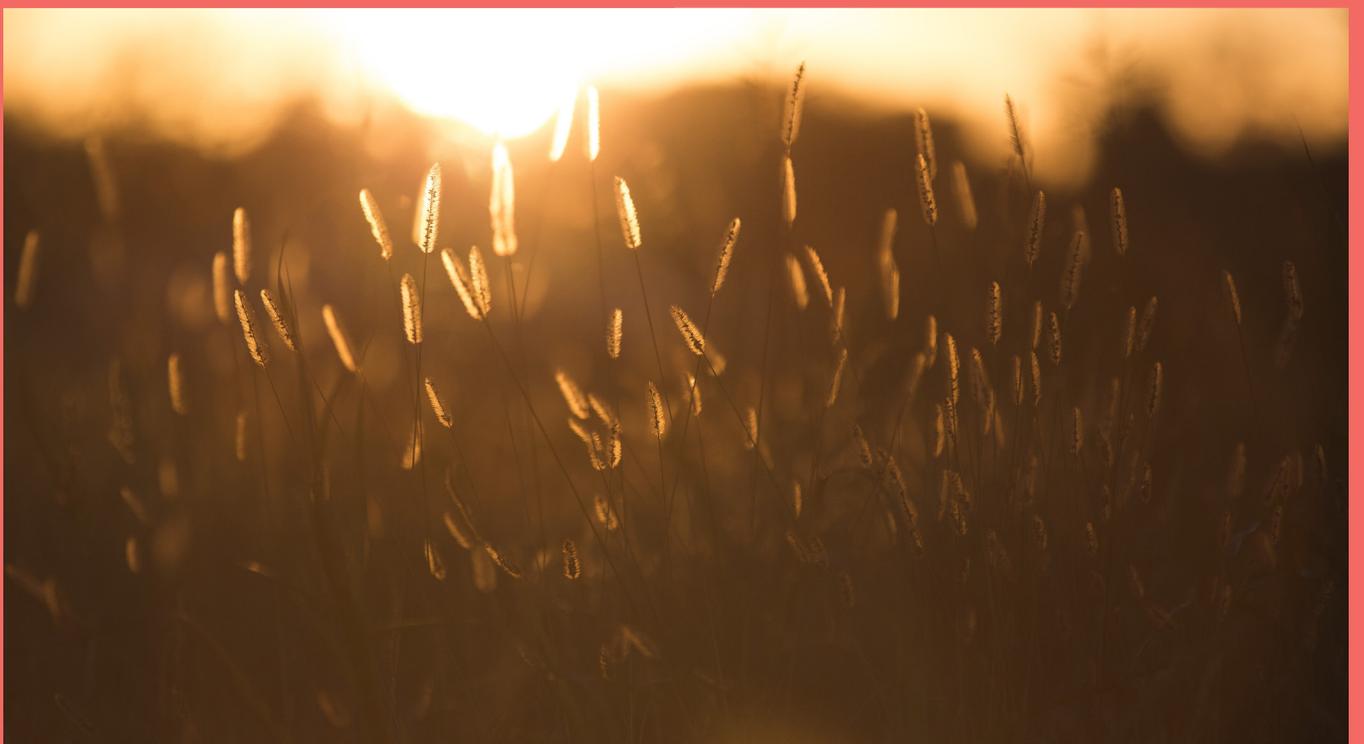


# Kansas Suicide Prevention Plan

*2021-2025*



# Table of Contents

- 03 / Introduction and Purpose**
- 04 / Dedication and In Memoriam**
- 05 / Statement of Need: Suicide in U.S. & Kansas**
- 12 / Methods & Means**
- 13 / Understanding Suicide**
- 13 / Strategic Plan Background**
- 18 / Goals and Objectives Summary Table**
- 32 / 5 Year Timeline At-A-Glance Table**
- 34 / Appendix 1: Additional Resources**
- 35 / Appendix 2: Service Members, Veterans, and Families Subcommittee and Governor's Challenge Team Action Plan**
- 39 / Appendix 3: Training Resources and Protocols**
- 40 / Appendix 4: Data Considerations**
- 49 / Appendix 5: References**
- 50 / Appendix 6: Contributors**

## Introduction /

Suicide is a preventable public health concern and requires a public, behavioral health approach to prevention efforts. Individuals, families, and whole communities are affected when someone dies by suicide. Suicide is complex, multi-faceted, and emotionally and financially costly. Everyone has a role to play in suicide prevention. Work must be done to consider and change factors that are known to contribute to suicide risk, such as adverse childhood experiences, lack of connectedness and healthy relationships in communities, socioeconomic factors, history of suicide attempts and ideation, access to lethal means, and lack of access to appropriate and adequate behavioral healthcare. Partners in the State of Kansas are committed to addressing suicide prevention using a comprehensive public health approach to lead efforts toward reducing suicide morbidity and mortality, with special attention to vulnerable populations with suicide rates greater than the general population. This comprehensive approach includes elements such as:

- Multi-sector partnerships working within a variety of settings
- Continued and improved data collection to identify and prioritize vulnerable populations as well as risk and protective factors that impact those populations
- Use of evidence-based initiatives to address suicide prevention
- Evaluation of approaches and activities to support continuous improvement and sustained impact
- Effective communications

Behavioral Health Services, housed under the Kansas Department for Aging and Disability Services (KDADS), has made significant strides in building public-private partnerships to develop and accomplish its suicide prevention goals and objectives, and to more adequately respond to the rising crisis of suicide in the state. Additionally, KDADS supports the Prevention Subcommittee of the Governor's Behavioral Health Services Planning Council in its role of contributing to, advising, connecting, and guiding suicide prevention efforts around the state. Key partners in suicide prevention include:

- Kansas Department of Health and Environment
- Kansas Suicide Prevention HQ
- Keys for Networking
- Office of the Kansas Attorney General
- Kansas Prevention Collaborative
- Kansas Consumer Advisory Council
- Kansas State Department of Education
- NAMI Kansas
- Kansas Department of Agriculture
- Kansas Department for Children and Families
- Kansas Commission on Veteran Affairs
- Association of Community Mental Health Centers of Kansas
- Individuals and families with lived experience including those with suicidal ideation, suicide attempt survivors, and suicide loss survivors
- Local suicide prevention coalitions

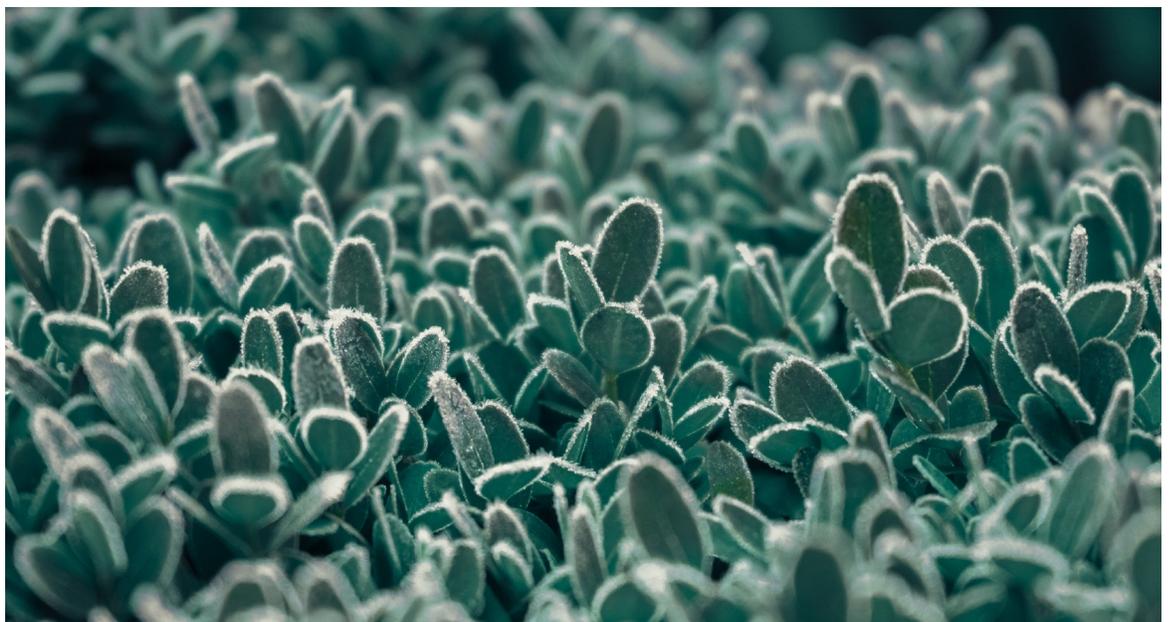
The Kansas Suicide Prevention Plan (2021-2025) outlines the activities and responsibilities necessary to accomplish suicide prevention goals and objectives across the lifespan. The primary purpose of this State Suicide Prevention Plan is to reduce death by suicide in Kansas. This plan will be renewed every 5 years, with reviews occurring at least annually, as needed, and based on any significant changes in data or resources. Annual reports will be submitted to the Governor's Behavioral Health Services Planning Council and the State Legislature or Governor, providing updates on the state of suicide and prevention efforts, the extent and effectiveness of any statute or rule related to suicide, and emerging needs. The plan is a guide for future priorities and decisions for the State of Kansas during the years 2021-2025. The plan addresses four strategic directions and related goals and objectives:

- Healthy and Empowered Individuals, Families and Communities
- Clinical and Community Preventive Services
- Treatment and Support Services
- Surveillance, Research, and Evaluation

## **Dedication and In Memoriam /**

Many people in Kansas are living with the effects of suicide every day. We think it is important to acknowledge the pain of those who have lost someone to suicide and the hard work of those recovering from suicide crises. All Kansans have benefited from a diverse group of suicide prevention advocates, professionals, first responders, clinicians and others who work passionately each day. This document is dedicated to all of you.

This plan is also dedicated in memory of Eric Harkness and Chris Ellis for their service to the Governor's Behavioral Health Services Planning Council in support of suicide prevention and behavioral health advocacy in Kansas.



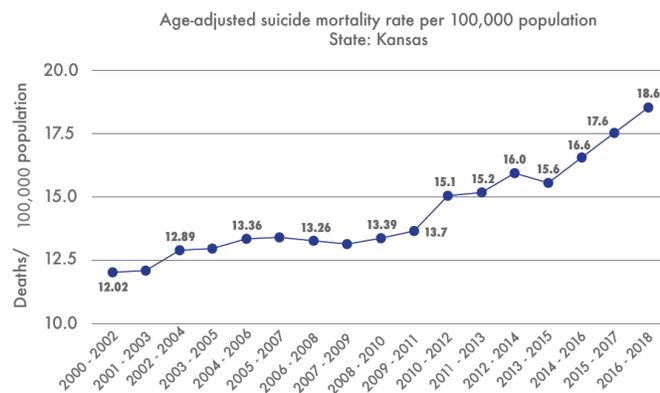
*“No matter where we live or what we do every day, each of us has a role in preventing suicide. Our actions can make a difference... We have no time to waste.”*

## *-2012 National Strategy for Suicide Prevention*

### **Statement of Need /**

Suicide is a serious personal and public health problem that has far reaching medical, economic, and psychosocial implications for Kansans. From 2015 to 2017, Kansas resident suicides cost an estimated \$2.24 billion (2017 US dollars) in medical expenses and work loss, and 46,837 years of potential life lost (YPLL) if people die before age 75<sup>1</sup>. The rate of suicide in Kansas increased by 70% between 2000 (12.02 per 100,000 persons) and 2018 (18.6 per 100,000 persons)<sup>2</sup>. (See Figure 1)

**Figure 1:**



The 2018 suicide rate was the highest in the last 20 years and is higher than the national rate (14.2 per 100,000 persons), which increased 35% during the same time period.<sup>3</sup> In 2018, suicide was the 9th leading cause of death among all ages and the 2nd leading cause of death following unintentional injuries for those age 15-34 years in Kansas.<sup>4</sup> In addition, from 2015 to 2017 there were 2,055 violent deaths (cases) among Kansas residents captured in the Kansas Violent Death Reporting System (KSVDRS). About three quarters (73.9%) of cases were suicide deaths (n=1,518).

<sup>1</sup>Kansas Violent Death Reporting System. (2019). 2015-2017 Death Circumstances Data. Kansas Department of Health and Environment Internal Data request.

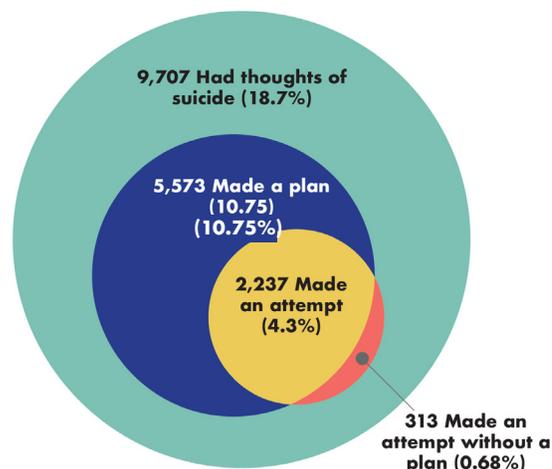
<sup>2</sup>Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2003). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available from: URL: [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars).

<sup>3</sup>Kansas Information for Communities (2020). 1999 and 2018 Vital Statistics Data, Bureau of Epidemiology and Public Health Informatics, KDHE.

<sup>4</sup>Kansas Information for Communities (2020). 2013-2017 Vital Statistics Data, Bureau of Epidemiology and Public Health Informatics KDHE. Retrieved from [http://kic.kdheks.gov/death\\_new.php](http://kic.kdheks.gov/death_new.php)

In addition to suicide deaths, it is also relevant to consider the number of people who are seeking help from healthcare providers for suicide attempts and ideation. From 2016 to 2018, emergency department visits and hospitalization rates increased for suicide ideation related injuries. More than 17,000 Kansans sought help in Emergency Departments for suicide attempts and/or ideation in 2018. To deliver comprehensive suicide prevention, plans must include strategies that target the whole population, including those people who have never experienced suicide (universal), those at an increased risk for suicide due to heightened risk factors (targeted), those who have thought about or planned for suicide (treatment), and those who have experienced a suicide loss. Figure 2 indicates the relationship between suicide thoughts, plans, and attempts among Kansas youth; this underscores the opportunity for intervention at a variety of stages in the contemplation process. The amount of time necessary to formulate a plan for suicide also provides time for successful intervention.

