

STATE STRATEGIES FOR AVERTING EARLY DEATHS

Innovations and Best Practices for Preventing Suicide

ACKNOWLEDGMENTS

This National Governors Association Center for Best Practices (NGA Center) publication is supported by a grant from the Center for Disease Control and Prevention (CDC). NGA Center also would like to thank CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) for their generous support of the convening which informed lessons learned highlighted in the publication.

NGA Center would also like to recognize Akeiisa Coleman for her thoughtful contribution to the convening and to this publication during her tenure at NGA. Her work was instrumental in the successful execution of the convening and in laying the foundation for this publication.

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Wilkniss, S. (2019). *Strategies for preventing suicide: Innovations and best practices In state-level approaches*. Washington, DC: National Governors Association Center for Best Practices.



EXECUTIVE SUMMARY

Death by suicide is a complex individual, relational and public health problem. The incidence of such deaths over the past two decades has increased nearly 30%, with half of states showing even higher rates.¹ The Intermountain West and the Pacific Northwest are disproportionately burdened with high (and increasing) rates of suicide, especially among middle-aged adults and certain at-risk populations. Evidence shows that suicide can be prevented, and state-level strategies to stem the trend are evolving. To facilitate state-to-state exchange of best practices in this especially challenged region of the country, the National Governors Association Center for Best Practices, in partnership with the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration, hosted a 1.5-day, day convening with governors' senior advisors from 13 states (**Alaska, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming**). Lessons learned fall into three main categories:



Take a Comprehensive, Collaborative Approach

Governors can set the vision and establish common goals across state government to drive cross-sector collaboration for addressing the factors that contribute to suicide and related self-injury. Data-informed coordination among public health, health and human services, behavioral health, public safety/corrections and other agencies that touch high-risk populations are instrumental in identifying opportunities and directing resources. Such a collaborative approach, guided by a shared plan, can expedite adoption of best practices to reduce suicide.



Foster Strategic Partnerships

Governors can convene and mobilize key stakeholders across systems to complement local efforts – including families, health care and social service providers, faith-based organizations, schools, senior centers, veteran organizations, tribal leaders and related sectors – to prevent suicide and promote resilience. More unique partnerships aimed at reducing suicide by highly lethal means, such as firearms, include state suicide leads, public health officials, firearm dealers, shooting ranges and gun shows.



Invest in Upstream Prevention Efforts

Governors can encourage policy, programmatic and budgetary alignment across agencies specifically aimed at modifying risk factors associated with suicide and promoting protective factors. Investing in primary prevention efforts at the individual and family levels as well as the community and societal levels is key. For example, many programs start with the school as a hub, and current emphasis on social emotional learning in schools may be effective in this effort.

INTRODUCTION

Suicide is a top-10 leading causes of death and one of only three causes that has increased in frequency.² Recent data from the Centers for Disease Control and Prevention (CDC) show that the overall rate has increased nearly 30% between 1999 and 2016, and experts consider suicide to be a major contributor to the decline in life expectancy in the United States.³ The highest rates of suicide occur in non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic white populations.⁴ However, rates have increased in all racial/ethnic groups in both women and men, with steep increases observed in middle-aged women (53%) and men (29%).⁵ Suicide rates for veterans and active military personnel recently surpassed that of civilians, and certain occupations are associated with higher rates.⁶ Notably, *nearly half of all decedents had no known mental health condition*, underscoring the complex, multideterminant nature of suicide and suggesting a broader array of possible protective factors.⁷ Figure 1 and Figure 2 summarize these contributing factors and intervention approaches based on the best evidence to date.⁸

Suicide rates are notably and consistently higher in rural counties than in metropolitan counties.⁹ It is especially prevalent in the Intermountain West and Pacific Northwest (see Figure 3). The reason for this higher rate is unclear, but contributing factors are thought to include demographic composition, residential instability, fewer economic opportunities and cultural influences in the region coupled with challenges accessing health and social support systems in these states because of their vast rural and frontier areas.¹⁰

In response to requests from states in this challenged region of the country, the National Governors Association Center for Best Practices (NGA Center), in partnership with CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA), convened 13 states in March 2018 – **Alaska, Arizona, Colorado,**

Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming – to discuss innovative approaches to suicide prevention. Key national and local experts at the meeting included representatives from the CDC Division of Injury Prevention; the SAMHSA Suicide Prevention Branch; the Federal Working Group on Suicide Prevention; the SAMHSA National and Region 8 administrators; the Center for the Study and Prevention of Suicide at the University of Rochester; the Suicide Prevention Resource Center (SPRC); the Defense Suicide Prevention Office; the Department of Veterans Affairs (VA); the U.S. Indian Health Service; Rocky Mountain Mental Illness Research, Education and Clinical Centers and Centers of Excellence; and the Great Plains Tribal Chairmen's Health Board. Lessons learned, resources and concrete initiatives shared at the convening are presented in the sections that follow. The majority of these findings are not regionally specific and highlight actions that all governors can take to prevent suicide.



Comprehensive Suicide Prevention Approach

A comprehensive suicide prevention approach brings together public health, behavioral health, human services, educators, employers and related sectors to improve systems and align policies and programs across state agencies (horizontal alignment) and with federal, state and community partners (vertical alignment).¹¹ Successful collaboration requires a dedicated infrastructure and sustainable investment (and reinvestment) strategy aimed at developing and maintaining prevention efforts and providing services and support to people in crisis. Governors play a key role in this approach, setting the vision, engaging key partners and empowering agency leaders to pursue a shared suicide prevention plan.

A comprehensive approach is data driven and includes an environmental scan across systems (e.g., kindergarten through grade 12 [K-12], higher education, health, public health and veterans affairs), usual sources of support (e.g., community nonprofit organizations, employers, religious/faith groups) and populations at high risk of suicide to identify gaps and opportunities. With that information, strategic plans can be tailored to fit the setting (e.g., schools, primary care settings, gun shows) and identify key partners.¹² Figure 2 on next page summarizes key prevention and intervention strategies matched to risk and protective factors that can be incorporated into a comprehensive approach.¹³ Additional information on these strategies can be found in the [CDC technical package on preventing suicide](#).

FIGURE 1. **Suicide: Contributing Factors**

- **Mental health conditions**
- **Relationship problems**
- **Crisis in the past or upcoming two weeks**
- **Substance misuse**
- **Physical health problems**
- **Job and financial difficulties**
- **Criminal legal problem**
- **Loss of housing**

FIGURE 2. CDC Strategies for Preventing Suicide

STRATEGY	APPROACH
Strengthen economic supports	<ul style="list-style-type: none"> • Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	<ul style="list-style-type: none"> • Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through system change
Create protective environments	<ul style="list-style-type: none"> • Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	<ul style="list-style-type: none"> • Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	<ul style="list-style-type: none"> • Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	<ul style="list-style-type: none"> • Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessens harms and prevent future risk	<ul style="list-style-type: none"> • Postvention • Safe reporting and messaging about suicide

Source: Stone, D. M., Holland, K. M., Bartholow, B., Crosby, A. E., Davis, S., & Wilkins, N. (2017). *Preventing suicide: A technical package of policies, programs, and practices*. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf>

Convening participants noted that the Zero Suicide initiative is a core component of a comprehensive approach and can serve as a starting point. This initiative, which is included in the 2012 National Strategy for Suicide Prevention,¹⁴ centers on a systemwide commitment to preventing suicide in all health and behavioral health care settings.¹⁵ Key elements of Zero Suicide include training clinicians and staff so that they feel confident treating individuals at risk of suicide; using evidence-based treatments that target suicidal thoughts and behavior; maintaining continuous contact and support as individuals transition between care settings; and taking a quality improvement approach, driven by data, to inform system change.^{16,17} In places where this system of suicide care has been adopted, the rate of deaths by suicide among plan members/system enrollees has decreased by 40% to 60%.¹⁸

Expert participants agreed, however, that an effective, comprehensive approach must go beyond health care settings and involve multiple, complementary interventions integrated at the community level. Such an approach not only incentivizes best practice screening and interventions in health systems but also addresses upstream risk factors to alter life trajectories.¹⁹ Best practice upstream prevention efforts map onto environments where target populations are found (e.g., adolescents attending

school, organized work sites) and provide specialized interventions for those at greater risk (e.g., students who have dropped out of school, unemployed workers).²⁰ At the NGA Center convening, the following steps for developing a comprehensive suicide-prevention approach were shared:

