Preventing Suicide in West Virginia:

A plan to address a silent epidemic

Prepared by the West Virginia Council for the Prevention of Suicide for:
SAMHSA

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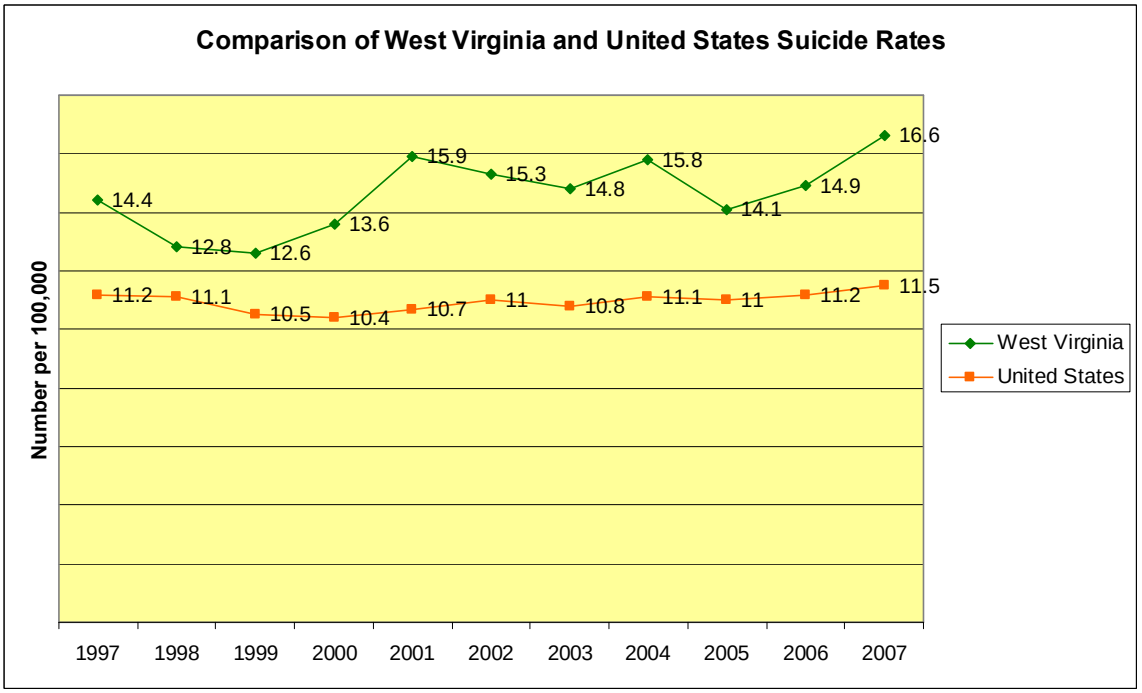
Introduction

Suicide is a significant problem in the United States and in West Virginia. It has been called a ñ*silent epidemic*ò[1] that ñexacts an enormous toll from the American people.ò[2]

On average, about 30,000 individuals in the United States died from suicide each year in the years 1997 ï 2007. Another 650,000 received emergency care after attempting to take their lives.[3] It is estimated that one person dies every 15.2 minutes due to suicide.[4]

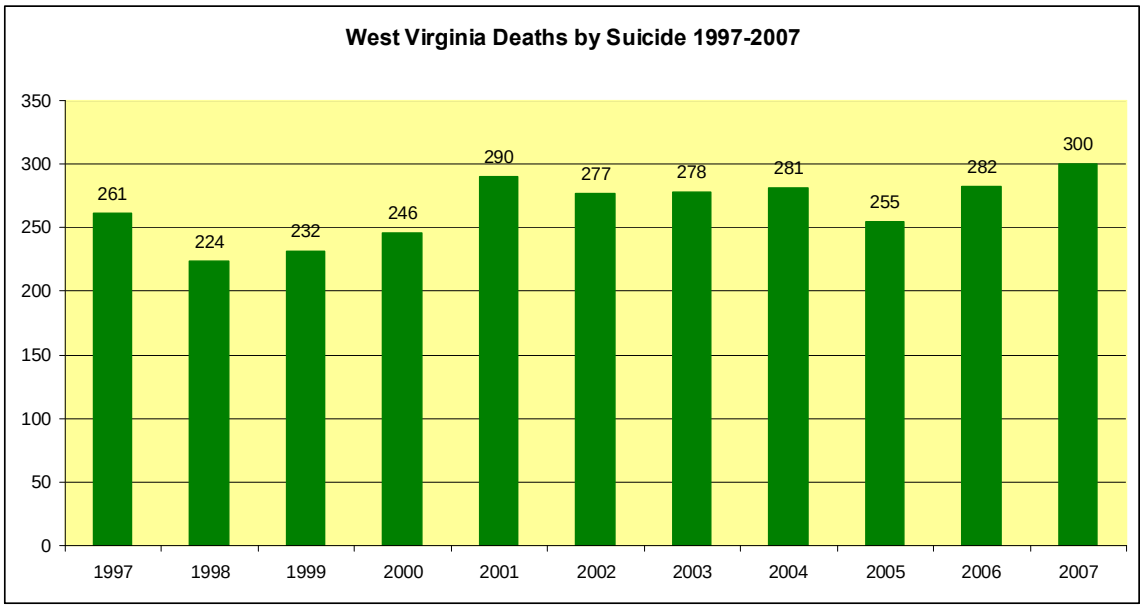
Data shows that 2,926 individuals in West Virginia died by suicide from 1997 ï 2007. West Virginiaôs suicide rate was higher than the national average in number of persons per 100,000 population who died by suicide in that time period.[5]



