National Strategy *for* Suicide Prevention

2024

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To those we have lost to suicide,

To those who struggle with thoughts of suicide,

To those who have made a suicide attempt,

To those caring for someone who struggles with thoughts of suicide,

To those left behind after a death by suicide,

To those in recovery, and

To all those who work tirelessly to prevent suicide and suicide attempts in our nation every day.

We believe that we can, and we will make a difference.

The 2024 *National Strategy for Suicide Prevention (National Strategy)* and its *Federal Action Plan (Action Plan)* come at a pivotal moment. This year, we mark 25 years since the release of Surgeon General Dr. David Satcher's *Call to Action to Prevent Suicide*, a landmark report that recognized suicide as a major public health concern in the United States and created the foundation for the first *National Strategy for Suicide Prevention* released in 2001. In 2012, the *National Strategy* was updated by Surgeon General Dr. Regina Benjamin and the National Action Alliance for Suicide Prevention (Action Alliance). A subsequent Call to Action was released in 2021 by Surgeon General Dr. Jerome Adams to fully implement the 2012 goals and objectives. Despite significant progress over the past two decades, much work remains to promote a coordinated and comprehensive approach to suicide prevention in communities across the country and at every level of government.

The Biden-Harris Administration has taken unprecedented steps to address the mental health crisis that has plagued our country for decades and was exacerbated by the COVID-19 pandemic. This new *National Strategy* and *Action Plan* are critical parts of those efforts. Together, they represent unparalleled support and investment from the federal government with strong collaboration from over 20 agencies and offices across the executive branch, support from the Suicide Prevention Resource Center (SPRC) and the Action Alliance, and an HHS-led project management team. I am particularly proud of the input and perspectives reflected in the Strategy from more than 2,000 field experts representing diverse geographic areas, races and ethnicities, settings, roles, and lived experiences in suicide prevention.

This new Strategy on suicide prevention is a critical component of our nation's work to improve mental health and overall well-being. Since beginning my current tenure as U.S. Surgeon General in 2021, the Office of the Surgeon General has made mental health and well-being a top priority. In 2023, we released a Surgeon General's Advisory on *Our Epidemic of Loneliness and Isolation*, which describes the harms of loneliness and isolation on both individual and societal health, including its effect on the risk for depression, anxiety, suicide, and premature death. The Advisory highlights the need for continued attention and focus on social connection as a key protective factor for health and well-being, including protecting against suicide risk. Two other U.S. Surgeon General's Advisories provide important information and actionable recommendations to protect youth mental health. The first Advisory on *Protecting Youth Mental Health*, released in 2021, outlines the

policy, institutional, and individual changes it will take to treat and prevent youth mental health challenges, including expanding and strengthening suicide prevention and mental health crisis services. The second Advisory on *Social Media and Youth Mental Health*, released in 2023, describes the potential benefits and harms of social media use, and calls for urgent action to create safer, healthier online environments to protect children.

Suicide remains a serious public health threat that touches the lives of many Americans. In 2022, nearly 50,000 lives were lost to suicide, 13.2 million people reported seriously considering suicide, 1.6 million reported a suicide attempt, and millions more supported someone close to them who was in distress. Disparities in suicide and suicide attempts still exist. Populations disproportionately impacted include Veterans, racial and ethnic minority groups, people with disabilities, LGBTQI+ populations, youth, middle-aged, and older adults, individuals with serious mental illness, and certain occupational groups, among others. For example, between 2018 and 2021, suicide rates rapidly increased among non-Hispanic Black or African American populations ages 10–24 (+36.6% increase) and 25–44 years (+22.9%), non-Hispanic American Indian and Alaska Native populations ages 25–44 (+33.7%), non-Hispanic multiracial populations ages 25–44 years (+20.6%), and Hispanic populations ages 25–44 years (+19.4%).

The stark reality is that despite significant advancements in the field, suicide rates in the United States continue to rise. Suicide rates increased by 12.7% from 2012 to 2022, with brief declines in 2019 and 2020. Existing gaps in social and economic risk factors (e.g., legal issues, exposure to violence, relationship challenges, poverty and financial strain), access to mental health resources and care persist, and there is a need for improved data, prevention, treatment, services, workforce, and research related to suicide, especially among populations disproportionately affected by suicide. Meanwhile, emerging issues such as the impact of social media on mental health, the intersection of suicide and substance use, and the unique challenges faced by groups that have been historically marginalized demand our immediate attention. This document stands as a testament to the urgency of confronting these challenges head-on as we seek to create a future where every individual feels valued and supported.

The loss of any life to suicide is heartbreaking, and the number of deaths remains far too high. Yet, there is also reason for hope. Since 2012, we have witnessed remarkable strides in understanding and addressing the complexities of suicide. Research has expanded our knowledge, interventions have evolved, and conversations about mental health have begun to resonate more deeply within our communities. The tireless efforts of advocates, health care professionals, and individuals with lived experiences have amplified the vital importance of comprehensive approaches to suicide prevention. I have been particularly encouraged by the advances in service delivery for individuals in crisis such as the transition to, and expansion of, the national 988 Suicide and Crisis Lifeline, as well as the expansion and implementation of effective prevention programs and interventions in states and communities, innovations in data and research efforts, and improvements in occupational health.

This new *National Strategy* acknowledges major advancements since 2012 and recognizes existing gaps and emerging issues in the field that demand our attention. At the heart of this strategy lies a call for a more coordinated and comprehensive public health approach to suicide prevention. This approach prioritizes collaboration between the public and private sectors as well as with people with lived experience and groups that have been disproportionately affected by

suicide. It also includes an *Action Plan* to be initiated over the next three years that outlines formal commitments made by agencies across the federal government to advance suicide prevention in the United States.

As the nation's doctor and as a parent, I care deeply about this issue. I have lost family, friends, and patients to suicide. I have witnessed the anguish of those struggling with the loss of someone they love to suicide. But I have also been inspired by the resilience and courage of individuals who have sought help and persevered through their darkest moments. And, I have seen the power of effective prevention and intervention approaches, in and outside of the health care setting.

Suicide takes an insurmountable toll on families, friends, caregivers, and communities across our nation. We must do more to prevent these tragic deaths and build healthier, more connected communities. Progress is possible, and it cannot come soon enough. I urge leaders and communities to join this vital effort to prevent suicide. Together, we can create a future where support, hope, and well-being are within reach for everyone.

Vivek H. Murthy, MD, MBA
Vice Admiral, U.S. Public Health Service
Surgeon General
U.S. Department of Health and Human Services

From the National Action Alliance for Suicide Prevention

On behalf of the National Action Alliance for Suicide Prevention (Action Alliance), we are proud and honored to support the 2024 *National Strategy for Suicide Prevention*.

The Action Alliance commits to continuing to serve as the steward for the *National Strategy*, bringing together public and private sector partners to ignite change and lead innovation that will concretely move forward the recommendations in this Strategy. It is only through cross-sector collaboration and partnership that we can achieve success in reducing suicidal thoughts, attempts, and deaths in the United States.

While there have been notable advances in the field of suicide prevention over the past decade, we must do more to ensure those advances translate into measurable and sustained improvements in our country's suicide-related indicators.

Following the release of the *National Strategy*, the Action Alliance commits to working with public and private sector partners to set quantifiable outcome goals and priority actions to track and sustain progress in saving lives.

Thank you for your dedication to preventing suicide.

Carolyn M. Clancy, MD
Public Sector Chair
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Craig S. Kramer, JD
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Active Minds, The American Association of Suicidology, The American Foundation for Suicide Prevention, The Jason Foundation, The Jed Foundation, Samaritans USA, SAVE-Suicide Awareness Voices of Education, and The Trevor Project, collaborating as the National Council for Suicide Prevention (NCSP), offer our strong support for the 2024 *National Strategy for Suicide Prevention*. As advisors who helped develop our nation's first two *National Strategies* and contributed to this new strategy, we commend all those involved for carrying forward the excellent work originated by former Surgeon Generals Dr. David Satcher and Dr. Regina Benjamin.

The NCSP members have a long history of working with our partners in the public and private sectors, as well as local communities throughout the country, and we remain dedicated to working aggressively to prevent further loss of life from suicide and to the improved health of all our fellow citizens. Among our members are survivors and those directly impacted by suicide who work in nearly every community in the country, so we know first-hand of the need for this work. Further, the new *National Strategy* addresses the needs and protection of our citizens, workplaces, and communities impacted by suicide, especially among special and historically marginalized populations, those with lived experience, and suicide loss survivors. For all these reasons, we pledge to collectively assist in the implementation of the goals and objectives in the *National Strategy*.

The *National Strategy* has brought tremendous value to the nation, direction for the states and community task forces, as well as much needed recognition of individuals and families impacted by suicide over the last decade. We are confident that the *Federal Action Plan* will go further to sustain the attention that suicide prevention needs in our country. This new *National Strategy* reflects lessons we have learned and incorporates advances in our understanding of new approaches to reducing the incidence of suicide. It serves as an important road map for states, tribes, local communities, and public and private entities as they work to prevent suicide and support those impacted by suicide.

The NCSP recognizes that creating, monitoring, and sustaining a *National Strategy* is an ambitious undertaking. It requires seeking the collective wisdom, expertise, and input from researchers and scientists, clinicians and public health experts, those who have attempted suicide, and those who are bereaved by suicide, as well as many other stakeholders. It requires input from multiple sectors—public, private, and nonprofit—as well as time and money. It also requires continual dedication to ensuring its use. It is because of that commitment that priorities and activities of suicide prevention becomes a reality.

We thank everyone for doing their part to make the new *National Strategy for Suicide Prevention* a guiding light that offers hope to our nation.

Respectfully submitted,

Daniel J. Reidenberg, PsyD
Managing Director
National Council for Suicide Prevention

National Strategy *for* Suicide Prevention

Executive Summary

2024

Twenty-five years ago, Surgeon General Dr. David Satcher issued the ground-breaking *Call to Action to Prevent Suicide.* This call ultimately led to the first *National Strategy for Suicide Prevention* in the United States in 2001.

Since that time, through the next strategy in 2012, until today, suicide prevention efforts have expanded significantly, ranging from advances in timeliness of data, to the growth in the science of suicide prevention, the development of new treatments, and increased research. People across the country are now aware more than ever that suicide is a pressing public health problem that is preventable. However, much more work is necessary to match the challenge of rising suicide rates.

The new 2024 *National Strategy for Suicide Prevention (National Strategy)* is meant to address gaps in the field and to guide, motivate, and promote a more coordinated and comprehensive approach to suicide prevention in communities across the country. The comprehensive approach addresses the many factors associated with suicide, with the recognition that there is no single solution. It seeks to prevent suicide risk in the first place (upstream prevention), identify and support people with increased risk through treatment and crisis intervention (downstream prevention), prevent reattempts, promote long-term recovery, and support survivors of suicide loss.

Carrying out the comprehensive approach relies on collaboration with public and private sector partners, people with suicide-centered lived experience, and people in populations disproportionately affected by suicide and suicide attempts. The foundation of comprehensive prevention includes a strong suicide prevention infrastructure at all levels, a competent and well-trained workforce, the use of quality data to help drive decision-making, and a strong science base, as laid out in the new strategy.

For the first time, in 2024, the *National Strategy* takes a "whole of government" approach. It was developed in collaboration with a federal Interagency Work Group, consisting of over 20 agencies and offices in 10 departments across the federal government. Support came from the Suicide Prevention Resource Center (SPRC) and the National Action Alliance for Suicide Prevention (Action Alliance), guided by a project management team co-led by officials at the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), alongside the National Institute of Mental Health (NIMH) and the U.S. Department of Health

and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE/HHS). Input and feedback from outside of the federal government came from a national needs assessment reaching more than 2,000 respondents and multiple listening sessions with people with lived experience, populations disproportionately affected by suicide, community members, practitioners, and suicide prevention experts.

The 2024 *National Strategy* builds upon the previous 2012 *National Strategy*. It addresses gaps and incorporates advances in the field. It specifically addresses health equity, youth and social media, and the intersection of suicide and substance use. Other examples of new content include the 988 Suicide and Crisis Lifeline, expanded workplace suicide prevention, and an increased focus on social determinants of health. These topics are addressed within the *National Strategy's* four Strategic Directions—Community-Based Suicide Prevention; Treatment and Crisis Services; Surveillance, Quality Improvement, and Research; and Health Equity in Suicide Prevention—and related Goals.

Strategic Direction 1: Community-Based Suicide Prevention

- **Goal 1:** Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships.
- **Goal 2:** Support upstream comprehensive community-based suicide prevention.
- **Goal 3:** Reduce access to lethal means among people at risk of suicide.
- **Goal 4:** Conduct postvention and support people with suicide-centered lived experience.
- **Goal 5:** Integrate suicide prevention into the culture of the workplace and into other community settings.
- **Goal 6:** Build and sustain suicide prevention infrastructure at the state, tribal, local, and territorial levels.
- **Goal 7:** Implement research-informed suicide prevention communication activities in diverse populations using best practices from communication science.

Strategic Direction 2: Treatment and Crisis Services

- **Goal 8:** Implement effective suicide prevention services as a core component of health care.
- **Goal 9:** Improve the quality and accessibility of crisis care services across all communities.

Strategic Direction 3: Surveillance, Quality Improvement, and Research

- **Goal 10:** Improve the quality, timeliness, scope, usefulness, and accessibility of data needed for suicide-related surveillance, research, evaluation, and quality improvement.
- **Goal 11:** Promote and support research on suicide prevention.

Strategic Direction 4: Health Equity in Suicide Prevention

- **Goal 12:** Embed health equity into all comprehensive suicide prevention activities.

- **Goal 13:** Implement comprehensive suicide prevention strategies for populations disproportionately affected by suicide, with a focus on historically marginalized communities, persons with suicide-centered lived experience, and youth.

- **Goal 14:** Create an equitable and diverse suicide prevention workforce that is equipped and supported to address the needs of the communities they serve.

- **Goal 15:** Improve and expand effective suicide prevention programs for populations disproportionately impacted by suicide across the life span through improved data, research, and evaluation.

For the first time, the *National Strategy* includes a *Federal Action Plan*. This plan is designed to improve accountability for suicide prevention efforts and to maximize federal infrastructure. Federal agencies committed to specific, short-term actions related to the goals and objectives included in the Strategy that they will carry out over the next three years. Following the release of the *National Strategy*, a plan will be developed to monitor and evaluate the *Federal Action Plan* and the *National Strategy*, overall. The federal government and the Action Alliance will serve as joint stewards, monitoring progress, identifying successes and barriers, and providing solutions for improvement.

This 2024 *National Strategy*, with its "whole of government" and comprehensive approach alongside the *Federal Action Plan* provides a path forward that together, with communities and partners, can make a difference and help address our national challenge to prevent suicide.

Contents

Introduction

Suicide is a complex public health issue requiring an ongoing, comprehensive approach to prevention across the United States and tribal nations. In April 2023, the White House requested that the U.S. Department of Health and Human Services (HHS), in partnership with agencies across the federal government, develop a new *National Strategy for Suicide Prevention (National Strategy)* and a *Federal Action Plan (Action Plan)*.

The previous *National Strategy* was released in 2012. This new *National Strategy* is urgently needed to address the growing concern about suicide trends and the ongoing mental health and overdose crises on the heels of the COVID-19 pandemic. In addition to the social isolation and the many losses that Americans have experienced, the pandemic revealed a range of inequities, including those related to access to social supports and health care resources. Communities, including schools, health care systems, workplaces, and faith institutions, are seeking ways to effectively address these inequities and other risks that are contributing to increasing suicide rates and behavioral health conditions.

The new *National Strategy* was developed by a federal Interagency Work Group (IWG) comprised of over 20 agencies in 10 federal departments across the government, with support from the Suicide Prevention Resource Center (SPRC), the National Action Alliance for Suicide Prevention (Action Alliance),

and a project management team co-led by officials at the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), alongside the National Institute of Mental Health (NIMH) and the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE/HHS). Also reflected in this 10-year strategy is the input of more than 2,000 people from across the United States who participated in a national needs assessment and a series of listening sessions, including people with suicide-centered lived experience, tribal members, youth, suicide prevention experts, and partners in the private sector. To read more about the strategy's development process, refer to Appendix D.

The *National Strategy* addresses gaps in the field and aims to guide, motivate, and promote a coordinated and comprehensive approach to suicide prevention in communities across the country and at the national, state, tribal, local, and territorial levels. Participation from people with suicide-centered lived experience and with people in populations disproportionately affected by suicide and suicide attempts is crucial for success. For the purposes of this *National Strategy,* disproportionately affected populations include groups with high rates of suicide or suicide attempts, typically greater than the average of the reference group (e.g., of the United States, state, racial or ethnic groups), as well as groups experiencing increasing trends.

For the first time, the *National Strategy* includes a *Federal Action Plan* to be implemented over the next three years (described below). These actions and the strategy overall will be monitored and evaluated regularly to determine progress and to identify barriers to suicide prevention. Actions will be updated during the 10-year life span of the *National Strategy* to ensure a sustained focus on cross-agency suicide prevention.

The forthcoming 2024 *National Strategy Monitoring and Evaluation Plan* will define core suicide prevention metrics to assess short- and long-term *National Strategy* progress. Implementation of federal actions will be monitored within the next three years. Longer-term core indicators will be monitored by the Action Alliance in collaboration with the federal government as joint stewards of the 2024 *National Strategy*. The Action Alliance will report on these core indicators annually.

2024 *National Strategy* Development

In addition to the input received, the development of the 2024 *National Strategy* considered recent trends in suicide and suicide attempts; suicide prevention history; and recent suicide-related reports, recommendations, and guidance, as follows:

Recent Trends

Suicide Deaths

Since the release of the 2012 *National Strategy*, age-adjusted suicide rates have increased by 12.7%, from 12.6 per 100,000 people in 2012 to 14.2 per 100,000 in 2022, with brief declines in 2019 and 2020. Suicide rates increased in 2021 and again in 2022. In 2022 alone, nearly 50,000 lives were lost to suicide. Between 2000 and 2022, rates increased approximately 36% (Centers for Disease Control and Prevention [CDC], 2024a).

Figure 1. **Age-adjusted suicide rates, 2000–2022, United States**
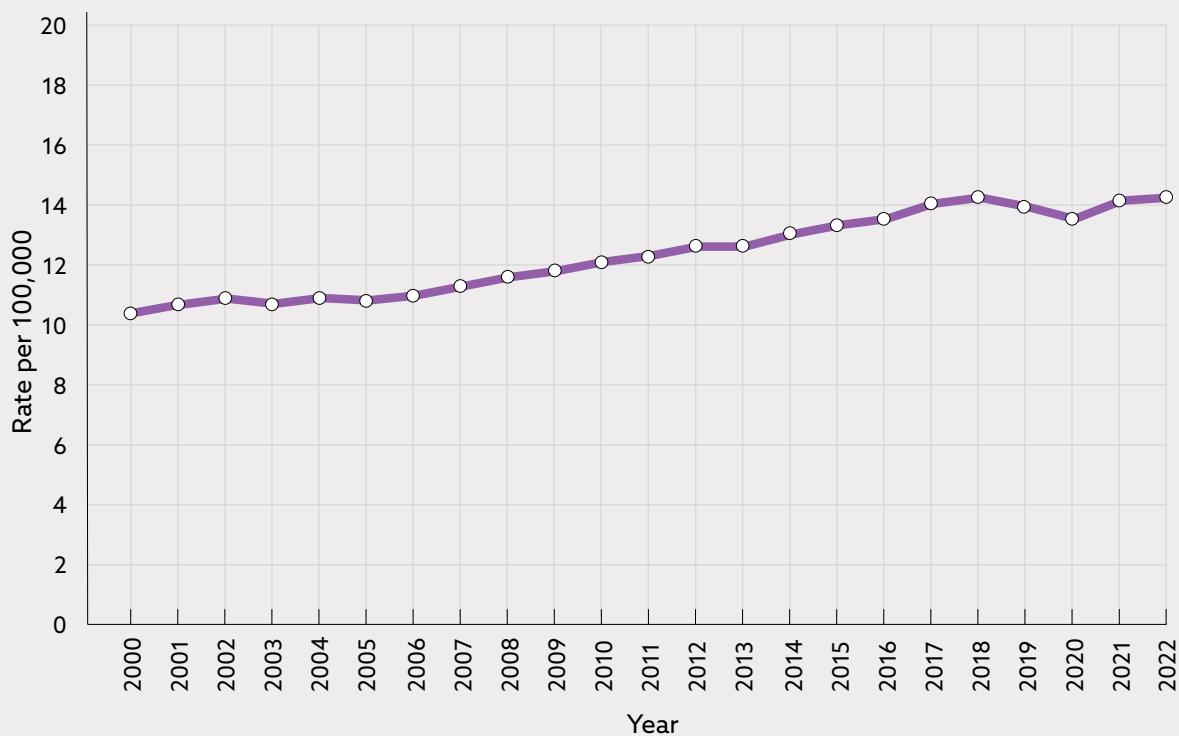
Source: CDC, 2024a

Suicide rates across the United States by state highlight geographic disparities. For example, rates in 2022 ranged from 6.1 per 100,000 in Washington, D.C., to 28.7 per 100,000, in Montana.

Figure 2. **Age-adjusted suicide rate per 100,000 for the United States by state of residence, 2022**
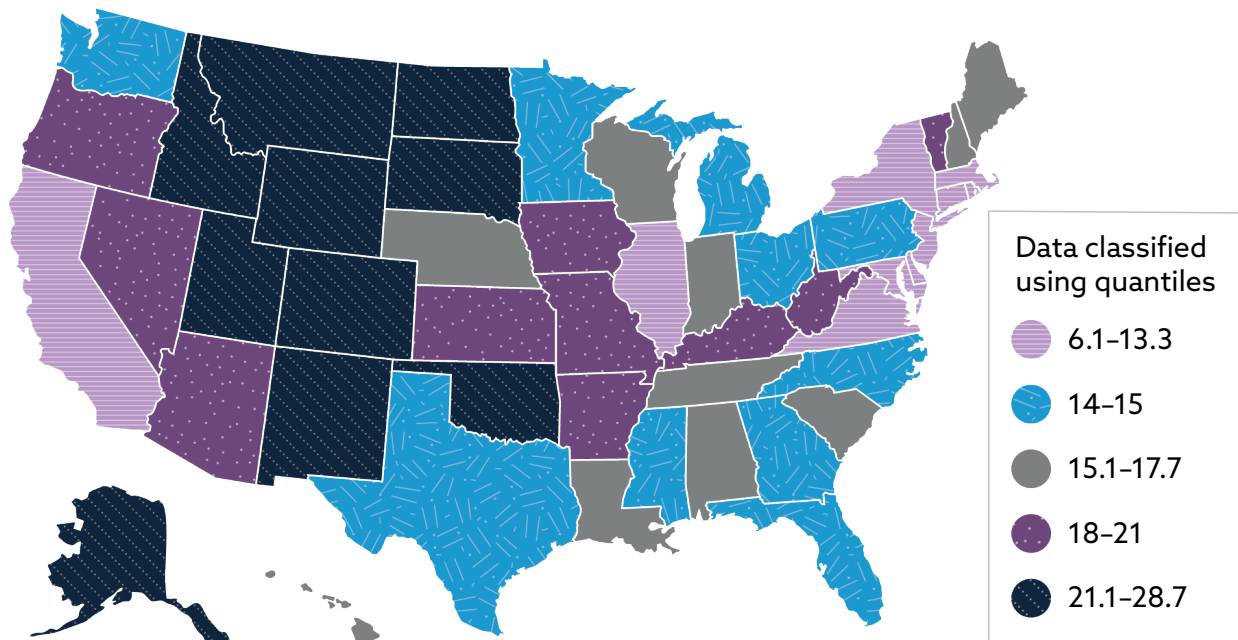
Source: CDC, 2024a

Suicide rates vary by age group. In 2022, suicide rates ranged from 2.4 per 100,000 among youth ages 10–14 years to 23.0 per 100,000 among people 85 years and older (CDC, 2024a).

Table 1. **Suicide rates by age, United States, 2022**

Age	Number of Suicides	Rate per 100,000
10–14	493	2.4
15–24	6,040	13.6
25–34	8,663	19.0
35–44	8,185	18.7
45–54	7,781	19.2
55–64	7,864	18.7
65–74	5,396	16.0
75–84	3,549	20.3
85+	1,493	23.0

Source: CDC, 2024a

Suicide rates by race and ethnicity point to additional disparities. Suicide rates ranged from 6.9 per 100,000 among non-Hispanic Asian populations to 27.1 per 100,000 among non-Hispanic American Indian and Alaska Native (AI/AN) populations. In 2022, 76% of suicides occurred among non-Hispanic White populations (see Table 2 for additional details) (CDC, 2024a).

Table 2. Age-adjusted suicide rates by race and ethnicity, United States, 2022

Race/Ethnicity	Number of Suicides	Age-Adjusted Rate per 100,000
Non-Hispanic		
American Indian and Alaska Natives	650	27.1
Asian	1,459	6.9
Black or African American	3,826	8.9
Native Hawaiian or Other Pacific Islander	95	14.3
White	37,481	17.6
More Than One Race	682	10.5
Hispanic	5,122	8.1

Source: CDC, 2024a

Considering the intersection of age, race, and ethnicity, between 2018 and 2021, suicide rates increased (Stone et al., 2023):

- 36.6% and 22.9% among non-Hispanic Black or African American populations ages 10–24 and 25–44 years, respectively
- 33.7% among non-Hispanic AI/AN populations ages 25–44
- 20.6% among non-Hispanic multiracial populations ages 25–44
- 19.4% among Hispanic populations ages 25–44 years

Suicide rates among females and males show large differences. Male age-adjusted suicide rates in 2022 were about four-fold higher than female rates (CDC, 2024a).

Table 3. Age-adjusted suicide rates by sex, United States, 2022

Sex	Number of Suicides	Age-Adjusted Rate per 100,000
Females	10,203	5.9
Males	39,273	23.0

Source: CDC, 2024a

Among females, the highest rates were among ages 45–54 years (9.0 per 100,000), non-Hispanic AI/AN (14.6 per 100,000), and non-Hispanic White females (7.3 per 100,000; CDC, 2024a).

Among males, the highest rates were among ages 75 years and older (43.9 per 100,000), non-Hispanic AI/AN (39.6 per 100,000), and non-Hispanic White males (28.1 per 100,000; CDC, 2024a).

Other populations disproportionately impacted by suicide include, for example:

- **Individuals who have served in the armed forces.** According to the most recent annual report released by the U.S. Department of Veterans Affairs (VA), the unadjusted suicide rate for Veterans increased 45%, from 23.3 per 100,000 in 2001 to 33.9 per 100,000 in 2021. Among non-Veteran U.S. adults, the suicide rate increased about 33%, from 12.6 per 100,000 in 2001 to 16.7 per 100,000 in 2021 (U.S. Department of Veterans Affairs, 2023). Some Veteran groups are at increased risk of suicide. Between 2020 and 2021, the age-adjusted suicide rate among female Veterans increased 24.1%. Male rates increased 6.3% in the same period (U.S. Department of Veterans Affairs, 2023). Among recent users of Veteran's Health Administration (VHA) health care services experiencing homelessness, the suicide rate increased 38.2% to 112.9 per 100,000 in 2021. AI/AN Veterans have the highest rate of suicide based on race and ethnicity (46.3 per 100,000) and AI/AN Veterans also saw the sharpest increase between 2020 and 2021 (51.8%) (VA, 2023).

- **Certain civilian occupational groups.** Men in construction and extraction (65.6/100,000) and women in installation, maintenance, and repair (26.6/100,000) had the highest suicide rates by major occupational group (Sussell et al., 2023).

- **Individuals living with mental disorders** (see box below).

Suicide Risk among People Living with Mental Disorders in the United States

People with diagnosed mental disorders (including substance use disorders) have a higher suicide risk than people without such diagnoses. However, the vast majority of people with mental disorders will not die by suicide (Brådvik, 2018; Holmstrand et al., 2015; Inskip et al., 1998; Nordentof et al., 2011). Suicide rates vary by how common (e.g., mood disorders) and how impairing (e.g., anorexia) the disorder is. Risk also varies based on the age of onset, the age of diagnosis, how many disorders are present, and based on demographic characteristics more generally, such as age and sex.

Population-based, longitudinal data on diagnoses and health care services received help to improve understanding of the level of suicide risk and when people with specific mental disorders are likely to experience increased risk. These data are gathered through studies of medical and behavioral health care services data linked to mortality records. Additional life experience information incorporated with health and mortality data provide further insight into suicide risk trajectories. Life experience may include employment history, education level, and criminal justice records. No U.S.-based life course registries exist, so most data come from health registries in Scandinavian countries. These efforts are still informative for U.S. suicide prevention approaches.

For example, early Danish registry research looked at the association between mental health diagnoses and hospitalization on suicide risk (Qin, 2011). Males ages 35 or younger diagnosed with schizophrenia had a 30% greater risk of suicide and females of the same age group had a 136% greater risk compared with living controls, adjusted for marital status, income, and place of residence. Suicide risk among middle and older age people with schizophrenia was also elevated but to a lesser extent (8% or less for middle-aged and older adult males; 22% or less for middle-aged and older adult females). This suggests that younger people diagnosed with schizophrenia who survive their initial course of illness may have increased risk of suicide, but risk is not as elevated over time. A more recent U.S. study of suicide risk among people with schizophrenia in the Medicare program using five national retrospective cohorts found similar results. The total suicide rate in the group with schizophrenia was 4.5 times higher than the general U.S. population and risk declined with age (Olfson et al., 2021a). Another study illustrates how timely diagnosis is critical in reducing suicide risk. Canadian research found that if diagnoses of schizophrenia spectrum disorder are delayed past age 25, and there are co-occurring mental disorders (e.g., mood, personality, and drug use disorders) present, suicide risk is significantly increased (Zaheer et al., 2020).

Strategic Directions in this *National Strategy* can help prevent suicide among persons with mental disorders through the following efforts:

1. Addressing social determinants of health in the community and preventing or treating behavioral health symptoms that increase risk of onset or exacerbate a disorder (as laid out in Strategic Directions 1 and 4).

2. Improving treatment access to avoid delayed diagnosis; providing social support to enhance treatment engagement, self-management skills, and sense of recovery; ensuring availability of quality crisis services that can lead to appropriate care stabilization during suicide risk and/or symptom exacerbation; and improving care quality and continuity (as laid out in Strategic Directions 2, 3, and 4).

3. Improving management of mental disorders across the life span through appropriate quality assessment and management of multiple mental and physical conditions (Strategic Directions 2 and 3), as well as receipt of community services (e.g., housing, economic and social supports, and consistent health and specialty care; Strategic Directions 1 and 4).

Suicide Thoughts and Attempts

Many more people think about and/or attempt suicide than those who die by suicide, and most people who think about or attempt suicide never go on to die by suicide (Wenzel et al., 2011). Understanding these patterns can help ensure timely prevention services are received. Data on suicide thoughts and attempts in the population come from self-reported survey data and from emergency departments and hospital records (called *nonfatal self-harm* in medical records). In 2022, 13.2 million adults reported seriously considering suicide, and 1.6 million adults reported making a suicide attempt (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

In 2021, 30% of female high school students and 14% of male students reported serious thoughts of suicide. Rates ranged from 18% among non-Hispanic Asian students to 27% among non-Hispanic AI/AN students. Fifty-eight percent of students with any same-sex sexual contacts and 45% of lesbian, gay, bisexual, questioning, or another non-heterosexual identity (LGBQ+) reported serious thoughts of suicide compared with 15% of heterosexual students (CDC, 2023g).

Trends in suicide thoughts over time between 2011 and 2021 indicate (CDC, 2023g):

- The percentage of female high school students who thought about suicide increased significantly from 19% in 2011 to 30% in 2021.

- Rates among non-Hispanic Black and White students and Hispanic students also increased significantly.

Thirteen percent of female high school students and 7% of male high school students reported making a suicide attempt in 2021 (CDC, 2023g). Non-Hispanic AI/AN students and non-Hispanic Black students reported the highest percentage of attempts, 16% and 14%, respectively (CDC, 2023g). More than 30% of students with same-sex sexual contacts and 22% of LGBQ+ students reported an attempt as compared with 6% of heterosexual students (CDC, 2023g).

Trends in suicide attempts over time between 2011 to 2021 indicate (CDC, 2023g):

- Suicide attempts among female students increased significantly from 10% in 2011 to 13% in 2021.

- Attempts among non-Hispanic Black students increased significantly from 8% in 2011 to 14% in 2021 and rates among non-Hispanic White students increased significantly from 6% in 2011 to 9% in 2021.

- Black students experienced an increase in suicide attempts requiring medical treatment from 2% in 2011 to 4% in 2021.

These increasing rates are troubling and point to increases in known suicide risk factors, potentially emerging risk factors, or decreases in protective factors. There is no single cause of suicide. Suicide is influenced by many factors at the individual, relationship, community, and societal levels (see Table 4). For more information on suicide disparities, see Strategic Direction 4 and Appendix G.

Turning to emergency department data (ED), rates of visits due to injuries from self-harm increased 39% from 112.8 per 100,000 in 2001 to 157.0 in 2021 (Figure 3, CDC, 2024b). Since the release of the 2012 *National Strategy*, rates of self-harm visits to the ED remained relatively similar.

Figure 3. **Age-adjusted rates for nonfatal self-harm visits to EDs, 2001–2021**
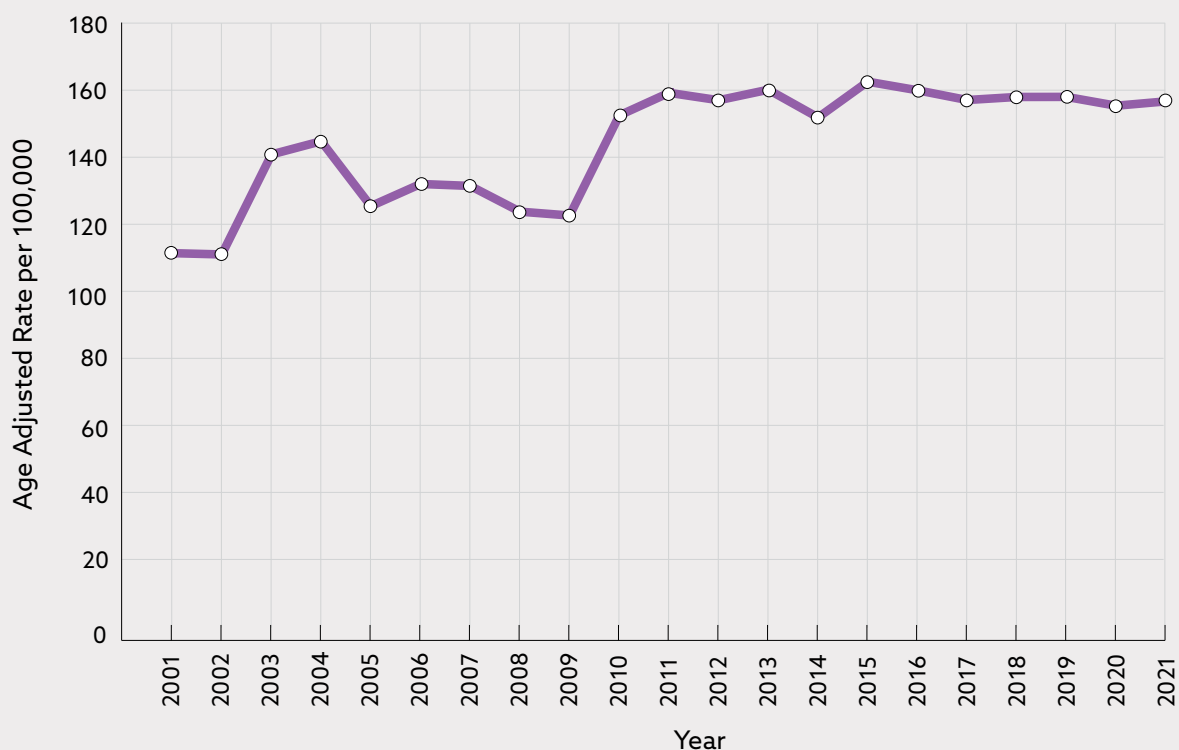
Source: CDC, 2024b

In 2021, females had a higher rate of ED visits (198.6 per 100,000) compared to males (116.9 per 100,000) (not shown, CDC, 2024b). Female rates were highest among ages 15–19 years (788.2 per 100,000) and 10–14 years (588.9 per 100,000). Among males, rates were highest among ages 15–19 years (265.1 per 100,000) and 20–24 years (232.2 per 100,000). Regardless of gender, self-harm attempt rates in 2021 were highest among people 15–19 (522.5 per 100,000; CDC, 2024b).

Suicide and suicide attempts can have long-lasting effects on friends, family members, entire communities, as well as on first responders and other exposed individuals. The economic toll of suicide and suicide attempts is often unspoken. Between 2015 and 2020, suicide and emergency department visits for non-fatal self-harm cost the nation more than $510 billion a year. This societal cost included medical spending, lost work productivity, reduced quality of life among individuals with non-fatal injuries, and avoidable mortality (Peterson et al., 2024).

These data highlight that we must do more to address disparities, tailor solutions, and advance comprehensive suicide prevention approaches.

Suicide Prevention History

There was little federal or state suicide prevention activity when the United States launched its first *National Strategy* in 2001. SAMHSA supported just one suicide prevention grant program. The grant was for networking and certification of suicide hotlines using a single national suicide prevention number. Also in 2001, NIMH and the American Foundation for Suicide Prevention (AFSP) hosted a workshop that considered the ethics and safety of whether individuals at risk for suicide could participate in clinical trials. The 2001 *National Strategy* helped drive increased suicide prevention activities, including the following actions:

- **2002:** Initiation of the Suicide Prevention Resource Center
- **2004:** Enactment of the Garrett Lee Smith Memorial Act
- **2005:** Initiation of the Garrett Lee Smith State and Tribal Youth Suicide Prevention grant program and the Campus Suicide Prevention grant program
- **2007:** Passage of the Joshua Omvig Veterans Suicide Prevention Act, establishment of the Veterans Crisis Line, and placement of suicide prevention coordinators in every VA Medical Center
- **2010:** Launch of the public-private *National Action Alliance for Suicide Prevention* and work with federal partners to update the 2001 *National Strategy*
- **2012:** Release of the 2012 *National Strategy for Suicide Prevention*

For additional information on advances since 2012, see below and refer to [Appendices E](#) and [F](#).

The launch of the 2012 *National Strategy* also helped generate substantial suicide prevention activities. The DOD adapted the goals and objectives from the 2012 Strategy in their *Strategy for Suicide Prevention* (2015) as did VA in their 2018–2028 *National Strategy for Preventing Veteran Suicide*. Other activities in communities and health care systems took hold, such as the creation and promotion of Zero Suicide, an aspirational goal and a framework for the systematic incorporation of evidenced-based suicide prevention care in health care systems. Zero Suicide was created through the work of the SAMHSA-funded Action Alliance Clinical Care Task Force. This work ultimately led to the establishment of the Zero Suicide grant programs by both SAMHSA and Indian Health Services.

