Guidance for State Suicide Prevention Leadership and Plans
Updated 4-21-14

The history, content, scope, breadth and ownership of state suicide prevention efforts vary widely. Suicide prevention leadership may come from a statewide coalition, governor's office, task force, or health agency (including public health, mental health, injury prevention and others). SAMHSA recommends that behavioral health (BH) agencies play a leadership role on suicide prevention efforts. SAMHSA also recommends that BH agencies play a part in shaping, implementing, monitoring and regularly updating their state suicide prevention plan. Mental Health Block Grant resources may be used for suicide prevention activities. Therefore, SAMHSA has created the following guidance for state suicide prevention leadership and plans based on best practices and the Office of the Surgeon General's and the National Action Alliance for Suicide Prevention's 2012 revised National Strategy for Suicide Prevention (NSSP) is incorporated in this document.

This guidance recognizes that states and their suicide prevention activities vary widely. SAMHSA suggests that state BH agencies lead in two ways. **The first is by raising the bar on suicide prevention and care as a central public health and behavioral health proble**m. Mental illness and substance abuse are possible factors in 90 percent of the 37,000 annual deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges BH agencies to lead in ways that are suitable to this growing area of concern and to help raise the bar through implementation of the National Strategy: including convening stakeholders, prioritizing suicide prevention in multiple sectors, building capacity (e.g., supporting coalitions, developing training resources) and "growing" suicide prevention efforts. In times of limited resources, leadership is most valuable.

The second area of guidance is to emphasize the value of having a written strategic plan that addresses suicide across the lifespan, in order to maximize existing resources, promote broad collaboration, and monitor progress. SAMHSA suggests the following key areas for inclusion in state suicide prevention plans—and efforts to implement the plans.

Key Plan Elements and Characteristics

State suicide prevention plans should contain core elements such as identifying evidenced based practices and programs that address prevention and treatment, training the existing behavioral health workforce on identifying, screening, assessing and treating individuals with suicidal thoughts and behaviors, and providing continuity of care so that those at high risk are able to safely transition from acute care settings to outpatient care. Plans should include working with medical professionals in primary care, as well as first responders and emergency department personnel, to increase the likelihood of effective treatment and care transitions during periods of elevated suicide risk. In addition, the following are key characteristics that contribute to an effective suicide prevention plan.

- **Plans should be data-driven, while strategies may be flexible.** In order to effectively allocate resources, states should identify and prioritize high-risk populations and settings by using available data that:
    - Identifies populations with both high numbers and high rates of suicide attempts and deaths (nationally, for example people with mental illness and elderly males are at elevated risk).
    - Points to geographic areas and settings in which risks of suicide are high (e.g., rural areas, behavioral health care settings, correctional settings, etc.)

- Characterizes patterns of suicide deaths and attempts, including which risk factors are associated with different populations (such as mental illness, substance abuse disorders, people just discharged from inpatient/emergency departments, people with prior attempts, etc.)
- Allows States to respond to suicide clusters with support and postvention.

EXAMPLE
Rhode Island plan- http://www.sprc.org/sites/sprc.org/files/RI%20Violence%20and%20Injury%20Prevention%20Plan.pdf(pp.32-35)

- **Plans should be comprehensive, but set priorities.** They should integrate and coordinate suicide prevention activities across multiple sectors and settings. They should address both risk and protective factors. The plan should account for differences within the state and incorporate monitoring over time for effectiveness. The plan should include goals, objectives, types of activities and special populations.

  EXAMPLE
  Massachusetts plan- http://www.sprc.org/sites/sprc.org/files/state_plans/plan_ma.pdf (pp. 19-30)

- **Plans should incorporate a collaborative effort by multiple public and private organizations, while focusing on what can first be done.** Suicide prevention cannot be a one-person or single-agency effort. Ultimately, health, mental health, substance abuse, education, justice, veterans and other agencies and private sector groups need to be involved and play a role in developing and implementing the plan. Coalitions, task forces, or multi-agency work groups can build commitment and ownership. Key players can include: schools/educational systems, healthcare systems, community prevention coalitions, criminal justice and aging systems. Behavioral health agencies should not only participate but offer key leadership based on their knowledge of and access to behavioral health resources and information. Given the elevated risk for people with mental health/ substance use disorders, a special focus within behavioral health systems of care is appropriate. Behavioral health systems should strive to eliminate suicides among those receiving care by providing training to the BH workforce on screening, assessing, and treating individuals with suicidal thoughts and behaviors,, promoting continuity of care among high risk groups such people discharged from inpatient units and Emergency Departments, linking to the National Suicide Prevention Lifeline and supporting Lifeline crisis centers within the state, and promoting and implementing evidence based interventions. See: http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf
  Suicide attempt survivors and family members who have lost loved ones to suicide who become engaged in the cause of suicide prevention and care are essential participants in any planning effort.

- **Plans should be clinically informed, but based on the public health approach.** BH agencies and professionals often focus on individual characteristics of suicidality and how those can be

treated. However, to be effective, suicide prevention plans should also take a public health approach, looking not only at individual characteristics, but identifying risk and protective factors in populations, partnering across sectors, and working across the spectrum of prevention, intervention, and postvention. This should involve non-BH settings such as primary care and Emergency Departments.

EXAMPLES
North Carolina plan-
http://www.injuryfreenc.ncdhhs.gov/About/YouthSuicidePreventionPlan.pdf (p. 9)
Colorado plan- http://www.sprc.org/sites/sprc.org/files/ColoradoTrust-SuicideReportFinal2009.pdf

- **Plans should focus on a lifespan approach**. Many state plans have focused exclusively on youth. While prioritizing youth suicide is urgent because of the special tragedy of losing young lives, suicide in midlife is more common and has been increasing in frequency. Effective state plans should focus on identifying risk and protective factors of populations across the lifespan and be flexible in addressing unique challenges related to various factors (geographic location, race, ethnicity, etc.).Planning should also take into account groups with elevated or increasing rates or numbers of suicide attempts or deaths, such as American Indian/Alaska Natives, Hispanic and LGBT youth, veterans and the military, and men in midlife.

  EXAMPLE
  Wyoming plan:
  http://www.sprc.org/sites/sprc.org/files/WY%20SuicidePreventionStatePlan%202011.pdf (pp.8-11)

- **Plans should utilize research and safety informed communications.** These efforts should be based on principles of safe messaging and promote hope, resilience, and awareness of the warning signs for suicide and how to connect individuals in crisis with assistance and care.

  EXAMPLES
  New Hampshire plan: http://www.dhhs.nh.gov/dphs/suicide/documents/plan.pdf (pp.4-5)
  Ohio plan (NSSP Based):
  http://www.sprc.org/sites/sprc.org/files/Ohio%20Suicide%20Prevention%20Plan%20for%202013--2016.pdf (pp.7-8)

- **Plans should promote accountability, and be regularly monitored, updated and revised.** The field is still learning how to prevent suicide; a commitment to learning that seeks improvement but does not blame is important. Data on suicide and suicide attempts should be monitored and analyzed on an annual basis, including suicidal behavior among those receiving care in behavioral healthcare systems. State suicide prevention plans should be living documents. Annual action plans should identify who is responsible for carrying out the different elements of the plan, and suicide prevention leaders should assess progress at least annually. Periodically (every 3 years at most), those involved in statewide suicide prevention

work should gather to look at the impact the plan has had, review updated data and resources, and update and/or revise the plan.

EXAMPLES
Alaska plan - http://dhss.alaska.gov/SuicidePrevention/Documents/CTN_Implementation_Report_2012.pdf
Tennessee evaluation plan (NSSP Based): http://tspn.org/wp-content/uploads/TSSP-Outcomes.pdf