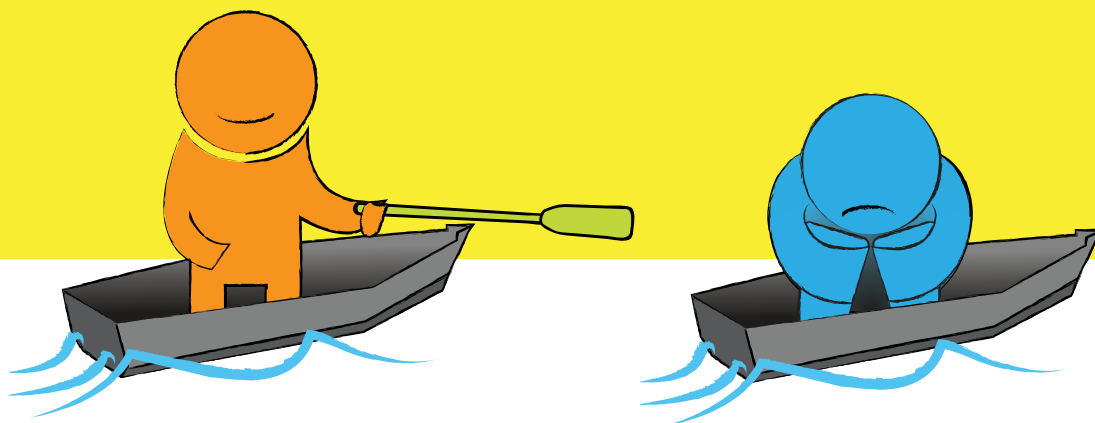


1 WORD VOICE L I F E

Be the 1 to start the conversation

STATE OF CONNECTICUT SUICIDE PREVENTION PLAN **2020-2025**





DEDICATION

This plan and the associated efforts to prevent suicide and build lives worth living are dedicated to the Connecticut residents, families, friends, and communities who are all affected in profound ways by suicide.

Are you having suicidal thoughts?

Suicidal thoughts by themselves aren't dangerous, but how you respond to them can make all the difference. Support is available.

Anyone can call the National Suicide Prevention Lifeline 24 hours a day, seven days a week, at 800-273-8255 (en español, 1-888-628-9454; TTY, 1-800-799-4889). Press 1 for the Veterans Crisis Line. In Connecticut, call 211 for National Suicide Prevention Lifeline services, or youth or adult mobile crisis services.

Don't feel like talking on the phone? Try Lifeline Crisis Chat (www.suicidepreventionlifeline.org/chat) or the Crisis Text Line by texting HOME or CT to 741741 or the Veterans Crisis Line by texting 838255.

If you want to plan ahead to help you stay safer in the future, download the My3 App from the National Suicide Prevention Lifeline. You can use the app to list your crisis contacts, make a safety plan, and use emergency resources. For more information, look in your phone's app store or go to <https://my3app.org/>



Are you concerned someone else might be at risk of suicide?

This person is fortunate you are paying attention. Here are five easy steps you can take to help:

- 1. Show you care.** This looks different depending on who you are and your relationship, but let the person know you have noticed something has changed and that their well-being matters to you. If appropriate, let them tell you how they are feeling and why.
- 2. Ask the question.** Make sure you both understand whether this problem is about suicide. "Are you thinking about suicide?"
- 3. Make the environment safer.** Help the person remove dangerous objects and substances from the places they live and spend time.
- 4. Get help.** This person may know who they want to talk to (a therapist, their guardian, their partner). You can also call the National Suicide Prevention Lifeline 24 hours a day, seven days a week, at 800-273-8255 for advice about how to help your loved one and how to get support yourself. Don't feel like talking on the phone? Try Lifeline Crisis Chat (www.suicidepreventionlifeline.org/chat) or the Crisis Text Line by texting CT to 741741.

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**Statement from the Connecticut Department of Children and Families and
Department of Mental Health and Addiction Services
Hartford, Connecticut**

September 2020

Dear Friends:

With a sense of excitement and urgency, we present the Connecticut Strategic Plan for Suicide Prevention (PLAN 2025), the result of a collaboration of many stakeholders committed to suicide prevention, including those with lived experience as survivors of suicide attempt and loss. Suicide death is a death like no other, and its ripple effect has a broad impact across space and time. No other type of death increases a survivor's risk of suicide, impacts populations so universally, and yet is also the most preventable cause of death. Preventing suicide requires everyone's commitment, from the individuals struggling with their own thoughts of suicide up to the systems and communities that support them. Only a strategic approach that engages everyone at every level will lead to the aspirational goal to eliminate suicide.

Although Connecticut has one of the lowest rates of suicide in the United States at 10.5 deaths per 100,000 people and is ranked 45th among the 50 states and the District of Columbia, one death is too many. An annual average of 403 Connecticut residents died from suicide between 2015 and 2019, which is a 14% increase from the annual average of 351 residents between 2010 and 2014. The unique stigma and shame associated with suicide keeps people from getting the support they need to prevent it or address their grief when they have experienced a loss. Additionally, the opioid epidemic and COVID-19 pandemic both have significantly increased individuals' risk of suicide due to the exacerbation of shared risk factors. A concerted, coordinated effort driven and organized by passionate stakeholders using the guiding principles outlined in PLAN 2025 is our best hope to mitigate this growing tragic public health and mental health problem.

PLAN 2025 was developed by the Connecticut Suicide Advisory Board (CTSAB) chaired by the Connecticut Department of Children and Families (DCF), the Connecticut Department of Mental Health and Addiction Services (DMHAS), and the Connecticut Chapter of the American Foundation for Suicide Prevention. The CTSAB is the single, statewide coalition for suicide prevention, intervention, and postvention response, and comprises volunteers and staff representing various state and community sectors. PLAN 2025 takes a more in-depth look into the five goals and 22 objectives established in PLAN 2020 that are aligned with the National Strategy for Suicide Prevention and Healthy People 2020. The development of PLAN 2025 required the significant engagement, commitment, and contributions of multiple individuals—including survivors, consumers, advocates, and representatives from state agencies and diverse organizations and systems—to ensure every reader would be compelled to join this fight and do what is within their power to make a difference and save lives in Connecticut.

The DCF, DMHAS, and CTSAB are committed to implementing the goals and objectives of the PLAN 2025. We hope you find the PLAN 2025 useful, and we thank you for your dedication to working together with us to prevent further suicide attempts and deaths in Connecticut. Be the 1 to start the conversation!

Very Respectfully,



Vannessa Dorantes, LMSW
Commissioner
Department of Children and Families



Miriam Delphin-Rittmon, PhD
Commissioner
Department of Mental Health and Addiction Services

Statement from the Connecticut Suicide Advisory Board Tri-Chairs

September 2020

Dear Fellow Suicide Prevention Champions:

The State of Connecticut has a long and proud history of leadership in the development of statewide suicide prevention priorities and programs. In 1989, the State Legislature mandated the creation of the Youth Suicide Advisory Board (YSAB) within the Department of Children and Families' (DCF) mandate. The Department of Public Health (DPH) developed the Interagency Suicide Prevention Network (ISPN) in 2000 to help address lifespan suicide prevention and to develop the state's first Connecticut Comprehensive Suicide Prevention Plan that was released in 2005. Coordinated prevention efforts and resources increased in 2006 when the Connecticut Department of Mental Health Addiction and Services (DMHAS) was funded by the federal Substance Abuse and Mental Health Services Administration for the Garrett Lee Smith Grant (GLS) Youth Suicide Prevention Initiative, with the YSAB advisory to the Grant, followed by two additional successful GLS Grants in 2011 and 2015.

The Connecticut Suicide Advisory Board (CTSAB) was established in January 2012, through the merger of the DCF YSAB and the DPH ISPN to facilitate collaborative efforts among state partners for suicide prevention, intervention, and postvention, and advance the state suicide prevention plan. The CTSAB meets monthly for programmatic and strategic planning to address issues related to suicide across the life span in Connecticut. The CTSAB is a diverse Network of Care that has grown steadily since its inception in 2012. At that time, membership included mainly state agencies and a select few per the YSAB mandate; membership was approximately 40 members and meeting attendance was approximately 10 to 12 people monthly. By 2015, when the last state plan was released, membership had grown to 170 members, with an average of 30 in attendance per meeting. Vast suicide prevention infrastructure improvements and community engagement since that time has helped the CTSAB to grow to a broad coalition of more than 700 people representing state and local agencies, profit and nonprofits, community and faith-based organizations, hospitals, military, schools, higher education, towns, private citizens, students, survivors, individuals with lived experience, and advocates. Meeting attendance averages 50 to 60 any given month, including during the transition to virtual meetings due to the COVID-19 pandemic of 2020. This vast growth has also led to the development of five Regional Suicide Advisory Boards (RSABs) to help meet the unique needs of each region of the state while promoting and actualizing the state plan's goals and objectives. The RSABs link to the CTSAB, and all are committed to the following mission and vision:

Mission: The CTSAB is a network of diverse advocates, educators, and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and health and wellness promotion.

Vision: The CTSAB seeks to eliminate suicide by instilling hope across the lifespan.

From June 2012 until September 2015, when the State of Connecticut Suicide Prevention Plan 2020 (PLAN 2020) was released, the CTSAB focused on priority areas that included: Statewide Network of Care that linked state-level to grass-roots local efforts; revision of Connecticut Strategy for Suicide Prevention Plan; promotion of Evidence-Based Best Practices for Suicide Prevention and Response and the "1 WORD, 1 VOICE, 1 LIFE...Be the 1 to start the conversation" initiative. These earlier priorities became embedded within PLAN 2020's five goals: 1) Integrate and coordinate suicide prevention activities across multiple sectors and settings; 2) Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors; 3) Promote suicide prevention as a core component of healthcare services; 4) Reduce access to lethal means of suicide among individuals with identified suicide risk; and 5) Increase the timeliness and usefulness of state and national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Though significant progress has been made on these goals, there is still much to be accomplished, and so it was determined that these goals will also drive this new State of Connecticut Suicide Prevention Plan 2025 (PLAN 2025).

We look forward to partnering with many constituent agencies, communities, survivors, and advocates in the implementation of PLAN 2025. It is designed to serve as a blueprint for suicide prevention activities in order to marshal resources, expertise, and political will toward our overarching goal—the elimination and reduction of lives lost to suicide.

Andrea Duarte, LCSW, MPH
CT Department of Mental Health
and Addiction Services

Tim Marshall, LCSW
CT Department of Children
and Families

Tom Steen
CT Chapter of the American
Foundation for Suicide Prevention

INTRODUCTION

The Connecticut State Suicide Prevention Plan 2025 (PLAN 2025) is a living, working document, designed to frame, organize, prioritize, and direct established and emerging suicide prevention, intervention, and postvention response efforts throughout the state through 2025. PLAN 2025 was developed through the ongoing efforts of an expanding group of professionals, those with lived experience of suicide loss, and those with lived experience of suicide attempts. This group meets monthly as the Connecticut Suicide Advisory Board (CTSAB) under the direction of tri-chairs from the Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and a suicide prevention nonprofit, currently the Connecticut Chapter of the American Foundation for Suicide Prevention.

The Philosophy of the Connecticut Suicide Prevention Plan 2020–2025

PLAN 2025 was built on the framework developed for PLAN 2020, the Connecticut Suicide Prevention Plan that guided work from 2015 through 2020. PLAN 2020 in turn was guided by recommendations from the Suicide Prevention Resource Center (SPRC). SPRC is the national technical assistance center for suicide prevention that supports states' implementation of the National Strategy for Suicide Prevention and related evidence-based best practices. Accordingly, PLAN 2025 is **data-driven** with flexible strategies for prevention. This recognizes that efforts and resources need to be directed toward high risk populations at moments of crisis, as well as towards population-wide upstream prevention strategies. PLAN 2025 is **comprehensive, but also highlights selected priorities**. Further, it was developed with an understanding of the need for **collaboration across a multitude of public and private organizations**. Suicide prevention is everyone's business. The plan uses a **combination of mental health and public health approaches** in order to prioritize prevention at both the individual and broader public levels. Suicide occurs **across the lifespan and across all identity groups**; the plan is intended to consider the relevant risk factors across and among identities and advocates for the development of strategies relevant to and emerging from these groups. Finally, the plan itself promotes **accountability** and is designed to be monitored, updated, and revised every five years.

Suicide prevention strategies and plans in Connecticut can best be described as **embedded and integrated**. This theme is central to both existing and emerging activities and recommendations. The notion of embedded suicide prevention reflects a comprehensive approach, which places responsibility for suicide prevention across a wide range of agencies, settings, individuals, and communities. The combination of unbearable pain and unrelenting hopelessness that leads to suicide ideation can happen to anyone. An individual's struggle may become apparent at a doctor's office, in a classroom, during an appointment with a job coach, to a peer, with a pastor, or in a multitude of other settings with a myriad of other people. PLAN 2025 is intended to be responsive to this, considering how the ultimate goal of suicide prevention can occur across identities and settings. The plan is intended to be used by a full range of health and behavioral healthcare providers, educators, state agencies, nonprofit organizations and foundations, communities, and individual citizens to develop creative, focused suicide prevention strategies that are responsive to public and individual need and responsive to shifting trends in cohorts and social contexts. To support this, example strategies within each goal are organized by sector, though, of course, many solutions and many individuals exist across sectors. Ultimately, **responsibility for suicide prevention and postvention** must be considered a community responsibility, with guidance and leadership of the CTSAB and its associated network of care.

The goals, objectives, example strategies, and commitments for implementation and monitoring laid out in PLAN 2025 follow the continuum of care model¹ laid out by the Institute of Medicine. This model stretches widely to cover efforts from health promotion to suicide prevention to intervention/treatment to sustaining recovery.

Health promotion strategies are designed to foster environments that support mental health and bolster the ability of the population to withstand challenges. An example of these efforts is the Gizmo's Pawesome Guide to Mental Health and associated curriculum.² The Gizmo curriculum, which supports mental health and social-emotional learning among elementary students, has been disseminated in a pilot project to more than 20 Connecticut public schools reaching 1,582 young students with messages of mental health and accessible coping strategies. Prevention efforts are delivered prior to the onset of a problem, with the intention of preventing the development of a suicidal crisis.

Prevention efforts can be further broken down into three levels in accordance with a public health framework. *Universal prevention* addresses the needs of the *whole population*. Examples of these include the 1 Word, 1 Voice, 1 Life media campaign. Originally launched throughout Connecticut in 2012, the 1 Word, 1 Voice, 1 Life has become a known symbol of suicide prevention in the state. In 2018, more than one-third of state residents reported being familiar with the campaign and its suicide prevention messaging. In the last year alone, Prevent Suicide CT has received 673 requests for materials that involved the shipment of more than 150,000 program-related items in both English and Spanish. Gatekeeper trainings are another example of universal prevention. They function similarly to first aid classes, increasing the percentage of the population trained and ready to see and respond to suicidal thoughts across settings. Since 2017, more than 23,000 residents have received gatekeeper training. The Connecticut chapter of the American Foundation for Suicide Prevention (AFSP) has facilitated and funded many of these trainings. The Connecticut chapter of AFSP has grown exponentially over the past five years, with the support of CTSAB and the tireless effort of chapter members. The chapter is now one of the strongest throughout the United States and has significantly supported suicide prevention in the state—not only through gatekeeper trainings, but also through fundraising, advocacy, supporting survivors of suicide loss, and leadership within CTSAB. *Selective prevention* targets those groups for whom risk of suicide and related behaviors is elevated. For example, college-aged youth, as a group, have an elevated risk of suicide attempts. Prevention programs, such as those under the auspices of Garrett Lee Smith state or campus grants funded by the federal Substance Abuse and Mental Health Administration, or prevention programming in residence halls, provide evidence-based interventions chosen specifically for this population. Military Fresh Check Days serve a similar purpose for the active duty population. Finally, *indicated prevention* focuses on the needs of individuals who show warning signs of elevated risk. These prevention efforts include programs such as peer support programs, support for survivors of suicide loss, and postvention programming and infrastructure for communities that have lost a member to suicide. Another example is the National Suicide Prevention Lifeline (NSPL), a network of crisis centers across the country that provides free telephonic and chat-based support to people in distress. In Connecticut, DMHAS, DCF, Department of Public Health, and the United Way collaborated to financially support the Connecticut-based NSPL services for the past five years.

Intervention includes both identifying those in crisis and providing evidence-based treatments for the suicidality and for the underlying or related conditions. Examples of the rapidly growing capacity within the state to identify those who are in crisis include: enhanced mobile crisis services and the use of a centralized call center hub at the United Way of Connecticut for both youth and adults; the use of the Ask Suicide-Screening Questions (ASQ) in healthcare settings serving youth; and the use of the Columbia Suicide Severity Rating Scale (CSSR-S) in healthcare settings serving all ages and populations. The Connecticut Zero Suicide Learning Community has been instrumental in supporting effective and sensitive identification and treatment efforts. Examples of evidence-based interventions for suicide risk include suicide specific treatments, such as Brief Cognitive Behavioral Therapy (BCBT), Cognitive Therapy for Suicide Prevention (CT-SP), Safety Planning Intervention (SPI) and Crisis Response Planning (CRP), Collaborative Assessment

and Management of Suicide (CAMS), Attempted Suicide Short Intervention Program (ASSIP) and Dialectical Behavior Therapy (DBT). In addition, evidence-based strategies to address underlying problems that are causing extreme emotional pain and blocking hope for the future also fall within treatments.

Recovery supports longer-term well-being and maintenance of gains after suicidal crises, or between them, for those with chronic experiences. Examples of efforts in this area include bolstering the continuity of care between settings, transitional support, encouraging the use of safety plans, and the broad array of strategies that help individuals thrive as they build and maintain meaningful lives. For example, for some individuals with lived experience of suicidality, sharing their experience with peers or through speakers bureaus may be an important part of their recovery, as well as supporting peers through challenging times and new losses.

Finally, PLAN 2025 makes use of the best available data on suicide deaths and suicidal thoughts and behaviors in Connecticut, to determine a baseline from which we developed measurable and achievable goals for the reduction of suicide in the state. These data serve as benchmarks moving forward and help inform suicide prevention strategies and activities over time. These data, strategies, and activities will be reviewed and reported to the CTSAB annually in September during National Suicide Prevention Week. An annual opportunity to reflect and adjust course allows the CTSAB to update the plan as needed, monitor progress, and disseminate information to communities.

The complementary overarching goals of any suicide prevention plan are 1) eliminating suicide attempts and deaths and 2) supporting the growth and thriving of individuals in the diverse lives they uniquely find to be worth living. The PLAN 2025 includes a specific **outcome for 2025**, while at the same time recognizing that suicide prevention is a rapidly changing landscape.

The Development of the Connecticut Suicide Prevention Plan 2020–2025

The State of Connecticut suicide prevention goals are grounded in the National Suicide Prevention Strategy 2012, a report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention, a public/private partnership.³ This group developed 13 National Strategy Goals and 63 objectives, derived from and spanning four strategic directions: Healthy Individuals, Families, and Communities; Clinical and Community Prevention; Treatment and Support Services; and Surveillance Research and Evaluation Goals.

During the development of PLAN 2020 (in 2013–2014), the CTSAB engaged in a multistage process to acquire consensus and identify five priority goals and their related objectives from the National Strategy that reflect the mission, vision, and priorities for Connecticut suicide preventions. In order to continue the progress and momentum associated with these goals, PLAN 2025 continues to focus on the goals and objectives established for PLAN 2020. While much progress has occurred, there is far to go to realize the desired outcomes. The process of updating the progress made towards the goals and objectives, and revising the suggested strategies, was accomplished through a combination of efforts, including: 1) presentations of the State Plan process to the Connecticut Suicide Advisory Board during meetings in July and October 2019; 2) the delegation of revisions and updates to Goals 3 through 5 to the respective subcommittees that have been leading the charge for each of these Goals (i.e., Zero Suicide, Lethal Means, and Data & Surveillance); 3) a CTSAB meeting dedicated to membership reflecting on and revising Goals 1 and 2; 4) a large survey (n=243) of the suicide prevention community at large to collect their experiences with progress in suicide prevention in the state, barriers to further progress, and suggestions for movement forward; and 5) 18 focus group sessions and key informant interviews with more than 100 representatives from various stakeholder groups (e.g., the Department of Labor, school wellness representatives, veterinarians including representatives of Suicide Awareness Voices of Education [SAVE], the Veterans Affairs Healthcare System,

the Connecticut National Guard, the Department of Agriculture, the regional suicide advisory boards, young adults coalitions, the American Foundation for Suicide Prevention, healthcare professionals working with opioid using populations, and groups focused on problem gambling, chronic health conditions, construction safety, and firearms safety).

CTSAB members, stakeholders, and survey respondents were asked to generate examples of possible strategies for each of the objectives of the five goals. These goals, objectives, and examples of possible strategies form the core of the PLAN 2025. Some of the strategies have been underway, while others emerged from discussions of gaps in suicide prevention, which also includes intervention and postvention response activities. Consumers of the plan are encouraged to use the goals, objectives, and strategies as guides to carrying out their respective suicide prevention activities in their own organizations and communities. One size does not fit all in suicide prevention. Different ages, occupations, and identities may have unique risk factors, resilience, and resource needs. For each of these groups, we highlight potential concerns and suggestions to consider.

Finally, this report includes targets for improvement in rates of suicide, based upon our current data. A central component of the plan—a systematic annual review and report out to the community—will help keep us on track and aware of progress as it is made.

The Scope of the Problem

Despite increased awareness, research, funding, and national agendas, in the United States, suicide deaths have been rising, without pause, since 1999. Between 1999 and 2018, the suicide rate increased 35%.⁴ While suicide is the 10th leading cause of death among the population as a whole, it is the 2nd leading cause of death for those aged 10 to 34, and the 4th leading cause of death for those aged 35 to 54.⁵ Suicide is a major public health problem that has far-reaching personal, social, and economic implications. In 2019, 48,324 people died by suicide in the United States. These deaths represent an overall suicide rate of 14.2 per 100,000 people.⁴ In more stark terms, there was an average of 132 suicide deaths per day, at the rate of one every eleven minutes. Deaths by suicide continue to outnumber those by both homicide and motor vehicle accidents.

For every suicide death, we lose the unique gifts of the individual who has died, but a suicide also creates dozens of loss survivors. In 2018, that amounted to more than seven million Americans coping with a suicide loss in their circle.⁶ A representative study of Americans found that half were acquainted with someone who had died by suicide, and of those, more than a third experienced moderate to extreme emotional distress after the loss.⁷ Suicide death is a death like no other. Loss survivors are at greater risk of suicide themselves, as well as suffering the immense pain and complex grief that can accompany losing a loved one to suicide, at times with effects impacting individuals, families, and communities for generations.

For every death by suicide, there are many more suicide attempts and countless other individuals who suffer with suicidal thoughts. In 2018, an estimated 10.7 million American adults (4.3% of the population) experienced serious suicidal thoughts and approximately 1.4 million American adults (0.5% of the population) made a suicide attempt.⁸ Nearly half a million people presented to hospital emergency departments with self-inflicted injuries. The human toll is devastating; suicide attempts and thoughts can result in physical pain, permanent injury, disrupted relationships, loss of liberties, stigma, and countless other consequences. In addition to the human toll, it is estimated that in 2015, combined medical and work-loss costs due to suicide and related suicidal behaviors totaled \$69 billion.⁹ Significant state and regional differences in suicide death rates exist, ranging from a rate of 25.0 per 100,000 people in New Mexico to 6.8

per 100,000 people in the District of Columbia. The Mountain states have the highest rate (22.0) and the Middle Atlantic states have the lowest (10.9).⁹ Connecticut ranks lower in terms of suicide death rate (45th out of 50) with a rate of 10.5 suicides per 100,000 residents. Though Connecticut has a lower death rate than much of the country, it has not been immune to the national trend of a worsening suicide rate. Over the last 20 years, suicide rates in Connecticut have increased by 19%, predominantly among adults age 25 and older.

Suicide rates vary widely by gender, age, racial, and ethnic group. Historically, gender differences are fairly consistent, with males representing 78% of all suicide deaths, while females have suicidal thoughts and non-fatal attempts at rates consistently higher.¹⁰ Importantly, though this gap still exists, it has been shrinking over the last decade such that women's rates of suicide deaths have been climbing more rapidly than men's.⁴

When thinking about suicide deaths and age groups, it is critical to attend to the difference between suicide rate and raw numbers of suicide death. The rate of suicide is higher among middle-aged adults (20 per 100,000) compared to young adults (14.5 per 100,000). However, suicide accounted for 21% of the young adult deaths that occurred that year, compared to 3% of the middle-aged adult deaths. While the number of young adults who die by suicide is fewer than that of older adults, suicide accounts for a substantial proportion of loss of life in this age group. Middle-aged adults are at higher risk of death by suicide; however, suicide accounts for a much smaller proportion of all middle-aged deaths because these adults have higher mortality rates in general.

Regarding suicide and race and ethnicity, the story remains complex. Suicide rates have consistently been highest for non-Hispanic Whites (18 per 100,000) and non-Hispanic American Indians and Alaskan Natives (22 per 100,000). Rates are much lower for non-Hispanic Asian and Pacific Islanders (7.0), Hispanic Whites (7.9), and non-Hispanic Blacks (7.2).¹⁰

However, the intersectional nature of demographics makes the picture even more complex. For example, though overall non-Hispanic Whites have a much higher rate of suicide than Blacks, when considering suicide among children 12 or younger, Black children have a higher rate of suicide and it has been increasing over time compared to White children.¹¹ Furthermore, relative risk among age and cohort groups can shift over time, making rapid reporting and analysis critical to understanding current and emerging needs. For example, the past decade has seen a rapid rise in the suicide rate for those in middle age and a shrinking of the gender gap. Further nuance is introduced when considering suicidal thoughts and behaviors. For example, overall rates of suicide ideation and attempts have been declining or holding steady for adolescents between 1991 and 2017. However, this was not the case for Black boys and girls, who reported an increase in suicide attempts over that same time period.¹² Though demographic patterns can help us understand the pattern and trends of suicidal thoughts and behaviors, we must keep in mind that any individual can be suicidal, regardless of particular demographic characteristics.

Those with existing mental health conditions, including substance abuse, are at increased risk for suicidal thoughts, attempts, and deaths. Additionally, those with a history of prior suicide attempts remain at the highest risk of dying by suicide. However, it is also critical to recognize that most people with mental health conditions will not attempt suicide. Similarly, most people who have attempted suicide will not make another attempt and will not die by suicide. While these conditions and histories are risk factors, they are not predictions. This dialectic has important implications for the need for a broad view of prevention and treatment. The PLAN 2025 aims to address the related issues of suicidal thoughts, attempts, and deaths and, more broadly, the incredible pain and unrelenting hopelessness that underlie them.

