The Surgeon General's Call to Action
TO IMPLEMENT THE NATIONAL STRATEGY FOR SUICIDE PREVENTION

A Report of the U.S. Surgeon General and of the
National Action Alliance for Suicide Prevention

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Preface from the Surgeon General

Together with the National Action Alliance for Suicide Prevention (Action Alliance), I am honored to present *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*. More than 20 years ago, Surgeon General David Satcher issued the landmark report *The Surgeon General's Call to Action to Prevent Suicide*, recognizing suicide as a major public health issue and calling for a national response. Although we have established a solid foundation for suicide prevention in the United States, much work remains to be done.

The *National Strategy for Suicide Prevention (National Strategy)*, first released in 2001 and updated in collaboration with the Action Alliance in 2012, identifies 13 goals and 60 objectives that address every aspect of suicide prevention—from fostering healthy and empowered individuals, families, and communities to providing effective prevention programs and clinical care. The Action Alliance has become a diverse and impactful partnership that is advancing implementation of the *National Strategy* across the public and private sectors every day.

Today we know more about suicide and how it can be prevented than we did in 1999. We understand that like other public health problems, such as obesity and cancer, suicide is influenced by many factors. As a result, suicide prevention efforts must engage all sectors, including public health, mental health, health care, social services, our military and Veterans, business, entertainment, media, faith communities, and education. These efforts must be informed by data, guided by the needs of the groups affected, and shaped by the voices of people who have experienced suicidal thoughts, plans, attempts, and losses.

In the past 20 years, suicide prevention activity has increased dramatically, and we have made progress in implementing the goals and objectives in the *National Strategy*. Adding to the momentum for collaboration around suicide prevention efforts, President Donald Trump signed Executive Order 13861, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), thus establishing a cabinet-level Task Force. As a Task Force member and Ambassador for PREVENTS, I have collaborated with federal, state, local, territorial, and tribal governments, as well as non-governmental entities and organizations to prevent suicide deaths. New sectors have become involved, and we have observed an increase in public awareness that suicide is preventable. However, there is still much work to be done to fully implement the *National Strategy*, and suicide remains a serious, and growing, public health problem. In 2019, more than 47,000 people died by suicide, and millions more struggled with serious thoughts of suicide or supported someone close to them who was in distress.

Experiencing a suicidal crisis or losing a loved one to suicide can have deep and long-lasting consequences. Families, friends, colleagues, neighbors, communities—and ultimately our entire nation—feel the effects of this suffering and loss. We can and must do more to prevent these deaths and distress and to help all Americans lead healthy and fulfilling lives.

At the same time, we recognize the substantial challenges ahead of us. A worldwide pandemic continues to impact the health and economic well-being of Americans. This crisis has brought renewed attention to deep-seated inequities in health, education, employment, housing, and other areas that affect the lives of millions of Americans. Problems resulting from the pandemic—including physical illness, loss of loved ones, anxiety, depression, job loss, eviction, and increased poverty—could all contribute to suicide risk.

Today, perhaps more than ever before in our recent history, we need to come together as a nation to strengthen and support one another—to be there for our friends, family members, colleagues, neighbors, and others facing difficult times. All of us have a role to play in spreading kindness and compassion and supporting one another when we are struggling.

Please join us in carrying out the actions outlined in this report to fully implement the *National Strategy* so that we may build strong and healthy communities, support those who may be struggling, and save lives.

Jerome M. Adams, MD, MPH
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

As co-chairs of the National Action Alliance for Suicide Prevention (Action Alliance), in partnership with U.S. Surgeon General Jerome Adams, we are pleased to release this *Call to Action*, which identifies six priority actions for suicide prevention in the United States. Established in 2010, the Action Alliance is the public-private partnership tasked with advancing the *National Strategy for Suicide Prevention (National Strategy)*. We are fulfilling this charge every day by championing suicide prevention as a national priority and bringing together diverse sectors—including health care, the justice system, first responders, faith leaders, communities of color, the media, and employers—to leverage their leadership roles in supporting efforts to implement the 2012 *National Strategy*. Our mission is fueled by more than 250 partner organizations dedicated to leading a coordinated national response to suicide.

The *National Strategy* recognizes that suicide is a complex issue requiring comprehensive solutions. No single strategy alone will be enough to reduce suicide rates. Suicide prevention efforts must combine strategies that promote resilience and wellness, identify and support individuals and groups at risk, provide effective crisis response and care for suicide risk, and support those who have been affected by suicide. These efforts must be guided by the voices of individuals with lived experience and tailored to the unique strengths and needs of groups who bear a disproportionate burden of suicide, including military service members, Veterans, indigenous communities, and ethnic, racial, sexual, and gender minorities.

We know that the coronavirus disease-2019 (COVID-19) pandemic is taking a tremendous toll on Americans' emotional and economic well-being. While no one is immune from the stress and anxiety resulting from this crisis, these effects are magnified in households that already faced systemic disparities before the pandemic began. During these times, we must focus on strengthening individuals and communities to cope with adversity, and supporting those who may be facing multiple challenges. We also need to ensure that those at risk for suicide are provided with effective care that will support their recovery.

Together with our many partners, we have made much progress in engaging new sectors, building public awareness and momentum, and leveraging resources to identify best practices in suicide prevention. We now know more about what works to prevent suicide than ever before. These evidence-based approaches must be implemented more widely.

Urgent action around suicide prevention is needed at the federal, state, tribal, and local levels to fully implement the goals and objectives of the *National Strategy* and change the trajectory of suicide in our country. The Action Alliance is ready and eager to lead the charge. The six actions and associated strategies outlined in this report will help move us closer to fully implementing the *National Strategy* and achieving our ultimate vision: a nation free from the tragedy of suicide. Please join us.

Sincerely,

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From the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) Office

Suicide is one of the most challenging societal issues of our time, affecting our Veterans at alarming rates. To address suicide within the Veteran community and to create an "all of nation" approach to prevent suicide more broadly, Executive Order 13861, known as The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), was signed on March 5, 2019. At the center of PREVENTS' work is the goal of preventing suicide. Achieving this goal requires culture change, seamless access to care, a connected research ecosystem, and robust community engagement. It also requires ongoing coordination with all sectors, institutions, and stakeholders. Because suicide is a national tragedy that affects all of us, in order to be successful, everyone must be engaged.

PREVENTS works to elevate and amplify existing suicide prevention initiatives and to address gaps in the efforts and services outlined in the first (2001) and updated (2012) *National Strategy for Suicide Prevention*. To accomplish the aspirational goals of PREVENTS, a comprehensive plan—or Roadmap—was developed over the course of a year and released to the public in June 2020. Several critical goals have been accomplished since the release of this public health approach:

- Construction of the PREVENTS office, comprising dedicated staff, detailed action officers from the PREVENTS Task Force federal departments, and contract support to operationalize the work of PREVENTS and the REACH campaign
- Launch of the REACH national public health campaign, developed specifically for this effort, which to date has 2.8+ billion media impressions, 642+ million video views, 7.7+ million website visits, and 15,000+ pledges
- Implementation of a scalable operational structure that currently involves more than a thousand individuals and organizations representing federal, state, local, and tribal governments; faith-based communities; nonprofit organizations; academia; Veteran and military service organizations; and other private industry partners, working collaboratively with specified roles and actions, using best-in-practice implementation strategies
- Creation of the framework and partnerships to implement a National Grant Program beginning in 2022, authorized by the Commander John Scott Hannon Act, passed into law in October 2020

Much has changed since the PREVENTS Executive Order was signed in March 2019, including a global pandemic that has created additional challenges and strain on the mental health and well-being of our nation. Recent polls have indicated that as many as a third of Americans are experiencing some form of mental health distress. More than ever before, these challenging times highlight the importance of collaboration and coordination as we engage all Americans to ensure that those in need are able to receive the care and support they deserve.

In 2021, PREVENTS looks forward to working with the Office of the Surgeon General and the Action Alliance to continue this critical work. The six actions and associated strategies outlined in this report are necessary and achievable. No single organization or entity can accomplish this alone, but together we will prevent suicide.

Barbara Van Dahlen, PhD
PREVENTS Executive Order Task Force
Executive Director

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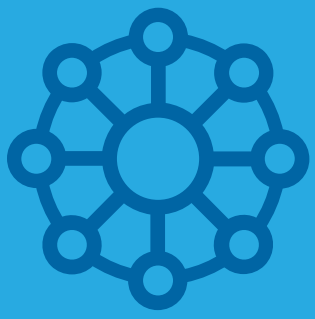

Introduction and Overview

Introduction and Overview

Suicide is a tragedy that touches the lives of millions of Americans. One of the 10 leading causes of death in the United States, suicide claimed more than 47,500 lives in 2019 alone.[1] Moreover, suicide rates are rising across the country.[2] From 1999 to 2019, the national suicide rate increased 32 percent—from 10.5 to 13.9 per 100,000.[1, 3]

These deaths are only the tip of an iceberg. For every person who dies by suicide, thousands more experience suicidal thoughts or attempt suicide. In a 2019 national survey, 1.4 million U.S. adults reported attempting suicide in the past year, 3.5 million adults reported making a suicide plan in the past year, and 12 million adults reported having serious thoughts of suicide in the past year.[4] Additionally, from 2008 to 2017, visits to the emergency department related to suicidal ideation or suicide attempts increased among all age groups.[5]

When someone experiences a suicidal crisis or dies by suicide, countless others—including family members, friends, teachers, and coworkers—are affected. Losing someone to suicide is a tragedy that has long-lasting consequences and may increase the risk for suicidal behaviors,[6, 7] which include preparatory acts, suicide attempts, and deaths.[8] The economic toll is immense as well. Suicide attempts and deaths by suicide are estimated to cost the nation more than $93 billion per year in medical costs and lost productivity.[9]

Although suicide is a complex behavior that can be influenced by many different factors, suicide is preventable. Suicide prevention requires a comprehensive approach that combines multiple strategies to reduce risk and strengthen protective factors at the individual, relationship, community, and societal levels.

1999 Surgeon General's Call to Action

Recognizing the need to make suicide prevention a national priority, in 1999 Surgeon General David Satcher issued *The Surgeon General's Call to Action to Prevent Suicide*.[10] The call came at a time of increased momentum around suicide prevention worldwide. U.S. suicide prevention efforts had been initiated decades earlier by dedicated grassroots activists—many of whom had lost someone to suicide or had faced a suicidal crisis themselves—but in the 1990s these efforts coalesced around the need to develop a national coordinated response. To that end, the United States participated in a landmark international conference in Canada in 1993, and five years later conducted its first-ever National Suicide Prevention Conference, in Reno, Nevada. Guided by the recommendations resulting from the national conference, Dr. Satcher's *Call to Action* introduced a blueprint for suicide prevention and called for the development of a comprehensive national strategy.

National Strategy for Suicide Prevention

In 2000, a federal steering group comprising diverse representatives from the public and private sectors conducted a series of public hearings to guide the development of a national strategy. Released jointly by Dr. Satcher and the National Council for Suicide Prevention in 2001, the *National Strategy for Suicide Prevention (National Strategy)* presented a detailed roadmap for preventing suicide in a comprehensive and coordinated way.[11]

In the years that followed, activity around suicide prevention swiftly expanded, with government agencies at all levels, nonprofit organizations, schools, and other entities initiating suicide prevention programs. Guided by the goals and objectives of the *National Strategy*, states nationwide developed their own state-level suicide prevention plans. At the federal level, key achievements included the enactment of the 2004 Garrett Lee Smith (GLS) Memorial Act, which provides funding for youth suicide prevention, and the 2007 Joshua Omvig Veterans Suicide Prevention Act, which directed the U.S. Department of Veterans Affairs (VA) to implement a comprehensive suicide prevention program for Veterans. GLS-funded suicide prevention programs have been found to have a long-term effect in reducing youth suicide rates.[12] Other accomplishments included the establishment and funding of the Suicide Prevention Resource Center and the National Suicide Prevention Lifeline (1-800-273-8255).

The 2001 *National Strategy* called for the establishment of a public-private partnership to lead the implementation of its 13 goals and 60 objectives. Launched in 2010, the National Action Alliance for Suicide Prevention (Action Alliance) brings together partners from diverse sectors—including health care, faith, news media, criminal justice and law enforcement, and business—and individuals with lived experience to advance suicide prevention in the United States.

As one of its first tasks, the Action Alliance worked closely with U.S. Surgeon General Regina Benjamin and numerous stakeholders from across the country to revise and update the *National Strategy* to reflect a decade of advancements in suicide prevention research and practice. This effort culminated with the release of the 2012 *National Strategy* that guides our suicide prevention efforts today.[8]

The Rationale for Action

Since the *National Strategy* was updated in 2012, suicide prevention efforts have expanded and multiplied. New research is increasing our understanding of how to best implement suicide prevention practices in health care systems and communities. New partners have become engaged in suicide prevention, including organizations and businesses that had not previously viewed suicide prevention as part of their mission. Although funding still may not reflect the serious and wide-reaching impact of suicide on our nation, more attention and resources are being dedicated than ever before. Recent examples include the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), launched in 2019,[13] and the Federal Communications Commission's (FCC's) decision to designate 988 as the national number for mental health crises[14] (which will be implemented by July 16, 2022).

Throughout these years, the suicide prevention field has also strengthened its commitment to ensuring that suicide prevention is guided by the voices of those with lived experience. Individuals who have personal knowledge of suicide are increasingly contributing their unique and vital insights to all aspects of suicide prevention, including program planning and evaluation, policy development, and service delivery. The voice of lived experience is helping to ensure that, as a society, we talk about mental health and suicide in a more inclusive, informed, and compassionate way. Insights from lived experience are guiding the provision of services and supports that best meet the needs of persons experiencing a suicidal crisis or who have lost someone to suicide, and are informing efforts to better prepare communities nationwide to respond to the aftermath of suicide and to support recovery among all who may be affected.

People with lived experience.
Individuals who have personal knowledge of suicide gained through direct, first-hand experience. They include people who have experienced suicidal thoughts, survived a suicide attempt, or lost a loved one to suicide.

And yet, much remains to be done. 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.[15] 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.

The urgency to prevent suicide has increased in recent years, as two major crises—the opioid epidemic and the coronavirus disease-2019 (COVID-19) pandemic—have dramatically impacted the health and economic well-being of millions of Americans. As *The Surgeon General's Spotlight on Opioids* notes, opioid misuse and opioid use disorders have contributed to devastating consequences, including thousands of overdose deaths, the transmission of HIV and viral hepatitis, and increased violence and child neglect.[16] The opioid crisis has a direct link to suicide, as substance misuse is a risk factor for suicide, and studies suggest that a significant number of opioid overdose deaths may have suicidal intent.[17] Further, the secondary consequences of overdose deaths, particularly those related to trauma and traumatic loss, may also increase suicide risk among those left behind.