The *National Strategy for Suicide Prevention Implementation Assessment Report (Assessment Report)* was released in 2017. It stated that never had there been so much suicide prevention activity in the United States (SAMHSA, 2017). Despite this growth in suicide prevention activities, suicide rates continued to rise (though decreases were subsequently observed in 2019 and 2020). The *Assessment Report* authors also noted they were unable to locate a single state or even a single community that was implementing all the recommended activities in the *National Strategy* (SAMHSA, 2017). Thus, it became apparent, that to be successful in reducing suicide, each community needed to adopt comprehensive prevention efforts.

The *Assessment Report* noted the need for 1) community-level suicide prevention infrastructure, 2) a blueprint specifying what a stable, comprehensive, and coordinated suicide prevention effort would look like at the community level, 3) utilization of a comprehensive and coordinated approach across all relevant settings, and 4) the need for regular and coordinated monitoring of *National Strategy* implementation (SAMHSA, 2017).

The 2021 Surgeon General's *Call to Action to Implement the National Strategy for Suicide Prevention* reinforced these findings:

> Although research has identified many strategies that can be effective in preventing suicide, these evidence-informed approaches have not yet been brought to scale. Findings from a comprehensive assessment of national progress toward implementation of the goals and objectives of the *National Strategy* show that while there are more suicide prevention efforts in the United States than ever before, they vary across states, and few are comprehensive or strong enough to have a measurable impact on reducing suicidal behavior. The *National Strategy* is far from being implemented nationally or in its entirety, and suicide prevention continues to lack the breadth and depth of the coordinated response needed to truly make a difference in reducing suicide. (Office of the Surgeon General, 2021)

This new 2024 *National Strategy* seeks to close the gaps identified in these previous reports and to motivate coordinated and comprehensive action in states and communities, ensuring progress is made through monitoring and evaluation.

Recent Reports, Recommendations, and Other Guidance Documents

Recent advances and guidance helped inform this strategy. President Biden introduced his unity agenda in his first State of the Union address in 2022. The agenda included a focus on improving mental health, supporting Veterans, and addressing the overdose crisis (The White House, 2023). These priorities helped pave the path to many federal resources and initiatives focused on suicide prevention. They also provided a foundation for continued commitments and action. *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention* in 2021 prioritized key activities to fully implement the 2012 *National Strategy* and to reverse the upward trend of suicide deaths in the United States (Office of the Surgeon General, 2021). On the heels of this Call to Action, HHS reviewed more than a dozen suicide prevention reports and documents from across the federal government and extracted over 300 recommendations for improving federal suicide prevention efforts. These recommendations were prioritized and gaps between recommendations and current federal activities were identified as areas for needed growth. These recommendations informed the development of the 2024 *National Strategy for Suicide Prevention* and *Federal Action Plan*.

Other Surgeon General reports informed the *National Strategy* development, including *Our Epidemic of Loneliness: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community*. This advisory describes the harms of loneliness on both individual and societal health. These harms include depression, anxiety, and premature death and consequences felt in schools, workplaces, and civic organizations (Office of the Surgeon General, 2023a). The advisory highlights the need for continued attention and focus on the key protective factor of connectedness. Two other U.S. Surgeon General's Advisories—*Protecting Youth Mental Health* and *Social Media and Youth Mental Health* also inform *National Strategy* goals and objectives related to youth suicide prevention.

The 2024 *National Strategy* also considered information from other recent government reports, including the following:

- *Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention and Response Independent Review Committee (SPRIRC):* This report provides 10 recommendations to address overarching issues in the military to improve service members' well-being. This includes a multi-factorial approach to address the complex factors associated with military suicide (Suicide Prevention and Response Independent Review Committee, 2023).

- *2023 National Veteran Suicide Prevention Annual Report:* This report provides the largest analysis of Veteran suicide rates.

- *Ring the Alarm: The Crisis of Black Youth Suicide in America:* This Congressional Black Caucus's Emergency Taskforce on Black Youth Suicide and Mental Health report highlights the concerning increase in suicide rates among Black youth and provided recommendations to reverse these trends and address disparities (Congressional Black Caucus on Black Youth Suicide and Mental Health, 2020).

- *Suicide Prevention Resource for Action:* CDC's update to its 2017 *Preventing Suicide Technical Package of Policy, Programs, and Practices* describes the best available evidence to prevent suicide. This document includes policies, programs, and practices to prevent suicide risk in the first place, to support people at increased risk, to prevent reattempts, and to support survivors and prevent additional suicides after a suicide loss.

For a full review of the process to create the 2024 *National Strategy*, see Appendix D.

National Strategy: Strategic Directions and Goals

Based on the above, the resulting 2024 *National Strategy* includes 15 goals and 87 objectives organized under four strategic directions:

Strategic Direction 1: Community-Based Suicide Prevention

- **Goal 1:** Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships.
- **Goal 2:** Support upstream comprehensive community-based suicide prevention.
- **Goal 3:** Reduce access to lethal means among people at risk of suicide.
- **Goal 4:** Conduct postvention and support people with suicide-centered lived experience.
- **Goal 5:** Integrate suicide prevention into the culture of the workplace and into other community settings.
- **Goal 6:** Build and sustain suicide prevention infrastructure at the state, tribal, local, and territorial levels.
- **Goal 7:** Implement research-informed suicide prevention communication activities in diverse populations using best practices from communication science.

Strategic Direction 2: Treatment and Crisis Services

- **Goal 8:** Implement effective suicide prevention services as a core component of health care.
- **Goal 9:** Improve the quality and accessibility of crisis care services across all communities.

Strategic Direction 3: Surveillance, Quality Improvement, and Research

- **Goal 10:** Improve the quality, timeliness, scope, usefulness, and accessibility of data needed for suicide-related surveillance, research, evaluation, and quality improvement.

- **Goal 11:** Promote and support research on suicide prevention.

Strategic Direction 4: Health Equity in Suicide Prevention

- **Goal 12:** Embed health equity into all comprehensive suicide prevention activities.

- **Goal 13:** Implement comprehensive suicide prevention strategies for populations disproportionately affected by suicide, with a focus on historically marginalized communities, persons with suicide-centered lived experience, and youth.

- **Goal 14:** Create an equitable and diverse suicide prevention workforce that is equipped and supported to address the needs of the communities they serve.

- **Goal 15:** Improve and expand effective suicide prevention programs for populations disproportionately impacted by suicide across the life span through improved data, research, and evaluation.

A description of all Goals within a Strategic Direction is provided. This includes why the goal is important, implementation considerations, and examples of current goal actions. A list of Objectives to further advance each Goal follows (see Appendix B for a listing of all Goals and Objectives).

Cross-Cutting Themes

Several themes cut across all four strategic directions. Health equity in suicide prevention, for example, is both central to the *National Strategy* as a whole and is Strategic Direction 4. Addressing health equity includes a focus on populations disproportionately affected by suicide and suicide attempts. The *National Strategy* also highlights the benefits of including people with suicide-centered lived experience as key partners and contributors in suicide prevention planning, implementation, research, and evaluation. It encourages work with multi-sectoral partners to address the many factors associated with suicide, including social determinants of health. These determinants cover levels of employment and income, education, adequate housing, food insecurity, health care access, and relationships and interactions, such as discrimination on the basis of race, ethnicity, sexual orientation, and gender identity, among others (U.S. Department of Health and Human Services, 2020).

The importance of a comprehensive approach to suicide prevention is woven throughout the *National Strategy*. This approach recognizes the many factors associated with suicide at the individual, relationship, community, and societal levels, called the *Social Ecological Model* (see Table 4).

Table 4. **Risk and protective factors for suicide based on levels of the Social Ecological Model**

Category	Risk factors	Protective factors

Individual	• History of:
	  ◦ Suicide attempt(s)
	  ◦ Depression
	  ◦ Other mental illness
	  ◦ Substance use
	  ◦ Adverse childhood experiences
	  ◦ Violence (as victim, perpetrator, or both)
	
	• Negative life stress:
	  ◦ Severe illness
	  ◦ Chronic pain
	  ◦ Criminal and/or legal problems
	  ◦ Financial loss or instability
	  ◦ Job problem or loss
	  ◦ Intergenerational trauma
	
	• Experiences of:
	  ◦ Hopelessness
	  ◦ Impulsivity
	  ◦ Aggression
	  ◦ Social isolation
	  ◦ Loneliness
		• Beliefs in:
		  ◦ Reasons for living
		  ◦ Cultural identity
		• Effective life skills:
		  ◦ Coping

Relationship	• Negative life events:
	  ◦ Family or loved one's suicide
	  ◦ Loss of relationship(s)
	
	• Negative relationships:
	  ◦ High conflict or violent relationships
	  ◦ Bullying
	  ◦ Social exclusion
	  ◦ Interpersonal racism and discrimination
		• Connection:
		  ◦ Social support
		  ◦ Close relationships with positive peers, parents, family, significant others
		  ◦ Variety of relationships and frequency of interactions

Category	Risk factors	Protective factors
Community	• Traumatic history: 　◦ Historical trauma 　◦ Suicide cluster • Risk environment 　◦ Community violence 　◦ Discrimination • Disconnection: 　◦ Stress of acculturation 　◦ Lack of access to health care	• Healthy environment: 　◦ Accessible and affordable high-quality health care (physical and behavioral) • Connection to: 　◦ School 　◦ Community 　◦ Social institutions
Societal	• Negative stereotypes about: 　◦ Help-seeking 　◦ Mental illness • Risk environment: 　◦ Unsafe media portrayals 　◦ Easy access to lethal means of suicide among people at risk 　◦ Systemic or institutional racism and discrimination	• Objections to suicide from: 　◦ Culture 　◦ Morals 　◦ Religious beliefs • Reduced access to lethal means of suicide

Sources: CDC, 2022b; Alvarez et al., 2022; Coimbra et al., 2022

Carrying out the comprehensive approach to suicide prevention includes:

• Ensuring strong leadership to convene and connect multi-sectoral partnerships

• Using data to:
　◦ Identify populations most impacted by suicide
　◦ Understand contributors to suicide and suicide attempts in these populations
　◦ Track trends in suicide and suicide attempts
　◦ Evaluate policies, programs, and practices

• Identifying and assessing gaps in existing community policies, programs, and practices

• Selecting, implementing, and evaluating multiple and complementary strategies with the best available evidence in community and health care settings (see CDC's *Suicide Prevention Resource for Action*)

• Creating robust communication and dissemination plans to share relevant trends and progress with the community and partners, including successes and lessons learned

Source: https://www.cdc.gov/suicide/programs/csp/index.html

The foundation of comprehensive suicide prevention requires strong suicide prevention infrastructure, a competent and well-trained workforce, the use of quality data to help drive decision-making, and a strong science base. Woven throughout the *National Strategy* is a focus on evaluation, including evaluation of the strategy itself.

States, tribes, local areas, and territories can use the *National Strategy* to inform suicide prevention planning and service delivery. These activities should include public health, health care, and other community leaders; other multi-sectoral partners, and people with suicide-centered lived experience. Scientists and evaluators can use the *National Strategy* to guide the research needed to advance suicide prevention. Funders and policymakers can consult the *National Strategy* when allocating resources for suicide prevention.

Federal Action Plan

For the first time, the *National Strategy* includes a three-year Federal Action Plan. This plan will improve accountability for suicide prevention efforts and maximize federal infrastructure. Federal agencies have committed to specific, short-term actions they will carry out related to the goals and objectives included in the *National Strategy*. The *Action Plan* does not provide a comprehensive list of all suicide prevention efforts that federal departments and agencies will carry out. Rather, it presents a set of priority actions advancing specific goals and objectives of the *National Strategy* within the first three years. These commitments, largely based on currently appropriated resources, will support critical short-term improvements in suicide prevention and set the foundation for longer-term efforts to reduce suicide rates.

Collaboration across the federal, state, tribal, local, and territorial levels is key to achieving and sustaining meaningful, equitable, and measurable advancement in suicide prevention. The *Action Plan* needs public and private sector support. Strong suicide prevention efforts and partnerships in states and communities can support the 10 essential public health services by promoting equitable policies, systems, and services to help reduce suicide and suicide risk (Figure 4).

Figure 4. **The 10 essential public health services**

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.

Assessment

Build and maintain a strong organizational infrastructure for public health

Assess and monitor population health

Investigate, diagnose, and address health hazards and root causes

Improve and innovate through evaluation, research, and quality improvement

Communicate effectively to inform and educate

Equity

Build a diverse and skilled workforce

Strengthen, support, and mobilize communities and partnerships

Assurance

Policy Development

Enable equitable access

Create, champion, and implement policies, plans, and laws

Utilize legal and regulatory actions

Created 2020

Source: CDC, 2024b

Addressing our nation's suicide rate depends on initiatives in both public health as well as health care delivery. According to one study (Ahmedani, 2019), 30% of people had a health care visit in the 7-days before suicide, over half within 30 days, and more than 90% within 365 days. Those who died by suicide averaged 17 health care visits during the past year.

Major Developments in the Field Since 2012

Addressing suicide thoughts, attempts, and deaths poses complex challenges. This is due, in part to the many factors associated with suicide. Advances in the field since 2012 include the following:

- Expansion of the number of effective prevention programs and interventions implemented in states and communities

- Improvements in the health system and in service delivery

- Innovations in the types of data examined and new data science techniques

- Expanded research efforts

- Improvements in occupational health

- Attention to emerging issues and capacity building

Many of these efforts include attention to the critical role of health equity in suicide prevention. Examples of these advances include the following:

Advances in service delivery

- SAMHSA support for the transition to and expansion of the National 988 Suicide and Crisis Lifeline, mobile crisis, crisis stabilization, and referrals to community services. The capacity for 988 has been vastly expanded to include chat, text, Spanish language, and other population-specific services (e.g., videophone for people who are deaf or hard of hearing). Additional efforts are under way to expand access for tribal communities. Call wait-times have significantly decreased from nearly 3 minutes to 49 seconds. SAMHSA continues to support capabilities and best practices for communities across the crisis care continuum (e.g., mobile outreach and referrals to community services). National Institutes of Health (NIH) also supports this work, conducting research to understand the most effective components of crisis services.

- Investment in Zero Suicide in Health Systems, a comprehensive, multi-setting approach to suicide prevention in health systems, by SAMHSA, NIH, and the Indian Health Service (IHS). There were 30 active Zero Suicide grants awarded in 2023 and upwards of 1,200 health care systems are implementing some or all of the Zero Suicide components (SAMHSA, n.d. and Zero Suicide Institute, 2024).

- Launch of the first National Center for Child Welfare Competent Mental Health Services by the Administration for Children and Families (ACF). This Center addresses youth in child welfare placements. It provides technical assistance and training to strengthen coordination and capacity among child welfare and mental health professionals and systems. It improves the quality of mental health services provided to children, young adults, and their families involved in the child welfare system and who have experienced adoption.

- Strengthened suicide prevention in schools. Department of Education (ED) bolstered the pipeline of mental health professionals serving in schools and expanded school-based mental health services and supports. This includes collaboration with the Centers for Medicare and Medicaid Services (CMS) to improve the delivery of school-based services through Medicaid and Children's Health Insurance Program.

Advances in prevention programming in states, tribes, and communities

- Tribal communities have received expanded funding through SAMHSA, IHS, NIH, and CDC. Many of these efforts address behavioral health conditions (i.e., mental health and substance use disorders). Strengths-based and other culturally aligned approaches seek to develop needed infrastructure and sustainable efforts to maintain gains and progress in suicide prevention.

- Expanded funding has gone to states and communities through a variety of programs, including SAMHSA's Garrett Lee Smith (GLS) State and Tribal Grant Program and its Campus Suicide Prevention program. These programs help identify people at risk for suicide, enhance mental health services, increase protective factors, reduce risk factors, and ultimately reduce suicide and suicidal behaviors. The *National Strategy for Suicide Prevention* grant programs help implement the *National Strategy,* with particular focus on suicide prevention and intervention among older adults, adults in rural areas, and American Indian and Alaska Native adults.

- CDC expanded its suicide prevention portfolio with funding for its Comprehensive Suicide Prevention Program (CSP) in 2020. As of 2024, CSP supports recipients in 23 states and one territory. These recipients implement and evaluate a comprehensive approach to suicide prevention with attention to populations disproportionately affected by suicide.

- VA funded its new Staff Sergeant Parker Gordon Fox Veteran suicide prevention grant program supporting community-based organizations across states, the District of Columbia, Guam, and American Samoa. The program provides or coordinates suicide prevention services for eligible Veterans and their families. This includes outreach, screening, clinical services, case management, peer support, and assistance with obtaining benefits.

- Department of Defense (DOD) has taken action to reduce suicide risk over the past two and a half years. The DOD is pursuing 83 new tasks across five lines, as directed by the Secretary of Defense in support of the Suicide Prevention and Response Independent Review Committee's (2023) recommendations, including, to:
  - foster a supportive environment
  - improve the delivery of mental health care
  - address stigma and other barriers to care
  - revise suicide prevention training
  - promote a culture of lethal means safety

Innovations in data and research

- CDC data improvements include:

  - Expansion of the National Violent Death Reporting System (NVDRS) to all 50 states, the District of Columbia, and Puerto Rico
  - Funding for surveillance of emergency department visits for self-harm in near real-time
  - Improvements in the timeliness of suicide data
  - Advances in data science

- CDC and NIH now conduct firearm injury prevention research, including preventing firearm suicide and suicide attempts.

- The Action Alliance released *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives* in 2014. This document created a new national research agenda to guide suicide prevention research aimed at better understanding how to prevent suicide thoughts, attempts, and deaths.

- NIMH's investments in suicide research quadrupled between 2014 and 2022.

Improvements in understanding and addressing occupation-related risks

- CDC launched a new Total Worker Health® Center of Excellence in 2021. This Center, dedicated exclusively to workplace mental health as part of an expanded occupational safety and mental health portfolio, includes a research agenda, partners, and research for intervention strategies. This new center is expected to contribute to the evidence base for improving mental health and well-being in several industries and sectors. These include health care, public health, first responders (including law enforcement), and agriculture. Additionally, in 2021, CDC launched a national social marketing campaign and projects to: identify and disseminate best practices for suicide prevention, reduce burnout, and improve the well-being of health care and public health workers.

- The Health Resources and Services Administration ([HRSA](#)) funded efforts to reduce burnout, promote mental health and wellness, and reduce suicide among the health care workforce.

- SAMHSA added [Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies](#) to their *Evidence-Based Resource Guide Series* in 2022.

- The U.S. Department of Agriculture (USDA) funds the [Farm and Ranch Stress Assistance Network](#) to strengthen programs that provide professional behavioral health counseling and other services to individuals in agricultural occupations.

- The U.S. Department of Justice (DOJ) published two reports that provide insight on data sources, relevant research, practices, policies, and approaches with potential to reduce suicide risk among law enforcement personnel.

  - [Recommendations Regarding the Prevention of Death by Suicide of Law Enforcement](#) assesses current efforts and evidence and makes recommendations (e.g., encouraging submission of data to the Law Enforcement Suicide Data Collection program).
  - [Best Practices to Address Law Enforcement Officer Wellness](#) identifies occupational stressors that can increase risk of adverse mental, physical, interpersonal, and behavioral outcomes among law enforcement agency personnel, as well as policies and practices to foster a culture of wellness. (U.S. Department of Justice, 2023).

Advances in knowledge, training, and capacity building

- Funding increased to support knowledge improvement, training, and capacity building through HHS's new [Center of Excellence on Social Media and Youth Mental Health](). This Center disseminates information, guidance, and training on the impact of social media use on children and youth.

- Significant increases in the SPRC budget will advance *National Strategy* implementation through infrastructure and capacity building.

There have been many improvements to suicide prevention work across the federal government and beyond over the last decade. We also recognize the reality that suicide rates are still increasing overall. This *National Strategy* represents a comprehensive, "whole of government" path forward. It builds on past successes and lessons learned and is focused on health equity. It advances a comprehensive public health approach to preventing suicide thoughts and behaviors among all members of our society, and especially among people disproportionately affected by suicide or suicide attempts.

1

Community-Based Suicide Prevention

Strategic Direction 1 focuses on community-based comprehensive suicide prevention activities that can help prevent the onset of suicide risk, sometimes called *upstream, universal,* or *primary prevention*. This strategy is focused on preventing suicide risk in the first place, identifying and supporting people at increased risk through treatment and crisis intervention, preventing reattempts, promoting long-term recovery, and supporting survivors of suicide loss.

Such activities can increase protective factors and decrease suicide risk factors that may lead to suicide thoughts, attempts, crisis situations, and deaths. Upstream prevention may have lasting positive outcomes across the life span (Hawkins, et al., 2016).

Community is a critical context for suicide prevention that encompasses the spaces where people live, work, learn, play, and/or worship. Community may be defined by geography, shared interests, or other characteristics such as race, ethnicity, disability, sexual orientation, gender identity, or military background. Community-based prevention is rooted in the cultural, social, and economic conditions and traditions of the populations being served. Every community can benefit from a coordinated, comprehensive suicide prevention approach that weaves together the many strands of prevention, intervention, and postvention.

A comprehensive approach begins with multi-sectoral partnerships. No one agency, organization, or sector can prevent suicide on its own (see Goal 1). All community-based organizations in public and private sector settings can take an active role in preventing suicide and creating communities where people can thrive. These include schools, places of employment, social service agencies, local businesses, legal systems, and other organizations and settings.

Shared strengths, capacities, expertise, and resources of a collective partnership can amplify the preventive impact beyond that of any one organization alone. Comprehensive suicide prevention requires a range of voices, identities, and perspectives informed by lived experience. This ensures that acceptable, accessible, and effective approaches to suicide prevention are chosen and implemented.

The comprehensive approach calls for communities to select, implement, and evaluate a range of strategies to address the many factors associated with suicide at the individual, relationship, community, and societal levels (see Goals 2, 3, 4, and 5). These decisions should be driven by data (see Strategic Direction 3). The most effective selections will complement existing suicide prevention programs such as the following strategies from the Centers for Diseases Control and Prevention's (CDC) *Suicide Prevention Resource for Action* (CDC, 2022c):

- Strengthening economic supports

- Creating protective environments (e.g., lethal means safety and workplace prevention)

- Improving access and delivery of suicide care

- Promoting healthy connections

- Teaching coping and problem-solving skills

- Identifying and supporting people at risk

- Lessening harms and preventing future risk (e.g., postvention)

All levels of government and tribal nations need strong suicide prevention infrastructure to carry out the comprehensive approach (see Goal 6). Integration of effective policies, programs, and practices; dissemination across community settings; and access to culturally relevant information and resources to get help, are essential (see Goal 7).

Federal investments in comprehensive suicide prevention approaches have grown since the 2012 *National Strategy*. In 2023, the Secretary of Defense outlined five lines of effort to reduce suicide risk among service members and their families (see Goal 2). In 2022, the Department of Veteran's Affairs (VA) launched its Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program to support Veterans and their families through a range of community services and resources across the country. In 2020, CDC launched its flagship Comprehensive Suicide Prevention program providing funding to states and communities to implement and evaluate a data-driven comprehensive approach with a focus on populations disproportionately impacted by suicide. In 2019, the VA announced Suicide Prevention 2.0, a population-based public health program combining community-based prevention strategies and evidence-based clinical strategies.

In ongoing commitments, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Garrett Lee Smith Youth Suicide Prevention Program (GLS) and the *National Strategy for Suicide Prevention* grant program for adults have provided millions of dollars to states,

territories, and institutions of higher education to implement youth and adult suicide prevention efforts, respectively. These federal investments have supported the field in expanding its focus from suicide prevention efforts largely based on intervening after someone is already experiencing a suicide-related crisis to creating environments that reduce communities' overall suicide risk. Evaluations of programs have shown the value of these efforts as evidenced by SAMHSA's GLS grant program in which counties and communities implementing GLS-funded prevention strategies showed decreased suicide for youth (see Figure 5, Godoy Garraza et al., 2019). Other evaluations of GLS are currently underway.

→ GOAL 1:
Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships.

Establish Partnerships

Suicide is a complex but preventable problem, often with many contributing causes. A combination of factors may increase suicide risk, such as job and financial problems, including housing and food insecurity; school problems; relationship problems, such as bullying, divorce, or breakups; adverse childhood experiences, such as physical abuse and neglect; chronic health conditions; mental illness; substance use; legal problems; easy access to lethal means among people at risk; historical trauma; and discrimination and racism, among others. Addressing these issues require a comprehensive approach to prevention that extends into communities. Not surprisingly, no single sector, agency, or organization can prevent suicide or carry out the comprehensive approach alone. Only by working together with diverse public and private sector partners and across community settings can we achieve measurable and sustained suicide prevention impacts at all levels.

Some Considerations

Integrating and coordinating suicide prevention into and across community settings and sectors can help reach people who may be at risk, wherever they live, work, learn, play, and/or worship, for the greatest impact. It is important to involve a wide range of partners, including, but not limited to, the following:

- People with suicide-centered lived experience and concerned community members
- Individuals from populations disproportionately affected by suicide and suicide attempts
- Nongovernmental and community-based organizations
- Federal, state, tribal, local, and territorial government agencies (e.g., those focused on public health, housing, economic security, justice, and education)
- Social services, substance use treatment and prevention services, health and behavioral health insurers and providers, health care systems, and first responders
- Private sector businesses
- News media, policymakers, and potential funders, such as foundations

Working together creates maximum impact. For example, the private sector may have flexibility in response to prevention opportunities as well as reach a variety of audiences with messaging, resources, and recommendations. Conversely, the public sector agencies may be able to influence

long-term policy and decision-making for sustained impact. Working together creates a network of coordinated efforts that reflect the varied contexts in which community members interact and the underlying factors that contribute to suicide risk.

What Success Looks Like

Successful partnerships maximize diverse experiences and expertise and foster creativity, new ideas, and perspectives. People engaged in such partnerships at the national, state, tribal, local, and territorial levels can create a shared agenda with a mutual vision for suicide prevention that is tied to goals, objectives, and actions with measurable outcomes, and where everyone has a defined role. For example, some people may have expertise in data collection and analysis, or program planning and evaluation, while others are expert communicators. Some bring a local perspective and have the pulse of the community, which can inform partners' understanding of cultural beliefs and context key to effective prevention. Others bring their lived experience of recovery to inform improvements in systems and services. Ideally, coalitions can be formed to bring diverse partners together and provide its members with the training, funding, resources, and support necessary to carry out their respective roles. Likewise, organizational commitment through implementation of evidence-informed policies, programs, and practices for suicide prevention can ensure efforts are effective and sustainable across partners.

Examples

- The National Action Alliance for Suicide Prevention (Action Alliance) has served as the nation's public-private partnership for suicide prevention since 2010. The Action Alliance was launched by senior executives in the federal government and the private sector. They serve as the coordinating body overseeing and supporting implementation of the *National Strategy*. The Action Alliance aligns and strengthens national suicide prevention efforts and catalyzes new high-priority efforts. Through this innovative partnership model and infrastructure, the Action Alliance has 1) brought new industries and organizations to the table, since 2012, (e.g., construction, entertainment, public safety, news media, finance, health care, transportation, faith-based organizations, and social media) and 2) launched innovations to transform health systems to reduce suicide, transform communities, and change the conversation around suicide prevention. For more information on the Action Alliance, visit https://theactionalliance.org/.

- Michigan's Preventing Suicide in Michigan Men (PRiSMM) program, a five-year CDC-funded program, brings together key individuals, organizations, and stakeholders who work to prevent suicide in Michigan men, a population that is at disproportionate risk for suicide. PRiSMM includes organizations in the construction, automotive, farming, and television and media industries, as well as the faith community. PRiSMM shares data and information from the perspective of men, for men, across a wide network. It created a suicide prevention social media guide, a risk factors and warning signs guide, and data presentations to disseminate and inform the PRiSMM partnership about suicide trends and suicide prevention efforts. One of PRiSMM's partners oversees Michigan's largest construction company which plans to implement strategies to improve mental health and suicide prevention among its employees. This partner has also been able to provide insight on how PRiSMM's suicide prevention messaging can reach Michigan men who work in construction. For more information, visit https://www.cdc.gov/suicide/programs/csp/programprofiles.html.

- Native Connections is a SAMHSA grant program focused on youth outcomes within tribal communities. It utilizes a community approach grounded in the traditional family structure of Indigenous people. This approach provides a unifying point to address many of the external challenges experienced by American Indian and Alaska Natives that contribute to suicide risk. These challenges and service gaps include poverty; accessing health services in an overburdened system; and a disproportionate impact of behavioral health issues, such as substance use disorder and suicide deaths in American Indian and Alaska Native communities. To learn more on Native Connections, visit https://www.samhsa.gov/native-connections.

- Founded in the values of community collaboration and engagement as well as the cultural heritage of the Pacific, Guam has developed a strategic prevention plan to create empowered youth, effective communication, strong leadership, grassroots engagement, and safe and healthy environments. To learn more, visit https://gbhwc.guam.gov/peace.

What We Should Do

Below are the objectives for Goal 1 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 1.1:** Create and sustain public-private partnerships and coalitions at the national, state, and local levels, representing diverse populations, perspectives, and broad suicide-centered lived experiences to extend reach and strengthen suicide prevention outcomes.

- **Objective 1.2:** Create and enhance connections between state agencies, tribal nations, and local communities to increase the reach of comprehensive suicide prevention activities and to strengthen outcomes.

- **Objective 1.3:** Strengthen and sustain collaborations across federal agencies to advance suicide prevention nationally by leveraging each agency's unique expertise, data, programs, and other resources.

→ GOAL 2:
Support upstream comprehensive community-based suicide prevention.

Focus on Comprehensive Suicide Prevention

Suicide thoughts, attempts, and deaths can have lasting impacts on individuals, families, caregivers, relationships, and entire communities. Suicide risk may occur in response to mental disorders, relationship break-ups, adverse childhood experiences, stigma related to help-seeking, substance use, and lack of access to affordable care, among others. A comprehensive community-based approach can address these many risks and prevent the long-lasting effects of suicide. An upstream approach can foster well-being and promote safe, stable, nurturing relationships and environments while preventing suicide and related harms.

> To learn more about the research and examples of effective policies, programs, and practices, see CDC's *Suicide Prevention Resource for Action*.

Some Considerations

Efforts to prevent someone from becoming suicidal are different from approaches taken once someone has thoughts about suicide or is in a crisis. Working upstream can prevent people from becoming suicidal in the first place and can have wide-ranging positive impacts across the life span. Effective upstream policies, programs, and practices as part of a comprehensive approach to prevention can address what are called *social determinants of health*. These determinants include social interactions such as social connectedness, economic stability, housing, education, and life skills. A range of social conditions can create disparities in social determinants of health. They include racism or discrimination; limited opportunities in support of positive health and well-being; and increased risk for suicide and related outcomes, such as drug overdose and adverse childhood experiences (Ayer et al., 2023; Education Development Center and National Association of County and City Health Officials, 2023; Hughes et al., 2017; Liu et al., 2023; Reider & Sims, 2016; SAMHSA, 2016).

The process for identifying the upstream efforts that best suit a specific community starts by understanding local conditions. Being aware of the latest trends and changes in suicide, suicide attempts, risk and protective factors, and identifying populations disproportionately impacted, will help focus prevention efforts. Assessing community strengths and gaps also informs effective suicide prevention. For example, states or local communities can assess:

• Community-identified priorities for prevention

• Availability of effective suicide prevention programs and services

• Local drivers or contributors of suicide risk (called indicators)

• Organizations with capacity to address social determinants of health and other risk and protective factors

Resources for Assessing and Supporting Upstream Suicide Prevention Efforts

• The Suicide, Overdose, and Adverse Childhood Experiences Prevention Capacity Assessment Tool (SPACECAT), from the Association of State and Territorial Health Officials, helps public health officials assess their capacity to address the intersection of suicide, overdose, and adverse childhood experiences. To learn more about the tool, visit https://my.astho.org/spacecat/suicide-data-indicators.

• CDC's Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence and Essentials for Childhood: Creating Safe, Stable, Nurturing Relationships and Environments for All Children provide concrete strategies to set communities up for success.

To learn more about one state's indicators and data sources used to measure progress across a range of risk and protective factors, visit the Colorado Shared Risk and Protective Factors Dashboard. The dashboard tracks indicators related to behavioral health, economic stability, connectedness, and positive social norms.

The following are examples of effective upstream strategies as part of a comprehensive suicide prevention approach from **CDC's Suicide Prevention Resource for Action**:

- **Strengthen economic supports:** Dow and colleagues (2020) examined the effect of state-level minimum wage and earned income tax credit (EITC) increases among adults ages 18–64 in the years 1999–2017 on overdose, alcohol-related deaths, and suicide deaths. Results showed no effect on rates of alcohol-related or overdose deaths and no effect for men or women with a bachelor's degree or higher. However, rates of non-overdose suicide deaths decreased following implementation of state policies providing increases in minimum wage and EITC, particularly among adult females and individuals with a high school or less education. This study suggests that economic policies, such as raising income, may reduce suicide rates among females and people with the lowest levels of income.

- **Promote healthy connections:** According to the CDC, social connectedness is the degree to which people have and perceive a desired number, quality, and diversity of relationships that create a sense of belonging, and being cared for, valued, and supported. Social connections can counter known suicide risk factors, such as feelings of loneliness; social isolation; mental health conditions; and bias, harassment, or discrimination (CDC, 2023). Programs that can impact connectedness may be found in schools (e.g., Sources of Strength), in the military (e.g., Wingman Connect), and through community engagement activities (e.g., community greening initiatives).

- **Teach coping and problem-solving skills:** Social and emotional learning (SEL) programs have been shown to reduce recognized risk factors for suicide. These include reductions in student anxiety, hopelessness, substance use, and sexual abuse. Zuni/American Indian Life Skills program, the Good Behavior Game, and Youth Aware of Mental Health have shown direct reductions on suicide ideation (Posamentier et al., 2023). Parenting skills to improve family relationships also teach coping and problem-solving skills and have shown impact with young families (e.g., The Incredible Years, Family Check-Up, *Familias Unidas*) For more information on the relationship between SEL programs and suicide prevention, visit https://pubmed.ncbi.nlm.nih.gov/35139714/.

- **Create protective environments:** Creating environments that address risk and protective factors where people live, work, learn, play, and worship can reduce suicide risk. For example, LGBTQI+ school health policies and practices benefit lesbian, gay, bisexual, and heterosexual students across a range of outcomes (Mintz et al., 2021). Gay-Straight Alliances or Gender and Sexuality Alliances (GSA) offer an inclusive and supportive space for all students to connect and share their lived experiences with one another and build peer support. Being involved in a GSA, or even the presence of a GSA within a school, has been associated with a reduced risk for suicide-related behaviors (e.g., suicide attempts) and positive youth development, a protective factor for suicide (Kaczkowski et al., 2022; Kia et al., 2021; Saewyc et al., 2014). On one campus, a GSA reduced suicide attempts associated with gay-bias victimization (Davis et al., 2014). For more information on creating and supporting GSAs, visit the Gay-Straight/Genders and Sexualities Alliances.

For more information on these upstream strategies, see CDC's *Suicide Prevention Resource for Action*.

What Success Looks Like

Successful upstream comprehensive community-based suicide prevention involves assessing the following:

- Community strengths and gaps

- Unique and broad-based risk and protective factors

- Trends in suicide and suicide attempts

- Populations disproportionately affected by these and related outcomes.

Prevention professionals and partners would use this information to advance comprehensive suicide prevention. This includes selection of effective upstream policies, programs, and practices related to economic stability, healthy connections, coping skills, substance use prevention, and providing access to downstream treatment and crisis intervention. A broad range of community partners in prevention efforts would be involved (see Goal 1). These partners might include key community agencies, such as K–12 schools, faith institutions, housing authorities, employment services agencies, and substance use treatment providers. These partners would be knowledgeable in suicide prevention best practices and would link their work with risk and protective factors to ongoing prevention efforts. Federal partners would support these community efforts in suicide prevention through technical assistance and by providing financial and public support for addressing risk and protective factors prevention.

Examples

- Colorado's Office of Suicide Prevention funds local organizations to implement full-scale, community-based, and comprehensive prevention efforts. These efforts are rooted in six core pillars: Connectedness, Economic Stability, Education and Awareness, Improving Access to Safer Suicide Care, Lethal Means Safety, and Postvention—each adapted from the strategies of CDC's *Suicide Prevention Resource for Action*. Larimer County highlights this collaborative work in action (Colorado Department of Public Health and Environment, 2023). Examples of their recent activities being evaluated include the following:

  - Partnering with local food security, housing, and transportation organizations to address economic stability efforts in the community
  - Hosting and supporting several events for LGBTQI+ connection
  - Training over 2,500 community members per year in Question, Persuade, Refer (QPR), an evidence-based training program that teaches people about warning signs for suicide, how to respond, how to offer hope, and how to get help
  - Promoting the Colorado Gun Shop Project that focuses on lethal means safety
  - Hosting peer support groups that focus on priority populations, including teens, working-aged men, and Veterans
  - Promoting Zero Suicide (a framework for system-wide transformation of health care settings toward safer suicide care) learning collaboratives and Collaborative Assessment and Management of Suicidality (CAMS) trainings

- Although still needing evaluation, older adult residences, such as retirement communities and assisted-living communities, have begun taking steps to reduce and respond to older adult suicide risk. Older adult residential efforts include promoting positive environments. This includes providing events and activities that increase social connectedness across members,

including volunteer days, regular game nights, and holiday parties. Other efforts include educating people and staff on strategies for maintaining positive mental health. Individual and staff training on the warning signs of suicide prepares the whole community to identify, connect, and refer individuals having thoughts of suicide to available mental health services. When these strategies are coupled with protocols and policies guiding when and how older adults receive mental health and crisis response services, the result is a comprehensive approach to suicide prevention that can reduce older adults' overall suicide risk. To learn more about older adult residential suicide prevention, see _Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers_ and _SPRC's The Role of Senior Living Community Professionals in Preventing Suicide_.

- In response to an independent review process, the Secretary of Defense (U.S. Secretary of Defense, 2023) outlined five lines of efforts that the U.S. Department of Defense (DOD) is taking to reduce suicide risk among service members and their families. These include improving schedule predictability, expanding mental health training programs that specifically focus on the needs of service members, providing lethal means safety education to unit leaders, including reduced access to privately owned firearms in barracks and dormitories. Further, DOD plans to integrate suicide prevention and education on risk and protective factors into all its policies and procedures, including efforts to prevent sexual assault and sexual harassment. This will ensure a military culture that increases help-seeking behaviors and supportive environments, reduces stigmatizing language and barriers to mental and behavioral health care, and promotes lethal means safety to ultimately reduce suicide.

What We Should Do

Below are the objectives for Goal 2 that will help advance the _National Strategy_ to improve suicide outcomes in the country.

- **Objective 2.1:** Assess community strengths and gaps to inform suicide prevention planning at the individual, relationship, community, and societal levels.

- **Objective 2.2:** Strengthen job and economic supports, especially among individuals, families, and communities disproportionately affected by suicide and overdose.

- **Objective 2.3:** Improve availability and access to culturally relevant suicide prevention information and community-helping resources, especially in underserved and historically marginalized communities.

- **Objective 2.4:** Implement and evaluate effective interventions that reduce the onset of suicide risk and promote connected individuals, families, and caregivers where they live, work, learn, play, and worship.

- **Objective 2.5:** Promote safe, stable, and nurturing relationships and environments to help prevent adverse childhood experiences and create positive childhood experiences.

- **Objective 2.6:** Implement and evaluate interventions addressing the intersection of suicide, substance use, and adverse childhood experiences, including those with a focus on improving social determinants of health across diverse populations.

