

Suicide Prevention in California: Three Goals for Developing a Statewide Plan

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Suicide Prevention in California: Three Goals for Developing a Statewide Plan

Testimony of Rajeev Ramchand¹
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Before the California Mental Health Services Oversight and Accountability Commission

May 24, 2018

My name is Rajeev Ramchand. I am a psychiatric epidemiologist and Senior Behavioral Scientist at the RAND Corporation. For the past decade, I have been conducting research to help policymakers and practitioners better address and prevent suicide in their communities. This includes work for the Department of Defense, the military service branches, the Department of Veterans Affairs, the National Institute of Mental Health, and the National Institute of Justice. Beginning in 2011, I led RAND’s evaluation of California’s suicide prevention and early intervention initiatives funded under Proposition 63, the Mental Health Services Act, and administered by the California Mental Health Services Authority, or CalMHSA. That evaluation documented the benefits of the Know the Signs campaign,³ variability in the services provided by California suicide crisis lines,⁴ and the potential economic and life-saving benefits of sustained training in a suicide prevention course, ASIST, throughout the state.⁵

¹ The opinions and conclusions expressed in this testimony are the author’s alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

² The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

³ J. Acosta, R. Ramchand, and A. Becker, “Best Practices for Suicide Prevention Messaging and Evaluating California’s ‘Know the Signs’ Media Campaign,” *Crisis*, Vol. 38, No. 5, February 23, 2017, pp. 1–13.

⁴ R. Ramchand, L. Jaycox, P. Ebener, M. L. Gilbert, D. Barnes-Proby, and P. Goutam, “Characteristics and Proximal Outcomes of Calls Made to Suicide Crisis Hotlines in California,” *Crisis*, Vol. 38, No. 1, January 2017, pp. 26–35.

⁵ J. S. Ashwood, B. Briscoombe, R. Ramchand, E. May, and M. A. Burnam, “Analysis of the Benefits and Costs of CalMHSA’s Investment in Applied Suicide Intervention Skills Training (ASIST),” *RAND Health Quarterly*, Vol. 5, No. 2, November 30, 2015, p. 9; K. C. Osilla, D. Barnes-Proby, M. L. Gilbert, and R. Ramchand, “A Case Study Evaluating the Fidelity of Suicide Prevention Workshops in California,” *RAND Health Quarterly*, Vol. 4, No. 3, December 30, 2014, p. 11.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is charged with developing a statewide suicide prevention plan. In my testimony today, I would like to highlight three goals that MHSOAC should consider when designing this plan to support local communities and stakeholders in preventing suicide across the state. The first goal is to provide better care to individuals we know are at risk for suicide and support their families. The second goal is to identify people who may be at risk of suicide but who might not yet be benefiting from support services. The third goal is to create environments that are designed to prevent death from suicide, but to do so in a way that is fair and balanced.

Treating People at Risk for Suicide, and Supporting Their Families

The relationship between mental health disorders and suicide is well-established. Suicide rates are elevated among people with schizophrenia, depression, borderline personality disorder, bipolar disorder, anorexia and bulimia, personality disorders, and anxiety disorders, including post-traumatic stress disorder.⁶ It is also elevated among those with substance use disorders, most notably opioid use disorders.⁷ But while most people who die by suicide have a mental health disorder, an individual with a mental health disorder's risk of suicide is actually still quite low.⁸ In other words, although many suicide deaths may have the presence of a mental health disorder, most people with a mental health disorder are not at acute risk of dying by suicide and will never attempt to take their lives.

What few people recognize is that not only are mental health problems common among those who die by suicide, many of those who die are already receiving mental health care from either a primary care provider or from a mental health professional. Nearly a quarter of the insured population who died by suicide had a mental health care visit in the month before their death, and almost half had a mental health care visit in the year before their death.⁹ This suggests that we need to improve the care that individuals engaged in mental health care are receiving.

There are four empirically supported ways to achieve this goal: promote the use of evidence-based care for those at risk of suicide; invest in developing new treatments for suicidality; use

⁶ E. Chesney, G. M. Goodwin, and S. Fazel, "Risks of All-Cause and Suicide Mortality in Mental Disorders: A Meta-Review," *World Psychiatry: Official Journal of the World Psychiatric Association*, Vol. 13, No. 2, June 2014, pp. 153–160.

