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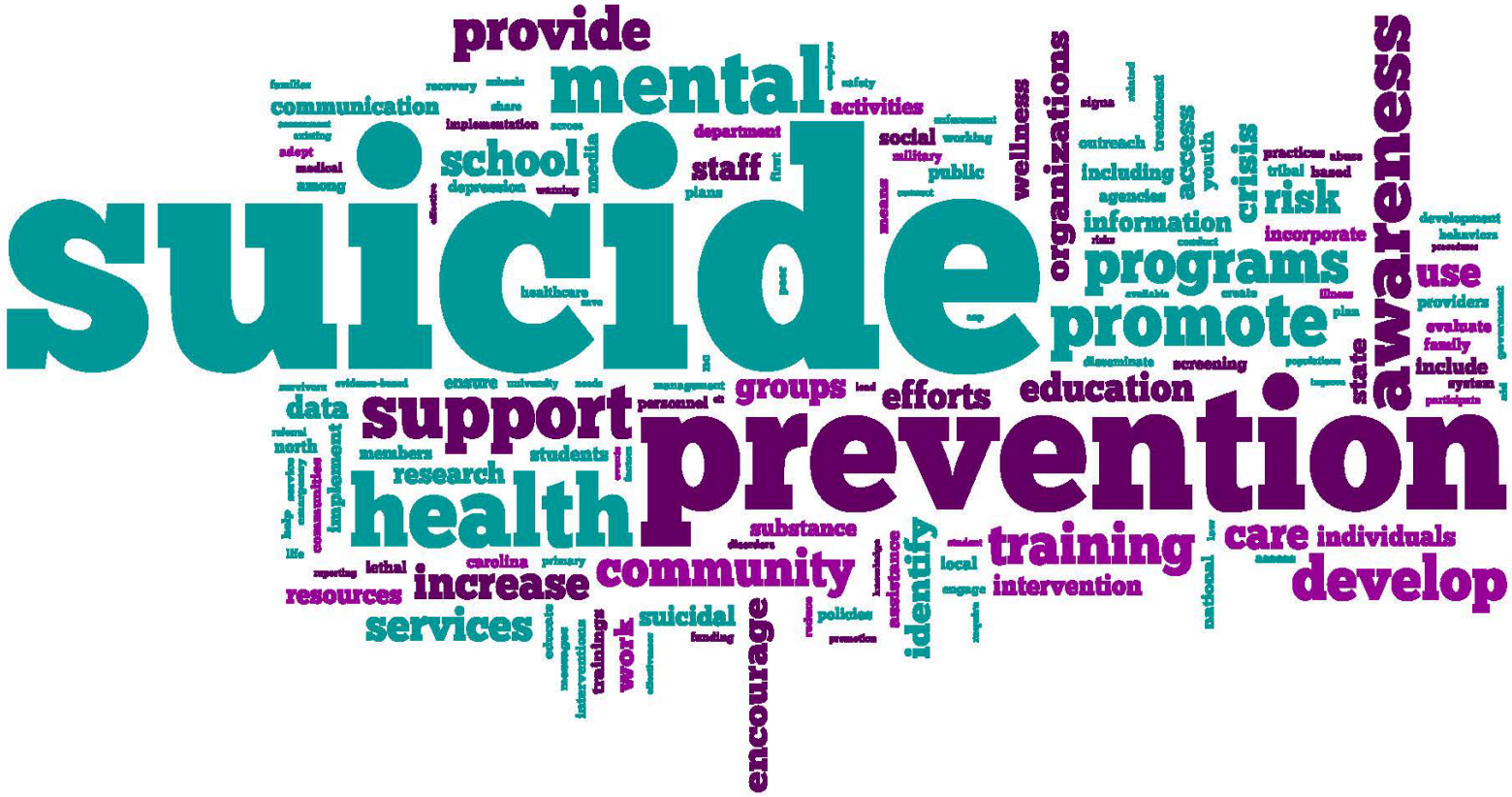

NORTH CAROLINA

SUICIDE PREVENTION PLAN

To empower North Carolinians with knowledge and examples of actions they can take to prevent suicide.

Injury and Violence Prevention (IVP) Branch
N.C. Chronic Disease and Injury Section
N.C. Division of Public Health

Policy Development/Prevention and Early Intervention Team
N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
N.C. Department of Health and Human Services

The University of North Carolina Gillings School of Global Public Health
Department of Health Behavior

Note: This plan has been designed to include hyperlinks that allow quick access to and from specific sections/areas of the plan. All hyperlinks will appear in blue underlined *italics*. To activate a hyperlink, simply place your mouse cursor over the hyperlink and click with your mouse. In order for hyperlinks to work, one must download the plan via Adobe. If you do not have Adobe, it is accessible for free at: http://get.adobe.com/reader

2015 N.C. Suicide Prevention Plan Planning Team Members

N.C. Injury and Violence Prevention Branch
Alan Dellapenna, MPH, Branch Head
Jane Ann Miller, MPH, Public Health Program Consultant
Margaret Vaughn, MPH/CPH, Public Health Program Consultant
Anna Austin, MPH, CDC/CSTE Applied Epidemiology Fellow
Kathleen Creppage, MPH, CDC/CSTE Applied Epidemiology Fellow
Nidhi Sachdeva, MPH, Injury Prevention Consultant

N.C. Division of Mental Health/ Developmental Disabilities/Substance Abuse Services
Community Policy Management Section
Sarah Potter, BSW, MPA, Community Wellness, Prevention, and Health Integration Team Lead
Susan E. Robinson, M.Ed., Suicide Prevention Coordinator, Mental Health Program Manager/Planner, Community Wellness, Prevention, and Health Integration

University of North Carolina at Chapel Hill Gillings School of Global Public Health
Department of Health Behavior
Robert J. Letourneau, MPH, Research Associate
Rachel Page, MPH, Research Associate
Carolyn E. Crump, PhD, Research Associate Professor

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A diverse group of more than 180 stakeholders helped to develop the 2015 N.C. Suicide Prevention Plan. Their efforts are acknowledged, including the contributions they made as representatives from 10 stakeholder groups: 1) Governmental Agencies/Departments (Federal, State, Local); 2) Tribal Governments; 3) Health Care Systems, Insurers, and Clinicians; 4) Businesses, Employers, and Professional Associations; 5) Primary and Secondary Schools; 6) Colleges and Universities (with direct service to students); 7) Nonprofit, Community, and Faith-based Organizations; 8) Research Organizations (including universities); 9) Individuals, Families, and Concerned Citizens; and 10) Military Entities.

2015 N.C. Suicide Prevention Plan WORKING AND CONSULTING GROUP MEMBERS

Susan Addams
Kimberly Alexander- Bratcher
Kim Allen
Margaux Austin
Landry Ballance
Bob Bamberg
Jim Barbee
Renee Batts
Paul Benfield
Victoria Bennis
Larry Bernstein
Chelsea Booth
Meredith Bower
Angel Bowers
Kathy Boyd
Lisa Brandyberry
Chuck Bridger
Rebecca Brown
Shelia Bunch
Erica Burgess
Genele Byrd
Sal Caraca
Paula Carden
Willa Casstevens
Becky Ceartas
Kimberly Chansen
Richard Chung
Cecil Coates
McKenzie Cook
Jen Counts
Tamera Coyne-Beasley
Vaughn Crawford
Gary Cunha
Megan Davies
Kimya Dennis
Deby Dihoff
Amy Douglas
Ann DuPre Rogers
Jeffery Eads
Brenda Edwards
Mary Edwards
Virginia Edwards
Susan Ennett
Kathryn Falbo-Woodson
Sandra Farmer
Debra Farrington
Ashley Fiore
Jodi Flick
Cynthia Floyd
Suzanne Follette-Black
Kristen Frankel
Matthew Gibson
Tony Gibson
Windy Gibson
James Gobble
Jane Goble-Clark
Whitney Gregg
Gregory Griggs
Catherine Guerrero
Andy Hagler
Jodi Hall
Ranota Hall
Chris Hamm
Gibbie Harris
Stacy Hawks
Blair Hedgecock
Michelle Hedgepeth-Smith
Dawn Henderson
Lynn Hennighausen
Paul Holden
Jessica Hord
Elizabeth Hudgins
Robin Huffman
David Humes
Amanda Johanson
Lynne Johnson
Ken Jones
Nicholle Karim
Anne Kimball
Jen Kimbrough
Liz Knight

2015 N.C. Suicide Prevention Plan WORKING AND CONSULTING GROUP MEMBERS (continued)

Daniel Krowchuk
Kimberli Lasyone
Sherry Lehman
Scott Lenhart
Kelly Lister
Denise Lovin
Cindy Lunsford
Ester M.Cooke
Chris Mackey
Amelia Mahan
Scott Marlow
Ed Markowski
Katherine Marshall
Steve Marshall
Glen Martin
Preeti Matkins
Gerri Mattson
Danielle Matula
Enrique McClymont
Connie Mele
Ashley Mercer
Denise Michaud
James Miller
Chris Minard
Rachel Monteverdi
Vicki Morrow
John Morrow
Snow Murphy
Rebecca Nagaishi
Gail Neely
Erica Nelson
Tina Nelson-Moss
Ann Nichols
Lynda Noffsinger
Tammy Norwood
Matthew Oelslager
Carol Orji
Jamachi Orji
Ellen Parks
Gregory Perkins
Martha Perry
Ruth Petersen
Kay Phillips
Parrish Ravelli
Stacey Ray
Sharon Rhyne
Chris Rich
Gregory Richardson
Michelle Ries
Ray Robbins
Tanner Robertson
Susan Robinson
Nina Rominger
Robert Rominger
Jennifer Rothman
Randi Rubenstein
Matt Sammis
Paul Savery
Larry Scholl
Frank Segal
Shade Shakur
Ted Sikes
Pam Silberman
Florence Siman
Jacqueline Simmons
Mary Beth Skarote
Jennifer Smith
Mary Smith
Roger Smock
Maria Soto
Harriett Southerland
Karen Stallings
Kristen Stefureac
Wendy Stewart
Stephanie Strickland
Meredith Swafford
David Swann
Jerry Swanner
Susan Taggart
Mary Tayal
Karen Thomas
Michael Toedt
Teneisha Towe
Christopher Townsend
Doug Trantham
Rodney Tucker
Molly VanDuser
Tom Vitaglione
Leza Wainwright
Newton Warren
Debbie Webster
James Weeks
Luckey Welsh
Leeanne Whisnant
Leanna White
Kathy Williams
Leona Williams
Carleen Wray
Doug Wright
Diane Yelverton
Carolyn Zahnow
Rick Zechman

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ACRONYMS

AAS	American Association of Suicidology
AFSP	American Foundation for Suicide Prevention
AMSR	Assessing and Managing Suicide Risk
ASIST	Applied Suicide Intervention Skills Training
CALM	Counseling on Access to Lethal Means
CBO	Community Based Organization
CDI	Chronic Disease and Injury Section
CIT	Crisis Intervention Team
CoC	Continuum of Care
DHHS	Department of Health and Human Services
DPH	North Carolina Division of Public Health
EAP	Employment Assistance Programs
EMS	Emergency Medical Services
FBO	Faith-based Organization
GLSMA	Garrett Lee Smith Memorial Act
HDD	Hospital Discharge Data
IRIS	North Carolina Incident Response Improvement System
IVPB	Injury and Violence Prevention Branch
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LME	Local Managed Entities
MCO	Managed Care Organizations
MH/DD/SAS	Mental Health, Developmental Disabilities and Substance Abuse Services
MVC	Motor Vehicle Crash
N.C. YRBS	North Carolina Youth Risk Behavior Survey
NAMI	National Alliance on Mental Illness
NCIOM	North Carolina Institute of Medicine
NC DETECT	North Carolina Disease Event Tracking and Epidemiologic Collection Tool
NC-VDRS	North Carolina Violent Death Reporting System
NSSP	National Suicide Strategy for Prevention
QPR	Question, Persuade and Refer
SAC	State Advisory Council
SAMHSA	Substance Abuse and Mental Health Services Administration
SD	Strategic Direction
SPRC	Suicide Prevention Resource Center
SRO	School Resource Officers
UNC	University of North Carolina at Chapel Hill Gillings School of Public Health
WISQARS	Web-based Injury Statistics Query and Reporting System

EXECUTIVE SUMMARY

A. Section 1 - Introduction

The North Carolina Injury and Violence Prevention (IVP) Branch is located in the Chronic Disease and Injury (CDI) Section, within the N.C. Division of Public Health (DPH), which has been designated by the N.C. General Assembly as the lead agency for injury prevention in North Carolina. The IVP Branch's programs provide funding, training, and technical assistance to public health professionals working across North Carolina. The Branch works to promote the use of research and data to ensure local communities are implementing initiatives that are effective. In 2004, the IVP Branch led stakeholders through a process to develop *Saving Tomorrow's Today, North Carolina's Plan to Prevent Youth Suicide* to align with six goals from the *2001 National Strategy for Suicide Prevention (NSSP).*

In late 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its second *National Strategy for Suicide Prevention*, outlining 13 goals and 60 objectives, organized by four strategic directions: 1) *Healthy and Empowered Individuals, Families, and Communities*; 2) *Clinical and Community Preventive Services*; 3) *Treatment and Support Services*; and 4) *Surveillance, Research, and Evaluation*. To coincide with its release, SAMHSA encouraged states to develop suicide prevention plans across the lifespan. Concurrent with the *2012 NSSP*, the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) worked with the North Carolina Institute of Medicine (NCIOM) to develop a mental health treatment-focused *Suicide Prevention and Intervention Plan*, which concentrates on the role of multiple medical care facilities to reduce suicide contemplations, attempts, and deaths in the state of North Carolina.

In late 2013, the IVP Branch initiated a 16-month process to develop a statewide *2015 N.C. Suicide Prevention Plan***.** The development of a new plan, seen as a complement to the DMH/DD/SAS plan, provided an opportunity to bring together a group of approximately 180 diverse suicide prevention stakeholders to create the plan.

The primary purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and to highlight examples of the actions they can take to reduce suicide. Funds and resources available to support coordinated suicide prevention efforts are limited. As such, the plan development process focused on developing a road map for stakeholder groups in North Carolina to address the burden of suicide. The road map approach aligns with current efforts across the state that leverage partnerships and resources to prevent suicide. Using this plan, practitioners from a variety of disciplines at the state, regional, and local level can align their efforts to plan, implement, and evaluate suicide prevention efforts.

Those interested in preventing suicide in North Carolina are encouraged to review the *2015 N.C. Suicide Prevention Plan* in its entirety. However, hyperlinks are provided to allow readers to quickly advance to various sections of the plan, including lists of examples of how each of the following 10 stakeholder groups can contribute to suicide prevention in North Carolina: 1) Governmental Agencies/Departments (Federal, State, Local); 2) Tribal Governments; 3) Health Care Systems, Insurers, and Clinicians; 4) Businesses, Employers, and Professional Associations; 5) Primary and Secondary Schools; 6) Colleges and Universities; 7) Nonprofit, Community, and Faith-based Organizations; 8) Research Organizations (including universities); 9) Individuals, Families, and Concerned Citizens; and 10) Military Entities.

B. Section 2 - How the 2015 N.C. Suicide Prevention Plan Was Developed

From September 2013 through December 2014, a planning team comprised of staff from the IVP Branch, the DMH/DD/SAS, Community Policy Management Section, and the University of North Carolina at Chapel Hill Gillings School of Global Public Health, Department of Health Behavior, led the plan development process. They engaged the assistance of more than 180 suicide prevention stakeholders, representing 10 stakeholder groups, from across the state. Stakeholders worked in either a Working Group or a Consulting Group. Members of both groups: a) completed an online survey to assess alignment of North Carolina activities and needs with the *2012 NSSP*; b) identified examples of what stakeholders in North Carolina are doing to address suicide; c) provided feedback on drafts of individual plan sections; and d) submitted endorsements of the plan.

Working Group members also attend two in-person meetings (April 30 and June 24, 2014). At the first in-person working group meeting participants worked in small groups to: a) determine how *2012 NSSP* objectives should remain for consideration in the North Carolina plan; and b) identify examples describing what stakeholder groups could be or are already doing to prevent suicide in North Carolina. Following the meeting, Working and Consulting Group members completed an online exercise to collect over 500 additional examples of what stakeholders are doing or could be doing to address suicide in North Carolina. At the second in-person meeting, Working Group members participated in small group activities.to prioritize goals and objectives by importance (e.g., reduces the burden of suicide in North Carolina, uses a comprehensive approach that targets multiple levels, uses interventions that are cost-effective) and feasibility (high, medium, low) for emphasis in the plan.

Following a formal review by the N.C. Department of Health and Human Services Office of Communications, the final version of the *2015 N.C. Suicide Prevention Plan* was completed and uploaded to the N.C. Injury and Violence Prevention Branch's website. Additional marketing materials were developed by IVP Branch staff as part of a separate communication and dissemination plan for the *2015 N.C. Suicide Prevention Plan*.

C. Section 3 - How Can You Use the 2015 N.C. Suicide Prevention Plan?

The plan was developed to provide stakeholders with a greater understanding of how everyone can contribute to the prevention of suicide and suicidal behaviors in our state, including the following examples:

Identify examples of what you can do. This plan was specifically created to allow anyone to pick it up and identify different ways that they can work to address suicide prevention in North Carolina.

> ***Example:*** *A business owner, distressed over the recent suicide of one of her staff members, refers to the plan to gather ideas on how to better promote mental health wellness and offer support for her employees.*

Identify resources. Increase your knowledge about the local and national resources available to people who are in crisis, so that you are able to provide information about those resources to those who might benefit.

> ***Example:*** *A university staff member familiarizes himself with the resources listed in Section 7 of the plan; subsequently, he posts and distributes information to students about the National Suicide Prevention Lifeline, the Trevor Project, and other resources.*

Advocate for suicide prevention. Contact local and state policymakers to express concern about the burden of suicide and suicidal behaviors within North Carolina, and to promote the development of strong suicide prevention practices and supportive resources for suicide loss and suicide attempt survivors statewide.

> ***Example:*** *An individual writes her legislator to advocate for easier accessibility to low- or no-cost mental health treatment resources within her community, utilizing the data about suicide in North Carolina within the plan to illustrate the burden of the problem within the state.*

Get involved/get trained. Promote accessibility of suicide intervention skills training for all, and utilize the resources described in this plan to complete training yourself, if you have not already done so.

> ***Example:*** *Upon reading about it in the plan, a health care provider enrolls in a* Question, Persuade, Refer (QPR) *training so that she can better understand and respond to patients who demonstrate warning signs of suicidal ideation and behavior.*

Leverage this information for funding opportunities. Use the data and information within this plan as supporting evidence to apply for funding for suicide prevention or mental health promotion programs, or research.

> ***Example:*** *The development director of a nonprofit organization applies for grant funding to support his organization's suicide prevention activities. He references the plan in the application to showcase the significant amount of interest in and concern about the problem of suicide in N.C. and to demonstrate the need for increased funding by highlighting data about its impact.*

Readers are encouraged to consider these ideas as a springboard to action and the overall plan as a guide for their efforts, as well as to share this plan with others in their communities. Suicide prevention efforts in North Carolina will be stronger, more sustainable, and have greater impacts if each of us develops a comprehensive understanding of the problem and is prepared to act, together.

D. Section 4 - What Does the Problem of Suicide Look Like in North Carolina?

Six data sources (five statewide and one national) were used to provide a broad, population-based overview of suicide and self-inflicted injury in North Carolina. Understanding the burden of suicide and self-inflicted injury in North Carolina is essential to developing and implementing effective prevention and intervention strategies:

- In 2012, suicide became the leading cause of injury death in North Carolina and remained so in 2013.
- Non-fatal self-inflicted injuries resulting in hospitalization or an Emergency Department (ED) visit are more common than suicide deaths.
- Firearms are the most common method of suicide in North Carolina.
- Males are more likely to die as a result of suicide than females. Females are more likely to be hospitalized or visit an ED for a self-inflicted injury than males.
- Youth and young adults have the highest rates of self-inflicted injury hospitalizations and ED visits of all age groups in North Carolina.
- In addition to sex and age, suicide related disparities in North Carolina have been identified by race, sexual orientation, and veteran status.

The *Burden of Suicide in North Carolina 2013*[1] and the *State of North Carolina Coordinated Chronic Disease, Injury, and Health Promotion State Plan 2013*[2] have additional information on the burden of suicide in North Carolina.

E. Section 5 - In What Direction Should N.C. Be Heading?

The *2015 N.C. Suicide Prevention Plan* aligns closely with the *2012 National Strategy for Suicide Prevention (NSSP)*[3]. As a result, the goals and objectives in the *2015 N.C. Suicide Prevention Plan* are organized according to the four strategic directions (SD) included in the *2012 NSSP.* These strategic directions outline a comprehensive strategy for suicide prevention through the continued support of effective approaches and the identification of areas in need of greater development or resources. The *2012 NSSP* included 13 Goals that describe more information about the strategic directions. Developers of the *2015 N.C. Suicide Prevention Plan* adopted all 13 Goals (Table ES-1). Color-shading is used throughout the plan to indicate the four strategic directions.

Table ES-1. N.C. Goals (n=13) by Strategic Direction.
#1 - Healthy and Empowered Individuals, Families, and Communities
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings. ***GOAL 2.*** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors. ***GOAL 3.*** Increase knowledge of the factors that offer protection from suicidal behaviors or promote wellness and recovery. ***GOAL 4.*** Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.
#2 - Clinical and Community Preventive Services
GOAL 5. Develop, implement, monitor effective programs that promote wellness and prevent suicide and related behaviors. ***GOAL 6.*** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. ***GOAL 7.*** Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
#3 - Treatment and Support Services
GOAL 8. Promote suicide prevention as a core component of health care services. ***GOAL 9.*** Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors. ***GOAL 10.*** Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

[1] North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (N.C. DPH), 2013a
[2] N.C. DPH, 2013b
[3] DHHS, 2012

Table ES-1. N.C. Goals (n=13) by Strategic Direction.
#4 - Surveillance, Research, and Evaluation
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action. ***GOAL 12.*** Promote and support research on suicide prevention. ***GOAL 13.*** Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

For the 61 objectives developed for the *2015 N.C. Suicide Prevention Plan*, stakeholders in North Carolina identified **32 prioritized objectives** (ordered by importance and feasibility) for emphasis in the *2015 N.C. Suicide Prevention Plan.* Table ES-2 lists the 32 prioritized objectives in rank order, based on weighted scoring of importance and feasibility. For each objective, the level of feasibility (high or medium) is noted following the wording of the objective.

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).		
Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
1	5.2	Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors. *High*
2	7.1	Develop training on suicide prevention to community groups. *High*
3	11.3	Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. *Medium*
4	9.1	Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings. *High*
5	8.3	Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide. *Medium*
6	1.1	Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities. *High*
7	8.2	Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. *High*
8	6.1	Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means. *High*
9	11.2	Improve the usefulness and quality of suicide-related data. *High*
10	13.3	Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective. *High/Medium*
11	4.1	Accurate data and resources readily available and accessible for pick up use by media and other. *Medium*
12	7.3	Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education. *Medium*
13	3.1	Promote effective programs/practices that increase protection from suicide risk. *High*
14	9.2	Disseminate and implement guidelines for clinical practice and continuity of care for providers working with people with suicide risk. *Medium*
15	10.3	Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups. *Medium*
16	13.6	Establish resources/guides to gain access to impact/effectiveness data (e.g. toolkit, resource centers). *High*
17	5.1	Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial/tribal/local suicide prevention programming. *Medium*
18	5.3	Strengthen efforts to increase access to/delivery of effective programs and services for mental health/substance use disorders. *High*
19	10.1	Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels. *Medium*

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).		
Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
20	2.4	Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care. *High*
21	1.5	Integrate suicide prevention into all relevant health care reform efforts. *Medium*
22	10.5	Provide health care providers, first responders, others with care/support when a patient under their care dies by suicide. *High*
23	8.8	Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge. *Medium*
24	2.1	Develop, implement, and evaluate communication efforts designed to reach defined segments of the population. *High*
25	2.2	Reach policymakers with dedicated communication efforts. *Medium*
26	7.5	Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk. *High*
27	9.5	Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental health/substance use disorders. *Medium*
28	7.2	Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. *High*
29	9.3	Promote the safe disclosure of suicidal thoughts and behaviors by all. *Medium*
30	3.2	Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders. *Medium*
31	3.3	Promote the understanding that recovery from mental and substance use disorders are real and possible for all. *Medium*
32	9.4	Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk. *Medium*

F. Section 6 - What Can We (Stakeholders) Do to Address Suicide in N.C.?

Planning process participants identified over 500 examples of what various stakeholder groups, collectively and individually, can do to address suicide in North Carolina.

Section 6 includes lists of stakeholder suicide prevention examples organized by strategic direction, with bolded objectives and examples representing prioritized objectives (i.e., high importance and high/medium feasibility). Examples are presented by stakeholder group in ascending order with three numerical references (i.e., #.#.#): the first number represents the goal number; the second represents the objective number; and the third represents the example number (i.e., 5.2.6 label refers to goal 5, objective 2, and example 6). Detailed information about examples identified is included in Appendix D of the plan. Some of the examples identified may be the same or similar for multiple objectives. In addition, some examples were identified as being relevant for more than one stakeholder group, and when so, are cross-listed. It is possible that some examples may also be relevant for additional stakeholder groups, but were not identified as such. The complete list of examples, presented by the stakeholder group(s) for which the example was identified, is included in Appendix E.

The examples identified through the planning process may or may not be inclusive of: a) all known evidence-based strategies; b) all types of interventions occurring in North Carolina c) examples relevant for all target audiences; or d) opportunities to address high risk-populations that available data indicate are disproportionally affected by suicide. Some examples may be more or less effective, as the plan development process did not require that all examples listed have evidence of effectiveness. For some examples, it may be important to tailor the activity for specific target populations at increased risk of suicide (e.g., people with disabilities, LGBTQ citizens, and military or veterans).

G. Section 7 - Where Can I Go to Learn More about Suicide Prevention?

The *2015 N.C. Suicide Prevention Plan* provides information and hyperlinks for additional resources about suicide prevention, at the state and national level, for the following categories: a) Suicide Prevention; b) Mental Health; c) Suicide Disparities ; d) Evidence Based-Practices; e) Advocacy and Awareness; and f) Data and Surveillance.

H. Section 8 - Endorsements

A total of 46 entities and organizations have provided a formal endorsement of the *2015 N.C. Suicide Prevention Plan.*

SECTION 1 – INTRODUCTION

A. Historical Context of National Suicide Prevention Efforts

In 1999, United States Surgeon General Dr. David Satcher declared suicide a public health problem. Conceptualization of suicide as a public health issue denoted its complexity as a genetic, psychological, neurobiological, social, cultural, and environmental issue. In response, the U.S. Department of Health and Human Services published the *National Strategy for Suicide Prevention (NSSP)*[4] in 2001. The strategy utilized the principles of prevention, intervention, and postvention as it pertained to the population at large (universal), those who were in high risk groups (selective), and those at immediate risk (indicated). The National Strategy's elements strived to engage public and private partnerships, policy makers, practitioners, agencies, families, and individuals in order to reduce suicide deaths and suicide attempts.

Through the tireless efforts of survivors, advocates, and providers and supported by surveillance data, the United States Congress passed the Garrett Lee Smith Memorial Act (GLSMA) in 2004. Named for Senator Gordon Smith's son, who died by suicide at the age of 21, funding is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). States, American Indian/Alaska Native Tribal nations, and colleges/universities could apply for a three-year funding cycle to address youth suicide. The first awards began in 2005 and continue to date. As a result, the development of intervention, prevention, and postvention programs, best practices, literature, surveillance, research, and resources has grown tremendously.

All GLSMA grantees, regardless of their affiliation or geographic location, continue to share their experiences, accomplishments, and challenges in a national effort to reduce suicides.

B. Historical Context of North Carolina Suicide Prevention Efforts

The North Carolina Injury and Violence Prevention (IVP) Branch is located in the N.C. Division of Public Health (DPH), Chronic Disease and Injury (CDI) Section. House Bill 724, enacted by the N.C. General Assembly in 2007, designated the N.C. Division of Public Health (DPH) as the lead agency for injury prevention in North Carolina, and instructed DPH to develop a statewide plan for injury prevention and to conduct other injury prevention activities.

The five-year strategic plan (*Building for Strength: NC's Plan for Preventing Injuries and Violence, 2009-2014*[5]) was developed by injury and violence prevention stakeholders from across the state and is overseen by the IVP State Advisory Council (SAC). The SAC includes six work teams addressing:

1. Data and surveillance
2. Research and evaluation
3. Messaging, policy, and environmental change
4. Saving lives (motor vehicle crashes, falls, unintentional poisoning, violence and assault, and **suicide)**
5. Building the injury prevention community
6. Workforce development

The IVP Branch's programs provide funding, training, and technical assistance to public health professionals working across North Carolina. The Branch works to promote the use of research and data to ensure local communities are working on initiatives that are effective.

The initial work of the IVP Branch to address the burden of suicide included a two-year grant (2002-2004) from the Governor's Crime Commission. This funding enabled the state to begin raising awareness about youth suicide prevention through regional events and served to establish suicide prevention gatekeeper training programs.

In 2004, the IVP Branch led stakeholders through a process to develop *Saving Tomorrows Today, North Carolina's Plan to Prevent Youth Suicide* [6] to align with six goals from the *2001 National Strategy for Suicide Prevention (NSSP).* This plan to

[4] U.S. Department of Health and Human Services (DHHS), 2001
[5] North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (N.C. DPH), 2009

prevent youth suicide was developed by the North Carolina Youth Suicide Prevention Task Force, which was formed in 1998 to address suicide rates among youth. The Task Force invited the participation of additional stakeholders to review the *2001 NSSP*, with the mission to prioritize the national goals that the stakeholders believed were relevant to the state of North Carolina and attainable given available resources.

From 2002 through2004, the IVP Branch built a suicide prevention program trainer cadre and provided awareness workshops throughout the state. The IVP Branch was a recipient of two GLSMA funding awards from SAMHSA (from 2008 through 2011 and 2011 through 2014), focusing on a variety of activities for the prevention of suicide, including provision of gatekeeper trainings for Child Family Support Teams, school-based and school-linked health center staff, community colleges, universities, areas with high military populations, juvenile justice staff, and mental health provider networks. The Branch also developed a training to understand the needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth. In addition, a state-wide communications campaign targeting youth was launched and included a website based on youth input and marketing prevention messages through youth friendly media.

C. Identifying the Need for a 2015 N.C. Suicide Prevention Plan

Increasingly, the general population has come to recognize that suicide is an important public health issue in our society. In addition to the thousands of personal losses, media coverage of suicides among notable individuals has raised the public consciousness. Suicide is often the result of a dynamic combination and interplay of factors. Although complex, as a community, state, and nation, we need not feel isolated in our efforts to reduce suicide and suicidal behavior. Concerned residents and organizations must work together to create interconnectedness across systems to strengthen our ability to help those at greatest risk. Suicide in North Carolina accounted for 3,536 deaths and 19,754 self-inflicted injury hospitalizations state-wide from 2009 through 2011.

In late 2012, SAMSHA released an updated *National Strategy for Suicide Prevention (NSSP).*[7] The goals (n=13) and objectives (n=60) included in *2012 NSSP* were organized by four strategic directions: 1) *Healthy and Empowered Individuals, Families, and Communities*; 2) *Clinical and Community Preventive Services*; 3) *Treatment and Support Services*; and 4) *Surveillance, Research, and Evaluation*. To coincide with its release, SAMHSA encouraged states receiving GLS funding to develop suicide prevention plans that address all age groups. State leadership, with the input from key stakeholders, decided to prepare a new plan addressing the entire life span.

Concurrent with the *2012 NSSP*, the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) worked with the North Carolina Institute of Medicine (NCIOM) to convene a task force to review the state's current suicide prevention and intervention system and identify strategies to enhance the system to better meet the needs of North Carolinians. Together, they released the treatment-focused *NC Suicide Prevention and Intervention Plan,*[8] which concentrates on the role of multiple medical care facilities (e.g., DMH/DD/SAS, Division of Medical Assistance, Local Managed Entities/Managed Care Organizations and contracted mental health providers) to reduce suicide contemplations, attempts, and deaths in the state of North Carolina. The report's first recommendation was to create a statewide suicide prevention and intervention plan.

A statewide suicide prevention plan will capitalize on the progress that has been made nationally in identifying best practice strategies to prevent suicide. In addition, a statewide plan addresses: the need to update North Carolina's most recent state plan (the 2004 youth suicide prevention plan); the need to focus efforts on emerging sub-populations disproportionally affected by suicide; and a desire at the IVP Branch to work with additional stakeholders to prevent suicide in North Carolina. The development of a new plan provided an opportunity to bring together a diverse group of stakeholders. The planning team guiding the plan development process worked with approximately 180 suicide prevention stakeholders to develop the *2015 N.C. Suicide Prevention Plan.*

[6] North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (N.C. DPH), 2004
[7] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention (DHHS), 2012
[8] North Carolina Institute of Medicine (NCIOM), 2012

D. Purpose of the 2015 N.C. Suicide Prevention Plan

The primary purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and to highlight examples of the actions they can take to reduce suicide.

While the Injury and Violence Prevention Branch has been charged as the lead agency for suicide prevention in the state of North Carolina, funds and resources available to support coordinated suicide prevention efforts are limited. As such, the plan development process focused on developing a road map for stakeholder groups in North Carolina to address the burden of suicide.

The road map approach aligns with current efforts across the state that leverages partnerships and resources to prevent suicide. The planning team made an explicit decision to avoid developing specific, measurable, achievable, relevant, and time-specific (S.M.A.R.T) objectives for the *2015 N.C. Suicide Prevention Plan*, given the limited coordination of efforts among a wide variety of suicide prevention stakeholders.

Using the content of Sections 4-7 of the plan (i.e., current data about suicide in N.C., a list of prioritized objectives, a comprehensive list of N.C. specific examples of what stakeholder groups can do, and a summary of suicide prevention resources), practitioners from a variety of disciplines at the state, regional, and local level can use the *2015 N.C. Suicide Prevention Plan* to implement and evaluate their own suicide prevention efforts. A glossary of terms is also included in Appendix A to define the terminology used throughout this plan.

Everyone can participate in the process to build a healthier and more supportive environment in which its residents can reach their greatest potential. Stakeholders involved with the planning process represented a wide variety of organizations, disciplines, and backgrounds, and are organized in 10 stakeholder groups modeled after groups identified in the *2012 NSSP*.

We encourage those interested to read this *2015 N.C. Suicide Prevention Plan* in its entirety. However, by clicking on the stakeholder group names listed below, readers may also advance to the section of the plan that lists examples identified for how each stakeholder group can contribute to suicide prevention in North Carolina.

1. Governmental Agencies/Departments (Federal, State, Local)
2. Tribal Governments
3. Health Care Systems, Insurers, and Clinicians
4. Businesses, Employers, and Professional Associations
5. Primary and Secondary Schools
6. Colleges and Universities
7. Nonprofit, Community, and Faith-based Organizations
8. Research Organizations (including universities)
9. Individuals, Families, and Concerned Citizens
10. Military Entities

SECTION 2 – HOW WAS THE 2015 N.C. SUICIDE PREVENTION PLAN DEVELOPED?

This section of the plan summarizes the plan development process. Additional detail about the eight steps used to develop the plan is in Appendix B.

From September 2013 through December 2014, a planning team led the process and included members from the N.C. Injury and Violence Prevention (IVP) Branch, the N.C. Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS), Community Policy Management Section, and the University of North Carolina at Chapel Hill Gillings School of Global Public Health, Department of Health Behavior.

In addition to a review of prior plans and resources related to suicide (in North Carolina, in other states, and nationally), the planning team developed a set of guiding principles that informed the content and organization of the *2015 N.C. Suicide Prevention Plan.* Central to the guiding principles was that the final document would: a) represent a plan for statewide use (i.e., not a plan for the IVP Branch, specifically); b) align with the 2012 National Strategy for Suicide Prevention (NSSP); c) provide a direction for where N.C. should be heading to prevent suicide; and d) emphasize examples of what stakeholders can do to prevent suicide.

During the plan development process, the planning team worked with more than 180 suicide prevention stakeholders, representing 10 stakeholder groups, from across the state. Stakeholders self-selected into one of two groups (Working Group or Consulting Group), with the main difference being that Working Group members would attend two in-person meetings. Both Working and Consulting Group members: a) completed an online survey to assess alignment of North Carolina activities and needs with the *2012 NSSP* (response rate = 82 percent); b) identified examples of what stakeholders in N.C. are doing to address suicide; c) provided feedback (via email) on drafts of individual plan sections (response rate = 31 percent); and d) submitted endorsements of the plan (46 organizations).

At the first in-person working group meeting held on April 30, 2014 62 Working Group members participated in small group activities, organized by the four strategic directions outlined in the *2012 NSSP,* to: a) determine how *2012 NSSP* objectives should remain for consideration in the N.C. Plan; and b) identify examples describing what stakeholder groups could be or are already doing to prevent suicide in North Carolina. Following the meeting, 78 Working and Consulting Group members completed an online exercise to collect over 500 additional examples of what stakeholder groups are doing or could be doing to address suicide in N.C. At the second working group meeting held on June 24, 2014, 60 Working Group members participated in small group activities to prioritize goals and objectives for inclusion in the plan. Facilitators conducted activities to prioritize objectives by importance (e.g., reduces the burden of suicide in N.C., uses a comprehensive approach that targets multiple levels, uses interventions that are cost-effective), then feasibility (high, medium, low), resulting in a total of 32 objectives being identified as prioritized objectives for emphasis in the *2015 N.C. Suicide Prevention Plan*.

By early September 2014, planning team members developed initial drafts of sections to be included in the plan. UNC Team members edited the list of stakeholder group examples for clarity, consistency, and relevance to the objectives. In late September 2014, planning team members launched an online exercise, by which Working and Consulting Group members provided feedback on a complete draft of the *2015 N.C. Suicide Prevention Plan*. Based on the feedback provided, the planning team emailed Working and Consulting Group a final draft version of the *2015 N.C. Suicide Prevention Plan* requesting formal endorsements of the plan. Following a formal review by the N.C. Department of Health and Human Services Office of Communications, the final version of the *2015 N.C. Suicide Prevention Plan* was completed and uploaded to the N.C. Injury and Violence Prevention Branch's website. Additional marketing materials were developed by IVP Branch staff as part of a separate communication and dissemination plan for the *2015 N.C. Suicide Prevention Plan*.

SECTION 3 – HOW CAN YOU USE THE 2015 N.C. SUICIDE PREVENTION PLAN?

The purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and examples of the actions they can take to reduce suicide. Everyone can participate in the process to build a healthier and more supportive environment in which residents of our state can reach their fullest potential.

This section of the plan describes how to navigate and apply the *2015 N.C. Suicide Prevention Plan* to your work.

A. How to Navigate the Plan

This plan includes hyperlinks that allow quick access to and from specific areas of the plan. For example, you can move quickly to various sections of the plan from the Table of Contents page. In addition, you can quickly move to: prioritized objectives; examples of what stakeholder groups can do or are doing to address suicide in North Carolina; and references to additional resources and suicide prevention plans.

All hyperlinks appear in blue underlined italics. To activate a hyperlink, simply place your mouse cursor over the hyperlink and click with your mouse.

B. How to Apply the Information Presented in the Plan to Your Efforts

Each of us has a role in preventing suicide in North Carolina, regardless of occupation or familiarity with the topic. The *2015 N.C. Suicide Prevention Plan* was developed to provide stakeholders with a greater understanding of how everyone can contribute to the prevention of suicide and suicidal behaviors in our state. Below are examples of how anyone can use this plan:

Identify examples of what you can do. This plan was specifically created to allow anyone to pick it up and identify different ways that they can work to address suicide prevention in North Carolina.

> ***Example:*** *A business owner, distressed over the recent suicide of one of her staff members, refers to the plan to gather ideas on how to better promote mental health wellness and offer support for her employees.*

Identify resources. Increase your knowledge about the local and national resources available to people who are in crisis, so that you are able to provide information about those resources to those who might benefit.

> ***Example:*** *A university staff member familiarizes himself with the resources listed in Section 7 of the plan; subsequently, he posts and distributes information to students about the National Suicide Prevention Lifeline, the Trevor Project, and other resources.*

Advocate for suicide prevention. Contact local and state policymakers to express concern about the burden of suicide and suicidal behaviors within North Carolina, and promote the development of strong suicide prevention practices and supportive resources for suicide loss and suicide attempt survivors statewide.

> ***Example:*** *An individual writes her legislator to advocate for easier accessibility to low- or no-cost mental health treatment resources within her community, utilizing the data about suicide in North Carolina within the plan to illustrate the burden of the problem within the state.*

Get involved/get trained. Promote accessibility of suicide intervention skills training for all, and utilize the resources described in this plan to complete training yourself, if you have not already done so.

> ***Example:*** *Upon reading about it in the plan, a health care provider enrolls in a Question, Persuade, Refer (QPR) training so that she can better understand and respond to patients who demonstrate warning signs of suicidal ideation and behavior.*

Leverage this information for funding opportunities. Use the data and information within this plan as supporting evidence to apply for funding for suicide prevention or mental health promotion programs or research.

> ***Example:*** *The development director of a nonprofit organization applies for grant funding to support his organization's suicide prevention activities. He references the plan in the application to showcase the significant interest in and*

concern about the problem of suicide in North Carolina and to demonstrate the need for increased funding by highlighting data about its impact.

The list above is not exhaustive. Consider these ideas as a springboard to action and the overall *2015 N.C. Suicide Prevention Plan* as a guide for your efforts. In Section 6 of the plan, please find specific examples of actions that people from a variety of backgrounds and occupations can take to prevent suicide in North Carolina.

We encourage you to share this plan with others in your community – at your workplace, within your faith community, in your neighborhood, and beyond. Continue the conversation about suicide and suicide prevention. Efforts in North Carolina will be stronger, more sustainable, and have greater impacts if each of us develops a comprehensive understanding of the problem and is prepared to act.

SECTION 4 – WHAT DOES THE PROBLEM OF SUICIDE LOOK LIKE IN NORTH CAROLINA?

Understanding the burden of suicide and self-inflicted injury in North Carolina is essential to developing and implementing effective prevention and intervention strategies:

- In 2012, suicide became the leading cause of injury death in North Carolina and remained the leading cause through 2013.
- Non-fatal self-inflicted injuries resulting in hospitalization or an Emergency Department (ED) visit are more common than suicide deaths.
- Firearms are the most common method of suicide in North Carolina.
- Males are more likely to die as a result of suicide than females. Females are more likely to be hospitalized or visit an ED for a self-inflicted injury than males.
- Youth and young adults have the highest rates of self-inflicted injury hospitalizations and ED visits of all age groups in North Carolina.
- In addition to sex and age, suicide related disparities in North Carolina have been identified by race, sexual orientation, and veteran status.

This section provides a general overview of: a) suicide and self-inflicted injury data sources; b) the burden of suicide and self-inflicted injury in North Carolina; c) disparities in suicide in the United States; and d) identifying disparities in suicide prevention in North Carolina.

A. Suicide and Self-Inflicted Injury Data Sources

Six data sources (five statewide and one national) were used to inform this section. Data are reported for North Carolina residents ages 10 and older, as per CDC guidelines for suicide reporting. This section summarizes the most current data from readily accessible data sources to provide a broad, population-based overview of suicide and self-inflicted injury.

North Carolina Statewide Data Sources

1. *North Carolina Violent Death Reporting System (NC-VDRS)* 2004-2011[9]
   NC-VDRS is a surveillance system that links death certificates, medical examiner reports, and incident reports from law enforcement agencies to provide detailed data on all violent deaths, including suicide, occurring in North Carolina. NC-VDRS is operated by the North Carolina Division of Public Health's Injury and Violence Prevention Branch. Data regarding suicide are available annually.

2. *North Carolina Hospital Discharge Data (HDD) System* 2004-2011[10]
   The Cecil G. Sheps Center for Health Services Research, under contract with the Division of Health Service Regulation, maintains the Hospital Discharge Data System collected by Truven Health Analytics. The data are retrieved from claims forms used by hospitals to bill payers. These data do not represent number of patients, but rather number of discharges (multiple discharges per patient are possible). Data regarding hospitalizations for self-inflicted injuries are available annually.

3. *North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC-DETECT)* 2008-2012[11]
   NC DETECT is a statewide surveillance system that collects and monitors emergency department (ED) visits for public health purposes. NC DETECT was created by the North Carolina Division of Public Health in collaboration with the Carolina Center for Health Informatics in the University of North Carolina Department of Emergency Medicine. NC DETECT receives data on a daily basis from hospital-affiliated EDs statewide. As of 2014, 123 North Carolina hospital-

[9] North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch. *North Carolina Violent Death Reporting System Data: 2004-2011* (Data file).
[10] North Carolina Department of Health and Human Services, Division of Public Health, State Center for Health Statistics. (2012). North *Carolina Hospital Discharge Data: 2004-2011*. Available from www.shepscenter.unc.edu/data-2/nc-hospital-discharge-data
[11] The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT). *North Carolina Emergency Department Data: 2008-2012* (Data file).

affiliated EDs submit data on a daily basis to NC DETECT, and four VA Medical Center EDs in North Carolina transmit data to NC DETECT. Data regarding ED visits for self-inflicted injuries are available annually.

