Minnesota Department of Health

Report to the Minnesota Legislature: Suicide Prevention Plan

January 15, 2000

MINNESOTA MDH DEPARTMENT OF HEALTH
Commissioner's Office
85 East Seventh Place, Suite 400
St. Paul, MN 55164-0882
(651) 296-8401
www.health.state.mn.us

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For more information, contact:
Family Health Division
Minnesota Department of Health
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Phone: (651) 281-9888
Fax: (651) 215-8953

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Table of Contents

Part I

Introduction and Background

Overview

Commissioner's Recommendations and Action Plan

Introduction and Background

The United States Surgeon General, David Satcher, has declared suicide a serious public health concern and has issued a call to action for each state to implement strategies to prevent suicide (1999, U.S. Public Health Service). At the request of the 1999 Minnesota Legislature (Ch. 245, Article 1, Section 3), the Minnesota Department of Health (MDH) has been convening and consulting with a large group of stakeholders to develop a suicide prevention plan for the state of Minnesota.

MDH has a responsibility to provide both leadership and technical assistance on mental health promotion to Minnesota's communities, and has recognized suicide as a leading public health issue, promoted as such in Healthy Minnesotans: Public Health Improvement Goals 2004. Healthy Minnesotans was developed with the 49 Community Health Boards and 26 statewide organizations comprising the Minnesota Health Improvement Partnership (MHIP). The document promotes a common public health agenda and includes health promotion strategies, including suicide prevention, requiring the engagement of diverse segments of the community. (1998, MDH)

Charge to the Group

For the first time in state history, at the request of MDH, more than 120 Minnesotans representing a broad range of constituencies have joined together to work toward the common goal of suicide prevention. The charge to this ad hoc advisory group is to consult with MDH on a study of suicide and to advise on the development of a suicide prevention plan. The group is comprised of representatives from community health, human services, mental health professionals, schools, health plans, advocates, suicide survivors (those who have lost a loved one to suicide), and others. Names and affiliations are included in Part III.

History

In October 1998, at the request of the U.S. Centers for Disease Control, MDH staff participated in a national suicide prevention conference in Reno, Nevada. The Healthy Minnesotans suicide prevention strategies were reviewed in the conference and helped to inform the resulting Surgeon General's Call to Action to Prevent Suicide. In addition to MDH, representatives from Minnesota included the Minnesota Department of Human Services, Hennepin County Community Health, the SA/VE (Suicide Awareness/Voices of Education) organization, and others. This Minnesota delegation joined with national researchers, clinicians, policy makers, advocates, and suicide survivors to examine what is known and not known about suicide and developed the set of national recommendations to prevent suicide presented in the Surgeon Generals' report. These recommendations serve as the framework for Minnesota's suicide prevention planning process.

Process

Beginning in August 1999, MDH convened bi-weekly a small planning group, including those who participated in the Reno conference. On October 25, 1999, in an effort to involve a broad representation of stakeholders in the planning process, the Commissioner of Health hosted a day-long working symposium of over 60 participants. Symposium participants, as well as those who provided input via small group meetings with MDH staff, telephone consultations, and written comment, have subsequently been invited to monthly meetings facilitated by MDH staff. Contributors to this process have developed a set of 28 strategies, included in Part II of this report, to recommend to the Commissioner of Health to consider in developing the suicide prevention plan. MDH will continue to convene monthly meetings through June 2000, as the plan is implemented.

Overview

Current Status:
The Minnesota Face of Suicide

The recently released Surgeon General's Report on Mental Health states that twenty-two percent of Americans have a "diagnosable mental disorder" but nearly two-thirds of them never seek care. The top two reasons cited in the report for not seeking care are concern about the stigma associated with mental disorders and lack of access (1999, U.S. Public Health Service).

This report reflects the "Minnesota face of suicide." Suicidal behaviors range from ideation and attempted suicide to self-inflicted death. In Minnesota, from 1993-1997:

- suicide ranks as the second leading cause of death among ten- to 34-year-olds;
- suicide is the eighth leading cause of death for all ages combined (Nationally, suicide also ranks as the eighth leading cause of death);
- three times as many Minnesotans died of suicide than from homicide; and
- in the 15-24 age group, three-and-a-half times more young Minnesotans died of suicide than from cancer. (1999, MDH)

The Minnesota data show that suicide is more prevalent in some groups than in others:

- males comprise approximately 80 percent of all suicide deaths;
- suicide is the second leading cause of death for young males in all racial and ethnic groups;
- the suicide rate for American Indians is consistently higher than for any other racial and ethnic group; and
- Minnesotans 65 years of age and older have the highest suicide rate of all age groups. (1999, MDH)

The three leading methods of suicide in Minnesota, and nationally, are firearms, suffocation and poisoning (1999, MDH).

While data on suicide attempts are scarce, preliminary data (likely to be undercounts) from the Twin Cities seven-county area appear to indicate:

- among females age ten through 39, self-inflicted poisoning is the leading cause of hospitalized injury;
- self-inflicted poisoning is the second leading cause of hospitalized injury overall; and
- self-inflicted cutting/piercing is the third leading cause of hospitalized injury among ten- through 14-year-olds. (1999, MDH & The Minnesota Hospital and Healthcare Partnership)

Commissioner's Recommendations and Action Plan

Prevent a Public Health Problem with a Public Health Approach

Suicide results in the tragic loss of human life as well as agonizing grief, fear, and confusion in families and communities. It extends its reach across multiple generations of families, communities, and systems. While suicide may not be prevented through a single approach, it is ideally suited to a community-based, public health approach. As evidenced in the recommended strategies in Part II of this report, Minnesota stakeholders have made a commitment to work together to cast an ever-widening net to save community members from taking their own lives.

While suicide involves multiple individual, social, and environmental components, it is rarely random or inevitable. **Minnesotans *<u>can</u>* take measures**

to prevent community members from attempting to kill themselves or from taking their own lives. Many traditional prevention approaches target those who are exhibiting suicidal behaviors. This and the Surgeon General's suicide prevention report highlight the need for approaches designed to promote the welfare of an entire population. These include identifying high risk populations, reducing risks, and building on strengths in individuals and communities, approaches commonly utilized by MDH to promote healthy communities.

Based on public health principles, mental health promotion strategies:

- raise awareness;
- reduce stigma associated with mental and substance abuse disorders, suicidal thoughts, and seeking help; and,
- facilitate ease of access to, and availability of, mental health care.

Suicidal behaviors should be studied in-depth using the same epidemiological principles that inform our understanding and approach to other health problems. Such ongoing study, with rigorous evaluation of multi-component prevention efforts, will help identify effective preventive strategies. This integrated public health approach has contributed to a greater than 40 percent reduction in suicides in the United States Air Force (1999, U.S. Public Health Service; 1999, Centers for Disease Control).