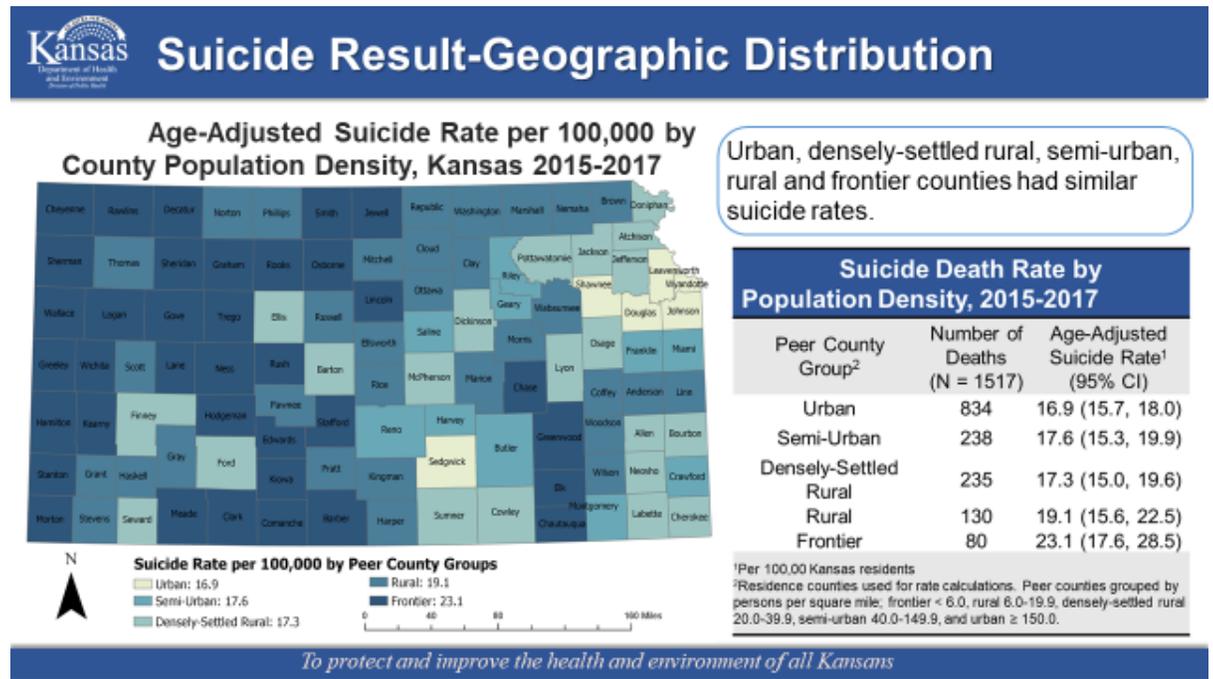
**Figure 2:** 2019 Kansas Student-Reported Suicide Thoughts, Plans, and Attempts



**Geographic Variation:** Kansas is a predominantly rural state, with one-third of the population living in two-thirds of its land mass. Suicide rates vary in different areas of Kansas due to the size and rural nature of our state. While the highest count of suicide deaths occurs in the urban counties of Kansas, the highest suicide rates are found in counties with population densities low enough to be classified as Frontier. In the map below, the Kansas Department of Health and Environment (KDHE) has values available for counties in Kansas by population density. The lowest rate of death by suicide per 100,000 is 0, the highest value is 57.4/100,000 (Woodson County), half of the values are between 13.9 and 23.9, and the median value is 18. High suicide rates and low population density present a unique problem to delivering healthcare, a barrier faced by 99 Kansas counties that are designated mental health professional shortage areas. Only the state's six urban counties are exceptions from this trend<sup>1</sup> (See Figure 3). To best meet the needs of all Kansans, the National Suicide Prevention Lifeline provides a responsive resource that is not dependent on proximity to brick and mortar location.

<sup>1</sup>Kansas Information for Communities (2020). 2013-2017 Vital Statistics Data, Bureau of Epidemiology and Public Health Informatics KDHE. Retrieved from [http://kic.kdheks.gov/death\\_new.php](http://kic.kdheks.gov/death_new.php)

Figure 3:



Kansans have been reaching out to suicide prevention resources, including the National Suicide Prevention Lifeline, in increasing numbers (See Figure 4). In addition to the National Suicide Prevention Lifeline, there are many hotlines and crisis text lines that provide services directed toward a specific population, such as Trans Lifeline, Trevor Project Lifeline, and Crisis Text Line. Though these crucial resources are too plentiful to list, a subset is found in Appendix 1.

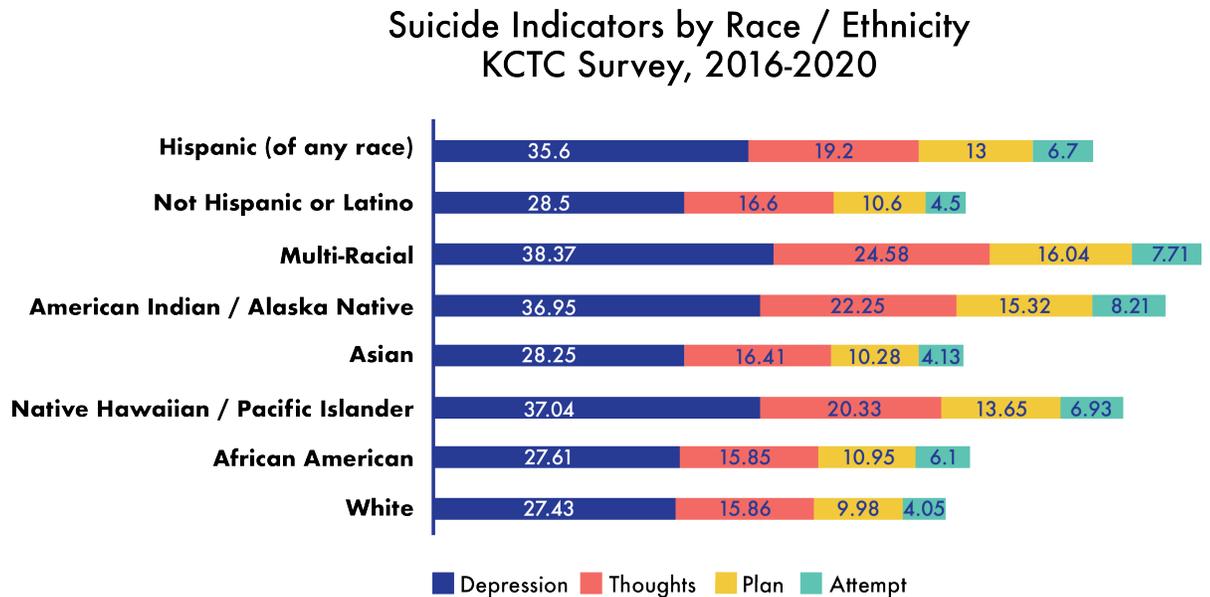
Figure 4:

**Number of calls to the Suicide Prevention Lifeline by Kansas Region, 2015-2019**

Region	2015	2016	2017	2018	2019
Northwest	178	279	263	247	333
Southwest	291	397	620	819	473.9
North Central	680	337	639	885	750
South Central	3,263	3,498	5,233	6,037	5,478
Northeast	6,217	5,905	8,122	8,760	9,309
Southeast	459	406	534	713	768
<b>Yearly Total</b>	<b>11,088</b>	<b>10,822</b>	<b>15,411</b>	<b>17,461</b>	<b>17,111</b>

**Race and Ethnicity:** Race and ethnicity are important factors for considering approaches to suicide prevention. There are racial and ethnic disparities present in all aspects of suicide data, including deaths, plans for suicide, attempts, and suicide ideation (See Figure 5).

Figure 5:



Of youth, those who identify as Multi-Racial report the highest frequency of serious thoughts of suicide, plans for suicide, and suicide attempts<sup>5</sup> (See Figure 5).

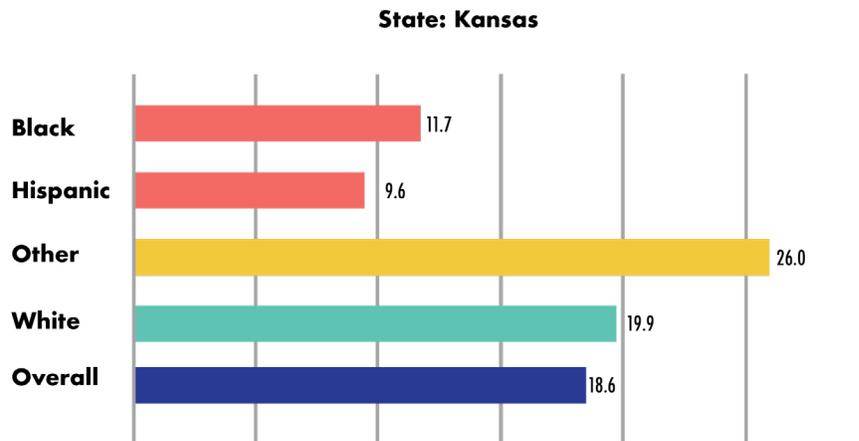
An average of 27% of white youth self-reported depression from 2016-2020, while 37% of Native American/Alaska Native and 38% of Multi-Racial youth reported depression for the same time period<sup>5</sup>. Given the small number of youth suicides, it is not possible to report on suicide death rates for the same group surveyed above. It is important that group-specific risk and protective factors be explored and leveraged in planning of state and local suicide prevention efforts.

Kansas data reflects a low number of suicides among Native American individuals, although this is because the size of this population group in Kansas is too small to produce reliable estimates. National trends suggest suicide rates tend to be higher among Native American and indigenous populations, which may hold true for Kansas and should be considered in discussions on suicide prevention in our state.

Non-Hispanic White people have the highest suicide rate at 19.9 per 100,000 (2016-2018)<sup>6</sup>, as presented in Figure 6.

<sup>5</sup>Kansas Communities That Care Student Survey. (2016-2020). Suicide Indicators by Race and Ethnicity [Data]. Learning Tree Institute at Greenbush on behalf of the Kansas Department for Aging and Disability Services]. Girard KS: Survey Publisher.  
<sup>6</sup>Kansas Health Matters [Internet]. Topeka (KS): Kansas Partnership for Improving Community Health [cited Feb 2020], Available from [www.kansashealthmatters.org](http://www.kansashealthmatters.org)

Figure 6: Age-Adjusted Suicide Mortality Rate per 100,000 Population by Race/Ethnicity



**Age, Sex, and Gender:** Suicide prevention efforts are often siloed by age groups. It is important to understand how Kansans of different ages are being affected by suicide and related risk factors as this helps with prevention and intervention planning. However, it is also important to note suicide prevention must occur across the lifespan to make a lasting impact on this public health problem.

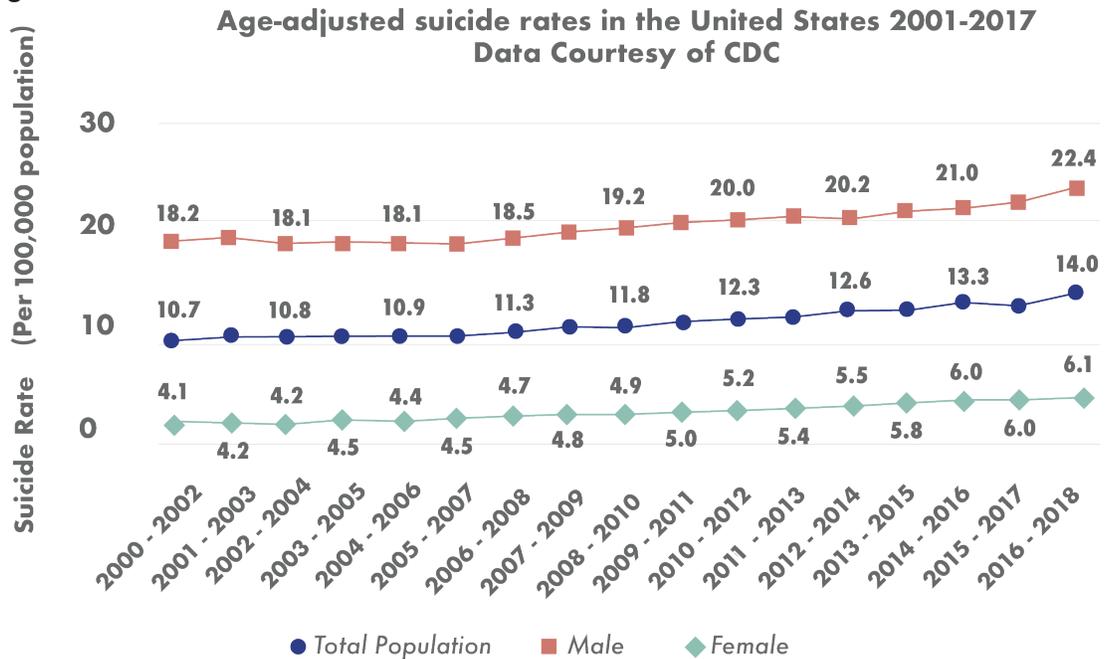
State level data reflects the need for a lifespan approach. Kansans aged 25-44 and 45-64 had the highest suicide rates, i.e., 25.7 and 24.9 per 100,000 respectively, compared to other age groups. Middle-aged adults also report the highest rates of depression, approximately 20% of 45-64 year olds. While the suicide rate for those ages 15-24 is not as high nor has it been increasing as quickly as the age groups previously discussed, suicide was the second-leading cause of death in this age group in 2017<sup>1</sup>. Syndromic Surveillance Data also shows that Kansas young people visit Emergency Departments for suicide ideation and attempts the most frequently. This trend may reflect differences in prevalence or may be indicative of the ability of older Kansans to access a wider variety of resources for support.

Suicide affects the lives of men and women in Kansas differently. From 2015-2017, the age-adjusted mortality rate of males (27.5 per 100,000) was 3.6 times the suicide rate of females (7.7 per 100,000). Males make up over three quarters (78.3 percent) of all suicide deaths in Kansas; however, suicides rates for both men and women have been increasing at the State and National levels<sup>7</sup> (See Figure 7).



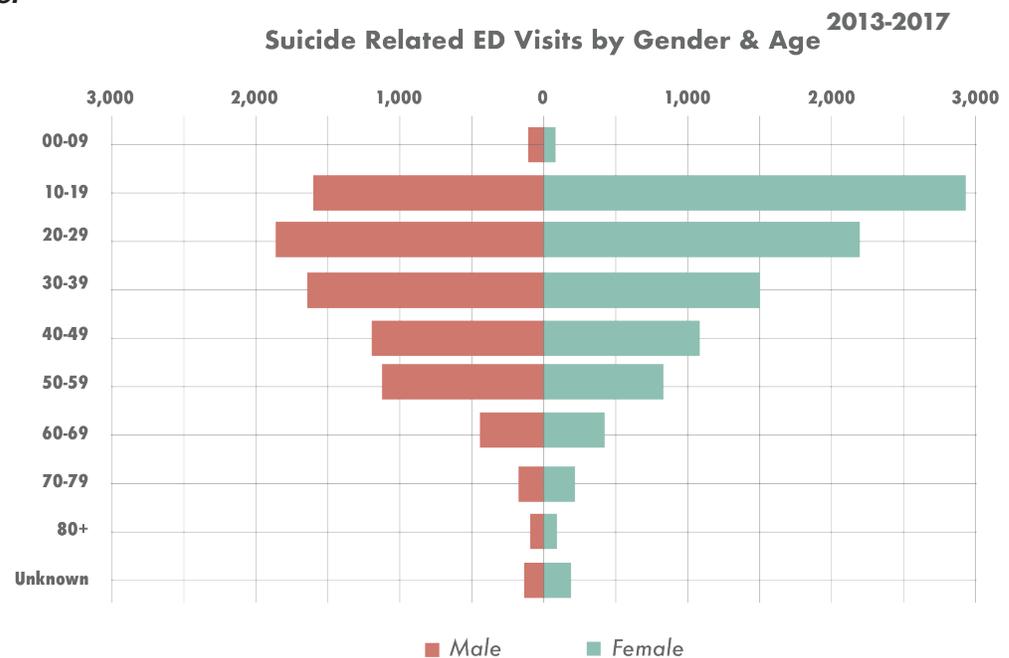
<sup>7</sup>Centers for Disease Control. (2019). 2013-2017 Behavior Risk Factor Surveillance System (BRFSS) Data.

