



National Association of County & City Health Officials

The National Connection for Local Public Health

05-01

STATEMENT OF POLICY

Suicide Prevention

Note: The number for the National Suicide Prevention Lifeline is 988.

Policy

The National Association of County and City Health Officials (NACCHO) recognizes the considerable burden and impact of suicide as a national public health issue and views suicide and suicide attempts as preventable. Local health departments (LHDs) play an important role in convening invested parties and partners within the community to conduct and promote primary, secondary, and tertiary prevention activities and services to prevent suicide. Additionally, NACCHO recognizes the importance of LHDs congruently implementing comprehensive, evidence-informed strategies at the intersection of suicide prevention and topics with which it correlates, including adverse childhood experiences, overdose, and violence.

NACCHO encourages LHDs to adopt suicide prevention policies and practices that:

Go upstream to reduce risk factors and bolster protective factors for suicide:

- Foster positive public dialogue to counter stigma, shame, prejudice, and silence and build public support for suicide prevention.
- Advocate for policies or offer programs that strengthen family and individual economic support, such as accessible and safe housing, living wages, and comprehensive health insurance coverage.
- Enhance community connectedness by supporting, offering, and/or promoting activities that promote social connectedness and reduce isolation, such as a neighborhood block party or a local farmers market.
- Create opportunities for individuals to develop trusting relationships with peers who encourage help-seeking behaviors, such as a peer mentorship program for high schoolers.
- Adopt and incorporate social justice into public health practice to address the root causes of disparities in suicide, such as dismantling structural inequalities, promoting anti-racist frameworks, and promoting wellbeing for all.²
- Layer suicide prevention strategies with adverse childhood experiences (ACEs) and overdose prevention strategies by targeting their shared risk and protective factors.

Identify strategies to lessen harms and prevent future risk for those at-risk for suicide:

- Provide guidance to the media to reduce stigma surrounding suicide through using non-stigmatizing language, preventing the perpetuation of myths relating to suicide, and refraining from sensationalizing suicide.
- Implement or share existing communication campaign materials highlighting the 988 national hotline and Crisis Text Hotline for crisis response intervention.
- Recruit and execute gatekeeper trainings, such as [Question, Persuade, Refer \(QPR\)](#) or [Garrett Lee Smith Youth Suicide Prevention Program](#), to identify individuals who are at risk for suicide facilitate referrals to treatment and other support services to community members.
- Collaborate with local emergency departments to train staff gatekeepers in [The Emergency Department Safety Assessment and Follow-Up Evaluation \(ED-Safe\)](#).
- Offer training to mandated reporters working with individuals across the lifespan (e.g., in schools, YMCA, senior centers) related to responding to crises, planning for safety, and conducting follow-up after a suicide.
- Create a map of local entities that temporarily store firearms for individuals who are at risk for suicide and have a firearm in their home (e.g., police stations, gun shops).

Implement evidence-based programming across levels of prevention to lower risk of suicide and increase protective factors within communities:

- Engage people with lived experience and organizations serving populations at high risk for suicide throughout the planning, design, implementation, and evaluation of suicide prevention programming.
- Provide opportunities for individuals with mental health and substance use disorders to connect to peers with lived or living experience (i.e., Peer Support Programs).
- Integrate programs to address lethal means safety into communities by conducting activities such as lethal means safety counseling, communicating safe storage practices, and limiting availability or accessibility of firearms and other lethal means where suicidal behaviors are most prevalent.
- Collaborate with local health systems to implement programs to ensure safe and effective care for suicide risk like the [Zero Suicide framework](#) and the [Collaborative Care Model \(CoCM\)](#).
- Educate local primary care, family medicine, pediatric, and geriatric providers on recognizing signs of suicidal ideation and establishing safety planning and follow-up contact/brief contract interventions as part of their standard practice.
- Support increased federal support for stable housing opportunities for low-income communities and individuals experiencing chronic homelessness including programs such as Section 8 Housing Choice Vouchers and Project Based Rental Assistance. Collaborate with schools, businesses, and community organizations to develop a plan for creating healthy organizational policies and cultures related to suicide knowledge, safety, support, and prevention practices (i.e., [Strong Schools Against Suicidality and Self-Injury](#), [The United States Air Force Suicide Prevention Program](#), [Together for Life](#), [Creating Suicide Safety in Schools](#)).
- Develop community building programs to provide opportunities for community members to participate in positive activities (i.e., community clean-up, group physical exercise.) and facilitate connection among their neighbors.

