



2019-2023 Rhode Island Violence & Injury Prevention State Plan

Suicide/Suicide Attempt Prevention Section

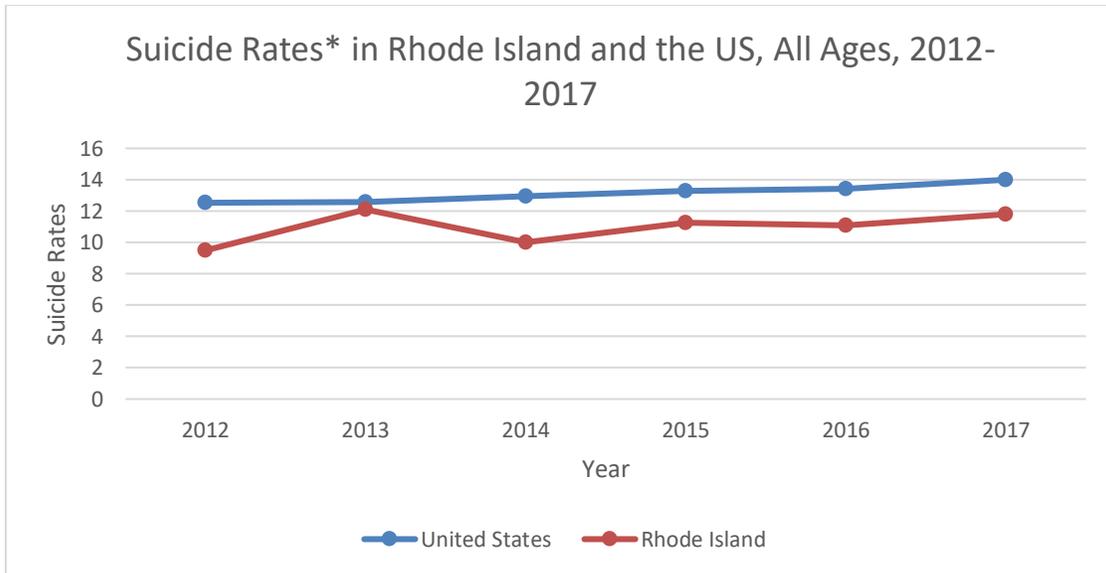
Disease Burden: US

In the United States, suicide and suicide attempts are serious public health problems. In 2017, suicide was the 10th leading cause of death in the US, and more than 47,000 Americans died by suicide.¹ The economic and human cost of suicidal behavior to individuals, families, and communities can be devastating.² Suicide and suicidal ideation can affect individuals of all ages, races, and socio-economic backgrounds; however, there are substantial variations in suicide trends and patterns by sociodemographic characteristics and geography. Nationally, suicide rates are higher for males than for females and are higher in non-metropolitan/rural communities than in urban areas.³ Recent trends have demonstrated an increase in suicides among working age adults age 45–64 and among teenage girls age 15-19.⁴

In 2017, suicide was the 11th leading cause of death overall in Rhode Island for all age groups, and the second leading cause of death for individuals age 15-34.¹ There were 129 suicide deaths in Rhode Island in 2017, or 11.79 deaths by suicide per 100,000 residents.⁵ This represents an estimated 25% increase in suicide deaths from the previous rate of 9.02 suicide deaths per 100,000 population in 2011 (See Figure 1).⁵ Aggregated data for 2012 to 2017 show that most Rhode Islanders who died by suicide were male (approximately 76%;), and adults age 35-64 (approximately 60%).⁵ Additionally, of the total suicide deaths in Rhode Island from 2012-2017, 93% of victims were identified as being non-Hispanic and White.⁵ Nationally, suicide *attempts* are much more common than death by suicide, with an estimated 1.3 million adults reporting attempting suicide in 2017,⁶ compared to just over 47,000 deaths by suicide in the same year.¹ The prevalence of self-reported suicidal ideation is tracked through the Rhode Island Youth Risk Behavior Survey (for middle and high school students) and the National Survey on Drug Use and Health for adolescents and adults (nationally and by state). The number of Rhode Island adolescents who have considered or attempted suicide is cause for concern. In 2017, 18% of Rhode Island middle school students reported seriously considering suicide, and 15.9% of Rhode Island high school students also reported serious thoughts of suicide.⁷ These statistics are alarming when put into context, showing that at minimum one out of every 10 middle and high