The COVID-19 pandemic continues to cause widespread illness and the loss of loved ones, while increasing social isolation and economic stress and reducing access to community and religious support—all factors that could potentially contribute to suicide risk.[18] These challenges are being felt even more strongly by communities of color, due to systemic factors that place many individuals and their families at an increased risk of being exposed to the virus, becoming seriously ill, failing to receive adequate care, losing their jobs and businesses, and suffering long-lasting health and economic consequences.[19] Although the impact of the pandemic on deaths by suicide is still unknown, new research is detecting increases in mental health problems—including suicidal thoughts—and in the misuse of alcohol and other drugs among U.S. adults.[20] Groups who may be particularly affected include younger adults, racial and ethnic minorities, essential workers, and unpaid adult caregivers.[20]

Conditions resulting from the pandemic could further exacerbate existing structural inequities that impact the health and well-being of groups identified as being at increased risk for suicidal behaviors. For example, high rates of suicidal behaviors among American Indian and Alaska Native youth have been linked to both historical trauma and long-lasting disparities in education, housing, and employment.[21] Sexual and gender minority youth, another group at a higher risk for suicide,[22] are more likely than others in the general population to experience structural inequities, such as discrimination in employment[23] and housing.[24] New research suggests that the pandemic may be seriously impacting the mental health of this population.[25]

While the opioid epidemic and the COVID-19 pandemic represent substantial challenges for suicide prevention, they also shed light on new opportunities. Our national response to the opioid epidemic has shown that effectively countering a serious behavioral health crisis requires a research-based, adequately funded, multi-component approach that focuses on both treating those who are experiencing addiction and preventing others from starting to misuse drugs.[26] By broadening perspectives about substance misuse and who can be affected, the national response has helped decrease prejudice toward individuals who experience addiction. The response has shown that substance use treatment—including care provided from a distance—is necessary, feasible, and effective.[27, 28] In addition, programs that have widely distributed naloxone to prevent opioid overdoses have brought attention to the role that communities can play in supporting individuals in distress and connecting them to sources of treatment and recovery.

Similarly, the COVID-19 pandemic has made it clear that high levels of stress can affect anyone's mental health and emotional well-being, thus spurring a public dialogue regarding the importance of sustaining wellness and seeking mental health supports when needed. The crisis has increased the acceptance and use of technology—particularly videoconferencing—to provide services and supports to individuals who may be struggling.[29] It has also highlighted the critical role that social connections and social support can play in promoting mental health and resilience. Finally, the pandemic has increased awareness that societal-level factors—such as lack of access to well-paying jobs, safe housing, enough food, high-quality education, and effective health care services—can strongly impact mental and physical health. More research is needed on these societal factors and how programs addressing them can play a role in preventing suicide.

The Call to Action

The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention (Call to Action) seeks to advance progress toward full implementation of the *National Strategy*, while taking into account the unique challenges and opportunities of our times. Like the *National Strategy*[8] (p. 8), this *Call to Action* is dedicated to the following:

> *To those who have lost their lives by suicide,*
> *To those who struggle with thoughts of suicide,*
> *To those who have made an attempt on their lives,*
> *To those caring for someone who struggles,*
> *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.*

The *Call to Action* emphasizes that the 13 goals and 60 objectives of the *National Strategy* remain as relevant today as they were when the strategy was last updated. However, to truly make a difference in reducing suicide rates, these goals and objectives need to be fully implemented. In particular, the *Call to Action* zeroes in on six key actions that must be implemented if we are to reverse the current upward trend in suicide deaths in the U.S.

Developed in consultation with many partners (see Appendix 1), the *Call to Action* has three key objectives:

- Activate a broad-based response to suicide (Actions 1 and 2)
- Implement evidence-based approaches that must be adopted more widely:
    - Lethal means safety (Action 3)
    - Safe and effective care for suicide risk (Action 4)
    - Enhanced crisis care systems (Action 5)
- Present priorities for improving the quality, timeliness, and use of data to guide suicide prevention (Action 6)

The six actions fall broadly into the four Strategic Directions of the *National Strategy* (see sidebar), and several relate to multiple goals and objectives across the four directions.

We know that reversing the upward trend in suicide rates will not be easy, particularly given the significant challenges ahead of us in the wake of the current pandemic, but we are better prepared than ever before. Guided by scientific evidence, collaboration across public and private sectors, and insights from people with lived experience, we know what we need to do—and, as a nation, we are ready to act.

Strategic Directions and Actions

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

- Action 1: Activate a broad-based public health response to suicide
- Action 2: Address upstream factors that impact suicide

Strategic Direction 2: Clinical and Community Preventive Services

- Action 3: Ensure lethal means safety

Strategic Direction 3: Treatment and Support Services

- Action 4: Support adoption of evidence-based care for suicide risk
- Action 5: Enhance crisis care and care transitions

Strategic Direction 4: Surveillance, Research, and Evaluation

- Action 6: Improve the quality, timeliness, and use of suicide-related data

Broadening the Vision

Broadening the Vision

In the past, suicide was often viewed as a mental health problem that affected a few individuals and could only be addressed by mental health specialists. Today we recognize that suicide is both a mental health and a public health concern. Like other public health problems, such as obesity and heart disease, suicide is affected by many influences—related to individual characteristics, interpersonal relationships, the community, and the larger society. Mental illness, substance misuse, social isolation, physical health problems, relationship issues, the loss of a loved one, a family history of suicide, access to lethal means, and legal or financial problems can all increase suicide risk or precipitate a suicidal crisis.[30, 31] Other factors—such as a sense of purpose, social connectedness and support, cultural identity, life skills, and access to effective health care—can play a protective role, moderating or "buffering" the impact of existing risk factors.

The *National Strategy* emphasizes that suicide prevention efforts are more likely to succeed if they are comprehensive, combining multiple strategies that work together to prevent suicide[8]—for example, teaching coping and problem-solving skills, promoting connectedness, identifying individuals at risk and connecting them to effective care, and providing support to those who have lost a loved one to suicide.[32]

Moving upstream.

This term comes from a classic story in which rescuers saving people from drowning in a rushing river are becoming exhausted. Finally, some of the rescuers wonder why all these people are falling in the river, and they decide to move upstream to see if there is a way to stop this from happening. Like the rescuers in this story, public health works to help those already at risk but also to address factors that can prevent others from becoming at risk in the first place.

Traditionally, suicide prevention efforts have more often focused on identifying and supporting individuals and groups at risk than on modifying "upstream" risk and protective factors that affect the whole population.[33] Recognizing the need to better understand and address these upstream factors, Strategic Direction 1 of the 2012 *National Strategy* calls for efforts focused on healthy and empowered individuals, families, and communities.[8]

The *National Strategy* recognizes that while we must continue to focus on individuals and groups at risk, we must also seek to modify the upstream societal factors that influence suicide risk and mental health,[33] including adverse childhood experiences,[34] unemployment,[35] a lack of safe and affordable housing,[36] and financial hardship.[37] More recent studies are exploring the potential role of other factors (e.g., exposure to air pollution) in increasing suicide risk.[38, 39]

In addition, we need to identify ways to strengthen the protective factors that promote strength and resilience (the ability to endure, respond to, and recover from stress and adversity[40]), thereby reducing suicide risk. Research suggests that efforts aimed at increasing protective factors can have long-lasting effects. For example, the Good Behavior Game, a school-based behavior management program that has been extensively studied, has been found to have long-term effects in preventing suicidal behaviors and related problems, such as substance misuse and violence, among youth.[41, 42] Other school-based prevention programs that build life skills and resilience have also been found to have long-term positive effects in supporting various health outcomes.[33, 43, 44] In addition, family-based prevention programs, conducted with diverse groups, have been found to have long-term effects on decreasing suicide risk and providing other related benefits (e.g., prevention of mental health problems).[45–47]

Suicide prevention theory and research have long identified the social context as crucial to protecting individuals and populations from suicide.[48, 49] Theories of suicide suggest that social factors, such as isolation and the feeling of being a burden to others, may increase suicide risk.[50–52] Opportunities to contribute—through gainful employment that pays a living wage, or by volunteering or mentoring—may help reduce suicide risk by fostering supportive relationships and a sense of meaning and purpose. These theories suggest that at our core, human beings need to be connected to one another and need to believe that they are making a meaningful contribution to society. Schools, workplaces, places of worship, and many other organizations in the community help provide opportunities for individuals to develop these positive connections and be of service in meaningful ways.

As some experts have noted, suicide prevention must go beyond identifying and addressing risk factors to charting a course toward building a purposeful, engaged life.[53] While we need to continue to increase understanding of why some people experience suicidal thoughts and behaviors, we also need to better understand the factors that help individuals overcome a crisis and recover, including key supports and reasons for living.

The six actions that follow are intended to continue the progress toward full implementation of the *National Strategy*. These actions include suicide prevention strategies that are appropriate for the general population, as well as for groups at risk and for individuals in crisis. The actions are intended to bring to scale approaches that have been found to be effective, and to expand our vision of suicide prevention to include both risk and protective factors—not only to reduce injury and death, but also to help all Americans lead purposeful and connected lives.

ACTION 1
Activate a Broad-Based Public Health Response to Suicide

Inspire and empower everyone to play a role in suicide prevention.

Action 1. Activate a Broad-Based Public Health Response to Suicide

Inspire and empower everyone to play a role in suicide prevention.

The *National Strategy* calls for the implementation of a broad-based public health response to suicide that engages all societal sectors—including government, health care systems and providers, businesses, educational institutions, community-based organizations, family members, and friends—in suicide prevention.[8] Suicide prevention should be infused into schools, workplaces, faith-based organizations, corrections, senior living communities, and other diverse settings and systems. Integrating suicide prevention into the work of all sectors will help create a network of community-wide supports to reduce risk, enhance protection, and support the implementation of culturally appropriate prevention efforts that are tailored to each group's unique needs and strengths.

Communication efforts can help activate a broad-based response to suicide by changing knowledge, attitudes, and behaviors related to mental illness and suicide. As a society, we need to be comfortable talking about suicide openly and without judgment. Research suggests that we have made tremendous headway in reducing the silence around mental illness and suicide that prevents so many from seeking help. In a recent nationally representative survey, the vast majority of Americans (93 percent) believed that suicide was preventable, at least sometimes, and three in four were comfortable being there for a loved one who might be struggling or having thoughts of suicide.[54] We must build on this progress and continue to change the conversation around suicide to engage all Americans in suicide prevention.

I was an inaugural appointee

of the Workplace Task Force when the Action Alliance was started in 2010. At that time, we suspected that the culture, jobs, and lifestyles of our workers in the construction industry might place them at an increased risk for suicide. One particular concern was substance misuse, including the use of prescribed opioid pain relievers to cope with chronic pain from years of hard work.

At that time, we didn't know the extent of the problem because national data on suicide among different occupations was not readily available. When CDC analyzed occupational data from 17 states in NVDRS several years later, they found that the construction and extraction industries had the highest suicide rates and the highest number of suicides among all industries. This finding persists in the most recent occupational data collected among 32 states in 2016.

In response, our industry mobilized to actively embed suicide prevention into its safety culture. Our Construction Industry Alliance for Suicide Prevention provides access to information, resources, and training on how to make mental health and suicide prevention part of a company's culture. Construction culture has shifted from getting workers home safely at the end of the shift to getting our people back to work safely from home.

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We also need to do better at translating what diverse systems, sectors, professionals, and individuals can do to reduce risk and build strengths. Every individual and organization must understand how they can support those who may be at risk for suicide and help everyone achieve a healthier and more connected, productive, and satisfying life.

People with lived experience have an important role to play in guiding and informing the implementation of a broad-based, inclusive, and effective response to suicide.[55] These individuals, who include program planners, health care providers, business leaders, teachers, and family members, have long contributed to improving supports for persons at risk for suicide by taking a lead role in the delivery of effective and compassionate care to prevent suicide. Their involvement has been key to emphasizing safety, dignity, and respect for individuals who may be experiencing a suicidal crisis. Stories and insights from those with lived experience can illustrate how we all can play a part in supporting others during a time of crisis.

Finally, we need to track our outreach efforts against established metrics and industry standard benchmarks to measure outcomes and inform continuous process improvement as messages are developed and tested, including segmented messaging to key subpopulations and the populations and communities at high suicide risk.

1.1 Broaden perceptions of suicide, who is affected, and the many factors that can affect suicide risk.

Although mental health conditions are often seen as the causes of suicide, suicide is rarely caused by any single factor. Many influences at the individual, relationship, community, and societal levels can increase suicide risk or precipitate a crisis, including social isolation, relationship problems, the loss of a loved one, and legal or financial issues.[30, 31] Other factors, such as a sense of purpose, social connectedness and support, opportunities to contribute, and access to effective care, can play protective roles.[30, 31]

The *National Strategy* identifies several groups as being at a higher risk for suicidal behaviors than the general population:[8]

- Certain demographic groups, for example:
  - Working-age men
  - Military service members and Veterans
  - American Indians and Alaska Natives
  - Sexual and gender minority populations
  - Older adults
  - Individuals in child welfare and justice settings
- Individuals experiencing risk factors linked with suicide, for example:
  - A history of suicidal behaviors
  - A loss of someone to suicide
  - Mental illness, substance misuse, and/or certain medical conditions

Studies have also found that suicide rates are higher in rural areas[3, 56] and in some occupations, such as construction.[57, 58]

Suicidal behaviors—as well as risk and protective factors for suicide—can vary among subgroups and change over time. For example, although suicide rates have been historically lower among Black people than among white people, recent studies have identified an alarming increase in suicidal behaviors and deaths among Black children and adolescents.[59–61] In some cases, the prevalence of suicidal behaviors and risk factors among some groups may not be known because data collection tools and systems do not yet collect this information or make it easily accessible. Access to timely and accurate data on deaths by suicide, suicide attempts, and related circumstances is critical in order to ensure that prevention efforts are reaching those most at risk. (For more on needed improvements to the quality and timeliness of suicide-related data, see Action 6.)

Research is shattering myths

about who dies by suicide and who engages in suicidal behaviors. The rate of self-reported suicide attempts by Black high school students rose over the past generation, even as attempt rates in students from other groups declined, according to research I led at the New York University (NYU) McSilver Institute that was published in the journal *Pediatrics* in 2019. These rising rates of suicide behavior engagement among Black youth become particularly salient to monitor given the current climate of racial unrest, the COVID-19 pandemic, and the rising rates of income inequality, all of which impinge on these youth's emotional and psychological well-being. We must focus attention and resources to get to the bottom of why this is happening, and mobilize protective factors like family education on the signs and indications of suicide risk to ensure that Black youth receive requisite support.