ñNumber per 100,000ò provides a statistic which enables a comparative analysis across states. Actual numbers produce a picture for the specific state, such as West Virginia. The chart below depicts the number of suicides for the years 1997

[1] See http://www.pbs.org/thesilentepidemic/
[2] U.S. Department of Health and Human Services, Public Health Service. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*.
[3] Ibid.
[4] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf
[5] Found at http://www.cdc.gov/injury/wisqars/fatal.html

through 2007. It ranges from 224 reported deaths by suicide in 1998 to 300 in 2007; more than one person died from suicide every two days in those 11 years.[6]



Intentional self-harm was the second leading cause of death among West Virginia males aged 15 to 24 in 2007 and according to the Centers for Disease Control it was exceeded only by accidents.[7] Younger West Virginians are affected the most by suicide according to statistics.[8] These data indicate that just over 1% of the deaths in 2002 and 2003 were due to intentional self-harm, but 5% of the years of potential life lost before age 65.

Young people are not the only ones who die from suicide. There were 215 deaths among West Virginians aged 25 ï 64 in 2007 attributed to intentional self-harm, about 20% of the 1,050 deaths in that age group in that year. About 83% of those deaths were males.[9]

Suicide also affects older people aged 65 and older, although that is not listed by the Bureau of Public Health as a ñleading causeòof death in West Virginians in that age group. Nationally in 2007, 5,421 older Americans died by suicide.[10] This averages out to 1 older American suicide death every 1 hour and 37 minutes.

People of all age groups attempt suicide, but older adults have a higher completion rate.

[6] Ibid.
[7] See http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html
[8] See http://www.wvdhhr.org/bph/oehp/vital03/vs_30.htm
[9] See http://www.cdc.gov/injury/wisqars/fatal.html
[10] See http://www.cdc.gov/injury/wisqars/fatal.html

Although older adults nationally and in West Virginia attempt suicide less often than those in other age groups, they have a higher suicide rate. Older Americans are more lethal in their attempts and die by suicide more often. For all ages combined, there is 1 suicide for every 20 attempts nationally. Among people aged 15 ï 24 years old, there is 1 completed suicide for every 100 ï 200 attempts. Over the age of 65, there is 1 completed suicide for every 4 attempts.[11]

Nationally, suicide deaths consistently outnumber homicide deaths by a margin of two to one. In 2002, twice as many Americans died from suicide than from HIV / AIDS. But research has shown that 90 percent of people who die by suicide have depression or another diagnosable (and treatable) mental illness or substance abuse disorder.[12] This suggests suicide can be, and is, preventable if these illnesses are identified and treated.

Efforts at preventing suicide began nearly a half-century ago, when the first suicide prevention center established in Los Angeles. This center and many others established after it, offered community service and crisis intervention.[13] In 1996, Gerald and Elsie Weyrauch of Marietta, Georgia began a grassroots effort to encourage public education and awareness, community action and grassroots advocacy to prevent suicide. The Weyrauchôs 34-year old physician daughter died by suicide and the couple adopted a goal to create a way for people who have lost someone to suicide to transform their grief into positive action to prevent future tragedies.[14]

In the 10 years since that initial effort, nearly every state has developed and implemented efforts to prevent suicide. A national hot line, to respond to individuals contemplating suicide, has been established. National and state conferences have shared information on suicide prevention, crisis intervention, and outreach methods. The countryôs Surgeon General has issued a report and a national strategy for suicide prevention has been developed.

Suicide prevention awareness and advocacy efforts in West Virginia began in 2001, with a small grant to Valley HealthCare System in Morgantown from the West Virginia Department of Health and Human Resources to create the HOTT (Helping Our Teens Thrive) Coalition. Two years later, the West Virginia Council for the Prevention of Suicide (WVCPS) was formed. The mission of the Council is to, ñReduce suicides in West Virginia and address the needs of survivors of suicide loss through evidence-based programs and practices in order to prepare communities, recognize, and support those at risk for suicide and survivors of

[11] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf
[12] http://www.spanusa.org/index.cfm?fuseaction=home.viewPage&page_id=8A13146B-E70F-213B-95A0CE83BC5518F6
[13] Op Cit U.S. Department of Health and Human Services, Public Health Service. 2001
[14] See http://www.spanusa.org/C_about-span.html

suicide loss.ò The vision of the Council is that West Virginia not lose one citizen to suicide.[15]

In the intervening years, the HOTT Coalition and the WVCPS have presented numerous workshops and conferences for educators, health and behavioral professionals, law enforcement agencies, students, college students, and social service providers. The Council has also sponsored the development of age-appropriate assessment protocols for early identification of potential suicide victims and referrals to services.