⁷ Chesney, Goodwin, and Fazel, 2014; H. C. Wilcox, K. R. Conner, and E. D. Caine, "Association of Alcohol and Drug Use Disorders and Completed Suicide: An Empirical Review of Cohort Studies," *Drug and Alcohol Dependence*, Vol. 76, Suppl., December 7, 2004, pp. S11–19.

⁸ J. T. Cavanagh, A. J. Carson, M. Sharpe, and S. M. Lawrie, "Psychological Autopsy Studies of Suicide: A Systematic Review," *Psychological Medicine*, Vol. 33, No. 3, April 2003, pp. 395–405; J. C. Franklin, J. D. Ribeiro, K. R. Fox, K. H. Bentley, E. M. Kleiman, X. Huang, K. M. Musacchio, A. C. Jaroszewski, B. P. Chang, and M. K. Nock, "Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research," *Psychological Bulletin*, Vol. 143, No. 2, February 2017, pp. 187–232.

⁹ B. K. Ahmedani, G. E. Simon, C. Stewart, A. Beck, B. Waitzfelder, R. Rossom, F. Lynch, A. Owen-Smith, E. M. Hunkeler, U. Whiteside, B. H. Operskalski, M. J. Coffey, and L. I. Solberg, "Health Care Contacts in the Year Before Suicide Death," *Journal of General Internal Medicine*, Vol. 29, No. 6, June 2014, pp. 870–877.

collaborative care for those at risk of suicide; and support the families of those who have attempted or are at risk of suicide.

Promoting Use of Evidence-Based Care for Those at Risk of Suicide

The first way to improve care for those at risk of suicide is to implement care strategies that we know work. Certain psychotherapies, like Dialectical Behavioral Therapy, that focus on not only the symptoms of mental illness but also specifically on the patient's desire to die have led to reductions in suicidal behaviors.¹⁰ There is also emerging evidence about the benefits of safety planning, a component in many evidence-based treatments that may also work as a stand-alone intervention. When constructing safety plans, patients at risk for suicide identify available supports and coping skills that they can access during periods when they are thinking about suicide.¹¹ Those who work with suicidal patients, and those studying to work with suicidal patients, should be aware of these clinical practices and how to implement them. Health systems can promote safety planning by prompting providers to record the plans in electronic medical record systems and by making plans accessible to patients via commonly used patient portals.¹² Finally, there is emerging evidence that offering follow-up phone calls, letters, text messages, and postcards can prevent acts of self-harm among those at risk of suicide.¹³ These follow-ups are feasible, easy-to-implement suicide prevention strategies that most health care agencies can adopt today.

Invest in Developing New Treatments for Suicidality

Even with increased awareness and use of evidence-based treatments and safety plans, there are only a few therapies known to treat suicidality. For this reason, it is equally important to invest in research on new treatments for preventing suicide. One of the most exciting treatments currently under investigation is ketamine. Emerging evidence suggests that for people in suicidal crises, a single, subanesthetic dose of ketamine can lower their suicidal thoughts in as quickly as

¹⁰ G. K. Brown, T. Ten Have, G. R. Henriques, S. X. Xie, J. E. Hollander, and A. T. Beck, "Cognitive Therapy for the Prevention of Suicide Attempts: A Randomized Controlled Trial," *Journal of the American Medical Association*, Vol. 294, No. 5, August 3, 2005, pp. 563–570; M. M. Linehan, K. A. Comtois, A. M. Murray, M. Z. Brown, R. J. Gallop, H. L. Heard, K. E. Korslund, D. A. Tutek, S. K. Reynolds, and N. Lindenboim, "Two-Year Randomized Controlled Trial and Follow-Up of Dialectical Behavior Therapy Versus Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder," *Archives of General Psychiatry*, Vol. 63, No. 7, July 2006, pp. 757–766; M. D. Rudd, C. J. Bryan, E. G. Wertenberger, A. L. Peterson, S. Young-McCaughan, J. Mintz, S. R. Williams, K. A. Arne, J. Breitbart, K. Delano, E. Wilkinson, and T. O. Bruce, "Brief Cognitive-Behavioral Therapy Effects on Post-Treatment Suicide Attempts in a Military Sample: Results of a Randomized Clinical Trial with 2-Year Follow-Up," *The American Journal of Psychiatry*, Vol. 172, No. 5, May 2015, pp. 441–449.

