



South Carolina Suicide Prevention Coalition

Strategy for Suicide Prevention

2022 State Plan

Suicide Prevention Coalition

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Columbia, SC 29201

www.osp.scdmh.org



South Carolina
Department of Mental Health

DMH

Office of Suicide Prevention



This document is dedicated to the people of South Carolina. Its intention is to shed light and hope on the efforts of suicide prevention, intervention, and postvention across the state.

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Letter from Coalition Chairs



Dear fellow South Carolinians,

Suicide is a public health problem and a leading cause of death in the United States, and it is preventable. Suicide is currently the 10th leading cause of death in South Carolina and the third leading cause of death for children ages 10-24. It is also currently the second leading cause of death for those ages 25-34 in South Carolina. Two times as many people died by suicide than alcohol related vehicle accidents in South Carolina according to the Centers for Disease Control and Prevention.

The mission of the SC Suicide Prevention Coalition is, *"To develop broad-based support for suicide prevention through reducing stigma, advocating for change in policies and practices, and raising awareness about the public health issue of suicide - a preventable death - and with this living document we will continue to promote this statewide effort."*

Over the last few years, our South Carolina Suicide Prevention Coalition partners have worked together to achieve significant progress in increasing awareness, resources and care in our state. Our focus continues to be creating hope and saving lives. Even during the pandemic, South Carolina accelerated the work of moving forward with increasing access to best practice mental health care for everyone. One example of this is the statewide launch of the mental health self-check questionnaire, [Hope.ConnectsYou.org](https://www.hopeconnectsyou.org). We are the first in the nation to provide an interactive questionnaire for all South Carolinians, ages 18 and older. It assists participants in identifying needs, validating their experiences, and providing connection with trained staff from SCDMH and DAODAS for support and resources. Our many partners continue to offer various virtual trainings and events to equip our residents with innovative educational opportunities about mental health programs and suicide prevention, ensuring we all play an important part in this statewide fight to stop suicide.

"The greatness of a community is most accurately measured by the compassionate actions of its members." - Coretta Scott King

We are grateful for all of our SC suicide prevention champions and their work to save lives each and every day.

Senator Katrina Shealy and Dr. Kenneth Rogers



MISSION

The Coalition's mission is to develop broad-based support for suicide prevention through reducing stigma, advocating for change in policies and practices, and raising awareness about the public health issue of suicide — a preventable death.

Our History



Since suicide has been a topic of concern in the state of South Carolina for quite some time. In 2004, South Carolina's (SC) first Suicide Prevention Plan was released through the SC Department of Health and Environmental Control (SCDHEC), with an update later released in 2010.

The SC Suicide Prevention Coalition was relaunched in December 2016 with then-SC Department of Mental Health (SCDMH) State Director John H. Magill as the Coalition Chair. The purpose of the relaunch was to identify the state's need for suicide prevention, intervention, and postvention work. The relaunch of the Coalition included leadership and experts from state agencies, members of the SC Legislature, and community stakeholders.

The Coalition implemented a newly revised state plan in 2018. Throughout the last several years membership of the Coalition increased. In 2020 two additional Coalition Chairs were appointed to join Senator Katrina Shealy as Chair: Dr. Kenneth Rogers, SCDMH State Director and American Foundation for Suicide Prevention (AFSP) SC Associate Director, Vanessa Riley.

Since the Coalition's inception and throughout changes in leadership and representation, the goal remains unchanged: **Hope.**

Language Matters

“Using safe language allows a person to share their experiences without judgment, as they may be trying to communicate something that is very hard to put into words.”

Your Words Have **Power**

We cannot change the culture until we change the conversation.

Stigma has been a barrier to discussing suicide openly and honestly in past years. As we developed a better understanding about suicide, we began having open conversations and acknowledged suicide as a public health issue. When we say “Language Matters,” we need to be aware of the impact our language can have on those who experience suicidal thoughts and behaviors, as well as those who have survived a loss of someone to suicide. By using safe language when someone is talking about suicide, we increase our understanding and focus on the help and resources they need. Using safe language allows a person to share their experiences without judgment, as they may be trying to communicate something that is very hard to put into words. We do not want to minimize the pain and severity of the experience the person feels.

It is helpful to consider using language we would use with other health conditions, which does not place judgment or blame on the person who died by the health condition, such as a heart attack or cancer. For example, we would say a person “died of a heart attack,” just as we would say a person “died of a suicide.” This moves toward the view of suicide as a public health matter, opening up valuable conversations that promote understanding.

We want to change how society understands mental health and suicide – because when we open up and connect, talking can save lives. There are many terms used when talking about suicide; only some will be reviewed here. If you would like to review a full list, these terms are further described in the glossary in Appendix A.

When talking about suicide, language matters. There are terms we should avoid using because they perpetuate suicide’s stigma and moral judgment. We want to create an environment for safe discussions through caring and respectful language.

Language Matters

Some Guidelines When Talking About Suicide

Don't Use Words That Are Stigmatizing

- ◆ Commit Suicide/Chose Suicide
- ◆ Successful Attempt
- ◆ Failed Suicide Attempt
- ◆ Suicide Victim

Do Use Language Such as

- ◆ Died by Suicide
- ◆ Took his/her own life or ended life
- ◆ Attempt or Lived Experience
- ◆ Person who died by suicide

According to the National Alliance for Suicide Prevention, “communications can be a powerful tool to promote resiliency, encourage help-seeking, publicize prevention successes, and encourage actions that help prevent suicide.”³ We can promote hope through sharing stories of recovery from those with lived experience, or those who have experienced a suicidal crisis or a suicide attempt.