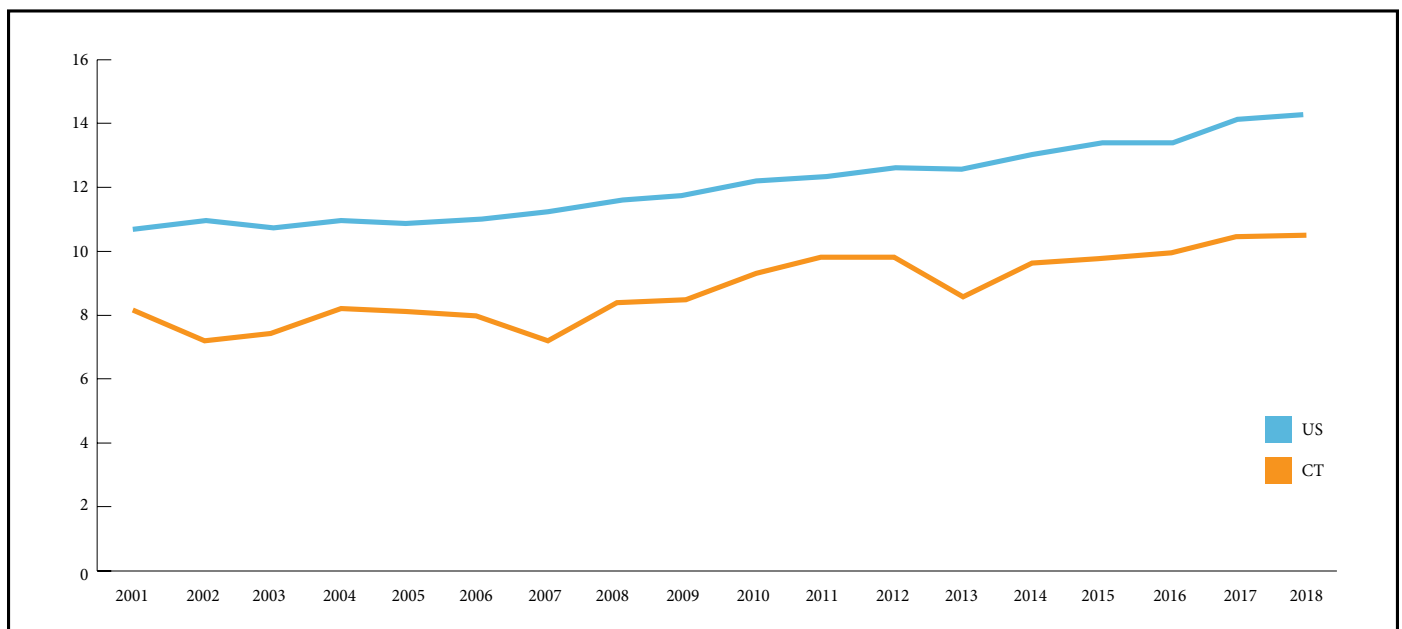
Suicide in Connecticut

Data sources for suicidal thoughts, behaviors, and deaths in Connecticut include multiple sources. The Connecticut National Violent Death Reporting System (CTVDRS), maintained by the Connecticut Department of Public Health (DPH) with the support of a federal Centers for Disease Control and Prevention grant, records data on suicide deaths. The CTVDRS is the state level of the National Violent Death Reporting System, which is a federal surveillance system that aggregates data on the characteristics and circumstances associated with violent deaths from multiple sources into one anonymous database. The Chime Data database collates data from inpatient admissions, hospital-based outpatient surgery, and emergency department visits. The Connecticut School Health Survey/Connecticut Youth Risk Behavior Survey (YRBS) and the Behavioral Risk Factor Surveillance System (BRFSS) collect self-reported data from representative samples of state residents. Together, these data provide baseline data that identifies high risk groups and trends, providing the basis for determining targets for reduction in suicide and suicide-related behaviors in Connecticut. Some observations from these data sources are described below.

While the rate of suicide is comparatively low in Connecticut (45th in the nation in 2018), one suicide death is too many. The DPH recorded the following suicide deaths via the CTVDRS: 384 in 2015; 389 in 2016; 403 in 2017; and 420 in 2018. Additionally, though Connecticut's rates have remained lower than most other states, Connecticut has not been immune to the national trend of increasing suicide deaths. The suicide rate has pushed upward in the state since 2007, consistent with a corresponding national rise (Figure 1).

Figure 1.

Age-Adjusted Suicide Death Rates over Time, United States and Connecticut

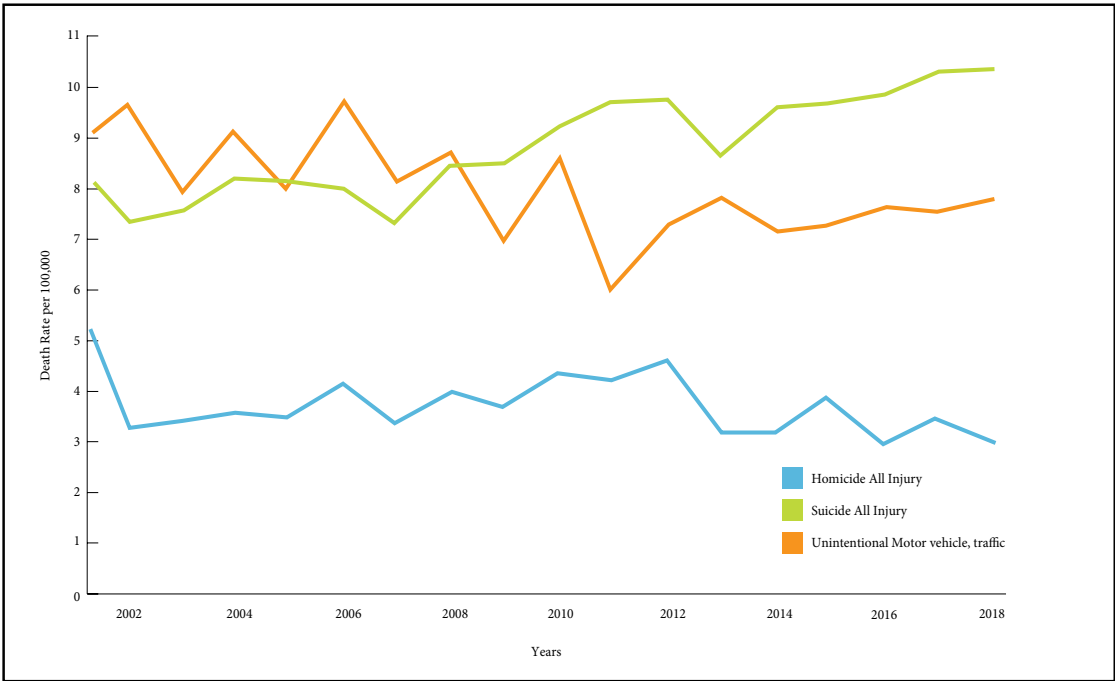


Data source: <https://wisqars-viz.cdc.gov>

Additionally, deaths by suicide have continued to rise, while deaths by other preventable causes, such as homicides and motor vehicle accidents, have fallen (Figure 2). To put Connecticut deaths by suicide in context, in 2018, 420 people died in Connecticut by suicide while 92 died by homicide.¹³

Figure 2.

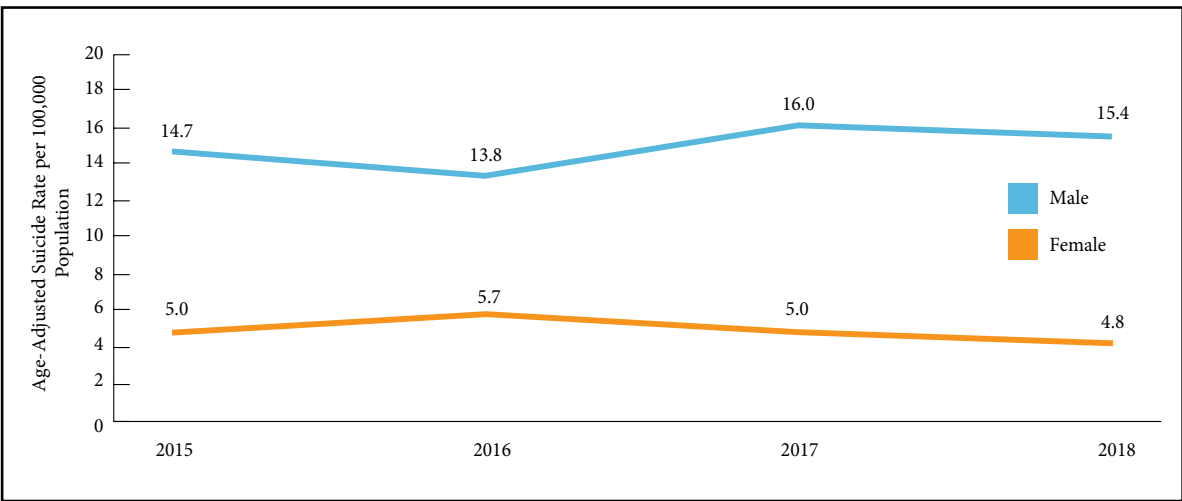
Age-Adjusted Deaths Rates (Suicide, Homicide, Motor Vehicle) over Time, Connecticut



Data source: <https://wisqars-viz.cdc.gov>

Figure 3.

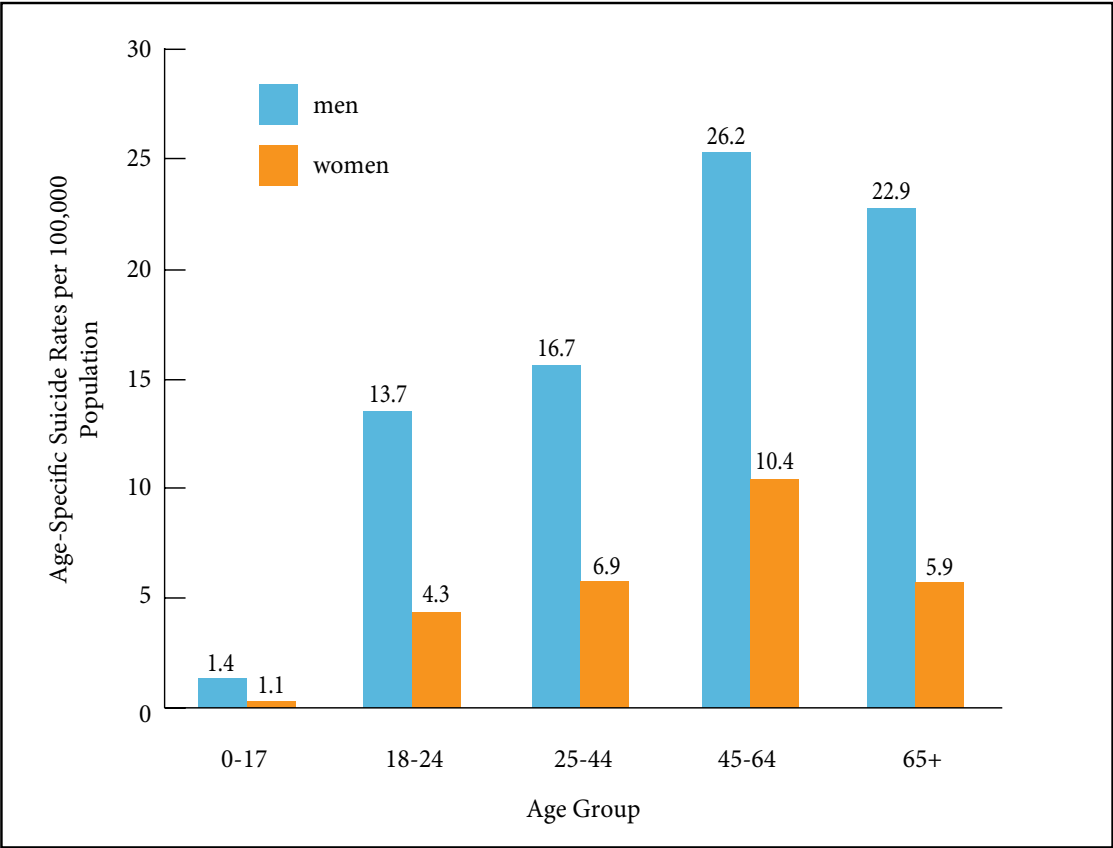
Age-Adjusted Suicide Rates, by Sex, Connecticut



Data source: <https://wisqars-viz.cdc.gov>

Figure 4.

Age-Specific Suicide Rates by Age Group and Sex, per 100,000 Connecticut Population, 2015 to 2018



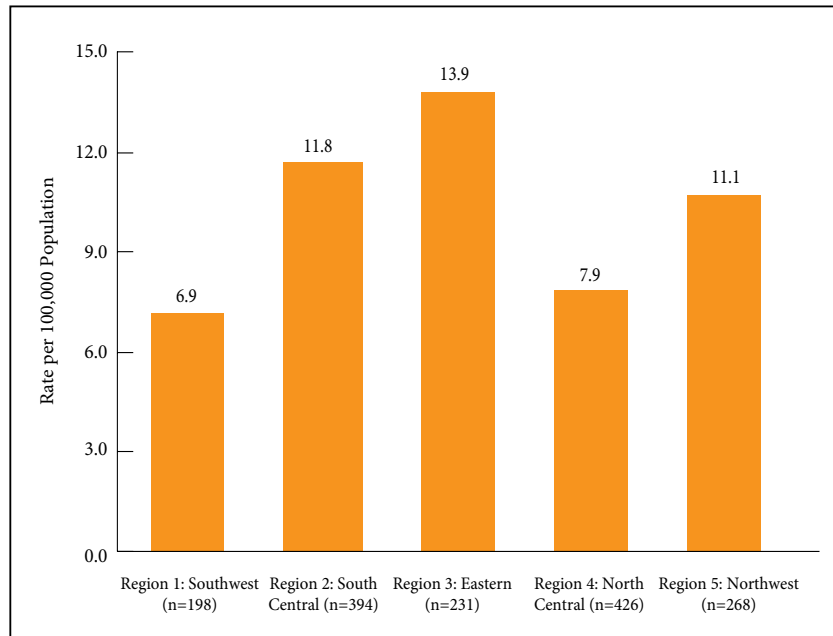
Data source: CTVDRS

Overall, suffocation/hanging remains the most common method of suicide death in Connecticut in recent years (36%). The most common methods of suicide death varied by sex, however. Among men, firearms (34%), hanging (29%), and drug overdoses (10%) were the most common. Among women, hanging (37%), drug overdoses (32%), and firearms (11%) were the most common.

There are regional differences in suicide rates across Connecticut (Figure 5). Higher rates are observed in the Eastern Region, while lower rates are observed in the Southwest Region. Regions align with the Regional Suicide Advisory Boards, which are divided by DMHAS service regions. The reasons for regional differences are not well understood and require further investigation.

Figure 5.

Suicide Rates by Suicide Advisory Board Regions, 2015 to 2018



Data source: CTVDRS

Suicidal Thoughts and Behaviors in Connecticut

In addition to suicide deaths, suicidal thoughts and behaviors cause extensive suffering. They are both an important risk factor for possible death by suicide, but also a signal of immense pain and suffering in their own right.

As is typically found nationally, in Connecticut women have a higher rate of suicide and self-harm related emergency department (ED) and hospital visits. Rates are consistently highest among young adults (15 to 24 years old) and decline as age increases. Though historically Hispanic/Latinx individuals had the highest rate of suicide and self-harm related ED and hospital visits in Connecticut, these rates have declined such that in recent years there has been no substantial difference in the suicide attempt rates across racial and ethnic groups among those requiring medical treatment.

In contrast to the steady increase in suicide deaths, non-fatal suicide attempts that result in ED visits or hospitalizations have gradually declined since 2012. This decline is observed among both men and women and across racial and ethnic groups. Hospital attended suicide attempts have declined for people aged 15 to 24 and stayed relatively stable for older age groups.

It is important to note that due to a change in data coding, data from 2014 and earlier cannot be directly compared to data from 2015 and onwards; thus, these statements reflect data from 2015 onward. There are many possible interpretations of this data, including the possibility that more Connecticut residents are using other services for their suicidality instead of attending the hospital (e.g., Mobile Crisis), that residents have less access to emergency resources and thus are using these services less, or that medically serious yet nonfatal suicide attempts are truly declining. The limited amount of data makes drawing strong conclusions impossible, but highlights the critical nature of quickly accessible, accurate, and linked data across the spectrum of suicidality to allow facile public health responses.

A representative survey of Connecticut adults found that 12.4% of adults reported having thought about

suicide.¹⁴ Younger adults (18 to 34 years old), those with lower incomes (below \$75,000), and those who are disabled were more likely to report having had ideation than older adults, those with higher incomes, and those who were not disabled. Approximately 3.8% of Connecticut adults reported having made a suicide attempt at some point during their lifetime. Among high school aged youth in Connecticut, 12.7% reported seriously considering suicide in the past year, while 6.7% reported making a suicide attempt in the past year.¹⁵

Charting the Future—Measuring our Progress

The overarching goal of this suicide prevention plan is the elimination of suicide and suicidal behaviors. This philosophy acknowledges that a single loss of life to suicide is one too many. This framework aligns with the healthcare system's Zero Suicide initiative, which holds a belief that all suicides among people in contact with healthcare are preventable. At the same time, we recognize that there are benchmarks along the way to reaching this aspirational goal. The first is to reverse the trend and see the rate of suicide deaths falling rather than rising. A second is to see a meaningful decline in the state's suicide death rate. To this end, we have aligned PLAN 2025 with the goals of the American Foundation for Suicide Prevention (AFSP), which has targeted a reduction in suicide deaths of 20% by 2025.¹⁶ Thus, the 2025 targets for Connecticut are a reduction in deaths by suicide from the 2018 rate of 10.6 to a 2025 rate of 8.48.

The CTSAB, under the direction of Tri-Chair leadership, which is made up of two state department chairs and one foundation chair, will continue to disseminate best practice knowledge, advocate for policies that support thriving lives, and address emerging needs for suicide prevention in the state of Connecticut. Successful suicide prevention efforts require sustained attention, resources, and commitment from all sectors of our public and private agencies, our communities, and ourselves. Through a multipronged process, we have prioritized the following areas for coordinated suicide prevention efforts throughout the state:

GOAL 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

GOAL 2: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

GOAL 3: Promote suicide prevention as a core component of healthcare services.

GOAL 4: Reduce access to lethal means of suicide among individuals with identified suicide risk.

GOAL 5: Increase the timeliness and usefulness of state and national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

The Plan also includes specific Areas of Focus for CTSAB itself (listed after the Goals section). These areas of focus will help the CTSAB continue to build and refine its activities so it can best support all stakeholders as they work toward the goals of Plan 2025.

We see PLAN 2025 as a living document. It is our hope that individuals and communities, private and public agencies, universities, and community organizations will use it as a framework and an inspiration for developing their own suicide prevention activities. Tailoring these goals and objectives for both specific populations and settings highlights the fact that suicide prevention will not look the same for every person, agency, or community. To aide in drawing what might be of most use to your goals from this plan, we have included examples of possible action steps for different stakeholders within each goal.

The CTSAB believes that suicide is preventable through sustained attention, resources, collaboration, and commitment from our entire community. As CTSAB Tri-chair Tom Steen, who lost his son Tyler to suicide, has written, "As time went by, I began to recover and decided to honor my son's memory by helping others who are at risk. I have found that the best way to prevent suicide is through communication and education."

Be the 1 to start the conversation.

GOALS, OBJECTIVES, AND EXAMPLES OF POSSIBLE STRATEGIES

Within each goal, specific objectives are highlighted. For each objective, we provide an update on the current status of the objective, general recommendations as to how to proceed, and a list of examples of possible strategies individuals or organizations may take to further the associated objective. While the possible strategies are organized by sector, please note that these lists are not exhaustive. Many strategies cross the lines of sector and, similarly, many individuals and organizations exist in multiple sectors.

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

➔ Objective 1.1: Integrate, establish, and sustain suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs.

Current Status: The membership of the CTSAB had grown to more than 700 members from diverse sectors, demonstrating the growing desire within the state to be involved in suicide prevention. Members of the CTSAB have continued to work within and across their respective agencies and communities to raise the profile of suicide prevention initiatives. Strong institutional and leadership support for suicide prevention has continued through the Connecticut Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), and designated staff from each agency co-chair the CTSAB. In addition, CTSAB leadership has expanded to include a third co-chair from the Connecticut Chapter of the American Foundation for Suicide Prevention, integrating the efforts of this private foundation with DMHAS and DCF. Suicide prevention activities are a key area of focus for the newly instituted Regional Suicide Advisory Boards (RSABs), further facilitating the connection between state-wide and region-specific suicide prevention efforts.

As further discussed under Goal 3, the implementation of Zero Suicide approaches in varied healthcare settings has embedded suicide prevention throughout the state's healthcare systems. As discussed under Goal 4, connections have been made between organizations and agencies that oversee access to lethal means (e.g., firearms distributors, the Department of Transportation) to support suicide prevention. These are but two examples; the diverse membership of the CTSAB has contributed to the integration of suicide prevention into the core values of a broad range of settings.

General Recommendations: Continue to identify, foster, and sustain attitudes and behaviors within agencies and programs that support the evaluation and adoption of suicide prevention, intervention, and postvention initiatives. Central to this effort is the institutionalization of embedded language, policy, and activity in agencies for which suicide prevention may not traditionally be part of the central mission.

Examples of Possible Strategies:

Everyone

- a. Engage the leadership of agencies and organizations that are peripheral to mental healthcare and provide education on the diversity of risk factors for suicide. Leverage non-healthcare related settings and interactions to prevent suicide.
- b. Integrate suicide prevention into trainings for staff and volunteers who may encounter individuals during high risk times outside of acute healthcare settings (e.g., domestic violence crisis centers,

providers of legal services for immigrant populations, those working with unemployed individuals, those working with incarcerated and newly released individuals, those working with youth transitioning out of foster care, providers working with individuals newly diagnosed with chronic or serious mental or physical health problems, those who work with the bereaved, such as funeral directors, individuals selling firearms and providing training in their use, faith leaders).

- c. Continue to advocate for strong educational administrative support of measures designed to capture suicide risk among youth (e.g., The Connecticut School Health Survey/Youth Risk Behavior Survey).
- d. Continue and enhance relationships among foundations and nonprofit organizations involved in prevention and postvention training, support, and grief support.
- e. Continue broad dissemination of the CTSAB media campaign: 1 Word, 1 Voice, 1 Life.
- f. Support resources and staff that contribute to sustaining the work already done to suffuse suicide prevention into the work of diverse organizations (e.g., training and dissemination of suicide prevention curriculum, gatekeeper trainings, distribution of resources, postvention plan development and updating, technical assistance).
- g. Create sustainability plans so that the suicide prevention efforts of schools, towns, districts, agencies, departments, and clinics are robust to staff changes, turnover, and leadership changes.

Educators

- a. Craft guidelines for suicide prevention and intervention training for behavioral health, nursing and medical education programs, and professional development.
- b. Provide gatekeeper trainings to members of boards of education to demonstrate the need for suicide prevention programming and demonstrate what a potential response to suicidality looks like.
- c. Suicide prevention fits into the current focus on school climate, social-emotional learning, and a multi-tiered student mental health framework. However, even though promoting student health and mental health is suicide prevention itself, schools also need to intentionally attend to students who may exhibit or be at risk of suicide or suicidal ideation.

Healthcare Providers

- a. Support mandatory suicide prevention workforce development requirements for licensed health and behavioral health providers.

State Agency Staff

- a. Expand mission statements to include suicide prevention.
- b. Include suicide prevention-related deliverables in state agency health and behavioral health service contract language when possible and appropriate.
- c. Support state contracted behavioral providers to have a suicide prevention education and/or awareness component integrated into the delivery of their services, within allowable funding requirements.
- d. Integrate suicide prevention training into state agency staff training, leveraging existing systems.

➡ **Objective 1.2 Establish effective, sustainable, and collaborative suicide prevention activities at the state, tribal, and local levels.**

Current Status: The number and reach of suicide prevention activities, educational events, and training through private and public agencies and community groups in Connecticut has expanded exponentially. The capacity within the state to provide suicide prevention trainings such as Question, Persuade, Refer Gatekeeper Training and Applied Suicide Intervention Skills Training (ASIST) has grown rapidly. This has been made possible, in part, through grant and foundation funding, as well as by an increased investment of resources from multiple partnering state agencies and community organizations. Collaborative projects with the AFSP Chapter, the Jordan Porco Foundation, the Benny Fund, and the Brian Dagle Foundation supporting the state plan goals and objectives have maximized available resources. CTSAB subcommittees focused on particular subpopulations (e.g., armed forces, schools) have been created and retired as projects and needs dictate. Collaborations across state agencies and with community organizations, school systems, colleges, law enforcement, and health and behavioral healthcare systems have been achieved to integrate suicide prevention into many systems, with support from the federal Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention.

General Recommendations: Efforts should be made to identify those activities that have the strongest empirical base and those that can become sustainable within agencies, particularly in light of frequent funding changes. Continue to develop creative collaborations among agencies and organizations to maximize effectiveness, use resources effectively and efficiently, and encourage sustainability.

Examples of Possible Strategies:

Everyone

- a. Support suicide prevention/postvention connections within as well as across institutions. For example, explore collaborations between the Army National Guard and the Air National Guard; between the Department of Labor and the Department of Veterans Affairs; between the Problem Gambling Service and mental health/substance abuse treatment facilities.
- b. Partner with underrepresented groups and individuals to start culturally relevant conversations within communities about suicide risk and how to seek help. Consider using the Community Conversation model. For an example, see the Asian-American Pacific Islander Ambassadors program piloted by the Problem Gambling Service to get conversations about addiction started in this particular at-risk population.

Educators

- a. Identify sources of funding to continue to support the printing and distribution of student referral cards and guides for teachers for an ongoing commitment to suicide prevention efforts in school.
- b. Add the Connecticut mobile crisis, Crisis Text Line, and National Suicide Prevention Lifeline numbers to the back of K-12 and college student and faculty/staff IDs.

Healthcare Providers

- a. Improve communication and collaboration between community providers and state-operated mental health facilities. Identify mechanisms that ensure open communication with community providers.

State Agency Staff

- a. Compile self-reports on agency programming and prevention activities. Examine the evidence base of existing programs and strategies to increase support for their sustainment and funding.

➡ Objective 1.3 Sustain and strengthen collaborations across state agencies to advance suicide prevention.

Current Status: The continued partnership of DCF and DMHAS in chairing the CTSAB has provided numerous opportunities for both formal and informal collaborations across these state agencies. Connections with the Office of Child Advocate, the Department of Public Health, Office of the Chief Medical Examiner, and other state agencies have been particularly successful in the context of the Data and Surveillance subcommittee, which has supported increased communication of suicide data across agencies (see Goal 5 for details). Newer connections with agencies traditionally less engaged in suicide prevention (e.g., Department of Transportation, Department of Agriculture, Department of Labor) have yielded new successes (e.g., expanded training opportunities for railroad employees, new suicide prevention signage on bridges and overpasses, culturally responsive initiatives and statewide collaborations to support farmer stress and suicide prevention, new materials to help Unemployment Office staff recognize and respond to individuals expressing suicidal thoughts).