- Partner with local schools to develop and implement social-emotional learning (SEL) programs (such as the [Youth Aware of Mental Health Program](#)) with components related to suicide prevention and help-seeking.

Increase access to crisis care and navigate care transitions:

- NACCHO supports Medicaid policies that promote and ensure access to telemental health services.
- Organize opportunities for providers to work with community members in lower socioeconomic areas if there is a community health clinic within the confines of a local health department's jurisdiction.
- Reduce barriers to accessing crisis care systems such as crisis call centers, mobile crisis teams, receiving and stabilization facilities, and 988.

Enhance access and use to real-time and equitable suicide-related data:

- NACCHO supports the integration of data science methods to analyze electronic health records and identify individuals at-risk for suicide.
- In order to improve surveillance, data infrastructure, and capacity for consistent data-driven implementation and evaluation of suicide prevention efforts., NACCHO encourages increased federal resources in data infrastructure and workforce for local health departments.
- Maintain and regularly update a comprehensive suicide prevention plan to analyze and utilize data to inform action at the state and local levels.
- Develop diverse partnerships for data dissemination in readily useable forms to support quality improvement work and improve data linkage across systems.
- Ensure high-risk and underrepresented communities are included in data collection practices to monitor trends.

Justification

Suicide is a leading cause of serious injury and death in the United States. According to provisional data, a record high of 49,369 people died by suicide in 2022.¹ Suicide is among the top nine leading causes of death for Americans ages 10-49 years old.² In the 2021 Youth Risk Behavior Survey (YRBS), 22.2% of high school students reported seriously contemplating suicide in the previous 12 months, 17.6% reported they made a suicide plan, and 10.2% reported attempting suicide in the previous 12 months.³ For every suicide death in 2021, there were three hospitalizations for self-harm and 8 suicide-related emergency department visits.⁴ It is estimated that suicide and nonfatal self-harm cost over \$500 billion in medical and work loss expenditures.⁵

Specific populations are disproportionately affected by suicide, suicide attempts, and suicidal ideation, including individuals identifying as non-Hispanic American Indian/Alaska Native (AI/AN), LGBTQIA+, veterans, older adults (particularly 75 years and older), and people with disabilities.⁶ Provisional data show a slight decrease in numbers of suicide deaths among AI/AN youth (-6.1%) and overall youth ages 10-24 (-8.4%) between 2021 and 2022.¹ Black youth ages 10-19 years old saw the largest increase in suicide rates from 2000-2020 (up by 78%),⁷ and one study found that Black children ages 5-11 years old are two times more likely to die by suicide than white children.⁸

Suicide requires a public health approach to prevention that identifies broad patterns of suicide and suicidal behavior. Factors at the individual, relationship, community, and societal levels can contribute to suicide risk, including current or prior history of adverse childhood experiences, bullying, loss of relationships, historical trauma, and access to lethal means.⁹ Suicide is a multifaceted issue with risk factors at the individual, relationship, community, and societal levels, including current or prior history of adverse childhood experiences, bullying, loss of relationships, historical trauma, and access to lethal means. For example, research shows a positive association between firearm availability at the state level and significantly higher odds of individual suicide.^{10,11} Indeed, firearms are by far the most commonly used and most lethal means of suicide, accounting for over 50% of all suicides, followed by suffocation and poisoning (26% and 12% respectively).¹ The lethality of firearm suicides is indisputable; approximately 90% of suicide attempts involving a firearm injury resulting in death.¹ Comprehensive suicide prevention includes identifying and addressing broad patterns of suicide and suicidal behavior, such as access to lethal means, and engaging in approaches that address this at multiple levels, from statewide firearms policies to individual safe storage practices.