Educating the public about suicide is critical for encouraging help-seeking, raising awareness of risk in vulnerable populations, and advocating for new interventions and prevention strategies for those at risk. When suicide is talked about safely and accurately, we can help reduce the likelihood of its occurrence.

Language Matters

Helpful Definitions

Suicide Attempt

A self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury, but the individual does not die.

Suicide

Death caused by injuring oneself with the intent to die as a result of the behavior.

Suicidal Ideation

Thinking about, considering or planning for suicide. Ideation can be mild (i.e., not wanting to wake up) or more severe and clear (i.e., wanting to die by a certain method).

Suicidal Intent

Past or present evidence that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and inferred in the absence of suicidal behavior.

Preparatory Behavior

Acts or preparation towards engaging in suicide or self-harm behavior, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).

Non-suicidal Self-injury

Self-injurious behaviors where the intention is not to kill oneself.

Lived Experience

People with lived experience are individuals who have experienced a suicide attempt, or suicidal thoughts and feelings.¹

Loss survivor

An individual who has experienced a suicide loss.

Understanding How Suicide Impacts SC

SC Suicide Prevention Approach

We can prevent suicide and we know early intervention is key.

In studying suicide, understanding “how” and “why” it is happening is just as important as answering the “who, what, when, and where” questions.

Suicide is a complex problem occurring within constantly changing physical and social environments influenced by human behavior. There is a call from leaders in the field, including the Centers for Disease Control and Prevention (CDC), to address suicide prevention through a public health approach, using systems thinking.^{4,5} The public health approach targets large-scale changes and interventions so that entire populations are benefitted. The public health model for injury prevention has four steps:

1. Define and monitor the problem.
2. Identify the causes.
3. Develop and test intervention strategies.
4. Assure widespread adoption.

By using data to learn more about suicide in SC (Steps 1 &2), we can target resources to reach people when they need it most (Steps 3&4).

We can prevent suicide and we know early intervention is key. **We also know more than 90% of people who attempt suicide and survive do not go on to die by suicide.**⁶ The better-quality data that we can access, the better we can target interventions and resources and save lives.

In studying suicide, understanding “how” and “why” it is happening is just as important as answering the “who, what, when, and where” questions. The Coalition uses a mixed methods approach, where both quantitative (i.e., suicide death rates, key demographics affected) and qualitative data (i.e., stakeholder interviews, lived experience) tells the most comprehensive story of suicide prevention. SC has access to data on suicide deaths, through the SCDHEC SC Community Assessment Network (SCAN) database and the SC Violent Death Reporting System (SCVDRS). SC also has emergency department and hospital data on suicide attempts through the SC Integrated Data System (SCIDS), maintained by the SC Revenue and Fiscal Affairs Office (RFA). To our knowledge, very few states have access to statewide suicide attempt data in hospital settings and this serves as a great resource for statewide suicide prevention efforts.*