The benefits of saved lives are immeasurable, including the social and emotional well-being of families and communities. Other benefits include not only savings in medical costs of suicide attempts, but also savings associated with the impact of untreated mental illness and brain disease in a variety of settings and systems including:

- health care,
- social services,
- education,
- employment,
- law enforcement, and
- corrections.

By determining these actual costs, MDH and its partners can inform efforts to balance the allocation of efforts and resources between intervention needs with prevention needs.

The 28 recommended Minnesota suicide prevention strategies, in Part II of this report, represent the thorough and thoughtful work of a committed group of Minnesotans. These strategies will serve to guide MDH in providing leadership and technical assistance on mental health promotion to Minnesota's communities. However, support and efforts from multiple partners are needed to provide for a truly comprehensive approach to suicide prevention. The following action plan reflects the capacities of MDH and its partners to work together to reduce suicide as a leading cause of death among so many Minnesotans.

Minnesota Department of Health 2000 Action Plan

Utilizing a population focus to maximize reach and to engage multiple stakeholders, the Minnesota Department of Health is committed to addressing suicide as a significant public health problem in Minnesota through the following activities:

- Suicide prevention reflects, and will be promoted through, the priorities set forth in two of the department's new Strategic Directions: 1) eliminating disparities in health status, and 2) bringing the community together on public health goals. By coordinating and enhancing collaboration among state, county, and community agencies to further develop mental health policy in Minnesota, MDH will ensure that suicide prevention is a priority for the state of Minnesota.

- MDH will continue to seek input from the

suicide prevention ad hoc advisory group in implementing the suicide prevention plan. MDH recognizes the Department of Human Services State Mental Health Advisory Council as a valuable resource to these efforts and will take leadership in enhancing collaboration with this body to ensure appropriate linkages are made as the plan is implemented.

- MDH will evaluate the recommendation of the ad hoc advisory group to establish a new statutorily-created Suicide Prevention Council and alternatively consider adding suicide prevention as a charge to existing state advisory bodies.

- MDH is reviewing 50 community health plans recently submitted to MDH by all of the community health boards to determine community needs and priorities regarding suicide and mental health. For example, in their 2000-2003 Public Health Plan, Dakota County ranked mental health as their county's number one health problem, as determined by community assessment. Information from the 50 plans will be utilized to inform MDH policy, budget, and technical assistance priorities.

- MDH will ensure that any data practice implications associated with implementing suicide prevention strategies are identified and addressed with appropriate stakeholders.

- Through the continuing leadership of MDH, the recommendations in this report will be promoted through the work of the Minnesota Children's Cabinet, the Rural Health Advisory Committee, the Maternal & Child Health Advisory Task Force, the Adolescent Health Action Plan, and others.

Specific examples of how MDH will pursue these recommendations through other activities include:

1) The Minnesota Health Improvement Partnership (MHIP) will include suicide prevention in its work to improve adolescent health care and to expand understanding of the underlying conditions affecting health.

2) MDH will work with the Office of Minority Health Advisory Group to understand and respond to the indicated disparity of suicide among American Indians.

3) MDH will recommend that the governor's SAFE council explore the discontinuation of reporting suicide as a crime statistic.

4) MDH will advocate that mental health care availability and quality be a priority for the administration's 2001 health reform proposals.

5) Statewide and local grantees of the Tobacco and Youth Risk Behaviors Endowment will be encouraged to address tobacco and other substance abuse as a risk factor for developing a mental disorder (1999, U.S. Public Health Service).

6) MDH and the School Mental Health Partnership will work with the Minnesota Department of Children, Families, & Learning and the Coordinated School Health project to explore the development of an integrated K-12 suicide prevention program.

7) MDH will ask the State Community Health Services Advisory Committee (SCHSAC) to promote suicide prevention awareness and education among local public health policymakers and officials.

- MDH will develop a plan to assess and organize its resources to address public health

goals and strategies for mental health, including suicide prevention.

- MDH and the suicide prevention ad hoc advisory group will continue to solicit input from key stakeholders, gather information, build relationships with minority and under represented communities to address suicide prevention, tap into existing collaborations and efforts addressing related issues, and network with other state and national agencies and experts working in suicide prevention.

- The ad hoc advisory group will assist MDH in developing a comprehensive implementation plan, including identifying and clarifying the roles of key stakeholders, developing objectives for each strategy, and determining costs associated with individual components of the overall plan. This plan will be considered in the MDH planning process for the next biennial budget.

- Because the 2000 legislative session is a non-budget year, MDH will not be seeking legislation to implement these recommendations prior to the next biennial budget. And, reflective of the governor's emphasis on ensuring government is limited and accountable, pursuing this plan will not exclusively result in requests for additional government funding. We will challenge ourselves and our partners to re-focus and better leverage existing programs and activities.

Part II

Ad Hoc Advisory Group
Recommendations

Ad Hoc Advisory Group Recommended Minnesota Suicide Prevention Strategies

The following strategies are recommended by the ad hoc advisory group. MDH will evaluate and consider inclusion of specific statutory and fiscal requests relating to these recommendations for the 2001 legislative session.

These strategies reflect the combined efforts of over 120 statewide contributors, guided by the 15 key recommendations in the Surgeon General's Call to Action to Prevent Suicide. Evidence-based and prioritized by leading national experts, these 15 recommendations are categorized as **Awareness, Intervention, and Methodology**, or **AIM**:

> **Awareness:** Appropriately broaden the public's awareness of suicide and its risk factors;
>
> **Intervention:** Enhance services and programs, both population-based and clinical care;
>
> **Methodology**: Advance the science of suicide prevention.

The strategies presented here provide a framework for further collaboration, implementation, and evaluation of a comprehensive, ongoing state plan to prevent suicide. Strategies are prioritized by the group, in the order listed, and the group's intentions are that strategies be dependent upon staffing capacity within MDH. Each strategy, while unique to Minnesota, corresponds to one of the AIM categories in the Surgeon General's report: Awareness, Intervention, and Methodology.

* **Preliminary cost estimates are provided, include existing funds, and will be refined in the implementation planning effort.**

PRIORITY ACTIVITIES NECESSARY TO IMPLEMENT THE PLAN AND STRATEGIES:

Make suicide prevention a priority for Minnesota and continue coordination of efforts.

MDH staff should continue to coordinate the implementation of the suicide prevention plan in collaboration with assigned staff from other state departments and appropriate community advisory bodies. In line with the Surgeon General's recommendations, this effort should be delivered through a primary prevention, public health approach, with MDH staff designated to suicide prevention to ensure continuity of these efforts. Implementation of the plan should include a statewide technical assistance conference for key stakeholders. MDH will ensure that suicide prevention is considered a priority public health issue for the state of Minnesota, especially as it reflects the goals of the MDH Strategic Directions. ******Fiscal impact from all sources: $150,000 annually.*

Enhance and formalize statewide collaboration of multiple stakeholders.