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1.2 Empower every individual and organization to play a role in suicide prevention.

Every individual and organization in the community has a role to play in promoting health and well-being, reducing risk factors, and increasing protective factors for suicide. For this to happen, we all must understand how we can help prevent suicide by supporting the implementation of effective suicide prevention strategies. For example:[32, 62]

- Help other people build life skills (e.g., coping, problem solving) and resilience
- Increase social connectedness and support
- Identify and support people at risk
- Support lethal means safety
- Support access to effective care
- Seek help, support, and care when experiencing suicidal thoughts
- Support individuals who have been affected by a suicide attempt or death

All community members should be equipped to build protective factors and to recognize the warning signs of suicide and respond appropriately to individuals in crisis by connecting them to sources of help. Two good resources are the National Suicide Prevention Lifeline (1-800-273-8255) and the new 988 number that will become operational by July 16, 2022 and will connect callers to the Lifeline. (For more on crisis care and related resources, see Action 5.)

1.3 Engage people with lived experience in all aspects of suicide prevention.

People with lived experience can play an important role in increasing understanding of how to respond effectively to suicide risk, identifying and driving needed improvements in policies and systems, and enhancing interventions for providing short- and long-term support to individuals who have experienced thoughts of suicide, made a suicide plan or attempt, or lost a loved one to suicide.

Guidance from people with lived experience can be particularly useful in implementing evidence-based prevention strategies in real-life settings. Engaging people with lived experience in the planning, design, implementation, and evaluation of suicide prevention efforts can also help reach diverse groups and meet their unique needs, thereby improving the quality and impact of suicide prevention efforts.

Sharing stories of lived experience can be a powerful way to increase understanding of what it is like to experience suicidal thoughts and behaviors. These stories may help reduce stigma by providing a personal connection to another human being's journey and promoting respect and compassion for those who may be experiencing suicidal thoughts or behaviors. In collaborating with people with lived experience to share their stories with others, it is important to ensure that the information is conveyed in a way that supports the safety of the audience and the well-being of the narrator.

1.4 Use effective communications to engage diverse sectors in suicide prevention.

Communication efforts can help activate a broad-based response to suicide by changing knowledge, attitudes, and behaviors to support prevention. For example, these efforts can increase help-seeking by publicizing available care and supports for those at suicide risk; teach families, friends, co-workers, and others how best to support people in their lives who are struggling; and strengthen suicide prevention efforts by educating decision-makers about effective policy and systems change for prevention.

Goal 2 of the *National Strategy* calls for the implementation of communication efforts that are research-based and reflect safe messaging recommendations specific to suicide.[8] Decades of research indicate that public communications efforts are most effective when they have defined goals, are designed to reach specific populations, and feature a specific "call to action."[63] Communications should be tied to an overall prevention strategy and connect to other programmatic efforts, such as education programs, available supports and services, and other resources that can help the audience take action. Credible and culturally appropriate messages should be developed and conveyed through the channels (e.g., billboards, social media, events) most likely to reach and be trusted by the intended audience. Communication planners should engage their intended audiences to co-design suicide prevention efforts from the beginning, thereby informing choice of language, channels, and platforms—and helping to ensure that the call to action is accessible and realistic for them.

All individuals and organizations communicating about suicide—including suicide prevention leaders, advocates, and programs—must also ensure that their messages reflect existing recommendations regarding safety. The Action Alliance's *Framework for Successful Messaging* is an online resource for developing safe and effective messages about suicide.[64] How news stories and entertainment depictions of suicide are framed can support prevention or lead to harmful outcomes, such as imitation of suicidal behaviors. The *Recommendations for Reporting on Suicide*[65] and *National Recommendations for Depicting Suicide*[66] (in entertainment) provide guidance on how to depict and cover suicide safely and in ways that will be helpful to someone who may be struggling. (More information on these resources is available in Appendix 2.)

Action 1: Priorities for Action

- State government and public health entities should implement the Suicide Prevention Resource Center's *Recommendations for State Suicide Prevention Infrastructure* to support comprehensive (i.e., multi-component) suicide prevention in communities.

- Prevention leaders from the public and private sectors, at all levels (national, state, tribal, and local), should align and evaluate their efforts consistent with the Centers for Disease Control and Prevention (CDC) resource *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, to expand the adoption of suicide prevention strategies that are based on the best available evidence.

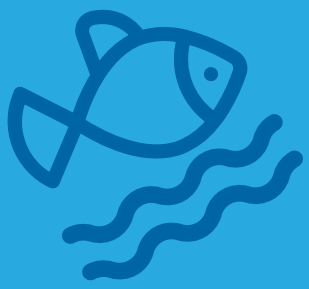
- Federal agencies and state, tribal, local, and county governments and coalitions should strengthen their prevention efforts by developing strategic suicide prevention plans based on available public health data. Mechanisms for the prompt sharing of innovations and best practices should be developed and supported.

- State and local suicide prevention coalitions and health systems should actively reach out to organizations serving populations at high risk for suicide; these systems should also reach out to individuals with lived experience in order to learn from them and engage them in designing prevention efforts.

- The public and private sectors should invest in patient-centered research and include people with lived experience in research design and implementation.

- Federal agencies, mental health and suicide prevention non-governmental organizations, and others conducting communication efforts should ensure that suicide prevention communications campaigns (1) are strategic, (2) include clear aims for behavior changes that support broader suicide prevention efforts, and (3) measure their impact.

- The federal government (Congress) should expand and sustain support for states, territories, communities, and tribes to implement comprehensive suicide prevention initiatives similar to the Comprehensive Suicide Prevention Program, funded by CDC, and the Garrett Lee Smith youth suicide prevention grants, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), which have been shown to reduce suicide in participating counties, particularly in rural areas.[12] Funding targeting substance use disorder should be broad enough in scope to allow for interventions that address suicide prevention and related workforce and infrastructure needs.



ACTION 2
Address Upstream Factors that Impact Suicide

Focus on ways to protect everyone from suicide.

Action 2. Address Upstream Factors that Impact Suicide

Focus on ways to prevent everyone from suicide.

Strategic Direction 1 of the *National Strategy* calls attention to the need to "create supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems" (p. 29).[8] Toward this end, suicide prevention efforts should include strategies aimed at reducing risk and increasing protection among all Americans. In particular, suicide prevention efforts must consider factors that influence the health of the population, including economic stability, education, social and community context, health care, and neighborhood and built environments.[67] For example, to prevent suicide among Black children and adolescents, we must address key upstream factors, such as disparities in health care and exposure to racism.[68]

As previously noted, suicide prevention theory and research suggest that two upstream strategies may be particularly effective in protecting individuals from suicide risk: increasing social connectedness, and providing opportunities for individuals to make a meaningful contribution.[32] Research also suggests that buffering the impact of economic stressors, such as unemployment and the threat of eviction, can play a protective role.[32] Diverse sectors and groups can contribute to the implementation of these strategies, including organizations that may not think of their work as contributing to suicide prevention. Addressing these types of societal-level factors that can affect suicide risk provides a critical opportunity to partner with diverse sectors, communities, and groups to impact suicide and other health issues as part of a broad-based collective effort.

A few years ago, the Yurok Tribe

declared a state of emergency due to a suicide cluster among young people ages 16–34. Six of the seven who died by suicide were male, and those who died were not engaged in the health care system.

Engaging young people can be difficult. If they are not coming into our health care system, what would be another way to reach out to them? One of the ways we thought of was through a cultural activity.

Weaving tribal culture into our suicide prevention strategy is something we do constantly and in many different ways. An example is a traditional rope-making activity conducted by leaders who hold this cultural knowledge. The activity brings young people together with others in the community to make rope from hazel sticks. The rope is then used to repair our traditional houses.

The activity brought together some of our cultural leaders, native clinicians, and other positive role models, along with young men in the community who could benefit from the training and enhanced cultural knowledge. It was very well received. When it was time to have conversations about mental health, it was a real, natural process. Some of the conversations continued throughout the afternoon and into the next day.

Participants were able to walk away from this activity with an act of generosity, of giving back to the tribal community by repairing our houses—in a traditional way.

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2.1 Promote and enhance social connectedness and opportunities to contribute.

Research has consistently identified social isolation as a strong risk factor for suicide and other negative health outcomes[69–71] and has identified social connectedness to family,[72] school,[73] and community as a protective factor.[74] In fact, connectedness has been a key component of theories about suicide since French sociologist Émile Durkheim first identified a link between suicide and low social integration in the late 1800s.[49, 75] Positive, meaningful, and supportive social connections can make individuals feel valued, cared for, trusted, and respected.[50] Opportunities to make a meaningful contribution to society can support the development of these positive connections and also enhance one's sense of purpose, thereby increasing reasons for living.[52]

Based on a recent review of the evidence, CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* recommends two specific approaches to increasing connectedness that have been linked to such benefits as reduced stress and improved attitudes toward help-seeking:[32]

Suicide prevention is

important to my faith community because of the increasing numbers of suicides we have experienced in our congregation and in the community. I also had a relative who died by suicide and another one who attempted suicide.

The faith community is important in the area of suicide prevention because many people seek spiritual support when life gets tough, and this is often the first place people come to for help and direction. Many faith leaders support people struggling with suicide by directing them to mental health resources, creating a safe place to share their experiences, and emphasizing suicide awareness throughout the year. In my role as a professional counselor, I am committed to providing therapeutic options to those in need and am hopeful that we can prevent these deaths by offering persons hope that includes their faith as an option for coping with their troubles.

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- **Peer norm programs** that support the development of positive connections with peers and encourage help-seeking and the development of connections to trusted helpers
- **Community engagement activities** that bring together members of the community, such as a walking program or a community garden

All individuals and organizations in the community, including workplaces, schools, faith-based organizations, and youth, senior, and Veteran centers, can play a role in enhancing connectedness and fostering opportunities to contribute. Examples include providing peer support to others, participating in service-learning activities, or serving as a volunteer.

Efforts to increase positive social connections and opportunities to contribute should be inclusive and tailored to the needs of specific groups (e.g., ethnic, racial, and sexual and gender minorities; adolescents; older adults). Through activities such as support groups and peer-delivered services, people with lived experience can play an important role in fostering these connections and opportunities and providing hope to individuals who may be struggling. Online and social media-based approaches, by presenting both challenges and opportunities for suicide prevention, can also be safely and effectively used to enhance feelings of connectedness among young people.[76]

2.2 Strengthen economic supports.

Economic factors are linked to suicide risk in different ways. Research has long identified financial problems as a factor that can precipitate a suicidal crisis in a person at risk.[77] Studies have also found that suicide rates increase during times of economic recession.[78, 79] For example, an analysis of suicide deaths in 16 states during the U.S. housing crisis that started in 2006 found that deaths by suicide related to evictions and foreclosures doubled from 2005 to 2010.[77] The study concluded that housing loss can precipitate a suicidal crisis and that prevention efforts should provide support to prevent home loss, particularly during times of economic crisis.

Experts note that the relationship between an economic crisis and suicidal behaviors can vary, depending on such factors as the unemployment rate, unemployment protection, the minimum wage, and access to welfare benefits.[80–82] Emotional factors, such as the fear of losing one's job or being evicted—either now or in the near future—may also increase psychological distress that could contribute to suicide risk.[83, 84]

Buffering the impact of these risk and precipitating factors by strengthening economic support systems may reduce suicide risk and also contribute to improved mental and physical health. An evidence review conducted by CDC identified two approaches that have been found to reduce suicide risk:[32]

- **Strengthening household financial security** through efforts such as unemployment benefits programs, transfer payments related to retirement and disability, medical benefits, and other forms of family assistance

- **Housing stabilization policies**, such as programs that protect homeowners from foreclosures and evictions

Although local suicide prevention programs may not be able to directly address these economic factors, they can monitor trends (e.g., increases in unemployment, evictions, or homelessness) and partner with others in the community to recognize and reduce associated distress. For example, suicide prevention coordinators and coalitions could partner with organizations in the community, such as unemployment offices, to provide training to employees on suicide prevention and to educate them about crisis lines and other resources. Similarly, suicide prevention programs could partner with workplaces that may

be downsizing to ensure that their workers are aware of options, benefits, and community services and supports. These programs should also consider ways to provide support to affected individuals and their families.

Employers have a significant opportunity to influence the mental health and well-being of their employees through workplace culture, policies, practices, and programs. By educating and engaging employers, we can ensure that they become part of the overall effort to prevent suicide.

The first time I called The Trevor Project, I was a scared college student in rural Kansas, and having a trained crisis counselor on the other end of the line who was ready to listen and accept me for who I am saved my life. According to The Trevor Project's 2020 National Survey on LGBTQ Youth Mental Health, 40 percent of LGBTQ youth seriously considered attempting suicide in the past year, with more than half of transgender and nonbinary youth having seriously considered it. But these data should not be interpreted to mean that LGBTQ youth are prone to suicide because of their sexual orientation or gender identity. LGBTQ youth are at a higher risk of suicide because of increased experiences of internalized stigma, discrimination, violence, and rejection from others.

I know all too well how rejection from family, friends, and faith can compound and lead to negative mental health outcomes. But we also know that suicide is preventable and that every person can contribute to ending it. The Trevor Project's research has found that LGBTQ youth who report having at least one accepting adult were 40 percent less likely to report a suicide attempt in the past year. And you do not need to be an expert on mental health or LGBTQ identities to be that one accepting adult—you just have to listen, be affirming, and have empathy. That's what The Trevor Project does every day and why it is vital that all national suicide prevention strategies be LGBTQ inclusive and competent. Thankfully, that one counselor was there to remind me that I wasn't alone and that I did not need to be fixed, because nothing was broken.

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Vice President of Advocacy and Government Affairs
The Trevor Project

2.3 Engage and support high-risk and underserved groups.

As discussed in Action 1, the prevalence of suicidal behaviors—and of risk and protective factors for suicide—varies across groups and subgroups and changes over time. Suicide prevention efforts should focus on populations disproportionately impacted by suicide in different ways. Some groups may have high or increasing rates of suicidal thoughts and behaviors. Others may experience factors that can increase the risk for suicidal behaviors, such as social isolation and unemployment, or have fewer protective factors in their lives, such as access to effective mental health care. To develop and implement suicide prevention efforts tailored to each group's unique needs and strengths, program planners must review the data available from existing sources and conduct their own data-gathering efforts, as needed.

To be effective, efforts aimed at preventing suicide must include members of the affected group—particularly persons with lived experience—and organizations already working with this population, not only as key informants but also as leaders, experts, and partners. This will help ensure that suicide prevention efforts are grounded in a thorough understanding of the relevant risk and protective factors, consider local strengths and assets, and are tailored to address the unique factors that may contribute to suicide prevention in the most effective and sustainable ways.