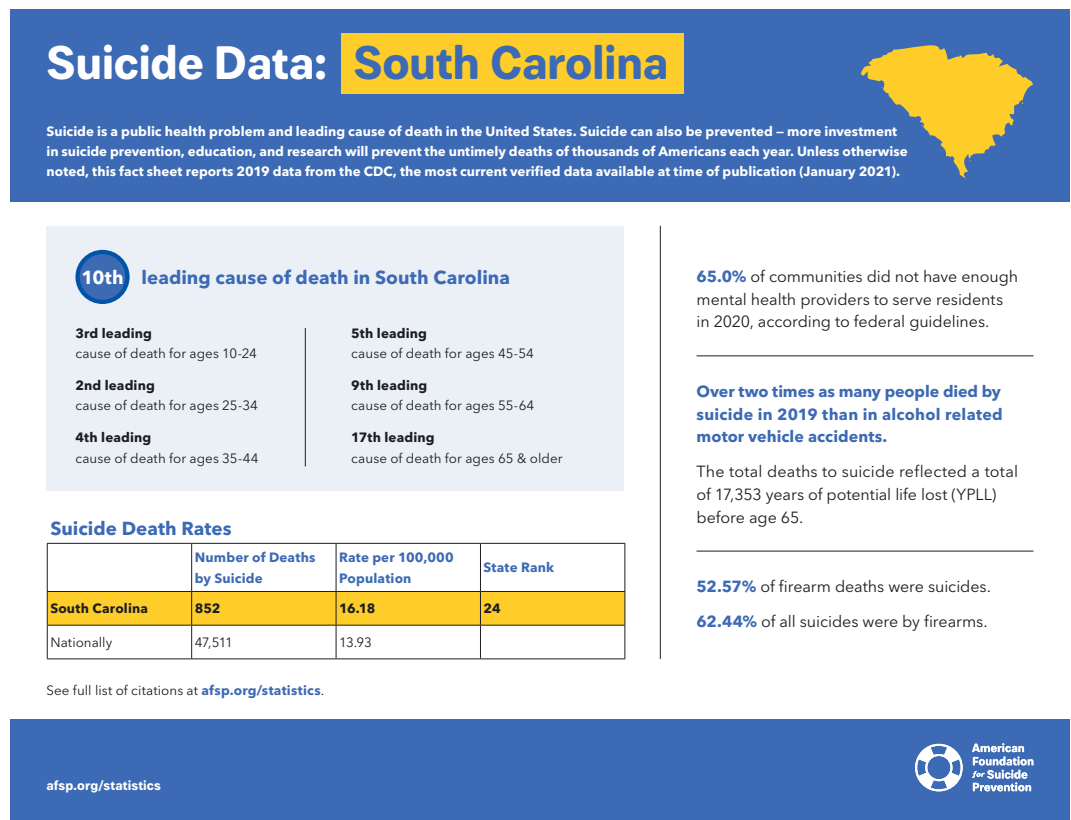
Understanding How Suicide Impacts SC

SC Suicide Deaths and Attempts

There were 4,059 deaths from suicide between 2015 and 2019 in SC, bringing the suicide average rate to 15.68 per 100,000.⁷ Based on 2019 data, SC is ranked 24th in the U.S. for suicide deaths, making it the 11th leading cause of death in SC. A person dies by suicide every 11 hours, costing more than \$748 million in lifetime medical and work loss cost in 2010.⁸ Demographic groups with the highest rates of suicide death in SC 2015 to 2019 include people who are: Whites, non-Hispanics, males, and people between ages 45-54 and 55-64. Demographic groups that have concerning upward trends include people who are Black/African Americans, Other Races, and males.⁷ There can be multiple circumstances around suicide that can create the perfect storm. According to SCVDRS data from 2015 to 2017, the most common circumstances around SC suicide deaths included mental health and physical health problems for males and females.⁹ Firearms were used in most SC suicide deaths (63%) between 2015 and 2019.⁷

* Footnote: Suicide attempt data comes from RFA and includes all SC ED hospital data. This data set is 2016-2019, and excludes 2015 due to the ICD 10 code changes that occurred during that year. Demographic titles, including race and age groups, are a reflection of the data source. Rates (per 100,000) were included when the data source allowed. DHEC Data rates are based upon 2000 Census numbers.

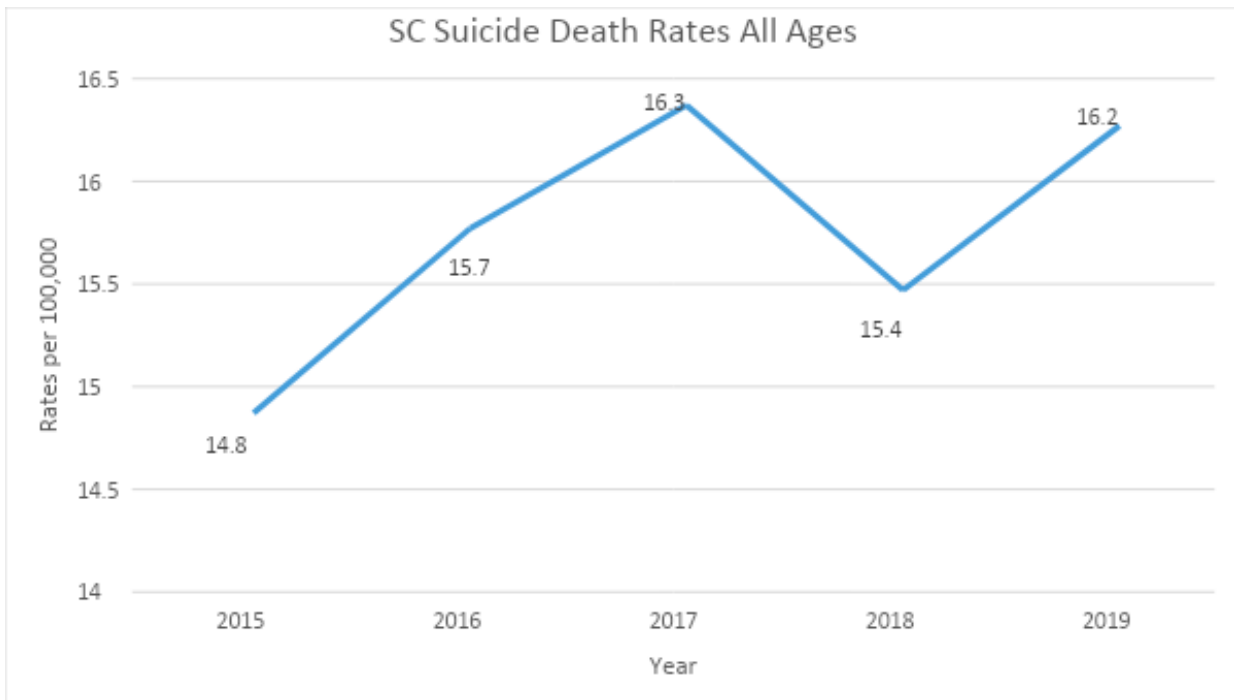
Figure 1.
2019 SC Suicide Statistics
Overview