- **Objective 2.7:** Implement and evaluate effective interventions reflecting a comprehensive public health approach to suicide prevention, especially in populations disproportionately impacted by suicide.

- **Objective 2.8:** Expand existing federal support to states and communities nationwide for comprehensive suicide prevention that incorporates both upstream and downstream prevention strategies across the life span.

→ GOAL 3:
Reduce access to lethal means among people at risk of suicide.

Reduce Access to Lethal Means Among People at Risk

In 2022, suicides by firearm comprised more than half (55%) of all suicide deaths in the United States (CDC, 2024a). Further, nearly 90% of people who use a firearm in a suicide attempt will die from their injury, making firearms the most lethal method of suicide (Conner et al., 2019). Other means of suicide used in 2022 included suffocation (25%), poisoning (12%), and other (8%) (e.g., cutting; CDC, 2024a). While attempted suicide is a leading risk factor for later death by suicide, most people who attempt suicide and survive never go on to die by suicide (Botswick et al., 2016; Carroll et al., 2014). Upstream prevention can prevent suicide risk in the first place. However, if someone is seriously considering suicide, an important community-based approach is to put time and distance between the person and the lethal means of carrying out an attempt.

International efforts have repeatedly shown that lethal means safety interventions are some of the most successful strategies in suicide prevention. Reduced access to lethal means among people at risk is associated with reductions in suicides (Bandara et al., 2022; Gunnell et al., 2007; Lee et al., 2021; Pirkis et al., 2015; Sarchiapone et al., 2011; Ueda et al., 2015). Suicide rates decline when access to a common and highly lethal means of suicide is reduced. In recent years, both CDC and NIH received funding to conduct research to prevent firearm-related injuries and deaths, including suicide. For more information on these prevention efforts, visit https://www.cdc.gov/violenceprevention/firearms/index.html and https://www.nimh.nih.gov/science-news/2020/nimh-awards-funding-for-research-on-preventing-firearm-injury-and-mortality.

Some Considerations

Research indicates that among people who made serious suicide attempts, many thought about suicide for as little as 5 to 10 minutes before they acted (Simon et al., 2001; Deisenhammer et al., 2009). This suggests that suicide attempts can be impulsive, so safe and secure storage of lethal means can mean the difference between life and death among people at risk. Even if people have considered suicide in the past, the decision to act can take place in just minutes. Research suggests that when one means of suicide is unavailable or not accessible, people rarely substitute a different means of suicide (Hawton, 2007). In the case of firearms, if any other means are substituted, the likelihood of death from the alternative means will be reduced, since firearms are the most lethal method of suicide.

Effective and promising interventions related to reducing risk for firearm suicide include:
- Storing firearms unloaded, separate from ammunition, in a locked place or with a locking device (Harvard Injury Control Research Center, 2012).
- Counseling on access to lethal means by health care and mental health providers in emergency departments (EDs), within crisis services, and other settings (Johnson et al., 2011; Miller et al., 2020; Sale et al., 2018).

- Implementing laws intended to limit a child's access to firearms within the home as well as mandatory waiting periods when someone is purchasing a firearm (Azad et al., 2020; Hamilton et al., 2018; RAND Corporation, 2023). However, waiting periods may only be effective when the purchaser does not already own a firearm.

- Providing community information about out-of-home temporary storage of firearms and expanding the availability of this option (e.g., https://coloradofirearmsafetycoalition.org/gun-storage-map/).

- Implementing extreme risk protection orders (sometimes called *red flag laws*) that allow for the temporary removal of firearms from a person at risk during a crisis period (Dalafave, 2021).

- Engaging trusted messengers to encourage safe firearm storage practices can enhance the potential success of firearm-related interventions (Conner et al., 2019). Trusted messengers can include firearm retailers, ranges, manufacturers, and advocacy organizations.

Other effective interventions for reducing access to other lethal means include:

- Constructing barriers on bridges, buildings, railroads, and other infrastructure

- Implementing safeguards to remove potential ligature (tying off) points, such as in jails, prisons, and hospitals

- Implementing policies to limit access to lethal means in occupational settings, for example medications (also see Goal 5)

- Storing medications and household products safely

It is important for all community efforts to be led and informed by community leaders and people with lived experience to reduce health disparities and to help protect against unintended trauma.

The above interventions help to create safer environments to support people who may be at risk of suicide. Another way to create protective environments is by reducing or preventing risk behaviors associated with suicide, such as drug and alcohol use, at the individual and community levels. Research indicates that during the 24-hour period preceding a suicide attempt, acute use of alcohol in a given hour is associated with increased intensity of suicidal ideation in the next hour (Bagge et al., 2014). Acute use of alcohol is also associated with a rapid transition from a desire to die to a suicide attempt (Bryan et al., 2016). Data show that alcohol intoxication is most commonly present in suicide by a firearm among young adult and middle-aged men (Conner et al., 2014). One recent study showed that all types of substance use disorders were significantly associated with suicide death (Lynch et al., 2020).

Interventions that address the relationship between alcohol and suicide include policies such as alcohol taxes, zoning, or restrictions on alcohol availability that serve to decrease alcohol use and alcohol use disorder (AUD; SAMHSA, 2022). Clinical policy interventions include targeting AUD and addressing the importance of AUD screening and suicide prevention efforts during treatment of AUD (Arakelian et al., 2023; Glasner, et al., 2023; SAMHSA, 2016). Assessing the motivation for drinking and the amount consumed prior to an attempt can be used to develop a personalized distress safety plan. This plan can address high-risk periods and warning signs and includes strategies for avoiding alcohol.

> To learn more about the role lethal means play in suicide and guidance for reducing access during times of risk, read *Lethal Means and Suicide Prevention: A Guide for Community and Industry Leaders*.

What Success Looks Like

Achieving Goal 3 would include engaging communities in the use of policies, programs, and practices that result in reducing access to lethal means among people at risk. This includes safe and secure storage of firearms, medications, and household products (e.g., poisons), especially among people at risk. Achieving Goal 3 would also include implementing workplace polices that support lethal means safety among occupational groups with increased rates of suicide and people who may have access to lethal means as part of their jobs. These would include law enforcement, military, veterinarians, and health care workers. It would also include institutional polices to keep people safe in health care and carceral settings such as prisons. Working with partners to limit access to lethal means in the physical environment and creating protective environments inclusive of substance use prevention also play important roles in a comprehensive approach to suicide prevention.

Examples

- The American Foundation for Suicide Prevention (AFSP) and the National Shooting Sports Foundation (NSSF) developed the *NSSF/AFSP Suicide Prevention Toolkit*. The toolkit helps firearms retailers, shooting range operators, and firearm owners understand the risk factors and warning signs of suicide; know what resources are available when someone is worried about a customer, a peer, or oneself; and engage in secure storage of firearms. The toolkit includes promotional materials and has been promoted nationwide. To learn more about this initiative, visit https://www.nssf.org/safety/suicide-prevention.

- Prevention professionals are partnering with firearm retailers, instructors, and ranges as part of Gun Shop projects across the country. These programs work together to promote suicide prevention information as a key component of responsible ownership. Including trusted messengers as part of the solution builds bridges to save lives. For more information, visit https://www.hsph.harvard.edu/means-matter/gun-shop-project.

- California is using its CDC Comprehensive Suicide Prevention funding to:
  - Train health and behavioral health providers and pharmacists in safe storage so they can then educate their patients
  - Provide Counseling on Access to Lethal Means (CALM) trainings to communities
  - Disseminate educational materials to law enforcement and first responders to promote help-seeking behavior, including education on safe and secure storage
  - Share educational materials and campaigns that educate partners and community members about existing state policies around safe and secure storage

- Rural and Alaska Native communities are disproportionately impacted by youth suicide and also have high rates of firearm ownership. NIH funded the University of Michigan (2020–2024) to develop and implement the Family Safety Net (FSN) intervention to reduce youth firearm suicides. FSN builds on Alaskan family values to strengthen household firearm safe and secure

storage practices, focuses on collectivist culture and norms in all practices, and includes Alaska Native community members in assessing the feasibility, acceptability, and fidelity of safe firearm storage practices. To learn more about the research project, visit Family Safety Net— Keeping Our Loved Ones Safe (umich.edu).

- The VA provided 1 million cable gun locks to Veterans in Fiscal Year 2023. The Keep It Secure campaign and website also support secure storage of lethal means including firearms and medications. To learn more, visit Firearm Suicide Prevention and Lethal Means Safety—REACH (va.gov).

- The Department of Justice (DOJ) supports efforts at reducing access to lethal means for people at risk and took the following actions:
  - Issued a new rule requiring gun retailers to certify that they have secure gun storage devices compatible with existing inventory available for sale
  - Made funding available for schools to engage in public awareness campaigns
  - Made funding available to implement and research extreme risk protection order laws
  - Funded the first national extreme risk protection order resource center
  - Released a comprehensive guide to secure storage
  - Made funding available for local law enforcement to acquire secure storage devices for distribution

- The Department of Education issued new resources for school administrators on the importance of safe firearm storage. The U.S. Secretary of Education released a letter encouraging principals to take action and increase awareness of the importance of safe storage due to the prevalence of guns in the home being use in youth suicide. The DOJ has made funding available for schools to engage in these public awareness campaigns.

What We Should Do

Below are the objectives for Goal 3 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 3.1:** Train community members and implement effective ways to reduce access to lethal means among people at risk, including safe and secure storage of firearms, medications and poisons, ligatures, and other means in homes, workplaces, communities, and the physical environment.

- **Objective 3.2:** Evaluate policies, programs, and practices that put time and space between a person at risk and a lethal means of suicide, including their impact in historically marginalized communities.

- **Objective 3.3:** Partner with firearm and other relevant organizations and communities to incorporate suicide awareness and prevention as basic tenets of firearm safety and responsible ownership.

- **Objective 3.4:** Implement effective substance use prevention and harm reduction programs, practices, and policies that can help reduce suicide risk at the individual and community levels.

→ **GOAL 4:**
Conduct postvention and support people with suicide-centered lived experience.

Provide Postvention After Suicide Deaths and Support for People With Suicide-Centered Lived Experience

The period following a suicide loss, attempt, or crisis is crucial to the health and well-being of individuals and the surviving friends, family members, caregivers, students, co-workers, neighbors, and others impacted by the event. Postvention after a suicide loss and support for people with suicide-centered lived experience provides people with the care and resources they need to prevent an increase in their suicide risk. Messaging that encourages help-seeking and hope can be helpful during this time. When additional suicide attempts or deaths occur close in time and/or geography, which is called a *suspected suicide cluster*, these events may need further systematic assessment to confirm the cluster, possible investigation to better understand the factors associated with the cluster, and implementation of a community response to prevent further events (Trinh et al., 2024; Ivey-Stephenson et al., 2024).

Some Considerations

Postvention practices after a suicide death may include debriefing, counseling, and other outreach and support. Use of evidence-based or best practices for conveying information about a suicide loss should be shared safely along with culturally relevant supportive services and other resources.

Considerations following suicide attempts or deaths among those impacted may include:

- New or worsened mental health concerns, such as anxiety and depression
- Guilt
- Social isolation
- The surfacing of unresolved or new risk(s) for suicide
- Physical and/or emotional scars
- Stigmatizing or discriminatory reactions toward the person who died or attempted suicide or toward their family and friends
- Practical concerns resulting from the attempt or death such as financial worries
- Unsafe communication or media reporting about the event (see Goal 7)
- Additional suicides, including in rare instances, suicide or suicide attempt clusters.

People who are regularly exposed to suicide as part of their job have specific postvention needs that may differ from the general population. For example, some occupational groups are more likely to have many exposures to suicide over their career. Professionals who are repeatedly exposed to trauma can have a heightened risk for suicide and mental health challenges if needed supports are not available or accessible. First responders and other occupational groups with increased risk of suicide need suicide prevention and postvention programs and protocols.

Community members, employers, and school personnel; cultural, spiritual, and other leaders; and people with lived experience have a role to play in helping to inform, improve, expand, and carry out postvention and community response protocols and programs with the best available evidence. Support groups and other groups need evidence-based guidelines and protocols to carry out postvention and to support people with suicide-centered lived experience.

Individuals who have experienced suicide loss or the effects of their own or others' suicide thoughts and attempts can offer unique insights into what others go through after such an event. Many types of support—peer/social, emotional, tangible, and informational—can be helpful to survivors. For example, many practical, logistical, and real-world concerns can be navigated with guidance from people with lived experience. These may include cleanup after formal investigation efforts and making funeral arrangements, among other activities. Resources related to mental health treatment; community prevention resources (e.g., self-care, services, prevention programs); and crisis intervention can also be provided to impacted friends, family, and other community members who may be struggling after a suicide or a suicide attempt.

What Success Looks Like

How a community or organization responds after a suicide can impact, positively or negatively, the risk for future attempts and losses. In successfully achieving Goal 4, individuals, employees, students, families, and other groups will have evidence-based postvention and support options available and accessible. These can help reduce feelings of isolation and lessen the challenges people face after a suicide or suicide attempt. The ultimate result will be protection against future risk for suicide.

> **The Suicide Prevention Resource Center (SPRC) hosts several resources focused on postvention for a variety of settings, including schools, workplaces, and health care settings. See https://sprc.org/effective-prevention/a-comprehensive-approach-to-suicide-prevention/provide-for-immediate-and-long-term-postvention/.**

Examples

- Local Outreach of Suicide Survivor (LOSS) Teams provide a unique model for engaging suicide loss survivors and others with suicide-centered lived experience in peer support following a suicide death. The LOSS Teams train individuals who have suicide-centered lived experience in trauma-informed crisis response. These volunteer-based teams are called in to support families, schools, faith institutions, and other community organizations following a death by suicide in a community. LOSS Teams were first launched in 1998 at the Baton Rouge Crisis and Trauma Center. Since that time, LOSS Teams now operate in many communities. For more information, visit https://losscs.org/.

- The StandBy Support After Suicide program provides face-to-face outreach, telephone support, and referrals to community services through a professional crisis response team. Research found that clients of the program were significantly less likely to be at high risk for suicidal ideation and attempts compared to a group that did not receive the intervention (Visser et al., 2014).

- The American Foundation for Suicide Prevention created the Healing Conversations program, which provides personal support after a suicide loss through phone, virtual, and in-person conversations with trained volunteers who also survived a suicide loss. For more information, visit https://afsp.org/healing-conversations.

- Florida's First Responder Suicide Deterrence Task Force (Task Force), including members of the first responder community and the Florida Statewide Office for Suicide Prevention, released their *Annual Report* in 2021. In it, they made recommendations for reducing first responder suicide. The Task Force engaged in a variety of initiatives which include the following:
   ◦ Creating the *First to Respond, First to Ask for Help* campaign
   ◦ Investing in culturally competent evidence-based counseling and peer support services
   ◦ Increasing worker compensation benefits for post-traumatic stress-induced mental health challenges

   In 2022, the Task Force became an established member of the Florida Suicide Prevention Coordinating Council to sustain their important work. To learn more, visit https://www.myflfamilies.com/suicideprevention/first-responder-mental-health-and-suicide-deterrence-subcommittee.

- The National Consortium on Preventing Law Enforcement Suicide released the *Comprehensive Framework for Law Enforcement Suicide Prevention*, which outlines the full spectrum of needed efforts that include support after a suicide death or attempt. To learn more, visit https://www.theiacp.org/sites/default/files/2021-09/_NOSI_Framework_Final%20Copy%2001.pdf.

What We Should Do

Below are the objectives for Goal 4 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 4.1:** Provide community-based care and support options to individuals bereaved by suicide.

- **Objective 4.2:** Provide community-based care and support options to individuals who have survived a suicide attempt or who struggle with thoughts of suicide.

- **Objective 4.3:** Engage suicide attempt survivors in the development, implementation, and evaluation of guidelines and protocols for suicide survivor support groups, programs, and policies.

- **Objective 4.4:** Promote the adoption and evaluation of community-relevant guidance for the identification, assessment, and community-led response to potential suicide or suicide attempt clusters.

- **Objective 4.5:** Support suicide prevention and whole person health among health care workers and other occupational groups who experience traumatic exposure to suicide risk, such as first responders, health care providers, and crisis workers.

→ GOAL 5:

Integrate suicide prevention into the culture of the workplace and into other community settings.

Focus on Workplaces and Community Settings

The community settings where people spend significant amounts of time are prime spots for prevention, and these settings may vary over the life span. For example, children, teens, and young adults spend significant time in schools, after-school programs, youth organizations, colleges, and workplaces. These are important locations for upstream prevention (see Goal 2). Families may spend time together at places of worship. They may also interact with the following:

- Health and behavioral health care sector (see Strategic Direction 2)

- Social service organizations (e.g., protective services, foster care, senior centers, temporary financial assistance, food stamps, and housing)

- Juvenile justice system

Adults may also spend significant time at their workplaces; in formal or informal social organizations (e.g., sports activities, volunteer organizations); and in health settings. All people working in these settings have a role in preventing suicide among their clientele. Community settings can integrate effective suicide prevention policies, programs, and practices into their operations for worker safety and well-being. This combined effort provides critical support to people who may be at increased risk of suicide so that nobody falls through the cracks.

Some Considerations

Workplaces

Workplaces can integrate pro-social norms and behaviors as part of their culture and values through comprehensive suicide prevention planning efforts. This could include effective policies, programs, and practices that prioritize employee well-being, help-seeking, and connectedness. Efforts could also include collecting worker satisfaction and well-being data for continuous quality improvement. Enacting such cultural shifts takes strong leadership support and buy-in at all levels. In addition to employers, employee groups can be important groups with which to partner. These groups include unions, trade organizations, and employee resource groups (Health Action Alliance, 2022; Leigh & Chakalov, 2021; Mind Share Partners, 2023; SkillSignal, 2023).

Implementation of effective policies, programs, and practices impacting employee health and well-being may include:

- Enabling self-care through flexible scheduling, paid time off, family and medical leave, and gradual re-integration into the workplace after a hospitalization or other prolonged absence

- Implementing consistent work shifts and shared decision-making between supervisors and employees to avoid employee burnout and to improve relationships and morale

- Providing culturally relevant informational community resources in breakrooms and other communal areas (e.g., substance use disorder treatment, screening and assessment, financial resources)

- Offering ongoing opportunities for connectedness and peer support
- Establishing programs that promote conflict resolution, coping skills, and stress reduction
- Promoting the social norm that seeking help is a sign of strength
- Providing training for all employees to learn the signs of suicide risk and how to respond effectively
- Implementing effective suicide and violence prevention programs for workplace issues like bullying, sexual harassment, online harassment and abuse, and dating violence
- Reducing access to lethal means of suicide among people at risk while on the job such as firearms, lethal medications, and access to high structures
- Creating suicide prevention and crisis response plans before a crisis occurs

Workplaces can also offer supportive resources, such as:

- Opportunities for screening and referral
- Employee Assistance Programs (EAPs) or other short-term counseling options
- Postvention support after a suicide or suicide attempt
- Education about crisis services, such as the 988 Suicide and Crisis Lifeline
- Provision of health insurance policies that offer coverage for behavioral health treatment like substance use treatment, mental health care, and couples counseling

These initiatives can improve worker mental health, connectedness, and well-being. They also positively impact measures of occupational effectiveness, such as improved job satisfaction, job security, workplace safety, and decreased absenteeism and presenteeism.

Other Community Settings

Civic organizations, places of worship and other community settings have a large role to play in suicide prevention. Many items mentioned above also pertain to other community settings. These entities can do the following:

- Create suicide prevention and crisis response policies and plans before a crisis occurs
- Implement and evaluate effective suicide prevention programs, including upstream programs, in schools and other youth-serving organizations (see Goal 2)
- Provide culturally relevant information and connection to services
- Promote help-seeking as a strength
- Promote opportunities for connectedness
- Train all staff/individuals in identifying and effectively responding to someone who may be at risk of suicide through training
- Provide postvention support and safe messaging after a suicide

Online Community Settings

In recent years, online gaming, chat groups, and other online settings and platforms have grown in use. They attract a range of people, some of whom may be at increased risk of suicide.

Using digital platforms allows access to a broad array of information and social circles. These settings can potentially increase depression, anxiety, and suicide risk, especially among youth, related to the following:

- Experiencing cyberbullying

- Receiving unsafe and/or unwanted content in social media feeds

- Comparing oneself to others

- Missing opportunities for health behaviors and socializing in real life (Office of the Surgeon General, 2023b)

Further, according to the Surgeon General's Advisory on *Social Media and Youth Mental Health*, adolescent girls and transgender youth are disproportionately impacted by online harassment and abuse which are associated with negative emotional effects (Office of the Surgeon General, 2023b). However, these platforms also present opportunities for support, access to helping resources, and connections that transcend geographic boundaries (e.g., among LGBTQI+ populations). Collaborating with digital and technology companies to create a safer more protective online environment for youth may help prevent suicide. Interventions include educating parents, caregivers, guardians, educators, and youth in digital literacy. This would include learning more about risks and harms present in some digital environments and ways to interact more safely in that space.

What Success Looks Like

Achieving Goal 5 creates universal safety nets and extends support systems in communities where people live, work, learn, play, and worship. Whether at work, in the community, or online, people would interact with those who know how to identify individuals at risk and how to respond, have easy access to information and a range of helping resources, have opportunities for connectedness, and have the time and means for seeking out help and services. Over time, approaches to suicide prevention and improving mental health are finding their way into workplaces and popular media platforms and through a range of programs, campaigns, and other resources.

Examples

Programs

- Together for Life is a workplace program implemented to address suicide among police officers. It focused on interventions to foster an organizational culture promoting mutual support and solidarity among members. It included trainings and education campaigns to improve suicide risk identification, awareness of resources, and help-seeking. The program was highly regarded by the police force and resulted in a reduction of suicides (Mishara & Martin, 2012).

- Strong Schools Against Suicidality and Self-Injury is a German school-based organizational initiative designed to improve staff knowledge and confidence in recognizing and properly addressing student self-injury and suicidality. Staff who attended a two-day workshop demonstrated increases in knowledge and confidence immediately after the workshop and at six-month follow-up evaluations (Growschwitz et al, 2017).

- Comprehensive policies and practices that can reduce suicide among incarcerated populations include the following:
  - Routine suicide prevention training for all staff
  - Standardized intake screening and risk assessment
  - Safe physical environments
  - Emergency response protocols
  - Notification of suicidal behavior through the chain of command
  - Critical incident stress debriefing and death review
  - Quality improvement (Stijelja & Mishara, 2022)

- Question, Persuade, and Refer (QPR) is an hour-long training to reduce stigma and increase knowledge about suicide risk factors, warning signs, and available resources. QPR trainings also improve participants' abilities to ask individuals about their suicide thoughts or plans and persuade them to seek help. QPR has been found to improve skills such as asking about suicidal ideation and referring individuals to treatment (Litteken & Sale, 2018).

Campaigns

- The nonprofit Construction Industry Alliance for Suicide Prevention works with construction industry partners to reduce suicide through its STAND Up for Suicide Prevention campaign. It provides construction partners with tools and information to help them create safe cultures, provide training to identify and help those at risk of suicide, raise awareness about suicide prevention, and normalize conversations around suicide and mental health. To learn more, visit https://www.preventconstructionsuicide.com/pledge-to-stand-up.

- The National Football League's *NFL Total Wellness* initiative provides new, mid-career, transitioning, and retired players with resources, supports, and programs to support their overall health and well-being, including promoting positive mental health and suicide prevention (National Football League, 2024). To learn more, visit https://totalwellness.nfl.com/.

- CDC's Health Worker Mental Health Initiative seeks to support the mental health of the nation's diverse health workforce. The initiative includes a national campaign that seeks to do the following:
  - Educate about the cost of poor mental health in the workforce
  - Develop best practices, resources, and interventions for health care workers
  - Develop partnerships
  - Invest in development of data, screenings, trainings, resources, and policies
  - Conduct a social marketing campaign to normalize the conversation around mental health (Cunningham et al., 2022)

To learn more on the campaign, visit https://blogs.cdc.gov/niosh-science-blog/2022/05/24/mental-health-initiative/.

Resources

- **Suicide Prevention: Evidence-Informed Interventions for the Health Care Workforce:** This guide from the American Hospital Association (AHA) with support from CDC provides evidence-informed strategies and tactics for suicide prevention among health workers. To learn more, visit https://www.aha.org/system/files/media/file/2022/09/suicide-prevention_evidence-informed-interventions-for-the-health-care-workforce.pdf.

- **Understanding and Preventing Burnout among Public Health Workers:** To address the issue of burnout among public health workers, CDC worked with academia to develop a 10-part training series for public health leaders and supervisors. This training provides managers with information about organizational-level approaches to burnout prevention. To learn more, visit https://www.cdc.gov/niosh/learning/publichealthburnoutprevention/default.html.

- **Comprehensive Blueprint for Workplace Suicide Prevention:** This website provides free online guidance for developing comprehensive approaches to suicide prevention in workplaces. To learn more, visit, https://theactionalliance.org/communities/workplace/blueprintforworkplacesuicideprevention.

- **Manager's Guide to Suicide Postvention in the Workplace:** This guide presents 10 action steps that organizational leaders can take to provide immediate and long-term support to their work community following a suicide death. To access these resources, visit https://theactionalliance.org/communities/workplace.

Recommendations

- The *Surgeon General's Advisory on Social Media and Youth Mental Health*, released in May 2023, describes the potential benefits and harms of social media use and calls for urgent action to create safer, healthier online environments to protect children.

- The American Psychological Association released a *Health Advisory on Social Media Use in Adolescence* in May 2023. The report provides 10 research-based recommendations for creating digital spaces for youth that are both safe and beneficial. The recommendations call for:
  - Investing in research on social media and youth
  - Providing youth education on positive social media use
  - Monitoring social media to ensure it is safe
  - Placing safeguards within social media structures minimizing harmful information
  - Ensuring age-appropriate materials and functionality are tailored to youth (American Psychological Association, 2023).

What We Should Do

Below are the objectives for Goal 5 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 5.1:** Integrate suicide prevention into workplace values, policies, culture, and leadership at all levels.

- **Objective 5.2:** Create, implement, and evaluate organizational programs, practices, and policies to support worker well-being and suicide prevention.

- **Objective 5.3:** Implement and evaluate effective programs, practices, and policies in suicide prevention and crisis response in settings where people live, work, learn, play, and worship, and ensure ongoing staff training and development.

- **Objective 5.4:** Train community members, organizations, and civic groups to identify and respond to people who may be at risk of suicide.

- **Objective 5.5:** Work with the public and private sectors to implement and evaluate recommended practices and policies to support safer digital technology use, especially among youth and young adults.

GOAL 6:

Build and sustain suicide prevention infrastructure at the state, tribal, local, and territorial levels.

Focus on Infrastructure

Suicide prevention infrastructure at the state, tribal, local, and territorial levels is important to ensure availability of the capacity and resources needed to implement effective and sustained comprehensive suicide prevention in communities. However, suicide prevention infrastructure in most states is limited, making it difficult to impact suicide rates.

> **A state suicide prevention infrastructure is a state's concrete, practical foundation or framework that supports suicide prevention-related systems, organizations, and efforts. It includes the fundamental parts, and the organization of those parts, that are necessary for planning, implementation, evaluation, and sustainability. To learn more, visit https://sprc.org/state-infrastructure/.**

Some Considerations

Adequate state infrastructure includes six key elements: Authorize, Lead, Partner, Examine, Build, and Guide, according to the Suicide Prevention Resource Center (SPRC). While state infrastructure can help improve suicide prevention, territories, local communities, and tribes may apply or adjust the same principles presented here to fit their specific context.

Authorize

It is ideal to *Authorize* a lead agency or organization to coordinate suicide prevention activities across multiple agencies. The lead agency can do the following:

• Identify dedicated and sustainable resources required to carry out all six functions

• Maintain a state suicide prevention plan to support coordinated and comprehensive suicide prevention to be updated every 3 to 5 years (see Build)

• Evaluate the state plan, and provide an annual report to the legislature or governor to maintain accountability

• Share progress and emerging needs

Lead

The agency can *Lead* by maintaining a dedicated full-time suicide prevention director or suicide prevention coordinator and core staff positions. This agency can provide training and technology to carry out all six functions and develop staff capacity to respond to information requests from officials, community members, and the media. Core staff may include data managers, epidemiologists, behavioral health specialists, data analysts, program managers, program planners, trainers, evaluators, and communication professionals.

Staff training and the development of knowledge and skills related to comprehensive suicide prevention are essential and may include the following:

- Partnership development
- Use of high-quality data for decision-making
- Up-to-date knowledge of the evidence for suicide prevention, intervention, and postvention
- Implementation and evaluation of effective prevention strategies and approaches tailored to populations disproportionately affected by suicides and suicide attempts
- Community-informed safe messaging and communication strategies

The suicide prevention lead and/or core staff can bring their expertise to collaborative partnerships and strategic planning.

Partner

Components of the *Partner* function include the following:

- Forming a suicide prevention coalition with public and private sector representation
- Adopting a shared vision to support a comprehensive approach to suicide prevention across individual, relationship, community, and societal levels
- Developing a shared language

The benefits of partnering include potential access to a range of resources (e.g., personnel, data, and funding); increased capacity to reach populations most impacted; reduced duplication of efforts; and knowledge sharing. Written agreements should be developed to formalize partnerships and detail commitment and responsibilities. (see Goal 1).

Examine

The comprehensive public health approach to suicide prevention relies on data. Rapidly evolving technology gives greater opportunities to work with traditional and novel data sources and employ data science techniques to better inform decision-making. It also provides opportunity to implement effective suicide prevention policies, programs, and practices. Infrastructure that supports the delivery and use of integrated, real-time public health data is essential to the *Examine* function. This may require significant modernization of existing technology, upskilling of the workforce to manage and use systems, data, and advanced analytic tools; and updating data processes, standards, and policies to enable high-quality, timely data to be accessed and shared appropriately. This includes better connecting public health and health care sectors. Investments to date in data modernization are laying the groundwork for the infrastructure needed. Sustainability will be needed to fulfill the *Examine* function.

Additional considerations for the *Examine* function relate to the design and use of data collection tools and data collected. Examples include the following:

- Ensuring that populations disproportionately affected by suicide thoughts, attempts, or deaths are represented
- Working with tribes to establish agreements for data stewardship

- Employing methods to ensure proper confidentiality and privacy are maintained when distributing or displaying data
- Ensuring reporting or translation of data does not inadvertently convey biased information against groups most impacted

Using data within a strong infrastructure supports a comprehensive approach to suicide prevention based on the best available evidence, across the life span. It should also be tailored for the context and populations disproportionately affected by suicides or suicide attempts. Elements of a comprehensive approach include upstream and downstream strategies and approaches found in the CDC *Suicide Prevention Resource for Action* and throughout this *National Strategy*.

Build

Sustained funding and other resources to carry out and evaluate the comprehensive approach is essential. Diverse agencies, funding, resources, staff, and volunteers are needed who can bring together assets, expertise, experiences, and cultures to inform responsive prevention efforts. Ideally, any guiding suicide prevention plan will call for implementation of a comprehensive, life span approach to suicide prevention that reaches all facets of a state or community. Comprehensive plans will call for a variety of upstream and downstream prevention strategies with explicit roles for multiple partners. Implementation requires staff and resources dedicated to monitoring and evaluating prevention strategies over time.

Guide

Lead suicide prevention agencies are equipped to *Guide* and support suicide prevention efforts in the local community with adequate resources and other components of necessary infrastructure. Lead agencies can provide funding, consultation, and a range of training opportunities to local communities to engage in key tasks such as strategic suicide prevention planning and implementing evidence-informed and comprehensive approaches to suicide prevention.

What Success Looks Like

Achieving Goal 6 involves national, state, tribal, local, and territorial investments in suicide prevention infrastructure. Suicide prevention infrastructure in states and communities strengthens the ability to implement comprehensive suicide prevention approaches. Adequate infrastructure includes all six essential elements—Authorize, Lead, Partner, Examine, Build, and Guide— in place with continual analysis into ongoing resource, funding, and support needs.

State suicide prevention professionals can build upon these six essential elements and ensure that they are prepared to provide ongoing updates and reports to state legislatures on the cost benefit of investments in the suicide prevention infrastructure.

Local-level suicide prevention professionals will be most effective when they are familiar with the elements of the suicide prevention infrastructure and ensure their local efforts contribute to state or territorial suicide prevention capacity. States and territories with strong infrastructures can develop a common vision for suicide prevention with their state and local partners, guided by a state suicide prevention plan informed by diverse community members.

Examples

- Kansas recognized the need to strengthen their suicide prevention infrastructure in 2019 and completed an internal assessment of SPRC's Infrastructure Recommendations. They found that many of the essential elements were missing, so they brought together a State Suicide Prevention Plan Work Group. This group, which included state agencies, people with lived experience, local coalitions, and nonprofit organizations, identified key goals and objectives to include in a state comprehensive suicide prevention plan, which was updated in 2021. Kansas prioritized developing a state-level suicide prevention coalition representing their diverse communities, regions, and sectors to better coordinate existing suicide prevention efforts. Several state agencies partnered to inform budget requests to the state legislature, which approved a budget line item for suicide prevention in 2022. This collective focus enabled the state to fill key suicide prevention roles in the state's lead agency, fund the Kansas Suicide Prevention Coalition, provide mini-grants to local communities, and maintain active engagement from diverse organizations implementing the state suicide prevention plan.

- Over the past decade, Ohio invested in the county and regional suicide prevention coalitions by providing trainings, funding, and resources to communities. Trainings centered on strengthening local coalition structures, functioning, strategic planning, and membership. Funding was provided in mini-grants to local groups to invest in evidence-informed suicide prevention strategies and ensure they receive additional technical support. County and regional coalition representatives also sit on state-level advisory boards and inform the suicide prevention needs, funding decisions, and plans of the state. This direct investment in local infrastructure supported the development of a strong collaboration toward achieving mutual suicide prevention goals in Ohio.

- SAMHSA's Garrett Lee Smith State and Tribal Youth Suicide Prevention grant program is a dramatic example of the importance of sustained funding on suicide outcomes. First established by the Garrett Lee Smith Memorial Act in 2004, initial evaluation studies found the program reduced deaths by suicide and nonfatal suicide attempts in counties with grant-funded activities compared with counties not receiving grant funding. This finding was encouraging, but the impact faded after one year, on average. SAMHSA responded to this finding by making the grants larger and longer. When the program was reevaluated, the reduction in mortality was found to last two years on average. This saved an estimated 882 young lives between 2007 and 2015. Ultimately, this additional impact on youth mortality was associated with years of continued funding, pointing to the need for sustained resources within states and communities.

Figure 5. **Youth suicide mortality in counties implementing the Garrett Lee Smith Youth Suicide Prevention Program over time**
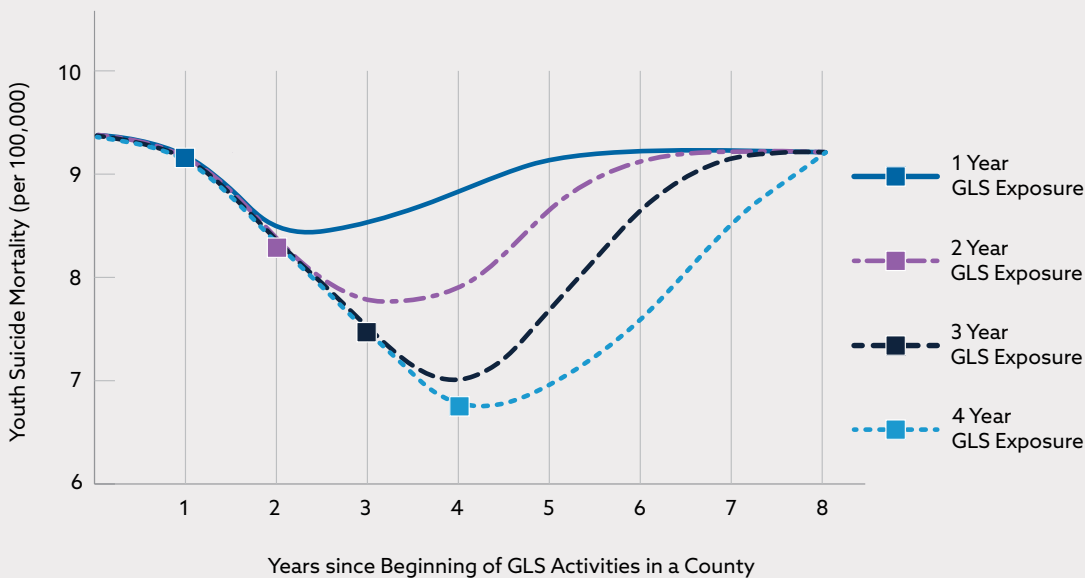
Source: Godoy Garraza et al., 2019

What We Should Do

Below are the objectives for Goal 6 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 6.1:** Create and maintain core staff positions in offices of suicide prevention across state, tribal, local, and territorial levels to build and sustain comprehensive suicide prevention programming, including hiring people with suicide-centered lived experience and people representing the diversity of communities being served.

- **Objective 6.2:** Train staff across state, tribal, local, and territorial levels about comprehensive suicide prevention, including building partnerships; use of data for decision-making; selection, implementation, and evaluation of effective prevention strategies; and communication activities.

- **Objective 6.3:** Modernize data systems and infrastructure and build staff capacity in surveillance, data analysis, and program and policy evaluation across state, tribal, local, and territorial levels.

- **Objective 6.4:** Establish and sustain public and private funding streams for implementation and evaluation of effective suicide prevention programming at the state, tribal, local, and territorial levels, with attention to populations disproportionately affected by suicide.

- **Objective 6.5:** Develop, implement, evaluate, and routinely update data-informed state, tribal, local, and territorial suicide prevention plans that reflect a comprehensive approach to suicide prevention.

Implement research-informed suicide prevention communication activities in diverse populations using best practices from communication science.

Focus on Communication Efforts

How we talk and message about suicide and suicide prevention matters. The framing we use has the potential to open a door to dialogue, understanding, and support, or it may have unintended effects, such as increased perceived isolation, discrimination, and/or stigma. Evidence-based communication can increase awareness, provide information, shift attitudes and beliefs, and promote help-seeking behavior. Experts in communication science, social marketing, and media are key partners in this endeavor and can bring specialized skill sets to suicide prevention communication.

In a recent survey, 94% of respondents believed suicide can be prevented; three-quarters of those indicated an understanding that most people who die by suicide show some signs beforehand; and 96% reported they would take action to help prevent suicide if someone close to them was thinking about it (American Foundation for Suicide Prevention et al., 2022). Information needs to be accurate, understandable, practical, and action oriented because empowering communities with the knowledge about warning signs and what to do can be lifesaving.

Some Considerations

Safe messaging guidelines seek to protect audiences from messages that inadvertently increase suicide risk. Certain types of public messaging about suicide or lived experiences of suicide thoughts and attempts can increase risk, even if they are shared in a well-meaning way.

Decades of research show unsafe messaging can contribute to real-world increases in suicide attempts and deaths—a phenomenon known as the *Werther effect* (Domaradzki, 2021; Etzersdorfer et al., 2004; Niederkrotenthaler et al., 2010; Niederkrotenthaler and Till, 2019).