2.4 Dedicate resources to the development, implementation, and evaluation of interventions aimed at preventing suicidal behaviors.

Research is key to guiding action by helping us understand what works to reduce suicide risk and strengthen protective factors in different systems and with diverse populations. Goal 12 of the *National Strategy* called for the implementation of new research on suicide prevention and for the dissemination and application of findings. However, funding for suicide prevention research and for the evaluation of comprehensive suicide prevention programs continues to be very limited.[85] More resources should be dedicated to developing, implementing, and evaluating programs aimed at preventing suicide. The research must be conducted in collaboration with the affected communities, including individuals with lived experience.

As noted, much of the existing research has focused on identifying individuals at risk and assessing the effectiveness of clinical supports and care. Suicide prevention interventions and research must also focus on upstream risk and protective factors for suicide—such as social connectedness, coping skills, opportunities to contribute, and economic supports—and identify ways to best address them in partnership with other organizations in the community. In addition, suicide-related outcomes must be incorporated into existing programs and research in related fields (e.g., violence prevention, prevention of substance misuse, positive youth development, response to adverse childhood experiences and trauma) that focus on upstream factors relevant to suicide prevention.[86, 87]

Action 2: Priorities for Action

- Private companies and workplaces should leverage their health care benefits purchasing power to enhance employee mental health (e.g., invest in benefits and programs to prevent and treat behavioral health problems) and work to shape worksite values and culture to promote mental health by providing access to crisis support, support to employees following a suicide, and ongoing mental health wellness programming.

- Suicide prevention leads in federal, state, tribal, and local public health and behavioral health agencies should partner with their counterparts in labor and workforce, housing, health care, and other public assistance agencies to collaborate on strengthening economic supports for families and communities.

- Foundations and other philanthropic organizations that support early intervention programs—particularly those targeting (1) social determinants of health (e.g., reducing poverty and exposure to trauma, improving access to good education and health care, improving health equity) and/or (2) enhanced social interactions (e.g., improved parenting skills) and problem-solving and coping skills—should ensure that these programs include outcomes related to suicide (e.g., ideation, plans, attempts) and evaluation of those programs for suicide-related outcomes.

- Federal government and private sector research funders should support the analysis of existing data sets of longitudinal studies to determine the impact of various interventions (e.g., home visitation, preschool programs, substance misuse, child trauma) on suicidal ideation, plans, and attempts, and on deaths by suicide. This could include such projects as the CDC's efforts to assess and prevent adverse childhood experiences and examine their effect on suicide-related problems, and National Institutes of Health (NIH) initiatives that focus on aggregating prevention trial data sets to better understand the long-term and cross-over effects of prevention interventions on mental health outcomes, including suicide risk,[88] and to address suicide research gaps.[89, 90]

ACTION 3
Ensure Lethal Means Safety

Keep people safe while they are in crisis.

Action 3. Ensure Lethal Means Safety

Keep people safe while they are in crisis.

Although different paths can lead a person from suicidal intent to an attempt, research suggests that many suicidal crises are short-lived, with the time period between the decision to act on suicidal thoughts and a suicide attempt averaging less than 10 minutes.[91] Moreover, individuals who are thinking about suicide, even when they experience strong intent, are often ambivalent about their wish to die. Although it is commonly believed that reducing access to a lethal means of suicide will lead to substitution with another lethal means, in many cases this does not occur.[92] As a result, putting time and distance between a person at risk and lethal means of self-harm can save lives.

Firearms, which are highly lethal,[93] are the most common means of suicide in the United States, accounting for more than half (51 percent) of all suicides.[94] Among military service members, about 60 percent of suicides involve firearms,[95] and among Veterans this number reaches 70 percent.[96] Approximately 90 percent of suicide attempts involving a firearm injury result in death.[97] After firearms, the most common methods of suicide are suffocation, poisoning, and falls.[94] Although most suicide deaths are firearms-related, most suicide attempts involve poisoning.[97]

When someone is at risk for suicide, removing ready access to means that may be used in a suicide attempt (e.g., firearms, medications, illicit drugs, poisonous household chemicals, and materials that can be used for hanging or suffocation) can mean the difference between life and death when a suicidal crisis occurs. Reducing access to lethal means of suicide when individuals are in crisis is an effective strategy for preventing suicide.[43, 98] Goal 6 of the *National Strategy* promotes the implementation of diverse approaches to lethal means safety in clinical and community settings.

3.1 Empower communities to implement proven approaches.

Research has identified several proven community-based approaches to lethal means safety, each of which needs to be adopted more widely.[99] These approaches, described below, vary by type of method.

Firearms. Recommended approaches to firearms-related lethal means safety include the following:[99, 100]

- Storing firearms unloaded, with ammunition stored separately, in a gun safe or tamper-proof storage box or with external locking devices, such as cable locks
- During periods of crisis or acute suicide risk, temporarily storing firearms away from the home—for example, with a relative or friend; in a self-storage unit; at a gun shop, shooting range, or pawn shop; or with law enforcement

- Partnering with gun retailers, ranges, and clubs to promote firearms safety by recognizing the signs that a purchaser may be in distress, educating purchasers on safety, facilitating safe storage, and distributing safety devices[101]
- Considering implementation of extreme risk laws—also known as extreme risk protection orders (ERPOs) or gun violence restraining orders—enacted in some states, which set in place a legal process for temporarily removing firearms from people who may pose an extreme risk to themselves or others, as per the recommendations of the Federal Commission on School Safety[102, 103]

Partnering with people with lived experience can be critical to engaging firearm owners and building support to implement these approaches.

Poisoning. Suicides by poisoning can include the use of medicines, illegal drugs, and poisonous chemicals. Recommended approaches to reducing access to these substances among individuals at risk for suicide include the following:[99]

- Partnering with pharmacies and drug companies to modify medicine packaging (e.g., blister packaging) and to reduce package sizes
- Partnering with health care systems and providers to ensure the safe prescribing of opioids (including naloxone kits)
- Educating consumers on the safe storage and disposal of medicines, including drug lockboxes, and about medication disposal sites and drug take-back events
- Partnering with drug companies and law enforcement to implement drug buy-back programs and confidential drug return programs
- Reducing access to poisonous chemicals, such as pesticides

Talking about firearms

can feel taboo because of politics. But reducing access isn't about confiscation; it can be a friend or family member helping to lock up firearms or temporarily moving them out of the home of someone going through a rough time. Engaging firearms experts in lethal means safety education and research is critical if we want to develop and disseminate effective, respectful messages.

In the Colorado Firearm Safety Coalition, we've established creative collaborations between the firearms and suicide prevention communities. Education and outreach activities include providing suicide prevention awareness training at shooting range events and creating the first statewide map of temporary firearm storage locations in 2019. National partnerships and government programs, like those from the VA and the Department of Defense, are getting lethal means safety messages to broader communities. Although we need more research to know how these partnerships and messaging affect firearms storage and suicide rates, they clearly have already led to exciting new connections and ideas.

I dream that in 10 years, the concept of "lethal means safety" will be a cultural norm like "Friends don't let friends drive drunk." At its core, this approach is about recognizing that—regardless of gun ownership or political views—no one wants to lose a family member or friend to suicide.

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Associate Professor of Emergency Medicine
University of Colorado School of Medicine
Research Physician, Eastern Colorado Geriatric Research, Education, and Clinical Center, Veterans Health Administration

Other lethal methods. Other lethal methods of suicide include suffocation, falling from high places, and inhaling carbon monoxide from motor vehicle exhaust. Effective approaches to preventing suicide by suffocation include reducing access to ligatures (e.g., ropes, belts) and ligature points (e.g., beams, door knobs, trees). These approaches are primarily relevant to settings such as health systems, college dormitories, military barracks, prisons, detention facilities, and jails. Effective strategies to prevent suicide by falling include restricting access to sites such as bridges and rail lines, and installing physical barriers, fencing, or safety nets.[104] To prevent carbon monoxide poisoning, one strategy is to install a device that detects unsafe cabin levels of the gas, warns the driver, and—if levels rise above a determined threshold in a stationary car—turns off the engine.[99]

My husband, an active-duty U.S. Marine drill instructor, died by suicide in 1994.

My life and the lives of all those exposed to his death were irrevocably changed that day. I was very young (and pregnant) at the time, a military spouse without the tools or situational awareness to navigate a suicide intervention, let alone a discussion about lethal means safety. Twenty-six years later, having devoted my professional life and career to suicide prevention and to caring for survivors of suicide loss, I know that lethal means safety is as critically important today as it was then—particularly given the lethality and high rates of firearm-related suicide in the military and Veteran communities. Over the last decade, TAPS [Tragedy Assistance Program for Survivors] has supported more than 16,000 bereaved survivors of military or Veteran suicide loss. We know from thousands of cases how serious an issue lethal means is to addressing Veteran suicide.

Here are some of the things we've learned:

- One thing many TAPS survivors wish they had had before their loved one died is proactive counseling around lethal means safety planning for military members and their families.
- Discussions about lethal means can be challenging if firearms are a large part of the Veteran's identity, but these conversations must happen because they can save lives.
- The time for learning about these issues is right now, not in a moment of crisis.
- In the military, where safety instruction starts in basic training and continues throughout a career, lethal means training should be a permanent fixture.
- Military service members and family members transitioning out of the service—an often stressful and disorienting time—should be reacquainted with lethal means safety as a comprehensive wellness strategy.
- We must bridge the military-to-civilian transition gap by training civilian providers on lethal means safety.

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Senior Director of Suicide Postvention
Tragedy Assistance Program for Survivors

3.2 Increase the use of lethal means safety counseling

Research suggests that providing counseling on lethal means safety to patients at risk for suicide is effective in increasing the adoption of safety practices.[105, 106] Although several national organizations and professional associations have endorsed the use of lethal means safety counseling with patients at risk for suicide, health care providers often receive only minimal training in this area, and few provide this type of counseling to patients.[102, 107]

Counseling on lethal means should be routinely conducted as part of safety planning with individuals at risk. Recommended approaches include training diverse health care providers—including nurses, social workers, case managers, and certified peer workers—on lethal means safety counseling, and incorporating safety planning with lethal means counseling into suicide prevention protocols and care pathways (see also Action 5).

Asking about firearms or other lethal means should not be viewed as an abrupt shift in a clinical conversation, but rather as a type of safety assessment—similar to questions about the use of seat belts, bike helmets, and carbon monoxide alarms—that providers can routinely ask patients and their families.[102] However, several barriers prevent providers from providing this type of counseling, including discomfort in talking with patients about firearms, the misperception that suicide is inevitable, and a lack of awareness that lethal means safety works.[107] Resources and tools, such as a recently piloted Web-based decision aid,[108] are needed to help providers overcome these barriers. (Information on free online training for health care professionals is included in Appendix 2.)

3.3 Dedicate resources to the development, implementation, and evaluation of interventions aimed at addressing the role of lethal means safety in suicide and suicide prevention.

Although research on reducing access to lethal means among persons at risk has increased since the *National Strategy* was last updated, more research is needed,[91] for example:

- Foundational research to increase our understanding of factors related to lethal means use and safety, including method choice, firearm ownership and/or access to firearms in the home,[109] the role of social networks and contacts, and differences across sociodemographic groups
- Effectiveness evaluations to test the impact of different lethal means safety strategies and interventions
- Translation and dissemination research to identify effective components of each intervention and to extend and adapt these interventions to various populations and settings
- Communications research with various audiences (e.g., individuals at risk, family members and friends, health care providers, other industry and community partners) to identify and test messages regarding lethal means safety and to assess the acceptability of various approaches

- Research to determine whether lethal means safety counseling is effective in promoting firearms-related lethal means safety behaviors among adults, and whether these practices are associated with reduced suicide risk

Additional funding from private and public sources will be needed to support this research. Although federal funding of research involving firearms has been limited, with Congressional funding in FY2020, NIH[110] and CDC[111] have awarded research grants to understand and prevent firearm-related injuries, deaths, and crime, including those related to suicide. More funding is needed to support the development, implementation, and evaluation of other prevention efforts addressing the needs of diverse populations in various settings.

Action 3: Priorities for Action

- The federal government and private sector entities can support efforts to ensure that updated information on lethal means safety policies, programs, and practices (e.g., ERPOs, firearm owner and retailer education, bridge barriers, medication packaging, carbon monoxide shut-off sensors in vehicles) is incorporated into existing national clearinghouses and resource centers so that local municipalities, states, and tribes can adopt and evaluate them for their prevention benefits.
- States, communities, and tribes should collaborate with the private sector to increase awareness of and take action to reduce access to firearms and other lethal means of suicide, including opioids and other medications, alcohol and other substances or poisons, and community locations (e.g., railways, bridges, parking garages) where suicidal behaviors have occurred. This urgent multi-sector effort is key to saving lives by reducing access to lethal means for individuals in crisis.
- Health systems and payers should leverage their existing training and resources and collaborate on a national initiative to train general and specialty health care providers and care teams on safety planning and lethal means counseling.
- SAMHSA and the VA should coordinate to ensure that lethal means safety assessment and counseling are incorporated into the assessment and intervention procedures of the National Suicide Prevention Lifeline and Veterans Crisis Line call centers, particularly in preparation for the national launch of 988.
- The federal government can prioritize and fund research and program evaluation analyzing community and clinical lethal means safety interventions (e.g., ERPOs, firearm owner and retailer education, bridge barriers, medication packaging, carbon monoxide shut-off sensors in vehicles) at the population level.
- State and federal governments should collaborate with the private sector on a synchronized public health communication campaign addressing lethal means safety in the context of suicide prevention, which should then be evaluated to determine prevention benefits and inform future communication efforts.

ACTION 4
Support Adoption of Evidence-Based Care for Suicide Risk

Ensure safe and effective suicide care for all.

Action 4. Support Adoption of Evidence-Based Care for Suicide Risk

Ensure safe and effective care for all.

Goals 8 and 9 of the *National Strategy* call attention to the need to include suicide prevention as a core component of all health care services, rather than limit it to services provided by mental health specialists, and to improve professional and clinical training and practice.[8] To support the adoption of safe and effective care for suicide risk, an Action Alliance work group drew on findings from successful suicide prevention efforts, such the U.S. Air Force Suicide Prevention Program[112] and the Perfect Depression Care program conducted by the Henry Ford Health System,[113] to develop recommendations for a gold standard of care for people with suicide risk.[114]

These practices have been incorporated into the comprehensive Zero Suicide framework for providing effective care for suicide risk in health systems.[115, 116] Zero Suicide provides a model of integrated practices and transformative culture and systems change. Now implemented in numerous health care organizations, including behavioral health programs, general and psychiatric hospitals, primary care settings, and health plans, Zero Suicide is showing effectiveness in decreasing suicidal thoughts and behaviors among patients in care and in lowering the number of hospitalizations and the related costs.[115] To encourage bringing Zero Suicide to scale across the nation, SAMHSA provides grants to implement Zero Suicide in health care systems, and a Zero Suicide toolkit can be accessed on the SAMHSA website.

