WASHINGTON STATE

Suicide Prevention Plan

Washington State Department of
Health

Are you having suicidal thoughts?

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

You can call the **National Suicide Prevention Lifeline** 24 hours a day, seven days a week, at **800-273-8255**. Press 1 for the Veterans Helpline. If you're under 21, you can ask to talk to a peer at Teen Link.

Don't feel like talking on the phone? Try Lifeline Crisis Chat (www.suicidepreventionlifeline.org/gethelp/lifelinechat.aspx) or the Crisis Text Line at 741741.

If you might be at risk of suicide again, download the My3 App from the National Suicide Prevention Lifeline. You can use the app to list your crisis contacts, make a safety plan and use emergency resources. For more information: www.suicidepreventionlifeline.org/gethelp/my3-app.aspx

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

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

1. **Look for warning signs.** Some common warning signs of suicide risk are listed on page 12.
2. **Show you care.** This looks different depending on who you are and your relationship, but let the person know you have noticed something has changed and it matters to you. If appropriate, let them tell you how they're feeling and why.
3. **Ask the question.** Make sure you both understand whether this problem is about suicide. "Are you thinking about suicide?"
4. **Restrict access to lethal means.** Help the person remove dangerous objects and substances from the places they live and spend time.
5. **Get help.** This person may know who they want to talk to (a therapist, their guardian, their partner). You can also call the **National Suicide Prevention Lifeline** 24 hours a day, seven days a week, at **800-273-8255**.

Don't feel like talking on the phone? Try Lifeline Crisis Chat (www.suicidepreventionlifeline.org/gethelp/lifelinechat.aspx) or the Crisis Text Line at 741741.

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK

www.suicidepreventionlifeline.org

Washington State
Suicide Prevention Plan

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Core Principles

of the Washington State Suicide Prevention Plan

These principles were identified by the State Suicide Prevention Plan Steering Committee as the key values and attitudes underlying the content of the plan.

- Suicide is a preventable public health problem, not a personal weakness or family failure.
- Everyone in Washington has a role in suicide prevention. Suicide prevention is not the responsibility of the health system alone.
- Many people avoid discussing suicide. Silence and stigma about suicide harm individuals, families and communities.
- To prevent suicide in Washington, we must change the factors we know contribute to suicide risk, such as childhood trauma, isolation in our communities, access to lethal means and lack of access to appropriate behavioral healthcare.
- Suicide does not affect all communities equally or in the same way. Suicide prevention programs should be based on the best available research and best practices, while reflecting community needs and local cultures.
- People experiencing mental illness, substance use disorders, trauma, loss and suicidal thinking and behavior deserve dignity, respect and the right to make decisions about their care.

Silence and stigma about suicide harm individuals, families and communities.

Recommendation Summary

The plan is split into four Strategic Directions, based on the National Strategy for Suicide Prevention.[1] Each includes relevant goals and recommendations for policy, system change and community action that could make them a reality.

STRATEGIC DIRECTION 1
Healthy and Empowered Individuals, Families and Communities

In a healthy and empowered community, everyone understands their role in prevention and suicide is prevented upstream, before a crisis.

Goals:

1. The general public considers suicide a public health issue requiring public participation.

2. Individuals, families and institutions understand that they have a role in improving community behavioral health and preventing suicide.

3. News media report responsibly on behavioral health and suicide.

4. Social media spread appropriate, supportive messages about behavioral health and suicide.

5. Social and emotional health education is integrated into early learning programs, community programs and K-12 schools.

6. Connectedness (the connections a person has among family, friends, peers and community; how connected people are to health and social services; and how well services collaborate) is promoted as a protective factor to prevent suicide, and includes community-wide interventions and programs for marginalized and at-risk populations.

Key recommendations:

- Support a diverse, effective suicide prevention workforce that coordinates public awareness campaigns and leads coalitions.

- Improve schools' connection to behavioral healthcare providers and ability to provide social and emotional health education.

- Educate journalists on appropriate reporting on suicide and behavioral health, and improve news organizations' policies on suicide reporting.

- Improve communication about suicide on social media.

- Create and maintain programs improving connectedness, focusing on high-priority populations and groups experiencing serious stressors.

Figure 1: Strategic Directions Diagram adapted from the National Strategy for Suicide Prevention

STRATEGIC DIRECTION 2
Clinical and Community Preventive Services

Suicide prevention programs directed to those who need them most can help identify people at risk and keep them safe.

Goals:

1. Tribal, state, local and institutional systems adopt comprehensive suicide prevention programs.

2. High-quality suicide recognition and referral trainings are widely available.

3. Designated health professions are trained in suicide assessment, treatment and management.

4. Screening for and limiting access to lethal means is conducted to reduce suicide risk for people in crisis.

5. Community members are aware of local resources, including behavioral health services and crisis lines.

Key recommendations:

• Support comprehensive suicide prevention programming in K–12 and higher education by implementing existing legislation.

• Consider new legislation requiring comprehensive suicide prevention programming in child welfare, juvenile justice and unemployment services systems and build comprehensive prevention programming in multiple sectors. Improve trainings on suicide assessment, treatment and management for health professionals and consider expanding the list of health professions required to receive training.

• Make recognition and referral training available to the public and designated professions.

• Support legislation, technology and public education to reduce access by people in crisis to lethal means, including firearms and medications. Market and promote community crisis resources and tailor services to specific communities.

STRATEGIC DIRECTION 3
Treatment and Support Services

When a person in crisis seeks treatment, it should be accessible, appropriate and respectful.

Goals:

1. Access to mental healthcare, substance abuse treatment and crisis intervention services is expanded.

2. Emergency departments and inpatient units provide for the safety, well-being and continuity of care of people treated for suicide risk.

3. Families and concerned others are involved, when appropriate, throughout a person at risk's entire episode of care.

4. Effective suicide postvention-aftercare programs (programs providing care and support for the community and loved ones after a suicide) are in place to provide support after a suicide loss.

Key recommendations:

- Create a workgroup on continuity of care after acute care discharge that will make/ disseminate patient care recommendations for people who have attempted suicide.

- These recommendations would include follow-up protocols, coordination with health and community services, safety planning, lethal means restriction and support for patients at frequent risk.

- Improve connections between behavioral healthcare providers and community resources through best practice recommendations, training and system improvements.

- Improve care access through telemedicine and patient-centered medical homes.

- Integrate peer support programs into care systems.

- Educate healthcare providers on best practices for involving a person at risk's self-defined care network in their treatment.

STRATEGIC DIRECTION 4
Suicide Surveillance, Research and Evaluation

Research, data and evaluation should inform all suicide prevention programming.

Goals:

1. Effective suicide and behavioral health data surveillance systems are in place to guide prevention.

2. Researchers and state agencies collaborate on suicide prevention research and evaluation.

3. Suicide prevention activities are evaluated and improved.

Key recommendations:

- Improve state agencies' capacity to collect, analyze and publicize data on suicide and behavioral health.

- Build and staff a clearinghouse of state data on suicide.

- Create and use a guidance document on research needed to move this plan forward.

- Build evaluation into all suicide prevention programs to improve programming and advance the field.

In 2012, 30 people in Chelan and Douglas counties died by suicide. Suicides had been rising there for a few years, and the community hit a crisis point. "The outcry for 'someone' to do something was huge," says clinical psychologist Julie Rickard. "I began to get calls, texts, and emails related to what could be done and who would step up to do it. The Suicide Prevention Coalition of North Central Washington (SPCNCW) was born."

The coalition, based in Wenatchee, first investigated the community's barriers and needs. It designed an informational campaign about suicide prevention, selected a suicide recognition and referral training, and chose trainers representing the community. In one year, more than 3,200 people were trained.

The results came quickly. Suicides in Chelan and Douglas counties decreased by more than half in the first year, and by 2014 there were eight suicides across both counties.[2] "It is possible to impact the suicide rate in a relatively short period of time," says Julie Rickard. "It takes community involvement, support from the cities and administrators, and active engagement from its members to be successful. People can and do make a difference every day!"

A note on language

This document does not use the common phrase *commit suicide*. Using the word "commit" may imply a criminal act and could increase stigma against suicide.

As recommended by the *Associated Press Stylebook*, phrases such as, "killed himself, took her own life or died by suicide" are more factual and respectful.

Introduction

Suicide is a serious public health problem in Washington State. The state's suicide rate is almost 15 per 100,000, 11 percent higher than the national rate. On average, three people die by suicide every day, and Washington families and communities are grieving the loss of over 5,000 people to suicide from 2010 to 2014. In an average week, there are 65 hospitalizations from self-inflicted injury. Recent survey data tell us that more than 4 percent of adults and 20 percent of 10th graders in Washington seriously considered suicide in the past year.[3]

A web of biological, psychological, social, environmental and situational factors influences suicidal behaviors. Risk factors, including childhood trauma, substance abuse, poverty and untreated mental health problems, are common in our state. Yet many people cannot get behavioral healthcare because of provider shortages, the stigma associated with mental illness or the cost of care.

Washington is a leader in developing community and policy solutions to suicide. Across the state, advocates challenge communities and policymakers to face the problem of suicide head-on. Suicide prevention coalitions provide training and advocacy. Student-led prevention clubs bring peer education to schools and colleges. Support groups help bereaved families and friends navigate grief and empower members to become part of the solution. Behavioral healthcare providers treat patients at risk of suicide and save lives. Tribal governments are leaders in bringing culturally tailored solutions to their communities. Academic researchers, public health professionals and community-based organizations

provide expertise and resources statewide and beyond our borders. And our state has established training requirements for behavioral health and primary care providers—the first state in the country to do so.

Many of our suicide prevention practices are relatively new and the evaluation data are evolving. Lowering the state suicide rate will take long-term investment from all of us. Strong community work and groundbreaking policy are steps in the right direction.

This plan sets the path forward for all Washingtonians to find their role and to work together to prevent suicide in our state.

History of Washington's state plan

In 1995, the Department of Health and the University Of Washington School Of Nursing wrote the first state plan for youth suicide prevention, and the state legislature provided funding for prevention programs focused on youth and young adults 10 to 24 years old. The plan was revised in 2009, and again in 2014, to align with the National Strategy for Suicide Prevention.

In March 2014, Governor Jay Inslee signed House Bill 2315 into law, requiring the Department of Health to create a statewide suicide prevention plan for people of all ages. A large steering committee, and many people who participated in local listening sessions, came together to help make this statewide plan useful and relevant to communities across the state. (See Appendix D on page 67.)

The plan's goals and recommendations work together with the Washington State Plan for Healthy Communities, the Healthiest Next Generation Initiative and the Department of Health's Strategic Plan.

We are grateful for the dedication and commitment of everyone who participated in creating this plan on behalf of the people of Washington.

Directly talking about suicide will help us work against the barriers caused by stigma and solve this urgent public health problem.

Understanding Suicide

Many people's first question about suicide is, "Why?" There is no easy answer. Suicide research is a growing field, helping to increase our understanding and to recognize the effectiveness of traditional practices in our communities. The voices of suicide attempt survivors and those who have lost loved ones to suicide help explain how a person in crisis can turn toward suicide. Research is evolving and we still have much to learn.

Many people feel negative or uncomfortable about suicide and those who have personal experience with it. This is called stigma, and it limits our ability to prevent suicide. Discomfort talking about suicide stems from cultural and religious traditions, fear of worsening the problem by discussing it and the shame, guilt and isolation felt by many who have experienced suicide loss or risk. Some suicide risk factors, such as depression, cognitive disability and substance use, also carry stigma.

Stigma can make it very hard for people to seek help or to feel a sense of dignity in a crisis. It isolates people who have lost loved ones to suicide, who often fear being treated badly or facing other consequences. Stigma can even stop researchers, funders, community leaders and policymakers from addressing suicide. **Directly talking about suicide will help us work against the barriers caused by stigma and solve this urgent public health problem.**

Risk factors: What leads to suicide risk?

Two of the strongest predictors of suicide risk are mental illness and substance abuse.[4] The Centers for Disease Control and Prevention (CDC) and other experts identify several other risk factors, noted below:[5]

Risk Factors for Suicide

Individual	Relationship	Community	Societal
• Previous attempt(s) • History of mental disorders, particularly clinical depression • History of alcohol and substance abuse • Feelings of hopelessness • Impulsive or aggressive tendencies • Loss (relational, social, work or financial) • Illness and disability, including loss of physical or mental funtioning	• Family history of suicide • Family history of child maltreatment • Isolation, a feeling of being cut off from other people	• Local epidemics of suicide • Barriers to accessing mental health treatment	• Easy access to lethal methods • Cultural and religious beliefs (e.g., belief that suicide is a noble resolution of a personal dilemma, or belief that older people have little value to the community) • Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

Depending on other factors, two people with the same behavioral health disorder or trauma history could have very different health outcomes. What makes the difference is a key question in research, but we must remember that even for a person with several risk factors, suicide is not inevitable. For example, someone considering suicide may have experienced childhood trauma, be having an episode of major depression, be upset about losing their job last week and own a firearm. The childhood trauma happened in the past and cannot be changed, but the trauma reactions and depression are treatable; a friend, relative, or local law enforcement could temporarily take custody of the firearm until after the crisis passes, and the pain of job loss could be lessened through counseling or peer support.

Some risk factors, such as access to lethal objects and the effect of job loss or trauma history, are part of larger community problems influenced by public policy. A community and policy approach to solutions has guided the development of this plan.

Trauma and suicide risk

The Adverse Childhood Experiences (ACE) study, first conducted in the mid-1990s, examined the long-term health effect of trauma exposure, violence and loss in childhood.[6] ACE data link childhood trauma with suicide risk factors and suicide attempts later in life.

A person's ACE score is based on answers to a questionnaire listing specific traumatic experiences. The higher the score, the greater chance of a wide range of long-term health problems. Several of these contribute to suicide risk:

• Alcoholism and alcohol abuse
• Depression
• Intimate partner violence
• Poor quality of life

A study of ACE data showed that a score of seven or more increased childhood-adolescent suicide attempts 51-fold and adult suicide attempts 30-fold.[7]

Many population groups suffering from historical trauma also have many forms of health disparities, including elevated suicide. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines this as "multigenerational trauma experienced by a specific cultural group. Historical trauma can be experienced by 'anyone living in families at one time marked by severe levels of trauma, poverty, dislocation, war, etc., who are still suffering as a result.'"[8] It may show up as:

• unresolved grief from historical events that has not been acknowledged, expressed or resolved;

• grief as a result of loss that has not been acknowledged by the public and is not openly discussed, isolating communities who have had that experience;

• internalized oppression, self-hatred and self-destructive behavior.[8]

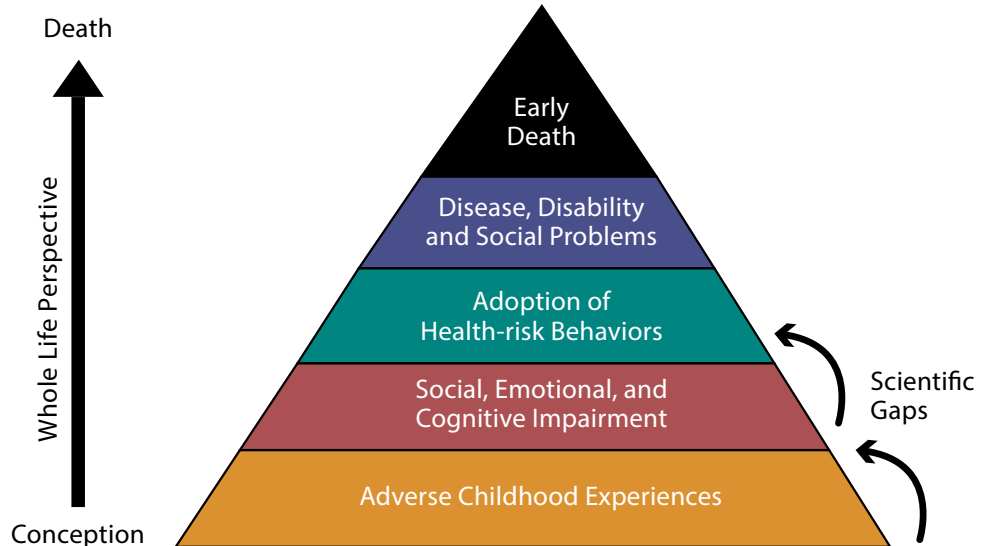**This diagram, adapted from CDC materials, shows how childhood trauma can lead to early death.**

Figure 2: Diagram showing progression from trauma to early death, CDC

Those affected include American Indians and Alaska Natives, groups of people who have experienced racism or cultural exclusion over multiple generations and members of families with intergenerational experiences of poverty.

Substance abuse and suicide risk

People who abuse substances are twice as likely as the general public to have mood disorders or anxiety disorders, and they are at elevated risk of suicide.[9] A review of multiple cohort studies shows that people treated for alcohol abuse or dependence are 10 times more likely to die by suicide than the general population, and people who inject drugs are 14 times more likely to die by suicide.[10]

The percentage of people who are intoxicated at the time of suicide death varies from study to study,[11] but several indicate that intoxicated people are more likely to use lethal means, particularly firearms.[12] One study found acute alcohol intoxication more strongly related to suicidal behavior than habitual drinking, with a strong relationship between the amount of alcohol consumed and the risk of suicidal behavior.[13] Using data from a national sample, another found that youth who reported binge drinking were three to four times more likely to report suicide attempts than peers who did not drink.[14]

Populations disproportionately impacted by suicide

The effect of trauma on individual and community health shows why some groups have higher suicide attempt and completion rates than the general population.

According to the National Strategy for Suicide Prevention,[1] Washington state data and other sources, groups at increased risk of suicidal behavior include:

- Men over 45 years old for suicide death,[15] while women and girls are more often hospitalized for self-inflicted injury
- American Indians and Alaska Natives
- People from areas with higher poverty and lower educational attainment
- Veterans, members of the armed forces and their families

- People living in small-town rural communities
- People who have had contact with criminal justice and child welfare systems
- People with mental illness and substance abuse disorders, history of suicidal behavior and some other medical conditions
- Latina youth[16]
- Lesbian, gay, bisexual, transgender, queer and questioning populations, particularly youth who come from highly rejecting families.[17]

Populations with elevated suicide risk have diverse identities and experiences, and a one-size-fits-all approach to suicide prevention does not work.[18] Some guidelines on tailoring messages, interventions and programming to a specific community include:

- If the community did not initiate the project, those who did must involve community members and leaders from the beginning and respect them as experts on their own experience.
- People involved in a suicide prevention intervention for a community of which they are not members should become familiar with the community's history, risk and protective factors, cultural norms around language and communication, beliefs about death and definition of the problem.
- One or a few members of a community should never be treated as representative of an entire demographic group.
- Diverse groups of people working together on a suicide prevention project must put values of inclusion and equity front and center in decision making and program design.
- Accessibility concerns such as transportation, cost, language translation, space and materials accessible for people with disabilities and location must be considered in intervention design.

I attempted to take my life because of a breakup when I was 16. I woke up and I was fine, but I was really mad. I just didn't want to live!

I'd been trying to get a gun, and word got around. The school called my mom and a social worker came to talk to me. But what really changed my mind was my dad. I could feel his love, and it felt like he would lay down his life for me. Thinking about that would snap me out of it—suicide would hurt my family more than I'm hurting now. In my worst moments the thought lingers, but now I know I could never go through with suicide.

My faith gets me through those times—knowing that something bigger is out there and I shouldn't rob myself of what is yet to come. My kids give me a sense of purpose. I'm able to say to myself, "No, that's not an option, you can't do that." And I was really lucky to have that connection with my dad.

—Annie Ost, Spokane

Reducing the risk

Protective factors—skills and characteristics that lessen the impact of risk—do not necessarily make risk factors go away. Instead, they may give a person the skills or supports to get through difficulties with their health and wellness intact.

It is useful to know the protective factors for specific groups of people. Appendix A includes evidence-based and best-practice resources and programs for several groups.

Protective Factors for the General Population[5]

Individual	Relationship	Community	Societal
• Skills in problem solving, conflict resolution and nonviolent handling of disputes	• Strong connections to family and community support • Support through ongoing medical and mental healthcare relationships	• Effective clinical care for mental, physical and substance use disorders • Easy access to a variety of clinical interventions and support for help-seeking	• Restricted access to highly lethal means of suicide • Cultural and religious beliefs that discourage suicide and support self-preservation

Upstream prevention

Strong protective factors available before and during a crisis can make the difference between life and death, and can steer people who have experienced serious trauma or adversity away from suicide. Early prevention through strengthened protective factors is often called upstream prevention.

Imagining the path to suicide as a river, most suicide interventions focus on spotting and catching people who are about to go over the waterfall at the river's end and fall to the rocks below, resulting in injury or death. Upstream prevention focuses on helping people out of the river sooner or preventing them from falling in at all.

Upstream prevention can happen at many levels:[19]

- Community programs that help reduce the effect of risk factors such as childhood trauma, poverty, racism, other forms of discrimination, mental illness and substance abuse

- Community interventions that improve how families and institutions such as schools and early childhood programs function

- Solutions that reduce suicidal thinking or provide immediate intervention after a triggering event (examples: anti-bullying policies in schools, workplace policies requiring suicide risk screening for employees who are demoted or terminated, supports for suicide loss survivors)

- Programs promoting connectedness and help-seeking for vulnerable and marginalized populations, social and emotional learning in early education, and improved media storytelling about behavioral health and recovery

Project AWARE: Advancing Wellness and Resilience in Education

Project AWARE takes an upstream approach to reducing suicide by focusing on student mental health. The project trains school staff members, parents and adult community members in Youth Mental Health First Aid. This equips adults to detect and respond to youth mental health issues.

Project AWARE also offers school-based behavioral health services such as prevention education, screening, referrals, case management and treatment. By combining Positive Behavior Intervention Supports and Student Assistance Programs, Project AWARE gives youth timely supports and tools for mental wellbeing. The project is expected to shift mental wellness and suicide risk over time.[20]

Warning signs: How can we tell someone might be at risk?

About 80 percent of people who attempt suicide show some warning signs first.[21] Knowing and recognizing these signs can help family and friends support a loved one before suicidal thinking turns into action. Warning signs can be acute and urgent or simply red flags for concern.

The American Association of Suicidology recommends emergency mental healthcare for someone showing these warning signs:[22]

- Talking or writing about death, dying, or suicide, especially if this is unusual or related to a personal crisis or loss

- Seeking ways to kill themselves (for example, collecting pills or making plans to purchase a weapon during a crisis)

- Directly or indirectly threatening suicide:
  - Direct threats like "I am going to kill myself."
  - Indirect threats like "I can't do this anymore," "No one would miss me if I were gone," or "You have meant a lot to me, please don't forget me."

Warning signs that mean we need more information about a person's suicide risk include:

- Hopelessness
- Acting reckless or engaging in risky activities, seemingly without thinking
- Withdrawing from friends, family or society
- Dramatic mood changes
- No reason for living; no sense of purpose in life
- Rage, uncontrolled anger, seeking revenge
- Feeling trapped—as if there's no way out
- Increasing alcohol or drug use
- Anxiety, agitation, unable to sleep or sleeping all the time

Even people who know a lot about suicide often miss warning signs. Recognizing these signs, knowing how to help and having the right places to get help or make a referral can save a life. For more information about suicide awareness, intervention skills training and community resources, see Appendix A.

Suicide in Washington

Suicide deaths are just the tip of the iceberg in Washington, and experts generally agree that suicide and suicidal behavior are underreported. For every suicide death,[23] there are three hospitalizations for self-inflicted injury[24] and an estimated 225 adults who seriously consider suicide.[25] There are no statewide data on those who attempt suicide but do not receive medical attention or are released from the emergency department without being hospitalized. We also cannot measure the emotional pain of those whose friends or family members have attempted or died by suicide.

Please note that the data in this section do not include people who have died under the Death with Dignity Act. Washington State data do not classify these deaths as suicides.[26]

Suicide deaths in Washington

From 2010 to 2014, 5,094 people in Washington lost their lives to suicide. Those who died ranged from 10 to more than 85 years old.

Washington's 2013 suicide rate was 14.7 per 100,000 people, 11 percent higher than the national rate. Suicide rates in western states are consistently higher than the national rate.[28] The reasons are not completely clear, but may include lack of access to healthcare, residential instability, unemployment, limited economic resources, higher suicide rates in rural areas, social isolation, mental illness, substance abuse and access to firearms.[29]

Figure 3:
Suicide death rates per 100,000 by state, 2013[27]

Rates per 100,000 population
- 6.7 to 12.0
- 12.1 to 13.8
- 13.9 to 16.4
- 16.5 to 22.9

Suicide trends over time

Figure 4 shows how the Washington State and the national suicide rates have changed over time. At every time point between 1980 and 2014, Washington's rate was higher than the national rate.
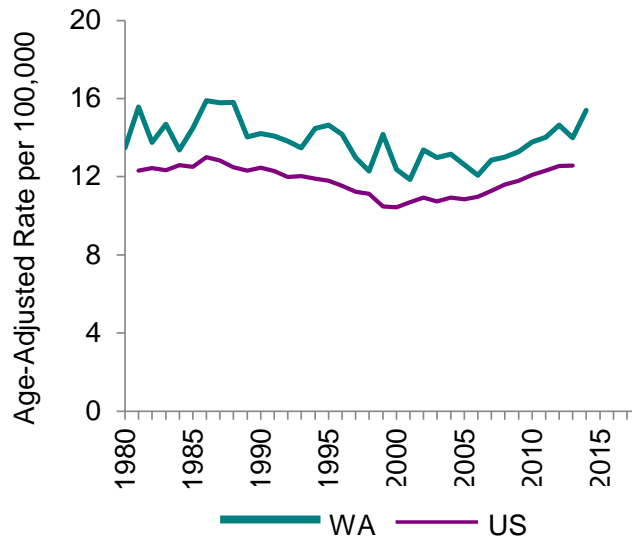

Figure 4: Suicide death rates per 100,000 in Washington State, 1990–2014

Geographic variation

Suicide rates vary in different parts of Washington. Because of the way rates are compared, a small difference may be statistically significant while a larger one is not. Statistical significance means the difference is very unlikely to be due to chance.

From 2010 to 2014, six counties' rates were higher than the state rate: Clallam, Grays Harbor, Okanogan, Pierce, Skamania and Stevens. King County's suicide rate is lower than the state rate, but it has the
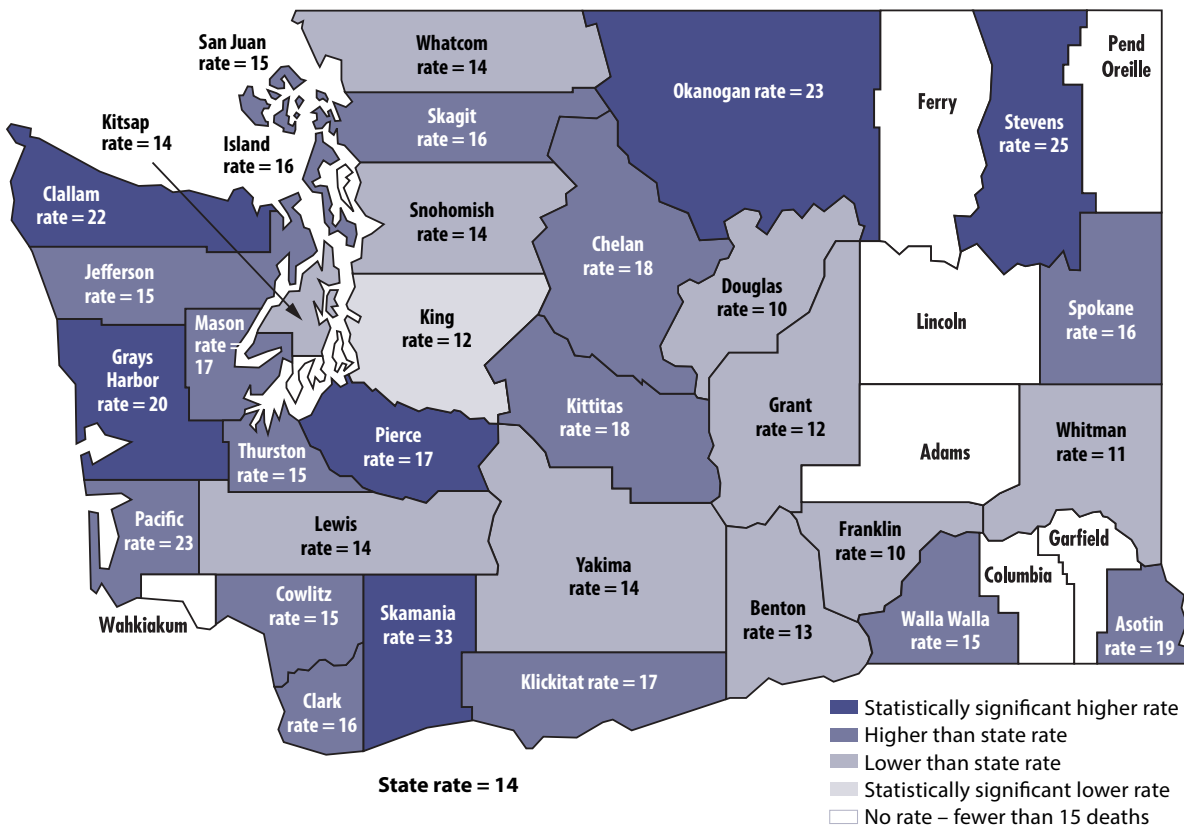

Figure 5: County suicide rates per 100,000 people compared to the state rate, 2010–2014

Source: Washington State Department of Health, Death Certificates

largest population and the highest number of suicides in the state. Seven counties have small populations and had too few suicides to calculate a suicide rate. This does not mean that there are not suicides in these counties.

County-level data do not always accurately reflect suicide losses in communities. For example, in 2013 both the Spokane Tribe of Indians and the Colville Confederated Tribes declared a suicide state of emergency because of high numbers of suicide deaths. Clark County's Battle Ground School District, located in a town of fewer than 18,000 residents, lost seven students to suicide between 2011 and 2013. Neither pattern of loss was clear from a glance at county data.

In Washington and nationally, suicide rates are higher outside urban areas and highest in small-town rural areas.

Geography	Rate per 100,000
Urban	14
Suburban	16*
Large town rural	16*
Small town rural	18*

Figure 6:
Suicide rates per 100,000 in urban, suburban and rural communities in Washington, 2010–2014

The asterisk indicates statistical significance.

Source: Washington State Department of Health, Death Certificates

Race and ethnicity

Suicide rates in Washington are highest among American Indian and Alaska Native and white populations, consistent with national rates.

Each of these broad demographic groups is very diverse with regard to national origin and ethnicity, which can mask subgroup differences in the impact of suicide. For example, the broad Asian population's overall low suicide rate may hide the high impact of suicide in some Asian ethnic groups.
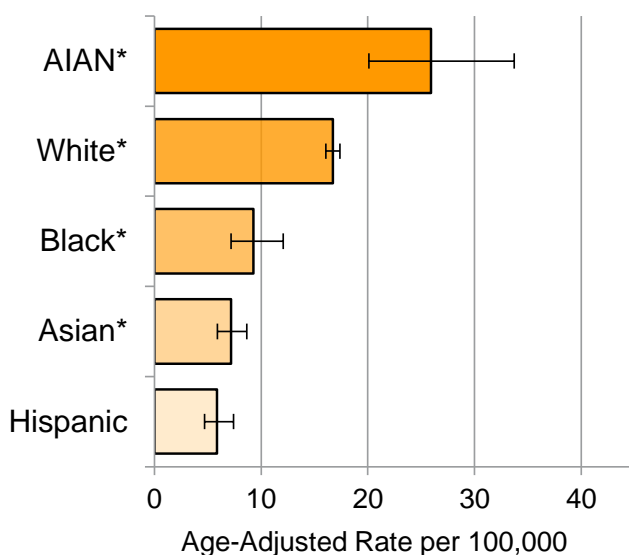

Figure 7:
Suicide rates by race and Hispanic origin in Washington, 2012–2014

* Non-Hispanic, single race only

AIAN = American Indian/Alaska Native

Native Hawaiian/Other Pacific Islander not included (unreliable rates due to small numbers)

American Indians and Alaska Natives face severe historical trauma, high rates of poverty and isolation, cultural taboos around death and suicide, and lack of access to mental healthcare. In response, many tribes in Washington are building strong suicide prevention programs reflecting specific community needs and strengths.

Very little research focuses on why suicide rates are higher among white populations. There is some research about middle-aged and elderly white men, who have the highest rate. CDC National Violent Death Reporting System data from 16 states show the most common circumstances around suicide for white men include mental and physical health problems, trouble in intimate relationships, alcohol dependence and problems at work.[30] Cultural taboos about seeking help and appearing vulnerable can isolate white men from both support systems and resources that could help.
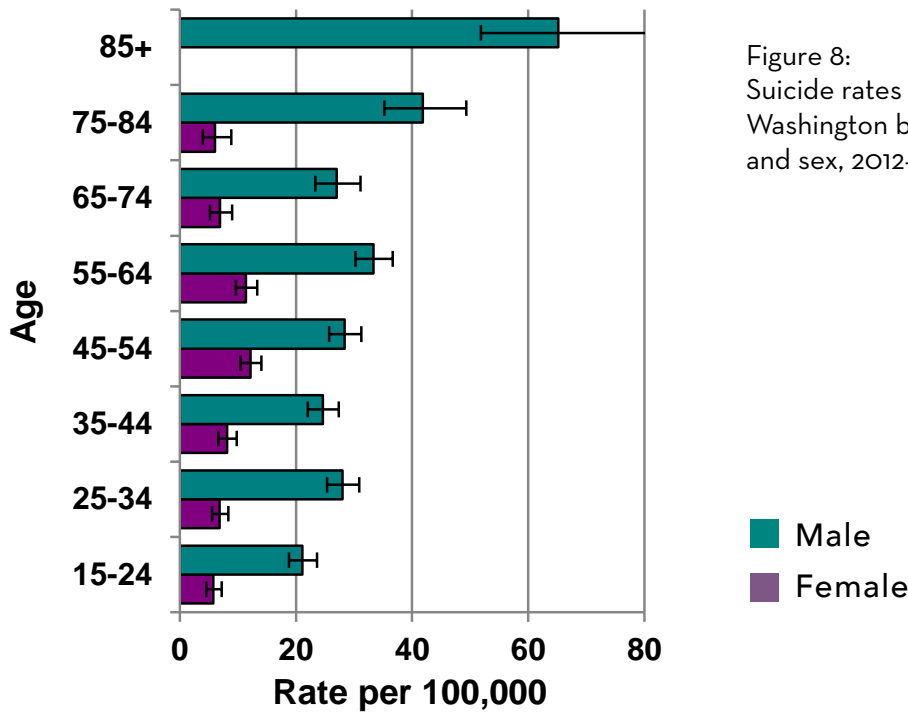

Figure 8:
Suicide rates in Washington by age and sex, 2012–2014

Age, sex and gender

Information on the gender identity of people who have died by suicide is incomplete in some cases. Death certificate forms offer choices of male or female, a decision sometimes based only on physical appearance. Therefore, a person's gender identity may not be accurately reflected, making it difficult to learn about suicide among transgender and gender nonconforming populations.

The loss of a person of any age to suicide is tragic and avoidable. Suicides of young people receive a lot of media and community attention, though Washington's suicide rates for adults are higher.

During 2012–2014, 77 percent of suicide deaths in Washington were males. Men 75 and older had the highest rate (42 per 100,000) while men 45 to 64 had the highest total number of suicides. Gender accounts for some of this difference; men are more likely to use firearms or hanging, the most lethal means.[31]

National data linked the recent economic recession to increases in middle-aged adult suicides, showing that external economic factors were involved in 37 percent of suicides.[32] For elderly men, contributing factors include economic insecurity, loss of significant relationships, loneliness, fear of being a burden, and the physical and mental stresses of aging.[33]

Over time, different age groups' suicide rates have changed. The rate for adults 45 to 64 years old has increased since 1990, while the rate for adults 65 and older declined. The youth suicide rate declined in the late 1990s but has been increasing since 2000.

Figure 9:
Suicide trends by age, 1990–2014
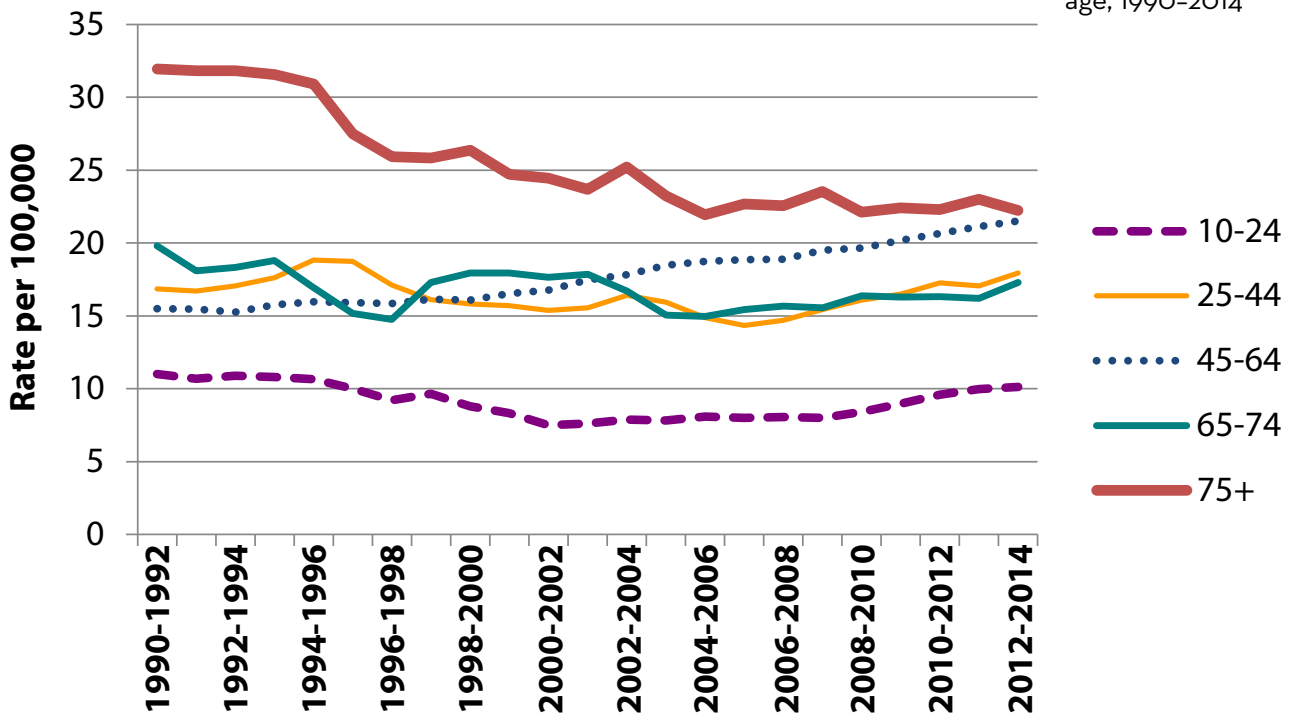
Suicide in populations connected to the armed forces

About 13 percent of Washington's population has participated in the armed forces. In 2010, the age-adjusted suicide rate among Washington's military members (veteran or active duty) was 55 per 100,000, compared to 15 per 100,000 for those not in the military. From 2000 to 2010, the military suicide rate was higher than the non-military rate every year; 16 percent of males and 26 percent of females in the military who died by suicide over those years were under 35; and over 60 percent of the suicides were by firearm.[34]

From 2012 to 2014, of the 3,150 deaths by suicide in Washington, 700 had participated in the armed forces. More than half of those over 65 who died by suicide were veterans.

Figure 10: Suicide and armed forces participation, 2012–2014

| Age Group (years) | U.S. Armed Forces Participation | | | |
| | Yes | | No | |
	Number of suicides	Percent of suicides	Number of suicides	Percent of suicides
10–24	24	6	387	94
25–44	144	14	854	86
45–64	236	20	945	80
65+	296	56	231	44
Total	700	22	2,417	78

Source: Washington State Department of Health, Death Certificates

Washington's Healthy Youth Survey data show that children of military families are at higher risk of suicide. A higher percentage of 10th graders with parents in the military reported symptoms of depression in the past year compared to 10th graders from civilian families. They also answered yes more frequently to questions about serious consideration of suicide, making a suicide plan and attempting suicide, and fewer than half answered yes when asked if there were adults to whom they could turn for help when feeling sad or hopeless.[35]

Means of suicide

In 2014, 545 Washingtonians died by suicide using firearms. Suffocation (largely hanging) and poisoning (drug or medication overdose or swallowing harmful substances) were also common.

Figure 11: Leading causes of suicide, 2014

Cause	Percent of Deaths
Firearms	49
Suffocation	23
Poisoning	19
Fall	3
Cut	2
Other (drowning, fire, unspecified)	2

Source: Washington State Department of Health, Death Certificates

Self-inflicted injury hospitalizations in Washington

There were 10,179 hospitalizations for self-inflicted injuries in Washington from 2012 to 2014, a state rate of 50 per 100,000. These hospitalizations declined between 1994 and 1999. From 2000–2010 rates slowly increased, but they have since declined.
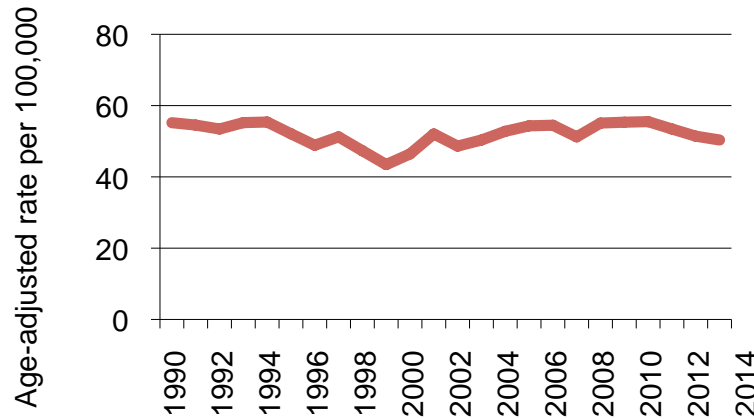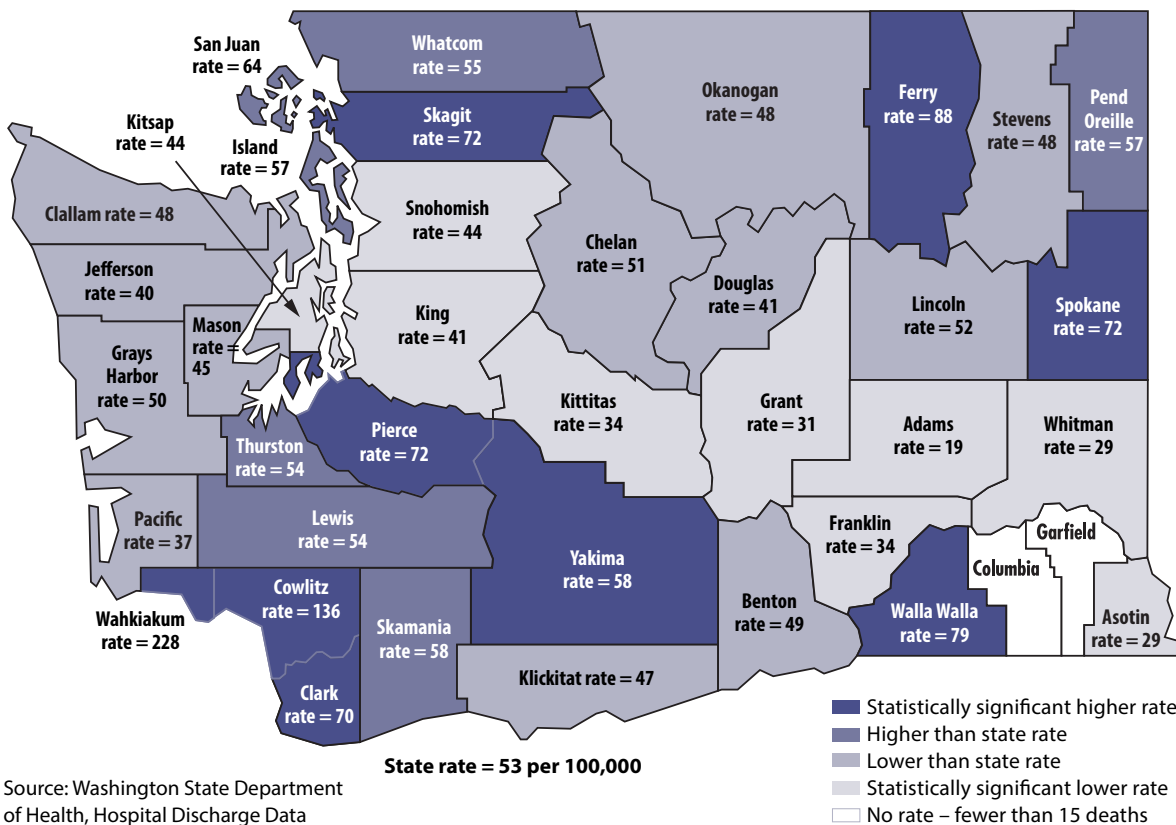

Figure 12: Self-inflicted injury hospitalizations, 1990–2014

Geographic variation in hospitalization for self-inflicted injury

Hospitalization rates for self-inflicted injuries vary. In 2010–2014, nine counties had rates significantly higher than the state rate: Clark, Cowlitz, Ferry, Pierce, Skagit, Spokane, Wahkiakum, Walla Walla and Yakima. Nine counties had rates significantly lower than the state rate: Adams, Asotin, Franklin, Grant, King, Kitsap, Kittitas, Snohomish and Whitman.

Figure 13: Self-inflicted injury hospitalizations by county of residence, 2010–2014

San Juan rate = 64
Whatcom rate = 55
Okanogan rate = 48
Ferry rate = 88
Stevens rate = 48
Pend Oreille rate = 57
Kitsap rate = 44
Skagit rate = 72
Island rate = 57
Clallam rate = 48
Snohomish rate = 44
Chelan rate = 51
Jefferson rate = 40
Douglas rate = 41
Lincoln rate = 52
Spokane rate = 72
Mason rate = 45
King rate = 41
Grays Harbor rate = 50
Kittitas rate = 34
Grant rate = 31
Adams rate = 19
Whitman rate = 29
Thurston rate = 54
Pierce rate = 72
Pacific rate = 37
Lewis rate = 54
Yakima rate = 58
Franklin rate = 34
Garfield
Wahkiakum rate = 228
Cowlitz rate = 136
Skamania rate = 58
Benton rate = 49
Columbia
Walla Walla rate = 79
Asotin rate = 29
Clark rate = 70
Klickitat rate = 47

State rate = 53 per 100,000

Statistically significant higher rate
Higher than state rate
Lower than state rate
Statistically significant lower rate
No rate – fewer than 15 deaths

Source: Washington State Department of Health, Hospital Discharge Data

Age, sex and gender differences in hospitalization for self-inflicted injury

From 2012–2014, 62 percent of people hospitalized for self-inflicted injuries were female. Women and girls had higher hospitalization rates than males in all age groups under 75.

Means of self-inflicted injury

In 2014, 81 percent of hospitalizations for self-inflicted injury in Washington involved poisoning (drug or medication overdose or swallowing harmful substances). Injury from cutting oneself was a distant second. Only three percent involved firearms or suffocation (typically hanging) because these means are much more likely to result in death.
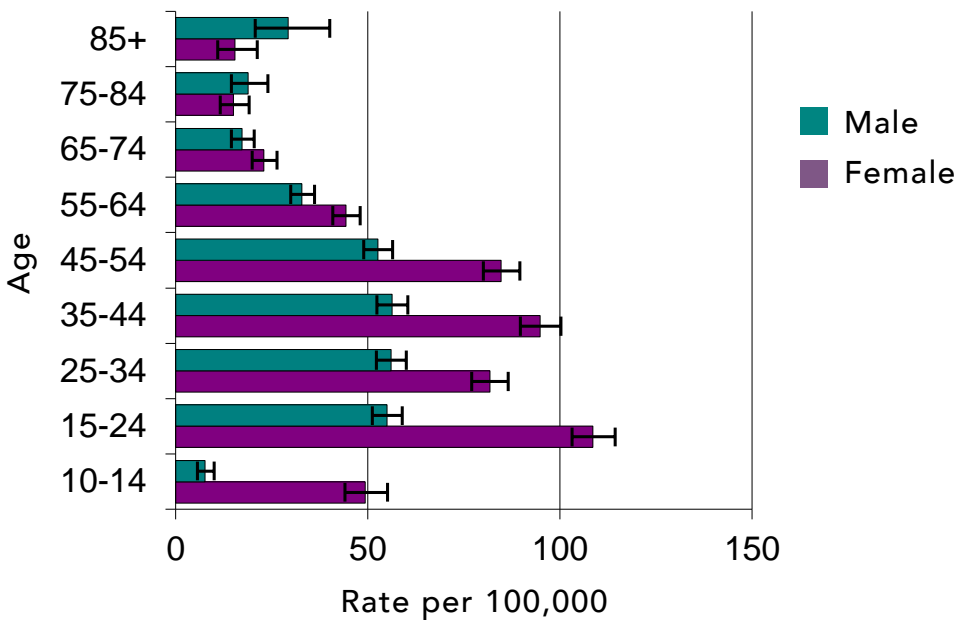

Figure 14:
Self-inflicted injury hospitalizations by age and sex, 2012–2014

Method	Percent of Hospitalizations
Poisoning	81
Cut	10
Other	9

Figure 15:
Leading injury, 2014

Source: Washington State Department of Health, Hospital Discharge Data

Serious suicidal thinking in Washington

Mental Health America ranks Washington State 48 out of 50 states in providing mental wellness and access to care among youth and adults.[36] A low overall ranking indicates higher prevalence of mental illness and lower rates of access to care. The 2012–2013 National Survey of Drug Use and Health found 4.3 percent of Washington's adults 18 and older had seriously considered suicide in the past year. Washington has the 44th highest state rate of suicidal thinking among adults.[37]
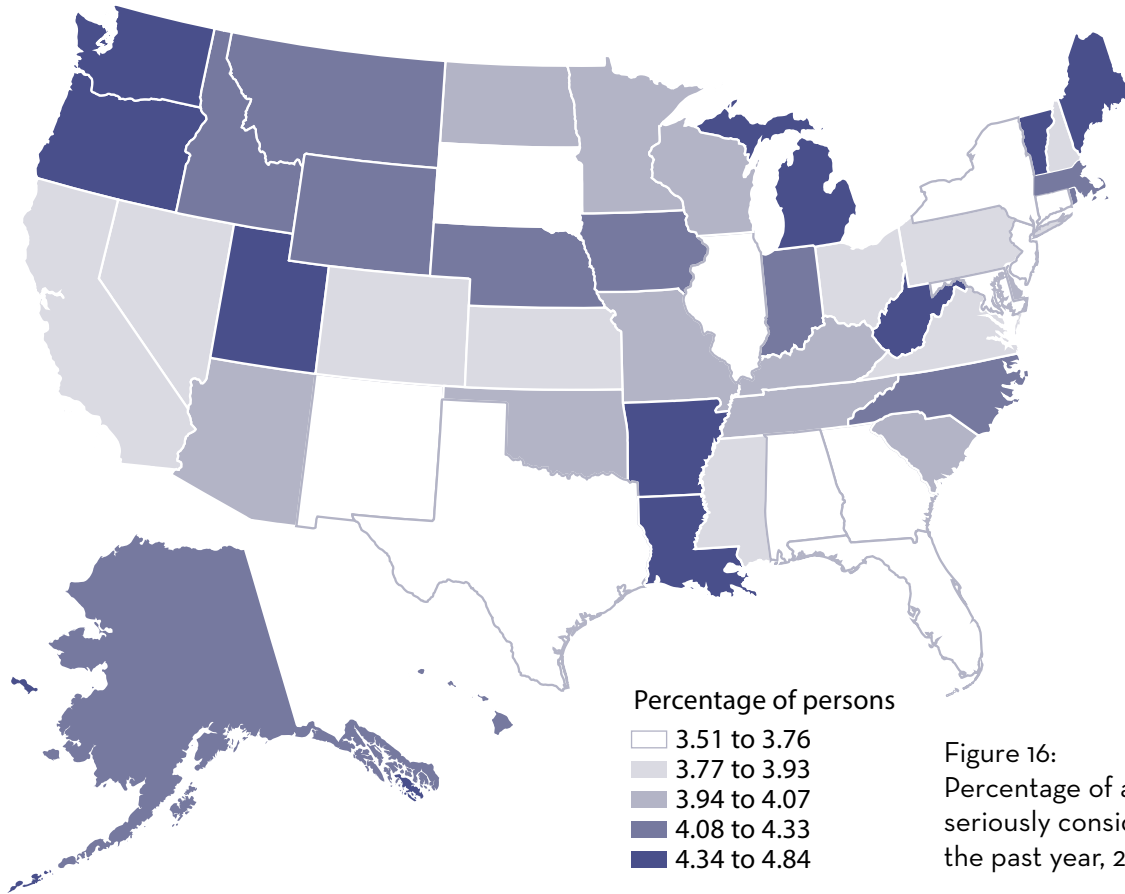

Percentage of persons

- ☐ 3.51 to 3.76
- 3.77 to 3.93
- 3.94 to 4.07
- 4.08 to 4.33
- 4.34 to 4.84

Figure 16:
Percentage of adults 18 and older seriously considering suicide in the past year, 2012-2013

... 4.3 percent of Washington's adults 18 and older had seriously considered suicide in the past year.

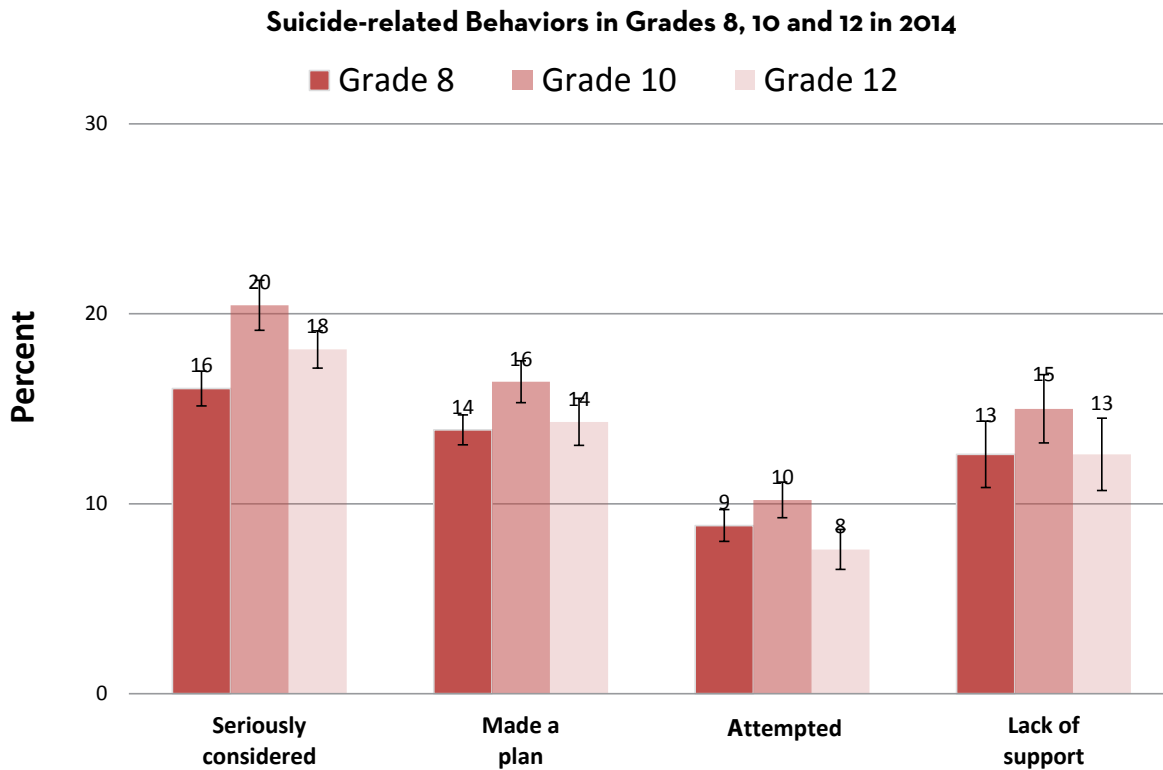The 2014 Healthy Youth Survey showed suicidal thoughts and behaviors are also common among Washington youth.

Suicide-related Behaviors in Grades 8, 10 and 12 in 2014

■ Grade 8   ■ Grade 10   ■ Grade 12

Figure 17: Answers to suicide-related questions on the Healthy Youth Survey by grade, 2014

Mental illness without appropriate treatment in Washington

It is estimated that up to 90 percent of people who die by suicide have a diagnosable behavioral health disorder.[4] Of all the states, Washington has one of the highest percentages of adults with mental illness (21 percent) and adults reporting unmet needs for mental healthcare (26.3 percent).[36] An estimated 10.6 percent of Washington youth have had at least one major depressive episode[36] and nearly half of children in need of mental healthcare in 2011–2012 did not receive it.[38]

Most Washingtonians have some form of health insurance, but nearly half of the population faces barriers to mental health services because of geography and income challenges. Limited access to transportation and appropriate access to physical and behavioral healthcare providers reduces community integration and wellbeing, increasing risk.

About 75 percent of the state is considered a Mental Health Professional Shortage Area by federal standards. More than 90 percent of the state is eligible for federal funding to recruit and retain primary care providers. Affordable and accessible healthcare is critical to reducing suicide and must be taken into account to understand suicide rates in the state.[39]

The cost of suicide and the benefit of prevention

The CDC estimates that each suicide death costs $1.2 million and each hospitalization costs almost $33,000, based on medical costs and the cost of lost productivity.[40] Applied to Washington, the estimated cost of suicide deaths in 2014 was over $1.3 billion, and the cost of hospitalizations for suicide attempts was almost $109 million.

These calculations do not include the financial or emotional toll a death or hospitalization takes on the family and community. Grieving loved ones or members of a suicide attempt survivor's support system often invest significant time and money in their own treatment and recovery, and many people and communities continue to suffer for years after a suicide.

Recommendations listed in the following four sections will require financial investment from various sources. The London School of Economics has found that behavioral health interventions and suicide prevention activities, including suicide training for health professionals, early diagnosis and treatment of depression at work and suicide barriers on bridges, have a significant return on investment.[41] In the long run, investment in suicide prevention will improve community wellness and save money and lives.
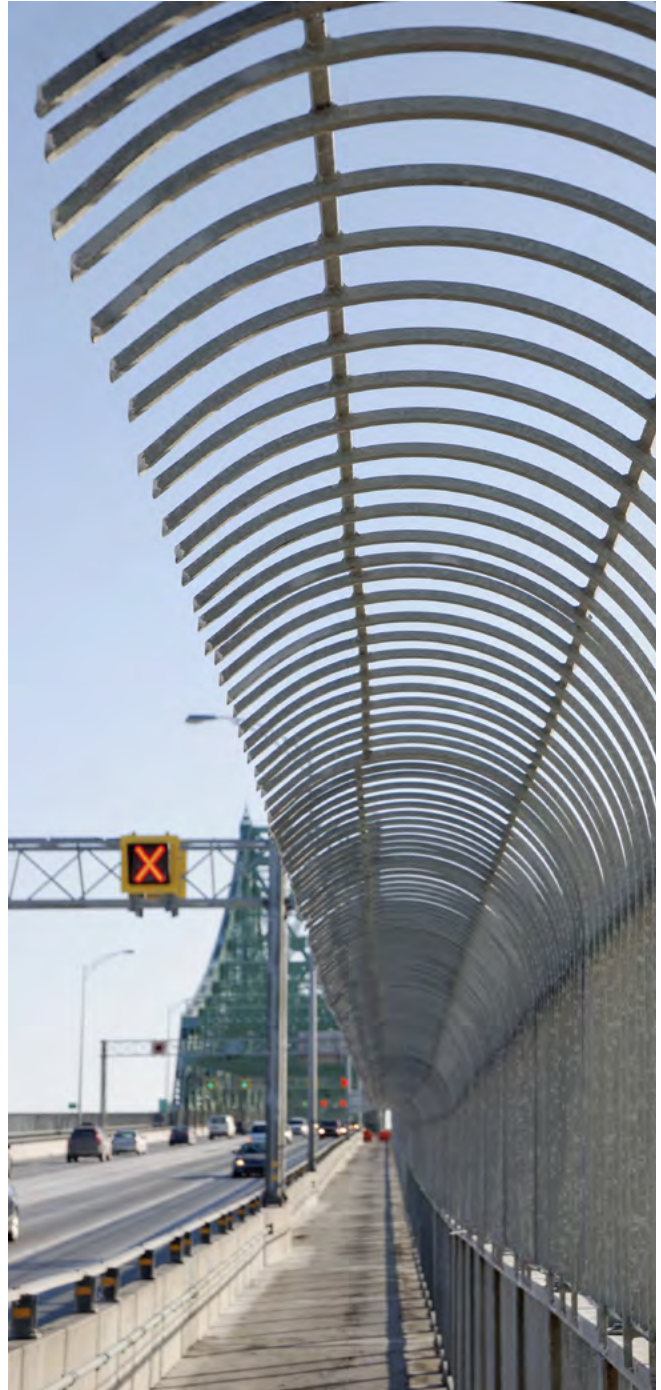
... investment in suicide prevention will improve community wellness and save money and lives.

Goals and Recommendations

This plan follows the structure of the National Strategy for Suicide Prevention[1] and includes Washington-specific goals and recommendations. Recommendations came from the State Suicide Prevention Plan Steering Committee and meetings with other stakeholders and are consistent with other state and national public health approaches.

Strategic Direction 1
Healthy and Empowered Individuals, Families and Communities

Strategic Direction 3
Treatment and Support Services

Strategic Direction 4
Surveillance, Research and Evaluation

Strategic Direction 2
Clinical and Community Preventive Services

STRATEGIC DIRECTION 1
Healthy and Empowered Individuals, Families and Communities
Goals:
1. The general public considers suicide a public health issue requiring public participation.
2. Individuals, families and institutions understand that they have a role in improving community behavioral health and preventing suicide.
3. News media report responsibly on behavioral health and suicide.
4. Social media spread appropriate, supportive messages about behavioral health and suicide.
5. Social and emotional health education is integrated into early learning programs, community programs and K-12 schools.
6. Connectedness (the connections a person has among family, friends, peers, and community; how connected people are to health and social services; and how well services collaborate) is promoted as a protective factor to prevent suicide, and includes community-wide interventions and programs for marginalized and at-risk populations.

STRATEGIC DIRECTION 2
Clinical and Community Preventive Services
Goals:
1. Tribal, state, local and institutional systems adopt comprehensive suicide prevention programs.
2. High-quality suicide recognition and referral trainings are widely available.
3. Designated health professions are trained in suicide assessment, treatment and management.
4. Screening for and limiting access to lethal means is conducted to reduce suicide risk for people in crisis.
5. Community members are aware of local resources, including behavioral health services and crisis lines.

STRATEGIC DIRECTION 3
Treatment and Support Services
Goals:
1. Access to mental healthcare, substance abuse treatment and crisis intervention services is expanded.
2. Emergency departments and inpatient units provide for the safety, well-being and continuity of care of people treated for suicide risk.
3. Families and concerned others are involved, when appropriate, throughout a person at risk's entire episode of care.
4. Effective suicide postvention-aftercare programs (programs providing care and support for the community and loved ones after a suicide) are in place to provide support after a suicide loss.

STRATEGIC DIRECTION 4
Suicide Surveillance, Research and Evaluation
Goals:
1. Effective suicide and behavioral health data surveillance systems are in place to guide prevention.
2. Researchers and state agencies collaborate on suicide prevention research and evaluation.
3. Suicide prevention activities are evaluated and improved.

STRATEGIC DIRECTION 1
Healthy and Empowered Individuals, Families and Communities
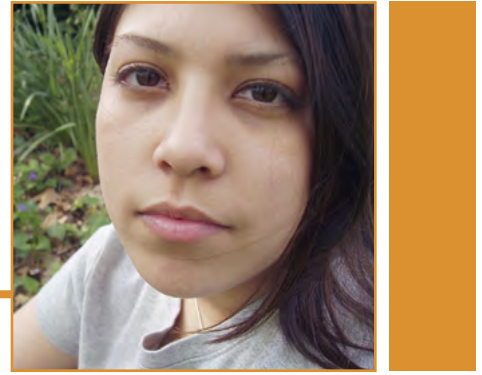
For many who have died by suicide, there were missed opportunities to get support before risk developed. Deaths from heart disease in adulthood can be reduced by encouraging lifelong habits of diet and exercise. Similar to deaths from heart disease in adulthood being reduced by encouraging lifelong habits of diet and exercise, suicides can be reduced by nurturing social and emotional health, positive community influences and cultural practices.

Creating cultural change, identifying and intervening in early indicators of suicide risk and promoting protective factors can make a difference. These solutions require public involvement, shifts in how we think and talk about behavioral health and policies promoting a healthy and fair Washington.

Helpful Terms

Behavioral healthcare
Healthcare that focuses on mental wellness and functioning by addressing addiction and substance abuse, mental illness, self-destructive behaviors and other concerns. This is a more inclusive term than mental health.

Connectedness
The connections a person has among family, friends, peers, and community; how connected people are to health and social services; and how well services collaborate.

Cultural competence
A set of attitudes, behaviors, practices and policies allowing individuals and systems to work appropriately with people from different cultural backgrounds.[42]

Postvention or aftercare
Programs providing care and support for the community and loved ones after a suicide. This includes supports in the school, faith community, or workplace; healing activities aligned with community cultures; and one-on-one and group supports for people grieving a loss.[43]

Stigma
Negative judgment or discomfort with suicide, behavioral health disorders, or people with lived experience of these.

Suicide contagion (also known as "copycat suicide")
Other suicide attempts or deaths following a suicide.

In 2010, White Swan had five youth suicides in five months. It was pretty bad out here. About 25 of our youth got together and decided they had to do something about it. With funding from White Swan Arts and Recreation, they founded the White Swan Dream Makers. They made television PSAs and handed out thousands of cards with signs, symptoms and resources on them. They presented at school assemblies. Two girls shared stories about their lives—it was very personal and impressive. We were even asked to do a presentation in Washington, D.C., and a school on the coast paid for us to come talk to their students.

The impact has been a lot fewer suicides. One suicide is too many, but we've only had two since 2010. The youth really do care, and they want to help. A lot of them were headed down the wrong road, and being in the group changed their lives. They feel like the group has become their family.

It's important for people to know that youth working with youth is so different from adults working with youth. They listen more to each other. So why not give youth the chance to help their community? It creates leaders, and it creates success.

—Darlene Lamb, advisor to the Yakama Nation's White Swan Dream Makers

GOAL 1: The general public considers suicide a public health issue requiring public participation.

Common myths about suicide are a barrier to effective prevention. By oversimplifying the causes (e.g., seeing suicide risk as a personal weakness or blaming suicide on family problems), behavioral healthcare systems are limited in their ability to prevent suicide.

A public health approach to suicide recognizes that prevention requires organized solutions to reduce stigma, foster environments where helpful conversations are possible and motivate everyone to do their part.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Create common language about suicide as a public health problem in messages from public agencies.	• State agencies (Department of Health; Health Care Authority; Department of Social and Health Services (DSHS), etc.) • Local and tribal governments • Local health agencies • Higher education institutions • Suicide prevention organizations • Journalists • General public
Create a statewide health promotion campaign about protective factors, using culturally competent and adaptable messages to reach all communities.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
• Perform research on how public health approaches to suicide prevention affect public conversation and program design.	• Suicide researchers • Suicide prevention organizations

GOAL 2: Individuals, families and institutions understand that they have a role in improving community behavioral health and preventing suicide.

Sometimes, the response to the mention of suicide is: "That is not my responsibility." This attitude often comes from discomfort and fear. While many fear that they lack the skills to intervene, being part of suicide prevention does not require clinical knowledge. Shifting this perspective can bring communities together to improve prevention.

There are 12 suicide prevention coalitions in Washington,[44] which bring together concerned people to discuss suicide and take action. Many more coalitions make suicide a priority (examples: those working on firearm safety, substance abuse prevention and community safety). These groups are where the community formally engages in suicide prevention. Prevention also happens in our families, relationships, religious communities and workplaces.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Make and publish a short list of action steps that everyone can take to help prevent suicide. Include suggestions for distribution in media, at community events, etc.	• State agencies • Suicide prevention organizations • Local and tribal governments • Educational institutions • Journalists • Faith community leaders • Policymakers • Health professionals • Private funders • Suicide prevention coalitions • People with positive stories • Military • Youth-serving and youth-led groups • Mental health consumer groups
Host public awareness events that dispel suicide myths and encourage new people to participate in prevention. Publicize respectful, positive personal stories showing that community support prevents suicide even for people at high risk.	
Expand peer-to-peer suicide support, education and prevention programs.[45]	
Create and distribute a toolkit for starting suicide prevention coalitions and initiatives.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Build a diverse[46] and skilled suicide prevention workforce to create suicide prevention coalitions and build their capacity for action, focusing resources on high-need communities.	• Suicide prevention coalitions • Suicide prevention organizations • Lawmakers and taxpayers • Private funders

GOAL 3: News media report responsibly on behavioral health and suicide.

News media have the power to change how we think and talk about suicide and mental wellness. Stories about recovery and treatment can raise awareness of suicide as a public health problem, correct myths about suicide and link people in crisis with resources for help.

Uninformed news reporting, however, can promote myths that suicide is not preventable, is an individual or family failing, or happens suddenly with no visible cause.[47]

Journalists and news organizations need information about behavioral health, suicide, and how to accurately report on both. Media can be a strong ally in fighting stigma around suicide and mental illness.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Post guidelines for appropriate and culturally competent suicide reporting on websites of behavioral health and suicide prevention organizations. Train spokespeople on these guidelines and encourage them to explain the guidelines to journalists who request interviews.	• Behavioral health professionals • Suicide prevention organizations • People and organizations consulted by media on behavioral health issues • Spokespeople for communities at elevated risk of suicide • Journalists and news organizations • People with a positive story • Schools of journalism • High school journalism programs
Media follow guidelines for safe messaging when reporting on suicide and behavioral health. Consult experts for guidance on best practices.	
Pitch and publish stories on suicide prevention in news media outside the context of an immediate crisis, including non-English-language and tribal news media.	
Identify news organizations with appropriate behavioral health and suicide reporting policies, and assist others in adopting similar guidelines.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Create a curriculum module on appropriate suicide and behavioral health reporting for use in high school, college and graduate journalism classes.	• Schools of journalism • High school journalism programs • Suicide prevention organizations

GOAL 4: Social media spread appropriate, supportive messages about behavioral health and suicide.

Social media is often criticized as a place for cyberbullying, insensitive or indifferent responses to requests for help and unsafe messages after a suicide loss. But social media can also give those at risk of suicide a way to learn about resources and ask for help, opening the door for friends to intervene. Its strength is in the social connections and support systems it can build among peers with similar experiences, and the information readily available about prevention programs and crisis resources.

In 2015, with the help of Washington mental health experts, Facebook improved its tools to support suicidal users, adding options for reporting and responding to a troubling post and links to resources. Other social media platforms also have reporting procedures in place.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Create a statewide, culturally flexible social marketing campaign to raise suicide awareness and promote crisis line resources.	• State agencies • Local health agencies • Suicide prevention organizations • Social media users • Mental health bloggers • Public figures on social media • Youth • K-12 and higher education institutions • Social media companies • Online suicide resources
Widely distribute tips for safely dealing with behavioral health and suicide to social media users, suicide prevention organizations and others.	
Include Washington-based mental health bloggers, tweeters and other public figures on social media in trainings on suicide recognition and referral.	
Use social media videos, public service announcements and other creative approaches to spread messages of hope and support about suicide prevention.	
Commit to appropriately discussing suicide and safely responding to suicide threats on social media.	
Track reports of suicide threats on social media that originate from Washington. Track clicks to crisis resources from Washington-based social media campaigns.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Create youth-appropriate training on how to address suicide on social media for use by youth, suicide prevention coalitions, educators and others.	• Suicide prevention organizations • Youth • Educators • Other social media users • Department of Health and contracted evaluator
Evaluate the effect of social marketing and social media campaigns for suicide prevention.	

GOAL 5: Social and emotional health education is integrated into early learning programs, community programs and K-12 schools.

About half of mental disorders appear by age 14.[48] Nearly all youth suicide prevention programs focus on identifying students already at risk of suicide and connecting them to resources, but preventing suicide risk upstream is equally critical. Public, tribal and independent K-12 schools and out-of-school-time programs are prime places to explore the power of upstream prevention.

Programs designed to help children and youth develop social and emotional skills include home visitation during pregnancy-postpartum and infancy, parenting skills training for families from infancy through adolescence, out-of-school-time programs building personal skills and connections and classroom curricula. The effect of these programs on suicidal behaviors is rarely measured, but social and emotional learning reduces other problems such as drug and alcohol abuse, risky sexual behaviors, tobacco use and poor nutrition and improves peer connectedness and quality of life.

There are also several programs for adults who work with youth to increase the knowledge of behavioral health and mental wellness. Improving the emotional health literacy of education staff members and youth development professionals may help with early identification of vulnerable youth.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Establish state benchmarks for social and emotional health education.	• Legislature • Office of the Superintendent of Public Instruction (OSPI) and workgroup • Educational Service Districts • School districts • Department of Health • Department of Early Learning • Washington State Arts Commission
Survey Washington schools to learn which teach social and emotional health education, and assess district capacity.	
Develop a rigorous training program on the effect of adverse childhood experiences, and promote schools' use of trauma-informed practices to lessen the effects.	
Re-introduce HB 1900 (2015), legislation clarifying the roles of school counselors, social workers and psychologists in supporting students' behavioral health.	
Increase social and emotional development promotions in Child Profile health mailings. Create suicide prevention and behavioral health mailings for families of adolescents.	
Promote social and emotional development skill-building programs for families in high-need communities.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Create a compendium of research-based resources promoting social and emotional health for infants, toddlers and K-12 students for daycare centers, early childhood programs and schools.	• OSPI • Department of Early Learning • Legislature • Early childhood programs • Educational Service Districts • School districts • School nurses, counselors, psychologists, social workers
Amend the staffing allocation for basic education to fully staff school nurses and counselors in all K-12 schools.	
Train Educational Service District personnel to train educators on the Compassionate Schools curriculum.[50] Identify students affected by adverse childhood experiences, and promote behavioral health and wellbeing for all students.	

A few members of our coalition went to a local high school to support and participate in a talk about depression by the senior class valedictorian. Two of our presenters followed her talk with information about getting help for depression and suicidal thinking.

Afterwards, a student stopped by our table to get the resource list and started talking with a volunteer. Turned out that the student was suicidal and had been too afraid and shy to ask for help. The prevention specialist who set up the presentation was five feet away and was able to connect with the student within about two minutes. Our being there might have saved this student's life. This is why we do what we do.

—Jeff McKenna, chair of the MAD-HOPE coalition working on suicide prevention in Whatcom County

GOAL 6: Connectedness is promoted as a protective factor to prevent suicide, and includes community-wide interventions and programs for marginalized and at-risk populations.

Connectedness reduces social isolation, a risk factor for suicide. Socially connected people have more opportunities to ask for or get help during a crisis, and families' connectedness to community resources protects against suicide risk.

Connectedness is helpful for everyone and is critical for populations at increased risk of suicide because of geographic, cultural, and personal isolation or marginalization. For example, small-town rural communities where people are geographically isolated and services are limited experience higher suicide rates;[23] lesbian, gay, bisexual, transgender and questioning youth who are disconnected from their families have a significantly higher suicide attempt rate than their peers with supportive families;[17] and middle-aged men, many of whom find help-seeking challenging even for serious problems such as job loss and addiction, have a high and growing suicide rate.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Promote connectedness programs in neighborhoods, communities and among cultural groups and high-risk populations.[51]	• Local and state government agencies • Tribal governments and programs • Community-based organizations • Private funders • Department of Veterans Affairs and other veterans organizations • Department of Corrections • Mental health consumer groups • Suicide prevention organizations • Schools and school districts • Behavioral health professionals • Faith communities • OSPI
Use media, community leadership and training to increase suicide prevention competence in connectedness initiatives.	
Maintain programs promoting family connectedness for people at risk of suicide, including LGBTQ youth, older adults and people experiencing behavioral health problems.[52]	
Improve connectedness to community behavioral health resources and schools' family referral practices in ongoing legislation implementation (House Bill 1336, Laws of 2013).	
Fund and evaluate programs maintaining connectedness for people at high risk of suicide during transitional periods.[53]	
Long-term Recommendations (4–5 years)	Who Plays a Role?
Establish comprehensive programs to increase connectedness among isolated residents of the same geographic area.	• Suicide researchers • Local and state government agencies • Tribal governments and programs • Community-based organizations • Community leaders • General public • Behavioral health professionals
Pursue health equity initiatives to reduce racism, homophobia, ageism, gender bias, mental illness stigma, and other prejudices that create isolation and discourage help-seeking.	
Research and design campaigns to help middle-aged men in their 40s and 50s feel comfortable seeking help for crises and behavioral health needs.	

Resources

- For excellent guidelines and tools for culturally competent social marketing:
  http://www.cdc.gov/obesity/health_equity/culturalRelevance.html

- For information about World Suicide Prevention Day and National Suicide Prevention Week:
  http://www.suicidology.org/about-aas/national-suicide-prevention-week

- For suicide prevention messaging including social marketing campaigns:
  http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/framework

- Youth Suicide Prevention Program's Community Action Toolkit is a starting point for a new coalition or community group:
  http://www.yspp.org/take_action/community_toolkit.htm

- Free, downloadable RAND Suicide Prevention Program Evaluation Toolkit providing step-by-step guidelines and tools for evaluating military and community-based suicide prevention programs:
  http://www.rand.org/content/dam/rand/pubs/tools/TL100/TL111/RAND_TL111.pdf

- CDC's Evaluaction tool for building program evaluation:
  http://vetoviolence.cdc.gov/apps/evaluaction/

- This article gives useful, research-based strategies for building collaborative capacity in a community coalition:
  http://systemexchange.msu.edu/upload/collab_capacity.pdf

- Safe and appropriate messages for social media campaigns on behavioral health or suicide prevention:
  http://www.eiconline.org/teamup/wp-content/files/teamup-mental-health-social-media-guidelines.pdf

- Resources for journalists on safe and appropriate reporting on suicide:
  http://reportingonsuicide.org/

- National Suicide Prevention Lifeline's short scripts for responding to suicide on social media:
  http://www.suicidepreventionlifeline.org/about/social.aspx

- Your Life Matters campaign includes messages about suicide prevention for Buddhist, Christian, Hindu, Muslim, Jewish and Native American religious communities:
  http://actionallianceforsuicideprevention.org/task-force/faith-communities/YLM-spiritual

STRATEGIC DIRECTION 2
Clinical and Community Preventive Services

The programs discussed here are more focused than community empowerment initiatives but less focused than clinical treatment. They spread awareness about suicide and take action, such as limiting access to means commonly used in suicide attempts and promoting helping resources.

Helpful Terms

Comprehensive suicide prevention program
A program that works to prevent suicide by engaging in prevention, intervention with people at risk, and postvention-aftercare following a crisis.

Crisis lines
Phone hotlines, usually available 24 hours, where a person in crisis can speak anonymously with a trained crisis counselor.

Lethal means
Things people might use in a suicide attempt that are likely to result in death (for example, firearms, medications and poisons).

Recognition and referral training
Training focused on basic facts about suicide, how to identify a person at risk and how to connect them with appropriate resources (sometimes called gatekeeper training; see note under Goal 2 on page 39).

A soldier who had joined the Washington National Guard after returning from deployment came into the Joint Services Support (JSS) office at Camp Murray, asking for help finding a job. While talking with the Employment Transition Team, the soldier revealed financial struggles, fear of returning home because of domestic violence, overwhelming depression and suicidal thoughts.

The JSS's multidisciplinary team sprang into action. Five weeks later the soldier had a regular therapy schedule, gift cards for food and gas, an electronic benefits card, a refreshed résumé, a suicide prevention mentor, an order of protection against the abusive partner, and safe transitional housing. Outstanding disability claims had been resolved, the soldier was about to move into an apartment and a job offer had come through from a prominent Washington company. The soldier's life had moved from a place of desperation to a place of stability.

It is not unique for a person seeking help to have multiple needs spanning many systems. What is unique is that this soldier was able to get all of these needs met in one place by a collaborative, supportive team of professionals, each of whom was well-trained and attuned to depression and suicide risk.

The JSS states that its purpose is to "enhance the quality of life for all Guard members, their families, and the communities in which they live and contribute to readiness and retention in the Washington National Guard." The JSS at Camp Murray combines strong and supportive leadership, cross-system teamwork, and attention to soldiers' emotional needs and ability to thrive at work—a program model that improves job performance and saves lives.

GOAL 1: Tribal, state, local and institutional systems adopt comprehensive suicide prevention programs.

Trainings designed to raise suicide awareness, improve clinicians' skills and guide response to a suicide loss are widely available in Washington and are required for certain professionals. But training alone does not solve the problem; it must be part of comprehensive, systems-level suicide prevention programming.

Figure 18: Diagram of elements of a comprehensive suicide prevention approach (derived from the U.S. Air Force's effective approach by the Jed Foundation)[54]

Develop life skills

Promote social connectedness

Restrict access to potentially lethal means

Comprehensive approach to mental health promotion and suicide prevention

Identify students at risk

Follow crisis management procedures

Increase help-seeking behavior

Provide mental health services

Comprehensive prevention programming can be part of many systems—including local, state or tribal governments, hospitals, military bases, correctional facilities, schools and unemployment services offices. Recent legislation is improving suicide prevention programming in K-12 education. Many other systems would benefit if comprehensive prevention programming were a priority.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Acknowledge the relationship between childhood trauma and suicide risk, and integrate adverse childhood experiences prevention[55] and trauma-informed care into community governance and planning.	• State agencies, including Department of Corrections, Juvenile Rehabilitation Administration (JRA) and Employment Security Department
Distribute comprehensive suicide prevention toolkits and encourage institutions to modify materials for their use, particularly in communities with elevated suicide rates.	• Labor unions, including law enforcement unions • Professional associations • Suicide prevention organizations
Support tribes in replicating evidence-based programs and tribal best practices through funding and technical assistance, if requested.	• Washington employers • County governments and correctional systems
Develop comprehensive suicide prevention programs within higher education institutions, including community and technical colleges.[56]	• Tribal governments and correctional systems • Bureau of Indian Affairs
Partner with a Washington-based employer to start a model comprehensive suicide prevention program.	• Northwest Portland Area Indian Health Board • Foster care agencies
Help K-12 schools comply with state requirements on crisis plan development.	• WorkSource sites • Legislature
Use death certificates and emerging violent death (WA-VDRS) data to identify groups most in need of suicide prevention support.	
Coordinate communication among Washington's military installations about suicide prevention, and create a network of suicide prevention coordinators to share resources and knowledge.	
Create a network of correctional system suicide prevention coordinators to share resources and knowledge.	

Partner with a Washington-based employer to start a model comprehensive suicide prevention program.

Long-term Recommendations (4–5 years)	Who Plays a Role?
Encourage unions and professional associations in occupations at high suicide risk[57] to develop comprehensive prevention programs.	• State agencies • Labor unions • Professional associations • Suicide prevention organizations • Washington employers • Department of Corrections • Tribal jails
Consider legislation requiring staff training and comprehensive suicide prevention programming in Washington's child welfare, juvenile justice and unemployment services systems, modeled on House Bill 1336 (Laws of 2013).	• County governments • Tribal governments • Bureau of Indian Affairs • Northwest Portland Area Indian Health Board
Promote workplace behavioral health supports and Crisis Intervention Training (CIT) in law enforcement systems, and improve cooperation among state, local and tribal law enforcement agencies.	• Foster care agencies • JRA • Other juvenile justice programs • Employment Security Department • WorkSource sites
Encourage all-staff CIT in correctional facilities to improve inmate care and support accreditation standards.	• Legislature • Police unions • County and tribal corrections systems

GOAL 2: High-quality suicide recognition and referral trainings are widely available.

Recognition and referral (R&R) training helps people without clinical training fulfill their role in suicide prevention. It is most appropriate for concerned community members and people who regularly come in contact with people at risk.[58] While many at risk get care from behavioral health and primary care providers, research shows that many others turn to family or friends for help instead.[59] Some people at risk show warning signs that those closest to them may notice first. A person at risk benefits from an informed support network ready to connect them to the right help.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Inventory effective recognition and referral (R&R) trainings available in Washington, including those focused on marginalized and at-risk groups, weaving together cultural and evidence-based practices.	• Professional Educator Standards Board • Department of Health • All stakeholders named in Goal 1 • Suicide prevention organizations • Social service systems and peer support groups • Suicide researchers • Private foundations
Ensure R&R training is available as part of comprehensive suicide prevention programming at the tribal, state, local and institutional levels.	
Offer R&R trainings tailored to family members and caregivers of people at elevated risk of suicide, including older adults, people with substance abuse disorders, people receiving nonclinical services in medical and correctional facilities, and people experiencing stressful transitions.	
Fund and staff high-quality R&R trainings in neighborhoods and communities. Tailor training to community profiles and needs.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Build R&R training into orientation and continuing education for first responders (law enforcement, fire, EMTs, victim service providers, child and adult protective services investigators, etc.) and workers who come in contact with the public.[60]	• State agencies • Private employers • Human resources staff members • OSPI • Issues of Abuse trainers • Suicide prevention organizations • Training curriculum developers • Department of Corrections • Healthcare companies • Suicide researchers
Improve and standardize R&R content in the Issues of Abuse course required for new teachers.	
Require system-specific R&R training for all staff members working with older adults, including Meals on Wheels drivers, residential facility staff, family caregivers, Medicaid-funded transportation providers and medical translation interpreters.	

A note on language: Trainings on recognizing a person at risk and connecting them to an appropriate resource are often called gatekeeper training. In some communities, the word gatekeeper is a reminder of people and systems that create barriers to getting help. Instead, we will use the term Recognition and Referral, or R&R, training.

GOAL 3: Designated health professions are trained in suicide assessment, treatment and management.

Suicide prevention is relevant to all areas of healthcare, not only behavioral health systems. A large analysis of research found that 45 percent of people who died by suicide had seen a primary care provider within the month before their death, 77 percent within the past year. Older adults who died by suicide were even more likely to have had recent contact with a primary care provider. On the other hand, only about 30 percent of those who died by suicide had received mental healthcare during the last year of life.[4]

A 2013 Washington State Department of Health study found that only 50 percent of psychologists, 25 percent of social workers and 6 percent of counselors in Washington had been trained in suicide risk assessment. Of 37 health profession education programs evaluated in the study, few included pre-credential training on suicide.[62] In 2012, state legislation mandated suicide prevention training for behavioral health and primary care providers.[63] As these requirements move into implementation, their impact on the professions involved will be evaluated.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Inventory effective suicide assessment, treatment and management trainings available in Washington, including those focused on marginalized and at-risk groups and weaving together cultural and evidence-based practices.	• Stage agencies • Suicide prevention training experts from healthcare fields • Legislature • SEIU • Training Partnership • Community-based organizations • Local governments • Tribal governments and agencies • Private foundations • Suicide prevention organizations • Suicide researchers
Ensure best practices for supporting patients at discharge from services, including creating self-management and safety plans, are part of health professionals' mandated training.	
Explore benefits and costs of requiring additional health professions to have suicide prevention training for certification. Add training mandates as appropriate.	
Fund and staff high-quality suicide assessment, treatment and management training. Tailor training to community profiles and needs.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Require content on suicide assessment, treatment and management in health science and social service courses taught in higher education in Washington.	• Higher education institutions • Legislature
Convene stakeholders to explore the feasibility of adding suicide prevention training as part of the basic training and/or 12-hour continuing education requirement for home care aides, and consider whether it should be required or recommended.	

GOAL 4: Screening for and limiting access to lethal means is conducted to reduce suicide risk for people in crisis.
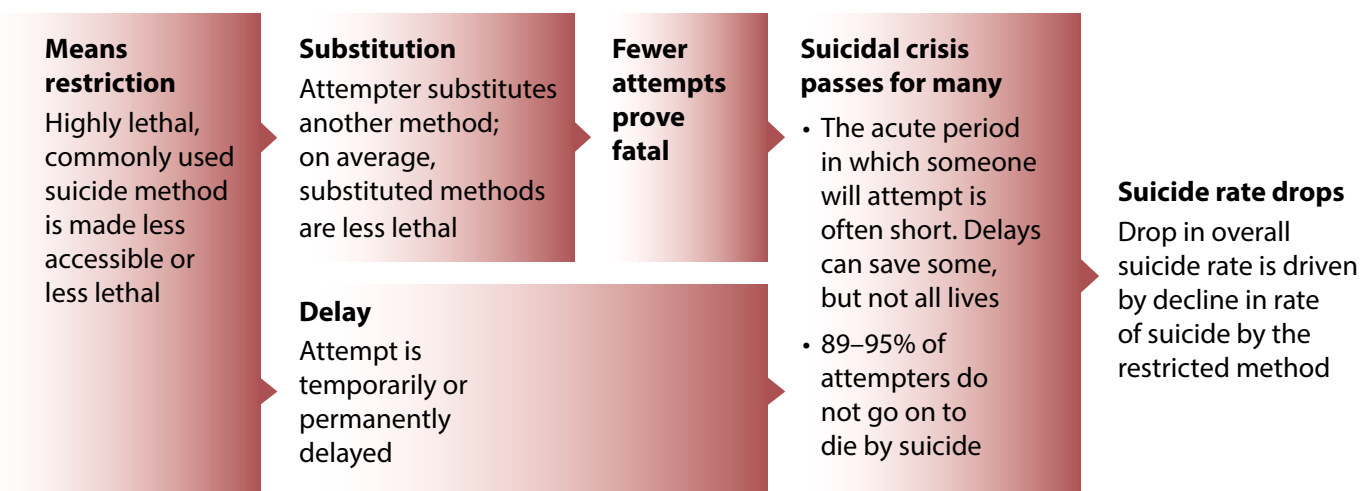
Most people who die by suicide in Washington use a firearm, suffocation (frequently hanging), or poisoning (drug or medication overdose or swallowing harmful substances). About half of suicides in Washington involve firearms. Less common, but still of concern, are suicide deaths by jumping/falling or cutting.

Limiting or reducing an at-risk person's access to lethal means, known as means restriction, effectively prevents suicides.[63]

*This is a public health safety issue, like wearing motorcycle helmets and knowing the signs of a stroke. We universally recommend that people experiencing depression and/or significant stress, and especially people experiencing suicidal thoughts, **do not have easy access to firearms** (or pills, etc.).*

—Group Health behavioral health providers' messaging since 2012

Figure 19:
Conceptual model of how reducing access to a highly lethal and commonly used suicide method saves lives at the population level.[63]

Means restriction
Highly lethal, commonly used suicide method is made less accessible or less lethal

Substitution
Attempter substitutes another method; on average, substituted methods are less lethal

Delay
Attempt is temporarily or permanently delayed

Fewer attempts prove fatal

Suicidal crisis passes for many
- The acute period in which someone will attempt is often short. Delays can save some, but not all lives
- 89–95% of attempters do not go on to die by suicide

Suicide rate drops
Drop in overall suicide rate is driven by decline in rate of suicide by the restricted method

Many suicidal crises are brief. Research shows that the time between deciding on suicide and an attempt is often less than an hour, sometimes as short as 10 minutes. If a lethal method is not immediately available, the crisis will often pass, and the person may never attempt suicide. Others may still make an attempt but use a less deadly method. A suicide attempt using a gun leads to death in 85 to 90 percent of cases; an attempt by medication overdose or a sharp instrument leads to death about 1 to 2 percent of the time.[63] It is important to understand that most people who attempt suicide once and survive never attempt again. Putting time, distance and other barriers between a person at risk and the most lethal means can make the difference between life and death.

Though limiting access to materials used for hanging is difficult, even in restrictive places such as jails and hospitals, limiting or reducing access to other lethal means is possible at both the individual and community levels. Safe storage of firearms and medications, reduced access to common poisons and placement of suicide barriers at the edges of tall buildings and bridges are proven strategies.

| Short-term Recommendations (1–3 years)	Who Plays a Role?
Develop a statewide social marketing campaign around safe firearm storage in partnership with firearm owners and retailers.[64]	• State agencies • Rural health providers • Firearm owners • Firearm retailers • Injury prevention advocates • Suicide prevention organizations • Employers • Department of Fish and Wildlife • Hunter education curriculum developers and instructors • Healthcare companies and providers • Local governments and health agencies • Tribal governments and programs • Agency Medical Directors' Group • Legislature • Local law enforcement • Suicide researchers • Washington State Pharmacy Association • Pharmacy educators
Design a best-practice recognition and referral training for firearm owners. Offer training in partnership with firearm owner organizations, firearm retailers, occupations that require firearm use, and in communities where hunting is a cultural practice or social norm.	
Integrate suicide prevention training[65] into instructor training for the state-approved hunter education course, and improve the course content on safe storage and suicide prevention.	
Train primary care and behavioral health professionals to integrate lethal means counseling into routine and acute care and discharge procedures.	
Include or encourage the purchase of effective safe storage devices with every firearm purchase.	
Implement the Washington State Agency Medical Directors' Group's 2015 guidelines on prescribing and managing opioid medications.[66]	
Consider legislation giving families and/or law enforcement a process to temporarily prohibit an at-risk person from purchasing or possessing a firearm during a crisis.	
Consider legislation that establishes a process for voluntary, temporary safekeeping of a person at risk's firearms with law enforcement or family members.	
Consider legislation imposing consequences on adults who leave or store a loaded firearm where a child can obtain it, causing injury or death.	
Provide safe medication disposal programs.	
Convene a short-term workgroup to examine strategies for preventing suicide through pharmacy policies and practices.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Offer educational materials encouraging recognition and referral of other gun owners at risk of suicide at the point of firearm purchase.	• Firearm retailers and owners • Suicide prevention organizations • Department of Transportation • Department of Corrections • Pharmaceutical companies • Legislature • Firearm manufacturers
Encourage development and use of new safety technologies to reduce access to lethal means.[67]	

In the 2.5 years since my son's death I have learned that his story is, sadly, not uncommon. I have become oddly close with other mystified parents of seemingly successful, engaged, social young men and women who took their lives. They are my partners in grief, and in understanding why suicide is the number two killer of youth in Washington State, just behind accidents.

My son retrieved a gun that was unlocked because it had not been fired in many years and didn't think there was any ammunition in the house. Although we have learned that he was showing some warning signs, I will never know what he was thinking, because that gun left him with no chance of survival.

My son was a trained marksman who had attended gun camp every summer. He had also taken the hunter safety class, and was, as his hunting mentor said, "safer with a gun than any adult I know." I have great respect for the people who trained my son, but not once did any of the safety materials include warnings for parents of youth that 79 percent of firearm deaths in Washington State are suicides. I had not dreamed that my son was suicidal, much less that he would consider using a gun to take his life. I sincerely hope that other parents safely store firearms and ammunition out of the reach of children.

—Kathleen Gilligan, whose son Palmerston Burk died from suicide by firearm in King County in 2012
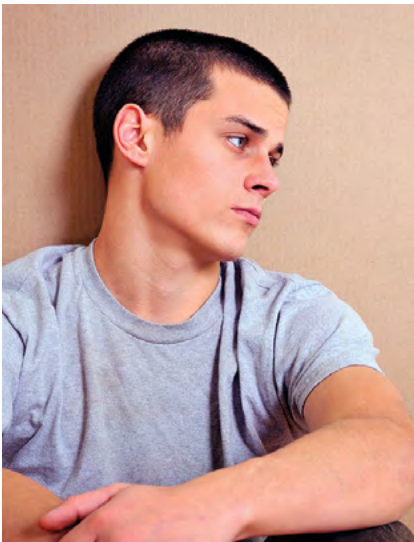
GOAL 5: Community members are aware of local resources, including behavioral health services and crisis lines.

Crisis lines, including chat and text services for people unwilling or unable to talk by phone, provide immediate access, often 24 hours a day, to crisis intervention. They are an access point for emergency care, clinical assessment, referral and treatment. When other providers are closed and personal support networks are unavailable, crisis lines can be a lifeline for people at risk of suicide.

Crisis lines are heavily used. From October 1, 2014 to September 30, 2015, 46,633 calls to the National Suicide Prevention Lifeline originated in Washington, 22,937 from people who selected the Veterans Crisis Line for help.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Widely market existing local behavioral health resource guides and databases, and how to find and use them.[68]	• Local governments and health agencies
Explore creation of a specifically staffed crisis line, similar to the Veterans Lifeline, for tribal members.	• Local crisis clinics and resource lines • 211 referral system • Healthcare companies and providers
Prominently display local crisis line and National Suicide Prevention Lifeline numbers and messages encouraging help-seeking in public and private locations (examples include liquor stores, public transportation, billboards and public service announcements in multiple media).	• Tribal behavioral health providers • Retail store owners • Advertising companies • State agencies • Public transit agencies
Raise awareness of crisis resources in K-12 schools and higher education.[69]	• Media outlets • Higher education institutions • School districts
Display crisis line information and suicide prevention materials in primary care, behavioral health and emergency department settings. Give them to patients and their supporters at appointments or interventions relevant to suicide, including discharge after a suicide attempt.	• School health clinics • WIC locations • Hospital social workers • Suicide prevention organizations • General public
Encourage attendees at meetings, trainings and events relevant to suicide prevention to save a 24-hour crisis line number in their cell phones.	• Twelve-step programs • Faith-based organizations
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Engage local celebrities and public figures as ambassadors of suicide prevention.	• Suicide prevention organizations • Event organizers
Evaluate how publicity campaigns change crisis resource use.	• Local celebrities • Suicide researchers • Program evaluators
Recognize the link between alcohol intoxication and suicide risk, and explore the feasibility of including suicide crisis resources on alcoholic beverage labels and packaging.	• Liquor and Cannabis Board • Legislature

I got really depressed. I stopped talking to people. I pushed on through the day, put a fake smile on, and then went to school and pretended everything was fine. But it wasn't.

I called the suicide hotline. It was like a friend that just wanted to help me. It hit me that my parents were there for me; my friends were there for me. I just had to talk to someone. I wasn't alone, and the deafening silence I sat in wasn't some sort of prison I was going to be in forever. I knew it would get better.

—Donny, a Tri-Cities student who got help for suicidal thoughts after learning about crisis lines at school

Resources

- For the free, downloadable RAND Suicide Prevention Program Evaluation Toolkit with step-by-step guidelines and tools for evaluating military and community-based suicide prevention programs:
http://www.rand.org/content/dam/rand/pubs/tools/TL100/TL111/RAND_TL111.pdf

- CDC's Evaluation tool for building program evaluAction:
http://vetoviolence.cdc.gov/apps/evaluaction/

- Many R&R training publishers maintain data on their trainings. See Appendix A for links to publishers.

- SAMHSA's National Registry of Evidence-Based Programs (http://www.nrepp.samhsa.gov/) and Practices and SPRC's Best Practice Registry (http://www.sprc.org/bpr) include guidelines to meet the standards for listing in their directories.

- National Alliance on Mental Illness's Crisis Intervention Training Toolkit for establishing a CIT program in your community:
http://www2.nami.org/Content/ContentGroups/Policy/CIT/CJCIT_Toolkit.pdf

- University of South Florida's Youth Suicide Prevention School-Based Guide toolkit for schools considering suicide prevention programming:
http://theguide.fmhi.usf.edu/

STRATEGIC DIRECTION 3
Treatment and Support Services

Clinical care and support services provide treatment for people experiencing behavioral health disorders and suicide risk.

These systems improve the accessibility, appropriateness and continuity of care and provide supports that can be put in place after a suicide loss.

When I was 26, I had a good life and a lot of things going for me. But I started feeling this horrible depression and suicidality—all I could think about was that I wanted to die.

My religion and culture didn't encourage therapy, but I was desperate. I went to a therapist and told him that I was there because I wanted to die. He was very supportive, but we never again discussed my suicidality, which was getting worse and worse. Even when I was hospitalized for suicide ideation and eventually for attempts, the word suicide was not ever mentioned. Not by my therapist or any of the medical professionals I interacted with, from the paramedics to the hospital staff.

Although my therapy began years ago and the training for doctors and therapists has had many changes through those years, I found that up to my last hospitalization in 2010, my experience was the same. I had a completely different experience the last time I was hospitalized. I had always believed that suicide would stay an option in the back of my mind, if things got too bad. But at my last hospitalization I learned otherwise. The doctor who saw me spoke directly about my being suicidal and told me there was hope for a day when I would no longer feel this way. He referred me to Dialectic Behavioral Therapy. Through this type of evidence based therapy I have found that suicidal thoughts are something you can get through.

The advice I would give to someone in my situation: You are a VERY important individual, your message is urgent. Even if it doesn't feel that any of the professionals where you go to get help are listening to you, continue to speak up, continue to look for help don't give up...until you find it!

—Diana Cortes, Seattle

Helpful Terms

Behavioral health organizations (BHOs)
Will purchase and administer public mental health and substance use disorder services under managed care. BHOs are single, local entities that assume responsibility and financial risk for substance use disorder treatment, and the mental health services previously overseen by the Regional Support Networks, including inpatient, outpatient and involuntary treatment and crisis services, jail proviso services, and services funded by federal block grants.[70]

Continuity of care
Is "maintained when one provider links to another care provider, the transition in care is smooth and uninterrupted for the patient, and the essential clinical information is provided."[71]

Health home or patient-centered medical home
Offers coordinated care to people with multiple chronic conditions, including behavioral health disorders. It is a team-based approach involving the patient, family and care providers. Health homes enhance access to care through providers or care teams available via phone, email, or in-person visits 24/7 and patient navigators who can help patients access care.

Postvention or aftercare
Programs providing care and support for the community and loved ones after a suicide. This includes supports in the school, faith community, or workplace; healing activities aligned with community cultures; and one-on-one and group supports for people grieving a loss.[43]

Safety plan
A document created by a person at risk and a clinician, outlining what coping skills, people and resources may be of help in a crisis.

Telemedicine
Allows healthcare access by remotely providing clinical services to clients. Can rapidly advance access to care and educational services in rural communities.

Telehealth
Uses technology to support patient and employee distance learning. Can rapidly advance access to care and educational services in rural communities.

GOAL 1: Access to mental healthcare, substance abuse treatment and crisis intervention services is expanded.

Access to behavioral healthcare is a critical concern, especially in rural areas. All but four Washington counties are federally designated Health Professional Shortage Areas for mental health, indicating a lack of appropriate psychiatric care, geographic barriers to service access, or both.[39] Challenges in rural areas include difficulty recruiting and retaining providers, limited inpatient/outpatient services and few transportation options.

The way Washington provides behavioral healthcare is changing rapidly under the Healthier Washington Initiative.[72] Legislation has passed directing the state to integrate the payment and delivery of physical and behavioral health services under Medicaid by 2020. Like mental health services currently, chemical dependency services will be provided under managed care beginning in 2016.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Organize a workgroup to identify and promote best practice models for clinic-to-community linkages between providers of physical and behavioral healthcare, community-based organizations and other systems to increase access to timely and appropriate screening, referral, care and follow-up. Educate mental health and crisis service providers about interacting with systems serving their clients, such as community corrections, child welfare and military systems.	• Physical and behavioral health professionals • Behavioral healthcare consumers • Community-based organizations • Correctional systems • Health researchers • State agencies • Higher education institutions • Tribal governments and programs • Military programs
Encourage new partnerships among community-based organizations serving populations disproportionately impacted by suicide.[73]	• Hospital discharge planners, case managers, health record managers
Use systems approaches (such as case management, electronic health record alert systems and patient care coordinators) to improve timely and effective care for patients at risk.	• EHR system vendors • County and tribal corrections systems • Legislature
Improve county correctional facilities' ability to meet inmates' mental healthcare needs through staff training, system-level changes and mental health service funding.	• Screening, Brief Intervention and Referral to Treatment (SBIRT) rollout sites
Support *New Blue H* report[74] telehealth and telemedicine recommendations, including supporting payment and coverage of telehealth/telemedicine services in Medicaid and commercial plans.	
Ensure Section 1115 Medicaid waiver allows Washington to design and finance patient-centered medical home services.	
Expand the Screening, Brief Intervention and Referral to Treatment (SBIRT) pilot at Division of Behavioral Health and Recovery (DBHR) in the Washington State Department of Social and Health Services.[75]	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Assist programs for populations disproportionately affected by suicide in developing evidence-based and best practice behavioral health services.	• Behavioral health professionals • Healthcare companies and providers • Suicide and health researchers • Tribal governments and programs • Correctional systems • Military programs • State agencies • Community-based organizations • Educational institutions
Develop a health literacy campaign to educate the public about behavioral health services covered by the Affordable Care Act.	
Expand and coordinate multi-disciplinary care teams and wraparound services statewide using the patient-centered medical home model.	

I encouraged my primary care physician to screen his older patients for suicide risk if they seemed depressed or had suffered recent losses. My doctor called me one day and said, "OK, Paul, I asked this older patient of mine who was recently diagnosed with prostate cancer and lost a brother one month ago if he, by chance, had any thoughts about suicide. He did. Now what do I do?"

He was able to keep the patient, whom he had known for years, with him until I arrived. I set up a mental health evaluation right in his office. The man was clinically depressed but hiding it well, and had already made a suicide plan. After a brief stay in the hospital for a thorough evaluation, providers addressed his chronic sleep disorder and depressed mood, after which he continued outpatient care with a behavioral healthcare team and his physician. Almost 70, the man made a full recovery and became an active volunteer driver for a charitable organization.

—Paul Quinnett, Ph.D., QPR Institute, Spokane

GOAL 2: Emergency departments and inpatient units provide for the safety, well-being and continuity of care of people treated for suicide risk.

Suicide attempts and self-injury make up an increasing portion of emergency department visits,[76] and facilities must be able to identify, treat and follow up with those at risk. Suicide risk is especially elevated during the days and weeks following hospitalization for a suicide attempt, especially for people diagnosed with major depression, bipolar disorder and schizophrenia.[77] Emergency and inpatient units that provide follow-up care do not have shared protocols, and many also lack the resources to make appropriate outpatient referrals and support patient follow-through.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Convene a Continuity of Care Workgroup including mental health acute and outpatient care providers, diversion and crisis teams to: • Recommend evidence-based and best practices for continuity of care after a suicide attempt, including the use of patient safety plans and ongoing assessment; • Help local health agencies, healthcare systems, community service organizations and educational institutions build these protocols into their services; • Evaluate patient-centered medical homes and managed care plan case management to improve continuity of care for patients frequently at risk of suicide; • Recommend best practices for educating patients and their supports about lethal means restriction as part of discharge and continuity of care; • Evaluate mobile crisis team services and make recommendations for funding and increasing their role as a post-discharge support.	• Continuity of Care workgroup • Community crisis providers • Correctional systems • Local health agencies • Tribal health agencies • Behavioral health organizations • State agencies • Legislature • Private and government funders
Fund and staff peer support specialists to assist in follow-up care after a hospital or acute care discharge or crisis service encounter.[78]	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Evaluate brief screening models for suicide risk in acute care settings (similar to SBIRT) and continuity of care services.	• Suicide researchers • Department of Health • Aftercare workgroup

GOAL 3: Families and concerned others are involved, when appropriate, throughout a person at risk's entire episode of care.

A person's support network can be a source of strength in times of crisis and during recovery. Strong social ties "decrease the threat-level appraisal of the experienced stress and increase a person's ability to cope with the stressful event or situation."[79]

The National Action Alliance for Suicide Prevention recommends that a suicidal person's "personal needs, wishes, values and resources should be the foundation for a continuing care and safety plan" and that one who is in crisis or has lost a loved one to suicide be allowed to choose for themselves who will be included in their aftercare and recovery.[80] Exceptions are noted for minors and dependent adults, who may have legal or clinical requirements governing their care. Providers must also carefully screen for domestic and sexual violence when considering who is safe to involve in a support network.

The care network may offer general support (positive contact, transportation and childcare during appointments, messages of love and concern), crisis support (getting a person to a hospital or crisis center and visiting them while there, arranging for care of the home, children, or pets during crisis care or recovery) and ongoing attentiveness to signs of a new crisis.[59] Supports such as these are a key part of care for people at risk of suicide.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Develop and evaluate model protocols for safely involving a self-defined care network in treatment, planning for discharge and self-management.	• State agencies • Private funders • Suicide researchers • Health professionals • Advocates against sexual and domestic violence • Mental health consumer groups • Suicide prevention organizations
Educate health and social service providers on involving a self-defined care network in suicide-related treatment.	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Add to Washington's evidence base and tribal best practices for suicide interventions involving a patient's self-defined care network.	• Those using model protocols • Suicide researchers • Tribal governments and programs • State agencies

GOAL 4: Effective suicide postvention-aftercare programs are in place to provide support after a suicide loss.

Care for those grieving after a suicide can include families and friends, classmates, coworkers, employers and organizations. Postvention-aftercare programs connect people to mental healthcare and bring organizations and communities together to handle the immediate aftermath of a suicide. These programs can encourage a healthy and preventive approach to funerals, memorial services and long-term community suicide prevention activities, and serve as a protective measure against suicide contagion.

Postvention may also involve outreach by teams of professionals and survivors of suicide loss, face-to-face and online support groups, cultural activities, healing circles, workplace interventions by human resources or employee assistance plan staff members, therapy or counseling and other ways for those grieving after a suicide to come together to deal with their grief in positive, culturally appropriate ways.

Best practices in postvention have been identified,[81] but more research is particularly needed on effective suicide bereavement groups and facilitator training.

| Short-term Recommendations (1–3 years)	Who Plays a Role?
Convene a postvention/aftercare workgroup to: • Survey and evaluate Washington's existing aftercare services, and assess resource gaps; • Assess the need for appropriately trained[82] suicide loss support group facilitators; • Pull together a statewide network of suicide loss support groups; • Increase the state's capacity to provide technical assistance in applying best practices to postvention/aftercare programs; • Create a bereavement toolkit with community-specific content, to be distributed by law enforcement, medical examiners, coroners, emergency departments, funeral directors, funeral services counselors or medical investigators and available to the general public online; • Develop a strategic plan to evaluate, design and deploy postvention programs in schools, workplaces, faith communities, reservations, social service agencies and correctional facilities.	• State agencies • Postvention workgroup
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Use the Washington-Violent Death Reporting System (WA–VDRS), as appropriate, to identify suicide clusters and needed resources.	• Department of Health • Tribal governments • Suicide researchers
Evaluate evidence-based programs and tribal best practices for postvention/aftercare.	

Resources

- The Zero Suicide framework proposes that all suicides of medical and behavioral healthcare clients are preventable. Modeling the Henry Ford Health System's highly successful suicide prevention program, Zero Suicide presents an aspirational challenge and the tools to get your health system there:
http://zerosuicide.sprc.org/about

- *Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines* is available on the National Action Alliance for Suicide Prevention's website:
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/NationalGuidelines.pdf

- *After a suicide: A Toolkit for Schools* gives practical, user-friendly guidelines for postvention in a school setting:
http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf

- The National Suicide Prevention Lifeline's online manual provides guidance on postvention activities online:
http://www.sprc.org/sites/sprc.org/files/library/LifelineOnlinePostventionManual.pdf

- *A Manager's Guide to Suicide Postvention in the Workplace* provides guidance for managers and human resource staff on postvention in the workplace:
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Managers-Guidebook-To-Suicide-Postvention-Web.pdf

- *Lifeline Australia* offers guidelines and standards for suicide bereavement groups, including information on training content and core competencies for facilitators:
https://www.lifeline.org.au/Get-Help/Facts---Information/Suicide-Bereavement

- SAMHSA's *Treatment Improvement Protocol: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* gives background information and guidance to substance abuse treatment providers who encounter clients or patients at risk of suicide. Available free of charge:
https://store.samhsa.gov/shin/content/SMA09-4381/TIP50.pdf

Care for those grieving after a suicide can include families and friends, classmates, coworkers, employers and organizations.

STRATEGIC DIRECTION 4
Suicide Surveillance, Research and Evaluation
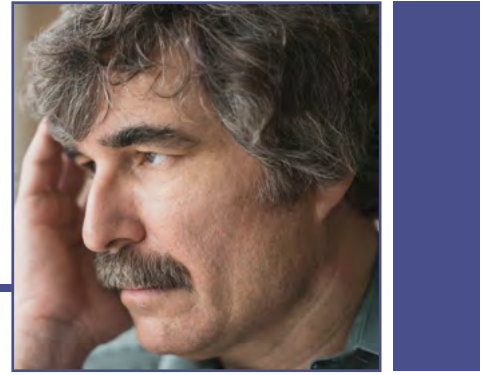
Washington's state agencies, health systems, suicide prevention programs and researchers work hard to learn about suicide and how to prevent it. They generate and examine information about the number of lives lost to suicide, and the causes and effects of suicide loss and suicidal behavior, to help improve suicide prevention programs.

In 2014, the Washington Office of Financial Management compiled youth suicide data from 2009 to 2011 into a map showing suicide clusters by census tract as part of a research brief on deaths by firearm. The map clearly indicated that parts of Northeast Washington and the Olympic Peninsula—generally rural areas with few suicide prevention services— were in need of extra support.[83]

Later that year, the Office of the Superintendent of Public Instruction offered funding for youth suicide prevention in underserved areas. Using the map, the selected contractor, the Youth Suicide Prevention Program, focused its program on Northeast Washington. Over 2014–2015, it created three new suicide prevention coalitions in the region, engaging healthcare providers, educators, law enforcement, child welfare, local health departments and community-based organizations. The new staff began building comprehensive suicide prevention programs in local school districts and held community-wide public suicide awareness events. While working with one coalition, Okanogan County's behavioral health provider explored placing mental health providers in each school district to give students access to timely care. The Department of Health is partnering with local health agencies to build services in the high-need peninsula communities as well.

This work shows the power of surveillance data to direct prevention services to high-need communities. Data are a key tool for suicide prevention.

Helpful Terms

Suicide surveillance
The continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, use and evaluation of public health practice around suicide.

Suicidology
The academic field of research on suicide.

GOAL 1: Effective suicide and behavioral health data surveillance systems are in place to guide prevention.

Data surveillance systems can be used to monitor health issues, identify individuals at high risk and track the progress of interventions.

The table below describes Washington's data systems that give insight into suicide and suicidal behaviors, and notes their limitations.

| Data Source	Purpose (related to suicide)	Key Data	Limitations
Death certificates	Provides information about how many people die of suicide and characteristics of those people	Age, race, sex, ethnicity, residence, occupation, education	Missing circumstances surrounding the death, including substance use; gender identity not identified
Violent Death Reporting System (WA–VDRS)	Provides a clearer understanding of circumstances around suicide details	Demographics, mental health problems, recent life stressors	Data collection began in 2015 in 9 counties; analysis report will be available in 2017
Hospitalization data (CHARS and the Trauma Registry)	Provides data on how many people are hospitalized for a suicide attempt or self-injury	Age, sex, place of residence	Race and ethnicity data incomplete; no data on gender identity; does not reflect non-hospitalized suicide attempts; does not clearly distinguish non-suicidal self-injury from suicide attempt
Healthy Youth Survey	Provides prevalence of depressive feelings, suicidal thoughts and behaviors for students in grades 6, 8, 10 and 12	Age, race, ethnicity; health risk behaviors, such as alcohol and drug use and suicidal behavior	Occurs every other year; reaches only youth in school
Behavioral Risk Factor Surveillance System	Collects information from adults on mental health status, and firearm ownership and storage	Age, sex, race, ethnicity, gender identity	No data on suicide thoughts, plans, attempts; mental health data collected are not broadly distributed
Emergency department visits	Provides data on how many people are seen in an emergency department for a suicide attempt	Age, sex, date of visit	Data not yet collected statewide; does not include patient names, limiting ability to link with other data

Data Source	Purpose (related to suicide)	Key Data	Limitations
National Survey on Drug Use and Health	Provides data on mental health status, suicidal thoughts and plans among adults	Age, state, access to mental health services	Not all data analyzed at a state level, such as suicide attempts
Department of Defense Suicide Event Report	Provides information about how many in the armed forces die of suicide or attempt suicide	Based on postmortem information gathered retrospectively	Not available outside DoD
Suicide Prevention Application Network – Department of Veterans Affairs	Compiles all suicide events and deaths from VHA providers	Demographics, suicide safety plan in place, circumstances	Does not include veterans who get care outside the VHA system
Electronic health record data from healthcare companies	Patient tracking, quality control, identification of trends	Depending on provider, partial or full list of health services the patient has received	Not required to share publicly; confidentiality concerns; does not include care at another facility
Insurance company claims data	Tracking patient use of covered services, quality control	Full list of care paid for by the insurer	Does not include clinical detail
Child Death Review reports	Informing suicide prevention efforts for those under 18 years old	Circumstances, modifiable risk factors and recommendations for prevention	Limited number of counties; timing varies by county and could be far after the event
Washington Emergency Medical Services Information System (WEMSIS)	The latest version allows coding of EMS calls involving suicide attempts and people at risk of suicide	Details of EMS contact, including impressions, injuries, symptoms and treatment provided	

Short-term Recommendations (1–3 years)	Who Plays a Role?
Improve the state agencies' capacity to analyze, advise on collection of and make publicly available mental health and suicide-related data.	• Stage agencies • Healthy Youth Survey Planning Committee • Legislature • Hospital staff • Emergency departments • Department of Veterans Affairs • Department of Defense • Suicide researchers • Local governments and health agencies • Tribal governments and programs • Private funders • County Health Officers
Make WA-VDRS data publicly available, where appropriate.[84]	
Monitor the completeness of race and ethnicity data for people hospitalized for self-inflicted injuries, and analyze when data are available.	
Propose adding or expanding more detailed demographic questions for groups at high risk of suicide to the Healthy Youth Survey. Analyze suicidal behavior questions for these groups and make data publicly available.	
Ensure the terms *sex* and *gender* are reported correctly in state data reports to increase reporting accuracy and inclusion of trans and gender-nonconforming people.	
Mandate reporting by emergency departments to the syndromic surveillance system, including completing external cause International Classification of Disease codes for suicidal behaviors. Analyze and make appropriate aggregate data publicly available.	
Promote broader distribution of existing state-level military suicide data.	
Encourage linkage of DoD/VA and American Indian/Alaska Native data sets to state-based data sets to enhance knowledge base and improve prevention efforts.	
Dedicate funding for local health agencies to conduct Child Death Reviews and disseminate data and recommendations.	

Long-term Recommendations (4–5 years)	Who Plays a Role?
Develop recommendations for the system built to query comprehensive medical record data to identify suicidal behaviors.	• State agencies • County crisis clinics • Suicide prevention organizations • Correctional systems • Child welfare systems • Students • Academics • Policymakers • Trainers • Senior service systems • Other appropriate service systems
Investigate the usefulness and cost of a centralized crisis clinic surveillance system.[85]	
Improve data collection by training service system staff members to conduct psychological autopsies or fatality reviews in cases of suicide and make aggregated data available to researchers and the public.	
Build and maintain a centralized, easily accessible online clearinghouse of Washington suicide data. Field questions and data requests through the clearinghouse.	

Data surveillance systems can be used to monitor health issues, identify individuals at high risk and track the progress of interventions.
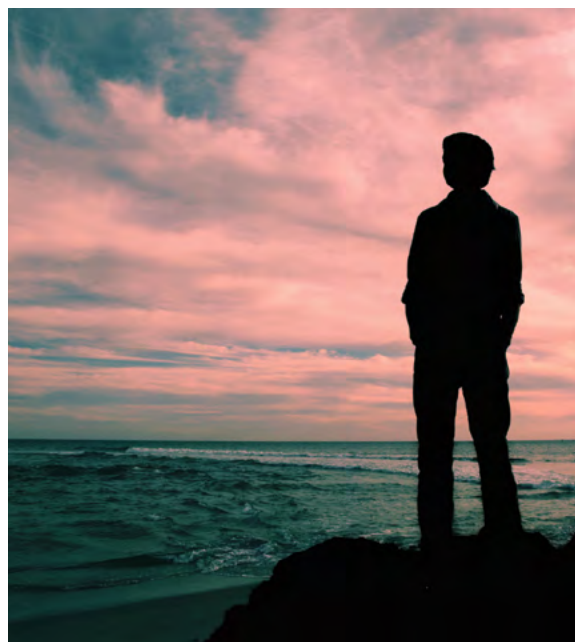
GOAL 2: Researchers and state agencies collaborate on suicide prevention research and evaluation.

Suicide research is a growing field, but has long been limited by stigma. Discomfort with funding, conducting and publishing suicide research has narrowed the field of researchers, leaving many important questions unanswered.

Because completed suicides and suicide attempts are relatively rare, research quality is sometimes a concern. Studies on suicide interventions are often unable to prove that they prevented suicidal behavior. Instead they rely on self-reported information such as suicidal thoughts and depression severity. Patients who want to "perform well" may not answer these questions honestly. Also, a study participant who may have left treatment, never made it to treatment or died by suicide could be excluded from the final numbers, leading to incorrect conclusions about program effectiveness.

Academic researchers, curriculum developers, and clinical intervention designers who live in Washington are heavily involved in research in academic and healthcare settings. Recent state legislation requires suicide prevention training for several health professions. Researchers will be able to study training outcomes, increasing the variety of evidence-based trainings. By linking their research expertise to prevention programs and available state data, Washington will continue to contribute to suicide research.

Short-term Recommendations (1–3 years)	Who Plays a Role?
Create collaborations among state agencies, training providers and academic researchers to and analyze the effect of suicide prevention training. Improve the range of evidence-based trainings and tribal best practices available in Washington as needed.	• State agencies • Suicide prevention training providers and publishers • Suicide researchers • Professional Educator Standards Board • Academic institutions
Create a research guidance document to move the Washington State suicide prevention plan forward, including focus on populations most affected by suicide.[86]	
Long-term Recommendations (4–5 years)	**Who Plays a Role?**
Create a competitive research fellowship for innovative projects using state suicide data, aligned with the guidance document.	• State agencies • Suicide researchers • Private funders
Create a virtual suicide research institute for researchers to share ideas and use state suicide data.	

GOAL 3: Suicide prevention activities are evaluated and improved.

To build the knowledge base of suicide prevention work in Washington, we need to evaluate and update our trainings and programs. We have directly included recommendations for program evaluation in the recommendations and resources listed throughout the plan.

Putting the Plan in Place: Next Steps

PHASE 1: Doing the work

The plan's recommendations range from projects already under way to aspirational goals. Everyone has a role in putting the plan into action. Many people reading this plan already do suicide prevention work, but some of us are getting involved for the first time. Here is what you can do to get started.

1. **Decide what you'll do.**
   First, find the recommendations that apply to you by searching the *Who Plays a Role?* column. Then choose the recommendations that make the most sense for you.

2. **Make an action plan.**
   Think about putting that recommendation into action. Will you need money? Volunteers? Access to researchers? A change in policy? You can use the form in Appendix E to organize your plans. Every strategic direction has a list of resources and evaluation tools at the end.

3. **Do your project.**

4. **Evaluate your project.**
   If you have the resources to work with a professional evaluator, use their services here. If not, a free and easy-to-use evaluation tool for suicide prevention programs is available here: http://www.rand.org/pubs/tools/TL111.html

5, **Tell us about it!**
   The Department of Health is interested in learning about any programs or initiatives you've developed and implemented to prevent suicides in your community or organization. Send a note to SuicidePreventionPlan@doh.wa.gov about what you did and how it went.

PHASE 2: Impact evaluation and updates

We will look at how the plan affects suicide in Washington and will provide updates on implementation.

Everyone has a role in putting the plan into action.

Appendices

Appendix A: Programs and Resources

National crisis resources

- **National Suicide Prevention Lifeline:** 800-273-8255
  http://www.suicidepreventionlifeline.org/gethelp.aspx
  24-hour hotline, chat and text services available. Press 1 for the Veterans Helpline.

- **The Institute on Aging's Friendship Line:** 800-971-0016 or friendshipline@ioaging.org
  Crisis and support line for adults who are 60 or older or have disabilities.
  8:30 a.m. to 5:00 p.m. (Pacific time)

- **Trevor Project Lifeline:** 866-488-7386
  http://www.thetrevorproject.org/section/get-help
  24-hour hotline focusing on LGBTQ young people in crisis, chat and text services available

- **Trans Lifeline:** 877-565-8860
  http://www.translifeline.org/
  This line is primarily for transgender people experiencing a crisis.
  Hours are limited, check the website for details.

- **SAMHSA Behavioral Health Treatment Services Locator:**
  https://findtreatment.samhsa.gov/

Statewide crisis resources

- **Teen Link:** 866-833-6546
  Hotline for youth staffed by trained peer volunteers, open from 6:00 to 10:00 p.m. (Pacific time)

- **211 Information and Referral Hotline:** 2-1-1 is an easy-to-remember phone number for information, referrals and other assistance. See 211's searchable database.
  http://win211.org/

- **Washington Recovery Helpline:** 866-789-1511
  24-hour help for substance abuse, problem gambling and mental health

County resource guides

- **Resource list for each county in Washington:** http://4people.org/index.html
- **Other county resource guides** may be available through your local health department, chamber of commerce, school district or other organizations.

Community suicide prevention trainers in Washington

- **Livingworks Education** keeps a searchable list of trainers:
  https://www.livingworks.net/training-and-trainers/find-a-trainer/

- **QPR Institute:** http://www.qprinstitute.com/
  You can request a list of local trainers.

- **The Youth Suicide Prevention Program:** www.yspp.org
  Offers a variety of trainings on suicide prevention with youth and young adults, including system-level interventions for schools and postvention after a suicide loss.

- **Forefront: Innovations in Suicide Prevention:** http://www.intheforefront.org/training
  Innovations in Suicide Prevention offers a variety of trainings on suicide prevention.

- **Check with your local suicide prevention coalition.** Many of them offer training.
  http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/YouthSuicidePrevention/
  SuicidePreventionCoalitions

- **If you are affiliated with the military**, contact your installation's suicide prevention coordinator or chaplain (many of them are suicide prevention trainers).

Information on vicarious trauma and self-care

This resource provides information, questionnaires and document templates, and research on burnout, compassion fatigue and the need for self-care in the helping professions:
http://socialwork.buffalo.edu/resources/self-care-starter-kit.html

Evidence-based and best practice programs

The Suicide Prevention Resource Center's Best Practice Registry lists programs and materials that have been evaluated for compliance with known best practices in suicide prevention. Contact people and scope of availability are listed with each entry. There are programs designed for:

- Diverse settings in need of general and specific guidelines on cultural competence
- Schools and youth programs
- Law enforcement
- Senior programs
- Means restriction initiatives
- Workplaces
- Behavioral health consumers
- LGBTQ populations and those who work with them, including significant content on transgender suicide prevention
- American Indian and Alaska Native communities
- Substance abuse treatment settings
- Higher education and college campuses
- Foster care settings
- Correctional facilities
- Healthcare settings
- Crisis hotlines
- Behavioral healthcare settings
- Families
- Military settings
- Suicide bereavement groups
- Systems in need of postvention support
- Suicide attempt survivors

The registry and information about how to apply for listing is available at: http://www.sprc.org/bpr

- **The state of Oregon** maintains a list of tribal best practices, which are evaluated on several measures of cultural appropriateness and longevity, elders' buy-in, outcomes and benefits. The list and supporting information are available here: http://www.oregon.gov/oha/amh/Pages/ebp.aspx

- Evidence-based programs are listed on **SAMHSA's National Registry of Evidence-Based Programs and Practices**: http://www.nrepp.samhsa.gov/
  Search for "suicid" (to pull up results that include the words suicide, suicidal, suicidality).

Appendix B: House Bill 2315

ENGROSSED SUBSTITUTE HOUSE BILL 2315 AS AMENDED BY THE SENATE
Passed Legislature - 2014 Regular Session
State of Washington 63rd Legislature 2014 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Orwall, Harris, Cody, Roberts, Short, Morrell, Manweller, Green, Jinkins, Fitzgibbon, Tharinger, Ryu, Goodman, Ormsby, Pollet, and Walkinshaw) READ FIRST TIME 02/05/14.

AN ACT Relating to suicide prevention; amending 2012 c 181 s 1 2 (uncodified); reenacting and amending RCW 43.70.442; adding new 3 sections to chapter 43.70 RCW; creating a new section; and providing an expiration date.

———

NEW SECTION. Sec. 4. A new section is added to chapter 43.70 RCW 22 to read as follows:

(1) The secretary, in consultation with the steering committee convened in subsection (3) of this section, shall develop a Washington plan for suicide prevention. The plan must, at a minimum:

    a. Examine data relating to suicide in order to identify patterns and key demographic factors;

    b. Identify key risk and protective factors relating to suicide; and

    c. Identify goals, action areas, and implementation strategies relating to suicide prevention.

(2) When developing the plan, the secretary shall consider national research and practices employed by the federal government, tribal governments, and other states, including the national strategy for suicide prevention. The plan must be written in a manner that is accessible, and useful to, a broad audience. The secretary shall periodically update the plan as needed.

(3) The secretary shall convene a steering committee to advise him or her in the development of the Washington plan for suicide prevention. The committee must consist of representatives from the following:

    a. Experts on suicide assessment, treatment, and management;

    b. Institutions of higher education;

    c. Tribal governments;

    d. The department of social and health services;

    e. The state department of veterans affairs; 10 (f) Suicide prevention advocates, at least one of whom must be a suicide survivor and at least one of whom must be a survivor of a suicide attempt;

    f. Primary care providers;

    g. Local health departments or districts; and

    h. Any other organizations or groups the secretary deems appropriate.

(4) The secretary shall complete the plan no later than November 15, 2015, publish the report on the department's web site, and submit copies to the governor and the relevant standing committees of the legislature.

Appendix C: Relevant State Legislation

Bill and Year	Affected Law	Impact
SSHB 1163 (2011)	RCW 28A.230.095	• Adds mental health and suicide prevention education to student health and fitness requirements.
	RCW 28A.300.285 RCW 28A.300.288	• Convenes a workgroup on bullying and harassment prevention. • Requires OSPI to work with state and community partners on school pilot programs on youth suicide prevention. • Requires compilation of higher education institutions' policies on harassment, intimidation and bullying prevention and recommendations for improvement.
ESHB 2366 (2012)	RCW 43.70.442	• Requires training on suicide assessment, treatment and management every six years for several behavioral health professions. • Requires development of a model list of training programs. • Requires a study on how suicide assessment, treatment and management training affects healthcare for suicidal patients.
ESHB 1336 (2013)	RCW 28A.410.226	• Requires school nurses, counselors, social workers and psychologists to get training on youth suicide screening and referral for certification.
	RCW 28A.410.035	• Requires the course on issues of abuse new teachers must take for certification includes content on recognition, initial screening and response to emotional or behavioral distress in students.
	RCW 28A.320.127	• Requires each school district to have a plan in place for recognition, initial screening and response to emotional and behavioral distress in students during the 2014–15 school year and sets core content. • Requires OSPI and School Safety Advisory Committee to develop a model plan.
	RCW 28A.310.500	• Requires that each Educational Service District develop and maintain the capacity to train on youth suicide screening and referral, and student emotional and behavioral distress. • Convenes a task force to make recommendations on school-provider partnerships to support students in need.

Appendix C continued

Bill and Year	Affected Law	Impact
ESHB 1336 (2013) *continued*	RCW 71.24	• Funds Mental Health First Aid training for teachers and educational staff.
ESHB 2315 (2014)	RCW43.70.442, amended	• Requires a one-time suicide assessment, treatment and management training for primary care physicians and other health professionals. • Requires updates to model list of approved trainings every two years.
SSB 6431 (2014)	RCW 28A.300.288	• Requires OSPI to work with state and community partners to implement youth suicide prevention activities in schools, giving funding priority to those with students at the highest risk.
SHB 1138 (2015)	Chapter 67, Laws of 2015	• Creates a task force on mental health and suicide prevention in higher education.
ESHB 1424 (2015)	RCW 43.70.442, amended	• Requires Department of Health to adopt rules establishing minimum standards for training programs on the model list by June 30, 2016. • Beginning January 1, 2017 the list must include only trainings that meet the minimum standards. • Beginning July 1, 2017 all trainings taken by health professionals for certification must be on the model list.

Appendix D: Contributors

Department of Health Staff

Karyn Brownson	State Suicide Prevention Plan Project Manager
Dolly Fernandes	EMS and Trauma and Injury Violence Prevention Section Manager
Therese Hansen	Research Analysis and Data Section Manager
Katherine Harris-Wollburg	Washington State Department of Health
Kirstin McFarland	Intentional Injury Prevention Specialist
Sigrid Reinert	Suicide Prevention Specialist
Jennifer Sabel	Injury and Violence Prevention Epidemiologist
Steve Saxe	Office of Community Health Systems Director
Kathy Schmitt	Office of Health Professions and Facilities Deputy Director
Taylor Schraudner	Washington Violent Death Reporting System, Program Manager
Sam Watson-Alvan	Rural Health Primary Care Office Director

Steering Committee Members

Kristina Armenakis	NW Network of Bisexual, Trans, Lesbian & Gay Survivors Of Abuse
Nadja Baker	American Foundation for Suicide Prevention, loss survivor
Linda Batch	National Alliance of Mental Illness & Nursing Care Quality Assurance Commission
Michelle Borsz	VA Puget Sound
Brian Buckingham	Sophie Trettevick Indian Health Center
Ace Bulger	NAMI Eastside
Sevan Bussell	Odyssey Youth Center
Erin B. Carroll	Washington State University–Health and Wellness Services
Daniel W. Clark	Washington State Psychological Association & WA State Patrol
Lauren Davis	Forefront: Innovations in Suicide Prevention
Sue Eastgard	Forefront: Innovations in Suicide Prevention
Jake Fawcett	Washington State Coalition Against Domestic Violence
Charissa Fotinos	Health Care Authority
LaRessa Fourre	Washington State Department of Social and Health Services
Dorothy Hanson	Washington State Department of Veterans Affairs
Courtenay Hendricks	Public member and loss survivor
Ron Hertel	Washington Office of Superintendent of Public Instruction
Susanne Hughes	League of Women Voters of Washington
Fredda Jaffe	American Association of Marriage and Family Therapists
Dean Johnny	J&J Solutions Foundation
Shana Johnny	Washington State Department of Health
Tim Livingston	Washington Professional Counselors Association
Julie Madsen	National Guard JSS
Kevin Martin	Washington Academy of Family Physicians
Benjamin Miller	Seattle University
Mark Nelson	Washington State Department of Social and Health Services
Daneil Newcomb	Northwest Network/Outspoken
Najla Neumann	National Alliance to End Veteran Suicide, MCD, WVAC
Tina L. Orwall	Representative Washington State Legislature
Emily Parzybok	Center for Gun Responsibility
Lori Pender	Washington Alliance for Gun Responsibility/Center for Gun Responsibility

Paul Quinnett	The QPR Institute
Shannon Rauh	Youth Suicide Prevention Program
Michael Reading	Crisis Clinic Seattle & King County Suicide Prevention Coalition
Greg Reger	VA Puget Sound Healthcare System
Debbie Reisert	Forefront volunteer and suicide loss survivor
Eva Rooks	Washington State Department of Health
Cheryl Sanders	Vice Chairwoman, Lummi Nation; American Indian Health Commission Vice Chair
Peter Schmidt	Veteran Training Support Center
Tommy Simpson	Washington State Department of Health and Washington State Department of Veterans Affairs
Dennis Smith	Granite Falls Community Coalition, Granite Falls Family Support Center
Jennifer Stuber	Forefront: Innovations in Suicide Prevention and University of Washington
Vicki Wagner	Youth Suicide Prevention Program
Scott Waller	Washington State Department of Social and Health Services
Peggy West	National Suicide Prevention Resource Center (retired)
Ursula Whiteside	Forefront: Innovations in Suicide Prevention
Rebecca Wolf	Washington Army National Guard Suicide Prevention Program
Adam Zangenberg	Washington Army National Guard

Listening Session Locations and Hosts

Gonzaga University, Spokane, WA
Benton/Franklin County Youth Suicide Prevention Coalition, Kennewick, WA
Cowlitz Tribe of Indians, Longview, WA
Mukilteo Youth Coalition, Mukilteo, WA
Tulalip Tribes, Tulalip, WA
Camp Murray JSS, Tacoma, WA
North Sound Mental Health Administration Tribal Mental Health Conference, Bow, WA
OSPI Student Support Conference, Wenatchee, WA

Outside Reviewers

Shasta Cano-Martin, Lummi CEDAR Project
Tenzin Dennison, Okanogan Behavioral Health Care
Grace Hong, Department of Social and Health Services
King County Youth Advisory Board
Marsha Linehan, The Linehan Institute
Barb Lucenko, Department of Social and Health Services
Logan Micheel, Washington Coalition of Sexual Assault Programs
Mandy Paradise, Office of Superintendent of Public Instruction
Julie Rickard, Confluence Health System
Karie Rainer, Washington State Department of Corrections
Greg Simon, Group Health and Mental Health Research Network
Roy Walker, Washington Association of Area Agencies on Aging

Appendix E: Action Planning Tool

What is the problem you want to address?

Explain in one or two sentences what problem your community, institution or system needs to solve.
For example: There is not a school counselor at my school; There is not a culturally relevant recognition and referral training available for my community; The suicide rate in my county is higher than the state rate; My healthcare practice does not ask the right questions about patients' suicide risk.

_____

_____

_____

Which recommendation(s) from the plan do you want to follow to solve this problem?

_____

_____

_____

What do you want to be the final outcome?

Briefly explain what will change when your project works.
For example: My school will have a counselor available at least half time; A recognition and referral training appropriate for my community's language and culture will exist; My county's suicide rate will go down in the next two years; My practice will have appropriate questions about suicide risk in all forms, protocols and records.

_____

_____

_____

What resources do you already have for this project?

These could be people who support your project or have the knowledge you need, materials and supplies, funding, space, technology, etc.

_____

_____

_____

Appendix E continued

What resources do you need? Is there anything else that might make it hard to succeed?

_____

_____

_____

What are the steps to completing your project?

These are the things that need to get done in between starting and completing your project.
For example, hiring a staff person, applying for funding or getting donations, finding meeting space, reaching out to elected officials and learning more about how others have solved the problem.

Task	Who's in charge	Deadline	How we'll know it worked

How will you evaluate your success?

Will you use an evaluation tool you have, hire an evaluator or rely on project outcomes?

_____

_____

_____

How will you celebrate your success and thank those who helped?

_____

_____

_____

Appendix F: Endnotes

1. 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.* http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

2. Harris, W. (Chelan County Coroner) and Clem, S. (Douglas County Coroner), personal communication, 6/15/2015

3. Washington State Department of Health: Death Certificate Data; Hospital Discharge Data; Comprehensive Hospitalization Abstract Reporting System (CHARS) data. Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Washington, 2014. HHS Publication No. SMA–15–4895WA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Looking Glass Analytics (2015). *Healthy Youth Survey 2014 Report of Results: Statewide Results, Grade 10.* http://www.askhys.net/library/2014/StateGr10.pdf

4. American Foundation for Suicide Prevention. (2015). *Key Research Findings.* https://www.afsp.org/understanding-suicide/key-research-findings

5. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. (2015.) *Suicide: Risk and Protective Factors.* http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

6. Centers for Disease Control and Prevention, Division of Violence Prevention. (2014). *Family Health History and Health Appraisal Questionnaires.* http://www.cdc.gov/violenceprevention/acestudy/questionnaires.html

7. Dube. SR, Anda. RF, Felitti, VJ, Chapman, DP, et al. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association. 2001;* 286: 3089-3096.

8. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, Policy Research Associates, Inc. *Fact Sheet: Historical Trauma.* http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/General/Historical%20Trauma%20SAMHSAs%20Gains%20Center.pdf

9. Wilcox HC, Conner KR, & Caine ED. Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies. *Drug and Alcohol Dependence, 2004:76,* S11–S19; Kessler RC, Borges G & Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry,* 1999:56, 617–626.

   Conway K, Compton W, Stinson F, Grant B. Lifetime Comorbidity of DSM-IV Mood and Anxiety Disorders and Specific Drug Use Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry,* 2006: 67(2), 247-257. http://dx.doi.org/10.4088/JCP.v67n0211

10. Wilcox HC, Conner KR, & Caine ED. Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies. *Drug and Alcohol Dependence,* 2004:76, S11–S19.

11. Cherpitel CJ, Borges GL, Wilcox HC. Acute alcohol use and suicidal behavior: a review of the literature. *Alcoholism: Clinical and Experimental Research. 2004;* 28(5 Suppl): 18S-28S.

12. For example, Kaplan MS, McFarland BH, Huguet N, Conner K, Caetano R, Giesbrecht N, Nolte KB. Acute alcohol intoxication and suicide: a gender-stratified analysis of the National Violent Death Reporting System. *Injury Prevention. 2013;* Feb, 19(1), 38-43; Sher L, Oquendo M, Richardson-Vejlgaard R, Makhija N, Posner K, Mann J, Stanley B. Effect of acute alcohol use on the lethality of suicide attempts in patients with mood disorders. *Journal of Psychiatric Research.* 2009; 43(10): 901–905.

13. Borges G and Rosovsky H. Suicide attempts and alcohol consumption in an emergency room sample. *Journal of Studies on Alcohol and Drugs.* 1996; 57(5):543-8.

Appendix F continued

14. Windle M, Miller-Tutzauer C, Domenico D. Alcohol use, suicidal behavior, and risky activities among adolescents. *Journal of Research on Adolescence. 1992;2(4):* 317-330.

15. Centers for Disease Control and Prevention. (2013). *Morbidity and Mortality Weekly Report: Suicide Among Adults Aged 35–64 years – United States 1999–2012. 2013;* 62(17): 321–325.

16. Zayas L, Lester R, Cabassa L, and Fortuna L. Why Do So Many Latina Teens Attempt Suicide? A Conceptual Model for Research. *American Journal of Orthopsychiatry. 2005;* 75(2): 275-287.

17. Ryan C, Huebner D, Diaz RM and Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics. 2009;* 123(1): 346-52; Coleman et. al. Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism. 2011;* 13:165–232.

18. See Pace University's comprehensive toolkit on multicultural competency, available for free by contacting Dr. Brian Petersen (bpetersen@pace.edu) or Dr. Richard Shadick (shadick@pace.edu). More information on this publication is available on the Suicide Prevention Resource Center's Best Practices Registry: http://www.sprc.org/bpr/section-III/suicide-prevention-multicultural-competence-kit

19. Suicide Prevention Resource Center. (2012). *Upstream Youth Suicide Prevention Expert Panel Meeting Summary.* http://www.sprc.org/sites/sprc.org/files/library/Upstream_Youth_Suicide_Prevention_Expert_Panel_Meeting%20Summary.pdf

20. Project AWARE is a collaboration between the Office of Superintendent of Public Instruction (OSPI) and three implementing districts: Battle Ground, Shelton, and Marysville. For more information and staff contacts, see http://www.k12.wa.us/SecondaryEducation/AWARE.aspx

21. Fisher D. Literacy educator's role in suicide prevention. *Journal of Adolescent & Adult Literacy. 2005;* 48(5): 364-374.

22. American Association of Suicidology. *Know the Warning Signs of Suicide.* http://www.suicidology.org/resources/warning-signs

23. Unless otherwise indicated, data on suicide deaths in this section comes from Washington State's Death Certificate data.

24. Unless otherwise indicated, data on nonfatal self-inflicted injuries in this section comes from the Washington State Department of Health's Center for Health Statistics, WA Hospital Discharge Data from Comprehensive Hospitalization Abstract Reporting System (CHARS).

25. Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Washington, 2014.* HHS Publication No. SMA–15–4895WA. Rockville, MD.

26. For more information, see http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct

27. To calculate a suicide rate, the number of suicide deaths in a group or area is divided by the group or area's population. This figure is then multiplied by 100,000 to get a number that is easy to read. The number is expressed as a rate per 100,000 people.

28. Washington State Death Certificate data; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). http://www.cdc.gov/ncipc/wisqars

29. Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report: Regional Variations in Suicide Rates – United States, 1990–1994. 1997;* 46(34): 789-793. http://www.cdc.gov/mmwr/preview/mmwrhtml/00049117.htm; Searles VB, Valley MA, Hedegaard H and Betz ME. Suicides in Rural and Urban Counties in the United States, 2006–2008. *Journal of Crisis Intervention and Suicide Prevention. 2014;* 35(1):18-26. http://www.ncbi.nlm.nih.gov/pubmed/24067250

Appendix F continued

30. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). http://www.cdc.gov/ncipc/wisqars

31. Denning DG, Conwell Y, King D and Cox C. Method choice, intent, and gender in completed suicide. *Journal of Suicide and Life-Threatening Behavior. 2000; 30(3): 282-8.*

32. Hempstead K and Phillips J. Rising Suicide Among Adults 40–64 years: The Role of Job and Financial Circumstances. *American Journal of Preventive Medicine. 2015; 48(5): 491–500.*

33. Worthington, B. Elder Suicide: A Needless Tragedy. *Today's Geriatric Medicine: News and Insight for Professionals in Elder Care.* http://www.todaysgeriatricmedicine.com/news/exclusive_03.shtml

34. Washington State Department of Health and US Department of Veterans Affairs. Washington Veteran Suicide Fact Sheet.

35. Looking Glass Analytics. (2015). *Healthy Youth Survey 2014 Report of Results: Parents in the Military Among Students in the Statewide Sample (gr.10).* http://www.askhys.net/library/2014/ParentsInMilitaryGr10.pdf

36. Mental Health America. *Parity or Disparity: The State of Mental Health in America. 2015.* http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%20Report%20FINAL.pdf

37. Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings.* NSDUH Series H-48, HHS Publication No. (SMA). 2014; 14-4863. http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

38. MHA also estimates that 26% of Washington adults with mental illness, over 300,000 people, report unmet needs and 46% of children and youth in need of mental healthcare did not receive it in 2011–2012. See endnote 35.

39. US Department of Health and Human Services, Health Resources and Services Administration. (2015). *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations.* http://www.hrsa.gov/shortage

40. Centers for Disease Control and Prevention. *Cost of Injury Reports Application. 2014.* http://www.cdc.gov/injury/wisqars/cost/cost-learn-more.html

41. Knapp M, McDaid D and Parsonage M (eds.). *Mental Health Promotion and Prevention: The Economic Case.* Personal Social Services Research Unit, London School of Economics and Political Science. 2011. http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf

42. Isaacs M and Benjamin M (1991). *Towards a culturally competent system of care, volume II, programs which utilize culturally competent principles.* Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

43. Weekley N and Brock S. Suicide Postvention Strategies for School Personnel. In Canter A, Paige L and Shaw S (Eds.), *Helping Children at Home and School. 2010; S945–S948.* National Association of School Psychologists. http://www.nasponline.org/books-and-products/products/books/titles/helping-children-at-home-and-school-iii-cd-rom

44. See http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/YouthSuicidePrevention/SuicidePreventionCoalitions for a current list.

45. Examples: middle and high school peer education programs; peer supports for people who have lost loved ones to suicide; peer support programs for veterans and people in the military; mental health warmlines and many others.

46. A coalition should reflect the diversity of its community. Important people to have at the table include representatives from the local health department, behavioral healthcare providers, educators, people with experience of suicide loss or suicidal behavior, youth, local law enforcement, faith communities, educators and others.

47. Gold M, Jamieson P and Romer D. Media Contagion and Suicide Among the Young. *American Behavioral Scientist. 2003; 46(9): 1269– 284.* http://www.jstor.org/stable/42000514?seq=1#page_scan_tab_contents

48. National Institute of Mental Health Science News. *Mental Illness Exacts Heavy Toll, Beginning in Youth. 2005.* Discussing National Comorbidity Survey Replication (NCS-R) data. http://www.nimh.nih.gov/news/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml

49. The Child Profile Health Promotion System sends child health and safety information to all families with young children in Washington State by mail and e-mail. See http://www.doh.wa.gov/YouandYourFamily/Immunization/ChildProfileHealthPromotion

50. As defined by OSPI, a Compassionate School pays close attention to its learning environment. Staff learn of challenges the students face and try to remove barriers to living and learning. This goal is to make students feel safe and supported.

51. These include cultural celebrations and ceremonies; faith community activities; mental health clubhouses; intergenerational service programs; LGBTQ youth programs; and veterans' support organizations.

52. Family connectedness programs that fill a critical need include those supporting connectedness for youth at high risk, new and/or struggling parents, people with behavioral health disorders, and elders.

53. Groups in need of transitional support include people returning to the community from prison or jail, youth aging out of foster care, people returning to civilian communities from military service, refugees in the process of resettlement, and people leaving inpatient treatment programs.

54. Jed Foundation. *For Campus Professionals: Comprehensive Approach. 2015.* https://www.jedfoundation.org/professionals/comprehensive-approach

55. This includes prevention of violence against children, targeted behavioral health supports for parents, and interventions promoting safe and healthy families and communities.

56. A task force on this topic is being created under House Bill 1338. http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/House%20Passed%20Legislature/1138-S.PL.pdf

57. Some research using national data sets addresses which occupations are at highest risk nationally. For example, Stack S. Occupation and Suicide. *Social Science Quarterly. 2001; 82: 384–396.*

58. For example, educators, clergy, parents, bus drivers, law enforcement, youth workers and peer leaders.

59. National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force. *The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience. 2014.* http://actionallianceforsuicideprevention.org/task-force/suicide-attempt-survivors/

60. For example, state employees, bus drivers, bank customer service staff, faith leaders and lay staff, hairdressers, senior center staff, human resources staff, mail carriers, bartenders, etc.

61. Walsh E, Hooven C, Watson H and Eichorn A. *Washington State Department of Health Suicide Education Study. 2013.* http://www.doh.wa.gov/Portals/1/Documents/Pubs/631049.pdf

62. See Appendix C for details on this and other legislation.

63. Barber C and Miller M. Reducing a Suicidal Person's Access to Lethal Means of Suicide: A Research Agenda. *American Journal of Preventive Medicine. 2014; 47(3S2): S264–S272.*

Appendix F continued

64. Programs to consider for replication include the King County Lok-It-Up program (http://www.kingcounty.gov/healthservices/health/injury/lokitup.aspx) and the New Hampshire Firearm Safety Coalition's Gun Shop Project (http://www.theconnectprogram.org/firearms-safety-coalitions-role-nh-suicide-prevention).

65. At the time of publication, organizations in other states are working on suicide prevention video modules to be added to firearm safety trainings. A model from another field is the Counseling on Access to Lethal Means (CALM) training for healthcare providers, which could be adapted for hunter education. For more information, see http://www.sprc.org/bpr/section-III/calm-counseling-access-lethal-means

66. Washington State Agency Medical Directors' Group (2015). *Interagency Guidelines on Prescribing Opioids for Pain.* http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

67. These may include suicide-safer jail cell technology, technologies to prevent medication overdose, firearm personalization technology and effective suicide barriers in common jump locations.

68. See Appendix A for information about how to access your local behavioral health resource guide.

69. This could include putting information about these resources on student ID cards and discussing them, where appropriate, in classroom curriculum.

70. Washington State Department of Social and Health Services. B*ehavioral Health Organizations Fact Sheet. 2015.* https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO2/BHO%20Core%20Fact%20Sheet.pdf

71. Suicide Prevention Resource Center. *Continuity of Care for Suicide Prevention: The Role of Emergency Departments. 2013.* Waltham, MA: Education Development Center, Inc., pg. 1, ft. 3

72. For more information, see http://www.hca.wa.gov/hw/Pages/default.aspx

73. These populations include American Indians and Alaska Natives, active-duty service members and veterans, youth, older adults, and LGBTQ youth.

74. Washington State Department of Health. *The New Blue H: A Report on the Findings of the 2014 Rural Health Workgroup, a Partner Project Between the Washington State Department of Health and the Washington State Hospital Association. 2014.* http://www.wsha.org/our-members/rural-hospitals/the-new-blue-h-report/

75. Substance abuse is a significant risk factor for suicide. Screening, Brief Intervention, Referral to Treatment (SBIRT) is an evidence-based method of screening for substance use disorders. The Department of Social Health Services is currently piloting SBIRT in selected health clinics in four counties.

76. Knesper JD, MD, Department of Psychiatry, University of Michigan. *Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge from an Emergency Department or an Inpatient Psychiatry Unit.2011:* 27. http://www.sprc.org/sites/sprc.org/files/library/continuityofcare.pdf

77. Tidemalm D, Langstrom N, Lichtenstein P, Runeson B. Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long term follow-up. *British Medical Journal. 2008:* 337, a2205.

78. Bergson S. *Cost effectiveness of using peer providers.* New York Association of Psychiatric Rehabilitation Services E-News, 2/2/2011. http://www.nyaprs.org/e-news-bulletins/index.cfm?do=headlines&mn=2&yr=2011&article=77D2D51A082A461FC195477449A38681

79. Centers for Disease Control and Prevention: Division of Violence Prevention. *Strategic Direction for the Prevention of Suicidal Behavior: Promoting Individual, Family and Community Connectedness to Prevent Suicidal Behavior. 2015.* http://www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf

80. National Action Alliance for Suicide Prevention Clinical Care and Intervention Task Force. *Suicide Care In Systems Framework. 2011.* http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf

81. For up-to-date information about best practice guidelines for postvention, see the Suicide Prevention Resource Center's Best Practice Registry at http://www.sprc.org/bpr/

82. See the Department of Health's free Community Health Worker training including the Behavioral Health module (http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem), DBHR's peer counseling training (https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/Peer%20Training%20Application%20Process%202015.pdf), and NAMI's support group facilitator training (http://www2.nami.org/Content/NavigationMenu/Find_Support/Education_and_Training/Education_Training_and_Peer_Support_Center/NAMI_Support_Group/Default1066.htm).

83. Personal communication with Joe Campo of the Office of Financial Management, 6/17/15 http://www.ofm.wa.gov/researchbriefs/2013/brief071.pdf

84. Washington State Violent Death Reporting System began in January 2015. This CDC-funded system will provide surveillance data including circumstances surrounding suicide deaths.

85. Crisis centers are available in each county but there is currently no central depository of data or standard method for collecting information.

86. National Action Alliance for Suicide Prevention: Research Prioritization Task Force. *A prioritized research agenda for suicide prevention: An action plan to save lives. 2014.* http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Agenda.pdf

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