Suicide Prevention Action Plan Fact Sheet

Highest Risk Groups
In 2010:
▶ 78% of all deaths by suicide were among males.
▶ Nearly half (48%) of all suicides were among persons ages 45-64 years.
▶ The highest rates of suicide occurred among men ages 45-64 years (35.2 per 100,000) and men ages 65 years and older (35.4 per 100,000).
▶ Groups with increased rates of suicide include whites, older men, and divorced or widowed individuals.

Method
▶ Firearms are the most commonly used method of suicide, accounting for 40% of suicides. The percentage of suicides using firearms has dropped since the mid 1990s, when 50% of suicides were committed using firearms.

Suicide Trends
▶ From 2001 through 2010, 3,390 people died by suicide. There were nearly three times as many suicides as homicides.
▶ In 2010, 372 San Diegans died by suicide, for a rate of 11.5 per 100,000 population.
▶ Despite increases in recent years, suicide rates (as a proportion of the population) have actually declined substantially over the last 20 years, with the average rate from 1990 to 1994 (13.9 per 100,000) 18% lower than the average rate from 1990 to 1994.

Sources:
- San Diego County Medical Examiner, 2010 Annual Report (http://sandiego.ca.gov/me/docs/SDME_Annual_Report_2010.pdf)
- SANDAG, 2010 population estimates (accessed online at www.sandag.org)
**System Level Impact (SL):** The service delivery system and the capacity of specific service providers should be strengthened. A suicide prevention entity should be created to monitor the implementation of suicide prevention efforts and system-wide initiatives countywide. It is recommended that primary care physicians receive suicide prevention education so that they are better prepared to identify and address suicide risk factors among their patients. Changes to local laws or ordinances, or modifications to system practices at hospitals and other service locations, can address policy issues such as firearm safety and medication management.

**Selective Strategies:** Selective strategies focus on at-risk groups that have a greater probability of becoming suicidal, and aim to prevent the onset of suicidal behaviors. Four selective strategies are recommended for use in reaching high-risk populations:
- **Education (SE):** Suicide prevention education efforts should be expanded to reach identified at-risk populations. These efforts should capitalize on community strengths and involve community stakeholders throughout the process—particularly those most at risk for suicide, in the community as a whole and/or specific target populations.
- **Training for Providers (STP):** STP work directly with clients at risk for suicide need more training and support. For selective populations, the definition of provider should be broadened to include people outside of the behavioral services sector. For many selective populations, the initial point of contact is a community organization. Key outcomes of provider training and education, providers working with high-risk populations need support to ensure they feel successful at their jobs and reduce burnout.

**Skill Building and Training for Community Members/ Clients (SST):** Building the strengths and resources already available in many communities, SST will be expanded to provide tools for clients who may not access traditional mental health systems. Examples include: 1. Community collaborative relationships between providers and hospitals, and access between multiple systems and providers. Local efforts should be expanded to address these and other barriers to integration of an integrated system. Increased coordination between outpatient providers and hospital staff or discharge planners may save a life by ensuring the link to ongoing support following high risk events.

**Provision of Community Based Services (ICB):** Transportation and engagement of community members in mental health services. Approaches to addressing these and other barriers include the provision of home-based mental health services, as well as mental health services located at community centers, primary care clinics, and other well-recognized sites in the community.

**Identification of High Risk Behaviors/Events (IRB):** Some events, including recent discharge from the hospital for a mental health crisis, or diagnosis of a chronic medical condition, greatly increase risk for suicide. But high risk behaviors are often missed in routine practice. More attention must be paid across diverse cultures and populations; more research needs to be conducted to identify additional high risk behaviors and events. Data should be generated to inform uniform interventions for those at highest risk for suicide.

**Integrate System of Care for High Risk Individuals (ISC):** The system of care for high risk individuals needs further integration. Current collaborative relationships are often hampered by issues of geography and access between multiple systems and providers. Local efforts should be expanded to address these and other barriers to integration of an integrated system. Increased coordination between outpatient providers and hospital staff or discharge planners may save a life by ensuring the link to ongoing support following high risk events.

**Coordinate Suicide prevention services and priorities to ensure needs are being met across systems.**

**Include the voice of those who are being served, particularly those most at risk for suicide, in the planning of training and interventions to ensure strategies are successful.**

**Use data to evaluate prevention efforts and inform program planning.** Strengthening data collection, quality, sharing, and evaluation efforts will ensure a robust system to evaluate the impact of suicide prevention efforts, to inform future decision-making, and to expand knowledge.