Establish by statute and staff, a statewide Suicide Prevention Advisory Council, with members appointed by the Governor, to advise MDH and other state agencies on the implementation of the suicide prevention plan. Ensure representation from greater Minnesota; minority populations; suicide survivors; clinicians; elementary, secondary, and higher education; mental health advocates; consumers of health and mental health services; health plans; older Minnesotans; youth; children's advocates; and government agencies. ******Fiscal impact from all sources: $50,000 annually.*

Each of the following strategies must be implemented through culture- and age-specific approaches and include rigorous evaluation components.

AWARENESS STRATEGIES

Broaden statewide awareness and outreach to reduce stigma and increase help-seeking behaviors. *Fiscal impact from all sources for strategies Awareness 1 through 5: *$1,500,000 annually.*

Awareness-1. Develop and promote the **use of common language, uniform terminology, and consistent messages** regarding suicide, depression, mental illness, brain diseases, substance abuse, symptoms, warning signs, risk factors, and help-seeking actions and behaviors of those at risk and of community helpers and "gatekeepers" (who are in a position to identify warning signs and make referrals). Determine and utilize effective language and approaches to diverse audiences.

Awareness-2. In coordination with existing statewide efforts (i.e. Minnesota Department of Human Services), implement an ongoing, coordinated multi-strategy, multi-media, and **multi-partner public awareness and anti-stigma campaign, utilizing influential spokespersons**, targeting high risk populations and "gatekeepers." Utilize common language, uniform terminology, and consistent messages, as detailed above. Include culture- and age-specific approaches. Ensure the campaign raises awareness of suicide as a public health issue and that many suicides are preventable.

Awareness-3. **Establish partnerships with Minnesota media vendors** to promote increased public service for suicide prevention. Create public/private collaborations that support and educate media vendors, associations, reporters, advertising vendors, and entertainment industry about suicide, suicidal behavior, mental illness, substance abuse, and help-seeking and promote the development of fair, effective, accurate, and culturally-appropriate media policies and practices.

Awareness-4. **Eliminate the reporting of suicide as a crime statistic.** Report suicide as public health data to reduce criminal stigma associated with suicide and suicide behaviors.

Awareness-5. **Increase awareness and education to state, county, and local policymakers and officials** on suicide, suicidal behavior, depression, mental illness, brain disease, and substance abuse and their impact on health care, social service, education, law enforcement, employment, and corrections systems.

Finance core community-based programs. Secure funding to assure core community-based programs to provide outreach, advocacy, and education to populations at risk for suicide and to provide education, training, networking opportunities, and skill development in communities and schools. Determine a fair, coordinated, and efficient way of financing programs, including grants, funding of direct services, and funding from public and private sources. **Fiscal impact from all sources for strategies Awareness 6 and 7: $3,000,000 annually.*

Awareness-6. Build **community capacity** to provide outreach, advocacy, and education through home- and community-based programs to high risk populations who are socially and physically isolated (minority populations, youth, persons in correctional programs, the elderly, and persons who are gay, lesbian, bisexual and transgender). Ensure programming includes symptoms of depression, substance abuse, mental illness, and brain diseases, warning signs of suicide, resource identification and use, healthy coping and help-seeking behaviors.

Awareness-7. Identify community-based agencies that can promote suicide prevention through their networking, outreach, referral activities, understanding of suicide, and ability

to reduce stigma. **Facilitate networking and referrals** between these and other public, private, and community-based mental illness and substance abuse prevention and treatment agencies.

INTERVENTION STRATEGIES

Study access to mental health care.

***Fiscal impact from all sources for strategies Intervention 1 through 4: $100,000 annually.*

Intervention-1. In coordination with existing studies in Minnesota, study **universal access to, coverage of, and related costs of adequate mental health care**. Study to include access to mental health consult within 24 hours of inpatient admission; access to mental health services in correctional programs and in other licensed facilities, including foster care; aftercare upon discharge; assessment of the effectiveness of the parity law and its limitations given federal law, to access necessary medications (i.e. co-pay costs, access to psychiatry). Identify gaps and barriers, develop collaborative strategies to improve access and promote availability of mental health professionals, and prioritize recommendations.

Intervention-2. Study the feasibility of extending and expanding the **senior drug program to cover mental health medications**, including psychotropic medications, for consumers with DSM -IV diagnosed disabilities. Develop recommendations.

Intervention-3. Study **impact of patients' rights laws** on access to crisis mental health care. Develop recommendations addressing barriers.

Intervention-4. Study associated costs and recommend adequate **mental health professional/student ratio** in schools, colleges, and universities.

Promote education, training, skill development in communities and schools.

***Fiscal impact from all sources for strategies Intervention 5 through 9: $250,000 annually.*

Intervention-5. Study and develop a statewide **K-12 prevention and intervention program**, including integrated curriculum, socially and culturally responsive and emotionally and physically safe school policies and practices, community-based resources and networks. Address trust-building and confidentiality issues between students and school staff. Ensure the program provides for staff support to implement identified protocols. Identify, utilize, and evaluate existing evidence-based materials and evaluate new program components. Ensure program development includes input from minority populations, greater Minnesota, youth, parents, and representatives from high risk populations.

Intervention-6. Promote **employee assistance and workplace programs** to support and refer employees with mental illness, depression, substance abuse behaviors, and brain diseases in collaboration with employer and professional associations, unions, labor industry, and safety council.

Intervention-7. Develop and promote the implementation of culturally-specific and age-appropriate **patient education** on suicide, suicidal behavior, depression, mental illness, brain diseases, use of medications, substance abuse, access to lethal methods, referrals and help-seeking, as indicated. Identify, utilize, and evaluate existing evidence-based materials. Work with employers of health professionals to ensure adequate staff support to implement protocols. Ensure development includes input from community stakeholders, health care organizations and subsidiaries.

Intervention-8. Educate and promote the role of **natural community "helpers"** (clergy, spiritual leaders and advisors, coaches, community business people, community education, private organizations, etc.) to support self-preservation instincts and encourage culture- and age-specific help-seeking behaviors. Education to "helpers" should include the symptoms of depression, mental illness, substance abuse, brain diseases, the warning signs of suicide, prevention skills, how to restrict access to lethal methods, and how to make effective referrals to culture- and age-specific interventions and/or resources.

Intervention-9. **Educate communities and schools staff** on the co-occurrence of substance abuse with depression, mental illness, and brain disease. Explain the relationship between impulsive behaviors in children and youth and access to lethal methods. Provide examples of how to intervene.