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[15] See http://www.wvsuicidecouncil.org/

Purpose of this Plan

The vision of the West Virginia Council for the Prevention of Suicide is that ñWest Virginia does not lose one citizen to suicide.ò It is the hope that this Plan will provide guideposts for working toward that vision.

Many suicides can be prevented by developing protective factors and reducing risk factors. Protective factors include effective and assessable clinical care for mental, physical, and substance use disorders; strong connections to family and community support; skills in problem solving, conflict resolution, and nonviolent handling of dispute; and cultural and religious beliefs that discourage suicide and support self-preservation. Risk factors include mental illnesses; history of trauma or abuse; family history of suicide; job or financial loss; loss of a relationship; lack of social support; stigma associated with seeking help; and exposure to others who have died by suicide.[16]

No agency or organization can fully address the problem ï it requires the attention, effort, and coordination of multiple organizations, groups, and individuals. These include organizations, agencies, and individuals providing behavioral health services, health care providers, school systems and universities, law enforcement, court officials, senior citizen organizations, faith-based organizations, and groups of families and friends of people who have died by suicide.

While representing a new and coordinated endeavor, the Suicide Prevention Plan builds on current activities and endeavors, hopefully avoiding a duplication of effort at a time when resources are limited. The work of the WVCPS has been based on this coordination of existing resources. It is believed this plan will guide further development of these efforts, leading West Virginia toward achieving the Councilôs vision.

This plan builds on current activities and endeavors.

This plan has been provided for review to the West Virginia Mental Health Planning Council, the West Virginia Behavioral Healthcare Providers Association, the West Virginia Primary Care Association, the Bureau for Behavioral Health and Health Facilities, and other health, social service, and education providers and organizations. It is hoped that this process will lead these organizations and individuals to considering the recommendations for addressing this ñ*silent epidemic.*ò

[16] U.S. Department of Health and Human Services, Public Health Service. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*.

Development Process

In 2001, Valley HealthCare System responded to an Announcement of Fund Availability from the Children's Division of the Office of Behavioral Health Services in the West Virginia Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities. Valley HealthCare System proposed the development and implementation of a public awareness and information project to create awareness and understanding of a "*silent epidemic*": suicide among adolescents in West Virginia.

The small grant, funded through the Community-Based Mental Health Services Block Grant, enabled the creation of the Helping Our Teens Thrive Coalition (HOTT Coalition). This coalition was composed of representatives of health and behavioral health providers, educators, and interested individuals. In the beginning years, several seminars and workshops were provided to alert school personnel and the interested public in the number of children who were dying by suicide in West Virginia as well as what was needed to prevent such untimely and tragic deaths.

The workshops and seminars were well received and the HOTT Coalition was re-formed and expanded into the West Virginia Council for the Prevention of Suicide. The WVCPS understood that people of all ages die by suicide. The "target population" addressed by the WVCPS was expanded to include adults and the Council began providing bi-annual conferences which attract the attendance of several hundred health and behavioral health providers and other individuals. A Website (http://www.wvsuicidecouncil.org) has been created, providing statistics and information on suicide and offering help for individuals in crisis. The Council has developed awareness curriculums covering all age groups, and currently provides workshops covering the entire lifespan.

WVCPS has a Website: www.wvsuicidecouncil.org

In addition to information and education, the Council sponsored the development of protocols for suicide assessment with Dr. William Fremouw from the WVU Department of Psychology. The Council along with Dr. Fremouw have developed suicide risk assessment for three age groups, the Adolescent Screening and Assessment Protocol-20 (ASAP-20), the Suicidal Adult Assessment Protocol (SAAP), and the Suicidal Older Adult Protocol (SOAP). These instruments have been published in the Book "*Innovation in Clinical Practice*".[17]

The plan is based on the goals and objectives in the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Specific goals and objectives, strategies, and activities for implementation were drafted by the Council

[17] See http://www.wvsuicidecouncil.org

membership and circulated for review and comment to stakeholder groups and individuals.

Implementation of the plan is a shared responsibility. Certainly, the Council will play a major role in coordinating efforts in achieving the plan. But all stakeholders providers of health and behavioral health services, teachers, higher education, law enforcement, the courts, families and friends of people who have died by suicide and the general public, have roles in preventing untimely and tragic deaths.

Priority Populations

This plan addresses suicide prevention for all persons in West Virginia, regardless of age, race, or gender. Data from 2007 indicates that West Virginiaûs 300 reported deaths by suicide were equal to 16.6 suicides per 100,000 population, the 7th highest in the United States.[18] However, some population groups are more at risk than others.

The Centers for Disease Control publishes data showing the number of suicides by age group. The following chart shows deaths by suicide for the years 1997 through 2007.