- ▶ Analyze your data to determine need and establish priorities – a data dashboard can facilitate tracking and continuous quality improvement.
- ▶ Conduct state- and local-level environmental scans to identify initiatives, programs and leaders; determine readiness; and direct resources.
- ▶ Maintain broad and consistent leadership involvement.
- ▶ Set goals aligned across all partners.
- ▶ Identify key risk and protective factors.
- ▶ Select or develop interventions with at-risk populations and upstream prevention efforts in mind.
- ▶ Monitor, track and evaluate initiatives for continuous program improvement and to measure meaningful outcomes.
- ▶ Include sustainability planning.^{21,22}

CDC, SAMHSA and SPRC offer resources, including implementation guides for program design, implementation, tracking and evaluation (e.g., [CDC technical package on preventing suicide](#) and [SPRC's Resources and Programs](#)). At the state level, Colorado and Washington illustrate the type of comprehensive, governor-led approaches that can be carried out in partnership with state legislatures.



Strategic Partnerships

When considering the social geography and where collaboration could improve suicide prevention efforts, several natural partnerships and innovative opportunities emerge. Law enforcement/public safety leads are natural partners due to their often front-line position on the crisis response continuum and their role in preventing suicide among incarcerated populations. Partnering effectively with community leaders and natural support systems, such as faith-based organizations and schools, is essential to a comprehensive prevention approach. Other vital partners include entities focused on suicide prevention in specific at-risk populations, such as veterans, AI/AN populations and employers whose occupations are associated with higher rates of suicide. Convening participants emphasized that identifying champions for those populations and taking time to build relationships with them are essential to establishing effective partnerships. They noted that intentionally finding areas of agreement and recognizing points of divergence are invaluable in relationship

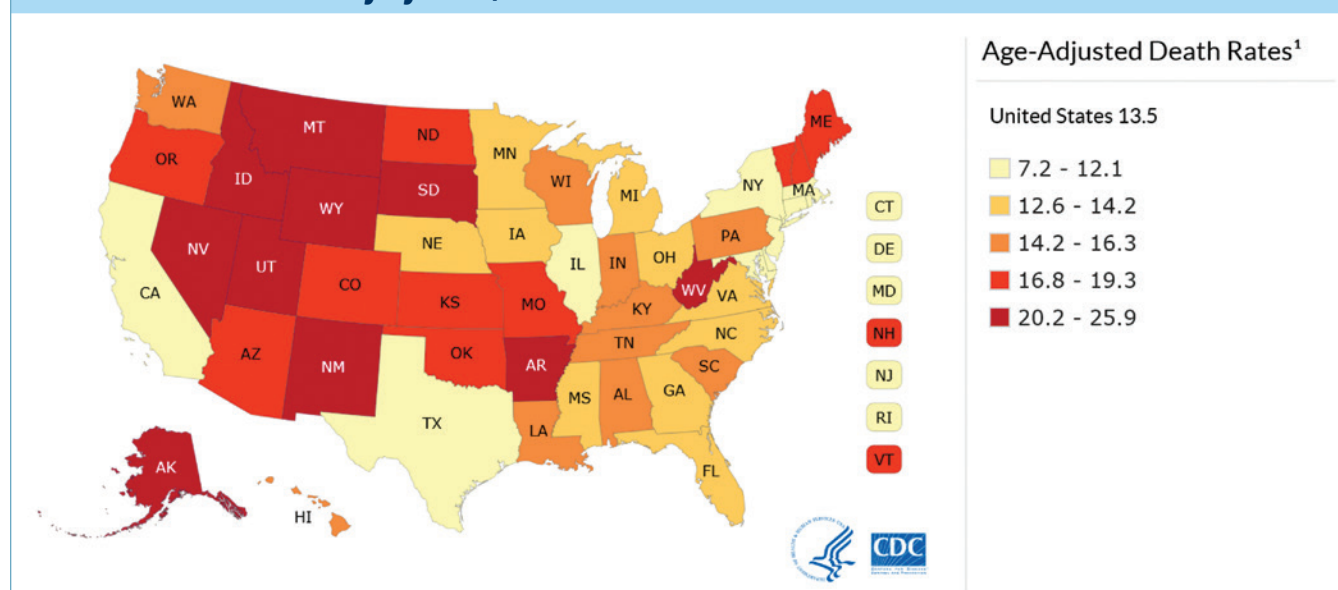
building among multiple partners, especially when tackling contentious issues such as stigma and lethal means. One example is Utah's strategic partnership among health, public safety and the Utah Shooting Sports Council (USSC). The state's phased approach to collaboratively raising awareness and reducing access to lethal means provides a model for partnership.