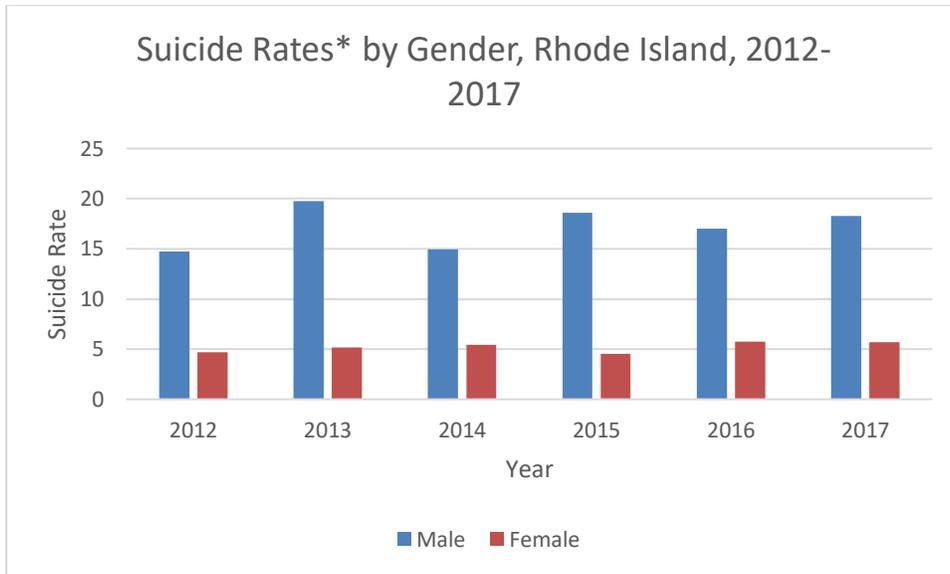
school students in Rhode Island had serious thoughts about suicide in 2017. These findings underscore the need for continued public health efforts to recognize, assess, and appropriately refer youth in Rhode Island who are experiencing suicidal ideation in order to prevent suicide attempts and deaths.

Rhode Island Suicide Deaths



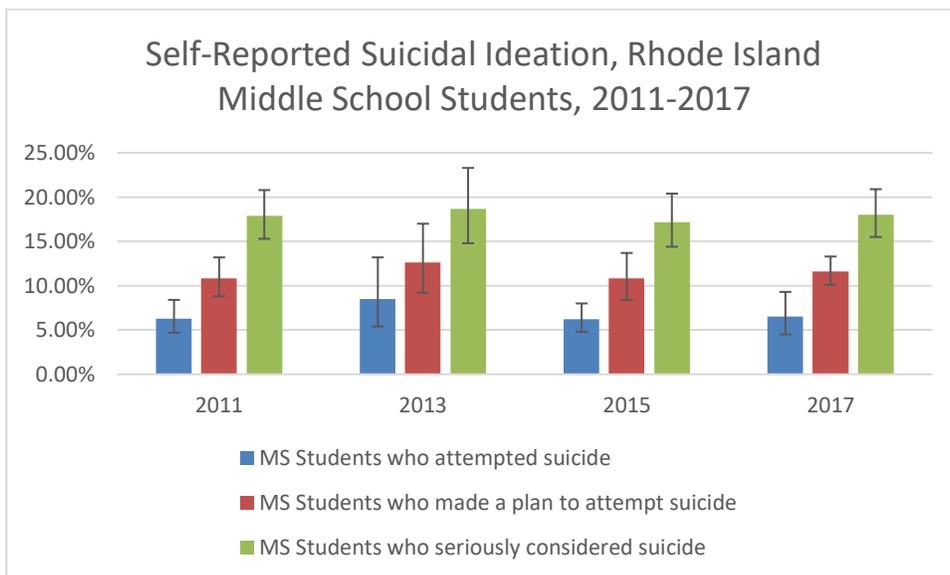
National Center for Health Statistics (NCHS) Vital Statistics System for numbers of deaths.