General Recommendations: Continue to use and develop creative collaborations at all levels throughout organizations and agencies. Continue to expand the network of state agencies united in the goal of suicide prevention to those less traditionally involved.

Examples of Possible Strategies:

Everyone

- a. Continue building connections and collaborations with Departments that have historically been viewed as peripheral to suicide prevention efforts (e.g., the Department of Social Services, Department of Labor, Department of Corrections, Department of Agriculture). Support their efforts to train staff and make suicide prevention resources accessible to their clients.
- b. Identify the best entry point for introducing suicide prevention trainings to an organization or system. For example, the Connecticut Education Association union versus local school districts.

Educators

- a. Connect school districts that have successfully implemented suicide prevention events and trainings with school districts that are encountering barriers in implementing such programs or are newly interested in initiating programming. For example, the superintendent of one district or principal of one school could connect to another superintendent or principal to provide insight and guidance about the successful implementation of suicide prevention trainings.

Healthcare Providers

- a. Follow up with school staff after emergency department encounters when the school is involved in transport.

State Agency Staff

- a. Coordinate recommendations, policies, and trainings across agencies where appropriate, especially to support staff wellness.
- b. Actively encourage and support the formalization of suicide prevention collaborations across state agencies, such as the Departments of Children and Families, Mental Health and Addiction

Services, Public Health, Education, Correction, and the Office of Early Childhood.

- c. Explore the One Health Initiative and potential integration of suicide prevention to support integrated systems to address the needs of farmer stress and suicide.

➡ Objective 1.4 Develop and sustain public-private partnerships to advance suicide prevention.

Current Status: Over the last five years, foundations, healthcare organizations, universities, trade organizations, and other non-governmental groups have become strong members of the CTSAB community. Interest in suicide prevention has grown in the private sector and CTSAB is well poised to engage and ignite this willingness.

General Recommendations: Continue strengthening and refining existing relationships with private partners and identify new collaborators that represent a wide range of private organizations that share an interest in suicide prevention.

Examples of Possible Strategies:

Everyone

- a. Work closely with Connecticut firearms manufacturers in a partnership to increase gun safety. Develop suicide prevention material for firearm packaging.
- b. Connect with workplace human resources departments to encourage or mandate the provision of suicide prevention and mental wellness education similar to other occupational health and safety training programs.
- c. Provide sensitivity training for employers to improve support for staff who may be struggling with mental health; for example, treating employees hospitalized for a mental health issue with the same concern, respect, and accommodations an employee hospitalized for a surgery might receive.

State Agency Staff

- a. Pursue collaboration for state, private, and federal grants for education awareness and marketing.
- b. Conduct needs assessment for agencies that serve populations at risk.

Nonprofit Agency Staff

- a. Get “star-power” for public service announcements.
- b. Collaborate with workplaces to provide trainings not only about recognizing a suicidal crisis, but about how to provide accommodations and support re-entry to work post-crisis.
- c. Expand the reach of the Gizmo curriculum by training Youth Service Bureaus, foundations, or other organizations to deliver the training, to alleviate time demands on teachers.

➡ Objective 1.5 Integrate suicide prevention into all relevant healthcare reform efforts.

Current Status: The role of suicide prevention in healthcare has shifted in light of the Zero Suicide framework and the new Joint Commission regulations (see Goal 3 for more details). At the same time, it is vital to continue to attend to how suicide prevention and intervention are included as the healthcare landscape continues to change on a local and national level.

General Recommendations: Identify potential for the full range of suicide prevention efforts at all levels of care and in all health-related settings. Continue to implement population- and setting-specific recommendations for prevention, intervention, and postvention.

Examples of Possible Strategies:

Educators

- a. Develop and document organization protocols in the aftermath of suicidal events, including practice drills and annual training.

Healthcare Providers

- a. Identify, recommend, develop, and disseminate best practices policies that are flexible enough to be adapted to various components of the healthcare system.
- b. Educate personnel at all levels in healthcare organizations in suicide prevention (e.g., doctors, allied health providers, paraprofessionals, organizational staff).
- c. Ensure adequate and responsive after-care, especially post-discharge from acute forms of care.
- d. Develop and document organization protocols in the aftermath of suicidal events, including practice drills and annual training.

State Agency Staff

- a. Develop and document organization protocols in the aftermath of suicidal events, including practice drills and annual training.

Nonprofit Agency Staff

- a. Develop and document organization protocols in the aftermath of suicidal events, including practice drills and annual training.

Goal 2: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

➡ **Objective 2.1 Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.**

Current Status: Suicide prevention programming and training have been a central focus of efforts by the CTSAB and member agencies and have expanded widely over the last five years. The number of individuals in Connecticut specifically trained in talking about suicide risk has increase substantially. For example, from 2015 through 2019, more than 29,000 Connecticut residents were trained in suicide prevention and intervention. The following suicide prevention gatekeeper and clinical trainings, among others, have been offered in the state during the last year: QPR Gatekeeper Training, QPR Training of Trainers; safeTALK; ASIST; Assessing and Managing Suicidal Risk; Talk Saves Lives; Talk Saves Lives–Firearms; Recognizing and Responding to Suicide Risk for Primary Care; Collaborative Assessment and Management of Suicidality; and Clinical Core Competencies for Suicide Prevention. Additional suicide prevention programming has touched thousands of other lives within the state. These programs include Signs of Suicide, the Gizmo curriculum (life skills curriculum for mental health and suicide prevention), JPF Fresh Check Days, and 4 What’s Next.

General Recommendations: The evaluation of existing and emerging suicide prevention programming is essential to ensuring the provision of *effective* suicide prevention activities. Therefore, we recommend continuing cross-agency collaboration and coordination with planned evaluation activities. We also recommend regularly examining the national evidence base for existing and newly identified prevention programs to assess their efficacy.

Examples of Possible Strategies:

Everyone

- a. Continue to identify gaps in programming, identify resources, and strengthen coordination.
- b. Conduct robust evaluations of suicide prevention programming to understand its impact.
- c. Advocate for policies requiring suicide prevention training and continuing education in best practices in suicide prevention for the health, mental health, and educational professionals.
- d. Create a Suicide Prevention Champions list of agency directors, superintendents, clinic directors, and the like with suicide prevention training and programming success stories to connect them with others in their professional circles to support system development and engagement efforts.
- e. Consider the needs of both the community and the professionals involved in the response to a death by suicide when developing community postvention plans.
- f. Provide resources and training to communities about best practices, safe messaging, and appropriate timing for different types of postvention responses.
- g. Think creatively about ways to identify and address the grief and suicide prevention needs of survivors who are not able or ready to attend grief support groups.
- h. Formalize the role of the RSABs and provide support (funding, staffing, training, technical assistance/project management) to make this happen.
- i. Perform evaluation to ensure outcomes meet goals and objectives.
- j. Support the implementation fidelity and quality improvement efforts.

Educators

- a. Utilize the Connecticut Healthy Campus Initiative to disseminate information and train college faculty, staff, and peer leaders to implement evidence-based practices on campuses throughout the state.
- b. Increase the focus on elementary age youth, both to spread mental health promotion and suicide prevention strategies earlier and to engage parents more easily at a time when they tend to be most involved.
- c. Improve the communication between local school districts and state level agencies (SDE, DCF) to address the lack of specific protocols for postvention response and to help formalize efforts.

➡ **Objective 2.2** Encourage community-based settings to implement effective programs and provide education that promotes wellness and prevents suicide and related behaviors.

Current Status: The link between mental health and substance use conditions, and suicide is well established. While a small minority of people with mental illness will die by suicide, a large proportion (90%) of those who die by suicide have struggled with mental health conditions.¹⁷ Similarly, while most people struggling with substance do not die by suicide, substance use disorders increase risk of suicide death. Community agencies that serve those with mental illness and substance use disorders are well positioned to integrate suicide prevention. In addition, other settings whose primary mission and focus are not specifically mental health/illness—such as schools, universities, faith communities, youth services, senior centers, and workplaces—are well positioned to deliver programs that promote wellness as well as increase awareness of suicide risk. Furthermore, upstream programs that promote health and wellness across domains are a critical part of a comprehensive suicide prevention plan.

General Recommendations: Broaden the scope of suicide prevention to include the promotion of wellness and identify those community organizations and agencies that might be well positioned to develop programs with a focus on wellness, the promotion of protective factors, and the reduction of modifiable risk factors.

Examples of Possible Strategies:

Everyone

- a. Go to where the community is rather than requiring people to come to you (e.g., use webinars, Zoom, technology, lunch and learns, and the like).
- b. Increase suicide prevention trainings in non-mental health related settings (e.g., stand-downs on construction sites, new employee orientations, unemployment offices, homeless shelters, and the like).
- c. Enhance training capacity at the local level by conducting more train-the-trainer events.
- d. Create and support culturally relevant community settings that foster healthy connections, such as community centers, faith-based organizations, school activities, and health clubs, and that can serve as alternatives to settings that foster community but involve common risk factors (e.g., bars, casinos).
- e. Increase access to warm lines and other telephone-based supports staffed by peers with lived experience.
- f. Provide training and technical assistance to help regions design prevention and postvention response plans (rather than simply helping with the response itself).
- g. Develop a speakers bureau of individuals with lived experience of suicidal thoughts and attempts who have received training and support on safe messaging and can share their experiences with the community.
- h. Develop a poster for substance use and mental health agencies waiting rooms educating the clients on the risks of suicide.

Educators

- a. Use existing campus-community coalitions to provide resources and education to promote mental health and wellness as an upstream pathway to preventing suicide.

- b. Identify youth leaders and train them as Gatekeepers using evidence-based programs (e.g. QPR, Talk Saves Lives) to bring safe messaging training back to their own communities and priority populations.
- c. Identify and implement evidence-based and informed upstream mental health wellness and suicide prevention programs for youth at risk for anxiety and depression (e.g., Good Behavior Game, Gizmo's Pawesome Guide to Mental Health Curriculum, 4 What's Next, Signs of Suicide for Middle and High School).
- d. Offer professional development on suicide prevention and risk through the State Department of Education and track the numbers trained per district.
- e. Invite a representative from the SDE to formally join the CTSAB leadership group.

Nonprofit Agency Staff

- a. Identify and use more evidence-based online suicide prevention trainings to allow greater access to this resource.
- b. Repeatedly conduct systematic outreach to key stakeholders to understand need and offer training opportunities.

Objective 2.3 Intervene to reduce suicidal thoughts and behaviors in populations at heightened risk.

Current Status: Public and private agencies throughout Connecticut continue to work to identify, respond to, and support people at heightened risk for suicide and suicide related behaviors. However, certain demographic groups are at increased risk and may not be sufficiently identified.

General Recommendations: Use current data to identify those populations, cohorts, and settings that have high and/or increasing vulnerability for suicide and suicide related behaviors. Use best practices, specific to a particular cohort, to reduce suicidality.

Examples of Possible Strategies:

Everyone

- a. Establish policies, procedures, and protocols in various settings to ensure individuals at risk of suicide are identified and connected to resources and services that support their own unique needs, wellness, and safety.
- b. Connect with people at natural touchpoints where they may be experiencing unanticipated or stressful transitions (e.g., Department of Labor, banks, workplaces, employee assistance programs, courts, insurance claims, unions, chambers of commerce). For example, increase suicide prevention awareness campaigns in these locations, provide suicide prevention trainings to staff, and consider including mental health resources in emails/mailing.
- c. Include education about basic elements of mental health and help seeking, both independently and in addition to suicide prevention outreach (e.g., "What is a therapist?" "The difference between sadness and depression," "Myths about suicide") to help reduce barriers and stigma.
- d. Design and implement comprehensive postvention plans for specific impacted settings and populations (e.g., school systems, faith communities, veterans groups).
- e. Support those who serve and treat suicidal individuals, including physicians, therapists, case workers, social workers.

- f. Use creative tools (e.g., Uber, Lyft, transportation grants, technology) to help people living in transportation-challenged regions to access services.
- g. Consider the needs and points of contact for middle-aged populations, particularly men, given the high rates of suicide in this demographic and the absence of resources focused on this particular age group.
- h. Include seniors and aging populations in suicide prevention efforts and collaborate with agencies and providers that serve this often “siloed” population.
- i. Engage with the community of people with disabilities in order to better understand and respond to suicidality in this population.
- j. Establish a support group that can be attended with a buddy for military service members who self-identify as suicidal or have been discharged from the hospital.
- k. Connect military service members who have suicidal thoughts or behaviors with an individual peer support person or buddy.
- l. Continue to use recent Connecticut data about suicide-related behaviors to identify trends and groups at elevated risk.
- m. Connect individuals to economic supports that reduce suffering and despair (e.g., state assistance programs, unemployment resources, job finding, skill building).
- n. Proactively partner with members of communities/populations at higher risk to develop or implement culturally responsive programming.
- o. Continue to assess high risk populations in diverse settings, particularly those that may be marginalized or overlooked (e.g., those with unstable housing, incarcerated individuals, older adults, middle-aged men).

Educators

- a. Utilize videos and technology to support education, engagement, and outreach efforts, especially for youth. Use YouTube, TikTok, podcasts, wellness apps, and on-demand recordings. Use quick reference (QR) codes to share information. Make a Gizmo’s Pawesome Guide to Mental Health² video.
- b. Establish and implement virtual education modules of evidence-based, evidence-informed best practice training and programming.
- c. Engage youth in helping develop new approaches that resonate with their peers.
- d. Ensure all faculty and staff are trained Gatekeepers so when students reach out to trusted adults, they are prepared to recognize, respond, and connect them to the help they need.
- e. Encourage families to connect with school personnel when a child has been impacted by an adverse experience so school staff may offer supports to help protect them against trauma and suicide risk (e.g., loss of a parent or trusted adult, divorce, exposure to violence, significant illness of a family member).

Healthcare Providers

- a. Investigate and intervene at the intersection of substance use disorders and suicide risk. Similar individuals are at high risk for both.

State Agency Staff

- a. Assess suicide risk of individuals involved in legal proceedings that may increase risk factors associated with suicide (e.g. divorce, custody changes, loss of freedom, status changes, financial loss).

Goal 3: Promote suicide prevention as a core component of healthcare services.

➡ Objective 3.1: Promote the adoption of “Zero Suicide” as an aspirational goal by healthcare and community support systems that provide services and support to defined patient populations.

Current Status: The Zero Suicide approach¹⁸ and related recommended evidence-based, best practice strategies have been adopted by many health and behavioral healthcare systems within Connecticut with the support from the CTSAB and Connecticut Zero Suicide Learning Community (Connecticut ZSLC) that was established October 2015 by the DMHAS CTSAB Tri-Chair and representatives from the Institute of Living/Hartford Healthcare in collaboration with the Connecticut Hospital Association. As of June 2020, 120 staff representing 35 systems were members of the Connecticut ZSLC.

General Recommendations: Effort must continue to identify, educate, and engage stakeholders in the implementation of the Zero Suicide approach within health and behavioral healthcare settings. Additionally, attention must turn to maintaining Zero Suicide approaches in the long term. The Connecticut ZSLC must expand membership to ensure broad representation and integration of the Zero Suicide approach statewide.

Examples of Possible Strategies:

Healthcare Providers

- a. Help healthcare systems and military units establish mechanisms for staff to safely identify themselves or their peers and when they observe complacency or fatigue setting in and impacting their work with the suicidal patients they care for.
- b. Provide complacency fatigue/compassion fatigue trainings to health and behavioral health workforces, especially inpatient and emergency department settings. Develop protocols to normalize and ameliorate this common side effect of high intensity workplaces.
- c. Create and disseminate a Zero Suicide campaign kit for healthcare systems. Include marketing efforts in encouraging systemic adoption of the Zero Suicide approach.

➡ Objective 3.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Current Status: Connecticut health and behavioral healthcare systems have adopted protocols, policies, and procedures in line with the Zero Suicide approach. The Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) have held accredited systems accountable to national patient safety goals and protocols specific to suicide as of July 1, 2019.

General Recommendations: Promote and support the development and adoption of protocols, policies, and procedures aligned with the national requirements and evidence-based practices.

Examples of Possible Strategies:

Everyone

- a. Involve survivors of suicide attempts and survivors of suicide loss in developing protocols, policies, and procedures across systems and settings.
- b. Promote the National Action Alliance Framework for Successful Messaging guidelines in all protocols, policies, and procedures.

Healthcare Providers

- a. Offer technical assistance for health systems looking to adopt new protocols, policies, and procedures.
- b. Encourage healthcare systems to make available opportunities for those affected by suicide, personally or professionally, to have an active role in system protocol improvement.
- c. Engage and train rural healthcare providers in suicide prevention and intervention.
- d. Create separate pathways through emergency department settings for people with different types of mental health crises (e.g., suicidality, mania, psychosis, intoxication) rather than housing diverse needs together.
- e. Explore peer support resources and consider the development and assessment of peer support groups for individuals living with suicidal experiences.

➡ Objective 3.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Current Status: The Joint Commission and CARF hold accredited systems accountable to national patient safety goals specific to the screening, assessment, intervention, and care for individuals at risk for suicide as of July 1, 2019. The Connecticut Suicide Advisory Board Zero Suicide Learning Collaborative is actively supporting these practices.

General Recommendations: Advocate and support agencies in their efforts to follow the joint commission and CARF national standards to provide timely access to these services.

Examples of Possible Strategies:

Healthcare Providers

- a. Educate systems on the Zero Suicide gold standard of timely access for each type of service.
- b. Continue to monitor and improve protocols to facilitate timely access to care.
- c. Promote best practice standards for triaging individuals seeking care at all levels of care.
- d. Provide education to healthcare professionals in diverse settings (e.g., emergency departments, primary care, cancer centers, dialysis) about suicide prevention, with a special focus on suicide prevention for the disability community.
- e. Provide training and support for providers around the most effective and sensitive language to use when asking about the presence of suicidal thoughts and the reasons for suicidal desire.
- f. Provide training to emergency department (ED) staff at all levels about how to make the assessment

of something as intimate and sensitive as suicide as supportive as possible in an ED setting (e.g., recognizing that the traditional ED system/training is typically designed to respond to physical emergencies rather than mental health ones).

- g. Continue to train medical and mental health care professionals on accurate and respectful language around suicide (e.g., died by suicide instead of committed or completed suicide).

State Agency Staff

- a. Continue to advertise and promote Mobile Crisis services as an alternative to 911.
- b. Consider supporting an expansion of Child Mobile Crisis services so they are “mobile” at all hours.
- c. Increase the capacity of Mobile Crisis and expand it to include Spanish-speaking providers.
- d. Infuse suicide prevention training into existing mandates for violence and sexual assault trainings.

Objective 3.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

Current Status: Connecticut healthcare systems are adopting strategies promoted in the transitions element of the Zero Suicide approach, including the development of new services to support the continuity of care to ensure the safety and well-being of all patients assessed and treated for suicide risk.

General Recommendations: Healthcare systems should develop pathways between all levels of intervention to support continuity of care in an effort to ensure the safety and well-being of all patients assessed and treated for suicide risk.

Examples of Possible Strategies:

Healthcare Providers

- a. Develop a database to capture key data elements and to link repeat emergency department (ED) visits and inpatient admissions. Measure readmission rates.
- b. Ensure that patients discharged from the ED are linked to outpatient providers promptly and effectively.
- c. Due to substantially heightened risk of suicide during transitions among levels of care and back to the community, develop and reinforce the use of safety and/or mental health promotion plans for each patient prior to discharge.
- d. Encourage health and behavioral healthcare providers to utilize caring contacts (e.g., follow-up calls, texts, cards) to support connections to care and prevent future attempts of clients/patients.
- e. Consider the different needs by age groups in inpatient settings (e.g., an 18-year-old may not be comfortable rooming with an older adult).
- f. Create hospital-based peer support groups that consumers may be referred to after discharge.
- g. Promote continuity of care and the safety of all patients treated at all levels of the healthcare system.
- h. Provide additional education for parents of children and teens who have attempted suicide (e.g., support groups, programs attached to partial hospitalization programs, school-based resources) after discharge from the ED or inpatient unit.

Nonprofit Agency Staff

- a. Develop and provide support services for family members of suicidal individuals.

➡ Objective 3.5: Encourage healthcare delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Current Status: Continuous quality improvement efforts related to suicide prevention vary by agency/setting and are governed by existing accreditation bodies. Quality improvement staff in health and behavioral healthcare organizations are active members of suicide prevention initiatives of their systems, and are represented on the CTSAB Zero Suicide Learning Community.

General Recommendations: Improvements can occur through individual agencies, accrediting organizations, and professional groups. The CTSAB can provide further outreach to health and behavioral healthcare agencies and encourage the sharing of suicide prevention continuous quality improvement efforts aligned with the elements of the Zero Suicide approach and High Reliability Organization framework.

Examples of Possible Strategies:

Everyone

- a. Support systems in performing, at minimum, annual facility-based audits related to the seven key elements of the Zero Suicide approach to ensure continued growth and accountability.

Healthcare Providers

- a. Tailor training to staff needs and their roles in health and behavioral healthcare settings (i.e., the Zero Suicide Workforce Survey).
- b. Engage professional organizations and healthcare professionals in lobbying for increased standards of care for suicidal clients.

➡ Objective 3.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.

Current Status: CTSAB and ZSLC engage and provide forums to enhance communication between mental health providers, substance abuse services, and community-based programs guided by those with lived experience.

General Recommendations: CTSAB and ZSLC continue to host forums and encourage further engagement and collaborations as a statewide effort.

Examples of Possible Strategies:

Everyone

- a. Conduct an inventory of peer support programs in Connecticut, both to provide a central resource of programs and to help identify gaps in access to such programs.
- b. Establish a speakers bureau of individuals with lived experience to share their stories.

Healthcare Providers

- a. Encourage individuals with lived experience to inform services provided by mental health providers and substance abuse services.

State Agency Staff

- a. Agencies can provide a safe and easily accessible space, literally and figuratively, for those with all types of lived experience to ensure their voice is incorporated into Zero Suicide implementation.

Nonprofit Agency Staff

- a. Continue collaboration among providers of mental health and substance abuse services, and peer support programs to facilitate supportive transitions between levels of care.
- b. Encourage peers to inform services provided by community-based programs.

Objective 3.7: Coordinate services among suicide prevention and intervention programs, healthcare systems, and accredited local crisis centers.

Current Status: DMHAS, DCF, and the United Way of Connecticut promote the use of mobile crisis services. DCF has memorandums of agreement with all public school systems and hospital emergency departments. The Connecticut Alliance to Benefit Law Enforcement educates state, municipal, and campus police and mental health providers in crisis intervention. Crisis Intervention Teams (CIT) are present in towns and on campuses. Suicide prevention is integrated into mobile crisis provider training and CIT training for mental health clinicians.

General Recommendations: Continue to identify areas of potential partnership and linkages between these kinds of programs and settings. Expand the use of mobile crisis services in settings with clinical staff (i.e., health care providers, clinicians, schools, National Guard).

Examples of Possible Strategies:

Educators

- a. Provide education to school systems, families, and other healthcare providers regarding the Mobile Crisis service.

Healthcare Providers

- a. Continue to promote the use of the Columbia Suicide Severity Rating Scale¹⁹ screening tool across state and private agencies.
- b. Implement real time clinical information and/or sharing of safety plans for veterans being discharged from community EDs or inpatient units after a suicide attempt. Encourage suicidal veterans in community care to connect with the Department of Veterans Affairs.
- c. Expand knowledge of non-traditional programs and wellness resources (e.g., yoga, peer support, meditation, massage, journaling) both to providers and to clients.

State Agency Staff

- a. Explore opportunities to involve peer support in Mobile Crisis services.

➡ **Objective 3.8: Develop collaborations between emergency departments and other healthcare providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.**

Current Status: Health and behavioral healthcare systems have been working to educate community members, police departments, and schools about how to assess imminent risk and opportunities for community-based resources to provide care prior to an emergency department referral.

General Recommendations: There is a need, particularly in light of recent healthcare legislation, to identify the best places for the provision of timely, quality, and effective care. Healthcare and behavioral healthcare systems are using evidence-based tools to screen all individuals to identify who may be at risk. Those identified at risk should be directed to an appropriate pathway of care.

Examples of Possible Strategies:

Everyone

- a. Support programs that assist youth and others in getting care before they reach a crisis point (e.g., presenting at the emergency department with imminent suicidal risk).
- b. Continue to foster a multi-tiered system that can respond differently to different levels of need/acuity.

Healthcare Providers

- a. Link community clinics to hospitals. Create strong partnerships between community clinics and hospitals to assist with continuity of care.
- b. Implement evidence-based suicide prevention training into all levels of healthcare systems, considering the training needs of both clinical and non-clinical staff.
- c. Healthcare systems will utilize evidence-based tools to identify those at risk and develop an appropriate pathway to care.
- d. Discuss and implement the safety planning tool for emergency department (ED) patients, as a model of evidence-based best practices.
- e. Integrate those with lived experience into EDs to support peers.

Goal 4: Reduce access to lethal means of suicide among individuals with identified suicide risk.

➡ **Objective 4.1: Encourage healthcare providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.**

Current Status: National data suggest that healthcare providers who interact with individuals at risk for suicide do not routinely assess for access to lethal means. Currently in Connecticut, there is limited data available to effectively determine the frequency to which healthcare providers assess access to lethal means among patients at risk. However, lethal means counseling education and trainings among healthcare providers have occurred and these types of trainings have increased over the last several years.

For example, some health and behavioral healthcare systems have built staff capacity to talk with patients and parents of patients about lethal means. Training includes counseling around access to lethal means, lethal means safety planning, and safety planning with clients and patients.

General Recommendations: There is a great need to inform health and behavioral healthcare providers, as well as the public, about the importance of lethal means safety in preventing suicides and to emphasize that it applies to all potential means of suicide, not just firearms. Given that reducing access to lethal means is a highly effective suicide prevention strategy, this is an important area of education for health and behavioral healthcare providers who work with individuals at high risk. These providers include ED staff, primary care providers, pediatricians, and mental health providers. Education for providers must focus on provider attitudes, beliefs, and behaviors, as well as recommended strategies for communicating about sensitive topics, such as firearm access, with patients. Providers should also receive training in discussing all types of lethal means safety and security with patients and their families.

Examples of Possible Strategies:

Everyone

- a. Acknowledge the discomfort and challenges often inherent in conversations about firearms.
- b. Compile and evaluate the current lethal means counseling trainings ongoing in the state.
- c. Develop guidelines and educational plans for the training of health and behavioral health providers on lethal means counseling.
- d. Publicize opportunities (e.g., drop boxes and “take-back” programs) to safely dispose of prescription drugs and poisons.
- e. Continue to promote medication take-back locations at pharmacies, health centers, methadone clinics. Explore creative and effective site locations.
- f. Implement a strategy that focuses on lethal means access in high risk locations: bridges, train stations/tracks, public parking garages, public parks.
- g. Encourage Counseling Access to Lethal Means (CALM)²⁰ training and Safety Planning²¹ training.

Educators

- a. Educate families on lethal means access and what they can do to reduce the risk for youth at home from a safety perspective (e.g., poison prevention, lock boxes, discarding unused medications, safe storage of firearms).