Over the past ten years, there were a reported 2,926 deaths by suicides in WV. This works out to an average of 292 completed suicides a year in WV. Over this ten year period, the year with the lowest reported number of completed suicides was 1998 with 224 reported; the year with the highest reported number of completed suicides was 2007 with 300 reported.

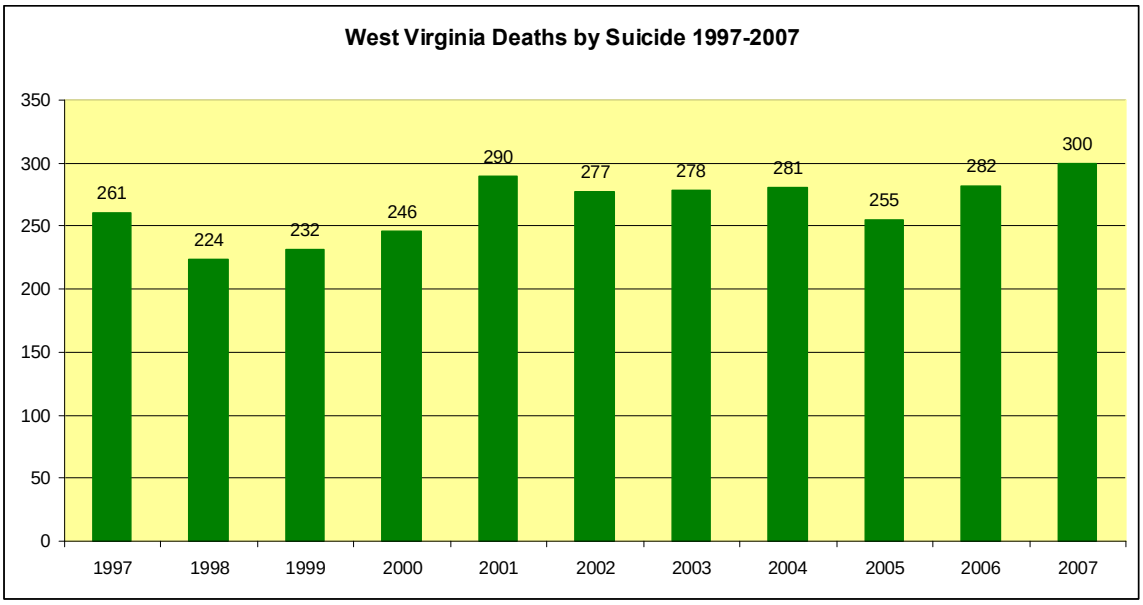


Table 1 breaks down the reported completed suicides in WV by age and gender. In 2007 there was a reported 33 completed suicide among the ages of 15 to 24 in WV, with a rate of 14.45, which ranked 11th in the nation. Males accounted for 94% (n=31) of deaths by suicide among this age group, while females accounted for 6% (n=2). The suicide rate among males of this age group for 2007 was 26.43, which ranked 8th in the nation. Among the age group of 25 to 64, there were a reported 215 deaths by suicides in 2007. Males accounted for 83% (n=178) of suicide deaths among this age group, while females accounted for

[18] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

17% (n=37). The male suicide rate for this age group for 2007 was 36.50, which ranked 5th in the nation. The suicide rate for females during this year was 7.45, which ranked 27th nationally. Males among the age group of 65+ had the highest suicide rate in WV with a reported rate of 37.89, which ranked 13th in the nation. Among this age group, there were a reported 52 deaths by suicides in WV. Males accounted for 87% (n=45), while females accounted for 13% (n=7). Among all age groups, WV had a consistently higher rate of suicide than the national average.

Table 1: Completed Suicide by Age

	15-24	Rate	25-64	Rate	65+	Rate
Male	31	26.43 (8th)	178	36.50 (5)	45	37.89 (13)
Female	2	1.80 (44)	37	7.45 (27)	7	4.32 (21)
Total	33	14.45 (11th)	215	21.85 (8th)	52	18.52 (12th)
US Total	4,140	9.76	24,847	15.52	5,421	14.29

Table 2 breaks down completed suicides in WV by ethnicity. The ethnic group with the highest rate of suicide in WV was white individuals, with a rate of 16.70, which accounted for 96% of suicide deaths in WV. The group with the second highest rate were Asian/Pacific Islander individuals, with a rate of 15.24 (n=2), which accounted for 1% of completed suicides in WV. The group with the third highest rate were black individuals with a rate of 14.69 (n=10), which accounted for 3% deaths by suicide in WV.