¹¹ B. Stanley and G. K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice*, Vol. 19, 2012, pp. 256–264.

¹² V. Little, J. Neufeld, and A. R. Cole, "Integrating Safety Plans for Suicidal Patients Into Patient Portals: Challenges and Opportunities," *Psychiatric Services*, March 1, 2018.

¹³ A. J. Milner, G. Carter, J. Pirkis, J. Robinson, and M. J. Spittal, "Letters, Green Cards, Telephone Calls and Postcards: Systematic and Meta-Analytic Review of Brief Contact Interventions for Reducing Self-Harm, Suicide Attempts and Suicide," *British Journal of Psychiatry*, Vol. 206, No. 3, March 2015, pp. 184–190.

one hour, and the effects can persist up to seven days.¹⁴ The science on therapies like ketamine is still limited and will benefit from further research, including research with sample sizes large enough to detect potential changes in suicide attempts and deaths.

Collaborative Care for Those at Risk of Suicide

People at risk for suicide can benefit not only from specific therapies, but also from specific ways of administering care. Collaborative care is a specific primary care approach for treating behavioral health issues, including suicide risk, that has the potential to save lives. Under the collaborative care model, traditional primary care is extended to include a team consisting of a care coordinator and a specialty behavioral health care provider, who typically provides case consultation to the primary care team. This team collaborates to create a holistic plan for the patient based on evidence-supported treatments, sets patient goals, and monitors whether goals are achieved, making adaptations when patients are not making adequate process. Collaborative care has been tested in over 80 randomized control trials, and while it has not been specifically shown to reduce suicide deaths, meta-analyses have confirmed its benefits for patients with depression and anxiety.¹⁵ Since January 2018, collaborative care has had a designated Current Procedural Terminology code, and Medicare and health care plans like Kaiser Permanente cover it. Other health care systems in California, including MediCal, should be incentivized to implement collaborative care within their systems.

Support the Families of Those Who Have Attempted or Are at Risk of Suicide

Part of the benefit of collaborative care lies in its holistic approach of treating the person, not just their disorder. Patients who may be at risk of suicide have family members and friends who often serve as caregivers. These parents, spouses, siblings, children, and friends ensure their loved ones adhere to prescription regimens, take them to medical appointments, and help manage symptoms and behaviors stemming from the underlying mental health disorder. In fact, as is the case with most medical treatments, many of the available treatments for mental health disorders are most effective when caregivers understand and support their loved one through them. However, the care provided to suicidal people often ignores caregivers and the fundamental role they play in preventing suicide.

Health care providers and health systems need to be more inclusive with caregivers. They need to make sure caregivers are aware of the treatments their loved ones are receiving and the implications for suicide risk, always doing so in a way that respects the patients' privacy. But adequately supporting caregivers must extend beyond improving caregiving tasks to supporting caregivers themselves. Our research has shown that caregiving for people with mental health symptoms can be all-encompassing and stressful. In fact, caregivers to people with mental

¹⁴ S. T. Wilkinson, E. D. Ballard, M. H. Bloch, S. J. Murrrough, A. Feder, P. Sos, G. Wang, C. A. Zarate Jr., and G. Sanacora, "The Effect of a Single Dose of Intravenous Ketamine on Suicidal Ideation: A Systematic Review and Individual Participant Data Meta-Analysis," *The American Journal of Psychiatry*, Vol. 175, No. 2, February 1, 2018, pp. 150–158.

¹⁵ J. Archer, P. Bower, S. Gilbody, K. Lovell, D. Richards, L. Gask, C. Dickens, and P. Coventry, "Collaborative Care for Depression and Anxiety Problems," *Cochrane Database of Systematic Reviews*. October 17, 2012.

illnesses are at increased risk for depression themselves.¹⁶ If a caregiver is depressed, the care they are providing to their loved one likely suffers, increasing suicide risk for the person they are providing care for and possibly themselves.