Bureau of Census for population estimate.¹

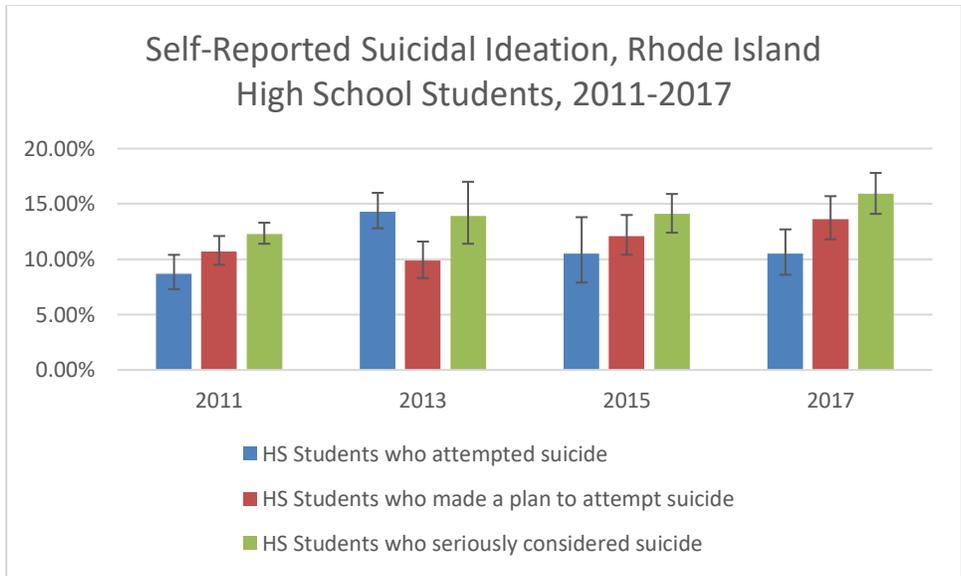


NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimate.¹

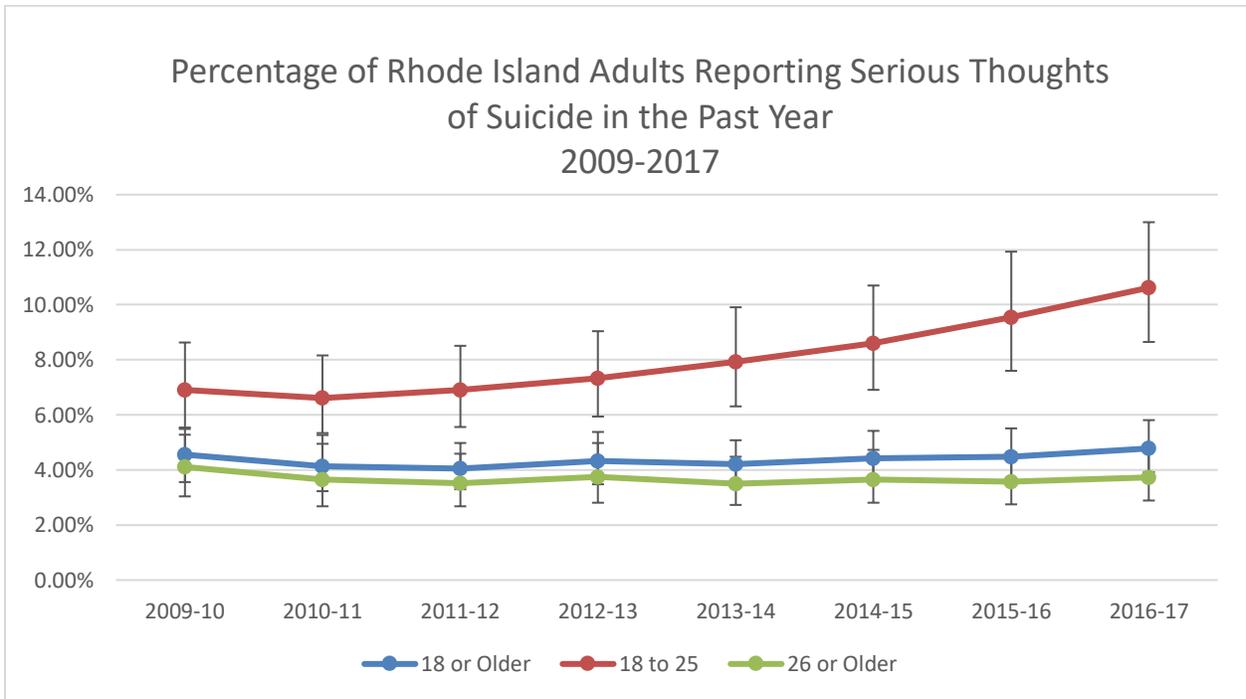
Rhode Island Self-Reported Suicidal Behavior