Ensure professional training. Secure funding for state departments, in consultation with the Suicide Prevention Advisory Council, to assess professional training needs and facilitate education, professional training, cross-training, and networking opportunities, including community-based crisis response teams. ***Fiscal impact from all sources for strategies Intervention 10 through 12: $250,000 annually.***

Intervention-10. Work with educational institutions to include **course work and curricula** on prevention, intervention, and screening for suicide, suicidal behavior, depression mental illness, substance abuse, and brain diseases (and their co-occurrence) in education, health, mental health, corrections, law enforcement, social services, clergy and other faith-based professions' associate and baccalaureate programs. Course work to include trust-building and confidentiality.

Intervention-11. Require and provide start-up funds for **Continuing Medical Education-, Clinical Pastoral Education-, and other Continuing Education-eligible training**, both basic and advanced, on prevention, intervention, screening for, and co-occurrence of, suicide, suicidal behavior, depression, mental illness, brain diseases, and substance abuse for education, health, corrections, social services, and religious/spiritual professionals, including foster care providers. Curricula to include trust-building and confidentiality issues. Study and recommend state standards for education and corrections.

Intervention-12. Work with **professional licensing, certifying and re-certifying, and accrediting bodies** to include education requirements on prevention, intervention, and screening for suicide, suicidal behavior, depression, mental illness, brain diseases, and substance abuse (and their co-occurrence).

Strengthen crisis response, "safety net," and follow-up care, especially in schools. ***Fiscal impact from all sources for strategies Intervention 13 through 14: $35,000 annually, assuming staff capacity.***

Intervention-13. Identify gaps, barriers to, and costs for basic **suicide crisis, "safety net," and follow-up services, especially in schools**. Provide recommendations to ensure trained suicide crisis teams and networks in every community, including schools, colleges, and universities. In addition to requiring credentials of providers, ensure providers receive adequate training regarding suicide, suicide ideation, and suicide attempts (including correctional and law enforcement staff). Promote collaborations of consumers, providers, families, and other stakeholders to create comprehensive "safety net"

of community response to people at high risk for suicide.

Intervention-14. Strengthen **emergency services** requirements in the Comprehensive Mental Health Act (CMHA).

METHODOLOGY AND RESEARCH STRATEGIES

Conduct a study of suicide in Minnesota.

Ensure and enhance state and community capacity to collect and utilize data necessary for analysis and evaluation of prevention efforts. Secure funding for MDH to collaborate with federal, regional, state, county, and other local agencies in conducting a study of suicide and suicidal behaviors in Minnesota. ***Fiscal impact from all sources for strategies Methodology 1 through 3: $500,000 annually.***

Methodology-1. Establish state capacity to collaborate with federal, regional, state, county, and other agencies to **collect, analyze, and report Minnesota-specific data** on suicide and suicidal behaviors (i.e. statewide inpatient, outpatient coding of external cause of injury on medical records, including psychiatric hospitals; follow-back studies). Include demographically-specific data (regional and community-specific), data on those who are insured vs. uninsured, suicide attempts post-hospitalization outcomes, and associated costs of suicide and suicidal behaviors (health, social services, law enforcement, etc.).

Methodology-2. Conduct state interagency **review of all child suicides** under age 15.

Methodology-3. As not all suicides are reported as such, study **suicide reporting practices** and make necessary recommendations.

Promote a Minnesota research agenda.

***Fiscal impact from all sources for strategy Methodology 4:** $125,000 *annually*.

Methodology-4. Identify **Minnesota's research agenda**; establish partnerships to promote scholarships/fellowships and provide technical assistance to secure funds for research to understand risk and protective factors related to suicide, suicidal behaviors, effective prevention programs, clinical treatments, and culturally-specific interventions.

Restricting access to highly lethal methods of suicide.

Fiscal impact from all sources for strategies Methodology 5 through 7: $50,000 annually.

Methodology-5. Promote and enforce **means restrictions** (i.e. safe storage of firearms, medications, and toxic substances; use of trigger locks, etc.).

Methodology-6. **Educate the public, law enforcement, and judges on the Child Access Protection (CAP) law**, intended to hold adults responsible for keeping firearms away from children. Assess effectiveness of the law and develop recommendations.

Methodology-7. Study **policies of public and private licensed institutional care**, including foster care and jails, regarding suicide prevention and intervention practices and access to methods to commit suicide. Provide recommendations.

Part III

Supporting Documents

References

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10 Leading Causes of Deaths by Age Group
Minnesota 1993-1997

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All ages combined
1	Congenital Anomalies 574	Unintentional Injury 155	Unintentional Injury 121	Unintentional Injury 151	Unintentional Injury 1,027	Unintentional Injury 895	Cancer 1,255	Cancer 3,244	Cancer 6,402	Heart Disease 44,735	Heart Disease 52,035
2	SIDS 349	Congenital Anomalies 66	Cancer 38	Suicide 39	Suicide 393	Suicide 497	Unintentional Injury 875	Heart Disease 2,064	Heart Disease 4,035	Cancer 31,685	Cancer 43,192
3	Other Perinata Conditions 196	Cancer 41	Congenital Anomalies 17	Cancer 37	Homicide 227	Cancer 378	Heart Disease 840	Unintentional Injury 631	Chronic Obstr. Pulmonary Dis 628	Stroke 13,902	Stroke 15,035
4	Short Gest./ Low Birthwt. 175	Homicide 23	Heart Disease 9	Congenital Anomalies 19	Cancer 112	AIDS/HIV 283	Suicide 564	Stroke 344	Stroke 588	Chronic Obstr. Pulmonary Dis. 7,338	Chronic Obstr. Pulmonary Dis. 8,179
5	Maternal Complications 179	Pneumonia & Influenza 16	Homicide 9	Homicide 18	Heart Disease 64	Heart Disease 222	AIDS/HIV 456	Suicide 335	Unintentional Injury 491	Pneumonia & Influenza 6,676	Unintentional Injury 8,141
6	Placental Complications* 110	Heart Disease 14	Pneumonia & Influenza 5	Heart Disease 13	Congenital Anomalies 37	Homicide 203	Cirrhosis 186	Cirrhosis 277	Diabetes 471	Diabetes 3,735	Pneumonia & Influenza 7,057
7	Respiratory Distress 64	Septicemia 4	Septicemia 3	Stroke 6	Stroke 20	Stroke 49	Homicide 148	Diabetes 240	Cirrhosis 309	Unintentional Injury 3,732	Diabetes 4,638
8	Unintentional Injury 63	Stroke 4	Stroke 2	Pneumonia & Influenza 6	Chronic Obstr. Pulmonary Dis 14	Diabetes 44	Diabetes 141	AIDS/HIV 158	Suicide 208	Nephritis 1,866	Suicide 2,416
9	Perinatal Infections 58	Perinatal Conditions 4	AIDS/HIV 1	Chronic Obstc. Pulmonary Dis. 5	AIDS/HIV 12	Congenital Anomalies 39	Stroke 120	Chronic Obstr. Pulmonary Dis. 139	Pneumonia & Influenza 150	Atherosclerosis 1,342	Nephritis 2,018
10	Heart Disease 39	AIDS/HIV** 3	Benign Neoplasms*** 1	Septicemia**** 1	Pneumonia & Influenza 12	Pneumonia & Influenza 29	Pneumonia & Influenza 67	Pneumonia & Influenza 96	Nephritis 77	Septicemia 882	Atherosclerosis 1,409