Understanding How Suicide Impacts SC

SC Suicide Deaths and Attempts

Figure 2. 2015-2019 SC Suicide Death Rates All Ages

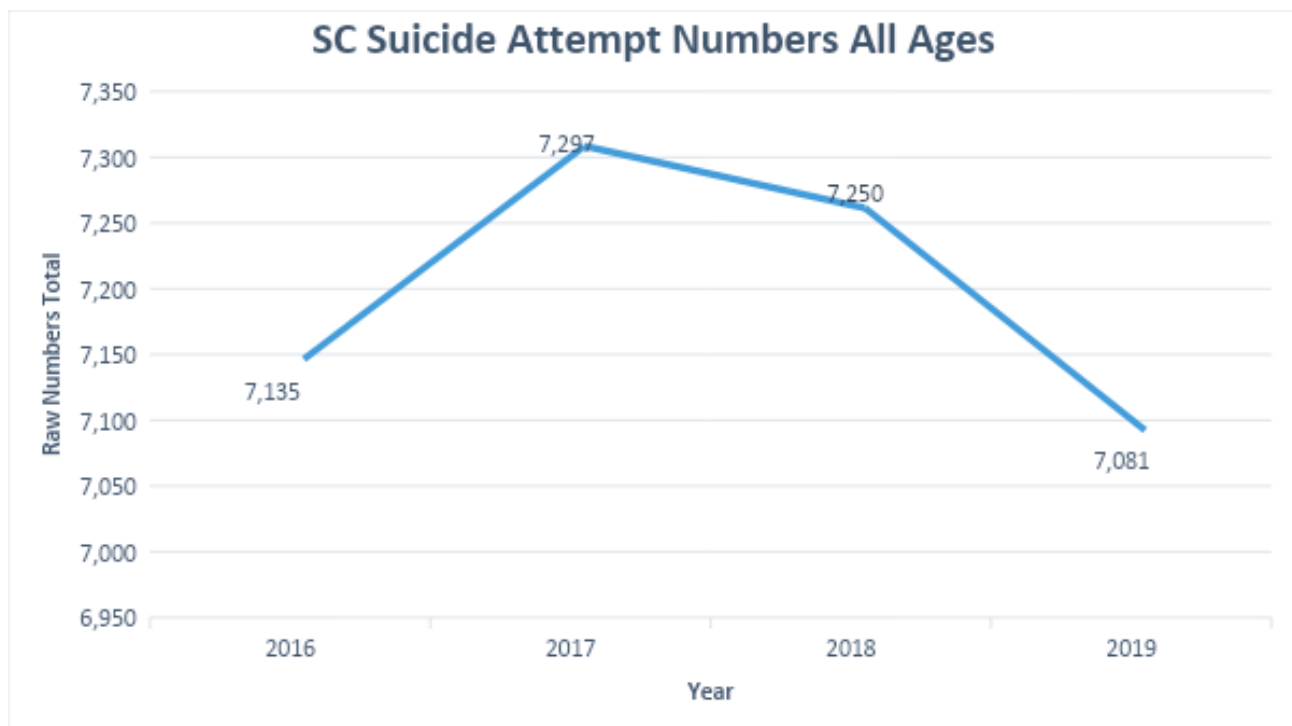


There were 28,763 suicide attempts in SC that were treated in the hospital setting from 2016 to 2019. The most common suicide attempt methods were poisoning/toxic effects and cutting/piercing. Demographic groups with the highest rates of suicide attempts in SC include females, Other Race, and ages 15-19.¹⁰ Demographic groups that have concerning upward trends include females, Black/African Americans, and Other Races within the age groups of 10-14, 15-19, 20-24, 25-34, and 35-44. Poisoning/toxic effects (60%) and cutting/piercing (26%) were most often used in suicide attempts between 2016 and 2019.¹⁰

Understanding How Suicide Impacts SC

SC Suicide Deaths and Attempts

Figure 3. SC 2016-2019 SC Suicide Attempt Numbers All Ages



Nearly everyone has a preconception about who is most likely to die by suicide. However, as Figures 4 and 5 illustrate below, any notion that suicide overwhelmingly affects one age group more than another is unfounded. Every age group is at risk of suicide, so plans to reduce suicide across an entire state must include strategies addressing all ages. There can be multiple circumstances increasing risk, and these circumstances vary across age groups. For youth and young adults (ages 10-24), drug use, financial stress, family trauma, and bullying are all multiple circumstances related to suicide death in SC.^{9, 11} For adults over the age of 25, mental health problems and current depressed mood were the leading circumstances in suicide deaths.⁹ Other leading circumstances for ages 25-44 included intimate relationship issues and jobs. For ages 45 and older, physical health problems and intimate relationship issues were other leading circumstances.⁹

Understanding How Suicide Impacts SC

Figure 4. 2015-2019 SC Suicide Death Numbers by Age Group

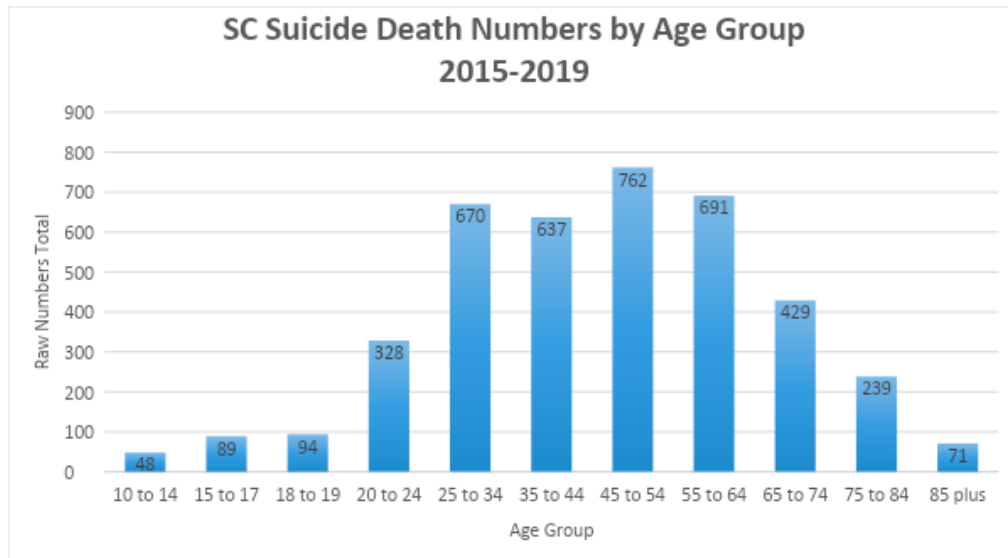
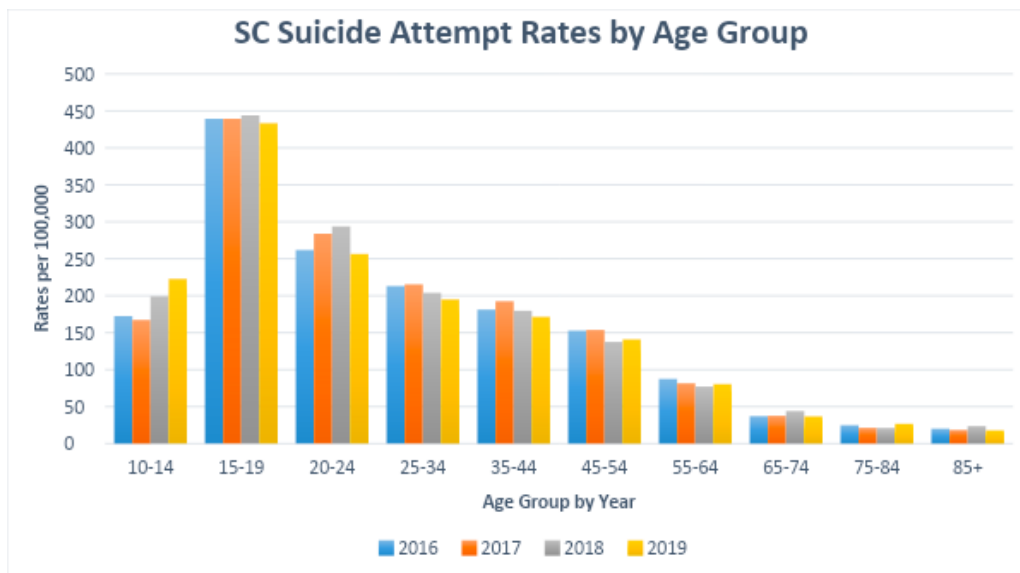