Convening participants underscored that strategic partnerships with high-risk populations hinge on a culturally competent approach.

Veterans

Experts at the NGA Center convening shared unique strategies to improve suicide prevention among veterans informed by relationship structures encountered while in military service. In that setting, unit cohesion can be a primary protective factor, creating a sense of belonging, trusting relationships and a broader support network. Upon leaving the service, the absence of this connectedness, which results in social isolation, can be a risk factor for suicide. States can explore partnerships with veteran-serving groups like Semper Fi, which hosts meetings for veterans and organizes reunions for units, as a component that facilitates the transition from active-duty military to civilian life. In addition, states can build on local efforts such as the Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families, launched by SAMHSA and VA in February 2018.²³

FIGURE 3. **Suicide Mortality by State, 2017**



COLORADO: Comprehensive, Collaborative, Public Health Approach to Suicide Prevention

Colorado has set an ambitious goal to reduce deaths by suicide in the state by 20% by 2024 and is developing a comprehensive plan to achieve it. The state is taking a cross-sector, collaborative and data-informed approach based on actionable research. State leaders are systematically building on existing infrastructure, collaborations and opportunities toward this goal. Key components include:

Leadership and political direction:

- Leadership support from the governor and the Colorado Legislature. (Gov. Jared Polis and Gov. John Hickenlooper before him prioritized a comprehensive approach.)
- In the past few years, legislation supporting the comprehensive suicide prevention approach has facilitated infrastructure development.

Key infrastructure:

- Senior executive leadership through the Colorado Department of Public Health and Environment.
- Suicide Prevention Commission (public-private partnership) and multiple years of consistent funding to improve suicide prevention efforts in the state.
- The Colorado-National Collaborative, formed in 2015 of state, local and national experts — a partnership to design and implement the first state-level comprehensive suicide prevention strategy and tracking processes to share lessons learned with other states.
- State investment in a statewide mental health crisis system and support across federal, county and community behavioral health centers.

Agreement on approach:

- Agreement among state public health and mental health leads on the direction of activities and resources, with a focus on both upstream and downstream interventions.
- Multiphase implementation approach starting with six counties.

Using CDC's [Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#) and [Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention](#) as starting points, Colorado coupled best practices with state-specific data gleaned through the interactive [Colorado Violent Death Reporting System](#) to set priorities. Resulting priority areas include:

- **Zero Suicide Initiative.** The initiative is a commitment to focusing on preventing suicide across health and behavioral health care settings through a practical, evidence-based framework. Colorado is instituting the Zero Suicide approach across settings of care and populations, including mental and behavioral health, integrated care, emergency departments, hospitals, primary care (a priority for older adults), U.S. Departments of Veterans Affairs and Defense programs, and Colorado Department of Corrections populations.
- **Youth: Primary Prevention, Shared Risk and Protective Factors.** Invest in and align primary prevention efforts across systems to enhance protective factors and encourage help-seeking behaviors for high-risk populations. Areas of focus include schools, courts, foster care, child welfare, early childhood programs, faith-based organizations (Faith-based organizations), military families and others deemed essential to individual communities.
- **Adults: Safety, Public Awareness and Changes in Social Norms.** Address policies and practices in these domains, starting with priority populations and systems, including veterans, high-risk industries and occupations (such as construction), criminal justice systems and financial service systems (e.g., unemployment, bankruptcy).
- **Older Adults: Primary Care and Connecting With Community Services.** Improve capacity in primary care and community service settings to address suicidal ideation and promote connectedness for older adults across a range of services and populations, including social services, senior centers, assisted or active living, death and dying services, fall prevention, faith-based organizations, veterans, public service providers, home-based care and pain management.

This multiphase effort will begin with **six counties** based on need, resources, local partners and the priorities identified above. Health systems, prison systems, government agencies (state and county) and community-based agencies engaged in prevention efforts will conduct an environmental scan of local approaches, including populations served, care settings, funding sources and existing collaborations. They will then partner with the state to build strategic partnerships in each county to establish community buy-in and ownership and develop a fiscally sustainable approach. The state is working with research partners on a multipronged evaluation approach.