There are examples of support to caregivers. The National Alliance of Mental Illness offers Family-to-Family, a 12-session educational program for family members of people with mental illness that reduces caregiver burden and improves family members' feelings of empowerment.¹⁷ Perry Hoffman and Alan Fruzzetti have developed a similar program, called Family Connections, for families of people with borderline personality disorder.¹⁸ However, these programs are few and far between. Few health care providers know about them, and there is a lack of resources to implement them. Supporting families of those at risk of suicide is a huge gap in our efforts to prevent suicide, and one that the state can certainly help fill.

Detecting More People at Risk for Suicide

As I have just discussed, there are specific suicide prevention strategies for people receiving mental health care. However, not all of those who could benefit from this care are currently receiving it. Although it is arguably the strongest risk factor for suicide, only one-third of those with a mental health disorder are receiving mental health treatment.¹⁹ Among the 4 percent of Americans who have serious thoughts of taking their own lives each year, only one-third are in mental health treatment.²⁰ Of those not receiving mental health care, one-quarter felt that they needed mental health services.²¹ How can we find these people who are not in mental health treatment and get them into care that might help prevent suicide?

Emergency departments are a good place to start. Forthcoming research from the national Mental Health Research Network finds that in a sample of insured people who died by suicide, 48 percent had had an emergency department visit in the past year, and 20 percent had visited an emergency department in the past month.²² Moreover, 60 percent of those who make a nonfatal

¹⁶ R. Ramchand, T. Tanielian, M. P. Fisher, C. A. Vaughn, T. E. Trail, C. Batka, P. Voorhies, M. Robbins, E. Robinson, and B. Ghosh-Dastidar, *Hidden Heroes: America's Military Caregivers*. Santa Monica, Calif.: RAND Corporation, RR-499-TEDF, 2014.

¹⁷ L. Dixon, A. Lucksted, B. Stewart, J. Burland, C. H. Brown, L. Postrado, C. McGuire, and M. Hoffman, "Outcomes of the Peer-Taught 12-Week Family-to-Family Education Program for Severe Mental Illness," *Acta Psychiatrica Scandinavica*, Vol. 109, No. 3, March 2004, pp. 207–215.

¹⁸ P. D. Hoffman, A. E. Fruzzetti, E. Buteau, D. Penney, M. L. Bruce, F. Hellman, and E. Struening, "Family Connections: A Program for Relatives of People with Borderline Personality Disorder," *Family Process*, Vol. 44, No. 2, June 2005, pp. 217–225.

¹⁹ R. C. Kessler, O. Demler, R. G. Frank, M. Olfson, H. A. Pincus, E. E. Walters, P. Wang, K. B. Wells, and A.M. Zaslavsky, "Prevalence and Treatment of Mental Disorders, 1990 to 2003.," *New England Journal of Medicine*, Vol. 352, No. 16, 2005; pp. 2515–2523.

²⁰ K. Piscopo, R. N. Lipari, J. Cooney, and C. Glasheen, *Suicidal Thoughts and Behavior Among Adults: Results from the 2015 National Survey on Drug Use and Health*, Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2016.

²¹ Piscopo et al., 2016.

²² Ahmedani BK. Personal Communication. March 18, 2018.

suicide attempt seek medical care for their attempt, and many of them may receive this care in an emergency room.²³

What promise do emergency departments hold in preventing suicide? First, they can implement screening to identify populations that may be at risk. In 2015, Parkland Hospital in Dallas, Texas began screening every patient for suicide risk during every emergency department encounter; 6 percent screened positive for further assessment.²⁴ In fact, implementing universal screening in emergency departments doubles the number of people identified as needing treatment for suicide risk.²⁵ Once these people are identified, hospital staff can provide acute crisis care. In a recent multisite clinical trial, emergency department patients who screened positive for suicide risk were provided with further screening, a safety plan intervention, and a series of supportive phone calls upon discharge. Those who received this intervention had 5 percent fewer suicide attempts in the following year.²⁶

