can also be source of support. Wisconsin has partnered with the Gay-Straight Alliance for Safe Schools to create this support and educate school personnel about how best to support LGBT youth.

**Strategic Opportunities**

- Convene state and federal veterans service organizations (e.g., the VA, the National Guard, county veterans service officers) to better coordinate activities that will address suicide among this population. (*Selective preventive intervention*)
- Evaluate the efficacy of Man Therapy in actually impacting help-seeking and suicide in the target population. (*Selective preventive intervention*)
- Bring together key partners who might address other high-risk groups to develop partnerships and collaborations to address suicide. (*Selective preventive intervention*)

**Evaluation Considerations**

- Number of coalitions that are targeting specific subpopulations at elevated risk as determined by use of local data.
- Number of individuals in high-risk populations who have been impacted by targeted suicide prevention activities.

<sup>4</sup>Family Acceptance Project™. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-52.



### Resources

- ✓ The Trevor Project, suicide prevention and crisis intervention for LGBTQ youth: [www.thetrevorproject.org](http://www.thetrevorproject.org)
- ✓ DryHootch, a veterans peer support organization working with vets from all eras: [dryhootch.org](http://dryhootch.org)
- ✓ Man Therapy, an example of a targeted media campaign designed to appeal to working-age men: [mantherapy.org](http://mantherapy.org)

### *Objective C: Evaluate interventions used to reduce suicide attempts and deaths in Wisconsin.*

Evaluation is a “driving force for planning effective suicide prevention strategies, improving existing programs, informing and supporting policy, and demonstrating the results of resource investments.”<sup>5</sup> Whatever suicide prevention interventions are selected, there is a need to know if they have made a difference. One step to selecting prevention interventions is to examine how they have been implemented in other states or communities and whether they have been effective. Finally, there is also a need to determine if this plan for suicide prevention leads to reduced morbidity and mortality due to suicide.

Wisconsin will prioritize the use of evidence-based strategies whose implementation and outcomes have demonstrated a positive impact on the incidence of suicide, self-harm, and associated risk and protective factors. Wisconsin will also assist local coalitions to choose interventions with identified outcomes and to develop evaluation tools to use. Identifying the expected outcome and how it is to be measured is an important first step to any initiative.

### Strategic Opportunities

- Provide training on and require the use of evidence-based and best practices and solid evaluation strategies for grant programs, when available.
- Promote evidence-based and best practices at state-sponsored trainings and events.
- Providing training and guidance on evaluation practices.

### Evaluation Considerations

- Number of trainings provided for local coalitions on evaluating their suicide prevention programs.
- Number of local coalitions that include individuals who have participated in evaluation training.
- Number of local coalitions that are evaluating programs and activities they are implementing.
- Percentage of suicide prevention programs and activities that are evaluated.

### Resources

- ✓ Suicide Prevention Resource Center, online trainings: [training.sprc.org/](http://training.sprc.org/)
- ✓ Suicide Prevention Resource Center, Best Practices Registry: [www.sprc.org/bpr](http://www.sprc.org/bpr)
- ✓ For all health care settings, Institute for Health Care Improvement: [www.ihc.org](http://www.ihc.org)
- ✓ For behavioral health settings, NIATx: [www.niatx.net](http://www.niatx.net)

<sup>5</sup>National Strategy for Suicide Prevention, page 71.

## References

Wisconsin Department of Health Services, Injury Research Center at the Medical College of Wisconsin, Mental Health America of Wisconsin. (2014). *The Burden of Suicide in Wisconsin 2007-2011*.

[www.dhs.wisconsin.gov/publications/p0/p00648-2014.pdf](http://www.dhs.wisconsin.gov/publications/p0/p00648-2014.pdf)

U.S. Department of Health and Human Services. (2012). *National Strategy for Suicide Prevention: Goals and Objectives for Action*.

[actionallianceforsuicideprevention.org/NSSP](http://actionallianceforsuicideprevention.org/NSSP)

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework*.

[actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf](http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf)

## Appendix 1

### Key Wisconsin Accomplishments to Date

- 1998 Helping Others Prevent and Educate about Suicide (HOPES), a group by and for survivors of suicide loss, is founded.
- 2002 Department of Health Services releases first *Wisconsin Suicide Prevention Strategy*.
- 2004 Department of Health Services identifies youth suicide prevention as a priority through its Prevention/Early Intervention in Mental Health grant; the first dedicated suicide prevention funding. First six mini-grants for suicide prevention awarded. Over 50 such mini-grants have been awarded to date.
- 2006 Mental Health America of Wisconsin receives Garrett Lee Smith Youth Suicide Prevention grant on behalf of the State of Wisconsin.
- 2008 First *Burden of Suicide in Wisconsin* report issued with data from 2001-2006.
- 2009 As a result of a state strategic planning summit Prevent Suicide Wisconsin is founded to brand Wisconsin's suicide prevention efforts and provide state level leadership. A steering committee is formed, logo is developed, and website introduced.
- 2009 First Wisconsin Warrior summit brings together veterans, their families, veterans service organizations, and civilian human and social services staffs to learn about the needs of veterans, especially those struggling with mental health and substance use issues, as well as suicidal thoughts and behavior. Six such summits have been held.
- 2011 First Communities in Action to Prevent Suicide conference held to bring together key suicide prevention stakeholders in Wisconsin. Four conferences have been held to date.
- 2012 Mental Health America of Wisconsin receives second Garrett Lee Smith Youth Suicide Prevention grant.
- 2013 First Perfect Depression Care learning community created as five organizations send teams to Henry Ford Health System to learn about its systemic effort to reduce suicides. A second learning community is formed in 2014.
- 2014 An updated report, *The Burden of Suicide in Wisconsin 2007-2011*, is released.