Minnesota Department of Health
Source: Minnesota Death Certificates

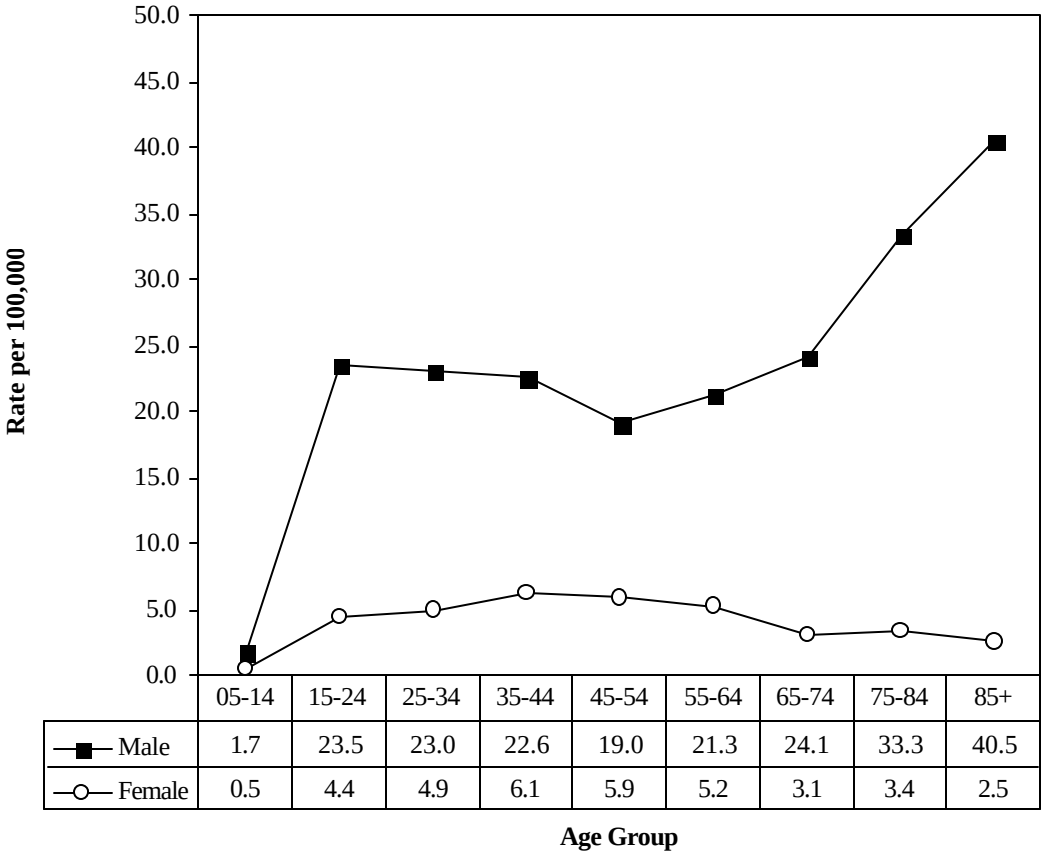
* Includes cord and membrane complications

** Other causes resulting in 3 deaths for this age group: benign neoplasms

*** Other causes resulting in1 death for this age group: chronic obstructive pulmonary disease, cirrhosis, nephritis, perinatal conditions

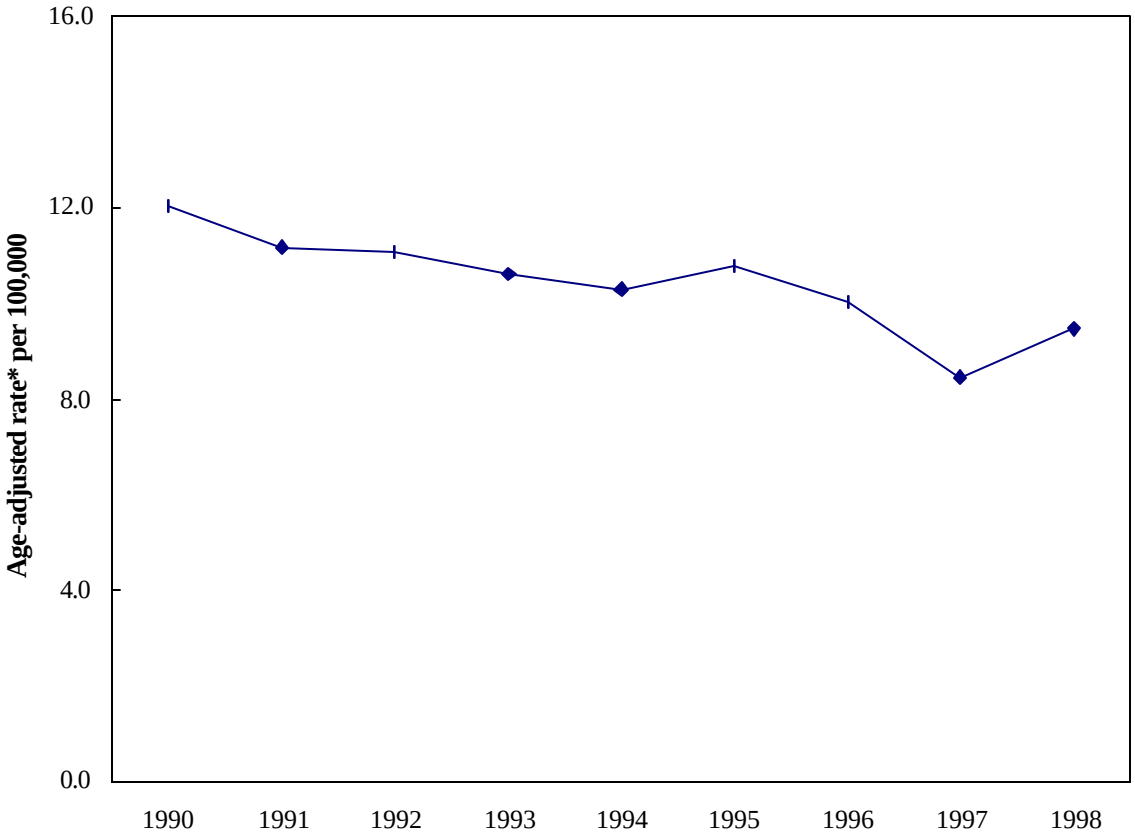
**** Other causes resulting in 1 death for this age group: benign neoplasms, nephritis, perinatal conditions

