Washington State Department of HEALTH

2025 Washington State Suicide Prevention Plan

This document contains information about suicide that may be upsetting or triggering for some readers. If you or someone you know is having thoughts of suicide, please reach out for help. Support is available 24/7:

Call, text, or chat online (chat.988lifeline.org) to reach the Suicide & Crisis Lifeline

988 SUICIDE & CRISIS LIFELINE

Press:

- **1** for the Veterans Crisis Line
- **2** to get support in Spanish
- **3** for the LGBTQIA2S+ Youth Line
- **4** for the Native & Strong Lifeline

For all other callers, stay on the line to be connected to a crisis counselor.

Your life matters. Help is available, and recovery is possible.

Washington State Department of HEALTH

DOH 971-076 CS May 2025
To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Acknowledgements

The Washington State Department of Health acknowledges the sovereign Tribal Nations and Urban Indian Organizations (UIO) within our state's borders and recognizes that meaningful suicide prevention work must be grounded in authentic partnership with Tribal and Native communities with an understanding of the historical impacts on the health of Native people today. Since spring 2021, we have engaged in collaborative efforts with Washington's Native communities including Washington's Tribal Nations and UIO to ensure their voices, wisdom, and perspectives are reflected throughout this plan.

This engagement began with a dedicated workgroup of Native prevention advocates who met monthly to develop specific recommendations for suicide prevention in American Indian & Alaskan Native (AI/AN) communities. Their insights helped shape our understanding of how historical trauma, cultural strengths, and Indigenous ways of knowing must inform our prevention approaches. Through Tribal Wellness and Resiliency Gatherings (2022-2024), we expanded this dialogue to include broader community perspectives and traditional knowledge.

Formal Government-to-Government consultation, including Dear Tribal Leader Letters and a listening session hosted by Port Gamble S'Klallam Tribe in February 2024, support proper protocols and Tribal sovereignty. Regular presentations and feedback sessions with the Tribal 988 Subcommittee & Tribal Centric Behavioral Health Advisory Board provided additional opportunities for Tribal leaders and health experts to shape the plan's development.

The priorities and perspectives shared through this engagement are woven throughout the plan's goals and objectives. For example, our emphasis on social connectedness and community bonds appears in multiple objectives, including those promoting intergenerational mentoring programs and community spaces for gathering. The plan's focus on economic stability and support, particularly in Strategic Direction 1, reflects Tribal input about addressing fundamental needs for community wellness. Objectives addressing historical trauma and promoting cultural healing practices were developed in direct response to Tribal guidance, as were those calling for Indigenous-led research frameworks and data sovereignty. This is particularly evident in Strategic Direction 4, which emphasizes the importance of culturally informed approaches to data collection and research.

This engagement is reflected throughout the plan, particularly honoring the Pulling Together for Wellness Framework, which is based in Native Ways of Knowing and is responsive to the Seven Generations priniciple (see page 32). The framework's influence can be seen in our emphasis on cultural strengths, intergenerational connections, and holistic approaches to prevention. We are grateful for the generosity of Tribal partners in sharing their knowledge and remain committed to ongoing collaboration in implementing these strategies.

Table of Contents

Letter from Leadership

Every death by suicide is a painful tragedy, and each death creates waves of pain that reach families, friends, colleagues, and communities — there is no bottom to the depth of the loss when someone dies by suicide.

It is a serious public health problem. It is also a largely preventable cause of death.

The state's first suicide prevention plan was written in 1995 by DOH and the University of Washington's School of Nursing to address youth suicide prevention. That work led to suicide prevention funding for youth and young adults. That plan was revised in 2009 and again in 2014.

In March 2014, then Governor Jay Inslee signed House Bill 2315, which required DOH to create a statewide suicide prevention plan for people of all ages. A large steering committee came together, and many people participated in local listening sessions. Washington's first comprehensive plan for suicide prevention debuted in 2016.

A lot has happened since then. The pandemic laid bare the most glaring disparities in our health care systems, including in suicide prevention efforts across the nation. For the last two years, a dedicated team at DOH has worked with people from across the state to address gaps in the plan. We are endlessly grateful to the community members and professionals who have graciously invested their time and energy, their stories, and their expertise over the last two years.

We learned from those most affected by suicide and highlighted the voices of those with lived experience. The objectives are based on research and evidence, and also community wisdom and lived experience. For example, we know that suicide disproportionately impacts certain populations. To offer culturally responsive interventions, this plan embeds health equity considerations into all prevention strategies. It is a comprehensive, equity-focused approach to addressing suicide in our state.

This plan represents more than 30 years of learning, planning, and connecting across Washington. We strongly believe that the vital connections in this plan will create ripples that lead to waves of change. We hope to see those waves roll toward a future where people are resilient and supported, where community connections thrive, and preventable suffering is significantly reduced.

Promoting mental health and preventing suicide is the responsibility of all of us.
We invite you to join us and thousands of others across the state to save lives and help people thrive.

Executive Summary

Vision for Suicide Prevention in Washington:

In 10 years, community connections thrive, overall resilience and well-being are strengthened, and preventable suffering related to mental health and suicide is eliminated. People have access to timely, affordable, culturally resonant, and trauma-informed health resources and services, which respect autonomy and reflect their strengths, needs, and goals.

How we will achieve this vision:

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

Goal 1: Make health equity part of all upstream suicide prevention activities.

Goal 2: Put into practice upstream prevention strategies for communities most affected by suicide, focusing on historically marginalized communities and people with lived experience of suicide.

Goal 3: Enhance well-being and connectedness as a key protective factor against suicide for people of all ages.

Goal 4: Address upstream risk factors and social determinants of health to prevent suicide and promote resilience.

Strategic Direction 2: Multi-Sector Suicide Prevention

Goal 1: Make health equity part of all multi-sector suicide prevention activities.

Goal 2: Develop and put into practice multi-sector suicide prevention strategies for groups most affected by suicide, especially historically systemically oppressed communities and people with lived experience.

Goal 3: Improve safety measures and responsible practices to protect people when they are at higher risk of suicide.

Goal 4: Provide support to people and communities after an inicident occurs and help people who have personal experience with suicide.

Goal 5: Make suicide prevention part of workplace culture and other community settings.

Goal 6: Build and sustain suicide prevention infrastructure at the state, Tribal, and local levels.

Goal 7: Create an equitable and diverse suicide prevention workforce that is prepared and supported to meet the needs of all communities served.

Goal 8: Create effective, wide-ranging, collaborative, and sustainable suicide prevention partnerships.

Goal 9: Use communication best practices to create research-informed suicide prevention messaging that addresses the unique needs of each community.

Strategic Direction 3: Treatment and Crisis Services

Goal 1: Embed health equity into all treatment and crisis services.

Goal 2: Improve treatment and support services for groups most affected by suicide, focusing on historically systemically oppressed communities, people with lived experience, and youth.

Goal 3: Improve the quality and accessibility of crisis care services across all communities.

Goal 4: Include effective suicide prevention services as a core component of health care.

Goal 5: Create an equitable and diverse treatment and crisis workforce that is equipped and supported to address the needs of the communities they serve.

Strategic Direction 4: Data Collection, Quality Improvement, and Research

Goal 1: Make health equity part of all data collection, quality improvement, and research activities.

Goal 2: Improve the data needed for suicide-related data collection, research, evaluation, and quality improvement.

Goal 3: Support more research on suicide and suicide prevention.

Goal 4: Use what we learn to create better suicide prevention programs for all ages and for groups most affected by suicide.

Introduction

Suicide is a leading cause of death, particularly among young people, veterans, middle-aged men, and American Indian and Alaska Natives (AI/AN). Between 2018 and 2022, more than 1,200 Washington residents died by suicide each year, making it the eighth leading cause of death in the state. The impact of suicide creates ripples that extend far beyond these deaths. Many others face thoughts of suicide, attempts, and other mental health concerns.

Communities often struggle to make sense of the devastating aftermath of losing a loved one to suicide. The economic and societal costs of suicide are also significant, estimated at over $12.8 billion annually in Washington alone (CDC WISQARS, 2024).

Recognizing the urgent need to address this challenge, Washington released its first statewide, all-ages suicide prevention plan in 2016. Since then, the field of suicide prevention has made meaningful progress that includes:

- Expanded access to mental health services
- Increased funding for prevention programs
- Improved data collection
- Research and development of more intersectional data

- Fostered collaboration among partners

Major achievements in Washington include:

- Increased screening for mental health and suicide risk in health care settings
- Establishment of the 988 Suicide & Crisis Lifeline for communities throughout the state
- Implementation of evidence-based prevention programs in schools and communities

Despite these advances, much work remains to be done. Suicide prevention is constantly evolving. New research, best practices, and challenges emerge all the time. The COVID-19 pandemic heightened the urgency of this issue by intensifying mental health concerns and increasing social isolation, both of which are risk factors for suicide. Additionally, there is also growing recognition of the need to address the social determinants of health (the conditions in the places where people are born, work, live, grow, and age) that contribute to disparities in suicide risk.

Social determinants of health: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These can include factors such as economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

Social Determinants of Health

To meet these and other challenges, Washington needs an updated, comprehensive plan for suicide prevention. This new plan builds on the foundation laid in 2016 and incorporates new strategies and priorities.

Health equity: The state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities.

First and foremost, health equity must be the core of our work. We recognize that certain people, including members of the LGBTQIA2S+ community, American Indian and Alaska Natives (AI/AN), and people who live in rural communities, face disproportionate barriers to accessing mental health care and support. These disparities are rooted in systemic inequities, like discrimination, poverty, and historical trauma, that must be addressed to prevent suicide effectively. Thus, this plan prioritizes:

- Culturally responsive programming
- Targeted investments in communities that have been historically, systemically, and intentionally excluded
- Policies that promote social and economic justice

Second, we know that suicide prevention is a complex issue that requires a multi-layer, multi-partner response from many parties across the state. In addition to improving access to personal support like psychotherapy or medication as an important part of suicide prevention, the updated plan also addresses the social determinants of health that shape mental health outcomes at the community and society levels. By taking a broad view of suicide prevention, we can address root causes that includes:

- Strengthening economic supports
- Promoting healthy connections
- Enhancing life skills and resilience
- Creating protective environments

Third, we must improve collaboration and collective action to help prevent suicide. No single agency, organization, or sector can solve this problem alone. Instead, we must work together to coordinate our efforts, share resources, and leverage strengths. We are adding breadth and depth to the roster of partners in our state's suicide prevention network will help us reach our goal. By breaking down silos and fostering genuine collaboration, we can create a more seamless, effective system of care and support for those in need.

Finally, this approach emphasizes the importance of data-informed decision-making and continuous quality improvement. We must invest in robust systems to track death by suicide, attempts, and risk factors in real time. We must also prioritize research and evaluation to identify best practices, measure progress, and refine our strategies over time. By integrating data and continuous quality improvement practices to guide our efforts, we can ensure that our limited resources are being used in the most effective and efficient way possible.

Done right, a comprehensive approach represents a bold, forward-thinking vision for suicide prevention in Washington. It recognizes the complex, multi-faceted nature of this problem and calls for a coordinated, equity-focused response that engages all sectors of society. By working together in new and innovative ways, we can create a future where every Washingtonian has the support, resources, and hope they need to live a full and healthy life.

This plan has been informed by extensive input from partners across the state, including people with lived experience, families, service providers, researchers, and policymakers. It reflects a shared vision of a Washington where everyone has the support and resources they need to live healthy, fulfilling lives with the knowledge they can get help for thoughts of suicide and other emotional distress when needed.

As we begin the next phase of our state's suicide prevention efforts, we invite all Washingtonians to join us in this critical work. Together, we can build a stronger, more resilient Washington, where hope, healing, and recovery are within reach for all.

Emerging Challenges

Social media use is nearly universal among Washington's youth, with up to 95% of teens ages 13-17 reporting use of social media platforms. This widespread and extensive use has prompted national concern, culminating in a **2023 Surgeon General's Advisory on Social Media and Youth Mental Health**. The advisory highlights that while social media can offer benefits like social connection and access to information, particularly for marginalized teens, there are significant risks that warrant urgent attention.

Research has linked excessive and problematic social media use to various mental health concerns in youth, including increased risk of depression, anxiety, sleep problems, and feelings of social exclusion. The Surgeon General's advisory cites a longitudinal study of U.S. adolescents which found that those who spent more than three hours per day on social media faced double the risk of experiencing poor mental health outcomes (Riehm et al., 2019). Social media can also expose youth to harmful content, cyberbullying, and social comparison that may negatively impact self-esteem and body image. Given these potential risks and the Surgeon General's call to action, it is crucial that our suicide prevention strategies in Washington include efforts to promote healthy social media habits, improve digital literacy, and create safer online environments for our youth.

Prevention in Action:
Safer Homes, Suicide Aware by UW's Forefront

Three out of every four firearm fatalities are suicides.[1] This statistic drives the mission of Safer Homes, Suicide Aware, an innovative program led by the University of Washington's Forefront Suicide Prevention center.

Safer Homes, Suicide Aware takes a unique approach to suicide prevention by focusing on a critical factor: access to lethal means, particularly firearms and medications. The program targets two high-risk groups: men ages 35-64 and veterans. Both of these groups are statistically more likely to use firearms in suicide attempts.

A collaborative approach sets this program apart. A diverse task force guides the work, bringing together experts from various fields to develop effective strategies. Safer Homes, Suicide Aware partners with firearms retailers, medical providers, pharmacy professionals, and veteran-serving organizations to make sure each group understands its crucial role in preventing suicides.

The program's reach extends beyond professional circles. Safer Homes, Suicide Aware engages directly with community members at public events ranging from gun shows to National Night Out gatherings. The program offers free locks in exchange for participation in a survey about secure storage practices and suicide risk awareness. This innovative approach not only provides tangible tools for firearm safety but also gathers valuable data and raises public awareness.

The effectiveness of Safer Homes, Suicide Aware isn't just anecdotal. A peer-reviewed study in 2019 found statistically significant improvements in both secure storage behavior and suicide risk knowledge among program participants.

Brett Bass, a program manager at Forefront, emphasizes the positive impact of their work: "Every conversation we have, every lock we distribute, has the potential to save a life. We're not just changing practices. We're changing mindsets. By making secure storage a norm and openly discussing suicide prevention, we're building safer, more resilient communities."