Policymakers and emergency departments may need to be convinced that the extra effort of screening for suicide risk and counseling is worth it. Fortunately, that evidence exists. Follow-up postcards or text messages appear to be so cheap that they ultimately *reduce* total healthcare costs, and more-intensive interventions also have very high value.²⁷ With strategic partnerships, emergency departments can shift some of these responsibilities to other agencies. For example, in California, the Santa Clara County crisis hotline has a partnership with the county's emergency department and arranges for telephone follow-up with patients at risk of suicide. RAND recommends crisis hotlines pursue such partnerships, both to prevent suicides locally and to help financially sustain crisis lines.²⁸

Still, some people who die by suicide have not seen any health care provider within a month, or even a year, of their death. This includes students, employees, and inmates in prisons and jails. Many of these institutions are already engaged in efforts to prevent suicide, and many others

²³ Piscopo et al., 2016.

²⁴ K. Roaten, C. Johnson, R. Genzel, F. Khan, C. S. North, "Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System," *Joint Commission Journal on Quality and Patient Safety*, Vol. 44, No. 1, January 2018, p. 4–11.

²⁵ E. D. Boudreaux, C. A. Camargo, Jr., S. A. Arias, A. F. Sullivan, M. H. Allen, A. B. Goldstein, A. P. Manton, J. A. Espinola, and I. W. Miller, "Improving Suicide Risk Screening and Detection in the Emergency Department," *American Journal of Preventive Medicine*. Vol. 50, No. 4, April 2016, pp. 445–453.

²⁶ I. W. Miller, C. A. Camargo, Jr., S. A. Arias, A. F. Sullivan, M. H. Allen, A. B. Goldstein, A. P. Manton, J. A. Espinola, R. Jones, K. Hasegawa, E. D. Boudreaux, and the ED-SAFE Investigators, "Suicide Prevention in an Emergency Department Population: The ED-SAFE Study," *JAMA Psychiatry*, Vol. 74, No. 6, June 1, 2017, pp. 563–570.

²⁷ P. Denchev, J. L. Pearson, M. H. Allen, C. A. Claassen, G. W. Currier, D. F. Zatzick, and M. Schoenbaum, "Modeling the Cost-Effectiveness of Interventions to Reduce Suicide Risk Among Hospital Emergency Department Patients," *Psychiatric Services*, Vol. 69, No. 1, January 1, 2018, pp. 23–31.

²⁸ R. Ramchand, L. H. Jaycox, and P. A. Ebener, "Suicide Prevention Hotlines in California: Diversity in Services, Structure, and Organization and the Potential Challenges Ahead," *RAND Health Quarterly*, Vol. 6, No. 3, June 2017, p. 8.

want to know what they can do. Unfortunately, the science does not yet provide very specific answers about effective strategies these organizations can pursue.²⁹

For this reason, evaluations of suicide prevention initiatives, like the evaluation CalMHSA funded RAND to conduct, are critical for broadening the evidence base. But rather than leave a vacuum of evidence, we can use available science and scientific methods to offer some suggestions.

I recently received funding from the National Institute of Justice to examine the types of suicide prevention strategies law enforcement agencies were engaged in across the United States and to identify gaps and potential solutions. Through this research, my colleague Jessica Saunders and I identified four pillars of support that law enforcement agencies can offer to prevent suicide among their officers. These pillars may be useful for other institutions to use to guide their suicide prevention efforts.

Pillar 1: Reduce Stress

Organizations should make attempts to reduce and respond to any unwarranted stress among their workforce. For example, a law enforcement agency may not be able to change the stress inherent in police work, but it could consider different shift schedules if sleep challenges are a cause of stress among its officers. However, stressors will be unique across organizations; for example, what's stressful to deputies in the Los Angeles County Sheriff Department may not be the same as what's stressful for members of the Los Angeles Police Department. Routine surveillance of stressors among populations is useful so that organizations can tailor interventions and policies to address the specific needs of their populations.

Pillar 2: Offer Support

Organizations should support their workforces' capacity to deal with stress. This can be done by promoting a culture of health that encourages positive ways to strengthen overall health and wellness. For example, some agencies offer yoga and mindfulness classes. Others offer restorative sleep rooms for officers to take naps, particularly during periods of high operational tempo.