Healthcare Providers

- a. Increase use of best practice education and training of health and behavioral health providers to encourage open conversations on lethal means safety plans, history of use, and safety, including locking, limiting, and removing access.
- b. Educate health and behavioral health providers on the spectrum of firearm risk reduction, including safe storage methods and the use of Extreme Risk Protection Orders (ERPO).
- c. Deliver training to primary care physicians and other front-line providers (e.g., Child Health

Development Institute's [CHDI] Educating Practices specific to suicide/lethal means).

- d. Develop provider "cue cards" to ask the necessary questions about lethal means.
- e. In addition to firearm safety, think broadly about lethal means and lethal means safety (e.g., medications, illicit drugs, heights, railway crossings).

State Agency Staff

- a. Expand a pilot program that distributes locked prescription boxes and lethal means counseling and include an evaluation component.

Nonprofit Agency Staff

- a. Research existing lethal means public service announcements for utilization in Connecticut.

➡ **Objective 4.2: Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.**

Current Status: Firearm safety materials were developed and distributed in collaboration with the National Shooting Sports Foundation (NSSF). The materials are associated with the national pilot implementation of the American Foundation for Suicide Prevention/NSSF Talk Saves Lives: Firearm Training for Retailers and Ranges. Brochures, display holders, and firearm safety magnets and stickers were purchased and shared with firearms retailers and ranges, and distributed at the Connecticut Talk Saves Lives trainings. These materials were also distributed to sites upon request, displayed at libraries, and were disseminated annually at American Foundation for Suicide Prevention walks, the Believe 208 5K dedicated to law enforcement suicide prevention and mental health promotion, and the annual Military Fresh Check Days to new recruits of the Connecticut Army National Guard.

General Recommendations: Continue to bring stakeholders together to discuss both challenges and opportunities. It is critical to actively and enthusiastically involve members of the firearm-owning community in discussions, outreach, and safety strategies.

Examples of Possible Strategies:

Everyone

- a. Continue to work with firearm-owning communities to develop suicide prevention and lethal means safety materials for firearm retailers to post and distribute.
- b. Develop new materials with firearm community representatives and providers who serve them (e.g., Department of Veterans Affairs, National Guard) that address the spectrum of firearm lethal means risk reduction, including safe storage methods, parts removal, legal transfer, and use of ERPO. Once developed, disseminate these materials widely.
- c. Advocate for policies requiring dissemination of trigger locks at firearm classes and with each firearm sale.
- d. Review firearm safety curriculum pistol permit course to see what safety and suicide prevention is included and then provide recommendations.
- e. Recommend policies that require firearm courses to include safe storage and suicide prevention content.

State Agency Staff

- a. Collaborate with the Department of Emergency Services and Public Protection Special Licensing and Firearms Unit to collaboratively issue safety and suicide prevention materials at the time of firearms purchases, whether through a public or private sale, and investigate the potential of requiring training as a condition of sale or maintaining retail licenses.
- b. Work with law enforcement to publicize temporary “safe storage” resources for firearms held by individuals at immediate risk for suicide, as well as drop boxes for unused medications.
- c. Continue to promote drug and firearm take-back days using social media and mailings, and advertise on the 2-1-1 calendar.
- d. Continue to develop partnerships with firearm owners, their communities (e.g., NSSF, Connecticut Citizens Defense League), and those who use firearms within their jobs (law enforcement, corrections, military, farmers) to develop population-specific campaigns, especially during high use periods that increase access and familiarity (i.e., hunting season, training periods).

Nonprofit Agency Staff

- a. Increase outreach and engagement efforts to more gun ranges and firearm distributors to increase knowledge of the existing toolkit, available materials, and suicide prevention training programs.

➡ Objective 4.3: Develop and implement new technologies and techniques to reduce access to lethal means.

Current Status: The CTSAB Lethal Means subcommittee was formed and has worked successfully to stay abreast of developments in lethal means safety across domains (e.g., firearms, transportation, medications). Advances have been achieved across arenas. Some changes in legislation have occurred; for example Ethan’s Law, which amended existing legislation to require that firearms be properly stored regardless of whether they are loaded, and changed the definition of minor to anyone 18 years of age or younger. A working relationship has been established with the Department of Transportation and work is ongoing with different divisions (e.g., railroad, highway). These connections have yielded Suicide Prevention signage on the Arrigoni Bridge in Middletown. The development of signage for a bridge in Suffield and bridges in other towns is underway. The Lethal Means subcommittee has also partnered with Connecticut Against Gun Violence to increase outreach and capacity. Finally, in collaboration with Connecticut Poison Control, a safety campaign to accompany the distribution of lock bag and lock boxes has been created.

General Recommendations: Continue to examine the best practices and new technologies in this area, as they are swiftly changing and developing. Additionally, we must support the evaluation of existing programs and technologies in our local communities to better understand their strengths and areas in need of improvement. Finally, it is important to continue to focus on lethal means safety broadly (e.g., including other methods in addition to firearms).

Examples of Possible Strategies:

Everyone

- a. Work with stakeholders to determine the use of safety-related tools for various lethal means, including guns, poisons, prescription drugs, and non-prescription drugs.

- b. Promote awareness of and use of smart guns and smart safety locks.
- c. Explore integrating safe storage of medications and firearms in smart home safety protocols and recommendations geared towards families.

Educators

- a. Focus safe storage campaigns on adolescents and caregivers. Provide gun locks and medication storage boxes directly to these consumers.
- b. Explore the use of Gaggle and Gaggle-like apps and similar technologies that allow school districts to monitor and respond to concerning content in student's work, emails, calendars, and the like.
- c. Link up with other school climate-focused organizations (e.g., Sandy Hook Promise, Love Wins, Wingman) to spread information about lethal means safety.

Healthcare Providers

- a. Target safe storage campaigns substance users and substance abuse providers. Provide gun locks and medication storage boxes directly to these consumers.
- b. Support access to and training in the use of NARCAN® to prevent opioid overdose.
- c. Work with medical professionals and veterinarians to develop institutionally relevant safety cultures around access to lethal means.

State Agency Staff

- a. Continue existing work to post crisis number signage at locations where suicide attempts and deaths are common (for example, bridges, railways, overpasses, parks). Connect with the Department of Energy and Environmental Protection to post in state parks.
- b. Assess whether referrals to DMHAS, which come in conjunction with ERPOs, are resulting in effective connections with mental healthcare.

Nonprofit Agency Staff

- a. Evaluate the impact of firearm safety and suicide prevention messaging.
- b. Disseminate lethal means safety education, materials, and aides.

Goal 5: Increase the timeliness and usefulness of state and national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

➡ Objective 5.1: Improve the timeliness of reporting vital records data.

Current Status: In 2014, the Connecticut Department of Public Health (Connecticut DPH) was awarded CDC funds to establish the Connecticut Violent Death Reporting System (CTVDRS). In 2015, Connecticut DPH began collecting data on violent deaths and has recently completed a report of three years of data (2015 to 2017). DPH is in the process of developing an Electronic Death Registry System (EDRS). The EDRS will be a secure web-based system to facilitate the collection and storage of

suicide-related data from various entities across the state, including funeral directors, medical facilities, medical providers, town clerks, and Office of Chief Medical Examiner. The EDRS will advance the completion of death certificates from its current paper-based process to electronic format. The EDRS will work with the OCME data system via interoperability, thereby reducing data entry. The EDRS will enable more timely and efficient data collection reporting of deaths to other state agencies that utilize these data.

General Recommendations: Maintaining the improvements to the speed with which data is available is important. Additionally, while the timeliness of the Connecticut Violent Death Reporting System (CTVDRS) data allows for it to be the official source of Connecticut suicide death data, the new EDRS will supplement data by adding out-of-state deaths of Connecticut residents not captured by the CTVDRS.

Examples of Possible Strategies:

State Agency Staff

- a. Explore novel methods to further enhance timely vital record reporting.
- b. Identify and apply for funding opportunities to sustain and expand the state's ability to report key data accurately and quickly.
- c. Explore the data reporting needs of specific communities and/or demographic groups, including preferred dissemination formats.

➡ Objective 5.2: Improve the usefulness and quality of suicide-related data.

Current Status: CTSAB's Zero Suicide Learning Community promotes quality improvement within health and behavioral healthcare systems that involves the utilization of existing morbidity and mortality data to guide system improvements. DPH's CTVDRS efforts include collaboration with state and local police to acquire details related to the circumstances surrounding suicide deaths.

General Recommendations: Encourage collaboration among the diverse local and state entities that collect, manage, evaluate, and disseminate suicide-related data to improve timely utilization practices.

Examples of Possible Strategies:

Healthcare Providers

- a. Inform health and behavioral healthcare systems about the myriad of sources and uses of suicide-related data.
- b. Train health and behavioral healthcare systems to identify, collect, report, and manage quality suicide-related data, particularly attempt data.

State Agency Staff

- a. Support data sources to enhance the quality and consistency of their data collection and reporting into state systems.
- b. Develop data streams that overlay risk populations (e.g., veteran status, employment type) with Department of Public Health data.

- c. If assisted suicide legislation passes in Connecticut, implement systems to collect data about any changes to funding for support for disability communities (e.g., homecare, lifesaving treatment).
- d. Consider including a question on gambling behavior on the Connecticut School Health Survey/ YRBS to better understand the relationship between this risk behavior and suicide within the state.
- e. Make state level data more easily accessible to consumers, nonprofit groups, and other state agencies.

➡ **Objective 5.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.**

Current Status: The CTSAB contracts with professionals who identify and analyze most recent data related to suicide deaths and attempts in the state. They identify trends and develop benchmarks and priorities for prevention efforts. In a recent survey, CTSAB members reported a desire for greater access to data, particularly data keyed to their local region or school district. Participants also requested more access to outcome data reflecting the impact of prevention and intervention initiatives. Recent changes that have supported reporting of relevant data across state agencies include the following:

- Office of Chief Medical Examiner (OCME) notifies the CTSAB Postvention Response Committee (PRC) of suicide deaths of youth 24 years of age and younger within 24 hours of the CTSAB PRC, then contacts the affected family and/or community members to offer assistance, support, and consultation.
- DPH has monthly contact with OCME, local police, and state police to routinely access their quantitative and qualitative data related to suicide deaths. A DPH and Department of Emergency Services and Public Protection memo of understanding exists to allow data transfer.
- State statutes support OCME data sharing with state agencies. Additional state statutes support data exchange among other state agencies.

However, data driven collaborations between state agencies and other relevant groups remain an area for growth and improvement.

General Recommendations: Develop a clear plan for the timely collecting, analyzing, and disseminating of data related to suicide deaths and attempts. Establish data collection goals that include data sources, suggestions for ways to acquire data, and potential obstacles to acquisition. Align state reporting systems with national reporting systems. Explore new data collection and reporting resources and partnership opportunities to enhance current capacities.

Examples of Possible Strategies:

Everyone

- a. Institute the Centers for Disease Control and Prevention acceptable term for self-directed violence and suicide (<https://stacks.cdc.gov/view/cdc/11997>).
- b. Where appropriate, include personal narratives of those with lived experience of suicidality and those who have survived the death of a loved one to suicide, with statistics. Get explicit permission from persons with lived experience and loss survivors described in examples.

Educators

- a. Promote the Connecticut School Health Survey/YRBS in Connecticut to schools and the public in order to increase participation and secure representative state-level data.
- b. Use suicide data of specific at-risk populations to guide culturally relevant prevention programs and policy efforts. For example, use the YRBS data to inform the work of the CTSAB School Wellness subcommittee.
- c. Use state-level data and national research findings to guide targeted areas and resources, and gaps in resources.
- d. Add suicide-related risk factor questions to school-based data collection instruments already being administered to limit survey burden.

Healthcare Providers

- a. Educate healthcare providers on the importance of coding suicide-related events accurately.

State Agency Staff

- a. Expand OCME death notification to the Postvention Response Committee from youth and young adults to all ages.
- b. Annually update Facts & Figures webpage on preventsuicide.org that contains the latest national and state data on suicide related behaviors and deaths in Connecticut.
- c. Train local and regional entities (e.g., health and behavioral healthcare providers, regional behavioral health action organizations, local and district health departments, campuses, school systems) to collect and manage suicide-related data.
- d. Educate local and regional entities (e.g., health and behavioral healthcare providers, regional behavioral health action organizations, local and district health departments, campuses, school systems) to access and utilize data.
- e. Collaborate with the Connecticut Open Data Initiative to expand State Data Plan recommendations to include mental health and suicide as a focal area, with strategies outlined to promote data availability, sharing, and integration.
- f. Interface with DPH State Agency Data Officer to inform development of DPH's legislatively mandated data access plan (HB 5517, Public Act 18-175), in order to facilitate access to suicide-related data.
- g. Expand state-level data transparency and availability in the areas of mental health and suicide.
- h. Make available user-friendly data materials in a single place. Advertise this resource to agencies, communities, and the public. Include trends and concerns for specific regional areas.
- i. Include suicide data among the regional profiles produced by the DMHAS-funded Regional Behavioral Health Action Organizations (RBHAOs).

Nonprofit Agency Staff

- a. Use state-level data and the National Action Alliance for Suicide Prevention’s “A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives” to identify partners who can use state-level data to advance suicide prevention research in Connecticut.

CTSAB Areas of Focus

The following areas of focus have been developed for the CTSAB organization itself. They will help the CTSAB continue to build and refine its activities so it can best support all stakeholders as they work toward the goals of Plan 2025.

1. Infrastructure: Build CTSAB’s capacity

- a. Review and formalize the CTSAB and RSAB governance structure
- b. Launch CTSAB subcommittees focused on specific subpopulations, issues, or settings as needed.
- c. Include virtual meeting capacity for all CTSAB meetings.
- d. Encourage and actively facilitate involvement from a greater diversity of partners.
- e. Build capacity to respond to legislative requests and queries.
- f. Collaborate with other state plan developers and implementers to ensure integration of suicide prevention, mental health promotion, and lived experience supports as they pertain to the content, especially behavioral health, social emotional learning, health equity, social determinants of health, trauma, and adverse childhood experiences. Existing plans include, but are not limited to, the Connecticut Healthy People-State Health Improvement Plan and the Children’s Behavioral Health Plan.

2. Awareness: Increase awareness and use of CTSAB and its resources

- a. Update the CTSAB website to make it more user-friendly.
- b. Support the development of and access to a database of evidence-based training, prevention, and media campaigns to help interested groups find appropriate resources.
- c. Conduct another marketing campaign to increase knowledge of resources and assess its impact.
- d. Develop a “core” CTSAB presentation that members may adapt to easily share CTSAB resources and basic suicide prevention information with the community.
- e. Increase the speed with which prevention resources are distributed to help capitalize on last-minute community-based prevention and education opportunities.
- f. Report monthly meeting attendance and annual listserv membership.
- g. Work with state departments and nonprofit agencies to report annual numbers of suicide prevention activities provided (e.g., trainings, support groups, awareness campaigns).

3. Advocacy:

- a. CTSAB will support a fully functioning Advocacy Subcommittee to support and promote policy priorities.

b. Specific goals include, but are not limited to, the following:

- i. Fully fund a statewide Suicide Prevention Coordinator position.
- ii. Amend Connecticut state legislation to reflect that CTSAB covers the lifespan, rather than only children and youth.
- iii. Mandate suicide assessment and intervention training for students in health and behavioral healthcare education programs.

Demographic Groups and Suicide Risk

Unbearable pain, hopelessness, and disconnection from support and meaning are factors that underlie suicidal thoughts and behaviors universally. However, the source of that pain, the factors that complicate hopelessness, the types of disconnections, and impact of environmental factors vary. Some of this variation is consistent with specific demographic groups or identities that an individual holds. It is important to remember that the constellation of factors that leads to any individual suicidal experience is unique and vast. As with the rest of PLAN 2025, users are encouraged to consider the content of this section as a starting point for developing or improving their own suicide prevention activities, with particular attention to the ways these efforts can become embedded in their agency's broader vision.

Lifespan

Suicide occurs at different rates and by different methods across the lifespan. Furthermore, these trends and patterns have changed over time. While there are common risk factors that occur across the lifespan, there are also risk factors and life-stage specific events that are particularly pertinent for different age groups.

Youth Suicide

Suicide is the second leading cause of death among people 10 to 24 years old.^{22,23} In the United States, suicide death rates were relatively stable from 2000 to 2007, and then sharply increased from 2007 to 2017 among 10- to 24-year-olds, with the sharpest increase among those aged 15 to 19.²³ Boys die by suicide at much higher rates than girls and also are significantly less likely to access mental health services in the year prior to their death.^{22,24,25} Looking at suicidal thoughts and behavior, data from the Connecticut School Health Survey finds that 12.7% of Connecticut high school students seriously considered suicide and 6.7% attempted suicide in the previous year.¹⁵

Risk and Protective Factors

While some risk and protective factors for suicide are common across all age groups, there are others that are specific to suicide risk among youth. Mental illnesses, including depression,^{26,27} substance abuse,^{27,28,29} and Attention Deficit Hyperactivity Disorder³⁰ have been linked to increased risk in suicide death among youth. Bullying is associated with suicidal behavior in both girls and boys, though for girls this relationship may be best explained by depression.³¹ Being the victim of violence is particularly harmful among the youngest youths, increasing the risk of a suicide attempt substantially among preteens.³² Acting as the perpetrator of violence is also a risk factor, though to a lesser degree.³² Additionally, while most youth who attempt suicide do not die by suicide, a past suicide attempt does place an individual at higher risk.

Unfortunately, the most at-risk individuals tend to not receive treatment. In fact, less than half of youth individuals who suffer from a severe mental illness, have a functional impairment, or experience intense suicidal ideation receive treatment.²² In 2019, about one in four Connecticut high school students said they

got the help they needed when feeling sad, hopeless, or anxious.¹⁵ Only 44.5% of Connecticut youth aged 12 to 17 who had a major depressive episode received depression care.³³

The good news is that there are numerous protective factors that can also be leveraged to support youth in seeking help and reducing suicidal behavior. Suicide prevention education and awareness programs help improve knowledge and encourage help-seeking attitudes related to the topic of suicide, but they have had less demonstrated success in increasing actual help-seeking behavior.³⁴ Screening and referral programs seem to have more success in connecting identified students to resources, as they do not rely on the student to self-identify as at risk and to proactively seek out help. Overall, social support can help protect against suicide in both direct and indirect ways. A peer social network that has received suicide prevention education is crucial, since studies have shown that most youths who experience suicide ideation or self-harm seek informal help from their peers.³⁵ Parental support and warmth is a valuable protective factor.³⁵ Receiving treatment at home has been shown to have some of the strongest effects, particularly in treatment engagement, compared to other psychological treatments.³⁶ In addition, family-involved treatments are especially effective for youth.

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Include youth in developing and deploying suicide prevention materials and activities.
- Promote teaching of mental health wellness and coping skills (e.g., meditation) in K-12 schools. For example, programs such as Gizmo's Pawesome Guide to Mental Health and curriculum, which takes an upstream approach to supporting the mental health and wellness of youth.
- Provide awareness training to students from middle school through college around signs of depression and suicidality and how to respond.
- Provide awareness training to all faculty and staff at all levels around signs of depression and suicidality and how to respond. Require updated and refresher training regularly.
- Ensure schools have crisis-trained clinicians on site.
- Regularly promote mobile crisis, hotline, and warm line resources in all communities statewide through physical posters and social media. Post flyers for the Crisis Text Line throughout schools.
- Support and promote community wellness initiatives, prevention education, and positive youth development activities.
- Develop and promote specialized prevention program for youth in foster care and those in contact with the juvenile justice system. These populations are more than four times as likely to attempt suicide.
- Use regional resource guides to assist clinicians when referring out to community resources.
- Provide timely outreach to communities and school after a suicide death.

Young Adults

Suicide is the second-leading cause of death among young adults/college-age individuals 18 to 29 years old.⁵ According to the 2016 National College Health Assessment II, 9.8% of college students reported that they seriously considered suicide in the past year and 1.5% of college students reported that they made a suicide attempt in the past year. Other survey studies have suggested even higher proportions of college students endorse passive suicidal

thoughts.³⁷ It is important to note that college itself does not appear to confer greater risk for suicide and, if anything, young adults of similar age who are not enrolled in college are at even greater risk than their college-attending peers. In Connecticut specifically, 8.2% of people 18 to 25 years old reported seriously thinking about suicide in the past year, a number that has increased over the last decade.³³

Risk and Protective Factors

While some risk and protective factors for suicide are common across all age groups, there are others that are specific to suicide risk among young adults. College students' reasons for not seeking treatment appear to be less driven by stigma (endorsed by 12%) and more so by the belief that treatment is not needed (endorsed by 66%).³⁸ Many of the college students undercut the seriousness of their mental health struggles by reporting that "stress in college is normal" and believing "the problem will go away on its own."⁷ Sleep problems, including persistent insomnia symptoms and nightmares, are associated with increased suicide risk.^{39,40} The relationship between persistent insomnia symptoms and suicide risk remains even after controlling for depressive symptoms. Alcohol use and misuse, common in this age group, is associated with greater risk of suicide death and suicidal behavior.

The presence of a social network helps protect young adults from suicide risk by providing sources of support and connection.^{41,42} In addition to the evidence-based approaches to suicide prevention that work across the lifespan, campus strategies that are tailored to encourage help-seeking behavior and address the barriers to treatment can also help.⁴² For example, Gatekeeper training programs may help faculty, staff, and students notice and respond to a student in distress they may have otherwise overlooked. In addition, these trainings help recipients intervene more effectively when they observe distress. However, these effects can wear off, so regular "booster" trainings are recommended.⁴³

In Connecticut, programs such as Connecticut Healthy Campuses Initiative QPR (Question, Persuade, Refer), Jordan Porco Foundation Fresh Check Days on campuses, Active Minds, NAMI on-campus student organizations, campus mental health services, and peer support program across the state offered by various organizations can support youth attending college. Young adults who are veterans or active duty military may be identified through Connecticut National Guard Behavioral Health Team and Department of Veterans Affairs programs. Young adults with serious mental illness may also be identified via DMHAS Young Adult Services. It is more challenging to reach young adults who are not connected to one of these organizations, and who may have increased rates of unemployment and other challenging life conditions. Programs such as Join Rise Be, a statewide, peer-run initiative to provide support and opportunity to young adults facing difficult circumstances, can be helpful to all youth adults.

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Involve family members and natural supports in the work with at-risk young adults in ways that are developmentally appropriate.
- Make greater use of social media for suicide awareness and referral.
- Encourage young adult participation on the CTSAB.
- Identify particular needs of those youth who are "aging out" of DCF state care.
- Provide QPR Training (Question, Persuade, Refer) for people in different roles working with this age group (e.g., faculty coaches, resident advisors).

- Encourage the development of peer run groups on campus, such as Active Minds.
- Support peer-led resources, such as support groups, warm lines, and peer recovery specialists.

Middle-Aged Persons

Middle-aged adults have high rates of death by suicide compared to older and younger age groups.⁴⁴ While middle-aged men make up the bulk of individuals who die by suicide, the rate of suicide has been increasing more rapidly among middle-aged women, particularly from 1999 through 2015.

Risk and Protective Factors

While middle-aged individuals share many of the same risk factors as the general population, they are also likely to experience additional complicating factors. There are many factors involved in the high rate of suicide among middle-aged people, including pressures of child and elder care, death of friends and family, chronic pain, and the ramifications of recessions and protracted unemployment. Work examining the lives of middle-aged individuals who died by suicide found that job/financial problems and criminal/legal problems were common among men who died by suicide, while health and family problems were more common among women. Both men and women had similar rates of intimate partner problems.⁴⁵ Of course, many of these problems co-occurred as, importantly, no single factor causes suicide. Middle-aged adults are not immune to the stigma associated with mental health treatment seeking.^{46,47} Among adults 55 and older, 70% of those with a mood or anxiety disorder did not access mental health services.⁴⁸ Protective factors include possessing coping and problem-solving skills, strong relationships with partners, friends, and family, connectedness to community and other social institutions, consistent and high quality physical and mental healthcare, and reduced access to lethal means.⁴⁹

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Suicide prevention awareness and training in settings where middle-aged adults naturally are (e.g., the workplace, parent-teacher associations, unemployment offices, sports games, religious centers).
- Increase referral and mental health services in employment settings.
- Increase suicide prevention training for primary care providers.
- Public health campaigns aimed to reduce stigma, specifically related to men asking for help with mental health or substance abuse issues.
- Promoting mental healthcare, especially during times of change, such as loss of work, family conflict, and financial issues.
- Continue to train professionals, family members, and communities about lethal means safety.
- Continue to attend to the role of societal safety nets as protective factors against suicide in this age group particularly.

Older Adults

Older adults are also at high risk for suicide; in fact men aged 75 and older have the highest rate of suicide death.¹³ Older adults may face ageist stereotypes and even beliefs from others that “they’re old, of course they want to die.”⁵⁰ However, suicide and suicidal desire is not a normative response to the challenges of aging. Suicide prevention efforts can be effective in reducing suffering and suicidal desire for older adults.

Risk and Protective Factors

While all age groups share some risk factors for suicide, older adults may experience several exacerbating factors, including psychiatric illness, medical conditions that significantly limit functioning or life expectancy, pain, declining role function (e.g., loss of independence or sense of purpose), social isolation, medication abuse or misuse, and impulsivity in the context of cognitive impairment. Furthermore, social isolation may make rescue less likely and the common use of firearms more likely to result in a fatality. While research on protective factors specific to older adult suicide is limited, there are indirect findings that suggest helpful paths. High quality geriatric care that takes a holistic approach and prioritizes physical and cognitive function would likely reduce a number of the risk factors that arise for older adults. Social connection and engagement is another area that likely helps to protect against suicidal desire.

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Late-life suicide prevention efforts must meet older adults where they are (primary care physician's office, geriatrician, senior centers, retirement communities, visiting nurse associations, and the like).
- Introducing depression and suicidal screening in non-clinical activities such as senior transportation, senior daycare, and senior companionship.
- Providing systematic outreach to seniors at elevated risk due to widowhood or social isolation.
- Work against ageist stereotypes and discriminatory policies.
- Providing gatekeeper training to aging services providers.
- Research and implement best practices for diagnosis and treatment for late life depression.

Nationally, there are large discrepancies in suicide death rates across racial and ethnic groups. As mentioned in the introduction to PLAN 2025, it is critical while observing these differences to keep in mind they intersect with other demographic factors and identities that also carry different levels of risk. No one, regardless of racial or ethnic group, is immune to suicidal thoughts, attempts, or death.