WASHINGTON: Comprehensive Legislative and Executive Approach to Addressing Suicide Prevention

Washington State has been a leader in advancing comprehensive suicide prevention efforts through legislation. Starting in 2011, laws have been enacted that focus on both upstream and health system approaches (see **Appendix A** for the full list of legislation). Priority domains include:

- Health care and behavioral health provider training requirements.
- Behavioral health and suicide prevention in schools (including K-12 and higher education).
- Public awareness campaigns and suicide prevention education among key partners (such as firearms dealers and firing ranges).
- Focus on at-risk populations (e.g., agricultural industry, veterans, youth).

In 2016, Gov. Jay Inslee issued an [Executive Order 16-02](#) to implement the state Suicide Prevention Plan. Implementation partners include the governor's health leadership team, U.S. Department of Veterans Affairs, the Governor's Office of Indian Affairs and the Washington Office of Superintendent of Public Instruction, among others. The focus is on conducting a gap analysis to inform policy, culturally competent programming and investment; a social marketing campaign; screening; and integration of primary care and behavioral health.

There is a growing body of research on promising practices for reducing suicide among military personnel and veterans. For example, the Military Suicide Research Consortium and the National Center for Veterans Studies have conducted multiyear studies on dozens of prevention and assessment tools and intervention models (resources are available on the [DoD Congressionally Directed Medical Research Programs](#) and [University of Utah National Center for Veterans Studies](#) sites). Based on the evidence, the VA health system has improved its suicide prevention efforts, but many veterans receive health care outside of the VA system. To improve outcomes in this population, states can support adoption of evidence-based and emerging practices by aligning policy and programming efforts with their state VA partners. When directly providing health care and services to veterans outside of VA's system, states can consider (1) requiring that providers undergo suicide assessment and intervention training as part of their licensure; (2) reimbursement approaches that incentivize evidence-based, culturally informed interventions;

and (3) tracking outcomes for veterans receiving care outside VA for continuous program improvement. See Appendix B for additional resources for engaging veterans.

American Indians/Alaska Natives

Convening participants agreed that a priority partnership opportunity in this region of the country is between state and tribal leaders. Building and maintaining these relationships in a culturally informed manner is essential to preventing suicide among AI/AN populations. Such partnerships can be challenging, however, because of the complicated history of disconnect between tribal and state leaders and the frequent turnover in tribal leadership. An important starting point, therefore, is working with area Indian Health Service (IHS) [behavioral health consultants](#) to connect with tribal leaders (e.g., Tribal Health Consortia).

Many of the factors that lead a person to consider suicide (e.g., hopelessness, unemployment, poverty) can be more pronounced in AI/AN communities, which are often in rural, isolated areas. IHS has three key suicide prevention initiatives: Zero Suicide, the Suicide Prevention and Care program, and the Substance Abuse and Suicide Prevention Program (SASPP). "Suicide prevention, intervention and postvention" is one of four focus areas of SASPP and makes up about a quarter of the 175 currently funded projects. More than half of the funded SASPP projects are dedicated to upstream activities through the Generation Indigenous Initiative Support component of the SASPP, a component that focuses on promoting positive AI/AN youth development and family engagement through the implementation of early intervention to reduce risk factors for suicidal behavior and substance abuse. The objectives are to build capacity for prevention and behavioral health intervention while engaging youth and families and increasing self-sufficiency in an evidence-based manner.



Upstream Prevention

Primary prevention efforts, such as building coping skills and fostering resiliency in children and youth, are invaluable components of suicide prevention. By developing coping skills in children and adolescents and building strong and supportive social networks, they feel more connected, have healthier coping attitudes and are more likely to ask for help when a crisis arises.²⁴ [Sources of Strength](#) is one evidence-based program that takes a strengths-based approach and focuses on hope and connectedness. The core elements of Sources of Strength are supportive adults, peer leaders with influence within their

social group and strategic messaging designed to support positive culture change in schools and other settings. A large randomized controlled study across 18 schools showed that the model resulted in empowered peer leaders who demonstrated increased healthy coping attitudes, were themselves more connected to adults and were four times more likely to refer individuals they were concerned about to an adult. Findings in the entire school population included increased acceptability of help seeking and increased perceptions that adults would

help suicidal students. Notably, students who were the least socially connected or most at risk saw the greatest benefit. Programs like Sources of Strength have also been found to have positive effects on substance use, mental health and violence.²⁵ Recognizing the multiple downstream benefits of primary prevention, some states are systematically investing in upstream suicide prevention. Idaho offers one such example of a data-driven, continuous quality improvement approach. See callout box on this page.