Pillar 3: Identify People at Risk of Suicide

Third, organizations may have policies or programs that identify people in need of additional support and encourage them to seek help. This may include efforts like marketing campaigns that

²⁹ R. J. Cramer, H. J. Wechsler, S. L. Miller, and E. Yenne, "Suicide Prevention in Correctional Settings: Current Standards and Recommendations for Research, Prevention, and Training," *Journal of Correctional Health Care: The Official Journal of the National Commission on Correctional Health Care*, Vol. 23, No. 3, July 2017, pp. 313–328; C. Katz, S. L. Bolton, L. Y. Katz, C. Isaak, T. Tilston-Jones, J. Sareen, and the Swampy Cree Suicide Prevention Team, "A Systematic Review of School-Based Suicide Prevention Programs," *Depression and Anxiety*, Vol. 30, No. 10, October 2013, pp. 1030–1045; A. Milner, K. Page, S. Spencer-Thomas, and A. D. Lamotagne, "Workplace Suicide Prevention: A Systematic Review of Published and Unpublished Activities," *Health Promotion International*, Vol. 30, No. 1, March 2015, pp. 29–37; K. Witt, A. Milner, A. Allisey, L. Davenport, and A. D. LaMontagne, "Effectiveness of Suicide Prevention Programs for Emergency and Protective Services Employees: A Systematic Review and Meta-Analysis," *Am J Ind Med*. Vol. 60, No. 4, April 2017, pp. 394–407.

promote available resources, so that people at risk of suicide know that help is available and where to turn. It could also include strategies that teach supervisors or peers to identify and intervene with people exhibiting signs of distress—interventions that are common but that lack strong empirical support.³⁰

Organizations might also consider screening for suicide risk, although such screening needs to be considered carefully when performed outside of health care settings. At schools, for example, standardized screening performs better than teacher observation, but schools may be unprepared for an influx of students who screen positive.³¹ Law enforcement and similar agencies are creating computer dashboards that flag officers after reaching a prespecified threshold of infractions; however, we do not know whether or how this information is used to support (as opposed to punish) officers.³² In both schools and workplaces, a high proportion of false positives creates the risk of potential unintended consequences that need to be considered carefully and prior to implementation.

Pillar 4: Facilitate Access to Care

Finally, organizations need to reduce barriers and facilitate access to care for those in need. Many in law enforcement believe that receiving mental health services will harm their career; agencies need to revise policies that may reinforce this perception and, if accurate, assure officers that such discrimination will not occur.³³ Students may not know how to access help, which is why many advocate for parents to store the number of the National Suicide Prevention Lifeline or Crisis Text Line into their and their children’s mobile phones. But facilitating access to care also means that organizations like schools, workplaces, and prisons that offer in-house mental health care services, or that contract with employee assistance programs to do so, assure that these entities use evidence-based approaches to screen for suicide risk, provide short-term care, and make appropriate referrals.

There is one additional setting in which we may be able to reach people at risk of suicide who are not engaged in the health care system, and that is through social media. Social media has the potential to reach many more people with suicide prevention messages than traditional social marketing methods, and it is particularly effective at connecting with hard-to-reach groups, such

³⁰ C. Burnette, R. Ramchand, and L. Ayer, *Gatekeeper Training for Suicide Prevention: A Theoretical Model and Review of the Empirical Literature*, Santa Monica, Calif.: RAND Corporation, RR-1002-OSD, 2015.

³¹ M. A. Scott, H. C. Wilcox, I. S. Schonfeld, M. Davies, R. C. Hicks, J. B. Turner, and D. Shaffer, “School-Based Screening to Identify At-Risk Students Not Already Known to School Professionals: The Columbia Suicide Screen,” *American Journal of Public Health*, Vol. 99, No. 2, February 2009, pp. 334–339; D. Hallfors, P. H. Brodish, S. Khatapoush, V. Sanchez, H. Cho, and A. Steckler, “Feasibility of Screening Adolescents for Suicide Risk in ‘Real-World’ High School Settings,” *American Journal of Public Health*, Vol. 96, No. 2, February 2006, pp. 282–287.

