CONNECTICUT



2025 - 2030

# Suicide Prevention Plan

State of Connecticut

UNITED WAY Connecticut

CONNECTICUT Suicide Advisory Board



# Dedication

This plan, along with the efforts to prevent suicide and foster lives of meaning and connection, is dedicated to the Connecticut residents, families, friends, and communities whose lives have been deeply impacted by suicide.

# Acknowledgments

We thank all of the Connecticut Suicide Advisory Board (CTSAB), coalition and committee members and unique key informants whose personal and professional experiences helped shape **PLAN 2030**. We are also grateful for the guidance and expertise of our development consultants, Alexis May, Ph.D. and Mrs. Sara Darlagiannis, and our formatting consultant Katie Gallo, Daydream Communications, LLC. Lastly, we thank the Connecticut Department of Mental Health and Addiction Services (DMHAS), the Connecticut Department of Public Health (DPH) and the United Way of Connecticut/211 for their contributions in the development of this plan. The creation of this plan was funded by the Connecticut Garrett Lee Smith (GLS) State Youth Suicide Prevention and Early Intervention Program, Partnerships for Hope and Healing Initiative (PH2) (SM086113) through a Substance Abuse and Mental Health Services Administration's (SAMHSA) grant to DMHAS.

# You are not alone, and help is always available. You matter.

We're glad you're here.

Are you having suicidal thoughts? You are not alone. Suicidal thoughts can be scary and uncomfortable, but there are many pathways to navigate them.

You may know someone who struggles with suicide, there are resources to help you support them.

You may have lost someone to suicide, there are grief resources and communities you can connect with who understand your pain.

You deserve to care for yourself. No matter where or who you are, there is help.

> ***Together, our state has worked to curate resources from both personal and professional experiences to ensure there is support available to you or someone you care about. Your experience matters; we are here to listen and support you. Help is available.***

Below are universally recognized free resources to start the conversation. On our resources page at www.preventsuicidect.org you can find an expanded list of more options to connect to hope, help and healing.



**Access to mental health support and mobile crisis services is available 24/7 in Connecticut through these resrouces:**

- All ages: call or text 988 anytime, 24/7 (for support and access to mobile crisis)
- Adults: call 211, then press 1, then press 2 (for support and access to mobile crisis)
- Youth: call 211, then press 1, then press 1 (for support and access to mobile crisis)

**Other Crisis Resources:**

- Chat online: 988lifeline.org/chat
- Text HOME or HOLA to 741741 for support
- Veterans: call 988, then press 1, or text 838255
- LGBTQ+ Youth: call 988, then press 3 (age 24 and under), or contact The Trevor Project: call 1-866-488-7386, text 678678, or visit chat.trvr.org
- Trans Lifeline: 877-565-8860 (confidential, 24/7 crisis support)

# Worried about someone else?

This person is fortunate you are paying attention.

First, take some time to ground yourself. This may look like taking a few deep breaths. These conversations can be difficult to navigate. Remind yourself: you are there to listen and support, not to solve. Suicidal thoughts are complex and are often an indicator of unresolved trauma or an understandable response to an unbearable situation.

Here is some guidance from the National Institute of Mental Health on how to start the conversation:

- **ASK:** "Are you thinking about suicide?" It's not an easy question to ask, but it can help start a conversation. Studies show that asking people if they are suicidal does not increase suicidal behavior or thoughts.
- **BE THERE:** Listening without judgment is key to learning what the person is thinking and feeling. Research suggests acknowledging and talking about suicide may reduce suicidal thoughts.
- **HELP KEEP THEM SAFE:** Reducing access to highly lethal items or places can help prevent suicide. Asking the person if they have a plan to harm themselves, and making lethal means less available or less deadly can help the person stay safe when suicidal thoughts arise.
- **HELP THEM CONNECT:** Connecting the person with the 988 Suicide & Crisis Lifeline (call or text 988) and other community resources can give them a safety net when they need it. You can also help them reach out to a trusted family member, friend, spiritual advisor, or mental health professional.
- **FOLLOW UP:** Staying in touch with the person after they have experienced a crisis or been discharged from care can make a difference. Studies show that supportive, ongoing contact can play an important role in suicide prevention.

**Looking for additional resources? Want to learn more about suicide prevention?**

**View the State Suicide Prevention Plan**
www.preventsuicidect.org/about/ctsab/state-suicide-prevention-plan/

< Scan this QR code

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**Visit the Connecticut Suicide Prevention Website**
www.preventsuicidect.org

< Scan this QR code

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

Dear Friends,

On behalf of the State of Connecticut, we respectfully present this State Suicide Prevention Strategic Plan for 2030 (**PLAN 2030**) with a great sense of purpose. This plan was intentionally developed by the Connecticut Suicide Advisory Board (CTSAB) and its statewide coalition to be a resource for anyone looking to champion suicide prevention in the state, whether community member or professional, because everyone has an important role to play. **PLAN 2030** aligns with the National Suicide Prevention Plan while also reflecting the unique needs of our state's citizens to prevent suicide here at home. Together by striving towards the goals within, we may reduce the number of people taking their own lives through the improved well-being and connectedness of every resident.

Suicide remains a significant public health challenge in Connecticut even though suicide rates here are lower than in most of the United States. *Each life lost is one too many*. Suicide impacts individuals, families, schools, workplaces and communities in profound personal ways. However, each person and place affected has the capacity through collaboration to engage in opportunities enclosed in this plan to prevent future loss, support those experiencing thoughts of suicide, and respond with care and compassion to those who are grieving a loss. Working together ensures that no one feels they must face their darkest moments alone.

Preventing suicide is never the responsibility of a single person, school, workplace or community. It requires a unified effort through fostering environments of acceptance, patience, resilience and hope and effective practices that may be learned and utilized at home, in schools, workplaces, hospitals and throughout the community.

We extend our deepest gratitude to the individual advocates with lived experience who bravely came forward to help shape **PLAN 2030**; those with chronic thoughts of suicide, those who have survived suicide attempts, and survivors of suicide loss. We also thank the community advocates who work tirelessly to educate people about suicide as this is the first step to preventing it; the providers who create the time and space for meaningful conversations without the fear of immediate hospitalization when individuals are not in acute crisis; and the settings and systems working to identify and address the gaps in services and environments to improve safety.

We want individuals and families supporting them to know that *you are not alone*. The Department of Children and Families, Department of Mental Health and Addiction Services and the CTSAB and coalition membership are sincerely committed to implementing **PLAN 2030** and preventing further loss of life to suicide. We hope you find the plan informative and useful in your own efforts, and we are here to support them. Thank you in advance for your dedication to partnering with us to prevent further suicide attempts and deaths in CT.

*Sincerely,*

Susan Hamilton

Susan Hamilton, MSW, JD
Commissioner
Department of Children and Families

Nancy Navarretta

Nancy Navarretta, MA, LPC
Commissioner
Department of Mental Health and Addiction Services

# How to Use This Document

The **Connecticut Suicide Prevention Plan 2030 (PLAN 2030)** provides a statewide framework that guides agencies, community members, and professionals committed to reducing suicide and strengthening protective factors across the state. **PLAN 2030** includes an Epidemiological Profile document as a supplement.

Together, these documents provide a coordinated, evidence-informed foundation for understanding suicide trends, identifying data, and supporting suicide prevention, intervention, and response. **PLAN 2030** helps individuals and organizations identify opportunities and align activities with statewide goals and objectives, apply effective strategies, monitor progress, and continuously strengthen suicide prevention efforts across Connecticut.

The **Introduction** establishes the purpose and background of the plan. The **Goals, Objectives, and Opportunities** section describes Connecticut's **PLAN 2030** framework and lists each goal, its objectives, current status, and possible opportunities.

**Appendix A** explains common terms, and **Appendix B** lists the acronyms used throughout the plan. **Appendix C** gives an overview of key risk and protective factors that affect suicide vulnerability and resilience, helping partners adapt prevention strategies for their communities. **Appendix D** describes the grants the state uses to support suicide prevention, so readers can see what funding is available and how it aligns with the plan's goals. The **References** section lists the sources used to develop this plan and support its objectives and opportunities.

We hope you find the information in this plan helpful as you support suicide prevention efforts across Connecticut.

> ***"PLAN 2030 is a statewide framework that aligns partners, strategies, and resources to strengthen suicide prevention and promote resilience across the state."***

## Core Purpose

**STATEWIDE FRAMEWORK**

Guides agencies, communities, and professionals

**STRENGTHEN PROTECTION**

Reduce suicide and build protective factors

## Plan Structure

**CLEAR ROADMAP**

Goals, objectives, status, and opportunities

**SHARED LANGUAGE**

Key terms and acronyms defined

**RISK & RESILIENCE**

Overview of factors shaping suicide vulnerability

**FUNDING SUPPORT**

Grants aligned with prevention goals

## Take Action

**PUT INTO PRACTICE**

Support suicide prevention across Connecticut

# Introduction

## Building a Safer, More Connected Connecticut

**Connecticut has the 4th lowest suicide rate in the United States.** From 2015 to 2023 the national age adjusted suicide rate increased by 6.0 percent while Connecticut's age adjusted suicide rate for the same period decreased by 11.2 percent. However, in 2023, suicide was among the top five leading causes of death for Connecticut residents ages 10-54; and, in 2024, there were 38,256 emergency department visits for suicidal ideation and 6,367 for suicide attempts in Connecticut across all ages (DPH, 2025). In Connecticut, we know that suicide is a serious public health problem that may be prevented.




Connecticut's suicide **rate decreased by 11.2%** (2015–2023)

**The National Strategy for Suicide Prevention (NSSP) (SAMHSA, 2024) was updated in 2024 for the first time since 2012 and offers a renewed framework to:**

- Prevent suicide risk before it emerges
- Identify and support individuals at increased risk through treatment and crisis intervention
- Reduce the likelihood of reattempts
- Promote long-term recovery
- Support survivors of suicide loss

**PLAN 2030** incorporates a subset of these updated goals and objectives, aligning with Connecticut's priorities. Its development focuses on three core aims:

1. Continuing the progress built over the last decade
2. Aligning with the current priorities of state agencies and communities
3. Updating goals and objectives to reflect the new NSSP

**As a result, the following five Goals and their 33 Objectives are the focus of PLAN 2030:**

1. Build and sustain suicide prevention infrastructure at the state, tribal, and local levels.
2. Implement comprehensive suicide prevention strategies for populations disproportionately affected by suicide, with a focus on historically marginalized communities, persons with suicide-centered lived experience, and youth.
3. Implement effective suicide prevention services as a core component of health care.
4. Reduce access to lethal means among people at risk of suicide.
5. Improve the quality, timeliness, scope, usefulness, and accessibility of data needed for suicide-related surveillance, research, evaluation, and quality improvement.

We believe that one death is too many, and we aspire to zero suicide losses. Striving towards zero means that we are committed to addressing the existing needs and gaps that contribute toward suicidal behavior and death among those at increased risk.

**Every five years, the Connecticut Suicide Advisory Board (CTSAB) refreshes the state plan for suicide prevention to provide a roadmap for the next five years. PLAN 2030** aligns with the current NSSP and builds upon prior state plans.

The CTSAB is tri-chaired by leaders from the Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and a representative of a local organization with expertise in mental health or a suicide prevention foundation, most recently the Brian Dagle Foundation. Under Conn. Gen. Stat. § 17a-52, the CTSAB includes a voting Board of various members representing specific populations tasked to increase public awareness, develop a state plan, recommend interagency policies and procedures, coordinate data utilization, make prevention and intervention programs recommendations, offer suicide prevention training and education, and make recommendations to Commissioners.

The CTSAB leads the state's suicide prevention, intervention, and response infrastructure. The CTSAB also includes one large statewide coalition and multiple active committees. Currently, they include Armed Forces-Governor's Challenge for Suicide Prevention Among Service Members, Veterans, and their Families (SMVF); Attempt Survivor/Lived Experience; Data to Action; Education and Advocacy; Lethal Means; Postvention; and Zero Suicide Learning Community (ZSLC) for Health and Behavioral Healthcare Providers. There are five suicide prevention service regions in Connecticut managed by Regional Behavioral Health Action Organizations (RBHAO), and their coalitions are also linked to the CTSAB. All of these entities utilize the state plan to strategically guide their activities.

**PLAN 2030** is based upon the best available Connecticut data for suicide loss, and suicidal thoughts and behaviors among its residents. These data establish a baseline for measurable, aspirational, and achievable goals and benchmarks to guide suicide prevention strategies and activities over time. Suicide prevention strategies and activities are reviewed annually by the CTSAB each September during National Suicide Prevention Month, a dedicated time to reflect, adjust, and share progress. This annual review process helps keep the state plan active, responsive, and accountable, and aligns with emerging trends and needs.

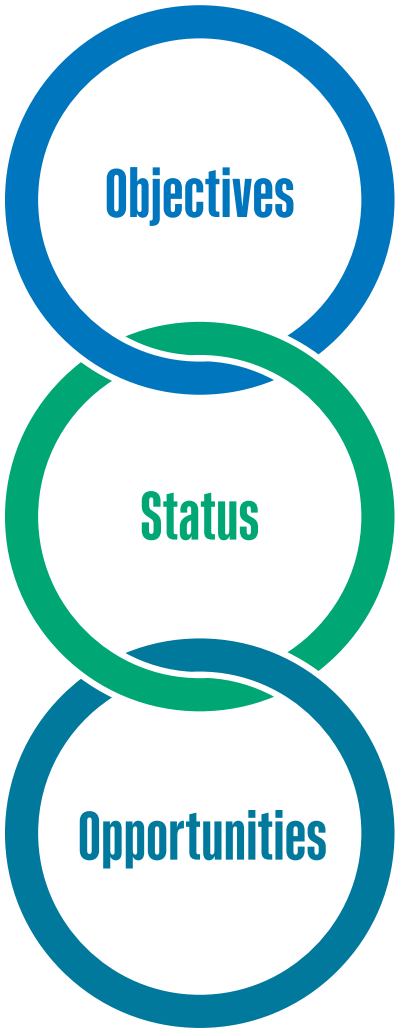
**PLAN 2030** is more than just a document—it is a five-year "Call to Action." It encourages every individual, family, community, sector, and system to contribute to a safer, more connected Connecticut. This is especially important as we continue to recover from the isolation, loneliness, and burnout emphasized by the SARS-CoV-2 (COVID-19) pandemic. Together, we can build a future where hope is within reach, support is visible, and no one has to face their struggles or a crises alone.

> ***PLAN 2030 outlines Connecticut's coordinated, data-driven, five-year approach to reducing suicide by uniting agencies, coalitions, and communities around shared goals, strategies, and accountability.***



# Goals, Objectives, and Opportunities

**PLAN 2030** is Connecticut's statewide framework for suicide prevention, built through a collaborative, multi-phased process led by the CTSAB. This framework is guided by the Continuum of Care model from the Institute of Medicine. **PLAN 2030** spans the full spectrum of behavioral health: from health promotion and suicide prevention to intervention, treatment, and sustained recovery.




## Goal Framework

**Each goal in this framework includes:**

- Clear objectives to drive progress.
- Status updates to track implementation.
- Opportunities for organizations, agencies, and communities to act.

Together, these elements offer actionable guidance for organizations, agencies, and communities working to reduce suicide and promote healing across Connecticut.



# Goal 1

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



## Objective 1.1

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

## Current Status

- Connecticut legislates that DCF, DMHAS and a representative of a local organization with expertise in mental health or suicide prevention tri-chair the Suicide Advisory Board.
- DMHAS, DCF, and the DPH have administrative staff assigned to manage and advance the state's suicide prevention, intervention, and response infrastructure, and direct federal suicide prevention grants.
- DMHAS and DCF have administrative staff to manage, advance, and evaluate the crisis service system, including one central 988 Suicide and Crisis Lifeline contact center for calls, texts, and chat, statewide youth and adult mobile

***Connecticut's suicide prevention system is led through a coordinated, multi-agency approach with lived experience at its core.***

***Statewide crisis services including 988, mobile response, and urgent care are available 24/7 to support individuals at risk.***

crisis services, youth and adult urgent crisis centers, and an adult peer respite program. Services are available 24 hours a day, 7 days a week, 365 days a year.

- DMHAS, DCF, and DPH have staff who manage and evaluate federal suicide prevention grants, as well as provide suicide prevention, intervention, and response services.
- Connecticut has five established suicide prevention regions supported by Regional Suicide Advisory Boards. These RSABs are managed by the RBHAO and contracted by DMHAS and DCF who oversee their work related to suicide prevention, intervention, and response to untimely deaths.
- Connecticut Department of Emergency Services and Public Protection (DESPP) funds the Connecticut Center for School Safety and Crisis Preparedness (CSSCP) at Western Connecticut State University to empower and strengthen school systems' ability to effectively negotiate all threats and hazards through the mission areas of prevention, protection, mitigation, response, and recovery, including suicide prevention, intervention, and response. The services include five regions served by mutual aid crisis teams and one paid Leader per region.
- Multiple CTSAB and RSAB staff have suicide-centered lived experience; those with suicide loss, thoughts, attempts, and supporting those with thoughts of suicide.



## Opportunities

1. Maintain and expand core staffing across state, regional, and local levels to support sustainable suicide prevention infrastructure.
2. Provide leadership opportunities to support suicide prevention, intervention, and response through coalitions and partnerships.
3. Prioritize hiring individuals with suicide-centered lived experience.

***24/7/365***

*Crisis services are available 24 hours a day, 7 days a week, year-round*

***5 REGIONS***

*Connecticut has five suicide prevention regions supported by Regional Suicide Advisory Boards*

***3 LEAD AGENCIES***

*DMHAS + DCF + DPH coordinate suicide prevention infrastructure and funding*

***1 STATEWIDE 988 CENTER***

*Centralized crisis response system*



# Objective 1.2

Train staff across state, tribal, and local levels about comprehensive suicide prevention, including building partnerships; use of data for decision-making; selecting, implementing, and evaluating effective prevention strategies; and communication activities.

# Current Status

- All RSAB staff have been trained in data collection, community planning, and priority reporting, strengthening local surveillance and strategic coordination capacity. They utilize available data, which guide their programmatic efforts in a timely manner.
- Beginning in 2022, local health departments/ districts received train-the-trainer instruction to educate municipal employees in helper strategies for suicide prevention.
- Numerous organizations have facilitated multiple types of evidence-based trainings, such as community helper trainings (e.g., Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills Training (ASIST)), Counseling on Access to Lethal Means (CALM), Columbia Suicide Severity Rating Scale (C-SSRS), and Connect Community Postvention Training.
- Suicide prevention programming currently available includes, but is not limited to: Signs of Suicide for Middle School and High School, Gizmo's Pawesome Guide to Mental Health© Elementary School Curriculum, Fresh Check Day Events, 4 What's Next, Sources of Strength, and Hope's Squad.

# Opportunities

1. Identify and address gaps, siloed efforts, and partnership opportunities to support and expand the suicide prevention infrastructure.
2. Expand training reach and sector engagement by strengthening and refining partnerships with private partners.
3. Continue cross-agency collaboration and coordination with planned evaluation activities to ensure training effectiveness and relevance.
4. Routinely review national evidence-based practice resources to guide selection and adaptation of suicide prevention, intervention, and response programs and strategies.
5. Update training recommendations and certifications based on staff roles and evaluation data.
6. Provide ongoing training and refresher courses on suicide to various sectors and settings tailored to address the needs of the specific population through different Connecticut-based learning methods (e.g., in-person, virtual, online learning management systems).
7. Engage partners not traditionally involved in mental health and suicide prevention to broaden the network of suicide prevention-informed community members, workplaces, and professionals.
8. Establish consistent implementation of evidence-based practices tailored to community needs across towns and organizations.
9. Identify programming gaps, align resources, and strengthen cross-coordination across systems to address them.
10. Provide technical assistance for quality improvement to sectors and settings working to advance suicide prevention efforts.
11. Educate suicide prevention staff on available data to guide decision-making and how it should be interpreted.
12. Monitor the existence, reach, quality, and impact of mandated suicide prevention education in schools.
13. Train loss survivors to support postvention response services.
14. Expand training and resources on safe messaging and appropriate timing for postvention response.
15. Offer undergraduate and graduate internships to engage students in the suicide prevention field.
16. Suicide prevention training should include promotion of state campaign, the 1 Word, 1 Voice, 1 Life brand, CTSAB website, and 988 Suicide and Crisis Lifeline.

# Objective 1.3

Modernize data systems and infrastructure and build staff capacity in surveillance, data analysis, and program and policy evaluation across state, tribal, and local levels.

# Current Status

- Connecticut's data systems have expanded to include tracking of suicide deaths as well as admissions for suicidal thoughts or behaviors (see Goal 5 for further detail), enhancing the state's ability to monitor trends and respond effectively. This infrastructure has been built through federal grant opportunities, with state funds supporting oversight and coordination, positioning Connecticut to continue modernizing its suicide prevention data systems and evaluation capacity.
- A public-facing, open-access Violent Injury Dada Dashboard that will contain aggregate, population-level suicide death, ideation, and behavior data is in development through a partnership among the DPH, DMHAS, DCF, UCONN Health Center, and the United Way of Connecticut/2-1-1. The Suicide Data Dashboard User Guide will be produced, and training will be made available to facilitate the use and application of the data.
- RSABs report to DCF and DMHAS on the services they perform.



## Opportunities

1. Complete the Suicide Data Dashboard.
2. Develop the Suicide Data Dashboard User Guide.
3. Standardize state and regional data reports.
4. Evaluate and advance suicide prevention policies.
5. Assess progress on the Goals and Objectives within the State Suicide Prevention Plan annually.

***Expanded data systems are strengthening Connecticut's ability to track and respond to suicide risk.***

# Objective 1.4

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

# Current Status

- The state established the 988 Suicide Prevention and Mental Health Crisis Lifeline Fund (Conn. Gen. Stat. § 17a-674a). DMHAS manages the funds and shall only be used for: (1) Ensuring the efficient and effective routing of contacts (calls, texts, chats) made to the 988 Suicide and Crisis Lifeline by persons in the state to an appropriate crisis center; and (2) personnel and the provision of acute mental health, crisis outreach and stabilization services by directly responding to the 988 Suicide and Crisis Lifeline.
- DMHAS developed a process for public donations by check to the "988 Suicide Prevention and Mental Health Crisis Lifeline Fund."
- The Connecticut Chapter of the American Foundation for Suicide Prevention (AFSP-CT) is active and hosts multiple fundraising activities. Half of the funds raised support AFSP-approved programs, training, and services in Connecticut, and the other half supports the national AFSP administration. The AFSP-CT collaborates with the CTSAB and RSABs to identify and implement suicide prevention aligned with the state plan.
- DMHAS, DCF and DPH have secured multiple federal grants to implement and evaluate suicide prevention initiatives. Current grants include the Substance Abuse Mental Health Services Administration (SAMHSA) funded Garrett Lee Smith (GLS) State Grant-Partnerships for Hope and Healing (PH2) and the Connecticut 988 Implementation Grant, and the Centers for Disease

***PUBLIC ACT 22-47***

*Established the 988 Lifeline Fund in Connecticut*

***50% / 50%***

*AFSP-CT funds support local programs and national efforts*

***MULTIPLE FEDERAL GRANTS***

*SAMHSA + CDC funding statewide prevention efforts*

***STATEWIDE INVESTMENT***

*Funding supports crisis response, outreach, and prevention services*

Control and Prevention (CDC)-funded Comprehensive Suicide Prevention (CSP) Grant (see Appendix D for further details).

- DMHAS has used SAMHSA block grant funds to support the Connecticut Governor's Challenge (GC) to Prevent Suicide Among Services Members, Veterans and Families (SMVF), and enhance suicide prevention education with a lived experience lens and develop support for those who live with chronic thoughts of suicide.
- Multiple Connecticut institutions of higher education have received SAMHSA's GLS Campus Suicide Prevention Grants. Recent grantees include Albertus Magnus, Connecticut College, Housatonic Valley Community College, and the University of Connecticut.
- Easter Seals Rally Point received a Veterans Administration (VA)-funded Staff Sergeant Parker Gordon Fox Suicide Prevention Grant that supports community-based suicide prevention efforts to meet the needs of veterans and their families through outreach, suicide prevention services, and connection to VA and community resources.
- The Mashantucket Pequot Tribal Nation received the SAMHSA Native Connections-Good Medicine grant designed to engage the tribe to prevent suicide and ensure mental health and substance use disorders are identified and treated effectively.



# Opportunities

1. Generate and formalize sustainable funding mechanisms to support long-term suicide prevention infrastructure at local, regional, and state levels.
2. Promote statewide awareness of existing grants and funding streams to ensure interested parties understand current investments and opportunities.
3. Educate funders and decision-makers at organizations, local, municipal, state, and federal levels about Connecticut's suicide prevention system and how they can contribute to its growth.
4. Promote the 988 Suicide and Crisis Lifeline Fund public donation option via check as a viable funding source for crisis services, and expand to electronic donation options.
5. Encourage state legislators to join the CTSAB to strengthen policy alignment and legislative engagement in suicide prevention efforts.
6. Design and launch broad-based public campaigns advocating for investment in suicide prevention and related public service initiatives.
7. Offer targeted presentations to Connecticut state leaders, showcasing the work of CTSAB and the impact of coordinated, cross-sector suicide prevention efforts.

# Objective 1.5

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

# Current Status

Connecticut maintains a structured and recurring process for comprehensive, lived-experience-informed suicide prevention planning. It receives quarterly technical assistance from the national Suicide Prevention Resource Center (SPRC) and utilizes their recommended guidance documents and frameworks. The Connecticut Suicide Prevention Plan is updated every five years to reflect emerging data, evolving priorities, and input from interested parties. At the regional level, RBHAOs update their workplans and priority reports annually, ensuring that local strategies remain responsive to community needs and aligned with statewide goals.

## Opportunities

1. Align Connecticut suicide prevention, intervention, and response initiatives with the NSSP to strengthen strategic coherence and facilitate federal funding eligibility.
2. Promote **PLAN 2030** statewide to ensure streamlined progress and coordinated action.
3. Prepare federal suicide prevention grant applications to advance the goals and objectives of **PLAN 2030**.
4. Ensure CTSAB and RSAB contracts and workplans advance the goals and objectives of **PLAN 2030** to enable scalable, system-wide implementation.
5. Utilize available state planning tools, templates, and frameworks to prepare a comprehensive **PLAN 2035**.

**STATEWIDE**

## Every 5 Years

**Connecticut Suicide Framework Plan**

Updated to reflect emerging data, evolving priorities, and input from lived-experience stakeholders.

**REGIONAL**

## Annually

**RBHAO Workplan**

Annual updates keep local strategies responsive to community needs and aligned with statewide goals.

**NATIONAL**

## Quarterly

**Suicide Prevention Resource Center (SPRC)**

Connecticut receives quarterly technical assistance and applies SPRC-recommended guidance documents and frameworks to inform its planning process.

# Objective 1.6

Provide community-based care and support options to individuals bereaved by suicide.

> ***Access to community-based support for suicide loss survivors remains limited, with gaps in availability, geography, and tailored care.***

# Current Status

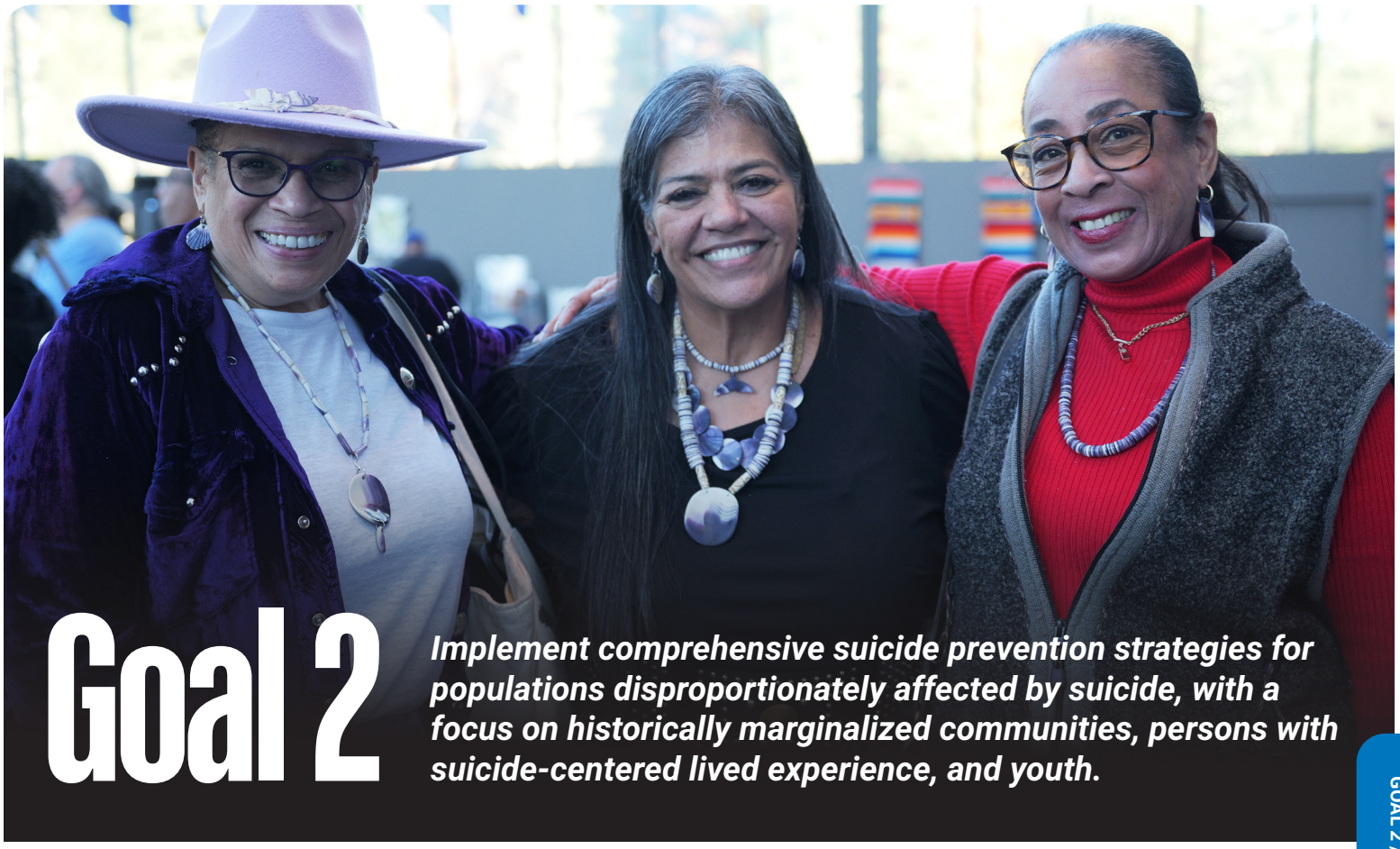
- Connecticut has a Suicide Prevention Response protocol that facilitates a timely response to survivors and those who may be impacted by a youth (age 0-17) or young adult (aged 18-24) suicide. Within 24 hours of a suicide loss, the Office of the Chief Medical Examiner (OCME) notifies the Office of the Child Advocate (OCA). Then the OCA notifies DMHAS, DCF, State Department of Education (CSDE) and the CSSCP to activate postvention crisis support based on local needs.
- Connecticut has limited available, community-based care and support for individuals bereaved by suicide. There are insufficient numbers of support groups to meet statewide need, and the COVID-19 pandemic crisis in 2020-21 further exacerbated this gap, leading to widespread closures of in-person groups, many of which have not resumed operations. Survivors of suicide loss often face geographic obstacles, with some traveling over an hour to attend a support group, underscoring the uneven distribution of resources across the state.
- While the AFSP's Healing Conversations program offers a valuable one-on-one support option, some pastoral or faith-based supports may not directly address suicide loss and are frequently restricted to current congregational members, leaving many survivors without care that is sensitive to their backgrounds or contextually relevant. Additionally, survivor loss needs vary depending on the type of loss experienced, and support needs to be tailored.
- Connect Postvention training is now available in all five suicide prevention regions to address these gaps. This training helps agencies and communities understand the profound impact of suicide loss and lays the groundwork for developing community-based postvention teams. These teams are tasked with ensuring that grief and loss resources are available and responsive to the needs of those affected.
- Some communities have developed Suicide Prevention Plans to facilitate evidence-based, coordinated survivor response services.

> ***Within 24 hours of a suicide loss, Connecticut activates a coordinated postvention response to support affected communities.***

# Opportunities

1. Expand the capacity and reach of grief and loss support groups statewide, ensuring curricula are population-responsive and supportive of individuals experiencing grief.
2. Establish a statewide system to recruit and train support group leaders with lived experience of suicide loss, prioritizing outreach to communities with unmet needs and under-resourced areas.
3. Increase knowledge and competency across sectors, including schools, human services, and healthcare, on how to support individuals and families bereaved by suicide.
4. Increase the number of communities with Postvention Plans.
5. Develop Postvention Teams in communities with Postvention Plans, creating local infrastructure that provides timely, relevant support and information to survivors within their communities.
6. Offer professional development training for clinicians supporting individuals, families, communities, and workplaces, bereaved by suicide loss.
7. Collaborate with the OCME and the Connecticut Funeral Directors Association to update and ensure uniform distribution of the survivor resource packet to the next of kin when a death has been designated as a suicide.





# Goal 2

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



## Objective 2.1

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

## Current Status

Many current suicide prevention activities and trainings offered in Connecticut emphasize recognizing warning signs and identifying individuals at risk, inquiring whether they are contemplating suicide, and assessing the likelihood of carrying out a plan. Some of these approaches lack perspective regarding adverse experiences and pay insufficient attention to uncovering the underlying cause of distress unique to an individual or impacted populations.

These service gaps are important to address to ensure barriers and opportunities are identified to reduce risk and save lives. Examples of population-specific programs available in Connecticut include AFSP's L.E.T.S. Save Lives, which focuses on the adverse experiences of black and brown communities, and the Mashantucket Pequot Tribal Nation Good Medicine Project.

# Opportunities

1. Use state, regional, and local data to identify which populations are at increased risk of suicidal thoughts, behaviors, and deaths to guide the selection of suicide prevention activities.
2. Involve representatives of these groups to inform the selection and tailoring of suicide prevention programs and their evaluation.
3. Develop or enhance 988 Suicide and Crisis Lifeline promotional materials guided by those with lived experience who represent these groups to ensure messaging resonates.
4. Identify populations with high service needs or who underutilize available resources such as mobile crisis services, crisis centers, and emergency departments to inform services and engagement improvements.



# Objective 2.2

Increase awareness and understanding of rural communities' unique barriers and challenges to better inform and improve suicide prevention activities.

***CABLE provides Crisis Intervention Teams Training to First Responders statewide.***

# Current Status

Rural communities in Connecticut face persistent challenges that contribute to unmet health and mental health needs. These include, but are not limited to, reduced access to health, substance use disorder, and mental health care, increased time to access urgent care or emergency services, inadequate public transportation, and unreliable broadband internet. These structural challenges must be addressed to strengthen suicide prevention efforts and expand fair access to care.

The Connecticut Alliance to Benefit Law Enforcement (CABLE) provides Crisis Intervention Team (CIT) Training to First Responders statewide. This ensures the broad provision of the services, even in rural areas.

# Opportunities

1. Distribute 988 Suicide and Crisis Lifeline and mental health resources, along with branded materials, where people frequent.
2. Increase distribution of safe storage of firearms and medication materials, medication disposal guidance, naloxone training, and dissemination.
3. Establish medication disposal drop-off locations.
4. Encourage local businesses to display 988 Suicide and Crisis Lifeline and 1 Word, 1 Voice, 1 Life campaign materials and advertisements on storefronts and other visible spaces to promote hope and connection.
5. Bolster mobile crisis services with trained local peer support who may respond more quickly until services arrive.
6. Expand crisis services in rural communities with unmet needs.
7. Support State Trooper partnership with mobile crisis service providers.
8. Collaborate with places of worship to establish a mental health ministry, host peer support and education programs, suicide prevention, naloxone, and other prevention trainings.
9. Identify and promote telemental health services.





# Objective 2.3

Increase awareness and understanding of the unique barriers and challenges of military and Veteran status to improve suicide prevention among Service Members, Veterans and their Families (SMVF).

# Current Status

Connecticut joined the national Governor's Challenge (GC) in the spring of 2022 to prevent suicide among SMVF. The GC is a task force of the CTSAB's Armed Forces Committee, which is co-led by the Department of Veterans Affairs, the VA Healthcare, veterans, service members, and representatives from various service organizations. This group has three priorities: developing provider education focused on how to identify and serve the SMVF population, increasing SMVF knowledge of and access to resources, and promoting the reduction of access to lethal means for those at risk of suicide in their homes, with an emphasis on firearms.

Additionally, since 2013, the Connecticut National Guard has implemented a number of evidence-based suicide prevention practices and supports in collaboration with the DMHAS-funded Military Support Program.

Despite progress, challenges persist for this population. Workforce shortages delay care, and some providers lack training in evidence-based practices. Military culture can discourage help-seeking due to stigma and fears about career impacts, especially related to medication use. These challenges highlight the need for outreach and improved provider training that is responsive to local and community contexts.

***The Connecticut National Guard has implemented a number of evidence-based suicide prevention practices.***

# Opportunities

1. Complete and disseminate the GC provider education curriculum for learning management systems.
2. Foster connection and awareness through training and engagement opportunities with SMVFs in Connecticut, using the GC toolkit, materials, and social media to promote visibility and access to crisis lines and resources.
3. Educate family members and caregivers about unique suicide risk and protective factors and how to help address them.
4. Train and educate SMVF peers to provide various types of support to reduce stigma and obstacles to care.
5. Identify and utilize programs and services for SMVFs driven by peer support.
6. Integrate peer support in Mobile Crisis services, prioritizing trained Veterans with lived experience.
7. Create opportunities for mobile crisis services to cross-train with the Connecticut National Guard and Veterans Administration of Connecticut (VACT) Healthcare.

# Objective 2.4

Increase suicide prevention programs, practices, and policies in support of and in collaboration with Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Two-Spirit individuals (LGBTQI2S+).

# Current Status

Among LGBTQI2S+ youth, lacking a sense of life purpose is strongly linked to suicide risk, with 22% attempting suicide in the past year (Trevor Project, 2024). This underscores the need for prevention efforts that affirm identity, build belonging, and support youth in envisioning a meaningful future. Connecticut has organizations serving LGBTQI2S+ communities, but it remains unclear how they connect to the state's suicide prevention system or whether they use established programs, practices, or policies.

# Opportunities

1. Engage LGBTQI2S+ serving organizations in suicide prevention, intervention, and response to build their capacity to prevent suicide and support those in suicide-centered lived experience.
2. Work with representatives of the LGBTQI2S+ community to inform population needs, gaps, and opportunities related to suicide prevention.
3. Create safe spaces for those questioning their gender identity and sexual orientation to express their thoughts and feelings, reduce stigma, and develop a sense of belonging.
4. Promote programs that support the exploration of life purpose to strengthen protective factors and reduce suicide risk.
5. Provide training and education to clinicians to increase their understanding of LGBTQI2S+ population differences in the context of suicide risk and prevention.
6. Support peer-to-peer resources for LGBTQI2S+ youth and young adults.
7. Inform policy development or improvement to support LGBTQI2S+ identity and safety.
8. Advocate and ensure that LGBTQI2S+ populations are represented in epidemiologic, programmatic, and service data.
9. Provide education and training to families and caregivers that increase their understanding of suicide-related risk and protective factors and build support for this population.

# Objective 2.5

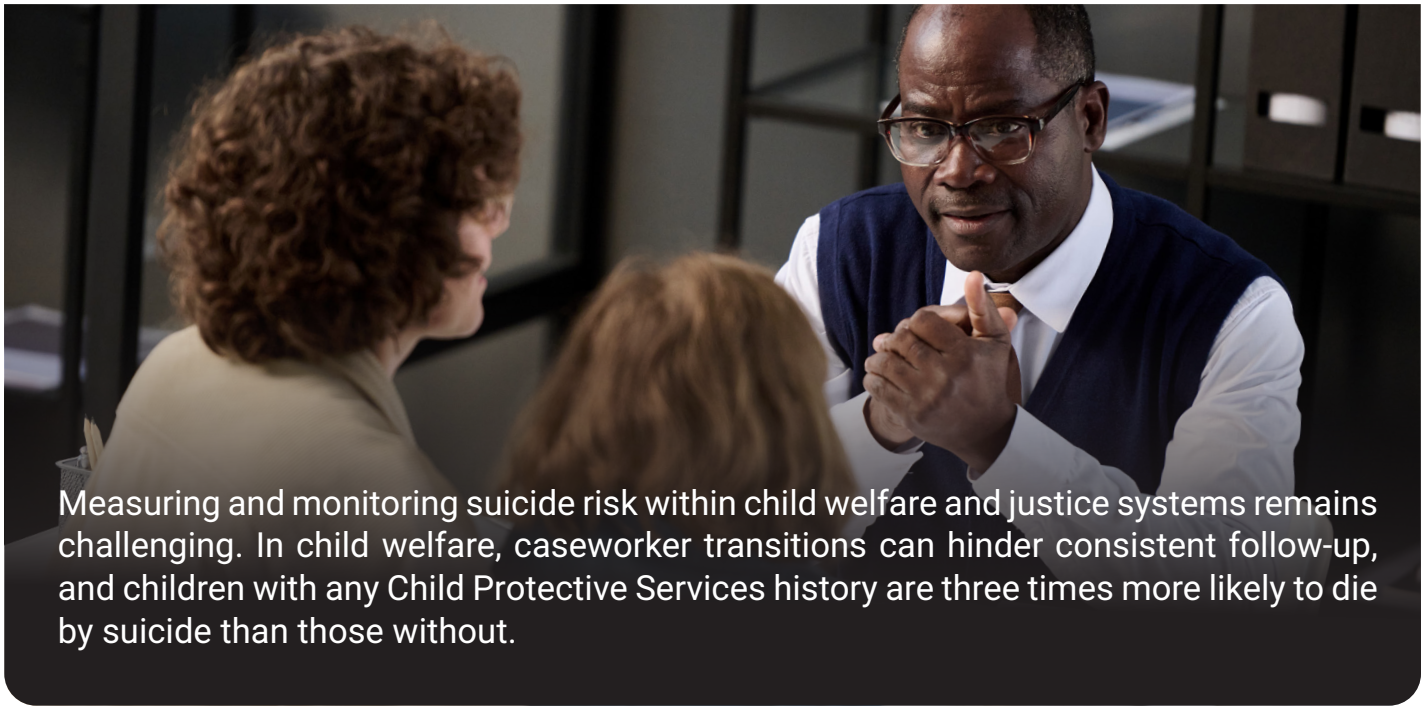
Improve and expand suicide prevention programs, practices, policies, and crisis response in child welfare, criminal and juvenile justice, behavioral health, and other systems serving populations disproportionately affected by suicide and ensure ongoing staff training and development.

# Current Status

For over ten years, the CTSAB has engaged and collaborated with different systems serving populations more significantly impacted by suicide. These include, but are not limited to, multiple state operated and private behavioral health systems for those with mental health and substance use disorders, the Connecticut Judicial Branch's Court Support Services Division for juvenile justice involved youth, and the Connecticut Departments of Agriculture for farmers, Correction for incarcerated adults and Correctional Officers, Labor for the Unemployed, and Military for Connecticut National Guard service members and veterans. These groups have adopted several evidence-based suicide prevention, intervention, and response strategies, training, screening, services, policies, and protocols, and increased safety measures in their environments.

Measuring and monitoring suicide risk within child welfare and justice systems remains challenging. DCF has made efforts to ensure that Child Protective Services (CPS) staff are able to identify risk factors and has implemented QPR training for staff. DCF is also working to ensure foster parents know about crisis services such as 988 Suicide and Crisis Lifeline, Mobile Crisis, and Urgent Crisis Centers.

The Connecticut State Department of Education (CSDE), together with DCF and DMHAS,



Measuring and monitoring suicide risk within child welfare and justice systems remains challenging. In child welfare, caseworker transitions can hinder consistent follow-up, and children with any Child Protective Services history are three times more likely to die by suicide than those without.

emphasizes that every school district should implement a well-coordinated, system-wide approach to suicide prevention planning. Such an approach creates a shared framework in which families, community-based partners, and schools work together to identify students earlier, respond consistently to signs of mental health distress, and ensure timely support for those at risk. In addition, Connecticut General Statute § 10-221(f) requires each district to review and update its written policies and procedures related to youth suicide prevention and youth suicide attempts. This statutory requirement reinforces the need for districts to maintain clear, current, and actionable protocols that align with statewide recommendations, including the use of the C-SSRS as the standardized tool for determining suicide risk.

## Opportunities

1. Continue to engage state-operated and private providers, including group homes and transitional living settings serving these populations, to sustain and enhance current suicide prevention, intervention, and response strategies.
2. Prioritize training developed by individuals with lived experience, using peer-informed models like Bridging the Gap, Intentional Peer Support, Alternatives to Suicide and Out of the Abyss.
3. Tailor suicide prevention materials for incarcerated individuals to assess risks and challenges to accessing these resources.
4. Develop low-barrier ways to distribute suicide prevention materials, such as printed handouts or peer-led sessions, and assess the real and perceived risks incarcerated individuals face when accessing them.
5. Assess opportunities for incarcerated populations to connect with crisis lines.
6. Evaluate protocols for individuals on parole using mobile crisis services to ensure safe, stigma-free help-seeking.
7. Expand peer-led education and support groups in high-risk settings, with tailored facilitator training for correctional facilities, residential centers, and psychiatric units.
8. Replace solitary confinement with trauma-informed, least-restrictive alternatives that reduce suicidal distress.
9. Increase the number of Crisis Stabilization Units (CSUs) to provide law enforcement with diversion options that connect individuals in crisis to timely, appropriate care.
10. Engage First Responders, Correctional Officers, and Parole Officers in CIT Training, suicide risk screening training, and education.

# Objective 2.6

Leverage social media use for youth and young adults to support suicide prevention efforts.

# Current Status

DMHAS, DCF and DPH-funded providers of suicide prevention, intervention, and response services are encouraged to promote suicide prevention using media and other methods, and data are collected on reach and engagements. However, Connecticut currently lacks a dedicated social media platform for statewide suicide prevention efforts. While nonprofits, agencies, and healthcare centers produce their own campaigns, the absence of a unified strategy limits reach and consistency. "The 1 Word, 1 Voice 1 Life..." Campaign, developed by the CTSAB, is due for an update to improve clarity, resonance, and engagement across youth audiences.

Additionally, related to social media, Connecticut does not have a state policy in place for specific safety safeguards for Artificial Intelligence (AI) companion chatbots used by youth. California and New York have passed these types of policies in direct response to increasing public health concerns and several high-profile cases involving teen self-harm and suicide related to interactions with conversational AI. These policies address disclosure, break reminders, safety protocols based on best practices, and accountability.

Youth in public schools are beginning to learn how AI can support their learning, but they also need guidance on how it may or may not be helpful for their health and mental health.

## Opportunities

1. Policy may be drafted and proposed to address the needed safety safeguards for AI companion chatbots.
2. AI education in schools can incorporate health and mental health safety content.
3. Engage youth and young adult focus groups to co-create targeted social media campaigns, drawing from TikTok challenges and short-form storytelling trends.
4. Refresh existing campaigns, including Connecticut 1 Word, 1 Voice, 1 Life with more precise objectives, emotionally resonant messaging, and public service announcements spotlighting 988 Suicide and Crisis Lifeline.
5. For maximum reach, ensure content is designed in multiple languages commonly spoken across Connecticut.

# Objective 2.7

Develop research priorities and implement prevention strategies to address the high rate of suicides among older adults.

# Current Status

Connecticut has made limited progress in targeting older adult serving providers and systems in suicide prevention, intervention and response mainly due to the way suicide prevention funding streams have focused on younger populations and their families and caregivers. The impact on the older population is limited at best. In recent years, there has been increased attention to making connections with Senior Centers and Veterans Coffee Houses to train the populations and staff in suicide prevention.

# Opportunities

1. Prevention efforts should focus on programs that rebuild connection through peer support, meaningful activities, and community engagement. Collaborating with staff from the Bureau of Aging in Connecticut and municipal partners who work directly with older adults can help tailor strategies to local needs and ensure outreach is usable for all.
2. Engage older adults, their families, and caregivers through Senior Centers, Senior Living areas, Skilled Nursing Facilities, and Faith Communities for training and education on suicide prevention, intervention, and response support.
3. Train home-based service staff (health aides, companions, Meals on Wheels) and home visiting clinical professionals (mental health clinicians, nurses, occupational and physical therapists) in trauma-informed care, and elder-specific suicide risk, prevention, screening, Counseling Access to Lethal Means (CALM), Safe Storage, and naloxone administration, especially those providing chronic pain management and palliative or hospice care services.
4. Facilitate connections between isolated or lonely older adults and social and community services.
5. Promote CALM, safe storage and disposal practices and materials to families and caregivers prior to discharge from hospitalization and during chronic illness treatment.
6. Engage suicide prevention researchers in Connecticut focused on older adult populations to learn about their studies.
7. Collect epidemiologic and programmatic data to support research applications and evaluation to support older adult population interventions.
8. Partner with pharmacies to distribute safe storage and disposal materials with medications.
9. Develop support for family or older adults struggling with suicidal ideation.



# Goal 3

***Implement effective suicide prevention services as a core component of health care.***



## Objective 3.1

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

## Current Status

The CTSAB's ZSLC was established October 2015 and is currently tri-chaired by representatives from the DMHAS, Hartford Healthcare, and the Connecticut Children's Medical Center. The ZSLC promotes the Zero Suicide approach, which includes best practice (BP) strategies to identify, engage, treat, and follow up with individuals at risk of suicide. The ZSLC promotes the requirements of accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (TJC) for reducing the risk of suicide (National Goal 8), and the Commission on Accreditation of Rehabilitation Facilities (CARF). Many health and behavioral healthcare systems have adopted these BPs statewide with a focus on behavioral health patients.

As of August 2025, 156 staff representing 69 health and behavioral healthcare providers and supportive organizations were members of the Connecticut ZSLC. This includes 35 systems with 72 sites across the state. Additionally, the "Why We Didn't Tell You" presentation was developed by attempt survivors who are members of the CTSAB Lived Experience Committee to educate providers on obstacles to care and promote empathetic BPs. The presentation has been delivered across Connecticut and nationally, amplifying the voices of lived experience in suicide prevention.

# Opportunities

1. Advance the Zero Suicide approach by engaging the health and behavioral healthcare community-based providers and systems in learning opportunities and communities.
2. Promote the Zero Suicide framework and BPs for health and behavioral healthcare.
3. Expand education efforts to ensure providers understand their role in suicide prevention—even for individuals without a behavioral health history.
4. Evaluate the current state of Zero Suicide adoption:
   - Distinguish between formal adoption verses implementation of specific elements.
   - Identify gaps and opportunities for deeper integration.
5. Increase engagement with community-based health and behavioral healthcare providers to assess and build their capacity to support at-risk individuals.

***69 healthcare systems across Connecticut are implementing suicide prevention best practices through the Zero Suicide Learning Community.***



# Objective 3.2

Develop and implement effective standard protocols to identify, engage, treat, and follow up with individuals with elevated suicide risk in health care, supporting the least restrictive environment.

***Statewide suicide prevention standards exist—but implementation and impact vary across providers.***

# Current Status

As of July 1, 2019, the TJC and the CARF began holding accredited systems accountable to national patient safety goals and protocols specific to suicide prevention. Health and behavioral healthcare systems in Connecticut that are accredited by these entities are required to adopt policies, procedures, and protocols aligned with the Zero Suicide approach and BPs. However, implementation varies significantly among providers, and the completeness and effectiveness of these efforts remain unknown at the state level.



# Opportunities

1. Provide discharge guidance to families and caregivers regarding the importance of support and close supervision at home within the two weeks following a suicide attempt, as well as connecting to treatment referrals.
2. Develop and implement suicide prevention protocols with a trauma-informed approach.
3. Modify protocols based on the context in which they are used (e.g., inpatient, outpatient, crisis centers).
4. Use electronic health record (EHR) algorithms to identify individuals at elevated suicide risk.
5. Focus on building connections and addressing the needs expressed by individuals at risk.
6. Enhance protocols with tools and literature, including materials from the Zero Suicide Toolkit, to support effective identification, engagement, treatment, and follow-up.

# Objective 3.3

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

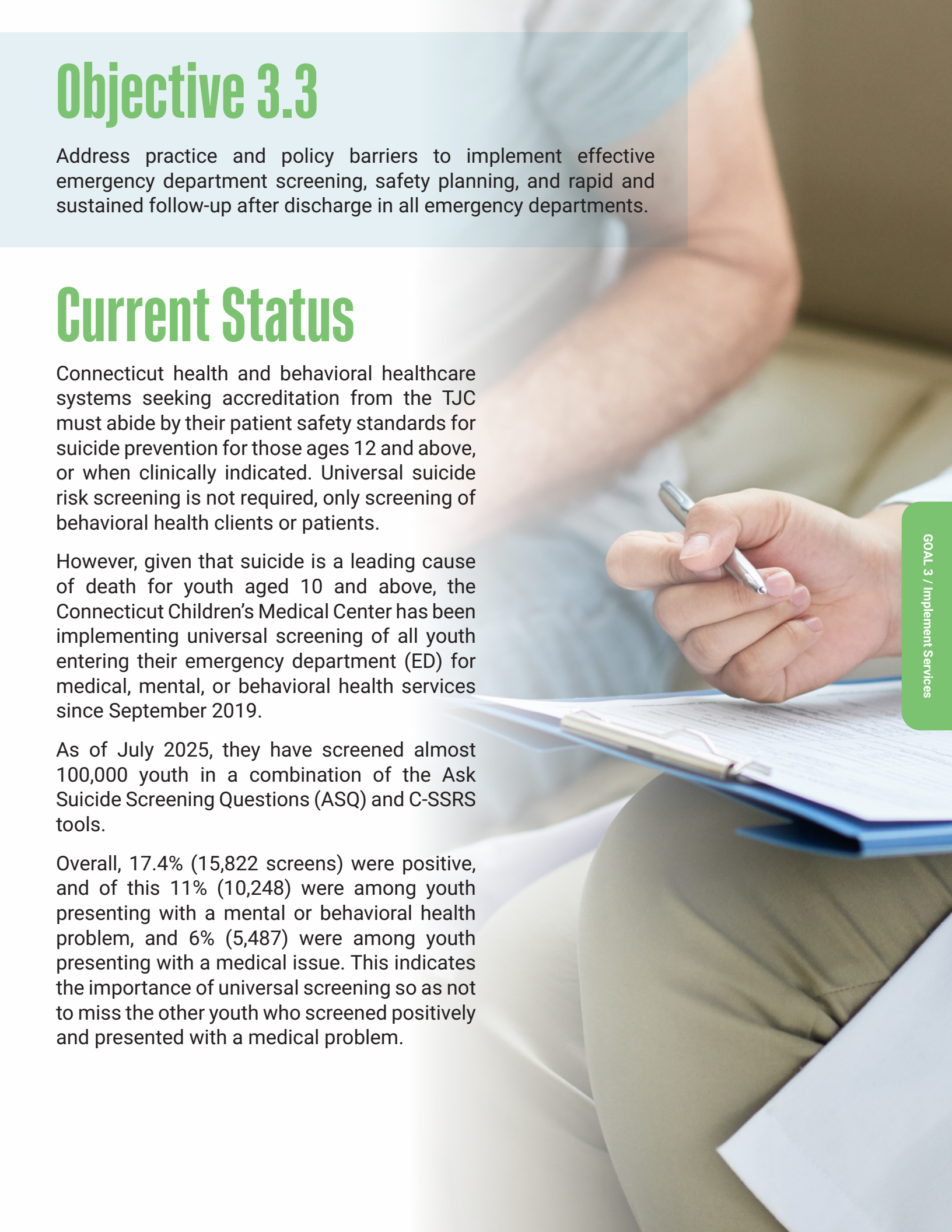
# Current Status

Connecticut health and behavioral healthcare systems seeking accreditation from the TJC must abide by their patient safety standards for suicide prevention for those ages 12 and above, or when clinically indicated. Universal suicide risk screening is not required, only screening of behavioral health clients or patients.

However, given that suicide is a leading cause of death for youth aged 10 and above, the Connecticut Children's Medical Center has been implementing universal screening of all youth entering their emergency department (ED) for medical, mental, or behavioral health services since September 2019.

As of July 2025, they have screened almost 100,000 youth in a combination of the Ask Suicide Screening Questions (ASQ) and C-SSRS tools.

Overall, 17.4% (15,822 screens) were positive, and of this 11% (10,248) were among youth presenting with a mental or behavioral health problem, and 6% (5,487) were among youth presenting with a medical issue. This indicates the importance of universal screening so as not to miss the other youth who screened positively and presented with a medical problem.



# Opportunities

1. Provide discharge guidance to families and caregivers regarding the importance of support and close supervision at home, especially within the two weeks following a suicide attempt, as well as connecting to treatment referrals.
2. Support healthcare systems with EDs in recognizing and overcoming challenges to delivering effective suicide care to universal populations, not only those presenting with mental health or behavioral health needs.
3. Promote the awareness of BP educational opportunities for ED-specific suicide prevention.
4. Train ED staff to implement suicide risk screening of all patients as appropriate for their position.
5. Train ED staff in CALM and safety planning.
6. Create safe environments in EDs for patients receiving services who have suicidal ideation.
7. Provide patients and their family members and caregivers with safety planning, safe storage education, materials, devices (safes, locks, bags), and medication disposal information during services and not just as ED discharge to allow time for environmental changes to be made prior to arrival home.
8. Outreach to patients and/or their family members and caregivers following ED discharge until connections to care have occurred and to facilitate the use of safety planning, not just the day or two after discharge.
9. Share supportive, informative resources with family members and caregivers, community-based providers and EDs to facilitate effective transitions.
10. Utilize peer support in EDs to reduce stigma and isolation and instill hope.

# Objective 3.4

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

***Crisis stabilization services exist, but access and coordination vary across regions and populations.***

# Current Status

Since the implementation of updated TJC and CARF standards in 2019, Connecticut's health and behavioral healthcare systems have placed increased emphasis on ensuring effective continuity of care for individuals at risk of suicide—particularly those presenting with behavioral health concerns. Despite this progress, care transitions remain challenging and inconsistent, influenced by factors such as provider type, patient age, and geographic access.

Currently, there are youth and adult crisis stabilization centers offering short-term, intensive support for behavioral health crises.

**Bridger Services & Peer Support**

- Some providers utilize bridger services and Peer Support Specialists to assist individuals during transitions in care. These roles offer peer-to-peer support, helping patients navigate complex systems and maintain continuity post-discharge.

However, these approaches are not yet universally adopted across all systems.

- The state has implemented one adult Peer Respite Program located in the city of New Britain.

***Continuity of care for individuals at risk of suicide remains inconsistent across providers and settings.***

***Transitions between crisis care, hospitals, and community services remain a critical gap in suicide prevention.***

***Peer support and bridger services help maintain continuity—but are not yet widely available statewide.***

# Opportunities

1. Increase non-ED alternatives such as Urgent Crisis and Stabilization Centers to reduce unnecessary use of high-intensity care.
2. Define effective care and engagement based on individual needs and preferences.
3. Build strong partnerships across different healthcare settings and levels of care to ensure continuity and connection for patients.
4. Replace passive referrals with active warm transitions between levels of care.
5. Develop care pathways informed by risk level, circumstances and patient choice.
6. Assign care coordinators to guide patients through different services within the suicide care continuum.
7. Maintain current service listings accessible to all settings.
8. Facilitate timely linkage to Outpatient Care ensuring patients discharged from EDs and Urgent Crisis Centers are promptly and effectively connected to outpatient providers.
9. Perform safety planning, including lethal means counseling during transitions between care levels and back to the community, and engage supportive family caregivers, and involved providers in their understanding and use.
10. Provide caring follow-up contact communications (calls, texts, cards) to maintain connection, bridge support until connections are made to the next level of care.
11. Make hospital- and community-based peer support groups accessible during treatment and post-discharge.
12. Ensure consistent care and safety protocols across all levels of health and behavioral healthcare systems.
13. Provide psychoeducational programs, training and support groups for families and caregivers of individuals who will be discharged after a suicide attempt. Support patients, families, and caregivers to advocate for school-based transitional support and reentry.

# Objective 3.5

Ensure suicide prevention competency in initial and continuing education of health professionals to achieve and maintain quality and effectiveness of suicide prevention services.

# Current Status

The TJC and CARF require hospital staff who care for patients at high risk for suicide or self-harm to participate in ongoing education and training appropriate to their roles (e.g., observation safety attendants, primary Registered Nurses). Staff must demonstrate competency in screening, assessing, intervening and treating these patients. Competency assessments should occur at hire, periodically thereafter, and whenever care processes change.

In Connecticut, multiple licensed healthcare professionals, including social workers, psychologists, nurses, occupational therapists, physical therapists, and emergency medical services (EMS), are required by law to complete continuing education in suicide risk identification and prevention at varying frequencies.

Some health and behavioral healthcare settings have implemented gatekeeper/community-helper training for interested staff or have required it and other trainings for certain staff based on their positions. Additional trainings being used by health and behavioral healthcare providers include the C-SSRS, ASQ, CALM and Safety Planning.

However, there remains a shortage of clinicians trained in BPs for intervening and treating individuals at risk of suicide. While Dialectical Behavior Therapy (DBT) is one recognized treatment method generally available in Connecticut, fewer clinicians are trained in more costly specialized approaches for suicidal ideation and treatment following an attempt that tend to be costly such as:

- Assessing and Managing Suicide Risk (AMSR)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)
- Brief CBT-SP

***Suicide prevention training is required across many healthcare roles—but access to advanced, evidence-based treatment training remains limited.***

***Ensuring competency in suicide prevention is a standard of care, yet a shortage of trained clinicians continues to impact service quality.***

# Opportunities

1. Health and behavioral healthcare providers from private practice to large systems should be encouraged to complete continuing education for suicide risk identification, intervention and treatment, including safety planning and counseling access to lethal means based on their professional roles and responsibilities.
2. Health and behavioral healthcare systems may develop policies that require staff to complete suicide-specific continuing education based on their unique roles and responsibilities. Employers may incentivize suicide-specific continuing education for their staff through allowing time, supervision, hosting training, and covering costs.
3. Promoted and offered low cost or no cost continuting education whenever possible to ensure broad access across systems and communities.
4. Integrate suicide-centered lived experience into continuing education.
5. Engage undergraduate and graduate clinical training programs to adopt BP suicide-centered models.



# Objective 3.6

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

***Tracking suicide-related data in healthcare systems remains inconsistent and largely unincentivized across Connecticut.***

# Current Status

Continuous quality improvement (CQI) efforts related to suicide prevention vary across agencies and settings, often guided by the standards of accreditation bodies such as the TJC and CARF. While many health and behavioral healthcare systems in Connecticut have the capacity to use EHRs to track patients at risk of suicide or those who have died by suicide, this practice remains optional and lacks formal incentives. Some systems have initiated EHR-based quality improvement or research projects to enhance the identification and treatment of individuals at risk.

The CTSAB's ZSLC includes quality improvement staff from various health and behavioral healthcare organizations, offering a platform to share strategies, resources, and data-driven approaches to improving suicide prevention practices statewide.

# Opportunities

1. Quality Improvement (QI) staff in health and behavioral healthcare settings should advocate for reimbursement structures that are directly tied to performance on CQI measures such that higher compliance with suicide prevention protocols results in higher reimbursement rates.
2. Health and Behavioral healthcare settings should collect suicide-centered data that may be utilized for various CQI projects to inform system-wide treatment improvements, policy and reduce readmits for suicide attempt, and associated suicide death (e.g. care pathway compliance, suicidal behavior, readmission and death prevalence rates).
3. Present CQI project outcomes to staff to engage them in making suicide-centered identification and treatment improvements.



Stronger incentives are needed to standardize how healthcare systems track and improve suicide prevention outcomes.

# Objective 3.7

Increase and leverage the use of electronic health records (EHR) to track and support implementation of best practices for suicide prevention.

# Current Status

Several health and behavioral healthcare systems in Connecticut have proactively modified their EHRs to support suicide prevention and care pathways. These modifications include embedded tools and workflows that facilitate the identification, engagement, screening, assessment, treatment, and connection to care for individuals at risk of suicide. In addition to these clinical enhancements, some systems are participating in research initiatives that leverage EHR-based algorithms to predict suicide risk.

These predictive models—often powered by machine learning—analyze structured and unstructured data to identify patients who may be at elevated risk, enabling earlier intervention and more targeted care. Additionally, algorithms within claims data are being used to help identify individuals at risk of suicide who may benefit from treatment engagement.



# Opportunities

1. Educate and encourage health and behavioral healthcare providers in various traditional and non-traditional settings and systems who do not utilize EHR technology of the benefits related to use pertaining to suicide identification and management components (e.g. private practices, educational settings, systems with embedded health and behavioral healthcare services).
2. Encourage health and behavioral healthcare providers who utilize EHRs to integrate available suicide identification and management components during both initial implementation planning and subsequent system upgrades. These components may include validated screening tools, suicide risk flags, safety planning templates, and care coordination workflows. Embedding these features into the EHR can streamline suicide prevention efforts, improve consistency across providers, and support timely interventions for individuals at risk.
3. Advance the understanding of how EHR and claims data algorithms improve suicide-centered care.

# Objective 3.8

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

# Current Status

Ensuring safe environments by reducing access to lethal means is one of the most effective suicide prevention strategies. Patients, families and their caregivers need clear, direct education about this critical practice. The Joint Commission (Goal 8) recommends using evidence-based practices, particularly for behavioral health patients. However, provider training and comfort with these approaches vary widely, and implementation remains inconsistent among various levels of care and across systems.

Some healthcare systems now require Safety Planning and CALM training during onboarding for particular staff and have developed procedures for distributing lockboxes, firearm locks and other safe storage materials to patients and families. Access to these items also varies. Some hospitals offer them freely through grants or philanthropic funding, while others refer families to external resources, some free and others at cost.

Tracking and standardizing these practices remains challenging even with EHRs, underscoring the need for policies at various levels requiring these practices for fair access to lethal means safety and to reduce suicide attempts and readmissions. It is unknown if individual health and behavioral health clinicians in private practice are 1) aware of the importance of performing Safety Planning and CALM with individuals with suicidal ideation or a history of attempts, 2) are seeking training, or 3) are implementing these practices with patients, their families and caregivers.



# Opportunities

1. Health and behavioral healthcare systems may update their policies to set minimum standards for their providers and settings pertaining to safety planning and CALM practices.
2. Require that discharge planning services include written discharge plans that are made in consultation with the patient, or the patient's family or caregiver and include safety plans, lethal means counseling, and guidance for preparing immediate safety at home and suicide prevention-centered homecare.
3. Provide patients and their family members and caregivers with safety planning, lethal means counseling, safe storage education, materials, devices (safes, locks, bags) or where to access them, and safe medication disposal information prior to discharge to allow time for environmental changes to be made in preparation for the patient's return home.
4. Ensure patients being discharged with opioids are also discharged with naloxone and that the patients, their family, and caregivers receive naloxone administration education.



# Objective 3.9

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

# Current Status

Members of the ZSLC include health and behavioral healthcare providers serving individuals with substance use issues and co-occurring disorders. Supportive agencies within the collaborative also offer naloxone training as part of gatekeeper and community-helper programs, equipping providers to respond to overdose risk alongside suicide prevention.

Hartford HealthCare's Behavioral Health Network has modified the Stanley - Brown Safety Plan to include additional safety planning questions more tailored to patients with co-occurring or primary substance use disorders to enhance suicide care management for these patients.



# Opportunities

1. Encourage substance use assessments to include evidence-based suicide screening, such as universal screening during rehabilitation, and provide CALM/Safety Planning for individuals who screen positive.
2. Sustain the inclusion of QPR training within naloxone distribution efforts, leveraging State Opioid Response grant funding to equip community helpers with suicide prevention skills alongside overdose response.
3. Engage individuals with lived experience of suicide risk and substance use disorders to inform service design, training, and care delivery, ensuring programs reflect real-world needs and foster trust.
4. Promote cross-sector collaboration between mental health and substance use disorder treatment to improve communication, coordination, and seamless transitions across care settings.
5. Educate Recovery Support Specialists on the intersection of substance use disorders and suicide risk, how to recognize and respond to peers they are supporting who may be at risk of suicide, and available resources.

# Objective 3.10

Support suicide prevention and whole person health among healthcare workers and other occupational groups who experience traumatic exposure to suicide, such as first responders, healthcare providers, and crisis workers. Provide education for medical professionals in how to support survivors after a loss.

# Current Status

Health and behavioral healthcare systems and occupational groups such as first responders, crisis workers and corrections staff frequently exposed to suicide risk have developed staff wellness programs, peer programs and encourage use of Employee Assistance Programs (EAP) to maintain mental health and access support especially following critical incidents. Hartford Healthcare also has a suicide Postvention Protocol that guides staff response to suicide loss within the healthcare system to ensure impacted patients and staff receive timely support.

The CTSAB with CABLE and State Police have created tailored materials for officers responding to suicide loss. Additionally, CABLE offers training to first responders to develop Peer Support Teams, and grassroots organizations like Thin Line Peer Support offer peer support for first responders statewide. Many school districts across the state have partnered with the Connecticut-based CSSCP to adopt the PREPaRE model to assess trauma risk and deliver mental health interventions after crisis events, including suicide attempt and loss.

DMHAS and DCF mobile crisis services staff have been provided Critical Incident Group Debriefing (CIGD) training, a short-term intervention designed to support people after a distressing or unusual event, including staff. DMHAS and DCF fund the RSABs to provide BP suicide postvention response guidance to various settings and communities, postvention plan development, and training using the CONNECT Postvention model, which emphasizes how to respond to suicide deaths in a coordinated, compassionate manner while also promoting healing within the community and reducing the risk of suicide contagion. The Connecticut National Guard has implemented postvention protocols through its Joint Resilience Directorate, and the Connecticut Department of Correction maintains an active EAP partnership to address staff adverse experiences through its POWER Program.

> ***Staff wellness and peer support programs are critical for those regularly exposed to suicide risk.***

# Opportunities

1. Expand the adoption of staff wellness programs among health and behavioral healthcare systems.
2. Promote awareness of the 988 Suicide and Crisis Lifeline among first responders and healthcare workers as a resource for both those they serve and themselves.
3. Engage EAP providers in postvention training to support workers who have experienced a suicide loss.
4. Foster collaboration between suicide prevention professionals and occupational associations to advance postvention planning, training, and supports.
5. Support the expanded development and use of postvention plans in health and behavioral healthcare settings, as well as in other sectors and communities.
6. Promote resources available to clinician-survivors of suicide loss, including the national Coalition of Clinician-Survivors.
7. Encourage caregivers and professional support of suicide loss survivors to seek help proactively, recognizing the risks of secondary trauma and burnout.
8. Normalize help-seeking and embed postvention supports into workplace wellness strategies.







# Goal 4

***Reduce access to lethal means among people at risk of suicide.***



## Objective 4.1

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

***Expanding access to lethal means safety training is equipping communities with the tools to prevent suicide.***

## Current Status

CALM and collaborative safety planning trainings are being promoted as highly effective BPs. Online trainings are widely promoted, and DMHAS and DCF fund the RSABs to deliver CALM America trainings upon request. The focus has broadened beyond healthcare providers to include the wider community. Training now targets key populations such as youth, older adults, families of Service Members and Veterans, incarcerated individuals, and staff across home-based, clinical, and long-term care settings.

State law permits any local or regional board of education to offer firearm safety programs to students in grades kindergarten to twelve. Additionally, CSDE, shall provide guides to aid local and regional boards of education in developing firearm safety programs for such students.

The GC continues to advance the Lethal Means Safety Priority Area by equipping individuals and families with suicide prevention knowledge and tools to make informed decisions about firearm access.

# Opportunities

1. Expand lethal means safety education across communities to reinforce that everyone has a role in suicide prevention.
2. For individuals at risk, family, friends, and caregivers can learn how to reduce access to lethal means through safe storage practices such as securing firearms, medications, sharps and ligature items, managing access, and facilitating their removal or disposal when or as needed.
3. Ensure safe storage and disposal educational materials are maintained, meet various populations' needs and are distributed broadly.

# Objective 4.2

Evaluate policies, programs, and practices that put time and space between a person at risk and a lethal means of suicide, including their impact on communities with unmet needs.

***Connecticut's firearm safety laws are a critical component of suicide prevention, helping save lives through temporary removal of lethal means.***



# Current Status

Connecticut's firearm legislation, particularly the Extreme Risk Protection Order (ERPO), has been a significant tool in suicide prevention. The ERPO allows family members, household members, and law enforcement to temporarily remove firearms from individuals deemed a danger to themselves or others. This law has been effective in preventing suicides, with studies estimating that it has saved between 32 and 76 lives from suicide with a firearm in the first 17 years of its existence (Swanson et. al., 2024).

The CTSAB Lethal Means Committee has developed materials to encourage safe practices within homes to reduce access to lethal means. These include – safe storage of medications and other substances, safeguarding home spaces, and firearm safe storage. Additionally, they have developed a firearms and suicide prevention education insert for permit classes and have collaborated across multiple state and non-profit agencies to post 988 Suicide & Crisis Lifeline signs statewide on bridges, overpasses, at railroad stations, and other locations.

DMHAS funds the Change the Script campaign that includes materials to encourage safe storage and provides free medication lock boxes and disposal bags upon request statewide. State policy supports medication disposal drop-boxes in police stations, and NaloxBoxes in communities and on college campuses.

Multiple healthcare providers, non-profits, and police departments collaborate annually to provide the #KeepKidsSafe Connecticut Statewide Gun Buyback and Gun Safe Giveaway Day to collect unwanted firearms and increase safe storage. Bi-annual National Drug Take-Back Days are promoted statewide to encourage community members to drop off their unused and expired medications.

Existing legislation supports discharge counseling with patients, their families and caregivers, but does not specify medication safety, storage or disposal education.

# Opportunities

1. Perform ongoing analysis of local data to identify populations affected by suicide risk to identify and address gaps.
2. Once priority populations are identified, convene experts in lethal means safety alongside trusted community partners to co-develop evidence-informed policies and practices.
3. Ensure these strategies are tailored to each group's context and can be implemented across systems to reduce risk and improve outcomes for all groups.
4. Identify policy opportunities to embed reducing access to lethal means suicide prevention education within existing educational requirements during the health and behavioral healthcare discharge process, and for firearms owners and those who use them in their professions.
5. Enhance existing safety requirements for high-risk areas (e.g. bridges, overpasses, railroads) to include 988 Suicide & Crisis Lifeline signage and barriers.
6. Promote how to access secure storage mechanisms for medications and firearms at no or low cost.
7. Continue to promote take-back days to reduce lethal means in homes.
8. Expand current 988 Suicide & Crisis Lifeline signage initiative to include parking lots, parks, waterfronts, and other public spaces to increase visibility of crisis support and prevention resources.

# Objective 4.3

Partner with firearms and other relevant organizations and communities to incorporate suicide awareness and prevention as basic tenets of firearm safety and responsible ownership.

## Current Status

The CTSAB Lethal Means Committee initiated a firearm safety workgroup in February 2023, bringing together multidisciplinary key informants from public health, firearm safety, and healthcare to create an educational document and PowerPoint presentation tailored for firearm instructors.

This initiative aligns with the Connecticut GC to Suicide Prevention Among SMVF, specifically supporting the Lethal Means Safety and Safety Planning priority area.

***Integrating suicide prevention into firearm safety is key to promoting responsible ownership and saving lives.***

***Engaging firearm owners and instructors in prevention efforts strengthens awareness, dialogue, and safe practices.***

***Partnerships with the firearm community are essential to advancing suicide awareness and safe storage practices.***

## Opportunities

1. Continue to convene and expand the firearm safety workgroup to explore opportunities to suicide awareness and prevention.
2. Actively engage members of the firearm-owning community in outreach, dialogue, and the development of safety strategies.
3. Update and distribute firearm safety materials to firearm dealers, instructors, ranges, and retailers.
4. Explore firearm training requirements associated with permitting and licensing and identify methods to include the developed PowerPoint presentation and suicide prevention resources, then and through renewal packets.
5. Partner to distribute safety and suicide prevention educational materials at firearm retailers, ranges, and to firearm using workforces (e.g, law enforcement, corrections, security, military, farmers).

# Objective 4.4

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

# Current Status

DMHAS, DCF and DPH fund a variety of substance use prevention and harm reduction programs and practices guided by BPs for the lifespan. The federal Substance Use Prevention and Treatment Block Grant through the SAMHSA requires a minimum 20% set-aside to support substance use prevention strategies. DMHAS utilizes these funds to support the substance use prevention infrastructure and multiple community grants, including the biennial regional prioritization process to assess needs and gaps in the state's substance use prevention, mental health promotion, suicide prevention, and gambling prevention efforts. The substance use prevention infrastructure works to build the capacity of prevention professionals and partnering organizations, communities, and settings such as schools, campuses, and workplaces, to prevent substance use among the people served, predominantly focused on youth and young adults and those serving them. Harm reduction programs exist to provide services to those who have an identified substance use disorder and mitigate risk associated with their disorders, provide direct care, Medication for Opioid Use Disorder (MOUD), Recovery Peer Support, etc. Additionally. Recovery Friendly Communities, Workplaces and Campuses continue to be engaged and expanded to provide supports to individuals in recovery or seeking recovery from substance use or mental health conditions by providing education, open communication and reducing stigma in supportive, welcoming environments that help individuals thrive. Many of these providers also support the suicide prevention infrastructure in the state and are aware of the significant intersection between the two and how addressing shared risk and protective factors can impact both.



# Opportunities

1. Strengthen cross-agency collaboration by promoting consistent communication and coordination around harm reduction practices.
2. Mitigate risks related to medication misuse by enhancing medication safety, access, use and disposal education, especially for adults with chronic health conditions and older adults, through organizational partnerships.
3. Integrate suicide prevention messaging with harm reduction messaging and promote in treatment programs and community environments to normalize help-seeking and reinforce access to care.
4. Expand the promotion and distribution of naloxone with suicide prevention gatekeeper/community-helper trainings.
5. Ensure through policy and practice the integration of suicide prevention education to staff and clients of harm reduction services.





# Goal 5

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



## Objective 5.1

Improve the quality, timeliness, scope, usefulness, and accessibility of suicide death data.

***Connecticut is strengthening suicide prevention through robust data systems that inform intervention, evaluation, and response.***

# Current Status

Under the management of the DPH's Injury and Violence Surveillance Unit, the Connecticut Violent Death Reporting System (CTVDRS) continues to provide Connecticut and its communities with a clearer understanding of violent deaths through gathering information on the complex circumstances surrounding violent deaths. These data and the insights gained from them continue to inform the development of prevention strategies, potential points for intervention, and ways to evaluate and improve of suicide rates at the state and community levels. The CTVDRS data also contribute to the National VDRS dataset. CTVDRS data are publicly available from 2015-2023, generally in 3-year and 5-year aggregations of data. CTVDRS aggregate data are provided to the CTSAB, researchers, and others. Regional data on suicide and homicide deaths are regularly provided to the RSABs by request.

There is a statewide process for postvention response to suicide loss of youth age 24 years and younger. Within 24-hours of the loss, the OCME notifies the Office of the Child Advocate and they then inform the CTSAB Postvention Response Team of responding state agencies and relevant partnering organizations depending on the location of the loss. This notification process ensures timely support and guidance to affected survivors, schools,

campuses and communities based on BPs.

DPH maintains monthly contact with OCME, local police, and state police to routinely access their quantitative and qualitative data related to suicide deaths. Data transfer is supported by a Memorandum of Understanding (MOU). State statutes support OCME data sharing with state agencies. Additional state statutes support data exchange among other state agencies. Twice per year, death certificate data of Connecticut residents who died by suicide or other violent deaths are uploaded to CTVDRS and integrated into the case information.

DPH's Electronic Death Registry System (EDRS), CT Vitals, allows death data providers (funeral directors, medical certifiers, and local registrars) to electronically create, update, sign/certify, and register death certificates. The EDRS works with the OCME data system via interoperability, thereby reducing data entry and enabling more timely and efficient data collection and reporting of deaths to other state agencies that utilize these data.

A public-facing Violent Injury Data Dashboard is being developed by the DPH with guidance from the CTSAB Data to Action (D2A) Committee Chairs, and UConn Health Evaluators. The dashboard is coordinated with existing suicide death, ideation and attempt data portals. These parties have developed a Violent Injury Data Dashboard Workgroup (VIDWG) to oversee the production, and a user guide will be developed while the dashboard is being finalized. The project is made possible through braided funding through the Connecticut DPH Office of Firearm Injury Prevention, the Office of Injury and Violence Prevention, and the Connecticut DMHAS' GLS Youth Suicide Prevention Grant-PH2 funded by the federal SAMHSA.

Associated with the GC, the state began planning for a Suicide Mortality Review Panel (SMRP) focused on Veteran and Service Member suicide deaths. Led by the D2A Committee co-chairs, the SMR Working Group was established in 2023 to design a statewide panel that will conduct standardized reviews of identified suicide deaths among Veterans and Service Members. Should the SMRP be launched it will draw from multiple clinical and non-clinical data sources to deepen its understanding of contributing factors and generate actionable, data-informed recommendations to prevent future deaths.



***Timely data sharing and coordinated reporting enable faster, more informed responses to suicide across communities.***

# Opportunities

1. Partner with the CTSAB D2A Committee and DPH Injury and Violence Surveillance and Prevention staff to establish a regular schedule for sharing Connecticut Violent Death Reporting System (CTVDRS) data with RSABs and the D2A Committee.
2. Identify and prioritize key data elements most useful to RSABs and community partners to guide prevention efforts.
3. Collaborate with CTVDRS data owners to:
    - Develop a reporting schedule aligned with RSAB needs.
    - Submit a standing data request based on agreed-upon frequency and content.
4. Develop an interactive Violent Injury Data Dashboard that includes suicide and violent death data from the CTVDRS, informed by CTSAB D2A Committee and prevention partners.
    - Create and maintain a Dashboard User Guide, updating it as new features are added.
    - Conduct statewide, regional, and local training to build data use and interpretation capacity.
5. Ensure that individuals with lived experience and those affected by suicide loss are meaningfully involved in shaping dashboard content, usability, and outreach strategies.
6. Use collaborative engagement to reflect various community needs and reduce data access challenges.
7. Establish a SMRP for Service Members and Veterans. Define pathways for sharing recommendations with state and regional systems to inform suicide prevention strategies. Assess the need for supportive policy to strengthen the SMRP and facilitate secure data access.

# Objective 5.2

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

# Current Status

Since the launch of **PLAN 2025**, Connecticut has advanced multiple mechanisms to improve the quality, timeliness, scope, usefulness, and availability of data on suicidal thoughts, behaviors, and related risk and protective factors. These efforts span surveillance systems, legislative mandates, strategic partnerships, and infrastructure development, each aimed at strengthening data-informed suicide prevention across the state.

In 2021, DPH built algorithms in the department's syndromic surveillance (SyS) system that identify ED and urgent care center patient visits that indicate suicidal thoughts, self-harm, and suicide attempts. The SyS collects suicidal ideation and attempt data from emergency departments across the state, and DPH prepares a monthly disaggregated data report that includes data at the state level, by RSAB regions, and by Local Health Departments and Districts. This report is shared with these providers and other persons responsible for suicide prevention. Conn. Gen. Stat. § 10-217h passed in 2022 mandates school participation in the Connecticut School Health Survey (CSHS), Connecticut's version of the CDC's Youth Risk Behavior Survey, which occurs each odd year. The survey collects data on suicidal ideation, suicide attempt, mental health, Adverse Childhood Experiences (ACEs), and protective factors, with demographic breakdowns.

Multiple schools and communities have instituted their own youth behavior surveys of high school students. Some capture suicide ideation, attempt, mental health, and other related risk and protective factor data while others do not. Additionally, some communities use established instruments, while others develop their own which dramatically impacts their validity, comparability, and result application. The CTSAB Data and Surveillance Committee was re-branded as the D2A in 2021, focusing on translating data into strategies that inform suicide prevention and response. The D2A Committee participated in two rounds of the national SPRC Communities of Practice in 2021 and 2022 and the national SMVF Technical Assistance Center's SMR Academy in 2024 and Summit in 2025, activities to strengthen data infrastructure.

RBHAOs that administer the RSABs, perform a biennial regional prioritization process that engages multiple key partners to identify needs and gaps in substance use disorder prevention, gambling disorder prevention, mental health promotion and suicide prevention, intervention and response, and opportunities to address them. This process is performed in odd years and results are posted to the DMHAS website. See Objective 5.1 Violent Injury Data Dashboard, which is also relevant to this objective.

# Opportunities

1. Develop a plan for regular and widespread dissemination of suicide ideation and attempt data and risk and protective factors.
2. Explore partnership opportunities to expand current prevention and treatment provider capacity to access and utilize data to drive their efforts.
3. Promote collaboration among local and state entities that collect, manage, and share suicide-related data to improve planning and response.
4. Institute engagement of affected populations and individuals with lived experience in all data synthesis, interpretation, and planning aspects.
5. Engage schools and communities to establish local validated surveys that include youth suicide ideation, attempt, and other related risk and protective factor measures.
6. See Violent Injury Data Dashboard in Objective 5.1.



# Objective 5.3

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

# Current Status

While there has been progress in Connecticut in the availability and use of novel data sources and analytic methods to monitor suicidal thoughts, behaviors, and related risk and protective factors, the state has not yet adopted innovations to make the data available to the public.

Some school districts in Connecticut contract with platforms like Gaggle, which use machine learning and human review to flag youth risk behaviors, but implementation remains inconsistent statewide.

Academic institutions such as Yale University, Wesleyan University, and UConn have contributed valuable research over the past two decades, developing algorithms and exploring suicide predictors, primarily before the emergence of newer data approaches. These efforts offer a strong foundation for future innovation and cross-sector collaboration.

Some health and behavioral healthcare systems in Connecticut are participating in research initiatives that leverage EHR-based algorithms to predict suicide risk. These predictive models—often powered by machine learning—analyze structured and unstructured data to identify patients who may be at elevated risk, enabling earlier intervention and more targeted care. Additionally, algorithms within claims data are being used to help identify individuals at risk of suicide who may benefit from treatment engagement.

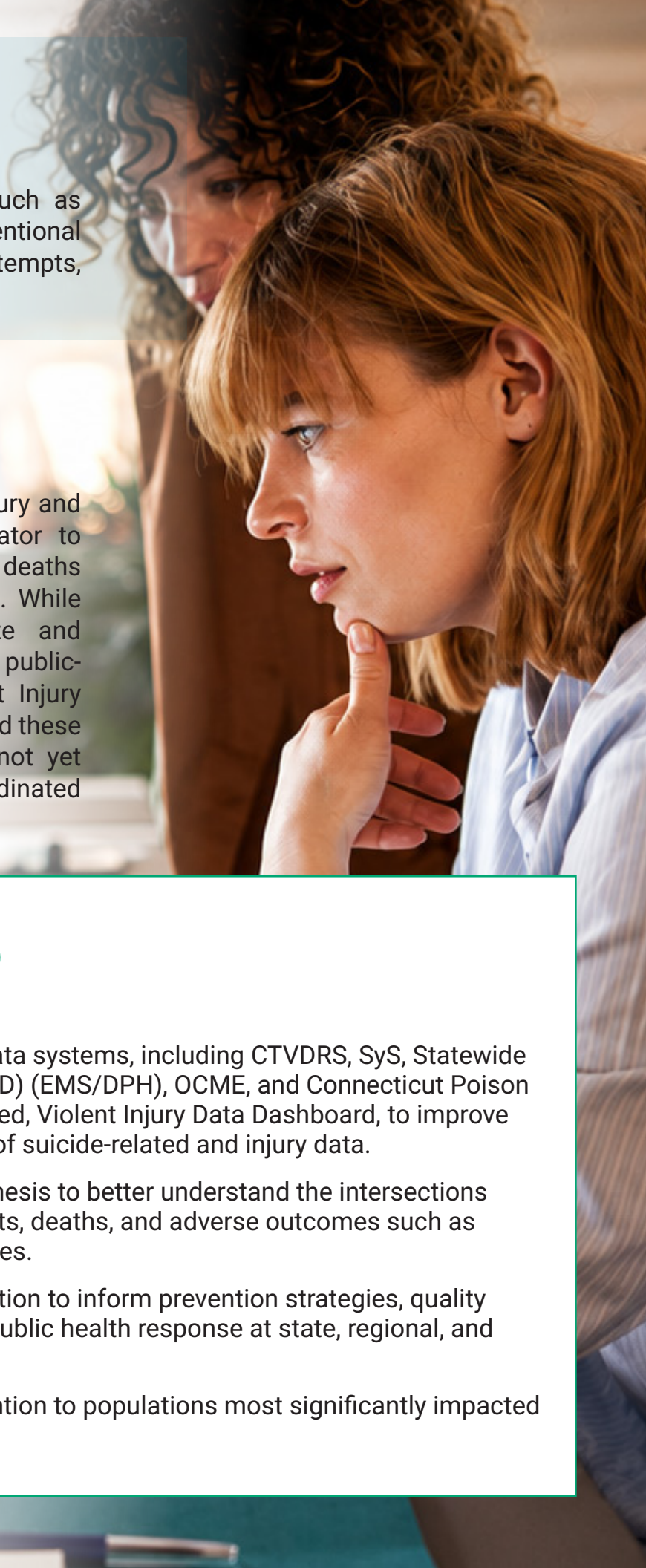
## Opportunities

1. Facilitate the understanding of novel successful approaches and encourage their expansion.
2. Build state and regional infrastructure to responsibly utilize emerging data sources such as social media, internet search trends, and digital communication platforms, to identify patterns of suicidal ideation, attempts, and associated risk factors.
3. Build novel data methods in evaluation and quality improvement of federally funded initiatives that address suicide.



# Objective 5.4

Integrate data on adverse outcomes such as unintentional overdoses and other unintentional injuries with data on suicide thoughts, attempts, and deaths.



# Current Status

The OCME collaborates with the DPH Injury and Violence Surveillance CTVDRS Coordinator to share data on unintentional overdose deaths that are later determined to be suicides. While DPH Epidemiologists regularly analyze and present overdose data, supported by a public-facing Overdose Dashboard, the Violent Injury Data Dashboard is still in development, and these data streams remain siloed. They are not yet systematically integrated to inform coordinated suicide prevention practice.



# Opportunities

1. Strengthen linkages across key data systems, including CTVDRS, SyS, Statewide Opioid Reporting Directive (SWORD) (EMS/DPH), OCME, and Connecticut Poison Control, and the soon to be released, Violent Injury Data Dashboard, to improve access, quality, and coordination of suicide-related and injury data.
2. Facilitate cross-system data synthesis to better understand the intersections between suicidal ideation, attempts, deaths, and adverse outcomes such as unintentional overdoses and injuries.
3. Promote collaborative data utilization to inform prevention strategies, quality improvement efforts, and timely public health response at state, regional, and community levels.
4. Ensure data integration, with attention to populations most significantly impacted by suicide and overdose.

# Objective 5.5

Evaluate the impact of the Connecticut State Suicide Prevention Plan on core indicators of Plan progress and the effects on suicide thoughts, attempts, and deaths.

***While evaluation is prioritized, Connecticut lacks a comprehensive system to track outcomes and measure impact across suicide prevention efforts.***

# Current Status

Since the launch of Connecticut's suicide prevention initiatives, detailed evaluation plans have been embedded within externally funded programs such as the CSP and PH2, in alignment with requirements from federal funders like the CDC and SAMHSA. The State Suicide Prevention Plan has consistently emphasized the importance of monitoring and evaluation across its goals and objectives. However, progress is typically assessed from one plan cycle to the following through broad trend analysis—primarily focused on suicide mortality—and general updates on objective status. While these efforts offer a high-level view of statewide activity, they do not include tracking of individual outcomes. At present, Connecticut lacks a comprehensive evaluation framework capable of assessing the effectiveness and impact of suicide prevention efforts across systems and populations.



# Opportunities

1. Sustain funding for evaluation activities initiated through federally supported initiatives, including personnel and data tracking systems.
2. Develop SMARTIE (specific, measurable, achievable, relevant, time-bound, inclusive and equitable) activities that advance the **PLAN 2030** goals and objectives to enable measurable progress aligned with NSSP core indicators.
3. Seek dedicated funding to support a comprehensive, statewide evaluation framework that assesses the effectiveness of suicide prevention strategies.
4. Establish mechanisms to monitor outcomes across service providers, systems, populations, and regions over time.

# Objective 5.6

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

# Current Status

The DPH reports that Connecticut has not experienced any suicide clusters in the past decade within towns, but there have been campuses that have experienced student losses in close proximity. The RSABs are funded by DMHAS and DCF to build their own capacity by being trained as trainers in utilizing and promoting evidence-based practices to guide the identification, assessment and response to suicide or suicide attempts, including clusters. This guidance and training are made available to communities and campuses.

***While no town-level clusters have been identified, campuses remain vulnerable to suicide losses in close proximity.***

***Connecticut is investing in local readiness—equipping communities to recognize and respond to emerging suicide clusters.***

# Opportunities

1. Promote training opportunities to towns and campuses on how they may use their data to drive their identification and assessment of the need to develop community-led response to potential suicide or suicide attempt clusters.
2. Conduct debriefings for all entities responding to a suicide or suicide attempt, focusing on lessons learned, opportunities to strengthen support, and planning for additional follow-up if needed.
3. Ensure all mobile crisis teams are equipped with current intervention and postvention response protocols and resource guides.
4. Encourage communities and campuses to host CONNECT Postvention trainings, intentionally form postvention teams and develop written plans, prioritizing outreach to areas significantly impacted by suicide loss.
5. Integrate suicide intervention and postvention response protocol into first responder recertification training.

# Appendix A- Glossary

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

**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.

**Attempt survivor**- see suicide attempt survivor.

**Behavioral health**- a state of mental/emotional being and/or choices and actions that affect wellness.

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

**Bereaved by suicide**- Family members, friends and others affected by the suicide of a loved one. Can be referred to as survivors of suicide loss.

**Best practices (BP)**- Activities or programs that are in keeping with the best available evidence regarding what is effective.

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

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

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

**Community helper** - 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 settings, such as schools, prisons, and the military.

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

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

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

**Culture**- the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions reflective of their community.

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

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

**Evaluation**- the standardized investigation of the value and impact of an intervention or program.

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

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

**Goal**- a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

**Gatekeepers**- see Community Helper

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

**Interested parties** - Entities including organizations, groups, and individuals that are affected by and contribute to decisions, consultations, and policies.

**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).

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

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

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

**Means/Methods**- The instrument, material, or method used to engage in self-inflicted injurious behavior, presumed to be suicidal if there is evidence of any intent to die as a result of the behavior.

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

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

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

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

**National Strategy for Suicide Prevention (NSSP)** - The National Strategy for Suicide Prevention is a comprehensive, whole-of-society approach to suicide prevention that provides concrete recommendations for addressing gaps in the suicide prevention field.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Safety plan**—A collaborative plan between patient and clinician that contains a written list of warning signs, coping responses, supports (both lay and professional), and emergency contacts that an individual may use to avert thoughts, feelings, or impulses or behaviors related to suicide, including restriction of access to lethal means.

**Safe and secure storage**- the proper, protective storage of firearms, medications, and other potentially lethal means to reduce the likelihood of suicide attempts.

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

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

**Stakeholders**—see Interested Parties

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

**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 cocaine, inhalants, hallucinogens and heroin.

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

**Suicidal ideation**—Thoughts of engaging in suicidal behaviors or serving as the agent of one's own death (active ideation), or preoccupation with death or being dead (passive ideation).

**Suicide** – Death caused by intentional self-directed injurious behavior with any intent to die. Instead of "committed" or "completed", it is currently recommended to use the phrase, "died by suicide".

**Suicide attempt** – A non-fatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior with or without injuries.

**Suicide attempt survivor** – a person who survived a prior suicide attempt.

**Suicidal thoughts**- General nonspecific thoughts of wanting to end one's life (either active or passive).

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

**Unintentional**—Term used for an injury that is unplanned; in many settings, these are termed accidental injuries.

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.

Source: Jacobs, D. G., & Klein-Benheim, M. (2024). Current status of suicide-focused assessment and treatment: An online resource for clinicians (Updated September 2024). Stop A Suicide Today. https://stopasuicide.org/wp-content/uploads/2024/09/Online-Resource-Sept-2024.pdf

# Appendix B- Acronym List

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|---|---|
| ACE | Adverse Childhood Experiences |
| AFSP | American Foundation for Suicide Prevention |
| AI | Artificial Intelligence |
| AMSR | Assessing and Managing Suicide Risk |
| ASIST | Applied Suicide Intervention Skills Training |
| ASQ | Ask Suicide Questions |
| BP | Best Practices |
| CABLE | Connecticut Alliance to Benefit Law Enforcement |
| CALM | Counseling Access to Lethal Means |
| CAMS | Collaborative Assessment and Management of Suicidality |
| CARF | Commission on Accreditation of Rehabilitation Facilities |
| CBT-SP | Cognitive Behavioral Therapy for Suicide Prevention |
| CDC | Centers for Disease Control and Prevention |
| CIGD | Critical Incident Group Debriefing |
| CIT | Crissis Intervention Team |
| CPS | Child Protective Services |
| CQI | Continuous Quality Improvement |
| CSHS | Connecticut School Health Survey |
| CSP | Community Suicide Prevention |
| CSSCP | Center for School Safety and Crisis Preparation |
| CSSRS | Columbia Suicide Severity Rating Scale |
| CSU | Crisis Stabilization Units |
| CT | Connecticut |
| CTSAB | Connecticut Suicide Advisory Board |
| CTVDRS | Connecticut Violent Death Reporting System |
| D2A | Data to Action |
| DCF | Department of Children and Families |
| DEA | Drug Enforcement Administration |
| DESPP | Department of Emergency Services and Public Protection |
| DMHAS | Department of Mental Health and Addiction Services |
| DPH | Department of Public Health |
| ED | Emergency Department |
| EDRS | Electronic Death Registry System |
| EHR | Electronic Health Records |
| EMS | Emergency Medical Services |
| ERPO | Extreme Risk Protection Order |
| GC | Governor's Challenge |
| GLS | Garrett Lee Smith |
| LGBTQI2S+ | Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Two-Spirit |
| MOU | Memorandum of Understanding |
| MOUD | Medication for Opioid Use Disorder |
| NSSP | National Strategy for Suicide Prevention |
| OCA | Office of the Child Advocate |
| OCME | Office of the Chief Medical Examiner |
| PH2 | Partnerships for Hope and Healing |
| QI | Quality Improvement |
| QPR | Question, Persuade, Refer |
| RBHAO | Regional Behavioral Health Action Organization |
| RSAB | Regional Suicide Advisory Board |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SDOE | State Department of Education |
| SMRP | Suicide Mortality Review Panel |
| SMVF | Service Members, Veterans, and their Families |
| SPRC | Suicide Prevention Resource Center |
| SWORD | Statewide Opioid Reporting Directive |
| SyS | Syndromic Surveillance System |
| TJC | The Joint Commission |
| UConn | University of Connecticut |
| VA | Veterans Administration |
| VACT | Veterans Administration of Connecticut |
| VIDWG | Violent Injury Data Dashboard Workgroup |
| ZSLC | Zero Suicide Learning Community |

# Appendix C- Risk & Protective Factors

**Protective Factors:**

Societal:
- Availability of physical and mental health care
- Restrictions of lethal means of suicide

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

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

Individuals:
- Coping and problem-solving skills
- Reasons for living (e.g., 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 (e.g., lack of access to providers or medications, prejudice, stigma)

Relationship:
- High conflict or violent relationships
- Family history of suicide

Individual:
- Mental illness
- Substance misuse
- Previous suicide attempt
- Impulsivity/aggression

# Appendix D- Types of Grants

Connecticut state agencies, tribes, organizations and college campuses are successful recipients of federally funded suicide prevention initiatives. These federal funds support key suicide prevention, intervention and response infrastructure development, capacity building and service delivery to populations at increased risk of suicide and those serving them statewide in various sectors and settings (e.g. communities, schools, college campuses, workplaces, hospitals, state agencies, and community organizations). The state agencies closely monitor the forecasts for federal funding opportunities and work collaboratively to prepare applications and administer grants when successfully received. The grants active during the next five years are in the table below in alphabetical order.

| Grant Title | Federal Funder & Title | Funded State Agency & Project Directors (PD) | Funding Period | Funding Amount | Prioritized Geography | Prioritized Populations |
|---|---|---|---|---|---|---|
| ***BeWellUconn Suicide Prevention (SP)*** | Substance Abuse and Mental Health Services Administration's (SAMHSA) GLS Campus Suicide Prevention Grant | University of Connecticut Student Health and Wellness (SHaW) | September 2024– September 2027 | $102,000 annually | Across all campuses | Undergraduate students across five campuses |
| **Priorities:** BeWellUConnSP will focus on suicide prevention and reduction of mental health and substance use disorders at UConn's five campuses by leveraging its JED Campus Initiative to achieve these goals: I) enhance access to evidence-based specialized suicide care to treat students at risk for suicide; II) implement new strategies that promote help seeking and reduce stigma; and III) improve identification of these disorders by educating and training staff and faculty. | | | | | | |
| | | | | | | |
| ***Connecticut 988 Implementation Initiative*** | Substance Abuse and Mental Health Services Administration's (SAMHSA) Cooperative Agreements for States and Territories to Improve Local 988 Capacity | Connecticut Department of Mental Health and Addiction Services (Funded Agency and PD); Co-PD- Connecticut Department of Children and Families | September 2023– September 2026 | $6,976,323 total ($2,325,441 annually) | Statewide | Individuals at increased risk of suicide across the lifespan. |
| **Priorities:** 1) Enhance recruitment, hiring, and training of the 988 workforce to meet a minimum 90% state or territory calls, chats, and texts demand; 2) implement additional technology and security measures to fully support 988 infrastructure and effective coordination across the crisis continuum; 3) improve 988 support and service for high-risk and underserved populations; 4) develop and implement comprehensive quality assurance plans, to include identification and review of critical incidents; and 5) develop and implement comprehensive 988 communication plans to align with SAMHSA's 988 partner toolkit. | | | | | | |
| ***Connecticut Comprehensive Suicide Prevention (CSP)*** | Centers for Disease Control and Prevention's (CDC) Comprehensive Suicide Prevention | Connecticut Department of Public Health (Funded Agency and PD); Co-PDs- Connecticut Department of Mental Health and Addiction Services and Connecticut Department of Children and Families | August 2020– August 2027 | $4,900,000 total ($700,000 annually) | Statewide | Individuals at increased risk of suicide across the lifespan and those serving them. |

| Grant Title | Federal Funder & Title | Funded State Agency & Project Directors (PD) | Funding Period | Funding Amount | Prioritized Geography | Prioritized Populations |
|---|---|---|---|---|---|---|
| **Priorities:** Implement and evaluate a comprehensive public health approach to suicide prevention in order to reduce suicide morbidity and mortality, with attention to one or more disproportionately affected populations representing a significant proportion of the suicide burden (i.e. large numbers) and with suicide rates greater than the general population in a jurisdiction (e.g. state, city). Key outcomes include a 10% reduction in suicide morbidity and mortality in the jurisdictions. | | | | | | |
| ***Connecticut Partnerships for Hope & Healing (PH2)*** | Substance Abuse and Mental Health Services Administration's (SAMHSA) Garret Lee Smith State Youth Suicide Prevention and Early Intervention Program | Connecticut Department of Mental Health and Addiction Services (Funded Agency and PD); Co-PDs- Connecticut Department of Public Health and Connecticut Department of Children and Families | September 2023 – September 2028 | $3,675,000 total ($735,000 annually) | Statewide | Youth and Young adults age 24 and under at increased risk of suicide across and those serving them. |
| **Priorities:** 1) Increase the number of youth-serving organizations who are able to identify and work with youth at risk of suicide; 2) increase the capacity of clinical service providers to assess, manage, and treat youth at risk of suicide; and 3) improve the continuity of care and follow-up of youth identified to be at risk for suicide, including those who have been discharged from emergency department and inpatient psychiatric units. | | | | | | |
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| ***Mashantucket Pequot Skeehch Wuyeekan (Good Medicine) Project*** | Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Mental Health Services (CMHS) | Connecticut Department of Mental Health and Addiction Services, Department of Health and Human Services, Substance Abuse and Mental Health Services | July 2025 - July 2026 | $1,000,000 total ($250,000 annually) | Regional/ National | Mashantucket Pequot Native Youth and Young adults age 24 and under |
| **Priorities:** 1) Preventing suicide and substance misuse 2) Reduce the impact of trauma and promote mental health among Native youth through the age of 24 years. 3) Increase the number of youth-serving organizations who are able to identify and work with youth at risk of suicide; 4) Improve the continuity of care and follow-up of youth identified to be at risk for suicide. | | | | | | |
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| ***Staff Parker Gordon Fox (SSG Fox SPGP)*** | Department of Veterans Affairs SSG Fox SPGP | Easterseals Capital Region & Eastern Connecticut; Veterans Rally Point;<br><br>Acting Project Director: Valerie Cammarota, MPH – Director of Grants & Digital Media | Yr 1: October 2024 – December 2025<br><br>Yr2: October 2025 – September 2026 | Yr1: $538,000<br><br>Yr2: $750,000 | Region 3 ( 41 Towns in Eastern CT) & Region 4 (Hartford County) | Veterans at increased risk of suicide, with a focus on those not currently connected to the VA.<br><br>(Immediate family members of enrolled Veterans are eligible for services.) |
| **Priorities:** 1) Outreach & Education: Targeted outreach and education efforts include public events for education and screening, media outreach, newsletters, referral pathways with partners, and a dedicated webpage for resources and referrals. Collaboration with regional and state advisory boards guides best practices and resource sharing, ensuring veterans receive vital support. 2) Screening Individuals At Risk: Comprehensive screening and assessment used to identify eligible veterans at risk of suicide and provide timely support. Immediate stabilization of Veterans in crisis so they can determine a path forward. 3) Referrals for Long-Term Clinical Treatment: Partnering with local VA Medical Centers, ensure timely and comprehensive long-term care for Veterans through warm-handoff referrals after stabilization. By establishing these pathways for connecting veterans to VA care, Veterans Rally Point will facilitate seamless access, enhancing overall well-being and reducing the risk of suicide. 4) Case Management & Wrap-Around Support: Comprehensive wrap-around services through individualized service plans (ISPs), case management, and connections to essential resources. Veterans will have access to social engagement and enrichment programming, promoting stability, resilience, and a strong support network to reduce suicide risk. | | | | | | |
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