Table 2: Completed Suicide by Ethnicity

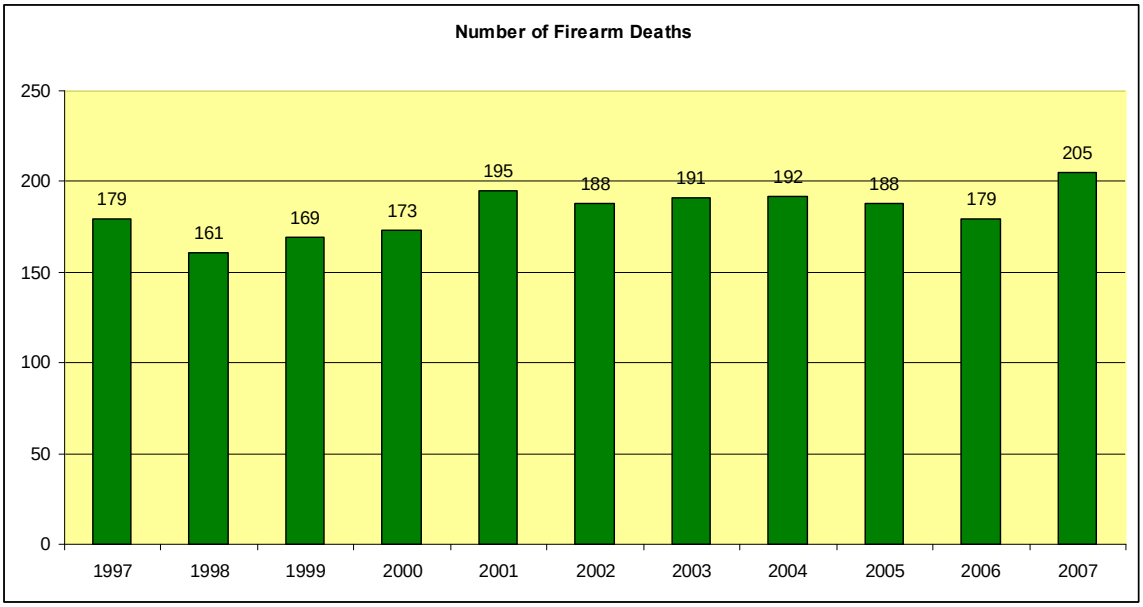
	Male	Rate	Female	Rate	Total	Rate
White	245	29.09	43	4.87	288	16.70
Black	8	22.96	2	6.02	10	14.69
American Indian/ Alaskan Native	0	0	0	0	0	0
Asian/Pacific Islander	1	15.32	1	15.16	2	15.24

Table 3 breaks down the number of suicide deaths by firearm in 2007. In WV, there were 205 deaths by suicide with a firearm. This ranked 9th in the nation among firearm deaths by suicide. Among the age group of 25 to 64, the rate of firearm deaths was 14.13 (n=139), which ranked third in the nation. Among males of this age group, males had a rate of 26.04 (n=127), which ranked 2nd in the nation. Among the age group of 65+, the rate of firearm deaths was 16.74

(m=47), which ranked 7th in the nation. Among this age group, males had a rate of 35.37 (n=42), which ranked 8th, while females of this age group ranked 6th with a rate of 3.09 (n=5). WV had all age groups ranked among the top 10 of firearm deaths in the US. In 2007, firearms accounted for 68% (n=205) of suicide deaths in WV. During the past 10 years, this was the highest number of suicides completed by firearms.

Table 3: Suicide by Firearm

	15-24	Rate (Rank)	25-64	Rate (Rank)	65+	Rate (Rank)
WV Male	18	15.35 (9th)	127	26.04 (2nd)	42	35.37 (8th)
US Male	1,727	7.92	9,800	12.32	3,607	22.54
WV Female	1	0.90 (24th)	12	2.42 (22nd)	5	3.09 (6th)
US Female	173	0.84	1,702	2.11	288	1.31
WV Total	19	8.32 (9th)	139	14.13 (3rd)	47	16.74 (7th)
US Total	1,900	4.48	11,502	7.19	3,895	10.27



*All rates are per every 100,000 people
*All data was obtained from the CDC National Vital Statistics System Web-based Injury Statistics Query and Reporting System (WISQARS)

Lesbian, Gay, Bisexual, Transgender (LGBT) Youth

The Action Alliance for Suicide Prevention recently identified LGBT youth as a priority population for suicide prevention. LGBT youth are at a higher risk of attempting suicide than heterosexual youth. LGBT youth are 1.5 to 7 times more likely to attempt suicide than other youth.[19] A recent study by the Suicide Prevention Resource Center found that LGBT youth are also more likely to be bullied by their peers, which increases the likelihood for attempted suicide.

Law Enforcement

Law enforcement officers are also at a heightened risk for suicide. The organization Badge of Life performed a study in 2008 that indicated that Law Enforcement officers have a suicide rate of 17.0/100,000.[20] This is higher than the national average of 11.2/100,000.[21] This study also indicated that Law enforcement is three times more likely to die by suicide than they are to be killed by assailants.