Race/Ethnicity

In Connecticut, where overall numbers of suicide are relatively low, and numbers are even smaller when divided by race and ethnicity, data must be interpreted with caution. When considering suicide deaths from 2015 through 2018, the age-adjusted suicide rate per 100,000 was 12.47 for non-Hispanic Whites, 5.19 for White Hispanics, 5.69 for Black non-Hispanics, and 5.05 for Asian/Pacific Islander non-Hispanics. Rates for American Indians/Indigenous people, Black Hispanics, and Asian/Pacific Island Hispanics were suppressed due to low raw numbers of cases.¹³

Black and African American Individuals

Though overall, Black Americans have a much lower rate of suicide death than White Americans, this summary statement conceals important nuances. For example, though the suicide rate within the Black population remains much lower than within the White population, the suicide rate among Black individuals rose more rapidly (25% increase) than among White individuals (5.9% increase) from 2015 to 2018.⁴⁴

Further, Black children have long had a higher rate of suicide death than White children. Rates of suicide among Black children aged 5 to 12 are twice as high as those of similarly aged White children, while rates of suicide among White teens aged 13 to 17 are double the rate of suicide of Black teens.¹¹ Age differences in trends are also observed in other ways. Among Black Americans, the age group with the highest risk of suicide death rate is people in early adulthood (those aged 20 to 34), while among White Americans, those in middle adulthood have the highest risk (those aged 50 to 59).¹³

According to the U.S. Census Bureau,⁵¹ in 2019, Connecticut had a population of approximately 3,282,395 people, with about 13% of the population being Black individuals. The suicide rate per 100,000 of Black individuals in Connecticut (5.69) was lower than the national rate amongst Black Americans (6.96)⁴⁴ and the Connecticut rate among White individuals (12.47).

In 2018, a similar proportion of Black adults (4.1%) reported past year suicide ideation compared to the national average (4.3%).⁵² Overall, the number of Black adults reporting suicide ideation has not changed between 2008 and 2018.⁵² Age-related patterns of suicide ideation are similar between Black adults and national averages. Specifically, those aged 18 to 25 have the highest rates, those 26 to 49 lower, and 50+ lower still.⁵³ However, the prevalence of suicidal thoughts among Black adults aged 18 to 25 has increased from 2008 (6%) to 2018 (9.5%). Past year suicide attempts in the same age group have trended up, but not increased to a statistically significant degree (1.5% in 2008 to 2.4% in 2018).

The picture of suicidal thoughts and behaviors among youth appears somewhat different. Historically, across sex and across racial and ethnic groups (with the exception of non-Hispanic multiple race youth), suicide ideation rates decreased from 1991 through the mid-2000s. Since then, rates have plateaued or started to climb.⁵⁴ Similarly, suicide attempts have either decreased or held steady through this same period across racial and ethnic groups, with the exception of Black teenagers, who had a small but statistically significant increase in past year suicide attempts. Additionally, Black teenage boys had a significant increase in suicide attempts that required medical treatment.¹²

In Connecticut specifically, Black youth have lower rates of suicide ideation than Hispanic youth and similar rates to White youth. There are no differences in racial and ethnic groups in suicide attempt rates. Black youth report similar rates of past year suicide ideation (11.0%) and lower rates of attempts (5.8%) than the national average for Black youth.

Risk and Protective Factors

The underpinnings of historically lower rates of suicide death among most Black Americans are complex and nuanced. Some theorize the presence of protective factors such as religion, strong family support, and community,^{55,56} while others suggest that problems with underreporting or misclassification of deaths may mask the true number of suicides in the Black community.⁵⁷ The increase in suicide among Black children and youth may be related to disparities in access to mental health treatment and limited provision of culturally competent mental healthcare. For example, mental health symptoms in Black youth and adults may be misunderstood, punished, and criminalized, preventing even the option of access to appropriate mental healthcare and directing individuals to the criminal justice system instead. Common social factors that occur at disproportionate rates for Black youth and are related to increased suicide risk, such as racial discrimination, poverty, exposure to violence, and adverse childhood experiences, likely also play a role.^{12,58} What is clear is that there is a dire need for more research to understand why this gap in the suicide rate has existed in the past, why it might be diminishing now, and how to best support Black individuals across the lifespan.

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Enthusiastically and actively seek out Black adults and youth to inform the development and provision of suicide prevention and interventions.
- Promote the understanding that no single demographic factor reduces an individual's risk of suicide.
- Identify and promote best practices for increasing the representation of Black individuals in mental health provider, research, and leadership roles.
- Support culturally humble mental health assessment, referral, and treatment to assure that Black youth and adults are receiving the most accurate and evidence-based care available.
- Encourage suicide screening in the primary care setting, as Black Americans are underserved in the mental healthcare system.

Hispanic/Latinx

Hispanic/Latinx is the fastest-growing minority group within the United States. Hispanic/Latinx identity comprises a wide diversity of ethnic groups and cultural backgrounds. The suicide rate among Hispanic/Latinx individuals has been growing in the last past years—from 5.8 in 2001 to 7.9 in 2018—especially among nonmetropolitan/rural areas.⁵⁹ On average, foreign-born Hispanic/Latinx suicide rates are 17% higher than those of U.S. born Latinxs. However, if migration is directed to areas with a large Latinx population, this effect is reduced.⁶⁰

In Connecticut, according to the Census Bureau, 18.5% of the population identified as Hispanic/Latinx. The suicide rate of Hispanic/Latinx individuals in Connecticut, 5.19, is lower than the national rate amongst Hispanic/Latinx of 7.26⁴⁴ and the Connecticut rate among non-Hispanic White individuals of 12.47.

In 2018, fewer Hispanic/Latinx adults (3.7%) reported past year suicide ideation compared to non-Hispanic/Latinx adults (4.5%).⁵² Overall, the number of Hispanic/Latinx adults reporting suicide ideation has increased between 2008 and 2018.⁵² Age-related patterns of suicide ideation are similar between Hispanic/Latinx individuals and national averages. Specifically, those aged 18 to 25 have the highest rates, those 26 to 49 lower, and 50+ lower still.⁵³ In Connecticut, YRBS data has consistently shown that Hispanic teens have substantially higher rates of suicide attempts (10.1%) than non-Hispanic White youth (5.7%).

Risk and Protective Factors

Many of the same risk factors that are relevant for the non-Hispanic/Latinx community are relevant to this community; however, a few may be particularly pertinent. Suicidal risk is associated with hopelessness. Within the Hispanic/Latinx communities, there is a clear correlation between depressive symptoms, feelings of loneliness, and hopelessness.⁶¹ Moreover, the mere “experience of thinking or feeling that one is isolated and disconnected from others”⁶¹ is linked to depression and suicidal behaviors. Parent-child conflict, lower engagement, and relationship disruption within the family can heighten the individual risk factors. Divorce rates have also been associated with suicides within this population.⁶² Structural disadvantages, such as challenges related to migration like language, employment, and immigration status, can heighten the risk of suicidal behaviors. The most robust evidence shows that having higher inequality in the labor market with the European-descendent population is a risk factor for U.S. born Hispanic/Latinx. For foreign-born Hispanic/Latinx, lower inequality in the labor market with the African American population is considered a risk factor.⁶²

Some specific factors may also reduce the risk of suicidal thoughts and behaviors. Ethnic identity achievement implies having a secure ethnic identity and a clear sense of cultural values. When members of this group can maintain their cultural values, instead of passively assimilating into the majority culture,⁶³ their risk of suicidal behaviors decreases.

There are two ways in which this can happen: cultural isolation from the mainstream culture and integration with it. Research shows that the most protective acculturation strategy combines meanings and values from both heritage and host cultures.⁶³ Hispanic/Latinx cultures are mostly described as collectivist; family and community play a critical role in well-being. This is especially relevant for teenagers and young adults, who rely on parents for support and help-seeking. Parental attachment and support, as well as cultural beliefs about family, have been found to reduce suicidal behaviors.⁶⁴ Both cultural isolation—especially in large communities—and intergroup dialogue can reduce loneliness among Hispanics/Latinx.⁶⁵ Higher levels of religious involvement and less religious diversity lead to greater community support by creating more emotional and social support. Furthermore, in areas with more religious homogeneity, members tend to share more values and build stronger support.⁶⁰

Recommendations. In addition to the universal recommendation for suicide prevention and postvention, the following may also be helpful to consider:

- Explicit and enthusiastic inclusion of members of the local Hispanic/Latinx communities in suicide prevention planning and programming.
- Recognize the complexities of the relationship between suicide and broader social contexts. Regarding this ethnic community, there are factors (e.g., family, community, and religious connections) that can have a dual risk and protective role.
- As seen before, immigrants have a higher suicide rate than U.S. born individuals in areas with lower immigrant concentration. Thus, attention is needed to assess ways migration status and cultural adaptation affect suicidal behaviors.
- Especially among college Hispanic/Latinx students, screen for and treat the presence of depressed mood.

Asians, Pacific Islanders, and Native Hawaiians

Asian Americans (AA), which includes persons with origins in the East, Middle, South, or Southeast Asia, are often combined in epidemiologic research and comprise 5.6% of the U.S. population. The largest groups within the United States consist of Chinese (3.79 million), Filipino (3.41 million), Indian (3.18 million), Vietnamese (1.73 million), Korean (1.7 million), and Japanese (1.3 million) (United States Census Bureau, 2014). The category of Pacific Islanders (PI) includes people with origins from Hawaii, Guam, Samoa, and other Pacific Islands (PI/NH). This category comprises 0.5 % of the U.S. population (United States Census Bureau, 2014). Clearly, this diverse group clusters individuals comprising different histories, reasons for and timelines of immigration or refuge, cultures, and religions.

In Connecticut, according to the Census Bureau, 5.9% of the population identified as Asian. The suicide rate of AA individuals in Connecticut, 5.05, is lower than the national rate among AA of 6.74⁴⁴ and the Connecticut rate among non-Hispanic White individuals of 12.47.

Suicide rates among AA and PI/NH are consistently lower than the national suicide rate⁶⁶ and, thus, the

population, as a group, might be considered at lower risk for suicide. Nevertheless, suicide was the leading cause of death for Asian Americans ages 15 to 24 in 2017. In 2018, fewer AA adults (2.9%) reported past year suicide ideation compared to national averages (4.3%).⁵³ Overall, the number of AA adults reporting suicide ideation has not changed between 2008 and 2018.⁵² Age-related patterns of suicide ideation are similar between AA individuals and national averages. Specifically, those aged 18 to 25 have the highest rates, those 26 to 49 lower, and 50+ lower still.⁵³

Risk and Protective Factors

In this population, prominent risk factors for suicide include social isolation, lack of support and acceptance from family, unemployment, poor coping during times of distress, mental illness, interpersonal conflicts, school problems, and stress with military service.^{67,68,69} High cultural affiliation does not appear to provide protection from suicide in native Hawaiian populations.⁷⁰ Age, in particular, has been associated with suicide ideation in the PI/NH populations, such that younger age is associated with a great incidence of suicide ideation.

Asians who immigrated to the United States as children have higher prevalence rates of both suicide and suicidal thoughts and behaviors than those born in the United States. Further complicating the picture, those who immigrated during adolescence or adulthood have lower yearly prevalence rates of ideation and attempts than either of the previous groups. Further research is required to fully understand the discrepant rates depending on age at immigration and the role of acculturation and family expectations. In addition, AA and PI/NH populations have lower rates of disclosure of their suicide ideation and mental health problems, and receive less mental health treatment.⁷¹ This may mean that suicidality is undercounted in these populations and that treatment is less likely to be provided.

Cultural identification and sense of belonging and affiliation are associated with a reduction in the risk of suicide attempts. In particular, family cohesion may be a particularly protective factor against suicidal behavior.⁶⁹ This is consistent with findings that in many AA cultures, the family is viewed as individuals' primary source of support and security.⁷² However, this work is not able to take into account the diversity of beliefs and norms across different cultural groups. While helpful to keep in mind, it is important not to assume any cultural truth applies to any single individual, regardless of their racial background.

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Explicit and enthusiastic inclusion of members of the local AA and PI/NH communities in suicide prevention planning and programming.
- Reduce the marginalization, alienation, and discrimination of AA and PI/NH identities across settings and environments.
- Consider the “model stereotype” mentality (that Asian Americans are “naturally smart,” “wealthy and successful,” for example) as a risk factor that may prevent individuals and their families from seeking help—and that this same stereotype may prevent providers from accurately assessing the needs of their AA patients.
- Acknowledge the presence of culture orientation, such as levels of acculturation and enculturation.⁷³ This can be helpful in reducing intergenerational cultural conflicts between parents and children that could act as risk factors.⁷⁴
- Make available translation services at all points of the prevention services spectrum.

- Focus on the intersection of identities; for example, subgroups within the AA population that are at greatest risk (youth, NH).
- Review of current best practices for AA and PI/NH-focused programs; for example, the DMHAS AAPI Ambassador Project, which partners with members of the AAPI community to start conversations in their own communities about risk, addictive behaviors, and how to seek help.

Native Americans and Alaskan Natives

Approximately 2% of the U.S. population identifies as Native American or Alaskan Native. Within this population specifically, suicide rates are even higher than among the general population. Suicide is the 8th leading cause of death for Native Americans/Alaskan Natives (NA/AN), while it is the 10th leading cause of death in the general U.S. population. The suicide rates for NA/AN aged 15 to 34 is approximately 200% higher than the national average.⁵⁴ In 2018, more NA/AN adults (5.8%) reported past year suicide ideation compared to the national average (4.3%).⁵³ Age-related patterns of suicide ideation are similar between NA/AN individuals and national averages. Specifically, those aged 18 to 25 have the highest rates, and those 26 to 49 have lower rates (there was not enough data to estimate rates in those 50 and older).⁵³

In Connecticut, approximately 1.3% of the population identifies as Native American. Given the relatively small population, it is difficult to make meaningful observations about the suicide rate among the population locally. Nevertheless, nationwide, some research has focused on suicide risk among NA/AN populations. It is important to note that more research focused on suicide risk in specific tribes is required. The following risk factors, protective factors, and recommendations are based on the general NA/AN population.

Risk and Protective Factors

Many of the suicide risk factors for suicide among NA/AN individuals are similar to those in other groups. The presence of mental illness, past history of suicidal behavior, familial violence/disruptions, traumatic experiences, access to firearms or other lethal means, hopelessness, impulsivity, and lack of support are associated with a greater risk of suicide in the NA/AN population.^{75,76,77} In addition, research has found that drug and alcohol use is a particularly strong risk factor of suicidal behaviors in AI/AN communities.^{76,78,79} Some family and community factors are also related to a greater risk in suicidal behaviors. In particular, intergenerational substance use has been associated with a greater risk of suicidal behaviors in NA/AN populations.^{75,76,78} While many of the individual risk factors for suicide are consistent with findings from the general population, the prevalence of these risk factors is higher in Native American and Alaska Native NA/AN because of the downstream effects of historical trauma and genocide as well as continued stresses of alienation, assimilation, discrimination, and community violence.⁷⁶

Preservation and promotion of NA/AN culture within communities has been associated with dramatic reductions in rates of youth suicide.⁸⁰ Strong connections between ethnic identity and culture are a means to develop self-esteem, self-respect, and cultural connectedness that lower risk of suicidal thoughts.^{76,78}

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Explicit and enthusiastic inclusion of members of the local Indigenous and NA/AN communities in suicide prevention planning and programming.
- Reduce the impact and erasure of historical trauma, alienation, and discrimination caused by a history of NA/AN oppression within the community.
- Actively recruit tribal leaders and tribal mental health and wellness practitioners when formulating

plans for NA/AN populations.

- Provide outreach consultation services to tribal leaders.
- Use media campaigns that focus on both risk and protective factors.
- Increase access to culturally humble behavioral healthcare.
- Focus on subgroups at risk, including youth among NA/AN communities.
- Implement prevention strategies such as Mindfulness and Community-Based Participatory Research Mental Health Promotion Programs that offer a means of strengthening connections between ethnic identity and culture as a key approach to reducing suicidal behaviors.^{81,82}

Lesbian, Gay, Bisexual, and Transgender + (LGBT+) Identities

Lesbian, gay, bisexual, and transgender populations have higher suicide death rates than the general population, especially among younger adolescents.^{83,84,85} However, reliable nationwide data is limited as the National Violent Death Reporting System (NVDRS) only began coding sexual and gender minority status in datasets in 2014.^{83,86} Estimates of suicide deaths among sexual orientation and gender minorities are further limited by the use of psychological autopsy studies, which typically rely on biological family members to report sexual orientation and gender identity.⁸³

Data on suicidal thoughts and behaviors among LGBT+ populations are more reliable than suicide death. The transgender population has the highest rate of suicide attempts (29%).⁸⁷ Lifetime suicide attempt rates of sexual orientation minorities (lesbian, gay, and bisexuals) are at least twice as high (11-20%) as those of their heterosexual peers (4%).⁸⁸ Of note, bisexuality is associated with a particular increased risk of suicidal ideation and attempts compared to both heterosexual and gay or lesbian populations; the risks are even higher for bisexual women than for bisexual men.^{89,90} Higher rates of mental illness, substance abuse, and lack of support, even within the sexual minority community, were identified as relevant risk factors.^{89,90}

Risk and Protective Factors

Across the board, researchers have identified both external and internal factors related to minority status, especially discrimination and stigma from institutional, legal, and personal sources, to substantially increase risk.⁹¹ Substance use problems are also associated with higher suicide risk, and are proposed to be a temporary coping resource for minority stress, and thus found at higher rates among LGBT+ individuals.⁹² Protective factors include acceptance by family and friends, presence of a minority community and social support, a sense of identity, and access to quality and culturally competent mental health treatment.^{83,85,90,91} Notably, substantial evidence supports the minority stress model, which suggests that environments hostile to sexual and gender minority groups lead to stress and increased risk of mental health issues compared to their heterosexual and cisgender peers.^{93,94,94,96}

Specific risk factors for LGBT+ populations vary among different sub-populations. For example, the transgender community faces an additional set of pressures. External minority stress (e.g., victimization, discrimination, stigma) and internal minority stress (e.g., concealment of identity, internalized transphobia, expectations of rejection) were consistently identified as risk factors, pointing to a need for policy changes to protect trans people from discrimination, aggression, and harassment from employers, educators, and healthcare providers.^{84,95,97} Mental health providers and researchers should also invest in educating and training to increase trans-affirmative care.^{84,95} Other gender identities across the gender continuum have received even less attention.

Sexual and gender minorities in adolescents and young adults have higher risks of suicidal ideation, behaviors, and death rates.^{85,88,91,98} Warning signs, including bullying, fear of future violence, and denial of problems by school or family, were identified and should be noted by clinicians when interacting with LGBTQ+ youths.^{85,99,100} GSA (Gay-Straight Alliance) in high schools, as well as LGBTQ+-inclusive anti-bullying policies can serve as protective factors against suicide risk.^{99,101}

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Promotion of specific crisis services (e.g., crisis hotlines) tailored towards these populations, with LGBTQ-affirming counselors.⁹⁸ For example, the TrevorLifeline (phone: 866-488-7386; text: 678678) for LGBTQ+ youth and young adults and the TransLifeline (877-565-8860) for and by trans youth and adults.
- Training and education on relevant topics for healthcare professionals, educators, and administrators, in order to help establish affirming and culturally humble interventions and environments.
- Explicitly signal affirming and supportive environments (e.g., including preferred pronouns in signature lines and introductions, posting affirming signage in clinics and schools, revise clinic and school forms to be inclusive of all genders and sexual orientations).
- Policies against violence, discrimination, and harassment at institutional, local, state, and societal levels to protect rights and increase safety for LGBTQ+ populations.

Mental Health Conditions

According to the CDC, 46% of those who die by suicide have a *diagnosed* mental health disorder. This statistic, however, does not account for individuals with *undiagnosed* mental illness.¹ Studies that include retrospective accounts from survivors of suicide loss estimate that a more accurate statistic is that 90-98% of those who die by suicide qualify for a diagnosis of a mental health disorder. It is important to note, though, that a very small fraction of individuals with mental health disorders, 5-8%, die by suicide. Put another way, most people who die by suicide have a mental health disorder, but most people who have mental health disorders do not die by suicide.

Risk Factors

- The most common diagnosis of individuals who die by suicide is depression, followed by anxiety disorder, bipolar disorder, schizophrenia, and Post-Traumatic Stress Disorder (PTSD).¹⁰² Comorbidity (i.e., multiple diagnoses) increases risk. Having an additional diagnosis of psychotic disorder, mood disorder, substance use disorder, or personality disorder incurs the highest risk.¹⁰³
- Suicide risk is especially high for the first 4 to 12 weeks after discharge from inpatient psychiatric treatment. The highest risk after discharge is for patients with depressive disorders, followed by bipolar disorder, schizophrenia, and substance use disorder.¹⁰⁴
- Experiencing psychosis increases individuals' risk of engaging in suicidal behaviors. This holds true for individuals who experience psychosis, but do not have a diagnosable mental health disorder (i.e., individuals who do not experience symptoms in line with a DSM-5 diagnosis).¹⁰⁵
- **Importantly, no individual diagnosis is a path to suicide.** It is the combination of mental health

problems with other vulnerability factors (e.g., comorbidity, previous suicide attempt, substance misuse, access to lethal means, isolation) that puts individuals at greatest risk. Thus, it is important to ask all patients about possible suicidal thoughts or behaviors. In fact, suicide screening is a best practice and is now required for all behavioral healthcare patients by most accreditation bodies.

- Research supports a relationship between stigma towards mental illness and suicidality. When public stigma is internalized by individuals with mental illness, they are at greater risk of experiencing suicidal ideation.¹⁰⁶ Efforts must be made to increase public knowledge of mental health disorders in order to decrease stigma.
- While the impact of the COVID-19 pandemic and the subsequent quarantine, economic fallout, and other consequences are not yet known, it is possible that these may exacerbate existing mental health conditions and perhaps bring on new ones. In particular, the combination of isolation, uncertainty, and stress are prime conditions for worsening mental health and increased suicide risk.

Interventions

Improving mental health can reduce suicide risk. Some evidence-based therapeutic interventions for suicidal thoughts and behaviors are listed below:

- Creating a crisis response plan or a safety plan, an easily accessible checklist of strategies and resources to use during an emotional crisis, has been shown to mitigate risk for suicide ideation and attempts, and increases mental health treatment attendance.^{107,108,109} Developing a “no suicide contract” with an individual is no longer considered an appropriate intervention and, in fact, can cause further harm.
- Collaborative Assessment and Management of Suicidality (CAMS), a therapeutic framework that can be added to other interventions to assist the patient and clinician in jointly identifying and addressing patient-specific suicidal “drivers.” CAMS has been shown to reduce suicidal ideation.^{110,111}
- Cognitive behavior therapy (CBT) is a psychotherapeutic technique that helps clients identify emotions, challenge unhelpful or inaccurate thinking, and develop new coping strategies in order to respond to emotional difficulties more effectively. There are several promising cognitive behavioral methods designed to specifically target suicidal thoughts and behaviors, including Brief CBT,^{112,113} CBT for Suicide Prevention,¹¹⁴ Post Admission Cognitive Therapy,¹¹⁵ and Attempted Suicide Short Intervention Program (ASSIP).¹¹⁶
- Dialectical behavior therapy (DBT) combines principles from cognitive behavioral therapy and mindfulness with a focus on learning to cope with extreme or changing emotions. It has been shown to effectively reduce self-harm and suicide attempts in individuals with borderline personality disorder, adolescents with previous lifetime suicide attempts, and heavy episodic drinkers with suicidal ideation.^{117,118,119}

Recommendations. In addition to the universal recommendation for suicide prevention and postvention, the following may also be helpful to consider:

- Increase use of evidence-based screening for all mental health disorders and suicide risk across health and behavioral healthcare and educational settings.
- Mandate suicide prevention training for all health and behavioral healthcare professionals.
- Provide in-depth, evidence-based suicide prevention and suicide intervention training for health and behavioral healthcare providers.

- Treat underlying mental health and behavioral health disorders, but simultaneously engage specifically with suicidal thoughts and processes as well as with other risk factors (e.g., reducing access to lethal means).
- Increase efforts to monitor progress and follow-up with patients in the period post-discharge, schedule a next appointment within 24 hours after post-discharge from acute settings¹²⁰ and regularly in the 4 to 12 weeks after discharge, when risk remains high.¹⁰⁴
- Follow up within eight hours of missed appointments.¹²⁰
- Support care transitions between levels of care with caring cards, calls, and letters.^{120,121}
- Promote and provide evidence-based online resources/treatments to reach individuals who otherwise do not have access to support or are prevented from utilizing existing support because of stigma.
- Support the evaluation and expansion of peer support programs, such as warm lines, certified Recovery Support Specialists, Emergency Department navigators, and Alternatives to Suicide support groups.
- Make efforts to increase public knowledge of mental health disorders to combat stigma.

Opioid Use Disorders

Addiction is a disease that can impact and consume every aspect of a person's life. The path to recovery is both possible and difficult. Due to the ongoing opioid epidemic within the state and the country, it is important to continue to work to understand and communicate the relationship between opioid use disorder (OUD) and suicide. Many who have OUD do not seek treatment or they encounter barriers when they do.¹²² Through understanding the many risk factors involved, we can provide accessible, functional, and non-judgmental care for a population that is in critical need of help and support.

According to the CDC, in 2018 there were 948 overdose deaths involving opioids in Connecticut, a rate of 27.5 deaths per 100,000 persons, which is nearly twice as high as the national rate.¹²³ While overdoses on prescription pain medication and heroin have been falling since 2016, overdoses from fentanyl have skyrocketed. In 2012, 13 people died of accidental overdose involving fentanyl in Connecticut. In 2018, fatalities in Connecticut involving synthetic opioids, mainly fentanyl and fentanyl analogs, rose to 767 deaths.¹²³

OUD is strongly related to suicide risk. In a study of nearly five million veterans, researchers found that those with OUD had a suicide risk six times that of the general public.¹²⁴ Amongst people who use heroin, the lifetime prevalence of attempted suicide is 20%-50%,^{125,132} far greater than the 3%-5% of the general population.^{133,134} An important shared risk factor for both suicide and OUD is chronic pain.^{135,136,137} Chronic pain increases the risk of depression two- to five-fold¹³⁸⁻¹⁴² as well as greatly increasing the use of prescription opioids. Psychological autopsy studies have revealed that depression is involved in as much as half to two-thirds of suicides.^{143,144}

It is important to consider both unintentional and intentional overdoses when trying to understand the relationship between Opioid Use Disorder (OUD) and suicide. Studies have shown that 20%-30% of those with OUD report a history of both unintentional overdose and suicide attempt.^{132,145} Experts in the field suggest that 20%-40% of overdose deaths may actually be better understood as suicide deaths.¹⁴⁶ It can be incredibly difficult to uncover the intent of overdose deaths,^{147,148} so without overwhelming evidence of suicidal intent, these deaths are often recorded as accidental. Further, the line between intentional and

unintentional overdose is hard to draw and there is growing evidence that an either-or model of intention is insufficient. For example, after a recent overdose, patients often report having had at least some desire to die¹⁴⁹ or being unsure whether or not their overdose was intentional.¹⁵⁰ Other studies have shown that those with OUD who have survived an opioid overdose stay at an elevated risk for experiencing a fatal opioid overdose¹⁵¹ and for death by suicide.^{152,153} While there are clearly some overdose deaths that are entirely unintended and some that are entirely motivated by a desire to die, there appears to be a large proportion that fall somewhere in the middle and future risk is conferred regardless of current motivation. Thus, it is important to assess and discuss suicide risk with survivors of all types of overdose, regardless of the apparent motivation.