Data Attribution and Disclaimer: N.C. DETECT is a statewide public health syndromic surveillance system, funded by the N.C. Division of Public Health (N.C. DPH) Federal Public Health Emergency Preparedness Grant and managed through collaboration between N.C. DPH and UNC-CH Department of Emergency Medicine's Carolina Center for Health Informatics. The N.C. DETECT Data Oversight Committee does not take responsibility for the scientific validity or accuracy of methodology, results, statistical analyses, or conclusions presented.

4. *North Carolina Youth Risk Behavior Survey (N.C. YRBS) 2013*[12]
   The N.C. YRBS is a school-based survey conducted by the N.C. Healthy Schools Initiative to assess health risk behaviors among high school and middle school students in North Carolina. Questions regarding suicide and suicidal attempts are included on the N.C. YRBS. The survey is administered in odd-numbered years and began in 1993. In 2013, a random sample of 1,846 high school students from 32 schools across North Carolina participated in the N.C. YRBS.

5. *Death Certificate Data 2013*[13]
   The North Carolina State Center for Health Statistics, Statistical Services Branch, Vital Statistics team provides death certificate data for every death in North Carolina. Only North Carolina residents with a North Carolina county address were considered for our purposes. Deaths were limited to events in which the primary cause of death was identified as an injury using the International Classification, 10th Revision (ICD-10) codes.

National Data Resources

1. *Web-based Injury Statistics Query and Reporting System (WISQARS) 1999-2012*[14]
   WISQARS is an interactive, online dataset that provides fatal and non-fatal injury, violent death, and cost of injury data. National and state-level data are available annually.

B. The Burden of Suicide and Self-Inflicted Injury in North Carolina

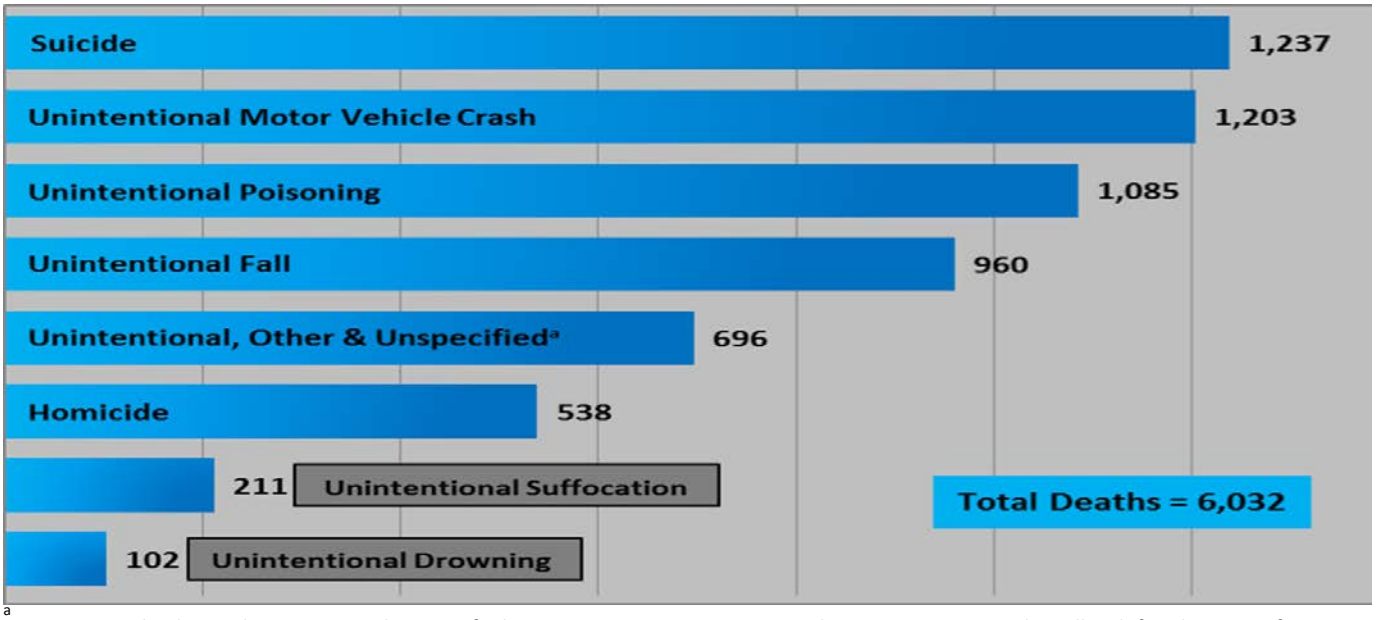
In 2012, suicide became the leading cause of injury death in North Carolina and remained the leading cause through 2013 (Figure 1). Between 2004 and 2011, the rate of suicide among North Carolina residents ages 10 and older remained relatively unchanged ranging from 13.4 deaths to 14.3 deaths per 100,000 North Carolina residents (Figure 2). Despite efforts to reduce the rate of suicide, the rate has not shifted over the last several years, which underscores the persistent nature of this public health problem in North Carolina.

Suicide deaths represent only a fraction of the burden of suicidal behavior in North Carolina. Non-fatal self-inflicted injuries resulting in hospitalization or an ED visit are even more common than suicide deaths. For example, in 2011, for every suicide death, there were over five hospitalizations and eight ED visits for self-inflicted injuries in North Carolina.

Historically in North Carolina, motor vehicle traffic crashes have been the leading cause of injury death, but in recent years, the number of deaths due to motor vehicle traffic crashes has declined. Though the number and rate of suicides have remained relatively stable in North Carolina since 2004, because of the declining number of motor vehicle traffic crash deaths, suicide became the leading cause of injury death in North Carolina in 2012 and remained so in 2013 with 1,237 deaths.

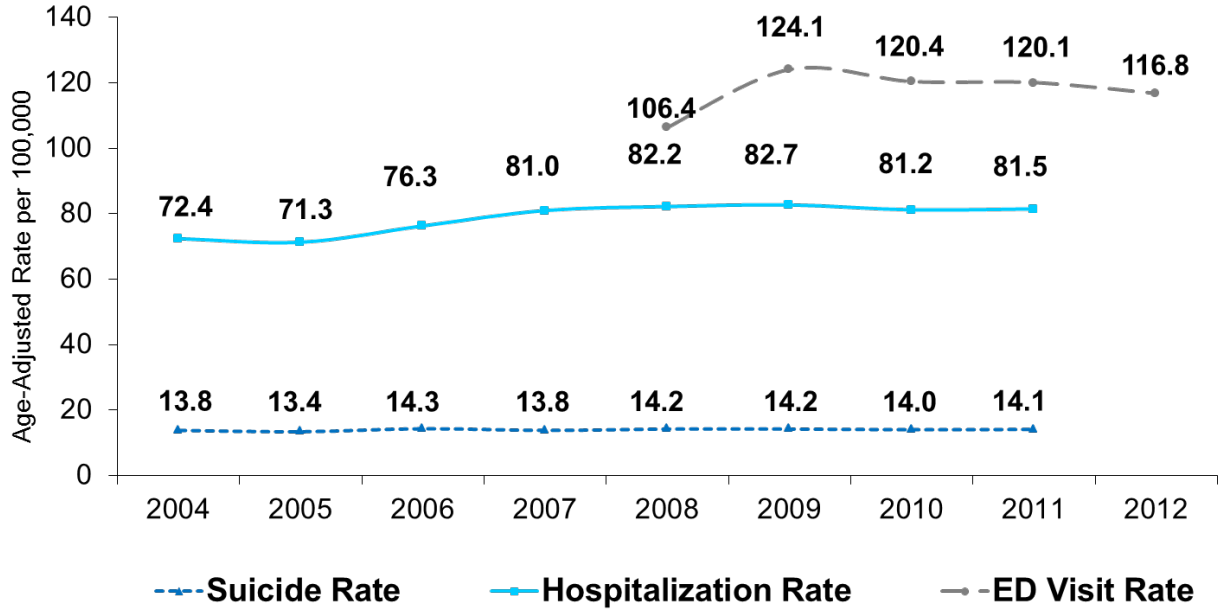
[12] North Carolina Department of Health and Human Services, Department of Public Instruction, N.C. Health Schools. (2014). *North Carolina Youth Risk Behavior Survey Data: 2013.* Retrieved from www.nchealthyschools.org/data/yrbs
[13] North Carolina State Center for Health Statistics, Statistical Services Branch, Vital Statistics. *Death Certificate Data: 2013* (Data file).
[14] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2014). *Web-based Injury Statistics Query and Reporting System.* Available from: www.cdc.gov/injury/wisqars

Figure 1. Leading Causes of Injury Death: N.C. Residents (N.C. Death Certificate Data, 2013)



[a] *Unintentional Other* and *Unintentional Unspecified* are two separate categories. *Other* comprises several smaller defined causes of death, while *Unspecified* refers to unintentional deaths that were not categorized due to coding challenges.

Figure 2. Rate of Suicide and Self-Inflicted Injury: N.C. Residents (NC-VDRS, 2004-2011; N.C. HDD, 2004-2011; NC DETECT, 2008-2012)



What is a rate?
A rate is calculated by dividing the total number of events that occurred in a population during a specified time period by the total population at risk during that time period. Rates are typically calculated per 100,000 population. For example, in 2011, there were 1,202 suicides among North Carolina residents ages 10 and older. By knowing the population of those over 10 in N.C. (i.e. 8,389,620) we can calculate the rate of suicide. The suicide rate per 100,000 North Carolina residents ages 10 and older in 2011 was 14.3, which was calculated as (1,202/8,388,048)*100,000. This is a crude rate. These rates can be further adjusted for age, as has been done in Figure 2.

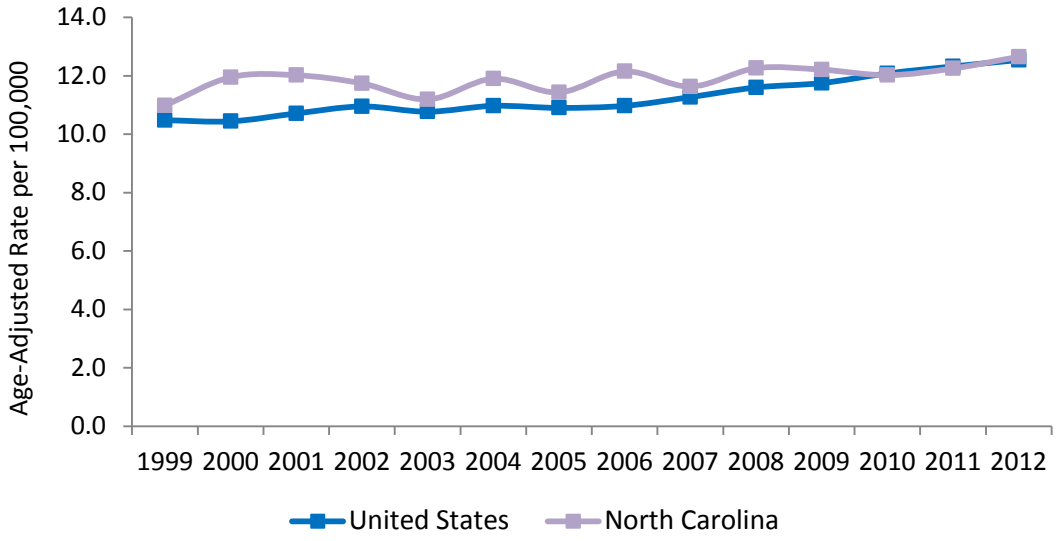
Because rates account for the total population at risk, rates allow for comparisons between different populations of interest. For example, the number of suicides in two populations may be the similar while the rates are very different. Between 2009 and 2011, there were 70 suicides in Durham County and 77 suicides in Catawba County among residents ages 10 and older. However, because the population of residents ages 10 and older was much larger in Durham than in Catawba (697,480 vs. 406,435), the suicide rate was much lower in Durham than in Catawba (8.6 vs. 16.5 suicides per 100,000 residents) highlighting differences in risk between these two populations that would not have been apparent based on raw numbers alone.

Suicide in North Carolina and the United States

Data obtained from WISQARS allows for a comparison of the N.C. suicide rate with the United States as a whole. Historically, the rate of suicide has been higher in North Carolina than in the U.S. However, in recent years, the rates have become more similar due to a slight increase in the United States rate. As noted earlier, the rate in North Carolina has remained relatively unchanged over the last several years with the 1999 to 2012 rates ranging from 11.1 to 12.7 suicides per 100,000 residents (Figure 3).

There may be differences in the state rate obtained from NC-VDRS and that reported by WISQARS. This is due to the fact that NC-VDRS bases data regarding suicides on three different data sources (death certificate, medical examiner, and law enforcement) whereas WISQARS primarily bases data regarding suicides on death certificate data only. In addition, the WISQARS data file may close at an earlier time point than the NC-VDRS file. This means that deaths that are classified as pending at that time and have not yet been assigned a manner such as suicide, homicide, or unintentional will not be included in the WISQARS data file, but may be included in the NC-VDRS data file.

Figure 3. Rate of Suicide in North Carol and the United States (WISQARS, 1999-2012)

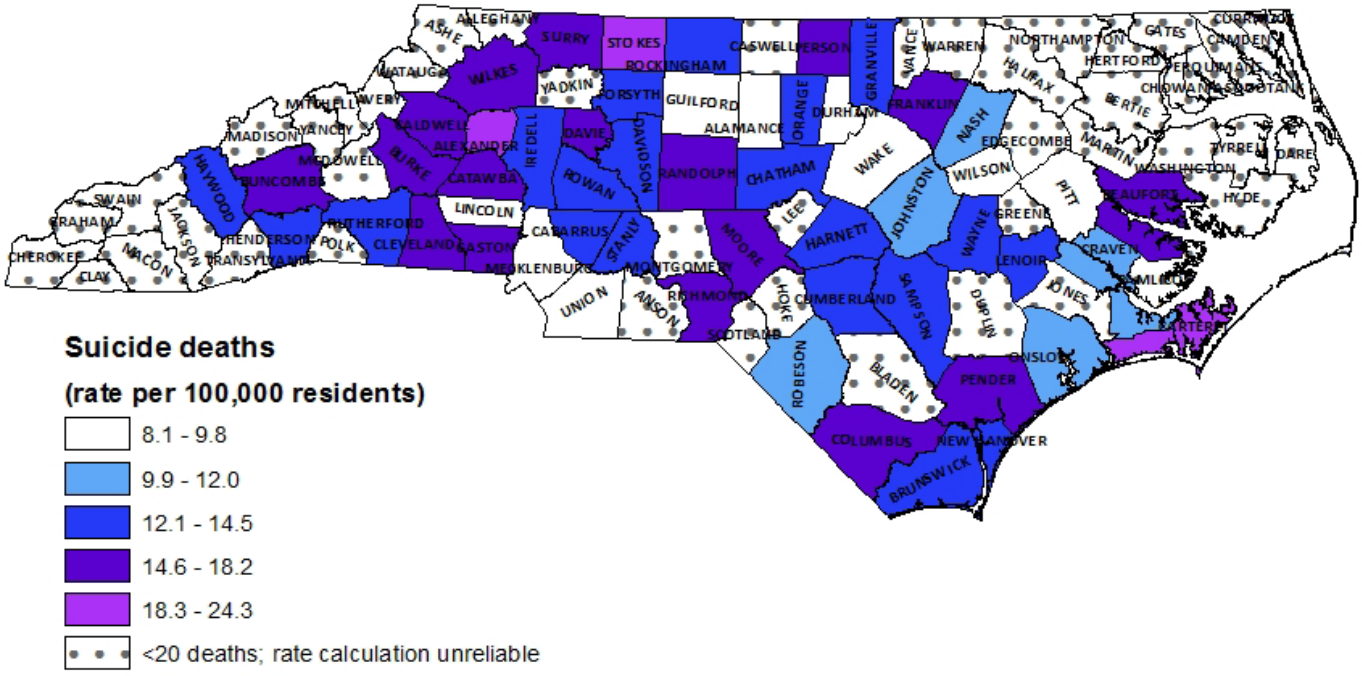


Suicide by County in North Carolina

Suicide rates vary across the state of North Carolina by region and county. By region, suicide rates appear to be somewhat higher in the Western region of the state. Counties with the highest rates of suicide between 2009 and 2011 include Carteret, Stokes, and Alexander counties. Differences in rates across counties may be due to multiple factors including differences in population, frequency of risk factors, socioeconomic characteristics, and resources between counties.

In Figure 4, counties shaded in white had fewer than 20 suicides from 2009 through 2011. Suicide rates per 100,000 residents have been suppressed for these counties as rates based on small numbers tend to be unreliable. For a comprehensive list of numbers and rates of suicide by county, please visit the Injury and Violence Prevention Branch webpage and access the *Burden of Suicide in North Carolina* report (http://injuryfreenc.ncdhhs.gov/DataSurveillance/2013BurdenofSuicide.pdf, pg. 26-27).

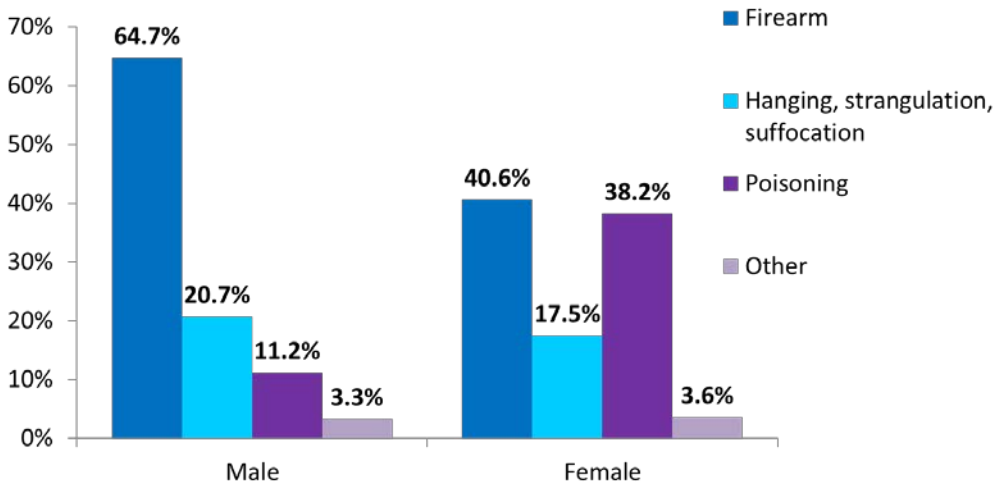
Figure 4. Rate of Suicide by County: N.C. Residents (NC-VDRS, 2009-2011)



Suicide Methods

For both males and females, firearms are the most common method of suicide in North Carolina. However, this method is more common among males than females and a much higher percentage of females die as a result of suicide by poisoning as compared to males (Figure 5). Thus, while males commonly use highly lethal means, such as firearms, to complete suicide, females are about as likely to use a firearm as poisoning to complete suicide.

Figure 5. Suicide Methods: N.C. Residents (NC-VDRS, 2009-2011)

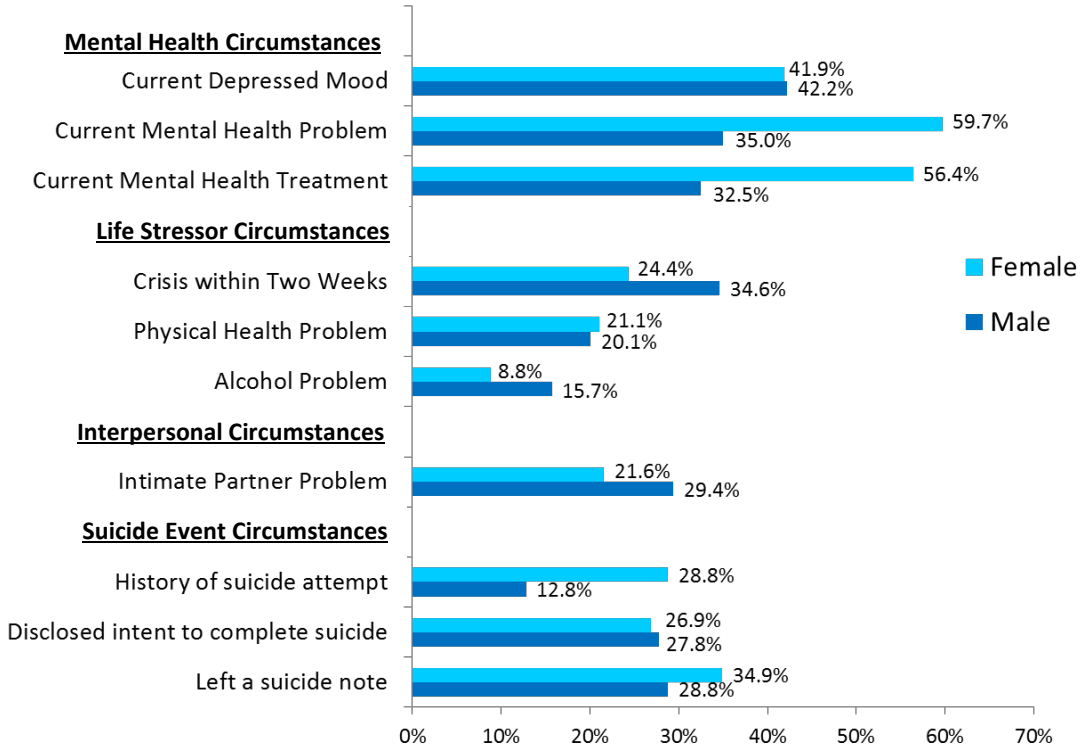


Suicide Circumstances

Circumstances surrounding suicides include mental health, interpersonal, life stressor, and suicide event circumstances. Circumstance information is available for a majority of suicide victims, and each victim may have more than one circumstance reported. The most common circumstances surrounding suicide in North Carolina are related to mental health including being described as having a depressed mood or treatment for mental illness at the time of death (Figure 6). Other commonly cited circumstances included having had a crisis within two weeks of death and intimate partner problems.

Differences in circumstances surrounding suicide are observed by sex. While males and females are about equally as likely to be described as having had a depressed mood at the time of death, females are more likely to have had a diagnosed mental health problem or to have been receiving mental health treatment at the time of death. In addition, males are more likely to have had a crisis within two weeks of death and to have had an alcohol problem or an intimate partner problem than females. Females are more likely than males to have a history of a suicide attempt which is consistent with the findings that females have higher rates of self-inflicted injury hospitalizations and ED visits than males while males have higher rates of completed suicide than females.

Figure 6. Suicide Circumstances: N.C. Residents (NC-VDRS, 2009-2011)



C. Disparities in Suicide in the United States

In the National Strategy for Suicide Prevention (NSSP), several groups were identified as being at an increased risk for suicide and suicidal behaviors on a national level. Data are readily available for some, but not all, of these groups in North Carolina and will be presented in the remainder of this section. As noted in the NSSP, limitations associated with the collection of suicide-related data can make it difficult to obtain reliable estimates for specific populations, and if collected, the information may not be readily available.

The NSSP has identified the following 10 groups as being at an increased risk for suicide in the United States:

1. American Indians/Alaska Natives
2. Individuals bereaved by suicide
3. Individuals in justice and child welfare settings
4. Individuals who engage in non-suicidal self-injury
5. Individuals who have attempted suicide
6. Individuals with medical conditions
7. Individuals with mental or substance use disorders
8. Gay, lesbian, bisexual, and transgender populations
9. Members of the Armed Forces and veterans
10. Middle age and older men

D. Identifying Disparities in Suicide in North Carolina

In this section, several suicide related disparities have been identified in North Carolina through four data sources: North Carolina Violent Death Reporting System; North Carolina Hospital Discharge System; North Carolina Disease Event Tracking and Epidemiologic Collection Tool; and North Carolina Youth Risk Behavior Survey. Together, these data sources help identify suicide by: a) age and sex; b) race; c) sexual orientation; and d) veteran status.

Suicide and Self-Inflicted Injury by Age and Sex

Differences in suicide and suicidal behavior exist by age and sex in North Carolina. In North Carolina, youth and young adults ages 10 to 24 have the lowest rates of suicide (Figure 7). Across all ages, males have a higher rate of suicide than females. The highest rate of suicide in North Carolina is among older adult males ages 85 and older.

In contrast, youth and young adults have the highest rates of self-inflicted injury hospitalizations and ED visits in North Carolina. These rates decline with advancing age, and rates are higher among females than males. The highest rates of self-inflicted injury hospitalizations and ED visits are among females ages 15 to 19. Overall, males are three times as likely to die as a result of suicide as females while females are more likely to be hospitalized or visit an ED for a self-inflicted injury than males (Figure 8). Youth and young adults have considerably higher rates of suicidal behavior resulting in non-fatal injury (e.g. self-inflicted injury hospitalizations and ED visits) than in death.

Figure 7. Rate of Suicide and Self-Inflicted Injury by Age: N.C. Residents (NC-VDRS, 2009-2011; N.C. HDD, 2009-2011; NC DETECT, 2009-2012)

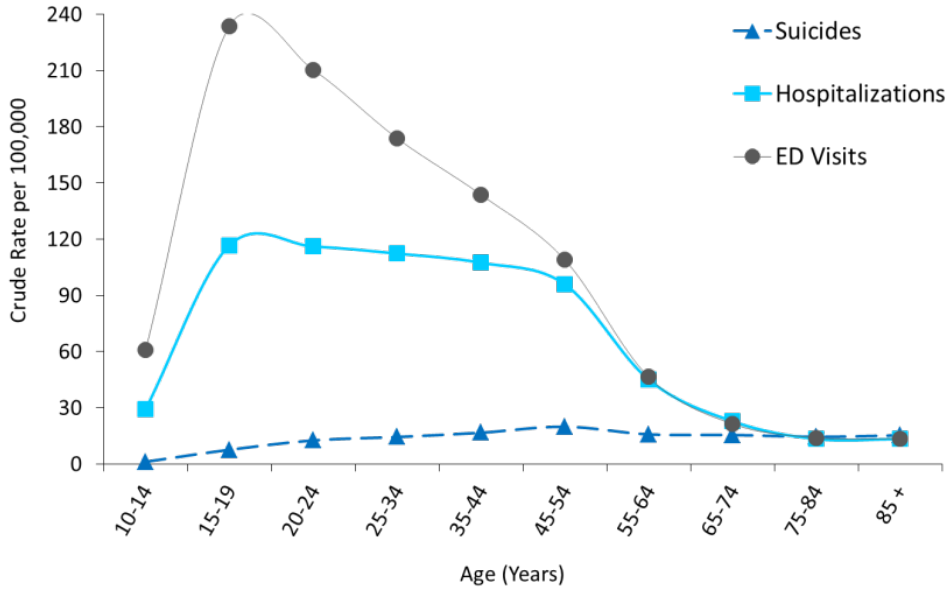
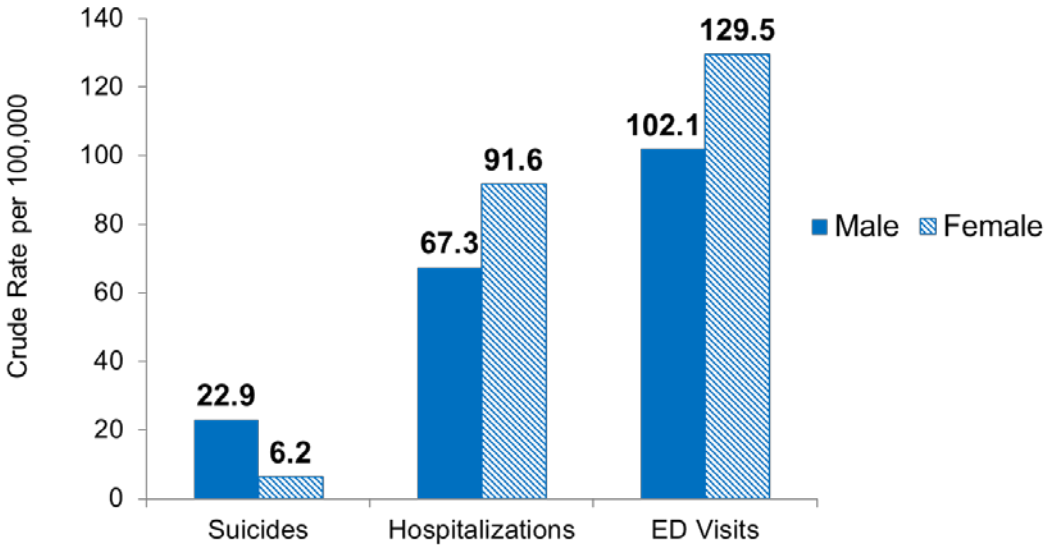


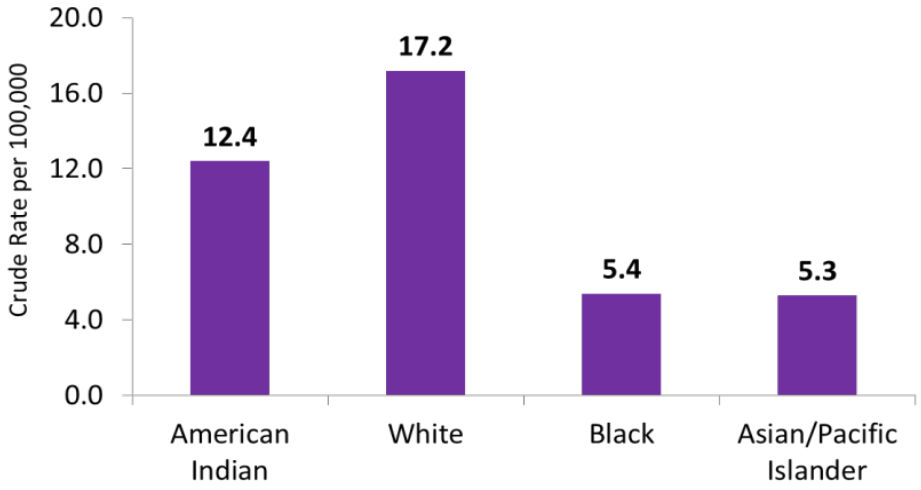
Figure 8. Rate of Suicide and Self-Inflicted Injury by Sex: N.C. Residents (NC-VDRS, 2009-2011; N.C. HDD, 2009-2011; NC DETECT, 2009-2012)



Suicide by Race

In North Carolina, whites followed by American Indians have the highest rate of suicide of all racial groups. From2009 through 2011, 89% of suicides among North Carolina residents were among whites and 97% were among non-Hispanics (Figure 9).

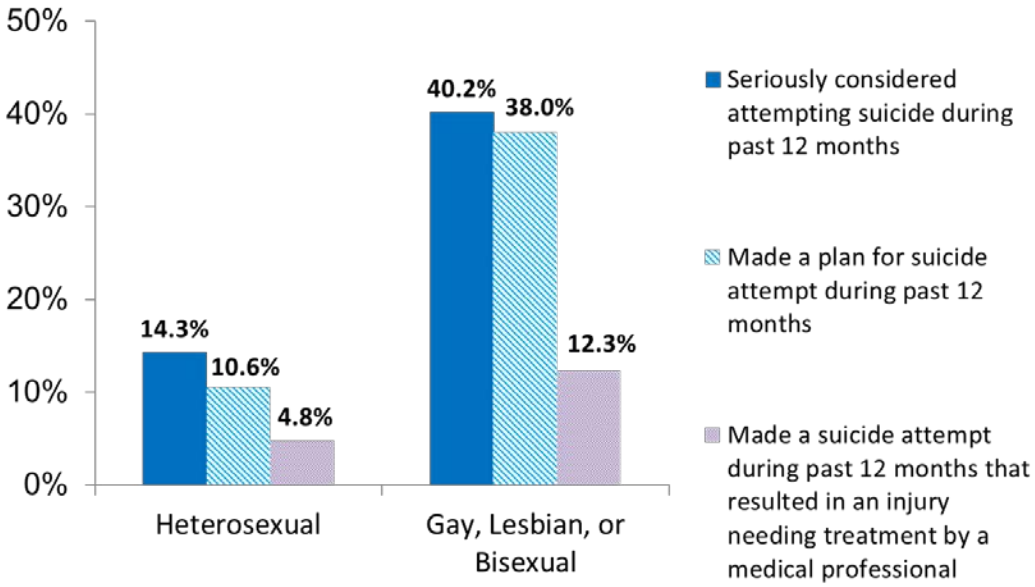
Figure 9. Rate of Suicide by Race: N.C. Residents (NC-VDRS, 2009-2011)



Suicidal Behavior among N.C. High School Students by Sexual Orientation

The percentage of North Carolina high school students reporting suicidal behaviors differs by sexual orientation. The percentage of students reporting having seriously considered attempting suicide or having made a plan for suicide in the past 12 months is significantly higher among students self-identifying as gay, lesbian, or bisexual than among students self-identifying as heterosexual (Figure 10).

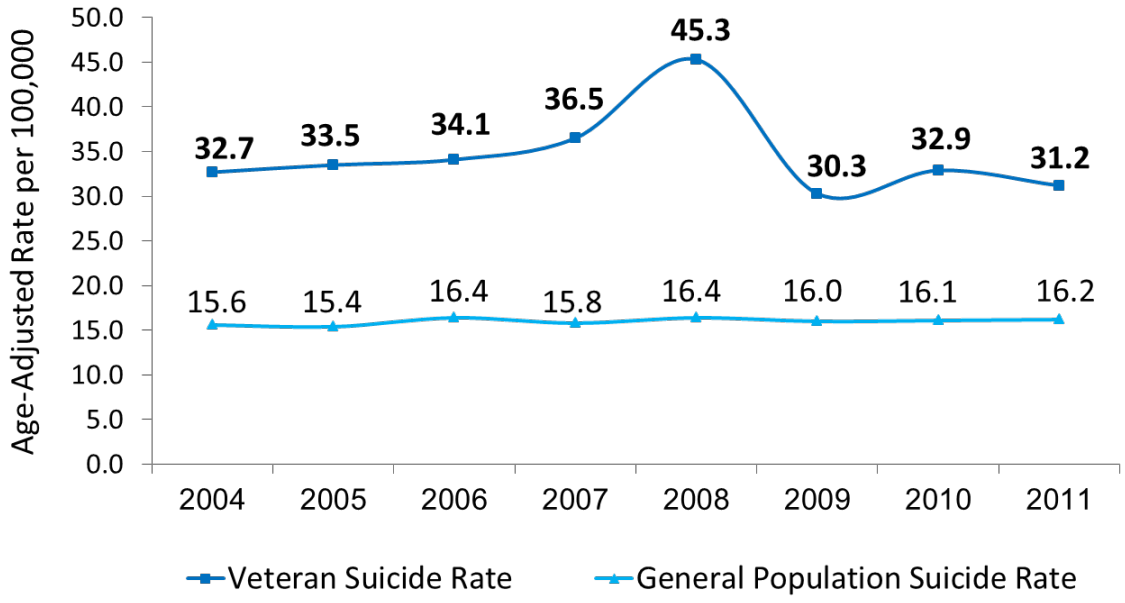
Figure 10. Suicidal Behavior among N.C. High School Students by Sexual Orientation (N.C. YRBS, 2013)



Rate of Suicide among Military Veterans

Over the last several years, military veterans have consistently had a higher rate of suicide than the general population in North Carolina. For example, in 2011, the veteran suicide rate that was nearly 2 times higher than the rate for the general population (Figure 11).

Figure 11. Suicide Rate among Military Veterans: N.C. Residents (NC-VDRS, 2004-2011)



For additional information about the burden of suicide in North Carolina, please click on links provided below:
The *Burden of Suicide in North Carolina 2013*[15] and The *State of North Carolina Coordinated Chronic Disease, Injury, and Health Promotion State Plan 2013*[16] have additional information on the burden of suicide in North Carolina.

Data figures and graphs provided in Section 4 are available in PowerPoint format here.

[15] North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (N.C. DPH), 2013a
[16] N.C. DPH, 2013b

SECTION 5 – IN WHAT DIRECTION SHOULD N.C. MOVE?

This section describes: a) strategic directions for North Carolina; and b) prioritized objectives identified within these strategic directions. Stakeholders involved with the process to develop the *2015 N.C. Suicide Prevention Plan* identified a total of 13 goals and 61 objectives (Appendix C), adapted from the *2012 National Strategy for Suicide Prevention (NSSP)* to guide the suicide prevention efforts in North Carolina.

A. Strategic Directions and Goals Identified for North Carolina

The *2015 N.C. Suicide Prevention Plan* aligns closely with the *2012 National Strategy for Suicide Prevention (NSSP)* As a result, the goals and objectives in the *2015 N.C. Suicide Prevention Plan* are organized according to the four strategic directions (SD) included in the *2012 NSSP* .The color-shading below is used throughout this plan to refer to the four strategic directions:

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

Developers of the *2012 NSSP* also identified seven shared themes across the four strategic directions:[17]

1. Foster positive public dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention.
2. Address the needs of vulnerable groups, tailor strategies to the cultural and situational contexts in which they are offered, and seek to eliminate disparities.
3. Coordinate and integrate with existing efforts addressing health and behavioral health and ensure continuity of care.
4. Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems.
5. Bring together public health and behavioral health.
6. Promote efforts to reduce access to lethal means among individuals with identified suicide risks.
7. Apply the most up-to-date knowledge base for suicide prevention.

Together, the shared themes and four strategic directions outline a comprehensive strategy for suicide prevention through the continued support of effective approaches and the identification of areas in need of greater development or resources *(*Table 1).

Table 1: Summary Statements for NSSP Strategic Directions[18]

Summary Statements for NSSP Strategic Directions	
Strategic Direction	**2012 NSSP Description**
Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities	• The goals and objectives in this strategic direction seek to create supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems. Suicide shares risk and protective factors with mental and substance use disorders, trauma, and other types of violence, such as bullying and domestic violence. • A wide range of partners can contribute to suicide prevention, including organizations and programs that promote the health of children, youth, families, working adults, older adults, and others in the community. All of these partners should integrate suicide prevention into their work. • Eliminating the biases and prejudices associated with suicidal behaviors, mental and substance use disorders, and exposure to violence is a key area of concern within this strategic direction. In particular, there is a need to increase the understanding that mental and substance use disorders respond to specific treatments and that recovery is possible.

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

[18] DHHS, 2012

Summary Statements for NSSP Strategic Directions	
Strategic Direction	**2012 NSSP Description**
	• Communication efforts, such as campaigns and social marketing interventions, can play an important role in changing knowledge, attitudes, and behaviors to promote suicide prevention. Safe and positive messages addressing mental illness, substance abuse, and suicide can help reduce prejudice and promote help seeking.
Strategic Direction 2: Clinical and Community Preventive Services	• Clinical and community-based programs and services play a key role in promoting wellness, building resilience, and preventing suicidal behaviors among various groups. Clinical preventive services, including suicide assessment and preventive screening by primary care and other health care providers, are crucial to assessing suicide risk and connecting individuals at risk for suicide to available clinical services and other sources of care. • Screening for depression and alcohol misuse have been endorsed by the United States Preventive Services Task Force and are now covered as preventive services under Medicare. • A wide range of community partners, including schools, workplaces, and faith-based organizations, also have an important role to play in delivering prevention programs and services to diverse groups at the local level. These community-based professionals and organizations should be competent in serving various groups, including racial, ethnic, sexual, and gender minorities, in a way that is culturally and linguistically appropriate. Greater coordination among community and clinical preventive service providers can have synergistic effects in preventing suicide and related behaviors.
Strategic Direction 3: Treatment and Support Services	• Individuals at high risk for suicide require clinical evaluation and care to identify and treat mental health and medical conditions and to specifically address suicide risk. • In the past, it was believed that appropriately treating underlying conditions (e.g., mood disorders, substance abuse) would remove the risk for suicide. However, this is not always the case. A growing body of evidence suggests that suicide prevention is enhanced when specific treatments for underlying conditions are combined with strategies that directly address suicide risk. • Evidence-based and promising approaches for caring for high-risk patients include safety planning (i.e., working collaboratively with each patient to develop an action plan for times of crises) and specific forms of psychotherapy that can be used to support treatment for underlying mental health conditions. • Addressing suicide risk may be particularly important when treating individuals who have survived a suicide attempt.
Strategic Direction 4: Surveillance, Research, and Evaluation	• The National Strategy's fourth strategic direction addresses suicide prevention surveillance, research, and evaluation activities, which are closely linked to the goals and objectives in the other three areas. • Public health surveillance refers to the ongoing, systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality. In contrast, research and evaluation are activities that assess the effectiveness of particular interventions, thereby adding to the knowledge base in the area of suicide prevention. • The past decade has seen substantial improvements in suicide-related surveillance, research, and evaluation. However, additional efforts are needed to inform and guide suicide prevention efforts nationwide. • The collection and integration of surveillance data should be expanded and improved. In addition, although some evidence is available regarding the effectiveness of particular interventions and approaches, there is a need to assess the effectiveness of new and promising practices.

The *2012 NSSP* included 13 goals that describe more information about the strategic directions. Developers of the *2015 N.C. Suicide Prevention Plan* adopted all 13 goals (Table 2).

Table 2: N.C. Goals (n=13) by Strategic Direction

N.C. Goals (n=13) by Strategic Direction.	
#1 - Healthy and Empowered Individuals, Families, and Communities	#2 - Clinical and Community Preventive Services
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings. ***GOAL 2.*** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors. ***GOAL 3.*** Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery. ***GOAL 4.*** Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	***GOAL 5.*** Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors. ***GOAL 6.*** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. ***GOAL 7.*** Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
#3 - Treatment and Support Services	#4 - Surveillance, Research, and Evaluation
GOAL 8. Promote suicide prevention as a core component of health care services. ***GOAL 9.*** Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors. ***GOAL 10.*** Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	***GOAL 11.*** Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action. ***GOAL 12.*** Promote and support research on suicide prevention. ***GOAL 13.*** Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

B. Prioritized Objectives

The following table highlights a list of **prioritized objectives**, ranked by importance and feasibility, as identified by the stakeholders involved in the plan development process. Appendix B, Section G provides details about the process used to prioritize objectives during the second Working Group Meeting (June 24, 2014).

In summary, the process involved a multi-step prioritization activity, whereby Working Group members assessed importance and feasibility for the list of objectives for each strategic direction. For **importance**, participants voted by considering a combination of factors related to the objective (e.g., reduces the burden of suicide in North Carolina, uses a comprehensive approach that targets multiple levels, uses interventions that are cost-effective). For **feasibility**, participants rated objectives deemed important during the first step as high, medium, or low by considering whether the objective could be accomplished in the immediate short-term (e.g., next 2 years), whether work is already under way to accomplish the objective, or current capacity (e.g., resources, staffing, and expertise) exists to achieve the objective. Objectives identified as important with either high or medium feasibility were considered prioritized objectives. Following the meeting, planning team members created a weighted score to standardize ratings across small groups.

Of the 61 objectives adapted from the *2012 NSSP* stakeholders in North Carolina identified **32 prioritized objectives** for emphasis in the *2015 N.C. Suicide Prevention Plan.* Table 3 lists the 32 prioritized objectives in rank order, based on weighted scoring of importance and feasibility. For each objective, the level of feasibility (high or medium) is noted following the wording of the objective. The color-coded legend below indicates the strategic direction for each objective listed in Table 3.

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

Table 3: Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).

Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).		
Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
1	5.2	Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors. *High*
2	7.1	Develop training on suicide prevention to community groups. *High*
3	11.3	Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. *Medium*
4	9.1	Adopt, disseminate, implement guidelines for the assessment of suicide risk among people receiving care in all settings. *High*
5	8.3	Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide. *Medium*
6	1.1	Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities. *High*
7	8.2	Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. *High*
8	6.1	Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means. *High*
9	11.2	Improve the usefulness and quality of suicide-related data. *High*
10	13.3	Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective. *High/Medium*
11	4.1	Accurate data and resources readily available and accessible for pick up use by media and other. *Medium*
12	7.3	Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education. *Medium*
13	3.1	Promote effective programs/practices that increase protection from suicide risk. *High*
14	9.2	Disseminate and implement guidelines for clinical practice and continuity of care for providers working with people with suicide risk. *Medium*
15	10.3	Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups. *Medium*
16	13.6	Establish resources /guides to gain access to impact/effectiveness data (e.g. toolkit, resource centers). *High*
17	5.1	Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial/tribal/local suicide prevention programming. *Medium*
18	5.3	Strengthen efforts to increase access to/delivery of effective programs and services for mental health/substance use disorders. *High*
19	10.1	Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels. *Medium*
20	2.4	Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care. *High*
21	1.5	Integrate suicide prevention into all relevant health care reform efforts. *Medium*
22	10.5	Provide health care providers, first responders, others with care/support when a patient under their care dies by suicide. *High*
23	8.8	Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge. *Medium*

Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).		
Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
24	2.1	Develop, implement, and evaluate communication efforts designed to reach defined segments of the population. *High*
25	2.2	Reach policymakers with dedicated communication efforts. *Medium*
26	7.5	Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk. *High*
27	9.5	Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental or substance use disorders. *Medium*
28	7.2	Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. *High*
29	9.3	Promote the safe disclosure of suicidal thoughts and behaviors by all. *Medium*
30	3.2	Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders. *Medium*
31	3.3	Promote the understanding that recovery from mental and substance use disorders are real and possible for all. *Medium*
32	9.4	Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk. *Medium*

SECTION 6 – WHAT CAN WE (STAKEHOLDERS) DO TO ADDRESS SUICIDE IN N.C.?