Military/Veterans and Families

Suicide has increased dramatically in the military since that start of the war on terrorism. The increased operational tempo, redeployment, combat exposure injury, and the impact on martial and family relationships create extreme stress and are contributing factors to suicide.[22] The Action Alliance for Suicide Prevention recently identified Military personnel and Veterans as a priority population for suicide prevention. In 2010 there were a reported 343 deaths by suicide among active-duty soldiers, National Guard, Army reserves, civilian employees of the Army and family members. It was also reported by the Army that there were 156 deaths by suicide among the National Guard in 2010. Of the 156 deaths by suicide in the National Guard less than 50% had been deployed to a war zone.[23] A SAMHSA study reported an annual average of 9.3 percent of veterans age 21 to 39 experienced at least one Major Depressive Episode within the past year. Research also estimates that 25 to 30 percent of veterans of the Iraq and Afghanistan wars have reported symptoms of a mental or cognitive disorder.[24] More than 6,000 veterans die by suicide each year. National statistics show that veterans constitute around 20 percent of deaths by suicide each year in the US.[25]

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[19] See http://www.sprc.org/library/SPRC_LGBT_Youth.pdf
[20] See http://www.badgeoflife.com/suicides.php
[21] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf
[22] Courage to Care Suicide Facts: *What Military Families should know to help loved one who may be at risk*
[23] See http://articles.cnn.com/2011-01-19/us/army.suicide.rate_1_army-suicides-suicides-among-active-duty-soldiers-suicide-rate/2?_s=PM:US
[24] See http://www.oas.samhsa.gov/2k8/veteransDepressed/veteransDepressed.htm
[25] http://www.defense.gov/news/newsarticle.aspx?id=58879

Important Risk and Protective Factors

The *National Strategy for Suicide Prevention: Goals and Objectives for Action* discusses important factors that might increase the risk for suicide.

People with these risk factors may be more likely to engage in suicidal behavior than people without them. Some risk factors may be reduced by interventions such as medications or social supports. Others, like previous suicide attempts, cannot be changed, but can alert others to an increased risk of suicide during periods of a recurrence of a mental illness or substance disorder or following a significantly stressful life event.

Risk factors generally fall into one of three categories. Biopsychosocial risk factors include issues that are related to health of the individuals or his/her family members. Environmental risk factors are generally situations in a personôs environment which may increase stress or support suicidal thoughts. Finally, sociocultural risk factors are those concerns within the culture that increase suicidal thoughts or behaviors.

These three sets of risk factors are listed in the table below:

Biopsychosocial	Environmental	Sociocultural
Mental illnesses, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders	Job or financial loss	Exposure to, including through the media, and influence of others who have died by suicide
Alcohol and other substance use disorders		
Hopelessness	Relational or social loss	Stigma associated with help-seeking behavior
Impulsive and/or aggressive tendencies		
History of trauma or abuse	Easy access to lethal means	Barriers to accessing health care
Some major physical illnesses		
Previous suicide attempt	Local clusters of suicide that have a contagious influence	Some cultural and religious beliefs
Family history of suicide		Lack of social support and sense of isolation

Thankfully, there are protective factors for suicide ï actions which can help counter suicide risks. Protective factors are varied and address individual attitudes and behaviors as well as the environment and culture of the community.

Protective factors include:

- Effective health care and clinical care for mental illnesses and substance abuse;
- Easy access to a variety of clinical interventions and supports, including peer support, for people seeking help;
- Restricted access to highly lethal means of suicide;
- Strong connections to family and community support; and
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes.

Both risk factors and protective factors are addressed in this plan.

It is essential to address and support the protective factors, as they have been helpful in preventing suicide. However, this plan cannot simply focus on protective factors alone since resistance to suicide is not permanent. The programs that support and maintain protection against suicide should be ongoing. As this plan is implemented, attention will be paid to addressing both the risk factors and the protective factors.

Plan Format

This suicide prevention plan is based on West Virginia-specific needs and resources. The format mirrors that of the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. The plan identifies goals and objectives and outlines the strategies and activities to accomplish such goals.

The plan is divided into the Awareness, Implementation, and Methodology (AIM) categories of the national plan. In addition, a section is devoted to development of the infrastructure needed to oversee the plan's implementation.

The four categories are defined as follows:

- **Infrastructure** – Goals, objectives, strategies, and activities addressing the tangible framework needed to secure resources to coordinate and provide information and technical assistance to organizations, agencies, and individuals working to implement goals and objectives within the plan, and to update the plan over time

- **Awareness** – Goals, objectives, strategies, and activities addressing increasing knowledge on a wide-scale basis

- **Implementation** – Goals, objectives, strategies, and activities addressing the programs and activities conducted to prevent suicide

- **Methodology** – Goals, objectives, strategies, and activities addressing program evaluation, surveillance, reporting, and research

The final section is a document to be used to create a work plan to assure achievement.

Infrastructure

The tangible framework needed for coordination of plan implementation, providing information and technical assistance to organizations, agencies, and individuals working to implement components of the plan, and to updating the plan over time.