While Zero Suicide is the gold standard for evidence-based care for suicide risk, comprehensive systems change for safer suicide care is a lengthy and challenging endeavor. In response to the need for a minimum standard of care for individuals at risk for suicide, in 2018 the Action Alliance developed *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe*. This report identifies individual recommended practices—such as screening and assessment for suicide risk, collaborative safety planning, treatment of suicidality, and the use of caring contacts—that can be adopted in outpatient mental health and substance misuse settings, emergency departments (EDs), and primary care.

Safe and effective practices for suicide care should be embedded into diverse clinical care settings, including primary care offices and clinics, EDs, inpatient and outpatient mental health practices and facilities, and other health systems. Like other established practices for addressing the risk for health problems such as heart disease or diabetes, best practices for preventing, identifying, and treating suicide risk should be incorporated into providers' everyday practice. There is also a need to increase the use of the Collaborative Care Model (CoCM), a team-based approach that allows a primary care provider to treat symptoms of mental illness in coordination with a care manager and a mental health specialist. This model of primary care integration has been shown to improve a range of patient outcomes, including suicide risk and health disparities. The CoCM approach is now covered by Medicare, many commercial health plans, and a growing number of state Medicaid programs.[117]

Access to treatment has long been a challenge for those in rural or remote settings, who often must drive for hours to access medical and behavioral health services. During the COVID-19 pandemic, federal restrictions on practicing across state lines have been eased and reimbursement has expanded, with a resulting rise in telehealth visits.[29] These expansions should be retained even after the pandemic has passed in order to improve access for those with distance, transportation, childcare, or other barriers to physically accessing services. Although more research on the use and efficacy of telehealth for suicide prevention is needed, existing evidence suggests that virtually delivered psychiatric services can have benefits similar to in-person therapy.[118] Remaining barriers that need to be addressed include the fear of adverse events and lawsuits, and disparities in access to computers and high-speed Internet.[18] Strengthening suicide prevention resources in critical access hospitals and rural health clinics can provide rural communities with the flexibility needed to determine the best approach to addressing suicide care challenges.[119]

Some of the evidence-based practices presented under Action 4 may also be appropriate for other settings that provide services to individuals at risk for suicide, including the justice system, university health services, school health clinics, and organizations that provide social services. Public and private stakeholders—including policymakers, payers, and accreditors—must take the steps needed to make these practices the standard of care for individuals at risk for suicide.

4.1 Increase clinical training in evidence-based care for suicide risk.

Objective 7.2 of the *National Strategy* recognizes the need to "provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk" (p. 77).[8] In a study conducted in England and Wales, training clinical staff in the management of suicide prevention at least every three years was among the key elements associated with lower rates of suicide among mental health patients.[120] Although several states have enacted legislation requiring training in the assessment and treatment of suicidality,[121] many behavioral health providers still receive only minimal training on how to care for patients at risk for suicide.[122–124]

Providing regular training to health care providers on how to recognize and address suicide risk is increasingly being recognized as an essential element of effective care.[115] Education in this area should be started early in clinical training and then updated on a regular basis. Different levels of providers and staff in diverse health systems, including primary care providers, should all receive at least basic training on how to identify suicide risk and provide appropriate support to diverse groups, including sexual and gender minorities.

Behavioral health providers are assumed to be equipped with skills to address patient suicide risk and therefore should have adequate training in evidence-based suicide prevention. Although suicide risk is often associated with mental illness, such as depression or an anxiety disorder, it also includes a distinct combination of symptoms that must be treated independently. If someone is suicidal and has a serious

mental illness, it is not enough to treat the illness and hope that the suicidality will resolve.[125] To be effective, care for the mental illness should be combined with specific treatment for suicidality.[126]

Evidence-based psychotherapies for addressing suicide risk include the following:[127]

- Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP)[128, 129]
- Dialectical behavior therapy (DBT)[130]
- Collaborative Assessment and Management of Suicidality (CAMS)[131, 132]
- Brief cognitive-behavioral therapy (BCBT)[133]
- Suicide-specific brief interventions, such as the Attempted Suicide Short Intervention Program (ASSIP)[134]

More work is needed to ensure that all behavioral health providers are prepared to assess suicide risk and to intervene, using evidence-based practices. Training on evidence-based suicide care practices should be incorporated into medical education programs and behavioral health graduate programs and should be included as criteria for professional licensure and license renewal. Professional associations and accrediting bodies should be encouraged to work together to advance training in suicide prevention. For example, for clinicians to maintain licensure or certification, state behavioral health licensing boards should add a continuing education requirement for suicide prevention. There is also a need to identify and address barriers to training, such as time, financing, and turnover of clinical staff.

4.2 Improve suicide risk identification in health care settings.

Studies have found that many individuals who die by suicide are seen by a health care provider in the weeks or months before their death.[135] These visits are opportunities to detect suicide risk, address safety, and connect persons at risk to appropriate sources for care and support.

Research suggests that asking patients about thoughts of suicide or self-harm is a simple and effective way to uncover most suicide risk[136] and does not increase a person's risk of suicidal behavior.[137, 138] This brief intervention can be done safely in many settings, including behavioral health care, primary care, and the ED. Universal screening in EDs has been found to nearly double the identification of suicidal patients.[139] Research on youth has also found that children age 10 or older can be safely and effectively screened for suicide risk in the pediatric ED.[140] More research is needed regarding younger children's understanding of and ability to report suicidal thoughts.[141]

The United States Preventive Services Task Force (USPSTF) has endorsed depression screening for adults and adolescents ages 12–18. The USPSTF notes that "screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up." The USPSTF

is in the process of updating its recommendations for suicide screening in primary care for youth[142] and adults.[143]

Identifying suicide risk through screening is a key component of recommended standard care.[114] For individuals screening positive for suicide risk, the next step is a more thorough assessment that collects detailed information about the person's risk, evaluates their immediate danger, and informs treatment decisions. Although the comprehensive suicide risk assessment is typically done by a behavioral health professional using a standardized suicide risk assessment tool, tools that do not require specialized mental health training are also available.[144]

The goal of suicide screening and assessment is not to predict suicide but rather to identify and address suicide risk, much as health care providers do in regard to other medical problems, such as heart disease or diabetes. For example, health care providers routinely assess patients for heart disease in order to identify and address relevant risk factors (e.g., unhealthy diet, lack of physical activity, smoking, high blood pressure) that can be addressed to prevent a heart attack or related problems, rather than to predict when a heart attack might take place. Similarly, identifying suicide risk and providing targeted, effective interventions is a key strategy for preventing suicide.

Screening and assessment for suicide risk should be conducted using workflows and electronic health record (EHR) fields that clearly indicate the need for suicide care. Training should also be provided to ensure that the interventions are done accurately and consistently and include appropriate follow-up and referrals.

The emergency department is

an essential location for suicide risk screening. A considerable literature collected over the past 25 years shows that emergency department patient populations have a higher proportion of patients with suicide risk than other medical settings or the general community. And, importantly, these patients don't always present with a psychiatric condition—they present with other medical problems, and their suicide risk is often missed. If universal screening is not being done, after their presenting problem is treated, the person is often discharged, with nothing about their mental health or suicide risk being assessed.

We once had a woman in her thirties present to the emergency department for severe abdominal pain. As it turned out, she had pretty serious liver problems. She's a good example of a person presenting at the emergency department with a medical complaint who would ordinarily not be asked any questions related to mental health or suicide risk. But because we had implemented universal screening in our emergency department, the nurse at triage used a quick screener to detect suicide risk. The physician who conducted a follow-up evaluation found that the woman was severely depressed and hopeless, and requested a psychiatric consult. The psychiatrist then came and did an evaluation. The patient was very sick, so she was first admitted to the hospital to treat her medical problem, then transferred to a psychiatric hospital to treat her depression. It is likely that none of the mental health care she received would have happened if we hadn't been asking those screening questions of everyone.

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4.3 Conduct safety planning with all patients who screen positive for suicide risk.

Safety planning is a brief intervention, conducted after a comprehensive suicide risk assessment, that has been shown to be effective in supporting safety among persons at risk for suicide.[145, 146] In this brief intervention, the health care provider works collaboratively with the person at risk to develop a plan for recognizing suicidal thoughts and managing them safely. The patient safety plan—also referred to as a *crisis response plan*[147]—identifies prioritized coping strategies that the person will use when such thoughts arise, including both actions that the person can take alone and actions to obtain social support from family members and friends and by contacting a health care provider or crisis call center. Safety planning should not be confused with no-suicide contracts, which have not been shown to be effective and can provide a false sense of security.[145]

In 2010, when I was the Executive Director of a crisis center,

I experienced the most acute suicidal crisis of my life, and spent seven days in a psychiatric hospital. At my discharge appointment with my family, more time was spent discussing my payment plan than my plan to keep myself safe. I went home wanting desperately to be okay, but I didn't know how, as my family and I were not told that I would be at an increased risk for suicide in the next few months or given a safety plan to serve as my roadmap for recovery. After all, if I had been recovering from a heart procedure, my family would have been given detailed instructions on how to care for my wounds, what to look for in case I needed to return to the hospital, and how to support my recovery. Instead, I ended up feeling embarrassed and like a complete failure when the thoughts of suicide returned. I was ashamed and mad at myself for not being magically "cured," and felt like a disappointment to my friends and family. No matter how badly I wanted to no longer have thoughts of suicide, they weren't going away. I loved my family, but I was hopeless and struggling to find the will to live. That only intensified my despair, pain, and sense that I was a burden. Within 90 days of discharge, I made an attempt to end my life.

I'm so grateful that I survived and had a chance to heal. Reconnecting to hope for life came through connections to loved ones and a spiritual-cultural healing that's hard to explain. But wanting to live is only the first part—learning how to live through the pain that led to my suicidal crisis took time. There is so much more we can do to better equip families, communities, treatment providers, and attempt survivors themselves with tools to safely transition from inpatient care to life back at home. As a suicide attempt survivor and a suicide prevention professional, I know how important it is to have the highest level of care during this high-risk period, and I am encouraged by the strong focus on care transitions in this Call to Action.

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As discussed in Action 3, *lethal means safety*—identifying possible means of self-harm that are available to the person at risk, and taking specific steps to reduce access to those means during a time of crisis—is a critical component of safety planning. This approach has repeatedly been shown to be effective in community-wide suicide prevention and was also identified as an important factor in the success of suicide prevention efforts conducted at the Henry Ford Health System.[148]

As a brief intervention tied to a specific risk, safety planning is similar to other types of health interventions conducted by health care providers, such as counseling on smoking cessation or weight control, which can be done in many settings. Safety planning with lethal means safety should be embedded in the suicide care protocols and electronic medical record systems used in all health care settings.

4.4 Increase the use of suicide safe care pathways in health care systems for individuals at risk.

The use of suicide safe care pathways can help health care systems continually monitor and enhance the quality of care provided to individuals at risk for suicide, thereby improving processes and outcomes. A key component of the Zero Suicide model, the suicide safe care pathway ensures that patients at risk for suicide are identified and provided with continuing care tailored to their needs. All patients are screened on past and present suicidal behavior, and positive screens are followed by a full assessment. Individuals identified as being at increased risk are entered into a suicide safe care pathway, thus ensuring that they are provided with the attention and support they need to stay safe and recover. Components include periodic assessments of suicidality and ongoing follow-up, including contacting patients who fail to show up for an appointment or withdraw from care. The inclusion of family members and other identified support persons in pathway implementation may help support patient engagement.

Implementation of a suicide safe care pathway requires that protocols and systems be in place to collect and analyze data to track services, ensure patient safety, and assess treatment outcomes.[149] The system should collect data on process measures, such as screening rates, safety planning, and services provided; care outcomes; suicide attempts and deaths; and any other relevant factors, such as sociodemographic characteristics, clinical history, and referrals to other sources of care.

EHRs can be programmed to support pathway implementation, for example, by prompting providers to conduct suicide risk screening and further risk assessment, and by facilitating connections to outpatient treatment.[150] These systems can also be designed to "pre-screen" new patients for strong risk factors for suicide, such as a history of suicidal ideation, plans, or attempts, and to alert the provider to needed next steps. Suicide safe care pathways need to be incorporated into existing EHRs and built into new systems. A quality measure should be developed that requires systems to track the number of patients who screen positive for suicide risk, are on a suicide safe care pathway, or receive a collaborative safety plan. Health care systems must also consider ways to collaborate to ensure that patients in the suicide safe care pathway continue to be followed as they move across different settings and systems.

4.5 Increase the use of caring contacts in diverse settings.

Caring contacts are brief interventions that use encouraging notes and messages (which do not require a response from the patient) to ensure that individuals at risk receive ongoing follow-up and support, with the goal of preventing suicidal behaviors.[151, 152] First tested more than four decades ago,[153] caring contacts have been found to decrease subsequent suicide attempts by helping prevent gaps in care that can occur for different reasons. Examples include the transition from inpatient to outpatient care, the time period between a crisis line call or ED visit and seeking follow-up treatment, the interval between scheduled care sessions, and gaps in care caused by missed appointments.[154]

The contacts can be provided in many ways, including through postcards or letters with brief expressions of caring, telephone follow-up calls with patients after discharge or a missed appointment, and text messages and e-mails generated by automated systems.[154] Although the messages can be designed to support diverse goals (e.g., provide information about resources or crisis lines, remind the person of upcoming appointments), they should always communicate that the sender cares about the person's well-being. The intervention can also be used in diverse settings, including EDs, hospitals, outpatient behavioral health programs, crisis centers, community mental health, and integrated primary care. Contacts can be made by clinical or non-clinical staff, including peers who have lived experience of a suicidal crisis. The contents, media used, and delivery options should be adapted to the needs and preferences of the recipients.

Like many attempt survivors,

I have found that sharing my experiences in service to others has been an important part of my recovery. Supporting others, educating our communities, and working for change have all helped me find meaning in my experiences and allowed me to transform my past pain into something positive. In the process, I have made connections with a community of people who deeply understand my struggles and are there to offer support when I need it.

Although engaging in this work has been profoundly healing, it hasn't benefited me alone. The inclusion of people with lived experience in suicide prevention enriches the entire field. Those of us with first-hand knowledge of what it's like to live with these challenges have unique skills and insights to contribute. We apply what we've learned while navigating systems to create more effective policies. We know from experience what works and what doesn't, and we use that knowledge to design better programs and supports. We benefit from the context of our lived experiences as we interpret data, evaluate outcomes, and help build better systems. We draw strength and compassion from our own struggles as we support our peers, and we use the power of our stories to give hope to others.