For the 61 objectives identified for inclusion in the *2015 N.C. Suicide Prevention Plan,* planning process participants identified examples of what various stakeholder groups, collectively and individually, can do to address suicide in North Carolina. This section of the plan includes lists of stakeholder group-specific of examples. Detailed summary information about examples identified by strategic direction, goals, and objectives are included in Appendix D.

NOTE ON HYPERLINKS: This plan has been designed to include several hyperlinks to provide instant access to specific areas (e.g. Stakeholder Example List). Hyperlinks appear in blue underlined *italics*. To activate a hyperlink: place your mouse cursor over the hyperlink and click with your mouse to toggle through sections of this plan.

A. Contextual Information about Examples Included in the Plan

The process used to identify what stakeholders can do to address suicide in North Carolina involved input from a wide variety of stakeholders participating on either the Working or Consulting Group. Some stakeholder groups may not have been well-represented. In addition, the degree to which all participants in the groups engaged in plan development process steps varied.

As a result, the examples identified through the planning process may or may not be inclusive of: a) all known evidence-based strategies; b) all types of interventions occurring in North Carolina; c) examples relevant for all target audiences; and d) opportunities to address high risk-populations that data (Section 4) show are disproportionally affected by suicide. Some examples may be more or less effective, as the plan development process did not require that all examples listed have evidence of effectiveness. For some examples, it may be important to tailor the activity for specific target populations at increased risk of suicide (e.g., people with disabilities, LGBTQ citizens, and military or veterans).

Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan. The examples alone do not provide sufficient information to consider all intervention actions. Please use the Resources identified in Section 7 to learn more about evidence-based or promising suicide prevention efforts, particularly the Suicide Prevention Resource Center's Registry of Best Practices. When selecting from the examples listed, remember that the impact to prevent suicide will vary by example.

B. Lists of Examples by Stakeholder Group

This section presents examples of what North Carolina stakeholders can do to address suicide, organized by 10 stakeholder groups (Tables 4-13). Each stakeholder group's list of examples is organized by strategic direction, and **bolded objectives and examples** represent prioritized objectives in the *2015 N.C. Suicide Prevention Plan.*

To more quickly navigate to the examples identified for a stakeholder group, click on the individual stakeholder group name in the list below (abbreviation for group, used in tables 4-13, is noted in parentheses):

1. Governmental Agencies/Departments (Federal, State, Local) (Gov't) (Table 4)
2. Tribal Governments (Tribal) (Table 5)
3. Health Care Systems, Insurers, and Clinicians (Health) (Table 6)
4. Businesses, Employers, and Professional Associations (Bus.) (Table 7)
5. Primary and Secondary Schools (Schools) (Table 8)
6. Colleges and Universities (College) (Table 9)
7. Nonprofit, Community, and Faith-based Organizations (Nonprofit) (Table 10)
8. Research Organizations (Research) (Table 11)
9. Individuals, Families, and Concerned Citizens (Indiv.) (Table 12)
10. Military Entities (Military) (Table 13)

Examples included in the *2015 North Carolina Suicide Prevention Plan* have been identified by a large number of content experts. Depending on your particular role in addressing suicide, some examples may be more relevant for you than

others. The examples identified are designed to initiate the discussion of What can I/we do to address suicide in North Carolina? What is feasible and practical to one individual or group may not be so to another, however, together we can achieve more. Suicide is a multifaceted issue and demands collaboration and an inter-disciplinary approach.

Some of the examples listed may be the same or similar for multiple objectives. In addition, many of the examples listed are relevant for more than one stakeholder group. To see the complete list of examples, organized in ascending order by strategic direction, goal, and objective, and showing the stakeholder group(s) for which the example was identified, please see Appendix E.

These efforts, when combined, move our state toward a comprehensive approach to address suicide. As described in Sections 1 and 2, this plan was created to complement the *2012 National Strategy for Suicide Prevention* (NSSP) (DHHS, 2012), which also describes a comprehensive approach. For more detail of how the strategic directions were identified and explanations for goals and objectives, please review the *2012 National Strategy for Suicide Prevention.*

For additional resources, please consult Section 7 – "Where can I go to learn more about suicide prevention?"-- which includes information about the evidence-based practices and interventions identified and reviewed by the Suicide Prevention Resource Center (SPRC), developed with support from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

NOTE ON HOW TO READ THE EXAMPLES

Examples for the *2015 N.C. Suicide Prevention Plan* are presented by stakeholder group in ascending order with three numerical references (i.e., #.#.#). The first number represents the goal number; the second represents the objective number; and the third represents the example number. In other words, an example with a 5.2.6 label refers to goal 5, objective 2, and example 6.

Examples that are **in bold** represent examples identified for prioritized objectives.

1. Governmental Agencies/Departments (Federal, State, and Local) Examples

Summary:

- More than 100 examples were identified for the Governmental Agencies/Departments (Federal, State and Local) stakeholder group, accounting for more than 20% of all examples collected.
- More than two thirds of all of the examples identified for Governmental agencies/departments (Federal, State and Local) are for Strategic Direction #1 (Health and Empowered Individuals, Families, and Communities).
- Governmental Agencies/Departments (Federal, State and Local) play an integral role in identifying, coordinating and monitoring statewide suicide prevention initiatives and activities. The primary roles identified for Governmental Agencies/Departments (Federal, State and Local) in North Carolina, as described in the examples, are to serve as potential leaders for advocacy, implementation of activities, policy enforcement, training and provision of funding.

Table 4: **Examples Identified for Government Agencies/Departments (Federal, State, and Local)**

Return to Stakeholder List

Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.4	Build on the partnership created by the State Health Plan between North Carolina's Division of Public Health, Office of State Personnel, and other key state agencies to identify bureaucratic obstacles to providing worksite wellness programs for state employees and to develop a state policy to address them.
1.1.7	Encourage N.C. General Assembly support to include suicide awareness and prevention in workplace safety meetings and briefings.
1.1.8	Engage clergy members at suicide prevention stakeholder meetings.
1.1.11	Ensure that Medical Examiners understand the importance of accurate documentation of suicide events, through training and technical assistance.
1.1.17	Incorporate suicide prevention training into professions that have exposure to traumatic events (e.g., law enforcement, EMS, fire and rescue, emergency department staff).
1.1.18	Increase funding for suicide prevention and treatment services.
1.1.32	Promote the use/adoption of model worksite programs developed by the Division of Public Health to guide development of worksite wellness policy and wellness interventions.
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.6	Identify a lead agency to coordinate and convene public and private stakeholders, assess needs and resources, and develop and implement a comprehensive strategic suicide prevention plan.
1.2.17	Promote, increase awareness, and support activities that support Senate Bill 526, the North Carolina School Violence Prevention Act - to prevent bullying or harassing behavior.
1.2.19	Provide free train-the-trainer events to develop volunteer peer networks as a way to increase sustainability of suicide prevention efforts.
1.2.24	Support Crisis Intervention Training (CIT) (e.g., for law enforcement).
1.2.25	Update the Crisis Intervention Training and Suicide Awareness training, which are a part of the N.C. Training and Standards Commission in the Department of Justice.
1.2.26	Work with lawmakers and school boards to design, pass, and implement a state initiative to incorporate suicide prevention efforts and teachings into school curricula.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.2	Collaborate with mental health Local Management Entities (LMEs) on local information, resources, and professional development/training opportunities.

Return to Stakeholder List

Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
1.3.3	Develop community coalitions to bring agencies, peers, and stakeholders into a consolidated effort to prevent suicide.
1.3.6	Lead a working group across agencies and partners to advance state-specific suicide prevention initiatives.
1.3.10	Support state suicide prevention working group(s) on as-needed basis.
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.1	Develop and distribute lists of local crisis intervention personnel to law enforcement departments that do not have advanced crisis training.
1.4.4	Lead statewide public/private partnership (modeled on National Action Alliance for Suicide Prevention) to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.5.4	Identify alternate services previously offered by Community Mental Health Clinics (CMHC), especially in rural areas.
1.5.5	Improve insurance coverage for mental illness so that it is equal to insurance for physical illness.
1.5.9	Require suicide screening questions on intake form in primary care visit and other health visits.
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	
2.1.1	Adopt and incorporate existing military communication efforts, educational activities and resources into civilian suicide prevention efforts.
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.10	Develop diverse communication/social marketing plan that targets message for individuals who receive publicly funded mental health care.
2.1.11	Develop suicide prevention train the trainer programs and disseminate information with community volunteers.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.2.5	Encourage student groups to send letters to legislators to support suicide prevention activities.
2.2.6	Evaluate effectiveness of suicide prevention and awareness communication efforts developed for policy makers.
2.2.7	Frame research/data to show the impacts of suicide prevention interventions for legislators.
2.2.8	Frame suicide prevention activities as cost beneficial for legislators.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	
2.3.1	Create accessible media tools to reach youth (e.g., It's OK 2 Ask"), to reduce stigma and increase help-seeking behavior by the North Carolina Department of Health and Human Services, Division of Public Health.
2.3.2	Create culturally competent online suicide awareness and prevention messages.
2.3.3	Develop and promote an online social media presence (Twitter, Facebook, etc.) and support the development of standardized messages (e.g. developed by research organizations, the Centers for Disease Control and Prevention).
2.3.4	Develop policy/procedure recommendations that emphasize the restriction of online promotion, information, and availability of how to perform suicide.
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).

Return to Stakeholder List

Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.10	Offer suicide prevention and awareness trainings (e.g., Question Persuade Refer) to agencies working in the community (e.g., Department of Social Services, school systems, senior centers, home health agencies).
2.4.12	Promote working with Tribal Governments as a priority in suicide prevention and education efforts to increase knowledge about the warning signs for suicide and how to connect individuals in crisis with assistance and care.
2.4.14	Provide and promote a suicide prevention hotline available 24/7.
2.4.15	Provide funding to support ongoing work conducted by taskforces and researchers to increase knowledge of the warning signs for suicide and connect individuals in crisis with assistance and care.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.13	Promote and share resources: National Registry of Evidence-based Programs and Practices from Substance Abuse and Mental Health Services Administration (SAMHSA) and Suicide Prevention Resource Center (SPRC) Best Practices Registry.
3.1.18	Promote suicide prevention training to peer volunteers that are free or low cost.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.4	Empower teachers and guidance counselors to openly discuss depression and mental illness in the school environment.
3.2.11	Include suicide prevention education messages in workplace safety meetings.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.8	Implement public awareness campaigns during May, Mental Health Awareness month, which targets decreasing stigma about mental disorders.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.3	Encourage linkages between local data and national databases when making data available and accessible for pick-up by media.
4.1.4	Ensure that accurate and current information about suicide and suicide prevention is included on all government websites, using accessible formats and through framing that is applicable to different populations, including those at high risk of suicidal ideation and/or suicidal behaviors.
4.1.7	Ensure that funding provided to suicide prevention programs require the development of accurate messages for use by media.
4.1.10	Incorporate communication messages for pick-up by media that de-stigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during May, Mental Health Awareness month, when media coverage may be intensified.
4.1.14	Report accurate suicide and suicidal behavior data and responsible information when talking to/working with the media.
4.1.15	Respond to media stories that do not promote resources or include inaccurate information.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	

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Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.4	Convene regular coordinating calls/working group for all state partners working to promote wellness and prevent suicide.
5.1.7	Ensure that individuals experiencing an acute mental health or substance abuse crisis receive timely specialized psychiatric treatment in coordination with available and appropriate community resources (e.g., The North Carolina Department of Health and Human Services, Division Of Mental Health, Developmental Disabilities and Substance Abuse Services has a Crisis Solutions Initiative. The initiative seeks to identify ways to expand existing best practices that have been proven to work on the local level, such as: Walk-In Crisis Centers and Short-Term Residential Treatment Options; Youth Mental Health First Aid; Person-Centered Crisis Prevention Plans; Telepsychiatry; EMS Pilot Programs; and Crisis Intervention Teams).
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.1.12	Support and promote Crisis Intervention Team (CIT) Training for all law enforcement.
5.1.14	Support measures/legislation designed to reduce access to guns as a lethal means for suicide.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.11	Promote and encourage implementation of suicide prevention programs known to be effective (e.g., Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth CIT, Question, Persuade, Refer (QPR)).
5.2.16	Provide suicide awareness and prevention training in elementary schools (e.g., Teaching Life Skills).
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.2	Collect county-specific lists of suicide prevention and mental and substance use disorder resources and referrals (e.g., American Foundation for Suicide Prevention (AFSP.org), suicide hotline, United Way 211 website).
5.3.6	Engage peer support specialists, who have personal experience with suicide, on treatment teams formed to support those with mental and substance use disorders.
5.3.12	Support funding opportunities for county-specific suicide prevention and mental and substance use disorder resources (e.g., AFSP.org, suicide hotline, United Way 211 website).
5.3.13	Support grants and funding to provide education and training for suicide prevention for citizens/students/community members experiencing mental and substance abuse disorders.
5.3.14	Support the development and dissemination of training and tools to peers to provide long-term recovery support to people in different stages of recovery.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.5	Develop and implement standardized policies, procedures, and processes for encouraging providers, who interact with individuals at risk for suicide, to routinely assess for access to lethal means of suicide.
6.1.10	Encourage the use of Evidence-Based Practices and promising practices in the screening and assessment of access to lethal means of suicide (e.g., CALM, Counseling on Access to Lethal Means).
6.1.11	Identify specific community providers (one per county) to serve as safety net organizations that encourage providers who interact with individuals at risk for suicide to routinely asses for access to lethal means.
6.1.12	Incorporate an approved flagging reporting process between medical professionals and firearms dealers that require medical professionals to report suicide risks for at risk patients that may apply for firearms permits or firearms background checks
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	

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Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
6.2.1	Examine and review current laws about firearm safety and responsible firearm ownership for changes that will lead to suicide prevention and increased awareness about suicide.
6.2.4	Support efforts for awareness and enforcement of the North Carolina Child Access Protection Law, which promotes firearm safety for people who reside with a minor.
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
6.3.1	Adopt components used for Operation Medicine Drop events to encourage the voluntary surrender of firearms.
6.3.4	Promote the use/conduct of Operation Medicine Drop events (held statewide in partnership involving Safe Kids North Carolina, the Drug Enforcement Administration, and law enforcement) to reduce the diversion of prescription drugs (a lethal means of suicide) through the voluntary surrender and safe disposal of prescription and other drugs.
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.2	Develop and provide train the trainer programs for suicide prevention and intervention to teach the classes throughout the community.
7.1.5	Expand efforts of the North Carolina Department of Health and Human Services, Division of Public Health to train school staff, nurses, social workers and teachers with the suicide prevention programs (e.g., Applied Intervention Skills Training, safeTALK, Lifelines Curriculum and Lifelines Postvention).
7.1.7	Incorporate people with lived experience of suicide (either self or loved one) in development and implementation of training activities.
7.1.9	Increase training and accountability of law enforcement for identifying likelihood of suicide.
7.1.13	Promote training in assessment and management of suicide risk (e.g. the Education Development Center's Assessing and Managing Suicide workshop).
7.1.15	Provide suicide prevention training and collaboration across state agencies.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.1	Conduct train-the-trainer events hosted by the North Carolina Department of Health and Human Services, Division Of Mental Health, Developmental Disabilities and Substance Abuse Services for Youth Mental Health First Aid to the state's Local Management Entities/Managed Care Organizations.
7.2.5	Implement Assessing and Managing Suicide Risk (AMSR) policies for mental health and substance use disorder providers.
7.2.6	Incorporate people with lived experience of suicide (either self or loved one) in development and implementation of training opportunities.
7.2.7	Provide training in the use and implementation of primary care toolkits (e.g., Suicide Prevention Resource Center's primary care toolkit).
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., Question, Persuade and Refer, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.4	Develop, train and implement evidence-based protocols to collaboratively manage suicide risk in each practice setting.
7.5.5	Establish trained Crisis Intervention Teams including law enforcement, mental health professionals, and advocates throughout North Carolina.

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Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
7.5.7	Identify barriers to communication between/among clinicians, first responders, crisis staff (e.g., HIPAA, electronic records, and failure to document) and develop strategies to improve communication.
7.5.8	Promote the use of Crisis Intervention Teams with law enforcement and first responders.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.1.1	Encourage relevant stakeholders (e.g., hospitals, primary care, mental health, public health and schools) to adopt an aspirational goal of zero suicides.
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.2.4	Develop community based volunteer peer recovery centers that are free to the public and provide education and support.
8.2.6	Provide in-depth training assessments to counselors/doctors/nurses to identify and treat high risk individuals to reduce number of individuals who commit suicide between assessment and first appointment.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.3.6	Prioritize, within government agencies, the need for timely access to suicidal risk assessment, intervention and effective care.
8.3.9	Support ongoing work across multiple agencies and organizations that promote the national resources on their websites and provide a live link (e.g. National Lifeline number, It's OK 2 Ask, Raleigh Hopeline, N.C.-NAMI).
8.3.10	Support policies and insurance plans that reward participants for acting pro-actively and seeking preventive services.
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.5.1	Develop mental health assessment as a Quality Care Measure, potentially linking to reimbursement mechanisms through other symptoms displayed (i.e. pain, fatigue).
8.5.3	Require relevant stakeholders to report suicide attempt and commitment metrics.
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.2	Fund peer support specialists for outreach and engagement.
8.6.3	Identify and disseminate available resources for links between mental health and substance abuse through national, local and other databases.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
8.8.7	Lead crisis continuum meetings that include Emergency Department staff, providers, and law enforcement to discuss alternative treatment options to Emergency Departments.
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.10	Promote a consistent and clear mandate to define Mobile Crisis Units services pertaining to suicide response.

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Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
9.1.11	Promote and ensure programs that effectively screen youth entering the juvenile justice system for substance abuse and mental health issues with a valid, reliable tool (e.g. North Carolina Department of Public Safety's The Reclaiming Futures Initiative).
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.2	Designate/award an organization with Suicide Prevention Best Practice Guidelines to serve as the gold standard for other organizations and encourage application of best practices for suicide prevention.
9.2.6	Encourage School Resource Officers (SRO) and Law Enforcement personnel to complete Crisis Intervention Team (CIT) trainings.
9.2.7	Identify and train hospital staff about populations most at risk for suicide (e.g., Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ), youth with special needs).
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.1	Adopt It's OK to ask philosophy across all Local Management Entities (LME)/Managed Care Organizations (MCO) providers.
9.3.2	Educate communities and individuals on HIPPA guidelines and that personal information (including psychological information) is confidential.
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.5.2	Develop tracking for suicidal attempt methodology (e.g. the development of a system to track mechanisms of suicidal attempts).
9.5.5	Require suicidality assessment as part of screening and assessment of new patients and determination of level of need for services.
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.1.2	Encourage state agencies to evaluate the quantity and quality of trainings conducted by Managed Care Organizations.
10.1.8	Provide employees with an Employment Assistance Programs (EAP) that includes comprehensive support programs for individuals bereaved by suicide.
10.1.9	Train lay people and community members in suicide awareness and prevention programs (e.g. Mental Health First Aid; Question, Persuade, Refer).
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.2.1	Develop a system to identify individuals in need of suicide related services who are not covered currently for treatment.
10.2.6	Mandate that Local Management Entities/Managed Care Organizations pay for services for any person who qualifies for indigent care or has Medicaid coverage, including individuals affected by a suicide attempt or bereaved by suicide.

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Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.3.3	Promote outreach to incorporate suicide attempt survivors in community suicide awareness, prevention and outreach groups.
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.4.2	Identify a lead agency in the community to lead a community response plan and community suicide prevention efforts.
10.4.3	Local Management Entities and Managed Care Organizations should support Psychological First Aid training in provider agency.
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
10.5.3	Evaluate availability of funds to support suicide awareness and prevention trainings for medical and mental health providers.
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.1.4	Improve the timeliness of reporting deaths classified as suicide by developing electronic reporting systems for both the Vital Records and the Medical Examiner Systems in North Carolina.
11.1.5	Increase funding and resources to support the transition to an electronic death record system.
11.1.6	Increase integration/linking of data collection systems between tribal and federal/state/local governments.
11.1.7	Increase resources and funding to the Office of the Chief Medical Examiner to facilitate timely death investigations.
11.1.8	Increase the timeliness and capacity for the processing of information from the North Carolina Violent Death Reporting System (N.C. VDRS).
11.1.10	Support funding for adequate staff to manage existing data services (e.g. second data abstractor for NC-VDRS).
11.2 Improve the usefulness and quality of suicide-related data.	
11.2.5	Expand questions included in the North Carolina Violent Death Reporting System (N.C. VDRS) that are targeted toward identifying details related to suicides.
11.2.7	Link N.C. Incident Response Improvement System (IRIS) data from DMH/DD/SAS to other data sources (e.g., death certificate, medical examiner, hospital discharge, ED) to gain a better understanding of suicide attempts.
11.2.9	Review and provide available data in greater detail (e.g., more specific subset groups, for example, youth 10 – 17).
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.1	Dedicate funding to increase capacity for quality data collection pertaining to suicides.
11.3.2	Evaluate available data provided in N.C. Treatment Outcomes and Program Performance System (NCTOPPS) and determine if additions should be considered for the routine collection, analysis, reporting, and use of suicide-related data.
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.3.7	Promote use and access to the North Carolina Violent Death Reporting System (N.C. VDRS), a public health, population-based surveillance system that contains detailed information on deaths that result from violence.
11.3.8	Require and provide mandatory training in the reporting of incidences of suicide.

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Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
11.4.1	Minimize and streamline the number of nationally representative surveys to minimize discrepancies in results and/or numbers.
11.4.3	Refine/add questions that are N.C. specific and address the needs and interests of our populations and needs through the N.C. Youth Risk Behavior Survey.
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.1.1	Connect with and secure sources of funding to support suicide prevention research in North Carolina.
12.1.2	Lead the effort to convene working group of suicide prevention research stakeholders.
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.2.2	Develop and support the use of social media for dissemination of suicide awareness, prevention and outreach efforts studied in the research agenda.
12.2.3	Provide clear and concise means to disseminate the suicide prevention agenda to the public.
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.3.1	Consider legislative supported incentives for timely dissemination of data.
12.3.2	Encourage and support partnerships between research organizations and state government to smooth the process of dissemination.
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
12.4.1	Promote partnership among governments, universities and research institutions to combine data and develop materials for general understanding (e.g. individual citizen and/or stakeholders form a variety of fields, such as adolescent health or public safety).
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.1.2	Continue to provide ongoing reports on North Carolina suicide rates for use at multiple levels to evaluate the impact and effectiveness of suicide prevention interventions.
13.1.7	Integrate the information collected in community health needs assessments to build County level action plans for suicide prevention interventions and activities.
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.2.3	Provide action plans, Department of Public Health and Department of Mental Health, for specific groups (i.e. faith-based, school-based, clinicians) based on effective interventions.
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.3.1	Collect data to plan and implement successful youth suicide prevention programs.
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.1	Create fact sheet regarding effectiveness of National Strategy for Suicide Prevention (NSSP) for publication on government websites and through social media.
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.4.3	Lead a partnership with academia, for both evaluation of and dissemination of the state suicide plan and the National Strategy for Suicide Prevention (NSSP) goals and objectives, as well as their short- and long-term health impacts as they are rolled out across the state.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.5.1	Utilize known stakeholder networks, including those established during the Working Group meetings to disseminate suicide prevention evidence and best practices.
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	

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Examples Identified for Government Agencies/Departments (Federal, State, and Local).	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
13.6.1	Compile national, state, and local suicide prevention resources into one central resource (e.g., NAMI and Jason Foundation).
13.6.3	Identify and disseminate suicide prevention impact/effectiveness resources (e.g., National Association of County and City Health Officials toolkit, and resources from Association of State and Territorial Health Officials, and American Public Health Association).

2. Tribal Governments

Summary:

- More than 40 examples were identified for the Tribal Governments stakeholder group, accounting for 8% of all examples collected.
- Tribal governments are encouraged to review the examples identified for Governmental Agencies/Departments (Federal, State and Local), given that there may be some overlapping opportunities for both stakeholder groups.
- More than half of the examples identified for Tribal Governments are in Strategic Direction #1-Healthy and Empowered Individuals, Families and Communities, with the most identified for *Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.* The primary roles identified for Tribal governments are to promote awareness, prevention and access to accurate information and data.

Table 5: Examples Identified for Tribal Governments

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Examples Identified for Tribal Governments.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.25	Pass tribal resolutions supporting suicide prevention and wellness promotion in tribal communities.
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.11	Pass tribal resolutions supporting suicide prevention.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.2	Collaborate with mental health Local Management Entities (LMEs) on local information, resources, and professional development/training opportunities.
1.3.7	Lead a working group across Tribal agencies and partners to advance tribal specific suicide prevention initiatives.
1.3.9	Participate in state suicide prevention working group(s).
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.5.5	Improve insurance coverage for mental illness so that it is equal to insurance for physical illness.
1.5.7	Integrate suicide prevention in governmental healthcare plans.
1.5.9	Require suicide screening questions on intake form in primary care visit and other health visits.
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.16	Involve tribal elders, leaders, and youth in developing suicide prevention, education, and awareness communication messages.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	

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Examples Identified for Tribal Governments.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.1	Adapt existing suicidal awareness, education and prevention training programs to use in Tribal communities.
2.4.6	Identify key advocates within Tribal community to implement education and training designed to increase knowledge about the warning signs for suicide and how to connect individuals in crisis with assistance and care.
2.4.12	Promote working with Tribal Governments as a priority in suicide prevention and education efforts to increase knowledge about the warning signs for suicide and how to connect individuals in crisis with assistance and care.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.1	Collaboratively work with agencies to identify risk assessment and protective opportunities in tribal communities and how residents can access services.
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.6	Identify key advocates within tribal community to implement education and training designed to promote the understanding that recovery from mental and substance use disorders is possible.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.3	Encourage linkages between local data and national databases when making data available and accessible for media.
4.1.4	Ensure that accurate and current information about suicide and suicide prevention is included on all government websites, using accessible formats and through framing that is applicable to different populations, including those at high risk of suicidal ideation and/or suicidal behaviors.
4.1.7	Ensure that funding provided to suicide prevention programs require the development of accurate messages for use by media.
4.1.10	Incorporate communication messages for media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during May, Mental Health Awareness month, when media coverage may be intensified.
4.1.14	Report accurate suicide and suicidal behavior data and responsible information when talking to/working with the media.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	

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Examples Identified for Tribal Governments.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.2.12	Promote and encourage wellness promotion and suicide prevention programs and promising practices used in other tribal communities.
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.13	Support grants and funding to provide education and training for suicide prevention for citizens/students/community members experiencing mental and substance abuse disorders.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.1	Adapt and tailor existing efforts to reduce access to lethal means in tribal communities.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.2.1	Examine and review current laws about firearm safety and responsible firearm ownership for changes that will lead to suicide prevention and increased awareness about suicide.
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.13	Promote training in assessment and management of suicide risk (e.g. the Education Development Center's Assessing and Managing Suicide workshop).
7.1.20	Utilize Suicide Prevention Resource Center's best practices registry (and other promising practices) to identify and adapt trainings for tribal communities in N.C.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.8	Promote the use of Crisis Intervention Teams with law enforcement and first responders.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.1.1	Encourage relevant stakeholders (e.g., hospitals, primary care, mental health, public health and schools) to adopt an aspirational goal of zero suicides.
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.3.8	Provide Crisis Intervention Teams within tribal healthcare entities.

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Examples Identified for Tribal Governments.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
Strategic Direction #4: Surveillance	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.1.6	Increase integration/linking of data collection systems between tribal and federal/state/local governments.
11.2 Improve the usefulness and quality of suicide-related data.	

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Examples Identified for Tribal Governments.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.4	Improve collaboration among government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
12.4.1	Promote partnership of government, universities and research institutions to combine data and develop materials for general understanding (e.g. individual citizen and/or stakeholders form a variety of fields, such as adolescent health or public safety).
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.3.1	Collect data to plan and implement successful youth suicide prevention programs.
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.5.1	Utilize known stakeholder networks, including those established during the Working Group meetings to disseminate suicide prevention evidence and best practices.
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	

3. Health Care Systems, Insurers, and Clinicians

Summary:

- 23 percent (n=121) of all examples identified for all stakeholder groups were for the Health Care Systems, Insurers, and Clinicians stakeholder group.
- The majority of examples identified were for Strategic Direction #3-Treatment and Support Services, followed closely by Strategic Direction #1-Health and Empowered Individuals, Families, and Communities.
- The goal for which the greatest number of examples was identified was Goal 8: Promote suicide prevention as a core component of health care services.
- This stakeholder group plays an integral role in the screening, diagnosis, and delivery of treatment and interventions to prevent suicide.

Table 6: Examples Identified for Health Care Systems, Insurers, and Clinicians

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.3	Adopt, promote and support Wellness Recovery Action Plans (WRAP) plans for students and their families.
1.1.5	Build partnerships (at multiple levels) for direct admissions in order to eliminate wait lists/lines in healthcare settings.
1.1.13	Ensure that hospital staff understand their roles in preventing suicide by providing training.
1.1.16	Incorporate multiple suicide prevention focused screenings into all primary health care visits.
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.1	Build partnerships to increase direct admissions for people at risk for suicide.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.1	Align goals with the Healthful Living Essential Standards for grades 6 to 9 for stress management (e.g., Apply help-seeking strategies for depression and mental disorders).
1.3.2	Collaborate with mental health Local Management Entities (LMEs) on local information, resources, and professional development/training opportunities.
1.3.10	Support state suicide prevention working group(s) on as-needed basis.
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.1	Advocate for greater integrated care in primary care and/or Emergency Department settings.
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.5.5	Improve insurance coverage for mental illness so that it is equal to insurance for physical illness.
1.5.8	Provide organizations additional training and continuing education around effective intervention and innovation in patient care.
1.5.9	Require suicide screening questions on intake form in primary care visit and other health visits.
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	
2.1.1	Adopt and incorporate existing military communication efforts, educational activities and resources into civilian suicide prevention efforts.

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.5	Create and display suicide prevention posters at healthcare facilities.
2.1.8	Develop communication messages for incorporating mental health screening into primary care.
2.1.12	Emphasize existing caregiver support programs, for suicide awareness, prevention and treatment, in communication messages to medical staff, patients, or family members
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.2.8	Frame suicide prevention activities as cost beneficial for legislators.
2.2.10	Promote policies to allow for insurance coverage for depression and suicide risk screening.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.7	Include families/significant others in discharge planning and education after a suicide attempt has occurred.
2.4.9	Involve families in efforts to increase knowledge of suicide and to open lines of communication about both prevention and intervention.
2.4.13	Provide Mental Health First Aid for employees.
2.4.17	Provide patient education materials about suicide warning signs/how to connect those in crisis.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.5	Educate and engage with other groups (e.g. faith-based, community, healthcare) who are active and/or interested in becoming active in suicide prevention activities that seek to increase protective factors from suicide risk.
3.1.11	Mandate policies that seek to incorporate suicide screening to identify suicide risk, including Emergency Department screening/psychological assessments, to refer, treat, or admit those at increased suicide risk.
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.16	Promote policies and practices that include families and/or significant others in discharge planning and education after a suicide attempt has occurred.
3.1.19	Promote the use of Brief Depression Screeners among primary care providers.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.2	Develop marketing strategies to promote understanding of the complexity of substance abuse and the importance of accessing services.
3.2.7	Host community awareness campaigns to reduce stigma and to increase access.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.3	Empower patients to discuss suicide and suicidal ideation.
3.3.11	Reinforce positive behaviors in order to encourage positivity and acknowledgment of progress during recovery processes.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
4.1.3	Encourage linkages between local data and national databases when making data available and accessible for media.
4.1.7	Ensure that funding provided to suicide prevention programs require the development of accurate messages for use by media.
4.1.10	Incorporate communication messages for media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during May, Mental Health Awareness month, when media coverage may be intensified.
4.1.14	Report accurate suicide and suicidal behavior data and responsible information when talking to/working with the media.
4.1.15	Respond to media stories that do not promote resources or include inaccurate information.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.1.15	Train Emergency Department personnel to identify signs of suicidal tendencies as a way to strengthen the coordination of suicide prevention programming.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.13	Promote mental health wellness and self care at clinic/community health fairs.
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.3	Develop and actively engage safety plans with at-risk mental and substance use disorder clients.
5.3.6	Engage peer support specialists, who have personal experience with suicide, on treatment teams formed to support those with mental and substance use disorders.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.2	Advocate for and inform legislation and policies that support limits to access to lethal means, including weapons, for populations at risk of suicide.
6.1.6	Develop mechanisms to reimburse for screening and early intervention services that include assessing for access to lethal means of suicide.
6.1.7	Educate primary care practitioners and emergency department staff in suicide awareness, identification methods, and lethal means screening protocols.
6.1.14	Provide education about safe medication storage and disposal for both prescription and over-the-counter drugs.
6.1.15	Provide suicide awareness, education and prevention training to clinicians, including tools and procedures for assessing for access to lethal means of suicide.
6.1.17	Work with health care and research to identify screening protocols, to assess access to lethal means that are effective and enforced within the military.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.3 Develop and implement new safety technologies to reduce access to lethal means.	

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.10	Increase training to clinicians on how to help people become socially connected and engaged in meaningful life activities.
7.1.11	Mandate suicide prevention training for medical facility/school staff.
7.1.13	Promote training in assessment and management of suicide risk (e.g. the Education Development Center's Assessing and Managing Suicide workshop).
7.1.17	Provide training to increase recognition among professional and family caregiver staff (i.e., at physical rehabilitation facilitates and among home care staff) that certain medical conditions are linked to suicide risk.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.2	Develop and standardize screening protocols for at risk patients.
7.2.4	Encourage trainings and certification programs in Mental Health First Aid (e.g., Carolinas HealthCare System).
7.2.5	Implement Assessing and Managing Suicide Risk (AMSR) policies for mental health and substance use disorder providers.
7.2.6	Incorporate people with lived experience of suicide (either self or loved one) in development and implementation of training opportunities.
7.2.7	Provide training in the use and implementation of primary care toolkits (e.g., Suicide Prevention Resource Center's primary care toolkit).
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., Question, Persuade and Refer, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.3.5	Work with Area Health Education Centers to offer continuing education courses to health providers in the allied health, dental health, medicine, mental health, nursing, pharmacy, and public health professions.
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.1	Adopt and mandate the use of crisis intervention plans with trauma-involved clients.
7.5.2	Adopt and mandate the use of emergency management guidelines/protocols to deal with crisis situations.
7.5.4	Develop, train and implement evidence-based protocols to collaboratively manage suicide risk in each practice setting.
7.5.7	Identify barriers to communication between/among clinicians, first responders, crisis staff (e.g., HIPAA, electronic records, and failure to document) and develop strategies to improve communication.
7.5.8	Promote the use of Crisis Intervention Teams with law enforcement and first responders.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.1.1	Encourage relevant stakeholders (e.g., hospitals, primary care, mental health, public health and schools) to adopt a zero suicide as an aspirational goal.
8.1.2	Increase focus on elder mental health, including increased screenings for suicide risk and depression.
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
8.2.5	Promote the development and use of policies and procedures to minimize the barriers encountered through transitions across levels of service/treatment (e.g., in-patient care, out-patient programs).
8.2.7	Support text-information programs (e.g., NC-NAMI Text 4 Teens) to provide teens in difficult situations a way to anonymously receive support.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.3.1	Create, maintain and share referral lists with other organizations.
8.3.2	Develop and implement standards for ensuring timely access across healthcare services.
8.3.3	Ensure communication between emergency/crisis services and follow-up outpatient services.
8.3.7	Promote open access models for suicide prevention and awareness for walk-in care clients.
8.3.8	Provide Crisis Intervention Teams within tribal healthcare entities.
8.3.11	Promote technology that will empower clients to have a role in their treatment and recovery.
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.4.1	Develop methods for healthcare providers, parents and schools to develop and communicate a school support plan for youth treated for suicide risk in Emergency Departments or hospital inpatient units.
8.4.2	Develop methods to monitor patients treated in Emergency Departments or hospital inpatient units to determine effectiveness of treatment.
8.4.3	Increase follow-up communication and connection (e.g., phone, text) with dischargees after care.
8.4.4	Promote collaboration between Emergency Department healthcare providers and outpatient care healthcare providers.
8.4.5	Utilize mobile app technology to engage individuals in their treatment and self care.
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.5.1	Develop mental health assessment as a Quality Care Measure, potentially linking to reimbursement mechanisms through other symptoms displayed (i.e. pain, fatigue).
8.5.2	Incorporate tools included in the Zero Suicide Toolkit into continuous quality improvement efforts.
8.5.4	Establish timely standards for follow-up appointments post discharge for suicide-related hospitalizations.
8.5.5	Utilize technology to follow-up with discharged patients and outpatient clients.
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.1	Develop and implement suicide prevention and outreach programs to nonprofits, community- and faith-based organizations, individuals, families and concerned citizens.
8.6.2	Fund peer support specialists for outreach and engagement.
8.6.4	Promote peer support groups that promote and employ life skills training.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.7.1	Track and report patient information and outcomes to determine effectiveness of treatment.
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
8.8.1	Create collaborations/workgroups to include outpatient providers and family members as part of discharge plans.
8.8.2	Employ mobile crisis to assess risk level and access alternative care.
8.8.3	Improve follow-up measures after Emergency Medical Services responses to a suicidal crisis (e.g., increase referrals to appropriate services).
8.8.4	Incorporate WRAP (Wellness Recovery Action Plan) trainings to Emergency Department staff.
8.8.5	Increase availability and use of short term crisis overnight beds in community programs.
8.8.6	Increase availability and use of tele-psychiatry to assess suicidal risk level.

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
8.8.7	Lead crisis continuum meetings that include Emergency Department staff, providers, and law enforcement to discuss alternative treatment options to Emergency Departments.
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.1	Adopt policies to include postpartum depression screening for gynecological, pediatric, and family medical visits.
9.1.2	Adopt and implement suicide awareness programs (e.g. Signs of Suicide).
9.1.3	Adopt and routinely use a validated depression screening scale for assessing patients.
9.1.12	Provide insurance coverage for preventive mental health services.
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.2	Designate/award an organization with Suicide Prevention Best Practice Guidelines to serve as the gold standard for other organizations and encourage application of best practices for suicide prevention.
9.2.5	Encourage Managed Care Organizations (MCO) to reimburse highly trained or certified clinicians at a higher rate to promote qualified clinicians.
9.2.7	Identify and train hospital staff about populations most at risk for suicide (e.g., LGBTQ, youth with special needs).
9.2.8	Increase community suicide prevention and awareness education campaigns to increase patient awareness and self-advocate to receive optimal care.
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.3	Encourage training of clinicians and other health care professionals in listening skills.
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.4.1	Develop Plan of Care or Discharge criteria to include someone other than individuals with distress.
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.5.1	Develop clear criteria for individuals to be considered safe in their environment.
9.5.2	Develop tracking for suicidal attempt methodology (e.g. the development of a system to track mechanisms of suicidal attempts).
9.5.5	Require suicidality assessment as part of screening and assessment of new patients and determination of level of need for services.
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.7.1	Develop and/or adopt objective and universally used depression screening scale(s) that are easily understood and used by Healthcare Practitioners.
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.1.1	Employment Assistance Programs (EAP) should maintain a current list of resources/database.
10.1.8	Provide employees with an Employment Assistance Programs (EAP) that includes comprehensive support programs for individuals bereaved by suicide.

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.3.3	Promote outreach to incorporate suicide attempt survivors in community suicide awareness, prevention and outreach groups.
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.4.1	Develop clear algorithms for guidelines to respond effectively to suicide clusters and contagion within cultural contexts.
10.4.4	Work with other stakeholder groups to develop a community response plan.
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
10.5.2	Develop protocols identifying when/what services to offer when a suicide occurs.
10.5.4	Identify and disseminate information about resources available within the community.
10.5.6	Incorporate suicide attempt survivors and survivors of suicide victims in the education for healthcare providers and first responders.
10.5.8	Provide peer based support for health care providers.
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.1.1	Develop better tracking tool(s) for outcomes of patients/services provided related to suicide prevention.
11.1.3	Disseminate suicide and suicidal behavior data collection practices for use by community partners.
11.1.9	Provide incentive(s) to healthcare, insurers and/or clinicians to provide/report data related to suicide.
11.1.11	Support policies and advancements to remove insurance clauses that discriminate against mental health/suicide deaths by denying claims.
11.2 Improve the usefulness and quality of suicide-related data.	
11.2.1	Collect and track data related to suicide (e.g. suicidal behaviors, suicidal ideation, and completions).
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.3.8	Require and provide training for mandatory training in the reporting of incidences of suicide.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	

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Examples Identified for Health Care Systems, Insurers, and Clinicians.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
13.1.4	Evaluate training programs that aim to integrate behavioral, mental health care and primary care, particularly for high risk populations.
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.2.5	Work with other organizations and researchers to identify information pertaining to cost effective interventions for suicide prevention.
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.3.5	Identify additional ways that behavioral and mental health can be integrated into primary care.
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to improve access to and effectiveness of data (e.g. toolkit, resource centers).	
13.6.1	Compile national, state, and local suicide prevention resources into one central resource (e.g., NAMI and Jason Foundation).
13.6.2	Encourage availability and distribution of suicide prevention toolkits appropriate for clinicians, individuals, and parents.
13.6.3	Identify and disseminate suicide prevention impact/effectiveness resources (e.g., National Association of County and City Health Officials toolkit, and resources from Association of State and Territorial Health Officials, and American Public Health Associations).

4. Businesses, Employers, and Professional Associations

Summary:

- Businesses, Employers, and Professional Associations were identified for several examples for how to address suicide in North Carolina.
- Almost half of all examples were identified in Strategic Direction #1-Healthy and Empowered Individuals, Families and Communities.
- The greatest number of examples (n=4) were identified for Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings and Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Table 7: Examples Identified for Businesses, Employers, and Professional Associations

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Examples Identified for Businesses, Employers, and Professional Associations.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.14	Improve linkages to providers after an employee has maximized Employee Assistance Program (EAP) benefits and follow-up on success of referrals.
1.1.19	Increase the presence and visibility of suicide prevention services provided by Employee Assistance Programs (EAP).
1.1.30	Promote suicide prevention through professional associations and through a willingness to fund suicide prevention and awareness efforts.
1.1.39	Utilize staff input to improve support and workplace wellness programs that seek to prevent suicide.
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.9	Involve Employee Assistance Programs (EAP) in suicide prevention efforts.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.10	Support state suicide prevention working group(s) on as-needed basis.
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.5.5	Improve insurance coverage for mental illness so that it is equal to insurance for physical illness.
1.5.6	Incorporate suicide prevention to Employee Assistance Programs (EAP).
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.7	Develop communication messages for Employee Assistance Programs (EAP) to educate employers that mental health should be treated the same as other physical ailments.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.2.11	Support outreach using business-friendly messages to increase suicide prevention activities to policy makers.