Suicide by Age Group
1990 - 1998
(9 year average)



	05-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Male	1.7	23.5	23.0	22.6	19.0	21.3	24.1	33.3	40.5
Female	0.5	4.4	4.9	6.1	5.9	5.2	3.1	3.4	2.5

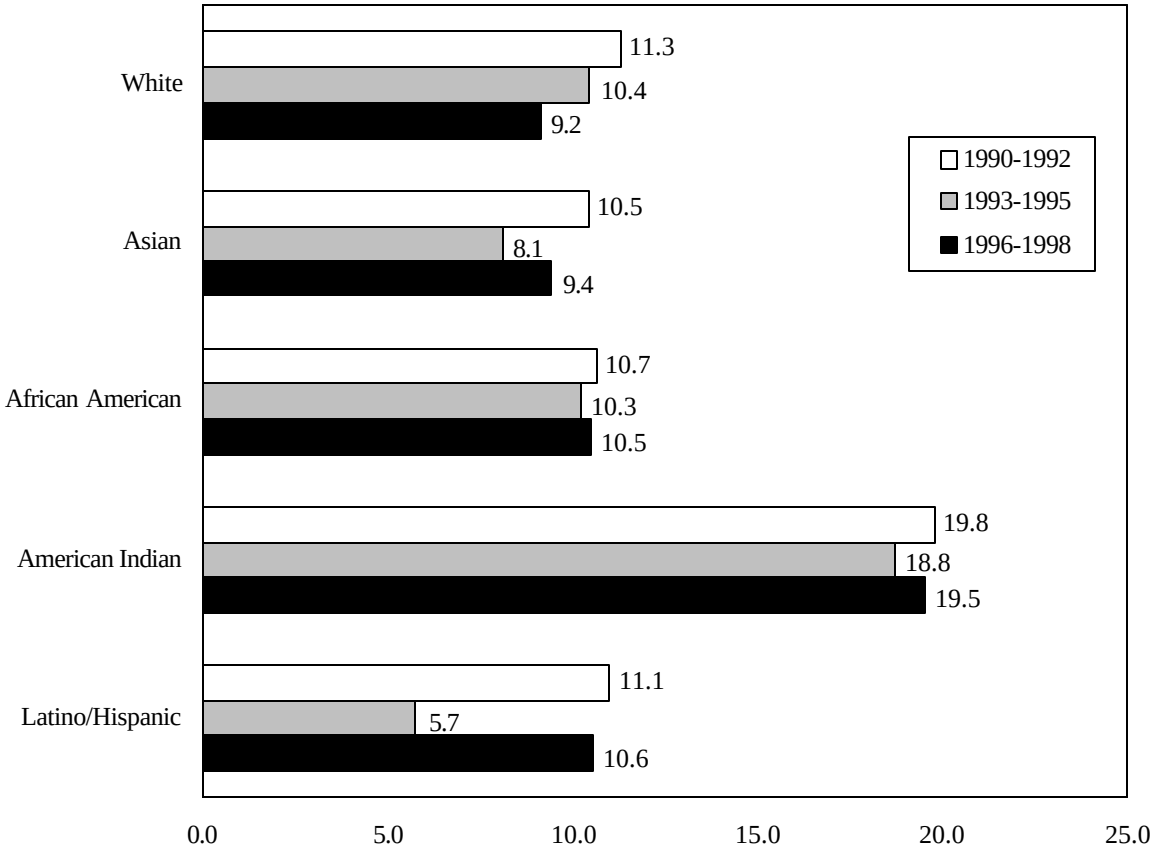
Suicide in Minnesota



* - Rate adjusted to the 1940 standard U.S. population.

	Minnesota Residents								
	1990	1991	1992	1993	1994	1995	1996	1997	1998
Rate	12.0	11.2	11.1	10.6	10.3	10.8	10.0	8.5	9.5
N	542	503	511	498	488	519	489	422	463

Minnesota Suicide Rate by Race/Ethnicity



Age-adjusted rate* per 100,000 population

	1990 to 1992		1993 to 1995		1996 to 1998	
	N	Rate	N	Rate	N	Rate
White	1476	11.3	1420	10.4	1283	9.2
Asian	21	10.5	21	8.1	26	9.4
African American	29	10.7	33	10.3	35	10.5
American Indian	30	19.8	29	18.8	30	19.5
Latino/Hispanic	18	11.1	11	5.7	22	10.6

* - Rate adjusted to the 1940 standard U.S. population

Suicide Prevention Strategies:
Healthy Minnesotans: Public Health Improvement Goals 2004

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problem: Suicide

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Business/ Work Sites	Other
Educate professionals and the community to recognize suicidal ideation and behaviors in adolescents and adults, to respond appropriately, and to make referrals for treatment and necessary supports	**T**	**T**	**T**	**T**	**Counseling Centers, Social Services, Faith Communities**	**T**	
Facilitate access to crisis and mental and chemical health programs and support services	**T**	**T**	**T**	**T**	**T**	**T**	
Collect and analyze data to inform interventions, policies, and the community	**T**	**T**	**T**				

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Business/ Work Sites	Other
Promote relational models, specific to culture and sexual preference, of attachment, self-efficacy, community connectedness, and healthy coping	**T**	**T**	**T**	**T**	**T**	**T**	
Promote and enforce means restrictions, including limiting access to firearms, promoting safe storage of firearms, and encouraging use of trigger locks	**T**	**T**	**T**	**T**	**T**	**T**	**Law Enforcement**
Assess (including self assessments) families, communities, and systems and build upon those strengths to address risks for suicide and suicide attempts	**T**	**T**	**T**	**T**	**T**	**T**	

Ad Hoc Advisory Group

List includes symposium participants and speakers,
focus groups, telephone consultations,
and written contributions.

j Denotes significant contributions.

j Lillian Abelson
ISD #728
Elk River, MN

Elizabeth Appel
Wabasso Public School
Wabasso, MN

Austin Youth Group
Austin, MN

Shannon Bailey
Dakota Co. Public Health
Apple Valley, MN

Marian Barcus
Itasca Co. HHS
Grand Rapids, MN

Lynn Boergerhoff
Hennepin Co. Community Health
Minneapolis, MN

Ron Brand
MN Association of Community
Mental Health Programs
St. Paul, MN

Nettie Bunn
Mayo Medical Center
Rochester, MN

Kathy Christensen
Riverview Clinic
Mankato MN

Tracy Clark
White Earth Indian Health Center
White Earth, MN

BJ Anderson
Coordinated School Health
MN Dept. of Children, Families &
Learning, Roseville, MN