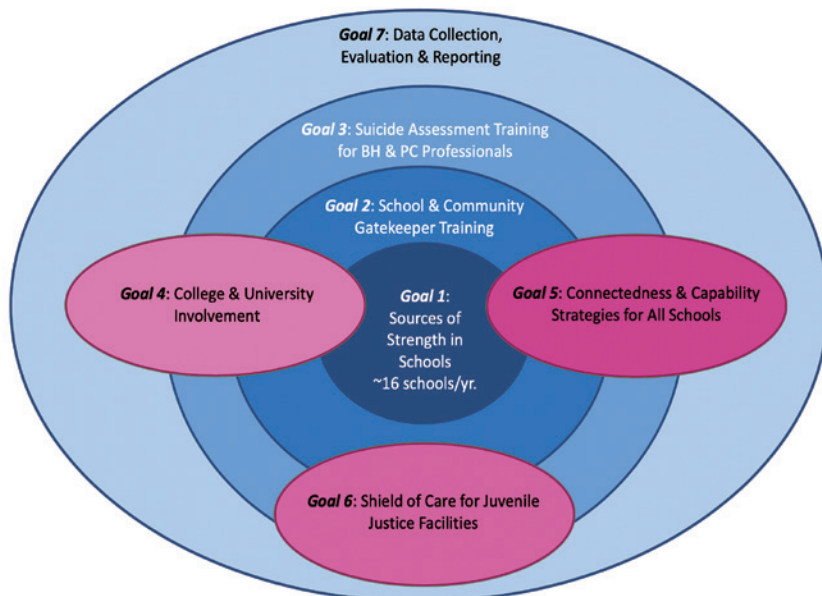
IDAHO: Moving Suicide Prevention Upstream

Idaho is pursuing a data-driven, comprehensive prevention and early intervention approach. In reviewing data from the 2017 Youth Risk Behavior Survey, Idaho saw an increase in suicide-related behaviors among adolescents and young adults: One in five Idaho high school students have considered suicide, one in five have a suicide plan and one of every 10 has attempted suicide. To stem this concerning trend, the Idaho State Department of Education, the Suicide Prevention Action Network of Idaho and stakeholders decided to focus on upstream approaches to address precursors and build resilience among at-risk youth. These partners developed a comprehensive suicide prevention model focused on children in primary and secondary school: the Idaho Lives Project. The initial comprehensive models (2014-2016) used funding through a Garrett Lee Smith grant from SAMHSA. The model (captured in the figure below) uses the [Sources of Strength](#) model. Schools are selected to participate in Source of Strength training based on an application that accesses readiness to benefit, support from school leadership and willingness to adopt the program with fidelity.

When its federal grant ended, the Idaho Department of Health and Welfare, with stakeholder support, was able to secure state funding based on the scope of the problem and data demonstrating the success of the suicide prevention efforts. The result was the implementation of the comprehensive model (2016 to present). Moving forward, Idaho will continue to expand the Sources of Strength program by providing annual training at 10 schools (middle schools and high schools) and piloting another program that builds social-emotional skills — the [Good Behavior Game](#) — in two to three elementary schools. Funding will also support three regional coordinators to work with school staff on implementing and maintaining their Sources of Strength program.

Initial Comprehensive Model: 2014-16

Federal Funding



Model Successes

80% of school programs sustained the approach:

- 40% of those have robust program.
- 40% are rebuilding.

Anecdotal evidence: lives saved, positive school climate, school unity, trusted adults, better conflict resolution.

Challenges

School staff turnover.
Administrator buy-in.
Training time.
Weather.