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Examples Identified for Businesses, Employers, and Professional Associations.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies	
2.3.3	Develop and promote an online social media presence (Twitter, Facebook, etc.) and support the development of standardized messages (e.g. developed by research organizations, the Centers for Disease Control and Prevention).
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.21	Work with contract organizations (e.g., insurance carriers, Employee Assistance Programs (EAPs) and wellness organizations) to promote health and prevent suicide by increasing knowledge among plan participants/enrollees about warning signs and how to connect those in crisis with care.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.17	Promote social connectedness among employees by offering opportunities to engage in community service work or recreational activities as teams.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.8	Identify neutral names for prevention programs that do not covey stigmatization.
3.2.12	Incorporate suicide awareness and prevention training into orientation and annual requirements for employees.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.7	Identify willing speakers (e.g., survivors of suicide victims) to serve as speakers at wellness programs to show that recovery from mental and substance use disorders is possible.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.2	Develop protocols for how a company or business will talk publicly to the media about suicide.
4.1.10	Incorporate communication messages for media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during May, Mental Health Awareness Month, when media coverage may be intensified.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.1	Advocate for legislative action toward strengthening the coordination, implementation and evaluation of suicide prevention programming.
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.1.13	Support and sponsor trainings related to suicide awareness and suicide prevention to strengthen the coordination, implementation, and evaluation of suicide prevention programming.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	

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Examples Identified for Businesses, Employers, and Professional Associations.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.2.4	Encourage business to implement wellness programs and ensure adequate insurance coverage for services and Employee Assistance Program (EAP) access.
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.7	Ensure access to support services for employees who have suffered loss (e.g., family death, illness, catastrophe).
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.3	Develop trainings for bartenders and hair dressers on recognizing suicidal ideation.
7.1.12	Partner with nonprofits (e.g., Save A Life) to provide free presentations and/or trainings to educate teens and adults on suicide prevention.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.7	Identify barriers to communication between/among clinicians, first responders, crisis staff (e.g., HIPAA, electronic records, failure to document) and develop strategies to improve communication.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.2.5	Promote the development and use of policies and procedures to minimize the barriers encountered through transitions across levels of service/treatment (e.g., in-patient care, out-patient programs).
8.2.7	Support text-information programs (e.g., NC-NAMI Text 4 Teens) to provide teens in difficult situations a way to anonymously receive support.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.3.5	Include suicide risk information in employee assistance programs (EAP) materials.
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	

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Examples Identified for Businesses, Employers, and Professional Associations.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.3	Identify and disseminate available resources for links between mental health and substance abuse through national, local and other databases.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.7.1	Track and report patient information and outcomes to determine effectiveness of treatment.
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.2	Adopt and implement suicide awareness programs (e.g. Signs of Suicide).
9.1.3	Adopt and routinely use a validated depression screening scale for assessing patients.
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.2	Designate/award an organization with Suicide Prevention Best Practice Guidelines to serve as the gold standard for other organizations and encourage application of best practices for suicide prevention.
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.1.8	Provide employees with an Employment Assistance Programs (EAP) that includes comprehensive support programs for individuals bereaved by suicide.
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	

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Examples Identified for Businesses, Employers, and Professional Associations.	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.2 Improve the usefulness and quality of suicide-related data.	
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
11.4.2	Partner with other organizations to reach marginalized/isolated/under represented populations in data collection efforts (e.g. AARP to conduct surveys with older adults).
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.1.3	Evaluate the effectiveness of suicide prevention interventions through Employee Assistance Programs (EAP).
13.1.13	Work with research organizations to implement and evaluate workplace-based suicide prevention programs.
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.2.1	Disseminate evidence for suicide prevention interventions through Human Resource (HR) departments, employee counseling services.
13.3 Examine how suicide prevention efforts are implemented in different communities, and demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.4 Disseminate information on the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	

5. Primary and Secondary Schools

Summary:

- Approximately one-fifth of all examples (n=89) identified were for the Primary and Secondary School stakeholder group.
- The greatest number of examples were identified for Strategic Direction #1- Healthy and Empowered Individuals, Families, and Communities, followed by Strategic Direction #2-Clinical and Community Preventive Services tied with Strategic Direction #3-Treatment and Support Services.
- One-fifth of the examples identified for this stakeholder group were noted for Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Table 8: **Examples Identified for Primary and Secondary Schools**

Return to Stakeholder List

Examples Identified for Primary and Secondary Schools	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.2	Adopt rules and/or policies that seek to prevent bullying in schools.
1.1.3	Adopt, promote and support Wellness Recovery Action Plans (WRAP) plans for students and their families.
1.1.9	Engage in activities to increase emotional intelligence and resiliency as part of character education efforts (e.g., use evidence-based practices such as Dialectical Behavioral Therapy).
1.1.24	Partner with non-profit/faith-based/community organizations (e.g., Save A Life) to provide suicide prevention and awareness information.
1.1.28	Promote resiliency and protective factors in primary schools (e.g., Good Behavior Game) by using recognized programs.
1.1.29	Promote suicide awareness education, outreach events and clubs to facilitate a preventative culture in schools.
1.1.34	Review/revise policies when applicable to promote suicide prevention and reduce stigmatization of high risk populations.
1.1.36	Sponsor support groups/clubs (e.g., Save a Life club) to promote a setting of togetherness and mental wellness for students.
1.1.37	Support Crisis Intervention Team (CIT) training for college/university staff (e.g. campus security, resources officers).
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.2	Create a working partnership with the Local Management Entities (LME) and Managed Care Organizations (MCO) serving their area.
1.2.4	Encourage Local Education Agencies (LEAs) and other relevant education agencies to adopt and maintain evidence-based prevention programs on a school systems-wide basis.
1.2.5	Establish school district protocols for preventing and addressing potential suicides, including alerts to a student's social media postings.
1.2.7	Implement and support suicide prevention programs (e.g., student-led *Save A Life* support groups).
1.2.12	Promote outreach and education through multiple forms of media, including social communication through texting and/or Facebook.
1.2.18	Promote/support anti-bullying programs in schools.
1.2.21	Require mandatory compliance with use of evidence-based assessment tools to detect and assess mental illness.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.2	Collaborate with mental health Local Management Entities (LMEs) on local information, resources, and professional development/training opportunities.

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Examples Identified for Primary and Secondary Schools	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
1.3.5	Include suicide prevention awareness in Healthy Living Curriculum, to address and reduce the stigma of suicide among youth and individuals who work directly with youth.
1.3.9	Participate in state suicide prevention working group(s).
1.3.10	Support state suicide prevention working group(s) on as-needed basis.
1.3.11	Work with the school board to write a curriculum that can be initiated in every middle and high school in the county to share: 1) its OK to ask for help; 2) where to go to get help; and 3) warning signs and risk factors to be able to pick up on an at-risk friend, classmate, sibling, or others.
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	
2.1.3	Communicate the importance of trainings that identify signs and symptoms of suicide and suicidal ideation to school administrators, staff, and parents of students.
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.9	Develop communication messages for teachers, administration, students and parents on resources available for referrals and mental health screenings.
2.1.15	Include the promotion and use of mandatory suicide prevention education and awareness curricula, developed for use in primary or secondary schools, in communication efforts targeting school administrators, staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers), and parents of students.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	
2.3.7	Ensure that school safety information on school districts websites is inclusive of suicide prevention.
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.3	Build capacity of lay health workers to deliver statewide suicide awareness and prevention curriculum.
2.4.20	Train student support services personnel to share suicide awareness and prevention information with other school personnel (eg. school nurses, school social workers, school psychologists, school counselors and school resource officers).
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.2	Conduct and/or host forums, health fairs, safety events directly addressing suicide awareness and prevention, wellness promotion, and recovery.
3.1.6	Educate parents about safe medication storage and disposal for both prescription and over-the-counter drugs.
3.1.7	Encourage school boards to promote and support the use of high school focused evidence based curriculum designed to increase protective factors for/reduce risk from suicide.
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.

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Examples Identified for Primary and Secondary Schools	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.3	Develop support groups which include education for life skills and coping skills.
3.2.4	Empower teachers and guidance counselors to openly discuss depression and mental illness in the school environment.
3.2.10	Include families/significant others in discharge planning and education after a suicide attempt as a way to reduce prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
3.2.14	Promote and allow open discussion of depression and thoughts of harm through communication with middle school entities.
3.2.15	Promote appropriate language among staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) and students regarding mental health issues that does not enforce stereotypes or degrade individuals (i.e. use of words like crazy, psycho).
3.2.17	Promote frank discussions of mental illness, depression, suicide, and self-harm in safe and open environments in middle and high school settings. This aligns with *State Healthful Living Essential Standards* for grade levels 6 - 9 concerning stress and stress management, and more specifically, the grade 8 standard of Apply help-seeking strategies for depression and mental disorders.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.2	Develop developmentally appropriate materials to educate children/youth on mental health issues.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.8	Ensure that school staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) understand appropriate communication guidelines and protocols when talking with the media following a student's suicide.
4.1.10	Incorporate communication messages for pick-up by media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during mental health awareness months when media coverage may be intensified.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.9	Promote use of on-line training modules for school staff (e.g. school nurses, school social workers, school psychologists, school counselors and school resource officers) and faculty to increase knowledge of student issues and how to manage them (e.g., the *Understanding Student Behavior in the Classroom* curriculum has a middle/high school version and a Pre K through 5th grade version).
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.1	Collaborate with statewide organizations (e.g. the North Carolina School Community Health Alliance) to support the work of school health centers to incorporate suicide education, awareness and prevention.

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Examples Identified for Primary and Secondary Schools	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.2.5	Encourage school staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) to participate in evidence based trainings, (e.g., Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth Crisis Intervention Training (CIT), Question, Persuade, and Refer (QPR)).
5.2.14	Provide Gatekeepers training to school employees (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) to: increase awareness of suicide; know risk factors and warning signs; know how and when to refer a student or co-worker; and serve as a knowledgeable member of the intervention and prevention team.
5.2.16	Provide suicide awareness and prevention training in elementary schools (e.g., Teaching Life Skills).
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.4	Develop/support school district processes for referring children and youth with potential needs for mental health/substance use disorder services.
5.3.8	Increase availability of mental health services in the schools through school-based centers or contracts with local social workers to provide mental health/substance use disorder counseling services for students.
5.3.11	Provide school staff with access to free counseling services through an Employment Assistance Program (EAP).
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.13	Promote and provide staff training in warning signs for suicidal behaviors.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.8	Incorporate suicide prevention and awareness modules into freshman year health curriculum.
7.1.11	Mandate suicide prevention training for medical facility/school staff.
7.1.12	Partner with nonprofits (e.g., Save A Life) to provide free presentations and/or trainings to educate teens and adults on suicide prevention.
7.1.14	Provide educational trainings for students, teachers, staff on: 1) warning signs risk factors; 2) how to provide help to students; 3) how to encourage student to ask for help if they suspects a friend may need help.
7.1.16	Provide training to increase awareness among school staff (e.g. school nurses, school social workers, school psychologists, school counselors and school resource officers), especially elementary, to connect at-risk behaviors (e.g., cutting, substance abuse, drinking and driving) and suicide.
7.1.18	Require curriculum for high schools to teach basic suicide prevention.
7.1.19	Train staff to identify students at risk for suicidal behaviors.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	

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Examples Identified for Primary and Secondary Schools	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
7.5.3	Develop district plans to include information on recognizing suicide risks and referring to appropriately trained specified school personnel to assess suicide risks and determine next steps (e.g., potential referral to mental health service provider).
7.5.10	Promote training in evidence-based crisis intervention methods such as Critical Incident Stress Management.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.2.3	Ensure implementation of school district protocols for recognizing suicide risks and referring to specified school personnel who are appropriately trained to assess suicide risks and determine next steps (e.g., potential referral to mental health service provider).
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.4	Promote peer support groups that promote and employ life skills training.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.7.1	Track and report patient information and outcomes to determine effectiveness of treatment.
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.2	Adopt and implement suicide awareness programs (e.g. Signs of Suicide).
9.1.7	Enforce the development and implementation of district plans to recognize suicide risks and procedures for referral to appropriately trained specified school personnel to assess suicide risks and determine next steps such as potential referral to mental health service provider.
9.1.14	Teach 5th and 6th graders about suicide, suicidal ideation and/or depression through age appropriate programs (e.g., Beyond Blue, Penny Resiliency Project, and Seligman's Flourishing).
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.1	Advocate for the availability of adequate support staff (e.g., counselors, social workers, school psychologists, school nurses, school resource officers) in school to support at-risk or recovering youth.
9.2.2	Designate/award an organization with Suicide Prevention Best Practice Guidelines to serve as the gold standard for other organizations and encourage application of best practices for suicide prevention.
9.2.4	Develop modes of communication between school support personnel (e.g., school psychologist, social worker, counselor).

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Examples Identified for Primary and Secondary Schools	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
9.2.7	Identify and train hospital staff about populations most at risk for suicide (e.g., LGBTQ, youth with special needs).
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.4	Ensure that students and staff have access to adequately trained staff for suicide risk assessment.
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.4.2	Inform parents and/or caregivers when students are assessed and engage them in the referral for ongoing treatment and care.
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.5.4	Enforce the development and implementation of district plans to recognize suicide risks and procedures for referral to appropriately trained specified school personnel to assess suicide risks and determine next step (e.g., referral to mental health service provider).
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.7.1	Enforce the development and implementation of district plans to recognize suicide risks and procedures for referral to appropriately trained specified school personnel to assess suicide risks and determine next step (e.g., referral to mental health service provider).
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.1.5	Improve identification of students who are impacted by suicide.
10.1.6	Initiate support groups for teens that have lost friends or classmates to suicide, including groups to talk about feelings and issues.
10.1.10	Work with the Department of Instruction to develop guidelines and implementation plans for crisis response teams at the district level.
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.2.2	Develop clear statewide guidelines for how/when to refer and obtain information and/or to educate staff about resources available in the community.
10.2.3	Educate staff about community resources for mental health.
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.3.2	Engage with government agencies to identify people to be involved with suicide awareness, prevention and outreach programs and activities.
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
10.5.1	Develop and maintain a grief crisis response plan.
10.5.5	Identify and provide suicide awareness and prevention resources to teachers, counselors and social workers.

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Examples Identified for Primary and Secondary Schools	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.1.3	Disseminate suicide and suicidal behavior data collection practices for use by community partners.
11.2 Improve the usefulness and quality of suicide-related data.	
11.2.1	Collect and track data related to suicide (e.g. suicidal behaviors, suicidal ideation, and completions).
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.3	Identify data collection systems specifically for suicide and/or suicide related behaviors on the school report card.
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.3.5	Include suicide statistics on the Annual Report of School Crime and Violence.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
11.4.5	Support school participation in Youth Risk Behavior Survey (YRBS) data collection efforts.
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.1.1	Conduct quantitative and qualitative research studies with students (e.g. focus groups on changes in stigma and attitudes towards suicide and suicidal behaviors).
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.2.2	Disseminate evidence for suicide prevention interventions through school counseling departments, student health centers, and/or medical schools.
13.2.4	Support staff in schools (e.g. counselors, school psychologists, social workers, school nurses, school resource officers) to be prepared and encouraged to share information on suicide prevention interventions.
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.3.8	Participate in community efforts seeking to identify which delivery structures might be most effective for the specific community or population (e.g., focus groups, community forums, discussions with support groups).
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	

6. Colleges and Universities

Summary:

- 75 examples were identified for the Colleges and Universities stakeholder group, accounting for 14% of all examples collected.
- Almost half of the examples identified for Colleges and Universities were in Strategic Direction #1-Healthy and Empowered Individuals, Families and Communities.
- Over one-fifth of examples identified for Colleges and Universities were related to Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Table 9: Examples Identified for Colleges and Universities

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Examples Identified for Colleges and Universities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.1	Actively and visibly promote suicide awareness, education and outreach on college and university campuses.
1.1.3	Adopt, promote and support Wellness Recovery Action Plans (WRAP) plans for students and their families.
1.1.6	Collaborate with other colleges/universities to conduct suicide prevention and awareness efforts (e.g., Eastern Carolina University mental health fair is very popular among the students on campus).
1.1.10	Engage leadership level (e.g. chancellor) support for university-wide suicide prevention efforts.
1.1.12	Ensure access to non-stigmatizing preventative care 24/7 for college and university students
1.1.20	Involve student organizations in suicide prevention efforts conducted on colleges and universities.
1.1.31	Promote the engagement of extensions services (e.g., NC State University) and/or 4-H chapters in community family wellness efforts.
1.1.34	Review/revise policies when applicable to promote suicide prevention and reduce stigmatization of high risk populations.
1.1.37	Support Crisis Intervention Team (CIT) training for college/university staff (e.g. campus security, resources officers).
1.1.38	Support wellness promotion activities during times of stress and transition (e.g. finals, college transfers).
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.7	Implement and support suicide prevention programs (e.g., student-led *Save A Life* support groups).
1.2.12	Promote outreach and education through multiple forms of media, including social communication through texting and/or Facebook.
1.2.13	Promote policies and procedures for re-integrating students to education settings following a suicide attempt.
1.2.27	Work with local nonprofits (e.g., National Alliance on Mental Illness) to initiate survivor groups on college and university campuses.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.9	Participate in state suicide prevention working group(s).
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.5.3	Encourage insurance companies to offer suicide prevention in coverage plans.
1.5.9	Require suicide screening questions on intake form in primary care visit and other health visits.
1.6 Create a Master List of what agencies are doing in suicide prevention.	

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Examples Identified for Colleges and Universities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
1.6.1	Work with nonprofit organizations to develop suicide prevention directories that are geographic area-specific (e.g., urban areas such as Triangle/Triad; regional areas for rural parts of state).
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.	
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.13	Include suicide prevention and/or wellness programs associated with counseling and/or student services on campus to increase suicide awareness and communication efforts.
2.1.14	Include the existence of support groups hosted by university health centers in campus-wide communication efforts.
2.1.17	Promote and support community walks as a way to increase suicide prevention awareness via media coverage of walks (e.g., It's OK 2 Ask.)
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.2.5	Encourage student groups to send letters to legislators to support suicide prevention activities.
2.2.7	Frame research/data to show the impacts of suicide prevention interventions for legislators.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	
2.3.3	Develop and promote an online social media presence (Twitter, Facebook, etc) and support the development of standardized messages (e.g. developed by research organizations, the Center for Disease Control and Prevention).
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.11	Promote suicide prevention training to incoming freshman on college and university campuses as a way to increase knowledge about the warning signs for suicide and how to connect individuals in crisis with assistance and care.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.2	Conduct and/or host forums, health fairs, safety events directly addressing suicide awareness and prevention, wellness promotion, and recovery.
3.1.10	Integrate evidence-based training that increase protection from suicide risk for faculty, student services, and residential assistance staff and evaluate training effectiveness.
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.15	Promote easily accessible medication drop sites to dispose of unused medications.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.9	Implement suicide de-stigmatization campaigns (e.g., The NC State University Counseling Center's Stop the Stigma campaign").
3.2.18	Provide presentations from/by a suicide survivor as a way to reduce prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.7	Identify willing speakers (e.g., suicide survivors) to serve as speakers at wellness programs to show that recovery from mental and substance use disorders is possible.
3.3.12	Restrict/ban firearms in residence halls and on campus.

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Examples Identified for Colleges and Universities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.3	Encourage linkages between local data and national databases when making data available and accessible by media.
4.1.6	Ensure that data used for pick-up by media cannot be modified or misinterpreted by clearly describing data collection methods and information about sample size.
4.1.9	Include suicide awareness in freshman orientations for journalism ethics.
4.1.10	Incorporate communication messages for pick-up by media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during mental health awareness months when media coverage may be intensified.
4.1.13	Provide data/research that inform public service announcements developed to support suicide awareness and prevention activities.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.5	Create, promote, and encourage suicide prevention and wellness programming on collect and university campuses.
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.7	Foster an inclusive, accessible, and diverse intellectual and cultural campus experience through the awareness of diversity issues and education (e.g., the Office for Institutional Equity and Diversity at NC State University).
5.2.9	Participate in suicide prevention trainings (e.g., NAMI Family to Family course, Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth Crisis Intervention Training (CIT), Question, Persuade, Refer (QPR)).
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.2	Collect county-specific lists of suicide prevention and mental and substance use disorder resources and referrals (e.g., AFSP.org, suicide hotline, United Way 211 website).
5.3.5	Encourage campus programs and/or student health centers to provide targeted outreach to at-risk LGBTQ populations.
5.3.12	Support funding opportunities for county-specific suicide prevention and mental and substance use disorder resources (e.g., AFSP.org, suicide hotline, United Way 211 website).
5.3.13	Support grants and funding to provide education and training for suicide prevention for citizens/students/community members experiencing mental and substance abuse disorders.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.13	Promote and provide staff training in warning signs for suicidal behaviors.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.3 Develop and implement new safety technologies to reduce access to lethal means.	

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Examples Identified for Colleges and Universities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.4	Educate teachers and other personnel using Evidence Based Practices (EBP) for suicide prevention curricula.
7.1.12	Partner with nonprofits (e.g., Save A Life) to provide free presentations and/or trainings to educate teens and adults on suicide prevention.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.2.9	Require training in suicide prevention in graduate programs of social work and other fields (e.g., public health).
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.3.1	Incorporate suicide prevention and assessments in curriculum of all human services programs.
7.3.2	Mandate suicide awareness and prevention training for those entering healthcare field.
7.3.3	Offer special certification programs in Suicidology.
7.3.4	Require curriculum for Bachelors level Psychology, Social Work and Sociology majors to teach basic suicide prevention.
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.4	Develop, train and implement evidence-based protocols to collaboratively manage suicide risk in each practice setting.
7.5.6	Graduate programs in social work and other fields should require training in suicide prevention.
7.5.10	Promote training in evidence-based crisis intervention methods such as Critical Incident Stress Management.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.1	Facilitate/support groups or self-help groups.
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.4	Promote peer support groups that promote and employ life skills training.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	

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Examples Identified for Colleges and Universities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.2	Adopt and implement suicide awareness programs (e.g. Signs of Suicide).
9.1.9	Implement depression screening for students (as part of October depression screening month- or anytime).
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.2	Designate/award an organization with Suicide Prevention Best Practice Guidelines to serve as the gold standard for other organizations and encourage application of best practices for suicide prevention.
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.1.4	Identify, maintain and distribute suicide awareness, prevention and outreach resources.
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.2.5	Implement evidence based programs for post-vention settings.
10.2.7	Provide easily accessible opportunities for attempt and suicide survivors to engage in therapy or support groups within the university setting or the surrounding community.
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.3.2	Engage with government agencies to identify people to be involved with suicide awareness, prevention and outreach programs and activities.
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.4.1	Develop clear algorithms for guidelines to respond effectively to suicide clusters and contagion within cultural contexts.
10.4.2	Identify a lead agency in the community to lead a community response plan and community suicide prevention efforts.
10.4.3	Local Management Entities and Managed Care Organizations should support Psychological First Aid training in provider agency.
10.4.4	Work with other stakeholder groups to develop a community response plan.
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	

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Examples Identified for Colleges and Universities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
10.5.4	Identify and disseminate information about resources available within the community.
10.5.7	Provide critical incident stress management (CISM) for those impacted by suicide (e.g., students and employees at university).
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.1.3	Disseminate suicide and suicidal behavior data collection practices for use by community partners.
11.2 Improve the usefulness and quality of suicide-related data.	
11.2.3	Develop system wide policies on reporting and postvention for suicide/suicide attempts.
11.2.10	Support the expansion of community-based research to identify community level factors related to suicide and suicide prevention.
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
11.4.4	Require university system to administer the American College Health Association survey at staggered intervals.
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
12.4.1	Promote partnership between government, universities and research institutions to combine data and develop materials for general understanding (e.g. individual citizen and/or stakeholders form a variety of fields, such as adolescent health or public safety).
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.1.1	Conduct quantitative and qualitative research studies with students (e.g. focus groups on changes in stigma and attitudes towards suicide and suicidal behaviors).
13.1.2	Continue to provide ongoing reports on North Carolina suicide rates for use at multiple levels to evaluate the impact and effectiveness of suicide prevention interventions.
13.1.3	Evaluate the effectiveness of suicide prevention interventions through Employee Assistance Programs (EAP).
13.1.4	Evaluate training programs that aim to integrate behavioral, mental health care and primary care, particularly for high risk populations.
13.1.5	Incorporate evaluation of research on suicide or suicidal behavior related to college/university programs and interventions.
13.1.6	Incorporate mechanisms to encourage reporting of data to funding sources that support suicide prevention interventions.
13.1.7	Integrate the information collected in community health needs assessments to build County level action plans for suicide prevention interventions and activities.
13.1.8	Participate in surveys to provide input on what types of support/interventions are most helpful, both pre and post care.
13.1.9	Participate in the Incident Response Improvement System (IRIS).
13.1.10	Share experiences with working in suicide awareness and prevention interventions.

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Examples Identified for Colleges and Universities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
13.1.11	Support evaluation efforts (e.g., Garrett Lee Smith, Injury Prevention Research Center at UNC-CH) to assess knowledge gains and increase in self-efficacy.
13.1.12	Work with business, employers and professional associations to evaluate workplace-based suicide prevention programs.
13.1.13	Work with research organizations to implement and evaluate workplace-based suicide prevention programs.
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.2.2	Disseminate evidence for suicide prevention interventions through school counseling departments, student health centers, and/or medical schools.
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.3.1	Collect data to plan and implement successful youth suicide prevention programs.
13.3.4	Examine policies and procedures for universities with low suicide rates for effectiveness.
13.3.7	Offer culturally tailored suicide prevention trainings for how programs can be implemented in different communities and demographic groups.
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	
13.6.1	Compile national, state, and local suicide prevention resources into one central resource (e.g., NAMI and Jason Foundation).

7. Nonprofit, Community, and Faith-based Organizations

Summary:

- 90 examples were identified for the Nonprofit, Community, and Faith-based Organizations stakeholder group, accounting for over 17% of all examples collected.
- Almost half of the examples for this stakeholder group were related to Strategic Direction #1-Healthy and Empowered Individuals, Families and Communities.
- Several (n=6) of the examples identified were for Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Table 10: Examples Identified for Nonprofit, Community, and Faith-based Organizations

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Examples Identified for Nonprofit, Community, and Faith-based Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.8	Engage clergy members at suicide prevention stakeholder meetings.
1.1.21	Involve/engage existing community and faith-based organizations (e.g. Faith Connections in Mental Illness in Chapel Hill) in conducting suicide prevention efforts in multiple sectors and settings.
1.1.22	Lobby, vote, write legislative representatives and advocate for the suicide awareness and prevention.
1.1.27	Promote opportunities of the N.C. Mental Health and Aging Coalition for professional, consumer, and government organizations to work together toward improving the availability and quality of mental health preventive and treatment strategies to older Americans and their families through education, research, and increased public awareness.
1.1.33	Promote the value of older adults as experienced contributing members of society.
1.1.35	Seek to develop older adult volunteerism to create a culture of engaged adults with a sense of purpose and connectedness to others.
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.14	Promote suicide prevention trainings across settings, including pastors, lay counselors, resource officers, first responders, and teachers.
1.2.15	Promote the de-stigmatization of discussion(s) about suicide and/or suicide ideation in multiple settings (e.g., church, school, family).
1.2.16	Promote the message that all citizens, regardless of education and profession, can have a role in detecting and preventing suicides.
1.2.20	Provide suicide crisis numbers/rape/ domestic violence/mobile crisis numbers accessible to all non-profit, community, or faith-based organization staff.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.2	Collaborate with mental health Local Management Entities (LMEs) on local information, resources, and professional development/training opportunities.
1.3.4	Encourage students to partner with local mental health, school social workers, and others to conduct awareness sessions and forums addressing suicide prevention.
1.3.10	Support state suicide prevention working group(s) on as-needed basis.
1.3.11	Work with the school board to write a curriculum that can be initiated in every middle and high school in the county to share: 1) its OK to ask for help; 2) where to go to get help; and 3) warning signs and risk factors to be able to pick up on an at-risk friend, classmate, sibling, or others.
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.3	Increase suicide prevention collaboration and education between nonprofit, community, and faith-based organizations.

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Examples Identified for Nonprofit, Community, and Faith-based Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.1	Advocate for greater integrated care in primary care and/or Emergency Department settings.
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	
2.1.2	Assess and adapt communication messages to educate the public about the signs of depression, make the public aware of the availability of local resources, and to push back against the stigma of asking for help with depression/ suicidal thoughts (e.g., Alleghany Lives).
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.17	Promote and support community walks as a way to increase suicide prevention awareness via media coverage of walks (e.g., It's OK 2 Ask.")
2.1.18	Promote community meetings to deliver suicide prevention outreach in underserved areas.
2.1.20	Work with non-profit (e.g., Save A Life) in developing communication efforts designed to raise awareness in the community and educate students, faculty, and community organizations on the warning signs, risk factors, and resources for suicide prevention.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.2	Build on the efforts conducted by the Mental Health Association of Central Carolinas, Inc., which promotes mental wellness through advocacy, prevention, and education in Mecklenburg and Cabarrus Counties to advocate for a better mental health system, prevent mental health crises, and educate communities about mental health issues to break the stigma of seeking treatment.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.2.9	Partner with nonprofits (e.g. Save A Life) to promote mental wellness through fundraising efforts and support systems to help policy makers implement more efforts towards suicide prevention in the state.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	
2.3.3	Develop and promote an online social media presence (Twitter, Facebook, etc) and support the development of standardized messages (e.g. developed by research organizations, the Center for Disease Control and Prevention).
2.3.6	Develop, track and evaluate online communication efforts to promote suicide prevention.
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.3.9	Work with nonprofits to create an online chat room for teens (e.g., Save A Life's TalkitOut") to talk freely and openly about concerns.
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.4	Create local suicide awareness and prevention chapters (e.g. Save A Life).
2.4.8	Integrate suicide risk and intervention tools into parenting programming (e.g., NAMI Parent to Parent).
2.4.16	Provide Mental Health First Aid to employees (alongside existing scheduled First Aid and cardiopulmonary resuscitation trainings.
2.4.19	Share information about suicide prevention with youth through awareness activities, social media, and meetings (e.g., Students Against Violence Everywhere (SAVE) chapters)
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.2	Conduct and/or host forums, health fairs, safety events directly addressing suicide awareness and prevention, wellness promotion, and recovery.

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Examples Identified for Nonprofit, Community, and Faith-based Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
3.1.3	Coordinate and communicate about efforts to develop peer based support groups.
3.1.5	Educate and engage with other groups (e.g. faith-based, community, healthcare) who are active and/or interested in becoming active in suicide prevention activities that seek to increase protective factors from suicide risk.
3.1.9	Increase and support peer-run organizations that provide suicide awareness, education, prevention.
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.14	Promote and support programs that work with nonprofits to educate teens and parents on warning signs, risk factors, and where to go and what to do it they suspect someone may be at risk.
3.1.21	Support the implementation of Compeer Programs by Mental Health Associations, which involve specially trained volunteers who provide encouragement and support to individuals with mental illness and who are working on achieving mental wellness.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.16	Promote awareness that it is OK to ask for help, that discussion on suicide does not lead to suicide, and discuss mental wellness and healthy ways to decrease life stressors (e.g., Save A Life's awareness programs).
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.7	Identify willing speakers (e.g., suicide survivors) to serve as speakers at wellness programs to show that recovery from mental and substance use disorders is possible.
3.3.9	Increase and/or promote outreach activities that model positive behaviors.
3.3.10	Recognize/Honor recovered individuals who contribute to society to help others.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.10	Incorporate communication messages for media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during mental health awareness months when media coverage may be intensified.
4.1.14	Report accurate suicide and suicidal behavior data and responsible information when talking to/working with the media.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.2	Collaborate with other organizations and nonprofits across the state to raise awareness and educate the community to promote wellness and prevent suicide.
5.1.6	Encourage collaboration across current suicide prevention activities offered by community/non-profit/faith-based organizations (e.g., Faith Connections in Mental Health, Recovery Innovations Wellness Recovery Action Plan (WRAP) and Wellness classes, and NAMI (National Alliance on Mental Illness) Peer Support specialists).
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.10	Partner with other nonprofits (e.g., Save A Life) to organize evidence based wellness promotion and suicide prevention trainings in the community.
5.2.11	Promote and encourage implementation of suicide prevention programs known to be effective (e.g., Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth CIT, Question, Persuade, Refer (QPR)).

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Examples Identified for Nonprofit, Community, and Faith-based Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.2	Collect county-specific lists of suicide prevention and mental and substance use disorder resources and referrals (e.g., AFSP.org, suicide hotline, United Way 211 website).
5.3.6	Engage peer support specialists, who have personal experience with suicide, on treatment teams formed to support those with mental and substance use disorders.
5.3.12	Support funding opportunities for county-specific suicide prevention and mental and substance use disorder resources (e.g., AFSP.org, suicide hotline, United Way 211 website).
5.3.13	Support grants and funding to provide education and training for suicide prevention for citizens/students/community members experiencing mental and substance abuse disorders.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.14	Provide education about safe medication storage and disposal for both prescription and over-the-counter drugs.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.2.2	Partner with other nonprofits, faith-based, and community groups nationwide that have been successful in developing suicide prevention policies related to firearm safety and responsible firearm ownership (e.g. NAMI New Hampshire).
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.1	Connect with the National Action Alliance for Suicide Prevention's Faith Communities Task Force (http://actionallianceforsuicideprevention.org/task-force/faith-communities) to develop and expand training resources.
7.1.3	Develop trainings for bartenders and hair dressers on recognizing suicidal ideation.
7.1.6	Help organize and train groups and organizations in the community to be proactive and not reactive before a suicide occurs.
7.1.12	Partner with nonprofits (e.g., Save A Life) to provide free presentations and/or trainings to educate teens and adults on suicide prevention.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.3	Encourage standard screening as part of counseling sessions held in faith-based organizations.
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.1	Adopt and mandate the use of crisis intervention plans with trauma-involved clients.
7.5.4	Develop, train and implement evidence-based protocols to collaboratively manage suicide risk in each practice setting.
7.5.8	Promote the use of Crisis Intervention Teams with law enforcement and first responders.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	

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Examples Identified for Nonprofit, Community, and Faith-based Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.3.1	Create, maintain and share referral lists with other organizations.
8.3.7	Promote open access models for suicide prevention and awareness for walk-in care clients.
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.1	Develop and implement suicide prevention and outreach programs to nonprofits, community and faith-based organizations, individuals, families and concerned citizens.
8.6.2	Fund peer support specialists for outreach and engagement.
8.6.4	Promote peer support groups that promote and employ life skills training.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
8.8.1	Create collaborations/workgroups to include outpatient providers and family members as part of discharge plans.
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.2	Adopt and implement suicide awareness programs (e.g. Signs of Suicide).
9.1.4	Attend conferences on mental health awareness.
9.1.6	Encourage suicide awareness and prevention programs to parish nurses.
9.1.13	Share information on mental health at every opportunity (e.g. health fairs, school fairs).
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.2	Designate/award an organization with Suicide Prevention Best Practice Guidelines to serve as the gold standard for other organizations and encourage application of best practices for suicide prevention.
9.2.8	Increase community suicide prevention and awareness education campaigns to increase patient awareness and self-advocate to receive optimal care.
9.2.9	Prioritize staff development for suicide awareness and prevention trainings.
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.1	Adopt It's OK to ask philosophy across all Local Management Entities (LME)/Managed Care Organizations (MCO) providers.
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.4.3	Provide free or low cost counselors and therapists to at-risk teens and families in need.
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.5.3	Disseminate information about policies to inform and raise awareness for communities.

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Examples Identified for Nonprofit, Community, and Faith-based Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.3.2	Engage with government agencies to identify people to be involved with suicide awareness, prevention and outreach programs and activities.
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
10.5.4	Identify and disseminate information about resources available within the community.
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.1.3	Disseminate suicide and suicidal behavior data collection practices for use by community partners.
11.2 Improve the usefulness and quality of suicide-related data.	
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.1.6	Incorporate mechanisms to encourage reporting of data to funding sources that support suicide prevention interventions.
13.1.9	Participate in the Incident Response Improvement System (IRIS).
13.1.10	Share experiences with those working in suicide awareness and prevention interventions.
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	

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Examples Identified for Nonprofit, Community, and Faith-based Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
13.3 Examine how suicide prevention efforts are implemented in different communities and demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	
13.6.1	Compile national, state, and local suicide prevention resources into one central resource (e.g., NAMI and Jason Foundation).

8. Research Organizations

Summary:

- Over 45 examples were identified for the Research Organizations stakeholder group, accounting for 9 percent of all examples collected.
- The greatest number of examples identified were related to Strategic Direction #1-Health and Empowered Individuals, Families and Communities, followed by those for Strategic Direction #4-Surveillance, Research and Evaluation.
- The greatest number of examples for this stakeholder group were related to Goal 13: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings, followed by Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.

Table 11: Examples Identified for Research Organizations

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Examples Identified for Research Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.15	Improve process for reporting and sharing research findings on suicide prevention at community and organizational levels.
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.22	Research and identify best way(s) to increase suicide awareness and reduce stigma.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.10	Support state suicide prevention working group(s) on as-needed basis.
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.2	Develop clinical trials for medications and behavioral modification.
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.5.10	Track and measure progress toward addressing gaps in insurance coverage for suicide prevention services
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.	
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.6	Develop and evaluate communication efforts for suicide prevention.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.2.6	Evaluate effectiveness of suicide prevention and awareness communication efforts developed for policy makers.
2.2.7	Frame research/data to show the impacts of suicide prevention interventions to legislators.
2.2.8	Frame suicide prevention activities as cost beneficial for legislators and taxpayers.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	

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Examples Identified for Research Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
2.3.5	Develop standardized online messaging recommendations for stakeholder groups to expand outreach and social media presence.
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.18	Provide tools to families, Faith-based Organizations and Nonprofits to begin conversations and dialogue about suicide prevention activities.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.20	Research, identify, and promote evidence-based interventions that bolster protective factors (e.g. The Good Behavior Game).
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.5	Evaluate suicide prevention training, education, anti-stigma campaigns, and determine which are the most effective.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.5	Evaluate mental health, developmental disabilities and substance abuse services that are available to active, Reserve, and National Guard members of the military, veterans, and their families to ensure that they are adequate to meet the needs today and in the future.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.1	Collaborate with agencies to ensure data findings about suicide prevention are accurate for use by the media.
4.1.3	Encourage linkages between local data and national databases when making data available and accessible for pick-up by media.
4.1.6	Ensure that data used by media cannot be modified or misinterpreted by clearly describing data collection methods and information about sample size.
4.1.10	Incorporate communication messages for media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during May, Mental Health Awareness Month, when media coverage may be intensified.
4.1.13	Provide data/research that inform public service announcements developed to support suicide awareness and prevention activities.
4.1.14	Report accurate suicide and suicidal behavior data and responsible information when talking to/working with the media.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.8	Incorporate voices/stories of individuals who have experienced suicide ideation/suicide attempts in the development and monitoring of programs.
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.

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Examples Identified for Research Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.6	Ensure that all wellness promotion and suicide prevention program implementation efforts are evaluated for effectiveness/fidelity.
5.2.9	Participate in suicide prevention trainings (e.g., NAMI Family to Family course, Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth Crisis Intervention Training (CIT), Question, Persuade, Refer (QPR)).
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.9	Increase research to document the cost to N.C. of suicide related issues, including services for mental and substance use disorders.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.4	Conduct research to identify effective protocols and screening procedures designed for providers, who interact with individuals at risk for suicide, to assess access to lethal means of suicide.
6.1.17	Work with health care and research to identify screening protocols, to assess access to lethal means that are effective and enforced within the military.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
6.3.2	Conduct and disseminate results from research studying the effectiveness of efforts/programs designed to reduce access to lethal means (e.g., CO shutoffs in automobiles, blister packs for medications, barriers for bridges).
6.3.3	Conduct research on firearm safety, including developing new technologies (e.g. gun locks).
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including those enrolled in graduate programs and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.7	Identify barriers to communication between/among clinicians, first responders, crisis staff (e.g., HIPAA, electronic records, failure to document) and develop strategies to improve communication.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	

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Examples Identified for Research Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.4	Attend conferences on mental health awareness.
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.5.2	Develop tracking for suicidal attempt methodologies (e.g. the development of a system to track mechanisms of suicidal attempts).
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.1.3	Evaluate institutional guidelines for suicide awareness and prevention.
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.3.2	Engage with government agencies to identify people to be involved with suicide awareness, prevention and outreach programs and activities.

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Examples Identified for Research Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.1.2	Develop tracking tool(s) and communication methods, to provide outcomes of individuals treated for depression, suicidal behaviors and/or suicide attempts, to medical professionals.
11.1.3	Disseminate suicide and suicidal behavior data collection practices for use by community partners.
11.2 Improve the usefulness and quality of suicide-related data.	
11.2.2	Conduct research studies among special populations (e.g. people with disabilities, prison inmates) to understand suicide risk and protective factors.
11.2.4	Evaluate the validity and accuracy of questions/indicators currently being used to assess suicide, suicidal ideation and/or behaviors.
11.2.6	Expand the use of qualitative data from survivors and practitioners.
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.2	Evaluate available data provided in N.C. Treatment Outcomes and Program Performance System (NCTOPPS) and determine if additions should be considered for the routine collection, analysis, reporting, and use of suicide-related data.
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.3.6	Promote open use and access to the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC- DETECT), a North Carolina's state-wide syndromic surveillance system.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.1.1	Connect with and secure sources of funding to support suicide prevention research in North Carolina.
12.1.3	Work with state agencies in N.C. to develop a statewide suicide prevention research agenda that includes N.C. specific research questions.
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.2.1	Conduct studies that align with the suicide prevention research and policy agenda.
12.2.4	Translate the research agenda for non-researchers, including an explanation of why certain areas are more relevant to N.C. than others and what non-researchers (e.g., community members, family members) can do to support research.
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.3.2	Encourage and support partnerships between research organizations and state government to smooth the process of dissemination.
12.3.3	Encourage the presence and availability of Principal Investigators for interviews and/or webinars with relevant stakeholders.
12.3.4	Work with other non-research groups to disseminate data and information, including a translation from research into lay terminology.
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	

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Examples Identified for Research Organizations	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
12.4.1	Promote partnership between government, universities and research institutions to combine data and develop materials for general understanding (e.g. individual citizen and/or stakeholders form a variety of fields, such as adolescent health or public safety).
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.1.11	Support evaluation efforts (e.g., Garrett Lee Smith, Injury Prevention Research Center at UNC-CH) to assess knowledge gains and increase in self-efficacy.
13.1.12	Work with business, employers and professional associations to evaluate workplace-based suicide prevention programs.
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.2.6	Work with the Institutes of Medicine to disseminate information about suicide prevention interventions.
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.3.1	Collect data to plan and implement successful youth suicide prevention programs.
13.3.2	Create a clearinghouse of EBPs used to address suicide prevention (similar to CA Clearinghouse that compiles research and data on child maltreatment).
13.3.3	Engage and extend community-based research to evaluate programs and develop evidence-based practices in different communities and demographic groups.
13.3.4	Examine policies and procedures for universities with low suicide rates for effectiveness.
13.3.6	Implement quantitative (e.g., surveys) and qualitative (e.g., focus groups) research to identify successful delivery structures and methods of dissemination in different communities and demographic groups.
13.3.9	Promote and share already existing national resources (e.g. NREPP, SPRC's Best Practices Registry) to address interventions in different communities and demographic groups.
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.4.4	Partner with state government, for evaluation and dissemination of the state suicide plan and the National Strategy for Suicide Prevention (NSSP) goals and objectives, as well as their short and long term health impacts as they are rolled out across the state.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	
13.6.3	Identify and disseminate suicide prevention impact/effectiveness resources (e.g., National Association of County and City Health Officials toolkit, and resources from Association of State and Territorial Health Officials, and American Public Health Associations).

9. Individuals, Families, and Concerned Citizens

Summary:

- 65 examples were identified for the Individuals, Families, and Concerned Citizens stakeholder group, accounting for 12 percent of all examples collected.
- The greatest number of examples identified were related to Strategic Direction #1-Healthy and Empowered Individuals, Families and Communities.
- The majority of examples were identified for Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.

Table 12: Examples Identified for Individuals, Families, and Concerned Citizens

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Examples Identified for Individuals, Families, and Concerned Citizens	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.7	Encourage N.C. General Assembly support to include suicide awareness and prevention in workplace safety meetings and briefings.
1.1.22	Lobby, vote, write legislative representatives and advocate for suicide awareness and prevention.
1.1.23	Participate in advocacy and lobbying activities to increase research funding for suicide prevention.
1.1.26	Promote grassroots community organizations to increase knowledge of the community needs and strengths while creating a stronger collective voice vis-à-vis government and professional groups.
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.8	Increase efforts in communities to offer supports, including identifying which delivery structures might be most effective for the specific community.
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.10	Support state suicide prevention working group(s) on as-needed basis.
1.3.11	Work with the school board to write a curriculum that can be initiated in every middle and high school in the county to share: 1) its OK to ask for help; 2) where to go to get help; and 3) warning signs and risk factors enable them to identify an at-risk friend, classmate, sibling, or others.
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.	
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.1.17	Promote and support community walks as a way to increase suicide prevention awareness via media coverage of walks (e.g., It's OK 2 Ask.)
2.1.19	Encourage as public speakers those who have personal or loved one experience with suicide attempt/ideation/loss in suicide prevention communication programs and activities.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.3	Contact policymakers and voice concerns about suicide and suicide prevention activities in N.C.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.

