DEPARTMENT OF HEALTH

Suicide Prevention State Plan

COMMUNITY ENGAGEMENT SUMMARY BRIEF

The Suicide Prevention Unit, in collaboration with the Minnesota Suicide Prevention Taskforce, is currently creating the 2023-2027 Minnesota State Suicide Prevention Plan. The plan will be used to determine strategy priorities to support suicide prevention across the state with objectives to guide the work of the Suicide Prevention Unit, the Taskforce, and communities in preventing suicide. A community engagement process was facilitated the summer of 2021 through spring of 2022 to gather feedback for incorporation into the state plan, which will be released in 2023. Community members were asked to identify strengths and concerns related to current suicide prevention efforts and priorities for how the Taskforce can build community capacity for prevention.

Community engagement process

Over 650 Minnesotans provided feedback through three main avenues: short survey, regional listening sessions, and audience-specific focus groups.

Short survey

- Over 300 respondents
- Two key questions about community strengths and concerns related to suicide prevention

Regional listening sessions

- Over 150 participants across five region-specific meetings and one meeting of tribal community members
- Cross-sector dialogues including survivors, youth, and system response professionals

Focus groups

- Over 125 participants engaged in small group, audience-specific discussions
- Including but not limited to youth, veterans, farmers, people living with mental illness, LGBTQIA, Black and Latino community members

Key findings

1. Prevention efforts should reflect peoples' lived experiences, specific to culture.
2. Prevention efforts must improve the competency of informal and formal responders to provide supports within natural relationships because there are insufficient mental health services.
3. Fears of involuntary hospitalization, law enforcement involvement, and other punitive consequences are a key barrier to asking for help and using services.
4. Investment in social emotional learning and mental health literacy and support for youth from preschool through young adulthood must be a priority.

5. Substance use and suicide are interconnected; prevention interventions must likewise be integrated.
6. Effective policies for suicide prevention, including policies that promote social determinants of health, need to be identified and promoted.

Prevention reflective of lived experiences

Across demographics and communities, people requested culturally specific prevention efforts including messaging, trainings, screenings, early intervention, and postvention, led by and specific to their lived experiences. Minnesotans, including Black women, rural older men, LGBTQ+ youth, veterans, persons with disabilities, and American Indians, want prevention efforts rooted in a connection to their peers with shared lived experiences. How people are willing to talk about mental health and suicidal experiences varies by culture, race, and gender; a one size fits all approach does not work. While asking about suicide directly is considered best practice in the field, community members reported it is also a barrier for many people to engage in suicide prevention discussions. American Indian community members described it being more appropriate to focus efforts on the positive pieces of belonging and cultural teachings versus an overemphasis on the harms of suicide directly. Farmers and men in general likewise requested a focus on gratitude for their work and an emphasis on the value of their roles in the community and using that as a base to expand into mental health conversations. New immigrants of various ethnicities expressed preference for body-based screening questions (i.e., physical pain, tiredness) and discussions based in scenarios (i.e., how someone might feel after childbirth or a job loss) as more effective ways to begin conversations about suicide. Across the spectrum of prevention and intervention, community members reported the value of peer and survivor led work, rooted in culturally affirming understandings of mental health.

Expanding the competency of informal and formal responders

Community members perceived the current emphasis of suicide prevention efforts to be on strengthening skills to identify those who are struggling and refer to mental health services. However, the service infrastructure to respond to referrals is not sufficient to meet the current demand; in many places' services are not available, waitlists are incredibly long, and too many people are ultimately not able to access the care they need. At the same time, many community members identified close relations as the first people to whom they disclose mental health struggles, yet those people are often described as ill-equipped to provide meaningful support. To address this, participants recommended prevention efforts to improve the competency of informal and formal responders to improve their abilities to provide meaningful support prior to referrals.

- Encourage, train, and equip **peers, families, and parents/caregivers**, with particular emphasis on helping parents/caregivers better support their children.
- **Invest in peer-to-peer care systems,** centered in leadership by people with lived experience, and equip youth in peer outreach and support roles.

- Encourage, train, and equip **youth workers, faith leaders, teachers, county veteran service officers, and others** in social services to provide more support beyond immediate referral.
- Encourage, train, and equip **licensed providers** including social workers and medical staff to serve people within their scope of licensure in tandem with referrals to higher care.

People with prior suicidal experiences emphasized the importance of informal and formal responders understanding the difference between having a suicide plan and access to means (previously called 'active ideation') versus suicidal thoughts without a plan and access to means (previously called 'passive ideation'). In many cases, people with lived experience reported their loved ones and/or system professionals responded to their disclosures by inadvertently escalating the situation. For example, some people with lived experience shared that when they disclosed suicidal thoughts, the person they confided in felt it was necessary to engage with emergency services or suggested types of care that were not helpful because at that time the person disclosing was seeking a conversation, validation, and connection rather than crisis intervention. Building the skills within natural relationships to support someone who is experiencing suicidal thoughts was also described as an effective strategy to reduce stigma and isolation and reinforce positive connections and sense of belonging.

Fear of punishment is a key barrier to service use and help seeking

People with prior suicidal experiences across demographics and communities reported in many cases receiving a punitive response after seeking help, particularly in the form of involuntary hospitalization or a law enforcement response, both of which can result in bodily harm and were described as traumatic. In best-case scenarios, unwanted law enforcement response resulted in community shame and a loss of people's anonymity; in worst-case scenarios, particularly for Black and American Indian people experiencing a mental health crisis, there is the fear that unwanted police response may result in death.

Additionally, the following potential punitive responses were identified as barriers:

- Involvement of child protective services, or children being removed (particularly emphasized by Black and American Indian women).
- Not being able to keep weapons (particularly emphasized by veterans and rural men).
- Not being able to keep jobs or being functionally demoted within their jobs.

Additionally, the fear of criminal consequences also came up as a barrier to truthfully disclosing suicidal ideation coping mechanisms, such as drug use.

Social emotional learning and mental health literacy for youth

Community members reported enthusiasm to prioritize investment in social emotional learning (SEL) and mental health literacy and supports for youth across the age spectrum in response to seeing youth struggle from isolation and the unique challenges the COVID-19 pandemic has posed in recent years. Community members recommended SEL and mental health literacy

education for pre-K and elementary aged youth, as well as supporting youth-led and peer support spaces for middle school and high school students. Additional supports were particularly requested for youth who have lost someone to suicide or have been affected by family suicide attempts.

Integrated substance use and suicide prevention interventions

Substance use was commonly described as self-medicating to compensate for lack of accessible mental health care or unhealed trauma. People with prior suicidal experiences identified the need for suicide prevention and intervention efforts to be more integrated with harm reduction and treatment services for substance use, as well as coordinated upstream prevention efforts.

Effective policies for suicide prevention

A key question that continuously surfaced throughout the community engagement process was "What policy changes do we know would be effective at reducing suicide?" Community members across sectors were interested in policies to address social determinants of health that are drivers of suicide; for example, removing barriers to housing or employment for people with criminal records or a history of substance use and increasing access to medical or mental health care. It was also recommended to adopt policies to expand or require suicide prevention training for various professions such as medical providers, county veteran services officers, law enforcement, and educators as well as updating school requirements to train students in youth mental health first aid or a similar skill. Community members also emphasized supporting policy changes to increase the capacity of the mental health workforce including peer specialists, such as changing reimbursement and certification processes.

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