## Appendix 2

### Prevent Suicide Wisconsin Steering Committee Members

- Shel Gross: Co-Chair
- Sue Opheim: Co-Chair
- Debi Traeder: Staff
- Heidi Bryan
- Deb DuFour
- Mark Flower
- Ginger Fobart
- Larry Hakes
- Sue Howell
- Janet McCord
- Chris Morano
- Debbie Rueber
- Mary VanHaute

#### State Agency Representatives:

- Department of Health Services, Division of Mental Health and Substance Abuse Services: Julianne Dwyer
- Department of Health Services, Division of Public Health: Susan LaFlash and Rebecca Cohen
- Department of Public Instruction, Division for Learning Support: Brenda Jennings and Gregg Curtis

## Appendix 3

### Key Findings from *The Burden of Suicide in Wisconsin 2007-2011*

- ✓ The **suicide rate** in Wisconsin remained relatively constant during the five-year period from 2007–2011 but **increased** over the eight-year period from 2004–2011. From 2007–2011, there were an average of 724 suicides per year.
- ✓ Counties clustered in the **Northern and Western regions** of Wisconsin experienced the highest suicide rates.
- ✓ In Wisconsin, individuals **aged 45–54** were at the greatest risk of dying by suicide, while **teens and young adults** were more likely to be seen in emergency departments or to be hospitalized for self-inflicted injuries than people in older age groups.
- ✓ Nearly four out of five persons who died by suicide were **male** while approximately three out of five patients hospitalized for a self-inflicted injury were **female**.
- ✓ **Whites** experienced the highest suicide rates followed by **American Indians/Alaskan Natives**, Asian/Pacific Islanders, Blacks, and Hispanics. **High school students of racial and ethnic minority backgrounds** were more likely to report suicidal thoughts and behaviors than their White peers.
- ✓ People with **less than a high school degree** appeared at heightened risk for suicide while people with a graduate or professional level degree appeared at reduced risk.
- ✓ **Divorced** people appeared at heightened risk for suicide while married people appeared at reduced risk.
- ✓ **Lesbian, gay, and bisexual teens** were more likely to report poor mental health, suicidal thoughts, and suicidal behaviors than their heterosexual peers.
- ✓ **Veterans** accounted for one out of five suicides in Wisconsin.
- ✓ **Firearms** were the most frequently utilized means of suicide in Wisconsin. Males used firearms more often than females who died by suicide. Suicide attempts using firearms were more likely to result in death than those in which other means were utilized.
- ✓ Among suicides with known circumstances, 51% of decedents had a current **mental health problem** and 43% were currently receiving mental health treatment.
- ✓ Among suicides with known circumstances, 26% of the decedents had an **alcohol problem** and 13% had another **substance abuse problem**. Among suicides in which toxicology testing was performed, 37% of decedents tested positive for alcohol and 19% tested positive for opiates.
- ✓ Of all suicides with known circumstances, 35% involved **intimate partner problems**.
- ✓ **Physical health and job problems** were life stressors involved in 23% and 21% of suicides with known circumstances.
- ✓ Among suicides with known circumstances, 24% of decedents had a **history of suicide attempts** and 34% **disclosed their intent to die by suicide to at least one person**.



**If you feel you are in a crisis, whether or not you are thinking about killing yourself, please call the Lifeline.**

**It is confidential and you can discuss any issue in your life, including substance use, economic worries, relationship and family problems, sexual orientation, getting over abuse, depression, mental and physical illness, and even loneliness.**

**Veterans and their loved ones can call 800-273-8255 and Press 1 or send a text message to 838255**

**If you are deaf or hard of hearing, contact the Lifeline via TTY by dialing 800-799-4889**

**Visit the website for further information, including the Lifeline Crisis Chat option:**





# Wisconsin Suicide Prevention Strategy

Released 2015

## Questions or Comments:



### **Mental Health America of Wisconsin**

(414) 276-3122

(866) 948-6483 (toll free)

[www.mhawisconsin.org](http://www.mhawisconsin.org)



Wisconsin  
Department of Health Services

### **Wisconsin Department of Health Services Division of Mental Health and Substance Abuse Services**

(608) 266-2717

[www.dhs.wisconsin.gov/mh/suicideprev.htm](http://www.dhs.wisconsin.gov/mh/suicideprev.htm)