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Examples Identified for Individuals, Families, and Concerned Citizens	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
2.2.12	Volunteer to speak for suicide prevention outreach/advocacy efforts aimed at policy makers.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	
2.3.3	Develop and promote an online social media presence (Twitter, Facebook, etc.) and support the development of standardized messages (e.g. developed by research organizations, the Centers for Disease Control and Prevention).
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.2	Attend trainings to help start conversations about suicide and suicide prevention.
2.4.5	Encourage open conversation and dialogue about suicide among family, friends, and other social networks.
2.4.7	Include families/significant others in discharge planning and education after a suicide attempt has occurred.
2.4.9	Involve families in efforts to increase knowledge of suicide and to open lines of communication about both prevention and intervention.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.2	Conduct and/or host forums, health fairs, safety events directly addressing suicide awareness and prevention, wellness promotion, and recovery.
3.1.4	Create volunteer peer networks that provide free suicide awareness and prevention education.
3.1.8	Encourage youth family members and friends to participate in drug free activities and events for youth.
3.1.9	Increase and support peer-run organizations that provide suicide awareness, education, prevention.
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.16	Promote policies and practices that include families and/or significant others in discharge planning and education after a suicide attempt has occurred.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.19	Work collaboratively with agencies to discover stories and narratives of individuals who struggle with suicide ideation or have family members whose loved ones died from suicide to share with prevention and outreach activities.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.4	Engage and volunteer within the community to participate and organize suicide awareness events that promote the understanding that recovery from mental and substance use disorders is possible.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.5	Ensure that children and adult family members and friends know to use and access credible resources, including information provided by the government.
4.1.10	Incorporate communication messages for media that destigmatize survivors of suicide prevention
4.1.11	Promote and share the stories of celebrities or other famous individuals who have experience with suicide.
4.1.12	Promote awareness and education during mental health awareness months when media coverage may be intensified.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	

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Examples Identified for Individuals, Families, and Concerned Citizens	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	
5.1.3	Connect with organizations working to promote awareness to share the voices/stories of individuals, who have experienced suicide ideation/suicide attempts, in the development and monitoring of programs.
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.1.11	Restrict access to guns among those suffering from mental illness.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.2	Contribute to coordinated efforts to develop peer-based support groups for suicide prevention and awareness.
5.2.8	Incorporate safety and wellness promotion into the structure of and community outreach conducted by neighborhood organizations (e.g., block watches, home owner associations).
5.2.9	Participate in suicide prevention trainings (e.g., NAMI Family to Family course, Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth Crisis Intervention Training (CIT), Question, Persuade, Refer (QPR)).
5.2.15	Provide assistance to peer support specialists working to increase the number and reach of community-based suicide prevention programs.
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
5.3.10	Learn to identify the stressors that contribute to a loved one's suicidal thinking and the mechanisms that reduce those stressors.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.3	Advocate for legislative/policy/procedure efforts designed to encourage increased screening of access to lethal means for those identified at risk for suicide.
6.1.8	Encourage open discussion among family and friends about whether homes that your children visit have firearms, including homes of relatives.
6.1.9	Encourage open discussions about suicide among family, friends, and social groups, including the need to advocate for legislation, polices, and procedures that encourage providers to routinely screen for access to lethal means for those identified at risk of suicide.
6.1.16	Safeguard all medications (a lethal means of suicide) among family and friends identified as at risk of suicide, especially after discharge from hospitals or during periods of stress.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.3	Develop trainings for bartenders and hair dressers on recognizing suicidal ideation.
7.1.7	Incorporate people with lived experience of suicide (either self or loved one) in development and implementation of training activities.
7.1.12	Partner with nonprofits (e.g., Save A Life) to provide free presentations and/or trainings to educate teens and adults on suicide prevention.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.6	Incorporate people with lived experience of suicide (either self or loved one) in development and implementation of training opportunities.

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Examples Identified for Individuals, Families, and Concerned Citizens	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.7	Identify barriers to communication between/among clinicians, first responders, crisis staff (e.g., HIPAA, electronic records, failure to document) and develop strategies to improve communication.
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.1	Develop and implement suicide prevention and outreach programs to nonprofits, community- and faith-based organizations, individuals, families and concerned citizens.
8.6.4	Promote peer support groups that promote and employ life skills training.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
8.8.1	Create collaborations/workgroups to include outpatient providers and family members as part of discharge plans.
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.5	Encourage formation and participation of suicide survivor groups.
9.1.8	Establish survivor support groups (e.g., Survivors of Suicide) for teens and youth.
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.8	Increase community suicide prevention and awareness education campaigns to increase patient awareness and self-advocate to receive optimal care.
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.1	Adopt It's OK to ask philosophy across all Local Management Entities (LME)/Managed Care Organizations (MCO) providers.

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Examples Identified for Individuals, Families, and Concerned Citizens	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.4.1	Develop Plan of Care or Discharge criteria to include someone other than individual with distress.
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.1.7	Participate in support groups (e.g., Triangle Survivors of Suicide) that provide support and resources for people who have experienced the loss of a loved one by suicide.
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).
10.3.2	Engage with government agencies to identify people to be involved with suicide awareness, prevention and outreach programs and activities.
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
10.5.6	Incorporate suicide attempt survivors and survivors of suicide victims in the education for healthcare providers and first responders.
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.2 Improve the usefulness and quality of suicide-related data.	
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	

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Examples Identified for Individuals, Families, and Concerned Citizens	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.1.8	Participate in surveys to provide input on what types of support/interventions are most helpful, both pre and post care.
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.3.8	Participate in community efforts seeking to identify which delivery structures might be most effective for the specific community or population (e.g., focus groups, community forums, discussions with support groups).
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	

10. Military Entities

Summary:

- 45 examples were identified for the Military Entities stakeholder group, accounting for 8 percent of all examples collected.
- Almost half of examples identified for Military Entities were related to Strategic Direction #1-Healthy and Empowered Individuals, Families and Communities.
- The greatest number of examples was identified for Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Table 13: Examples Identified for Military Entities

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Examples Identified for Military Entities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
Strategic Direction #1: Healthy and Empowered Individuals, Families, and Communities	
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	
1.1.12	Ensure access to non-stigmatizing preventative care 24/7 for college and university students in the military.
1.1.37	Support Crisis Intervention Team (CIT) training for college/university staff (e.g. campus security, resources officers).
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	
1.2.3	Encourage help-seeking behaviors and/or opportunities for people with mental health/substance use issues.
1.2.10	Involve military hierarchy in supporting suicide prevention and outreach.
1.2.23	Support and conduct peer led suicide prevention programs (e.g. National Alliance on Mental Illness).
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	
1.3.8	Participate in community projects to build a culture of recovery that is coordinated and easy to access by military personnel and their families.
1.3.9	Participate in state suicide prevention working group(s).
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.
1.5 Integrate suicide prevention into all relevant health care reform efforts.	
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.
1.5.9	Require suicide screening questions on intake form in primary care visit and other health visits.
1.6 Create a Master List of what agencies are doing in suicide prevention.	
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.	
2.1.1	Adopt and incorporate existing military communication efforts, educational activities and resources into civilian suicide prevention efforts.
2.1.4	Craft suicide prevention, education, and awareness messages specifically tailored to a variety of diverse audiences.
2.2 Reach policymakers with dedicated communication efforts.	
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	

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Examples Identified for Military Entities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
2.3.3	Develop and promote an online social media presence (Twitter, Facebook, etc.) and support the development of standardized messages (e.g. developed by research organizations, the Centers for Disease Control and Prevention).
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	
2.4.9	Involve families in efforts to increase knowledge of suicide and to open lines of communication about both prevention and intervention.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	
3.1 Promote effective programs/practices that increase protection from suicide risk.	
3.1.2	Conduct and/or host forums, health fairs, safety events directly addressing suicide awareness and prevention, wellness promotion, and recovery.
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.
3.1.18	Promote suicide prevention training to peer volunteers that are free or low cost.
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	
3.2.1	Create and facilitate open conversations and dialogue about suicide.
3.2.6	Expand Wounded Warrior Project and other prevention services to active duty service members.
3.2.13	Increase awareness about the Wounded Warrior Project-Fayetteville Chapter, which seeks to foster the most successful, well-adjusted generation of wounded service members in our nation's history by raising awareness and enlisting the public's aid for the needs of injured service members, helping injured service members aid, and assist each other, providing unique, direct programs and services to meet the needs of injured service members.
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	
3.3.1	Adopt North Carolina Institute of Medicine Task Force on Behavioral Health Services recommendations for the Military and their Families to ensure that the mental health, developmental disabilities and substance abuse services that are available to active, reserve, and national guard members of the military, veterans, and their families are adequate to meet the needs today and in the future.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.	
4.1.3	Encourage linkages between local data and national databases when making data available and accessible for pick-up by media.
4.1.10	Incorporate communication messages for media that destigmatize survivors of suicide prevention
4.1.12	Promote awareness and education during May, Mental Health Awareness Month, when media coverage may be intensified.
4.1.14	Report accurate suicide and suicidal behavior data and responsible information when talking to/working with the media.
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.
Strategic Direction #2: Clinical and Community Preventive Services	
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	

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Examples Identified for Military Entities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	
5.2.3	Develop and evaluate wellness promotion and suicide prevention oriented workshops specific to military populations.
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among residents with mental and substance use disorders.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	
6.1.14	Provide education about safe medication storage and disposal for both prescription and over-the-counter drugs.
6.1.17	Work with health care and research to identify screening protocols, to assess access to lethal means that are effective and enforced within the military.
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	
6.2.3	Provide education about firearm safety and responsible firearm ownership to military personnel.
6.3 Develop and implement new safety technologies to reduce access to lethal means.	
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	
7.1 Develop training on suicide prevention to community groups.	
7.1.12	Partner with nonprofits (e.g., Save A Life) to provide free presentations and/or trainings to educate teens and adults on suicide prevention.
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	
7.5.9	Promote training in evidence-based crisis intervention methods such as Critical Incident Stress Management
7.6 Employ cultural sensitivity; training should be universally designed and available.	
Strategic Direction #3: Treatment and Support Services	
GOAL 8. Promote suicide prevention as a core component of health care services.	
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	
8.3.4	Identify staff to provide suicide risk assessment to veterans.

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Examples Identified for Military Entities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	
8.6.2	Fund peer support specialists for outreach and engagement.
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	
9.1.2	Adopt and implement suicide awareness programs (e.g. Signs of Suicide).
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	
9.2.3	Develop and implement training programs to provide mental and behavioral health professionals knowledge and skills that enhance their abilities to provide quality care for active duty military service members, veterans, citizen soldiers and their families as well as enhance their marketability in finding employment with organizations that target military populations (e.g., Military Behavioral Health Graduate Certificate Program at Fayetteville State University).
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	
10.2.4	Expand existing programs (e.g. Tragedy Assistance Program Survivors, TAPS) to provide ongoing services for anyone who has suffered the loss of a military loved one, regardless of the relationship to the deceased or the circumstance of the death.
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).

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Examples Identified for Military Entities	
Note: Suicide and suicidal behaviors are a serious and sensitive topic. As such, we strongly encourage users of the 2015 N.C. Suicide Prevention Plan to collaborate with trained professionals to best mitigate unintentional harm when selecting from the examples outlined in the plan.	
10.3.2	Engage with government agencies to identify people to be involved with suicide awareness, prevention and outreach programs and activities.
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	
Strategic Direction #4: Surveillance, Research, and Evaluation	
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	
11.1 Improve the timeliness of reporting vital records data.	
11.2 Improve the usefulness and quality of suicide-related data.	
11.2.8	Review and improve usefulness of data regarding suicides among active military personnel.
11.2.11	Work with national databases to include data on military suicidal data (e..g., ideation, attempts, completions)
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	
GOAL 12. Promote and support research on suicide prevention.	
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	
12.2 Disseminate and implement the state suicide prevention research agenda.	
12.3 Promote the timely dissemination of suicide prevention research findings.	
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.	
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	
13.1 Evaluate the effectiveness of suicide prevention interventions.	
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.
13.5 Identify potential stakeholders necessary to disseminate evidence.	
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	

SECTION 7 – WHERE CAN I GO TO LEARN MORE ABOUT SUICIDE PREVENTION?

This section of the *2015 N.C. Suicide Prevention Plan* provides information and hyperlinks for additional resources about suicide prevention. This section summarizes resources for the following categories:

A. Suicide prevention
B. Mental health
C. Suicide disparities
D. Evidence-based practices
E. Advocacy and awareness
F. Data and surveillance

Resources available at the state and/or national level are shown for each category, when applicable. Some resources appear in multiple categories.

A. Suicide Prevention Resources

North Carolina Suicide Prevention Resources

1. **American Foundation for Suicide Prevention (AFSP) North Carolina Chapter**
   www.afsp.org/local-chapters/local-chapters-listed-by-state/north-carolina/afsp-north-carolina
   The American Foundation for Suicide Prevention (AFSP) established a new chapter in North Carolina in May 2014. The Chapter raises awareness about suicide and its prevention through community events, Out of the Darkness walks, AFSP programs, and gatekeeper trainings. The Chapter plans to expand training opportunities around the state, make more resources available to people whose lives have been affected by suicide, bring AFSP's Interactive Screening Program (ISP) to North Carolina campuses and communities, and collaborate with other organizations in continuing to build a grassroots advocacy network that promotes legislation and policies to prevent suicide and improve mental health.

2. **North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)**
   www.ncdhhs.gov/mhddsas
   The N.C. Division provides strategic and operational leadership and oversight to the public mental health, developmental disability and substance abuse service system. The Community Policy Management Section is primarily responsible for leadership, guidance and management of relationships with local management entities (LME/MCOs). LME/MCOs are where people go to find information on receiving mental health, developmental disability or substance abuse services. They are available 24 hours a day. LME/MCO by county: www.ncdhhs.gov/mhddsas/lmeonblue.htm. The Division also operates the Crisis Solutions Coalition, which works statewide to decrease the use of emergency departments and increase access to other services to help individuals resolve a crisis and get back to their homes, families, friends, and work. Learn more at http://crisissolutionsnc.org.

3. **National Suicide Prevention Lifeline in North Carolina 1-800-273-8255**
   www.suicidepreventionlifeline.org
   Provides access to 24/7/365 crisis response services, such as screening, triage and referral; walk-in crisis; mobile crisis management teams; or facility based crisis services through the DMH/DD/SAS Local Management Entities/Managed Care Organizations (LME/MCOs).

4. **North Carolina Division of Public Health, Injury and Violence Prevention Branch (IVPB)**
   www.injuryfreenc.ncdhhs.gov
   Suicide Prevention Program – addresses suicide among 10-24 year olds in North Carolina, with support from the Garrett Lee Smith grant. The GLS grant led to the creation of the *"It's OK 2 Ask"* website and provides suicide prevention trainings to communities. The Injury and Violence Branch also provides data and surveillance for suicide. For example, click here for a link to a report on the burden of suicide in North Carolina.

5. **Students Against Destructive Decisions – North Carolina State Chapter**
   www.doa.state.nc.us/yaio/ncsadd.aspx

N.C. SADD has more than 300 SADD chapters across the state. The chapters carry out projects during the school year such as seat belt checks of students driving to school, compliance checks of sales to minors, prevention activities at sports events, alcohol-free prom and graduation projects, school assemblies, and community projects focusing on highway safety and underage drinking and drug prevention

6. **North Carolina SAYSO (Strong Able Youth Speaking Out)**
   www.saysoinc.org
   Strong Able Youth Speaking Out is a statewide association of youth ages 14 to 24 who are or have been in the out of home care system that is based in North Carolina.

National Suicide Prevention Resources

1. **American Foundation for Suicide Prevention (AFSP)**
   www.afsp.org
   American Foundation for Suicide Prevention (AFSP) is a multifaceted organization made up of scientists, dedicated survivors of suicide loss, people with mental disorders and their families, and an expansive network of business and community leaders. They are a grassroots movement, a support network, an educator, a professional research organization, and a grant-making foundation. They organize hundreds of events in communities across the country, raising millions of dollars each year to support their work, both locally and nationally. They advocate for social change, supporting policies that contribute to reducing and preventing suicides nationwide. While AFSP does not provide direct services, such as counseling or running a crisis hotline, they do work closely with the organizations providing these services. See above for link to the N.C. chapter.

2. **American Association of Suicidology (AAS)**
   www.suicidology.org
   American Association of Suicidology (AAS) is a membership organization for suicide prevention and intervention, or those touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide.

3. **KBHC Kristin Brooks Hope Center**
   www.hopeline.com/aboutus.html
   KBHC's focus is on suicide prevention, awareness and education. They provide help and hope through crisis hotlines (including Vet2Vet), online crisis chat, a musical outreach tour, and college campus awareness events. 1-800-442-HOPE (1-800-442-4673)

4. **National Alliance on Mental Illness (NAMI)**
   www.nami.org
   National Alliance on Mental Illness (NAMI), the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports, and research and is steadfast in its commitment to raise awareness and build a community of hope for all of those in need. NAMI is the foundation for hundreds of NAMI State Organizations, NAMI Affiliates and volunteer leaders who work in local communities across the country to raise awareness and provide essential and free education, advocacy, and support group programs.

5. **National Action Alliance for Suicide Prevention**
   http://actionallianceforsuicideprevention.org
   The National Action Alliance for Suicide Prevention is a public/private partnership that advances the National Strategy for Suicide Prevention on a national level. The Alliance's task forces include focuses on infrastructure, high-risk populations and interventions. Their work includes the Framework for Successful Messaging, The Way Forward, a report which gives voice to suicide attempt survivors and bridges the gap between suicide attempt survivors, clinicians, hospital policy makers, and suicide prevention leaders. The Your Life Matters! campaign is designed to give faith communities of every tradition an opportunity to celebrate life, hope, and reasons to live. See above for link to the N.C. chapter.

6. **Samaritans USA**
   www.samaritansusa.org/index.php
   Samaritans USA, the organization comprising the individual Samaritans centers operating in the United States, is a member of the world's oldest and largest suicide prevention network, with 400 centers in 38 countries (from Argentina, Bosnia and Great Britain to India, Sri Lanka and Zimbabwe). Samaritans centers provide volunteer-staffed hotlines and professional and volunteer-run public education programs, suicide survivor support groups and many other crisis response, outreach, and advocacy activities and programs to the communities they serve as well as those throughout the country.

7. **SAVE - Suicide Awareness\Voices of Education**
   www.save.org
   The mission of SAVE is to prevent suicide through public awareness and education, reduce stigma and serve as a resource to those touched by suicide.

8. **Substance Abuse and Mental Health Services Administration (SAMHSA)**
   www.samhsa.gov/prevention/suicide.aspx
   SAMHSA is a branch of the U.S. Department of Health and Human Services. SAMHSA's Suicide Prevention Goal is to provide individuals, families, professionals, and organizations with information and resources to seek help, provide assistance, or implement suicide prevention programs in their communities. This website provides links to call centers, resource centers and suicide prevention webinars.

9. **Suicide Information and Education Center (SIEC)**
   http://suicideinfo.ca
   Suicide Information and Education Center is a branch of the Canadian Mental Health Association, CSP is an education center with the largest English language library dedicated to the collection and dissemination of suicide prevention, intervention and postvention resources.

10. **Suicide Prevention Resource Center (SPRC)**
    www.sprc.org
    Suicide Prevention Resource Center (SPRC) is the nation's federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. They provide technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide. They also promote collaboration among a variety of organizations that play a role in developing the field of suicide prevention. Services and resources provided by SPRC include:
    a. Best Practices Registry - Registry of best practices in suicide prevention co-produced with the American Foundation for Suicide Prevention.
    b. Training institute - Face-to-face workshops, webinars, and online self-paced courses.
    c. Publications - Toolkits, guides, research summaries, and information sheets on a variety of suicide prevention topics.
    d. E-newsletter and social media - News, funding and research updates, and announcements in their e-mail newsletter The Weekly Spark, and presence on Facebook and Twitter.
    e. Library - Extensive collection of manuals, reports, and articles on suicide prevention.
    f. Partnership building: Bringing together health and mental health providers to strengthen their capacity to prevent suicide among their patients and clients.
    g. Technical assistance - Help and tools for state, tribal, community, and campus suicide prevention organizations and coalitions, including recipients of Garrett Lee Smith youth suicide prevention grants.

11. **The Jason Foundation**
    http://jasonfoundation.com/about-us
    The Jason Foundation, Inc. (JFI) is dedicated to the prevention of the Silent Epidemic of youth suicide through educational and awareness programs that equip young people, educators/youth workers and parents with the tools and resources to help identify and assist at-risk youth.

12. **The Jed Foundation**
    www.jedfoundation.org/about
    The Jed Foundation's mission is to promote emotional health and prevent suicide among college and university students. To achieve this end, the organization collaborates with the public and leaders in higher education, mental health, and research to produce and advance initiatives that:
    a. Promote awareness and understanding that emotional well-being is achievable, mental illness is treatable and suicide is preventable
    b. Increase knowledge of the warning signs of suicide and emotional distress
    c. Foster help-seeking so that those who need supportive services reach out to secure them, or are referred to services by a peer
    d. Build and strengthen resilience, coping skills and connectedness among young adults, their peers, families and communities
    e. Facilitate adoption of a comprehensive, community-based approach to promote emotional health and protect at-risk students on campus
    f. Raise the importance of mental health services, policies and programs in the college selection process of students and parents

13. **The Trevor Project**
    www.TheTrevorProject.org
    Founded in 1998 by the creators of the Academy Award®-winning short film TREVOR, The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24.

14. **U.S. Department of Veteran Affairs**
    www.va.gov
    Provides resources to veterans, family members, spouses, employees and businesses who work with veterans. Their website provides information and access to information on a variety of mental health issues, veteran benefits, burial and memorial services, service providers and locations.

15. **Veterans Crisis Line**
    http://veteranscrisisline.net/GetHelp/ResourceLocator.aspx
    This website connects veterans, active duty, reserve and guards , or family and friends to suicide prevention resources, including the ability to locate suicide prevention coordinators, crisis centers, VA medical centers, Veterans Benefits Administration offices, Vet Centers and outpatient clinics. 1-800-273-8255 or text to 838255

B. Mental Health Resources

North Carolina Mental Health Resources

1. **Center for Child and Family Health**
   www.ccfhnc.org/about.php
   Center for Child and Family Health strives to define, practice, and disseminate the highest standards of care in the field of prevention and treatment of childhood trauma. The Center for Child and Family Health uniquely integrates community-based practice and academic excellence. Their professionals utilize multidisciplinary measurable approaches for professional training and research related to child traumatic stress.

2. **North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)**
   www.ncdhhs.gov/mhddsas
   The N.C. Division provides strategic and operational leadership and oversight to the public mental health, developmental disability and substance abuse service system. The Community Policy Management Section is primarily responsible for leadership, guidance and management of relationships with local management entities (LME/MCOs). LME/MCOs are where people go to find information on receiving mental health, developmental disability or substance abuse services. They are available 24 hours a day. LME/MCO by county: www.ncdhhs.gov/mhddsas/lmeonblue.htm. The Division also operates the Crisis Solutions Coalition, which works

statewide to decrease the use of emergency departments and increase access to other services to help individuals resolve the crisis and get back to their homes, families, friends, and work. Learn more at http://crisissolutionsnc.org.

3. **Josh's Hope Foundation**
   http://joshshopefoundation.org
   Josh's Hope Foundation works with young adults who have serious mental-health issues, helping them identify resources, build skills, and develop plans to successfully transition to adulthood.

4. **Mental Health Associations**
   Mental Health Associations are non-profit organizations that serve to educate, advocate and support people affected by mental illness. They also provide education to the communities in which they serve. Several exist throughout North Carolina, including the following regions:
   a. Mental Health Association of Central Carolinas, Inc. *www.mhacentralcarolinas.org*
   b. Mental Health Association in Forsyth County *http://triadmentalhealth.org*
   c. Mental Health America of the Triangle *http://mhatriangle.org*
   d. Mental Health Association in Greensboro *www.mhag.org*

5. **National Alliance on Mental Illness in North Carolina (NAMI-NC)**
   http://naminc.org
   The mission of National Alliance on Mental Illness (NAMI) North Carolina is to promote recovery and optimize the quality of life for those affected by mental illness. They provide support, advocacy, education and training through their nearly 40 affiliates across the state of North Carolina.

6. **North Carolina Collaborative for Children, Youth and Families**
   www.nccollaborative.org
   The North Carolina State Collaborative for Children and Families, through a System of Care framework, provides a forum for collaboration, advocacy, and action among families, public, and private child and family serving agencies and community partners to improve outcomes for all children, youth, and families.

7. **North Carolina Consumer Advocacy Networking and Support Organization**
   http://nccanso.org/living-well
   The North Carolina Consumer Advocacy, Networking and Support Organization (N.C. CANSO) is dedicated to enriching the lives of people who have lived with developmental disabilities, psychiatric illness, or addiction through the life-empowering mechanisms of education, advocacy, and support.

8. **North Carolina Families United**
   www.ncfamiliesunited.org
   N.C. Families United supports and unites the voices of children, youth, and families with mental health concerns to educate, support, and advocate for improved services and lives. They offer resources, mentoring, and supports for youth and families.

9. **North Carolina Infant Mental Health Association**
   www.ncimha.org
   The North Carolina Infant and Young Child Mental Health Association is a statewide interdisciplinary nonprofit organization that promotes this strong foundation for infants, toddlers, young children, and their caregivers through public awareness, advocacy, and professional development.

10. **North Carolina Mental Health Consumers Organization**
    www.ncmhco.org
    The mission of the North Carolina Mental Health Consumers Organization is to promote mutual help, advocacy, insight, support, socialization, and empowerment for people living with mental illness.

National Mental Health Resources

1. **Mental Health Association**
   www.mentalhealthamerica.net
   Mental Health America is dedicated to promoting mental health, preventing mental, and substance use conditions and achieving victory over mental illnesses and addictions through advocacy, education, research, and service.

2. **National Child Mental Health Network**
   www.cmhnetwork.org/news/national-childrens-mental-health-awareness-day-2012
   National Child Mental Health Network provides information focused on children's mental health care.

3. **National Child Traumatic Stress Network**
   www.nctsnet.org
   The mission of the National Child Traumatic Stress Network is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

4. **National Alliance on Mental Illness (NAMI)**
   www.nami.org
   National Alliance on Mental Illness (NAMI), the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports, and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need. NAMI is the foundation for hundreds of NAMI State Organizations, NAMI Affiliates and volunteer leaders who work in local communities across the country to raise awareness and provide essential and free education, advocacy, and support group programs.

5. **Substance Abuse and Mental Health Services Administration (SAMHSA)**
   www.samhsa.gov/prevention/suicide.aspx
   SAMHSA is a branch of the U.S. Department of Health and Human Services. SAMHSA's Suicide Prevention Goal is to provide individuals, families, professionals, and organizations with information and resources to seek help, provide assistance, and/or implement suicide prevention programs in their communities. This website provides links to call centers, resource centers, and suicide prevention webinars.

C. Resources Related to Suicide Disparities

Appendix D of the *2012 National Suicide Strategy for Suicide Prevention* (page #101) identifies a list of groups with increased suicide risk. The appendix includes a brief national summary and overview of data and resources for each specific group with an increased risk for suicide. The *2012 NSSP* identifies 11 groups at a disproportion risk for suicide and suicidal behaviors, including:

1. American Indians/Alaska Natives
2. Individuals bereaved by suicide
3. Individuals in justice and child welfare settings
4. Individuals who engage in nonsuicidal self-injury (NSSI)
5. Individuals who have attempted suicide
6. Individuals with medical conditions
7. Individuals with mental health or substance use disorders
8. Lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations
9. Members of the Armed Forces and veterans
10. Men in midlife
11. Older men

In North Carolina, available data (described in Section 4) identify that youth, members of the armed forces and veterans, and individuals who identify as lesbian, gay, or bisexual may be at increased risk of suicide or suicidal behavior. This section includes North Carolina or national resources available for these three groups and for individuals with medical conditions.

*North Carolina Resources for **Youth***

1. **Center for Child and Family Health**
   www.ccfhnc.org/about.php
   Center for Child and Family Health strives to define, practice, and disseminate the highest standards of care in the field of prevention and treatment of childhood trauma. The Center for Child and Family Health uniquely integrates community-based practice and academic excellence. Their professionals utilize multidisciplinary measurable approaches for professional training and research related to child traumatic stress.

2. **North Carolina Collaborative for Children, Youth and Families**
   www.nccollaborative.org
   The North Carolina Collaborative for Children and Families, through a System of Care framework, provides a forum for collaboration, advocacy, and action among families, public and private child and family serving agencies, and community partners to improve outcomes for all children, youth, and families.

3. **North Carolina Families United**
   www.ncfamiliesunited.org
   N.C. Families United supports and unites the voices of children, youth, and families with mental health concerns to educate, support and advocate for improved services and lives. They offer resources, mentoring, and supports for youth and families.

4. **North Carolina Infant Mental Health Association**
   www.ncimha.org
   The North Carolina Infant Mental Health Association is a statewide interdisciplinary nonprofit organization that promotes this strong foundation for prenatal to five years old and their caregivers through public awareness, advocacy and professional development.

5. **North Carolina SAYSO (Strong Able Youth Speaking Out)**
   www.saysoinc.org
   Strong Able Youth Speaking Out is a statewide association of youth aged 14 to 24 who are or have been in the out-of-home care system that is based in North Carolina.

6. **Our Children's Place**
   http://ourchildrensplace.com
   Our Children's Place (OCP) is a private nonprofit agency committed to the children of incarcerated parents.

7. **Students Against Destructive Decisions - North Carolina State Chapter**
   www.doa.state.nc.us/yaio/ncsadd.aspx
   N.C. SADD has more than 300 SADD chapters across the state. The chapters carry out projects during the school year such as seat belt checks of students driving to school, compliance checks of sales to minors, prevention activities at sports events, alcohol-free prom and graduation projects, school assemblies and community projects focusing on highway safety and underage drinking and drug prevention. The cornerstone of SADD's philosophy is student empowerment. Empowered students are confident, able to create change and control behavior in the effort to promote healthy and productive lifestyles. SADD empowers youth by giving them the resources and support to make healthy choices when confronted with challenges and difficult decisions.

*National Resources for **Youth***

1. **National Child Traumatic Stress Network**
   www.nctsnet.org
   The mission of the National Child Traumatic Stress Network is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

2. **SAVE - Suicide Awareness\Voices of Education**
   www.save.org
   The mission of SAVE is to prevent suicide through public awareness and education, reduce stigma, and serve as a resource to those touched by suicide.

*National Resources for Members of the **Armed Forces and Veterans***

1. **KBHC Kristin Brooks Hope Center**
   www.hopeline.com/aboutus.html
   KBHC's focus is on suicide prevention, awareness and education. They provide help and hope through crisis hotlines (including Vet2Vet), online crisis chat, a musical outreach tour and college campus awareness events. 1-800-442-HOPE (1-800-442-4673)

2. **Veterans Crisis Line**
   http://veteranscrisisline.net/GetHelp/ResourceLocator.aspx
   This website connects veterans, active duty/reserve and guards and/or family and friends to suicide prevention resources, including the ability to locate suicide prevention coordinators, crisis centers, VA medical centers, Veterans Benefits Administration offices, Vet Centers, and outpatient clinics. 1-800-273-8255 or text to 838255

3. **U.S. Department of Veteran Affairs**
   www.benefits.va.gov/benefits
   Provides resources to veterans, family members, spouses, employees, and businesses who work with veterans. Their website provides information and access to information on a variety of mental health issues, veteran benefits, burial, and memorial services, service providers and locations.

*National Resources for **LGBTQ-2S Individuals***

1. **SAVE - Suicide Awareness\Voices of Education**
   www.save.org
   The mission of SAVE is to prevent suicide through public awareness and education, reduce stigma and serve as a resource to those touched by suicide.

2. **The Trevor Project**
   www.TheTrevorProject.org
   Founded in 1998 by the creators of the Academy Award®-winning short film TREVOR, The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24.

*North Carolina Resources for Individuals with **Medical Conditions***

1. **North Carolina Division of Aging and Adult Services**
   www.ncdhhs.gov/aging
   The N.C. Division of Aging and Adult Services (DAAS) works to promote independence and enhance the dignity of North Carolina's older adults, people with disabilities, and their families through a community-based system of opportunities, services, benefits, and protections; to ready younger generations to enjoy their later years; and to help society and government plan and prepare for the changing demographics.

2. **North Carolina Division of Services for the Deaf and the Hard of Hearing**
   www.ncdhhs.gov/dsdhh
   The N.C. Division of Services for the Deaf and the Hard of Hearing (DSDHH) provides not only direct services to individuals with hearing loss and the agencies and businesses that serve them but also the resources and linkages to programs and services all across North Carolina. DSDHH's specially-trained staff, many of whom are deaf, hard of hearing, or deaf-blind, are housed at its seven Regional Centers located throughout the state. Thanks to their specialized and critical support, many North Carolinians with hearing loss are leading self-sufficient, productive and fulfilling lives.

3. **North Carolina Division of Services for the Blind**
   www.ncdhhs.gov/dsb
   The N.C. Division of Services for the Blind (DSB) has a long and rich history of services to the blind and visually impaired residents of the State. DSB is able to offer these services through cooperative efforts from Federal, State and County resources. Blind and visually impaired people as well as people with vision and hearing loss have benefited from our long partnership with the Lions Clubs and other consumer and advocacy groups throughout the State. The Division provides services statewide through staff in seven DSB District Offices and Social Workers for the Blind located in all North Carolina counties.

D. Evidence-Based Practices

National Resources for Best Practices

1. **Substance Abuse and Mental Health Services Administration (SAMHSA)**
   www.samhsa.gov/prevention/suicide.aspx
   SAMHSA is a branch of the U.S. Department of Health and Human Services. SAMHSA's Suicide Prevention Goal is to provide individuals, families, professionals, and organizations with information and resources to seek help, provide assistance, or implement suicide prevention programs in their communities. This website provides links to call centers, resource centers, and suicide prevention webinars.

2. **Suicide Prevention Resource Center (SPRC)**
   www.sprc.org
   Suicide Prevention Resource Center (SPRC) is the nation's federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. They provide technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide. They also promote collaboration among a variety of organizations that play a role in developing the field of suicide prevention. The Services and Resources Provided by SPRC include:
   a. Best Practices Registry - Registry of best practices in suicide prevention co-produced with the American Foundation for Suicide Prevention.
   b. Training institute - Face-to-face workshops, webinars, and online self-paced courses.
   c. Publications - Toolkits, guides, research summaries, and information sheets on a variety of suicide prevention topics.
   d. E-newsletter and social media - News, funding and research updates, and announcements in their e–mail newsletter The Weekly Spark, and presence on Facebook and Twitter.
   e. Library - Extensive collection of manuals, reports, and articles on suicide prevention.
   f. Partnership building - Bringing together health and mental health providers to strengthen their capacity to prevent suicide among their patients and clients.
   g. Technical assistance - Help and tools for state, tribal, community, and campus suicide prevention organizations and coalitions, including recipients of Garrett Lee Smith youth suicide prevention grants.

E. Advocacy and Awareness Resources

North Carolina Advocacy and Awareness Resources

1. **American Foundation for Suicide Prevention (AFSP) North Carolina Chapter**
   www.afsp.org/local-chapters/local-chapters-listed-by-state/north-carolina/afsp-north-carolina
   The American Foundation for Suicide Prevention (AFSP) established a new chapter in North Carolina in May 2014. The Chapter raises awareness about suicide and its prevention through community events, Out of the Darkness walks, AFSP programs, and gatekeeper trainings. The Chapter plans to expand training opportunities around the state, make more resources available to people whose lives have been affected by suicide, bring AFSP's Interactive Screening Program (ISP) to North Carolina campuses and communities, and collaborate with other organizations in continuing to build a grassroots advocacy network that promotes legislation and policies to prevent suicide and improve mental health.

2. **National Alliance on Mental Illness in North Carolina (NAMI-NC)**
   http://naminc.org
   The mission of National Alliance on Mental Illness (NAMI) North Carolina is to promote recovery and optimize the quality of life for those affected by mental illness. They provide support, advocacy, education and training through their nearly 40 affiliates across the state of North Carolina.

3. **North Carolina Collaborative for Children, Youth and Families**
   www.nccollaborative.org
   The North Carolina State Collaborative for Children and Families, through a System of Care framework, provides a forum for collaboration, advocacy and action among families, public and private child and family serving agencies and community partners to improve outcomes for all children, youth and families.

4. **North Carolina Consumer Advocacy Networking and Support Organization**
   http://nccanso.org/living-well
   The North Carolina Consumer Advocacy, Networking and Support Organization (N.C. CANSO) is dedicated to enriching the lives of people who have lived with developmental disabilities, psychiatric illness, and/or addiction through the life-empowering mechanisms of education, advocacy, and support.

5. **North Carolina Families United**
   www.ncfamiliesunited.org
   N.C. Families United supports and unites the voices of children, youth, and families with mental health concerns to educate, support and advocate for improved services and lives. They offer resources, mentoring, and supports for youth and families.

6. **North Carolina Mental Health Consumers Organization**
   www.ncmhco.org
   The mission of the North Carolina Mental Health Consumers Organization is to promote mutual help, advocacy, insight, support, socialization, and empowerment for people living with mental illness.

7. **North Carolina SAYSO (Strong Able Youth Speaking Out)**
   www.saysoinc.org
   Strong Able Youth Speaking Out is a statewide association of youth aged 14 to 24 who are or have been in the out-of-home care system that is based in North Carolina.

National Advocacy and Awareness Resources

1. **American Foundation for Suicide Prevention (AFSP)**
   www.afsp.org
   American Foundation for Suicide Prevention (AFSP) is a multifaceted organization made up of scientists, dedicated survivors of suicide loss, people with mental disorders and their families, and an expansive network of business and community leaders. They are a grassroots movement, a support network, an educator, a professional research organization and a grant-making foundation. They organize hundreds of events in communities across the country, raising millions of dollars each year to support our work, both locally and nationally. They advocate for social change, supporting policies that contribute to reducing and preventing suicides nationwide. While AFSP does not provide direct services, such as counseling or running a crisis hotline, they do work closely with the organizations providing these services. See above for link to the N.C. chapter.

2. **American Association of Suicidology (AAS)**
   www.suicidology.org
   American Association of Suicidology (AAS) is a membership organization for suicide prevention and intervention, or those touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. The goal of AAS is to understand and prevent suicide.

3. **Mental Health America**
   www.nmha.org
   Mental Health America is dedicated to promoting mental health, preventing mental and substance use conditions and achieving victory over mental illnesses and addictions through advocacy, education, research and service.

4. **National Alliance on Mental Illness (NAMI)**
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   http://actionallianceforsuicideprevention.org
   The National Action Alliance for Suicide Prevention is a public/private partnership that advances the National Strategy for Suicide Prevention on a national level. Their task forces include focuses on infrastructure, high-risk populations and interventions. Their work includes the Framework for Successful Messaging, The Way Forward, a report which gives voice to suicide attempt survivors and bridges the gap between suicide attempt survivors, clinicians, hospital policy makers, and suicide prevention leaders. The Your Life Matters! campaign is designed to give faith communities of every tradition an opportunity to celebrate life, hope, and reasons to live. See above for link to the N.C. chapter.

6. **National Child Traumatic Stress Network**
   www.nctsnet.org
   The mission of the National Child Traumatic Stress Network is to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

7. **Samaritans USA**
   www.samaritansusa.org/index.php
   Samaritans USA, the organization comprising the individual Samaritans centers operating in the United States, is a member of the world's oldest and largest suicide prevention network, with 400 centers in 38 countries (from Argentina, Bosnia and Great Britain to India, Sri Lanka and Zimbabwe). Samaritans centers provide volunteer-staffed hotlines and professional and volunteer-run public education programs, suicide survivor support groups and many other crisis response, outreach and advocacy activities and programs to the communities they serve as well as those throughout the country.

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a. Best Practices Registry - Registry of best practices in suicide prevention co-produced with the American Foundation for Suicide Prevention.
b. Training institute - Face-to-face workshops, webinars, and online self-paced courses.
c. Publications - Toolkits, guides, research summaries, and information sheets on a variety of suicide prevention topics.
d. E-newsletter and social media - News, funding and research updates, and announcements in their e–mail newsletter The Weekly Spark, and presence on Facebook and Twitter.
e. Library - Extensive collection of manuals, reports, and articles on suicide prevention.
f. Partnership building - Bringing together health and mental health providers to strengthen their capacity to prevent suicide among their patients and clients.
g. Technical assistance - Help and tools for state, tribal, community, and campus suicide prevention organizations and coalitions, including recipients of Garrett Lee Smith youth suicide prevention grants.

11. The Jason Foundation

http://jasonfoundation.com/about-us

The Jason Foundation, Inc. (JFI) is dedicated to the prevention of the Silent Epidemic of youth suicide through educational and awareness programs that equip young people, educators and youth workers and parents with the tools and resources to help identify and assist at-risk youth.

12. The Jed Foundation

www.jedfoundation.org/about

The Jed Foundation's mission is to promote emotional health and prevent suicide among college and university students. To achieve this end, the organization collaborates with the public and leaders in higher education, mental health, and research to produce and advance initiatives that:

a. Promote awareness and understanding that emotional well-being is achievable, mental illness is treatable and suicide is preventable
b. Increase knowledge of the warning signs of suicide and emotional distress
c. Foster help-seeking so that those who need supportive services reach out to secure them, or are referred to services by a peer
d. Build and strengthen resilience, coping skills and connectedness among young adults, their peers, families and communities
e. Facilitate adoption of a comprehensive, community-based approach to promote emotional health and protect at-risk students on campus
f. Raise the importance of mental health services, policies and programs in the college selection process of students and parents

13. The Trevor Project

www.TheTrevorProject.org

Founded in 1998 by the creators of the Academy Award®-winning short film TREVOR, The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people ages 13-24.

F. Data and Surveillance Resources

North Carolina Suicide Prevention Data and Surveillance Resources

1. North Carolina Death Certificate Data

http://vitalrecords.nc.gov/research.htm

The North Carolina State Center for Health Statistics, Statistical Services Branch, Vital Statistics team provides death certificate data for every death in North Carolina. Only North Carolina residents with a North Carolina county address were considered for our purposes. Deaths were limited to events in which the primary cause of death was identified as an injury using the International Classification, 10th Revision (ICD-10) codes.

2. **North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT)**
   www.ncdetect.org
   NC DETECT is a statewide surveillance system that collects and monitors emergency department (ED) visits for public health purposes. NC DETECT was created by the North Carolina Division of Public Health in collaboration with the Carolina Center for Health Informatics in the University of North Carolina at Chapel Hill, Department of Emergency Medicine. NC DETECT receives data on a daily basis from hospital-affiliated EDs statewide. As of 2014, 123 North Carolina hospital-affiliated EDs submit data on a daily basis to NC-DETECT, and four VA Medical Center EDs in North Carolina transmit data to NC DETECT. Data regarding ED visits for self-inflicted injuries are available annually.

3. **North Carolina Hospital Discharge Data (HDD) System**
   www.shepscenter.unc.edu/data-2/nc-hospital-discharge-data
   The Cecil G. Sheps Center for Health Services Research, under contract with the N.C. Division of Health Service Regulation, maintains the Hospital Discharge Data System collected by Truven Health Analytics. The data are retrieved from claims forms used by hospitals to bill payers. These data do not represent number of patients, but rather number of discharges (multiple discharges per patient are possible). Data regarding hospitalizations for self-inflicted injuries are available annually.

4. **North Carolina Violent Death Reporting System (NC-VDRS)**
   www.injuryfreenc.ncdhhs.gov/About/ncVDRS.htm
   NC-VDRS is a surveillance system that links death certificates, medical examiner reports, and incident reports from law enforcement agencies to provide detailed data on all violent deaths, including suicide, occurring in North Carolina. NC-VDRS is operated by the North Carolina Division of Public Health's Injury and Violence Prevention Branch. Data regarding suicide are available annually.

5. **North Carolina Youth Risk Behavior Survey (N.C. YRBS)**
   www.nchealthyschools.org/data/yrbs
   The N.C. YRBS is a school-based survey conducted by the N.C. Healthy Schools Initiative to assess health risk behaviors among high school and middle school students in North Carolina. Questions regarding suicide and suicidal attempts are included on the N.C. YRBS. The survey is administered in odd-numbered years and began in 1993. In 2013, a random sample of 1,846 high school students from 32 schools across North Carolina participated in the N.C. YRBS.

6. **2015 N.C. Suicide Prevention State Plan Data Figures**
   www.injuryfreenc.ncdhhs.gov/preventionResources/Suicide.htm
   This link includes access to a PowerPoint file containing the data figures and graphs provided in Section 4.

National Suicide Prevention Data and Surveillance Resources

1. **National Violent Death Reporting System (NVDRS) Centers for Disease Control and Prevention (CDC), HHS**
   www.cdc.gov/injury/wisqars/nvdrs.html
   NVDRS is a surveillance system that links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state in designing and implementing tailored prevention and intervention efforts, including for suicide. NVDRS also pools these data to better depict the scope and nature of violence.