2015 Youth Risk Behavior Survey⁷



2015 Youth Risk Behavior Survey⁷



Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2016–2017⁹

* Note: Rates are age-adjusted using published Centers for Disease Control methodology to ensure the differences in incidences or deaths among years or geographic areas and are not due to differences in the age distribution of the populations being compared.

Goals

Goal 1: Prevent suicide among Rhode Island residents.

Goal 2: Prevent suicide attempts among Rhode Island residents.

Recommendations

1. Increase screening and identification of Rhode Islanders who are at risk of death from suicide and refer them to appropriate clinical services.
2. Work to reduce the stigma associated with having a mental illness and/or seeking services for mental health and substance abuse issues.
3. Improve and expand behavioral health service delivery.
4. Promote efforts to reduce access to lethal means and methods that result in self-harm or a suicide attempt.
5. Coordinate and expand public health surveillance of suicide and suicide attempts.

Priority Populations

- All ages (life-course approach)
- Youth, age 15-24
- Individuals currently receiving care for mental illness and/or substance use
- Veterans

Risk Factors

Suicide and suicidal ideation can affect anyone, regardless of socioeconomic status, cultural background, or any other demographic indicator. However, there are some population groups that are at higher risk for suicide. They include, but are not limited to:

- American Indians and Alaskan natives
- Anyone bereaved by suicide

- Anyone in Criminal justice system and child welfare settings
- Anyone who intentionally hurt themselves (non-suicidal self-injury)
- Anyone who has previously attempted suicide
- Anyone with medical conditions
- Anyone with mental illness and/or substance use disorders
- Anyone who is lesbian, gay, bisexual, or transgender
- Members of the military and veterans
- Men in midlife (ages 45-64) and older men (65 and older)⁸

Evidence-based Interventions:

The US Substance Abuse and Health Services Administration (SAMHSA) defines evidence-based interventions as those that fall into one or more of three categories:

1. The intervention is included in a federal registry of evidence-based interventions, such as the National Registry of Evidence-based Programs and Practices (NREPP).
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal.
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which must be followed, these guidelines require interventions to be:
 - a. Based on a theory of change that is documented in a clear logic or conceptual mode **AND**
 - b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals **AND**
 - c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects. **AND**
 - d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and

key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

In order for a public health intervention to have a greater chance of success in reducing rates of suicide and suicide attempts in a community, not only must the intervention be evidence-based, it must be appropriate for the targeted population. Also, interventions have a much higher rate of success when addressing both factors that can lead to suicidal behavior: risk and protective factors. The presence of multiple risk factors increases the probability of suicidal ideation and behavior while the presence of multiple protective factors reduces this probability.

Comprehensive suicide prevention programs both reduce risk factors and increase protective factors.

Evidence-based suicide prevention interventions currently utilized by RIDOH's Violence and Injury Prevention Program (VIPP) include:

- Signs of Suicide training for high school and middle school students about peer-to-peer suicide prevention gatekeeper
- Question, Persuade, Refer (QPR): adult suicide prevention gatekeeper training
- Youth and Adult Mental Health First Aid: adult suicide prevention gatekeeper training

Recommendations and Associated Objectives

Recommendation 1: Increase screening and identification of Rhode Islanders who are at risk of death from suicide and refer them to appropriate clinical services.

Objectives:

- 1.1: Throughout the duration of the Plan, seek out additional federal, state, and private funding that increases the availability of evidence-based suicide prevention education and training programs in organizations and places where individuals and families congregate (e.g. schools, faith-based organizations, community groups, etc.).
- 1.2: Annually, provide 10 evidence-based suicide prevention gatekeeper trainings to community organizations, including but not limited to: schools, faith-based organizations, community action groups, Lesbian/Gay/Bisexual/Transsexual/Queer/Questioning (LGBTQQ) organizations, homeless shelters, and parent-teacher organizations.

- 1.3: By 2023, work with Rhode Island higher education officials to embed or enhance evidence-based suicide prevention/behavioral health training in curricula for human resources and business management programs in at least three Rhode Island colleges/universities.
- 1.4: By 2023, train emergency medical service professionals from a minimum of 10 different Rhode Island municipalities to recognize individuals in a mental health crisis and notify hospital emergency room staff of the need for a mental health assessment, when appropriate.
- 1.5: Every two years, or as often as funding allows, provide a Continuing Medical Education course for physicians that includes the topic of suicide and suicide prevention as a key aspect of the training.
- 1.6: By 2021, create and publish a RIDOH Policy Recommendation requiring all primary care physicians to conduct annual basic behavioral health screenings using evidence-based tools.
- 1.7: By 2021, develop an adaptable response protocol for Rhode Island law enforcement officials to use when encountering individuals who are experiencing suicidal ideation and/or mental illness crisis in all applicable settings (schools, normal patrols, social media posts, etc.).
- 1.8: By 2023, collaborate with the Rhode Island Executive Office of Health and Human Services' (EOHHS) Office of Medicaid to create and implement a reimbursable billing code for primary care physicians to conduct behavioral health screenings on Medicaid patients.
- 1.9: Encourage all Rhode Island-based groups involved in suicide prevention to participate in the Annual Primary Care Conference hosted by the Rhode Island Academy of Family Physicians (RIAFP) and distribute informational resources and/or conduct a presentation to attendees.
- 1.10: By 2021, create and publish a RIDOH Policy Recommendation that supports the creation of legislation requiring evidence-based suicide prevention education/training for all Rhode Island firstresponders not already required to do so (EMTs, fire fighters, etc.).

- 1.11: By 2023, establish a partnership between RIDOH and United Way of Rhode Island to ensure that current behavioral health resources are made available to 211 staff to share with their clients.
- 1.12: Throughout the duration of the Plan, ensure a list of local behavioral health resources is made available online and other available communication channels to all Rhode Island gatekeepers trained in evidence-based suicide prevention techniques.
- 1.13: By 2023, work with EOHHS' Office of Medicaid to enhance EPSDT (Early and Periodic Screening, Diagnosis and Treatment) mental/behavioral health services covered by Rhode Island's Medicaid program.

Recommendation 2: Work to reduce the stigma associated with having a mental illness and/or seeking services for behavioral health and substance use issues.

Objectives:

- 2.1: By 2023, work with the Rhode Island Department of Education (RIDE) to incorporate evidence-based education on mental illness in Rhode Island public schools' health education curricula to help reduce stigma among students.
- 2.3: In the next five years, provide support to existing behavioral health peer-support groups providing services for substance abuse, suicide loss, depression, and other relevant topics by promoting their meetings and services via RIDOH's website, publications, and other established communication systems (newsletters, listservs, etc.).
- 2.4: In the next five years, work to identify geographical locations within Rhode Island with a lack of behavioral health peer-support groups and share this information with the Rhode Island Substance Use and Mental Health Leadership Council.
- 2.5: By 2021, ensure that all suicide prevention resources for Rhode Islanders include a current list of local and community resources, in Rhode Island, that is maintained and updated regularly by RIDOH.
- 2.6: Throughout the duration of the Plan, develop and disseminate culturally sensitive and engaging public messaging to raise awareness of suicide among Rhode Island adults as a public health issue that is preventable through early actions of individuals and communities.

- 2.7: Annually conduct a review of a representative sample of Rhode Island media coverage concerning suicide for adherence to the American Foundation for Suicide Prevention's *Recommendations for Reporting on Suicide*. Note any that are not in compliance and provide the media organization with a copy of the recommendations as well as rationale for following them.
- 2.9: By the end of 2021, design and make available new, youth-friendly informational resources, in English and Spanish, on suicide and suicide prevention to all Rhode Island school districts, family physicians, and other relevant stakeholders.
- 2.10: By 2023, engage all Rhode Island colleges/universities on the importance of offering specific resources on suicide prevention and having a plan to refer students who are experiencing a behavioral health crisis to appropriate clinical services.
- 2.11: By 2023, obtain a letter of intent from the senior administration of at least one major healthcare system in Rhode Island to implement a Zero Suicide framework across all of their associated facilities/practices within three years of the letter being signed.
- 2.12: Throughout the duration of the Plan, use RIDOH and the Rhode Island Department of Behavioral Health Developmental Disabilities, and Hospitals (BHDDH) websites to increase the visibility of education and support programs designed to assist families who have members suffering from mental illness and use established communication channels to disseminate information on these programs to all Rhode Island behavioral health clinicians.