Examples of unsafe messaging practices include:

- Romanticizing suicide
- Describing suicide as an acceptable or inevitable result of life struggles
- Providing graphic descriptions of suicide
- Using disrespectful language, such as the phrase "committed suicide," which can connote a sin or a crime

On the other hand, safe messaging guidelines also provide evidence-informed recommendations for ensuring communication on suicide is not only safe but beneficial (known as the *Papageno effect*). Safe messaging includes the following:

- Describing suicide as largely preventable
- Emphasizing that suicide is a complex issue with many contributing risk and protective factors that can be addressed
- Using respectful language such as the phrase "died by suicide"

Certain suicide prevention messaging practices have been shown to reduce individuals' suicide risk. Research on the Papageno effect shows stories of individuals struggling with suicidal crisis and finding support to master the crisis directly influence listeners. For example, those with suicide thoughts show reduced levels of suicidality following exposure to these types of stories (Niederkrotenthaler, 2016; Till et al., 2018; Niederkrotenthaler & Till, 2020). Focusing on safe messaging avoids unintentional harm and promotes messages of hope and healing with real-world benefits.

Including individuals with suicide-centered lived experience adds valuable insights throughout the development and implementation of communication efforts. These individuals bring practical information about barriers to receiving care and support that can be incorporated into communication messages. Messages crafted and delivered by individuals with lived experience also convey authentic empathy. Perspectives grounded in experience help initiatives concentrate on the key elements that are likely to have the greatest impact on the local community.

Research found the use of social media can be associated with negative health outcomes, particularly for youth (e.g., Office of the Surgeon General, 2023b). However, social media also offers opportunities for beneficial communication about suicide prevention, as well as enhanced social support and connection. This is particularly true for LGBTQI+ youth, youth of color, rural youth, and other youth with historically marginalized identities (see Goal 5). Engaging young people directly represents a valuable opportunity for connection. Equipping young people with the knowledge and skills to make healthy digital choices enables a preventive effect across new technologies. Identifying youth with significant interest in prevention can provide early opportunities to develop future leaders, influencers, advocates, and champions. Digital and social media partners can also add value to communication efforts by delivering tailored messages from a broad matrix of potential stories and by monitoring and responding to harmful messages posted by users.

The actions of media, including news, entertainment, and social media, can have a range of effects—some positive and some negative. Media partners can be effective champions of suicide prevention by following guidelines for reporting on suicide, such as sharing stories of hope and recovery; providing local resources, including the 988 Suicide and Crisis Lifeline; and avoiding sensationalizing suicide thoughts, attempts, or deaths. Media organizations can provide information to their staff about current standards, guidelines, and ethics relevant to prevention efforts, and contribute their expertise in communications for suicide prevention campaigns. Behavioral health experts can also provide guidance about developing media material.

Communication about the 988 Suicide and Crisis Lifeline and other crisis support services will be most effective when they do the following:

- Clearly communicate that their services are for everyone

- Address questions or concerns about what happens if you reach out for help

- Encourage outreach

Messages about 988 can be adapted by local communities to ensure lifesaving possibilities are presented within the context of realistic expectations as crisis response service delivery currently varies greatly across the country. Communication efforts need to embrace principles of cultural humility and avoid unintentional harm. Positive outcomes from crisis helplines showcase appropriate ways that encourage individuals to seek help.

What Success Looks Like

Achieving Goal 7 needs to involve a variety of suicide prevention messengers including the following:

- Suicide prevention professionals, volunteers, and advocates
- News media, social media, and entertainment media
- Schools of journalism and mass communication

Each of these partners has a responsibility to understand best practices in safe suicide prevention messaging and to invest in trainings for professionals and volunteers about safe messaging. A shift in national, state, and local narratives from a focus on raising awareness of suicide to how to prevent suicide is imperative to reduce unsafe messaging practices and increase the promotion of stories that can positively impact the public.

Strong communication planning would be based on communication science best practices. This includes strategies such as audience research, message development and testing, and evaluation. Research into the impacts of social media on youth and young adult mental health must grow. The field needs better evidence on how to educate youth on safe social media practices, create spaces for diverse youth to develop healthy social connections, and put safeguards in place to minimize potential harms of social media use. All communication-based strategies should directly involve individuals with suicide-centered lived experience in their development, with the goal of providing safe and effective messaging focused on hope and healing.

Examples

- Following the release of Logic's popular song "1-800-273-8255," which included the 10-digit number for the National Suicide Prevention Lifeline, researchers saw an increase in calls and a decrease in suicides during the corresponding time period. To learn more, visit https://www.bmj.com/content/375/bmj-2021-067726.

- The *Framework for Successful Messaging* is a resource to help people develop messaging about suicide that is strategic, safe, positive, and makes use of relevant guidelines and best practices. The Positive Narrative component of the *Framework for Successful Messaging* is designed to increase how much public messaging is "promoting the positive" about suicide prevention, including the following:
  - Preventing suicide is actionable
  - Prevention works
  - Resilience and recovery are possible
  - Effective programs and services exist
  - Help is available

To learn more, visit the *Framework for Successful Messaging* website: https://suicideprevention messaging.org/.

- National partners came together to create the *988 Messaging Framework* to ensure consistent and accurate information about the 988 Suicide and Crisis Lifeline used in conjunction with the *988 Partner Toolkit*. To learn more about the toolkit, visit https://www.samhsa.gov/find-help/988/partner-toolkit. To learn more about the *988 Messaging Framework*, visit https://suicide preventionmessaging.org/988messaging/framework.

- The collaborative 988 Formative Research Project is designed to expand and improve 988 communication efforts through four central aims:

    1. Uncover knowledge, attitudes, beliefs, and perceptions about accessing crisis services among populations at higher risk for or disproportionately impacted by suicide

    2. Identify and explore barriers and motivators to accessing crisis services among these populations

    3. Inform culturally sensitive, responsive, and effective messaging development to help individuals access the 988 Suicide and Crisis Lifeline in times of crisis

    4. Identify trusted messengers that population groups turn to when facing difficult mental health challenges

Ongoing investments are essential in both communications and formative research to support the promotion of the 988 Suicide and Crisis Lifeline and other crisis or mental health resources using a shared messaging framework. To learn more about the project and to read the results, visit: https://suicidepreventionmessaging.org/988messaging/research.

What We Should Do

Below are the objectives for Goal 7 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 7.1:** Communicate the most recent suicide-related data and trends to a range of audiences in a safe, easy-to-understand way and to inform public health action.

- **Objective 7.2:** Increase public knowledge about suicide warning signs and that suicide is preventable, including the many factors that can increase or decrease suicide risk at the individual, relationship, community, and societal levels.

- **Objective 7.3:** In collaboration with people with suicide-centered lived experience, develop, implement, and evaluate effective and tailored communication activities that encourage help-seeking and provide instruction on how to support someone struggling or in a crisis.

- **Objective 7.4:** Communicate stories of help, hope, and healing using safe messaging strategies.

- **Objective 7.5:** In coordination with youth, develop, implement, and evaluate communication activities to foster healthy engagement among youth and young adults related to social media and other digital technology platforms.

- **Objective 7.6:** Engage news media, the entertainment industry, and schools of journalism and mass communication to encourage safe, accurate, and responsible reporting and depictions of suicide and positive mental health coping skills.

- **Objective 7.7:** Increase awareness of 988 and other crisis services with communications that are grounded in the principles of health equity and cultural sensitivity.

STRATEGIC DIRECTION 2

Treatment and Crisis Services

The 2012 *National Strategy for Suicide Prevention* (*National Strategy*) called for implementation of a systematic approach to suicide care in health systems. In the following years, research across multiple health systems in the United States demonstrated health care service utilization has the potential to help decrease rates of suicide thoughts, attempts, and deaths (Ahmedani et al., 2019; Ahmedani & Vannoy, 2014; Goldman-Mellor et al., 2019).

Additionally, research helped health systems identify groups with increased risk for suicide thoughts, attempts, and deaths in health care settings and when that risk is most elevated. Specifically, data indicate the highest risk periods for patient suicide risk occur within three months of discharge from inpatient psychiatric services (Forte et al., 2019; National Action Alliance for Suicide Prevention, 2019). Research also shows elevated suicide risk for patients treated in emergency departments (ED) for suicidal thoughts and attempts in the year following their visit (Goldman et al., 2019; Olfson et al., 2021b).

Suicide care in health systems has significantly improved over the last decade in identifying and treating suicide risk before and after a mental health crisis (Department of Health and Human Services, 2023; Hogan & Grumet, 2016). There has also been significant progress and initial investments in building

a crisis continuum. This includes enabling access to suicide care through mobile crisis, crisis stabilization, EDs, and public safety answering points in states and communities. This ensures timely access to mental health services and transition supports during a mental health crisis (SAMHSA, 2020). Increased use of telehealth services expanded access to mental health care and crisis services to populations disproportionately affected by suicide. This was spurred on by the COVID-19 pandemic. Focused efforts also ensured 988 Suicide and Crisis Lifeline services are accessible for a variety of populations including individuals who are deaf or hard of hearing (Gajarawala & Pelkowski, 2021; SAMHSA, 2023). See Strategic Direction 4. Building crisis care systems in the community and improving identification and treatment of suicide thoughts and attempts in health care are critical components of reducing suicide nationally.

Figure 6. **Suicide Care Pathways**
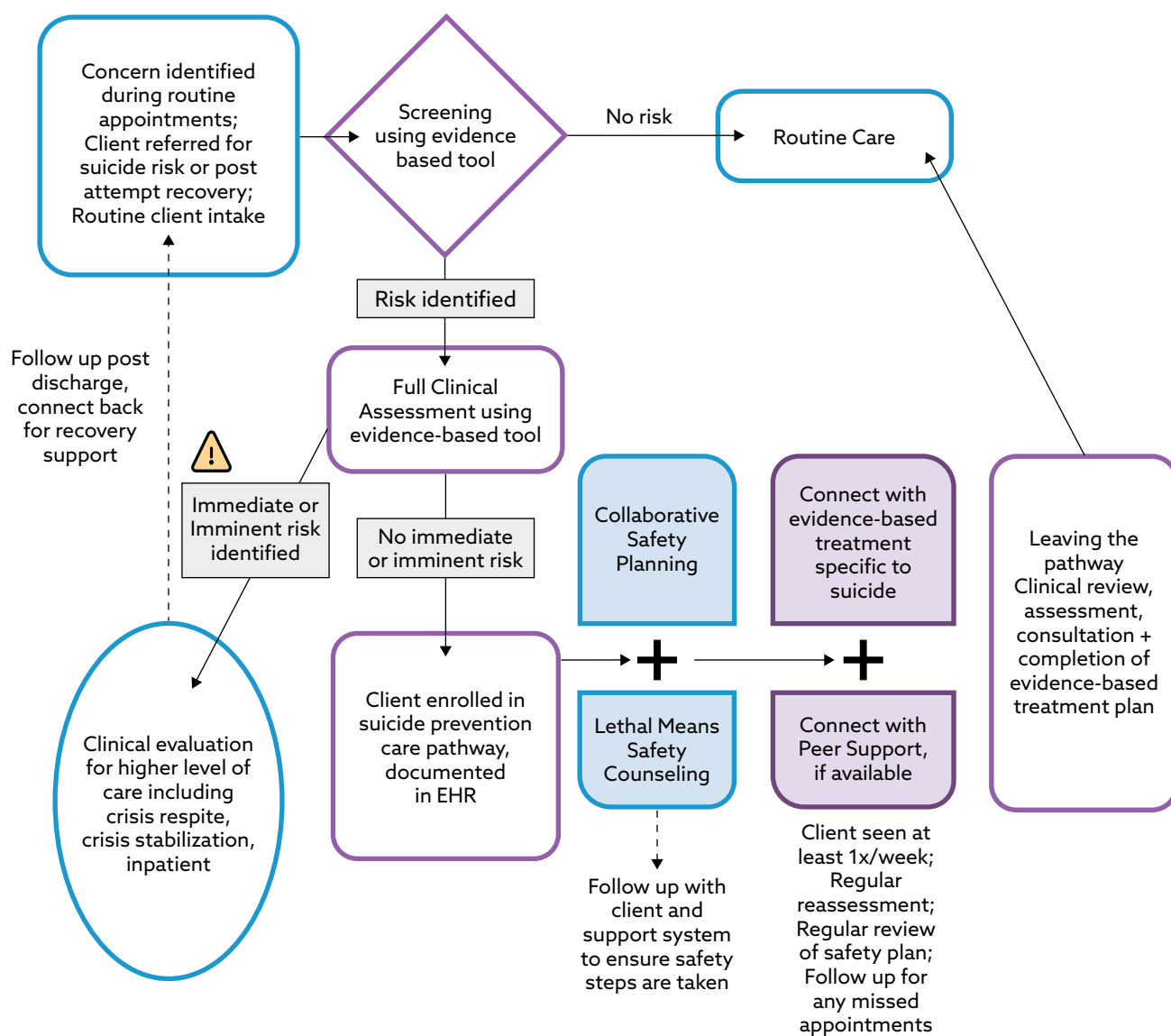
Goals 8 and 9 emphasize the critical importance of implementing a systematic approach to suicide care within health systems. These goals focus on the structural role of the health system in preventing suicide, rather than the responsibility resting solely in the hands of individual clinical providers. Systems need to be structured to facilitate standardized, caring, and evidence-based responses for everyone receiving care (see Figure 6). This ensures that individuals experiencing suicide risk are identified, supported, and provided with responsive and effective suicide-specific care and follow-up. Additionally, all staff need the tools, resources, time, and training relative to their roles. With their variety of services, health care systems function as both treatment providers and crisis referral sources. The systems that integrate suicide prevention as a core element throughout their services and across providers can achieve dramatic reductions in suicide thoughts, attempts, and deaths, as well as related health outcomes (Layman et al., 2021; Stapleberg et al., 2021). Agencies and organizations can create an effective continuum of crisis care through collaboration and coordination.

Systematic Approach for Health Care

In the comprehensive approach for suicide prevention, health care systems take responsibility for suicide and related health outcomes by integrating suicide prevention across health care services, programs, and policies. This can be done with an approach focused on continuous quality improvement (CQI). In this approach, data are used to monitor progress and identify areas where the system can implement, adapt, and improve best practices across service lines (see Strategic Direction 3). Specific practices include evidence-based and culturally informed screening, assessment, collaborative safety planning, lethal means counseling, and connection with evidence-based care options that directly address suicide. This includes Dialectical Behavior Therapy (Linehan et. al., 2006); Cognitive Behavior Therapy (Brown et al., 2005), and Collaborative Assessment and Management of Suicidality (Swift et al., 2021), among others.

Research demonstrates follow-up services ensuring consistent care delivery, and coordination across providers are critical aspects of a systematic approach to suicide prevention in health care. Research on the value of follow-up services for patients seen in the ED shows reductions in suicide attempts for those receiving post-discharge resources and telephone check-ins (Miller et al., 2017; Stanley et al., 2016). The widely implemented Zero Suicide framework (see Figure 7), generated successful examples of health care settings that adopted a systematic approach. Ongoing evaluation programs with a consistent set of progress indicators will further enhance the knowledge base in this area (Labouliere et al., 2018). For example, in a large study across New York State outpatient behavioral health clinics, systems' use of organizational best practices of the Zero Suicide model were associated with lower suicide thoughts, attempts, and deaths of people in their care (Layman et al., 2021). Likewise, an 11-year study tracked patient suicide outcomes within the Henry Ford Health System health maintenance organization (HMO) implementing Zero Suicide. The study found that while overall population suicide rates in the HMO's state significantly increased, the HMO membership suicide rates did not. Also, while suicide rates increased for non-mental health patients in the HMO, they decreased for patients receiving mental health services (Coffey et al., 2015).

Figure 7. **Seven elements of the Zero Suicide framework**

A wide variation exists in how health systems implement the Zero Suicide framework, and tracking national progress toward fidelity to the model is difficult. A recent report prepared for the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services summarized a series of case studies with eight health systems engaged in Zero Suicide. The report found that while approaches varied, system-specific tailoring and policy development helped build sustainability (RTI International, 2023). Ensuring accessible and timely data on suicide thoughts, attempts, and deaths in a community can strengthen and direct investments and CQI (Stapelberg et al., 2021).

The U.S. Department of Veterans Affairs (VA) has been a leader in suicide prevention since 2007, with the establishment of the Veteran's Crisis Line and suicide prevention coordinators placed in every VA medical center across the country. In 2018, VA implemented a public health approach involving community-based prevention to reach all Veterans and their families and evidence-based clinical interventions. These interventions were based on the VA/DOD Clinical Practice Guidelines for Suicide Prevention (U.S. Department of Veteran Affairs, 2018). VA's integrated health care system, robust electronic health record, and advancements in data analytics, dashboard development, and implementation science, all support suicide prevention efforts across the enterprise and with their community partners.

VA's Suicide Prevention 2.0 expands community interventions via the Governor's Challenge and the building of community coalitions focused on activities to support Veterans and their families. VA's annual Now Plan focuses on enhancements to maximize interventions within a year's time. VA has expanded the intervention, Safety Planning in the Emergency Departments (SPED) across the Veteran's Health Administration (VHA) health care system and is working with HHS/SAMHSA to expand this evidence-based intervention within communities. Utilizing data and surveillance

informs strategic planning and operational priorities to target Veteran subgroups most at risk and social determinants of health that impact crisis and distress. Additionally, VA has a robust research and program evaluation apparatus, including clinical trials, pilot demonstrations, large scale implementation and evaluation, and CQI. These activities inform a learning health care system optimizing efficiency and effectiveness in addressing Veteran suicide. With ongoing leadership commitment across all parts of VA, including robust training, evidenced-based interventions to identify and treat Veterans at risk, and quality control and improvement, VA's systematic approach is a model for the nation of what a health care system can do to impact suicide prevention.

Crisis Continuum of Care

Crisis intervention systems can provide a continuum of timely and effective support in the community (e.g., through mobile crisis, crisis stabilization, EDs, public safety answering points). These systems benefit from strong collaborations with behavioral health and emergency services. Crisis care will also benefit from trauma-informed practices and culturally responsive approaches such as mobile crisis outreach to limit coercive or invasive interventions. As with health care systems, a CQI approach links efforts with outcomes and supports crisis intervention systems in effectively responding to community needs.

Ideally, treatment and crisis services operate as cohesive, responsive, and effective systems of care. This integrated approach ensures individuals with an elevated risk for suicide receive responsive care in a timely manner and respects their dignity and individual autonomy. Enhancing crisis care and facilitating care transitions is one of five identified priorities for The White House strategy to prevent military and Veteran suicide. (The White House, 2021a). Several federal agencies are tasked with creating a Feasibility Analysis and Implementation Plan supporting broad adoption of evidence-based suicide risk assessment and safety planning within ED across the U.S. (The White House, 2021b).

In summary, Goals 8 and 9 address the need for effective clinical services in suicide prevention to be integrated into the health care system and coordinated with community-based crisis and emergency services. Taken together, the goals create a framework for enabling individuals to seek and receive effective and comprehensive support when and where they need it. Through timely access to effective care, Strategic Direction 2 aims to accelerate early intervention, thereby addressing suicide risk before it turns into a suicide attempt or death.

→ GOAL 8:
Implement effective suicide prevention services as a core component of health care.

Integrate Suicide Prevention as a Core Component of Health Care

Health care systems have critical opportunities to identify risk early and to get people care that specifically addresses suicide thoughts and intent (Raue et al., 2014). Individuals who died by suicide often visited health care settings during the time leading up to their death (Ahmedani et al., 2019). Even ED patients presenting without self-harm or suicidal ideation were found to be two times more likely to die by suicide than matched demographic controls (Goldman-Mellor et al., 2019). Suicide thoughts and attempts often go undetected in health care settings because there is

no standardized and routine screening and assessment. Health care settings can support people at risk by creating standard protocols for recognizing and addressing suicide risk. The Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau addresses this gap through its Bright Futures initiative that provides guidelines for clinicians to support the well-being of youth from birth to age 21. The Bright Futures Periodicity Schedule outlines preventive services clinicians can offer during every pediatric health care visit. A component of this schedule is regularly screening for developmental, social, behavioral, and mental health concerns. This includes depression and suicide risk screening and the conditions associated with increased suicide risk, in adolescence. For detailed information on the Periodicity Schedule and Bright Futures, visit https://mchb.hrsa.gov/programs-impact/bright-futures.

Studies show that immediate engagement with even brief suicide prevention interventions delivered in health care settings can help reduce subsequent suicide attempts (Doupnik et al., 2020; Hofstra et al., 2020; Hughes et al., 2023). For example, incorporating brief interventions delivered within routine emergency department (ED) care and paired with a telephone follow-up contact post-discharge can significantly reduce suicide thoughts, attempts, and deaths (Boudreaux et al., 2020).

Within the VHA, Safety Planning in the Emergency Department (SPED), an evidence-based intervention, is offered to some Veterans with suicide risk identified in a VHA Emergency Department or Urgent Care Center (ED/UCC). The SPED intervention has been shown to be associated with reduction in suicidal behavior in the six months following the ED visit (Stanley et al., 2018). All Veterans identified as having any risk receive information for the VA's crisis line, safety planning resources, and tailored follow-up contact after discharge. Additional care interventions, such as inpatient mental health services, are also offered based on identified risk level. Expansion of this model to community EDs across the country has the potential to save numerous lives and is called for by The White House in the 2021 *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Approach* national strategy (The White House, 2021b).

Lethal means safety is incredibly important to prevent suicide among individuals at risk, as mentioned in Strategic Direction 1. Health care systems can promote safe and secure storage practices, such as for medications and firearms, through routine lethal means safety counseling. They can also help people identify risks for access to lethal means as individuals transition back into the community from inpatient or ED care.

Additional advances in suicide prevention can be achieved by improving our understanding of, and preventing known risk factors and conditions associated with, an increased risk for suicide. For example, the federal Interdepartmental Serious Mental Illness Coordinating Committee recommended providing incentives for public and commercial health systems and health plans to track and report patient outcomes. These are related to survival (or death) for individuals with behavioral health conditions that carry elevated suicide risk (SAMHSA, 2015). Reporting could occur in the context of an individual presenting at the ED for an overdose or when someone is discharged from inpatient mental health and substance use treatment.

No matter how someone enters a health care system, or where they are in the care pathway when risk is identified, they need to receive the most effective services. Integrating suicide prevention into public and private health care services through standardized policies, protocols, training, and CQI sets the standard of care across the community in a sustainable way.

Recommended Standard of Care for People with Suicide Risk: Making Health Care Suicide Safe

This report from the National Action Alliance for Suicide Prevention was produced by a task force composed of public and private sector partners and identifies gaps in health care that contribute to suicide deaths, summarizes the evidence-based solutions that health care systems can adopt, and provides information on resources that are available to make care both safer and more effective.

Some Considerations

Settings. All health systems have critical roles in supporting responsive suicide prevention care, though available resources and staffing may differ. For example, providers and resources will differ between a large urban health care system and a small rural clinic. Some settings, such as the ED, interact with individuals for a limited time and do not establish a continuing relationship. Other settings, such as carceral (prison) or residential treatment facilities, have special security and clearance requirements. Additionally, health and behavioral health services (i.e., mental health and substance use services) are often delivered independently. However, substance use amplifies the risk for suicide thoughts, attempts, and deaths, and vice versa. To address this, integration or cooperation of health and behavioral health providers who treat people using substances or who have co-occurring disorders can help reduce the risk of suicide by providing responsive care (Rizk et al., 2021; SAMHSA, 2015; Wakai et al., 2020).

Key Settings for Identifying and Responding to Risk

- Primary care offices
- Emergency departments (EDs) and hospitals
- Substance use treatment
- Inpatient facilities
- Outpatient mental health centers
- Assisted living facilities

- Tribal health systems
- School health services
- Home health services
- Specialty care clinics, such as pain management, obstetrics and gynecology, and substance use health services

Continuous Quality Improvement. Having defined policies and practices in place are important to ensure health care services identify, engage, treat, and follow up with individuals with suicide risk. Policies and practices for tracking the implementation of services as well as monitoring outcomes can help keep patients safe. For example, using electronic health records (EHRs) can vastly improve data collection and analysis of patient care and outcomes. They also provide health care systems with the information they need to adhere to accreditation standards and safety goals.

Centerstone of Tennessee is a nationally recognized behavioral health provider using the Zero Suicide model. They made two meaningful clinical changes based on ongoing quality review of suicide death data. One year's quality review of data showed a significant portion of the suicide deaths involved individuals receiving only Centerstone medication services. The psychiatric team developed a revised protocol which involved a more stringent assessment for appropriateness of this service. They also became more purposeful in scheduling these appointments on the same day as other services. In addition, a decade-long review of suicide death data revealed most individuals in the system who die by suicide were not in Centerstone's Clinical Pathway for Suicide Prevention at the time of their death. This Pathway is activated by screening and assessing for overt suicide plans and/or preparations. However, from 2015–2020, a review of 69 individuals who died by suicide found 65% of them reported no thoughts about suicide and/or being better off dead or self-harm within 30 days of their death. Centerstone used these data to develop a second Suicide Prevention Pathway that identifies individuals who might be at future risk. This new pathway provides education, intervention, and treatment to address factors that increase suicide ideation.

Health care systems should track suicide thoughts, attempts, and deaths and collect data on protective factors as part of their data-driven CQI. The Joint Commission recently expanded its guidance on sentinel events, such as suicide deaths, to require a root cause analysis of the context surrounding the event while in a health care setting or within seven days of discharge from inpatient services; an ED; or behavioral health care services, such as day treatment or partial hospitalization (Joint Commission, 2023). Additionally, Gould et al. (2018) recommend that more research and evaluation are needed on follow-up calls that focus on the patient's perspective. Tracking individual progress from when a person enters the health care system through their transition back into the community can address critical gaps.

Perspectives from Lived Experience. Individuals using the health care system can benefit most when services are delivered in a way that respects cultural and spiritual traditions. Further, individuals with suicide-centered lived experience can offer invaluable insight and leadership to improve suicide preventive care. Expanding resources offered to individuals who have elevated suicide risk is critical. Connecting them to effective community-based peer supports provides opportunities to supplement clinical interventions. Several states officially recognize certified peer specialists who serve in critical roles like this and can bridge the gap between systems of care. For detailed information on the national standards for peer support certification, visit https://www.samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards.

Collaborative Person-Centered Care. Collaborative and person-centered support includes providers engaging people at risk for suicide to create personalized treatment and safety plans. This includes conversations about strategies to reduce access to lethal means, including safe and secure storage during periods of crisis, while respecting cultural values and beliefs. Providers may also consider engaging supportive families, friends, and caregivers in these conversations to help implement safety precautions. Providers can also recognize and make referrals when family and friends of someone with suicide risk need their own care and support.

Health and Crisis Care Workforce Suicide Prevention Skills. Health care systems can foster an environment that supports providers in offering effective, competent, and compassionate care. For example, sponsoring continuing education programs and providing paid and protected time for training can improve compassion care skills. At the policy level, licensing boards and

accrediting bodies can add suicide prevention training as a requirement. Changes at the system level can help integrate suicide prevention into the health care culture. These types of supports can empower individual providers with the knowledge, skills, and confidence to identify and respond to suicide risk (also see Goal 5 related to suicide prevention for the workforce).

Follow-Up. Following up with someone after an inpatient hospital stay or ED visit for suicide thoughts or attempts has shown reductions in suicidal behaviors (Boudreaux et al., 2020; Stanley et al., 2018). Active clinical follow-up can take the form of outreach to help individuals stay connected to support, remain engaged in treatment, and reduce future attempts and deaths. Health care systems that rely on their practice and patient outcome data for quality improvement efforts should also include follow-up services as part of their suicide prevention care.

What Success Looks Like

Success for Goal 8 means individuals with increased risk for suicide who enter the health care system would receive high-quality care aligned with best practices in suicide prevention. No door would be the wrong door for getting help. Regardless of where an individual might connect with health care (e.g., primary care office, ED) they would receive services that matched their current situation. They would:

- Receive a full assessment to determine their suicide risk
- Collaborate on creating a safety plan
- Engage in conversations around lethal means safety
- Receive evidence-based care specific to suicide

Health care providers would work within systems using built-in tools and resources to quickly recognize warning signs of suicide risk and provide effective supports. Health systems would routinely implement best practices across the clinical pathway and track outcomes among individuals on a continuing basis to identify opportunities for further improvement. Individuals would receive follow-up when transitioning between care settings, such as from an ED or inpatient center to outpatient care.

A health care system offering these services would increase the use of early intervention services, decrease the use of intensive crisis interventions, and prevent suicide thoughts, attempts, and deaths.

Examples

- The Chickasaw Nation Department of Health and Family Services (DHFS) began implementing the Zero Suicide framework within its health care systems in September 2016. Their efforts included:
  - Screening for suicide risk
  - Assessing the level of suicide risk
  - Engaging in safety planning using the Stanley-Brown Safety Plan (or a similar evidence-based tool)
  - Scheduling follow-up care appointments
  - Conducting a phone check-in within 72 hours of hospital discharge for a person identified as being at risk of suicide (Bryan et al., 2018; Stanley & Brown, 2012)

As a result, DHFS was better able to identify and support patients with increased risk of suicide and divert an average of 200 patients per year from inpatient to outpatient treatment for suicidality. This ensured that patients received the least intensive level of care needed and effective suicide-specific supports. Cost saving estimates show that DHFS is saving over $200,000 per year by reducing unnecessary inpatient hospital stays. To read the full success story, visit https://zerosuicide.edc.org/evidence/outcome-story/chickasaw-nation-departments-health-and-family-services.https://zerosuicide.edc.org/evidence/outcome-story/chickasaw-nation-departments-health-and-family-services.

- The Children's Hospital of Philadelphia (CHOP) began applying the Zero Suicide framework within its health care system in 2019. CHOP's Zero Suicide implementation team released a standardized outpatient behavioral health care clinical care pathway for children and youth at risk of suicide. Using care pathways has been cited as an effective strategy for standardizing patient care and improving health care quality (Lavelle et al., 2015; Roberts & Pate, 2022). CHOP's pathway provides clear, standardized protocols for health care staff to follow when screening for suicide risk, providing assessment, and determining appropriate levels of suicide-specific care. The pathway is regularly maintained and easy to access for all clinical staff. To view the clinical care pathway, visit https://www.chop.edu/clinical-pathway/suicide-risk-assessment-and-care-planning-clinical-pathway.

- Eight EDs across the United States conducted the Emergency Department Safety Assessment and Follow-up Evaluation 2 (ED-SAFE 2) in a clinical randomized trial from January 2014 to April 2018. ED staff received training on CQI, built CQI teams, and evaluated the effectiveness of suicide prevention protocols to identify areas for improvement. Each ED identified improvement efforts, with a specific focus on increasing universal suicide screening and collaborative safety planning for anyone at risk of suicide. Sites tracked suicide outcomes for each person screening positive for suicide risk for six months following individual discharge. Study results showed significant reductions in patients' post-discharge suicide-related ED visits, suicide attempts, and deaths following implementation and sustainment of the ED's suicide prevention protocols, screenings, and safety planning interventions. To read the full study, visit https://pubmed.ncbi.nlm.nih.gov/37195676.

What We Should Do

Below are the objectives for Goal 8 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 8.1:** Implement effective services to identify, engage, treat, and follow up with individuals with suicide risk as standard care in public and private health care delivery.

- **Objective 8.2:** Develop and implement effective standard protocols to identify, engage, treat, and follow up with individuals with elevated suicide risk in health care.

- **Objective 8.3:** Address practice and policy barriers in order to implement effective emergency department screening, safety planning, and rapid and sustained follow-up after discharge in all emergency departments.

- **Objective 8.4:** Promote effective continuity of engagement and care for patients with suicide risk when they transition between different health care settings and providers, especially crisis, emergency, and hospital settings, and between health care and the community.

- **Objective 8.5:** Ensure suicide prevention competency in initial and continuing education of health professionals to achieve and maintain quality and effectiveness of suicide prevention services.

- **Objective 8.6:** Incentivize and enable health care organizations to track suicide thoughts, attempts, and deaths in their patient and beneficiary populations to inform continuous quality improvement efforts.

- **Objective 8.7:** Increase and leverage the use of electronic health records to track and support implementation of best practices for suicide prevention.

- **Objective 8.8:** Implement effective health care practice strategies that encourage safe and secure storage of lethal means among people at increased risk of suicide.

- **Objective 8.9:** Ensure that suicide prevention services include the capability to identify and address co-occurring substance use issues and ensure that substance use treatment services include the capability to identify and address suicide risk.

→ GOAL 9:
Improve the quality and accessibility of crisis care services across all communities.

Figure 8. **Crisis Services**

Someone to Respond
Mobile Crisis Response
• Respond in community, clinical evaluation, de-escalation, safety planning
• Referrals to walk in, stabilization, and community supports

A Safe Place for Help
Crisis Receiving/
Walk In Centers
• Clinical evaluation, safety planning
• Referrals to stabilization, community supports, and inpatient, if needed
• Evidence-based interventions and peer support

Community Supports
(mental health centers,
CCBHCs, faith community, etc.)
• Crisis outreach, aftercare and follow up
• Evidence-based treatment

Someone to Talk To
24/7 988 Suicide and
Crisis Lifeline
• Dispatch Mobile crisis services
• Active listening, clinical evaluation and intervention, safety planning
• Care coordination support and follow up
• Coordination with 911 dispatch

Community
Emergency Responders
(EMS, Fire, Law
Enforcement, Dispatch)
• Triage in community
• Connection with Walk In Centers and Stabilization

A Safe Place for Help
Crisis Stabilization
• Short term options to move beyond crisis in supported and calm environment
• Evidence-based interventions and peer support
• Referrals to community supports and inpatient

Quality Crisis Care and Accessibility Is Important

An effective crisis system provides three core services: someone to talk to, someone to respond, and a safe place for help (SAMHSA, 2020). These core services and access to a full continuum of crisis services can be the life-saving difference during the limited time that a crisis is at its peak. Crisis care services provide essential support and facilitate help-seeking when it is most urgent. Research found that crisis services can contribute to decreased suicide attempts and suicide deaths (Hoffberg et al., 2020; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2013). Significant advancements in crisis services were made over the past several years as 988 became the new national suicide prevention hotline number.

The *National Guidelines for Behavioral Health Crisis Care* outlines the three core services noted above in this way:

1. Clinically staffed crisis call centers meeting the 988 Suicide and Crisis Lifeline standards provide real-time access to someone to talk to 24/7/365

2. Mobile crisis response teams for community-based responses meet someone where they are

3. Crisis receiving and stabilizing facilities within the community provide a place to go for mental health and substance use care (SAMHSA, 2020)

Someone to Talk To

Someone experiencing escalating suicide risk in the community needs immediate access to help. Crisis contact centers can often provide direct assistance to this person (SAMHSA, n.d.). Centers can also serve as the vital link to behavioral health crisis services, when necessary, including the health care systems. Local services are best prepared to offer support to individuals in their region, and having a centralized national resource also facilitates access to services.

Accredited local crisis centers started participating in a network known as the *National Suicide Prevention Lifeline* in 2005. This network provided access to hotline services through a single 10-digit toll-free number. Then, in 2022, this network of more than 200 state and local crisis centers transitioned to the three-digit code 988. Federal investment in the network rose from $7.2 million in fiscal year 2011 to $501.6 million in fiscal year 2023. This represents the single largest investment in suicide prevention. Nearly 20 states enacted legislation to support the network with additional state investment and infrastructure (National Alliance on Mental Illness, and Reimagine Crisis Response, n.d.). The 988 network offers a community mental health alternative to the public safety network access through 911 (SAMHSA, 2023). In many instances, crisis care services can immediately and directly support someone in an elevated risk state, including through the dispatch of mobile crisis services. This response can help prevent a potentially lethal outcome. For example, more than 98% of people who have calls, chats, or texts responded to by the 988 Lifeline receive the crisis support they need and do not require additional emergency services through accessing of 911 (SAMHSA, 2023a).

Someone to Respond

An individual experiencing a mental health crisis needs quick access to care. A mobile crisis team is trained to respond to behavioral health crises in the community. The team can respond to a mental health crisis instead of law enforcement. Their goal is to connect individuals with community-based resources and services and reduce the number of unnecessary ED or hospital visits. The team provides care that is the least restrictive and most effective in a person's normal environment.

The report *Assessing the Impact of Mobile Crisis Teams: A Review of Research* compiled research on the impact of mobile crisis teams. Preliminary results show that mobile crisis teams are effective in connecting individuals to services. The research also suggested these teams can reduce pressure on the health care systems and promote cost effectiveness (International Associations of Chiefs of Police, and UC Center for Police Research and Policy, n.d.). To learn more, visit https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Mobile%20Crisis%20Team%20Evaluations.pdf.

Community crisis response services need additional resources and support to fulfill their critical mission. Federal investment in infrastructure such as 988 and Certified Community Behavioral Health Clinics (mentioned below) have improved the crisis safety net. Ensuring that individuals have access to an effective continuum of crisis services also requires community resources, support, and Continuous Quality Improvement (CQI; National Council for Mental Wellbeing, 2023). All people looking for help with suicide risk need timely access to quality crisis care services, including culturally responsive assessments, interventions, lethal means counseling, and follow-up care. While there have been advancements to support mobile crisis service expansion, such as the enhanced federal medical assistance percentage (FMAP) for qualifying mobile crisis services, grants from the Centers for Medicare and Medicaid Services (CMS), and funding from SAMHSA such as the Community Crisis Partnership grants and the block grant set asides, more work is needed to ensure that responsive mobile crisis is available in every community.

A Safe Place for Help

A person looking for help with suicide risk, mental health, or substance use needs access to evidence-based services regardless of their ability to pay, place of residence, or age. Crisis stabilization centers provide services for individuals in need of safe, secure therapeutic environments. The goal of these centers is to stabilize the person to return to their community. In a recent analysis of data from the Arizona Crisis System, 63.3% of people using crisis stabilization services did not re-utilize any services within the next 30 days, and of those that did, 73% occurred in a crisis setting (mobile crisis or crisis facility) rather than an emergency department or inpatient hospital (Tomovic et al., 2024). Recently, states were required to use 5% of their Mental Health Block Grants to support evidence-based crisis systems including hotlines, mobile crisis, and crisis stabilization units (SAMHSA, n.d.). SAMHSA also launched implementation grant funding for Certified Community Behavioral Health Clinics (CCBHCs) to further build out community-based services spanning a range of supports. These include screening, assessment, treatment, care coordination, crisis response, and recovery supports for both mental health and substance use concerns (SAMHSA, 2023c).

Some Considerations

Perspectives from Lived Experience. Individuals with suicide-centered lived experience strengthen the quality and accessibility of crisis services by providing their authentic and personal perspectives. Evaluation and oversight initiatives that include this experiential knowledge ensure services meet individual and community needs and concerns.

People in crisis should be treated with dignity. Dignity includes respect for individual preferences, autonomy, confidentiality, and cultural norms while addressing issues of safety. Services can also engage and support the family and friends identified by the person in crisis. When someone has

an elevated risk for suicide, people in their social circle can be key partners in providing support and can also benefit from attention to their own behavioral health needs.

In some communities, a history of traumatic events involving emergency response systems can escalate the potential for unintended harm. It may also create barriers to even accessing crisis care at all. Many communities have benefited from the use of trauma-informed care approaches and efforts to reduce police intervention in crisis situations. These include mobile crisis outreach teams and other options to 911. These programs offer compassionate alternatives to traditional crisis response protocols. Collaborative models, including co-location of services, have shown promise in facilitating timely access to behavioral health care in crisis situations (Reist et al., 2022).