Figure 5. SC Suicide Attempt Rates by Age Group



Understanding How Suicide Impacts SC

The Need for More Data

...it is crucial that our state collects more specific and diverse information to help develop unique strategies for preventing suicide, especially among vulnerable populations.

While the SC data lens provides an in-depth look into the pervasiveness of suicide across many demographics, it is crucial that our state collects more specific and diverse information to help develop unique strategies for preventing suicide, especially among vulnerable populations. In collecting data about these groups, we learn their unique risk factors and how we might best assist individuals while respecting the elements of their cultures and situations. We need more accurate data collection in current sources, more accurate and inclusive data definitions, and more coordination of data sources.¹⁷ These issues include accurate and inclusive definitions around suicidality in data collection, such as:

- ◆ Expansion of racial categories beyond White, Black/African American, and Other Race,
- ◆ Improvement of data collection around ethnicity, as this data is often missing in large quantities,
- ◆ Inclusion of gender categories beyond male and female,
- ◆ Inclusion of sexual orientation data,
- ◆ Expanded definitions around military status,
- ◆ Collection of loss survivor data,
- ◆ Increased collection of suicide injury locations away from the home, and
- ◆ Increased real time data sources on suicidality.

Understanding Suicide

Vulnerable Populations, Protective/Risk Factors, and Warning Signs

The Coalition uses quantitative surveillance data to better understand who the vulnerable populations are in SC. However, qualitative data and lived experience helps to fill in the quantitative data gaps. According to SC stakeholder interview findings, people in the following populations were especially vulnerable for suicide risk, including:

- ◆ People in the Lesbian, Gay, Bisexual, Transgender, Queer, Asexual, Intersex, (LGBTQIA+) Communities
- ◆ People in the disability community,
- ◆ College students,
- ◆ People serving in the military or Veterans,
- ◆ People with low socioeconomic status, and
- ◆ Trauma survivors and those actively experiencing trauma.¹¹

Due to the fluid situation, data is emerging at a rapid pace around COVID-19's impacts on mental health, including suicide and vulnerable populations. COVID-19 has created an opportunity to bring mental health to the forefront, as taking care of mental health has emerged as an issue of interest during the pandemic. Past research from disease outbreaks predicts a rise in mental health care needs due to COVID-19.¹²⁻¹⁵ While we do not fully understand the impact of COVID-19 on mental health and suicide, the Coalition is utilizing the public health model to inform decision making. This approach includes using the most recent data available to make decisions about targeting resources and programming to vulnerable populations and geographic areas of need. The Coalition will continue to utilize data from ongoing SC suicide prevention initiatives to continue educating and intervening.

To properly design suicide prevention efforts and protocols, we need to better understand risk factors and how they contribute to an individual's suicidal experiences. Once we have a grasp on risk factors, we can begin instituting protective factors. Finally, we must familiarize ourselves with the warning signs of suicide. Knowing what to look for is critical to identifying individuals and connecting them to the support and mental health care they need.

Risk factors, protective factors, and warning signs are all important elements in suicide prevention, intervention, and postvention strategies. Risk factors are elements within a person's life that make it more likely an individual will be at risk of a mental health crisis. Risk factors include biological, psychological, or social aspects of the individual, their family or their environment. Protective factors are positive conditions and personal and social resources that reduce the likelihood of an individual developing a mental health crisis. For those already struggling with mental health concerns, these elements promote resiliency and reduce the potential for suicide and other high-risk behaviors.