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Reduce access to opioids by securing them within the household, or making only small amounts accessible at one time, and securing larger quantities.
- Promote the proper disposal of all unused prescribed pain medication at local police departments, or through use of disposal bags available at pharmacies.
- Screen for suicidal ideation upon all overdose hospitalizations.
- Improve linkage of overdose patients in the emergency department to recovery coaching and addiction treatment facilities.
- Improve access to and integration of mental health and substance misuse treatment resources.
- Strengthen comprehensive programs that address addiction treatment and harm reduction.
- Encourage the use and accessibility of medication-assisted treatments (MAT). For example, encourage and support diverse providers in training and registering to provide opioid replacement medications. Disseminate messages to combat the stigma associated with MAT.
- Ensure regular suicide screening for those on long-term opioid therapy, especially when risk factors change and warning signs are present.
- Mandate training of health and behavioral health professionals on evaluating substance misuse and suicide risk.
- Improve access to naloxone and encourage widespread training on how to identify an overdose, and how to use naloxone.
- Ensure the widespread distribution of fentanyl test strips (FTS). As of January 2019, FTS are available through the Connecticut DPH HIV Prevention Program.
- Educate opioid users that they should never use alone. Having other people around who can recognize the symptoms of an overdose can give someone the opportunity to administer naloxone, call 911, or help rescue as trained.
- Encourage opioid users to connect with local syringe services programs for information, support, and prevention tools.

Living with Chronic Medical Conditions or Disabilities

Living with chronic or terminal physical conditions can place significant stress on individuals and families. Limited support and understanding from the wider society complicates the experience and adds significant challenges. As with all challenges, individual responses vary widely. However, overall, the following factors are associated with higher suicide risk among people impacted by chronic medication conditions or disabilities.

Mental health comorbidity

The presence of physical health conditions is a risk factor for suicide attempts, even in the absence of a mental health disorder. However, people at the greatest risk of attempting suicide are those with mental-physical comorbidity.¹⁵⁴

Research suggests that mood disorders, especially depression, are the most strongly linked to late-life suicide and that much of the relationships between suicide and chronic illness is explained by mood disorders.^{155,156} Feelings of hopelessness, even among those never diagnosed with depression, can also affect suicidal ideation.¹⁵⁷ Research suggests that suicide risk is particularly elevated when the two types of illness (physical and mental) are first diagnosed close in time to each other, or when the mental health condition begins *after* the physical health condition.¹⁵⁸

It is important to note that though chronic and terminal health conditions are a risk factor for suicidal thoughts, most people with these health conditions are not suicidal.

Functional impairment

Pain, declining physical functioning, and limitations in activities of daily living are found to be significant risk factors for suicidal ideation.¹⁵⁹ For example, among patients fighting cancer who were referred to psychiatry for suicidal thoughts, 25% had the lowest score on a physical health performance scale and 80% were experiencing significant pain.¹⁵⁷

Qualitative studies report a potential explanation for the link between impairment and suicidality: illnesses and disabilities are most associated with suicidal thoughts when they threaten the person's independence, sense of usefulness, value, dignity, and/or pleasure with life. Accordingly, in a study including participants from four continents, poorer self-rated health was associated with the wish to die, suicidal ideation, and suicide.¹⁶⁰ These findings demonstrate the essential role not only of the physical illness or condition, but of the environment and community. For example, access, instrumental support, pain management, inclusion, and other supports may make a large difference in whether suicidal thoughts emerge.

Number of medical conditions

There appears to be an association between the total number of physical illnesses and the likelihood of a suicide attempt.¹⁶¹ Regardless of the kind, as the number of physical conditions increases, the risk of suicide ideation also rises.¹⁵⁴

Condition type/characteristics

Chronic medical conditions (CMCs) associated with suicide attempts are high blood pressure, heart attack/stroke, arthritis, chronic pain, and respiratory conditions. CMCs associated with planned suicide attempts are epilepsy, cancer, and heart attack/stroke. Epilepsy was the physical condition most strongly associated with suicide deaths. The authors suggest that the latter is best explained by individuals experiencing a decline in quality of life.¹⁵⁴

Another study found that cancer was the CMC most strongly correlated with suicide.¹⁶⁰ It is unclear why, but some types of cancer are associated with a higher suicide risk than others. For example, for men, gastrointestinal cancer had the strongest association, while for women it was brain cancer. Researchers propose this difference could be attributed to prognosis.¹⁵⁷

Time since diagnosis

Generally, CMCs are more strongly associated with suicidality if they occur early in life.¹⁵⁴ However, for some subgroups (cancer patients, adolescents, older adults) recent diagnoses imply greater risks. About 40% of deaths due to suicide among people with cancer occur in the first year after diagnosis. Moreover, the risk is highest within the first three months post-diagnosis, with a second peak period 12 to 14 months after diagnosis.¹⁵⁷

Age groups

Adolescents and young adults. The association between chronic illness and suicidal thoughts in this group depends on the presence/absence of mood disorders. Depression and smoking are both strong correlates for suicidal *thoughts and behavior*.¹⁵⁶ Cardiovascular conditions are associated with an increased risk of suicide *planning and attempts* among adolescents with suicidal ideation.¹⁶² For adolescents (13 to 17 years old), the onset of CMCs in adolescence is associated with greater risk of suicidal thoughts and behaviors, compared to onset in early or middle childhood.¹⁶²

Older adults. Among older men (65+), diagnoses received within three years before the study elevate suicide risk, compared to those received at any previous time in life.¹⁵⁵ Especially, the time shortly after a diagnosis of cancer is related to higher relative risks of suicide. For women, these findings are not as evident.¹⁵⁵

Oldest adults. Among men suffering from CMCs, there is a difference in suicide rates of older (ages 65 to 79 years, suicide rate 37.3), and oldest-old (ages 80+, suicide rate 66.2). For women, the rates remained more stable across the lifespan: 19.1 for older and 18.0 for oldest-old.¹⁵⁵

Intersection between physician-assisted suicide/aid in dying and suicide prevention

Discussions about assisted suicide for those with terminal illness intersect in important ways with suicide prevention. The active disability community in Connecticut has been vocal on the need for suicide prevention services for people with disabilities. There may be unintended consequences of assisted suicide legislation on people with disabilities. Peace¹⁶³ writes that “Many assume that disability is a fate worse than death. So we admire people with a disability who want to die, and we shake our collective heads in confusion when they want to live.” It is critical that medical professionals do not assume that despair among those with CMCs or terminal illnesses is necessarily related to their medical condition. Further, as with any person in pain, healthcare providers must endeavor to fully understand the sources of suffering and the tools available to lessen suffering and support a life worth living. People with disabilities have a right to responsive and culturally competent suicide prevention services. The CTSAB intends to continue to explore the needs of the disability community for such services.

Recommendations. In addition to the universal recommendations for suicide prevention and postvention, the following may also be helpful to consider:

- Do not assume suicide is a “rational” response to disability or chronic illness.
- Pay special attention to pain and functional impairment. In addition to working with patients to manage pain, increase supports to bolster independence.

- Educate medical and mental health professionals about the experiences of those with CMCs, disabilities, and terminal illnesses. Support training these professionals in working effectively with disabled individuals who are suicidal.
- Continue to support programs that support life and reduce suffering for all and avoid passing judgement on the worth or value of any individual life. Treat mental health conditions as seriously among those with disabilities or CMC as among those without.
- Encourage primary care physicians to facilitate referrals to mental health services.
- Some CMCs, such as cancer and epilepsy, imply greater risk by themselves. Therefore, the assessment for suicide risk should occur in medical settings addressing those conditions (e.g., cancer centers).
- Strengthen the integration between mental health and medical care, especially the assessment and screening for mood disorders (e.g., depression) and related symptoms (e.g., hopelessness).
- Pay close attention to patients who have multiple CMCs. A diagnosis must be seen as a stressful event; several diagnoses imply greater risk.
- Take into account the timing of diagnoses. In general, diagnoses that occur early in life imply greater suicide risk; however, adolescents, older adults, and cancer patients are exceptions to that rule.
- Consistently and enthusiastically encourage and facilitate participation from individuals within the disability and CMC communities in designing or implementing programs for these communities.

Occupations

Working in certain occupations has been associated with a greater risk of suicidal behavior. Given the different ways occupations are labeled and categorized by the federal government, local governments, trade organizations, and other sources of information, consistent data is limited. However, some patterns are noticeable.

According to a study of occupational groups and suicide,¹⁶⁵ for men, the highest suicide death rate was among those in the category of “construction and extraction.” Within this field, specific risk factors such as injuries, physical pain, psychological stressors, financial difficulties, unstable employment, and challenges with health insurance access may be common.¹⁶⁴ The occupational category with the largest recent increase in suicide rate, in addition to having the second highest suicide rate, was “arts, design, entertainment, sports, and media.” Occupations in the category of “installation, maintenance, and repair” had the third highest suicide rate. Among women, the highest suicide rate was the category of “arts, design, entertainment, sports, and media.” The second highest suicide rate for women was “protective services” and the third was “healthcare support.”¹⁶⁵

It is also important to acknowledge that the occupation-based suicide rates will differ from state to state, due to regional differences in occupations, unions, state policies, and socioeconomic differences. For example, a study in Georgia and a study in Colorado found different occupations had highest suicide rates.^{164,166} Overall, due to the economic disadvantages that come with working lower-paying, physically demanding jobs, professions at higher risk include agricultural, service, and skilled trade workers.¹⁶⁷ The limitations of available data make it hard to draw causal conclusions between specific professions and suicide risk, but recognizing increased risk in a certain sector suggests avenues for providing suicide prevention training and resources.

While there is little conclusive information about the relationship between suicide and occupation, theories of suicide help explain one possible relationship. Individuals who have greater comfort with or access to lethal means (e.g., firearms, medications, pesticides) are at a greater risk of acting on their suicidal desire than individuals with the same level of despair but an absence of access to means. Higher rates of suicide in specific professions, such as medical doctors, farmers, and law enforcement professionals, may be in part because of knowledge of and access to lethal means acquired in their profession.¹⁶⁸ It is common for individuals to use suicide methods that they already own, such as a personal firearm or prescribed medications.¹⁶⁷ For instance, farmers and agricultural workers have a higher chance of dying by pesticides compared to the general population.^{164,168} Additionally, doctors, medical trainees, and veterinarians are most likely to die by overdose,¹⁶⁹ due to their ability to easily access lethal medications. These professions also have high risk factors that may place them at higher risk of experiencing suicide ideation, such as stress connected to work and stigma around receiving help.¹⁷⁰ The combination of stressors that increase ideation and accessibility to lethal means may confer particular risk for suicide attempts and deaths. For example, veterinarian surgeons have a proportional mortality ratio for suicide of approximately four times that of the general population and around two times that of any other health care profession.¹⁷¹ Interventions that decrease stigma, increase access to care, and limit access to lethal means could be particularly beneficial for these groups.

Another concern related to occupations and suicide is suicide deaths that occur at the workplace. While this is relatively rare, in 2018 in the United States, 304 people died by suicide in their place of work.¹⁷² One cause of suicide in the workplace is due to the belief that dying outside of the home can protect family and friends from the burden of discovering the decedent. Men between the ages of 65 and 74 had the highest rates of workplace suicide, and 98% of the individuals were White. Protective service occupations, in addition to farming, fishing, and forestry professions, had the highest rates of suicide in the workplace. As is true of suicide deaths overall, the majority of individuals used firearms.¹⁶⁸

Risk factors that may exacerbate suicidality in certain occupations:¹⁶⁸

- High stress and psychologically demanding work can lead to negative mental health outcomes such as anxiety, depression, and post traumatic stress disorder (PTSD).
- Knowledge of, comfort with, and access to lethal means in the context of professional duties increases one's risk of acting on suicidal thoughts.⁷
- Low job satisfaction, low wages, long hours, and low decision latitude or low control from the employee were associated with suicide deaths.²
- Individuals experiencing financial hardship or instability and part-time employment were at greater risk.
- Chronic illness, depression, recent visit to the emergency department, social isolation, interpersonal conflicts, and being divorced or separated were associated with workplace suicides.
- Exposure to trauma and abuse of others, including animals.

Protective risk factors related to occupation

- Being employed full time
- Having private healthcare

- Having a bachelor's degree¹⁷³

Recommendations. In addition to suicide prevention strategies provided universally, additional suicide prevention strategies may include the following:

- Increased suicide awareness for high risk occupations through public health campaigns that target mental healthcare providers of individuals in these occupations.
- Gatekeeper training for supervisors, managers, and peers.
- Promotion of mental health, self-care, and work norms that support these occupations.
- For construction workers: implementing policies that promote a safe and healthy working environment for workers at the site, continuous conversations with employers about the importance of mental health, and efforts to increase the continuity of healthcare.
- Helping healthcare professionals access confidential mental healthcare via resources such as Health Assistance InterVention Education Network (HAVEN) (<https://www.haven-ct.org/>).

First Responders

First responders are firefighters, police officers, emergency medical technicians (EMT), and paramedics. They are the first to arrive at the scene of an accident and provide care to the injured or traumatized individuals. Every day while on the job they are at risk of witnessing and experiencing very traumatic events. First responders may be at an elevated risk for suicidal ideation and attempts based these occupational risk factors, among others: (1) occupational hazards and exposure^{174,175,176,177,178}; (2) direct access to firearms and other lethal methods¹⁷⁴; (3) capability for suicide (e.g., higher pain tolerance, frequent exposure to injury and death)^{174,178,179}; (4) erratic schedules (may affect sleep schedule or family life)^{174,175,177,178,179}; (5) stigma around seeking help^{174,176}; (6) focus on helping others at the expense of their own personal needs^{174,179}; (7) multiple high-risk jobs (e.g., police officer who is also an EMT).^{174,180} Most of these risk factors also apply to correctional officers, another group at higher risk of suicide. Although these risk factors for suicide attempts and ideation may occur across the general population, these risk factors are uniquely concentrated in the daily lives of first responders and correctional officers. As with any profession or identity, it is important to remember that while first responders are at greater risk, most do not experience suicidal thoughts or attempts.

First responders are at greater risk of developing posttraumatic stress disorder (PTSD), and many studies have identified PTSD to be a risk factor of suicide.^{174,181} For example, a representative study of firefighters found that between 8% and 22% met criteria for PTSD. An individual police officer often experiences significantly more traumatic events than an individual in the public sphere, which puts them at a higher risk for developing PTSD.¹⁸² About 15% of police officers have current PTSD symptoms, whereas only about 4% of the general population has current PTSD symptoms.¹⁸² There is evidence that first responders also have higher rates of alcohol use disorders as well as comorbid alcohol abuse and PTSD. The high rates of alcohol use disorders in first responders can also put them at a heightened risk for suicide. The comorbidity of PTSD and alcohol abuse can increase the likelihood of someone attempting suicide six-fold.

Though it is very common, mental illness of any kind is rarely talked about among first responders. Seeking outside help may be frowned upon and can jeopardize the trust within a precinct or unit.¹⁸² According to the National Volunteer Fire Council, 1 in 4 career firefighters and 1 in 5 volunteer firefighters had considered suicide at some point during their career.¹⁷⁷ Another study found that 16% of firefighters reported having

made a suicide attempt compared to 6% of the general population.¹⁷⁸ While rates of ideation and attempt appear to be higher in first responders, the data available suggest that suicide death rates are similar between first responders and the general male population.¹⁸³

Recommendations. In addition to suicide prevention strategies provided universally, additional suicide prevention strategies may include the following:

- Starting to erase the stigma within the workplace and allowing people a safe space to talk about their mental illness and/or suicide ideations.
- Promote and support mental wellness programs and peer support programs.
- Enhance lethal means counseling for this population to include a spectrum of options pertaining to their firearms access or reduced access.
- Educate mental health professionals about first responder and correctional officer culture and risk factors.
- Provide both trained peers and confidential healthcare professionals to first responders to allow multiple pathways to care.
- Conduct more research with EMT and paramedic populations as they are often grouped with firefighters, though the jobs can differ substantially.

Military/Veterans

Suicide rates for both service members and veterans have increased over the past 30 years, though patterns and risk factors differ for the two groups.

Service Members

In 2018, the rate of suicide deaths among active duty personnel was similar to that of a sex- and age-matched general U.S. population.¹⁸⁴ This means that the rate of suicide among active duty service members is consistent with the rate that would be expected in the general population. However, the suicide rate among National Guard members is higher than that of the population as a whole.¹⁸⁴

Due to the diversity of experiences that encompass military service, risk factors are similarly diverse. For example, suicide risk has increased for the campaigns of Operation Enduring Freedom and Operation Iraqi Freedom, suggesting that certain aspects of current campaigns might put service members at higher risk compared to members who served in early campaigns.¹⁸⁵ Another factor that creates variability in baseline risk is the branch and component of the military service. Within branches, the Army and the Marine Corps have the highest suicide rates within the military. The National Guard Component, combined across the Air and Army regardless of duty status, had the highest suicide rate.¹⁸⁶

Many risk factors for military personnel and veterans overlap with those for the general population: presence of mental illness, particularly comorbidity; psychological factors such as emotional reactivity; neurocognitive factors such as executive functioning problems and problem-solving; family history of mental disorders; and childhood adversities such as abuse and family dysfunction.¹⁸⁷ Additional risk factors may be more common among military populations. Combat exposure, regardless of the role the service member played in the event, such as witnessing or being an active agent in the event, can increase risk. The effects of combat exposure

may develop over time and can become a greater risk factor.¹⁸⁸ Moral injury is the injury to one's conscience, values, and beliefs, which can be an after-effect of participating in war. Moral injury includes guilt and shame attached to conducting harm and killing.¹⁸⁹

Veterans

Veterans account for 13.5% of suicides deaths in the United States, despite only accounting for 8% of the population. In 2017, the veteran suicide rate was 1.5 times the rate of non-veteran adults, accounting for age and sex.¹⁹⁰

According to the 2017 Connecticut Veteran Data Suicide Sheet, the suicide death rate for veterans in Connecticut is 20.3 per 100,000. In the state, veterans who are 75 years or older are at the highest risk for suicide, followed by veterans ages 55 to 74.¹⁹¹ Nationally, veterans who are 75 years or older are not the most at risk group, illustrating the need to focus resources on Connecticut's specific needs. Personal firearms are the most common method of suicide death for both females and male veterans. Drug and alcohol overdose is the most common method used in suicide attempts.¹⁸⁶ In 2017, 58.7% of veterans who died by suicide had a diagnosed mental health or substance disorder.¹⁹¹ Posttraumatic Stress Disorder (PTSD) is commonly associated with military experiences; however, some studies have found that individuals with other mental disorders, such as adjustment disorders and mood disorders, are more likely to be at risk for suicidal ideation and behavior than military personnel with PTSD.¹⁸⁹ Due to gender differences in the military, it is important to consider the different risk factors for female military personnel and veterans. Literature on female Army soldiers indicates that workplace difficulties and sexual violence can be risk factors for suicide.¹⁸⁵ Additionally, among female U.S. Air Force members, poorer workplace relationship satisfaction was associated with suicidal ideation, which was not case for male service members.¹⁹²

Recommendations. In addition to suicide prevention strategies provided universally, additional suicide prevention strategies may include the following:

- Publicize the Veterans Crisis Line: Provides 24/7 crisis services for all veterans by phone, text messaging, or online chat.¹⁹⁰
- Utilize the VA Suicide Prevention Coordinators located at every VA Medical Center.¹⁹⁰
- Offer programs that focus on interpersonal relationships within the unit to limit workplace difficulties and interpersonal violence.
- Train veteran healthcare providers to assess the signs of suicide and create a crisis plan with veterans in need.
- Offer military- and veteran-specific peer support and care navigator programs.
- Offer support groups for active duty members concerning mental health and suicidal thoughts and behaviors when stationed at base and deployed.
- Accessible, evidence-based, non-stigmatizing mental health treatment.
- Peer support programs and gatekeeper training.
- Life skills training pertaining to relationships with family and partners.
- Enhanced coordinated services to support service members struggling with co-occurring substance and mental health issues.

- Treatment programs that focus on distress tolerance and acceptance-based emotion regulation strategies.
- Encourage all mental healthcare providers, whether or not affiliated with the VA, to ask patients if they are a veteran and provide resources specific to veterans.

Unemployment

There is a substantial body of research establishing unemployment as a risk factor for suicide. Individuals experiencing long-term unemployment are at greater risk of attempting suicide than those who have a shorter duration of unemployment or are currently employed. There is a critical period post-job-loss (three months to one year) during which unemployed individuals are at highest risk of suicide. It has been hypothesized that within this time period, individuals begin to perceive their unemployed status as a long-term, rather than temporary, condition, increasing their sense of hopelessness, thereby increasing their risk for engaging in suicidal behavior.¹⁹³

Mental illness is associated with unemployment, such that individuals classified as having poor mental health (i.e., scoring high on measures of depression and anxiety symptoms and low on indicators of positive mental health) spend significantly more time unemployed than those with comparatively better mental health.¹⁹⁴ Research looking into the temporal relationship between onset of mental illness, unemployment, and suicide has yielded mixed results. There is evidence to suggest both that mental illness puts individuals at greater risk of experiencing unemployment and suicidal behavior (i.e., unemployment is an additional aggravating factor in the relationship between mental illness and suicide) and that unemployment increases individuals' vulnerability to developing or worsening already present mental illness.¹⁹⁵ Further research needs to be conducted to clarify the role of onset of mental illness in the pathway from unemployment to suicide.

Researchers have used the Great Recession (late 2007 to mid-2009) as a case study to better understand the relationship between unemployment/financial distress and suicide. Suicide rates in the United States accelerated in tandem with the onset of the recession.¹⁹⁶ When considering three indicators of economic vulnerability—housing foreclosure, unemployment, and poverty—poverty was the indicator most strongly associated with suicide, suggesting that suicide risk is heightened when unemployed individuals are in an impoverished financial condition.¹⁹⁷ Individuals whose household income falls below the poverty line are at higher risk for alcohol abuse than their higher socioeconomic status counterparts.¹⁹⁸ This is in line with the finding that those who died by suicide during the Great Recession were more likely to have been intoxicated at the time of their death than individuals who died by suicide prior to the recession.¹⁹⁷ While the long-term impact of the COVID-19 pandemic and subsequent economic fallout is not yet known, to the degree that unemployment is large, lasting, and prevalent for those already living on less means, increases in suicide rates can be expected.

Government assistance can serve as a protective factor against suicidality. States with more generous unemployment benefit programs had less extreme increases in suicide rates during the Great Recession.¹⁹⁹ This finding held true on an international scale. In an analysis of data on 30 countries from the WHO Mortality Database, it was found that countries offering greater financial assistance to unemployed individuals experienced a less severe impact on suicide rates during the Great Recession.²⁰⁰

Recommendations. In addition to suicide prevention strategies provided universally, additional suicide prevention strategies may include the following:

- Increase availability and accessibility of suicide-specific mental health interventions/treatments for unemployed and financially struggling individuals.
- Provide ample government assistance to unemployed and individuals with limited financial resources, including access to mental healthcare.
- Administer screenings for suicidality/mental health evaluations at sites providing assistance to unemployed individuals.
- Train staff who work on the frontlines of unemployment agencies to detect suicide warning signs and to compassionately and effectively respond.

Justice Involved Individuals

Involvement with the criminal justice system causes a significant amount of stress on the mind and body, which is associated with suicidal ideation in some individuals. Suicidal thoughts can begin as soon as the guilty verdict is announced, but can also take time to emerge and may not be present when one enters the jail or prison.²⁰¹ Jails and prisons present different risks. Individuals in jail face a great deal of uncertainty as they progress through the legal process, as the length of their legal process is often uncertain and changeable. Life during incarceration may be uncomfortable, noisy, crowded, and dangerous.

Risk factors associated with attempts during incarceration include: younger age, pretrial status, either minimum or maximum security (as opposed to medium), absence of suicide watch or close observation, higher education level, married or separated/divorced status, and housing in a single cell.²⁰² Inmates who are convicted of violent crimes may be at greater risk for a suicide attempt and ultimately death by suicide.²⁰² The amount of time inmates have been incarcerated may be a potential risk factor, but more importantly, specific things that occur within jails and prisons may put them at higher risk for suicide.²⁰² These include: the perception of being a burden or being unwanted,^{202,203} belief that there is no future,²⁰² difficulty adjusting to the correctional environment,²⁰² or struggling with meaning making while incarcerated.^{202,203}

Mental disorders and substance abuse are very important risk factors that cannot go unnoticed. A high proportion of inmates have experienced mental illness. Caucasian inmates with suicide attempt history and/or history of a psychiatric diagnosis are more likely to attempt suicide than inmates without such a history.²⁰⁴ Based on previous studies, nearly all inmates who died by suicide had a history of substance abuse and showed signs of agitation and/or anxiety, and nearly half of them had a conflict with another inmate. Around half of the inmates who died by suicide also displayed some sort of behavioral change and had recently received some “adverse information.” This information can include the loss of a family member, disruption of a previously close relationship, or disappointing news about a legal matter (e.g., loss of child custody or parental rights, failed appeal).²⁰⁵

Suicide is the second leading cause of death in U.S. jails.²⁰² Suicide rates in jails are three times higher than those in U.S. prisons.²⁰² According to the Bureau of Justice, rates among incarcerated individuals are nine times higher than in the general population.^{202,206} This may be due to conditions specific to prison and jail environments that are not typically experienced by the general public. This can include social isolation due to single cell placement,^{202,206,203} separation from social support systems in the community (i.e., family and friends),²⁰⁶ family conflict that arises from the impacts of incarceration,²⁰⁶ and hopelessness about the future when facing a long sentence and knowing that on release^{206,203} one will still have a criminal record.²⁰⁶

On average, more than 400 inmates die by suicide each year in jails and prisons and they are most often

White males in their 30s. People who are incarcerated for more violent crimes against other persons (e.g., sex crimes, murder) are more likely to die by suicide than those who commit non-violent crimes.²⁰⁴

There is evidence that shows that past violence in one's life may be a potential risk factor for suicide.²⁰² History of violence may also be associated with impulsivity, hostility, interpersonal alienation, and thwarted belongingness. These factors have also been shown to be risk factors of suicide.^{202,203} Individuals with these risk factors are more likely to face longer prison sentences, which may lead to more isolation and potentially perceived burdensomeness.^{202,203,204} The risk factors for juveniles in the criminal justice system are similar to those among youth who are not incarcerated and to the factors that are found in incarcerated adults.²⁰⁷

Recommendations. In addition to suicide prevention strategies provided universally, additional suicide prevention strategies may include the following:

- Provide inmates access to psychological help as often as possible and especially prior to significant events in the trial process (e.g., trials, parole hearings).
- Assess all inmates as soon as they are incarcerated so their mental health histories are known, in order to help identify those at higher risk.
- Encourage environmental and training modifications to support guards in effectively and consistently monitoring prisoners, particularly during nighttime hours, when most suicide attempts occur.
- Routinely and closely monitor inmates to facilitate fast interventions, so that attempts in progress can be interrupted.
- Repeatedly assess risk for suicide, rather than assessing only at the time of incarceration.
- Encourage therapists and guards to strive to understand inmates' experiences inside the prison as well as what is happening in their lives and families outside of the prison walls.
- Attend to continuity of mental healthcare (e.g., medication access, substance abuse treatment, connections to healthcare providers) when inmates are released.
- Provide gatekeeper training for all correction staff, including probation officers.
- Use evidence-based suicide screening and assessment (e.g., C-SSRS) of inmates, especially upon entrance, during changes in sentences, after court results, and prior to transfers.
- Ensure access to effective treatment modalities to address suicidal thoughts (e.g., Safety Planning, CBT, DBT, ASSIP).