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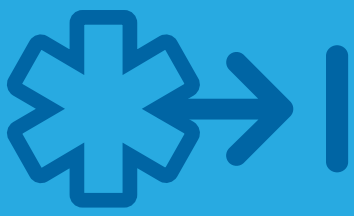
Caring contacts should be routinely provided to individuals at risk for suicide, similar to other standard protocols for following up with patients after other types of medical treatment, such as a surgical procedure.

Barriers to the use of this brief intervention include a lack of familiarity with the billing codes that may be used and (in some settings) a lack of reimbursement. Bundled payment options with International Classification of Disease (ICD) codes that provide payments for follow-up phone calls to patients discharged from a health care provider, such as an ED or inpatient hospital, could help address these financial barriers.

Action 4: Priorities for Action

- The federal government, professional associations, and accrediting bodies should collaborate to address barriers to adopting the Action Alliance's *Suicide Prevention and the Clinical Workforce: Guidelines for Training* to ensure increased clinical training in evidence-based care for suicide risk during graduate education and post-graduate training.
- State behavioral health licensing boards should add continuing education requirements for suicide prevention in order for clinicians to maintain licensure or certification.
- Payers from the public and private sectors should incentivize the delivery of evidence-based care via existing levers in contracting and reimbursement.
- Federal and state policymakers and commercial payers and health systems should take specific steps to improve outcomes for individuals with mental health and substance misuse conditions in primary care by using effective methods (e.g., CoCM) to integrate mental health and substance misuse treatment into primary care.
- To enhance workflows for suicide safe care, health systems should collaborate with EHR vendors to develop options for integrating screening, suicide safe care pathways, and safety planning into their EHR systems.
- Public and private health systems should adopt and/or implement the recommendations in *Recommended Standard Care for People with Suicide Risk* in all health care settings.



ACTION 5
Enhance Crisis Care and Care Transitions

Ensure that crisis services are available to anyone, anywhere, at any time.

Action 5. Enhance Crisis Care and Care Transitions

Ensure that crisis services are available to anyone, anywhere, at any time.

In many states, the only options available to an individual in suicidal crisis are a call to 911 or a crisis call line or a visit to the ED—and after this call or visit, the person loses contact with the health care system, only to resurface during the next crisis. As a result, individuals in crisis may be readmitted to a hospital multiple times and receive expensive and restrictive care that may not match their needs. This approach to crisis care is not only insufficient, it is also dangerous, as it does not ensure safety or treat suicidality. The long-term consequences of inadequate crisis care can include homelessness, involvement with the criminal justice system, and premature death.[155]

Although the police are frequently called on to respond to individuals who engage in self-harm or who exhibit suicidal ideation or suicidal behaviors, SAMHSA's recently released *National Guidelines for Behavioral Health Crisis Care* indicate that police officers and emergency medical services personnel should be involved in crisis response only if the nature of the crisis indicates that their involvement is needed (e.g., the person has a serious medical condition or poses an imminent threat of self-harm that cannot be de-escalated by phone-delivered crisis intervention). While local law enforcement has a role to play in mental health crisis response, crisis care should be provided by mental health specialists and others trained in mental health crisis response, who could include peers. This approach may contribute to more compassionate care and improved outcomes for individuals in crisis, and also reduce the burden that mental health crisis response places on law enforcement. As discussed in Action 5, strategy 5.5, the establishment of 988 as the national number for mental health crises[14] (effective by July 2022) will help address this problem by connecting callers who are experiencing a mental health crisis with appropriate responders.

Peer support is assistance and encouragement provided by individuals who share similar experiences. In the context of suicide prevention, peer support often refers to support provided to persons at risk for suicide by individuals who have experienced and overcome suicide risk themselves. Peers can provide support in many different capacities. Some peers are trained, certified by the state, and paid to assist in care. Others are trained to serve in a supportive role, such as helping individuals navigate health care. Still other individuals provide peer support on a volunteer basis, with limited or minimal training.

Individuals in crisis need immediate access to tailored services aligned with their needs, provided in the most comfortable and least restrictive setting, that will ensure their safety and connect them to continuing, effective care.[155] The Air Traffic Control (ATC) system that monitors commercial aircraft provides a useful

analogy. From takeoff to landing, each aircraft is continuously monitored by air traffic controllers, who are ready to step in when needed. Much like the ATC system never loses track of an airplane, a crisis care system should never lose track of a person at risk. Rather, the system must combine multiple approaches to stay connected, verify when a safe hand-off has occurred, and secure a "safe landing."

Ensuring that individuals at risk receive follow-up and are connected to sources of evidence-based ongoing care is best achieved through the use of a comprehensive and integrated crisis network that accepts all calls, welcomes all individuals who seek help at a health care setting, and provides real-time access to services that align with the needs of the person when and where the person needs it most. Individuals in crisis must be provided with appropriate and ongoing services regardless of their ability to pay, as intended by the Mental Health Parity and Addiction Equity Act,[156] which requires health insurers and group health plans to provide the same level of mental health and substance misuse treatment services and medical and surgical services to all individuals in need.

The experience of states that have developed effective crisis care systems, and of the individuals and families with lived experience who have relied on these supports, suggests that crisis care systems must include three key components: regional or statewide crisis service hubs that work in coordination with national crisis lines; centrally deployed 24/7 non-law enforcement mobile crisis teams; and crisis receiving and stabilization facilities with 24/7 availability.[155] All components should reflect the essential principles of crisis care, including partnering with law enforcement and emergency medical services, making significant use of peer support and peer-delivered services, and ensuring the safety and security of staff, peers, and individuals in crisis. Ongoing research and evaluation efforts addressing these services are needed to optimize individual outcomes as crisis care systems are further developed and implemented.

5.1 Increase the development and use of statewide or regional crisis service hubs.

Crisis call centers are clinically staffed statewide or regional centers that provide individuals in crisis with real-time access to a live person on a 24/7 basis—by telephone, text, chat, or other means. SAMHSA-issued guidelines indicate that, at a minimum, crisis call centers should do the following:[155]

- Operate every moment of every day
- Be staffed with clinicians overseeing clinical triage, and other trained team members to respond to all calls received
- Answer every call, or coordinate overflow coverage with a resource that also meets all minimum crisis call center expectations
- Assess the risk of suicide within each call in a manner that meets National Suicide Prevention Lifeline Risk Assessment Standards

- Coordinate connections to mobile crisis team services in the region
- Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed

To be most effective, the crisis center should function as a hub for the effective deployment of a range of crisis services (e.g., crisis stabilization, crisis respite, psychiatric hospitalization). A crisis service hub (e.g., NYC Well, Georgia Crisis & Access Line) uses connections to service providers and technological solutions (e.g., online databases, GPS-enabled mobile crisis dispatch) to ensure that individuals at risk are provided with the least invasive and most appropriate level of care. Sample capabilities include the ability to (1) track all persons who are waiting for care, how long they've been waiting, and where they are waiting, (2) access appointment slots for outpatient scheduling, and (3) identify and deploy the closest mobile crisis team. These ATC-like capabilities also help ensure follow-up and safety for individuals in crisis as they move across services and systems.

5.2 Increase the use of mobile crisis teams.

Mobile crisis teams are crews that can be dispatched to help the person in crisis at their home, workplace, or any other location in the community where the person is experiencing a crisis. These teams provide professional intervention and peer support in real time to the person in crisis in a comfortable environment. This approach has been found to be appropriate and effective at diverting individuals in crisis from psychiatric hospitalization and connecting them to outpatient services, while also reducing unnecessary involvement with law enforcement and lowering related costs.[155]

SAMHSA-issued guidelines indicate that, at a minimum, mobile crisis team services must:[155]

- Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation
- Respond where the person is (e.g., home, work, park) and not restrict services to particular locations, days, or times
- Connect individuals to facility-based care as needed through warm hand-offs, and coordinate transportation only if or when circumstances warrant transitions to other locations

These services should incorporate best practices, such as continuity of care. Ways to support continuity of care include scheduling outpatient follow-up appointments, providing a warm hand-off that actively engages and links the person at risk to treatment and other needed services, and offering caring contacts (see Action 4, strategy 4.5) that support continued follow-up.

5.3 Increase the use of crisis receiving and stabilization facilities.

Crisis stabilization facilities are home-like environments that offer a step-down option for persons who do not need inpatient care after their crisis episode. These settings provide individuals in crisis with "a place to go," where they can stay for short-term observation (less than 24 hours) and receive crisis stabilization services.[155] The facilities should accept not only referrals, but also walk-ins and drop-offs from first responders, including ambulance services, firefighters, and the police.

The following models are most often used to provide crisis stabilization services:[155]

- **Short-term residential facilities**. Also called crisis residential facilities, these sites should include licensed and/or credential clinicians onsite on a part-time basis and on-call.
- **Peer-operated respite**. In this model, the facility is typically staffed by peers who have personal experience with mental health challenges or suicide. Although these programs usually do not have licensed staff onsite, some facilities call on licensed providers to support suicide risk assessments.

Non-peer-run facilities that offer crisis receiving and stabilization services should meet several requirements:[155]

- Be staffed at all times (24/7), with access to a multidisciplinary team (e.g., psychiatrists, psychologists, social workers, nurses, licensed or credentialed clinicians, peers) capable of meeting the needs of individuals experiencing all levels of crisis
- Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated
- Address crisis issues related to both mental health and substance use
- Be able to assess physical health needs and deliver care for most major physical health problems and to connect individuals to other providers when needed

Facility-based programs should be adequately funded to deliver on the commitment of never rejecting a first responder referral or a walk-in referral, thereby ensuring diversion from the ED and the justice system.

5.4 Ensure safe care transitions for patients at risk.

Transitions in care—such as the transition from inpatient hospitalization to outpatient care in the community—are a time of increased suicide risk. Other care transitions include the time period following discharge from an ED or from other providers of crisis care services, including crisis stabilization facilities and mobile crisis teams. Studies have found that in the month after patients leave inpatient psychiatric care, the suicide death rate for these patients is 300 times higher (in the first week) and 200 times higher (in the

At the age of 13, I was given alcohol and cocaine by adults

and was sexually assaulted. I became angry and self-destructive. I was hospitalized at 16, diagnosed with depression and anxiety, and treated for cocaine dependence. Over the next 20 years, I was homeless, incarcerated, and cycled through treatment programs and shelters, while struggling with feelings of grief, shame, a lack of self-worth, not belonging, and self-hatred, and thoughts of suicide.

The philosophy embraced by peer support was critical to my recovery. I was so unbelievably fortunate to have others take a nonjudgmental, strengths-based, and loving approach with me—to find a path where others honored my experiences and recognized them as strengths. Because of this approach, I moved from homelessness to homeowner, became a husband and father, and sit as the director of housing for the very company and opportunity that saved my life. The fact that my experiences can be used to support others struggling with similar challenges is truly a blessing. I can now inspire hope in others by walking with them, sharing space, being authentically connected, and creating the opportunity for them to come up with their own solutions.

People with lived experience add a critical and necessary perspective that doesn't replace, but rather complements and enhances, work being done by clinicians. If we do this with equal respect for each other's work, our work becomes harmonious as we reflect the philosophy of peer support and the value of clinical care.

Christopher Bartz
Recovery Services Administrator I
RI International

first month) than the general population's.[157] Suicide risk is highest in the first few days after discharge from inpatient mental health care[158] and can stay elevated for months,[159, 160] yet many patients never attend their first outpatient appointment.[161, 162] Ensuring a timely transition in care has been shown to reduce risk of subsequent suicide. In a recent study, suicide risk in the six months following psychiatric hospitalization was reduced among youth ages 10-18 who had an outpatient mental visit within 7 days of discharge.[163]

Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care issued by the Action Alliance notes that inpatient and outpatient providers need to accept shared responsibility for the patient's care and work together to ensure a seamless transition with no interruption in services.[164] This approach includes the following components:

- Developing relationships, protocols, and procedures that allow for rapid referrals.
- Making a follow-up phone call within 24 hours of discharge from psychiatric hospitalization, a crisis stabilization unit, or an ED to check in with the patient, and maintaining contact until the person attends the first outpatient appointment. It is also important to consider ways to support the transition in care, such as holding a videoconference with the patient and the outpatient provider.

- Involving individuals with lived experience to inform practices.
- Involving family members and natural supports, including trained peer specialists, to increase social and emotional support, solve practical problems, and promote hope and ongoing recovery.
- Providing education to family members and natural supports.
- Providing brief interventions, such as safety planning and caring contacts, to reduce suicide risk during care transitions.

All health care providers who care for individuals at risk for suicide—in both clinical and community settings—should have policies, protocols, and pathways for ensuring continuity of care during transitions. For this to happen, financing related to care transitions needs to be improved. In particular, the case rate reimbursement structures need to be modified to support delivery of these services.

5.5 Ensure adequate crisis infrastructure to support implementation of the national 988 number.

The FCC has authorized the creation of a new three-digit number, 988, that will be used to connect callers to mental health crisis assistance. The new number will direct callers to the National Suicide Prevention Lifeline, as will the current 10-digit number 800-273-8255 (TALK).[165] Similar to 911, which connects people in need to first responders for other emergencies, 988 will connect callers to Lifeline crisis centers that will deliver intervention services by phone, triage the call to assess for additional needs, and coordinate connections to additional support, based on the team's assessment and the caller's preferences. All carriers are required to implement the new number nationwide by July 16, 2022.[165]

As noted in SAMHSA's report to the FCC as part of the National Suicide Hotline Improvement Act, the establishment of 911 gradually transformed the U.S. emergency medical system.[166] The 988 number has the potential to play a similar role in behavioral health emergency and crisis services, with 988 being used to access a coordinated crisis system with call centers at the hub, connecting to mobile outreach, crisis stabilization units, and emergency rooms, with ATC-type monitoring to prevent persons at acute risk from falling through gaps in care.

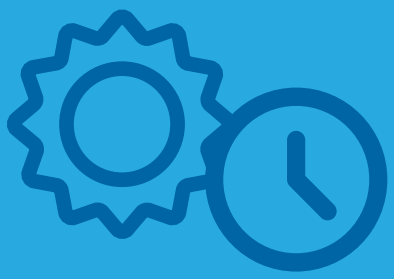
However, this national mental health crisis line will only work if there are sufficient personnel and infrastructure to keep up with the calls and provide an effective response. Crisis centers that respond to calls from state-run helplines and the National Suicide Prevention Lifeline will see an increased volume of calls and will need to increase their capacity to respond, which will require additional personnel and funding. The system will also need to include contingency plans for meeting periods of increased demand, such as following the death by suicide of a celebrity.[167]

Legislation for building a framework to run 988, called the National Suicide Hotline Designation Act of 2020,[14] was signed into law in October 2020 to allow states to add a fee to phone bills, much like 911. These

funds would go toward running 988, ensuring that the call line has the personnel, resources, and training necessary to support any increased call volume, including specialized resources for high-risk populations. Another potential funding source is a proposed new 5 percent set aside in the SAMHSA Mental Health Block Grant to support evidence-based crisis care programs.[168] Partnerships that combine federal and state funding, such as SAMHSA's state capacity grants administered through the National Suicide Prevention Lifeline, will be needed for the new 988 crisis line to achieve its full potential.