Figure 7:



This difference in suicide by gender may suggest a need to approach prevention, screening, and treatment in ways that address gender differences in suicide, as supported by other statistics and research studies. Disparities in suicide ideation, behaviors, means-utilized, and access of treatment are also observed along gender lines. More female youth (6-12th grade) report feeling depressed (33.1%; 19.4%), suicide ideation (17.5%; 10%), suicide plans (11.3%; 6.7%) and attempts (5.5%; 2.5%) than their male peers. In fact, more than twice the number of female students reported attempts than male students from 2013-2017<sup>4</sup> (See Figure 7). From KDHE’s Role of Public Health in Suicide Prevention, across age groups, more females seek treatment in Emergency Departments than males<sup>7</sup> (See Figure 8).

Figure 8:



<sup>9</sup>Kansas Violent Death Reporting System. (2019). 2015-2017 Death Circumstances Data. Kansas Department of Health and Environment. Internal Data request.

## Groups with Elevated Suicide Risk:

Effective communication and prevention efforts required targeted messaging and promotion to historically under-resourced populations who have faced factors leading to increased risk. Data shows that veterans, some occupational groups, and the LGBTQ+ population are disproportionately affected by suicide. According to the U.S. Department of Veterans Affairs, after accounting for differences in age and sex, risk for suicide among veterans was 22% higher than the general U.S. civilian population. In Kansas, there is an increasing trend in suicide deaths for veterans aged 18-34 rising from 1.1 to 3.4 deaths per 100,000 from 2005 to 2017. Gulf War Era veterans accounted for 45.9% of all veteran suicides from 2014-2019.<sup>8</sup>

According to the Kansas Violent Death Reporting System (KSVDRS), among Kansas residents 16 or older who died by suicide the most common 6 occupations were:

- **Unpaid:** 13% (e.g. housewives, homemakers, students, disabled, volunteers, patients, inmates, and those without work)
- **Construction and Extraction:** 11% (e.g. earth drillers, oil, gas, mining, explosives, rock splitters, etc.)
- **Transportation and Material Moving:** 10%
- **Production:** 8%
- **Management:** 7%
- **Sales:** 7%

Occupation groups varied between males and females. About 30% of females who died by suicide did not have a paying job compared to 9% of males. Males in farm, forest, or fishing groups had highest suicide rate (158.4 per 100,000). Among females, the highest mortality rate of workers was in healthcare support, 21.0 per 100,000<sup>1</sup>, followed by the healthcare practitioners and technical group, 13.8 per 100,000. It is important to offer occupation groups suicide prevention and postvention resources specific to needs.

The Trevor Project recently completed a nation-wide survey of 34,000 LGBTQ+ youth. Results show that 71% of respondents reported symptoms of depression, 39% had considered suicide, and 18% had attempted suicide<sup>9</sup>. Because sexual orientation and gender identity are not systematically recorded at time of death in Kansas, it is difficult to understand what disparities may exist in this state. This is an important area for research and data collection.

<sup>8</sup>Kansas Veteran Administration Database exported March 6,2019

<sup>9</sup>The Trevor Project. (2019). National survey on LGBTQ youth mental health. Retrieved from <https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results-2019.pdf>

## Methods & Means /

The KSVDRS gives some insight into the circumstances surrounding suicide deaths. Learning about circumstances and methods used in suicides provides valuable information in targeting suicide prevention efforts, including means-access reduction strategies. For example, firearms were utilized in the majority of suicide deaths from 2015-2017, and data shows that this method is most commonly chosen by men.

In addition to addressing safe storage of firearms, planning for the storage and access to intoxicating substances and medications is important as toxicology reports show that alcohol is a factor in 35% of suicides and opiates were responsible for 28% of suicide poisoning deaths. For most suicide deaths, loved ones report a number of different life stressors, mental health factors and other circumstances that could have contributed to their deaths. From 2015-2017, it was reported that 25% of suicide decedents disclosed thoughts of suicide and only 34% were reported to have a history of suicide thoughts. The vast majority of suicide disclosures happened to family members or intimate partners (69%)<sup>1</sup>.

Mental health concerns and services are an important component of addressing the suicide crisis in Kansas. While not all people who died by suicide had a known mental health condition at the time of their death, 42% did report a current mental health condition, with depression being the most common condition reported<sup>1</sup>. Given that only 18% were reportedly in treatment and that family was the most commonly reported person to know about thoughts of suicide, this plan will place an emphasis on preparing whole communities, not just healthcare providers, to recognize suicide risk. Suicide prevention must become everyone's business.



## Understanding Suicide /

A common question to suicide is, “Why?” There is no easy answer to this question. Suicide research is a growing field, helping to increase our understanding and to recognize the empirically supported interventions in our communities. Suicide attempt and suicide loss survivors offer a bold and crucial voice in explaining why individuals in crisis might turn to suicide, as well as identifying necessary approaches and resources to assist individuals and their support systems during that time.

Many people feel negative or uncomfortable about suicide and those who have personal experience with it; this is stigma. Stigma limits our abilities to prevent suicide. Cultural and religious traditions can also cause discomfort in discussing suicide, as well as fear of worsening the problem and the shame, guilt and isolation felt by many who have experienced loss or suicide risk. Effective suicide prevention efforts will recognize and work to dismantle the stigma held against both youth and adult consumers of mental health services and survivors of suicide crisis.

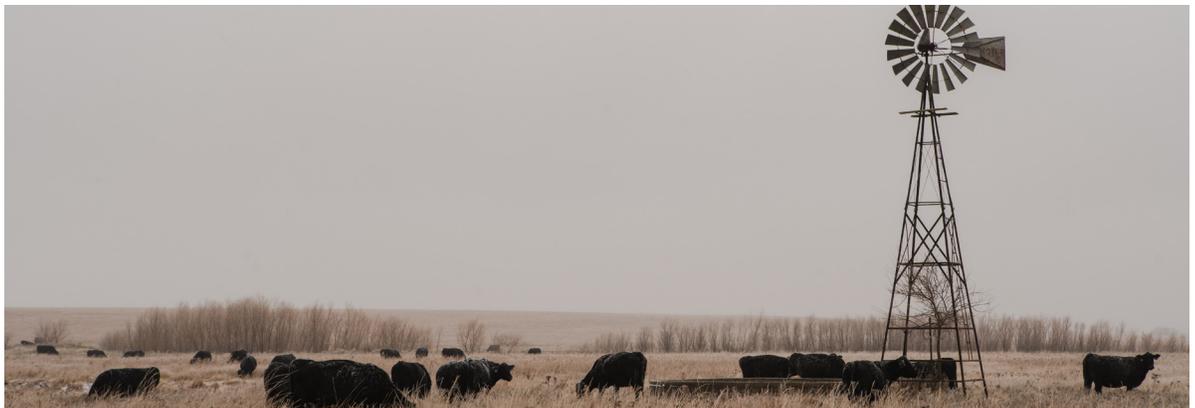
### **Strategic Direction #1 – Healthy and Empowered Individuals, Families, and Communities**

**Goal #1:** Integrate and coordinate suicide prevention activities across multiple sectors and settings.

- To truly impact the lives of Kansans and improve support available to those affected by suicide, it is necessary for this plan to identify a life course, multifaceted, comprehensive approach to suicide prevention. A strong infrastructure needs to be built in the state of Kansas to support this approach. Building a statewide suicide prevention coalition that represents both public and private sectors will provide opportunities for these partners to align their suicide prevention efforts and implement empirically supported interventions. Multiple state agencies have responsibilities and opportunities to advance suicide prevention efforts through their regulatory and service provision work. Increased collaboration is key to achieving suicide safer care for the people of Kansas. Some of the most important voices in shaping suicide prevention efforts should be people with lived experience of suicide attempts, thoughts, and loss. These individuals must be included in all levels of suicide prevention planning to ensure that the work is guided by their wisdom and addresses their needs.
- Establishing a statewide suicide prevention coalition will empower Kansans to connect suicide efforts currently underway and to support the fact that bringing people who represent multiple sectors from communities together with people from other communities in Kansas will improve prevention.
- Suicide prevention coalitions and organizations across Kansas bring passionate people together to discuss suicide and take action. Other

coalitions make suicide a priority (such as those with a mental health, public health, early childhood, problem gambling, and substance abuse prevention focus). These are parts of communities formally engaging in suicide prevention, alongside families, religious communities, and workplaces. •Input from diverse sectors including health, education, social services, justice, policy, and the private sector can help address suicide. Building partnerships and effective collaborations impacting each level of society are important to prevention. An Interagency Group of statewide partners assures effective use of resources, consistent and comprehensive messaging, and shared vision and initiatives. The Interagency Group consists of:

Agency	Role
Kansas Department for Aging and Disability Services	Leads State suicide prevention efforts and houses the State Suicide Prevention Coordinator
Office of the Kansas Attorney General	Houses the Kansas Youth Suicide Prevention Coordinator
Kansas Department for Children and Families	Works with, and provides resources for, some of the states most vulnerable populations
Kansas State Department of Education	Provides recommendations and supports training, planning, and policy for suicide prevention in schools
Kansas Department of Health and Environment	Facilitates the Interagency Group, collects data, and integrates suicide prevention into public health programs
Kansas Suicide Prevention HQ	Hosts the Suicide Prevention Lifeline and the State Suicide Prevention Resource Center



**Goal #2:** Strengthen and broaden public communication efforts about risk and protective factors for suicide.

- Communication efforts play an important role in suicide prevention. These efforts can change attitudes and behaviors among specific segments of the population, which in turn can promote changes in the environment that support suicide prevention. Communication efforts should be research-based and reflect safe messaging recommendations specific to suicide. Given that there are many organizations already doing the hard work of social and media messaging, it is important that they have access to high quality information to help them to identify their audiences.
- Additionally, policy makers at the state and local levels have an important part to play in supporting suicide prevention efforts with resources and policies.
- One function of the state suicide prevention coalition should be to provide information to advocates and policy makers about how to advance the work of suicide prevention in our state.

## **Strategic Direction #2 – Clinical and Community Preventive Services**

**Goal #1:** Target suicide prevention efforts by learning about and providing populations with heightened risk and/or behavioral health disparities with services and resources.

- Research and public health data have shown some groups are at a higher risk for dying by suicide. These groups include but are not limited to suicide loss survivors, justice or child welfare system involved individuals, those who engage in non-suicidal self-injury (NSSI), suicide attempt survivors, and those with mental health and/or substance use disorders.
- There are also a variety of demographic groups who are known to be at a higher risk. Some of these groups can be identified through Kansas data. For example, surveys of Kansas residents show that those of multiracial backgrounds have higher instances of suicidal thoughts and depression symptoms compared to the rest of the population, which may in part be explained by the unique stressors racial and ethnic minorities experience in our society. For some groups there is a gap in data that makes it difficult to plan effective interventions, such as LGBTQ+ individuals in Kansas. Efforts must be undertaken to not only improve the inclusivity of data collection, but also to use available data to adapt and target prevention and intervention efforts for groups with an increased risk of suicide.

**Goal #2:** Support local efforts to reduce access to lethal means.

- Reducing access to lethal means for suicide (e.g., bridge barriers, safe storage for firearms and medications) has been shown to save lives from suicide. It is incumbent on local suicide prevention advocates, firearms owners and advocates to work together towards a common goal of increasing safety from suicide during times of crisis. This can be accomplished through education and safety storage efforts. Considering the elevated risk of death by suicide involving a firearm, this objective is an extremely important one to gain local and state support, coordination, and clear communication. Additionally, parents, medical professionals and advocates can work together to limit prescriptions and access to over-the-counter medications that present a risk to safety for those who are considering suicide.

## Strategic Direction #3 – Treatment and Support Services

**Goal #1:** Promote a standard for suicide related behavioral care to improve access to services.

- In order to save lives, it is crucial that those experiencing suicide risk and their loved ones have access to effective support. Healthcare and behavioral health care providers should work with state agencies and regulators to implement robust workforce development initiatives to prepare providers to address suicide risk, adopt research backed screening and assessment tools, and provide treatments that are targeted at reducing suicide risk. Emphasis across providers on prioritizing suicide care will not only save lives, but will help to reduce stigma related to seeking help for suicide. This is achieved by normalizing suicide care as a part of health and behavioral health care.

**Goal #2:** Increase access to crisis services.

- It is too often the case that families and individuals are confused about how to navigate social service and mental health systems when they need to find help right away. Crisis systems often vary from community to community which can make seeking advice or knowing what to expect difficult. It is critical that statewide resources like crisis lines be adequately funded to help in times of imminent crisis.

- Crisis services also need to incorporate new technologies that increase access for adolescents. It must be acknowledged that no single technology or crisis line is a substitute for a comprehensive continuum of crisis services. Kansas should move toward a continuum that includes a technologically advanced and integrated crisis line, mobile crisis response teams, regional crisis stabilization beds, and advocacy groups so that Kansans, youth and adults alike, can receive services in their, or close to their, homes and support systems.

Efforts in this goal are intended to:

- Reduce the need for individuals accessing inpatient hospitalization
- Increase access to services post-discharge
- Increase services for preventative care, including outpatient mental health treatment

- Based on feedback from youth and adult consumers, their parents or caregivers, and their families, the State could recognize exemplary programs, services and individual providers as they are identified. Kansas could also encourage high-quality services by capturing the stories and experiences of those participating in improvement planning for services across the continuum of care.

**Goal #3:** Support Postvention.

- Individuals who have experienced a suicide loss can become at greater risk for suicide themselves. As such, it is important that supports be built to help those who have lost someone to suicide address their grief and possible risk. These supports should start at a policy level in organizations and communities. Individual level supports can be made available by supporting grief support groups and complicated grief mental health treatment. Special attention should be paid to those who respond to suicides in their communities.

## **Strategic Direction #4 – Surveillance, Research, and Evaluation**

**Goal #1:** Improve data collection related to suicide morbidity and mortality.

- Suicide prevention efforts are most efficient and effective when they are guided by data. Much progress has been made in Kansas to improve the quality of data available to suicide prevention activity planners, such as participation in the Violent Death Reporting System and inclusion of suicide related questions on the Kansas Communities that Care Survey.
- However, further standardization of data collection across the state, through coroners and law enforcement agencies, could improve prevention efforts. It is imperative that all data be made available to the public at regular and predictable intervals and be utilized by relevant state agencies in making decisions about resource allocation and service provision support.
- Deaths by suicide are not currently included as reportable conditions. Therefore, there is no standardization for how information is reported to KDHE. Kansas does not have a Coroner's Association to guide efforts encouraging shared vision and protocols among coroners for consistency in death investigations, documentation, and ordering an autopsy. In addition, law enforcement agencies have differing methods for reporting and providing information on deaths by suicide. Standardization would support consistent and improved data collection across the state.

**Goal #2:** Annually review and report on State Suicide Prevention Plan.

- Suicide is a serious public health problem that can be reduced through dedicated resources and efforts on the parts of many partners. Accountability and flexibility are key components to this plan being effective. An annual review will allow partners to update and refocus efforts as needed as well as keeping key stakeholders abreast of progress and roadblocks to progress.
- To provide the best opportunity for this State Plan to have measurable success, evaluation of the recommended activities and the overall plan is built from the beginning, culminating in reports to the State Suicide Prevention Plan Workgroup at least once per year.

**Goal #3:** Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

- One difficulty with suicide prevention is that it can take a long time to see reductions in suicide deaths due to the relatively small numbers of death compared to rates of suicidal ideation and suicide attempts. In order to ensure that suicide prevention efforts are having the intended effect and provided with an appropriate investment of time and resources, process measures must be identified and tracked.
- To provide the best opportunity for this State Plan to have measurable success, reports on the evaluation results of this plan will be provided by the State Suicide Prevention Plan Workgroup at least once per year to the Governor of the State of Kansas.