Go upstream to reduce risk factors and bolster protective factors for suicide:

Historically, suicide has been viewed primarily as a mental health concern. As a result, prevention efforts have focused on detecting individuals experiencing suicidal ideation or behaviors and connecting them to necessary mental health or crisis care.¹² While these efforts are necessary, they are insufficient to comprehensively prevent suicide. Data from the Center for Disease Control and Prevention's National Violent Death Reporting System (NVRDS) show that mental illness is only one among several factors that precipitate suicide. Other indicators include financial stress, legal challenges, substance use, and conflict with an intimate partner.¹³ Further, downstream efforts (i.e., detection and referrals) do not address the conditions and factors that exacerbate mental illness or lead to suicidal thoughts and behaviors in the first place.¹³ Economic conditions, for example, have been shown to influence suicide rates in the U.S. with rates typically increasing during recession periods and decreasing during periods of economic instability.¹⁴ One study links the presence of policies and programs that support individuals making low incomes with lower rates of suicide.¹⁵ Thus, efforts that support families economically may reduce upstream risk factors for suicide. Certain upstream conditions can also protect against suicide risk; for example, social connectedness amongst peers and community can bolster mental health and decrease isolation.

LHDs commonly serve as conveners among multi-sectoral partners in the community and are positioned to coordinate or direct activities that address upstream factors and influence suicide risk. Additionally, suicide shares many upstream risk and protective factors with other health outcomes that may also be priorities for LHDs, such as intimate partner violence, overdose, and adverse childhood experiences.^{16,17} LHDs can maximize impact with existing resources by focusing on activities that address shared risk factors and protective factors.

Identify strategies to lessen harms and prevent future risk for those at-risk for suicide:

According to The Social-ecological Model of Suicide Prevention, suicide risk is multi-factorial and impacted by factors from the individual (e.g., mental health symptoms, financial challenges)

to the societal level (i.e., health policy, stigma).¹⁸ Prevention efforts should include strategies that reduce risk factors, such as the availability of lethal means, and increase factors that promote resiliency at each level of the social-ecological model. Hospitals, health systems, mental health providers, and substance use treatment facilities can engage in prevention through activities such as universal screening and can better facilitate linking people to treatment services.¹² LHDs can also lead educational sessions to help providers better recognize signs of suicidal ideation, safety plan with patients, and intervene within their standards of practice. Each of these practices has been shown to reduce suicidal ideation in patients.¹⁹ Training community members as gatekeepers (e.g., Question, Persuade, Refer (QPR); Garrett Lee Smith Memorial Suicide Prevention Program) has been shown to have short- and long-term positive outcomes. Trainees report increases in knowledge of suicide and confidence in recognizing signs of suicidal ideation.^{20,21,22}

LHDs are well-positioned to tailor communications campaigns to best fit their community and its needs. LHDs have an opportunity to lead communications efforts by collaborating with local media and creating communications campaigns to lessen harm related to suicide. In recent years, there has been an increase in news media outlets reporting on suicide deaths in communities. News reporting of suicide deaths can potentially lead to community conversations about suicide and its impact. However, it is vital for local news and journalists to follow a set of media guidelines to report suicide deaths thoughtfully and empathically to the community to minimize increased risk of suicide attempts and deaths.^{23,24,25,26} LHDs can also collaborate with local media to raise awareness of the national 988 suicide hotline and other local suicide crisis intervention services. Interested LHDs can bolster their efforts with a [toolkit](#) developed by Substance Abuse and Mental Health Services Administration (SAMHSA) that can be shared amongst media channels.^{27,28}

Creating environmental changes in living, working, and recreational spaces can enhance positive health outcomes and reduce suicide risk.²⁹ This includes the creation of environmental changes in living, working, and recreational spaces (e.g., bridges, rooftops) to add protective structures to prevent suicide.²⁹ For example, modifying environments for individuals at risk can include restricting access to common suicide methods like firearms and medications.^{30,31} Integrating diverse strategies for lethal means safety into communities is crucial, considering the brief duration of many suicidal crises, with an average of less than 10 minutes between the decision to act on suicidal thoughts and a suicide attempt.^{29,32} The creation of an online map for voluntary out-of-home firearm storage can be used as a reference for community members seeking to temporarily store firearms for those who are at-risk for suicide. This involves a collection of all locations that provide voluntary, out-of-home safe firearm storage, such as gun shops and police stations.^{33,34} In 2021, the White House indicated that multi-state maps of these firearm storage locations are a promising approach to preventing suicide.³⁴

Implement evidence-based programming across levels of prevention to lower risk of suicide and increase protective factors:

LHDs can collaborate with individuals with living experience, community members, schools, healthcare systems, and government entities for effective integration and coordination of prevention activities. The provision of opportunities to engage people with lived experience (i.e., Peer Support Programs) is essential for individuals at-risk of suicide.³⁵ People with lived experience should be engaged throughout the planning and implementation process of prevention

activities to improve understanding of responses to suicide risk, identifying need, and enhancing community-based intervention of suicide.³⁶

Establishing protective environments also includes fostering healthy organizational policies and cultures in settings like schools, businesses, and community organizations.²⁹ Implementing policies, programs, and practices that promote help-seeking, skill building, and positive social norms can enhance access to services such as mental health treatment and financial counseling. Further, they can positively impact organizational culture and morale and further prevent risk factors such as depression and social isolation.²⁹ In addition, addressing social isolation, a significant suicide risk, involves facilitating meaningful social connections that make individuals feel valued and respected.²⁹ LHDs can facilitate community engagement activities like walking programs or community gardens to foster positive connections and a sense of purpose among community members.

Enhancing access to evidence-based care is also crucial for preventing suicide and boosting protective factors. The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention promotes integrating suicide prevention into all healthcare services, rather than confining it to mental health, and improving professional and clinical training.³⁶ LHDs can collaborate with partners from diverse clinical care settings including primary care offices, emergency departments, and mental health facilities to implement evidence-based care programs such as the Zero Suicide Framework and the Collaborative Care Model (CoCM).²⁹ These partnerships also provide opportunities to facilitate clinical training to enhance suicide risk identification and safety planning for all patients screening positive for suicide risk.²⁹ Studies show that many individuals who die by suicide interact with healthcare providers shortly before their death, highlighting the importance of well-trained providers in detecting risk and connecting individuals to resources.³⁷

LHDs can also implement community training and education opportunities to enhance life skills, which are crucial for minimizing risk of suicidal behaviors and achieving developmental milestones.²⁹ For example, partnering with schools to introduce social-emotional learning (SEL) programs like the Youth Aware of Mental Health Program teaches adolescents about themes related to mental health including self-help advice, stress and crisis, depression and suicidal thoughts, helping a friend in need, and asking for advice/help.²⁹ SEL programs are designed to enhance adolescents' problem-solving skills for dealing with adverse life events, stress, school concerns, and other problems, and have been proven to significantly decrease students' likelihood to attempt suicide or have severe suicidal ideation.²⁹ Caregiver programming such as The Incredible Years (IY) and Strengthening Families can bolster parenting skills and positive parent-child interactions.³⁸ As mentioned above, providing gatekeeper training such as the Applied Suicide Intervention Skills Training (ASIST) to community members (i.e., peers, teachers, coaches, clergy, emergency responders, etc.) can also prevent suicide by increasing the number of people who can identify and support people at risk for suicide or suicidal behaviors.^{29,39}

Increase access to crisis care and navigate care transitions:

More than 121 million people in the United States reside in areas with a shortage of mental health providers, especially in low-income urban and rural areas.⁴⁰ In-person visits can be barriers for those without reliable transportation, in spread-out geographic areas with few

providers, and/or with competing needs (e.g., job schedules, kids' school schedules). Telemental health services, or mental health care through the use of videoconferencing or telephone, has increased astronomically since the COVID-19 pandemic.⁴¹ Certain telemental health-based services can be used to assess depression and suicide ideation in patients without requiring an in-person visit.⁴¹ Telemental health allows access to providers who can assess and treat depression, anxiety, trauma-related symptoms, and other mental health issues.⁴² Studies show that mental health assessments that are conducted via telemental health have similar outcomes to those that are completed during in-person visits.⁴¹ This provides greater access to mental health treatment for communities with longer waitlists, but it is still vital for communities to staff appropriately. Emerging research suggests there may be interventions specifically designed to prevention suicide that can be delivered exclusively through telehealth platforms.⁴³

In addition to telemental health options, other organizations are thinking creatively about ways to increase provider access in rural areas. The National Health Service Corps (NHSC) connects behavioral health providers to Health Professional Shortage Areas (HPSAs) in exchange for student loan debt repayment.⁴⁰ This program has accounted for significant increases of behavioral health providers in rural areas of the country, and 61% of participating providers continued to practice in HPSAs after their NHSC commitment.⁴⁴ Thus, LHDs can advocate for and assist in organizing opportunities for NHSC providers to work with community members and/or incentivize behavioral health providers to practice in their communities and/or provide telemental health services. Telemental health and programs such as NHSC offer an opportunity to create more equitable access to mental health resources.