Survivors of Suicide Loss

Survivors of suicide loss are people who are grieving for, affected by, or exposed to the death of someone they know by suicide.^{208,209} Survivors themselves are at a higher risk of suicide ideation, behaviors, and death. At least 40% of the population in the United States is exposed to suicide of someone they know in their lifetime,^{210,211} which is a much higher rate than previously assumed. However, compared to suicide intervention and prevention, the experiences of survivors and strategies to help communities and individuals after a suicide loss (also known as “postvention”) are understudied.^{212, 213,214}

Exposure to suicide death and attempts are both associated with heightened risk of suicide ideation, attempts,

and deaths in survivors; the influence on suicide risk lasts many years on from the loss.²⁰⁸ Individuals who have attempted suicide also reported higher exposure to suicide attempts and deaths than individuals who have not attempted.²¹¹ The majority of research focuses on the experience of losing a family member.

- Suicide death of a family member is associated with a two to three times higher risk of a subsequent death by suicide in the family compared to unexposed individuals.²⁰⁸
- The loss of a spouse, a partner, or a child is associated with the most elevated risk of suicide deaths, especially in men who lost a wife to suicide.^{208,209,215}
- Exposure to the suicide death or the suicide attempt of a family member in childhood or adolescence (especially of a mother) increases the risks of suicide attempts and deaths.^{208,209}

Exposure to suicide deaths or attempts beyond kinship also elevates the risks of suicide ideation, behaviors, and deaths in survivors,^{208,211} though more extensive research is needed on survivors' reactions.^{211,213} For example, youth suffering the loss of a peer to suicide have increased risks in both suicide ideation and attempts.^{208,211} Also, suicide death of a colleague is associated with higher risk of a subsequent suicide in the workplace.^{208,216}

Suicide bereavement has been proposed as the reason for increased risks of suicide in survivors, as well as of other mental health problems (e.g., complicated or prolonged grief, posttraumatic stress disorder).^{208,209,212} Suicide bereavement is clinically observed to be different from other forms of bereavement, with higher intensity and longer duration.^{208,212} It can also be further complicated by experiences such as perceived responsibility, shame, stigma, relief, and social isolation.^{208,209,217} Survivors can experience prejudice (e.g., feelings of blame, annoyance, or pity from others) and discrimination (e.g., shaming, shunning, denial of support from community or workplace). Families may experience pressure to keep the suicide a secret, as well as social withdrawal.^{217,218}

The widespread awareness of the devastating and complex loss of a loved one or community member to suicide has led to the development of the field of postvention, which is efforts to reduce this risk and support healing after a suicide death. With these efforts, there is hope that some of the risks associated with suffering a suicide loss can be lessened. Thus, postvention for survivors of suicide loss and their communities are a critical part of prevention efforts.^{213,214,219}

Recommendations. In addition to suicide prevention strategies provided universally, additional suicide prevention strategies may include the following:

- Life history of exposure to suicide should be assessed and addressed by clinicians, therapists, and other providers.²⁰⁸
- Train relevant personnel (e.g., school, police, social services, first responders, funeral home directors) to respond appropriately and compassionately to suicide deaths, and make sure they have adequate training and support to do so.^{209,219}
- Provide supportive and culturally informed services, such as support group facilitated by fellow survivors,^{214,217,220} and grief interventions led by trained clinicians.²¹⁴
- Offer support and resources across a wide span of time, from directly after the death to months or years later, including peer support services.

- Offer support and resources widely throughout the community, rather than determining a priori who might be considered a bereaved or impacted individual.
- Expand survivor support initiatives across the state, particularly to under-connected regions.
- Communities should be educated in the difference between 1) prevention, 2) postvention planning design, and 3) deploying an actual postvention response.
- Continue and enhance relationships between and among other foundations and organizations involved in prevention and postvention training, support, and grief support.

Survivors of Suicide Attempts

Most individuals who think about suicide will not make a suicide attempt, and the majority of people who attempt suicide will not die by suicide.⁸ At the same time, past suicidal behavior is one of the strongest predictors we know of for future suicidal behavior. Just as with other risk factors, it is important to consider the individual circumstances of each person with lived experience, as these will infinitely vary. Importantly, the goal of suicide prevention efforts is not simply to stop deaths; it is to support each individual in thriving in a life they find worth living. All efforts, but especially those for individuals who have weathered a suicidal crisis or have chronic suicidal thoughts, can benefit from taking a life-building approach.

A large, worldwide study of suicidal thoughts and behavior found that a substantial proportion of suicidal behavior is short-lived, resolving within one year of onset and not reoccurring later in life. On the other hand, the remaining suicidal experiences tend to be highly persistent. This is especially the case when suicidal thoughts begin earlier in life. There are also certain risk factors that are associated with more persistent experiences of suicidal thoughts and behaviors over time, including childhood physical or sexual abuse, most mental illnesses (particularly anxiety disorders and impulse control disorders), and some physical conditions (particularly high blood pressure, headaches, and ulcers).⁴⁹

The experience of disclosing a past suicidal experience may have a large effect on *whether* an individual reaches out for help in the future. Beyond whether communication about past suicidal experience occurs, *how* it is received is also critical. Stigma, misinformation, and outdated policies can have a big impact on the experience of disclosing past suicidal behavior. Although suicidal individuals regularly identify their romantic partners as key sources of support, a common concern is uncertainty about how their partners might react when they are in crisis. These clinical observations align with empirical findings: approximately 60% of individuals chose to report their history of suicidality to their romantic partners but approximately 40% of them were met with stigma when they did so.²²¹ While disclosure is typically associated with positive outcomes, when it is met with stigma (e.g., ambivalence, anger, hostility), it can have detrimental effects.²²² Perceived stigma from social networks is correlated with depression symptom severity, and individuals with past suicidal behavior are more likely to experience stigma from close family members than clinicians.²²¹ Unfortunately, many professionals, as well as friends and romantic partners, do not know *how* best to respond to a loved one in need, even when they intend to be supportive. This can subsequently interfere with the effectiveness of suicide prevention interventions that include components that explicitly target and/or leverage personal sources of social support or reaching out to mental health professionals or emergency resources. Awareness campaigns, gatekeeper trainings, and presentations by individuals with lived experience all have the added benefit of increasing the general knowledge about and empathy for past suicidal experiences.

Recommendations. In addition to suicide prevention strategies provided universally, additional suicide prevention strategies may include the following:

- The insights of people with lived experience are extremely valuable in all stages of suicide prevention efforts. Involve people with lived experience in suicide prevention, so programs can be tailored effectively.
- Learn about various lived experiences with suicidality via resources such as [livethroughthis.org](https://www.livethroughthis.org) and [nowmattersnow.org](https://www.nowmattersnow.org).
- Develop peer support resources for those with lived experience.
- Provide suicide prevention training to peer support specialists, recovery coaches, support group meeting leaders, and others with various lived experience of mental illness.
- Explore peer-based resources such as Survivors of Suicide Attempts support groups or Alternatives to Suicide.
- Support individuals with lived experience to not just survive, but thrive and build and maintain meaningful lives.
- Collaborate with individuals in care to understand as much about past suicide attempt(s) to inform safety or crisis response plans.
- Learn from those in care about the response from providers, loved ones, employers, and others to their previous attempt in order to refine responses to be more effective.

APPENDIX A

Glossary

Accessibility (of care)—the location, hours, and placement of care that facilitates or inhibits individuals from getting care.

Activities—the specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

Adolescence—the period of physical and psychological development from the onset of puberty to maturity.

Advocacy groups—organizations that work in a variety of ways to foster change with respect to a societal issue.

Affected by suicide—All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.

Affective disorders—see mood disorders.

Anxiety disorder—an unpleasant feeling of fear or apprehension accompanied by increased physiological arousal, defined according to clinically derived standard psychiatric diagnostic criteria.

Assertive Community Treatment—a team approach to intensive, comprehensive, community-based treatment and support for individuals with chronic or persistent mental health challenges.

Attempt survivor—see suicide attempt survivor.

Behavioral health—issues, problems or challenges including mental and substance use disorders, severe psychological distress, and suicidal thinking or behavior.

Behavioral health challenges—issues, problems or challenges including mental and substance use disorders, severe psychological distress, and suicidal thinking or behavior.

Behavioral healthcare—clinical services that promote mental or emotional health, seek to prevent or treat behavioral health challenges, and/or support recovery.

Bereaved by suicide—family members, friends, and others affected by the suicide of a loved one.

Best practices—activities or programs that are in keeping with the best available evidence regarding what is effective.

Bibliotherapy—the use of self-help materials or recommended reading as a way of helping a person cope with mental health challenges.

Biopsychosocial approach—an approach to suicide prevention that focuses on those biological, psychological, and social factors that may be causes, correlates, and/or consequences of mental health or mental illness and that may affect suicidal behavior.

Bipolar disorder—a mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes.

Bisexual—an adjective that refers to individuals whose sexual orientation or identity involves sexual, physical, and/or romantic attraction to both men and women.

Care plan—a collaborative and comprehensive plan for treatment and/or support.

Causal factor—a condition that alone is sufficient to produce a disorder.

Cognitive behavior therapy for suicide prevention (CBT-SP)—an evidence-based form of therapy or treatment that specifically focuses on the thoughts and behavior that challenge suicidal individuals.

Cognitive/cognition—the general ability to organize, process, and recall information.

Community—a group of people residing in the same locality or sharing a common interest.

Comorbidity—the co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.

Comprehensive suicide prevention plans—plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social, and environmental factors.

Connectedness—closeness to an individual, a group, or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Consumer—a person using or having used a health service.

Contagion—a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Continuity of care—an approach to treatment or support that ensures that a person and his or her clinical records can go from one provider to another with few (if any) delays.

Core value—a concept describing a perspective and/or belief that attempt survivors identified as factors that make care both helpful and preferable for a person experiencing, or recovering from, a suicidal crisis.

Crisis respite—a facility that provides an individual with a supportive environment that promotes recovery from acute distress or crisis when a person is not in immediate danger.

Crisis support—care or services specifically aimed at helping individuals in mental or emotional distress.

Culturally appropriate—a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

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

Deliberate self-harm—see suicidal self-directed violence.

Depression—a constellation of emotional, cognitive, and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Dialectical behavior therapy—an evidence-based form of therapy or treatment that specifically focuses on controlling chronic or long-term suicidal thoughts, feelings, and behaviors.

Dignity—value and respect, concern for a person’s needs and feelings, and avoiding the use of labels and stereotypes.

Ecological model (social ecological model)—a framework for examining the factors that influence an issue that encompasses attitudes and behaviors at the individual, relationship or group, community, and social or cultural levels.

Effective—prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Elderly—persons aged 65 or more years.

Environmental approach—an approach that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Epidemiology—the study of statistics and trends in health and disease across communities.

Evaluation—the systematic investigation of the value and impact of an intervention or program.

Evidence-based—programs that have undergone scientific evaluation and have proven to be effective.

Federally qualified health centers (FQHCs)—health care organizations that serve an underserved area, provide comprehensive services, and receive special Medicare and Medicaid funding.

Follow-back study—the collection of detailed information about a deceased individual from a person familiar with the decedent’s life history or by other existing records. The information collected supplements that individual’s death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

Frequency—the number of occurrences of a disease or injury in a given unit of time; with respect to suicide, frequency applies only to suicidal behaviors that can repeat over time.

Gatekeepers—those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. Examples include clergy, first responders, pharmacists, caregivers, and those employed in institutional settings, such as schools, prisons, and the military.

Gay—an adjective that refers to persons whose sexual orientation or identity involves sexual, physical, and/or romantic attraction to individuals of the same sex.

Gender identity—an individual’s deeply rooted internal sense of gender. For most individuals, the sex assigned to them at birth aligns with their gender identity. This is not true for some others, however, who identify as transgender.

Goal—a broad and high-level statement of general purpose to guide planning on an issue, focusing on the result of the work.

Health—the complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Health and safety officials—law enforcement officers, fire fighters, emergency medical technicians (EMTs), and outreach workers in community health programs.

Healthy People 2020—the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2020.

HIPAA—the Health Insurance Portability and Accountability Act issued standards and safeguards about the use and disclosure of individual health information, privacy rights, and control of information.

Inclusion—meaningful engagement of persons from a specified group in the initiation, development, dissemination, promotion, implementation, and/or evaluation of activities.

Indicated intervention—intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Informed care decision—choices about treatment and support to promote health and well-being that are based on a clear understanding of the risks and benefits of available options.

Intentional injuries—injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries.

Intervention—a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention, or reducing access to lethal means among individuals with suicide risk).

Lesbian—an adjective that refers to women whose sexual orientation or identity involves sexual, physical, and/or romantic attraction to other women.

Lesbian, gay, bisexual, or transgender + (LGBT+)—an inclusive term that refers to those who identify as lesbian, gay, bisexual, transgender, and other sexual orientations and gender identities.

Lethal means—instruments, objects, or materials used for suicidal behavior that have a high rate of causing death.

Lived experience—defined as “personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people” and “the experiences of people on whom a social issue or combination of issues has had a direct impact.”

Lived expertise—the combination of lived experience and relevant training or practice that enables a person to apply personal knowledge to professional activities.

Means—the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Means restriction—techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Mental disorder—A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual’s cognitive, emotional, or social abilities; often used interchangeably with mental illness.

Mental health (see also behavioral health)—a person’s capacity to fully use his or her mental abilities, experience social and cognitive development, interact with others, and experience well-being.

Mental health challenges (see also behavioral health challenges)—the temporary or long-term symptoms, problems, or concerns that cause a person distress and/or disrupt his or her life, which includes traditionally defined “mental illness.”

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

Mental illness—see mental disorder.

Methods—actions or techniques that result in an individual inflicting self-directed injurious behavior; for example, overdose.

Minority stress—the way that individuals from underrepresented or stigmatized groups experience a number of stressors that directly relate to a minority identity (including lesbian, gay, bisexual, or transgender populations).

Mood disorders—a term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance. Disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states. Included are depressive disorders, bipolar disorders, mood disorders due to a medical condition, and substance-induced mood disorders.

Morbidity—the relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Mortality—the relative frequency of death, or the death rate, in a community or population.

Non-suicidal self-injury—self-injury with no suicidal intent. Same as non-suicidal self-directed violence (see Centers for Disease Control and Prevention surveillance definitions box at the end of this appendix).

NSSP—the National Strategy for Suicide Prevention.

Objective—a specific and measurable statement that clearly identifies what is to be achieved in a plan. It narrows a goal by specifying who, what, when, and where or clarifies by how much, how many, or how often.

Older adults—persons aged 60 or more years.

Outcome—a measurable change in the health of an individual or group of people that is attributable to an intervention.

Outreach programs—programs that send staff into communities to deliver services or recruit participants.

Peer—a person who has lived experience from mental or behavioral health challenges, particularly experience from a suicidal crisis.

Peer respite—crisis respite that is operated by peers, or includes significant numbers of staff who are peers.

Personality disorders—a class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress.

Person-centered approach—an approach to treatment that is guided by an individual's needs, wishes, strengths, values, resources, and goals.

Policy—a written or formal statement intended to guide the actions of governments, organizations, or individuals.

Postvention—a planned response after a suicide to help with healing and reduce risk of further suicide incidents.

Practice—a process, method, technique, approach, procedure, or other behavior that occurs on a regular basis.

Prevention—a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

Primary care—clinical services that are aimed primarily at general or physical health and well-being.

Program—a specific intervention, therapy, treatment, campaign, course, workshop, or other activity or resource designed to support or help someone.

Protective factors—factors that make it less likely that individuals will develop a disorder or experience a suicidal crisis. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Psychiatric disorder—see mental disorder.

Public information campaigns—large scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

Rate—the number per unit of the population with a characteristic, for a given unit of time.

Recovery— a concept of living a hopeful, meaningful, and fulfilling life despite behavioral health challenges.

Recovery practices (recovery-oriented services)—support or clinical practices and services that aim to support recovery.

Research—systematic investigation of a concept, theory, program, practice, or policy to increase general knowledge and understanding of its components, mechanisms, outcomes, or other qualities.

Resilience/Resiliency—a person's capacity for positive outcomes and/or protection from negative outcomes despite challenges.

Risk factors—characteristics, situations, or other elements in a person's life that make it more likely that he or she will develop a disorder or experience a suicidal crisis.

Safety plan—a written list of warning signs, coping responses, and support sources that an individual may use to avert or manage a suicide crisis.

Screening—administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools—instruments and techniques used to evaluate individuals for increased risk of certain health problems. Examples may be questionnaires, checklists, and self-assessment forms.

Selective intervention—intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-advocacy—the process of asserting one's rights and/or informing service or support providers about one's needs, wishes, strengths, values, resources, and goals.

Self-care or self-help—information a person acquires and/or actions a person takes to maintain or improve his or her health and well-being.

Self-directed violence (same as self-injurious behavior)—behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as either non-suicidal or suicidal.

Self-inflicted injuries—injuries caused by suicidal and non-suicidal behaviors such as self-mutilation.

Self-management—self-care that is specifically aimed at modifying, coping with, or tolerating behavioral health challenges.

Self-stigma—negative perceptions of oneself based on beliefs about a condition, disorder, or circumstance.

Sexual orientation—an individual's sexual, physical, and/or romantic attraction to men, women, both, or neither.

Social support—assistance that may include companionship, emotional backing, cognitive guidance, material aid, and special services.

Stakeholders—entities including organizations, groups, and individuals that are affected by and contribute to decisions, consultations, and policies.

Stigma—the combination of bias, negative stereotypes, fear, avoidance, shame, discrimination, and/or abuse that is associated with a labelled condition or circumstance.

Substance use disorder—a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use. Examples include maladaptive use of: legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens, and heroin.

Suicidal behaviors—behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

Suicidal crisis—a situation when a person is experiencing suicidal thoughts, feelings, and/or impulses, which may involve suicidal behavior.

Suicidal ideation—thoughts of engaging in suicide-related behavior.

Suicidal intent—when a person intended to kill him or herself or wished to die, and understood the probable consequences of his or her actions.

Suicidal plan—a thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt, often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

Suicidal self-directed violence—behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

Suicide—death caused by self-inflicted injury, poisoning, or suffocation; a fatal suicide attempt.

Suicide attempt—a self-inflicted injury, poisoning, or suffocation with some intent to die.

Suicide attempt survivor—a person who survived a prior suicide attempt.

Suicide crisis—a suicide crisis, suicidal crisis, or potential suicide is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

Suicide prevention supports—actions and activities that have the potential to prevent, intervene, or assist recovery from a suicidal crisis.

Support network—the persons identified by an individual as potential or active providers of tangible, social, emotional, or psychological support.

Surveillance—the ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

Transgender—someone whose gender identity or expression is different from the sex that was assigned to him or her at birth. Some transgender individuals take steps to transition from one sex physically and/or legally to another.

Trauma informed care—support or services that are aware of a person's potential history of sexual, physical, or emotional abuse, traumatic service experiences, and how such life experiences can impact behavioral health challenges and care.

Unintentional—term used for an injury that is unplanned. In many settings, these are termed accidental injuries.

Universal intervention—intervention targeted to a defined population, regardless of risk (this could be an entire school, for example, and not the general population, per se).

Utilization management guidelines—policies and procedures that are designed to ensure efficient and effective delivery (utilization) of services in an organization.

Warm line—a pre-crisis telephone-based service that provides supportive listening, social support, and/or advice about coping that is often staffed by peers or paraprofessionals.

Source: U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012.

APPENDIX B

Examples of Risk and Protective Factors in a Social Ecological Model

➡ Protective Factors:

Societal:

- Availability of physical and mental healthcare
- Restrictions on lethal means of suicide

Community:

- Safe and supportive school and community environments
- Sources of continued care after psychiatric hospitalization

Relationship:

- Connectedness to individuals, family, community, and social institutions
- Supportive relationships with healthcare providers

Individual:

- Coping and problem solving skills
- Reasons for living (eg., children in the home)
- Moral objections to suicide

➡ Risk Factors:

Societal:

- Availability of lethal means of suicide
- Unsafe media portrayals of suicide

Community:

- Few available sources of supportive relationships
- Barriers to healthcare (eg., lack of access to providers or medications, prejudice)

Relationship:

- High conflict or violent relationships
- Family history of suicide

Individual:

- Mental illness
- Substance abuse
- Previous suicide attempt
- Impulsivity/aggression

APPENDIX C

Suicide Prevention Resources

American Association of Suicidology (AAS)

www.suicidology.org

AAS promotes research, public awareness programs, public education, and training for professionals and volunteers. It serves as a national clearinghouse for information on suicide, publishing and disseminating statistics and suicide prevention resources. AAS also hosts annual national conferences for professionals and survivors.

American Foundation for Suicide Prevention (AFSP)

www.afsp.org

AFSP gives those affected by suicide a nationwide community empowered by research, education, and advocacy to take action against this leading cause of death. AFSP engages in the core strategies of funding scientific research, educating the public about mental health and suicide prevention, advocating for public policies in mental health and suicide prevention, and supporting survivors of suicide loss and those affected by suicide in our mission.

American Foundation for Suicide Prevention (AFSP) – LGBTQ Program

<https://afsp.org/lgbtq-suicide-and-suicide-risk>

AFSP works on suicide prevention among the LGBTQ population, including producing a conference, funding research grants, working to improve how the media covers anti-gay bullying, helping its chapter volunteers bring understanding of suicide into their local LGBT communities, and creating LGBT mental health educational resources and training tools.

American Veterinary Medical Association (AVMA) and the Connecticut Veterinary Medical Association (CVMA)

AVMA

<https://www.avma.org/resources-tools/wellbeing/self-care-veterinarians>

The AVMA Provides mental and physical well-being resources that promote self-care, including the Professional Quality of Life (ProQOL) assessment, a widely validated, self-administered assessment tool that measures the negative and positive effects of helping others who are experiencing suffering and trauma and the Wheel of Wellbeing.

CVMA Wellness Committee

<https://ctvet.org/vets/wellness-resources>

The CVMA Wellness committee provides resources to help others learn more about veterinarian well-being and to find support locally or nationally.

Wheel of Wellbeing: Wellbeing Tips for the Entire Veterinary Team

https://www.youtube.com/watch?v=5FmDQZ_p0UU

Centers for Disease Control and Prevention (CDC) – National Violent Death Reporting System

<https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html>

The Centers for Disease Control and Prevention (CDC) surveillance system links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state (34 states and the District of Columbia) in designing and implementing tailored prevention and intervention efforts, including for suicide. They also provide infographics on their webpage to help “link data to save lives.”

Centers for Disease Control and Prevention (CDC) – Web-Based Injury Statistics Query and Reporting System (WISQARS)

<https://www.cdc.gov/injury/wisqars/index.html>

WISQARS is an interactive database system that provides customized reports of data from a variety of sources on fatal and nonfatal injuries, violent deaths, and cost of injury. The system features a large amount of data on suicide.

Connecticut Department of Mental Health and Addiction Services (DMHAS)–Prevention and Health Promotion Division

<https://portal.ct.gov/DMHAS/Prevention-Unit/Prevention-Unit/Prevention-and-Health-Promotion-Division>

This division of DMHAS promotes the overall health and wellness of individuals and communities by preventing or delaying substance use. Prevention services comprise six key strategies, including information dissemination, education, alternative activities, strengthening communities, promoting positive values, and problem identification and referral to services.

Connecticut Department of Mental Health and Addiction Services – Problem Gambling Services (PGS)

<https://portal.ct.gov/DMHAS/Programs-and-Services/Problem-Gambling/PGS---Home-Page>

PGS provides training, information, and resources that support a comprehensive network of consumer-oriented problem gambling recovery services for people of Connecticut and that foster an environment throughout the state that promotes informed choices around gambling behavior.

Connecticut Suicide Advisory Board (CTSAB)

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

The CTSAB is a collaborative network of more than 600 people and 200 agencies representing local, community, and state agencies, for-profit companies and nonprofits, faith-based organizations, hospitals, military, schools, higher education, towns, private citizens, students, survivors, individuals with lived experience, and advocates. It is the single statewide advisory board in Connecticut that addresses suicide prevention, intervention, and response, and seeks to eliminate suicide by instilling hope across the lifespan. The CTSAB serves as a primary support to the five Regional Suicide Advisory Boards.

Regional Suicide Advisory Boards

<https://www.preventsuicidect.org/about-us/regional-sab-business>

Each Regional SAB is unique and self-autonomous and supports the overall vision of the statewide Connecticut Suicide Advisory Board and provides local and regional infrastructure for activities. The five Boards are coordinated by the Regional Behavioral Health Action Organizations for the Eastern, North Central, South Central, Southwestern, and Western regions.

Construction Financial Management Association – Suicide Prevention

<http://www.cfma.org/suicideprevention>

The Construction Financial Management Association (CFMA) suicide prevention page includes information, webinars, and national resources specific to the construction industry. There is a “Mental Health & Suicide Prevention for Construction Companies Needs Analysis and Integration Checklist” to help evaluate a company’s mental health and suicide prevention preparedness and culture. And the CFMA Suicide Prevention Committee “Chapter Champions” serve to provide and disseminate information and resources for suicide prevention and mental health promotion to chapters, members, and industry partners.

Construction Industry Alliance for Suicide Prevention (CIASP)

<https://preventconstructionsuicide.com>

The CFMA established the Construction Industry Alliance for Suicide Prevention (CIASP) to raise awareness about the risk of suicide within the construction industry and provide suicide prevention resources and tools to create a zero-suicide industry. The CIASP offers an online “Pledge to STAND up” for suicide prevention for contractors, union representatives, associations, industry suppliers and providers, and mental health organizations.

Analysis and Integration Checklist:

https://preventconstructionsuicide.starchapter.com/images/downloads/Integration_Resources/construction_industry_alliance_for_suicide_prevention_needs___integration_checklist.pdf

Three Levels of Integrating Suicide Prevention in Your Company:

https://preventconstructionsuicide.starchapter.com/images/downloads/Integration_Resources/ciasp___3_integration_levels.pdf

The Jed Foundation

www.jedfoundation.org

JED is a nonprofit that protects emotional health and prevents suicide for our nation’s teens and young adults. JED equips teens and young adults with the skills and knowledge to help themselves and each other; partners with high schools and colleges to strengthen their mental health, substance misuse, and suicide prevention programs and systems; and encourages community awareness, understanding, and action for young adult mental health.