[1] Centers for Disease Control. Web-Based injury statistics query and reporting system (WISQARS). Centers for Disease Control and Prevention website, 2020. Available: **https://www.cdc.gov/injury/wisqars/index.html**

Plan Framework and Guiding Principles

Problem Statement

In Washington, suicide remains a significant and preventable public health problem that affects many people, families, and communities. People who experience thoughts of suicide, suicide attempts, and death by suicide struggle to access culturally resonant and timely care, resulting in unacceptable suffering. Stressors and risk factors linked to suicide disproportionately impact many historically marginalized communities, and solutions must come from meaningful relationships with these communities.

Vision Statement

In 10 years, community connections thrive, overall resilience and well-being are strengthened, and preventable suffering related to mental health and suicide is eliminated. People have access to timely, affordable, culturally resonant, and trauma-informed health resources and services, which respect autonomy and reflect their strengths, needs, and goals.

Guiding Principles

To achieve this vision, our suicide prevention efforts will be guided by five core principles (Suicide Prevention Resource Center, 2019):

1. Centering Lived Experience

- Elevating the voices and experiences of people with lived experience of suicide, including attempt survivors, loss survivors, and those with lived experience of thoughts of suicide.
- Engaging people with lived experience in the planning, implementation, and evaluation of suicide prevention efforts to ensure that strategies are grounded in the realities of those most affected.
- Creating safe and supportive spaces for people to share their stories, insights, and recommendations for change.
- Support frameworks that leverage the lived experiences of people with multiple marginalized identities.

2. Partnerships and Collaborations

- Fostering genuine partnerships and collaborations across sectors, including health care, education, social services, justice, and community-based organizations.
- Leveraging the strengths, resources, and expertise of diverse partners to create a comprehensive and coordinated approach to suicide prevention.
- Promoting cross-sector communication, data sharing, and resource coordination to make sure everyone receives seamless and integrated care.
- Seek out and assist in the participation of partnerships across organizations that focus on specific identities to encourage intersectional discussions (for example, encouraging discussions between BIPOC and Disability Rights organizations).

3. Safe and Effective Messaging and Reporting

- Promoting safe and responsible messaging about suicide in the media, online platforms, and public communications.
- Adhering to best practices for reporting on suicide, including avoiding sensationalism, providing hope and resources, and emphasizing prevention.
- Educating journalists, content creators, and community leaders on the importance of safe messaging and the potential impact of their words and images.
- Whenever possible, prioritizing depictions of people with intersectional experiences.

4. Evidence-Based Prevention

Public health data should be collected and used in a just and equitable way. Historically, Tribes, people of color, people with disabilities, members of the LGBTQIA2S+ community, and others have been overlooked in data collection, analysis, and decision-making. Evidence-based prevention practices can include every community. Recognizing this, we're committed to strengthening our data practices and suicide prevention efforts to better support every community across Washington.

- Implementing suicide prevention strategies that are grounded in the best available research and evidence.
- Continuously evaluating the effectiveness of prevention efforts and using data to inform decision-making and quality improvement.
- Adapting evidence-based practices to meet the unique needs and contexts of diverse communities.
- Embracing emerging intersectional scholarship and implementation opportunities to expand the evidence base.

5. Culturally Informed Approaches

- Developing and implementing suicide prevention strategies that are culturally responsive, linguistically appropriate, and tailored to the unique needs and strengths of diverse communities.
- Engaging community leaders, elders, and cultural brokers in the design and delivery of prevention efforts to ensure cultural relevance and acceptability.
- Addressing the social, economic, and historical factors, including intersectional dimensions, that contribute to suicide risk in marginalized communities, including racism, discrimination, and intergenerational trauma.

These guiding principles provide a roadmap for our state's suicide prevention efforts. By centering lived experience, fostering partnerships, implementing evidence-informed strategies, promoting safe messaging, prioritizing culturally informed approaches, and working collaboratively towards a common vision, we can create a comprehensive and effective approach to preventing suicide in Washington. Together, we can build a future where all people and communities have the resources, support, and hope they need to thrive.

Prevention in Action:
988 Success in Washington

In 2020, the Federal Communications Commission (FCC) adopted the National Suicide Hotline Designation Act. This act made 988 the new, nationwide number for anyone experiencing a mental health crisis, including thoughts of suicide, substance use concerns, or any type of emotional distress.

Anyone can use this easy-to-remember three-digit dialing code to call or text the **988 Suicide & Crisis Lifeline**. Chat is also available online at the **988 Lifeline website**.

The Washington State Department of Health and the Health Care Authority (HCA) have worked closely with partners and community members to make sure the 988 Suicide & Crisis Lifeline in Washington offers compassionate and confidential services that are also culturally, linguistically, and geographically appropriate.

According to Dr. Joshua Jones, Chief Physician Officer at Olympic Medical Physicians in Port Angeles, Washington, 988 has made a drastic difference by saving lives and helping people stay out of the hospital.

"In our area, the Volunteers of America Western Washington staff the 988 number, and they do an incredible job. Many of my patients have used the line in many different stages of crisis, and the results have been phenomenal," Dr. Jones said.

Early successes from Washington's 988 system include:

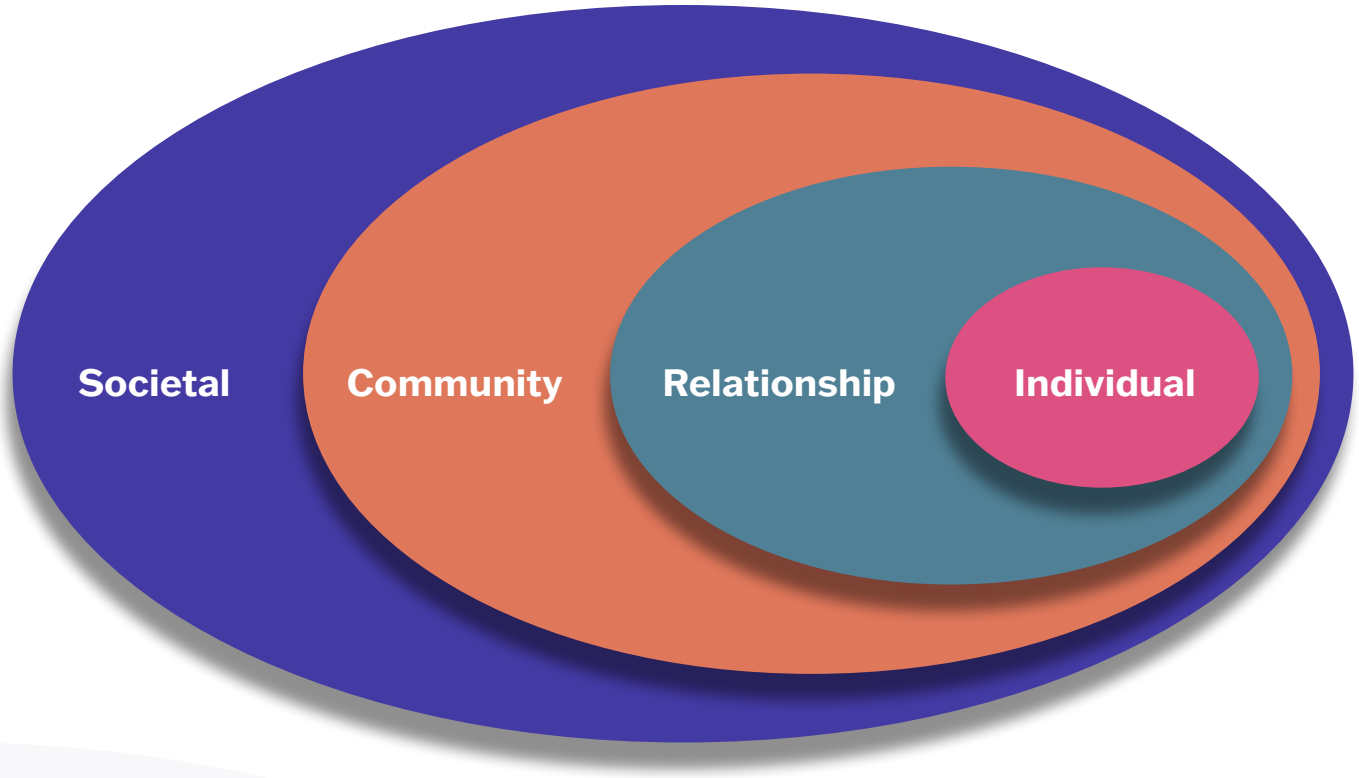
- Reaching and maintaining a 90% in-state answer rate (the percentage of calls, texts, and chats answered by Washington-based 988 counselors).
- Supporting a significantly increased volume of calls, texts, and chats.
- Developing and implementing the **Native & Strong Lifeline**.
- Engaging partner organizations and people with lived experience through the **Crisis Response Improvement Strategy (CRIS) Committee** and Subcommittees.
- Building an infrastructure to triage 911 mental health crisis calls to ensure callers are provided appropriate mental health resources.
- Launching a **campaign** to build awareness of 988 across the state and provide tailored messages for LGBTQIA2S+ people, American Indian and Alaska Native people, veterans, and people living in rural communities.
- Coordinating with HCA to develop a tech platform to manage and operate Washington's mental and behavioral health crisis response and suicide prevention system.

Understanding Suicide Risk and Resilience: A Comprehensive Approach

Suicide is a complex public health issue that can affect anyone, regardless of their background or circumstances. To effectively prevent suicide, we must understand the intricate interplay of factors that contribute to risk and resilience. The social-ecological model provides a comprehensive framework for examining these factors and developing holistic prevention strategies.

The Social-Ecological Model

The social-ecological model recognizes that an individual's behavior is shaped by multiple levels of influence, from personal factors to broader societal conditions (CDC, 2021). This model consists of four interconnected levels:



- **Individual Level:** Personal factors such as biological and psychological characteristics, personal history, and individual behaviors.
- **Relationship Level:** Close relationships with family, friends, intimate partners, and peers that may influence risk or protection.
- **Community Level:** Settings where social relationships occur, such as schools, workplaces, and neighborhoods, and their characteristics.
- **Societal Level:** Broad societal factors that create a climate influencing suicide risk, including social and cultural norms; health, economic, educational and social policies; and societal inequities.

Risk and Protective Factors Across the Social-Ecological Model

Within this framework, we can identify both risk factors that may increase the likelihood of suicidal behavior and protective factors that can help reduce risk and promote resilience. The following table outlines some of these factors at each level:

Table 4. Risk and protective factors for suicide based on levels of the social-ecological model.

Category	Risk factors	Protective factors
Individual	**History of:** ■ Suicide attempt(s) ■ Depression ■ Other mental illness ■ Substance abuse ■ Adverse childhood experiences ■ Violence (as victim, person who caused/causes harm, or both) **Negative life stress:** ■ Severe illness ■ Chronic pain ■ Criminal and/or legal problems ■ Financial loss or instability ■ Job problem or unemployment ■ Intergenerational trauma **Experiences of:** ■ Hopelessness ■ Impulsivity ■ Aggression ■ Social isolation ■ Loneliness	**Beliefs in:** ■ Reasons for living ■ Cultural identity **Effective life skills:** ■ Coping
Relationship	**Negative life events:** ■ Family or loved one's suicide ■ Loss of relationship(s) ■ Negative relationships ■ High conflict or violent relationships ■ Bullying ■ Social exclusion ■ Interpersonal racism or discrimination	**Connection:** ■ Social support ■ Close relationships with positive peers, parents, family, significant others ■ Variety of relationships and frequency of interactions

Category	Risk factors	Protective factors
Community	**Traumatic history:** ■ Historical trauma ■ Suicide cluster ■ Risk environment ■ Community violence ■ Discrimination ■ Disconnection ■ Stress of acculturation ■ Lack of access to health care	**Healthy environment:** ■ Accessible and affordable high-quality health care (physical and behavioral) **Connection to:** ■ School ■ Community ■ Social institutions
Society	**Negative stereotypes about:** ■ Help-seeking ■ Mental health ■ History of trauma, abuse, and adverse childhood experiences ■ Unsafe media portrayals ■ Easy access to lethal means of suicide among people at risk ■ Systemic or institutional racism and discrimination	**Objections to suicide from:** ■ Culture ■ Morals ■ Religious beliefs ■ Reduced access to lethal means of suicide

Sources: CDC, 2022; Alvarez et al., 2022; Coimbra et al., 2022.

The Dynamic Nature of Risk and Protective Factors

It's crucial to understand that risk and protective factors are not fixed or deterministic. They can change over time and vary in their impact on individuals. The presence of risk factors does not inevitably lead to suicidal behavior, just as the presence of protective factors does not guarantee immunity from suicide risk.

Factors that may increase risk in one person might not have the same effect on another, due to the complex interplay of individual, relational, community, and societal influences. Similarly, protective factors can be developed and strengthened over time, even in the presence of significant risk factors.

This dynamic nature underscores the importance of comprehensive, ongoing suicide prevention efforts that address multiple levels of the social-ecological model. By working to reduce risk factors and enhance protective factors across all levels, we can create a more supportive environment that promotes mental health and resilience for all Washingtonians.

Intersectionality of Risk Factors

While examining individual risk factors is essential, it's crucial to recognize that these factors do not exist in isolation. The concept of intersectionality highlights how multiple at-risk identities and experiences can intersect and compound, creating unique challenges and barriers (Cho et al., 2013; Crenshaw, 2017).

For example, an LGBTQIA2S+ person who also belongs to a historically marginalized racial or ethnic group may face discrimination and stigma based on both their sexual orientation and their race (Alvarez et al., 2022). This compounded oppression can lead to increased feelings of isolation, helplessness, and despair, potentially elevating the risk of suicidal thoughts and behaviors (Coimbra et al., 2022).

Intersectionality also sheds light on how systemic inequities and societal structures can create and perpetuate disparities in suicide risk (National Academies of Sciences, Engineering, and Medicine, 2017b). For instance, poverty and economic instability can intersect with other risk factors, like mental health conditions or substance use, making it more challenging for people to access the resources and support they need (Liu et al., 2023).

The experience of multiple, overlapping forms of trauma and adversity can have a cumulative impact on mental health and suicide risk (Education Development Center & National Association of County and City Health Officials, 2023). A person who has experienced childhood abuse, intimate partner violence, and racial discrimination may face a significantly heightened risk of suicidal behavior due to the compounding effects of these traumas (Hochhauser et al., 2020).

Implications for Suicide Prevention

By viewing suicide prevention through the lens of the social-ecological model and recognizing both the dynamic nature of risk and protective factors and the importance of intersectionality, we can develop more nuanced, effective strategies that:

- Address risk and protective factors at all levels of the social-ecological model
- Account for the unique experiences of individuals with intersecting identities and risk factors
- Are culturally responsive and address underlying systemic disparities
- Adapt to the changing needs of individuals and communities over time

This comprehensive approach allows us to move beyond individual-focused interventions and consider the broader social and environmental contexts that shape mental health and suicidal behavior. By doing so, we can create a more just, equitable, and effective system of suicide prevention that supports the mental health and well-being of all Washingtonians, regardless of their backgrounds or experiences.

Understanding Suicide in Washington: A Snapshot

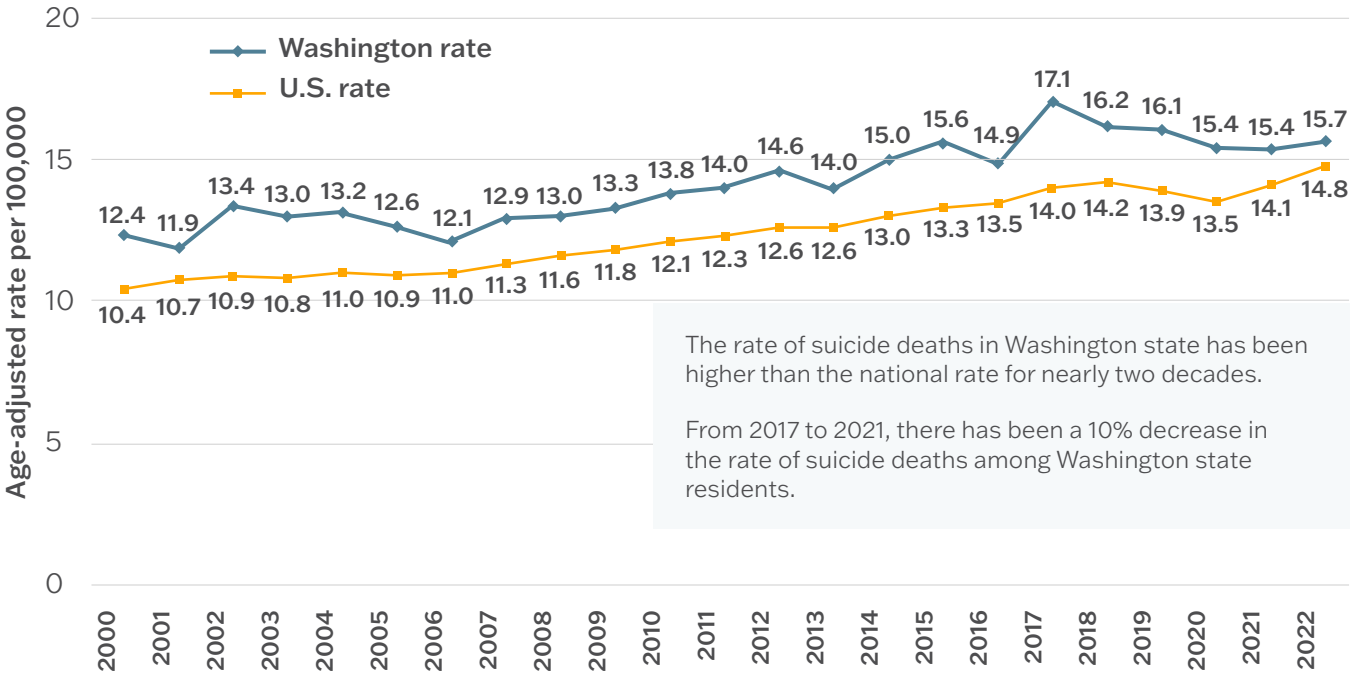
Suicide is a serious and preventable public health problem in Washington. It is frequently misperceived as an inevitable outcome for people with a mental health disorder or difficult life circumstances. However, like other injuries or acts of violence, suicide can be prevented. Most people who have experienced suicidal thoughts or survived a past attempt go on to live long lives when protective measures are implemented and they receive appropriate care.

Recent Trends

Suicide Deaths

Between 2018 and 2022, 6,190 Washington residents died by suicide. For nearly two decades, Washington's suicide rate has consistently exceeded the national average, highlighting the critical need for targeted prevention efforts within the state.

Figure 1. Age-adjusted suicide rates, 2000-2022, Washington and United States.



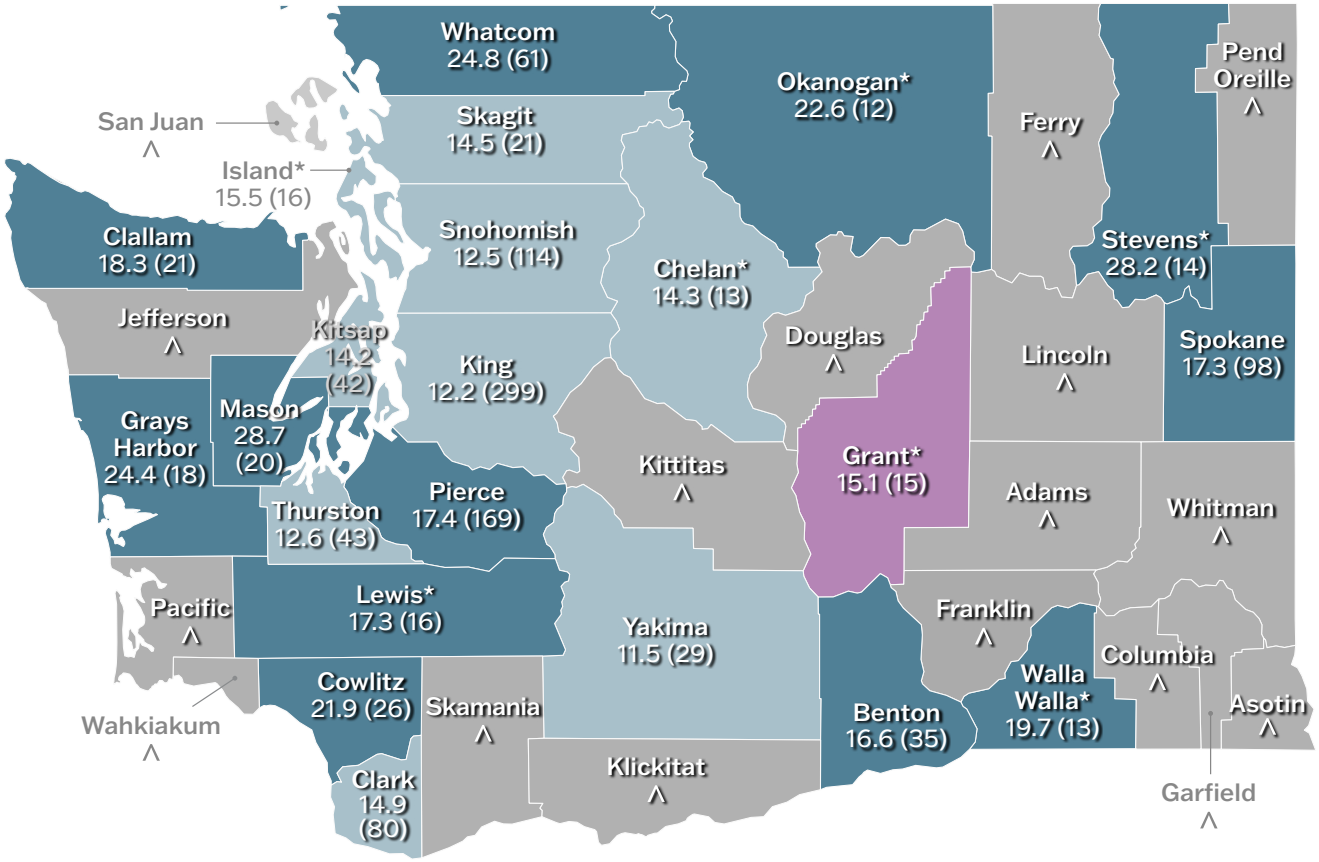
Washington Suicide Deaths	
Year	Number of Deaths
2000	727
2001	710
2002	811
2003	801
2004	823
2005	814
2006	796
2007	857
2008	884
2009	915
2010	947
2011	992

Washington Suicide Deaths	
Year	Number of Deaths
2012	1035
2013	1008
2014	1110
2015	1136
2016	1123
2017	1292
2018	1254
2019	1263
2020	1211
2021	1228
2022	1234

From 2017 to 2020, Washington saw a 10% decrease in its suicide rate, the state's rate remains above the national average. This recent decline suggests that prevention efforts may be beginning to have an impact, but also indicates the need for continued and intensified efforts.

The state age-adjusted rate of suicide is 15.7 deaths per 100,000 people. Suicide rates by county highlight geographic disparities (DOH, 2024).

Figure 2. Age-adjusted suicide rate per 100,000 for Washington by county, 2022.



Compared to state rate: Lower Not Different Higher Rate is Surpressed

Λ : Rate is supressed in county with 10 or fewer deaths.
* : Rate is not reliable in county with 16 or fewer deaths

Data source: Washington State Department of Heath, Center for Health Statistics, Death Certificate Data.
Data pulled: Sept. 26, 2024.

Suicide rates vary by age group. In 2022, suicide rates ranged from 1.75 per 100,000 among youth ages 10-14 years to 35.9 per 100,000 among people 85 years and older (DOH, 2024).

Table 1. Suicide rates by age, Washington, 2022.

Age	Number of Suicides	Age-Specific Rate, per 100,000
10-14	17	1.75
15-24	133	13.7
25-34	223	19.6
35-44	181	16.7
45-54	160	17.0
55-64	202	20.8
65-74	163	20.0
75-84	107	26.9
85+	48	35.9

Suicide rates by race and ethnicity point to additional disparities. Suicide rates ranged from 8.6 per 100,000 among non-Hispanic Asian populations to 22.0 per 100,000 among non-Hispanic American Indian and Alaska Native (AI/AN) populations. In 2022, 76% of suicides occurred among non-Hispanic White populations (DOH, 2024).

Table 2. Age-adjusted suicide rates by race and ethnicity, Washington, 2022.

Race/Ethnicity	Number of Suicides	Age-Specific Rate, per 100,000
White, NH	944	16.6
Black, NH	39	10.9
American Indian/ Alaska Native, NH	21	22.0
Asian, NH	69	8.6
Pacific Islander, NH	12	15.5
Multi-Race, NH	46	10.1
Hispanic as Race	92	9.2

NH = Non-Hispanic

Suicide rates among females and males show large differences. Male age-adjusted suicide rates in 2022 were about four-fold higher than female rates (DOH, 2024).

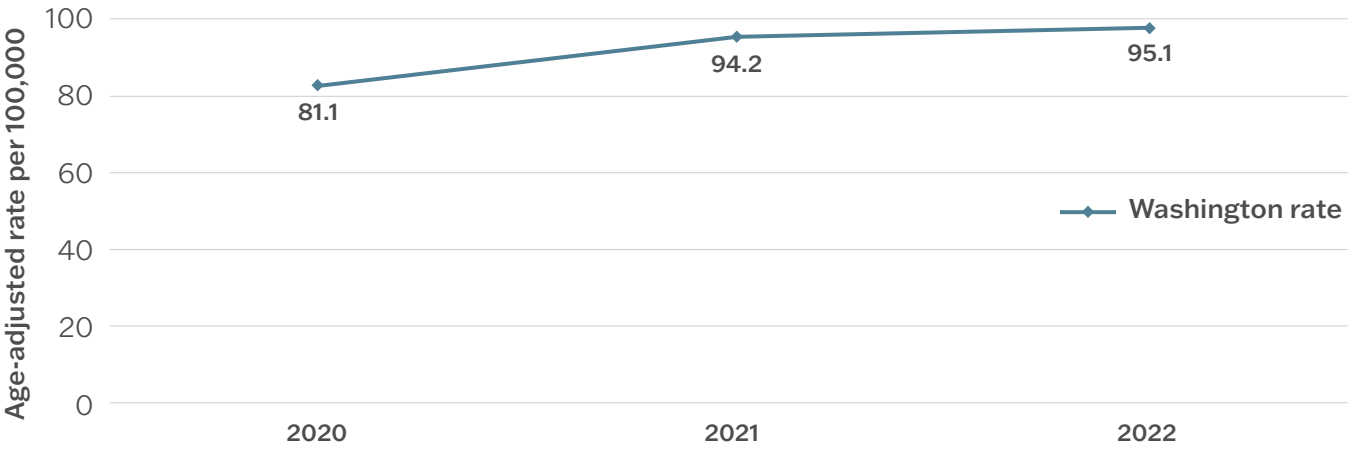
Table 3. Age-adjusted suicide rates by sex, Washington, 2022.

Sex	Number of Suicides	Age-Specific Rate, per 100,000
Female	253	6.0
Male	980	23.6

Suicide Thoughts and Attempts

Many more people think about and/or attempt suicide than those who die by suicide, and most people who think about or attempt suicide never go on to die by suicide (Wenzel et al., 2011). In 2022, 95.1 per 100,000 Washington residents visited an emergency department as the result of self-harm.

Figure 3. Washington self-harm ED visits rates (2020-2022).



When communities prioritize comprehensive prevention strategies, we can stop tragedies before they occur. This includes investing in crisis services, providing affordable mental health care access, promoting life skills education from an early age, and implementing workplace and community-based prevention programs. No single approach alone will prevent every suicide, but implementing protective factors through cross-sector collaboration creates an environment more protective against suicide behavior. With smart prevention practices, compassionate intervention, and a refusal to perpetuate stigma, we can make meaningful progress against this leading cause of death. Understanding these patterns can help ensure timely prevention services are received.

Prevention in Action:
Kellen CARES Foundation

In the face of loss, some find the strength to create hope. This is the story of the Kellen CARES Foundation, born from the heartbreaking loss of 19-year-old Kellen Erickson to suicide. Kellen's parents transformed their grief and knowledge of high suicide rates among men into action, establishing a foundation dedicated to helping boys and young men navigate mental health challenges.

Since its incorporation as a nonprofit in November 2020, the Kellen CARES Foundation has become a beacon of support and education in the Spokane area. The organization recognizes that addressing male suicide requires a comprehensive strategy that tackles isolation, promotes connection, and provides targeted resources.

At the heart of their work is the annual Helping Boys Thrive Summit, which features experts like Dr. Michael Gurian, a renowned author and gender brain specialist. These summits explore the unique aspects of male psychology and neurobiology to offer insights that can help parents, educators, and communities better support boys and young men.

The foundation's reach extends far beyond annual events. They've sponsored Youth Mental Health First Aid classes, supported the Cougs Care mental health club at Washington State University, and played a crucial role in bringing Hope Squad — a peer-to-peer suicide prevention program — to 11 Spokane area schools. The Kellen CARES Foundation also understands the power of personal stories and has brought in speakers like former NFL quarterback Ryan Leaf to share messages of resilience and hope. These events, along with various community sponsorships and media engagements, help destigmatize mental health discussions and promote awareness.

Kimber Erickson, Kellen's mother and the foundation's executive director, emphasizes the importance of their work: "Every person we reach is a potential life saved. We're not just providing resources. We're building a community that understands the unique challenges boys and men face. By fostering connections and giving them the tools to navigate their emotions, we're working to ensure that no other family has to experience the loss we did."

In the future, the Kellen CARES Foundation aims to expand its impact through more educational events, the development of community centers focused on mentorship and purpose-building for boys and young men, and increased awareness about the effects of technology and substance use on youth mental health.

Through their tireless efforts, the Kellen CARES Foundation is not just preventing suicide deaths — they're reshaping how we approach male mental health, one connection at a time.

kellencares.org

Prevention in Action:

WSU Skagit County's Agricultural Economic Advisory and Counseling Services

Farming is a stressful business and many of the pressures farmers faces are connected to financial concerns. This, combined with social isolation and stigma, has led to high rates of suicide among agricultural workers in Washington.

Since 2022, Washington State University (WSU) Skagit County has worked to combine economic advising and mental health support to address both issues. Economic advisor Jon Paul Driver makes presentations to farmers on economic issues and follows up with in-person visits. He helps farmers build their financial plans, instilling hope and a sense of control in an uncertain industry.

"One of the things that makes me successful is that the only thing that I do is agriculture. From the time that I was four, I was carrying milk pails. I was trained by my grandfather on how to know that hay is dry enough to bale. I have an instinctive nature about farmers. When a farmer doesn't do a final last step, such as put a tarp over crops to keep them dry, that is a sign of trouble."

Most importantly, once he is on-site, Driver looks for warning signs of mental health issues.

From 2022 to 2023, Driver presented to 1,800 people, resulting in 150 economic consulting sessions with 80 farmers. He's referred five of those farmers to WSU's counseling services, and all of them received support.

WSU Skagit County Director Don McMoran says, "2024 feels like we are entering the 1980s farm crisis that created Farm Stress/ Suicide Prevention work in the United States with low commodity pricing, high input costs, and high interest rates. Our farmers are experiencing high amounts of stress. We are fortunate that our state and national leaders recognize the issue and have provided funding for Washington State University and others to create programs and outreach to our stakeholders."

If you know a farmer or farm worker experiencing high levels of stress, please reach out to the Farm Aid resource call center at 1-800-FARM-AID or the Agristress Crisis call center at 1-833-897-AGRI (2474).

Strategic Directions, Goals, and Objectives

The Washington Suicide Prevention Plan is organized into four strategic directions. Each of these plays an important part in our comprehensive approach to suicide prevention. These strategic directions align closely with the **2024 National Strategy for Suicide Prevention**, though many have been revised for clarity. They also reflect the unique needs and priorities of our state as identified through extensive community and partner engagement (see Appendix B).

The four strategic directions are:

1	**Healthy and Connected Individuals, Families, and Communities**
2	**Multi-Sector Suicide Prevention**
3	**Treatment and Crisis Services**
4	**Data Collection, Quality Improvement, and Research**

Each strategic direction includes specific goals and objectives that provide a roadmap for action. These goals and objectives were developed through a collaborative process involving diverse partners, including people with lived experience, service providers, researchers, policymakers, and representatives from populations most affected by suicide.

While the national strategy includes a separate strategic direction focused on health equity, we have chosen to meaningfully embed equity considerations throughout all four of our strategic directions. This approach reflects our commitment to making sure equity is not a siloed effort, but rather an integral part of all suicide prevention activities in Washington.

The strategic directions are designed to be interconnected and mutually reinforcing. Together, they address the full spectrum of suicide prevention, including:

- Upstream efforts that promote mental health and well-being
- Intervention and crisis response
- Postvention support for those affected by suicide

We also recognize the need for strong data systems, ongoing research, and continuous quality improvement to guide and refine our efforts.

By aligning with the national strategy while tailoring our approach to the specific needs of Washington, we aim to create a coordinated, evidence-based, and culturally responsive suicide prevention plan. This plan calls for action across multiple sectors and levels of society. It recognizes that suicide prevention is a shared responsibility — one that requires the engagement of people and their families, communities, organizations, and systems.

As you review each strategic direction, you will find:

- An overview of the direction's focus and importance
- Specific goals that outline what we aim to achieve
- Objectives that provide more detailed guidance on how to reach these goals
- Examples of current initiatives or best practices related to each strategic direction

We encourage all partners to consider how they can contribute to implementing these strategic directions and to work collaboratively towards our shared vision of a Washington with no suicide deaths.

Prevention in Action:

American Indian Health Commission Pulling Together for Wellness: A Tribally Driven Framework for Indigenous Health

The American Indian Health Commission (AIHC) Pulling Together for Wellness (PTW) framework exemplifies the power of community-driven health initiatives. Developed under the guidance of Washington Tribal and Urban Indian Leaders, this comprehensive approach blends Indigenous wisdom with Western public health science, creating a unique wellness model that resonates deeply with Tribal communities.

A profound respect for cultural context lies at the heart of the framework. The model recognizes that true health and wellness cannot be achieved without honoring Indigenous peoples' traditions, values, and experiences. This cultural grounding forms the foundation upon which the entire framework is built.

"PTW is more than a health initiative — it's a return to our roots, a recognition that true healing comes when we honor our traditions and the interconnectedness of all aspects of our being," says JanMarie Ward, who facilitated efforts to develop the framework. "By weaving together our ancestral wisdom with modern knowledge, we're not just addressing health disparities; we're reclaiming our wholeness as Indigenous peoples and paving the way for the wellness of generations to come."

The framework's development was a collaborative effort, bringing together elders, youth, community members, program staff, and public health specialists. This diverse chorus of voices was orchestrated by the PTW Leadership Advisory Council (LAC), which played a crucial role in shaping the final model.

Central to the approach is the concept of holistic health, symbolized by the medicine wheel. This powerful symbol serves as a reminder that physical, mental, emotional, and spiritual health are all interconnected — a tapestry of wellness that can't be separated into distinct threads. It's a visual representation of the framework's commitment to nurturing the whole person: heart, mind, body, and soul.

The framework introduces the crucial concept of "Generational Clarity," acknowledging the impacts of historical and intergenerational trauma on Indigenous communities. It incorporates seven-generation thinking into its approach to policy, systems, and environmental change, ensuring that today's actions are considerate of long-term effects on future generations.

To implement these principles, the framework offers practical tools including an action planning process, a matrix linking goals to strategies, and 21 competency domains. These resources empower communities to address health disparities through culturally resonant methods. Importantly, the framework is being actively implemented to address the critical issue of suicide in Tribal communities. By integrating cultural practices, community support systems, and a holistic understanding of well-being, the framework provides a culturally appropriate approach to suicide prevention. This implementation recognizes that addressing suicide requires more than just crisis intervention — it necessitates a comprehensive strategy that strengthens community bonds, preserves cultural identity, and promotes overall mental and emotional wellness.

The framework stands as a testament to the resilience and wisdom of Indigenous communities. By interweaving traditional knowledge with contemporary health practices, it offers a promising path toward improved health outcomes, including suicide prevention, and overall well-being for Tribal populations.

1 STRATEGIC DIRECTION 1
Healthy and Connected Individuals, Families, and Communities

Creating environments that promote mental health, well-being, and social connectedness is a fundamental step to preventing suicide. This strategic direction focuses on upstream prevention efforts that aim to reduce the chances of someone considering suicide. By strengthening protective factors and addressing risk factors at the individual, family, and community levels, we can build resilience and create a strong foundation for suicide prevention.

We recognize the importance of social determinants of health in suicide prevention. Factors like economic stability, education, social and community context, and access to quality health care all play crucial roles in shaping mental health outcomes. This strategic direction emphasizes addressing these broader societal factors alongside personal and relationship-level interventions.

This strategic direction builds on these advances by promoting a comprehensive approach to fostering healthy people, families, and communities. It recognizes that suicide prevention starts long before a crisis occurs and requires investment in the social and emotional well-being of entire communities.

The goals and objectives in this section aim to:

- Strengthen economic supports
- Promote healthy connections
- Enhance life skills and resilience
- Create protective environments
- Address social and economic inequities that contribute to suicide risk

By focusing on these upstream factors, we can create communities where everyone has both the opportunity to thrive and ready access to support when they need it.

This approach aligns with recent public health insights, including the **U.S. Surgeon General's 2023 advisory on the importance of social connection for health and well-being** and the **CDC's 2022 Technical Package**. It emphasizes that suicide prevention goes beyond intervening in moments of crisis. Suicide prevention also relies on building stronger, more supportive communities that promote mental health and reduce the factors that contribute to thoughts of suicide and suicide attempts.

Goal 1: Make health equity part of all upstream suicide prevention activities.	
Objective 1.1	Improve upstream prevention by including perspectives and recommendations from groups most affected by suicide and people with lived experience of suicide.
Objective 1.2	Address social determinants of health and systemic issues that can increase suicide risk for people of all ages.
Objective 1.3	Promote upstream protective factors in communities most affected by suicide across state, Tribal, and local prevention efforts.
Objective 1.4	Fund and expand effective upstream prevention activities led by communities and peers.
Objective 1.5	Involve public and private organizations in upstream suicide prevention activities.
Goal 2: Start upstream prevention strategies for communities most affected by suicide, focusing on historically marginalized communities and people with lived experience of suicide.	
Objective 2.1	Start upstream suicide prevention activities that address the increasing rate of suicide thoughts, attempts, and deaths within racial, ethnic, and historically marginalized groups of all ages.
Objective 2.2	Improve and expand upstream programs, practices, policies, and systems serving groups of people most affected by suicide.
Objective 2.3	Improve and expand ongoing staff training and development for those serving groups of people most affected by suicide.
Goal 3: Enhance well-being and connectedness as a key protective factor against suicide for people of all ages.	
Objective 3.1	Begin interventions that reduce suicide risk and promote connection between people, families, and caregivers where they live, work, learn, play, and worship. Evaluate these interventions to make sure they are effective.
Objective 3.2	Encourage social engagement, build community connectedness, and reduce isolation through upstream interventions, like intergenerational mentoring programs, community centers, and technology-based social support interventions. Include programs and practices that strengthen social connection in state, Tribal, and local suicide prevention efforts.

Objective 3.3	Promote positive social norms around help-seeking, mental health care, and suicide prevention, especially among men and boys.
Objective 3.4	Partner with community organizations to expand evidence-based programs that promote social skills, empathy, conflict resolution, and healthy relationships among youth.
Objective 3.5	Educate the public, policymakers, and community partners about the importance of social connection for mental health and suicide prevention.
Objective 3.6	Invest in community spaces that allow for social gathering and connection.
Goal 4: Address upstream risk factors and social determinants of health to prevent suicide and promote resilience.	
Objective 4.1	Identify the community strengths and gaps that can inform planning at the individual, relationship, community, and societal levels.
Objective 4.2	Strengthen job and economic supports, especially among groups of people most affected by suicide and overdose.
Objective 4.3	Promote safe, stable, and nurturing relationships and environments to help prevent adverse childhood experiences and create positive childhood experiences.
Objective 4.4	Develop and put into practice effective substance harm reduction and prevention programs, practices, and policies that can help reduce suicide risk.
Objective 4.5	Offer interventions that address the intersection of suicide, substance use, and adverse childhood experiences.
Objective 4.6	Put into practice initiatives that address the mental health consequences of racism, discrimination, and historical trauma. These initiatives should focus on building resilience and promoting healing among communities of color, LGBTQIA2S+ people, and AI/AN people.
Objective 4.7	Include strategies to prevent intimate partner violence and sexual abuse, and support survivors with comprehensive suicide prevention efforts.
Objective 4.8	Create and use upstream interventions to create safe, supportive school environments and promote healthy peer relationships.

Objective 4.9	Support initiatives to improve school quality, increase high school graduation rates, and expand access to higher education and vocational training, particularly in underserved communities.
Objective 4.10	Put into practice upstream strategies that reduce incarceration, support successful re-entry, and address the mental health needs of carceral-involved groups.
Objective 4.11	Develop and put into practice upstream interventions to prevent homelessness, improve access to affordable housing, and provide supportive services for those experiencing housing instability.
Objective 4.12	Create and use programs that promote healthy social media use and digital well-being among youth, families, schools, and other youth-serving organizations.

Prevention in Action:
Lambert House

Lambert House was established in 1981 as the first 501c(3) house using social support to improve physical and mental health outcomes for LGBTQIA2S+ youth. Brandon Knox, the current Program Director, says: "LGBTQIA2S+ youth are at higher risk of suicide ideation and death by suicide. They experience higher levels of isolation and loneliness, powered by animus towards their identity from their family and community. In our program, LGBTQIA2S+ adults and allies act as role models, creating a safe place for youth to go when things aren't going well."

The Trevor Project has data supporting this, showing that an LGBTQIA2S+ youth who has even one supportive adult in their life has a 40% lower likelihood of attempting suicide.[1]

Over the decades, Lambert House has worked out a successful suicide prevention protocol for youth. They work further upstream from people in immediate crisis. Their protocol focuses on prevention or trying to reach people before the crisis point. They believe it's better to prevent the crisis than to intervene. Lambert House gets many referrals from doctors who view the organization's community work as complementary to their clinical work.

Lambert House has recently expanded on their existing program to teach youth awareness of social and emotional intelligence. This helps youth better determine how they are doing and feeling, which can help improve their mental health.

Ultimately, Knox feels "that the way we do suicide prevention hasn't changed in decades. Use social support to help youth feel less isolated and alone, an antidote to the things that drive those feelings."

[1] The Trevor Project Research Brief: Accepting Adults Reduce Suicide Attempts Among LGBTQ Youth, retrieved July 28, 2024 from **https://www.thetrevorproject.org/wp-content/uploads/2019/06/Trevor-Project-Accepting-Adult-Research-Brief_June-2019.pdf**

2 STRATEGIC DIRECTION 2
Multi-Sector Suicide Prevention

Suicide prevention requires a comprehensive, coordinated approach that engages all sectors of society. No single organization or agency can address this complex issue alone. This strategic direction focuses on fostering collaboration across many sectors and using evidence-based strategies to create a safety net of prevention, intervention, and postvention supports.

Over the past several years, more and more people have recognized that suicide prevention efforts must extend beyond physical health, mental health, and behavioral health care settings to reach people where they live, work, learn, and spend their time. Schools, workplaces, faith communities, social services, first responders, and other community organizations all have important roles to play in identifying and supporting people at risk of suicide.

This strategic direction builds on these advances by emphasizing the need for sustainable infrastructure, diverse partnerships, and the use of comprehensive strategies across sectors. It recognizes that effective suicide prevention requires "upstream" approaches that promote mental health and resilience, as well as "downstream" intervention and crisis response capabilities.

The goals and objectives in this section aim to:

- Help different sectors work together more effectively
- Expand evidence-based programming in community settings
- Enhance workforce capacity
- Create supportive environments that reduce suicide risk

By working together across sectors, we can weave a stronger safety net to catch people before they reach a point of crisis and provide compassionate, effective support to everyone who needs help.

Goal 1: Make health equity part of all multi-sector suicide prevention activities.	
Objective 1.1	Improve multi-sector suicide prevention by including perspectives and recommendations from groups most affected by suicide and people with lived experience of suicide.
Objective 1.2	Make sure all suicide prevention activities and efforts consider age, race, ethnicity, language, faith, sexual orientation, gender identity, disability, chronic conditions, insurance status, access to resources, and geographical location.
Objective 1.3	Fund and expand effective multi-sector suicide prevention activities led by communities and peers.
Objective 1.4	Involve public and private organizations in suicide prevention activities.
Goal 2: Develop and put into practice multi-sector suicide prevention strategies for groups most affected by suicide, especially historically marginalized communities and people with lived experience.	
Objective 2.1	Align suicide prevention activities that address the increasing rate of suicide thoughts, attempts, and deaths within racial, ethnic, and historically marginalized groups of all ages.
Objective 2.2	Increase awareness and understanding of the unique barriers and challenges of people most affected by suicide in all suicide prevention work.
Objective 2.3	Improve and expand prevention programs, practices, policies, and systems that both include and support people most affected by suicide.
Objective 2.4	Improve and expand ongoing staff training and development for people who work in communities most affected by suicide.

Goal 3: **Improve safety measures and responsible practices to protect people when they are at higher risk of suicide.**	
Objective 3.1	Educate community members on how to safely store and handle firearms, medications, poisons, and other potentially dangerous items at home, work, and in the community. Focus on helping people create safer environments during crisis periods.
Objective 3.2	Create policies, programs, and practices that give people time and space for support when they are at high risk of suicide. Ensure these measures are culturally sensitive and effective for all communities, including historically marginalized groups.
Objective 3.3	Work with firearm organizations to include suicide awareness and prevention in firearm safety and responsible ownership teachings.
Objective 3.4	Develop effective substance use prevention and harm reduction programs, practices, and policies to help reduce suicide risk for individuals and communities.
Goal 4: **Provide support after suicide events and help people who have personal experience with suicide.**	
Objective 4.1	Offer community-based care and support options to people who have lost a loved one to death by suicide.
Objective 4.2	Offer community-based care and support options to people who have survived a suicide attempt or have thoughts of suicide.
Objective 4.3	Include survivors in creating, using, and evaluating guidelines and protocols for suicide survivor support groups, programs, and policies.
Objective 4.4	Prevent suicide clusters by offering community-tailored support and guidance after a suicide death.
Objective 4.5	Support suicide prevention and overall health among people who deal with suicide-related trauma. This includes first responders, health care providers, and crisis workers.

Goal 5: Make suicide prevention part of workplace culture and other community settings.	
Objective 5.1	Make suicide prevention part of workplace values, policies, culture, and leadership at all levels.
Objective 5.2	Create, use, and evaluate organizational programs, practices, and policies that support worker well-being and suicide prevention.
Objective 5.3	Create, use, and evaluate effective programs, practices, and policies in suicide prevention and crisis response in settings where people live, work, learn, play, and worship. Make sure that all staff have ongoing training and development in these programs and practices.
Objective 5.4	Train community members, organizations, and civic groups to recognize and help people who may be having thoughts of suicide or experiencing a mental health crisis.
Objective 5.5	Work with public and private organizations to create, use, and evaluate best practices and policies to support safer digital technology use and social media use, especially among youth and young adults.
Goal 6: Build and sustain suicide prevention infrastructure at the state, Tribal, and local levels.	
Objective 6.1	Create and maintain core staff positions across state, Tribal, and local levels to build and sustain comprehensive suicide prevention programming. This includes hiring people with lived experience of suicide and people who represent the diversity of communities they serve.
Objective 6.2	Train staff across state, Tribal, and local levels on comprehensive suicide prevention, including: ■ Building partnerships ■ Using data to make decisions ■ Choosing and evaluating prevention strategies ■ Developing communication activities
Objective 6.3	Set up and maintain public and private funding sources for putting suicide prevention programs into practice and evaluating them.
Objective 6.4	Create, use, evaluate, and update data-informed plans that reflect a comprehensive approach to suicide prevention.

Goal 7: **Build an equity-focused treatment and crisis workforce that's well-prepared and supported to meet the needs of the communities they serve.**	
Objective 7.1	Provide more training and support for professionals and graduate students to improve cultural humility and responsiveness toward historically marginalized groups and people with lived experience.
Objective 7.2	Offer equity awareness education in health care settings and train health care professionals in ways to address existing barriers and reduce stigma.
Objective 7.3	Expand opportunities for more suicide prevention professionals who have lived experience of self-harm or suicide or come from historically systemically oppressed communities and groups most affected by suicide.
Objective 7.4	Create professional standards around suicide prevention, intervention, and postvention and make sure these standards meet the unique needs of groups most affected by suicide.
Goal 8: **Create effective, wide-ranging, collaborative, and sustainable suicide prevention partnerships.**	
Objective 8.1	Create and maintain public-private partnerships and coalitions at the state, Tribal, and local levels.
Objective 8.2	Create and maintain connections between state agencies, Tribal nations, and local communities to expand comprehensive suicide prevention activities and strengthen results.
Objective 8.3	Strengthen and maintain collaborations across state agencies to advance suicide prevention by using each agency's unique expertise, data, programs, and resources.
Objective 8.4	Set up a statewide suicide prevention network of practitioners, policymakers, researchers, and other partners that meets regularly to: ■ Share best practices ■ Discuss new trends ■ Examine data ■ Build partnerships ■ Promote proven suicide prevention strategies

Goal 9: Use communication best practices to create research-informed suicide prevention messaging that works for all communities.	
Objective 9.1	Communicate the latest suicide-related data and trends with different audiences in a safe, easy-to-understand way. Use these data to guide public health action.
Objective 9.2	Help more people recognize suicide warning signs. Spread the message that suicide can be prevented and talk about the many factors that can increase or decrease suicide risk at the individual, relationship, community, and societal levels.
Objective 9.3	Work with people who have lived experience with suicide to create, use, and evaluate effective, tailored messages that encourage help-seeking and supporting people who have thoughts of suicide or are in a mental health crisis.
Objective 9.4	Share stories of help, hope, and healing by using safe messaging strategies. (See page 44.)
Objective 9.5	Work with youth and young adults to create, use, and evaluate communication that engages them on social media and other digital platforms.
Objective 9.6	Work with technology companies, mental health professionals, and youth partners to develop and use strategies that promote digital literacy, encourage safe online behavior, and improve access to online mental health resources for youth and young adults.
Objective 9.7	Work with news media, the entertainment industry, and journalism schools to encourage positive mental health coping skills and safe, accurate, and responsible reporting about suicide.
Objective 9.8	Increase awareness of 988 and other crisis services with communications that promote health equity and cultural sensitivity.

Prevention in Action:
The Governor's Challenge to End Veteran Suicide

In January 2020, Washington state embarked on a crucial mission to protect those who have served our country. Governor Jay Inslee accepted the Governor's Challenge to End Veteran Suicide, launching a comprehensive effort to address suicide deaths among veterans.

The Governor's Challenge isn't just another government program. This united front brings together government agencies, nonprofit organizations, professional associations, medical and mental health experts, and Tribal members. This diverse coalition works to implement the Service Members, Veterans, and Families (SMVF) Suicide Prevention Strategic Plan. Members combine their expertise and resources to tackle this critical issue from every angle.

The Governor's Challenge partners have organized their efforts into three focused groups. The first group concentrates on identifying at-risk service members, veterans, and families through initiatives like "Ask the Question" and developing LEARN (Listen, Empathize, Assess, Respect, Next steps) trainings. They're also creating a comprehensive provider toolkit and working to combat stigmas associated with seeking help.

The second group focuses on promoting connectedness and improving transitions through peer support. They engage with Onward Ops, a veteran support organization, and reach out to all branches of military service to ensure veterans have a support network during critical life transitions.

The third group is dedicated to increasing lethal means safety and safety planning. They're expanding available safety tools, educating communities on secure weapon storage and transfer, and developing comprehensive safety plans for people with the greatest risk of suicide.

While reducing suicide rates among service members, veterans, and their families is a primary goal, the Governor's Challenge aims higher. The ultimate mission is to empower people and their communities with tools and resources to prevent suicide altogether. By fostering a culture of support, awareness, and proactive intervention, Washington state is working to create a future where every veteran feels valued, supported, and hopeful.

Through the Governor's Challenge, Washington is sending a clear message: Every life is worth saving, and together we can make a difference in the lives of those who have sacrificed so much for our country.

3 STRATEGIC DIRECTION 3
Treatment and Crisis Services

The 2016 Washington Suicide Prevention Plan called for a systematic approach to suicide care in health systems. In the years since, research has demonstrated that health care services can help decrease rates of suicide thoughts, attempts, and deaths (Ahmedani & Vannoy, 2014). This research has also helped identify groups at increased risk for suicide in health care settings and when they have the highest risk (National Action Alliance for Suicide Prevention, 2019).

Over the last several years, suicide care in Washington's health systems has significantly improved in identifying and treating suicide risk before and after a mental health crisis. Washington has also made major progress in building a crisis continuum that helps people get suicide care through mobile crisis teams, crisis stabilization centers, emergency departments, and the 988 Suicide & Crisis Lifeline. These efforts ensure timely access to mental health services and transition support during a mental health crisis.

The COVID-19 pandemic spurred increased use of telehealth services, which helped more people at risk of suicide get better access to mental health care and crisis services. Focused efforts have also been made to ensure 988 Suicide & Crisis Lifeline services are accessible for diverse populations, including individuals who are deaf or hard of hearing. In addition, the 988 Suicide & Crisis Lifeline has expanded its services to reach more people in need by offering helplines for veterans, people who speak Spanish, and LGBTQIA2S+ youth. In Washington, the 988 Lifeline includes the Native & Strong Lifeline, which supports AI/AN people who call from a Washington area code. Deaf and hard of hearing people can visit the 988 Lifeline website to get crisis support in American Sign Language over videophone. The 988 Lifeline also offers support via text/chat messages.

Crisis intervention systems in Washington provide a continuum of timely and effective support in the community. These systems benefit from strong partnerships with mental and behavioral health and emergency services. Our state's approach to crisis care emphasizes trauma-informed practices and culturally responsive approaches, like mobile crisis outreach, to limit forced or invasive interventions.

The goals and objectives in this section aim to:

- Improve the quality and accessibility of crisis care services
- Integrate suicide prevention as a core component of health care
- Enhance the capacity and diversity of the suicide prevention workforce
- Ensure equitable access to culturally responsive care
- Strengthen coordination between crisis services and other health care providers

In Washington, we strive for treatment and crisis services to operate as cohesive, responsive, and effective systems of care. This integrated approach helps make sure that people who have a high suicide risk get timely and responsive care that respects their dignity and individual autonomy. Goals 3, 4, and 5 address coordination with community and emergency services and make suicide prevention clinical services part of the health care system. Together, these goals create a framework for people in Washington to seek and receive effective and comprehensive support when and where they need it. Strategic Direction 3 aims to accelerate early intervention with timely access to effective care to address suicide risk before it turns into a suicide attempt or death.

Goal 1: **Embed health equity into all treatment and crisis services.**	
Objective 1.1	Improve crisis response and treatment by including perspectives and recommendations from groups most affected by suicide and people with lived experience.
Objective 1.2	Make all treatment and crisis services equitable by considering and including demographic information, like a person's age, race, ethnicity, sexual orientation, gender identity, disability, chronic conditions, and geographical location service delivery.
Objective 1.3	Fund and increase effective community, peer, and youth-led treatment and crisis services and initiatives.
Objective 1.4	Engage public and private sector partners in treatment and crisis services.

Goal 2: Improve treatment and support services for groups most affected by suicide, focusing on historically marginalized communities, people with lived experience, and youth.	
Objective 2.1	Build understanding of the unique barriers and challenges of people most affected by suicide in all treatment and support services.
Objective 2.2	Work with people most affected by suicide to increase, improve, and expand treatment and support programs, practices, policies, and systems that support their needs.
Objective 2.3	Improve and expand ongoing staff training and development for people who work in communities most affected by suicide.
Goal 3: Improve the quality and accessibility of crisis care services across all communities.	
Objective 3.1	Create and maintain a robust crisis care system through ongoing quality improvement to help people at risk of suicide.
Objective 3.2	Increase local collaboration and coordination between 988 Lifeline crisis centers and 911 Public Safety Answering Points; police, fire, and emergency medical services; and mental and behavioral health crisis services.
Objective 3.3	Expand effective mobile crisis teams, peer-led crisis services, and diversion programs to prevent unnecessary police interventions with people who call 988 or 911 for thoughts of suicide.
Objective 3.4	Increase timely access to assessment, intervention, lethal means safety counseling, and follow-up for people at risk of suicide.
Objective 3.5	Embed crisis services in the health care system.
Objective 3.6	Ensure crisis services are effectively provided to everyone including people with substance use disorders and that Crisis services counselors receive training to support people with substance use disorder.
Objective 3.7	Ensure crisis services can link people to ongoing sources of social support in their community after the crisis is resolved.

Goal 4: Include effective crisis response addresses as a core component of health care.	
Objective 4.1	Create and offer effective services to identify, engage, treat, and follow up with people at risk of suicide as standard care in public and private health care delivery.
Objective 4.2	Create and use effective standard health care protocols to identify, engage, treat, and follow up with people who have a high suicide risk.
Objective 4.3	Address barriers to providing effective emergency department screening, safety planning, and follow-up after discharge in all emergency departments.
Objective 4.4	Increase care for people with suicide risk when they transition between different health care settings and providers, especially crisis, emergency, and hospital settings, and between health care and the community.
Objective 4.5	Provide ongoing education and training in suicide prevention for all health care professionals so they can provide quality, effective suicide prevention services.
Objective 4.6	Incentivize and enable health care organizations to track suicide thoughts, attempts, and deaths in their patient populations to inform continuous quality improvement efforts.
Objective 4.7	Increase the use of electronic Health records to track and support the implementation of best practices for suicide prevention. Leverage these health records to achieve better communication across systems so we are catching people earlier and not losing them across the continuum of care.
Objective 4.8	Develop and use effective health care practice strategies that encourage safe and secure storage of lethal means, especially for people with a higher risk of suicide.
Objective 4.9	Make sure that crisis response addresses address co-occurring substance use disorders.

Goal 5: **Create an equitable and diverse treatment and crisis workforce that is equipped and supported to address the needs of the communities they serve.**	
Objective 5.1	Increase access to training and technical support for first responders and health care providers to improve cultural humility and responsiveness toward historically systemically oppressed groups and people with lived experience.
Objective 5.2	Support first responders and health care professionals in completing equity education to reduce stigma and address barriers to accessing health care services.
Objective 5.3	Work with partner organizations to improve HR and recruiting practices to diversify the pool of candidates who are working in the first responder field, providing more opportunities for first responders from systemically oppressed backgrounds.
Objective 5.4	Create professional standards around suicide prevention, intervention, and postvention that prioritize the needs of people most affected by suicide.
Objective 5.5	Make sure that crisis support and response strategies for historically systemically oppressed groups are grounded in cultural humility and inclusivity.

Prevention in Action:
Apoyo de "Women in Action" (Women in Action Support Group)

El grupo de apoyo "Women in Action" en el Valle de Walla Walla ejemplifica el poder de la unidad entre las mujeres, particularmente en la superación de barreras significativas para acceder a la atención de la salud mental y del comportamiento. Dirigido por Maria Remington, este grupo aborda retos como el apoyo a la salud mental, las barreras lingüísticas y la falta de seguro en la atención sanitaria, así como las limitaciones financieras a las que se enfrentan muchas mujeres de la comunidad agrícola.

Al unirse, estas mujeres han formado una sólida red de apoyo a lo largo de dos años, empoderándose mutuamente y descubriendo programas para ayudar a sus familias. Esta iniciativa pone de relieve la importancia de la solidaridad. Proporciona apoyo emocional y práctico y fomenta un sentimiento de empoderamiento y resiliencia comunitaria. Gracias a sus esfuerzos colectivos, estas mujeres están transformando sus vidas y abogando por un mejor acceso a servicios sanitarios esenciales, lo que demuestra el profundo impacto de la unidad y el apoyo mutuo.

« Empecé con la misión de facilitar el acceso a los servicios de salud mental a las personas desatendidas e ignoradas. Invité a un grupo de mujeres que comparten mis luchas y mis sueños a formar un espacio seguro para empoderarse y defenderse mutuamente. Estoy encontrando esperanza y solidaridad en este grupo, ya que nuestro objetivo es hacer frente a las disparidades económicas y crear un espacio para la conexión, el aprendizaje y el crecimiento para que podamos apoyarnos mutuamente y abogar por un futuro más inclusivo y equitativo.»

- Maria Remington

The Women in Action support group in the Walla Walla Valley exemplifies the power of unity among women, particularly in overcoming significant barriers to accessing mental and behavioral health care. Led by Maria Remington, this group addresses challenges such as mental health support, language barriers and lack of insurance in health care, and financial constraints that many women in the agricultural community face.

By coming together, these women have formed a robust support network over two years, empowering each other and discovering programs to aid their families. This initiative highlights the importance of solidarity. It provides emotional and practical support and fosters a sense of empowerment and community resilience. Through their collective efforts, these women are transforming their lives and advocating for better access to essential health services, demonstrating the profound impact of unity and mutual support.

" I started on a mission to provide access to mental health services for those who were underserved and overlooked. I invited a group of women who share my struggles and my dreams to form a safe space to empower and advocate for each other. I am finding hope and solidarity in this group, as we aim to address the economic disparities and create space for connection, learning, and growth so we can uplift each other and advocate for a more inclusive and equitable future."

- Maria Remington

4 STRATEGIC DIRECTION 4
Data Collection, Quality Improvement, and Research

Effective suicide prevention relies on a strong foundation of data, continuous quality improvement, and ongoing research. This strategic direction focuses on two main areas: enhancing our ability to understand, track, and respond to suicide trends and developing and refining evidence-based interventions and culturally informed approaches. By improving the quality, timeliness, and accessibility of suicide-related data, we can better inform prevention efforts and measure their impact.

Significant advancements in data collection, research methodologies, and data analysis techniques have moved the field forward in the last several years. However, it is still difficult to capture comprehensive and timely data, particularly for groups most affected by suicide. This strategic direction builds on recent advances by promoting new approaches to data collection, analysis, and application. It emphasizes the need for timely, actionable, and culturally informed data to drive decision-making and ongoing quality improvement in suicide prevention efforts.

The goals and objectives in this section aim to:

- Improve the quality and accessibility of suicide-related data
- Promote rigorous evaluation of prevention strategies
- Advance the science of suicide prevention
- Make sure research findings are effectively translated into practice

We also want to give special attention to addressing disparities in data collection and research to make sure our understanding of suicide risk and prevention includes people from all communities.

This approach recognizes that effective suicide prevention requires ongoing learning and adaptation. By fostering a culture of data-driven decision-making and continuous improvement, we can enhance the effectiveness of our prevention efforts and ultimately save more lives. Our approach also emphasizes the importance of collaboration between researchers, practitioners, policymakers, communities, and people with lived experience to make sure our research and data collection efforts are relevant, ethical, and effective.

Goal 1: **Make health equity part of all data collection, quality improvement, and research activities.**	
Objective 1.1	Improve data collection and research by including perspectives and recommendations from people with lived experience of suicide and groups most affected by suicide.
Objective 1.2	Make sure that all data collection, quality improvement, and research considers demographic information like age, race, ethnicity, sexual orientation, gender identity, disability, chronic conditions, and geographical location.
Objective 1.3	Fund and increase effective data collection, quality improvement, and research by communities and peers.
Objective 1.4	Engage public and private organizations in data collection, quality improvement, and research.
Goal 2: **Improve suicide-related data collection, research, evaluation, and quality improvement.**	
Objective 2.1	Improve the quality, timeliness, scope, usefulness, and accessibility of suicide death data, suicide-related thoughts and behaviors, and associated risk and protective factors.
Objective 2.2	Identify and validate new data and methods for suicide-related data collection, research, evaluation, and quality improvement.
Objective 2.3	Integrate data on adverse outcomes like unintentional overdoses and other unintentional injuries with data on suicide thoughts, attempts, and deaths.
Objective 2.4	Modernize data systems and infrastructure.
Objective 2.5	Build staff capacity in data collection and analysis and program and policy evaluation across state, Tribal, and local levels.
Objective 2.6	Define a set of indicators by which the impact of the state plan can be evaluated.
Objective 2.7	Identify and validate data and research methods related to the reduction of access to lethal means of harm.
Objective 2.8	Strengthen the measurement of social connection and loneliness indicators in suicide data systems and population health surveys.

Goal 3: Support more research on suicide and suicide prevention.	
Objective 3.1	Identify and pursue research opportunities, relevant findings, new data and methods, and changes in the epidemiology of suicide in the United States.
Objective 3.2	Learn more about groups most affected by suicide, their prevention and treatment opportunities, and health care and other public health policies, to reduce risk.
Objective 3.3	Learn more about the effects of social media use and digital technology on mental health, especially among youth, and identify opportunities to expand benefits and reduce harms.
Objective 3.4	Learn more about the connection between substance use disorder and suicide risk to improve prevention and treatment of these co-occurring conditions.
Objective 3.5	Learn more about suicide prevention peer support services that make people feel more capable and engaged in their recovery.
Objective 3.6	Where research has identified better practices, make them widely available to everyone.
Objective 3.7	Fund research on community-level and culturally informed interventions that increase social connections and reduce isolation and loneliness.
Objective 3.8	Develop research priorities and prevention strategies tailored to communities most affected by suicide.
Objective 3.9	Support Indigenous-led research frameworks, evaluation approaches, and traditional practices.

Goal 4: **Use what we learn to create better suicide prevention programs for all ages and for groups most affected by suicide.**	
Objective 4.1	Increase funding for research and evaluation of effective suicide prevention activities for communities most affected by suicide.
Objective 4.2	Evaluate and share specific and culturally informed approaches, models, and screening tools in different communities and contexts.
Objective 4.3	Make sure suicide-related data considers disparities and the unique challenges faced by groups most affected by suicide.
Objective 4.4	Support new ideas and community-based solutions for preventing suicide in historically marginalized groups through funding, resource provision, and prioritization practices.
Objective 4.5	Improve how we use and share data across communities and organizations to improve suicide prevention in historically systemically oppressed groups and groups most affected by suicide.
Objective 4.6	Consider the social determinants of health and systemic barriers that contribute to isolation and loneliness in groups most affected by suicide.

Prevention in Action:
Veteran's Challenge Coins

In the spring of 2022, the Sun Rise Rotary Club in Lewiston, Idaho, proposed creating a Challenge Coin that would specifically resonate with veterans. After deliberation, the group decided that a Suicide Awareness Challenge Coin would be the most impactful.

This group of veterans met for several weeks and designed the coin. To date, more than 5,000 coins have been distributed. Many veterans have said that the coin has had a tremendous positive impact on their lives. Coins also come with a small, laminated information card that lists local resources for veterans.

Coins are distributed peer-to-peer, to any veteran at no charge. Coins are handed out to veterans with one request: If you meet or see a veteran who is depressed, unhappy, or alone, give them the coin. This important connection creates a conversation between two veterans, and the veteran receiving the coin can call or text the VA number on the coin to get help.

For many veterans, this contact and conversation is the first step in dealing with memories or trauma. Many people have reported that after they gave a coin to a family member or friend, the recipient decided to call and get help.

> **" Is it the coin or the veteran-to-veteran contact? It doesn't matter. If a veteran calls for help instead of attempting suicide, it's a success."**
>
> **Chuck Whitman,** Asotin County Commissioner

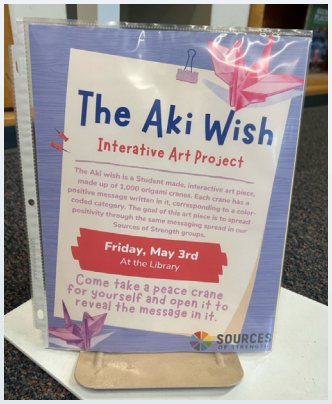
The Coin is not trademarked. Information is available through the Clarkston, WA VFW at 829 15th Street Clarkston, WA 99403. Call 509-758-4219 extension 1 or 208-791-4674.

Prevention in Action:
Sources of Strength — Aki Kurose Middle School

The **Sources of Strength Secondary Program** is a best-practice, evidence-based youth suicide prevention program designed to harness the power of peer social networks to change unhealthy norms and culture. Sources of Strength fosters relational connection and belonging through play, strengths-based storytelling, and strategic messaging campaigns to invite people to discover and share their own stories of strength.

Since 2019, the Washington State Department of Health (DOH) has partnered with Sources of Strength (Sources) to provide Washington communities (school or community-based youth-serving organizations) the opportunity to implement Sources.

The program trains adult advisors, but also involves peer leaders to enhance protective factors associated with reducing suicide at the school/community level. Funding is available for 14 to 19 sites per year including middle schools, high schools, Tribal organizations, and youth-serving community-based programs statewide. In the spring of 2023, Tribal Training for Trainers was provided to interested Tribal organizations.



Sources is a celebrated part of the community at Aki Kurose Middle School in Seattle's Rainier Valley. First implemented in 2022, enrollment has grown, creating two cohorts of student leaders. Aki Kurose serves over 800 students in 6th, 7th, and 8th grades, with over 65% identified as low income, 30% as English language learners, and 16% with disabilities. Approximately 30% of Aki's population identify as Black or African American, 25% as Asian, and close to 20% as Hispanic or Latinx, reflecting the diverse community of Southeast Seattle.

Rinn Ramcke, the school's Clinical Care Coordinator, believes that the best part of the program is the emphasis on leadership opportunities for students to serve the communities they live in. Student groups create projects that have included art installations, interviews with community mentors, and social media campaigns, all emphasizing their student-driven, community-centered approach to building resilience and promoting mental health awareness.

Conclusion

Suicide is a serious public health issue that has far-reaching consequences for people, families, and communities across Washington. The development of this comprehensive suicide prevention plan represents a crucial step forward in our efforts to reduce suicide rates, promote mental health and well-being, and create a safer and more compassionate Washington for all.

This plan is grounded in a deep understanding of the complex factors that contribute to suicide risk, including individual, interpersonal, community, and societal influences. By addressing these factors through a multi-level, equity-focused approach, we can create a more effective and sustainable prevention strategy that reaches all Washingtonians, particularly those who have been historically systemically oppressed or underserved.

A Call to Action

Preventing suicide is a shared responsibility that requires the active engagement and commitment of all Washingtonians. This plan serves as a call to action for people, families, communities, organizations, and policymakers across the state to join in the fight against suicide.

We all play a role in preventing suicide.

- Each one of us can prioritize our own mental health by doing something we're good at each day, seeking help when needed, and supporting others experiencing challenges or crises.
- Families can encourage open communication, promote resilience, and create safe and supportive home environments.
- Communities can break down stigma, promote social connectedness, and make sure everyone can get access to culturally responsive mental health resources.
- Health care providers can integrate suicide prevention into their practices, provide trauma-informed care, and collaborate with other service providers.
- Educators can promote mental health literacy, use evidence-based prevention programs, and create supportive school climates.
- Employers can prioritize employee well-being, provide mental health resources, and create a culture of support and inclusion.
- Policymakers can prioritize funding for suicide prevention, enact policies that promote health equity, and support research and evaluation efforts.

By working together across sectors and communities, we can create a comprehensive safety net that catches people long before they begin to have thoughts of suicide or reach a point of crisis.

Achieving Our Vision

The goal of this plan is to create a Washington, where every person can thrive and live a fulfilling life. We believe we can achieve this goal with ongoing, collaborative efforts that prioritize prevention and early intervention, along with accessible, culturally responsive care.

In a suicide-free Washington:

- Mental health is recognized as a fundamental component of overall health and well-being.
- People feel empowered to seek help without fear of stigma or discrimination.
- Communities have the knowledge, skills, and resources to support mental health and prevent suicide.
- Health care systems provide integrated, evidence-informed care that addresses both physical and mental health needs.
- Public policies and funding priorities reflect a commitment to suicide prevention and health equity.

By working towards this vision, we can create a future where no person, family, or community must bear the devastating loss of a loved one to suicide.

The release of this updated plan marks an important milestone in our state's efforts to prevent suicide, but it is only one guidepost along our journey. Achieving our vision of a suicide-free Washington will require ongoing commitment, collaboration, and innovation from all partners.

As we move forward with implementing the strategies and recommendations outlined in this plan, we must remain adaptable, responsive, and accountable. This includes:

- Building ongoing partnerships and collaborations to maximize resources, share knowledge, and coordinate our responses.
- Regularly reviewing and updating the plan based on new research, best practices, and community feedback or insights.
- Establishing clear metrics and benchmarks to track progress and evaluate the effectiveness of our prevention efforts.
- Prioritizing sustainable funding and resources to support the long-term success of our prevention efforts.

By embracing this plan as a living document and a shared roadmap for change, we can continue to make progress towards our goal of preventing suicide and promoting mental health for all Washingtonians.

Prevention in Action:
Seattle Children's Hospital Suicide Prevention Program

Suicide is the second leading cause of death for youth ages 10 to 24. In this age group, death by suicide is more common than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and lung disease combined. Research shows that 77% of youth who die by suicide had a health care contact in the last year, with 38% having had health care contact a month before their death.

Seattle Children's Suicide Prevention Program is an organization-wide effort to save lives by identifying and treating youth who are thinking about suicide. This organization prioritizes addressing this public health crisis and achieving the aspirational goal of zero suicides by implementing the Zero Suicide framework. With the support of generous donors, Seattle Children's launched the Zero Suicide Initiative Pathway in 2019 to bring suicide risk screening to medical clinics. In 2022, Seattle Children's and 16 other children's hospitals and health systems agreed to implementing the full Zero Suicide framework as part of a national collaborative funded by Cardinal Health Foundation. They aim to develop and implement a pediatric-specific, data-driven approach to improve the identification and care of children at risk for suicide in children's hospitals and health systems.

Dr. Molly Adrian PhD, Suicide Prevention Program faculty leader and Clinical Standard Work Zero Suicide Pathway co-sponsor, shared, "We are grateful to work in a system with passionate staff who see suicide prevention as part of their care of the whole health of a child. We are eager to continue our improvements and make information and resources about best suicide prevention practices easily accessible and embedded in the workflows that providers and staff use each day, to ensure the safest care possible."

The Suicide Prevention Program continues to work toward a standardized, evidence-based approach to treating youth at risk for suicide. This approach includes a suicide pathway to care, a series of guided steps to ensure high-quality care for every patient, and input from those with lived experience related to suicide through the creation of a Suicide Prevention Advisory board. We are in the process of developing a suicide care patient registry that would track each patient on the suicide pathway to care. This registry will help increase support and monitoring of patients during high-risk care transitions.

Seattle Children's Suicide Prevention Program and their Community Health Team work with local partners to advance suicide prevention efforts across Washington. Their initiatives focus on reducing access to lethal means, such as through safe firearm storage programs and safe medicine storage and disposal. They also work to promote mental health through resources like Youth Mental Health First Aid classes and community education for suicide prevention.

In an effort to educate parents and the community about the importance of suicide screening, the Seattle Children's Suicide Prevention Program partnered with an advertising agency, Little Hands of Stone, to create a PSA encouraging caregivers to ask kids about suicide. Available in both English and Spanish, the PSA is being shared via broadcast television, streaming video, and radio. It refers viewers to **seattlechildrens.org/mental-health-resources** for warning signs, resources, and ways to prevent suicide.

Appendices

Appendix A: Glossary

Adverse childhood experiences (ACEs): Potentially traumatic events that occur in a child's formative years (0–17), which could include experiencing violence, abuse, neglect, or growing up in an environment that undermines a child's sense of safety, stability, and bonding (CDC, 2023).

Affected by suicide: All individuals who may feel the impact of suicidal thoughts and attempts, including those bereaved by suicide, as well as community members and others.

Behavioral health: Prevention and service systems encompassing the promotion of emotional health and mental well-being; the prevention of mental and substance use disorders, substance use, suicide, and related problems; treatments and services for mental and substance use disorders; and recovery support. Behavioral health problems include substance use, serious psychological distress, suicide, mental disorders, and substance use disorders and overdose. The term also refers to a state of mental and/or emotional being and/or choices and actions that affect wellness.

Best practices: Activities or programs aligned with the best available evidence regarding what is effective.

Carceral: Related to the prison or correctional system.

Comprehensive approach to suicide prevention: An approach that brings together 1) prevention efforts to reduce the likelihood that community members will become suicidal, 2) responsive intervention and crisis supports for individuals who experience thoughts of suicide or make a suicide attempt, 3) quality effective treatment and recovery services that directly address suicide, and 4) postvention strategies for individuals and communities after a crisis or loss to suicide (CDC, 2022c).

Continuity of care: Process of ensuring ongoing care delivery and care coordination across providers and care teams.

Coping and problem-solving skills: Skills for emotional regulation in response to stressful life events, conflict resolution, and critical thinking (CDC, 2022).

Crisis care: Crisis services that provide intervention by trained professionals and paraprofessionals at the point of behavioral health crisis. Consumers access crisis services to seek assistance with a range of medical and nonmedical situations and to address a variety of behavioral health symptoms. Literature suggests that crisis service systems should include, at minimum, a crisis hotline, mobile response teams, and crisis receiving and stabilization centers (SAMHSA, 2020).

Crisis care continuum: Evidence-informed crisis services available to those experiencing a suicidal, mental, or behavioral health crisis, traditionally includes crisis call centers, mobile crisis teams, and crisis stabilization facilities.

Cultural humility: A lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but also starts with an examination of their own beliefs and cultural identities.

Culturally responsive: A practice that acknowledges background and cultural differences to make adaptations tailored to meet an individual's needs (CDC, 2020).

Downstream prevention: Intervention efforts that reduce the impact of suicide, suicide attempts, and other mental health crises after they have occurred while promoting dignity and empowerment for all impacted. See contrast with upstream prevention.

Economic supports: Household financial security in the form of livable wages, access to affordable and quality childcare services, insurance, and stable housing, as well as unemployment benefits and other temporary assistance.

Equity: Equity is achieved when it is recognized that each person (or group of people) has different circumstances, and resources are allocated accordingly to reach an equal outcome. (CDC, 2022)

Health disparities: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

Health equity: The state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities.

Intersectionality: The interconnected nature of social categorizations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

Intergenerational trauma: The concept that the experience and impact of trauma can be passed down through families, affecting individuals and communities across generations (Administration for Children and Families, n.d.).

Lethal means: Objects, substances, or places someone may use to attempt suicide (SPRC, 2020).

Lived experience: Personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people.

Peer support: Services provided by peer support workers may include emotional (e.g., mentoring), informational (e.g., parenting classes), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support (SAMHSA, 2023g; SAMHSA, 2023f).

Positive childhood experiences (PCEs): Experiences in which children feel safe in their families to talk about emotions and things that are hard and feeling supported during hard times (Bethell et al., 2019).

Postvention: Policies, programs, practices, and supports implemented in the aftermath of a suicide loss, attempt, or crisis intended to reduce further risk for suicide.

Protective factors: Individual, relationship, community, and environmental elements that make a negative outcome less likely.

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

Risk factors: Individual, relationship, community, and environmental elements that make a negative outcome more likely.

Social connectedness: The degree to which people have and perceive a desired number, quality, and diversity of relationships that create a sense of belonging, and being cared for, valued, and supported. (CDC, 2023).

Social determinants of health: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These can include factors such as economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

Substance use disorder (SUD): A health condition characterized by a cluster of cognitive, behavioral, and physiological symptoms that describe an individual's compulsive use of a substance despite significant adverse problems associated with the use (APA, 2022).

Suicide: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior (Crosby et al., 2011).

Suicide attempt: A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury (Crosby et al., 2011).

Suicidal ideation: Thoughts of engaging in suicide-related behavior (Crosby et al., 2011).

Trauma-informed approach: A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization (SAMHSA, 2023). Referred to variably as trauma-informed care or trauma-informed approach.

Upstream prevention: Also called primary prevention, refers to community-based efforts that address risk and protective factors before the onset of a crisis at the individual level. Such factors may include improving financial security and healthy connections, while decreasing exposure to trauma, racism, or disparate access to health care.

Appendix B: Community Engagement

The process of updating the Washington Suicide Prevention Plan was a comprehensive and deeply collaborative effort, designed to ensure that the final document truly represents the diverse voices, experiences, and needs of our state's communities. From the outset, our team was committed to a process of deep and authentic engagement that would place the voices of those most affected by suicide at the center of our work.

Throughout this journey, we were guided by several key principles:

- **Inclusivity:** We sought to engage a wide range of partners, including individuals with lived experience, service providers, policymakers, and representatives from communities disproportionately impacted by suicide.
- **Flexibility:** Our process was designed to be adaptable, allowing us to respond to new insights and changing needs as they emerged.
- **Continuous Learning:** We embraced a mindset of continuous improvement, using lessons learned from each phase to refine our approach.
- **Authenticity:** We strived for genuine, meaningful engagement,
- **Respect:** We worked to value the experience and expertise shared by all participants.

The Engagement Process

Our engagement process unfolded in two main phases, each building upon the insights and relationships developed in the previous stage.

Phase One: Laying the Groundwork

In this initial phase, we conducted structured one-on-one interviews with partners and focused group conversations with diverse representatives from the suicide prevention field.

These conversations yielded valuable insights into:

- Process improvements needed in suicide prevention efforts
- Resource allocation considerations
- Data needs for informed decision-making
- Operational challenges and opportunities
- Evaluation strategies to measure impact
- Implementation approaches for sustainable change

These findings were instrumental in shaping the structure and focus of the updated plan, ensuring that it addressed the most pressing needs identified by our partners.

Phase Two: Deep Dive

Building on the foundation laid in Phase One, we expanded our engagement efforts to include:

- **Technical Working Groups:** Eight groups comprised of subject matter experts, community-based organizations, and individuals with lived experience convened to examine and refine the plan's goals and objectives.
- **Community Workshops:** All-day workshops in Tukwila and Walla Walla brought together diverse voices from different regions of our state.
- **Focus Groups:** We conducted targeted sessions with priority populations to ensure their unique perspectives were incorporated into the plan.
- **In-Depth Interviews:** Additional one-on-one conversations allowed us to explore specific areas of the plan in greater detail.
- **Action Alliance Consultation:** Regular presentations to and consultations with Washington's Action Alliance for Suicide Prevention ensured alignment with ongoing efforts in the state.
- **Diverse Outreach:** We presented to and gathered input from coalitions, Tribal organizations, and other groups across Washington.

Phase Three: Refinement

- **Action Alliance Consultation:** We continued regular presentations to and consultations with Washington's Action Alliance for Suicide Prevention to ensure alignment with ongoing efforts in the state.
- **Diverse Outreach:** We continued to present to and gather input from coalitions, Tribal organizations, and other groups across Washington.
- **Public Survey:** An online survey, released alongside the public draft of the plan, provided an avenue for broader public input.

Thank you

Over the course of this project, we had the privilege of speaking with hundreds of individuals, many on multiple occasions. The contributions of each person — whether shared in a workshop, an interview, or through surveys — have left an indelible mark on this plan. No matter your background or role, we hope you see your perspective reflected in the final document.

A Living Document

The engagement process that shaped this plan is not just a means to an end, but a model for how we envision suicide prevention work moving forward in Washington. By fostering relationships, building shared understanding, and creating spaces for diverse voices to be heard, we have laid the groundwork for more effective and collaborative implementation of the plan's strategies.

As we move forward, we remain committed to the principles of inclusive engagement that guided this process. The Washington Suicide Prevention Plan is not a static document. Through its periodic action plan and updates, it should be a living roadmap that will continue to evolve as we learn, grow, and work together to prevent suicide in our communities.

To everyone who contributed their time, expertise, and personal experiences to this process: thank you. Your insights, passion, and commitment are the heart of this plan, and the foundation of our shared efforts to create a Washington free from suicide.

Safe Messaging Strategies for Suicide Prevention

Communicating about suicide requires care and sensitivity. Follow these guidelines to ensure your messages are safe and effective.

- **Emphasize Help and Hope:** Always include crisis resources and highlight that suicide is preventable.
- **Avoid Sensationalism:** Don't glorify or romanticize suicide. Avoid detailed descriptions of suicide methods.
- **Use Appropriate Language:** Say "died by suicide" instead of "committed suicide." Avoid terms like "successful" or "failed" attempt.
- **Provide Context:** Discuss suicide as a public health issue. Include risk factors and warning signs.
- **Consider the Audience:** Be especially careful when communicating with youth or those who may be at higher risk.
- **Share Stories of Recovery:** Include narratives of people who have overcome suicidal thoughts.
- **Be Mindful of Images:** Avoid graphic images. Use photos that convey hope and healing.

For more information, contact a suicide prevention expert or visit:

- **National Action Alliance for Suicide Prevention's Framework for Successful Messaging**
- **Recommendations for Reporting on Suicide**
- **SPRC's Safe and Effective Messaging for Suicide Prevention**

Remember: Safe messaging can save lives.

Appendix C: Action Plan

The comprehensive update of the state's Suicide Prevention Plan is a critical initiative aimed at addressing one of our most pressing public health challenges. Suicide is a complex issue that affects individuals, families, and communities across our state, and it demands a coordinated, multi-faceted response.

The 2025 Washington Suicide Prevention Action Plan is a vital component of our state's comprehensive approach to suicide prevention. This Action Plan serves as a dynamic roadmap for implementing the goals and objectives outlined in the main Suicide Prevention Plan over the next three years. It transforms our collective vision into concrete, measurable actions that will guide our work in reducing suicide rates and promoting mental health and well-being across Washington.

Key Features of the Action Plan:

- **Strategic Alignment:** Each action item in this plan is directly tied to specific strategic directions, goals, and objectives from the main Suicide Prevention Plan. This alignment ensures that our day-to-day efforts remain focused on our overarching strategy and long-term vision.
- **Collaborative Approach:** The plan identifies responsible agencies and partners for each action item, recognizing that effective suicide prevention requires a coordinated effort across multiple sectors and organizations. This approach fosters shared responsibility and leverages diverse expertise and resources.
- **Measurable Outcomes:** Clear metrics are provided for each year of the three-year implementation period. These metrics allow us to track progress, identify areas of success and challenge, and adjust our approach as needed. This data-driven approach ensures accountability and enables continuous improvement.
- **Flexibility and Adaptability:** While the plan provides a structured framework, it is designed to be a living document. It can evolve in response to new research, emerging needs, and lessons learned during implementation. This flexibility allows us to remain responsive to the changing landscape of suicide prevention.
- **Equity-Focused:** The Action Plan prioritizes equity by including initiatives that address the unique needs of diverse populations and communities disproportionately affected by suicide. This focus ensures that our prevention efforts reach those who need them most.
- **Capacity Building:** Many action items focus on building local capacity and empowering communities to lead suicide prevention efforts. This approach recognizes that sustainable change often begins at the grassroots level.

The Action Plan for 2025-2028 includes a range of strategic initiatives, each designed to address critical aspects of suicide prevention. These initiatives include:

- Funding and supporting local community coalitions to develop and implement their own strategic planning efforts
- Establishing a consistent schedule of statewide suicide prevention workshops, conferences, and summits
- Translating key resources into multiple languages, including ASL videos
- Creating messaging that links social determinants of health to suicide risk
- Restructuring the Action Alliance to enhance implementation efforts
- Developing regular progress reports and data updates
- Creating an online repository of evidence-based resources and culturally specific practices

Additional action items from DOH's work plan for the next 1 to 3 years will be incorporated to ensure a comprehensive and integrated approach to suicide prevention.

By working together to implement this Action Plan, we can create a stronger, more resilient Washington where every person has the support and resources they need to thrive. This plan is not just a document, but a call to action for all Washingtonians to play their part in preventing suicide and promoting mental health throughout our state.

The companion Action Plan spreadsheet provides detailed information on each action item, including responsible parties, timelines, and specific metrics for measuring success. We encourage all stakeholders to familiarize themselves with this document and consider how they can contribute to these vital efforts.

Together, we can make meaningful progress in suicide prevention and create a Washington where hope, help, and healing are accessible to all.

Appendix D: References

Ahmedani, B. K., & Vannoy, S. (2014). National pathways for suicide prevention and health services research. American Journal of Preventive Medicine, 47(3), S222–S228. **https://doi.org/10.1016/j.amepre.2014.05.038**

Alvarez, K., Polanco-Roman, L., Breslow, A. S., & Molock, S. (2022). Structural racism and suicide prevention for ethnoracially minoritized youth: A conceptual framework and illustration across systems. The American Journal of Psychiatry, 179(6), 422–433. **https://doi.org/10.1176/appi.ajp.21101001**

American Foundation for Suicide Prevention, National Action Alliance for Suicide Prevention, and Suicide Prevention Resource Center. (2022). Introduction and executive summary. Suicide Prevention Now. **https://suicidepreventionnow.org/**

American Psychological Association. (2023, May). Health advisory on social media use in adolescence. **https://www.apa.org/topics/social-media-internet/health-advisory-adolescent-social-media-use**

Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive childhood experiences and adult mental and relational health in a statewide sample: Associations across adverse childhood experiences levels. JAMA Pediatrics, 173(11), e193007. **https://doi.org/10.1001/jamapediatrics.2019.3007**

Centers for Disease Control and Prevention. (2020, November). Paving the road to health equity. Office of Health Equity. **https://www.cdc.gov/health-equity/what-is/paving-the-road-to-health-equity.html**

Centers for Disease Control and Prevention. (2021). The Social-Ecological Model: A Framework for Prevention. **https://www.cdc.gov/violence-prevention/about/?CDC**

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (2023, March). How does social connectedness affect health? **https://www.cdc.gov/social-connectedness/about**

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2022). Risk and protective factors. **https://www.cdc.gov/suicide/risk-factors/?CDC_AAref_Val=https://www.cdc.gov/suicide/factors/index.html**

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2022c). Suicide prevention resource for action: A compilation of the best available evidence. **https://www.cdc.gov/suicide/pdf/preventionresource.pdf**

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2023b). Comprehensive suicide prevention. **https://www.cdc.gov/suicide/programs/csp.html?CDC_AAref_Val=https://www.cdc.gov/suicide/programs/csp/index.html**

Centers for Disease Control and Prevention. (2024). Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Injury Prevention and Control. Retrieved October 9, 2024, from **https://www.cdc.gov/injury/wisqars/index.html**

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. Signs: Journal of Women in Culture and Society, 38(4), 785-810.

Coimbra, B. M., Hoeboer, C. M., Yik, J., Mello, A. F., Mello, M. F., & Olff, M. (2022). Meta-analysis of the effect of racial discrimination on suicidality. SSM Population Health, 20, 101283. **https://doi.org/10.1016/j.ssmph.2022.101283**

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 1989(1), 139-167.

Crenshaw, K. (2017). On intersectionality: Essential writings. The New Press.

Cwik, M. F., Tingey, L., Maschino, A., Goklish, N., Larzelere-Hinton, F., Walkup, J., & Barlow, A. (2016). Decreases in suicide deaths and attempts linked to the White Mountain Apache suicide Surveillance and Prevention System, 2001–2012. American Journal of Public Health, 106(12), 2183–2189. **https://doi.org/10.2105/ajph.2016.303453**

Education Development Center, & National Association of County and City Health Officials. (2023). Addressing the intersection of suicide, overdose, and adverse childhood experiences. **https://communitysuicideprevention.org/wp-content/uploads/CLSP-Addressing-Intersection-Guide.pdf**

Harvard Injury Control Research Center. (2012). Families. Means Matter. **https://www.hsph.harvard.edu/means-matter/recommendations/families/**

Hawkins, J. D., Jenson, J. M., Catalano, R., Fraser, M. W., Botvin, G. J., Shapiro, V., Hendricks Brown, C., Beardslee, W., Brent, D., Leslie, L. K., Rotheram-Borus, J., Shea, P., Shih, A., Anthony, E., Haggerty, K. P., Bender, K., Gorman-Smith, D., Casey, E., & Stone, S. (2016). Unleashing the power of prevention. American Journal of Medical Research, 3(1), 39. **https://doi.org/10.31478/201506c**

Hochhauser, S., Rao, S., England-Kennedy, E., & Roy, S. (2020). Why social justice matters: A context for suicide prevention efforts. International Journal for Equity in Health, 19(1), 1–8. **https://pubmed.ncbi.nlm.nih.gov/32450868/**

Liburd, L. C., Ehlinger, E., Liao, Y., & Lichtveld, M. (2016). Strengthening the science and practice of health equity in public health. Journal of Public Health Management and Practice, 22(1), S1–S4. **https://doi.org/10.1097/PHH.0000000000000379**

Litteken, C., & Sale, E. (2018). Long-term effectiveness of the Question, Persuade, Refer (QPR) suicide prevention gatekeeper training program: Lessons from Missouri. Community Mental Health Journal, 54, 282–292. **https://doi.org/10.1007/s10597-017-0158-z**

Liu, S., Morin, S. B., Bourand, N. M., DeClue, I. L., Delgado, G. E., Fan, J., Foster, S. K., Imam, M. S., Johnston, C. B., Joseph, F. B., Lu, Y., Sehrawat, U., Chun Su, L., Tavan, K., Zhang, K. L., Zhang, X., Saulsberry, L., & Gibbons, R. D. (2023). Social vulnerability and risk of suicide in US adults, 2016–2020. JAMA Network Open, 6(4), e239995. **https://doi.org/10.1001/jamanetworkopen.2023.9995**

National Academies of Sciences, Engineering, and Medicine. (2017a). The state of health disparities in the United States. In A. Baciu, Y. Negussie, A. Geller, & J. N. Weinstein (Eds.), Communities in action: Pathways to health equity. National Academies Press. **https://www.ncbi.nlm.nih.gov/books/NBK425844/**

National Academies of Sciences, Engineering, and Medicine. (2017b). The root causes of health inequity. In A. Baciu, Y. Negussie, A. Geller, & J. N. Weinstein (Eds.), Communities in action: Pathways to health equity. National Academies Press. **https://www.ncbi.nlm.nih.gov/books/NBK425845/**

National Action Alliance for Suicide Prevention. (2019). Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care. Education Development Center. **https://theactionalliance.org/sites/default/files/report_-_best_practices_in_care_transitions_final.pdf**

National Action Alliance for Suicide Prevention. (2022). Public perception survey results — Executive summary. **https://theactionalliance.org/resource/2022-public-perception-survey-results-executive-summary**

National Action Alliance for Suicide Prevention, Research Prioritization Task Force. (2014). A prioritized research agenda for suicide prevention: An action plan to save lives. **https://theactionalliance.org/resource/prioritized-research-agenda-suicide-prevention-action-plan-save-lives**

National Action Alliance for Suicide Prevention, Research Prioritization Task Force. (2015). U.S. national suicide prevention research efforts: 2008–2013 portfolio analyses. **https://theactionalliance.org/resource/us-national-suicide-prevention-research-efforts-2008-2013-portfolio-analyses**

Office of the Surgeon General. (2021). The Surgeon General's call to action to implement the national strategy for suicide prevention: A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. **https://www.hhs.gov/sites/default/files/sprc-call-to-action.pdf**

Office of the Surgeon General. (2023a). Our epidemic of loneliness and isolation: The U.S. Surgeon General's advisory on the healing effects of social connection and community. **https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf**

Office of the Surgeon General. (2023b). Social media and youth mental health: The U.S. Surgeon General's advisory. **https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf**

Peterson, C., Haileyesus, T., & Stone, D. M. (2024). Economic cost of U.S. suicide and nonfatal self-harm. American Journal of Preventive Medicine, 24, S0749–3797. **https://www.ajpmonline.org/article/S0749-3797(24)00081-3/fulltext**

Pfeiffer, P. N., King, C., Ilgen, M., Ganoczy, D., Clive, R., Garlick, J., Abraham, K., Kim, H. M., Vega, E., Ahmedani, B., & Valenstein, M. (2019). Development and pilot study of a suicide prevention intervention delivered by peer support specialists. Psychological Services, 16(3), 360–371. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6494743/**

Pirkis, J., Too, L. S., Spittal, M. J., Krysinska, K., Robinson, J., & Cheung, Y. T. (2015). Interventions to reduce suicides at suicide hotspots: A systematic review and meta-analysis. The Lancet: Psychiatry, 2(11), 994–1001. **https://doi.org/10.1016/S2215-0366(15)00266-7**

Riehm, K. E., Feder, K. A., Tormohlen, K. N., Crum, R. M., Young, A. S., Green, K. M., Pacek, L. R., La Flair, L. N., & Mojtabai, R. (2019). Associations Between Time Spent Using Social Media and Internalizing and Externalizing Problems Among U.S. Youth. JAMA psychiatry, 76(12), 1266–1273. 10.1001/jamapsychiatry.2019.2325

Roses in the Ocean. (2023). Lived experience of suicide. **https://rosesintheocean.com.au/**

RTI International. (2023, January). Implementing and sustaining zero suicide: Health care system efforts to prevent suicide. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. **https://aspe.hhs.gov/sites/default/files/documents/eb495e8decf07b8bda05a7f0a47a3270/implement-sustain-zero-suicide.pdf**

Saunders, H., & Panchal, N. (2023). A look at the latest suicide data and change over the last decade. KFF. **https://www.kff.org/mental-health/issue-brief/a-look-at-the-latest-suicide-data-and-change-over-the-last-decade/**

Schnitzer, P. G., Dykstra, H., & Collier, A. (2023, March). The COVID-19 pandemic and youth suicide: 2020-2021. Pediatrics, 151(3), e2022058716. **https://doi.org/10.1542/peds.2022-058716**

Substance Abuse and Mental Health Services Administration. (2016). Substance use and suicide: A nexus requiring a public health approach. In Brief. **https://store.samhsa.gov/sites/default/files/sma16-4935.pdf**

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2017). National strategy for suicide prevention implementation assessment report (HHS Publication No. SMA17–5051). **https://store.samhsa.gov/sites/default/files/sma17-5051.pdf**

Suicide Prevention Resource Center. (2019). State suicide prevention infrastructure recommendations. Education Development Center. **https://sprc.org/wp-content/uploads/2022/12/SPRC-State-Infrastructure-Full-Recommendations.pdf**

Suicide Prevention Resource Center. (2020). Topics and terms. **https://sprc.org/topics-and-terms/**

U.S. Department of Health and Human Services. (2024a, April). National Strategy for Suicide Prevention.

U.S. Department of Health and Human Services. (2024b, April). National Strategy for Suicide Prevention Federal Action Plan: FY 2024–26.

Washington State Department of HEALTH

DOH 971-076 CS May 2025

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.