Action 5: Priorities for Action

- The federal government and the private sector should address gaps, opportunities, and resource needs to achieve standardization among crisis centers in interventional approaches and quality assurance in preparation for the launch of 988.
- The federal government, states, and the private sector should work together to optimize system design, system operations, and system financing for 988 as the hub of an enhanced, coordinated crisis system, and enhance coordination between Lifeline 988 centers and 911 centers to reduce overreliance on 911 services and ED boarding (the practice of keeping admitted patients on stretchers in hallways due to crowding).
- The federal government should fund the necessary infrastructure to support crisis care (e.g., Congressional support for the 5 percent SAMHSA Mental Health Block Grant set-aside; core services identified in SAMHSA's *National Guidelines for Behavioral Health Crisis Care*) and should provide technical assistance to states looking to evolve crisis systems of care.
- The federal government and foundations should support research to identify effective models of mental health crisis response (e.g., coordinated efforts among mental health specialists, peers, and law enforcement) to improve short- and long-term effects on communities of color and other marginalized populations.
- The federal government and private sector payers should support the use of follow-up phone calls or texts within 24 hours of discharge from psychiatric hospitalization or emergency room discharge to check in with the patient, provide support, and maintain contact until the person's first outpatient appointment.
- The federal government should establish universally recognized coding for behavioral health crisis services, and public and private sector partners should collaborate with payers and health systems to increase adoption of the new coding.
- The federal government should support the development of an essential benefits designation that will encourage health care insurers to provide reimbursement for crisis services, thus reducing the financial burden on state and local governments to pay for those services, delivered within a structure that supports the justice system and ED diversion.



ACTION 6
Improve the Quality, Timeliness, and Use of Suicide-Related Data

Know who is impacted and how to best respond.

Action 6. Improve the Quality, Timeliness, and Use of Suicide-Related Data

Know who is impacted and how to best respond.

Suicide prevention efforts must be guided by timely and reliable data on the extent of suicide in a specific community or setting, the groups most affected, and relevant risk and protective factors that prevention strategies can address. Data collection at the national, state, and local levels is critical to monitoring trends, guiding suicide prevention efforts, informing public policy, and assessing the effects of programs and policies.[169] The various systems currently being used to track the pandemic (e.g., daily reports of new cases, hospitalizations, and deaths) clearly demonstrate the importance of capturing and sharing near real-time data to guide an informed public health response.

Goal 11 of the *National Strategy* calls for improvements in the quality and timeliness of suicide data and in the use of these data to inform prevention.[8] The need for timely data related to suicide has become more pronounced with the COVID-19 crisis, which is increasing various stressors that can affect mental health and suicide risk, including social isolation, traumatic losses of family members and friends, and economic hardship—particularly among communities of color.[170] Although the impact of these risk factors on mental health and suicide is still being explored, the pandemic has added urgency to an existing need to improve the timeliness and quality of suicide-related data to implement an effective response at the federal, state, tribal, and local levels.

The Minnesota Department of Health (MDH) is dedicated to protecting, maintaining, and improving the health of all Minnesotans. Using a data-driven approach can help us understand how frequently violent deaths are occurring, and identify areas where we can improve our systems and intervene to prevent these deaths.

In 2014, the MDH was first funded by CDC to begin setting up the Minnesota Violent Death Reporting System. At that time, 80 percent of violent deaths in Minnesota were suicides—compared with 65 percent nationwide. Having more details about the characteristics of people who die by suicide and the circumstances leading up to their deaths helps our prevention program understand the complexity of suicide, populations at increased risk, and gaps in our social services, criminal justice, health, and behavioral health systems that we should address. With this improved understanding, we are better able to target interventions and prevention initiatives to have a greater impact. For example, if the data indicate that many young adults who die by suicide do not have a behavioral health diagnosis, we can rethink which systems these individuals are interacting with and find ways to better connect them with behavioral health services that can adequately identify and treat mental illness.

Minnesota Department of Health Suicide Prevention Team

6.1 Increase access to near real-time data related to suicide.

Access to near real-time data on suicide is critical to detecting and responding to increases in suicide attempts and deaths by suicide, identifying emerging populations at risk, and assessing the effectiveness of suicide prevention efforts over time. Since the *National Strategy* was updated in 2012, the quality and timeliness of national suicide data have somewhat improved, and the gap between the close of the calendar year and when the national data for that year become available has narrowed. However, more work is needed to achieve near real-time access to this information.

Key Sources of National Data on Suicide Deaths

- CDC's National Vital Statistics System (NVSS), a nationwide surveillance system, collects and disseminates data on births and deaths. Information on suicide deaths includes demographic, geographic, and cause-of-death data obtained from death certificates. The National Death Index, a centralized database of death record information compiled from state vital statistics offices, is a component of NVSS.
- CDC's National Violent Death Reporting System (NVDRS), a state-based surveillance system, combines data from various sources (e.g., death certificates, law enforcement, coroner and medical examiner reports) to provide information on the circumstances surrounding violent deaths. Started in six states in 2003, NVDRS now includes all 50 states, the District of Columbia, and Puerto Rico.
- The annual Department of Defense Suicide Event Report presents data collected through a Web-based system on suicide attempts and deaths among active duty military service members.
- The U.S. Department of Veterans Affairs' *National Veteran Suicide Prevention Annual Report* presents data on suicide deaths among U.S. Veterans.

While some states are able to contribute mortality data to the National Vital Statistics System (NVSS) on a fairly rapid basis, others continue to experience delays in certifying and reporting these deaths, thereby delaying the release of national statistics. These states, and the local death investigation system within each state that provides the data, need additional support and resources to collect and report their data more efficiently, consistently, and quickly. States should also ensure that mortality and attempt data are shared in real time with their state and local suicide prevention leaders and other key stakeholders. In addition,

states should facilitate wider linkages to mortality data, especially by health systems and health plans, to enable better public health surveillance regarding patterns and correlates of mortality, and should support implementation of clinical quality improvement programs that will increase survival.

Data on the circumstances surrounding each suicide are collected through CDC's National Violent Death Reporting System (NVDRS). Although NVDRS has recently been expanded to all states, several states are still working to fully build their statewide data collection systems. A lack of centralized data systems and various logistical challenges associated with the collection of vital statistics; reports from law enforcement, coroners, and medical examiners; and other records continue to impact many states' capacity to rapidly collect information for the NVDRS. Thus, even when all state systems are up and running, the compiling of national data will encounter delays. These systems need to be improved so that the data can be reviewed annually to guide suicide prevention efforts at the state and federal levels.

6.2 Improve the quality of data on causes of death.

Studies suggest that suicide rates may be underestimated by as much as 30 percent. Suicides may be misclassified as homicides, accidents (unintentional deaths), or undetermined deaths (primarily deaths by drug overdose).[171] Many factors may contribute to the misclassification problem, including family reluctance to report the death as a suicide; legal, religious, and political pressure; and a lack of resources and training to adequately investigate the manner of death.

Moreover, each state has its own system, requirements, infrastructure, and resources related to death scene investigations and the preparation of death certificates. Challenges include a lack of consistency in definitions, burden of proof standards, and procedures across jurisdictions, and poor implementation of existing guidelines and best practices. Potential solutions include better standardizing of terms and definitions, procedures, and death certificate completion practices within and across states; improving and expanding training; improving communication across jurisdictions and disciplines; developing job aids to enhance consistency; and conducting additional research to better understand and address variations in practices across counties and states.[171] Death certificates and death investigation reports also need to be improved to better identify the characteristics of the person who died by suicide (e.g., sexual orientation, gender identity,[172] Veteran status,[173] and race or ethnicity, including Hispanic[174] and American Indian or Alaska Native[175]).

6.3 Expand the accessibility and use of existing federal data systems that include data on suicide attempts and ideation.

Data related to suicidal thoughts, plans, and attempts; risk factors; health care use; and other relevant outcomes are critical to identifying emerging trends, planning suicide prevention efforts, and assessing progress. These suicide-related data are currently available from a number of sources (see the following box on page 60 for examples). However, in many cases the data may not be available in formats that can be easily accessed and used by state and local suicide prevention programs.

Existing systems must continue to be strengthened and improved. For example, EDs should routinely use the external cause of injury code to identify suicide attempts (as opposed to self-harm with unspecified intent). Although a field to code cause of injury exists, it often is not completed uniformly across states. CDC's Youth Risk Behavior Surveillance System (YRBSS) survey should be expanded to more middle schools and should seek additional data, such as information on protective factors for suicide (e.g., school connectedness). New questions related to suicide—including questions that better identify specific groups, such as sexual and gender minority populations—should be added to existing data collection tools, such as state-level health surveys. Other variables of interest, such as risk and protective factors for suicide, should also be added to existing data collection instruments. States should make a concentrated effort to improve participation in these surveys; for example, in some states, schools in the largest metropolitan areas do not participate in the YRBSS or similar state surveys.

Access to and use of existing suicide-related data must also be improved. Existing data should be made openly available to state and local programs in formats that can be easily used to inform suicide prevention efforts. Although some sources may make raw data available to researchers, the data must be analyzed by epidemiologists and presented in formats (e.g., reports, tables, dashboards) that allow the information to be easily reviewed and applied. State and local suicide prevention programs need better access to usable data, or to experts who analyze these data, so that the information can be used to guide prevention actions.

Key Sources of Other Data Related to Suicide

- SAMHSA's annual National Survey on Drug Use and Health provides national and state-level estimates of suicide-related data (ideation, plans, and self-reported attempts) among adults, as well as data on substance misuse, mental health, and service use. Data on adults who report having seriously considered or attempted suicide are available online by state.

- CDC's nationally representative Youth Risk Behavior Surveillance System (YRBSS) survey of high school students, conducted every two years, includes questions on suicidal thoughts and behaviors. A middle school survey is also conducted by interested states, territories, tribal governments, and large urban school districts.

- CDC's cloud-based National Syndromic Surveillance Program provides near real-time electronic patient encounter data received from EDs and other health care settings in 47 states and the District of Columbia regarding visits where patients report suicidal thoughts or suicide attempts. Syndromic surveillance can serve as an early warning system for spikes in nonfatal suicide-related outcomes.

- CDC's National Electronic Injury Surveillance System—All Injury Program monitors nonfatal injuries and poisonings treated in a nationally representative sample of hospital EDs.

- The Department of Transportation's National Emergency Medical Services Information System is a national database that provides standardized data from states and territories on the provision of emergency medical services, including suicide-related activations of the 911 system that can be tracked over time to identify emerging trends.

- The Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project maintains databases on inpatient stays and ED visits that include data from many states on suicide ideation and attempts.

6.4 Improve coordination and sharing of suicide-related data across the federal, state, and local levels.

Although national data provide an overall view of the suicide problem, state and local data are key to planning effective prevention efforts. Suicide rates and risk groups at the regional, state, territorial, tribal, and local levels often vary considerably from national estimates. Now that NVDRS funds all 50 states, the information on circumstances associated with suicide deaths needed to guide state and local suicide prevention efforts will become increasingly available. However, there is still a need to create systems and to dedicate resources to improve coordination and near real-time availability between the local, state, and federal levels regarding the reporting of data related to suicide.[176] It is also critical to increase the capacity of all systems to provide near real-time data that are easily accessible and routinely used to guide decision-making at every level.

Improved access to information on suicide attempts is also needed. CDC is currently funding 10 states to conduct Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes (ED SNSRO) and is using the National Syndromic Surveillance Program to monitor suicide attempts during the COVID-19 pandemic.

States should consider ways to disseminate suicide-related data in useful formats so that these data may be more widely applied. For example, the state of Colorado makes suicide data from the Colorado Violent Death Reporting System available online, in a data dashboard format, so that every county can access the information and apply this knowledge to guide their suicide prevention efforts. In Connecticut, the state purchases hospital claims data to pinpoint localities and populations with elevated risk for suicide attempts. Other states should consider similar ways to support the dissemination and use of data on suicide attempts and deaths.

6.5 Use multiple data sources to identify groups at risk and to inform action.

Diverse data sources can help suicide prevention planners identify groups most at risk and allocate resources appropriately. For example, state data on suicide death and attempt rates can help decision-makers identify populations or geographic areas where rates are particularly high and formulate solutions. A study that used NVDRS data to map county-level distribution of suicides among members of the military and Veterans found that suicides were concentrated in a small number of counties.[177] By triangulating multiple sources of data, researchers were able to better understand the circumstances surrounding these deaths and identify potential intervention sites in the affected counties. To expand these types of analyses, CDC is linking NVDRS data to the Department of Defense Suicide Event Report to better understand the circumstances of suicide among active duty military, Veterans, and civilians.

Linking data available from local, state, and national data systems (e.g., those used for medical service billing) to existing data from suicide prevention efforts could facilitate program planning and outcome assessment. For example, research on youth suicide prevention has identified many existing data systems that could be potentially linked to suicide prevention efforts.[178, 179] Programs should also establish links to existing data on societal-level factors that impact suicide prevention, including unemployment and food insecurity, available from external sources, such as the U.S. Census.

Medical records are another source of data that can be used to guide prevention efforts. The VA uses risk algorithms that examine medical record data (also referred to as predictive modeling) to identify patients at high suicide risk and inform decisions about care.[180, 181] Its Veterans Health Administration, the largest integrated health care system in the United States, has started a program that uses predictive modeling to identify patients who can benefit the most from interventions aimed at preventing suicide.

Objective 8.1 of the *National Strategy* indicates that health care systems should conduct root cause analyses (a structured process to determine the causes of suicide attempts and deaths among patients served) to continually improve service quality by identifying and addressing system-related factors that affect patient safety. The VA has successfully used this approach following discharge from not only inpatient hospitalization,[158, 182] but also nursing home care units and long-term care facilities.[183] VA research also suggests that combining information obtained through root cause analyses with data available from other sources, such as the National Death Index, may help improve the classification of deaths by suicide.[184]

The Internet and social media sites can also provide data that can be useful to suicide prevention. For example, metrics on the volume of Internet searches related to suicide can help identify increases in information- or help-seeking related to suicide. A recent study found that these searches increased following the release of a popular TV series about a young person's suicide.[185] These data can be useful in identifying times when increased capacity to provide information and crisis support may be needed.