LHDs can also address barriers to accessing crisis response services, housing, and transportation. By increasing access to crisis call centers, mobile crisis teams, services like the national 988 lifeline, and receiving and stabilization facilities, LHDs can improve outcomes for individuals in crisis. For example, evaluations of crisis line networks in the U.S. have demonstrated effectiveness as suicide prevention tools, with suicidal crisis callers reporting significant reductions in intent to die, hopelessness, and psychological pain over the course of their crisis call.⁴⁵ In addition, studies have shown that homeless and suicidality strongly co-occur, with people who are chronically homeless experiencing worsened health outcomes including trauma, depression, anxiety, alcohol use, and psychological distress (all of which are suicidal risk factors).^{46,47} Therefore, providing stable housing opportunities and increasing access to rent and security programs for individuals experiencing chronic homelessness can decrease suicide risk by improving health outcomes and decreasing psychological distress.⁴⁶

Enhance access and use to real-time and equitable suicide-related data:

The collection of real-time and equitable suicide-related data can assist public health officials, researchers, practitioners, and the public to better understand the burden of suicide, populations who may be at-risk, and the need for effective intervention and prevention efforts. Leveraging electronic health record (EHR) data in identifying patients at-risk of suicide is a valuable endeavor for LHDs to consider. Recent research reveals promising results in using machine learning algorithms to develop predictive and calibrated models to identify individuals at high risk of suicide.^{48,49,50} Similarly, there is growing research in the successful use of Natural Language Processing (NLP) and machine learning techniques to predict first-time suicidality by analyzing narrative clinical notes and EHR data.^{51,52} However, it is necessary to note that machine learning algorithms can increase biases that further health inequities. A rational

combination of both clinician and statistical assessment methodologies can lower suicide risk prediction with increased efficiency and accuracy.⁵³

The findings of the 2023 State and Territorial Suicide Prevention Needs Assessment (SNA) revealed that only 22% of states (11 out of 49) reported that their state ensures that underserved and high-risk populations are sufficiently represented in their suicide-related data.⁵⁴ For example, LGBTQIA+ populations experience high rates of suicidal ideation and attempts, yet no U.S. jurisdiction or agency routinely or systematically collects information about individuals' sexual orientation and gender identity (SOGI) at the time of death.⁵⁵ Additionally, there is limited SOGI data collection in EHRs although tools for complete and comprehensive SOGI data collection exist.⁵⁶ Without this information, it is difficult to develop targeted suicide interventions and prevention strategies for those who identify as LGBTQIA+.⁵⁷ Equity in suicide data can also be achieved by engaging with key audience members throughout the data collection and research processes to increase representation in data and use of data by communities, identify and mitigate causes of suicide-related outcomes, and enhance equitable access and effectiveness of prevention efforts.⁵⁸

There is a push to link existing data systems to suicide prevention efforts to better track long-term outcomes and enhance understanding of the broader impacts of suicide prevention interventions. For example, data for The National Violent Death Reporting System (NVDRS), which collects and combines real-time reports from law enforcement, coroners, and medical examiners, is now being shared with state suicide prevention leadership to adapt suicide prevention efforts at state and local levels and highlight areas of additional focus.⁵ The CDC's comprehensive approach to suicide prevention plan also indicates the importance of establishing multi-sectoral partnerships and collecting real-time data to help states rapidly track and appropriately respond to changing patterns in suicidal behavior.⁶⁰ As a result of comprehensive suicide prevention funding from the CDC, local health departments and districts in Connecticut have been able to access near real-time data from emergency departments (EDs) on suspected suicide ideation and suicide attempts through the Connecticut Department of Public Health's EpiCenter syndromic surveillance system. Similarly, in Tennessee, the Tennessee Department of Public Health notifies community partners of suicide surveillance ED data through the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) to increase partner engagement and improve decision making.⁶¹

In conclusion, addressing the complex issue of suicide requires a multifaceted approach that transcends traditional mental health interventions alone. Suicide prevention must encompass a broad spectrum of strategies, including proactively reducing risk factors, enhancing protective factors, implementing proven prevention programs, improving crisis care and transitions, and utilizing real-time data to inform strategies and access. LHDs play a pivotal role in coordinating these efforts and can leverage community partnerships to implement evidence-based programs across various levels of prevention. By enhancing access to care, advocating for equitable data collection, and fostering supportive environments, the risks and impacts of suicide are mitigated, and individuals at risk receive the comprehensive support they need to thrive.

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