Jordan Porco Foundation

www.rememberingjordan.org

The Jordan Porco Foundation’s mission is to prevent suicide, promote mental health, and create a message of hope for young adults. We provide engaging and uplifting programming emphasizing peer-to-peer messaging promoting help-seeking behavior, self-care, and coping skills. Our programs challenge stigma by talking openly about mental health and educating about the risk factors and warning signs of suicide and other related mental health concerns. Programs include: www.freshcheckday.com and www.4whatsnext.org

Means Matter, Harvard School of Public Health

www.hsph.harvard.edu/means-matter

The mission of the Means Matter campaign is to increase the proportion of suicide prevention groups that promote activities that reduce a suicidal person’s access to lethal means of suicide. The website has a wide variety of information to help families, clinicians, suicide prevention groups, local communities, and colleges and universities.

National Action Alliance for Suicide Prevention

www.actionallianceforsuicideprevention.org/NSSP

The Action Alliance is dedicated to advancing the National Strategy, updated in 2012, with support from the National Strategy Revision/Update Task Force. The Action Alliance priorities are to achieve the greatest impact on reducing suicide in the nation. The Action Alliance is currently supporting work on three priority areas: transforming health systems, transforming communities, and changing the conversation about suicide.

National Alliance on Mental Illness

www.nami.org

NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI works to educate, advocate, listen, and lead to improve the lives of people with mental illness and their loved ones. The NAMI HelpLine can be reached Monday through Friday, 10 a.m.–6 p.m., ET. 1-800-950-NAMI (6264) or info@nami.org

National Institute on Alcohol Abuse and Alcoholism

www.niaaa.nih.gov

National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides leadership in the national effort to reduce alcohol-related problems. Alcohol is a significant risk factor for suicide, and the NIAAA publishes studies on how alcohol use interacts with conditions such as depression and stress to contribute to suicide. NIAAA also provides data on alcohol involvement in suicide.

National Institute on Drug Abuse

www.drugabuse.gov

National Institute on Drug Abuse (NIDA) funds and publishes studies on the effects of substance abuse on mental health, including suicide, and hosts Suicide Studies Lectures, which review current standards to define, classify, assess, and treat suicide-related disorders that sometimes play a role in drug abuse and addiction. NIDA also sponsored a landmark workshop, Drug Abuse and Suicidal Behavior.

National Organization for People of Color Against Suicide (NOPCAS)

www.nopcas.org

NOPCAS serves as the only national organization of its kind addressing the issue of suicide prevention and intervention, specifically in communities of color. Our primary focus and mission is to increase suicide education and awareness. We offer unique opportunities for outreach partnerships and community education efforts directed at communities of colors across the nation.

National Shooting Sports Foundation (NSSF)

<https://www.nssf.org/safety/suicide-prevention/suicide-prevention-toolkit>

The National Shooting Sports Foundation (NSSF) is the trade association for the firearm industry. Its mission is to promote, protect, and preserve hunting and the shooting sports. NSSF has a membership of thousands of manufacturers, distributors, firearms retailers, shooting ranges, sportsmen's organizations, and publishers nationwide. The AFSP-NSSF Suicide Prevention Program Toolkit includes an "After a Suicide" booklet developed to help prepare you and your staff to handle immediate concerns following a suicide, as well as look ahead to help those who have been affected. Additional materials in the toolkit help educate staff and customers about risk factors and warning signs related to suicide and how to help someone who is going through a difficult time. NSSF participates in national conversations to find common ground to make communities safer and advocates for effective solutions to prevent access to firearms by criminals, children, and the dangerously mentally ill who cannot responsibly handle firearms.

National Strategy for Suicide Prevention

www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

National Strategy for Suicide Prevention (National Strategy) is a call to action intended to guide the nation's suicide prevention efforts. Released by the U.S. Surgeon General and the Action Alliance, the National Strategy presents 13 goals and 60 objectives for suicide prevention and describes the role that each of us can

play in preventing suicide and reducing its impact on individuals, families, and communities. The National Strategy represents the combined work of advocates, clinicians, researchers, survivors, and others. It lays a framework for action to prevent suicide and guides the development of an array of services and programs.

National Suicide Prevention Lifeline (Lifeline)

www.suicidepreventionlifeline.org

The Lifeline provides immediate assistance 24 hours a day, 7 days a week to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number: 1-800-273-TALK (8255). The Lifeline leads multiple initiatives to raise public awareness and further the field of suicide prevention and provides informational materials featuring the phone number, such as brochures, wallet cards, and posters. ***On July 16, 2022, the 988 Mental Health/Suicide Prevention lifeline is scheduled to go live.**

Occupational Safety and Health Administration (OSHA) – Suicide Prevention

<https://www.osha.gov/preventingsuicides>

OSHA is the part of the United States Department of Labor that ensures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

Preventing Suicide: A Toolkit for High Schools

<https://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-HighSchools/SMA12-4669>

Promoting Emotional Health and Preventing Suicide – A Toolkit for Senior Centers

- **English:**
https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA15-4416?referer=from_search_result
- **Spanish:**
https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide-A-Toolkit-for-Senior-Centers-SPANISH/SMA15-4416SPANISH?referer=from_search_result

Samaritans USA

www.samaritansusa.org

Samaritans USA provides services to those at risk for suicide, provides support for those who have experienced a loss due to suicide, and educates caregivers and health providers. Crisis lines are the cornerstone of Samaritans USA's services. Samaritans USA also provides suicide prevention education to the public and survivor support groups.

STOP.TALK.PREVENT.

<http://www.stoptalkprevent.org>

Stop.Talk.Prevent. is a resource created for the construction industry in partnership with mental health, addiction, construction, and union leaders. The site offers information about events that raise awareness, offers support in developing action plans, and offers an opportunity to share stories of lived experience through testimony, in addition to ideas and resources. Stop.Talk.Prevent. is the sister site to Stop.Think.Prevent. (www.stopthinkprevent.com) that focuses on construction safety and provides resources and posters that promote workplace safety.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov

SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA funds and supports the National Lifeline and SPRC and manages the Garrett Lee Smith grant program, which funds state, territorial, and tribal programs to prevent suicide among youth. Multiple resources for suicide prevention can be found on the SAMHSA Publications and Digital Products page located at <https://store.samhsa.gov>.

Suicide Prevention Resource Center (SPRC)

www.sprc.org

SPRC is the only federally supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention. SPRC advances suicide prevention infrastructure and capacity building through consultation, training, and resources to enhance efforts in states, Native settings, colleges and universities, health systems, and organizations that serve populations at risk for suicide. SPRC also provides administrative and logistical support to the National Action Alliance for Suicide Prevention (Action Alliance) and supports the Zero Suicide Initiative that offers information, resources, and tools for safer suicide care. SPRC publishes an awareness newsletter (The Weekly SPARK) and hosts a searchable online library of evidence-based practices and “Programs with Evidence of Effectiveness.”

TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment:

<https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381>

Tragedy Assistance Program for Survivors

www.taps.org

Tragedy Assistance Program for Survivors (TAPS) provides comfort, care, and resources to all those grieving the death of a military loved one due to any cause. TAPS conducts regional survivor seminars for adults and youth programs at locations across the country, as well as retreats and expeditions around the world. TAPS connects survivors to counseling in their community and helps navigate benefits and resources. TAPS offers a 24/7 National Military Survivor Helpline: (800) 959-TAPS (8277)

The Trevor Project

www.thetrevorproject.org

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) young people under 25. The Trevor Support Center is where LGBTQ youth and allies can find answers to frequently asked questions and explore resources related to sexual orientation, gender identity, and more. TrevorSpace is an online international peer-to-peer community for LGBTQ young people and their friends.

The Trevor Project provides multiple 24-hour, toll-free, crisis intervention services:

- TrevorLifeline: 1(866) 488-7386
- TrevorChat: an online confidential instant messaging service
- TrevorText: Text START to 678-678

U.S. Department of Defense Suicide Prevention Office (DSPO)

<https://www.dspo.mil/>

The Defense Suicide Prevention Office (DSPO) was established in 2011 and is part of the Department of Defense. DSPO integrates a holistic approach to suicide prevention, intervention, and postvention using a range of medical and non-medical resources. Grounded in a collaborative approach, DSPO works with the military services and other governmental agencies, non-governmental agencies, nonprofit organizations, and communities to reduce the risk for suicide through data surveillance, program assessment, advocacy, policy oversight, and outreach and education.

U.S. Department of Veterans Affairs – Suicide

https://www.mentalhealth.va.gov/suicide_prevention/

This website is a resource collection providing access to support hotlines, self-assessments, treatment options, professional resources and forums, and various multimedia tools. It supports all members of the U.S. Armed Forces and reserve components, veterans, families, and providers.

24/7 Crisis Support:

- Call: 1-800-273-8255 and press 1
- Text: 838255
- Chat online: www.veteranscrisisline.net/chat

Sources: Some descriptions adapted from organization's websites; others from U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

APPENDIX D

Education and Training Options

AFSP Healing Conversations (HC)

www.afsp.org/HealingConversations

Formerly known as the Survivor Outreach Program. Trained AFSP volunteers, who are themselves survivors of suicide loss, offer understanding and guidance in the weeks and months following a suicide death.

Length: 2 hrs **Cost:** FREE

AFSP More Than Sad

www.afsp.org

Videos teach students and educators how to be smart about mental health (teens, parents, teachers). Two videos, Teen Depression and Preventing Teen Suicide, with downloadable facilitator tools.

Length: 25 min each **Cost:** FREE

AFSP Suicide Bereavement Clinician Training Program

www.afsp.org

Focused overview of the impact of suicide on survivors and the clinical and support responses that are needed. Intended for clinical professionals seeking to bolster their knowledge and understanding of—and empathetic regard for—people bereaved by suicide. Intended for physicians/psychiatric nurses, psychologists, certified counselors, social workers, and licensed marriage and family therapists. Also open to clergy, pastoral counselors, school personnel, and interested others. The workshop includes didactic and video presentations, group discussion, and case examples.

Length: 1 day (6.5 hrs) **Cost:** \$

AFSP Talk Saves Lives: An Introduction to Suicide Prevention

www.afsp.org

A community-based presentation that covers the general scope of suicide, the research on prevention, and what people can do to fight suicide. Attendees will learn the risk and warning signs of suicide, and how, together, we can help prevent it.

Length: 45-60 min **Cost:** FREE

Applied Suicide Intervention Skills Training (ASIST)

<https://www.livingworks.net/>

Comprehensive training that is for any “gatekeeper” age 16 years and older (those most likely to be in contact with the person). This is what the National Suicide Prevention Lifeline uses.

Length: 2 days **Cost:** \$

Ask, Care, Escort (ACE) Suicide Intervention Training

<https://www.armyg1.army.mil/hr/suicide/default.asp>

ACE is only available to authorized U.S. Army personnel. Teaches about the risk factors and warning signs of suicide, how to intervene with those at risk of suicide (Asking, Caring, and Escorting).

Length: 1.5 hrs **Cost:** FREE

Assessing and Managing Suicide Risk (AMSR)

<http://zerosuicideinstitute.com/amsr>

Clinician specific training, AMSR presents five of the most common dilemmas faced by providers and the best practices for addressing them. Various curricula for outpatient, substance use.

Length: 1 day (6.5 hrs) **Cost:** \$

Be A Link!® Community Gatekeeper Training

www.yellowribbon.org

Adult gatekeeper program that teaches how to identify the warning signs and risk and protective factors of suicide for youth, how to talk with teens/youth, and how to understand school liabilities, policies, and procedures. Additional training tracks are available for school staff, first responders, faith leaders, and youth peer leaders.

Length: 2 hrs **Cost:** \$

Connect Suicide Postvention Training

<https://theconnectprogram.org/>

Helps service providers respond in a coordinated and comprehensive way in the aftermath of a suicide or any sudden death. More than “just training,” Connect fosters relationship building and the exchange of resources among participants. Prior to the training, Connect staff work with the host agency to identify and incorporate local cultural issues and begin planning how the training will be applied and sustained.

Length: 2 days **Cost:** \$

Connect Suicide Prevention/Intervention Training

<https://theconnectprogram.org/>

Increases the capacity of professionals and communities to prevent suicide across the lifespan. It uses a public health approach and incorporates key elements of the National Suicide Prevention Strategy. The Connect Prevention Training also offers online modules for Healthcare or Mental Health Providers and School Personnel.

Length: 6 hrs **Cost:** \$

Connect Survivor Voices

<https://theconnectprogram.org/>

SurvivorVoices: Sharing the Story of Suicide Loss is a National Best Practice program that teaches those bereaved by suicide how to speak safely and effectively about their loss. Survivors of suicide loss are key partners in suicide prevention and postvention. While some individuals who take SurvivorVoices may never share their story publicly, participation in the training helps them with their own grief process and connects them with other survivors. For those who go on to share their stories publicly, they often use this new connectedness to energizes suicide prevention and bereavement support efforts (e.g., starting a survivor of suicide loss support group, hosting a teleconference site, starting a Life Keeper quilt project, initiating a suicide awareness event).

Length: 2 days **Cost:** \$

esuicideTALK

<https://www.livingworks.net/>

Online program, enabling anyone with an Internet connection to develop awareness about suicide and its prevention in a safe, customizable online space. Ideal for all English speakers age 15 and older who want to take the first steps toward suicide awareness and prevention. By helping to dispel the fear and stigma around suicide, esuicideTALK contributes to an open and supportive community where people at risk can get the help they need to stay safe.

Length: 1-2 hrs **Cost:** \$

4 What's Next

<https://4whatsnext.org/>

4 What's Next is a primary prevention program that builds resiliency in high school students by giving them the tools to handle stress and distress now and in their future.

Cost: \$

Gizmo's Pawesome Guide to Mental Health Curriculum

<https://www.gizmo4mentalhealth.org/>

A fun, flexible, turn-key curriculum for elementary youth that introduces the Gizmo's Pawesome Guide to Mental Health (Guide) using an animated PowerPoint, implementer discussion guide, and activities for youth. It may be implemented in various settings, such as public/private/parochial/ therapeutic schools, treatment locations, camps, and before or after school programs. Utilizes the evidence-based Safety Plan (Stanley and Brown, 2012) as the framework.

Length: 1 class period (can be broken up) **Cost:** FREE

Mental Health First Aid

<https://www.mentalhealthfirstaid.org/>

Learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help.

Length: 8 hrs **Cost:** FREE

Question, Persuade, Refer (QPR) Gatekeeper Training Program

<https://qprinstitute.com/>

Teaches how to identify and interrupt a potential crisis and direct that person to the proper care. Includes role-playing resulting in participants leaving the training with stronger confidence in serving as a gatekeeper utilizing best practices.

Length: 90 min **Cost:** FREE

safeTALK

<https://www.livingworks.net/>

Described as a suicide "alertness" training. Apply the TALK steps: Tell, Ask, Listen, and Keep Safe. Learn how to connect someone experiencing suicidal thoughts to community resources for help.

Length: 3 hrs **Cost:** FREE

Shield of Care

<https://www.tn.gov/behavioral-health/>

For juvenile justice programs. Teaches how to understand the risk and protective factors of suicide, how to increase self-efficacy to prevent suicide, and to understand suicide prevention strategies and skills.

Length: 8 hrs **Cost:** FREE

Signs of Suicide Program (SOS)

<https://www.mindwise.org/suicide-prevention/>

SOS Signs of Suicide (SOS) is a universal, school-based prevention program designed for middle school (ages 11-13) and high school (ages 13-17) students. The goals of this program are to decrease suicide and suicide attempts by increasing student knowledge and adaptive attitudes about depression; encourage personal help-seeking and/or help-seeking on behalf of a friend; reduce the stigma of mental illness; acknowledge the importance of seeking help or treatment; engage parents and school staff as partners in prevention through "gatekeeper" education; and encourage schools to develop community-based partnerships to support student mental health.

Length: 1 class period **Cost:** \$

APPENDIX E

Connecticut Suicide Rate by Age and Sex 2015–2018 and Target 2025 Rate

Table 1.

Connecticut Suicide Rate by Age and Sex 2015–2018 and Target 2025 Rate

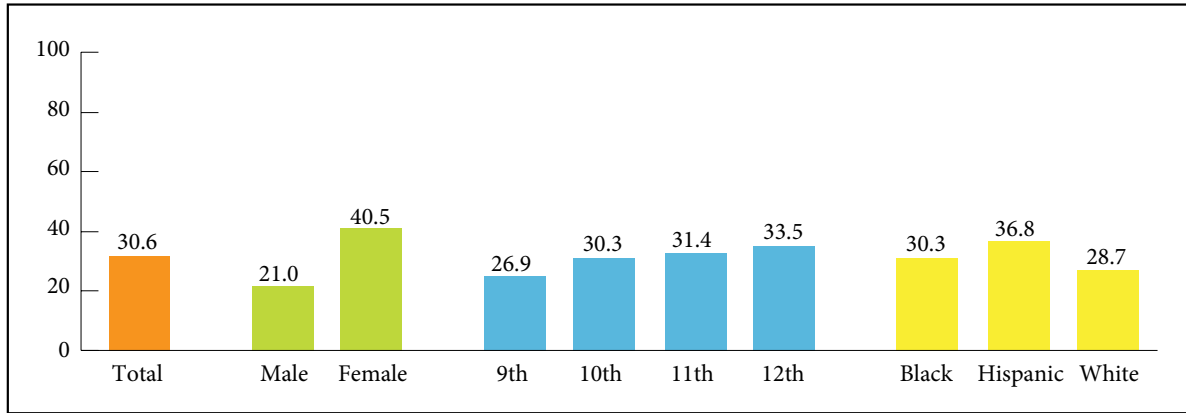
Age Range	Female Rate	Female Target Rate 2025	Male Rate	Male Target Rate 2025	Total Rate	Total Target Rate 2025
0-17	1.1	0.9	1.4	1.2	1.3	1.0
18-24	4.3	3.4	13.7	11.0	9.4	7.5
25-44	6.9	5.5	16.7	13.4	11.7	9.4
45-64	10.4	8.3	26.2	21.0	17.9	14.3
65+	5.9	4.7	22.9	18.3	12.4	9.9

APPENDIX F

Connecticut Youth Risk Behavior Survey (CTYRBS)

Figure 1.

Percentage of High School Students Who Felt Sad or Hopeless,
by Sex, Grade, and Race/Ethnicity, 2019



Source: CTDPH 2019 Connecticut School Health Survey (CSHS Summary Graphs)¹⁵

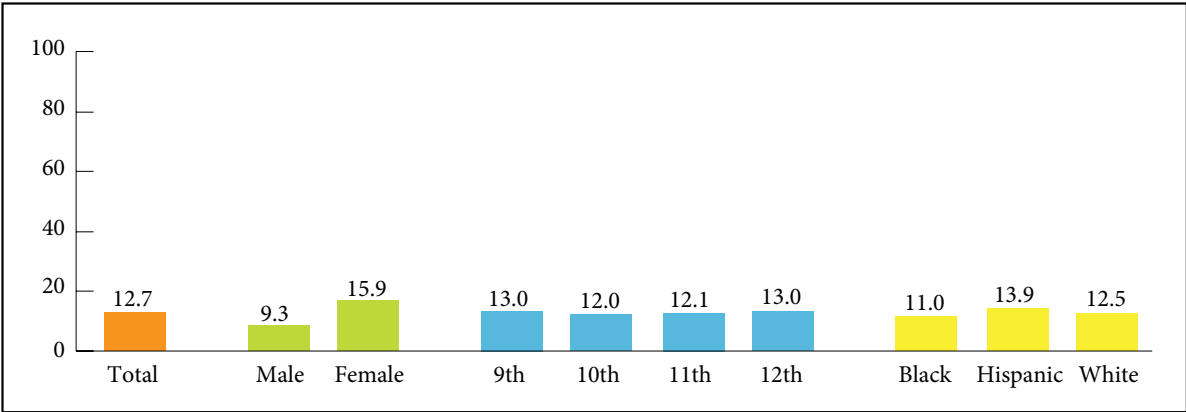
Table 1.

Percentage of Students Who Felt Sad or Hopeless Almost Every Day for
Two Plus Weeks in a Row, Past 12 Months, Connecticut and United States (YRBS, 2017)

	CT	US
Total	26.9	31.5
Male	19.2	21.4
Female	34.8	41.1
9th	24.8	29.8
10th	26.5	32.5
11th	29.7	32.5
12th	26.1	31.0
Black	26.9	29.2
Hispanic/Latinx	29.1	33.7
White	25.0	30.2

Figure 2.

Percentage of High School Students Who Seriously Considered Attempting Suicide,
by Sex, Grade, and Race/Ethnicity, 2019



Source: CTDPH 2019 Connecticut School Health Survey (CSHS Summary Graphs)¹⁵

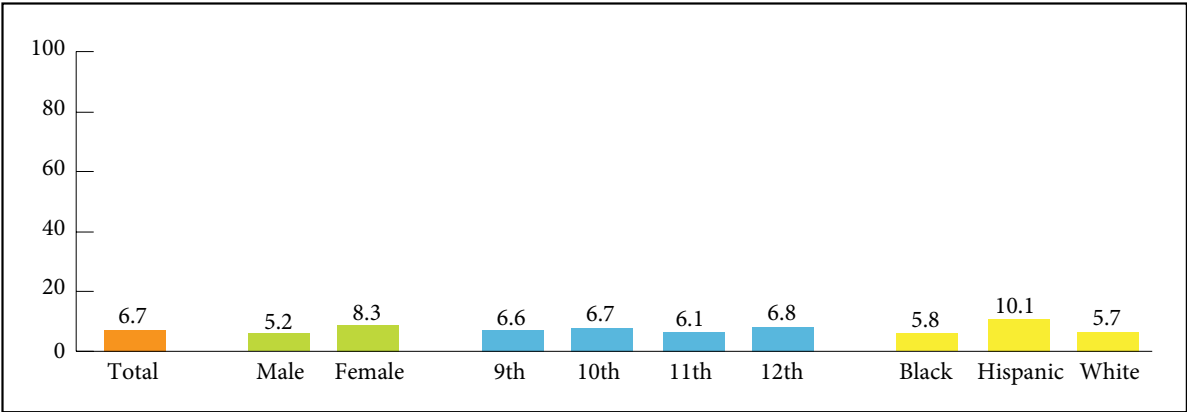
Table 2.

Percentage of Students Who Seriously Considered Attempting Suicide During the Past 12 Months,
Connecticut and United States (YRBS, 2017)

	CT	US
Total	13.5	17.2
Male	10.9	11.9
Female	16.8	22.1
9th	14.8	16.3
10th	13.7	17.3
11th	14.1	17.5
12th	10.9	17.4
Black	14.1	14.7
Hispanic/Latinx	14.7	16.4
White	12.8	17.3

Figure 3.

Percentage of High School Students Who Attempted Suicide,
by Sex, Grade, and Race/Ethnicity, 2019



Source: CTDPH 2019 Connecticut School Health Survey (CSHS Summary Graphs)¹⁵

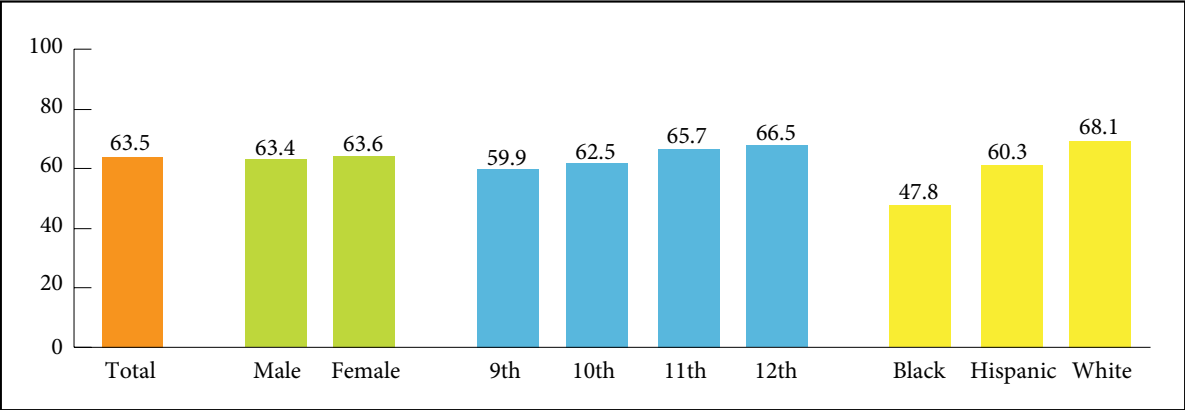
Table 3.

Percentage of Students Who Actually Attempted Suicide One or More Times During the Past 12 Months,
Connecticut and United States (YRBS, 2017)

	CT	US
Total	8.1	7.4
Male	7.8	5.1
Female	8.4	9.3
9th	8.0	8.3
10th	9.3	8.6
11th	6.4	6.1
12th	8.1	5.8
Black	10.5	9.8
Hispanic/Latinx	8.7	8.2
White	7.2	6.1

Figure 4.

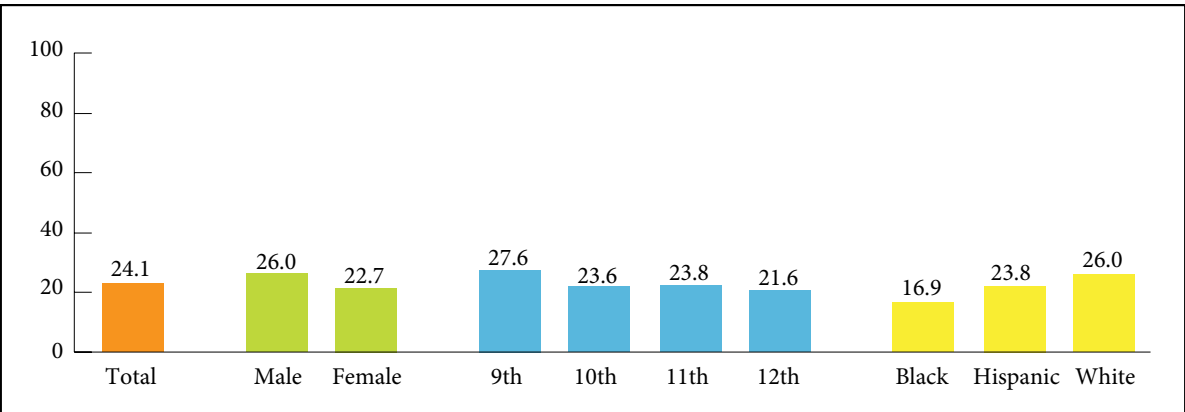
Percentage of High School Students Who Reported There is at Least One Teacher or Other Adult in Their School That They Can Talk to if They Have a Problem, by Sex, Grade, and Race/Ethnicity, 2019



Source: CTDPH 2019 Connecticut School Health Survey (CSHS Summary Graphs)¹⁵

Figure 5.

Percentage of High School Students Who Most of the Time or Always Get the Kind of Help They Need, by Sex, Grade, and Race/Ethnicity, 2019



Source: CTDPH 2019 Connecticut School Health Survey (CSHS Summary Graphs)¹⁵

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