Other sources of data needed to inform prevention efforts include qualitative studies (e.g., focus groups, key informant interviews), which can increase understanding of risk and protective factors for suicide among particular groups and inform the development of culturally tailored prevention programs. The first-hand experience of people with lived experience is another type of information that must guide the implementation of suicide prevention efforts.

Action 6: Priorities for Action

- The federal government should support near real-time collection of data on deaths by suicide and nonfatal suicide attempts in a group of sentinel states to develop the framework for a national early warning system for suicidal behavior in the U.S. The system would create a central database that links multiple data sources and would build state and local capacity to translate data trends into prevention efforts in a timely manner. In addition, the federal government should expand ED SNSRO to monitor nonfatal suicide-related outcomes, track spikes and potential clusters in suicide attempts, and identify patterns, all of which can then inform prevention activities.

- The public and private sectors should collaborate on a near real-time suicide dashboard that pulls data from existing national, state, tribal, and community databases to make data on deaths by suicide and suicide attempts timelier and more accessible, thus linking the dashboard to prevention actions on the ground.

- The federal government should implement Recommendation 1.8 of the Interagency Serious Mental Illness Coordinating Committee, which calls on public and private health care systems to routinely link mortality data for serious mental illness (SMI) and serious emotional disturbance (SED) populations, and supports the standardization of similar data gathering across state and local systems for SMI and SED populations within the justice system.

- Professional organizations connected to coroners and medical examiners at the state and national levels should release guidance on and support wide-scale implementation of coding sexual orientation and gender identity in death investigations.

- The federal government should implement the PREVENTS Executive Order recommendation for the U.S. Department of Health and Human Services and the VA to propose legislative changes that mandate a standardized process for uniform ED data reporting across the United States specific to the external cause of injury (e.g., suicide attempt).

- Health care systems should work with public sector agencies to support the linkage of mortality data with health record, social, geographic, education, and criminal justice data systems to strengthen data quality and increase accountability for patient outcomes across key systems.

- State suicide prevention coordinators and community suicide prevention leaders should routinely monitor available data to identify trends and evaluate their own efforts.

CONCLUSION

Conclusion

Since Dr. Satcher issued the first *Surgeon General's Call to Action to Prevent Suicide* more than 20 years ago, the United States has made tremendous progress in launching a broad-based coordinated response to suicide. For the last 10 years, the Action Alliance has worked to strategically advance implementation of the *National Strategy's* high-priority objectives, in collaboration with federal agencies, health systems, non-governmental organizations, business and community leaders, and many others. Today, suicide prevention efforts in the United States are more widespread than ever before,[15] and research suggests that the vast majority of Americans recognize that suicide can be prevented and want to be there for someone who is struggling or having suicidal thoughts.[54]

The time for action is now. To truly make a difference in reducing suicide, we need to move closer to fully implementing the goals and objectives in the *National Strategy*, thereby increasing the reach, breadth, and impact of our suicide prevention efforts. The six priority actions and related strategies presented in this *Call to Action* are intended to do just that.

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APPENDIX A
Acknowledgments

Appendix A: Acknowledgments

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APPENDIX B
Resources

Appendix B: Resources

The following selected resources can support the implementation of the six actions presented in this report.

Action 1. Activate a Broad-Based Public Health Response to Suicide

Suicide Prevention Planning

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf?s_cid=cs_293

This CDC technical package presents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide.

Suicide Prevention Resource Center (SPRC) Effective Prevention Model
http://www.sprc.org/effective-suicide-prevention

Designed to help develop and implement suicide prevention efforts in any setting, SPRC's Effective Suicide Prevention Model includes three elements—strategic planning, keys to success, and a comprehensive approach—that work together to make suicide prevention efforts successful in achieving desired outcomes and using limited resources most efficiently.

Communication

Framework for Successful Messaging
http://suicidepreventionmessaging.org/

Developed by the Action Alliance, this website can help individuals and organizations who communicate about suicide develop messages that are strategic, safe, and focused on solutions.

Healthy People 2030
https://health.gov/healthypeople/about/workgroups/mental-health-and-mental-disorders-workgroup

Developed by the U.S. Department of Health and Human Services, the Healthy People initiative (or Healthy People 2030) provides national objectives and targets related to mental health and mental disorders and substance misuse, and provides evidence-based resources and data to track progress toward achieving these objectives throughout the decade.

National Recommendations for Depicting Suicide
https://theactionalliance.org/messaging/entertainment-messaging/national-recommendations

Developed by the Action Alliance, in collaboration with the Substance Abuse and Mental Health Services Administration and the Entertainment Industries Council, this resource provides national recommendations for depicting suicide in entertainment content.

REACH
https://www.reach.gov/

The REACH public health campaign encourages a culture of openness, support, and belonging surrounding the topic of suicide, and mental health more broadly. Through REACH, the federal government is now able to engage Americans nearly a billion times per month to REACH those who are struggling with mental health challenges, substance misuse and addiction, and self-destructive or suicidal thoughts and behaviors.

Recommendations for Reporting on Suicide
https://reportingonsuicide.org/

This brief guide to the "do's and don'ts" of responsible reporting was developed by leading experts in suicide prevention and in collaboration with several international suicide prevention and public health organizations, schools of journalism, media organizations, key journalists, and Internet safety experts.

SPRC Strategic Communication Planning Video Series
http://www.sprc.org/resources-programs/strategic-communication-planning

These brief videos feature expert advice on developing a suicide prevention communication plan, understanding your audience, and evaluating your communications efforts.

Lived Experience

Engaging People with Lived Experience: A Toolkit for Organizations
http://www.sprc.org/livedexperiencetoolkit/about

This online toolkit was developed by SPRC to assist organizations and agencies leading suicide prevention programs in their communities with recruiting and engaging individuals with lived experience.

Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines
https://theactionalliance.org/resource/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines

Prepared by the Action Alliance's Survivors of Suicide Loss Task Force, this report outlines how communities can effectively respond to the devastating impact of suicide loss. The report paves the way for advances in postvention services, including support for the bereaved after a suicide.

The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience
https://theactionalliance.org/resource/way-forward-pathways-hope-recovery-and-wellness-insights-lived-experience

Prepared by the Action Alliance's Suicide Attempt Survivors Task Force, this report summarizes eight core values and offers a lens through which suicide prevention can be envisioned to embrace safety and bring hope and meaning to those in suicidal despair.

Research and Evaluation

A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives
https://theactionalliance.org/resource/prioritized-research-agenda-suicide-prevention-action-plan-save-lives

Developed by the Action Alliance's Research Prioritization Task Force and the National Institute of Mental Health, this resource outlines the research areas that show the most promise in helping to reduce the rates of suicide attempts and deaths.

RAND Suicide Prevention Evaluation Toolkit
https://www.rand.org/pubs/tools/TL111.html

This toolkit was designed to help program staff overcome common challenges to evaluating and planning improvements to their programs. The toolkit's design and content are the result of a rigorous, systematic review of the program evaluation literature to identify evaluation approaches, measures, and tools used elsewhere.

Action 2. Address Upstream Factors that Impact Suicide

Hiring Our Heroes
https://www.hiringourheroes.org/

Launched in 2011, the U.S. Chamber of Commerce's Hiring Our Heroes initiative is a nationwide effort to connect Veterans, service members, and military spouses with meaningful employment opportunities. PREVENTS, Hiring Our Heroes, and the VA partnered in November 2019 to launch Wellbeing in the Workplace, a collaborative workplace mental health effort. An initial group of 30 companies, representing 6 million employees, signed the *Pledge to Prioritize Mental Health and Emotional Wellbeing in the Workplace* at a launch ceremony in Washington, D.C. The companion Wellbeing Guidebook was created to assist companies with the basic steps in creating an emotionally healthy workforce. Through this ongoing initiative, employers are committing to prioritizing mental health and well-being in the workplace and recognizing that the health and well-being of their employees is both good for business and good for America.

A New Way to Talk About Social Determinants of Health
https://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html

Developed by the Robert Wood Johnson Foundation, this guide discusses why we need a better way to talk about the social determinants of health, and best practices to assist in conversation with different audiences around this concept.

Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy
http://www.paininthenation.org/assets/pdfs/TFAH-2017-PainNationRpt.pdf

This report from the Well Being Trust and Trust for America's Health provides high-level ways to address the many factors that contribute to diseases of despair.

Projected Deaths of Despair During the Coronavirus Recession
https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

This report from the Well Being Trust estimates the impact of the coronavirus pandemic in the United states on *deaths of despair*—defined as deaths to drugs, alcohol, and suicide—based on similar past situations.

Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior
https://www.cdc.gov/violenceprevention/pdf/suicide_strategic_direction_full_version-a.pdf

This CDC resource describes ways to prevent suicide by strengthening connectedness and social bonds within and among individuals, families, and communities.

SPRC Comprehensive Approach
http://www.sprc.org/effective-prevention/comprehensive-approach

This model presents nine strategies that form a comprehensive approach to suicide prevention. Each strategy is a broad goal that can be advanced through an array of possible activities.

Action 3. Ensure Lethal Means Safety

CDC Firearm Violence Prevention: unded Research
https://www.cdc.gov/violenceprevention/firearms/funded-research.html

This webpage provides information on funding opportunities from CDC's National Center for Injury Prevention and Control related to the prevention of firearm violence.

Lethal Means & Suicide Prevention: A Guide for Community & Industry Leaders
https://theactionalliance.org/resource/lethal-means-suicide-prevention-guide-community-industry-leaders

This Action Alliance report describes the role of reducing access to lethal means among those who may be at risk for suicide, and highlights actions by governments, organizations, and industries that have resulted in lives being saved.

Means Matter
https://www.hsph.harvard.edu/means-matter/

This website, maintained by the Harvard Injury Prevention Research Center at the Harvard School of Public Health, provides information about the connection between firearms at home and increased risk of suicide.

The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)
https://www.va.gov/PREVENTS/

Launched in June 2019, this nationwide roadmap aims to implement a comprehensive approach to ending the national tragedy of suicide. The roadmap includes 10 overarching recommendations to inform suicide prevention across various sectors.

SPRC Reduce Access to Means of Suicide
http://www.sprc.org/comprehensive-approach/reduce-means

This SPRC webpage provides information and the latest resources on lethal means safety.

Action 4. Support Adoption of Evidence-Based Care for Suicide Risk

Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments
https://www.sprc.org/edguide

This guide is designed to improve patient outcomes after discharge by assisting ED health care professionals with decisions about the care and discharge of patients with suicide risk.

Critical Crossroads: Pediatric Mental Health Care in the Emergency Department Care Pathway Toolkit
https://www.hrsa.gov/critical-crossroads

This toolkit is designed to assist EDs in improving the identification, management, and continuity of care for children and adolescents who present to the ED in a mental or behavioral health crisis. The toolkit walks the user through the available resources that support the creation of a customized care pathway through various stages of patient management.

Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe
https://theactionalliance.org/resource/recommended-standard-care

This Action Alliance report outlines recommended standard care aimed to help health systems better identify and support people who are at increased risk of suicide.

Suicide Prevention Toolkit for Primary Care Practices
http://www.sprc.org/settings/primary-care/toolkit

This toolkit, which can be used by all primary care providers, contains tools, information, and resources to implement state-of-the art suicide prevention practices and overcome barriers to treating suicidal patients in the primary care setting.

Zero Suicide Toolkit
http://zerosuicide.edc.org/toolkit

This SPRC website provides information and tools for developing a Zero Suicide program in health and behavioral health care systems.

Action 5. Enhance Crisis Care and Care Transitions

Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care
https://theactionalliance.org/resource/best-practices-care-transitions-individuals-suicide-risk-inpatient-care-outpatient-care

This Action Alliance report presents feasible, evidence-based practices for health systems to improve patient engagement and safety during the transition from inpatient to outpatient care.

Crisis Now
https://crisisnow.com/

Developed by the Action Alliance, the National Association of State Mental Health Program Directors, RI International, and the National Suicide Prevention Lifeline, this website provides communities with a roadmap to safe, effective crisis care that diverts people in distress from the ED and jail by developing a continuum of crisis care services that match people's clinical needs.

Crisis Now: Transforming Services Is Within Our Reach
https://theactionalliance.org/sites/default/files/inline-files/CrisisNow%5B1%5D.pdf

Developed by the Action Alliance's Crisis Services Task Force, this report identifies the core elements of effective crisis care.

National Guidelines for Behavioral Health Crisis Care: A Best Practices Toolkit
https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care

Released in 2020, these national guidelines are intended to help states and communities develop and implement effective crisis services and systems.

Crisis Lines

988 Number

https://www.fcc.gov/document/fcc-designates-988-national-suicide-prevention-lifeline

This new telephone number will connect callers to the National Suicide Prevention Lifeline. *Note: This number will be in place by July 2022 but is not yet operational.*

Crisis Text Line

https://www.crisistextline.org/

Text-messaging support is available for those in crisis. Callers text "HOME" to 741741 from anywhere in the United States at any time to obtain support from trained crisis counselors.

Military Crisis Line and Veterans Crisis Line
https://www.veteranscrisisline.net/get-help/military-crisis-line
https://www.veteranscrisisline.net/

Phone-based text-messaging and online chat support is provided at no cost to all service members, including members of the National Guard and National Reserve, and all Veterans, even if they are not registered with the VA or enrolled in VA health care.

National Suicide Prevention Lifeline (1-800-273-8255)
https://suicidepreventionlifeline.org/

This 24-hour toll-free confidential suicide prevention hotline is available to anyone in suicidal crisis or emotional distress. Pressing "1" connects callers to the crisis lines for military service members and Veterans.

TrevorLifeline (1-866-488-7386)
https://www.thetrevorproject.org/get-help-now/

Crisis services are provided by phone, chat, and text to LGBTQ persons by The Trevor Project, the leading national organization providing crisis intervention and suicide prevention services to LGBTQ young people.

Action 6. Improve the Quality, Timeliness, and Use of Suicide-Related Data

Data Infrastructure: Recommendations for State Suicide Prevention
http://www.sprc.org/sites/default/files/StateInfrastructureDataSupplement.pdf

This detailed supplement to the Suicide Prevention Resource Center (SPRC) resource *Recommendations for State Suicide Prevention Infrastructure* can help state and local leaders understand the data resources and systems needed to effectively direct suicide prevention efforts.

Healthy People 2030
https://health.gov/healthypeople

Healthy People provides 10-year, measurable public health objectives, and tools to help track progress toward achieving them.

Locating and Understanding Data for Suicide Prevention
https://training.sprc.org/enrol/index.php?id=35

This free SPRC online course helps participants locate and apply suicide-related data to inform their prevention efforts.

Strategic Planning, Step 1: Describe the Problem and Its Context
http://www.sprc.org/strategic-planning/problem-context

This SPRC webpage provides guidance on how to describe the suicide problem and offers relevant data resources.

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA