

# 1 WORD VOICE LIFE

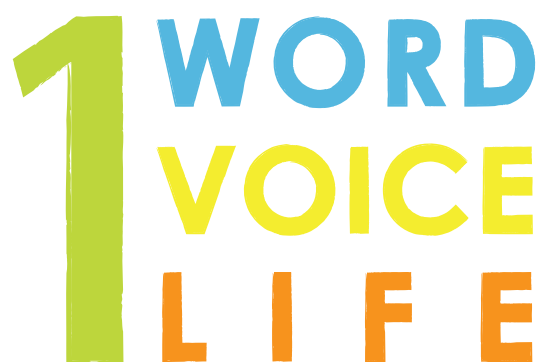
Be the 1 to start the conversation

## STATE OF CONNECTICUT SUICIDE PREVENTION PLAN 2020





*This plan and the many prevention efforts associated with it are dedicated to the Connecticut residents, families, friends and communities who are affected in profound ways by suicide.*



Be the 1 to start the conversation

# **STATE OF CONNECTICUT SUICIDE PREVENTION PLAN *2020***



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**The State of Connecticut**  
**Department of Children and Families and Department of Mental Health and Addiction Services**  
**Hartford, CT**

December, 2014

Dear Friends:

We are pleased to present the new Connecticut Strategic Plan for Suicide Prevention (PLAN 2020), the result of a collaboration of many stakeholders committed to suicide prevention. While acknowledging the complexity of the personal and situational factors associated with suicidal behavior, a public health approach is regarded as the one most effective to reduce suicide attempts and deaths.

Although Connecticut has one of the lowest rates of suicide in the United States, an average of 351 residents per year over the past five years have died from suicide, almost three times the number of homicides. Suicide deaths are largely preventable, and even one death is too many. Therefore, a concerted force organized around the guiding principles outlined in PLAN 2020 is our best hope for addressing this tragic public health and mental health problem. Connecticut stakeholders must mobilize their resources in a rapid response to prevent further death and disability associated with suicide.

An integrated and coordinated effort with multiple partners is a keystone of the public health approach. Collaboration among public health, mental health, medical, social services, law enforcement, military, political and other community stakeholders is crucial to prevent suicide attempts and deaths. The PLAN 2020 was developed by the Connecticut Suicide Advisory Board (CTSAB). The CTSAB is supported and co-chaired by the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS), and is comprised of volunteers and staff representing a variety of state and community sectors. PLAN 2020 establishes five goals and 22 objectives for Connecticut to initiate state prevention activities, and is aligned with the National Strategy for Suicide Prevention and Healthy People 2020. The fact that suicides are preventable calls for organized activation of our resources driven by data and evidence-based best practices to address the goals and objectives in this plan to prevent suicide attempts and deaths. Multiple individuals, including survivors, consumers, advocates, and representatives from state agencies and diverse organizations, contributed input and feedback that shaped this document.

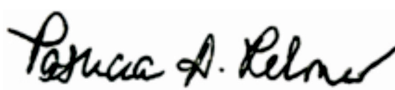
The PLAN 2020 is designed to be accessible to everyone and it is our goal that individuals, communities, institutions and organizations use the plan as their working template to guide their efforts small and large to prevent suicide attempts and deaths and ultimately save lives in Connecticut.

The DCF, DMHAS and CTSAB are committed to the full implementation of the goals and objectives of the PLAN 2020. We hope you find the PLAN 2020 useful, and we thank you for your dedication to working together with us to prevent further suicide attempts and deaths in our state.

Sincerely,



Joette Katz, JD  
Commissioner  
Department of Children and Families



Patricia Rehmer, MSN, ACHE  
Commissioner  
Department of Mental Health and Addiction Services

**Statement from the CTSAB Co-Chairs**  
**Andrea Iger Duarte, MSW, MPH, LCSW and Tim Marshall MSW, LCSW**

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) at the Department of Children and Families (DCF). The Department of Public Health (DPH) developed the Interagency Suicide Prevention Network (ISPN) in 2000 and in 2005 the first Connecticut Comprehensive Suicide Prevention Plan was released. Coordinated prevention efforts and resources increased in 2006 when the Connecticut Department of Mental Health and Addiction Services was an inaugural grantee of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith Grant (GLS), with the YSAB advisory to the Grant, followed by a second successful GLS Grant in 2011.

The Connecticut Suicide Advisory Board (CTSAB) was established in January 2012, and is composed of members from institutions of higher education, state agencies, community organizations and mental health facilities. The board was formed as a merger of the Connecticut Department of Children and Families (DCF) Suicide Advisory Board and the DMHAS/DPH Interagency Suicide Prevention Network to facilitate collaborative efforts among state partners for suicide prevention, intervention and postvention. The CTSAB meets monthly for programmatic and strategic planning to address issues related to suicide across the life span in Connecticut. The membership of the board and the Network of Care has grown steadily since its inception, with 169 members representing 76 sectors including: state and local agencies, profits and non-profits, community and faith-based organizations, hospitals, military, schools, higher education, towns, private citizens, students, survivors and advocates. Importantly, these members are committed and active, as evidenced by meeting attendance averaging 30 and with 60% of members attending six meetings or more per year. This commitment is essential to our:

**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.

**and our**

**Vision:** The CTSAB seeks to reduce and eliminate suicide by instilling hope across the lifespan and through the use of culturally competent advocacy, policy, education, collaboration and networking.

Priority areas have included:

- 1) Raise statewide awareness of suicide prevention with the “**1 WORD, 1 VOICE, 1 LIFE...Be the 1 to start the conversation**” initiative;
- 2) Develop a Statewide Network that links state-level with grass-roots local efforts;
- 3) Promote Evidence-Based Best Practices for Suicide Prevention and Response; and
- 4) Revise CT Strategy for Suicide Prevention.

We look forward to partnering with many constituent agencies, communities, survivors and advocates in the implementation of The Connecticut State Suicide Prevention PLAN 2020 (PLAN 2020). It is designed to serve as a blueprint for suicide prevention activities so that we can marshal resources, expertise and political will toward our overarching goal: the reduction of lives lost to suicide.

The CTSAB would like to extend a warm thanks to Professor Nina Rovinelli Heller from the UCONN School of Social Work and member of the CTSAB for agreeing to author State PLAN 2020. In addition to her writing, Professor Heller facilitated the CTSAB activities in developing the priorities of State Plan 2020.

## INTRODUCTION

The Connecticut State Suicide Prevention PLAN 2020 (PLAN 2020) is a living, working document, designed to frame, organize, prioritize, and direct established and emerging suicide prevention efforts throughout the state through 2020. PLAN 2020 was developed through the ongoing efforts of an expanding group of professionals and suicide survivors who meet regularly as part of the Connecticut Suicide Advisory Board (CTSAB), and of the Statewide Network of Care, under the direction of Co-Chairs from the Connecticut Departments of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF).

### The Development of the Connecticut Suicide Prevention Plan 2020

In accordance with recommendations<sup>i</sup> from the Suicide Prevention Resource Center, a national clearinghouse for suicide prevention, the PLAN 2020 is **data-driven** with flexible strategies for prevention. This allows efforts and resources to be directed toward both high risk populations and settings. The plan is also **comprehensive with set priorities**, developed with an understanding of the need for **collaboration across multiple public and private organizations**. The risk factors for suicide are well documented<sup>ii</sup> and mental health issues are prominent; the plan utilizes a **combined mental health-public health approach**, in order to target prevention at both the individual and broader public levels. Suicide occurs **across the lifespan**; the plan is intended to consider the relative risk factors across the lifespan and advocates the development of cohort-specific strategies. Central to the plan is the use of **safety informed communications** at all levels of suicide prevention. Finally, the plan promotes accountability and is designed to be regularly monitored, updated and revised.<sup>iii</sup>

Suicide prevention strategies and plans in the state of Connecticut can best be described as **embedded** and this theme is central to both existing and emerging activities and recommendations. The notion of embedded suicide prevention reflects our commitment to a comprehensive approach that places responsibility for suicide prevention across a wide range of agencies, settings, individuals and communities. The plan is intended to be used by a range of service providers and professional agencies to develop creative, targeted suicide prevention strategies that are responsive to public and client need and to shifting demographic trends in different populations, cohorts and social contexts. Ultimately, **responsibility for suicide prevention**, as well as postvention, must be considered a community responsibility, with the guidance and leadership of the Connecticut Suicide Advisory Board and Network.

The goals, objectives, example strategies, and commitments for implementation and monitoring laid out in the PLAN 2020 involve three levels of intervention in accordance with a public health framework. *Universal comprehensive preventive interventions* address the needs of the *whole population*. An example of this is the **1 Word, 1 Voice, 1 Life** media campaign launched in Connecticut in 2012. This multipronged media campaign was disseminated widely through radio public service announcements, shopping mall media kiosks, movie theater previews and publicity materials available to organizations throughout the state. *Selective interventions* target those groups for whom risk of suicide and related behaviors is elevated. For example, college-aged youth, *as a group*, have an elevated risk; interventions such as those supported by the federally funded DMHAS administered Garrett Lee Smith Grant, to Connecticut campuses, promotes wellness and provided evidence-based interventions chosen specifically for this population that may have an elevated risk. Finally, *indicated preventive interventions* focus on the needs of individuals who show some warning signs of elevated risk. These interventions are often indicated for high risk individuals who may have prodromal symptoms of mental health or substance use conditions. Screening interventions may be implemented with these individuals through primary care offices or college health and disciplinary offices, for example.



Lastly, the PLAN 2020 makes use of the best available data on suicide deaths and suicidal behaviors in the state of Connecticut, to determine a baseline from which we developed measurable and achievable goals for the reduction of suicidal behaviors and the reversal of disturbing trends in Connecticut. These will serve as benchmarks moving forward and will help to direct suicide prevention activities. Annual updates to the plan will allow us to monitor and disseminate our progress toward meeting these benchmarks.

The overarching goal of any suicide prevention plan is the elimination and reduction of suicide and suicide related behaviors. The PLAN 2020 includes specific **targeted outcomes for 2020**.

### The Scope of the Problem

Throughout the world, the suicide rate has been climbing. The World Health Organization reports that each year nearly one million people die by suicide, resulting in a mortality rate of 16 per 100,000, or a staggering death every 40 seconds.<sup>iv</sup> This represents an increase over the past 45 years of 60%, and it is estimated that by the year 2020, suicide will account for 2.4% of the global disease burden. At the same time, it should be noted that, given the impact of stigma, obtaining accurate suicide data is a challenge, resulting in false negatives by underreporting and differences in the mechanisms for investigating and reporting these deaths.<sup>v</sup>

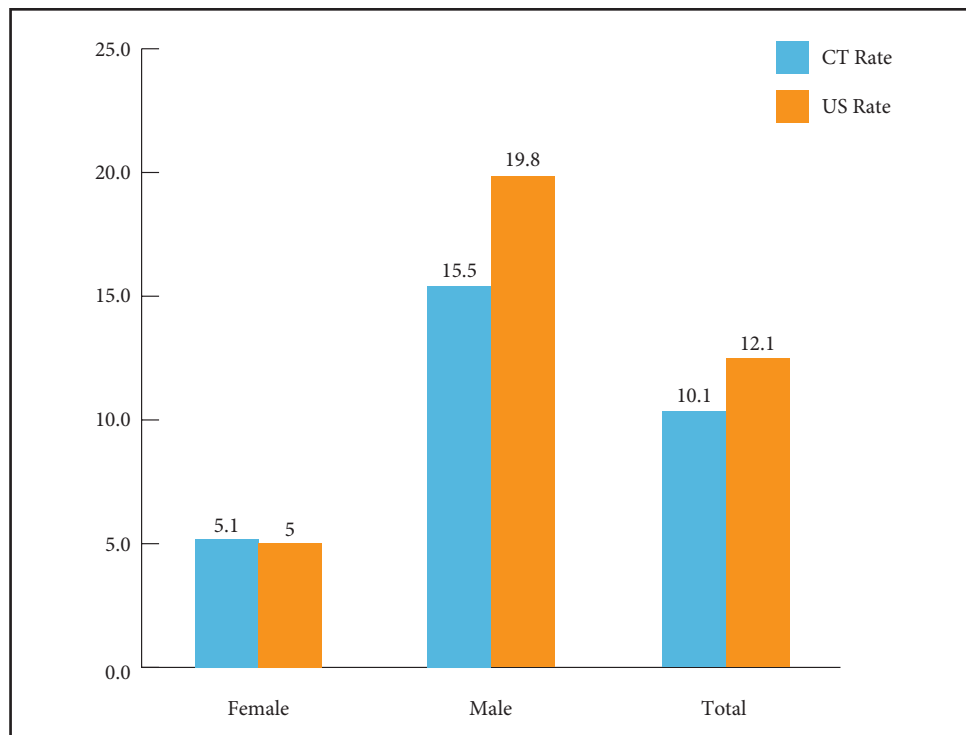
In the United States, suicide and suicidal behaviors have been identified as major public health problems that have far-reaching personal, social and economic implications. In 2012, the latest year for which national data are available, there were 40,600 deaths by suicide. In contrast, during the same year, there were 14,827 homicides (U.S. Department of Justice, 2013)<sup>vi</sup> and 33,561 motor vehicle fatalities (NHTSA, 2013).<sup>vii</sup> Suicide is the tenth leading cause of death and epidemiologists have shown that unlike other causes of death, suicide death rates have been steadily increasing by more than 2% a year (CDC, 2013)<sup>viii</sup>.

In 2011, nearly half a million people presented to hospital emergency departments for self-inflicted injuries. Of these, 224,000 sustained injuries significant enough to require hospitalization.<sup>ix</sup> It is estimated that for every person who dies by suicide, 30 others make an attempt. Furthermore, a prior attempt is one of the strongest risk factors for suicide. The human toll is significant; conservative estimates are that for every death by suicide, there are at least six survivors.<sup>x</sup> Nearly five million Americans became survivors of suicide in the past 10 years, placing some at elevated risk for suicide themselves. In 2010 alone, the number of suicide survivors grew by 230,184 people. In addition to the human toll, it is estimated that 41.2 billion dollars were lost in combined medical and work costs in 2011, due to suicide and related suicidal behaviors.<sup>xi</sup>

There exist significant state and regional differences in suicide death rates, ranging from a rate of 23.2 per 100,000 in Wyoming to 6.8 in the District of Columbia. The Mountain states have the highest rate (18.3) and the Middle Atlantic the lowest at 9.4.<sup>xii</sup> United States and Connecticut comparison total and gender data are presented below (Figure 1.). While Connecticut's total and male rates are substantially lower than the U.S. figures, the suicide rate for females is equivalent.

Figure 1.

### Suicide Rates (per 100,000) Connecticut (2012) and U.S. (2010) Total and Gender



Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 2/2/14.

Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Healthy People 2020. US rates based on 2010 data. <http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=28&topic=Mental+Health+and+Mental+Disorders&objective=MHMD-1&anchor=124>

There are significant age, gender, racial and ethnic group differences in suicide deaths and behaviors. Furthermore, relative risk among age and cohort groups can shift, making timely reporting and analysis critical to understanding current and emerging needs. For example, whereas in the United States in 2010, suicide was the second leading cause of death<sup>xiii</sup> among 25–34 year olds and the third leading cause of death among those aged 15–24, the recent increase in suicides among 45–54 year olds actually represents the highest actual rate of suicide of any age cohort. According to the Centers for Disease Control and Prevention, the annual age-adjusted suicide rate in the 35–64 year old group increased 28.4%, from 13.7 per 100,000 population in 1999 to 17.6 in 2010. The suicide rate for adults over the age of 65 was 14.9 per 100,000 in 2010.<sup>xiv</sup> Gender differences are fairly consistent, with males representing 80% of all suicide deaths, while females have suicidal thoughts and non-fatal attempts at rates consistently higher.<sup>xv</sup> Among racial and ethnic groups, suicide rates are highest for non-Hispanic Whites (14.1%) followed by those for American Indians and Alaskan Natives (11.0%). Rates are much lower for Asian and Pacific Islanders (6.2%), Hispanics (5.9%), and Blacks (5.1%).<sup>xvi</sup>

Those with existing mental health conditions, including substance abuse, are at increased risk for suicidal thoughts, attempts and deaths; it is estimated that 90% of those who die by suicide have at least one diagnosable mental health condition, most commonly a mood disorder.<sup>xvii</sup> Those with anxiety disorders,

borderline personality disorder and schizophrenia are also at elevated risk. Finally, those with a history of prior suicide attempts remain at the highest risk of dying by suicide.<sup>xxiii</sup> This has important implications for the need for a broad view of prevention and treatment. The PLAN 2020 addresses the issues of suicidal thoughts and non-fatal attempts as well as suicide fatalities.

### Suicide and Suicidal Behaviors in Connecticut

In Connecticut where the rate of suicide is comparatively low at 45th in the nation in 2010<sup>xx</sup>, there are significant trends and concerns that inform our efforts at the state level. The Office of the Connecticut Chief Medical Examiner (OCME) reported 364 suicide deaths in 2012; 367 in 2011; 342 in 2010; 308 in 2009; 296 in 2008; 250 in 2007; and 257 in 2006. Suicide statistics are typically reported as a suicide rate per 100,000. The suicide rate has pushed upward in the state since 2007, and as with the national rate, as of 2012<sup>xx</sup>, men have a significantly higher rate (15.49) than women (5.05).<sup>xxi</sup> To put Connecticut deaths by suicide in context, when in 2012, 373 people died in Connecticut by suicide, 151 died by homicide.<sup>xxii</sup>

In addition, people who make non-fatal suicide attempts often require hospitalization. Data show the overall rate of hospitalization from self-injury in 2012 was 78 per 100,000.<sup>xxiii</sup> The highest rates of hospitalization for self-injury were observed among youth aged 20–24 and 15–19, with rates declining by age. Among major racial and ethnic groups, Whites were at highest risk of hospitalization (81/100,000). Consistent with self-report data on suicide attempts, women were at higher risk than men. Among counties, the highest rates of hospitalization were observed among New Haven, Middlesex and New London counties. Most common means of self-injury were poisoning by solid or liquid substances, including narcotics (74%), and cutting or piercing (17%). Outcomes of medically serious self-injury: roughly a third of patients were discharged to a psychiatric facility following hospital discharge, 1% died from their injuries in the hospital, and the average length of stay was nearly five days. This length of stay, similar to stays for other significant medical conditions, underscores the need for intensive treatment.

Data sources in addition to the OCME include the Connecticut School Health Survey/Youth Risk Behavior Survey (YRBS) and the 2012 CT Hospital Inpatient Discharge Database (HIDD). The 2009 and 2011 YRSB, a national school-based survey, provided information about percentages of high school students who felt sad or hopeless, considered attempting suicide, actually attempted suicide and who made an attempt that resulted in need for medical intervention. Results for Connecticut indicate differential risk by gender, as expected, and by race and ethnicity. This data has important implications for suicide prevention in a number of settings. The HIDD hospital data<sup>1</sup> provides information about numbers of hospitalizations for self-injury by gender, age, race/ethnicity and county. These data sources taken together 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.

### Connecticut Suicide Facts at a Glance

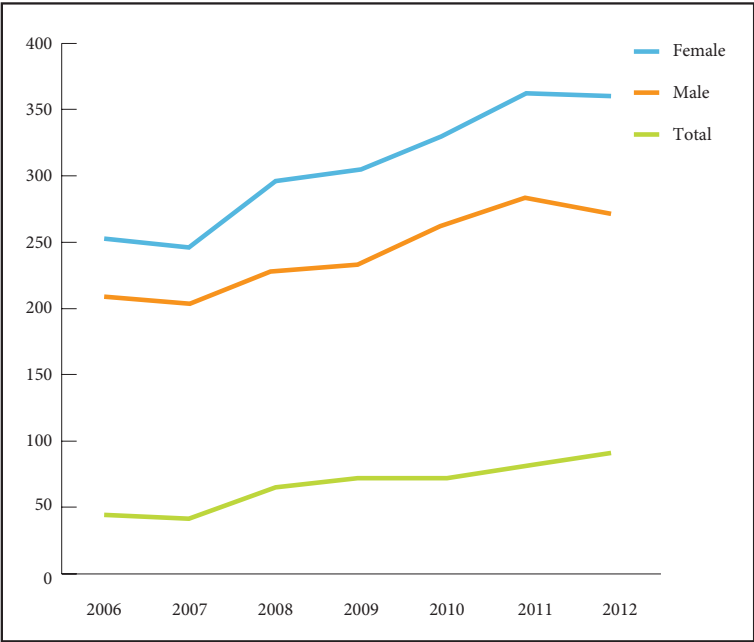
A brief snapshot indicates that certain demographic groups have higher rates of suicide than others; for example, Whites and men, especially ages 35 to 54. There are also regional differences by county. Suicide deaths vary by method of suicide. In 2012, 36.5% of people died by hanging/strangulation, followed by 29.4% by gunshot and 13.7% by substance overdose. The remaining 20.5% involved eight other methods. Method of death also varies by gender and age<sup>xxiv</sup> (Figures 2 and 3).

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<sup>1</sup> See Appendix I

Figure 2.

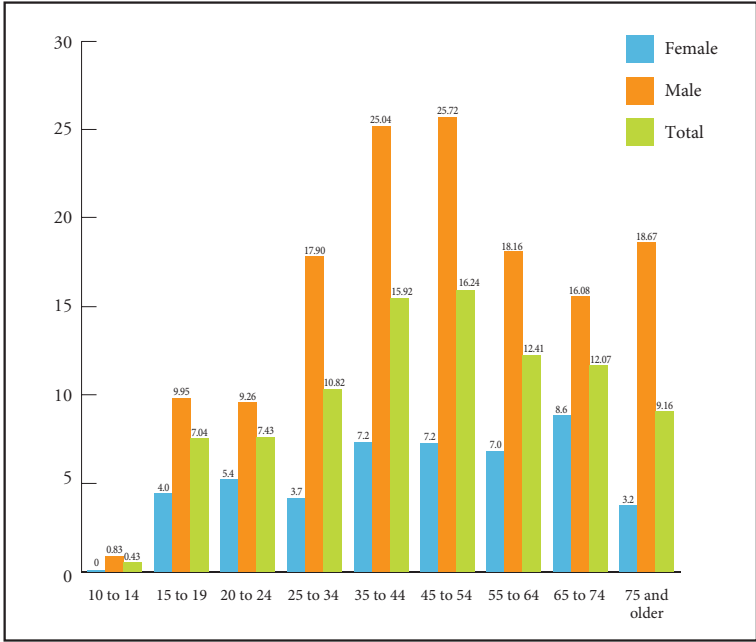
Number of Suicides in Connecticut Total and by Gender 2006–2012



Office of the Medical Examiner Deaths by Suicide 2006–2012  
Retrieved 5/29/13. [http://www.ct.gov/ocme/lib/ocme/documents/other/07-2011\\_bereavement\\_brochure.pdf](http://www.ct.gov/ocme/lib/ocme/documents/other/07-2011_bereavement_brochure.pdf)

Figure 3.

Suicide Rate in Connecticut by Age and Gender 2012



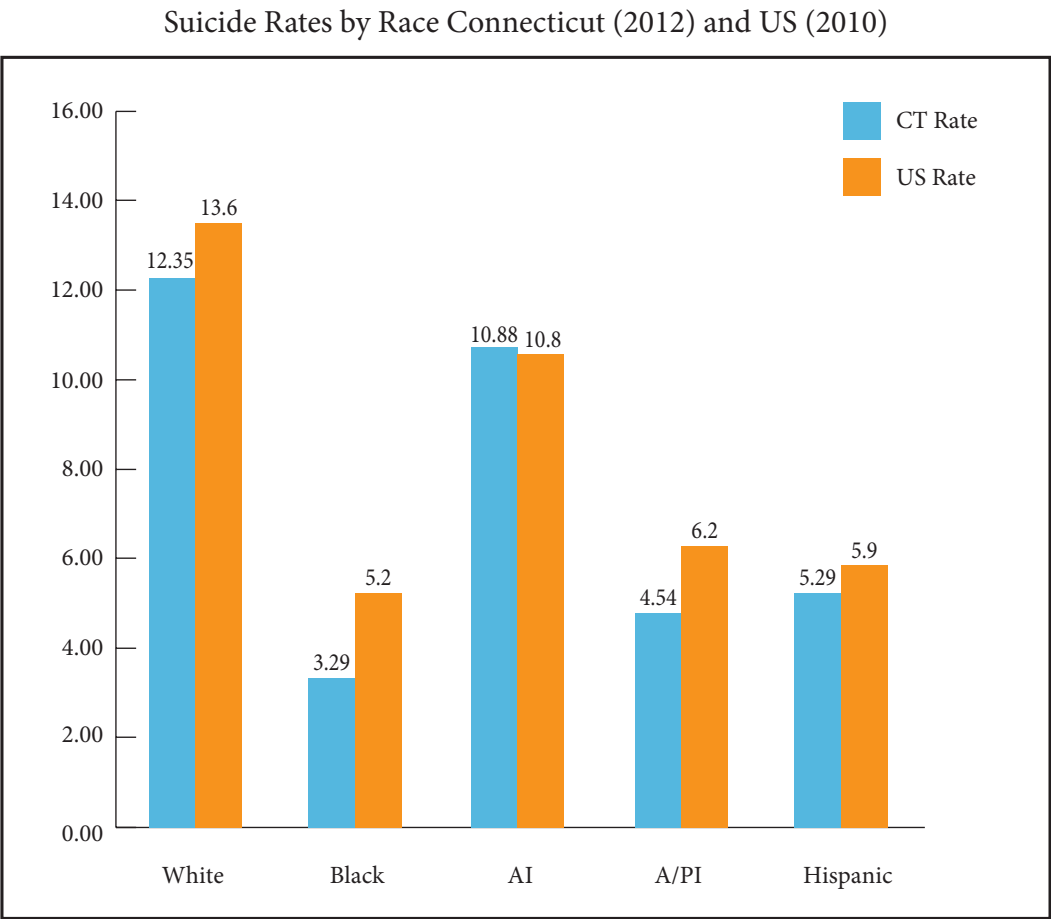
Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.<sup>2</sup>

<sup>2</sup> Table with numerical values for age and gender deaths from 2006–2012 appears in the Appendix

Suicide Rates by Race

Connecticut suicide deaths vary by race; however, this data needs to be considered with caution given the low numbers. For example, Native Americans, who are known to have an elevated risk of suicide nationally, appear as the second highest population in the 2012 Connecticut data. That rate, however, is based on the death of one Native American person in 2012 (Figure 4.).

Figure 4.



Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.  
Healthy People 2020. US rates based on 2010 data. <http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=28&topic=Mental+Health+and+Mental+Disorders&objective=MHMD-1&anchor=124><sup>3</sup>

<sup>3</sup> Tables with numerical values for race deaths for the years 2006–2012 appear in the Appendix

### *Differences by County*

There are regional differences in suicide rates in Connecticut by county, ranging from a low of 7.4 in Fairfield County to 15.7 in Middlesex County. This differential is not yet well understood and requires further investigation. (See Table 1.)

Table 1.

Number and Rate of Suicide by Connecticut  
County of Residence 2012

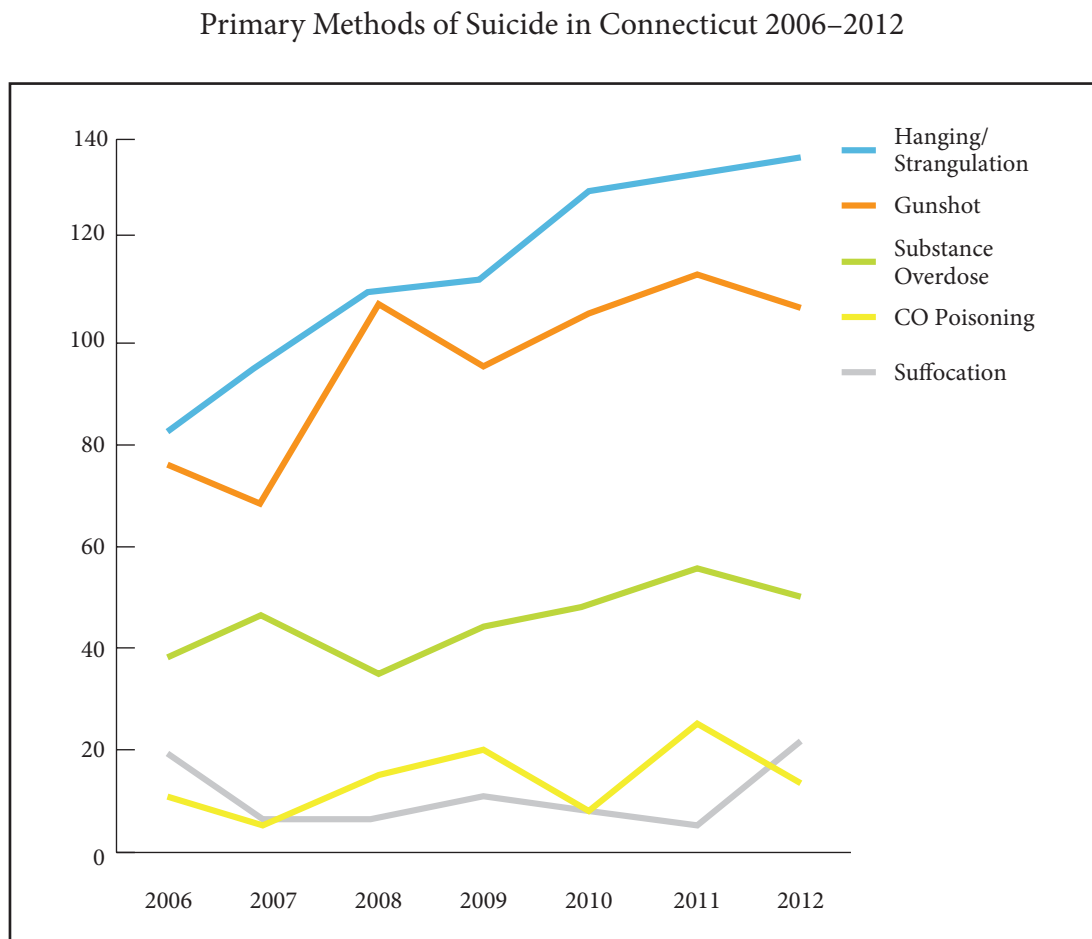
County	n	Population	Rate/100,000
Middlesex	26	165,602	15.7
Litchfield	27	187,530	14.4
Windham	14	117,599	11.9
Tolland	17	151,539	11.2
Hartford	99	897,259	11.0
New London	30	274,170	10.9
New Haven	69	862,813	8.0
Fairfield	69	933,835	7.4
Total	351	3,590,347	9.8

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

### Methods of Suicide

The method of suicide also varies with hanging/strangulation accounting for more than a third of the deaths, followed by gunshot at almost a third. Nearly three quarters of men die by hanging/strangulation or gunshot, while women are more likely to die by hanging/strangulation and substance overdose. Notably, the method of death has changed from 2006–2012<sup>4</sup> (Figure 5 and 6).

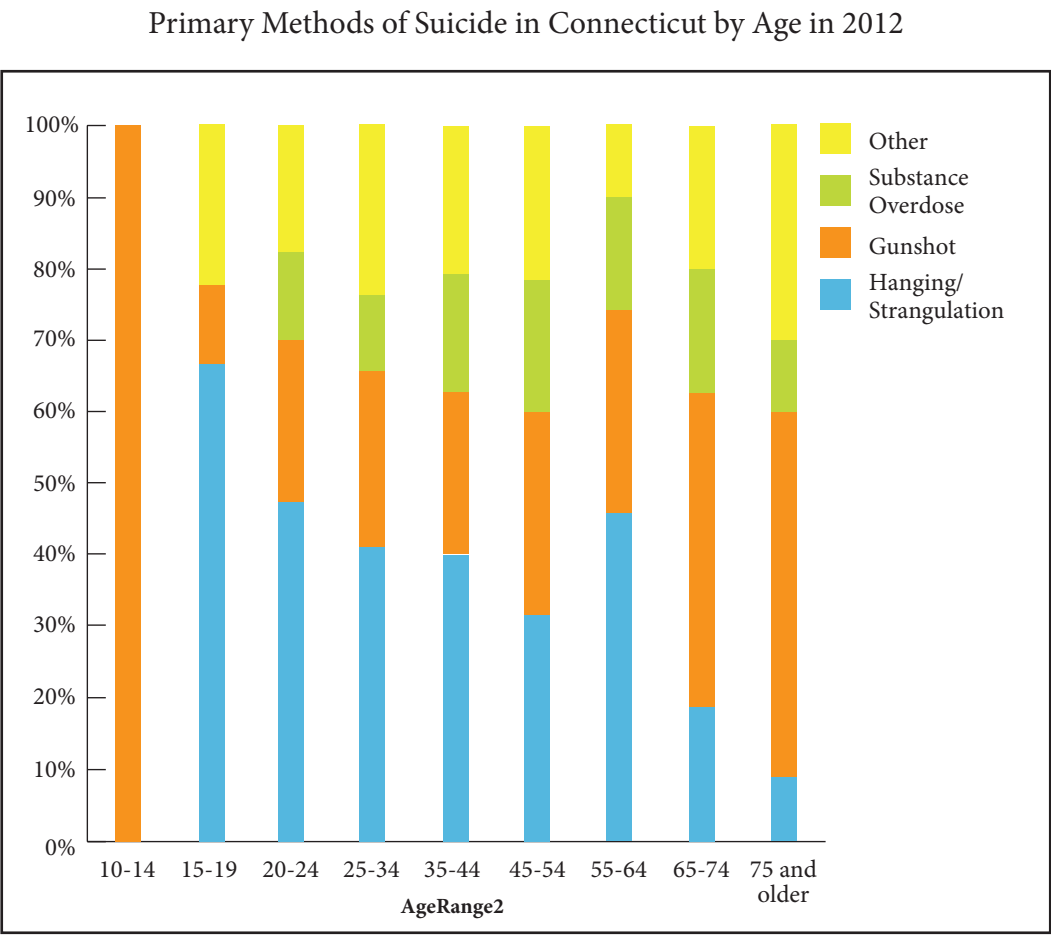
Figure 5.



Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

<sup>4</sup> Note: Numerical Values for Primary Methods of Suicide by gender and age and for 2006–2012 in Connecticut are located in the Appendix

Figure 6.



Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.



## State of Connecticut Suicide Prevention Goals and Objectives

The State of Connecticut suicide prevention goals, themselves, are derived, in part, from the National Suicide Prevention Strategy 2012 (NSPS), a report of the U.S. Surgeon General, and the National Action Alliance for Suicide Prevention, a public-private partnership. This group developed 13 NSPS goals and 63 objectives, derived from and spanning four strategic directions: 1) Healthy Individuals, Families and Communities; 2) Clinical and Community Prevention; 3) Treatment and Support Services; and 4) Surveillance Research and Evaluation Goals.<sup>xv</sup> The CTSAB endorses each of these NSPS goals, objectives and directions and through a comprehensive, multi-staged process identified five priority goals and related objectives that reflect the priorities for Connecticut suicide prevention efforts. This process included: 1) an online member survey of priorities and current activities and needs; 2) review of all available state level suicide and suicide related data; 3) consensus building discussions at monthly board meetings; 4) triangulation of diverse opinions through small group discussion; 5) consideration of existing initiatives and gaps, and identification of resource capability. In addition, goals were considered in the context of shifting trends and data provided by our consultants. These processes led us to a general consensus about five priority goals.

These goals were presented at the CTSAB 2014 Annual Meeting at which members were asked to generate examples of possible strategies for each of the objectives of the five goals. These collectively derived goals, objectives and examples of possible strategies form the core of the PLAN 2020. Some of the strategies have been enacted, while others emerged from discussions of gaps in suicide prevention activities and knowledge of national best practices. 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 agencies and communities. In addition, we have identified some of these goals, objectives and strategies for monitoring that will serve as the basis for annual review of data and reorganization of priority planning and programming. We have also, in recognition that “one size does not fit all” in suicide prevention, identified, on the basis of Connecticut and national data and the opinions of suicide prevention experts throughout the state, thirteen priority populations at elevated risk for suicide and related behaviors. For each of these populations we highlight current concerns and areas for future attention.

Finally, this report includes targets for improvement in rates of suicidal behaviors, based upon our current data. This will allow for a central component of the plan, the systematic annual review and an updated report of PLAN 2020.

## GOALS, OBJECTIVES AND EXAMPLES OF POSSIBLE STRATEGIES

### 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:** Members of the CTSAB work within their respective agencies and communities to raise the profile of suicide prevention initiatives and they report significant advances since the 2005 Connecticut State Plan. There is strong institutional and leadership support for suicide prevention through the CT Departments of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF) and the Department of Public Health (DPH), as well as designated staff from DMHAS and DCF co-chairs of the CTSAB. Furthermore, networking among agency staff committed to suicide prevention has grown significantly since the implementation of the 2005 plan.

**General Recommendations:** Work to identify and foster attitudes, behaviors and practices within agencies and programs that support the evaluation and adoption of new initiatives for prevention, intervention and postvention. 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:

- a. Develop contracted language that can be embedded in all relevant departments, such as the Department of Mental Health and Addiction Services, the Department of Children and Families and the Department of Public Health.
- b. Children and Families Behavioral Health (more than 459 district services) requires all DCF contracted behavioral providers to have a suicide prevention education and/or awareness component in the delivery of each service. Develop the same for other state agencies including Department of Mental Health and Addiction Services as appropriate, and review existing contracts for inclusion of this requirement.
- c. Expand state and non-profit agency mission statements to include suicide prevention, when relevant.
- d. Advocate for stronger educational administrative support of measures designed to capture suicide risk at schools, (for example, The Youth Risk Behavior Survey or YRBS).
- e. Support and provide mandatory suicide prevention training for social workers and licensed mental health providers.
- f. Integrate suicide prevention into trainings for domestic violence crisis center volunteers and staff.
- g. Integrate suicide prevention into trainings for staff that provide legal services for immigrant populations.
- h. Integrate suicide prevention training into police agencies, utilizing existing systems.
- i. Partner with faith-based organizations
- j. Continue broad dissemination of the CTSAB media campaign, 1 Word, 1 Voice, 1 Life.

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

**Current Status:** There has been a proliferation of suicide prevention activities, education and training through private and public agencies and community groups in Connecticut since the 2005 State Plan.<sup>5</sup> This has been made possible, in part, through grant funding. Collaborative projects have been developed.

**General Recommendations:** Efforts should be made to identify those activities that have the strongest empirical base and can become sustainable within agencies. Develop creative collaborations among agencies in order to maximize effectiveness, best use of available resources and sustainability.

**Examples of Possible Strategies:**

- a. Work with tribal health councils and related groups to identify representation on the CTSAB and to identify and develop suicide prevention specific to the population.
- b. Compile self-reports on agency programming and prevention activities and include in statewide database through CTSAB.
- c. Establish and utilize subgroups of the CTSAB and broader network according to population and setting focus; for example, youth, corrections, middle-aged adults.

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

**Current Status:** The rapid and strategic expansion of the membership of the CTSAB has strengthened the collaborative nature of suicide prevention in Connecticut across agencies such as DCF and DMHAS and their contracting providers, and colleges and universities through the Garrett Lee Smith grants.

**General Recommendations:** Continue to use and develop creative collaborations at all levels throughout organizations and agencies.

**Examples of Possible Strategies:**

- a. Bring commissioners of state agencies together to share latest available suicide data, to develop integrated suicide prevention strategies and resources.
- b. Develop a common Memorandum of Understanding that can be used across state agencies for suicide prevention efforts.

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

**Current Status:** We are at the early stages of identifying public-private partnerships for the development of suicide prevention resources and programs.

**General Recommendations:** Develop a plan to identify possible collaborators representing a wide range of private organizations that share interest in suicide prevention.

**Examples of Possible Strategies:**

- a. Provide funding to private agencies to fund collaboration based on results-based accountability.
- b. Get “star power” for public service announcements.
- c. Publicize public action steps.

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<sup>5</sup> PowerPoint slide from annual report

- d. Pursue collaboration for state, private and federal grants for education awareness and marketing.
- e. Conduct needs assessment for agencies that serve populations at risk.
- f. Work closely with Connecticut firearms manufacturers in a partnership to increase gun safety. Develop suicide prevention material for firearm packaging.
- g. Identify high ranking legislative advocates to advance suicide prevention language into policies and laws at the state level.
- h. Examine existing collaborations and partnerships for member/sector inclusion. Identify non-represented groups and create strategic plan to invite new members to represent them on the CTSAB.

➔ **Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.**

**Current Status:** This is an area for significant growth as the Affordable Care Act takes effect and opportunities emerge for integrated behavioral health care.

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

**Examples of Possible Strategies:**

- a. Identify key organizations and leaders in the health care community. Engage them in the CTSAB organization and activities.
- b. Identify, recommend, develop and disseminate best practices policies and protocols to be adapted to various components of the health care system.
- c. Educate personnel at all levels in health care organizations in suicide prevention. (For example, doctors, allied health providers, paraprofessionals, organizational staff.)
- d. Ensure adequate and responsive aftercare, especially post-discharge from acute forms of care.
- e. 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 greatly expanded from 2011 to 2014. For example, the following suicide prevention programs, among others, have been offered in the state during the last year:

- Question, Persuade, Refer Gatekeeper Program (QPR)
- QPR Training of Trainers
- Applied Suicide Intervention Skills Training (ASIST)

- Assessing and Managing Suicidal Risk (AMSR)
- Assessing Suicidal and Self-Injurious Youth (ASSIY)
- TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
- Connect Prevention and Training of Trainers
- Connect Postvention and Training of Trainers
- Mental Health First Aid; Recognizing and Responding to Suicide Risk—
- Primary Care Fresh Check
- SafeTalk
- Survivor Voices Training and Training of Trainers
- Signs of Suicide (SOS)
- Depression Outreach Alliance
- CampusConnect
- Student Support Network; and Active Minds.<sup>6</sup>

**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.

#### Examples of Possible Strategies:

- Continue to meet within agencies and the CTSAB to identify gaps in programming and to identify resources and strengthen coordination.
- Evaluate media campaigns including CTSAB website, social media and mass media placement.
- Utilize the CT Healthy Campus Initiative to disseminate information and train college staff to implement evidence-based practices on campuses throughout the state.
- CTSAB to make available through their website links to best practices resources through national organizations such as Suicide Prevention Resource Center (SPRC).
- Develop and enact legislation requiring suicide prevention training and continuing education for the health, mental health and educational professionals.

#### ➡ Objective 2.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

**Current Status:** The link between mental health and substance use conditions, and suicide and suicide related behaviors is well established. While a small minority of people with mental illness will die by suicide, a large proportion (90%) of those who do die by suicide have struggled with mental health conditions. Community agencies who serve those with mental illness are well positioned to work with those at risk. In addition, other settings whose primary mission and focus are not specifically mental health/illness, such as schools, universities and youth clubs, are well positioned to deliver programs that promote wellness.

**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

<sup>6</sup> See Appendix J for Trainings by Source and Number Served

develop programs with a focus on wellness, the promotion of protective factors and the reduction of risk factors.

#### Examples of Possible Strategies:

- a. Utilize current infrastructures to enhance/implement suicide prevention/intervention programs.
- b. Promote “Connect Prevention” to communities so they can develop unified language to address suicide prevention.
- c. Promote “Connect Prevention” to communities so they can develop unified language to address suicide prevention.
- d. Use existing campus-community coalitions to provide resources and education to promote wellness and prevent suicide.
- e. Provide training and materials to local community agencies.
- f. Provide training of trainers for evidence-based programs.
- g. Produce suicide prevention curricula for schools.
- h. Identify youth leaders and train them as QPR Gatekeepers to bring safe messaging training back to their own communities and priority populations.
- i. Educate each of DCF’s 25 community collaborations and make recommendations about promoting the implementation of effective suicide prevention and promotion of wellness and recovery.
- j. Develop and implement best practices yoga and wellness programs for youth at risk for anxiety and depression.
- k. Present healthy lifestyles to promote wellness through media campaigns, workshops for groups at elevated risk for suicidal thoughts and behaviors and mental health conditions.
- l. Conduct systematic outreach to key stakeholders to offer training opportunities.
- m. Offer professional development on suicide prevention and risk through the CT Department of Education and track the numbers trained per district.

#### ➡ Objective 2.3: Intervene to reduce suicidal thoughts and behaviors in populations at risk.

**Current Status:** Public and private agencies throughout Connecticut continue to work with people at heightened risk for suicide and suicide related behaviors. Certain demographic groups, however, are at increased risk and may not be sufficiently identified.

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

#### Examples of Possible Strategies:

- a. Use recent Connecticut data about suicide related behaviors to identify trends and groups at elevated risk.
- b. Develop programs aimed to ameliorate risk factors in high risk groups.
- c. Continue to assess high risk populations in different settings and demographic groups, particularly those populations that may be marginalized or overlooked. For example, the homeless,



incarcerated, elderly.

- d. Identify the best opportunities by person, setting, and the like for intervening through the analysis of available data.
- e. Engage the community of people with disabilities in order to better understand and respond to suicidality in this population.

### Goal 3: Promote suicide prevention as a core component of health care services.

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

**Current Status:** The adoption of “Zero Suicides” as an aspirational goal is promoted by the National Strategy for Suicide Prevention and the philosophy is one shared by the CTSAB.<sup>xxvi</sup>

**General Recommendations:** Facilitate discussions among staff involved in suicide prevention and the range of public and private agencies that work with populations at risk about endorsing this stance. Commitment and resources should follow.

##### Examples of Possible Strategies:

- a. Agencies set goals relative to reducing the number of suicides in the populations they serve.
- b. Systematically expand the *1 Word, 1 Voice, 1 Life* campaign to include a “Zero Suicide” message.
- c. Develop and disseminate public service announcements.
- d. Link with community health education professionals at hospitals to incorporate suicide prevention and “zero suicide” messages within all of their health education programming.
- e. Include marketing department/public affairs offices in developing and implementing this message.
- f. Use effective evidence-based care, safety planning, lethal means restriction and follow up care.

#### ➡ 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:** While individual agencies and trainings promote the delivering of collaborative, responsive and least restrictive settings, there is more to be done in terms of using current research and best practices to inform the development and implementation of these protocols.

**General Recommendations:** Utilize current and emerging research to develop the most responsive, caring and humane responses to the range of human despair that can result in suicidal behavior.

##### Examples of Possible Strategies:

- a. Solicit feedback from survivors of suicide attempts about best responses to suicidal behaviors.
- b. Promote safe messaging.
- c. Include survivors of suicide attempts on the CTSAB.
- d. Include questions related to response to suicidal crises on agency patient satisfaction surveys.
- e. Develop both prototypic and specialized flow charts identifying the process by which agencies will respond to a suicidal client.

- f. Offer assessment services in atypical settings such as recreation centers and houses of worship.
- g. Promote continuity of care and the safety of all patients treated at all levels of the health care system.
- h. Develop innovative “wrap-around” services for people at risk.

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

**Current Status:** We do not currently have centralized data that tracks all timely access for those at heightened risk.

**General Recommendations:** Encourage agencies to review, develop and implement processes for timely access to these services and to develop means for evaluation and improvement.

**Examples of Possible Strategies:**

- a. Develop recommendations and protocols in agencies for timely access to care and share these among CTSAB member agencies.

➡ **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.**

- a. Develop a presentation using CT data and recruit CTSAB members to develop and present educational materials for hospital emergency room directors and staff.
- b. Develop a database to capture key data elements and to link duplicate/repeat emergency department visits and inpatient admittance. Measure readmission rates.
- c. Ensure that emergency room/department discharges are linked to outpatient providers.
- d. Promote continuity of care and the safety of all patients treated at all levels of the health care system.
- e. Align procedures with those developed by accrediting organizations. Identify where there is room for developing higher standards.
- f. Develop and provide support services for family members of suicidal individuals.

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

**Current Status:** This varies by agency/setting and may be governed by existing accreditation standards. Health care organizations are represented on the CTSAB.

**General Recommendations:** Improvements should occur through individual agencies, accrediting organizations and professional groups. The CTSAB can provide further outreach to health care agencies and encourage the sharing of suicide prevention responses specific to these settings.

**Examples of Possible Strategies:**

- a. Develop a suicide prevention specialized team in health care settings that can in turn provide in-service trainings.



- b. Expand gatekeeper training to staff in health care settings.
- c. Encourage health care professionals to lobby their own professional organizations to increase standards for care of the suicidal client.

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

**Current Status:** This is in progress, in part due to linkages forged through the CTSAB and the CT Garrett Lee Smith Suicide Prevention Initiative, but this is primarily informal at present.

**General Recommendations:** Professional and peer helping relationships can strengthen the support and safety nets for people with suicidal behaviors. Strengthen these through ongoing linkages.

**Examples of Possible Strategies:**

- a. Establish links between providers of mental health and substance abuse services and peer support groups.
- b. Identify current links to community-based services and encourage introductions and collaboration.

➡ **Objective 3.7: Coordinate services among suicide prevention and intervention programs, health care systems and accredited local crisis centers.**

**Current Status:** Suicide prevention activities currently occur in each of these kinds of programs and settings but the degree to which these have been systematically coordinated is unclear.

**General Recommendations:** Continue to identify areas of potential partnership and linkages between these kinds of programs and settings.

**Examples of Possible Strategies:**

- a. Provide links between suicide prevention services and domestic violence crisis centers.
- b. Work with community crisis centers to gather data about referral and coordination patterns, gaps and opportunities.
- c. Engage the Regional Mental Health Boards to participate in the CTSAB.
- d. Consider plans to promote the use of the Columbia Suicide Severity Rating Scale screening tool across state and private agencies.

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

**Current Status:** Some health care agencies are represented on the CTSAB and there are existing collaborations. As the number of people insured in Connecticut rises, patterns of emergency department, crisis units and primary care use may shift.

**General Recommendations:** There is a need, particularly in light of recent health care legislation, to identify the best places for the provision of timely, quality and safe care.

### Examples of Possible Strategies:

- a. Link community clinics to hospitals.
- b. Develop plans of care that direct patients through various levels of care.
- c. Implement evidence-based suicide prevention training into all levels of health care systems.
- d. Discuss and implement safety planning strategies for emergency department patients as a model of evidence-based best practices.

## Goal 4: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

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

**Current Status:** We currently have no data on mental health practitioners' routine assessment of at risk clients for access to lethal means. The national data suggest that this is not routinely performed.

**General Recommendations:** There is a great need to publicize the role of lethal means restriction in preventing suicides and to stress that it applies to all potential means of suicide, not just firearms. Given that reducing access to lethal means is an effective prevention strategy, the CT data on method of death by suicide and lack of uniform protocols, this is an important area for education of mental health providers and families and friends of people at risk for suicidal behavior. Education must focus on provider and family attitudes, beliefs and behaviors.

### Examples of Possible Strategies:

- a. Develop a subcommittee of the CTSAB to develop guidelines and educational plans for the training of providers on lethal means counseling.
- b. Develop and disseminate to the public and providers clear statements of what constitutes lethal means, including firearms, poisons, prescription and illegal drugs, and the like.
- c. Consider the socio-legal political climate in the discussion of lethal means restrictions.
- d. Deliver training to primary care physicians and other front-line providers.
- e. Develop an educational public service announcement that educates the public about lethal means restrictions.
- f. Develop provider "cue cards" to ask the necessary questions about lethal means.
- g. Provide links from the CT Suicide Prevention website to Counseling On Access to Lethal Means, <http://training.sprc.org/course/description.php#course3>.
- h. Publicize opportunities (like drop boxes and "take-back" programs) to safely dispose of prescription drugs and poisons.

### ➡ 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:** While there has been a model of suicide prevention/firearm dealer collaboration in the state of New Hampshire, there are limited efforts in Connecticut.

**General Recommendations:** Consider bringing stakeholders together to begin discussions about possible collaborations under the auspices of the CTSAB.

**Examples of Possible Strategies:**

- a. Gauge interest among gun dealers to partner with the CTSAB regarding lethal means restrictions.
- b. Develop awareness suicide prevention and lethal means restriction materials for gun shop owners to post and distribute.
- c. Use a similar approach to the CT tobacco merchant education model to collaborate and inform regarding warning signs and opportunities for prevention and intervention.
- d. Recommend policies that require firearm courses to include safe storage and suicide prevention content.
- e. Work toward recommending legislation and local ordinances that would require dissemination of trigger locks at classes and with each sale of arms at stores.
- f. Engage firearm dealers in QPR and other suicide prevention trainings.
- g. Work with police to develop and publicize temporary “safe storage” facilities for lethal means held by individuals at immediate risk for suicide.

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

**Current Status:** While safety technologies are available, they are not widely legislated or used.

**General Recommendations:** Consider CTSAB subcommittee to examine research in this area and make recommendations for greater awareness of and utilization of these existing and emerging technologies.

**Examples of Possible Strategies:**

- a. Work with stakeholders to determine current level of safety utilization related to the various lethal means including guns, poisons, and prescription and non-prescription drugs.
- b. Develop recommendations for the implementation of best available technologies to reduce access.
- c. Post crisis number signage at locations where, according to OCME data, people have made suicide attempts (for example, bridges, railways, overpasses, parks).
- d. Support access to and training in the use of Narcan to prevent opioid overdose.

**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 following objectives are grouped together due to significant overlap of recommended strategies:

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

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

➡ **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 of Connecticut. They are able to identify trends and develop benchmarks and priorities for prevention efforts. In a recent survey, CTSAB members reported that while they generally have access to the data they need in their suicide prevention efforts, they would like to have easier access, with one portal for securing it. There are, however, gaps in the data that is available on a timely basis. The complexities in obtaining accurate, timely, consistent data are well identified in the literature but these may be mitigated by the CT Department of Public Health grant award (2014–2019) to participate in the National Violent Death Reporting System (NVDRS).

**General Recommendations:** Develop a clear plan for the timely gathering, analyzing and posting of data related to suicide deaths and attempts in CT. Identify data collection goals, where data can be obtained and what obstacles may exist. Align state reporting systems with those on the national level.

**Examples of Possible Strategies:**

- a. Include on the CTSAB website a regularly updated data page that contains the latest national and state data on suicide related behaviors and deaths in Connecticut.
- b. Strengthen ties between the CTSAB and the Office of the Medical Examiner and local police for the timely access of data related to untimely deaths. This could allow, in the case of suicide, for assistance, support and consultation with affected families and communities.
- c. Obtain a memorandum of understanding with the Office of the Medical Examiner and collaborate on data collection, particularly identifying other field/populations of interest.
- d. Inform and educate hospitals, the public and the judiciary about the importance of reporting timely and accurate suicide data.
- e. Develop quarterly reporting of vital statistics, including deaths by suicide and suicide attempts.
- f. Provide training to those who are in positions to collect data, so that they can reliably recognize, categorize and standardize the data.
- g. Expand the distribution base of entities that receive the “cleaned” data; that is, all 30 hospitals, clinics, and the like.
- h. Improve the usefulness and quality of suicide related data for grants, funding, education and resources, and make available in one central location.
- i. Provide training to health care providers regarding the proper coding of suicide related events.
- j. Provide user-friendly data materials for distribution to agencies and communities. Include trends and concerns for specific areas.
- k. Institute the consistent use of nomenclature for various forms of self-directed violence.
- l. Where feasible, put a “human face” on the statistics, with permission from suicide survivors and family members.
- m. Include suicide data in regional profile development produced by Regional Area Councils.
- n. Use suicide-related data to implement prevention efforts and inform policy efforts and decisions, all related to specific populations.
- o. Use multiple state level data sources such as the CT Health Information Network, Hospital Inpatient Discharge Database and the Office of the Chief Medical Examiner.

- p. Use state level data and national research findings to guide targeted areas and resources and gaps in resources.
- q. Add suicide prevention questions to the CT Health Survey.
- r. 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 the most immediate needs for suicide prevention research in the state of Connecticut.

## Introduction to the Groups at Elevated Risk

The 2012 National Strategy for Suicide Prevention identified on the basis of multiple sources of data, groups with particularly increased risk for suicide and suicide related behaviors. These include: American Indians/Alaska Natives; individuals bereaved by suicide; individuals in justice and child welfare settings; those who engage in nonsuicidal self-injury; those who have attempted suicide; individuals with chronic medical conditions; those with mental health and substance use conditions; lesbian, gay, bisexual and transgender populations (GLBT); military members and veterans; men in midlife and older men.<sup>xxvii</sup> These priorities are based upon national data and trends and do not necessarily reflect regional differences in populations at risk.

Here in Connecticut, several sources inform our selection of populations for inclusion in this version of PLAN- 2020. First, data collected through the Office of the Medical Examiner, the CT Hospital Database, National Vital Statistics Reports, the CDC Morbidity and Mortality Weekly Report, the CDC Youth Online High School Youth Risk Behavior Surveillance Survey among others have been reviewed and inform our recommendations. Here, we report on groups in three domains: by lifespan; by race and ethnicity; and by special population, which is defined as a group holding a certain status/identification, area of challenge or setting. In addition to using data to determine which groups to highlight at this point in time, we relied on a broad group of Connecticut experts in suicide prevention who have expertise in working with members of at-risk groups. Some of these experts are professional providers; others may be suicide survivors; several identify as both. This process has insured both data-driven and expert-driven approaches, from those who have knowledge of the lived experience of suicide and its impact on individuals, families and communities. As with previous sections of the PLAN 2020, users are encouraged to consider this content as a starting point for developing and implementing their own suicide prevention activities, with particular attention to where those efforts can become embedded in their agency's broader visions.

### Lifespan:

Suicide occurs with different rates and methods across age groups and these trends change over time. Age groups also share common risk factors and have ones that are specific to each. Finally, while many of our prevention strategies are common to all age groups, some we present here are specific, based upon factors such as prevalence, choice of method and risk factors.

### Youth Suicide

Youth suicide is a particularly devastating problem from several different vantage points. The CDC (2012)<sup>xxviii</sup> reports that among those 10 to 24 years of age, suicide is the third leading cause of death, resulting in approximately 4,600 deaths each year. Nationally, the young are most likely to die by firearm (45%), by suffocation (40%) and by poisoning (8%). (Please note: different reporting agencies consider youth to age 19, breaking out 20–24 and 25–29 as young adult; nonetheless, the statistics are troubling.)

Actual deaths by suicide in this age group are not the only concern. Results from the 2011 National Youth Risk Behavior Survey (YRBS) suggest that of US high school students, 16% in a given year reported seriously

considering suicide; 13% reported having a plan for doing so; and 8% actually made a suicide attempt. The data is equivocal; boys die by suicide at significantly higher rates than their girl counterparts; 81% of suicide deaths in this age group are boys; the remaining 19% are girls. However, girls are far more likely to attempt suicide than die by suicide. Nationally, Hispanic youth were more likely to report suicide attempts than their peers.<sup>xxix</sup> The YRBS is a national school-based survey conducted by the CDC and state governments to monitor priority health-risk behaviors among high school students. It is conducted every two years during the spring semester. The national survey samples ninth through twelfth graders in public and private schools. Connecticut samples public high school students.

In the State of Connecticut, the Office of the Chief Medical Examiner reports the following confirmed youth deaths by suicide, by gender and by year.

Table 2.

Connecticut Youth Suicide Frequency and Rate  
by Age and Gender 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
10 to 14	0	0	1	0.83	1	0.83
15 to 19	5	4.0	14.4	9.95	18	7.04

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 3.

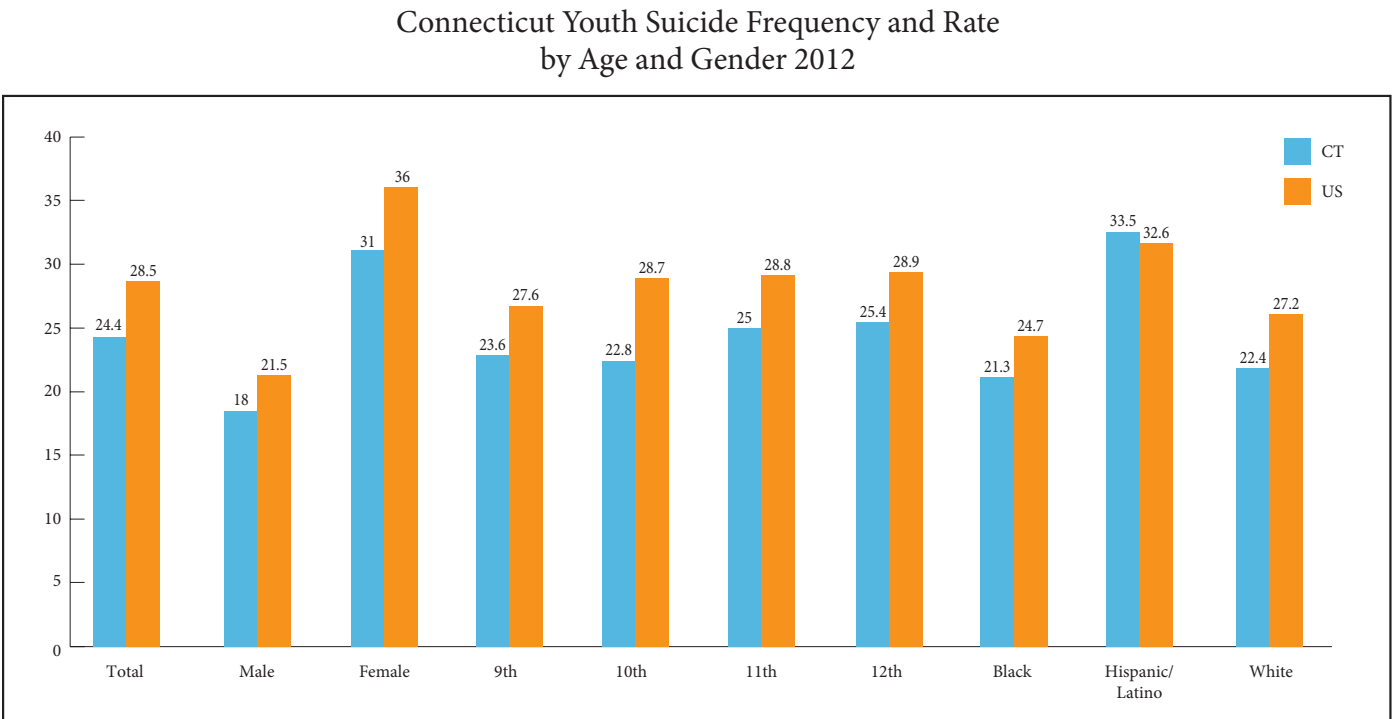
Connecticut Suicide Frequency by Age and Gender, 2006–2012

	Ages 1-9		Ages 10-14		Ages 15-19		TOTALS	
	F	M	F	M	F	M	F	M
2006	0	0	0	1	2	13	2	14
2007	0	0	0	0	1	13	1	13
2008	0	0	3	3	2	12	5	15
2009	0	1	1	0	6	10	7	11
2010	0	0	0	0	2	9	2	9
2011	0	0	0	1	2	12	2	13
2012	0	0	0	1	5	13	5	14

Adapted from Office of the Chief Medical Examiner, State of Connecticut <http://www.ct.gov/ocme/cwp/view.asp?a=2165&q=295126>

While youth deaths by suicide are of great concern, equally concerning are the related depressive and suicidal thoughts, plans and attempts. As at the national level, CT youth reported concerning rates of suicide related thoughts and behaviors in the YRBS in 2011.

Figure 7.



Source: YRBS, 2011 data. <http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=CT>  
Accessed: March 23, 2014

Additionally, youth reported other serious suicide related behaviors<sup>7</sup>:

- 14.6% of all students reported having seriously considered attempting suicide during the past 12 months (11.9 % of males and 17.3% of females).
- 11 % of all students reported having made a plan about how they would attempt suicide during the past 12 months (9.8% of males and 12.2% of females).
- 6.7% of all students reported having actually attempted suicide one or more times during the last 12 months (5.2% of males and 8.2% of females).
- 2.8% of students reported having made a suicide attempt during the last 12 months that resulted in an injury, poisoning or overdose that had to be treated by a doctor or a nurse (3% of males; 2.5% of females).<sup>xxx</sup>

<sup>7</sup> See Appendix H for additional CT Youth Suicide Related Behaviors



Suicide prevention efforts for youth in Connecticut can focus on micro- and macro-level interventions:

- Broaden suicide prevention efforts to include a focus on prevention of suicide *and* on suicide related thoughts and behaviors that are often precursors to a fatal attempt.
- Provide psycho-education for family members and natural support systems.
- Educate that lethal means restrictions with youth will also include attention to the high-risk method for this population: asphyxia and hanging.
- Provide education and interventions regarding lethal means restriction.
- Increase awareness across the state of risk factors for youth.
- Promote suicide prevention training in all settings where youth congregate (schools, communities, houses of worship, and the like).
- Advocate for legislation and resources to ensure ready access to quality mental health services.
- Embed suicide prevention services and funds in youth programs.
- Develop specialized prevention programs for those youth in foster care and those who have contact with the juvenile justice system. These populations are almost four times more likely to attempt suicide.
- Consider the differences of suicide and related behaviors among youth related to other demographic characteristics such as gender, race/ethnicity and sexual orientation.
- Advocate for legislation that mandates annual suicide prevention training for middle schools and high schools.
- Provide timely outreach to communities after a suicide.
- Promote universal behavioral health screens including substance abuse and depression.
- Consider the development of a suicide prevention conference that addresses youth and young adults, with separate tracks for educators, peers, family members, researchers and direct service providers.
- Train school nurses and other school personnel in Youth Mental Health First Aid.
- Provide Question, Persuade, Refer (QPR) for Youth presentations.



### Young Adult/College Aged

Accurate data for suicide deaths in young adults is difficult to obtain because of the different age groupings used by reporting agencies. For example, the 2010 U.S. Official Final Report aggregates data for the 15 to 24 year old group, obscuring any differences between adolescents and young adults in morbidity and related factors. In Connecticut the OCME does report data for the 15 to 19 year olds and for the 20 to 24 year olds.

Table 4.

Connecticut Suicide Frequency and Rate by Age and Gender, Late Adolescent and Young Adult 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
15 to 19	5	4.0	13	9.95	18	7.04
20 to 24	6	5.4	11	9.26	17	7.43

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.

Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

College student data is derived from the American College Health Association/National College Health Assessment (ACHNA/NCHA) Undergraduate Survey (2012). Students reported the following occurrences within the prior 12 months: 44.6% had feelings of hopelessness; 85.2% felt overwhelmed; 56.6% felt very lonely; 59.5% felt very sad; 29.5% felt so depressed it was difficult to function; 49.9% felt overwhelming anxiety; 6.9% seriously considered suicide; 5.5% intentionally cut, burned, bruised or injured themselves; and 1.2% attempted suicide.<sup>xxxi</sup> Additionally, students reported significant difficulty handling academics, finances, intimate relationships and family problems. Furthermore, young adults have the highest rate of treatment for intentional self-injury of all groups. College students with particular needs include those with mental health problems, prior suicide attempts and bereavement by suicide, veterans and active duty students, Hispanic/Latino students and LGBT students.

Programs such as CT Healthy Campuses Initiative, JED Foundation, QPR (Question, Persuade, Refer), Jordan Matthew Porco Healthy Check and the Garrett Lee Smith Grants make it possible to develop programs and provide services for those young adults who are in the educational systems across the state. Young adults who are veterans or active duty military may be identified through DMHAS Military Support Program and Veterans Administration programs. It may be more challenging to reach those young adults who are neither college nor military connected and may have increased rates of unemployment and other challenging life conditions. Pilot data (2002) from the National Violent Death Reporting System found that most 18 to 24 year olds who died by suicide were not students and were as likely to be high school drop-outs or in trouble with the law as to be college students.<sup>xxxii</sup>

Suicide prevention efforts for this population can include, in addition to more universal efforts, the following:

- 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 technology 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 custody.
- Utilization of the seven strategies referenced in the Jed Foundation Suicide Model for Comprehensive Mental Health Promotion and Suicide Prevention for Colleges and Universities.
- Provide QPR Training (Question, Persuade, Refer) for those working with this age group.
- Encourage the development of peer-run groups on campus, such as Active Minds.
- Develop e-blasts of resources available in CT that address the continuum of services and programs available for young adults to campus leaders.

### *Middle-Aged Persons*

National suicide rates for middle-aged men have increased disproportionately since the 1990s and this is currently the highest risk age/gender group. According to the 2012 National Strategy, men in this cohort share universal risk factors, but may have additive risk related to the under-reporting of mental health problems, avoidance of help-seeking, involvement in interpersonal violence, economic hardship related to the recent recession and attendant longer term unemployment, and disruption of intimate relationships.<sup>xxxiii</sup> At the same time, rates for middle-aged women have not shown the same consistent pattern.

Table 5.

Connecticut Suicide Frequency and Rate by Age and Gender  
for Middle Aged Adults 2012

Age Range	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
35 to 44	17	7.2	56	25.04	73	15.92
45 to 54	21	7.2	71	25.72	92	16.24
55 to 64	17	7.0	41	18.16	58	12.41

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 6.

Connecticut Suicide Frequency of Middle-Aged Persons  
by Gender, 2006–2012

	Ages 30 -39		Ages 40-49		Ages 50-59	
	F	M	F	M	F	M
2006	6	45	15	43	17	48
2007	5	28	14	54	12	40
2008	10	36	17	58	21	50
2009	9	47	0	49	24	58
2010	10	34	23	71	16	63
2011	13	37	21	71	19	68
2012	12	44	19	75	22	54

Source: <http://www.ct.gov/ocme/cwp/view.asp?a=2165&q=295126>  
Retrieved 5/22/2014.

Suicide prevention efforts can focus on the following areas:

- Consider public health campaigns targeted to reduce stigma associated with male help-seeking for mental health and substance abuse issues.
- Increase referral and service availability in employer settings.
- Increase training of primary care physicians.
- Develop creative strategies for engaging middle-aged men in treatment.
- Train and counsel professionals, family members and communities for lethal means restriction.
- Greater consideration of the role of job and financial strain as risk factors for suicide, consistent with emerging research.

### Older Adults

While all age groups share some risk factors for suicide, older adults have several additional or exacerbating factors including: comorbid general medical conditions that significantly limit functioning or life expectancy, and pain and declining role function; for example, loss of independence or sense of purpose; social isolation, inflexible personality or marked difficulty adapting to change; medication abuse or misuse; and impulsivity in the context of cognitive impairment.<sup>xxxiv</sup> Furthermore, their social isolation may make them less likely to be rescued and their most frequent choice of method, firearm (67%), is more apt to result in a fatality. For every completed suicide among older adults, an estimated two to four attempts occur, while in younger adults the ratio of completed suicide to attempts may be as high as 200 to 1.<sup>xxxv</sup> Research has shown that 58% of older adults who die by suicide have seen a primary care provider within the last month of their life.<sup>xxxvi</sup> Specialized training for geriatricians and primary care physicians is essential.

The Administration on Aging and the Substance Abuse and Mental Health Services Administration (SAMSHA) recommend universal, selective and indicated prevention efforts by aging service providers; mental health providers and primary health care providers.<sup>xxxvii</sup> These may include:

- Providing systematic outreach to seniors at elevated risk due to widowhood or social isolation.
- Introducing depression and suicidality screening in non-clinical activities such as senior transportation, senior daycare and senior companionship.
- Providing gatekeeper training to aging service providers and laypersons.
- Routine screening for suicide and mental health conditions in primary care.
- Implementing best practices for diagnosis and treatment for late life depression.<sup>xxxviii</sup>
- Training and counseling for lethal means restriction.

### Race/Ethnicity<sup>9</sup>

There are significant differences among racial/ethnic groups in rates of suicide nationally. In Connecticut, where overall numbers of suicide are relatively low, and numbers even smaller when divided by race and ethnicity, data must be considered with caution. While the 2012 suicide rates range from 12.35 for Whites (N=315), the lowest rate was for Asian/Pacific Islanders (N=7). According to this data, American Indian/Native Americans have a high rate at 10.88, but this is the result of one death in this group in 2012.

Table 7.

Number and Rate of Suicides in Connecticut 2006 to 2012 by Race

Year	White n	White Rate	Black n	Black Rate	American Indian/Native American n	American Indian/Native American Rate	Asian/ Pacific Islander n	Asian/ Pacific Islander Rate	Hispanic n	Hispanic Rate
2006	228	8.62	10	2.94	0	0	6	4.91	12	3.05
2007	218	8.31	9	2.64	0	0	1	.81	20	4.96
2008	258	9.90	11	3.23	0	0	6	4.78	20	4.77
2009	262	10.09	18	5.20	0	0	6	4.57	22	5.06
2010	285	11.04	17	4.75	0	0	12	8.30	26	5.40
2011	328	12.77	16	4.43	1	11.07	5	3.38	17	3.44
2012	315	12.35	12	3.29	1	10.88	7	4.54	27	5.29

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14. Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

<sup>9</sup> Please note: The terms used to describe various ethnic/racial groups reflect the language typically used in national data sets and research. There may be geographic differences in the use of various terms.

## Blacks

In 2010, the suicide rates for Blacks (5.37) was slightly less than half that of the overall United States rate (12.08), was the sixteenth leading cause of death for Blacks of all ages and the third leading cause of death for Black males ages 15 to 24. There are, however, significant differences in rates among age<sup>xxxix</sup> groups in the Black population. For example, Black men ages 25 to 34 have the highest rate at 16.43. Furthermore, the average age of Black suicide decedents is 32, compared to that of White decedents at 44. This has significant impact on the Black community. Black women have historically had the lowest rates of suicide at 1.85 with a range of 2.08 for 15 to 24 year olds and 2.6 for 35 to 64 year olds. The data is complicated by the fact of rates of .77 for women aged 65 to 84 and 1.09 for those 85 or over, both with total numbers of deaths too low for precision.

In spite of relatively low rates of suicide deaths, Black adults 19 and older report similar rates of suicidal behavior compared to other United States adults. There are ethnic differences as well; adult Caribbean Blacks have a higher suicide rate than African-Americans, but among adolescent males, African American Blacks were nearly five times more likely than Caribbean Blacks to make an attempt. There have been attempts to explain the relatively lower rates by which Blacks die by suicide. What is known is that for women, having a strong sense of Black identity appears to confer some protection; religion, social and emotional support seem to play a crucial role for both Black men and women.<sup>xi</sup>

- In Connecticut 10.1 percent of the population (362,296 people) identified as Black or African American in the 2010 Census.<sup>xii</sup>
- Suicide prevention efforts can be tailored to Connecticut's Black population through:
  - Adoption of general prevention strategies.
  - Increasing understanding of ethnic-specific risk and protective factors.
  - Prevention strategies developed with particular attention to strengthening existing protective factors.
  - Co-develop suicide prevention efforts with faith-based communities.
  - Develop culturally congruent practices for prevention and interventions.

## Hispanic/Latino

According to 2010 data, the suicide rate (5.85) for Hispanics of all ages is slightly less than half of the overall U.S. population (12.08), the twelfth leading cause of death for Hispanics of all ages, and the third leading cause of death for Hispanic males ages 15 to 34.<sup>xiii</sup> The highest rate is for Hispanic males age 85 and over (30.58) and the lowest at 10.69 for ages 15 to 24. Rates for Hispanic women range from a high of 8.21 for ages 35 to 64 to a low of 3.27.

There are also ethnic variations in this broad group of Hispanics with Puerto Ricans having the highest rates of suicide attempts. There has been an increase in lifetime prevalence of suicide attempts among 18 to 24 year old Puerto Rican women and Cuban men, and among 45 to 64 year old Puerto Rican men.<sup>xiiii</sup>

Immigration is also implicated in differences related to immigration status. For example, U.S. born Hispanics have higher rates of suicidal ideation and suicide attempts than Hispanic immigrants. Immigrating as a child rather than as an adolescent or adult appears to result in higher suicide risk. Similarly, U.S. born Hispanic adolescents who have U.S. born parents have a higher risk of suicide attempts than their counterparts with

immigrant parents.<sup>xiv</sup> Hispanics who died by suicide had the second highest rate of alcohol use among racial/ethnic groups during an attempt and 28% were intoxicated at the time of their suicide death.

In the U.S. 2010 Census reports for Connecticut, 13.4% of the population (479,087) identified as Hispanic or Latino, making this the highest ethnic/racial population.

In addition to suicide prevention strategies provided universally, suicide prevention strategies for Hispanic populations can include the following:

- Attention to unique protective factors, such as familism, ethnic affiliation, religiosity and moral objections to suicide; and for youth, caring from teachers<sup>xv</sup> and other trusting adults, including parents and family members.
- The development of strategies that target specific risk factors such as alcoholism, underutilization of mental health services and greater likelihood of not seeking or receiving mental health services when needed.
- Develop strategies to address specific risk factors associated with a suicidal crisis: alienation; acculturative stress and family conflict; hopelessness and fatalism; and discrimination.
- Better understand the issues related to relatively high rates of non-suicidal behaviors.

#### *American Indians/Alaskan Natives (AI/AN)*

Nationally, the suicide rate for American Indians/Alaskan Natives (16.93) is much higher than for the total U.S. population (12.08 per 100,00). It is the leading cause of death for all AI/AN and the second leading cause for youth ages 10 to 24.<sup>xvi</sup> Youth are at particular risk, with rates that decrease significantly after early adulthood, in contrast to the overall U.S. population where rates increase with age. The CDC recently (2013) found, however, that AI/AN men and women ages 35 to 64 had a greater percentage increase in suicide rates between 1999 and 2010 than any other racial/ethnic group. Notably, rates increased for women at 81.4% and for men at 59.5%. Rates vary dramatically between tribes.

In Connecticut, in the 2010 U.S. Census<sup>xvii</sup>, .3% of the population (11,256) identified as American Indian or Native American<sup>xviii</sup> and it is unclear how many live within or have strong association with tribes. Given this relatively small population and two reports of suicide deaths by the OCME from 2006 to 2011, it is difficult to make meaningful observations about the suicide rate in this population. Nevertheless, nationwide, several risk factors specific to this population have been identified, including: historical trauma, alienation, acculturation, discrimination, community violence, low patterns of mental health service access and use, and contagion.<sup>xix</sup>

In addition to universal statewide suicide prevention strategies, efforts can be focused in the following ways:

- Actively recruit tribal leaders and tribal mental health and wellness practitioners and youth for involvement in the CTSAB.
- Provide outreach consultation services to tribal leaders.
- Strengthen data surveillance procedures and reporting.
- Use media campaigns that focus on both risk and protective factors for this population.



### *Asians, Pacific Islanders and Native Hawaiians*

Asians (which include persons with origins in the Far East or Southeast Asia) are often combined in the mortality data sets and comprise 4.8% of the U.S. population. The category of Pacific Islanders includes people with origins from Hawaii, Guam, Samoa and other Pacific Islands. This category comprises 0.2% of the U.S. population.<sup>i</sup>

According to the 2010 U.S. Census, in Connecticut, 3.8% of the population identified as Asian, for a population of 135,565. The largest of these groups was Asian Indian at 46,415. Six other Asian groups have populations less than 1.0% and it should be noted that this is a diverse group, with different histories, reasons for immigration or refuge, and cultures.

Asians have a suicide rate approximately one-half that of the overall U.S. rate of 12.08 per 100,000 and suicide was the tenth leading cause of death for Asians/Pacific Islanders and the second leading cause of death for youth ages 15 to 24.<sup>ii</sup> In the U.S. for this population of males, the rate is generally comparable from ages 15 to 24 (10.41 per 100,000) to ages 35 to 64 (11.45 per 100,000). The highest risk group are older adult men at 29.76 per 100,000, but the numbers of death are low, making precision difficult. The lifetime prevalence of suicidal ideation and attempts are lower than in any other ethnic group. Asians who immigrated to the U.S. as children have higher prevalence rates of both suicide and suicidality than those born in the U.S. 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.<sup>iii</sup> Further research is required to fully understand the discrepant rates depending upon age at immigration and what role acculturation and family expectations may play.

Of particular concern are the findings that Asian and other Pacific Islander high school students have reported higher rates of suicidal behaviors than the general population of high school students.<sup>iiii</sup> Asian female students appear to be at increased risk, reporting higher rates of suicidal thoughts and behaviors than their male counterparts and white males and females. Importantly, about 62% of Asians who attempted suicide reported that their first attempt occurred when they were under age 18, highlighting the vulnerability for this group in adolescence.<sup>iv</sup>

There are documented protective factors for Asians and Pacific Islanders, which include: cultural identification and sense of belonging and affiliation, associated with a 69% reduction in the risk of suicide attempts<sup>v</sup> and strong family cohesion, organization and parental belonging. Cohort-specific risk factors include high levels of family conflict, such as witnessing family violence, and among college students, parent-child conflict. Immigrant Asian populations may have problems navigating mental health systems secondary to discrimination and language proficiency issues. Both college students and adults who perceive discrimination report higher rates of suicidal ideation and attempts.<sup>vi</sup>

In addition to universal statewide prevention efforts, the following targeted efforts can be utilized:

- Consider the “model stereotype” mentality (that Asian-Americans are “naturally smart,” wealthy and successful, for example) as a risk factor that may prevent Asians and their families from seeking help—and may prevent providers from accurately assessing their needs.
- Make available translation services at all ends of the prevention services spectrum.
- Provide outreach to the Asian communities with suicide prevention awareness materials that are culturally appropriate.
- Develop practitioner expertise in culturally competent practice.

- Where available, work with community health workers who may have specialized cultural understandings.
- Recruit young adult and adolescents to an advisory board of the CTSAB.

### *Lesbian, Gay, Bisexual, and Transgender (LGBT)*

Estimates of the prevalence of gay, lesbian and transgender people is also imperfect, due in large part to differences in definitions of classification/identification or behavior. Attempts to ascertain the scope of risk for suicide by LGBT persons is hindered by the lack of data sources that include sexual orientation or identity. For example, the U.S. death certificate and the reporting system, NVDRS, do not include this information and we do not know if LGBT people are more likely to die by suicide. Research has then relied on the psychological autopsy, a labor intensive method of gaining an understanding of the reasons an individual died by suicide. There has not, however, been unequivocal evidence from these studies that there was a disproportionate risk of death by suicide.

The data on suicidal thoughts and behaviors is more reliable. There is strong evidence from population based studies that being gay, lesbian or bisexual confers elevated risk for suicide attempts,<sup>lvii</sup> particularly, but not exclusively, for youth. Consider the following results from several meta-analyses of studies:<sup>lviii</sup>

Lifetime prevalence rates of suicide attempts in gay and bisexual male adolescents and adults are four times higher than comparable heterosexuals.<sup>lix</sup>

- Lifetime suicide attempts among lesbian and bisexual females are almost twice those of their heterosexual counterparts.<sup>lx</sup>
- Lesbian, bisexual and gay (LBG) youth were three times more likely than their heterosexual counterparts to report a suicide attempt in the past year.
- LGB youth were three times more likely to report a lifetime suicide attempt and four times more likely to report a medically serious attempt.<sup>lxi</sup>
- 12 to 19% of LGB adults report making a suicide attempt, compared to less than 5% of heterosexual adults.
- 30% of LBG adolescents report attempts, as opposed to 8 to 10% of their heterosexual counterparts.<sup>lxii</sup>

The limited research on suicide and transgender people is even more concerning with 41% of respondents to the 2009 National Transgender Discrimination Survey reporting lifetime suicide attempts.<sup>lxiii</sup>

Specific risk factors for this population may include the effects of “minority status” and discrimination at the personal, institutional and legal levels. It is argued that the elevated risk for suicide attempts is not a function of sexual orientation per se, but of negative responses to it.

Protective factors include family acceptance, a sense of safety, positive identity, connection to caring others, and access to quality and culturally competent mental health treatment.<sup>lxiv</sup>

In addition to general suicide prevention strategies, the following may be useful:

- Recruitment of adolescent, young adult and adult LGBT members to the CTSAB Board and/or Network.
- Develop alliance with True Colors for peer training for suicide prevention.



- Strengthen alliances with local schools regarding stigma and suicide prevention.

### *Military/Veterans*

Suicide rates for members of the military and veterans, historically lower than that of the general population, have been increasing significantly, nearly doubling from 2001 to 2009. As of 2010, the Army National Guard had the largest increase in total suicides, more than doubling the 2009 rate. The CDC now reports that veterans account for 20% of the suicides in the U.S. and are overrepresented in those recently returning from Iraq and Afghanistan and for those who receive Veterans Administration (VA) services.<sup>lxv</sup> In a study of veteran deaths between 2003 and 2008, 69% were caused by firearm, nearly always a fatal method.<sup>lxvi</sup> Half of all people who die by suicide in the Veterans Health Administration have a known mental health condition.

The Department of Defense (DOD) follows active duty/National Guard/Reserves while the VA follows those who have separated from the military. In 2007, the VA initiated an integrated approach to suicide prevention. The DOD developed the Defense Suicide Prevention Office in 2011 to oversee all development and implementation of suicide prevention strategies throughout the military.

The following are risk factors in military personnel, some of which 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 such as problem-solving; family history of mental disorders; and childhood adversities.<sup>lxvii</sup> The literature has increasingly focused on the role of deployment and combat exposure on suicide risk, about which there have been some conflicting findings. Future research needs to focus on the circumstances under which deployment raises suicide risk in military personnel and the complex relationships between mental health issues, suicidality and deployment.

Risk factors that may be exacerbated in military personnel include the following:

- The traumatic nature of combat exposure, specifically related to threats of improvised explosive devices.
- Prolonged and repeated deployments and uncertainties about tour extensions.
- New life-saving interventions that promote survival but leave individuals with high distress related to serious health issues and disfigurements.
- Effects of traumatic brain injury.

Specific protective factors may include:

- Social support and cohesion within one's unit.
- Positive contact with family and frequency of contact with spouse.
- Buffering effects of positivity.
- Post-traumatic growth in the aftermath of traumatic events.
- Available, quality, non-stigmatizing mental health treatment.

In addition to general suicide prevention strategies, the following may be useful:

- Collaboration between National Guard/Active Duty and VA services to ensure smooth transitions in care.
- Work to engage with families of active duty/veterans in order to educate about risk factors,

warning signs and how to access help in the various systems.

- Encourage use of peer support resources.
- Development of strategies to reduce stigma related to help-seeking.

### *Criminal Justice*

Suicide in jails and prisons in the U.S. is a significant public health problem. It is the leading cause of death in U.S. local jails and the fourth in state prisons. In 2010, there were 520 suicides in state prisons and local jails, according to the U.S. Bureau of Justice, at rates far above that of the general population. The majority of these deaths occur in inmates age 25 to 34 years of age, though the highest rates are among those 17 or younger and 55 or older.<sup>lxviii</sup>

Despite the lack of privacy and access to weapons, suicide is the third leading cause of death in prisons.<sup>lxix</sup> Corrections settings typically involve high monitoring and restriction to lethal means (sharp objects and drugs, for example), though the majority of suicides in prison are by hanging. In addition, it is theorized that jail suicides result from two primary factors: that the jail environment is conducive to suicide and that the inmate is in a crisis situation.<sup>lxx</sup>

Among individuals in the juvenile justice system it is reported that suicide rates are four times higher than in the general population.<sup>lxxi</sup> Additionally, it is reported that among suicide attempts reported by youth in juvenile facilities, 60% were violent attempts. Research suggests that more than half of all detained youth experience suicidal ideation and a third have a history of suicidal behaviors.<sup>lxxii</sup> In juvenile detention centers, there are 17,000 suicide related incidents each year; more than half of these juveniles report current suicidal ideation, and a third have a history of suicidal behaviors.<sup>lxxiii</sup>

Those with contact with criminal justice systems share risk factors with the general population, but may also have higher degrees of family discord and abuse, history of prior interpersonal conflict, prior involvement with special education services, legal and disciplinary problems, and prior offenses, among others. Significant relationships were found between suicide risk and traumatic experiences and substance abuse among young people in juvenile detention.

Protective factors among juvenile and adult inmates may include: a sense of control over one's destiny; problem solving and conflict resolution skills; adaptable temperament; support and connections from one's home and community; positive school experiences; religious beliefs that protect against suicide; and housing that is "suicide resistant" and proximal to staff.<sup>lxxiv</sup>, <sup>lxxv</sup> In addition, access to high quality mental health services that provide strong community referrals are protective.

There are different risks and protections afforded inmates in different kinds of settings and prevention efforts should address the continuum from pre-adjudication to incarceration, to probation and parole. Studies by the National Center on Institutions and Alternatives, commissioned by the Department of Justice, have issued a broad and specific set of recommendations for suicide prevention and intervention at the policy and direct services levels. A number of important recommendations, including screening and assessment, reassessment and attention to community reentry, are offered in the Mental Health Assessment in Juvenile Justice: Report on Consensus Conference.<sup>lxxvi</sup>

In Connecticut, where prisons and jails form one integrated system, a screen to determine inmates' level of risk for suicide, the Suicide Risk Assessment (HR-517), is administered to all inmates at intake to a CT correctional facility. Connecticut Department of Corrections (CDOC) direct contact employees are required to receive training in suicide prevention and related topics. In addition, the UConn Health Center

Correctional Managed Health Care policy details procedures for prevention and intervention.

In addition to the general suicide prevention strategies, the following can be recommended:

- Continued specific training for all corrections personnel.
- Strong mental health assessment and ongoing screening for suicidality.
- The availability and resourcing of high quality mental health and substance abuse services.
- “Suicide watch” protocols for those assessed at increased risk for suicide.
- A focus on the continuum from pre-adjudication to incarceration to probation and parole.

### *Mental Health/Substance Abuse*

Between 90% and 98% of people who die by suicide have a diagnosable mental health condition.<sup>lxxvii</sup> The existence of a psychiatric condition is second only to a prior suicide attempt as a major risk factor for dying by suicide. Comorbidity increases suicide risk. The most common mental health conditions associated with increased risk of suicide are depression and bipolar illness, followed by substance use, borderline personality and eating disorders. Those with schizophrenia have an attempt rate of 20 to 40% and 5% die by suicide.<sup>lxxviii</sup> There is a strong association between suicide fatality and post-traumatic stress disorder. It is important to note, however, that despite these risks, of those with a mental health diagnosis, 90% *do not* die by suicide.<sup>lxxix</sup> It then becomes important to identify which people are at the highest risk of suicidal thoughts and behaviors, while providing high quality and prompt treatment for the mental health condition that places them at elevated risk.

Given the strong association between mental health conditions and suicidal thoughts and behaviors, recommendations for suicide prevention mirror those for good mental health and substance abuse treatment:

- High quality and highly accessible mental health and substance abuse treatment.
- Focus on a recovery model that values the individual and optimizes symptom reduction and promotes optimal functioning.
- Ongoing training for mental health professionals and paraprofessionals in all settings.
- Increase in availability of Mental Health First Aid and Youth Mental Health First Aid Training.
- Development of culturally competent services.
- Increase linkages with faith-based organizations.
- Provide wrap-around services that address substance abuse problems.
- Consider alcohol and drugs to be lethal means for some addicted persons and others.
- Follow regional trends in “drugs of choice,” such as heroin, that may be implicated in intentional overdoses, and develop targeted strategies for prevention.

### *People with Chronic Health Conditions and Disabilities*

Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system,

traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.<sup>lxxx</sup> In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality.

Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.<sup>lxxxi</sup>

Until recently, the CTSAB was considering assisted suicide of the terminally ill as a separate issue from suicide prevention. The active disability community in Connecticut, however, 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. Peace (2012) 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.”<sup>lxxxii</sup> People with disabilities have a right to responsive suicide prevention services. The CTSAB intends to continue to explore the needs of the disability community for such services.

#### Targeted Recommendations:

- Develop greater scrutiny of someone’s intentions to die.
- Identify and train practitioners to develop expertise in the work with disabled people who are suicidal.
- Do not “assume” suicide is a “rational” response to disability.
- Treat mental health conditions as aggressively as with a person without disability.
- CTSAB should encourage and increase participation from the disability community and encourage educational presentations.

## Charting the Future: Measuring Our Progress

The overarching goal of any suicide prevention plan is the elimination and reduction of suicide and suicide related behaviors. The PLAN 2020 includes targeted outcomes for 2020. All targets are derived from the analysis of current data. We are tracking one measure of suicide (deaths) and one measure of medically serious attempts (as measured by hospitalization for self-injury). Both measures can be tracked consistently and reliably annually and by demographic group. We have adopted a target of a 10% reduction by 2020, which is in alignment with the mental health goals of Healthy People 2020. Thus, the 2020 targets for the reduction of deaths by suicide is a reduction from the 2012 rate of 10.14 to a 2020 rate of 9.13. We have determined a target of a 10% reduction of hospitalizations for self-injury from 2014 to 2020.<sup>10</sup>

## Summary and Conclusions

The impact of suicide and suicidal behaviors have far-reaching implications for individuals, their families, friends and communities. In 2012, more than an average of one person per day died by suicide in Connecticut and thousands more were left to mourn and carry on in the face of devastating loss. As staggering as these losses are, there is hope. Globally, the World Health Organization and in the U.S., the National Action Alliance for Suicide Prevention have pioneered comprehensive suicide prevention strategies

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<sup>10</sup> See Appendix I for tables of current hospitalization data

that have mobilized efforts in many domains. Suicide is now being recognized not only as a mental health issue but as a public health challenge.

Here in Connecticut, through Plan 2020, we have highlighted the commitment and priorities of many stakeholders—survivors, providers, and public and private agencies—to come together to reduce both self-injury and deaths by suicide in the state. Our overarching goal and outcome is to realize a 10% reduction in suicide deaths and in non-fatal suicide attempts (as measured by hospitalization rates) by 2020. Through a multipronged and inclusive 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 health care services.
- GOAL 4: Promote efforts to 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.

We offer Plan 2020 as a working document. It is our hope that individuals and communities, private and public agencies, schools, universities and community organizations will use it as a framework for developing their own suicide prevention activities. Tailoring these goals and objectives for both special populations and settings ensures a targeted approach, best suited to both general and specialized intervention efforts. As such, we have included with each goal and objective examples of possible interventions.

The Connecticut Suicide Advisory Board (CTSAB), under the direction of Co-Chairs Andrea Duarte of the CT Department of Mental Health and Addiction Services and Tim Marshall of the CT Department of Children and Families, will continue to disseminate best practice knowledge, set priorities for clinical workforce development and address emerging needs for suicide prevention in the state of Connecticut.

The CTSAB believes that **suicide is preventable** through sustained attention, resources, collaboration and commitment from all sectors of our public and private agencies and our communities.

As 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.

## APPENDIX A

### Glossary

**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.

**Behavioral health**—A state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support.

**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.

**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.

**Community**—A group of individuals residing in the same locality or sharing a common interest.

**Comorbidity**—The co-occurrence of two or more disorders, such as depressive disorder and substance use disorder.

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

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

**Contagion**—A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

**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, including 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.

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



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

**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; it focuses on the end result of the work.

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

**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.

**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.

**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**—A blanket term that refers to those who identify as lesbian, gay, bisexual or transgender.

**Means**—The instrument or object used to carry out a self-destructive act; for example, chemicals, medications, illicit drugs.

**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**—The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

**Mental health services**—Health services that are specifically designed 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 high levels of chronic stress experienced by members of minority populations (including lesbian, gay, bisexual or transgender populations) as a result of the prejudice and discrimination they experience from the dominant group in society.

**Mood disorders**—Persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states or, if in the opposite direction, depressed emotional states. These disorders include depressive disorders, bipolar disorders, mood disorders because of 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.

**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.

**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).

**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 individuals that is attributable to an intervention.

**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.

**Postvention**—Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

**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.

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



**Psychiatric disorder**—See mental disorder.

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

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

**Risk factors**—Factors that make it more likely that an individual will develop a disorder. Risk factors may encompass biological, psychological or social factors in the individual, family and environment.

**Safety plan**—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 (for example, questionnaires, checklists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

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

**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.

**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.

**Substance use disorder**—A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes 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 ideation**—Thoughts of engaging in suicide-related behavior.

**Suicidal intent**—When a person intended to kill him or herself or wished to die and that the individual 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. —There is evidence (explicit and/or implicit) that at the time of injury the individual

**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-directed injurious behavior with any intent to die as a result of the behavior.

**Suicide attempt**—A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

**Suicide attempt survivors**—Individuals who have 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.

**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 physically and/or legally transition from one sex to another.

**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).

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 health care
- 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 health care providers

##### **Individual:**

- Coping and problem solving skills
- Reasons for living (for example, 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 health care (for example, 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

I	<b>Ideation</b>
S	<b>Substance Abuse</b>
P	<b>Purposelessness</b>
A	<b>Anxiety</b>
T	<b>Trapped</b>
H	<b>Hopelessness</b>
W	<b>Withdrawal</b>
A	<b>Anger</b>
R	<b>Recklessness</b>
M	<b>Mood Changes</b>

### Warning Signs: IS PATH WARM?<sup>11</sup>

A person in acute risk for suicidal behavior most often will show:

Warning Signs of Acute Risk:

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.
- These might be remembered as expressed or communicated ideation. If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

Additional Warning Signs:

- Increased **substance** (alcohol or drug) **use**
- No reason for living; no sense of **purpose** in life
- **Anxiety**, agitation, unable to sleep or sleeping all the time
- Feeling **trapped**, like there's no way out
- **Hopelessness**
- **Withdrawal** from friends, family and society
- Rage, uncontrolled **anger**, seeking revenge
- Acting **reckless** or engaging in risky activities, seemingly without thinking
- Dramatic **mood changes**.

These warning signs were compiled by a task force of expert clinical-researchers and “translated” for the general public. The **origin of IS PATH WARM?**

If you know someone who exhibits warning signs of suicide:<sup>12</sup>

- Do not leave that person alone and remove any objects that can be used in a suicide attempt
- Call the US National Suicide Prevention Lifeline at 800-273-TALK(8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

<sup>11</sup> <http://www.suicidology.org/resources/warning-signs>

<sup>12</sup> 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

## APPENDIX D

### Suicide Prevention Resources

#### **American Association of Suicidology (AAS)**

[www.suicidology.org](http://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](http://www.afsp.org)

AFSP funds research and offers educational programs and resources for professionals, survivors of suicide loss and the public. With the Suicide Prevention Resource Center, AFSP coproduces the Best Practices Registry (BPR) for Suicide Prevention. AFSP's Public Policy Division, SPAN USA, promotes and keeps track of policies and legislation related to suicide prevention. AFSP chapters provide connections to local resources and services addressing suicide prevention. The chapters also organize awareness events.

#### **American Foundation for Suicide Prevention: LGBT Initiative**

<https://www.afsp.org/content/search?SearchText=LGBT+SUICIDE+INITIATIVE>

This initiative works on suicide prevention among the LGBT population in a number of ways, 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.

#### **The Jed Foundation**

[www.jedfoundation.org](http://www.jedfoundation.org)

The Jed Foundation works to promote emotional health and prevent suicide among college and university students. The Jed Foundation's programs include: ULifeline, an online resource that gives students access to campus-specific resources and allows them to take an anonymous mental health screening; the Half of Us campaign with mtvU, which uses online, on-air, and on-campus programming to encourage help-seeking; Love is Louder, a movement online and in communities to build connectedness and increase resiliency; and more.

#### **Jordan Matthew Porco Memorial Foundation**

<http://www.rememberingjordan.org/mission/>

Our goal is to help prevent suicide among the college age student population by increasing awareness, identifying resources available to students, helping friends and family recognize the warning signs of depression, encouraging at-risk persons to seek out help, and providing financial support to those organizations and programs dedicated to suicide prevention.

#### **Means Matter, Harvard School of Public Health**

[www.hsph.harvard.edu/means-matter](http://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](http://www.actionallianceforsuicideprevention.org/NSSP)

The National Strategy for Suicide Prevention provides the framework for suicide prevention for the United States. First published in 2001 and then updated in 2012, 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 Alliance on Mental Illness**

[www.nami.org](http://www.nami.org)

National Alliance on Mental Illness (NAMI) is a membership organization dedicated to building better lives for Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research. It sponsors awareness events, provides training about mental illness and sponsors the NAMI Helpline—a phone crisis line. NAMI has state organizations and local affiliates across the United States.

### **National Guard/Reserve**

[http://www.army.mil/standto/archive\\_2014-09-18/](http://www.army.mil/standto/archive_2014-09-18/)

The website for the National Guard's suicide prevention program features a six-part film on resilience among National Guard personnel. Other resources include a media gallery, a list of military and nonmilitary organizations with information on suicide, and news stories from National Guard leadership and other branches of the military.

### **National Institute on Alcohol Abuse and Alcoholism, NIH, HHS**

[www.niaaa.nih.gov](http://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, NIH, HHS**

[www.nida.nih.gov](http://www.nida.nih.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](http://www.nopcas.org)

NOPCAS addresses suicide prevention, intervention, and postvention in communities of color. NOPCAS provides professional development and culturally appropriate training for lay and professional audiences as well as sponsoring survivor/bereavement support groups. It also provides the online crisis intervention network entitled “I’m Alive,” staffed by certified volunteers, and a speakers bureau.

### **National Strategy for Suicide Prevention**

[www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html)

This is the product of a unique public/private partnership through the National Action Alliance for Suicide Prevention. It outlines the goals and objectives for the national suicide prevention efforts.

### **National Suicide Prevention Lifeline (Lifeline)**

[www.suicidepreventionlifeline.org](http://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 also provides informational materials featuring the phone number, such as brochures, wallet cards and posters.

### **National Violent Death Reporting System (NVDRS) Centers for Disease Control and Prevention (CDC), HHS**

[www.cdc.gov/injury/wisqars/nvdrs.html](http://www.cdc.gov/injury/wisqars/nvdrs.html)

NVDRS is a surveillance system that links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state in designing and implementing tailored prevention and intervention efforts, including for suicide. NVDRS also pools these data to better depict the scope and nature of violence.

### **Samaritans USA**

[www.samaritansusa.org](http://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.

### **State of Connecticut Department of Mental Health and Addiction Services (DMHAS) Suicide Prevention and Mental Health Promotion Initiatives**

<http://www.ct.gov/DMHAS/cwp/view.asp?a=2912&q=335130>

The goal of the CCSPI is to bring sustainable evidence-based, suicide prevention and mental health promotion policies, practices and programs to scale at institutions of higher education statewide for students up to age 24. The project is a collaborative effort involving DMHAS and the CT Departments of Children and Families (DCF), Public Health, Higher Education, Veterans Affairs, and the CT State University System, CT Community College System, University of CT Health Center, True Colors, Multicultural Leadership Institute, United Way of CT, Wheeler Clinic and the Veterans Administration CT Healthcare System.

### **State of Connecticut Suicide Prevention**

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

One Word, One Voice, One Life multimedia campaign. This campaign seeks to “start the conversation” with community or campus members about suicide prevention and mental health promotion by engaging them to consider how they would start the conversation with someone they believe is at risk.

### **Substance Abuse and Mental Health Services Administration, HHS**

[www.samhsa.gov](http://www.samhsa.gov)

SAMHSA funds and supports the National Lifeline and Suicide Prevention Resource Center and manages the Garrett Lee Smith grant program, which funds state, territorial and tribal programs to prevent suicide among youth.

### **Suicide Prevention Resource Center (SPRC)**

[www.sprc.org](http://www.sprc.org)

ASPRC is a SAMHSA-funded, national center that helps strengthen the efforts of state, tribal, community and campus suicide prevention organizations and coalitions and organizations that serve populations with high suicide rates. It provides technical assistance, training, a variety of resource materials, a current awareness newsletter (The Weekly SPARK) and a searchable online library.



## **Suicide Prevention Resource Center (SPRC) and American Foundation for Suicide Prevention (AFSP)**

[www.sprc.org/bpr](http://www.sprc.org/bpr)

This registry contains approximately 100 suicide prevention programs, including student curricula and peer leader programs, gatekeeper trainings, and trainings for health and mental health professionals. The registry is organized into three sections. Section I: Evidence-Based Programs lists interventions that have undergone evaluation and demonstrated positive outcomes. Most of these are the suicide prevention programs in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).

## **TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, 2009**

<http://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA09-4381>

### **Video companion:**

[www.store.samhsa.gov/product/Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/VA10-TIP50](http://www.store.samhsa.gov/product/Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/VA10-TIP50)

TIP 50 provides direct practice tools and strategies for identifying those at risk. Also contains information on how substances may affect clinical presentation.

## **Tragedy Assistance Program for Survivors**

[www.taps.org](http://www.taps.org)

Tragedy Assistance Program for Survivors (TAPS) provides information and services to those who have suffered the loss of a military loved one due to any cause. It offers webinar-based courses, six of which concern suicide, for mental health professionals. Other resources include crisis services, online support groups, seminars for survivors, and the Good Grief Camp for children grieving the loss of a loved one in the military.

## **The Trevor Project**

[www.thetrevorproject.org](http://www.thetrevorproject.org)

This national organization focused on crisis and suicide prevention among lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth provides a 24-hour, toll-free, crisis intervention phone line (1-866-488-7386); an online, social networking community for LGBTQ youth aged 13 to 24 and their friends and allies; educational programs for schools; and advocacy initiatives.

## **U.S. Department of Defense Suicide Prevention Website**

<http://www.health.mil/Military-Health-Topics/Conditions-and-Treatments/Suicide-Prevention>

This website provides information on recognizing symptoms of those at risk for suicide, links to suicide prevention in each branch of the military, and a list of outside organizations that can provide information and assistance.

## **U.S. Department of Defense/U.S. Department of Veterans Affairs Suicide Outreach**

[www.suicideoutreach.org](http://www.suicideoutreach.org)

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.

## **Web-Based Injury Statistics Query and Reporting System (WISQARS) CDC, HHS**

[www.cdc.gov/injury/wisqars](http://www.cdc.gov/injury/wisqars)

This 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.



## APPENDIX E

### Additional Gender and Age Data

Table 8.

Number of Suicides in Connecticut Total and by Gender 2006–2012

Year	Female	Male	Total
2006	45	212	257
2007	43	207	250
2008	66	230	296
2009	73	235	308
2010	74	268	342
2011	84	283	367
2012	93	271	364

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 9.

Number and Rate of Suicides in Connecticut Total and by Gender 2006 to 2012

Year	Female Number	Female Rate	Male Number	Male Rate	Total Number	Total Rate
2006	45	2.50	212	12.40	257	7.32
2007	43	2.40	207	12.13	250	7.14
2008	66	3.68	230	13.47	296	8.45
2009	73	4.05	235	13.68	308	8.75
2010	74	4.03	268	15.40	342	9.57
2011	84	4.58	283	16.22	367	10.25
2012	93	5.05	271	15.49	364	10.14

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics. Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 2/2/14.  
Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 10.

## Connecticut Suicide Number and Rate by Age and Gender 2012

Age Range	Female Number	Female Rate	Female Target Rate 2020	Male Number	Male Rate	Male Target Rate 2020	Total Number	Total Rate	Total Target Rate 2020
10 to 24	11	3.15	2.84	25	6.77	6.09	36	5.01	4.51
25 to 64	63	6.40	5.76	207	21.95	19.76	270	14.01	12.61
65 and older	18	5.89	5.30	39	17.18	15.47	57	10.70	9.63

Source: State of Connecticut, Department of Public Health. Annual State Population with Demographics.

Retrieved from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>; Accessed 7/6/13 and 2/2/14.

Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

## APPENDIX F

### Additional Method of Suicide Data

Table 11.

Method of Suicide in CT 2012 (n=364)

Method of Suicide	n	Percent
Hanging/Strangulation	133	36.5
Gunshot	107	29.4
Substance Overdose	50	13.7
Suffocation	22	6.0
CO Poisoning	15	4.1
Incision/Cut	10	2.7
Jump	9	2.5
Drowning	6	1.6
Train	6	1.6
Motor Vehicle	4	1.1
Other	2	.5

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 12.

## Method of Suicide in Connecticut 2012 by Gender (n=)

Method of Suicide	n	Percent
Hanging/Strangulation	31.2	38.4
Gunshot	10.8	35.8
Substance Overdose	33.3	7.0
Suffocation	8.6	5.2
Jump	5.4	1.5
CO Poisoning	2.2	4.8
Drowning	3.2	1.1
Incision/Cut	2.2	3.0
Train	1.1	1.8
Motor Vehicle	1.1	1.1
Other	1.1	.4

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

Table 13.

## Primary Methods of Suicide in Connecticut 2006–2012

Year	Hanging/ Strangulation	Gunshot	Substance Overdose	CO Poisoning	Suffocation
2006	85	78	39	12	19
2007	96	71	46	7	8
2008	109	106	36	16	8
2009	111	95	44	20	12
2010	127	105	48	10	9
2011	130	112	54	25	7
2012	133	107	50	15	22
Total	791	674	317	105	85

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

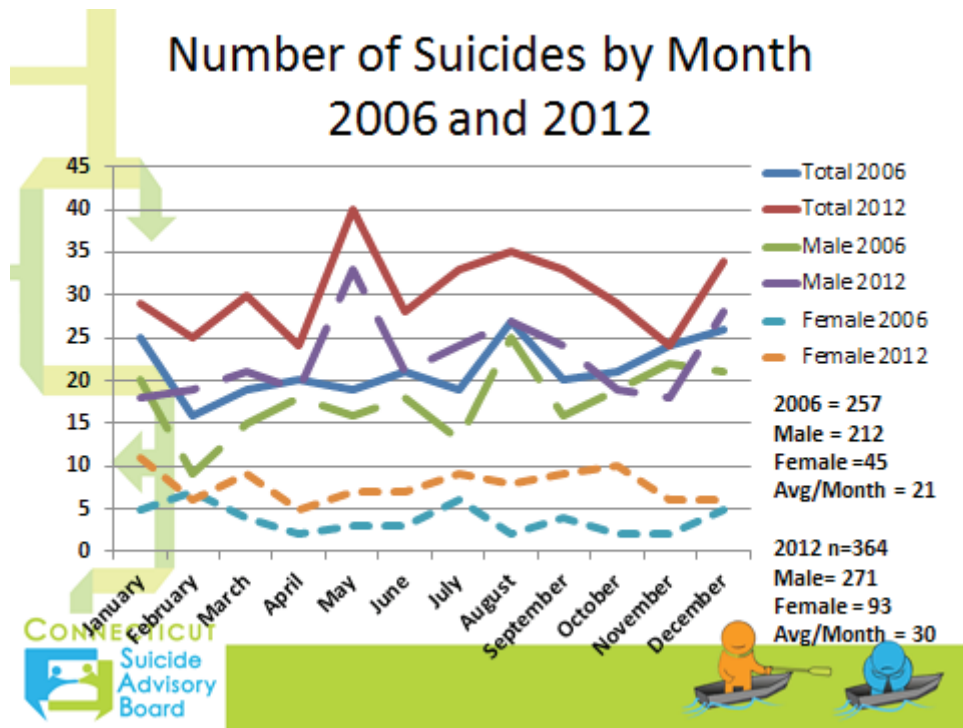
Table 14.

## Primary Methods of Suicide in Connecticut by Age 2012

Year	Hanging/ Strangulation	Gunshot	Substance Overdose	CO Poisoning	Suffocation
10–14	0	1 (100)	0	0	1
15–19	12 (66.7)	2 (11.1)	0	4 (22.2)	18
20–24	8 (47.0)	4 (23.5)	2 (11.8)	3 (17.6)	17
25–34	19 (40.4)	12 (25.5)	5 (10.6)	11 (23.4)	47
35–44	29 (39.7)	17 (23.3)	12 (16.4)	15 (20.5)	73
45–54	30 (32.6)	26 (28.3)	15 (16.3)	21 (22.8)	92
55–64	27 (46.6)	16 (27.6)	9 (15.5)	6 (10.3)	58
65–74	6 (17.6)	16 (47.0)	5 (14.7)	7 (20.6)	34
75 and older	2 (8.7)	12 (52.2)	2 (8.7)	7 (30.4)	23

Source: Office of Connecticut Medical Examiner Deaths by Suicide 2006–2012 Retrieved 5/29/13.

## APPENDIX G



## APPENDIX H

### Youth Risk Behavior Survey (YRBS) 2009 and 2011

Table 15.

Youth Risk Behavior Survey (YRBS 2011)  
Percent of students who felt sad or hopeless almost every day for two plus weeks in a row,  
past 12 months

	CT	US
Total	24.4	28.5
Male	18	21.5
Female	31	36
9th	23.6	27.6
10th	22.8	28.7
11th	25	28.8
12th	25.4	28.9
Black	21.3	24.7
Hispanic/Latino	33.5	32.6
White	22.4	27.2



Figure 8.

Youth Risk Behavior Survey (YRBS 2011)  
Percent of students who seriously considered attempting suicide  
during the past 12 months

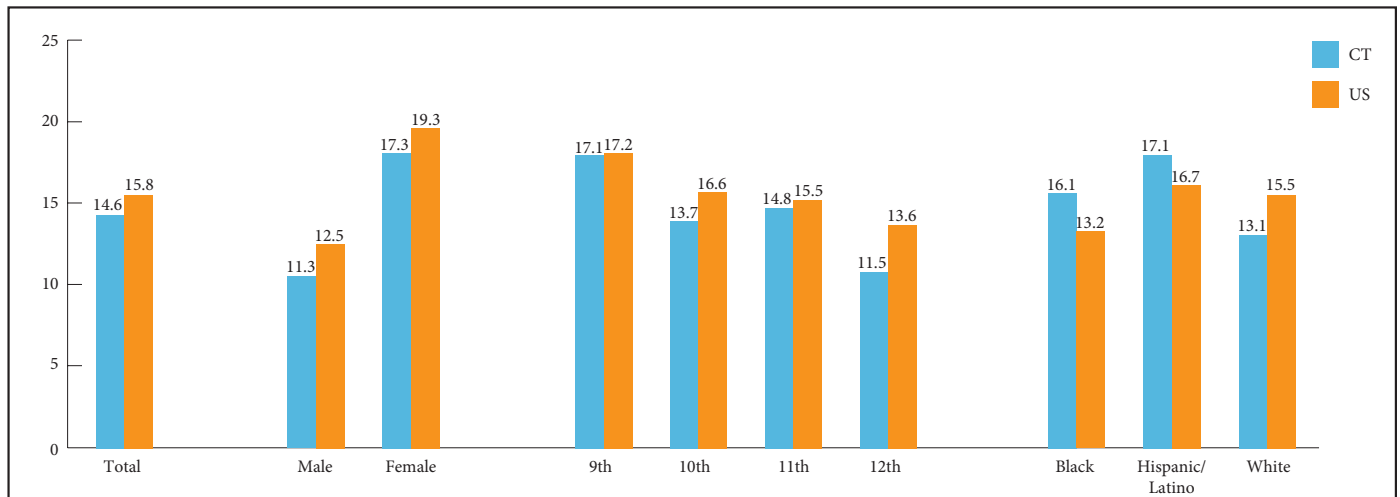


Table 16.

Youth Risk Behavior Survey (YRBS 2011)  
Percent of students who seriously considered attempting suicide  
during the past 12 months

	CT	US
Total	14.6	15.8
Male	11.9	12.5
Female	17.3	19.3
9th	17.1	17.2
10th	13.7	16.6
11th	14.8	15.5
12th	11.5	13.6
Black	16.1	13.2
Hispanic/Latino	17.1	16.7
White	13.1	15.5

Figure 9.

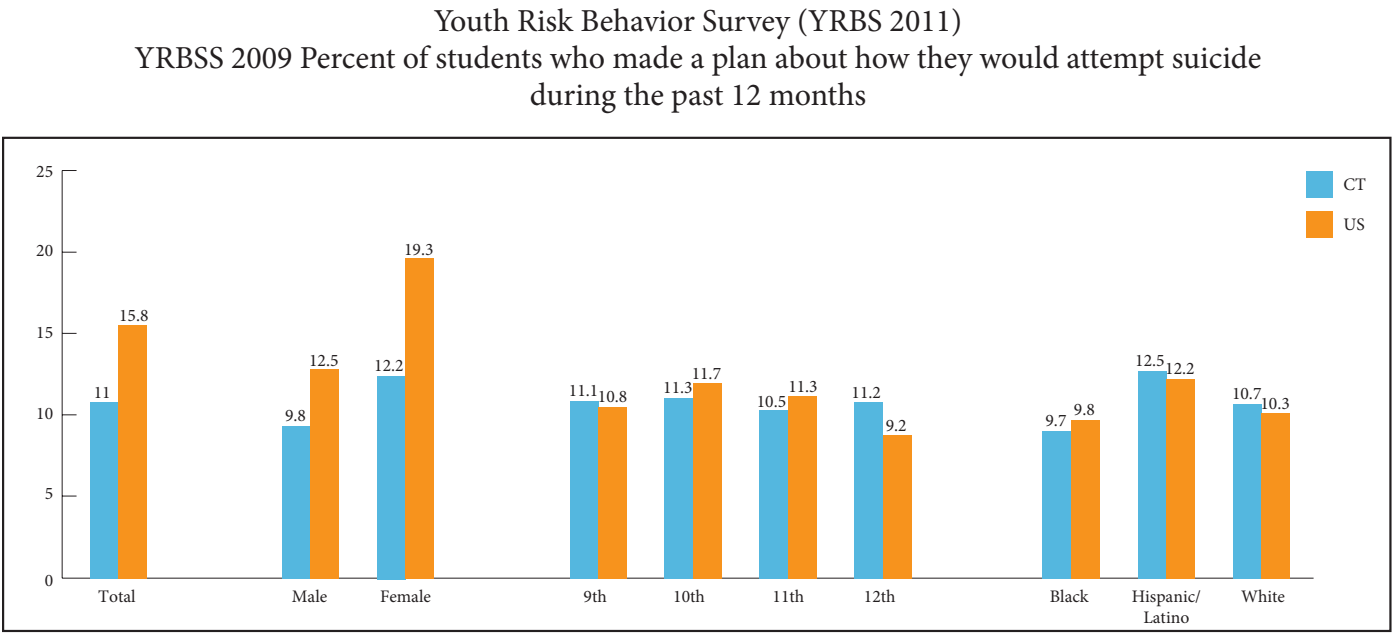


Table 17.

Youth Risk Behavior Survey (YRBS 2011)  
YRBSS 2009 Percent of students who made a plan about how they would attempt suicide  
during the past 12 months

	CT	US
Total	11	15.8
Male	9.8	12.5
Female	12.2	19.3
9th	11.1	10.8
10th	11.3	11.7
11th	10.5	11.3
12th	11.2	9.2
Black	9.7	9.8
Hispanic/Latino	12.5	12.2
White	10.7	10.3

Figure 10.

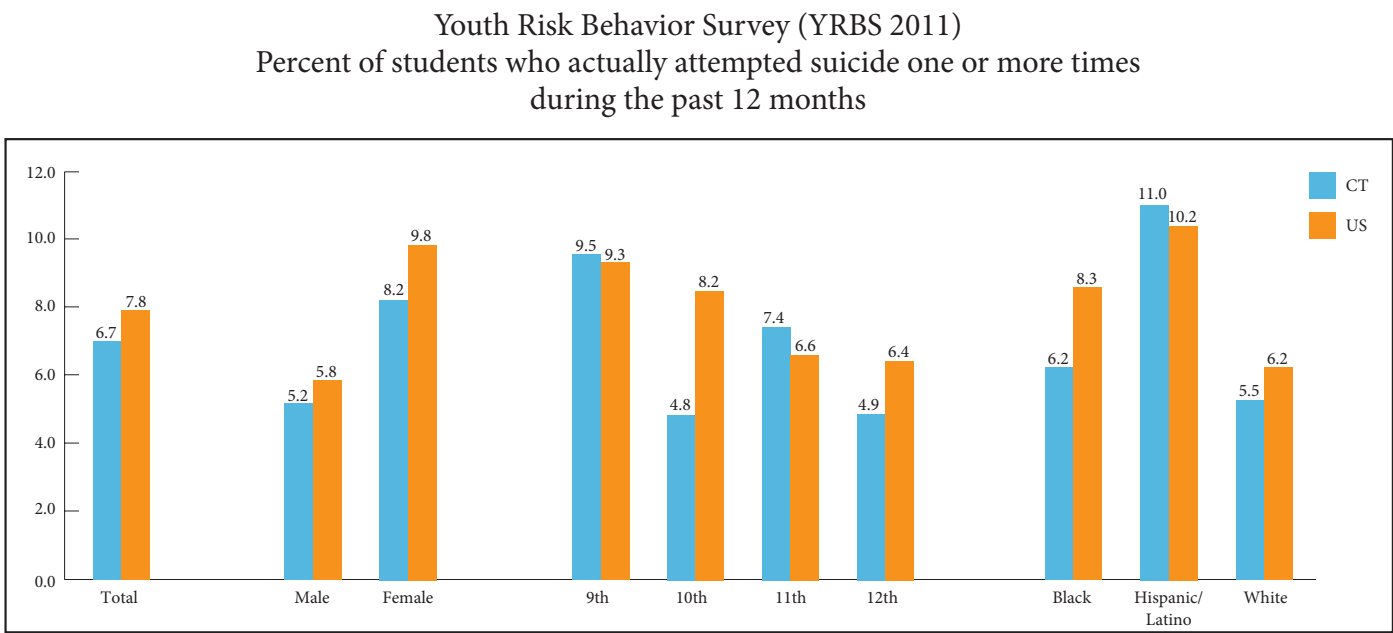


Table 18.

Youth Risk Behavior Survey (YRBS 2011)  
Percent of students who actually attempted suicide one or more times  
during the past 12 months

	CT	US
Total	6.7	7.8
Male	5.2	5.8
Female	8.2	9.8
9th	9.5	9.3
10th	4.8	8.2
11th	7.4	6.6
12th	4.9	6.4
Black	6.2	8.3
Hispanic/Latino	11.0	10.2
White	5.5	6.2

Figure 11.

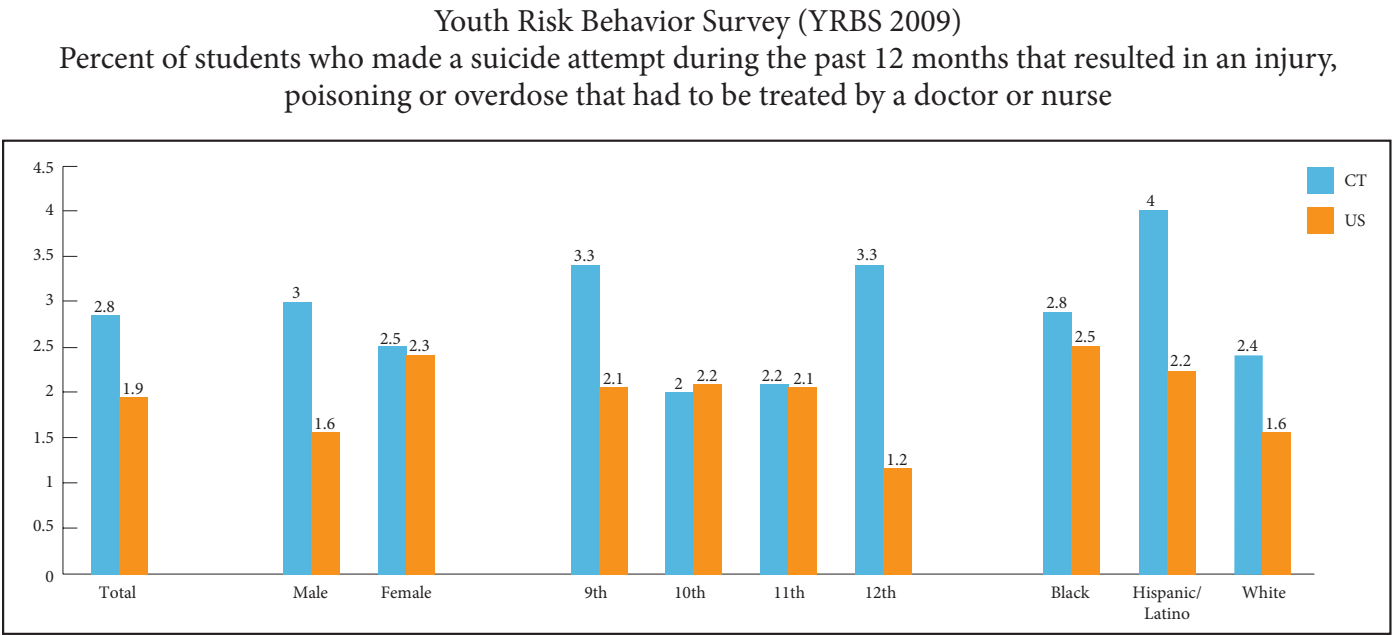


Table 19.

Youth Risk Behavior Survey (YRBS 2009)  
Percent of students who made a suicide attempt during the past 12 months that resulted in an injury,  
poisoning or overdose that had to be treated by a doctor or nurse

	CT	US
Total	2.8	1.9
Male	3	1.6
Female	2.5	2.3
9th	3.3	2.1
10th	2	2.2
11th	2.2	2.1
12th	3.3	1.2
Black	2.8	2.5
Hispanic/Latino	4	2.2
White	2.4	1.6

## APPENDIX I

### Connecticut Self-Injury Hospital Data

Table 20.

Connecticut hospitalizations for self-injury, 2012 CT Hospital Inpatient Discharge Database (HIDD).

		Number of Hospitalizations	Rate per 100,000
Total Population (10 and over)		2453	78
Age	10 to 14	73	31
	15 to 19	304	119
	20 to 24	308	137
	25 to 34	431	102
	35 to 44	448	92
	45 to 54	508	89
	55 to 64	270	61
	65 to 74	56	22
	75 plus	55	22
Race/Ethnicity	Asian Alone	23	19
	Black or African American alone	210	71
	Hispanic or Latino	311	73
	Other	82	-
	White alone, not Hispanic or Latino	1827	81
Gender	Male	1081	70
	Female	1372	85
County	Fairfield	465	60
	Hartford	594	77
	Litchfield	119	71
	Middlesex	132	89
	New Haven	716	96
	New London	201	85
	Tolland	100	74
	Windham	82	79

Sources: Hospital Inpatient Discharge Database (HIDD), CT Department of Public Health; U.S. Census Bureau, 2008–2012 American Community Survey.

Note: Differences by age, race, gender and county were statistically significant at the .05 level.

Table 21.

## Means of Self-Injury, 2012 HIDD

	N	%
Poisoning - liquid/solid	1807	73.7%
Poisoning - gas	25	1.0%
Hanging	50	2.0%
Drowning	3	.1%
Firearms	16	.7%
Cutting or piercing	413	16.8%
Jumping	21	.9%
Other	102	4.2%
Late effects of prior injury	16	.7%
<b>Total</b>	<b>2453</b>	<b>100.0%</b>

Source: Hospital Inpatient Discharge Database (HIDD), CT Department of Public Health.

Table 22.

Outcomes of self-injury, 2012 HIDD:  
Percent discharged to a psychiatric facility, percent expired, and length of stay.

	N	Discharged to Psych Facility	Expired	Length of Stay (days)
Poisoning - liquid	1807	37%	0.6%	4.1
Poisoning - gas	25	4%	0.0%	4.6
Hanging	50	18%	16.0%	8.1
Drowning	3	33%	33.3%	3.0
Firearms	16	13%	25.0%	8.9
Cutting or piercing	413	13%	0.2%	6.5
Jumping	21	43%	0.0%	9.6
Other	102	14%	1.0%	7.6
Late effects of prior injury	16	0%	0.0%	5.5
<b>Total</b>	<b>2453</b>	<b>31%</b>	<b>1.1%</b>	<b>4.8</b>

Sources: Hospital Inpatient Discharge Database (HIDD), CT Department of Public Health; Annual State Population Estimates, CT Department of Public Health <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388152>.

Table 23.

Connecticut hospitalizations for self-injury among youth ages 15 - 24 and adults 25+,  
2012 CT Hospital Inpatient Discharge Database (HIDD)

		Youth 15 - 24		Adults 25+	
		Number Hospitalized	Rate per 100,000	Number Hospitalized	Rate per 100,000
Total Population		612	127	1,768	72
Race/Ethnicity	Asian Alone	7	37	15	16
	Black or African American alone	68	110	134	61
	Hispanic or Latino	94	107	205	76
	White alone, not Hispanic or Latino	420	135	1,364	74
Gender	Female	384	166	841	76
	Male	228	93	927	75
County	Windham	26	155	55	69
	Tolland	30	92	69	74
	New London	67	175	127	70
	New Haven	154	129	531	93
	Middlesex	29	139	100	86
	Litchfield	35	152	83	62
	Hartford	152	129	423	71
	Fairfield	103	87	352	59

Source: CT Department of Public Health, 2013



## APPENDIX J

### Trainings by Source and Number Served

#### GLS Grantees:

- Connecticut College
  - 2 Peer Models (38)
  - 1 Connect Prevention (29)
  - 8 Other (406)
- Manchester Community College
  - 18 Question, Persuade, Refer Gatekeeper Program (159)
- Norwalk Community College
  - 5 Question, Persuade, Refer Gatekeeper Program QPR (62)
- Sacred Heart
  - 3 Question, Persuade, Refer Gatekeeper Program (QPR) (22)
  - 2 Connect Prevention (38)

#### Community:

- Wheeler Clinic
  - 9 Question, Persuade, Refer Gatekeeper Program QPR (180)
  - 1 TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (30)
  - 3 Question, Persuade, Refer Gatekeeper Program (QPR) TOT (82)
  - 2 Connect Prevention TOT (45)
  - 1 Connect Postvention TOT (35)
  - 1 Survivor Voices Training TOT
  - 1 Recognizing and Responding to Suicide Risk – Primary Care (48)
  - 3 Applied Suicide Intervention Skills Training (ASIST) (27)
  - 1 SafeTalk (13)
  - 5 Mental Health First Aid (77)
  - 1 Mental Health First Aid Youth TOT (2)
  - 10 Assessing and Managing Suicidal Risk (AMSR)AMSR: 4 DMHAS (8) and 6 EMPS (56)
  - 3 Assessing and Intervening with Suicidal and Self-Injurious Youth (24)
- Veterans Administration
  - 2 Question, Persuade, Refer Gatekeeper Program (QPR) (22)
  - 1 TIP 50 (10)
- Regional Action Councils
  - 32 Question, Persuade, Refer Gatekeeper Program (QPR) (987)
- Department of Children and Families
  - 1 Applied Suicide Intervention Skills Training (ASIST)

## ENDNOTES

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- <sup>lxxxii</sup>Peace, W. J. (2012). Comfort care as denial of personhood. *Hastings Center Report* 42, no. 4,14-17. DOI: 10.1002/hast.38.



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