2. **Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0, 2011 National Center for Injury Prevention and Control, CDC, HHS**
   www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html
   To address the current lack of a uniform definition on fatal and nonfatal self-harm, CDC developed this resource to improve understanding of self-directed violence and standardize data collection. The definitions and data elements were developed in collaboration with the U.S. Department of Veterans Affairs and the U.S. Department of Defense.

3. **Suicide Prevention Data Reports Office of Applied Studies, SAMHSA, HHS**
   www.oas.samhsa.gov/suicide.cfm
   This website lists reports that provide surveillance data on suicidal thoughts and behaviors.

4. **Suicidal Thoughts and Behaviors Among Adults**
   www.oas.samhsa.gov/2k9/165/Suicide.htm
   This issue of The National Survey on Drug Use and Health Report examines suicidal thoughts and behaviors among adults aged 18 and older. Data are presented by age group, gender, and past year substance use disorder. All findings in the report are based on 2008 data.

5. **Web-based Injury Statistics Query and Reporting System (WISQARS)**
   www.cdc.gov/injury/wisqars
   WISQARS is an interactive, online dataset that provides fatal and non-fatal injury, violent death, and cost of injury data. National and state-level data are available annually.

SECTION 8 – ENDORSEMENTS

The following entities have provided an endorsement of the *2015 N.C. Suicide Prevention Plan*:

Adolescent Pregnancy Prevention Campaign of North Carolina
www.appcnc.org
3708 Mayfair St. Suite 310, Durham, N.C. 27707

Community Care of North Carolina, Inc.
www.communitycarenc.com
2300 Rexwoods Drive, Suite 100, Raleigh, N.C. 27607

Alliance Behavioral Healthcare
www.alliancebhc.org
4600 Emperor Blvd, Suite 200 Durham, N.C. 27703

Daymark Recovery Services, Inc.
www.daymarkrecovery.org
2129 Statesville Blvd, Salisbury, N.C. 28147

American Foundation for Suicide Prevention, North Carolina Chapter
www.afsp.org/local-chapters/find-your-local-chapter/afsp-north-carolina
PO Box 25536, Winston-Salem, N.C. 27114

Department of Public Safety – Juvenile Justice
www.ncdps.gov
3010 Hammond Business Place, Raleigh N.C. 27603

Department of Youth, Family, and Community Sciences at North Carolina State University
http://yfcs.cals.ncsu.edu
512 Brickhaven, Raleigh N.C. 27695

Brain Injury Association of NC
www.bianc.net
6604 Six Forks Rd., Ste. 104, Raleigh, N.C. 27615

Division of Mental Health, Developmental Disabilities, and Substance Abuse
Community Wellness, Prevention, and Health Integration
www.ncdhhs.gov/mhddsas
325 N. Salisbury St. Raleigh, N.C. 27603

Breaking the Silence
627 Orindo Drive, Durham, N.C. 27713

North Carolina School Psychology Association
http://ncspaonline.com
PO Box 12661, Durham, N.C. 27709

Fayetteville State University Department of Social Work
www.uncfsu.edu/sw
1200 Murchison Road, Fayetteville, N.C. 28301

Cardinal Innovations Healthcare Solutions
www.cardinalinnovations.org
4855 Milestone Avenue, Kannapolis, N.C. 28081

Healthy Carolinians of Orange County
www.orangecountync.gov/healthycarolinians
300 W. Tryon St., Hillsborough, N.C. 27278

Center for Behavioral Health and Wellness at N.C. A&T State University
www.ncat.edu/cbhw
913 Bluford Street, Greensboro, N.C. 27401

HopeLine, Inc.
www.hopeline-nc.org
PO Box 10490, Raleigh, N.C. 27605

Center for Prevention Services
www.preventionservices.org
1117 E. Morehead St., Suite 200, Charlotte, N.C. 28204

Levine Children's Hospital
www.carolinashealthcare.org/levine-childrens-hospital
1000 Blythe Blvd, Charlotte, N.C. 28232

Chronic Disease and Injury Section
North Carolina Division of Public Health
www.publichealth.nc.gov/chronicdiseaseandinjury
5505 Six Forks Road, Raleigh, N.C. 27609

Mecklenburg County Provided Services Organization
http://charmeck.org/mecklenburg/county/PSO/Pages/default.aspx
3500 Ellington Street, Charlotte, N.C. 28211

CoastalCare
www.coastalcarenc.org
3809 Shipyard Boulevard, Wilmington, N.C. 28403

NC State University, Department of Social Work
http://socialwork.chass.ncsu.edu
Campus Box 7639, Raleigh, N.C. 27695

National Alliance on Mental Illness (NAMI) North Carolina
www.naminc.org
309 W. Millbrook Rd., Suite 121, Raleigh, N.C. 27609

Methodist Home for Children
www.mhfc.org
1041 Washington Street, Raleigh, N.C. 27605

National Association of Social Workers-North Carolina Chapter
www.naswnc.org
PO Box 27582, Raleigh, N.C. 27601

Orange County Health Department
www.orangecountync.gov
300 W. Tryon St. Hillsborough, N.C. 27278

National Association of Students against Violence Everywhere
www.nationalsave.org
322 Chapanoke Road, Suite 110, Raleigh, N.C. 27603

Partners for Healthy Youth
www.partners4healthyyouth.org
301 F State Street, Greensboro, N.C. 27408

NC Academy of Family Physicians
www.ncafp.com
1303 Annapolis Drive, Raleigh, N.C. 27608

Peace of Mind, Inc.
www.peace-of-mind-inc.com
817 West Front Street, Lillington, N.C. 27546

NC Child
www.ncchild.org
3109 Poplarwood Court, Suite 300, Raleigh, N.C. 27604

REAL Crisis Intervention Inc.
www.realcrisis.org
1011 Anderson Street, Greenville, N.C. 27858

North Carolina Division of Social Services
www.ncdhhs.gov/dss
820 S. Boylan Ave., 2410 Mail Service Center, Raleigh, N.C. 27699

Recovery Innovations
www.RecoveryInnobations.org
401 E Lakewood Ave, Ste E1-A Durham, N.C.
2407 Memorial Dr. Greenville, N.C.
1311 Health Dr. New Bern, N.C.
30 Parkview Dr. West Henderson, N.C.

North Carolina Department of Public Instruction
www.NCpublicSchools.org
301 N. Wilmington Street, Raleigh, N.C. 27601

Save a Life
www.helpingsavealife.com
Cary, N.C.

North Carolina Department of Transportation
www.ncdot.gov
1 South Wilmington Street, Raleigh, N.C. 27601

Smoky Mountain LME/MCO
www.smokymountaincenter.com
356 Biltmore Ave. Asheville, N.C. 28801

North Carolina Office on Disability and Health Children and Youth Branch
N.C. Division of Public Health
www.ncdhhs.gov/dph/wch/aboutus/disability.htm 5601
Six Forks Road, Raleigh, N.C. 27609

Teen Health Connection
www.teenhealthconnection.org
3541 Randolph Road, Suite 206, Charlotte, N.C. 28211

North Carolina School Health Training Center
College of Health Sciences
Appalachian State University
http://ncshtc.appstate.edu
730 Rivers St., Edwin Duncan Hall, Boone, N.C. 28607

The North Carolina Public Health Foundation
www.ncphf.org
308-F West Millbrook Road, Raleigh, N.C. 27609

The Shore Grief Center
www.theshoregriefcenter.org
105 River Watch Lane, Youngsville, N.C. 27596

UNC Injury Prevention Research Center
www.iprc.unc.edu
CB#7505, 137 E Franklin St Ste 500, Franklin St Plaza,
University of North Carolina at Chapel Hill
Chapel Hill, N.C. 27599-7505

Triangle Survivors of Suicide
www.TriangleSOS.org
105 Starwood Ln, Holly Springs, N.C. 27540

Union Academy
http://unionacademy.org
675 N MLK Jr. Blvd., Monroe, N.C. 28110

SECTION 9 – REFERENCES

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North Carolina Institute of Medicine [NCIOM]. (2012). *Suicide Prevention and Intervention Plan: A Report of the NCIOM Task Force on Suicide Prevention and Intervention.* Morrisville, N.C.: North Carolina Institute of Medicine. Retrieved from: www.sprc.org/sites/sprc.org/files/NCIOM%20Suicide%20Prevention%20and%20Intervention%20Plan%202012.pdf

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SECTION 10 – APPENDICES

Appendix A. Glossary
Appendix A provides a Glossary of terminology addressed in this plan. This Glossary draws heavily on the terminology and definitions applied in the 2012 National Strategy for Suicide Prevention Plan (NSSP).

Appendix B. Summary of Process to Develop the *2015 N.C. Suicide Prevention Plan*
Appendix B provides detailed information about the 11 steps used to develop the 2015 N.C. Suicide Prevention Plan.

Appendix C. 2015 N.C. Suicide Prevention Goals and Objectives
Appendix C includes a list of North Carolina's Suicide Prevention Strategic Directions, Goals, and Objectives. Prioritized objectives are noted in rows that are color-shaded.

Appendix D. *2015 N.C. Suicide Prevention Plan* Objectives by Stakeholder Group Examples
Appendix D shows the number of examples identified for each objective by stakeholder group by Strategic Direction, Goal and Objectives. Prioritized objectives are those with bold formatting.

Appendix E. *2015 N.C. Suicide Prevention Plan* Examples by Stakeholder Groups
Appendix E provides a list of all examples of what stakeholder groups can do to address suicide in NC.

APPENDIX A. GLOSSARY

American Association of Suicidology (AAS): a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS works to advance scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

American Foundation for Suicide Prevention (AFSP): a multifaceted organization made up of scientists, survivors of suicide loss, people with mental disorders and their families, and an expansive network of business and community leaders. AFSP is a grassroots movement, a support network, an educator, a professional research organization and a grant-making foundation. While AFSP does not provide direct services, such as counseling or running a crisis hotline, they do work closely with the organizations providing these services.

Applied Suicide Intervention Skills Training (ASIST): The ASIST workshop is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. www.livingworks.net

Best Practices Registry (BPR): a registry funded by SAMHSA and found on the SPRC website. Its purpose is to identify, review, and disseminate information about best practices that address specific objectives of the National Strategy for Suicide Prevention. The BPR is organized into three sections, each with different types of best practices. The three sections do not represent levels, but rather they include different types of programs and practices reviewed according to specific criteria for that section. Section I: Evidence-Based Programs lists interventions that have undergone evaluation and demonstrated positive outcomes. Section II: Expert and Consensus Statements lists statements that summarize the current knowledge in the suicide prevention field and provide best practice recommendations to guide program and policy development. Section III: Adherence to Standards lists suicide prevention programs and practices whose content has been reviewed for accuracy, likelihood of meeting objectives, and adherence to program design standards. BPR listings include only materials submitted and reviewed according to the designated criteria and do not represent a comprehensive inventory of all suicide prevention initiatives.

Compeer: a volunteer-based program in which people volunteer to regularly spend time with an adult or youth who is receiving mental health services. The goal is to provide supportive friendships for people in mental-health care, typically as a complement to therapy, in order to help and support them on their journey of recovery from mental illness.

Connectedness: the degree to which a person or group is socially close, interrelated, or shares resources with other people or groups. One of the *National Strategy's* primary aims is to promote opportunities and settings to enhance connectedness among persons, families, and communities. Connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance for prevention.

Crisis Intervention Team (CIT) training: a training program developed in a number of U.S. states to help law enforcement react appropriately to situations involving mental illness or developmental disability.

Dialectical Behavioral Therapy (DBT): invented by Marsha Linehan, a psychologist, who modified traditional cognitive behavioral therapy (CBT) for the treatment of chronically suicidal and self-injurious individuals with borderline personality disorder (BPD). In standard DBT, different types of psychosocial therapies (e.g., individual psychotherapy, group skills training and even phone consultations) may be used as part of treatment. DBT differs from traditional CBT in its emphasis on validation—a powerful tool whereby the therapist and the patient work on accepting uncomfortable thoughts, feelings and behaviors rather than struggling with them. Once an identified thought, emotion or behavior has been validated, the process of change no longer appears impossible, and the goals of gradual transformation become reality. The term dialectics refers to the therapist's goal of establishing a balance between acceptance and change and effectively integrating these two fundamental principles of successful therapy. DBT also focuses on the development of coping skills.

Employee Assistance Program (EAP): an employer-sponsored service designed to address personal or family issues, including mental health, substance abuse, various addictions, marital problems, parenting problems, emotional problems, or financial or legal concerns. This is typically a service provided by an employer to the employees, designed to assist employees in getting help for these problems so that they may remain on the job and effective.

Evidence-based programs: programs that have undergone scientific evaluation and have proven to be effective.

Gatekeepers: those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify people at risk of suicide and refer them to treatment or supporting services as appropriate. Examples include clergy, first responders, pharmacists, caregivers, and those employed in institutional settings, such as schools, prisons, and the military.

Intervention: a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention, or reducing access to lethal means among individuals with suicide risk).

LGBTQ-2S (Lesbian, Gay, Bisexual, Transgender, Questioning, and Two-spirit): Sexual orientation (e.g., heterosexual, lesbian, gay, bisexual) can be defined as the desire for intimate emotional, romantic, physical or sexual relationships with people of the same gender/sex, different gender/sex, or multiple genders or sexes. Transgender is a term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth. Two-Spirit is a contemporary term that refers to the historical and current First Nations people whose individual spirits were a blend of male and female spirits. This term has been reclaimed by some in Native American LGBTQ communities in order to honor their heritage and provide an alternative to the Western labels of gay, lesbian, bisexual, or transgender.

Local Education Agency (LEA): synonymous with a local school system or a local school district, indicating that a public board of education or other public authority maintains administrative control of the public schools in a city or county.

Local Management Entity/Managed Care Organization (LME/MCO): North Carolina transitioned its publicly funded MH/DD/SAS system from a fee-for-service system to a more tightly coordinated managed care system. LME/MCOs are responsible for managing dollars from Medicaid, and from state and federal block grants for mental health, substance abuse, and developmental disability services. LME/MCOs will receive a per member per month (PMPM) payment to manage all the mental health, substance abuse, and developmental disabilities services and supports for the Medicaid recipients in their service area. LME/MCOs also receive an allocation of state and federal block grant funds to help provide services to people who are not eligible for Medicaid, and receive varying levels of local support.

Local Outreach to Suicide Survivors (LOSS) team: this program is an active model of postvention made up of a team of trained survivors who go to the scenes of suicides to disseminate information about resources and be the installation of hope for the newly bereaved. The primary goal of an Active Postvention Model (APM) that this program is based upon is to let survivors of suicide know that resources exist as soon as possible following the death.

National Action Alliance for Suicide Prevention: the public-private partnership working to advance the *National Strategy for Suicide Prevention.*

National Alliance on Mental Illness (NAMI): the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community of hope for all of those in need. NAMI is the foundation for hundreds of NAMI State Organizations, NAMI Affiliates and volunteer leaders who work in local communities across the country to raise awareness and provide essential and free education, advocacy and support group programs.

National Registry of Evidence-based Programs and Practices (NREPP): a searchable online database of mental health and substance abuse interventions. All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for Quality of Research and Readiness for Dissemination. The purpose of NREPP is to help the public learn more about available evidence-based programs and practices and determine which of these may best meet their needs. NREPP is one way that SAMHSA is working to improve access to information on evaluated interventions and reduce the lag time between the creation of scientific knowledge and its practical application in the field.

North Carolina Department of Public Instruction (NC DPI): administers the policies adopted by the State Board of Education and offers instructional, financial, technological and personnel support to all public school systems in the state.

Peer support: people with similar experiences may be able to listen, give hope and guidance toward recovery in a way that is different, and may be just as valuable, as professional services. Peer services include mutual support groups, peer-run programs and services in traditional mental health agencies provided by peer support specialists. While peer support groups may be composed entirely of people who have simply learned through their own experience, some types of peer providers undergo training and certification to qualify. In addition to direct services, many peer-run organizations advocate to improve opportunities for people recovering from mental illnesses.

Person at risk: an individual who is showing signs and symptoms of suicidal thought processes and may have made plans or taken actions toward completing suicide.

Postvention: response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Prevention: a strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

Protective factors: conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate the risk of negative outcomes. Protective factors are characteristics that make it less likely that individuals will consider, attempt, or die by suicide.

Resilience: capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Question, Persuade and Refer: gatekeeper trainings to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. www.qprinstitute.com

Suicide attempt survivor: an individual who has survived a prior suicide attempt.

Suicide loss survivor: family members, friends, and others affected by the suicide of a loved one.

Suicide Prevention Resource Center (SPRC): the nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention***.** They provide technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide. In addition, they also promote collaboration among a variety of organizations that play a role in developing the field of suicide prevention.

Train-the-trainer: a method used to train individuals to become qualified to teach a particular program. After completion of the training, these individuals have trainer credentials to train others on the workshop.

Wellness Recovery Action Plans (WRAP): a group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources (wellness tools) and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness.

Worksite wellness: worksites have the opportunity to encourage healthy habits and help prevent health problems such as diabetes, depression, and heart disease. A positive wellness culture in the workplace contributes to the physical, mental, and emotional well-being of workers.

Zero Suicide: an approach developed by the National Action Alliance for Suicide Prevention. Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and also a specific set of tools and strategies. Its core proposition is that suicide deaths for people under care are preventable and that the bold goal of zero suicides among people receiving care is an aspirational challenge that health systems should accept. Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems.

APPENDIX B. SUMMARY OF PROCESS TO DEVELOP THE 2015 N.C. SUICIDE PREVENTION PLAN

This appendix for the *2015 N.C. Suicide Prevention Plan* describes the steps taken during the 16-month (September 2013-December 2014) plan development process. The eight action steps to develop the *2015 N.C. Suicide Prevention Plan* are described in the following sub-sections.

1. Formation of Planning Team
2. Completion of Initial Planning Steps
3. Identification N.C. Suicide Prevention Stakeholders and Formation of Working and Consulting Groups
4. Completion of Online Survey to Assess Alignment with the 2012 NSSP
5. In-Person Working Group Meeting #1
6. Online Exercise to Refine Examples Identified for Plan Objectives
7. In-Person Working Group Meeting #2
8. Review Process for Draft 2015 N.C. Suicide Prevention Plan

A. Formation of Planning Team

To develop and facilitate a planning process to develop the *2015 N.C. Suicide Prevention Plan*, the IVP Branch entered into a contract with a team from the University of North Carolina at Chapel Hill, Gillings School of Global Public Health, Department of Health Behavior.

During a 16-month process (September 2013 – December 2014), UNC staff/faculty (**Robert J. Letourneau**, MPH, **Rachel Page**, MPH, and **Carolyn E. Crump**, PhD) planned and facilitated 15 in-person or conference call meetings with the planning team members from the IVP Branch (**Alan Dellapenna**, MPH, Branch Head; **Jane Ann Miller**, MPH, Public Health Program Consultant; **Margaret Vaughn**, MPH/CPH, Public Health Program Consultant; **Anna Austin**, MPH, CDC/CSTE Applied Epi. Fellow; **Kathleen Creppage**, MPH, CDC/CSTE Applied Epi. Fellow; **Nidhi Sachdeva**, MPH, Injury Prevention Consultant) and the N.C. Division of Mental Health/ Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS), Community Policy Management Section (**Sarah Potter**, BSW, MPA, Policy Development/Prevention and Early Intervention Team Lead).

All planning team members provided input into communications with stakeholders participating in the state plan development process.

B. Completion of Initial Planning Steps

Document Review

The initial work of the planning team was informed by a review conducted by UNC Team members of prior plans and documents relevant to suicide in North Carolina, including: *Saving Tomorrows Today* [19] the N.C. *Suicide Prevention and Intervention Plan* (NCIOM, 2012) developed by N.C. Institute of Medicine for the DMH/DD/SAS; and data reports developed by the IVP Branch, *The Burden of Suicide in N.C.* [20]

UNC Team members also reviewed other suicide prevention plans, including: the 2012 *National Strategy for Suicide Prevention* (DHHS, 2012); and several other state plans (Tennessee, Michigan, Oklahoma, Alaska, Maine) that were either recently updated or recognized by SAMHSA as being comprehensive. For the review of these plans, UNC team members: created summaries to share and discuss with the planning team; identified overlap/differences in purposes; and identified complementary objectives and strategies.

Development of Guiding Principles and Plan Outline

Early in the planning process, the planning team identified a set of guiding principles for how the *2015 N.C. Suicide Prevention Plan* would be developed. Given that the state of North Carolina does not have funding to coordinate state-wide suicide prevention activities, planning team members identified seven principles to guide the planning process, including:

[19] NCDPH, 2004

[20] North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (NCDPH), 2011; NCDPH, 2013a

1. Focus the plan on all age groups (i.e., not just youth as was the case in 2004).
2. Create a state plan not a plan for the IVP branch.
3. Align with the 2012 NSSP to provide direction (goals and objectives).
4. Provide a direction for where North Carolina should be heading to prevent suicide and emphasize examples of what stakeholders can do to prevent suicide (to allow existing or new suicide prevention partners to see where they fit with others seeking to address suicide).
5. Complement the 2012 NCIOM Plan developed for the DMH/DD/SAS.
6. Use the plan development process as motivator to build partnerships among a wide range of stakeholder groups.
7. Include summary information about evidence-based strategies, yet remain strategic in limiting how much educational material is included in the plan (i.e., by including links to existing resources that describe the problem, risk and protective factors, and/or effective strategies, when possible).

C. Identification N.C. Suicide Prevention Stakeholders and Formation of Working/Consulting Groups

The process to develop the *2015 N.C. Suicide Prevention Plan* provided multiple opportunities to increase networking and communication among suicide prevention stakeholders in the state of North Carolina.

By early 2014, the planning team identified a list of stakeholders involved with suicide prevention activities across the state. The original list of approximately 150 stakeholders was identified through discussion among planning team members, with N.C. Division of Public Health IVP Branch staff, and a review of stakeholders who helped to develop the 2004 youth suicide prevention plan. The planning team also used the *2012 National Strategy for Suicide Prevention* (DHHS, 2012) as a guide to organize its initial list into 10 stakeholders groups. For example, the planning team: combined Federal/State/Local Government Agencies/Departments into one group; separated Primary/Secondary School from College/University (the latter emphasizing direct involvement with students); and added several other distinct stakeholder groups (Appendix Table B-1).

Appendix Table B-1. Ten Stakeholder Groups Identified for the 2015 N.C. Suicide Prevention Plan Development Process				
Government Agencies/ Departments (Federal/State/Local)	Tribal Governments	Healthcare Systems, Insurers, and Clinicians	Businesses, Employers, and Professional Associations	Primary and Secondary Schools
Colleges or Universities (direct student involvement)	Nonprofit, Community, and Faith-based Organizations	Research Organizations (including universities)	Individuals, Families, and Concerned Citizens	Military Entities

Acknowledging the limitations that stakeholders can experience when participating in statewide strategic planning processes (e.g., limited time, travel and cost restrictions to attend in-person meetings), the planning team asked stakeholders to select their preferred level of input by self-selecting into either a Working Group or Consulting Group. The main difference between the two groups was that Working Group members would attend two in-person meetings during the planning process. Members of both Working and Consulting Groups would also participate in the plan development process in the following ways: a) complete online survey to assess alignment of North Carolina activities and needs with the *2012 NSSP*; b) identify examples of what stakeholders in North Carolina are doing to address suicide; c) provide feedback (via email) on drafts of individual plan sections; d) review (via email) near final draft of full state plan; e) be invited to provide a formal endorsement of the final plan; and f) promote and disseminate the final plan once completed.

From January to February 2014, the planning team conducted outreach efforts to its original list of suicide prevention stakeholders by sending email invitations to participate in the plan development process. During this time, approximately 120 additional stakeholders were recommended for referral, and contacted by the planning team. In total, the planning team emailed more than 275 stakeholders with an invitation that included the following components:

1. An announcement of the process to develop a *2015 N.C. Suicide Prevention Plan* , including a description of how the 2015 plan would build on the 2004 youth suicide prevention plan and complement the 2012 *Suicide Prevention and Intervention Plan* developed by the NCIOM for the DMH/DD/SAS.
2. A request to respond to a brief online survey (web link provided) designed to: identify a stakeholder's preferred level of participation in the planning process (e.g., Working Group, Consulting Group, or decline to participate); and collect names and contact information for other stakeholders to invite (the original list of stakeholders, organized by stakeholder group, was provided for review).
3. An announcement that Working and Consulting Group members would be asked to complete a more in-depth on-line survey to assess how/the degree to which stakeholders believe North Carolina's suicide prevention activities and needs align with *2012 NSSP* (web link to the *2012 NSSP* provided).
4. A description of the dates identified for the two in-person meetings that Working Groups members would be invited to attend (April 30, 2014 and June 24, 2014).
5. A request to forward the invitation email to other stakeholders (internal or external) involved with suicide prevention (e.g., if the person originally contacted was not able, or was the incorrect contact at the organization, to commit to participate).
6. Links to other resources, including the full *2012 NSSP* and an eight-page PDF summary of the *2012 NSSP* developed by the planning team.

During this initial invitation process, approximately 63 percent of those contacted replied, with 92 stakeholders (52 percent) self-selecting into the Working Group, 66 stakeholders (37 percent) self-selecting into the Consulting Group, and 19 stakeholders (11 percent) declining to participate. In late February 2014, Alan Dellapenna, IVP Branch Head, sent stakeholders expressing interest in joining the Working and Consulting groups an email to thank them for agreeing to participate and to describe the next steps in the planning process.

Additional stakeholders joined the plan development process at various points following the initial invitation period. This resulted in 118 stakeholders in the Working Group and 66 in the Consulting Group, for a total of 184 stakeholders participating.

D. Completion of Online Survey to Assess Alignment with the 2012 NSSP

In late February/early March 2014, planning team members developed an on-line survey for Working and Consulting Group members to:

1. Assess applicability of *2012 National Strategy for Suicide Prevention* (NSSP) to N.C. Suicide Prevention activities.
2. Assess if the work currently being conducted by N.C. organizations aligns with the NSSP goals.
3. Prioritize NSSP goals for inclusion in the *2015 N.C. Suicide Prevention Plan.*
4. Collect additional information about stakeholders work.

The survey provided an opportunity to introduce additional details about the *2012 NSSP* strategic directions and goals. In addition to an eight-page PDF summary of the *2012 NSSP* developed by the planning team, the survey provided a five-page list of examples of suicide prevention activities occurring in North Carolina. The planning team also included survey questions designed to obtain information to inform the structure of the first working group meeting (e.g., by identifying more about respondents work, knowledge, skills, and interests in suicide prevention). The survey was sent to all Working and Consulting Group members and included seven primary components, each with separate scales and responses (Appendix Table B-2).

Appendix Table B-2. Working and Consulting Group Survey Components and Scale/Response Categories.	
Component	Component
1. Stakeholder Group Membership (primary)	Select one of 11 groups
2. Degree to which N.C. as a whole addresses NSSP goals	0 = not at all, 7 = completely
3. Degree to which organization addresses NSSP goal s	0 = not at all, 7 = completely
4. Prioritization of NSSP goals for use in N.C.	Select minimum of 4, maximum of 7
5. Level of professional expertise with strategic directions	0 = Novice, 7 = Expert
6. Geographical areas served by organization	City, County, Region, State, Natl., Other
7. Current work focus (using Continuum of Care model)	1-Prevention; 2-Early Intervention Screening, 3-Crisis

	Services, 4- Treatment; 5-Recovery; 6-Post-vention; 7-Broad-based

The response rates from both the Working and Consulting Groups were high (82 percent overall for both groups combined).

Survey results indicated: a) range of expertise across Stakeholder Groups; b) range of work focus, with highest concentration of work among respondents in Prevention, Early Intervention Screening, and Intervention (which includes Crisis Services, Treatment, and Recovery) levels of the Continuum of Care (CoC) model; and c) need for networking (i.e., a limited knowledge of who is doing what in suicide prevention in North Carolina).

Another finding from the survey was the degree to which respondents felt that *2012 NSSP* goals should be included or prioritized in the *2015 N.C. Suicide Prevention Plan.* Eight NSSP goals were prioritized by ≥50 percent of respondents and five NSSP goals were prioritized by fewer than ≤43 percent of respondents. The survey also assessed differences between the degree to which stakeholders believe North Carolina as a whole and respondents organizations, specifically, are addressing NSSP goals (on a scale of 0 not at all to 7 completely). In general, respondents felt that their organizations were working in suicide prevention similarly to the state as a whole for Strategic Directions 1-3. Strategic Direction 4 had a noticeable difference between what respondents felt the state was doing as a whole when compared to what their organizations were doing, however, many respondents also selected don't know for how the state or their organization was addressing goals for Strategic Direction 4.

During the survey development process, planning team members decided to capitalize on an in-person opportunity to collect feedback about the *2012 NSSP* among youth, rather than asking youth members in either the Working or Consulting Groups to complete the online survey. At a regularly scheduled Youth Advisory Council (YAC) meeting held in March 2014, two planning team members assisted with the facilitation of a structured focus group that:

- Prioritized eight NSSP goals for the North Carolina plan (Goals 1, 3, 4, 6, 7, 9, 10 11, and 13)
- Identified current activities in suicide prevention that are valuable to them as youth
- Discussed youth roles in suicide prevention, including youth roles as leaders for suicide prevention
- Identified what stakeholders are doing well to address suicide
- Identified things stakeholders could be doing better to address suicide
- Discussed opportunities for the Working and Consulting groups to value youth input into the plan development process.

E. In-Person Working Group Meeting #1

On April 30, 2014, planning team members facilitated a *2015 N.C. Suicide Prevention Plan* Working Group meeting in Raleigh, NC. Sixty-two Working Group members from all ten stakeholder groups (Appendix Table B-1) attended the meeting.

The goal of the meeting was to engage stakeholders in the process to develop a *2015 N.C. Suicide Prevention Plan* that identifies collective efforts to address suicide in North Carolina. To reach this goal, the following three objectives were highlighted during different meeting sessions: 1) Build shared understanding of suicide prevention in North Carolina; 2) Conduct small group work to identify which/how NSSP objectives fit with North Carolina efforts to prevent suicide and examples of stakeholder group roles/opportunities to address NSSP objectives; 3) Provide opportunities for networking within/among stakeholder groups**.**

The meeting agenda was organized into 10 parts:

1. Welcome, Review of Agenda and Introductions/Networking
2. Overview of the 2014 Suicide Prevention Plan Development Process
3. Interactive Stakeholder Small Group Activity
4. Overview of the Burden of Suicide in North Carolina
5. Overview of State-wide Efforts to Prevent Suicide
6. Call to Action for Preventing Suicide in North Carolina
7. Working Lunch

8. Breakout Session Parts I and II (Identify and discuss how NSSP objectives fit with North Carolina suicide prevention efforts and examples of stakeholder group opportunities to address objectives); Part III (review the work of parts I and II)
9. Next Steps Discussion
10. Wrap Up and Meeting Feedback Discussion/Form collection

Two meeting activities involved discussion and the collection of Working Group ideas about the *2015 N.C. Suicide Prevention Plan.* During a morning Stakeholder Group Activity, participants worked to answer two questions: 1) How their group may benefit from having a state plan; and 2) Who may be missing from the stakeholder group and how can they try to get them involved? Worksheets were provided for groups to document and submit one set of answers discussed per table. Participants used large post-it notes to display their responses. Attendees reviewed stakeholder postings throughout the day.

The majority of the afternoon sessions at the meeting involved a three-part breakout session.

Breakout Session Part I: Revising/Refining Objectives and Identifying Examples to Address Suicide in North Carolina
Organized in small groups by strategic direction expertise (including a diversity of stakeholder groups when possible), attendees worked in assigned groups to complete the following steps:

Step 1:

- Reviewed a list of NSSP objectives (that correspond to each strategic direction and goal) to determine how the objectives should remain for consideration in the plan.
- Decided if the objective fits for North Carolina and if not, removed it from further consideration.
- Noted ideas for how the objective could be revised to better fit were recorded when applicable.
- Identified additional objectives, when necessary, to support the related NSSP goal in North Carolina.

Step 2:

- Identified stakeholder groups that have opportunities to address the objectives selected in Step 1.
- Identified examples of stakeholder groups who could be or are already working to prevent suicide in North Carolina.

Breakout Session Part II: Revising/Refining Objectives and Identifying Examples to Address Suicide in North Carolina
Share results from small group work within a strategic direction. Participants discussed which objectives were kept as is, modified or added within each strategic direction. Facilitators identified one or two points of contact (for each goal group) who agreed to review a summary of goal group discussions (documented by a note-taker) following the meeting.

Breakout Session Part III: Review of Breakout Session Results
To share results from, and collect comments about, small group work across strategic directions, attendees visited visual lists for each strategic direction to study the goals, objectives, and stakeholder group role examples identified by goal groups in Steps #1 and #2.

F. Online Exercise to Refine Examples Identified for Plan Objectives

On May 19, 2014, planning team members conducted additional follow-up with Working and Consulting Group members by emailing a web link to a Summary of the April 30, 2014 Working Group meeting. The document included a summary of meeting accomplishments, summary of small group activities, and a summary of feedback collected using a meeting feedback form.

Included with this communication, working and consulting group members were reminded that at the April 30, 2014 meeting, Working Group members (organized by strategic directions and goals from the *2012 NSSP*) developed a preliminary list of examples or opportunities that stakeholder groups currently contribute or could contribute to address suicide in North Carolina. To augment this preliminary list, planning team members invited Working and Consulting Group members to complete an on-line exercise designed to collect additional input on examples or opportunities of what stakeholder groups are doing or could be doing to address suicide in NC.

To complete the exercise, Working and Consulting group members were provided opportunities to select or skip strategic directions, goals, and objectives that they would review (e.g., because of varying interest, knowledge, skill, or experience levels). For each goal respondents selected to review, they had the opportunity to review and provide additional examples for the associated objectives. Each objective included a list of stakeholder group examples as identified prior to or during the April 30, 2014 meeting. For each objective respondents selected to review, they had the option to add additional stakeholder group examples.

Respondents decided how they wanted to approach the exercise. They could choose to review: a) only those goals and objectives for which they felt they had adequate expertise; b) only those goals and objectives for which they believed the stakeholder group(s) they align with have a role; or c) all of the goals and objectives. Respondents could start and end the exercise at any point prior to the deadline (June 2, 2014) and could return to the survey multiple times (provided the exercise was completed at the same computer each time). Responses collected were confidential, not anonymous (responses were linked to IP addresses using the program to track progress).

A total of 78 members of the Working and Consulting Group participated in the exercise (response rate = 47.6 percent) and over 500 additional examples were identified for the state plan. Following the collection of examples, planning team members edited the examples for clarity, consistency, and relevance to the objectives. In many cases, action words were added to the examples for consistency in how all examples were worded and also to show intent of the stakeholder group for which examples were provided. In some cases, planning team members moved examples to different objectives because they related more clearly and directly to a different objective.

G. In-Person Working Group Meeting #2

On June 24, 2014, planning team members facilitated the second *2015 N.C. Suicide Prevention Plan* Working Group meeting at the Unitarian Universalist Fellowship in Raleigh. Sixty of the 118 Working Group members from a variety of stakeholder groups (Appendix Table B-1) attended the meeting.

The goal of the meeting was to continue engagement with stakeholders to develop a *2015 N.C. Suicide Prevention Plan* that identifies collective efforts to address suicide in North Carolina. To reach this goal, the following four objectives were addressed during the meeting:

1. Prioritize goals and objectives for inclusion in the plan.
2. Identify and fill gaps in a list of Stakeholders examples to address suicide prevention in North Carolina.
3. Discuss and identify next steps for the *2015 N.C. Suicide Prevention Plan* development process.
4. Provide opportunities for networking among stakeholder groups.

The meeting agenda was organized into 12 parts:

1. Welcome, Review of Agenda and Introductions
2. Overview of the *2015 N.C. Suicide Prevention Plan* Development Process to Date
3. Introduction to Prioritization of Objectives by Importance and Feasibility
4. Small Group Work to Prioritize Objectives by Importance and Feasibility
5. Introduction to Walkabout Activity
6. Walkabout Activity: Review Prioritization Results for each strategic direction
7. Discuss Observations from Walkabout Activity
8. Small Group Activity to Address Gaps in Stakeholder Group Suicide Prevention Examples for Prioritized Objectives
9. Small Group Activity to identify Communication, Dissemination and Endorsements Opportunities for the Completed *2015 N.C. Suicide Prevention Plan*
10. Overview of Next Steps
11. Large Group Activity to Collect Feedback about Continued Engagement
12. Wrap Up and Completion of Meeting Feedback Forms

Planning team members facilitated discussion using three interactive activities designed to inform content for and communication about the *2015 N.C. Suicide Prevention Plan:* 1) Prioritization Activity; 2) Assessment of Gaps in Suicide Prevention Examples Activity; and 3) Communication, Dissemination, and Endorsements Activity

1. Prioritization Activity

The first activity was conducted in small groups, whereby participants worked to prioritize objectives, previously identified by Working Group members, by importance and feasibility. Attendees were divided into four breakout groups aligning with the strategic directions in the 2012 National Strategy for Suicide Prevention (NSSP) (Appendix Table B-3). Group assignment was based on attendees self-reported area of expertise. Across the four strategic direction small groups, the number of attendees ranged from 7 to 19.

Appendix Table B-3. Strategic Direction Breakout Group Goals, Objectives and Attendees.[a]

Strategic Direction	Goal #s	# of Objectives	# Mtg. Attendees
#1 - Healthy and Empowered Individuals, Families, and Communities	1, 2, 3, 4	14	18
#2 - Clinical and Community Preventive Services	5, 6, 7	12	19
#3 - Treatment and Support Services	8, 9, 10	21	17
#4 - Surveillance, Research, and Evaluation	11, 12, 13	14	7

[a] On June 10, 2014, planning team members sent a follow-up communication to Working Group members describing that a portion of the meeting would involve small group work with attendees divided into one of four strategic direction small groups. Working Group members were provided an opportunity stay in, or change, strategic direction small groups to which they were assigned at the April 30, 2014 meeting, if desired.

Each small group was facilitated by planning team members through a three-step prioritization activity, designed to assess importance and feasibility for the list of objectives previously identified for the strategic direction. Depending on group size and number of objectives for a strategic direction, each group was given a predetermined number of dots to use as votes for the first round of voting for importance. The second round of voting was conducted for feasibility.

Step I: for **importance**, participants were asked to vote (by placing a dot on large flip-chart paper) for objectives they identified as important. Participants were asked to consider importance as a combination of factors related to the objective:

1. Reduces the burden of suicide in North Carolina
2. Uses strategies that employ evidence-based practices
3. Promotes sustained/long-lasting effects for North Carolina residents
4. Uses a comprehensive approach that targets multiple levels (e.g., individual, relationship, community, society)
5. Uses interventions that are cost-effective
6. Addresses specific high-risk populations in North Carolina
7. Addresses health disparities for suicide

Following voting, planning team members facilitated group discussion to build consensus and understanding for importance.

Step II: for **feasibility**, participants were asked to assess the feasibility to achieve the objectives judged important during the first round of voting. Feasibility was rated by participants placing a dot on large flip-chart paper under the most appropriate column (High, Medium, or Low feasibility or attendees could also indicate Don't Know). Prior to voting, participants were asked to consider whether the objective could be accomplished in the immediate short-term (e.g., next 2 years). Thus to judge the feasibility of an objective participants were asked to consider: a) work is already under way to accomplish the objective, and/or; b) current capacity exists to achieve the objective (e.g., resources, staffing, and expertise). Following voting, planning team members facilitated discussion to build consensus for the feasibility ratings identified. To complete the activity, each small group identified the objectives judged as Important and with High and/or Medium feasibility (i.e., prioritized objectives) using stars (*) on the flip-chart paper used in each small group. These flipcharts were then posted in the large meeting room.

Step III: Following a brief lunch, all meeting attendees reconvened in the main room to conduct a walkabout activity designed to build consensus about the objectives prioritized by small groups. Relevant comments and suggestions received during this exercise were incorporated into the process by planning team members. Some of the information collected provided additional examples for how stakeholders can address suicide prevention in North Carolina.

As a final outcome of the three-part prioritization activity, a total of 32 objectives were identified as prioritized objectives for emphasis in the *2015 N.C. Suicide Prevention Plan.* Following the meeting, planning team members also created a weighted score to standardize ratings across small groups. To do so, the total number of votes cast for importance for each objective was divided by the number of participants voting (small groups organized by strategic direction included a range of 7 to 19 participants, Appendix Table 3).

2. Assessment of Gaps in Suicide Prevention Examples Activity

Working by tables assigned by Stakeholder Groups attendees completed an activity to fill in the gaps for examples by objective identified (during the prior activity) as most important/most feasible. Table groups were encouraged to focus their efforts to identify additional examples for objectives that, previously, had no or few examples identified for their specific stakeholder group (or other stakeholder groups, time permitting). The primary purpose of this exercise was to ensure comprehensiveness in the number and types of examples that describe how a variety of North Carolina stakeholder groups can work to address the prioritized objectives. A total of 149 additional examples were collected at the meeting, added to the 504 collected prior to the meeting, for a grand total of 653 examples.

3. Communication, Dissemination, and Endorsements Activity

During the final activity of the meeting, attendees were sitting at tables organized by stakeholder group. Each table was asked to brainstorm opportunities for communication and dissemination of the *2015 N.C. Suicide Prevention Plan.* To guide this discussion, each table was provided with a worksheet including three questions: 1) What type of announcements or other events could be used to inform the public of the plan's completion; 2) Who should be notified directly about this plan's existence; and 3) What are the ways we could notify them (e.g., what are our dissemination options).

A total of 172 communication and dissemination methods were identified by small groups. The most common responses were Media (n=43), social media (n=18), the use of professional boards, associations, societies and other groups (n=14) and the use of websites (n=11).

In addition, a total of 159 suggestions were provided about specific populations that can be targeted using communication and dissemination efforts for the *2015 N.C. Suicide Prevention Plan.* The most common audiences/ populations identified include: State, City and County Government Officials (n=17), professional organizations and associations (n=13), mental health promotion and suicide prevention organizations (n=13), medical providers and affiliated groups (n=12), nonprofit and community based groups (n=11), and mental health and substance abuse providers and systems of care (n=10).

On July 31, 2014, planning team contacted Working Group and Consulting Group members by emailing a web link to a Summary of the June 24, 2014 Working Group meeting. The document included a summary of meeting accomplishments, written feedback from small group activities, and a summary of feedback/satisfaction collected using a meeting feedback form.

H. Review Process for Draft 2015 N.C. Suicide Prevention Plan

In August/early September, planning team members developed and reviewed initial drafts of sections to be included in the *2015 N.C. Suicide Prevention Plan.* They also agreed on the importance that formatting for the plan should include easy-to-navigate hyperlinks for the on-line version of the plan. Also during this time, two UNC Team members also edited the list of stakeholder group examples for clarity, consistency, and relevance to the objectives. In many cases, action words were added to the examples for consistency in how all examples were worded and also to show intent of the stakeholder group for which examples were provided. In some cases, planning team members moved examples to different objectives because they related more clearly/directly to a different objective.

In late September 2014, planning team members developed an online method by which Working and Consulting Group members could provide feedback on a full draft of the *2015 N.C. Suicide Prevention Plan.* The online exercise allowed Working and Consulting Group members to review individual sections or the entire plan (skip patterns allowed reviewers to provide feedback on only the sections for which they wanted to provide feedback).

For each section of the plan, reviewers had the opportunity to provide: a) general feedback; b) specific comments on the section's clarity/purpose; c) additional concepts they would like to see included; and d) feedback about the ease/challenges faced in navigating through the plan (e.g., formatting, use of hyperlinks). Responses collected were confidential, not anonymous (due to responses being linked to IP addresses).

Following the collection and integration of feedback provided via the online exercise, the planning team emailed Working and Consulting Group members, in late October 2014, a near final version of the *2015 N.C. Suicide Prevention Plan.* This version was provided so that Working and Consulting Group members could seek formal endorsements from the organization(s) they represent. The communication sent by the planning team described process by which endorsements could be provided, and showed an example of how an entity endorsing the plan would be listed in the final version of the plan. All endorsements were collected by December 31, 2014.

After a formal review and minor editing by the Office of Communications at the North Carolina Division of Public Health, the final version of the *2015 N.C. Suicide Prevention Plan* was completed in January 2015 and uploaded to the N.C. Injury and Violence Prevention Branch's Suicide prevention website.

APPENDIX C. 2015 N.C. SUICIDE PREVENTION GOALS AND OBJECTIVES

To align with the 2012 National Strategy for Suicide Prevention (NSSP) (DHHS, 2012), North Carolina has identified 13 goals and 61 objectives to address suicide prevention. This appendix includes a list of all goals and objectives identified. Objectives that stakeholders identified as Prioritized (n=32) (please see Appendix B and Sub-Section G for a description of prioritization process used) are noted in rows that are color-shaded, within each of the four strategic directions, including: 1) Healthy and Empowered Individuals, Families, and Communities; 2) Clinical and Community Preventive Services; 3) Treatment and Support Services; and 4) Surveillance, Research, and Evaluation.