³² R. Ramchand, J. Saunders, K. C. Osilla, V. Kotzias, E. Thornton, L. Strang, and M. Cahill, “Suicide Prevention in U.S. Law Enforcement Agencies: A National Survey of Current Practices,” *Journal of Police and Criminal Psychology*, 2018.

³³ Ramchand et al., 2018.

as LGBTQ youth.³⁴ Social media provides opportunities for a person’s online network to learn about and intervene with people who express suicidal thoughts, and as of last year Facebook is bypassing the person’s network altogether and using artificial intelligence to detect suicidal posts and intervene in such cases.³⁵ Learning more about the success of these approaches, and adapting them as new social media platforms increase in popularity, is a promising area for the future of suicide prevention.

Creating Safer Environments

The third goal MHSOAC should consider in its suicide prevention strategy focuses not on a patient’s desire to take their own life, but rather on the means they use to do so. Specifically, policy, research, and practice can directly address guns, which each year take more lives in California by suicide than they do by homicide. In 2016, California lost 4,294 lives to suicide. 1595 of these suicides, or roughly one third, were caused by firearms. Of the 159 children under 18 who took their lives, 41 used a firearm to do so.³⁶

California has some of the most restrictive gun laws in the country. This includes a Child Access Prevention law, which makes gun owners criminally liable if a loaded firearm or unloaded handgun is stored in a way that allows a child under 18 to access it.³⁷ The state’s Child Access Prevention law is important. In RAND’s recent review of the effects of 13 gun policies, these laws have the strongest evidence that they reduce suicides, especially youth suicide.³⁸ Continued enforcement of this policy will remain an important component of California’s suicide prevention strategy.

As the state enacts new gun laws or considers expanding existing laws, such as expanding the criteria of who can request a temporary firearm restraining order, it is important to consider evaluating these laws’ effects.³⁹ There is a dearth of research on the effects of gun policies, largely because the federal government has not funded such research at levels comparable to

³⁴ V. M. Silenzio, P. R. Duberstein, W. Tang, N. Lu, X. Tu, and C. M. Homan, “Connecting the Invisible Dots: Reaching Lesbian, Gay, and Bisexual Adolescents and Young Adults at Risk for Suicide Through Online Social Networks,” *Social Science and Medicine*, Vol. 69, No. 3, August 2009, 1982, pp. 469–474.

³⁵ J. Robinson, G. Cox, E. Bailey, S. Hetrick, M. Rodrigues, S. Fisher, and H. Herrman, “Social Media and Suicide Prevention: A Systematic Review,” *Early Intervention in Psychiatry*, Vol. 10, No. 2, April 2016, pp. 103–121; J. Novet, “Facebook Is Using A.I. to Help Predict When Users May Be Suicidal,” *CNBC*, 2018.

³⁶ Centers for Disease Control and Prevention, “Web-Based Injury Statistics Query and Reporting System (WISQARS): Fatal Injury Data,” webpage, undated.

³⁷ Giffords Law Center to Prevent Gun Violence, “Child Access Prevention in California,” webpage, last updated October 31, 2017.

³⁸ A. R. Morral, R. Ramchand, R. Smart, C. R. Gresenz, S. Cherney, N. Nicosia, C. C. Price, S. B. Holliday, E. L. Petrun Sayers, T. L. Schell, E. Apaydin, J. L. Traub, L. Xenakis, J. S. Meyers, R. I. Karimov, B. Ewing, and B. A. Griffin, *The Science of Gun Policy: A Critical Synthesis of Research Evidence on the Effects of Gun Policies in the United States*, Santa Monica, Calif.: RAND Corporation, RR-2088-RC, 2018.

³⁹ R. J. Foley and D. Thompson, “Few States Let Courts Take Guns from People Deemed a Threat,” Associated Press, February 18, 2018.

causes of death of similar magnitudes.⁴⁰ In this small pool of evidence, some of the best comes from Dr. Garen Wintemute at the University of California at Davis. The state recently invested \$5 million in Dr. Wintemute and his team at the University's Firearm Violence Prevention Research Center to continue this line of research. Given the limited federal funding for studying firearms and suicide, California's investment is critical and should be applauded and sustained.