Donna Alt
Edina, MN

Sharon Autio
MN Department of Human Services
St. Paul, MN

Randy Baker
BEC
Mankato, MN

Alison J. Becker
Wright County Public Health
Buffalo, MN

j Dave Boyd
SA/VE
Edina, MN

j Karalee Brunjes
Greater MN Christian Counseling
Services
So. St. Paul, MN

Theresa Carufel
Centre for Mental Health Solutions
Edina, MN

j Jackie Casey
SA/VE
Minneapolis, MN

Deborah Condon
Crisis Connection
Minneapolis, MN

j Ted Arneson
Minneapolis, MN

Mark Anderson
Senator Wellstone's Office
St. Paul, MN

Roberto R. Aviña
La Familia Guidance Center, Inc
St. Paul, MN

Stan Barber
MN Correctional Facility
Red Wing, MN

Jan Biebl
St. Paul/Ramsey Public Health
Roseville, MN

Rachel Boyum
Olmsted Co. Public Health
Rochester, MN

Janny Brust
Allina
Minneapolis, MN

David Chollar, LISW
Regions Hospital
St. Paul, MN

Millie Caspersen
Hennepin Co. Medical Center CIC
Minneapolis, MN

j Mary Crossen
MN Department of Children,
Families & Learning
Roseville, MN

Laurie Dahl
Immanuel St. Joseph's/Mayo Health System
Mankato MN

j Ruthie M. Dallas
MN Department of Human Services
St. Paul, MN

Renee Dahring
Hennepin co.
Minneapolis, MN

Vicki Dalle Molle
NAMI Olmsted Co.
Rochester, MN

j Jane Dietzman
Tobacco Control
Minnesota Department of Health

District 202 Youth Group
Minneapolis, MN

Alexandra Drivas
MN School Psychologists Assn.
St. Paul, MN

Kathy Dubbels
Olmsted Co. Public Health
Rochester, MN

Suzanne Dugan
Mankato State University Security
Mankato, MN

Michael Earhart
BHSI
Minneapolis, MN

j Dave Eichers
WIC
Minnesota Department of Health

j Larraine Felland
MN Department of Human Services, Mental Health
St. Paul, MN

j Sue Fiedler
SA/VE
Excelsior, MN

Bruce Field
La Familia Guidance Center
St. Paul, MN

j Michelle Finstad
Hennepin Co. Community Health
Minneapolis, MN

j Kris Flaten
State Advisory Council on Mental Health
St. Paul, MN

Terry Fleetham
Ramsey Co. Crisis Center
Minneapolis, MN

j Jeanne Forbes
Minneapolis Public Schools
Woodbury MN

Kathie Foreman
Immanuel St. Joseph's-MHS, Sex Assault Resource
Mankato, MN

Dana Fox
UBH
Minneapolis MN

Teri Funk
Safe Haven for Youth
Prior Lake, MN

Anna Gaichas
Injury & Violence Prevention
Minnesota Department of Health

Joyce Gallery
3 Counties for Kids
New Ulm, MN

Lili Garfinkel
PACER.
Minneapolis, MN

Tom Gaffney
Itasca Co. HS
Bovey, MN

Ellie Garrett
MN Council of Health Plans
St. Paul, MN

José González
Minneapolis Dept. Of Health
Minneapolis, MN

Barb Goodwin
HCMHC
Minneapolis, MN

Kerri Gordon
Senator Leo Foley's Office
St. Paul, MN

Deborah Goschy
MRCI, Employment Supt Spec.
Eagle Lake, MN

j Geri Graham, Coord Schl Hlth
MN Department of Children, Families & Learning
Roseville, MN