Appendix Table C-1. N.C. Suicide Prevention Plan Goals and Objectives.
Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.
Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.
Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.
Sustain and strengthen collaborations across state agencies to advance suicide prevention.
Develop and sustain public-private partnerships to advance suicide prevention.
Integrate suicide prevention into all relevant health care reform efforts.
Create a Master List of what agencies are doing in suicide prevention.
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.
Develop, implement, and evaluate communication efforts designed to reach defined segments of the population
Reach policymakers with dedicated communication efforts.
Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.
Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.
Promote effective programs/practices that increase protection from suicide risk.
Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
Promote the understanding that recovery from mental and substance use disorders are real and possible for all.
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.
Accurate data and resources readily available and accessible for pick up use by media and other.
Strategic Direction 2: Clinical and Community Preventive Services
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.
Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.
Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.
Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.
Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
Develop and implement new safety technologies to reduce access to lethal means.
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
Develop training on suicide prevention to community groups.
Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-

Appendix Table C-1. N.C. Suicide Prevention Plan Goals and Objectives.
risk behavior, and the delivery of effective clinical care for people with suicide risk.
Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.
Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.
Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.
Employ cultural competence; training should be universally designed and available.
Strategic Direction 3: Treatment and Support Services
GOAL 8. Promote suicide prevention as a core component of health care services.
Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.
Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.
Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.
Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.
Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.
Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.
Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.
Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.
Promote the safe disclosure of suicidal thoughts and behaviors by all.
Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.
Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.
Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.
Implement guidelines on documentation of assessment and treatment of suicide risk.
Provide ongoing training and technical assistance for all objectives for Goal 9.
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.
Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.
Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.
Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Appendix Table C-1. N.C. Suicide Prevention Plan Goals and Objectives.
Strategic Direction 4: Surveillance, Research and Evaluation
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.
Improve the timeliness of reporting vital records data.
Improve the usefulness and quality of suicide-related data.
Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.
Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.
GOAL 12. Promote and support research on suicide prevention.
Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.
Disseminate and implement the state suicide prevention research agenda.
Promote the timely dissemination of suicide prevention research findings.
Develop and support a repository of research resources to help increase and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.
Evaluate the effectiveness of suicide prevention interventions.
Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.
Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.
Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.
Identify potential stakeholders necessary to disseminate evidence.
Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).

APPENDIX D. *2015 N.C. Suicide Prevention Plan* STRATEGIC DIRECTIONS, GOALS AND OBJECTIVES BY STAKEHOLDER GROUP EXAMPLES

A. Summary Information about Examples Identified by Strategic Direction and Goals

Organized by strategic direction, *Appendix Table D-1 - 4* show the number of examples identified for each goal by stakeholder group. For all goals, planning process participants identified examples for almost all stakeholder groups. For some stakeholder groups, however, no examples were identified. In these cases, this does not mean that the stakeholder group(s) do not have a role to address the goal, simply that examples were not identified. Developers of the plan did not intend to identify examples for every stakeholder and every goal. Section B of Appendix D summarizes the total number of examples identified for each objective by stakeholder group.

Strategic Direction #1 Healthy and Empowered Individuals, Families, and Communities

This strategic direction identifies how to promote prevention and awareness of suicide through education, provision of support and mental health services, provision of community trainings and services, outreach through schools, organizations, agencies and workplaces to increase our efforts and provide effective activities to prevent suicide and suicidal behaviors. Plan developers identified the greatest number of examples for goals in this strategic direction and examples were identified for all stakeholder groups for all four goals (Appendix Table D-1). Section B of Appendix D summarizes the total number of examples identified for all objectives (n=14) in strategic direction #1, by stakeholder group.

Appendix Table D-1. Number of Strategic Direction #1-Healthy and Empowered Individuals, Families, and Communities Examples by Goals and Stakeholder Group(s).

SD/Goal	Govt.	Tribal	Health	Bus.	Schools	College	Non-profit	Re-search	Indiv.	Military
Goals for SD #1	55	29	45	28	48	47	51	30	36	29
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	22	10	14	10	22	20	18	7	9	10
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	18	8	14	8	10	11	17	10	13	7
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	7	4	10	6	12	9	12	5	9	7
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.	8	7	7	4	4	7	4	8	5	5

Strategic Direction #2 Clinical and Community Preventive Services

This strategic direction identifies how to prevent suicide and suicidal behaviors through crisis intervention trainings and the incorporation of first responders/public safety officials in the development and implementation of effective practices. It describes different mechanisms to engage staff and coworkers into programs and/or trainings to develop skills to encourage risk reduction and suicide prevention and awareness. Plan developers identified examples for the majority of stakeholder groups for the three goals in Strategic Direction #2. The greatest number of examples were identified for two of the 10 stakeholder groups: Government Agency/Departments (Federal, State, and Local) and Health Care Systems, Insurers and/or Clinicians (Appendix Table D-2). Section B of Appendix D summarizes the total number of examples identified for all objectives (n=12) in Strategic Direction #2, by stakeholder group.

Appendix Table D-2. Number of Strategic Direction #2-Clinical and Community Preventive Services Examples by Goals and Stakeholder Group(s).										
SD/Goal	Govt.	Tribal	Health	Bus.	Schools	College	Non-profit	Re-search	Indiv.	Military
Goals for SD #2	35	10	28	10	21	21	21	12	19	9
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.	13	4	6	6	10	9	10	6	9	3
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	8	2	6	0	1	1	2	4	4	3
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	14	4	16	4	10	11	9	2	6	3

Strategic Direction #3 Treatment and Support Services

This strategic direction identifies how critical community and support systems are in suicide prevention and awareness. It addresses how trainings can provide appropriate resources for personnel to respond to an attempt/crisis situation. Collaborating stakeholders prepare the community/group/individual to provide effective and evidence based practices for suicide prevention. Plan developers identified examples for all stakeholder groups for each of the three goals in Strategic Direction # 3 (Appendix Table D-3). Section B of Appendix D summarizes the total number of examples identified for all objectives (n=21) in Strategic Direction #2, by stakeholder group.

Appendix Table D-3. Number of Strategic Direction # 3-Treatment and Support Services Examples by Goals and Stakeholder Group(s).										
SD/Goal	Govt.	Tribal	Health	Bus.	Schools	College	Non-profit	Re-search	Indiv.	Military
SD #3 Goals	31	5	57	10	24	14	21	7	14	9
GOAL 8. Promote suicide prevention as a core component of health care services.	12	3	31	4	3	3	7	1	4	3
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	9	1	15	4	12	4	11	3	6	3
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	10	1	11	2	9	7	3	3	4	3

Strategic Direction #4 Surveillance, Research and Evaluation

Strategic direction four addresses how data and surveillance systems can be increased/streamlined to enhance tracking and prevention of suicide and suicidal behaviors. The government, working directly with local research organizations, can develop, enhance and streamline existing mechanisms to understand the circumstantial characteristics of suicide and suicidal behaviors. This section also identifies areas for future funding, development, and support. Plan developers identified examples for all stakeholder groups for the three goals in Strategic Direction # 4 (Appendix Table D-4); however, the majority were identified for Governmental Agency/Department (Federal, State, and Local) and Research Organizations. One third of all examples identified for Research organizations were for Strategic Direction #4. Section B of Appendix D summarizes the total number of examples identified for all objectives (n=14) in Strategic Direction #4, by stakeholder group.

Appendix Table D-4. Number of Strategic Direction # 4 Examples by Goals and Stakeholder Group(s).										
SD/Goal	Govt.	Tribal	Health	Bus.	Schools	College	Non-profit	Re-search	Indiv.	Military
SD #4: Surveillance, Research and Evaluation	33	4	14	6	11	13	7	28	4	4
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.	16	2	7	2	6	5	2	8	1	3
GOAL 12. Promote and support research on suicide prevention.	7	0	0	0	0	1	0	8	0	0
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	10	2	7	4	5	7	5	12	3	1

B. Summary Information about Examples Identified by Objectives by Stakeholder

Organized by strategic direction, Tables D-5 to D- 8 show the number of examples identified for each objective by stakeholder. Prioritized objectives are those with **bold** formatting. The numbers of examples are hyperlinked to the stakeholder's examples listed in Section 6.

Strategic Direction #1 Healthy and Empowered Individuals, Families, and Communities

Strategic direction one identifies how to promote prevention and awareness of suicide through education, provision of support and mental health services, provision of community trainings and services, outreach through schools, organizations, agencies and workplaces to increase our efforts and provide effective activities to prevent suicide and suicidal behaviors. Table D-5 includes the number of examples identified by objective and stakeholder group for Strategic Direction #1.

Appendix Table D-5. Number of Examples for Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.										
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.	**6**	**1**	**4**	**4**	**9**	**10**	**6**	**1**	**4**	**2**
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.	6	1	1	1	7	4	4	1	1	3
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.	4	3	3	1	4	1	4	1	2	2

Appendix Table D-5. Number of Examples for Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
1.4 Develop and sustain public-private partnerships to advance suicide prevention.	2	1	1	1	1	1	2	2	1	1
1.5 Integrate suicide prevention into all relevant health care reform efforts.	**4**	**4**	**5**	**3**	**1**	**3**	**2**	**2**	**1**	**2**
1.6 Create a Master List of what agencies are doing in suicide prevention.	0	0	0	0	0	1	0	0	0	0
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.										
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population	**4**	**2**	**5**	**2**	**4**	**4**	**5**	**2**	**3**	**2**
2.2 Reach policymakers with dedicated communication efforts.	**5**	**2**	**4**	**3**	**2**	**4**	**4**	**5**	**4**	**2**
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.	5	1	1	2	2	2	4	2	2	2
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.	**4**	**3**	**4**	**1**	**2**	**1**	**4**	**1**	**4**	**1**
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.										
3.1 Promote effective programs/practices that increase protection from suicide risk.	**3**	**2**	**5**	**2**	**4**	**5**	**7**	**2**	**6**	**3**
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	**3**	**1**	**3**	**3**	**7**	**3**	**2**	**2**	**2**	**3**
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.	**1**	**1**	**2**	**1**	**1**	**1**	**3**	**1**	**1**	**1**

Appendix Table D-5. Number of Examples for Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.										
4.1 Accurate data and resources readily available and accessible for use by media and other.	8	7	7	4	4	7	4	8	5	5

Strategic Direction #2 Clinical and Community Preventive Services

Strategic direction two identifies how to prevent suicide and suicidal behaviors through crisis intervention trainings and the incorporation of first responders/public safety officials in the development and implementation of effective practices. SD2 identifies different mechanisms to engage staff and coworkers into programs and/or trainings to develop skills to encourage risk reduction and suicide prevention and awareness. Appendix Table D-6 includes the number of examples identified by objective and stakeholder group for Strategic Direction #2.

Appendix Table D-6. Number of examples for Strategic Direction 2: Clinical and Community Preventive Services by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.										
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.	5	1	2	3	2	2	3	2	3	1
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.	2	1	1	1	4	2	2	2	4	1
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.	6	2	3	2	4	5	5	2	2	1
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.										
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.	4	1	6	0	1	1	1	2	4	2

Appendix Table D-6. Number of examples for Strategic Direction 2: Clinical and Community Preventive Services by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.	2	1	0	0	0	0	1	0	0	1
6.3 Develop and implement new safety technologies to reduce access to lethal means.	2	0	0	0	0	0	0	2	0	0
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.										
7.1 Develop training on suicide prevention to community groups.	**6**	**2**	**4**	**2**	**7**	**2**	**4**	**0**	**3**	**1**
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.	**4**	**1**	**6**	**1**	**1**	**2**	**2**	**1**	**2**	**1**
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.	**0**	**0**	**1**	**0**	**0**	**4**	**0**	**0**	**0**	**0**
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.	0	0	0	0	0	0	0	0	0	0
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.	**4**	**1**	**5**	**1**	**2**	**3**	**3**	**1**	**1**	**1**

Appendix Table D-6. Number of examples for Strategic Direction 2: Clinical and Community Preventive Services by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
7.6 Employ cultural sensitivity; training should be universally designed and available.	0	0	0	0	0	0	0	0	0	0

Strategic Direction #3 Treatment and Support Services

Strategic direction three identifies how critical community and support systems are in suicide prevention and awareness. SD3 addresses how trainings can provide appropriate resources for personnel to respond to an attempt/crisis situation. Collaborating stakeholders prepare the community/group/individual to provide effective and evidence based practices for suicide prevention. Appendix Table D-7 includes the number of examples identified by objective and stakeholder group for Strategic Direction #3.

Appendix Table D-7. Number of Examples for Strategic Direction 3: Treatment and Support Services by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
GOAL 8. Promote suicide prevention as a core component of health care services.										
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.	1	1	2	0	0	0	0	0	0	0
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.	**3**	**1**	**3**	**2**	**2**	**2**	**1**	**1**	**1**	**1**
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.	**3**	**1**	**6**	**1**	**0**	**0**	**2**	**0**	**0**	**1**
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.	0	0	5	0	0	0	0	0	0	0

Appendix Table D-7. Number of Examples for Strategic Direction 3: Treatment and Support Services by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.	2	0	4	0	0	0	0	0	0	0
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.	2	0	3	1	1	1	3	0	2	1
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.	0	0	1	0	0	0	0	0	0	0
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.	**1**	**0**	**7**	**0**	**0**	**0**	**1**	**0**	**1**	**0**
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.										
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.	**2**	**0**	**4**	**2**	**3**	**2**	**4**	**1**	**2**	**1**
9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.	**2**	**0**	**4**	**1**	**4**	**1**	**3**	**0**	**1**	**1**

Appendix Table D-7. Number of Examples for Strategic Direction 3: Treatment and Support Services by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.	**3**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**1**	**0**
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental and/or substance use disorders.	**2**	**0**	**3**	**0**	**1**	**0**	**1**	**1**	**0**	**0**
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.	0	0	0	0	0	0	0	0	0	0
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.	0	0	1	0	1	0	0	0	0	0
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.	0	0	0	0	0	0	0	0	0	0
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.										
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.	**3**	**0**	**2**	**1**	**3**	**1**	**0**	**1**	**1**	**0**

Appendix Table D-7. Number of Examples for Strategic Direction 3: Treatment and Support Services by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.	2	0	1	0	2	2	0	0	0	1
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**2**	**2**	**2**
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.	2	0	2	0	0	0	0	0	0	0
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.	**1**	**0**	**4**	**0**	**2**	**2**	**1**	**0**	**1**	**0**

Strategic Direction #4 Surveillance, Research and Evaluation

Strategic direction four addresses how data and surveillance systems can be increased/streamlined to enhance tracking and prevention of suicide and suicidal behaviors. The government, working directly with local research organizations, can develop, enhance and streamline existing mechanisms to understand the circumstantial characteristics of suicide and suicidal behaviors. This section also identifies areas for future funding, development, and support. Appendix Table D-8 includes the number of examples identified by objective and stakeholder group for Strategic Direction #4.

Appendix Table D-8. Number of Examples for Strategic Direction 4: Surveillance, Research and Evaluation by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.										
11.1 Improve the timeliness of reporting vital records data.	6	1	4	0	1	1	1	2	0	0
11.2 Improve the usefulness and quality of suicide-related data.	**3**	**0**	**1**	**0**	**1**	**2**	**0**	**3**	**0**	**2**
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.	**5**	**1**	**2**	**1**	**3**	**1**	**1**	**3**	**1**	**1**
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.	2	0	0	1	1	1	0	0	0	0
GOAL 12. Promote and support research on suicide prevention.										
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.	2	0	0	0	0	0	0	2	0	0
12.2 Disseminate and implement the state suicide prevention research agenda.	2	0	0	0	0	0	0	2	0	0
12.3 Promote the timely dissemination of suicide prevention research findings.	2	0	0	0	0	0	0	3	0	0
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prev. and care in the aftermath of suicidal behaviors.	1	0	0	0	0	1	0	1	0	0

Appendix Table D-8. Number of Examples for Strategic Direction 4: Surveillance, Research and Evaluation by Objectives and Stakeholder Group(s).										
SD/Goal/Objective	Govt.	Tribal	Health	Bus.	Schools	College	Nonprofit	Research	Indiv.	Military
GOAL 13. Evaluate the impact/effectiveness of suicide prevention interventions and systems and synthesize/disseminate findings.										
13.1 Evaluate the effectiveness of suicide prevention interventions.	2	0	1	2	1	1	3	2	1	0
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.	1	0	1	1	2	1	0	1	0	0
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.	**1**	**1**	**1**	**0**	**1**	**3**	**0**	**6**	**1**	**0**
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.	3	1	1	1	1	1	1	2	1	1
13.5 Identify potential stakeholders necessary to disseminate evidence.	1	0	0	0	0	0	0	0	0	0
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g. toolkit, resource centers).	**2**	**0**	**3**	**0**	**0**	**1**	**1**	**1**	**0**	**0**

APPENDIX E. *2015 N.C. Suicide Prevention Plan* EXAMPLES BY STAKEHOLDER GROUPS

This appendix provides a list of all examples (of what stakeholder groups can do to address suicide in North Carolina) that were identified during the process to develop the *2015 N.C. Suicide Prevention Plan.* The examples are presented in ascending numerical order by strategic direction, goal, and objective. The examples identified for prioritized objectives are formatted in **bold** (see Appendix B Sub-Section G for a description of the prioritization process). An X indicates the stakeholder group(s) for which the example applies (as identified by stakeholders involved with process to develop this plan). Please note that some examples may apply to other/additional stakeholder groups.

You are encouraged to use this appendix to review examples identified for the stakeholder group(s) to which you belong, and to identify potential partners for collaboration to prevent suicide prevention in North Carolina. The following abbreviations are used for stakeholder group names: ***Govt*** *= Governmental Agencies/Departments (Federal, State, Local);* ***Tribal*** *= Tribal Governments;* ***Hlth*** *= Health Care Systems, Insurers, and Clinicians;* ***Bus*** *= Businesses, Employers, and Professional Associations;* ***Schls*** *= Primary and Secondary Schools;* ***Coll*** *= Colleges and Universities;* ***Nonpro*** *= Nonprofit, Community, and Faith-based Organizations;* ***Rsrch*** *= Research Organizations;* ***Indiv*** *= Individuals, Families, and Concerned Citizens; and* ***Mil*** *= Military Entities.*

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.

Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities											
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.											
1.1 Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.											
1.1.1	Actively and visibly promote suicide awareness, education and outreach on college and university campuses.						x				
1.1.2	Adopt rules or policies that seek to prevent bullying in schools.					x					
1.1.3	Adopt, promote and support Wellness Recovery Action Plans (WRAP) for students and their families.			x		x	x				
1.1.4	Build on the partnership created by the State Health Plan between North Carolina's Division of Public Health, Office of State Personnel, and other key state agencies to identify bureaucratic obstacles to providing worksite wellness programs for state employees and to develop a state policy to address them.	x									
1.1.5	Build partnerships (at multiple levels) for direct admissions in order to eliminate wait lists/lines in healthcare settings.			x							
1.1.6	Collaborate with other colleges/universities to conduct suicide prevention and awareness efforts (e.g., Eastern Carolina University mental health fair is popular among the students on campus).						x				
1.1.7	Encourage North Carolina General Assembly support to include suicide awareness and prevention in workplace safety meetings and briefings.	x								x	
1.1.8	Engage clergy members at suicide prevention stakeholder meetings.							x			

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
1.1.9	Engage in activities to increase emotional intelligence and resiliency as part of character education efforts (e.g., use evidence-based practices such as Dialectical Behavioral Therapy).					x					
1.1.10	Engage leadership level (e.g., chancellor) support for university-wide suicide prevention efforts.						x				
1.1.11	Ensure that Medical Examiners understand the importance of accurate documentation of suicide events, through training and technical assistance.	x									
1.1.12	Ensure access to non-stigmatizing preventative care 24/7 for college and university students						x				x
1.1.13	Ensure that hospital staff understand their roles in preventing suicide by providing training.			x							
1.1.14	Improve linkages to providers after an employee has maximized Employee Assistance Program (EAP) benefits and follow-up on success of referrals.				x						
1.1.15	Improve process for reporting and sharing research findings on suicide prevention at community and organizational levels.								x		
1.1.16	Incorporate multiple suicide prevention focused screenings into all primary health care visits.			x							
1.1.17	Incorporate suicide prevention training into professions that have exposure to traumatic events (e.g., law enforcement, EMS, fire and rescue, emergency department staff).	x									
1.1.18	Increase funding for suicide prevention and treatment services.	x									
1.1.19	Increase the presence and visibility of suicide prevention services provided by Employee Assistance Programs (EAP).				x						
1.1.20	Involve student organizations in suicide prevention efforts conducted on colleges and universities.						x				
1.1.21	Involve/engage existing community and faith-based organizations (e.g., Faith Connections in Mental Illness in Chapel Hill) in conducting suicide prevention efforts in multiple sectors and settings.							x			
1.1.22	Lobby, vote, write legislative representatives and advocate for suicide awareness and prevention.							x		x	
1.1.23	Participate in advocacy and lobbying activities to increase research funding for suicide prevention.									x	

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
1.1.24	Partner with nonprofit/faith-based/community organizations (e.g., Save A Life) to provide suicide prevention and awareness information.					x					
1.1.25	Encourage passage of tribal resolutions supporting suicide prevention and wellness promotion in tribal communities.		x								
1.1.26	Promote grassroots community organizations to increase knowledge of the community needs and strengths while creating a stronger collective voice vis-à-vis government and professional groups.									x	
1.1.27	Promote opportunities of the N.C. Mental Health and Aging Coalition for professional, consumer, and government organizations to work together toward improving the availability and quality of mental health preventive and treatment strategies to older Americans and their families through education, research, and increased public awareness.							x			
1.1.28	Promote resiliency and protective factors in primary schools (e.g., Good Behavior Game) by using recognized programs.					x					
1.1.29	Promote suicide awareness education, outreach events and clubs to facilitate a preventative culture in schools.					x					
1.1.30	Promote suicide prevention through professional associations and through a willingness to fund suicide prevention and awareness efforts.				x						
1.1.31	Promote the engagement of extension services (e.g., NCSU) or 4-H chapters in community family wellness efforts.						x				
1.1.32	Promote the use/adoption of model worksite programs developed by the N.C. Division of Public Health to guide development of worksite wellness policy and wellness interventions.	x									
1.1.33	Promote the value of older adults as experienced contributing members of society.							x			
1.1.34	Review/revise policies when applicable to promote suicide prevention and reduce stigmatization of high risk populations.					x	x				
1.1.35	Seek to develop older adult volunteerism to create a culture of engaged adults with a sense of purpose and connectedness to others.							x			

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
1.1.36	Sponsor support groups/clubs (e.g., Save a Life club) to promote a setting of togetherness and mental wellness for students.					x					
1.1.37	Support Crisis Intervention Team (CIT) training for college/university staff (e.g., campus security, resources officers).					x	x				x
1.1.38	Support wellness promotion activities during times of stress and transition (e.g., finals, college transfers).						x				
1.1.39	Utilize staff input to improve support and workplace wellness programs that seek to prevent suicide.				x						
1.2 Establish effective, sustainable, and collaborative suicide prevention efforts and activities at the state, tribal, and local levels.											
1.2.1	Build partnerships to increase direct admissions for people at risk for suicide.			x							
1.2.2	Create a working partnership with the Local Management Entities (LME) and Managed Care Organizations (MCO) serving their area.					x					
1.2.3	Encourage help-seeking behaviors or opportunities for people with mental health/substance use issues.										x
1.2.4	Encourage Local Education Agencies (LEAs) and other relevant education agencies to adopt and maintain evidence-based prevention programs on a school systems-wide basis.					x					
1.2.5	Establish school district protocols for preventing and addressing potential suicides, including alerts to a student's social media postings.					x					
1.2.6	Identify a lead agency to coordinate and convene public and private stakeholders, assess needs and resources, and develop and implement a comprehensive strategic suicide prevention plan.	x									
1.2.7	Implement and support suicide prevention programs (e.g., student-led *Save A Life* support groups).					x	x				
1.2.8	Increase efforts in communities to offer supports, including identifying which delivery structures might be most effective for the specific community.									x	
1.2.9	Involve Employee Assistance Programs (EAP) in suicide prevention efforts.				x						
1.2.10	Involve military hierarchy in supporting suicide prevention and outreach.										x
1.2.11	Pass tribal resolutions supporting suicide prevention.		x								

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
1.2.12	Promote outreach and education through multiple forms of media, including social communication through texting or Facebook.					x	x				
1.2.13	Promote policies and procedures for re-integrating students to education settings following a suicide attempt.						x				
1.2.14	Promote suicide prevention trainings across settings, including pastors, lay counselors, resource officers, first responders, and teachers.							x			
1.2.15	Promote the de-stigmatization of discussion(s) about suicide or suicide ideation in multiple settings (e.g., church, school, family).							x			
1.2.16	Promote the message that all citizens, regardless of education and profession, can have a role in detecting and preventing suicides.							x			
1.2.17	Promote, increase awareness, and support activities that support State Bill 526: School Violence Prevention--anti-bullying law – to prevent bullying or harassing behavior.	x									
1.2.18	Promote/support anti-bullying programs in schools.					x					
1.2.19	Provide free train-the-trainer events to develop volunteer peer networks as a way to increase sustainability of suicide prevention efforts.	x									
1.2.20	Provide suicide crisis numbers/rape/ domestic violence/mobile crisis numbers accessible to all non-profit, community, or faith-based organization staff.							x			
1.2.21	Require mandatory compliance with use of evidence-based assessment tools to detect and assess mental illness.					x					
1.2.22	Research and identify best way(s) to increase suicide awareness and reduce stigma.								x		
1.2.23	Support and conduct peer led suicide prevention programs (e.g., National Alliance on Mental Illness).										x
1.2.24	Support Crisis Intervention Training (CIT) (e.g., for law enforcement).	x									
1.2.25	Update N.C. Crisis Intervention Training and Suicide Awareness training, which are a part of the NC Training and Standards Commission in the Department of Justice.	x									

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1.2.26	Work with lawmakers and school boards to design, pass, and implement a state initiative to incorporate suicide prevention efforts and teachings into school curricula.	x									
1.2.27	Work with local nonprofits (e.g., National Alliance on Mental Illness) to initiate survivor groups on college and university campuses.						x				
1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.											
1.3.1	Align goals with the Healthful Living Essential Standards for grades 6 to 9 for stress management (e.g., Apply help-seeking strategies for depression and mental disorders).			x							
1.3.2	Collaborate with mental health Local Management Entities (LMEs) on local information, resources, and professional development/training opportunities.	x	x	x		x		x			
1.3.3	Develop community coalitions to bring agencies, peers, and stakeholders into a consolidated effort to prevent suicide.	x									
1.3.4	Encourage students to partner with local mental health, school social workers, and others to conduct awareness sessions and forums addressing suicide prevention.							x			
1.3.5	Include suicide prevention awareness in Healthy Living Curriculum, to address and reduce the stigma of suicide among youth and individuals who work directly with youth.					x					
1.3.6	Lead a working group across agencies and partners to advance state-specific suicide prevention initiatives.	x									
1.3.7	Lead a working group across Tribal agencies and partners to advance tribal specific suicide prevention initiatives.		x								
1.3.8	Participate in community projects to build a culture of recovery that is coordinated and easy to access by military personnel and their families.										x
1.3.9	Participate in state suicide prevention working group(s).		x			x	x				x
1.3.10	Support state suicide prevention working group(s) on as-needed basis.	x		x	x			x	x	x	

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
1.3.11	Work with the school board to write a curriculum that can be initiated in every middle and high school in the county to share: 1) it's OK to ask for help; 2) where to go to get help; and 3) warning signs and risk factors to be able to pick up on an at-risk friend, classmate, sibling, or others.					x		x		x	
1.4 Develop and sustain public-private partnerships to advance suicide prevention.											
1.4.1	Develop and distribute lists of local 'crisis intervention' personnel to law enforcement departments that do not have advanced crisis training.	x									
1.4.2	Develop clinical trials for medications and behavioral modification.								x		
1.4.3	Increase suicide prevention collaboration and education among nonprofit, community, and faith-based organizations.							x			
1.4.4	Lead statewide public/private partnership (modeled on National Action Alliance for Suicide Prevention) to advance suicide prevention.	x									
1.4.5	Participate in state-led public-private partnership to advance suicide prevention.		x	x	x	x	x	x	x	x	x
1.5 Integrate suicide prevention into all relevant health care reform efforts.											
1.5.1	Advocate for greater integrated care in primary care or Emergency Department settings.			x				x			
1.5.2	Advocate to the government to include suicide prevention in healthcare reform.	x	x	x	x	x	x	x	x	x	x
1.5.3	Encourage insurance companies to offer suicide prevention in coverage plans.						x				
1.5.4	Identify alternate services previously offered by Community Mental Health Clinics (CMHC), especially in rural areas.	x									
1.5.5	Improve insurance coverage for mental illness so that it is equal to insurance for physical illness.	x	x	x	x						
1.5.6	Add suicide prevention to Employee Assistance Programs (EAP).				x						
1.5.7	Integrate suicide prevention in governmental healthcare plans.		x								
1.5.8	Provide organizations additional training and continuing education around effective intervention and innovation in patient care.			x							
1.5.9	Require suicide screening questions on intake form in primary care visit and other health visits.	x	x	x			x				x
1.5.10	Track and measure progress toward addressing gaps in insurance coverage for suicide prevention services								x		

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
1.6 Create a Master List of what agencies are doing in suicide prevention.											
1.6.1	Work with nonprofit organizations to develop suicide prevention directories that are geographic area-specific (e.g., urban areas such as Triangle/Triad; regional areas for rural parts of state).						x				
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.											
2.1 Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.											
2.1.1	Adopt and incorporate existing military communication efforts, educational activities and resources into civilian suicide prevention efforts.	x		x							x
2.1.2	Assess and adapt communication messages to educate the public about the signs of depression, make the public aware of the availability of local resources, and to push back against the stigma of asking for help with depression/ suicidal thoughts (e.g., Alleghany Lives).							x			
2.1.3	Communicate the importance of trainings that identify signs and symptoms of suicide and suicidal ideation to school administrators, staff, and parents of students.					x					
2.1.4	Craft suicide prevention, education, and awareness messages, each tailored to specific and diverse audiences.	x	x	x	x	x	x	x	x	x	x
2.1.5	Create and display suicide prevention posters at healthcare facilities.			x							
2.1.6	Develop and evaluate communication efforts for suicide prevention.								x		
2.1.7	Develop communication messages for Employee Assistance Programs (EAP) to educate employers that mental health should be treated the same as other physical ailments.				x						
2.1.8	Develop communication messages for incorporating mental health screening into primary care.			x							
2.1.9	Develop communication messages for teachers, administration, students and parents about resources available for referrals and mental health screenings.					x					
2.1.10	Develop diverse communication/social marketing plan that targets message for individuals who receive publicly funded mental health care.	x									
2.1.11	Develop suicide prevention train-the-trainer programs and disseminate information with community volunteers.	x									

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2.1.12	Emphasize existing caregiver support programs for suicide awareness, prevention and treatment, in communication messages to medical staff, patients, or family members			x							
2.1.13	Include suicide prevention or wellness programs associated with counseling or student services on campus to increase suicide awareness and communication efforts.						x				
2.1.14	Include the existence of support groups hosted by university health centers in campus-wide communication efforts.						x				
2.1.15	Include the promotion and use of mandatory suicide prevention education and awareness curricula, developed for use in primary or secondary schools, in communication efforts targeting school administrators, staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers), and parents of students.					x					
2.1.16	Involve tribal elders, leaders, and youth in developing suicide prevention, education, and awareness communication messages.		x								
2.1.17	Promote and support 'community walks' as a way to increase suicide prevention awareness via media coverage of walks (e.g., It's OK 2 Ask.)						x	x		x	
2.1.18	Promote community meetings to deliver suicide prevention outreach in underserved areas.							x			
2.1.19	Encourage to serve as public speakers who have personal or loved one experience with suicide attempt/ideation/loss in suicide prevention communication programs and activities.									x	
2.1.20	Work with nonprofit (e.g., Save A Life) in developing communication efforts designed to raise awareness in the community and educate students, faculty, and community organizations on the warning signs, risk factors, and resources for suicide prevention.							x			
2.2 Reach policymakers with dedicated communication efforts.											
2.2.1	Advocate for and support increased opportunities and funding initiatives for suicide prevention activities.	x	x	x	x	x	x	x	x	x	x

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2.2.2	Build on the efforts conducted by the Mental Health Association of Central Carolinas, Inc., which promotes mental wellness through advocacy, prevention, and education in Mecklenburg and Cabarrus counties to advocate for a better mental health system, prevent mental health crises, and educate communities about mental health issues to break the stigma of seeking treatment.							x			
2.2.3	Contact policymakers and voice concerns about suicide and suicide prevention activities in N.C.									x	
2.2.4	Develop fact sheets about at-risk groups for suicide, including talking points and data.	x	x	x	x	x	x	x	x	x	x
2.2.5	Encourage student groups to send letters to legislators to support suicide prevention activities.	x					x				
2.2.6	Evaluate effectiveness of suicide prevention and awareness communication efforts developed for policy makers.								x		
2.2.7	Frame research/data to show the impacts of suicide prevention interventions for legislators.	x					x		x		
2.2.8	Frame suicide prevention activities as cost beneficial for legislators.	x		x					x		
2.2.9	Partner with nonprofits (e.g., Save A Life) to promote mental wellness through fundraising efforts and support systems to help policy makers implement more efforts toward suicide prevention in the state.							x			
2.2.10	Promote policies to allow for insurance coverage for depression and suicide risk screening.			x							
2.2.11	Support outreach using business-friendly messages to increase suicide prevention activities to policy makers.				x						
2.2.12	Volunteer to serve as spokespersons for suicide prevention outreach/advocacy efforts aimed at policy makers.									x	
2.3 Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.											
2.3.1	Create accessible media tools to reach youth (e.g., It's OK 2 Ask), to reduce stigma and increase help seeking behavior by the North Carolina Department of Health and Human Services, Division of Public Health.	x									
2.3.2	Create culturally competent online suicide awareness and prevention messages.	x									

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2.3.3	Develop and promote an online social media presence (Twitter, Facebook, etc.) and support the development of standardized messages (e.g., developed by research organizations, the Centers for Disease Control and Prevention).	x			x		x	x		x	x
2.3.4	Develop policy/procedure recommendations that emphasize the restriction of online promotion, information, and availability of how to perform suicide.	x									
2.3.5	Develop standardized online messaging recommendations for stakeholder groups to expand outreach and social media presence.								x		
2.3.6	Develop, track and evaluate online communication efforts to promote suicide prevention.							x			
2.3.7	Ensure that 'school safety' information on school districts' websites is inclusive of suicide prevention.					x					
2.3.8	Utilize Social Media Guidelines for Mental Health Promotion and Suicide Prevention when developing messages for online use established by Substance Abuse and Mental Health Services Administration (SAMHSA).	x	x	x	x	x	x	x	x	x	x
2.3.9	Work with nonprofits to create an online chat room for teens (e.g., Save A Life's TalkitOut) to talk freely and openly about concerns.							x			
2.4 Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.											
2.4.1	Adapt existing suicidal awareness, education and prevention training programs to use in Tribal communities.		x								
2.4.2	Attend trainings to help start conversations about suicide and suicide prevention.									x	
2.4.3	Build capacity of lay health workers to deliver statewide suicide awareness and prevention curriculum.					x					
2.4.4	Create local suicide awareness and prevention chapters (e.g., Save A Life).							x			
2.4.5	Encourage open conversation and dialogue about suicide among family, friends, and other social networks.									x	
2.4.6	Identify key advocates within Tribal community to implement education and training designed to increase knowledge about the warning signs for suicide and how to connect individuals in crisis with assistance and care.		x								

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2.4.7	Include families/significant others in discharge planning and education after a suicide attempt has occurred.			x						x	
2.4.8	Integrate suicide risk and intervention tools into parenting programming (e.g., NAMI Parent to Parent).							x			
2.4.9	Involve families in efforts to increase knowledge of suicide and to open lines of communication about both prevention and intervention.			x						x	x
2.4.10	Offer suicide prevention and awareness trainings (e.g., Question Persuade Refer) to agencies working in the community (e.g., Department of Social Services, school systems, senior centers, home health agencies).	x									
2.4.11	Promote suicide prevention training to incoming freshman on college and university campuses as a way to increase knowledge about the warning signs for suicide and how to connect individuals in crisis with assistance and care.						x				
2.4.12	Promote working with Tribal Governments as a priority in suicide prevention and education efforts to increase knowledge about the warning signs for suicide and how to connect individuals in crisis with assistance and care.	x	x								
2.4.13	Provide 'Mental Health First Aid' for employees.			x							
2.4.14	Provide and promote a suicide prevention hotline available 24/7.	x									
2.4.15	Provide funding to support ongoing work conducted by taskforces and researchers to increase knowledge of the warning signs for suicide and connect individuals in crisis with assistance and care.	x									
2.4.16	Provide Mental Health First Aid to employees (alongside existing scheduled First Aid and cardiopulmonary resuscitation trainings.							x			
2.4.17	Provide patient education materials about suicide warning signs/how to connect those in crisis.			x							
2.4.18	Provide tools to families, faith-based organizations and Nonprofits to begin conversations and dialogue about suicide prevention activities.								x		

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Strategic Directions – Goals – Objectives – Examples		Govt	Tribal	Hlth	Bus	Schls	Coll	Nonpro	Rsrch	Indiv	Mil
2.4.19	Share information about suicide prevention with youth through awareness activities, social media, and meetings (e.g., Students Against Violence Everywhere (SAVE) chapters)							x			
2.4.20	Train student support services personnel to share suicide awareness and prevention information with other school personnel (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers).					x					
2.4.21	Work with contract organizations (e.g., insurance carriers, Employee Assistance Programs (EAPs) and wellness organizations) to promote health and prevent suicide by increasing knowledge among plan participants/enrollees about warning signs and how to connect those in crisis with care.				x						
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.											
3.1 Promote effective programs/practices that increase protection from suicide risk.											
3.1.1	Collaboratively work with agencies to identify risk assessment and protective opportunities in tribal communities and how citizens can access services.		x								
3.1.2	Conduct or host forums, health fairs, safety events directly addressing suicide awareness and prevention, wellness promotion, and recovery.					x	x	x		x	x
3.1.3	Coordinate and communicate about efforts to develop peer based support groups.							x			
3.1.4	Create volunteer peer networks that provide free suicide awareness and prevention education.									x	
3.1.5	Educate and engage with other groups (e.g., faith-based, community, healthcare) who are active or interested in becoming active in suicide prevention activities that seek to increase protective factors from suicide risk.			x				x			
3.1.6	Educate parents about safe medication storage and disposal for both prescription and over-the-counter drugs.					x					
3.1.7	Encourage school boards to promote and support the use of high school focused evidence based curriculum designed to increase protective factors for/reduce risk from suicide.					x					
3.1.8	Encourage youth family members and friends to participate in drug free activities and events for youth.									x	

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3.1.9	Increase and support peer-run organizations that provide suicide awareness, education, prevention.							x		x	
3.1.10	Integrate evidence-based training that increases protection from suicide risk for faculty, student services, and residential assistance staff and evaluate training effectiveness.						x				
3.1.11	Mandate policies that seek to incorporate suicide screening to identify suicide risk, including Emergency Department screening/psychological assessments, to refer, treat, or admit those at increased suicide risk.			x							
3.1.12	Promote and deliver Mental Health First Aid classes to increase protection from suicide risk.	x	x	x	x	x	x	x	x	x	x
3.1.13	Promote and share resources: National Registry of Evidence-based Programs and Practices from Substance Abuse and Mental Health Services Administration (SAMSHA) and Suicide Prevention Resource Center (SPRC) Best Practices Registry.	x									
3.1.14	Promote and support programs that work with nonprofits to educate teens and parents on warning signs, risk factors, and where to go and what to do it they suspect someone may be at risk.							x			
3.1.15	Promote easily accessible medication drop sites to dispose of unused medications.						x				
3.1.16	Promote policies and practices that include families or significant others in discharge planning and education after a suicide attempt has occurred.			x						x	
3.1.17	Promote social connectedness among employees by offering opportunities to engage in community service work or recreational activities as teams.				x						
3.1.18	Promote suicide prevention training to peer volunteers that are free or low cost.	x									x
3.1.19	Promote the use of Brief Depression Screeners among primary care providers.			x							
3.1.20	Research, identify, and promote evidence-based interventions that bolster protective factors (e.g., The Good Behavior Game).								x		

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3.1.21	Support the implementation of 'Compeer Programs' by Mental Health Associations, which involve specially trained volunteers who provide encouragement and support to individuals with mental illness and who are working on achieving mental wellness.							x			
3.2 Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.											
3.2.1	Create and facilitate open conversations and dialogue about suicide.	x	x	x	x	x	x	x	x	x	x
3.2.2	Develop marketing strategies to promote understanding of the complexity of substance abuse and the importance of accessing services.			x							
3.2.3	Develop support groups which include education for life skills and coping skills.					x					
3.2.4	Empower teachers and guidance counselors to openly discuss depression and mental illness in the school environment.	x				x					
3.2.5	Evaluate suicide prevention training, education, anti-stigma campaigns, and determine which are the most effective.								x		
3.2.6	Expand 'Wounded Warrior Project' and other prevention services to active duty service members.										x
3.2.7	Host community awareness campaigns to reduce stigma and to increase access.			x							
3.2.8	Identify neutral names for prevention programs that do not covey stigmatization.				x						
3.2.9	Implement suicide de-stigmatization campaigns (e.g., The NCSU Counseling Center's Stop the Stigma campaign").						x				
3.2.10	Include families/significant others in discharge planning and education after a suicide attempt as a way to reduce prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.					x					
3.2.11	Include suicide prevention education messages in workplace safety meetings.	x									
3.2.12	Incorporate suicide awareness and prevention training into orientation and annual requirements for employees.				x						

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
3.2.13	Increase awareness about the Wounded Warrior Project-Fayetteville Chapter, which seeks to foster the most successful, well-adjusted generation of wounded service members in our nation's history by raising awareness and enlisting the public's aid for the needs of injured service members, helping injured service members aid, and assist each other, providing unique, direct programs and services to meet the needs of injured service members.										x
3.2.14	Promote and allow open discussion of depression and thoughts of harm through communication with middle school entities.					x					
3.2.15	Promote appropriate language among staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) and students regarding mental health issues that does not enforce stereotypes or degrade individuals (i.e. use of words like crazy, psycho).					x					
3.2.16	Promote awareness that it is OK to ask for help, that discussion on suicide does not lead to suicide, and discuss mental wellness and healthy ways to decrease life stressors (e.g., Save A Life's awareness programs).							x			
3.2.17	Promote frank discussions of mental illness, depression, suicide, and self-harm in safe and open environments in middle and high school settings. This aligns with *State Healthful Living Essential Standards* for grade levels 6 - 9 concerning stress and stress management, and more specifically, the grade 8 standard of Apply help-seeking strategies for depression and mental disorders.					x					
3.2.18	Provide presentations from/by a suicide survivor as a way to reduce prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.						x				
3.2.19	Work collaboratively with agencies to discover stories and narratives of individuals who struggle with suicide ideation or have family members who have died from suicide to share with prevention and outreach activities.									x	

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		Govt	Tribal	Hlth	Bus	Schls	Coll	Nonpro	Rsrch	Indiv	Mil
3.3 Promote the understanding that recovery from mental and substance use disorders are real and possible for all.											
3.3.1	Adopt North Carolina Institute of Medicine Task Force on Behavioral Health Services recommendations for the Military and their Families to ensure that the mental health, developmental disabilities and substance abuse services that are available to active, reserve, and national guard members of the military, veterans, and their families are adequate to meet the needs today and in the future.										x
3.3.2	Develop developmentally appropriate materials to educate children/youth on mental health issues.					x					
3.3.3	Empower patients to discuss suicide and suicide ideation.			x							
3.3.4	Engage and volunteer within the community to participate and organize suicide awareness events that promote the understanding that recovery from mental and substance use disorders is possible.									x	
3.3.5	Evaluate mental health, developmental disabilities and substance abuse services that are available to active, Reserve, and National Guard members of the military, veterans, and their families to ensure that they are adequate to meet the needs today and in the future.								x		
3.3.6	Identify key advocates within tribal community to implement education and training designed to promote the understanding that recovery from mental and substance use disorders is possible.		x								
3.3.7	Identify willing speakers (e.g., suicide survivors) to serve as speakers at wellness programs to show that recovery from mental and substance use disorders is possible.				x		x	x			
3.3.8	Implement public awareness campaigns during May, Mental Health Awareness month, that targets decreasing stigma about mental disorders.	x									
3.3.9	Increase or promote outreach activities that model positive behaviors.							x			
3.3.10	Recognize/Honor recovered individuals who contribute to society to help others.							x			
3.3.11	Reinforce positive behaviors in order to encourage positivity and acknowledgment of progress during recovery processes.			x							