## Goals & Objectives Summary Table /

The following Strategic Directions, Goals, Objectives, and Actions/Activities represent identified gaps in the State’s comprehensive approach to suicide prevention. These components will require a need for dedicated resources from the State of Kansas for implementation. This plan is a set of recommendations for the State of Kansas, public, and private partners to support by allocating the necessary human, fiscal, and organizational resources to suicide prevention. All of the following goals and objectives are intended to benefit all Kansas youth and adult consumers, parents, and family members.

For the timeline sections, the following parameters describe the terms suggested:

Short-term: Within 12-14 months

Medium-term: 14-36 months

Long-term: 3+ years

### Strategic Direction 1. Healthy and Empowered Individuals, Families and Communities

(Primary Universal Prevention and Continuum of Care)

#### Goal 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings

1.1.1 Establish a statewide suicide prevention coalition which is used to integrate prevention and treatment efforts across sectors

#### Action/Activities:

1. Establish representative stakeholder cohorts in the coalition.
2. Create a resource repository for youth, families, partners, consumers, service providers, and other stakeholders.
3. Outreach to, and involve, the business community to develop partnerships with public and private industries to better supply supportive resources.
4. Initially meet at least once, annually, as a state suicide prevention coalition, in person or online.

#### Stakeholders

Youth and adult consumers, parents, and family members, Kansas Department for Aging and Disability Services (KDADS), Kansas Prevention Collaborative (KPC), Keys for Networking, Office of the Attorney General, NAMI (National Alliance on Mental Illness) Kansas, suicide prevention coalitions, suicide prevention organizations, lawmakers and taxpayers, and private funders

#### Timeline

#1 & #4 - Short-term; #2 and #3 - Medium-term

1.1.2 Sustain and strengthen collaborations across state agencies to advance suicide prevention.

**Action/Activities:**

1. Seek input from diverse sectors including health, education, social services, justice, policy, and the private sector to help address suicide.
2. Opportunity for submission and distribution of partnerships and effective collaborations that impact each level of society.
3. Continue the State Interagency Group of statewide partners to assure effective use of resources, consistent and comprehensive messaging, and a shared vision and initiatives.
4. Continue data collaboration through support of multi-agency membership of the SEOW.

**Stakeholders**

Youth and adult consumers, parents, and family members, KDADS, Kansas Department of Health and Environment (KDHE), Kansas Attorney General's Office, Kansas Department for Children and Families (DCF), Kansas State Department of Education (KSDE), and KSPHQ, NAMI Kansas

**Timeline**

Short-term & Ongoing

1.1.3 Include those with lived experience in suicide prevention efforts.

**Action/Activities:**

1. Invite Kansans with lived experience related to suicide to participate in review of all Strategic Directions, Goals, and Objectives contained in this State Suicide Prevention Plan.
2. Create an online opportunity for distribution and submission of feedback from Kansas citizens with lived experience related to suicide.
3. Share feedback gathered from youth and adult consumers, parents, and family members in every meeting of the work group tasked with creation, maintenance, and revision of the State Suicide Prevention Plan.

**Stakeholders**

Youth and adult consumers, parents, and family members with lived experience related to suicide, KDADS, NAMI Kansas

<b>Goal 2: Strengthen and broaden public com- municatio efforts about risk and protective factors for suicide</b>	<b>Timeline</b>	Short-term
	1.2.1 Empower local stakeholders to utilize publicly available data to plan suicide prevention messaging campaigns.	
	<b>Action/Activities:</b>	
	1. Local suicide prevention and behavioral health prevention coalitions establish partnerships with local health departments to better understand and utilize data. 2. Establish the State Epidemiological Outcomes Workgroup (SEOW) as a statewide partner in creating an accessible suicide data report. 3. Support local efforts to produce targeted messaging to geographic, industry, age and other groups.	
	<b>Stakeholders</b>	State Epidemiological Outcomes Workgroup, KDADS, KDHE, local suicide prevention coalitions, local behavioral health prevention coalitions, and local health departments
	<b>Timeline</b>	Medium-term
	1.2.2 Utilize strategic communication campaigns with positive messages and warning sign education to connect people with appropriate care.	
	<b>Action/Activities:</b>	
	1. Engage youth and those with lived experience to identify and guide meaningful messages for awareness and prevention campaigns. 2. Identify partners and stakeholders who are invested in disseminating suicide prevention messages and create coordination opportunities. 3. Utilize the National Action Alliance safe messaging framework to guide decision making about messages and guidelines for different platforms. <a href="http://suicidepreventionmessaging.org/guidelines-topic-list">http://suicidepreventionmessaging.org/guidelines-topic-list</a> .	
	<b>Stakeholders</b>	Youth and adult consumers, parents, and family members, State Interagency Group, youth, people with lived experiences, Keys for Networking, NAMI Kansas, Consumer Advisory Council
<b>Timeline</b>	Short-term and Ongoing	

1.2.3 Engage media partners in efforts to promote safe and responsible reporting and messaging for suicide deaths and prevention.

**Actions/Activities: Focus on safe reporting with media**

1. Provide media reporting recommendations when contacted about suicide related stories (<https://reportingonsuicide.org/recommendations/>).
2. Encourage media partners to share the National Suicide Prevention Lifeline and/or a local crisis resource in any story related to suicide.

**Stakeholders**

State Interagency Group, State Suicide Prevention Coalition, media partners, local crisis resources

**Timeline**

Short-term & Ongoing

1.2.4 Reach policymakers with dedicated communication efforts.

**Actions/Activities:**

1. Make suicide prevention educational materials available to inform advocates, community organizations, and policy makers about best practices, current data and research, and the priorities of this plan.

**Stakeholders**

State Interagency Group, State Suicide Prevention Coalition, media partners, local crisis resources, youth and adult consumers, parents, and family members

**Timeline**

Short-term & Ongoing

## Strategic Direction 2. Clinical and Community Preventive Services (Select and Indicated Prevention Strategies)

**Goal 1: Target suicide prevention efforts by learning about and providing populations with heightened risk and/or behavioral health disparities with services and resources**

2.1.1 Establish guidance and priorities for collecting data on populations where there is little or no data available.

**Action/Activities:**

1. Use national data trends to identify and inform at-risk population data gaps in the state.
2. Support efforts to collect additional demographic data related to at-risk populations including LGBTQ, racial minorities, people with disabilities, veterans and others, with existing state and local surveys and institutional reporting systems.
3. Provide guidance for best practices for collection of new data with at-risk populations.

**Stakeholders**

KDADS, KDHE, SEOW

**Timeline**

#1 and #2 - Short-Term; #3 - Medium-Term

2.1.2 Develop and support culturally informed suicide prevention efforts for diverse populations.

**Action/Activities:**

1. Develop Kansas specific best practices document regarding cultural norms and attitudes around suicide for different populations and disseminate to stakeholders using existing resources and Kansas specific data: [https://www.integration.samhsa.gov/health-wellness/well-ness-strategies/2012\\_National\\_Strategy\\_for\\_Suicide\\_Prevention.pdf](https://www.integration.samhsa.gov/health-wellness/well-ness-strategies/2012_National_Strategy_for_Suicide_Prevention.pdf).
2. Identify at-risk communities with culturally diverse populations within Kansas for targeted outreach. This includes rural/frontier Kansans, farmers, military veterans, LGBTQ, American/Alaskan Native, and others.
3. Provide technical assistance for community organizations, local health departments, Community Mental Health Centers (CMHC's), school districts, colleges, and prevention coalitions to engage at-risk and under-resourced populations in a culturally informed way.
4. Engage in bi-yearly assessment of suicide deaths and clusters, attempts, health disparities, and other risk factors across Kansas amongst diverse populations to ensure effective outreach is being done.

	<b>Stakeholders</b>	KDHE, KDADS, KSPHQ, KPC, Office of the Attorney General, Kansas Board of Regents, KSDE, NAMI Kansas, Keys for Networking, DCF, ACMHCK, Kansas Commission on Veterans Affairs, Kansas Native American Affairs Office, Kansas Department of Agriculture, Rural and Frontier Agencies/Groups
	<b>Timeline</b>	#1 & #2 - Short-term; #3 - Medium-term; #4 - Long-term
	2.1.3 Meet the specific needs of the Service Members, Veterans, and Families (SMVF) population for suicide prevention by supporting and promoting SMVF's goals as identified in action/activities below.	
	<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Identify priority areas for VSO Goodwill training collaboration and implement VSO Goodwill training plan.</li> <li>2. Increase cultural competency about the SMVF population statewide through online training with PsychArmor Institute.</li> <li>3. Recognize the SMVF Subcommittee's Strategic Plan and Annual Report to the Governor's Behavioral Health Services Planning Council as a separate document, specific to the SMVF population, supporting the subcommittee's strategic plan and updating this State Suicide Prevention Plan to include the goals, objectives, and activities of this volunteer group.</li> </ol>	
	<b>Stakeholders</b>	Youth and adult consumers, parents, and family members, KDADS, Kansas Mental Health Coalition, area local Veterans Affairs Offices and Officers, area Goodwill, ACMHCK, Schools, Federally Qualified Health Centers (FQHCs), Behavioral Sciences Regulatory Board (BSRB), Kansas Association of Addiction Professionals (KAAP), DCF, Crisis Intervention Team (CIT) Programs, KPC
	<b>Timeline</b>	#1 - Short-term; #2 & #3 - Medium-term
<b>Goal 2: Support local efforts to reduce access to lethal means</b>	<p>2.2.1. Support local efforts to work with gun shops, firearms owners, shooting ranges, etc. to promote safe storage.</p> <p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Recommend integration of suicide prevention training regarding safe storage into instructor training for state-approved hunter education course, improving the content specific to safe storage and suicide prevention.</li> <li>2. Review and select for recommendation and promotion the National Shooting Sports Foundation resources (videos, toolkits, etc.) for firearms industry businesses.</li> <li>3. Encourage local efforts to engage representatives from gun shops, shooting ranges, local law enforcement, and Veterans Administration to form workgroups focused on developing an action plan specific to this objective.</li> </ol>	

	<b>Stakeholders</b>	KDADS, Kansas Department of Wildlife, Parks and Tourism, suicide prevention coalitions, Office of the Attorney General, Regional Bureau of Alcohol, Tobacco, Firearms, and Explosives, Kansas Commission on Veterans Affairs
	<b>Timeline</b>	#2 - Short-term; #1 and #3 - Long-term
2.2.2. Support local efforts to promote safe storage and medication disposal practices.		
<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Educate community members about safe storage and proper disposal of medications in the home.</li> <li>2. Support local prescription take back efforts through partnerships with local law enforcement, health departments, etc. <ol style="list-style-type: none"> <li>a. Promote DCCCA's Safe Medication Disposal ToolKit</li> </ol> </li> <li>3. Cross-promote suicide intervention resources with take-back efforts (i.e. Share the National Suicide Prevention Lifeline on promotional materials).</li> <li>4. Store large amounts of over-the-counter and/or prescription medications in locked locations and dispose of prescription medications when no longer needed. <ol style="list-style-type: none"> <li>a. Promote the national "Find a Pharmacy Disposal Location" resource.</li> </ol> </li> </ol>		
	<b>Stakeholders</b>	Family members, local prevention coalitions, Individuals, law enforcement, pharmacies
	<b>Timeline</b>	Short-term
<b>Strategic Direction 3. Treatment and Support Services (Treatment and Recovery Directions)</b>		
<b>Goal 1: Promote a high standard for suicide related behavioral healthcare to improve access to services</b>	3.1.1 Workforce development/training will be available for evidence based tools and treatments.	
	<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Establish a training committee within the coalition to research, identify, and disseminate information regarding evidence-based practices in suicide prevention and intervention and opportunities for increased training.</li> <li>2. Facilitate opportunities for coalitions to bring evidence-based practice training for local clinicians, including Assessment and Management of Suicide Risk (AMSR) and Counseling on Access to Lethal Means (CALM).</li> <li>3. Advocate for minimum educational requirements regarding suicide prevention and intervention for accredited behavioral health education programs in the State of Kansas.</li> </ol>	

<b>Stakeholders</b>	Kansas Suicide Prevention Coalition, Board of Regents, CMHCs, clinicians, BSRB
<b>Timeline</b>	#1 Short-term; #2 & #3 - Long-term to ongoing
3.1.2 Create opportunities for youth and adult consumers, parents, and family members to provide recommendations about treatment and recovery efforts.	
<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Deliver needed information and support, based on the determined choices of youth and adult consumers, parents, and family members throughout all phases of building state and local suicide services and recovery efforts.</li> <li>2. Support consumer and family run organizations to train providers and payers on recognizing and planning for safety and self-determination when accessing urgently-needed responses.</li> <li>3. Provide youth and adult consumers, parents, and family members with access to services that reflect consumer choice.</li> </ol>	
<b>Stakeholders</b>	Consumer Advisory Council, Keys for Networking, NAMI-Kansas, Oxford Houses, SASS-MoKan, youth and adult consumers, parents, and family members
<b>Timeline</b>	Short-term and ongoing
3.1.3 Utilize best practices such as Zero Suicide and The Joint Commission's National Patient Safety Goal to identify protocols and procedures for embedding suicide care in behavioral health and healthcare settings.	
<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Increase screening for suicide risk in healthcare settings using validated assessment and screening tools such as the Columbia Suicide Severity Rating Scale.</li> <li>2. Provide training to all healthcare staff on recognizing and addressing suicide risk.</li> <li>3. For clinical staff, ensure a basic level of skill in assessing, managing, and treatment planning for patients at risk of suicide, including safety planning and reduction of access to lethal means.</li> <li>4. Create protocols for robust and predictable outreach and follow-up for people who are transitioning levels of care for example after accessing Emergency Departments or discharging from inpatient mental health and substance use treatment.</li> </ol>	
<b>Stakeholders</b>	Community mental health centers (CMHCs), hospital systems, primary healthcare providers, FQHC's, KDADS, KDHE, ACMHCK

	<b>Timeline</b>	Medium-term
	3.1.4. Promote special attention to populations who experience multiple risk factors for suicide related behavior.	
	<b>Action/Activities:</b> <ol style="list-style-type: none"> <li>1. Educate workforce regarding interpersonal risk factors (ACEs, violence, harassment, etc.).</li> <li>2. Educate workforce regarding intrapersonal risk factors (substance use, prior attempts, self-harm, dual diagnosis, etc.).</li> <li>3. Educate workforce regarding environmental risk factors (poverty, rural vs. urban, health disparities, etc.).</li> </ol>	
	<b>Stakeholders</b>	ACMHCK, CMHCs, State Suicide Prevention Coalition, local suicide prevention coalitions, KDHE, KDADS
	<b>Timeline</b>	Short-term and ongoing
	3.2.1. Ensure all youth and adult consumers, parents, and family members have access to immediate support in times of suicide and other crises by supporting crisis hotlines with follow-up service links.	
	<b>Action/Activities:</b> <ol style="list-style-type: none"> <li>1. Allocate resources sufficient to support an in-state answer rate of at least 90% for all National Suicide Prevention Lifeline callers from Kansas.</li> <li>2. Make plans for national implementation of the three digit mental health crisis line (i.e. 988) by creating connections between crisis services, mental health providers, and state agencies; and allocating sufficient resources to assist with moving toward an integrated system.</li> <li>3. Encourage providers of telephone support lines to implement safety assessments in line with standards consistent with those of the National Suicide Prevention Lifeline.</li> <li>4. Publicize local, state and national lines including text, voice, Spanish language, and specialized lines for those with visual or hearing impairments.</li> <li>5. Engage media in social compaigns that demonstrate what happens when they call or text these lines — what to expect.</li> </ol>	
	<b>Stakeholders</b>	Family members, KSPHQ, COMCARE, telephone support providers, KDADS, KDHE, mental health centers
	<b>Timeline</b>	Medium-term

3.2.2 Make an app available statewide to facilitate communication with youth and allow youth in crisis, or those concerned about others, to readily connect with mental health providers.

**Action/Activities:**

1. Attorney General’s office will post RFP in conjunction with the Department of Administration to purchase such services.
2. Work with identified stakeholders on implementation planning.
3. Work to obtain needed resources to respond appropriately to identified youth needs.

**Stakeholders**

AG Staff, KSPHQ, Mental Health Centers, Keys for Networking, KDADS, families

**Timeline**

Medium-term

3.2.3 Educate youth and adult consumers, parents, and family members on their rights, roles and responsibilities in the treatment process by providing training on best practices and access to responsive services.

**Action/Activities:**

1. Connect existing information networks for families and consumers to demystify navigating the current Kansas system during times of crisis.
2. Provide training and support to parents, families, and caregivers on creating and enacting a person-centered emotional and physical safety plan.
3. Identify and teach participants in services to evaluate programs and services and support them through their organizations with funding at the individual and state levels.

**Stakeholders**

AG Staff, KSPHQ, Mental Health Centers, Keys for Networking, KDADS, families, emergency departments, law enforcement, NAMI Kansas, Consumer Advisory Council

**Timeline**

Short-term & Ongoing

3.2.4. Enhance crisis services by improving communication to and from youth and adult consumers, parents, and family members, and implementing evaluation and quality improvement.

	<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Support efforts to build a comprehensive continuum of crisis services in communities.</li> <li>2. Advocate for increased resources and services for family members of those in crisis.</li> <li>3. Standardize processes and practices for improving communication to gain more evaluation and quality improvement feedback from youth and adult consumers, parents, and family members.</li> <li>4. Collect service-participant satisfaction information regularly and utilize to improve services.</li> <li>5. Identify and implement funding of consumer organizations to invite participants-in-services' evaluation by identifying and supporting participation from individuals and groups.</li> <li>6. Utilize evaluation, quality improvement, and satisfaction feedback to guide state efforts to plan, deliver services, and evaluate their impact.</li> </ol>	
	<p><b>Stakeholders</b></p>	<p>KDADS, Managed Care Organizations, State Suicide Prevention Coalition, peer and family led organizations and advocacy groups, Consumer Advisory Council, Keys for Networking, NAMI-Kansas, Oxford Houses, SASS-MoKan, youth and adult consumers, parents, and family members</p>
	<p><b>Timeline</b></p>	<p>#1 - Short-term; #2 &amp; #3 - Medium-term and ongoing</p>
<p><b>Goal 3: Support Postvention activities</b></p>	<p>3.3.1 Support the ability of public and private sector stakeholders' response to suicide deaths and provide grief support to suicide loss survivors.</p>	
	<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Build capacity in communities and regions to provide suicide grief and loss support through a variety of formats (e.g., in-person and digital) <ol style="list-style-type: none"> <li>a. Improve the links between the crisis lines and local services and supports, including service providers and peer and family led organizations and advocacy groups to help people get services where and when they need them.</li> <li>b. Make groups' guidance materials and other resources such as space and comfort items available to such groups.</li> <li>c. Recruit volunteers from youth and adult consumers, parents, and family members to participate in efforts to support and deliver grief and loss support services.</li> </ol> </li> <li>2. Promote the importance of suicide grief support groups and connecting to local resources.</li> </ol>	
	<p><b>Stakeholders</b></p>	<p>Law enforcement, first responders, Consumer Advisory Council, Keys for Networking, NAMI-Kansas, Oxford Houses, SASS-MoKan, youth and adult consumers, parents, and family members</p>

<b>Goal 2: Increase access to crisis services</b>	<b>Timeline</b>	Short-term and ongoing
	3.3.2 Support the development of policies and programs to support public and private sector stakeholders' response to suicide deaths and provide grief support to suicide loss survivors.	
	<b>Action/Activities:</b>	
	<ol style="list-style-type: none"> <li>1. Encourage partnerships within communities to collaborate and stay abreast of needs.</li> <li>2. Solicit available summaries from Community Responders/Crisis Teams of their postvention response to the State Suicide Prevention Coordinator.</li> <li>3. Provide guidance for supporting health care providers, first responders, peer-to-peer support, EAP, treatment providers, and other. <ol style="list-style-type: none"> <li>a. Establish debriefing teams to encourage healthy recovery of responders.</li> <li>b. Create a guidance document to improve continuity of care.</li> <li>c. Train treatment providers and crisis responders to create crisis response plans including actions of response to deaths by suicide of an employee, student, client, etc.</li> </ol> </li> <li>4. Encourage organizations to create a crisis response plan which includes plans for responding to a suicide death of an employee, student, client, etc.</li> <li>5. Expect publicly-funded suicide prevention programs to meet standards of suicide prevention best practices such that they link to local resources, and offer connections to youth, family consumer advocacy organizations to assure they get services when they need them.</li> </ol>	
<b>Stakeholders</b>	Coalitions, CMHCs, KDADS, KDHE, law enforcement associations, Kansas Emergency Medical Services Association, human resources (SHRM at State level), USDs, youth and adult consumers, parents, and family members.	
<b>Timeline</b>	#1 & #2 - Short-term; #3 #4 & #5 - Medium-term	

#### Strategic Direction 4. Surveillance, Research, and Evaluation

<b>Goal 1: Improve data collection related to suicide morbidity and mortality</b>	4.1.1 Support increased suicide data quality through standardization of suicide terminology and definitions as well as improved collection of reporting on demographics and other data gaps (identified in 2.1.1) through designation of suicide as a reportable condition.
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	<p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Develop handbook of standardized suicide terminology and definitions based on national data trends and best research evidence.</li> <li>2. Improve data quality and utility by incorporating and standardizing data collection regarding demographics (e.g., sexual orientation, gender identity, occupation, and so on) or other data gaps identified in 2.1.1.</li> <li>3. Propose policy and educate legislators regarding needed system reform to ensure data collection consistency across state departments and data collectors (e.g., law enforcements, coroners and medical examiners, etc.) and to make a suicide a reportable condition.</li> <li>4. Distribute handbook and provide training/education to data collectors and describers regarding standardized suicide definitions.</li> </ol>				
	<table border="1"> <tr> <td data-bbox="537 554 776 680"><b>Stakeholders</b></td> <td data-bbox="776 554 1528 680">Statewide Suicide Prevention Coalition, legislators, KDADS, KDHE, law enforcement associations, CMHCs, county health departments</td> </tr> </table>	<b>Stakeholders</b>	Statewide Suicide Prevention Coalition, legislators, KDADS, KDHE, law enforcement associations, CMHCs, county health departments		
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	<table border="1"> <tr> <td data-bbox="537 680 776 747"><b>Timeline</b></td> <td data-bbox="776 680 1528 747">#1 and #2 - Short-term; #3 - Long-term; #4 - Medium-term</td> </tr> </table>	<b>Timeline</b>	#1 and #2 - Short-term; #3 - Long-term; #4 - Medium-term		
<b>Timeline</b>	#1 and #2 - Short-term; #3 - Long-term; #4 - Medium-term				
	<p>4.1.2 Support efforts to gather timely mortality statistics.</p> <p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. Develop and adopt statewide standardized death reporting protocols, forms, and systems and inclusion of variables related to suicide mortality to garner complete and valuable context around suicide deaths.</li> <li>2. Encourage training on and the use of standardized death reporting protocols, forms, and systems to support the gathering of timely and adequate death statistics and information surrounding suicide deaths for use by the KDHE Office of Vital Statistics and Kansas Violent Death Reporting System.</li> </ol> <table border="1"> <tr> <td data-bbox="537 1178 776 1272"><b>Stakeholders</b></td> <td data-bbox="776 1178 1528 1272">KDHE; law enforcement associations; coroners and medical examiners; hospitals</td> </tr> <tr> <td data-bbox="537 1272 776 1335"><b>Timeline</b></td> <td data-bbox="776 1272 1528 1335">Long-term</td> </tr> </table>	<b>Stakeholders</b>	KDHE; law enforcement associations; coroners and medical examiners; hospitals	<b>Timeline</b>	Long-term
<b>Stakeholders</b>	KDHE; law enforcement associations; coroners and medical examiners; hospitals				
<b>Timeline</b>	Long-term				
<p><b>Goal 2. Annually review and report on State Suicide Prevention Plan</b></p>	<p>4.2.1 Request assistance from SEOW to review available data annually and more frequently.</p> <p><b>Action/Activities:</b></p> <ol style="list-style-type: none"> <li>1. SEOW will provide annual review and update of the Kansas Behavioral and Mental Health Profile which will include any additional suicide related indicators for new data collected.</li> <li>2. SEOW will report progress on suicide data indicators in the Kansas Suicide Prevention State Plan and disseminate annual data brief/status update.</li> </ol>				

	<b>Stakeholders</b>	State Suicide Prevention Plan Workgroup, KDADS, KDHE, suicide prevention organizations and coalitions, and Kansas Office of the Attorney General
	<b>Timeline</b>	Short-term
	4.2.3 Report on progress, revisions, and roadblocks to plan efforts in annual report.	
	<b>Action/Activities:</b> <ol style="list-style-type: none"> <li>1. Researchers and State agencies will collaborate on suicide prevention research and evaluation.</li> <li>2. State Suicide Prevention Plan Workgroup will recommend an evaluation plan for the State Plan to the Kansas Department for Aging and Disability Services through the Governor's Behavioral Health Services Planning Council Prevention Subcommittee.</li> <li>3. An evaluation report on the State Suicide Prevention Plan will be provided to the Governor of Kansas at least annually in a report to the Governor's Behavioral Health Services Planning Council from the Prevention Subcommittee.</li> </ol>	
	<b>Stakeholders</b>	Youth and adult consumers, parents, and family members, State Suicide Prevention Plan Workgroup, KDADS, KDHE, suicide prevention organizations and coalitions, and Kansas Office of the Attorney General, SEOW
	<b>Timeline</b>	#1 & #2 - Medium-term; #3 Medium-term and Annual
<b>Goal 3: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize &amp; disseminate findings</b>	4.3.1. Measure the process factors associated with the Kansas State Suicide Prevention Plan.	
	<b>Action/Activities:</b> <ol style="list-style-type: none"> <li>1. Include in the 4.2.3 Evaluation Plan, measures for process factors to indicate progress toward success and provide opportunities for course-correcting if unsuccessful.</li> <li>2. Track involvement of identified stakeholders and document participation.</li> <li>3. Document any known milestones in suicide prevention efforts in Kansas.</li> <li>4. Document the names of new evidence-based strategies implemented in Kansas communities.</li> <li>5. Document the population demographics being served in implemented Kansas suicide prevention strategies.</li> </ol>	
	<b>Stakeholders</b>	Youth and adult consumers, parents, and family members, State Suicide Prevention Plan Workgroup, KDADS, KDHE, suicide prevention organizations and coalitions, and Kansas Office of the Attorney General, SEOW
	<b>Timeline</b>	#1 - Short-term; #2-#5 Medium-term

# 5 Year Timeline At-A-Glance

2021	2022	2023	2024	2025
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## Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

Objective 1.1.1 - Establish a statewide coalition which is used to Integrate prevention and treatment efforts across sectors	X	X	X		
Objective 1.1.2 - Sustain and strengthen collaborations across State agencies to advance suicide prevention	X	X	X	X	X
Objective 1.1.3 - Include those with lived experience in suicide prevention efforts	X	X			
Objective 1.2.1 - Empower local stakeholders to utilize publicly available data to plan suicide prevention messaging campaigns		X	X		
Objective 1.2.2 - Utilize strategic communication campaigns with positive messages and warning sign education to connect people with appropriate care	X	X	X	X	X
Objective 1.2.3 - Engage media partners in efforts to promote safe and responsible reporting and messaging for suicide deaths and prevention	X	X			
Objective 1.2.4 - Reach policymakers with dedicated communication efforts	X	X			

## Strategic Direction 2: Clinical and Community Preventive Services

Objective 2.1.1 - Establish guidance and priorities for collecting data on populations where there is little or no data available	X	X	X		
Objective 2.1.2 - Develop and support culturally informed suicide prevention efforts for diverse populations	X	X	X	X	X
Objective 2.1.3 - Meet the specific needs of the Service Members, Veterans, and Families (SMVF) population for suicide prevention by supporting and promoting SMVF's Goals as identified in action/ activities below	X	X	X		
Objective 2.2.1 - Support local efforts to work with gun shops, firearms owners, shooting ranges, etc. to promote safe storage	X	X	X	X	X
Objective 2.2.2 - Support local efforts to promote safe storage and medication disposal practices	X	X			

### Strategic Direction 3: Treatment and Support Services

Objective 3.1.1 - Workforce development and training will be available for evidence-based tools and treatments	X	X	X	X	X
Objective 3.1.2 - Create opportunities for youth and adult consumers, parents, and family members to provide recommendations about treatment and recovery efforts	X	X	X	X	X
Objective 3.1.3 - Utilize best practices such as Zero Suicide and The Joint Commission's National Patient Safety Goal to identify protocols and procedures for embedding suicide care in behavioral health and healthcare settings		X	X	X	
Objective 3.1.4 - Promote special attention to populations who experience multiple risk factors for suicide related behavior	X	X			
Objective 3.2.1 - Ensure all youth and adult consumers, parents, and family members have access to immediate support in times of suicide and other crises by supporting crisis hot-lines with follow-up service links		X	X	X	
Objective 3.2.2 - Make statewide app available to facilitate communication with youth and allow youth in crisis, or those concerned about others, to readily connect with mental health providers		X	X	X	
Objective 3.2.3 - Education youth and adult consumers, parents, and family members on their rights, roles and responsibilities in the treatment process by providing training on best practices and access to responsive services	X	X	X	X	X
Objective 3.2.4 - Enhance crisis services by improving communication to and from youth and adult consumers, parents, and family members, and Implementing evaluation and quality improvement	X	X	X	X	X
Objective 3.3.1 - Support the improved ability of public and private sector stakeholders' response to suicide deaths and provide grief support to suicide loss survivors	X	X	X	X	X
Objective 3.3.2 - Support the development of policies and programs to support public and private sector stakeholders' response to suicide deaths and provide grief support to suicide loss survivors	X	X	X	X	

### Strategic Direction 4: Treatment and Support Services

Objective 4.1.1 - Standardize definitions of data collected related to suicide data and education to data collectors and describers (will need to be Legislated to be consistent in all state departments and data collectors [law enforcement, coroners, etc.]) Suicide could become a reportable condition	X	X	X	X	X
Objective 4.1.2 - Support efforts to gather timely mortality statistics					X
Objective 4.2.1 - Request assistance from SEOW to review available data annually and more frequently	X	X	X	X	X
Objective 4.2.2 - Report out from State agencies, coalitions, and stakeholders (youth, parents, and families) on actions taken or not taken in State Plan	X	X			
Objective 4.2.3 - Report on progress, revisions, and roadblocks to the plan efforts in annual report			X	X	X
Objective 4.3.1 - Measure the process factors associated with the Kansas State Suicide Prevention Plan	X	X	X		