Settings. Crisis care services are a critical bridge between the community and the health care system. Interventions may take place in the community (e.g., home, work, school); by way of health care services (e.g., mobile crisis outreach teams, emergency medical services); or via a technology-based connection (e.g., phone, text, or chat). Sometimes the crisis care system needs to engage with and coordinate all three. This highlights the crucial role of 988 as a centralized point of contact. A critical point of collaboration is the intersection of emergency responses linked to 988 and 911 services. Strong partnerships between emergency response systems and behavioral health services ensure community resources are focused and efficient.

In 2022, the Veterans Crisis Line (VCL) implemented three-digit dialing to access crisis care with the launch of Dial 988 then Press 1. This increased awareness and access to 24/7/365 crisis services for Veterans, service members, and concerned parties. VCL also reaches Veterans through its caring letters project. The project uses a series of mailed letters to expresses care and concern and offers Veterans opportunities to reconnect with treatment options. Its Peer Support Outreach Center also connects Veterans with VA and community resources.

Improving Crisis Care Provider Skills. Supporting the needs of crisis care providers, including attention to their health and mental health, will support them in their vital roles working with people experiencing suicide risk. Support begins with the professional and paraprofessional training programs and continues with agencies and institutions that recruit potential counselors. Improving aspects of equity and diversity within the workforce starts with improving the pipeline for crisis counselors. Additionally, cross-training crisis counselors and professionals addressing suicide prevention and substance use will promote holistic care and will allow individuals to receive appropriate support regardless of their entry point into the system. At the agency or organization level, counselors need equitable compensation and ongoing training opportunities. Changes at the system level can create broad and lasting improvements to strengthen the crisis care workforce.

What Success Looks Like

Success for Goal 9 will ensure that anyone in crisis will know how to get help, including the number to call, and where to go for services. Every community across the country would have a seamless crisis care continuum in place that includes:

* Local crisis call center in the 988 network

* Mobile crisis teams that respond to behavioral health emergencies in the community

* Variety of crisis stabilization options

These three core elements will provide timely access to appropriate and effective care by addressing suicide risk before it escalates into a suicide attempt or death. With ongoing investment from multiple sources and the use of CQI, communities will be able to sustain the crisis service infrastructure needed to be effective and responsive to local needs.

Examples

- In 2018, Utah created a free 40-hour crisis certification training for all staff who work in mental health crisis lines and warmlines. State staff and crisis care expert volunteers jointly administer the certification program. This training strengthens Utah's crisis workforce and ensures consistent, effective crisis care across the state. Universities across the state are now incorporating the 40-hour certification into social work programs so graduates will have this certification when they enter the workforce, further bolstering the state's crisis infrastructure. To learn more about Utah's certification program, visit https://nashp.org/utahs-crisis-worker-certification-successes-and-lessons-learned/.

- Beginning in July 2022, The Trevor Project partnered with the 988 Suicide and Crisis Lifeline to make responsive assistance available. Youth and young adults can now access customized LGBTQI+ crisis services by pressing "3" when calling 988 or through chat and text. A subnetwork that includes The Trevor Project provides this specialized support through its national network of crisis counselors trained in counseling skills specific to LGBTQI+ identity and issues. In December 2023, 988 served over 45,000 LGBTQI+ crisis contacts (SAMHSA, 2023b). To learn more about 988's LGBTQI+ specific resources, visit https://988lifeline.org/help-yourself/lgbtq/.

- In November 2022, Volunteers of America Western Washington (VOA) launched the Native and Strong Lifeline. This program serves Washington's American Indian and Alaska Native communities. Native and Strong crisis counselors are tribal members with ties directly to their local communities. They are trained in crisis intervention with special content on traditional healing practices that emphasize the lived experiences, traditions, and wisdom of Native people. This program is integrated into Washington's 988 Suicide and Crisis Lifeline network. To learn more about the Native and Strong Lifeline, visit https://www.samishtribe.nsn.us/departments/health/native-and-strong-lifeline.

- The Kansas Suicide Prevention Headquarters (KSPQH) and Douglas County Emergency Services and Crisis Line worked to develop a 911 Call Diversion Program. This program transfers mental health crisis calls that do not require a law enforcement or medical response from 911 to the local 988 Suicide and Crisis Lifeline provider. The Douglas County Crisis Line staff de-escalate the crisis via phone or by sending a mobile crisis unit to individuals in need of in-person support. When needed, mobile crisis team members can also be dispatched with first responders. Anyone needing additional support is transported to an acute crisis facility. This ensures all individuals in the county receive responsive crisis services. To support the coordination across 911 and 988, Douglas County provides Public Safety Access Point training and has a memorandum of understanding between KSPQH and Douglas County Emergency Services. For more information on Kansas's crisis response services, visit https://www.ksphq.org/988-2/.

What We Should Do

Below are the objectives for Goal 9 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 9.1:** Develop and maintain a robust crisis care system through ongoing quality improvement to help people at risk of suicide.

- **Objective 9.2:** Increase local collaboration and coordination between 988 centers and 911 Public Safety Answering Points; police, fire, and emergency medical services; and behavioral health crisis services to improve quality of care for those in crisis.

- **Objective 9.3:** Through expansion of effective mobile crisis teams and diversion programs, reduce unnecessary police interventions with individuals who call 988 or 911 with suicidal thoughts.

- **Objective 9.4:** Increase timely access to assessment, intervention, lethal means safety counseling, and follow-up for people at risk of suicide along the crisis care continuum.

- **Objective 9.5:** Ensure that crisis services are integrated into health care delivery.

- **Objective 9.6:** Ensure that 988 crisis counselors and other components of crisis services provide effective suicide prevention services to all users, including those with substance use disorders.

STRATEGIC DIRECTION 3

Surveillance, Quality Improvement, and Research

Strategic Direction 3 focuses on enhancing data on suicide thoughts, attempts, deaths, and risk and protective factors, as well as promoting rigorous research.

Surveillance of health outcomes and associated factors allows us to do the following:

- Track the impact of suicide and changes over time
- Identify suicide prevention needs among specific communities and groups
- Strengthen efforts to reduce suicide

Quality improvement in surveillance data is needed to better capture the diversity and needs of the population; enhance the completeness and consistency of data collection; and further accessibility, useability, and timeliness. Good quality data enable suicide prevention evaluation and are important for applying research advances to improve prevention practices, and ultimately, to reduce the impact of suicide. Implementing a prioritized and robust research agenda allows for building of the evidence base on what contributes to suicide risk and what can be done to prevent suicide.

The goals of Strategic Direction 3 provide guidance on continued enhancements and necessary innovations in these areas. Goal 10 emphasizes the importance of improving data relevant to suicide prevention for public health surveillance, research, evaluation, and quality improvement. The focus is on improving the quality, timeliness, scope, usefulness, and accessibility

of data on suicide thoughts, attempts, and deaths. It also addresses the need for better data to understand the contributors to suicide and the context in which these suicide outcomes may occur. This includes using diverse data sources (containing health outcomes, known risk and protective factors, or other data) and applying emerging technologies and methods to extract information from these data. This goal promotes a comprehensive understanding of suicide thoughts and attempts and potential trajectories of risk, and it provides the metrics to assess the effectiveness of prevention strategies.

Goal 10 emphasizes the benefits of collaboration among public and private partners (e.g., health systems and academic centers). Collaborations are also an important component in establishing agreements for accessibility and stewardship of tribal-owned data. Tribal nations' inherent sovereign authority to administer the collection, ownership, and application of their own data is rooted in a tribal nation's right to govern their people. Effective collaborations with tribal nations around data sharing will be founded on the tribe's rights and through partnerships with tribal leadership. The core purpose of all data collected in tribes is to benefit their citizens.

Goal 11 focuses on promoting and supporting suicide prevention research. These research priorities will build upon what we know about the complexities of suicide and effective prevention strategies. A significant aspect of this goal is the inclusion of diverse settings such as tribal communities and populations (e.g., middle-aged males), in research. Inclusion of individuals receiving or delivering interventions (e.g., providers, individuals with lived experience, family members) in addressing factors that impede or enhance delivery of evidence-based suicide prevention programs and practices is important for implementation. This goal also explores the technology's role in mental health and suicide risk, particularly among youth.

→ GOAL 10:
Improve the quality, timeliness, scope, usefulness, and accessibility of data needed for suicide-related surveillance, research, evaluation, and quality improvement.

Improve Data

Quality, timely, and actionable data about suicide thoughts, attempts, and deaths, and related risk and protective factors are essential to successful prevention efforts. Public health leaders rely on data collected and reported through multiple systems to help prioritize investment, track progress, build the evidence base, and guide quality improvement efforts. While there have been notable advances in the field related to the accessibility and timeliness of suicide-related data, more work is needed to improve timeliness without sacrificing data quality. Ongoing efforts to modernize data system infrastructure and better connect data systems and sources can do the following:

- Support efforts to ensure data are more readily available for use in understanding risk trajectories and comorbidities (e.g., adverse childhood experiences, substance use)
- Help drive quality improvements in clinical care

Improvements in analytic tools and methodology can help maximize the benefits of data extracted from various sources. Incorporating new methods and diverse data sources enhances capabilities for translating data for decision-making.

Data and Surveillance Task Force: Recommendations and Progress

The National Action Alliance for Suicide Prevention established the Data and Surveillance Task Force to help improve and expand the information available about suicidal thoughts, attempts, and deaths. The task force issued recommendations for improving national data systems for suicide surveillance, for enhancing or expanding existing systems, and for improving the quality, timeliness, usefulness, and accessibility of data on suicidal thoughts, attempts, and deaths. The 2014 publication reviewed 28 national data systems for feasibility of use in the surveillance of suicidal thoughts, attempts, and deaths. The review included data systems capturing the full continuum of suicide risk (e.g., thoughts, attempts, deaths); how the data are collected (e.g., census, sample, survey, administrative data files, self-report, reporting by care providers); and the strengths and limitations of the survey or data system. The task force also made the following recommendations to improve data and surveillance efforts in the United States:

1. Use standard definitions for suicide thoughts, attempts, and deaths.

2. Work toward common data elements across systems, as well as adding missing sociodemographic information, such as sexual orientation and gender identity to better identify groups at higher risk.

3. Improve the ability to monitor changes at the regional, state, or county level or among subpopulations.

4. Improve the timeliness and quality of information from death certificates.

5. Endorse the use of external cause coding (a data element needed to identify likely suicide attempts) on medical records as a requirement for reimbursement by insurance carriers.

6. Support inclusion of suicide-related items in data systems that capture real-time information on hospital ED visits to improve the monitoring of trends in suicidal behavior.

7. Encourage all states to include suicide attempts by youth aged 12–17 years as a health condition to be reported to the state health department.

Progress has been made on several of these recommendations:

• Inclusion of sexual orientation and gender identity has expanded in surveys (e.g., for example the Centers for Disease Control and Prevention's [CDC's] Youth Risk Behavior Surveillance System [YRBSS] and the Substance Abuse and Mental Health Service Administration's [SAMHSA] National Survey on Drug Use and Health [NSDUH]) and added to some state death certificates (e.g., California).

• Improving the quality of death investigations, such as the Collaborating Office for Medical Examiner and Coroners, including recognition that suicide deaths for individuals under age 10 years do occur and should be investigated and documented accordingly.

- CDC's National Syndromic Surveillance Program supports near real-time information on self-harm and suicide attempts reported from 78% of U.S. emergency care settings.

- CDC is exploring "Nowcasting" to offer real-time estimates of U.S. suicide mortality (Choi et al., 2020; https://pubmed.ncbi.nlm.nih.gov/33355678/).

- CDC provides quarterly estimates of suicide rates through the National Vital Statistics System Mortality Dashboard with only a six-month lag in reporting suicide deaths.

Some Considerations

Data on Suicide Deaths. Suicide mortality data in the United States are derived from death certificates and captured in CDC's National Vital Statistics System (NVSS). Suicides may be tracked over time to observe trends and changes in overall suicide rates or by sex, race, ethnicity, geography, age, and means of suicide, among other factors. In the past, suicide mortality data lagged by several years which created a barrier for suicide prevention planning. The lag time is now significantly reduced, and provisional mortality data are available within about six months. Final and provisional data are available at https://wonder.cdc.gov/, and https://www.cdc.gov/injury/wisqars/index.html. The CDC's National Center for Health Statistics provides access to provisional mortality tables, chart, and reports as part of its Vital Statistics Rapid Release program.

In addition to NVSS, CDC's National Violent Death Reporting System (NVDRS), a state-based surveillance system, captures information on suicide—including the who, when, where, and how—from death certificates, the coroner, the medical examiner, and law enforcement reports. Data from states are compiled into an anonymized database for analysis. Since the 2012 *National Strategy for Suicide Prevention*, the NVDRS expanded from 16 states to all 50 states, the District of Columbia, and Puerto Rico. For more information, visit https://www.cdc.gov/violenceprevention/datasources/nvdrs/.

Despite positive changes, data challenges remain. Delays in reporting suicide mortality to the public continue. In part, this is due to the need to conduct death investigations to determine if a death was self-inflicted, and if it was, whether it was intentional (i.e., suicide) or unintentional. Suicide rates have long been underestimated (Snowdon & Choi, 2020) given the following reasons:

- Challenges in determining intent

- Variations in training and educational backgrounds among coroners

- Differing philosophies among medical examiners and others related to determining the manner of death (Stone et al., 2017)

These and other factors may lead to misclassification of suicide outcomes, and the impact has been found to vary across race, ethnicity, sex, and method of death (e.g., Ali et al., 2021; Huguet et al., 2012). Efforts are underway to improve practices and policies related to death scene investigations and manner of death determinations. See https://www.cdc.gov/nchs/comec/index.htm.

Additional improvements are needed in suicide data collection to reduce racial and ethnic misclassification (Arias et al., 2016; Jim et al., 2014) and to capture information on sexual orientation, gender identity, and Veteran status to better quantify the impact in these groups. Fortunately, federal activities are currently underway to modernize standards for data collection on race and ethnicity. For more information, see Initial Proposals for Revising the Federal Race and Ethnicity Standards and recommendations for advancing the collection of sexual orientation and gender identity at time of death (see Haas et al., 2019).

Complete External Cause of Injury Coding is Urgently Needed

Incomplete External Cause of Injury Coding in Health Care Systems. Knowing if and when individuals attempt suicide is fundamental for suicide prevention efforts in health care settings. About half of U.S. states require documentation of "external cause" for emergency care and hospitalizations involving injury. External cause signifies whether the injury was intentional self-harm, unintentional, due to assault, legal intervention/war, or undetermined. Recent analyses using data from the Agency for Healthcare Research and Quality's (AHRQ's) Healthcare Cost and Utilization Project documented considerable variation in the rate of missing external cause codes among ED visits and hospitalizations involving injury. This is associated with documentation mandates (AHRQ, 2021a and 2021b). Documentation of external cause for all health care events involving injury is essential for appropriate patient care, clinical quality improvement, and public health surveillance.

What's Being Done? The 2021 *Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention* highlighted the need for complete external cause of injury. It is also mentioned in Priority 4 of the Action Alliance's An Action Plan to Strengthen Mental Health and the Prevention of Suicide in the Aftermath of COVID-19. The National Institute of Mental Health (NIMH) is committed to working with federal partners to explore and pursue any potentially viable path to complete documentation of external cause of injury in health care data.

Data on Suicide Thoughts, Behaviors, and Risk and Protective Factors. The landscape of data sources for suicidal thoughts, attempts, and associated risk and protective factors is wider ranging than for suicide deaths. These data come from population-based surveys, administrative databases, other contextual sources, and near real-time emergency department (ED) data.

Two major population surveys that provide annual or biennial information on suicide risk include SAMHSA's National Survey on Drug Use and Health (NSDUH) and CDC's Youth Risk Behavior Surveillance System (YRBSS).

- NSDUH is a nationally representative survey conducted annually among the civilian noninstitutionalized population ages 12 or older in the United States (https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health). It collects information on suicide thoughts, plans, attempts, mental health conditions, and treatment for substance use or mental disorders, among other risks.

- YRBSS is a set of surveys administered to high school students every other year at national, tribal government, state, territory, and local school district levels (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm). YRBSS collects data on health risk-related behaviors and experiences affecting the lives of young people. These include mental health, substance use, and suicide thoughts, plans, and attempts, including a question as to whether a suicide attempt required medical attention. Data are also collected about some protective factors, such as school connectedness. Since 2012, YRBSS has added questions on new items impacting suicide risk, including dating violence, cyber bullying, and use of devices and social media.

Both NSDUH and YRBSS collect data at the national level. This provides a snapshot of what is happening across the country and a comparison for state or local data when available. State-level estimates are available for NSDUH, and YBRSS data are available for most states, some territories, some local school districts, and some tribal governments.

Another population-based survey is CDC's Behavioral Risk Factor Surveillance System (BRFSS). It collects data on adult U.S. residents in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and Palau. The BRFSS questionnaire includes a core component asked by all states, optional modules that states may choose to use, and state-added questions. Data are available at the national and state levels, while some data are available for geographic subdivisions within states (https://www.cdc.gov/brfss/). The BRFSS does not include a direct question about suicide risk, but it does include several items related to mental health, health care access, substance use, and adverse childhood experiences (ACEs), as well as other related topics, as part of the core component or a module. The ACEs module includes a question that asks whether the respondent ever lived with someone "who was depressed, mentally ill, or suicidal."

Additional databases are available through AHRQ's Healthcare Cost and Utilization Project (HCUP). Currently, the availability of nationwide databases may lag up to two years, while the majority of state databases are typically available within one year. AHRQ provides information from health care systems related to nonfatal suicidal behavior and treatment and in-hospital deaths.

- The Nationwide Emergency Department Sample (NEDS) is the largest all-payer ED database in the United States, yielding national estimates of ED visits, including those for suicide attempts and thoughts of suicide. It provides information on patient demographics (e.g., age, urban/rural residence, community-level income, and race and ethnicity); clinical diagnoses and procedures; nature of ED visits; discharge disposition; and ED charge and cost information. The NEDS is derived from the universe of ED visits in 42 states plus the District of Columbia from the HCUP State Inpatient Databases and State Emergency Department Databases.

- The National Inpatient Sample is the largest publicly available all-payer inpatient health care database and is designed to produce U.S. regional and national estimates of inpatient utilization, including hospital stays related to suicidal behavior. It also includes data on access, cost, quality, and outcomes.

One important advance since 2012, is the use of syndromic surveillance to track and monitor ED visits for instances of suicide thoughts and attempts in near real time (i.e., within 24 hours of patient visits). These data cover 78% of EDs across all 50 states, Washington, D.C., and Guam, and can detect, understand, and monitor unusual levels of suicide thoughts and attempts to determine if a response is needed. These data can also inform timely suicide prevention planning.

Data limitations include a lack of complete data on race and ethnicity and no information on sexual orientation, gender identity, or Veteran status. As of September 2023, 20 recipients of CDC's Comprehensive Suicide Prevention program were funded to analyze syndromic surveillance data for suicide prevention planning and evaluation. For more information on CDC's National Syndromic Surveillance Program, see https://www.cdc.gov/nssp/overview.html.

Information on risk and protective factors can also be gleaned from certain records that provide information on living contexts. These include sources of data on economic indicators such as livable wages, foreclosures, bankruptcy filings, and unemployment rates; data on gun ownership and attitudes and beliefs around storage during periods of crisis; and data on health service accessibility barriers (e.g., health professional shortage areas from the Health Resources and Services Administration [HRSA; https://data.hrsa.gov/tools/shortage-area]). Data on state and federal funding allocations supporting prevention, intervention, treatment, and postvention infrastructure, as well as data on training availability and utilization among professionals serving the community, can also be used by public health leaders and communities to consider available resources to reduce risk.

Local Data. Local communities and organizations can gather, maintain, and share data to inform suicide prevention efforts. Core community institutions can maintain data records pertaining to suicide, mental health, and known risk and protective factors for suicide, such as rates of substance use, ACEs, and social determinants of health. These institutions may include local departments of public health, K–12 schools, universities, social services agencies, juvenile justice institutions, and health and mental health providers. Exploring ways for partners to share data, as appropriate, and honoring tribal sovereignty and tribal data sovereignty can improve local suicide prevention efforts.

Community groups can also benefit from conducting their own needs assessment and listening sessions, hosting other community discussions, and collaborating with local or state public health officials to understand the following:

- Local perceptions, beliefs, needs, and context influencing suicide

- Impact of suicide and suicide attempts and changes in rates

- Prevention strategies that are most likely to be effective

Some community coalitions have formed data subcommittees. These subcommittees bring together partners with access to different types of data as well as those with suicide-centered lived experience to facilitate stronger data sharing and more equitable data analysis.

Some tools and other resources available to assist communities in their data collection efforts include:

- The National Fatality Review-Case Reporting System (NFR-CRS), funded by HRSA, is a web-based system that contains detailed information on factors contributing to a child's death, including suicides. These details come from Child Death Reviews (CDR). The CDR is a multidisciplinary community-based review process in which teams of professionals systematically identify potential causes and contributing factors to pediatric deaths, including suicide. These factors may be at the individual, systems, and community levels. The aim is to address identified factors to prevent future deaths. A researcher database is available from the NFR-CRS to examine pediatric suicide deaths (Trigylidas et al, 2016; Schnitzer et al., 2019;

Schnitzer et al., 2023). For more information on the National Center for Fatality Review, visit https://ncfrp.org/.

- The *Community-Led Suicide Prevention Toolkit* provides core steps communities can take for suicide prevention planning, including strengthening their access to and use of data. For more information, visit https://communitysuicideprevention.org/element/data/.

- The Association of State and Territorial Health Officials (ASTHO) developed a Suicide Indicator Explorer, an interactive tool to assist communities in identifying suicide prevention data sources. For more information, visit https://my.astho.org/spacecat/suicide-data-indicators.

Ultimately, understanding local context is important in guiding communities' suicide prevention decision-making (also see Goals 1 and 2).

Advances in Data Science Methods and Use of Novel Data Sources. Since the 2012 *National Strategy*, major advances have occurred in analytic methods and novel data sources for tracking and monitoring suicide thoughts, attempts, deaths, and related risk and protective factors. The number of publications applying data science methods (e.g., data linkage, machine learning) to identify, predict, classify, or describe suicidal thoughts, nonfatal attempts, or deaths doubled between 2017 and 2020 (Wulz, et al., 2022). Data science methods are also being applied to reduce data processing time. Advances in the use of novel data sources, such as social media, Internet browser data, and other social networking and digital platforms are also now available. Using these data sources and data science methods, scientists estimated weekly suicide fatalities in the United States that closely correlated with actual mortality data (Choi et al., 2020). This important study establishes a novel real-time approach of tracking suicides and provides the potential for an effective public health response (Choi et al., 2020). Further work is needed to identify, validate, and apply novel data and methods for suicide surveillance, research, evaluation, and quality improvement to keep pace with current and emerging methods and technology.

Data Integration. Data integration involves combining data from multiple data sources to facilitate a more comprehensive understanding of health outcomes and associated risk and protective factors and to verify data quality. Achieving this goal requires collaboration and data sharing among groups that collect suicide-related data and those seeking to use data for program improvement. For example, a recent quality improvement study in California reviewed deaths in electronic health records (EHRs) from an academic health setting and compared them against the state's public health death file. The study found 19% of deceased patients were marked alive in the EHR (Wenger et al., 2023). Key groups seeking to improve the quality of data include state vital statistics offices, local coroners and medical examiners, death scene investigators, EDs, health care systems, and insurance companies.

For more information about prioritized data and surveillance for suicide prevention, see *Prioritizing Improved Data and Surveillance for Suicide in the United States in Response to COVID-19*.

Challenges to Accessing Linkable Death Data

Knowing whether suicide prevention efforts reduce the risk of suicide death is fundamental. The 2021 *Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*, and the 2017 Interdepartmental Serious Mental Illness Coordinating Committee's (ISMICC) Report to Congress call for tracking and reporting survival/mortality as outcomes (ISMICC, 2017). Yet accessing death data in the U.S. is challenging, as these data are owned by 57 jurisdictions (50 states, the District of Columbia, New York City, and five territories). Each has their own policies on accessing and using the data for research, surveillance, and quality improvement. The 57 jurisdictions' policies collectively determine policies for using the two national systems for linkable death data: CDC's National Death Index and the Social Security Administration's full Death Master File. National access generally based on the most restrictive policy among the 57 jurisdictions.

What's Being Done? The Office of the Assistant Secretary for Planning and Evaluation's Office of Behavioral Health, Disability, and Aging and the National Institute of Mental Health are conducting a systematic inventory (https://aspe.hhs.gov/compendium-policies-use-linkable-mortality-data) of the formal policies on the use of linkable death data for patient-centered outcomes. Identifying which entities can use data, the scope of permitted uses, and requirements for use may also help identify approaches to increase the access and useability of death data systems. This in turn would increase opportunities to assess effectiveness and quality of suicide prevention efforts.

Workforce. Increased capacity is needed in states, tribes, localities, and territories to improve the accessibility and usefulness of data. These jurisdictions will need clear policies, protocols, and staff training related in data sharing, data quality standards, and data literacy at all levels. This ranges from basic data skills to advanced data science methods (see Goal 6). Improvements in these areas will impact and support best practices in areas such as collecting suicide-related morbidity and mortality data that includes information about race, ethnicity, sexual orientation, gender identity, Veteran status, and occupation. Expanding workforce training is a key component of ongoing efforts to modernize data and ensure our workforce is equipped to use these data. As the Council of State and Territorial Epidemiologists (CSTE) noted in their 2019 report *Driving Public Health in the Fast Lane: The Urgent Need for a 21st Century Data Superhighway*, "a capable workforce that uses data well ensures critical public health action to save lives." For more information, visit https://cdn.ymaws.com/www.cste.org/resource/resmgr/pdfs/pdfs2/Driving_PH_Display.pdf.

The CSTE Injury Surveillance Workgroup with support from CDC published a core set of data science competencies and developed an on-the-job training program to promote data science training at the state, territory, local, and tribal levels. For more information, visit https://www.cste.org/page/dstt-webpage.

Perspectives from Lived Experience. Agencies and organizations engaged in data collection, analysis, and reporting can benefit from insights of persons with lived experience. They can help identify what information maybe be most useful for program and policy efforts in the community. Engaging individuals with lived experience and leaders from the community ensure that data are actionable and interpreted and communicated in a way that avoids unintentionally marginalizing communities disproportionately affected by suicide thoughts, attempts, or deaths (also see Goal 7).

Evaluating the *National Strategy* and the *Federal Action Plan*. An effective *National Strategy* guides and generates activities across the public and private sectors that can ultimately play a role in reducing suicidal thoughts, attempts, and deaths. The 2024 *National Strategy for Suicide Prevention* is the first to include an action plan. The *Federal Action Plan (Action Plan)* is strategically aligned to advance *National Strategy* goals and objectives. Many of these actions directly impact states and communities. For example, expanding funding to states for comprehensive suicide prevention, training educators in suicide prevention, and expanding mobile crisis services. Additionally, states, tribes, local communities, and territories can use the *National Strategy* and *Action Plan* to create their own actions.

A forthcoming federal monitoring and evaluation plan will:

- Monitor the implementation of federal actions
- Identify relevant core indicators of *National Strategy* implementation and suicide risk reduction
- Develop an approach to evaluate progress of the *National Strategy* over the next 10 years

Effective monitoring and evaluation will help update and improve the *National Strategy*, inform policy and programmatic decision-making, and enhance future suicide prevention efforts.

What Success Looks Like

Success for Goal 10 means agencies and organizations that collect and store data related to suicide will have up-to-date, high-quality, actionable data and information that can be appropriately shared with community partners. Communities can use these data and information to strengthen suicide prevention efforts through program implementation, policymaking, and research. Clear evidence of positive impact can create momentum and lead to increased resources and support. This will benefit ongoing quality improvement in community-based suicide prevention and accelerate positive health outcomes. Additionally, a robust national effort to track implementation of the 2024 *National Strategy* will help identify areas of progress for the field as well as areas that need further investment and focus.

Examples

- Alaska uses their Violent Death Reporting System (VDRS) to bring together death certificate, medical examiner, and law enforcement data. This provides a more comprehensive pictures of violent deaths, including suicide. Alaska strengthened identification of suicide deaths within its systems and expand understanding of what circumstances preceded suicides. Alaska's VDRS data are shared with state, local, and Veteran suicide prevention partners so they can directly inform state suicide prevention planning and selection of prevention strategies for different populations across the state. For more information on how states are using VDRS to inform suicide prevention efforts, visit https://www.safestates.org/page/NVDRSStories.

- Vermont initiated the Suicide Data Linkage Project which brings together 12 data partners in the state through signed memoranda of understanding. Partners range from the Vermont Judiciary to the Vermont Department on Aging to the Vermont Violent Death Reporting System. Vermont linked cases across data sources. This allowed them to examine different public systems that people interacted with prior to their deaths. Additionally, they identified incidents, circumstances, and risk factors associated with suicide deaths. This information is being used to improve suicide prevention strategies. View Vermont's Data Linkage Project Report here https://legislature.vermont.gov/assets/Legislative-Reports/HSI-Suicide-Data-Linkage-Project-9.12.23.pdf.

- The Ohio Public Health Information Warehouse is a self-service online tool anyone can use to obtain the most recent public health data available in Ohio. The application allows users to create custom reports, charts, and maps from a variety of data sources. Users can view cause of death data and directly compare rates, numbers, demographics, and time and location of suicides and other related deaths, such as accidental overdoses or homicides. To access the Ohio Public Health Information Warehouse, visit https://publicapps.odh.ohio.gov/EDW/DataCatalog.

- The State of Washington created a syndromic surveillance program named the Rapid Health Information Network (RHINO). RHINO collects ED data on suicide thoughts and attempts from across the state into one platform that is monitored daily. Washington uses this platform to identify zip codes with case counts above what would normally be expected in a given time period. Health officers across the state get automatic alerts about increases in cases displaying unusual demographic patterns. This information is then shared with partners in the areas flagged so they can use the information to inform their local suicide prevention and postvention efforts. To learn more, visit https://www.cdc.gov/suicide/programs/ed-snsro/index.html.

What We Should Do

Below are the objectives for Goal 10 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 10.1:** Improve the quality, timeliness, scope, usefulness, and accessibility of suicide death data.

- **Objective 10.2:** Improve the quality, timeliness, scope, usefulness, and accessibility of data on suicide thoughts and behaviors and associated risk and protective factors.

- **Objective 10.3:** Identify and validate novel data and methods for suicide-related surveillance, research, evaluation, and quality improvement.

- **Objective 10.4:** Integrate data on adverse outcomes such as unintentional overdoses and other unintentional injuries with data on suicide thoughts, attempts, and deaths.

- **Objective 10.5:** Evaluate the impact of the *National Strategy for Suicide Prevention* on core indicators of *Strategy* progress and the effects on suicide thoughts, attempts, and deaths.

→ **GOAL 11:**
Promote and support research on suicide prevention.

Promote Research

Efficient and effective suicide prevention is guided by understanding the contributors to and the progression of suicidal thinking and attempts, along with related risk and protective factors. Pursuing a prioritized research agenda helps to focus efforts on the information that will have the most significant impact on addressing suicide risk.

An Action Alliance Task Force developed the *Prioritized Research Agenda for Suicide Prevention* in 2014. This agenda focused support on the research most likely to reduce suicide rates (National Action Alliance for Suicide Prevention, 2014). This allowed public and private funders to consider a common strategy to reduce suicide thoughts and attempts more efficiently. Some examples of scientific advancements over the past decade include the following:

- Developing and applying risk algorithms in health care (e.g., Shaw et al., 2022)
- Implementing Zero Suicide approaches in health care systems (e.g., RTI International, 2023)
- Testing of brief interventions (Doupnik et al., 2020)
- Informing rapid-action treatments based on safety and dosing research (e.g., Domany & McCullumsmith, 2022)

Many programs and practices now recommended in other Strategic Directions benefited from the evidence of effectiveness driven by this prioritized research. Continuing to focus on research that can have the greatest potential impact, can further contribute to the success of *National Strategy* efforts.

Some Considerations

The 2014 *Prioritized Research Agenda for Suicide Prevention* considered high-risk populations, suicide methods used, and settings where at-risk individuals may be found (e.g., EDs, criminal justice system) to focus on opportunities to save lives most quickly. These opportunities were built on available surveillance data, highlighting the importance of accessible quality surveillance investments. Although a number of intervention approaches have been found to be effective, their implementation and sustainability are important for achieving reductions in suicide prevention.

Substance use is a risk factor for suicide. New research addresses interventions for both substance use and suicide risk (see Ries et al., 2022, and Voss et al., 2013). This research resulted from improved specialty care options addressing mental disorders and addictions (e.g., Certified Community Behavioral Health Centers) and interest among primary care providers to address both issues. Moreover, growing evidence indicates that youth exposed to upstream substance use prevention programs have reduced risk for suicide thoughts and attempts in their later teens and early adulthood. This may be due to building protective factors and reducing risk factors that are common to both substance use and suicide (e.g., Posamentier et al., 2023). Leveraging public-private partnerships recommended under Strategic Direction 1 can spur other collaborative research, for example studies engaging workers from industries with increased risk of substance use and suicide (e.g., construction industry workers).

Technology-based communications present new opportunities for outreach, support, and treatment for underserved groups. Social media and digital technology are rapidly evolving and often exert dynamic influence over the thoughts and behaviors of users, particularly young people. Digital monitoring and assessment are important tools for evaluating fluctuating suicide risk. An ongoing need exists to produce high-quality and up-to-date research that can provide guidance on how best to use digital technology to support protective factors and safety during use to reduce potential harms.

Research to Practice. Implementing evidence-based and promising practices is critical for advancing suicide prevention. However, translating research findings into actionable practice, remains a challenge. Research is needed that supports expansion and reach of effective programs and initiatives in communities. Resources are needed for program evaluation (e.g., pre-, and post-surveys, training in data literacy) to establish baseline risk and potential program benefits. Adoption, implementation, and sustainment of proven interventions will also be needed. For example, a study of implementation of the effective ED-SAFE suicide prevention program in emergency care found that the reduced patient suicide risk outcomes were more pronounced over the stages of implementation. This reflects the iterative improvements that need to take place as part of continuous quality improvement (Boudreaux et al., 2023). The researchers noted that implementation of interventions in health care settings face challenges over time. These challenges include staff turnover, fatigue, and reduced adherence to the delivery of suicide preventive practices that can contribute to waning effectiveness.

Perspectives from Lived Experience. Individuals with lived experience can offer valuable perspectives from the identification of research priorities through the interpretation and communication of research results. Multiple benefits result from experiences in what's called Community-Based Participatory Research (CBPR). Some of the benefits include increased relevance and usefulness of research results, improved community trust, enhanced cultural responsiveness, and increased participation rates in research. For more information on CBPR, see https://pubmed.ncbi.nlm.nih.gov/29355352/.

Experiential knowledge of community members provides essential context for research design and results. Lived experience offers insights into real-world factors that impact the effectiveness of interventions. Individual and group experiences grounded in the local community context can help ensure equity and cultural relevance in research approaches. Clinical research that systematically develops, adapts, and validates interventions with different populations will prove the most effective for broad implementation and benefits.

Individuals with lived experience note that there is a need for more research on peer support programs identified as promising practices (Schlichthorst et al., 2020). A wide range of potential interventions are catalogued under "peer support services," however more research is needed to enhance the many ways in which peers can safely and effectively provide support.

What Success Looks Like

Achieving Goal 11 would result in focused and prioritized research studies that are valued and informed by the field and end users. These include people with lived experience, concerned family members, peers, and suicide loss survivors, among others. People who provide intervention and support to individuals struggling with suicidal thoughts or who are impacted by suicide, can use

research findings to inform their organizational, community, and policy efforts and decisions. Communication about research progress tailored to people invested in suicide prevention can instill hope. Input from the users of research remains critical to further improve and expand available evidence-based prevention efforts. Public opinion surveys increasingly indicate that people view suicide as preventable (National Action Alliance for Suicide Prevention, 2022). Knowing how to advance and sustain effective prevention strategies can ensure time and money are well-invested.

Examples

- NIMH funded multiple research efforts since 2012 to advance the evidence base for Zero Suicide's goal of preventing suicide among people treated in health care systems. This research linked medical record data to patient suicide risk and also evaluated quality improvement efforts in suicide care. Several studies developed valid suicide risk identification approaches using medical records to inform further risk assessment and intervention approaches (e.g., Simon et al., 2018; Su et al., 2020). Other research documented the degree to which outpatient mental health clinics enacted best practices for safer care. They found better adherence to Zero Suicide organizational best practices was associated with lower rates of patient suicide attempts and deaths (Layman et al., 2021).

- The Collaborative Assessment and Management of Suicidality (CAMS) intervention is a therapeutic suicide-specific risk assessment and treatment planning model. It aims to support mental health providers in shared decision-making with clients to effectively manage client suicidal thoughts and/or attempts. Multiple trials of CAMS with diverse populations found significant reductions in suicidal thoughts, symptom distress, depression, and hopelessness for individuals receiving CAMS compared to other treatment modalities (Comtois et al., 2011; Pisterello et al., 2021; Andreasson et al., 2016; Ryberg et al., 2019; Jobes et al., 2017).

- Researchers are beginning to harness digital supports in suicide prevention efforts. Youth involved in the justice system have very high rates of suicidal thoughts and behaviors. NIMH funded researchers to better connect youth at increased risk of suicide in the justice system to behavioral health services. Researchers developed e-Connect, a digital clinical decision support system (Elkington et al 2023). The support technology assisted probation officers in identifying suicide risk and helped to refer youth to appropriate services. Levels of suicide risk fell into three clinical need classifications (crisis/imminent risk, crisis/non-imminent risk, non-crisis). Compared to care as usual, probation officers using e-Connect were five times more likely to identify at-risk youth; 11 times more likely to make referrals; and youth were 17 times more likely to initiate treatment (Elkington et al., 2023).

- NIMH, as part of the National Institutes of Health (NIH) Helping to End Addiction Long-Term (HEAL) Initiative, supported multiple primary care studies to identify and test collaborative care models to better address co-occurring opioid use disorder, mental disorders, and suicide risk. Health care organizations combined medicated-assisted treatment for opiate use disorder with evidence-based treatments for co-occurring mental disorders. They brought together a primary care provider, a care manager, and a behavioral health specialty consultant for each patient. These studies track the impacts of collaborative care models on opiate use recovery; mental disorders and treatment patterns; daily functioning; and risk for premature death, including suicide.

- Peer support services in suicide prevention are thought to improve social connectedness, hopelessness, and recovery as well as engagement in services at a lower cost. The numbers of crisis services hiring peer support staff to assist in initial contacts, mobile outreach, and follow-up efforts are increasing. However, peer support services for suicide prevention would benefit from a stronger evidence base. Approaches need to support individuals being served and ensure the well-being of peers. NIMH supports research on safe and effective models of adult peer support in suicide prevention. The PREVAIL study (Lapidos, 2019) is examining how peers can enhance hope and belongingness and support acute risk management and safety planning of recently discharged psychiatric inpatients with heightened risk of suicide. The study also examines peer-developed strategies on how to safely share self-disclosures in a way that provides support to the individual being assisted and supports the peers' well-being while preventing burnout.

What We Should Do

Below are the objectives for Goal 11 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 11.1:** Identify and pursue potential high-value research opportunities informed by the 2014 resource *A Prioritized Research Agenda for Suicide Prevention*, relevant findings from subsequent research, new data and methods, and changes in the epidemiology of suicide in the United States.