Goal: Develop broad-based support for suicide prevention among providers of behavioral health and health care services

Objective: By 2015, all professional behavioral health and health care organizations in West Virginia will include suicide prevention activities in goals and objectives for the organization

Strategy: WVCPS will coordinate with WVBHPA, WVPCA, school health services, and college and university health services, to encourage behavioral health and health care organizations and providers to adopt suicide prevention ***within their mission***

Activities:

- The Chair and Executive Director of the West Virginia Council for the Prevention of Suicide will work with the Executive Directors and Chairs of other health care and behavioral health organizations to develop a strategy to encourage inclusion of suicide prevention goals into the plans of member organizations of WVBHPA

Goal: WVCPS will establish an "endowment fund" for the purpose of furthering and sustaining operational goals of the organization

Objective: By 2015, the WVCPS will develop and establish an endowment fund in order to further sustainability

Activities:

- WVCPS Board Members will participate in a letter writing campaign to stakeholders in order to raise money for the endowment fund
- WVCPS Board Members and staff will encourage stakeholders to remember the WVCPS when doing estate planning
- WVCPS will hold one fund raising event each year to raise funds for the endowment fund

Awareness

Increase public knowledge of suicide-related issues in West Virginia, including risks and protective factors for suicide and available prevention and intervention resources in the local community and throughout the state.

Goal: WVCPS programs and services will target WV highest risk populations and their families. Such services will entail a continuum from preventive to supportive linkage leading to appropriate treatment and postvention services as needed

Objective: By 2015, Co-operative agreements with WV identified high risk populations will be established that detail projects, services, activities and materials to be available and provided by both parties

Strategy: West Virginia Council for the Prevention of Suicide will develop and distribute printed and Web-based information designed to increase ***community*** knowledge about risk factors for suicide, protective factors, and resources for prevention and intervention

Activities:

- Director and/or Council Board President will meet with the appropriate state and/or agency official to align expectations and access additional support for materials and resources for adequate coverage statewide
- WVCPS will specifically target other high risk populations, including but not limited to: LGBTQIA, youth in the Juvenile Justice system, veterans, National Guard, Reserves, Active Duty military, as needed

Objective: By 2015, WVCPS will ensure availability of education in suicide assessment, management of risk behaviors, and identification and promotion of protective factors for all WV health care providers

Strategy: WVCPS will utilize a variety of educational forums and formats to provide for pre-service and in-service education of health care providers

Activities:

- Continue bi-annual conferences sponsored by WVCPS
- Assure attendance of staff at one national conference on suicide prevention annually
- Use information from the SPRC and the CDC to develop and disseminate suicide prevention fact sheets

Implementation

Enhancing and promoting programs, services, and activities to prevent suicide by promoting protective factors and reducing risks.

Goal: Promote mental wellness

Objective: Decrease stigma with media-based approach

Strategy: West Virginia Council for the Prevention of Suicide will measure prejudice toward receiving services for mental health and/or substance abuse issues and create a plan to reduce stigma

Activities:

- By 2015, the Council will have developed media materials, presentations, and conducted community roundtables in WV counties

Objective: A campaign to increase efforts to reduce access to lethal means and methods of self-harm among people who have been assessed as at risk for suicide will be developed and implemented by 2015

Strategy: WVCPS will continue to develop and implement activities to readily access the potential for suicide and reduce access to lethal methods of self-harm for people assessed at risk

Activities:

- Continue to provide information to encourage the use of assessments in health care, education, and social service settings
- Develop and distribute a fact sheet with statistics regarding use of medications and suicide risk for distribution to providers, communities, and individuals at risk
- Collaborate with the Department of Natural Resources and/or other entities to develop and implement a public education campaign concerning safely storing and securing firearms

- Collaborate with the Department of Natural Resources and/or other entities to distribute gun locks

- Encourage health care and behavioral health professionals to counsel families and friends about preventing access to means of suicide for persons who have attempted suicide

Goal: Develop a support network for individuals who have been affected by a death of suicide

Objective: Increase postvention efforts and resources

Strategy: WVCPS will encourage and support organizations to develop or enhance support groups for people who have been affected by suicide

Activities:

- Research and disseminate a training program for behavioral health, health care, and social service providers on appropriately supporting suicide survivors

- Research and disseminate a training program for medical, fire, and law enforcement personnel who respond to attempted and completed suicides

- Disseminate with contact information for the Suicide Prevention Lifeline for law enforcement, firefighters, EMS personnel, faith based communities, funeral homes and other first responders

- Research and utilize a Train the Trainerôs curriculum for facilitators or leaders of support groups for the individuals affected by the death of a loved on due to suicide, including procedures for marketing such support groups

Methodology

Gathering data to evaluate the effectiveness of programs, activities, and clinical treatments, and conducting suicide-specific surveillance and research.

Goal: Utilize data to inform planning and decision-making

Objective: Improve the current data collection and results information system

Strategy: Disseminate county, state, and national data

Activities:

- Collect and analyze WV county, state, and national comparable data to inform planning
- Publicly disseminate results through web-based efforts
- Participate in the state WVSEOW work group
- Evaluate all program activites and consumer satisfaction and disseminate the results
- Executive Director and staff will meet with the evaluation staff to determine the data to be collected and reported for the coming year. Evaluation staff will present outcome reports to the Council at itsôregular quarterly meetings

Achieving the Goals of the Plan

This plan has six goals and eight objectives. It includes strategies and activities which are designed to accomplish the goals and objectives. It is a five year plan ï expected to be completed or modified by 2015.