# Appendix 1: Additional Resources

## Potential Resource Appendix

1. [Suicide Prevention Program for Retailers and Ranges • NSSF](#)
2. [Safe Medication Disposal Toolkit](#)
3. [Pharmacy Disposal Locations](#)
4. [Support Groups in Kansas](#)
5. [RAND Suicide Prevention Program Evaluation Toolkit](#)
6. [Media Reporting Recommendations](#)
7. [Zero Suicide](#)
8. [Joint Commission National Patient Safety Goals 2020](#)
9. [Military Veterans: Suicide Prevention - Mental Health - VA](#)
10. [Racial and Ethnic Groups | Suicide Prevention Resource Center](#)
11. [Suicide and Lesbian, Gay, Bisexual and/or Transgender People](#)
12. [Resources for Kansas Farmers](#)
13. [Kansas Rural Health Resources](#)

## Suicide Prevention Hotline Resources

1. [National Suicide Prevention Lifeline Chat](#)
2. [Crisis Text Line](#)
3. [SAMHSA Treatment Referral Hotline \(Substance Abuse\)](#)
4. [National Sexual Assault Hotline](#)
5. [National Teen Dating Abuse Hotline](#)

## Outside Sources/Links to Stakeholders

1. [Kansas Behavioral Health Services](#)
2. [Kansas Prevention Collaborative](#)
3. [Keys for Networking, Inc.](#)
4. [Office of the Kansas Attorney General](#)
5. [NAMI Kansas, Inc.](#)
6. [Kansas Consumer Advocacy Council](#)
7. [Association of Community Mental Health Centers of Kansas](#)
8. [Kansas Department for Aging and Disability Services \(KDADS\)](#)
9. [KSPHQ: Kansas Suicide Prevention HQ](#)
10. [Kansas Department for Children and Families](#)
11. [Kansas Department of Agriculture](#)
12. [Kansas State Department of Education](#)
13. [Kansas Commission on Veterans Affairs](#)
14. [Kansas Department of Health and Environment](#)

## Appendix 2: Service Members, Veterans, and Families Subcommittee and Kansas Governor's Challenge Combined Action Plan (8/2020)

### Service Members, Veterans, and Families (SMVF) Action Plan

The following Strategic Directions, Goals, Objectives, and Actions/Activities represent identified gaps in the State's approach to suicide prevention specifically for Service Members, Veterans, and Families (SMVF). These components will require dedicated resources from the State of Kansas for implementation. These recommendations follow a similar format to the comprehensive State Suicide Prevention Plan. All the following goals and action items are intended to benefit Kansas SMVF.

Not all of the goals proposed in the national guidance to the Governor's Challenge State Teams were prioritized for inclusion in the Kansas Action Plan.

For the Timeline sections, the following parameters describe the terms suggested:

Short-term: Within 12-14 months completed, in-process, and within the next year

Medium-term: 14-36 months

Long-term: 3+ years

### Strategic Direction 1: Healthy and Empowered Individuals, Families and Communities

**Goal 1.** Integrate and coordinate SMVF suicide prevention activities across multiple sectors and settings.

**Goal 3.** Increase knowledge of the factors that offer SMVFs protection from suicidal behaviors and that promote their wellness and recovery.

#### Action/Activities:

1. Create a Message Committee.
  - A. Talk to Governor's Office regarding informational video.
  - B. Work to establish a committee.
2. Develop the LiveConnectedKS message (resilience-focused).
3. Craft the message - phrase, paragraph, page (community, SMVF service/social organizations, business partners).
4. Identify stakeholders, organizations, opinion-leaders to target (pp. 13-14).
5. Identify team to attend Messaging/Social Media Conference in DC, July, 11-12 2019.
6. Create Governor's video.
7. Create website and social media content.

#### Timeline:

Short-term  
Short-term  
Short-term  
Short-term  
Short-term  
Short-term

#### Parties Responsible

KDADS, WSU CEI

## Strategic Direction 2: Clinical and Community Preventive Services

**Goal 7.** Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

### Action/Activities:

1. Identify message.
2. Increase awareness of TAPS (Tragedy Assistance Program) to TEM (Traumatic Event Management).
3. Make military cultural competence part of Kansas State message using PsychArmor.
4. Identify important SMVF contacts with Community Mental Health Centers and determine what currently exists.
5. Identify key contacts with crisis lines and crisis triage centers.
6. Identify key contacts with Crisis Intervention Teams (CITs).
7. Identify chairpersons of suicide prevention coalitions.
8. Identify key contacts with National Guard and USAR Chaplains.
9. Identify key contacts with Veteran Support Organizations.
10. Identify key contacts with Directors of Psychological Health (DPH).

### Timeline:

Short-term  
Short-term  
Short-term  
Short-term  
Short-term  
Short-term  
Short-term  
Short-term  
Short-term  
Short-term

### Parties Responsible

KDADS, SMVF Subcommittee, Veterans Commission

## Strategic Direction 3: Treatment and Support Services

**Goal 8.** Promote suicide prevention as a core component of health care services.  
**Goal 9.** Promote and implement effective clinical and professional practices for assessing and treating SMVFs identified as being at risk for suicidal behaviors.

### Action/Activities:

1. Promote positive, resilient and health promotion messaging for SMVF about mental health and suicide prevention.
  - A. Zero Suicide.
  - B. Consistent messaging for service providers. (LiveConnectedKS message)
2. Draft a slogan.
3. Create a website.
4. Research NH's "Ask the Question" program.
5. Obtain information on the CSSRS for use with SMVF.
6. Promote 3 questions to as many people as possible.
  - A. "Do you have a military connection?"
  - B. "Are you thinking about suicide?"
  - C. "How many times have you thought about suicide?"
7. Forward information on Postvention terms of suicide and disseminate standard definitions for suicide-related behaviors.

### Timeline:

Short-term  
  
Short-term  
Short-term  
Short-term  
Short-term  
  
Short-term

### Parties Responsible

KDADS, WSU CEI, SMVF Subcommittee, Kansas Suicide Prevention Resource Center

## Strategic Direction 4: Surveillance, Research, and Evaluation

**Goal 13.** Evaluate the impact and effectiveness of SMVF suicide prevention intervention and systems, and synthesize and disseminate finding to inform future efforts.

### Action/Activities:

1. Observation of consistent messaging and common language used among SMVF Governor's Challenge.
  - A. Develop Review Team to ensure SMVF Governor's Challenge is following guidelines.
  - B. Review guidelines and develop and disseminate a submission protocol for documents to be reviewed for consistency.
  - C. Meet to review guidelines prior to Implementation Academy.
2. Disseminate evaluation information using common language and consistent messaging.
  - A. Draft evaluation report and submit for review.
  - B. Develop dissemination plan and platforms for distribution.
3. Evaluate use of suicide media reporting guidelines in Kansas.
  - A. Schedule meeting to assign responsibility for action steps 1.3. B-E
  - B. Set up surveillance mechanism to review suicide media being distributed in Kansas.
  - C. Develop checklist for reviewing media.
  - D. Review suicide media being distributed in Kansas for effective use of guidelines stated from #1.
  - E. If messaging does not meet guidelines, provide resources to reporter.
4. Establish a group to determine how to collect specific SMVF post-mortem data.

### Timeline:

Short-term

Short-term

Short-term

Short-term

### Parties Responsible

KDADS, SEOW

## Appendix 3: Training Resources and Protocols

### School-Based Programs and Training Resources

- [Suicide in Schools](#) - Training offered by Kansas Suicide Prevention HQ based on book for schools by Terri A. Erbacher, Jonathan B. Singer, and Scott Poland
- [Talking Together and Suicide Prevention](#) - Evidence-based training offered by Kansas Suicide Prevention HQ
- [Yellow Ribbon](#) - National Best Practices Program gatekeeper training for teachers and administrators
- [More Than Sad](#) - High School program supported by American Foundation for Suicide Prevention with training provided by Kansas Suicide Prevention HQ
- [Sources of Strength](#) - Peer-to-peer training for youth (elementary through high school) focusing on suicide, substance use, violence and bullying prevention

### Intervention Strategy Training

- [ASIST \(Applied Suicide Intervention Skills Training\)](#) - Workshop for identifying suicide risk and safety planning provided by many Kansas organizations
- [C.A.L.M. \(Counseling Access to Lethal Means\)](#) - Training for parents or counselors focusing on skill-building to restrict access to lethal means
- [Managing Suicide Risk in Substance Use Treatment Settings](#) - Presentation for substance use treatment professionals provided by Kansas Suicide Prevention HQ
- [QPR \(Question. Persuade. Refer\)](#) - Training offered by many in Kansas on emergency response to a person in crisis
- [Suicide Risk Assessment: The Columbia Suicide Severity Rating Scale](#) - Implementation trainings offered by Kansas Suicide Prevention HQ
- [Zero Suicide](#) - Effective framework involving organizations committing to system-wide safer suicide care in health and behavioral health care systems



## Appendix 4: Data Considerations

The Centers for Disease Control and Prevention’s WISQARS™ is an interactive, online database that provides fatal and nonfatal injury, violent death, and cost of injury data. Researchers, the media, public health professionals, and the public can use WISQARS™ data to learn more about the public health and economic burden associated with unintentional and violence-related injury in the United States. Additionally, data from the State Suicide Prevention Plan Workgroup includes information the following data considered by the State Suicide Prevention Plan Workgroup includes information from the Kansas Violent Death Reporting System (KSVDRS). KSVDRS, a program of Kansas Department of Health and Environment, is a state-based surveillance system that compiles information on violent deaths, including suicides, from multiple sources — death certificates, coroner and medical examiner reports including toxicology, and law enforcement reports — into a usable, anonymous database. KSVDRS increases our knowledge about where violent deaths occur, who is most at risk, the factors that contribute to violent deaths, and it allows us to track trends over time. For more information visit <https://www.kdheks.gov/idp/KsVDRS.htm>.

Suicide deaths are the top 10 leading cause of death for all ages. For those ages 10-34 years, it is the second leading cause of death following unintentional injury. (Data table 1)

Data Table 1:

10 Leading Causes of Death, Kansas  
2015 - 2017, All Races, Both Sexes

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 158	Unintentional Injury 42	Unintentional Injury 30	Unintentional Injury 35	Unintentional Injury 340	Unintentional Injury 438	Unintentional Injury 441	Malignant Neoplasms 1,046	Malignant Neoplasms 3,247	Heart Disease 13,875	Heart Disease 17,019
2	Short Gestation 120	Malignant Neoplasms 12	Malignant Neoplasms 18	Suicide 19	Suicide 229	Suicide 307	Malignant Neoplasms 275	Heart Disease 817	Heart Disease 1,987	Malignant Neoplasms 11,856	Malignant Neoplasms ---
3	SIDS 58	Homicide 11	Congenital Anomalies ---	Malignant Neoplasms 16	Homicide 133	Homicide 107	Suicide 250	Unintentional Injury 514	Chronic Low Respiratory Disease 580	Chronic Low Respiratory Disease 4,436	Chronic Low Respiratory Disease 5,190
4	Unintentional Injury 45	Congenital Anomalies ---	Cerebrovascular ---	Congenital Anomalies ---	Malignant Neoplasms 25	Malignant Neoplasms 85	Heart Disease 240	Suicide 270	Unintentional Injury 557	Cerebrovascular 3,520	Unintentional Injury 4,486
5	Maternal Pregnancy Comp. 41	Heart Disease ---	Benign Neoplasms ---	Chronic Low Respiratory Disease ---	Heart Disease 20	Heart Disease 69	Homicide 80	Liver Disease 218	Diabetes Mellitus 399	Alzheimer's Disease 2,577	Cerebrovascular 4,082
6	Placenta Cord Membranes 22	Perinatal Period ---	Chronic Low Respiratory Disease ---	Cerebrovascular ---	Congenital Anomalies 11	Diabetes Mellitus 33	Liver Disease 71	Diabetes Mellitus 163	Cerebrovascular 344	Unintentional Injury 2,044	Alzheimer's Disease 2,614
7	Bacterial Sepsis 20	Benign Neoplasms ---	Homicide ---	Heart Disease ---	Influenza & Pneumonia ---	Liver Disease 24	Diabetes Mellitus 61	Cerebrovascular 148	Liver Disease 307	Diabetes Mellitus 1,624	Diabetes Mellitus 2,285
8	Necrotizing Enterocolitis 13	Chronic Low Respiratory Disease ---	Septicemia ---	Homicide ---	Septicemia ---	Complicated Pregnancy 12	Cerebrovascular 49	Chronic Low Respiratory Disease 136	Suicide 230	Influenza & Pneumonia 1,539	Influenza & Pneumonia 1,750
9	Neonatal Hemorrhage 13	Six Tied ---	Diabetes Mellitus ---	---	Four Tied ---	Nephritis 11	Septicemia 18	Nephritis 63	Nephritis 172	Nephritis 1,392	Nephritis 1,656
10	Atelectasis 12	Six Tied ---	---	---	Four Tied ---	Two Tied 10	Influenza & Pneumonia 17	Homicide 56	Septicemia 143	Atherosclerosis 1,143	Suicide 1,544

WISQARS™ Note: For leading cause categories in this State-level chart, counts of less than 10 deaths have been suppressed (---).

Produced By: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention  
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Suicides are the most common type of violent death among Kansas residents. From 2015-2017, 1518 suicide deaths occurred among Kansas residents. Suicides comprised almost three quarters (73.9%) of the violent deaths with age-adjusted rate of 17.4 per 100,000 persons (Data table 2).

**Data Table 2: All Violent Deaths Among Kansas Residents by Intent: 2015-2017**

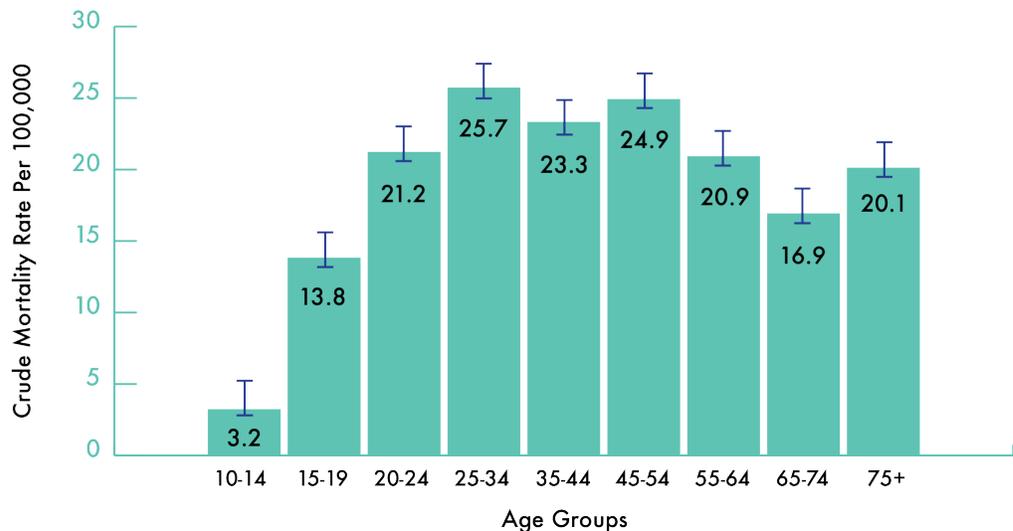
Intent	N	% Total Violent Deaths	Age-Adjusted Death Rate <sup>1</sup> Per 100,000 <sup>2</sup> (95% CI)
Suicide	1,518	73.9%	17.4 (16.5, 18.3)
Homicide	424	20.6%	5.0 (4.5, 5.5)
Unintentional Firearm	18	0.9%	–
Legal Intervention	29	1.4%	0.4 (0.2, 0.5)
Undetermined	66	3.2%	0.7 (0.6, 0.9)
<b>Total:</b>	<b>2,055</b>	<b>100%</b>	<b>23.8 (22.7, 24.8)</b>

Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE  
<sup>1</sup>Rates for counts less than 20 are considered unreliable and are not calculated  
<sup>2</sup>Age-Adjusted rates calculated using the 2,000 U.S. Standard Population

### I. Socio-demographics

Adults ages 20 years or older had higher suicide rate than younger population 10-19 years old (Data Table 3). Young adults (20-30yrs old) and older adults (35-64yrs old) had comparable suicide rates.