Policy is not the only way to ensure safe environments that have the potential to prevent suicides. Within healthcare settings, providers working with kids should ask parents how they store their guns at home, while those working with suicidal patients should know how to talk about guns and encourage those thinking about suicide to voluntarily, and temporarily, remove guns from their immediate environments.⁴¹ To do so effectively, providers need to know legal options for the temporary transfer and storage of firearms. In California, a person with a valid firearm safety certificate can hold a gun temporarily for an immediate family member at risk of suicide without having to undergo a background check through a licensed firearm retailer, which is required for most other private transfers.⁴² However, family members may not have safety certificates when a suicidal crisis occurs, so if a person in crisis is willing to temporarily part with their weapons, it may be worth designing easy, rapid mechanisms to allow this to occur legally.

Guns are not the only way people take their lives—in 2016, 1,382 people in California took their lives by suffocating to death. A small, but significant, fraction of these occurred in psychiatric hospitals or inpatient psychiatric units, locations where patients may be acutely suicidal and where they may easily have access to rope, cords, or fabric that can be used to strangle themselves. Because of this risk, last year the Joint Commission—the body that accredits hospitals in the United States—established recommendations that psychiatric hospitals and hospital units that work with suicidal patients prevent ligature risks. This means that there should not be points within the patient rooms, bathrooms, corridors, or common areas where a patient could loop or tie material for the purpose of taking their life.⁴³

As a community committed to suicide prevention, we should always balance policy requirements with practicality. The president of the American Psychiatric Association expressed concern last November that the resources required by facilities to meet these ligature risk standards can be excessive and ultimately threaten the availability of psychiatric hospital beds.⁴⁴

⁴⁰ D. E. Stark and N. H. Shah, "Research on Gun Violence Versus Other Causes of Death," *Journal of the American Medical Association*, Vol. 317, No. 13, April 4, 2017, p. 1379.

⁴¹ Council on Injury, Violence, and Poison Prevention Executive Committee, "Firearm-Related Injuries Affecting the Pediatric Population," *Pediatrics*, Vol. 130, No. 5, November 2012, pp. e1416-1423; G. J. Wintemute, M. E. Betz, and M. L. Ranney, "Yes, You Can: Physicians, Patients, and Firearms," *Annals of Internal Medicine*, Vol. 165, No. 3, August 2, 2016, pp. 205–213.

⁴² A. D. McCourt, J. S. Vernick, M. E. Betz, S. Brandspigel, and C. W. Runyan, "Temporary Transfer of Firearms from the Home to Prevent Suicide: Legal Obstacles and Recommendations," *JAMA Internal Medicine*, Vol. 177, No. 1, January 1, 2017, pp. 96–101.

⁴³ The Joint Commission, "November 2017 Perspectives Preview: Special Report: Suicide Prevention in Health Care Settings," webpage, October 25, 2017.

⁴⁴ M. Moran, "Joint Commission Standards on Ligature Risks Cause Concern," *Psychiatric News*, 2017.

This is an example of a well-meaning requirement that might jeopardize other suicide prevention strategies; no one would argue that ligature-resistant facilities should be pursued at the cost of an inpatient psychiatric bed. The state should monitor the Joint Commission's ligature-resistant standards, support facilities to become ligature resistant, and evaluate the potential impact of these requirements on the availability of mental health services in the state—especially for smaller agencies and those in areas with limited resources.

Conclusion

In preparing my remarks today, I reflected on how much California already has done to prevent suicide. From the initiatives funded under Proposition 63 to the state's commitment to research and evaluation, California should be applauded for its recent efforts to combat suicide. But while the suicide rate has not escalated as dramatically in California as it has in the country overall, it still has risen, claiming 4,294 lives in 2016 relative to 3,077 in 1999—a rate increase from nine per 100,000 to 11 per 100,000. We must adopt the attitude that the time to end suicide is now. This will require first stabilizing the increasing trend in suicide deaths, then reversing it.

Today I have identified the strategies with the strongest evidence base for preventing suicide. As the MHSOAC develops the state's suicide prevention strategy, it should keep three goals in mind. First, provide better care to people we know are at risk for suicide, and support their families. Second, identify people who may be at risk of taking their lives but who might not yet be benefiting from the services available to support them. And third, create safe environments in a fair and balanced way.

Thank you.