- **Objective 11.2:** Expand research related to populations disproportionately affected by suicide, their prevention and treatment opportunities, and health care and other public health policies, to reduce risk.

- **Objective 11.3:** Conduct research to expand understanding of the effects of social media use and digital technology on mental health, especially among youth, and identify opportunities to expand benefits and reduce potential harms.

- **Objective 11.4:** Expand understanding of overlapping pathways of substance use and suicide risk to inform opportunities for prevention and treatment of these co-occurring conditions.

- **Objective 11.5:** Conduct research to identify suicide prevention peer support services that are effective for enhancing client self-efficacy, personal recovery, treatment engagement, and clinical outcomes.

- **Objective 11.6:** Where research has identified better practices, develop and test approaches to enable widespread implementation of such practices as standard and effective care.

STRATEGIC
DIRECTION
4

Health Equity in Suicide Prevention

Every community across the United States includes individuals who have experienced suicidal thoughts, attempts, and deaths. However, some populations are disproportionately impacted (Stone et al., 2021).

Ensuring equity in a public health approach to suicide prevention requires active collaboration to assess and meet the needs of all individuals and communities. These include those with:

- Disparate impacts
- Poor access to effective suicide prevention programs and services
- Current and past societal disadvantage or limited autonomy, such as incarcerated persons and children; Centers for Disease Control and Prevention [CDC], 2020; Honchhauser et al., 2020)

Health equity requires a commitment to recognize conditions in individuals' environments that influence their long-term health outcomes, such as suicide, and to address social determinants of health within prevention efforts (Liburd et al., 2016; U.S. Department of Health and Human Services, 2020).

Populations in the United States disproportionately impacted by suicide include non-Hispanic American Indian and Alaska Native (AI/AN) youth, middle-aged and older adults, non-Hispanic White males, rural populations, and Veterans, among others (CDC, 2023a). Suicide thoughts and attempts remain high among lesbian, gay, bisexual, transgender, queer, and questioning

(LGBTQI+) high school students (The Trevor Project, 2023). LGBTQI+ adults also experience higher rates of suicide thoughts and attempts than non-LGBTQI+ identifying adults (James et al., 2016).

In recent years (2018–2021), suicide increased significantly among females and non-Hispanic Black youth ages 10–24. Rates also increased among non-Hispanic Black persons, non-Hispanic multiracial persons, and Hispanic young adults ages 25–44 years (see Table 5; Stone et al., 2021).

Suicide attempts disproportionately impact youth ages 15–19, especially females (CDC, 2024b) and LGBQ+ young people (CDC, 2023g). Attempt rates have increased among children and youth (CDC,2024b), including non-Hispanic Black youth (CDC, 2023g).

Limited data are available on suicide among people with disabilities. However, according to a recent CDC report (Czeisler et al., 2021), during the COVID-19 pandemic, adults with disabilities were more likely to report serious suicide ideation, new or increased substance use to cope, and symptoms of anxiety and depression in the past month, compared with adults without disabilities. A study examining data from the 2015–2019 National Surveys of Drug Use and Health found that adults with a disability were over two times more likely than adults without a disability to report suicidal ideation, planning, and attempts; and adults with more limitations had progressively increased risk (Marlow et al., 2021).

While there are multiple contributors to suicide, many of these groups experiencing rapidly increasing suicide trends represent groups that have been historically marginalized (see Table 5; National Academies of Sciences, Engineering, and Medicine et al., 2017a; Saunders & Panchal, 2023). When considering these groups, it is critical to know that being of a certain age, race, ethnicity, and/or sexual or gender minority identity does not put an individual at risk. Rather, there are life experiences and circumstances that impact the lives of those individuals that increase risk (Ndugga & Artiga, 2023; The Trevor Project, 2023).

Table 5. **Disparities in suicide deaths and attempts**

Populations with Suicide Disparities	Suicide Deaths	Suicide Attempts
Disproportionately affected	• Middle aged adults 35–64 years • Older adults 75+ • Non-Hispanic American Indian/ Alaska Native (AI/AN) persons, especially ages 10–24 years • Non-Hispanic White persons, especially males • Rural populations • Veterans • Certain occupational groups, such as construction • People with less than a high school education	• Youth 15–19, especially females • LGBQ+ young people

Populations with Suicide Disparities	Suicide Deaths	Suicide Attempts
Populations with increasing rates	• Youth ages 10–24, especially females, and non-Hispanic Black youth • Hispanic and Non-Hispanic AI/AN, Black, and multi-racial persons ages 25–44	• Children/youth • Non-Hispanic Black youth

Sources (Mortality): CDC, 2023a, 2024a; Sussell, et al., 2021; Han et al., 2016; Garnett & Curtin, 2023; Stone, et al., 2023.

Sources (Morbidity); CDC, 2024b; CDC, 2023g; The Trevor Project: 2023 U.S. National Survey on the Mental Health of LGBTQ Young People; Still Ringing the Alarm An Enduring Call To Action For Black Youth Suicide Prevention (jhu.edu)

Also see Table 4 in the introduction for factors that may increase or decrease risk of suicide.

Since the release of the 2012 *National Strategy for Suicide Prevention,* promising work to address health disparity groups in suicide prevention was completed. Examples include the following:

- In 2014, the National Action Alliance for Suicide Prevention (Action Alliance) released *The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience*. This guide describes how to create sustainable suicide prevention programing, practices, and policies that are informed and driven by individuals with suicide-centered lived experience.

- In 2019, the U.S. Department of Veterans Affairs (VA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Governor's Challenge. This convening brings state policymakers and leaders together to develop and implement a comprehensive suicide prevention plan to prevent suicide among service members, Veterans, and their families (SMVF). In the same year, VA approved Suicide Prevention 2.0 (SP 2.0), a population-based public health model to reach Veterans both inside and outside VA care. SP 2.0 moves suicide prevention beyond a one-size-fits-all model to a blended model combining community-based prevention strategies and evidence-based clinical strategies. It empowers action at the national, regional, and local levels. The program aligns state Governor's Challenge initiatives and the Together With Veterans rural peer-to-peer initiative, and brings VHA Community Engagement and Partnership coordinators to help communities adapt an evidence-informed public health model to local needs and resources.

- In 2020, CDC launched its Comprehensive Suicide Prevention program to address suicide in populations disproportionately affected by suicide and suicide attempts. As of September 2023, CDC funded activities in 23 states and one territory.

- In 2021, in response to the COVID-19 pandemic, the American Rescue Plan Act funded CDC's National Institute for Occupational Safety and Health to develop and launch its Health Worker Mental Health Initiative. https://www.aha.org/suicideprevention/health-care-workforce/suicide-prevention-guide

- In 2021, the Suicide Prevention Resource Center (SPRC) established the Lived Experience Advisory Committee to help guide messaging and programming for SPRC.

- In 2022, the National Academies of Sciences, Engineering, and Medicine held a three-part virtual public workshop series focused on suicide prevention in Indigenous communities. See https://nap.nationalacademies.org/read/26745/chapter/2.

- In July 2023, SAMHSA hosted a three-day Black Youth Suicide Prevention Initiative Policy Academy. It featured and connected resources and strategies from the public and private sectors to enhance Black youth suicide prevention. The goal of the ongoing Center for Mental Health Services Black Youth Suicide Prevention Initiative is to reduce the suicidal thoughts, attempts, and deaths of Black youth and young adults between the ages of 5 and 24 in the country. The policy academy supported eight state teams in developing action plans to reduce suicidal thoughts, attempts, and deaths among Black youth in their state. They identified important data sources, risk and protective factors, opportunities for strategic partnerships, avenues for community and youth leadership, and communication and evaluation strategies. Each state received support from an external subject matter expert in Black youth suicide to support their action plan development. This model will be used for a policy academy on older adult suicide headed by the SAMHSA Evidence Based Practices Resource Center. Multi-disciplinary state teams will gather to develop action plans to address older adult suicide in their respective states.

Much more work is needed to address populations disproportionately impacted by suicide to reduce and eliminate health disparities. Strategic Direction 4 includes ways that various sectors and communities can engage in this important work.

Goal 12 emphasizes including voices of suicide-centered lived experience and populations disproportionately affected by suicide in all suicide prevention planning, practice, and partnerships in the public and private sectors. This goal focuses on upstream suicide prevention that addresses social determinants of health and emphasizes effective youth-, peer-, and community-run interventions.

Goal 13 outlines the need for comprehensive suicide prevention strategies specifically developed for a range of populations disproportionately impacted by suicide and historically marginalized populations at risk. Specific populations need effective interventions that consider their unique strengths, community barriers, and resources.

Tribal Population Considerations

Multigenerational trauma can be experienced by people from a particular cultural, racial, or ethnic group. American Indian and Alaska Native (AI/AN) people are one such group. Clinician and researcher Maria Yellow Horse Brave Heart describes such trauma as historical trauma and defines it as "cumulative emotional and psychological wounding over the life span and across generations, emanating from massive group trauma experience" (Brave Heart, 2003). The impacts on communities experiencing historical trauma are profound.

For Indigenous people, specifically, the historical trauma of colonization, intergenerational grief, forced removal from ancestral lands, violence, boarding schools, and cultural assimilation, combined with poverty, institutional racism, and discrimination negatively impact overall physical and mental health and may increase risk for suicide and suicide attempts (Big Foot, 2021; Ehlers et al., 2022).

Tribes and tribal organizations are addressing prior and present harm by establishing and offering culturally-based services. Tribal organizations have long provided the necessary Indigenous knowledge and findings, and critical cultural-based approaches that are effective in Indian country to prevent and reduce suicide (Cwik et al.,2016). Casey Family Programs and the Johns Hopkins Center for Indigenous Health conducted a two-year study that found, "The well-being of the individual is inseparable from the well-being of the community. Individual healing and the healing of the entire community must go hand in hand," (Johns Hopkins Bloomberg School of Public Health, n.d.) https://cih.jhu.edu/programs/cultureforward/.

Multiple federal agencies (e.g., SAMHSA, NIH, CDC) support studies in which tribes are strengthening culturally relevant practices in order to reduce suicidal thoughts and attempts, as well as substance use, in their communities. Some of these activities include traditional drumming and dance, sweat lodges (Schiff & Moore, 2006), use of Native languages (Hilf, 2017), beading, and traditional hunting, fishing and planting practices to improve food sovereignty (U.S. Department of Agriculture, n.d.).

Federal agencies are committed to recognizing the systemic inequities experienced by Indigenous communities. Examples include the Administration for Children and Families resources on historical trauma (https://www.acf.hhs.gov/trauma-toolkit/trauma-concept) and SAMHSA's tribal-specific focus on suicide and substance use prevention as part of Native Connections and many other grant-funded programs. See https://www.samhsa.gov/native-connections for more information.

Goal 14 seeks to increase and enhance diversity in the suicide prevention workforce. Cultivating an inclusive pool of professionals trained in health equity and suicide prevention best practices who provide a range of perspectives will facilitate the success of prevention, intervention, and postvention efforts described here and throughout the strategy.

Finally, Goal 15 highlights ways to improve surveillance and suicide prevention practices to better meet the needs of the diversity of populations disproportionately affected by suicide. As mentioned in Strategic Direction 3, suicide-specific data that accounts for factors such as race, ethnicity, geographical location, disability, occupation, Veteran status, sexual orientation, and gender identity can signal to prevention staff where efforts would be most effective in reducing suicidal thoughts, attempts, and deaths.

There remains a need to conduct research dedicated to developing culturally-specific and effective interventions, including among groups largely left out of suicide prevention research and engagement. These populations include individuals with disabilities, such as the deaf and

hard of hearing communities; people with neurodiverse conditions; and certain industries and occupational groups, such as construction and mining, health care workers, and first responders. As the demographics of our country continue to change, the need for a wide array of culturally responsive and tailored approaches in suicide prevention is increasing.

→ GOAL 12:
Embed health equity into all comprehensive suicide prevention activities.

Embed Health Equity

Social determinants of health can impact multiple health outcomes including suicidal thoughts, attempts, and deaths. Differences in the distribution of formal policies, programs, institutional practices, and access to resources resulted in suicide health disparities (National Academies of Sciences, Engineering, and Medicine et al., 2017b). Groups experiencing disparities can be identified by characteristics such as age, race, ethnicity, sexual orientation, gender identity, disability, chronic conditions, and geographical location, among others. Engaging people in communities where they live, work, learn, play, and/or worship and addressing health equity throughout the planning, implementation, and evaluation of comprehensive suicide prevention helps reinforce protective factors and break down prevention barriers, thereby paving the way for improved success (CDC, 2023b; Office of the Surgeon General, 2021).

Some Considerations

Social determinants of health: A comprehensive approach to suicide prevention considering changes over the life span help embed health equity into prevention efforts. As people age, they interact in different settings and may face additional or new risk and protective factors leading to changes in prevention needs. For example, risk and protective factors for suicide will likely differ between youth and adults or between middle-aged and older adults. These changes may differ further still among people with serious mental or physical illness. As mentioned in Strategic Direction 1, the impact of social determinants of health as risk and protective factors can be compounded over time and affect people different over the course of their lives. When developing prevention strategies, consider developmental and/or transitional periods when unique risk and protective factors are present.

Suicide prevention planning: Many states, tribes, local communities, and territories develop suicide prevention plans outlining goals and strategies to reduce suicidal thoughts, attempts, and deaths within the jurisdictions and populations they serve. Goals and objectives related to effective policies, programs, and practices for populations disproportionately impacted by suicide thoughts, attempts, and deaths can increase the likelihood of preventing suicide. This also ensures health equity remains a priority (Perry et al., 2022). Research suggests that addressing the role that discrimination and racism play in increasing suicide risk can increase help-seeking behaviors and reduce the risk of suicide thoughts and behaviors for disproportionately underrepresented groups (Saewyc, 2014; Child Trends, 2022).

Community and youth engagement: When focusing on specific populations, include community leaders and individuals with lived experience from those populations. Doing so can help improve intervention success by identifying and addressing barriers in prevention implementation that might not be currently known or visible. It can increase the credibility of prevention messages

and programs. For example, firearm owners can provide insight on how to talk about safe and secure storage in a culturally sensitive and inclusive way. People with lived experience can offer culturally specific perspectives about the social and structural factors that contribute to suicide risk and protection.

Similarly, suicide prevention efforts that engage and empower public and private sector community partners can improve the likelihood of success, especially for historically marginalized and disproportionately affected populations. For example, connecting with partners who can address social determinants of health, such as unemployment and housing or food insecurity, can be instrumental in addressing upstream challenges that may increase suicide risk.

What Success Looks Like

Success for this goal will look like comprehensive suicide prevention efforts that include attention to health equity from initial planning through implementation and evaluation. This includes collaborating with partners to address social determinants of health and engaging populations disproportionately affected by suicide. Programs and resources will be focused on community-defined needs, decreasing health disparities and improving prevention outcomes.

Examples

- Data showing that Black youth suicide rates had significantly increased over the past decade prompted the Congressional Black Caucus (CBC) to establish the Emergency Taskforce on Black Youth Suicide and Mental Health (Taskforce) in April 2019. This group included the country's leading Black academic, research, and practice experts. The Taskforce gathered feedback directly from Black youth on suicide and mental health so their perspectives and experiences could guide Taskforce efforts. The 2020 Taskforce report outlined recommended policies and actions for diverse community sectors and partners in addressing Black youth suicide. It ranged from increasing research and funding to investing in the development of evidence-based interventions for preventing Black youth suicide (Congressional Black Caucus on Black Youth Suicide and Mental Health, 2020). To read the full report, visit https://theactionalliance.org/resource/ring-alarm-crisis-black-youth-suicide-america.

- SAMHSA's Service Members, Veterans, and their Families (SMVF) Technical Assistance Center provides support to states and territories to develop committees that promote mental health and reduce suicide in the military and Veteran community. These committees include active-duty military service members, Veterans, and community mental health and suicide prevention professionals. In 2019, SMVF launched the Interagency Leadership Initiative. This initiative brought together 23 state and territorial SMVF teams to strengthen state leadership support for and collaboration in military-specific mental health and suicide prevention strategic plans. The SMVF teams focused on strengthening implementation of their strategic plans with diverse initiatives. These ranged from ensuring access to mental health care to expanding peer support and military culture training in community service providers. Their goal was to reduce risk factors for suicide such as substance use, homelessness, military sexual trauma, and incarceration. To learn more about the SMVF TA center, visit https://www.samhsa.gov/smvf-ta-center/about.

- The White Mountain Apache Tribe used tribal data to gather and track information on suicide thoughts, attempts, and deaths on their reservation. These data allowed them to focus prevention and intervention efforts where they were needed most. Their efforts helped reduce the suicide rate over time for the reservation, despite general population increases during the same time period (Cwik et al, 2016). To read more about this success story, visit https://sprc.org/news/white-mountain-apache-tribe-decreases-suicide-deaths-and-attempts/.

- Prevent Suicide Wisconsin created a free webpage featuring resources, statistics, and information on suicide risk and suicide behavior among individuals with disabilities. Resources and information are specifically for individuals living with autism, epilepsy, and Tourette's syndrome, and for those who are deaf or hard of hearing. The webpage describes the importance of organizations committed to suicide prevention also being committed to understanding disabilities and recognizing the dignity and worth of all people. To learn more, visit https://www.preventsuicidewi.org/people-with-disabilities.

- In 2021, SPRC launched the Lived Experience Advisory Committee (LEAC) which brings together external advisors who have various forms of suicide-centered lived experience. The LEAC has provided guidance for a variety of resources for the field. Insight from LEAC member contribute to positive messaging, enhanced safety, and a stronger awareness of the unique needs of the lived experience community and opportunities for addressing those needs. LEAC members also help SPRC to identify new and unique ways to promote the involvement of lived experience in suicide prevention efforts. These include publishing lists of recommended actions that states and territories can take to engage those with lived experience in collection of suicide prevention needs assessment data. To learn more about the SPRC LEAC, visit https://sprc.org/lived-experience-advisory-committee/.

What We Should Do

Below are the objectives for Goal 12 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 12.1:** Improve community-based suicide prevention by incorporating perspectives and recommendations from populations disproportionately affected by suicide and from people with diverse suicide-centered lived experience.

- **Objective 12.2:** Address social determinants of health and systemic issues impacting suicide risk among those disproportionately affected by suicide across the life span.

- **Objective 12.3:** Incorporate suicide prevention activities with consideration to age, race, ethnicity, sexual orientation, gender identity, disability, chronic conditions, and geographical location into all prevention efforts, as applicable.

- **Objective 12.4:** Promote upstream protective factors among populations disproportionately affected by suicide across state, tribal, local, and territorial suicide prevention efforts.

- **Objective 12.5:** Fund and increase effective community, peer, and youth-led suicide prevention activities and initiatives.

- **Objective 12.6:** Engage and incorporate public and private sector partners with experience working with populations disproportionately affected by suicide into suicide prevention activities.

→ **GOAL 13:**

Implement comprehensive suicide prevention strategies for populations disproportionately affected by suicide, with a focus on historically marginalized communities, persons with suicide-centered lived experience, and youth.

Focus on Special Populations

Preventing suicide requires focusing on populations disproportionately affected or where suicide rates are increasing. Effective prevention efforts require considering unique strengths, challenges, barriers, and resources. The Cultural Theory and Model of Suicide includes three considerations for understanding how culture impacts suicide, as follows:

- Culture affects the types of stressors associated with suicide

- Cultural meanings associated with stressors and suicide affect the development of suicidal thoughts, one's threshold of tolerance for psychological pain, and subsequent suicidal acts

- Culture affects how suicidal thoughts, intent, plans, and attempts are expressed (Chu et al., 2010)

The model was developed by analyzing suicide research among African American, Asian American, American Indian and Alaska Natives, and LGBTQ+ adults, but culture expands beyond race and ethnicity, sexual orientation, and gender identity. Other groups may also fit the model based on the above characteristics, including people with disabilities (Marlow et al., 2021), rural populations, and Veterans, among others. Collaborating with people who are part of these groups can help address suicide risk factors, develop focused interventions, improve risk assessment tools, and improve communication regarding suicide prevention activities.

Some Considerations

Developing focused prevention and intervention strategies: It is important to consider current and historical events impacting broad population risk like the COVID-19 pandemic or culturally specific risk such as historical trauma experienced by racial/ethnic groups. These events not only can impact people now, they can also impact future generations. CDC's 2022 data indicate that older adults above the age of 75 had the highest suicide rates among all age groups (CDC, 2024a). Developing suicide prevention protocols for older adults where they live and receive care could decrease their risk.

Rural communities continue to see increases in suicide rates (CDC, 2023e). Suicides in non-urban environments increased 46% between 2000 and 2020 (CDC, 2023e). Non-Hispanic White males and American Indian and Alaska Native people are disproportionately represented in rural suicides (CDC, 2023e). Improving systems to address the needs of rural communities remains a key priority in suicide prevention plans and efforts. Evaluation of SAMHSA's Garrett Lee Smith State and Tribal Youth Suicide Prevention grants found reductions in youth suicide in counties implementing grant-funded activities were greater in rural counties than in urban counties, although sparsely populated rural counties with less than 2,000 youth were excluded from the analyses (Walrath, 2015).

Those experiencing barriers to care and support may use social media sites to connect, especially youth and young adults. These networks present opportunities to provide support and resources. For example, online settings can offer safe spaces for LGBTQI+ persons to access effective care services.

Perspectives from lived experience: Recognizing the strengths and challenges associated with specific populations reflects cultural humility and respect. Including people from historically marginalized groups in program development and delivery supports the dignity of individuals by countering negative stereotypes and perceived limitations. Individuals who have been impacted by suicide have key roles to play in informing suicide prevention efforts. These include persons with lived experience, persons in groups disproportionately impacted by suicide, associated family members/caregivers and peers, those overseeing and providing programs and health care.

What Success Looks Like

Suicide prevention initiatives will reflect the characteristics and circumstances of specific populations, build on their strengths, and address their unique barriers and challenges. The result will be tailored interventions that directly address community needs and decrease suicide risk.

Examples

- The Farm State of Mind American Farm Bureau Association hosts a resource directory of materials for addressing and understanding stress, mental health concerns, and suicide risk for farmers and farm families. It includes key research, trainings on rural resilience, and information on opioid use. To learn more about the initiative, visit https://www.fb.org/initiative/farm-state-of-mind.

- Native Americans for Community Action (NACA) identified an ongoing disparity in Arizona. Most of the youth in their community juvenile justice detention center were from two towns on a local Native American reservation. NACA chose an evidence-based program called Coping and Support Training (CAST) to implement with the schools in these towns. The goal was to help 13–17-year-old youth manage emotions in healthy ways, make healthy decisions, reduce substance use, and improve grades. Six schools participated in the program. Teachers led curriculum implementation and received direct feedback and support from NACA throughout the process. Pre- and post-test results each have shown improvements in students' self-reported sense of self-worth, coping ability, and school connectedness. This has helped minimize youth risk for entry into the justice system and served as protective factors against long-term suicide risk. To read the full success story, visit https://sprc.org/news/building-life-skills-connectedness-and-resilience-in-youth/.

- The Trevor Project developed and released two social media guides for LGBTQ+ youth providing recommendations for creating online spaces to promote youth well-being and minimizing exposure to unsafe and harmful content. *Online Safety for LGBTQ Young People* was the first guide released in 2023. It provides strategies that apply to many different social media platforms. *Protect Your Space and Well-Being on Instagram* was the second guide. It provides strategies to control one's Instagram feed with unique "how to" information for each recommendation. Recommendations in both guides center on managing the types of posts and comments in newsfeeds, considering who to interact with on social media and how to increase positive social connections. It also recommends steps to take to get help if someone is worried about themself or someone else on social media.

- The Center for Elderly Suicide Prevention at the Institute on Aging (The Center) provides counseling, referrals to community services, grief support programs, and wellness checks for older and disabled adults in California. The Center developed the Friendship Line California to serve both a crisis intervention hotline and a non-emergency emotional support warmline. The Friendship Line supports older adults and individuals with disabilities by encouraging phone calls focused on any broad-based needs or concerns. The Friendship Line was developed in response to local data showing that older adults were not calling regular crisis lines because they didn't see themselves as in crisis, but they were struggling with loneliness and depression. To learn more visit https://www.ioaging.org/services/all-inclusive-health-care/psychological-services/center-for-elderly-suicide-prevention/.

What We Should Do

Below are the objectives for Goal 13 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 13.1:** Implement and evaluate focused suicide prevention activities across the life span that address the increasing rate of suicide thoughts, attempts, and deaths within racial, ethnic, and historically marginalized groups.

- **Objective 13.2:** Increase awareness and understanding of the unique barriers and challenges of rural communities to better inform and improve suicide prevention activities.

- **Objective 13.3:** Increase awareness and understanding of the unique barriers and challenges of military and Veteran status to improve suicide prevention among service members, Veterans, and their families.

- **Objective 13.4:** Increase suicide prevention programs, practices, and policies in support of and in collaboration with LGBTQI+ individuals.

- **Objective 13.5:** Improve and expand suicide prevention programs, practices, policies, and crisis response in child welfare, criminal and juvenile justice, behavioral health, and other systems serving populations disproportionately affected by suicide and ensure ongoing staff training and development.

- **Objective 13.6:** Leverage social media use for youth and young adults to support suicide prevention efforts.

- **Objective 13.7:** Develop research priorities and implement prevention strategies to address the high rate of suicides among older adults.

→ GOAL 14:
Create an equitable and diverse suicide prevention workforce that is equipped and supported to address the needs of the communities they serve.

Focus on Workforce Equity

Diversifying the behavioral health workforce, expanding multilingual services, and improving inclusivity in health care workplaces can help provide support for individuals of various cultures to receive the best standard of care. Approaches that emphasize cultural humility and inclusivity can help break through the structural aspects of social determinants of health. Formal training and

organizational leadership support can help professionals embrace principles of cultural respect and responsiveness. Mental health treatment research shows people of color who match their providers' racial identity are more satisfied with their care and perceive better quality of care (Meyer & Zane, 2013). However, many racial and ethnic groups are underrepresented among mental health professionals, especially psychiatrists (Wyse, et al., 2020). The suicide prevention workforce will benefit from tools and resources that help them more effectively serve communities.

Improving workforce training in settings where people are disproportionately impacted by suicide can also be an effective suicide prevention strategy. For example, youth who are involved with the child welfare system are 3–5 times more likely to die by suicide compared to youth in the general population (Katz, et al., 2011; Segal, et al., 2021). Risk factors may include the experience of interpersonal violence; abuse or neglect; housing, economic, and caregiving instability; and low levels of connectedness (Castellví, et al., 2017). Child welfare leadership and staff are natural partners for suicide prevention due to their unique access to this grouped disproportionately impacted by suicide.

Some Considerations

Addressing bias: Many historically marginalized groups experience bias and discrimination in mental health care settings (Mays, et al., 2017). These encounters can create a lack of trust and impact future help-seeking practices. In one study, reported LGBTQ+ individuals who reported a lack of trust with their mental health providers were less likely to be satisfied with their care and less likely to seek further mental health treatment (Schuller & Crawford, 2022). These experiences show the need for change in cultural responsiveness because health care services play a vital role in suicide prevention as described in Strategic Direction 2. Cultural responsivity requires examining institutional policies and practices to identify barriers to health equity. Increasing training around cultural humility and anti-bias work to reduce the likelihood of adverse experiences for people receiving mental health care. Including cultural responsiveness in professional standards will convey the importance of education about health equity. Training and technical assistance can further enhance the knowledge and skills of professional education.

Perspectives from lived experience: People from historically marginalized groups can contribute important information to education and training for other professionals. As partners or independent training providers, individuals from racial, ethnic, and historically marginalized groups can contribute to the cultural education of suicide prevention professionals. Topics could include insights about culture-specific lived experience and appropriate supports for social connections. It is essential this work is mutually beneficial for both the suicide prevention field and historically marginalized groups, rather than the latter individuals only offering their expertise.

What Success Looks Like

Success for Goal 14 will mean an increasingly knowledgeable and diverse workforce in suicide prevention. Initiatives will have enhanced capability for serving racial, ethnic, and historically marginalized communities. As a result, program outcomes will match the unique needs and challenges that contribute to suicide risk in populations disproportionately impacted by suicide.

Examples

- The U.S. Department of Health and Human Services houses the National Culturally and Linguistically Appropriate Services (CLAS) Standards that provide a blueprint for health care organizations to advance health equity, improve health care quality, and eliminate health care disparities. The Office of Minority Health used the CLAS standards to develop the Think Cultural Health website. This site provides free accredited online educational programs for a variety of health care professions. These include physicians, nurses, behavioral health providers, and disaster and emergency management personnel. Each program provides focused information for the given professions to build their knowledge, skills, and awareness of cultural and linguistic competency. To learn more about the CLAS standards and associated programs and resources, visit https://thinkculturalhealth.hhs.gov/clas/standards and https://minorityhealth.hhs.gov/cultural-and-linguistic-competency.

- The Massachusetts Coalition for Suicide Prevention Alliance for Equity released the *Widening the Lens: Exploring the Role of Social Justice in Suicide Prevention—A Racial Equity Toolkit* in 2021. This toolkit was developed through the coalition's efforts to center social justice within their suicide prevention efforts. It provides a series of actions and processes that local organizations and community groups can use to have conversations and institute practices. These actions acknowledge and address suicide prevention and racial equity, cultural humility, intersectionality, and more. The toolkit includes case studies, exercises, and handouts that can used to guide them through system and culture change necessary to address social justice and racial equity. To access the toolkit, visit https://www.mcspnow.com/_files/ugd/6ba405_6e9b04a98de444978b4c502e64a6af6d.pdf.

- The Star Behavioral Health Provider (SBHP) training was created and launched in 2011. It was designed through a partnership between the Military Family Research Institute at Purdue University, the Center for Deployment Psychology, the Indiana National Guard, and the Indiana Family and Social Services Administration. Since that time, the training expanded to 32 states and is available through universities, military branches, and state agencies. SBHP training provides community mental health providers with education on military culture, context, and resources to increase their effectiveness supporting service members. The SBHP training maintains an updated and searchable list of mental health providers who participated in culturally competent military and Veteran trainings to increase military access to providers better able to support them. To learn more about the SBHP program, visit https://starproviders.org/.

- Michigan's Department of Health and Human Services collaborated with members of the University of Michigan's Youth Depression and Suicide Prevention Research Program and the state's Child Welfare Administration to implement the state's Garrett Lee Smith (GLS) Youth Suicide Prevention program. Michigan's GLS project incorporated workforce training, screening, and protocol development within the child welfare system. Training and support focused on reaching staff at pre-service, as a new hire, and at continuing education time points with evidence-informed programs and strategies. These efforts included hosting LivingWork's safeTALK trainings for foster care agencies (Kahsay, et al., 2020), providing in-person and virtual conferences, and developing free publicly available suicide prevention learning modules for Michigan higher education child welfare courses. The GLS team developed best-practice protocol recommendations that support child welfare staff in responding to youth with an

elevated risk for suicide. The GLS team also participated in developing learning resources and protocols focused on safe household firearm storage (Magness, et al., 2023). To learn more, visit https://firearminjury.umich.edu/education-training/childwelfare/.

What We Should Do

Below are the objectives for Goal 14 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 14.1:** Increase access to training and technical support for professionals and graduate students to improve cultural humility and responsiveness toward historically marginalized groups and individuals with suicide-centered lived experiences.

- **Objective 14.2:** Focus equity education and awareness on health care professionals and settings to address existing barriers and reduce stigma.

- **Objective 14.3:** Increase the number of professionals in suicide prevention from historically marginalized communities, people with suicide-centered lived experience, and other populations disproportionately affected by suicide.

- **Objective 14.4:** Create professional standards around suicide prevention, intervention, and postvention with a dedicated competency focused on working with populations disproportionately affected by suicide.

- **Objective 14.5:** Ensure historically marginalized groups are provided crisis support and response strategies grounded in cultural humility and inclusivity.

→ GOAL 15:
Improve and expand effective suicide prevention programs for populations disproportionately impacted by suicide across the life span through improved data, research, and evaluation.

Improve Data, Research, and Evaluation

Quality data form the foundation for effective initiatives. These data can help identify problems and track changes over time. In some cases, increasing access to existing data sources is needed, while in other instances, the data have yet to be collected (e.g., improving equity in recruitment in clinical trials) (Buffenstein et al., 2023). Accurate assessment of health disparities can focus efforts for improving research and evaluation with populations disproportionately affected by suicide. Improving suicide prevention initiatives will depend on awareness and dissemination of evidence-informed best practices.

Some Considerations

Collaboration: Intervention trials and community surveys contribute to better understanding of populations disproportionately impacted by suicide. They improve recruitment and collection of demographic data of understudied groups. Changes in organizational policy or infrastructure and resources may be necessary to optimize the benefits of enhanced data collection. Partnerships between agencies that collect suicide-related surveillance data and community organizations that include people disproportionately affected by suicide can improve available data. As previously

mentioned, collaboration with tribal nations' must consider the authority of tribes to administer the collection, ownership, and application of their own data.

Universities and other higher education institutions play a major role in developing research projects throughout the country. More data are needed to better understand risk and protective factors, unique warning signs, and effective interventions for populations disproportionately impacted by suicide. Also, more research is needed regarding the impact of structural issues such as racism and discrimination on suicide risk among various racial and ethnic groups and LGBTQI+ individuals to inform mental health-interventions and policies. To support this work, research teams may consider including co-leads and/or advisory groups from disproportionately affected populations in planning and implementation as part of community-based participatory research approaches.

Informing clinical care: Health care systems play a crucial role in multiple areas of suicide prevention, as noted in [Strategic Direction 2](#) and [Goal 14](#). Existing practices and requirements tracking health indicators and maintaining documentation creates possibilities for collecting and utilizing data related to health equity. In many cases though, screening and assessment tools being used were not tested or validated among people of different race, ethnicity, age, or groups of disproportionately affected people. Suicide prevention work can be improved with data collection and clinical practice that use culturally appropriate screening and assessment tools.

Perspectives from lived experience: Incorporating perspectives from individuals within the community provides insights into the research and evaluation priorities most relevant for populations disproportionately affected by suicide. Lived experience can also help identify new possibilities for disseminating and implementing culturally appropriate evidence-based programs. These types of collaborative partnerships can generate increased funding and resources for suicide prevention.

What Success Looks Like

Success of Goal 15 means that more complete demographic characteristics would be included in all major surveillance, research, and evaluation projects related to suicide. Health care settings would employ culturally appropriate screening and assessment tools and people with lived experience would contribute to research development, implementation, and evaluation. As a result, suicide prevention would experience more rapid progress in understanding and addressing the needs of populations that are disproportionately affected by suicide.

Examples

- Both SAMHSA and CDC have provided historic levels of investment in suicide prevention research, programming, evaluation, and data collection over the past decade. SAMHSA's grant programs enable universities and agencies across states, communities, and tribes to develop and test effective interventions for youth suicide prevention. These include the Garrett Lee Smith Campus Suicide Prevention and State and Tribal grants. Grants to Implement Zero Suicide in Health Systems contribute to a growing body of research and best practices on how to prevent suicide in health care. CDC funding to expand Violent Death Reporting Systems to all 50 states, the District of Columbia, and Puerto Rico provides significantly more data available to inform suicide prevention programming. CDC's recent

launch of its Comprehensive Suicide Prevention program funds recipients to use data-driven decision-making to implement and evaluate the best available evidence for suicide prevention in populations disproportionately impacted by suicide.

- The Cultural Assessment of Risk for Suicide (CARS) created a screening assessment tool that addresses cultural variations in the presentation of suicide risk. CARS was informed by the Cultural Theory and Model of Suicide (described in Goal 13). This model characterizes the many cultural variations in suicide risk among ethnic and sexual minority groups. The tool was tested with 950 adults from the general population. Minority participants reported experiencing the cultural risk factors identified in the tool to a greater extent than non-minority participants. Results also showed reliability in identifying cultural suicide risk factors not available in other assessment tools. Ultimately, CARS can help behavioral health providers measure cross-cultural variations in suicide-related distress, meaning, risk and protective factors, intention, and plans. To learn more about CARS, visit https://www.researchgate.net/ publication/235378188_A_Tool_for_the_Culturally_Competent_Assessment_of_Suicide_The_ Cultural_Assessment_of_Risk_for_Suicide_CARS_Measure.

- The Columbia-Suicide Severity Rating Scale (C-SSRS) is a suicide risk screening and assessment tool developed in 2007. Since that time, the C-SSRS has been used extensively and further evaluated, receiving gold standard status from the U.S. Food and Drug Administration making it a preferred evidence-based instrument for measuring suicidal ideation (Giddens et al., 2014). Over the past decade, the Columbia Lighthouse Project evaluated the C-SSRS within different settings and in different populations. These included with first responders, and in health care, military, school, and carceral settings. The Columbia Lighthouse Project adapted the C-SSRS screening for different groups by creating C-SSRS "cards" that include key C-SSRS questions and focused content for participant groups. To learn more about the C-SSRS, visit https://cssrs.columbia.edu/.

- The AAKOMA Project's 2022 State of Mental Health of Youth of Color surveyed 2,905 youth of color to better understand their experiences of mental health challenges, suicide thoughts and attempts. The sample was composed of Black (20%), Latino (32%), Asian American/ Pacific Islander (19%), Native American (15%) and multicultural (20%) youth ages 13–17. Youth reported moderate to severe symptoms of anxiety (50.1%) and depression (53%) in the past seven days. More than 25% of youth reported serious thoughts of suicide and 18% reported at least one suicide attempt in the past year (Breland-Noble, 2023). To learn more, visit https://aakomaproject.org/somhyoc2022/.

- The Rural Health Information Hub houses the Rural Data Explorer. The Rural Data Explorer is a useful tool for anyone seeking to understand disparities among different demographic groups within metro and non-metro regions of the United States. The Explore provides a variety of data sources in one central public-facing platform that is easy to use and navigate. Examples of data sources include the U.S. Census Bureau, the National Center for Health Statistics, and the Health Resources and Services Administration (HRSA) Area Health Resources Files. Users can explore state and county level data and organize it according to metro vs. non-metro status. Data can also be organized by age, race, ethnicity, tribal, and Veteran status demographics. Social determinants of health, from poverty rates, to education, to health care access can be explored. To access the tool, visit https://www. ruralhealthinfo.org/data-explorer.

- In 2023, SPRC re-launched a new Best Practice Registry (BPR). The registry includes suicide prevention programs, policies, and practices with evidence of effectiveness in preventing suicide or addressing suicide risk and protective factors. The BPR centered the goal of increasing health equity within best-practice programs. SPRC encourages submission of programs into the registry that are guided by the following:
  - Varied frameworks
  - Known best practices in the field of suicide prevention or related fields such as substance use or violence prevention
  - Culturally relevant approaches and local knowledge

  The BPR allows users to search listed programs by those that have been tested with different populations and in different places and settings. This enables users to choose programs that better align with their local cultures, populations, and contexts. To visit the SPRC BPR, visit https://bpr.sprc.org/.