Recommendation 3: Improve and expand behavioral health service delivery.

Objectives

- 3.1: By 2022, create and publish an informational report that details how increased Medicaid reimbursements for behavioral health services are linked to enhanced behavioral health outcomes for consumers and increased access to behavioral health services and share this information with EOHHS' Office of Medicaid.
- 3.2: In the next five years, seek out federal, state, or private funding to establish a behavioral health emergency department diversion program for adults who present at Rhode Island emergency departments with behavioral health issues and/or substance use disorders.

- 3.3: By 2021, work with Substance Use and Mental Health Leadership Council and/or BHDDH to re-establish the monthly meetings of Rhode Island community mental health centers and other relevant stakeholders with the goal of coordinating mental health care across RI and fulfilling relevant objectives of this Plan.
- 3.4: By 2023, collaborate with BHDDH to develop a navigational framework for behavioral healthcare providers, with Screening, Brief Intervention, Referral and Treatment (SBIRT) professionals embedded in all of Rhode Island's community health centers.
- 3.6: Beginning in 2019, work with appropriate EOHHS staff to identify existing feasible insurance reimbursement mechanisms for behavioral tele-medicine services.
- 3.7: By 2022, work with CurrentCare Rhode Island to expand the number of behavioral health clinicians that regularly submit relevant patient data to the CurrentCare system.
- 3.8: Work with Rhode Island graduate and medical programs to promote Healthcare Professionals Loan Repayment Program (HPLRP) to recently graduated Rhode Island behavioral health clinicians who are willing to work in identified Mental Health Service Provider Shortage Areas within Rhode Island.
- 3.9: To better serve the Latino(a)/Hispanic population in Rhode Island, work with Rhode Island-based healthcare systems to continuously recruit Spanish-speaking behavioral clinicians using incentives such as the HPLRP.
- 3.10: By 2023, create a visual map of the administrative structure for behavioral health services among State agencies that creates a clear vision, guidelines for provider organizations, and delineation of responsibilities.
- 3.11: By 2021, create a formal recommendation of occupations that are licensed or certified by RIDOH that should include suicide-prevention training as part of the pre-requisites for licensure/certification.
- 3.12: Throughout the duration of the Plan, work with the Rhode Island Chapter of the National Alliance on Mental Illness (NAMI) to promote existing support services and groups for families of those suffering from a mental illness and/or suicidal ideation.
- 3.13: By 2023, create and disseminate an informational packet of behavioral health resources consisting of hotlines, behavioral health providers' information, child psychiatry services, and screening tools, to all Rhode Island medical providers.

- 3.14: By 2023, educate and inform policy makers on the need to expand student-assistance programs to all Rhode Island public middle and high schools.
- 3.15: Beginning in 2019, research and document feasible insurance reimbursement mechanisms for provision of counseling services in Rhode Island middle and high schools to ensure consistent funding for these services in Rhode Island schools.

Recommendation 4: Promote efforts to reduce access to lethal means and methods that result in self-harm or a suicide attempt.