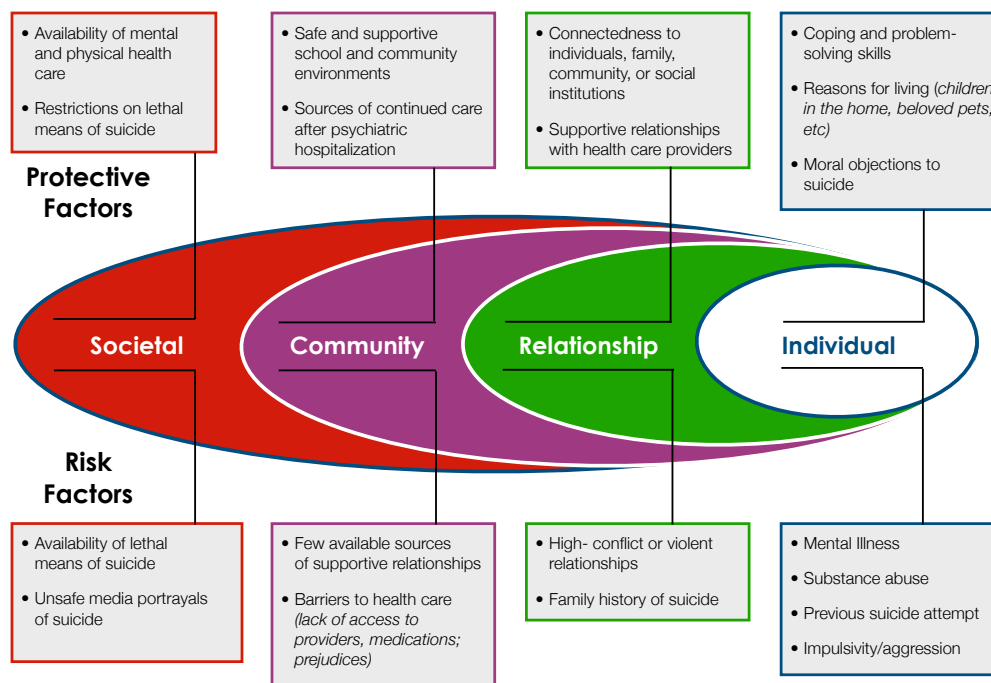
Understanding Suicide

Socioecological Model

One of the best tools for helping us understand risk and protective factors is the Socioecological Model, which categorizes the various factors that impact our lives.¹⁶ The model has four levels: Societal, Community, Interpersonal/Relationship, and Individual. Definitions and examples are listed below:

- ◆ Societal level refers to federal, state, and local policies that affect suicide prevention, intervention, and postvention (e.g., insurance coverage laws for mental health care).
- ◆ Community level refers to the geographical position on a smaller scale, as well the physical and social environment where people live, work, and play (e.g., stigma around seeking mental health care). This level also includes organizations that affect mental health care and suicide prevention, intervention, and postvention, thereby creating continuity between systems.
- ◆ Interpersonal/Relationship level refers to the health of the individual's connections to other people, such as romantic interests, friends, peers, and family members, and how those connections affect their mental health.
- ◆ Individual level refers to factors that are within that person, such as mental health concerns, financial concerns or job loss, a substance use problem, or pain from past or current trauma or loss.

Figure 6. Suicide Prevention Socioecological Model 16



SC Suicide Prevention Coalition Goals

Goal #1

Provide opportunities to improve health-seeking behavior and access to support, through promotion of information, resources, and programs designed to increase awareness that suicide is a preventable health problem.

Goal #2

Identify and address gaps in the statewide system of care by developing action plans through engaging community partners and stakeholders.

Goal #3

Increase suicide-specific legislation to promote education, awareness, research, funding, and other needs as they emerge in our state.

Goal #4

Improve identification and distribution of prevention, intervention, and postvention resources to the community.

Goal #5

Promote efforts to increase awareness of lethal means safety as an important part of a comprehensive approach to suicide prevention.

Resources

For Emergencies: If an individual is in immediate danger or poses a threat to someone else, please call 911.

State

◆ Deaf Services Hotline

1-803-339-3339 (VP) or deafhotline@scdmh.org

◆ Hope Connects You - Anonymous Self-Check Questionnaire

<https://hope.connectsyou.org/welcome.cfm>

◆ SC HOPES

1-844-SC-HOPES (724-6737)

◆ South Carolina Crisis Text Line

Text "HOPE4SC" to 741741

◆ South Carolina Department of Mental Health's Mobile Crisis Team

1-833-364-2274

◆ TU-APOYO (COVID Mental Health Line for Spanish Speakers)

1-833-TU-APOYO (882-7696)

◆ United Way

211
<https://www.uwasc.org>

Resources

National

◆ Crisis Text Line

Text "HOPE4SC" to 741741
<https://www.crisistextline.org>

◆ National Suicide Prevention Lifeline

1-800-273-8255 (TALK)
<https://suicidepreventionlifeline.org>

◆ Para la Prevencion de Suicidio

1-888-628-9454
<https://suicidepreventionlifeline.org/help-yourself/en-espanol>

◆ Trans Lifeline

1-877-565-8860
<https://www.translifeline.org>

◆ Trevor Project Lifeline (LGBTQIA+)

1- 866- 488-7386
<https://www.thetrevorproject.org>

◆ Veterans Crisis Line

1- 800- 273-8255 (Press 1)
Or Text a message to 838255
<https://www.veteranscrisisline.net>



Resources

National, State and Community Organizations

Direct Mental Health Care

✦ **South Carolina Department of Mental Health (SCDMH)**

DMH Public Information: 803-898-8581

Deaf Services: 800-647-2066 V-TTY

<https://scdmh.net>

Support Groups for Persons with Suicidal Thoughts or Behaviors

✦ **Mental Health America of South Carolina (MHA-SC)**

1-803-779-5363

<https://mha-sc.org>

✦ **National Alliance on Mental Illness (NAMI-SC)**

1-803-733-9591

<https://namisc.org>

Support for Loss Survivors

✦ **American Foundation for Suicide Prevention (AFSP)**

[AFSP.org/find-a-support-group](https://afsp.org/find-a-support-group)