UTAH: Strategic Partnerships to Reduce Access to Lethal Means

Putting time and distance between a person and his or her preferred means of suicide can reduce suicide deaths, injuries and attempts. It allows time for the immediate crisis to pass and for the person to connect with support structures. Reducing access to lethal means during times of crisis is critical to a comprehensive suicide prevention approach and may require some atypical strategic partnerships. Across the country, firearms are the most lethal means of completing suicide. In Utah, **86%** of all firearm deaths are suicides ([Utah Department of Health findings](#)). This remarkable statistic prompted state leaders to pursue multiple firearm safety initiatives with a unique set of partners. A workgroup composed of representatives from the Utah Department of Human Services, Department of Health, Department of Public Safety, USSC and other local stakeholders built a relationship over a year that focuses on building trust, analyzing the data and developing a shared vocabulary that would resonate with partners in the gun community.

The outcome of this work is the **“Is Your Safety On?” campaign**. As part of this initiative, Utah has distributed more than 150,000 cable-style gun locks and developed a suicide awareness module for concealed carry permit instructors to incorporate into their training. A survey of concealed carry instructors revealed that almost two-thirds of instructors were open to including suicide prevention in their classes, and about 70% said that they would hold on to a gun for a friend in crisis. In addition, Utah used existing models of medication safety (e.g., safe storage and disposal) to engage the gun industry in gun-specific safety approaches, working with firearm dealers, shooting ranges, gun shows and associations. Methods included training for gatekeepers, public service announcements (PSAs) and materials focused on the safe storage of firearms. The state supplemented these efforts with **mini-grants** for:

- Gatekeeper training that targets firearm owners and provides outreach and education to firearm dealers, shooting ranges, gun shows and others on firearm safety for suicide prevention.
- Dissemination or promotion of “Is Your Safety On?” PSAs and materials.
- Purchase and targeted distribution of safe storage tools to at-risk individuals and their caretakers.
- Targeted outreach and prevention activities focused on high-risk individuals.

Conclusion

Death by suicide can be prevented. Along with other “diseases of despair,”²⁶ however, rates of suicide have increased in the recent past.²⁷ The NGA Center convening of state leaders from 13 states in the Intermountain West and Pacific Northwest in March 2018 highlighted the following lessons learned about state-level interventions to stem the tide:

- ▶ **Take a Comprehensive, Collaborative Approach.** Governors can play a powerful role in setting the vision and establishing a shared suicide prevention plan to drive cross-sector collaboration at the state level.
- ▶ **Foster Strategic Partnerships.** Governors can use their convening power to mobilize key stakeholders across systems to modernize policy, programmatic and practical approaches that complement local efforts to prevent suicide and promote resilience.

- ▶ **Invest in Upstream Prevention Efforts.** Governors can encourage policy, programmatic and budgetary alignment across state government aimed at modifying risk factors associated with suicide and promoting protective factors. Given that many primary prevention programs start with the school as a hub, the current trends in education toward creating social-emotional learning and safe and positive school climates can be used to reduce suicide and related risk factors.

NGA Center acknowledges CDC for its generous support in developing this white paper. The contents of this white paper are solely the responsibility of the authors and do not necessarily represent the official view of CDC.

APPENDIX A: Sample State Comprehensive Legislative Approach to Addressing Suicide Prevention

WASHINGTON STATE

2011: House Bill 1163 – 2011-12

- Primarily addressed bullying in schools; included mental health and suicide prevention in health and fitness learning standards for students and provided funding for youth suicide prevention.

2012: House Bill 2366 – 2011-12

- Required mental health care professionals to complete training in suicide assessment, treatment and management every six years beginning January 2014; commissioned a study by the Washington State Department of Health (DOH) on how evidence-based training affects all licensed health care professionals' ability to identify, refer, treat and manage patients with suicidal ideation.

2014: House Bill 2315 – 2013-14

- Added the requirement that other health care professionals – nurses, doctors, physician assistants, osteopaths, etc. – complete one-time training in suicide assessment, treatment and management; required the Washington State DOH to develop a model list of approved suicide training programs, convene a steering committee and develop a statewide plan for suicide prevention.

2015: House Bill 1424 – 2015-16

- Requires the Washington State DOH to revisit the list of training programs created under House Bill 2315, set evaluation criteria and determine which training programs belong on the list; after July 2017, all the training health care providers receive for certification must be on the list.
- **Note:** Report to the Legislature: Suicide Education Study (2013): <https://www.doh.wa.gov/Portals/1/Documents/Pubs/631049.pdf>

2013: House Bill 1336 – 2013-14

- Written to improve schools' capacity to prevent student suicide; required educational service districts to build capacity to train on suicide. Required school district crisis plans; suicide content in teachers' Issues of Abuse course; and three-hour training for school nurses, counselors, psychologists and social workers.

2015: House Bill 1138 – 2015-16

- Created a task force on mental health and suicide prevention at Washington institutions of higher education (IHEs).

2016: House Bill 2793 – 2015-16

- Created the Safer Homes Task Force to raise public awareness and increase suicide prevention education among partners in key positions to prevent suicides; created a Safe Homes Project to certify firearms dealers and firearms ranges that meet specified requirements as Safer Homes Partners; requires pharmacist suicide prevention and lethal means training.

2017: House Bill 1379 – 2017-18

- Implemented a comprehensive approach to suicide prevention and behavioral health in higher education.

2017: House Bill 1612 – 2017-18

- Created a Suicide-Safer Homes Project account to support prevention efforts and develop strategies for reducing access to lethal means.

2018: House Bill 2513 – 2017-18

- Implemented a comprehensive approach to suicide prevention and behavioral health in higher education, with enhanced services to student veterans.

2018: HB 1047 – 2017-18

- Protected the public's health by creating a system for safe and secure collection and disposal of unwanted medications – a first-in-the-nation statewide program.

2018: HB 2671 – 2017-18

- Created a task force on behavioral health and suicide prevention in the agricultural industry; funded a pilot program based on the task force's recommendations.

2018: SB 5553 – 2017-18

- Permitted the voluntary waiver of firearm rights.

2018: SB 6514 – 2017-18

- Required the University of Washington School of Social Work to develop a statewide resource for behavioral health and suicide prevention for the state's IHEs.
- Required the Student Achievement Council to administer a suicide prevention in higher education grant program.
- Beginning June 1, 2019, IHEs must submit behavioral health reports to the University of Washington. Campus data will include the counselor-to-student ratio, number of student referrals to offsite behavioral health providers, number of students identifying emotional distress as reasons for withdrawal and number of student suicide attempts and deaths.

COLORADO

2000: HB 2000-1432

- Created the Office of Suicide Prevention in the Colorado Department of Public Health and Environment.

2012: HB 12-1140

- Outreach to health care facilities providing services to Coloradans following a suicide attempt.

2014: SB 14-088

- Created the Suicide Prevention Commission.
- Most relevant to the development of comprehensive recommendations; initiated the Colorado-National Collaborative.

2016: SB 16-147

- Systems framework improvements across a range of systems, including health care, community mental health centers, criminal justice, education, emergency medical services, faith-based organizations and insurance plans.
- The Zero Suicide bill.

2018: SB 18-272

- School grant program to assist public schools and districts with suicide prevention strategies.

APPENDIX B: Select Public Service Announcements and Additional Resources

Public Service Announcements

Idaho

- "Serve & Protect": <https://youtu.be/uXySJzRpe6U>
- "Fishing Buddies": <https://youtu.be/DT6Dgsbxy18>
- "MVP": https://youtu.be/W_xOaps0QYA
- "No. 1 Wife": <https://youtu.be/BLdloKJJlyc>

Utah

- "Is Your Safety On?" – Gun Range: <https://www.youtube.com/watch?v=iZ6GAJ9-ED8>
- "Is Your Safety On?" – Teen Suicide: <https://utahsuicideprevention.org/firearmsafety>

Resources From Key Federal Agencies

Centers for Disease Control and Prevention: Suicide Prevention

<https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf>

Substance Abuse and Mental Health Services Administration Suicide Prevention Resource Center

<http://www.sprc.org/>

Indian Health Service (IHS): Suicide Prevention and Care Program

<https://www.ihs.gov/suicideprevention/>

IHS Division of Behavioral Health

<https://www.ihs.gov/dbh/aboutus.staff>

Resources for Engaging Veterans

- Local U.S. Department of Veterans Affairs (VA) suicide prevention coordinators are at every VA facility:
 - Go to <http://www.veteranscrisisline.net/ResourceLocator> to find a suicide prevention coordinator and other VA and community resources.
- Online toolkit for community health providers:
 - https://www.mentalhealth.va.gov/communityproviders/military_resources.asp
- PsychArmor Institute courses on veteran and military issues:
 - <https://psycharmor.org/>

ENDNOTES

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