**Data Table 3. Crude Suicide Rates per 100,00 Kansas Residents by Age Groups 2015 -2017**



(KSVDRS), Bureau of Health Promotion, KDHE  
 Data Source: 2015-2017 Kansas Violent Death Reporting System

About three quarters (78%) of suicide deaths were males who had 3.6 times the suicide rate of females (27.5 versus 7.7) (Data table 4). Out of every 100,000 Kansas residents, about 28 males and 8 females died of suicide (Data table 5). White, non-Hispanic people had the highest suicide rate of 18.5 per 100,000 among all races and ethnicities except for American Indian or Alaska Native people. Black, Asian or Pacific Island, and Hispanic races and ethnicities had similar suicide rates.

**Data Table 4: Demographics of suicide among Kansas residents, 2015-2017**

Sex (N=1518)	N	%	Age-Adjusted Death Rate <sup>1,2</sup> (95% CI)
Male	1,187	78	32.0(30.2, 33.9)
Female	331	22	9.0 (8.0, 9.9)
Race/Ethnicity (N=1518)	N	%	Age-Adjusted Death Rate <sup>1,2</sup> (95% CI)
White, Non-Hispanic	1,267	84	21.5 (20.3, 22.7)
Black or African American, non-Hispanic	58	4	11.4 (8.4, 14.5)
American Indian,Alaska Native, non-Hispanic	19	1	—
Asian/Pacific Islander, non-Hispanic	28	2	11.1 (6.7, 15.4)
Hispanic	96	6	10.8 (8.5, 13.1)
Two or more races, non-Hispanic	38	3	—
Other or unknown race, non-Hispanic	12	<1	—

<sup>1</sup>Age-Adjusted rates calculated using the 2,000 U.S. Standard Population  
<sup>2</sup>Per 100,000  
 \*Rates suppressed when count is less than 20  
 Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

**Data Table 5: Demographics of suicide among Kansas residents, 2015-2017**

Marital Status (N=1,513)	N	%
Never Married	571	38
Married/Civil Union/Domestic Partnership	469	31
Divorced	356	24
Others <sup>1</sup>	107	7
Veteran <sup>2</sup> (N=1,449)	N	%
Served in Military	267	18
Never served in military	1,182	82
Education (N=1,487)	N	%
12th grade or less	237	16
High school graduate or GED	569	38
Some college credit, but no degree	317	21
Associate/Bachelor's Degree	295	20
Master or higher degree	69	5

<sup>1</sup>Include widowed, separated, and single status  
<sup>2</sup>People 18 years or older  
 \*Rates suppressed when count is less than 20  
 Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

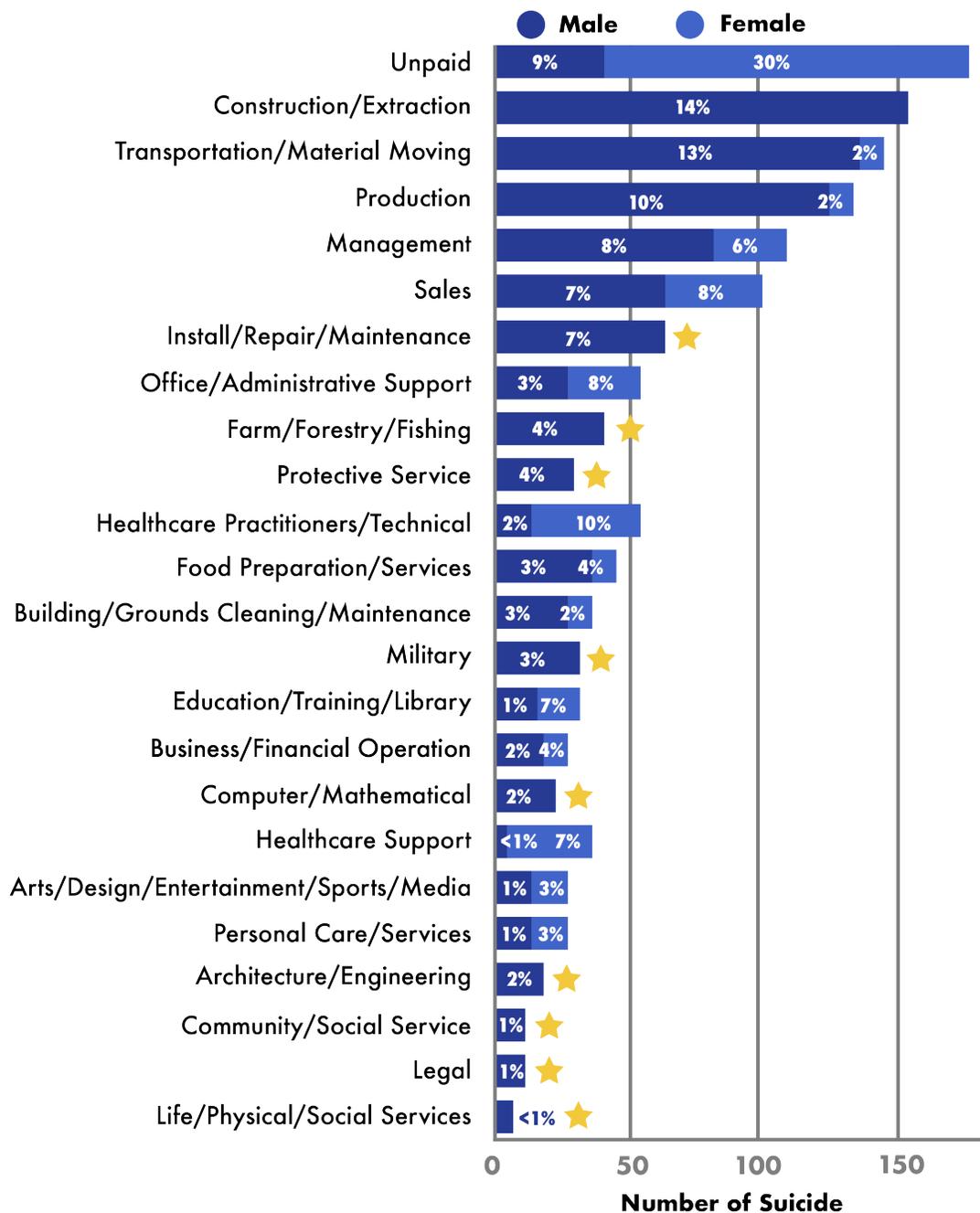
Among Kansas civilian population 18 years or older, the age-adjusted suicide rate among veterans was 67.3 per 100,000 persons, which was 3.4 times the suicide rate of non-veterans (19.9 per 100,000).

More than half (54%) of Kansas residents who died by suicide did not receive any college education, and 1 out of 4 of those who died by suicide had college or Professional degrees (Table 2).

About 38% of people who died by suicide were never married, followed by people who were married or in a civil union or domestic partnership (31%), and those were divorced (24%).

Among Kansas residents who died by suicide 16 years or older from 2015 to 2017, the most common occupation groups were unpaid (housewife, homemaker, student, disabled, volunteer, patient, inmate, those who did not work), construction and extraction (e.g. earth drillers, oil, gas, and mining, explosive worker, rock splitters, and others), transportation and material moving, production, management, and sales. Occupation groups varied differently between males and females (Data Table 6). About 3 out of 10 females who died by suicide did not have paid jobs compared to the 9% of males.

**Data Table 6. Suicide among Kansas Residents ≥16years old in the Standard Occupational Classification (SOC) major group, by sex, 2015-2017**



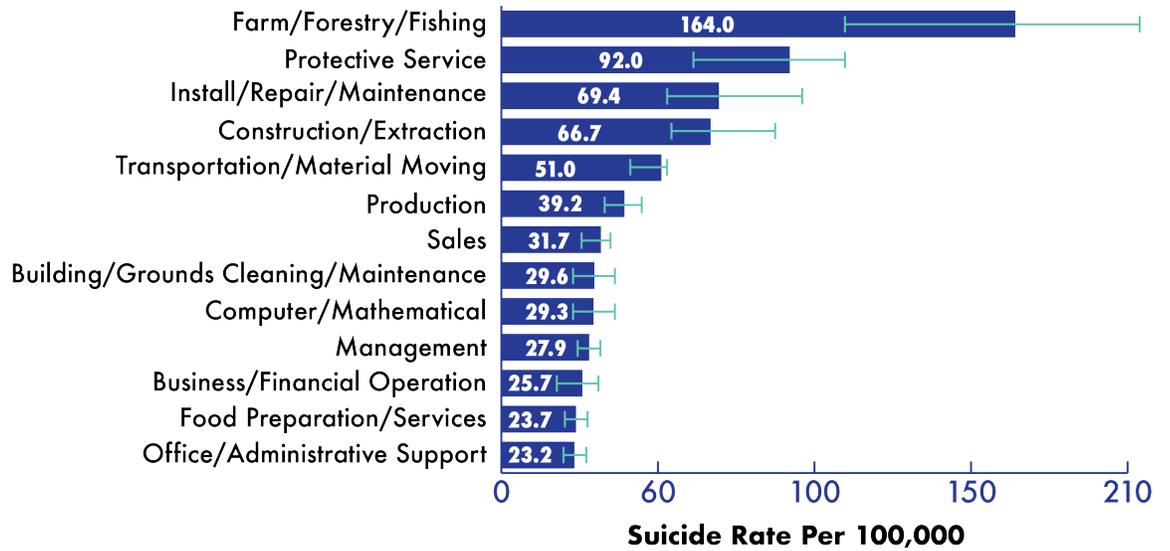
\*Death counts for each sex <5 not shown

Unpaid: Housewife, homemaker, student, disabled, volunteer, patient, inmate, or those without a job

Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

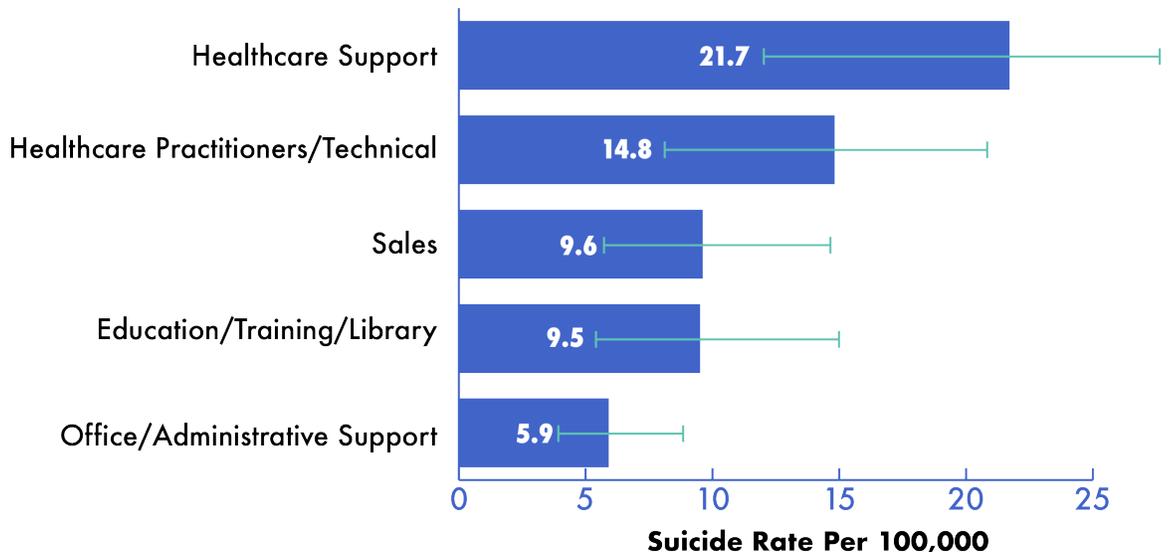
Unpaid and Military groups were excluded for male calculation due to the lack of denominators. Among Kansas civilian population 16 years and older, males in the farm, forest or fishing group had the highest suicide rate (164.0 per 100,000), except for males in the protective service group with a suicide rate of 92.0 per 100,000 (Data Table 7). For females, the suicide rate was the highest in healthcare support, 21.7 per 100,000, but it was not statistically different from others, except for the office and administrative support group, 5.9 per 100,000 (Data Table 8).

**Data Table 7. Crude Suicide Rate among Males by Occupation Group, Kansas 2015-2017**



Data Source: 2015-2017 Kansas Violent Reporting System (KSVDORS), Bureau of Health Promotion, KDHE

**Data Table 8. Crude Suicide Rate among Females by Occupation Group, Kansas 2015-2017**

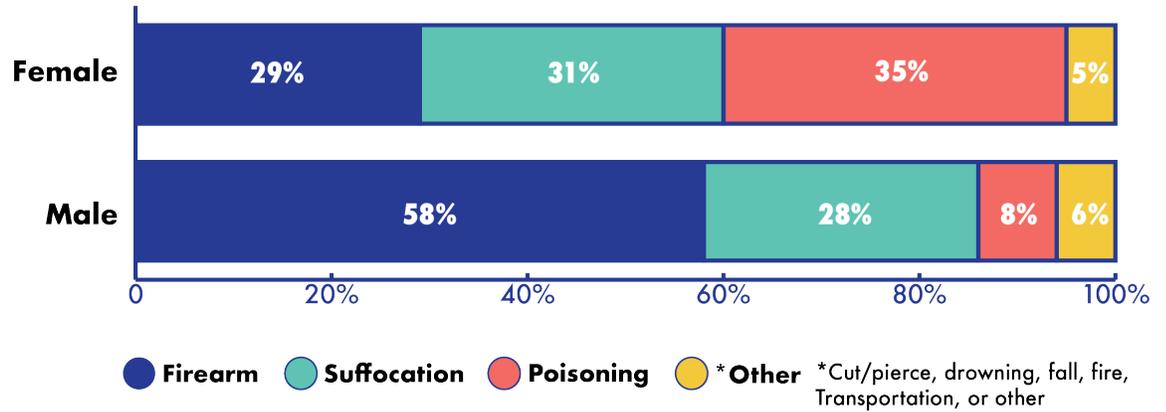


Data Source: 2015-2017 Kansas Violent Reporting System (KSVDORS), Bureau of Health Promotion, KDHE

## II. Cause of Death

The common mechanisms of suicide were firearms, suffocation or hanging, and poisoning or drug overdose. Firearms were more predominately used by males (58% versus 29%,  $p < 0.0001$ ), while poisoning and overdose were more common among females (35% versus 8%,  $p < 0.0001$ ) (Data Table 9).