- The National Institute of Mental Health (NIMH) is providing two rounds of funding in fiscal years 2023 and 2024 supporting research projects that examine risk and protective factors for suicide unique to African American or Black youth under the age of 25. This funding encourages researchers to do the following:
  - Examine the role of social determinants of health within Black youth risk and protective factors
  - Develop new or adapted methods for assessing suicide risk among African American or Black youth through culturally appropriate mechanisms
  - Develop an understanding of Black youth suicide that can contribute to more effective prevention and intervention efforts

  NIMH encourages applicants to identify strategies for facilitating research participation among Black youth and their families and strategies to engage diverse research professionals representing the fields of minority mental health, health disparities research, and suicide research, among others. To view the funding announcement, visit https://grants.nih.gov/grants/guide/rfa-files/RFA-MH-22-141.html.

- The U.S. Department of Veteran Affairs (VA) releases the *National Veteran Suicide Prevention Annual Report* every year. It brings together data from military, Veteran, and public health sources, such as the Veterans Health Administration records and CDC's National Death Index. Data are linked with death certificate data which allows VA to better understand the demographics, circumstances, and risk and protective factors related to military Service Member and Veteran suicide deaths. The VA can use demographic and circumstantial data to identify the following:
  - Subgroups of Veterans disproportionately impacted by suicide
  - What means of suicide are being used
  - What services Veterans interact with prior to their deaths

  The report also includes data-informed calls to action that both the military and broader community agencies can take up to help prevent suicide. To read the most current *National Veteran Suicide Prevention Annual Report*, visit https://www.mentalhealth.va.gov/suicide_prevention/data.asp.

What We Should Do

Below are the objectives for Goal 15 that will help advance the *National Strategy* to improve suicide outcomes in the country.

- **Objective 15.1:** Increase funding for academic and community-led research on, and evaluation of, effective suicide prevention activities in populations disproportionately impacted by suicide.

- **Objective 15.2:** Develop, disseminate, and evaluate specific and culturally informed screening tools to address suicide among populations disproportionately affected by suicide.

- **Objective 15.3:** Ensure that suicide-related data used for surveillance, research, evaluation of prevention and treatment, and quality improvement enable assessment of disparities, especially for populations disproportionately affected by suicide.

- **Objective 15.4:** Improve the awareness and dissemination of culturally relevant suicide prevention best practices among populations disproportionately affected by suicide.

- **Objective 15.5:** Support the development of promising practices and practice-based evidence to inform suicide prevention in historically marginalized and excluded groups through funding, resource provision, and prioritization practices.

- **Objective 15.6:** Enhance data sharing, data linkage, and translation of data to action across community groups to improve suicide prevention in historically marginalized groups and groups disproportionately impacted by suicide.

From Strategy to Action

The *National Strategy* provides a framework and foundation to organize action on suicide prevention across the United States. It allows people to work together in large organizations and small to identify what actions have the greatest potential to reduce the impact of suicide for Americans. The associated *Federal Action Plan* represents the federal government's first three years of actions to implement the strategy. It also represents a starting point for other organizations and communities to develop their own plans—a way for the whole nation to work together to reduce the toll of suicide.

Glossary

absenteeism: Prolonged time away from work or series of absences from work due to illness. See also *presenteeism*.

adverse childhood experiences (ACEs): Potentially traumatic events that occur in children's formative years (0–17), which could include experiencing violence, abuse, or neglect or growing up in an environment that undermines a child's sense of safety, stability, and bonding (Centers for Disease Control and Prevention [CDC], 2023c).

affected by suicide: All individuals who may feel the impact of suicidal thoughts and attempts, including those bereaved by suicide, as well as community members and others.

behavioral health: Prevention and service systems encompassing the promotion of emotional health and mental well-being; the prevention of mental and substance use disorders, substance use, suicide, and related problems; treatments and services for mental and substance use disorders; and recovery support. Behavioral health problems include substance use, serious psychological distress, suicide, mental disorders, and substance use disorders and overdose. The term also refers to a state of mental and/or emotional being and/or choices and actions that affect wellness.

beneficiary populations: Individuals entitled to receive services under insurance policy coverage.

bereaved by suicide: Individuals who have been impacted by the loss of a loved one to suicide (also referred to as *survivors of suicide loss*).

best practices: Activities or programs aligned with the best available evidence regarding what is effective.

carceral: Related to the prison or correctional system.

Certified Community Behavioral Health Clinics: SAMHSA-defined clinical model provides comprehensive, coordinated mental health and substance use services across the life span (Substantive Abuse and Mental Health Services Administration [SAMHSA], 2023).

comprehensive approach to suicide prevention: An approach that brings together 1) prevention efforts to reduce the likelihood that community members will become suicidal, 2) responsive intervention and crisis supports for individuals who experience thoughts of suicide or make a suicide attempt, 3) quality effective treatment and recovery services that directly address suicide, and 4) postvention strategies for individuals and communities after a crisis or loss to suicide.

continuity of care: Process of ensuring ongoing care delivery and care coordination across providers and care teams.

continuous quality improvement: A data-informed process to measure implementation efforts over time and identify needed adjustments to reach success.

coping and problem-solving skills: Skills for emotional regulation in response to stressful life events, conflict resolution, and critical thinking (CDC, 2022c).

crisis care: Crisis services that provide intervention by trained professionals and paraprofessionals at the point of behavioral health crisis. Consumers access crisis services to seek assistance with a range of medical and nonmedical situations and to address a variety of behavioral health symptoms. Literature suggests that crisis service systems should include, at minimum, a crisis hotline, mobile response teams, and crisis receiving and stabilization centers (SAMHSA, 2020).

crisis care continuum: Evidence-informed crisis services available to those experiencing a suicidal, mental, or behavioral health crisis, traditionally includes crisis call centers, mobile crisis teams, and crisis stabilization facilities.

culturally responsive: A practice that acknowledges background and cultural differences to make adaptations tailored to meet an individual's needs.

culture: The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group.

cyberbullying: A pattern of unwanted aggressive behavior that inflicts harm or distress on a targeted individual and which occurs through technology. Also called *electronic bullying* (CDC, n.d.).

digital platform: Online technology spaces for content creation, social media, gaming, knowledge transfer, or e-commerce.

disability: Any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions; CDC, 2022a).

downstream prevention: Intervention efforts that reduce the impact of suicide, suicide attempts, and other mental health crises after they have occurred while promoting dignity and empowerment for all impacted. See contrast with *upstream prevention*.

economic supports: Household financial security in the form of livable wages, access to affordable and quality childcare services, insurance, and stable housing, as well as unemployment benefits and other temporary assistance.

emergency responders: Includes law enforcement, fire, emergency medical services, dispatch, and coroners. Also referred to as *first responders*.

epidemiology: Study of distribution and determinants of health-related states, conditions, or events in specified populations and the application of that study to the control of health problems.

equity: Equality is achieved when each person (or group of people) is given the same resources or opportunities. Equity is achieved when it is recognized that each person (or group of people) has different circumstances, and resources are allocated accordingly to reach an equal outcome. (CDC, 2022a)

evaluation: The systematic investigation of the value and impact of an intervention or program.

evidence-based programs: Programs, practices, activities, policies, procedures, and interventions that are guided by the best research evidence with practice-based expertise, evaluation, cultural competence, and the values of the persons receiving the services and that promote positive individual-level or population-level outcomes.

evidence-informed: Approach, program, or practice that blends knowledge from research, real-world practice, and local knowledge but has not had the benefit of full or robust evaluation.

gender identity: A person's deep internal sense of being female, male, or another identity.

harm reduction: Typically associated in the context of substance use, "harm reduction is a public health approach that focuses on mitigating the harmful consequences of drug use, including infectious disease transmission and overdose, by providing care that is free of stigma and centered on the needs of people who use drugs. Harm reduction programs also offer critical linkages to treatment for substance use disorders and other resources for populations with less access to care" (CDC, 2023d). A practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower people who use drugs and their families with the choice to live healthier, self-directed, and purpose-filled lives. (SAMHSA, 2023e)

health: The complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

health equity: The state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities (CDC, 2022a).

Healthy People 2030: The national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2030. For more information, see https://health.gov/healthypeople.

institutional review board (IRB): Group designated to monitor research efforts to protect the well-being, privacy, and rights of human subjects.

institutional, structural, or systemic racism: "Structural racism refers to racism that disadvantages people of color at the level of societal systems, which includes social structures, institutions, systems, ideologies, policies, and cultural forces that have an impact on both material opportunities and access to power" (Alvarez et al., 2022).

intervention: A strategy, program, or approach intended to prevent an outcome or to alter the course of an existing condition, such as reducing access to lethal means among individuals with suicide risk or connecting someone who may be struggling to crisis services.

intergenerational trauma: The concept that the experience and impact of trauma can be passed down through families, affecting individuals and communities across generations (Administration for Children and Families, n.d.).

lethal means: Objects, substances, or places someone may use to attempt suicide (Suicide Prevention Resource Center [SPRC], 2020).

LGBTQIA2S or LGBTQI+ people: Abbreviation for *lesbian, gay, bisexual, transgender, queer, intersex, asexual, and Two-Spirit*. The additional "+" stands for all other identities not encompassed in the short acronym. Additionally, "Though Two-Spirit may now be included in the umbrella of LGBTQ, the term 'Two-Spirit' does not simply mean someone who is a Native American or Alaska Native and gay. Traditionally, Native American Two-Spirit people were male, female, and sometimes intersexed individuals who combined activities of both men and women with traits unique to their status as two-spirit people. In most tribes, they were considered neither men nor women; they occupied a distinct, alternative gender status" (Indian Health Service, n.d.).

ligatures: Physical elements in an environment that could be used to support a noose or other strangulation devices, especially, for a suicide attempt.

marginalized groups or populations: Groups of people who have historically experienced systemic disparities and exclusion based on cultural identity or difference.

mental disorder: A "mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning" (World Health Organization, 2022a).

mental health: A "state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (World Health Organization, 2022b).

mental health conditions: A "broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm" (World Health Organization, 2022a).

mental health services: Health services that are specifically designed for the care and treatment of persons with mental health conditions. Mental health services include hospitals and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

mortality data: Information relating to deaths or fatalities.

neurodiverse conditions: Variation in brain functioning.

older adults: Persons aged 65 or more years.

peer support: Services provided by peer support workers may include emotional (e.g., mentoring), informational (e.g., parenting classes), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support (SAMHSA, 2023g; SAMHSA, 2023f).

positive childhood experiences (PCEs): Experiences in which children feel safe in their families to talk about emotions and things that are hard and feeling supported during hard times (Bethell et al., 2019).

postvention: Policies, programs, practices, and supports implemented in the aftermath of a suicide loss, attempt, or crisis intended to reduce further risk for suicide.

presenteeism: Nonproductive work time that can include working while sick (Brooks et al., 2010). Also see *absenteeism*.

prevention: A strategy or approach that reduces the likelihood of onset or delays the onset of adverse health problems, increases individual or community protection from a negative result, or reduces the harm resulting from conditions or behaviors.

private sector organizations: Nongovernmental agencies such as nonprofit organizations, foundations, and businesses. Private organizations may be nimbler than governmental agencies and bring the ability to advocate for policy change at multiple levels. Depending on the organization, private sector partners also bring a unique opportunity to reach different audiences and networks within their influence with messaging, resources, and recommendations.

protective factors: Individual, relationship, community, and environmental elements that make a negative outcome less likely.

public sector organizations: Government or government-funded agencies, which can include federal, state, county, and city departments. Governmental organizations are often responsible for funding, regulation, and implementation of enacted policies. Public organizations generally cannot engage in direct advocacy or lobbying efforts.

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

risk factors: Individual, relationship, community, and environmental elements that make a negative outcome more likely.

safe messaging: "Media or personal communications about suicide or related issues that do not increase the risk of suicidal behavior in vulnerable people, and that may increase help-seeking behavior and support for suicide prevention efforts" (SPRC, 2020).

safety plan (collaborative): Evidence-based strategy that includes a self-defined written list of warning signs, coping responses, and support sources that an individual may use to avert or manage a suicide crisis. Best practices call for safety plans to be done in a collaborative manner with the client or patient.

screening: Administrating a brief standardized tool, instrument, or protocol to identify individuals who may be at risk for suicide.

screening tools: Instruments and techniques (e.g., questionnaires, check lists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

secondary trauma: Distress brought about from exposure to the traumatic experiences of others.

sentinel event: "Patient safety event that results in death, permanent harm, or severe temporary harm" (Joint Commission, 2024).

sexual orientation: An individual's different forms of sexual, physical, romantic, and/or emotional attraction, behaviors, and identities. This includes attraction toward people of just one gender or of multiple genders and includes the lack of experiencing attraction (The Trevor Project, n.d.).

social connection: A continuum of the size and diversity of one's social network and roles, the functions these relationships serve, and their positive or negative qualities (Office of the Surgeon General, 2023).

social connectedness: The degree to which people have and perceive a desired number, quality, and diversity of relationships that create a sense of belonging, and being cared for, valued, and supported. (CDC, 2023).

social determinants of health: Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These may include economic stability, education, health care access, housing security, and relationships and interactions with people in the community (U.S. Department of Health and Human Services, 2020).

substance use disorder (SUD): A health condition characterized by a cluster of cognitive, behavioral, and physiological symptoms that describe an individual's compulsive use of a substance despite significant adverse problems associated with the use (American Psychiatric Association, 2022).

suicide: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior (Crosby et al., 2011).

suicide attempt: A nonfatal, 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. (Crosby et al., 2011)

suicide attempt survivor: Individuals who have survived a suicide attempt.

suicide-centered lived experience: "Individuals with suicide-centered lived experience can include those who have had thoughts of suicide, survived a suicide attempt, lost a loved one to suicide, or provided substantial support to a person with direct experience of suicide" (Roses in the Ocean, 2023).

suicide cluster: "A suicide cluster may be defined as a group of suicides or suicide attempts that occur closer together in time and/or space than would normally be expected in a given community. The two most common types of suicide clusters are:

- **Point clusters (or spatial-temporal clusters):** A greater-than-expected number of suicides that occur within a time period in a specific location. This might be in a community or an institution such as a school, university, or psychiatric inpatient setting.

- **Mass clusters (or temporal clusters):** A greater-than-expected number of suicides within a time period that are spread out geographically." (Ballesteros et al., 2024).

suicide crisis: A suicide crisis or potential suicide is a situation in which a person is attempting to kill themselves or is seriously contemplating or planning to do so. It is considered a behavioral health emergency, requiring immediate suicide intervention and emergency behavioral health treatment.

suicidal ideation: Thoughts of engaging in suicide-related behavior (Crosby et al., 2011).

suicide prevention infrastructure: Concrete, practical foundation or framework that supports suicide prevention-related systems, organizations, and efforts, including the fundamental parts and organization of parts that are necessary for planning, implementation, evaluation, and sustainability (SPRC, 2019).

suicide-related indicators: Data related to suicide thoughts, nonfatal attempts, and deaths.

surveillance: The ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control (https://www.cdc.gov/training/publichealth101/surveillance.html).

syndromic surveillance: Syndromic surveillance is an innovative surveillance approach that provides public health officials with a timely system for detecting, understanding, and monitoring health events. By tracking symptoms of patients in emergency departments—before a diagnosis is confirmed—public health can detect unusual levels of illness or condition to determine whether a response is warranted (CDC, 2023f).

systems approach: An integrated and multidisciplinary team process to design, implement, and evaluate the delivery of quality care that does not rest responsibility on individual providers or departments within a health system but rather transforms how a system operates.

systemic issues: Long-standing and pervasive issues arising from the systems, policies, and environments that surround individuals, contributing to increased risk for suicide.

trauma-informed approach: A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices;

and seeks to actively resist re-traumatization (SAMHSA, 2023h). Referred to variably as *trauma-informed care* or *trauma-informed approach*.

tribal nations: There are currently 574 federally recognized tribes in the United States. "While tribal sovereignty is limited today by the United States under treaties, acts of Congress, Executive Orders, federal administrative agreements, and court decisions, what remains is nevertheless protected and maintained by the federally recognized tribes against further encroachment by other sovereigns. Tribal sovereignty ensures that any decisions about the tribes with regard to their property and citizens are made with their participation and consent" (U.S. Department of the Interior, 2017).

upstream prevention: Also called *primary prevention*, refers to community-based efforts that address risk and protective factors before the onset of a crisis at the individual level. Such factors may include improving financial security and healthy connections, while decreasing exposure to trauma, racism, or disparate access to health care.

unintentional injury: An injury that is unplanned. In some settings, these injuries may be termed *accidental injuries*. However, within public health contexts, to underscore prevention opportunities, *unintentional* is preferred.

warmline: A phone number you can call to have a conversation with someone who can provide support during hard times. Warmlines are staffed by trained peers who have been through their own mental health struggles and know what it's like to need help.

National Strategy for Suicide Prevention Goals and Objectives

STRATEGIC DIRECTION 1:
Community-Based Suicide Prevention

→ **GOAL 1:**
Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships.

Objective 1.1:

Create and sustain public-private partnerships and coalitions at the national, state, and local levels, representing diverse populations, perspectives, and broad suicide-centered lived experiences to extend reach and strengthen suicide prevention outcomes.

Objective 1.2:

Create and enhance connections between state agencies, tribal nations, and local communities to increase the reach of comprehensive suicide prevention activities and to strengthen outcomes.

Objective 1.3:

Strengthen and sustain collaborations across federal agencies to advance suicide prevention nationally by leveraging each agency's unique expertise, data, programs, and other resources.

→ GOAL 2:
Support upstream comprehensive community-based suicide prevention.

Objective 2.1:

Assess community strengths and gaps to inform suicide prevention planning at the individual, relationship, community, and societal levels.

Objective 2.2:

Strengthen job and economic supports, especially among individuals, families, and communities disproportionately affected by suicide and overdose.

Objective 2.3:

Improve availability and access to culturally relevant suicide prevention information and community-helping resources, especially in underserved and historically marginalized communities.

Objective 2.4:

Implement and evaluate effective interventions that reduce the onset of suicide risk and promote connected individuals, families, and caregivers where they live, work, learn, play, and worship.

Objective 2.5:

Promote safe, stable, and nurturing relationships and environments to help prevent adverse childhood experiences and create positive childhood experiences.

Objective 2.6:

Implement and evaluate interventions addressing the intersection of suicide, substance use, and adverse childhood experiences, including those with a focus on improving social determinants of health across diverse populations.

Objective 2.7:

Implement and evaluate effective interventions reflecting a comprehensive public health approach to suicide prevention, especially in populations disproportionately impacted by suicide.

Objective 2.8:

Expand existing federal support to states and communities nationwide for comprehensive suicide prevention that incorporates both upstream and downstream prevention strategies across the life span.

→ GOAL 3:
Reduce access to lethal means among people at risk of suicide.

Objective 3.1:

Train community members and implement effective ways to reduce access to lethal means among people at risk, including safe and secure storage of firearms, medications and poisons, ligatures, and other means in homes, workplaces, communities, and the physical environment.

Objective 3.2:

Evaluate policies, programs, and practices that put time and space between a person at risk and a lethal means of suicide, including their impact in historically marginalized communities.

Objective 3.3:

Partner with firearm and other relevant organizations and communities to incorporate suicide awareness and prevention as basic tenets of firearm safety and responsible ownership.

Objective 3.4:

Implement effective substance use prevention and harm reduction programs, practices, and policies that can help reduce suicide risk at the individual and community levels.

→ GOAL 4:
Conduct postvention and support people with suicide-centered lived experience.

Objective 4.1:

Provide community-based care and support options to individuals bereaved by suicide.

Objective 4.2:

Provide community-based care and support options to individuals who have survived a suicide attempt or who struggle with thoughts of suicide.

Objective 4.3:

Engage suicide attempt survivors in the development, implementation, and evaluation of guidelines and protocols for suicide survivor support groups, programs, and policies.

Objective 4.4:

Promote the adoption and evaluation of community-relevant guidance for the identification, assessment, and community-led response to potential suicide or suicide attempt clusters.

Objective 4.5:

Support suicide prevention and whole person health among health care workers and other occupational groups who experience traumatic exposure to suicide risk, such as first responders, health care providers, and crisis workers.

→ GOAL 5:
Integrate suicide prevention into the culture of the workplace and into other community settings.

Objective 5.1:

Integrate suicide prevention into workplace values, policies, culture, and leadership at all levels.

Objective 5.2:

Create, implement, and evaluate organizational programs, practices, and policies to support worker well-being and suicide prevention.

Objective 5.3:

Implement and evaluate effective programs, practices, and policies in suicide prevention and crisis response in settings where people live, work, learn, play, and worship, and ensure ongoing staff training and development.

Objective 5.4:

Train community members, organizations, and civic groups to identify and respond to people who may be at risk of suicide.

Objective 5.5:

Work with the public and private sectors to implement and evaluate recommended practices and policies to support safer digital technology use, especially among youth and young adults.

→ GOAL 6:
Build and sustain suicide prevention infrastructure at the state, tribal, local, and territorial levels.

Objective 6.1:

Create and maintain core staff positions in offices of suicide prevention across state, tribal, local, and territorial levels to build and sustain comprehensive suicide prevention programming, including hiring people with suicide-centered lived experience and people representing the diversity of communities being served.

Objective 6.2:

Train staff across state, tribal, local, and territorial levels about comprehensive suicide prevention, including building partnerships; use of data for decision-making; selection, implementation, and evaluation of effective prevention strategies; and communication activities.

Objective 6.3:

Modernize data systems and infrastructure and build staff capacity in surveillance, data analysis, and program and policy evaluation across state, tribal, local, and territorial levels.

Objective 6.4:

Establish and sustain public and private funding streams for implementation and evaluation of effective suicide prevention programming at the state, tribal, local, and territorial levels, with attention to populations disproportionately affected by suicide.

Objective 6.5:

Develop, implement, evaluate, and routinely update data-informed state, tribal, local, and territorial suicide prevention plans that reflect a comprehensive approach to suicide prevention.

→ GOAL 7:

Implement research-informed suicide prevention communication activities in diverse populations using best practices from communication science.

Objective 7.1:

Communicate the most recent suicide-related data and trends to a range of audiences in a safe, easy-to-understand way and to inform public health action.

Objective 7.2:

Increase public knowledge about suicide warning signs and that suicide is preventable, including the many factors that can increase or decrease suicide risk at the individual, relationship, community, and societal levels.

Objective 7.3:

In collaboration with people with suicide-centered lived experience, develop, implement, and evaluate effective and tailored communication activities that encourage help-seeking and provide instruction on how to support someone struggling or in a crisis.

Objective 7.4:

Communicate stories of help, hope, and healing using safe messaging strategies.

Objective 7.5:

In coordination with youth, develop, implement, and evaluate communication activities to foster healthy engagement among youth and young adults related to social media and other digital technology platforms.

Objective 7.6:

Engage news media, the entertainment industry, and schools of journalism and mass communication to encourage safe, accurate, and responsible reporting and depictions of suicide and positive mental health coping skills.

Objective 7.7:

Increase awareness of 988 and other crisis services with communications that are grounded in the principles of health equity and cultural sensitivity.

Treatment and Crisis Services

→ GOAL 8:

Implement effective suicide prevention services as a core component of health care.

Objective 8.1:

Implement effective services to identify, engage, treat, and follow up with individuals with suicide risk as standard care in public and private health care delivery.

Objective 8.2:

Develop and implement effective standard protocols to identify, engage, treat, and follow up with individuals with elevated suicide risk in health care.

Objective 8.3:

Address practice and policy barriers in order to implement effective emergency department screening, safety planning, and rapid and sustained follow-up after discharge in all emergency departments.

Objective 8.4:

Promote effective continuity of engagement and care for patients with suicide risk when they transition between different health care settings and providers, especially crisis, emergency, and hospital settings, and between health care and the community.

Objective 8.5:

Ensure suicide prevention competency in initial and continuing education of health professionals to achieve and maintain quality and effectiveness of suicide prevention services.

Objective 8.6:

Incentivize and enable health care organizations to track suicide thoughts, attempts, and deaths in their patient and beneficiary populations to inform continuous quality improvement efforts.

Objective 8.7:

Increase and leverage the use of electronic health records to track and support implementation of best practices for suicide prevention.

Objective 8.8:

Implement effective health care practice strategies that encourage safe and secure storage of lethal means among people at increased risk of suicide.

Objective 8.9:

Ensure that suicide prevention services include the capability to identify and address co-occurring substance use issues and ensure that substance use treatment services include the capability to identify and address suicide risk.

→ **GOAL 9:**

Improve the quality and accessibility of crisis care services across all communities.

Objective 9.1:

Develop and maintain a robust crisis care system through ongoing quality improvement to help people at risk of suicide.

Objective 9.2:

Increase local collaboration and coordination between 988 centers and 911 Public Safety Answering Points; police, fire, and emergency medical services; and behavioral health crisis services to improve quality of care for those in crisis.

Objective 9.3:

Through expansion of effective mobile crisis teams and diversion programs, reduce unnecessary police interventions with individuals who call 988 or 911 with suicidal thoughts.

Objective 9.4:

Increase timely access to assessment, intervention, lethal means safety counseling, and follow-up for people at risk of suicide along the crisis care continuum.

Objective 9.5:

Ensure that crisis services are integrated into health care delivery.

Objective 9.6:

Ensure that 988 crisis counselors and other components of crisis services provide effective suicide prevention services to all users, including those with substance use disorders.

Surveillance, Quality Improvement, and Research

→ GOAL 10:

Improve the quality, timeliness, scope, usefulness, and accessibility of data needed for suicide-related surveillance, research, evaluation, and quality improvement.

Objective 10.1:

Improve the quality, timeliness, scope, usefulness, and accessibility of suicide death data.

Objective 10.2:

Improve the quality, timeliness, scope, usefulness, and accessibility of data on suicide thoughts and behaviors and associated risk and protective factors.

Objective 10.3:

Identify and validate novel data and methods for suicide-related surveillance, research, evaluation, and quality improvement.

Objective 10.4:

Integrate data on adverse outcomes such as unintentional overdoses and other unintentional injuries with data on suicide thoughts, attempts, and deaths.

Objective 10.5:

Evaluate the impact of the *National Strategy for Suicide Prevention* on core indicators of *Strategy* progress and the effects on reducing suicidal thoughts, attempts, and deaths.

→ GOAL 11:

Promote and support research on suicide prevention.

Objective 11.1:

Identify and pursue potential high-value research opportunities informed by the 2014 resource *A Prioritized Research Agenda for Suicide Prevention*, relevant findings from subsequent research, new data and methods, and changes in the epidemiology of suicide in the United States.

Objective 11.2:

Expand research related to populations disproportionately affected by suicide, their prevention and treatment opportunities, and health care and other public health policies, to reduce risk.

Objective 11.3:

Conduct research to expand understanding of the effects of social media use and digital technology on mental health, especially among youth, and identify opportunities to expand benefits and reduce potential harms.

Objective 11.4:

Expand understanding of overlapping pathways of substance use and suicide risk to inform opportunities for prevention and treatment of these co-occurring conditions.

Objective 11.5:

Conduct research to identify suicide prevention peer support services that are effective for enhancing client self-efficacy, personal recovery, treatment engagement, and clinical outcomes.

Objective 11.6:

Where research has identified better practices, develop and test approaches to enable widespread implementation of such practices as standard and effective care.

STRATEGIC DIRECTION 4:
Health Equity in Suicide Prevention

→ GOAL 12:
Embed health equity into all comprehensive suicide prevention activities.

Objective 12.1:

Improve community-based suicide prevention by incorporating perspectives and recommendations from populations disproportionately affected by suicide and from people with diverse suicide-centered lived experience.

Objective 12.2:

Address social determinants of health and systemic issues impacting suicide risk among those disproportionately affected by suicide across the life span.

Objective 12.3:

Incorporate suicide prevention activities with consideration to age, race, ethnicity, sexual orientation, gender identity, disability, chronic conditions, and geographical location into all prevention efforts, as applicable.

Objective 12.4:

Promote upstream protective factors among populations disproportionately affected by suicide across state, tribal, local, and territorial suicide prevention efforts.

Objective 12.5:

Fund and increase effective community, peer, and youth-led suicide prevention activities and initiatives.

Objective 12.6:

Engage and incorporate public and private sector partners with experience working with populations disproportionately affected by suicide into suicide prevention activities.

→ GOAL 13:
Implement comprehensive suicide prevention strategies for populations disproportionately affected by suicide, with a focus on historically marginalized communities, persons with suicide-centered lived experience, and youth.

Objective 13.1:

Implement and evaluate focused suicide prevention activities across the life span that address the increasing rates of suicide thoughts, attempts, and deaths within racial, ethnic, and historically marginalized groups.

Objective 13.2:

Increase awareness and understanding of the unique barriers and challenges of rural communities to better inform and improve suicide prevention activities.

Objective 13.3:

Increase awareness and understanding of the unique barriers and challenges of military and Veteran status to improve suicide prevention among service members, Veterans, and their families.

Objective 13.4:

Increase suicide prevention programs, practices, and policies in support of and in collaboration with LGBTQI+ individuals.

Objective 13.5:

Improve and expand suicide prevention programs, practices, policies, and crisis response in child welfare, criminal and juvenile justice, behavioral health, and other systems serving populations disproportionately affected by suicide and ensure ongoing staff training and development.

Objective 13.6:

Leverage social media use for youth and young adults to support suicide prevention efforts.

Objective 13.7:

Develop research priorities and implement prevention strategies to address the high rate of suicides among older adults.

→ GOAL 14:

Create an equitable and diverse suicide prevention workforce that is equipped and supported to address the needs of the communities they serve.

Objective 14.1:

Increase access to training and technical support for professionals and graduate students to improve cultural humility and responsiveness toward historically marginalized groups and individuals with suicide-centered lived experiences.

Objective 14.2:

Focus equity education and awareness on health care professionals and settings to address existing barriers and reduce stigma.

Objective 14.3:

Increase the number of professionals in suicide prevention from historically marginalized communities, people with suicide-centered lived experience, and other populations disproportionately affected by suicide.

Objective 14.4:

Create professional standards around suicide prevention, intervention, and postvention with a dedicated competency focused on working with populations disproportionately affected by suicide.

Objective 14.5:

Ensure historically marginalized groups are provided crisis support and response strategies grounded in cultural humility and inclusivity.

→ GOAL 15:

Improve and expand effective suicide prevention programs for populations disproportionately impacted by suicide across the life span through improved data, research, and evaluation.

Objective 15.1:

Increase funding for academic and community-led research on, and evaluation of, effective suicide prevention activities in populations disproportionately impacted by suicide.

Objective 15.2:

Develop, disseminate, and evaluate specific and culturally informed screening tools to address suicide among populations disproportionately affected by suicide.

Objective 15.3:

Ensure that suicide-related data used for surveillance, research, evaluation of prevention and treatment, and quality improvement enable assessment of disparities, especially for populations disproportionately affected by suicide.

Objective 15.4:

Improve the awareness and dissemination of culturally relevant suicide prevention best practices among populations disproportionately affected by suicide.

Objective 15.5:

Support the development of promising practices and practice-based evidence to inform suicide prevention in historically marginalized and excluded groups through funding, resource provision, and prioritization practices.

Objective 15.6:

Enhance data sharing, data linkage, and translation of data to action across community groups to improve suicide prevention in historically marginalized groups and groups disproportionately impacted by suicide.

Differences between the 2012 and 2024 *National Strategy for Suicide Prevention*

Overview

The 2012 *National Strategy for Suicide Prevention (National Strategy)* offered strategies and actions needed to advance suicide prevention at the national, state, tribal, local, and territorial, levels. The 2024 *National Strategy* builds upon this critical work by presenting the latest advances in suicide prevention and new and emerging topics in the suicide prevention field. This included adding key content at the request of The White House focused on health equity, youth and social media, and substance use. A focus on health equity is woven throughout the *National Strategy* and to emphasize its importance further, a new Strategic Direction on health equity was created. The 2024 *National Strategy* showcases a more inclusive and comprehensive approach to suicide prevention.

Content Additions

Content on the youth and social media and the intersection of suicide and substance use were added. The new Strategic Direction on health equity provides guidance on centering equity throughout all prevention work. Content related to the National Suicide Prevention Lifeline (NSPL) was also updated to reflect the transition to the three-digit 988 Suicide and Crisis Lifeline in 2022 and the contribution of 988 to the crisis care continuum. Additionally, an emphasis on incorporating suicide-centered lived

experience, referring to individuals who have had thoughts of suicide, survived a suicide attempt, lost a loved one to suicide, or provided substantial support to a person with direct experience of suicide, in prevention efforts was incorporated throughout the Goals and Objectives (Roses in the Ocean, 2023).

Changes to the Strategic Directions

The 2012 Strategic Directions were updated and revised to reflect developments in the field of suicide prevention over the past 10 years, including the addition of a new Strategic Direction on health equity.

Strategic Direction 1

The 2012 *National Strategy* "Strategic Direction 1: Health and Empowered Individuals, Families, and Communities" focused on the coordination of suicide prevention activities across sectors and settings, partner engagements in suicide prevention, safe and effective prevention messaging, and risk and protective factors for suicide. In the 2024 *National Strategy*, Strategic Direction 1 is "Community-Based Suicide Prevention" and includes content on lethal means, postvention, community settings and workplaces, and upstream prevention, with attention to social determinants of health.

The 2012 clinical elements of Strategic Direction 1 were moved to the 2024 Strategic Direction 2 to preserve the focus on community-based strategies for suicide prevention. These changes allow the 2024 *National Strategy* to include more upstream approaches, which address and prevent the factors that lead to suicide risk and suicidal behavior as well as address calls from the field to advance the core national and state infrastructures necessary for effective suicide prevention.

Strategic Direction 2

In the 2012 *National Strategy*, "Strategic Direction 2: Clinical and Community Preventive Services" focused on effective suicide prevention strategies, lethal means safety, and suicide prevention training in community and clinical settings, while "Strategic Direction 3: Treatment and Support Services" focused on advancing suicide prevention as a core component of health care services, the treatment and assessment of suicidal behaviors, support for those affected by suicide, and community prevention strategies. The clinical and support services elements of Strategic Directions 1, 2, and 3 of the 2012 *National Strategy* were combined into "Strategic Direction 2: Treatment and Crisis Services" in the 2024 *National Strategy*, which allowed for a deepened focus on systemic implementation in health care of best practices, crisis care services, and substance use treatment services. As previously noted, the goals and community-based elements of the 2012 *National Strategy* were moved to the 2024 Strategic Direction 1. These changes allow the 2024 Strategic Direction 2 to focus exclusively on treatment and clinical activities and crisis services, and Strategic Direction 1 to exclusively focus on community services.

Strategic Direction 3

In the 2012 *National Strategy*, "Strategic Direction 4: Surveillance, Research, and Evaluation" focused on suicide-related national surveillance systems, suicide prevention research, and the evaluation of prevention interventions and systems. This Strategic Direction is now "Strategic Direction 3: Surveillance, Quality Improvement, and Research." It focuses on suicide-related data and surveillance, and research, including the effects of social media use on mental health, and the overlapping pathways of substance use and suicide risk. A substantial change from the 2012 *National Strategy* was integrating evaluation throughout all Strategic Directions rather than having it in just one Strategic Direction. These changes allow the 2024 *National Strategy* to emphasize the importance of using data, surveillance tools, and evaluation strategies to continuously improve suicide prevention efforts.

Strategic Direction 4

The 2024 *National Strategy* also contains "Strategic Direction 4: Health Equity in Suicide Prevention." This new Strategic Direction focuses on opportunities to embed health equity approaches into comprehensive prevention strategies, thereby advancing an equitable and diverse suicide prevention workforce, centering the experiences of historically marginalized communities and disproportionately affected populations, and providing key content on the topics of interest (youth and social media, the intersection of substance use and suicide, equity, and the crisis care continuum).

The changes woven throughout the entire 2024 *National Strategy* and the creation of this new Strategic Direction recognize the need for increasing equity within the field of suicide prevention.

Changes in Goals and Objectives

The 2012 Goals and Objectives were updated, revised, and in some cases, replaced or combined to reflect 1) advances in data, science, and best practices; populations disproportionately affected by suicide; and other emerging issues; 2) changes in the focus areas of the field over the past decade; and 3) areas where the 2012 actions have been completed. The 2012 *National Strategy* contained a total of 13 Goals and 60 Objectives. The 2024 *National Strategy* has 15 Goals and 87 Objectives.

2024 *National Strategy for Suicide Prevention* Methodology

Introduction

The *National Strategy for Suicide Prevention (National Strategy)* was originally released in 2001 and then updated in 2012 by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention (Action Alliance), the nation's public-private partnership for suicide prevention.

The 2012 *National Strategy* was intended to guide suicide prevention efforts in the United States through 2022. Most recently, a Call to Action was released by the U.S. Surgeon General in 2021, calling for a renewed focus on the implementation of the 2012 *National Strategy*. In March 2023, in recognition of the changing landscape and trends in suicide prevention, The White House Domestic Policy Council (DPC) charged the Department of Health and Human Services (HHS), acting through the Suicide Prevention and Crisis Care subcommittee (SPCC) of the Behavioral Health Coordinating Council (BHCC), to develop a new 2024 *National Strategy for Suicide Prevention and Federal Action Plan*. A Project Management Team was co-led by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC) alongside the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the National Institute of Mental Health (NIMH). The team was charged with managing the development, review, and approval of a revised *National Strategy* and a new *Federal Action Plan (Action Plan)*. This also included collaborating with the Suicide Prevention Resource Center (SPRC) and the Action Alliance in the development process.

The 2024 *National Strategy* would pick up where the 2012 *National Strategy* left off, and it would include content to address the following priorities areas: health equity, youth and social media, and substance use and suicide. It would also include significant content on crisis care and the launch of the 988 Suicide and Crisis Lifeline. Recognizing the urgent need to address rising suicide rates with a coordinated and collaborative response, federal leadership set an accelerated timeline for updating the *National Strategy* and committing to federal suicide prevention actions, with a release slated for early 2024.

Methods for Gathering Public and Private Sector Input and Feedback

Led by the Project Management Team, three steps were taken to gather private and state-level partner feedback on the 2024 *National Strategy* Goals and Objectives, content, and White House priority areas.

Needs Assessment

In spring 2023, the Action Alliance conducted the *National Strategy* Needs Assessment (NSNA). This assessment gathered perspectives from individuals impacted by suicide and/or involved in suicide prevention across the nation on the needs, successes, and areas for growth within the suicide prevention field. Emphasis was placed on gathering feedback from a wide range of U.S. geographies, populations, workplaces, and suicide-centered lived experiences, ensuring populations disproportionately impacted by suicide were provided with the opportunity to inform the development of the 2024 *National Strategy*.

The Action Alliance disseminated the NSNA from April 18, 2023, through May 12, 2023, using a convenience sample of representatives in the suicide prevention and related fields. Specific attention was placed on disseminating the needs assessment to organizations representing underserved and historically marginalized populations, as well as to organizations serving individuals with lived experience related to suicide. The needs assessment was disseminated to 245 organizations who were asked to share with their contacts. Respondents from 49 states, three U.S. territories, and the District of Columbia (D.C.) participated, representing diverse geographic areas, races and ethnicities, settings, roles, and lived experiences in suicide prevention. The NSNA asked individuals the following:

- How familiar they were with the 2012 *National Strategy*

- How they have used the *National Strategy* within their roles

- What Strategic Directions from the *National Strategy* aligned with their roles and what amount of emphasis should be placed on the Goals within their identified Strategic Directions

- What they believed would be most helpful in enabling partners to track progress in advancing the *National Strategy*

- What strategies and populations needed to be represented within a new *National Strategy* to increase equity in suicide prevention.