Objectives

- 4.1: Annually provide evidence to relevant State agency Directors on the effectiveness of reducing suicide rates through comprehensive firearm safety policies.
- 4.2: Throughout the duration of the Plan, raise awareness of current firearm-safety laws, under Rhode Island General Law Chapter 11-47 Weapons and promote locations that provide free resources allowing Rhode Islanders to comply with current laws (gunlocks, etc.) via firearm vendors, shooting ranges, and RIDOH's website.
- 4.3: By 2021, provide all Rhode Island-licensed peer-recovery service organizations and medical provider organizations with information on how substance abuse and other high-risk behaviors are linked to suicide and promote existing evidence-based training opportunities for counselors so they can recognize suicidal ideation in their clients.
- 4.4: By 2021, establish a work group of stakeholders from a variety of healthcare, public safety, and community organizations to develop an implementation plan for incorporating counseling on access to lethal means (CALM) training into all relevant settings.
- 4.5: Throughout the duration of the Plan, research and provide evidence to Rhode Island legislators on the effectiveness of using blister packaging for over-the-counter and prescription drugs as a way to discourage their use as lethal means.
- 4.6: Annually provide suicide prevention resources and/or training to a minimum of five gun-store employees/owners that helps them identify actively suicidal customers and take actions consistent with statutory authority.
- 4.7: Throughout the duration of the Plan, coordinate with the US Drug Enforcement Agency (DEA) to promote the use of take-back days to dispose of unused or expired

prescription/illicit drugs at designated locations in Rhode Island (police stations, fire departments, pharmacies, etc.)

- 4.8: Throughout the duration of the Plan, work with the Rhode Island Office of the Health Insurance Commissioner (OHIC) to examine Rhode Island health insurers' policies regarding 90-day supplies of prescription medications and create and disseminate a list of recommendations for prescribers to help them avoid giving large quantities of lethal medication to at-risk patients.
- 4.9: By 2021, establish a partnership with the Regional Center for Poison Control and Prevention to ensure their frontline staff receive suicide prevention training and that they offer information on suicide/suicide prevention on their website.

Recommendation 5: Coordinate and expand public health surveillance of suicide and suicide attempts.

Objectives

- 5.1: Annually, review peer-reviewed literature for new and emerging suicidal ideation screening tools and evaluate their potential for use in various settings throughout Rhode Island.
- 5.2: By the end of 2020, publish a report that includes all current sources of data on suicides and suicide attempts and any data gaps that should be addressed.
- 5.3: By 2021, establish memorandums of understanding with all applicable State agencies so that RIDOH receives de-identified data on suicide attempts by individuals under their care/jurisdiction.
- 5.4: By 2021, identify and implement a feasible method to incorporate reports on suicide attempts into various first-responder report systems where it is not already included (i.e EMTs, police, fire fighters, etc.).
- 5.5: By 2021, submit new regulations requiring first-responders to identify suicides and/or suicide attempts correctly on relevant reporting mechanisms as well as appropriate training (i.e EMS logs, police reports, etc.).
- 5.6: By 2023, establish an Adult Death Review Team to examine all adult suicides that take place in Rhode Island and identify the underlying cause(s).

- 5.7: Throughout the duration of the Plan, provide education to Rhode Island school administrators on the value of asking students about suicidal ideation/behavior while using peer-reviewed literature to demonstrate that there is no proven harm in asking these questions.
- 5.8: Annually conduct a health disparities evaluation of populations in Rhode Island to clarify which groups are at a higher risk of death by suicide/suicide attempts and classify these populations by as many criteria as possible (gender, sexual orientation, etc.).
- 5.9: Annually review the incidence of intentional poisonings in Rhode Island that are caused by use or misuse of illicit and legal drugs/medications for trends that can be quantified and addressed.
- 5.10: Annually review national suicide data to target occupations who have a higher risk of suicidal ideation and provide information on mental illness and suicide prevention to those occupations through their interactions with State agencies (licensing, permitting, etc.).

References:

1. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS), National Vital Statistics System
2. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. Division of Violence Prevention. Suicide Prevention: A Public Health Issue. https://www.cdc.gov/violenceprevention/pdf/asap_suicide_issue2-a.pdf
3. Ivey-Stephenson AE, Jakc SP, Haileyesus T et al. Suicide trends among and within urbanization levels by sex, race/ethnicity, age group, and mechanism of death—United States, 2001-2015.
4. Curtin SC, Warner M, Hedegaard H. Increase in suicide in the United States, 1999–2014. NCHS data brief, no 241. Hyattsville, MD: National Center for Health Statistics. 2016.
5. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS), National Vital Statistics System. Bureau of Census for population estimate.
6. SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2017.
7. 2017 Youth Risk Behavior Survey Results, Rhode Island.
8. Substance Abuse and Mental Health Services Administration, “Populations at Risk for Suicide”. <https://www.samhsa.gov/suicide-prevention/at-risk-populations>. Last updated: 10/09/2014