✦ **Alliance of Hope**

<https://allianceofhope.org/>

✦ **Friends For Survival**

<https://friendsforsurvival.org/>

✦ **Healing Conversations**

<https://afsp.org/healing-conversations>

✦ **Suicide Awareness Voices of Education (SAVE)**

<https://save.org/find-help/coping-with-loss/>

Resources

National, State and Community Organizations

Resources for Attempt Survivors

◆ **[American Foundation for Suicide Prevention \(AFSP\)](https://afsp.org/after-an-attempt)**

<https://afsp.org/after-an-attempt>

◆ **[Suicide Awareness Voices of Education \(SAVE\)](https://save.org/find-help/attempt-survivor-resources)**

<https://save.org/find-help/attempt-survivor-resources>

Resources for Stories of Hope and Recovery

◆ **[American Foundation for Suicide Prevention \(AFSP\)](https://afsp.org/blog)**

[AFSP.org/blog](https://afsp.org/blog)

◆ **[National Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/stories)**

<https://suicidepreventionlifeline.org/stories>

◆ **[Substance Abuse and Mental Health Services Administration \(SAMHSA\)](https://store.samhsa.gov/product/Stories-Of-Hope-And-Recovery-A-Video-Guide-for-Suicide-Attempt-Survivors/SMA12-4711DVD)**

[https://store.samhsa.gov/product/Stories-Of-Hope-And-Recovery-A-Video-Guide-for-Suicide-Attempt- Survivors/SMA12-4711DVD](https://store.samhsa.gov/product/Stories-Of-Hope-And-Recovery-A-Video-Guide-for-Suicide-Attempt-Survivors/SMA12-4711DVD)

Resources

National, State and Community Organizations

Training Opportunities

◆ **American Foundation for Suicide Prevention (AFSP) - SC Chapter**

1- 803-528-4315

AFSP.org/sc

◆ **Mental Health America of South Carolina (MHA-SC)**

1-803-779-5363

<https://mha-sc.org>

◆ **National Alliance on Mental Illness (NAMI-SC)**

1-803-733-9591

<https://namisc.org>

◆ **South Carolina Department of Mental Health
Office of Suicide Prevention**

1-803-896-4740

<http://osp.scdmh.org>

◆ **South Carolina National Guard**

1-803-299-2736

Current Coalition Members

Chairs

Sen. Katrina Shealy *(2016 - present)*

South Carolina State Senate District 23
Chairman of Family & Veteran Services Committee
South Carolina Suicide Prevention Coalition Co-Chair

Dr. Kenneth Rogers *(2020 - present)*

State Director
South Carolina Department of Mental Health
South Carolina Suicide Prevention Coalition Co-Chair

Current Coalition Members

Members

SFC Christopher Allen (2016 - present)

State Suicide Prevention Program Manager
South Carolina Army National Guard

Jennifer Butler MSW, LISW-CP/S (2019 - present)

Director of the Office of Emergency Services
Office of Emergency Services
South Carolina Department of Mental Health

Dr. Robert Breen (2016 - present)

Medical Director of Acute Services at Bryan Psychiatric Hospital
South Carolina Department of Mental Health

Michael Cunningham (2016 - present)

Vice President for Community Health Partnerships
AnMed Health Systems

Shannon D'Alton, MSN, CPNP, CHPPN (2021 - present)

Department of Pediatrics
The Medical University of South Carolina

Rep. Shannon Erickson (2016 - present)

South Carolina State House District 124

Sara Goldsby MSW, MPH (2020 - present)

State Director
South Carolina Department of Alcohol and Other Drug Abuse Services

Sec. William Grimsley – (March 2020 - present)

MG, US Army (Ret)
Secretary of Veterans' Affairs
South Carolina Department of Veterans Affairs

Dr. Jim Hayes (2016 - Present)

South Carolina - Board President
National Alliance on Mental Illness

Kathy Hugg, LPC (2021 - present)

Director of Behavioral Health
South Carolina Department of Health and Human Services

Current Coalition Members

Members

Col. Chris Hyman (2020 to present)

Director of Plans, Operations and Training
South Carolina Army National Guard

Susan Jackson RN, MPH (2018 - present)

Program Manager
DHEC South Carolina Violent Death and State Unintentional Drug Overdose Reporting Systems

Thornton Kirby (2016 - present)

President and CEO
South Carolina Hospital Association

Alisa Liggett (2016 - present)

Chairperson, Student Care and Outreach Team
University of South Carolina

Bill Lindsey (2017 - present)

Executive Director
National Alliance on Mental Illness - South Carolina

Judge Amy McCulloch (2016 - present)

Probate Judge
Richland County, South Carolina

John H. Magill (2016 - present)

State Director (Retired)
South Carolina Department of Mental Health
South Carolina Suicide Prevention Coalition Chair (2016-2019)

Dr. Sabrina Moore (2016 - present)

Director, Office of Student Intervention Services
South Carolina Department of Education

Dr. Meera Narasimhan MD, DFAPA (2016 - present)

Professor and Chair, Department of Neuropsychiatry and Behavioral Science
& Sr. Medical Director, Behavioral Health
Prisma Health (Midlands)
Special Advisor to University of SC President
Health Innovations and Economic Development
University of South Carolina

Current Coalition Members

Members

Karen Reynolds (2018 - present)

Executive Director of Innovations
South Carolina Hospital Association

Janie Simpson (2018 - present)

Chairperson
South Carolina Mental Health State Planning Council

Molly Spearman (2016 - present)

State Superintendent of Education
South Carolina Department of Education

Dr. Shawn Stinson, MD FACP (2017 - present)

Senior Vice President of Healthcare Innovation and Improvement
Blue Cross Blue Shield of South Carolina

Col. Ronald Taylor (2016 - present)

Chief of Staff
South Carolina National Guard (Retired)

John Tjaarda (2022-present)

Area Director
American Foundation for Suicide Prevention

Dr. Peter Warren (2017- present)

Suicide Prevention Program Manager
Columbia Veterans' Affairs Health Care System

Stacy Warren

Program Officer
The Duke Endowment

Kacey Schmitt MSW, LISW-CP/S (2018 - present)

Director of Social Work
South Carolina Department of Health and Environmental Control

Amanda Whittle J.D., CWLS (2019 - present)

Agency Director and State Child Advocate
South Carolina Department of Children's Advocacy

Thank you to all who have contributed to this work over the years.