Specific timelines for objectives and activities are not listed in this plan. It is expected that major responsibility and accountability to achieve the plan will be given to the West Virginia Council for the Prevention of Suicide.

The grid on the following pages is provided for use by the Council in developing a work plan.

Goals and objectives are re-stated in each of one of four categories: Infrastructure, Awareness, Implementation, and Methodology. Activities planned for each of the objectives are then listed. To the right of the activities are projected dates (year) for completion. The work plan to be developed will establish target dates for completion of each activity and could be ñcontinuousòor a specific date.

The final column is headed ñEffort Requiredòand is an important item to consider for achieving the plan. ñEffort Requiredòwill consider the resources needed ï human resources, funding, physical or technical resources, and activity or project management requirements.

INFRASTRUCTURE						
Goal: Develop broad-based support for suicide prevention among providers of behavioral health and health care services						
Objective: By 2015, all professional behavioral health and health care organizations in West Virginia will include suicide prevention activities in goals and objectives for the organization						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT REQUIRED**
Chair and Executive Director of the West Virginia Council for the Prevention of Suicide will work with the Executive Directors and Chairs of other health care and behavioral health organizations to develop a strategy to encourage inclusion of suicide prevention goals into the plans of member organizations of WVBHPA						

Goal: WVCPS will establish an ñendowment fundò for the purpose of furthering and sustaining operational goals of the organization						
Objective: By 2015, the WVCPS will develop and establish and endowment fund in order to further sustainability						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT REQUIRED**
WVCPS Board Members will participate in a letter writing campaign to stakeholders in order to raise money for the endowment fund						
WVCPS Board Members and staff will encourage stakeholders to remember the WVCPS when doing estate planning						
WVCPS will hold one fund raising event each year to raise funds for the endowment fund						

AWARENESS

Goal: WVCPS programs and services will target WV highest risk populations and their families. Such services will entail a continuum from preventive to supportive linkage leading to appropriate treatment and **postvention services** as needed

Objective: By 2015, Co-operative agreements with **WV identified high risk populations** will be established that detail products, services, activities and materials to be available and provided by both parties

ACTIVITY	2011	2012	2013	2014	2015	EFFORT REQUIRED
Director and/or Council Board President will meet with the appropriate **state and/or agency** official to align expectations and access additional support for materials and resources for adequate coverage statewide.						
WVCPS will specifically target other high risk populations, **including but not limited to: LGBTQIA, youth in the Juvenile Justice system, veterans, National Guard, Reserves, Active Duty military, as needed**						

Objective: By 2015, the WVCPS will ensure availability of education in suicide assessment, management of risk behaviors, and identification and promotion of protective factors for all WV ***health care providers***						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT REQUIRED**
Continue bi-annual conferences sponsored by the WVCPS						
Assure attendance of staff and at least two Council members of the WVCPS at least one national conference on suicide prevention annually						
Use information from the SPRC and the CDC to develop and disseminate suicide prevention fact sheets						

IMPLEMENTATION						
Goal: Promote mental wellness						
Objective: Decrease stigma with media-based approach						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT REQUIRED**
By 2015, the Council will have developed media materials presentations and conducted community roundtables in WV counties						
Objective: A campaign to increase efforts to reduce access to lethal means and methods of self-harm among people who have been assessed as at risk for suicide will be developed and implemented by 2015						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT REQUIRED**
Continue to provide information to encourage the use of assessments in health care, education, and social service settings						
Develop and distribute a fact sheet with statistics regarding use of medications and suicide risk for distribution to providers, communities, and individuals at risk						

Collaborate with the Department of Natural Resources and/or other entities to develop and implement a public education campaign concerning safely storing and securing firearms						
Collaborate with the Department of Natural Resources and/or other entities to distribute gun locks						
Encourage health care and behavioral health professionals to counsel families and friends about preventing access to means of suicide for persons who have attempted suicide						

Goal: Develop a support network for individuals who have been affected by a death of suicide						
Objective: Increase postvention efforts and resources						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT REQUIRED**
Research and disseminate a training program for behavioral health, health care, and social service providers on appropriately supporting suicide survivors						
Research and disseminate a training program from medical, fire, and law enforcement personnel who respond to attempted and completed suicides						

Disseminate with contact information for the Suicide Prevention Lifeline for law enforcement, firefighters, EMS personnel, faith based communities, funeral homes and other first responders						
Research and utilize a Train the Trainerôs curriculum for facilitators or leaders of support groups for the individuals affected by the death of a loved on due to suicide, including procedures for marketing such support groups						

METHODOLOGY						
Goal: Utilize data to inform planning and decision-making						
Objective: Improve the current data collection and results information system						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT REQUIRED**
Collect and analyze WV county, states, and national comparable data to inform planning						
Publicly disseminate results through web-based efforts						

Participate in the state WVSEOW work group						
Evaluate all program activites and consumer satisfaction and disseminate the results						
Executive Director and staff will meet with the evaluation staff to determine the data to be collected and reported for the coming year. Evaluation staff will present outcome reports to the Council at itsôregular quarterly meetings						