One open-ended question was also provided, allowing respondents to share what areas or emerging issues they felt were missing from the 2012 *National Strategy*. Finally, respondents were asked a series of voluntary demographic questions. Nearly 2,600 individuals representing diverse settings, regions, and populations participated in the NSNA.

Listening Sessions

In spring 2023, SPRC, SAMHSA/Center for Mental Health Services (CMHS), and the Action Alliance led the development and implementation of five 90-minute subject matter expert listening sessions (listening sessions). These listening sessions were conducted via Zoom on April 27, May 1, May 2, and May 8, 2023. The listening sessions gathered input from four subject matter expert groups, including those focused on equity and behavioral health, individuals with suicide-centered lived experience, and youth and young adults. A total of 79 individuals participated in the listening sessions. Participants were asked to reflect on the 2012 *National Strategy* and to share thoughts on areas of success and lessons learned since the 2012 *National Strategy*, as well as on areas in need of additional focus from the field. Participants also shared their thoughts on what populations they believed were most overlooked within the field of suicide prevention, how to better support those populations, and how to represent diverse populations in the new *National Strategy*. Finally, participants were asked to share their ideas for ensuring strong representation of The White House focus areas within the *National Strategy* (healthy equity, suicide and substance use, and youth and social media). Emphasis was again placed on ensuring individuals who participated in the listening sessions represented diverse backgrounds, experiences, and perspectives in order to strengthen diversity, equity, and inclusion within the 2024 *National Strategy* development process.

The Action Alliance hosted a 90-minute Executive Committee listening session. This listening session brought together 31 members of the Action Alliance's Executive Committee (EXCOM) and their staff to discuss achievements made and lessons learned over the past decade in suicide prevention, areas where more work is needed, priority populations, and how to best integrate The White House's priority areas within the new *National Strategy*.

Additionally, at their request, the Department of Transportation and the U.S. Department of Justice hosted a special listening session, facilitated by the Action Alliance and SPRC, to focus on the unique needs of the public safety field as it relates to suicide prevention. During that session, 27 leaders provided insight and suggestions to make sure that a revised *National Strategy* considered key opportunities to support emergency responders.

Finally, the U.S. Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) hosted a virtual tribal listening session on the 2024 *National Strategy and Federal Action Plan* to engage with tribal leaders and tribal behavioral health professionals on critical issues related to suicide prevention among American Indian and Alaska Natives they would like to see represented in the new strategy, as well as to receive guidance on essential communication and implementation considerations for the strategy's release. Over 70 leaders attended the session, providing guidance on the importance of reflecting the impacts of intergenerational trauma as well as tailoring approaches and messaging to resonate with tribal communities.

The information gathered from both the NSNA and listening sessions informed the content, organization, and format of the 2024 *National Strategy for Suicide Prevention*.

Interagency Work Group

To gather federal partner feedback, the Project Management Team led a series of federal Interagency Work Group (IWG) meetings. A team from SPRC and the Action Alliance supported the development of these meetings with guidance from the Project Management Team representatives from CDC, SAMHSA, NIMH, and ASPE. These meetings brought together over 20 federal agencies/offices across ten Executive Branch departments divided into two phases.

Phase 1

Phase 1 consisted of four IWG meetings hosted between April 26, 2023, and May 24, 2023. During this phase, IWG agencies reviewed the 2012 *National Strategy* Strategic Directions, White House priority areas, and the NSNA and listening session reports. IWG agencies provided recommendations for improving the *National Strategy* as well as reflections and key takeaways from the NSNA and listening session reports. Feedback from IWG agencies was collected through a variety of methods, including online feedback forms, emails from IWG agency members, and in-meeting breakout group discussions. SPRC and Action Alliance staff facilitated meetings, collected IWG agency feedback, and recorded recommendations and decisions made, sharing all reports with the Project Management Team. The feedback from federal partners during Phase 1 informed the drafting of the 2024 *National Strategy* Strategic Directions, Goals, and Objectives. The DPC, HHS leadership, and IWG agencies also provided feedback on draft *National Strategy* Goals and Objectives during this phase.

Phase 2

Phase 2 consisted of eight IWG meetings hosted between June 14, 2023, and January 10, 2024. During this phase, IWG members reviewed previous work by the SPCC to identify actions to operationalize the 2021 Surgeon General's Call to Action, identified draft goals of the 2024 *National Strategy* that best related to their agencies' roles, and worked within their agencies to draft agency-specific action items to include in a Federal Agency *National Strategy Action Plan*. The Project Management Team, SPRC, and the Action Alliance provided the IWG agencies with guidance for drafting feasible and impactful action items that could be implemented within the next three years. The *Action Plan* was limited to three years to allow appropriate time to complete existing activities; plan and resource new work; and ensure agencies could assess impact and pivot as needed in later years, scaling up effective activities, sunsetting those that had run their course or were less impactful, and addressing emerging needs. Agencies were asked to draft action items that 1) had the potential for strong impact; 2) could be prioritized by agency; 3) could expand existing agency efforts within suicide prevention; 4) were specific, achievable, and measurable; 5) addressed disparities in suicide prevention; and 6) integrated the voices of lived experience.

During the IWG meetings, agencies collaborated on action item development and identified areas of gaps or potential collaboration within action items across agencies. Additionally, during this phase, all IWG agencies were invited to participate in one-on-one planning calls with *National Strategy* Project Management leads, as well as SPRC and Action Alliance representatives. These calls supported the agencies in identifying specific areas of focus for their action items and steps to take in pursuing agency leadership approval of action items. Several iterations of agencies' action items were drafted, reviewed, and cleared by agency leadership and the Project Management Team prior to completion of Phase 2.

Through the two-phase process, the IWG agencies provided direct input, feedback, and recommendations for improving the *National Strategy* and ensuring its format and content were useful for the field. The agencies also identified and committed to their own roles in implementing the new *National Strategy*.

Methods for Drafting *National Strategy* Strategic Directions, Goals, and Objectives

During Phase 1 of the IWG meetings, the Project Management Team, SPRC, and the Action Alliance incorporated feedback from all sources in drafting 2024 *National Strategy* Strategic Directions, Goals, and Objectives. IWG agencies provided feedback on the drafted content through an iterative process of meetings and written suggestions.

In addition, the Project Management Team decided to revise the four Strategic Directions in the 2012 *National Strategy* to better reflect current needs and future development within the field of suicide prevention. The final 2024 *National Strategy* now includes the following four Strategic Directions: Community-Based Suicide Prevention; Treatment and Crisis Services; Surveillance, Quality Improvement, and Research; and Health Equity in Suicide Prevention. These new Strategic Directions ensure the 2024 *National Strategy* focuses on and is representative of the feedback provided from federal, state, and private sector partners, while minimizing repetition of content across objectives. Of particular significance, Strategic Direction 4: Health Equity in Suicide Prevention provides the field with increased focus, guidance, and actions specific to equity in suicide prevention.

During the revision, special attention was placed on ensuring The White House's priority areas were adequately represented across all Strategic Directions in the revised *National Strategy*. The 2024 Strategic Directions, Goals, and Objectives were finalized in November 2023.

Methodology Impacts

While the accelerated timeline for revision presented challenges, the in-depth processes used to gather feedback from federal, state, and private partners improved the organization, readability, and usefulness of the 2024 *National Strategy*. Through a robust understanding of all partners' needs, challenges, experiences, and successes in moving the field of suicide prevention forward, the revised National Strategy is designed for real-world action and impact. The inclusion of The White House priority areas within the 2024 *National Strategy* ensures that new and emerging topics in the field of suicide prevention are adequately addressed. All feedback and review processes contributed to a stronger resource for the broader suicide prevention field that 1) ensures disparities in suicide prevention are recognized, 2) an equity lens is applied to all Strategic Directions, and 3) partners can identify their roles to play within suicide prevention.

The inclusion of the *Action Plan* for implementing the *National Strategy* provides a testament to the national commitment for suicide prevention. Other nonfederal partners are encouraged to review this *Action Plan* as a model they can use to inform the creation of their own action plans for advancing the 2024 *National Strategy*. A communications plan will be launched to ensure broad dissemination, and awareness of the strategy across state, tribal, local, and territorial communities.

A Brief History of Suicide Prevention in the United States from 2012 to 2023

Prior History

A timeline of national milestones in the field of suicide prevention from 1958 to 2012 is in the [2012 *National Strategy for Suicide Prevention*, Appendix C](#).

The *National Strategy*

The *National Strategy for Suicide Prevention (National Strategy)* was originally released in 2001 by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention (Action Alliance) and was last updated in 2012. In 2021, the U.S. Surgeon General issued a [Call to Action to Implement the National Strategy for Suicide Prevention](#), (Office of the Surgeon General, 2021) asking for a renewed focus on implementation of the 2012 *National Strategy*.

In 2023, the White House launched an effort to revise and update the 2012 *National Strategy*. The charge and coordination of the work was entrusted to the Department of Health and Human Services' (HHS) Suicide Prevention and Crisis Care subcommittee (SPCC) of the Behavioral Health Coordinating Council (BHCC). The SPCC subcommittee was already working to advance implementation of the 2021 Surgeon General's Call to Action, the 988 Suicide and Crisis Lifeline, and community-based comprehensive and coordinated suicide prevention efforts.

The 2024 *National Strategy* development was led by a Project Management Team with expert input from the newly formed Interagency Work Group (IWG)

comprised of agency suicide prevention leads across HHS and other federal departments, with support from the Suicide Prevention Resource Center (SPRC) and the Action Alliance.

Topics of interest were added to the 2024 *National Strategy* to showcase alignment with broader national priorities in the suicide prevention field: health equity, youth and social media, substance misuse and suicide, and crisis care.

Key Developments and Accomplishments

Since the release of the 2012 *National Strategy*, progress has been made toward implementing its goals and objectives. Research funding has grown; new grant opportunities were made available for communities and states; and the new National Suicide Prevention Lifeline three-digit number 988 became available. Additionally, policies and laws were signed and implemented to increase access to suicide crisis care, reduce stigma, and prevent suicides in our nation.

These are just some of the highlights, and a more complete listing is available in Appendix F. Among these key developments was the *Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives* (National Action Alliance for Suicide Prevention, 2014), which evolved from one of the goals in the 2012 *National Strategy* that emphasized the need to prioritize research to reduce suicide. Additionally, the first portfolio of analyses of U.S. research investments was published in 2015: *U.S. National Suicide Prevention Research Efforts: 2008–2013 Portfolio Analyses* (National Action Alliance for Suicide Prevention, 2015).

The 2017 *National Strategy for Suicide Prevention Implementation Assessment Report* noted that there was more suicide prevention activity in the United States than ever before (Substance Abuse and Mental Health Administration [SAMHSA], 2017). This statement was established by comparing the benchmark activities detailed in the 2010 publication *Charting the Future of Suicide Prevention: A Progress Review of the National Strategy and Recommendations for the Decade Ahead* with the initiatives compiled by a collaborative advisory group.

Federal Policy Initiatives

In 2015, President Obama signed the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, named in memory of Clay Hunt, a military Veteran who lost his life to suicide in 2011. The law is aimed at reducing suicides of active-duty military personnel and Veterans by improving their access to quality mental health care. In 2018, President Trump signed the Executive Order to Improve Access to Mental Health Care for Transitioning Service Members (U.S. Department of Veterans Affairs, n.d.). The order was written to ensure Veterans have access to any needed mental health care for at least one year following discharge from military service. Research showed that in the year following discharge from active duty, the transition from military service to civilian life could pose many challenges that increased the risk of suicide (U.S Department of Veterans Affairs, 2019). In addition, in 2019, President Trump signed Executive Order 13861 to create the National Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). In 2021, President Biden signed the Brandon Act, named in memory of Petty Officer Third Class Brandon Caserta who died by suicide in 2018. The law required a self-initiated referral process for service members to request a mental health evaluation through a commanding officer or supervisor grade E-6 or above confidentially.

The National Suicide Hotline Improvement Act became law in 2018. This act required the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Veterans Administration to report on the effectiveness of the existing National Suicide Prevention Lifeline (NSPL) and the potential value of a three-digit number as the new national suicide prevention number. The findings were shared with the Federal Communications Commission (FCC), and in July of 2020, the FCC issued a final order designating 988 as the new NSPL and Veterans Crisis Line (VCL) number. That October, the National Suicide Hotline Designation Act of 2020 was signed into law, incorporating 988 into statute as the new NSPL and VCL phone number. In July 2022, the United States transitioned to this easy-to-remember three-digit 988 number, which improved access to immediate support to meet the nation's growing mental health, suicide, and substance use distress needs. The 988 Suicide and Crisis Lifeline offers 24/7 call, text, and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crises, as well as any other kind of emotional distress. Based on data provided by 988 call centers, approximately 98% of answered 988 calls do not require an emergency response. Of the 2% of the calls that do require an emergency response, over 60% of those calls are ones where the caller agrees that emergency services are needed and collaborates with the counselor to receive those services (SAMHSA, 2023a).

The Suicide Training and Awareness Nationally Delivered for Universal Prevention (STANDUP) Act of 2021 was unanimously supported by the U.S. House and Senate and was signed by President Biden in 2022. The law is designed to encourage states and tribes to implement and expand evidence-based suicide prevention training in schools.

Program Initiatives

The National Violent Death Reporting System (NVDRS) is an active surveillance system that collects data regarding violent deaths, including suicide, in the United States. The NVDRS links information from over 600 unique data elements to provide insight about why a death occurred. In 2002, NVDRS began collecting data in six states, and by 2018, the Centers for Disease Control and Prevention (CDC) expanded NVDRS funding to all 50 states, Washington D.C., and Puerto Rico (Liu et al., 2023).

The Mayor's Challenge was launched in March 2018 with representation from eight cities. The goal of the Mayor's Challenge was to eliminate suicide among Veterans, service members, and their families by promoting a comprehensive public health approach that empowers communities to act. It expanded into the Governor's Challenge in 2019, with seven states participating and replicating the community effort at a state level. As of 2023, 54 states and territories are in the Governor's Challenge, and 19 communities are in the Mayor's Challenge (SAMHSA, 2023e).

SPRC launched the first-ever State Suicide Prevention Infrastructure Recommendations in 2019. The guidelines lay out essential infrastructure elements for advancing state suicide prevention efforts.

In January 2020, CDC received its first appropriation and launched its flagship Comprehensive Suicide Prevention Program (CSP), funding activities in nine states to implement and evaluate a comprehensive approach with special attention to populations that are disproportionately affected by suicide. To carry out the comprehensive approach, funded recipients 1) convene multi-sectoral partnerships; 2) use data (as available) to identify populations disproportionately impacted and to understand risk and protective factors in those populations; 3) assess current suicide

prevention programs in the jurisdiction and where gaps exist; 4) select, implement, and evaluate suicide prevention strategies and approaches with the best available evidence from CDC's Suicide Prevention Resource for Action; and 5) develop a robust communication plan to keep partners apprised of progress, successes, and lessons learned. By 2023, CDC's CSP program was funding activities in 23 states and one territory.

In March 2020, COVID-19 was declared a pandemic with a stay-at-home order issued, leading to increases in distress, worsening mental health, and causing nearly a million deaths from the disease across the United States in one year, with some communities hit particularly hard. To address these challenges, funding was made available to provide resources, including, but not limited to, support for virtual suicide prevention programming, a campaign to reinforce the concept "we're in it together," and the expansion of tele-mental health.

Timeline 2012–2024

2012

- The U.S. Surgeon General and the National Action Alliance for Suicide Prevention (Action Alliance), the nation's public-private partnership for suicide prevention comprised of senior leaders from the federal government and the private sector, release the revised 2012 *National Strategy for Suicide Prevention*.

- President Obama signs Executive Order 13625—Improving Access to Mental Health Services for Veterans, Service Members, and Military Families, which establishes the Federal Interagency Task Force on Military and Veterans Mental Health.

- The Action Alliance releases the *Suicide Care in Systems Framework* report, outlining best practices for preventing suicide in health care settings, catalyzing the national Zero Suicide initiative.

2013

- The Substance Abuse Mental Health Services Administration (SAMHSA) releases the *National Strategy for Suicide Prevention (National Strategy)* grant program focused on adult suicide prevention to help states implement the *National Strategy* recommendations.

2014

- With strategic input from experts in the field, the Action Alliance releases the nation's first-ever *Prioritized Research Agenda for Suicide Prevention*.

- The Action Alliance launches the *Framework for Successful Messaging*, the first of several national resources released to improve strategic public messaging to support suicide prevention efforts.

- The U.S. Department of Veterans Affairs (VA) releases the first yearly *National Veteran Suicide Prevention Annual Report*, the largest national yearly analysis of Veteran suicide rates each year. To access the most recent report as well as the archives visit Veteran Suicide Data and Reporting—Mental Health.

- The Action Alliance releases *The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience*, the first report to inform national suicide prevention efforts from the perspective of suicide attempt survivors.

- SAMHSA and the Suicide Prevention Resource Center (SPRC) collaborate to launch the Zero Suicide Academy, which provides training for health and behavioral health organizations.

- SAMHSA develops the first Zero Suicide grant program to provide resources to states to support health system transformation and the adoption of the Zero Suicide framework in health systems.

2015

- The National Defense Authorization Act is passed mandating the U.S. Department of Defense (DOD) to report on suicide deaths among military family members in addition to suicide deaths of service members.

- President Obama signs the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, which aims to reduce suicides of active duty military personnel and Veterans by improving their access to quality mental health care.

- SAMHSA and SPRC publish the *Zero Suicide Toolkit*, which provides tools for health system organizational change to improve suicide care which supports the Zero Suicide Academy.

- The Action Alliance releases *Responding to Grief, Trauma, and Distress After Suicide*, national guidelines to support suicide loss survivors.

- The American Indian/Alaska Native Task Force of the Action Alliance establishes an annual Hope for Life Day (September 10) and releases the *Hope for Life Day Toolkit*.

- A nationally representative public perception survey is launched on on behalf of the Anxiety and Depression Associations of America, American Foundation for Suicide Prevention, the National Action Alliance for Suicide Prevention, and the Suicide Prevention Resource Center to gauge attitudes and beliefs about mental health and suicide. It was repeated in 2018, 2020, 2022, and 2024.

- The first portfolio analyses report of U.S. research investments is published: U.S. National Suicide Prevention Research Efforts: 2008–2013 Portfolio Analyses.

- The DOD releases the *Department of Defense Strategy for Suicide Prevention*, which is modeled after the *National Strategy* but specifically addresses the needs of service members and their families.

2016

- The National Institute of Mental Health (NIMH) establishes suicide prevention as one of the institute's top research priorities.

2017

- SAMHSA releases the first *National Strategy for Suicide Prevention Implementation Assessment Report* to assess national progress in implementing *National Strategy* recommendations, which indicates additional coordination and wide-scale implementation is still needed five years after the 2012 *National Strategy* launch.

- CDC releases *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (Technical Package), which lays out strategies and approaches with the best available evidence in support of a comprehensive approach to prevent suicide.

- Indian Health Services funds the first cohort of Tribal Zero Suicide grantees (the second is in 2022).

- The Action Alliance releases *Transforming Communities: Key Elements for Comprehensive Community-Based Suicide Prevention*, a framework for how to strengthen community suicide prevention nationwide. (In 2021, CDC supports the launch of the *Community-Led Suicide Prevention* toolkit to translate this framework into tools for communities.)

2018

- Congress passes and President Trump signs the National Suicide Hotline Improvement Act of 2018 into law, which requires SAMHSA and the VA to issue a report on the effectiveness of the existing National Suicide Prevention Lifeline (NSPL) and the potential value of a three-digit number being designated as the new national suicide prevention number, paving the way for the 988 Suicide and Crisis Lifeline.

- CDC releases its first *Vital Signs* on suicide, promoting suicide as more than a mental health concern.

- CDC expands the National Violent Death Reporting System (NVDRS) to all 50 states, Washington D.C., and Puerto Rico, which for the first time allows all states to collect and track data from death certificates, coroner/medical examiner reports, law enforcement reports, and toxicology reports into one anonymous database to help inform prevention efforts for suicides and other forms of violent premature death.

- President Trump signs Executive Order 13822—Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life, which directs the VA, DOD, and Homeland Security to work together to ensure newly discharged service members and Veterans have access to any needed mental health care for at least one year following their discharge from military service.

- The Action Alliance releases *Recommended Standard Care for People with Suicide Risk*, establishing minimum guidelines for delivering evidence-based care to people at risk for suicide in a variety of health care settings.

- The VA releases the 10-year *National Strategy for Preventing Veteran Suicide*, modeled after the 2012 *National Strategy*, which sets a vision for comprehensive Veteran suicide prevention in the country.

- The U.S. Department of Justice (DOJ) launches the National Consortium on Preventing Law Enforcement Suicide to develop a strategic and collaborative response to suicide among law enforcement officers.

- The VA and SAMHSA collaborate to launch the Mayor's Challenge (which expands in 2019 to include the state-level Governor's Challenge), which establishes state and community collaboration and strategic planning around suicide prevention for Veterans.

2019

- The Zero Suicide Institute releases the *Tribal Zero Suicide Toolkit* to support the transformation of suicide care and suicide prevention in tribal communities and tribal health systems.

- President Trump signs Executive Order 13861 to create the National Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). The PREVENTS road map was released in 2020.

- The Action Alliance releases *Suicide Prevention Competencies for Faith Leaders: Supporting Life Before, During, and After a Suicidal Crisis* to equip faith leaders with the capabilities needed to prevent suicide and provide care and comfort for those affected by suicide.

- SPRC releases *State Suicide Prevention Infrastructure Recommendations* to help states build effective, comprehensive, and sustainable suicide prevention efforts.

- The American Association of Suicidology, the American Foundation for Suicide Prevention, and United Suicide Survivors International release *Report of Findings to Direct the Development of National Guidelines for Workplace Suicide Prevention*.

- CDC funds 10 states through its Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes initiative to increase the timeliness and use of self-harm syndromic surveillance data, collected through the National Syndromic Surveillance Program.

- CDC forms a suicide prevention team and releases a three-year strategic plan focused on data, science, action, and collaboration.

2020

- President Trump signs the National Suicide Hotline Designation Act of 2020 into law, paving the way for the Federal Communications Commission (FCC) to issue a final order designating 988 as the new National Suicide Prevention Lifeline and Veterans Crisis Line number, with the official name being the 988 Suicide and Crisis Lifeline. The press 1 option was maintained for the Veterans Crisis Line.

- The Congressional Black Caucus releases *Ring the Alarm: The Crisis of Black Youth Suicide in America*, which calls for focused research and action to address growing trends of suicide deaths among Black youth in America.

- SAMHSA significantly expands state suicide prevention funding during the COVID-19 pandemic.

- NIMH launches Practice-Based Suicide Prevention Research Centers, which are integrated, transdisciplinary research programs aimed at developing, refining, and testing effective and scalable approaches for reducing suicide rates in the United States. The centers support research that could not be achieved using standard research project grant mechanisms.

- The Action Alliance releases *Lethal Means and Suicide Prevention: A Guide for Community and Industry Leaders* to spur innovation and collaboration around effective strategies to reduce access to lethal means for individuals at risk for suicide.

- The VA translates a 10-year strategy into operational plans via Suicide Prevention 2.0, which unifies specific clinical services and advancements across the national, regional, and local levels with community-based suicide prevention policy, plans, and services, and Suicide Prevention Now.

- The VA begins implementation of Suicide Prevention 2.0 (SP 2.0) to reach Veterans both inside and outside VA care.

- Veterans Comprehensive Prevention, Access to Care, and Treatment Act (COMPACT Act) expands access to services.

- The Commander John Scott Hannon Veterans Mental Health Care Improvement Act broadens mental health care and suicide prevention programs to effectively evaluate and treat mental health conditions for Veterans.

- COVID-19 is declared a pandemic with stay-at-home orders issued, reducing the ability of many people to work and go to school. Many suicide risk factors increase, such as new or worsening mental health symptoms, increased substance use, loss of friends and family to COVID-19, and job and economic downturns (March 2020).

- CDC establishes its Comprehensive Suicide Prevention program to support states and communities to implement and evaluate a data-driven approach to suicide prevention using strategies and approaches with the best available evidence from its Technical Package, including a focus on disproportionately affected populations.

- With support from CDC and SAMHSA, the Action Alliance launches the Mental Health and Suicide Prevention National Response to COVID-19, which brings together influential leaders recommending change across six priority areas to transform mental health and suicide prevention nationwide in the wake of the pandemic.

2021

- SAMHSA implements a 5% crisis set aside within its Mental Health Block Grant program to provide dedicated funding to states to support the transformation of crisis care delivery.

- The Surgeon General and the Action Alliance collaborate to release *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*.

- President Biden signs the Brandon Act into law, which works to increase the availability of timely mental health support by creating a self-initiated referral process for service members seeking a mental health evaluation by allowing services to be provided confidentially.

- The Surgeon General releases *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*, urgent action from across sectors and community leaders.

- President Biden releases *Reducing Military and Veteran Suicide*, an updated strategy to advance a comprehensive cross-sector, evidence-informed public health approach.

- CDC releases the first of three reports documenting the state of state, tribal, and territorial suicide prevention. This series of reports document and synthesize information about state, tribal, and territorial suicide prevention policies, programs, infrastructure, and climate; identifies barriers and facilitators to implementing suicide prevention strategies; provides insight into suicide rate increases; and shares lessons learned with the field to inform future preventive action.

- The Department of Health and Human Services' Behavioral Health Coordinating Council launches the Suicide Prevention and Crisis Care subcommittee (SPCC). In 2023, the SPCC supported the development of the 2024 *National Strategy for Suicide Prevention* and *Federal Action Plan* and strengthening the overall behavioral health crisis continuum though interagency coordination.

2022

- DOJ launches Law Enforcement Suicide Data Collection to help agencies better understand and prevent suicides among current and former law enforcement officers, corrections employees, 911 operators, judges, and prosecutors.

- The VA releases grant funds for community-based suicide prevention efforts, known as the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, resulting in $52.5 million to support community-based Veteran suicide prevention.

- President Biden signs the Supporting the Resiliency of Our Nation's Greatest (STRONG) Veterans Act of 2022 into law, which gives the VA new authority and resources to strengthen its mental health and suicide prevention programs and to support Veterans' mental health and well-being through increased training, outreach, and mental health care delivery and research.

- President Biden signs the STANDUP Act of 2021 into law, which strengthens suicide prevention training for state, local, and tribal educational organizations.

- The FCC mandates that 988, the new Suicide and Crisis Lifeline number, be available to all landline and cell phone users, providing a single three-digit number to access a network of over 200 local and state-funded crisis centers.

- President Biden signs the Public Safety Officer Support Act of 2022 to allow for the payment of death and disability benefits under certain circumstances in which, following exposure to certain traumatic events while on duty, a public safety officer dies by suicide or is totally and permanently disabled as a result of the exposure or an attempt to die by suicide.

- CDC expands the National Violent Death Reporting System (NVDRS) to include a Public Safety Officer Suicide Module to increase data collection nationally around public safety suicide deaths to inform prevention efforts.

- President Biden signs Executive Order 14074—Advancing Effective, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety, resulting in Recommendations Regarding the Prevention of Death by Suicide of Law Enforcement in 2023.

- CDC releases Suicide Prevention Resource for Action, which updates its 2017 Technical Package, providing the best available evidence as part of a comprehensive approach to preventing suicide.

- President Biden signs the Bipartisan Safer Communities Act, creating unprecedented investment to promote access to mental health services and enhance school safety and security initiatives and to address gun violence in communities.

- Native and Strong Lifeline goes live in Washington state as the first-ever Tribal 988 Suicide and Crisis call center.

- President Biden announces a four-part Unity Agenda, which includes enhanced support for Veterans and resources to address the overdose epidemic and mental health crisis.

2023

- SPRC re-launches the Best Practice Registry with enhanced focus on health equity in suicide prevention.

- SAMHSA launches the 988 Suicide and Crisis Lifeline LGBTQI+ subnetwork.

- SAMHSA launches 988 Suicide and Crisis Lifeline Spanish language chat and text.

- The Surgeon General releases the advisory *Our Epidemic of Loneliness and Isolation*, highlighting the importance of social connection and community for our health and well-being.

- The Surgeon General releases the advisory *Social Media and Youth Mental Health*, highlighting the positive and negative impacts on young people and outlining actions policymakers, technology companies, parents and caregivers, researchers, and young people can take to create safer digital spaces.

- SAMHSA launches 988 Suicide and Crisis Lifeline videophone for the deaf and hard of hearing.

- Initial results from 988 Formative Research are released, which highlight key considerations to improve more responsive and tailored messaging for suicide prevention.

- CDC elevates mental health as a top agency priority.

- SAMHSA releases Strategic Plan, which includes the goal of enhancing access to suicide prevention and mental health services.

2024

- CDC publishes new guidance on assessing, investigating, and responding to suicide clusters.

- President Biden releases the 2024 *National Strategy for Suicide Prevention* and accompanying three-year *Federal Action Plan*.

Disparities in Suicide

What Are Health Disparities?

A health disparity is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage (National Center for Chronic Disease Prevention and Health Promotion, 2022). Health disparities adversely affect groups of people who have experienced greater obstacles to health based on characteristics historically linked to discrimination and exclusion, such as the following:

- Racial or ethnic group

- Religion

- Socioeconomic status (e.g., income, education, occupation)

- Gender

- Age

- Mental disorder

- Cognitive, sensory, or physical disability

- Sexual orientation or gender identity

- Geographic location

Health Disparities and Suicide

A comprehensive approach to suicide prevention includes acknowledging and addressing health disparities in suicide. Suicide thoughts, attempts, and deaths are influenced by the conditions in which people live, work, learn, play, and worship. These conditions have an impact at the individual, relationship, community, and societal levels and are often referred to as social determinants of health.

In addition, to the above-named factors, the conditions that contribute to increased suicide risk include, but are not limited to, the following:

- Relationship problems

- Job and/or school concerns

- Substance use

- Racism and/or societal discrimination

- Barriers to physical and mental health care access

- Financial challenges

- Social isolation

- Loneliness

- Easy access to lethal means, such as firearms and prescription medications, among people at risk

- Experiences of violence or trauma, including domestic violence, sexual assault, and adverse childhood experiences

It is critical to acknowledge health disparities in suicide, as some populations experience more of these negative conditions than the general U.S. population. This may then increase suicide risk with certain populations disproportionately affected by suicide (e.g., non-Hispanic White males or non-Hispanic American Indian/Alaska Native people) or suicide attempts (e.g., LGBTQI+ youth). Addressing social determinants of health in these populations and others help reduce suicide. In addition to groups that are disproportionately affected by suicide or suicide attempts, other groups that historically had lower rates of suicide are now experiencing significant increases in suicide rates, especially post-COVID-19 (e.g., non-Hispanic Black populations). See Table 5 in Strategic Direction 4.

Addressing Health Disparities in Suicide

Utilizing a comprehensive public health approach to suicide prevention can help to address disparities in suicide. A comprehensive approach works upstream to prevent suicide risk in the first place, identifies and supports people at increased risk, prevents reattempts, promotes recovery, and supports survivors of suicide loss. Carrying out the comprehensive approach requires the following:

- Strong leadership

- Multi-sectoral partnerships

- Use of data to identify disproportionately affected populations and to identify risk and protective factors

- Leveraging existing suicide prevention programs

- Filling gaps by implementing multiple and complementary prevention strategies with the best available evidence

- Effective communications about progress, successes, and lessons learned

- Rigorous evaluation

A comprehensive approach includes prevention strategies both upstream, to prevent suicide risk in the first place (e.g., by addressing social determinants of health in communities), and further downstream through evidenced-based treatment interventions, health systems changes, and crisis intervention.

CDC's 2022 *Suicide Prevention Resource for Action* describes strategies based on the best available evidence to prevent suicide. These include the following:

- Strengthening economic supports

- Creating protective environments

- Improving access to and delivery of suicide care

- Promoting healthy connections

- Teaching coping and problem-solving skills

- Identifying and supporting people at risk

- Lessening harms and preventing future risk

Collectively, these strategies provide a framework for ensuring that key disparities contributing to suicide risk are addressed within our prevention efforts, including financial issues, unsafe community environments, poor access to health and mental health services, and unhealthy relationships. By addressing these social determinants of health, we can reduce long-term suicide risk in both individuals and communities and increase protective factors against suicide. Understanding the assets, strengths, and cultural protective factors can also contribute to building suicide prevention strategies that will be accepted and adopted by communities disproportionately impacted by suicide. Developing, nurturing, and sustaining community partnerships can help to identify ways to build connection into suicide prevention activities.

For additional information on strategies to prevent suicide among populations that experience health disparities and those who are at an increased risk for suicide, visit CDC resource *Preventing Suicide Requires a Comprehensive Approach*. This resource provides steps for different sectors to advance suicide prevention efforts, including health care systems, schools and employers, the public health sector, states and communities, the media, and the general public.

Resources for Groups with Increased Suicide Risk

To accurately understand, measure, and track the public health issue of suicide, it is critical to ensure the regular collection, dissemination, and monitoring of diverse data sources that inform our understanding of the issue of suicide in our communities. It is especially important to ensure data sources include information on groups experiencing health disparities and may therefore be exposed to factors that lead to higher risk.

Additional information for supporting diverse communities and populations is available from the Suicide Prevention Resource Center's (SPRC's) Online Library (https://sprc.org/online-library) and select Population pages (https://sprc.org/populations/). For information on evidence-based and best practices programs and guidelines, visit SPRC's Best Practices Registry (https://bpr.sprc.org/), an online library of suicide prevention programs and interventions searchable by population or setting.

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Accessible Descriptions for Complex Figures

Figure 1. **Age-adjusted suicide rates, 2000–2022, United States**

Line graph illustrating the age-adjusted suicide rates per 100,000 for each year: **2000**, 10.4; **2001**, 10.7; **2002**, 10.9; **2003**, 10.73; **2004**, 10.92; **2005**, 10.84; **2006**, 11; **2007**, 11.3; **2008**, 11.6; **2009**, 11.8; **2010**, 12.1; **2011**, 12.3; **2012**, 12.6; **2013**, 12.6; **2014**, 13; **2015**, 13.3; **2016**, 13.5; **2017**, 14; **2018**, 14.2; **2019**, 13.9; **2020**, 13.5; **2021**, 14.1; and **2022**, 14.2.

Figure 2. **Age-adjusted suicide rate per 100,000 for the United States by state of residence, 2022**

U.S. map illustrating the age-adjusted suicide rates per 100,000 for states of residence. States are grouped by rate ranges:

6.1 to 13.3: California, Illinois, New York, Massachusetts, Connecticut, Rhode Island, New Jersey, Delaware, Maryland, Virginia

14 to 15: Washington state, Minnesota, Michigan, Ohio, Pennsylvania, Texas, Mississippi, Georgia, Florida, North Carolina

15.1 to 17.7: Nebraska, Wisconsin, Indiana, Tennessee, Louisiana, Alabama, South Carolina, Maine, New Hampshire, Hawaii

18 to 21: Oregon, Nevada, Arizona, Kansas, Iowa, Missouri, Arkansas, Kentucky, West Virginia, Vermont

21.1 to 28.7: Idaho, Montana, North Dakota, South Dakota, Wyoming, Utah, Colorado, New Mexico, Oklahoma, Alaska

Figure 3. **Age-adjusted rates for nonfatal self-harm visits to EDs, 2001–2021**

Line graph illustrating the age-adjusted rates per 100,000 for nonfatal self-harm visits to emergency departments for each year: **2001**, 112.82; **2002**, 112.44; **2003**, 141.58; **2004**, 145.42; **2005**, 126.52; **2006**, 132.97; **2007**, 132.4; **2008**, 124.91; **2009**, 123.78; **2010**, 152.95; **2011**, 159.53; **2012**, 157.37; **2013**, 160.43; **2014**, 152.34; **2015**, 162.77; **2016**, 160.27; **2017**, 157.43; **2018**, 158.32; **2019**, 158.34; **2020**, 155.77; and **2021**, 157.03.

Figure 4. **The 10 essential public health services**

https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.

ASSESSMENT

- **Essential Public Health Service #1:** Assess and monitor population health status, factors that influence health, and community needs and assets.
- **Essential Public Health Service #2:** Investigate, diagnose, and address health problems and hazards affecting the population.

POLICY DEVELOPMENT

- **Essential Public Health Service #3:** Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
- **Essential Public Health Service #4:** Strengthen, support, and mobilize communities and partnerships to improve health.
- **Essential Public Health Service #5:** Create, champion, and implement policies, plans, and laws that impact health.
- **Essential Public Health Service #6:** Utilize legal and regulatory actions designed to improve and protect the public's health.

ASSURANCE

- **Essential Public Health Service #7:** Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
- **Essential Public Health Service #8:** Build and support a diverse and skilled public health workforce.
- **Essential Public Health Service #9:** Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
- **Essential Public Health Service #10:** Build and maintain a strong organizational infrastructure for public health.

Created 2020

Figure 6. **Suicide Care Pathways**

A decision tree with two options at two points. The path starts at "Concern identified during routine appointments. Client referred for suicide risk or post-attempt recovery. Routine client intake." Next is "screening using evidence-based tool." This step is the first decision point: If no risk is identified, the client goes to routine care and has a clinical review, assessment, and consultation, and completes an evidence-based treatment plan. If a risk is identified, the client undergoes a full clinical assessment using an evidence-based tool. This is the second decision point.

If the full clinical assessment identifies an immediate or imminent risk, the client receives a clinical evaluation for a higher level of care, including crisis respite, crisis stabilization, and inpatient admission. There is a follow-up post-discharge, and staff connect back for recovery support.

If the full clinical assessment identifies no immediate or imminent risk, the client is enrolled in the Suicide Prevention Care Pathway, which is documented in the client's electronic health record (or EHR). This pathway includes collaborative safety planning and lethal means safety counseling. Staff follow up with the client and their support system to ensure safety steps are taken. Next, the client connects with evidence-based treatment specific to suicide and with peer support, if available. The client is seen at least once per week and has a regular reassessment and a regular review of their safety plan. Follow-up is conducted for any missed appointments. ← Back to Figure 6

Figure 8. **Crisis Services**

This figure presents elements of the crisis care continuum among six elements, with five making up a circle, and one in the center of the circle. Each has a bullet list. The five elements comprising the outer circle include:

Service 1: Someone to Respond: Mobile Crisis Response. It includes respond in community, clinical evaluation, de-escalation, safety planning and referrals to walk in, stabilization, and community supports.

Service 2: A Safe Place for Help, such as crisis receiving and walk-in centers. It includes clinical evaluation and safety planning; referrals to stabilization, community supports, and inpatient; and evidence-based interventions and peer support.

Service 3: A Safe Place for Help and Crisis Stabilization. It includes short-term options to move beyond crisis in a supported and calm environment, evidence-based interventions and peer support, and referrals to community supports and inpatient.

Service 4: Community Emergency Responders, such as emergency medical services, fire department, law enforcement, and dispatch. It includes triage in the community, connection with walk-in centers, and stabilization.

Service 5: Community Supports, with the examples of mental health centers, Certified Community Behavioral Health Clinics (or CCBHCs), and faith communities. This service includes crisis outreach, aftercare, and follow up and evidence-based treatment.

The sixth element in the center of the circle is **Service 6:** Someone to talk to, such as 24/7 988 Suicide and Crisis Lifeline. It includes dispatch mobile crisis services; active listening, clinical evaluation and intervention, and safety planning; care coordination support and follow-up; and coordination with 911 dispatch. ← Back to Figure 8