Gretchen Grewe
Elk River, MN

Louise Griffith
Lakeville, MN

Barbara Grodin
Hennepin County
Minneapolis, MN

Patrick Gromek
Burnsville, MN

Marge Haff
Golden Valley, MN

Tammy Hammerlund
Grand Rapids, MN

George Hanson
MN Dept. of Children, Families & Learning
Roseville, MN

j Paula Haraldson
Cornelia Place
Minneapolis, MN

Marlene Hardy, Director
Mille Lacs CD Outreach
Onamia, MN

j Lois Harrison
MCSHN
Minnesota Department of Health

David Hartford, Behavioral Care
St. Joseph's Hospital
St. Paul, MN

Merrily Hazelton
Winona Co. PHN Service
Winona, MN

j Peg Heaver
Coordinated School Health
Minnesota Department of Health

Dina Hennen
LeSueur, MN

Peggy Sue Hesse
Mankato Psychology Clinic
Mankato MN

Stella Hofrenning
Rural Health & Primary Care
MN Department of Health

j Sandy Holmstoen
MN Association for Children's Mental Health
Bloomington, MN

Joann Holt-Angerman
Victim Services, Advocate
Rochester, MN

j Jim Holmseth
Immanual St Joseph's/Mayo Health Systems
Mankato, MN

Joline Hovland
Sex. Viol. & Abuse Crisis Ctr.
Wilmar, MN

j Mary Huggins
Hennepin Co. Mental Health
Minneapolis, MN

Debra Jahnke
Rural Health & Primary Care
Minnesota Department of Health

j Kathy Jefferson
MN Department of Human Services
St. Paul, MN

Carol Jensen
MSU Security
Mankato MN

Jan Jernell
Family Health
MN Department of Health

Mary Pat Jewison
Olmsted Co. PHS
Rochester, MN

Gloria Johnson
Parkview Home
Hancock, MN

Patty Johnson
SA/VE
Edina, MN

Tom Johnson
NAMI
St. Paul, MN

Judith A Kahn
U of MN Konopka Institute
Minneapolis, MN

j Betty Kaplan
Healthy Beginnings
Minnesota Department of Health

Karen Lilledahl
Mental Health Association
Minneapolis, MN

Nancy Kern
Maternal & Child Health
Minnesota Department of Health

j Mark Kinde
Injury & Violence Prevention
Minnesota Department of Health

j Mary Kluesner
SA/VE
Edina, MN

j Al Kluesner
SA/VE
Edina, MN

Becky Kowalkowski
MCASA
Alexandria, MN

j Candy Kragthorpe
Family Health
Minnesota Department of Health

Diana Kuklinski
Bemidji Area Indian Health Serv.
Bemidji, MN

Jane Larson
HRC Mental Health Ctr
Superior, WI

Pamela Lausche
Leech Lake Soc Srvs, MH
PHS Indian Hospital
Cass Lake, MN

Karen Lilledahl
Mental Health Association of MN
Minneapolis, MN

Katie Linde
BlueCross BlueShield of MN
Eagan, MN

j Karen Lloyd, Ph.D.
HealthPartners
Minneapolis, MN

Kim Loidolt
Child's Mntl Hlth, Pact 4 Families
Melrose, MN

Alan Loose
Lutheran Social Services
St. Paul, MN

Wendy Machmer
Mental Health Assoc. of MN
Duluth, MN

Gary Mager
MN Department of Human Services
St. Paul, MN

j Pati Maier
Fetal Alcohol Syndrome
Minnesota Department of Health

Family Health
Minnesota Department of Health

Janice Maine
HCMC, Behavioral
Minneapolis, MN

Chisago Co. Public Health
Center City, MN

Esther Maki

j Jill Marks
Minneapolis, MN

Maureen Malloy

Maureen Marrin
Consumer/Survivor Network
St. Paul, MN

Wayne Marzolf
MN Dept.of Agriculture
St. Paul, MN

Ted Matthews
Community Education
Morris, MN

j Rita Mays
Nutrition
MN Department of Health

Nancy McCloone
CPNP Mankato Clinic
Mankato MN

Kevin McHenry
Sen. Leo Foley's Office
St. Paul, MN

Bonnie McIntyre
MN Department of Children, Families & Learning; Children's Mental Health; Roseville, MN

Sandy Menge
Centre for Mental Health Solutions
Minneapolis MN

Donna McDonald
Gerard
St. Louis Park, MN

David McRoberts
Parkview Home
Hancock, MN

Mari Mevisson
Injury & Violence Prevention
MN Department of Health

Mary Jo Moore
Olmsted Co. Public Health
Rochester, MN

Brian Morseth, Henn. Co. MH Ctr.
Health Services Bldg.
Minneapolis, MN

Amy Moser
Youth & Aids Projects
Minneapolis, MN

Dick Myers
MN Children with Special Health Needs
MN Department of Health

Maureen Myhre
Supportive Living Services
Brooklyn Center, MN

Marcia Nagel
Mankato West
Mankato MN

Lin Nelson
MN Department of Health

Ginny Nimmo
ISD #77
North Mankato MN

Kristi Obrecht
Carlton Co. Public Health
Cloquet, MN

Susan Obremski
Crisis Connection
Richfield, MN

Katie Ojanpa
Mankato East High School
Mankato, MN

Amy Okaya
Sexual Assault Prevention
MN Department of Health

Sheryl Olson
Anoka Co. Community Health
Anoka, MN

j Miriam Olson
SA/VE
Edina, MN

Ted Olson
MN Dept of Human Services
St. Paul, MN

Melissa Ostercamp
Hennepin Co. Health Promotion
Minneapolis, MN

Kunle Oyeyemi
Integrated Community Res
Minneapolis, MN

Kimberley Peck
MN Employee Assistance Program
St. Paul, MN

Tom Peterson
MH Consumer/Survivor Netwrk
St. Paul, MN

Hal Pickett, Child & Adol Psych
Univ of MN, Dept of Psychiatry
Minneapolis, MN

Kristy Pierce
Collab. Mvment for Improvemnt
St. Paul, MN

j Tracy Pierson
SA/VE
Richfield, MN

j Lara Pratt
Hennepin Co. Comm. Health
Minneapolis, MN

Linda Quistad-Berg
Winona Co. PHNS
Winona, MN

Pat Rautiola
Hennepin County, CTC Progrm
Eagan, MN

Trisha Prentice
Red Lake Substance Abuse Prog
Red Lake, MN

Tim Reardon
The Alliance for Fams & Children
St. Louis Park, MN

Mary Regan
MCCCA
St. Paul, MN

j Ralph Rickgarn
Minneapolis, MN

j Dolore Rockers
Home Place
Austin, MN

j Jon Roesler
Injury & Violence Prevention
MN Department of Health

Mary Rose
American Indian Family Center
St. Paul, MN

Susan Roth
MN Planning
St. Paul, MN

Tamara Rubin
New Hope, MN

Laura Ryan
Alternative Learning Center
Waseca, MN

Susan Rynda
LeSeuer Co. Human Services
LeCenter, MN

Sandi Savage
Fond du Lac, Min No Aya Win
Cloquet, MN

Paula Schaefer
MN DOC
St. Paul, MN

Gerry Schmidt
Blue Earth Co.
Mankato, MN

j Rachel Schott
Light for Life Foundation of MN
Mankato, MN

Mary Schulte
Centre for Mental Health Solutions
Edina, MN

David Schultz
MN Department of Human Services
St. Paul, MN

Lee Schultz
MN Planning
St. Paul, MN

Rochelle Schultz
Rural Health & Primary Care
Minnesota Department of Health
Bill Sheehan

PACT 4, Hlth & Human Srvcs.
Wilmar, MN

j Pat Shortall
Immanuel - St. Joseph's Hosp
Mankato, MN

j Terry Haugen-Sjostrom
Crisis Connection
Minneapolis MN

Cheryl Smoot
Maternal & Child Health
Minnesota Department of Health

Linda Snyder, PHN
ISD #622, Tartan High School
Oakdale, MN

Galen Stahle
American Psychiatric Society
Minnetonka, MN

Val Stanton
Supportive Living Services
Brooklyn Center, MN

Mike Stetzler
MN Department of Human Services
St. Paul, MN
Lt. Kevin H. Stoll

Minneapolis Police Dept.
Minneapolis, MN

Washington Co. PH & Envrnmt
Stillwater, MN

Center for Health Statistics
MN Department of Health

Jean Streetar

j David Stroud

Vince Stuehrenberg

Mankato Police
Mankato MN

Esther Tatley, PHN
Shoreview, MN

j Kristen Teipel
Adolescent Health
Minnesota Department of Health

Mary Tomes
ISD #622, LC Webster Elementary
No. St. Paul, MN

Diane Torrel
Northland Ctr, St. Louis Co. Health
Virginia, MN

j Cindy Turnure
Center for Health Statistics
Minnesota Department of Health

Erin VanEps
Kandiyohi Co. Public Health
Willmar, MN

Nancy Vanderburg
MCSHN
Minnesota Department of Health

Regan Warren
Safe Haven For Youth
Prior Lake, MN

Dorothy Webb
Mercy Hosp AdBH/AnokaHenn
Coon Rapids, MN

Joe Whitehawk, Director
Upper Sioux Community
Granite Falls, MN

Jean Wilhide
Crisis Connection
Richfield, MN

j Dawn Williams
Minneapolis MN

Gloria Winter
MRCI
Mankato, MN

Delight Wreed
N. Mankato, MN

John Yoakam
U of MN Youth & Aids Projects
Minneapolis, MN

j Cary Zahrbock
BHSI
Minneapolis, MN

Kristi Zellman
Watonwan Co. Public Health
St. James, MN

Wendy Zierman
Health Care for the Homeless
Minneapolis, MN