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
3.3.12	Restrict/ban firearms in residence halls and on campus.						x				
GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.											
4.1 Ensure that accurate data and resources are readily available and accessible for use by media or others.											
4.1.1	Collaborate with agencies to ensure data findings about suicide prevention are accurate for use by the media.								x		
4.1.2	Develop protocols for how a company or business will talk publicly to the media about suicide.				x						
4.1.3	Encourage linkages between local data and national databases when making data available and accessible for pick-up by media.	x	x	x			x		x		x
4.1.4	Ensure that accurate and current information about suicide and suicide prevention is included on all government websites, using accessible formats and through framing that is applicable to different populations, including those at high risk of suicide ideation or suicidal behaviors.	x	x								
4.1.5	Ensure that children and adult family members and friends know to use and access credible resources, including information provided by the government.									x	
4.1.6	Ensure that data used for pick-up by media cannot be modified or misinterpreted by clearly describing data collection methods and information about sample size.						x		x		
4.1.7	Ensure that funding provided to suicide prevention programs require the development of accurate messages for use by media.	x	x	x							
4.1.8	Ensure that school staff e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) understand appropriate communication guidelines and protocols when talking with the media following a student's suicide.					x					
4.1.9	Include suicide awareness in freshman orientations for journalism ethics.						x				
4.1.10	Incorporate communication messages for pick-up by media that destigmatize survivors of suicide prevention	x	x	x	x	x	x	x	x	x	x
4.1.11	Promote and share the stories of celebrities or other famous individuals who have experience with suicide.									x	

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
4.1.12	Promote awareness and education during May, Mental Health Awareness Months when media coverage may be intensified.	x	x	x	x	x	x	x	x	x	x
4.1.13	Provide data/research that inform public service announcements developed to support suicide awareness and prevention activities.						x		x		
4.1.14	Report accurate suicide and suicidal behavior data and responsible information when talking to/working with the media.	x	x	x				x	x		x
4.1.15	Respond to media stories that do not promote resources or include inaccurate information.	x		x							
4.1.16	Use timely and widely covered news events to engage the media (e.g., WUNC radio) in targeted discussion about suicide awareness.	x	x	x	x	x	x	x	x	x	x
Strategic Direction 2: Clinical and Community Preventive Services											
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.											
5.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.											
5.1.1	Advocate for legislative action toward strengthening the coordination, implementation and evaluation of suicide prevention programming.				x						
5.1.2	Collaborate with other organizations and nonprofits across the state to raise awareness and educate the community to promote wellness and prevent suicide.							x			
5.1.3	Connect with organizations working to promote awareness to share the voices/stories of individuals who have experienced suicide ideation/suicide attempts, in the development and monitoring of programs.									x	
5.1.4	Convene regular coordinating calls/working group for all state partners working to promote wellness and prevent suicide.	x									
5.1.5	Create, promote, and encourage suicide prevention and wellness programming on college and university campuses.						x				
5.1.6	Encourage collaboration across current suicide prevention activities offered by community/non-profit/faith-based organizations (e.g., Faith Connections in Mental Health, Recovery Innovations' Wellness Recovery Action Plan (WRAP) and Wellness classes, and NAMI (National Alliance on Mental Illness) Peer Support specialists).							x			

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
5.1.7	Ensure that individuals experiencing an acute mental health or substance abuse crisis receive timely specialized psychiatric treatment in coordination with available and appropriate community resources (e.g., The North Carolina Department of Health and Human Services, Division Of Mental Health, Developmental Disabilities and Substance Abuse Services has a Crisis Solutions Initiative. The initiative seeks to identify ways to expand existing best practices that have been proven to work on the local level, such as: Walk-In Crisis Centers and Short-Term Residential Treatment Options; Youth Mental Health First Aid; Person-Centered Crisis Prevention Plans; Telepsychiatry; EMS Pilot Programs; and Crisis Intervention Teams).	x									
5.1.8	Incorporate voices/stories of individuals who have experienced suicide ideation/suicide attempts in the development and monitoring of programs.								x		
5.1.9	Promote use of on-line training modules for school staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) and faculty to increase knowledge of student issues and how to manage them (e.g., the *Understanding Student Behavior in the Classroom* curriculum has a middle/high school version and a Pre K through 5th grade version).					x					
5.1.10	Reach out to support groups, including Survivors of Suicide (e.g., Triangle Survivors of Suicide) to strengthen the coordination, implementation, and evaluation of suicide prevention programming at multiple levels.	x	x	x	x	x	x	x	x	x	x
5.1.11	Restrict access to guns among those suffering from mental illness.									x	
5.1.12	Support and promote Crisis Intervention Team (CIT) training for all law enforcement.	x									
5.1.13	Support and sponsor trainings related to suicide awareness and suicide prevention to strengthen the coordination, implementation, and evaluation of suicide prevention programming.				x						
5.1.14	Support measures/legislation designed to reduce access to guns as a lethal means for suicide.	x									

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
5.1.15	Train Emergency Department personnel to identify signs of suicidal tendencies as a way to strengthen the coordination of suicide prevention programming.			x							
5.2 Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.											
5.2.1	Collaborate with statewide organizations (e.g., the North Carolina School Community Health Alliance) to support the work of school health centers to incorporate suicide education, awareness and prevention.					x					
5.2.2	Contribute to coordinated efforts to develop peer-based support groups for suicide prevention and awareness.									x	
5.2.3	Develop and evaluate wellness promotion and suicide prevention oriented workshops specific to military populations.										x
5.2.4	Encourage businesses to implement wellness programs and ensure adequate insurance coverage for services and Employee Assistance Program (EAP) access.				x						
5.2.5	Encourage school staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) to participate in evidence based trainings, (e.g., Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth Crisis Intervention Training (CIT), Question, Persuade, and Refer (QPR)).					x					
5.2.6	Ensure that all wellness promotion and suicide prevention program implementation efforts are evaluated for effectiveness/fidelity.								x		
5.2.7	Foster an inclusive, accessible, and diverse intellectual and cultural campus experience through the awareness of diversity issues and education (e.g., the Office for Institutional Equity and Diversity at NC State University).						x				
5.2.8	Incorporate safety and wellness promotion into the structure of and community outreach conducted by neighborhood organizations (e.g., block watches, home owner associations).									x	

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Strategic Directions – Goals – Objectives – Examples		Govt	Tribal	Hlth	Bus	Schls	Coll	Nonpro	Rsrch	Indiv	Mil
5.2.9	Participate in suicide prevention trainings (e.g., NAMI Family to Family course, Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth Crisis Intervention Training (CIT), Question, Persuade, Refer (QPR)).						x		x	x	
5.2.10	Partner with other nonprofits (e.g., Save A Life) to organize evidence based wellness promotion and suicide prevention trainings in the community.							x			
5.2.11	Promote and encourage implementation of suicide prevention programs known to be effective (e.g., Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Crisis Intervention Training (CIT), Youth CIT, Question, Persuade, Refer (QPR)).	x						x			
5.2.12	Promote and encourage wellness promotion and suicide prevention programs and promising practices used in other tribal communities.		x								
5.2.13	Promote mental health wellness and self care at clinic/community health fairs.			x							
5.2.14	Provide Gatekeepers training to school employees (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers) to: increase awareness of suicide; know risk factors and warning signs; know how and when to refer a student or co-worker; and serve as a knowledgeable member of the intervention and prevention team.					x					
5.2.15	Provide assistance to peer support specialists working to increase the number and reach of community-based suicide prevention programs.									x	
5.2.16	Provide suicide awareness and prevention training in elementary schools (e.g., Teaching Life Skills).	x				x					
5.3 Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.											
5.3.1	Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among citizens with mental and substance use disorders.	x	x	x	x	x	x	x	x	x	x
5.3.2	Collect county-specific lists of suicide prevention and mental and substance use disorder resources and referrals (e.g., AFSP.org, suicide hotline, United Way 211 website).	x					x	x			
5.3.3	Develop and actively engage safety plans with at-risk mental and substance use disorder clients.			x							

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
5.3.4	Develop/support school district processes for referring children and youth with potential needs for mental health/substance use disorder services.					x					
5.3.5	Encourage campus programs or student health centers to provide targeted outreach to at-risk LGBTQ populations.						x				
5.3.6	Engage peer support specialists, who have personal experience with suicide, on treatment teams formed to support those with mental and substance use disorders.	x		x				x			
5.3.7	Ensure access to support services for employees who have suffered loss (e.g., family death, illness, catastrophe).				x						
5.3.8	Increase availability of mental health services in the schools through school-based centers or contracts with local social workers to provide mental health/substance use disorder counseling services for students.					x					
5.3.9	Increase research to document the cost to N.C. of suicide related issues, including services for mental and substance use disorders.								x		
5.3.10	Learn to identify the stressors that contribute to a loved one's suicidal thinking and the mechanisms that reduce those stressors.									x	
5.3.11	Provide school staff with access to free counseling services through an Employment Assistance Program (EAP).					x					
5.3.12	Support funding opportunities for county-specific suicide prevention and mental and substance use disorder resources (e.g., AFSP.org, suicide hotline, United Way 211 website).	x					x	x			
5.3.13	Support grants and funding to provide education and training for suicide prevention for citizens/students/community members experiencing mental and substance abuse disorders.	x	x				x	x			
5.3.14	Support the development and dissemination of training and tools to peers to provide long-term recovery support to people in different stages of recovery.	x									
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.											
6.1 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.											
6.1.1	Adapt and tailor existing efforts to reduce access to lethal means in tribal communities.		x								

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
6.1.2	Advocate for and inform legislation and policies that support limits to access to lethal means, including weapons, for populations at risk of suicide.			x							
6.1.3	Advocate for legislative/policy/procedure efforts designed to encourage increased screening of access to lethal means for those identified at risk for suicide.									x	
6.1.4	Conduct research to identify effective protocols and screening procedures designed for providers, who interact with individuals at risk for suicide, to assess access to lethal means of suicide.								x		
6.1.5	Develop and implement standardized policies, procedures, and processes for encouraging providers, who interact with individuals at risk for suicide, to routinely assess for access to lethal means of suicide.	x									
6.1.6	Develop mechanisms to reimburse for screening and early intervention services that include assessing for access to lethal means of suicide.			x							
6.1.7	Educate primary care practitioners and emergency department staff in suicide awareness, identification methods, and lethal means screening protocols.			x							
6.1.8	Encourage open discussion among family and friends about whether homes that your children visit have firearms, including homes of relatives.									x	
6.1.9	Encourage open discussions about suicide among family, friends, and social groups, including the need to advocate for legislation, polices, and procedures that encourage providers to routinely screen for access to lethal means for those identified at risk of suicide.									x	
6.1.10	Encourage the use of Evidence-Based Practices and promising practices in the screening and assessment of access to lethal means of suicide (e.g., CALM, Counseling on Access to Lethal Means).	x									
6.1.11	Identify specific community providers (one per county) to serve as safety net organizations that encourage providers who interact with individuals at risk for suicide to routinely asses for access to lethal means.	x									

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
6.1.12	Incorporate an approved 'flagging reporting' process between medical professionals and firearms dealers that require medical professionals to report suicide risks for at risk patients that may apply for firearms permits or firearms background checks	x									
6.1.13	Promote and provide staff training in warning signs for suicidal behaviors.					x	x				
6.1.14	Provide education about safe medication storage and disposal for both prescription and over-the-counter drugs.			x				x			x
6.1.15	Provide suicide awareness, education and prevention training to clinicians, including tools and procedures for assessing for access to lethal means of suicide.			x							
6.1.16	Safeguard all medications (a lethal means of suicide) among family and friends identified as at risk of suicide, especially after discharge from hospitals or during periods of stress.									x	
6.1.17	Work with health care and research to identify screening protocols, to assess access to lethal means that are effective and enforced within the military.			x					x		x
6.2 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.											
6.2.1	Examine and review current laws about firearm safety and responsible firearm ownership for changes that will lead to suicide prevention and increased awareness about suicide.	x	x								
6.2.2	Partner with other nonprofits, faith-based, and community groups nationwide that have been successful in developing suicide prevention policies related to firearm safety and responsible firearm ownership (e.g., NAMI New Hampshire).							x			
6.2.3	Provide education about firearm safety and responsible firearm ownership to military personnel.										x
6.2.4	Support efforts for awareness and enforcement of the North Carolina Child Access Protection Law, which promotes firearm safety for people who reside with a minor.	x									
6.3 Develop and implement new safety technologies to reduce access to lethal means.											
6.3.1	Adopt components used for Operation Medicine Drop events to encourage the voluntary surrender of firearms.	x									

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
6.3.2	Conduct and disseminate results from research studying the effectiveness of efforts/programs designed to reduce access to lethal means (e.g., carbon monoxide shutoffs in automobiles, blister packs for medications, barriers for bridges).								x		
6.3.3	Conduct research on firearm safety, including developing new technologies (e.g., gun locks).								x		
6.3.4	Promote the use/conduct of Operation Medicine Drop events (held statewide in partnership among Safe Kids North Carolina, the Drug Enforcement Administration, and law enforcement) to reduce the diversion of prescription drugs (a lethal means of suicide) through the voluntary surrender and safe disposal of prescription and other drugs.	x									
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.											
7.1 Develop training on suicide prevention to community groups.											
7.1.1	Connect with the National Action Alliance for Suicide Prevention's Faith Communities Task Force (http://actionallianceforsuicideprevention.org/task-force/faith-communities) to develop and expand training resources.							x			
7.1.2	Develop and provide train-the-trainer programs for suicide prevention and intervention to teach the classes throughout the community.	x									
7.1.3	Develop trainings for bartenders and hair dressers on recognizing suicidal ideation.				x			x		x	
7.1.4	Educate teachers, instructors, and other personnel using Evidence Based Practices (EBP) for suicide prevention curricula.					x	x				
7.1.5	Expand efforts of the North Carolina Department of Health and Human Services, Division of Public Health to train school staff, nurses, social workers and teachers with the suicide prevention programs (e.g., Applied Intervention Skills Training, safeTALK, Lifelines Curriculum and Lifelines Postvention).	x									
7.1.6	Help organize and train groups and organizations in the community to be proactive and not reactive before a suicide occurs.							x			
7.1.7	Incorporate people with lived experience of suicide (either self or loved one) in development and implementation of training activities.	x								x	

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
7.1.8	Incorporate suicide prevention and awareness modules into freshman year health curriculum.					x					
7.1.9	Increase training and accountability of law enforcement for identifying likelihood of suicide.	x									
7.1.10	Increase training to clinicians on how to help people become socially connected and engaged in meaningful life activities.			x							
7.1.11	Mandate suicide prevention training for medical facility/school staff.			x		x					
7.1.12	Partner with nonprofits (e.g., Save A Life) to provide free presentations or trainings to educate teens and adults on suicide prevention.				x	x	x	x		x	x
7.1.13	Promote training in assessment and management of suicide risk (e.g., the Education Development Center's Assessing and Managing Suicide workshop).	x	x	x							
7.1.14	Provide educational trainings for students, teachers, staff on: 1) warning signs risk factors; 2) how to provide help to students; 3) how to encourage student to ask for help if they suspects a friend may need help.					x					
7.1.15	Provide suicide prevention training and collaboration across state agencies.	x									
7.1.16	Provide training to increase awareness among school staff (e.g., school nurses, school social workers, school psychologists, school counselors and school resource officers), especially elementary, to connect at-risk behaviors (e.g., cutting, substance abuse, drinking and driving) and suicide.					x					
7.1.17	Provide training to increase recognition among professional and family caregiver staff (i.e., at physical rehabilitation facilitates and among home care staff) that certain medical conditions are linked to suicide risk.			x							
7.1.18	Require curriculum for high schools to teach basic suicide prevention.					x					
7.1.19	Train staff to identify students at risk for suicidal behaviors.					x					
7.1.20	Utilize Suicide Prevention Resource Center's best practices registry (and other promising practices) to identify and adapt trainings for tribal communities in N.C.		x								

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
7.2 Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.											
7.2.1	Conduct train-the-trainer events hosted by the North Carolina Department of Health and Human Services, Division Of Mental Health, Developmental Disabilities and Substance Abuse Services for Youth Mental Health First Aid to the state's Local Management Entities/Managed Care Organizations.	x									
7.2.2	Develop and standardize screening protocols for patients, specifically at risk patients.			x							
7.2.3	Encourage standard screening as part of counseling sessions held in faith-based organizations.							x			
7.2.4	Encourage trainings and certification programs in Mental Health First Aid (e.g., Carolinas HealthCare System).			x							
7.2.5	Implement Assessing and Managing Suicide Risk (AMSR) policies for mental health and substance use disorder providers.	x		x							
7.2.6	Incorporate people with lived experience of suicide (either self or loved one) in development and implementation of training opportunities.			x						x	
7.2.7	Provide training in the use and implementation of primary care toolkits (e.g., Suicide Prevention Resource Center's primary care toolkit).	x		x							
7.2.8	Provide training(s) on suicide awareness and prevention (e.g., QPR, Mental Health First Aid) to mental health and substance abuse providers.	x	x	x	x	x	x	x	x	x	x
7.2.9	Require training in suicide prevention in graduate programs of social work and other fields (e.g., public health).						x				
7.3 Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.											
7.3.1	Incorporate suicide prevention and assessments in curriculum of all human services programs.						x				
7.3.2	Mandate suicide awareness and prevention training for those entering healthcare field.						x				
7.3.3	Offer special certification programs in Suicidiology.						x				
7.3.4	Require curriculum for Bachelors level Psychology, Social Work and Sociology majors to teach basic suicide prevention.						x				

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
7.3.5	Work with Area Health Education Centers to offer continuing education courses to health providers in the allied health, dental health, medicine, mental health, nursing, pharmacy, and public health professions.			x							
7.4 Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.											
7.5 Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.											
7.5.1	Adopt and mandate the use of crisis intervention plans with trauma-involved clients.			x				x			
7.5.2	Adopt and mandate the use of emergency management guidelines/protocols to deal with crisis situations.			x							
7.5.3	Develop district plans to include information on recognizing suicide risks and referring to appropriately trained specified school personnel to assess suicide risks and determine next steps (e.g., potential referral to mental health service provider).					x					
7.5.4	Develop, train and implement evidence-based protocols to collaboratively manage suicide risk in each practice setting.	x		x			x	x			
7.5.5	Establish trained Crisis Intervention Teams including law enforcement, mental health professionals, and advocates throughout North Carolina.	x									
7.5.6	Graduate programs in social work and other fields should require training in suicide prevention.						x				
7.5.7	Identify barriers to communication between/among clinicians, first responders, crisis staff (e.g., HIPAA, electronic records, failure to document) and develop strategies to improve communication.	x		x	x				x	x	
7.5.8	Promote the use of Crisis Intervention Teams with law enforcement and first responders.	x	x	x				x			
7.5.9	Promote training in evidence-based crisis intervention methods such as Critical Incident Stress Management										x
7.5.10	Promote training in evidence-based crisis intervention methods such as Critical Incident Stress Management.					x	x				
7.6 Employ cultural sensitivity; training should be universally designed and available.											
Strategic Direction 3: Treatment and Support Services											
GOAL 8. Promote suicide prevention as a core component of health care services.											
8.1 Promote the adoption of zero suicides as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.											

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
8.1.1	Encourage relevant stakeholders (e.g., hospitals, primary care, mental health, public health and schools) to adopt a zero suicide as an aspirational goal.	x	x	x							
8.1.2	Increase focus on elder mental health, including increased screenings for suicide risk and depression.			x							
8.2 Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.											
8.2.1	Facilitate/support groups or self-help groups.						x				
8.2.2	Develop and implement peer support groups within agencies that are trained to identify people/colleagues at risk and help connect them to treatment.	x	x	x	x	x	x	x	x	x	x
8.2.3	Ensure implementation of school district protocols for recognizing suicide risks and referring to specified school personnel who are appropriately trained to assess suicide risks and determine next steps (e.g., potential referral to mental health service provider).					x					
8.2.4	Develop community based volunteer peer recovery centers that are free to the public and provide education and support.	x									
8.2.5	Promote the development and use of policies and procedures to minimize the barriers encountered through transitions across levels of service/treatment (e.g., in-patient care, out-patient programs).			x	x						
8.2.6	Provide in-depth training assessments to counselor/doctors/nurses to identify and treat high risk individuals to reduce number of individuals who commit suicide between assessment and first appointment.	x									
8.2.7	Support text-information programs (e.g., NC-NAMI Text 4 Teens) to provide teens in difficult situations a way to anonymously receive support.			x							
8.3 Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.											
8.3.1	Create, maintain and share referral lists with other organizations.			x				x			
8.3.2	Develop and implement standards for ensuring timely access across healthcare services.			x							
8.3.3	Ensure communication between emergency/crisis services and follow-up outpatient services.			x							
8.3.4	Identify staff to provide suicide risk assessment to veterans.										x
8.3.5	Include suicide risk information in employee assistance programs (EAP) materials.				x						

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8.3.6	Prioritize, within government agencies, the need for timely access to suicidal risk assessment, intervention and effective care.	x									
8.3.7	Promote open access models for suicide prevention and awareness for walk-in care clients.			x				x			
8.3.8	Provide Crisis Intervention Teams within tribal healthcare entities.		x	x							
8.3.9	Support ongoing work across multiple agencies and organizations that promote the national resources on their websites and provide a live link (e.g., National Lifeline number, It's OK 2 Ask, Raleigh Hopeline, NC-NAMI).	x									
8.3.10	Support policies and insurance plans that reward participants for acting pro-actively and seeking preventive services.	x									
8.3.11	Promote technology that will empower clients to have a role in their treatment and recovery.			x							
8.4 Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.											
8.4.1	Develop methods for healthcare providers, parents and schools to develop and communicate a school support plan for youth treated for suicide risk in Emergency Departments or hospital inpatient units.			x							
8.4.2	Develop methods to monitor patients treated in Emergency Departments or hospital inpatient units to determine effectiveness of treatment.			x							
8.4.3	Increase follow-up communication and connection (e.g., phone, text) with dischargers after care.			x							
8.4.4	Promote collaboration between Emergency Department healthcare providers and outpatient care healthcare provides.			x							
8.4.5	Utilize mobile app technology to engage individuals in their treatment and self care.			x							
8.5 Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.											
8.5.1	Develop mental health assessment as a Quality Care Measure, potentially linking to reimbursement mechanisms through other symptoms displayed (i.e. pain, fatigue).	x		x							
8.5.2	Incorporate tools included in the Zero Suicide Toolkit into continuous quality improvement efforts.			x							
8.5.3	Require relevant stakeholders to report suicide attempt and commitment metrics.	x									

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8.5.4	Establish timely standards for follow-up appointments post discharge for suicidal related hospitalizations.			x							
8.5.5	Utilize technology to follow-up with discharged patients and outpatient clients.			x							
8.6 Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.											
8.6.1	Develop and implement suicide prevention and outreach programs to nonprofits, community and faith-based organizations, individuals, families and concerned citizens.			x				x		x	
8.6.2	Fund peer support specialists for outreach and engagement.	x		x				x			x
8.6.3	Identify and disseminate available resources for links between mental health and substance abuse services through national, local and other databases.	x			x						
8.6.4	Promote peer support groups that promote and employ life skills training.			x		x	x	x		x	
8.7 Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.											
8.7.1	Track and report patient information and outcomes to determine effectiveness of treatment.			x							
8.8 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.											
8.8.1	Create collaborations/workgroups to include outpatient providers and family members as part of discharge plans.			x				x		x	
8.8.2	Employ mobile crisis to assess risk level and access alternative care.			x							
8.8.3	Improve follow-up measures after Emergency Medical Services responses to a suicidal crisis (e.g., increase referrals to appropriate services).			x							
8.8.4	Incorporate WRAP (Wellness Recovery Action Plan) trainings to Emergency Department staff.			x							
8.8.5	Increase availability and use of short term crisis overnight housing ("beds") in community programs.			x							
8.8.6	Increase availability and use of tele-psychiatry to assess suicidal risk level.			x							
8.8.7	Lead crisis continuum meetings that include Emergency Department staff, providers, and law enforcement to discuss alternative treatment options to seeking care at Emergency Departments.	x		x							

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GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.											
9.1 Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings.											
9.1.1	Adopt policies to include postpartum depression screening for gynecological, pediatric, and family medical visits.			x							
9.1.2	Adopt and implement suicide awareness programs (e.g., Signs of Suicide).			x	x	x	x	x			x
9.1.3	Adopt and routinely use a validated depression screening scale for assessing patients.			x	x						
9.1.4	Attend conferences on mental health awareness.							x	x		
9.1.5	Encourage formation and participation of suicide survivor groups.									x	
9.1.6	Encourage suicide awareness and prevention programs to parish nurses.							x			
9.1.7	Enforce the development and implementation of district plans to recognize suicide risks and procedures for referral to appropriately trained specified school personnel to assess suicide risks and determine next steps such as potential referral to mental health service provider.					x					
9.1.8	Establish survivor support groups (e.g., Survivors of Suicide) for teens and youth.									x	
9.1.9	Implement depression screening for students (as part of October depression screening month, or anytime).						x				
9.1.10	Promote a consistent and clear mandate to define Mobile Crisis Units services pertaining to suicide response.	x									
9.1.11	Promote and ensure programs that effectively screen youth entering the juvenile justice system for substance abuse and mental health issues with a valid, reliable tool (e.g., North Carolina Department of Public Safety's The Reclaiming Futures Initiative).	x									
9.1.12	Provide insurance coverage for preventive mental health services.			x							
9.1.13	Share information on mental health at every opportunity (e.g., health fairs, school fairs).							x			
9.1.14	Teach 5th and 6th graders about suicide, suicidal ideation or depression through age appropriate programs (e.g., Beyond Blue, Penny Resiliency Project, and Seligman's Flourishing).					x					

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9.2 Disseminate, and implement guidelines for clinical practice and continuity of care for providers who work with people with suicide risk.											
9.2.1	Advocate for the availability of adequate support staff (e.g., counselors, social workers, school psychologists, school nurses, school resource officers) in school to support at-risk or recovering youth.					x					
9.2.2	Designate/award an organization with Suicide Prevention Best Practice Guidelines to serve as the gold standard for other organizations and encourage application of best practices for suicide prevention.	x		x	x	x	x	x			
9.2.3	Develop and implement training programs to provide mental and behavioral health professionals knowledge and skills that enhance their abilities to provide quality care for active duty military service members, veterans, citizen soldiers and their families as well as enhance their marketability in finding employment with organizations that target military populations (e.g., Military Behavioral Health Graduate Certificate Program at Fayetteville State University).										x
9.2.4	Develop modes of communication among school support personnel (e.g., school psychologist, social worker, counselor).					x					
9.2.5	Encourage Managed Care Organizations (MCO) to reimburse highly trained or certified clinicians at a higher rate to promote qualified clinicians.			x							
9.2.6	Encourage School Resource Officers (SRO) and Law Enforcement personnel to complete Crisis Intervention Team (CIT) trainings.	x									
9.2.7	Identify and train hospital staff about populations most at risk for suicide (e.g., LGBTQ, youth with special needs).			x		x					
9.2.8	Increase community suicide prevention and awareness education campaigns to increase patient awareness and self-advocate to receive optimal care.			x				x		x	
9.2.9	Prioritize staff development for suicide awareness and prevention trainings.							x			
9.3 Promote the safe disclosure of suicidal thoughts and behaviors by all.											
9.3.1	Adopt It's OK to ask philosophy across all Local Management Entities (LME)/Managed Care Organizations (MCO) providers.	x						x		x	

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9.3.2	Educate communities and individuals on HIPAA guidelines and that personal information (including psychological information) is confidential.	x									
9.3.3	Encourage training of clinicians and other health care professionals in listening skills.			x							
9.3.4	Ensure that students and staff have access to adequately trained staff for suicide risk assessment.					x					
9.3.5	Promote suicide awareness, prevention, and education to demonstrate the effectiveness of preventive treatment.	x	x	x	x	x	x	x	x	x	x
9.4 Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk.											
9.4.1	Develop Plan of Care or Discharge criteria to include someone other than individual with distress.			x						x	
9.4.2	Inform parents or caregivers when students are assessed and engage them in the referral for ongoing treatment and care.					x					
9.4.3	Provide free or low cost counselors and therapists to at-risk teens and families in need.							x			
9.5 Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental or substance use disorders.											
9.5.1	Develop clear criteria for individuals to be considered safe in their environment.			x							
9.5.2	Develop tracking for suicidal attempt methodology (e.g., the development of a system to track mechanisms of suicidal attempts).	x		x					x		
9.5.3	Disseminate information about policies to inform and raise awareness for communities.							x			
9.5.4	Enforce the development and implementation of district plans to recognize suicide risks and procedures for referral to appropriately trained specified school personnel to assess suicide risks and determine next step (e.g., referral to mental health service provider).					x					
9.5.5	Require suicidality assessment as part of screening and assessment of new patients and determination of level of need for services.	x		x							
9.6 Implement standardized protocols in emergency departments based on clinical presentation to allow for different responses based on clinical needs.											
9.7 Implement guidelines on documentation of assessment and treatment of suicide risk.											
9.7.1	Develop or adopt objective and universally used depression screening scale(s) that are easily understood and used by Healthcare Practitioners.			x							

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9.7.1	Enforce the development and implementation of district plans to recognize suicide risks and procedures for referral to appropriately trained specified school personnel to assess suicide risks and determine next step (e.g., referral to mental health service provider).					x					
9.8 Provide ongoing training and technical assistance for all objectives for Goal 9.											
GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.											
10.1 Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.											
10.1.1	Employment Assistance Programs (EAP) should maintain a current list of resources/database.			x							
10.1.2	Encourage state agencies to evaluate the quantity and quality of trainings conducted by Managed Care Organizations.	x									
10.1.3	Evaluate institutional guidelines for suicide awareness and prevention.								x		
10.1.4	Identify, maintain and distribute suicide awareness, prevention and outreach resources.						x				
10.1.5	Improve identification of students who are impacted by suicide.					x					
10.1.6	Initiate support groups for teens that have lost friends or classmates to suicide, including groups to talk about feelings and issues.					x					
10.1.7	Participate in support groups (e.g., Triangle Survivors of Suicide) that provide support and resources for people who have experienced the loss of a loved one by suicide.									x	
10.1.8	Provide employees with an Employment Assistance Programs (EAP) that includes comprehensive support programs for individuals bereaved by suicide.	x		x	x						
10.1.9	Train lay-people and community members in suicide awareness and prevention programs (e.g., Mental Health First Aid; Question, Persuade, Refer).	x									
10.1.10	Work with the Department of Instruction to develop guidelines and implementation plans for crisis response teams at the district level.					x					
10.2 Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.											
10.2.1	Develop a system to identify individuals in need of suicide related services who are not covered currently for treatment.	x									

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10.2.2	Develop clear statewide guidelines for how/when to refer and obtain information or to educate staff about resources available in the community.					x					
10.2.3	Educate staff about community resources for mental health.					x					
10.2.4	Expand existing programs (e.g., Tragedy Assistance Program Survivors, TAPS) to provide ongoing services for anyone who has suffered the loss of a military loved one, regardless of the relationship to the deceased or the circumstance of the death.										x
10.2.5	Implement evidence-based programs for postvention settings.						x				
10.2.6	Mandate that Local Management Entities/Managed Care Organizations pay for services for any person who qualifies for indigent care or has Medicaid coverage, including individuals affected by a suicide attempt or bereaved by suicide.	x									
10.2.7	Provide easily accessible opportunities for attempt and survivors of suicide victims to engage in therapy or support groups within the university setting or the surrounding community.						x				
10.2.8	Provide information to individuals impacted by suicide (e.g., referral card, hotline information).			x							
10.3 Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.											
10.3.1	Develop and maintain a peer based support system incorporating existing services from a variety of current stakeholders, (e.g., private, community and government).	x	x	x	x	x	x	x	x	x	x
10.3.2	Engage with government agencies to identify people to be involved with suicide awareness, prevention and outreach programs and activities.					x	x	x	x	x	x
10.3.3	Promote outreach to incorporate suicide attempt survivors in community suicide awareness, prevention and outreach groups.	x		x							
10.4 Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.											
10.4.1	Develop clear algorithms for guidelines to respond effectively to suicide clusters and contagion within cultural contexts.			x							
10.4.2	Identify an agency in the community to lead a community response plan and community suicide prevention efforts.	x									

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10.4.3	Local Management Entities and Managed Care Organizations should support Psychological First Aid training in provider agency.	x									
10.4.4	Work with other stakeholder groups to develop a community response plan.			x							
10.5 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.											
10.5.1	Develop and maintain a grief crisis response plan.					x					
10.5.2	Develop protocols identifying when/what services to offer when a suicide occurs.			x							
10.5.3	Evaluate availability of funds to support suicide awareness and prevention trainings for medical and mental health providers.	x									
10.5.4	Identify and disseminate information about resources available within the community.			x			x	x			
10.5.5	Identify and provide suicide awareness and prevention resources to teachers, counselors and social workers.					x					
10.5.6	Incorporate suicide attempt survivors and survivors of suicide victims in the education for healthcare providers and first responders.			x						x	
10.5.7	Provide critical incident stress management (CISM) for those impacted by suicide (e.g., students and employees at university).						x				
10.5.8	Provide peer based support for health care providers.			x							
Strategic Direction 4: Surveillance, Research and Evaluation											
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.											
11.1 Improve the timeliness of reporting vital records data.											
11.1.1	Develop better tracking tool(s) for outcomes of patients/services provided related to suicide prevention.			x							
11.1.2	Develop tracking tool(s) and communication methods, to provide outcomes of individuals treated for depression, suicidal behaviors or suicide attempts, to medical professionals.								x		
11.1.3	Disseminate suicide and suicidal behavior data collection practices for use by community partners.			x		x	x	x	x		
11.1.4	Improve the timeliness of reporting deaths classified as suicide by developing electronic reporting systems for both the Vital Records and the Medical Examiner Systems in North Carolina.	x									
11.1.5	Increase funding and resources to support the transition to an electronic death record system.	x									

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11.1.6	Increase integration/linking of data collection systems between tribal and federal/state/local governments.	x	x								
11.1.7	Increase resources and funding to the Office of the Chief Medical Examiner to facilitate timely death investigations.	x									
11.1.8	Increase the timeliness and capacity for the processing of information from the North Carolina Violent Death Reporting System (NC VDRS).	x									
11.1.9	Provide incentive(s) to healthcare, insurers or clinicians to provide/report data related to suicide.			x							
11.1.10	Support funding for adequate staff to manage existing data services (e.g., second data abstractor for NC-VDRS).	x									
11.1.11	Support policies and advancements to remove insurance clauses that discriminate against mental health/suicide deaths by denying claims.			x							
11.2 Improve the usefulness and quality of suicide-related data.											
11.2.1	Collect and track data related to suicide (e.g., suicidal behaviors, suicidal ideation, and completions).			x		x					
11.2.2	Conduct research studies among special populations (e.g., people with disabilities, prison inmates) to understand suicide risk and protective factors.								x		
11.2.3	Develop system wide policies on reporting and post-vention for suicide/suicide attempts.						x				
11.2.4	Evaluate the validity and accuracy of questions/indicators currently being used to assess suicide, suicidal ideation or behaviors.								x		
11.2.5	Expand questions included in the North Carolina Violent Death Reporting System (NC VDRS) that are targeted toward identifying details related to suicides.	x									
11.2.6	Expand the use of qualitative data from survivors and practitioners.								x		
11.2.7	Link N.C. Incident Response Improvement System (IRIS) data from DMH/DD/SAS to other data sources (e.g., death certificate, medical examiner, hospital discharge, ED) to gain a better understanding of suicide attempts.	x									
11.2.8	Review and improve usefulness of data regarding suicides among active military personnel.										x

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11.2.9	Review and provide available data in greater detail (e.g., more specific subset groups, for example, youth 10 – 17).	x									
11.2.10	Support the expansion of community-based research to identify community level factors related to suicide and suicide prevention.						x				
11.2.11	Work with national databases to include data on military suicidal data (e..g., ideation, attempts, completions)										x
11.3 Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.											
11.3.1	Dedicate funding to increase capacity for quality data collection pertaining to suicides.	x									
11.3.2	Evaluate available data provided in N.C. Treatment Outcomes and Program Performance System (NCTOPPS) and determine if additions should be considered for the routine collection, analysis, reporting, and use of suicide-related data.	x							x		
11.3.3	Identify data collection systems specifically for suicide or suicide related behaviors on the school report card.					x					
11.3.4	Improve collaboration with government, state agencies, and community based organizations to promote capacity building in data collection and analysis.	x	x	x	x	x	x	x	x	x	x
11.3.5	Include suicide statistics on the Annual Report of School Crime and Violence.					x					
11.3.6	Promote open use and access to the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC-DETECT), a North Carolina's state-wide syndromic surveillance system.								x		
11.3.7	Promote use and access to the North Carolina Violent Death Reporting System (NC VDRS), a public health, population-based surveillance system that contains detailed information on deaths that result from violence.	x									
11.3.8	Require and provide training for mandatory training in the reporting of incidences of suicide.	x		x							
11.4 Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.											
11.4.1	Minimize and streamline the number of nationally representative surveys to minimize discrepancies in results or numbers.	x									

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11.4.2	Partner with other organizations to reach marginalized/isolated/under represented populations in data collection efforts (e.g., AARP to conduct surveys with older adults).				x						
11.4.3	Refine/add questions that are NC specific and address the needs and interests of our populations and needs through the NC Youth Risk Behavior Survey.	x									
11.4.4	Require university systems to administer the American College Health Association survey at staggered intervals.						x				
11.4.5	Support school participation in Youth Risk Behavior Survey (YRBS) data collection efforts.					x					
GOAL 12. Promote and support research on suicide prevention.											
12.1 Develop a state suicide prevention research agenda with comprehensive input from multiple stakeholders.											
12.1.1	Connect with and secure sources of funding to support suicide prevention research in North Carolina.	x							x		
12.1.2	Lead the effort to convene working group of suicide prevention research stakeholders.	x									
12.1.3	Work with state agencies in N.C. to develop a state-wide suicide prevention research agenda that includes N.C. specific research questions.								x		
12.2 Disseminate and implement the state suicide prevention research agenda.											
12.2.1	Conduct studies that align with the suicide prevention research and policy agenda.								x		
12.2.2	Develop and support the use of social media for dissemination of suicide awareness, prevention and outreach efforts studied in the research agenda.	x									
12.2.3	Provide clear and concise means to disseminate the suicide prevention agenda to the public.	x									
12.2.4	Translate the research agenda for non-researchers, including an explanation of why certain areas are more relevant to N.C. than others and what non-researchers (e.g., community members, family members) can do to support research.								x		
12.3 Promote the timely dissemination of suicide prevention research findings.											
12.3.1	Consider legislative supported incentives for timely dissemination of data.	x									
12.3.2	Encourage and support partnerships between research organizations and state government to smooth the process of dissemination.	x							x		

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12.3.3	Encourage the presence and availability of Principal Investigators for interviews or webinars with relevant stakeholders.								x		
12.3.4	Work with other non-research groups to disseminate data and information, including a translation from research into lay terminology.								x		
12.4 Develop and support a repository of research resources to help expand and improve research on suicide prevention and care in the aftermath of suicidal behaviors.											
12.4.1	Promote partnership between government, universities and research institutions to combine data and develop materials for general understanding (e.g., individual citizen or stakeholders form a variety of fields, such as adolescent health or public safety).	x					x		x		
GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.											
13.1 Evaluate the effectiveness of suicide prevention interventions.											
13.1.1	Conduct quantitative and qualitative research studies with students (e.g., focus groups on changes in stigma and attitudes towards suicide and suicidal behaviors).					x					
13.1.2	Continue to provide ongoing reports on North Carolina suicide rates for use at multiple levels to evaluate the impact and effectiveness of suicide prevention interventions.	x									
13.1.3	Evaluate the effectiveness of suicide prevention interventions through Employee Assistance Programs (EAP).				x						
13.1.4	Evaluate training programs that aim to integrate behavioral, mental health care and primary care, particularly for high risk populations.			x							
13.1.5	Incorporate evaluation of research on suicide or suicidal behavior related to college/university programs and interventions.						x				
13.1.6	Incorporate mechanisms to encourage reporting of data to funding sources that support suicide prevention interventions.							x			
13.1.7	Integrate the information collected in community health needs assessments to build county level action plans for suicide prevention interventions and activities.	x									
13.1.8	Participate in surveys to provide input on what types of support/interventions are most helpful, both pre and post care.									x	

Appendix Table E-1. 2015 NC Suicide Prevention Plan Examples by Stakeholder Groups.											
Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
13.1.9	Participate in the Incident Response Improvement System (IRIS).							x			
13.1.10	Share experiences with working in suicide awareness and prevention interventions.							x			
13.1.11	Support evaluation efforts (e.g., Garrett Lee Smith, Injury Prevention Research Center at UNC-CH) to assess knowledge gains and increase in self-efficacy.								x		
13.1.12	Work with business, employers and professional associations to evaluate workplace-based suicide prevention programs.								x		
13.1.13	Work with research organizations to implement and evaluate workplace-based suicide prevention programs.				x						
13.2 Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.											
13.2.1	Disseminate evidence for suicide prevention interventions through Human Resource (HR) departments, employee counseling services.				x						
13.2.2	Disseminate evidence for suicide prevention interventions through school counseling departments, student health centers, or medical schools.					x	x				
13.2.3	Provide action plans, N.C. Department of Public Health and N.C. Department of Mental Health, for specific groups (i.e. faith-based, school-based, clinicians) based on effective interventions.	x									
13.2.4	Support staff in schools (e.g., counselors, school psychologists, social workers, school nurses, school resource officers) to be prepared and encouraged to share information on suicide prevention interventions.					x					
13.2.5	Work with other organizations and researchers to identify information pertaining to cost effective interventions for suicide prevention.			x							
13.2.6	Work with the Institutes of Medicine to disseminate information about suicide prevention interventions.								x		
13.3 Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective.											
13.3.1	Collect data to plan and implement successful youth suicide prevention programs.	x	x				x		x		
13.3.2	Create a clearinghouse of evidence-based programs used to address suicide prevention (similar to California Clearinghouse that compiles research and data on child maltreatment).								x		

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
13.3.3	Engage and extend community-based research to evaluate programs and develop evidence-based practices in different communities and demographic groups.								x		
13.3.4	Examine policies and procedures for universities with low suicide rates for effectiveness.						x		x		
13.3.5	Identify additional ways that behavioral and mental health can be integrated into primary care.			x							
13.3.6	Implement quantitative (e.g., surveys) and qualitative (e.g., focus groups) research to identify successful delivery structures and methods of dissemination in different communities and demographic groups.								x		
13.3.7	Offer culturally tailored suicide prevention trainings for how programs can be implemented in different communities and demographic groups.						x				
13.3.8	Participate in community efforts seeking to identify which delivery structures might be most effective for the specific community or population (e.g., focus groups, community forums, discussions with support groups).					x				x	
13.3.9	Promote and share already existing national resources (e.g., NREPP, SPRC's Best Practices Registry) to address interventions in different communities and demographic groups.								x		
13.4 Disseminate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.											
13.4.1	Create fact sheet regarding effectiveness of National Strategy for Suicide Prevention (NSSP) for publication on government websites and through social media.	x									
13.4.2	Disseminate fact sheets for suicide prevention and awareness to communities.	x	x	x	x	x	x	x	x	x	x
13.4.3	Lead a partnership with academia, for both evaluation of and dissemination of the state suicide plan and the National Strategy for Suicide Prevention (NSSP) goals and objectives, as well as their short and long term health impacts as they are rolled out across the state.	x									

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Strategic Directions – Goals – Objectives – Examples		*Govt*	*Tribal*	*Hlth*	*Bus*	*Schls*	*Coll*	*Nonpro*	*Rsrch*	*Indiv*	*Mil*
13.4.4	Partner with state government, for evaluation and dissemination of the state suicide plan and the National Strategy for Suicide Prevention (NSSP) goals and objectives, as well as their short and long term health impacts as they are rolled out across the state.								x		
13.5 Identify potential stakeholders necessary to disseminate evidence.											
13.5.1	Utilize known stakeholder networks, including those established during the Working Group meetings to disseminate suicide prevention evidence and best practices.	x									
13.6 Establish resources/guide to gain access to impact/effectiveness data (e.g., toolkit, resource centers).											
13.6.1	Compile national, state, and local suicide prevention resources into one central resource (e.g., NAMI and Jason Foundation).	x		x			x	x			
13.6.2	Encourage availability and distribution of suicide prevention toolkits appropriate for clinicians, individuals, and parents.			x							
13.6.3	Identify and disseminate suicide prevention impact/effectiveness resources (e.g., National Association of County and City Health Officials toolkit, and resources from Association of State and Territorial Health Officials, and American Public Health Associations).	x		x					x		