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Appendices

Appendix A – Language Matters:

The following terms are defined in reports from the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention:

- **Affected by suicide:** All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.
- **Bereaved by suicide:** Family members, friends, and others affected by the suicide of a loved one (also referred to as "survivors of suicide loss").
- **Means:** The instrument or object used to carry out a self-destructive act, such as chemicals, medications, or illicit drugs.
- **Methods:** Actions or techniques that result in an individual inflicting self-directed injurious behavior, such as overdose, suffocation, etc.
- **Preparatory acts:** Acts or preparation toward making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or a thought, such as assembling a method (such as collecting pills) or preparing for one's death by suicide (writing a suicide note, giving things away).
- **Postvention:** Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.
- **Protective factors:** Positive conditions and personal and social resources that reduce the likelihood of an individual developing a disorder. For those already struggling with a disorder, these elements promote resiliency and reduce the potential for suicide and other high-risk behaviors. Protective factors may encompass biological, psychological, or social aspects in the individual, their family, or their environment.
- **Resilience:** Capacities within a person or organization 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.
- **Risk factors:** Elements within a person's life that make it more likely that individual will develop a disorder. Risk factors may encompass biological, psychological, or social aspects in the individual, their family or their environment.
- **Suicidal behaviors:** Conduct related to suicide, including preparatory acts, suicide attempts and deaths.
- **Suicidal ideation:** Thinking about, considering, or planning suicide.
- **Suicidal plan:** A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior, such as a description of a time frame and method.
- **Suicide experiences:** Suicidal ideations, suicide plans, and suicide attempts. People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts, and people who experience all forms of suicidal thoughts and behaviors are at greater risk of dying by suicide.
- **Suicide (die by suicide, death by suicide, suicide death):** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- **Suicide attempt:** A non-fatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
- **Suicide crisis (suicidal crisis or potential suicide):** A situation in which a person is attempting to kill themselves or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

Appendices

The following terms are provided from the Centers for Disease Control and Prevention, Division of Violence Prevention:

Terms for Use/Definitions^{1,2}

- **Suicide Attempt:** A self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury, but the individual does not die.
- **Aborted Suicide Attempt:** A person takes steps to injure self but stops prior to fatal injury. This can occur at any point during the act such as after the initial thought or after onset of behavior.
- **Interrupted Suicide Attempt:** A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act such as after the initial thought or after onset of behavior.
- **Suicide:** Death caused by injuring oneself with the intent to die as a result of the behavior.
- **Suicidal Ideation:** Thinking about, considering or planning for suicide. Ideation can be mild (i.e., not wanting to wake up) or more severe and clear (i.e., wanting to die by a certain method).
- **Suicidal Intent:** Past or present evidence that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and inferred in the absence of suicidal behavior.
- **Preparatory Behavior:** Acts or preparation towards engaging in suicide or self-harm behavior, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
- **Non-suicidal self-injury:** Behaviors where the intention is not to kill oneself.

Terms Not Acceptable For Use¹

- **Completed or Committed Suicide:** This terminology implies achieving a desired outcome. Alternate term: Died by Suicide
- **Failed or Unsuccessful Attempt:** This terminology gives a negative impression of the person's action, implying an unsuccessful effort aimed at achieving death. Alternate term: Suicide attempt
- **Nonfatal Suicide:** This terminology is a contradiction. "Suicide" indicates a death, while "nonfatal" indicates that no death occurred. Alternate term: Suicide attempt
- **Successful Suicide:** This term also implies achieving a desired outcome. Alternate term: Suicide or Death by Suicide
- **Suicidality:** This terminology is often used to refer simultaneously to suicidal thoughts and suicidal behavior, such as assessing for suicidality. These phenomena are vastly different in occurrence, associated factors, consequences and interventions so should be addressed separately when describing specific thoughts and/or behaviors. Alternate terms: Suicidal thoughts and suicidal behavior.
- **Suicide Gesture, Manipulative Act, and Suicide Threat:** Each of these terms gives a value judgment with a pejorative or negative impression of the person's intent. They are usually used to describe an episode of nonfatal, self-directed violence. A more objective description of the event or behavior is preferable.

Appendices

Appendix B – Agency Acronyms/Abbreviations

AFSP	American Foundation for Suicide Prevention
CDC	Centers for Disease Control and Prevention
DHHS	U.S. Department of Health and Human Services
MHA	Mental Health America
NAMI	National Alliance on Mental Illness
RFA	South Carolina Revenue and Fiscal Affairs
SAMHSA	Substance Abuse and Mental Health Services Administration
SCAN	SC Community Assessment Network
SCDHEC	South Carolina Department of Health and Environmental Control
SCDMH	South Carolina Department of Mental Health
SCIDS	South Carolina Integrated Data System
SCVDRS	South Carolina Violent Death Reporting System



South Carolina Suicide Prevention Coalition

Strategy for Suicide Prevention
2022 State Plan

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