**Data Table 9. Mechanism of Suicide by Sex Among Kansas Residents, 2015-2017**



Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

**Data Table 10. Number of Youth Suicide (10-18 years old) by Sex and Cause of Death**

Cause of Death	Male	Female
Firearm	34	*
Suffocation	18	13
Motor Vehicle and Poisoning	5	5

### Among youth suicide deaths (10-18 years old) (Table 3)

- 60% of young males died by firearm
- Most young females died by hanging or suffocation

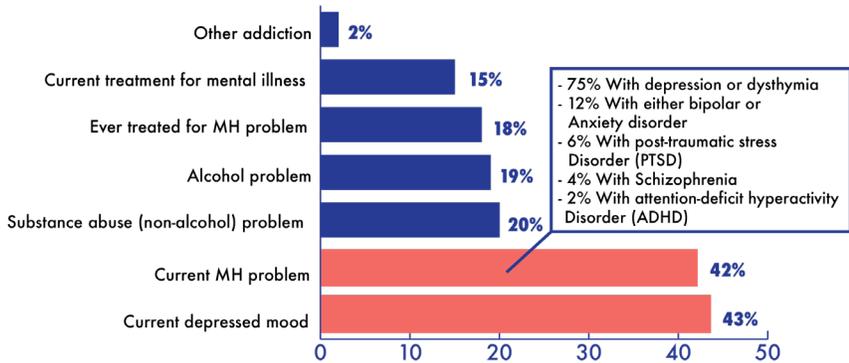
\*Death Count < 5 suppressed

Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

### III. Circumstances

Circumstances were known for 92.0% of suicide deaths (n=1,397) among Kansas residents from 2015-2017. The suicide circumstances are shown below by mental health and substance abuse, interpersonal, life stressor, and suicide-specific circumstances (Data Tables 11-14).

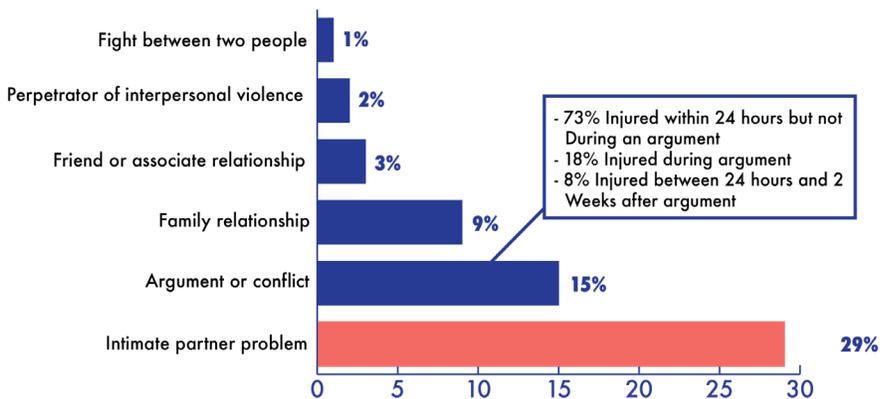
**Data Table 11. Percent of Suicide Deaths by Mental Health (MH) and Substance Abuse Circumstance among Kansas Residents, 2015-2017**



Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

About 2 in 5 had current depressed mood or mental health problems. About 1 in 5 of those who died by suicide had substance abuse, alcohol problems, or never received mental health treatment. Among people diagnosed with mental health problems, most (75%) had depression or dysthymia, and 12% had bipolar or anxiety disorder.

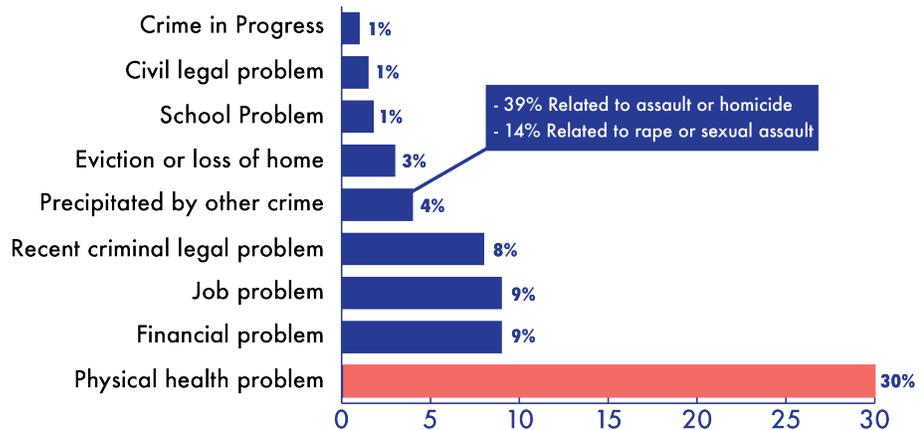
**Data Table 12. Percent of Suicide Deaths by Interpersonal Circumstance among Kansas Residents, 2015-2017**



Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

Among those who died by suicide, about 29% had intimate partner problems. Approximately 15% of suicide deaths was preceded by argument or conflict. Almost one on ten (9%) of suicide deaths had known family relationship problems. Among those preceded by argument or conflict, most (73%) were injured within 24 hours of but not during the argument.

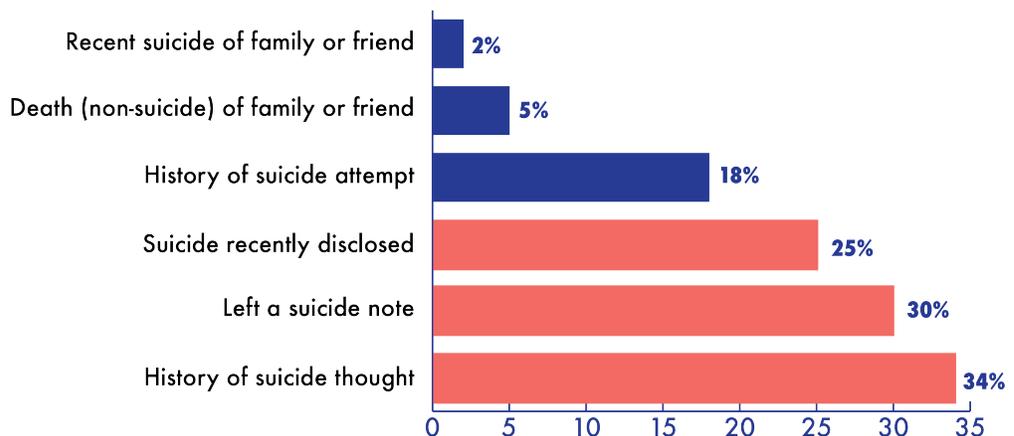
**Data Table 13. Percent of Suicide Deaths by Life Stressor Circumstances among Kansas Residents, 2015-2017**



Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

Physical health problems appeared to contribute to 30% of suicide death. About 1 in 10 suicide deaths was perpetrated by other crimes, 39% were related to assault or homicide, and 14% were related to rape or sexual assault.

**Data Table 14. Percent of Suicide Deaths by Suicide-Specific Circumstances Among Kansas Residents, 2015-2017**



Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

About 1 in 3 Kansas residents who died by suicide had thought about suicide in the past or left a suicide note, 25% had disclosed suicide intent recently, and 18% had previously attempted suicide.

Among those who disclosed suicide intent, 37% disclosed to a previous partner, 32% told other family members, 17% told friends or colleagues, 3% disclosed to their health care worker, neighbors, or healthcare worker and other person, and 10% informed other persons.

#### IV. Toxicology

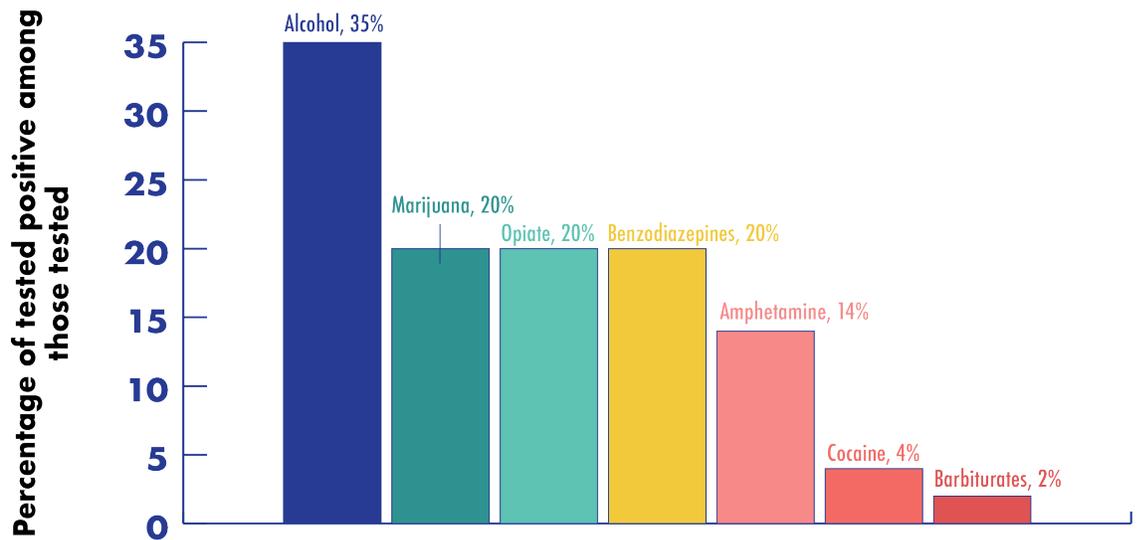
Toxicology reports were available for 77.9% of Kansas residents who died by suicide. Among those with toxicology screens, different substances were tested based on each situation. Because multiple substances usually contribute to suicide poisoning deaths, results from table 5 are not mutually exclusive.

More than 60% of those who died by suicide with toxicology reports were tested for alcohol, Marijuana, Opiates, Benzodiazepine, Amphetamine, Cocaine, and Barbiturates. Among this population (Data Table 15):

- Alcohol was present in 35% of those tested for alcohol.
- Among those tested for marijuana, Opiate, or Benzodiazepine, about 1 in 5 (20%) tested positive.
- Amphetamine was present in 14% of those tested for Amphetamine.
- Cocaine was present in 4% of those tested for cocaine.
- Barbiturates was present in 2% of those tested for Barbiturates.

Among suicide deaths tested for anticonvulsant or antipsychotic, about 45% tested positive, and as for antidepressant, more than half (56%) were tested positive. Muscle relaxant was present in 36% of those tested for muscle relaxant.

**Data table 15. Positive Toxicology Results for Suicide Deaths among Kansas Residents, 2015-2017**



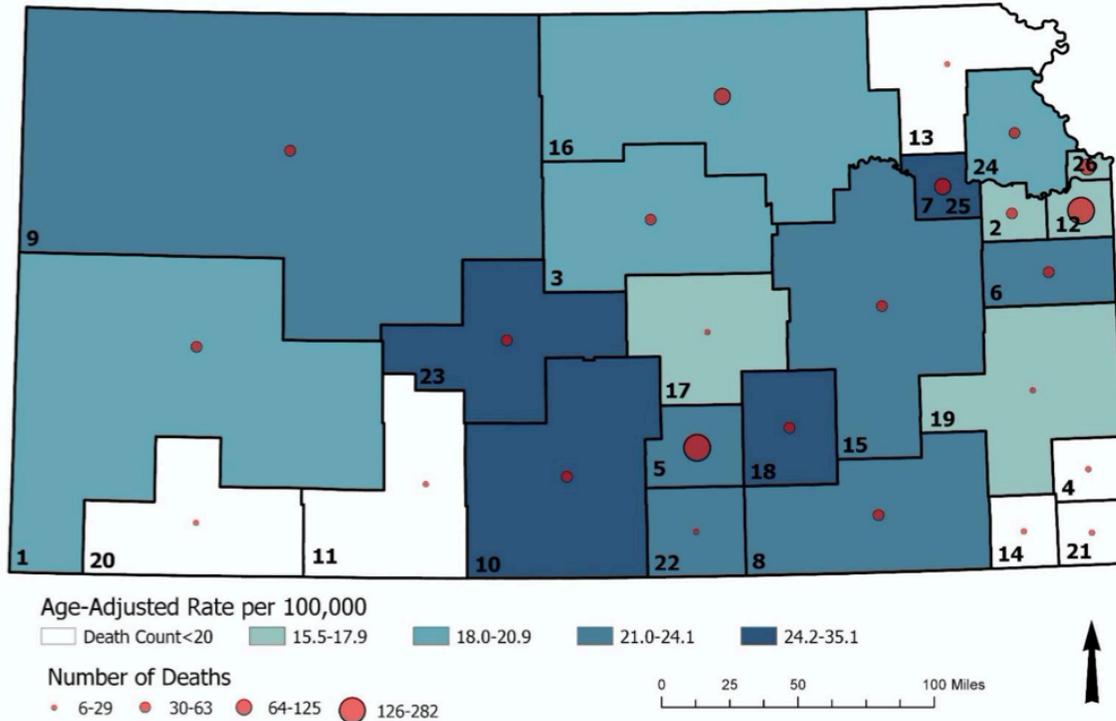
Data Source: 2015-2017 Kansas Violent Reporting System (KSVDRS), Bureau of Health Promotion, KDHE

The following map and table report data on suicide deaths among Kansas residents from 2015-2017. The age-adjusted suicide death rate is presented per 100,000, by community mental health center coverage areas (Data Table 16).

Data Table 16:

## Suicide Deaths among Kansas Residents, 2015-2017

by Community Mental Health Center Coverage Areas



Community Mental Health Center <sup>1</sup> (CMHC) Coverage Area	#	Age-Adjusted Death Rate <sup>2</sup>	Community Mental Health Center <sup>1</sup> (CMHC) Coverage Area	#	Age-Adjusted Death Rate <sup>2</sup>
01 Compass Behavioral Health	54	19.6 (14.3, 24.8)	14 Labette Center for Mental Health Services	17	*
02 Bert Nash CMHC Inc.	52	17.9 (12.8, 23.0)	15 CrossWinds Counseling & Wellness	44	21.3 (14.7, 28.0)
03 Central Kansas MHC	45	20.9 (14.7, 27.2)	16 Pawnee Mental Health Services	86	19.8 (15.4, 24.3)
04 CMHC of Crawford County	17	*	17 Prairie View, Inc.	29	15.5 (9.7, 21.4)
05 COMCARE of Sedgwick County	282	21.7 (19.2, 24.3)	18 South Central Mental Health Counseling Center Inc.	47	28.7 (20.4, 37.1)
06 Elizabeth Layton Center, Inc.	37	24.1 (16.1, 32.2)	19 Southeast Kansas MHC	26	16.2 (9.6, 22.7)
07 Family Service & Guidance Center	125	27.5 (22.6, 32.5)	20 Southwest Guidance Center	13	*
08 Four County MHC	47	22.3 (15.7, 29.0)	21 Spring River Mental Health & Wellness	6	*
09 High Plains MHC	60	22.2 (16.2, 28.2)	22 Sumner County MHC	12	*
10 Horizons MHC	63	27.0 (20.0, 34.0)	23 The Center for Counseling and Consultation	41	35.1 (23.9, 46.3)
11 Iroquois Center for Human Development Inc.	7	*	24 The Guidance Center Inc.	58	19.4 (14.3, 24.5)
12 Johnson County MHC	259	16.9 (14.8, 19.0)	25 Valeo Behavioral Healthcare	125	27.5 (22.6, 32.5)
13 Kanza Mental Health & Guidance Center	14	*	26 Wyandot Center for Community Behavioral Health Care Inc.	76	17.8 (13.7, 21.8)

\*Suppressed when death count <20.

<sup>1</sup>MHC from Kansas Department for Aging and Disability Services. <sup>2</sup>Age-adjusted death rate per 100,000 with 95% confidence interval, adjusted using the 2000 U.S. standard population. Data Source: 2015-2017 Kansas Violent Death Reporting System (KSVDRS), Bureau of Epidemiology and Public Health Informatics. Prepared by Yidan Pei, Kansas Department of Health and Environment, Mar. 2020

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## Appendix 6: Contributors

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